Adult Elective Orthopaedic Services: Clinical Delivery Model and Options Appraisal Process

*Partnership for Orthopaedic Excellence: North London*

Version 1.2
17 May 2019
**Section key**

This document uses colour coding for the proposed clinical delivery model criteria and non-financial options criteria so that they can be mapped to the relevant sections of the clinical delivery model.

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Navigating these documents
This paper contains a description of the clinical delivery model for adult elective orthopaedic services in north central London and a description of how the options appraisal process will be carried out by the clinical commissioning groups (CCGs).

Essentially the clinical delivery model sets out the commissioners’ requirements for a new adult elective orthopaedic service. The options appraisal is how commissioners will assess whether options put forward meet these requirements. Specifically:

- Section 6.1 of the Options Appraisal Process explains the weightings for each criterion that will be assessed
- Sections 6.1.1 to 6.1.4 of the Options Appraisal Process explains to providers the factors that will be taken into account in the scoring of options
- Section 6.2 of the Options Appraisal Process explains how the financial submission will be assessed
- Appendix 3 to the Options Appraisal Process is the document that providers are required to complete to set out their responses to the commissioners’ requirements
- Appendix 4 to the Options Appraisal Process is the document that providers are required to complete to explain the financial impact of their proposal.

Providers will be sent the clinical delivery model on Friday 17 May and given seven weeks to put forward submissions of options to become an elective orthopaedic centre. The deadline for receipt of responses will be noon on Friday 5 July.

Within the same timeline, all providers who will be a base hospital in the new arrangements will be asked to submit a more limited return to allow assessment of the system impact of proposals to be elective centres (the relevant sections are indicated in the submission of options form).
Clinical Delivery Model
1. Aims and objectives of the service

This document sets out a clinical delivery model for a networked model of care Partnership for Orthopaedic Excellence: North London with an ambition for an international reputation for high-quality patient outcomes and experience, education and research.

The objective is for this to be secured through:

- Excellent timely diagnostics and outpatient care, both pre- and post-operatively, at local base hospital sites, working seamlessly within local musculoskeletal (MSK) pathways, including both prevention and self-management
- Elective centre(s) which would provide at-scale delivery of consolidated, ring-fenced elective orthopaedic surgery with excellent perioperative care
- A focus on consistent excellent patient education and rehabilitation, pre-operatively and post-operatively
- Appropriate flows to a super specialist centre for the most complex patients who cannot be appropriately cared for in local or elective hospitals
- Improvement in the delivery of local trauma services, by separating the delivery of planned and emergency orthopaedic services, whilst maintaining a surgical workforce who provide both planned and emergency care to best practice standards.

1.1. Our vision

Our vision was set out in our draft case for change, published in August 2018.

Developed and validated through a series of clinical design workshops, our vision is to deliver services from dedicated state-of-the-art orthopaedic elective surgical centres (also known as cold, or hub, centres), separated from existing emergency departments and co-located with high dependency units (HDU), with the size and scale to enable a full spectrum elective offering and a robust rota. Trauma activity would be maintained at local hospital trusts. Freeing up beds and theatres would also be consistent in supporting the north central London (NCL) Sustainability and Transformation Partnership (STP) urgent and emergency care strategy and would make efficiencies as a natural consequence of these improvements; offering better value for money.

Through the network Partnership for Orthopaedic Excellence: North London, providers would work collaboratively to ensure that patients receive an optimum patient experience. In addition, providers would adopt a business model which ensures the financial and other benefits of consolidation are shared between all providers and commissioners, rather than creating ‘winners and losers’.

The key design principles generated through clinical engagement and approved by the five north central London CCGs’ joint commissioning committee in December 2018 are set out in table 1.
Table 1: Key design principles

- **Differentiation of levels or tiers of service** at different hospitals.
  - Incorporated into the model

- **Partnership approach** with all hospitals being seen as ‘base hospitals’ with a stake in an elective centre.
  - Incorporated into the model

- **Staffing model** with clinical staff working into the unit from the base hospitals, particularly surgeons following the patient to the elective centre and providing continuity of care.
  - Incorporated into the model

- **Development of common standards and pathways approach**, overseen by a clinical network with a standard set of outcomes to which all organisations must adhere and are used to measure success with clinical governance/oversight.
  - Incorporated into the model

- All **outpatient care**, pre- and post-operatively, to stay at base hospitals (i.e. as at present).
  - Incorporated into the model

- Elective procedures on **children and most adolescents** (under 18 years of age); trauma; and spinal surgery to stay at base hospitals (i.e. as at present). For children’s procedures, the base hospital would act as a filter, with complex referrals continuing to go to Great Ormond Street Hospital (GOSH) and the Royal National Orthopaedic Hospital (RNOH).
  - Incorporated into the model

- **Care-coordination function** (navigators) to work across base hospitals and elective centre(s), with a particular focus on patients with vulnerabilities.
  - Incorporated into the model

- **Multi-disciplinary team working** to be a core component of the model. The clinical network would develop expectations about how this would operate. It is noted that there should be opportunities to do some of this virtually.
  - Incorporated into the model

- **High-dependency capability** — the elective centre needs to be able to manage a range of conditions and complexity; to do this they will require appropriate back-up medical services and step-up care.
  - Incorporated into the model
2. **Levels/tiers of service**

In north central London we want to move to a three-tiered model of hospital provision for adult elective orthopaedic services.

<table>
<thead>
<tr>
<th>Base hospitals</th>
<th>Elective orthopaedic centres</th>
<th>Super specialist hospital</th>
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<tbody>
<tr>
<td>Support the operation of the elective orthopaedic centres as part of a clinical network, manage outpatients and post-operative follow-up, some day-cases and all trauma care alongside an accident and emergency department.</td>
<td>Able to undertake a mixture of some complex and all routine elective activity. Able to treat medically complex, as well as some orthopedically complex, patients with appropriate back up medical services and step-up care. This activity is (mostly) commissioned by local clinical commissioning groups, although some will sit with NHS England’s (NHSE) Specialised Commissioning.</td>
<td>Undertake only tertiary and complex patients that cannot be appropriately cared for in local or elective hospitals. This activity is (mostly) commissioned by NHS England with a national catchment area and would be fulfilled by the Royal National Orthopaedic Hospital NHS Trust (RNOH) in Stanmore. This super specialist work does not form part of this review.</td>
</tr>
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</table>

The overarching principle of this model of care is that orthopaedic surgeons will remain employed by their existing base hospital with a job-plan including both programmed activities covering elective and emergency care. For surgeons at base hospitals, their current elective surgical commitments would move with them to the elective centre.

3. **Number of elective centres**

The clinical delivery model is not prescriptive about the number of elective orthopaedic centres required in north central London. This process may determine that there should be more than one elective centre. If this is the case, each centre may manage different levels of medical and orthopaedic complexity.

4. **The patient pathway**

Our aim is to develop world class orthopaedic services in north central London, bound together through a clinical network Partnership for Orthopaedic Excellence: North London. These would deliver excellent patient outcomes and reflect the highest levels of productivity, so that patients who require surgery receive a high-quality service with the minimum possible wait.

The elective centre(s) would form part of the wider provision of elective orthopaedic care in NCL and would be a collaborative arrangement between hospital trusts. Patients would initially be seen at their local or base hospital before receiving treatment at an elective
centre. The elective centre(s) would have ‘ring-fenced’ theatres and beds to minimise the risk of cancellations. Following treatment, patients would return to their usual setting of care and receive follow-up appointments and rehabilitation at their local base hospital or in the community.

Figure 1 provides a high-level view of the envisaged pathway, how an elective centre could work with base hospitals, and how patients could get their care delivered between base hospitals and the elective centre for outpatients, treatment and rehabilitation.
Figure 1: High-level pathway view
5. Overarching model of care

Providers of orthopaedic care, working within the clinical network Partnership for Orthopaedic Excellence: North London, will work with primary and community care to ensure an optimal end-to-end pathway for all patients requiring access to musculoskeletal (MSK) services, ensuring that there is a suitable clinical pathway for everyone referred into the system.

5.1. Links with the community MSK pathway

Base hospitals will need to work with their local MSK services to take referrals via established primary and community care routes (single point of access, first contact practitioners and referral management centres).

5.2. Accessing the elective centre

Transfers to the elective centre will be made via a patient’s base hospital in line with protocols agreed by the clinical orthopaedic network, Partnership for Orthopaedic Excellence: North London.

5.3. Acceptance and exclusion criteria

It is expected that each local hospital will transfer patients in a timely manner to the elective centre(s), in order to allow the 18-weeks' target of referral to treatment to be met. Referrals must be in line with evidence-based thresholds of care. Arrangements for referral targets and waiting times, including maximum transfer times, will be agreed through the orthopaedic clinical network. Any breach of patient access targets will be required to be reported through the appropriate commissioner arrangements.
6. Defining the new service model

There are a number of essential requirements, which will be assessed as part of Criterion 1 – fit with the clinical delivery model within the options appraisal process.

Table 2: Essential criteria

<table>
<thead>
<tr>
<th>Essential criteria</th>
<th>Essential</th>
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<tbody>
<tr>
<td>Each elective centre must deliver a minimum of 4,000 procedures a year(^1) (both inpatient spells and day-cases).</td>
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<tr>
<td>A defined ward (or wards) for elective orthopaedic patients with ring-fenced orthopaedic beds(^2) and associated staffing (either in a separate building or equivalent ring-fenced facility) must be provided.</td>
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<tr>
<td>A dedicated ultra clean air theatre suite designed specifically to meet the needs of orthopaedic surgery with appropriately trained orthopaedic theatre staff must be provided, with capability to operate six or seven days per week, with three sessions per day.</td>
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<tr>
<td>Appropriate post-operative high dependency care must be provided, level two as a minimum.</td>
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<tr>
<td>Providers need to demonstrate the level 3 arrangements to manage deteriorating or complex patients who require intensive care support for a short period of time(^3).</td>
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<tr>
<td>Arrangements for appropriate overnight medical cover, at sufficient seniority supported by on-call arrangements (both medical and surgical), to enable the safe care of medically complex patients must be provided.</td>
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</table>

There are also a number of essential clinical requirements (table 3) which will need to be co-located with the elective centre, which all options will need to meet. These will also be assessed under Criterion 1 of the options appraisal.

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1 As set out in the draft case for change (August 2018) the review of literature evidenced that international centres of excellence with high quality outcomes conduct a minimum of 4,000 procedures a year for each site.

2 The Getting it Right First Time report (2012) confirms that a genuine elective orthopaedic ring-fence that is rigidly enforced is essential if best outcomes are to be achieved. If there is a breach of any kind – including supposedly ‘clean’ surgical patients – of the ring-fence, then surgeons are advised to cancel their lists and require that the ward is closed and deep cleaned before joint replacement can begin again. It is worth remembering that when infections do occur, as is more likely in a non-ringed circumstance, it is necessary to go through the same deep clean procedures.

3 Level 2 – High Dependency Unit (HDU). Patients needing single organ support (excluding medical ventilation) such as renal haemofiltration or ionotropes and invasive BP monitoring. They are staffed one nurse to two patients. Level 3 – intensive care, patients requiring two or more organ support (or needing mechanical ventilation alone). Staffed with one nurse per patient and usually with a doctor present in the unit, 24 hours per day.
### Table 3: Essential clinical requirements

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Essential</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adherence to safety standards as judged by prevailing standards</td>
<td></td>
</tr>
<tr>
<td>Deteriorating patients’ protocols</td>
<td></td>
</tr>
<tr>
<td>Compliance with NHS England Specialised Commissioning service specifications (case mix dependent)⁴</td>
<td></td>
</tr>
<tr>
<td>All surgical consultants and associate specialists have the required expertise</td>
<td></td>
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<tr>
<td>Specialist nursing</td>
<td></td>
</tr>
<tr>
<td>Theatre inventory of appropriate equipment and a resilient supply chain and decontamination arrangements</td>
<td></td>
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<tr>
<td>Theatre inventory of implant components</td>
<td></td>
</tr>
<tr>
<td>Transfusion service</td>
<td></td>
</tr>
<tr>
<td>Infection control services</td>
<td></td>
</tr>
<tr>
<td>Anaesthetists – specialising in orthopaedic care</td>
<td></td>
</tr>
<tr>
<td>Other standard hospital support services applicable to any elective site</td>
<td></td>
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</tbody>
</table>

There is also a range of other essential services, including support services, which we believe are required to be **accessible on-site of the elective centre but not necessarily to be co-located** (table 4).

