Improving planned orthopaedic inpatient surgery in north west London

Pre-consultation business case executive summary

Proposal developed by
NHS North West London
Acute Provider Collaborative

Supported by
NHS North West London Integrated Care Board

Executive summary

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 – have worked together increasingly closely throughout the response to COVID-19.

Emerging from the COVID-19 pandemic, the trusts have been developing a more strategic approach to their planned care recovery, aligned to the wider North West London Integrated Care System strategy. In addition to restoring capacity and tackling long waits, they are seeking to address underlying, shared challenges by improving the quality, equity, efficiency and sustainability of their planned care for the long term. They want to make better use of their collective resources and support each other to identify, adopt and embed best practice consistently.

The four trusts – who came together formally as an acute provider collaborative in July 2022 – have been building on the benefits of a number of 'fast track surgical hubs' they established during the pandemic. These were facilities within their hospitals that focused on specific, routine operations separated as far as possible from urgent and emergency care. This meant that operations were less likely to be put on hold when there was pressure on emergency services. In addition, evidence built over many years show that when this type of surgery is undertaken frequently, in a systematised way, there is an improvement in both quality and efficiency.

Following significant engagement and exploratory work, the North West London Acute Provider Collaborative is now proposing the development of a dedicated elective centre for orthopaedics, a specialty with some of the longest waits and widest variations in performance.

The elective orthopaedic centre would bring together low complexity, inpatient orthopaedic surgery for the population of north west London in a purpose-designed centre of excellence at Central Middlesex Hospital, completely separated from emergency care services. This means that:

- patients would have faster and fairer access to surgery and would be much less likely to have their surgery postponed due to emergency care pressures
- care would be of a consistently high quality, benefitting from latest best practice and research, provided by clinical teams that are highly skilled in their procedures
- the centre would 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 other north west London hospitals by the consolidation of low complexity surgery in the elective orthopaedic centre would be released for surgical patients who have more complex needs and for other specialties.

Purpose of the pre-consultation business case

This pre-consultation business case sets out the:

- detailed rationale for an elective orthopaedic centre
- proposed clinical model and how it was developed
- process for selecting the best scope of care and optimal location for the centre
- approach to public and patient involvement and how it has shaped the development of the elective orthopaedic centre so far
- plans for implementing the proposal if it is decided to go ahead
- contribution that the elective orthopaedic centre will make to financial sustainability in north west London
- approval process and next steps.

The key challenges for elective orthopaedic care

There are six key drivers for change:

- **Growing demand and increasing waiting times**

Over 15,000 people were waiting for all types of orthopaedic care in north west London hospitals as at the end of September 2022, including just under 200 patients waiting for orthopaedic surgery for longer than a year. 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.

Without intervention, the north west London orthopaedic waiting list will continue to grow faster than the capacity to provide care. This will become particularly challenging over the next few years, as modelling shows that the number of people needing orthopaedic surgery in north west London will increase by almost 20 per cent by 2030, growing the waiting list by more than three times.

- **Population health challenges, including large health inequalities**

Musculoskeletal (MSK) disorders are the third leading contributor to the burden of disease in Greater London. MSK conditions are also one of the most common co-morbidities for the most deprived 20 per cent of the population. People from areas of high deprivation and older people are over-represented on waiting lists for elective orthopaedic care at a time when there is growing awareness of the importance of reducing health inequalities.

- **Underperformance against key quality indicators, wide variations in quality and disruption to planned care caused by surges in unplanned care**

Performance against national indicators for outcomes and experience in elective orthopaedic care in north west London is among the best, for some measures in some trusts. But there is significant potential for improvement in all of the trusts and a high degree of unnecessary variance between trusts. Across all measures and all trusts, the north west London average national performance ranking is third quartile.

Further variation – and room for improvement – can be seen in a review of wider quality indicators, including for access and operational performance. Of note is the relatively poor performance in terms of the cancellation rate for elective care which is often directly connected to the impact of surges in unplanned care on sites which provide both elective and urgent and emergency care.

