verve

Consultation Evaluation Final Report

Improving planned orthopaedic inpatient surgery in North West London

Authors: Clive Caseley and Sue Clegg

Date: 06 February 2023

verve

CONTENTS

MyOfficeClub
67-71 Lewisham
High Street
London SE13 5JX

REG VAT GB 858230025
Registered in England Company
Number 05358457
Registered office:
24 Old Bond Street, London W1S 4AP

+44 207 017 2011

hello@vervecommunications.co.uk
www.vervecommunications.co.uk

1. EXECUTIVE SUMMARY

1.1 ABOUT THIS REPORT

1.1.1 OVERVIEW

This report presents and analyses comments received during public consultation on proposed changes to planned orthopaedic inpatient surgery in North West London. It assesses views on:

- The main proposal to develop an elective orthopaedic centre for North West London, and
- The preferred location for the centre at Central Middlesex Hospital.

The consultation period was between 19 October 2022 and 20 January 2023. The process was led jointly by NHS North West London[1], which is the Integrated Care Board (ICB) responsible for commissioning NHS care for people living in the eight North West London boroughs, and the North West London Acute Provider Collaborative[2].

The Collaborative, which also led development of the proposal, comprises the four NHS acute trusts in North West London:

Chelsea & Westminster Hospital NHS Foundation Trust
The Hillingdon Hospitals NHS Foundation Trust
Imperial College Healthcare NHS Trust
London North West University Healthcare NHS Trust.

1.1.2 WHAT THIS REPORT CONTAINS

Based on analysis of the comments received, this report identifies perceived benefits, concerns and issues for consideration. It should be noted that:

This includes both qualitative and quantitative information, and combines responses from a variety of sources to provide a comprehensive overview of the feedback and comments received

An indication of the relative weight of opinion is provided, broken down by different groups of respondents where this is meaningful and justified by the data

In the detailed analysis, we have aimed to capture all substantive points made to provide a checklist of engagement issues to consider.

1.1.3 COMPLIANCE

A range of statutory duties and other requirements govern consultation processes. These are set out in this report which also includes a summary of engagement activity and commentary on the extent to which these requirements were met.

This report was independently prepared by Verve Communications Limited to inform development of a decision-making business case by the Collaborative for consideration by NHS North West London.

1.2 SUMMARY OF PARTICIPATION

Consultation responses were received from individuals and organisations, and through a variety of channels including: a questionnaire (print and online); face-to-face and virtual events; staff

[1] https://www.nwlondonics.nhs.uk/about-nhs-nw-london
[2] https://www.nwl-acute-provider-collaborative.nhs.uk

engagement meetings; focus groups and one-to-one interviews; community outreach by the Collaborative and the NHS North West London communications and engagement teams.

Table 1 shows a summary of the main consultation activities and level of participation.

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

Table 1. Summary of participation and response
*in online sessions with staff there were instances where several people joined from one laptop – so numbers may be higher, and information on numbers attending was not supplied for all meetings.

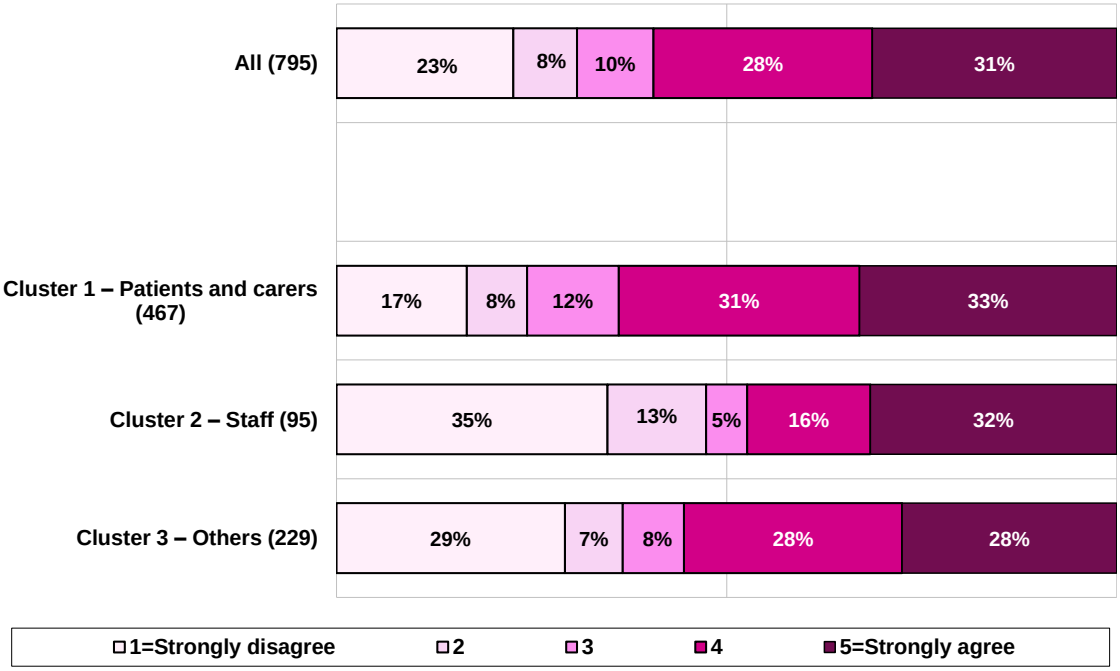
1.3 SUMMARY QUANTITATIVE RESPONSES

The survey received 807 responses. Please note, not all answers sum to 100% as respondents may not answer all questions. It should be noted that 28% of responses were from people from Hillingdon, this is twice as many as from the next largest responses (Ealing 14% and Hammersmith & Fulham 13%). 8% of responses were from Brent, 7% were from Hounslow, 7% from Westminster, 6% from Kensington & Chelsea and 6% from Harrow. 11% of responses were from people living outside of the 8 boroughs.

- 59% of responses were from patients and carers
- 12% of responses were from NHS staff
- 29% of responses were from 'others', that is, people who identified as 'member of the public' (28%) or 'responding on behalf of an organisation' (1%)

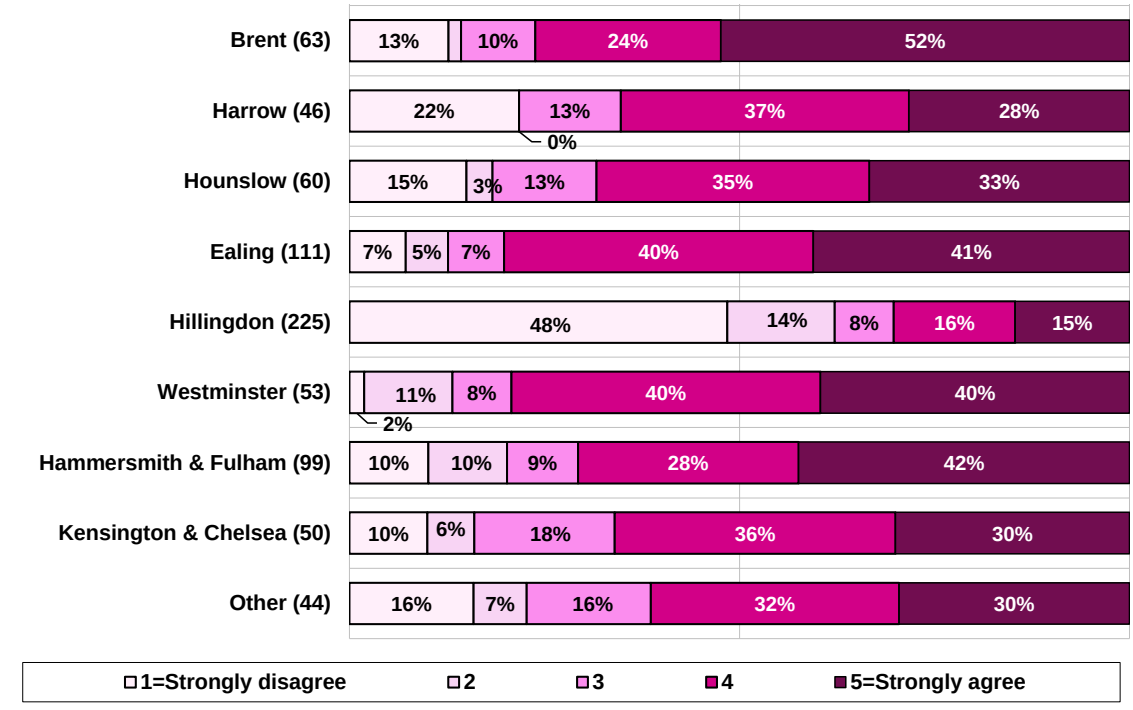
- Hillingdon had the greatest proportion of responses from people in the 'other' category – with 43% in that category; 20% of Hillingdon responses were from patients and carers and 31% from staff.

- Overall, 59% of respondents agreed with the proposal to develop an elective orthopaedic centre in North West London



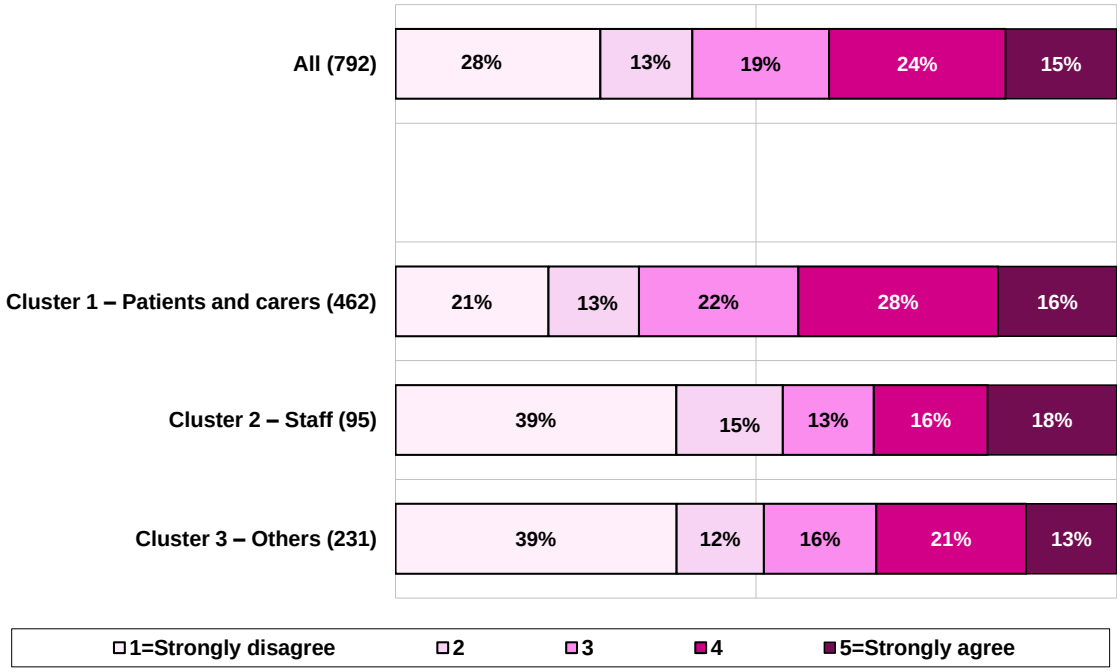
Source: Verve Communications 2023 Base: All respondents who gave a valid answer (267)

- People in 7 of the 8 boroughs were supportive of the proposal, whilst people from Hillingdon were more likely to disagree:



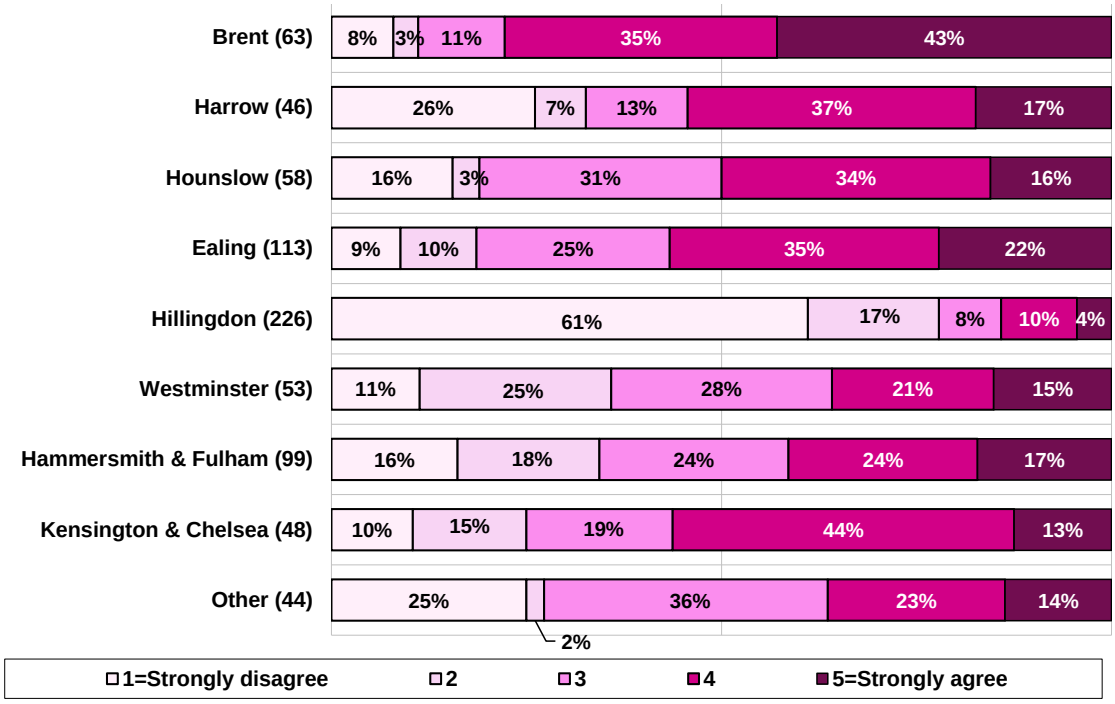
Source: Verve Communications 2023 Base: All respondents who gave a valid answer

- When asked about the proposal to site the elective orthopaedic centre at Central Middlesex Hospital 39% of people agreed with the proposal and 41% disagreed with it; patients and carers were more likely to agree than staff or others.



Source: Verve Communications 2023 Base: All who gave a valid answer

More people in Hillingdon disagreed with the proposal to site the centre at Central Middlesex Hospital than those from other boroughs.



Source: Verve Communications 2023 Base: All respondents who gave a valid answer

- The main reasons given for disagreeing with Central Middlesex Hospital as the site for an elective orthopaedic centre related to travel.

1.4 SUMMARY QUALITATIVE RESPONSES

Overall participants thought that the proposal for an elective orthopaedic centre for most routine surgery was a good idea and hoped that it would help to reduce waiting times for patients.

There were some people who would prefer to have all their treatment at their local hospitals, generally for the sake of convenience.

There were two main concerns raised by people: the first related to travel to and from the proposed elective orthopaedic centre at Central Middlesex Hospital for patients, visitors and staff and the second related to services at home for people after they were discharged from hospital.

Some participants would have preferred the hub to be located at Mount Vernon hospital – generally these were staff at Hillingdon and Mount Vernon hospitals and people who lived near Mount Vernon.

Some potential inequalities have been identified, and a list of mitigations put forward by participants is presented.

2. ABOUT THE CONSULTATION

2.1 CONTEXT AND PRE-CONSULTATION

2.1.1 BACKGROUND

Orthopaedic surgery has some of the longest waiting times in North West London and faces a variety of systemic challenges.

A Case for Change has been developed, which identified six key drivers for change:

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

Clinicians and managers from across the four acute trusts in North West London worked with GPs, other healthcare professionals, patient representatives and partners to develop a solution to meet these challenges.

This work was taken forward by the four acute trusts as a Collaborative following its formal establishment in July 2022. The Collaborative led a detailed clinical design and options appraisal

process which culminated in the proposal, supported in principle by NHS North West London, to develop an elective orthopaedic centre for North West London located at Central Middlesex Hospital.

2.1.2 PRE-CONSULTATION BUSINESS CASE

The proposal and the process by which it was developed is contained in the Pre-Consultation Business Case (PCBC) *Improving planned orthopaedic inpatient surgery in North West London*[3].

Both NHS North West London and the North West London Joint Health Overview and Scrutiny Committee (JHOSC) determined that the proposal constituted a substantial service change and therefore required public consultation. NHS England gave authorisation to proceed, and NHS North West London approved the PCBC at its public board meeting on 27 September 2022.

The PCBC contains as appendices four reports to inform consultation engagement plans developed by the Collaborative:

- Appendix 1 – Equality Health Impact Assessment (May 2022)
  Detailed review of the proposals and their potential impact on people sharing "protected characteristics" and other identified groups experiencing health inequality or inequality of access.

- Appendix 2 – Integrated Impact Assessment (Carnall Farrer, September 2022)
  Demographic analysis of the North West London population, and potential barriers and mitigations for key groups and communities as part of a wider assessment.

- Appendix 3 – Travel Analysis
  Review of transport access and journey time changes relating to the preferred location for the elective orthopaedic centre.

- Appendix 4 – Public Engagement Report (Verve Communications, July 2022)
  Pre-consultation engagement exercise to understand patients' perceptions on the case for change to inform development of the emerging proposals and plans for consultation.

2.2 VERVE'S ROLE

This report has been produced by Verve Communications Limited[4], a company which specialises in supporting consultation exercises and patient, public and stakeholder engagement by NHS organisations. Verve was commissioned to support the consultation, to provide an independent review and analysis of the comments received, and to prepare a summary report on the consultation exercise and response. In delivering this, Verve was specifically asked to:

Facilitate a series of eight public 'deliberative' meetings organised by the Collaborative, record the discussions and incorporate within the consultation analysis
Review notes provided to us from consultation meetings with patients, public and/or staff undertaken by the Collaborative and ICB communications and engagement teams and analyse the key points

[3] https://www.nwl-acute-provider-collaborative.nhs.uk/-/media/website/elective-orthopaedic-centre/improving-planned-orthopaedic-inpatient-surgery-nwl-pcbc.pdf?rev=adf10acb7bd245f185ff9360c90ce054&hash=980FE4D11170F5E4EB40E8487692FE19
[4] https://vervecommunications.co.uk/

Undertake focus group meetings to explore the equalities impact of proposals on groups experiencing inequality or health inequalities, including those sharing 'protected characteristics' identified by the Collaborative, based on its equality impact assessment, as being most likely to be impacted
Support development of the questionnaire hosted by the Collaborative and analyse the data provided to us, including developing a 'code frame' for capturing and categorising free text responses
Capture and evaluate all the feedback from all sources and summarise in a report.

Please note: Our role in respect of consultation feedback from those meetings not facilitated by Verve was to give advice on collection of comments and analyse notes provided to us by NHS engagement teams. Similarly, information on consultation promotion and the dates, times and attendance at events and meetings summarised in this report was provided to us by the Collaborative.

We would like to put on record our thanks to our NHS communications and engagement colleagues for their support and the information provided to us, and a very positive working relationship throughout the consultation.

2.3 EQUALITIES AND IMPACTS

2.3.1 HEALTH AND HEALTHCARE INEQUALITIES - DUTIES

When major changes to NHS services are proposed there are statutory requirements derived from both the NHS Act 2006 and the Equality Act 2010 to consider equalities and health inequalities. For those commissioning or providing public services there are two principal duties:

1. To meet the Public Sector Equality Duty (PSED)[5]
2. To take account of the likely implications for changes to services or the location or access arrangements for groups or individuals protected under the Act.

In addition, the Mayor of London has set six tests for NHS service change, which include consideration of health and healthcare inequalities.

A key objective for this consultation was to ensure that people sharing 'protected characteristics' defined by the Act who potentially face disproportionate impact are engaged in order to take account of their views and specific needs.

2.3.2 EQUALITY IMPACT ASSESSMENT

An Equality Impact Assessment (EIA) is part of a structured process to meet these duties by taking equality of opportunity into consideration when proposing changes to services. As described previously, a detailed Equality Health Impact Assessment (May 2022) was conducted to inform the PCBC. This contained a detailed review of the proposal and its potential impact on people sharing "protected characteristics" and other identified groups experiencing health inequality or inequality of access.

The Equality Health Impact Assessment identified the following groups in particular as being at risk of disproportionate impact by the proposal:

- Elderly patients
- Disabled patients
- Black and minority ethnic patients for whom English is a second language

[5] https://www.equalityhumanrights.com/en/advice-and-guidance/public-sector-equality-duty

- Patients from deprived areas.

Informed by this analysis and drawing on the local knowledge and relationships of NHS North West London's borough engagement leads, the programme of focus groups was organised which is detailed in a later section of this report.

The questionnaire included demographic monitoring questions which, where justified by the data, enables analysis of quantitative responses and categorised free text comments by equalities groups – hence providing the opportunity to identify similarities or differences in views between different groups.

In addition, the community outreach activity to support the consultation also sought to ensure that 'duty to involve' was inclusive of groups sharing protected characteristics and is detailed in a separate section of this report.

2.3.3 COMMUNITIES AND TRAVEL

The PCBC also contains detailed analysis of the travel and transport implications of relocating surgery for some residents to an elective orthopaedic centre at Central Middlesex Hospital, including travel times from all parts of North West London.

This analysis provided the information necessary for NHS North West London and the Collaborative to identify communities likely to be particularly affected and we understand that this underpinned the approach to engagement, particularly the community outreach activities.

2.4 ABOUT THE CONSULTATION ENGAGEMENT PROCESS

2.4.1 PRINCIPLES AND OVERVIEW

The consultation period was between 19 October 2022 and 20 January 2023. The process was led by NHS North West London, which is the Integrated Care Board (ICB) responsible for commissioning NHS care for people living in the eight North West London boroughs, and the North West London Acute Provider Collaborative.

The consultation engagement built on work undertaken during pre-consultation to inform development of the PCBC. In order to gain meaningful, timely feedback, relevant questions were asked at each stage. During pre-consultation the focus was "what does good look like" while consultation engagement focused more clearly on the clinical model and preferred location. Independent reports analysing and summarising responses were commissioned for decision-making meetings and published at each stage:

1. North West London orthopaedic services engagement, Verve, July 2022 (PCBC Appendix 4 – Public engagement report)
2. This document has been commissioned to inform the Decision-Making Business Case (DMBC)

Given the diverse nature of North West London's population, the consultation engagement was designed to be as accessible as possible and offer a wide range of ways in which people could participate. This included promotion to encourage completion of questionnaire and support attendance at events; outreach through community networks; and providing support for those who needed it, for example people for whom English is not a first language, people with learning disabilities and people without access or confidence to engage online.

More detail of the communication and engagement activities is provided in later sections of this report and Appendices. Verve's commentary on this activity showing relevant guidance is at 4.6.

The Collaborative and NHS North West London teams designed a comprehensive and proactive engagement programme to support the consultation. They also sought feedback and advice from the eight local authorities in North West London. A table in the appendices shows the contacts made and engagements with local authorities.

In summary, the key elements of the consultation engagement programme were as follows, and each is described in more detail in the following sections:

- Open meetings and drop-ins
- Community outreach meetings
- Staff events
- Focus groups and interviews
- Questionnaire

People could also respond by email or telephone and organisations could submit written responses.
Within this, the consultation programme included structured, facilitated 'deliberative' sessions to ensure that participants were able to test the case for change and model as well as respond to consultation questions, and to actively suggest solutions and mitigations.

2.4.2 COMMUNICATIONS

Website and information available
During consultation, it is important that information is provided to enable informed responses.

The Collaborative website (linked to and from each of the acute trusts' and the ICS's websites) included a summary of the case for change, clear information about the proposal and the rationale behind it and details of the consultation and how to take part.

This information was also contained in a consultation booklet which could be downloaded and was also distributed in hard copy format.

It can be found here: https://www.nwl-acute-provider-collaborative.nhs.uk/key-projects/nwl-elective-orthopaedic-proposal

The Collaborative has printed and distributed a total of:
1,100 of the full consultation documents
8,250 of the summary documents
3,650 of the printed questionnaires
265 posters.

These were allocated to all four trusts in the Collaborative for their total of nine hospitals providing orthopaedic surgery to distribute in selected clinical areas where a high footfall of orthopaedic patients would be expected. The ICB communications and engagement team were also given an allocation to take to meetings/send to community organisations.

Imperial College Healthcare NHS Trust mailed a hard copy summary document and questionnaire to 2,094 people who were recent or current orthopaedic surgery patients.

For people interested in understanding the proposals in more depth, the full Pre-Consultation Business Case and an Executive Summary could also be found on the Collaborative website.

These documents can be downloaded via the links below:
https://www.nwl-acute-provider-collaborative.nhs.uk/-/media/website/elective-orthopaedic-centre/improving-planned-orthopaedic-inpatient-surgery-nwl-pcbc.pdf
https://www.nwl-acute-provider-collaborative.nhs.uk/-/media/website/elective-orthopaedic-centre/improving-planned-orthopaedic-inpatient-surgery-nwl-exec-summary.pdf

To inform discussion at engagement events, clinicians gave scene-setting presentations with a clear and concise slide deck and were on hand to answer questions.

Communications including social media
To support engagement, the Collaborative and NHS North West London teams developed a communications programme using a variety of channels. These included:

- Social media – paid and organic
- PR and news media/local publications
- Reach through partner communication channels
- Direct emails and other communication to patients.

A table in the appendices shows the channels and metrics for social media and other channels.

2.4.3 ACCESSIBLE INFORMATION

Accessibility of information was an important aspect of the engagement, both in encouraging participation and providing a range of flexible opportunities through which to respond.

Support was made available to those who needed it to access information or compete the questionnaire, which included:

Translated versions or access to interpreters for people for whom English is not a first language or who need a BSL signer

The consultation materials stated that audio, large and Braille formats would be made available on request. No requests for these were received.

Easy-Read was available in digital format on the consultation website. One request was received for this to be shared digitally.

Support was offered to people with a learning disability or difficulty in communicating.

Different ways were offered in which people could participate. This included:
Events in a variety of formats
Outreach through community organisations and trusted networks in order to reach patient groups and communities who may otherwise not participate
Flexibility of engagement, for example offering 1:1 interviews.

Promotional material emphasised that feedback was welcome through a choice of channels, specifically mentioning:

Questionnaire (online or printed, with Freepost available)

Feedback direct to the Collaborative team via telephone (0203 number)

Email to dedicated consultation inbox or post, with Freepost.

2.5 COMMUNITY OUTREACH

2.5.1 BUILDING AND STRENGTHENING RELATIONSHIPS

The consultation was supported by community outreach organised at a borough level, engaging with partners in the voluntary and community sector, for example offering to send speakers to local meetings and attending events to encourage people to complete the questionnaire.

The consultation was also an opportunity to further develop relationships, and a wide variety of local groups were approached, informed by the networks maintained by the NHS North West London engagement team as well as the Collaborative's networks. Advice was also sought from the eight local authorities in North West London and from the relevant Healthwatch teams.

This element is key to ensuring involvement by groups sharing protected characteristics or others at risk of health inequality. Appended to this report are tables showing groups actively involved and their constituent memberships, and a wider group of organisations invited to take part or advertise the consultation.

2.5.2 REACHING PEOPLE WHERE THEY ARE

It was recognised that some groups of people may still find barriers to participation or may bring specific experience or perspectives which it was important to ensure were included and heard during the consultation.

A flexible approach was taken to engaging seldom heard groups, providing choices for participation to suit them - for example working with and through trusted organisations and organising events where people are, rather than expecting them to "come to us".

This method of outreach was particularly effective in arranging focus groups to gather views from people in the priority groups identified in the Equalities Impact Assessment.

2.6 QUESTIONNAIRE

2.6.1 DEVELOPING AND HOSTING THE QUESTIONNAIRE

The PCBC sets out the consultation proposals including the preferred option for location of the elective surgery centre. The questionnaire was developed by the Collaborative and NHS North West London with support and advice from Verve. The draft questionnaire was also shared with Capsticks who are providing legal advice on the proposed service change process.