### Table 4: Essential services not required to be co-located

<table>
<thead>
<tr>
<th>Service</th>
<th>Essential</th>
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<tbody>
<tr>
<td>Access to musculoskeletal radiology, including access to CT and MRI scanning equipment</td>
<td></td>
</tr>
<tr>
<td>Mental health – psychiatry</td>
<td></td>
</tr>
<tr>
<td>Plastic surgery (part of the multi-disciplinary team available to support elective surgery, generally will be required on a planned rather than emergency basis)</td>
<td></td>
</tr>
<tr>
<td>Vascular surgery (immediate telephone advice and on-site support must be available within one hour of a request)</td>
<td></td>
</tr>
<tr>
<td>Medical support services (incorporating a range of general medical and medical subspecialties) – e.g. cardiology, neurology, diabetes, infectious diseases, care of the elderly</td>
<td></td>
</tr>
<tr>
<td>Clinical support services – e.g. pathology, nuclear medicine, interventional radiology, microbiology</td>
<td></td>
</tr>
</tbody>
</table>

⁴ NHS standard contract for Major Trauma service (all ages)
NHS standard contract for specialised orthopaedics (adult)
Finally, there are a number of features for innovation where within the essential requirements we are looking for providers to describe their vision for delivery (table 5).

**Table 5: Features for innovation**

- **Intensive rehabilitation support** for patients during their in-patient stay – seven day a week service with extended hours. Presumption should be that patients are mobilised on the day of surgery (unless clinically inappropriate).

- **Clinical governance** – providers will need to set out their proposed clinical governance structure for the elective centre. Specifically:
  - How clinical governance and accountability will sit within the host organisation, particularly the role of the medical director;
  - How clinical governance will operate in a partnership arrangement between two or more providers;
  - How the elective centre will work with base hospitals to ensure robust clinical governance arrangements, particularly tracking of readmissions and serious incidents (SIs); and
  - How patients will be involved in the clinical governance arrangements.

- **Multi-disciplinary team (MDT) working.** As part of the clinical orthopaedic network **Partnership for Orthopaedic Excellence: North London**, the intention is to establish MDT working across the elective centre, base hospitals and super specialist centre.

  Providers are asked to set out how they would envisage the elective centre working within the overarching governance of the clinical network (particularly if there is more than one centre) to ensure consistency of clinical practice and patient experience, and a clear sense that the elective centre is part of the delivery of a unified approach to elective orthopaedic care.

  **See section 12: Orthopaedic clinical network.**

- **Care coordination.** There will be a need for a defined team to manage discharge at the elective centre (including equipment needs). The team would have a particular focus on patients with vulnerabilities or those with complex needs (non-medical). They would also:
  - Follow-up with the base-hospital to ensure that there is continuity and appropriate ongoing patient care in the community.

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Providers to explain this in Section 3 of the submission of options document

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Providers to explain this in Section 3 of the submission of options document
• Have access to step-down facilities (if required)
• Have effective links to social care to support discharge
• Ensure that the discharge to assess team and protocols were in place (as required).
• Ensure an emphasis on rehabilitation and reablement, be more explicit about taking a more strengths-based approach with patients, maximising opportunities for independence, including assistive technology as well as equipment.

**Pre-operative assessment.** To be owned by the elective centre as an important part of the consent process and to ensure consistency of practice which would prevent on-the-day surgical cancellations. Pre-operative assessment protocols to enable standardised practice across the network, **Partnership for Orthopaedic Excellence: North London.**

Options include:

- **Base hospitals to identify complex patients who will require a more in-depth anaesthetist managed pre-operative assessment**
- **Digital solutions to enable base hospitals to start the pre-operative process, against an agreed protocol, to enable screening tests needed prior to surgery e.g. an echocardiogram, to be in place at the base hospital and take place there prior to onward referral to the elective centre**
- **Providers to consider whether they want to deliver an outreach model with pre-operative assessment delivered by the elective centre across a variety of sites, including base hospitals.**

**Patient education**

To be delivered to a consistent model developed by the orthopaedic clinical network **Partnership for Orthopaedic Excellence: North London** with standardised core materials, including a website.

Face-to-face patient education to be managed by the elective centre, although could be across a range of sites (including base hospitals). To include consistent pre-habilitation assessment and support; joint school for hip and knee replacements; and pre-operative patient education materials to be developed for the full range of orthopaedic procedures.

**Clinical case-mix**

In their submission, providers are asked to set out their expectations in terms of the case mix they could safely manage at the proposed centre that would meet all relevant safety standards.

This should include which day-case procedures they would manage at the elective centre and which would take place at base hospitals. These assumptions would need to be modelled into the supporting activity and financial proposal.
Medical complexity

As previously set out, it is expected that the elective centre(s) would be able to undertake procedures on medically complex patients, with appropriate back-up medical services and step-up care.

Providers are asked to set out their assumptions in terms of any specific cohorts of patients that they feel could not be managed in the elective centre and these assumptions would need to be modelled into the supporting activity and financial proposal. For instance, practice elsewhere would suggest that sickle cell or haemophiliac patients would need to be treated at specialist units which may not necessarily be an elective unit.

7. Interdependent services

Providers putting forward proposals to become an elective orthopaedic centre will be assessed on how interdependent services will be impacted by the establishment of a new model of care. To do this all providers within the system, including those that will remain as a base hospital but are not putting forward a proposal to be an elective centre, will be asked to provide information as part of the submission of options process. The assessment of criterion 4 (impact on other services) will include an assessment of the capacity requirements remaining at base hospital sites for dependent services (e.g. paediatrics, spinal surgery and trauma).

Table 6: Interdependencies

Paediatrics and adolescents (under 18 years of age)

- Base hospitals would act as a filter through to specialist paediatric and adolescent orthopaedic surgery at specialist tertiary centres (GOSH and RNOH)
- For the small numbers of patients having surgery at base hospitals, as at present – base hospitals need to demonstrate separate list arrangements (cohorting on adult trauma lists should not be the practice); surgeons with appropriate skill set; and appropriate paediatric aftercare.

Trauma

Central to the model is the continuation of high-quality non-elective adult orthopaedic services and trauma services (including fractured neck of femur services) at all base hospital sites.

- Base hospitals designated as trauma units would continue to meet the service specification including the provision of operating theatre access and in-house rotas. Specifically:
  i) Modelled theatre and ring-fenced bed requirements to manage current and projected trauma workload
  ii) Management of trauma on-call arrangements to ensure full cover; and consideration to whether job-plans would need to be reviewed to formalise any non-job planned activities that
currently take place as a result of the co-location of trauma and elective surgery

- **Major trauma – out of scope**: delivered via existing designated sites (St Mary’s and The Royal London).
- Robustness of the proposed base hospital arrangements to be tested by the trauma network as part of the assessment process.

### Spinal surgery

- Spinal surgery is not included within the planned scope of the elective orthopaedic centre, although a base hospital which is also an elective centre could elect to manage their own spinal activity through the elective centre.
- Base hospitals need to demonstrate that they have modelled their theatre and ring-fenced bed requirements to manage their current and projected spinal workload.
- Specialist and tertiary spinal surgery to be provided at RNOH and National Hospital for Neurology and Neurosurgery. Spinal surgery is also provided by Whittington Health NHS Trust and the Royal Free London NHS Foundation Trust (on both the Chase Farm and Barnet hospital sites).
- Robustness of the proposed base hospital arrangements and proposed capacity to be tested by the spinal network as part of the assessment process.

### Base hospital services

- Outpatient adult orthopaedic services.
- Access to MSK radiology, including access to CT and MRI scanning equipment.
- Contribution to the early pre-assessment screening using protocols agreed by the clinical network, **Partnership for Orthopaedic Excellent: North London**.
- Rehabilitation service including physiotherapists and occupational therapists.
- Emergency follow-up for post-surgical complications (e.g. infections or dislocations) for all patients treated on both emergency and elective pathways.

### Community and primary care orthopaedic services

- MSK single point of access.
- First contract practitioners.
- Direct access physiotherapy.
- Community physiotherapy, OT and nursing services.
8. Enablers

Table 7: Transport

Appropriate transport arrangements (for those meeting eligibility criteria) are vital for patients with vulnerabilities and also the efficiency of the elective centre. Providers are asked to describe how they will manage transport arrangements for patients meeting eligibility thresholds.

Table 8: Digital

- There are significant opportunities across the orthopaedic network Partnership for Orthopaedic Excellence: North London to look to digital integration of systems to support a new model of care, particularly by sharing information across the whole care pathway, joining up pre-operative assessment and sharing images. Scoping work has started on this and will continue through the clinical network in conjunction with the NCL digital programme
- Providers should ensure that their level of digital maturity would support interoperability with disparate systems across the North London Partners (NLP) digital footprint and further the London-wide digital footprint. The items below are needed as a minimum to integrate with the Health Information Exchange (HIE) and the planned centralised image exchange for London
- All provider systems must be able to provide data using HIE standards such as (HL7, FHIR) to enable real-time integration with their electronic patient record (EPR) or their trust integration engine. Where this is not possible the provider should be able to provide the data in near real-time utilising batch files from their data warehouse
- An agreed minimum dataset from all participating care providers in the orthopaedic pathway would be needed in digital format. The data needs to be coded data or in a structured format
- All providers involved in the care pathway would utilise the patients NHS number as their primary identifier. To this end, all providers should ensure that they have at least 80% spine compliance with their NHS numbers. This would ensure appropriate linking of patient’s records from multiple sources
- Providers should demonstrate how they would support electronic workflow for patients on the pathway
- All systems must be on the N3/HSCN network or equivalent to enable connectivity
To enable image sharing HIE profiles, such as the reporting workflow (RWF) and the image exchange (XDSi), should be supported. This would facilitate linking up radiology events and PACS imaging.

Providers PACS and RIS managers or vendors should be able to facilitate historical data on boarding by triggering the publication information of documents and images onto the One London Central HUB platform for an agreed period of time.

Provider systems should utilise SNOMED/NICIP as the standard vocabulary used for metadata.

9. Workforce

It is expected that providers would propose a workforce model to support and meet the needs of a new service model for elective orthopaedic care in north central London.

Table 9: Workforce plan

The workforce plan set out by providers should detail how the workforce would be developed to ensure:

- The roles at elective centre(s) are in place
- The key principles (set out below) would be met
- NLP STP workforce programme alignment will be achieved.

In addition, providers are asked to evidence how the workforce plan would ensure that:

- The relevant essential requirements are met, i.e. how staffing would be identified and established to provide a defined ward for elective orthopaedic patients
- The relevant essential clinical requirements are met, i.e. provision of specialist nursing workforce
- The relevant essential services would be delivered, i.e. how staffing would be identified and/or established to provide vascular surgery support
- The relevant interdependent services are provided.

In proposing a workforce plan that would meet the above requirements, providers should also consider how they would:

- Develop and use new roles within the workforce
- Leverage the opportunity that portability of expert staff between organisations and locations would offer
- Address issues of workforce supply and turnover.

The workforce plan should include how providers will:

- Adopt the appropriate and relevant north central London workforce policies including the NCL recruitment and selection policy which will enable future staff sharing across sites.
• Ensure retention and recruitment of the workforce, particularly in light of national and acute local shortages of clinical staff – these strategies will also need to demonstrate alignment and integration with the NCL workforce programme projects in these areas
• Consider the appropriate use of new and emerging roles (and provision of training for) roles such as, trainee nurse associates (TNAs), advanced clinical practitioners (ACPs) and physician associates (PAs)
• Align and integrate with NCL workforce programme projects focusing on reducing use of bank and agency staff
• Consider the deployment of staff to maximise efficiency and staff experience, and outline how they will support development of, and use, key portability options such as the NCL employment license and NCL Mandatory and Statutory Training (MaST) work (amongst others)
• Outline plans to ensure a favourable experience for staff of working in the new service.