- **Insufficiently joined-up care across primary, community and acute services and care that is not sufficiently focused on the needs of the patient**

NHS acute trusts in north west London receive generally positive feedback from patients about their planned orthopaedic care, especially 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 orthopaedic surgery 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. Previous engagement has shown elderly or disabled patients often say travel to appointments is a problem. Patients also highlight communication problems, such as a lack of coordination between GPs and hospital services or confusing information.

- **Unnecessary variations in theatre utilisation and downtime**

Theatre utilisation varies between 76 per cent and 93 per cent, while average cases per session range from 1.15 to 1.96.

- **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 the need to provide a greater range of training and career development opportunities as well as more flexible working and more resilient cover.

How an elective orthopaedic centre will help address the key challenges

As highlighted by the national GIRFT (Getting It Right First Time) programme, there are three key ways of improving quality and productivity for high volume low complexity surgery. These are by:

- separating elective and non-elective surgery
- ensuring ‘right procedure, right place’ and increasing day case surgery rates
- improving the utilisation of assets, increasing theatre productivity and creating more efficient care pathways.

The elective orthopaedic centre model proposed incorporates changes that will deliver improvements in all three of these areas. These anticipated improvements have been modelled against anticipated demand to show that the orthopaedic waiting list backlog in north west London would be reduced significantly.

In addition, quality performance in existing NHS elective orthopaedic centres is significantly better than the current performance for north west London as a whole, indicating the potential for adopting a similar model here.

In terms of population health, while many of the levers for preventing and mitigating MSK disorders sit outside the control of acute hospitals and even the wider NHS, the elective orthopaedic centre would deliver benefits (of faster, higher quality care) particularly to older patients and patients from more deprived backgrounds who have proportionately more demand for elective orthopaedic care. This may be directly through the elective orthopaedic centre itself or by freeing up more orthopaedic surgery capacity on sites where patients with more complex needs can be treated.

The elective orthopaedic centre model also brings significant workforce benefits. For staff, there are new types of role and career progression as well as extended training and education opportunities. And for the service, there are opportunities for increasing the resilience of cover as well as overall efficiency from more standardised ways of working based on evidenced best practice.

The proposed clinical model and how it was developed

The proposed elective orthopaedic centre is intended to be part of an improved end-to-end pathway for musculoskeletal disorders, as shown by Samira’s case study. Work exploring the potential for an elective orthopaedic centre has benefited from an opportunity to align improvements in planned acute care with a review of the wider musculoskeletal pathway being led by North West London ICB.

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

This is an example of how the pathway would work in practice. After having had hip pain for a few months and with a family history of arthritis, Samira, aged 70, makes an appointment with her GP.

After a discussion, Samira and her local GP decide to ask for advice from a hospital specialist, booking her in for an x-ray at a local community diagnostic centre to help inform that review. Her GP also puts her in touch with the local community musculoskeletal service to consider any immediate help, such as physiotherapy or 'social prescribing', for example to exercise classes.

Samira is able to keep track of her appointments and consultations via a secure app on her phone. She also uses the app to access exercise videos and record her symptoms. She gets a message to book an online appointment to speak with her GP and a surgical specialist from a local hospital – they are all able to see her x-ray – and they decide she doesn't yet need a hip replacement but that she should be closely monitored.

After two years, Samira's GP and hospital surgeon let her know that her latest x-ray and online symptom tracker show that she should now consider a hip replacement. It is a routine replacement and she is in good health. So, she is able to book in her surgery at the elective orthopaedic centre for 12 weeks later. While she waits, she is asked to take part in 'joint school' – a mix of advice and support online and in-face at her local hospital – to help ensure she has the best possible outcome from her surgery.

Samira has her hip replacement under the case of the surgeon from her local hospital and goes home after a short stay. She is booked in for an immediate programme of physiotherapy and rehabilitation – a mix of online and in face support at her local hospital.

Samira is able to ask for further review and advice from her local hospital specialist if and when she feels she needs it. Longer term, she continues to take part in an online programme of exercise and advice and benefits from periodic physiotherapy support.

