BRITISH JOURNAL OF HOSPITAL MEDICINE

North central London elective orthopaedic network and health service innovation to improve the quality of NHS patient care

Health service innovation is required to meet the ever-growing demands of modern medicine. This editorial discusses the transformation of the north central London elective orthopaedic network and the essential principles which future integrated care systems could incorporate.

Joshua W Thompson[1]

Alice O'Brien[2]

Anna Stewart[2]

Rob Hurd[2,3]

Fares S Haddad[1]

Author details can be found at the end of this article

Correspondence to:
Joshua W Thompson;
joshua.thompson@doctors.org.uk

How to cite this article:
Thompson JW, O'Brien A, Stewart A, Hurd R, Haddad FS. North central London elective orthopaedic network and health service innovation to improve the quality of NHS patient care. Br J Hosp Med. 2021. https://doi.org/10.12968/hmed.2021.0326

Within the UK NHS, there is a greater need than ever for system redesign and improvement, to reduce variability in care quality, patient outcomes and equality of access to health services (NHS England, 2019a, b). As a result, clinical commissioners and five north central London NHS trusts currently providing adult elective orthopaedic surgery collaborated as part of North London Partners in Health and Care to propose and develop dedicated elective orthopaedic centres. The objective was to create an orthopaedic clinical network that would join services under one quality improvement umbrella, providing high volume elective surgery in two dedicated elective orthopaedic centres. The primary goal or 'case for change' for these centres was to diminish the variation in care quality and patient outcomes, while tackling ever-growing elective waiting list times, driving improvement in service productivity, and delivering best practice care across the north central London population.

However, the combination of this orthopaedic clinical network, and the model and principles upon which it was founded, have potential far beyond their initial intention. The learning opportunities from the creation of these elective orthopaedic centres could contribute to the innovation and improvement of health service delivery outside of these trusts or orthopaedic practice altogether.

These essential principles could be replicated in the future by other integrated care systems; namely multi-trust collaboration, driven by invested and enthusiastic clinical leadership, early patient and public engagement, and clarity regarding the necessity for change. Although the intricacies of the model are beyond the scope of this editorial, there are valuable elements that are shared (North London Partners in Health and Care, 2020).

At a regional and national level there is an impetus for change, supported by the literature reporting superior care quality and efficiency through the consolidation and ring-fencing of high volume surgical and orthopaedic elective care (Gabor et al, 2019; Yapp et al, 2021). Systems must be developed to streamline and expedite these processes, especially where there is established favouring evidence, if the NHS is to prosper in a high-demand environment.

Why do it? The case for change

Clear articulation of the case for change was pivotal to the proposal and to the execution of the project.

Multiple studies have identified significant geographical variability within NHS orthopaedic care, with racial and socioeconomic disparity in accessibility to common elective orthopaedic services (Garriga et al, 2019; Williams et al, 2020). Furthermore, there are still substantial variations in patient outcomes following lower limb arthroplasty across clinical commissioning groups within the NHS, favouring patient outcomes in higher surgical volume healthcare centres (Garriga et al, 2019).

Combined with the unpredictability and intensity of trauma work, and not restricted to orthopaedic care, elective work is regularly cancelled as a result of theatre or bed capacity restraints (Memarzadeh et al, 2017). As with many other specialties, patient

waiting times for orthopaedic elective operations are a significant concern, regardless of the exponential effects of the COVID-19 pandemic (Williams et al, 2020). North central London is no different. Successive UK governments have focused on the issue and devised various strategies to attempt to reduce waiting list times with limited success. Independent sector treatment centres and low demand distant hospitals lacked accountability and surgical responsibility, and ultimately reported poorer patient outcomes (Oussedik and Haddad, 2009).

