Improving planned orthopaedic inpatient surgery in north west London

Decision-making business case

Proposal developed by
NHS North West London
Acute Provider Collaborative

Supported by
NHS North West London Integrated Care Board

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1 Executive summary

1.1 Overview

This decision-making business case (DMBC) sets out the case for bringing together much of the routine, inpatient orthopaedic surgery for the population of north west London in a purpose-designed, centre of excellence at Central Middlesex Hospital (CMH), completely separated from emergency care services. The North West London Integrated Care Board (ICB) is asked to endorse the DMBC and give the go-ahead for the proposal to proceed to the development of a full business case and implementation.

The centre will form a key part of an improved inpatient pathway for adults who need routine, planned orthopaedic procedures, such as a hip or knee replacement, who are otherwise generally well. Outpatient care (including pre-operative assessment and post-operative rehabilitation and follow-up) will continue to be available at a range of north west London hospitals, with responsibility for the end-to-end care of eligible patients remaining under the surgical team of their 'home' orthopaedic hospital. Their 'home' surgical team will travel with them to undertake the surgery, supported by the centre's permanent clinical support team. Day case and complex orthopaedic surgery will also continue in the north west London hospitals where they are provided currently.

The DMBC follows on from a pre-consultation business case (PCBC) published on 27 September 2022 and now reflects and responds to views, concerns and suggestions gathered from a wide range of stakeholders, including through an extensive public consultation involving over 1,959 individuals or organisations. The DMBC also takes into account the formal response to the proposal of the North West London Joint Health Overview and Scrutiny Committee (JHOSC).

The DMBC includes a refreshed integrated impact assessment (IIA) which systematically evaluates the likely impact of the proposal on different groups within the population of north west London, including those with protected characteristics.

Further assurance on the proposal was sought from two external bodies. The London Clinical Senate (LCS), an impartial arm's length advisory body, was supportive of the case for change and the direction of travel. The proposal also underwent assessment against the Mayor of London's six tests to be applied to all proposals for significant service change. The Mayor's review recognised the significant opportunity presented by the proposal to improve patient outcomes, reduce waiting times and tackle the planned care backlog more efficiently. Both reviews included recommendations which have been addressed within the DMBC through a refreshed IIA, more detailed workforce planning and additional analysis.

The DMBC has been developed in line with the NHS England guidance document, *Planning, assuring and delivering service change for patients (version 3, March 2018)* and *Addendum to Planning, assuring and delivering service change for patients, May 2022*.

The DMBC sets out a clear rationale for change in planned orthopaedic surgical care, with updated evidence, including:

- growing demand and increasing waiting times
- population health challenges, including large health inequalities
- underperformance against key quality indicators, wide variations in quality and disruption to planned care caused by surges in unplanned care
- insufficiently joined-up care across primary, community and acute services and care that is not sufficiently focused on the needs of the patient
- unnecessary variations in theatre utilisation and downtime
- staff recruitment and retention challenges.

While independent evaluation of responses to the public consultation showed overall support for the proposed changes to planned orthopaedic inpatient surgery, a number of concerns and suggestions were raised that have been carefully considered in the development of the DMBC. This has resulted in revisions to the proposal set out in the PCBC, primarily in the following five areas.

The five themes and our responses in summary are:

Travel

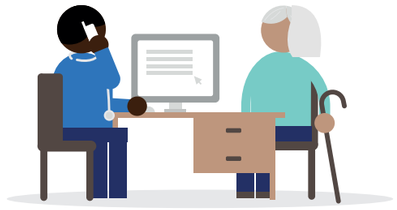
Issues: Journeys to Central Middlesex Hospital may be too complex, long or expensive for some patients.

Responses: We commissioned a detailed review of travel by public transport, helping to inform a three-step travel support solution, including the provision of free travel for patients unable to travel to or from the elective orthopaedic centre for their surgery independently or via an existing patient transport scheme and who would encounter a long, complex and/or costly journey by public transport. We anticipate this transport offer will be for around a third of elective orthopaedic centre patients.

Site location

Issues: There was less support for the elective orthopaedic centre to be located at Central Middlesex Hospital, primarily due to travel concerns. Some people, primarily staff and stakeholders in Hillingdon, would prefer the centre to be located at Mount Vernon Hospital.

Responses: We reviewed our assumptions for the site options appraisal to check the validity of our preferred location. Central Middlesex continues to score highest against clinical criteria, has the shortest median travel time by car and by public transport and meets a higher number of desirable criteria.



Clinical model and patient experience

Issues: With the elective orthopaedic centre focusing on the surgical procedure and 'home' hospitals on the pre- and post-operative care, there is a risk that care is not fully joined-up across hospitals. There are also concerns about lack of connectivity between hospital and community services.

Responses: The clinical model has been developed with consideration of the whole patient pathway. We are working closely with the ICB on reprocurement of community musculoskeletal (MSK) services to help ensure speedy access to specialist advice and decision-making and seamless discharge and rehabilitation support. All care, other than the actual surgery, would continue to be provided at a patient's 'home' orthopaedic hospital or, where appropriate, via digital platforms. And we are developing a cadre of 'patient navigators' to provide easy, direct access to information and support about all aspects of the service, including transport.

Workforce model and staff experience

Issues: Some staff seem uncertain about or opposed to the proposal and there is a risk there won't be enough staff for the elective orthopaedic centre and/or continuing orthopaedic services at the other hospitals across north west London.

Responses: While the proposal has been clinically led throughout, we need to do more to involve more staff in detailed planning and implementation. This further input will include shaping the most effective workforce model and recruitment approach. Consultants from each of the 'home' orthopaedic hospitals will travel with their patients to provide the surgery and we will develop opportunities for some other staff to 'rotate' between – spend blocks of time in – the centre and other orthopaedic services to develop experience and build skills across a range of care. As orthopaedic services will continue at each of the 'home' orthopaedic hospitals, we do not expect that anyone will have to move to the centre if they did not wish to do so, although we anticipate that a significant number of staff will want to move. With any approach, we will need to recruit permanent staff – for the centre and/or for services at other hospitals – and so have begun to explore a collective recruitment campaign.

Equity

Issues: There are concerns over the potential for exacerbating or creating inequalities.

Responses: We have put a strong focus on ensuring equity throughout the development of our proposal, including the use of the IIA alongside our consultation feedback to identify key challenges and responses. We know that people from black, Asian and other minority ethnic communities may be less likely to seek orthopaedic surgery than other groups, which the proposal will help tackle through even more detailed waiting list monitoring and improved communications, engagement and support. We will work closely with the ICB on the reprocurement of MSK services to address this across the whole patient pathway. We are putting in place specific approaches to preventing and addressing potential digital exclusion. For patients with more complex needs who are not eligible for the elective orthopaedic centre, the efficiencies we gain from consolidating low complexity care at a centre of excellence will be shared across all four acute trusts for the benefit of all orthopaedic patients. And the additional support we will provide for patients who would have long, complex or expensive journeys to Central Middlesex is being shaped particularly by the needs of patients who would find it difficult to travel by public transport and/or were less likely to have private means of transport.

More broadly, the DMBC details how the proposal – and the clinical model in particular – has evolved in response to feedback from stakeholders and how it is intended to be refined further as it moves forward into implementation. As such, the DMBC is not an implementation plan for the proposal, nor is it intended to provide all of the detail of a full business case (FBC) which is required to secure capital funding. However, it does aim to provide the evidenced rationale for a decision to proceed to the production of an FBC and to signal the additional information that needs to be addressed within that case.

The DMBC includes a refreshed benefits realisation plan that draws on a range of evidence and analysis to set out anticipated, tangible benefits under a range of headings. This includes:

- all orthopaedic surgery patients will have faster and fairer access to surgery
- patients at the elective orthopaedic centre will be much less likely to have their operation postponed due to emergency care pressures
- orthopaedic surgery will be of a more consistently high quality, benefitting from latest best practice and research, provided by clinical teams highly skilled in their procedures
- the elective orthopaedic centre will be extremely efficient, enabling more patients to be treated at a lower cost per operation
- staff will have a greater range of opportunities to develop their skills and experience

Finally, the DMBC includes detail on how the proposal will be taken forward in terms of governance, finances and detailed implementation.

1.2 Background

The four acute NHS trusts in north west London – Chelsea and Westminster Hospital NHS Foundation Trust, The Hillingdon Hospitals NHS Foundation Trust, Imperial College Healthcare NHS Trust and London North West University Healthcare NHS Trust (LNWH) – worked together increasingly closely throughout the response to COVID-19. This led to the establishment of a formal acute provider collaborative in July 2022.

As we emerged from the COVID-19 pandemic, the collaborative developed a more strategic approach to its planned care recovery, aligned to the strategy of the wider North West London ICB. In addition to restoring capacity and tackling long waits, the collaborative sought to address long-standing needs to improve the quality, equity, efficiency and sustainability of its planned care. The four acute providers aimed to build on a number of 'fast track surgical hubs' they established during the pandemic. Orthopaedics was identified as the first area for further development as a surgical speciality with some of the longest waits and where there are wide variations in the application of best practice and where quality indicators show potential for significant improvement.

To support collaborative and coordinated working across the acute providers, a lead provider model was put in place alongside the development of the initial fast track surgical hubs. LNWH is the lead provider for orthopaedic care and, again drawing on evidenced best practice, the trust led work exploring with partners the potential for a dedicated elective orthopaedic centre for north west London. Exploration of the potential for an elective orthopaedic centre for north west London became more formalised in late 2021 with the setting up of collaborative-wide project teams and oversight mechanisms. The work also benefited from an opportunity to align improvements in planned acute care with a review of the wider MSK pathway being led by the ICB on similar timescales.

The exploratory work undertaken in 2021 and 2022 culminated in a formal proposal by the acute provider collaborative, supported by the ICB, to develop an elective orthopaedic centre for north west London. In line with legislation, the ICB (as 'commissioner' of the services) and the North West London JHOSC (as the relevant oversight and scrutiny committee), agreed that the proposal reflected a 'substantial material' service change and a legal duty of public involvement was discharged by way of public consultation. A PCBC was approved by the ICB on 27 September 2022 and a public consultation, incorporating feedback from JHOSC and other stakeholders, took place between 19 October 2022 and 20 January 2023.

The North West London JHOSC considered the proposal formally at its meeting on 8 March 2023 and verbally responded.

1.3 Public consultation approach and evaluation

This public consultation sought views on the main proposal to develop an elective orthopaedic centre for north west London and the preferred location for the centre at Central Middlesex Hospital. The consultation period ran from 19 October 2022 until 20 January 2023. The process was led jointly by NHS North West London and the North West London Acute Provider Collaborative.

The consultation was supported by the specialist agency, Verve Communications Ltd, who also undertook an independent evaluation of the responses. Verve produced a comprehensive consultation evaluation report which was published in February 2023.

The proposal was discussed at the North West London JHOSC meeting on 20 July 2022 and draft PCBC documents, consultation delivery plans and related materials were shared with health and adult social care cabinet members and health scrutiny committee chairs for the eight local authorities in north west London. The Collaborative also submitted reports to and attended the following local authority meetings: Health and Adult Social Care Policy and Accountability Committee, London Borough of Hammersmith & Fulham, November 2022; Children & Adults, Public Health & Voluntary Sector Policy and Scrutiny Committee, City of Westminster, December 2022; Health and Social Care Select Committee, London Borough of Hillingdon, January 2023.

A total of 1,959 individuals and organisations participated in the consultation, as follows:

Activities	Number of participants
Open meetings and drop-ins	247
Community outreach meetings	373
Staff events	450+
Focus groups and interviews	70
Questionnaire	807
Responses from the public by email or telephone	5
Organisational responses	7
Total	**1,959**

Written responses were received from the following local authorities: London Borough of Hammersmith & Fulham, Royal Borough of Kensington and Chelsea and the City of Westminster.

Overall, participants supported the plan for an elective orthopaedic centre for routine surgery and understood the main benefit was to reduce waiting times for patients. There were some people who would prefer to have all their treatment at their local hospitals, generally for the sake of convenience.

There were two main concerns raised:

- Travel to and from the proposed elective orthopaedic centre at Central Middlesex Hospital. This was by far the most commonly made comment across all feedback channels.
- Services at home for people after they were discharged from hospital.

Some participants would have preferred the centre to be located at Mount Vernon Hospital. Generally, these were staff at Hillingdon and Mount Vernon hospitals and people who lived near Mount Vernon. A number of concerns relating to equity were raised, including: the potential to worsen inequalities due to travel issues; the increased use of digital channels; and the patients with more complex needs who would not be eligible for care at the elective orthopaedic centre. The impact on staff and existing recruitment and retention challenges were also raised as issues.

As part of the adaptive consultation approach, people were recruited to take part in focus groups and

interviews to boost the representation of groups who, at the mid-point of the consultation, were underrepresented. The underrepresented groups were: elderly patients; disabled patients; black, Asian and minority ethnic patients for whom English is a second language; and patients from deprived areas. The public consultation report summarises feedback from these participants separately as well as incorporating it into the overall summary.

1.4 Responding to feedback

We identified five key feedback themes for response from the consultation plus the updated integrated impact assessment and reports from the London Clinical Senate and the Mayor of London's office.

The five themes are:

- **Travel** – journeys to Central Middlesex Hospital may be too complex, long or expensive for some patients.
- **Site location** – there was less support for the elective orthopaedic centre to be located at Central Middlesex Hospital, primarily due to travel concerns. Some people, primarily staff and stakeholders in Hillingdon, would prefer the centre to be located at Mount Vernon Hospital.
- **Clinical model and patient experience** – with the elective orthopaedic centre focusing on the surgical procedure and 'home' hospitals the pre- and post-operative care, there is a risk that care is not fully joined-up across hospitals. There are also concerns about lack of continuity between hospital and community services.
- **Workforce model and staff experience** – some staff seem uncertain about or opposed to the proposal and there is a risk there won't be enough staff for the elective orthopaedic centre and/or continuing orthopaedic services at the other hospitals across north west London
- **Equity** – there are concerns over the potential for exacerbating or creating inequalities. This is primarily in relation to greater use of digital options that could make it harder for patients who aren't digitally savvy or who don't have easy or affordable access to a private space with Wi-Fi and a suitable mobile device; patients whose conditions are too complex for the elective orthopaedic centre and the risk of them having less priority and so waiting longer; travel issues particularly affecting poorer patients or patients with additional accessibility needs.

We have carefully considered the feedback and have revised our proposals – and plans for implementation – in response.

Travel

Central Middlesex is the most centrally located hospital in north west London but, wherever we place the centre, some patients will face longer journeys. We think the benefits of a single centre of excellence outweigh the inevitable downside of longer travel times for some patients. And we also believe we can significantly minimise the impact on affected patients.

In response to feedback through the consultation, we have undertaken a much deeper analysis of potential journeys and travel times – moving on from considering only median travel times to modelling the complexity and cost of a range of sample journeys. This has demonstrated the need to take account of all of these factors in determining who needs extra support and how we can best provide that extra support.

Our approach incorporated into the DMBC is to create a three-step travel offer for elective orthopaedic centre patients:	
Step 1: **Information** ALL PATIENTS	Provide all patients with the latest information on the range of options for travel to and from Central Middlesex. The information will be provided proactively, fully accessible and available in whatever languages and formats are required.
Step 2: **Facilitation** ALL PATIENTS	Provide all patients with practical support – via a team available by telephone or online – to help understand and book the different travel options and, wherever possible, to access additional support.
Step 3: **Patient transport** ELIGIBLE PATIENTS	For patients who are unable to travel to or from the elective orthopaedic centre for their surgery independently or via an existing patient transport scheme – and who would encounter a long, complex and/or or costly journey by public transport, we would provide transport – a car ambulance or taxi – free of charge. We would like to work with patient and community groups to develop this approach. We currently anticipate that we would extend a transport offer to around a third of elective orthopaedic centre patients, including a small number of patients who currently have a complex journey to their local hospital and may not currently be eligible for support.

Site location

We undertook a detailed site options appraisal to arrive at our preferred location of Central Middlesex. This included consideration of the option of having two elective orthopaedic centres, one at Central Middlesex and one at Mount Vernon (being our two existing orthopaedic surgery sites that do not have A&E departments). Details of the options appraisal are included in the PCBC, which was published alongside the public consultation materials.

We have reviewed our assumptions for the site options appraisal to check the validity of our preferred location. Central Middlesex continues to score highest against clinical criteria, has the shortest median travel time by car and by public transport and meets a higher number of desirable criteria. A two centre approach would not be able to deliver the patient outcome and access improvements through standardisation at the same pace for routine inpatient surgery, which in turn could impede more complex orthopaedic surgery and surgical specialties at 'home' hospitals, including Mount Vernon.

Clinical model and patient experience

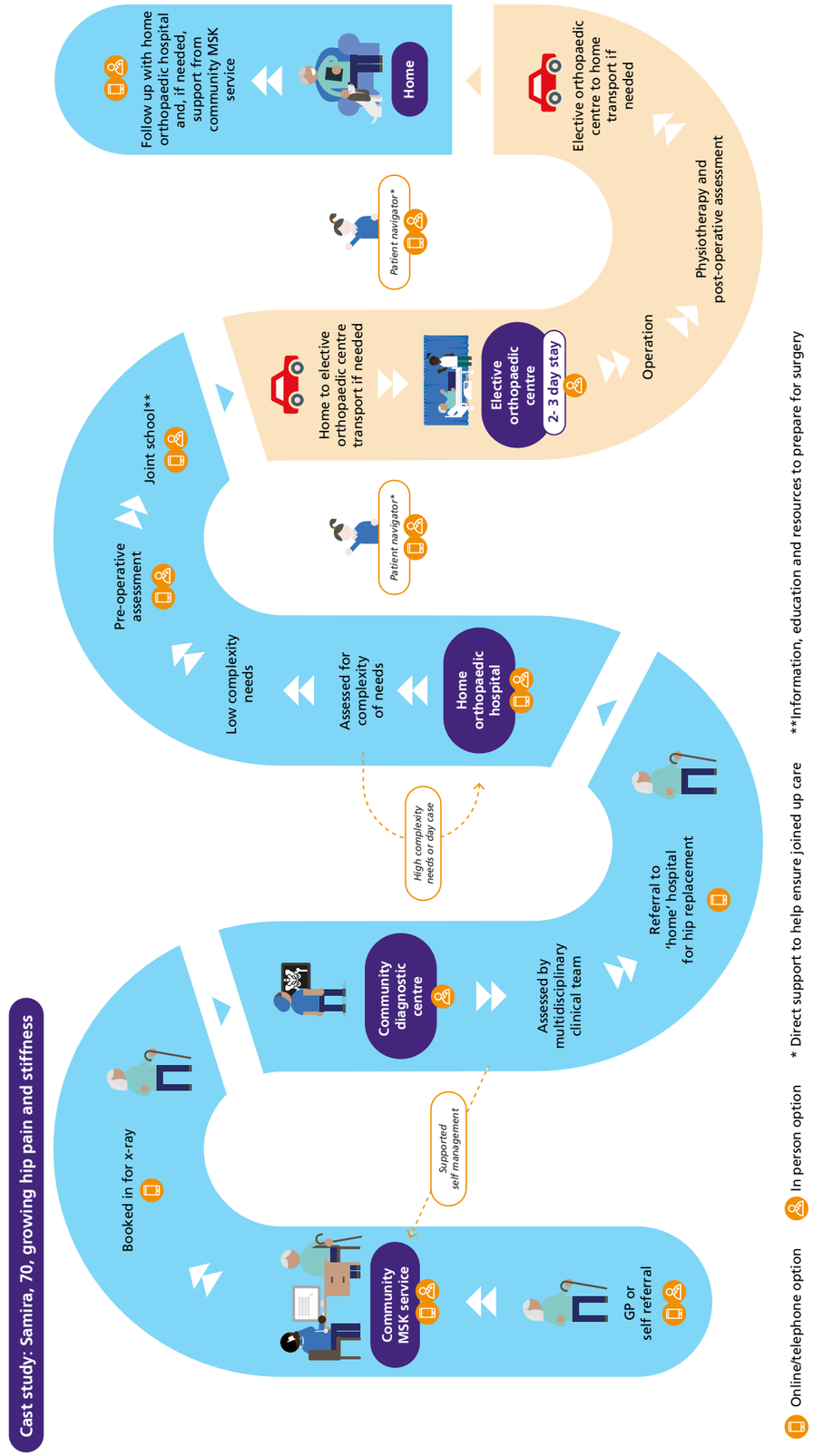
The clinical model has been developed with consideration of the whole patient pathway, including routes into and out of MSK community services as well as within and between hospital services. Fundamentally, patients with low complexity needs who are eligible for the elective orthopaedic centre remain under the care of their 'home' surgical team at all stages in their hospital journey, accessing their pre- and post-operative care locally and travelling with their surgical team to the elective orthopaedic centre only for their procedure. Patients with complex needs – or those eligible for day case surgery – will continue to be offered care at their local orthopaedic hospital, with the benefit that additional capacity will be available there due to the consolidation of low complexity inpatient surgery at the elective orthopaedic centre.

The ICB's parallel procurement of community MSK services is providing additional opportunities to create a more joined-up experience for patients. Patients will be offered a single point of access to the most appropriate community-based treatment and, when specialist advice or care is needed, a consistent and timely onward referral to one of our 'home' orthopaedic hospitals. Post-surgery, the elective orthopaedic centre's discharge hub will act as single point of referral to the eight north west London boroughs for patients who need social care, community rehabilitation or bedded rehabilitation.

There has also been a strong focus on ensuring digital platforms – such as our sector's increasingly popular care information exchange – help to break down site and organisational silos. Digital options will be offered wherever possible. Patient information, including patient letters, will have a consistent approach in terms of content, terms, tone and branding, helping patients to experience our care as a joined-up pathway.

We are also developing a cadre of 'patient navigators' to provide easy, direct access to information and support about all aspects of the service, including transport.

Figure 1 – Case study of how the elective orthopaedic centre will work within an overall improved MSK pathway



Workforce model and staff experience

While the proposal has been led by senior clinicians from across the four acute providers, and we have been expanding engagement with wider staff groups providing orthopaedic care across our hospitals, it's clear we need to do more to involve all staff in detailed planning and implementation if we go ahead. This further input would help us develop the most effective workforce model and recruitment approach.

We are estimating an elective orthopaedic team totalling around 336, with most staff based permanently at the centre. Consultants from each of the 'home' orthopaedic hospitals will travel with their patients to provide the surgery and we will develop opportunities for some other staff to 'rotate' between – spend blocks of time in – the centre and other orthopaedic services to develop experience and build skills across a range of care.

As orthopaedic services will continue at each of the 'home' orthopaedic hospitals, we do not expect that anyone will have to move to the centre if they did not wish to do so, although we anticipate that a significant number of staff will want to move. If we did require specific groups of staff to move, we would consult affected staff formally and TUPE arrangements would be put in place.

With any approach, we will need to recruit permanent staff – for the centre and/or for services at other hospitals – and we have begun to explore a collective recruitment campaign that will emphasise the range of additional opportunities provided by our integrated approach to orthopaedic care.

Equity

We have put a strong focus on ensuring equity throughout the development of our proposal – we have used the integrated impact assessment, alongside our consultation feedback to identify key challenges and possible responses. We know that people from black, Asian and other minority ethnic communities may be less likely to seek orthopaedic surgery than other groups which the proposal will help tackle through even more detailed waiting list monitoring and improved communications, engagement and support.

In terms of potential digital exclusion, we want to make the most of digital and other technological advances – which can increase convenience for some patients and avoid potentially painful or complex journeys to hospital – without leaving anyone behind. We are tackling this issue across all of our services and will roll out new responses to support the new clinical model, including tailored communications and face-to-face service options for patients who do not want – or are not able – to use digital platforms. We will also offer interested patients help with building and using their digital skills to support their health and healthcare.

In terms of patients with more complex needs, we have been modelling workforce requirements to ensure the proposed move of routine inpatient surgery to the elective orthopaedic centre will support a greater focus on complex surgery at the other sites. The efficiencies we will gain from consolidating low complexity care at a centre of excellence will be shared across all four acute trusts for the benefit of all orthopaedic patients.

In terms of travel, the additional support we will provide for patients who would have long, complex or expensive journeys to Central Middlesex is being shaped particularly by the needs of patients who would find it difficult to travel by public transport and/or were less likely to have private means of transport.

1.5 Implementation and continued public and patient involvement

Following a formal decision to implement the proposal as revised, we will move into mobilisation phase following completion and approval of the FBC. A gateway approach will be taken, with key review points to ensure the programme is ready to proceed to the next phase.

London North West University Healthcare NHS Trust, which manages Central Middlesex Hospital, will act as the host organisation for the elective orthopaedic centre. The Trust will set up the centre to run as a separate operational division, with its own service line reporting. An elective orthopaedic management board will be established, operating within the Trust's existing governance arrangements.

The acute provider collaborative will also establish a partnership board, operating in shadow until the centre is ready to go live. The partnership board will support implementation, helping to resolve any barriers and risks and, once live, overseeing evaluation of benefits and impacts.

Through our early engagement, which informed the development of our formal proposal, and through the public consultation programme and integrated impact assessment, we have built up lots of insight about what our patients and local communities need and would like to see from their orthopaedic care and from wider MSK services. We are developing plans for how best to build and respond to this insight as we move to implementation and also feeding into plans to improve wider community-based MSK services.

The diverse mix of contacts and relationships we have made over the last 18 months is key to this ongoing engagement, which will include:

- Inviting the 200 plus people who took part in the consultation and who gave us permission to keep them informed – as well as the community organisations who supported us, particularly in reaching individuals who are not so engaged with our services – to take part in involvement activities through a regular email update about the project (and wider MSK service improvements).
- Continuing to include lay partner roles in the governance structure for implementation (including oversight of ongoing involvement plans and patient and community feedback and experience indicators).
- Developing an iterative engagement plan using a variety of methods to expand our understanding of patient and community needs and views to inform the further development and implementation of the elective orthopaedic centre and related care pathways. The iterative plan (plus the insights and responses to those insights) to be overseen as part of the main project governance for implementation and for onward, continuous improvement.

1.6 Updated benefits realisation plan

We have developed a more detailed framework for monitoring achievement of the anticipated benefits of the proposal across the four acute providers and the wider ICB. It includes a revised and expanded set of key performance indicators (KPIs) with clearly designated owners and validated trajectories. This includes benefits under the following seven KPI themes:

- Clinical outcomes and experience
- Patient access
- Productivity (Getting it Right First Time – GIRFT)
- Cost-effectiveness
- Transport
- Patient satisfaction
- Workforce

There will also be detailed monitoring of benefits to ensure that local and national best practice benchmarks are achieved and feedback on cost-effectiveness, transport and patient experience.

1.7 Finance

The financial case shows that implementation of the proposal as set out would improve both productivity and efficiency of orthopaedic surgery services by Year 2.

The revenue benefit to the North West London ICS is £4.0m per year, driven by reduced unit costs through productivity and efficiency, and increased throughput (and positive impact on the waiting list), activity and therefore income. This has marginally reduced from the PCBC analysis by c.£100k due to the costs of enhanced transport arrangements. Subject to endorsement of the DMBC, the APC will draw up an FBC. The FBC will review the financial assumptions, including building towards the GIRFT target of all-day operating, six days a week. Once the APC Board in Common has approved the FBC, it will oversee implementation of the elective orthopaedic centre.

This benefit will be distributed across the four trusts in accordance with their pre-existing levels of 'overspend' against the tariff funding levels, subject to any agreement on reinvestment or service redesign across the acute collaborative.

Capital funding requirement and source are unchanged from the PCBC.

1.8 Assurance and advice

The programme has fully applied the NHS England major service change assurance, with patient, public and stakeholder engagement embedded in our approach. Legal advice and guidance has been sought to ensure the programme offers a high level of compliance with legal and other requirements. Independent assurance through NHS England (NHSE) and the Mayor of London's assessment against six tests for service changes has also been completed. Recommendations received through assurance and assessment have been fully considered and are included under the responses to the five themes.

Legal duties

The Programme Board, in conjunction with north west London system partners, has paid careful attention to ensure all of the legal duties have been met. In addition to the formal public consultation, we have met with North West London JHOSCs to seek their views on the consultation, the consultation report and our response. The ICB also commissioned an IIA for inclusion in the PCBC and DMBC to enable it to have regard to the impact of the proposal on equalities and inequalities.

The Secretary of State's four tests plus NHS England's 'bed test'

NHS England, in *Planning and delivering service changes for service users* guidance, published in 2018, and *Addendum to Planning, assuring and delivering service change for patients,* May 2022, outlines good practice on the development of proposals for major service changes and reconfigurations.

Building on this, the Secretary of State outlines that proposed service changes should be able to demonstrate evidence to meet four tests plus NHS England's 'bed test'.

Test 1: **Strong public and service user engagement**	Public and patient engagement has informed the planning process from its earliest stages and will continue into implementation, transition and service delivery. Public consultation has been completed.
Test 2: **Consistency with current and prospective need for service user choice**	Patients will continue to have their choice of care providers both inside and outside of north west London, as per the PCBC and in accordance with the NHS Choice Framework.
Test 3: **A clear clinical evidence base**	The case for change has been independently verified by the London Clinical Senate and engagement with a range of clinicians across the system.
Test 4: **Support for proposals from clinical commissioners**	This case has been developed by the North West London Acute Provider Collaborative in partnership with the North West London ICB.
Test 5: **NHS England's bed test**	This test does not apply, as there are no plans to reduce beds. NHSE has confirmed through their Stage 2 assurance gateway.

The PCBC passed Stage 2 of this process on 6 October 2022, before moving to public consultation. Following public consultation, NHS England has been kept informed of the proposed next steps once all feedback from the consultation has been gathered and analysed. NHS England has confirmed that it will not be undertaking formal assurance of the DMBC following the independent report on the consultation.

ICB assurance

- North West London ICB considered the PCBC on 27 September 2022. In addition to ensuring that the ICB fulfils its legal duties, the ICB raised five specific points that the DMBC includes response to:
  - There has been a comprehensive and robust public consultation.
  - Potential risks to exacerbating inequalities highlighted in the PCBC (including transport and digital exclusion) have been addressed.
  - Benefits in terms of reducing waiting lists and improving quality have been clarified.
  - More detailed workforce planning has been undertaken and that there is support across the clinical body that the proposal is deliverable and that job planning and other issues have been resolved.
  - All the financials are robust and there is confirmation that there will be no additional requests for money from the ICB in order to deliver the business case (revenue or capital).

The financial model underpinning the DMBC was presented to the Finance and Performance Committee (F&PC) on 10 March 2023 for partnership assurance and scrutiny in advance of the North West London APC Board in Common Cabinet meeting on 14 March 2023.

London Clinical Senate

The London Clinical Senate has provided impartial, expert advice as part of the assurance process for NHS England. The London Clinical Senate found that the proposals were grounded in evidence and best practice. They were supportive of the case for change and the direction of travel.

Meeting the Mayor's tests

A letter from the Mayor of London sets out his consideration for the programme against four of his six tests for healthcare transformation and notes he is broadly supportive of the proposed changes. The Mayor of London will complete his assessment of the six tests in advance of North West London ICB's meeting on 21st March 2023. His assessment will be made available to members of the ICB in advance of the meeting and published alongside the DMBC should the ICB endorse the DMBC.

1.9 Governance

Decision-making process

Following the close of the public consultation, the feedback was analysed by Verve Communications Ltd. The consultation evaluation report was published in draft and released to the North West London ICB Board on 27 January 2023. Following completion of the report, it was published online on 8 February 2023.

The findings from the consultation were presented to the North West London JHSOC on 8 March 2023.

This DMBC document was presented in draft to the North West London Acute Provider Collaborative (APC) Board in Common on the 14 March 2023. The final report was presented to the North West London ICB Board on 21 March 2023.

Decision-making recommendations

The North West London Integrated Care Board is asked to:

- **ENDORSE** this DMBC and proceed with the proposed elective orthopaedic centre described in the public consultation and as updated within this DMBC in response to the consultation findings and feedback from external, independent assurance and advice.

- **NOTE** that the DMBC includes:

Travel

a) Proposals to enhance travel arrangements including providing comprehensive information on travel options, help with planning journeys and help to access support for transport.

b) In cases where patients are unable to travel by their own means and who were not eligible for existing support schemes and would have a long, complex or costly journey by public transport, we will provide transport at no charge. We estimate a third of the patients treated at the centre in the future will require transport.

Site location

c) Confirmation of Central Middlesex Hospital (CMH) as the location for the elective orthopaedic centre because:

- CMH is the most centrally located hospital in north west London. We believe the benefits of a single centre of excellence outweigh the inevitable downside of longer travel times for some patients.
- CMH, being a site that does not provide emergency care, can provide ring-fenced capacity for planned orthopaedic care.
- The site has the best quality estate in north west London and requires minimal capital investment.

We provided details of the options appraisal in the PCBC which was published alongside the public consultation materials.

Clinical model and patient experience

d) Details of the clinical model and how it has been augmented through greater clarity on pre-operative and post-discharge care so that patients are clear about their entire planned orthopaedic care pathway.

e) Consideration of the whole patient pathway, across MSK community services as well as within and between hospital services.

f) Continued patient engagement and co-production planning during the transitional period to the elective orthopaedic centre opening and beyond.

Workforce model and staff experience

g) A collective recruitment campaign that will emphasise the range of additional opportunities provided by our integrated approach to orthopaedic care.

h) Proposals to expand the role for all staff in the detailed planning and implementation for the elective orthopaedic centre following approval of this DMBC. We will achieve this through:
- a review of all staff involvement activities undertaken to date to ensure that staff are aware and have been informed about the proposal. Extra sessions will be held where necessary. This is being taken forward locally at each of the trusts.
- an ongoing programme of involvement for all staff who work in orthopaedic surgical and related care, so that they can help shape the final proposals and, if it goes ahead, the implementation plan and beyond.

i) An enhanced training programme to ensure the elective orthopaedic centre will have staff ready to operate in accordance with the levels of quality, productivity and efficiency required from day one.

Equity

j) A revised approach to ensure there is no default to digital for patients navigating care pathways. We are tackling this issue across all of our services and will roll out new responses to support the new clinical model, including tailored communications and face-to-face service options for patients who do not want or are not able to use digital platforms.

k) Even more detailed waiting list monitoring and improved communications, engagement and support, given we know that people from black, Asian and other minority ethnic communities may be less likely to seek orthopaedic surgery than other groups.

Financial

l) Confirmation that capital funding is unchanged from the PCBC, and no further capital funding will be sought from the ICB.

m) The revenue benefit to the north west London system has been marginally reduced by c.£100k (£4m from £4.1m) due to the costs of enhanced transport arrangements.

n) The annual cost of delivering the range of planned orthopaedic services within scope for the elective orthopaedic centre will reduce from £31m to £27m.

o) An expanded benefits realisation plan which includes a full suite of productivity and financial metrics to monitor the centre's delivery of best practice theatre productivity and length of stay metrics.

Implementation

p) Plans for London North West University Healthcare NHS Trust to act as host for the elective orthopaedic centre, managing the centre and providing all logistical support for it to operate as a free standing business division with its own service line reporting.

q) An elective orthopaedic centre management board will be in place prior to commencement, operating within the LNWH governance arrangements.

r) An extended benefits realisation plan to monitor achievement of EOC benefits as set out in the pre-consultation business case but with revised and expanded KPI themes and metrics, designated owners and validated trajectories.

- **ENDORSE** the approach to implementation assurance which will be overseen by the NWL APC and delivered by London North West University Healthcare NHS Trust through the establishment of a clinically chaired Partnership Board.

- **NOTE:**
  i) The Public Consultation Report and the Integrated Impact Assessment.
  ii) Subject to endorsement of the decision making business case, the Acute Provider Collaborative will draw up a Final Business Case. The FBC will review the financial assumptions, including building towards the GIRFT target of all-day operating, six days a week. Once the APC Board in Common has approved the FBC, it will oversee implementation of the elective orthopaedic centre.
  iii) The Joint Health Overview and Scrutiny Committee is due to respond formally to the consultation report on 8 March 2023 and we will address this:
    – Within the final DMBC to be submitted to the North West London Integrated Care Board (NWL ICB) on 14 March 2023.
  iv) The NWL ICB's Strategic Commissioning Committee, a sub-committee of the ICB, approved the submission of the DMBC to the ICB subject to inclusion of further measures in the Benefits Realisation Plan. These have been included.
  v) The Mayor of London will complete his assessment of his six tests for major service reconfigurations in London in advance of NWL ICB's meeting on 21 March 2023. His assessment will be made available to members of the ICB in advance of the meeting and published alongside the DMBC should the ICB endorse the DMBC.

2 Introduction and background

Chapter 2 sets out the proposal to create an elective orthopaedic centre and how the case for change has been reviewed and validated since the PCBC, including a refreshed IIA.

Key messages

The six drivers for change identified in the PCBC remain unchanged:

- Growing demand and increasing waiting times
- Population health challenges, including large health inequalities
- Underperformance against key quality indicators, wide variations in quality and disruption to planned care caused by surges in unplanned care
- Insufficiently joined-up care across primary, community and acute services and care that is not sufficiently focused on the needs of the patient
- Unnecessary variations in theatre utilisation and downtime
- Staff recruitment and retention challenges

Through the systematic and evidenced based approach of an IIA, we considered the likely impact on the different groups of the population of north west London, including those with protected characteristics and those with higher levels of deprivation. The DMBC includes recommendations that respond to the five main IIA findings below:

- The Core20 population (most deprived) within NWL has an above-average T&O activity per head, but below-average wait times, and is less impacted by travel in the recommended model.
- Our white community has a higher average service usage, length of stay and waiting time than other black and minority ethnic groups.
- While our elderly community makes up most of T&O elective demand per 1,000 population, their surgery is usually more complex.
- Women in NWL have a higher service demand and longer length of stay than men, suggesting they will be most impacted by service changes.
- While other protected characteristics were hard to analyse due to lack of data, mitigating actions, including staff training and awareness, will need to be detailed to avoid discrimination against these protected characteristics.

2.1 Origins of the proposal

The four acute NHS trusts in north west London – Chelsea and Westminster Hospital NHS Foundation Trust (CWHFT), The Hillingdon Hospitals NHS Foundation Trust (THHFT), Imperial College Healthcare NHS Trust (ICHT) and London North West University Healthcare NHS Trust (LNWH) – have been working closely together throughout the response to COVID-19 and in the period since we emerged from the pandemic. This led to the establishment of a formal Acute Provider Collaborative (APC) in July 2022.

The APC forms part of the North West London ICS. The provision of healthcare services for the population of north west London is overseen by the North West London ICB and it is the population's needs that are at the heart of the proposal set out in the PCBC, which aims to improve planned elective orthopaedic care service delivery.

The case to improve planned elective orthopaedic care service delivery remains undiminished. To support collaborative and coordinated working across the acute collaborative providers, a lead provider model was put in place. LNWH is the lead provider for elective orthopaedic care and, again drawing on evidenced best practice, the Trust has led work on exploring the potential for a dedicated elective orthopaedic centre for north west London, focused on determining whether greater benefits to patient care in terms of quality, equity, efficiency and sustainability would be achieved by creating an elective orthopaedic centre for routine, planned inpatient orthopaedic surgery in north west London.

Following review of NHS England's four tests for service change and engagement with the North West London Joint Health Overview and Scrutiny Committee (JHOSC), the JHOSC considered the proposals to be a substantial variation/development and based on that the programme concluded that full public consultation was required. This started in October 2022 following agreement and publication of the PCBC. Since the conclusion of the consultation process in January 2023, all north west London system partners remain absolutely committed to the proposal for an elective orthopaedic centre at the earliest opportunity.

We have carefully considered all of the feedback received on the elective orthopaedic centre proposal through the public consultation, assurance, and advisory processes. This DMBC sets out the feedback we received, together with our responses and final recommendations.

2.2 Ambition of the elective orthopaedic centre

The vision for a north west London elective orthopaedic centre is consistent with the model recommended by GIRFT and the British Orthopaedic Association (BOA) and adopted widely in London and nationally.

The intention is to create a centre of excellence for planned orthopaedic care, delivering productivity and quality of care for patients that consistently meets best practice, delivers optimum value and builds on the learning from the South West London Elective Orthopaedic Centre (SWLEOC) model and other elective orthopaedic centres.

The north west London elective orthopaedic centre will be fit for the future. It is designed using evidence from a range of sources, in addition to GIRFT and the BOA, including the National Joint Registry and other professional bodies.

There will be sufficient capacity to meet current and future demand resulting in timely access to services.

The potential benefits for patients will be:

- faster access (due to sufficient capacity)
- equitable access
- consistent and best practice care in a centre of excellence
- better clinical outcomes
- improved pre-operative care
- shorter length of inpatient stay

- dedicated facilities and reduced likelihood of cancellation
- dedicated, specialist post-operative care and service
- increased investment due to potential savings from repatriation from out of sector
- a COVID-secure environment

The GIRFT vision is for 'cold' elective surgical hubs, offering ring-fenced beds and ultra clean air theatres, thus delivering evidence-based best practice in relation to protection against infection. Standardisation of care ensures the highest levels of productivity and value for money. This proposal is compatible with best practice recommendations from GIRFT, as shown in Table 1 below, and is supported by the National Director of Clinical Improvement for the NHS.

Table 1 – GIRFT best practice recommendations for elective orthopaedics

Theme	GIRFT comment	Elective orthopaedic centre meets best practice?
Ring-fenced beds	Best practice is rigidly to enforce ring-fencing of elective orthopaedics minimises infection. Some trusts have achieved this, others have not.	✓
Hot and cold sites	By separating "hot" unplanned emergency work from their "cold" elective work, trusts have seen reductions in average length of stay, reductions in cancellations of surgery and increased elective activity during winter pressures.	✓
Minimum volumes	Surgeons should perform 35 or more total hip replacements per year to avoid increased complication rates. There is still work to be done with providers to achieve this.	✓
Choice of implant	Surgeons should follow the evidence that choice of implant should be tailored to the patient need. Best practice is that 80% of patients over 70 should receive a cemented hip.	✓
Surgical site infection (SSI)	Variation in SSI rates were found when GIRFT started their visits. Ring-fencing, hot/cold sites and laminar flow are key factors in reducing infections.	✓
Rehabilitation services	Particularly relating to increased physiotherapy service for elective and hip fracture patients – 7 days a week in hospital and continuity into the community.	✓
Procurement	Variable implant costs and use of loan kits has been tackled through improved visibility and price negotiations.	✓

2.3 Revised case for change

The case for change was widely accepted during the consultation and assurance process. The subsequent changes are due to updates in modelling and analysis refreshed since the PCBC and this chapter sets out the key considerations.

The six drivers for change identified in the PCBC remain undiminished:

- Growing demand and increasing waiting times.
- Population health challenges, including large health inequalities.
- Underperformance against key quality indicators, wide variations in quality and disruption to planned care caused by surges in unplanned car.
- Insufficiently joined-up care across primary, community and acute services and care that is not sufficiently focused on the needs of the patient.
- Unnecessary variations in theatre utilisation and downtime.
- Staff recruitment and retention challenges.

Waiting lists and waiting times

The total north west London orthopaedics waiting list for care has been rising with an approximate 30% increase since April 2022 following elective recovery since the disruption caused by COVID-19. Due to winter pressures, this list has grown by about 1,000 additional patients since the publication of the PCBC. The waiting list, as of January 2023, currently stands at over 16,000 patients.

Waiting times from decision to admit (DTA) have improved slightly since 2021/22, although still worse than 2019/20. DTA is measured from when the patient is added to the waiting list once the patient and clinician decide there is a need for surgery until completion of the surgery itself.

The number of patients waiting more than a year in north west London for elective orthopaedic surgery specifically has risen by c.200 from 4 patients pre-COVID-19.

Since the PCBC, modelling on the impact of the elective orthopaedic centre opening has been updated. Waiting times between DTA and surgery for inpatients as a result of establishing an elective orthopaedic centre will see a reduction in the region of 3-weeks at Year 1 and 9-weeks at Year 2. This will mean patients waiting times for orthopaedic surgery will halve in most cases at Year 2 and the number of patients on the waiting list will reduce to pre-COVID levels.

Table 2 – Modelled reduction of DTA waiting times for day case and inpatients for all north west London elective trauma and orthopaedic care following the opening of the EOC (midpoint (range) in weeks)

	No EOC	EOC opens	
	Current DTA	Year 1	Year 2
EOC Inpatient	22 (18-29)	19 (15-24)	13 (9-18)
NWL Day case (excluding EOC)	15 (13-16)	11 (8-15)	6 (3-10)

Population health

Demographic analysis of the historic use of elective T&O services across north west London has shown that some health inequalities exist across deprivation and ethnicity. Addressing these is a priority for North West London ICB, and actions to reduce health inequalities will be incorporated into the design and implementation of the EOC.

The IIA has noted that historic use of elective T&O services is slightly higher in the more deprived areas of north west London. This reflects the higher prevalence of MSK disorders in the more deprived deciles of the population, which the Mayor of London has also noted.

The IIA has also noted that the historic use of elective T&O services is lower in the black and minority ethnic (BAME) groups, compared to the White population. Research from the 2022 Health Survey of England1 indicates a similar prevalence of MSK conditions among BAME ethnic groups compared to the national average. While the BAME groups have a younger population on average, so you would expect a lower use of elective T&O services, there is still a gap when adjusting for age. This suggests inequalities in access to elective T&O services.

The MSK pathway will be routinely reviewed to identify and resolve bottlenecks to enable a seamless pathway, and identify areas which might be driving health inequalities in access or outcomes. The EOC will actively monitor waiting lists to avoid introducing any further inequalities within any protected characteristics or higher levels of deprivation. These inequalities are likely to arise at different points throughout the MSK pathway and the EOC can help reduce inequalities within secondary care. However, the new community MSK pathway offers an opportunity to address inequality earlier in the pathway.

Underperformance against key quality indicators

North west London performance for elective orthopaedic care using model hospital data and patient reported outcome measures (PROMs) refreshed to Q2 2022/23 shows no change in underperformance against key quality indicators (KQI) when compared to the PCBC.

1 https://digital.nhs.uk/data-and-information/publications/statistical/health-survey-for-england

Table 3 – Key quality indicators for north west London

	ICHT	LNWH	CWHFT	THHFT
PCBC KQI Average	Q3	Q3	Q3	Q4
DMBC KQI Average	Q3	Q3	Q3	Q4

Key	Q1 – Top quartile performance	Q2 – Second quartile performance	Q3 – Third quartile performance	Q4 – Bottom quartile performance

Estates and efficiencies

There remains significant variation in theatre utilisation and downtime across the north west London acute trusts providing elective orthopaedic surgery since the PCBC.

As part of the high volume low complexity programme, GIRFT has set targets for ICSs and providers to achieve the following:

- Cases per session – 2 cases per 4 hour list
- Theatre utilisation – 85% utilisation by 2024/25

Table 4 – Theatre efficiency and utilisation across north west London

	PCBC (FY 2020/21)		DMBC (FY 2021/22)	
	Average number of orthopaedic cases per operating session	Theatre session utilisation (capped)	Average number of orthopaedic cases per operating session	Theatre session utilisation (capped)
NWL ICB T&O	1.4	70%	1.8	63%

Table 4 shows that while north west London theatre utilisation has not recovered post COVID-19, there have been improvements in the number of patients treated per session for all orthopaedic surgery. This is an average of all simple and complex, elective and trauma, inpatient and day case procedures across the system.

The development of a north west London elective orthopaedic centre will enable more transformational change right through the peri-operative orthopaedic surgery pathway that addresses the barriers to effective and efficient theatre utilisation along with improving outcomes for patients and ensuring nobody is left behind. The development ensures that there is a clear focus and place for longer routine cases and shorter cases including day cases delivered more locally, both of which are commonly referred to as high volume low complexity surgery. Offering high volume low complexity surgery using this model offers proven efficiencies of scale and has been shown to improve quality and patient experience.

Conclusion

The case for change as compelling and as relevant as when the PCBC was published. The demand for elective orthopaedic care remains high in north west London with over 1,000 people added to the waiting list since the PCBC was published. The mixed use of theatres and beds owing to demands for urgent and emergency care continues to challenge achieving more effective theatre utilisation and quality improvements for more routine, planned inpatient orthopaedic surgery in NWL.

2.4 Refreshed Integrated Impact Assessment (IIA)

North west London understands that the implementation of an elective orthopaedic centre and a new clinical model may disproportionately impact some groups of the population. To understand this potential impact an IIA, Equality Health Impact Assessment (EHIA) and Quality Impact Assessment (QIA) have been completed with full details published in the PCBC and the IIA subsequently refreshed for the DMBC, so that it is as up to date as possible.

Integrated Impact Assessment (IIA)

The IIA takes a systematic and evidenced based approach to considering the likely impact on the different groups of the population of north west London, including those in the more deprived areas within north west London, and those with protected characteristics as defined by the UK government[2], and sets out the mitigating actions that will be incorporated into the implementation plan. It provides evidence and information to North West London ICS decision-makers to enable them to fulfil their duties under section 149 of the Equality Act 220 and section 14z35 of the NHS Act 2006.

The refreshed IIA had three main changes from the previous IIA included within the PCBC, as follows:

1. The activity levels of the more deprived deciles are comparable to the whole of the north west London population, while the previous analysis showed a higher activity level among the most deprived population compared to the whole population.
2. Average waiting times for women to receive elective Trauma and Orthopaedic (T&O) services were also found to be slightly higher than men due to the expanded time period in the examined data extraction methodology as opposed to the previous version where we found a slightly lower wait time for women on average.
3. Hospital Episodes Statistics database records only a small number of elective T&O patients discharged to care homes, suggesting a minimal impact on care homes. However, many patients discharged to their usual places of residence may require care at home which will not be represented in the data.

This means that the main findings from the IIA are as follows:

- The Core20 population (most deprived) within north west London has an above-average T&O activity per head, but below-average wait times, and are less impacted by travel to CMH than other populations.
- The white population has a higher average service usage, length of stay and waiting time than other black and minority ethnic groups.
- The elderly make up most of T&O elective demand per 1,000 population, but tend to be considered ASA 3 or 4 (which is out of scope for the elective orthopaedic centre).
- Women have a higher service demand and longer length of stay than men, suggesting they will be most impacted by service changes.
- While other protected characteristics were hard to analyse due to lack of data, mitigating actions, including staff training and awareness, will need to be detailed to avoid discrimination and to promote equality of opportunity against these protected characteristics.