The model draws on extensive best practice, from north west London and nationally. This includes guidance from NICE and best practice recommendations from the national GIRFT programme.

It has taken financial, activity and workforce considerations into account. It also draws on an Equalities and Health Impact Assessment (EHIA) and an Integrated Impact Assessment (IIA), incorporating actions to improve equity and to mitigate negative impacts – most significantly, increased travel times.

The clinical model makes best use of the wide range of expertise and facilities of all four acute trusts and maintains planned orthopaedic surgical services on all of the hospitals that currently provide these services (see map opposite).

Current provision of planned orthopaedic care in north west London

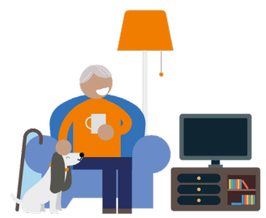
*Not including pre-operative assessment

The centre would bring together elective, inpatient orthopaedic surgery for adult patients with an ASA[1] classification of 1 or 2 (low complexity – no or only mild systemic disease). Patients who need day case surgery or more complex surgery or who have additional health risks would be offered surgery in whichever of the north west London hospitals currently providing orthopaedic surgical care is suitable for their needs.

Whichever surgical service they have, their end-to end surgical care would 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 would travel with them to undertake the surgery, supported by the centre's permanent support team.

1 The physical status of the PATIENT as recorded by an anaesthetist for the operative procedure. This is the American Society of Anesthesiologists (ASA) Physical Status Classification System.

North West London elective orthopaedic centre model of care

Patient has concerns or symptoms	Specialist advice and review	Pre-operative assessment	'Prehabilitation'	Surgical care	Discharge	Post operative review	Rehabilitation
GP/community	Discussion with GP or community MSK team to decide whether to seek specialist advice and/or review (virtual where possible) Provide immediate self-care advice and support	 Advice/discussion to agree next steps, including diagnostics at local community diagnostics centre (virtual/ face to face) Discussion to agree need for surgery and book pre-operative assessment at 'home' orthopaedic hospital (virtual where possible)					Second post operative follow up	Community physiotherapy
'Home' orthopaedic hospital		Patient assessed – booked in for elective orthopaedic centre surgery if needs in scope (virtual where possible)	Joint school and other information and preparation for surgery – mix of virtual and face to face at 'home' orthopaedic hospital		 Planning and preparation for rehabilitation and discharge		Six-week post operative follow up	Six – 12 month 'patient initiated follow up'
Elective orthopaedic centre				Surgery undertaken by 'home' orthopaedic surgeon with specialist elective orthopaedic centre team – with flexible scheduling to maximise theatre utilisation Immediate physiotherapy		Specialist outreach support		

The 'home' orthopaedic hospital refers to whichever of the north west London hospitals currently providing orthopaedic surgery the patient chooses, generally their nearest one.

Process for selecting the best scope of care and where the centre is best located

The process for assessing and selecting a preferred option is an important step before public consultation. The options selection process addressed two questions:

- which care pathways should be incorporated within the elective orthopaedic centre
- where should the elective orthopaedic centre be located

There were eight long list options for care pathways set out for evaluation:

Table 1: Summary of service options to deliver the principle of an elective orthopaedic centre

Option	Description
Option 0	Do nothing – Retain the current model of distributed elective orthopaedic surgery across the north west London catchment area.
Option 1	Do nothing plus – Option 0 plus orthopaedic joint weeks* (based on proof of concept currently being undertaken).
Option 2	Do minimum – Option 1 plus return to 'business as usual' activity levels pre COVID-19.
Option 3	All north west London elective orthopaedic inpatient activity but no day cases.
Option 4	Host hospital orthopaedic day cases and elective inpatients + north west London hip and knee joint replacements.
Option 5	Host hospital orthopaedic day cases and elective inpatients + all north west London orthopaedic elective inpatients.
Option 6	Host hospital orthopaedic day cases and elective inpatients + north west London orthopaedic day cases and elective inpatients.
Option 7	Host hospital orthopaedic day cases and elective inpatients + north west London day cases and elective inpatients + NHS day cases and elective inpatients currently treated in the private sector (the latter applies to this option only).