The North London Partners in Health and Care elective orthopaedic centre model focused on addressing this demand, as well as patient and health inequalities, a goal that is universal across the NHS, and therefore indisputably present beyond orthopaedic practice (NHS England, 2019a, b). The North London Partners in Health and Care proposal hypothesised improving and standardising elective orthopaedic care delivered within north central London, through the reorganisation of services and centralisation into specialist high volume healthcare centres. The introduction of elective orthopaedic centres is intended to implement 'best practice' elective orthopaedic care by separating elective from emergency orthopaedic patient procedures; reducing surgical site infection, cancellation rates, waiting list times and revision rates (The Royal College of Surgeons of England, 2007; NHS England, 2019b). Combined orthopaedic networks offer further advantages with regards to research, training and investment opportunities, which could be replicated in other integrated care networks.

What was important about how this project was carried out?

This project was fundamentally an exercise in effective collaboration; across multiple trusts and services, among clinical leadership, and through patient and public engagement, with a common goal or purpose at the forefront of this combined approach.

The North London Partners in Health and Care elective orthopaedic centres were built on enthusiasm, engagement and direction from the clinical leadership of the trusts involved, from the initiation of the process. Inspiring and motivated leadership is needed in a project of this scale, to initiate change, maintain momentum and engage others in the project's success.

The uniqueness of the north central London elective orthopaedic centre proposal is the collaborative co-design of its future services by residents, staff, NHS organisations and local voluntary sector stakeholders across north central London. At the core of the reconfiguration proposal was a robust approach for public and patient engagement throughout the entirety of the planning process, from its earliest stages and continued through to the introduction of the elective orthopaedic centres. Patients and residents were involved throughout each stage of the process; from the governance group to all workshops, designing the public facing materials, and accounted for half of the options appraisal panel.

Similarly, a framework for collaboration between multiple trusts was set up to co-design the proposal, in contrast to the customary process of assessing competitive proposals from opposing trusts, thus expediting processes while avoiding wasted valuable time and resources. Undoubtedly this approach has not only facilitated higher colleague, patient and public satisfaction, but it has also accelerated the process for successful approval.

Recognising the interdependencies, opportunities for replication and learning opportunities for other care services

A strength of any healthcare reform is recognising the interdependencies that are essential to ensure a positive change in practice is achieved.

Retention of interdependent services was paramount for the elective reconfiguration and integration of services. Similarly, great importance was placed on ensuring a 'benefits realisation approach', reviewing a variety of metrics to check that the intended benefits of the new model are being achieved, such as reduced waiting times and increased patient satisfaction.

The authors' approach was to identify positive learning opportunities from elsewhere, while acknowledging that there is not a one-size-fits-all template in any given geography. Learning from the successes and challenges of other regions introducing elective orthopaedic centres has allowed the authors to build a robust service model. This can address each facet of musculoskeletal care, pre-, peri- and postoperative care, while looking to encompass new approaches.

Continuing the theme of contiguous learning, the pandemic has facilitated radical evolution of previously established paradigms and allowed the timetable of improvement processes that are typically met by regulatory and financial barriers to be redefined (Haddad, 2020). Valuable lessons have been learned during the pandemic that can be extracted for future healthcare innovations to adapt and change practice effectively, efficiently and expediently.

In future, the authors might consider refining current processes for the implementation of innovation projects and changes to practice. By working together in partnership – not competition, positively engaging and collaborating with others, innovation within the NHS can be taken forward in a less adversarial way, which may help to engender trust. Where consensus has built around change, the authors propose that there could be a more permissive, streamlined NHS assurance process, which might enable faster progress. The authors challenge the continuation of traditional elective pathways littered with persistent bed occupancy issues, theatre delays and ultimately patient cancellations secondary to necessary emergency care prioritisation. This requires a systemic change at the highest level.

As the NHS adapts into an era of integrated care systems, this reconfiguration will set a great example of improving secondary care services in the UK through a concerted effort by all stakeholders responsible for providing integrated care, but also the public receiving its care. It is important to foster an environment of generosity and shared learning, contributing elements of the process that were successful, but more importantly sharing areas that require further improvement.

Conclusions

The collective approach adopted within north central London by clinical commissioners, multiple trusts, the public and patients offers strong evidence of the potential for collaborative reform within the current healthcare system. This model provides a template for future reconfigurations that are required to tackle the ever-growing demand on NHS specialties that endeavour to deliver best practice while enduring pervasive challenges.