9.1. Key principles

The overarching principle is that the current elective surgical commitments of surgeons at base hospitals will move with them to the elective centre. Surgeons will remain employed by the base hospital, with a job-plan that includes both elective and emergency commitments.

Providers may wish to refer to the South west London elective orthopaedic centre (SWLEOC) model of staffing as a starting point for their thinking. This includes a core team of nursing and anaesthetic staff at the centre, servicing the needs of orthopaedic surgeons from the base hospitals working at the centre. However, any model should clearly evidence how it has been designed and developed to deliver the specific needs and unique challenges of NCL.

There a number of key expectations around the management and engagement of the workforce:

• Providers will be asked to set out how they would manage demand and capacity modelling and job planning across the elective centre and base hospital; this would include a key focus on how e-rostering and e-job planning will be deployed to effectively manage the workforce across this to ensure that trauma capacity and capability at the base hospitals is not undermined
• Table 10 provides an example of the dedicated orthopaedic team expected to be based at the elective centre and the staff who should be available. Providers should use this as a guide when determining their workforce proposals, including skill mix and capacity to be provided at different times (to be specified) across the extended service
• Orthopaedic surgeons would continue to be employed by the base hospitals and would be expected to have job plans that include outpatients, trauma lists and on-call
arrangements at the base hospital site, alongside planned elective work at the elective centre

- NCL has particular workforce challenges regarding cost of living and acute shortages of professional staff (including middle-grade doctors and nurses), as well as staff in lower paid roles; this will mean that providers would need to detail the plans and infrastructure they have and would put in place to address these challenges. This would include minimising use of bank and agency staff and how they would ensure maximum fill rates when such staff are deployed

- Depending on the range of services provided from the centre, there may be a need to provide specialist teams to deliver the appropriate standard of care. These may be employed by the centre or drawn from base hospitals. The provider should detail their planned solution(s) to this, and outline steps to be taken to establish agreements and relationships with partner organisations to provide these solutions

- Given the partnership approach with all base hospitals having a stake in an elective centre, orthopaedic surgeons would work across two sites. A proportion (to be determined by providers) of providers’ additional staff would also work across two sites

- Providers are expected to demonstrate how they will limit the need for teams and individuals to work across more than three sites as this could have a detrimental on patient and staff experience

- Providers should consider how they might deploy their staff to maximise efficiency and staff experience; including travel and London weighting considerations, as well as the adoption of NCL approaches such as:
  - Bilateral provider agreement(s) to share staff
  - ‘Passporting’ of specified staff to work throughout clinical pathways and follow the patient
  - Recognition of other providers’ training – as a minimum MaST and other clinical training (to be specified by providers).

**Table 10: Roles at the elective centre**

**Clinical leadership structure** for the elective centre, including a medical director.

**Managerial leadership structure** for the elective centre.

** Appropriately established and staffed HDU and peri-operative care on-site** to enable the safe care of medically complex as well as orthopedically complex patients.

**Arrangements for appropriate and fully staffed overnight medical cover**, including HDU, at sufficient seniority supported by on-call arrangements (both medical and surgical), to enable the safe care of medically complex patients.

**Orthopaedic trainees** – the centre would operate on the principle that trainees would continue to be aligned to the base hospitals. Trainees would follow their training consultant to the elective centre on their consultant’s operating days to get their required exposure to elective cases. The presumption is the elective centre would function without any reliance on overnight or ward-based support from trainees.
**Experienced anaesthetists in post** – consultant anaesthetists, junior grade anaesthetists, potentially further anaesthetist to cover anaesthetic issues

Providers need to describe the model which is envisaged:

- **Pure model** where all anaesthetic support is provided by the staff working exclusively at the elective centre; or
- **Hybrid-model** where some anaesthetic support is provided by clinicians from the base hospital carrying out planned sessions in the centre.

**Nursing staff** – theatre coordinator/sister, scrub nurses, staff nurses, recovery nurses, anaesthetic nurses.

**Medicines management support** in post – including specialist pharmacists.

Experienced **musculoskeletal radiologists**.

Experienced physiotherapists, occupational therapists, radiographers and other **allied health professionals** – offering a seven-day, extended hours service.

**Infectious disease consultant** cover.

**Administrative and clerical staff.**

**Pathway co-ordinator**/care navigation function to work across the elective centre and all feeder base hospital, with a particular focus on patients with vulnerabilities who may find it more difficult to navigate the pathway (these roles can draw on models developed for primary care).

**Business support** – finance, HR, IT, procurement, logistics.

**10. Teaching, training, education and research**

A driving principle of the review is that the proposed workforce models at base sites, elective centre(s), and super specialist centres, provide sufficient volume and opportunities for the teaching, training and education of key clinical staff including therapists, nurses and doctors. It is also anticipated that the elective centre(s) would have sufficient volumes to take part in research trials and forge significant and formal academic links with appropriate academic partners.

A further key principle of developing orthopaedic elective centre(s) focuses on developing research and education, particularly for complex procedures. Through this approach, providers would improve capacity in this field nationally, become eligible to join the International Society of Orthopaedic Centers (www.isocweb.org), and provide specialist training for a new generation of doctors and allied health workers.

Trauma and orthopaedic education and training is a key dependency whose implications need to be worked through in a collaborative way as part of the development and
implementation of a new clinical delivery model. With regards to doctors in training, as in the SWLEOC model, the model is based on the principle that doctors in training would continue to be aligned to the base hospitals. Doctors in training should then follow their consultant to the elective centre on their consultant’s operating days to get their required exposure to elective cases.

This is likely to present challenges with regards to rota management and service provision that should be addressed in detail within any education and training plan provided by providers. However, the model should also offer significant opportunities for training and education through access to this range of activities and procedures and increases the benefits for doctors working within this model.

It is also anticipated that therapists and nursing staff would also have increased opportunities for intra organisational rotations and training and development.

Table 11: Teaching, training and education

The education, training and research plan that is requested from providers must include how they would contribute to relevant continuing professional development, education and training, including:

- How education and training capacity/capability/governance is built into the options which they are putting forward for consideration
- Show how, for clinical staff at the elective centre and the base hospital, they would contribute to support orthopaedic education and training across other NCL providers as part of the development of integrated care arrangements
- Show how they would conduct and exhibit a commitment to clinical research, specifically:
  - Function as an academic centre (i.e. has residents or fellows in training)
  - Five peer-reviewed publications in top 10 journals per year as a minimum.

11. Financial and activity modelling

11.1. Financial principles

It is expected that activity would be shared across hospitals with the elective orthopaedic centre(s). It is therefore important, in order to mitigate the risk of financial ‘winners and losers’ that all providers accessing the centre(s) agree, alongside clinical commissioners, to a shared set of financial principles.\(^5\)

As agreed by the Joint Commissioning Committee at its January 2019 meeting, the contract form for the elective centre would be via amendments to existing NHS contracts. Within this

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\(^5\) The methodology described for assessing the financial impact on the health system has been written on the basis that Payment by Results continues to be the framework by which money moves around the system and all organisations are held to account for separate control targets. We appreciate that this system is changing; PbR is likely to be replaced and system-wide control targets will be introduced. As the new framework becomes clearer the methodology for assessing the financial impact of each option may need to change. However, commissioners will continue to concentrate upon the changes to the cost of the whole system, the efficiencies generated and the impact on legacy services.
overriding principle, providers are asked to set out the detail of how they would manage a partnership agreement between the elective centre and base hospitals.

Providers are asked to submit their proposals on the financial model based on the following principles:

- The provider hosting the elective centre will be responsible for the building and the staff that support the centre
- The financial operation of the elective centre will be overseen by a board made up of representatives of the participating providers. The arrangements of the board will be set out in a partnership agreement between the participating organisations. The financial risks and rewards of the elective centre will be shared between the participating organisations according to the terms of the partnership agreement and proportionate to the use of the elective centre
- In the event that a multi-centre solution is the preferred option, there will need to be a decision with participating organisations about whether there is a single board and partnership agreement or separate arrangements covering each proposed elective centre
- The introduction of the elective centre will be cost-neutral to commissioners.

**In south west London, this financial model has been successfully put in place.**

Unless providers have strong views to the contrary, we intend to replicate this model in north central London and providers should assume that Payment by Results (PbR) applies to elective orthopaedics in the following way:

- Initially referrals are made to orthopaedic surgeons working in a base hospital. The base hospital undertakes diagnostic and assessments that generate outpatient payment by results income as it does at the moment
- Surgeons are employed by the base hospital, with a job-plan that includes both elective and emergency commitments
- The base hospital refers the patient to the host provider, and PbR income for the inpatient episode is paid to the host provider
- The elective centre reimburses the base provider for an agreed number of sessions provided by each orthopaedic surgeon plus a share of the margin
- Follow-up outpatients will take place at the base hospital with an appropriate outpatient PbR income.

**11.2. Volume and capacity**

NCL covers a population of approximately 1.52 million people of which approximately 7,840 undergo an elective orthopaedic procedure each year at one of the five NCL provider trusts. In addition, approximately 14,500 patients from outside NCL choose to have procedures within NCL, and a further 980 NCL patients are treated in independent sector hospitals. The elective orthopaedic centres would cover all patients who are within clinical scope and who choose to use them.

The following tables set out current and anticipated volumes of elective orthopaedic activity over the next five years (split between day-cases and in-patient procedures). In all cases, the baseline activity is the recorded activity for year 2017; adjusted for the changes at The Royal Free Hospital NHS Foundation Trust, where much of the orthopaedic activity has moved from the Barnet Hospital and Royal Free Hospital sites to the new elective centre at Chase Farm Hospital.
Table 12: Baseline activity and forecast activity for 2023

<table>
<thead>
<tr>
<th>Episodes</th>
<th>Baseline Activity</th>
<th>Projected 2023 Activity</th>
<th>% Change in Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Day Cases</td>
<td>Elective Inpatients</td>
<td>Total Activity</td>
</tr>
<tr>
<td>North Middlesex Hospital</td>
<td>2,486</td>
<td>425</td>
<td>2,911</td>
</tr>
<tr>
<td>Chase Farm Hospital</td>
<td>2,160</td>
<td>1,746</td>
<td>3,636</td>
</tr>
<tr>
<td>Barnet Hospital</td>
<td>10</td>
<td>143</td>
<td>153</td>
</tr>
<tr>
<td>Royal Free Hospital</td>
<td>190</td>
<td>244</td>
<td>434</td>
</tr>
<tr>
<td>The Whittington Hospital</td>
<td>1,425</td>
<td>624</td>
<td>2,050</td>
</tr>
<tr>
<td>University College Hospital</td>
<td>2,046</td>
<td>1,312</td>
<td>3,359</td>
</tr>
<tr>
<td>Sub-Total</td>
<td>8,318</td>
<td>4,234</td>
<td>12,552</td>
</tr>
<tr>
<td>The Royal National Orthopaedic Hospital</td>
<td>5,734</td>
<td>5,445</td>
<td>11,179</td>
</tr>
<tr>
<td>Sub-Total</td>
<td>14,052</td>
<td>9,669</td>
<td>23,721</td>
</tr>
<tr>
<td>Independent Hospitals</td>
<td>769</td>
<td>366</td>
<td>1,135</td>
</tr>
<tr>
<td>Total</td>
<td>14,821</td>
<td>10,035</td>
<td>24,866</td>
</tr>
</tbody>
</table>

Table 12 shows that demand for orthopaedic surgery is anticipated to increase by 2.2% (average 0.38% per annum) although the increase is not consistent across the area. This estimate takes account of the demands of a growing and ageing population, together with published commissioner clinical plans and evidence-based thresholds of care.

In table 13, we have made some assumptions about how much of the activity shown in table 12 might be treated in an elective centre. We have assumed that the activity suitable for an elective centre would be:

- Most of the 3,091 episodes would be forecast for North Middlesex Hospital
- All of the 3,651 episodes would be forecast for Chase Farm Hospital
- Most of the 1,948 episodes would be forecast for the Whittington Hospital – with spinal procedures remaining
- 68% of inpatients and 73% of day cases would be forecast for UCLH (based on the experience of the Royal Free Hospital NHS Foundation Trust where it was found that a proportion of patients could not be treated at the elective centre, Chase Farm, because of underlying medical conditions).

