Improving planned orthopaedic inpatient surgery in north west London

Pre-consultation 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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Foreword

Our response to the COVID-19 pandemic has shown just what can be achieved when we work more collaboratively across our acute hospitals, joining up our care and making the best possible use of our combined expertise and resources.

One of the ways we were able to maintain more planned care during the later phases of the pandemic was by establishing 'fast track surgical hubs'. These were facilities within our 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 our emergency services.

As we come out of the pandemic with long waiting lists and many other challenges, we want to draw on best practice and go further with our improvements. We know that we have particularly long waiting times for orthopaedic care and that we have some way to go to be amongst the very best performing trusts for quality in orthopaedic surgery.

Evidence shows that when routine operations, like joint replacements, are done frequently, in a systematic way, there are improvements in both quality and efficiency. This allows patients to get better care, more quickly and more fairly. There are already successful examples of where this has been done across the NHS, such as at the South West London Elective Orthopaedic Centre in Epsom.

This is why we want to bring together much of the routine, inpatient orthopaedic surgery for the population of north west London in a purpose-designed centre of excellence, completely separated from emergency care.

Clinicians and managers from across the four acute trusts have worked with GPs and other colleagues, as well as with patients and lay partners, to develop a detailed proposal for an elective orthopaedic centre and we have identified Central Middlesex Hospital as our preferred location.

We now want to share this proposal with as many patients, local residents and staff as possible. We know that bringing surgery together to improve waiting times and quality would mean longer travel times for some patients – we want to know if local people support this trade off and to gather more ideas on how we could make travel, and access more generally, as easy as possible.

We are really committed to improving health and healthcare with – and for – our local communities. We look forward to hearing your views!

Dr Roger Chinn Chair of the North West London Elective Orthopaedic Centre Programme Board

1 Introduction and background

1.1 Origins of the proposal

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 been working together increasingly closely throughout the response to COVID-19. This led to the establishment of a formal acute provider collaborative in July 2022.

The acute provider collaborative 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.

As we have emerged from the COVID-19 pandemic, the collaborative has been developing a more strategic approach to its planned care recovery, aligned to wider ICB strategy. In addition to restoring capacity and tackling long waits, the collaborative is seeking to address long-standing needs to improve the quality, equity, efficiency and sustainability of its planned care.

The four acute providers have been building on a number of 'fast track surgical hubs' they established during the pandemic. These are centres that focus on 'high volume, low complexity' surgery – routine procedures that when undertaken by surgical teams frequently, drawing systematically on established best practice, we see an improvement in both quality and efficiency. The hubs are also separated, to some degree, from emergency care, enabling better infection control and making it less likely that operations are postponed due to surges in unplanned demand.

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. London North West University Healthcare NHS Trust is the lead provider for orthopaedic care and, again drawing on evidenced best practice, the trust has been leading work on exploring with partners the potential for a dedicated elective orthopaedic centre for north west London. This work is seeking to determine whether significantly greater benefits in terms of quality, equity, efficiency and sustainability could be achieved by bringing together more 'high volume low complexity' orthopaedic surgery in a purpose-designed centre of excellence.

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 musculoskeletal (MSK) pathway being led by the ICB on similar timescales. In addition, NHSE established a 'transformation investment fund' in 2021 to support schemes that promoted recovery from the COVID-19 pandemic. Funds to support a potential elective orthopaedic centre development have been earmarked within the allocation for north west London for 2022/23.

1.2 Aims of the pre-consultation business case

The exploratory work undertaken in 2021 and 2022 has culminated in a formal proposal by the acute provider, supported by the ICB, to develop an elective orthopaedic centre for north west London.

A 'substantial material' service change requires a formal public consultation. The determination of a 'substantial material' change is made by the 'commissioner' of the service, informed by discussion with the relevant oversight and scrutiny committee (OSC) and/ or JHOSC.

The ICB considers that the development of an elective orthopaedic centre for north west London, as proposed by the acute provider, would be a 'substantial material' change and so does require a formal public consultation. This also reflects the views of the North West London JHOSC which formed part of an extensive stakeholder engagement programme.

To enable the public consultation to proceed, a PCBC must first be approved by NHS England.

The objectives of this PCBC are to:

- set out a balanced case for change
- show how stakeholders have been involved in informing, developing and evaluating the proposed change, including consideration of all viable options
- show how the proposal aligns with other relevant strategies, including for the wider MSK pathway
- describe the expected impacts, risks and benefits of the change for service users
- demonstrate an effective approach to public consultation that will ensure service users and members of the public who may be impacted by the proposal will be able to feed in their views and that those views will fairly inform next steps
- demonstrate that the proposal is compliant with the Secretary of State for Health and Social Care's tests of service change, NHSE's bed closures test and the Mayor of London's six tests for major hospital reconfigurations.

1.2.1 Structure of the PCBC

This PCBC was developed in accordance with NHSE guidance and is structured as follows:

- Executive summary
- Introduction and background, summarising how the proposal originated and providing an overview of the population of north west London as well as the NHS and other organisations involved in the proposal and the strategic priorities that north west London is working towards
- Case for change, summarising the key drivers for change and how they are likely to be impacted by an elective orthopaedic centre as proposed
- Developing the clinical model, describing the approach and inputs to the clinical model as well as the equality and quality impact analysis
- Clinical model, detailing the clinical model for the proposed elective orthopaedic centre
- Appraisal of options to deliver the clinical model, setting out the long and shortlists of potential options, the critical success factor assessment, economic analysis and pre-consultation feedback findings
- Engagement, setting out the legal context for engagement and then detailing the pre-consultation engagement
- Implementing the preferred option, showing the application of the four NHS tests of service change to the proposed model, NHSE's bed closures test and the Mayor of London's six tests for major hospital reconfigurations
- Financial appraisal, setting out the financial projections, sensitivities and affordability
- Approval process, setting out the governance structure, roles and responsibilities, use of external advisors and information governance issues
- Next steps recommendations, setting out next steps for the consultation process and for the further development of the elective orthopaedic centre and other pathway changes

1.3 Geography and demographics

The North West London Integrated Care System covers eight boroughs:

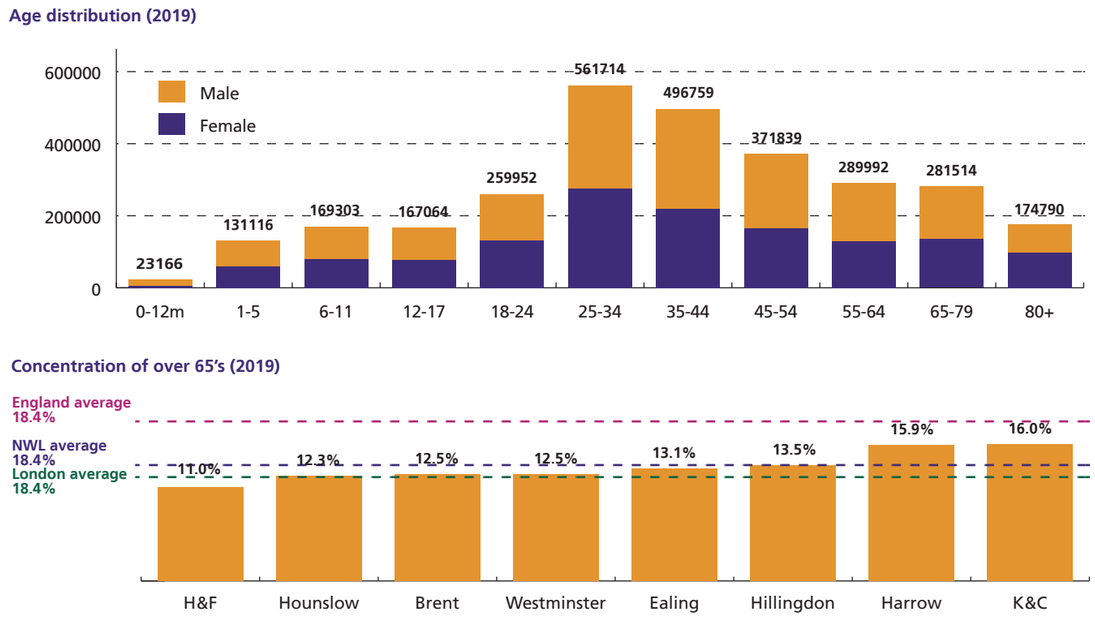
- London Borough of Brent
- London Borough of Ealing
- London Borough of Hammersmith and Fulham
- London Borough of Harrow
- London Borough of Hillingdon
- London Borough of Hounslow
- Royal Borough of Kensington and Chelsea
- City of Westminster

It has a total population of around 2.4 million people (see Figure 1 below).

Figure 1: The eight boroughs of north west London and the four acute trusts and their hospitals

The population of north west London has a slightly older age distribution to the rest of London but the number of over 65 year olds is still significantly less than the national average (see Figure 2). There is significant variation in age distribution across the eight boroughs of north west London. For example, Kensington and Chelsea and Harrow have around a 20 per cent higher concentration of over 65s than Hammersmith and Fulham.

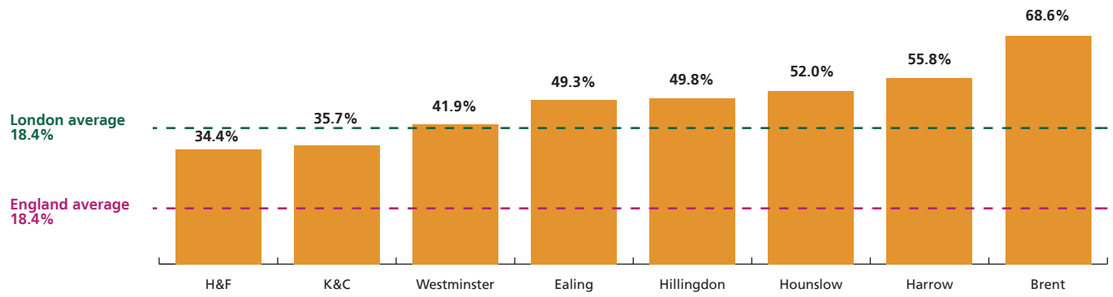
Figure 2 – Concentration of over 65s in the boroughs of north west London (2019)



Source: North West London Needs Assessment, data from Public Health England

Ethnic diversity in north west London is greater than that of London as a whole (51 per cent non-white in north west London vs 41 per cent non-white across London) and significantly greater than in England as a whole (16 per cent non-white on average) (see Figure 3). People from ethnic minority backgrounds often live in more deprived areas and have both particular health and care needs and challenges in accessing services.[1]

Figure 3 – Proportion of the population who are non-white in the boroughs of north west London (2019)

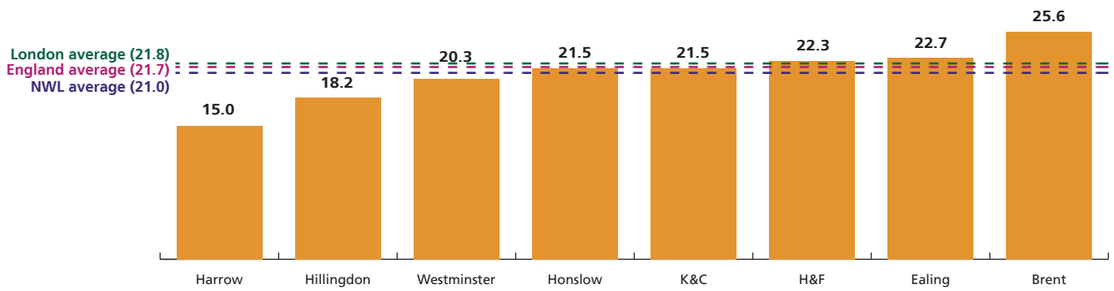


Source: North West London Needs Assessment, data from Public Health England

Areas of deprivation exist in all of the boroughs of north west London but there are particular concentrations of deprivation in Brent, west Ealing and south Hillingdon (see Figure 4). People in the bottom 40 per cent of income distribution are almost twice as likely to report poor health than those in the top 20 per cent.[2] As with the rest of London, unemployment is a significant issue in north west London, when compared to the rest of the country.

1 Poverty, ethnicity and place (2011) https://www.jrf.org.uk/sites/default/files/jrf/migrated/files/poverty-ethnicity-place-full.pdf
2 Living in poverty was bad for your health long before COVID-19 (2020) https://www.health.org.uk/publications/long-reads/living-in-poverty-was-bad-for-your-health-long-before-COVID-19

Figure 4 – Index of multiple deprivation score in the boroughs of north west London (2019)



Source: North West London Needs Assessment, data from Office for Health Improvement and Disparities (OHID)

Living in poor quality or overcrowded housing is associated with worse health outcomes. All eight boroughs of north west London have more overcrowded households than the national average.

Educational attainment is strongly linked with health behaviours and outcomes. For school readiness, three north west London boroughs are in the top 25 per cent nationally and the other five are broadly in line with the national average. For children with free school meals status, seven north west London boroughs are in the top 25 per cent nationally.

Crime affects physical and mental health in many ways, including distress to victims, economic harm, and significantly poorer outcomes for people in the criminal justice system. All eight boroughs of north west London are more 'crime deprived' than the national average.

Poor air quality is the largest environmental risk to public health in the UK. All eight boroughs of north west London are above the national average for air pollution. Hammersmith and Fulham, Kensington and Chelsea and Westminster are also above the London average.

1.4 Strategic priorities

The proposal for an elective orthopaedic centre for north west London reflects national NHS strategy and guidance and helps meet – and align – a number of strategic priorities for the North West London ICS and the acute provider collaborative.

1.4.1 National strategy

The long-term ambition of the NHS is captured in the interconnected 'quadruple aim', to improve:

- the quality and experience of care for patients
- the health and well-being of the wider population
- the well-being and engagement of staff
- efficiency and productivity, especially by eliminating waste.

The quadruple aim also underpins the NHS approach to tackling the additional challenges created by the COVID-19 pandemic, as set out in *The NHS Delivery Plan for tackling the COVID-19 backlog of elective care*[3], 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
- 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.

This is supported by similar guidance issued by the British Orthopaedic Association[4] on restoring elective orthopaedic services.

The separation of elective services from emergency services has long been seen as a key approach to improving quality and productivity, as set out in an NHSE presentation to lead providers in 2020[5] which summarised the benefits as 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 GIRFT programme is part of an aligned set of programmes within NHSE. It is providing support to local health and care systems for elective recovery of 'high volume low complexity' (HVLC) surgery services, such as trauma and orthopaedics. 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".

1.4.2 North West London Integrated Care System strategy

The four key objectives of the ICS are to:

- improve outcomes in population health and health care
- prevent ill health and tackle inequalities in outcomes, experience and access
- enhance productivity and value for money
- support broader economic and social development.

Following the first wave of COVID-19 infections, the North West London ICS established a number of multidisciplinary and system-wide clinical reference groups (CRGs) to review emerging clinical evidence and best practice and to support collaborative improvement across areas of care. CRGs operate based on the following principles:

- To provide system wide clinical leadership
- To ensure a partnership between primary, acute care, community and mental health
- To promote clinical standardisation
- To encourage a data driven approach reflecting local and population data needs
- To support the adoption of innovation
- To adopt a quality improvement (QI) based approach to continual development and improvement.

3 https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2022/02/C1466-delivery-plan-for-tackling-the-COVID-19-backlog-of-elective-care.pdf

4 "Re-starting non-urgent trauma and orthopaedic care: Full guidance", the British Orthopaedic Association, May 2020.

5 "Elective Surgery High Volume Centres: Common Characteristics and Expectations in London", Elective Surgery Recovery and Transformation Programme, NHS England and NHS Improvement London Region, Lead Providers Workstream, July 2020.

The Orthopaedic Clinical Reference Group (CRG), set up in 2020, is aligned to the wider North West London MSK network. The CRG identified the need to transform orthopaedic surgical care alongside alignment with, and improvement of, community MSK pathways. The CRG's key recommendations for orthopaedic surgical care include:

- developing a centre of excellence and networked working for HVLC 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.

One of North West London ICS's priorities is to strengthen out-of-hospital care and it has developed borough-based health and care partnerships with integrated leadership. These borough teams are using population health data to target care where it is needed most. They are aiming to ensure consistent, high quality, integrated care across north west London, placing more focus on prevention, management of long-term conditions and improved access and outcomes for people with mental health needs, learning disabilities and autism. Improvements to the wider MSK pathway are a key element of this work.

1.4.3 Acute care strategy

The acute provider collaborative is establishing a joint 'statement of intent' – the working draft currently includes objectives to:

- make the most of our collective resources, ensuring we provide high-quality care as quickly as possible according to clinical need
- achieve continuous improvements in quality, efficiency and outcomes by supporting each other to identify, adopt and embed best practice
- proactively tackle unwarranted variations and inequalities in access and experience
- make better collective use of our corporate and clinical support services
- promote the development of alliances and networks at all levels to support the development of more joined-up care between and within specialties
- ensure our hospitals attract and retain excellent staff by fostering a supportive and inclusive working culture with a commitment to learning and development, health and well-being
- develop care models and care pathways that better meet the needs of our patients and communities, ensuring we understand and respond to the views of all our users
- achieve more rapid and consistent spread of innovation, research and technology.

A North West London Acute Care Programme Board was established in early 2021 to support collaborative working across the four acute trusts in north west London. A precursor to the North West London Acute Provider Collaborative, it includes stakeholders from the ICB, the wider ICS and lay partners as well as a range of leads for the acute trusts.

The Acute Care Programme Board identified the need to explore the potential for an elective orthopaedic centre as one of its first collaborative programmes.

1.4.4 The acute providers

The four acute NHS trusts that make up the acute provider collaborative are independent organisations overseen by a board in common. The 12 hospitals run by the trusts provide a wide range of acute and specialist care, with an increasing degree of networking, as well as service consolidation where appropriate, to support consistent high-quality care and the rapid spread of learning and research.

Chelsea and Westminster Hospital NHS Foundation Trust provides care primarily at its Chelsea and Westminster Hospital and West Middlesex Hospital sites. Both hospitals have A&E departments, maternity services and paediatric services. Specialist services provided by the Trust include burns care and HIV and sexual healthcare.

The Hillingdon Hospitals NHS Foundation Trust provides care primarily at its Hillingdon Hospital and Mount Vernon Hospital sites. Hillingdon Hospital includes an A&E department and maternity services.

Imperial College Healthcare NHS Trust provides care primarily at five hospital sites: Charing Cross Hospital includes an A&E department and a hyper acute stroke unit; Hammersmith Hospital provides a range of mainly specialist, planned care services as well as a regional heart attack centre; Queen Charlotte's and Chelsea Hospital provides maternity care and women's health services; St Mary's is the major trauma centre for the sector, with an adult and children's A&E department, and it also provides maternity care; the Western Eye is a specialist eye hospital.

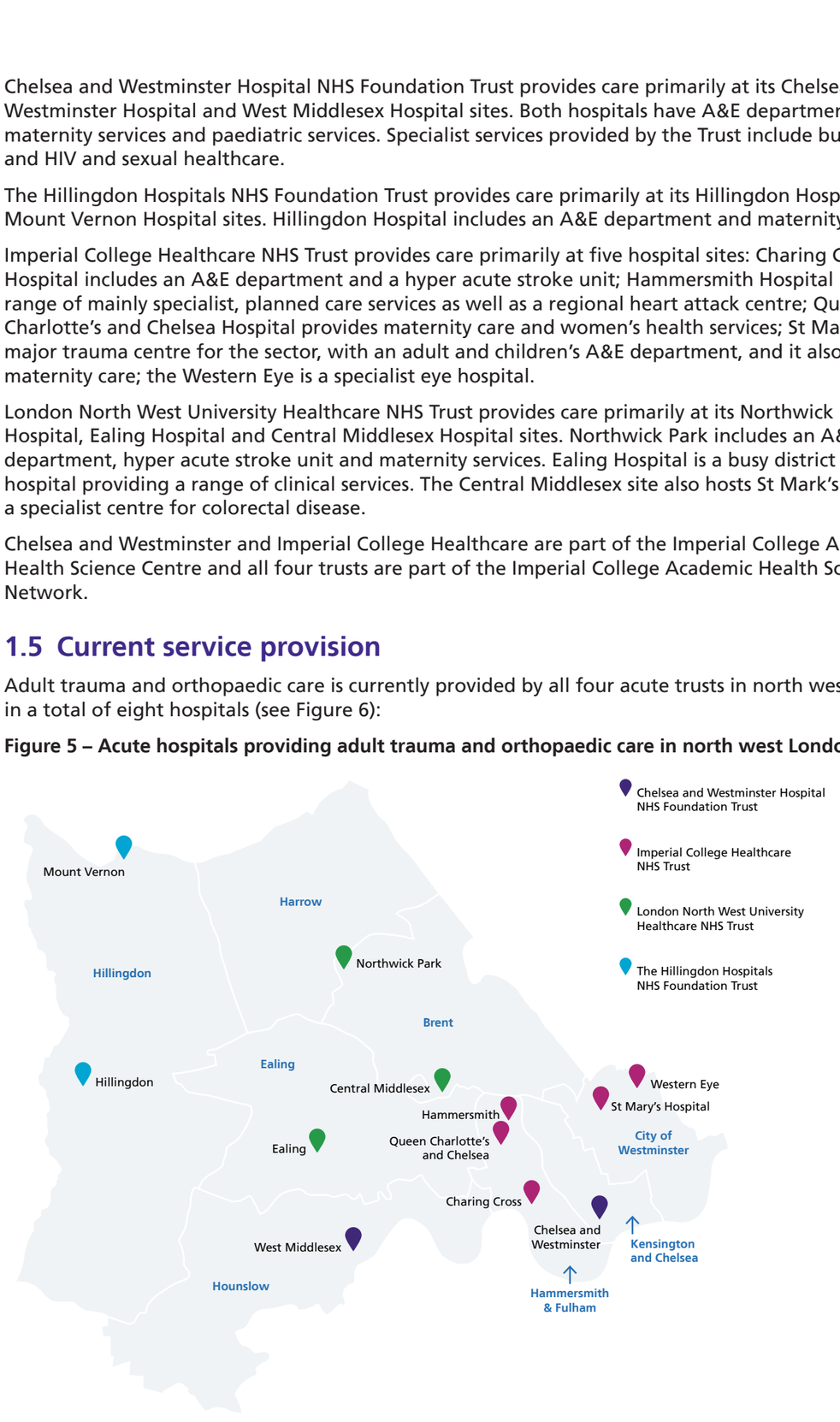
London North West University Healthcare NHS Trust provides care primarily at its Northwick Park Hospital, Ealing Hospital and Central Middlesex Hospital sites. Northwick Park includes an A&E department, hyper acute stroke unit and maternity services. Ealing Hospital is a busy district general hospital providing a range of clinical services. The Central Middlesex site also hosts St Mark's Hospital, a specialist centre for colorectal disease.

Chelsea and Westminster and Imperial College Healthcare are part of the Imperial College Academic Health Science Centre and all four trusts are part of the Imperial College Academic Health Science Network.

1.5 Current service provision

Adult trauma and orthopaedic care is currently provided by all four acute trusts in north west London in a total of eight hospitals (see Figure 6):

Figure 5 – Acute hospitals providing adult trauma and orthopaedic care in north west London



The hospitals provide different ranges of orthopaedic surgical care, as shown in Figure 6.

Figure 6 – Provision of adult elective orthopaedic care, by type of service and classification of clinical need, by acute hospital in north west London

*Not including pre-operative assessment

Within the inpatient surgery there is further clinical classifications as set out in Table 1.

Table 1 American Society of Anesthesiologists classification system

American Society of Anesthesiologists physical status classification system	
ASA PS Classification	Definition
ASA I	A normal healthy patient.
ASA II	A patient with mild systemic disease. Mild diseases only without substantive functional limitations.
ASA II	A patient with severe systemic disease.

The type of surgical care provided by each hospital is to some degree related to the availability of laminar flow theatres which are required for open surgery. There are 23 laminar flow theatres across north west London in total (see Table 2).

Table 2: Laminar flow theatres in north west London acute hospitals

Trust	Site	Number of laminar flow theatres
Chelsea and Westminster Hospital NHS Foundation Trust	West Middlesex Hospital	2
	Chelsea and Westminster Hospital	2
Imperial College Healthcare NHS Trust	St Mary's Hospital	2
	Charing Cross Hospital	3
London North West University Healthcare NHS Trust	Central Middlesex Hospital	3
	Northwick Park Hospital	3
	Ealing Hospital	3
The Hillingdon Hospitals NHS Foundation Trust	Hillingdon Hospital	2
	Mount Vernon Hospital	3

1.5.1 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 is using a set of draft principles to guide the creation and development of this lead provider role, which sees the lead provider:

- selected and appointed at a system level, by specialty
- responsible for engaging clinical and managerial leaders across all providers in a system
- responsible for 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
- responsible for having oversight of clinical outcomes and productivity at a system level and using the system's continuous improvement methodology to reduce any unwarranted variation
- responsible for identifying a system clinical lead to participate in the London Clinical Panel to agree best practice standards in clinical outcomes and productivity.

London North West University Healthcare was designated as the lead provider for orthopaedics for north west London as part of process that allocated the key elective specialties across the four acute providers. Work is continuing on developing this role and ways of working as part of the recently established North West London Acute Provider Collaborative.

2 Case for change

There are six key drivers for change:

- 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

2.1 Epidemiology and public health challenges

2.1.1 Growing demand and increasing waiting times

The key headlines on demand and the waiting list challenge are as follows:

- 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 time from decision to admit, which is measured from the date the patient and clinician decide to add the patient to the waiting list for surgery until completion of the surgery itself, has increased sharply since pre-COVID-19.
- The number of patients waiting more than a year in north west London for orthopaedic surgery has risen from 4 pre-COVID-19 to just under 200 for elective orthopaedic surgery.
- Without intervention, the north west London orthopaedic waiting lists will continue to grow faster than the existing capacity to provide care.
- The implementation of an elective orthopaedic centre will potentially reduce the number of patients waiting by up to 30% and will also reduce patient waiting times by over 6 weeks.
- Significant variability exists in waiting list performance across the north west London providers. The new elective orthopaedic centre will ensure rapid progress towards consistent and much improved 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 reduced in size compared to pre-COVID-19 numbers due to many patients having their care disrupted during the pandemic. However, as we see this demand return, the waiting list has been growing – increasing by 22% in the last 6 months alone.

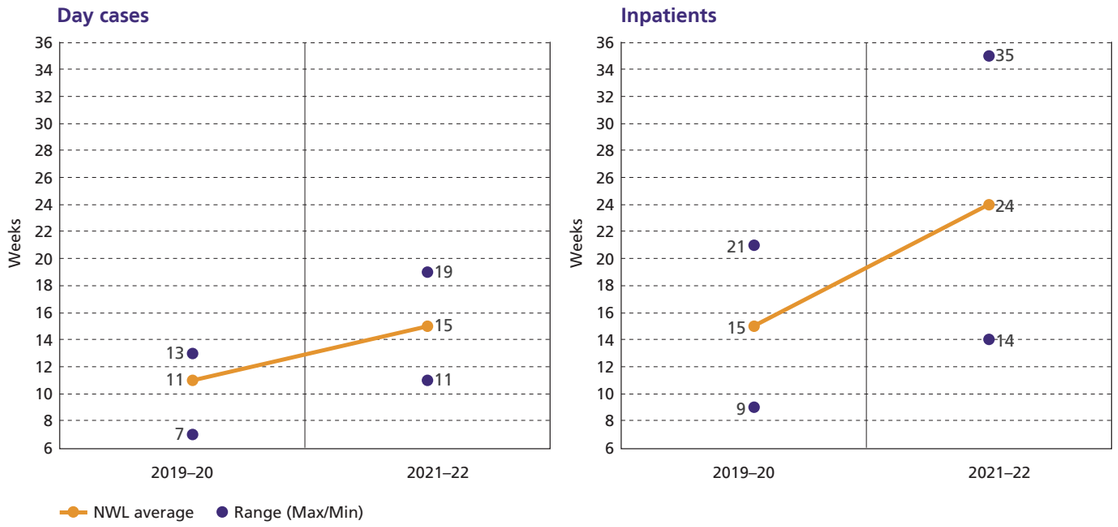
Even though procedures like hip or knee replacements are not usually considered to be time critical, waiting for treatment can have an extremely negative impact on quality of life and many conditions can worsen over time, making treatment and recovery harder. The implementation of the elective orthopaedic centre directly aims to tackle this urgent need to address the long waits for elective orthopaedic surgery by providing additional protected capacity for patients across north west London.

Waiting times from decision to admit

Waiting time from decision to admit is measured from the date the patient and clinician decide to add the patient to the waiting list for surgery until completion of the surgery itself.

The table below shows a range of the earliest and latest wait times for surgery following a decision to admit patients have been experiencing in north west London. This waiting time for inpatients has risen by ~9 weeks on average from pre-COVID-19 levels to 24 weeks in 2021/22. For day cases, it has increased by ~4 weeks. While not reflecting the full waiting time from referral to treatment, these time frames for surgical waiting times are the key metrics which will be impacted following the proposed service configuration changes in the elective orthopaedic centre.

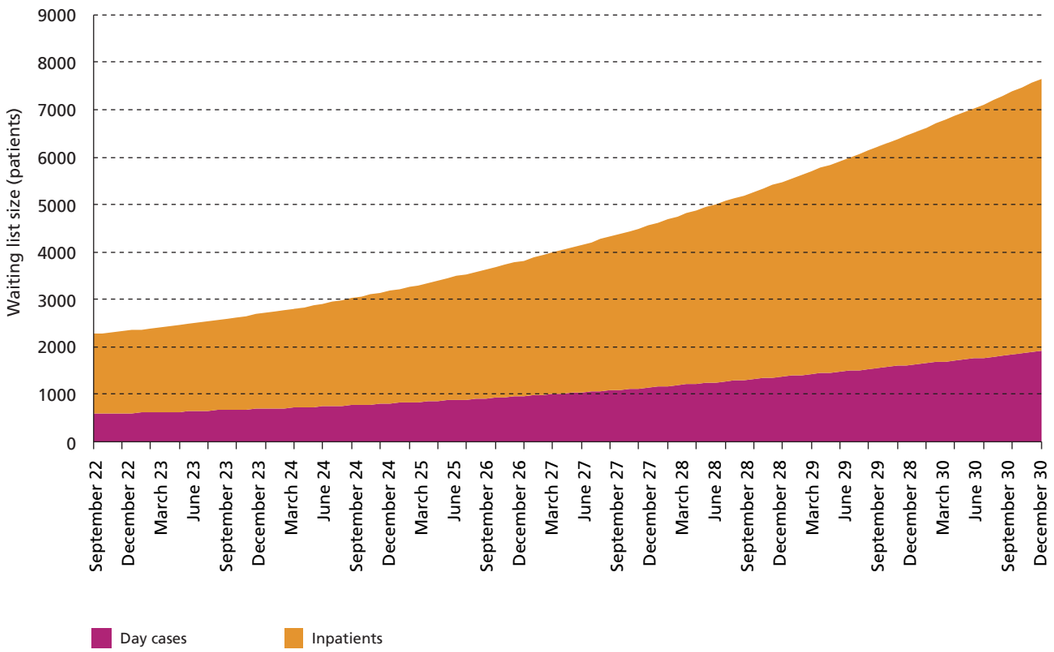
Table 3 – North west London orthopaedics breakdown of average decision to admit (DTA) to treatment waiting times



Waiting list size

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 (see Figure 7). Without intervention, the north west London orthopaedic waiting lists will continue to grow faster than the existing capacity to provide care.

Figure 7 – North west London orthopaedic surgery Patient Tracking List (PTL[6]) growth to 2030, with activity levels unchanged (north west London elective orthopaedic centre in-scope procedures and ASA grades only)



The modelling above represents the expected PTL for those procedures in-scope for the new north west London elective orthopaedic centre:

- all sector inpatient admissions; only LNW day case admissions
- excludes all spinal procedures
- revisions activity removed in respect of ICHT, CWHFT & THHFT (retained for LNWUHT)
- ASA-3 graded activity removed in respect of ICHT, CWHFT & THHFT (retained for LNWUHT)

As highlighted by the national GIRFT programme, there are three key ways of improving productivity – as well as quality – 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 our assets, impacting on theatre productivity and efficient patient flows.

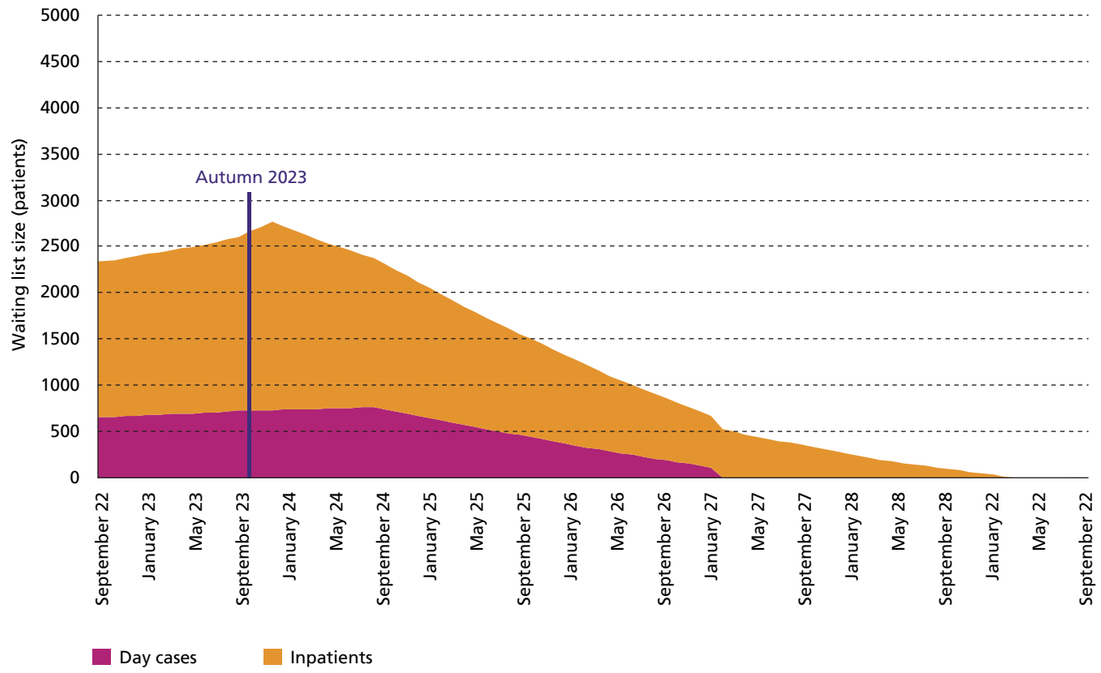
Additional detail and case studies on the GIRFT website[7].

The elective orthopaedic centre model proposed incorporates changes that will deliver improvements in all three of these areas. These anticipated improvements have been modelled theoretically against anticipated demand (see Figure 8) to show that the waiting list backlog would be reduced significantly.

6 A patient tracking list 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.

7 https://www.gettingitrightfirsttime.co.uk/hvlc/

Figure 8 – Modelled improvement in north west London orthopaedic waiting list as a result of establishing an elective orthopaedic centre (NWL EOC in-scope procedures and ASA grades only)



Waiting times

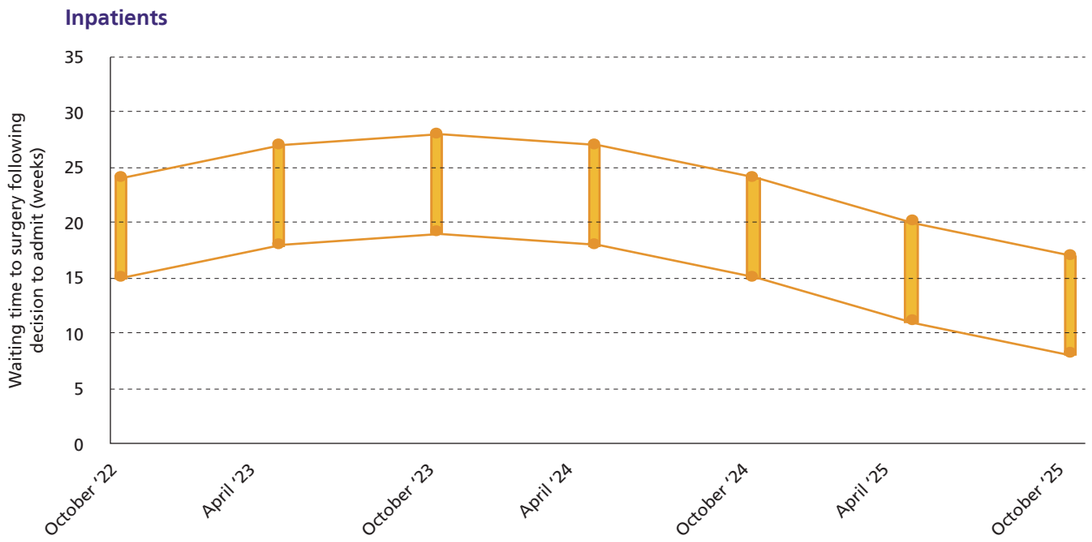
Modelling to assess the impact of the implementation of the elective orthopaedic centre on patient waiting times from decision to admit has been completed. The analysis is represented in the table below which demonstrates an improvement in the volume of patients waiting and the waiting times from the decision to admit following the implementation of the elective orthopaedic centre model of care.

Table 4 – Benefit of implementing the elective orthopaedic centre on patient access

	Waiting list size	Waiting time
North west London sector – inpatients	Reduction of ~30% by October 2025	Reduction of ~7 weeks by October 2025
Worth west London sector – day cases	Reduction of ~30% by October 2025	Reduction of ~8 weeks by October 2025

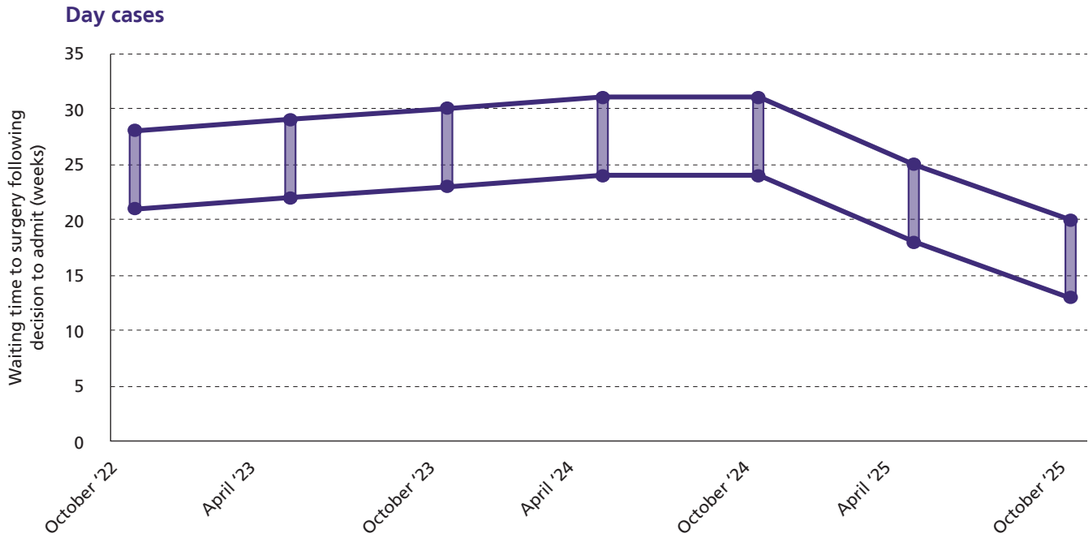
Figures 9 and 10 show how establishing an elective ortheopaedic centre improves waiting times over the first two year period once established

Figure 9 – Modelled improvement in north west London orthopaedic waiting times between decision to admit and admission for inpatients as a result of establishing an elective orthopaedic centre



This shows a potential reduction of ~7 weeks in the two years following implementation of the elective orthopaedic centre.

Figure 10 – Modelled improvement in north west London orthopaedic waiting times between decision to admit and admission for day cases as a result of establishing an elective orthopaedic centre.

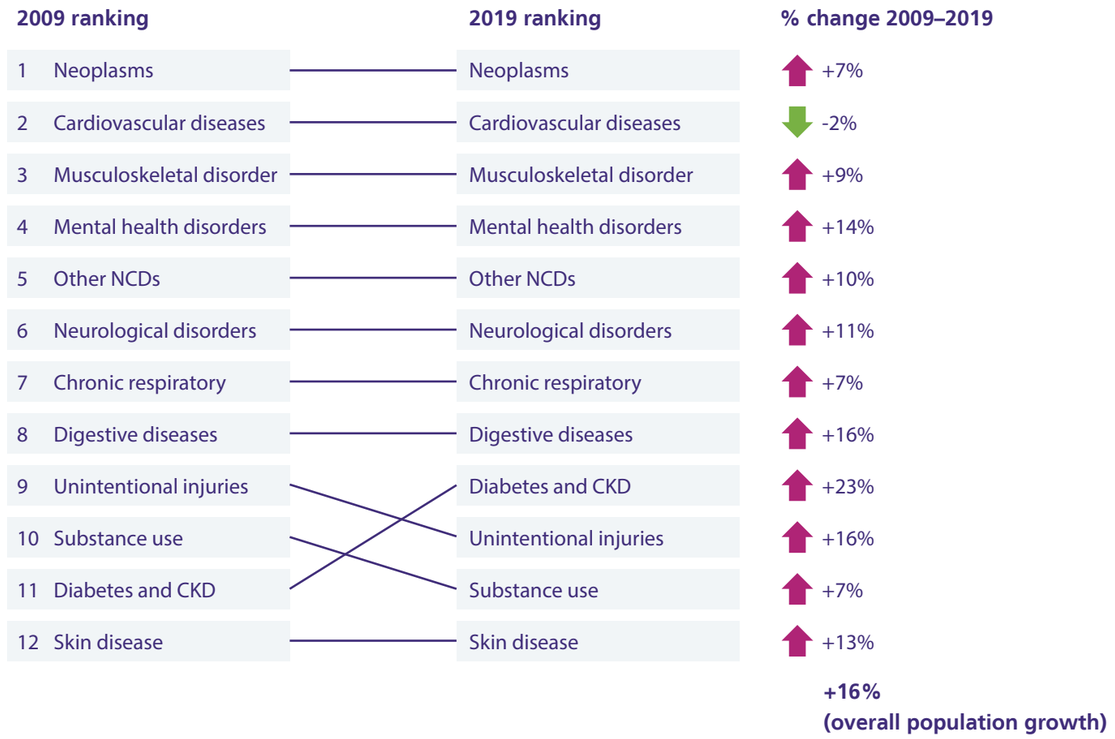


This shows a potential reduction of ~8 weeks in the two years following implementation of the elective orthopaedic centre

2.1.2 Population health challenges, including large health inequalities

Musculoskeletal disorders remain the third leading contributor to the burden of disease (represented by disability-adjusted life years (DALYs) in Greater London and increased by nine per cent between 2009 and 2019 (see Figure 14). Analysis shows similarity between the boroughs.

Figure 14 – Ranked burden of disease in Greater London, 2009-2019, total DALYs by cause



MSK conditions are also one of the most common co-morbidities for the most deprived (identified by the national Index of Multiple Deprivation) 20 per cent of the population. This most deprived quintile has been identified as the key target cohort for health interventions in NHSE's population health model, CORE20PLUS5. (The 'PLUS5' refers to the five clinical areas identified nationally for additional focus – maternity, severe mental health, chronic respiratory disease, early cancer diagnosis and hypertension case finding.)

The need for elective orthopaedic care also correlates with deprivation and with older age (see Figures 15 and 16). The most deprived quintile of the north west London population make up 37 per cent of those undergoing orthopaedic procedures relative to eight per cent of the least deprived quintile. People aged 55 to 84 make up two thirds of elective orthopaedic patients in north west London.

Figure 11 – north west London population by age compared with elective orthopaedic care by age (2019 and 2021)

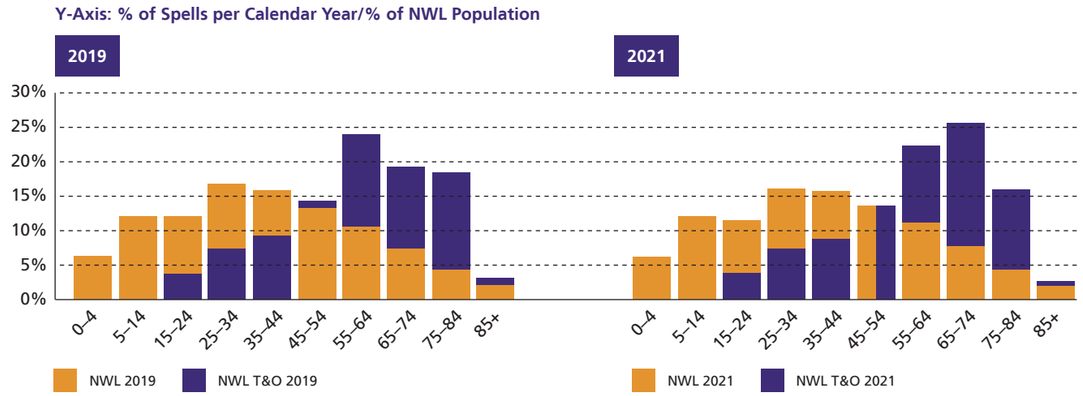
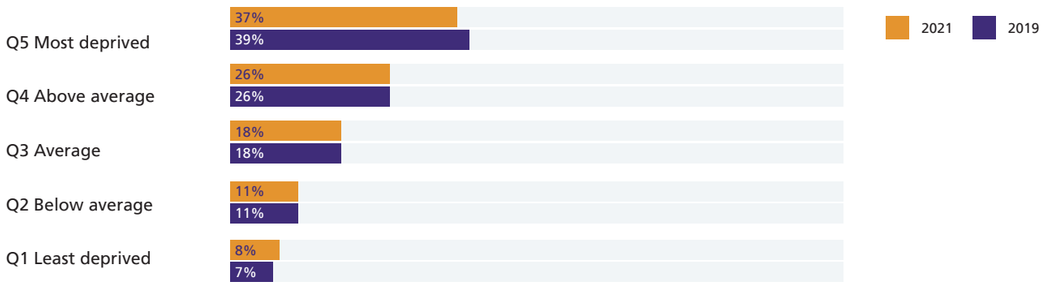


Figure 12 – North west London elective orthopaedic patients mapped against deprivation: Percentage of patients per Carstairs deprivation index per calendar year (2019 and 2021)



Source: HES Data via Dr Foster

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 as they have proportionately more demand for elective orthopaedic care. This may be directly through the 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.

2.2 Clinical challenges

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

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.

Table 5 – North west London performance for elective orthopaedic care using 'model hospital'* data and patient reported outcome measures (PROMs) by trust

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

For comparison, Table 6 shows performance for the same metrics for a range of NHS elective Orthopaedic centres. Performance in these centres is significantly better than the current performance for north west London as a whole, suggesting an elective Orthopaedic centre model can offer a significant opportunity to deliver improvements in outcomes and experience.

Table 6 – Performance for elective orthopaedic care using 'model hospital' data and patient reported outcome measures (PROMs) across a range of NHS elective orthopaedic centres

KPI	SWELEOC	Royal Cornwall	Lincoln	Gloucester	Nottingham	EOC average
5 year revision rate hips	Q4	Q1*	Q4	Q3	Q1	Q2
5 year revision rate knees	Q1	Q3	Q4	Q3	Q2	Q3
PROMS – OKS	Q3	Q2	Q3	Q1*	Q2	Q2
PROMS – OHS	Q4*	Q2	Q4*	Q1	Q2	Q3
PROMS Eq5d hips	Q3	Q2	Q3	Q1	Q2	Q2
PROMS Eq5d knees	Q3	Q2	Q3	Q1	Q2	Q2
Length of stay hips	Q1	Q1	Q1	Q3	Q3	Q2
Length of stay knees	Q1	Q1	Q1	Q3	Q3	Q2
Cost per WAU orthopaedic surgery	Q2	Q2	Q4	Q1*	Q2	Q2
Readmission rate knee	Q2	Q1	Q1	Q3	Q3	Q2
Readmission rate hips	Q2	Q2	Q2	Q2	Q2	Q2
Implants – cemented/hybrid hips in over 70s	Q1	Q1	Q1	Q1	Q1	Q1
Average	Q2	Q2	Q3	Q2	Q2	Q2

SWLEOC: South West London Elective Orthopaedic Centre

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 (see Table 7). 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.

Table 7 – North west London elective orthopaedic care ranked in the top decile and quartile for quality performance nationally, by trust

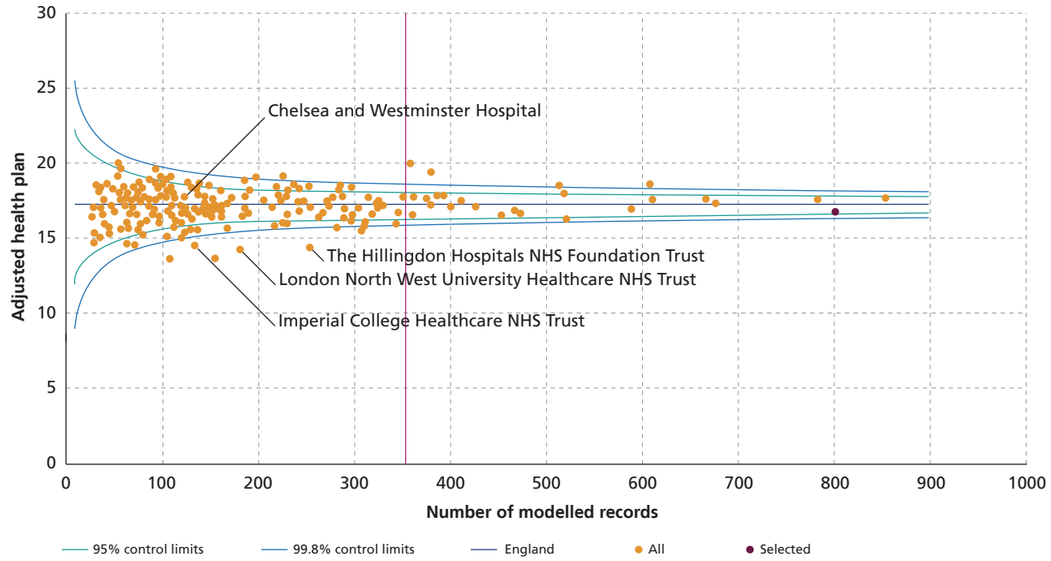
	Top decile		Top quartile	
	Quality of care (PROMs, LoS, implants)	Complications (Readmission rate, revision rate)	Quality of care (PROMs, LoS, implant)	Complications (Readmission rate, revision rate)
London North West University Healthcare NHS Trust	✗	✗	✓	✓
Imperial College Healthcare NHS Trust	✗	✓	✗	✓
Chelsea and Westminster Hospital NHS Foundation Trust	✗	✗	✓	✓
The Hillingdon Hospitals NHS Foundation Trust	✗	✗	✗	✗
Overall (ICS average)	✗	✗	✓	✓

Looking specifically at the Oxford Knee Score (OKS)[9] (see Figure 13), three out of seven national outliers are trusts within north west London. (The OKS is a 12-item patient reported outcome measure specifically designed and developed to assess function and pain after total knee replacement surgery. It is short, reproducible, valid and sensitive to clinically important changes.)

8 The national Patient Reported Outcome Measures (PROMs) programme - https://www.england.nhs.uk/wp-content/uploads/2018/08/proms-guide-aug-18-v3.pdf

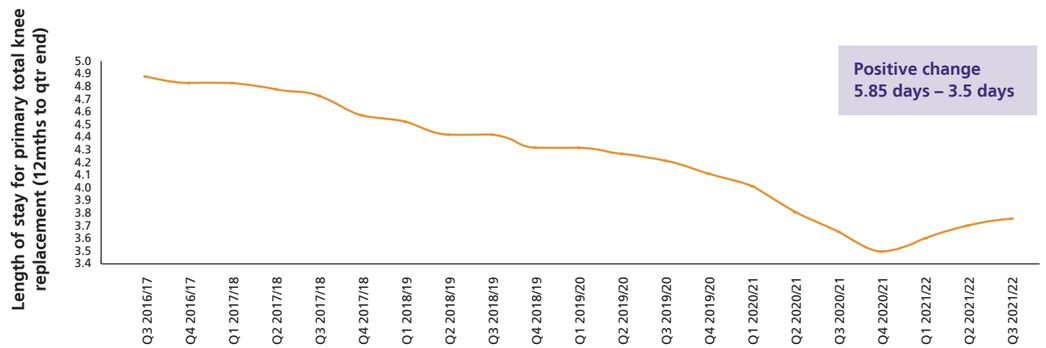
9 http://www.orthopaedicscore.com/scorepages/oxford_knee_score.html

Figure 13 – Oxford Knee Score for total knee replacement in 2018/19 – Case mix-adjusted average health gain



The proposed elective orthopaedic centre would incorporate standardised clinical and operational processes, based on evidenced best practice, across the whole patient pathway. This would increase quality across the board. The increase in volume and the separation of elective and unplanned care would also bring benefits in terms of the development of expertise and a reduction in disruption to elective care. An indication of the improvements that can be achieved through an elective orthopaedic centre model can be seen in Figure 14 which shows improvements in length of stay following total knee replacement before and after the national focus on improving the high volume, low complexity surgery.

Figure 14 – Length of stay for total knee replacements with focus on 'high volume, low complexity' focus



As presented by GIRFT at NHS Confederation Expo June 2022

2.2.2 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, 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 also 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. There is increasingly close alignment between the teams working on the Elective Orthopaedic Centre and on the MSK pathway specification.

2.3 Estates and efficiency challenges

2.3.1 Unnecessary variations in theatre utilisation and downtime

There is significant variation in theatre utilisation and downtime across the north west London acute trusts providing elective orthopaedic surgery (see Figures 15 and 16).

Figure 15 – Operating theatre session utilisation across north west London by hospital (providing elective orthopaedic surgery) (2021)

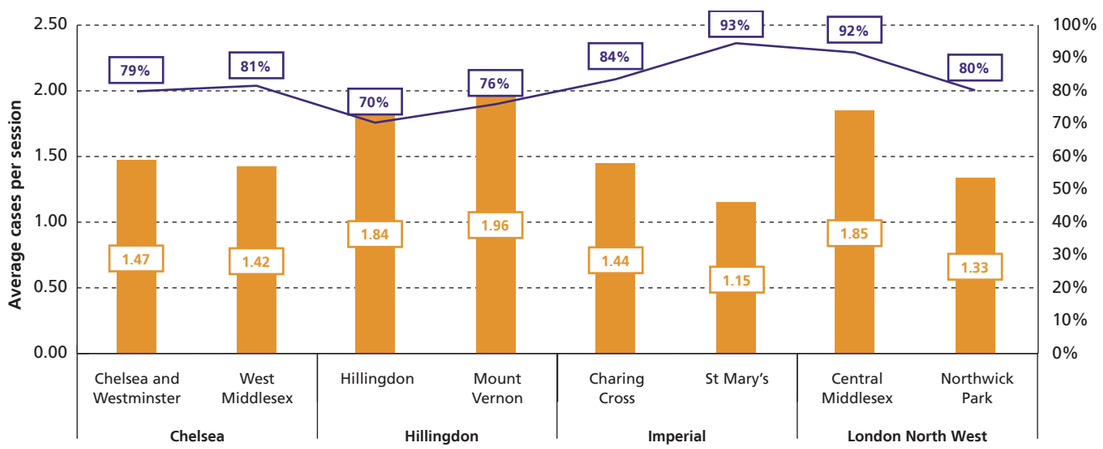
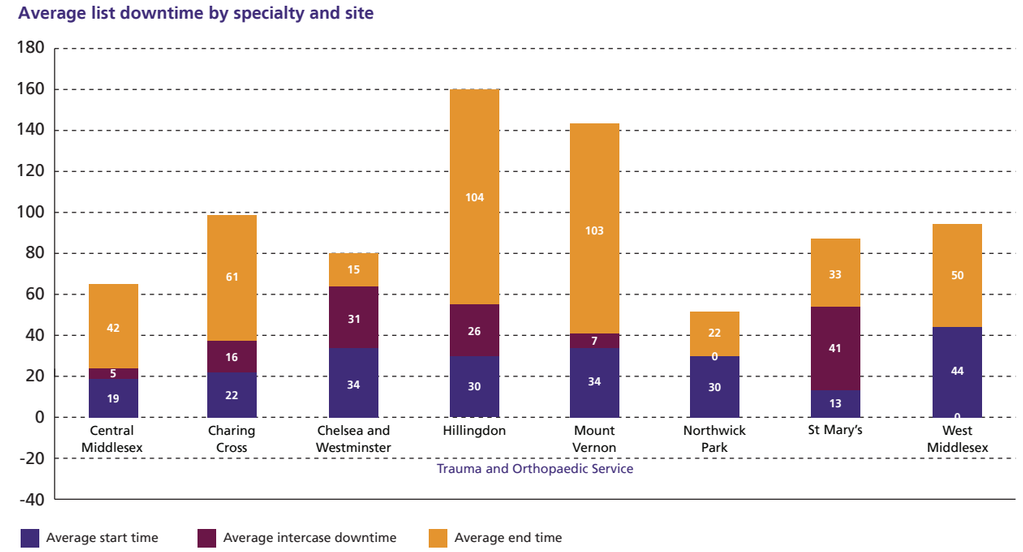


Figure 16 – Operating theatre session downtime for orthopaedic surgery across north west London by trust (2021)



A common approach to planned orthopaedic care, with all staff drawing systematically on best practice and learning from one another, would bring benefits across all aspects of care including theatre efficiency and productivity.

2.4 Workforce 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.

As an innovative care model, with its potential for a range of new roles and ways of working and an aspiration to embed best clinical practice, the elective orthopaedic centre will help us with both 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.

3 Developing the clinical model

3.1 Process to develop the clinical model

The model of care builds on increasing collaboration across north west London during the COVID-19 pandemic. The development of the model was led by the North West London Orthopaedic CRG. The group is continuing to engage, through workshops and discussion, to improve and detail the model further.

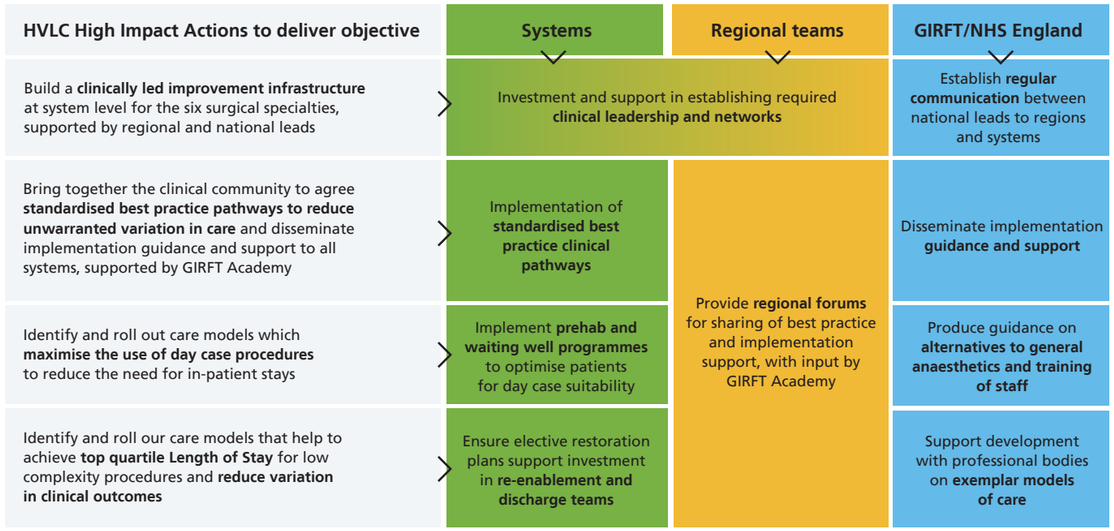
It draws on extensive best practice collateral, from north west London and nationally. This includes guidance from NICE[10] and best practice recommendations from GIRFT[11] [12] (see Table 8 and Figure 17). It envisages greater use of recognised insight, including PROMs[13] the National Joint Registry[14] and the American Society of Anesthesiologists (ASA) Physical Status Classification System.[15] It also follows north west London MSK guidelines on self-care and secondary care referrals[16] [17] .

Table 8 – GIRFT best practice recommendations for elective orthopaedics

Theme	GIRFT comment	EOC meets best practice?
Hot and cold sites	Best practice is to rigidly enforce ring fencing of elective orthopaedics minimises infection. Some trusts have achieved this, others haven't.	✓
Service design	Best practice is to rigidly enforce ring fencing of elective orthopaedics minimises infection. Some trusts have achieved this, others haven't.	✓
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	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, resulting in savings of £18m p.a. on hips and knee implant costs alone.	✓

10 https://www.nice.org.uk/guidance/published?ndt=Guidance&ndt=Quality%20standard
11 "Getting it Right First Time in Orthopaedics: reflecting on success and reinforcing improvement", GIRFT, February 2020.
12 https://gettingitrightfirsttime.co.uk/wp-content/uploads/2020/08/GIRFT-Hip-and-Knee-replacement-pathway-May-2020-003.pdf
13 https://digital.nhs.uk/data-and-information/data-tools-and-services/data-services/patient-reported-outcome-measures-proms
14 https://www.njrcentre.org.uk/njrcentre/default.aspx
15 https://www.datadictionary.nhs.uk/attributes/asa_physical_status_classification_system_code.html
16 "Musculoskeletal Services: Supporting Self-management Pharmacological Management Triage Specification Referral Criteria", North West London Collaboration of Clinical Commissioning Groups, December 2020.
17 "Musculoskeletal: Referral Criteria to Secondary Care", North West London Collaboration of Clinical Commissioning Groups, December 2020.