By assessing each of these options against agreed investment objectives and critical success factors, this was shortlisted to five options:

Option 1 - This option scored low. There is limited evidence currently of the benefits of joint weeks, as they tend to have a detrimental effect on productivity in the weeks before and after. It was, however, the most appealing of the 'Do nothing' options as it offered more potential for productivity improvements than returning to business as usual which was less credible as a baseline comparator option.

Option 4 - This option delivers improved clinical outcomes for the patient cohort it serves. It largely meets the objectives of improved access, equality and productivity for that cohort, and offers an opportunity for staff to work in a centre of excellence. It also largely meets the national and sector strategic agenda. It scores lower than other options because it does not fully meet investment objectives or critical success factors, other than improved clinical outcomes, because it benefits a more limited cohort of patients.

Option 5 - This was the highest scoring option, delivering improved clinical outcomes to the patient cohort it serves. It fully meets all critical success factors, meeting the national and sector strategic agenda whilst being deliverable within the expected resource. This was the only option that was considered to be value for money given that the projected level of activity within scope of this option is deliverable within the currently available NWL estate.

Option 6 - This option, while fully or largely meeting the objectives and fully meeting the national and sector agenda and being broadly supported by partners, was considered only partially affordable or deliverable given the size of the capacity required. It was considered likely that there is no location that could be identified that could reasonably or affordably provide the capacity required.

Option 7 - The advantages and disadvantages of this option were similar to Option 6, but scored lower against two criteria. It was considered unachievable within the required timeframe because of the complexity of untangling existing arrangements with providers and was also considered more complex in terms of governance. As with Option 6, it was considered likely that there is no location that could be identified that could reasonably or affordably provide the capacity required.

Each of these shortlisted options were then assessed against a list of weighted evaluation criteria. The results of the final service evaluation show that the preferred service option is Option 5 which scored higher than the other options. This is driven by:

1. **Quality of care and safety** – Option 5 is marginally better because wider evidence base of success with other centres of excellence.
2. **Workforce** – Recruitment better with centres of excellence, although there is a tipping point beyond which the benefits of consolidation are eroded where other sites risk becoming denuded, for example, for trauma. This will be addressed in the workforce model.
3. **Operational sustainability** – Currently, north west London does not have a fully hypothecated workforce across the system for elective and emergency orthopaedic surgery. There are underlying workforce gaps. A relatively much larger centre would create less flexibility if located in hospitals that have A&E and trauma which may have to repatriate surgeons to maintain core services in the originating hospitals.

There were ten main long list options for location set out for evaluation:

This included all non-specialist hospitals in north west London.

1. Central Middlesex Hospital (CMH)
2. Charing Cross Hospital
3. Chelsea and Westminster Hospital
4. Ealing Hospital
5. Hammersmith Hospital
6. Hillingdon Hospital
7. Mount Vernon Hospital (MVH)
8. Northwick Park Hospital
9. St Mary's Hospital
10. West Middlesex Hospital

Non NHS sites beyond these ten were also considered.

Essential and desirable critera from a clinical perspective were applied as set out in Table 15 on page 56.

It was agreed that the shortlisted sites must have the following requirements:

- the ability to improve accessibility and ring-fence orthopaedic beds
- the right physical and digital infrastructure
- a workforce able to deliver the services
- potential for the elective orthopaedic centre rollout
- enable timely, appropriate and co-ordinated interactions with clinicians
- deliver clear patient-focused communication
- support continuity of care for patients
- good environmental accessibility
- a modern surgical care environment.

By assessing each of the sites against these requirements, two sites were shortlisted as clinically appropriate to host the elective orthopaedic centre. These two sites are Central Middlesex Hospital (CMH) and Mount Vernon Hospital (MVH).

Both CMH and MVH are already established providers of elective orthopaedic care and are protected from emergency and urgent care surges. Both sites have laminar flow theatres of high quality. For example, CMH has the BeCAD (Brent emergency care and diagnostics) theatre suite with three laminar flow theatres and available beds in situ and MVH has a modern Diagnostic and Treatment Centre. CMH and MVH both have the requisite clinical and non-clinical adjacencies available for the patient group, with an opportunity to co-locate the theatre suite with the inpatient care.