The consultation questionnaire is shown in the Appendices. Key elements of the questionnaire are:

- Monitoring questions (to determine participants' status and location)
- Consultation options

Headline views on the clinical model (level of support, plus free text reasons)
Headline views on the preferred location (level of support, plus free text reasons)
Alternatives to the consultation options (free text)

- Potential benefits and challenges

Top 8 benefits identified in pre-consultation (priority list, plus free text reasons)
Top 8 concerns identified in pre-consultation (priority list, plus free text reasons)
Summary attitude questions (agree/disagree statements, plus free text reasons)

- Demographic monitoring, to provide a view on the reach of the engagement and to enable responses to be cross tabulated with personal information, including relevant equalities 'protected characteristics".

A digital version of the questionnaire was hosted on the Collaborative website, and can be reached through this link:
https://www.nwl-acute-provider-collaborative.nhs.uk/key-projects/elective-orthopaedic-centre-consultation-survey

There was also a print version distributed by the Collaborative communications and engagement team for return via the team or by FREEPOST; 244 questionnaires were returned via FREEPOST.

During a midpoint review of survey completion numbers by borough the consultation team adapted plans to improve participation through this channel, whilst also promoting other feedback mechanisms. This involved:

- Direct mailing from all four acute trusts promoting the consultation link online or through a postal mailout of paper questionnaires to be returned to the Freepost address
- Promoting directly with patients in clinical areas and at hospital sites
- Utilising existing community meeting opportunities to promote the consultation

All questionnaire responses were then collated into a single database by the Collaborative team and provided to Verve as a datafile for analysis.

2.6.2 QUESTIONNAIRE ANALYSIS

Quantitative data collected through the questionnaire was analysed in two ways:

- Headline responses to each question or statement (all respondents)
- Differences of response according to the demographic and other monitoring questions (cross tabulations).

For qualitative data (free text comments), a coding frame was developed from review of the first n=269 responses and used to code and cluster all subsequent comments in order to understand the most common themes expressed.

One established, the code frame was kept under review and updated as more substantive points were made and/or more comments received, which enabled categories to be meaningfully sub-divided.

Verve works with a specialist quantitative research company who use industry standard methodologies to categories and quantify free text. The company is registered for, and works to, the procedures set out in the quality standard for ISO20252 which governs coding and validating free text comments derived from surveys.

Summary charts for questionnaire responses are shown in this report.

2.7 OPEN ENGAGEMENT MEETINGS

A programme of open engagement meetings was developed to support the consultations, with the following objectives:

- To provide the opportunity for people to find out more about the proposals and find support to respond through the questionnaire
- To engage inclusively across the eight North West London boroughs
- To enable more in-depth consideration of views.

26 open meetings and drop-ins were held during the consultation period; these were a mixture of structured 'deliberative' events, facilitated by Verve and drop-in meetings run by the consultation team held across the eight boroughs of North West London. Two online deliberative events were facilitated by Verve, open to people across all eight boroughs and beyond. The table below gives details of the open engagement meetings.

Date	Venue	Attendance	Borough	Verve facilitated
31/10/22	Chelsea & Westminster Hospital	3	Kensington and Chelsea	Yes
31/10/22	Ealing Town Hall	7	Ealing	Yes
31/10/22	Brent Civic Centre	0	Brent	Yes
01/11/22	Harrow Civic Centre	8	Harrow	Yes
04/11/22	St Matthews Conference Centre, Westminster	1	Westminster	Yes
04/11/22	West Middlesex University Hospital	0	Hounslow	Yes
09/11/22	Shepherd's Bush Library	14	Hammersmith and Fulham	
09/11/22	Chelsea Football Club	9	Kensington and Chelsea	
10/11/22	Hayes & Harlington Community Centre	5	Hillingdon	Yes
10/11/22	Hounslow Library	3	Hounslow	
11/11/22	Maida Vale Library	8	Westminster	
14/11/22	Ealing Central Library	10	Ealing	
15/11/22	Online public event	7	Cross-borough	Yes
16/11/22	Irish Cultural Centre, Hammersmith	8	Hammersmith and Fulham	Yes
17/11/22	Old Lyonians Sports Centre	4	Harrow	
21/11/22	Uxbridge Library	2	Hillingdon	
01/12/22	Chalkhill Community Centre	6	Brent	
12/01/23	Online public event	35	Cross-borough	Yes
16/01/23	Central Middlesex Hospital	10	Brent	
16/01/23	Charing Cross Hospital	15	Hammersmith and Fulham	
17/01/23	Chelsea & Westminster Hospital	15	Kensington and Chelsea	
18/01/23	West Middlesex Hospital	20	Hounslow	
18/01/23	Northwick Park Hospital	21	Harrow	
18/01/23	St Mary's Hospital	13	Westminster	
19/01/23	Hillingdon Hospitals	5	Hillingdon	
20/01/23	Ealing Hospital	18	Ealing	

Table 2. Summary of open engagement meetings

A total of 247 people attended the open meetings and drop-ins.

Eventbrite was used to promote the facilitated events and participants were asked to register, using the platform (sample links are shown below).
https://www.nwl-acute-provider-collaborative.nhs.uk/events#eoc
https://www.eventbrite.com/e/brent-community-meeting-on-improving-bone-and-joint-surgery-for-adults-tickets-444209842597

2.7.1 INDEPENDENTLY FACILITATED EVENTS

Within the open engagement meetings, the Verve team was asked to facilitate one 'deliberative' event per borough and two online workshops.

'Deliberative' refers to the process by which participants explore a subject informed by input and questions/answer sessions with experts. It seeks to understand the reasons behind the opinions people hold and to test whether these change as they become better informed. This approach is commonly used to explore complex issues and trade-offs or where people may have pre-conceptions but not fully formed views.

Clinical leaders gave scene-setting presentations to inform each session, followed by break-out groups or 1:1 interviews, facilitated by Verve were used to gather comments using a structured discussion guide.

All notes from every meeting were collected, and clustered around themes in a similar way to the free text comments in the questionnaire for inclusion in the overall consultation analysis.

2.8 QUALITATIVE FIELDWORK

Following the first set of borough-based, clinician-led public meetings and community outreach drop-in sessions the consultation team carried out a full review of activities at week five to understand the demographics of people reached thus far in the consultation process, in order to agree on adaptations to the approach and better reach priority target groups.

To hear the voices from as many people as possible the qualitative phase of the work specifically targeted people who were underrepresented in the work to date. Informed by the Equalities Impact Assessment and the analysis of participation to date Verve was able to draw on the local knowledge and relationships of NHS North West London's borough engagement leads, to connect with local groups and organisations. The aim was to recruit from the following groups of people to boost representation:

- Elderly patients
- Disabled patients
- Black and minority ethnic patients for whom English is a second language
- Patients from deprived areas.

We took a flexible approach to enable groups and individuals to take part in ways which suited them, including:

Recruitment of group members to focus groups – online or in person
Facilitators attending groups' extant meetings
One to one, or paired interviews in person, online or by telephone

These sessions were professionally facilitated, with tailored discussion guides. The qualitative fieldwork consisted of 6 online focus groups, 2 in-person focus groups, 1 in person drop in to an

extant meeting, 1 online drop in to an extant meeting, 1 telephone interview and 1 in person interview. A total of 70 people took part in the qualitative fieldwork. Table 3. shows a summary of qualitative fieldwork

Date	Format	Group/Org	Attendees
30/11/22	Drop in to extant meeting – in person	Harrow Association of Somali Voluntary Organisations	18
05/12/22	Telephone interview with deaf interpreter	Harrow Deaf United Club	1
08/12/22	Online focus group	French African Welfare Association	8
12/12/22	Online focus group	BME Health Forum	8
15/12/22	In person focus group	Harrow Carers	6
15/12/22	In person focus group	Age UK: Kensington and Chelsea	6
05/01/23	In person interview with interpreter	Romanian and East European Hub	1
09/01/23	Drop in to extant meeting - online	Action on Disability Kensington and Chelsea	3
09/01/23	Online focus group	Mind in Harrow	6
10/01/23	Online focus group	Westminster & Kensington and Chelsea Carers Service	3
12/01/23	Online focus group	Harrow Patient Participation Network	7
20/01/23	Online focus group	Heathrow villages	3

Table 3. Qualitative fieldwork meetings

People who took part in the fieldwork shown in the table above were asked to fill in a form to collect demographic data. 18 people responded and their responses are shown in a table in the appendices.

2.8.1 FORMAT AND DESCRIPTION OF METHODOLOGY

Experienced facilitators were briefed on the consultation and proposed changes to orthopaedic care in North West London and used discussion guides to conduct semi-structured focus groups, drop-in focus groups and one-to-one interviews. Please see Appendix for the topic guide.

Focus groups consisted of around six-to-eight people organised specifically for the purpose of gathering feedback from groups identified in the EIA. Where facilitators dropped into pre-existent group meetings the numbers have varied, but the facilitator has continued to conduct the meeting as far as possible using the same methodology as with the focus groups.

Focus groups have been conducted online and in-person, dependent on the availability and or preference of the organisations involved.

2.8.2 HOW SESSIONS WERE FACILITATED

Facilitators provided an overview of the proposed changes to orthopaedic care, including the rationale behind the proposed changes, intended benefits, information about the changes themselves and the process of consultation. Please see Appendix for the topic guide.

Attendees were invited to introduce themselves and state (if applicable and if comfortable) whether they have any experience of receiving musculoskeletal care before beginning with a

series of questions designed to prompt discussion and responses about the proposed changes to orthopaedic care.

STAFF ENGAGEMENT MEETINGS

As well as internal news stories about the proposal and consultation, a schedule of staff engagement meetings at all affected hospitals was arranged by the Collaborative to provide the opportunity for staff to find out more and begin to feed in their views. Please note, a core group of mainly senior clinical staff from across the Collaborative have been leading on the development of the clinical proposal. The output of their clinical design meetings and wider workshops are not included within the staff engagement report.

A similar set of presentation slides were given at these events, and a pro forma provided by Verve for engagement leads to use to gather comments. The following information was supplied to Verve by the consultation team.

Trust	Date	Format	Attendance
Chelsea & Westminster	13/10/22	Online	18
Chelsea & Westminster	22/11/22	Online: Update at all-staff meeting	182
Chelsea & Westminster	Monthly	Agenda item on monthly sub directorate MDT meetings	12-25
Imperial College Healthcare	14/10/22	MS Teams	9 - Departmental Leads
Imperial College Healthcare	14/10/22	MS Teams	Clinicians - Surgeons and Anaesthetists
Imperial College Healthcare	17/10-21/10/22	MS Teams	Clinicians - Surgeons and Anaesthetists
Imperial College Healthcare	17/10-21/10/22	MS Teams	Operational Teams / Wards
London North West University	12/10/22	Online	32 - clinical
London North West University	25/10/22	Online	23 - clinical
London North West University	28/10/22	Online	143 - clinical
Hillingdon Hospitals	12/10/22	Online	7
Hillingdon Hospitals	13/10/22	Online	6
Hillingdon Hospitals	14/10/22	Online	5
Hillingdon Hospitals	18/10/22	Mount Vernon	6-10
Chelsea and Westminster	September 2022	Online	Operational Leads
Imperial College Healthcare	September 2022	Online	Operational Leads
LNW	September 2022	Online	Operational Leads
Hillingdon Hospitals	September 2022	Online	Operational Leads

Table 4. Staff Engagement Meetings

2.9 ANALYSIS

2.9.1 HOW QUALITATIVE RESPONSES WERE ANALYSED

'Qualitative' responses refer to the free text comments which were received during the consultation from a variety of sources:

- Questionnaire free text questions
- Deliberative events – group discussions and Q&A session
- Drop-in events – collected through pro forma
- Focus groups – from facilitator notes
- Miscellaneous comments – received by post, email, telephone.

Qualitative data was analysed by recurring themes, similarities and differences within and between groups and types of participants. Data from the deliberative events, drop in events, focus groups and miscellaneous comments were analysed using an analytical framework devised using the main topic areas of the consultation and the themes arising. Data from the open ended questions in the survey were analysed by developing a coding frame which involved clustering similar answers together to develop categories. The coding frame was constantly checked against new answers and modified if new categories were needed.

Responses to the consultation were also invited from Healthwatch and other partners and stakeholder organisations and seven have been received and included within the analysis.

2.9.2 HOW QUANTITATIVE RESPONSES WERE ANALYSED

Closed questions in the survey were analysed numerically to produce information about the numbers answering. Further analysis was undertaken using cross tabulations to explore the characteristics of people answering in particular ways; cross tabulations by borough were also undertaken. Where numbers were sufficient to be meaningful cross tabulation data is discussed.

2.10 MEETING GUIDANCE AND BEST PRACTICE

2.10.1 RELEVANT DUTIES AND COMPLIANCE

Duties and statutory guidance relevant to this consultation are:

The NHS Act (amended - s14Z55 for ICBs) and statutory guidance[6]
The Gunning Principles[7]
The Government's Consultation Principles[8]
The Equality Act 2010[9].

Also relevant are:

The Government's Four Tests[10], specifically, the requirement for strong public and patient engagement
The Mayor of London's Six Tests[11], which include requirements:
To take into account health and healthcare inequalities

[6] https://www.england.nhs.uk/get-involved/resources/docs/ Working in Partnership with People and Communities - Statutory Guidance (NHS England, July 2022 Version 1. Publication reference: B1762)
[7] https://www.local.gov.uk/sites/default/files/documents/The%20Gunning%20Principles.pdf
[8] https://www.gov.uk/government/publications/consultation-principles-guidance
[9] https://www.legislation.gov.uk/ukpga/2010/15/contents
[10] http://qna.files.parliament.uk/qna-attachments/446472/original/NHS%20E%20planning%20service%20chnage%20guidance.pdf
[11] https://www.london.gov.uk/programmes-strategies/health-and-wellbeing/champion-challenge-collaborate

For meaningful patient and public engagement, including with marginalised groups, in line with Healthwatch recommendations.

The current statutory guidance is *Working in Partnership with People and Communities* (NHS England, July 2022 Version 1. Publication reference: B1762), which can be downloaded from: https://www.england.nhs.uk/get-involved/resources/docs/

This identifies ten principles for working with people and communities (see p.8, p.24) which are set out below.

Figure 1. Ten principles for working with people and communities

In addition, the courts have established guiding principles for what constitutes a fair consultation exercise, known as the Gunning principles:

- Consultation must take place when the proposal is still at a formative stage
- Sufficient information and reasons must be put forward for the proposal to allow for intelligent consideration and response
- Adequate time must be given for consideration and response
- The product of consultation must be conscientiously taken into account.

A table is attached as an Appendix to this report which sets out the ten principles and the Gunning principles, and a short commentary drawn from this report to summarise how these have been addressed.

3. FINDINGS

3.1 SURVEY RESPONSES

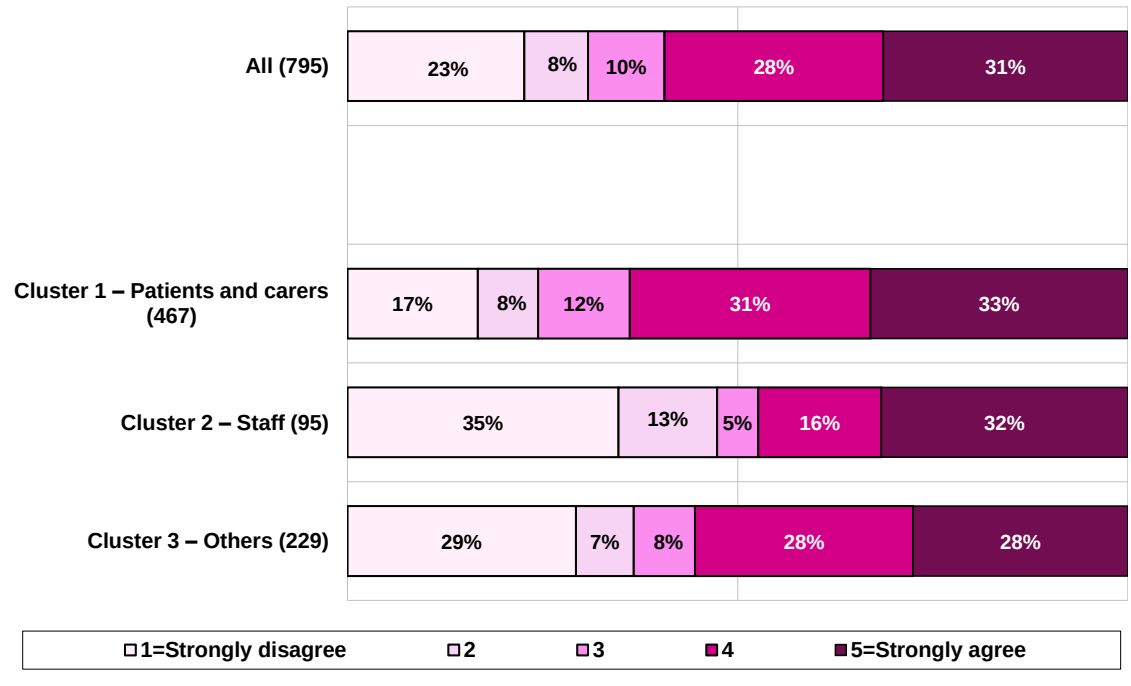
The survey received 807 responses. The tables with full details of the responses can be found in the Appendices. The summary findings are presented here. For the sake of brevity, the numbers given in this section do not include people whose responses were neither positive nor negative – that is, the answers given at the midpoint in a Likert scale. The percentages shown below represent the proportion of people answering each question, unless otherwise stated. Please note: in some instances numbers do not total 100% as respondents may not have answered all questions or all elements of a question.

It should be noted that 28% of responses were from people from Hillingdon. This is twice as many as from the next largest borough responses (Ealing 14% and Hammersmith and Fulham 13%). 8% of responses were from Brent, 7% from Hounslow, 7% from Westminster, 6% from Kensington & Chelsea and 6% from Harrow. 11% of responses were from people living outside the 8 boroughs of North West London.

- 59% of responses were from patients and carers
- 12% of responses were from NHS staff
- 29% of responses were from 'others', that is, people who identified as 'member of the public' (28%) or 'responding on behalf of an organisation' (1%)

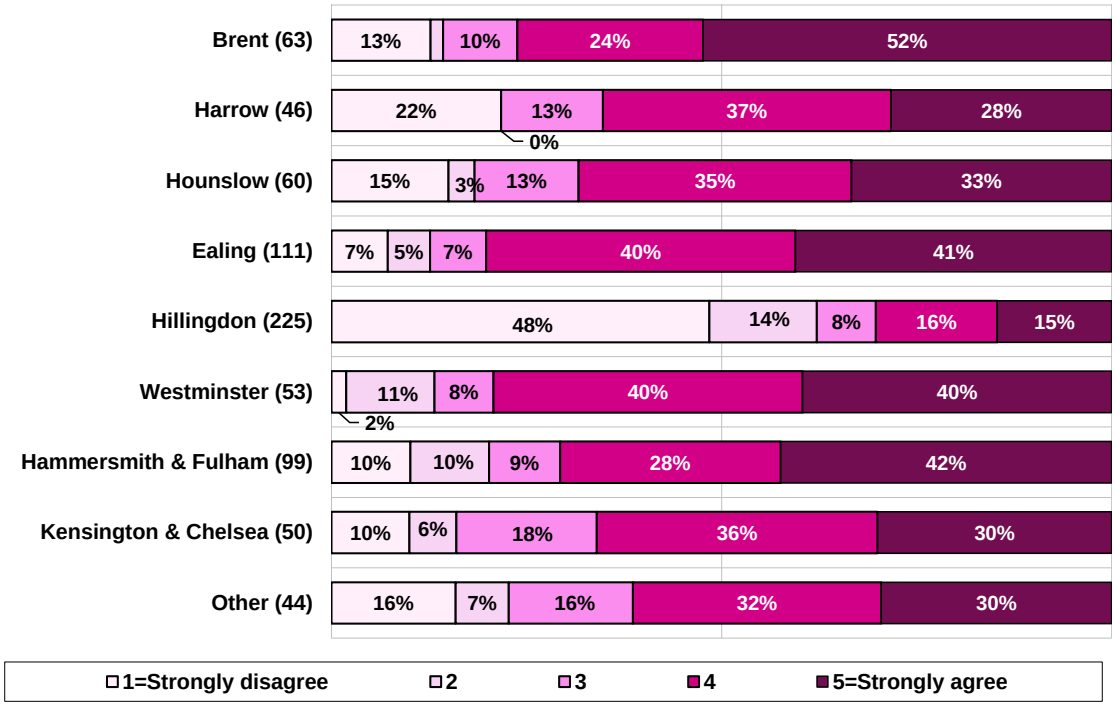
Hillingdon had the greatest proportion of respondents in the 'other' category at 43%; 20% of Hillingdon responses were from patients and carers and 31% from staff.

Overall, 59% of respondents agreed with the proposal to develop an elective orthopaedic centre in North West London.



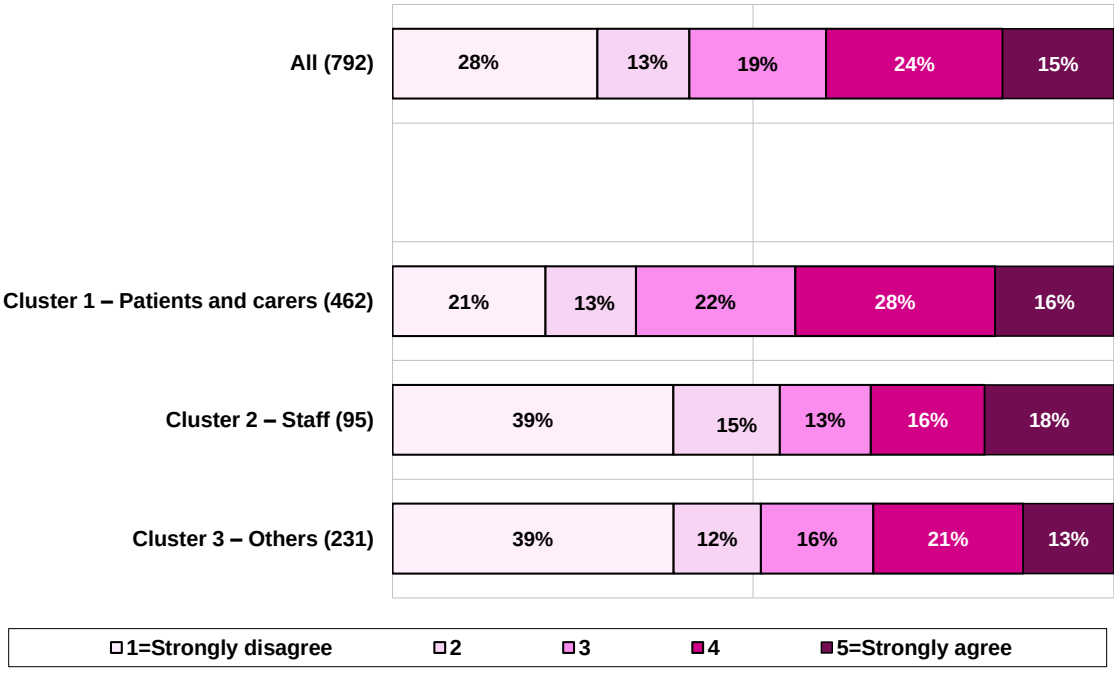
Source: Verve Communications 2023 Base: All respondents who gave a valid answer (267)

People in 7 of the 8 boroughs were supportive of the proposal, whilst people from Hillingdon were more likely to disagree:



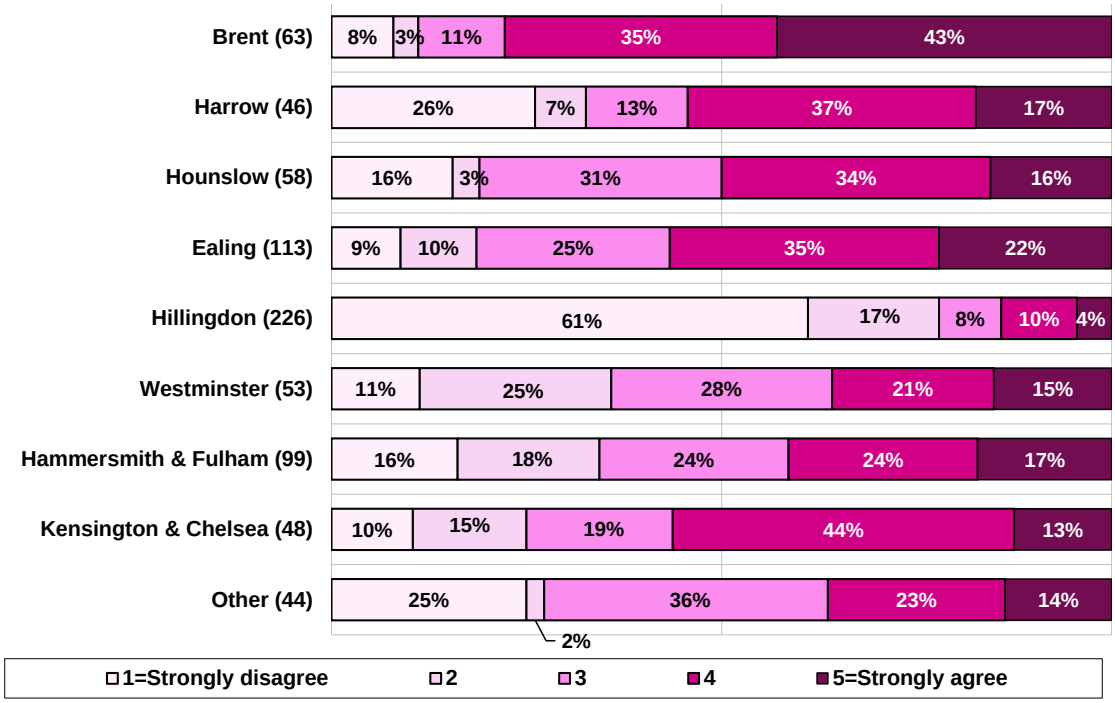
Source: Verve Communications 2023 Base: All respondents who gave a valid answer

When asked about the proposal to site the elective orthopaedic centre at Central Middlesex Hospital 39% of people were supportive of the proposal and 41% of people disagreed with it; patients and carers were more likely to agree than staff or others:



Source: Verve Communications 2023 Base: All who gave a valid answer

More people in Hillingdon disagreed with the proposal to site the centre at Central Middlesex Hospital than those from other boroughs:



Source: Verve Communications 2023 Base: All respondents who gave a valid answer

The main reasons given for disagreeing with Central Middlesex Hospital as the site for the centre related to travel, with staff and others being more likely to cite travel issues as a problem.

People had the opportunity to say why they had given the answer they had, using a free text box. 27% of those who answered said they thought that the proposal was the best option for the future of routine orthopaedic services in North West London, and 14% said they thought that Mount Vernon Hospital would be a better choice for an elective orthopaedic centre, and 11% wanted to keep things as they currently are.

Respondents were asked how well they thought the proposal would meet various challenges Note, for brevity the data below sums agree/strongly agree and disagree/strongly disagree and does not present the numbers of people who answered in the middle of the Likert scale, denoting that they neither agreed nor disagreed. The full tables can be found in the appendices):

- Improving clinical outcomes by providing most routine surgery in a specialist centre focusing on best practice for this type of care
  67% agreed
  21% disagreed

- Providing the same, high quality services wherever patients live in North West London
  62% agree
  28% disagree

- Reducing waiting times between referral and surgery
  63% agree

23% disagree

- Improving efficiency, reducing the cost of surgery and providing more surgery for the same cost
  65% agree
  23% disagree

- Reducing the likelihood of last moment cancellations
  57% agree
  27% disagree

- Help to join up care across hospitals and between hospitals, GPs and community-based services by having simpler routes into and out of surgical services for example
  60% agree
  26% disagree

- Help to improve health more generally by providing faster, better surgical care for everyone who needs it
  62% agree
  25% disagree

- Make it easier for patients by offering more services and communications online
  48% agree
  35% disagree

Breakdowns on these answers by clusters can be found in the appendices.