Figure 17 – GIRFT framework for improving quality and outcomes in high volume, low complexity surgery



3.2 Process for developing and refining options and evaluating the shortlist

Service and site options were developed and refined through a series of workshops, including clinical input. See Chapter 6 for details of the approach to identification and appraisal of the delivery options, and evaluation of the shortlist.

3.3 Process to develop the finance and activity model

In developing the financial model for the elective orthopaedic centre, the emergence of the acute provider collaborative has been recognised. Although this does not change the statutory basis on which NHS trusts operate, the emergence of the collaborative has engendered a more collaborative approach to financial and contractual arrangements between the four trusts in north west London. The trusts have developed, with the support of the North West London ICB leadership, a joint working arrangement which allows for greater coordination and collaboration, and which explicitly enables major projects such as the north west London elective orthopaedic centre by providing for risk-share and joint management arrangements. The trusts take joint responsibility for ensuring that the benefits for the system are delivered, and that the risks for all partners in the project are mitigated. This means that, from a financial perspective, it does not matter which trust is the 'lead provider' – rather, all of the trusts will work together to secure the benefits of the project for their patients, carers, staff and local population.

The financial model has been developed to reflect with as much precision as possible the likely financial consequence of the new north west London elective orthopaedic centre, including host hospital day care (DC) and elective (EL) caseload and taking on the elective activity for the wider north west London sector (excluding the more complex cases at ASA 3 and above and revisions, as described elsewhere in the case). Capacity maximisation and efficiency/effectiveness has been at the centre of the model's development, which has been reviewed by a group of finance leads from each of the Trusts (the north west London elective orthopaedic centre Finance Working Group) and by the north west London Acute Chief Financial Officer's Group.

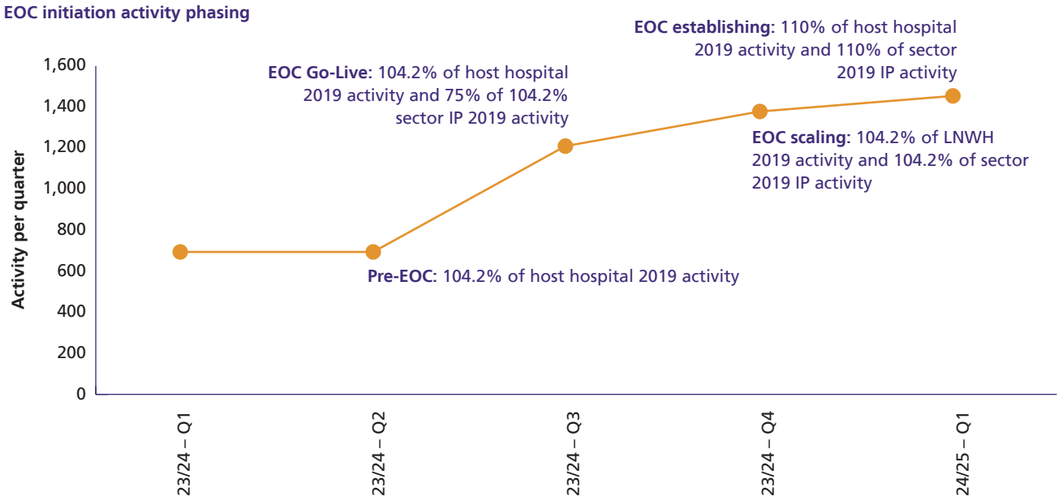
Capital investment assumptions

- The £9.412m capital requirement is now fully funded and reflected in the North West London Acute Collaborative capital programme.
- The capital costs are based on RIBA Stage 4 Design costings, including a 23% optimism bias risk adjustment.

Activity planning assumptions

- Activity modelling is reflective of the north west London Operating Plan needs, up to the end of 2024/25 (in line with national planning assumptions for the NHS). After this point the cumulative impact of Greater London Authority (GLA) population demand growth beyond 2025 up to 2029 is used, as this exceeds the 110% modelled in the operating plan (2029 is the ceiling year in the model as this is when beds become a limiting resource – activity beyond this point plateaus). This approach provides for some resilience in the model in the case of increased population-driven demand.
- Activity in year one of the service gradually increases to allow for a manageable pathway transition. Details of the activity ramp up that lead to the recurrent capacity (as detailed above) are as follows (the plan assumes commencement in Autumn 2023).

Figure 18 – North west London elective orthopaedic centre activity phasing per quarter



Workforce modelling

- The financial model has been developed using a collaborative workforce model, which has been developed in partnership with multidisciplinary service clinical leads. This means that the workforce model has been informed by clinical and managerial expertise, and then tested in discussion with a broader group of colleagues.

Developing the costs of the service model

- The approach to costing has been informed by service-line reporting within the trusts and by a review of reference costs which are used to set prices for NHS-funded services in England and has been tested by the north west London Elective Orthopaedic Centre Finance Working Group
- Investments in supporting corporate services have been captured with estates charges being costed with the facilities team and with increased investment in other revenue support functions such as ICT, finance and insurance being captured based on the % of host hospital existing costs represent of direct clinical spend.
- The detailed modelling for the elective orthopaedic centre includes various uplifts to model and mitigate financial risk including optimism bias (as detailed above), the impact of indexation (revenue and capital), a significant temporary staffing premium (reflecting current market backfill needs), the application of a 10% discounted cash flow adjustment to account for the time value of money and a financial provision to take account of anticipated 'did not attends' (DNAs) within the service.

Efficiency and value for money

- The financial model includes some key assumptions in relation to improvements in efficiency which help to deliver better value for money. There are two key elements to this value for money assessment – reducing the cost of the service at the same time as improving patient pathways which leads to better value for money for the NHS estate.
- Looking first at the improvements in cost, benefits to all the trusts (and hence the local NHS) have been quantified using a series of assumptions based on a move initially to the efficiency levels of the most efficient provider in north west London (based on the 2019/20 National Cost Collection (NCC) inflated to current year prices), and then on a phased move to upper quartile efficiency. This approach shows that the benefits of combining the service delivery model on a single site and then driving up productivity and efficiency (primarily through achieving GIRFT best practice average length of stay and theatre utilisation) will drive an initial north west London £4.1m annual cost saving using this method. The preferred option (Option 5) provides the greatest financial benefit of the described options using this approach.
- In principle, the model and the efficiency escalator are site-neutral. In effect, benefits can be delivered on any single-site location across north west London as the benefits come from improved efficiency and productivity through the management of the service as a single team. However, there is a further level of benefit for the system which has been reflected in the financial modelling. Across the north west London estate, and within the north west London acute providers estate, there are a number of high-quality and high cost facilities which were secured under the Private Finance Initiative model (or variants thereof). The annual costs of these sites are fixed to a higher degree than 'standard' NHS property and it is a key principle that the utilisation of these sites should be maximised to ensure the best value for money. The choice of site – Central Middlesex Hospital – for the preferred option reflects the objective of maximising the use of currently underutilised capacity.
- Outpatient modelling has been assumed as cost neutral in all modelling scenarios. A further level of efficiency and service improvement is possible here, but there is work to do with clinical leaders to develop the optimum service model, taking into wider transformation of outpatient delivery.

3.4 Pre-consultation engagement

A series of pre-consultation engagement sessions was held. See Chapter 7 for details of these engagement sessions, including the approach taken, key themes from the engagements, and planned future engagement.

3.5 Impact assessment

Equality health impact assessment

North west London understands that the implementation of an elective orthopaedic centre may disproportionately impact some groups of the population. To understand this impact, an EHIA has been carried out. This takes a systematic and evidenced based view to considering the likely impact on the different groups of people, and sets out the mitigating actions that will be incorporated into the implementation plan.

The evidence considered in the EHIA includes:

- HES (https://digital.nhs.uk)
- Dr Foster (https://drfoster.com)
- Model Hospital (https://model.nhs.uk)
- GLA Housing Led Population Projections (https://data.london.gov.uk/dataset)
- Office for National Statistics (https://www.ons.gove.uk)
- Google Maps (https://maps.google.com/maps)
- Trust theatre systems

Summary of the EHIA

Previous research, and local analysis, suggests potential negative impacts for patients for whom access to a healthcare setting is a challenge, in particular:

- elderly patients
- disabled patients
- Black and minority ethnic patients for whom English is a second language
- patients from deprived areas

Consideration has been given to these groups in the option appraisal for a preferred site within north west London, and Central Middlesex Hospital has been shown to be the most accessible viable site for an elective orthopaedic centre.

As the centre plans for implementation it will develop detailed operational policies to address the specific needs of patients, for example virtual pre-operative assessment to avoid hospital attendance where appropriate.

Staff's needs will be considered by the workforce group, which is developing an employment model. Best human resource practice will be followed in any negotiations or consultations with affected staff.

The following are recommended to mitigate possible negative impact on patients (ref "Equality and Health Inequalities Impact Assessment: High volume low complexity surgical hubs – Orthopaedics" – Health Innovation Network South London and Imperial College Health Partners, Dec 2021):

- Improved population level data dashboard should be set up at ICS level to analyse patient data (including comorbidities) to provide assurance that HVLC hubs are not creating health inequalities, particularly for those with communication issues, translation needs, serious mental illness, learning disabilities and deprivation.
- Ensure consistent application of the HVLC criteria so that patients are prioritised based upon their clinical requirements, with a particular focus on better preparation for surgery, patients with comorbidities requiring additional medical intervention from both primary care and pre-operative teams to stabilise their long-term condition.
- Improved monitoring of waiting lists for HVLC procedures to ensure all patients are seen in a reasonable and equitable time period. Action should be taken to monitor and mitigate against greater impact upon certain groups that face inequalities, for example, patients with disabilities, economic deprivation and lack of support network.

Equality of impact by protected characteristics

This section sets out a summary of the EHIA for each protected characteristic, and the mitigating actions. A full version can be seen in Appendix 1.

Age:

- The north west London elective orthopaedic population is older than the general population. The older population are more likely to require inpatient than day case surgery, the primary admission type for the elective orthopaedic centre.
- Travel and accessibility for older people, those with disabilities and individuals on low incomes could be a barrier to orthopaedic surgery.
- Actions to reduce/eliminate negative impacts in relation to age are:
  - develop clinical model which minimises visits to the centre by providing outpatient care at local trusts
  - develop virtual pre-operative assessment where suitable, alongside face-to-face options to avoid digital exclusion
  - design the centre to be compliant with current legislation regarding accessibility and wayfinding
  - develop standard discharge operating policies in collaboration with community colleagues to ensure effective discharge from hospital
  - ensure all future quantitative research is segmented according to demographics including age
  - identify any age-specific groups in north west London and involve them in the public consultation
  - capacity and growth issues will need to be addressed in future developments of the centre.

Disability:

- Research from the London Equality Impact Assessment (EIA) (ref. "Equality and Health Inequalities Impact Assessment: High volume low complexity surgical hubs – Orthopaedics" – Health Innovation Network South London and Imperial College Health Partners, Dec 2021) identifies that those with disabilities find it harder to navigate the healthcare system.
- Analysis of the current north west London waiting list shows that hypertension, obesity and diabetes are the most frequently recorded long-term conditions.
- Long-term conditions that are well-managed would not necessarily result in exclusion from the centre. However, those requiring additional time and medical intervention to stabilise their long-term condition (particularly if it was a recent diagnosis) prior to surgery may not meet the criteria and would require surgery at their local trust. They could, therefore, have differential waits for their procedure but would have equal clinical outcomes.
- Actions to reduce/eliminate negative impacts in relation to disability are:
  - develop clinical model which minimises visits to the centre by providing outpatient care at local trusts
  - develop virtual pre-operative assessment where suitable, alongside adjustments for those with physical or sensory disabilities, learning disabilities and those on the autistic spectrum

- design the centre to be compliant with current legislation regarding accessibility and wayfinding
- review the transport requirements of the patient group, including disabled access and parking, and explore the potential for dedicated transport provision to the centre, as has been introduced by SWLEOC
- ensure that groups and communities working with people with disabilities are involved in the consultation, using a range of formats and methods
- continually involve patients, through a variety of methods, to make sure that wards meet multiple mental health and care needs, including disability
- work with staff disability networks to ensure necessary adjustments for staff with disabilities
- ensure there is sufficient and accurate diversity data to monitor how people with disabilities use services and what their particular needs are
- monitor elective orthopaedic waiting times across the sector to ensure that patients who are not eligible for treatment at the centre do not wait longer, and take mitigating action if such waits are revealed.

Deprivation:

- Deprivation can be a barrier to access to healthcare. Analysis has found that patients in the top three quintiles of the wealth distribution benefit twice as much as those in the bottom fourth quintile; and have more choice of where they have their hip replacement surgery.
- Over half of the north west London population are more deprived than the national average, with a particular concentration of high deprivation in the middle of the north west London sector.
- Analysis of travel times shows that residents of the most deprived parts of the north west London sector have increased travel times to CMH, by car and public transport, compared to today; the CMH option, however, has reduced travel times compared to the other options considered.
- Actions to reduce/eliminate negative impacts in relation to deprivation are:
  - involve as many communities as possible in the development, looking specifically at how to listen to those from deprived areas
  - pay particular attention to the travel needs of patients, families and carers from deprived areas
  - north west London will consider travel solutions (including dedicated transport provision to the centre) and encourage people to apply for travel reimbursement through the Department for Work and Pensions, providing simple access to information
  - staff travel impacts will be analysed and incorporated in staff consultation
  - work with Transport for London in relation to adjustments to support affordable access, for example adapting bus routes
  - develop clinical model which minimises visits to the centre by providing outpatient care at local trusts.

Gender affirmation:

- 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.
- For the data analysis, the main source of data is Hospital Episode Statistics (HES), which does not generally record reliable details of this protected characteristic.
- Actions to reduce/eliminate negative impacts in relation to gender affirmation are:
  - the clinical team will consider therapeutic activities which address the specific needs of the transgender community
  - improve knowledge and cultural competency among staff through awareness and training
  - ensure policies to protect the rights of transgender staff are known and followed
  - make available specific advice and support to make sure that trans individuals are supported appropriately when admitted to the centre
  - identify any trans specific groups in north west London and involve them in the public consultation
  - establish ways of capturing data on transgender patients to ensure we understand the needs of this community and how they use services.

Marriage and civil partnership:

- For the data analysis, the main source of data, HES, does not generally record reliable details of this protected characteristic.
- Actions to reduce/eliminate negative impacts in relation to marriage/civil partnership are:
  - throughout the development of the centre, feedback will be received from patients and staff with a range of partnership status. Any specific issues will be highlighted if they emerge and responded to accordingly
  - establish ways of capturing data on patient partnership status to ensure equity of access.

Pregnancy and maternity:

- A significant proportion of patients within the orthopaedic HVLC pathways are 50 years or over and therefore highly unlikely to be pregnant, therefore it has been 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 that will undergo elective orthopaedic surgery.
- The majority of nursing staff, the largest staff group in the elective orthopaedic centre, are female. The centre will develop HR policies and procedures that recognise the needs of the workforce including considering staff's caring responsibilities.
- Actions to reduce/eliminate negative impacts in relation to pregnancy and maternity are:
  - throughout the programme development process, it is expected that north west London will receive feedback from a range of people and highlight any specific issues specific to pregnancy and maternity if they emerge and respond to these issues accordingly
  - pregnant women will not be eligible for treatment in the centre due to their clinical complexity
  - the centre will develop HR policies and procedures that recognise the needs of the workforce including parental leave, flexible working and caring responsibilities
  - consult staff on access to the centre, including car parking and travel costs, and consider solutions.

Race:

- In England, people from ethnic minority backgrounds face a range of inequalities compared to white groups in their health experience, including their access to health, and outcomes from using health services.
- This structural disadvantage has been underlined by the COVID-19 pandemic. Assumptions and stereotypes within healthcare provision can 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.
- 47% of north west London's known ethnicity is non-white. The non-white proportion is slightly greater in the elective orthopaedic cohort.
- Actions to reduce/eliminate negative impacts in relation to race are:
  - the communications and involvement strategy will be aimed at providing opportunities for the population of north west London to be involved in the development of the programme and to give their feedback, regardless of protected characteristic. A range of methods to encourage involvement will include communities that are hard to reach.
  - north west London will:
    - ensure any public-facing information on the programme and any subsequent proposals are provided in appropriate formats, if needed
    - ensure links have been made with the BAME Forum, local faith communities or cultural groups, to encourage involvement and gain feedback through all stages of public involvement
    - ensure that Friends, Families and Travellers (the national charity working on behalf of all Gypsies, Travellers and Roma) receive information on all involvement activity
    - work with staff BAME networks to understand their needs and meets the NHS and local Workforce Race Equality Standard (WRES)
    - develop a consistent mechanism of robust equalities-based involvement to ensure that all voices are heard
  - develop end-to-end pathways in collaboration with the north west London MSK network
  - carry out positive regular monitoring of the ethnicity of the patients using the centre, and develop plans to address any disparities
  - the workforce workstream will develop strategies to ensure appropriate BAME representation in the staff group
  - all of the above actions will be overseen by the Programme Board and will be reviewed regularly.

Religion:

- Some research for specific religious groups has found providers lack understanding of patients': religious and cultural beliefs; language-related patient-provider communication barriers; modesty needs; lack of understanding of disease processes and the healthcare system; lack of trust or suspicion about the healthcare system, including providers; and system-related barriers.
- For the data analysis, the main source of data, HES, does not generally record reliable details of this protected characteristic.
- Actions to reduce/eliminate negative impacts in relation to religion/beliefs are:
  - identify and engage faith groups in north west London through public engagement and involvement
  - work with staff spirituality networks and chaplaincy teams to make sure north west London meets the needs of patients and staff from differing religious and faith backgrounds
  - establish ways of capturing data on patient religions/beliefs to ensure north west London understands the needs of this community and how they use services.

Sex:

- Known higher life expectancy for women could be shown in their 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.
- 51.9% of the elective north west London trauma and orthopaedics patient spells were female in 2021.
- Actions to reduce/eliminate negative impacts in relation to sex are:
  - centre design will reflect the expected gender mix to meet NHSE's 'enhancing privacy and dignity' policies, including single sex accommodation, changing and toilet facilities
  - ensure that the centre's staff facilities also provide privacy and dignity for staff
  - develop procedures to ensure patients have access to appropriate chaperone where necessary
  - all quantitative research will be segmented according to demographics, including sex.

Sexual orientation:

- Almost one in four lesbian, gay, bisexual 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).
- For the data analysis, the main source of data, HES, does not generally record reliable details of this protected characteristic.
- Actions to reduce/eliminate negative impacts in relation to sexual orientation are:
  - any feedback in relation to this impact will be considered throughout the development and co-design process and appropriate actions agree
  - north west London will work with:
    - LGBTQI+ community groups to identify and engage with potential service users in this group
    - staff LGBTQI+ network to understand the needs of staff

3.6 Avoiding digital exclusion

We will put measures in place to ensure the proposed elective orthopaedic centre service is inclusive and meets the needs of the population it is serving – this will include plans to address digital exclusion.

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.

Our work will be guided by digital inclusivity guidelines set by NHS Digital, and recommendations from the NW London digital inclusion steering group, based on evidence from a recent research study. One of the recommendations in the NW London ICS digital inclusion research report is the development of a digital inclusivity charter which we will follow.

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 which can be tailored depending on an individual's need and choice. We will design and implement digital services that are easy to use and which are fully tested by a cross section of patients. 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.

When communicating with our patients, it is essential that we define and deliver an approach so we can record and recognise every patient's individual needs and preferences, to ensure they can easily access communications, information and care. 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 to identify groups of people who are digitally excluded who might need access to the internet, a device or digital education and training. 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. This can lead to improved self-management of long-term conditions.

We plan to train a group of staff in our sector to become digital champions who can then help support and educate digitally excluded groups, patients, residents and other staff who would like to develop and improve their skills. This work will include education and training offered in different languages. We will also work with other external organisations to share and signpost external digital inclusion education programmes.

We also plan to work with other community organisations within the NWL ICS who already offer members of the public access to digital devices. Working with partner organisations, we also plan to develop a database to measure up take and use of the digital devices. This will help us to measure digital maturity and whether access to digital technology is improving within the sector.

There are plans for a digital inclusivity dashboard, in connection with our health inequality framework, which will pull together data from various source to help us to monitor and measure the improvements we make. It will also help us to review and grow our understanding of digital exclusion and its implications for more vulnerable groups.

The views of our patients and members of the public are important to us, we realise we can always do more to provide inclusive services - we will continue to have conversations and undertake research, particularly centred on the challenges experienced by our patients when communicating with our hospitals and staff, and managing their care, and to better understand the role, and the best use of digital technology.

3.7 Quality impact assessment

This quality impact assessment (QIA) tool is designed to quantify potential impacts on quality from any proposal to change the way services are commissioned and/or delivered. Each proposal will need to be assessed as to whether it will impact adversely on patients, staff and organisations.

The QIA is summarised in the table below.

Table 9 – Summary of the Quality Impact Assessment

Quality Impact Assessment	Commentary
Impact / risks of making this change on Patient Experience	The proposed development has been informed by best practice and guidance and been assured through the NHSE assurance checks. These included including Test 1: Strong public and patient ; Test 2: Consistency with current and prospective need for patient choice and Test 3: Clear clinical evidence base. Final decision making will be informed by the public consultation, the integrated impact assessment and review of clinical quality and patient access metrics.
Impact / risks of making this change on Patient Safety	
Impact / risks of making this change on Clinical Effectiveness	
Impact / risks of making this change on staff satisfaction	A detailed workforce programme has been developed to support this development which in turn is supported by the wider NWL People Plan. This includes a focus on staff engagement, recruitment, training and development, flexible working, training and development opportunities. This is a key area of focus by the programme board and continues to be monitored through the risk management process.

Patient Experience

Details

- Some patients from north west London will be required to travel further for their surgery, and increased journey time may affect their satisfaction.
- Travel analysis shows the preferred option in comparison to the other north west London elective orthopaedic providers, is the most accessible site in terms of average travel time by public transport and car. However this can have a differential impact depending on where the patient journey starts.
- The preferred option is within the ultra-low emission zone introduced in October 2021 and patients travelling into the hospital in a car which is not exempt will be charged.
- The service model will mean that patients whose surgery is within the scope of the elective orthopaedic centre will be listed for surgery at the centre. Patients will continue to have a choice of provider as per the national patient choice framework.
- The elective orthopaedic centre will be a centre of excellence and will work to national best practice standards as set out by GIRFT, which aim to improve the quality of care.

Assurance

- patient travel analysis (Appendix 4)
- public engagement (Appendix 5)
- learning from other centres (SWLEOC; Royal Cornwall; Lincoln; Nottingham; Gloucester)
- application of GIRFT principles to the proposed way of working
- PROMS

KPIs

- GIRFT – average length of stay; cases per operating list: revision rates; emergency readmissions (ref: www.gettingitrightfirsttime.co.uk)
- Friends and Family test (found in divisional clinical governance/performance reports)
- complaints/PALS queries (found in divisional clinical governance/performance reports)
- PROMs scores (ref: www.england.nhs.uk/statistics/statistical work areas/patient reported outcome measures (PROMs)).

Patient Safety

Details

- GIRFT best practice sets out safety standards including the ring-fencing of elective orthopaedics for infection control purposes. The centre will comply with these standards.
- Care for under 18 year olds will not be delivered at this site.
- Spinal surgery and anaesthetically complex (ASA3+) surgery will not be offered in the centre.
- The design of the centre will be subject to Health Building Note (HBN) standards where they apply and any derogation will not be detrimental to safety.
- As a centre of excellence, the centre will employ staff with relevant expertise and interest in elective orthopaedics.
- Advanced nursing and therapist roles will be introduced to provide professional expertise and continuity of care.

Assurance

- Any derogation from HBN standards will be signed off by the Project Group, with no compromise to patient safety.
- Advanced nursing and therapist roles will be signed off by the Chief Nursing Officer/AHP Lead and will meet professional requirements (Health Care Professional Council and Royal College of Nursing).
- The centre will be governed under a partnership arrangement, which will include a clinical leadership team, with regular multidisciplinary team governance.

KPIs

- Datix reporting; complaints/PALS reporting (found in divisional clinical governance/performance reports)
- litigation rates (ref: www.gettingitrightfirsttime.co.uk)
- surgical site infection rates (Public Health England – now Office for Health Improvement and Disparities – www.gov.uk)
- readmission rates; revision rates (ref: www.njrcentre.org.uk)
- comparative mortality and morbidity reporting (found in divisional clinical governance/performance reports)
- clinical governance framework including multidisciplinary peer review.

Clinical Effectiveness

Details

- GIRFT standards set out best practice productivity and quality and the centre will expect to achieve these.
- As a sector-wide service, patient access for those patients in scope will be equalised, but those outside the scope of the centre will experience differential waits.
- Standardisation will result in improved productivity and outcomes, and will improve waiting lists over time.

Assurance

- A partnership board and partnership agreement will be established to ensure effective partnership working.
- A single waiting list will be implemented.

KPIs

- PROMs for hips and knees (ref: www.england.nhs.uk/statistics/statistical work areas/patient reported outcome measures (PROMs)
- waiting list performance (North West London ICS and NHSE)

Staff Satisfaction

Details

- A change in the location of work will adversely affect some staff.
- Surgeons and anaesthetists will be job planned to carry out surgery and post-operative care at the centre, remaining contracted to their host employer.
- There is a risk of short-term staff shortages as the centre is set up and workforce levels are adjusted across north west London.
- As a centre of elective orthopaedic excellence there will be career and development opportunities for staff.

Assurance

- staff consultation
- staff survey
- staff listening events
- medical model and standard operating procedure for care of patients in the centre.

KPIs

- staff metrics – vacancy; retention; turnover; sickness/absence rates (trust reporting)
- informal staff feedback

4 Clinical model

4.1 Scope and vision

The proposed elective orthopaedic centre is intended to be part of an improved end-to-end pathway for musculoskeletal (MSK) disorders (see Figure 23).

Patients will benefit from early assessment of their needs virtually or close to home and will be supported immediately to maximise their health and, where possible, reduce symptoms. If surgery is required, they will be guided to the surgical care service that can best meet their needs. If they are broadly well 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 need day case surgery or more complex surgery or who have additional health risks will be offered surgery in whichever of the north west London hospitals that currently provide orthopaedic surgical care is suitable for their needs.

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

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 separated 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 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.

Figure 19: 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.

4.1.1 Proposed scope for the elective orthopaedic centre

The centre will be able to offer elective orthopaedic surgery to adult patients with an ASA classification of 1 or 2 (no or only mild systemic disease).

Patients categorised as ASA 3 and above will not be suitable due to the need for close proximity to other specialist teams and clinical support services.

Day case surgery has been excluded currently to maintain shorter travel distances for patients on the day of surgery. (Day case surgery and complex surgery provided by London North West University Healthcare will take place in the elective orthopaedic centre as it is their 'home' orthopaedic hospital.)

Some inpatient orthopaedic procedures are also out of scope, including spinal surgery and joint revisions. Spinal surgery in north west London is provided through a separate centralised service run by Imperial College Healthcare's neurosurgical service made up of neurosurgeons as well as orthopaedic surgeons. A dedicated orthopaedic centre is also in line with GIRFT recommendations for elective hubs.

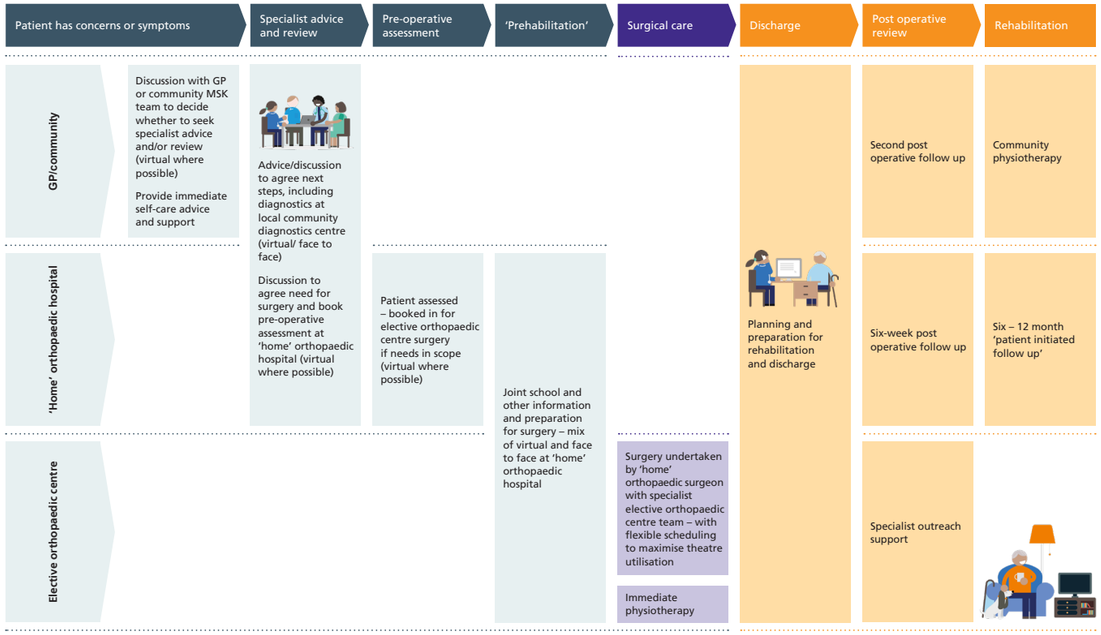
Paediatric orthopaedic surgery is also out of scope.

Some patients whose needs are in scope for the proposed elective orthopaedic centre are currently offered surgery in independent sector facilities. These patients will be able to access the elective orthopaedic centre.

4.2 Overview of proposed clinical model

The North West London Clinical Reference Group (CRG) agreed a draft model in May 2022 (see Figure 20) and are continuing to incorporate improvements through further discussion and engagement.

Figure 20 – North west London elective orthopaedic centre model of care



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

The model will also support best clinical practice, including:

- NICE guidance NG 157 and 197
- multimodal, standardised pain control protocol, including local infiltration analgesia
- multimodal management of blood loss, such as the use of tranexamic acid
- NICE guidelines supporting venous thromboembolism prophylaxis
- PROMs and National Joint Registry data collection via integrated software
- standardised post-operative prescribing
- standardised patient information and advice

The proposed best practice pathway of care for elective orthopaedic inpatients is detailed in Figure 25, showing day of surgery (pre-operative, intra-operative and post-operative) phases through to the inpatient phase.

4.3 Activity modelling

Activity and capacity modelling has been carried out to assess the six service options in terms of their projected impact on the system's future capacity.

The activity projections have been undertaken using data from the following sources:

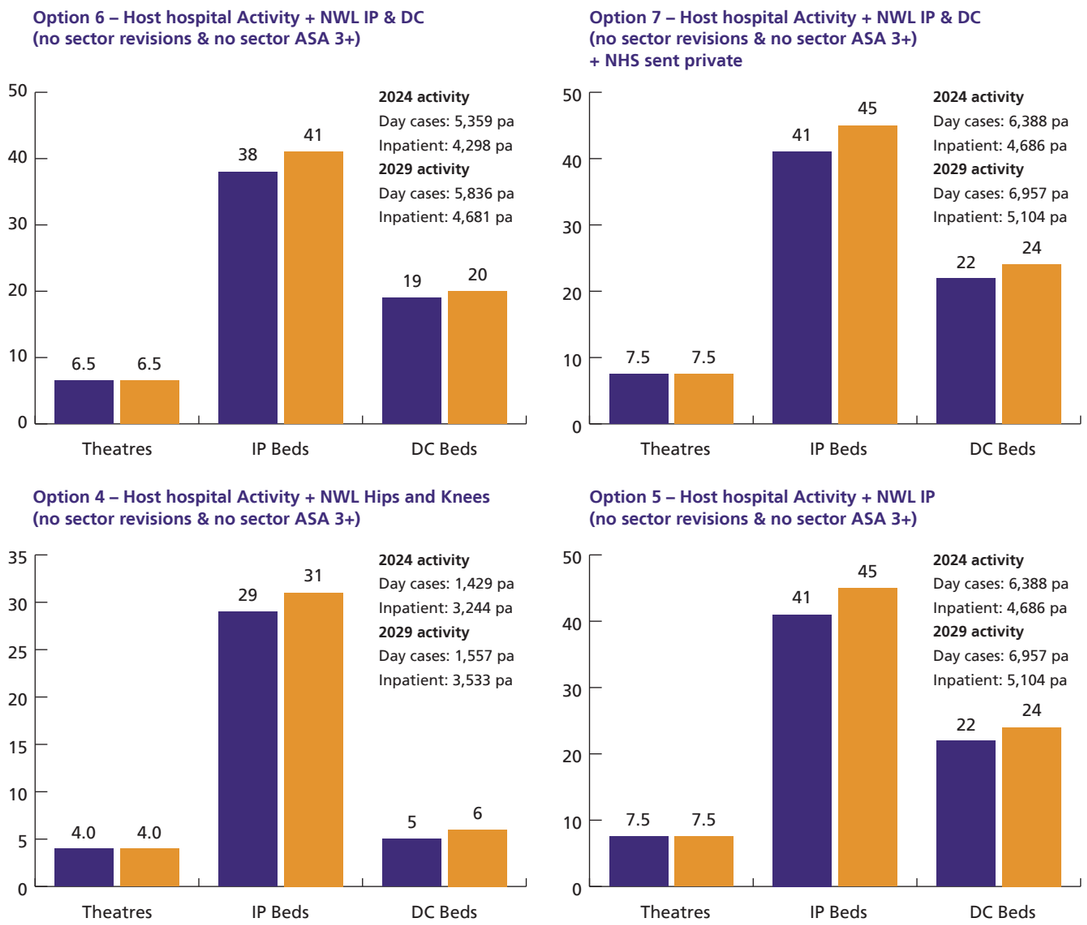
- Local plans
- GLA Housing Led Population Projections
- Expert opinion
- Newton-PAS Data
- Dr Foster 2019
- Host hospital Theatre System Activity 2019
- 2019 clinical commissioning groups (CCG) data
- Trust Data Systems
- Model Hospital data

Six activity and capacity options (listed in Figure 21) have been modelled, starting with the baseline position and building up incrementally from a host hospital activity position to all north west London sector activity. As more demand is consolidated from the sector, the theatre and bed requirements increase accordingly.

The key activity modelling assumptions are as follows:

- Historic inpatient and day care activity from all north west London elective orthopaedic providers (excluding spinal surgery, ASA 3, 4, 5s and revisions) in north west London was used as a basis for the demand model.
- Activity data from 2021 and 2022 was not considered due to COVID-19 pandemic effects. Considering that in 2019 waiting lists in north west London had been relatively stable, this activity was used as a proxy for demand.
- Demand was forecast to 2030 utilising 2019 data adjusted for patient demographic-specific population change as per 2020 GLA Housing Led Population Growth Projections.
- Impact of other demand influencing factors – such as the changes in BMI, local orthopaedic demand influencing initiatives and changes in utilisation of the private sector – were considered non-trivial to model and thus not included in demand forecasts.
- Demand converted into theatre requirements based on 49 surgery weeks per year:
  - 10 planned surgical sessions per 4-hour theatre list per week for weekdays
  - 2 planned surgical sessions per 4hour theatre list at weekends (Saturday only, 60% of theatres).
- Inpatient: 2 cases per 4-hour list
- Day case:
  - Y1 – 4 cases per 4-hour list
  - Y2 onwards – 5 cases per 4-hour list
- Using expert opinion, length of stay was set to Model Hospital top decile (average 2.3 days LOS) and bed utilisation was set to 90%.
- The number of theatres required has been rounded up to the nearest 0.5 of a theatre. Sensitivity analysis has been completed to test the robustness of the number of cases per session.

Figure 21 – North west London elective orthopaedic centre activity and capacity options*



* For Option 5, there are projected 4.58 theatres in 2024 and 4.84 theatres in 2030.

As stated above, the activity modelling for the six options excludes the north west London ASA 3s and revisions as these will be treated within the host hospitals. This position was agreed by the north west London elective orthopaedic centre clinical advisors.

The activity and capacity options shown above are evaluated from a financial and non-financial perspective in the economic case of this business case.

As our plans develop further, engagement with the London Ambulance service will be undertaken to understand, plan and where possible, mitigate any additional pressure on patient transport or ambulance services. Current standard operating procedures are included in Appendices 4 and 5.

4.4 Workforce

4.4.1 Workforce vision

North West London ICS has set out a People Plan, with a commitment to a workforce vision, the values and behaviours they will uphold and the actions they will take. 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. 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 acute provider collaborative has set out its People Priorities for:

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 well-being of our staff (across the North West London ICS).

The workforce model for the elective orthopaedic centre forms part of the acute provider collaborative's initial priorities, under priority 2, 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 centres

- 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 skills 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.

The emerging plan is currently at a high level with granular details to be incorporated into the decision-making business case and implementation plan.

4.4.2 Workforce capacity and capability

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.

The roles and whole time equivalent (WTE) for the proposed workforce model have been designed and quantified (Table 10):

Table 10 – Multidisciplinary team required for a north west London elective orthopaedic centre

Multidisciplinary team required for a north west London elective orthopaedic centre*			
20 Administrative and clerical	29 Allied health professionals	26 Consultants	4 Management
27 Medical (non consultant)	243 Nursing	2 Pharmacists	351 Grand total

*Numbers rounded

All trusts have been asked to complete a workforce data collection return using a consistent set of principles to identify the establishment (WTE) currently required to deliver the transferring activity, as well as staff in post (WTE). This activity is ongoing, and will provide a clear understanding of the recruitment and development requirements to successfully staff the proposed north west London elective orthopaedic centre. A review will be undertaken of the staffing arrangements at each of the acute trusts to ensure that the transfer of staff linked to the ASA 1 and 2 activity will not destabilise remaining services or impact on minimum staffing levels.

The workforce model will operate on the principle of a single team at the preferred site, which is managing the ASA 1s and 2s. This team will comprise of a combination of staff who transfer with the activity and recruitment into establishment gaps. The trauma and orthopaedics workforce who remain in each trust will specialise in the more complex cases, ASA 3s and 4s, and the non-elective cases.

Impact on residual services

Chelsea and Westminster Hospital NHS Foundation Trust (CWFT)

ASA 3 and 4 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 to medical rotas to ensure that residual services are not negatively impacted.

Imperial College Healthcare NHS Trust (ICHT)

ASA 3 and 4 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 the trauma and orthopaedics directorate, but strain could be placed on theatre nursing teams.

London North West University Healthcare NHS Trust (LNWHT)

While ASA 3 activity for LNWHT is in scope of the elective orthopaedic centre, ASA 4 activity and more complex cases will be managed on the Northwick Park Hospital site, with an isolated session enabling patient access to the intensive care unit. There are not expected to be any additional staffing challenges to the ones that are currently in place (anaesthetists).

The Hillingdon Hospitals NHS Foundation Trust (THHT)

Validated ASA 1 and 2 activity would be transferred to the elective orthopaedic centre with day cases remaining at Mount Vernon Hospital and ASA 4 activity undertaken at Hillingdon Hospital. Many of the staff currently delivering the transferring ASA 1 and 2 activity are doing so as a small proportion of their role, and it is unlikely that they will transfer with the activity. Some of these staff will be specialists (therapy staff), and 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, and there is 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.

It would also impact on the ability to run the weekend therapy rota and out of hours emergency respiratory rota and be detrimental to plans to implement the planned increase in weekend occupational therapy and physiotherapy, which is part of the trust's drive to reduce length of stay (dependent on recruitment to sufficient posts).

As day case activity is being retained (the largest proportion of activity undertaken), this could provide an opportunity to direct resources to address both growth and the patient tracking list (PTL) 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:

1. There are current vacancies across the staff groups which will be transferred to support ASA 1 and 2 activity (to be recruited into).
2. 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 with the repurposing of capacity.

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

To support the transition to the proposed model of working, we are tracking current staff availability metrics (establishment (WTE), staff in post (WTE), vacancy (WTE & %), in month starters and leavers, and bank and agency fill rates for medical and nursing) to ensure that if required we are able to put in place specific interventions to maintain and strengthen existing trauma and orthopaedic services.

4.4.3 Recruitment and retention

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.

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.

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 collaborative 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:

- post-anesthesia care unit (PACU) nurse qualified
- advanced nurse practitioner
- qualified ward nurse
- anaesthetic registrar
- consultant anaesthetist
- consultant orthopaedic surgeon
- physiotherapist
- radiographer

The biggest gaps in the existing workforce are for qualified (28.7 WTE) and unqualified (26.8 WTE) nursing, while other roles are known to be ‘hard to fill’. So, as well as exploring all conventional routes to recruitment, 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.

The development of innovation into the workforce including the introduction of new roles and effective ways of working would provide excellent opportunities for learning and development via rotational programmes.

The recruitment pipeline will be monitored via the existing programme governance structure on an ongoing basis to understand potential workforce risks in meeting the proposed timeline.

4.4.4 Teaching, training, education and research

A driving principle is that the proposed workforce models, at the base sites and the elective orthopaedic centre, provide sufficient volume and opportunities for the teaching, training and education of key clinical staff, including therapists, nurses and doctors. The proposed elective orthopaedic centre would have sufficient volumes to take part in research trials and forge formal academic links with appropriate academic partners.

A further key principle of developing the north west London elective orthopaedic centre is to focus on developing research and education. Through this approach, providers would improve capacity in this field nationally, and provide specialist training for a new generation of doctors and allied health workers.

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.

4.4.5 Working arrangements

Working arrangements will be linked to business need, with the following options available for the different staff groups:

- some staff will be employed directly by the host trust
- some of the workforce will be covered by existing portability agreements (Memorandum of Understanding for staff portability or digital passport).

Under the proposal that the elective orthopaedic centre will be hosted by host hospital in the first instance, it is expected that all staff, with the exception of consultants and junior doctors from provider trusts, will be directly employed by host hospital.

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 South West London elective orthopaedic centre (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.

The presumption is the elective orthopaedic centre would function without any reliance on overnight or ward-based support from trainees.

HEE would be involved in the development of the training model to ensure training requirements are fully integrated into delivery plans.

This is likely to present challenges with regards to rota management and service provision that should be addressed in detail within any education and training plan developed by providers.

However, the model should also offer opportunities for training and education through access to this range of activities and procedures and increase the benefits for doctors working within this model.

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

There is therefore an expectation that provider trusts will release posts to support the elective orthopaedic centre. If they are currently staffed, a review will be undertaken to determine whether the requirements for TUPE transfer have been met, with transition plans developed. If the post is vacant then it will need to be included within recruitment plans.

An assessment will be undertaken to understand any variance in remuneration and reward as a result of staff choosing to or being required to work in the North West London ICS elective orthopaedic centre and provisions will be explored to ensure that no member of staff is worse off than in their previous role.

4.4.6 Staff communications plan

We aim to ensure that all staff are aware of our plans and feel able to contribute to the consultation and we will ensure that affected staff feel able to shape the plans

Information on the proposed north west London elective orthopaedic centre has been made available within each trust via stakeholder newsletters as well as a website news story.

Meetings are being planned with trade union representatives in advance of meeting with the trauma and orthopaedic directorate and affected staff at each of the trusts, with a joint presentation from the trust clinical and workforce leads.

A set of questions and answers is being developed within the workforce workstream to ensure consistency in approach, and will continue to be updated to address any queries raised by staff.

5 Appraisal of options to deliver the clinical model

This section documents the range of options identified for the pathways that could be included in the elective orthopaedic centre and the location of the services, and the process for shortlisting these options as well as their subsequent evaluation. There is a commitment to a fair appraisal of the various options to finalise a solution that offers the best services for patients in north west London. This chapter includes:

- A summary of the options for the pathways to be provided in the elective orthopaedic centre
  - An outline of the range of 8 options.
  - The process of shortlisting this down to five options and then one preferred pathway offer (8>5>1 service).
- A summary of the options for sites that could host the elective orthopaedic centre (that is, the clinical evaluation stage)
  - An outline of the range of 10 named site options
  - The process for shortlisting this down to two sites that were deemed clinically appropriate for further consideration (10>2 sites).
- The two-site options then had further assessments applied; these looked at access, capacity and estate. The access assessment compared the data and analysis of travel times – see Appendix [4]. The capacity assessment has been undertaken using Model Hospital data and the estate included The Hillingdon Hospitals NHS Foundation Trust Estates Strategy, published in October 2021.
- Consideration was given to both a two-site option, utilising both CMH and MVH and single-site options (CMH or MVH). Given the findings under the estate review and the GIRFT best practice guidance point to a single-site option and consideration of the desirable criteria for the elective orthopaedic centre, this has progressed to a single-site option for north west London as part of the overall system elective recovery plan and future sustainability. This identified the one preferred site option of CMH (2>1 sites).

5.1 Longlisted options and appraisal against the critical success factors

Pathways to be incorporated into the elective orthopaedic centre

The following eight options were identified based on delivering the principle of creating an elective orthopaedic centre of excellence for north west London, drawing upon the experience of other recently established NHS elective orthopaedic centres. While the Royal National Orthopaedic Hospital is located in north west London, it was not considered as an option as it plays a regional role rather than a sector one, and does not carry out the routine, low complexity orthopaedic procedures considered in the is business case. Do nothing/ Do minimum options were included in line with NHSE service change guidance. These options are summarised in the table below.

Table 11 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+ – 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 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).

Shortlisting the pathway options

A workshop was held in November 2021 to shortlist the options for the services, with representation from orthopaedic clinicians, therapies, estates, operations, nursing and finance. The workshop qualitatively assessed each option against the investment objectives (IOs) and critical success factors (CSFs).

Table 12 – Investment objectives

Reduce inequalities	To reduce inequalities by delivering accessible elective orthopaedic care to groups within our population who find it harder to access care
Improve outcomes	To deliver improved outcomes without raising costs
Improve equality of access	To improve equality of access by introducing a single waiting list for inpatient elective orthopaedics across north west London
Achieve best practice	To achieve best practice by reducing variation and meeting top decile performance for length of stay and cases per list
Reduce infections	To reduce surgical site infection and the impact of Covid by achieving the physical separation of elective orthopaedics from emergency activity
Improve staff and patient satisfaction	To recruit, retain and develop staff and achieve high levels of staff satisfaction By achieving the above, to improve patient experience

Table 13 – Critical success factors

Strategic fit	How well the option: • Meets the north west London HVLC strategic aims (that is, risk mitigation; resilience and recovery; system redesign) • Meets host hospital site configuration principles
Capacity and capability	How well the option: • Can be delivered within a robust sector-wide governance framework • Appeals to all partner trusts
Affordability	How well the option: • Can be financed from available capital funds • Aligns with ICS investment priorities
Achievability	How well the option: • Can ensure operational start date in 2022/23 to start improving PTL back to pre-COVID business as ususal • Can provide the required staffing numbers • Can be delivered with appropriately skilled staff
Value for money	How well the option: • Optimises the use of NHS resources (that is, staff; estate) • Optimises the use of available north west London estate

The clinical model was advised and tested with the North West London Orthopaedic CRG and North West London Musculoskeletal Network Group.

From the longlist of the eight service options, five service options were shortlisted during the workshop by assessing each option against the IOs, and the CSFs.

The shortlisted options were Options 1, 4, 5, 6 and 7. The rationale for each of the shortlisted options are detailed below.

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, even though it received the same score, 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 any IO or CSF, 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 while 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 north west London 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 time frame because of the complexity of untangling existing arrangements with providers, and also was considered more complex in terms of governance and appeal to the four acute trusts. 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.

Choosing the preferred pathway option

The scoring of the five shortlisted service options was undertaken by a multidisciplinary group, including clinical representation, to identify one preferred option for the services. The following evaluation criteria were developed, weighted and scored to reflect their relative order of importance:

Table 14 – Weighted scores for shortlisted service options

			Option 1	Option 4	Option 5	Option 6	Option 7
Evaluation criteria	**Sub-criteria**	**Criteria weightings**	**Weighted scores**				
1 Quality of Care and Safety	a) Impact on clinical outcomes b) Improved patient safety c) Enhanced infection control	23	46	161	184	161	161
2 Activity and Capacity	a) Can accommodate activity and has capacity to expand to meet demand	10	20	60	70	70	70
3 Patient Pathways, Flow and Access	a) Facilitates more efficient pathways, supporting rapid flow, as reflected in impact on PTL b) Supports more equitable access and patient choice c) Reduces lengths of stay d) Lowers likelihood of cancellation e) Model of care addresses inequalities	20	20	120	140	120	120
4 Workforce	a) Enables improved retention and recruitment b) Staff development – excelling in orthopaedics c) Workforce remains a key consideration in all North West London Trust Board Assurance Frameworks	18	36	108	144	108	108
5 System Wide	a) Achieves centre of excellence for all major joints b) More effective management and use of theatre resources	5	5	30	35	40	40
6 Operational sustainability	a) Services can be maintained in the event of a surge in demand or through subsequent waves of COVID b) Enables separation of elective and emergency activity	15	15	90	105	90	90
7 Ease of Implementation/ Deliverability	a) Requires minimal disruption to services during implementation	12	96	60	60	48	48
8 Teaching and Research	a) The solution supports teaching and research activities by providing an environment of sufficient size which will be attractive to staff.	5	30	40	40	30	30
Total Weightings = 100		108					
TOTAL RAW SCORE			**23**	**50**	**57**	**50**	**50**
TOTAL WEIGHTED SCORE			**268**	**669**	**778**	**667**	**667**
RANK			**5**	**2**	**1**	**3**	**3**

For the purposes of economic and financial modelling, London North West University Healthcare NHS Trust and its Central Middlesex Hospital has been used but the principles could apply to any of the north west London hospitals hosting the elective orthopaedic centre. 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 there is a wider evidence base of success with other centres of excellence.
2. **Workforce** – recruitment is better with centres of excellence, although there is a tipping point beyond which the benefits of consolidation are eroded because other sites become 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. There are underlying workforce gaps. A relatively much larger centre would create less flexibility if located in hospitals that have A&E and trauma and which may have to repatriate surgeons to maintain core services in the originating hospitals.

The clinical model for the elective orthopaedic centre is based on treatment of all north west London ASA 1 and 2 inpatient cases, excluding spinal and joint revisions. The day case and ASA 3, 4 and 5 cases plus spinal and joint revisions will be treated as currently and are not part of the service change.

Sites for the elective orthopaedic centre (the clinical evaluation)

With this PCBC, north west London aims to demonstrate full open-minded consideration of all options including and not limited to the site previously proposed. North west London is committed to providing the best services for its patients, and this involves addressing the limitations of prior approaches.

A clinical workshop was held in August 2022 to define the essential criteria for the location of the elective orthopaedic centre (from a clinical perspective) and shortlist the options, as well as to build out the desirable criteria of the centre.

Table 15 – Evaluation criteria developed at clinical workshop

Essential Criteria	Desirable Criteria
• Be accessible to our north west London community and those that need care – with a mix of virtual and face to face depending on need – keep options open for those who are not digitally enabled • Suitable infrastructure for orthopaedic surgery, for example, laminar flow theatres – needs to also cover workforce, which must be identifiably north west London workforce • Must cover end-to-end sharing of information, enable good communication and seamless care – for example, pre-op assessment through to post-op pathway – and with robust discharge arrangements • Deliver a shared care record for our patients • Standardisation of PTL – enables equitable access – and reduce pockets of unwarranted variation • Must be staffed through local workforce • Facilities on-site are interdependent • Must be 'neutral territory' – which is seen as a system asset, not part of one of the organisations • Ability to ring-fence elective orthopaedic beds throughout the year to create winter resilience • Meet the needs of the north west London community and case mix • Capacity to expand in future if demand increases • Delivers on GIRFT expectations, for example, six day a week access to high quality care	• Short travel time for patients and staff • Create a good track record of outcomes to build momentum • Create an environment and infrastructure for better training and leveraging technology and innovation – for example, robotics • Be attractive for commercial partners to increase sustainability • Reduce cost of outsourcing to independent providers • Good patient transport options, and public transport access for staff and patients

The following 10 named options were identified for the clinical evaluation (that is, the nine hospitals offering orthopaedic inpatient surgery in North West London ICS, and two other hospitals in north west London not offering inpatient surgery – Ealing Hospital and Hammersmith Hospital), and the workshop also considered novel sites beyond the 10 named:

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

North west London is committed to an open and transparent process and has taken a balanced scorecard approach to the requirements for the elective orthopaedic centre site or sites in assessing the longlist of potential sites and identify those that are clinically suitable.

The shortlisted sites must:

Have the ability to improve accessibility:

- have the ability to ring-fence elective orthopaedic beds throughout the year to create winter resilience
- be accessible to the north west London community and those that need care – with a mix of virtual and face to face depending on need – keep options open for those who are not digitally enabled, have language barriers, and impairments such as hearing and visual
- enable standardisation of the PTL (that is, addressing population segments over- and under-represented on the PTL) – enabling equitable access and reducing pockets of unwarranted variation
- meet the needs and case mix of the north west London community
- deliver on GIRFT expectations, for example, six-days-a-week access to high-quality care.

Have the right physical and digital infrastructure:

- have suitable infrastructure for orthopaedic surgery for example, laminar flow theatres
- have facilities on-site that are interdependent (that is, clear pathways) and provide seamless care in and out of hospital (that is, pre- and post-operative support and discharge arrangements)
- cover end-to-end sharing of information (including delivery of the shared care record), enable good communication and seamless care – for example, pre-op assessment through to post op pathway – and with robust discharge arrangements
- be a 'neutral territory' – which is seen as a system asset, rather than belonging to one of the organisations
- have the capacity to expand in future if demand increases.

Have a workforce able to deliver the services:

- support a sufficient workforce, which must be an identifiably north west London workforce and staffed locally
- have staff with a consolidated view of working to the same standards, clinical outcomes and patient experience, with outcomes measured and standards tested continuously.

Patient, public and clinical feedback was collected in the pre-consultation engagement and through workshops. Key themes were identified for what good care would look like in the elective orthopaedic centre. Views were collected on the concerns and risks to the programme that will need to be addressed, and we will continue to develop the programme in response to these.

The sites must:

Have potential for the elective orthopaedic centre rollout:

- alignment between the strategies of the elective orthopaedic centre and the site
- avoid causing excess levels of disruption to the existing services.

Interactions with clinicians:

- timely, appropriate, co-ordinated and effective care with good patient outcomes
- face-to-face appointments, especially at the time of diagnosis and first appointments, with physiotherapists to ensure patients understand what they are being asked to do, and are doing exercises correctly
- clinicians working with patients to include them in decisions about care – and taking time to explain care to patients, and listening to concerns and complaints

- good communications between clinicians, with patients being treated with respect and in a friendly way.

Deliver clear patient-focused communication:

- patients being kept informed about what is happening and understanding the care pathway
- clear, jargon-free communications
- easy to use and easy to understand systems, for example, how to reschedule appointments
- having systems in place so patients do not have to explain their conditions and circumstances at each appointment.

Support continuity of care:

- waiting times should be as short as possible
- a holistic approach from diagnosis onwards, with support along the full care pathway
- continuity of care, with patients able to see the same clinicians at appointments
- pain management should be offered while people are waiting for operations.

Have good access:

- short travel times for patients and staff
- good access, including public transport links and good parking (for both patients and staff) – including for people with disabilities. It was suggested that a shuttle bus could operate between hospitals to alleviate travel issues, such as higher travel costs
- if travelling further for surgery, pre- and post-operative care should be close to home
- having good information about how to get to hospitals, how parking works – including costs and how payments are made, and transport routes – including proximity of stations and bus stops (see travel analysis in Appendix 4).

Have a modern environment:

- ensure that individuals with additional needs are understood and accommodated, for example, checking whether people with vision impairments can use apps and other technology with screen readers and other assistive devices
- an environment that enables better training for staff
- an infrastructure that enables leveraging of technology and innovation, for example robotics
- an attractive offer for commercial partners to engage with, to increase sustainability of the services, for example, through use of managed services for equipment
- a set up that enables the system to reduce the cost of patients being treated by independent providers.

5.2 Shortlisted options

The table below (Table 16) summarises the refinement of the longlist of elective orthopaedic centre site options using the balanced scorecard approach outlined above. All but two sites (CMH and MVH) were ruled out as they did not meet the clinical criteria, particularly concerning the ability to ring-fence beds for elective capacity. The findings from the shortlisting exercise align with the pre-consultation feedback obtained.

Table 16 – Results of the site option shortlisting process, with scores reached through consensus discussion at the workshop in August 2022

Options	Essential requirements met?	Desirable requirements met?	Align with site strategy?	Level of disruption to create EOC on existing services	Key risks/other considerations
Key	Yes currently / Could be met in future / No		Yes/No	Low/Medium/ High	
Central Middlesex Hospital	✓	✓	✓	Low	Been part of site strategy for a while and disruption will be minimal – formation of an elective orthopaedic centre would not displace the current patient flow
Charing Cross Hospital	✗ (ring-fencing)	Could be met in future	✗	High	Not ring-fencing throughout the year – can ring-fence current volume but not elective orthopaedic centre volume (as many acute specialties). Co-location with critical care bed base – elective orthopaedic centre will have an impact on that bed base
Chelsea and Westminster Hospital	✗ (ring-fencing)	Could be met in future	✗	High (for non-elective services)	
Ealing Hospital	✗	✗	✗	High	
Hammersmith Hospital	Could be met in future	Good geographic location	✗	High (due to other spec. services)	The site has lots of specialised services (for example, cardiac and renal) with specific requirements, and not looking to be developed. The site is also not currently suitable (that is, laminar theatres)
Hillingdon Hospital	✗	✗	✗	High	Will be disruption to manage if this is not selected as a key site.
Mount Vernon Hospital	✓	Difficulties with access (travel time)	✓ (for current capacity)	Low (for current capacity)	Cannot take on additional capacity than it is currently handling
Northwick Park Hospital	✗	✗	✗	High	Would have to knock down buildings
St. Mary's Hospital	✗	✗	✗	High	Co-location with critical care bed base – elective orthopaedic centre will have an impact on that bed base
West Middlesex Hospital	✗ (ring-fencing)	Could be met in future – not close to public transport	✗	High (for non-elective services)	
Novel site(s) **(for example, Westfield Shopping Centre)**	Could be met in future	Potentially good transport options	N/A	High	Not many previous NHS sites to use. St Charles – not for this clinical infrastructure

Both CMH and MVH are already well-established providers of elective orthopaedic care and protected from emergency and urgent care surges. Both sites have laminar flow theatres of high quality. For example, CMH has the BeCAD theatre suite with 3 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.

5.3 Appraisal of the shortlist

The site shortlist consisted of CMH and MVH. The key difference between the CMH and MVH 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 in order to operate as the elective orthopaedic centre. Model Hospital data, while at trust and not site level, shows THHT as already performing well with very limited capacity to treat additional trauma and orthopaedic cases.

As 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 the hospital sites that currently provide 'routine' orthopaedic surgery and other sites from all parts of the sector. Distances were measured from lower layer super output areas (LSOAs), which are small geographical areas of approximately the same population size to provide a fairer unit of comparison than boroughs which vary in size.

As can be seen from the figures below (Figures 22 and 23), the CMH site has the shortest median travel times from north west London LSOAs for travel by car and the second-shortest by public transport. CMH has the shortest median off-peak travel time by car at 22 minutes, and 45 minutes 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 LSOAs. Off-peak has been used as the elective orthopaedic centre will only provide inpatient elective services to ASA 1 and 2 categories, excluding joint revisions and spinal.