The following mitigating actions proposed to address the identified risks in the IIA are:

Access

Continuation of existing travel support schemes and provision of patient transport for those facing long, complex or costly journeys.

A single referral system to ensure equal access for all eligible patients.

Virtual pre-operative assessment where suitable (with face-to-face options to avoid digital exclusion).

Adequate disabled parking and access and wayfinding.

Monitoring of elective orthopaedic waiting times to ensure equitable access for those with protected characteristics and higher levels of deprivation.

Providing patient choice of site for surgical care at point of referral, in line with NHS Choice Framework[3].

2 https://www.gov.uk/discrimination-your-rights
3 https://www.gov.uk/government/publications/the-nhs-choice-framework

Patient experience

- Develop a patient experience strategy and delivery plan, including co-design and co-production with patients and staff.
- Set up an Equality, Diversity, and Inclusion committee comprising staff and patient group representatives.
- Improve knowledge and cultural competency amongst staff through awareness and training.
- Develop strategies to ensure appropriate BAME and gender representation in the staff group.

Outcomes

- Standardised processes across the routine inpatient orthopaedic surgical pathway for the whole of north west London, alongside adjustment for individual patient needs.
- Develop standard operating policies for discharge in collaboration with community colleagues.
- Review quality outcome data and patient reported outcomes for all patient groups and set action plans for unwarranted variations.
- Routinely review the end-to-end MSK pathway to identify and resolve bottlenecks to enable a seamless pathway.
- Enhanced training for all clinicians and support staff to understand the drivers behind the variations in outcomes for protected characteristics and how to account for them.

The IIA is included as Appendix B.

3 The public consultation

Chapter 3 sets out our public consultation approach with patients, staff and stakeholders and their feedback on the proposal including recommendations on how to overcome potential challenges and further improve the proposal to develop an elective orthopaedic centre in north west London.

Key messages

1. Consultation responses were received from a range of individuals and organisations in a range of media to enable accessibility, with a total of 1,959 participants.
2. Overall, participants supported the plan for an elective orthopaedic centre for routine surgery and understood the main benefit was to reduce waiting times for patients.
3. There were some people who would prefer to have all their treatment at their local hospitals, generally for the sake of convenience.
4. The public consultation report helped focus on the potential challenges and improvements which patients shared with us. We have themed these under:
   a. Clinical model and patient experience
   b. Workforce and staff experience
   c. Site location
   d. Travel
   e. Equity

The final section addresses the feedback and sets out proposed responses including revised clinical and workforce models and a transport solution to support all patients who might face a long, complex or expensive journey to the elective orthopaedic centre.

3.1 Approach and process that we followed to undertake the consultation

A 14-week public consultation was held between 19 October 2022 and 20 January 2023, led by NHS North West London ICB and the North West London APC. The link to the full report can be found in Appendix A, and the executive summary is shown in Appendix F. The consultation approach built on early engagement with patients and the public in June 2022, which had previously informed the development of the formal elective orthopaedic centre proposal set out in the PCBC. While the early engagement focused on 'what good looks like', the public consultation focused more clearly on the clinical model and the preferred location of the north west London elective orthopaedic centre at CMH in Park Royal. An independent qualitative research agency, Verve Communications Ltd, was commissioned to analyse responses and produce an evaluation report.

The consultation team designed an engagement programme to offer a wide and accessible range of ways for the diverse population of north west London to participate. Priority groups were identified through the programme's EHIA and included:

- 45+ age group who are already on our waiting lists and their families and carers
- people with more complex health care needs
- black, Asian and other minority ethnic groups
- LGBTQIA+ groups
- groups likely to incur longer travel times
- residents living in the most deprived areas

The key elements of the consultation engagement included: a questionnaire; open, clinician led meetings (in-person and online); drop-in sessions; community outreach meetings; staff events; and focus groups and interviews. This was supported through a promotional programme to encourage completion of the questionnaire, generate attendance at community events and offer support to consultees with specific needs, such as translation support for those for whom English is not a first language or an easy read version of the core consultation material. All eight local authorities were engaged for advice and feedback ahead of and during the consultation period.

Working with community organisations, people were recruited to take part in focus groups and one-to-one interviews to boost the representation of groups who, at the mid-point of the consultation, were under-represented in participation. The under-represented groups were elderly patients, disabled patients, black and minority ethnic patients for whom English is a second language, and patients from deprived areas. The public consultation report summarises feedback from these participants separately as well as incorporating it into the overall summary.

Feedback is summarised in this chapter, along with key recommendations and outputs from the governance and assurance mechanisms outlined. Further detail can be found in the full report here[4].

3.2 Breakdown of participants who responded to the consultation

Consultation responses were received from a range of individuals and organisations across a range of media to enable accessibility, with a total of 1,959 participants (see Appendix F).

Table 5 – consultation participants

Activities	Number of participants
Open meetings and drop-ins	247
Community outreach meetings	373
Staff events	450+
Focus groups and interviews	70
Questionnaire	807
Responses from the public by email or telephone	5
Organisational responses	7
Total	1,959

Responses were received from the following local authorities in north west London and are reproduced in full in the public consultation report:

- London Borough of Hammersmith and Fulham
- Royal Borough of Kensington and Chelsea
- City of Westminster

In addition, we submitted reports to and attended the following local authority meetings:

- Health and Adult Social Care Policy and Accountability Committee, London Borough of Hammersmith & Fulham, 16 November 2022
- Children & Adults, Public Health and Voluntary Sector Policy and Scrutiny Committee, City of Westminster, 5 December 2022
- Health and Social Care Select Committee, London Borough of Hillingdon, 26 January 2023

4 https://www.nwl-acute-provider-collaborative.nhs.uk/-/media/website/nwl-acute-provider-collaborative/documents/nwl-eoc-consultation/nwl-elective-surgery-consultation-report-final.pdf?rev=d3dc29180fd34296a03afeb94b2c24ac

More specifically, the survey received 807 responses (although not all answers sum to 100% as not every respondent answered every question):

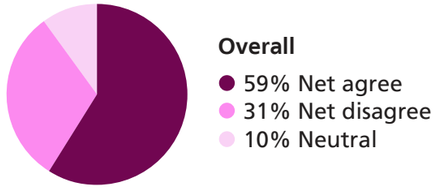
- 28% of responses were from people from Hillingdon. This is twice as many as from the next largest responses from Ealing and Hammersmith and Fulham
- 14% from Ealing
- 13% from Hammersmith and Fulham
- 11% of responses were from people living outside of the 8 boroughs
- 8% from Brent
- 7% from Hounslow
- 7% from Westminster
- 6% from Kensington and Chelsea
- 6% from Harrow

Furthermore, 59% of responses were from patients and carers, 12% of responses were from NHS staff, 29% of responses were from 'others' (people who identified as a member of the public or responding on behalf of an organisation).

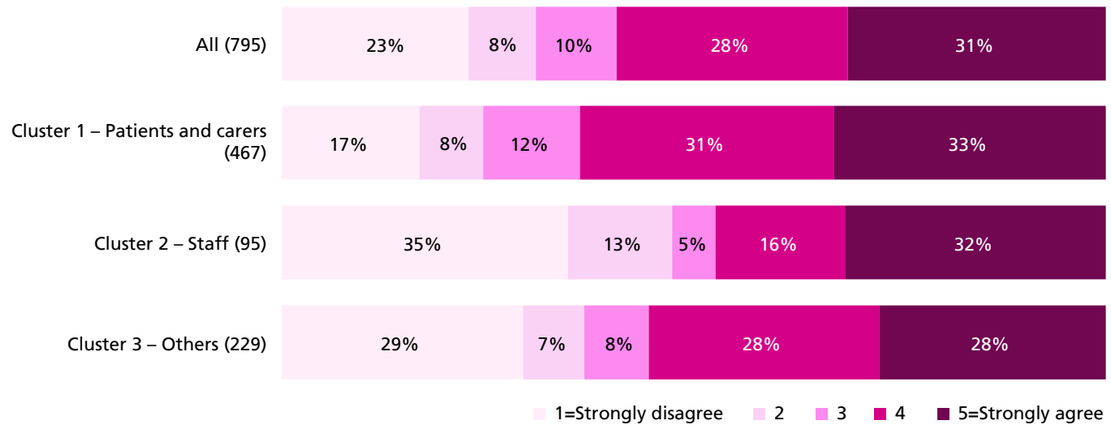
3.3 Summary quantitative feedback

Overall, there was a strong response from the public, providing an opportunity to integrate patient voice into the development of the elective orthopaedic centre. Details of the pieces of feedback received during consultation can be found in Appendix D. The charts below (from the Public Consultation Report) show 59% of participants "agreed" or "strongly agreed" with the proposal.

We have acknowledged and addressed the feedback from those who had concerns in sections 3.4 and 3.5.



To what extent do you agree with the proposal to develop an elective orthopaedic centre for most routine, inpatient orthopaedic surgery in north west London?
[Responses by audience cluster]



Source: Verve Communications 2023 | Base: All respondents who gave a valid answer (267)

To what extent do you agree with the proposal to develop an elective orthopaedic centre for most routine, inpatient orthopaedic surgery in north west London? [Responses by borough]

Source: Verve Communications 2023 | Base: All respondents who gave a valid answer (267)

3.4 Summary of the consultation feedback and five key themes

As well as answer the survey questions, respondents also had an opportunity to give their comments and feedback on areas of interest.

Overall, participants supported the plan for an elective orthopaedic centre for routine surgery and understood the main benefit was to reduce waiting times for patients. There was less support for the elective orthopaedic centre to be located at Central Middlesex Hospital, primarily due to travel concerns.

Five key themes were subsequently synthesised from the qualitative feedback received from the public consultation:

1. Clinical model and patient experience
2. Workforce and staff experience
3. Site location
4. Travel
5. Equity

Clinical model and patient experience

Concerns related to how the new elective orthopaedic centre will fit into the overall MSK pathway and liaise with interdependent services (particularly adult social care). Recommendations for improvement largely focused on alignment with the wider care pathway and standardising the quality of and access to care. The concern is that orthopaedic care may become more fragmented, between the elective orthopaedic centre and 'home' orthopaedic hospitals or between hospital and community services.

Ensuring we continue to gather, understand and respond to patient and community needs, views and feedback was highlighted. We were asked to outline engagement and communications plans to ensure patients, staff and other relevant stakeholders and communities were involved and given a voice throughout the development and implementation stages.

There were comments about both making sure adequate digital infrastructure was in place and those with less access to technology or digital literacy are not excluded, as well as ensuring interoperability of information systems is in place to support the whole patient pathway.

Greater clarity was requested on how performance will be monitored including activity, quality of care, waiting times and impacts on inequalities.

Workforce model and staff experience

Staff experience and capacity was a recurring theme, with patients and staff alike mentioning requirements such as safe and sustainable staffing for the elective orthopaedic centre and T&O services within the acute trusts and staff engagement for managing the transition to the new system.

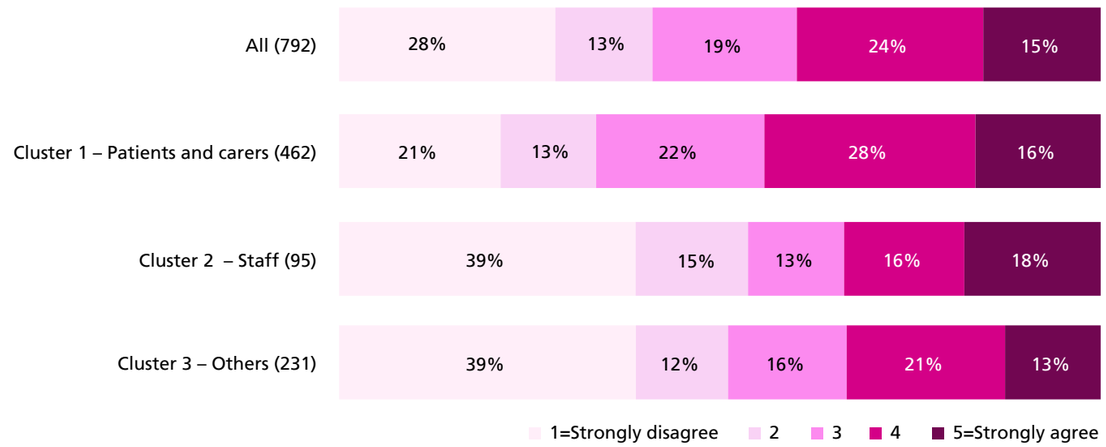
Staff flagged uncertainty about what the proposal means for them and the risk of not enough staff for the elective orthopaedic centre and continuing orthopaedic services at the other hospitals across north west London.

Site location

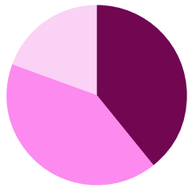
Concerns over patient transport to CMH as the preferred site were highlighted. This included people who would prefer the centre to be located at MVH and people who wanted clarity on why a reduced scope option, where the activity currently at Mount Vernon stays at Mount Vernon, was not feasible.

We have acknowledged concerns over hosting the elective orthopaedic centre at CMH and have devised an appropriate transport solution (see section 4.3). This would be particularly relevant to those coming from Hillingdon, who accounted for 28% of responses (twice as many as from the next largest responses when counted by borough) and who were the least likely to agree with the preferred site option (as seen in the charts below, taken from the Public Consultation Report).

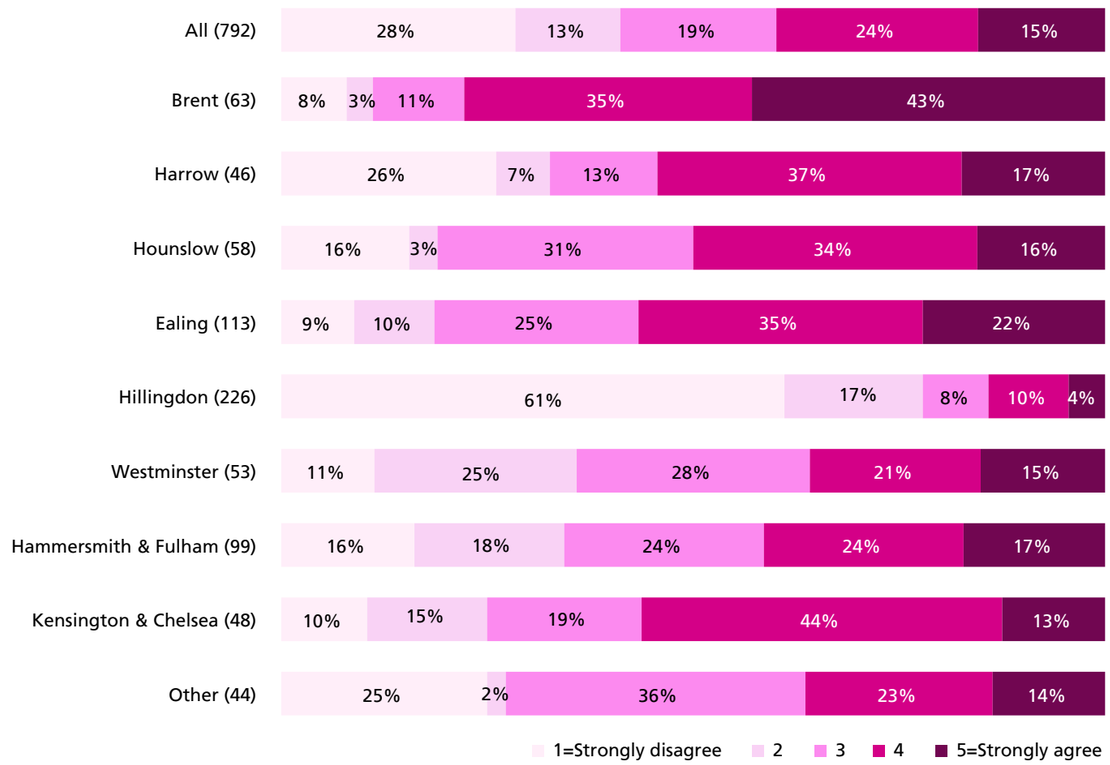
To what extent do you agree with the preferred location of the elective orthopaedic centre at Central Middlesex Hospital? [Responses by audience cluster]



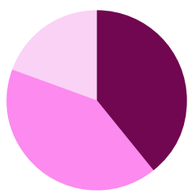
Source: Verve Communications 2023 | Base: All respondents who gave a valid answer (267)



To what extent do you agree with the preferred location of the elective orthopaedic centre at Central Middlesex Hospital? [Responses by borough]



Source: Verve Communications 2023 | Base: All respondents who gave a valid answer (267)



Travel

Changes to journeys for patients, staff and carers were frequently flagged including longer, more complex and more expensive journeys, and with deprived groups being disproportionately impacted by the changes. It was also highlighted that we should consider the relative ability of each group to absorb changes as well as the changes to travel times for each group.

Environmental sustainability was raised by some participants who were concerned about the effect on the carbon footprint of the proposed changes in transport pathways.

Equity

There was a risk that the proposal could exacerbate existing inequalities or creates new ones, in particular:

- greater use of digital options would make it harder for patients who are not digitally savvy or who do not have easy or affordable access to a private space with Wi-Fi and a suitable mobile device
- patients whose conditions are too complex for the elective orthopaedic centre may end up being a lower priority and so wait longer
- travel issues would particularly affect poorer patients or patients with additional accessibility needs.

3.5 Addressing the five key themes from the consultation

The output from the consultation has been considered and is summarised under the themes:

Clinical model and patient experience

The clinical model has been developed with input from clinicians, patients, and community groups, to examine our orthopaedic care through the lens of patient pathways, both within and between hospitals and, importantly, across hospital care and wider, MSK community services. This includes focus on how digital platforms – such as our sector's increasingly popular Care Information Exchange – could help to break down site and organisational silos. This updated model and supporting enablers are described in section 4.1.

The DMBC also includes details of the communication and engagement plan moving forward in section 5, which outlines the structures and channels that will be put in place to allow this continued engagement and outreach to take place including staff engagement, patient engagement, public engagement, a lay partner and inviting individuals and organisations who previously participated in involvement activities. In addition, we see the diverse contacts and relationships we have made through the engagement and consultation work to date as being central to continued engagement and involvement in the further development and implementation of the model.

We have also reviewed and expanded our approach within the Benefits Realisation Plan (BRP) in section 5.4. In addition to an enhanced range of KPI themes and metrics, we have included specific owners for each theme and ensured that metrics link to the appropriate part of the proposed elective orthopaedic centre management and system governance structures. The BRP covers clinical outcomes, efficiency and productivity, patient access, transport, patient satisfaction and workforce, as per the case for change.

Workforce model and staff experience

While the proposal has been led by senior clinicians from across the four acute providers and we have been expanding engagement with wider staff groups providing orthopaedic care across our hospitals, it is clear that all staff need to be involved in detailed planning and implementation.

This further input will help us develop the most effective workforce model and recruitment approach. We estimate that there would be an elective orthopaedic centre team totalling around 280 staff from day one, with most of the EOC team being based permanently at the centre. Consultants from each of the 'home' orthopaedic hospitals would travel with their patients to undertake surgery. We would want to explore opportunities for some other staff to 'rotate' between – spend blocks of time in – the centre and other orthopaedic services to develop experience and build skills across a range of care. The workforce model and implementation plan is outlined in section 5.6.

Site location

As part of the PCBC, we undertook a detailed site options appraisal to arrive at our preferred location of CMH. This included consideration of the option of having two elective orthopaedic centres, at CMH and MVH. In response to the consultation feedback, we strengthened the site option appraisal analysis with further detail on a reduced scope option. However, despite this, the outcome remains unchanged.

Travel

CMH is the most centrally located hospital in north west London. We believe the benefits of a single centre of excellence outweigh the inevitable downsides and unintended consequences on patient journeys. For this reason we have developed a solution that we believe will support patient all patient journeys and not just minimise potential adverse impact on patients. This is described in section 4.3.

Equity

We have put a strong focus on ensuring equity throughout the development of our model and we have used the IIA (section 2.4) alongside our consultation feedback to identify key challenges and possible responses. We know that people from black, Asian and other minority ethnic communities currently access our orthopaedic services in smaller numbers than we would expect which the model will help tackle through even more detailed waiting list monitoring and improved communication, engagement and support. We want to help address this issue as part of plans to take forward the elective orthopaedic centre proposal.

Specifically in terms of potential digital exclusion (section 4.1.8), we have been exploring responses more generally across all our services and would look to roll them out to support the new clinical model. This would include ensuring tailored communications and face-to-face service options for patients who did not want – or were not able – to use digital platforms. We will offer interested patients help with building and using their digital skills to support their health and healthcare by working with partner organisations across north west London, linking in to existing and future programmes across the sector.

In terms of patients who have more complex needs – and who would therefore not be eligible for having their surgery at the elective orthopaedic centre – we have been modelling workforce requirements to ensure the proposed move of low complexity surgery to the elective orthopaedic centre supports a greater focus on complex surgery at the other sites. The efficiencies we would gain from consolidating low complexity care at a centre of excellence would be shared across all four acute trusts for the benefit of all orthopaedic patients (section 4.1.7).

4 The revised model following the public consultation

Chapter 4 sets out the enhancements to the clinical model of care and the rationale for the selection of CMH as the single site for the north west London elective orthopedic centre.

Key messages

- The clinical model will better support patients through each stage of their surgical pathways with access to digital and non-digital communications and care, support with journey planning and transport where necessary.
- As a centre of excellence, the north west London elective orthopaedic centre will coordinate care planning from local pre-operative care through to local post-discharge rehabilitation and follow-up.
- There is a road map for the continued development of north west London MSK and the elective surgical pathways to deliver more joined-up high-quality care to north west London communities, irrespective of borough or local hospital.
- This integrated approach will ensure patients are managed in the right place at the right time across north west London and that we make the best use of our resources for our patients.
- Focusing the elective orthopaedic model of care on a single site will provide greater benefits to patients and staff.
- To fully account for the concerns raised throughout public consultation, we have created a travel solution to support any patients facing a long, complex or costly journey to the elective orthopaedic centre.

4.1 Clinical strategy

Clinical leads from across the north west London acute trusts have worked in collaboration to develop a clinical strategy for elective orthopaedic surgery. The strategy underpins the expected benefits from the MSK pathway and sets out the clinical ambition to provide a centre of excellence for elective orthopaedic surgery (see Appendix G).

4.1.1 Integrated MSK pathway

The MSK pathway will be clinically and digitally integrated service, with strong relationships between primary care, secondary care, community services and third sector voluntary organisations. With a single point of access, the most appropriate community-based treatment to be offered is based on clinical need but, where secondary care intervention is required, onward referral is integrated and seamless to ensure efficient use of secondary care and improved patient experience.

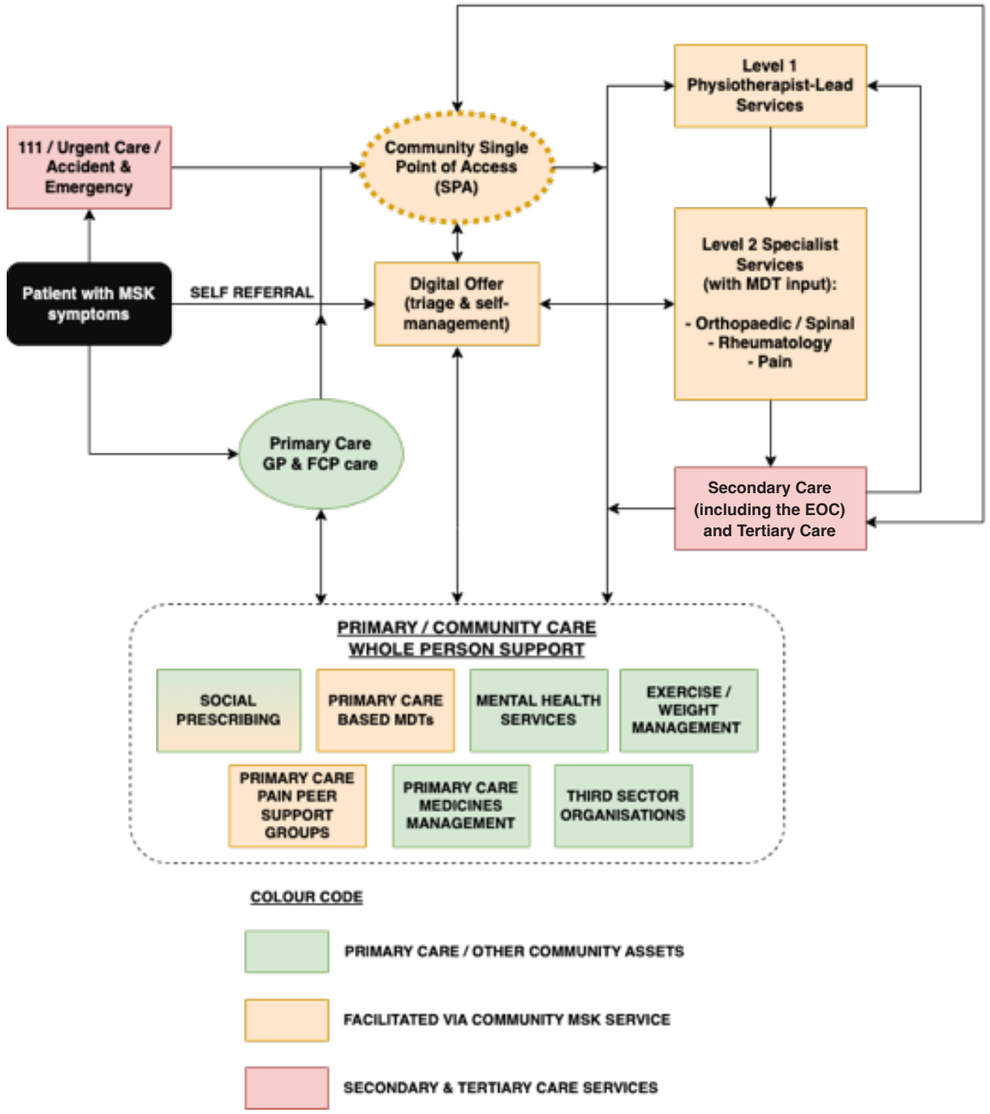
There will be outreach to under-served communities to target unmet need and monitor the end-to-end pathway to better understand where patients are hesitant to present or likely to drop out.

This pathway will be commissioned by North West London ICB for the north west London population (16 years and older). This end-to-end MSK pathway will be delivered by a multidisciplinary team of MSK clinicians providing triage, assessment, diagnosis, treatment and care planning for patients with MSK conditions. The updated pathway is part of the North West London ICS ambition to ensure that high-quality care is delivered to the north west London population in the most appropriate setting, supporting primary care, system recovery and maximising patient outcomes and satisfaction. It will be fully integrated with the plans for the elective orthopaedic centre, as described.

This pathway has been developed in line with national guidance including from NICE[5], NHSE BestMSK[6], GIRFT[7] and NHS Evidence Based Interventions[8]. It has also incorporated locally agreed pathways[9] informed by local needs and services.

The end-to-end MSK pathway intends to treat a range of MSK conditions with exclusion criteria including under 16s; those not registered with a GP in north west London ICS; non-MSK podiatry; and NHS England specialist commissioning services. This is shown in the diagram below.

Figure 2 – North west London MSK Pathway

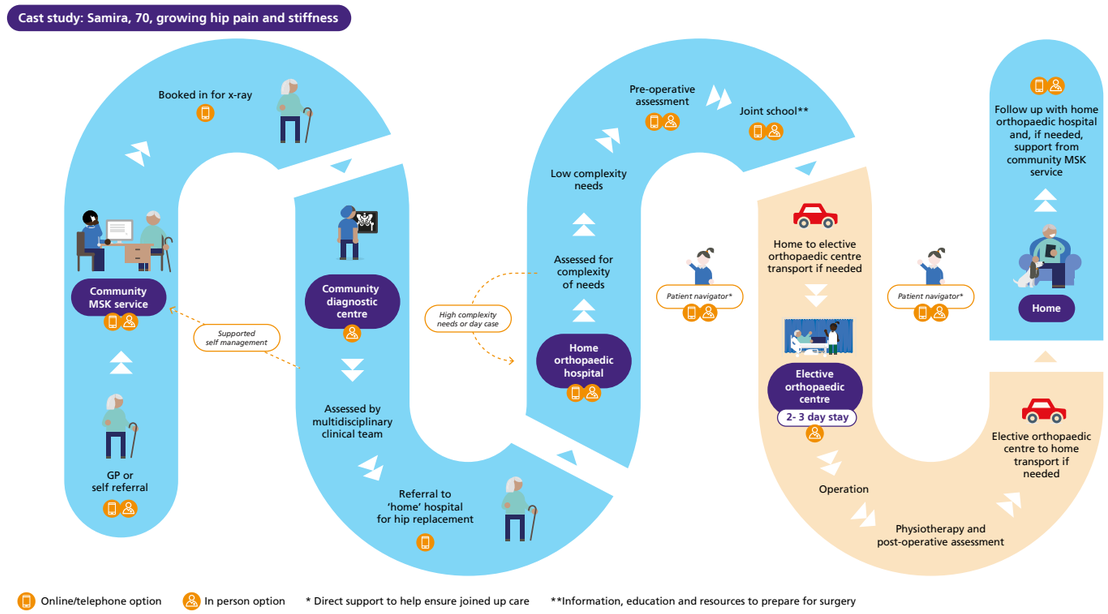


To outline how the pathway would work in practice, see Figure 3 for a case study about Samira and her journey through the MSK pathway and the elective orthopaedic centre.

*First Contact Physiotherapists

5 https://www.nice.org.uk/guidance/conditions-and-diseases/musculoskeletal-conditions
6 https://future.nhs.uk/NationalMSKHealth/groupHome
7 https://gettingitrightfirsttime.co.uk/workstreams/
8 https://www.england.nhs.uk/evidence-based-interventions/
9 https://www.nwlondonics.nhs.uk

Figure 3 – Case study of how the elective orthopaedic centre will work within an overall improved MSK pathway



4.1.2 The elective orthopaedic clinical model

The clinical model will better support patients through each of stage of their surgical pathways for MSK disorders (see Figure 5). As a centre of excellence, the north west London elective orthopaedic centre will coordinate care planning from local pre-operative care through to local post-discharge rehabilitation and follow-up.

Patients will benefit from early assessment of their needs virtually or close to home in the community. If surgery is required, they will be guided to the surgical service that can best meet their needs. If they are broadly well (ASA 1 or 2[10]) and require a routine inpatient procedure (such as a hip replacement), they will be able to have their surgery at the elective orthopaedic centre.

Patients who have additional health risks will be offered surgery in whichever of the north west London hospitals that currently provides orthopaedic surgical care is suitable for their needs, usually their home hospital.

Whichever surgical service they access, their end-to-end surgical care will remain under the same surgical team based at their 'home' orthopaedic hospital to help ensure a seamless experience. If they have their surgery at the elective orthopaedic centre, their 'home' surgical team will rotate to the new centre as well, supported by the centre's permanent support team.

10 https://www.asahq.org/standards-and-guidelines/asa-physical-status-classification-system

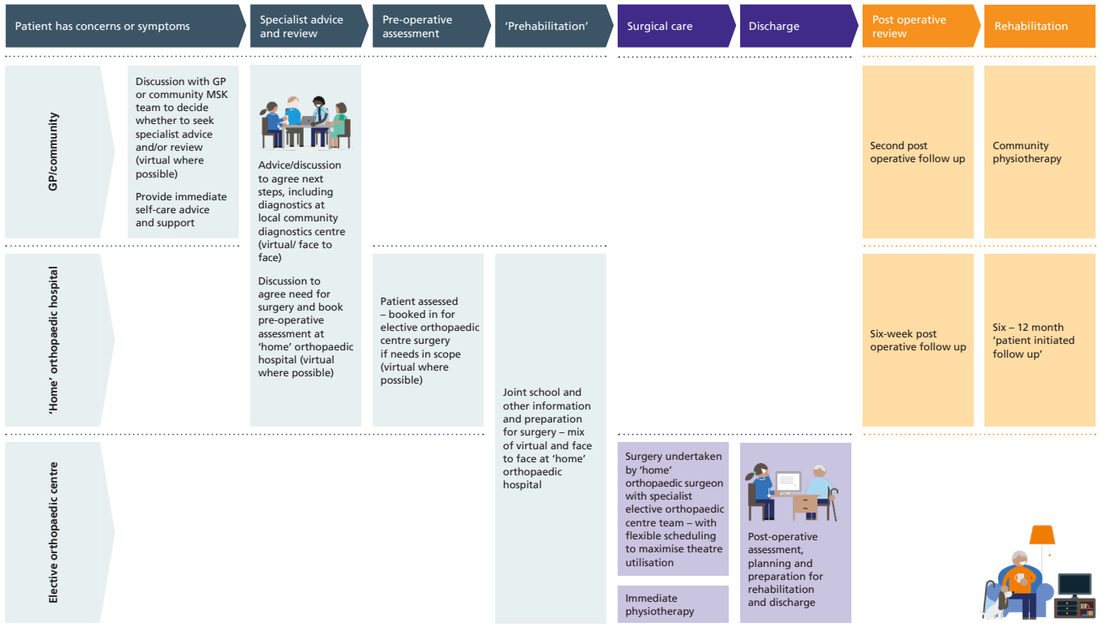
The elective orthopaedic centre will bring together the low complexity, inpatient, orthopaedic surgery for north west London in a purpose-designed centre of excellence, completely separate from emergency care services. This means that:

- patients will have faster and fairer access to the surgery they need and are much less likely to have their surgery postponed due to emergency care pressures elsewhere
- the care they have will be of a consistently high quality, benefitting from latest best practice and research insights and a clinical team who are highly skilled in their procedure
- the centre will be extremely efficient, enabling more patients to be treated at a lower cost per surgery
- patients will have better outcomes, experience, and follow-up.

In addition, capacity is created in the 'home' orthopaedic hospitals by the consolidation of low complexity surgery in the elective orthopaedic centre and this capacity will be available to be used for surgical patients who have more complex needs and for other specialties.

Figure 4 – Map of Future Orthopaedic Surgical Care Provision in North West London

Figure 5 – Case study of the NWL elective orthopaedic centre clinical model



The North West London Clinical Reference Group (CRG), including community and primary care MSK partners, agreed the draft clinical model in May 2022 and has continued to incorporate improvements through further discussion and engagement with the clinical development workstream of the Elective Orthopaedic Centre Programme Board. This has been developed with the representative clinical cabinet convened to undertake careful consideration of the feedback received in the public consultation. They have set out and updated the clinical model and strategic delivery framework in a format to support future planning and decision making. This will feed into the clinical design workstream through the transition and implementation phases.

4.1.3 Pre-operative assessment

Secondary care outpatient pre-operative assessment

Once a plan for surgery is agreed through shared decision making, patients will undergo pre-operative assessment. Pre-operative assessment will be undertaken close to home at the 'home' hospital using agreed protocols. Eligible patients (ASA 1 and 2) will be added to the patient waiting list for the elective orthopaedic centre to have their surgery and perioperative care conducted there.

There will be a small number of patients where it might be helpful for them to visit the elective orthopaedic centre in advance of the day of surgery or possibly to undertake their pre-assessment or joint school there. These patients might include those with anxiety or additional needs where a hospital visit is judged to be helpful for them. Every effort will be made to accommodate these needs through liaison between the home trust and the elective orthopaedic centre team.

For all NHS providers in north west London, pre-operative consultations and post-operative rehabilitation will take place at the 'home' site or virtually, with routine inpatient orthopaedic surgery taking place at the elective orthopaedic centre. If, at the point of shared decision making to list a patient for surgery, a patient requests an alternative to the elective orthopaedic centre for routine inpatient orthopaedic surgery, a risk benefit assessment would be undertaken, considering the patient's clinical status and any protected characteristics that may be relevant, to determine whether surgery at the 'home' site is warranted. Where this variation is warranted, the partnership board and APC Board in Common will monitor patient pathways so that a full and ongoing assessment of productivity, accessibility and inclusion can be made.

Joint school

While waiting for their surgery, patients will be enrolled in a 'joint school' – a combination of pre-habilitation, pre-operative physiotherapy and education. This will be delivered through a mix of online and face-to-face advice and support sessions at their home hospital or in the community close to their home.

4.1.4 Managing deteriorating patients

As a well-established stand-alone elective site, the mechanisms to manage unexpected deterioration are well tested and embedded on the CMH site. Based on this existing approach, a protocol-driven model of peri-operative care will be delivered, with standardised anaesthetic and post-operative analgesia regimes. Post-operative patients will remain the responsibility of orthopaedics with anaesthetics providing advice on pain management and help with the deteriorating patient.

The existing Enhanced Care Unit (ECU) on CMH is led by anaesthetics for patients needing higher levels of care, under an existing standard operating procedure (SOP). It is not anticipated that the ECU will be required for elective orthopaedic centre patients because of the patient selection criterion (ASA 1 and 2), however all these safety features will be available to all patients having operative procedures at the new centre.

Within the elective orthopaedic centre, a Post Anaesthetic Care Unit (PACU) has been developed for patients who require additional monitoring, for example patients with home continuous positive airway pressure (CPAP) machines. The SOPs will be closely based on the pre-existing Abbey Ward PACU SOPs.

4.1.5 Support on discharge from the elective orthopaedic centre

Patients will be discharged with a planned appointment for follow-up and arrangements in place for ongoing therapy/rehabilitation. Patients who have attended the elective orthopaedic centre will have outpatient follow-up at their home hospital. Any unexpected complications or requirement for an emergency or unanticipated attendance or treatment will be managed at the home hospital. Patients will be given contact details and instructions on discharge to access clinical support and advice at their home hospital should this be required. Discharge will be routinely communicated to both the GP, community services and the home hospital trust for the patient.

A small group of patients may require additional support during their post-operative recovery period. These patients will be identified as early as possible in their pathway, ideally at the pre-operative assessment or early in their hospital admission as part of standardised protocols.

LNWH already has relationships with the range of adult social care providers with a discharge hub at CMH that works in partnership with three local authorities. After surgery, the discharge hub will act as single point of referral to the eight north west London boroughs for social care, community rehabilitation and bedded rehabilitation.

Sometimes patients require short-term support to help them get back to normal and stay independent. This is known as reablement care. This is for a maximum of six weeks. If needed, patients will be discharged once a start date for reablement has been confirmed.

Figure 6 – Elective orthopaedic centre patient pathway post-operatively

<table>
<tr><th colspan="3">Care co-ordination by NWL EOC discharge hub</th><th colspan="4">Support from home hospital and local community</th></tr>
<tr><td rowspan="2">Discharge planning begins at the pre-operative assessment</td><td rowspan="2">Patient operation</td><td rowspan="2">Inpatient post-op-erative physiother-apy and rehabilita-tion</td><td>Supported rehabilitation in usual place of residence</td><td rowspan="2">Clinical review (up to six weeks) by home hospital</td><td>Community physiotherapy</td><td rowspan="2">Patient initiated follow up at six to 12 months</td></tr>
<tr><td>+/- reable-ment package (max six weeks)</td><td>GP clinical review if needed</td></tr>
</table>

4.1.6 Multidisciplinary team and clinical support services

The best clinical outcomes are achieved by drawing on the expertise of the multidisciplinary team and the elective orthopaedic centre clinical model is built around this. A team of specialist therapists will support best practice length of stay by delivering a 7-day a week physiotherapy and discharge planning service through to the community discharge teams. In addition, for the small number of patients not undertaking pre-operative education or joint school locally, they will also deliver pre-operative advice, education, and support.

Radiological colleagues have been engaged in the clinical and activity modelling. Radiological support, in theatres and post-operatively, has been factored into the staffing and clinical model.

Likewise, pathology support has been incorporated into the model. A protocol for blood transfusion, where this might be needed, will be developed as one of a number of clinical protocols, in advance of implementation.

4.1.7 Equity of care for patients not treated at the elective orthopaedic centre

The alignment of the clinical model and wider MSK pathway will ensure patients are managed in the right place at the right time across north west London and that we make the best use of our resources for our patients. The MSK network will track and monitor patient outcomes across the whole pathway including those treated at the centre and treated at the acute trusts. This will be undertaken by both the elective orthopaedic centre and APC respectively.

The elective orthopaedic centre development is intended to strengthen the ability of the system to manage demand for T&O and other elective specialities. The expected vacated capacity in the home trusts, based on the average number of cases assuming existing case mix, should increase theatre capacity at those acute trusts. This should make trauma and complex activity more resilient across north west London acute trusts.

Tracking both routine and complex surgery activity for inpatients and day case surgery are important KPIs as the centre develops. These KPIs form part of the BRP (see Appendix C) to ensure that a two-tier model of care is not introduced into north west London.

4.1.8 Avoiding digital exclusion

We will put measures in place to ensure the proposed elective orthopaedic centre service is inclusive and meets the needs of all the population it is serving. It is important to note that current 'analogue' ways of delivering services have the potential to exclude, as patients may not have the ability and/or inclination to physically travel to hospital appointments. Digital channels offer the prospect of mitigating this, though we should also include plans to address digital exclusion. Such plans will be guided by the digital inclusivity guidelines issued by NHS Digital.

We know not everyone is able to access or afford a digital device or the internet and some people do not have the skills or the confidence to manage their appointments and care or receive information online. Others may wish to choose non-digital options when communicating and receiving care from their hospital. We are committed to measuring and understanding digital exclusion and its effect on care to help us develop solutions and support, particularly for the most vulnerable groups of people in our communities, so that we do not exacerbate health inequalities.

A key element of implementing the elective orthopaedic centre proposal will be the design and delivery of digital and non-digital communications and care options. We will use existing systems which are familiar to patients, supplemented by additional communication and specific information related to the elective orthopaedic centre and the procedures.

The implementation of any new digital services design stage will involve patients and include options to meet the different needs of individuals. In addition, we will continue to offer non-digital alternatives such as face-to-face consultations, telephone consultations and administration services and postal delivery for written communications, when patients cannot or do not wish to access our digital applications.

We plan to develop systems that will give staff information to help them communicate with patients effectively, and to help avoid digital exclusion, for example when a patient does not have an email address on record or has not consented to receiving digital communications. This will help us make sure we provide other communications approaches, such as a postal letter.

We also plan to work in partnership with local authorities and other projects that are in progress within north west London to identify groups of people who are digitally excluded who might need access to: the internet; a device; or digital education and training. We will work with other external organisations to share and signpost external digital inclusion education programmes which can lead to improved self-management of long-term conditions. We know if we can support people to use digital health tools, they may experience improved or additional services which will benefit their wider health and wellbeing.

4.2 Site selection

4.2.1 Choice of host for elective orthopaedic centre

In the public consultation, there was less support for the elective orthopaedic centre to be located at Central Middlesex Hospital, primarily due to travel concerns. Some people, primarily staff and stakeholders in Hillingdon, would prefer the centre to be located at Mount Vernon Hospital.

To respond to this feedback, we reviewed our assumptions for the site options appraisal to check the validity of our preferred location. Central Middlesex continues to score highest against clinical criteria, has the shortest median travel time by car and by public transport and meets a higher number of desirable criteria.

Currently, elective orthopaedic services are carried out across multiple sites in north west London. The proposed service change aims to improve quality, access and patient experience for routine inpatient orthopaedic surgery in north west London by creating a single referral system that brings all ASA 1 and 2 cases from across north west London into the new elective orthopaedic centre.

As part of the PCBC, we carried out an options appraisal that started with a long list of ten sites. A clinical workshop held in August 2022 developed a series of essential and desirable criteria used to score each option. The workshop assessed how closely each of the ten options aligned with the site strategy and how much disruption each option would cause.

Scoring each option against the criteria left only two sites on the shortlist: CMH and MVH, which aligned with the pre-consultation feedback obtained. All other sites were ruled out as they did not meet the clinical criteria, particularly concerning the ability to ring-fence beds for elective capacity. The process of selecting the two shortlisted sites remains valid.

In response to the public consultation, we reviewed our assumptions for the two shortlisted sites, starting with the application of three lenses originally used. Our findings are the time are included below:

1. **Clinical evaluation** – the key difference between sites is capacity: CMH is currently underutilised with 50% bed occupancy and MVH is operating at near optimum capacity and so would require both theatre and bed capacity expansion to operate as the elective orthopaedic centre.
2. **Impacts on transport and travel time** – MVH has greater mean travel times for both public and private transport, nearly double the average travel time compared to CMH, with a larger impact on the more deprived communities. MVH was also scored very poorly for accessibility ratings by TfL, although this area is serviced by other providers. Howevere, MVH would also mean a higher increase in total carbon dioxide emissions than CMH.
3. **Estates and economic evaluation** – CMH is a high-quality clinical estate which has a surplus of bed capacity available for use. A more extensive expansion would be potentially needed to host the elective orthopaedic centre at MVH.

This has reconfirmed the assessment that CMH would be the best choice of site to host the elective orthopaedic centre.

4.2.2 Two elective orthopaedic centres option

We have looked into the feasibility of having two elective orthopaedic centres, to respond to the consultation feedback, particularly from Hillingdon. In practice, due to the capacity constraints at MVH, this would mean that MVH maintains its current levels of activity and capacity and the scope of the elective orthopaedic centre being reduced to cover only for patients who do not currently use MVH.

This would make it significantly harder to reduce the unwarranted clinical variation and would make it difficult for MVH to improve its current quality and operational performance levels. For instance, the South West London Elective Orthopaedic Centre has more than 40 clinicians from their 4 participating trusts who all work to the same pathways and productivity standards. Additionally, the volume of patients going through the elective orthopaedic centre would be lower, which would make it harder to achieve the reduction in the waiting list set out in the case for change.

From a workforce perspective, a two centre approach would mean duplication of some specialist roles across two sites, meaning it would be harder to achieve safe nursing ratios and there would need to be higher investment in site management. Resilience to absorb vacancies and build a ‘surgical hub’ identity and culture would be impacted.

Recent data shows that trainees and training in trauma and orthopaedic surgery have been disproportionately affected by the covid-19 pandemic and reduced elective surgery volume. EOC will offer an important solution for this problem in north west London and will provide future trainees with high volume training in a supervised high volume performance environment. Splitting across two sites would diminish this opportunity for NWL.

4.3 The transport solution to support the preferred model

4.3.1 Response to public consultation

In addition to the analysis and evaluation outlined above, we acted on the feedback that has come through the public consultation, particularly on travel and the potential impact on workforce.

In response to this feedback, we have designed a robust travel solution that will provide support to any patients facing a long, complex, or costly journey to the elective orthopaedic centre.

The concerns raised by patients, staff, and stakeholders over the course of public consultation were considered alongside a review of key recent publications on patient transport (which highlighted that long or costly patient journeys can be a significant barrier to care). The key areas of concern raised within the public consultation were around travel times, journey complexity and costs. These areas correlate closely with the findings of an extensive review completed by Age UK in 2018 which showed older people encountered several challenges when travelling to hospital that included long and uncomfortable public transport journeys and cost[11].

Healthwatch UK also surveyed patients, commissioners, and charity organisations on their experience of patient travel to and from NHS services[12]. The outcomes of this further echoed the concerns raised and provided valuable insight into how patients travel to appointments (although it is important to note that the patients travelling to the elective orthopaedic centre are not likely to need to attend repeatedly). The reviews concluded that transport to hospital can be a major challenge for many patients and called on NHS England to review current arrangements and eligibility criteria. Moreover, NHS England and NHS Improvement formally commissioned a national review into non-emergency

11 Painful Journeys – Why getting to hospital appointments is a major issue for older people, Age UK, 2018.
On the road and away from home: a systematic review of the travel experiences of cancer patients and their carers,
12 There and Back - what people have told us about travelling to and from NHS services, Healthwatch UK, 2019

patient transport services[13] that concluded in 2021 with an update to patient eligibility criteria and key recommendations published in 2022.

The updated criteria included consideration of a patient's wider mobility needs and suggested that local systems may wish to add further criteria when determining eligibility for non-emergency patient transport that included consideration of:

- long distances to travel
- high cost associated with travel by taxi
- limited/complex public transport options

The review also recommended that best practice was to provide patients with information and assistance on how to plan and book their independent journey, access to healthcare travel cost schemes and local community resources. These recommendations correlated strongly with the feedback received from patients and staff during the public consultation process.

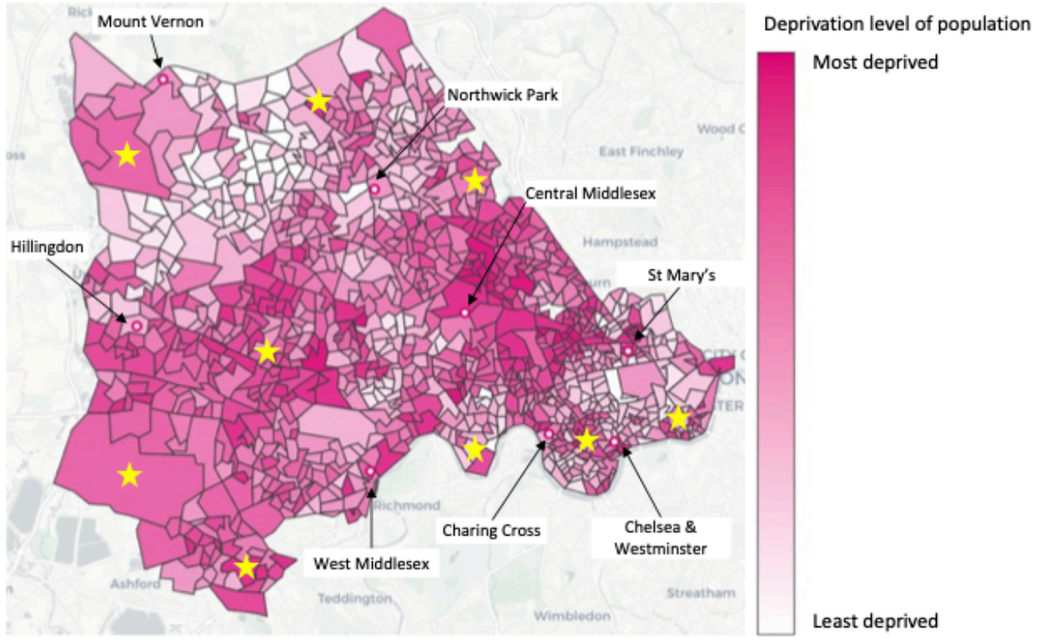
Alongside national best practice and recommendations, the arrangements at neighbouring elective orthopaedic centres were also assessed. Feedback from these centres demonstrated that the challenge faced by patients travelling longer distances had been recognised and support had been put in place to help patients travel.