Appraisal of the shortlisted site options

Assessment against the clinical requirements had identified two appropriate sites for the elective orthopaedic centre. A set of non-clinical lenses has been applied to both CMH and MVH to determine whether they should be taken forward as options for the elective orthopaedic centre.

Access to sites:

- Analysis was conducted on the average time to travel to all of the candidate hospital sites from all parts of the sector
- CMH site has the shortest median travel times for the north west London population for travel by car and the second shortest by public transport, both significantly less than the MVH site
- Analysis also showed that the CMH site provides an improvement in travel times for the most deprived areas of north west London compared to the other options considered.

Capacity:

- MVH has the capacity to address its current level of activity for ASA 1s and 2s. However it does not have the infrastructure or the beds to take on the elective orthopaedic activity for all of north west London
- Model Hospital data, while at Trust and not site level, shows The Hillingdon Hospitals NHS Foundation Trust as already performing well with very limited capacity to treat additional trauma and orthopaedics cases
- CMH has good quality inpatient beds available at the site currently

Estates:

- CMH is a high-quality clinical estate. It is also anchored within the Old Oak Common Re-development area, contributing to the socio-economic development of the area. The expansion of theatres is within the current footprint and does not disrupt current services or create any planning challenges and the bed capacity for the elective orthopaedic centre is already in situ.
- For Mount Vernon, planning permission is likely to be difficult to secure due to the planning designations for the site and the estate has significant challenges in terms of the extent of backlog maintenance required, reflecting the poor condition of a number of buildings.

Assessment of a two-site option

Due to the capacity constraints at MVH, a potential two site option utilising both CMH and MVH has been considered. Recognising the status in respect of capacity and estate as set out above, the two-site option has been considered against the desirable criteria for the elective orthopaedic centre (see Section 5); in particular, the impact on workforce and the ability to deliver efficiencies and progress at pace.

To provide a two-site solution would require both CMH and MVH to have the same infrastructure to deliver the outlined improvement in performance and this would incur some ongoing double running costs and a split workforce which would not achieve the aim of a single cohesive workforce and training benefits or the economies of scale through establishment of a hub.

There would be a need for additional workforce. The nursing workforce model assumes a ratio of 1:6 qualified nurses to beds and so, where beds are not multiples of six, this would increase the nursing requirement and create inefficiencies. The medical workforce would be split across more sites and existing rotas would not be able to accommodate growth. Needing to operate theatres across two sites would also place further pressure on anaesthetists and ODPs, both of whom are in short supply. Additional staffing requirements would place further pressure on staff where there are existing challenges, particularly the hard to recruit areas.

A dual site option would mean that expertise is not held within one site, and this could inhibit service development and increase the risk of variations in practice. A positive aspect of having dual sites would be that staff have a choice of centres to work at.

This assessment, combined with the GIRFT best practice guidance for a single site, shows a single site option as the preferred option.

The assessments against access, capacity and estate show CMH as the preferred option for a single, stand-alone site for the elective orthopaedic centre for north west London.

The results of the economic appraisal show that Option 5 has the most positive net present value (NPV) of the shortlisted model of care options, which indicates it is the best value for money option. This is a result of this option achieving the optimal balance between efficiency gains and activity, income and costs associated with each incremental increase in activity within the elective orthopaedic centre for each shortlisted option.

The options evaluation therefore finds care pathway Option 5 at CMH to be the preferred option on the basis that:

- The necessary clinical requirements are met by the CMH site option
- Transport access to CMH is better than other suitable sites for both private and public transport options
- The expansion of theatres is within the current footprint of CMH and it does not disrupt current services or create any planning challenges
- The bed capacity for the elective orthopaedic centre is already in situ and available for use
- The economic evaluation supports care pathway Option 5.