Figure 22 – Off-peak driving travel times (private transport) from every north west London LSOA to each site

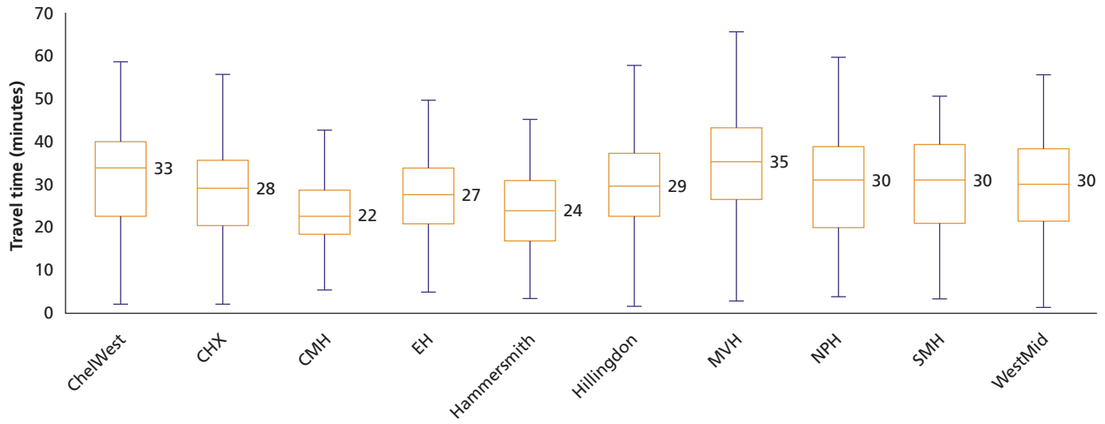
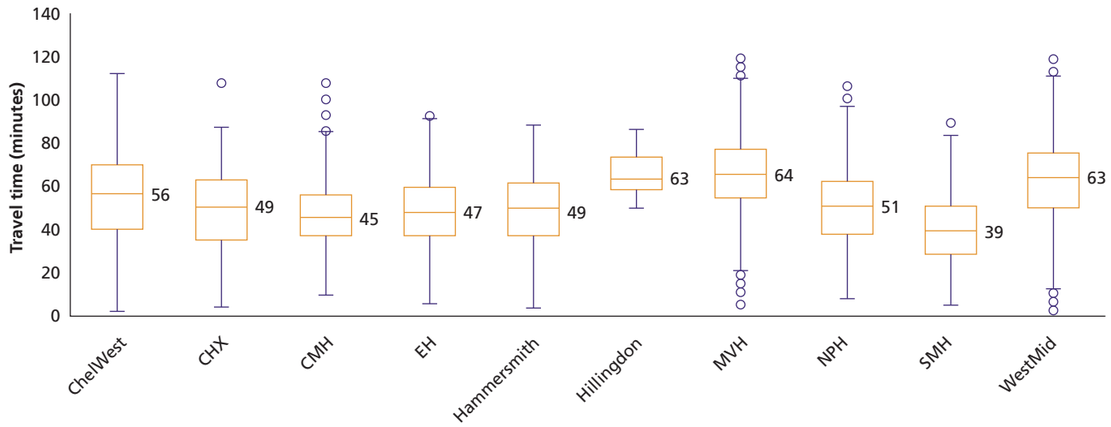


Figure 23 – Off-peak public transport times from every north west London LSOA to each site



The CMH site is located in the centre of the North West London ICS. As shown in the analysis above, it offers the shorter travel times relative to other north west London sites.

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. THHT is the only trust in north west London that has not seen an increase in admitted waiting lists between April 2022 and August 2022 and is at near maximum capacity and so changes to this site would likely result in adverse impacts to waiting times and equality of access and timeliness of treatment.

Estate

CMH is a high-quality clinical estate which has a surplus of bed capacity available for use. It is also anchored within the Old Oak Common Redevelopment 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.

As set out in the THHT Estates Strategy[18], planning permission at MVH is likely to be difficult to secure due to the planning designations for the site and the estate has significant challenges; backlog maintenance and poor condition.

5.4 Qualitative benefits appraisal

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; particularly the impact on workforce and the ability to deliver efficiencies and progress at pace to ensure that the elective orthopaedic centre is operationalised at the earliest opportunity.

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.

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 ODP's, both of which are in short supply and difficult to fill. 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.

The positive of having dual sites would be giving staff a choice of centres to work at.

This assessment combined with the GIRFT best practice guidance for a single site show a single-site option is the preferred.

In addition to the EHIA for protected characteristics and the demographic analysis undertaken by the host hospital as part of its statutory duty to consider reducing inequalities and in accordance with the NHS approach to planning for service change, NHS North West London commissioned an integrated impact assessment (IIA) for inclusion in the PCBC which includes:

- description of 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
- identification of any mitigating actions for any negative impacts on the population in the inequality groups including those with protected characteristics

The IIA is included at Appendix 2. The IIA has been fully considered in the development of the proposals included in this PCBC. The IIA will be refreshed following conclusion of the public consultation in order 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.

18 https://www.thh.nhs.uk/documents/_Publications/strategy-docs/THH_Esates_Strategy_Feb_2022.pdf

The IIA travel time analysis broadly aligns with the findings from the host hospital's travel time analysis and the findings from the informal engagement process. While all options result in an increase in travel times, the dual site option considered in the IIA has the lowest average increase, with CMH having only a marginally longer travel time. An elective orthopaedic centre in MVH has the highest average travel times for all protected characteristic groups.

In terms of sustainability, of the single site options CMH will result in a lower increase of total CO2 emitted, substantially below the level of increase with MVH, and only marginally higher than for the dual site option

It should be noted that it is likely that the ultra low emissions zone (ULEZ) operated by Transport for London (TfL) will result in a greater proportion of patients taking public transport to their appointments to hospitals within the ULEZ (for example, CMH), which will mitigate against the increase in CO2 emissions. In addition, the host hospital has published its Green Plan . The Trust has adopted this Green Plan to mitigate and adapt to the impacts of climate change, while continuing to improve health and well-being by delivering high quality health care. This Green Plan sets out the Trust's vision for delivering sustainable healthcare and outlines the Trust's commitments and actions being undertaken across a range of areas, including promoting the use of car sharing and use of teleconferencing to minimise inter-site travel. In terms of the elective orthopaedic centre, moving forward the host hospital will seek to put in place additional taxi and/or minibus services in response to the informal engagement and will discuss with TfL how public transport can be enhanced to address access challenges for specific population cohorts. The Trust will also draw upon the experience of established or recently created elective orthopaedic centres elsewhere in London and will consider any other measures adopted to support patient access in those locations.

The North West London ICS Green Plan has also been published. The ICS has developed its Green Plan to drive the decarbonisation of sites and operations and provide a commitment to NHS England's net zero targets – to mitigate the NHS's impact on climate change. This three-year plan aims to help north west London trusts deliver on their own green plans and support all north west London organisations who are taking action to reduce energy use along with greenhouse gas (GHG) emissions.

Single-site 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.

5.5 Economic appraisal

For the purposes of economic and financial modelling, London North West University Healthcare NHS Trust and its Central Middlesex Hospital has been used but the principles could apply to any of the NWL hospitals hosting the elective orthopaedic centre. The preferred option will enable a significant increase in the volume of elective orthopaedic surgery undertaken in north west London. For example, for the hospital option modelled, this includes an additional 3,500 procedures annually based on current cases per session.

The results of the economic appraisal show that Option 5 has the most positive NPV of the shortlisted model of care options, which makes it the most financially attractive option as it will have the highest cash inflows over time, compared to cash outflows. 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.

Adopting a discount factor of 10% to recognise inflationary risk and further reductions in the value of money over a 25-year period, Option 5 generates the best increase in discounted cashflow over the appraisal period of £35.5m with the next option, Option 7, resulting in a 52% lower NPV than Option 5.

Table 17 – Economic appraisal summary for shortlisted service options showing the NPV

Economic appraisal (NPV 25 years)		
Option	**Name of option**	**£m**
Option One – base case	Do nothing+ – current model plus joint weeks (POC)	(9.24)
Option Four	Host hospital DC & IP + north west London Hips & Knees	(0.233)
Option Five – preferred option	Host hospital DC & IP + north west London IP	35.495
Option Six	Host hospital DC & IP + north west London DC & IP	3.593
Option Seven	Host hospital DC & IP + north west London IP and DC + NHS IP and DC cases treated privately	16.924

Impact on income and expenditure

The impact of each option on the income and expenditure position is shown in the Table 18 below.

Table 18 – Income and expenditure (net revenue impact) position

Option	Name of option	Year 1 £m	Year 2 £m	Year 3 £m	Year 4 £m	Year 5 £m	Total £m
Option one – Baser case	Do nothing+ – Current model plus joint weeks (POC)	(0.872)	(0.908)	(0.922)	(0.934)	(0.948)	(4.584)
Option four	Host hospital DC & IP + NWL Hips & Knees	(0.336)	0.128	0.118	0.108	0.97	0.115
Option five – Preferred option	Host hospital DC & IP + NWL IP	0.240	4.051	4.080	4.109	4.138	16.618
Option six	Host hospital DC & IP + NWL DC & IP	(2.113)	0.908	0.947	0.987	1.026	1.755
Option seven	Host hospital DC & IP + NWL IP & DC + NHS IP & DC cases treated provetely	(2.097)	2.433	2.494	2.554	2.614	7.998

Over the initial 5-year term, Option 5 presents the most positive improvement in income and expenditure position, contributing £16.6m over a 5-year period with Do nothing representing a future deterioration of £4.6m over the same period.

Capital investment and costs

Table 19 – Capital investment

Option	Description	Total £m
Option one – Base case	Do nothing+ – Current model plus joint weeks (POC)	0
Option four	WH DC & IP + NWL Hips & Knees	(4.995)
Option five – Preferred option	Host hospital DC & IP + NWL IP	(9.412)
Option six	Host hospital DC & IP + NWL DC & IP	(18.247)
Option seven	Host hospital DC & IP + NWL IP & DC + NHS IP & DC cases treated privately	(22.664)

The cost of capital has been treated consistently for all 5 options presented and the revenue costs captured in the income and expenditure position above. If considering solely the cost of investment, then Option 7 would need the greatest level of capital funding with Do nothing requiring no investment. This measure should be looked at in the context of return and which option has the opportunity to deliver the best return for financial investment.

Based on the discounted cash flow opportunity, Option 5 provides the best return on investment, generating £3.8m of cash flow for every £1m invested.

In conclusion, the economic appraisal showed Option 5 to be the preferred care model option (see section 5.1). Of the care model options assessed, Option 5 has the most positive NPV, generates the best increase in discounted cash flow, the most positive improvement in income and expenditure position and the best return on investment.

5.6 Clinical benefits of the preferred option

Clinical benefits of the preferred option include the ability of the CMH system to:

- ring-fence elective orthopaedic beds throughout the year to create winter resilience
- standardise the PTL, enabling equitable access and reducing pockets of unwarranted variation
- deliver on GIRFT expectations
- have suitable infrastructure for orthopaedic surgery, for example, laminar flow theatres.

5.7 Conclusion

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

- the economic evaluation supports care pathway Option 5
- the necessary clinical requirements are met by CMH
- access options are most optimal of the shortlisted sites, for both private and public transport
- the expansion of theatres is within the current footprint of CMH and does not disrupt current services or create any planning challenges
- the bed capacity for the elective orthopaedic centre is already in situ.

The following sections of this PCBC focus on only this preferred option.

6 Engagement

6.1 Our approach to public and patient participation

The NHS Act 2006 details a legal duty for NHS Trusts and clinical commissioning groups (CCGs) to involve individuals to whom services are being or may be provided. Since the replacement of CCGs with ICBs, this is now the duty of the ICB. This can be through consultation or provision of information. Individual involvement can include the following:

- participation in consultation
- developing and considering proposals for changes to the way services are provided
- influencing decisions which affect the operation of services
- decisions made which impact commissioning arrangements which would subsequently impact service users

To meet the above legislative requirements and the "four tests" of service change outlined from the Secretary of State to NHSE, together with the 5th test on bed numbers, public engagement should be sought early and continue through the process. A broad range of engagement activities should be completed.

The NHSE Guidance "Planning, assuring and delivering service change for patients" (2018) notes public involvement as being critical in the development, planning and decision making of proposals for service change. This has been further reinforced in the Addendum to this guidance published on 20 March 2022. It is acknowledged that early involvement gives warning of issues of concern likely to be raised by local communities. Involvement could be with a range of stakeholders including:

- diverse communities
- local Healthwatch organisations
- local voluntary sector
- NHSE where appropriate

To ensure the public consultation programme is fair and proportionate, north west London will follow the set of guidelines referred to as the 'Gunning Principles' as follows:

1. Proposals must still be at a formative stage: public bodies need to have an open mind during a consultation and decisions cannot already have been made.
2. Sufficient information around proposals to permit 'intelligent consideration': people involved in the consultation need to have enough information to make an intelligent input into the process.
3. Adequate time for consideration and response: enough time should be given for people to undertake informed consideration and then provide their feedback, and also for public bodies to analyse the results of consultation and make the final decision?
4. Consultation feedback must be conscientiously taken into account.

There is also the requirement that a proposal satisfies the government's four tests of service change, which are:

- Strong public and patient engagement
- Consistency with current and prospective need for patient choice
- Clear, clinical evidence base
- Support for proposals from clinical commissioners

It also needs to set out the impact against the 5th test regarding bed closures.

The public consultation programme has set three main objectives, to:

- ensure the views and knowledge of a diverse range of stakeholders and service users (patients, carers, staff, NHS partners, local authorities and wider stakeholders) – particularly groups most likely to be impacted – inform the proposed development of an elective orthopaedic centre in north west London
- test the rationale underpinning proposed changes to how orthopaedic surgery is organised in north west London with service users, building an evidence base to inform decision-making
- ensure a fair and transparent process for engagement and consultation, meeting all statutory requirements for proposed health service changes.

Patients and the public in initial involvement activities have raised issues about routes/patient pathways into and out of surgical services. North west London expects this consultation will generate wider feedback on needs, views and preferences for changes beyond the specific scope of the elective orthopaedic centre, which can be used to inform current thinking in primary and community care to improve MSK services as part of the overall MSK pathway.

It is important to note that the public consultation programme should not be a stand-alone exercise but rather part of ongoing engagement and dialogue as proposals are developed.

6.2 Involvement to date

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), 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 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.

Patients and the public

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.

See Appendix 4 for details of the public engagement report.

Clinical Staff

Given the proposed change to north west London's orthopaedic services, it is vital that clinical staff are not only involved, but that the whole programme is focused on those who would be impacted by the changes. Clinical alignment and input to the development of the elective orthopaedic centre was sought.

A series of meetings and workshops were held to support this process. These were attended by senior medical, nursing and allied health professional (AHP) representatives from both the acute and community teams.

Examples of these are the virtual clinician meeting and clinical workshop held on the 25 and 30 August 2022. Across these engagements there was attendance by a breadth of representatives from different clinical groups as well as each hospital site including:

- Medical directors
- Clinical leads
- Nursing leads
- AHP leads
- MSK community team leads

During engagements, feedback and comments were gathered regarding:

- Why north west London needs an elective orthopaedic centre?
- What expected clinical benefits there are from north west London having an elective orthopaedic centre?
- What the model of care should be?
- What clinical requirements there would be for the elective orthopaedic centre site?
- What sites the elective orthopaedic centre could be based in from a purely clinical perspective?

Opportunity for discussion and feedback was maximised by circulating the presentation in advance with the full list of possible attendees. During the workshop, attendees were split evenly into smaller groups with a facilitator for each group, to allow opportunity for each voice to be heard. Additional opportunity for discussion and feedback was offered at the end of the workshop.

Feedback from involvement to date

Engagement so far has demonstrated clearly that there is alignment in the understanding that an elective orthopaedic centre would be beneficial for north west London:

- People understood the need to reduce waiting lists, and were grateful work was being done 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 NHSE 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 by their local trust – less compromise through infection 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 going forward
  - 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 winter resilience.
- The site must have suitable infrastructure for orthopaedic surgery, for example, laminar flow theatres.
- Facilities on-site must be interdependent.
- There must be capacity to expand in future if demand increased.
- It would be desirable for the site to be accessible with short travel times and good transport links for staff and patients.

The feedback from clinical engagement regarding which sites the elective orthopaedic centre could be based in from a purely clinical perspective is explored in the 'Options development' section of this report.

Applying pre-consultation engagement findings to the options appraisal process

Overall, engagements were considered valuable in aiding development of the proposal for an elective orthopaedic centre. The Equality and Health Impact Assessment (EHIA) has been used to identify groups who may be affected by the proposed changes and who need to be reached the consultation programme. This includes groups who are most affected by health inequalities.

The concerns raised during pre-consultation have highlighted the need to fully contextualise information for groups and any concerns will be incorporated into formal consultation.

6.3 Planned future engagement

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.

The EHIA (Appendix 1) and IIA (Appendix 2) have both been used to inform the consultation plans.

Consultation communication and engagement channels

The events and implementation plans for consultation aim to gather as much feedback as possible. This is supported by a consultation brochure and plan (Appendix 5 and 6). These include the programme of activities set out in Table 20.

Table 20 – Programme of activities

Events	Implementation plan
Clinician-led, qualitative research events	Will include a presentation on the proposals, opportunity for questions and clarifications and breakout elements to gather views and feedback via deliberative methodology. Should be at least 8 face-to-face events (one per borough) plus two virtual events – target of at least 300 people Face-to-face events devolved to local trust/ICS (borough based partnerships) engagement team, with central materials and support of independent qualitative researchers/facilitators. A pool of clinicians will be established centrally via the Elective Orthopaedic Centre programme. Recruitment via local and central promotion/leads with sign up required will also take place.
Drop-in engagement sessions	Half-day sessions to be held in acute and community NHS locations – participants are free to turn up at their own convenience. Consultation documents will be available in display format on location plus video and/or slides. The aim is for at least 16 sessions (two per borough) and a target of at least 100 questionnaires to be completed. Trust/ICS/Borough Based Partnership communications and engagement staff will be available on location to answer questions and support members of the public with questionnaire. Sign-up not needed.
Outreach community focus groups	At least ten sessions are planned involving targeted groups, run by independent qualitative researchers/facilitators. The aim is for 5-7 participants per group as this will be optimum to enable rich discussion. A mix of geographic and specialist groups will be invited – the format would remain flexible in order to reach target groups e.g. through virtual meetings, in-clinic or at existing community group meetings. Telephone interviews for people with accessibility issues will be offered.
Awareness/ engagement hybrid community outreach events	Slots will be incorporated into existing engagement/outreach activities/events. Communications and engagement staff will be available to answer questions/encourage attendance at specific events or to support completion of questionnaires. Particular focus will be placed on targeted groups and geographic locations.
Dedicated section of acute hospitals microsite	The core content (consultation document – see Appendix 6), a questionnaire and links into and out of all trusts/ICS will be added to the new collaborative website.

7 Implementing the preferred option

This section of the report sets out the practical steps needed to deliver the option identified. The PCBC sets out the plan for what will happen after the consultation phase. Specifically, how north west London plans to manage the project and how successful delivery of the service will be ensured in accordance with best practice.

7.1 Delivery model for the preferred option

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
- Well-evidenced submissions that point to evidence that supports their perspective
- Representatives of the general population or specific localities who may be potentially impacted
- Views from under-represented people or equality groups.

This final report and a refreshed Integrated Impact Assessment will be shared with the north west London JHOSC for comment, which will then inform the development of a decision-making business case, 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 Acute Providers Collaborative and be directly management by the North West London Elective Orthopaedic Centre Development Programme Board.

Programme management arrangements

A robust programme management and governance structure has been developed. This will ensure accountability through clear allocation of responsibilities and regular reporting, thus allowing timely identification and addressing of any issues which may arise.

Programme management approach

We will follow the PRINCE2 principles in their approach to project management to ensure the delivery of the project. 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 budgeted for within the £9.4m capital investment and costs. The project implementation budget is inclusive of costs associated with the programme team including workstreams and external advisors providing the technical support required to develop a decision making business case and potentially a full business case and the transition to implementation.

Strategic risks, constraints and dependencies

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 Acute Provider Collaborative Board and North West London Integrated Care Board if/when required. The key risks are summarised below:

Risk Description	Mitigating Actions	Level (controlled)
Focus on population health and patient care		
There is a risk that the development of the centre has unintended consequences impacting on inequalities and equity of access and poor patient experience	Integrated Impact, equality impact assessment and quality impact assessment completed. Following NHSE Planning, assuring, and delivering service change for patients' guidance.	Moderate
There is a risk that patients are unable to access services at the centre due to transport difficulties, both physical and financial.	Travel analysis included in the integrated impact assessment, which identifies key risk groups, namely deprived and elderly/disabled populations. Transport policies will be developed, incorporating access to transport credits. Supplementary transport options will be actively explored, learning from other centres, including dedicated transport	Moderate
There is a risk that delay to this programme timeline results in increased waiting times for patients awaiting orthopaedic surgery.	Manage and mitigate programme delays and potential risk to safe patient care caused by delays through NWL Acute Provider Collaborative quality and operational governance.	Moderate
There is a risk that programme delays result in continuation of relatively low scores on clinical outcome metrics	Clinical leadership, use of best practice guidance and data through the design, development, and implementation phases across the programme governance.	Moderate
Focus on staff		
There is a risk that the implementation of the proposed development is delayed by shortage of key staff groups and retention becomes challenged if staff experience is poor.	Comprehensive engagement and involvement plan which includes all key stakeholder groups including staff communication, engagement, and consultation. Collaboration between all NWL acute trusts and embedded within the NWL Acute Provider Collaborative People Priorities	Moderate
Focus on service change		
There is a risk that the Ultra-Low Emission Zone charge will generate public opposition to the development	Travel analysis within the Integrated Impact Assessment and continues to be measured through public consultation and future decision making.	Moderate
Data quality may impact assumptions in the modelling which may impact delivery of the planned benefits realisation plan.	Review and validation through programme governance, triangulation with operational and clinical experience.	Moderate
Focus on key enablers		
Lack of a single digital patient pathway platform results in resource-heavy and ineffective administration.	Implementation of sector-wide electronic patient record and single patient tracker lists(waiting lists)	Low
There is a risk of exclusion of patients owing to the dependency of the service model dependency on digital tools	The programme will adopt the NWL eight-point digital inclusion strategy, and will engage patients so that we can develop a set of design principles and approaches that can be applied	Low
There is a risk that the implementation is delayed by longer than expected building time scales, including logistical challenges of building in a live environment	Manage and mitigate through programme and host governance.	Moderate
Focus on sustainability		
Increased travel times for some patients will result in a marginal increase in CO2 omissions.	The impact is measured as marginal and likely to be mitigated by established green projects.	Low

Change management plan

Table 21 below details the agreed processes which will take place if changes are required to be made during the project implementation:

Table 21 – Change management process

Change	Process Approval Process
Design proposal/changes potential impacting the **Clinical model** **Workforce model** **Digital enablement** **Financial model**	Workstream lead to review and assess request & impact with the project manager. Engage financial workstream lead to assessment cost impact. Engage wider stakeholders where wider 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 for decision making. Clinical proposals can be referred and further tested with north west London Orthopaedic CRG and/or north west London Musculoskeletal Network and/or north west London Clinical Advisory Group in before or after presentation to the north west London elective orthopaedic centre Development Programme Board
Day to day decisions and changes	Project manager to assess impact and risk to the programme, engaging stakeholders and leads as required. Escalate to programme director if time critical or risk is assessing 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.	Programme Director to assess impact of material changes and present to Programme SRO to confirm approach. Present to north west London elective orthopaedic centre Programme Board for decision making including escalation route depending on nature of matter. Complete north west London elective orthopaedic centre Programme Board directions. Present to north west London Acute provider collaborative Board in Common or delegated cabinet for approval. Present to north west London ICB Partnership Board for approval where appropriate or advises. Ensure appropriate action is taken with local authority stakeholders and NHSE

Post-project evaluation

North West London ICB and Acute Provider Collaborative are is committed to ensuring a robust post-project evaluation takes place so that positive lessons can be learned from the project. The aims are to:

- Facilitate continuous learning which can be implemented in later stages of the project as well as in future projects.
- Ensure the project plan is on track with milestones and project risks.
- Enable measuring of performance against the project aims.
- Produce valuable feedback and knowledge which can be shared to promote positive change.

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 post-implementation review (PIR) will be carried out six months following the completion of the works with the comprehensive PER undertaken two years after completion. To gain maximum value from the PER, this will include representatives from each of the major project stakeholder groups.

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 in Table 22 below:

Table 22 – Benefits Realisation Plan: targeted improvement on key performance indicators

Benefit Description	KPI theme	Expected benefits	Target improvement	By when
Productivity	Average length of stay	Improved productivity	Top decile	Year two
Cost Effectiveness	Cost per Weighted Activity Unit	Better use of resources	2nd quartile	Year two
Clinical Outcomes and Experience	Patient reported outcomes PROMS – Oxford hip & knee scores; Eq5d	Improved patient satisfaction Reduced burden on primary care	2nd quartile	Year two
	30 day readmission rate	Improved productivity Better outcomes	Top quartile	Year one
	Cancellation for (a) clinical and (b) non-clinical reasons	Improved patient satisfaction Better use of resources	(a) 1% and (b) 2%	Year one
	Cemented hip implants > 70 years old	Better outcomes	2nd quartile	Year two
	5 year revision rate	Improved patient satisfaction Reduced burden on primary care Better use of resources	Top quartile	Year six
Patient Access	Reduced waiting time to decision to admit for inpatients	Improved patient satisfaction	Reduction in waiting time of ~8 weeks	Year two
	Reduce number of patients waiting for elective orthopaedic surgery	Improved patient satisfaction	Reduction of ~30% in waiting list size	Year two
Patient Satisfaction	Patient friends and family test	Improved patient satisfaction	Top quartile	Year two
Workforce Impact	Staff survey	Improved staff satisfaction High training programme feedback	Top quartile	Year two
	Staff recruitment and retention	Low vacancy rates and low turnover	Top quartile for NWL	Year two
Environment	Compliance with Department of Health and Social Care Health Building Notes (HBNs) and Health Technical Memoranda (HTMs)	Best practice quality of environment for patients and staff	Full compliance, subject to agreed derogations	Year one

8 Financial appraisal

This chapter covers 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. Each of the options for service delivery have been modelled in detail, testing 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. The preferred option provides an opportunity to reduce costs for the trusts and the health and care system in north west London, through the development of a single site, well-led, efficient and effective elective centre.

For the purposes of economic and financial modelling, London North West University Healthcare NHS Trust and its Central Middlesex Hospital has been used but the principles could apply to any of the NWL hospitals hosting the elective orthopaedic centre.

Modelling has been undertaken on the proposed host trust's income and expenditure position, all trust income and expenditure position, the lead trust's balance sheet and cashflow.

The Financial Case covers:

- key assumptions in the financial model
- impact on the trust's income and expenditure position
- impact on the trust's balance sheet
- cashflow implications
- efficiency savings
- affordability of the scheme

8.1 Financial projections

Impact on the Trust's income and expenditure position

When reviewing the income and expenditure (I&E) position for the host hospital, it is important to consider both the impact for the trust and for the collaborative. This has been assessed over year one (implementation year) and year two (the recurrent position) of the project.

The recurrent annual benefit to the I&E position for the host trust (and then for redistribution across the collaborative) is £4m (£0.2m in year one due to marginal tariff relief for sector overheads/stranded costs and phased activity plans – in effect, allowing for a transition to full capacity and efficiency). The calculation for this benefit is shown below:

Table 23 – Impact of the north west London elective orthopaedic centre on the Trust's income and expenditure position

	C&W Year Two (Full Year) £	Hillingdon Year Two (Full Year) £	Imperial Year Two (Full Year) £	LNWH Year Two (Full Year) £	NWL Sector Total £
Income and Expenditure					
Total Clinical Income £	6,735,296	4,924,416	5,874,450	11,484,553	
Total Cost £	(7,165,517)	(6,069,792)	(7,088,562)	(13,348,626)	
NWL Current Profit/(Loss)	**(430,221)**	**(1,145,376)**	**(1,214,112)**	**(1,864,073)**	**(4,653,782)**
NWL Current Loss Avoided					4,653,782
Revenue Development Costs EOC					(539,130)
(Investment)/Cost Reduction from EOC					**4,114,652**
Activity In Scope					
Inpatients (ASA 2 and Below)	1,093	826	956	1,114	**3,989**
Inpatients (ASA 3)				277	**277**
Day Cases				1,412	**1,412**

Financials expressed in brackets is a negative – where cost exceeds income, is a charge or is to communicate a financial loss
Financials expressed without a bracket is a positive – where income exceeds costs, is an asset or is to communicate a financial profit

NCC is National Cost Collection[19].

'Income' is based on national tariff and is distributed to the elective orthopaedic centre from the operating budgets for each Trust (in turn derived from the contracts with the North West London ICB and other sources, as well as non-NHS funding streams). Set against this are pay costs of £12.3m and £15.7m and non-pay costs of £10.1m and £13.0m initially (and capital charges of £0.8m). In year one we have made some assumptions in relation to productivity and efficiency improvement across the four trusts.

Impact on the Trust's balance sheet

Traditional capital charges calculations, used across the NHS and the wider public sector, have been used over the course of the investment. For the preferred option, £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.

Assets have been depreciated (with respective capital charges costed at 3.5%) over the useful life of the investment. The capital investment plan, with associated capital charges in year one and year two of the proposal, is shown below (Table 24).

19 https://www.england.nhs.uk/costing-in-the-nhs/national-cost-collection/

Table 24 – Impact of the north west London elective orthopaedic centre on the Trust's balance sheet

Balance Sheet for Host Trust – Asset Net Book Value	Initial	Year 1	Year 2	Year 3	Year 4	Year 5
Each year, the value of the investment is reduced by depreciation, and is shown on the balance sheet of the host trust. The depreciation charge is shown below.	**Investment Year 1 £000**	**Year End Value £000**	**Year End Value £000**	**Year End Value £000**	**Year End Value £000**	**Year End Value £000**
Refurbishment (25 Years useful life)	7,610	7,305	7,001	6,697	6,392	6,088
Development Costs (25 Years useful life)	577	554	531	508	485	462
Equipment (7 Years useful Life)	1,225	1,050	875	700	525	350
Balance Sheet for Host Trust – Asset Net Book Value	**9,412**	**8,910**	**8,407**	**7,905**	**7,402**	**6,900**

Annual Depreciation Charge for Host Trust	Year 1	Year 2	Year 3	Year 4	Year 5
Each year, some of the value from the capital investment is charged to the income and expenditure account for depreciation – this is an increase in expenditure to cover the cost of the investment.	**Dep Charge £000**	**Dep Charge £000**	**Dep Charge £000**	**Dep Charge £000**	**Dep Charge £000**
Refurbishment (25 Years useful life)	(304)	(304)	(304)	(304)	(304)
Development Costs (25 Years useful life)	(23)	(23)	(23)	(23)	(23)
Equipment (7 Years useful Life)	(175)	(175)	(175)	(175)	(175)
Annual Depreciation Charge for Host Trust	**(502)**	**(502)**	**(502)**	**(502)**	**(502)**

Annual Cost of Capital Charge for Host Trust	Year 1	Year 2	Year 3	Year 4	Year 5
Each year, the host trust has to pay a 'cost of capital charge' to DHSC to cover the cost to the government of the investment – this is standard practice across all government bodies.	**Cost of Capital £000**	**Cost of Capital £000**	**Cost of Capital £000**	**Cost of Capital £000**	**Cost of Capital £000**
Refurbishment (25 Years useful life)	(261)	(250	(240)	(229)	(218)
Development Costs (25 Years useful life)	(20)	(19)	(18)	(17)	(17)
Equipment (7 Years useful Life)	(40)	(34)	(28)	(21)	(15)
Annual Cost of Capital Charge for Host Trust	**(321)**	**(303)**	**(285)**	**(268)**	**(250)**

Cash flow implications

In considering investment proposals, it is usual to review the cash flows over time – and then to apply a discount factor to calculate the NPV. A discounted cash flow forecast has been developed over a 25-year period to the model, based on a discount factor of 10%.

A higher discount factor has been applied to the case to reflect growing inflation pressures and in turn the depletion of the value of money over time. Over this period, it is modelled that £35.5m will be the discounted cash flow benefit to the acute collaborative over the next 25 years (commencing with effect from autumn 2023).

Table 25 – Impact of the north west London elective orthopaedic centre on the Trust's cash flow

	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10	Year 11	Year 12	Year 13
LNWH DC & IP + NWL IP	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Revenue cash	1,063	4,856	4,868	4,879	4,891	4,891	4,891	4,891	4,891	4,891	4,891	4,891	4,891
Capital cash	-9,412												
Total	**-8,349**	**4,856**	**4,868**	**4,879**	**4,891**	**4,891**	**4,891**	**4,891**	**4,891**	**4,891**	**4,891**	**4,891**	**4,891**
Disc Fact 10%	1.000	0.909	0.826	0.751	0.683	0.621	0.565	0.514	0.467	0.425	0.386	0.351	0.319
NPV	**-8,349**	**4,415**	**4,021**	**3,664**	**3,340**	**3,037**	**2,763**	**2,514**	**2,284**	**2,079**	**1,888**	**1,717**	**1,560**

	Year 14	Year 15	Year 16	Year 17	Year 18	Year 19	Year 20	Year 21	Year 22	Year 23	Year 24	Year 25	Total
LNWH DC & IP + NWL IP	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Revenue cash	4,891	4,891	4,891	4,891	4,891	4,891	4,891	4,891	4,891	4,891	4,891	4,891	118,374
Capital cash													-9,412
Total	**4,891**	**4,891**	**4,891**	**4,891**	**4,891**	**4,891**	**4,891**	**4,891**	**4,891**	**4,891**	**4,891**	**4,891**	**108,962**
Disc Fact 10%	0.290	0.264	0.240	0.218	0.198	0.180	0.164	0.149	0.135	0.123	0.112	0.102	
NPV	**1,418**	**1,291**	**1,174**	**1,066**	**968**	**880**	**802**	**729**	**660**	**602**	**548**	**499**	**35,570**

The model shows the positive impact on the host trust. The impact on the other trusts over time will be nil as costs are offset through redeployment to other services.

Efficiency savings

NCC data has been used (inflated to current prices) to determine the cost savings that will be released as a result of the elective orthopaedic centre development. Based on the first full year of activity (year two of financial model), there is a potential that this model will release £4m in efficiencies, primarily from moving to GIRFT standards for LOS and theatre utilisation. This is the key financial benefit of the elective orthopaedic centre model – with consolidation to a single-site allowing for significant improvements in operational productivity, as well as benefits for patients and improved outcomes.

The model takes the detailed patient-level costings (PLICS[20]) from the trusts, which gives an indication of the costs of the work being undertaken within the trusts, drawn directly from the trusts' reporting systems. In effect, across the four trusts it costs £4m more to treat these patients than the modelled costs within the elective orthopaedic centre.

20 PLICS is Patient Level Information and Costing Data

Table 26 – Calculating efficiency gains

	Adjust NWL PLICS				Option 5 LNWH DC & IP + NWL IP	
	19/20 PLICS Elective IP Cost	19/20 PLICS Elective DC Cost	Price Corrected 21/22 PLICS Elective IP Cost	Price Corrected 21/22 PLICS Elective DC Cost	21/22 PLICS Elective IP Full Cost £	21/22 PLICS Elective DC Full Cost £
ICHT	7,418	1,096	7,418	1,129	7,088,562	
Hillingdon	7,131	1,803	7,345	1,857	6,069,792	
CW	6,366	2,739	6,557	2,821	7,165,517	
LNW	6,609	2,341	6,807	2,411	9,857,132	3,491,494
PLICS Costed Options					**30,181,003**	**3,491,494**
	Total Current Cost Avoided (PLICS)					**33,672,496**
	New EOC Modelling Costing					**-29,575,696**
	Recurrent Cost Reduction/(Investment)					**4,096,800**

As mentioned, greater detail on stranded costs will be worked through as part of the main pillar of work of the finance workstream. However, to test the efficiencies calculated through the NCC method above, the three core efficiency drivers have been calculated using a bottom-up costing measure to test the reasonableness of the determine value added.

Theatre utilisation savings

Reviewing the analysis through Model Hospital, the level of expected savings can be determined through the expected number of cases to be completed during a standard 4-hour theatre session. Currently, the average number of cases through theatres (based on the case mix in scope) is 1.6 per theatre for the four north west London providers. Based on GIRFT standards, the average number of cases through a standard theatre session is expected to be 2.3 (weighted based on the day case activity in scope).

Length of stay savings

With the GIRFT modelling principles adopted, the expected patient LOS would be 2.3 days for the elective patients in scope. The sector's current performance is 2.6 days for elective care and 3.7 days for knee replacements specifically and 3.4 days for hip replacements.

Table 27 – Organisation cross charging at full tariff and marginal cost

	Year One – Organisational Cross Charging – Full Tariff Basis	
	Option 5 – Host hospital DC & IP + NWL IP	
NWL Organisation	Activity (Elective DC and IP)	Full Tariff £
Imperial College Healthcare NHS Trust	636	3,909,089
The Hillingdon Hospitals NHS Foundation Trust	550	3,276,899
Chelsea and Westminster Hospital NHS Foundation Trust	727	4,481,930
		11,667,919

	Year One – Organisational Cross Charging – Marginal Rate	
	Option 5 – Host hospital DC & IP + NWL IP	
NWL Organisation	Activity (Elective DC and IP)	Marginal Cost £
Imperial College Healthcare NHS Trust	636	2,956,239
The Hillingdon Hospitals NHS Foundation Trust	550	2,556,672
Chelsea and Westminster Hospital NHS Foundation Trust	727	3,380,954
		8,893,866
		2,774,053

8.2 Hosting arrangements

Hosting arrangements and impact on lead trust and partner trusts

- Given that the preferred model is for the service to be sited at Central Middlesex Hospital, the costing model assumes that the service will be hosted and assumes that staff will be employed by the host organisation. However, the 'standard costing' approach, coupled with the national pay scales for NHS staff, means that the 'hosting' costs would be largely undifferentiated if a different trust was the lead provider. Similarly, and provided that the model is based on a single-site delivery approach, the model is largely transferable between different trusts, bar the differentiation in costs for inner/outer London staff weightings and the consequences of fixed Private Finance Initiative costs. The sensitivity analysis addresses the impact of different staff deployment options.
- The elective orthopaedic centre will be run as a stand-alone business unit (in financial terms) within the host trust, in line with the approach adopted elsewhere and to provide transparency to all stakeholders on the financial outcomes. In terms of clinical and managerial leadership arrangements, the host trust will have a degree of discretion around inclusion within an existing division, or the creation of a separate division, provided that appropriate and adequate clinical and managerial leadership is in place.
- The elective orthopaedic centre business unit will have an 'income budget' of £29m, and when operating at full capacity, will be expected to deliver the activity within this budget (the model shows a small surplus, reflecting the improved efficiency benefit to the host trust of the host trust's activity being delivered more efficiently). Patient-level costing data shows that the activity is currently costing the four trusts £33m to deliver – and the move to a single elective orthopaedic centre will reduce this cost by £4m. This provides the collaborative trusts with two challenges. The host trust must run at a high level of efficiency to deliver the activity at tarrif and the partner trusts must either reduce their costs or redeploy these to activities which are not loss-making, leading to an overall improvement in the collaborative financial position by £4m.
- To some degree, given that the trusts are operating as an acute collaborative, it is not material where this operating surplus is located, but the current model assumes that 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. Any resources provided by each trust to the elective orthopaedic centre will be reimbursed at full direct cost – for example, clinical staff who work within the trust providing services – with quarterly reimbursement.
- In order to model the implementation of the elective orthopaedic centre, 'income' movements across the four trusts have been modelled based on the Host hospital average tariff and local Market Forces Factor (MFF) (this aligns with the costing model deployed). Detailed in the table below is the year two (first full year) income and activity plan transfers that will be required to wider north west London providers in scope. In effect, £17m of 'activity' moves from the three partner trusts to the host trust. The key challenge for the trusts as a collaborative is to ensure that the cost associated with this activity either moves across to the lead provider, is used in another way, or is reduced. Each of the finance teams within the collaborative are working on an approach to determine a mutually agreed way forward. The model does not take into account the potential benefits of utilising the additional capacity freed up at each of the partner trusts at this stage, recognising that there will be a combination of opportunity and risk.

Table 28 – Organisational cross charging on a full tariff basis

	Organisational Cross Charging - Full Tariff Basis	
	Option 5 – LNWH DC & IP + NWL IP	
NWL Organisation	Activity (Elective DC and IP)	Full Tariff £
Imperial College Healthcare NHS Trust	956	5,874,450
The Hillingdon Hospitals NHS Foundation Trust	826	4,924,416
Chelsea and Westminster Hospital NHS Foundation Trust	1,093	6,735,296
		17,534,161

- As described above, the four trusts have been working more closely together on a range of joint projects since the formation of the collaborative. To support this, the trusts have signed up to a set of principles – 'the multi-system financial framework' – and these have been adopted. In particular, in year one of the business case this assumes that marginal rate accounting will be reflected for the incoming activity to the lead provider (providing the referring organisation's financial stability over the transition year to cover overheads). As the case has progressed, the trusts have refined this approach and a specific financial framework for the development of the elective orthopaedic centre has been developed and agreed. This should not impact on the operation of the elective orthopaedic centre, but provides for a clear framework for each of the trusts to plan their finances in a time of resource constraint and financial challenge.

8.3 Sensitivities

There are five areas of risk that have been modelled as the most significant areas of potential variation against the modelling assumptions deployed above. These risks are largely a reflection of the current position in the planning phase for this development, and are regularly refreshed through the Finance Working Group. As workforce and procurement delivery workstreams gather pace over the coming months, it is expected that any further impact under these themes will become known with greater certainty.

Sensitivity – optimism bias

Due to the risk to current supply chain prices, it is necessary to consider various views on the appropriate optimism bias applied to the capital costs assumed within this case. In this scenario, a relatively risk adverse approach has been taken, adding 23% to costs in line with national guidance.

Considering a mitigated position, taking the robustness of valuations collated so far and also that inflation at 5% has already been built into the base budgets before optimism bias is applied, it is considered that 15% would be sufficient, which would reduce capital costs by £0.575m and annual revenue costs by £0.046m against the model presented.

Looking at the month on month inflationary increase over the planning and delivery period, a 2% increase per month would be a prudent assumption to capture the impact of hyperinflation. This would result in an increase in capital requirements of £503k and £41k annual revenue implications.

Sensitivity – impact of inner London weighting

Two of the three referring trusts within the elective orthopaedic centre pay staff the NHS inner London weighting. The host trust is based in outer London and so staff working there are paid the NHS outer London weighting. If all staff members working as part of the elective orthopaedic centre are paid on the same inner London weighting basis, this would increase the annual cost by £0.827m. Presently services on the host trust site do not pay inner London weighting and if such a material change in the terms for London staff was applied, it would be reasonable to suggest that Market Forces Factor (MFF) which is paid to trusts would need to be adjusted to compensate for this pressure. There is currently no proposal to make a change of this nature. The current MFF premium paid to the inner London centres is £0.219m for the activity in scope and therefore it would be reasonable to assume that this could reduce the cost implication of paying inner London weighting down to £0.608m.

Sensitivity – reliance on temporary staffing

Given some potential challenge on moving workforce across the sector, it is important to consider the impact of a greater reliance on agency staffing than would normally be expected. The projected establishment is currently showing an expectation that 4% of the establishment will be filled with agency and 10% with locum/bank staff. Shown below is the impact if 25%, 50%, 75% or 100% of the remaining vacancies were to be filled with agency which generates an annual cost range of between £0.7m to £2.8m, making this the single biggest financial challenge to the model.

Sensitivity – LOS reductions

GIRFT principles have been the foundation to calculate the required bed capacity to deliver the projected level of activity. This assumes an average LOS of 2.3 bed days for all inpatient care. Detailed below is the cost impact (based on service-line reporting direct bed day costs) if LOS was to move in 0.2 of a day intervals from 2.3 days to 3.5 days.

This would require between £0.2m and £1,3m to cover the cost of additional ward staff.

Sensitivity – theatre utilisation

As part of the development of the clinical model, the number of cases per 4-hour theatre session has been based on GIRFT standards of 2 inpatient cases per list of 4 day cases. Based on variability across the sector, two other flow models have been considered (as detailed below) which could result in a cost consequence of between £1.2m and £2m, if the capacity needed to be replaced with Waiting List Initiative lists (if the trust were able to generate capacity within operational hours then the cost of the options modelled would be between £0.455m and £0.797m). It is important to note that there is a high degree of confidence that the model utilisation is possible due to the referred elective caseload being below ASA 3.

8.4 Conclusions

The north west London elective orthopaedic centre financial analysis includes the income and expenditure position for the first two years as set out below. This shows a net income and expenditure benefit in the first full year of operation of £4.1m to the north west London system.

Table 29 – Income and expenditure summary for years one and two

	Year 1 2022/23 £m	Year 2 2023/24 £m
Income	23.177	29.530
Expenditure	(22.937)	(25.479)
Surplus/(Deficit)	240	4.051

The capital spend is profiled £8.0m in 2022/23 and £1.41m in 2023/24.

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 highlights the robustness of the modelling when tested against a number of 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.

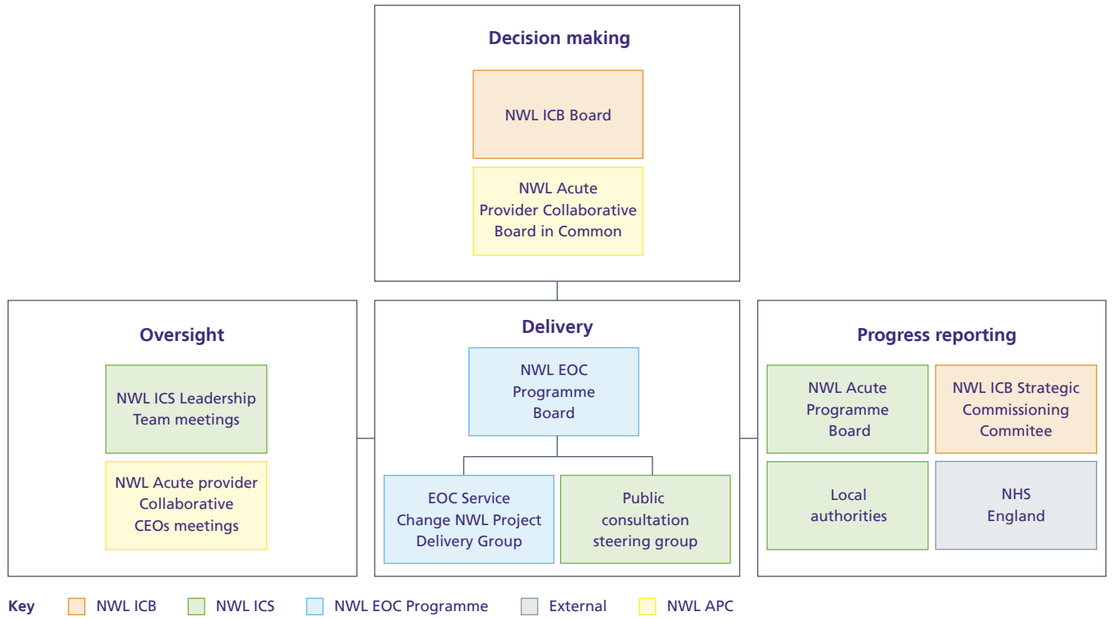
9 Approval process

9.1 Improving planned orthopaedic inpatient surgery in north west London

The programme has had a robust governance structure in place since establishment. This has needed to be adapted and updated to reflect the changing environment of north west London from CCGs and lead providers to the formal establishment of the North West London ICB (NHS North West London) and North West London Integrated Care System on 1 July 2022 and the progression of lead providers into an acute provider collaborative.

The Programme Board has agreed the following governance and resource structure for this current and ongoing programme of work, see Figure 24 below.

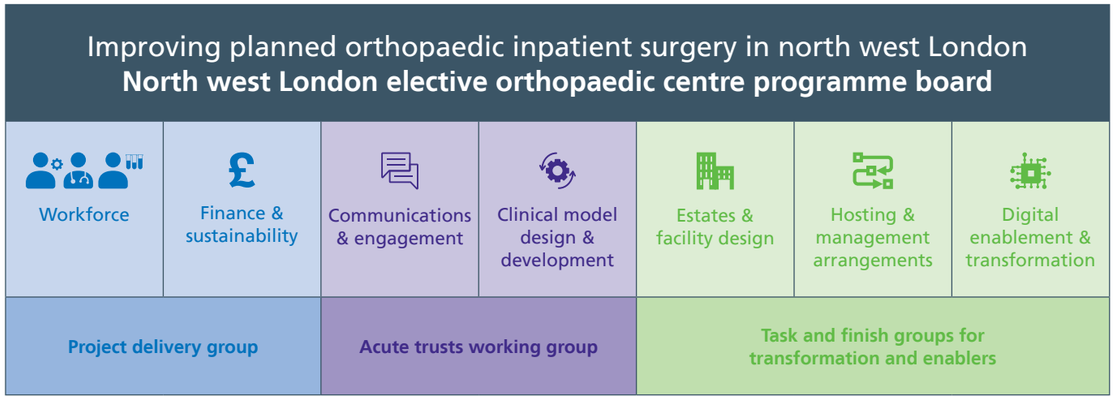
Figure 24 – Improving planned orthopaedic inpatient surgery in north west London governance



The key elements of this governance structure include:

- A clear governance though from the programme board to the North West London ICB and Acute Provider Collaborative Trust Boards.
- The interface between the Programme Board and its assurance mechanism.
- The interface between the Trust Boards and their assurance mechanisms.
- Links to local authority including the North West London Joint Hospital Oversight and Scrutiny Committee through the North West London ICB Board

A comprehensive north west London elective orthopaedic centre programme 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 the figure below:



Roles and responsibilities

The consultation 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 Acute Provider Collaborative 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 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.

The consultation phase of this proposed service transformation is being led by the joint SROs and supported by the Programme Team, led by Martina Dineen, Programme Director. The document has been developed with the Acute Provider Collaborative with the support of the North West London ICB, in addition to providing assurances to NHSE.

Use of External Advisors

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
- Cliniplan – provision of health planning expertise
- Hampton Healthcare Consulting – supported development of the OBC
- Vercity Group – assistance in delivery of project design
- Verve – carried out 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 DPIA is required. Prior to this, an information governance review is needed of the full pathway. This review is needed to understand the systems in use across the full pathway, which personnel are using them, how and what for. In addition, a clinical safety case will also be written. These processes are under way.

9.2 Regulatory tests

The NHSE 'Planning and delivering service changes for service users' published in 2018, outlines good practice on the development of proposals for major service changes and reconfigurations. Additionally, the Mayor of London has released a framework for major hospital reconfigurations containing a series of six tests.

This section demonstrates how north west London has met the Secretary of State's four tests; NHSE's bed closure test and the Mayor of London's six tests during the process of pre-consultation.

In order to ensure the requirements of both sets of tests and to avoid duplication, questions have been assessed and aligned as best as possible.

The NHSE's 5 tests

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 will help us identify and address key concerns or considerations as soon as possible, thus allowing for early action and resolution.

Appendix 4 includes detail of the extensive stakeholder engagement which has already been undertaken. The methods and approaches for pre-consultation have included presentations, discussions, surveys, meetings and emails. The plan is to continue to expand these activities moving forward.

A summary of the types of activities carried out to date includes:

- Establishment of a Communications and Engagement Team, who are responsible for developing the communications and engagement activities required to support the programme.
- Stakeholder mapping has been undertaken to help identify key groups. This will ensure their role in the service change, level of engagement and how they will influence the development of the proposal, is clearly understood.
- A series of public engagements, including the engagement work by Verve (see Appendix 5) which North West London ICS commissioned to gather feedback on the proposed approach for service change.
- Clinical staff engagement has been critical to the development of the proposal. North west London has harnessed the expertise and evidence base provided by senior clinical staff in feedback sessions to help with decision making regarding the proposed care model and site requirements. Overall feedback from engagement sessions has been positive and it is clear that orthopaedic and MSK teams across north west London are aligned in their vision for the elective orthopaedic centre.

- External stakeholders have been engaged throughout the process to date. These engagements have included local MPs, Healthwatch and patient advocacy group representatives from each borough which will be impacted by the proposed service change.

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.

The proposed service change will not negatively impact on the choices available to service users as there is no reduction, but rather an increase in capacity for providing orthopaedic services in north west London.

Although there is a reduction in the choice of providers who deliver elective orthopaedic surgery in north west London, this will 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 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 improve access to the 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. This is outlined in detail in Chapter 4 of this report.

Independent review of this case for change will be sought through submission to the London Clinical Senate.

The COVID-19 pandemic negatively impacted waiting lists for orthopaedic surgery in north west London. With more than 12,000 people currently waiting for orthopaedic care across the country; 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 NWL.

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 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.

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

Test 5: NHSE's bed closures test

From 1 April 2017, NHSE introduced a new test to evaluate the impact of any proposal that includes a significant number of bed closures. This is to ensure commissioners are able to evidence that one of the following three conditions have been met:

- sufficient alternative provisions have been made, such as increased GP or community services.
- new treatments or therapies will reduce specific categories of admissions.
- where a hospital has been using beds less effectively than the national average, that there is a credible plan to improve performance without affecting service user care.

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 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.

Having reviewed the North West London's Programme documentation and 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 Programme Team is continuing to liaise with the Mayor of London's office on the six tests as part of final decision making. The six tests are outlined below.

Mayor's 6 tests

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.

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 independently scrutinised 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.

Test 3: Financial investment and savings

Sufficient funding is identified (both capital and revenue) and available to deliver all aspects of plans including moving resources from hospital to primary and community care and investing in prevention work. Proposals to close the projected funding gap, including planned efficiency savings, are credible.

Test 4: Social care impact

Proposals take into account a) the full financial impacts on local authority services (including social care) of new models of healthcare, and b) the funding challenges they are already facing. Sufficient investment is available from Government to support the added burden on local authorities and primary care.

Test 5: Clinical support

Proposals demonstrate widespread clinical engagement and support, including from frontline staff.

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.

10 Next steps and recommendations

North west London is committed to understanding and reducing inequalities its population may face in the healthcare setting. There is a requirement to understand the impact of the proposed changes on health inequalities. An initial integrated impact assessment (IIA) has been developed and supplements the EHIA which has already been developed. The IIA will continue to be reviewed and refined in response to new data or lines of enquiry. A finalised report will be prepared after the public consultation. While an impact assessment does not determine the decision it will assist decision-making.

Following approval of the 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 25.

Figure 25 – Elective orthopaedic centre timelines overview programme

A governance structure has been put in place to ensure the consultation process is robust. The results of public consultation are an important factor in health service decision making and are one of a number of factors that need to be taken into account in decision making.

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.

The results of public consultation are an important factor in health service decision making and are one of a number of factors that need to be taken into account in decision making.

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 inquiry

Glossary of Terms

Term/ Abbreviation	Definition
ASA	American Society of Anesthesiologists
AHP	Allied health professional
BaU	Business as usual
CMH	Central Middlesex Hospital
CSFs	Critical Success Factors
CRG	Clinical Reference Group
CW	Chelsea and Westminster Hospital
CWFT	Chelsea and Westminster Hospital NHS Foundation Trust
CXH	Charing Cross Hospital
DALY	Disability Adjusted Life Years
DC	Day case
DNA	Did not attend
DMBC	Decision making business case
EOC	Elective orthopaedic centre
EH	Ealing Hospital
EHIA	Equality and Health Impact Assessment
FBC	Full Business Case
GIRFT	Getting it Right First Time
HVLC	High Volume Low Complexity
HH	Hillingdon Hospital
I&E	Income and Expenditure
ICB	Integrated Care Board
ICHT	Imperial College Healthcare NHS Trust
ICS	Integrated Care System
IIA	Integrated Impact Assessment
IMD	Index of Multiple Deprivation
IP	Inpatient
JHOSC	Joint Health Overview and Scrutiny Committee
LCS	Locally Commissioned Services
LNWH	London North West University Healthcare NHS Trust
LoS	Length of stay
LSOA	Lower Layer Super Output Area
MSK	Musculoskeletal
MVH	Mount Vernon Hospital
NHSE	NHS England and NHS Improvement
NPH	Northwick Park Hospital
NPV	Net present value
NWL	North West London
OBC	Outline Business Case
PCBC	Pre-Consultation Business Case
PER	Post-evaluation review
PIR	Post-implementation review
PLICS	Patient Level Information and Costing System
POA	Pre-operative assessment
PROMs	Patient Reported Outcome Measures
PTL	Patient Tracking List
RIBA	Royal Institute of British Architects
SMH	St Mary's Hospital
SMI	Severe mental illness
SOC	Strategic Outline Case
SWL	South West London
SWLEOC	South West London Elective Orthopaedic Centre
THHT	The Hillingdon Hospitals NHS Foundation Trust
T&O	Trauma and orthopaedics
WM	West Middlesex Hospital

Appendix 1 – Equality Health Impact Assessment

Putting patients at the HEART of everything we do

NHS
London North West Healthcare
NHS Trust

Equality Impact Analysis template

Title of document/service being assessed	Development of a north west London Elective Orthopaedic Centre at Central Middlesex Hospital
Date initial screening completed	December 2021
Date of full equality impact assessment commencement	January 2022
Date of full equality impact assessment completion	May 2022

1. What are the intended outcomes of this work? Include outline of objectives and function aims

The north west London integrated care system, through a collaboration of its four acute provider trusts, is building on the concept of fast-track surgical hubs to develop a more strategic, larger-scale approach to improving our provision of "high volume, low complexity" surgery across the sector, beginning with orthopaedic surgery.

The driver is to improve quality as well as to significantly expand access and shorten waiting times over the next few years. We have been exploring how we might best establish an elective orthopaedic centre for north west London alongside maximising our planned surgery capacity overall.

The patient benefits include:

- faster and equitable access for patients awaiting orthopaedic surgery across North West London.
- six day a week access to high quality care designed on best practice (GIRFT & NICE) principles the consistent application in a dedicated surgical centre, reducing the risk of cancellation of patients.
- strengthening and consolidating interfaces with MSK pathways pre and post operatively for patients.
- dedicated specialist pre and post operative patient care on site supported with digital care and networked teams.

The development of a NWL EOC will enable multidisciplinary teams across the NW London ICS deliver orthopaedic surgical care that:

- meets best practice standards and care as set out by GIRFT and NICE

- achieves top quartile, and ultimately top decile productivity in relation to theatre throughput and length of stay using Model Hospital data
- separates elective orthopaedics from trauma services, in line with the NHS Long Term Plan, Royal College of Surgeons' requirements and National Clinical Advisory Team reviews.
- delivers care in a purpose-designed environment separate from the pressures of emergency care.
- supports surgical skills training, new role development while offering new and flexible models of working
- continually improves and innovates patient care and modern surgical practice.

2. Who will be affected by this work? e.g. staff, patients, service users, partner organisations etc.

A number of service delivery models have been explored. The preferred model is that the following elective orthopaedic patients will be treated at the centre:

- Patients referred for inpatient surgery following outpatient investigation under Imperial College Healthcare Trust, Chelsea and Westminster Hospital Trust and The Hillingdon Hospitals Trust (known collectively as the partner trusts), excluding those with complex anaesthetic needs or a need for joint revision surgery
- Patients referred for inpatient and day case surgery following outpatient investigation under London North West University Healthcare Trust (known as the host trust)

Patients requiring spinal surgery and children will not be treated at the centre.

The following approximate numbers of patients will be treated in the centre.

Admission Type	Annual Activity
Inpatient	4,500
Day case	1,500

Patients will be referred into the centre at the point of addition to the waiting list and will receive their pre-operative assessment and surgery under the care of the centre. Apart from this, they will undertake their pre- and post-operative outpatient care at their local trust (or the trust at which they chose to be referred from primary care).

The centre will employ c.330 WTE staff, from the following staff types:

Staff Type	WTE
Nursing	230
Medical	38
Allied Health Professions	35
Admin/Management	29

Of these, approximately 200 WTE are posts currently employed at partner trusts. The employment model has not been determined and is under discussion amongst the partners.

Key partners include:

- Primary care, who refer patients to acute trusts for orthopaedic care, and who provide continuity of care
- Community organisations, in particular those which support discharge
- Local authorities, which will provide support and scrutiny on behalf of their residents

3. What evidence have you considered?

Where local north west London data are available, analysis is provided in this document. Where this is not available, reference is made to analysis provided in the equality impact assessment for orthopaedics across London ("Equality and Health Inequalities Impact Assessment: High volume low complexity surgical hubs – Orthopaedics" – Health Innovation Network South London and Imperial College Health Partners, Dec 2021). Where studies and research have been used, reference is made throughout the document to the specific resources.

Main data sources used were:

- Hospital Episode Statistics (HES) (https://digital.nhs.uk)
- Dr Foster (https://drfoster.com)
- Model Hospital (https://model.nhs.uk)
- GLA Housing Led Population Projections (https://data.london.gov.uk/dataset)
- Office for National Statistics (https://www.ons.gove.uk)
- Google Maps (https://maps.google.com/maps)
- Trust theatre systems

4. Age

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.[1] 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.[2]

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

[1] Implementation of a standardized protocol to manage elderly patients with low energy pelvic fractures: can service improvement be expected? (2017) https://link.springer.com/content/pdf/10.1007/s00264-017-3567-2.pdf

[2] 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/

significantly lower than before injury.[3] 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.[4]

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%).[5] 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.

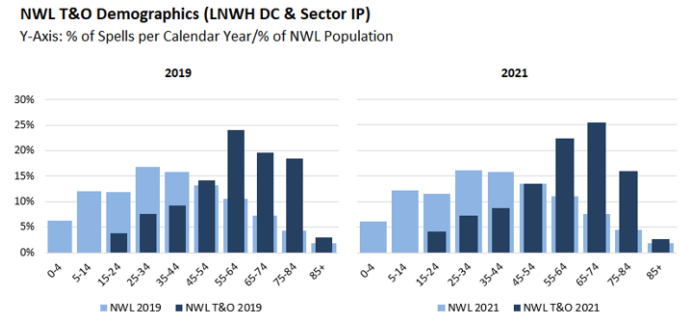
As would be expected, the NWL elective orthopaedic population is older than the general population. The older population are more likely to require inpatient than day case surgery, the primary admission type for the elective orthopaedic centre. The older population are also more likely to have co-morbidities, or have more complex surgeries, and be categorised as ASA 3 or above. This would mean that they would be seen in a trust, and their pathway would not change.

Travel and accessibility for older people, those with disabilities and individuals on low incomes could be a barrier to orthopaedic surgery. Section 13 shows that 90% of the elective orthopaedic centre's target population lives in the boroughs of NWL and shows the expected travel times to NWL trust sites by public transport and car. Central Middlesex Hospital, the most likely location for the elective orthopaedic centre, has the shortest average travel time.