In addition:

- RNOH has indicated they would seek to use the elective centre to release capacity at the Stanmore site. They estimate that as many as 1,500 episodes could be undertaken in the elective centre, either as new activity that the trust currently turns away or current activity with lower complexity
- Patients in NCL can currently choose to use independent hospitals in preference to NHS providers. We would anticipate that the availability of a dedicated NHS orthopaedic elective centre may attract a substantial number of these patients away from the independent sector.

Taken together, we estimate that this gives a range of activity that could be provided in an elective centre of between 11,000 to 13,400 episodes per annum. However, providers are free to modify these assumptions in respect of their own hospital’s activity. The rationale for any changes will be tested as part of the options appraisal and needs to be carefully documented in the finance narrative.
Table 13 – Baseline activity by commissioner (or groups of commissioner)

<table>
<thead>
<tr>
<th>Episodes</th>
<th>Baseline Activity</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Barnet CCG</td>
<td>Camden CCG</td>
</tr>
<tr>
<td>Elective Inpatients</td>
<td>9</td>
<td>0</td>
</tr>
<tr>
<td>North Middlesex Hospital</td>
<td>527</td>
<td>87</td>
</tr>
<tr>
<td>Chase Farm Hospital</td>
<td>41</td>
<td>0</td>
</tr>
<tr>
<td>Barnet Hospital</td>
<td>96</td>
<td>66</td>
</tr>
<tr>
<td>Royal Free Hospital</td>
<td>46</td>
<td>20</td>
</tr>
<tr>
<td>The Whittington Hospital</td>
<td>58</td>
<td>253</td>
</tr>
<tr>
<td>Sub-Total</td>
<td>778</td>
<td>425</td>
</tr>
<tr>
<td>The Royal National Orthopaedic Hospital</td>
<td>215</td>
<td>39</td>
</tr>
<tr>
<td>Sub-Total - NCL Providers</td>
<td>993</td>
<td>464</td>
</tr>
<tr>
<td>Independent Hospitals</td>
<td>59</td>
<td>3</td>
</tr>
<tr>
<td>Other NHS Providers</td>
<td>101</td>
<td>56</td>
</tr>
<tr>
<td>Total</td>
<td>1,161</td>
<td>523</td>
</tr>
</tbody>
</table>

Table 14: Range of potential activity for an elective centre

<table>
<thead>
<tr>
<th>Episodes</th>
<th>Projected 2023 Activity</th>
<th>Potential for Elective Centre (Low)</th>
<th>Potential for Elective Centre (High)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Day Cases</td>
<td>Elective Activity</td>
<td>Total Activity</td>
</tr>
<tr>
<td>North Middlesex Hospital</td>
<td>2,672</td>
<td>419</td>
<td>3,091</td>
</tr>
<tr>
<td>Chase Farm Hospital</td>
<td>2,400</td>
<td>1,451</td>
<td>3,851</td>
</tr>
<tr>
<td>Barnet Hospital</td>
<td>11</td>
<td>159</td>
<td>170</td>
</tr>
<tr>
<td>Royal Free Hospital</td>
<td>206</td>
<td>241</td>
<td>447</td>
</tr>
<tr>
<td>The Whittington Hospital</td>
<td>1,319</td>
<td>630</td>
<td>1,948</td>
</tr>
<tr>
<td>University College Hospital</td>
<td>2,169</td>
<td>1,315</td>
<td>3,483</td>
</tr>
<tr>
<td>Sub-Total</td>
<td>8,577</td>
<td>4,214</td>
<td>12,791</td>
</tr>
<tr>
<td>The Royal National Orthopaedic Hospital</td>
<td>5,926</td>
<td>5,526</td>
<td>11,452</td>
</tr>
<tr>
<td>Sub-Total</td>
<td>14,503</td>
<td>9,824</td>
<td>24,337</td>
</tr>
<tr>
<td>Independent Hospitals</td>
<td>80</td>
<td>371</td>
<td>451</td>
</tr>
<tr>
<td>Total</td>
<td>15,204</td>
<td>10,211</td>
<td>25,415</td>
</tr>
</tbody>
</table>

Table 15: Bed days associated with the baseline and forecast activity

<table>
<thead>
<tr>
<th>Bed Days</th>
<th>Baseline Activity</th>
<th>Projected 2023 Activity</th>
<th>Elective Inpatients</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Bed Days</td>
<td>Total Beds</td>
<td></td>
</tr>
<tr>
<td>North Middlesex Hospital</td>
<td>1,913</td>
<td>6.2</td>
<td></td>
</tr>
<tr>
<td>Chase Farm Hospital</td>
<td>6,549</td>
<td>21.1</td>
<td></td>
</tr>
<tr>
<td>Barnet Hospital</td>
<td>926</td>
<td>3.0</td>
<td></td>
</tr>
<tr>
<td>Royal Free Hospital</td>
<td>1,336</td>
<td>4.3</td>
<td></td>
</tr>
<tr>
<td>The Whittington Hospital</td>
<td>2,647</td>
<td>8.5</td>
<td></td>
</tr>
<tr>
<td>University College Hospital</td>
<td>6,349</td>
<td>20.5</td>
<td></td>
</tr>
<tr>
<td>Sub-Total</td>
<td>19,718</td>
<td>64</td>
<td></td>
</tr>
<tr>
<td>The Royal National Orthopaedic Hospital</td>
<td>31,669</td>
<td>102</td>
<td></td>
</tr>
<tr>
<td>Sub-Total</td>
<td>51,388</td>
<td>166</td>
<td></td>
</tr>
<tr>
<td>Independent Hospitals</td>
<td>1,218</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>52,606</td>
<td>170</td>
<td></td>
</tr>
</tbody>
</table>

Table 15 is intended to give providers a guide for the amount of capacity required. It shows the current number of bed days associated with the baseline inpatient activity and, with the
forecast activity together with the number of beds, this translates into 85% occupancy. The same occupancy has been applied to every provider.

**To help providers with their responses to this proposal, they will be given a copy of the activity model and a simple costing tool together with instruction on how these may be used. Support will also be available to complete the costing and activity proposal.**

11.3. Delivering efficiencies

Elective centres would be expected to facilitate an optimised pathway so that elective orthopaedic care in north central London is as productive as possible for both providers and commissioners. Monitor⁶, subsequently NHS Improvement⁷, and now NHS England, has set out a series of interventions to improve productivity in elective care.

Realising the full benefits requires complementary efforts across the patient pathway, from preparing patients and setting their expectations before admission, to processes during surgery (including choice of anaesthesia) and postoperative mobilisation and therapy.

Providers are asked to set out how they have included increasing productivity into their modelling of how an elective centre would operate, including any expectations around a six or seven day/week operation.

Providers are also requested to indicate the potential quantum of additional savings through standardised purchasing, smarter stock-holding and scaled-up decontamination, which builds on work undertaken in NCL to date around standardisation and consolidation.

In order to make a rounded analysis of the financial implications of options, all providers (irrespective of whether they are putting forward an option to be an elective centre) will be asked to complete finance and activity spreadsheets and a finance narrative to support their financial submission.

**For the elective centre:**

- A description of the financial model and partnership agreement they would envisage to support the running of the elective centre
- How efficiency, or productivity, gains have been factored into the modelling
- Implementation plan for opening the elective centre, including go-live date and any associated phasing up to full capacity
- Capital, estates (see estates section below) and digital (see table 8) requirements, and how any capital requirements would be met
- The anticipated cost of implementation and the providers’ proposals for meeting this cost.

**For base hospitals:**

- Description of how released capacity and workforce would be utilised and over what time period, and any enabling capital spend to enable released capacity to be repurposed (see estates section below)

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• Details of any stranded costs and the pace at which these can be absorbed
• Any risks associated with reducing or absorbing costs
• Any opportunity costs or savings that would could be identified, such as the value of reduced cancelled operations.

A guide to the estates considerations to be included in the finance narrative:
A description of any capital works required to deliver an elective centre including:
• Whether capital is required for a new build or refurbishment of existing property
• The value of capital required
• The phasing of expenditure
• The impact on revenue costs
• The anticipated source of funding and whether this will require authority to be granted from outside of the Trust before proceeding (NHSE/I, HMT etc)

Information relating to the impact on the base hospital(s)
A description of any estate that will be vacated as a result of changes to elective surgery and what plans there are for this space. In the event that the plans require refurbishment of vacated property, a description of any capital works as above.

12. Orthopaedic clinical network
A key feature of the model is the creation of an elective orthopaedic network. This forum will enable the delivery of higher quality elective orthopaedic care, improved outcomes and greater consistency and standardisation across the north central London footprint.

The development of the full detail of these network arrangements will continue to be refined, however, the outline governance principles of the orthopaedic clinical network are:
• There will be a single orthopaedic network in north central London, Partnership for Orthopaedic Excellence: North London, giving governance oversight for clinical and operational activity of the elective centre(s)
• The network will take an overview of the clinical governance of the elective centre(s) in north central London, and operational clinical governance will be the responsibility of the elective centre(s)
• The network would include the oversight of the wider elective orthopaedic pathway, including outpatients and day surgery but not including trauma, though close links with trauma services will be maintained
• The network will appoint a chair to act as clinical leader, individual sites will identify a clinical lead who will work with the network leader, and clinicians will also be identified to work on individual time-limited projects
• The network will foster a culture of openness and transparency between all participating organisations, will work to improve multi-disciplinary team working across all tiers of hospital, and ensure a focus on continuous quality improvement as the network grows and matures
• In the event of there being more than one elective centre, the network will ensure protocols are consistent and shared between all partners in the network, so that there are unifying pathway and treatment protocols and a continuous focus on unwarranted variation to achieve best outcomes and experience for patients
• The network will work to an agreed work programme, seeking to reduce unwarranted variation and set up standardised protocols based on best practice:
  o Common quality standards and KPIs, including monitoring of surgical volumes across sites and surgeons
  o All providers in the network will join the National Orthopaedic Alliance Vanguard
  o A common pathway for the delivery of elective orthopaedic care.

13. Standards and performance of the elective orthopaedic service

Patient experience
The standards we should be aiming to achieve for patients in NCL:

- To be compliant with all patient access targets
- To reduce cancellations for elective orthopaedic procedures to 0% for preventable reasons (e.g. due to beds being unavailable)
- To reduce on the day-cancellations due to anaesthetic review to zero (unless there was a material change in the patient’s clinical condition between pre-operative assessment and the day of surgery)
- Develop a maximum transfer time between being seen at the base hospital and referral to the elective centre
- To generate patient satisfaction scores in the top decile (PROMs, PREMs and Friends and Family test)
- Patients benefit from an accessible service and continue to have choice for elective orthopaedic care
- Active patient forums in the elective centre to define local patient experience, set up broadly in line with the British Orthopaedic Association (BOA) Patient Liaison Group standards
- As part of the National Orthopaedic Alliance Vanguard, aim towards gold kitemark against the quality standards for all procedures undertaken.

Clinical standards
Specific clinical standards we would expect to see in the future model of care:

- Sites in NCL should demonstrate a critical mass for complex procedures support the safe and effective delivery of care
Individual surgeons should be supported to undertake a sufficient volume of procedures each year to enable the safe and effective delivery of care, which should reflect the BOA guidance on implementing GiRFT. Orthopaedic equipment on the shelf for a minimum of 90% of cases. Consistent use of enhanced recovery pathways across NCL. Overall deep infection rates of less than 1%.

**Performance thresholds:**
- Theatre utilisation – four primary joint replacement operations (or equivalent) in a two-session day
- Length of stay to be in upper quartile
- Development of standard protocols for prostheses across NCL.

14. **Branding**

To create a consistency of experience across the whole of the network, it is expected that the elective centre or centres operate using a consistent set of branding, either **Partnership for Orthopaedic Excellence: North London** (or agreed revised branding).
Options Appraisal Process
1. Introduction

This paper explains the approach the commissioners will take to the appraisal of the options received from providers.