Involvement

The project has benefited from significant input from stakeholders, staff and, increasingly, patients and the public. Patient representatives have been involved at different stages in the development of the elective orthopaedic concept and there is now a lay partner as a permanent member of the programme board to help ensure an effective and consistent approach to patient and public involvement.

Key stakeholders, including local authorities (informally and formally via the North West London Joint Health Overview and Scrutiny Committee (JHOSC)), other providers, Healthwatch and campaign groups have been kept up to date with plans for developing proposed changes. And, with the support of the sector's MSK network and Orthopaedic Clinical Reference Group, there have been a series of meetings and workshops with a range of clinicians and other representatives from across primary, acute and community care.

Patient and public involvement approach

To explore views on a potential elective orthopaedic centre, the Acute Provider Collaborative worked with a specialist, independent agency, Verve, to undertake a small engagement programme in summer 2022. There was a series of focus groups, telephone interviews and two online community events. Seventy-eight people took part in the engagement, having been recruited by contacting stakeholders and community groups in the area.

Key themes from involvement activities

Engagement so far has indicated a widespread view that an elective orthopaedic centre would have significant benefits for the population of north west London.

People understood the need to reduce waiting lists and were pleased that work was being undertaken to enable this. There was an appetite for change to happen quickly so that waiting lists did not continue to grow.

Clinical groups wanted to align with GIRFT and NICE guidance. They felt that standardisation of care would remove variation and improve patient outcomes and experiences. They also emphasised the impact this would have on reducing inequalities across the north west London population.

Clinical groups also highlighted the benefit of having ring-fenced capacity for beds which would result in:

- Reduced bed pressure
- Enhanced capacity for complex patients to be cared for in their local hospital
- Less compromise through infection prevention and control issues
- Better training opportunities for staff.

The proposed care model was generally welcomed but some key considerations and concerns were expressed during feedback:

People were worried that the plans could result in a two-tier system from two perspectives:

- Could fast-tracking routine surgery be detrimental to people with more complex needs?
- Would increasing the use of digital technologies leave behind people who could not use them?

All groups agreed that for the care model to be successful it was essential that:

- Processes are seamless and standardised (including digital, clinical pathways, etc)
- There is choice and ease of access for patients who cannot use digital technologies
- There is shared decision making on the development of the care model
- There is a standardised community pathway to complement the care model so that patients are not lost in the system pre and post discharge.

From a clinical perspective only, some key requirements for the elective orthopaedic centre site were highlighted:

- There must be the ability to ring-fence elective orthopaedic beds throughout the year to create resilience
- The site must have suitable infrastructure for orthopaedic surgery, such as laminar flow theatres
- Facilities on site must be interdependent
- There must be capacity to expand in future if demand increases
- The site should be easily accessible with the shortest possible travel times and good transport links for staff and patients.

Overall, involvement activities were considered valuable in aiding development of a proposal for an elective orthopaedic centre. As part of the formal consultation process, a wider group of stakeholders will be engaged.

The EHIA and IIA have been used to identify groups who may be affected by the proposed changes and who need to be reached through the consultation programme. The EHIA includes groups who are most affected by health inequalities. This is included at Appendix 1. In addition, as the NHS has a statutory duty to consider reducing inequalities, this forms part of the NHS approach to planning for service change. Accordingly, there is a formal requirement to produce an IIA and include this as part of the pre-consultation business case (PCBC) documentation. The IIA is included at Appendix 2 and has informed the development of the proposals contained within this PCBC. The IIA will be refreshed following conclusion of the public consultation in order to ensure that the evidence on equalities and inequalities which will be considered by decision-makers is as up to date and comprehensive as possible.

Public consultation

In line with statutory duties and NHS England (NHSE) guidance, NHS North West London is required to ensure that the public are consulted on proposed major service changes.

Summary of planned activities

With the support of NHS North West London, the Acute Provider Collaborative plans to run a public consultation from 19 October 2022 until 20 January 2023. The consultation will aim to be fair and proportionate, reaching a diverse mix of the population to be served by the proposed elective orthopaedic centre.