Participants had the opportunity to add some explanation for their answers in open text boxes. 18% said they had concerns about access to/the impact of digital technology, 17% expressed concerns about the location of Central Middlesex Hospital and 11% wanted to keep services as they are. A full breakdown of the answers can be found in the appendices.

People were asked which challenges were the most important to tackle (and being able to choose up to 3), the top answers were:

- Reducing waiting times between referral and surgery (68%)
- Improving clinical outcomes by providing most routine inpatient surgery in a specialist centre which focuses on best practice for this type of care (50%)
- Helping to improve health more generally by providing faster, better, surgical care for everyone who needs it (41%), and
- Providing the same high quality service wherever people live in North West London (40%)

People were asked their opinions about siting the proposed elective orthopaedic centre at Central Middlesex Hospital with outpatient appointments remaining at local hospitals or online:

- I would be willing to travel further for the best orthopaedic surgery and outpatients closer to home
  55% agree
  34% disagree

- I would prefer my orthopaedic surgery to be at my local hospital even if it meant I had to wait longer

43% agree
42% disagree

- I am concerned about travelling further for surgery, but overall I feel that patients would benefit from the proposed changes
  47% agree
  37% disagree

- I am concerned that some staff would need to move between hospitals regularly
  61% agree
  16% disagree

- I am concerned that 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
  70% agree
  13% disagree

Breakdowns for each of the above statements by cluster can be found in the appendices.

The top reasons given for these answers related to transport and travel

3.2 QUALITATIVE RESPONSES

The qualitative responses presented in this section come from the focus groups, one to one interviews and events facilitated by Verve, and the data gathered by NHS colleagues from other engagement events. Quotations are used in this section to illustrate points made by respondents

In general there was support for the proposed model of care, however, there were two major caveats to that support; transport and discharge to home.

3.2.1 PROPOSAL FOR CREATING AN ELECTIVE ORTHOPAEDIC CENTRE FOR MOST ROUTINE SURGERY

Support for the model

- Generally, participants thought that creating an elective orthopaedic centre was a good idea – and people understood that separating planned surgery from urgent and emergency surgery was likely to reduce cancellations for planned operations

- For many people the benefits outlined in the proposal outweighed the inconveniences of needing to travel further to the centre – however, travel was the biggest issue raised – the complexity of journeys, longer journeys, more time needed and the costs

  "Great idea – about time it needs to be done. I mean, ever since I heard there was an elective centre in South East London, I thought, why don't they get on with it? Obviously, there's a lot of detail that needs to be sorted out, but I think it's absolutely necessary."

- Some participants pointed out that they already had to go to different hospitals for different aspects of care (an example given was for MRI scans), so they did not see this model of care as being different from their current experiences.

- Reducing the chances of last minute cancellations of operations was seen as a benefit of the model. It was deemed to be especially important for people who need to make arrangements for when they leave the hospital. One person said she lived alone and would need to get relatives from abroad to come and help her; a late cancellation would mean loss of money as flights would not be able to be changed at short notice. Further, people with mental health conditions said that cancellations led to great anxiety for them, so reducing the chances of this happening would be beneficial to them.

- Some participants thought that the proposal would be of benefit for the majority of patients, including those with complex needs for whom the elective orthopaedic centre would not be suitable:

  "Free up capacity locally to reduce waiting times for more complex issues"

Concerns about the model

- Some people were sceptical about whether the proposal could work and, if it did work, whether it could achieve its goals. There were some comments that basing the plan on the model used for the South West London Elective Orthopaedic Centre was problematic because the geography was very different and travel was more difficult in North West London; further, people wanted to see evidence of how successful the model had been in achieving its goals; there were comments that more evidence should be given on what counted as success in South West London. Participants also requested clarity on what constitutes 'routine' surgery and would have liked information about what the parameters are for this.

- People had strong concerns about discharge after routine orthopaedic surgery, from the difficulty of getting home from the hospital (and what transport arrangements there might be to facilitate this) to what sort of care and support there would be in the community. Some participants had had bad experiences of being discharged without support in the past; there were queries about how the model was proposing to deal with issues such as these

- There were people who were against the proposals in principle, believing that they would not solve the problems the NHS currently faces; they saw patient choice (to be referred for operations to hospitals with shorter waiting lists) and increasing staffing levels for current services as the main requirements at the moment. They had concerns that an elective orthopaedic centre would take staffing resources away from other hospitals.

  "If this proposal goes ahead, there must be a full choice retained for patients in the future"

- There were some people who would prefer to keep the status quo and have surgery at their local hospital:

  "I want my hospital, not that one. There is nothing wrong with my local hospital so why do I need to go there?"

- Some participants raised concerns about staff needing to travel between sites, and some clinical staff who attended were of the opinion that multisite working could mean losing some skilled staff.

- Participants who had complex needs queried how the proposals would affect them. Some people worried that if resources were being put into routine operations for people with few or no co-morbidities those with complex needs might face longer waiting lists.

- Some people asked how the model would reduce health inequalities, saying that people from some communities might be more disadvantaged than they currently are by having to travel further

3.2.2 PROPOSAL TO LOCATE THE ELECTIVE ORTHOPAEDIC CENTRE AT CENTRAL MIDDLESEX HOSPITAL

Whilst the model of an elective orthopaedic centre was generally seen in a positive light, the proposed location at Central Middlesex Hospital was less well received, in particular for people who would have long, complex, or expensive journeys to the hospital

Experience of Central Middlesex Hospital

- People with experience of Central Middlesex Hospital felt that the facilities there were good

Travel

- The most discussed issue across all of the qualitative fieldwork (and in the survey) was transport and travel to Central Middlesex Hospital. Many people pointed out that for some patients the journey would be more difficult, complicated and costly than going to their local hospital. There were many comments that people who could not afford the journey to and from the hospital would be disadvantaged. Some participants commented that the median travel times, cited in the documentation and at presentations, were not reflective of the difficulty or cost of some journeys.

- Whilst many people were willing to travel further for elective surgery getting to Central Middlesex Hospital in particular was seen as problematic; this view largely depended on where people lived and the public transport from their area to Central Middlesex Hospital

  "This kind of specialist centre… I think it's a good thing. In London they have UCL and people come from all over… and they are not talking about transport there."

- For those with relatively easy journeys to Central Middlesex Hospital the proposed location was not a problem, even if the journey was longer. However, for people whose journeys were be complicated (for example, changing buses several times) or a great deal longer than going to their local hospital the location was seen as problematic

  "It's not for the benefit of the patient to ask them to travel an hour or two for the operation. The need to not get stressed, nervous, and feel under pressure before the operation."

- There were also concerns that visitors would have difficult journeys

- Driving to Central Middlesex Hospital was seen as a problem as the traffic around the hospital was said to be very busy, finding car parking was difficult and parking was expensive

- Concerns were raised by many participants about travel for patients with mobility problems or pain. People said that the nearest tube station did not have a lift and was a long walk for people struggling with pain or movement problems

- Overall, there was concern that those who could drive and afford parking, or who could afford to take a taxi, would benefit more from the hub being at Central Middlesex Hospital than those who would find travel very difficult, complex and/or expensive – and for the latter group there were strong concerns that the service would be worse than that currently offered.

- There were comments from those who had seen the presentations at events that the transport information was not realistic; median distances were felt not to be a fair reflection of reality. Peopled pointed out that journeys involved cost as well as distance and time, and that people making the journey were likely to have orthopaedic pain and mobility issues.

Alternative sites

- Some people queried why Central Middlesex Hospital had been chosen rather than Mount Vernon, which was said to have the advantage of being easier to access

3.2.3 DIGITAL SERVICES

- The proposals for having more digital engagement with patients were seen as good and efficient ways of using people's time for patients who were happy to use them, however, participants were concerned that some people would not be able to utilise digital services and were at risk of missing out. Strong views were expressed that there needed to be alternatives to digital communications and appointments for all who wanted them

- There was some concern expressed about whether patient notes would be in the right place, at the right time, if people were receiving care from more than one hospital.

3.2.4 SPECIFIC FEEDBACK FROM FOCUS GROUPS AND INTERVIEWS WITH UNDERREPRESENTED GROUPS

People were recruited to take part in focus groups and one to one interviews to boost the representation of groups who, at the mid-point of the consultation, were underrepresented in the work to date – particularly after an analysis of the survey answers to that date. The underrepresented groups were:

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

The feedback in this section is specifically from the focus groups and interviews with underrepresented people.

- Some participants believed that the proposed model, and in particular the siting of the elective orthopaedic centre at Central Middlesex Hospital had the potential to create or exacerbate inequalities, rather than reduce them, for example people who did not have access to their own transport might find the journey to Central Middlesex Hospital too expensive to make by taxi and too arduous by public transport. Even those who had access to a car would have to pay for parking, which might be beyond their means. A concern which came up across all of the focus groups was the potential for travel problems to disadvantage some of the most vulnerable people including older people, people with disabilities, people who were economically deprived and carers.

- One group comprising Black and minority ethnic people said that people from some ethnic backgrounds are less likely to seek elective surgery as they do not understand the benefits of it and currently there is not the time or capacity for people in the system to explain fully why they should consider orthopaedic surgery. The group felt that people from their communities would need extra input from health professionals, and support in hospitals to ensure their cultural needs were met. After surgery people would need support to undertake

physiotherapy. All these elements would need to be in the model to ensure more equity for some communities.

- People for whom English was not their first language sometimes struggled to understand written and verbal communications. Interpreters, when available, were helpful, but they were not there all the time when people were in hospital. One participant described having a problem booking a taxi to get home after an operation because she did not know how to ask for help on a busy ward.

- Some participants said that people from their communities were already missing out on elective orthopaedic surgery because there was a perception that it is for people who have the time and lifestyle to be able to exercise before and after surgery:

  "I always think of orthopaedic surgery as the most middle-class of surgeries. It's not for people where we're living."

  Participants said that for the plan to break down barriers and reduce health inequalities this needs to be understood and acted upon.

- People in jobs without sick pay said they would not be able to take several weeks, or more, off work after an operation.

- Concerns were raised by people with additional needs, who said that the complexities of navigating care across different hospitals could stand in the way of them seeking, or going ahead with, orthopaedic care. It was thought that travel to Central Middlesex Hospital could be particularly off putting for people with additional needs if the journey was unknown to them or was thought to be too complicated to undertake.

- People who lived on their own, especially older people and people with disabilities, were concerned about the process of being discharged from hospital, and the level of support they might get once they were at home. These people expressed worries that they would be disadvantaged if they could not cope alone at home, and worried about what step down care would be available for them. They felt that people who lived with others were at an advantage as they would have help to hand.

- Participants felt strongly that digital services should be a choice, as there were still many people who could not use, or chose not to use, technology for many reasons. The general opinion was that some people would be digitally excluded unless alternatives were available, and non-digital access was easy.

3.2.5 GENERAL FEEDBACK NOT FOCUSSED ON SPECIFIC PROPOSALS

- Some people felt the proposal was primarily focussed on surgery, and they felt that a more holistic approach was needed to ensure good patient outcomes. They tended to talk about care after surgery, including discharge practices, to ensure that people could get home safely and have adequate support in their homes for day-to-day tasks

- Physiotherapy after discharge was discussed, including the need to ensure that people were able to undertake their exercises and have ongoing support from physiotherapists. People said good outcomes could only be achieved with good aftercare:

  "For example, if you haven't properly planned discharge with somebody with a hip replacement and you send them home on a shuttle bus…and they dislocate that hip on the way home, because they haven't understood the physio instructions – they haven't

had long enough to understand it - they'd end up in an A&E department having to have it put back. So, you're back on the revolving door circuit."

- Some concerns were raised about whether patients' notes and information would be fully available on all sites, in the right place at the right time
- There were also a small number of issues raised about patient confidentiality and the safety of their data if information was being shared between sites
- There were queries about how GPs would be supported to help their patients when they were discharged, and whether this sort of support was part of the plan
- Participants felt that communications needed to be very good and co-ordinated in order for the plan to work – for example, patients had to be sure of where their next appointment was
- Communications in different languages was also raised – participants gave instances of patients not understanding communications from hospitals and missing appointments which, in turn, led to them being taken off waiting lists
- Some people asked about how people with dementia would be supported and how their needs would be met

3.2.6 POTENTIAL MITIGATIONS RAISED BY PARTICIPANTS

Travel

- Planning with patients and their families/carers about how they will get to Central Middlesex Hospital for operations, and back again
- Have an integrated taxi service which could take two or three patients to Central Middlesex Hospital in one journey
- Develop a fleet of trained taxi drivers who could transport patients safely, especially post operatively, and see them into their homes
- Promote community transport
- Have shuttle buses between hospitals. Shuttle buses should have lifts and grab bars to help less mobile people
- Have local minibuses to pick people up en route to Central Middlesex Hospital
- All transport options put in place should be available for carers as well as patients
- Public transport buses should drive into the hospital campus and stop directly outside the hospital rather than on the road outside
- Reduce car parking fees for carers, for example, have the first 90 minutes free
- Allow patients to choose to have surgery at their local hospital

Communications

- Invest in communications materials to ensure they are accessible, for example, in different languages and easy read versions
- Have BSL interpreters available at appointments and in hospitals whilst people are inpatients
- Ensure there are hearing loops in reception areas
- Systems should flag that deaf people need text messages not telephone calls
- Hospital masks should have clear sections so lip readers can communicate
- Ensure patient notes are available to all who need them

- Make sure patients know about systems which are in place, such as Patient Knows Best, so that those who choose to can use them.

Support

- Consider doing pre-operative assessments online to minimise travel, or do them with GPs and local pharmacists
- Patients should be put in touch with local services who can help them and their carers when they get home, for example, to help with physiotherapy and emotional support
- Have a real person as a point of contact, not an automated service
- Ensure that people with additional needs have the support they need at appointments, whilst in hospital and once they get home
- Discharge should be co-ordinated to include social services, carers, pharmacists and any other service needed, all of whom should be fully informed about the patient's progress. Care at home should be in place before discharge
- Have advocates for inpatients to help overcome cultural barriers during hospital stays
- Have a rehabilitation centre for people who need care at home, as step down care after their hospital stay, to reduce the stress for carers
- Put in place reablement packages for the first six weeks post-surgery, including physiotherapy, occupational therapy and social care
- Ensure that Central Middlesex Hospital has a canteen which opens into the evening so visitors and carers can get a hot meal.
- Some people with additional needs such as mental health issues had experienced support from staff when they needed operations, such as having the contact details of a named nurse who helped them throughout their patient journey, including helping them to arrange transport and managing appointments. This was seen as particularly beneficial when a patient had to go to different hospitals. Participants with additional needs would welcome this level of support
- For some people with additional needs, for example people on the autistic spectrum, being able to visit unfamiliar hospitals ahead of having surgery would be beneficial
- Planning with patients and their carers, well ahead of having surgery, would help them to access the services being proposed

Other

- Research should be done to assess whether there is a reduction of the number of people from Black and minority ethnic communities on waiting lists before and after any changes to services.

3.3 RESPONSES FROM ORGANISATIONS

Seven responses were received from organisations. Generally the responses supported the elective orthopaedic centre model, but concerns were raised about the proposal for the hub being sited at Central Middlesex Hospital, as transport to and from the hospital was deemed to be difficult.

The table below summarises the responses, all of which appear in full in the appendices.

Organisation name	Borough	Main points about the proposal
Cllr Sarah Addenbrooke, Lead Member for Adult	Kensington & Chelsea	• Welcomed the consideration of different models of care building on best practice.

Organisation name	Borough	Main points about the proposal
Social Care and Public Health at the Royal Borough of Kensington and Chelsea		• Concerns about residents having to travel out of borough for inpatient orthopaedic surgery – due to taking more time away from paid work and increased travel costs. • Car ownership in the borough is relatively low, raising a concern about reliance on public transport to attend clinical appointments. • Urged the Healthier North-West London team to work with the Council on supporting local employment and apprenticeship pathways re local jobs in healthcare and continuing to consult with residents in a meaningful way, and to have meaningful engagement between the ICS and the Joint Health and Wellbeing Board in decision making processes such as consultations.
City of Westminster – Children, Adult Public Health and Voluntary Sector Policy & Scrutiny Committee	Westminster	• The Chair and Committee support the plans and recommendations • The following were Highlighted for further consideration: o Wasted time for staff, travel distance for patients and plans to address these issues with the opening of the orthopaedic in-patient surgery in NW London o Concerns about whether patients would be able to choose to attended the proposed centre o Whether consideration will be given to other personal requirements of patients
Hammersmith & Fulham Save Our NHS (HAFSON)	Hammersmith & Fulham	• Endorsement of the proposal in general terms • Endorsement of Central Middlesex Hospital as the site for the hub • Concerns were raised about transport, from several perspectives, including for patients, visitors and staff. • Welcomed the idea presented in the full business case for developing a shuttle bus services, with the caveat that trained staff would be needed to ensure safe delivery home of post operative patients. • Called for greater clarity on what constitutes 'routine' surgery and patient choice in the model. • More detail on how the model will work in the longer term was requested and the impacts on hospitals other than Central Middlesex Hospital. • Digital systems should not be the default and patients should have choices, to avoid exclusion of those unable to use technology for any reason. • Would welcome more detail on staff development, governance, finance

Organisation name	Borough	Main points about the proposal
		arrangements and whether the service would remain in public ownership.
Hammersmith and Fulham Health and Adult Care Policy and Accountability Committee.	Hammersmith and Fulham	• The committee see the elective orthopaedic centre proposals as a welcome solution to the challenge of addressing the backlog of orthopaedic services across NWL, however, the plan would be further enhanced if patient transport and travel issues could be suitably resolved. • Patients should have choice about where to have their operation, with no disadvantages. • Public transport links to Central Middlesex Hospital were of concern – and the committee urges the Trust to continue to explore the feasibility of establishing a patient dedicated service. • Travel costs and transportation negatively impact marginalised and economically vulnerable groups. • More detail on staffing provision would be welcomed, including potential impacts on local provision. • There are concerns about digital inclusion, and the committee would welcome measures to ensure that those most affected are not further disadvantaged.
Mayor of London		• Broadly supportive of the proposed changes. • Considers the final plans should: o Account for the potential risks of widening health inequalities identified in the Nuffield Trust review, and offset these risks with actions to improve equity in elective orthopaedic centre in NWL o Put forward a detailed workforce plan addressing the risk that of shifting staff to the new orthopaedic centre could reduce capacity in surrounding hospitals and services. o Show how capacity freed up by the shift in activity to the elective orthopaedic centre will be used or redeployed to realise the potential savings associated with the proposal. o Set out a detailed consideration of the impact of the changes on social care services in NWL.
Nuffield Trust (draft report commissioned by the Mayor of London)		NOTE: The Mayor's comments, above, are based on the Nuffield Trust's draft report.

Organisation name	Borough	Main points about the proposal
Adult Social Care and Health Select Committee Royal Borough of Kensington and Chelsea	Kensington and Chelsea	• Welcomed an increase in healthcare resources for orthopaedics and the setting up of a specialist centre to reduce waiting lists for elective surgery in orthopaedics. • A number of concerns were raised for consideration: o Transportation, particularly for those using public transport, to Central Middlesex Hospital more likely to be a barrier for those in RBKC because of distance to travel, and there could be further impact for those with physical and financial barriers to accessing transport services o The business case presents some mitigations to transport barriers but these need to be explored in more detail as part of the implementation o Careful monitoring will be needed of wait times and differences between those choosing to have elective surgery in their local hospitals and those choosing to use the proposed elective orthopaedic centre o The business case acknowledges that deprivation can be a barrier to accessing healthcare - RBKC has areas of deprivation in the north, south and south-west of the borough.

4. APPENDICES

4.1 APPENDIX – QUESTIONNAIRE

Public consultation survey:

Improving planned orthopaedic inpatient surgery in north west London

1. **Which of the following best describes you?** (Please tick one option)

- ☐ Current / recent orthopaedic surgery patient in north west London (within last five years)
- ☐ Carer / family member of a patient
  Please tell us which hospital: .....
- ☐ Member of the public
- ☐ Member of NHS staff
- ☐ Responding on behalf of an organisation

2. Please tell us which organisation: .....

Where you live

Use your home address if answering as an individual OR your organisation address if answering as a representative of an organisation.

3. **Please provide the following information from your postcode:**

The first part of your postcode (this may have two to four characters, for example W14, WC1N, NW1):

.....

4. **The first number of the second part (for example 1, 0 or 3)**

.....

5. **Which borough do you live in?** .....

Your views on the current proposal

The consultation document sets out the reasons we believe we need to change the way we organise orthopaedic surgery for people living in north west London. We are proposing that most routine, inpatient surgery should be carried out at a single specialist centre (elective orthopaedic centre) while other types of orthopaedic surgical care (such as outpatient care, surgery for patients with complex needs, urgent orthopaedic surgery) would continue to be provided at the nine hospitals that currently provide orthopaedic surgical care.

After analysis, we have selected Central Middlesex Hospital as the location for the proposed elective orthopaedic centre (the consultation document explains how we selected this

6. **To what extent do you agree with the proposal to develop an elective orthopaedic centre for most routine, inpatient orthopaedic surgery in north west London?**

Please indicate your level of agreement below, where a score of 1 is strongly disagree and a score of 5 is strongly agree. Please tick ONE option

1 Strongly disagree	2 Disagree	3 Neither agree nor disagree	4 Agree	5 Agree strongly	Don't know	Prefer not to say

7. **Why do you think this?** (You may leave this box empty if you have no other comments)

8. **To what extent do you agree with the preferred location of the elective orthopaedic centre at Central Middlesex Hospital?**

Please indicate your level of agreement below, where a score of 1 is strongly disagree and a score of 5 is strongly agree. Please tick ONE option

1 Strongly disagree	2 Disagree	3 Neither agree nor disagree	4 Agree	5 Agree strongly	Don't know	Prefer not to say

9. **Why do you think this?** (You may leave this box empty if you have no other comments)

10. **Do you think there are any alternative options which should be considered to meet the challenges set out in the consultation document?**

The consultation document describes the key challenges as we see them for orthopaedic surgical care in north west London and how we believe the proposal would help tackle these challenges.

11. How well do you think the proposal would help to meet each of the following challenges?

Please indicate your level of agreement to each statement below, where a score of **1 is strongly disagree** and a score of **5 is strongly agree**.

I believe the proposal for orthopaedic surgery could...	**1** Strongly disagree	**2** Disagree	**3** Neither agree or disagree	**4** Agree	**5** Agree strongly	**Don't know**	**Prefer not to say**
Improve clinical outcomes by providing most routine inpatient surgery in a specialist centre that focuses on best practice for this type of care							
Provide the same, high quality service wherever patients live in north west London							
Reduce waiting times between referral and surgery							
Improve efficiency, reducing the cost of surgery and providing more surgery for the same cost							
Reduce the likelihood of last moment cancellations							
Help to join up care across hospitals and between hospitals, GPs and community-based services, by having simpler routes into and out of surgical services for example							
Help improve health more generally by providing faster, better surgical care for everyone who needs it							
Make it easier for patients by offering more services and communications online							

12. Please let us know why you have given this response (You may leave this box empty if you have no other comments).

13. Thinking about the following challenges, which do you believe are the most important to tackle?

Please put an X in the second column for UP TO THREE from the following list

I believe these challenges are the most important to tackle…	X
Improve clinical outcomes by providing most routine inpatient surgery in a specialist centre that focuses on best practice for this type of care	
Provide the same, high quality service wherever patients live in north west London	
Reduce waiting times between referral and surgery	
Improve efficiency to reduce the cost of surgery and provide more surgery for the same cost	
Reduce the likelihood of last moment cancellations	
Help to join up care across hospitals and between hospitals, GPs and community-based services, by having simpler routes into and out of surgical services for example	
Help improve health more generally by providing faster, better surgical care for everyone who needs it	
Make it easier for patients by offering more services and communications online	

14. Please let us know why you have given this response (You may leave this box empty if you have no other comments).

15. Thinking about a single elective orthopaedic centre at Central Middlesex Hospital (with outpatient appointments at a local hospital or online), please indicate how strongly you agree with each of the following statements.

In my opinion…	1 Strongly disagree	2 Disagree	3 Neither agree or disagree	4 Agree	5 Strongly agree	Don't know	Prefer not to say
I would be willing to travel further to receive the best orthopaedic surgery, with my outpatient appointments closer to home							
I would prefer my orthopaedic surgery to be at my local hospital even if it meant I had to wait longer							
I am concerned about travelling further for surgery, but overall I feel that patients would benefit from the proposed change							
I am concerned that some staff would need to move between hospitals regularly							
I am concerned that 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							

16. Please add any additional comments about travel and transport to Central Middlesex Hospital. We are particularly keen to hear suggestions for how travel and transport may be made easier for patients, or the site made more accessible. (You may leave this box empty if you have no other comments).

About you

We are committed to ensuring everyone has the chance to participate fully in the activities and decisions of our organisations. By completing the following section, you will help us to understand who we are reaching and how to better serve everyone in our community. We will cross-reference this information with your answers, to help us understand the views of different groups within our community.

Please tick **ONE** option for each question. All responses are optional and will remain anonymous.

17. Which age group are you in?

- ☐ 11 – 15
- ☐ 16 – 18
- ☐ 19 – 24
- ☐ 25 – 34
- ☐ 35 – 44
- ☐ 45 – 54
- ☐ 55 – 64
- ☐ 65 – 79
- ☐ 80+
- ☐ Prefer not to say

18. Which of the following options best describes how you think of yourself?

- ☐ Female
- ☐ Male
- ☐ Non-binary
- ☐ In another way
- ☐ Prefer not to say

19. Is your gender identity the same as the gender you were given at birth?

- ☐ Yes
- ☐ No
- ☐ Prefer not to say

20. Do you consider yourself to have a disability?

- ☐ Yes
- ☐ No
- ☐ Prefer not to say

21. Please select what best describes your ethnicity

- ☐ White: Welsh/English/Scottish/Northern Irish/British
- ☐ White: Irish
- ☐ White: Gypsy or Irish Traveller
- ☐ White: Any other White background
- ☐ Mixed: White and Black Caribbean
- ☐ Mixed: White and Black African
- ☐ Mixed: White and Asian
- ☐ Mixed: Any other mixed background
- ☐ Asian/Asian British: Indian
- ☐ Asian/Asian British: Pakistani
- ☐ Asian/Asian British: Bangladeshi
- ☐ Asian/Asian British: Any other Asian background
- ☐ Black or Black British: Black - Caribbean
- ☐ Black or Black British: Black - African
- ☐ Black or Black British: Any other Black background
- ☐ Other ethnic background: Chinese
- ☐ Other ethnic background: Any other ethnic group
- ☐ Prefer not to say

22. Please indicate which option best describes your religion or belief

- ☐ No religion
- ☐ Buddhist
- ☐ Christian
- ☐ Hindu
- ☐ Jewish
- ☐ Muslim
- ☐ Sikh
- ☐ Atheist
- ☐ Any other religion
- ☐ Prefer not to say

23. Please indicate the option which best describes your sexual orientation

- ☐ Heterosexual
- ☐ Gay
- ☐ Lesbian
- ☐ Bisexual
- ☐ None of the above
- ☐ Prefer not to say

Keeping in touch with you

24. It would help us to know how you heard about this consultation

- ☐ My local hospital website
- ☐ Another website (please state)
- ☐ Newspaper
- ☐ Posters in the community
- ☐ Social media (Facebook/Twitter/Instagram)
- ☐ Word of mouth
- ☐ Don't know / can't remember
- ☐ Other (please state)

.....