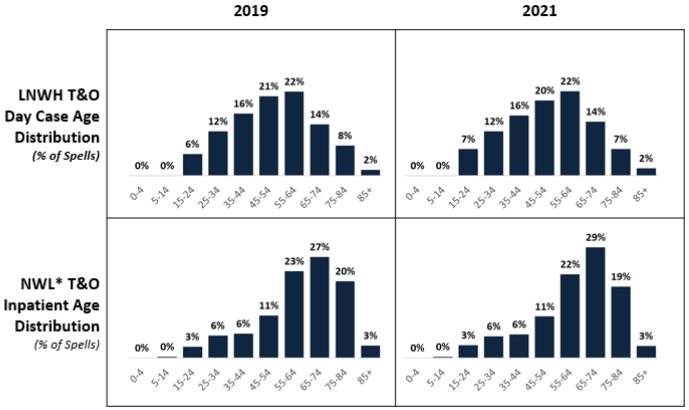
[3] Recovery of health-related quality of life in a United Kingdom hip fracture population (2015) https://online.boneandjoint.org.uk/doi/full/10.1302/0301-620X.97B3.35738?rfr_dat=cr_pub++0pubmed&url_ver=Z39.88-2003&rfr_id=ori%3Arid%3Acrossref.org

[4] 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

[5] 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



Source: HES Data (Dr Foster); GLA Housing Led Projections 2020



*Source: HES Data (Dr Foster); * NWL T&O includes IP activity of LNWH, ICHT, THHT & CWFT*

Given the low numbers of children within the T&O day case and inpatient spells, there are no specific safeguarding, consent and welfare issues that need to be taken into account, over and above what already exists for acute providers. Whichever organisation ends up being the legal host of the EOC will develop policies which meet all current legislation and NHS guidance.

Actions to reduce/eliminate negative impacts in relation to age are:

i. Develop clinical model which minimises visits to the centre by providing outpatient care at local trusts
ii. Develop virtual pre-operative assessment where suitable, alongside face-to-face options to avoid digital exclusion
iii. Design the centre to be compliant with current legislation regarding accessibility and wayfinding
iv. Develop discharge standard operating policies in collaboration with community colleagues to ensure effective discharge from hospital
v. Ensure all future quantitative research is segmented according to demographics including age
vi. Identify any age-specific groups in NWL and involve them in the public consultation
vii. Capacity and growth issues will need to be addressed in future developments of the centre

5. Disability.

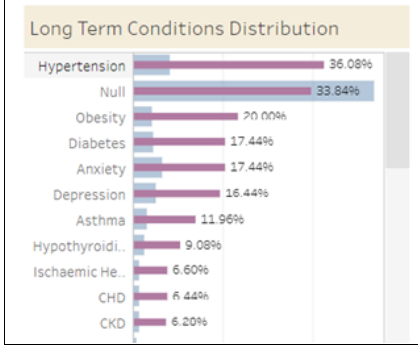
Research from the London EIA (ref. "Equality and Health Inequalities Impact Assessment: High volume low complexity surgical hubs – Orthopaedics" – Health Innovation Network South London and Imperial College Health Partners, Dec 2021)) identifies:

- 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. Additionally, for these patients with hearing impairments going to new and unfamiliar locations could present additional communication barriers.
- 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. Research by Mencap found that hospital visiting policies during COVID restricted any family members / carers from accompanying patients with learning disabilities (LD) to provide support and assist with communication. 1 in 4 learning disability nurses they surveyed said that during the pandemic they had seen examples where carers, family members or supporters had not been allowed in hospital to accompany patients with LD. Although guidance issued on 8 April 2020 stated that someone with a learning disability or autism could have someone present if the patient has cause for distress

- 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. Individuals with autism have sensory sensitivities that affect how they access healthcare services. They may choose to avoid healthcare facilities or have adverse reactions in clinical settings because of their condition.
- 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. Hospital Episode Statistics) does not generally record reliable details of this protected characteristic.

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.[6] 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.[7] Of all risk factors assessed, cardiac disease was identified as one of the strongest predictors of 30-day mortality following hip fracture surgery.

Analysis of the current NWL wating list shows that hypertension, obesity and diabetes are the most frequently recorded long term conditions:



[6] 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

[7] 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

Long term conditions that are well-managed would not necessarily result in exclusion from the centre. However, those requiring additional time and medical intervention to stabilise their long term condition (in particular if it was a recent diagnosis) prior to surgery may not meet the criteria and would require surgery at their local Trust. They could, therefore, have differential waits for their procedure but would have equal clinical outcomes.

The clinical model has been discussed with primary care and community colleagues, in particular though the NWL MSK network and orthopaedic Clinical Reference Group. The expressed ambition of all partners is that the patient pathway is as seamless as possible, regardless of disability. Starting at primary care, GPs will refer the patient to their local hospital under a standard referral pathway, starting to inform patients about the potential for surgery at the EOC. Standardised discharge pathways from the EOC will also be developed, led by the EOC therapy team.

Actions to reduce/eliminate negative impacts in relation to disability are:

i. Develop clinical model which minimises visits to the centre by providing outpatient care at local trusts
ii. Develop virtual pre-operative assessment where suitable, alongside adjustments for those with physical or sensory disabilities, learning disabilities and those on the autistic spectrum
iii. Design the centre to be compliant with current legislation regarding accessibility and wayfinding
iv. Review the transport requirements of the patient group, including disabled access and parking, and will explore the potential for dedicated transport provision to the centre, as has been introduced by SWL elective orthopaedic centre
v. Ensure that groups and communities working with people with disabilities are involved in the consultation, using a range of formats and methods
vi. Continually involve patients, through a variety of methods, to make sure that our wards meet multiple mental health and care needs, including disability
vii. Work with staff disability networks to ensure necessary adjustments for staff with disabilities
viii. Ensure that we have sufficient and accurate diversity data to monitor how people with disabilities use services and what their particular needs are
ix. Monitor elective orthopaedic waiting times across the sector to ensure that patients who are not eligible for treatment at the centre do not wait longer, and take mitigating action if such waits are revealed

6. Gender reassignment (including transgender) Consider and detail evidence on transgender people. This can include issues such as privacy of data and harassment.

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.

Mitigation – Improving knowledge and cultural competency. The GMC provides a short 'top tips' video https://www.gmc-uk.org/ethical-guidance/ethical-hub/trans-healthcare

For the data analysis, the main source of data (HES or Hospital Episode Statistics) does not generally record reliable details of this protected characteristic.
Actions to reduce/eliminate negative impacts in relation to gender reassignment are:

i. The clinical team will consider therapeutic activities which address the specific needs of the transgender community
ii. Improve knowledge and cultural competency amongst staff through awareness and training
iii. Ensure policies to protect the rights of transgender staff are known and followed
iv. Make available specific advice and support to make sure that trans individuals are supported appropriately when admitted to the centre
v. Identify any trans-specific groups in NWL and involve them in the public consultation
vi. Establish ways of capturing data on transgender patients to ensure we understand the needs of this community and how they use services

7. Marriage and civil partnership. Consider and detail evidence on marriage and civil partnership. This can include working arrangements, part-time working, caring responsibilities.

Research on orthopaedic trauma and marriage status from the US found a link between discharge destination and marital status.[8] 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

[8] Marriage Status Predicts Hospital Outcomes Following Orthopedic Trauma (2020) https://pubmed.ncbi.nlm.nih.gov/32030312/

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 or Hospital Episode Statistics) does not generally record reliable details of this protected characteristic.

Actions to reduce/eliminate negative impacts in relation to marriage/civil partnership are:

i. Throughout the development of the centre, we expect to receive feedback from patients and staff with a range of partnership status. We will highlight any specific issues if they emerge and respond to these issues accordingly
ii. Establish ways of capturing data on patient partnership status to ensure equity of access

8. Pregnancy and maternity. Consider and detail evidence on pregnancy and maternity. This can include working arrangements, part-time working, caring responsibilities.

Pregnancy presents unique challenges to orthopaedic surgeons.[9] 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.[10] 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.

The majority of nursing staff, the largest staff group in the elective orthopaedic centre, are female. The centre will develop HR policies and procedures that recognise the needs of the workforce including considering staff's caring responsibilities.

[9] Pregnancy and the orthopaedic patient (2012) https://www.orthopaedicsandtraumajournal.co.uk/article/S1877-1327(12)00071-1/fulltext
[10] Treatment of Pregnant Patients With Orthopaedic Trauma (2017) https://digitalcommons.pcom.edu/cgi/viewcontent.cgi

Actions to reduce/eliminate negative impacts in relation to marriage/civil partnership are:

i. Throughout the programme development process, we expect to receive feedback from a range of people. We will highlight any specific issues specific to pregnancy and maternity if they emerge and respond to these issues accordingly
ii. Pregnant women will not be eligible for treatment in the centre due to their clinical complexity
iii. The centre will develop HR policies and procedures that recognise the needs of the workforce including parental leave, flexible working and caring responsibilities
iv. Consult staff on access to the centre, including car parking and travel costs, and consider solutions

9. Race Consider and detail race related evidence. This can include information on difference ethnic groups, Roma gypsies, Irish travellers, nationalities, cultures, and language barriers.

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. Ethnic minority groups are disproportionately affected by socio-economic deprivation, a key determinant of health status. This is driven by a wider social context in which structural racism and discrimination can reinforce inequalities among ethnic groups, e.g., housing, employment, which evidence shows in turn can have a negative impact on the physical and mental health of people from ethnic minority groups.

The COVID-19 pandemic has underlined the structural disadvantage experienced by people from ethnic minority backgrounds who have been at greater risk of contracting and dying from COVID-19. The death rate has been higher among ethnic minority populations, and early data from intensive care units found a disproportionate number of patients with COVID-19 were from ethnic minority background. Even when accounting for age and geography, there have been more deaths per capita in all ethnic minority groups (other than white Irish) than among white British people. A fear amongst ethnic minority patients of acquiring Covid 19 whilst being treated within an hospital environment could impact upon the number agreeing to their surgical procedure.

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. In the US, they found healthcare professionals appear to have implicit bias in terms of positive attitudes towards white patients and negatives towards patients of colour.

Difference in literacy levels is another challenge, firstly although people may be able to speak English they might not be able to read it, thereby affecting the ability to understand written health related materials. Fewer than one third of Bangladeshi and Pakistani women and fewer than two thirds of older Bangladeshi and Pakistani men can read English. Furthermore, even if letters and patient information leaflets are translated, people may not be able to read their own language. The study 'Access to health care for ethnic minority populations (Szczepura, 2005) found that over half of older Bangladeshi and Pakistani women cannot read their own language and about 20% of older men. 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.

References:

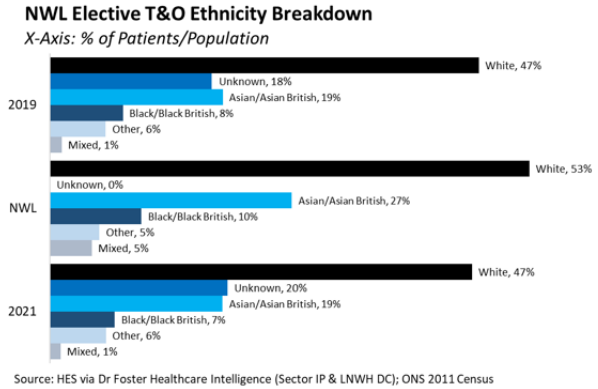
- The health of people from ethnic minority groups in England, The King's Fund, Raleigh and Holmes 2021. The complexities of race and health, Danso and Danso, 2021.
- Will COVID-19 be a watershed moment for health inequalities? Institute of Health Equity and Health Foundation 2020
- Access to health care for ethnic minority populations, Szczepura, 2005; Implicit Racial / Ethnic Bias Among Health Care Professionals and Its Influence on Health Care Outcomes: A Systematic Review, 2015

Musculoskeletal conditions are some of the most common conditions affecting the population, and some Black, Asian and minority ethnic groups in the UK are 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.[11] Studies from the US have found White individuals are more likely to get joint surgery than other ethnic groups.[12] 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.

As shown below, 47% of NWL's known ethnicity is non-white. The non-white proportion is slightly greater in the elective orthopaedic cohort.

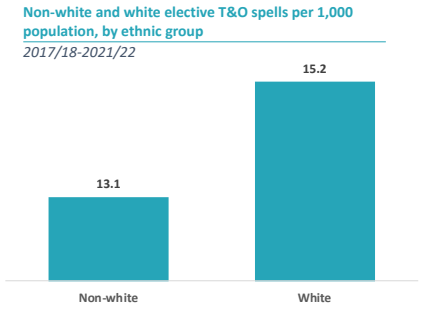
[11] Musculoskeletal conditions and Black, Asian and minority ethnic people: addressing health inequalities (2020) https://raceequalityfoundation.org.uk/wp-content/uploads/2020/10/MSK-Report-Addressing-Health-Inequalities.pdf

[12] 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/



Source: HES Data (Dr Foster)

The white population of NWL also have a higher number of elective T&O spells per thousand population, 16% higher than the non-white population.



All four trusts are experienced in working with diverse communities and have multiple policies in place to protect patients. For instance:

- Privacy Dignity and Respect Policy
- Policy and procedure for safeguarding adults at risk
- Spiritual healthcare policy
- Gender recognition standard operating procedures (SOP)
- Intimate examination, care and chaperone policy
- Information governance policy
- Disability in employment policy
- Equality, diversity and inclusion policy

- Inclusive communication and interpretation procedures and protocols

Actions to reduce/eliminate negative impacts in relation to race are:

i. The communications and involvement strategy will be aimed at providing opportunities for the population of NWL to be involved in the development of the programme and to give their feedback, regardless of protected characteristic. A range of methods to encourage involvement will include communities that are hard to reach
ii. We will:
    a. ensure any public facing information on the programme and any subsequent proposals are provided in appropriate formats, if needed.
    b. ensure links have been made with the BAME Forum, local faith communities or cultural groups, to encourage involvement and gain feedback through all stages of public involvement.
    c. ensure that "Friends, Families and Travellers" (the national charity working on behalf of all Gypsies, Travellers and Roma) receive information on all involvement activity.
    d. work with staff BAME networks to understand their needs and meets the NHS and local Workforce Race Equality Standard (WRES)
    e. develop a consistent mechanism of robust equalities-based involvement to ensure that all voices are heard
iii. Develop end-to-end pathways in collaboration with NWL musculoskeletal network
iv. Carry out positive regular monitoring of the ethnicity of the patients using the centre will be undertaken and plans developed to address any disparities
v. The workforce workstream will develop strategies to ensure appropriate BAME representation in the staff group
vi. The EOC will 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
vii. All of the above actions will be overseen by the Programme Board and will be reviewed regularly

10. Religion or belief. Consider and detail evidence on people with different religions, beliefs or no belief. This can include consent and end of life issues.

Some research for specific religious groups found 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; and system-related barriers. Mitigation - 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.

For the data analysis, the main source of data (HES or Hospital Episode Statistics) does not generally record reliable details of this protected characteristic.

Actions to reduce/eliminate negative impacts in relation to religion/beliefs are:

i. Identify and engage faith groups in NWL throughout public engagement and involvement
ii. Work with staff spirituality networks and chaplaincy teams to make sure we meet the needs of patients and staff from differing religious and faith backgrounds
iii. Establish ways of capturing data on patient religions/beliefs to ensure we understand the needs of this community and how they use services

11. Sex. Consider evidence on men and women. This could include access to services and employment.

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 are differences between men and women with musculoskeletal condition incidence, disease presentation, diagnosis and management.[13] 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.[14] Following surgery, differences also remain between men and women. Analysis of data from the Scottish Hip Fracture Audit indicated that the men were

[13] Does Sex Matter in Orthopedic Care? (2018) http://www.orthojournalhms.org/19/article38_45.html

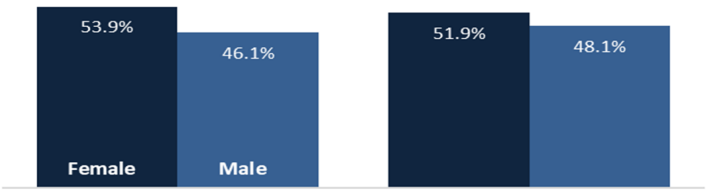
[14] Geographical variation in the provision of elective primary hip and knee replacement: the role of socio-demographic, hospital and distance variables (2009) https://pubmed.ncbi.nlm.nih.gov/19542267/

less likely to return home or mobilise independently at the 120-day follow-up.[15] 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.[16]

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.

Gender Breakdown of Elective NWL T&O Patients

Y-Axis: % of Spells



Source: HES Data via Dr Foster

Actions to reduce/eliminate negative impacts in relation to sex are:

i. Centre design will reflect the expected gender mix to meet NHS England's "enhancing privacy and dignity" policies, including single sex accommodation, changing and toilet facilities
ii. Ensure that the centre's staff facilities also provide privacy and dignity for staff
iii. Develop procedures to ensure patients have access to appropriate chaperone where necessary
iv. All quantitative research will be segmented according to demographics including sex

[15] Gender differences in epidemiology and outcome after hip fracture (2008) https://online.boneandjoint.org.uk/doi/full/10.1302/0301-620X.90B4.20264

[16] 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

12. Sexual orientation Consider and detail evidence on heterosexual people as well as lesbian, gay and bisexual people. This could include access to services and employment, attitudinal and social barriers.

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.[17]

For the data analysis, the main source of data (HES or Hospital Episode Statistics) does not generally record reliable details of this protected characteristic.

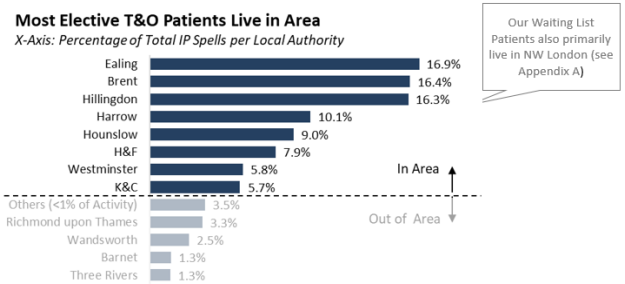
Actions to reduce/eliminate negative impacts in relation to sexual orientation are:

i. Any feedback in relation to this impact will be considered throughout the development and co-design process and appropriate actions agree
ii. We will work with:
    - LGBTQI+ community groups to identify and engage with potential services user in this group
    - Staff LGBTQI+ network to understand the needs of staff

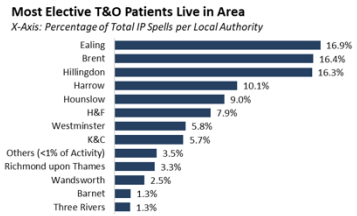
[17] LGBTQ+ in Orthopaedics: Creating an Open and Inclusive Environment (2022) https://pubmed.ncbi.nlm.nih.gov/35609262/

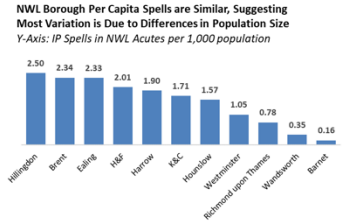
13. Other identified groups Consider and detail evidence on groups experiencing disadvantage and barriers to access and outcomes. This can include different socio-economic groups, Carers, geographical area inequality, income, resident status (migrants, asylum seekers).

Geography and access:
90% of the elective orthopaedic centre's target population lives in the boroughs of NWL and shows the expected travel times to NWL trust sites by public transport and car. Central Middlesex Hospital, the most likely location for the elective orthopaedic centre, has the shortest average travel time by car, and the second shortest average travel time (second to St Mary's Hospital) by public transport.

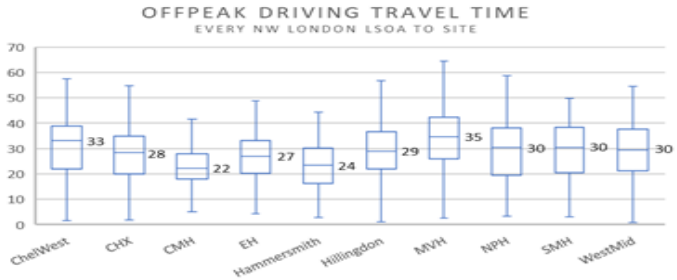


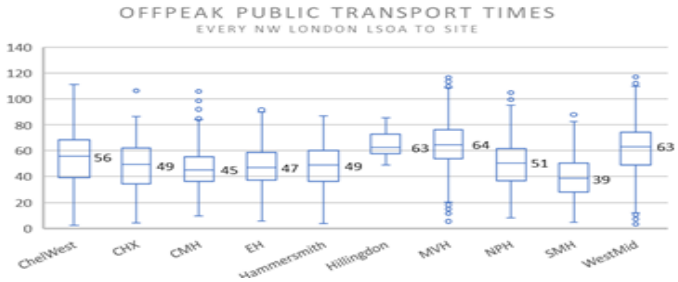
Source: HES Data (Dr Foster)





Source: HES Data (Dr Foster); GLA Housing Led Projections 2020





Deprivation:
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 distribution6 benefit twice (thrice) as much as those in bottom fourth (fifth) quintile; and have more choice of where they have their hip replacement surgery eg. access to NHS funded independent providers, while the two bottom quintiles do not). As the deep dive analysis were unable to access waiting times or activity data for the independent sector used for HVLC hubs it was difficult to explore this further.

Research has assessed the differences in healthcare provision between deprivation groups for T&O patients. For hip replacement, research 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.[18] 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

[18] 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/

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.[19] Potential explanations of the link between deprivation and mortality include poorer health status, living conditions and access to services amongst more deprived populations.

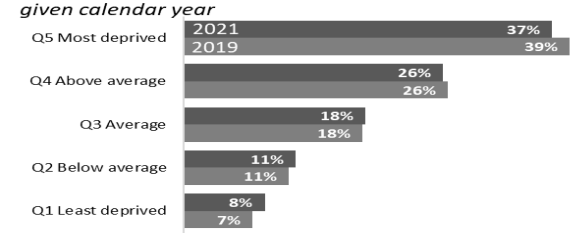
Based upon the areas covered by the 5 Integrated Care System areas in London, previous data has been analysed to identify if patients living in more deprived areas have equity of access to surgery in the six specialties (including orthopaedics). Analysing the number of total hip replacements and total knee replacement (per 100,000 population) carried out on patients living in the most deprived and least deprived Index of Multiple Deprivation (IMD) deciles for each ICS. This found that in 2020 South West London (SWL) and North West London ICS have patients living in deprived areas who are less likely receive their hip replacement compared to London and national average. However, this could be due to more stringent referral management process

Graphs below show that over half of the NWL London population are more deprived than the national average, with a particular concentration of high deprivation in the middle of the NWL sector.

Analysis of travel times shows that residents of the most deprived parts of the NWL sector have significantly reduced travel times to Central Middlesex Hospital, by car and public transport.

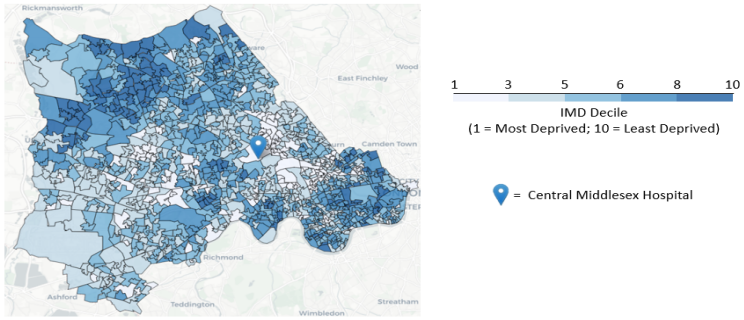
NWL EL T&O Patients by Deprivation

X-Axis: % of patients per deprivation index for each given calendar year



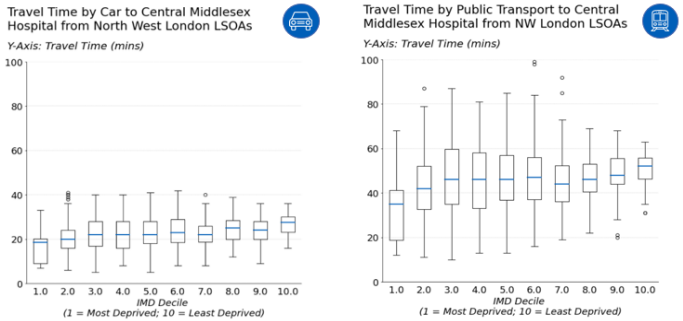
Source: HES Data via Dr Foster

[19] 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/



Source ONS: 2019 IMDs by LSOA

Deprivation | The most deprived LSOAs have statistically significantly reduced travel times to CMH by car and public transport



At an individual level, those from deprived areas may not necessarily have improved access as it depends on numerous other factors e.g. car ownership, and ability to pay for transport, parking and/or ULEZ

Actions to reduce/eliminate negative impacts in relation to deprivation are:

i. Involve as many communities as possible in the development, looking look specifically at how we listen to those from deprived areas
ii. Pay particular attention to the travel needs of patients, families and carers from deprived areas
iii. We will consider travel solutions (including dedicated transport provision to the centre) and encourage people to apply for travel reimbursement through the Department of Work and Pensions, providing simple access to information
iv. Staff travel impacts will be analysed and incorporated in staff consultation
v. Work with Transport for London in relation to adjustments to support affordable access, for example adapting bus routes
vi. Develop clinical model which minimises visits to the centre by providing outpatient care at local trusts

14. Engagement & Involvement

How have you engaged stakeholders with an interest in protected characteristics in gathering evidence or testing the evidence available?

The engagement plan is summarised in Appendix A.

15. Summary of Analysis

Previous research, and local analysis, suggests potential negative impacts for patients for whom access to a healthcare setting is a challenge, in particular:

- Elderly patients
- Disabled patients
- Black and Minority Ethnic patients for whom English is a second language
- Patients from deprived areas

Consideration has been given to these groups in the option appraisal for a preferred site within NWL, and Central Middlesex Hospital has been shown to be the most accessible viable site for an elective orthopaedic centre.

As the centre plans for implementation it will develop detailed operational policies to address the specific needs of patients, for example virtual pre-operative assessment to avoid hospital attendance where appropriate.

Staff's needs will be considered by the workforce group, which is developing an employment model. Best human resource practice will be followed in any negotiations or consultations with affected staff.

The following are recommended to mitigate the impact on patients (ref "Equality and Health Inequalities Impact Assessment: High volume low complexity surgical hubs – Orthopaedics" – Health Innovation Network South London and Imperial College Health Partners, Dec 2021):

- Improved population level data dashboard should be set up at ICS level to analyse patient data (including co-morbidities) to provide assurance that HVLC hubs are not creating health inequalities, particularly those with communication issues, translation needs, serious mental illness, learning disabilities and deprivation
- Ensure consistent application of the HVLC criteria so that patients are prioritised based upon their clinical requirements, with a particular focus on better preparation for surgery patients with co-morbidities requiring additional medical intervention from both primary care and pre-operative team to stabilise their long-term condition.
- Improved monitoring of waiting lists for HVLC procedures to ensure all patients are seen in a reasonable and equitable time period. Action should be taken to monitor and mitigate against greater impact upon certain groups that face inequalities (e.g., patients with disabilities, economic deprivation and lack of support network).

16 Eliminate discrimination, harassment and victimisation

The EOC will aim to eliminate discrimination, harassment and victimisation through

- Make available specific advice and support to make sure that trans individuals are supported appropriately when admitted to the centre
- Work with staff BAME networks to understand their needs and meets the NHS and local Workforce Race Equality Standard (WRES)
- Centre design will reflect the expected gender mix to meet NHS England's "enhancing privacy and dignity" policies, including single sex accommodation, changing and toilet facilities
- Provide anonymous reporting mechanism to be able to identify the root cause of any occurrences of discrimination, harassment or victimisation
-

17 Advance equality of opportunity

The EOC will advance equality of opportunity through

- 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 race, gender, age or other protected characteristics
- Develop virtual pre-operative assessment where suitable, alongside face-to-face options to avoid digital exclusion for those with physical or sensory disabilities, or those who are not confident using technology
- Consideration of therapeutic activities which address the specific needs of the transgender community
- Standardised processes across the pathway for the whole of NWL, meaning that all patients will have the same opportunities for treatments
- 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
- Consideration of travel solutions (including dedicated transport provision to the centre) and encourage people to apply for travel reimbursement through the Department of Work and Pensions, providing simple access to information
- Robust data collection to enable continual understanding and improvement

18 Promote good relations between groups

The EOC will promote good relations between groups through

- Consideration of how to maintain the level of BAME representation in the staff group
- Enhanced training for all clinicians and support staff to understand how to adjust approach for different cultures
- Identification any specific groups within NWL to represent that protected characteristic and involve them in the public consultation

19 Risk Scoring

You will also need to score each of your negative impacts from the information/data for each Protected Characteristic and from the outcome of Engagement & Involvement exercise and record the scoring in your Action Plan.

Use the Matrix below

Matrix for Full Equality Impact Assessments

1. PROBABILITY -What is the likelihood of the service, policy or function having an impact on staff or patients of the Trust? Use the table below to assign this incident a category code.

MEASURES OF PROBABILITY		
Descriptor	**Level**	**Description**
Rare	1	The service, policy or function will only impact under exceptional circumstances
Unlikely	2	The service, policy or function is not expected to have an impact but will do in some circumstances
Possible	3	The service, policy or function may have an impact on occasion
Likely	4	The service, policy or function is likely to impact, but not on a persistent basis
Almost Certain	5	The service, policy or function is likely to impact on many occasions and on a persistent basis

2. SEVERITY OF IMPACT -Identify the highest possible impact of the service, policy or function. (Use this table as a general guide)

Examples of Discrimination according to descriptor

Descriptor	
Negligible 1	Patient complaining that their dignity has been infringed due to having to wait in reception after eyes being dilated.
Low 2	Temporary relocation of Clinic due to refurbishment. Patients required to travel longer distance to attend clinic.
Medium 3	Uneven surfaces making it dangerous for wheelchair users to manoeuvre across.
High 4	Service excludes particular patients due to their religious requirements.
Very High 5	Emergency Fire Escape: Lack of accessible escape routes for disabled patients.

Action Plan

Equality Impact Score - Use the matrix below to grade the risk. E.g. 2 x 4 = 8 = Yellow or 5 x 5 = 25 = Red

	Severity of Impact				
Probability	**Negligible 1**	**Low 2**	**Medium 3**	**High 4**	**Very High 5**
1 Rare	1	2	3	4	5
2 Unlikely	2	4	6	8	10
3 Possible	3	6	9	12	15
4 Likely	4	8	12	16	20
5 Almost Certain	5	10	15	20	25

	Unmitigated score: 4x3=12 Target score: 4x2=8
	Actions required to reduce/eliminate negative impact: 1. Develop clinical model which minimises visits to the centre by providing outpatient care at local trusts 2. Develop virtual pre-operative assessment where suitable, alongside adjustments for those with physical or sensory disabilities, learning disabilities and those on the autistic spectrum 3. Design the centre to be compliant with current legislation regarding accessibility and wayfinding 4. We will review the transport requirements of the patient group, including disabled access and parking, and will explore the potential for dedicated transport provision to the centre, as has been introduced by SWL elective orthopaedic centre 5. Ensure that groups and communities working with people with disabilities are involved in the consultation, using a range of formats and methods 6. Continually involve patients, through a variety of methods, to make sure that our wards meet multiple mental health and care needs, including disability 7. Work with staff disability networks to ensure necessary adjustments for staff with disabilities 8. Ensure that we have sufficient and accurate data to monitor how people with disabilities use services and what their particular needs are 9. Monitor elective orthopaedic waiting times across the sector to ensure that patients who are not eligible for treatment at the centre do not wait longer, and take mitigating action if such waits are revealed
Gender reassignment	Potential negative impact:

Protected characteristic	Impact and action
Age	Potential negative impact: There is a risk that older patients will disproportionately experience difficulties accessing the centre and navigating services, resulting in lower quality care Unmitigated score: 4x3=12 Target score: 4x1=4
	Actions required to reduce/eliminate negative impact: 1. Develop clinical model which minimises visits to the centre by providing outpatient care at local trusts 2. Develop virtual pre-operative assessment where suitable, alongside face-to-face options to avoid digital exclusion 3. Design the centre to be compliant with current legislation regarding accessibility and wayfinding 4. Develop discharge standard operating policies in collaboration with community colleagues to ensure effective discharge from hospital 5. Ensure all future quantitative research is segmented according to demographics including age 6. Identify any age-specific groups in NWL and involve them in the public consultation 7. Capacity and growth issues will need to be addressed in future developments of the centre
Disability	Potential negative impact: There is a risk that patients with disabilities will disproportionately experience difficulties accessing the centre and navigating services, and will experience particular communication difficulties, resulting in lower quality care. There is also a risk that staff with disabilities will experience specific difficulties working in the centre.

	Actions required to reduce/eliminate negative impact: 1. Throughout the development of the centre, we expect to receive feedback from patients and staff with a range of partnership status. We will highlight any specific issues if they emerge and respond to these issues accordingly 2. Establish ways of capturing data on patient partnership status to ensure equity of access
Pregnancy / maternity	Potential negative impact: There is a risk that staff who are pregnant or on parental leave will experience discrimination or be disproportionally affected by the relocation of their work base, resulting in loss of morale, loss of opportunity and poor work-life. Unmitigated score: 3x3=9 Target score: 3x2=6
	Actions required to reduce/eliminate negative impact: 1. Throughout the programme development process, we expect to receive feedback from a range of people. We will highlight any specific issues specific to pregnancy and maternity if they emerge and respond to these issues accordingly 2. Pregnant women will not be eligible for treatment in the centre due to their clinical complexity 3. The centre will develop HR policies and procedures that recognise the needs of the workforce including parental leave, flexible working and caring responsibilities 4. Consult staff on access to the centre, including car parking and travel costs, and consider solutions
Race	Potential negative impact:

	There is a risk that patients or staff who have undergone, or are undergoing, gender reassignment will experience intentional or unintentional discrimination in their interactions with the centre, resulting in lower quality care or staff satisfaction. Unmitigated score: 3x3=9 Target score: 3x1=3
	Actions required to reduce/eliminate negative impact: 1. The clinical team will consider therapeutic activities which address the specific needs of the transgender community 2. Improve knowledge and cultural competency amongst staff through awareness and training 3. Ensure policies to protect the rights of transgender staff are known and followed 4. Make available specific advice and support to make sure that trans individuals are supported appropriately when admitted to the centre 5. Identify any trans-specific groups in NWL and involve them in the public consultation 6. Establish ways of capturing data on transgender patients to ensure we understand the needs of this community and how they use services
Marriage / civil partnership	Potential negative impact: There is a risk that patients or staff of certain partnership status will experience intentional or unintentional discrimination in their interactions with the centre, resulting in lower quality care or staff satisfaction. Unmitigated score: 3x3=9 Target score: 3x1=3

	6. All of the above actions will be overseen by the Programme Board and will be reviewed regularly
Religion or belief	Potential negative impact: There is a risk that patients or staff of some religious or faith groups will experience intentional or unintentional discrimination in their interactions with the centre, resulting in lower quality care or staff satisfaction. There is also a risk that patients from some religious or faith backgrounds receive less satisfactory care due to their specific needs not being met. Unmitigated score: 3x3=9 Target score: 3x2=6
	Actions required to reduce/eliminate negative impact: 1. Identify and engage faith groups in NWL throughout public engagement and involvement 2. Work with staff spirituality networks and chaplaincy teams to make sure we meet the needs of patients and staff from differing religious and faith backgrounds 3. Establish ways of capturing data on patient religions/beliefs to ensure we understand the needs of this community and how they use services
Sex	Potential negative impact: There is a risk that patients or staff of a particular gender will experience intentional or unintentional discrimination in their interactions with the centre, resulting in lower quality care or staff satisfaction. There is also a risk that patient privacy and dignity will be compromised during their care. Unmitigated score: 3x3=9

	There is a risk that patients from some ethnic backgrounds will disproportionately experience difficulties accessing the centre and navigating services, including where English is not their first language, resulting in lower quality care. There is also a risk that staff from some ethnic backgrounds will experience intentional or unintentional discrimination, resulting in loss of morale, loss of opportunity and poor work-life. Unmitigated score: 4x3=12 Target score: 4x2=8
	Actions required to reduce/eliminate negative impact: 1. The communications and involvement strategy will be aimed at providing opportunities for the population of NWL to be involved in the development of the programme and to give their feedback, regardless of protected characteristic. A range of methods to encourage involvement will include communities that are hard to reach 2. We will: • ensure any public facing information on the programme and any subsequent proposals are provided in appropriate formats, if needed. • ensure links have been made with the BAME Forum, local faith communities or cultural groups, to encourage involvement and gain feedback through all stages of public involvement. • ensure that “Friends, Families and Travellers” (the national charity working on behalf of all Gypsies, Travellers and Roma) receive information on all involvement activity. • work with staff BAME networks to understand their needs and meets the NHS and local Workforce Race Equality Standard (WRES) • develop a consistent mechanism of robust equalities-based involvement to ensure that all voices are heard 3. Develop end-to-end pathways in collaboration with NWL musculoskeletal network 4. Carry out positive regular monitoring of the ethnicity of the patients using the centre will be undertaken and plans developed to address any disparities 5. Workforce workstream will develop strategies to maintain the level of BAME representation in the staff group.

Other groups: Deprivation	Potential negative impact: There is a risk that patients suffering from deprivation will disproportionately experience difficulties accessing the centre and navigating services, resulting in lower quality care. Unmitigated score: 4x3=12 Target score: 4x2=8
	Actions required to reduce/eliminate negative impact: 1. Involve as many communities as possible in the development, looking look specifically at how we listen to those from deprived areas 2. Pay particular attention to the travel needs of patients, families and carers from deprived areas 3. We will consider travel solutions (including dedicated transport provision to the centre) and encourage people to apply for travel reimbursement through the Department of Work and Pensions, providing simple access to information 4. Staff travel impacts will be analysed and incorporated in staff consultation 5. Work with Transport for London in relation to adjustments to support affordable access, for example adapting bus routes 6. Develop clinical model which minimises visits to the centre by providing outpatient care at local trusts
Other groups: Unspecified	Means will be established to actively monitor for unintended consequence resulting in diminished equality in other undefined groups, e.g., single carers, and action taken to mitigate

	Target score: 3x1=3
	Actions required to reduce/eliminate negative impact: 1. Centre design will reflect the expected gender mix to meet NHS England's "enhancing privacy and dignity" policies, including single sex accommodation, changing and toilet facilities 2. Ensure that the centre's staff facilities also provide privacy and dignity for staff 3. Develop procedures to ensure patients have access to appropriate chaperone where necessary 4. All quantitative research will be segmented according to demographics including sex
Sexual orientation	Potential negative impact: There is a risk that patients or staff of a particular sexual orientation will experience intentional or unintentional discrimination in their interactions with the centre, resulting in lower quality care or staff satisfaction. Unmitigated score: 3x3=9 Target score: 3x1=3
	Actions required to reduce/eliminate negative impact: 1. Any feedback in relation to this impact will be considered throughout the development and co-design process and appropriate actions agree 2. We will work with: • LGBTQ+ community groups to identify and engage with potential services user in this group • Staff LGBTQ+ network to understand the needs of staff

Descriptor	Potential Impact on Individual(s)	The Potential for complaint/ Litigation	Potential Impact on Organisation
Negligible 1	• No impact or adverse outcome	• Unlikely to cause complaint/ litigation	• No risk at all to organisation
Low 2	• Short term impact	• Complaint possible • Litigation unlikely	• Minimal risk to organisation
Medium 3	• Semi-permanent impact	• Litigation possible but not certain. • High potential for complaint.	• Needs careful PR • Reportable to SHA • External investigation (e.g. HSE)
High 4	• Permanent impact	• Litigation certain expected to be settled for < £1M	• Service closure • Threat to Divisional/Directorate objectives/priorities • Local publicity
Very High 5	• Permanent and severe impact	• Litigation certain expected to be settled for > £1M	• National adverse publicity • Threat to Trust objectives/priorities

Appendix A: Draft Engagement and Involvement Plan

Emerging proposal to develop a north west London elective orthopaedic centre

1. Background

The north west London integrated care system through a collaboration of its four acute provider trusts is building on the concept of fast-track surgical hubs to develop a more strategic, larger-scale approach to improving our provision of 'high volume, low complexity' surgery across the sector, beginning with orthopaedic surgery. The driver is to improve quality as well as to significantly expand access and shorten waiting times over the next few years. We have been exploring how we might best establish an elective orthopaedic centre for north west London alongside maximising our planned surgery capacity overall.

A high level core narrative to support exploration of an elective orthopaedic centre has been developed and presented to key stakeholders at the NWL Joint Health Overview and Scrutiny Committee. This narrative sets out the case for change and work required to develop a fuller proposal, including putting in place effective project management, governance and a programme of engagement and involvement. Read the high level narrative as part of the acute care programme briefing: Exploring a north west London elective orthopaedic centre

This engagement and involvement planning document aims to set out the core activities and deliverables required for all key phases including pre-consultation engagement, as well as formal public consultation, with key stakeholders.

2. Objectives

- To ensure the proposals for the NW London elective orthopaedic centre reflect and respond to the needs and views of all users (patients, carers, staff, NHS partners, local authorities and wider stakeholders) by enabling opportunities to influence and co-design key elements including the clinical pathway and workforce model and with a particular focus on addressing health inequalities
- To build widespread support for the change and investment required
- To ensure all statutory requirements for service change engagement/consultation are met

3. Engagement and involvement timeline

Timeline	Activity	Objectives/other comments	Responsible
March 2022	Draft service change/develop options report for acute care programme board with approval to move to pre-consultation/informal engagement	*Covered through engagement involved in development of the OBC*	Project team – *completed*
March 2022	Initial approach to key stakeholders at Joint Health Overview and Scrutiny Committee (JHOSC) on emerging proposals for NWLEOC Informal discussions with other stakeholders through one-to-one meetings and sharing paper on emerging proposals – HFSON, Healthwatch, MPs and councillors	• Gain support to continue developing detailed proposals • Commitment to developing an engagement/involvement programme and to return to JHOSC with fuller proposals	Acute care comms group – *completed*
March 2022	Early communications with all staff to introduce the emerging proposal and intention to engage further	• Publication of acute care briefing • Item in staff briefings *(completed at ICHT)* • Video for staff briefing (CCG/ICS)	
March 2022	Alert NHS England London to our approach and future need for consultation Explore advice of specialist consultation experts on same (possibly Consultation Institute)	To check and get support for approach	
March 2022	Align/coordinate engagement approach with other MSK/T&O developments in NWL – develop a high level narrative?		
March 2022	Agree involvement approach and establish support, including administrative support to deliver engagement activities	Scheduling and invitations for virtual meetings, agenda, note-taking	
March 2022	Gather and collate existing user data/insights, with special focus on health inequalities impact	Findings to inform detailed involvement plan and approach	
March 2022	Share/check high level engagement approach with strategic lay forum and equivalent	Validate the plan	
March 2022	Set up a steering/reference group to focus on engagement, define ToRs and include: • operational leads • clinical leads • workforce leads • representation from all providers (general	• Use the group to check/challenge ongoing engagement plans • Requires dynamic leadership to chair and enable inclusion of a variety of voices • Project team to support with identifying invitees	

	managers/service managers) • Healthwatch/patient representatives • lay partners.		
April to mid-May 2022	***Electoral period (purdah) – restrictions on engagement with stakeholders***	***Period to be used for involvement, to inform more formal proposal for next JHOSC***	
April 2022	Hold first steering group meeting and agree terms of reference, frequency and work streams • Recommended four meetings - kick off to input to draft involvement plan – including sharing initial user insights work - second to discuss findings and inform plans for formal consultation - third ahead of formal consultation to validate plans - fourth to review consultation outcome report, to guide implementation plans		
April 2022	Set-up small communications working group with leads from each trust/ICS and include a lead for user insights	Lead on ensuring communications actions/activities for respective trusts and CCQ/ICS are carried out	
April 2022	Design involvement plan based on areas of interest and concern emerging from existing user insights e.g. series of themed workshops/focus groups/interviews Develop a set of broad, open-ended questions for testing, based on collated user insights sets of broad and open-ended questions to accompany the collateral -	Other channels available: • A north west London-wide 'collaborative space' virtual event – open forum for discussion around proposals for the entire MSK pathways	

	tailored sets for public/patients and for staff groups		
April 2022	Commission external communications agency to produce collateral for engagement with patient/public groups and staff, which includes: • an explainer of what we are trying to achieve • what possible change models can look like • supplementary content to use as promotion for websites/intranet/social media (should include proposal for what suggested workforce model might be).	• Aligned with narrative around MSK pathways • NCL have produced a video that can be used as a guide	
April 2022	Commission qualitative researchers to carry out the involvement activities		
April 2022	Identify and create lists of patients/public groups for pre-consultation engagement. Target these groups via all four trusts and CCG/ICS channels to promote involvement activities (all four trusts and CCG/ICS channels)	• Understand the need and benefits • Raise concerns • Opportunity to feed into design principles for ideal elective orthopaedic centre	
April 2022	Identify and create lists of multi-disciplinary staff for engagement including: • staff likely to be directly affected • staff indirectly affected • staff representatives and trade unions	• Opportunity for staff to understand how proposals will affect them and raise concerns • Enable co-design of the work force model Dependency – baselining of staff affected from each Trust	

	Targeted communications to promote involvement activities		
April 2022	Agree, establish and brief clinical leads for engagement with all stakeholders	• Assert clinical gravitas behind emerging proposal	
Involvement period			
April-May 2022	Carry out involvement activities with public and patients Carry out involvement activities with staff groups	Opportunity for groups to raise issues/concerns and contribute ideas towards the design of MSK pathways	
June 2022	Forward planning for imminent public consultation including all documents (full, summary and easy-read documents) and start preparing materials for consultation activities.	Build on collateral already developed during the involvement phase	
June 2022	Organise NHSE assurance activities including required evidence and documents	Visits and reports by clinical senate and programme assurance teams	
End June – early July 2022	Findings of involvement activities to inform worked up proposals/outline business case for the NWLEOC to be presented back to JHOSC and other elected stakeholders (via existing Trust contact programmes). Potential deliverables include updated narrative, report from involvement activities and briefs documents	• Next JHOSC meeting to be held in July (dates TBC) • Official decision on level of public consultation required – expected to be the full 12-week period for a service change of this size	
End June – early July 2022	Report to acute care programme and ICS board with recommendations for moving to consultation		
End June – early July 2022	Final approval to launch full public consultation from ICS		
End June – early July 2022	Final sign off for consultation documentation		

Formal public consultation			
Mid-July	**Launch public consultation with possible deliverables:** • Consultees database • Content for website section/interactive response form • Content for Intranet section/internal channels • PowerPoint presentations: internal/external • Newsletter articles • Email address/Freepost address • Consultation documentation • Distribution of consultation materials • Launch introductory letter/email • Newspaper advertisements • Internal staff meeting events • Attend OSC meeting • Programme of consultee/stakeholder meetings • Patient/user group meeting/s • Public meeting/s • News releases • Social media channels		
Mid July 2022	12-week public consultation period	NB – possibility we may be asked to carry out a 14 week consultation as this falls during the summer months	
Mid July 2022	Undertake formal staff consultation process aligned with change management policy and processes across the four trusts	Notify trade unions of upcoming staff consultation ahead of undertaking	
Mid Sept 2022	Consultation period closes		
Post-consultation period			
Mid – Sept –	Analysis of consultation responses to inform a	To be presented to steering group to formulate response	

Appendix 5

Equality Analysis – Due regard process

LNWH as a public body has a duty to have Due Regard to the need to:

1. Eliminate discrimination, harassment and victimisation and any other conduct prohibited by the Equality Act 2010
2. Advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not.
   This involves considering the need to:
   - Remove or minimise disadvantages suffered by people due to their protected characteristics
   - Take steps to meet the needs of people with protected characteristics that are different from the needs of people who do not share them
   - Encourage people with protected characteristics to participate in public life or in other activities where their participation is law
3. Foster good relations between people from different groups. This involves tackling prejudice and promoting understanding between people from different groups.

It is necessary to actively seek opportunities to fulfil the above duties.

Protected Characteristics

- Age
- Disability (& carers)
- Gender Re-assignment
- Marriage & Civil Partnership
- Pregnancy & Maternity
- Race
- Religion & Belief
- Sex
- Sexual Orientation

Questions to consider

- Does Due Regard apply and why/why not?
- Which Protected Characteristics / Human Rights could potentially be impacted negatively?
- What is the potential impact?
- What data and information sources would you use to inform your work to help apply Due Regard?
- Who do you need to talk to / involve?
- What are the relevant factors?
- Have all views been considered?
- What mitigations could be considered? Are they practical/ doable?
- If the mitigations are not practical / doable, what is the justification?

Human Rights; 5 principles

- **F**airness
- **R**espect
- **E**quality
- **D**ignity
- **A**utonomy

Think NHS Constitution;

- Duty to protect and promote Human Rights for every individual

If challenged:

Are you confident that the decisions made and the outcomes of this project are:

- ✓ Non discriminatory
- ✓ Promote equality of opportunity
- ✓ Foster good relations between people with any of the protected characteristics

- Can you produce evidence that Due Regard has been conscientiously and proportionately undertaken and all the necessary views have been considered before any decisions were agreed?
- Can you, if after starting a course of action and a problem relating to a protected characteristic materialises, evidence that Due Regard was then undertaken and used to determine whether to continue or not and therefore influencing the decision?
- Can you evidence that the substance and reasoning of any decisions are not based upon personal bias and values and can be fully supported with documented evidence?

and outline implementation plan				Eight months for construction of centre (building new theatres as per emerging proposals)		
consultation outcome report and final business case	Consultation outcome report to go through governance channels with recommendations, for response and decision-making business case • Acute care programme board • ICS board • All trust boards?	Inform consultees of response and decision	Produce consultation outcome/response publication	Implementation of decision for service change/development – construction of elective orthopaedic centre	Develop detailed communications plan to support implementation of the centre, including potential staff recruitment campaign	Commission and open centre to receive sector wide patients and teams
mid Oct 2022	Mid – Sept – mid Oct 2022	October 2022	October 2022	October – Nov 2022	TBC	TBC

Appendix 2 – Integrated Impact Assessment

North west London EOC Integrated Impact Assessment

September 2022

Executive Summary

By creating an Elective Orthopaedic Centre (EOC), north west London aims to provide top decile orthopaedic care for its population

Background

- Through collaboration of its four acute provider trusts, north west London Integrated Care System (ICS) wants to develop a strategy to reduce health inequalities for its population and support the recovery of elective surgery following the covid-19 pandemic
- North west London aims to do this through the creation of fast-track surgical hubs, which manage "high volume, low complexity" surgical procedures, in line with best practice standards of care recommended by GIRFT, NICE and the NHS Long Term Recovery Plan
- This approach will be applied to elective orthopaedic services in the first instance
- Elective orthopaedic surgery is currently provided across 8 different sites, with varying waiting times, access and outcomes

Care Model

- The clinical model is based on best practice principles and intends to provide:
  - A single point of referral for inpatient ASA category 1 & 2 elective orthopaedic activity
  - A six day a week service of high quality care designed on best practice (GIRFT and NICE) principles, in a dedicated surgical centre
  - Delivery of orthopaedic care in a purpose-designed, ring-fenced environment separated from the pressures of emergency care
  - Strengthened and consolidated interfaces with musculoskeletal (MSK) pathways pre and post operatively for patients
  - Dedicated specialist pre and post operative care on site supported with digital systems and networked teams

Expected benefits

- Reduction of inequalities for the population of north west London through faster and equitable access
- Achievement of top decile outcomes and productivity
- Reduced risk of procedure cancellation for patients
- Creation of a centre of excellence for surgical skills training, with new role development and flexible models of working
- Continued improvement and innovations in modern surgical practice through the removal of variation and sharing of information/skills

This IIA fulfills north west London ICS's legal requirement to assess the impact the proposed service change may have on the population and identifies potential mitigations

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 the impact potential options have on equalities

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)

Source: 1) Section 149 of the Equality Act 2010, 2) Section 2 of the NHS Act 2006

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

Option 1

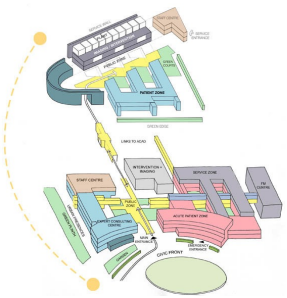
Central Middlesex Hospital (CMH) as a single EOC site

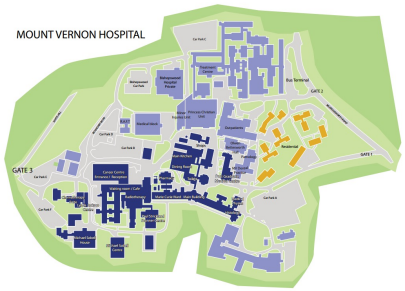
Option 2

Mount Vernon Hospital (MVH) as a single EOC site

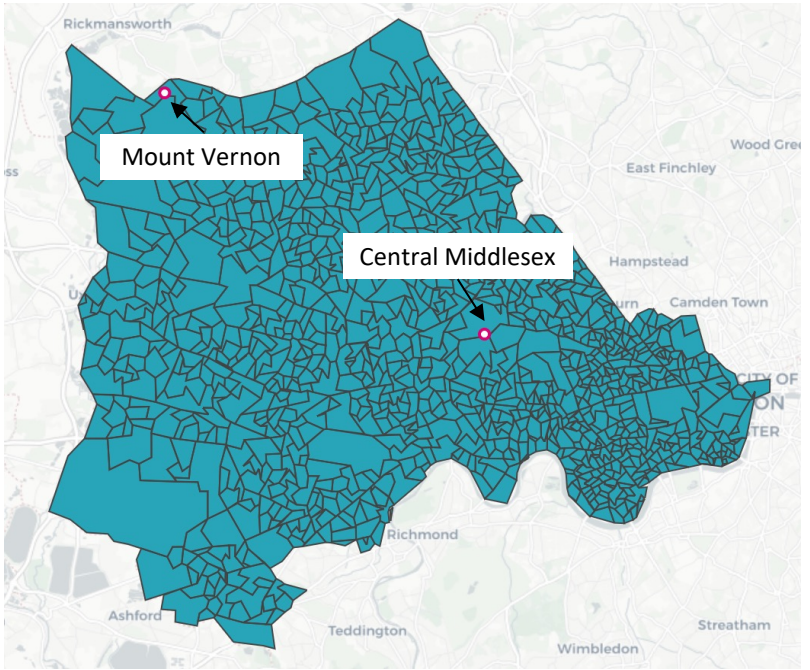
Option 3

CMH and MVH operating as dual sites





Map of north west London EOC options



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

Scope of the north west London Integrated Impact Assessment

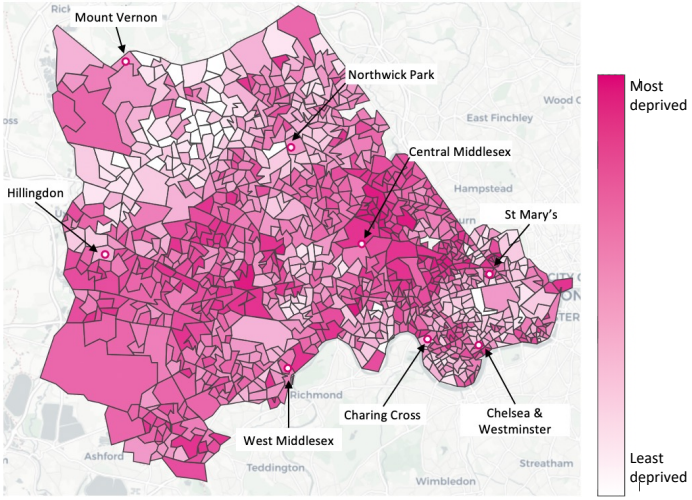
- The IIA considers three options
  1. Central Middlesex Hospital (CMH) as a single EOC site
  2. Mount Vernon Hospital (MVH) as a single EOC site
  3. CMH and MVH operating as dual sites
- It will not look at the impact on London Ambulance Services or consider the emergency travel times:
  - The services are all planned elective and confined to those in ASA category 1 and 2 (no or only mild systemic disease)
  - 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 in ASA category 1 & 2 have been excluded as the number of patients is less than 20% of total potential activity
- 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

The key findings of the IIA are that the creation of an EOC is likely to have a positive impact for the more deprived and non-white populations

- There are **8 hospital sites that provide elective orthopaedic services** to the residents of north west London
- The population is relatively **evenly distributed**, with the main population centres around the Hillingdon, St Mary's, and Central Middlesex hospital sites
- Areas with higher deprivation levels are concentrated across the **middle and south west region of north west London**, with pockets in the north west and north east. Central Middlesex hospital is based in an area with the **bottom 10-20% most deprived communities**. Compared to its counterparts, Mount Vernon hospital is **surrounded by areas with the least deprivation**
- Amongst the hospital sites that currently provide elective orthopaedic services, **Northwick Park and Central Middlesex are surrounded by areas with relatively higher populations of non-white people.** There are higher populations of white people in areas near Mount Vernon, Charing Cross and Chelsea & Westminster hospital sites
- **Any of the proposed options for a centre of excellence in north west London will increase overall travel times** compared to the current 8 hospital sites. Mitigations need to address this, and whether the benefits of swifter access, higher quality and productivity justify developing a centre of excellence. Of the single site options analysed, **Central Middlesex has the lowest impact and relative proportionate benefits to the deprived and non-white populations**
- **Carbon emissions increase** for all options with Mount Vernon being nearly x4 current and x3 Central Middlesex
- 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 for this **to continue under any proposed option**

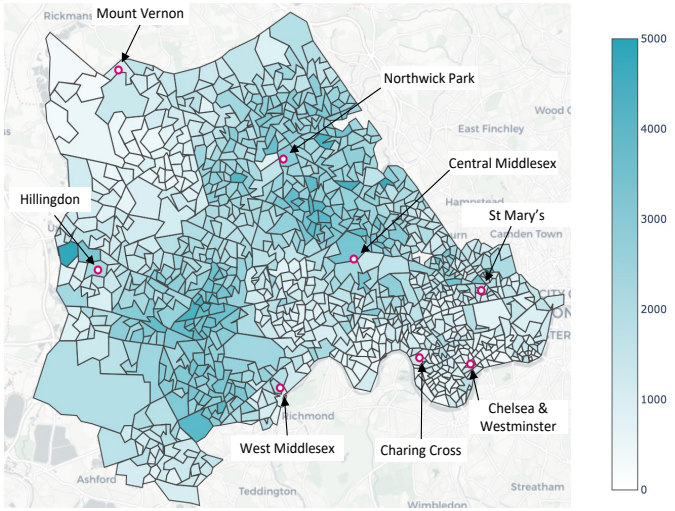
LSOA population deprivation level heatmap

All ages



LSOA BAME population heatmap

All non-white populations



Source: 2011 census, ONS geospatial data, CF analysis

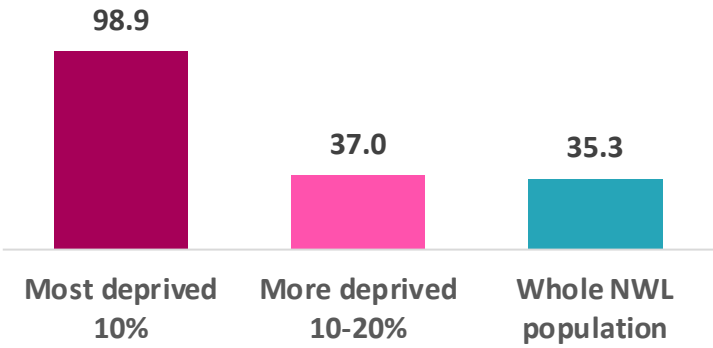
Quantitative analysis showed the health benefits will be for the elderly, and more deprived communities, and may help with access for the non-white community

- Studies have shown deprivation to be associated with increased mortality after emergency admission with a hip fracture**.** The most deprived 10% **have nearly three times the elective trauma and orthopaedic (T&O) spells per head** compared to that of the whole north west London population

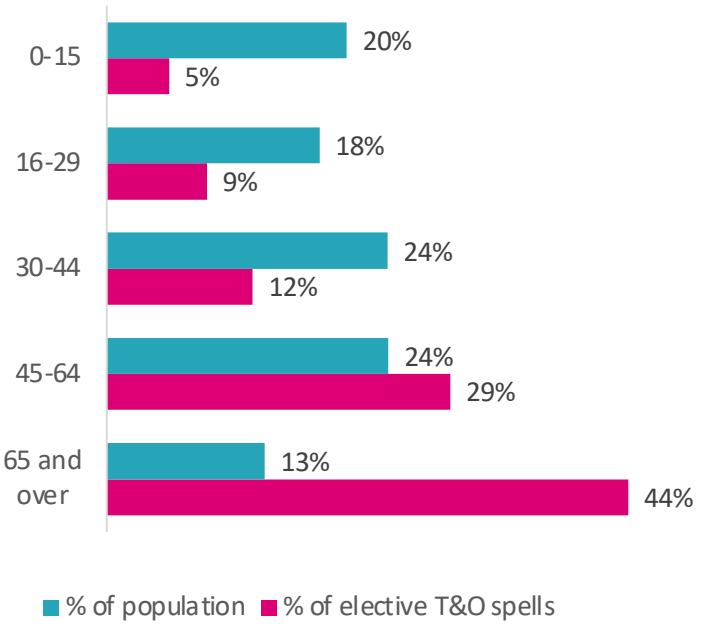
- Studies have shown that quality of life and mortality rates are higher for those over 80 years old as well as have a higher prevalence of orthopaedic procedures. Patients aged 65+ make up 44% of the elective T&O procedures, **nearly three times higher per head compared to the 45-64 age group**, and nearly seven times higher than the 16-44 age group

- Non-white groups are generally disproportionately represented in musculoskeletal conditions due to a higher prevalence of the risk factors and have difficulties accessing healthcare services. However North west London activity data shows that the **non-white population have 14% fewer elective spells per head than white people**, which suggests issues with accessing elective orthopaedic services.