Consultation will take place across varying times, locations and channels with particular focus on people:

- identified as being most at risk of barriers to access or poorer health outcomes
- belonging to minoritised groups
- sharing one or more protected characteristic.

Consultation communication and engagement channels

The events and implementation plans for consultation aim to gather as much feedback as possible. These include the programme of activities set out below:

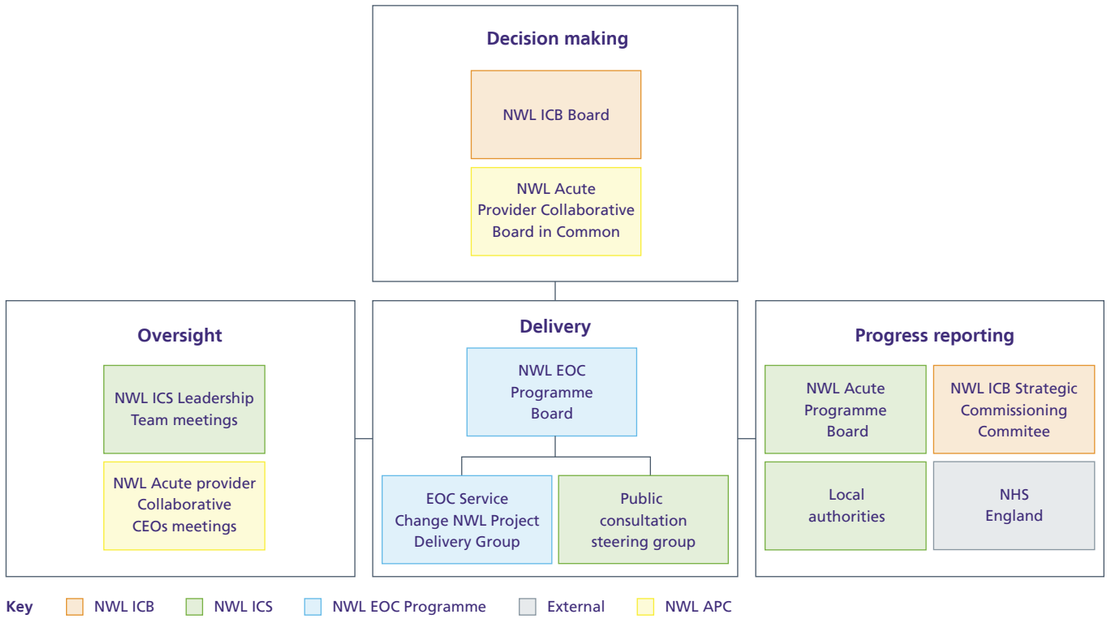
- Clinician-led, qualitative research events
- Drop-in engagement sessions
- Outreach community focus groups
- Awareness/engagement hybrid community outreach events
- Dedicated section of acute hospitals microsite.

North west London elective programme governance

The programme governance structure in Figure 2 will oversee the public consultation and provide updates to the North West London Joint Health Overview and Scrutiny Committee.

The joint Senior Responsible Officers (SROs) for this programme are Pippa Nightingale, CEO London North West Hospitals NHS Trust, and Professor Tim Orchard, CEO Imperial College Healthcare NHS Trust, working closely with Toby Lambert, North West London ICB Executive Director of Strategy & Population Health.

Figure 2 – Improving planned orthopaedic inpatient surgery in north west London governance



Financial impact

Each of the options for service delivery has been modelled in detail and tested for efficiency and value for money. In addition, the options for different sites across north west London have been considered using the outcomes from the service options.

As a result of improved productivity and efficiency associated with the proposed elective orthopaedic centre, £4m would be released for reinvestment on an annualised basis. Capital funding of £9.4m for the development has now been agreed.

Considering 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.

Regulatory approval

The NHS England 'Planning and delivering service changes for service users' outlines good practice on the development of proposals for major service changes and reconfigurations and includes four tests for service change plus a bed closure test. Additionally, the Mayor of London has released a framework for major hospital reconfigurations containing a series of six tests.

Having reviewed NHS North West London's Programme documentation and having received advice from the London Clinical Senate, NHS England London is assured that: the four tests are met; the option set out in this 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.