Please provide your email address if you would like to be kept up to date with the consultation and future development of orthopaedic surgery in north west London

.....

Please note, **we will not** link your email address to the answers you have given to the consultation questions

You can read our privacy policy by visiting www.nwlondonics.nhs.uk.

4.2 APPENDIX – SOCIAL MEDIA, METRICS AND OTHER CHANNELS OF COMMUNICATION USED DURING THE CONSULTATION

<table>
<tr><th>Social media</th><th>Metrics</th></tr>
<tr><td>Platforms used</td><td>NHS North West London
Twitter
Facebook
Imperial College Healthcare
Twitter
Facebook
LinkedIn
The Hillingdon Hospitals
Twitter
Instagram
Facebook
LinkedIn
Nextdoor
Chelsea and Westminster Hospital
Twitter
Facebook
Instagram
London North West University Healthcare
LinkedIn
Facebook
Twitter</td></tr>
<tr><td>Organic posts</td><td>NHS North West London (ICB)
Twitter - 15 posts, 4895 impressions in total
Facebook - 15 posts – reach 287 in total
<table>
<tr><th>ICB Next Door</th><th>ICB Citizen Panel</th><th>Where</th><th>Date</th></tr>
<tr><td>15295</td><td>2711</td><td>NWL</td><td>15/11/2022</td></tr>
<tr><td>5027</td><td>1292</td><td>NWL</td><td>14/12/2022</td></tr>
<tr><td>4892</td><td>687</td><td>NWL</td><td>11/01/2023</td></tr>
<tr><td>1502</td><td>307</td><td>Hillingdon</td><td>28/10/2022</td></tr>
<tr><td>1259</td><td>221</td><td>Harrow</td><td>27/10/2022</td></tr>
<tr><td>1326</td><td>279</td><td>Hounslow</td><td>27/10/2022</td></tr>
<tr><td>1356</td><td>298</td><td>Ealing</td><td>26/10/2022</td></tr>
<tr><td>1430</td><td>447</td><td>Brent</td><td>25/10/2022</td></tr>
<tr><td>Total 32087</td><td>Total 6242</td><td></td><td></td></tr>
</table>
Imperial College Healthcare
Facebook:
Number of posts: 39</td></tr>
</table>

	Reach: 25,980 Likes: 102 Click-throughs: 439 Twitter: Number of posts: 44 Impressions: 22,507 Likes: 33 Click-throughs: 71 LinkedIn: Number of posts: 12 Impressions: 8,599 Likes: 50 Clicks: 96 **The Hillingdon Hospitals** Facebook: Number of posts: 22 Reach: 8,259 Likes: 19 Staff Facebook Group: Number of posts: 6 Reach: 344 Likes: 7 Twitter: Number of posts: 28 Impressions: 7,219 Likes: 14 Link clicks: 17 Instagram: Number of posts: 8 Reach: 2,230 Likes: 26 Nextdoor: Number of posts: 3 Impressions: 3,428 LinkedIn: Number of posts: 3 Impressions: 529 Likes: 5 **Chelsea & Westminster Hospital** Facebook: Number of posts 14

<table>
<tr><td></td><td>Overall reach 6,529

Twitter
Number of posts – 19
Total impressions – 5,317

Instagram
Number of posts – 4 posts, 8 stories
Overall reach 3,347

London North West University Healthcare
LinkedIn:
Number of posts: 20
Impression: 9,531
Likes: 67
Clicks: 137

Facebook:
Number of posts: 25
Reach: 16,710
Likes: 58
Clicks: 67

Twitter:
Number of posts:21
Impressions: 8,340
Engagement: 148
Retweets: 9
Likes: 11</td></tr>
<tr><td>Paid posts run by Verve on Facebook</td><td>Campaign advertising public events:
<table><tr><th>Ad set name</th><th>Impressions</th><th>Reach</th><th>Link clicks</th></tr><tr><td>All</td><td>43,4826</td><td>73,440</td><td>4,403</td></tr><tr><td>North West London</td><td>31,8554</td><td>65,488</td><td>3,210</td></tr><tr><td>Hillingdon</td><td>53,193</td><td>21,527</td><td>504</td></tr><tr><td>Hammersmith and Fulham</td><td>36,325</td><td>16,000</td><td>411</td></tr><tr><td>Virtual Event</td><td>26,754</td><td>12,116</td><td>278</td></tr></table>
Campaign specifically advertising online public events
<table><tr><td>All</td><td>27,1246</td><td>72,896</td><td>1,872</td></tr></table></td></tr>
<tr><td>Collaborative website</td><td></td></tr>
<tr><td>Questionnaire hosted</td><td>4022 page views to consultation homepage
1676 views to survey page
1442 views to proposal page
807 surveys completed online (of these, 244 surveys were received to the Freepost address)</td></tr>
</table>

Documents	267 combined downloads of consultation materials
Print and promotion	
Consultation documents and leaflets	Three print-runs over the consultation period – total printed: 1,100 full consultation documents 8,250 of the summary consultation leaflets (including 2,094 sent as part of direct mailing to patients from Imperial College Healthcare)
Printed surveys	3,650 in total over three print runs. 2,094 were sent as part of Imperial College Healthcare's direct mail, alongside the summary leaflets. The rest were distributed evenly across the four acutes to distribute across hospital locations and the ICB to take to meetings and share with community organisations.
Posters	265 posters – allocated to each Trust to put up across 9 hospital sites and to the ICB to take to meetings and share with community organisations.
Easy Read	Made available in digital format on the consultation section of the acute provider collaborative microsite and sent upon request to consultees.
Emails	Launch press release email sent to NWL MPs, local authorities, Healthwatches and NHS campaign groups on 20 October Further emails to NWL MPs, local authorities, Healthwatches, GP practices and NHS campaign groups re: consultation events on 21 October 2022 (total c.2,300 emails) Further Stakeholder / Member / GP Letters re: consultation events on 25 October 2022 (total c.1,400 emails) Final call emails sent to stakeholders / members / GP practices mailing lists for submissions on 6 January 2023 (total c.2,300 emails)
Hospital site activity	Volunteers and patient experience representatives at Imperial College Healthcare and Chelsea & Westminster Hospital were briefed to periodically speak with patients in hospital waiting areas to raise awareness of the consultation and encourage completion of the survey. A briefing was also provided to patients attending Joint School clinics (in-person and virtually) to encourage participation.
Direct mail to patients	All four acute provider trusts sent a direct mail to patients who are either currently on the waiting list for orthopaedic surgery or who have had their surgery in the previous one year.
	Chelsea and Westminster Hospital sent a text message via the DrDoctor application to the waiting list. 1740 patients were contacted.

	London North West University Healthcare sent an SMS message to 1477 patients. A further 109 hard copy letters were sent to patients without a mobile number. The Hillingdon Hospitals sent 2477 SMS messages to patients on the waiting list. Imperial College Healthcare sent 2094 letters to patients on the waiting list with surveys and a Freepost envelope enclosed.
Media/Press	
News releases	A press release announcing the launch of the launch of the consultation with details on how members of the public could share their views, was issued by all acute provider trust to their local press contacts.
News coverage	Imperial College Healthcare: Three articles, including from one title pitched to (This is Local London): https://www.thisislocallondon.co.uk/news/23090417.super-surgical-centre-planned-brent/ https://www.kilburntimes.co.uk/news/23090417.super-surgical-centre-planned-brent/ https://london-post.co.uk/share-your-views-on-nhs-proposal-to-improve-orthopaedic-surgery-in-north-west-london/ London North West University Healthcare: Brent and Kilburn Times 31 Oct 2022 Harrow Times 31 Oct 2022 The Hillingdon Hospitals: https://www.hillingdontimes.co.uk/news/23245770.plans-centralise-knee-hip-replacement-ops---views-sought/ https://www.mylondon.news/news/west-london-news/west-london-hospital-1200-patients-24541352

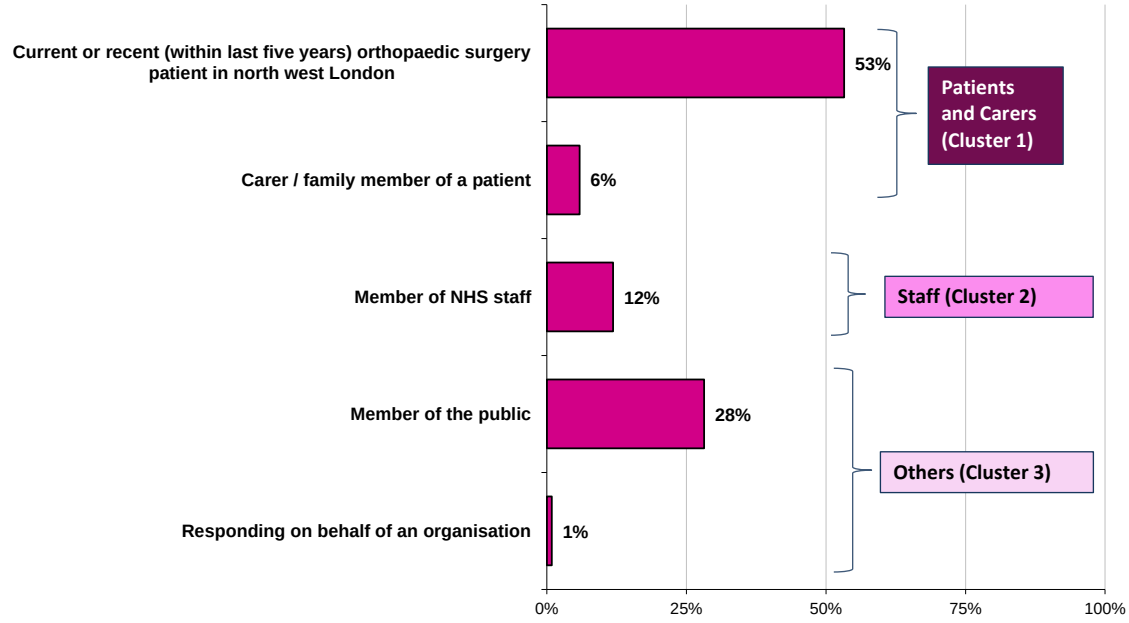
4.3 APPENDIX – ENGAGEMENT WITH LOCAL AUTHORITIES

Lead organisation(s)	Details of engagement
Integrated Care Board with the acute provider collaborative	NW London Joint Health Overview & Scrutiny Committee – Lesley Watts (CEO Chelsea & Westminster Foundation Trust, accompanied by Rob Hurd, CEO, and Rory Hegarty, Director of communications, ICB on 7 December 2022 Communications were sent to all local authorities in North West London prior to the start of the consultation and during the consultation period.
Imperial College Healthcare	Health and Adult Social Care Policy and Accountability Committee, London Borough of Hammersmith & Fulham – attended by Chief executive Tim Orchard and stakeholder relations lead Mick Fisher on 16 November 2022 – consultation response received 18 January 2023 Children, Adult Public Health and Voluntary Sector Policy and Scrutiny Committee, Westminster City Council – attended by Medical Director Raymond Anakwe and stakeholder relations lead Mick Fisher on 5 December 2022 – consultation response received 16 January 2023 **Other local authority and stakeholder meetings where the consultation was discussed** Hammersmith & Fulham Save our NHS, Brent Patient Voice and Ealing Save our NHS – attended by Tim Orchard on 14 November 2022 Cllr Ben Coleman, London Borough of Hammersmith & Fulham – attended by Tim Orchard on 3 November 2022 Cllr Natalia Perez, London Borough of Hammersmith & Fulham – attended by Tim Orchard on 4 November 2022 Cllr Nafsika Butler-Thalassis, Westminster City Council – attended by Tim Orchard on 8 November 2022 Cllr Ketan Sheth, London Borough of Brent, - attended by Tim Orchard on 25 November 2022 Nickie Aiken MP met with Tim Orchard on 9 December 2022 Cllr Ketan Sheth, London Borough of Brent – attended by Tim Orchard on 4 January 2023
Chelsea & Westminster Foundation Trust	CEOs Brent, Hounslow, Westminster and NWL ICS - attended by Lesley Watts on 17 November 2022 Meeting with Cllr Campbell from RBKC - Lesley Watts on 13 December 2022 All Local Authorities & CEO's of NWL - quarterly catch-up with Lesley Watts on 12 January 2023

Lead organisation(s)	Details of engagement
London North West University Healthcare	Presentation made to the LNWH Patient and Carer Participation Group – 11 November 2022
The Hillingdon Hospitals	Agenda item to discuss the proposal at the Hillingdon Council Health and Social Care Select Committee 26 January 2023 (falls outside of consultation period)

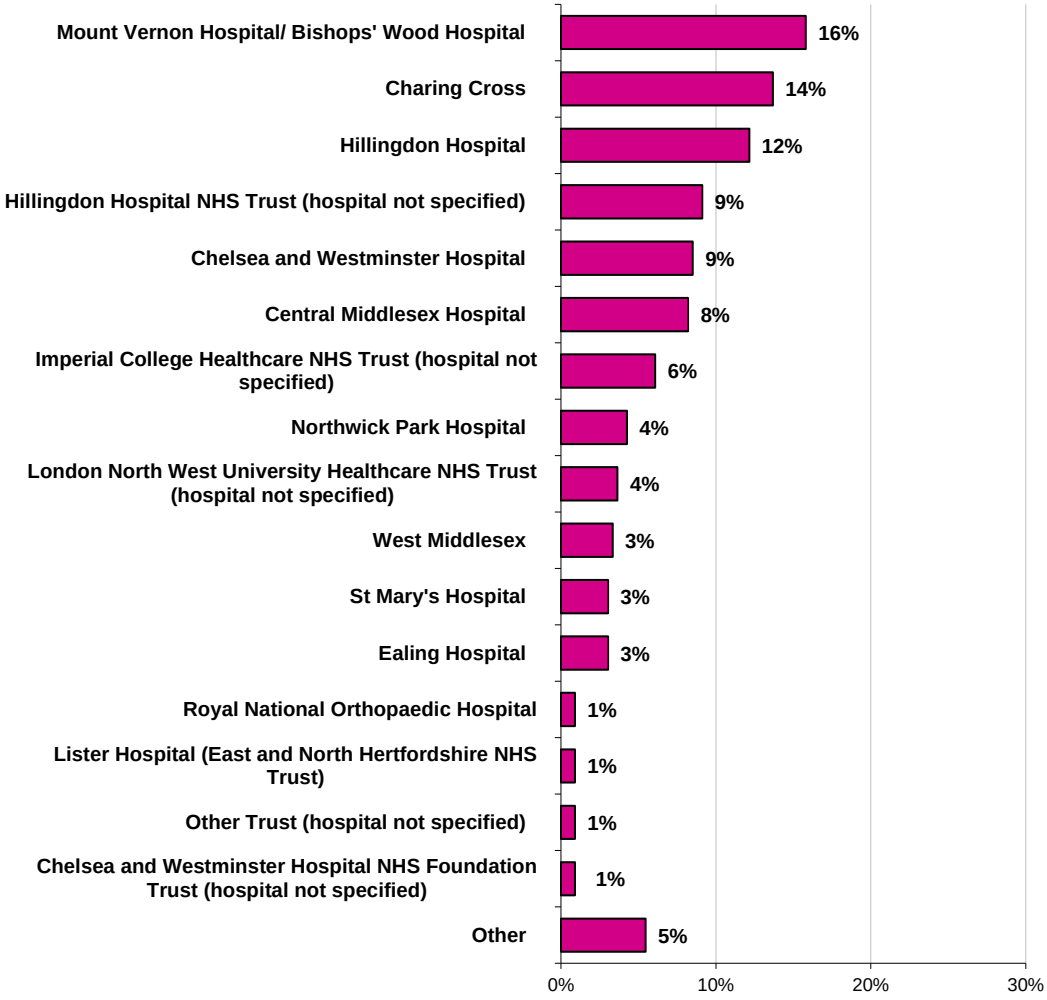
4.4 APPENDIX – QUANTITATIVE RESPONSE, ABOUT RESPONDENTS

Which of the following best describes you?
Showing analytical clusters



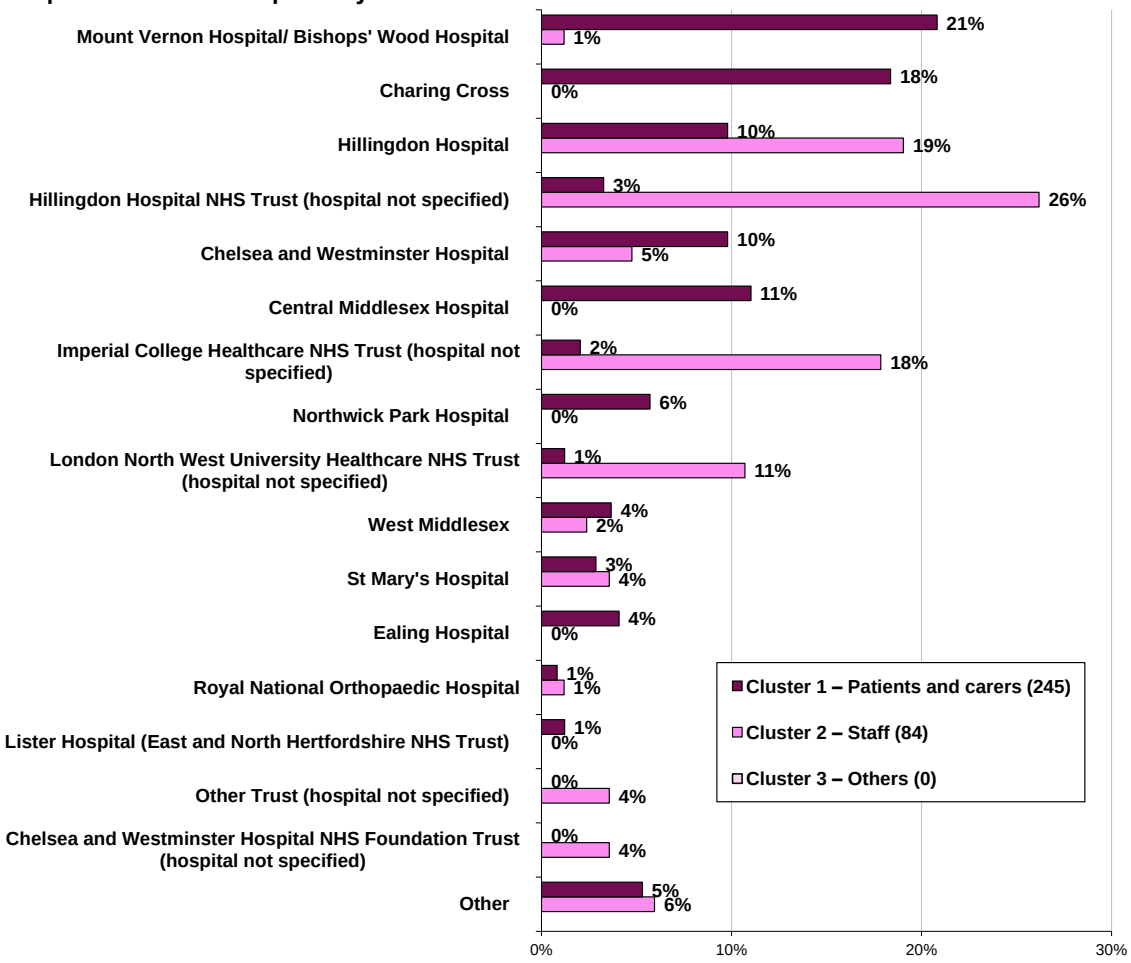
Source: Verve Communications 2023 Base: All respondents (802)

Respondents' local hospitals



Source: Verve Communications 2023 Base: All staff and patients (332)

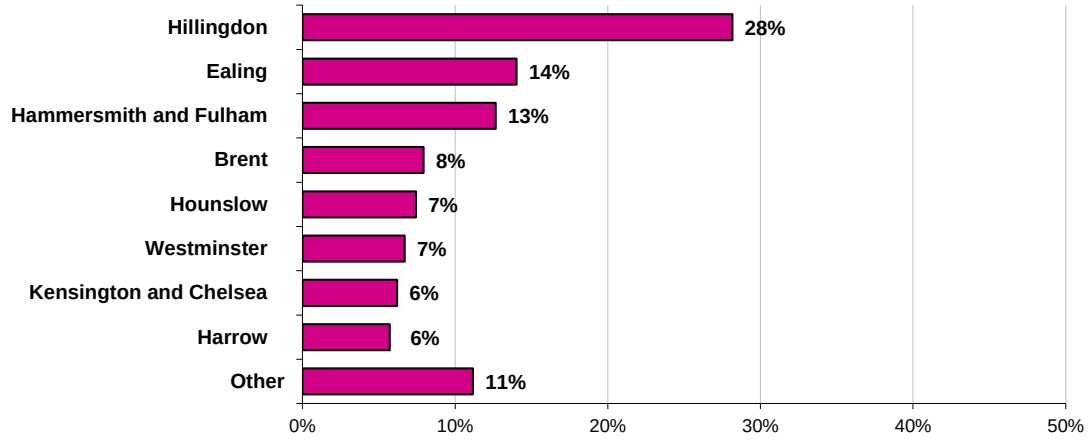
Respondents' local hospitals by clusters



Source: Verve Communications 2023

Base: All paitents and staff who named their hospital

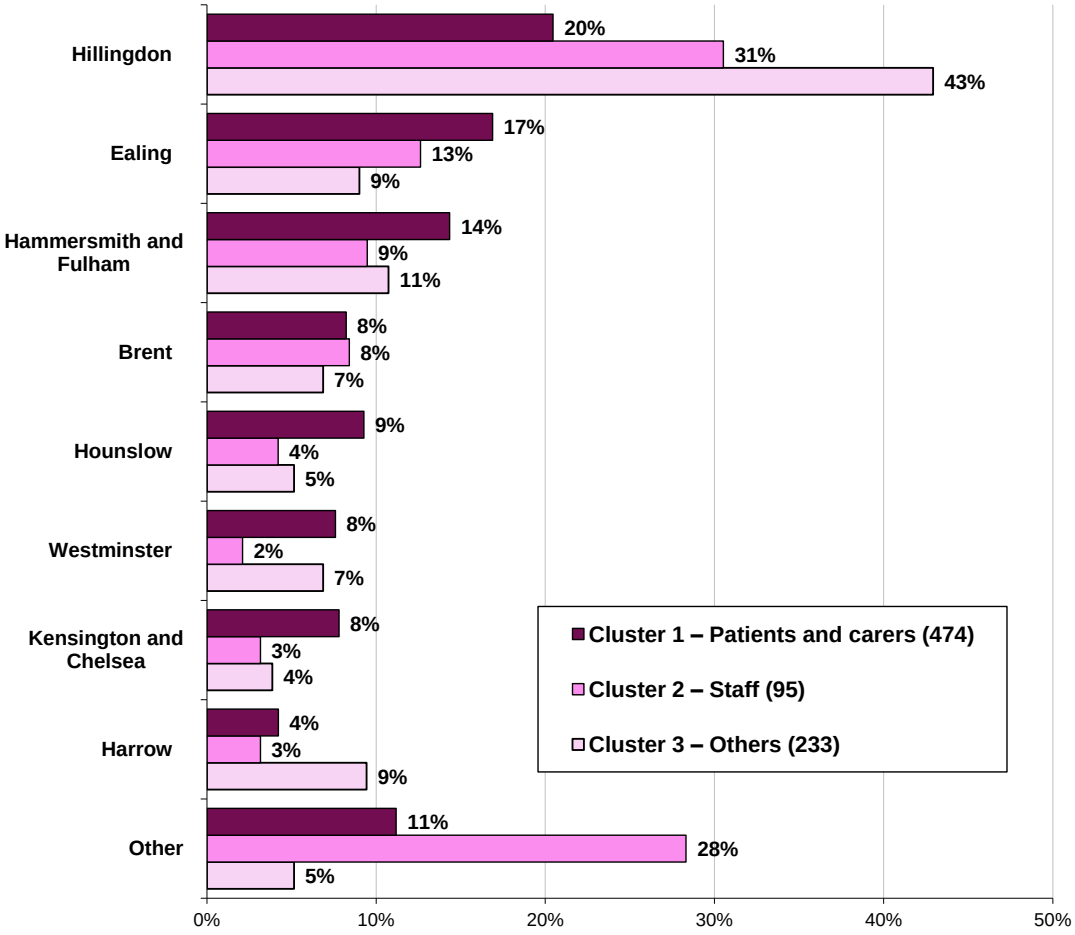
Boroughs respondents lived in



Source: Verve Communications 2023

Base: All respondents who gave a valid response (806)

Boroughs respondents lived in by cluster

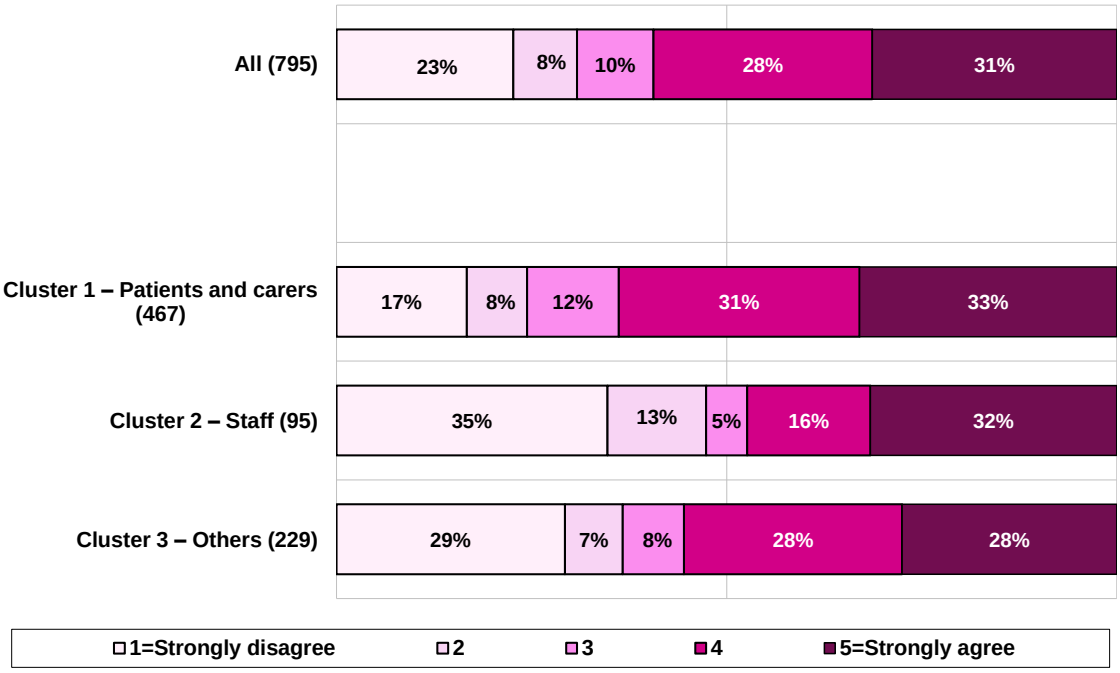


Source: Verve Communications 2023 Base: All who gave a valid response

4.5 APPENDIX – QUANTITATIVE RESPONSES, BY QUESTION

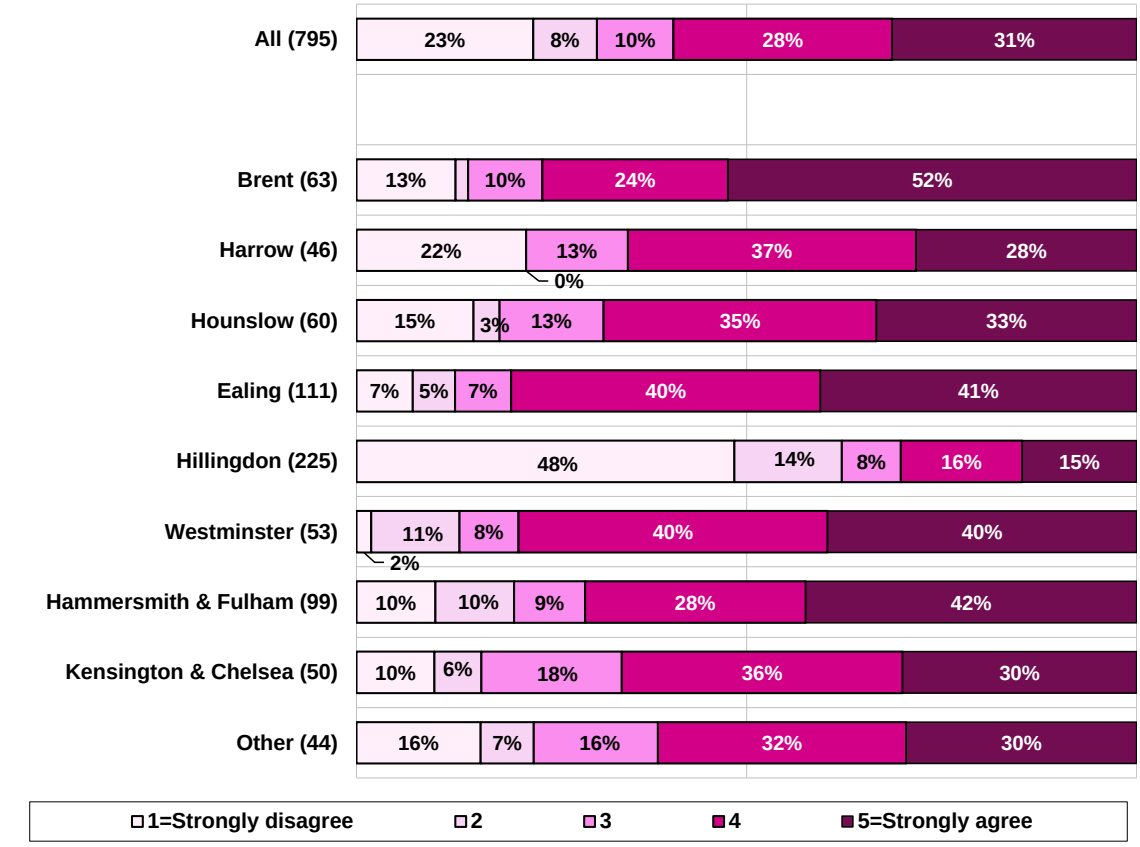
Please note: these data were generated by choosing answers which were analysed on a Likert scale. The middlemost answer denotes a response which is neither agree nor disagree.