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



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



Source: 2011 census, ONS geospatial data, CF analysis

Demographic analysis

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

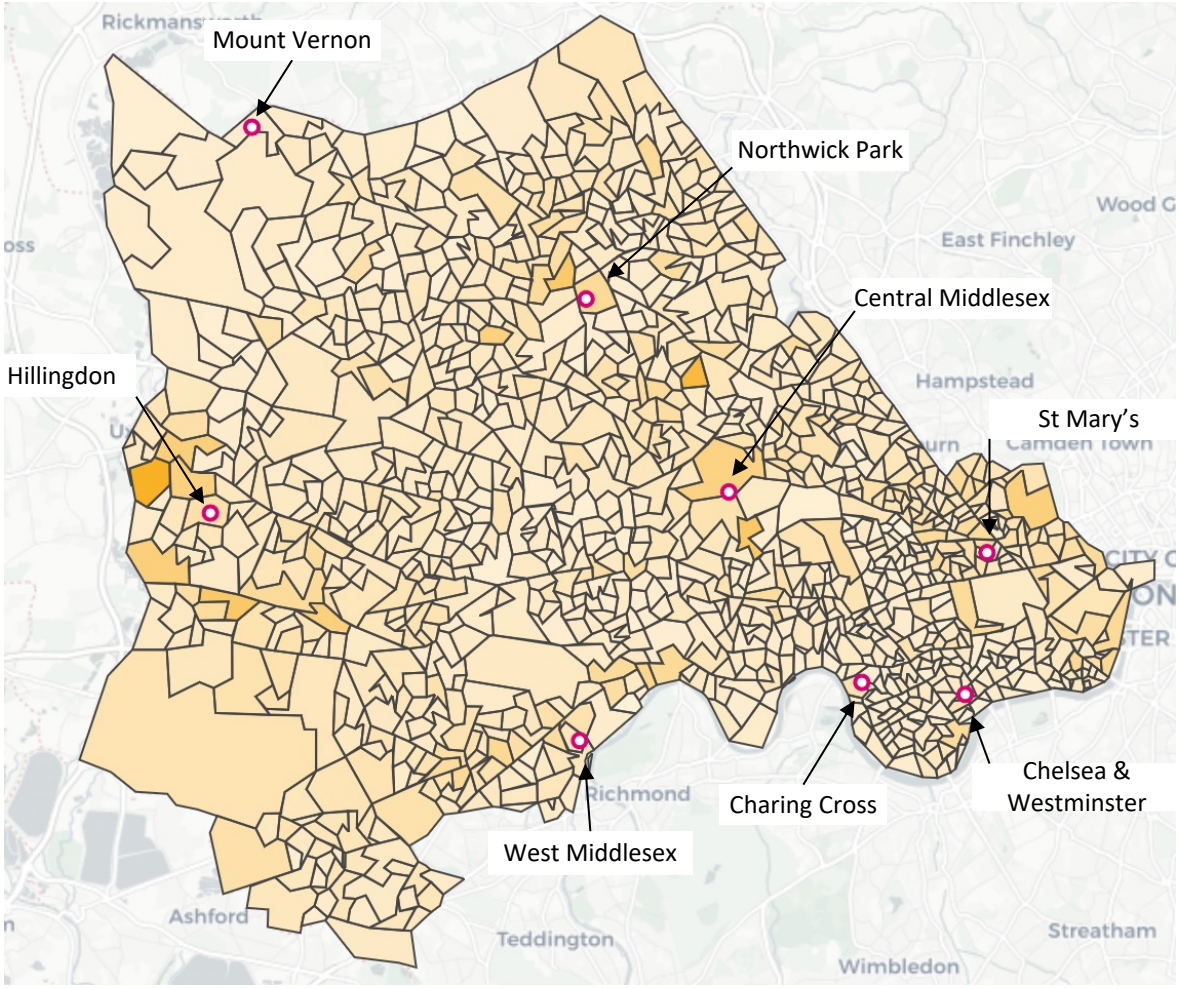
The demographic analysis is useful to show where populations are clustered into geographical areas and are therefore more likely to be impacted by changes in the location of services. Populations will also be impacted by changes in the quality of services but this impact is not dependent on the physical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

LSOA population heatmap

All ages



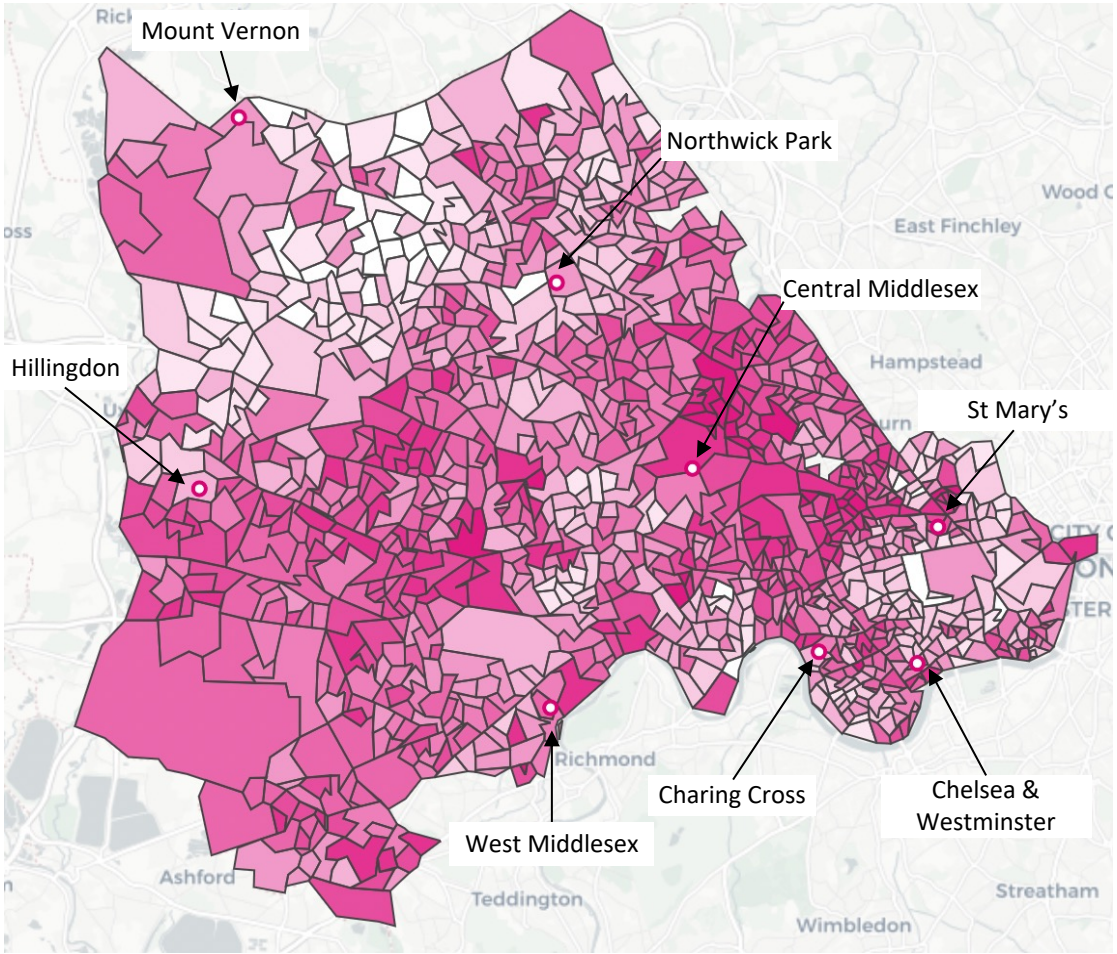
- North west London has a population of 2,110,469 people
- North west London's population is reasonably evenly distributed across the LSOAs
- The main population centres are around the Hillingdon, St Mary's, and Central Middlesex hospital sites
- Areas surrounding the Hillingdon hospital site have approximately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

Source: ONS population estimates Mid-2020, CF analysis

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



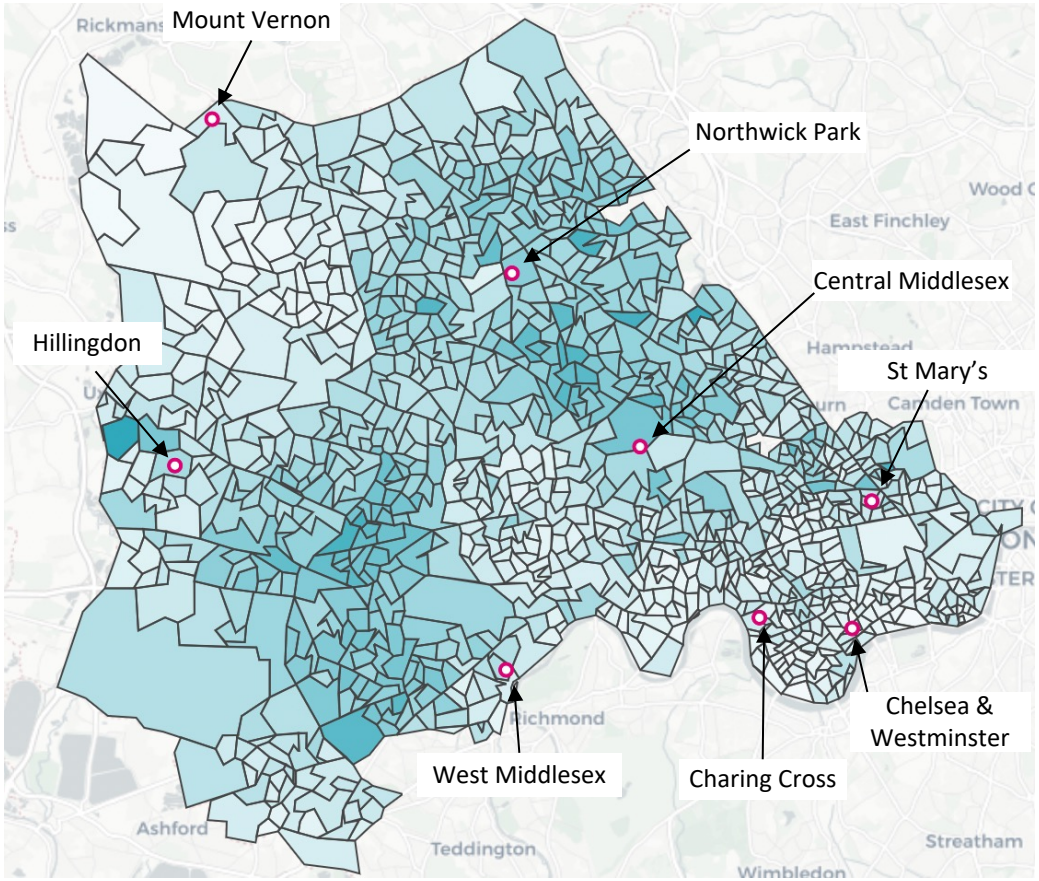
- Areas with higher deprivation levels are concentrated around the middle and south west regions, with pockets in the north west and north east
- north west London hospitals offering elective orthopaedic services, with the exception of Mount Vernon hospital site, are located in areas with higher deprivation 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

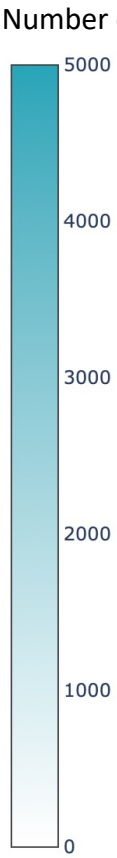
Source: Ministry of Housing, Communities and Local Government, CF analysis

North west London is overall ethnically diverse, with pockets of higher non-white populations around Northwick Park, Central Middlesex, Hillingdon hospital sites

LSOA non-white population heatmap

All ages





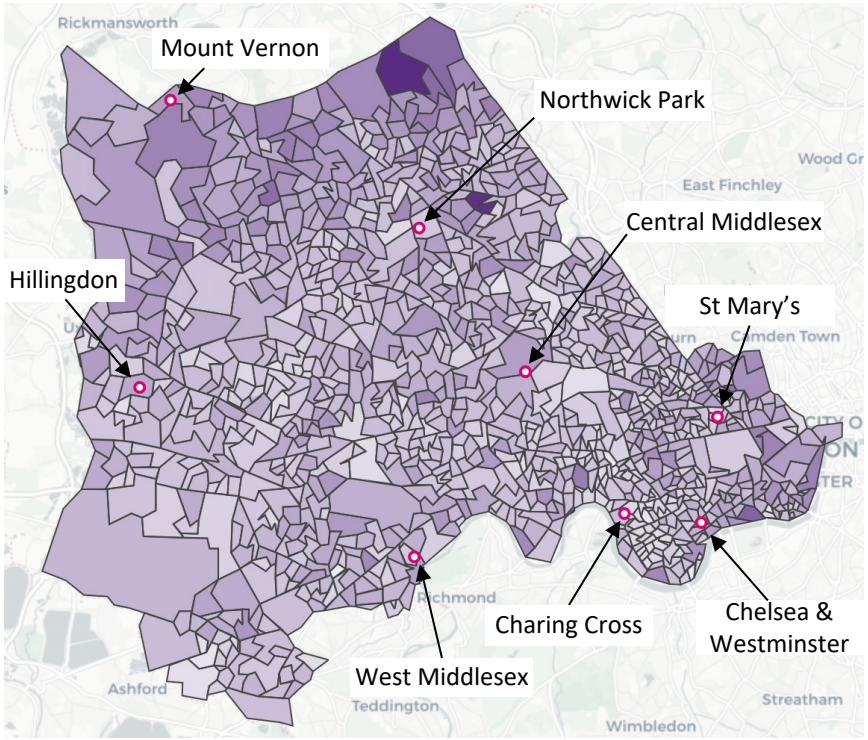
- Areas across central north west London are ethnically diverse, with higher volumes of non-white populations
- Amongst the hospital sites that offer elective orthopaedic services, Northwick Park and Central Middlesex are surrounded by areas with relatively higher populations of non-white people
- Although Hillingdon hospital site is close to an area with the highest volume of non-white 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

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+

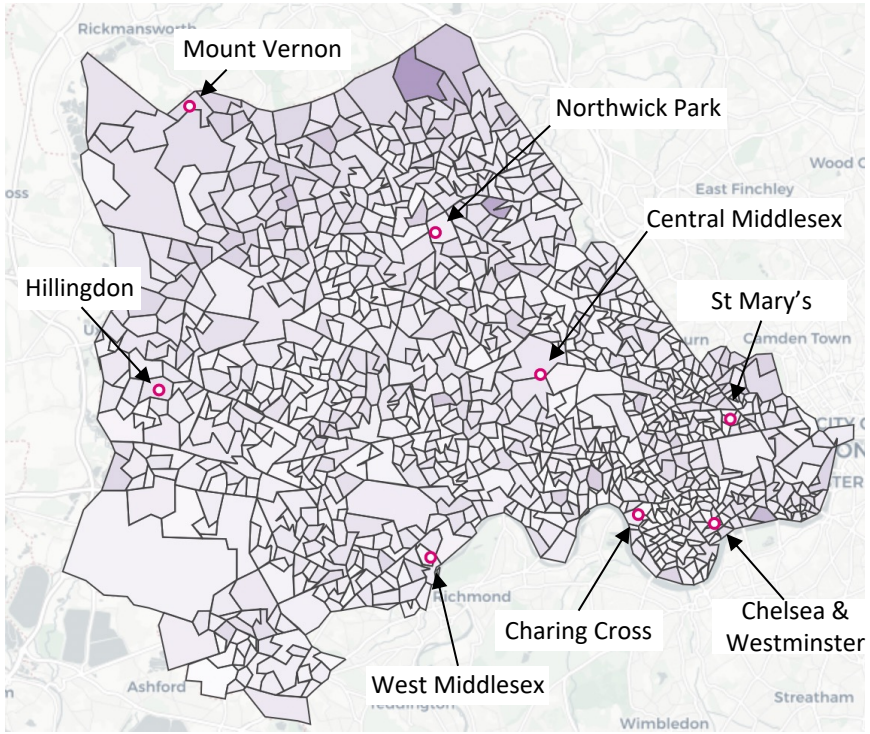
LSOA population of the elderly 65 and over heatmap,

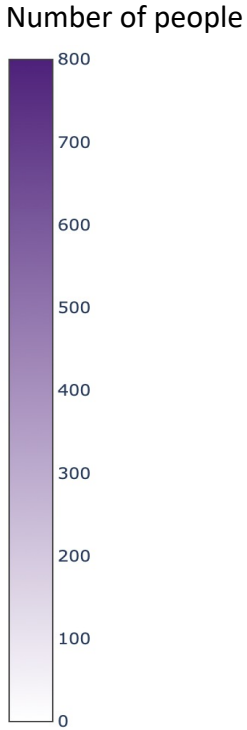
Female and Male, Age 65+



LSOA population of the elderly 80 and over heatmap,

Female and Male, Age 80+





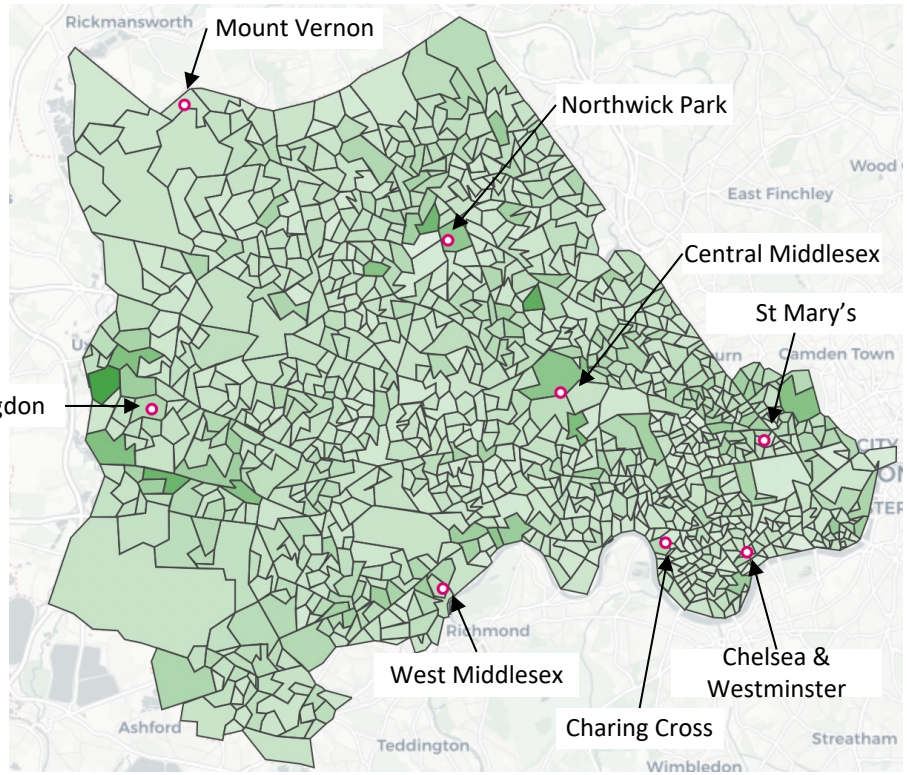
- The heatmap shows a fairly equal distribution of the elderly population across north west London, both for groups aged 65+ and 80+, but there are some areas with higher numbers across the Northern-most and south east regions
- Northwick Park is the hospital site closest to the LSOAs with the highest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

Source: ONS population estimates Mid-2020, CF analysis

There is an even distribution of gender across north west London

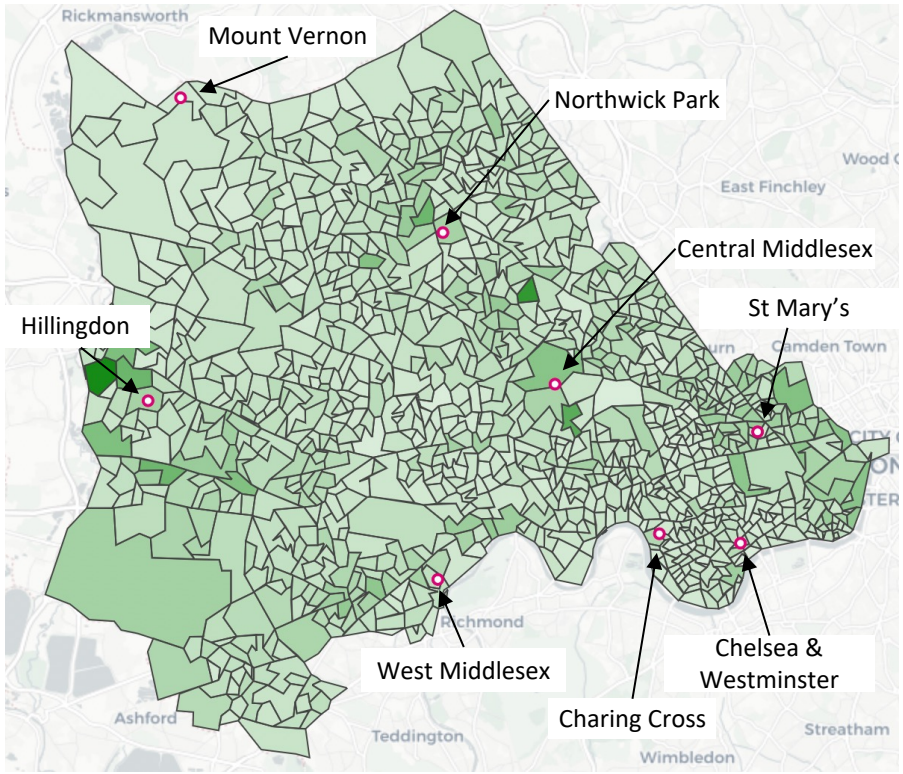
LSOA population heatmap

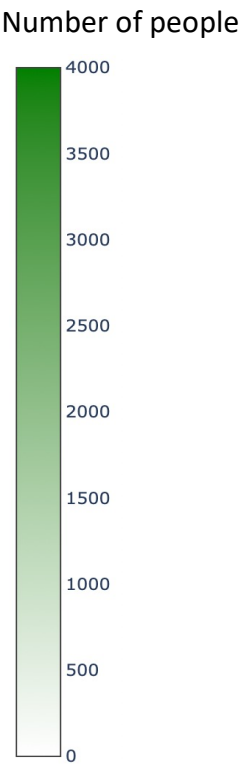
All ages, female



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

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 to 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 CORE20PLUS5 groups.

Protected Characteristic Groups:

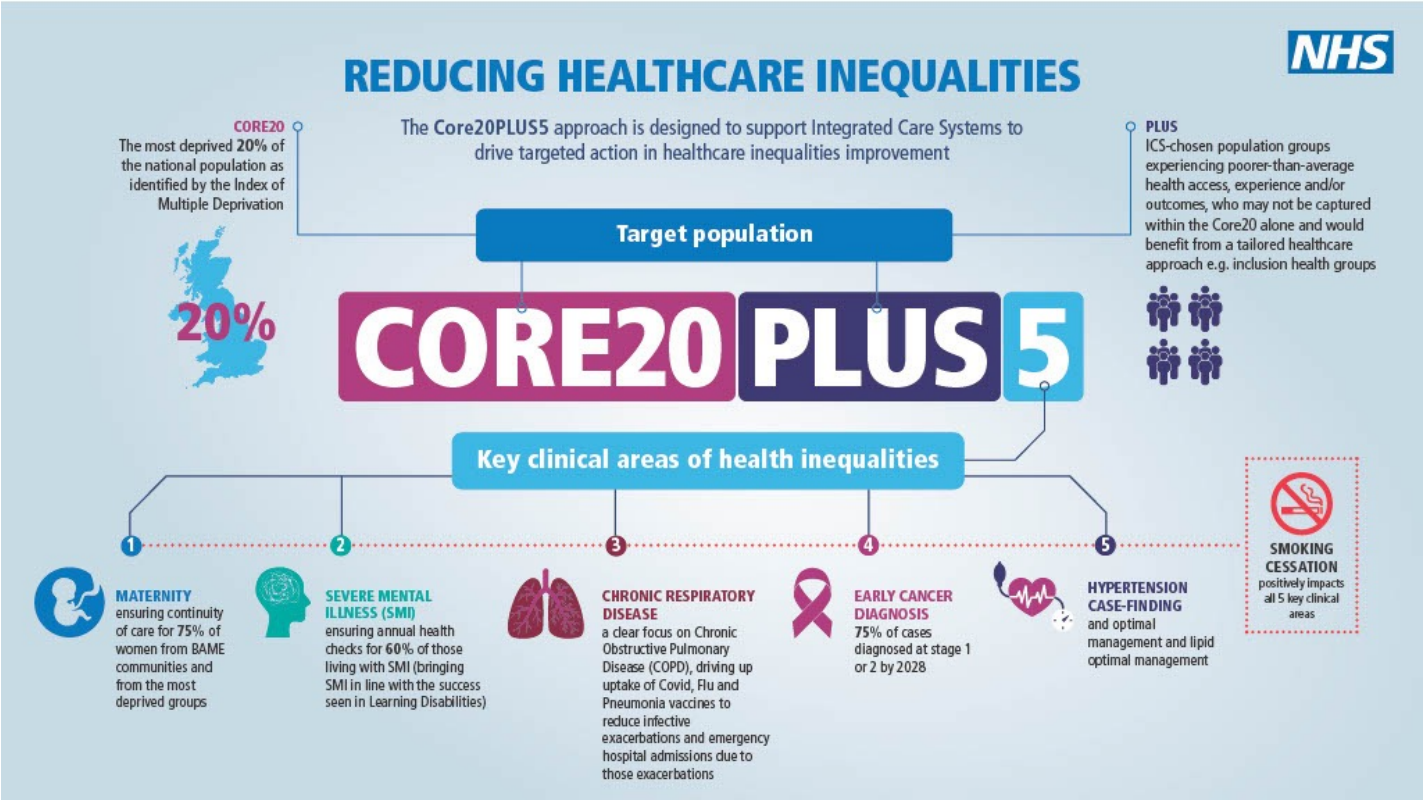
- Deprived communities
- Race (including colour, nationality, ethnic or national origin)
- Age
- Sex (Male/Female)
- People with disabilities
- Gender reassignment
- Religion or belief
- Sexual orientation
- Being married or in a civil partnership
- Being pregnant or on maternity leave

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 20% most deprived, 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.

There is a strong evidence base showing that deprivation can lead to worse healthcare 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. 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/

Deprivation is considered using a range of indices, two of which have been considered as part of this IIA

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**.

Carstairs indices of deprivation

Carstairs scores were originally created for Scottish postcode sectors in 1981 as a measure of material deprivation, with the most recent update from the 2011 census.

The scores are constructed from four census variables: car ownership, male unemployment, overcrowding and low social class.

Since 1981, scores have been updated every ten years. Although there have been changes in some of the census variable definitions over time, the variables used in subsequent years have been kept as similar as possible to those first used.

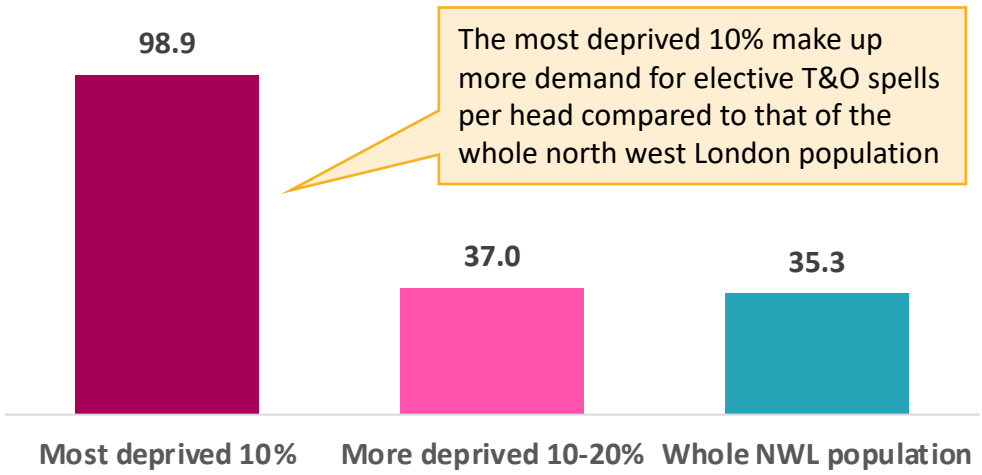
Carstairs indices of deprivation are measured in **quintiles**.

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/

Service change will likely have a more significant impact on the most deprived population (as per IoD2019) as it makes up most of the total demand for T&O

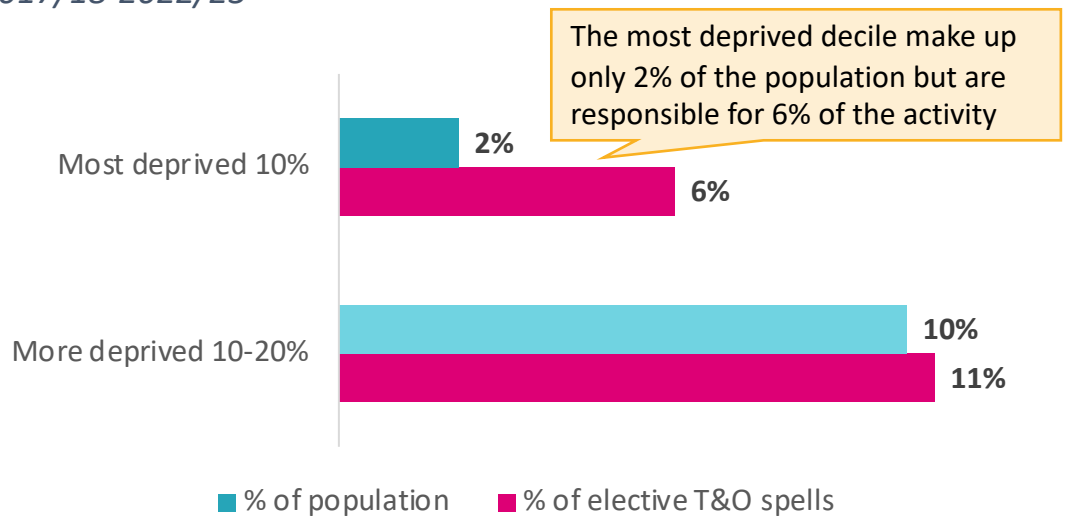
Elective T&O spells per 1,000 population by English indices of deprivation

2017/18-2022/23



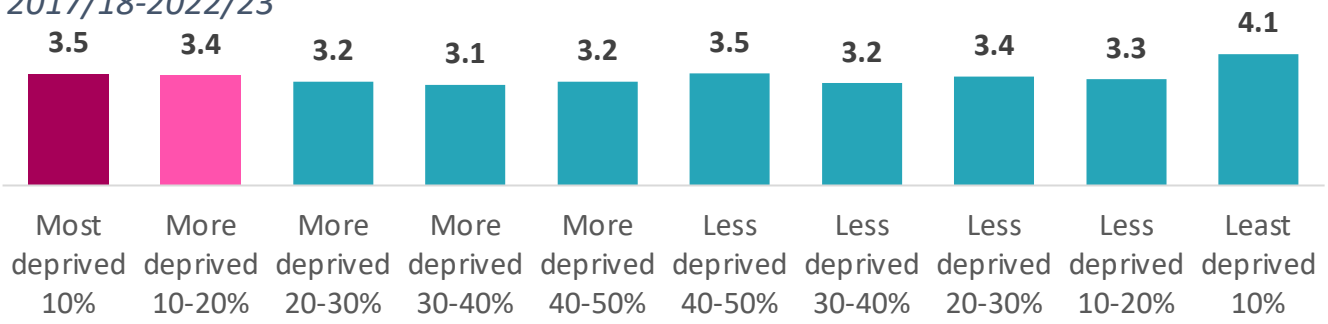
Population of bottom two most deprived areas in NWL compared to their activity, by English indices of deprivation

2017/18-2022/23



Elective T&O patient average length of stay, by English indices of deprivation

2017/18-2022/23



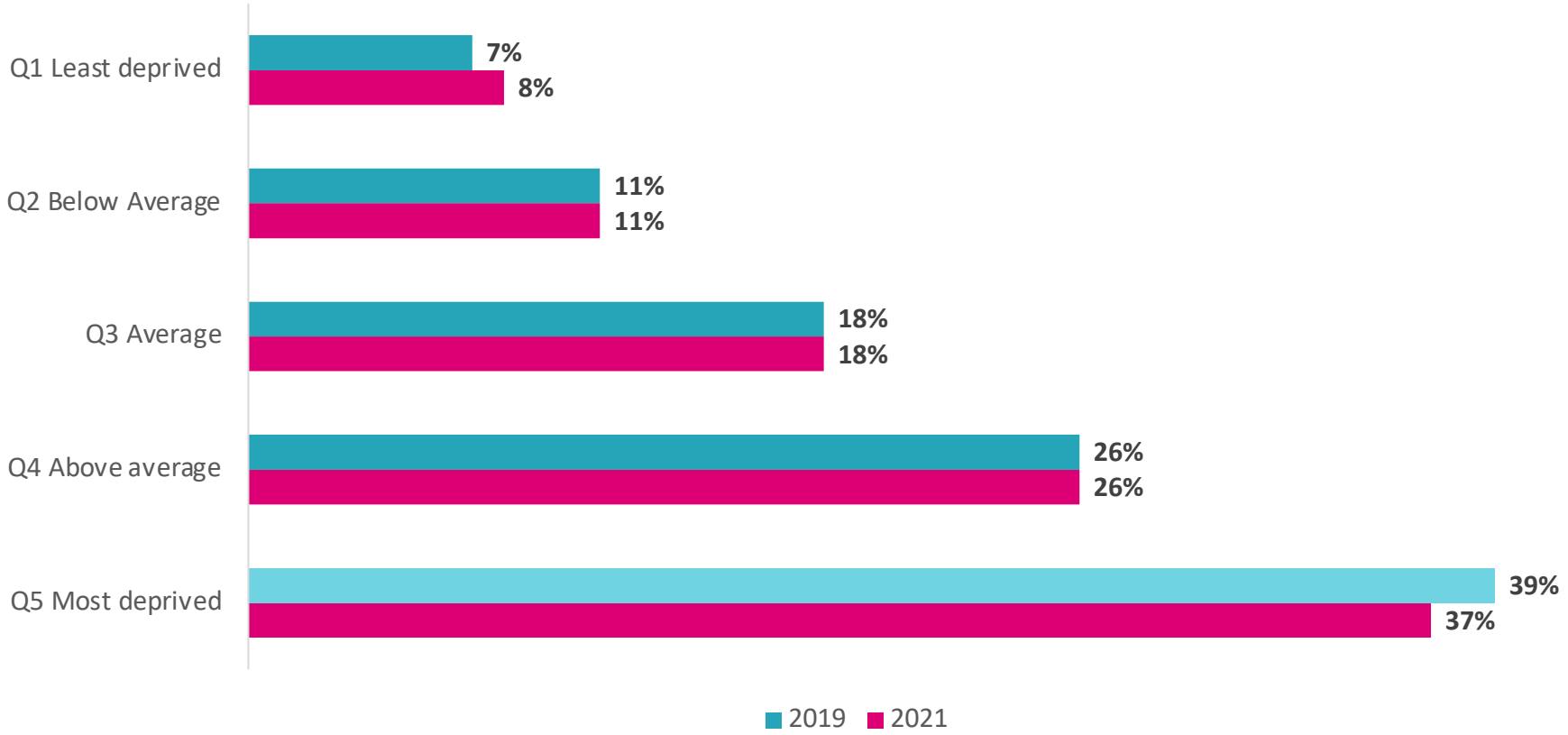
There is relatively little variation in the average LOS across the different deprivation levels, where the least deprived 10% of the population appears to have the longest average LOS

Source: Hospital Episode Statistics Admitted Patient Care, ONS population projections, English indices of deprivation, CF analysis

Using the Carstairs deprivation index, almost two thirds of elective orthopaedic patients are from the most deprived areas or areas with above average levels of deprivation

% of elective T&O patients by Carstairs deprivation index by calendar year

2019/2021



Source: Analysis from north west London Elective Orthopaedic Centre Outline Business Case (May 2022)

Studies have shown that those from ethnic minority backgrounds face difficulties accessing healthcare, and experience worse outcomes

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, which impacts the ability to understand written health related materials, and this is more pronounced in women. 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 are 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. 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.

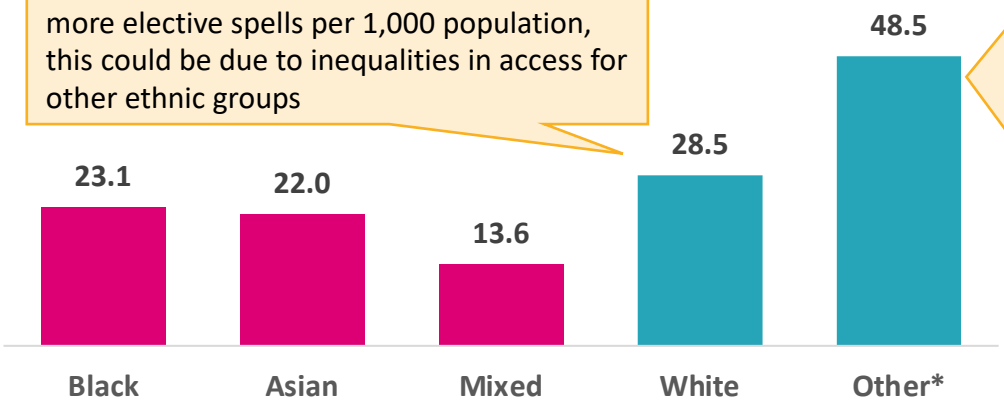
Source: Musculoskeletal conditions and Black, Asian and minority ethnic people: addressing health inequalities (2020) https://raceequalityfoundation.org.uk/wp-content/uploads/2020/10/MSK-Report-Addressing-Health-Inequalities.pdf
Geographical variation in the provision of elective primary hip and knee replacement: the role of socio-demographic, hospital and distance variables (2009) https://pubmed.ncbi.nlm.nih.gov/19542267/

Higher service usage and longer length of stay demonstrates that White populations will be more impacted by service change compared to non-white communities

Non-white and White elective T&O spells per 1,000 population, by ethnic group

2017/18-2022/23

Although the White population accounts for more elective spells per 1,000 population, this could be due to inequalities in access for other ethnic groups

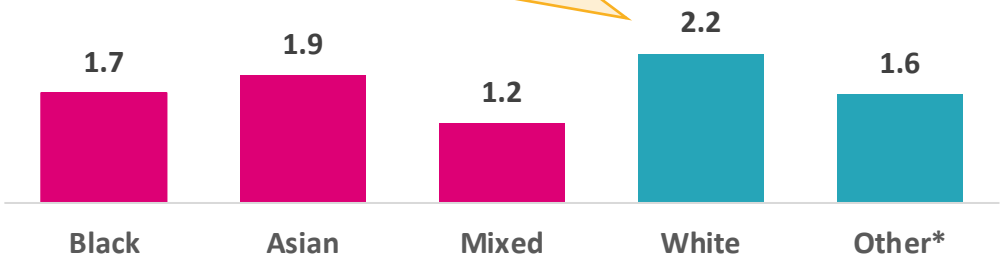


'Other' ethnicities have the highest number of elective spells per 1,000 population, although make up the smallest proportion of the population

Patients and their length of stay (LOS) per 1,000 population, by ethnic group

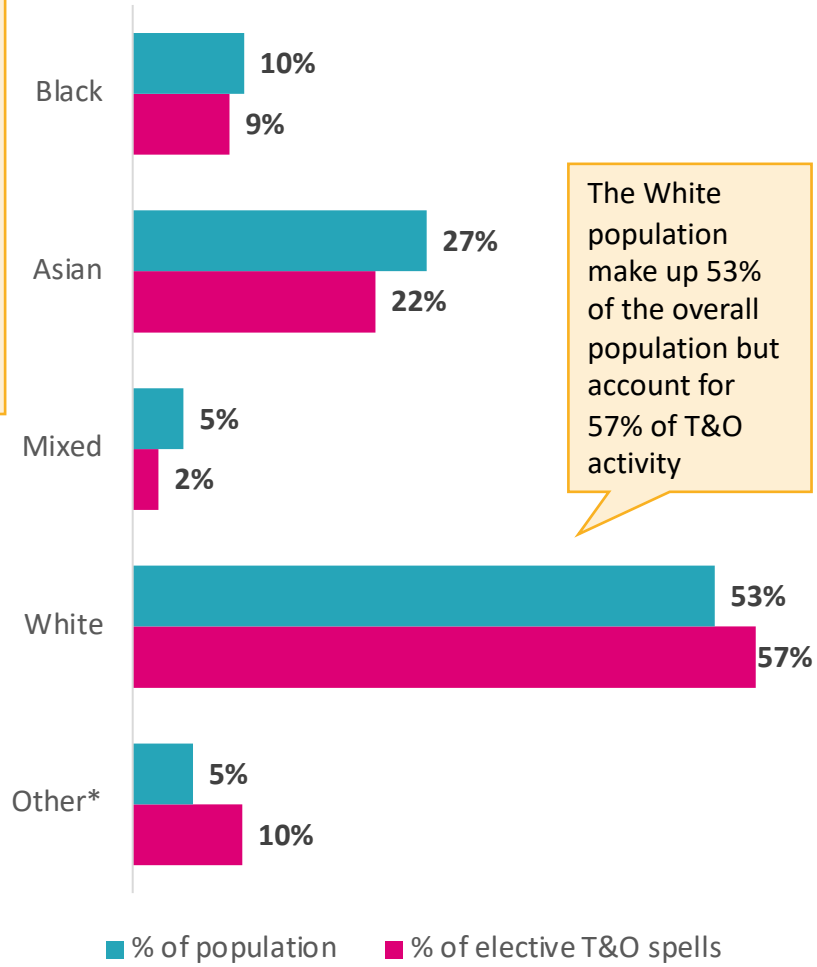
2017/18-2022/23

The White population have a slightly longer average LOS compared to the non-white communities



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

2017/18-2022/23



The White population make up 53% of the overall population but account for 57% of T&O activity

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

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

Studies show that the impact on quality of life and mortality rates are higher for those over 80 years old, and 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.

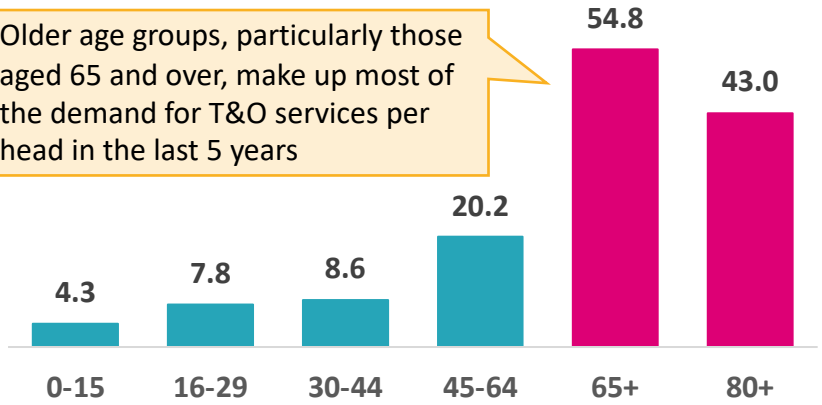
Source: Geographical variation in the provision of elective primary hip and knee replacement: the role of socio-demographic, hospital and distance variables (2009) https://pubmed.ncbi.nlm.nih.gov/19542267/
Recovery of health-related quality of life in a United Kingdom hip fracture population (2015) https://online.boneandjoint.org.uk/doi/full/10.1302/0301-620X.97B3.35738?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
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

The elderly will likely benefit more from service change as they make up most of T&O elective demand and have a longer length of stay compared to younger people

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

2017/18-2022/23

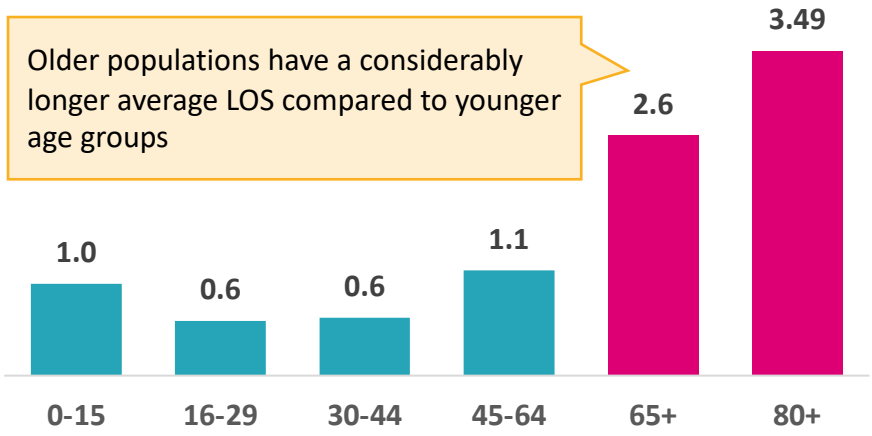
Older age groups, particularly those aged 65 and over, make up most of the demand for T&O services per head in the last 5 years



Patients and their length of stay (LOS) per 1,000 population, by age band

2017/18-2022/23

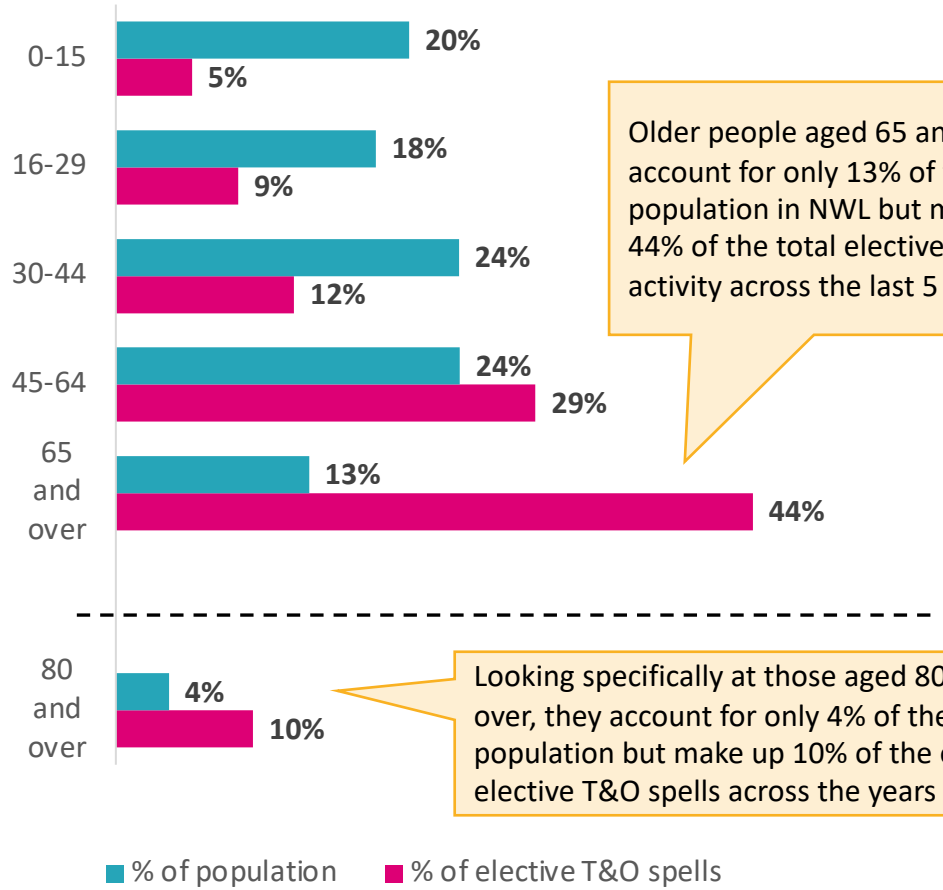
Older populations have a considerably longer average LOS compared to younger age groups



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

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 13% of the overall population in NWL but make up 44% 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 10% of the overall elective T&O spells across the years

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. However they may still benefit from the EOC, as the workforce remaining in trusts may be able to specialise in the more complex procedures

Studies show that men and women approach healthcare services differently, and will 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

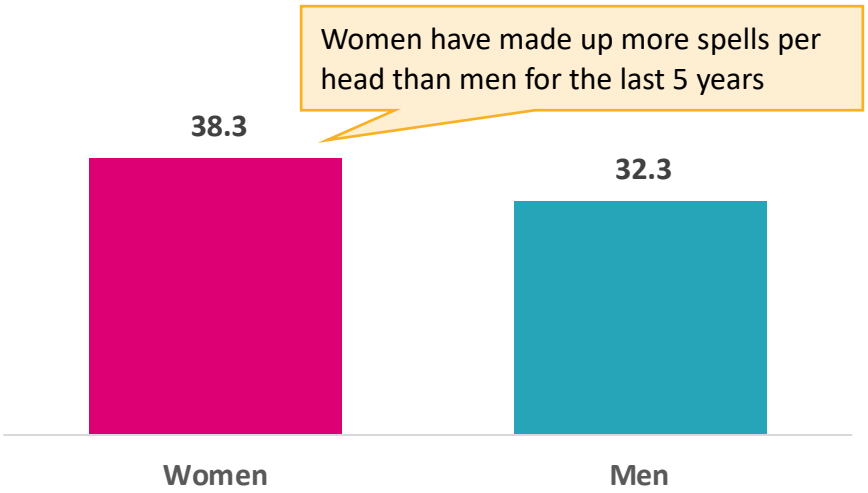
There are differences between men and women with musculoskeletal condition incidence, disease presentation, diagnosis and management. As examples of this, osteoarthritis, osteoporosis and hip fractures are more prevalent in women, whilst osteosarcoma is more prevalent in men, and men experience higher 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.90B4.20264
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

Higher service demand, especially considering population proportions, and a longer length of stay shows service developments will likely have a greater impact on women

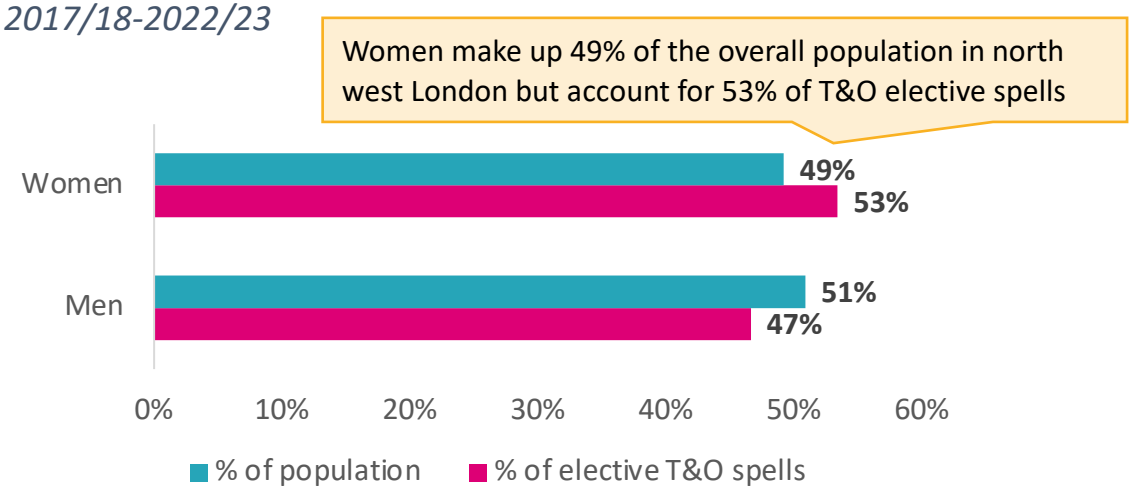
Elective T&O spells per 1,000 population by sex

2017/18-2022/23



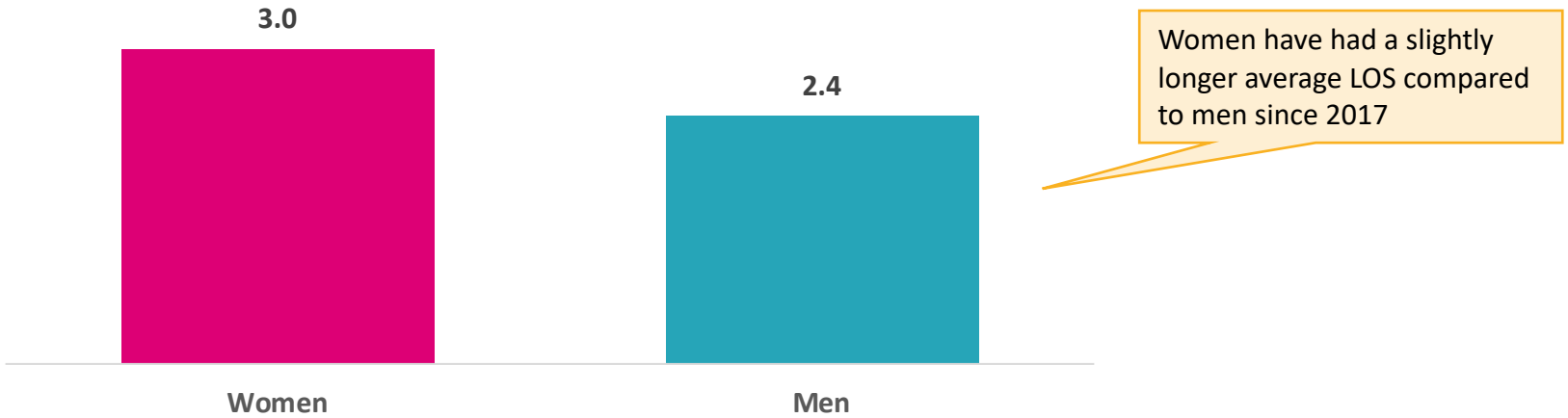
Population of women and men in NWL compared to their activity, by sex

2017/18-2022/23



Patients and their length of stay (LOS) per 1,000 population, by sex

2017/18-2022/23



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

Patient tracking list waiting list

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. This analysis will support the analysis of which populations will likely be more affected by the service change.