4.3.2 New travel analysis

The feedback received through public consultation cited that reviewing only median travel times was not a fair measure as there were likely to be cohorts of patients who experienced very long and complex journeys. On this basis, ten archetype journeys were developed that modelled a journey that was over 45 minutes in time and from a lower layer super output area (LSOA) with high level of deprivation. These archetype journeys would provide insight into the difference in time, complexity and cost that patients may encounter when travelling to CMH as opposed to their home hospital.

13 NHS Non-Emergency Patient Transport Services review, NHS England, 2019

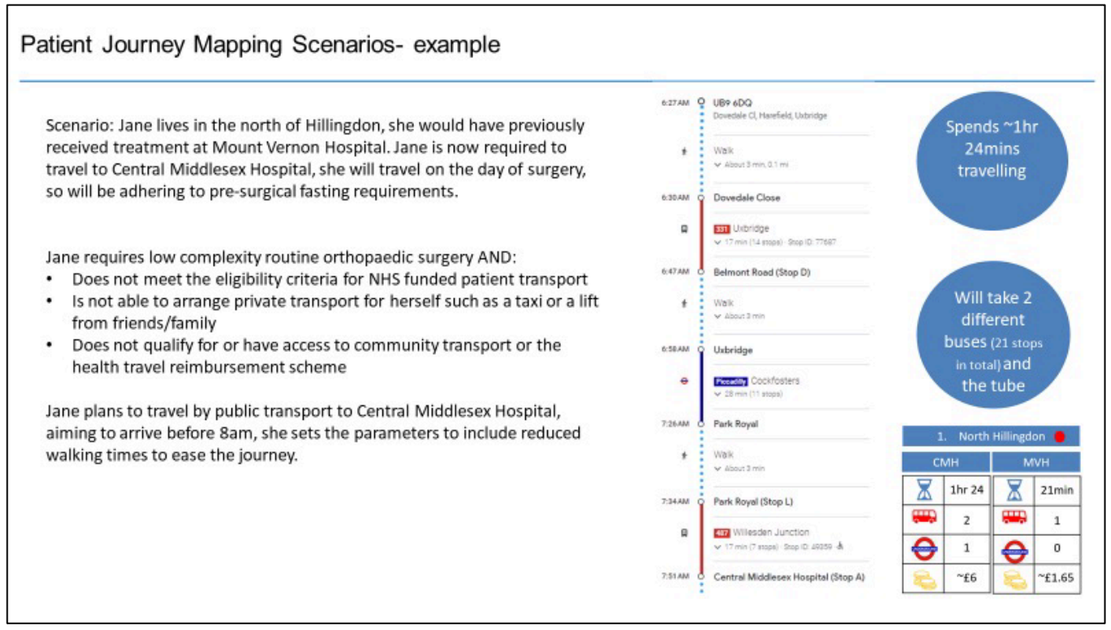
Figure 7 – LSOA map showing the 10 archetypes identified to demonstrate all areas covered LSOA population deprivation level heatmap (All ages)



*two journeys mapped for Hammersmith and Fulham

The analysis showed the current journey to the home hospital and compared this to the journey to CMH for ten different scenarios across north west London.

Figure 8 – Example of analysis with patient story



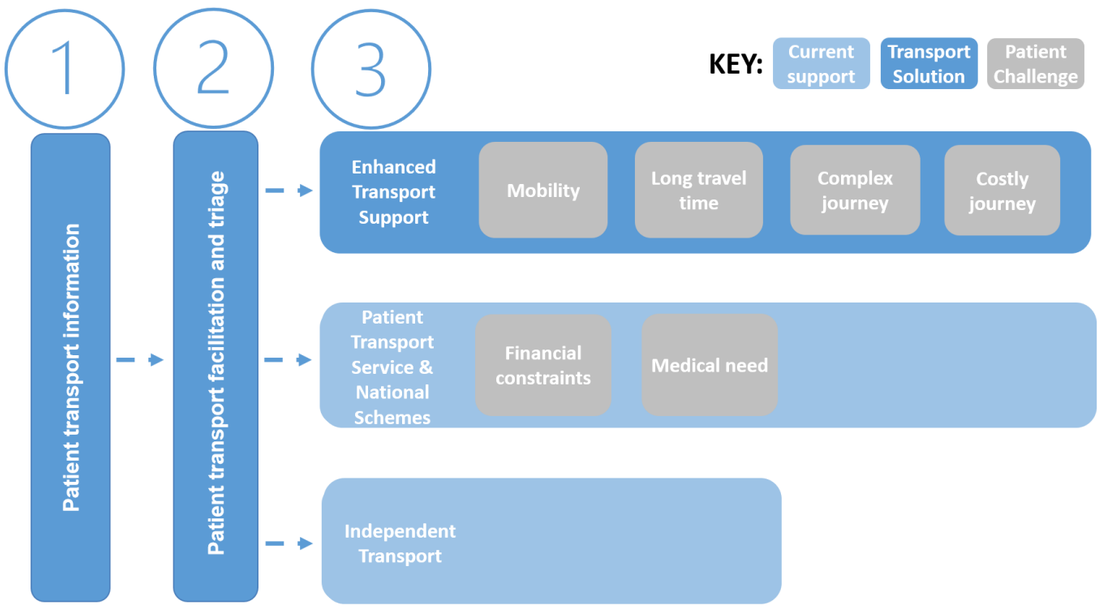
The analysis highlighted the areas in north west London for which a journey to CMH would be considerably longer, more complex and more costly than patients' current journeys. Further analysis of the profile of patients across the sector approximated the number of patients residing in the identified areas who would most likely encounter a complex or costly journey if travelling by public transport.

The analysis showed that following the implementation of a risk assessment and triage process that considered travel time, complexity, and cost, approximately 25% of north west London patients attending the elective orthopaedic centre could qualify for support with their travel arrangements, given that approximately 1,300 out of 5,175 patients (instead of the current 240, typically from Ealing, Harrow and Brent) would have to undergo long journeys. Under the revised criteria, a further 5% of patients would incur long, complex, or costly journeys and be eligible for support.

4.3.3 The proposed transport solution

The solution has been designed with best practice recommendations from national reviews and public consultation suggestions as the basis for identifying a resolution. It is best considered as a three-step approach that will provide patients and their families with the level of support that they need to access care effectively at the elective orthopaedic centre. The solution includes providing information and signposting to available resources, facilitation for all patients and carers and transport for those who require it. The inclusion of additional eligibility criteria in line with national review outcomes will enable patients who have mobility challenges and have a long, complex journey on public transport or prohibitive costs to access patient transport. The solution is outlined below in more detail.

Figure 9 – The Proposed Transport Solution



Step 1: Information – all patients

The first step is to provide all patients travelling to the elective orthopaedic centre with up-to-date information on transportation to CMH. This will include information for those travelling independently by car or taxi in terms of directions, parking and drop-off locations. There will also be information available that signposts patients to financial resources and support available through national schemes such as the Healthcare Travel Cost Scheme and community services.

Step 2: Facilitation – all patients

The second element of support builds on the information provided and supplements this with facilitation support. This will enable patients to plan their journey effectively with a member of staff who can advise and signpost patients to national and local support schemes and will assess if a patient will encounter a long, complex or costly journey if they are considering travelling by public transport.

Step 3: Patient Transport provision – eligible patients (revised criteria)

For patients who are unable to travel to or from the elective orthopaedic centre for treatment independently or through support from national schemes and who will encounter a long, complex or costly journey by public transport, typically a car ambulance or taxi will be provided. This will ensure that patients can access care at the elective orthopaedic centre from across north west London in a fair and equitable manner.

We aim to offer transport information and facilitation support to all patients attending the elective orthopaedic centre. Patients will be able to access information digitally where they prefer to, or their transport support options will be explained to them by the care navigator team. This will include asking patients how they are planning to travel to the elective orthopaedic centre and, if required, providing patients and carers with information on where CMH is located, how best to travel there from home, and information on support such as the Healthcare Travel Cost Scheme. If, on assessment, patients can't rely on friends or family for support with getting to their appointment and they have mobility challenges or live at a distance that would require them to navigate a long, complex journey on public transport that may be costly, travel support will be booked to and from the centre at no charge.

5 Implementing the model

Chapter 5 sets out how the recommended model of care would be delivered, including details of the governance approach (comprising a partnership level and an organisational level) and workstreams.

Key messages

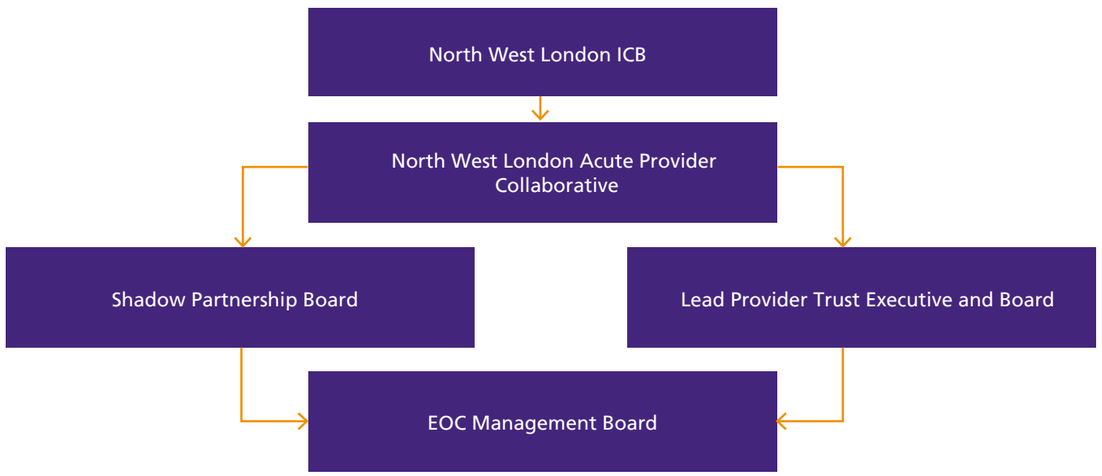
- The implementation model has been developed based on best practice evidence and draws on learning and feedback from the public consultation and external, independent assurance and advice.
- Continued engagement and involvement with patients, staff and carers is central to the implementation of the new model of care and the development of the north west London elective orthopaedic centre.
- London North West University Healthcare NHS Trust would act as host for the new elective orthopaedic centre, managing the new EOC and providing all logistical support for the EOC to operate as a free-standing business division with its own service line reporting.
- An extended BRP to monitor achievement of elective orthopaedic centre benefits has been developed with revised and expanded KPI themes and metrics, designated owners and validated trajectories.
- An elective orthopaedic centre Management Board will be in place prior to commencement, operating within the LNWH governance arrangements.
- The Shadow Partnership Board will provide clinically led system oversight, working alongside the Acute Provider Collaborative.
- The development will reflect the aims of the North West London ICB and LNWH Green Plan.

5.1 Governance model

The governance approach for the elective orthopaedic centre will comprise two elements:

1. **Partnership level** – Shadow Partnership Board
2. **Operational level** – the elective orthopaedic centre will be hosted and run by London North West Healthcare NHS Trust (LNWH) as Lead Provider as a ring-fenced entity within the Trust's governance structures.

Figure 10 – Governance approach to north west London% elective orthopaedic centre

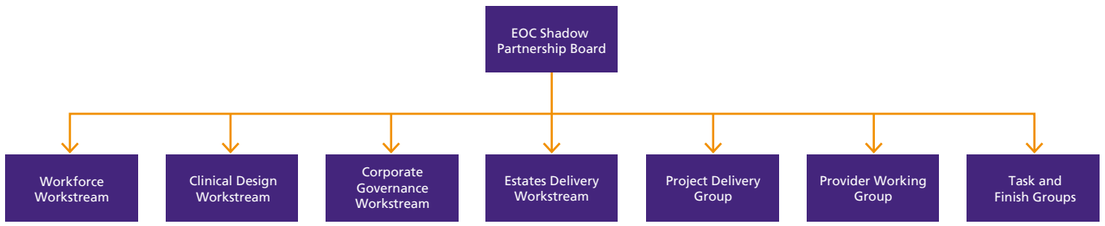


The elective orthopaedic centre partnership model is entirely consistent with the LNWH Trust vision "to place quality at our heart", by providing high-quality care, underpinned by high-quality support services and partnerships, with its four strategic priorities:

- We will provide high quality, timely and equitable care in a sustainable way.
- We will be a high-quality employer where all our people feel they belong and are empowered to provide excellent services and grow their careers.
- We will base our care on high quality, responsive, and seamless non-clinical and administrative services.
- We will build high quality, trusted ways of working with our local people and partners so that together we can improve the health of our communities.

The Elective Orthopaedic Centre Shadow Partnership Board

Figure 11 – The Elective Orthopaedic Centre Shadow Partnership Board Governance Framework



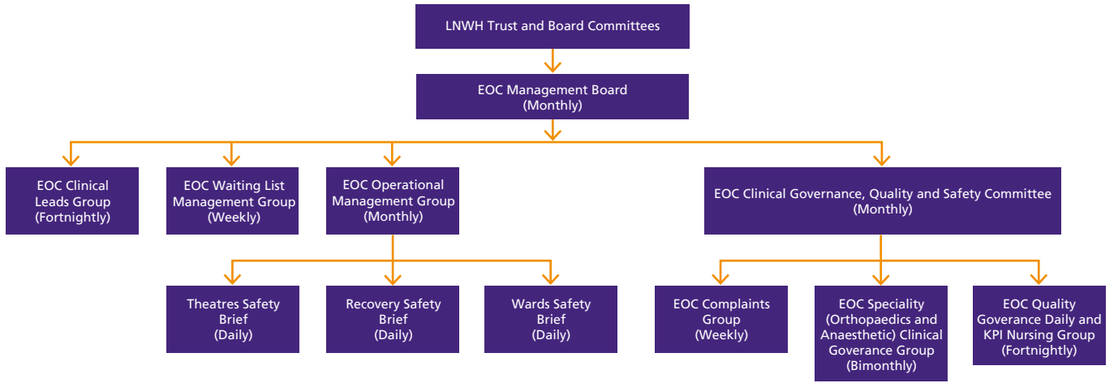
The Shadow Partnership Board will meet monthly, will be chaired by the lead provider Senior Responsible Officer (SRO) and will include senior clinical representation from each of the four acute providers. It has responsibility for performance, clinical leadership, governance and risk, and finance and workforce matters.

The Shadow Partnership Board is supported by four workstreams and three group types to allow an agile transition from 'decision-making' through 'mobilisation' to 'implementation' of the elective orthopaedic centre. It will run in shadow form until the elective orthopaedic centre goes live and will then formally operate as the Partnership Board.

The Elective Orthopaedic Centre Management Board

Operationally, the elective orthopaedic centre will be run by LNWH as a stand-alone business unit with its distinct budget, cost centre and service line reporting. In a similar fashion to the LNWH clinical divisions, for governance purposes the Elective Orthopaedic Centre Management Board will report to the Trust Executive Group and upwards to the Trust Board. The Elective Orthopaedic Centre Senior Leadership Team will be members of the Trust Executive Group, and the existing LNWH divisional governance framework will be mirrored by the elective orthopaedic centre, as set out in Figure 12.

Figure 12 – The Elective Orthopaedic Centre Management Board Governance Framework



The Elective Orthopaedic Centre Management Board will review information reported by operational groups within the centre, the governance team and corporate partners including estates, finance and human resources. This forum will provide the platform for the discussion and communication of key elective orthopaedic centre and trust operational, business, performance, quality, safety and governance issues. This meeting will be attended by the elective orthopaedic centre leadership triumvirate, clinical leads, the elective orthopaedic centre estates, finance and HR business partners, general manager, heads of nursing and therapies and the clinical governance lead.

The Elective Orthopaedic Centre Clinical Governance, Quality and Safety Committee maintains oversight of the governance, quality, safety and patient experience activities of the elective orthopaedic centre. It will review reports on a variety of incidents, providing the opportunity to share the recommendations and learning derived from incidents. The Committee will review and maintain the elective orthopaedic centre risk register, review and ratify SOPs, policies and guidelines, review and monitor key performance and quality indicators and provide a platform for discussing performance and celebrating innovation and success. The attendance will consist of the elective orthopaedic centre leadership triumvirate, representation from the medical, nursing, therapies, management and the governance team.

In parallel with the LNWH governance, accountability to the NWL APC for strategy and business delivery will be through the Elective Orthopaedic Centre Shadow Partnership Board. The specifics of these reporting lines will be set out in the partnership agreement, to be drafted in the period April to May 2023. This will be designed in light of the APC's principles:

- Reduction in unwarranted variation in outcomes and access to services.
- Reduction in health inequalities
- Greater resilience across systems. including mutual aid. better management of system-wide capacity and alleviation of immediate workforce pressures.
- Better recruitment, retention, development of staff and leadership talent, enabling providers to collectively support national and local people plans.
- Consolidation of low-volume or specialised services.
- Efficiencies and economies of scale.

5.2 Implementation approach

The implementation model has been developed based on best practice evidence and draws on learning and feedback from the public consultation and external, independent assurance and advice. Our approach has been designed to mitigate the challenges and risks we have heard during consultation and that we have identified during our own implementation planning. Initial planning has informed the high-level approach and details the system-wide key enablers.

Following a formal decision to implement the proposed model of care, the programme will enter a mobilisation phase. A gateway approach will be taken towards mobilisation, with the programme required to pass through successfully each gateway before proceeding to the next.

This DMBC is not a final implementation plan for the proposal, nor a replacement for the further detailed work required for the full business case (FBC) required to secure the capital funding. However, it does signal clear requirements that need to be addressed within the FBC in more detail to ensure appropriate implementation. It has been developed in line with the five case model found in The Green Book guidance issued by HM Treasury and investment appraisal for capital projects[14].

Figure 13 – Gateway approach to implementation

Pre-planning

- Identify key milestones/actions required for clinical design and transformation, workforce, corporate, estate, patient transport, engagement and co-production workstreams
- Identify work stream leads
- Establish shadow partnership board after FBC approval, incorporating workstream leads
- Appoint shadow Medical Director, senior nurse and lay partner

Gateway 1 April/May 2023

- Mobilisation plan, including detailed clinical design and transformation, workforce, corporate, estates, patient transport, engagement and co-production workstream timeline and risk stratification, written and approved by shadow partnership board
- Partnership agreement drafted and feedback sought from all partners (NWL acute Trusts, ICB and MSK partners)
- Substantively appoint EOC senior management structure

Gateway 2 Pass through to go live

- All key workstream milestones achieved
- Pre go live risk assurance
- Assured benefits realisation plan trajectory and action plan (underpinned with the agreed clinical strategy)
- Partnership agreement signed off by all partners and partnership board formally established
- External assurance steps where necessary

Transition to business as usual/future state

- Move to business as usual
- Benefits realisation monitoring and reporting
- Optimisation
- Future planning

As Figure 13 demonstrates, once a formal decision has been made to proceed with the proposed model of care, the review will enter into gateway 1 which is the planning gateway.

This planning gateway 1 will encompass:

- mobilisation plan, including detailed workstream timeline and risk stratification, written and approved by the Shadow Partnership Board
- partnership agreement drafted and feedback sought from all partners (including north west London acute trusts, ICB and MSK partners)
- substantive appointment of the elective orthopaedic centre senior management team

The APC Board in Common, alongside some external assurers and subject matter experts, will then be required to review these plans for their adequacy and identify areas for further development where they are required. Examples of the external assurers that will be used as part of implementation assurance are a nominated lead from social care to review plans around discharge planning, external clinical assurance and challenge from the medical director of an established elective orthopaedic centre and early engagement with the GIRFT Accreditation Team.

Assurance of the mobilisation phase of the programme remains the responsibility of the APC Board in Common; they will hold managerial accountability for the implementation of the service model set out in this DMBC.

14 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/749086/Project_Business_Case_2018.pdf

Programme management arrangements

A robust programme management and governance structure has been developed. This will ensure accountability through a clear allocation of responsibilities and regular reporting, thus allowing timely identification and addressing of any issues which may arise. PRINCE2 principles will be followed in the approach to project management to ensure project delivery. PRINCE2 this is the de facto standard in use in the public sector in the UK.

Project implementation budget

The project implementation costs for the project have been included within the £9.4m capital investment budget. The project implementation element of the budget is inclusive of costs associated with the programme team including workstreams and external advisers providing the technical support required to develop a decision-making business case, FBC and the transition to implementation.

Change management plan

Table 6 below details the agreed process which will take place if changes are required to be made during the project implementation.

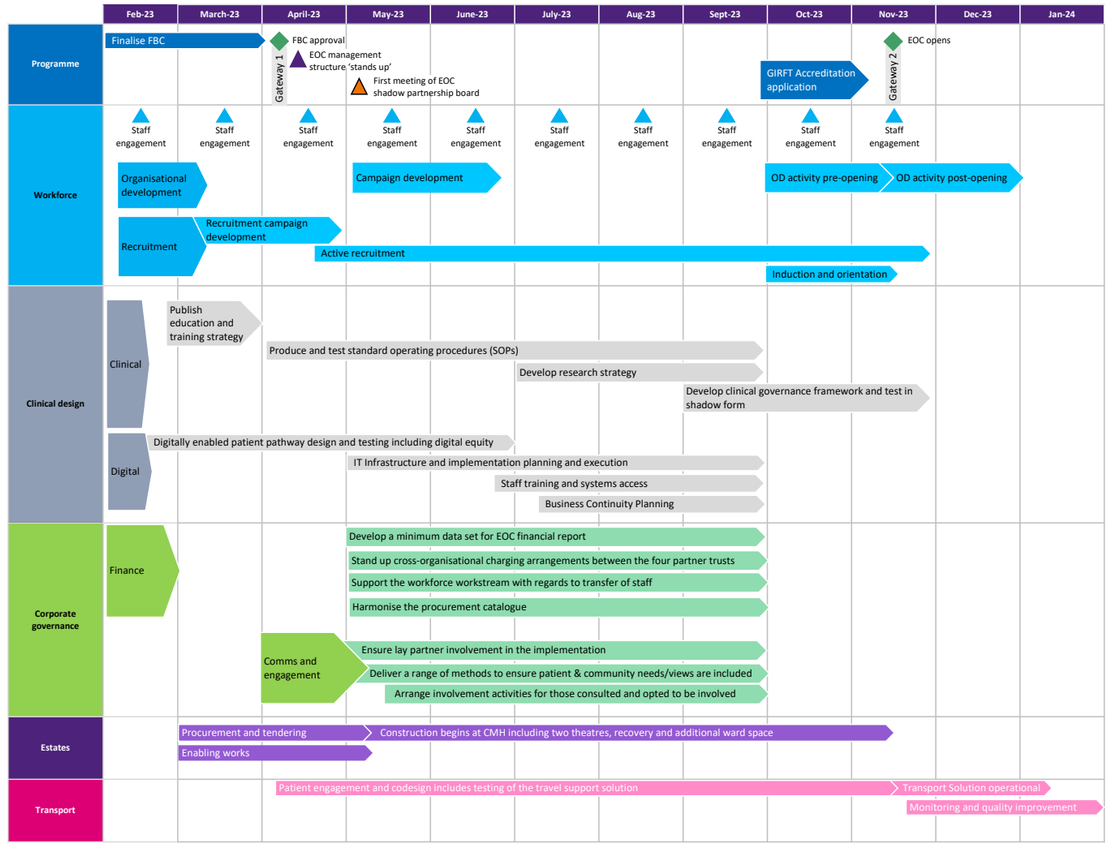
Table 6 – Change management process

Change	Process approval process
Design proposal/changes potentially impacting the: **1. clinical model** **2. workforce model** **3. digital enablement** **4. financial model**	• Workstream lead to review and assess request and determine impact with the project manager. Engage financial workstream lead to assessment cost impact. • Engage wider stakeholders where broader interdependencies, risks or opportunities are identified with a focus on end-to-end pathway care. • Workstream lead and senior responsible officer to make request or recommendation to North West London Elective Orthopaedic Centre Development Programme Board, or its successor Shadow Partnership Board, for decision making. • Clinical proposals can be referred and further tested with north west London Orthopaedic Clinical Reference Group (CRG) and/or north west London Musculoskeletal Network and/or north west London Clinical Advisory Group before or after presentation to the North West London Elective Orthopaedic Centre Development Programme Board, or its successor Shadow Partnership Board.
Day-to-day decisions and changes	• Mobilisation manager to assess impact and risk to the programme, engaging stakeholders and leads as required. Escalate to Managing Director (the host provider SRO) if time critical or risk is assessed as major or above. • Assess cost impact and act according to delegated financial thresholds.
Significant decisions – such directing major exceptions to the plan, halting or pausing significant elements	• Managing Director to assess impact of material changes and present to Shadow Partnership Board to confirm approach, including escalation route depending on nature of matter. • Comply with north west London elective orthopaedic centre Shadow Partnership Board directions. • Present to North West London APC Board in Common or delegated cabinet for approval. • Present to North West London ICB for approval where appropriate or advised. Ensure appropriate action is taken with local authority stakeholders and NHS England.

5.3 Timeline and key milestones

Proposed milestones for the transition and implementation of the elective orthopaedic centre are shown in Figure 14 at a programme level and for each of the four workstreams described above.

Figure 14 – Implementation Timeline and Key Milestones



5.4 Our communication and engagement plan

Continued engagement and involvement with patients, staff and carers is central to implementing the new model of care to better inform development of the elective orthopaedic centre and allow continued improvement.

We have built up a significant volume of insight over the past 18 months about what patients and local communities in north west London want and need from inpatient orthopaedic care and wider MSK services. This has been established through the public and patient involvement activities that informed the development of the initial proposal for an elective orthopaedic centre and even more so through the formal public consultation on the proposal and the IIA. We are committed to continuing to build and respond to this insight, to inform both the continued development and implementation of the elective orthopaedic centre and supporting inpatient services and the related plans to improve community-based MSK services.

It begins with ensuring we communicate proactively and openly with all of our audiences to raise awareness and understanding of what our services offer and what they involve, now and as they change. This will be an integrated approach across the APC hospitals and with community services. Patient information, including patient letters, will have a consistent approach in terms of content, terms, tone and branding, helping patients to experience our care as a joined-up pathway even as they move between their home orthopaedic hospital and the elective orthopaedic centre. We will also

ensure that information about travel support options, follow-up care and help with queries or concerns as well as feedback prompts are widely publicised and consistent.

We then see the diverse contacts and relationships we have made through the engagement and consultation work to date as being central to continued engagement and involvement on inpatient orthopaedic services and wider MSK care. We propose doing that in the following ways:

- Inviting the 200 plus people who took part in the consultation and who gave us permission to keep them informed – as well as the community organisations who supported us with particularly in reaching individuals not generally engaged with our services – to take part in involvement activities through a regular email update about the project (and wider MSK service improvements).
- Continuing to include lay partner roles in the governance structure for implementation (including oversight of ongoing involvement plans and patient and community feedback and experience indicators).
- Developing an iterative plan, employing a variety of methods, for expanding our understanding of patient and community needs and views to inform the further development and implementation of the elective orthopaedic centre and related care pathways. The iterative plan (plus the insights and responses to those insights) to be overseen as part of the main project governance for implementation and for onward, continuous improvement:
  - ad hoc co-design workshops for specific elements of implementation, for example, transport options
  - patient panels – for feedback via email, for example, on patient information
  - all staff
  - surveys
  - focus groups
  - continuing to triangulate existing sources of patient feedback and insight.

5.5 Expected benefits of the model

Benefits realisation plan (BRP)

Successful implementation of the changes proposed by implementing an end-to-end MSK pathway across north west London with a dedicated elective orthopaedic centre would deliver improvements for both the people receiving elective adult orthopaedic services in north west London and for the staff delivering them.

A framework has been developed for monitoring benefits realisation with the ICB and the four acute trusts. This includes KPI themes, metrics, target improvement and expected milestones for achievement, as shown in Appendix C.

The purpose of the benefits framework is to:

- describe the set of productivity and efficiency, quality and operational benefits we expect to achieve through the implementation of an elective orthopaedic centre for north west London and how a subset of key indicators can be quantified
- demonstrate the impact of the changes to services in north west London to the public, commissioners and providers
- provide a focus for all stakeholders during and post-implementation, to monitor the value and to ensure the reconfiguration is delivering the changes required
- describe specific and measurable performance indicators, which directly link to benefits
- enable the realisation of the programme's benefits which will be monitored at a system and EOC level
- provide an early warning system for the programme to take remedial action if the achievements are not as expected and to address any issues arising.

Post-consultation changes to the BRP

The BRP is shown in Appendix C. All of the KPI themes within the BRP have been reviewed by programme board to ensure the baseline and target metrics remain valid and the trajectories continue to be achievable. Where more recent data is available, the baseline metrics have been updated.

The key categories of benefit are summarised below together with changes since the PCBC.

Table 7 – Key categories of benefit and changes since the PCBC

Benefit description	Expected benefits	Changes since the PCBC
Clinical outcomes and experience	Improved patient satisfaction. Reduced burden on primary care.	Baseline position updated where more recent data available across the range of metrics.
Patient access	Improved patient satisfaction.	Baseline adjusted to more recent December 2022 rather than September 2022, as per the PCBC. Metrics now show inpatients and day cases separately. Waiting list and waiting time now monitored separately for in-scope and out-of-scope activity to ensure the risk identified during consultation of a potential two-tier service can be mitigated.
Productivity	Improved productivity.	Baseline position updated for length of stay metrics. Additional metrics added for theatre productivity (already included in EOC modelled activity and capacity).
Cost-effectiveness	Better use of resources.	Target for improvement recalibrated based on revised financial projections
Transport	Reduced numbers of patients who do not attend. Improved access to patient transport system. Improved patient satisfaction.	Included as a separate and additional area to reflect the importance attached to transport in the consultation response, rather than simply being picked up in the general patient satisfaction survey.
Patient satisfaction	Reduced number of complaints. Issues raised as part of complaints requiring action are addressed. Improved qualitative assessment.	Expanded in-scope to address feedback from the consultation.
Workforce	Low vacancy rates and low turnover.	Metrics and trajectories revalidated.

In response to the feedback received, a comprehensive review has been undertaken of the BRP. As a result, an enhanced approach to analysis of the patient perspective has been included as follows.

As part of the implementation of the elective orthopaedic centre and to assess the effectiveness of the new approach, the team is developing a comprehensive set of measures of service quality and accessibility from the patient's perspective. The measures outlined below will supplement existing business as usual processes including the Friends and Family Test (FFT) and review of patient complaints which will provide a broader assessment of the patient's view of service quality for the elective orthopaedic centre for all of the north west London hospitals providing planned orthopaedic care.

There will be a consolidated set of metrics and analysis comprising baseline and targets including the following:

- FFT scores, which provide a service/site/ward-based assessment for the elective orthopaedic centre and the other north west London hospitals providing planned orthopaedic care in respect of other elements of the pathway (pre-admission to and post-discharge from the elective orthopaedic centre)
- volume and nature of patient complaints for the elective orthopaedic centre and the home hospitals.
- bespoke and focused qualitative patient survey for the elective orthopaedic centre
- targeted patient transport impact analysis, which was identified as a particular area of concern in the Public Consultation Report, as described below:

  a) Qualitative patient feedback focused on patients who live more than 45 minutes away from the proposed location of the elective orthopaedic centre.

  B) Analysis of the profile of patients who do not attend (DNA) by postcode and age to test the assumption that patients who have mobility challenges or live further are more likely to be late/DNA.

  c) Post-implementation, a continuous review of the Patient Transport System data to analyse activity and the reason for eligibility and to see if there is a correlation between uptake and reduction in the DNA rate.

Patient access KPI themes have been expanded to separate out inpatients and day cases and to show separately the impact on services which are in-scope and out-of-scope for the elective orthopaedic centre. The latter will be managed by the APC Board in Common rather than the Elective Orthopaedic Centre Management Board. Monitoring of the benefits in this way will ensure the risk of a two-tier system for in-scope and out-of-scope services is minimised as remedial action to ensure consistent quality can be taken early on. Both sets of data will be reviewed by the Shadow Partnership Board.

Two patient pathway areas of focus have been identified as part of the consultation feedback and assurance review. These relate to access to MSK services pre- and post-operatively and the impact on social services of introducing the elective orthopaedic centre. While these are two key issues, they do not form part of the BRP as they are indirectly associated with the establishment of the elective orthopaedic centre. Access to MSK outside the EOC will be addressed through the patient satisfaction surveys and staff feedback within MSK and the elective orthopaedic centre. The impact on social services will be addressed through monitoring of the interaction with social services by the North West London ICB, the APC Board in Common and the Elective Orthopaedic Centre Management Board.

Management Reporting

The BRP data will be shared at the monthly Shadow Partnership Board meetings in the form of a consolidated summary report containing quantitative and qualitative analysis with feedback to the Elective Orthopaedic Centre Management Board and the originating hospitals.

A more detailed report will be considered by the Elective Orthopaedic Centre Management Board, which will also respond to recommendations from the Shadow Partnership Board, with escalation as required through LNWH Trust governance arrangements.

Post-evaluation review

The vision for this proposal, which constitutes one of the core objectives of the development, is to improve orthopaedic care and access across the whole patient pathway. A post-evaluation review (PER) will assess how well benefits have been realised and if there are any further actions required to enable greater delivery of benefits. Any lessons learned will be shared with future projects of a similar nature.

An initial PER will be carried out six months following the completion of the works. This will review the effectiveness of the model, patient experience and outcomes, building on the specific measures already outlined. It will have an explicit focus on patients from groups with protected characteristics to understand their experience of orthopaedic care in the model. This will inform providers and the clinical network of progress against overarching aims to report into the ICS leadership team and point to adjustments that providers may need to make to further improve care.

A comprehensive PER will be undertaken two years after completion. To gain maximum value from the PER, this will include representatives from each of the major project stakeholder groups.

5.6 Implementation challenges and risk management

Management of any significant barriers and risks to implementation will be undertaken via the Shadow Partnership Board and elective orthopaedic centre Management Board, with monthly reports to the APC Board in Common. Should there be anything that cannot be managed by these entities, then they will be escalated by exception to the ICB Accountable Officer who will have delegated authority to decide if they are so material that implementation cannot proceed, or the mitigating steps which need to be put in place to allow progression.

Risk management

A comprehensive project risk register has been developed for all risks identified, using qualitative measures to calculate the overall level of risk according to their impact and probability. The full risk register records:

- Category of risk
- Description of the risk
- Likelihood of risk occurring
- Consequence of the risk
- Risk rating
- Mitigating actions
- Post-mitigation risk scoring
- Risk owner
- Review date
- Direction of travel
- Risk status

The risk register is reviewed and updated on a regular basis through the programme governance with key risks escalated to the North West London APC Board and North West London ICB if and when required. The highest scoring mitigated risks are summarised below:

Table 8 – Risk register[15]

Risk description	Mitigating actions	Mitigated risk score
Clinical care		
There is a risk that the planned number of cases per list is not achieved	Implement best practice pathways supported by effective resources, training and development, and advanced operational intelligence. Clinical and operational agreement across partnerships and standing operational policies. Engagement of clinical staff in solutions.	8
Financial		
There is a risk that energy and other supply chain pressures will affect project timelines and costs	Monitor and ensure early procurement of items where appropriate. Review of supply chains as per Secretary of State for Health instruction. Increase optimism bias from 15% to 23% in financial model.	12
There is a risk of insufficient capital funding to support the required theatre expansion and other infrastructure changes	Capital funding secured based on the outline business case (OBC) requirement. If the programme exceeds time thresholds, there is potential to allocate capital via LNWH agreed in principle. Control of implementation costs via proposed governance structure.	9
Significant increase in workforce to be based on the CMH site which, if not filled with substantial recruitment, then temporary staffing will be attracted at a higher cost	Agency premium has been factored in based on LNWH's current recruitment profile. Engagement and co-design of workforce plan with stakeholders. Sensitivity analysis in the OBC will reflect the risk to savings based on greater reliance on temporary staffing.	9
Operational		
Risk that delay to the project results in continuation of relatively low scores on clinical outcome metrics	Start to make changes prior to the new elective orthopaedic centre opening, for example, Joint Weeks. Robust elective orthopaedic centre programme governance and monitoring via Programme Board and APC governance. Clinical leadership, use of best practice guidance and data through the design, development, and implementation phases across the programme governance.	12
There is a risk that elective recovery across surgical specialities continues to impact on capacity available for orthopaedics at CMH	LNWH executive-led recovery delivery group meets fortnightly to monitor recovery across surgical specialties to plan and avoid any CMH orthopaedic impact.	12
There is a risk that delay to the project results in increased patient waiting times	Robust programme governance with ongoing surgical recovery plans and monitoring.	12
There is a risk that the implementation is delayed by shortage of key staff groups and that staff experience is poor	Executive-led workforce workstream to develop staffing strategies, including recruitment drives, rotational posts and ensure continuous professional development. Comprehensive engagement and involvement plan which includes all key stakeholder groups including staff communication, engagement, and consultation.	12
There is a risk that lack of clinical engagement with the EOC will result in under-utilisation of the elective orthopaedic centre and unexpected pressure on the non-host trusts and north west London	Undertaking from each trust to contribute to expected activity levels. EOC programme governance, mobilisation and centre management including multidisciplinary team leadership Risks and benefits and supporting financial incentives to be incorporated in mobilisation plans. Professional/medical director leads and EOC Managing Director support. Clinical governance framework to measure and assure service quality and outcomes.	12
Lack of a single digital patient pathway platform results in resource-heavy, inefficient management of patient pathways between organisations	Managed by digital workstream with regular updates to the Shadow Partnership Board. Implementation of sector-wide digital platforms.	9
Strategic		
There is a risk of public opposition to the proposed development of an elective orthopaedic centre	Comprehensive engagement and involvement strategy to ensure user views inform the plan. Lay partner membership of the programme board and workstreams. Detailed and robust insights on the impact of all patient groups through a robust EHIA. Public consultation will inform mitigation with co-design with stakeholders and JHOSC.	9

Mitigated Risk Score	
15+	High
8 to 12	Medium
4 to 6	Low
< 4	Minimal

15 Summarised from NWL EOC Risk Register 22-02-2023

5.7 Workforce model

5.7.1 Workforce vision

North West London ICS has set out a People Plan with a commitment to a workforce vision, values and behaviours they will uphold and the actions they will take. The vision is set out below.

Our people are able to provide great care for our patients and communities because they have the skills, tools and capacity to do their jobs and the environment they work in is inclusive and supportive. Staff are motivated and engaged and have opportunities to grow, develop and innovate.

The vision has five collective goals: to Care, Lead, Include, Grow and Transform.

To support the achievement of the People Plan goals, the APC has set out its People Priorities for:

- Safe and sustainable staffing to reduce vacancies, turnover and premium rate temporary staff.
- Workforce redesign to support new models of care and new ways of working.
- Maximising the use of new roles.
- Developing the collaborative as a great place to work and London's acute employer of choice.
- Improving HR service effectiveness, efficiency and impact.
- Building more equitable and fair organisations (across the North West London ICS)
- Improving the health and wellbeing of our staff (across the North West London ICS).

The workforce model for the elective orthopaedic centre forms part of the APC's initial priorities, under priority two, workforce redesign. This will align with the Transform pillar of the north west London People Plan and equip the workforce with the skills and structures to deliver new clinical models of care; operate in agile ways using technology; and transform operating models for support services.

The developing workforce plan for the north west London elective orthopaedic centre aims to:

- make a significant difference to our ability to recruit and retain staff by making the north west London elective orthopaedic centre and base hospitals desirable and innovative places to work for relevant staff, including training and non-training medical staff (including GPs), AHPs and nursing staff
- enable productive working by enhancing digital capability and developing consistent pathways
- utilise processes that are in existence (portability agreement) and being developed across north west London to build flexibility and mobility. This would allow staff to work in different organisations and locations, particularly orthopaedic surgeons, anaesthetists and other relevant clinical staff who would follow the patient between base hospitals and the proposed elective centre
- develop consistent ways of working together with north west London-wide clinical protocols driven by the orthopaedic network
- decrease the unsustainable strain on clinicians by increasing the level of cover to recognised standards
- improve training opportunities for junior clinicians through greater access to specialists
- reduce sickness and absence rates with a decreased workload reducing stress and tiredness
- develop new roles where appropriate, which are likely to include advanced clinical practitioners and care navigators
- reduce the use of bank and agency staff through more effective cover of the rotas through existing staff
- deliver on the vision of 21st century care set out in the NHS Long Term Plan by reviewing skill mix, creating new types of roles and utilising different ways of working
- develop training models in partnership with Health Education England (HEE) that ensure undergraduates have access to the highest quality education and training
- ensure there are no unintended consequences for interdependent staff groups and services such as trauma, paediatrics and spinal
- develop north west London support networks including system-wide multidisciplinary team
- working structures and defined escalation pathways to access clinical expertise for complex patients
- develop a north west London-wide recruitment strategy for orthopaedics.

5.7.2 Workforce capacity and capability

The workforce model has been developed collaboratively with the multidisciplinary service leads, built up on activity modelling and outcome requirements that deliver GIRFT standards for all patients, following GIRFT Best Practice Pathway and NICE guidance. The workforce model will be reviewed throughout the development and implementation of the workforce plan to ensure that it remains the optimal model to deliver the desired outcomes.

The roles and WTE numbers of staff for the proposed workforce model have been designed and quantified.

Table 9 – Staffing requirements for November 2023 opening

Staff required for the centre			
15 Administrative and Clerical	21 Allied Health Professionals	20 Consultants	4 Management
22 Medical (non consultant)	194 Nursing	2 Pharmacists	279

Table 10 – Predicted staffing position for November 2023

Based on being able to recruit to pre-existing vacancy levels across the staff groups (accounting for existing fill rates).

Predicted staffing			
11 Administrative and Clerical	18 Allied Health Professionals	20 Consultants	3 Management
22 Medical (non consultant)	152 Nursing	2 Pharmacists	228

We have estimated the elective orthopaedic centre staffing position for November 2023 using the current vacancy rates across all staff groups. Based on this estimate there will be a temporary staffing requirement of 51 WTEs to meet the staffing requirements for November 2023 opening of 279 WTEs. There is an average fill rate across medical and nursing in T&O of 90% across NWL. Therefore, specific focus will need to be given to developing the temporary staffing pool to support the substantive workforce. Recruitment exercises will continue to be run to build a sufficient pipeline to move towards the 336 WTE requirement for 1st April 2024.

The proposed staffing model for the elective orthopaedic centre will consist of a single team at the north west London elective orthopaedic centre preferred site, doctors rotating to support the transferring patient activity and there will be consideration of rotational posts for specialist or hard to recruit roles.

Although it had been anticipated in the PCBC that there would be transfer of staff with the transferring activity, having analysed the workforce data returns, we have been unable to identify an organised grouping of staff whose principal purpose is delivering the transferring activity, so at this point we do not anticipate a requirement for staff to transfer employers. Instead, staff (not including doctors) currently delivering the activity within one of the provider trusts, will remain in their post and will be given the opportunity to apply for a role at the elective orthopaedic centre (the process for this is being developed).

As there will be orthopaedic surgery remaining with home trusts undertaken by their staff and plans being developed to utilise existing capacity, it is not expected that any redundancies will be required.

We will continue to engage with staff throughout the implementation phases and should an organised grouping of staff be identified whose principal purpose is delivering the transferring activity, then those staff identified will transfer with the activity to the elective orthopaedic centre host under the protections of a 'TUPE transfer'.

Should there be any proposed changes for staff, there will be formal consultation with those staff directly affected. This would most likely be from May 2023, following any approval of the FBC.

There is, therefore, an expectation that there will be a greater reliance on direct recruitment to staff the elective orthopaedic centre.

The staffing risks grow for the EOC host with an increased requirement for direct recruitment and they decrease for 'home' trusts who will be able to strengthen their staffing position.

Impact on residual services

Chelsea and Westminster Hospital NHS Foundation Trust (CWFT)

Local ASA 3 and 4 and day cases activity will continue to be delivered at CWFT. There is a small risk that should consultants not want to move with the transferring activity they could choose to take up posts elsewhere, which would have an impact on residual services. There will need to be a review of the impact on medical rotas to ensure that residual services are not negatively impacted.

Imperial College Healthcare NHS Trust (ICHT)

Local ASA 3 and 4 and day cases activity will continue to be delivered at ICHT, with the Charing Cross site being potentially designated as the major revision centre for the sector. There are not considered to be any risks around staffing to deliver this activity within T&O directorate, but strain could be placed on theatre nursing teams.

London North West University Healthcare NHS Trust (LNWHT)

Local day cases and ASA 3 will be delivered adjacent to the north west London elective orthopaedic centre with ASA 4 activity delivered at Northwick Park Hospital. No risks have been identified around staffing to deliver this activity.

The Hillingdon Hospitals NHS Foundation Trust (THHT)

Local day cases will be delivered at MVH with ASA 4 activity undertaken at HH. Many of the staff currently delivering the transferring ASA 1 and 2 activity are doing so as a small proportion of their role. It is unlikely that they will transfer with the activity. Some of these staff will be specialists (therapy staff). There is the potential risk that if the repurposing of the released capacity is not within a specialism of interest to them, they may choose to take up new roles elsewhere that are more attractive to them. Should this risk materialise, resulting in an increase in turnover of AHPs (hard-to-fill), this would impact on the ability to run joint schools, manage ASA 3 and 4 activity and day cases remaining on-site and potentially impact wider developments to increase weekend occupational therapy and physiotherapy.

The retention of day case activity (the largest proportion of activity undertaken) could provide an opportunity to direct resources to address both growth and the PTL (that is, waiting list) backlog, offering services that are aligned to the special interest of any affected staff. Rotational posts will be explored as a potential solution, but there is a risk that the distance between THHT and CMH may mean that the posts are not as attractive.

Overall, it is expected that trusts (ICHT, CWFT and THHT) will strengthen their staffing position supporting residual services as:

- there are current vacancies across the staff groups which will be transferred to support ASA 1 and 2 activity (to be recruited into)
- where small proportions of roles are currently utilised to support delivery of ASA 1 and 2 activity, it is unlikely that these staff will transfer with the activity, thereby enabling trusts to strengthen their staffing position and supporting the repurposing of capacity.

As highlighted above for THHT, the likely strengthening of staffing positions for residual services could provide an opportunity to redirect resources to address growth and waiting list backlog at all of the provider trusts.

5.7.3 Recruitment and retention

It is expected that the majority of staff will be directly recruited to the elective orthopaedic centre host. As we have been unable to establish an organised grouping of staff whose principal responsibility is the transferring activity, we will be offering staff (currently within the affected services) within the 'home' trusts the opportunity to apply for a role in the elective orthopaedic centre (the process will be developed should we move forward with implementation).

Inclusive recruitment practices introduced/developed as part of the NHS People Plan in 2020 will be reviewed across the trusts, to evaluate their impact. All vacancies will be promoted in the local community or through community channels, to ensure the adverts reach a diverse pool of candidates. Selection panels will be diverse, and members will have had appropriate training. These are some of the interventions that evidenced contribution to organisational culture change in a report by NHS Employers and commissioned by NHS England and NHS Improvement on Inclusive Recruitment – Leading Positive Change (April 2021).

We plan to work with an agency to support the design of a dedicated recruitment campaign for the elective orthopaedic centre. This will include the identification of innovative ways of recruiting to key roles. Specific recruitment plans/specialist campaigns will be developed for the gaps identified in each staff group for the agreed workforce model. Delivery will be aligned with the People Priorities being developed for the acute provider.

We plan to hold a number of open days for nursing and AHP roles, seeking to advertise the AHP open days in universities giving the opportunity to appoint to Band 4 student posts while they await their Health and Care Professions Council registration/exam results. We also plan to explore the ongoing international nurse recruitment across the acute trusts to support the recruitment pipeline for the elective orthopaedic centre.

There will be groups of staff retained by provider trusts, who will rotate to the elective orthopaedic centre to undertake the transferring patient activity. This will apply to doctors and will be explored for hard-to-fill and specialist roles. Staff currently involved in delivering the transferring patient activity will be given the opportunity to express their interest in taking up roles in the elective orthopaedic centre. This process will run concurrently with the external recruitment campaign.

Developing new ways of working across the system is crucial to developing a sustainable workforce model that builds local capacity, capability and competency to deliver care across end-to-end best practice MSK pathways.

The new model will provide opportunity to attract staff to north west London, together with challenges recruiting to a number of key disciplines.

The clinical model will enhance training opportunities, resulting in improved skills across the workforce and improved recruitment and retention. All trusts have been asked to review existing staffing gaps and ensure recruitment activity is paced up locally to support the transition to the new centre to strengthen and maintain sustainable staffing levels. The APC will also explore possibilities for joint recruitment campaigns for key staff groups. It is likely that recruitment will commence at pace to secure staffing for future gaps identified in the following staff groups:

a) post-anaesthesia care unit (PACU) nurse qualified

b) advanced nurse practitioner

c) qualified ward nurse

d) anaesthetic registrar

e) consultant anaesthetist

f) consultant orthopaedic surgeon

g) physiotherapist

h) radiographer

We will be exploring all conventional routes to recruitment, through the North West London Health Academy, utilise, develop and design training and skills programmes with the partnership skills providers to upskill existing staff and consider the use of alternate roles. There are a number of courses currently available ranging from diploma to Masters level across nursing; physician associates; MSK ultrasound; advanced clinical practice; physiotherapy; operating department practice; and a number of entry level apprenticeship courses.

Retention

Retention is one of the key priorities in the APC people priorities. Initiatives are being explored to retain staff within north west London, which will support the strengthening of staffing levels across the system.

Retention initiatives and reviews of workforce pressures will be considered across the pathway to ensure that specific actions (for example recruitment and retention plans, employee experience) are undertaken in a coordinated manner to avoid damaging recruitment and retention in different parts of the pathway.

The concerns raised through the public consultation around loss of staff as a result of travel/multi-site travel issues, will be largely mitigated by the fact that apart from doctors it is expected that the majority of staff will be directly recruited by the host, with others given the option to apply for roles.

Development of relevant apprenticeship posts, rotations, new roles for internal development (for example advanced care practitioners) will provide a greater opportunity for staff to develop and maintain skills across the pathway which will also support staff retention.

Options for flexible working will be made available for staff regardless of their role. The anticipated operating hours will provide an opportunity to offer staff more flexible working patterns and we will explore opportunities for colleagues from all professions who have recently retired to return to practice in the elective orthopaedic centre.