To what extent do you agree with the proposal to develop an elective orthopaedic centre for most routine, inpatient orthopaedic surgery in North West London?



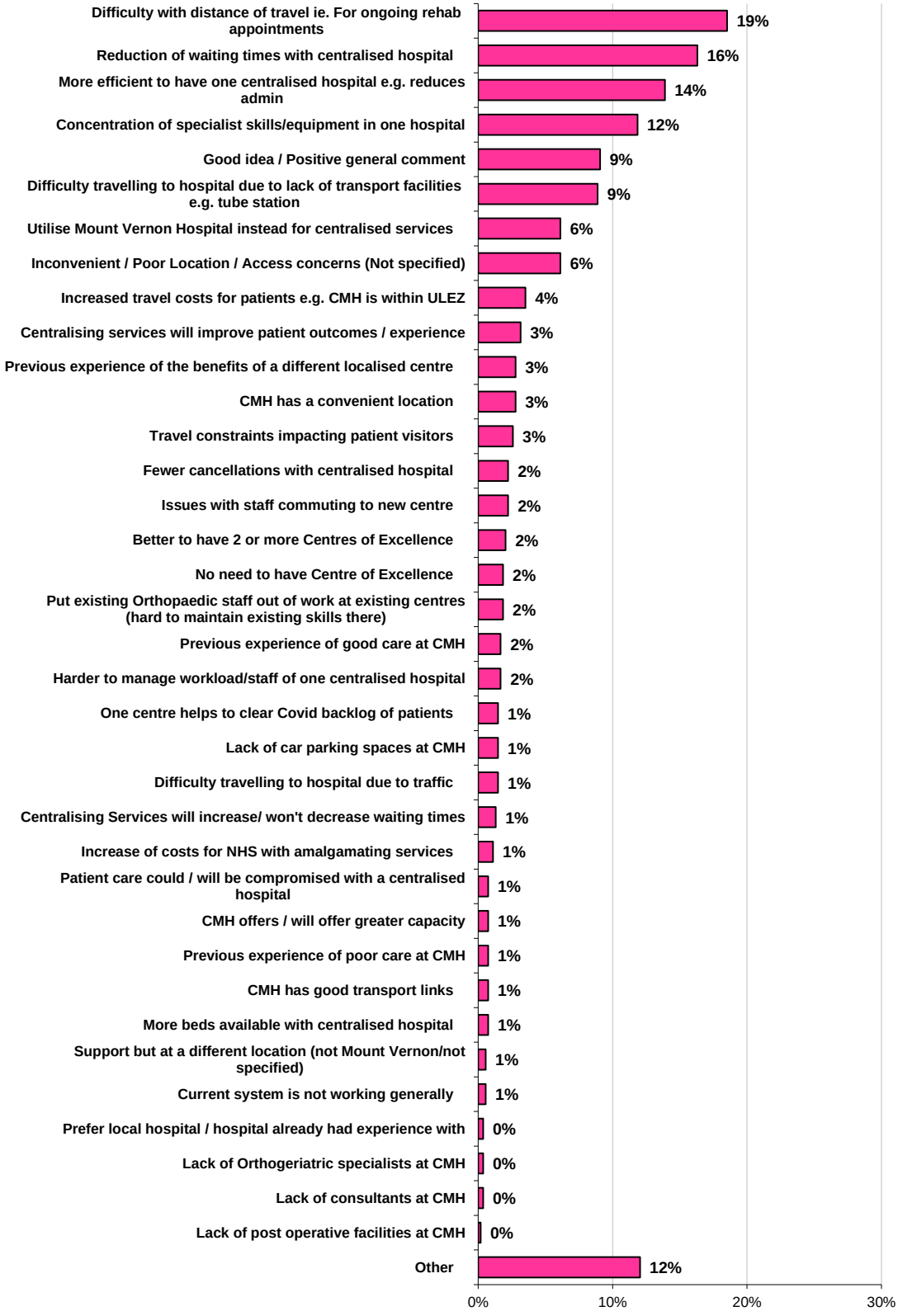
Source: Verve Communications 2023 Base: All respondents who gave a valid answer (267)

To what extent do you agree with the proposal to develop an elective orthopaedic centre for most routine, inpatient orthopaedic surgery in North West London by borough.



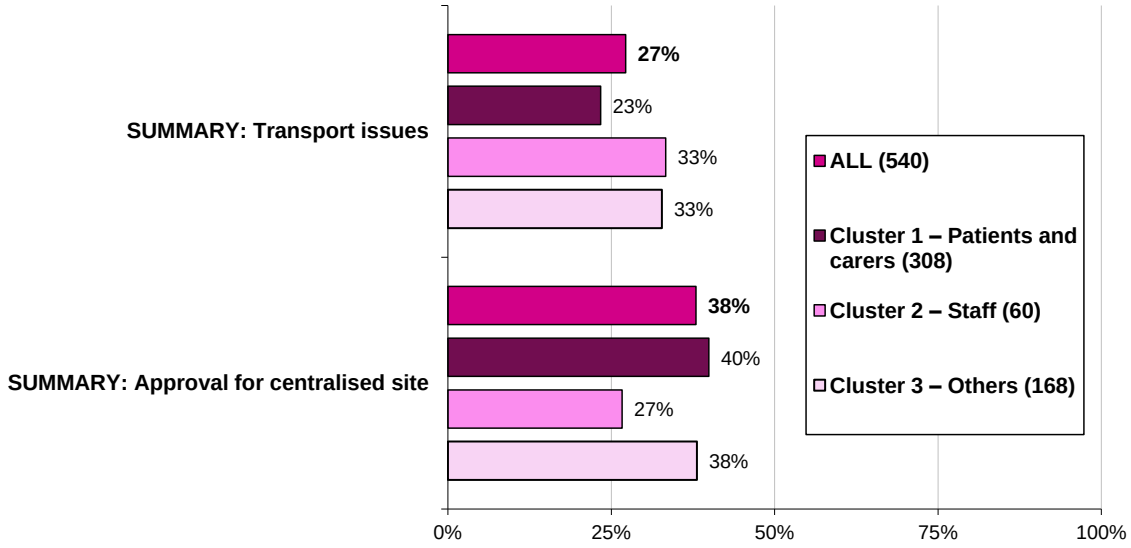
Source: Verve Communications 2023 Base: All respondents who gave a valid answer

Why do you think this? (analysis of open text from the survey)



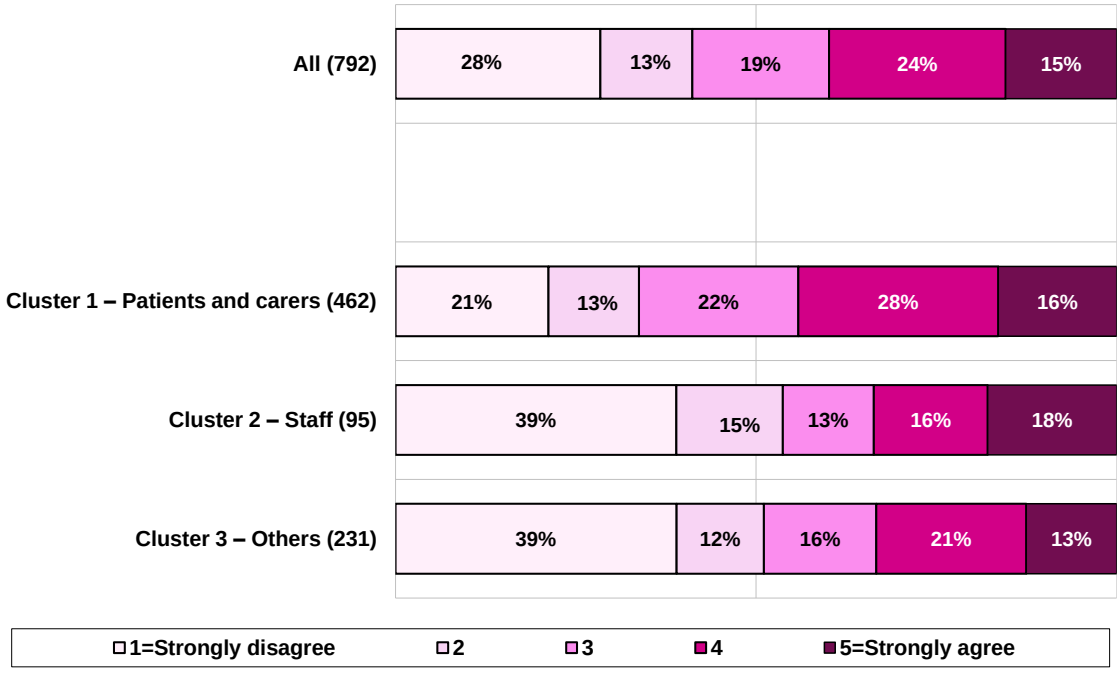
Source: Verve Communications 2023 Base: All respondents who gave a valid response 540)

Why do you think this, summarised by cluster



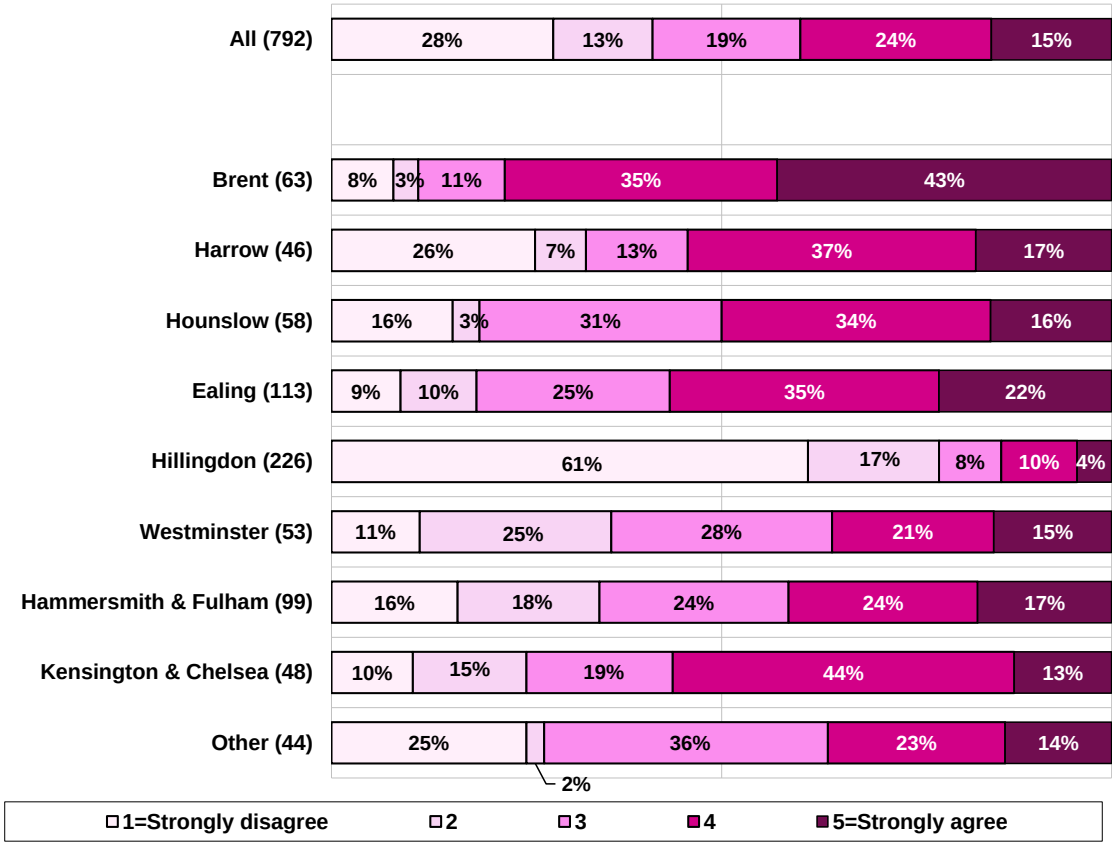
Source: Verve Communications 2023 Base: All who made a comment

To what extent do you agree with the preferred location of the elective orthopaedic centre at Central Middlesex Hospital?



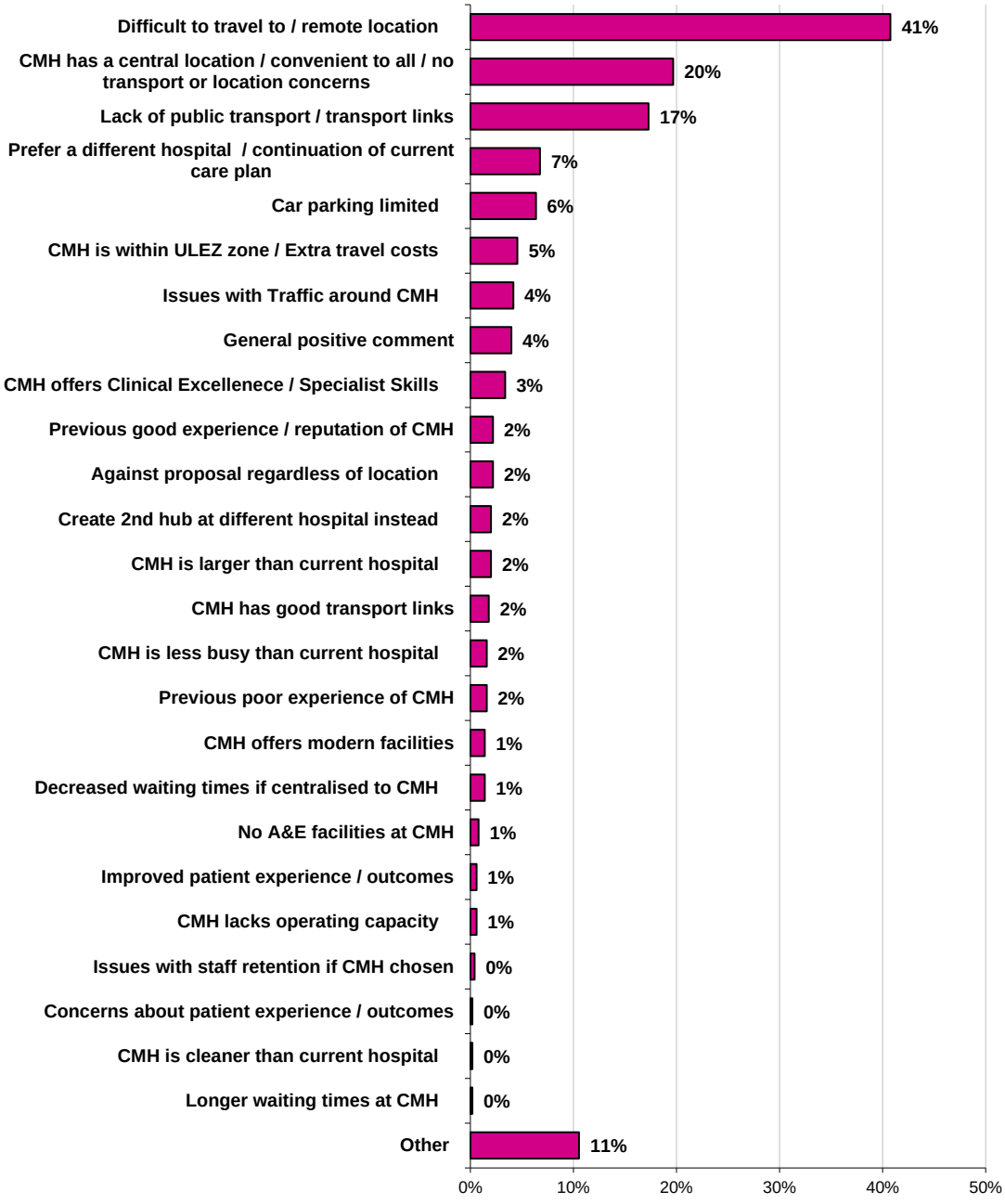
Source: Verve Communications 2023 Base: All who gave a valid answer

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



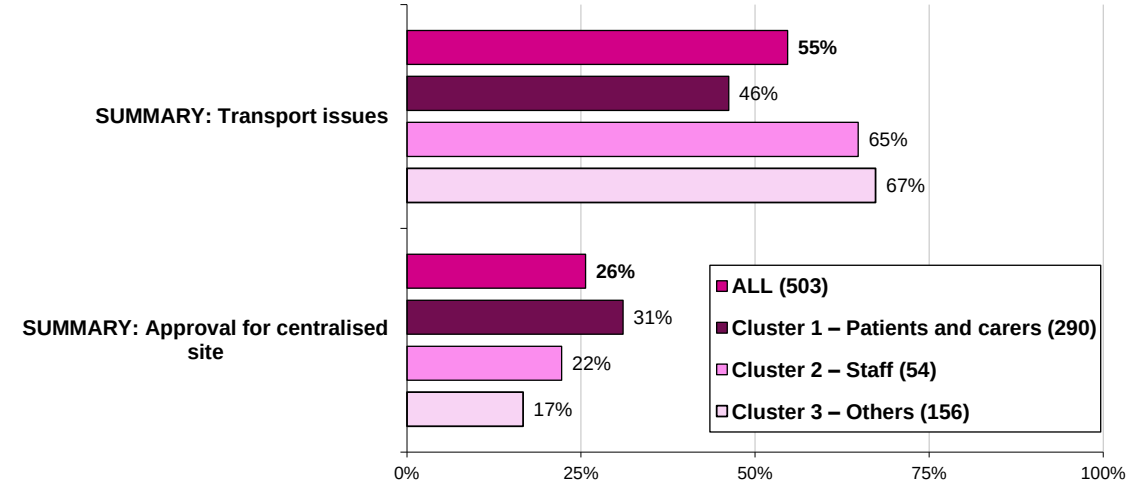
Source: Verve Communications 2023 Base: All respondents who gave a valid answer

Why do you think this?



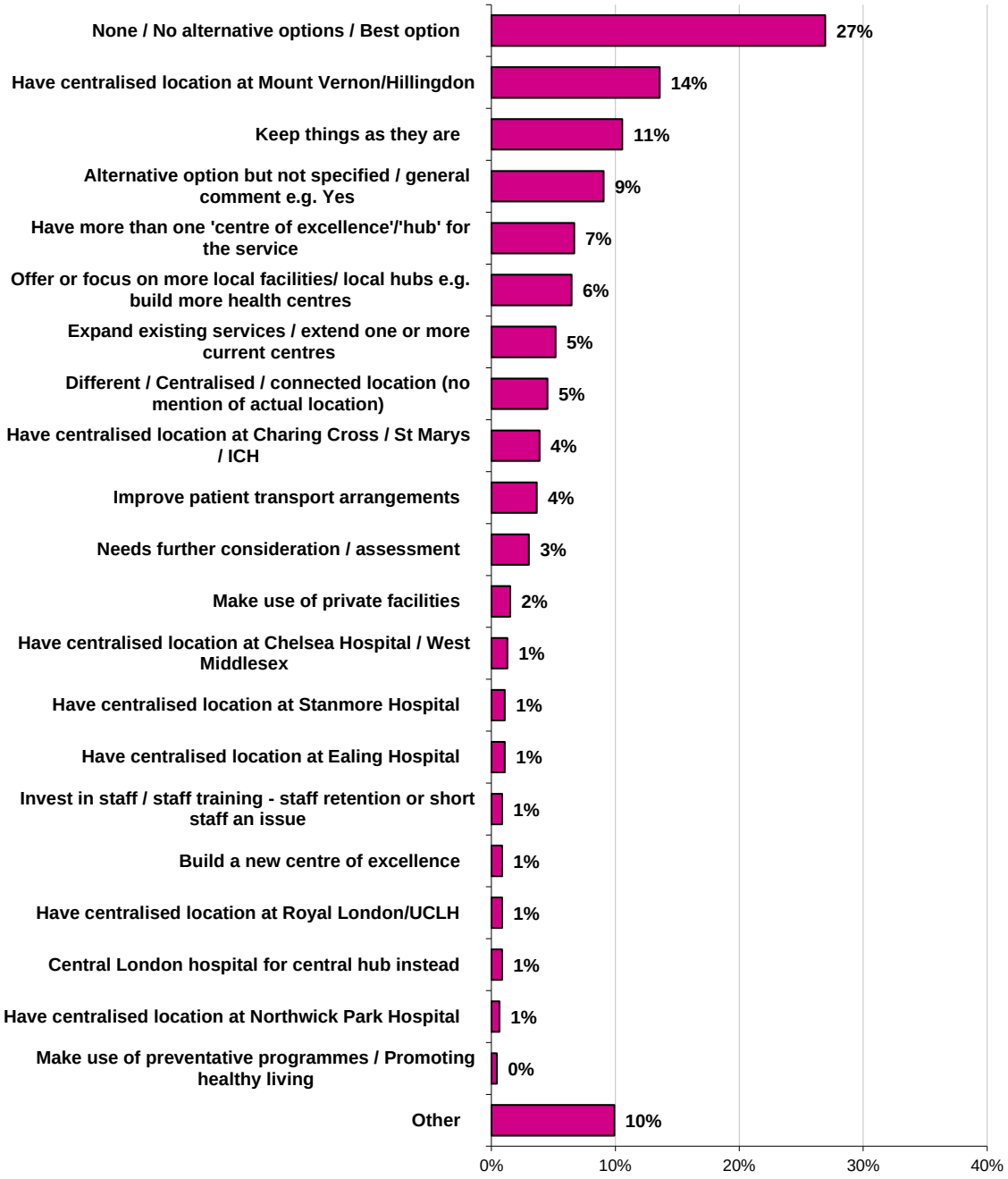
Source: Verve Communications 2023 Base: All respondents who gave a valid response (503)

Why do you think this? Summarised and split by cluster



Source: Verve Communications 2023 Base: All who made a comment

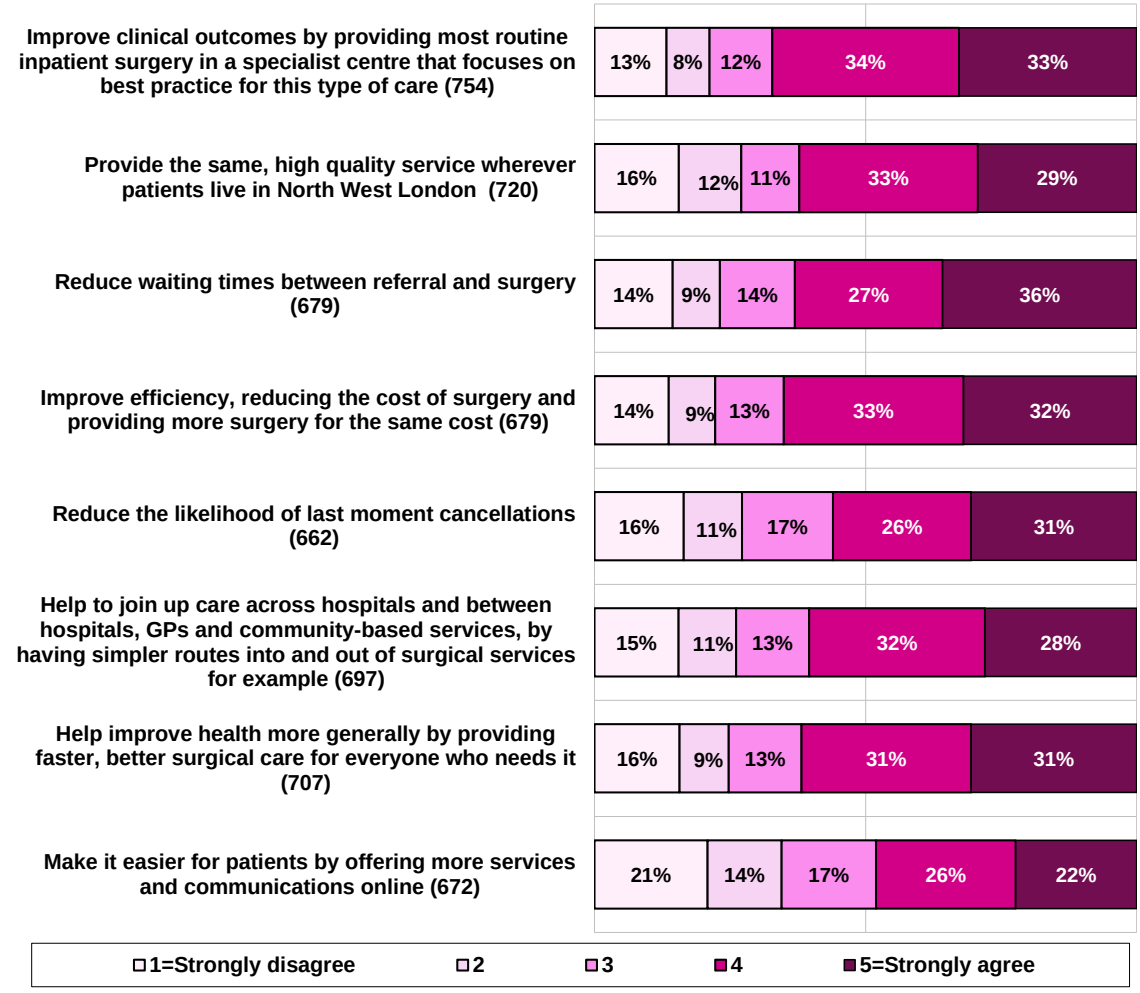
Do you think there are any alternative options which should be considered to meet the challenges set out in the consultation document?