2. Feedback from the engagement on the draft case for change

In August 2018, a draft case for change was published for engagement with patients, residents and wider stakeholders, which took place between 17 August and 19 October 2018. The following table sets out the main areas of feedback from this engagement process, and details how they are being addressed over the remaining stages of the review.

Table 1: Main areas of feedback

<table>
<thead>
<tr>
<th>Main area raised during engagement and reflected in the independent evaluation of the engagement</th>
<th>Being addressed through…</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Patient experience:</strong> Patients with vulnerabilities (e.g., those with learning disabilities, dementia, and/or mental health issues) might find it difficult to travel to and find their way around an unfamiliar hospital, with unfamiliar staff. It was suggested that consideration could be given to having people available to assist them on arrival.</td>
<td>Clinical delivery model: Inclusion of care co-ordination function in the model of care and transport section. Options appraisal: To include a scored section on patients with vulnerabilities within the patient experience section (Criteria 3).</td>
</tr>
<tr>
<td><strong>Continuity of care:</strong> There were several points raised around the subject of continuity of care. In the majority of cases, these were about the location of pre-operative assessments and post-operative care/rehabilitation. These comments indicate that there is a need for the review to clearly explain where these activities will take place at the next stage of engagement.</td>
<td>Clinical delivery model: To be specific about where pre-operative assessment and patient education sit in the pathway. Options appraisal: That detailed consideration will be given to the fit with the clinical delivery model (Criteria 1) and about how providers who are putting themselves forward to be an elective centre propose to manage patient education and pre-operative assessment.</td>
</tr>
<tr>
<td><strong>Patients with complex needs:</strong> It was not clear where patients with complex needs (e.g., those with comorbidities) would have their surgery. This is a growing section of the population and it will be important for the review to produce clear and well justified recommendations.</td>
<td>Clinical delivery model: To include an essential requirement for all elective centres to have an HDU to be able to manage medically and orthopedically complex patients safely. Options appraisal: Criterion 1 will include an assessment of providers’ proposals around inclusion of an HDU, case-mix and managing clinical complexity.</td>
</tr>
</tbody>
</table>

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8 "Verve engagement evaluation report, North Central London adult elective orthopaedic services review" pages 5-6, NCL CCGs Joint Commissioning Committee 6 December 2018
<table>
<thead>
<tr>
<th><strong>Main area raised during engagement and reflected in the independent evaluation of the engagement(^8)</strong></th>
<th><strong>Being addressed through...</strong></th>
</tr>
</thead>
</table>
| **Integration:** Contributors stressed the importance of joined up working and integration between clinical, social care and rehabilitation services. The role of an **integrated IT system was important** if care is to be delivered across multiple locations. | **Clinical delivery model:** To include a section on digital requirements for the new system.  
**Options appraisal:** IT and digital considerations are included as part of the deliverability score (Criterion 2). |
| **Travel (always a key concern for public and patients):** With the assumption that future proposals could mean more time and money spent on travelling to appointments, as well as the potential impact on those with mobility impairments and/or economically deprived residents. There were repeated comments suggesting that an **in-depth transport analysis should be considered** so that the implications can be fully understood. | **Clinical delivery model:** To include a section on transport requirements.  
**Options appraisal:** Criterion 3: patient experience will specifically address transport considerations.  
**Public consultation:** once a preferred option(s) has/ve been selected, a detailed travel analysis will need to be carried out and published as part of public consultation. |
| **Across the system:** A number of people mentioned the potential risk of unintended/indirect consequences for other parts of the local health economy. For example, loss of elective income could damage the viability of services at base hospitals, and the separation of trauma and elective orthopaedic work could have a detrimental effect on staff training, skills, job satisfaction and retention/recruitment. | **Clinical delivery model:** To include sections on interdependent services.  
**Options appraisal:** Hurdle criterion included on whole system financial impact of any proposals. Criterion 4: impact on other services, looks at the impact on other services of options to be an elective centre.  
**System-wide sense check:** Has been built-in to take place after the options appraisal process in order to take a step back and ensure that the preferred options are congruent when taken as a whole. |
| **Patient choice:** Some members of the public raised concerns about the potential restriction of patient choice through consolidating elective services onto a small number of sites. | **Clinical delivery model:** The clinical delivery model ensures that referrals will continue to be made to base hospitals, with pre- and post-operative care managed locally. Surgeons from the base hospital would carry out surgery at the elective centre(s). Patient choice would still exist to enable patients to access care providers outside north London. |
| **The model:** More detail and reassurance were sought about the practicality of separating ‘hot’ and ‘cold’ work, based on the concern that staff might be pulled back to | **Clinical delivery model:** The model of care has been based on the successful model of care in south west London (SWLEOC).  
**Options appraisal:** This will test the deliverability of the options put forward and |
Table 2: Engagement process for developing the criteria

<table>
<thead>
<tr>
<th>March 2019</th>
<th>April 2019</th>
<th>May 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Programme Board – 6 March</td>
<td>• Options appraisal criteria workshop – 1 April</td>
<td>• Joint Commissioning Committee – 2 May</td>
</tr>
<tr>
<td>• Finance steering group – 8 March</td>
<td>• Clinical network meeting – 3 April</td>
<td>Agree the clinical delivery model and options appraisal criteria and weightings</td>
</tr>
<tr>
<td>• Clinical delivery model workshop – 18 March</td>
<td>• Programme Board – 8 April</td>
<td></td>
</tr>
<tr>
<td>• Digital: new ways of working workshop – 20 March</td>
<td>Recommend a clinical delivery model and options appraisal criteria and weightings to the JCC (subject to stakeholder comments)</td>
<td></td>
</tr>
<tr>
<td>• Finance steering group – 29 March</td>
<td>Socialisation of the model with key stakeholders for comment: HEE, LWAB, Trauma Network, Spinal Network, Estates Board, Digital team and Health and Care Cabinet</td>
<td></td>
</tr>
</tbody>
</table>

Drawing on the extensive engagement around the draft case for change, the Adult Elective Orthopaedic Services Programme Executive developed an initial proposal for evaluating provider options, including the clinical delivery model criteria. These proposals were then tested with a range of key stakeholders, including through a workshop with clinical and patient representatives. The proposed criteria and weightings were amended as a result of this feedback (see appendix 1).
3.2. Options appraisal process

Figure 1: options appraisal process

The process at each stage needs to be objective, transparent and robust.

The process of assessing options and selecting a preferred option is an important step prior to a public consultation. It is designed to ensure all of north central London has excellent high-quality services which will drive forward the future of orthopaedics locally, nationally and internationally.

The process through which the criteria and weightings applied (set out in Figure 1) will enable the commissioners to determine the preferred option. It is therefore important that care is taken in deciding the process, and that stakeholders and patients and the public have been fully involved in the process.

The process set out in this document will be used to identify a longlist of options, refine these to a shortlist by applying a simple set of hurdle criteria, and then to identify a preferred option from that shortlist by applying scored non-financial criteria and conducting a financial assessment. It is this preferred option which will form the basis of a future public consultation.
3.3. The process for selecting a preferred option

**Figure 2: Submissions of options process**

The adult elective orthopaedic services review is a collaborative Sustainability and Transformation Partnership, North London Partners in Health and Care (STP)-wide initiative with strong clinical engagement. As set out in figure 2, this level of mature collaboration and support will continue throughout the process.

3.4. Six-week process for the submission of options

In the first instance, the commissioners will run a **six-week process** leading up to the submission of options by existing STP providers. Appendix 3 sets out the form for providers to submit their options.

This six-week process of seeking submissions of options from providers is anticipated to start in mid-May 2019, following the Joint Commissioning Committee discussion on 2 May 2019.

During this time the programme will:

- **Offer support** to providers to advise on bid writing and materials and capacity to support finance and activity modelling
- **Host an expert event** (involving Health Education England (HEE) and wider stakeholders) to help inform the education and training section of the submission
- **Host a collaborative workshop** half-way through the process, for providers to share their emerging proposals and gain visibility about any intersections between provider submissions, particularly around key dependencies.

3.5. Creating the short-list

The STP providers will be required to meet a number of hurdle criteria in the options that they put forward. The shortlist will be made up of all options that meet these hurdles, together with a counter-factual (essentially a projection of how the service will look if no service transformation takes place).

These hurdle criteria will not rule out options that make use of any site available to the providers, nor collaborations between providers or between providers and the independent...
sector, providing they support delivery of the requirements set out in the clinical delivery model.

The hurdle criteria are as follows:

- The provider must already be a provider of elective orthopaedic services
- The elective centre(s) must be located on a site operated by members of the Sustainability and Transformation Partnership, North London Partners in Health and Care
- The option must demonstrate a favourable income and expenditure impact for the system after two years of operation, against a counter-factual that includes growth and cost of growth: If the proposal is not able to show cost neutrality then it cannot be considered to be a viable option.

3.6. Selecting a preferred option from a shortlist

Following the shortlisting of options there will then be a workshop, date still to be confirmed but most likely in July 2019, to assess both the non-financial and financial elements of the written proposals.

3.6.1. At the workshop:

- Attendees will apply a consensus score to each proposal and a counter-factual (the impact of not developing elective orthopaedics) for each sub-criterion and will record the scores, along with reasons for the scores. All reasonable efforts will be made to arrive at a consensus score for each sub-criterion. If consensus is not achievable, the average score will be applied but the programme board of the adult elective orthopaedic services review and the senior management committee of the NCL CCGs will be informed of the full range of scores applied so that they are informed of the variance of views
- STP providers will be invited to present their options and to answer questions, but these will be used for clarification only and not scored separately.

3.6.2. After the workshop:

- The scores will be counted to arrive at a ranking and conclude which option scores the best
- The differences in scores between different options will be noted to enable the programme board of the adult elective orthopaedic services review and the senior management committee of the NCL CCGs to consider the robustness of the scoring as part of their discussions to put forward a recommendation to the joint commissioning committee of the NCL CCGs.

In parallel, a finance group will assess providers’ financial submissions as described below.

The scoring of the non-financial criteria will be carried out by clinical commissioners and patient and resident representatives. Appendix 2 sets out the details of the proposed membership of the scoring panel for the non-financial criteria and the individuals tasked with carrying out the financial assessment. It also sets out the other specialist inputs that will be available to help inform these individuals in their deliberations.
After the scoring:

- A system-wide sense check will be conducted in collaboration with providers to ensure that there are no unintended consequences arising from the preferred option.
- The outcome of the options appraisal process and the system-wide sense-check will be presented to both the programme board of the adult elective orthopaedic services review and the senior management committee of the NCL CCGs.

Following this the CCGs will:

- Make a recommendation to the JCC as to the preferred option to put forward to public consultation.

4. Further checks and assurance in the process

The options appraisal process is the first of a number of opportunities to test the clinical model. There will be further checkpoints where the new model of care can be assured from a whole system perspective to ensure all of north central London has excellent services which will drive forward the future of orthopaedics locally, nationally and internationally:

- Pre-consultation business case
- NHS England assurance, including a review by the London Clinical Senate
- A consultation
- Decision-making business case
- Individual trusts’ business cases (depending on whether capital investment is required)
- System-assurance and planning around go-live of the new service; gateway tests to be developed as the programme progresses.