Temporary staffing

We plan to review and continuously monitor the temporary staffing pool across all staff groups to understand the capacity and likelihood of being able to supply the support required to the elective orthopaedic centre. This will enable us to make any necessary interventions to build or develop the temporary staffing pools across all staff areas. We will be able to utilise the collaborative bank for nurses, which will enable a streamlined path to take up shifts in the EOC – further work will be undertaken to increase the number of nurses taking up shifts on the collaborative bank and we will be working on marketing material with communications teams across the four trusts.

Temporary staffing shifts for staff outside of medical and nursing are taken up through local banks, with use of agency. We will need to make sure the pipeline for these staff is sufficient within the host systems. There are good fill rates across administrative and AHPs, with the latter pipeline generated via agency.

5.7.4 Teaching, training, education and research at the core of the clinical and quality strategy

This innovative model of surgical hubs has been shown to offer significant opportunities and benefits for the teaching, training and education of key clinical staff, including doctors, nurses and therapists. Consolidating large volumes of routine elective surgery allows for excellent whole team routines, skills and relationships to be developed that enhance the training environment and make care consistently more efficient and safer. Attention to training, education and research will drive the culture, behaviours and expectations necessary for a high performing centre of excellence. This approach directly supports safe and high-quality care.

The elective orthopaedic centre will be a protected facility dedicated entirely to elective care, with ring-fenced resources that allow them to stay active even when emergency pressures rise. These hubs are now seen as a key resource for more robust and sustainable elective services, backed by bodies such as NHS England and the Royal College of Surgeons of England.

Surgeons in training

Training is at the core of good care and the provision of an expert workforce for the future. Orthopaedic specialty surgical trainees will work and operate with and under the supervision of their normal clinical supervisors as part of the home trust surgical team, travelling to the elective orthopaedic centre for theatre operating sessions.

The development of the north west London elective orthopaedic centre was discussed and supported by the national Specialist Advisory Committee for Trauma and Orthopaedic Surgery, the body with delegated authority for training in trauma and orthopaedic surgery on behalf of the Joint Royal Colleges of Surgery and the Joint Committee for Surgical Training. The model and proposal is endorsed and felt to offer significant opportunities for improved training. Recent data shows that trainees and training in trauma and orthopaedic surgery have been disproportionately affected by the COVID-19 pandemic and reduced elective surgery volume. The specialty has the largest proportion of 'outcome 10' assessments at trainee annual competency assessments, where trainees have not been able to achieve the expected standards of operating because of the impact of the COVID-19 pandemic. The elective orthopaedic centre will offer an important solution for this problem in north west London and will provide future trainees with high volume training in a supervised high volume performance environment.

This support is caveated with the requirement for the elective orthopaedic centre to be designed and established in line with the GIRFT accreditation criteria which put training at the heart of the centre. The North West London ICB have made this commitment (section 5.6), which will benefit clinical training for all specialties and will also support high-quality care.

Table 11 – GIRFT 'high volume low complexity' (HVLC) criteria for staff and training

Headline criteria	Core elements of headline criteria	What we will be looking for	Evidence	CQC KLOE
1. Dedicated & ring-fenced clinical and operational teams	1a. Robust clinical staffing model	Clear rotional or permanent clinical staffing model in place Staff vacancy rates are low Hub has, or aims for, 80% substantive staff across all staff groups and on a rolling monthly basis Hub review the number of additional hours that staff work to ensure staff well being	Self-certification Rotas Vacancy data Copy of plans	Effective
	1b. System in place to enable staff to work effectively at hub sites and to move efficiently between hubs	Passporting process & rotational models fully embedded Induction processes are in place for all staff, including these from other sites and visiting clinicians	Related policies Conversations with staff during site visit Self-certification	Effective
	1c. Robust ring-fencing applied to hub staff	Chief Executive/Exec Tripartite decision required for breaking of ring-fence of hub staff Winter/emergency pressures plans in place to avoid hub cancellations	Self-certification Conversation with staff during site visit Copy of plans	Effective
	1d. Effective strategy to address future staffing issues & robust staff management processes	Plans to address recruitment and retention in place (e.g. networking with neighbouring hubs, rotational or innovative posts) Plans for sole-development and ongoing training Robust staffing processes such as appraisal, disciplinary etc.	Self-certification Copy of approach and results Copy of plans Copy of policies	Safe

Headline criteria	Core elements of headline criteria	What we will be looking for	Evidence	CQC KLOE
2. Supported training of junior doctors & wider MDT	2a. There are regular, scheduled, training opportunities at the hub for junior doctors, including fellows	Dedicated training operating lists to agreed GIRFT rations (e.g. 8 cataracts per training list v 10 non-training list)	Example theatre lists Model hospital data Conversations with staff during visits	Effective
	2b. Hub staff offered regular, relevant continued professional development (CPD) opportunities	Systematic training opportunities in place for relevant hub staff	Training records	Effective
3. Strategy & approaches that promote staff well-being	3a. Staff have access to necessary basic facilities and services	There is sufficient parking and transport arrangements for staff not permanently based at the hub Staff access to a dedicated area for breaks/ lunch There is lockable storage and changing facilities are available for hub and non-hub staff Smart card/relevant logon information for staff not permanently based at the hub is collected in a timely way	Observation during visit Conversations with staff during site visit Self-certification	Effective
	3b. Staff feel safe in their work environment	Necessary estates safety checks carried out Outdoor areas and parking is well lit	Self-certification Observation during visit	Effective
	3c. Staff feel valued and respected in their work environment	Evidence of regular engagement with staff at all levels with evidence of actions taken to address suggestions and comments Good levels of staff satisfaction	Self-certification Examples of impact Vacancy, sickness and turnover rates Trend data	Effective

Anaesthetists

The large volume of joint arthroplasty provides significant opportunities for the development of skills and training in regional anaesthesia as well as general anaesthesia in a fit and healthy (ASA 1 and 2) patient population. The clinical workstream team will explore with the School of Anaesthesia for Health Education England how these opportunities can be best developed and used.

Allied Healthcare Professionals (AHPs)

In addition, the elective orthopaedic centre offers considerable opportunities for training and to develop real expertise and confidence for nurses, theatre operating department practitioners, physiotherapists and other AHPs. Clinicians have the opportunity to grow and develop in conventional roles working in a specialist environment or to develop advanced skills working more broadly in extended roles that support this innovative pathway such as advanced nurse practitioners supporting ward care, reporting radiographers, consultant or advanced practice therapists.

Sharing best practice

In addition, the volume of clinical work undertaken in the elective orthopaedic centre provides opportunities for clinicians from home trusts and community partners to undertake placements at the elective orthopaedic centre to develop their understanding of the whole patient pathway. It is also provides opportunities to upskill and to develop competences and confidence that can be shared across providers to improve the clinical skills, knowledge and quality of care across north west London.

Research

Consolidating large volume elective work and expert clinical teams presents real opportunities for the elective orthopaedic centre to lead and develop research programmes of work that will have meaningful impact for patients undergoing treatment for MSK procedures. The acute trusts are well placed to support this with excellent links with Imperial College and the new MSK laboratory in the Sir Michael Uren Building at the White City Campus.

Investing in our staff

Placing training and research as a core element and expectation of everything that we do will encourage the elective orthopaedic centre to continue to: aim for the highest standards; to remain reflective and responsive to change; progress and challenge; and embrace true multidisciplinary working. Trauma and orthopaedics 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. Our commitment to provide an excellent environment for training will help to make the elective orthopaedic centre a great place for all to work, supporting our recruitment, retention and staff wellbeing. The positive impacts of all of these for patient safety are well recognised.

5.7.5 Working arrangements

Consultant job planning

Consultants will be required to have updated job plans in place to support the north west London elective orthopaedic centre via existing portability agreements, while doctors in training, as in the SWLEOC model, would continue to be aligned to the base hospitals. Doctors in training should then follow their consultant to the proposed elective centres on their consultant's operating days to get their required exposure to elective cases.

Job planning will be aligned with training junior doctors to ensure the delivery of high-quality education, training and supervision. It is intended that travel between sites in a single day will be avoided, while we will explore whether it is feasible to have annualised job plans.

We are aware that there could be a requirement for consultants to alter long-standing working arrangements to incorporate their commitments to the elective orthopaedic centre and so we plan to review job planning guidance across the trusts to inform a consistent approach to job planning with support provided from HR leads and medical directors. Job planning for the elective orthopaedic centre will need to commence outside of some annual job planning cycles and is expected to commence in the period May to July 2023 should the proposal progress.

Doctors in training

Initial conversations have taken place with HEE and we will liaise with HEE in the development of the training model to ensure training requirements are fully integrated into delivery plans. The presumption is the elective orthopaedic centre would function without any reliance on overnight or ward-based support from trainees.

Junior doctor support is likely to present challenges with regards to rota management and service provision and these will be addressed in detail within any education and training plan developed by providers.

5.7.6 Staff experience

The APC is currently reviewing the following opportunities where people improvement objectives may benefit from a collaborative approach. These are:

a) a joint programme to improve staff engagement and experience across the group

b) an employee value proposition

c) optimising the use of diversity data to drive and track improvement

d) de-biasing our HR processes and procedures

e) improving the progression of our colleagues with protected characteristics.

We aim to share and spread the best Equality, Diversity and Inclusion (EDI) practice within the APC, including EDI education and leadership programmes.

Should the proposal be approved, we plan to engage with staff to understand what we can introduce to make the elective orthopaedic centre a desirable place to work.

The elective orthopaedic centre will be designed in line with best practice staffing ratios, which should create a better environment for staff to work in. Staff will be encouraged and find it easier to take their breaks and rest.

We plan to review the provision of wellbeing support across the acute collaborative and identify areas/initiatives where pooling resource or sharing access could be achieved and would create benefits across the collaborative. Work is already in progress on a shared approach to financial wellbeing.

We plan to embed a learning culture where all team members are actively encouraged to suggest ideas for improving efficiency and outcomes.

We plan to monitor the outputs from the staff survey to gain insight into staff experience at the elective orthopaedic centre, comparing against wider T&O services and overall staff survey outputs. This will enable us to make the necessary improvements to ensure that the elective orthopaedic centre is a desirable place to work.

5.7.7 Workforce implementations

Workforce engagement

The clinical model has been led and developed by senior clinicians from across all four acute trusts and the ICB. Much wider and deeper involvement will be essential if there is agreement to take the proposal forward. So far, wider staff groups have been kept informed and have been able to raise concerns or questions with their managers or via a dedicated email[16].

We are developing an ongoing programme of involvement for all staff who work in orthopaedic surgical and related care so that they can help shape the final proposals and, if it goes ahead, the implementation plan and beyond.

Following the public consultation, we will be holding monthly sessions to be led by trust programme leads and supported by workforce leads. Workforce leads will meet with staff side representatives to discuss and keep them updated on the proposal and staff side will also be invited to the monthly sessions. To improve attendance and reach staff who cannot attend, we will be actively promoting these sessions to staff through existing communication outlets and sessions, with recordings being made available via the intranet and local systems. We will provide regular updates via pre-existing directorate meetings.

16 nhsnwl.eoc@nhs.net

5.8 Implementing the transport solution

The transport solution, described in section 4.3.3, has been designed to provide information and facilitation to all patients attending the elective orthopaedic centre for their operations, with transport being made available at no charge for any patients facing a long, complex, or costly journey to the elective orthopaedic centre. This section outlines our agreed approach to implementation of that solution and will be fully developed through the implementation phase in readiness for go live.

We have already identified the patients and stakeholders that are likely to be affected by this transport solution and have consequently incorporated them into our co-design approach. Following the approval of the FBC, patients and key stakeholders will be further involved in the development of the transport solution, including the patient portal, scheduling, tracking system, communication and governance.

We will undertake pilot testing of the transport solution to ensure that it meets the requirements of patients, providers and other stakeholders while operating as intended. This will include collecting qualitative feedback from patients on their experience, reviewing patient attendance data, and uptake of the proposed solution. These metrics are new and currently in development (see Appendix C – BRP).

The elective orthopaedic centre team including the care navigator roles will be aware of the travel support available to patients and the associated resources so that they feel confident about how to support patients to navigate their pathways.

The development of travel information, facilitation and travel solution will be monitored through implementation and feature in the gateway assurance framework. The transport solution will be improved continuously through quality improvement initiatives based on feedback from stakeholders, emerging technology solutions, and as the elective orthopaedic centre is fully embedded in north west London's health and care system.

5.9 Translation and interpretation services

If LNWH is chosen as the lead provider, then CMH would provide the elective orthopaedic centre with language services in line with LNWH's inclusive communication and interpretation procedures and protocols. This service can be configured for: face-to-face interpreting, telephone call translation, video call translation, deaf and/or blind communication related services and print translations – and also provides a service for those using and designing communication services with digital and non-digital patients.

This service is currently operational at CMH and would be engaged during the design, transition and implementation stages before the go live of the centre. Feedback is monitored by CMH's patient and carer participation feedback group. They would provide a report to the elective orthopaedic centre's weekly governance meeting once the centre is operational.

5.10 Environmental sustainability of services

The elective orthopaedic centre has a responsibility and commitment to meet NHS England's net zero targets for emissions and mitigate the impact of the NHS on climate change. In response to feedback, we have outlined how the centre will give due consideration to environmental sustainability.

The implementation has been developed with consideration of the North West London ICB Green Plan (March 2022), a three-year plan which will start to reduce emissions from our sites, working practices and supply chain and support organisations within the ICB to deliver on their own green plans. The plan aims to bring positive change for our patients, communities and staff and address inequalities through improving environmental health and embedding social values.

The development will similarly reflect the overall aims of the LNWH Green Plan, published in August 2022. The ambition is to become a leader in the field of sustainable healthcare by proactively engaging with our staff on sustainability matters so that they are integral to, and feel part of, delivering our Green Plan.

The refurbishment of operating theatres at LNWH will be carried out under a partnership with ByCentral (PFI Project Co) which has developed trust-wide initiatives to meet the NHS objectives of Carbon Zero and Carbon Zero Plus. These initiatives include:

- planned lifecycle replacement programme that moves to modern (lower carbon) technology wherever possible (for example, over the operational phase of the PFI almost all light fittings are LED)
- targeted energy improvement works (for example, boiler burner upgrades, direct drive motors)
- energy investment initiatives (for example, installation of solar PV supported by battery technology) linked to external funding opportunities)
- wider carbon zero investments and opportunities hosted by external local initiatives (for example, Old Oak and Park Royal Development Corporation led local heat network that seeks to supply heat energy to the CMH site from a local data centre. The trust has endorsed this with a letter of "in principle" support for business case development.

Operationally, the elective orthopaedic centre will help achieve carbon and resource savings through:

- the transition towards virtual pre-operative assessment, reducing the need for patient travel
- streamlining of high volume, low complexity surgical instrument kits
- streamlined care pathways for patients to ensure the first contact is the right contact
- reduced orthopaedic staff travel between sites with direct recruitment model
- ASA 1 and 2 allows for high proportion of regional anaesthesia that can reduce anaesthetic gases use

6 Financial case

Chapter 6 sets the revenue and capital financial case for the development of the north west London elective orthopaedic centre, and the changes applied since in response to the consultation findings and feedback from external, independent assurance and advice.

Key messages

- The development of a north west London elective orthopaedic centre would both improve productivity and efficiency of orthopaedic surgery services by Year 2.
- Capital funding and source required to develop an elective orthopaedic centre is unchanged at £9.4m.
- The revenue benefit to the north west London system has been marginally reduced by c.£100k (£4m from £4.1m) due to the costs of enhanced transport arrangements.
- The annual cost of delivering the range of planned orthopaedic services within scope for the elective orthopaedic centre will reduce from £31m to £27m.

6.1 What has changed since the PCBC

This chapter covers the changes in the financial impact of the preferred model on the acute trusts within north west London and on the finances for the broader NHS in north west London since the PCBC. The changes modelled are as a direct result of the consultation and assurance process.

Each of the responses to the assurance process has been assessed from a financial standpoint and the only material change from a financial perspective is the patient transport solution. The proposed transport solution has been costed at £106k per year, which will increase the annual running cost of the elective orthopaedic centre.

This has reduced the net surplus of the elective orthopaedic centre from £4.1m to £4.0m, starting in the first full year of operation. This is in absolute terms and considers operating at full capacity. The new income and expenditure summary can be seen below.

Table 12 – Income and expenditure summary for years 1 to 5

	Year 1	Year 2	Year 3	Year 4	Year 5
	2023/24	2024/25	2025/26	2026/27	2027/28
	£k	£k	£k	£k	£k
Income	18,906	31,613	32,742	33,917	35,097
Expenditure	(18,766)	(27,645)	(28,583)	(29,594)	(30,632)
Surplus/deficit	140	3,968	4,159	4,323	4,464

The other elements of the financial case have not been impacted by the assurance process. For further details, please see the PCBC. These elements have been summarised below, although assumptions are being reviewed and updated as part of the FBC process.

- The recurrent annual benefit to the income and expenditure (I&E) position for the host trust (and then for redistribution across the collaborative) is £4m. In Year 1 this is £0.2m due to marginal tariff relief for sector overheads/stranded costs and phased activity plans allowing for a transition to full capacity and efficiency.
- This will result in a reduction of the cost to the North West London ICS of providing routine services within the new EOC from £31m to 27m, i.e., c.13%. This is based on the same levels of activity in scope as set out in the PCBC (see Table 13). See below for more details on how this is achieved.

- £9.4m of capital investment has been modelled, which includes development costs for project management, clinical pathway modelling, activity planning, ICT transformation and legal fees in addition to the development works costs (including design fees) and equipment. Capital funding has been agreed and is being sourced from the NHS TIF, following a successful bid.
- The discounted cash flow benefit to the acute collaborative will be £35.5m over 25 years. This reflects a higher discount factor to reflect growing inflation pressures.
- Through moving to GIRFT standards for lengths of stay and theatre utilisation, as stated above, the elective orthopaedic centre will release £4m in annual efficiency savings when running at full capacity from Year 2.
- This benefit will be distributed across the four trusts in accordance with their pre-existing levels of 'overspend' against the tariff funding levels, subject to any agreement on reinvestment or service redesign across the acute collaborative.
- Sensitivity modelling has been undertaken on optimism bias, inner London weighting, reliance on temporary staffing, length of stay reductions and theatre utilisation.

Table 13 – Impact of the north west London elective orthopaedic centre on Trust activity at Year 2 (full year)

	CWHFT	THHFT	ICHT	LNWH	NWL Sector Total
Inpatients (ASA 1 & 2)	1,093	826	956	1,114	**3,989**

The £4m annual benefits to the I&E position are achieved through:

- reduced unit costs through productivity and efficiency (see below for more details)
- increased throughput (and positive impact on PTL or waiting list), activity and therefore income, as well and other productivity and efficiency gains

The benefits realisation plan described in Appendix C includes an assessment of the impact on unit costs of achieving target improvements in productivity and efficiency and is set out below.

Table 14 – Targeted improvements in productivity

North west London activity	Total activity	Total NCC cost £	Baseline weighted activity unit (WAU) cost	Target weighted activity unit cost (WAU)
Weighted activity unit (All activity against TFC 110 T&O)	229,582	£84,578,734	£368	£351 (5% reduction)
Weighted activity unit (Elective DC and IP against TFC 110 T&O)	9,996	£35,582,380	£3,569	£3,163 (11% reduction)

This shows:

1. Weighted activity unit (WAU) all activity – targeting a 5% cost reduction, as there is no change to trauma, which is out of scope.
2. WAU elective activity – 11% cost reduction, as only routine inpatient orthopaedic activity is in scope.

The financial savings will be achieved by delivering a service that is more efficient in line with GIRFT standards, enabled by a modern facility and centralisation to provide the critical mass and clinical expertise. The elective orthopaedic centre will add capacity to the north west London system to treat more patients. This undertaking requires more staff. With the elective-orthopaedic-centre-enabled service transformation, we are able to treat those additional patients more efficiently. This will reduce the unit cost compared to a 'do nothing' option.

The medical workforce cost will transfer to the elective orthopaedic centre via recharges. At present, we have not identified an organised grouping of staff whose principal role is the delivery of the transferring activity. As result, it is anticipated that these staff will remain in the 'home' trusts, strengthening their staffing positions by reducing vacancy rates and being utilised to deliver replacement activity (additional complex activity and repurposed capacity). Plans for the repurposing of capacity have been scoped and are being developed by the three 'home' trusts.

Taking into account the modelling principles employed and the results of the sensitivity analysis, the financial case demonstrates that the financial modelling assumptions are sufficiently prudent that the model is able to absorb the most likely outcomes over mobilisation and over the longevity of the case.

The sensitivity and scenario analysis has been reviewed by the Financial Workstream and revalidated. This analysis highlights the robustness of the modelling when tested against a number of key parameters.

The principles underpinning the proposed financial and commercial arrangements between the north west London acute trusts have been jointly developed and agreed by the chief financial officers of the acute trusts.

7 Assurance and advice

Chapter 7 sets out:

- **The legal duties that apply, including public involvement, consultation with local authorities, consideration of equalities and inequalities via the EHIA and IIA, the independent assurance applied throughout the development programme, including key recommendations from the ICB at the PCBC stage.**
- **The role of the LCS provided as part of the NHS England assurance process and their recommendations.**
- **The London Mayor's 6 tests assessment and recommendations.**

Details of the assurance outputs received from each source can be found in Appendix D.

Key messages

- The programme has fully applied the NHSE major service change assurance process, putting patient and stakeholder engagement and consultation at the very centre.
- The Mayor's support to the proposal based on assessment against tests 1-4 have given an important London perspective. The Mayor's final assessment will be published to inform decision making.
- Legal advice and guidance has been sought throughout to ensure the programme can offer a high level of compliance to patients and all stakeholders.

7.1 Legal duties

This section sets out the main legal duties that are relevant to the process as described in the PCBC, including consultation and the DMBC for establishing the elective orthopaedic centre. The legal duties are as follows:

1. the duty of public involvement under sections 14Z45 and 242 of the NHS Act 2006
2. the duty to consult with local authorities under regulation 23 of the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013
3. the Public Sector Equality Duty under section 149 of the Equality Act 2010
4. the duty to reduce health inequalities under section 14Z35 of the NHS Act 2006
5. NHS commissioner duty to secure continuous improvement in quality and duty to promote integration under sections 3 and 3a of the NHS Act 2006, restated in section 25 of the Health and Care Act 2022 as responsibilities to be taken on by newly created integrated care boards
6. the Gunning Principles for lawful consultation

In addition to the formal public consultation, we have met with the local authority JHOSC to seek their views on the consultation report and our response. We have also taken on board feedback based on the Mayor of London's six tests for major service reconfiguration. We have revisited our clinical model, pathways and approach to reflect the recommendations of the LCS.

Public involvement

NHS providers and commissioners are subject to duties to: involve service users, their carers and representatives in the planning of health services; the development of proposals for changes in those services; and decisions affecting the operation of those services. Almost 2,000 responses were received during the 14-week public consultation on a proposal to develop a centre of excellence for elective orthopaedic surgery in north west London. The process was led jointly by NHS North West London which is the ICB responsible for commissioning NHS care for people living in the eight north west London boroughs and the North West London APC.

The public consultation complied with the Gunning principles of lawful consultation. These principles are:

- Consultation takes place when proposals are still at a formative stage.
- There is sufficient information to give 'intelligent consideration' to the proposals.
- There is adequate time for consideration and response.
- 'Conscientious consideration' must be given to the consultation responses before a decision is made.

Consultation with local authorities

Where proposals will give rise to a substantial development or variation in health services, the NHS is required to consult with the local authorities for the areas where services will change. Throughout the process of planning for the consultation, the consultation itself and during the period after the consultation, there has been regular engagement with the JHOSCs across the eight boroughs covered by the proposal for the establishment of an elective orthopaedic centre. In addition, a formal response to the proposals was requested from the North West London JHOSC and this was provided verbally on 8th March 2023.

Equalities and inequalities

North West London understands that the implementation of an elective orthopaedic centre may disproportionately impact some groups of the population. An EHIA has been carried out to understand this impact and to comply with the Public Sector Equality Duty and also the duty to reduce inequalities. This takes a systematic and evidence-based approach to considering the likely impact of the proposals on the different groups of people and sets out the mitigating actions to be incorporated into the implementation plan. In addition to the EHIA, NHS North West London commissioned an IIA for inclusion in the PCBC. The IIA has been refreshed after the conclusion of the public consultation and an independent assurance review by the Mayor of London's Office has been undertaken. This is to ensure that the evidence on equalities and inequalities that will be considered by decision-makers is as up to date and comprehensive as possible in showing impacts and potential mitigations.

Service improvement

The ICB must exercise its functions with a view to securing continuous improvement in the quality of services provided to its population. The proposals for the elective orthopaedic centre have at their heart a strong focus on continuous improvement with an aspiration to be best practice. This is evidenced by its target improvements in performance in terms of: clinical and operational activities; transport; patient satisfaction; workforce; and value for money.

The improvements described above are incorporated into a comprehensive BRP, shown in Appendix C. This includes baseline performance and target improvements in key metrics covering each of the service improvement areas described above.

Effective, efficient and economic

The ICB must exercise its functions effectively, efficiently and economically. The North West London ICB has undertaken its own assurance in respect of: improvements in quality; robustness of the financial and workforce projections; ensuring inequalities have been addressed; and that there has been a comprehensive and robust public consultation.

7.2 Assurance requirements

7.2.1 The Secretary of State's four tests plus NHSE 'bed test'

NHS England, in 'Planning and delivering service changes for service users' guidance, published in 2018, outlines guidance on the development of proposals for major service changes and reconfigurations. In May 2022, this was supplemented by the "Addendum to Planning, assuring and delivering service change for patients".

The NHS England guidance sets out how new proposals for change should be tested through independent review and assurance by NHSE. This includes four tests for service change and NHS England's fifth test for proposed bed closures. There are no plans to reduce beds, therefore this test does not apply.

NHS England operates a two-stage assurance process and the PCBC was reviewed before the public consultation. On 6th October 2022, NHS England confirmed the programme had been assured against the four tests and successfully passed "Stage 2 – assurance checkpoint".

Following public consultation, NHS England has been kept informed of the proposed next steps once all feedback from the consultation has been gathered and analysed.

The four tests plus 'bed test'

Test 1: Strong public and service user engagement

This section evaluates the extent to which service users and the public have been involved in the development of proposals so far. North west London understands and values the requirement for this engagement and wants the people of north west London to have their say in the development of their elective orthopaedic centre. Feedback from the public and service users has helped us to identify and address key concerns or considerations, thus allowing for early action and modifying the model.

A successful 14-week public consultation was held between 19 October 2022 and 20 January 2023, led by North West London ICB and the North West London APC. The link to the full report can be found in Appendix A, and the executive summary is shown in Appendix F. The consultation approach built on early engagement with patients and the public in June 2022, which had previously informed the development of the formal elective orthopaedic centre proposal set out in the PCBC.

Our communication and engagement plan, outlined in section 5.4, describes our ongoing commitment to engagement with patients and carers, public, staff and local authorities.

Test 2: Consistency with current and prospective need for service user choice

This test is mainly concerned with the choices set out in the NHS Choice Framework. Those that are relevant here are:

- choosing where to go for your first outpatient appointment
- asking to change hospital if you have to wait longer than the maximum waiting times.

We do not anticipate that the proposed service change will negatively impact on the choices available to service users, as all providers will continue to deliver elective orthopaedic surgery and there will be an increase in capacity for providing orthopaedic services in north west London. We therefore expect any negative impact as a result of a single site to be offset by improved waiting times and better outcomes.

A specific area of the proposal where service user choice could have been impacted is in the use of digital technologies for pre-assessment. North West London ICS has ensured that patient choice is protected by including the offering of face-to-face or telephone appointments and pre-assessment for those who cannot use the digital pathway, or do not feel comfortable using it.

Service user choice will improve from a quality perspective as the proposed service change will enhance access to orthopaedic services through standardised pathways and waiting lists. Additionally, service users will be cared for in a purpose built, specialist environment. This is in line with GIRFT best practice guidance.

Test 3: A clear clinical evidence base

This test is to demonstrate that there is sufficient clinical evidence on the case for change as published in the PCBC. Independent advice on the case for change has been sought from the LCS. They made five summary recommendations:

- The proposal is communicated clearly and effectively in a way that is meaningful to the public to enable a truly engaged consultation.
- Engagement continues and extends with all stakeholders.
- Service changes are developed to improve outcomes for all, and work is undertaken to ensure that changes do not inadvertently cause disadvantage or widen inequalities.
- Workforce planning and development is sufficiently advanced to support the proposed model.
- Operational details are clearly developed to enable implementation.

The COVID-19 pandemic negatively impacted waiting lists for orthopaedic surgery in north west London, with more than 16,000 people waiting for orthopaedic care as of January 2023. The proportion of people waiting more than 52 weeks for care has increased by more than a quarter during the pandemic.

Increased health service capacity through physical separation of elective from urgent services is a key element of the NHS Delivery Plan for tackling the COVID-19 backlog of elective care. This can be delivered in the form of a dedicated and protected surgical hub such as an elective orthopaedic centre, enabling a step change in the quality, efficiency and outcomes of elective orthopaedic provision across north west London.

Although north west London has areas where there are excellent clinical outcomes for orthopaedic surgery, including low readmission and 're-replacement' rates for knee and hip surgery, this varies across hospitals. Some patients currently face inequalities in accessing care and have poorer health outcomes as a result.

Through standardisation and removal of variation, an elective orthopaedic centre will address the COVID-19 backlog and these inequalities, aligning with GIRFT best practice recommendations.

Test 4: Support for proposals from clinical commissioners

This test is to provide assurance that the proposal has the approval of local commissioners. Formal support has been obtained from the accountable officers of the four north west London acute trusts and the North West London ICB which demonstrate support for the case for change, the work undertaken to date on development of the proposal that north west London should have an elective orthopaedic centre including comprehensive engagement and endorsement for moving to formal public consultation. North West London ICB has specified five specific points are met as part of their own assurance process (see section 7.2.2)

NHS England London has formally confirmed that they are assured that the four tests have been met.

Test 5: NHSE's bed closures test

This test is only applied where the proposal includes plans to significantly reduce bed numbers. This proposed service change focuses on relocating services and utilising unused capacity rather than closing beds.

Following receipt of confirmation from NHS North West London that there is no planned reduction in bed numbers as a result of the new elective orthopaedic centre proposal, NHS England London has formally confirmed that the Bed Closure Test is not applicable.

Conclusion

Having reviewed the North West London's Programme documentation and received advice from the LCS, NHS England London is assured that: the four tests are met; the option set out in the PCBC is affordable; financial and workforce considerations have been addressed appropriately at PCBC stage; and that given there is no planned reduction in the number of patient beds attached to this scheme, the 'Beds test' is not applicable. On this basis, they have provided formal approval that the scheme should proceed to public consultation.

7.2.2 ICB assurance

North West London's ICB considered the PCBC on 27th September 2022. In addition to ensuring that the ICB fulfils its legal duties, the ICB raised five specific points that they would seek further assurance on in this decision-making business case.

Table 15 – North West London ICB – Key Assurance Points

The ICB said	Action taken
There has been a comprehensive and robust public consultation.	The process of consultation and our response to it is covered in Chapter 3.
Inequalities highlighted in the PCBC (including transport and digital exclusion) have been addressed.	The IIA (Appendix B) lays out the expected impacts on the population. The transport solution and actions to avoid digital exclusion are outlined in section 4.3 and 4.1.8.
Clarity on what the benefits will be in terms of reducing waiting lists and improving quality.	Appendix C sets out the BRP. The ICB wishes to ensure that the elective orthopaedic centre delivers material and best practice outcomes for residents, at best practice levels of productivity (for example, length of stay; theatre availability and productivity).
Workforce planning has been undertaken and that there is sign up from the clinical body that this is deliverable, and that job planning issues have been resolved and trauma rotas can be staffed etc.	Section 5.6.2 sets out the required staff, how workforce will be delivered and the potential impacts on other sites, and the support from the clinical body.
All the financials are robust and that there will be no request for additional money from the ICB in order to deliver the business case (revenue or capital).	Chapter 6 sets out the financials. Providers have confirmed to the ICB that no additional capital or revenue is required to deliver this business case.

The financial model underpinning the DMBC was presented to the Finance and Planning Committee (F&PC) on 10 March 2023 for partnership assurance and scrutiny in advance of the North West London APC BiC in Common Cabinet meeting on 14 March 2023. The LNWH CFO presented the changes from PCBC to DMBC; highlighting key sensitivities and discussing the process for securing the anticipated efficiency savings. No concerns for the DMBC were noted, but the F&PC set out a small number of key areas to develop further in the event the DMBC is approved – including the level of ambition against GIRFT metrics and key productivity indicators. The LNWHT CFO noted that this would align with a request from the ICB Strategic Capability Committee (SCC) and agreed to undertake this work.

7.3 Advice

7.3.1 Clinical advisory from London Clinical Senate

The LCS is an impartial, advisory, arms-length body that provides support to the NHS by giving independent, strategic advice to decision-makers. It also has a remit to provide assurance to NHS England about the clinical aspects of major service redesigns.

As part of the NHS England assurance process for the elective orthopaedic centre, the LCS were asked to provide advice on the development. Following a panel discussion with senior clinicians leading the development, the Senate produced a preliminary report, Advice on proposals for adult elective orthopaedic services reconfiguration in North West London: case for change, clinical models, and the development of potential solutions, dated 13th October 2022.

In summary, the findings of the LCS review were as follows:

"The London Clinical Senate found that the proposals were grounded in evidence and best practice. They were supportive of the case for change and the direction of travel. They also identified a number of recommendations as the team move forwards and these are detailed in the body of this report. In sum, the review panel recommend that:

- *The proposal is communicated clearly and effectively in a way that is meaningful to the public to enable a truly engaged consultation.*
- *Engagement continues and extends with all stakeholders.*
- *Service changes are developed to improve outcomes for all, and work is undertaken to ensure that they do not inadvertently cause disadvantage or widen inequalities.*
- *Workforce planning and development is sufficiently developed to support the proposed model.*
- *Operational details are clearly developed to enable implementation."*

The Senate concluded its review by supporting the proposals for a north west London elective orthopaedic centre on the CMH site. This is based on reviewing the documentation and presentations made to the review team. A summary of the report and recommendations will be published by North West London ICB.

7.3.2 The Mayor's six tests

The Mayor of London applies six tests to all proposals for significant service change in London. The Mayor commissioned the Nuffield Trust to assess proposals for planned orthopaedic inpatient surgery in north west London during the public consultation. The final two tests will be applied to this DMBC.

Test 1: Health inequalities and prevention of ill health

The impact of any proposed changes on health inequalities has been fully considered at a sustainability and transformation plan level. The proposed changes do not widen health inequalities and, where possible, set out how they will narrow the inequalities gap. Plans clearly set out proposed action to prevent ill health.

The review of the proposal under the first test identified the need to revisit the analysis undertaken to demonstrate the potential impact of the elective orthopaedic centre on deprived groups, while also recognising that there may be a significant unmet need for elective orthopaedic care among this group. The refreshed IIA (Appendix B) shows that the elective trauma and orthopaedic activity per 1,000 population in deprived populations is comparable to the national average.

The Mayor of London's report also acknowledges the importance of assessing the travel needs and requirements of patients from deprived areas and those who may struggle to travel longer distances, and consideration is given to these factors in section 4.3.

Travel costs, times and complexities have been explicitly considered. The travel solution (section 4.3) has been updated in response to ensure patients from deprived areas or at risk of long and complex journeys are supported.

Although we cannot break out simple and complex cases from the current data set, the proposed service change is expected to benefit both those attending the elective orthopaedic centre and those remaining at their home hospitals.

Test 2: Hospital beds

Given that the need for hospital beds is forecast to increase due to population growth and an ageing population, any proposals to reduce the number of hospital beds will need to be scrutinised independently for credibility and to ensure these demographic factors have been fully taken into account. Any plans to close beds should also meet at least one of NHS England's newly introduced 'common sense' conditions.

The Mayor of London's report acknowledges and supports the proposal to increase bed and theatre capacity for elective orthopaedic patients in north west London and the impact of this in terms of increasing capacity for other forms of care at sites around the sector. While worries that demand could exceed capacity, the modelling covers both the routine and complex procedures.

Risks are noted, and were acknowledged within the PCBC, in relation to the movement of clinical resource to staff the new centre and the potential to destabilise other services. These risks form part of the detailed workforce plan for the proposed service (section 5.6) with four routes proposed to staff the elective orthopaedic centre.

Test 3: Financial investment and savings

The PCBC set out potential savings to the system as a result of establishment of the elective orthopaedic centre This DMBC has revalidated the projected savings which have reduced marginally from £4.1m to £4.0m, as a result of the enhanced patient transport arrangements to be implemented following feedback from the consultation.

The projected saving represents a net financial benefit to the system of c.13% against the baseline position of £31m service cost.

No change has been identified in the capital investment requirement of £9.4m as set out at PCBC stage. This will be covered by a recent, successful bid for funding from the national TIF.

The sensitivity and scenario analysis against a range of key parameters has been revalidated and remains robust.

In summary, the proposed establishment of the elective orthopaedic centre is projected to deliver a significant saving to the system and represents value for money with a payback period of 5 years.

The principles underpinning the proposed financial and commercial arrangements between the north west London acute trusts have been jointly developed and agreed by the chief financial officers of the acute trusts.

Test 4: Social care impact

Detail was requested on how the proposed changes to elective orthopaedic services may impact on adult social care, which was not included within the PCBC, including relationships with adult social care services and monitoring and mitigation of risks.

Overall, we expect the impact on social care to be minimal, and potentially reduce in the long run. We have analysed available data and expect the number of additional patients that need social care packages to be under 20 people annually and are likely to be predominantly physical support.

This is an increase of approximately 0.1% in the total number of people across north west London with social care packages. It is likely to be an overestimate, as a proportion of them will have social care packages in place before admission, so are not additional social care packages as a result of the procedure. This analysis has looked at the percentage of patients that require social care historically and their age demographic, which showed that less than 1% of patients under 45 require social care. Due to the elective orthopaedic centre pathway being available to the low complexity patients, additional volumes going through the centre will mainly be younger patients with limited comorbidities as reflected in the recent Royal College of Anaesthetists NAP7 audit[17].

The burden on social care is also like to reduce in the long run. The elective orthopaedic centre will help to improve outcomes for patients, which will increase independence and mobility for some patients, reduce their deterioration, and reduce the level of social care that they will need in the long run. It is difficult to quantify this impact.

LNWH already has relationships with a range of adult social care providers, with a discharge hub at CMH that currently acts as a single point of referral to three local authorities. They will continue to coordinate referrals to all eight local authorities. More detail around post-operative care and the discharge pathway has been added to section 4.1 of the DMBC. Local authorities were specifically engaged in the proposal as part of the public consultation, and through the JHOSC assurance process, and no concern has been raised about the impact on social care by the Director of Adult Social Services.

Test 5: Clinical support

The proposals demonstrate widespread clinical engagement and support, including from frontline staff. As stated above in response to test 1 of the NHS England four tests for service change, the overall feedback from clinicians has been positive and it is clear that orthopaedic and MSK teams across north west London support the vision for the new elective orthopaedic centre.

Test 6: Patient and public engagement

Proposals demonstrate credible, widespread, ongoing, iterative patient and public engagement, including with marginalised groups, in line with Healthwatch recommendations.

Revised feedback on tests 1 to 4, and feedback on tests 5 to 6, is expected from the Mayor's office following publication of the consultation report and submission of this DMBC for further review and consideration.

17 https://associationofanaesthetists-publications.onlinelibrary.wiley.com/doi/10.1111/anae.15989

8 Governance and next steps

Chapter 8 sets out the programme's governance structure, including the bodies that are responsible for decision-making, oversight, delivery, and progress reporting and recommendation to the North West London ICB.

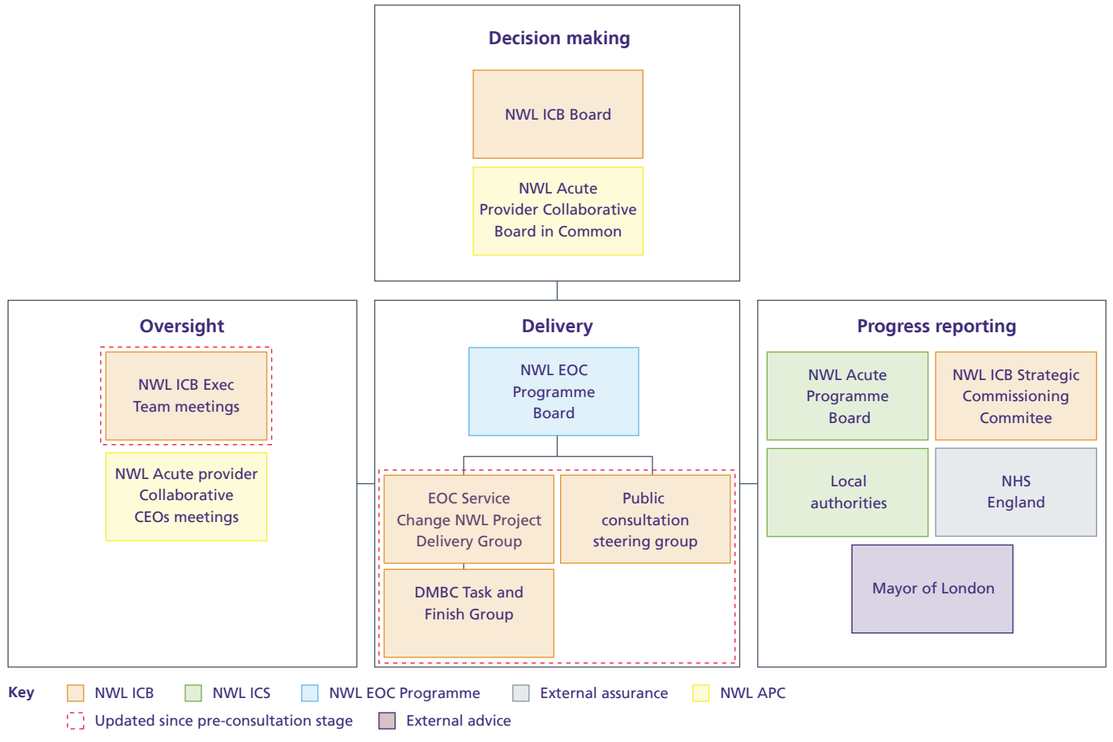
Key messages

- The DMBC recommends that the North West London ICB endorse the proposed model of care as described in the public consultation and as updated within this DMBC in response to the consultation findings and feedback from external, independent assurance and advice.
- The programme governance structure includes clear interfaces between the North West London ICB and APC Trust Board, and between the Programme and Trust boards.
- Links to local authorities across the sector including the JHOSCs through pre-engagement, public consultation and decision making have ensured this is an integrated approach.

8.1 Governance structure

The programme has had a robust governance structure in place since establishment. This has been adapted and updated from the PCBC (see Figure 15) to show oversight from the North West London ICB executive team and demonstrate how the Project Delivery Group, Task and Finish Group and the Public Consultation Steering Group support the North West London Elective Orthopaedic Centre Programme Board.

Figure 15 – Improving planned orthopaedic inpatient surgery in north west London governance

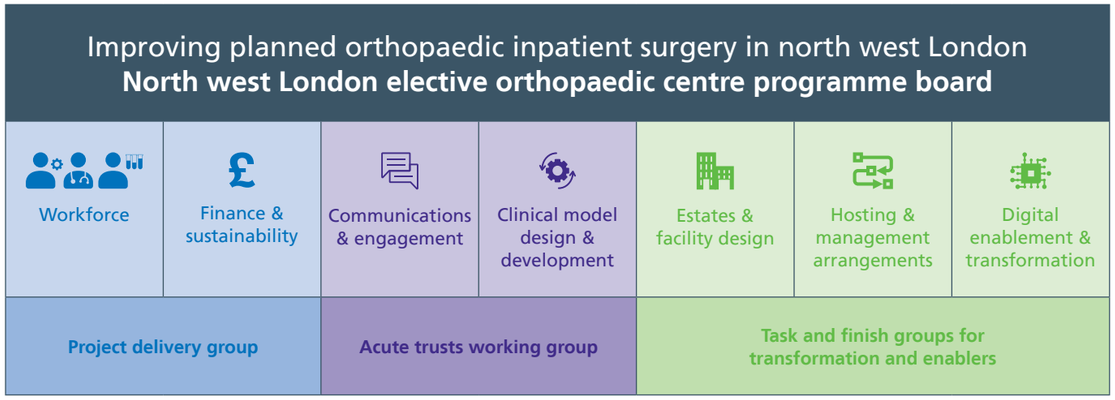


The key elements of this governance structure include:

- a clear governance route through from the Programme Board to the North West London ICB and APC Trust Board in Common
- the interface between the Programme Board and its assurance mechanism
- links to local authority, including the North West London JHOSC through the North West London ICB
- continued engagement with NHSE in their expert advisory role
- links to the Mayor of London with regards to the assessment of his six tests for major service reconfigurations in London

Three types of programme specific groups continue to support workstreams across the programme, as illustrated in Figure 16 below.

Figure 16 – Programme groups that support the implementation of the elective orthopaedic centre



Roles and responsibilities

The decision-making phase of the service change to develop an elective orthopaedic centre as a system hub for north west London is being overseen by the same programme board on behalf of the North West London APC and the North West London ICB. The Programme Board provides regular updates to the North West London ICB and the respective Trust boards and this will continue as activities move forward. The joint SROs for this programme are Pippa Nightingale, Chief Executive of London North West University Healthcare NHS Trust and Professor Tim Orchard, Chief Executive of Imperial College Healthcare NHS Trust, working closely with Toby Lambert, North West London ICB Executive Director of Strategy and Population Health.

Use of External Advisers

The following external organisations have supported the project so far:

- Acumentice – modelling impact on waiting list size and times
- Capsticks – legal advice
- Carnall Farrar – supported development of the PCBC and DMBC
- Cliniplan – provision of health planning expertise
- HKS – modelling impact on travel time and cost
- Hampton Healthcare Consulting – supported development of the OBC, PCBC and DMBC
- Vercity Group – assistance in delivery of project design
- Verve Communications Ltd. – conducted the public consultation and several stakeholder engagement activities

Information governance

It is of absolute importance that clinical and corporate information is managed effectively while being utilised to its maximum potential for the benefit of service users and the public. Effective management of information requires appropriate policies, procedures and accountability to provide a robust governance framework.

Patient identifiable data (PID) can be classed as any information, electronic or paper format that would allow a third party to identify the patient. The proposed service change will result in a change in the way PID is handled.

A Data Protection Impact Assessment (DPIA) screening form has been completed and north west London has confirmed that a Data Processing Agreement (DPA) is required. Prior to this, an information governance review is needed covering the full pathway. This review is needed to understand the systems in use across the entire pathway, which personnel are using them, how and for what. In addition, a clinical safety case will also be written. These processes are under way with a planned completion date by June 2023.

8.2 Governance timeline

Set out below are the key milestones in the timeline for approval of the DMBC:

Table 16 – Decision making process timeline

Date	Milestone	Governance forum	Purpose
20 January 2023	End of public consultation	N/A	N/A
27 January 2023	Receive public consultation report	NWL Elective Orthopaedic Centre Programme Board NWL ICB Service Change Governance Project Delivery Group Public Consultation Steering Group	Review
30 January 2023	Receive public consultation report and agree to publish	NWL APC CEO meeting	Review and sign off
6 February 2023	Publish public consultation	N/A	N/A
14 February 2023	Receive public consultation report	NWL APC Board in Common	Review and advise
16 February 2023	Present IIA to NWL ICB EHIA panel	NWL ICB EHIA panel	Sign off (IIA)
23 February 2023	Present public consultation report, refreshed IIA and refreshed evidence informing decision making	NWL ICB Strategic Commissioning Committee	Scrutiny and decision to proceed to NWL ICB
8 March 2023	Present public consultation report and update	NWL JHOSC	Receive final comments from JHOSC
14 March 2023	Present draft DMBC	NWL APC Board in Common	Decision making and approval to publish to NWL ICB
21 March 2023	**Present DMBC**	**NWL ICB Board**	**Sign off – final decision**

8.3 Recommendations to the Integrated Care Board

The North West London ICB is asked to:

- **ENDORSE** this DMBC and proceed with the proposed elective orthopaedic centre described in the public consultation and as updated within this DMBC in response to the consultation findings and feedback from external, independent assurance and advice.
- **NOTE** that the DMBC includes:

Travel

a) Proposals to enhance transport arrangements including providing comprehensive information on travel options, help with planning journeys and help to access support for transport.

b) In cases where patients are unable to travel by their own means and who were not eligible for existing support schemes and would have a long, complex or costly journey by public transport, we will provide transport at no charge. We estimate a third of the patients treated at the centre in the future will require transport.

Site Location

c) Confirmation of Central Middlesex Hospital as the location for the new elective orthopaedic centre because:

- The majority of the consultation respondents supported this location.
- CMH is the most central hospital in north west London. We believe the benefits of a single centre of excellence outweigh the inevitable downside of longer travel times for some patients.
- The CMH, being a site that does not provide emergency care, can provide ring-fenced capacity for planned orthopaedic care.
- The site has the best quality estate in north west London and requires minimal capital investment.

We provided details of the options appraisal in the PCBC, which was published alongside the public consultation materials.

Clinical model and patient experience

d) Details of the clinical model and how it has been augmented through greater clarity on pre-operative and post-discharge care so that patients are clear about their entire planned orthopaedic care pathway.

e) Consideration of the whole patient pathway, across MSK community services as well as within and between hospital services.

f) Continued patient engagement and co-production planning during the transitional period to the new elective orthopaedic centre opening and beyond.

Workforce model and staff experience

g) A collective recruitment campaign that will emphasise the range of additional opportunities provided by our integrated approach to orthopaedic care.

h) Proposals to expand the role for all staff in the detailed planning and implementation for the new elective orthopaedic centre following approval of this DMBC. We will achieve this through:

- a review of all staff involvement activities undertaken to date to ensure that staff are aware and have been informed about the elective orthopaedic centre proposal. Extra sessions will be held where necessary. This is being taken forward locally at each of the trusts.
- an ongoing programme of involvement for all staff who work in orthopaedic surgical and related care, so that they can help shape the final proposals and, if it goes ahead, the implementation plan and beyond.

i) An enhanced training programme to ensure the new elective orthopaedic centre will have staff ready to operate in accordance with the levels of productivity and efficiency required from day one.

Equity

j) A revised approach to ensure there is no default to digital for patients navigating care pathways. We are tackling this issue across all of our services and will roll out new responses to support the new clinical model, including tailored communications and face-to-face service options for patients who do not want or are not able to use digital platforms.

k) Even more detailed waiting list monitoring and improved communications, engagement and support, given we know that people from black, Asian and other minority ethnic communities may be less likely to seek orthopaedic surgery than other groups.