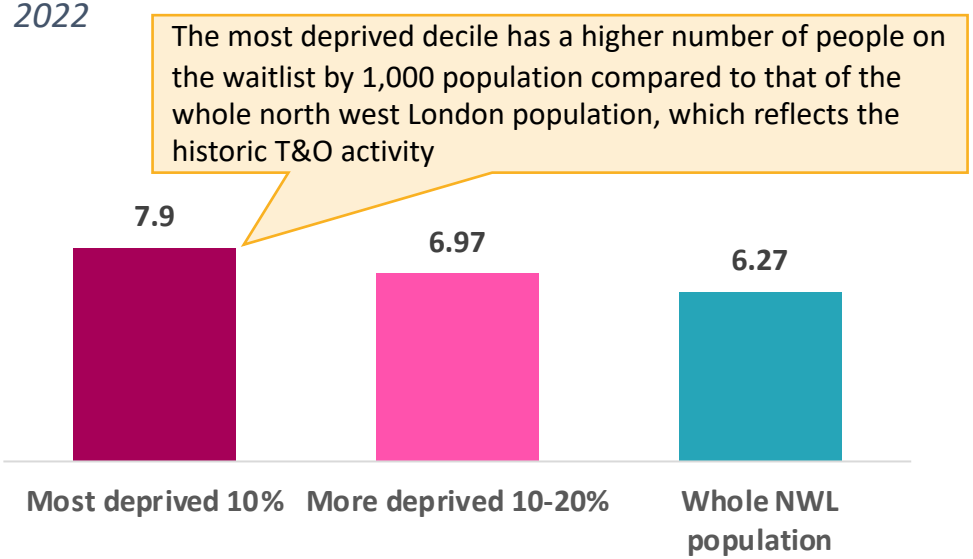
For each of the characteristic groups, the following analysis was made:

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

The bottom two most deprived deciles have a higher number of people on the waitlist per 1,000 population compared to the whole north west London population

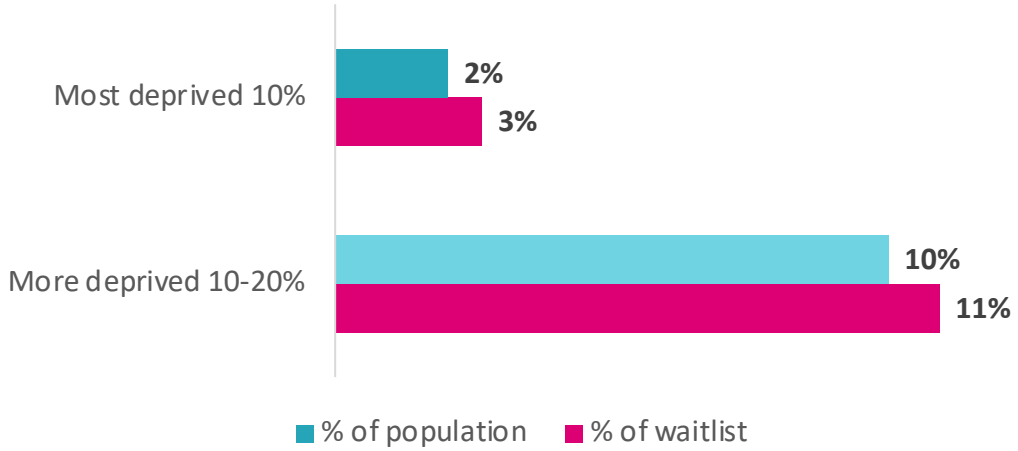
People on waitlist for elective T&O per 1,000 population by deprivation

2022



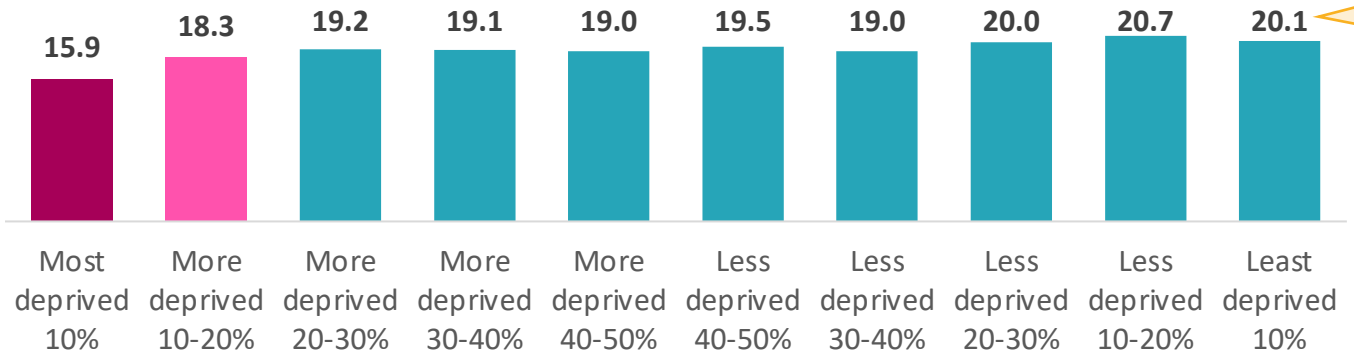
Population of bottom two most deprived areas in NWL compared to proportion of waiting list, by deprivation

2022



Average wait time in weeks, by deprivation

2022



The bottom two most deprived deciles in north west London have the lowest average waiting time

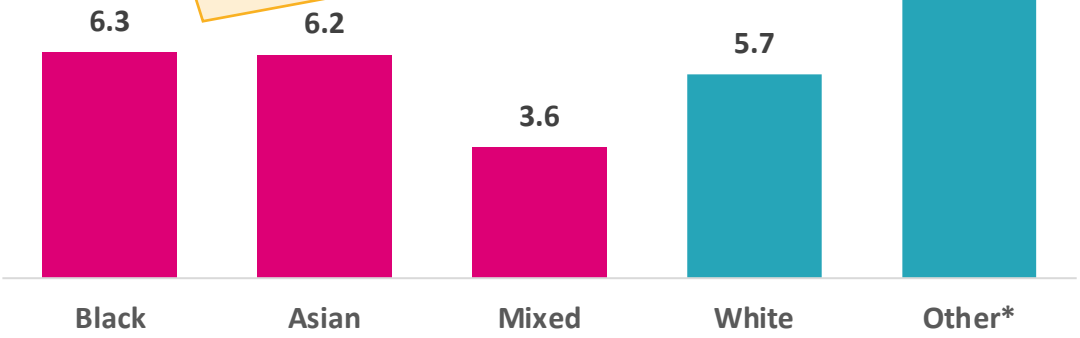
Source: Hospital Episode Statistics Admitted Patient Care, ONS population projections, English indices of deprivation, CF analysis

The white population account for the largest proportion of the waiting list and have a longer average waiting time compared to all other ethnic groups

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

2022

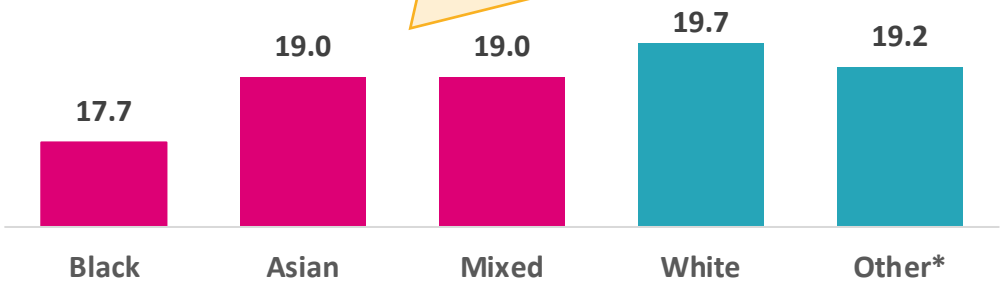
While the 'Other' ethnic group has the highest number of people on the waitlist, Black and Asian communities still have amongst the highest and double those who are Mixed-race



Average wait time in weeks, by ethnic group

2022

Although the white population have the highest average waiting time, Asian and Mixed-race people have a similar waiting time



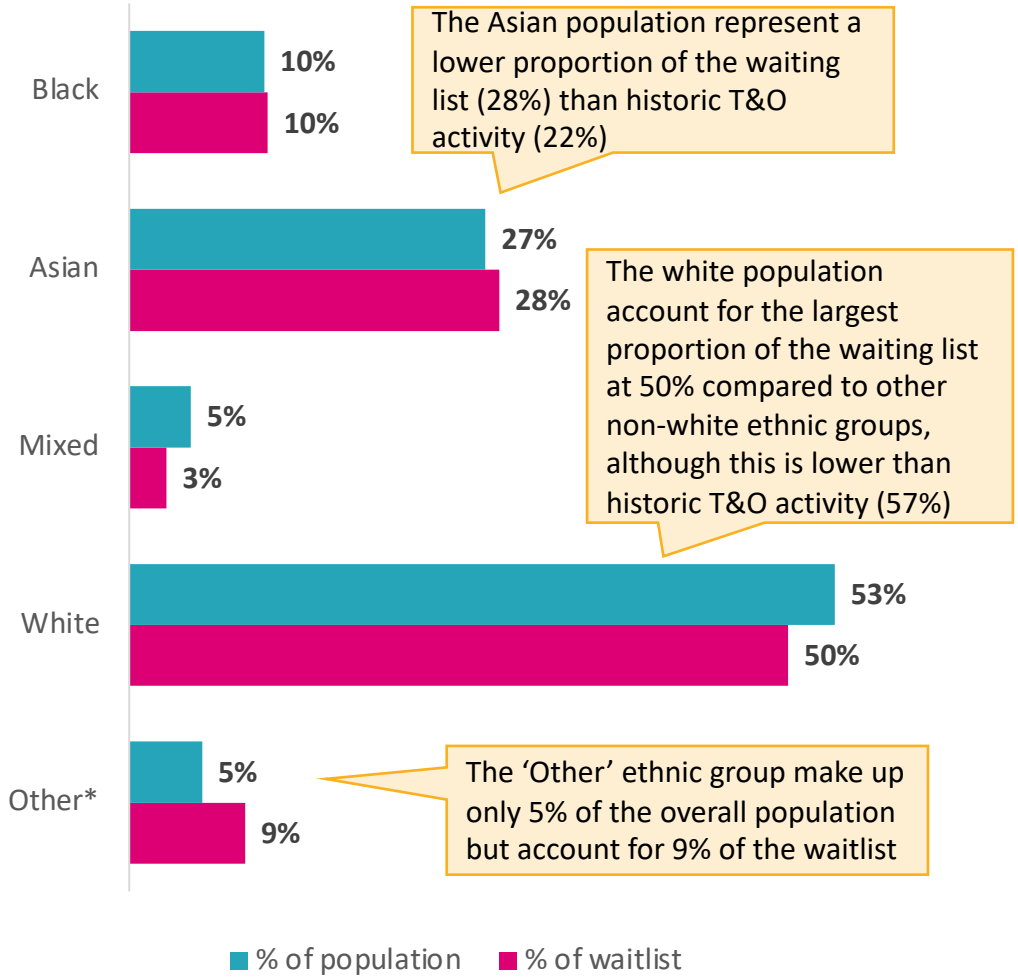
Population of bottom two most deprived areas in NWL compared to proportion of waiting list, by ethnic group

2022

The Asian population represent a lower proportion of the waiting list (28%) than historic T&O activity (22%)

The white population account for the largest proportion of the waiting list at 50% compared to other non-white ethnic groups, although this is lower than historic T&O activity (57%)

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



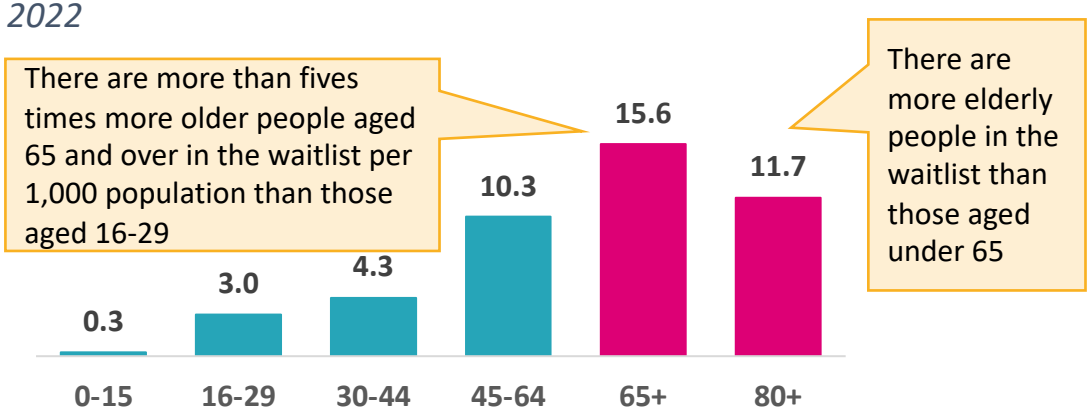
Source: Hospital Episode Statistics Admitted Patient Care, ONS population projections, CF analysis

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

Older age groups have the most people on the waitlist and account for a significantly larger proportion of the waitlist compared to their population

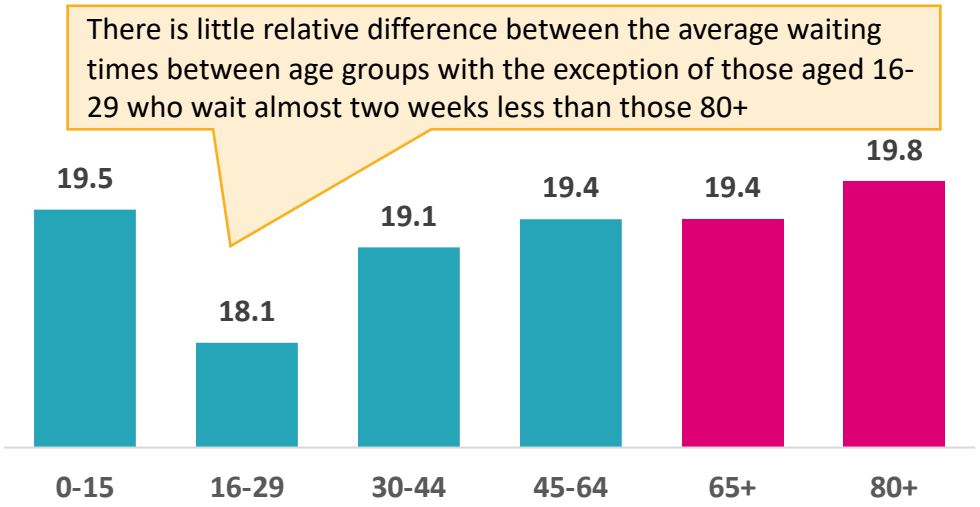
People on waitlist for elective T&O per 1,000 population by age band

2022



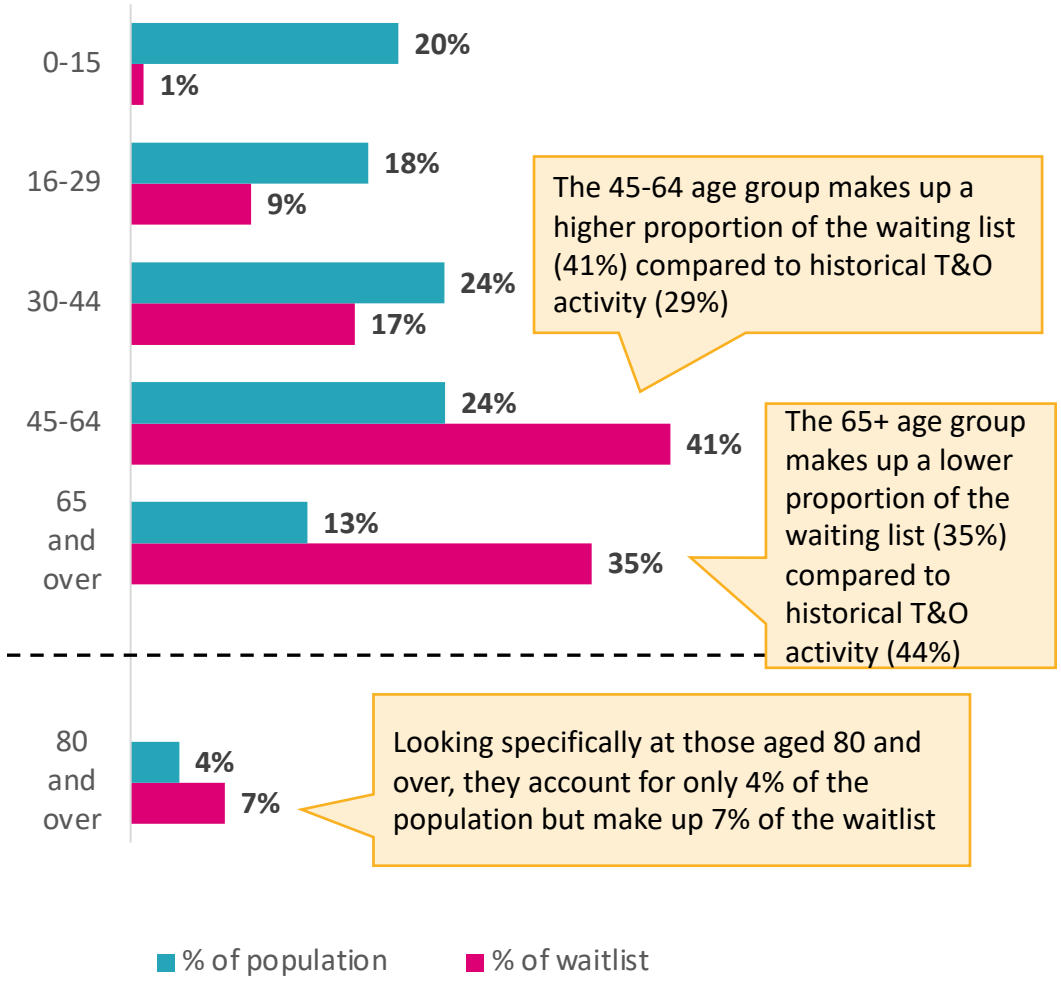
Average waiting time in weeks, by age band

2022



Population of bottom two most deprived areas in NWL compared to proportion of waiting list, by age band

2022

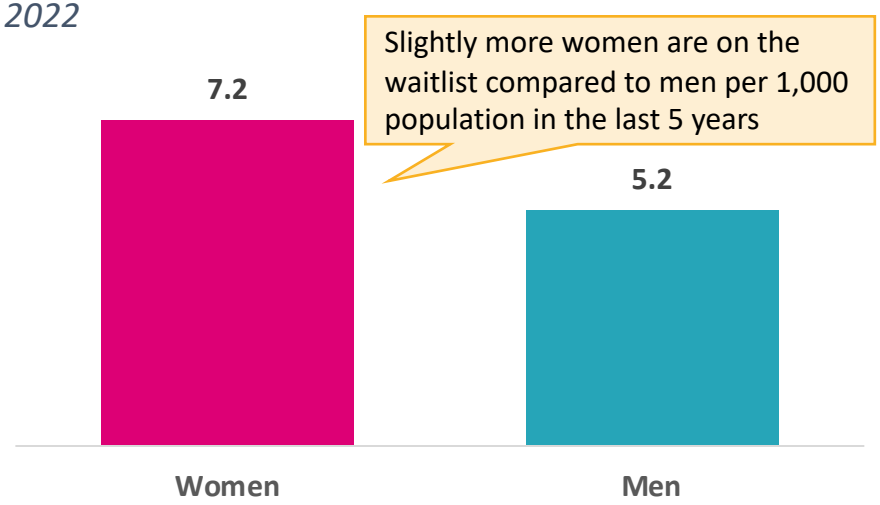


Source: Hospital Episode Statistics Admitted Patient Care, ONS population projections, CF analysis

There are slightly more women on the waitlist per 1,000 population and they account for the majority of the waitlist but have a slightly lower average waiting time

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

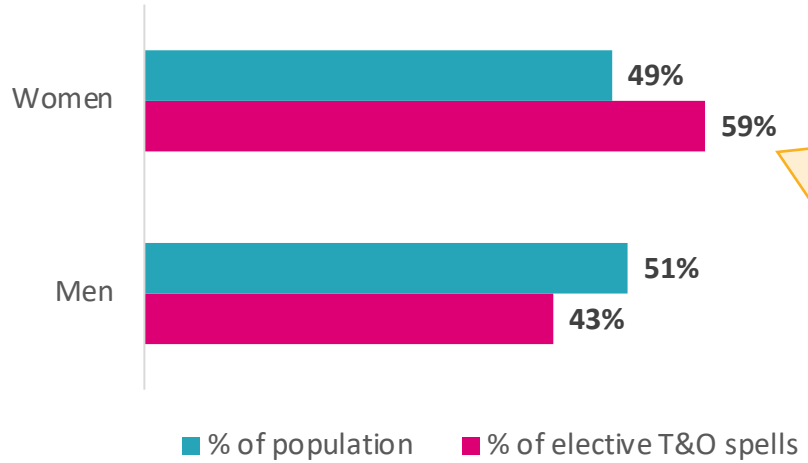
2022



Slightly more women are on the waitlist compared to men per 1,000 population in the last 5 years

Population of bottom two most deprived areas in NWL compared to proportion of waiting list, by sex

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

2022

Women have a slightly shorter average waiting time of 0.4 weeks compared to men

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

Travel time analysis methodology

The following methodology is 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

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

Average travel times for all protected groups 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

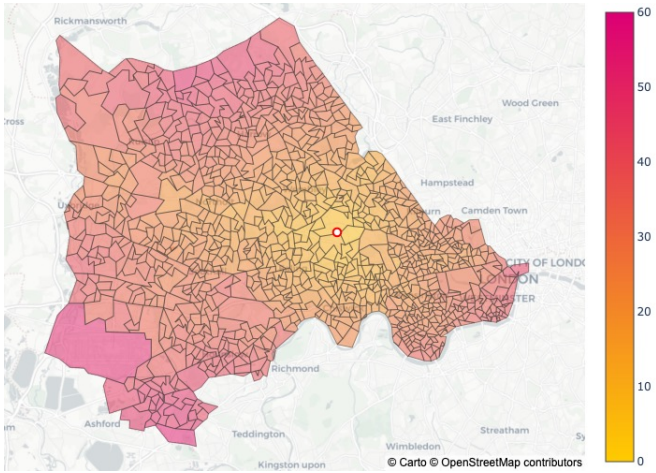
An EOC in Central Middlesex benefits Core20PLUS5 and some racial groups with a slight negative impact on white and Asian, compared to the general population

- Across different travel methods, service redevelopment results in an increase in travel times for all protected characteristic groups
- Amongst the protected groups, those in CORE20 benefit the most from option 1 as they have a lower increase in travel time compared to the general population
  - On average, their travel time 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
- Similarly, this option is beneficial for the Black, Black British, Caribbean or African communities compare to the general population across all transport methods
- This option also 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

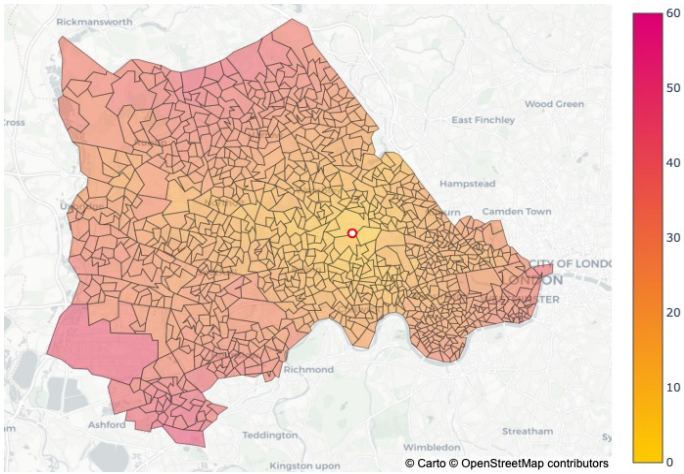
Key highlights from the travel time analysis for protected groups if an EOC was developed in Central Middlesex

	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
CORE20PLUS5	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

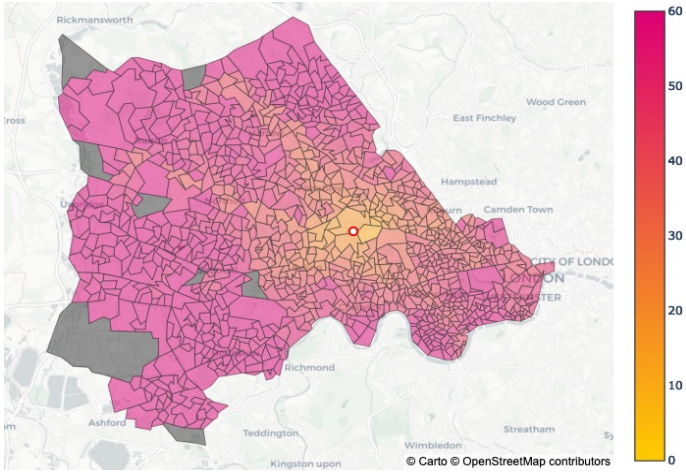
Peak travel time (minutes)



Off-peak travel time (minutes)



Public transport travel time (minutes)



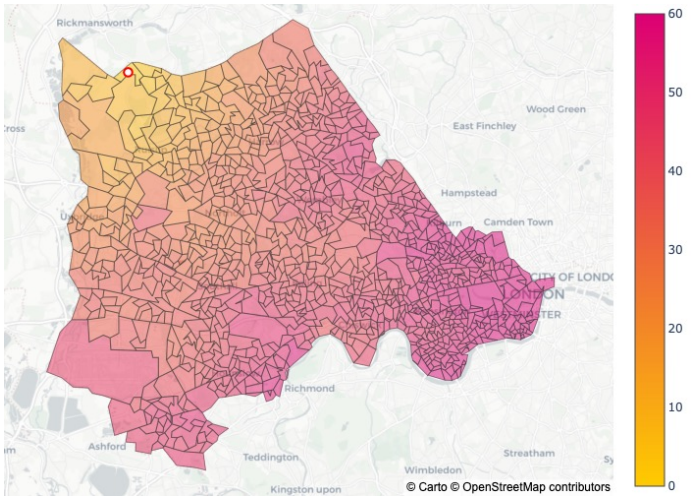
An EOC in Mount Vernon (MVH) has the highest average travel times for all protected groups but benefits the elderly and Asian or Asian British populations

- Across different travel methods, service redevelopment 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
- Average travel times for this option is almost doubled for those all protected groups travelling during peak and off-peak driving times compared to other remaining options
- The elderly population benefits from this option but there are only relatively small differences between the general population's travel times
  - 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 also benefit from 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 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
  - 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

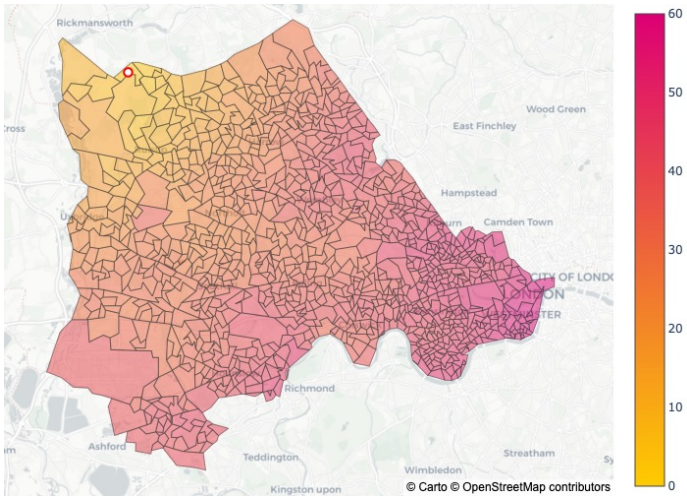
Key highlights from the travel time analysis for protected groups if an EOC was developed in Mount Vernon

	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
CORE20PLUS5	47.2	3.4	5	23	39.8	2.9	5	23	73.7	1.8	3	23

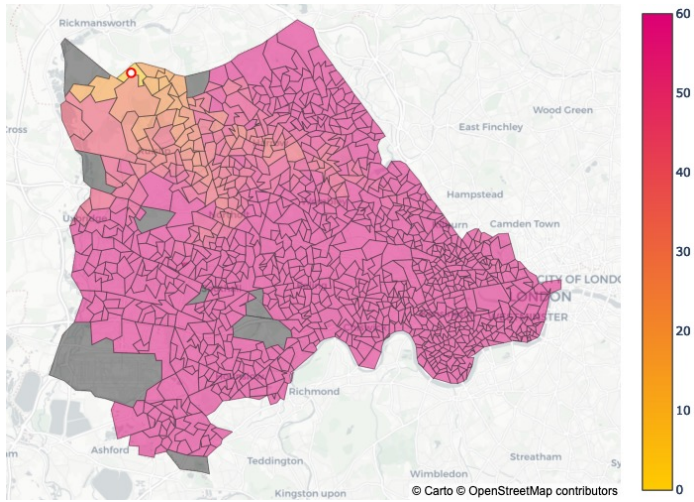
Peak travel time (minutes)



Off-peak travel time (minutes)



Public transport travel time (minutes)



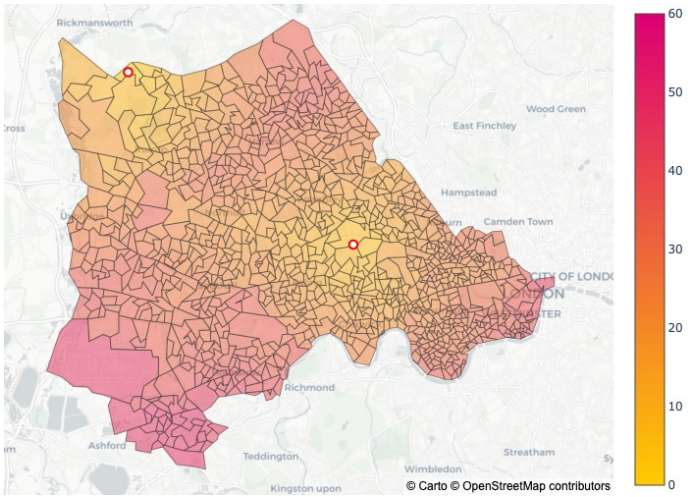
A Dual EOC on the two sites has the smallest increase in travel times and does not result in disproportionate effects on protected groups

- 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 CORE20plus5 group benefits the most from this option with the shortest average travel time
  - 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 protected group will be travelling further
  - However, 13% more of the population will travel through ULEZ compared to the general population
- The Black, Black British, Caribbean or African ethnic group also slightly benefits from 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

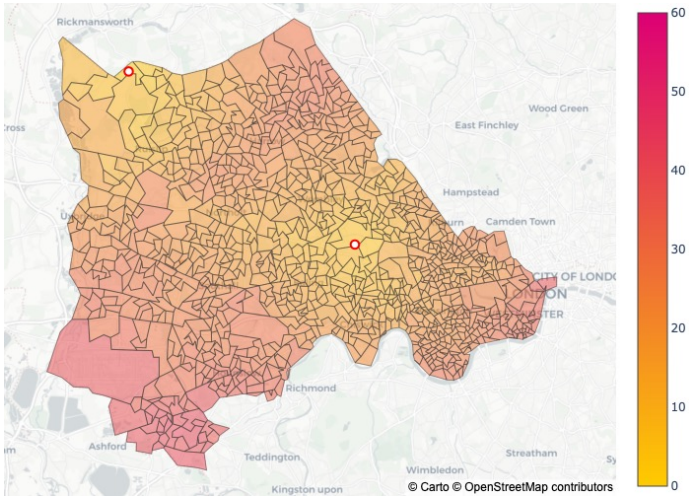
Key highlights from the travel time analysis for protected groups if an EOC was developed in both Central Middlesex and Mount Vernon

	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
CORE20PLUS5	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

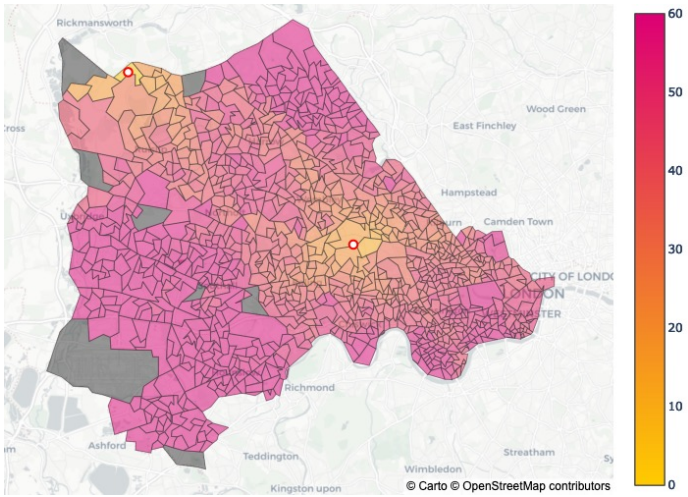
Peak travel time (minutes)



Off-peak travel time (minutes)



Public transport travel time (minutes)



Sustainability

All options are likely to increase total CO2 emissions with option 1 marginally higher than option 3 and option 2 nearly x4 increase

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
- 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 that have been identified have been categorised into three – 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
- 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

The following mitigating actions will be incorporated into the implementation plan, to address the risks in access, experience and outcomes

Mitigations for risk to access

i. **Continue Patient Transport Services (PTS)** for those who need special support getting to and from appointments at the EOC
ii. Provision of **travel solutions (including dedicated transport to the EOC)** for those not eligible for PTS but would be otherwise unable to travel to appointments, and encourage people to apply for travel reimbursement through the Department of Work and Pensions, providing simple access to information
iii. 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 race, gender, age or other protected characteristics
iv. Work with Transport for London in relation to **adjustments to support affordable access, for example adapting bus routes**
v. 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
vi. Understand requirements for **disabled access and parking**
vii. Develop clinical model which **minimises visits to the centre** by providing outpatient care at local trusts
viii. Analyse and incorporate **impact on staff travel** in staff consultation

Mitigations for risks to patient experience

i. 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**
ii. Design the EOC to be compliant with **current legislation regarding accessibility and wayfinding**
iii. **Improve knowledge and cultural competency amongst staff** through awareness and training
iv. 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
v. Develop procedures to ensure patients have **access to appropriate chaperone** where necessary
vi. Consider therapeutic activities which address the specific needs of the transgender community, and ensure policies to protect the rights of transgender staff are known and followed
vii. **Leverage existing policies in place at trusts**, which have been developed using the experience of working with diverse communities
viii. Develop **HR policies and procedures that recognise the needs of the workforce** including parental leave, flexible working and caring responsibilities
ix. Ensure that the centre's staff facilities provide **privacy and dignity for staff**

The following mitigating actions will be incorporated into the implementation plan, to address the risks in access, experience and outcomes

Mitigations for risks to outcomes

i. **Standardised processes across the pathway for the whole of north west London**, meaning that all patients will have the same opportunities for treatments

ii. Develop **discharge standard operating policies in collaboration with community colleagues** to ensure effective discharge from hospital

iii. Monitor elective orthopaedic waiting times across the sector to ensure that patients **who are not eligible for treatment at the centre do not wait longer,** and take mitigating action if such waits are revealed

iv. **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 and 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 non-white 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

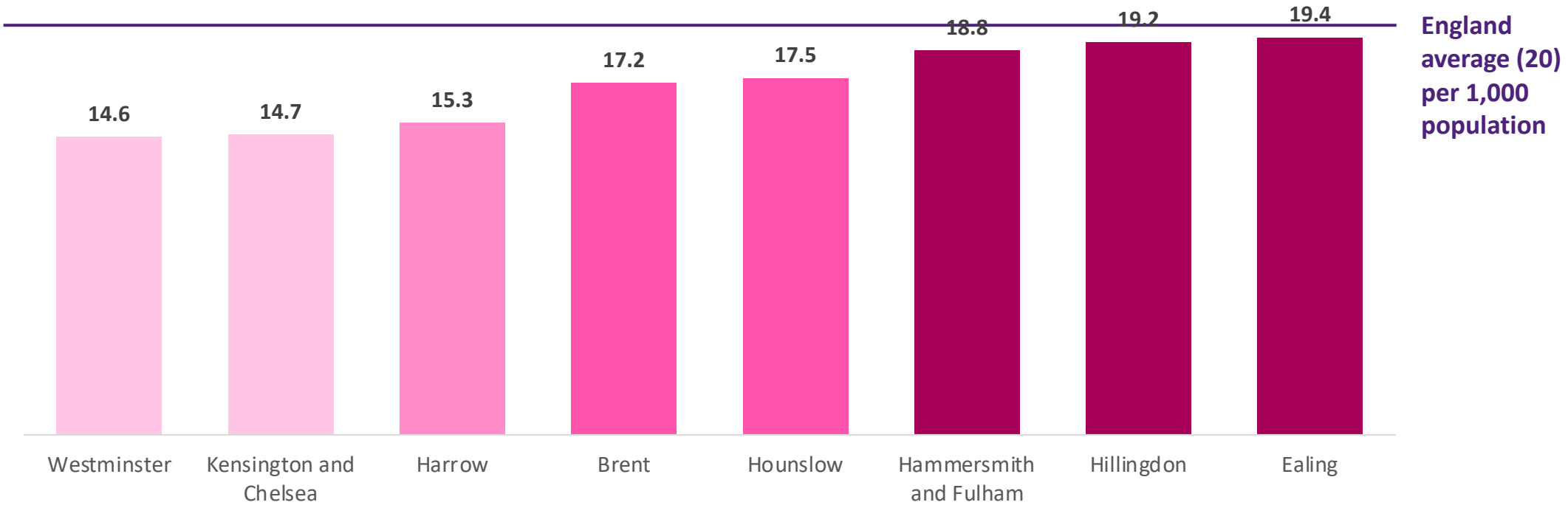
This appendix includes the analysis of inequality groups undertaken and other indicators of patient outcomes considerations that do not provide key findings for consideration

- People with disabilities
- Gender reassignment
- Religion or belief
- Sexual orientation
- Marital status
- Pregnant or on maternity leave
- Other indicators of patient outcomes

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

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

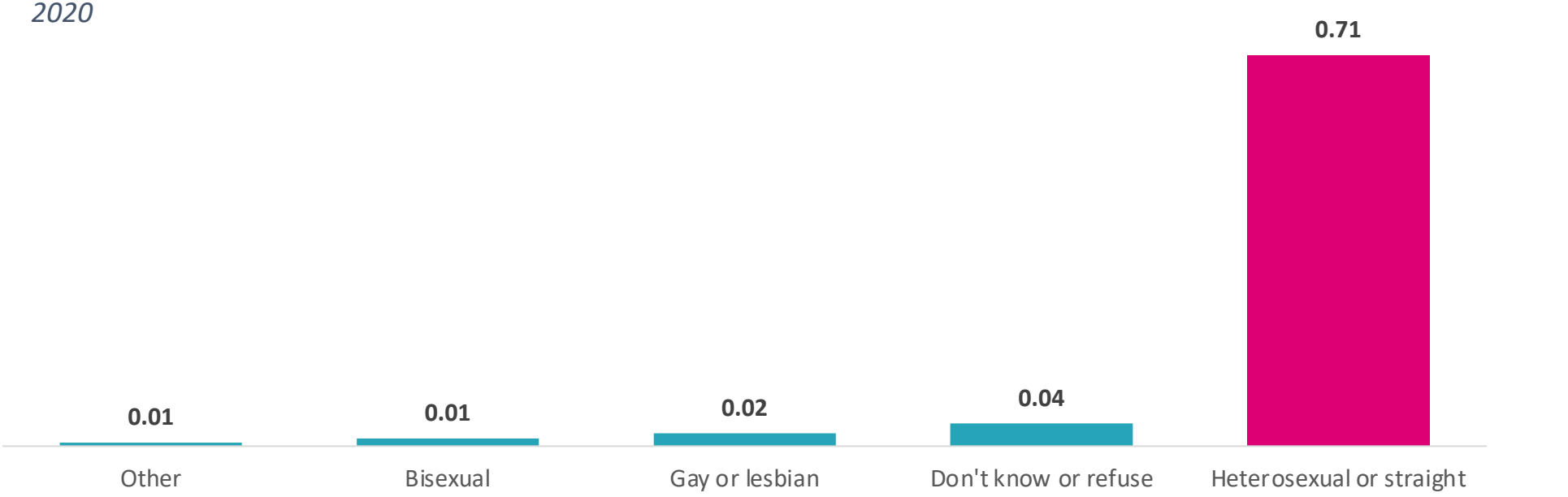
There is a known lack of demographic data and NHS data for those that have had gender reassignment

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.

The Annual Population survey shows that there is a higher proportion of people who identify as heterosexual or straight than other sexual orientations in London

London residents (aged 16 and over) and their registered sexual orientation per 1,000 population, by sexual orientation

2020



- 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

Studies show trans people can be deterred from using health services due to negative attitudes and 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

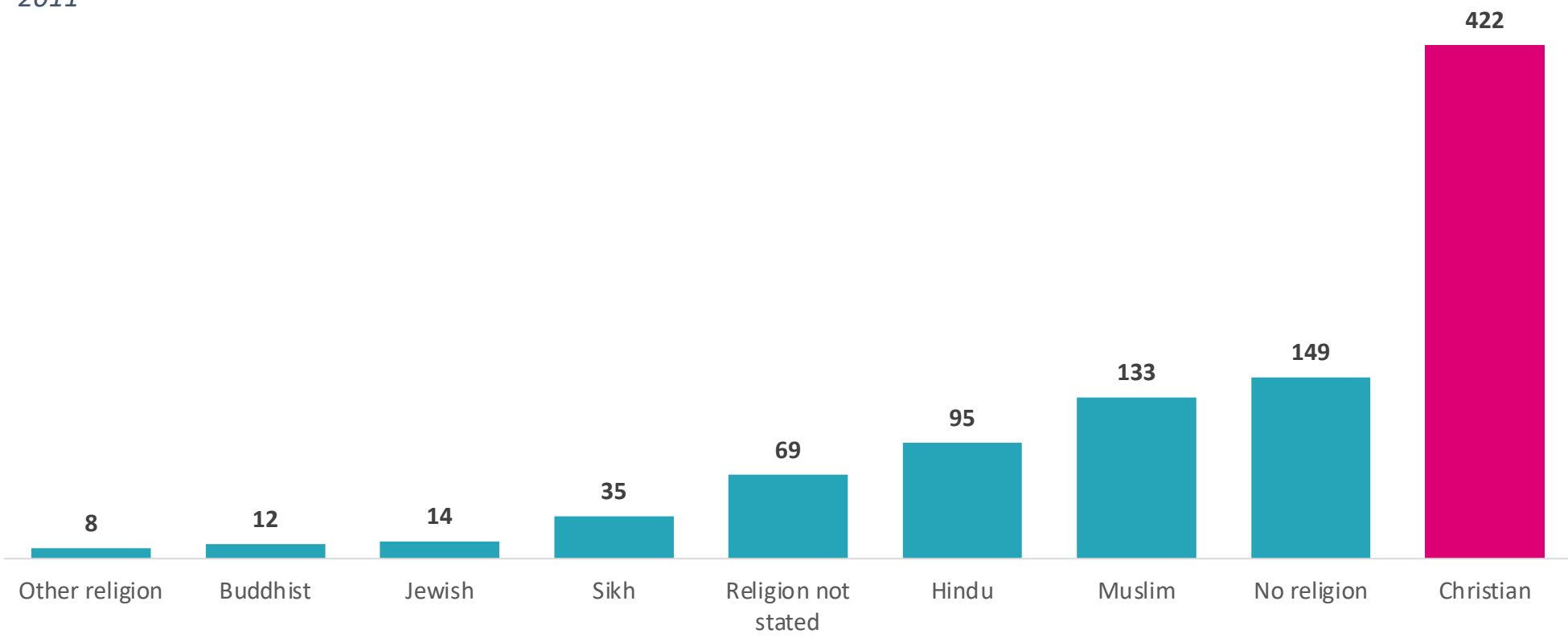
For the data analysis, the main source of data (HES) does not generally record reliable details of this protected characteristic.

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

North west London has a higher population of people who identify with the Christian religion 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

Studies show some religious groups can be deterred from using health services due to 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

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

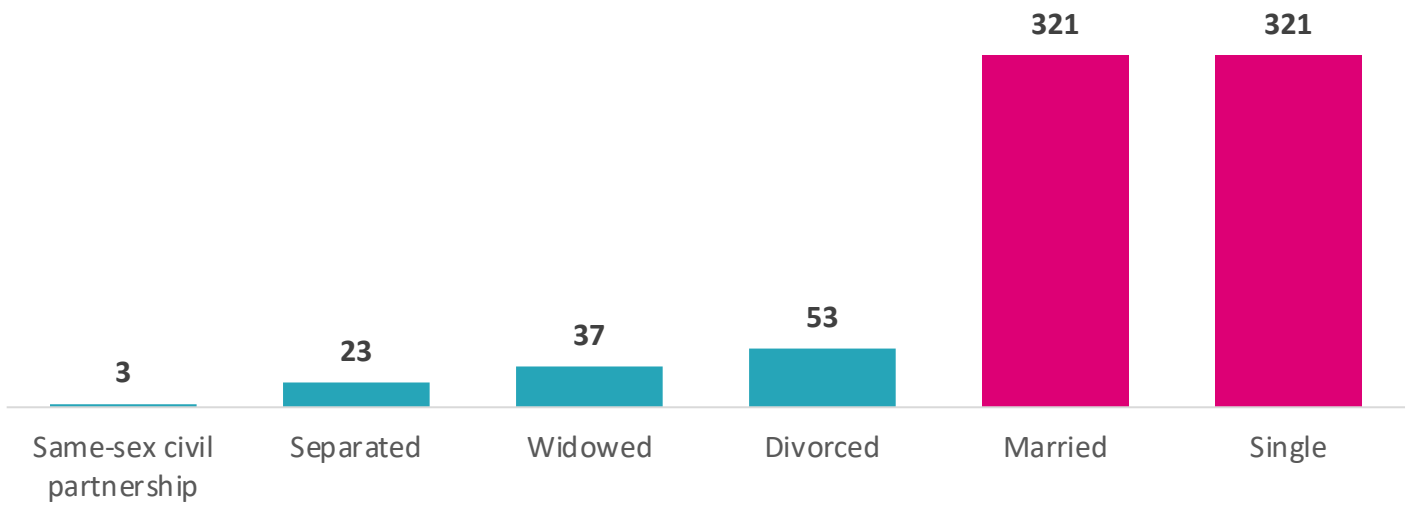
For the data analysis, the main source of data (HES) does not generally record reliable details of this protected characteristic.

Source: LGBTQ+ in Orthopaedics: Creating an Open and Inclusive Environment (2022) https://pubmed.ncbi.nlm.nih.gov/35609262/

Data capture indicates proportionately more married and single people than those with other relationship statuses based on data capture which is limited

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

Studies show 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

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.

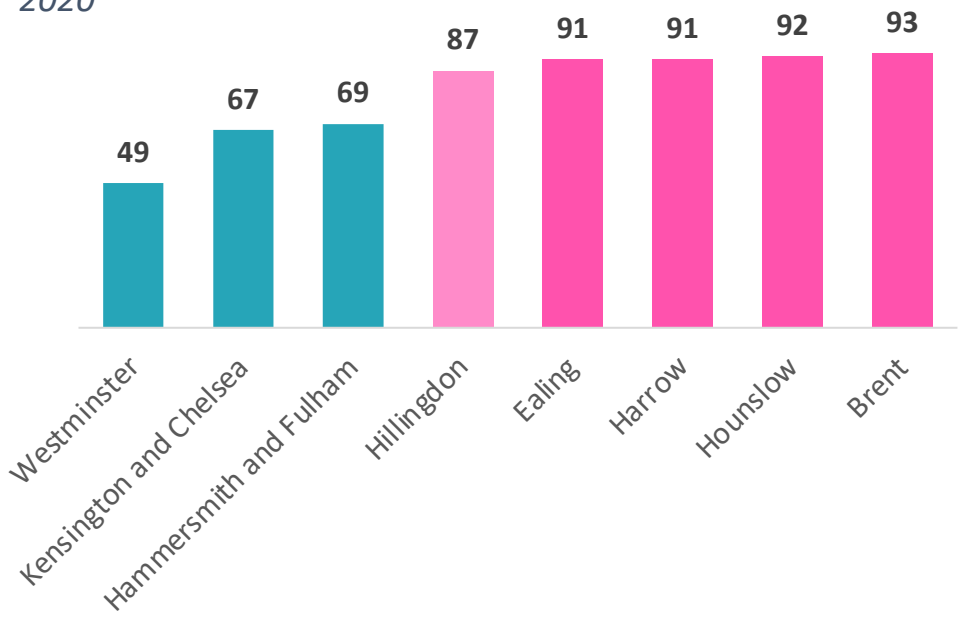
For the data analysis, the main source of data (HES) does not generally record reliable details of this protected characteristic.

Source: Marriage Status Predicts Hospital Outcomes Following Orthopedic Trauma (2020) https://pubmed.ncbi.nlm.nih.gov/32030312/

Using conceptions as an indicator for pregnancies, some local authorities in north west London have a disproportionate number of pregnancies compared to others

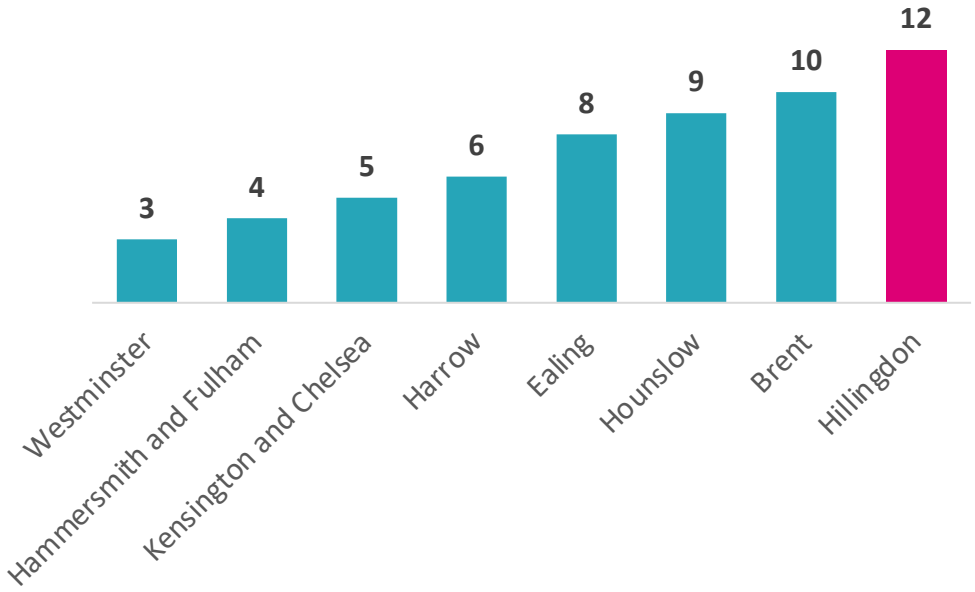
Conceptions per 1,000 women aged over 18, by NWL local authorities

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

Pregnant patients are at higher risk during orthopaedic surgery, however 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 underperforming 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 July 2022

Site Name	Ward Name	Positive response (%)	Negative response (%)
St Mary's Hospital (HQ)	Major Trauma Ward	100%	0%
St Mary's Hospital (HQ)	Valentine Ellis Ward	100%	0%
St Mary's Hospital (HQ)	Albert Ward	57%	14%
Northwick Park Hospital	Eliot	100%	0%
Mount Vernon Hospital Site	Trinity	97%	0%
Hillingdon Hospital	Kennedy	88%	6%
Charing Cross Hospital	7 South Ward	82%	5%
Chelsea & Westminster Hospital NHS Foundation Trust		96%	2%
NWL ICB – T&O average		**89%**	**4%**
National - T&O average		**94%**	**3%**

Full trust FFT scores included as FFT scores for T&O specialty unavailable for Chelsea & Westminster Hospital

Source: NHS Friends and Family Test

Appendix 3 – Travel analysis

Equity Impact Assessment

Travel Impact Analysis

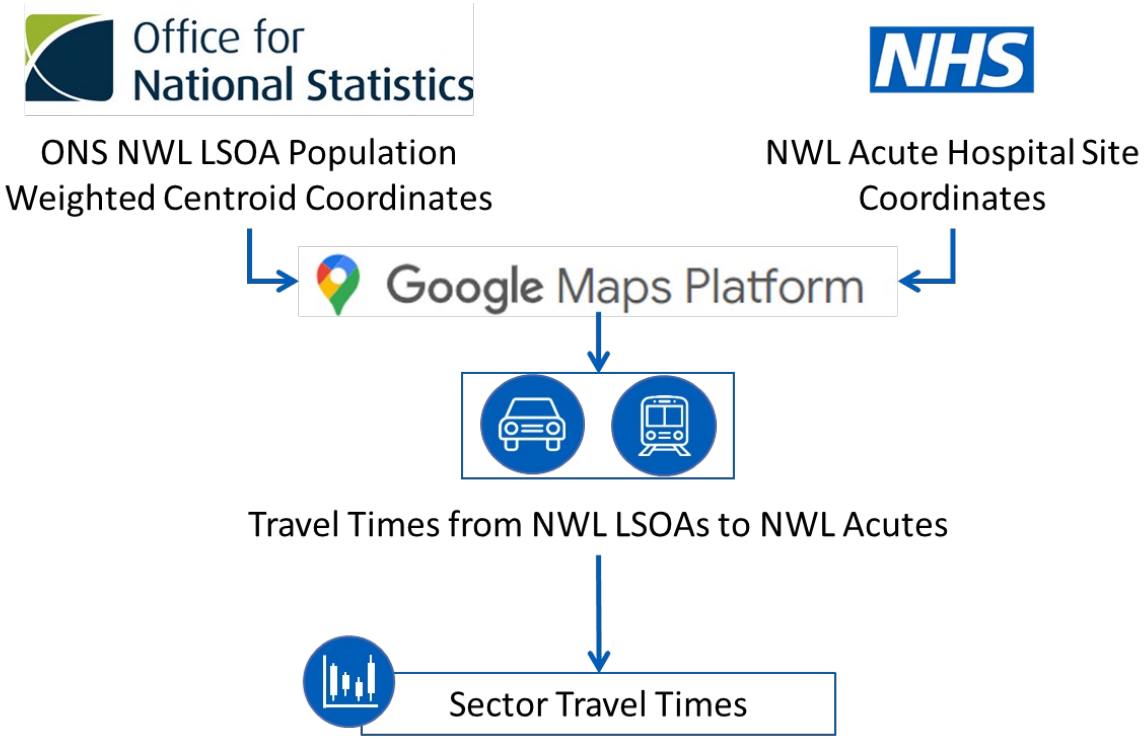
North West London Elective Orthopaedic Centre

13/10/2022

v1.6

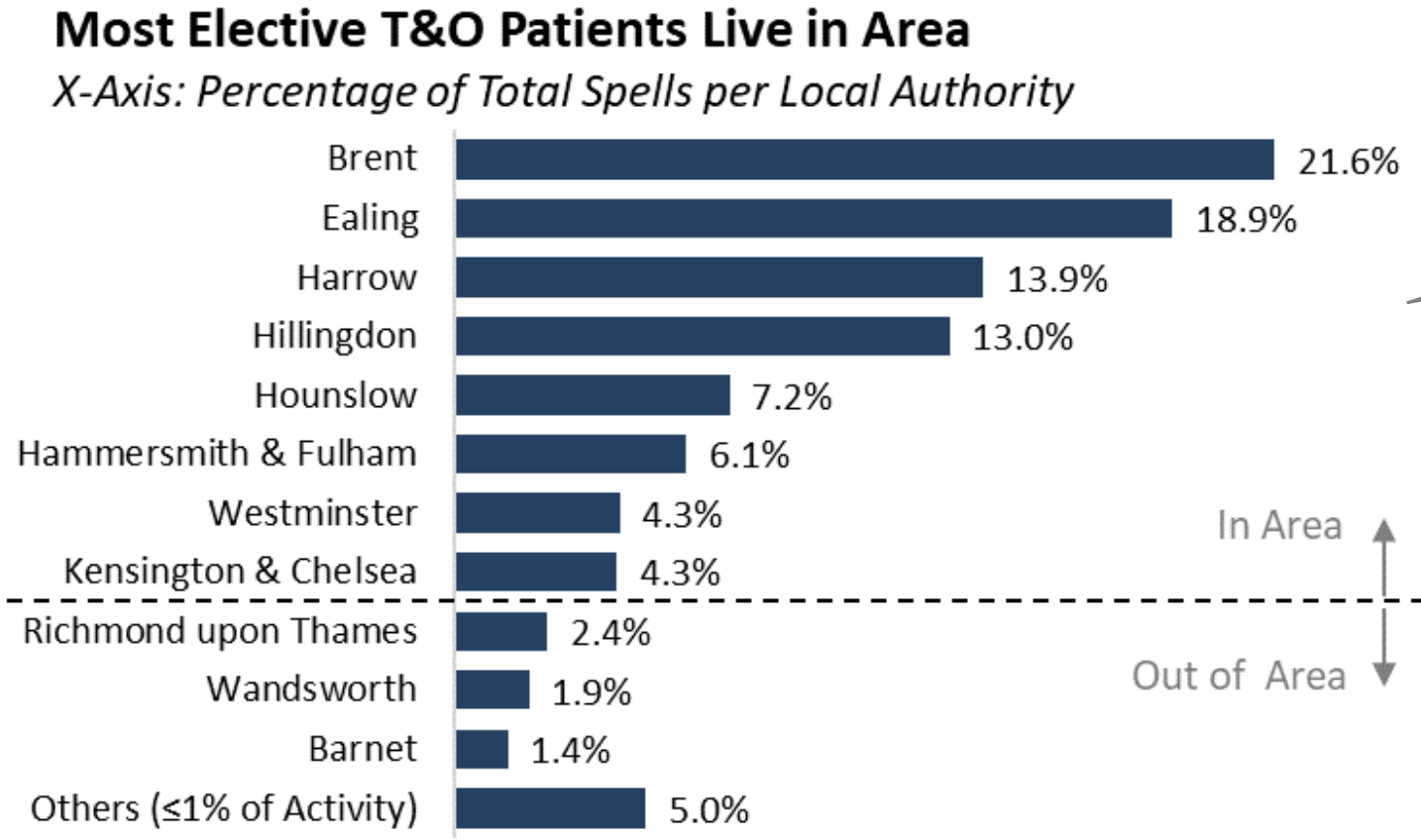
Methodology | 90% of NWL IP and LWNH DC live in North West London, so this analysis will focus on these boroughs

- Using an industry standard travel time API, journey times were calculated from each North West London (NWL) acute hospital site to each NWL Lower Layer Super Output Area (LSOA).
- LSOAs are small geographical areas designed to be of a similar population size, with an average of approximately 1,500 residents or 650 households.
- Travel times included traffic conditions during off-peak travel times (11am) as most surgical procedures require patient arrival outside of peak times.
- Travel times were calculated from population-weighted LSOA centroids, which are known to reflect real life journeys more than geometric centroids [1].