5. Hurdle criteria, scored non-financial criteria and financial assessment

5.1. Hurdle criteria

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Description</th>
<th>Scoring</th>
</tr>
</thead>
<tbody>
<tr>
<td>Existing provider</td>
<td>That the provider is already a provider of elective orthopaedic services</td>
<td>Pass/Fail</td>
</tr>
<tr>
<td>North London Partners in Health and Care</td>
<td>Elective centre(s) located on a site operated by member of the Sustainability and Transformation Partnership, North London Partners in Health and Care (STP).</td>
<td>Pass/Fail</td>
</tr>
<tr>
<td>Financial</td>
<td>The option will need to demonstrate a favourable income and expenditure impact for the system after two years of operation, against a counterfactual that includes growth and cost of growth.</td>
<td>Pass/Fail</td>
</tr>
<tr>
<td>Criteria</td>
<td>Description</td>
<td>Scoring</td>
</tr>
<tr>
<td>----------</td>
<td>-------------</td>
<td>---------</td>
</tr>
<tr>
<td>Within the health system we anticipate that:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Commissioners will continue to purchase the same volume of activity regardless of the model that is adopted.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• In the short term there will be financial winners and losers amongst the providers of services resulting from these changes. It may be necessary for providers to agree short-term financial arrangements to mitigate for any temporary losses.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>To meet this hurdle condition each proposal will need to be demonstrate that:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• The cost to commissioners will be no more than the cost of orthopaedics if there were to be no development. It follows that: any changes to the patient pathway do not result in new Payment by Results (PbR) costs (such as additional outpatients attendances), there is no net increase to the prices from Market Forces Factor (MFF) variations or other factors and there are no new costs that providers expect commissioners to fund</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• The provider proposing the option is able to show that the elective centre is a more efficient model of care with lower costs than the current model of care. If there are new costs associated with the model, such as capital costs or patient transport costs, then these must be offset against savings elsewhere</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Other acute providers impacted by the change to elective orthopaedics should be able to show that the impact on the cost of trauma and other legacy services is negligible, and that any stranded costs associated with the loss of elective surgery can be rapidly absorbed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• There should be no cost implications for community or primary care services.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

9 The methodology described for assessing the financial impact on the health system has been written on the basis that Payment by Results (PbR) continues to be the framework by which money moves around the system and all organisations are held to account for separate control targets. We appreciate that this system is changing; PbR is likely to be replaced and system-wide control targets will be introduced. As the new framework becomes clearer the methodology for assessing the financial impact of each option may need to change. However any new methodology will continue to concentrate upon the changes to the cost of the whole system, the efficiencies generated and the impact on legacy services.
6. Options appraisal criteria and weightings

6.1. Non-financial criteria

Scores will be applied to each sub-section 0 to 5. The following scoring matrix will be applied.

*Table 3: Scoring matrix to be applied*

<table>
<thead>
<tr>
<th>Score</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Very weak or not answered</td>
</tr>
<tr>
<td>1</td>
<td>Poor</td>
</tr>
<tr>
<td>2</td>
<td>Satisfactory</td>
</tr>
<tr>
<td>3</td>
<td>Good</td>
</tr>
<tr>
<td>4</td>
<td>Very good</td>
</tr>
<tr>
<td>5</td>
<td>Exceptional</td>
</tr>
</tbody>
</table>

The weightings will then be applied to get an overall score for the sub-section and section. Each overall section score will be assigned a proportion of the overall score – in relation to the section weighting.

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Detail of what is to be assessed</th>
<th>Sub-section weighting</th>
<th>Section weighting</th>
<th>Key</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Criterion 1: Fit with the clinical delivery model</strong></td>
<td>How the provider proposes to deliver the <strong>essential and innovation features</strong> of the clinical delivery model to achieve effective, safe care for patients?</td>
<td>50%</td>
<td>40%</td>
<td>Clinical delivery model – essential and innovation features</td>
</tr>
<tr>
<td></td>
<td>How well the provider’s workforce plan supports the aspirations of the clinical delivery model?</td>
<td>40%</td>
<td>40%</td>
<td>Clinical delivery model – workforce plan</td>
</tr>
<tr>
<td></td>
<td>The provider’s proposals for improving education, training and research capability in NCL?</td>
<td>10%</td>
<td>40%</td>
<td>Clinical delivery model – education, research and training</td>
</tr>
<tr>
<td>Criteria</td>
<td>Detail of what is to be assessed</td>
<td>Sub-section weighting</td>
<td>Section weighting</td>
<td>Key</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>-----------------------</td>
<td>------------------</td>
<td>------------------</td>
</tr>
<tr>
<td><strong>Criterion 2: Deliverability</strong></td>
<td>Material risks that could delay or prevent a decision from being made</td>
<td>65%</td>
<td>20%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Material risks that could delay or prevent the scheme from being implemented once a decision to proceed has been taken.</td>
<td>35%</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Criterion 3: Patient experience</strong></td>
<td>How well does the option offer a quality service tailored to the needs of patients with vulnerabilities or those with complex needs (non-medical)?</td>
<td>30%</td>
<td>25%</td>
<td>Patient experience</td>
</tr>
<tr>
<td></td>
<td>How will the option deliver an accessible service for all patients and carers in north central London?</td>
<td>40%</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>How will the option improve patients’ experience of care?</td>
<td>30%</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Criterion 4: Impact on other services</strong></td>
<td>Trauma services</td>
<td>60%</td>
<td>15%</td>
<td>Impact on other services</td>
</tr>
<tr>
<td></td>
<td>Paediatric and adolescent surgery</td>
<td>10%</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Spinal surgery</td>
<td>10%</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Primary and community services</td>
<td>20%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### 6.1.1 Criterion 1: Fit with the clinical delivery model

<table>
<thead>
<tr>
<th>Sub-criterion</th>
<th>Description</th>
<th>Key</th>
</tr>
</thead>
<tbody>
<tr>
<td>How does the option deliver the essential innovation features of the clinical delivery model to achieve effective, safe care for patients?</td>
<td>The assessment will take account of how the essential requirements and innovation features of the clinical delivery model will be met.</td>
<td>Clinical delivery model – Section 6</td>
</tr>
</tbody>
</table>
| How well the provider’s workforce plan supports the aspirations of the clinical delivery model? | The assessment will cover how:  
  - The **roles at elective centre(s)** will be put in place  
  - The **key workforce principles** would be met  
  - **NLP STP workforce programme alignment** would be achieved. | Clinical delivery model – Section 9 |
| The provider’s proposals for improving education, training and research capability in NCL? |  
  - **Improved research outcomes** [Pointers - high scoring options will demonstrate that the quality and quantity of research will be enhanced and that there will be patient benefits accruing]  
  - **Impact on education and training** [Pointers - Scoring will recognise that there could be both positive and negative impacts on education and training] | Clinical delivery model – Section 10 |
6.1.2.  Criterion 2: Deliverability

Definition: the relative difficulty associated with bringing the option to completion.

Providers will not be asked to submit a specific response in relation to this criterion. This criterion will be assessed holistically against all the information provided for each option.

<table>
<thead>
<tr>
<th>Sub-criterion</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Material risks that could delay or prevent a decision from being made</td>
<td>The assessment will take account of:</td>
</tr>
<tr>
<td></td>
<td>- The degree of support from key stakeholders that the proposal is able to demonstrate</td>
</tr>
<tr>
<td></td>
<td>- The complexity of the proposal including factors such as whether the project will need to obtain capital funding before it can receive support</td>
</tr>
<tr>
<td></td>
<td>- The complexity of the governance arrangements for making a decision</td>
</tr>
<tr>
<td></td>
<td>- If the demonstration that the proposal is affordable is likely to be difficult and/or require compromise and negotiation between stakeholders.</td>
</tr>
<tr>
<td></td>
<td>High-scoring options would demonstrate that there would be no risk or that risk is not applicable to the proposal</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Material risks that could delay or prevent the scheme from being implemented once a decision to proceed has been taken</th>
<th>The assessment will take account of implementation programmes that involve:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>- Complex governance arrangements</td>
</tr>
<tr>
<td></td>
<td>- High implementation costs</td>
</tr>
<tr>
<td></td>
<td>- Significant change required to business processes or IT systems</td>
</tr>
<tr>
<td></td>
<td>- Significant disruption to the workforce and/or ways of working</td>
</tr>
<tr>
<td></td>
<td>- Major capital works</td>
</tr>
<tr>
<td></td>
<td>- Challenges associated with maintaining safe and efficient patient services during the implementation stage.</td>
</tr>
<tr>
<td></td>
<td>While high-scoring options could demonstrate that there would be no risk or that risk is not applicable to the proposal, if a risk is acknowledged but mitigated sufficiently it can still score well.</td>
</tr>
</tbody>
</table>

6.1.3.  Criterion 3: Patient Experience

<table>
<thead>
<tr>
<th>Sub-criterion</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>How well does the option offer a quality service tailored to the needs of</td>
<td>Options will be assessed against the extent to which they have considered patients with additional needs, either through (non-medical) complexity or vulnerability, in terms of planning of the service model.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Key</th>
<th>Patient experience Sections 8 and 13</th>
</tr>
</thead>
</table>
### Sub-criterion Description

<table>
<thead>
<tr>
<th>Sub-criterion</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>patients with vulnerabilities or those with complex needs (non-medical)?</td>
<td></td>
</tr>
<tr>
<td>How will the option deliver an accessible service for all patients and carers in north central London?</td>
<td>Options will be assessed against both the design of the service model and plans to meet transport requirements.</td>
</tr>
<tr>
<td>How will the option improve patients’ experience of care?</td>
<td>Options will be scored on the extent to which the model of care would improve patients’ experience of orthopaedic services. This will include how options will meet the performance measures in the clinical delivery model.</td>
</tr>
</tbody>
</table>

#### 6.1.4. Criterion 4: Impact on other services

This criterion will be assessed by looking at all of the submissions provided as part of the submissions of options process, including those from providers who only envisage a role for their organisation as a base hospital.

<table>
<thead>
<tr>
<th>Sub-criterion</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paediatric and adolescent surgery</td>
<td>Options will be assessed on the likely impact of the option on paediatric and adolescent surgery in north central London as a whole</td>
</tr>
<tr>
<td>Trauma</td>
<td>Options will be assessed on the likely impact of the option on trauma services in north central London as a whole</td>
</tr>
<tr>
<td>Spinal surgery</td>
<td>Options will be assessed on the likely impact of the option on spinal surgery in north central London as a whole</td>
</tr>
</tbody>
</table>
### 6.2. Financial assessment

Providers are asked to complete the pro-forma at Appendix 4 to explain the system-wide financial impact of their proposal.

The financial assessment of each option will take into account all of the information included by providers in the pro-forma at Appendix 4. The assessment will be based on a rounded judgement looking at all of the submissions, including those from providers who only envisage a role for their organisation as a base hospital.

The individuals tasked with carrying out the financial assessment will not score individual financial responses, but will use the information put forward by providers in the Appendix 4 pro-forma to report back to the programme board of the adult elective orthopaedic services review and the senior management committee of the NCL CCGs on the expected financial impact of each option.
Appendix 1: Options appraisal workshop

A workshop was held on 1 April 2019 to consider the proposed options appraisal criteria and weightings. It was attended by 32 people, including clinicians representing primary, community and secondary care and a range of disciplines (AHPs, nurses, surgeons and GPs).

In recruiting resident representatives to participate in the workshop we were very conscious of the need to ensure we had a wide reach, including those people who didn’t have access to computers and smartphones in their day-to-day lives. To do this we made efforts to ensure that the opportunity to be involved was widely publicised. Specifically, we:

- Shared this opportunity with colleagues in partner organisations: CCGs, provider communications teams, local authorities and Healthwatch, asking them to publicise the opportunity both online and offline
- Shared this involvement opportunity with voluntary sector organisations and asked them to share the information with their members and service users
- Attended events in different boroughs which gave our engagement team the chance to meet residents face-to-face and encourage them to participate, including helping residents to fill in hard copies of the application form
- Contacted 50 voluntary sector organisations and community groups by both phone and email, alerting them to the opportunity and asking them to help us in offering opportunities to register and get involved.

The text in blue indicates wording that was amended, or sub-criteria added, following the workshop with clinical and patient representatives on 1 April 2019. Changes to the weightings following the workshop are indicated in green.