Financial

l) Confirmation that capital funding is unchanged from the PCBC, and no further capital funding will be sought from the ICB.

m) The revenue benefit to the north west London system has been marginally reduced by c.£100k (£4m from £4.1m) due to the costs of enhanced transport arrangements.

n) The annual cost of delivering the range of planned orthopaedic services within scope for the elective orthopaedic centre will reduce from £31m to £27m.

o) An expanded BRP, which includes a full suite of productivity and financial metrics to monitor the centre's delivery of best practice theatre productivity and length of stay metrics.

Implementation

p) Plans for LNWH to act as host for the new EOC, managing the new EOC and providing all logistical support for the EOC to operate as a free-standing business division with its own service line reporting.

q) An Elective Orthopaedic Centre Management Board will be in place prior to commencement, operating within the LNWH governance arrangements.

r) An extended benefits realisation plan to monitor achievement of elective orthopaedic centre benefits as set out in the PCBC but with revised and expanded KPI themes and metrics, designated owners and validated trajectories.

- **ENDORSE** the approach to implementation assurance which will be overseen by the North West London APC and delivered by London North West University Healthcare NHS Trust through the establishment of a clinically chaired Elective Orthopaedic Centre Partnership Board.
- **NOTE:**

  i) The Public Consultation Report and the IIA.

  ii) Subject to endorsement of the decision making business case, the Acute Provider Collaborative will draw up a Final Business Case. The FBC will review the financial assumptions, including building towards the GIRFT target of all-day operating, six days a week. Once the APC BiC has approved the FBC, it will oversee implementation of the elective orthopaedic centre.

  iii) The JHOSC is due to respond formally to the consultation report on 8th March 2023 and we will address this:

  – within the final DMBC to be submitted to the North West London ICB on 14th March 2023.

  iv) The North West London ICB's Strategic Commissioning Committee, a sub-committee of the ICB, approved the submission of the DMBC to the ICB subject to inclusion of further measures in the BRP. These have been included.

  v) The Mayor of London will complete his assessment of the six tests he applies to major service reconfigurations in London in advance of North West London ICB's meeting on 21st March 2023. His assessment will be made available to members of the ICB in advance of the meeting and published alongside the DMBC should the ICB endorse the DMBC.

9 Glossary of terms

Term/ Abbreviation	Definition
APC	Acute Provider Collaborative
ASA	American Society of Anaesthesiologists
AHP	Allied health professional
BOA	British Orthopaedic Association
BAU	Business as usual
CMH	Central Middlesex Hospital
CXH	Charing Cross Hospital
CW	Chelsea and Westminster Hospital
CWFT	Chelsea and Westminster Hospital NHS Foundation Trust
CRG	Clinical Reference Group
Core20	The most deprived 20% of the national population, as identified by the national Index of Multiple Deprivation,
CSFs	Critical Success Factors
DPIA	Data protection impact assessment
DC	Day case
DMBC	Decision-making business case
DTA	Decision to admit
DNA	Did not attend
DALY	Disability Adjusted Life Years
EPR	Electronic patient records
EOC	Elective orthopaedic centre
EH	Ealing Hospital
EHIA	Equality and Health Impact Assessment
FFT	Friends and family test
FBC	Full Business Case
GIRFT	Getting it Right First Time
GLA	Greater London Authority
HBN	Health building note
HEE	Health Education England
HVLC	High Volume Low Complexity
HH	Hillingdon Hospital
I&E	Income and Expenditure
IMD	Index of Multiple Deprivation
ICB	Integrated Care Board
ICS	Integrated Care System
ICHT	Imperial College Healthcare NHS Trust
IIA	Integrated Impact Assessment
IP	Inpatient
IOs	Investment objectives
JHOSC	Joint Health Overview and Scrutiny Committee
LOS	Length of stay
LCS	Locally Commissioned Services
LNWH	London North West University Healthcare NHS Trust
LSOA	Lower Layer Super Output Area
MFF	Market forces factor
MVH	Mount Vernon Hospital
MSK	Musculoskeletal
NCC	National Cost Collection
NPV	Net present value
NHSE	NHS England and NHS Improvement
NPH	Northwick Park Hospital
NWL	North West London
OBC	Outline Business Case
OSC	Oversight and scrutiny committee
OKS	Oxford Knee Score
PLICS	Patient Level Information and Costing System
PAS	Patient administration system
PID	Patient identifiable data
PTL	Patient Tracking List
PROMs	Patient Reported Outcome Measures
PLICs	Patient-level costings
PACU	Post-anaesthesia care unit
PER	Post-evaluation review
PIR	Post-implementation review
PCBC	Pre-Consultation Business Case
POA	Pre-operative assessment
QIA	Quality impact assessment
QI	Quality improvement
RIBA	Royal Institute of British Architects
SMH	St Mary's Hospital
SMI	Severe mental illness
SOC	Strategic Outline Case
SSI	Surgical site infection
SWL	South West London
SWLEOC	South West London Elective Orthopaedic Centre
TIF	Transformation investment fund
TfL	Transport for London
THHT	The Hillingdon Hospitals NHS Foundation Trust
T&O	Trauma and orthopaedics
ULEZ	Ultra-Low Emission Zone
WM	West Middlesex Hospital
WAU	Weighted activity unit
WTE	Whole-time equivalent
WRES	Workforce Race Equality Standard

10 Appendices

Appendix A – Bibliography

Pre-consultation business case

https://www.nwl-acute-provider-collaborative.nhs.uk/-/media/website/elective-orthopaedic-centre/improving-planned-orthopaedic-inpatient-surgery-nwl-exec-summary.pdf?rev=258164efbd314209957847a679f82adf&hash=451CD5A94514C1349A5D20D3BFC5EDDC

Public consultation report

https://www.nwl-acute-provider-collaborative.nhs.uk/-/media/website/nwl-acute-provider-collaborative/documents/nwl-eoc-consultation/nwl-elective-surgery-consultation-report-final.pdf?rev=d3dc29180fd34296a03afeb94b2c24ac

Assessment of North West London's proposed elective orthopaedic care centre against the first four of the Mayor's Tests

https://www.nuffieldtrust.org.uk/files/2023-01/nuffield-trust-nwl-elective-orthopaedic-care-web.pdf

North West London Joint Health Overview and Scrutiny Committee (JHOSC) meeting – Wednesday 8th March 2023 at 10am

https://democraticservices.hounslow.gov.uk/ieListDocuments.aspx?CId=594&MId=12759&Ver=4

Appendix B – Integrated Impact Assessment (Executive Summary) v9

North west London EOC Integrated Impact Assessment

March 2023

What has changed in this version of the IIA

The methodology for the data analysis for the IIA was refreshed to more accurately capture T&O activity in north west London and collect more recent data

Methodology

- In this version of the IIA, we extracted data for elective T&O activity from Hospital Episode Statistics Admitted Patient Care database using the **treatment specialty of the consultant at the point of managing the patient ('tretspef')** rather than the specialty of the consultant when they were engaged ('mainspef') as this will better accurately capture all elective cases
- The data was extracted for a longer period (up to August 2022) as more data became available on the Hospital Episode Statistics Admitted Patient Care database
- To calculate the activity per head, we used the **average population of NWL from 2017 to 2020** rather than the mid point 2020 data used previously. For analysis based on ethnicity, we used the 2021 ONS census data as the yearly population projections did not disaggregate the population by ethnicity
- We introduced additional analysis showing the **prevalence of musculoskeletal data nationally** and elective T&O **patients discharged to care homes to model the impact on social care**
- We did not reference the Carstairs deprivation index in this version as this has been removed from the PCBC as advised by the Nuffield Trust. This uses Indices of Multiple Deprivation throughout
- The NHS Friends and Family Test outcomes were updated using December 2022 data and to better reflect elective T&O wards

Highlights of changes

- The **activity levels of the more deprived deciles are comparable to the whole of the NWL population** using the new methodology, while the previous analysis showed a higher activity level among the most deprived population compared to the whole population
- Average waiting times for women to receive elective T&O services were also **found to be slightly higher than men** due to the expanded time period examined data extraction methodology as opposed to the previous version where we found a slightly lower wait time for women on average
- Hospital Episodes Statistics database records only a small number of elective T&O patients discharged to care homes, suggesting a minimal impact on social care, however, **many patients discharged to their usual places of residence may require care at home which will not be represented in the data**
- The **mitigating actions** to address the access, patient experience, and outcomes risks **have been refreshed using insights from the public consultation report**

Executive Summary

The aims of the Elective Orthopaedic Centre are to improve quality, access and patient experience for routine inpatient orthopaedic surgery in north west London

Background

- The four acute provider trusts in north west London formed an Acute Provider Collaborative (APC) as part of the north west London (NWL) ICS to work together to deliver the highest standard of care and reduce health inequalities in the local population
- North west London aims to do this through the creation of fast-track surgical hubs, which manage "high volume, low complexity" procedures (in line with best practice standards of care recommended by GIRFT, NICE and the NHS Long Term Recovery Plan)
- These separate routine planned inpatient care from emergency pressures can improve overall quality of care for patients
- Elective orthopaedic surgery is currently provided in 9 different sites in NWL, with varying access, outcomes and waiting lists

Care Model

The clinical model is based on best practice principles and will provide:

- A centre of clinical excellence and an exemplar for best evidence-based practice
- Delivery of elective orthopaedic care in a purpose-designed, ring-fenced environment
- Delivery of care in a hub:
  - i. pre- and post-operative assessment, care and rehabilitation delivered in local hospitals or the community
  - ii. surgery and immediate perioperative care delivered in the Elective Orthopaedic Centre
  - iii. Seamless and standardised referral and treatment pathways, integrated with wider community and acute provider musculoskeletal, therapy and rehabilitation services for ASA category 1 & 2 inpatients undergoing elective orthopaedic surgery
- Digitally supported pathways facilitating sharing and transfer of information between sites/providers/teams and to give patients access to their information, results as well as materials for education and to support self-care
- A six day-a-week service providing high quality, multi-disciplinary care based on best practice to improve efficiency and access for all patients

Expected benefits

- Achieving compliance with national standards of care across treatment pathways
- Improvements in clinical quality metrics, patient satisfaction and experience; achieving top decile outcomes and addressing poor performance and patient outcomes across North West London
- Reduction of inequalities for the population of North west London through faster and equitable access
- Improved productivity and efficiency utilising skills and resources effectively to address the growing patient waiting list as well as continued patient needs and demands
- A better understood, more reliable and easier to navigate pathway for patients and carers
- A centre of clinical excellence with opportunities for education, training as well as workforce skills and development (including opportunities for new role development and flexible models of working for surgeons, anaesthetists, nurses and allied health professionals). This centre will draw on and attract the best talent to work and provide care in North West London
- Continued improvement and innovations in modern surgical practice through close multi-disciplinary working, common standards and shared learning among professionals across North West London

This IIA fulfills north west London ICS's legal requirement to assess the potential impacts of the proposed service change and identify appropriate mitigating actions

Purpose of the Integrated Impact Assessment (IIA)

- Supports the evaluation of the reasons for a proposed change to services and understand the consequences
- Help develop policy, especially regarding health, accessibility and the environment
- Help decision makers and stakeholders be better informed about any decision that is made
- Ensures due attention is paid to both the positive and negative impact that potential options may have on equalities, and identifies mitigations against the negative impacts

Commissioner's compliance with Public Sector Equality Duty (PSED)[1]

- Eliminate unlawful discrimination, harassment and victimisation
- Advance equality of opportunity between people who share a relevant protected characteristic and people who do not share it
- Foster good relations between people who share a relevant protected characteristic and those who do not share it

NHS Act 2006 (section 14Z35)[2]

- According to s.14Z35, each integrated care board must have regard to the need to reduce inequalities between people with respect to their ability to access services
- Additionally, to reduce inequalities between patients with respect to the outcomes achieved for them by the provision of health services (including the outcomes described in section 14Z34(3))

Integrated Impact Assessment approach

- Describe the demographic composition of north west London
- Travel time analysis of resultant changes in patient journeys to service location changes
- Identification and impact analysis on inequality groups to identify any disproportionate impact
- Assessment of impacts on sustainability and the environment
- Identify mitigating actions for any negative impacts on the population in the inequality groups including those with protected characteristics (see slide 16) and in the more deprived deciles
- Describe the impact on social care and outline recommendations to manage the impact

Source: Section 149 of the Equality Act 2010, Section 2 of the NHS Act 2006

The scope of the IIA focuses on three potential options and is limited to the ASA category 1 & 2 surgical care services that are proposed to move to the EOC

Scope of the North west London Integrated Impact Assessment

- The IIA considers the impact on travel times from eight different sites under the following three proposed options. Ealing is excluded as an existing site as they only do outpatient care with no pre-operative assessment.
  1. Central Middlesex Hospital (CMH) as a single EOC site
  2. Mount Vernon Hospital (MVH) as a single EOC site
  3. CMH and MVH operating as dual sites
- It will not look at the impact on London Ambulance Services or consider the emergency travel times:
  i. The services are all planned elective and confined to those in ASA category 1 and 2 (no or only mild systemic disease)
  ii. Patients who need day case surgery, more complex surgery or who have additional health risks are not within scope of the EOC
- It will not consider patient flows, as patients will be treated by their respective team at the EOC
- Flows outside of north west London for elective orthopaedic surgery have been excluded as the number of patients is less than 20% of total potential activity
- Population group travel times have been calculated by comparing average travel times for each option compared to that population group going to their nearest hospital offering elective T&O services
- Sustainability analysis has been calculated using historic annual activity, with assumptions on the number of trips per spell
- Analysis has also been done to determine the demography of all protected characteristic groups (see appendix). However, lack of robust indicators and comprehensive data by LSOA has rendered it difficult to draw and discuss conclusions other than for deprivation, race, age and gender

Three EOC site options and current elective orthopaedic services were assessed in the travel time analysis

Option 1

Central Middlesex Hospital (CMH) as a single EOC site

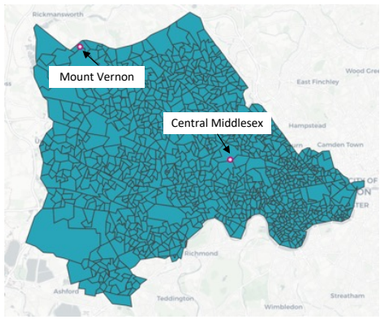
Option 2

Mount Vernon Hospital (MVH) as a single EOC site

Option 3

CMH and MVH operating as dual sites

Map of north west London EOC options



Deprived communities

The Core20 population has an above-average T&O activity per head, but below-average wait times, and is less impacted by travel to CMH than other populations

Demographics

- More deprived areas are concentrated around the middle and south west regions
- Most hospitals offering elective orthopaedic services are in relatively deprived areas, with the exception of Mount Vernon
- Central Middlesex is based in an area with the bottom 10-20% most deprived communities

Use of T&O Services

- Prevalence of MSK conditions is slightly higher in lower deprivation deciles
- Elective T&O activity per 1000 population is slightly higher in deprived populations compared to the whole population, although this is not a significant difference
- Otherwise activity levels are comparable to the proportion of population for each decile of deprivation

Waitlist Analysis

- The Core20 population has a higher number of people on the waitlist by 1,000 population compared to that of the whole north west London population, which reflects the historic T&O activity
- Those in Core20 group has the lowest average waiting time

Travel Time Analysis

- Amongst the protected groups, those in Core20 had the lowest average travel times
- Amongst the protected groups, those in Core20 are least impacted by option 1 (CMH), as they have a lower increase in travel time: their travel time for this option is 5 minutes less during peak times, 4 minutes less during off-peak times, and just over 7.5 minutes less for those using public transport
- Deprived populations are more likely to need patient transport currently and under any proposed option than average

Source: Ministry of Housing, Communities and Local Government, Hospital Episode Statistics Admitted Patient Care, ONS population projections, English indices of deprivation, Office for Health Improvement & Disparities Fingertips data, NWL data, Hospital Episode Statistics Admitted Patient Care, CF analysis

Race

The White population has a higher average service usage, length of stay and waiting time than other ethnic groups

Demographics

- North west London is overall ethnically diverse, with pockets of higher BAME populations around Northwick Park, Central Middlesex, Hillingdon hospital sites
- There are higher populations of white people in areas near Mount Vernon, Charing Cross and Chelsea & Westminster hospital sites

Use of T&O Services

- The White population makes up 46% of the overall population, but accounts for 57% of T&O activity. This is expected as the White population has a higher average age, but may also be influenced by inequalities in access to care for other ethnic groups
- North west London activity data shows that the BAME population have 35% fewer elective spells per head than white people. This reduces to 23% when adjusting for age, however it suggests issues with accessing elective orthopaedic services

Waitlist Analysis

- The White population has the highest average wait time (26.0 weeks), with wait times for Black, Asian, Mixed and 'Other' populations being 24.9, 24.6, 23.6 and 20.9 weeks, respectively
- The 'Other' ethnic group makes up only 5% of the overall population, but 9% of the waiting list
- The Asian population represents 28% of the waiting list, but only 17% of historic T&O activity
- The white population account for the largest proportion of the waiting list at 50% compared to other BAME ethnic groups, although this is lower than historic T&O activity (61%)

Travel Time Analysis

- Option 1 (CMH) has the most negative effect on Asian populations, although the difference is small
- The preferred option would mean 3% more White people travelling compared to the general population
- The analysis shows no significant disproportionate adverse effects on protected characteristic groups arising from the preferred option
- All individuals travelling, regardless of protected group or travelling method, will have to travel through ULEZ

Source: 2011 ONS census, Hospital Episode Statistics Admitted Patient Care, Musculoskeletal health: trends, risk factors and disparities in England, NWL data, CF analysis

Age

The elderly make up most of T&O elective demand per 1,000 population, although they are more likely to be considered ASA 3 or 4, and therefore not treated in the EOC

Demographics

- The older population is equally distributed across North west London with Northwick Park the site closest to the LSOAs with the highest 65+ and 80+, but there are some areas with higher numbers across the Northern-most and south east regions

Use of T&O Services

- Those aged 80 and over account for only 4% of the population but make up 7% of elective T&O spells
- Those aged 65 and over account for only 14% of the overall population in NWL but make up 41% of the total elective T&O activity
- The cohort of older people aged 65 and over are more likely to have co-morbidities, and so be considered as ASA 3 or above. This will mean they are less likely to be in scope for treatment at the EOC

Waitlist Analysis

- Those above 65 years have the longest average wait time, with people over 80 years spending almost six weeks longer on average than those aged 30 to 44
- The 45-64 age group makes up a slightly higher proportion of the waiting list (41%) compared to historical T&O activity (39%)
- The 65+ age group makes up a similar proportion of the waiting list (35%) compared to historical T&O activity (34%)
- Those aged 80 and over account for only 4% of the population but 7% of the waitlist

Travel Time Analysis

- The elderly and deprived populations are least likely to access current services or the EOC using public transport due to challenges of cost and logistics, and so most likely to need patient transport currently and under any proposed option
- Those aged 65 and above had slightly below average travel times for every option
- The elderly population would have the shortest travel time compared to other protected groups if the EOC were developed in Mount Vernon, as there is a slight 3% drop in the elderly population travelling through ULEZ from this service change

Source: ONS population estimates Mid-2020, Hospital Episode Statistics Admitted Patient Care, ONS population projections, NWL data, CF analysis

Sex (Male/Female)

Women have a higher service demand and longer length of stay than men, suggesting they will be most impacted by service changes

Demographics

- There is a relatively equal distribution of women and men across north west London

Use of T&O Services

- Women have made up more spells per head than men for the last 5 years
- Women make up 49% of the overall population in NWL but account for 54% of T&O elective spells
- Prevalence of musculoskeletal conditions is higher in women
- In all deprivation deciles, women have higher T&O activity than men on average

Waitlist Analysis

- There are more women on the waitlist for T&O services per 1,000 population and they have a slightly longer waiting time on average compared to men
- There have been more women on the waitlist compared to men per 1,000 population in the last 5 years
- Women spend over two weeks longer on the waiting list on average compared to men
- Women make up 49% of the overall population in North west London but account for 59% of the total waitlist

Travel Time Analysis

- Men and women have identical travel times for all options

Source: ONS population estimates Mid-2020, Hospital Episode Statistics Admitted Patient Care, ONS population projections 2017 - 2020, NWL data, CF analysis

Mitigating actions, including staff training and awareness, will need to be detailed to avoid discrimination against other protected characteristics

There is limited NHS and population data for some of the characteristics that are considered protected under the Equality Act 2010, therefore most of our research around the potential risks and mitigations regarding these groups was qualitative. This is a widely recognised challenge and there are initiatives in place to improve this, and it should be considered in the future development of the service once data becomes available.

Disability

- People with disabilities can face barriers to access healthcare, and quality of life for those with cognitive impairments is worse after hip fracture procedures, so adjustments will need to be made according to individual patient needs

Gender Reassignment

- Transgender people can be deterred from using health services due to negative attitudes and lack of knowledge or understanding from some healthcare professionals

Sexual Orientation

- Members of the LGBT+ community continue to witness discriminatory or negative remarks, which result in avoided treatments for fear of discrimination

Religion and Beliefs

- Studies show some religious groups can be deterred from using health services due to lack of understanding from providers on their religion and culture

Marriage or Civil Partnership

- Single or widowed patients are linked to longer lengths of stay, and their discharge destination, with a higher likelihood of being discharged to nursing care

Source: ONS population projections, Department for Work and Pensions Stat-Xplore DLA statistics, National Sexual Orientation statistics 2020, CF analysis Total Joint Arthroplasties in Transgender Patients: Unique Considerations for an Emerging Patient Population (2022), Transgender Health in Orthopaedic Care: A Literature Review (2020), Religion and Belief Matter (2008), Religion and Spirituality in Surgery (2017), LGBTQ+ in Orthopaedics: Creating an Open and Inclusive Environment (2022), Marriage Status Predicts Hospital Outcomes Following Orthopedic Trauma (2020), CF analysis

The risks identified have been grouped into three categories – risks to access, risks to patient experience and risks to outcomes

Risks To Access

- This represent risks of patients being unable to access orthopaedic care that they would have previously been able to access
- This is primarily driven by increases in travel time compared to the current model of care, and the subsequent increases in carbon emissions
- This risk particularly applies to the most deprived communities, for whom transport costs represent a higher percentage of budget, and the those with disabilities, who have difficulties with travelling at all due to a range of different logistical challenges

Risks To Patient Experience

- This represents risks of patients feeling excluded from healthcare services due to the set up of the hospital and the attitude of clinical and support staff
- These risks are not specific to orthopaedic care, but must be considered in the implementation of the EOC, to ensure that all groups with protected characteristics are treated equally

Risks To Outcomes

- This represents risks of patients experiencing unwarranted variation in outcomes, due to lack of understanding of their specific needs and differences in quality of treatment by the EOC compared to their previous place of care

We have proposed mitigations for each type of risk, which should be carried out alongside the proposed engagement plan to allow continued improvement

Risk Category	Proposed Mitigations
Access	• Continuation of existing travel support schemes and **provision of patient transport** for those facing long, complex or costly journeys • A **single referral system** to ensure equal access for all eligible patients • **Virtual pre-operative assessment** where suitable (with face-to-face options to avoid digital exclusion) • Adequate disabled parking and access, and wayfinding • **Monitoring of elective orthopaedic waiting times** to ensure equitable access for those with protected characteristics and higher levels of deprivation • Provide **patient choice of site for surgical care** at point of referral, in line with NHS Choice Framework
Patient Experience	• Develop a **patient experience strategy and delivery plan** including co-design and co-production with patients and staff. • Set up an **Equality, Diversity, and Inclusion committee** comprising staff and patient group representatives • **Improve knowledge and cultural competency amongst staff** through awareness and training • Develop strategies to ensure appropriate **BAME and gender representation in the staff group**
Outcomes	• **Standardised processes across the routine inpatient orthopaedic surgical pathway** for the whole of north west London, alongside adjustment for individual patient needs • Develop **discharge standard operating policies** in collaboration with community colleagues • Review quality outcome data and patient reported outcomes for all patient groups and **set action plans for unwarranted variations** • Routinely **review end to end MSK pathway** to identify and resolve bottlenecks to enable a seamless pathway, and identify areas which might be driving health inequalities in access or outcomes • **Enhanced training for all clinicians and support staff** to understand the drivers behind the variations in outcomes for protected characteristics, and how to account for them
Continuous improvement	• Continue to proactively engage with patients, staff, local authorities, hospitals, residents' association and communities with protected characteristics • Look at enhanced ways to collect regular data on all protected characteristics, within GDPR rules, to enable a better understanding of the use of services, the experiences and the outcomes for these groups

Demographic analysis

The demographic analysis shows north west London has pockets with greater populations of groups with protected characteristics

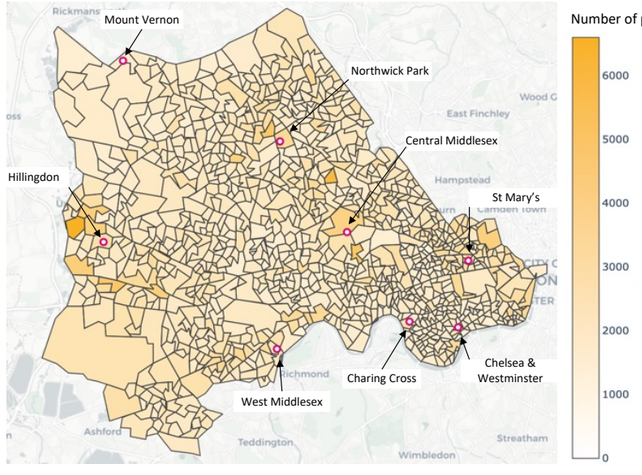
The demographic analysis is useful to show where populations are clustered into geographical areas and are therefore more likely to be impacted by changes in the location of services. Populations will also be impacted by changes in the quality of services, but this impact is not dependent on the physical location of the service.

- North west London has a population of 2.1 million people, with areas around the Hillingdon hospital site having double the population density to those surrounding Mount Vernon and Charing Cross hospital sites
- The current hospital sites offering elective orthopaedic services are located in areas with higher deprivation levels compared to the rest of north west London, with the exception of Mount Vernon which is surrounded by the least deprived areas
- The hospital site that is based in an area with the most deprived population is Central Middlesex, providing services for those in the bottom 10-20% most deprived communities
- North west London is ethnically diverse with areas surrounding Northwick Park and Central Middlesex hospital sites having approximately twice as many BAME residents as those around Mount Vernon
- The demography of older people are of a specific interest due to the nature of orthopaedic services and their use of these services and so both age 65+ and 80+ age bands have been considered separately
- Northwick Park is the hospital site closest to the LSOAs with the highest populations of elderly people for both 65+ and 80+
- There is an even distribution of male and female across north west London

North west London population is evenly distributed, with Hillingdon hospital site having roughly double the population density of Mount Vernon and Charing Cross

LSOA population heatmap

All ages



- North west London has a population of 2,110,469 people
- North west London's population is reasonably evenly distributed across the LSOAs
- The main population centres are around the Hillingdon, St Mary's, and Central Middlesex hospital sites
- Areas surrounding the Hillingdon hospital site have approximately double the population density compared to Mount Vernon and Charing Cross

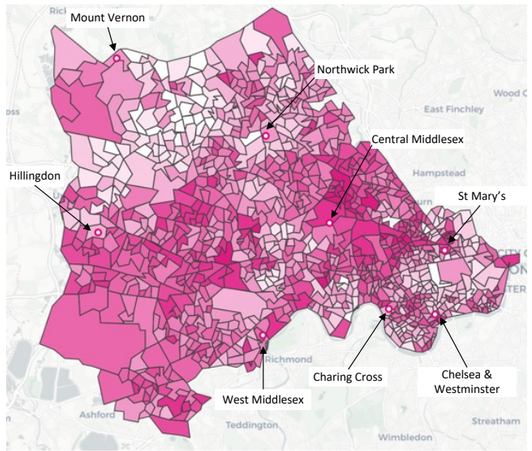
Source: ONS population estimates Mid-2020, CF analysis

Deprived communities

Most hospitals that offer elective orthopaedic services appear to be around areas with higher deprivation levels compared to the rest of North west London

LSOA population deprivation level heatmap

All ages



- Areas with higher deprivation levels are concentrated around the middle and south west regions, with pockets in the north west and north east
- North west London hospitals offering elective orthopaedic services, with the exception of Mount Vernon hospital site, are located in areas with higher deprivation levels compared to the rest of north west London
- Central Middlesex hospital is based in an area with the bottom 10-20% most deprived communities
- St Mary's hospital is surrounded by the 20-30% most deprived communities
- Compared to its counterparts, Mount Vernon hospital is surrounded by areas with the least deprivation

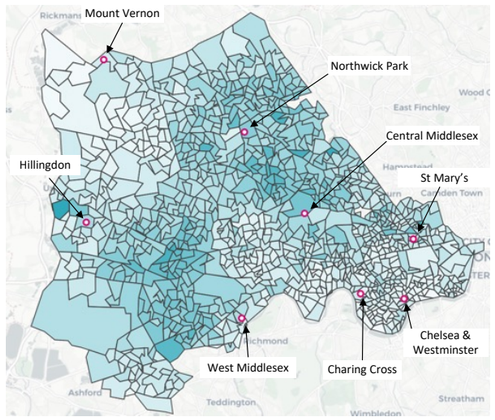
Source: Ministry of Housing, Communities and Local Government, CF analysis

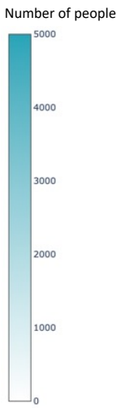
Race

North west London is overall ethnically diverse, with pockets of greater BAME populations around Northwick Park, Central Middlesex, Hillingdon hospital sites

LSOA BAME population heatmap

All ages





- Areas across central North west London are ethnically diverse, with higher volumes of BAME populations
- Amongst the hospital sites that offer elective orthopaedic services, Northwick Park and Central Middlesex are surrounded by areas with relatively higher populations of BAME people
- Although Hillingdon hospital site is close to an area with the highest volume of BAME people, its other surrounding areas have higher white populations
- There are higher populations of white people in areas near Mount Vernon, Charing Cross and Chelsea & Westminster hospital sites

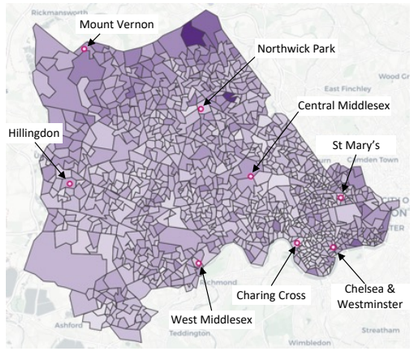
Source: 2011 ONS census, CF analysis

Age

The older population is equally distributed across north west London, with Northwick Park closest to the LSOAs with the greatest proportion of 65+ and 80+

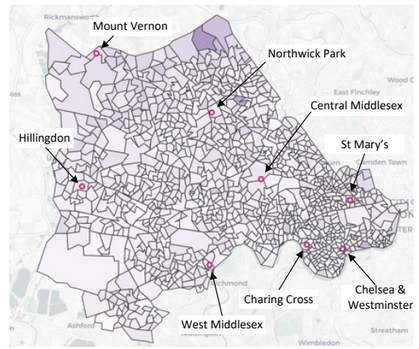
LSOA population of the elderly 65 and over heatmap,

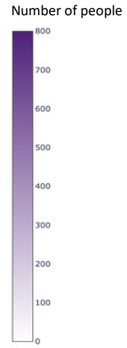
Female and Male, Age 65+



LSOA population of the elderly 80 and over heatmap,

Female and Male, Age 80+





- The heatmap shows a fairly equal distribution of the elderly population across North west London, both for groups aged 65+ and 80+, but there are some areas with higher numbers across the Northern-most and south east regions
- Northwick Park is the hospital site closest to the LSOAs with the highest number of older people in both age groups

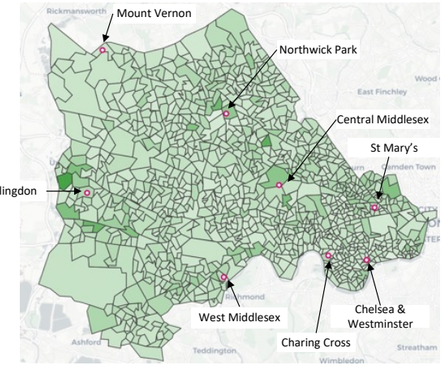
Source: ONS population estimates Mid-2020, CF analysis

Sex (Male/Female)

There is an even distribution of gender across north west London

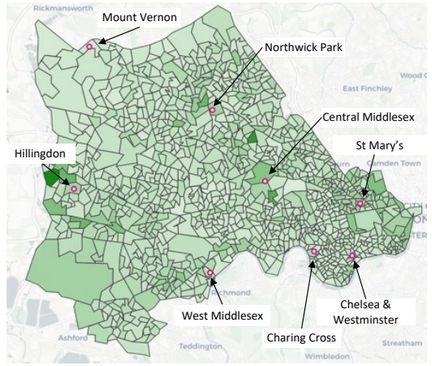
LSOA population heatmap

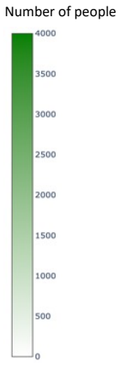
All ages, female



LSOA population heatmap

All ages, male





- The heatmap shows a relatively equal distribution of women and men across north west London whilst having a slightly higher population of men
- However, data shows the highest volumes around Hillingdon hospital site which mirrors the overall population distribution

Source: ONS population estimates Mid-2020, CF analysis

Health Impacts Analysis

The Health Impacts analysis focuses on protected groups to understand the impact on them, develop mitigations and advance equality of opportunity

The groups considered in this analysis are the 9 protected characteristic groups as defined by the UK Government[1], where it is against the law to discriminate against those with these characteristics plus deprived communities in North west London. There is a strong evidence base that shows that deprivation can lead to worse health outcomes and it is a core part of the NHS Long Term plan to address inequalities and part of North west London's vision and strategy to reduce unwarranted variations, particularly for those from deprived communities. The scope of the analysis in this IIA considers the CORE20 groups.

Protected Characteristic Groups:

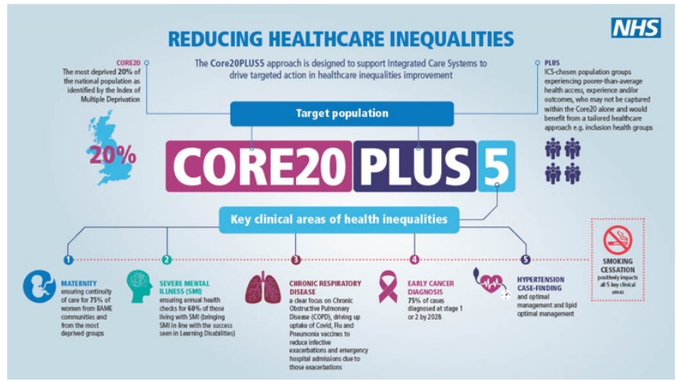
- Deprived communities
- Race (including colour, nationality, ethnic or national origin)
- Age
- Sex (Male/Female)
- People with disabilities
- Gender reassignment
- Religion or belief
- Sexual orientation
- Being married or in a civil partnership
- Being pregnant or on maternity leave

For each of these groups, we have assessed:

1) Research into any differences in overall healthcare outcomes for these populations
2) Research into any differences in trauma and orthopaedic outcomes for these populations
3) Analysis of any difference in activity and outcomes for these populations, although this is limited to where the data exists

[1] https://www.gov.uk/discrimination-your-rights

The Core20PLUS5 is an approach that aims to reduce health inequalities by considering the most deprived 20%, certain population groups and clinical priorities



CORE20PLUS5 is a national approach designed by NHS England and NHS Improvement that aims to reduce health inequalities at the national and system level. The "**Core20**" represents the most deprived 20% of the population as identified by IMD. Whilst "**PLUS**" refers to population groups identified to have poorer-than-average health access and outcomes that may be excluded from the Core20, such as protected characteristic groups. Lastly, "**5**" is five established clinical areas of focus (maternity, severe mental illness, chronic respiratory disease, early cancer diagnosis, and hypertension case-finding,

Source: NHS England, https://www.england.nhs.uk/about/equality/equality-hub/national-healthcare-inequalities-improvement-programme/core20plus5/#:~:text=Core20PLUS5%20is%20a%20national%20NHS,clinical%20areas%20requiring%20accelerated%20improvement.

Deprived communities

There is a strong evidence base showing that deprivation can lead to worse outcomes in healthcare, and specifically in orthopaedics

Experiences in healthcare

Deprivation can be a barrier to access to healthcare. In the study 'Divided by choice? For profit providers, patient choice and mechanisms of patient sorting the English National Health Service' (Beckert and Kelly, 2021). analysed whether deprivation impacted access / choice to NHS-funded hip replacement in the independent sector. Their analysis found that patients in the top three quintiles of the wealth distribution benefit twice (thrice) as much as those in bottom fourth (fifth) quintile; and have more choice of where they have their hip replacement surgery e.g. access to NHS funded independent providers, while the two bottom quintiles do not). As the deep dive analysis was unable to access waiting times or activity data for the independent sector used for HVLC hubs, it was difficult to explore this further.

Experiences in trauma and orthopaedics

Various studies have assessed the differences in healthcare provision between deprivation groups for T&O patients. For hip replacement, studies have found that **more affluent groups receive greater provision** (i.e., those in more deprived areas received fewer hip operations), although there is evidence that these inequalities have narrowed over time. However, in North west London ICS, more deprived groups had slightly more elective trauma and orthopaedic services compared to less deprived groups. An interaction was found, whereby the deprivation effect was greatest in older age groups. Contrary to this, people living in the most deprived areas obtained more knee operations. Another study of outcomes following hip fracture found **deprivation was to be associated with increased mortality 30, 90 and 365 days after emergency admission with a hip fracture**. Potential explanations of the link between deprivation and mortality include poorer health status, living conditions and access to services amongst more deprived populations.

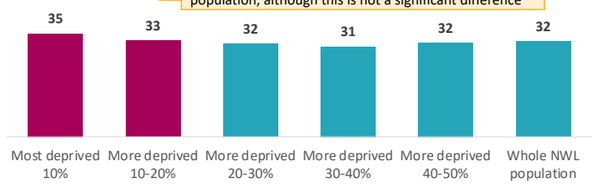
Source: Geographical variation in the provision of elective primary hip and knee replacement: the role of socio-demographic, hospital and distance variables (2009) https://pubmed.ncbi.nlm.nih.gov/19542267/, The impact of social deprivation on mortality following hip fracture in England and Wales: a record linkage study (2016) https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4981619/

Deprived communities

T&O activity per head is slightly higher in the more deprived deciles in NWL compared to the whole population, mirroring the spread of national prevalence of MSK conditions

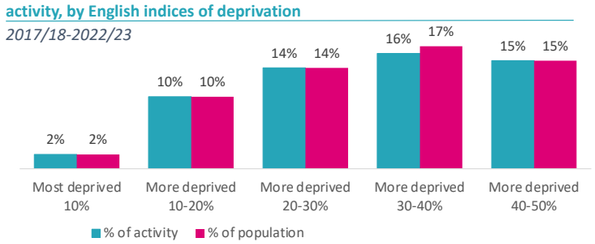
Elective T&O spells per 1,000 population by English indices of deprivation*

2017/18-2022/23



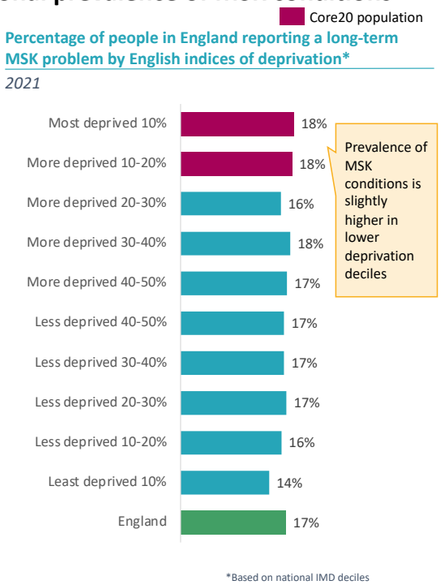
Population of bottom two most deprived areas in NWL compared to their activity, by English indices of deprivation

2017/18-2022/23



Percentage of people in England reporting a long-term MSK problem by English indices of deprivation*

2021



*Based on national IMD deciles

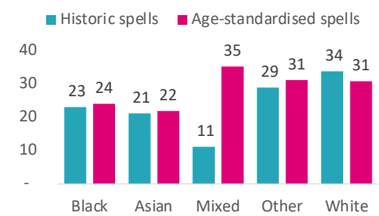
Source: Hospital Episode Statistics Admitted Patient Care, ONS population projections, English indices of deprivation, Office for Health Improvement & Disparities Fingertips data, CF analysis

Race

The White population has a higher usage of elective T&O services; Black and Asian ethnic groups have lower usage even when adjusting for the age profile of each group

BAME and White historic and age-standardised elective T&O spells per 1,000 population, by ethnic group[1]

2017/18-2022/23



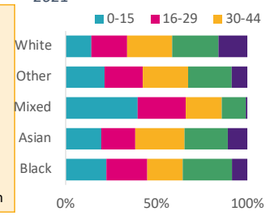
Historic activity per 1,000 population is higher for White people.

When standardising activity for the proportionally older white population in NWL, activity is more similar across ethnic groups, although still higher for the White population

The Mixed ethnic group shows a high level of age-standardised activity per 1,000 people, due to a high proportion of children under 15, however small numbers mean this group is subject to wider variation

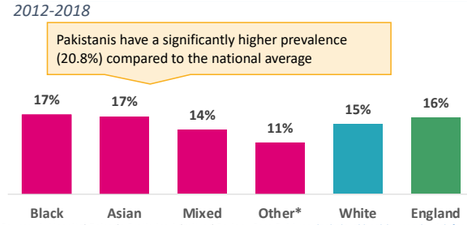
BAME and White population breakdown by age group

2021



National prevalence of musculoskeletal conditions, by ethnicity[2]

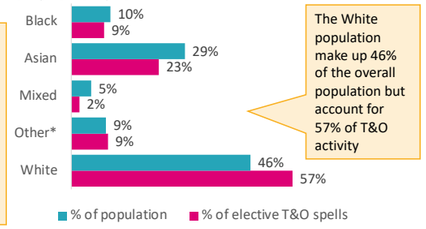
2012-2018



This analysis uses a simple average of prevalence among subgroups and does not account for differences in populations of subgroups

Population of ethnic groups in NWL compared to their activity, by ethnic group[1]

2017/18-2022/23



The White population make up 46% of the overall population but account for 57% of T&O activity

Source: 1. Hospital Episode Statistics Admitted Patient Care 2. Musculoskeletal health: trends, risk factors and disparities in England, 2021 ONS Census data , CF analysis

*Constitutes Chinese or 'any other ethnic group' as per HES definition

Race

Prevalence of musculoskeletal conditions is similar for most ethnic groups, but studies have shown that those from ethnic minority backgrounds face difficulties accessing care

Experiences in healthcare

In England, people from ethnic minority backgrounds face a range of inequalities compared to white groups in their health, as well as in their access to, experience of and outcomes from using health services. People from ethnic minority groups are more likely to report being in poorer health and to report poorer experiences of using health services than their White counterparts. This has been underlined by the COVID-19 pandemic.

There are assumptions and stereotypes within healthcare provision that create racial bias. Research shows that healthcare professionals may have strong stereotypical views, lack cultural awareness and ability which can create barriers and generated resentment.

Difference in literacy levels is another challenge across healthcare, which impacts the ability to understand written health related materials. Studies have shown this is more pronounced in women and older men (Szczepura, 2005). Furthermore, even if letters and patient information leaflets are translated, people may not be able to read their own language. Health literacy and understanding written information could have a negative impact upon certain ethnic minority groups including appropriate referrals for surgery, prioritisation, and outcomes if there is a lack of understanding of the surgical procedure and aftercare.

Experiences in trauma and orthopaedics

Musculoskeletal conditions are some of the most common conditions affecting the population, and some Black, Asian and minority ethnic groups in the UK. BAME groups have historically been disproportionately represented due to a higher prevalence of the risk factors such as levels of physical inactivity, Vitamin D deficiency, poverty, socio-economic factors, working in manual occupations and pre-existing long-term conditions such as diabetes but recent data from the 2022 Health Survey of England indicates a similar prevalence of MSK conditions among BAME ethnic groups compared to the national average except for two groups: Pakistanis with significantly higher prevalence and Chinese with significantly lower prevalence). Studies from the US have found White individuals are more likely to get joint surgery than other ethnic groups. One study in the UK found higher 1-year mortality after fracture in black women and women of 'other' ethnic groups (mainly Arab) compared to white women. These findings are in line with the majority of other studies, and suggested reasons include potential differences in high-intensity rehabilitation in hospital, differences in post-discharge physical therapy and non-fracture related differences in mortality caused comorbidity severity or socioeconomic factors.

Sources: Access to health care for ethnic minority populations, Szczepura, 2005; Musculoskeletal conditions and Black, Asian and minority ethnic people https://pubmed.ncbi.nlm.nih.gov/15749788/; addressing health inequalities (2020) https://raceequalityfoundation.org.uk/wp-content/uploads/2020/10/MSK-Report-Addressing-Health-Inequalities.pdf, Geographical variation in the provision of elective primary hip and knee replacement: the role of socio-demographic, hospital and distance variables (2009) https://pubmed.ncbi.nlm.nih.gov/19542267/, Musculoskeletal health: trends, risk factors and disparities in England https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1120336/Musculoskeletal_health_data.ods

Age

Studies show that the impact on quality of life and mortality rates is higher for those over the age of 80, who have a higher prevalence of orthopaedic procedures

Experiences in trauma and orthopaedics

The presentation of orthopaedic conditions have been shown to be different for different age groups, with mortality higher for those over 80 years old.

Pelvic fractures in the elderly are known to have distinct differences compared to those in young adults. In younger patients, pelvic fractures are usually the result of high-energy trauma (including road traffic collision), whereas in older groups these are mostly the result of low-energy injuries, falls, or repeated stresses to osteopenic and osteoporotic bone (fragility pelvic fractures). Rates of joint surgery increase with age but then fall in the oldest age groups.

Analysis of data from individuals with a hip fracture found that in the general population, quality of life improved in the year after the fracture, but remained significantly lower than before injury. Quality of life did not however improve in patients over 80 years, and secondary measures of function showed similar trends. In addition, mortality is higher for older individuals following a hip fracture (1-year mortality was 19% for those aged > 80 years vs 8% for those aged ≤ 80 years). 30-day mortality following hip fracture surgery has also been found to be significantly higher for older individuals.

Analysis of adults sustaining major orthopaedic trauma found that 30-day mortality in older patients with fractures is greater (6.8% *vs* 2.5%), although critical care episodes are more common in the young (18.2% *vs* 9.7%). Older people are less likely to be admitted to critical care beds and are often managed in isolation by surgeons. In older people, fracture surgery accounted for 82.1% of procedures.

Source: Geographical variation in the provision of elective primary hip and knee replacement: the role of socio-demographic, hospital and distance variables (2009) https://pubmed.ncbi.nlm.nih.gov/19542267/
Recovery of health-related quality of life in a United Kingdom hip fracture population (2015) https://online.boneandjoint.org.uk/doi/full/10.1302/0301-620X.9783.35738?rfr_dat=cr_pub++0pubmed&url_ver=Z39.88-2003&rfr_id=ori%3Arid%3Acrossref.org
Predictors of early mortality after hip fracture surgery (2013) https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3824905/#:~:text=We%20aimed%20to%20determine%20predictors,previous%20history%20of%20cardiac%20disease
The impact of age on major orthopaedic trauma (2017) https://online.boneandjoint.org.uk/doi/full/10.1302/0301-620X.99B12.BJJ-2016-1140.R2

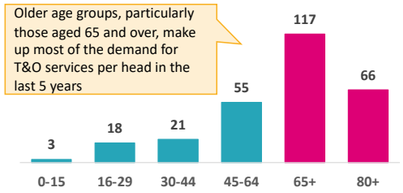
Age

The elderly will likely benefit more from service change as they make up most of T&O elective demand, although may not be eligible for treatment at the EOC

Elective T&O spells per 1,000 population, by age band

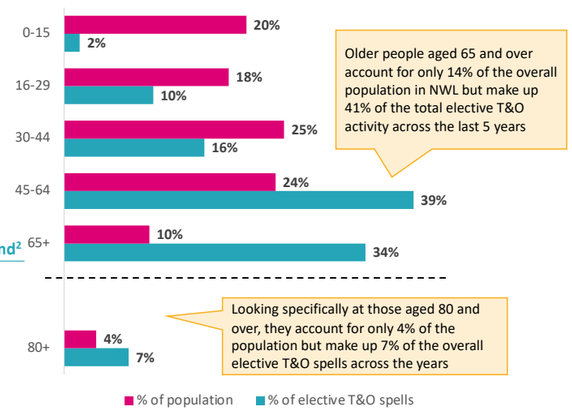
2017/18-2022/23

Older age groups, particularly those aged 65 and over, make up most of the demand for T&O services per head in the last 5 years



Population of age groups in NWL compared to their activity, by age band

2017/18-2022/23



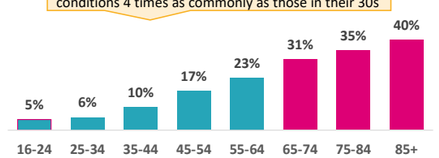
Older people aged 65 and over account for only 14% of the overall population in NWL but make up 41% of the total elective T&O activity across the last 5 years

Looking specifically at those aged 80 and over, they account for only 4% of the population but make up 7% of the overall elective T&O spells across the years

National prevalence of musculoskeletal conditions, by age band[2]

2017-2018

Prevalence of musculoskeletal conditions increase with age with those above 80 years having MSK conditions 4 times as commonly as those in their 30s



The cohort of older people aged 65 and over are more likely to have co-morbidities, and so be considered as ASA 3 or above. This will mean they are less likely to be in scope for treatment at the EOC.