The transformation of the north central London elective orthopaedic network provides essential principles that future integrated care systems could incorporate; clear articulation of collective goals, attentive clinical leadership, and co-design through multi-trust collaboration and public engagement, in an effort to address health inequalities and establish a system to deliver best practice care.

Clinicians should aspire to develop innovative models of health service delivery that drive up proficiency, productivity and levels of care. It is hoped that the endeavours within north central London will stimulate further innovations that translate beyond the locality and specialty.

Acknowledgements

The authors would like to thank the collaborative stakeholders in their entirety; clinical commissioners, the five NHS trusts, clinical leaders, members of the public, patients, local government and voluntary stakeholders in their help and support in the genesis of the North Central London Elective Orthopaedic Network and the introduction of the dedicated elective orthopaedic centres.

Author details

[1]Department of Trauma and Orthopaedic Surgery, University College London Hospital Foundation NHS Trust, London, UK

[2]North London Partners in Health and Care, London, UK

[3]Royal National Orthopaedic Hospital NHS Trust, London, UK

Key points

- The transformation of the north central London elective orthopaedic network provides essential principles which future integrated care systems could incorporate.
- The model focused on addressing the service demand, as well as patient and health inequalities, a goal which is universal across the NHS, and therefore indisputably present beyond orthopaedic practice.
- The collective approach adopted within north central London by clinical commissioners, multiple trusts, the public and patients offers strong evidence of the potential for collaborative reform within the current healthcare system.
- Clinicians should aspire to develop innovative models of health service delivery that drive up proficiency, productivity and levels of care.

References

Gabor JA, Padilla JA, Feng JE et al. A dedicated revision total knee service: a surgeon's perspective. Bone Joint J. 2019;101-B(6):675–681. https://doi.org/10.1302/0301-620X.101B6.BJJ-2018-1504.R1

Garriga C, Leal J, Sánchez-Santos MT et al. Geographical variation in outcomes of primary hip and knee replacement. JAMA Netw Open. 2019;2(10):e1914325. https://doi.org/10.1001/jamanetworkopen.2019.14325

Haddad FS. The year of COVID-19. Bone Joint J. 2020;102-B(12):1597–1598. https://doi.org/10.1302/0301-620X.102B12.BJJ-2020-2094

Memarzadeh A, Taki H, Tissingh E, Hull P. The decline of elective operating at major trauma centres. Ann R Coll Surg Engl. 2017;99(2):166–168. https://doi.org/10.1308/rcsann.2017.0007

NHS England. What are integrated care systems? 2019a. https://www.england.nhs.uk/integratedcare/integrated-care-systems/ (accessed 17 June 2021)

NHS England. NHS long term plan. 2019b. https://www.longtermplan.nhs.uk/ (accessed 17 June 2021)

North London Partners in Health and Care. Adult elective orthopaedic services: decision-making business case. 2020. https://conversation.northlondonpartners.org.uk/wp-content/uploads/2020/10/200904_NLP-Orthopaedic-Care-Consultation-Report-v-0-17e.pdf (accessed 17 June 2021)

Oussedik S, Haddad F. Further doubts over the performance of treatment centres in providing elective orthopaedic surgery. J Bone Joint Surg Br. 2009;91-B(9):1125–1126. https://doi.org/10.1302/0301-620X.91B9.22869

The Royal College of Surgeons of England. Separating emergency and elective surgical care: recommendations for practice. 2007. https://www.rcseng.ac.uk/library-and-publications/rcs-publications/docs/seperating-emergency-and-elective/ (accessed 17 June 2021)

Williams P, Beard DJ, Verghese N. Yet another iceberg? The hidden potential harm of elective orthopaedic waiting lists. 2020. https://www.boa.ac.uk/resources/knowledge-hub/yet-another-iceberg-the-hidden-potential-harm-of-elective-orthopaedic-waiting-lists.html (accessed 17 June 2021)

Yapp LZ, Walmsley PJ, Moran M et al. The effect of hospital case volume on re-revision following revision total knee arthroplasty. Bone Joint J. 2021;103-B(4):602–609. https://doi.org/10.1302/0301-620X.103B4.BJJ-2020-1901.R1