<table>
<thead>
<tr>
<th>Area</th>
<th>Detail of what is to be assessed</th>
<th>Sub-section weighting</th>
<th>Section weighting</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Criterion 1: Fit with the clinical model</strong></td>
<td>How does the option deliver the essential innovation features of the clinical delivery model to achieve effective, safe care for patients?</td>
<td>50%</td>
<td>40% (was 45%)</td>
</tr>
<tr>
<td></td>
<td>How well does the provider’s workforce plan support the aspirations of the clinical delivery model?</td>
<td>40% (was 35%)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>The provider's proposals for improving education, training and research capability in NCL?</td>
<td>10% (was 15%)</td>
<td></td>
</tr>
<tr>
<td><strong>Criterion 2: Deliverability</strong></td>
<td>Material risks that could delay or prevent a decision from being made</td>
<td>65% (was 50%)</td>
<td>20%</td>
</tr>
<tr>
<td></td>
<td>Material risks that could delay or prevent the scheme from being implemented once a decision to proceed has been taken</td>
<td>35% (was 50%)</td>
<td></td>
</tr>
<tr>
<td><strong>Criterion 3: Patient experience</strong></td>
<td>How well does the option offer a quality service tailored to the needs of patients with vulnerabilities or those with complex needs (non-medical)?</td>
<td>30%</td>
<td>25% (was 20%)</td>
</tr>
</tbody>
</table>
### Area

<table>
<thead>
<tr>
<th>Detail of what is to be assessed</th>
<th>Sub-section weighting</th>
<th>Section weighting</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>How will the option deliver an accessible service for patients and carers in north central London?</strong></td>
<td>40%</td>
<td></td>
</tr>
<tr>
<td><strong>How will the option improve patients’ experience of care?</strong></td>
<td>30%</td>
<td></td>
</tr>
<tr>
<td><strong>Criterion 4: Impact on other services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Paediatric and adolescent services</td>
<td>60%</td>
<td>(was 70%)</td>
</tr>
<tr>
<td>Trauma</td>
<td>10%</td>
<td>15%</td>
</tr>
<tr>
<td>Spinal surgery</td>
<td>10%</td>
<td>(was 20%)</td>
</tr>
<tr>
<td><strong>Community and primary orthopaedic services</strong></td>
<td>20%</td>
<td></td>
</tr>
</tbody>
</table>

Some elements of the clinical delivery model initially formed part of the hurdle criteria. However, following further discussion after the workshop, it was felt that assessing some aspects of the proposed model of care twice, once in the hurdle criteria and again at the options appraisal stage could be an overly complex process. Therefore, these aspects will now only be considered as part of the options appraisal.
Appendix 2: Proposed evaluation panels

The scoring of the non-financial criteria will be carried out by clinical commissioners and patient and resident representatives. This appendix sets out the details of the proposed membership for the scoring panels for the financial and non-financial criteria. It also sets out the other specialist inputs that will be available to help inform the scoring panel in their deliberations.

Proposed evaluation team for non-financial criteria

The panel will comprise:

**Clinical Commissioning Group representatives**

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr Dee Hora</td>
<td>Planned Care Clinical Lead, NCL</td>
</tr>
<tr>
<td>Dr Mateen Jiwani</td>
<td>Medical Director, Enfield CCG</td>
</tr>
<tr>
<td>Jennie Williams</td>
<td>Lead Director of Quality, NCL CCGs</td>
</tr>
<tr>
<td>Ruth Donaldson</td>
<td>Director of Commissioning, Barnet CCG</td>
</tr>
<tr>
<td>Simon Goodwin</td>
<td>Director of Finance, NCL CCGs</td>
</tr>
<tr>
<td>Will Huxter</td>
<td>Director of Strategy, NCL CCGs</td>
</tr>
</tbody>
</table>

Other commissioners: specialised commissioning and some neighbouring commissioners may be asked to join the panel depending on the materiality of their flows into NCL (NHSE to be asked to take a view)

**Patient and public representatives**

Five or six representatives, representing the spread of boroughs in north central London and drawing on the desktop equalities impact analysis. This will include the two patient and public representatives on the programme board.

In addition to the panel carrying out the scoring:

- **Expert independent support to the process** including review and analysis of all the provider submissions will be provided by NEL CSU
- **Expert specialist input and written advice** will be sought and shared with the panel to assist their deliberations:
  - North West London Spinal Network and North London Trauma network will be asked to provide written feedback around these key dependencies
  - HEE, plus NCL Estates Board and Digital Board
- Members of the **Adult Elective Orthopaedic Services Programme Executive** and the **independent clinical adviser** to the programme will be available on the day to provide technical input and guidance to the panel
- **Provider representatives** may also be asked to present at the session to answer any questions on their submissions.
Proposed team for the finance assessment

**Clinical Commissioning Group representatives**

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
</tr>
</thead>
<tbody>
<tr>
<td>Simon Goodwin</td>
<td>Director of Finance, Barnet, Camden, Enfield, Haringey and Islington CCGs</td>
</tr>
<tr>
<td>Ruth Donaldson</td>
<td>Director of Commissioning, Barnet CCG</td>
</tr>
</tbody>
</table>

Two of four NCL CCG Deputy Directors of Finance

In addition to the panel carrying out the scoring:

- **Expert independent support** to the process including review and analysis of all the provider submissions will be provided by NEL CSU
- Members of the **Adult Elective Orthopaedic Services Programme Executive** and if required the **independent clinical adviser** to the programme will be available to provide technical input and guidance to the panel at the options appraisal scoring panel
- **Provider representatives** may also be asked to present at the session to answer any questions on their submissions
Appendix 3: Submissions of options (issued May 2019)

North Central London Adult Elective Orthopaedic Services Review

Provider details

Organisation Name(s)
Submission completed by
Role
Email
Telephone
Plan signed off by Chief Executive(s)
Email
Telephone

I confirm that the contents of this submission of options are an accurate representation of the activity that this organisation(s) plan to undertake to deliver the vision of the North Central London Adult Elective Orthopaedic Review.

Signature(s)........................................................................................................................................................................

Date: ..................................................................................................................................................................................

Submission

Please submit all options by noon on Friday 5 July 2019 to camccg.nclorthopaedics@nhs.net
Section key

<table>
<thead>
<tr>
<th>Clinical delivery model – essential and innovation features</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical delivery model – workforce plan</td>
</tr>
<tr>
<td>Clinical delivery model – education, research and training</td>
</tr>
<tr>
<td>Patient experience</td>
</tr>
<tr>
<td>Finance narrative</td>
</tr>
<tr>
<td>Impact on other services</td>
</tr>
</tbody>
</table>
Section 1. Submission of Options information

Title

Provision of adult elective orthopaedic services in north central London in the best interests of patients: Improving experience and clinical outcomes

Background

North London Partners in Health and Social Care [www.northlondonpartners.org.uk](http://www.northlondonpartners.org.uk) initiated a review of adult elective orthopaedic services in February 2018. The review evaluated services across five north central London (NCL) boroughs: Barnet, Camden, Enfield, Haringey and Islington. Currently adult elective orthopaedic services are delivered from 10 local sites. Evidence indicates consolidating surgery onto a smaller number of specialist sites and separating elective and emergency orthopaedic care positively impacts care quality by improving clinical outcomes and patient experience by reducing unwarranted variation. The beneficial effect is demonstrated in both trauma and planned care.

**Our vision was set out in our draft case for change, published in August 2018**

Developed and validated through a series of clinical design workshops, our vision is to deliver services from dedicated state-of-the-art orthopaedic elective surgical centres (also known as cold or hub centres), separated from existing emergency departments, and co-located with high dependency units (HDU), with the size and scale to enable a full spectrum elective offering and a robust rota. Trauma activity would be maintained at the local hospital trusts. Freeing up beds and theatres would also be consistent in supporting the NCL Sustainability and Transformation Partnership, North London Partners in Health and Care (STP) urgent and emergency care strategy and would make efficiencies as a natural consequence of these improvements; offering better value for money.

We are seeking submissions of options from current NCL providers deliver a clinical delivery model for a networked model of care **Partnership for Orthopaedic Excellence: North London**, with an ambition for an international reputation for high-quality patient outcomes and experience, education and research to be secured through:

- Excellent timely diagnostics and outpatient care, both pre and post operatively, at local base hospital sites working seamlessly within local MSK pathways, including both prevention and self-management
- Elective centre(s) which would provide at scale delivery of consolidated, ring-fenced elective orthopaedic surgery with excellent perioperative care
- A focus on consistent excellent patient education and rehabilitation pre-operatively and post-operatively
- Appropriate flows to a super specialist centre for the most complex patients who cannot be appropriately cared for in local or elective hospitals
- Improvement in the delivery of local trauma services, by separating the delivery of planned and emergency orthopaedic services, whilst maintaining a surgical workforce who provide both planned and emergency care to best practice standards.

---

Providers are asked to set out how they will meet the criteria below in order to be considered as:

- A base hospital
- An elective centre
- A base hospital and elective centre combined.

To support providers to complete their submissions, there are two papers (clinical delivery model and options appraisal criteria and weighting). An excel spreadsheet that includes finance and activity modelling accompanies this submission of options and is required to be completed and submitted at the same time.

<table>
<thead>
<tr>
<th>If two or more providers are submitting a collaborative option, they are asked to confirm the governance arrangements that will operate to oversee the partnership.</th>
</tr>
</thead>
</table>

Providers are asked to set out discussions that have been had with key local stakeholders about the proposed option and model of care.
Section 2. Hurdle Criteria

Providers are asked to confirm that their proposal meets the hurdle criteria and provide evidence to this effect:

For further information please see section 3.5 of the Clinical Delivery Model.

<table>
<thead>
<tr>
<th>How the hurdle criteria will be met (five sides maximum)</th>
<th>Yes/No</th>
</tr>
</thead>
<tbody>
<tr>
<td>The provider must already be a provider of elective orthopaedic services</td>
<td>Yes/No</td>
</tr>
<tr>
<td>The elective centre(s) must be located on a site operated by members of the Sustainability and Transformation Partnership, North London Partners in Health and Care</td>
<td>Yes/No</td>
</tr>
<tr>
<td>The option must demonstrate a favourable income and expenditure impact for the system after two years of operation, against a counter-factual that includes growth and cost of growth: If the proposal is not able to show cost neutrality then it cannot be considered to be a viable option.</td>
<td>Assessed via finance and activity spreadsheet and finance narrative</td>
</tr>
</tbody>
</table>
Section 3. Clinical delivery model – essential and innovation features

Outline criteria (Maximum 15 sides of A4)

Providers are requested to set out their proposed service delivery model, ensuring that this covers how the essential and innovation features of the clinical delivery model would be met.

For further information please see section 6 of the clinical delivery model.
Section 4. Clinical delivery model – workforce plan

Outline Criteria

How well the provider's workforce plan supports the aspirations of the clinical delivery model?

For further information please see section 9 of the clinical delivery model.

Workforce Plan Description (maximum five sides of A4)
Outline Criteria

How the provider is able to describe how they will improve education, training and research capability in NCL?

For further information please see section 10 of the clinical delivery model.

Education, Training and Research Description (maximum five sides of A4)
Section 6. Patient Experience

Outline Criteria

Providers are asked to set out:

1. How well does the option offer a quality service tailored to the needs of patients with vulnerabilities or those with complex needs (non-medical)?
2. How will the option deliver an accessible service for all patients and carers in north central London?
3. How will the option improve patients’ experience of care?

For further information please see sections 8 and 13 of the clinical delivery model.

Patient Experience Description (maximum five sides of A4)
Section 7. Finance pro-forma and narrative

To be completed by all providers

Outline Criteria

Providers are asked to complete and return:

- A forecast of activity (excel spreadsheet).
- A pro-forma of financial information (excel spreadsheet) and
- A pro-forma of further information and narrative

See appendix 4 for details:
Section 8. Interdependent dependencies

Outline Criteria
Providers are asked to set out the how they will address key dependencies:

1. **Paediatric and adolescent services**
2. **Trauma**
3. **Spinal services**
4. **Community and primary orthopaedic services**

Please see section 7 of the clinical delivery model for further information

Key Clinical Dependencies Description (Maximum 10 sides of A4)
Section 9: Any additional information (Maximum two sides of A4)

Can be completed by all providers
Appendix 4: Adult Elective Orthopaedic Services in North London: Pro-forma for provider responses

There are two parts to this response.

- Part A is for providers proposing to operate an orthopaedic elective centre as set out in the Clinical Delivery Model.
- Part B is for all providers and describes the impact of no longer providing elective orthopaedics in your hospitals.

These responses will be used to assess the deliverability and financial elements of the appraisal.

To help providers with their responses to this proposal, providers will be given a copy of the activity model and a simple costing tool together with instruction on how these may be used. Support will also be available to complete the costing and activity proposal.

Some elements of this proforma may be shared separately as part of an excel submission, they are presented here for completeness.