Source: Hospital Episode Statistics Admitted Patient Care, ONS population projections, CF analysis

Sex (Male/Female)

Studies show that men and women approach healthcare services differently and present with different orthopaedic conditions, with men experiencing worse outcomes

Experiences in healthcare

Known higher life expectancy for women could be shown over representation on the waiting list for elective care. It is worth noting that men and women make very different use of primary care (with adult women having substantially greater consultation rates across all illness categories and women being more likely than men to consult if they have an illness episode). Ref: Do men consult less than women? An analysis of routinely collected UK general practice data. (Wang et al, 2013)).

There is an interaction between gender and ethnicity as it is often reported that women in some minority groups find it especially important to see a female doctor. (Ref. Attitudes to and perceived use of health care services among Asian and non-Asian patients in Leicester (Rashid and Jagger, 1992)). Service provision needs to reflect this, and consideration given to the gender breakdown of staff.

Experiences in trauma and orthopaedics

There are differences between men and women with musculoskeletal condition incidence, disease presentation, diagnosis and management. As examples of this, osteoarthritis, osteoporosis and hip fractures are more prevalent in women, whilst osteosarcoma is more prevalent in men, and men experience higher mortality from hip fractures, trauma and sepsis. Rates of joint surgery have been found to be higher in women. Following surgery, differences also remain between men and women. Analysis of data from the Scottish Hip Fracture Audit indicated that the men were less likely to return home or mobilise independently at the 120-day follow-up. Mortality at 30 and 120 days was higher for men. This has been supported by other research, indicating 1-year mortality following hip fracture is greater for men.

Source: Does Sex Matter in Orthopedic Care? (2018) http://www.orthojournalhms.org/19/article38_45.html
Gender differences in epidemiology and outcome after hip fracture (2008) https://online.boneandjoint.org.uk/doi/full/10.1302/0301-620X.9084.20264
Recovery of health-related quality of life in a United Kingdom hip fracture population (2015) https://online.boneandjoint.org.uk/doi/full/10.1302/0301-620X.97B3.35738?rfr_dat=cr_pub++0pubmed&url_ver=Z39.88-2003&rfr_id=ori%3Arid%3Acrossref.or

Sex (Male/Female)

Women have a higher service demand compared to population levels, suggesting they will be most impacted by service changes

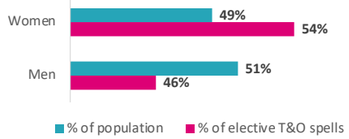
Elective T&O spells per 1,000 population by sex

2017/18-2022/23

Women have made up more spells per head than men for the last 5 years

Population of women and men in NWL compared to their activity, by sex

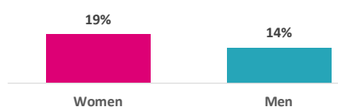
2017/18-2022/23



Women make up 49% of the overall population in NWL but account for 54% of T&O elective spells

National prevalence of musculoskeletal conditions, by sex[2]

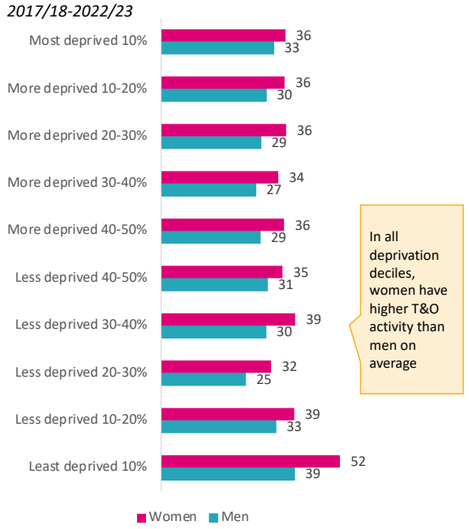
2017-2018



Prevalence of musculoskeletal conditions is higher in women

Elective T&O spells per 1,000 population for all deprivation deciles* in NWL population by sex

2017/18-2022/23



In all deprivation deciles, women have higher T&O activity than men on average

*Based on national IMD deciles

Source: Hospital Episode Statistics Admitted Patient Care, ONS population projections 2017 - 2020, CF analysis

Patient tracking list data has supported the analysis of which populations will likely be more affected by the service change

In addition to the activity from HES, we have analysed waiting list data through the patient tracking list (PTL). PTL is a list of patients who need to be treated by given dates in order to start treatment within maximum waiting times set out in the NHS Constitution.

For each of the characteristic groups, the following analysis was made:

1) Number of people on the waiting list per 1,000 population
2) Average waiting times in weeks
3) Proportion of the group that make up the overall waiting list compared to their population size

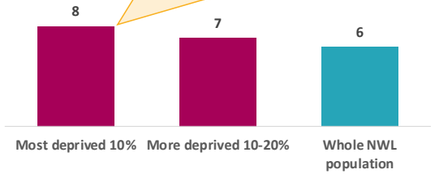
Deprived communities

Although the most deprived 20% has the greatest number of people on the waitlist, their average wait time is lower than average

People on waitlist for elective T&O per 1,000 population, by deprivation[1*]

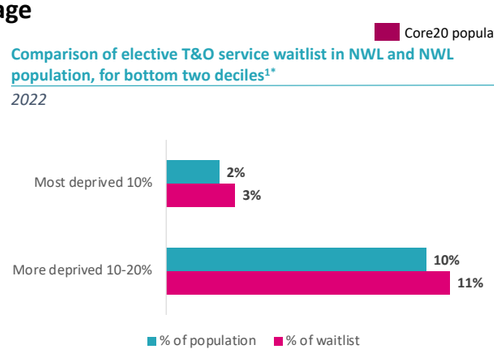
2022

The most deprived decile has a higher number of people on the waitlist by 1,000 population compared to that of the whole North west London population, which reflects the historic T&O activity



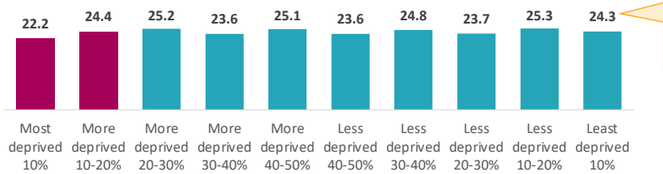
Comparison of elective T&O service waitlist in NWL and NWL population, for bottom two deciles[1*]

2022



Average wait time in weeks, by deprivation[2*]

2022



The most deprived decile in North west London has the lowest average waiting time

Source: 1. NWL data, 2. Hospital Episode Statistics Admitted Patient Care, CF analysis

*Based on national IMD deciles

Age

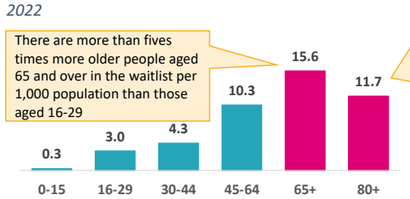
Older age groups have the most people on the waitlist per 1000 population and have longer average waiting times compared to younger age groups

People on waitlist for elective T&O per 1,000 population by age band[1]

2022

There are more than fives times more older people aged 65 and over in the waitlist per 1,000 population than those aged 16-29

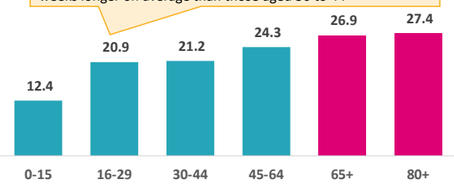
There are more elderly people in the waitlist per 1000 population than those aged under 65



Average waiting time in weeks, by age band[2]

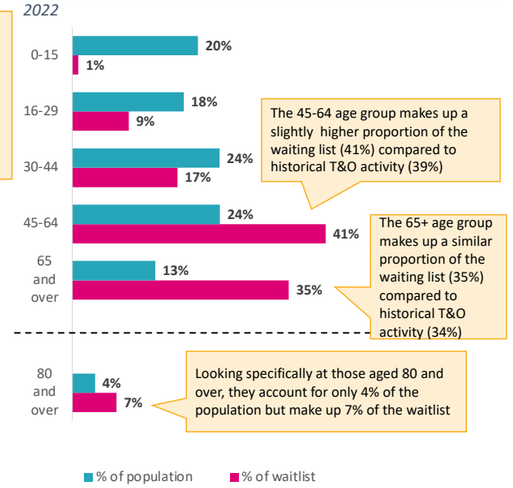
2022

Older populations above 65 years have the longest waiting time on average, with people over 80 years spending almost six weeks longer on average than those aged 30 to 44



Comparison of elective T&O service waitlist in NWL and NWL population, by age bands

2022



The 45-64 age group makes up a slightly higher proportion of the waiting list (41%) compared to historical T&O activity (39%)

The 65+ age group makes up a similar proportion of the waiting list (35%) compared to historical T&O activity (34%)

Looking specifically at those aged 80 and over, they account for only 4% of the population but make up 7% of the waitlist

Source: 1. NWL data, 2. Hospital Episode Statistics Admitted Patient Care, CF analysis

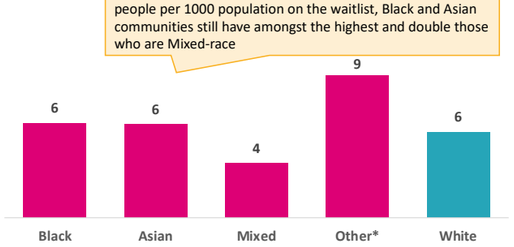
Race

The waiting list by ethnic group broadly reflects population splits, although the White population has a longer average waiting time compared to other ethnic groups

People on waitlist for elective T&O per 1,000 population, by ethnic group[1]

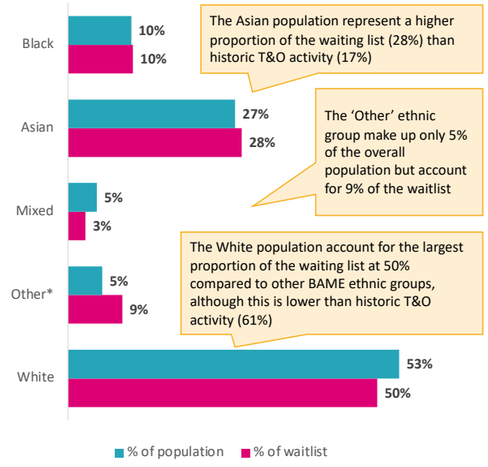
2022

While the 'Other' ethnic group has the highest number of people per 1000 population on the waitlist, Black and Asian communities still have amongst the highest and double those who are Mixed-race



Comparison of elective T&O service waitlist in NWL and NWL population, by ethnic group

2022



The Asian population represent a higher proportion of the waiting list (28%) than historic T&O activity (17%)

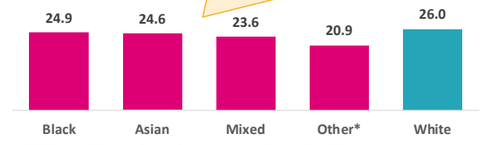
The 'Other' ethnic group make up only 5% of the overall population but account for 9% of the waitlist

The White population account for the largest proportion of the waiting list at 50% compared to other BAME ethnic groups, although this is lower than historic T&O activity (61%)

Average wait time in weeks, by ethnic group[2]

2022

The White population have the highest average waiting time, with Black and Asians people being seen between 1.1 and 1.3 weeks faster on average



Source: 1. NWL data, 2. Hospital Episode Statistics Admitted Patient Care, CF analysis

*Constitutes Chinese or 'any other ethnic group' as per HES definition

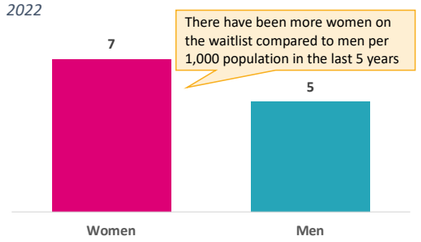
Sex (Male/Female)

There are more women on the waitlist for T&O services per 1,000 population and they have a slightly longer average wait time than men

People on waitlist for elective T&O per 1,000 population by sex[1]

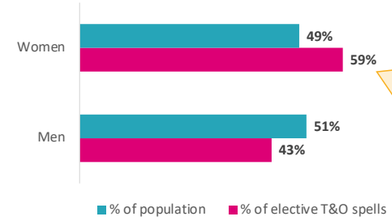
2022

There have been more women on the waitlist compared to men per 1,000 population in the last 5 years



Comparison of elective T&O service waitlist in NWL and NWL population, by sex[1]

2022



Women make up 49% of the overall population in North west London but account for 59% of the total waitlist

Average waiting time in weeks, by sex[2]

2022

Women spend over two weeks longer on the waiting list on average compared to men

Source: 1. NWL data, 2. Hospital Episode Statistics Admitted Patient Care, CF analysis

Travel Time Analysis

TravelTime API was used to calculate the travel times and distances between hospital sites and LSOAs

- The TravelTime API (https://traveltime.com/) was used to calculate the average journey time and distance between each population-weighted LSOA in the North west London ICS and the surrounding area to the North west London hospital sites
- The TravelTime API accurately calculated distance and time based on actual travel routes, rather than using an 'as the crow flies' estimate, making it an accurate platform to use for this analysis

Peak travel times:

- Weekday morning average travel time was used as an estimate for peak

Off-peak travel times:

- Weekday lunchtime was used as an estimate for off-peak

Public transport travel times:

Weekday morning public transport travel times were used for public transport.

However, public transport travel times have limitations and have primarily been included to show differentiation between options.

- There were a few LSOAs that the API was unable to find transport links for
- However, as these LSOAs had very low populations, excluding these from the analysis will have a negligible impact on the overall analysis

The travel time analysis methodology was repeated for each service group, travel mode, modelling assumption, option and population group

1 Retrieve travel time data	Use the TravelTime API to find the travel time between each LSOA centre and each site
2 Calculate BAU statistics	Find the closest site to each LSOA under the current conditions. Use the LSOA population to calculate summary statistics
3 Compare option for the general population	For each option, find the new site under the given assumption and compare the summary statistics
4 Compare option for the protected groups	For each protected group, use the relevant population of the LSOAs to recalculate the summary statistics and compare to the general population

The summary statistics calculated are:

- Average travel time in minutes
- Difference from BAU in minutes
- Percentage of the population travelling further than BAU
- Percentage of people travelling through the Ultra Low Emission Zone (ULEZ) and may incur a ULEZ charge

General population

While all options result in an increase in travel times, the dual site option has the lowest average increase, with Central Middlesex only marginally longer

- For the general population, the development of all options results in an increase in travel time
- The dual site option across all modes of transport results in the smallest increase in travel time of roughly 9-10 minutes for peak and off-peak driving, and a 20 minutes on public transport (half the increase compared to MV option)
- Of the single site options, Central Middlesex has the lowest travel time across all modes of transport, but as Central Middlesex is within the ULEZ zone, those who are driving non-compliant cars will incur a ULEZ charge
- The average travel times for Central Middlesex are between 2 mins and 5 mins higher than the dual site option
- Across the different modes of transport, the development of an EOC in Mount Vernon results in the largest increase in travel time (29 minutes, 24 minutes and 42 minutes respectively)

	Peak				Off-peak				Public transport			
	Avg. travel time (mins)	Difference from BAU (mins)	% travelling further	% travelling through ULEZ	Avg. travel time (mins)	Difference from BAU (mins)	% travelling further	% travelling through ULEZ	Avg. travel time (mins)	Difference from BAU (mins)	% travelling further	% travelling through ULEZ
Baseline (BAU)	14.6	-	-	52	12.5	-	-	52	29.8	-	-	50
Option 1: Central Middlesex	27.2	12.6	79	100	23.1	10.6	79	100	51.8	22	88	100
Option 2: Mount Vernon	43.8	29.2	95	43	36.9	24.4	95	43	71.9	42.1	97	43
Option 3: Dual site option	25.3	10.7	74	83	21.5	9	74	82	49.9	20.1	84	82

Source: CF analysis

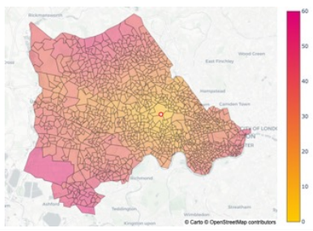
We calculated average travel times for all protected groups and deprivation decile for each option and travel mode

Average travel times (mins)									
	Option 1: Central Middlesex			Option 2: Mount Vernon			Option 3: Central Middlesex and Mount Vernon (dual site)		
	Peak	Off-peak	Public Transport	Peak	Off-peak	Public Transport	Peak	Off-peak	Public Transport
Men	27.2	23.1	51.8	43.8	36.9	71.9	25.3	21.5	49.9
Women	27.2	23.1	51.9	43.5	36.7	71.8	25.2	21.4	49.9
Elderly (65+)	27.8	23.6	52.6	42.7	36.0	70.5	25.1	21.3	50.0
Elderly (80+)	27.9	23.7	52.6	42.4	35.8	69.6	24.9	21.2	49.8
CORE20PLUS 5	22.4	19.0	44.2	47.2	39.8	73.7	22.1	18.8	44.1
Asian or Asian British	28.1	23.9	54.3	40.8	34.5	70.4	26.4	22.4	52.6
Black, Black British, Caribbean or African	23.9	20.4	47.2	44.1	37.2	71.2	23.1	19.6	46.4
Mixed or multiple ethnic groups	26.1	22.2	49.6	45.1	38.1	72.3	24.6	20.9	48.2
Other ethnic group	24.9	21.1	47.9	47.5	40.1	72.0	24.2	20.5	47.2
White	27.7	23.5	52.0	44.7	37.7	72.7	25.4	21.6	49.7
Groups other than white	26.6	22.6	51.6	42.8	36.1	71.0	25.2	21.5	50.2

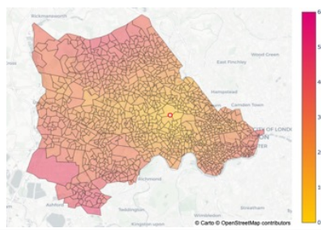
We highlighted the impacts on travel time for protected groups and CORE20 if an EOC was developed in Central Middlesex

	Peak				Off-peak				Public transport			
	Average travel time (mins)	Difference from general population (mins)	Difference from general population in % travelling further	Difference from population % travelling through ULEZ	Average travel time (mins)	Difference from general population (mins)	Difference from general population in % travelling further	Difference from population % travelling through ULEZ	Average travel time (mins)	Difference from general population (mins)	Difference from general population in % travelling further	Difference from population % travelling through ULEZ
CORE20	22.4	-4.8	-17	0	19	-4.1	-18	0	44.2	-7.6	-16	0
Black, Black British, Caribbean or African	23.9	-3.3	-14	0	20.4	-2.7	-14	0	47.2	-4.6	-10	0
White population	27.7	0.5	3	0	23.5	0.4	3	0	52	0.2	0	0
Asian or Asian British	28.1	0.9	1	0	23.9	0.8	1	0	54.3	2.5	3	0

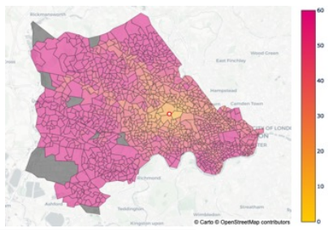
Peak travel time (minutes)



Off-peak travel time (minutes)



Public transport travel time (minutes)



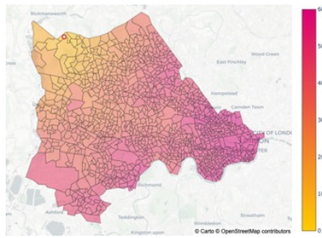
An EOC in Central Middlesex benefits CORE20 and some ethnic groups, with a slight negative impact on white and Asian, compared to the general population

- Across different travel methods, service development results in an increase in travel times for all protected characteristic groups and those in the CORE20
- Those in CORE20 have a lower increase in travel time compared to the general population
  - On average, their travel time is 5 minutes less than the general population during peak times, 4 minutes less during off-peak times, and just over 7.5 minutes less for those using public transport
- Similarly, this option has a lower impact on travel times for the Black, Black British, Caribbean or African communities compared to the general population across all transport methods
- This option has a slight negative effect on the White population that travel during peak and off-peak times
  - 3% more White people travel as a result of the service change compared to the general population in both cases
  - There is no significant difference between travel times compared to the general population for White people using public transport
- Whilst this option has the most negative effect on Asian or Asian British populations, the increase of travel time compared to the general population is relatively small
  - For example, the average travel times is only roughly 1-2.5 minutes more than the general population
- Considering the effect on Asian or Asian British communities, the analysis shows no significant disproportionate adverse effects on protected characteristic groups arising from this option
- Additionally, all individuals travelling, regardless of protected group or travelling method, will have to travel through ULEZ and incur the cost from this if they are driving and their car is not ULEZ compliant
- The elderly and deprived populations are least likely to access current services or the EOC using public transport due to challenges of cost and logistics and so likely to need patient transport currently and under any proposed option

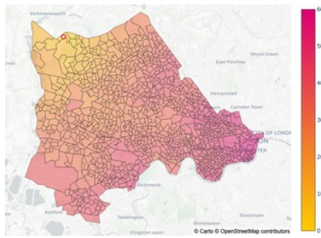
We highlighted the impacts on travel time for protected groups and CORE20 if an EOC was developed in Mount Vernon

	Peak				Off-peak				Public transport			
	Average travel time (mins)	Difference from general population (mins)	Difference from general population in % travelling further	Difference from population % travelling through ULEZ	Average travel time (mins)	Difference from general population (mins)	Difference from general population in % travelling further	Difference from population % travelling through ULEZ	Average travel time (mins)	Difference from general population (mins)	Difference from general population in % travelling further	Difference from population % travelling through ULEZ
Asian or Asian British	40.8	-3	1	-22	34.5	-2.4	1	-22	70.4	-1.5	1	-22
Elderly (65+)	42.7	-1.1	-3	-3	36	-0.9	-3	-3	70.5	-1.4	-2	-3
Elderly (80+)	42.4	-1.4	-4	-3	35.8	-1.1	-4	-3	69.6	-2.3	-3	-3
'Other' ethnic group	47.5	3.7	4	17	40.1	3.2	4	17	72	0.1	2	17
CORE20	47.2	3.4	5	23	39.8	2.9	5	23	73.7	1.8	3	23

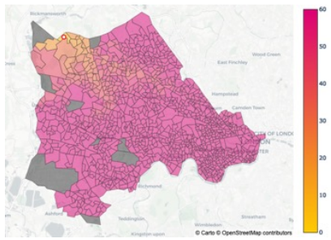
Peak travel time (minutes)



Off-peak travel time (minutes)



Public transport travel time (minutes)



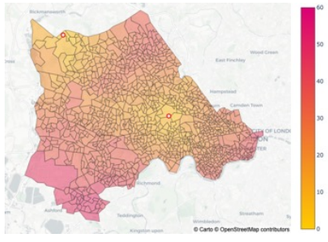
An EOC in Mount Vernon has the highest average travel times but has the least impact on the elderly and Asian/Asian British populations

- Across different travel methods, service development results in an increase in travel times for all protected characteristic groups
- Developing an EOC in Mount Vernon, compared to the other single site option and a dual site option, will result in the highest average travel times across all protected groups and those in the CORE20
- Average travel times for this option is almost doubled for those all protected groups and those in the CORE20 travelling during peak and off-peak driving times compared to other options
- The elderly population will have the shortest travel time compared to other protected groups or CORE20 for this option
  - There is a slight 3% drop in the elderly population travelling through ULEZ from this service change
- The Asian or Asian British ethnic group will be least impacted by this option, mainly though a significant 22% drop in the Asian or Asian British population travelling through ULEZ from this service change
  - Beyond having a slightly shorter travel time of 3 minutes less compared to the general population, only 1% more of the Asian or Asian British ethnic group will be travelling further
- The 'Other' ethnic group will be negatively affected with the longest average travel times for peak and off-peak driving
  - Compared to the general population, 4% more of the protected group will be travelling further
  - However, 60% of the protected group will travel through ULEZ zones, a 17% increase from the general population
- The CORE20 group will be the most negatively affected by this option across all travel methods
  - They will have amongst the longest average travel time across all travel methods
  - Compared to the general population, 5% more of the CORE20 group will be travelling further which may widen inequalities in deprivation
  - 66% of the protected group will travel through ULEZ zones, a 23% increase from the general population
- As the Mount Vernon site is outside of the ULEZ charge zone, the % of the population travelling through ULEZ zones is on average lower than for other options

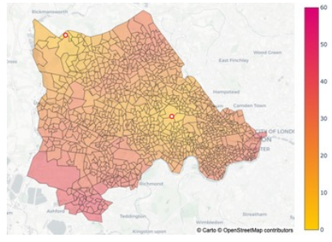
We highlighted the impacts on travel time for protected groups and CORE20 if an EOC was developed in both Central Middlesex and Mount Vernon

	Peak				Off-peak				Public transport			
	Average travel time (mins)	Difference from general population (mins)	Difference from general population in % travelling further	Difference from population % travelling through ULEZ	Average travel time (mins)	Difference from general population (mins)	Difference from general population in % travelling further	Difference from population % travelling through ULEZ	Average travel time (mins)	Difference from general population (mins)	Difference from general population in % travelling further	Difference from population % travelling through ULEZ
CORE20	22.1	-3.2	-12	12	18.8	-2.7	-13	13	44.1	-5.8	-12	13
Black, Black British, Caribbean or African	23.1	-2.2	-10	6	19.6	-1.9	-10	7	46.4	-3.5	-7	4
Asian or Asian British	26.4	1.1	2	0	22.4	0.9	2	1	52.6	2.7	4	-4

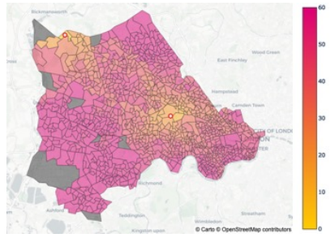
Peak travel time (minutes)



Off-peak travel time (minutes)



Public transport travel time (minutes)



A Dual EOC on the two sites has the smallest increase in travel times and does not result in disproportionate effects on protected groups

- Whilst the service reconfiguration will result in an increase in travel times for all protected characteristic groups, developing a dual site will result in a smaller overall increase across all the options
- For every travel method, a dual site EOC in both Central Middlesex and Mount Vernon allows for the shortest average travel time for all protected groups compared to single site options
- The CORE20 group is least impacted by this option with the shortest average travel time compared to the general population
  - Compared to the general population, they will have a travel time that is 2-6 minutes faster across the different methods of transport and 12% less of the CORE20 will be travelling further
  - However, 13% more of the CORE20 will travel through ULEZ compared to the general population
- The Black, Black British, Caribbean or African ethnic group is less impacted by this option as it will have amongst the lowest average travel times compared to other protected groups across the different travel modes
  - Compared to the general population, 10% less of the protected group will be travelling further if driving during peak or off-peak times and 7% less if travelling using public transport
- The Asian or British Asian ethnic group, compared to other protected groups in this option, will be the most negatively affected
  - Whilst there is a higher average travel time against the general population, these increases are relatively small varying between 1-3 minutes between the travel methods
  - This is similar to the higher percentage of the population travelling further compared to the general population varying from 2-4% between the travel methods
- Considering the limited effect on Asian or Asian British population, the analysis shows no significant disproportionate adverse effects on protected characteristic groups arising from this option

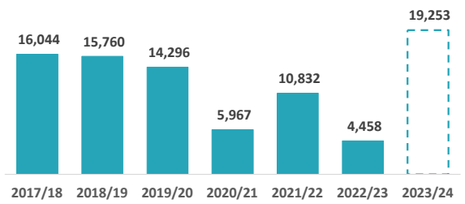
Social care impact analysis

Only a small proportion of elective T&O patients are discharged to care homes in NWL, although this does not consider those requiring care at home

Forecast*

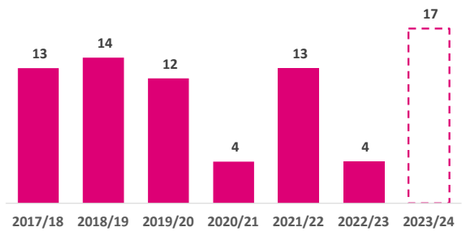
Discharge destinations for elective T&O patients in NWL
2017 - 2023

Discharge to usual place of residence



Some patients discharged to their usual place of residence may require care at home which will not be reflected in the data

Discharge to care homes



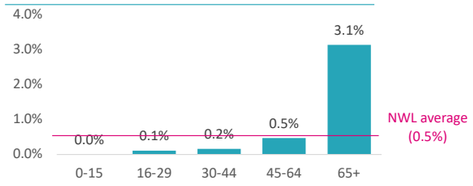
Only about one elective T&O patient is discharged to care homes in NWL per month. The number of discharges to care homes have been relatively stable except during the peak of the Covid pandemic

*Assumes a 20% growth in MSK activity following the EOC as per the PCBC report

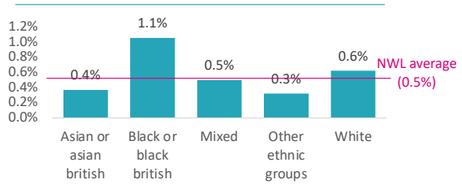
Source: Hospital Episode Statistics Admitted Patient Care, CF analysis

Approximately 0.5% of the NWL population is flagged as requiring social care, which is highest in 65+, Black and most deprived populations

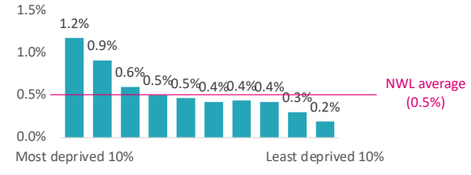
Percentage of NWL population with a social care flag *by age*



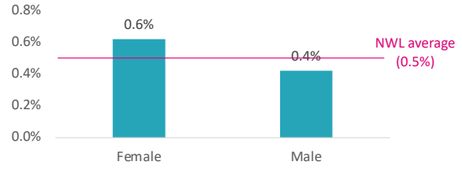
Percentage of NWL population with a social care flag *by ethnicity*



Percentage of NWL population with a social care flag *by deprivation decile*



Percentage of NWL population with a social care flag *by gender*

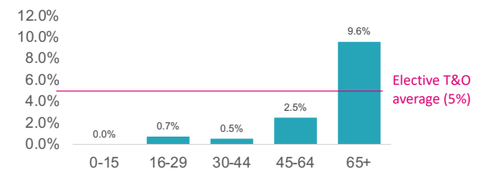


Individuals are defined as requiring social care if they are listed on the local authority social care database as paying for social care. This may exclude those who require care at home from relatives or friends but do not have the means to pay for social care, and so will not appear on the database. Social care requirements should be understood on admission, and planned into discharge processes

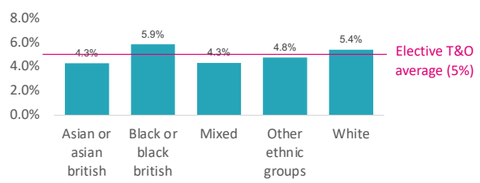
Source: WSIC download from NWL ICB

Analysis of 2019/20 elective T&O activity shows that approximately 5% of patients had a social care flag, skewed towards the older, female and more deprived populations

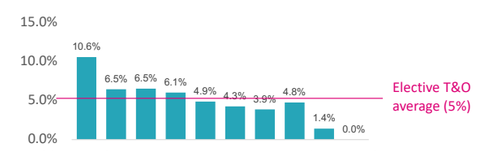
Percentage of elective T&O patients with a social care flag *by age in 2019/20*



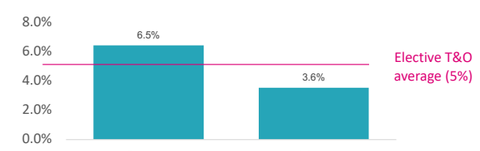
Percentage of elective T&O patients with a social care flag *by ethnicity in 2019/20*



Percentage of elective T&O patients with a social care flag *by deprivation decile in 2019/20*



Percentage of elective T&O patients with a social care flag *by gender in 2019/20*



The expected additional volumes of elective T&O patients start at 355 in year 2, peaking at 799 by year 7. A recent RCoA audit has shown that these additional volumes will mainly be younger patients with limited co-morbidities. Applying the historic distribution of elective T&O activity by age to the additional volumes demonstrates that there will be approximately 20 patients that will go through the EOC that will be ASA 1 or 2 and require social care. This may be an overestimate as a proportion of them will have social care packages in place before admission, so are not additional social care packages as a result of the procedure.

Source: WSIC download from NWL ICB, HES activity data from 2019/20, RCoA audit - https://associationofanaesthetists-publications.onlinelibrary.wiley.com/doi/10.1111/anae.15989

Sustainability

All options are likely to increase total CO2 emissions with option 1 marginally higher than option 3, and option 2 causing figures to almost quadruple

Sustainability analysis looks at the potential impacts of changes to service provision and possible refurbishment or construction of new sites on the environment. In order to assess this, we have looked at both the operational emissions from hospital sites, as well as vehicular emissions based on patient travel to and from the sites, for the different options.

Option	Total CO2 (kg)	% change from BAU
Baseline (BAU)	7,136	-
Option 1: Central Middlesex	16,535	132%
Option 2: Mount Vernon	33,742	373%
Dual site option	14,440	102%

Constant	Value	Source
kg CO2 per mile	0.28	BEIS Conversion Factors 2021
Trips per spell	2.00	Journey to and from, exclude visitors (standard used in previous IIAs)
% journeys by car	0.36	National Travel Survey 2021

- The development of all options will result in a significant increase in CO2 emissions. All providers in north west London and the ICS have developed green plans which include actions to mitigate and so any changes due to the EOC will be considered as part of their implementation.
- Despite an increase in over double the amount of CO2 emissions, developing two sites will result in the overall smallest increase amongst all over options
- Of the single site options, Central Middlesex will result in a lower increase of total CO2, 17,207 kg less than the amount emitted for the other single site option for Mount Vernon
- It is likely that the ULEZ charge will result in a greater proportion of patients taking public transport to their appointments to hospitals within the ULEZ (e.g. Central Middlesex), which will mitigate against the increase in CO2 emissions

Source: BEIS Conversion Factors 2021, Journey to and from exclude visitors, National Travel Survey 2021, CF Analysis

Mitigating Actions

The risks identified have been grouped into 3 categories: risks to access, risks to patient experience and risks to outcomes

Risks to access

- This represent risks of patients being unable to access orthopaedic care that they would have previously been able to access
- This is primarily driven by increases in travel time compared to the current model of care, and the subsequent increases in carbon emissions
- This risk particularly applies to the most deprived communities, for whom transport costs represent a higher percentage of budget, and the those with disabilities, who have difficulties with travelling at all due to a range of different logistical challenges

Risks to patient experience

- This represents risks of patients feeling excluded from healthcare services due to the set up of the hospital and the attitude of clinical and support staff
- These risks are not specific to orthopaedic care, but must be considered in the implementation of the EOC, to ensure that all groups with protected characteristics are treated equally

Risks to outcomes

- This represents risks of patients experiencing unwarranted variation in outcomes, due to lack of understanding of their specific needs and differences in quality of treatment by the EOC compared to their previous place of care

The following mitigating actions will be incorporated into the implementation plan, to address the risks in access and experience

Mitigations for risk to access

- Provision of **travel solutions (including dedicated transport to the EOC)** for those facing long, costly or complex journeys
- Work with Transport for London in relation to **adjustments to support affordable access, for example adapting bus routes**
- **Monitoring of elective orthopaedic waiting times** to ensure equitable access for those with protected characteristics and higher levels of deprivation
- Understand requirements for and make provisions for **disabled access and parking**
- A **single referral system**, meaning that everyone who is clinically eligible for care at the EOC has the same access to care, regardless of their deprivation level, race, gender, age or other protected characteristics
- Develop **virtual pre-operative assessment where suitable**, alongside adjustments for those with physical or sensory disabilities, learning disabilities and those on the autistic spectrum, and face-to-face options to avoid digital exclusion
- Provide **patient choice of site for surgical care** at point of referral, in line with NHS Choice Framework

Mitigations for risks to patient experience

- **Improve knowledge and cultural competency amongst staff** through awareness and training
- Develop a **patient experience strategy** including co-design and co-production
- Set up an **Equality, Diversity, and Inclusion committee** comprising staff and patient group representatives to coordinate ED&I activities
- Develop strategies to ensure **appropriate BAME and gender representation** in the staff group
- Design and build the EOC **in line with NHS guidance and local trust policy** including:
  1. Design the EOC to reflect the expected gender mix to meet NHS England's "enhancing privacy and dignity" policies, including **single sex accommodation, changing and toilet facilities**
  2. Provide **all of its literature in multiple languages**, and patients will have access to Language Line. These are standard policies already in existence in LNWH and other trusts
  3. Design the EOC to be compliant with **current legislation regarding accessibility and wayfinding**
  4. Develop procedures to ensure patients have **access to appropriate chaperone** where necessary
  5. **Leverage other existing policies in place at trusts**, which have been developed using the experience of working with diverse communities

The following mitigating actions will be incorporated into the implementation plan, to address the risks outcomes and allow continuous improvement

Mitigations for risks to outcomes

- **Standardised processes across the pathway for the whole of North west London**, meaning that all patients will have the same opportunities for treatments
- Develop **discharge standard operating policies in collaboration with community colleagues** to ensure effective discharge from hospital
- Routinely **review end to end MSK pathway** to identify and resolve bottlenecks to enable a seamless pathway, and identify areas which might be driving health inequalities in access or outcomes
- Review quality outcome data and patient reported outcomes for all patient groups and **set action plans for unwarranted variations**
- **Enhanced training for all clinicians and support staff** to understand the drivers behind the variations in outcomes for protected characteristics, and how to account for them

Continuous improvement

We recognise that these mitigating actions will need to be continuously improved throughout the implementation and running of the EOC, to ensure that the EOC is at the forefront of driving equality and minimising unwarranted variation in outcomes. To ensure that the engagement with the protected groups continues, we will do the following

- Continue to proactively engage with patients, local authorities, hospitals, residents' associations, communities with protected characteristics (e.g. "Friends, Families and Travellers" - the national charity working on behalf of all Gypsies, Travellers and Roma) throughout the Consultation process and beyond to gather feedback and feed this into the design and implementation of the EOC
- Continue to proactively engage with staff networks (e.g. the Staff LBGTQI+ network) throughout the Consultation process and beyond to gather feedback and feed this into the design and implementation of the EOC
- Develop strategies to ensure appropriate BAME and gender representation in the staff group
- Look at enhanced ways to collect regular data on all protected characteristics, within GDPR rules, to enable us to understand the use of services, the experiences and the outcomes from these groups and look at mitigating actions to reduce any remaining unwarranted variations

Appendix

Appendix summary

This appendix includes the limited analysis of groups with protected characteristics undertaken and other indicators of patient outcomes considerations that do not provide key findings for consideration

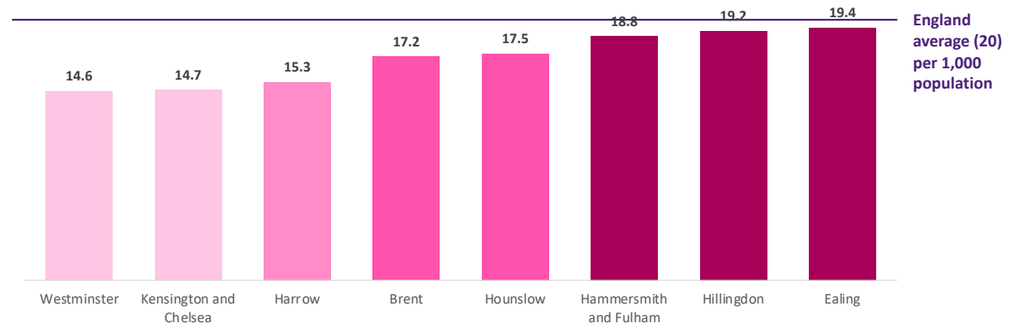
- People with disabilities
- Sexual orientation
- Gender reassignment
- Religion or belief
- Marital status
- Pregnant or on maternity leave
- Other indicators of patient outcomes
- Friends and Family Test

People with disabilities

North west London local authorities have a lower number of people on disability living allowance per 1,000 population compared to the national average

Number of people on disability living allowance per 1,000 population, by NWL LA

Feb-2022



- As there is no direct, updated record of people with disabilities in the NWL region, prevalence can indirectly be demonstrated by other metrics such as the number of disability living allowance (DLA) claimants
- The local authorities of North west London have a lower average number of people with DLA compared to the rest of the country

Source: ONS population projections, Department for Work and Pensions Stat-Xplore DLA statistics, CF analysis

People with disabilities

Studies show people with disabilities can face barriers to access healthcare, and quality of life for those with cognitive impairments is worse after hip fracture procedures

Experiences in healthcare

- Hearing impairment - Mask wearing creates a substantial barrier to healthcare services for individuals communicating through lip-reading, British sign language or relying on facial expressions.
- For people with learning disabilities making reasonable adjustments within healthcare provision is a requirement of the Equality Act 2010 (e.g., Easy-read information, avoiding medical jargon or longer appointment times). However often these are not put in place which can be a barrier to accessing healthcare settings, made worse by COVID restrictions on hospital visiting policies
- People with autism may have difficulty accessing and using online or telephone services to make appointments coupled with the fact that individuals with autism may have poor organisational skills prevent access to healthcare services.
- People living with severe mental illness (SMI) experience some of the worst inequalities, with a reduced life expectancy with 2 in 3 deaths due to preventable physical illnesses such as cardiovascular disease. Diabetes is 1.9 times more prevalent compared to those without SMI.

Experiences in trauma and orthopaedics

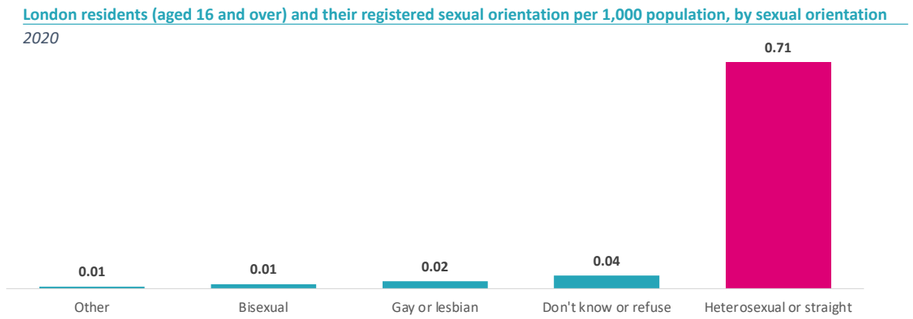
- Within Trauma and Orthopaedics, analysis of data on individuals following a hip fracture found that quality of life was significantly lower for patients with cognitive impairment compared to those without.
- In addition, 1-year mortality was greater for those patients with cognitive impairment (shown by an abbreviated mental test score ≤ 8).
- Looking at disabilities more broadly; analysis of 30-day mortality after hip fracture surgery showed a range of factors are linked to 30-day mortality including walking ability, the number of comorbidities and pre-existing dementia, cardiac disease, chronic obstructive pulmonary disorder and renal failure.
- Of all risk factors assessed, cardiac disease was identified as one of the strongest predictors of 30-day mortality following hip fracture surgery

For the data analysis, the main source of data (HES) does not generally record reliable details of this protected characteristic.

Source: Recovery of health-related quality of life in a United Kingdom hip fracture population (2015) https://online.boneandjoint.org.uk/doi/full/10.1302/0301-620X.97B3.35738?rfr_dat=cr_pub++0pubmed&url_ver=Z39.88-2003&rfr_id=ori%3Arid%3Acrossref.org
Predictors of early mortality after hip fracture surgery (2013) https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3824905/#:~:text=We%20aimed%20to%20determine%20predictors,previous%20history%20of%20cardiac%20disease

Sexual Orientation

The Annual Population Survey shows that there is a higher proportion of people who identify as heterosexual or straight than as other sexual orientations in London



- Whilst the figures from the Annual Population Survey for London's sexual orientation breakdown appear relatively small for 1,000 population, it demonstrates that there are considerably more heterosexual individuals than those that identify as non-heterosexual across the London region
- Another potential limitation of this dataset to note when considering the proportionate demography of this protected characteristic group is the amount of survey respondents this is based on compared to the actual population (only 7,174 respondents which made up roughly 0.8% of London's population in 2020)

Source: National Sexual Orientation statistics 2020, CF analysis

Sexual Orientation

Studies show LGBT people continue to witness discriminatory or negative remarks, which result in avoided treatments for fear of discrimination

Experiences in healthcare

Almost one in four lesbian, gay, bi-sexual and trans (LGBT) people (23 per cent) have witnessed discriminatory or negative remarks against LGBT people by healthcare staff. In 2018 six per cent of LGBT people – including 20 per cent of trans people – have witnessed these remarks. One in eight LGBT people (13 per cent) have experienced some form of unequal treatment from healthcare staff because they're LGBT. One in seven LGBT people (14 per cent) have avoided treatment for fear of discrimination because they're LGBT (Ref. LGBT in Britain – Health. Stonewall, 2018). Lesbian, gay, bisexual, transgender, and queer (LGBTQ+) individuals may encounter added challenges in the orthopaedics healthcare setting

Experiences in trauma and orthopaedics

It was not possible to find any specific studies on the experiences of orthopaedics by individuals with different sexual orientations

For the data analysis, the main source of data (HES) does not generally record reliable details of this protected characteristic.

Source: LGBTQ+ in Orthopaedics: Creating an Open and Inclusive Environment (2022) https://pubmed.ncbi.nlm.nih.gov/35609262/

Gender reassignment

There is a known lack of demographic data and NHS data for those that have had gender reassignment

Unfortunately, there is a lack of NHS and population data on people that have gone through gender reassignment. Whilst this is widely recognised and there are initiatives to improve this, there is still no sufficient, robust data that can be used to determine their demography. As it is not possible to consider this within the demographic analysis now, it should be considered in the future development of the service once data becomes available.

Gender reassignment

Studies show trans people can be deterred from using health services due to negative attitudes and a lack of knowledge or understanding from some healthcare professionals

Experiences in healthcare

A national report published in 2016 (ref. Trans healthcare: What can we learn from people's experiences? Healthwatch, March 2020) found that trans people encounter issues when using the NHS due to the negative attitudes and lack of knowledge or understanding from some healthcare professionals. It is a criminal offence under the Gender Recognition Act 2004, to tell people about a person's previous gender without permission from the individual except when made to a health professional for medical purposes. Although Healthwatch found that trans people's experiences highlighted that often health professionals did not use their preferred or correct name, gender or pronouns in written and verbal communication. This can be highly distressing and deter trans people from using health services for fear of discrimination and prejudice.

Experiences in trauma and orthopaedics

It was not possible to find any specific studies on the experiences of orthopaedics by individuals who had gone through gender reassignment

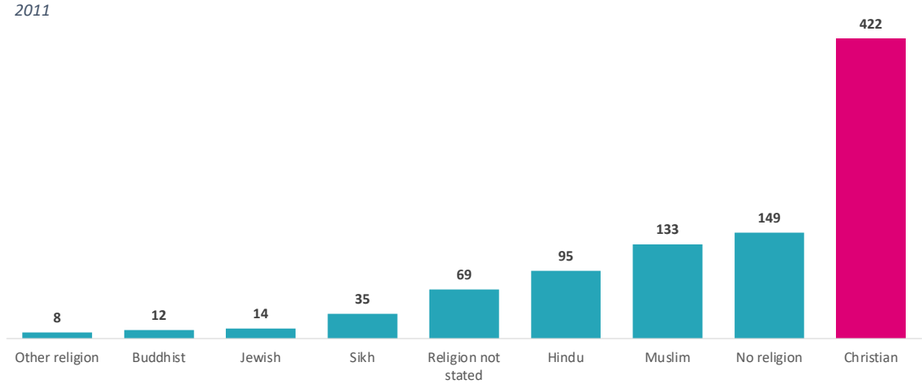
For the data analysis, the main source of data (HES) does not generally record reliable details of this protected characteristic.

Source: Total Joint Arthroplasties in Transgender Patients: Unique Considerations for an Emerging Patient Population (2022) https://journals.lww.com/jaaos/Fulltext/2022/07010/Total_Joint_Arthroplasties_in_Transgender.5.aspx
Transgender Health in Orthopaedic Care: A Literature Review (2020) https://scholararchive.ohsu.edu/concern/etds/br86b399h?locale=en

Religion or belief

North west London has a higher population of people who identify as Christian compared to other religions or beliefs

NWL Residents and their registered religion or belief per 1,000 population, by religion or belief
2011



- There is a lack of data within Hospital Episode Statistics regarding patients' religion or belief, as well as sexual orientation, by LSOA
- The ONS census demonstrates that there are significantly more people of Christian belief compared to other groups in NWL per 1,000 population

Source: ONS 2011 Census, CF analysis

Religion or belief

Studies show some religious groups can be deterred from using health services due to a lack of understanding from providers on their religion and culture

Experiences in healthcare

Some research for specific religious groups found a lack of providers' understanding of

- Patients' religious and cultural beliefs
- Language-related patient-provider communication barriers
- Patients' modesty needs
- Patients' lack of understanding of disease processes and the healthcare system
- Patients' lack of trust and suspicion about the healthcare system, including providers

Although religion and cultural awareness was not raised as specific issues within the patient interview insights, it is worth noting in relation to inclusion with any cultural awareness training included in the recommendations.

Experiences in trauma and orthopaedics

It was not possible to find any specific studies on the experiences of orthopaedics by individuals from different religious groups

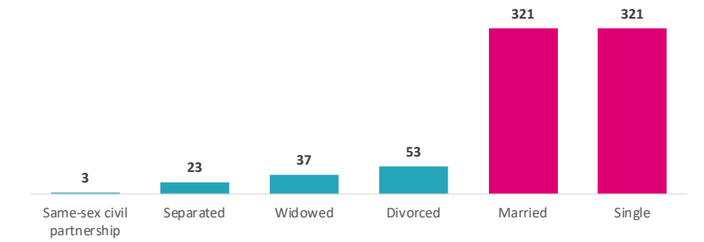
For the data analysis, the main source of data (HES) does not generally record reliable details of this protected characteristic.

Source: Religion and Belief Matter (2008) https://www.nes.scot.nhs.uk/media/bxoddw5x/religionandbelief.pdf
Religion and Spirituality in Surgery (2017) https://academic.oup.com/book/24624/chapter-abstract/187940049

Being married or in a civil partnership

Data capture shows there are proportionately more married and single people than people with other relationship statuses in north west London

NWL Residents (aged 16+) and their marital status per 1,000 population, by marital status
2011



- The latest ONS census data shows that there are considerably more married or single individuals per 1,000 population across North west London compared to those with different relationship status
- Further, there is also an approximate equal number of married and single people per 1,000 population during the year this data was captured

Source: ONS 2011 Census, CF analysis

Being married or in a civil partnership

Studies show single or widowed patients are linked to longer lengths of stay, and are more likely to be discharged to nursing care

Experiences in trauma and orthopaedics

Research on orthopaedic trauma and marriage status from the US found a link between discharge destination and marital status. Single patients and widowed patients were more likely to be discharged to a nursing home, long-term care facility, or skilled nursing facility compared to married patients. Additionally, single and widowed patients had longer length of hospital stay than their married counterparts. The research suggests those who are single or widowed should have early social work intervention to establish clear discharge expectations and prepare for care support in the home.