The North West London Elective Orthopaedic Centre Programme Team is continuing to liaise with the Mayor of London's Office on the six tests as part of final decision making.

Implementation

Post-consultation process

Following closure of the public consultation, all data and feedback will be analysed and captured in one report, produced by an independent organisation specialising in consultation analysis.

The report will capture all responses highlighting the following:

- Relevant to and/or having implications for the model of care and preferred option
- Appropriately evidenced submissions that support their perspective
- Identification of elements of the general population or specific localities which may be potentially impacted
- Views from under-represented people or equality groups.

This final report and a refreshed IIA will be shared with the North West London JHSOC for comment which will then inform the development of a decision-making business case (DMBC) which will be presented to the North West London Integrated Care Board for decision making.

Transition to implementation and implementation stages would reside under the North West London Acute Provider Collaborative and be directly managed by the North West London Elective Orthopaedic Centre Development Programme Board.

Next steps/potential implementation

Following approval of this PCBC by the North West London ICB at its public board on the 27 September, an indicative timeline of programme milestones was set out. This may be subject to change but can be seen in Figure 3.

Throughout the formal consultation, we will respond to questions raised by the public, NHS staff and other stakeholders.

Once the consultation process is complete, all the responses received will be collated and taken into consideration.

There will be an independent report compiled on the consultation responses along with an update to the IIA. A full report on the consultation will be created and submitted the North West London JHOSC.

A decision making business case will be developed underpinned by the following principles:

- conscientious consideration to consultation feedback before making a final decision
- consultation and collaboration with relevant local authorities in respect of the proposal
- principles of lawful decision-making – reasonableness, taking account of relevant factors and inquiries.

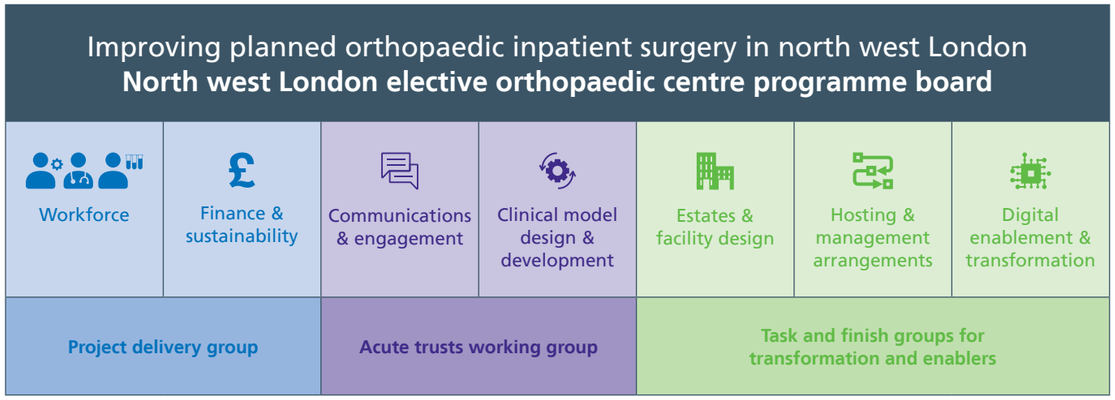
Figure 3 – Elective orthopaedic centre timelines overview programme

Implementation would be overseen by the North West London Elective Orthopaedic Centre Programme Board which will adopt a robust set of project management tools including:

- a risk management plan to identify and categorise risks to escalate via the Programme Board and Acute Provider Collaborative governance routes
- co-design and user-centred design with service users, lay partners and staff
- a change management plan to manage changes that are required to be made during the project implementation
- a benefits realisation plan to assess whether the benefits originally proposed have been achieved
- a consistent project delivery group
- a clear reporting structure.

A comprehensive structure has been established which enables effective progress reporting, oversight, decision making and delivery. A range of programme specific groups have been created, as illustrated in Figure 4.

Figure 4 – Programme workstreams supporting the North West London Elective Orthopaedic Centre Programme Team



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