Source: Verve Communications 2023

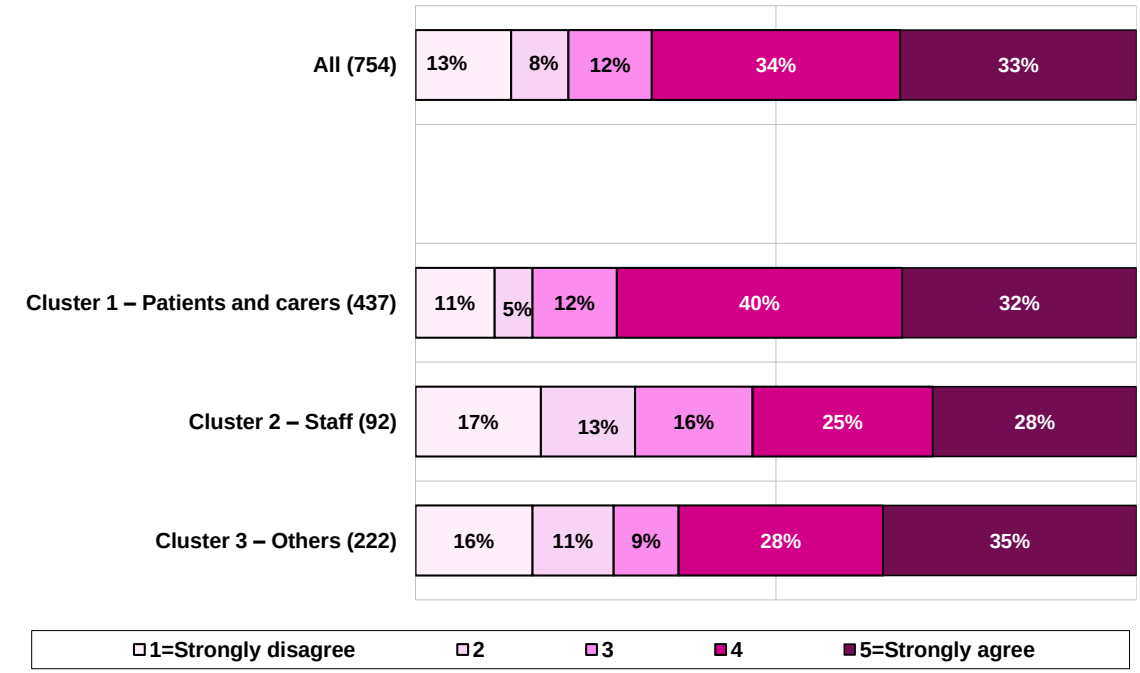
Base: All respondents who gave a valid response (464)

How well do you think the proposal would help to meet each of the following challenges?



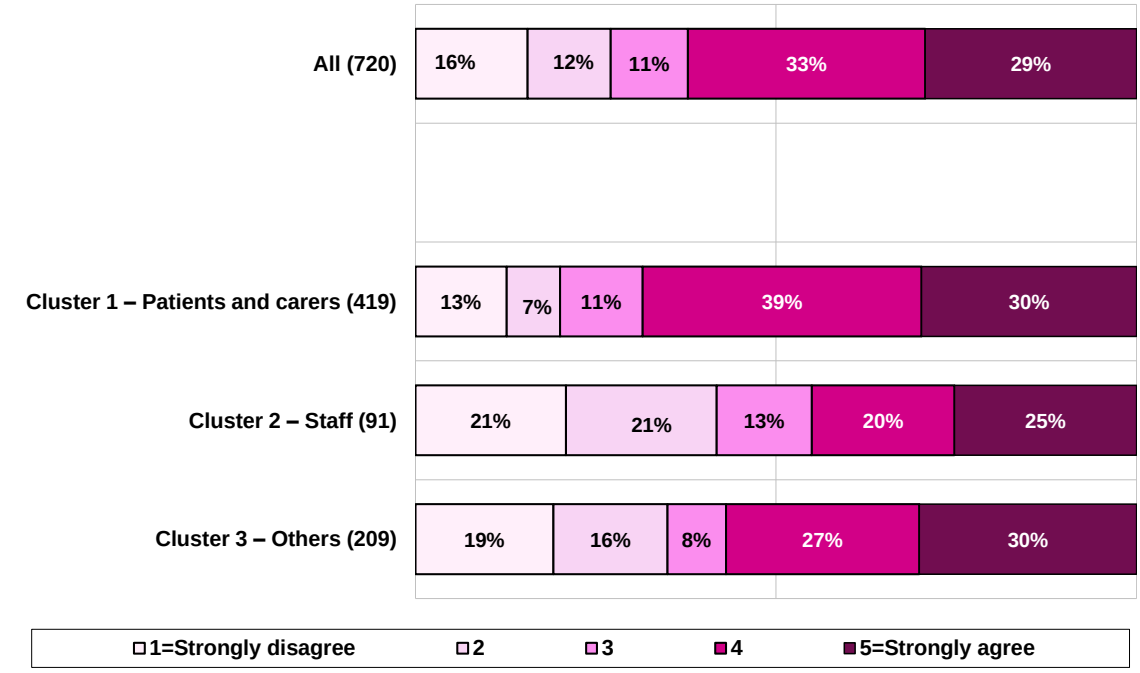
Source: Verve Communications 2023 Base: All who gave a valid answer

How well do you think the proposal would improve clinical outcomes by providing most routine inpatient surgery in a specialist centre that focuses on best practice for this type of care – by cluster



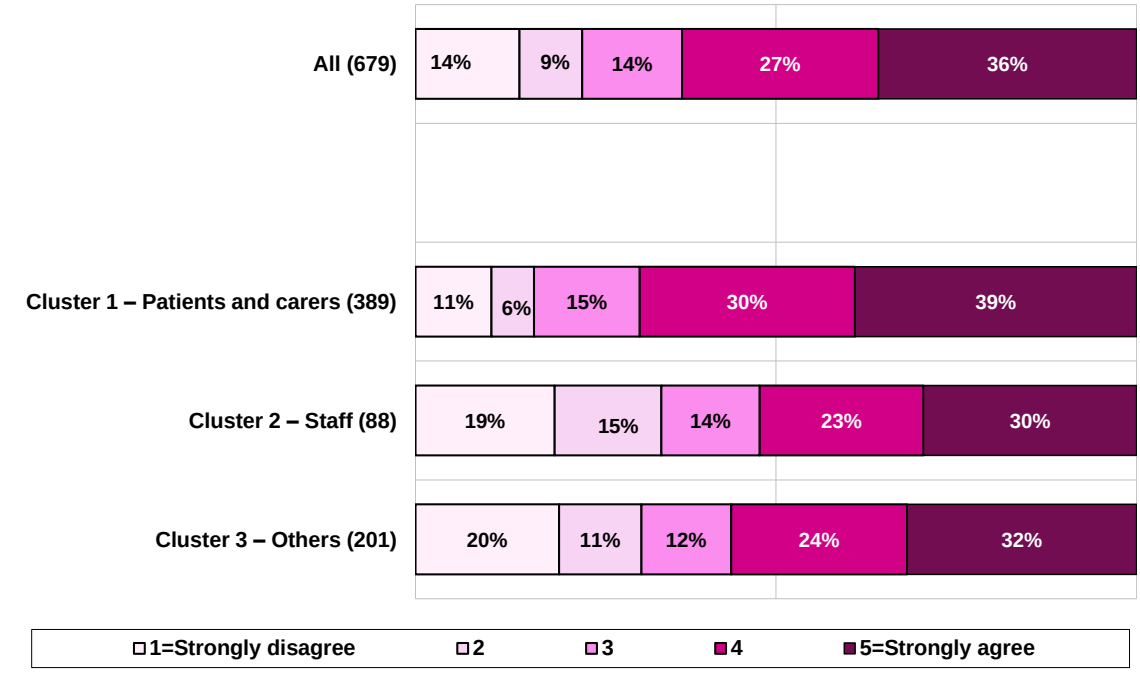
Source: Verve Communications 2023 Base: All who gave a valid answer

How well do you think the proposal would provide the same, high quality service wherever patients live in North West London – by cluster



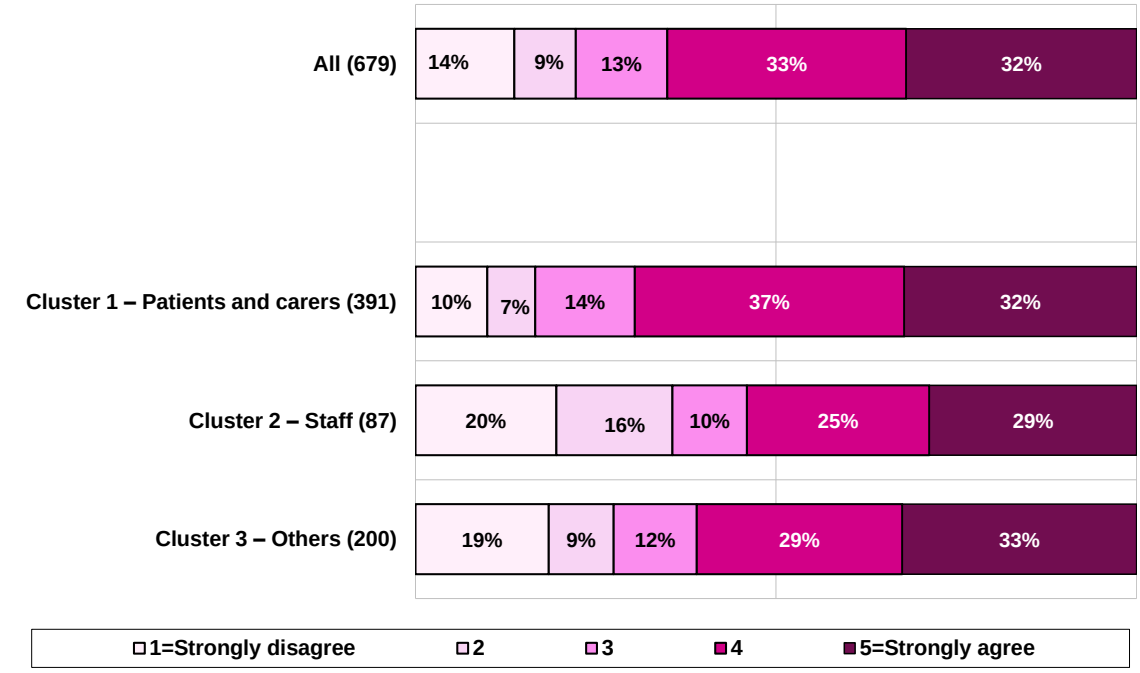
Source: Verve Communications 2023 Base: All who gave a valid answer

How well do you think the proposal would reduce waiting times between referral and surgery – by cluster



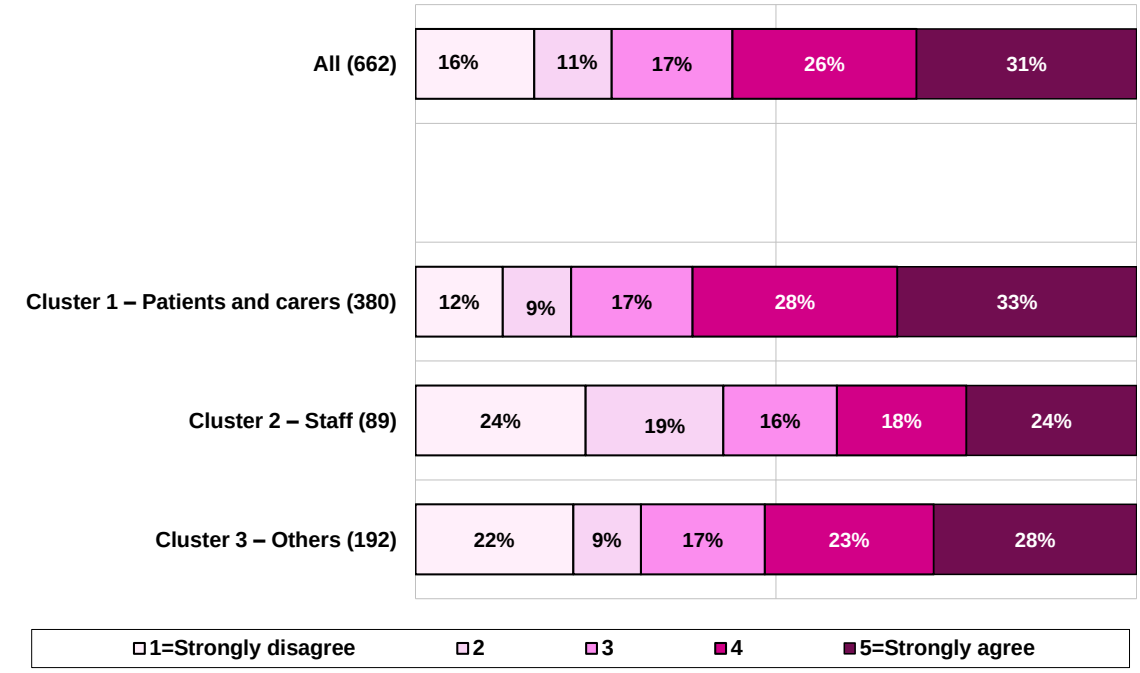
Source: Verve Communications 2023 Base: All who gave a valid answer

How well do you think the proposal would improve efficiency, reducing the cost of surgery and providing more surgery for the same cost – by cluster



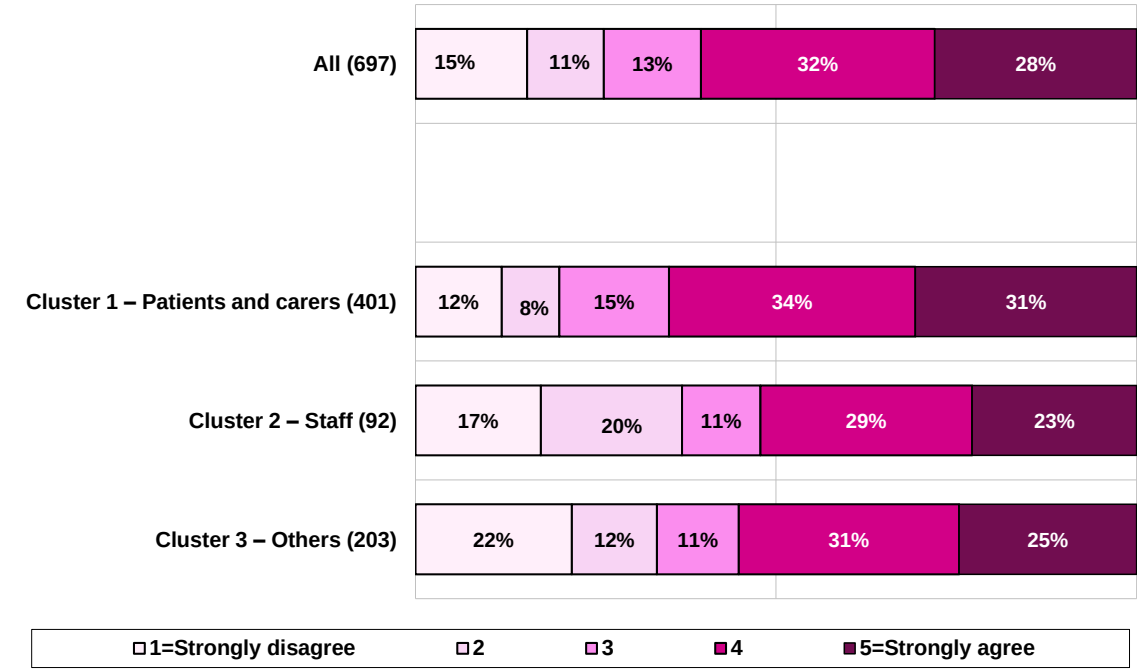
Source: Verve Communications 2023 Base: All who gave a valid answer

How well do you think the proposal would help to reduce the likelihood of last moment cancellations – by cluster



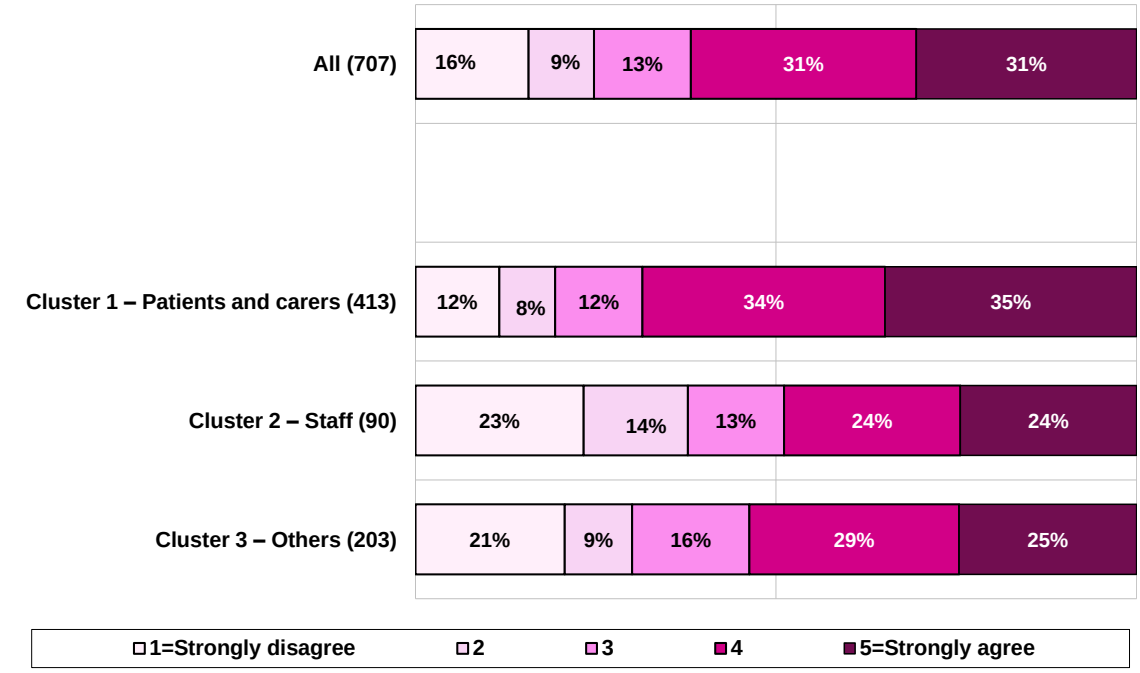
Source: Verve Communications 2023 Base: All who gave a valid answer

How well do you think the proposal would help to join up care across hospitals and between hospitals, GPs and community-based services, by having simpler routes into and out of surgical services for example – by cluster



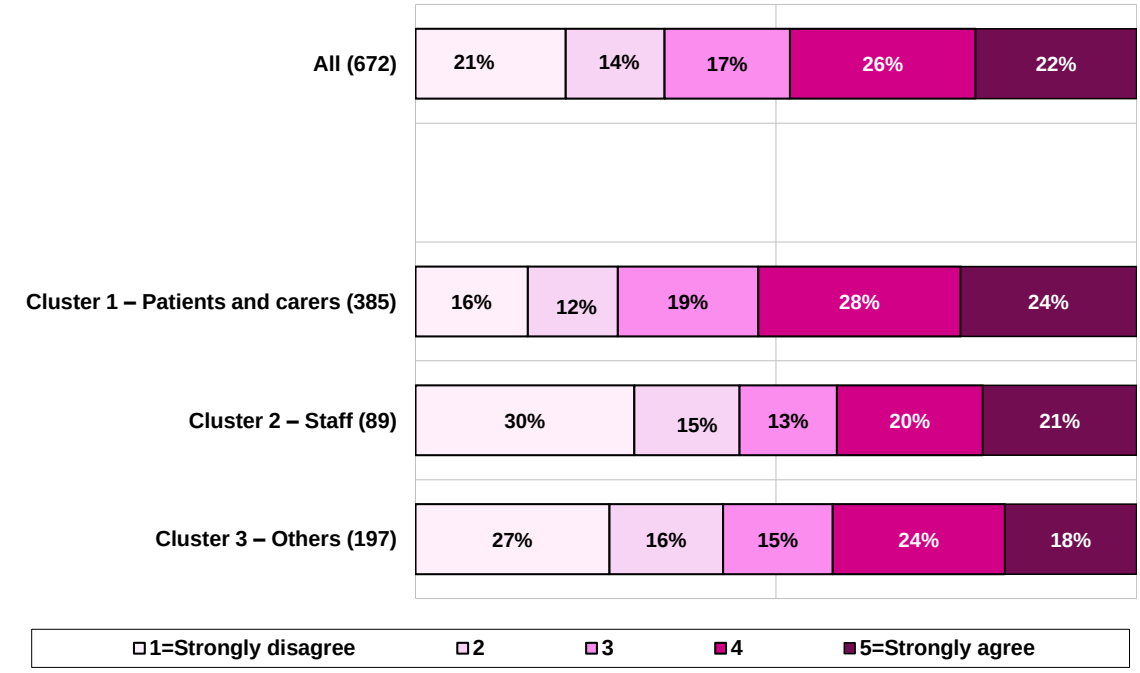
Source: Verve Communications 2023 Base: All who gave a valid answer

How well do you think the proposal would help to improve health more generally by providing faster, better surgical care for everyone who needs it – by cluster



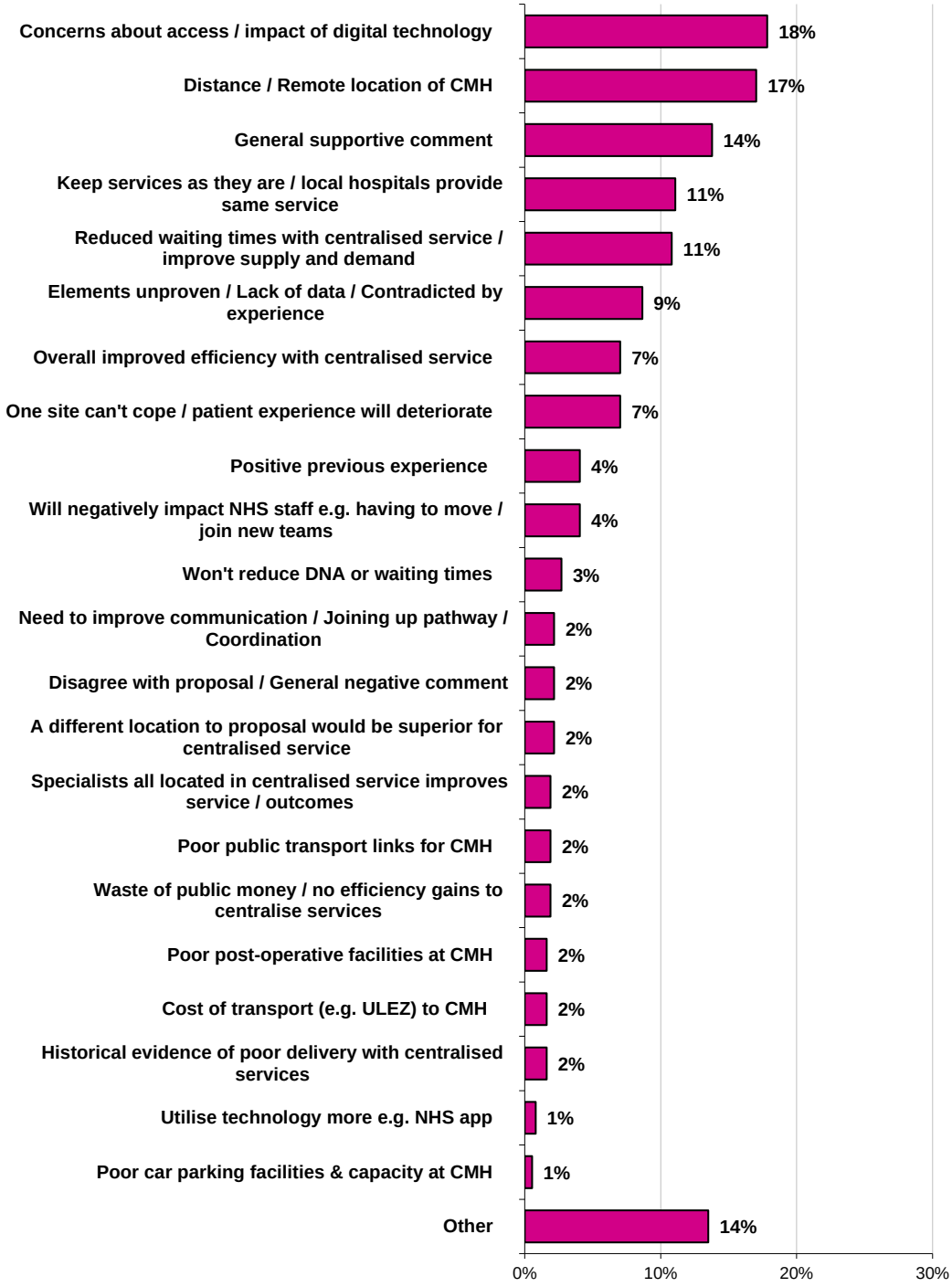
Source: Verve Communications 2023 Base: All who gave a valid answer

How well do you think the proposal would help to make it easier for patients by offering more services and communications online - by cluster



Source: Verve Communications 2023 Base: All who gave a valid answer

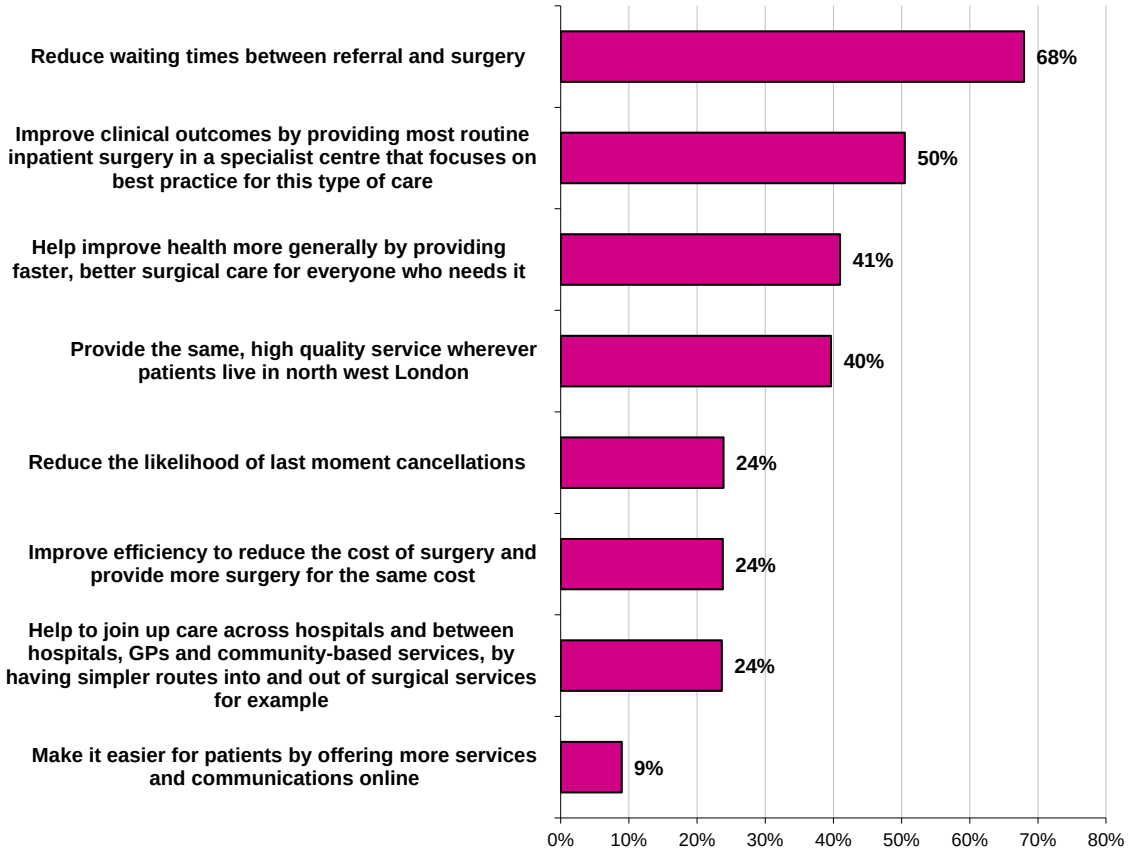
Please let us know why you have given this response (open text responses)