For the data analysis, the main source of data (HES) does not generally record reliable details of this protected characteristic.

Source: Marriage Status Predicts Hospital Outcomes Following Orthopedic Trauma (2020) https://pubmed.ncbi.nlm.nih.gov/32030312/

Being pregnant or on maternity leave

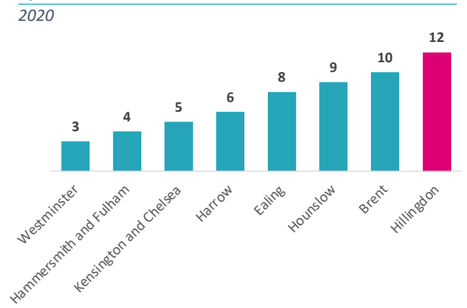
Using conceptions as an indicator for pregnancies shows some local authorities have significantly more pregnancies than others in north west London

Conceptions per 1,000 women aged over 18, by NWL local authorities

2020

Conceptions of women aged 18 and under per 1,000 women, by NWL local authorities

2020



- Conception rates can be used as estimates of all pregnancies of women residing in England and Wales
- These figures are measured from maternities and abortions, but exclude pregnancies that end in miscarriages or illegal abortions
- There is a higher concentration of conceptions for women over 18 years old in Brent, Hounslow, Harrow, Ealing, and Hillingdon
- Hillingdon also has the highest amount of conceptions for those 18 and under per 1,000 population compared to other local authorities

Source: ONS conception rates 2020

Being pregnant or on maternity leave

Pregnant patients are at higher risk during orthopaedic surgery (although they are not in the cohort of patients who are proposed to undergo elective surgery in the EOC)

Experiences in trauma and orthopaedics

Pregnancy presents unique challenges to orthopaedic surgeons. Firstly, there are two patients requiring consideration in each decision. Physiological changes contribute to the presentation of certain orthopaedic conditions unique to pregnancy, and impact the management of trauma involving pregnant women. While elective orthopaedic procedures can generally be postponed until after delivery, trauma usually demands more urgent intervention. Fracture management in pregnant patients is challenging. Anatomic and physiologic changes in pregnancy increase the complexity of treatment. Maternal trauma increases the risk of adverse pregnancy outcomes including foetal loss, preterm birth, placental abruption, caesarean delivery, and maternal death. As a result of this, T&O management of pregnant patients requires more planning than for the general population.

A significant proportion of patients within the orthopaedic HVLC pathways are 50 years or over (and therefore highly unlikely to be pregnant), therefore we have assumed that this protected characteristic will impact a relatively small cohort. Additionally, there are increased risks for pregnant women to undergo elective surgery, therefore it is unlikely there will be a high volume of patients who are pregnant will undergo elective orthopaedic surgery.

For the data analysis, the main source of data (HES) does not generally record reliable details of this protected characteristic.

Source: Pregnancy and the orthopaedic patient (2012) https://www.orthopaedicsandtraumajournal.co.uk/article/S1877-1327(12)00071-1/fulltext
Treatment of Pregnant Patients With Orthopaedic Trauma (2017) https://digitalcommons.pcom.edu/cgi/viewcontent.cgi

The latest Friends and Family Test outcomes show North west London ICB T&O services performed better on positive feedback from patients compared to the national average

The Friends and Family Test (FFT) is a patient feedback tool collected monthly to help service providers and commissioners understand patient experience of the service provided, as well as help identify where improvements are needed.

FTT Results for NWL ICB T&O sites and wards December 2022

Site Name	Ward Name	Positive response (%)	Negative response (%)
West Middlesex University Hospital	Osterley 1	100%	0%
West Middlesex University Hospital	Osterley 2	100%	0%
Central Middlesex Hospital	Abbey Suite	100%	0%
Mount Vernon Hospital Site	Trinity	93%	4%
Charing Cross Hospital	7 South Ward	75%	13%
Chelsea & Westminster Hospital NHS Foundation Trust	Lord Wigram	100%	0%
Chelsea & Westminster Hospital NHS Foundation Trust	David Evans	96%	2%
NWL ICB – T&O average		**95%**	**3%**
National - T&O average		**93%**	**4%**

Source: NHS Friends and Family Test, December 2022

The measure of deprivation used in the IIA was the Index of Multiple Deprivation

English indices of deprivation (IoD2019)

- The English indices of deprivation were most recently updated in 2019 (IoD2019). The Index of Multiple Deprivation (IMD) is the official measure of relative deprivation in England and is part of several outputs that form the Indices of Deprivation (IoD2019).
- The IoD2019 is based on 39 separate indicators, organised across seven distinct domains of deprivation which are combined and weighted to calculate the Index of Multiple Deprivation 2019 (IMD 2019). This is an overall measure of multiple deprivation experienced by people living in an area and is calculated for every Lower-layer Super Output Area (LSOA), or neighbourhood, in England. All neighbourhoods are then ranked according to their level of deprivation relative to that of other areas.
- English indices of deprivation are measured in **deciles**.

Source: English indices of Deprivation 2019, https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/835115/IoD2019_Statistical_Release.pdf
Carstairs Scores, https://www.gla.ac.uk/schools/healthwellbeing/research/mrccsosocialandpublichealthsciencesunit/programmes/inequalities/healthinequalities/determinantsofhealthandhealthinequalitiesinscotland/carstairsscores/

Appendix C – Benefits realisation plan (BRP)

KEY

Out of Scope	Non-LNWH day cases, and ASA 3 and 4 activity, spinal, paediatric and out of area activity. Out-of-scope activity to be monitored by the NWL Acute Provider Collaborative. * Note LNWH day case waiting list will also be monitored by the EOC as part its performance monitoring.
Year 1	12 month period beginning November 2023.
Year 2	12 month period beginning November 2024.
New and developmental KPIs.	Note – some of the additional KPIs relating to transport and patient satisfaction are of necessity work in progress and will need to be baselined prior to opening.

Benefit Description	KPI theme	Expected benefits	Baseline	Target improvement	By when	Owner
Productivity	Average length of stay – hips	Improved productivity	3.1 – 4.1 days (Model Health - 12 months to end Q2, 2022/23)	Top decile 2.3 days	Year 2	EOC Medical Director
	Average length of stay – knees	Improved productivity	3.2 – 5.7 days (Model Health - 12 months to end Q2, 2022/23)	Top decile 2.3 days	Year 2	EOC Medical Director
	Cases per list – Inpatient	Improved productivity	1.3 – 2.5 cases per list for mixed lists across NWL hospitals (Combined T&O - Model Hospital 2022/23)	GIRFT Target 2 cases per 4 hour list	Year 1	EOC Medical Director
	Cases per list – Day Case	Improved productivity		5 cases per 4 hour list	Year 2	EOC Medical Director
Cost-Effectiveness	Cost per Weighted Activity Unit – Alla planned Orthopaedic activity	Better use of resources	£368	£351 (2nd Quartile)	Year 2	EOC Managing Director
	Cost per Weighted Activity Unit –Orthopaedic inpatients and day case activity	Better use of resources	£3,569	£3,1633 (2nd Quartile)	Year 2	EOC Managing Director

Benefit Description	KPI theme	Expected benefits	Baseline	Target improvement	By when	Owner
Clinical Outcomes and Experience	Patient reported outcomes PROMS – Oxford hip score	Improved patient satisfaction	3rd Quartile Health gain 21.807 – 23.278	2nd quartile	Year 2	EOC Medical Director
	Patient reported outcomes PROMS – Oxford knee score	Reduced burden on primary care	4th quartile Health gain 14.179 – 17.685	2nd quartile	Year 2	EOC Medical Director
	Patient reported outcomes PROMS – Oxford hip Eq5d	Improved patient satisfaction Reduced burden on primary care	3rd quartile Health gain 0.416 - 0.480	2nd quartile	Year 2	EOC Medical Director
	Patient reported outcomes PROMS – Oxford knee Eq5d	Improved patient satisfaction Reduced burden on primary care	3rd quartile Health gain 0.288 - 0.347	2nd quartile	Year 2	EOC Medical Director
	30 day readmission rate – hips	Improved productivity Better outcomes	1.6% – 12.5% (MH – 12 months to end Q2, 2022/23)	Top quartile 4.5%	Year 1	EOC Medical Director
	30 day readmission rate – knees	Improved productivity Better outcomes	2.5% – 12.1% (MH – 12 months to end Q2, 2022/23)	Top quartile 4.5%	Year 1	EOC Medical Director
	Cancellation for (a) clinical reasons	Improved patient satisfaction Better use of resources	1.8% – 3.5% (MH - 12 months to end Q2, 2022/23)	1%	Year 1	EOC Medical Director
	Cancellation for (b) non-clinical reasons	Improved patient satisfaction Better use of resources	3.1% – 8.2% (MH – 12 months to end Q2, 2022/23)	2%	Year 1	EOC Medical Director
	Cemented hip implants > 70 years old	Better outcomes	68.1% - 76% (MH – 12 months to end–Q2, 2022/23)	2nd quartile	Year 2	EOC Medical Director
	5 year revision rate– hips	Improved patient satisfaction Reduced burden on primary care Better use of resources	3rd quartile 1.0%	Top quartile 0.5%	Year 6	EOC Medical Director
	5 year revision rate – knees	Improved patient satisfaction Reduced burden on primary care Better use of resources	4th quartile 2.0%	Top quartile 1.0%	Year 6	EOC Medical Director

Benefit Description	KPI theme	Expected benefits	Baseline	Target improvement	By when	Owner
Patient access	Reduction in EOC waiting list size for High Volume Low Complexity inpatients	Improved patient satisfaction	Waiting list size as at December 2022.	Reduction of of ~38% by October 2025 Year 2		EOC Managing Director
	Reduction in waiting list size for Low Volume High Complexity inpatients	Improved patient satisfaction	Waiting list size as at December 2022.	Reduction of of ~36% by October 2025		Acute Provider Collaborative
	Reduction in waiting list size for NWL sector day cases*	Improved patient satisfaction	Waiting list size as at December 2022.	Reduction of of ~57% by October 2025		Acute Provider Collaborative
	Reduction in EOC waiting time for High Volume Low Complexity inpatients	Improved patient satisfaction	Waiting list size as at December 2022.	Reduction of ~9 weeks by October 2025		EOC Managing Director
	Reduction in waiting time for Low Volume High Complexity inpatients	Improved patient satisfaction	Waiting list size as at December 2022.	Reduction of ~9 weeks by October 2025		Acute Provider Collaborative
	Reduction in waiting time for NWL sector day cases	Improved patient satisfaction	Waiting list size as at December 2022.	Reduction of ~9 weeks by October 2025		Acute Provider Collaborative
Transport	Analysis of patients who DNA	Reduced DNAs		% DNA rate reduction As a subset: % DNA rate reduction of patients who live at long distance/ ++age Target improvement to be agreed by the EOC Management Board and the Shadow Partnership Board.	Year 2	EOC Estates and Facilities Lead
	Continuous review of PTS	Improved access to PTS amongst eligible patients	Baseline to be determined prior to opening.	12% of overall EOC patients who were able to access PTS took up the service. Review assumptions at end of Year 1.	Year 1	EOC Estates and Facilities Lead
	Patient friends and family test	Improved patient satisfaction	Baseline to be determined prior to opening.	Top quartile	Year 2	EOC Estates and Facilities Lead

Benefit Description	KPI theme	Expected benefits	Baseline	Target improvement	By when	Owner
Patient Satisfaction	Volume and nature of patient complaints	Reduction in number and scope of complaints	Baseline to be determined prior to opening.	Tbc	Year 1	EOC Director of Nursing
	Qualitative patient survey	Improved qualitative assessment	Baseline to be determined prior to opening.	Tbc	Year 1	EOC Director of Nursing
	Qualitative patient feedback	Improved patient satisfaction		Target improvement to be agreed by the EOC Management Board and the Shadow Partnership Board, based on EOC Operational Management Group recommendations Baseline position to be determined based on data for period six months prior to opening the EOC, with initial post-opening survey six months after opening and then continuing six monthly thereafter.	Year 2	
Workforce Impact	Staff satisfaction	Staff engagement	6.9	7.0 (Top quartile, NHS Staff Survey)	Year 2	EOC Director of Nursing
		Staff morale	5.7	5.9 (Top quartile, NHS Staff Survey)	Year 2	EOC Director of Nursing
	Staff recruitment and retention	Low vacancy rates and low turnover	TBC	10% (Agreed by Workforce Workstream)	Year 2	EOC HR Lead

Appendix D – Matrix of consultation and assurance and assessment findings

Methodology

The tables below have been developed from the assurance outputs (chapter 7) and public consultation findings (chapter 3) received, with sources laid out against each theme. The feedback spans from the pre-consultation stage to the decision-making stage. Feedback has not been weighted in this matrix.

Sources:

- Public consultation
- Refreshed IIA
- NWL ICB
- LCS
- NHS England
- M ayor of London

Themes:

- Clinical model and patient experience
- Workforce model and staff experience
- Site Selection
- Travel
- Equity
- Other i.e. specific pieces of feedback that did not sit within the five themes

Table 1 – Distribution of the feedback received group by themes

Source	Clinical Model and Patient Experience	Workforce Model and Staff Experience	Site Location	Travel	Equity	Other
Public Consultation	●	●	●	●	●	
IIA	●	●	●	●	●	
NWL ICB	●	●		●	●	●
NHS England with LCS advice confirmed the programme has been assured against the four Secretary of State tests and successfully passed Stage 2 of the Service Reconfiguration assurance process18						
LCS	●	●			●	●
NHSE	●	●		●	●	●
Mayor of London	●	●		●	●	●

18 https://www.england.nhs.uk/publication/planning-assuring-and-delivering-service-change-for-patients/

Table 2 – Summary of feedback addressed by theme

Source	Clinical Model and Patient Experience	Workforce Model and Staff Experience	Site Location	Travel	Equity	Other
Public Consultation	Detail on connectivity of care within the clinical model and MSK pathway has been included in Chapter 4.	The impact on staff has been included in Chapter 5.	Our site assumptions have been reviewed for the options appraisal to check the validity of our preferred location in Chapter 4.	The travel solution has been created in response to public consultation feedback in Chapter 4.	Ensuring equity of access, transport, complexity at other sites and preventing digital exclusion have been outlined in Chapter 4.	
IIA	Refreshed IIA includes recommend-ations and revised mitigations in Chapter 2.	The IIA suggested the use of policies and procedures to support staff working in the EOC in Chapter 5.	We looked at site location through the lens of the site options in the travel analysis in Appendix B.	The transport solution is described in Chapter 4.	The IIA proposed recommend-ations and mitigations to further improve patient experience and ensure equity of access are in Chapter 2.	
NWL ICB	The ICB requested additional clarity on what the benefits will be in terms of reducing waiting lists and improving quality (see Chapter 5).	The ICB wanted evidence that workforce planning has been undertaken (see Chapter 5).		Inequalities highlighted in the PCBC (including transport and digital exclusion) have been addressed in Chapter 4.	Inequalities highlighted in the PCBC (including transport and digital exclusion) have been addressed in Chapter 4.	The DMBC must show robust financials (see Chapter 6) and include evidence of a comprehensive public consultation (see Chapter 3).
NHS England with LCS advice confirmed the programme has been assured against the four Secretary of State tests and successfully passed Stage 2 of the Service Reconfiguration assurance process						
LCS	Case studies and additional detail on the MSK pathway and clinical model were included in Chapter 4 in response to feedback. GIRFT best practice has been incorporated into multiple workstreams.	A range of workforce considerations were suggested to inform the development of the workforce model in Chapter 5.			An IIA informed the PCBC and now has been refreshed for the DMBC in Chapter 2.	More detail on environmental sustainbility has been provided in Chapter 5.
NHSE	NHS England's Test 2 notes the input of the London Clinical Senate in Chapter 7.	Additional detail around workforce model and imple-ment-ation has been included in Chapter 5.		Suggested exploring alternative patient transport options including hospital transport and taxis (see Chapter 4 for Transport Solution)	PCBC included initial travel analysis and a commitment to extend this to travel complexity and accessibility. This has been completed with a recommend-ation and in consideration of the public consultation.	The BRP and risk register have been refreshed at the PCBC and DMBC in Chapter 5.
Revised feedback on tests 1 to 4, and feedback on tests 5 and 6 is expected from the Mayor's office following the publication of the consultation report and submission of this DMBC for further review and consideration.						
Mayor of London	IIA has been refreshed in Chapter 2 to review the risk of widening health inequalities (Test 1). The impact on social care is described in section 7.3.2 and the discharge pathway outlined in section 4.1.5 (Test 4).	Additional detail around the direct recruitment workforce model has been included in chapter 5 (Test 2).		The transport solution to support those at risk of long and complex journeys is described in section 4.3 (Test 1).	Includes response to how more complex patients will be treated to avoid a two-tier system in section 4.1.7 (Test 1). Monitoring is detailed in the BRP in section 5.5.	The financial modelling has been updated in Chapter 6 (Test 3).

Appendix E – Mayor of London's Letter

MAYOR OF LONDON

Helen Pettersen
Regional Director for London
NHS England

Penny Dash
Chair
North West London Integrated Care System

Matthew Swindells
Joint Chair
North West London Acute Hospitals

Rob Hurd
Chief Executive Officer
North West London Integrated Care System

Date: 19 January 2023

Dear Helen, Penny, Matthew and Rob,

I want to start by thanking the North West London Integrated Care System team for their helpful engagement with the process to apply my six tests to the proposals for 'Improving planned orthopaedic inpatient surgery in north west London'. This has supported my team to better understand the proposed changes and the objectives and analysis behind them.

As Mayor, I have committed to using my influence and role as a political leader to champion, challenge and collaborate with the NHS and other health partners on behalf of all Londoners. As part of this role, I have developed six tests to apply to all major health and care transformation and reconfiguration programmes. These tests are designed to help me challenge the NHS to demonstrate that major changes are in the best interests of all Londoners.

In November 2022, I reviewed and refreshed my six tests. However, given that the public consultation for these proposals was launched before the six tests were refreshed, I am assessing them against the previous version of the tests. Those tests cover:

- health inequalities and the prevention of ill health
- hospital beds
- financial investment and savings
- social care impact
- clinical support
- patient and public engagement.

In November 2022, I commissioned the Nuffield Trust to carry out an independent expert review of the proposed changes against the six tests. I have used this analysis to inform my position on the proposals. A copy of this review is attached to this letter.

This letter sets out my view on the proposed changes against the first four of my tests. Following the publication of the consultation report and final plans in the forthcoming decision-making business case (DMBC), I will share my final position on the proposed changes against all six tests.

City Hall, Kamal Chunchie Way, London E16 1ZE
mayor@london.gov.uk ◆ london.gov.uk ◆ 020 7983 4000

MAYOR OF LONDON

Overall, I am broadly supportive of the proposed changes. They represent a significant opportunity to improve patient outcomes, reduce waiting times, tackle the elective care backlog and deliver care more efficiently. The model of care being developed has the potential to be adapted and emulated by both other systems and other types of service across London, to the great benefit of patients. However, in part because of the major potential these changes hold, it is crucial to ensure that the benefits they generate for the health of Londoners and towards efforts to reduce health inequalities are optimised. It is in that spirit that I share my position on the proposals at this stage of their development.

To allow me to support the DMBC, I would like to draw your attention to several key points for you to consider during the next phase of developing the proposals. In particular, the final plans should:

- Account for the potential risks of widening health inequalities that are identified in the Nuffield Trust review, and offset these risks with actions to improve equity in elective orthopaedic care in north west London.
- Put forward a detailed workforce plan that addresses the risk that shifting staff to the new elective orthopaedic centre (EOC) could reduce capacity in surrounding hospitals and services.
- Show how capacity freed up by the shift in activity to the EOC will be used or redeployed, in order to realise the potential savings associated with the proposed changes.
- Set out a detailed consideration of the impact of the changes on social care services in north west London.

Test 1: Health inequalities and the prevention of ill health

The pre-consultation business case (PCBC) for the proposals claims that elective orthopaedic surgery use in north west London is currently skewed towards the most deprived population group, and implies that, since their use of these services is disproportionately high, improvements to elective orthopaedic care generated by the proposed changes will disproportionately benefit this group. However, indicative analysis by the Nuffield Trust suggests that the share of elective orthopaedic surgery in north west London used by the most deprived parts of the population is broadly in line with population size, rather than being disproportionately high. This would mean that, at best, the activity rate is proportionate to the relative level of need in that population group. However, given that the PCBC for these proposals identifies a higher musculoskeletal disease burden in the most deprived groups, this proportion of activity may in fact indicate a relatively high level of unmet need for elective orthopaedic care. This entails a risk that the changes will disproportionately benefit less deprived groups, and thereby widen health inequalities. Given this, the DMBC should revisit this analysis to ensure that the risk of widening health inequalities is appropriately considered and mitigated.

The proposed new EOC is a 'high volume low complexity' hub, where patients with multiple comorbidities, particularly if these are poorly managed, will be ineligible for treatment. Since the incidence of multiple comorbidities increases significantly with deprivation, there is a substantial risk that the group of patients eligible for treatment at the new centre will be less deprived than those deemed ineligible. This would appear to mean that the benefits generated by the creation of the new centre, such as improved clinical outcomes and reduced waiting times, would accrue disproportionately to less deprived parts of the north west London population. In this respect, the proposed changes risk widening health inequalities. The PCBC argues that patients ineligible for treatment at the new EOC will experience equal clinical outcomes. However, since the chief clinical benefit of the changes appears to be that treatment in the new centre will involve lower rates of

City Hall, Kamal Chunchie Way, London E16 1ZE
mayor@london.gov.uk ◆ london.gov.uk ◆ 020 7983 4000

complications, more evidence is needed to explain how patients treated outside of the centre will experience improved clinical outcomes. As things stand, this risk should be offset by wider actions to improve healthcare equity in orthopaedic care in north west London. These actions should be clearly set out in the DMBC, alongside health inequality metrics and targets for the scheme.

It is positive that analysis in the PCBC shows that median travel times to the new EOC by both car and public transport are lowest for the most deprived groups in north west London. However, it is crucial to understand differences in travel costs, as well as travel times, associated with the proposed changes, and I would want to see evidence on this in the DMBC. I am pleased to see the commitment in the PCBC to pay particular attention to the travel needs of patients and carers from deprived areas and to explore solutions to support affordable access. Attention should also be paid to the needs of groups who may struggle to travel long distances, such as disabled people, older people and those who do not speak English.

Test 2: Hospital beds

The proposed changes will involve a significant increase in bed and theatre capacity for elective orthopaedic patients in north west London, as well as opening up bed capacity for other forms of care in hospitals from which inpatient elective orthopaedic care will be transferred to Central Middlesex Hospital (CMH). However, I note that analysis by the Nuffield Trust suggests that without further actions in addition to those set out in the proposals, demand for elective orthopaedic care in north west London will continue to outstrip NHS capacity.

The proposed changes involve a substantial shift in clinical resource from surrounding hospitals to CMH, in order to staff the new centre. This risks diminishing clinical staff levels in those hospitals, as well as destabilising interdependent services, including emergency care – potentially leading to an effective reduction in bed capacity for other forms of care. Since more deprived groups disproportionately use emergency care, such an impact on emergency care would generate a health inequalities risk. These risks are helpfully raised in the proposal documentation published to date.

However, given the gravity of the risks, I would anticipate that the DMBC will include a more detailed workforce plan that sets out how the risks will be addressed and monitored over time, including mechanisms for tracking the effects of the changes on capacity in surrounding hospitals.

Test 3: Financial investment and savings

I welcome the fact that the EOC can be established at CMH with capital investment that is fully funded in the local acute capital programme. It is also positive that this change would enable the NHS to more efficiently use assets at CMH that it is already contractually committed to paying for, and that annual revenue savings of £4m are anticipated once the centre is fully established.

Under the proposals, £17m of elective orthopaedic activity is being moved from three north west London trusts to the new centre at CMH. For the potential ICS-wide savings of this shift to be realised, these three trusts will need to either be able to export the full cost of the 'referred' patients out of their own cost bases when activity is moved, or re-use existing capacity for other forms of patient care in a way that is fully funded. The PCBC rightly acknowledges this as a critical challenge, but the DMBC should set out in detail how this challenge will be addressed – including outlining how, where costs cannot be exported, capacity will be redeployed or activity reduced.

City Hall, Kamal Chunchie Way, London E16 1ZE
mayor@london.gov.uk ◆ london.gov.uk ◆ 020 7983 4000

MAYOR OF LONDON

Test 4: Social care impact

One of my priorities for any major service change is that the impact on adult social care is well considered. I note that the PCBC does not set out how the proposed changes will affect adult social care services. This should be considered in detail in the DMBC. It is important that this includes modelling of the expected impact of the changes over time on the size and profile of demand for local social care services, as well as setting out how risks associated with potential shortfalls and inequalities in social care support will be monitored and mitigated. Given the shift in patients from multiple boroughs to CMH, it is also important that the DMBC sets out appropriately resourced plans to develop relationships between CMH and the full range of adult social care services that it will be working with if the EOC is established.

Thank you for the opportunity to comment on the proposals. I will be publishing this letter on the Greater London Authority website in the next few days. I plan to share my final position against all six tests once I have reviewed the consultation report and the revised proposals that will follow in the DMBC.

Yours sincerely,

Sadiq Khan
Mayor of London

Cc: Geoff Alltimes, Independent Chair, London Estates and Infrastructure Board
Dr Roger Chinn, Chief Medical Officer, Chelsea and Westminster Hospital NHS Foundation Trust
Dr Michael Gill, Chair, London Clinical Senate
Toby Lambert, Executive Director of Strategy and Population Health, North West London Integrated Care System
Martin Machray, Executive Director of Performance, NHS England – London
Dr Chris Streather, Medical Director, NHS England – London

City Hall, Kamal Chunchie Way, London E16 1ZE
mayor@london.gov.uk ◆ london.gov.uk ◆ 020 7983 4000

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1. EXECUTIVE SUMMARY

1.1 ABOUT THIS REPORT

1.1.1 OVERVIEW

This report presents and analyses comments received during public consultation on proposed changes to planned orthopaedic inpatient surgery in North West London. It assesses views on:

- The main proposal to develop an elective orthopaedic centre for North West London, and
- The preferred location for the centre at Central Middlesex Hospital.

The consultation period was between 19 October 2022 and 20 January 2023. The process was led jointly by NHS North West London[1], which is the Integrated Care Board (ICB) responsible for commissioning NHS care for people living in the eight North West London boroughs, and the North West London Acute Provider Collaborative[2].

The Collaborative, which also led development of the proposal, comprises the four NHS acute trusts in North West London:

Chelsea & Westminster Hospital NHS Foundation Trust
The Hillingdon Hospitals NHS Foundation Trust
Imperial College Healthcare NHS Trust
London North West University Healthcare NHS Trust.

1.1.2 WHAT THIS REPORT CONTAINS

Based on analysis of the comments received, this report identifies perceived benefits, concerns and issues for consideration. It should be noted that:

This includes both qualitative and quantitative information, and combines responses from a variety of sources to provide a comprehensive overview of the feedback and comments received

An indication of the relative weight of opinion is provided, broken down by different groups of respondents where this is meaningful and justified by the data

In the detailed analysis, we have aimed to capture all substantive points made to provide a checklist of engagement issues to consider.

1.1.3 COMPLIANCE

A range of statutory duties and other requirements govern consultation processes. These are set out in this report which also includes a summary of engagement activity and commentary on the extent to which these requirements were met.

This report was independently prepared by Verve Communications Limited to inform development of a decision-making business case by the Collaborative for consideration by NHS North West London.

1.2 SUMMARY OF PARTICIPATION

Consultation responses were received from individuals and organisations, and through a variety of channels including: a questionnaire (print and online); face-to-face and virtual events; staff

[1] https://www.nwlondonics.nhs.uk/about-nhs-nw-london
[2] https://www.nwl-acute-provider-collaborative.nhs.uk

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engagement meetings; focus groups and one-to-one interviews; community outreach by the Collaborative and the NHS North West London communications and engagement teams.

Table 1 shows a summary of the main consultation activities and level of participation.

Activities	Number of participants
Open meetings and drop-ins	247
Community outreach meetings	373
Staff events	*450
Focus groups and interviews	70
Questionnaire	807
Responses from the public by email or telephone	5
Organisational responses	7
Total	1,959

Table 1. Summary of participation and response
*in online sessions with staff there were instances where several people joined from one laptop – so numbers may be higher, and information on numbers attending was not supplied for all meetings.

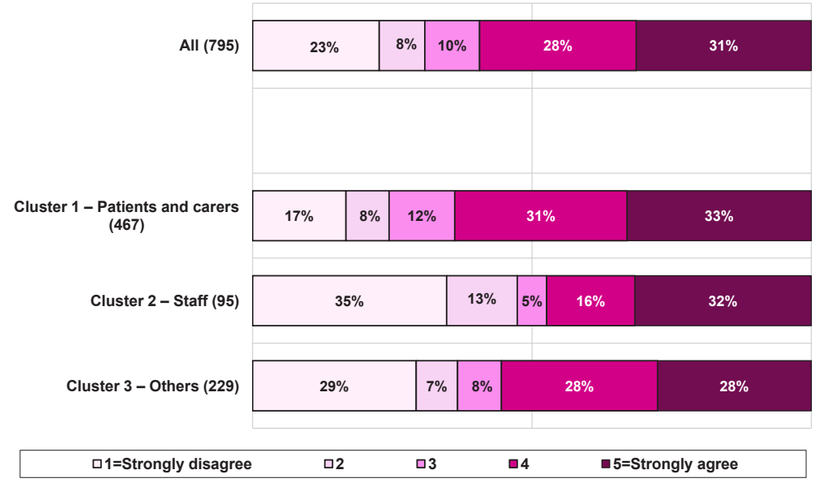
1.3 SUMMARY QUANTITATIVE RESPONSES

The survey received 807 responses. Please note, not all answers sum to 100% as respondents may not answer all questions. It should be noted that 28% of responses were from people from Hillingdon, this is twice as many as from the next largest responses (Ealing 14% and Hammersmith & Fulham 13%). 8% of responses were from Brent, 7% were from Hounslow, 7% from Westminster, 6% from Kensington & Chelsea and 6% from Harrow. 11% of responses were from people living outside of the 8 boroughs.

- 59% of responses were from patients and carers
- 12% of responses were from NHS staff
- 29% of responses were from 'others', that is, people who identified as 'member of the public' (28%) or 'responding on behalf of an organisation' (1%)

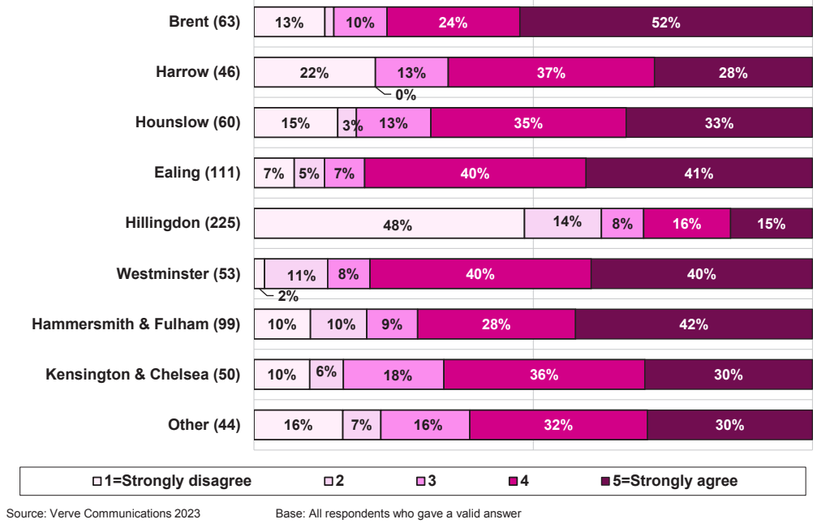
- Hillingdon had the greatest proportion of responses from people in the 'other' category – with 43% in that category; 20% of Hillingdon responses were from patients and carers and 31% from staff.

- Overall, 59% of respondents agreed with the proposal to develop an elective orthopaedic centre in North West London



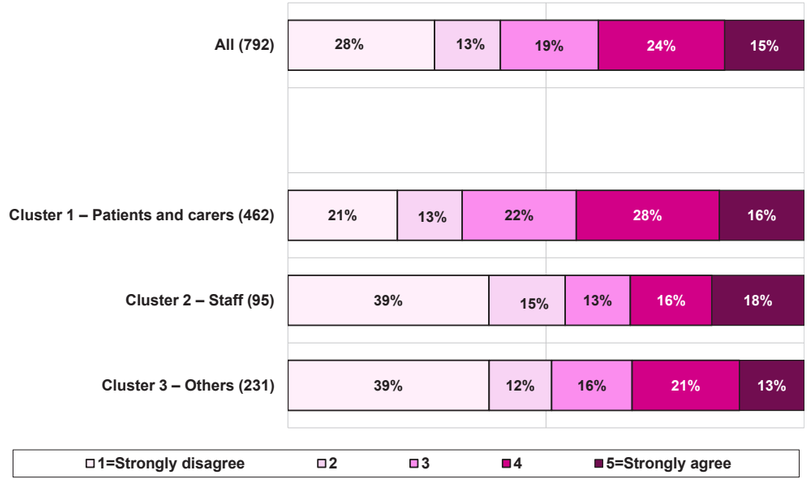
Source: Verve Communications 2023 Base: All respondents who gave a valid answer (267)

- People in 7 of the 8 boroughs were supportive of the proposal, whilst people from Hillingdon were more likely to disagree:



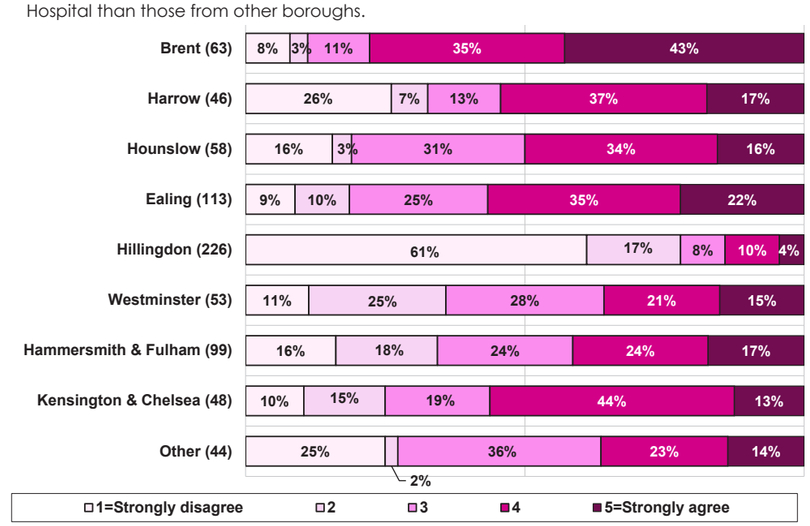
Source: Verve Communications 2023 Base: All respondents who gave a valid answer

- When asked about the proposal to site the elective orthopaedic centre at Central Middlesex Hospital 39% of people agreed with the proposal and 41% disagreed with it; patients and carers were more likely to agree than staff or others.



Source: Verve Communications 2023 Base: All who gave a valid answer

- More people in Hillingdon disagreed with the proposal to site the centre at Central Middlesex Hospital than those from other boroughs.



Source: Verve Communications 2023 Base: All respondents who gave a valid answer

- The main reasons given for disagreeing with Central Middlesex Hospital as the site for an elective orthopaedic centre related to travel.

1.4 SUMMARY QUALITATIVE RESPONSES

Overall participants thought that the proposal for an elective orthopaedic centre for most routine surgery was a good idea and hoped that it would help to reduce waiting times for patients.

There were some people who would prefer to have all their treatment at their local hospitals, generally for the sake of convenience.

There were two main concerns raised by people: the first related to travel to and from the proposed elective orthopaedic centre at Central Middlesex Hospital for patients, visitors and staff and the second related to services at home for people after they were discharged from hospital.

Some participants would have preferred the hub to be located at Mount Vernon hospital – generally these were staff at Hillingdon and Mount Vernon hospitals and people who lived near Mount Vernon.

Some potential inequalities have been identified, and a list of mitigations put forward by participants is presented.

Appendix G – Draft Clinical Strategy (Clinical Cabinet 2023)

Abstract

We will provide the best patient care and experience, continuously improve clinical outcomes, and become a place of work that supports our team to excel.

System vision

Introduction

This document sets out the overarching clinical strategy for Elective Orthopaedic Surgery. The strategy reflects national guidance and best practice and helps meet – and align – a number of strategic priorities for the north west London ICS and the acute provider collaborative.

The strategy aims to describe the direction of travel for elective orthopaedic services focusing on the establishment of an elective orthopaedic centre within the sector. The strategy outlines the clinical cabinet ambition to provide:

- Continuity of care across organisational boundaries
- Continuous improvement leading to high-quality clinical outcomes
- Equitable and inclusive access to care
- Collaboration and engagement with patients
- High-quality education, training and experience for staff

The strategy is structured in line with strategic planning guidance, is evidence based and has been co-produced with the clinical cabinet team. It outlines the strategic context, current arrangements and the sets the direction of travel for service transformation.

Strategic Context

Musculoskeletal (MSK) conditions affect almost one third of the population, that is over 20million people, symptoms can have a significant impact on people's quality of life and independence. Up to 30% of consultations in general practice are related to MSK conditions[19], the service sees an ever-increasing demand for services as people live longer with complex health needs. While most patients can be initially managed with education, self-care and within primary care, orthopaedic referrals from primary care continue to rise by 7-8% each year and there is a growing demand for operative treatments; according to the 2017 Global Burden of Disease study, musculoskeletal conditions were the biggest contributor to global disability. Orthopaedic procedures make up 26% of all surgical procedures and there are no signs of demand abating. Unaddressed, it is anticipated that demand will quickly outstrip resources and capacity. Recent research funded by the Scottish government indicates that if no action is taken then patients listed for hip or knee replacement surgery in 2022 may have to wait up to 7-years to undergo their surgery. New more efficient and effective ways of working are required. An integrated approach across healthcare is required to ensure patients are managed in the right place at the right time across north west London, and that we make the best use of our resources for our patients. Elective surgical services currently face significant pressures competing with surges in demand for unplanned care and, following the COVID-19 pandemic, unacceptably long waits. The NHS approach to tackling the additional challenges created by the COVID-19 pandemic, is set out in The NHS Delivery Plan[20] for tackling the COVID-19 backlog of elective care, by:

- increasing health service capacity, including through the physical separation of elective from urgent and emergency services to improve the resilience of elective delivery as well as service efficiency
- prioritising diagnosis and treatment, reducing the maximum length of time that patients wait
- for elective care and treatment

19 NHSE https://www.england.nhs.uk/elective-care-transformation/best-practice-solutions/musculoskeletal/
20 https://www.england.nhs.uk/coronavirus/publication/delivery-plan-for-tackling-the-covid-19-backlog-of-elective-care/

- transforming the way we provide elective care, including by increasing activity through dedicated and protected surgical hubs
- providing better information and support to patients, including to prepare for surgery in the best way possible.

The GIRFT programme for Trauma and Orthopaedics [21]is well established and evidenced, orthopaedics was the pilot specialty when the improvement programme was launched in 2015. The methodology was subsequently developed and applied to numerous other surgical specialties. The GIRFT programme supports local health and care systems to develop 'high volume low complexity' (HVLC) surgery services. It advocates the development of standardised pathways and adoption of best practice, as well as pooling of capacity and resources. This includes "establishing and maintaining ring-fenced elective capacity at a system level for HVLC procedures, adopting 'hub' models where appropriate". This approach has been evidenced to produce tangible benefits for the quality of care and patient outcomes, performance and efficiency and financial sustainability for patients.

North west London ICS has established a number of multidisciplinary and system-wide CRGs to support elective care recovery and service transformation through review of emerging clinical evidence and best practice. The Orthopaedic CRG, set up in 2020 aims to support collaborative improvement across areas of care and works closely with the wider north west London MSK network. The CRG, taking into consideration the best practice and outstanding outcomes from neighbouring elective orthopaedic surgical centres, identified the need to transform orthopaedic surgical care and to align with, and improve of community MSK pathways. The CRG's key recommendations for orthopaedic surgical care include:

- developing a centre of excellence and networked working for high volume, low complexity orthopaedic care which provides reliable and efficient surgical pathways that deliver a high-quality experience for patients and staff through rigorous application of best practice and continuous learning
- providing dedicated, ring-fenced NHS operating theatres and beds for patients requiring elective orthopaedic surgery
- ensuring rehabilitation support is in place for patients after surgery.

The approach to orthopaedic surgical care will be supported by and integrated across the sector with community musculoskeletal services that will ensure a seamless pathway which is well understood by and accessible to patients, carers and healthcare professionals. A key feature of this will be to ensure that access to high-quality care equitable so that most care is delivered close to the patient, whether in the community or in a patient's local hospital.

To support the recovery of elective care guidance was also issued by the British Orthopaedic Association on restoring elective orthopaedic services. The separation of elective services from emergency services has long been seen as a key aspiration to improving quality and productivity, as set out in an NHSE presentation to lead providers in 2020 which summarised the benefits of a separation of services providing:

- less fragmented services and improved patient navigation
- improved patient experience
- shorter stays, waits, and lower risk of cancellation
- improved outcomes and a reduction in unwarranted variation in patient care and revision rates
- improved specialisation to enable training, research and availability of advanced treatment
- reciprocal benefits to emergency and acute care provision.

The success of this approach is well evidenced and demonstrated in the results achieved in centres which have adopted this pattern of working, notably the SWLEOC where separating the activity from the emergency activity being undertaken across the region and even in the host trust, has been identified as key to the success of the model over the past 18 years.

21 https://gettingitrightfirsttime.co.uk/surgical_specialties/orthopaedic-surgery/

Current Arrangements

Service Provision

Adult trauma and orthopaedic care are currently provided by all four acute trusts in north west London in a total of eight hospitals. The increased pressures on healthcare services as a result of an ageing population, COVID-19 pandemic and the resulting delays in elective care and increases in unplanned care have meant that elective orthopaedic surgery is often de-prioritised, none of the eight hospitals are currently in a position to provide ring-fenced beds for elective orthopaedic patients. This means that these services can never function efficiently, and the service is unreliable for patients and frustrating for staff. Patients deteriorate clinically while they wait for extended periods, they may come to harm, they cannot contribute functionally or economically to society, and they have a very poor experience.

Lead provider for orthopaedic care

To support collaborative and coordinated working across acute providers, especially in terms of elective care recovery, a lead provider model is being implemented for key surgical specialties in many

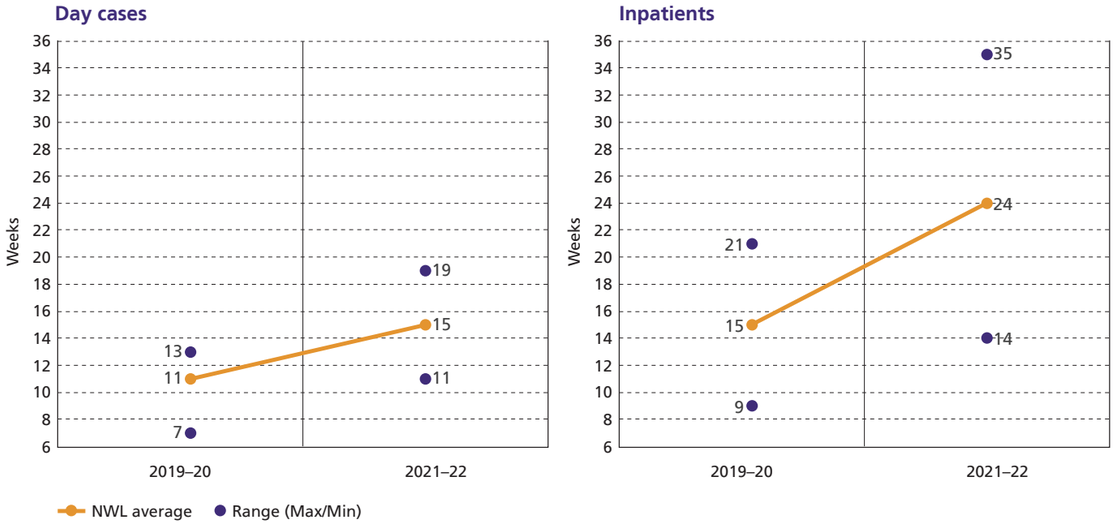
integrated care systems. north west London ICS has set draft principles to guide the creation and development of a lead provider role, which sees the lead provider selected and appointed at a system level, for orthopaedics London north west Hospitals Trust has been selected and holds responsibility for:

- engaging clinical and managerial leaders across all providers in a system
- coordinating and having oversight of waiting lists so that a system population has equity of access to care, based on clinical priority and waiting time
- oversight of clinical outcomes and productivity at a system level and using the system's continuous improvement methodology to reduce any unwarranted variation
- participating in the London Clinical Panel to agree best practice standards in clinical outcomes and productivity for the specialty

Performance

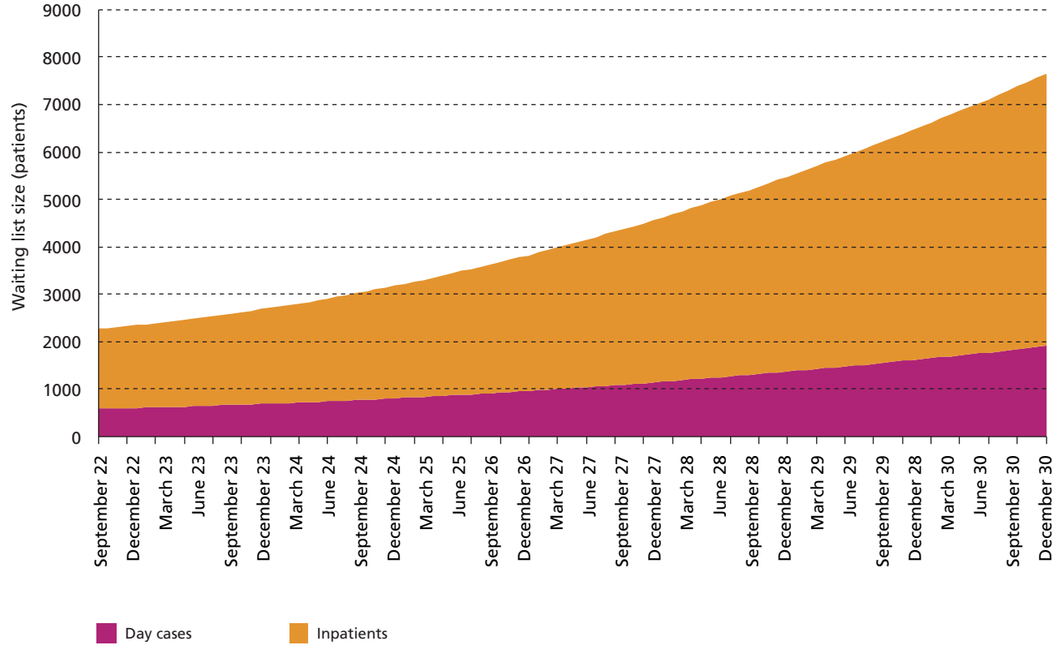
Over 15,000 people were waiting for orthopaedic care in north west London hospitals as at the end of September 2022. This includes all patients waiting for outpatient appointments, diagnostics or surgical procedures. This total patient waiting list for orthopaedics care did reduce in size compared to pre-COVID-19 numbers as elective services largely shut down, patients did not attend hospital for anything other than urgent care and patients were reluctant to travel to hospital. However, as we see this demand return, the waiting list has been growing – increasing by 22% in the last 6 months alone.

North west London orthopaedics breakdown of average DTA to treatment waiting times (Source: Public Consultation Business Case, 2022)



Demand for services in north west London will become particularly challenging over the next few years, as modelling shows that the number of people needing orthopaedic surgery will increase exponentially by 2030 if activity levels remain the same. Without intervention, the north west London orthopaedic waiting lists will continue to grow faster than the existing capacity to provide care

North west London orthopaedic surgery Patient Tracking List (PTL6) growth to 2030, with activity levels unchanged (north west London elective orthopaedic centre in-scope procedures and ASA grades only) Source: Public Consultation Business Case, 2022



Challenges

The four key challenges experienced by the service are outlined in this chapter. These challenges are the key drivers for change.

1. Growing demand and increasing waiting times
2. Clinical outcomes
3. Insufficiently joined-up care
4. Staff recruitment and challenges

Growing demand and increasing waiting times

The north west London orthopaedics waiting list has been rising with a c22% increase in the last 6 months as the disrupted demand during COVID-19 returns – currently standing at over 15,000 patients waiting for care. Of the total number of patients waiting, the number waiting for surgery has increased sharply since COVID-19, there are almost 200 patients who have been waiting for over a year. Without intervention, the north west London orthopaedic waiting lists will continue to grow faster than the existing capacity to provide care. Patients deteriorate clinically while they wait for extended periods, they may come to harm, they cannot contribute functionally or economically to society and they have a very poor experience.

Elective orthopaedic surgical services will focus on consistent, improved and sustained performance. Even though procedures like hip or knee replacements are not usually considered to be time critical, waiting for treatment can have an extremely negative impact on quality of life and many conditions can worsen over time, making treatment and recovery harder. While many of the levers for preventing and mitigating MSK disorders sit outside the control of acute hospitals and even the wider NHS, elective orthopaedic surgical services should deliver fast, high-quality care, particularly to older patients and patients from more deprived backgrounds as they have proportionately more demand for elective orthopaedic care. This may be directly through an elective orthopaedic centre itself – which would take patients in order of clinical need from across the whole of north west London – or by freeing up more orthopaedic surgery capacity on sites where patients with more complex needs can be treated.

Clinical Outcomes

The table below shows the performance of the four hospitals in north west London against key quality indicators. As is evident, the majority of the performance analysis shows north west London hospitals performing at or below third quartile performance, demonstrating significant scope for improvement. There is also inconsistent performance, highlighting scope for uniformly consistent performance at improved levels. There are aspects of national guidance, inferior quality outcomes, financial inefficiencies and variations in clinical practice and standards where there are clear opportunities to offer an improved service for patients across north west London and to use our resources more efficiently.