[1] Burden, A et al.; Using address data to compare accuracy of accessibility to health services ; GLA (2012)

Patient Locations | 90% of NWL IP and LWNH DC live in North West London, so this analysis will focus on these boroughs



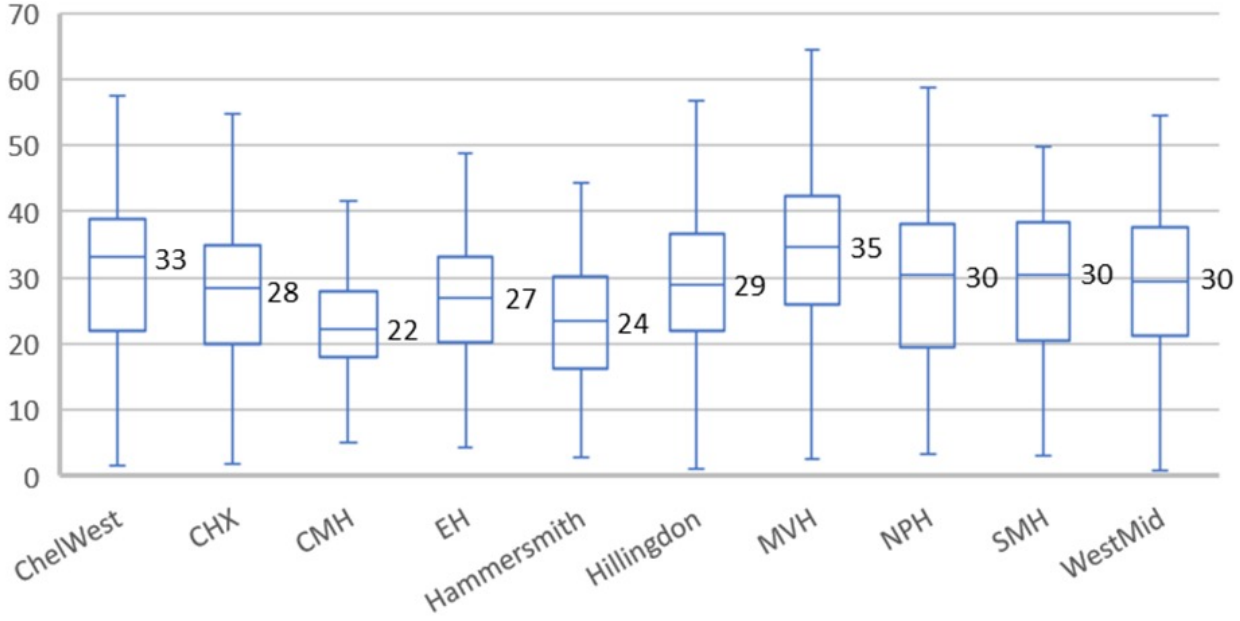
Patients on the NWL Acute orthopaedic waiting lists also primarily live in NWL boroughs (see Appendix A)

Source: HES Data (Dr Foster)

Site Travel Appraisal | CMH has the shortest median travel times from NW London LSOAs of all the sites under consideration for the NWL Elective Orthopaedic Centre

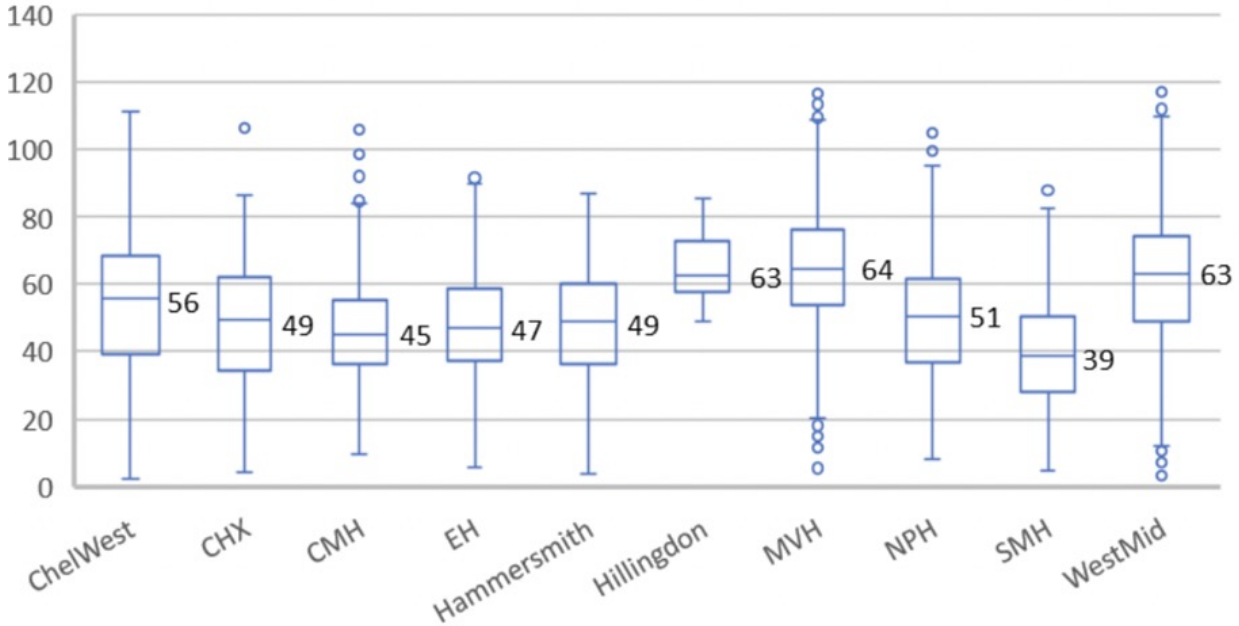
Off-peak driving travel time from NWL LSOAs to NWL acute hospital sites

Y-Axis: travel time (minutes)



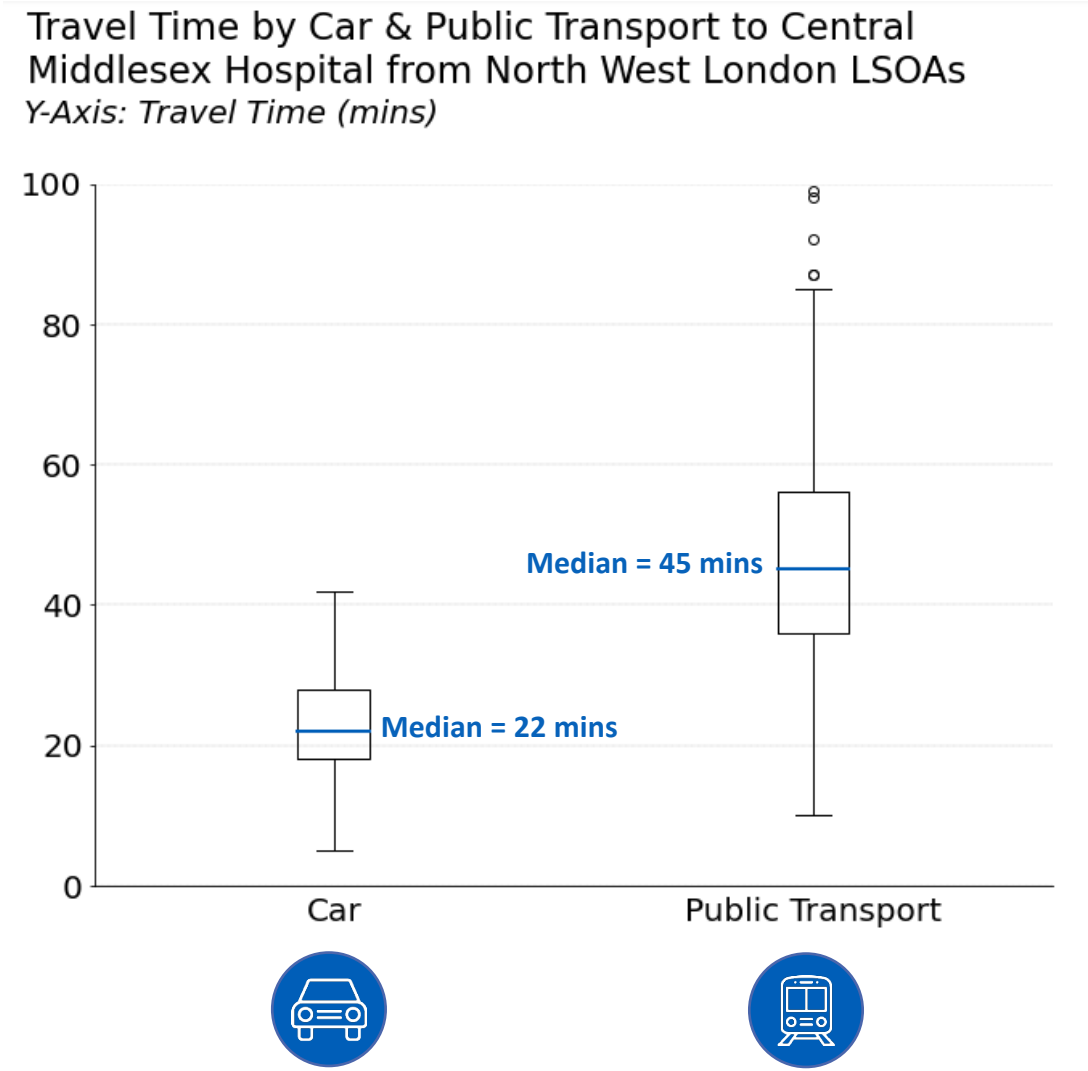
Off-peak public transport travel time from NWL LSOAs to NWL acute hospital sites

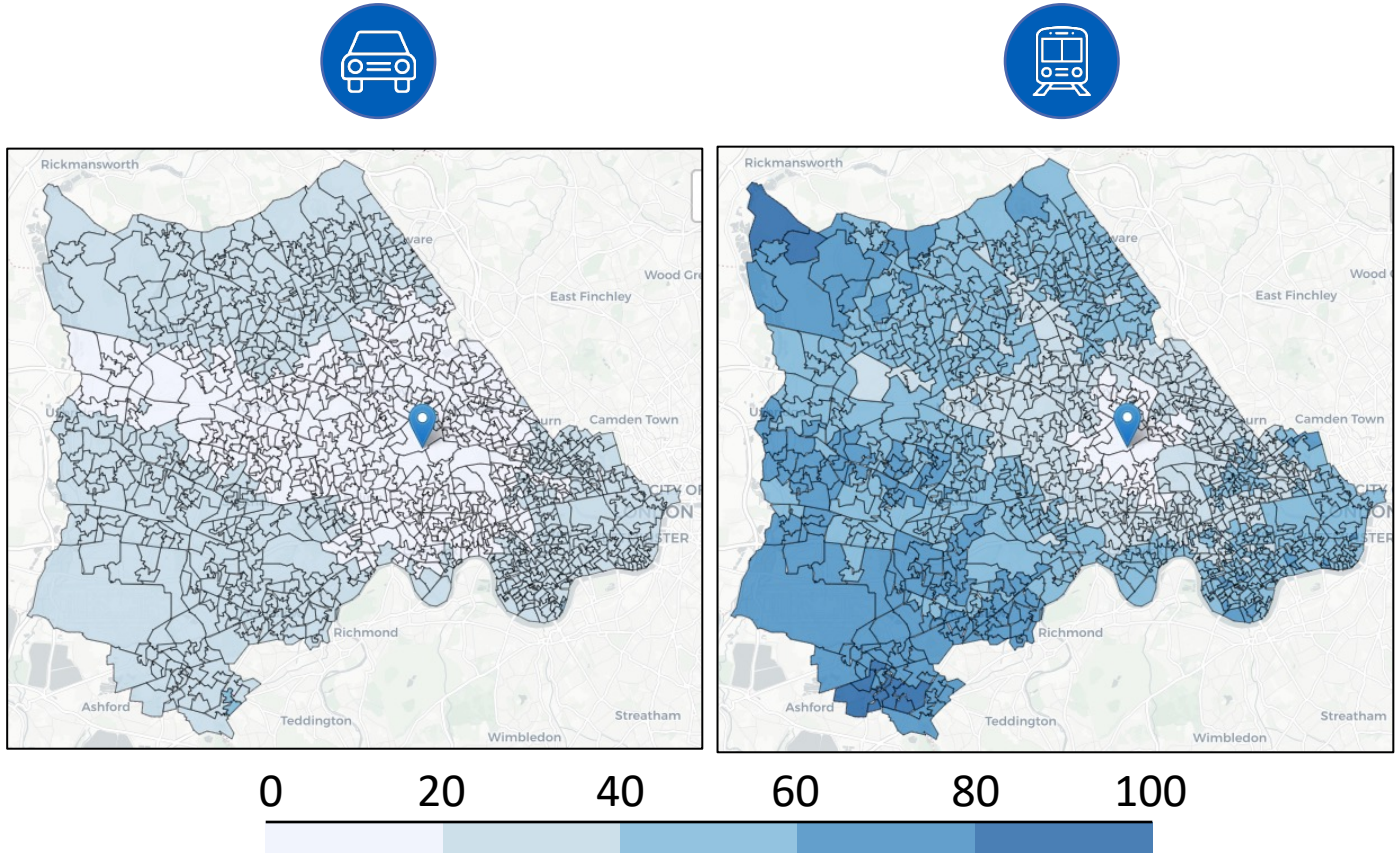
Y-Axis: travel time (minutes)



See Appendix G for box-plot explanation. Data Sources: ONS; Google Maps Platform (all travel times off peak)

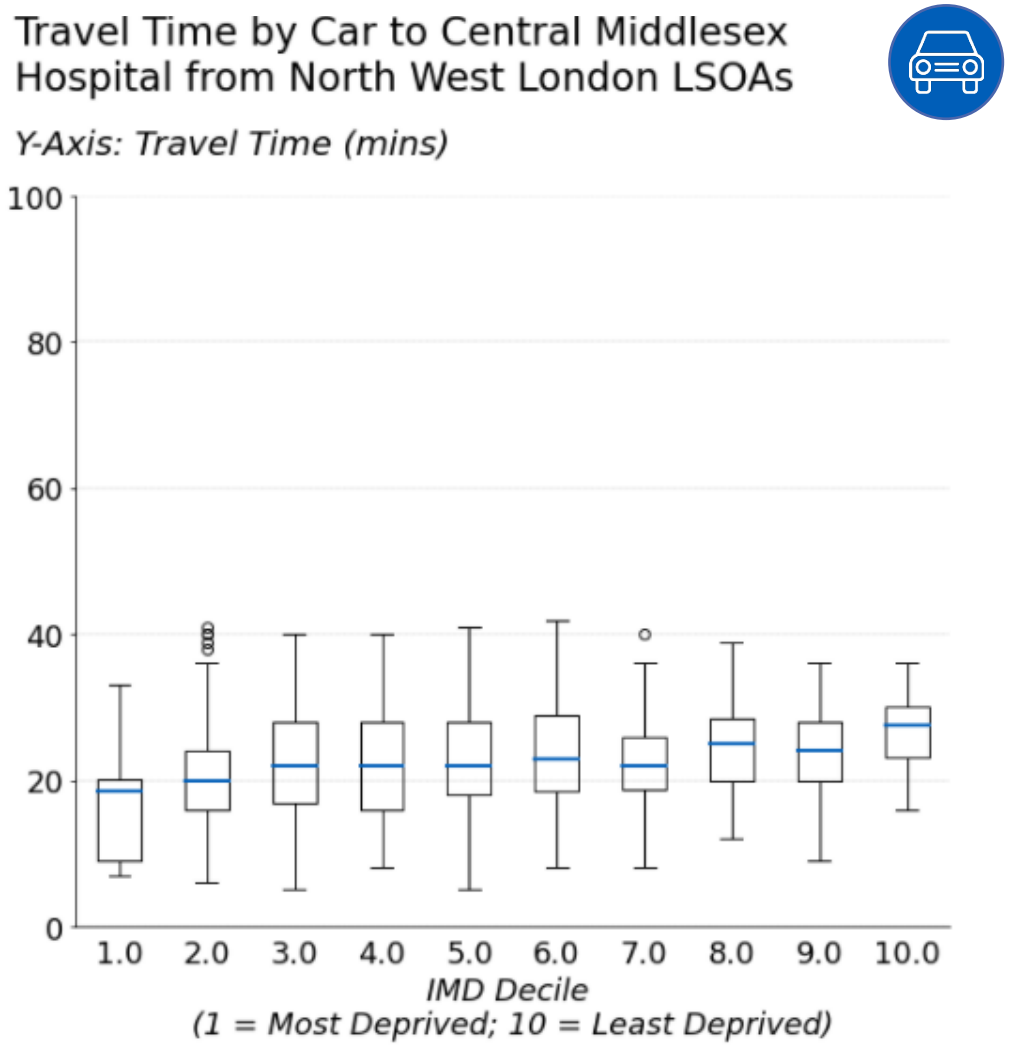
EOC Travel Times | The Median Travel Time from NWL LSOAs by Car is 22 mins and 45 mins by Public Transport

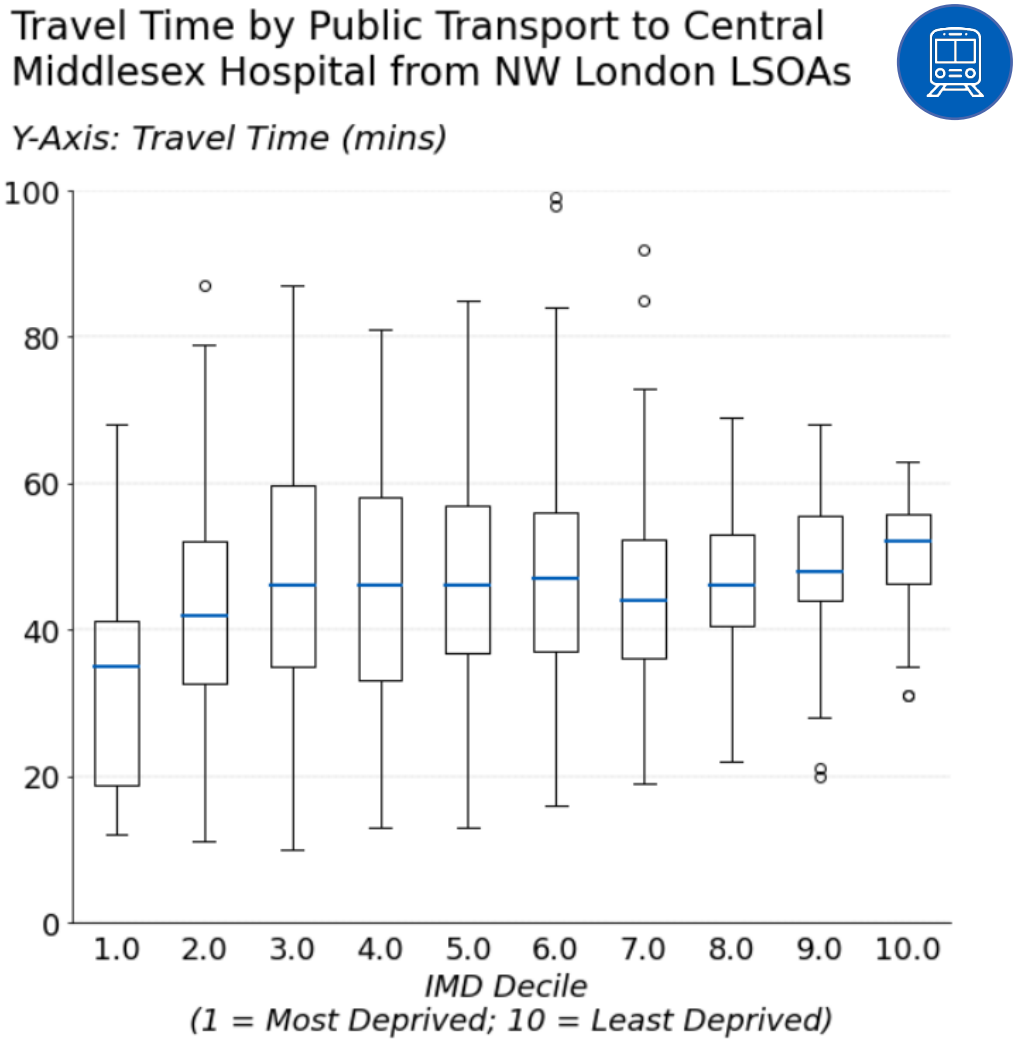




Data Sources: ONS; Google Maps Platform (all travel times off peak)

Deprivation | The most deprived LSOAs have statistically significantly reduced travel times to CMH by car and public transport



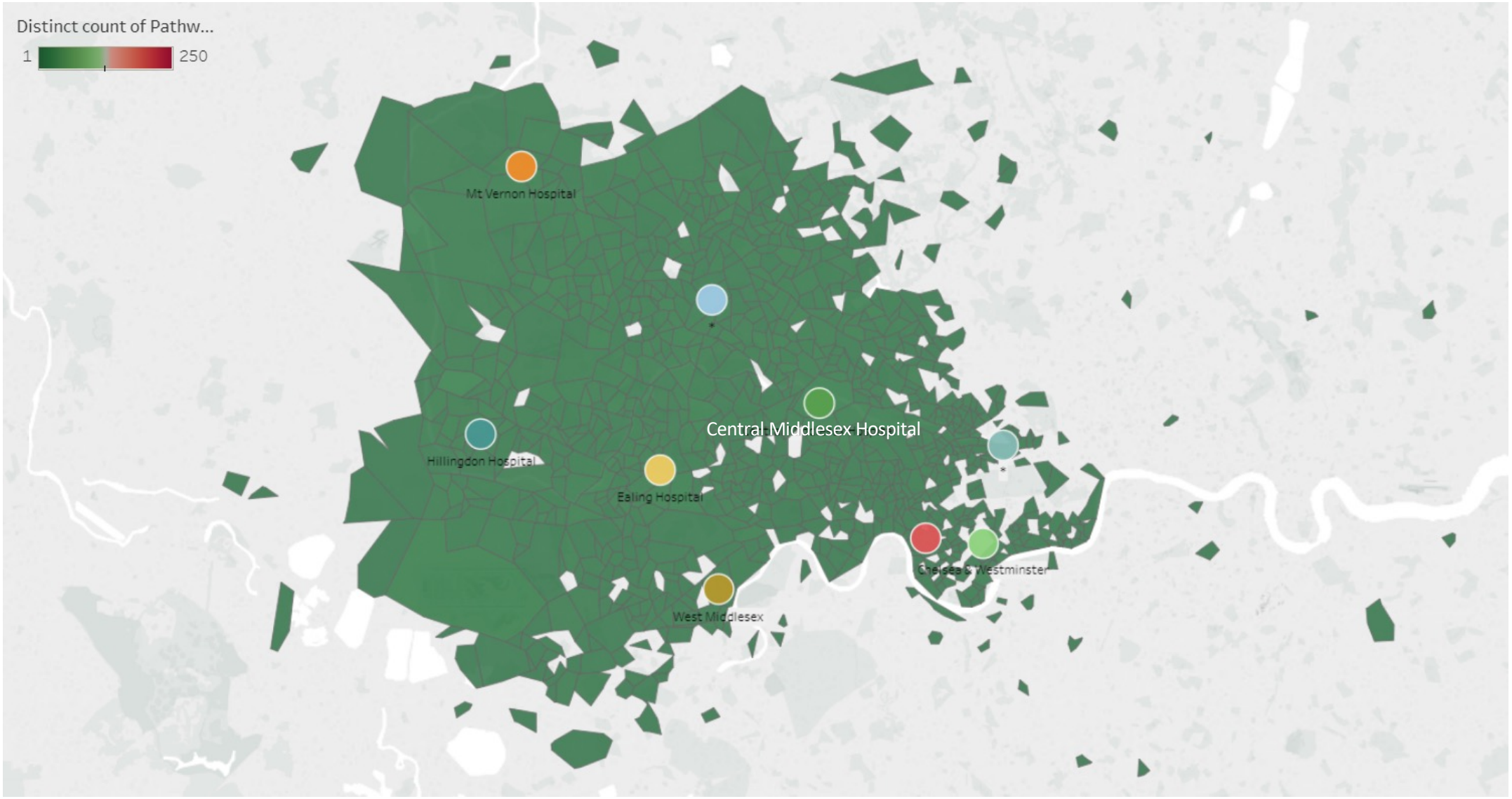


At an individual level, those from deprived areas may not necessarily have improved access as it depends on numerous other factors e.g. car ownership (see Appendix C), and ability to pay for transport, parking (Appendix D) and/or ULEZ (Appendix E)

Limitations | The interpretation of this analysis should be considered alongside the limitations

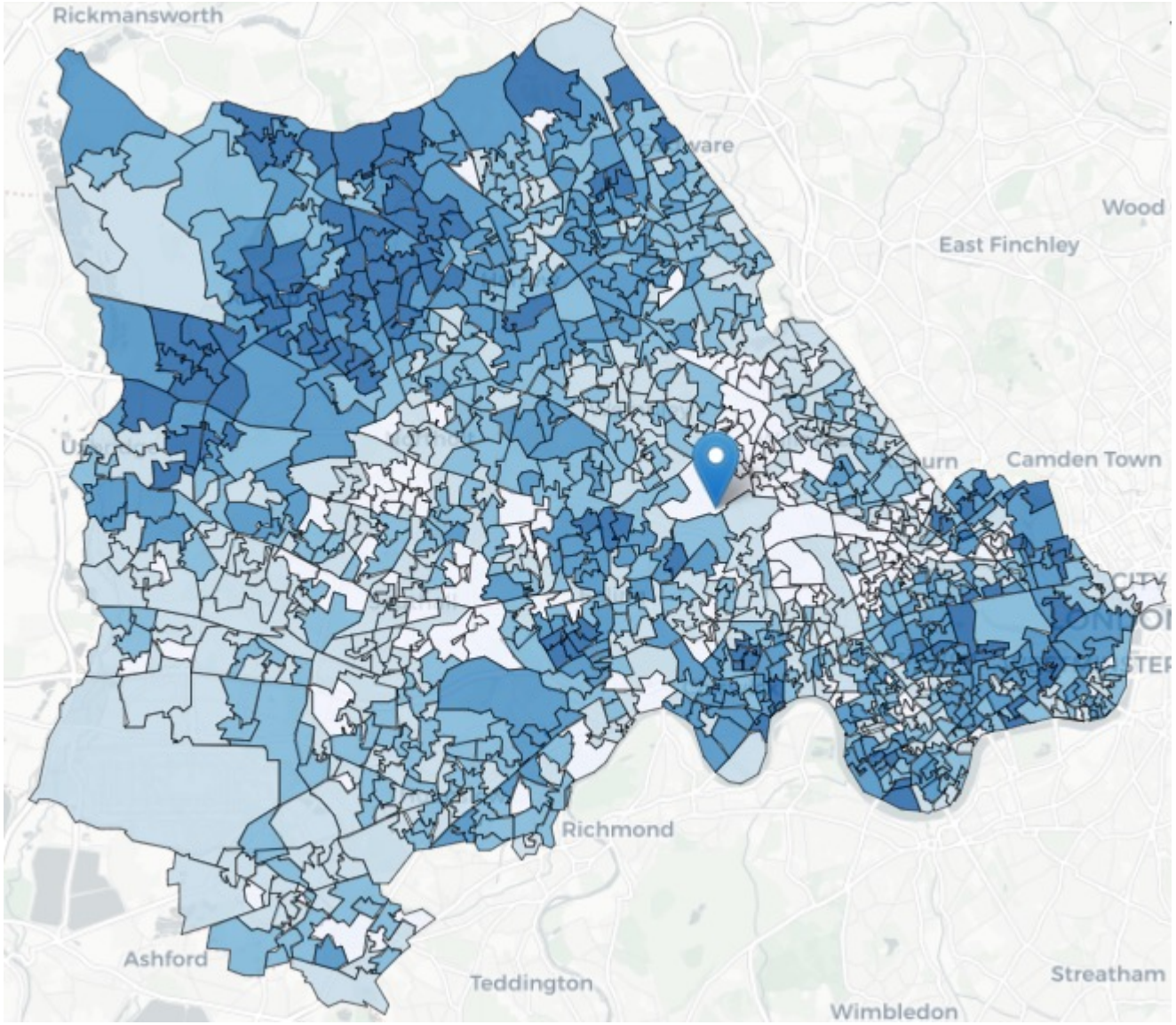
- This analysis considers transport evenly across LSOAs making up the boroughs where patients have historically originated from (see Slide 1). There will be a small proportion of patients who are from out of area; this analysis cannot comment on their travel times.
- This analysis does not weight any LSOAs more highly than others. This is accepted due to the fact LSOAs are defined to include a narrow population between 1,500 and 3,000 people.
- This analysis does not take into account any other factors associated with an LSOA (e.g. obesity or age distribution) that may make some LSOAs produce higher volumes of patients requiring elective orthopaedic surgery.
- All travel times are calculated off peak (specifically at 11am on a weekday). This is deemed reasonable as most patients will arrive for surgery by 7am or 12am on a weekday.
- Travel time analysis is from LSOA population weighted centroids rather than patient addresses. While this is a good estimate of average travel time, at an individual level this will either under or overestimate travel times for those living within a particular LSOA.

Appendix A | Geographical Distribution of Patients on the NWL T&O Waiting List



Source: WSIC NWL Waiting List PTL Map (MDS Submission); Latest Data: 08/08/2021

Appendix B | Deprivation in NWL



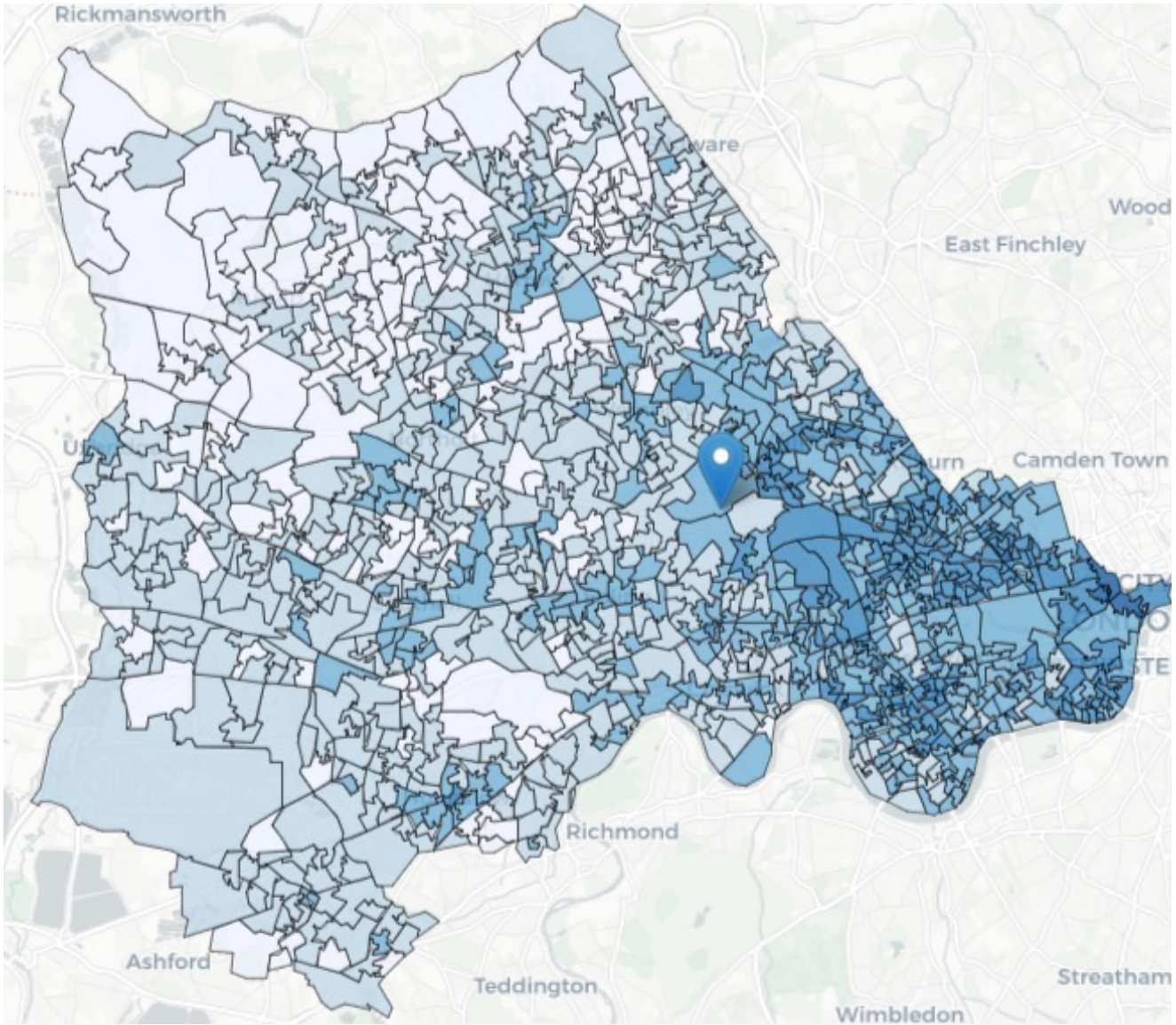
1 3 5 6 8 10

IMD Decile
(1 = Most Deprived; 10 = Least Deprived)

= Central Middlesex Hospital

Source ONS: 2019 IMDs by LSOA

Appendix C | Car ownership is lower in Inner NWL than Outer NWL



0 20 40 60 80 100

% Households with no cars or vans (2011)

= Central Middlesex Hospital

Source ONS: 2011 Census Data

Appendix D | Car Parking Charges in Central Middlesex Hospital

Parking charges

Public car parking charges at Central Middlesex, Ealing, Northwick Park and St. Mark's hospitals

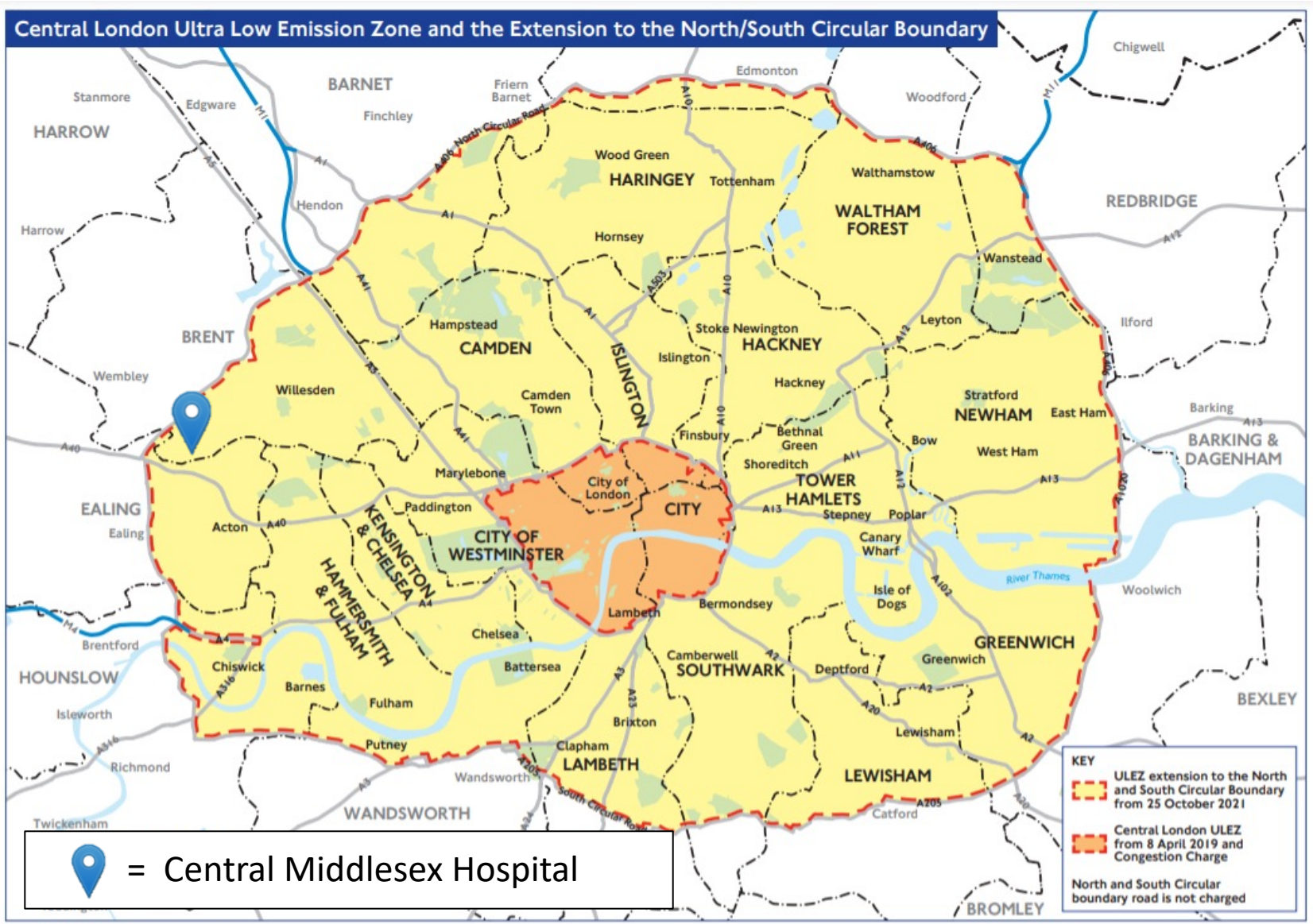
- Up to 1 hour: £2.80
- Up to 2 hours: £5.30
- Up to 3 hours: £5.70
- Up to 5 hours: £6.60
- Up to 8 hours: £10.00
- Over 8 hours: £12.70

If you have a disabled badge, you can park for up-to six hours for free in our disabled bays. Other concessions are available.

Source: https://www.lnwh.nhs.uk/car-parking

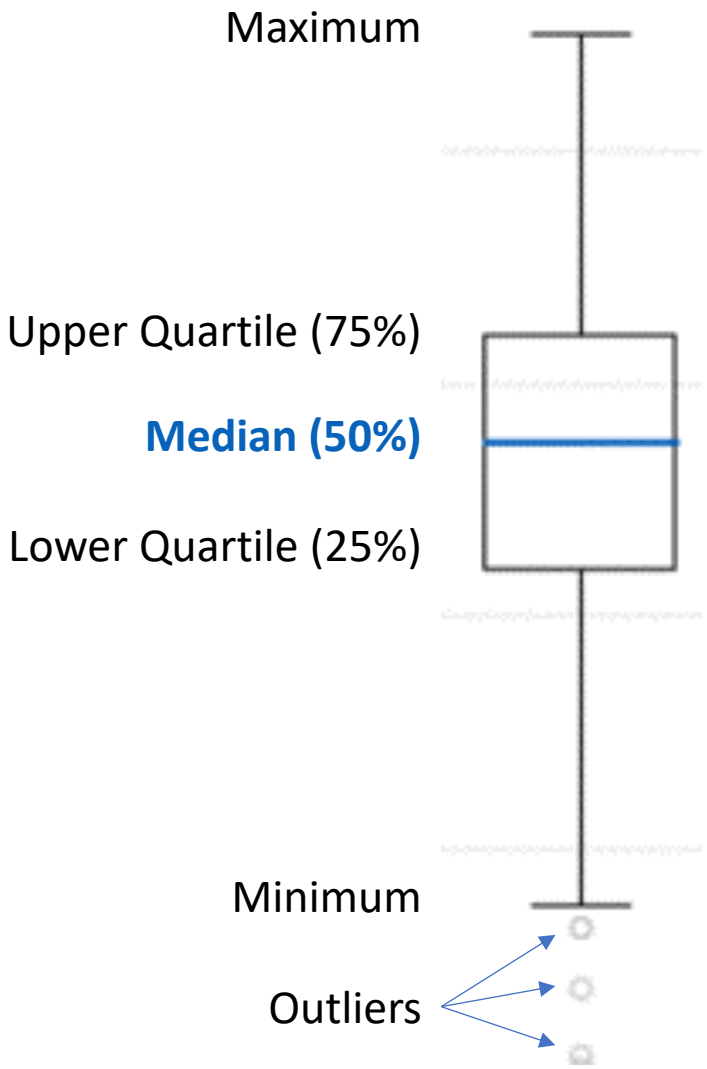
Appendix E | Some Patient's will have to travel into the ULEZ zone for their orthopaedic care

£12.50 for cars, smaller vans, motor bikes and other lighter vehicles



Source: tfl.gov.uk

Appendix F | Box plots visually show the distribution of numerical data (in this case LSOA travel time per hospital site) and skewness through displaying the data min, max. quartiles and median



Appendix G | Results of Deprivation-Travel Time Statistical Testing

Kruskal–Wallis *H* test: H-Statistic = 57.8; p <0.001

Post-hoc tests using Conover squared ranks test

Multiple Test Correction using Holm–Bonferroni method

IMD Decile (p-value)

IMD Decile (p-value)	1	2	3	4	5	6	7	8	9	10
1	1.000000	0.376064	0.009444	0.013261	0.002305	0.000377	0.011415	0.000005	0.000114	0.000004
2	0.376064	1.000000	0.809355	1.000000	0.203453	0.024201	0.943185	0.000081	0.009584	0.000398
3	0.009444	0.809355	1.000000	1.000000	1.000000	1.000000	1.000000	0.066454	0.809355	0.024975
4	0.013261	1.000000	1.000000	1.000000	1.000000	1.000000	1.000000	0.024055	0.442767	0.014730
5	0.002305	0.203453	1.000000	1.000000	1.000000	1.000000	1.000000	0.268782	1.000000	0.066454
6	0.000377	0.024201	1.000000	1.000000	1.000000	1.000000	1.000000	1.000000	1.000000	0.230952
7	0.011415	0.943185	1.000000	1.000000	1.000000	1.000000	1.000000	0.144976	1.000000	0.036235
8	0.000005	0.000081	0.066454	0.024055	0.268782	1.000000	0.144976	1.000000	1.000000	1.000000
9	0.000114	0.009584	0.809355	0.442767	1.000000	1.000000	1.000000	1.000000	1.000000	1.000000
10	0.000004	0.000398	0.024975	0.014730	0.066454	0.230952	0.036235	1.000000	1.000000	1.000000

Kruskal–Wallis *H* test: H-Statistic = 40.5; p <0.001

Post-hoc tests using Conover squared ranks test

Multiple Test Correction using Holm–Bonferroni method

IMD Decile (p-value)

IMD Decile (p-value)	1	2	3	4	5	6	7	8	9	10
1	1.000000	0.145533	0.000448	0.001348	0.000402	0.000120	0.010480	0.000470	0.000027	0.000181
2	0.145533	1.000000	0.380828	1.000000	0.342406	0.089936	1.000000	0.386361	0.020176	0.086299
3	0.000448	0.380828	1.000000	1.000000	1.000000	1.000000	1.000000	1.000000	1.000000	1.000000
4	0.001348	1.000000	1.000000	1.000000	1.000000	1.000000	1.000000	1.000000	1.000000	1.000000
5	0.000402	0.342406	1.000000	1.000000	1.000000	1.000000	1.000000	1.000000	1.000000	1.000000
6	0.000120	0.089936	1.000000	1.000000	1.000000	1.000000	1.000000	1.000000	1.000000	1.000000
7	0.010480	1.000000	1.000000	1.000000	1.000000	1.000000	1.000000	1.000000	0.624604	0.692931
8	0.000470	0.386361	1.000000	1.000000	1.000000	1.000000	1.000000	1.000000	1.000000	1.000000
9	0.000027	0.020176	1.000000	1.000000	1.000000	1.000000	0.624604	1.000000	1.000000	1.000000
10	0.000181	0.086299	1.000000	1.000000	1.000000	1.000000	0.692931	1.000000	1.000000	1.000000

Appendix 4 – Public engagement report

verve

REPORT

North West London Orthopaedic services engagement

Author: Sue Clegg and Clive Caseley

Date: July 2022

verve

CONTENTS

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EXECUTIVE SUMMARY

The North West London Integrated Care System (NWL ICS) offers orthopaedic services at eight hospitals across its patch. The orthopaedic and musculoskeletal (MSK) teams across North West London believe that waiting times - which increased due to the Covid-19 pandemic – need to be reduced, care should be more patient focussed and health inequalities need to be reduced by levelling up to provide the best standards for all patients. Using lessons learned during the pandemic and building on models in place in other parts of London, NWL ICS's orthopaedic and musculoskeletal teams have proposed changes to improve services in the future.

This engagement work, undertaken by Verve, gathered feedback on the proposed approach for improvement from people across North West London in 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.

The engagement showed that:

- People understood the need to reduce waiting lists, and were grateful work was being done to enable this. There was an appetite for change to happen quickly so that waiting lists did not continue to grow
- People did not usually understand the complexities of NHS systems
- The model proposed, including one centre for routine surgeries, was generally welcomed, however some concerns were expressed:
    - 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?

Several barriers to care were identified, including:

- Being lost in the system
- Not having face-to-face appointments especially for diagnosis and being starting physiotherapy
- The digital divide for people unable or unwilling to use technology
- Travel to and parking at hospitals
- Lack of access to therapies

For most people having a choice of where to have routine surgery (and possibly having to travel further) was less important than shorter waiting times.

Practitioners who took part in the engagement felt that the plans were too focussed on secondary care and raised concerns about whether in the future more people would be referred to them, for example for physiotherapy, as they were already having capacity problems.

Participants thought that good care needed to be timely, appropriate, co-ordinated and effective. They had further suggestions relating to interactions with clinicians, communications, continuity of care, access and taking account of people's additional needs.

Our recommendations include:

- Ensuring clarity of communications by reducing unnecessary detail, providing explanations of terminology and reducing jargon
- Being clear about how the changes will benefit all patients, not just those eligible for routine surgery
- Offer more explanation about the proposed hub, and how it will work and how and where patients having routine surgery will be offered pre and post operative care
- Explain what choices people will have
- Give more detail about care co-ordination
- In the next stage of consultation ensure the inclusion of groups who are potentially disproportionately or differentially affected by the changes, people who would be eligible for routine surgery and people from all boroughs in NWL

1. INTRODUCTION

1.1 BACKGROUND

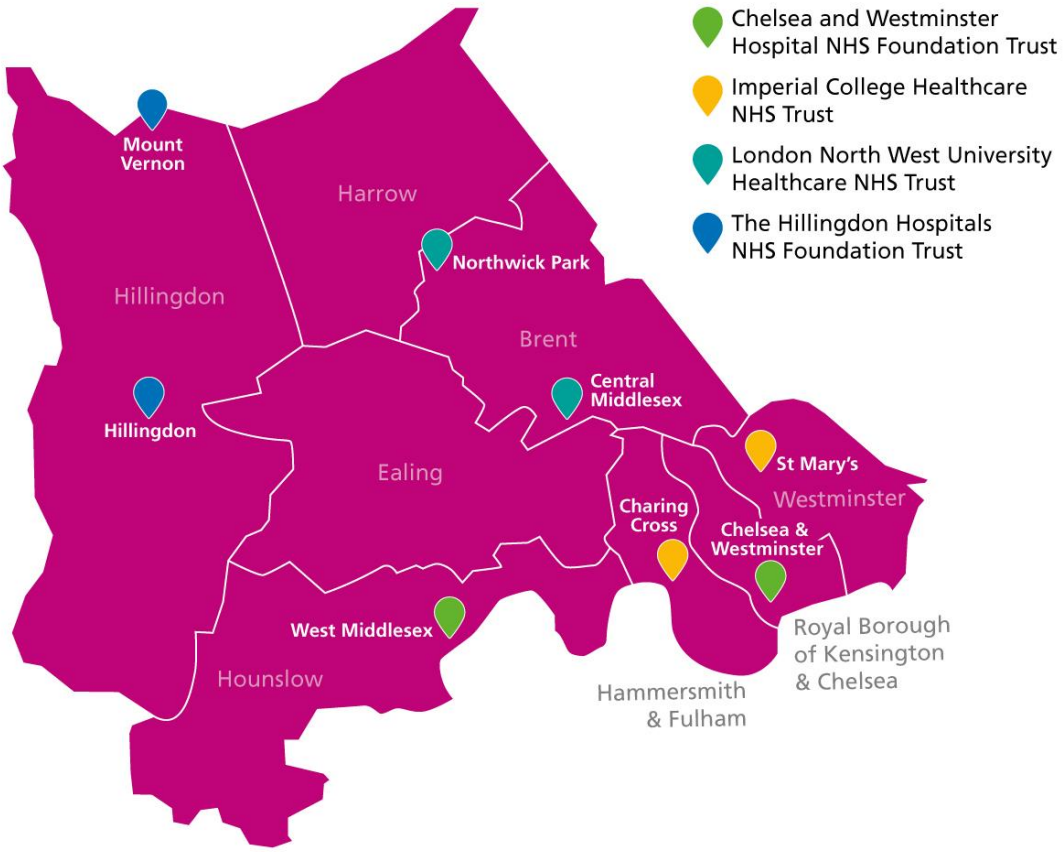
The North West London Integrated Care System (NWL ICS) covers the boroughs of Brent, Ealing, Hammersmith & Fulham, Harrow, Hillingdon, Hounslow, Kensington & Chelsea and Westminster.

Approximately 2.2 million people live in the eight boroughs.

NWL ICS provides hospital, community health and general practices services, including the following NHS acute trusts:

- Chelsea & Westminster Hospital
- The Hillingdon Hospitals
- Imperial College Healthcare
- London North West University Healthcare

Orthopaedic services are offered at eight hospitals:



Several issues led the orthopaedic teams across North West London to look at how orthopaedic services are currently delivered:

The Covid-19 pandemic had a negative impact on waiting lists for orthopaedic surgery, with more than 12,000 people currently waiting for orthopaedic care; the proportion of people waiting more than 52 weeks for care has increased by more than a quarter during the pandemic. Waiting for treatment can have adverse effects on quality of life, making it harder for people to go about their day-to-day activities. Further, conditions may get worse over time making them harder to treat and recover from.

NWL ICS is also keen to ensure that care is more patient focussed. Previous engagement revealed that patients with bone and joint problems had several concerns: frustration with long waiting times between initial assessment and surgery and when attending appointments; having to chase follow up appointments; worrying about having their surgery re-scheduled; communication problems such as lack of co-ordination between GPs and hospital services and being given confusing information; and some patients, including elderly people and those with disabilities, find travel to appointments problematic. The overall message was that patients wanted more control over their care, which they wanted to be organised in clear, consistent and straightforward ways.

NWL ICS has some excellent clinical outcomes for orthopaedic surgery, including low readmission and 're-replacement' rates for knee and hip surgery. However, this varies across the hospitals and it is known that some patients face inequalities in accessing care and have poorer health outcomes – particularly patients who are elderly, those who have disabilities, people from more deprived areas and those from Black, Asian and other minoritised groups. The aim for the future is to level up to the best standards for all patients.

To prepare for the future of orthopaedic services NWL ICS wish to reduce waiting lists, make the most of digital and other technological advances – whilst ensuring that no one is left behind, and attract and retain staff.

Using lessons learned during the pandemic and building on models in place in South West London NWL ICS's orthopaedic and MSK teams are working towards a plan to improve services in the future.

1.2 AIMS AND OBJECTIVES

The aims of this engagement exercise were to gather feedback on the proposed approach for improvement and to identify thematically any issues which need to be considered as the programme progresses.

To meet these aims the people were invited to attend two online community events, one of eight focus groups (seven online and one in person) or be interviewed by telephone. The engagement was designed to:

- Identify patient and public views on the case for change and the positives and negatives relating to a centre for routine surgery
- Understand the likely impacts of the plan, particularly on people sharing protected characteristics or otherwise at risk of health inequalities

The engagement will be used to inform the more detailed proposals for the next stage of the process to enable the development of a high-quality consultation.

1.3 VERVE

Verve is an independent full-service agency specialising in supporting NHS organisations in delivering transformation and change.

Verve was commissioned by North West London Integrated Care System to undertake engagement with people living in its patch for early stage discussions about the future of orthopaedic and musculoskeletal services. This document has been produced independently by Verve and represents our own analysis and recommendations.

We are grateful for the assistance and support of NWL ICS colleagues, the wider group of stakeholders and the residents of North West London who took part in the engagement. We would especially like to thank the community groups who helped us to recruit people to the focus groups, particularly Kensington and Chelsea Over 50s Forum[1] who arranged for a facilitator to visit a specially convened meeting to talk to some of their members and the Hear Women GarGar Foundation[2] who recruited members to fill an online focus group.

1.4 THIS REPORT

This is an independent report written by Verve.

The report describes the methodology used, the findings of the engagement and presents recommendations based on the findings. Anonymised quotations are used in the report to illustrate points made.

[1] https://www.kensingtonandchelseaforum.org.uk/
[2] http://www.hearwomen.org/

3. METHODOLOGY

3.1 ABOUT QUALITATIVE RESEARCH

This engagement used qualitative methods to ensure that people's views and experiences could be explored in detail.

The aim of qualitative research is to define and describe the range of emergent issues and to explore linkages, rather than to measure their extent. The use of qualitative methods means that we do not collect, or report, on the numbers of people holding particular views or experiences.

3.2 DESIGN

The engagement exercise was designed to hear the views of people about orthopaedic and MSK services in North Central London. Two online community events, eight focus groups (seven online and one in person) and four telephone interviews took place in June 2022. Seventy eight people took part in the engagement.

3.3 RECRUITMENT

NWL ICS compiled a list of stakeholders and community groups who were sent information about the engagement, including a flyer with a brief outline of the purpose of the work and details of how to book on to the community events (see Appendices).

Recruitment to the community events was via Eventbrite – people could connect via an URL or a QR code and book on to either of the two dates offered. Sign ups were capped at 50 per event to allow for attrition to a capacity of 40 at each event. Both events reach the cap of 50 sign ups. Some people contacted the Verve after the cap was reached and were invited to take part in a focus group instead of a community event.

Verve compiled a supplementary list of community organisations across the eight boroughs. NWL ICL emailed all community organisations introducing the project and Verve. Verve's specialist recruiter followed up with emails and phone calls inviting the community organisations to promote the focus groups and community events to their members.

Two community groups each recruited enough of their members to fill a focus group: the Kensington and Chelsea Over 50s Forum arranged a special meeting and invited a Verve facilitator to run the meeting as a focus group in person as their members could not use technology to attend online sessions; and the Hear Women GarGar Foundation recruited enough of their members to fill an online focus group. We are grateful to all who helped with our recruitment.

People who took part in focus groups and telephone interviews were offered a £20 gift voucher as a thank you for taking part.

3.4 FIELDWORK

Seventy eight people took part in the engagement in total, 36 in community events and 42 in focus groups and interviews. All fieldwork took place in June 2020. All the questions asked by participants during the fieldwork are collated in the Appendices and will be used by the NWL ICS team to formulate a set of FAQs for the next stage of the work.

Many participants said they were grateful for the opportunity to take part in the engagement – one person said:

"It's important for us to know that you are listening to us"

3.4.1 COMMUNITY EVENTS

The online community events were designed to give people the opportunity to listen to clinicians talk about why they thought change was needed to orthopaedic and MSK services, what the changes might look like and what benefits they saw the changes bringing. After the presentations the participants split into small groups, with a Verve facilitator, to give their thoughts and views; facilitators used a short topic guide to lead the discussions (see Appendices). Each small group formulated questions to take back into a final plenary session to put to a panel of clinicians. The groups were offered the opportunity to ask questions about the information they had heard in the presentations and about their own bone and joint problems, if they had any. People could also use the Zoom chat function to leave comments and ask questions. Whilst some people commented about their own bone and joint problems the questions asked all related to the information from the presentations. The community events were 90 minutes long.

3.4.2 FOCUS GROUPS AND INTERVIEWS

Eight focus groups and four interviews were help. Seven focus groups were online and 1 was face-to-face. Verve facilitators undertook all the fieldwork. Facilitators explained why change was thought to be needed, what the changes might be, and what benefits the changes could bring and used a topic guide to lead the discussions (see Appendices). The focus groups were approximately 90 minutes long. Telephone interviews used the same topic guide and lasted between 20 and 45 minutes.

3.5 ANALYSIS

Qualitative methods produce many hours of recordings from events, focus groups and interviews. In this engagement there were 2 community events and 8 focus groups of 90 minutes and four telephone interviews of approximately 30 minutes.

The researchers involved in the fieldwork used their notes and recordings to synthesise the material thematically.

At the end of the fieldwork the researchers and the analyst have a debriefing session where they discussed the main themes arising out of the engagement and any outliers.

The analyst familiarised themself with all the data and themes, looking for similarities and differences. There is constant checking between analysis and original data to check for veracity.

The report is based on the findings from the thematic analysis.

4. FINDINGS

The findings represent the views of participants analysed and presented thematically. Where particular types of people held a view, or where there are outlying views we make clear how and why they differ.

4.1 THE NEED FOR CHANGE

4.1.1 UNDERSTANDING THE NEED FOR CHANGE

People understood that waiting lists had increased during the pandemic and that there was a need to reduce them; they welcomed the work being done to enable this to happen. There was a call for the proposed changes to happen quickly so that waiting lists would start to reduce sooner rather than later.

More people expressed positive opinions about the potential changes than Verve have seen in similar engagement exercises.

People were positive about the idea of centralised provision of routine orthopaedic care, saying that it was a good way of maximising staff usage and developing clinical expertise. One participant said:

> *"It seems a good idea to centralise it so that everything gets fed in to one area and can be dished out with shorter waiting lists, because otherwise it's only going to get worse and at the moment I just can't see that it can carry on the way it is"*

For many people having a shorter wait for surgery outweighed any inconvenience of travelling to a hospital further from their home.

4.1.2 CONCERNS EXPRESSED

Some concerns were raised about having to travel further for surgery by people who would have longer or more difficult journeys, for example a group of people from Kensington & Chelsea worried about how they would get to Central Middlesex Hospital. However, this group was mainly made up of older people, some with complex health problems, who would be unlikely to be offered 'routine' surgery, and some could see the benefit for other people.

Parking at Central Middlesex Hospital was deemed to be bad, including for blue badge holders, and concerns were expressed about how people would get there if they could not use public transport.

Some people questioned whether the waiting times for physiotherapy would be reduced, as well as the waiting times for surgery.

Concerns were expressed about whether the plans could result in a two tier system on two counts: questions were asked about whether patients having routine surgery would be fast tracked to the detriment of people with more complex needs; and people worried that a move to more digital and technological systems would leave behind people who could not interact in this way.

4.2 BARRIERS TO CARE

4.2.1 BEING LOST IN THE SYSTEM

Generally people who had experience of secondary care praised it highly. However, people said that the pathway to getting secondary care was problematic. Many described a disconnect between GPs and other services – with difficulties getting referrals to physiotherapy, occupational therapy and secondary care. A participant said:

> *"There's no proper line of communication between the GP and the hospital and it just leaves you in the dark"*

Many people had experienced poor co-ordination of services and being 'left in limbo', not knowing where they were in the system, and not knowing to whom they could talk to progress their treatment or to find out what was happening. A participant said:

> *"Just being discharged home from one borough to another, the communication isn't good. Things take time to be connected and people can sometime wait 2-3 weeks for a physio"*

One participant wrote their own care plan and visited each team involved in her care, copying all of them into emails because there had been no communication between the teams until the patient took control.

People had also experienced long waits between appointments, again, meaning that they felt lost in the system.

4.2.2 THE IMPORTANCE OF FACE-TO-FACE APPOINTMENTS

For many people not having face-to-face appointments was a concern. Some had experienced being diagnosed with a bone or joint problem over the telephone and had been given physiotherapy exercises by phone or email. This led to worries about whether diagnoses were correct, whether exercises were being done properly or could be doing more harm than good. A participant who had been diagnosed in a telephone call said:

> *"On the basis of the phone call, I got sent some exercises, which then I had to log on online to get to. I just wanted an email with some exercises, but more than that, not seeing someone f2f is worrying"*

For most people having a face-to-face appointment for diagnosis and initial physiotherapy sessions was desirable and increased their confidence that they were getting the right care. A participant said:

> *"If it means either constantly waiting in the unknown or somebody doing something, to physically see somebody, I'd hire a jet. I'm prepared to do whatever it takes for someone to actually look at my knee, rather than try to describe it over the phone to a GP"*

4.2.3 THE DIGITAL DIVIDE

Some people liked the idea of having access to information about their condition and their patient journey in an app or by other digital means. When Joint School was explained during the community events several people thought this was a very good idea and would overcome the feeling of being lost in the system. However, many people were anxious about care being

provided remotely or digitally for a variety of reasons: some people did not have access to the internet, nor a smart phone; some people were not confident of their abilities to use apps or technology generally, even if they had the means to do so; people who were blind or had vision impairments were concerned about whether apps or other offers would work with their technology such as screen readers; and some people simply did not want to engage digitally.

For people who could not, or did not want to, engage digitally there was a fear that online services would replace face-to-face services, and this was seen as unacceptable. For these participants there was a view that being directed to digital services was being 'fobbed off'. Many of the participants who felt they could not engage digitally were older people, but there were also concerns from some people for whom English is not their first language. One person said:

"I feel we're being brushed off to the far corners"

4.2.4 TRAVEL TO CENTRAL MIDDLESEX HOSPITAL

It should be noted that many of the people who took part in the engagement were unlikely to be offered routine orthopaedic surgery at Central Middlesex Hospital as they had co-morbidities; during all sessions there were explanations about the hub being used for routine surgery for people who were very unlikely to need more than a minimum hospital stay, consequently, some views about travel relate to problems for people with disabilities and co-morbidities.

People who knew Central Middlesex Hospital said that parking is bad and felt that this would need to be improved. There were also concerns about getting to the hospital by public transport, and participants pointed out that people with bone and joint problems can find walking difficult, so proximity to public transport was important. A participant said:

"The problem is when you have got bone and joint pain, transport is difficult, walking is difficult"

People who had used patient transport for hospital appointments reported several problems, for example, transport arriving on time – or being very early and then having a long wait at the hospital, or not turning up at all. One person had experienced difficulties because she was a wheelchair user – she had once been refused patient transport because of her wheelchair and at other times she had been 'tied' into the front seat – she said:

"They tie me up like a fly in a spider's web. I had to travel in the front seat like that and was crying with pain"

4.2.5 LACK OF ACCESS TO THERAPIES

There were some concerns expressed about whether there would be sufficient aftercare if people are discharged from hospital very soon after an operation – people asked whether services such as physiotherapy would be able to cope with the proposed changes.

People thought that free or reduced cost gym memberships should be available for people with bone and joint problems, saying that this would encourage people to do their physiotherapy exercises and possibly become generally fitter. There was a perception that there was a lack of gym facilities for older people.

Some women prefer women only sessions in gyms and swimming pools, and participants reported that there were very few of these available. Women from some ethnic backgrounds found this particularly problematic.

4.2.6 ACCESS PEOPLE WITH DISABILITIES

Wheelchair users reported that waiting areas and consulting rooms were often too small for wheelchair users – they might be able to get into a consulting room but they could not manoeuvre their chair once in there. Waiting areas were too small, particularly if there was more than one wheelchair in there at a time. Beds and examination couches often did not go down far enough for wheelchair user to transfer onto them. There was a lack of hoists, for example, for people needing MRI scans.

People with vision impairments said their needs were often not taken into account by healthcare professionals – for example they might need more time in an appointment. People said that if they needed support to find their way in hospitals they sometimes had to wait too long to be assisted to their appointment.

People with vision impairments who use assistive technologies on their smartphones or other devices sometimes find that health related software is not compatibly meaning they cannot use the apps etc.

4.2.7 OTHER CONCERNS

Participants did not like going to clinics where all patients had been given the same appointment time, saying that it led to long wait times in clinics and very busy waiting rooms. This was thought to be for the benefit of the providers rather than the patients, and there was a call for a more patient-centred approach. One patient said:

> *"They say patients come first and yet they say everyone come in at the same time because it's more convenient for them. They ask everyone to be there at 7a.m. If you come from further afield you'd have to get up at 3a.m."*

Some people expressed a concern that if they made a complaint their care would be compromised, meaning that they either did not make a complaint or they waited until their care was over. They were not reassured by information from hospitals and care providers about complaint handling procedures and felt that there was a need for an independent moderator to ensure a more arms' length approach.

People with extra needs, including disabilities, co-morbidities, caring responsibilities and language needs thought that the system in general needed to support them better, not least by finding out at the beginning of their patient journey what their needs were and accommodating them as much as possible throughout their care.

Patients sometimes felt that hospitals did not have enough time to properly involve them in their own care, which led to people feeling that they were not able to discuss care options or be part of the decision making process.

4.3 PATIENT CHOICE

The potential changes to orthopaedic and MSK services in North West London would see routine surgery offered on one site only, at Central Middlesex Hospital, rather than across eight hospitals across the patch as it is now. Participants discussed whether effectively reducing their choice of where to go for routine surgery in this way was a problem. Generally people did not consider a lack of choice of location for routine surgery to be a problem, saying that a reduction in waiting times and other benefits such as very experienced clinical teams outweighed not being able to choose a hospital, possibly one closer to home.

Some people wondered whether there would be other opportunities for choice, for example, choosing which consultant or surgeon they would see if they were referred to the hub. For some participants this would be important, and they would like to have information about clinicians to enable them to make a choice.

People who had had surgery in the past said they would prefer to go to hospitals where they had already received care from, saying that they thought the clinical teams would understand their condition better and there would be continuity of care. For some people treatment in familiar surroundings was important and was likely to lead to them feeling they had some control over their care.

Participants with complex needs also preferred to have care in familiar surroundings, where they had been seen before, whether for orthopaedic/MSK care or for other conditions. Again, there was a perception that continuity of care would be better, their patient records would be readily available and clinical teams would understand their conditions and needs. A participant said@

> *"Continuity is very important, having someone who understands you, your history, your pain, who knows whether things are changing over time. You get tired of telling your story all the time, you just want someone who knows you."*

For many people it was important to be able to choose whether they used technology or not – even if they had the means to do so. Many older people did not want to be made to embrace technology to access care and felt that they would almost certainly miss out in some ways if this happened – for example, by not being able to use apps, respond to messages or download exercise instructions. There was a fear that establishing technology as the way forward would create a two tier system, with those unable or unwilling to use it 'going to the bottom of the pile'. Further, views were expressed by some participants that the quality of healthcare would diminish if more were delivered digitally. A participant said:

> *"I'm wary of the drive towards using technology to replace interactions with healthcare professionals… I think this will inevitably reduce the quality of healthcare you receive"*

4.4 PRACTITIONERS' VIEWS

Information about the community events was sent to many stakeholders across North West London. Some service providers chose to attend the community events and their views about the possible changes to services are presented separately in this section.

Practitioners expressed a concern that the plans seemed to mainly relate to secondary care; they questioned how services such as physiotherapy and occupational therapy fitted into the scheme. There was a strong view expressed that there were already capacity issues for therapies across the whole pathway and they questioned what would be done about this as at the moment most cases practitioners saw were complex, adding in routine patients for after-care would increase their workload. One person said:

> *"I think they may have a rose-tinted opinion of what we can offer in the community. There's a lot of stress in the system currently. A lot has to happen prior to a patient getting to the elective hub and that needs to be looked at"*

Questions were raised about whether GPs had a good understanding of alternatives to surgery, with practitioners expressing the view that a lack of understanding led to patients being pushed towards a surgery pathway as a default.

Practitioners thought that polyclinics were needed to give access to a variety of services such as mental health, obesity clinics, exercise and therapies. Further, practitioners were of the view that there was need for primary and secondary care to work more closely together.

4.5 WHAT GOOD LOOKS LIKE

People discussed what good care looked like.

4.5.1 TIMELY, APPROPRIATE, CO-ORDINATED AND EFFECTIVE

The most important things people identified were that care should be timely, appropriate, co-ordinated and effective. That is, waiting times should be as short as possibly, they should be referred to appropriate services, care should be co-ordinated by providers and the outcomes of care should be good.

Other elements which contributed to good care were:

4.5.2 INTERACTIONS WITH CLINICIANS

- Face-to-face appointments, especially at the time of diagnosis and first appointments with physiotherapists to ensure patients understand what they are being asked to do, and are doing exercises correctly
- Clinicians working with patients to include them in decisions about care – and taking time to explain care to patients, and listening to concerns and complaints
- Good communications between clinicians and with patients
- Being treated with respect and in a friendly way

4.5.3 COMMUNICATIONS

- Being kept informed about what is happening – and understanding what the care pathway is
- Clear, jargon free communications

- Easy to use and easy to understand systems, for example, how to reschedule appointments
- Having systems in place so patients do not have to explain their conditions and circumstances at each appointment

4.5.4 CONTINUITY OF CARE

- A holistic approach from diagnosis onwards, with support all along the care pathway
- Continuity of care – by seeing the same clinicians at appointments
- Pain management should be offered whilst people are waiting for operations

4.5.5 ACCESS

- Good access, including public transport links and good parking – including for people with disabilities. It was suggested that a shuttle bus could operate between hospitals to alleviate travel issues and higher travel costs
- If travelling further for surgery pre and post operative care should be close to home
- Having good information about how to get to hospitals, how parking works – including costs and how payments are made, and transport routes – including proximity of stations and bus stops

4.5.6 ADDITIONAL NEEDS

- Ensure that additional needs are understood and accommodated, for example, checking whether people with vision impairments can use apps and other technology with screen readers and other assistive devices

5. DISCUSSION AND RECOMMENDATIONS

People tended to be supportive of the plans outlined in the engagement, and welcomed the work being done to reduce waiting lists – there was an appetite for change to happen quickly. There was a relatively positive response to the idea of a centre for routine planned surgery. Some concerns were expressed about the disconnect along the current pathway, including difficulties getting referrals and being 'lost' in the system – and people hoped a new system might sort some of these issues out. A strong negative response was heard from many people about the over-reliance on digital technologies. Some fears were expressed that the plans could result in a two tier system on two counts – if routine cases are fast tracked for care to the detriment of more complex cases and people being left behind if they could not use technology.

Generally people did not understand the complexities of NHS systems, and often found explanations of how they work confusing – this included which Trusts provide care, what primary and acute care was, who commissioners were, the acronyms used, how systems worked together and why some care appears to be delivered by private providers. It is important to note that for many people understanding the intricacy of the system is far less important than being in receipt of good care – as discussed above the most important elements identified as crucial to good care were that it is timely, appropriate, co-ordinated and effective.