Source: Verve Communications 2023

Base: All respondents who gave a valid response (370)

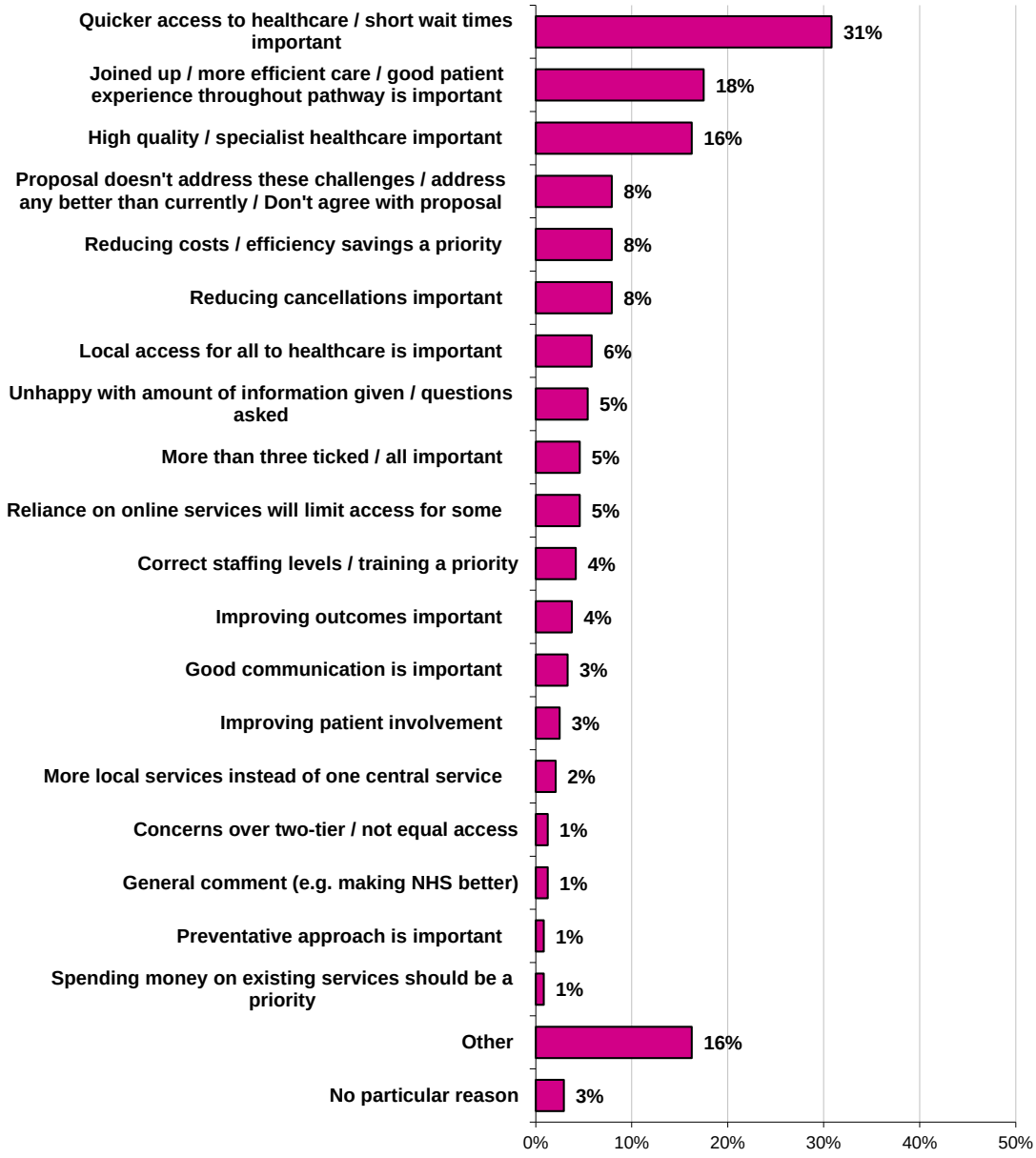
Thinking about the following challenges, which do you believe are the most important to tackle?



Source: Verve Communications 2023

Base: All respondents who gave a valid response (749)

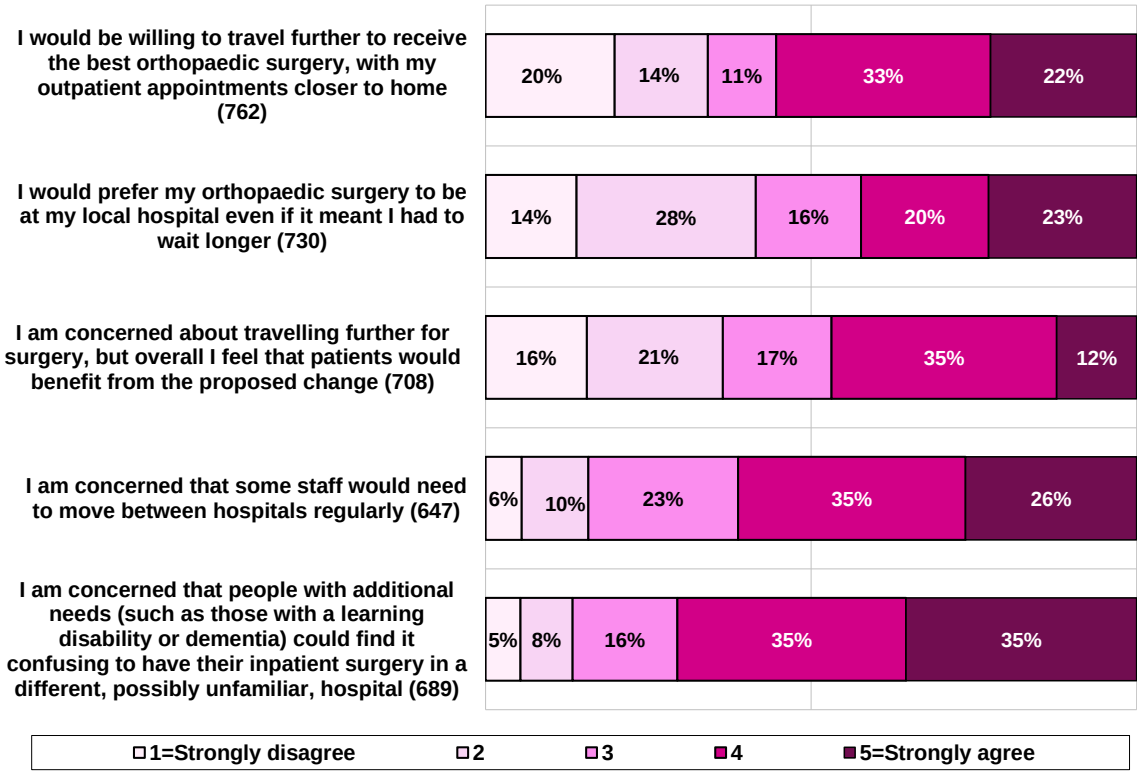
Please let us know why you have given this response (open text responses)



Source: Verve Communications 2023

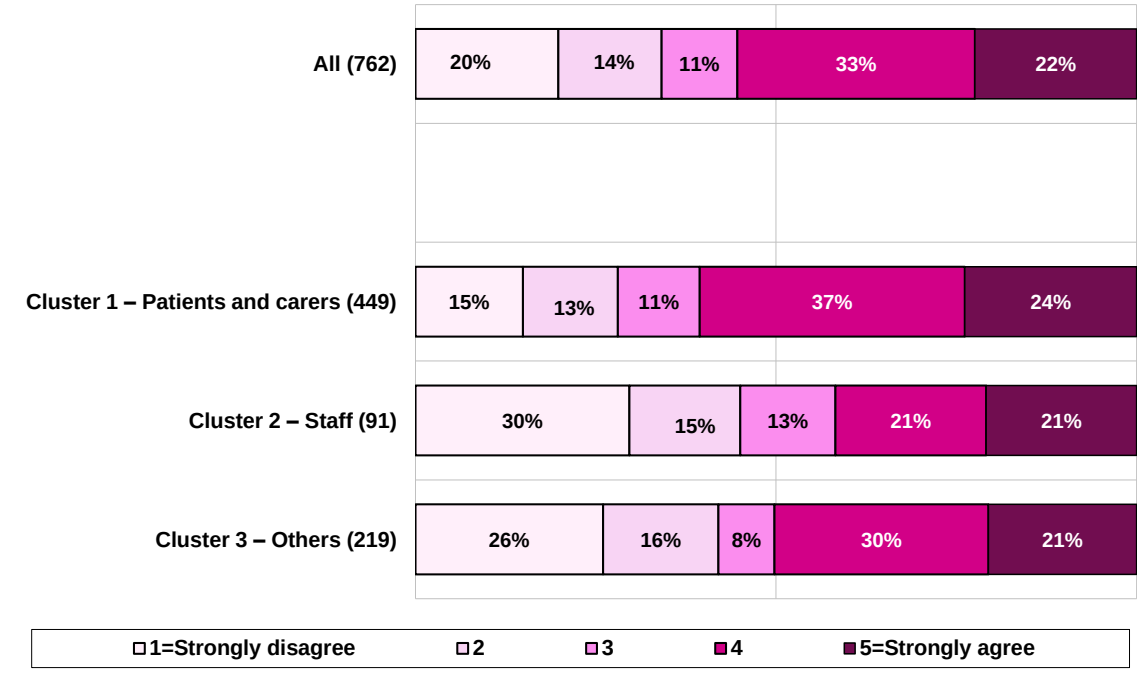
Base: All respondents who gave a valid response (240)

Thinking about a single elective orthopaedic centre at Central Middlesex Hospital (with outpatient appointments at a local hospital or online), please indicate how strongly you agree with each of the following statements.



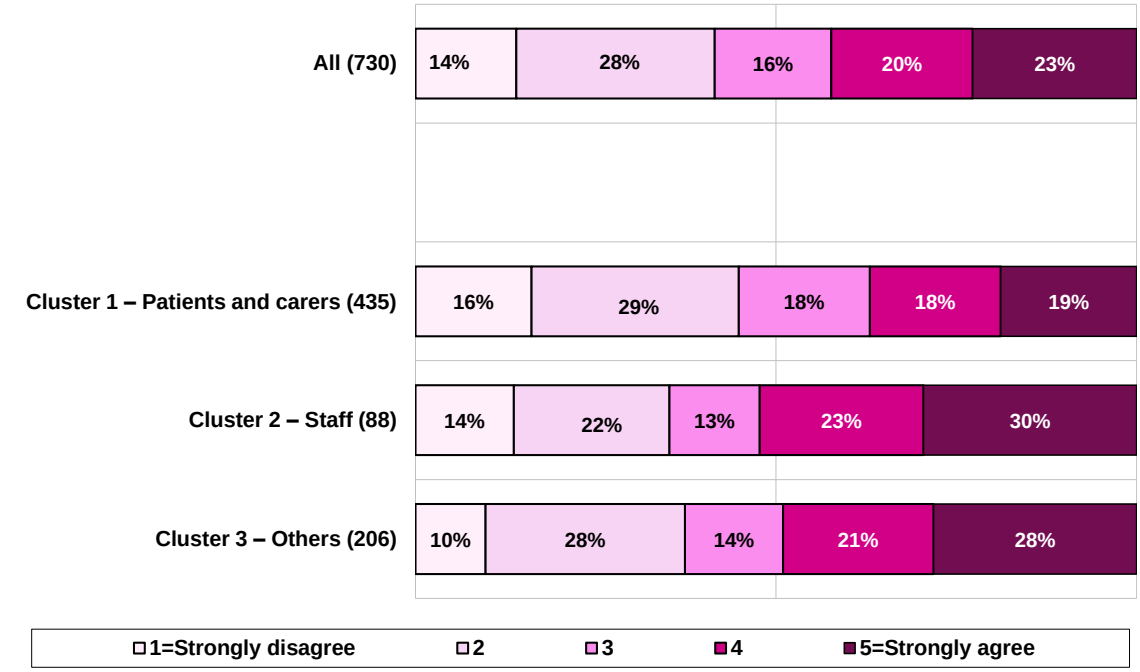
Source: Verve Communications 2023 Base: All who gave a valid answer

I would be willing to travel further to receive the best orthopaedic surgery, with my outpatient appointments closer to home – by cluster



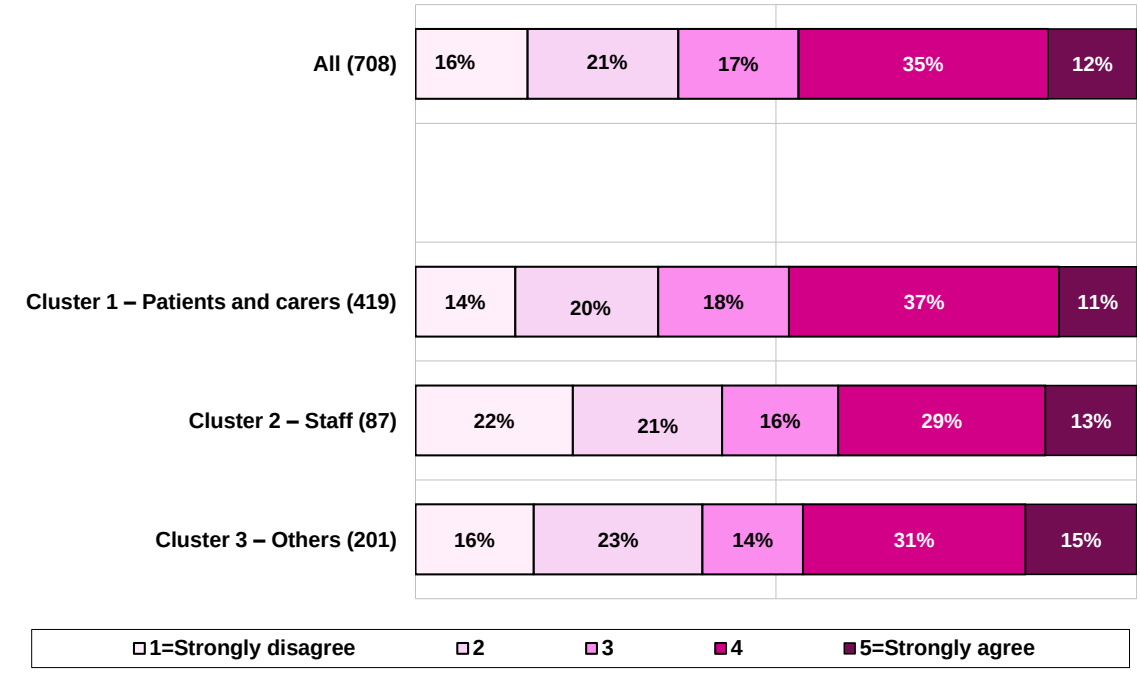
Source: Verve Communications 2023 Base: All who gave a valid answer

I would prefer my orthopaedic surgery to be at my local hospital even if it meant I had to wait longer – by cluster



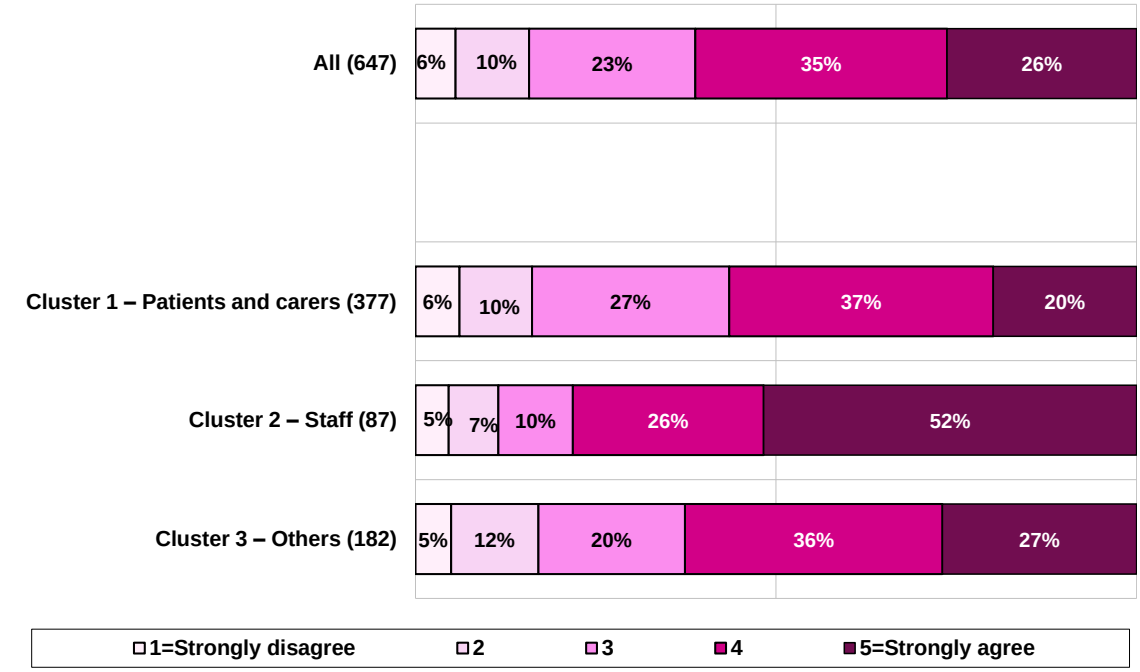
Source: Verve Communications 2023 Base: All who gave a valid answer

I am concerned about travelling further for surgery, but overall I feel that patients would benefit from the proposed change – by cluster



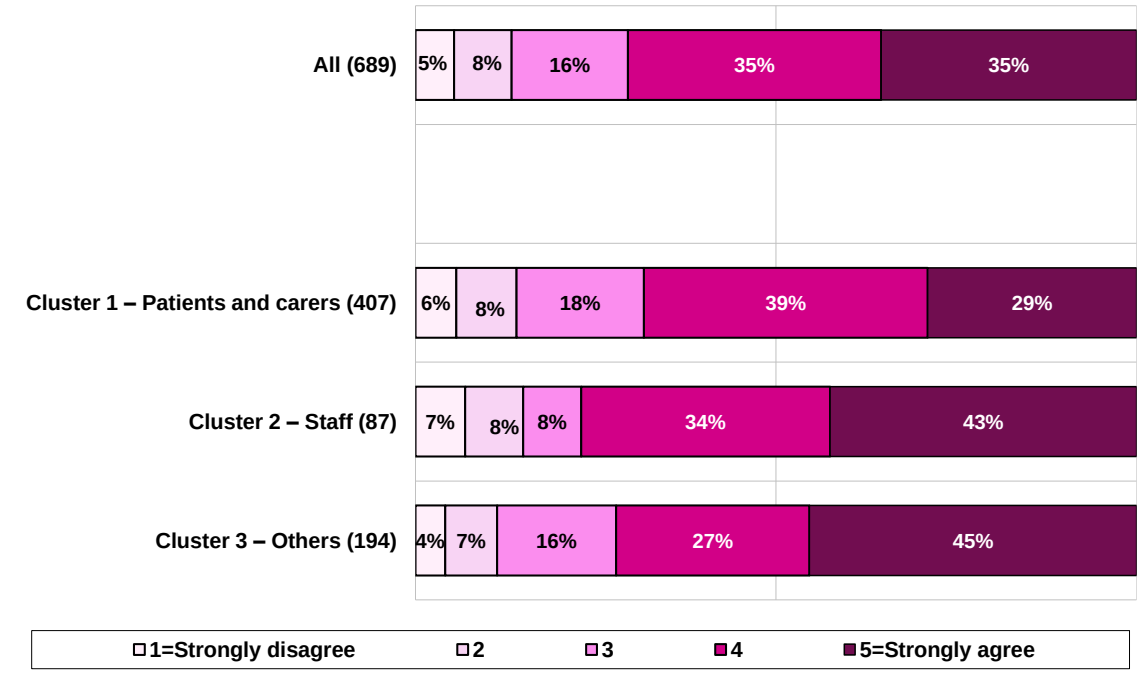
Source: Verve Communications 2023 Base: All who gave a valid answer

I am concerned that some staff would need to move between hospitals regularly – by cluster



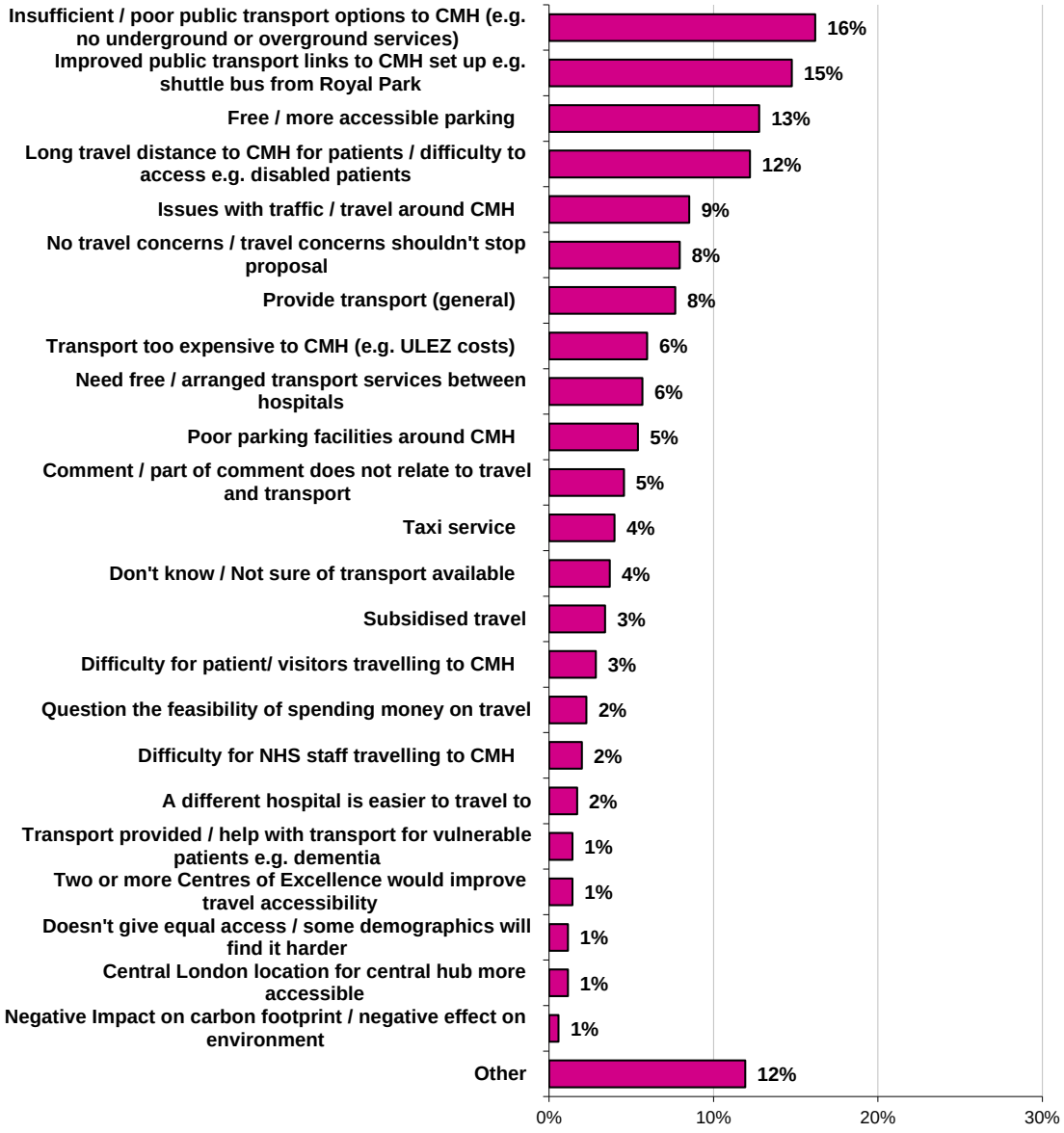
Source: Verve Communications 2023 Base: All who gave a valid answer

I am concerned that 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 – by cluster



Source: Verve Communications 2023 Base: All who gave a valid answer

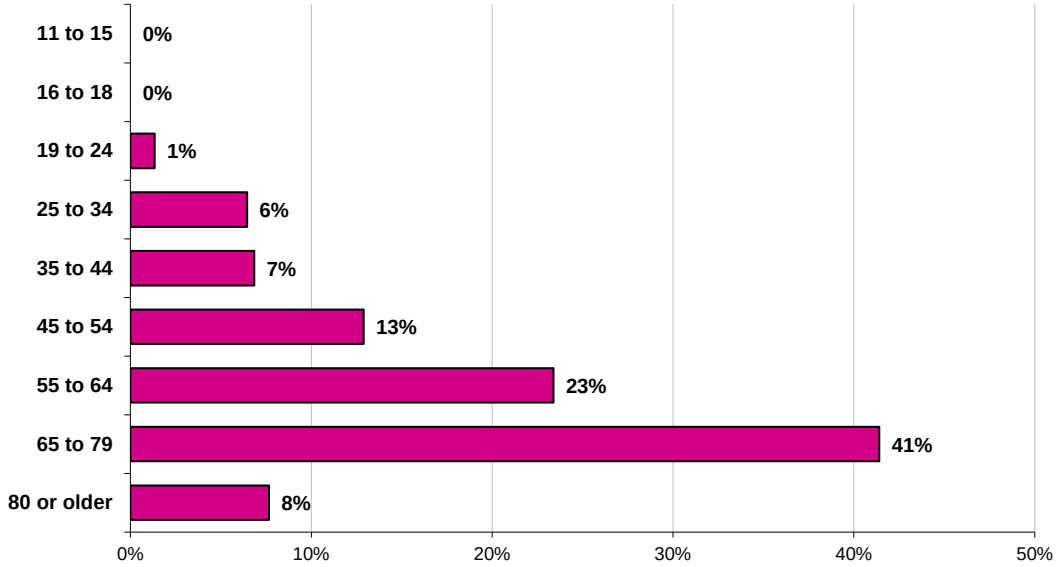
Please add any additional comments about travel and transport to Central Middlesex Hospital site. We are particularly keen to hear suggestions for how travel and transport may be made easier for patients, or the site made more accessible. (open text responses)



Source: Verve Communications 2023 Base: All respondents who gave a valid response (352)