Part A – Proposal to operate an orthopaedic elective centre

1. Commercial model

Please indicate whether you are willing to adopt the financial model operating in SW London as described in the Clinical Delivery Model. Please describe the detail of the financial model and governance arrangements you would propose.

2. Please indicate the current and anticipated cost of inpatient orthopaedics

<table>
<thead>
<tr>
<th>Year</th>
<th>2019-20</th>
<th>2020-21</th>
<th>2021-22</th>
<th>2022-23</th>
<th>2023-24</th>
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<tbody>
<tr>
<td><strong>Income</strong></td>
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<tr>
<td>PbR income</td>
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<tr>
<td>Other income</td>
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<td><strong>Total Income</strong></td>
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<tr>
<td><strong>Direct Costs</strong></td>
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<tr>
<td>Medical staff (employed)</td>
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<tr>
<td>Medical staff (recharged)</td>
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<tr>
<td>Nursing staff</td>
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<tr>
<td>AHP staff</td>
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<tr>
<td>Admin and managerial staff</td>
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<tr>
<td>Other staff</td>
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<td><strong>Sub-Total Direct Staff</strong></td>
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<td>Theatre consumables</td>
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<tr>
<td>Pharmacy</td>
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<tr>
<td>Medical consumables</td>
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<td>Other TBA</td>
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<tr>
<td><strong>Sub-Total Direct non-staff costs</strong></td>
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<tr>
<td><strong>Sub-Total Direct Costs</strong></td>
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</tr>
</tbody>
</table>
### Indirect Costs
- Pathology
- Pharmacy
- Radiology
- Therapy services
- Other

**Sub-Total Indirect Costs**

### Overheads
- TBA
- Capital charges
- Sub-total overheads

**Total Costs**

**Contribution**

---

3. Please indicate the current and anticipated cost of **day case orthopaedics**

<table>
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<tr>
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<tbody>
<tr>
<td>PbR income</td>
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<td>Other income</td>
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<td><strong>Total Income</strong></td>
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<tr>
<td>Medical staff (employed)</td>
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<td>Medical staff (recharged)</td>
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<td>Nursing staff</td>
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<td>AHP staff</td>
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<tr>
<td>Admin and managerial staff</td>
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<td>Other staff</td>
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<td><strong>Sub-Total Direct Staff</strong></td>
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<td>Theatre consumables</td>
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<td>Pharmacy</td>
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<tr>
<td>Medical consumables</td>
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<td>Other TBA</td>
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<tr>
<td><strong>Sub-Total Direct non-staff costs</strong></td>
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<tr>
<td><strong>Sub-Total Direct Costs</strong></td>
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<table>
<thead>
<tr>
<th>Indirect Costs</th>
<th>2019-20</th>
<th>2020-21</th>
<th>2021-22</th>
<th>2022-23</th>
<th>2023-24</th>
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</thead>
<tbody>
<tr>
<td>Pathology</td>
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<td>Pharmacy</td>
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<td>Radiology</td>
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<tr>
<td>Therapy services</td>
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<td>Other</td>
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<tr>
<td><strong>Sub-Total Indirect Costs</strong></td>
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</tbody>
</table>
**Overheads**

TBA

**Capital Charges**

**Sub-total Overheads**

<p>| | | | | |</p>
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<tbody>
<tr>
<td><strong>Total Costs</strong></td>
<td></td>
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<tr>
<td><strong>Contribution</strong></td>
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</table>

Please describe how the costs in 1 and 2 above were arrived at including any core assumptions that had to be made.

**Assumptions to adopt:**

**Inflation:** All costs and income should be at a 2019-20 baseline

**Timeline:** Assume that a decision to proceed is taken at the start of 2020-21 and that an implementation programme begins shortly after.

The “Medical staff (recharged)” row is for the cost of medical staff that will be employed by other providers, but working a number of sessions in the elective centre.

4. **Activity volumes**

Please indicate the volume of orthopaedic activity you anticipate.

<table>
<thead>
<tr>
<th></th>
<th>2019-20</th>
<th>2020-21</th>
<th>2021-22</th>
<th>2022-23</th>
<th>2023-24</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Elective Inpatient episodes</strong></td>
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<tr>
<td>In the elective centre</td>
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<tr>
<td>In the main hospital</td>
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<tr>
<td><strong>Total Inpatient episodes</strong></td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td><strong>Day cases</strong></td>
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<tr>
<td>In the elective centre</td>
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<tr>
<td>In the main hospital</td>
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<tr>
<td><strong>Total day case episodes</strong></td>
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<tr>
<td><strong>Total Elective Episodes</strong></td>
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</tbody>
</table>

This should be consistent with the activity model.

5. **Core facilities**

Please indicate the changes required in core facilities.

<table>
<thead>
<tr>
<th></th>
<th>2019-20</th>
<th>2020-21</th>
<th>2021-22</th>
<th>2022-23</th>
<th>2023-24</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Inpatient beds</strong></td>
<td></td>
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</tr>
<tr>
<td>In main hospital</td>
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<tr>
<td>In dedicated elective centre</td>
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</tr>
<tr>
<td><strong>Total beds</strong></td>
<td></td>
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<td></td>
</tr>
<tr>
<td><strong>Theatre facilities used for elective orthopaedics</strong></td>
<td></td>
<td></td>
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<tr>
<td>Dedicated theatres</td>
<td></td>
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<td></td>
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<tr>
<td>Average theatre sessions (weekly)</td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>Day case theatres</td>
<td></td>
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</tbody>
</table>
6. **Efficiency and productivity**

Please indicate how you intend to use this development to improve efficiency and/or productivity. Areas to be considered could include:

- Unit costs
- Patient staff ratios
- Length of stay
- Standardised purchasing and smarter stock-holding
- Scaled-up decontamination
- Fewer cancellations
- Quality gains that will deliver an economic benefit, for example reduction in readmission rates and revision surgery
- Hours of working including 6/7 day working.

Where possible please be specific about the value of efficiency gains that could be delivered. This will be taken into account when the cost to the whole economy is considered.

7. **Capital expenditure**

Please provide details of any capital expenditure that will be required to deliver the project:

- Information on the investment required into the elective orthopaedic hospital(s) including whether this a new build or refurbishment of existing property
- Description of the hospital property of where estate is available to meet the specification outlined (“the site”), including site plan, ownership details etc
- Confirmation that the site supports the wider clinical objectives set out in the programme
- Any clinical constraints the site offers in terms of delivering the scheme, including location, access from public highways, presence on site, internal layout implications etc
- Any estate constraints the site offers in terms of delivering the scheme, including planning consent, listed building consent, TPOs, environmental issues, or service/utility issues
- An indicative programme to deliver the capital works necessary to develop the site into an elective orthopaedic centre
- Key risks and interdependencies in delivering this programme
- Confirmation of any NHS services that will need to be relocated because of the programme, with information as to where they are likely to be moved to
- Any third-party leasing or occupancy issues that might impact delivering the programme
- An estimate (with evidence) of the capital costs (including fees, VAT and other associated costs) in delivering this capital programme, including decant costs
- Indication of where this funding is coming from
- Indication as to whether this investment impacts (+/-) any other local investments
- Indication as to whether the scheme facilitates the disposal of any NHS estate
- Indication as to whether the scheme and this investment removes any backlog maintenance
- Estimates of likely estate operating costs for the service (including capital charges, rent, rates, VAT, service charge etc).

8. **Digital**
Indicate how you envisage delivery of the digital element of the Clinical Delivery Model described in section 8. If you anticipate that there may be risks to the delivery of this indicate what these are and how you propose to mitigate these risks.

9. **Implementation**
Describe the key points of the implementation plan that is envisaged to deliver the elective centre including:

- A go-live date
- Any phasing that you anticipate
- Any significant risks you anticipate

Indicate any non-recurrent costs arising from implementation. Areas to be considered could include:

- Double running costs
- Project management
- Specialist matter experts
- Removals
- Other
Part B – Proposal to cease providing elective orthopaedic inpatients

1. Indicate the current and anticipated cost of inpatient orthopaedics with no mitigating action to manage stranded costs

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2. Indicate the current and anticipated cost of day case orthopaedics with no mitigating action to manage stranded costs

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| Direct Costs            |         |         |         |         |         |
| Medical staff (employed)|         |         |         |         |         |
| Medical staff (recharged)|        |         |         |         |         |
| Nursing staff           |         |         |         |         |         |
| AHP Staff               |         |         |         |         |         |
| Admin and managerial staff|      |         |         |         |         |
| Other staff             |         |         |         |         |         |
| **Sub-Total Direct Staff** |     |         |         |         |         |
| Theatre consumables     |         |         |         |         |         |
| Pharmacy                |         |         |         |         |         |
| Medical consumables     |         |         |         |         |         |
| Other TBA               |         |         |         |         |         |
| **Sub-Total Direct non-staff costs** | |         |         |         |         |
| **Sub-Total Direct Costs** |       |         |         |         |         |

| Indirect Costs          |         |         |         |         |         |
| Pathology               |         |         |         |         |         |
| Pharmacy                |         |         |         |         |         |
| Radiology               |         |         |         |         |         |
| Therapy services        |         |         |         |         |         |
| Other                   |         |         |         |         |         |
| **Sub-Total Indirect Costs** |       |         |         |         |         |

| Overheads               |         |         |         |         |         |
| TBA                     |         |         |         |         |         |
| Capital charges         |         |         |         |         |         |
| **Sub-total Overheads** |         |         |         |         |         |

| Total Costs             |         |         |         |         |         |
| **Contribution**        |         |         |         |         |         |

Describe how the costs in 1 and 2 above were arrived at including any core assumptions that had to be made.

**Assumptions to adopt:**

**Inflation:** All costs and income should be at a 2019-20 baseline

**Timeline:** Assume that a decision to proceed is taken at the start of 2020-21 and that an implementation programme begins shortly after.
The line "Medical Staff (recharged)" should show any costs recharged to the provider of the elective centre as a credit.

3. Stranded costs
Explain your approach to managing stranded costs.

Explain how these stranded costs arise:

- Unused capacity
- Underutilised staff
- Overhead absorption

Explain how you propose to mitigate the impact of stranded costs:

- Action to take
- Timescale
- Impact

Do any of these changes require changes to be made to commissioning plans and agreement with commissioners?

Will any of these changes have an impact on services in other providers?

4. Indicate the current and anticipated cost of inpatient orthopaedics following mitigation to manage stranded costs

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5. Indicate the current and anticipated cost of Day Case orthopaedics following mitigation to manage stranded costs

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6. **Activity volumes**
Please indicate the volume of elective orthopaedic activity you anticipate.

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This should be consistent with the activity model.

7. **Core facilities**
Please indicate the changes anticipated in core facilities.

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Will there be any vacated space resulting from these changes?
- Details of the space freed up from relocating the services to the elective hospital, condition and any issues arising
- Indication as to what uses this freed-up space could be used for (alternative uses), or whether the space/building/land could be disposed of
- Indication as to whether the shift of services impacts from an estates perspective those services left within the base hospital(s)
8. **Capital expenditure**
Please provide details of any capital expenditure that will be required to deliver the mitigation described above such as the refurbishment of vacated space. Information on the investment required:

- Description of the hospital property
- Confirmation that the site supports the wider clinical objectives set out in the programme
- Any clinical constraints the site offers in terms of delivering the scheme, including location, access from public highways, presence on site, internal layout implications etc
- Any estate constraints the site offers in terms of delivering the scheme, including planning consent, listed building consent, TPOs, environmental issues, or service/utility issues
- An indicative programme to deliver the capital works necessary to develop the site into a new use
- Key risks and interdependencies in delivering this programme
- An estimate (with evidence) of the capital costs (including fees, VAT and other associated costs) in delivering this capital programme, including decant costs
- Indication of where this funding is coming from
- Indication as to whether this investment impacts (+/-) any other local investments
- Indication as to whether the scheme facilitates the disposal of any NHS estate
- Indication as to whether the scheme and this investment removes any backlog maintenance
- Estimates of likely estate operating costs for the service (including capital charges, rent, rates, VAT, service charge etc).

9. **Efficiency and productivity of legacy services**
Indicate how this development could impact on the efficiency of legacy services. Areas to be considered:

- Unit costs
- Patient staff ratios
- Length of stay