North west London performance for elective orthopaedic care using 'model hospital'* data and PROMs by trust (Source: Public Consultation Business Case, 2022)

KPI	Imperial	LNWH	ChelWest	Hillingdon/ MVH	Sector average
5 year revision rate hips	Q3	Q1	Q4	Q4	Q3
5 year revision rate knees	Q4	Q2	Q1*	Q4	Q3
PROMS – OKS	Q4*	Q4*	Q2	Q4*	Q4
PROMS – OHS	Q2	Q3	Q3	Q4	Q3
PROMS Eq5d hips	Q2	Q3	Q2	Q4	Q3
PROMS Eq5d knees	Q3	Q4	Q2	Q4	Q3
Length of stay hips	Q3	Q2	Q1	Q1	Q2
Length of stay knees	Q4	Q3	Q2	Q1	Q3
Cost per WAU orthopaedic surgery	Q4	Q3	Q1	Q3	Q3
Readmission rate knee	Q1*	Q4	Q4	Q4	Q3
Readmission rate hips	Q1*	Q1	Q4	Q4	Q2
Implants – cemented/hybrid hips in over 70s	Q4	Q4	Q3	Q4	Q4
Average	Q3	Q3	Q3	Q4	Q3

* The Model Health System is a data-driven improvement tool that enables NHS health systems and trusts to benchmark quality and productivity.

Key	Q1* – Top decile performance	Q1 – Top quartile performance	Q2 – Second quartile performance	Q3 – Third quartile performance	Q4 – Bottom quartile performance	Q4* – Bottom decile performance

The potential for improvement, as well as variation, is particularly demonstrated when quality data for elective orthopaedic care is analysed to show which of the north west London trusts, if any, sit in the top decile or quartile for performance. No more than one north west London acute provider achieves top decile or top quartile performance for any group of indicators. No north west London trust achieves top decile performance for patient reported outcome measures (PROMs)8, length of stay, implants, readmission rate or revision rate. There are clear opportunities to improve the care that is provided for patients in north west London so that better, safer and high-quality care can be expected by and delivered for all.

	Top decile		Top quartile	
	Quality of care (PROMs, LoS, implants)	Complications (Readmission rate, revision rate)	Quality of care (PROMs, LoS, implant)	Complications (Readmission rate, revision rate)
London North West University Healthcare NHS Trust	✗	✗	✓	✓
Imperial College Healthcare NHS Trust	✗	✓	✗	✓
Chelsea and Westminster Hospital NHS Foundation Trust	✗	✗	✓	✓
The Hillingdon Hospitals NHS Foundation Trust	✗	✗	✗	✗
Overall (ICS average)	✗	✗	✓	✓

(Source: Public Consultation Business Case, 2022)

Insufficiently joined-up care

NHS acute trusts in north west London receive generally positive feedback from patients about their

planned orthopaedic care, in particular that staff are caring, kind and helpful. Patients are less positive about their experience of the healthcare system. In particular, patients with experience of MSK and orthopaedic services report frustration with long waiting times between their initial assessment and surgery or while attending their appointments, having to chase up for their follow-up appointments or feeling worried due to re-scheduling or cancellations.

During engagement activities, patients and the public highlighted that there should be a standardised community pathway which would complement improvements to the elective care model. They are concerned that it is easy for patients to become 'lost' in the system before and after referral or admission to hospital. Some patients face inequalities in accessing care and have poorer health outcomes as a result. This is particularly the case for patients who are elderly, have disabilities, are from deprived areas and from black, Asian and other minority ethnic groups. For example, previous engagement has shown elderly or disabled patients often say travel to appointments is a problem. Patients highlight communication problems, such as a lack of coordination between GPs and hospital services or confusing information. Many patients want more control over their care and would like the health system to organise services in a way that is clearer and more consistent and straightforward. Innovative 'one stop shop' models of care, such as 'joint weeks' or 'mass clinics', which save everyone's time, are popular with patients and clinicians but it is often difficult to organise resources in this way and they are often prone to disruption due to surges in unplanned demand.

With the wider community MSK pathway under review, and due to be re-procured, by the north west London Integrated Care Board, there is a real opportunity to create more joined-up care across primary, community and acute services and promote integrated patient pathways across elective orthopaedics.

Staff recruitment and retention challenges

Recruitment and retention of skilled and engaged staff is one of the biggest challenges facing the NHS. Key issues include:

- providing a greater range of training and career development opportunities, including new roles, such as advanced clinical practitioners and care navigators
- making it easier for staff to move across roles and partner employers, with common approaches to ways of working
- increasing resilience, including through greater appropriate cover
- reducing sickness and absence rates
- increasing more flexible working
- reducing the use of bank and agency through more effective cover of the rotas with permanent staff
- ensuring trainees and students have access to the highest quality education and training.

Model of Care

Vision for Elective Orthopaedic Surgery

The vision is to advance clinical excellence and share best practice worldwide. The service aims to provide the best patient care and experience, continuously improve patient outcomes, and become a place of work that supports team members to excel. To deliver this, we will establish an elective orthopaedic centre that is fully embedded and integrated within the wider patient musculoskeletal pathways so that improved end-to-end care is delivered for patients with musculoskeletal (MSK) disorders across north west London. This will involve close collaborative working with adjacent services and providers across north west London. This includes primary and community care, secondary care and social care providers.

Patients who need day case surgery or complex surgery or those who have additional health risks will be offered surgery in their 'home' hospital that currently provides orthopaedic surgical care. Patients

who require routine inpatient surgery (ASA I and II) will be prepared for surgery by their 'home' hospital and referred to a dedicated elective orthopaedic centre for their surgery by their 'home' hospital team. The end-to-end responsibility of surgical care will remain under the surgical team based at their 'home' hospital to help ensure a seamless experience. If they have their surgery at the elective orthopaedic centre, their 'home' surgical team will travel with them to undertake the surgery, supported by the centre's permanent clinical support team.

A model of care that includes an elective orthopaedic centre that offers low complexity, inpatient, orthopaedic surgery in a purpose-designed centre of excellence that is completely separated from emergency care services offers several benefits that have been evidenced in national guidance and have demonstrated that:

- patients will have faster and fairer access to the surgery they need and are much less likely to have their surgery postponed due to emergency care pressures elsewhere
- the care is of a consistently high quality, delivered by a team who are highly skilled in their procedure
- the centre will be extremely efficient, enabling more patients to be treated at a lower cost per surgery
- patients will have better outcomes, experience and follow-up.

In addition, capacity created in the 'home' orthopaedic hospitals by the consolidation of low complexity surgery in the elective orthopaedic centre will be able to be used for surgical patients who have more complex needs and for other specialties.

The Clinical Model

The delivery of the clinical model is centred around 4 core principles. It is acknowledged that it will require not insignificant adjustment to working patterns and relationships but focusing on these core principles serves to support decision making which means that the selected model will deliver the intended benefits while remaining patient centred and responsive to the feedback that we have received during consultation and after careful consideration.

The Elective Orthopaedic Centre will:

- Deliver clinical excellence and continuity of care
- Deliver care that reflects a culture of continuous improvement and is evidence based
- Be a product of co-production and will be fully integrated with wider community musculoskeletal pathways
- Deliver efficient, high-quality care with a focus on equitable access and excellent patient outcomes for all patients across north west London

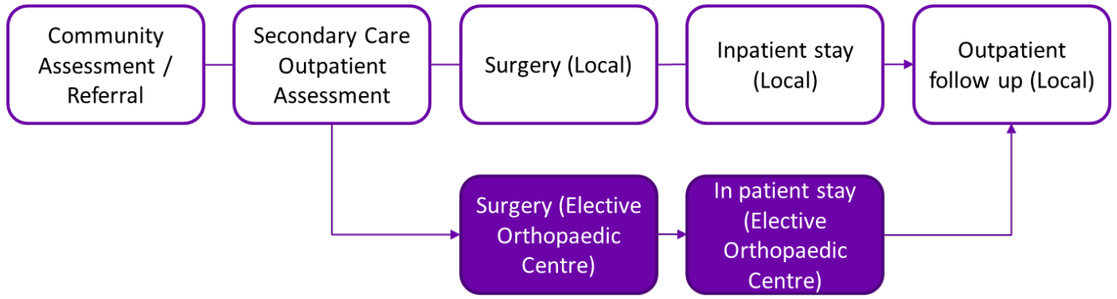
This will be facilitated by:

- Ongoing collaboration and engagement reflecting respect for and insights from patient choice, preferences and staff feedback
- The use of digital technology to support patient access, information and education
- A commitment to high-quality research, training and education
- Efficient and effective operational processes
- A commitment to active audit, and clinical governance processes with active monitoring and reporting

The clinical model will offer a seamless integrated journey for the patient through pre-operative care and treatments, whether undertaken in hospital or the community through assessment, surgery and rehabilitation. Technology and digital design will be used to facilitate this and to enhance communication and information sharing between clinicians and different elements of the pathway.

This will empower patients and carers to access their own information and records. Examples include a shared electronic patient record, shared digital imaging, the remote collection of patient outcome measures, the development of virtual and online educational materials for patients and carers and over time the development of a virtual pre-assessment platform to support local provision via home trusts.

The Patient Journey



Community assessment and referral into secondary care

The clinical model and patient pathway involves referral from a community provider to the local hospital trust at a time when secondary care expertise is judged to be helpful or desired and/or when surgical treatment is being considered.

Secondary care outpatient assessment

Once surgery is agreed on through shared decision making, patients will undergo pre-operative assessment. Patients will be listed for surgery at their local hospital, eligible patients (ASA 1 and 2) will be added to the patient waiting list for the Elective Orthopaedic Centre to have their surgery and perioperative care conducted there.

Pre-habilitation, pre-operative physiotherapy and patient education

These will be provided either in the local home trust for the patient or in the community close to home.

Inpatient care

The inpatient pathway will be protocolised to support best practice and standardised efficient pathways. Ward-based care will be provided by daily senior grade surgeon ward rounds and a resident on-ward junior doctor presence supported by (specialist) nurses and therapists providing multidisciplinary post-operative care.

If in the unlikely event a patient required critical care, support will be provided if required by the on-site enhanced care unit team. The ECU has a small number of beds and is linked to the Northwick Park Hospital Critical Care unit. This facility is primarily provisioned for LNWH home patients as it is not anticipated that ASA 1 or 2 patients who have been scheduled for routine surgery will routinely need this level of care. There are well-rehearsed SOPs in place for patient transfer to NPH where necessary for post-operative emergency medical or surgical care. Patients will be given contact details and instructions on discharge to access clinical support and advice should this be required. Discharge will be routinely communicated to both the primary care provider and the local hospital trust for the patient.

Outpatient follow-up care

Patients will be discharged with a planned appointment for follow-up and arrangements in place for ongoing therapy/rehabilitation. Patients who have attended the elective orthopaedic centre will have outpatient follow-up at their local hospital. Any unexpected complications or requirement for an emergency or unanticipated attendance or treatment will be managed at the local hospital. Patients will be given contact details and instructions on discharge to access clinical support and advice should this be required. Discharge will be routinely communicated to both the primary care provider and the local hospital trust for the patient.

A small group of patients may require additional support during their post-operative recovery period. These patients will be identified as early as possible in the pathway. After surgery the discharge hub will

act as a single point of referral to the eight north west London boroughs for social care, community rehabilitation and bedded rehabilitation.

Sometimes patients require short-term support to help them get back to normal and stay independent known as reablement care. This is for a maximum of six weeks. If needed, patients will be discharged once a start date has been confirmed.

The Elective Orthopaedic Centre

Recognising that optimising productivity in a mixed trauma and planned surgery environment is challenging, the development of an elective orthopaedic centre as a shared resource for all patients across north west London is underway. All acute trusts will be able to direct suitable patients to the centre, the EOC will provide equitable access to referring trusts and expertise at the centre. Although located on the CMH site, the inpatient beds are ring-fenced and protected from the pressures of urgent and emergency care (and other) pathways.

The ethos of the elective orthopaedic centre is to provide an excellent high-quality service. There will be some patients for whom variation from the clinical model of care is warranted and, in some cases, necessary. For example, there will be a small number of patients where it might be helpful for them to visit the EOC in advance of the day of surgery. Patient choice is important and will be respected as per the NHS Choice Framework.

If, at the point of shared decision making to list a patient for surgery, a patient requests an alternative to the elective orthopaedic centre for routine inpatient orthopaedic surgery, a risk benefit assessment would be undertaken with consideration of the patient's clinical status and any protected characteristics that may be relevant.

Day case surgery has been excluded currently to maintain shorter travel distances for patients on the day of surgery but this will be reviewed as the service develops and matures. Day case surgery and planned orthopaedic surgery for patients graded up to and including ASA 3, provided by London north west University Healthcare NHS Trust will continue to take place in the facilities of the EOC. This surgery already takes place in this facility as it is their 'home' orthopaedic hospital and the necessary support and adjacencies including critical care support have already been put in place to support this work.

The increase in capacity and efficiency offered by the EOC will mean that for some patients who currently need to have their surgical treatment procured, planned and delivered in the private sector, sometimes away from their local environment, their needs will now fall in-scope for the proposed elective orthopaedic centre, and they will be able to access treatment locally, closer to home.

Equity, inclusion, and access

Ensuring everyone can access services on an equal footing is a key priority for the NHS. North west London understands that the implementation of an elective orthopaedic centre may disproportionately impact some groups of the population. To understand this impact, as part of its statutory duty to consider reducing inequalities an EHIA and an Integrated Impact Assessment has been carried out. This takes a systematic and evidenced based approach to considering the likely impact of the change on the different groups of people and sets out the mitigating actions to be included in any service changes.

Some of the actions being taken to reduce health inequalities in NWL MSK pathway include:

1. A strong focus on ensuring equity throughout the development of service changes – we have used the IIA alongside our consultation feedback to identify key challenges and possible responses.
2. People from black, Asian and other minority ethnic communities may be less likely to seek orthopaedic surgery than other groups which the service aims to tackle this through even more detailed waiting list monitoring and improved communications, engagement and support.
3. Potential digital exclusion: the service aims to make the most of digital and other technological advances -which can increase convenience for some patients and avoid potentially painful or complex journeys to hospital -without leaving anyone behind. A roll out of new digital solutions to support the clinical model will include tailored communications and face-to-face service options for patients who do not want –or are not able –to use digital platforms.
4. Patients with more complex needs: review of workforce requirements to ensure the proposed move of routine inpatient surgery to the elective orthopaedic centre would support a greater focus on complex surgery at the other sites. The efficiencies gained from consolidating low complexity care at a centre of excellence would be shared across all four acute trusts for the benefit of all orthopaedic patients.
5. Travel: the additional support for patients who would have long, complex or expensive journeys to Central Middlesex is being shaped particularly by the needs of patients who would find it difficult to travel by public transport and/or were less likely to have private means of transport.

Patient Experience

The service has built up a significant volume of insight about what patients and local communities in north west London want and need from inpatient orthopaedic care and wider MSK services. The ambition is to continue to engage with patients and local communities as the elective orthopaedic centre is established and use this insight to shape the service we offer to patients.

The service aims to provide a high-quality patient experience by ensuring care is provided in line with best practice guidelines, by a skilled multidisciplinary team who provide patient-centred care. Published literature[22][23][24] outlining orthopaedic patient feedback on the aspects of care that impacts their surgical experience along with feedback from our patients underpins the approach that the service adopts:

- Providing care with compassion and empathy
- Providing high-quality patient information to ensure that patients are well informed about their surgical procedure and the expected outcomes.
- Patient education programmes to support patients though their care journey from referral through to treatment
- A multidisciplinary team approach, ensuring patients can share their concerns and receive support from the best placed member of the team
- Post-operative care and effective discharge planning are key in alleviating patient concerns around postsurgical pain and anxiety associated with post-operative living arrangements

22 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7503134/
23 https://pxjournal.org/cgi/viewcontent.cgi?article=1348&context=journal
24 https://www.magmutual.com/learning/article/improving-patient-experience/

Patient feedback both qualitative and quantitative is key to continuous service improvement, there are processes in place to ensure that it is collected, analysed and acted upon across the patient pathway through the elective orthopaedic centre. In addition to this, there will be ongoing engagement with the contacts established through the consultation and engagement completed to date that will also inform the service through implementation.

The model of care and arrangement of elective orthopaedic inpatient surgery services promotes the following patient experience benefits:

- support faster and fairer access for patients who need orthopaedic surgery across northwest London
- prevent conditions from getting worse when waiting a long time for surgery
- mean fewer postponed operations due to urgent and emergency care pressures
- help care to be more joined-up across the whole of the musculoskeletal care pathway
- support more focus on care before and after surgery to help reduce the risks of surgery and enable faster recovery

Improving Quality and Outcomes

How does the service plan to improve outcomes

The benefits that will be delivered by establishing the EOC are best considered through the 6-domains of quality applied to orthopaedic surgery, the approach is outlined here and will be developed through mobilisation and implementation of the elective orthopaedic centre.

1. **Safe: Avoiding harm to patients from the care that is intended to help them.**

Bringing together an expert team to regularly and routinely undertake elective orthopaedic surgery at scale in the EOC will make this surgery safer for patients. Safe practice is supported by strong well-rehearsed and trained teams working to best practice guidelines and learning from each other.

Enhanced safety will be delivered by standardising pathways and protocols. Specifically, standardised protocols around ring-fencing beds, antibiotic prophylaxis, venous thromboprophylaxis, transfusion guidance and early safe post-operative mobilisation will drive up standards for all patients across north west London, achieve compliance with best practice, national standards, and make care safer.

Close monitoring of adherence to standards, performance, and patient outcomes will allow any risks to patient safety or quality to be identified early and to be addressed. Specifically, outcomes will be reviewed in multidiscipinlary team meetings, participation in the national joint registry project and other national audits, participation in the UK Health Security Agency Surgical Site Surveillance for Infection programme. Placing training, and innovation at the heart of the EOC will instil a culture of continuous learning, maintaining best practice and standards to keep patients and staff safe.

The structure, processes, policies, culture and people of the EOC will all lend themselves to supporting a sustainable culture of patient safety, offering all 6 elements of a successful safety management system.

- **A safety plan**: A strategic plan and system to identify, eradicate, manage and mitigate risks to patient safety. The EOC will adopt and incorporate the clinical governance and patient safety framework in place at LNWH as the host trust/lead provider for the EOC.
- **Policies, procedures, and processes**: Adopting evidence-based practice and national standards to make care safer and to improve quality of care for all. This includes standards across the whole pathway; for treatment, implant selection, patient preparation, ring-fencing of beds, staffing levels and discharge procedures.
- **Training and induction**: Preparing staff, equipping them with the knowledge, tools and access to perform effectively and to promote patient safety. There is a specific workforce plan for the EOC which addresses this area in detail. A core team of staff will be recruited to the EOC. Surgeons and trainee surgeons and anaesthetists will attend the EOC on a sessional basis from their home trust. Other staff may be offered the opportunity to undertake rotational specialist placements at the EOC in order to disseminate learning, skills and experience. All staff will undergo training and familiarisation to allow them to function fully and safely in the EOC. Training grade surgeons and anaesthetists will be offered training passports with agreement from their school of training and Health Education England in order to ensure that prior learning and experience is recognised and that they are able to take advantage of the full training opportunity of the EOC.
- **Monitoring**: The EOC will commit to and participate fully in all relevant national audit programmes, the national joint registry, clinical surveillance, patient outcomes reporting as well as a local programme of clinical audit and quality improvement. Knowledge and learning will be shared with the EOC teams but also with local trusts for wider dissemination across north west London.
- **Supervision**: Putting training at the core of the EOC offers a strong lever for safety and quality improvement but also introduces an obligation to have a strong focus on supervision. Surgery and perioperative care in the EOC will be consultant led and trainee involvement will be directly supervised with best clinical and training practice. Supervision on ward areas is equally important and the EOC will have a separate and distinct workforce from the host trust so that the clinical pathways remain protected even during times of pressure on other emergency pathways and so that appropriate staffing and skill mix are maintained to allow excellent clinical care but also excellent training and supervision.
- **Reporting**: The EOC will report performance on quality and safety metrics through the LNWH governance structures but a Partnership board from all acute providers will also have oversight. The Acute Collaborative Board in Common with delegated authority to the Quality Committee will receive reports and have ultimate responsibility for the performance, quality, safety and running of the centre.

2. **Effective: Providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit (avoiding underuse and misuse, respectively)**.

Offering treatments that are evidence based and in line with best practice. Twenty-five percent of the total hip replacement types available in the UK do not have any evidence to support their safety or effectiveness. The EOC will offer surgery using only evidence-based implants, highly rated by the Orthopaedic Data Evaluation Panel. Standardised referral pathways and criteria will mean that treatments are offered and targeted to those patients likely to benefit across NWL so that they are more likely to be effective.

3. **Patient-centred: Providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions.**

The patient pathways have been considered and designed to align with best practice but also to allow for some necessary variation and differences, to accommodate patient preferences and choice or where patients have additional needs. While the default model of care will mean that patients who are assessed as ASA1 or 2 will be offered surgery in the EOC, it is recognised that for some patients this may be better provided in their local hospital in order to meet specific individual needs. This is anticipated to be a small number of patients and capacity will be maintained in home/local trusts to accommodate these patients locally. The ethos of the centre is to remain patient centred while offering the best care for all patients.

The development of the EOC is an important and major step in advancing high-quality, equitable and patient – centred care for all across north west London. Bringing this clinical work into one centre of excellence will improve care for patients across north west London. Any change can be worrying for patients or staff and the clinical model recognises that progress to standardising pathways and treatments will be gradual with the potential for ongoing and increased benefits for patients and the service.

A good example of the iterative benefits that will be derived from this centre is that initially, surgeons from individual trusts will operate on and be responsible for patients from their own trusts, with a trust-based patient list. This recognises the need to develop patient and staff confidence in the model. Patient and staff groups have both expressed their anxieties about being operated on or followed up by a surgeon from a different hospital.

The evidence from other established centres suggests that we could obtain even greater benefits in efficiency and for equity by consolidating the waiting lists from all 4 acute trusts into one patient list. This would mean that any surgical team could operate on any patient which would allow operating lists to be planned and scheduled with even greater efficiency and improved equity of access. We recognise however, that confidence in the model, surgeons, colleagues and care are just as important as the evidence for the new model of care and that this will take time to develop. The model of care at the EOC will therefore necessarily develop iteratively over time, responding to the needs and preferences of patients and staff over time. The need for the clinical model to develop over time has been shown by the evolution of the South West London EOC (SWLEOC) over the past 18 years as the largest and most productive UK elective Joint Replacement Centre.

4. Timely: Reducing waits and sometimes harmful delays for both those who receive and those who give care.

Establishing the EOC will increase the surgical capacity to address the existing large patient waiting lists and increased referral rates and patient demand. This is an evidence-based approach which has been successful elsewhere. Current data suggests that this is a national problem and that 'doing nothing' will mean that patients in Scotland who are offered surgery today will wait 7-years before they are offered their surgery. NWL is the last London region to develop this model and the available evidence shows that NWL patients are disadvantaged by a lack of capacity. Research undertaken in NWL shows that those patients who wait the longest periods for their treatment report a deterioration in their health and quality of life. At worst, patients waiting over 39-months for hip and knee replacement reported a quality of life 'worse-than-death'.

Moving the surgery for ASA 1 and 2 patients into the EOC will release theatre, ward and critical care capacity in local home trusts that can then be used to offer more timely treatment for those patients who for reason of more complex conditions, comorbidities or who are sicker or frailer, are not eligible for treatment at the EOC. In this way, access to timely treatment is improved for all.

In addition, the elective centre at Charing Cross Hospital has been commissioned by NHS England as a Specialist Major Joint Revision Centre which will offer further opportunities to streamline pathways and to improve timely access to appropriate care across north west London.

5. Efficient: Avoiding waste, including waste of equipment, supplies, ideas, and energy.

Offering high volume low complexity surgery using this model offers proven efficiencies of scale and has been shown to improve quality and patient experience.

6. Equitable: Providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status.

The benefits in this domain are both progressive and cumulative. Improving the timeliness of access to appropriate care is an early (immediate) opportunity and success. As care standards are driven up to uniformly excellent levels, the full range of treatments will become increasingly and equally accessible for all patients across NWL irrespective of personal characteristics. We anticipate that the maturity and sustainability of improvements in equity will develop as the clinical model develops in response to the needs, beliefs, and preferences of our patients.

Improvement interventions, monitoring and engagement

Improvement interventions and monitoring of outcomes will be continuous and will be supported by active and ongoing engagement with patients and carers as well as staff. Identified themes for monitoring and engagement are detailed below, based on GIRFT criteria for high volume low complexity surgery hubs.

A framework has been developed for the monitoring of benefits realisation with the ICB and the four acute trusts. This includes metrics, target improvement and expected milestones for achievement, as shown below.

Benefits Realisation Plan: targeted improvement on key performance indicators

KEY

Activity to remain within home hospitals	Non-LNWH day cases, and ASA 3 and 4 activity, spinal, paediatric and out of area activity. Parallel monitoring to be undertaken across the system for both access and outcomes by the Shadow Partnership Board and through North West London Acute Provider Collaborative quality governance. * Note LNWH day case waiting list will also be monitored by the EOC as part its performance monitoring.
Year 1	12 month period beginning November 2023.
Year 2	12 month period beginning November 2024.
New and developmental KPIs.	Note – some of the additional KPIs relating to transport and patient satisfaction are of necessity work in progress and will need to be baselined prior to opening.

Benefit Description	KPI theme	Expected benefits	Baseline	Target improvement	By when	Owner
Productivity	Average length of stay - hips	Improved productivity	3.1 – 4.1 days (Model Health - 12 months to end Q2, 2022/23)	Top decile 2.3 days	Year 2	EOC Medical Director
	Average length of stay - knees	Improved productivity	3.2 – 5.7 days (Model Health - 12 months to end Q2, 2022/23)	Top decile 2.3 days	Year 2	EOC Medical Director
	Cases per list – Inpatient	Improved productivity	1.3 – 2.5 cases per list for mixed lists across NWL hospitals (Combined T&O - Model Hospital 2022/23)	2 cases per 4 hour list	Year 1	EOC Medical Director
	Cases per list – Day Case	Improved productivity		5 cases per 4 hour list	Year 2	EOC Medical Director
Cost-Effectiveness	Cost per Weighted Activity Unit – All planned Orthopaedic activity	Better use of resources	£368	£351 (2nd Quartile)	Year 2	EOC Managing Director
	Cost per Weighted Activity Unit –Ortho-paedic inpatients and day case activity	Better use of resources	£3,569	£3,1633 (2nd Quartile)	Year 2	EOC Managing Director

Benefit Description	KPI theme	Expected benefits	Baseline	Target improvement	By when	Owner
Clinical Outcomes and Experience	Patient reported outcomes PROMS - Oxford hip score	Improved patient satisfaction	3rd Quartile Health gain 21.807 - 23.278	2nd quartile	Year 2	EOC Medical Director
	Patient reported outcomes PROMS Oxford knee score	Reduced burden on primary care	4th quartile Health gain 14.179 - 17.685	2nd quartile	Year 2	EOC Medical Director
	Patient reported outcomes PROMS - Oxford hip Eq5d	Improved patient satisfaction Reduced burden on primary care	3rd quartile Health gain 0.416 - 0.480	2nd quartile	Year 2	EOC Medical Director
	Patient reported outcomes PROMS - Oxford knee Eq5d	Improved patient satisfaction Reduced burden on primary care	3rd quartile Health gain 0.288 - 0.347	2nd quartile	Year 2	EOC Medical Director
	30 day readmission rate - hips	Improved productivity Better out-comes	1.6% – 12.5% (MH - 12 months to end Q2, 2022/23)	Top quartile 4.5%	Year 1	EOC Medical Director
	30 day readmission rate - knees	Improved productivity Better out-comes	2.5% – 12.1% (MH - 12 months to end Q2, 2022/23)	Top quartile 4.5%	Year 1	EOC Medical Director
	Cancellation for (a) clinical reasons	Improved patient satisfaction Better use of resources	1.8% - 3.5% (MH - 12 months to end Q2, 2022/23)	1%	Year 1	EOC Medical Director
	Cancellation for (b) non-clinical reasons	Improved patient satisfaction Better use of resources	3.1% - 8.2% (MH - 12 months to end Q2, 2022/23)	2%	Year 1	EOC Medical Director
	Cemented hip implants > 70 years old	Better out-comes	68.1% - 76% (MH - 12 months to end Q2, 2022/23)	2nd quartile	Year 2	EOC Medical Director
	5 year revision rate - hips	Improved patient satisfaction Reduced burden on primary care Better use of resources	3rd quartile 1.0%	Top quartile 0.5%	Year 6	EOC Medical Director
	5 year revision rate - knees	Improved patient satisfaction Reduced burden on primary care Better use of resources	4th quartile 2.0%	Top quartile 1.0%	Year 6	EOC Medical Director

Benefit Description	KPI theme	Expected benefits	Baseline	Target improvement	By when	Owner
Patient Access	Reduction in EOC waiting list size for High Volume Low Complexi-ty inpatients	Improved patient satisfaction	Waiting list size as at December 2022.	Reduction of of ~38% by October 2025 Year 2		EOC Managing Director
	Reduction in waiting list size for Low Volume High Complexity inpatients	Improved patient satisfaction	Waiting list size as at December 2022.	Reduction of of ~36% by October 2025		Acute Provider Collaborative
	Reduction in waiting list size for NWL sector day cases*	Improved patient satisfaction	Waiting list size as at December 2022.	Reduction of of ~57% by October 2025		Acute Provider Collaborative
	Reduction in EOC waiting time for High Volume Low Complexity inpatients	Improved patient satisfaction	Waiting list size as at December 2022.	Reduction of ~9 weeks by October 2025		EOC Managing Director
	Reduction in waiting time for Low Volume High Complexity inpatients	Improved patient satisfaction	Waiting list size as at December 2022.	Reduction of ~9 weeks by October 2025		Acute Provider Collaborative
	Reduction in waiting time for NWL sector day cases	Improved patient satisfaction	Waiting list size as at December 2022.	Reduction of ~9 weeks by October 2025		Acute Provider Collaborative

Benefit Description	KPI theme	Expected benefits	Baseline	Target improvement	By when	Owner
Transport	Analysis of patients who DNA	Reduced DNAs		% DNA rate reduction As a subset: % DNA rate reduction of patients who live at long distance/ ++age Target improvement to be agreed by the EOC Management Board and the Shadow Partnership Board.	Year 2	EOC Estates and Facilities Lead
	Continuous review of PTS	Improved access to PTS amongst eligible patients	Baseline to be determined prior to opening.	12% of overall EOC patients who were able to access PTS took up the service. Review assumptions at end of Year 1.	Year 1	EOC Estates and Facilities Lead
	Patient friends and family test	Improved patient satisfaction	Baseline to be determined prior to opening.	Top quartile	Year 2	EOC Estates and Facilities Lead
Patient Satisfaction	Volume and nature of patient complaints	Reduction in number and scope of complaints	Baseline to be determined prior to opening.	Tbc	Year 1	EOC Director of Nursing
	Qualitative patient survey	Improved qualitative assessment	Baseline to be determined prior to opening.	Tbc	Year 1	EOC Director of Nursing
	Qualitative patient feedback	Improved patient satisfaction		Target improvement to be agreed by the EOC Management Board and the Shadow Partnership Board, based on EOC Operational Management Group recommendations Baseline position to be determined based on data for period six months prior to opening the EOC, with initial post-opening survey six months after opening and then continuing six monthly thereafter.	Year 2	
Workforce Impact	Staff satisfaction	Staff engagement	6.9	7.0 (Top quartile, NHS Staff Survey)	Year 2	EOC Director of Nursing
		Staff morale	5.7	5.9 (Top quartile, NHS Staff Survey)	Year 2	EOC Director of Nursing
	Staff recruitment and retention	Low vacancy rates and low turnover	TBC	10% (Agreed by Workforce Workstream)	Year 2	EOC HR Lead

(Source: Decision-Making Business Case DRAFT, 2023)

On-site Facilities and delivery of the clinical model

The clinical model will be delivered at the CMH site which will be expanded to 5 state-of-the-art operating theatres with laminar flow facilities. Currently London north west University Hospitals NHS Trust (LNWH) uses 3-operating theatres to deliver elective orthopaedic surgery including some day surgery cases, this includes patients assessed as ASA3. It is proposed that with the development of the EOC, LNWH will continue to offer surgery for patients graded ASA3 and for some day case procedures. The supporting infrastructure and critical care support is already in place to allow this. Patients being treated by teams from the other 3 trusts will be ASA 1 and 2 only. ASA 3 and 4 patients will undergo treatment locally in their home trusts. The site provides a small number of level 2/3 beds suitable to support the existing ASA 3 patient activity undertaken by LNWH and this can be made available in the unlikely event that an ASA 1 or 2 patient requires a short period of additional support/monitoring. Otherwise, there are well-rehearsed pathways to transfer patients who deteriorate unexpectedly or who require additional support or care to Northwick Park Hospital.

The model for delivery of care will be agreed by the EOC Programme Board and ratified by the Acute Programme Board. The aim is to offer maximum benefits of the new EOC for patients across NWL while avoiding anything that would destabilise LNWH. Four options have been considered.

a) Each Acute provider trust will assume the running of the EOC for a two-week period, scheduling and delivering surgery using all 5 operating theatres with surgical teams attending from the local home trust.

b) LNWH will use one theatre at the CMH to provide ASA 3 and day case surgery and each of the other 3 acute providers will assume the running of the other 4 theatres for a 2-week period.

c) **LNWH will use one theatre at the CMH to provide ASA 3 and day case surgery. Each of the acute providers will assume the running of one of the other 4 theatres each day to deliver planned ASA 1 and 2 patient activity in the EOC. This will allocate 2 operating theatres to LNWH each day and one each to Chelsea and Westminster Hospital NHS Foundation Trust, Imperial College Healthcare NHS Trust and Hillingdon Hospital NHS Foundation Trust.**

d) LNWH will continue to operate out of 3 operating theatres at the CMH while theatre sessions in the other 2 operating theatres will be scheduled and booked on a rotational basis for the other 3 trusts.

Option C is preferred and judged to maximise the benefits of the EOC without destabilising LNWH; efficiencies of scale; bringing teams from across NWL on-site together as a step to closer working, improved quality and safety outcomes; allowing for the development of regular processes, routines and teams working together.

All options will require adjustments to be made to team job plans and these will be agreed through local trust job planning in the first instance. It is recognised that there will be a need for recruitment to achieve the aims of the EOC and it is important to be clear that this model represents an increase in capacity across NWL with obvious benefits rather than a simple transfer of existing work.

Workforce

North west London ICS has set out a People Plan, the vision sets out that our people are able to provide great care for our patients and communities because they have the skills, tools and capacity to do their job and the environments they work in are inclusive and supportive.

To support the achievement of the People Plan goals, the APC has set out its

People Priorities :

1. Safe and sustainable staffing to reduce vacancies, turnover and premium rate temporary staff.
2. Workforce redesign to support new models of care and new ways of working.
3. Maximising the use of new roles.
4. Developing the collaborative as a great place to work and London's acute employer of choice.
5. Improving HR services effectiveness, efficiency and impact.
6. Building more equitable and fair organisations (across the North West London ICS).
7. Improving the health and wellbeing of our staff (across the North West London ICS).

The workforce model for the elective orthopaedic centre forms part of the workforce redesign priority for the sector. The model aims to provide the elective orthopaedic surgical teams with the skills and structures to deliver new clinical models of care; operate in agile ways using technology and transform operating models for support services.

Elective Orthopaedic Centre Workforce Model

The elective orthopaedic centre will become a centre of excellence by bringing together surgical teams from across north west London to work together to deliver high-quality care. The centre's workforce model focusses on ensuring continuity of care for patients, the opportunity for continuous improvement that can be shared across all contributing hospital teams and enhanced training and teaching opportunities across all disciplines. The scale of the centre and expected number of patients sets a solid foundation for staff to thrive and work together as a team to reduce unwarranted variation in practice, improve clinical outcomes and share their learning and best practice with teams at their home hospitals.

Consultant and anaesthetist staffing model

Each of the four acute trusts will review their funded consultant establishment. Formal team job planning will be required for each team and the new model of care will almost certainly require a reorganisation of the working patterns and structures for consultants. It is recognised that this represents an expansion of capacity across north west London and as such, following job planning, it is anticipated that additional recruitment may be required. Consultants will be responsible and job-planned to contribute to governance at both the EOC and in their home trusts which will facilitate sharing of best practice between the EOC and he home trusts and teams.

Medical non-consultant

Training grade junior doctors will remain based at their home hospitals and will work at the EOC using passporting arrangements agreed with Health Education England., The team will have the opportunity to train within a dedicated surgical centre alongside a team of expert clinicians and dedicated specialist support staff. In addition to training grade doctors, the EOC will provide 24-hour resident medial cover. These posts will be recruited directly to the EOC.

Nursing staffing model

There will be a dedicated nursing team at elective orthopaedic centre that are trained and skilled in orthopaedic care. The team will work collaboratively within the MDT with oversight from the host trust for professional management and support. The centre will enable teams from local home trusts to work collaboratively with them. The centre will offer educational and rotational placement programmes as it is recognised that both support staff retention, provide an attractive opportunity for those looking to develop their skills and support the ethos of continuous improvement by bringing experience and best practice from home hospitals to the centre and vice versa.

Administrative and Clerical model

There will be a dedicated administrative and clerical team to support EOC patients through their patient journey. This will include booking patients in for their surgery and providing information about the centre, its location and how to get there, signposting patients who need additional support with transportation to the appropriate resources, supporting with coordination and booking of pre-surgery appointments and tests and post-surgery follow-up appointments at the appropriate location. The team will be recruited by the host Trust and managed accordingly, they will work in collaboration with the EOC MDT team and also with their peers at referring the referring trusts to ensure patients have a seamless journey through the centre and back to their local trust.

Allied Health Professionals

A dedicated team will be recruited to support patients during perioperative treatments and immediate recovery, assessments before discharge and liaison with community support if required. The team will work closely with the MDT and with their peers in referring hospitals to ensure a seamless patient journey. The team will also work collaboratively with community MSK teams to ensure patients who need it are supported close to home with any further care needs.

The workforce model has been developed collaboratively with the multidisciplinary service clinical leads, built up on activity modelling and outcome requirements that deliver GIRFT standards for all patients, following GIRFT Best Practice Pathway and NICE guidance. The workforce model will be reviewed throughout the development and implementation of the workforce plan to ensure that it remains the optimal model to deliver the desired outcomes.

As a true centre of excellence, the elective orthopaedic centre will attract the best and brightest talent to work in north west London. This innovative care model, with potential for a range of new roles and ways of working will help to embed best clinical practice and to support ongoing professional development, offering challenging careers with growth opportunities and the right environment to develop real excellence and expertise among the multidisciplinary team. This will directly support staff recruitment and retention. Ensuring the elective orthopaedic centre is part of an integrated, end-to-end pathway together with the other north west London hospitals providing orthopaedic surgical care and with primary and community care partners, will help with wider staff recruitment and retention too.

There are potential advantages for the wider system also. Over time, we anticipate that the EOC will be able to support and offer rotations and placements for nurses and allied health professionals from across the acute provider and community trusts/partners which will help to develop a better understanding of the whole patient pathway for clinicians as well as supporting the development and dissemination of specialist knowledge and skills across the region.

Staff experience

The developing workforce plan for the north west London elective orthopaedic centre aims to support positive staff experience by providing an environment that is purpose built with provisions for staff wellbeing, multidisciplinary team education, training and innovation and supports efficient patient flows. The elective orthopaedic centre will have a dedicated management team to provide staff with senior support and oversight on a day-to-day basis and will be further supported by the host trust's leadership team. The opportunity for teams across the eight hospitals to attend the centre for learning and training opportunities will further boost staff experience, not just for the EOC staff, but also for their peers at referring hospitals.

The impact of the workforce model that we would hope to see would include:

- Development of consistent ways of working together with north west London-wide clinical protocols driven by the orthopaedic network
- Successful recruitment and retention of staff at the centre and in home hospitals
- Reduced staff sickness and absence rates at the centre
- Development of new roles where appropriate, which are likely to include advanced clinical practitioners and care navigators
- Low bank and agency staff reliance
- Development of north west London support networks including system-wide multidisciplinary team working structures and defined escalation pathways to access clinical expertise for complex patients
- development of a north west London-wide recruitment strategy for orthopaedics that includes education and rotation opportunities for staff to develop enhanced skills and specialisation in orthopaedic care

Training, Education and Research

This innovative model of care has been shown to offer significant opportunities and benefits for training. Consolidating large volumes of routine elective surgery allows for excellent whole team routines, skills and relationships to be developed that enhance the training environment and make care consistently more efficient and safer.

Training is at the core of good care and the provision of an expert workforce for the future. Orthopaedic specialty trainees will work and operate with and under the supervision of their normal clinical supervisors as part of the home trust surgical team, travelling to the EOC for theatre operating sessions.

In order to achieve this, they will need the usual digital, site and electronic access and permissions to allow them to function. This will be achieved through liaison with HEE and LNWUH to agree training passports for this group of doctors. Training standards and expectations will be identical to those provided in the home trust with the expectation that a trainee can operate under the supervision of their consultant trainer within their competence.

The large volume of joint arthroplasty provides significant opportunities for the development of skills and training in regional anaesthesia as well as general anaesthesia in a fit and healthy (ASA 1 and 2) patient population. The clinical workstream team will explore with the School of Anaesthesia for HEE how these opportunities can be best developed and used.

In addition, the EOC offers considerable opportunities for training and to develop real expertise and confidence for nurses, theatre operating department practitioners, physiotherapists and other allied health professionals. Clinicians have the opportunity to grow and develop in conventional roles working in a specialist environment or to develop advanced skills working more broadly in extended roles that support this innovative pathway such as advanced nurse practitioners supporting ward care, reporting radiographers, consultant or advanced practice therapists etc

This flexibility and opportunity will help to address the recognised challenges of recruitment to 'hard-to-fill' roles, will offer the professional and career challenge and development that supports staff retention and satisfaction. We will, through the north west London Health Academy, utilise, develop and design training and skills programmes with the partnership skills providers to upskill existing staff, and consider the use of alternate roles. There are a number of courses currently available ranging from diploma to masters level across nursing; physician associates; MSK ultrasound; advanced clinical practice, physiotherapy, operating department practice, and a number of entry level apprenticeship courses.

In addition, the volume of clinical work undertaken in the EOC provides opportunities for clinicians from home trusts and community partners to undertake placements at the EOC to develop their understanding of the whole patient pathway and to upskill and to develop competences and confidence that can be shared across providers to improve the clinical skills, knowledge and quality of care across north west London.

Placing training as a core element and expectation will encourage the EOC to continue to aim for the highest standards, to remain reflective and responsive to change, progress and challenge and to embrace true multidisciplinary working. Our commitment to provide an excellent environment for training will help to make the EOC a great place for all to work, supporting our recruitment, retention and staff wellbeing. The positive impacts of all of these for patient safety are well recognised.

The development of the NWL EOC has been discussed by and is supported by the national Specialist Advisory Committee for Trauma and Orthopaedic surgery, the body with delegated authority for training in trauma and orthopaedic surgery on behalf of the Joint Royal Colleges of Surgery and the Joint Committee for Surgical Training. The model and proposal is endorsed and felt to offer significant opportunities for improved training with the caveat and requirement that the centre should achieve the GIRFT standards for training in surgical hubs.

Recent data shows that trainees and training in trauma and orthopaedic surgery have been disproportionately affected by the covid-19 pandemic and reduced elective surgery volume. The specialty has the largest proportion of 'outcome 10' assessments at trainee annual competency assessments, where trainees have not been able to achieve the expected standards of operating because of the impact of the covid pandemic. The EOC will offer an important solution for this problem in north west London and will provide future trainees with high volume training in a supervised high volume performance environment.

The model for training has been discussed in more detail with and will be developed in collaboration with Health Education England. The clinical cabinet and workstream have been working with the Schools of Surgery and Anaesthesia to do this and will continue to regularly engage with them as the EOC programme progresses. In addition, the clinical cabinet have agreed to recruit trainee representatives to join the clinical, training and workforce workstreams in order to add their insights. The intention is to place training at the heart of the EOC.

This support is caveated with the requirement for the EOC to be designed and established in line with the GIRFT accreditation criteria which put training at the heart of the centre. The NWL ICB have made this commitment which will benefit clinical training for all specialties and will also support high-quality care.

GIRFT HVLC criteria for hub accreditation including training

Headline criteria	Core elements of headline criteria	What we will be looking for	Evidence	CQC KLOE
1. Dedicated & ring-fenced clinical and operational teams	1a. Robust clinical staffing model	Clear rotional or permanent clinical staffing model in place Staff vacancy rates are low Hub has, or aims for, 80% substantive staff across all staff groups and on a rolling monthly basis Hub review the number of additional hours that staff work to ensure staff well being	Self-certification Rotas Vacancy data Copy of plans	Effective
	1b. System in place to enable staff to work effectively at hub sites and to move efficiently between hubs	Passporting process & rotational models fully embedded Induction processes are in place for all staff, including these from other sites and visiting clinicians	Related policies Conversations with staff during site visit Self-certification	Effective
	1c. Robust ring-fencing applied to hub staff	Chief Executive/Exec Tripartite decision required for breaking of ring-fence of hub staff Winter/emergency pressures plans in place to avoid hub cancellations	Self-certification Conversation with staff during site visit Copy of plans	Effective
	1d. Effective strategy to address future staffing issues & robust staff management processes	Plans to address recruitment and retention in place (e.g. networking with neighbouring hubs, rotational or innovative posts) Plans for sole-development and ongoing training Robust staffing processes such as appraisal, disciplinary etc.	Self-certification Copy of approach and results Copy of plans Copy of policies	Safe
2. Supported training of junior doctors & wider MDT	2a. There are regular, scheduled, training opportunities at the hub for junior doctors, including fellows	Dedicated training operating lists to agreed GIRFT rations (e.g. 8 cataracts per training list v 10 non-training list)	Example theatre lists Model hospital data Conversations with staff during visits	Effective
	2b. Hub staff offered regular, relevant continued professional development (CPD) opportunities	Systematic training opportunities in place for relevant hub staff	Training records	Effective
3. Strategy & approaches that promote staff well-being	3a. Staff have access to necessary basic facilities and services	There is sufficient parking and transport arrangements for staff not permanently based at the hub Staff access to a dedicated area for breaks/ lunch There is lockable storage and changing facilities are available for hub and non-hub staff Smart card/relevant logon information for staff not permanently based at the hub is collected in a timely way	Observation during visit Conversations with staff during site visit Self-certification	Effective
	3b. Staff feel safe in their work environment	Necessary estates safety checks carried out Outdoor areas and parking is well lit	Self-certification Observation during visit	Effective
	3c. Staff feel valued and respected in their work environment	Evidence of regular engagement with staff at all levels with evidence of actions taken to address suggestions and comments Good levels of staff satisfaction	Self-certification Examples of impact Vacancy, sickness and turnover rates Trend data	Effective

Clinical Governance Overview

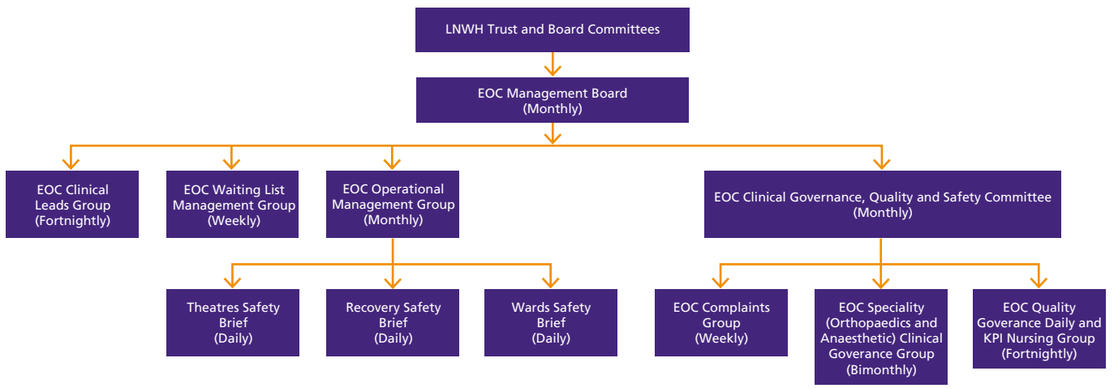
Summary of arrangements

Operationally, the elective orthopaedic centre will be run by LNWH as a stand-alone business unit with its distinct budget, cost centre and service line reporting. In a similar fashion to the LNWH clinical divisions, for governance purposes the elective orthopaedic centre Management Board will report to the Trust Executive Group and upwards to the Trust Board. The elective orthopaedic centre senior leadership team will be members of the Trust Executive Group, and the existing LNWH divisional governance framework will be mirrored by the elective orthopaedic centre.

Clinical leadership will be provided by a medical director and nursing director, the medical director will chair a representative clinical council/management board which will include multidisciplinary representatives from partner trusts. This will be the primary management group for the EOC tasked with delivering the strategic goals of the centre.

The Elective Orthopaedic Centre Clinical Governance, Quality and Safety Committee maintains oversight of the governance, quality, safety and patient experience activities of the elective orthopaedic centre. It will review reports on a variety of incidents, providing the opportunity to share the recommendations and learning derived from incidents. The Committee will review and maintain the elective orthopaedic centre risk register, review and ratify SOPs, policies and guidelines, review and monitor key performance and quality indicators, and provide a platform for discussing performance and celebrating innovation and success. The attendance will consist of the elective orthopaedic centre leadership triumvirate, representation from the medical, nursing, therapies, management and the governance team.

The EOC will put in place a strong clinical governance framework to support the drive to improve clinical and quality patient outcomes and the patient experience, to maximise efficiency and financial sustainability and to deliver excellence. A culture of continuous learning and improvement will help us to recognise and address any unwarranted variation and poor outcomes early on and to improve the care and access to excellent care that we provide for all patients across north west London. The proposed governance structure is below:



Source: Decision Making Business Case DRAFT, 2023

Proposal developed by
NHS North West London Acute Provider Collaborative
nwl-acute-provider-collaborative.nhs.uk

Supported by
NHS North West London Integrated Care Board

March 2023