We recommend that for the next stage of the process the NWL ICS team consider the following:

- Ensure that communications are jargon free – including:
  - Clarify what 'routine' surgery is
  - 'Elective surgery' was not understood – consider 'planned surgery' and explain the difference between planned and emergency surgery
  - Explain what musculoskeletal service are

- The case for change document will give a lot of detail about who is involved in the system, how they will work together, financial considerations etc. Assuming this will be available to the public if they wish to read it, consider how much of this sort of detail is needed in the engagement sessions

- Explanations should be provided for terms including:
  - Primary care
  - Acute care
  - Secondary care

- Be clear how the changes will benefit ALL patients, not just those eligible for routine surgery at the hub – explain how people with more complex needs will get their care, and whether there will be any changes directly affecting them

- Explain in more detail why the hub would be sited at a hospital without an A&E

- Explain what will happen if something goes wrong during a routine surgery – how will patients receive extra care they need? For example, would they be taken by ambulance to another hospital?

- Explain in more detail how and where patients receiving routine surgery at the hub will receive pre and post operative care

- Explain whether/where patients will be able to make choices – for example, will patients be able to choose which surgeon they see?

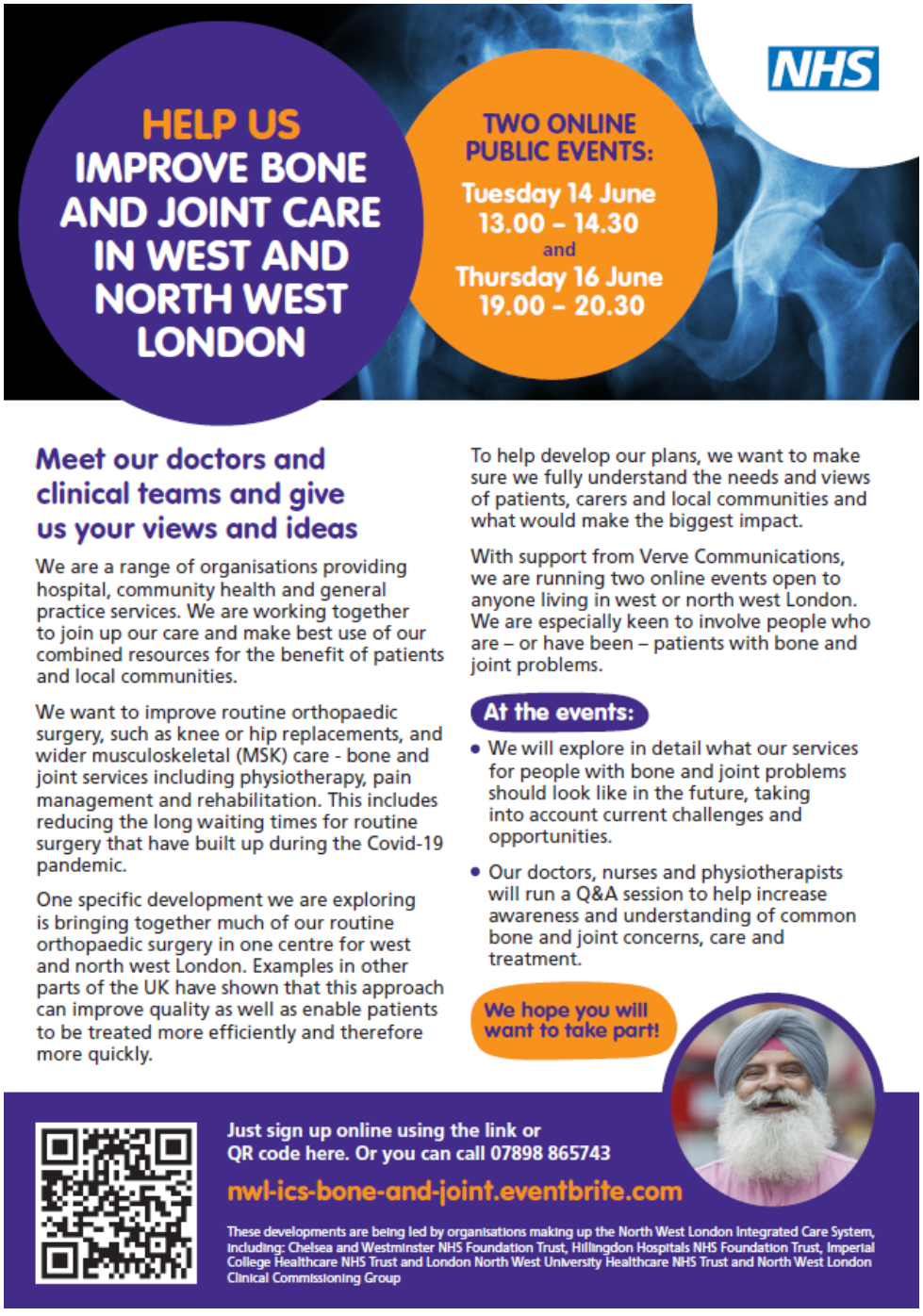
- Explain in detail how care will be co-ordinated between different clinicians and hospitals

- In the consultation stage ensure the following groups are included:
    - Groups potentially differentially or disproportionately impacted, for example transgender people taking hormone therapies and people with some types of disabilities
    - People who would be eligible for routine surgery
    - People from all the boroughs in NWL

6. APPENDICES

6.1 FLYER

This flyer was sent to contacts across North West London by the NWL ICS team, including colleagues, other service providers and community contacts.



6.2 DEMOGRAPHICS OF PARTICIPANTS

Participants were asked to fill in a short online form to collect anonymous demographic data. Seventy-eight people took part in the engagement. Thirty-three filled in the demographic survey. The findings from the survey were as follows:

Boroughs people lived in:

Brent	4
Ealing	4
Hammersmith & Fulham	9
Harrow	0
Hillingdon	0
Hounslow	0
Kensington & Chelsea	7
Westminster	9
Other	0

Age groups:

18-24	0
25-34	1
35-44	4
45-54	4
55-64	7
65+	17
Prefer not to say	0

Gender:

Female	23
Male	10
Transgender	0
Non-binary	0
Prefer not to say	0
Other	0

Gender the same as the sex assigned at birth:

Yes	30
No	1
Prefer not to say	2

Sexual orientation:

Heterosexual	26
Lesbian	0
Gay	0
Bisexual	0
Prefer not to say	4
Other	1
No answer	2

Ethnic background:

White	21
Mixed	0
Asian or Asian British	5
Black or Black British	4
Prefer not to say	0
Other	1
No answer	2

Disabilities or long term health conditions:

Yes	21
No	9
Prefer not to say	3

Disabilities or long term health conditions – type:

Physical disability	16
Speech impairment	0
Mental health condition	9
Blind or impaired vision	0
Deaf or hard of hearing	3
Wheelchair user	6
Learning difficulties	0
Prefer not to say	6

NB: people could choose more than one category so adds to more than 33

Marital or civil partnership status:

Married	12
Registered civil partnership	0
Never married/registered civil partnership	10
Divorced	2
Separated	0
Widowed	4
Prefer not to say	4
No answer	1

Religion:

Atheist	0
Buddhist	2
Christian	13
Hindu	0
Jewish	2
Muslim	7
Sikh	0
No religion	6
Other	0
Prefer not to say	3

6.3 RESEARCH MATERIALS

6.3.1 TOPICS DISCUSSED IN COMMUNITY EVENT BREAKOUT GROUPS

The breakout groups in the community events discussed the presentations they had heard in the opening plenary group.

Facilitators in the breakout groups guided the discussions around:

- The case for change
- The opportunities which changes could bring
- Views on a centre offering routine orthopaedic care
- Participants' views on what good care looked like.

In the final part of the discussion participants agreed on questions to be asked in the final plenary.

6.3.2 TOPICS DISCUSSED IN FOCUS GROUPS AND TELEPHONE INTERVIEWS

Facilitators briefly explained why change was considered necessary and what the future services might look like. Participants then discussed the following topics in relation to current and future services:

- What good care looks like and what affects people's viewpoints, including their own experiences of what worked well and what could be improved
- Patient choice, and views about one site offering routine orthopaedic care
- Views on travelling, including potentially travelling further for surgery, and what could make things easier for people
- Barriers and enablers in accessing healthcare

6.4 QUESTIONS FROM PARTICIPANTS

This section brings together the questions participants asked in the community events (in breakout groups, plenary sessions and Zoom chat) and in the focus groups. The questions are grouped under themes.

About the model

- How many people will benefit from this?
- What are the criteria for 'routine' surgery?
- Will people be able to choose which surgeon they see?
- Is this project able to carry the clinicians forward to the hub as some might be reluctant to move?

About the pathway

- What will the new pathway look like? How will it be any different/better than the current pathway? Will it be any quicker?
- Will the pathway mean quicker access to care?
- Where will people's first appointments be?
- What kind of emergency care would be available if there were difficulties with routine operations?
- Where will aftercare happen, including rehab?
- Will community physio/OT pilots continue?

About the hub

- Do you think these hubs will reduce the length of stay post-operatively and how will you accommodate this if there are complications – e.g. illness, DC planning, step down care etc? What impact will this have on patient flow if patients end up staying longer to recover?
- Has there been follow up with people who participated in the 'trial' hubs during the pandemic? How satisfied were they, what was the recovery time post-surgery, what was the impact on quality of life?
- Will Central Middlesex Hospital be the hub for ALL MSK?
- Will patients with complex/multiple conditions be seen at the hub?
- Will car parking at Central Mid improve? It is terrible at the moment.

Co-ordination along the pathway and across the system

- Will the care pathway be co-ordinated by SPOC to prevent the patient having to co-ordinate their own care pathway?
- How do you foresee this pathway working with a multitude of different providers across NWL from start to finish of the patient journey given the complexity of the system?
- How will discharge planning work across so many boroughs?
- How will you ensure good communication, including image sharing, between different service providers?

About the programme and implementation

- How will the plans be implemented?
- What are the next steps in the process?
- What are the timelines for getting this up and running?
- How long will it take to set up the new system? When will it happen?
- How soon will the new hub be set up? (The faster the better)
- Do you see a role on Health and Wellbeing boards?
- Will there be pilots for the plans? If so, how will they be implemented? Where will it start? Will it be an iterative process so that you can learn from the pilot?

About resources and finance

- How will this be financed? Where are resources coming from? How is it being set up?
- How much will all this cost?
- How will this hub be achieved on an operational level? Are they taking staff away from existing hospitals?
- If people are fast tracked it creates more demand on physio and OT services as more people will be going through the system – does the current system have capacity?

Support along the pathway

- Is there opportunity for pre-habilitation e.g. physio exercises before surgery to maximise the chance of fast post-op recovery?
- How will you monitor whether people are doing physiotherapy correctly if they have been given exercises by email or over the phone?
- Hackney has a service with a paramedic in a car, could something like this be adapted in North West London for post operative orthopaedic surgery?
- Could you provide free limited gym membership for people to do physiotherapy exercises – in the past there was a scheme for people with arthritis.
- What role will social prescribing have?

Condition-specific questions

- Will gait analysis be available?
- How is osteoporosis part of the plan?
- Can joint replacements be made to last longer?
- Will special equipment on loan be available to all patients?
- How will people with complex conditions fit into the plan – what will the hub do for them?
- In France they offer pelvic care during childbirth – why does this not happen here?
- Can they put a hydro-therapy pool in the Middlesex?

Communication and clarity

- Will the new pathway be transparent so that patients know where they are on the pathway and what to expect will happen next?
- At the moment everything is called a hub – it doesn't mean a lot because there is a lot of confusion

About access

- How is access for people with disabilities, such as parking, going to be managed?
- How will people with hearing impairments be able to access care?
- Will there be fewer remote diagnoses, for example, over the phone?
- I hope you can take feedback seriously because at the moment the system is a rollercoaster.

About technology

- Will there be opportunity for more face-to-face contact with clinicians than there is currently – especially for diagnosis and monitoring?
- How will you work with people who do not have internet connection or smart phones? It looks as though a lot of care will be on mobile apps.
- Paramedics have apps on their tablets which allow them to scan a patient – will this type of facility be available in primary care?

Appendix 5 – Consultation brochure

PUBLIC CONSULTATION

Improving planned orthopaedic inpatient surgery in north west London

The four acute NHS trusts in north west London have come together to propose a new way of organising planned orthopaedic (bone and joint) inpatient surgery for adults. Our aim is to improve the quality and efficiency of orthopaedic surgery so that we can provide better care, to more people, more quickly and more fairly.

Find out more and tell us what you think
Closing date for feedback is Friday 20 January 2023

Proposal developed by
NHS North West London
Acute Provider Collaborative
Supported by
NHS North West London

Contents

Extra support to use and understand this consultation document

We have produced a summary of this consultation document, also available in large-type and easy read versions. You can get these from our website. If you would like a printed copy sent to you, a braille or audio version, or a translation into another language, please contact the consultation team on nhsnwl.eoc@nhs.net

Overview

Our response to the Covid-19 pandemic has shown just what can be achieved when we work more collaboratively, joining up our care and making the best possible use of our combined expertise and resources.

One of the ways we were able to maintain more planned care during the later phases of the pandemic was by establishing 'fast track surgical hubs'. These were facilities within our 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 our emergency services.

As we come out of the pandemic with long waiting lists and many other challenges, we want to draw on best practice and go further with our improvements. We want to bring together much of the routine, inpatient orthopaedic surgery for the population of north west London in a purpose-designed centre of excellence, completely separated from emergency care. Evidence built over many years shows that when this type of surgery is done frequently, in a systematic way, there is an improvement in both quality and efficiency.

Clinicians and managers from across the four acute trusts have worked with GPs and other colleagues, as well as with patients and lay partners, to develop a detailed proposal for an 'elective orthopaedic centre'– orthopaedic services have some of the longest waiting times in north west London. We now want to share this proposal with as many patients, local residents and staff as possible, to hear your views and ideas so that we can continue to improve health and healthcare with – and for – our local communities.

Dr Roger Chinn

Chair of the North West London Elective Orthopaedic Centre Programme Board

What is planned orthopaedic inpatient surgery?

Orthopaedic surgery treats damage to bones, joints, ligaments, tendons, muscles and nerves (the musculoskeletal system). Patients may be referred to an orthopaedic surgeon for a long-term condition that has developed over many years, such as osteoarthritis.

Hip and knee replacements are the most common type of orthopaedic surgery offered in the NHS. However, other types of surgery of the hips, knees, shoulders, elbows, feet, ankles and hands are also types of orthopaedic surgery.

Planned surgery is when patients have their operation booked in advance. It is generally arranged after a referral to hospital by a GP or community service followed by an assessment by hospital specialists in an outpatient clinic. It is sometimes called 'elective' or 'non-emergency' care.

Inpatient care describes when a patient stays in hospital while receiving medical care or treatment.

About this consultation

We are holding a public consultation between Wednesday 19 October 2022 and Friday 20 January 2023 to get feedback on our proposal. We want to connect with as many people as possible across north west London, ensuring everyone has the chance to find out more, share their views and possibly get involved in the project.

The proposed change could affect anyone who needs inpatient orthopaedic surgery in the future, who lives in one of the eight boroughs of north west London or in a neighbouring area and who might be a patient in one of the hospitals involved in our proposal. If the proposal goes ahead, there would be a change to where and/or how surgery would take place for around 4,000 adults per year.

To inform our decision-making, we would welcome feedback from anyone with an interest in these services, including:

- Anyone who is currently having or has had planned orthopaedic surgery
- Anyone currently on our waiting lists for orthopaedic surgery or who might need these services in future
- Families and carers of people who use, have used or might use these services
- Residents of Brent, Ealing, Hammersmith and Fulham, Harrow, Hillingdon, Hounslow, Kensington and Chelsea, Westminster and neighbouring areas who might use hospital services in north west London
- Staff and professional representative bodies such as trade unions, local medical committees and Royal Colleges
- Community representatives, including the voluntary sector
- Staff and partners in health and social care
- Local authorities.

By inviting people to take part in the consultation we want to understand whether:

- We have developed the best possible solution to the current challenges in providing planned orthopaedic surgery in north west London
- We are doing all we can to ensure that services are of the best quality
- We are doing the right things to ensure everyone who needs care can access it in a timely way
- There are more things we could do to make services responsive and tailor them for those with specific needs
- You have any alternative proposals, and what they are

There are several ways in which you can give your views during the consultation on pages 24–25.

Responsibility for this consultation

The Integrated Care Board in North West London is called NHS North West London. It is the statutory NHS organisation responsible for developing a plan that meets the health needs of the local population, managing the NHS budget and arranging for the provision of health services in north west London. They – and NHS England London – have given the go ahead for this consultation following a review of a 'pre-consultation business case' developed by the North West London Acute Provider Collaborative. The pre-consultation business case provides much more detail on the elective orthopaedic centre proposal – it is available on the collaborative's website: nwl-acute-provider-collaborative.nhs.uk/eoc

The North West London Acute Provider Collaborative is made up of the four acute NHS trusts in north west London – Chelsea and Westminster NHS Foundation Trust, The Hillingdon Hospitals NHS Foundation Trust, Imperial College Healthcare NHS Trust and London North West University Healthcare NHS Trust. They are independent organisations but make strategic decisions together to help share best practice, use resources in the best way for all patients, and develop consistently high quality services. In total, they manage 12 acute and specialist hospitals as well as some community-based and online services.

The North West London Integrated Care System brings together all health and care organisations in north west London. It covers the eight boroughs of north west London (see the map to the right).

Next steps after the consultation

After the North West London Acute Provider Collaborative has considered everyone's views on the proposal, they will produce a consultation outcome report. This will be used to develop a 'decision-making business case'. NHS North West London will then consider the decision-making business case and its recommendations in order to decide whether to implement the proposal, update the proposal or find an alternative solution.

Our proposal

Our ambition

We want to bring 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, 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 operation 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 operation.

Patients would have better outcomes, experience and follow-up.

In addition, capacity created in other north west London hospitals by bringing together routine surgery in the elective orthopaedic centre would be able to be used for surgical patients who have more complex needs and for other specialties.

Why are we suggesting changes to orthopaedic surgery?

We need to reduce our waiting times

The Covid-19 pandemic has had a big impact on waiting times for planned care across the entire NHS, particularly for orthopaedic care, which accounts for more than a quarter of all surgery nationally.

In August 2022, more than 15,000 people were waiting for orthopaedic care in north-west London hospitals. Just under 3,700 of these people had had their initial assessment and were waiting for an operation. The proportion of people waiting more than 52 weeks for orthopaedic care has increased by more than a quarter during the pandemic. Even though procedures like hip or knee replacements are not usually considered to be time critical, waiting for treatment can badly affect your quality of life and many conditions can worsen over time, making treatment and recovery harder.

We need all our care to be consistently of the highest quality

Performance against national indicators for clinical outcomes and patient experience in northwest London is amongst the best, for some measures in some trusts. But there is much room for improvement in all trusts and a lot of unnecessary variance between trusts. North west London hospitals are in the bottom half for many quality measures when ranked against all NHS trusts in England.

Hospitals in north west London also perform relatively poorly in terms of cancellation rates for orthopaedic operations. This is related to the impact of urgent and emergency care pressure at hospitals that provide planned, urgent, and emergency care. And there is also wide variation across our trusts in terms of how well our operating theatres are used, including how much unnecessary ‘down time’ there is between operations.

We need to make our care more patient focused

Though we generally get positive feedback from patients that our staff are caring, kind and helpful, they are much less positive about their experience of navigating the healthcare system. Patients have reported frustration with long waiting times between their initial assessment and surgery or while attending their appointments, having to chase up their follow-up appointments or feeling worried due to re-scheduling or cancellations.

Elderly or disabled patients often say travel to appointments is a problem. Patients also highlight communication problems, such as lack of coordination between GPs and hospital services or confusing information. Patients say they want more control over their care and they want us to organise our care system so that it is as clear, consistent and straight forward as possible.

We need to help improve health and reduce health inequalities

Musculoskeletal (MSK) disorders are the third leading contributor to the burden of disease in Greater London. MSK conditions are one of the most common long-term health conditions for the most deprived 20 per cent of the population. While many of the ways to prevent and limit the impact of MSK disorders sit outside the control of acute hospitals and even the wider NHS, improving orthopaedic surgery would particularly help older patients and patients from more deprived backgrounds.

We need to be prepared for the future

If we do nothing, our waiting lists will continue to grow faster than our capacity to provide care. By 2030 we expect the number of people waiting for orthopaedic surgery in north west London will increase by almost a fifth if we continue as we are now.

We also want to make sure we make the most of digital and other technological advances, without leaving anyone behind.

And it’s really important that we continue to attract and retain great staff who love their jobs, and to continue to build their skills and expertise.

How would services change?

All or some elements of planned orthopaedic surgical care are currently provided in nine hospitals in north west London. There are many differences between the hospitals. Some have A&E departments and intensive care units and special types of operating theatres and so are suitable for more complex types of surgery and for operations on patients with more complex needs. These hospitals are also more affected by urgent and emergency care pressures. Other hospitals have more dedicated day-case surgery facilities, suitable for less complex surgery.

Currently, where you go if you need orthopaedic surgery depends to a large degree on where you live and whether you have any preferences. But the complexity of your needs and the surgery you require also have an impact. For example, if you have a number of other health problems which means you are at more risk from surgery, you will need to have your operation at a hospital with more intensive after-care services. The map shows which hospitals provide which types of planned orthopaedic surgical care.

Current provision of planned orthopaedic surgical care in north west London

Proposed provision of planned orthopaedic surgical care in north west London

The proposed elective orthopaedic centre would bring together most 'routine' orthopaedic inpatient surgery for patients who are otherwise generally well – an example of what is known as 'low complexity, high volume' surgery. There are around 4,000 operations of this type in north west London each year. Evidence built over many years shows that when this type of surgery is done frequently, in a systematic way, there is an improvement in both quality and efficiency.

Outpatient care (including pre-operative assessment and post-operative rehabilitation and follow up) would continue to be provided as and where it is now. And day case and complex surgery would continue in the hospitals where they are provided currently.

If a patient can have their operation at the elective orthopaedic centre, their end-to-end care would remain under the surgical team based at their 'home' orthopaedic hospital. Their 'home' surgical team would travel with them to undertake the surgery, supported by the centre's permanent clinical support team and an electronic patient record system that is shared by all the hospitals in north west London. This would help provide joined up care and make sure that expertise continues to be developed across the surgical teams in north west London.

How would it work for patients in practice?

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.

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.

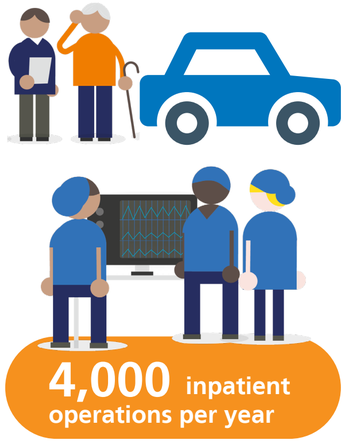
Samira has her hip replacement under the case of the surgeon from her local hospital and goes home after a short stay. She is booked in for an immediate programme of physiotherapy and rehabilitation – a mix of online and in face support at her local hospital.

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.

How was Central Middlesex Hospital selected as the proposed location and what would it mean for patients?

We assessed all of the NHS acute hospital sites in north west London (excluding the specialist Western Eye and Queen Charlotte's and Chelsea hospitals), as well as the possibility of using non-NHS sites.

A single elective orthopaedic centre at Central Middlesex Hospital was found to be the best option as:



It is a modern and high quality estate which, with some limited expansion and remodelling, could offer a 41-bed facility tailored to systematised surgery

It is one of only two hospitals in north west London that does not provide urgent and emergency care, so is much less impacted by urgent and emergency care pressures

None of the existing services would need to be moved as there is plenty of room for expansion.

Accessibility

We undertook detailed analysis of the average time to travel to each of our hospitals from all parts of north west London (see chart below).

We found that Central Middlesex Hospital has:

- The shortest median (midpoint) travel time by car at 22 minutes
- The second shortest median (midpoint) travel time by public transport at 45 minutes.

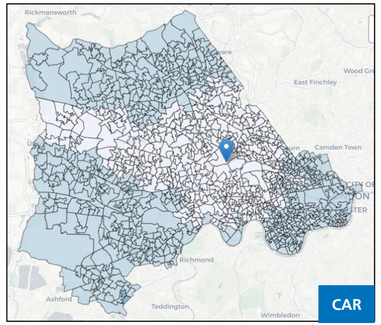
We calculate around 4,000 inpatient operations per year could be provided at an elective orthopaedic centre at Central Middlesex Hospital following a systematised 'high volume, low complexity' approach. This would enable the centre to provide routine surgery for all patients with low complexity needs who currently have these operations in north west London hospitals (see table).

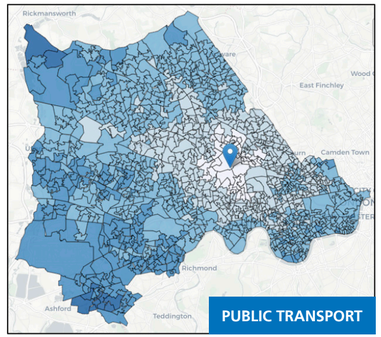
Low complexity inpatient orthopaedic operations in north west London hospitals by borough of patients (2019).

Borough	Number of operations
Brent	687
Ealing	714
Hammersmith and Fulham	333
Harrow	430
Hillingdon	665
Hounslow	381
Kensington and Chelsea	235
Westminster	244
Boroughs outside of North West London	532
Total	4,221

More detailed information on the selection of Central Middlesex Hospital can be found in the pre-consultation business case nwl-acute-provider-collaborative.nhs.uk/eoc

Travel time in minutes to Central Middlesex Hospital, from across north west London





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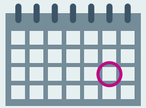
More practicalities

What services would be included in the elective orthopaedic centre?

The elective orthopaedic centre would offer only low complexity, planned inpatient surgery. Complex inpatient surgery would be out of scope, as would joint revisions (for when a hip or knee replacement needs to be repaired or replaced again) and spinal surgery. Spinal surgery in north west London is provided through a separate centralised service run by Imperial College Healthcare's neurosurgical service made up of neurosurgeons as well as orthopaedic surgeons. Children's orthopaedic surgery is also out of scope.

Day case surgery has been excluded currently on the basis that there is greater benefit from shorter travel distances on the day of surgery. Day case surgery and some complex surgery provided by London North West University Healthcare would continue at Central Middlesex Hospital as that is also one of their 'home' orthopaedic hospitals.



What are the timescales?

We have prioritised the development of this proposal in order to tackle the backlog in our waiting lists and improve the quality of orthopaedic care as quickly as possible.

After consulting with a wide range of people likely to be affected by the proposed changes, we would like to take a decision on whether or not to proceed to implementation by early 2023. If the decision is to proceed, a period for contracting and construction would follow, with the elective orthopaedic centre able to open by autumn 2023.

What works would be involved and how much would it cost?

We estimate it would cost around £9.4 million to expand capacity and make the building changes at Central Middlesex Hospital.

This includes the cost of building two additional laminar flow operating theatres, creating a larger recovery unit and remodelling some parts of the existing estate.

Benefits and challenges

Care and quality benefits

The development of an elective orthopaedic centre for north west London would help clinical teams to provide orthopaedic surgical care:

- that consistently meets national best practice standards by having greater specialisation in specific operations
- that is more efficient by taking a more systematised approach, drawing on national best practice
- that separates planned orthopaedic surgery from urgent and emergency services, in line with guidance and policy from NHS England, Royal College of Surgeons and the National Clinical Advisory Team
- that makes best use of the facilities and skills of the four acute trusts that supports surgical skills training and new role development as well as better and more flexible ways of working
- that supports continuous improvement and innovation.

Patient experience benefits

As well as improved quality of care, the proposed changes in planned orthopaedic inpatient surgery would:

- 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.

Staff benefits

While the development of an elective orthopaedic centre would require change for many staff working in this specialty, it would:

- support the development of both planned and urgent and emergency surgical skills across all the north west London teams
- allow greater specialisation in skills for staff based permanently in the centre
- support more focus on research, education and innovation
- facilitate the development of new roles and ways of working.

Challenges

We know that with any change there may be some disadvantages for some people. We think the key challenges for this proposal would be:

- some patients would have to travel further to get to and from Central Middlesex Hospital to have their operation
- some visitors would also have to travel further
- some staff would have to work in a different hospital to the one they work in now and may need to work on different sites on different days
- people with additional needs (such as those with a learning disability or dementia) could find it confusing to have their inpatient surgery in a different, possibly unfamiliar, hospital.

We are developing plans to minimise these challenges, looking at how other centres have developed solutions. For example, the South West London Elective Orthopaedic Centre, established in 2004, has a contract in place with a local taxi firm to provide transport for patients who would otherwise struggle to get there and back home. We are also very keen to get your ideas through the consultation events and survey.

We also heard concerns in our earlier discussions with patients and local communities that a greater use of digital services and apps could leave some patients behind. We are exploring potential dedicated roles for digital coaches and care co-ordinators as part of the further detailed planning for the proposed elective orthopaedic centre. Again, we are very keen to hear more views and ideas.

How the proposals could affect different communities in north west London

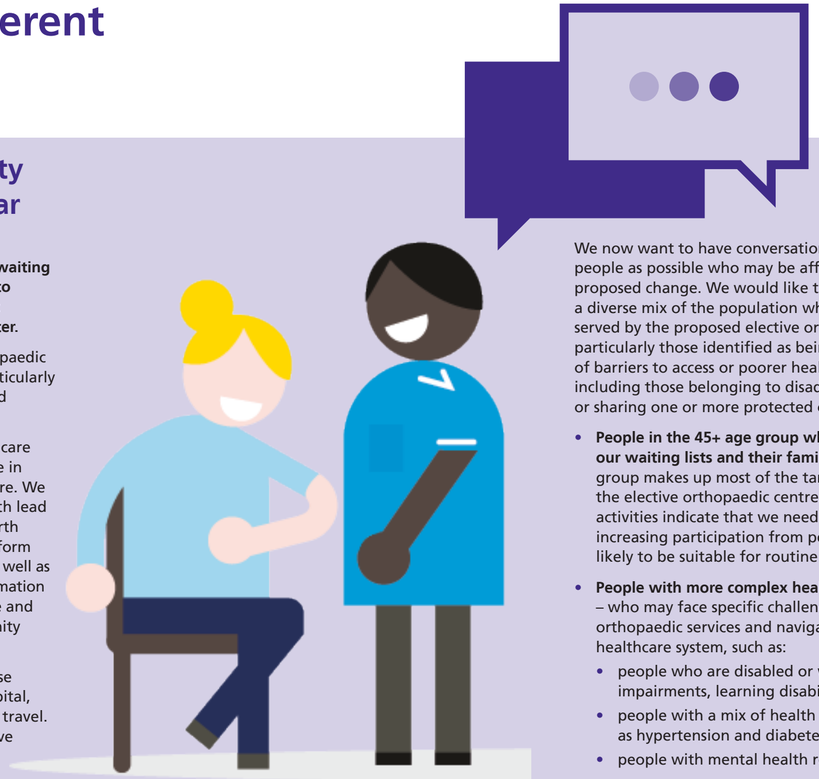
When the NHS proposes changes to services, we need to make sure we take into account the needs of everyone who uses or will use these services in future.

As part of our work in developing the proposal we have carried out an equalities and health impact assessment (EHIA) and a travel analysis and we have compiled feedback to date from patients and local communities. This includes the outcome of conversations with just over 70 people this summer about bone and joint care in north west London and some early feedback on the possibility of a dedicated centre for planned orthopaedic surgery.

What some community members told us so far

People understand the need to reduce waiting times and support work to enable this to happen as quickly as possible, even if it means travelling further to be seen faster.

- A dedicated centre for routine orthopaedic surgery was seen as a good idea, particularly as a way of maximising staff time and developing clinical expertise.
- Our patients generally praised acute care and most of the concerns raised were in relation to pathways into hospital care. We have shared these insights widely with lead clinicians and partners within the north west London healthcare system to inform how the implementation of issues, as well as informing improvement and transformation projects, such as a project to improve and standardise the provision of community musculoskeletal services.
- Some concerns were raised about ease of travel into Central Middlesex Hospital, particularly for those with further to travel. We are exploring how we can improve accessibility to the site.



We now want to have conversations with as many people as possible who may be affected by the proposed change. We would like to hear from a diverse mix of the population who would be served by the proposed elective orthopaedic centre, particularly those identified as being most at risk of barriers to access or poorer health outcomes,and including those belonging to disadvantaged groups or sharing one or more protected characteristic.

- **People in the 45+ age group who are already on our waiting lists and their families/carers –** this group makes up most of the target population for the elective orthopaedic centre. Our involvement activities indicate that we need to focus on increasing participation from people most likely to be suitable for routine surgery.
- **People with more complex health care needs** – who may face specific challenges in accessing orthopaedic services and navigating the healthcare system, such as:
  - people who are disabled or who have hearing impairments, learning disabilities or autism
  - people with a mix of health needs, such as hypertension and diabetes
  - people with mental health related issues.
- **Black, Asian and other minoritised groups** – people from minoritised ethnic groups (particularly those for whom English is their second language) are more likely to report poorer outcomes. The Covid-19 pandemic has further highlighted structural disadvantages faced by these groups. We need to make sure our plans for the elective orthopaedic centre do not deepen these inequalities.
- **LGBTQIA+ groups** – high incidences of prejudice experienced by people identifying as LGBTQIA+, including negative attitudes from healthcare professionals, may prevent individuals from accessing treatment.
- **Groups likely to incur longer travel times** – while Central Middlesex Hospital site has the shortest average travel time by car and the second shortest average travel time by public transport, there is variation in travel times for residents across the boroughs. We need to ensure we understand views on accessibility from across the sector.
- **Residents living in the most deprived areas** – deprivation can be a barrier in access to healthcare and our EHIA indicates that over a half of the north west London population are more deprived than the national average, with a particular concentration of high deprivation in the middle of the geographical region.

How would our staff be affected by this proposal?

As we move forward with public consultation, we will also be stepping up engagement with staff and partners to develop the detail of care pathways, staffing models and training and support plans for the proposed elective orthopaedic centre.

Based on what we know works well in other centres, we envision a staffing model where some staff – such as ward, theatre and administrative staff – would be based permanently at Central Middlesex Hospital. Then other staff – primarily surgeons – would move with 'their' patients from their 'home' orthopaedic care to the elective orthopaedic centre to undertake the surgery.

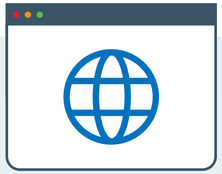
If the proposal is taken forward, we would undertake a formal consultation with the staff who are affected. Other types of planned orthopaedic care will continue at all hospitals that currently provide planned orthopaedic care and so we would continue to need orthopaedic staff in these hospitals.

Evidence used in developing our proposal

Evidence in the UK and around the world shows that undertaking 'high volume, low complexity' surgery in dedicated centres, in a systematised way with specialist staff, is likely to result in better quality of care for patients.

Further information on the evidence behind our proposals can be found on our website nwl-acute-provider-collaborative.nhs.uk/eoc. This includes:

- A national review of adult elective orthopaedic services in England Getting It Right First Time (GIRFT) (2015)
- High volume low complexity (HVLC) programme GIRFT
- Separating emergency and surgical care: recommendations for practice Royal College of Surgeons (2007)
- The case for surgical hubs Royal College of Surgeons (2022)
- Reconfiguration of clinical services: what is the evidence? The King's Fund (2014)
- Examining new options and opportunities for providers of NHS care. The Dalton Review (2014)
- International Society of Orthopaedic Centres



The main data sources used include:

- Hospital Episode Statistics (HES) digital.nhs.uk
- Dr Foster drfoster.com
- Model Hospital model.nhs.uk
- GLA Housing Led Population Projections data.london.gov.uk/dataset
- Office for National Statistics www.ons.gov.uk
- Google Maps maps.google.com/maps

We also reviewed the trusts' own databases on complaints, theatre usage etc.

Key case study

South West London Elective Orthopaedic Centre

Since 2004, planned orthopaedic surgery across south west London has been consolidated at SWLEOC (South West Elective Orthopaedic Centre), a centre of excellence for orthopaedic surgery. SWLEOC is a partnership between four acute trusts and is the largest hip and knee replacement centre in the UK, providing elective orthopaedic surgery services for 1.5 million people across the region with around 5,200 procedures a year. The facility is located on the Epsom Hospital site but is self-contained with 71 beds and a high dependency unit. The Care Quality Commission has rated the service as outstanding – its highest rating. Read more at eoc.nhs.uk

1.5 million
people received elective orthopaedic surgery

5,200
procedures a year

71
beds and a high dependency unit

How to give your views

We have gathered some ideas and views from patients and community groups that have helped inform this proposal for an elective orthopaedic centre. We are now carrying out a formal 14-week public consultation programme to inform a decision on whether the proposal should be progressed and how it could be improved.

We want to get the views of as many patients, residents, staff and partners as possible to inform our plans during our public consultation – running between Wednesday 19 October 2022 and Friday 20 January 2023.

We would like to hear your views on:

- Whether we have developed the best possible solution to the current challenges in providing planned orthopaedic surgery in north west London
- Are we doing all we can to ensure that services are of the best quality
- Are we doing the right things to ensure everyone who needs care can access it in a timely way
- Whether there are more things we could do to make services responsive and tailor them for those with specific needs

We are also interested to receive alternative proposals to the solution we have laid out in this document.

All feedback will be evaluated by Verve Communications, an independent company who have been engaged to receive and evaluate feedback regardless of how it is submitted.

Ways to take part in the consultation

Complete a printed questionnaire

Please let us know your comments and views on these proposals by completing the consultation questionnaire and returning it in the post using the Freepost address provided.

If you do not have access to a printed questionnaire, you can download one from our website, print it and complete it. Alternatively we would be very happy to send you one.

Complete our questionnaire online

You can also complete the consultation questions using our online survey at: nwl-acute-provider-collaborative.nhs.uk/eoc

This can be completed on a desktop computer or on a mobile device.

Give your feedback on the phone

If you would find it easier to speak to someone to give your thoughts you can call the consultation team on 020 3311 7733.

All feedback will be included in the analysis of responses, regardless of how it is given.

Write to us

If you would rather write your feedback down without using our questionnaire, you can write your thoughts down in a letter or email. If you are feeding back on behalf of an organisation, please state the name of the organisation in your correspondence. It is also helpful if you can let us know which borough you live in or the first part of your postcode, to help us analyse responses fully. Return postal letters to: FREEPOST: HEALTHIER NORTH WEST LONDON or email: nhsnwl.eoc@nhs.net

Invite the programme team to speak to your group

The programme team would be happy to come to speak to your group and receive your feedback.

To arrange this, please contact the team by calling 020 3311 7733 or emailing nhsnwl.eoc@nhs.net

Come to a public meeting

We are holding a public meeting in each borough. These meetings are an opportunity to meet with the programme team and other interested residents to find out more about our proposals and give your views.

These events are discussions that give everyone the opportunity to participate.

To attend, you will need to book in advance, so that we can ensure we have adequate space and staff to hear everyone's views.

We are also holding 'drop-in' sessions in some of our hospitals and other local community venues.

You get find event details on our website nwl-acute-provider-collaborative.nhs.uk/eoc

Additional help to respond to these proposals

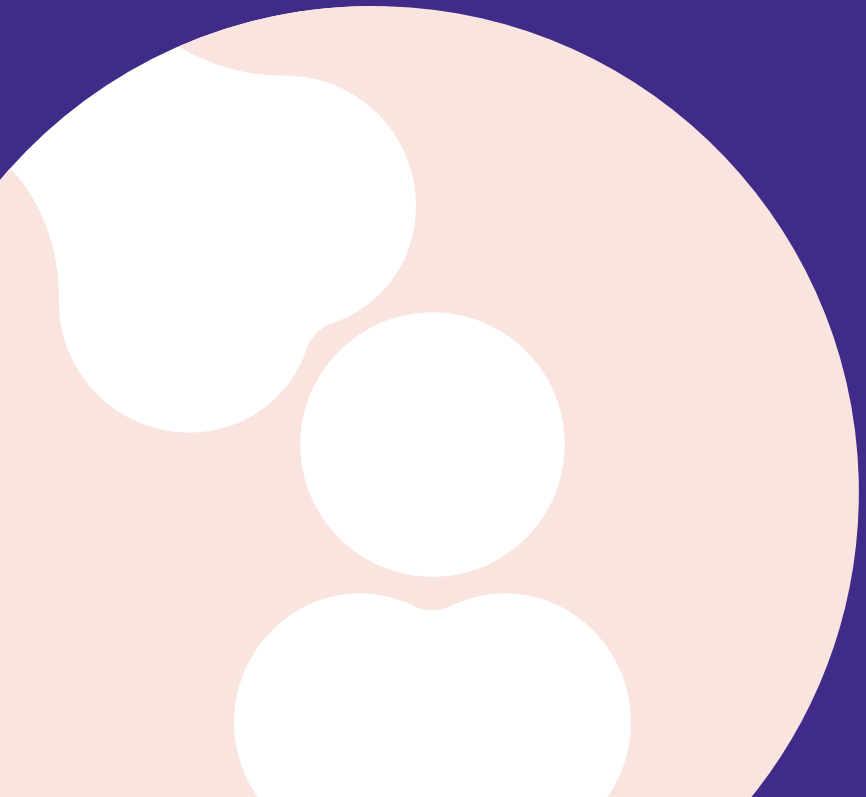
- We can provide support for those who may need some additional help to participate.
- We offer translations and additional support if English is not your first language.
- We also offer versions of this consultation document in audio, large print, Easy-Read or Braille format, on request.
- We can offer support to participate if you have a learning disability or difficulty in communicating.
- You can give your feedback verbally by calling us.

Once produced, all versions of the document will be available on our website.
Please contact us on 020 3311 7733 or email nhsnwl.eoc@nhs.net for more information or to make a request.

Getting more involved

If the proposal goes ahead, we want to continue to draw on the views and ideas of patients and members of the public so that our services are tailored to your needs.

We have a range of ways for patients and members of the public to get involved in service changes – such as this proposed development and others. If you are interested in getting more involved, please email nhsnwl.eoc@nhs.net



Proposal developed by
NHS North West London
Acute Provider Collaborative
Supported by
NHS North West London

October 2022

Appendix 6 – Consultation plan

Consultation plan
Proposal for north west London elective orthopaedic centre

This paper sets out the scope of a public consultation on the proposed development of an elective orthopaedic centre for north west London. It includes an outline programme of audiences and activities, including areas of particular focus.

1 Background

The four acute NHS trusts in north west London who have come together as an Acute Provider Collaborative want to build on their existing fast-track surgical hubs to develop a more strategic approach to improving the provision of 'high volume, low complexity' surgery, beginning with orthopaedic surgery. The drivers are to improve quality as well as to significantly expand access and shorten waiting times. We have been exploring the potential for an elective orthopaedic centre for north west London. We think the best location for the centre would be the Central Middlesex Hospital – it is amongst our best quality existing estate, it has good travel times from all parts of the sector, it is one of only two sites that do not provide urgent and emergency care services and there is good potential to expand and remodel existing facilities to meet the needs of an elective centre.

We have sought the early views of patients and community groups as part of work to develop a formal proposal for an elective orthopaedic centre. These initial insights indicate that patients and the public understand the benefits of the proposed approach, especially in helping to tackle the current waiting list backlog. We also had many constructive suggestions for how we can improve orthopaedic care more generally, especially to build pathways into and out of surgical services to better meet the needs and preferences of patients. We have incorporated these views into our proposals and we are now developing a formal 12-week public consultation programme to help the NHS in north west London reach a decision on whether or not we should progress our proposal and how it could be improved.

In order to ensure our public consultation programme is fair and proportionate we will follow the set of guidelines referred to as the 'Gunning Principles' (based on the legal case R v London Borough of Brent ex parte Gunning, 1985) as follows:

1. Proposals must still be at a formative stage: public bodies need to have an open mind during a consultation and decisions cannot already have been made.

2. Sufficient information around proposals to permit 'intelligent consideration': people involved in the consultation need to have enough information to make an intelligent input into the process.

3. Adequate time for consideration and response: enough time should be given for people to undertake informed consideration and then provide their feedback and also for public bodies to analyse the results of consultation and make the final decision

4. Consultation feedback must be conscientiously taken into account

There is also the requirement that a proposal satisfies the government's four tests of service change, which are:

- Strong public and patient engagement
- Consistency with current and prospective need for patient choice
- Clear, clinical evidence base
- Support for proposals from clinical commissioners

It also needs to set out the impact against the 5th test regarding bed closures.

2 Services and options

Around 4,000 patients a year currently have 'high volume, low complexity' orthopaedic inpatient surgery at hospitals across north west London: at Mount Vernon, Northwick Park, Hillingdon, St Mary's, Charing Cross, Chelsea and Westminster, West Middlesex and Central Middlesex.

We would propose to bring these inpatient surgeries together at the preferred single site location of Central Middlesex Hospital in a specially designed, systematised surgery centre, creating improvements in quality and efficiency and opening up capacity on the other sites to support other specialties.

All patients would continue to have their pre and post surgery care provided by the orthopaedic team at their local hospital, with a team of surgeons moving with their patients to undertake the surgery at the specialist centre, to benefit from its permanent, specialist workforce and its systematised way of working.

Orthopaedic day case patients would continue to have a choice of hospitals providing routine orthopaedic services, as now, and other hospitals in the sector with more specialist high dependency and intensive care units will continue to offer surgery for patients with more complex healthcare needs or more complex surgeries.

3 Consultation scope

3.1 Objectives

- To ensure the views and knowledge of a diverse range of stakeholders and service users (patients, carers, staff, NHS partners, local authorities and wider stakeholders), - particularly groups most likely to be impacted – inform the proposed development of an elective orthopaedic centre in north west London.
- To test the rationale underpinning proposed changes to how orthopaedic surgery is organised in north west London with service users, building an evidence base to inform decision-making.
- To ensure a fair and transparent process for engagement and consultation, meeting all statutory requirements for proposed health service changes.

Patients and the public in initial involvement activities have raised issues about routes/patient pathways into and out of surgical services. We expect this this consultation will generate wider feedback on needs, views and preferences for changes beyond the specific scope of the elective orthopaedic centre, we can be used to inform current thinking in primary and community care to improve musculoskeletal services.

3.2 Target groups

Throughout the consultation programme and beyond we will pay due regard to the duties placed on NHS organisation under the Equality Act 2010 regarding the public sector equality duty ('PSED') and the duty to reduce health inequalities, and duties under the NHS Act 2006 (as amended). We recognise that service design and communications should be appropriate and accessible to meet the needs of diverse communities.

The consultation will aim to reach and include a diverse mix of the population to be served by the proposed elective orthopaedic centre, particularly those identified as being most at

risk of barriers to access or poorer health outcomes, and including those belonging to minoritised groups or sharing one or more protected characteristic. These priority groups have been identified through a combination of carrying out an Equalities and Health Impact Assessment (EHIA), as well as insights gained through a programme of early involvement activities carried out to help shape formal proposals.

Equality and diversity monitoring data gathered through the early involvement activities also highlights that we need to ensure high and consistent participation of residents from across all eight north west London boroughs (Brent, Ealing, Hammersmith & Fulham, Harrow, Hillingdon, Hounslow, Kensington & Chelsea and Westminster), as residents from Harrow, Hillingdon and Hounslow were under-represented in the initial phase of involvement.

We would also ensure we make arrangements to ensure the consultation is accessible to those members of the public with protected charateristics eg. use of large-type; braille; easy-read summary; translation into most common languages; audio versions.

3.3 Priority groups for consultation

1) **45+ age group who are already on our waiting lists and their families/carers** – This group makes up the majority of the target population for the elective orthopaedic centre. Our involvement activities indicate that we need to focus on increasing participation from people most likely to be suitable for routine surgery.

2) **People with more complex health care needs –** who may face specific challenges in accessing orthopaedic services and navigating the healthcare system, such as:
   - disabled people including those with sensory disabilities, hidden disabilities, learning disabilities or autism
   - specific comorbidities or long term health issues such as hypertension and diabetes
   - people with mental health related issues.

3) **Black, Asian and other minority ethnic groups** – people from minoritised ethnic groups such as refugees and migrants, and particularly those for whom English is their second language, are more likely to report poorer outcomes. Furthermore, the Covid-19 pandemic has highlighted structural disadvantages faced by these groups. We need to ensure plans for the elective orthopaedic centre do not deepen these inequalities.

4) **LGBTQIA+ groups** – high incidences of prejudice experienced by people identifying as LGBTQIA+, including negative attitudes from healthcare professionals may prevent individuals from accessing treatment.

5) **Groups likely to incur longer travel times** – while the Central Middlesex Hospital site has the shortest average travel time by car and the second shortest average travel time by public transport, there is some variation in travel times for residents across the boroughs. We need to ensure we understand views on accessibility from across the sector.

6) **Residents living in the most deprived areas** – deprivation can be a barrier in access to healthcare and our EHIA indicates that over a half of the north west London population are more deprived than the national average, with a particular concentration of high deprivation in the middle of the geographical region.

3.4 Staff and health and care partners

Running alongside the public consultation programme, we are planning involvement activities for a wider group of our staff and health and care partners. A formal consultation with staff will be carried out in respect of the workforce implications of the proposed option. Other aspects of orthopaedic services will continue at all hospitals that currently provide orthopaedic care and so we will continue to need orthopaedic staff in those hospitals.

3.5 Timescales

We are working towards start date for public consultation of Monday 17 October 2022 running for 12 weeks until closing on Friday 20 January 2023.

Subject to the volume and content of responses this consultation period may be extended if it would be helpful to hear more views. The phases of the programme will depend on what decisions are made at several key stages.

4 Consultation collateral

- **Core content** – consultation document (approximately 20 page booklet) and online presence (featuring Acute Provider Collaborative 'microsite') to include:
  - who we are – context of acute collaborative and other health and care partners, ICB and ICS
  - background to the proposal - challenges and opportunities
  - explanation of key terms
  - objectives, how the consultation will inform decision making, timelines and mechanisms for reporting back
  - details of the proposal itself – including what it would mean for patients (with breakdown of anticipated positive and negative impacts for all patient cohorts), any options appraisals that we have undertaken, clinical rational and evidence base
  - depending on decisions about scope, information and questions about related areas that we are also looking to improve
  - outline set of questions and detail of all ways to respond
  - overall summary.

- **Supporting documents**
  - Travel time modelling and analysis
  - Equalities and Health Impact Assessment/Integrated Impact Assessment
  - Pre consultation business case

- **Consultation questionnaire** (quantitative) and **topic guide** (qualitative)

- **Short explainer animation(s)/video(s) (tbc)**
  - Explaining systematised surgery
  - Explaining our specific proposal more broadly (possibly in wider context of acute care collaboration)
  - Explaining or specific proposal more broadly (possibly in context of wider improvements for orthopaedic/MSK services

- **Additional content**
  - Standalone summary proposals/consultation
  - Core slide set
  - Promotional content for consultation activities – flyers, digital flyers/banners, paid for content/ads, digital signage ads
  - Tailored emails

- News stories – external and internal

5 Programme of public consultation activities

5.1 Clinician-led, qualitative research events

- To include a presentation on the proposals, opportunity for questions and clarifications and breakout elements to gather views and feedback via deliberative methodology
- At least 8 face-to-face events (one per borough) plus two sector-wide virtual events – (target of at least 300 people)
- Face-to-face events devolved to local trust/ICS (borough based partnerships 'BBP') engagement team, with central materials and support of independent qualitative researchers/facilitators
- Establish and brief pool of clinicians centrally via EOC programme
- Recruitment via local and central promotion/leads – sign up required

5.2 Drop-in engagement sessions

- Half-day sessions in acute and community NHS locations – participants are free to turn up at their own convenience. Consultation documents available in display format on location plus video and/or slides
- At least 16 sessions (two per borough) – (target of at least 100 questionnaires completed)
- Trust/ICS/BBP communications and engagement staff available on location to answer questions and support members of the public with questionnaire.
- Interpreting support/translators may be required
- Sign-up not needed

5.3 Outreach community focus groups

- If required up to ten sessions involving targeted groups who are assessed as being under-represented during the consultation, run by independent qualitative researchers/facilitators
- Aim for 5-7 participants per group as optimum to enable rich discussion
- Mix of geographic and specialist groups – the format would remain flexible in order to reach target groups e.g. through virtual meetings, in-clinic or at existing community group meetings. Offer telephone interviews for people with accessibility issues
- Remuneration to community organisations hosting these session to cover their administrative costs and refreshments

5.4 Awareness/engagement hybrid community outreach events

- Slots incorporated into existing engagement/outreach activities/events
- Communications and engagement staff available to answer questions/encourage attendance at specific events or to support completion of questionnaire
- Particular focus on targeted groups and geographic locations

5.5 Dedicated section of acute hospitals microsite

- Core content
- Questionnaire
- Links into and out of all trusts/ICS

6 Programme of awareness/promotional activities

6.1 'Owned'

- All those who have signed up for more information via earlier involvement activities
- Links included with FFT texts/flyers in clinics/flyers in appointment letters for orthopaedic patients (to be confirmed following information governance considerations)
- Trust key stakeholder contacts
- All trust/ICS websites and member/partner mailing lists (including community group databases as appropriate)
- NW London citizen panel and residents group
- NW London musculoskeletal network contacts
- Hard copy flyers/digital screen ads in trusts and other NHS locations
- Trust/ICS social media accounts

6.2 'Borrowed'

- Cascade of print materials through community organisations/public spaces – libraries, community centres, housing associations
- Local authority channels – website, social media. Newsletters
- Local Healthwatch channels

6.3 'Bought'

- Promoted posts on Next Door etc.
- Pay per click social media campaign/Google ads
- Press ads (to be considered if required)

7 Analysis and evaluation

We will commission an independent qualitative research agency to integrate responses from all sources into a single outcome report, combining quantitative survey responses (target of at least 2,000) with notes from events and meetings and formal consultation submission.

To understand the effectiveness of the consultation activities in enabling opportunities for public participation, we will track both reach and participation metrics:

- **Reach**
  - Traffic to websites
  - Social media impressions, partner/influencer followers
  - Sign up to events/public meetings
  - Average footfall figures for sites of printed material cascade
  - Circulation figures of paid media

- **Participation**
  - Number of completed questionnaires
  - Attendees to community events/public meetings
  - Number of focus group and interview participants

At the point of interaction with consultation materials, we will also seek to capture information relating to:

- Protected characteristics
- Borough of residence
- Promotional channels through which participants accessed the consultation materials
- Consent to be kept informed and contacted about this and further NHS developments

A full report on the outcome of the consultation will be published and shared through all owned channels during the period between the consultation closing and recommendations for decision-making, and will be supported by further communications and involvement plans as required.

Following consultation and analysis of all responses, a decision-making business case (DMBC) will be developed showing how views captured by consultation have informed the final proposal and recommendation/s.

8 Governance, advice and guidance

8.1 Communications and engagement workstream

Project delivery group: membership to include named communications leads for Acute Provider Collaborative and for ICB/ICS.

Communications working and steering group: will seek to include input from acute lay partner/equivalent; local authority representative; Healthwatch representative; relevant programme team members and acute trusts/ICS communications and engagement staff. Report into project delivery group and elective orthopaedic programme board via communications and engagement workstream updates.

8.2 North West London Joint Health Overview and Scrutiny Committee and borough health overview and scrutiny committees

Local government is a key stakeholder in all service reconfiguration, providing an important oversight and scrutiny function. The NHS must consult the local authorities in north west London when considering any proposal for a substantial development or variation of the health service in the area.

The 2013 Health Scrutiny Regulations place a statutory duty on the NHS to formally consult a local authority where the NHS has under consideration any proposal for a substantial development of the health service in the area of that local authority, or for a substantial variation in the provision of such a service. Where substantial change proposals affect more than one local authority area, the affected local authorities form a Joint Committee to be consulted. The North West London Joint Health Oversight and Scrutiny committee (NW London JHOSC) has already been in existence for several years.

NHS representatives have already attended two meetings of the existing NW London JHOSC to provide updates on the development of a proposal to create an elective orthopaedic centre (9 March and 20 July 2022). The NW London JHOSC has advised they think a formal public consultation is required on the proposal and requested to receive details in writing of the consultation plan in advance of the start date for public consultation. The NW London JHOSC has also recommended that:

- the NHS considers the best strategy for the consultation to reach as many people as possible, utilising key partners across NW London
- the committee agrees to the NHS embarking on a full consultation that starts on the first week of September [subsequently advised planning public consultation start date of mid October]
- a clear reference is made to how the findings of the consultation will input into the business case
- the full business case is brought back to a later meeting
- the NHS provide an effective communication strategy to clearly set out the pathway from primary to secondary care for patients and residents across NW London.

As stated above, a full report on the outcome of the consultation will be produced and shared with the NW London JHOSC during the period between the consultation closing and the date of recommendation/s being considered for decision-making. Following consultation and analysis of all responses, a decision-making business case (DMBC) will be developed showing how views captured by consultation have informed the final proposal. We will discuss with the NW London JHOSC the timetable for their consideration of the consultation outcome report and DMBC before the date of any recommendation/s being considered for decision by NHS North West London.

9 Consultation delivery plans

Four individual Trust-level consultation delivery plans developed jointly with ICS borough based partnership engagement teams, which will focus on activities by each borough while ensuring sector-wide consistency.

Chelsea and Westminster Hospital NHS Foundation Trust
Chelsea and Westminster Hospital
West Middlesex University Hospital
Borough consultation delivery plans: Hounslow/Kensington and Chelsea

Imperial College Healthcare NHS Trust
Charing Cross Hospital
Hammersmith Hospital
Queen Charlotte's & Chelsea Hospital
St Mary's Hospital
Western Eye Hospital
Borough consultation delivery plans: Hammersmith & Fulham/Westminster

London North West University Healthcare NHS Trust
Central Middlesex Hospital
Ealing Hospital
Northwick Park Hospital
St. Mark's Hospital
Borough consultation delivery plans: Brent/Ealing/Harrow

The Hillingdon Hospitals NHS Foundation Trust
Hillingdon Hospital
Mount Vernon Hospital
Borough consultation delivery plan: Hillingdon

Key milestones:

- Pre-consultation: planning, content creation and event organisation
- Consultation period: 12 week consultation from 17 October 2022 – 20 January 2023 with continued promotion of all consultation activities and online questionnaire
- Post-consultation: analysis and reporting consultation outcomes and decision

9.1 Roles and responsibilities

Central communications and engagement team to enable delivery of all Trust/borough level plans:

- Co-ordinate all project delivery teams
- Central database to reach target audiences

- Develop core consultation documents and suite of promotional materials/templates to support all activities
- Develop microsite for acute care collaborative and establish central contact mechanisms e.g. email/phone lines
- Manage all external contractors e.g. design agency, qualitative researchers
- Monitor planning and delivery of all borough community and drop-in evets
- Qualitative researchers (external agency as part of central team)
    - Develop research questionnaire
    - Chair and facilitate all borough community events – face-to-face and online
    - Conduct focus groups as required
- Administrative support (as part of central team) - working with Trust's communications and borough-based engagement teams, central communications team and qualitative research agency:
    - Arrange physical distribution of print materials, contacting community groups
    - Diary management of clinicians to lead community events/speak at outreach events
    - Contact community groups/organisations as required
    - Other event support as required

Communications leads at each Trust:

- Overseeing delivery of consultation plan, working with borough engagement leads at the ICB to deliver in the boroughs that each Trust leads on
- Stakeholder management and co-ordination

ICB borough-based partnership engagement teams:

- Events management, connection into the community and relationship management to enable recruitment to focus groups, setting up other outreach opportunities and agreeing community locations/venues for distribution of print materials
- Promoting activities through ICB channels

9.2 Outline schedule

Timeline	Activity
Pre-consultation period (mid-August-early October)	Set-up four project delivery groups with communications leads at each Trust and ICB borough engagement leads. Develop four corresponding delivery plans covering all eight boroughs.
	Draft core consultation document to submit as part of Pre-Consultation Business Case for NHSE assurance process.
	Commission and brief qualitative research agency to: • develop consultation questionnaire • design and facilitate focus groups and community events • carry out individual evaluation of all engagement outputs and produce report
	Create event guide to ensure adoption of consistent style/format across all boroughs
	Create brief and commission design agency to create user-friendly versions of core consultation document, alongside a suite of promotional materials
	Consolidate database/target groups

	Build microsite for acute care collaborative projects working with task and finish group across the collaborative
	Agree feedback mechanisms – main consultation email address and numbers
	Finalise public-facing version of consultation document. Draft and final copy to populate microsite and for all print/promotional materials from the core consultation document.
	Create list of clinicians to lead on engagement activities
	Arrange pool of translators to support public at drop-in sessions
Consultation period 17 October-20 January 2023	Implement and monitor consultation delivery plans
	Weekly feedback meetings to support reporting Communications leads with research agency
	Monthly progress report for submission to project delivery group, EOC and acute care programme boards
Post-consultation Jan/Feb 2023 TBC	Oversee production of consultation outcome report to inform decision making business case
	Share consultation findings with all internal and external stakeholders, including: • NW London JHOSC and local authority HOSCs • Publish consultation outcome to consultees via all Trust and ICB channels

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