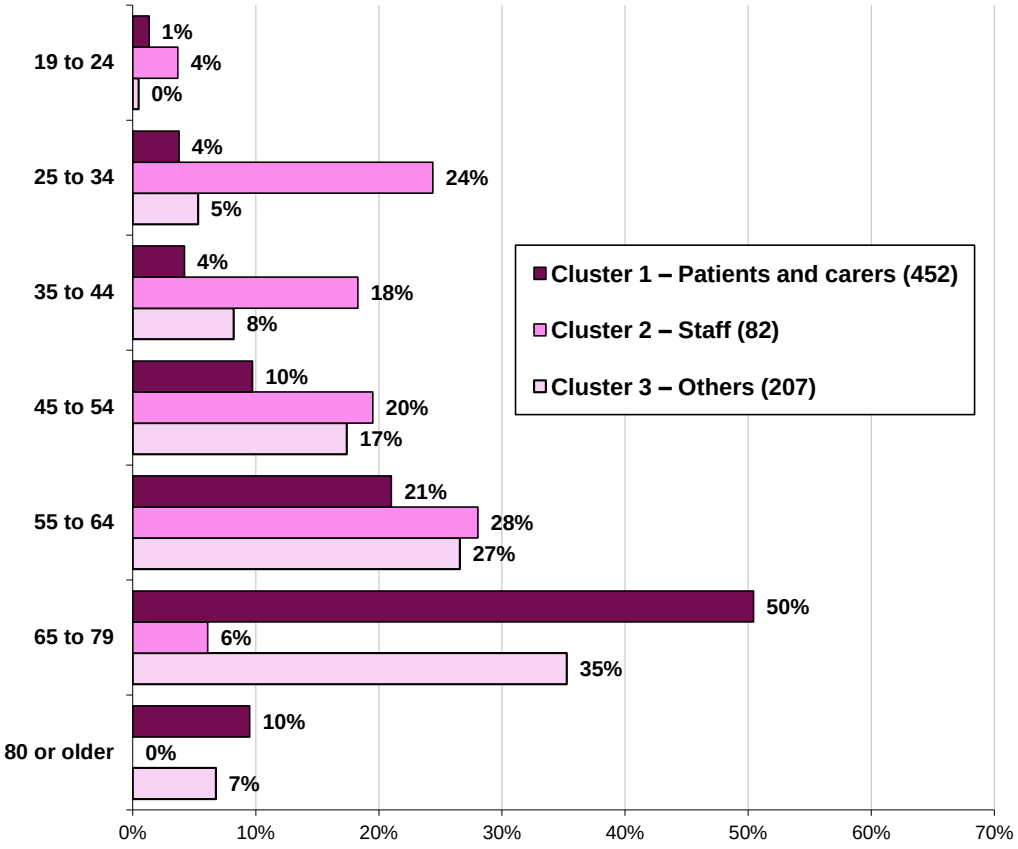
4.6 APPENDIX – QUANTITATIVE RESPONSES, DEMOGRAPHICS

Age groups of respondents



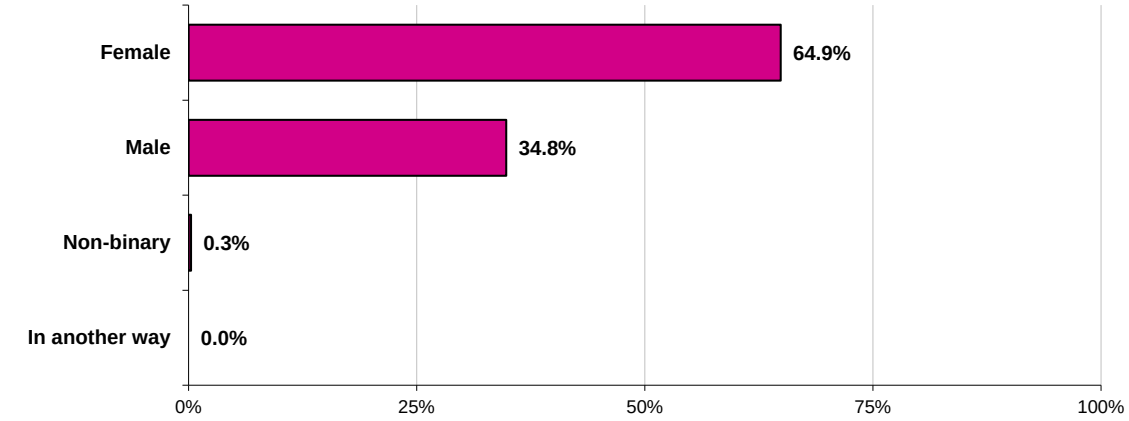
Source: Verve Communications 2023 Base: All who gave a valid response (744)

Age groups by clusters



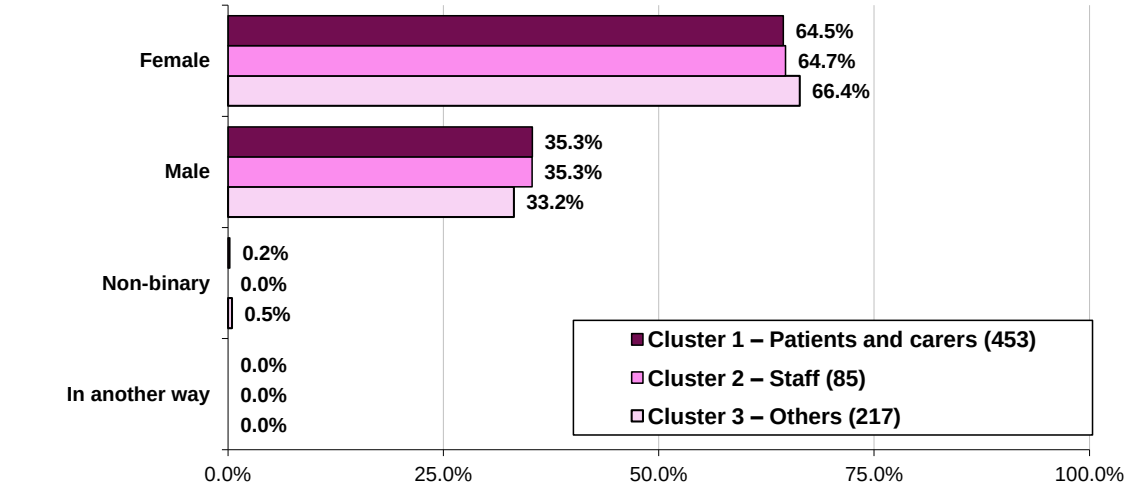
Source: Marketing Means 2023 Base: All who gave a valid response (276)

Gender



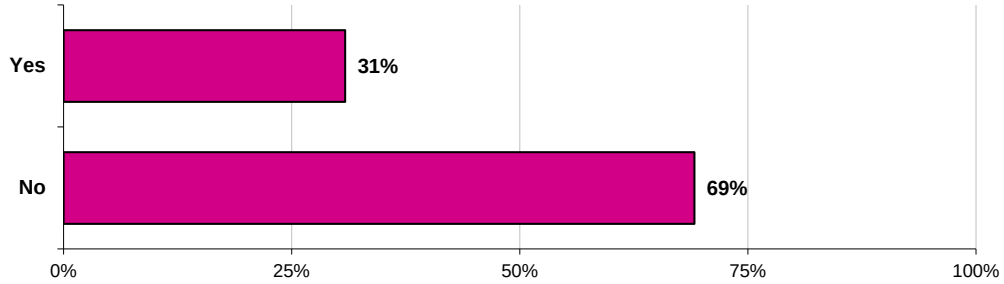
Source: Verve Communications 2023 Base: All respondents who gave a valid response (758)

Gender by cluster



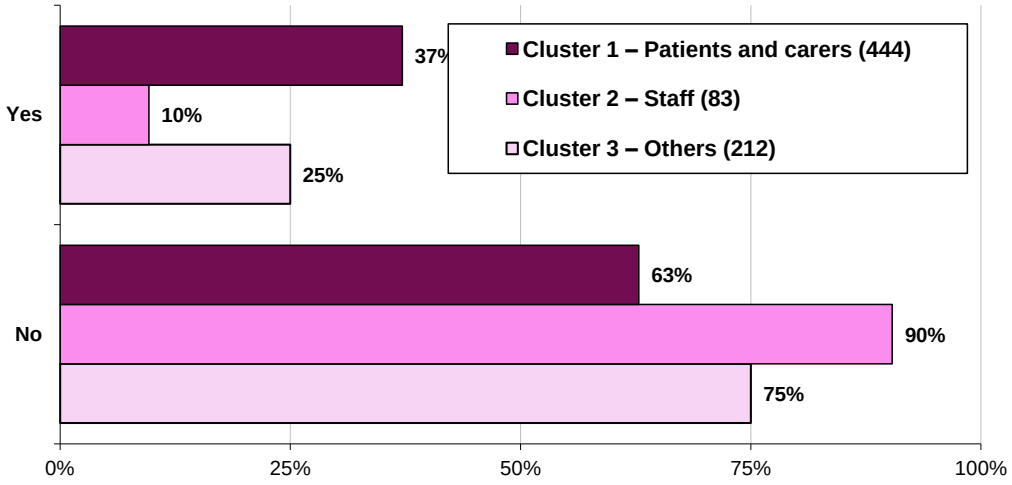
Source: Verve Communications 2023 Base: All who gave a valid response

Disability



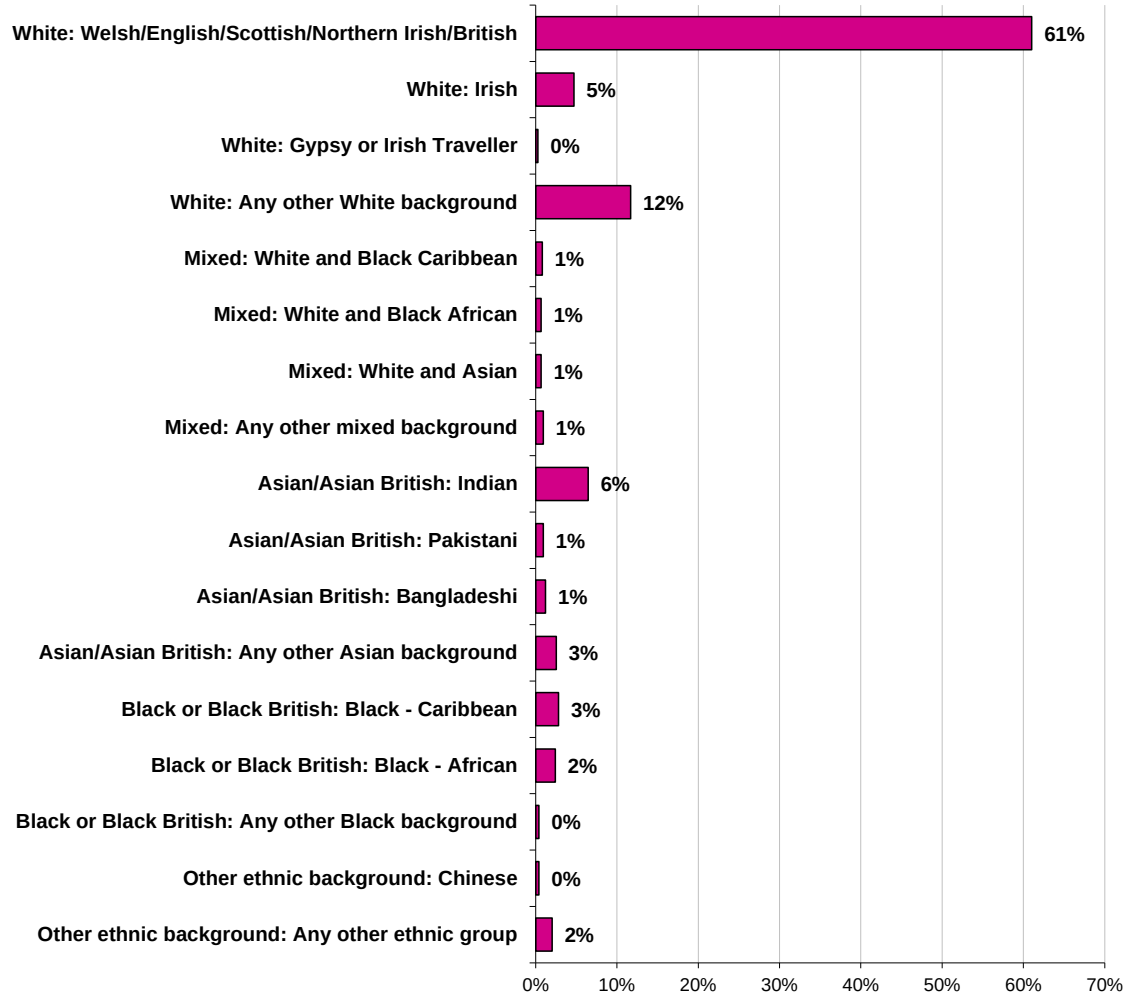
Source: Verve Communications 2023 Base: All respondents who gave a valid response (742)

Disability by clusters



Source: Verve Communications 2023 Base: All who gave a valid response

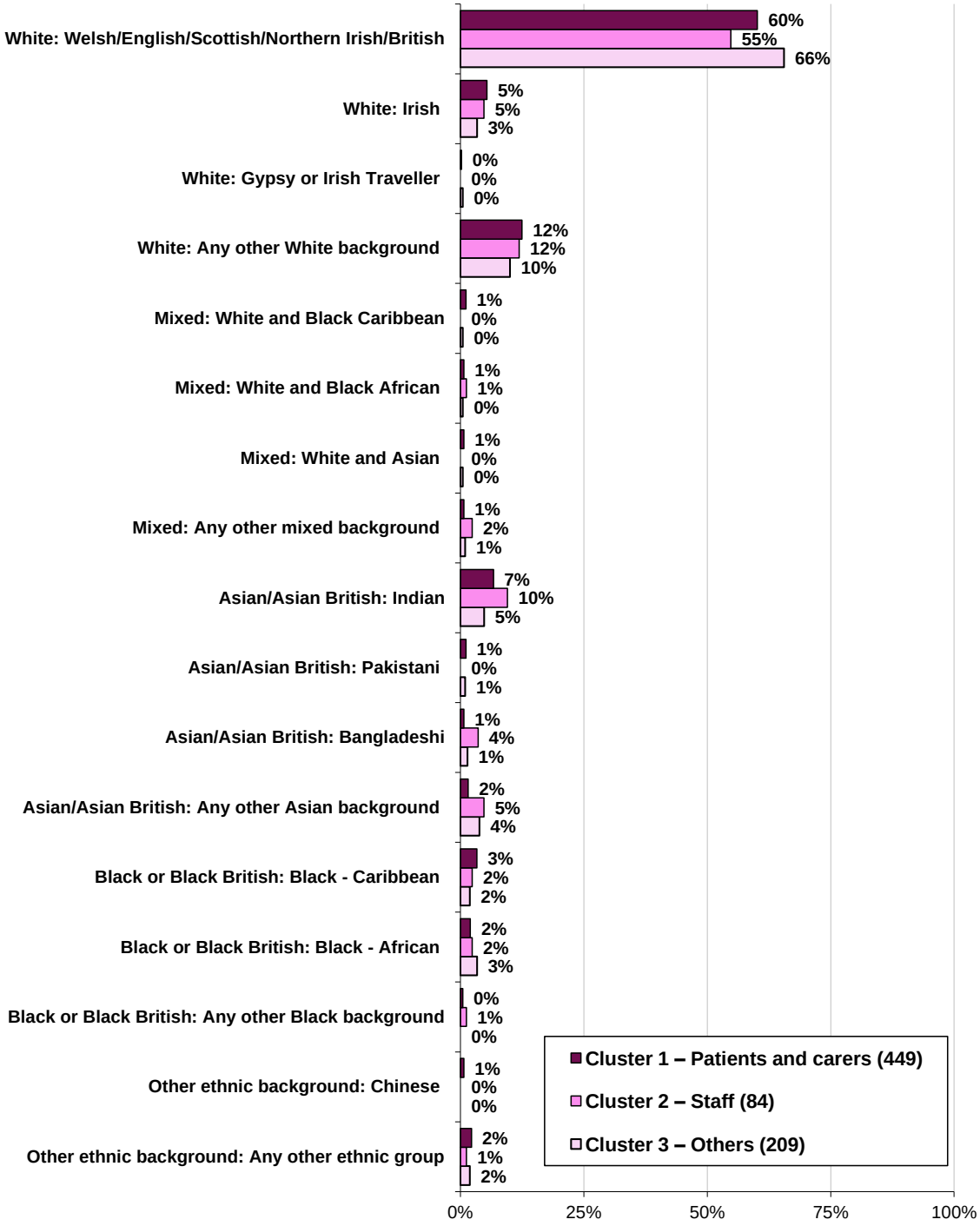
Ethnicity



Source: Verve Communications 2023

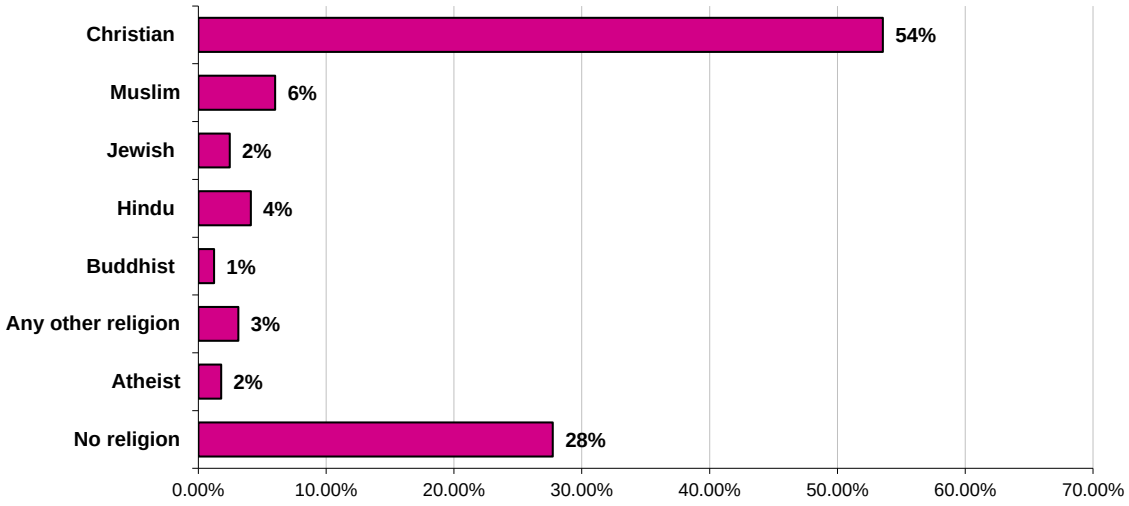
Base: All respondents who gave a valid response (744)

Ethnicity by clusters



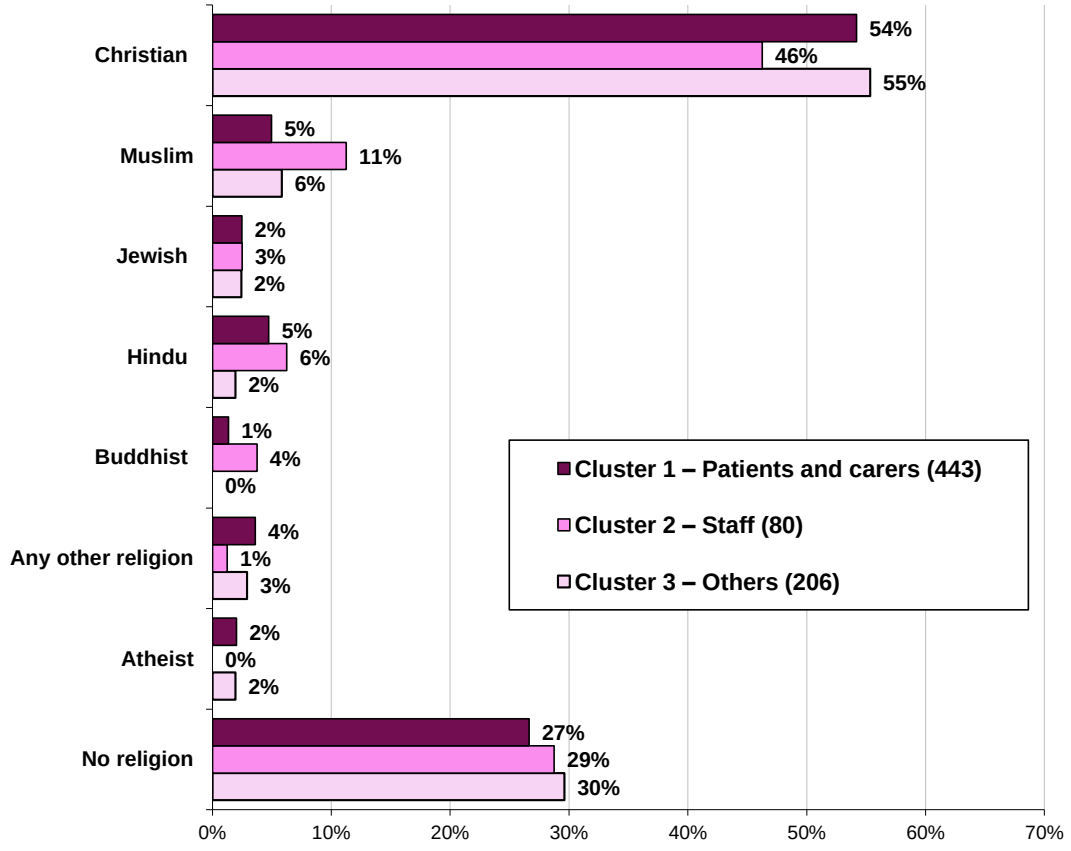
Source: Verve Communications 2023 Base: All who gave a valid response

Religion or belief



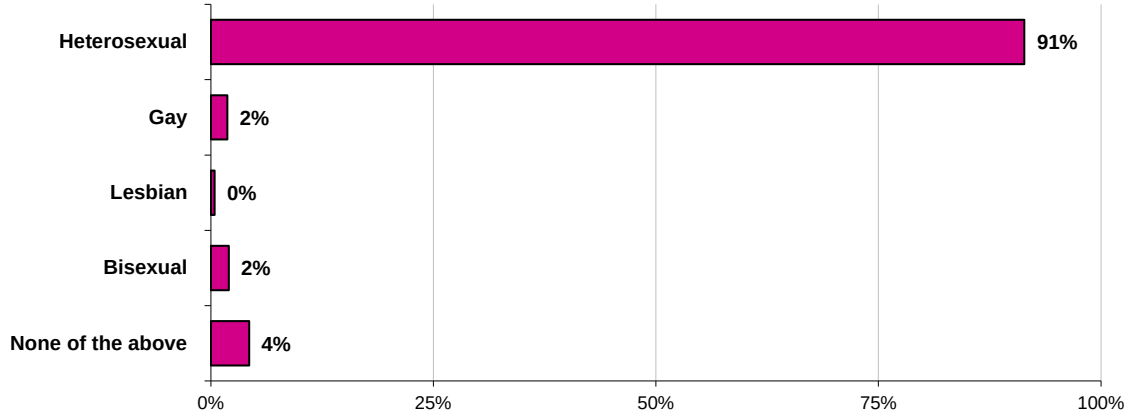
Source: Verve Communications 2023 Base: All who gave a valid response (732)

Religion or belief by clusters



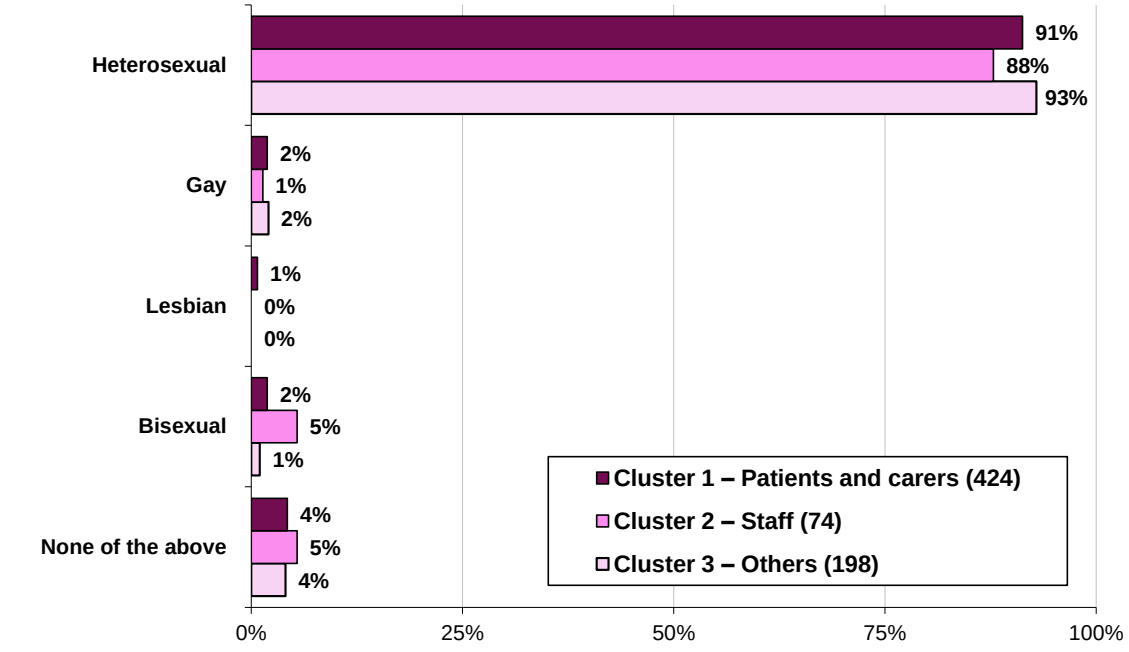
Source: Verve Communications 2023 Base: All who gave a valid response

Sexual orientation



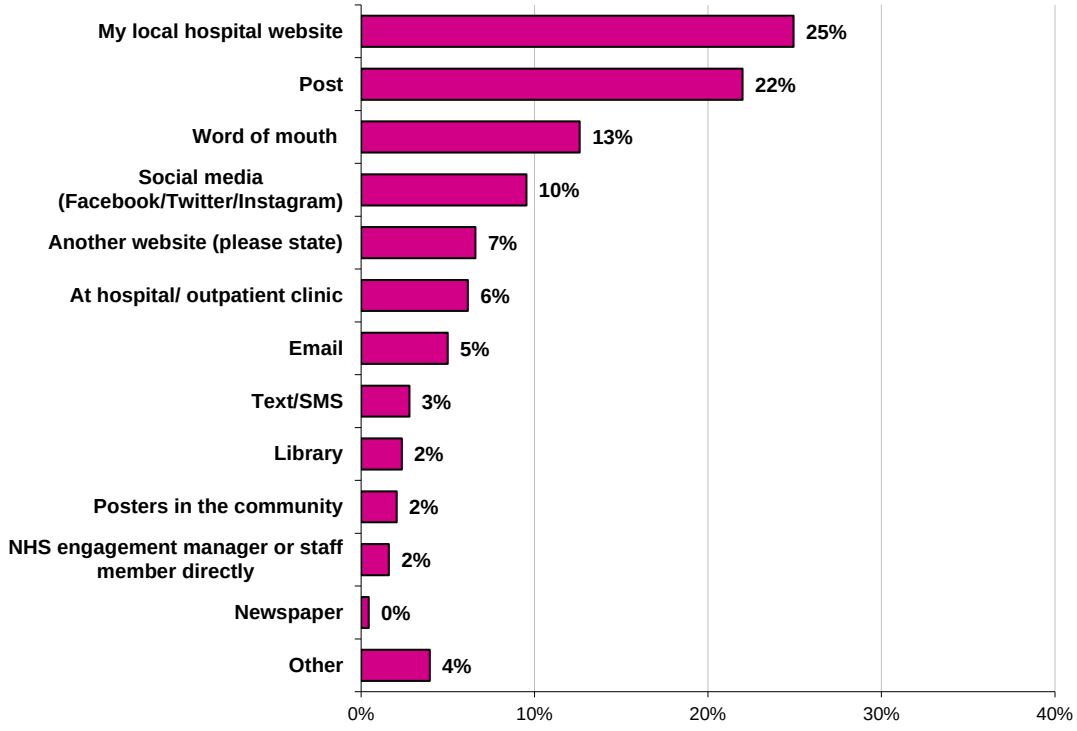
Source: Verve Communications 2023 Base: All who gave a valid response (698)

Sexual orientation by clusters



Source: Verve Communications 2023 Base: All who gave a valid response

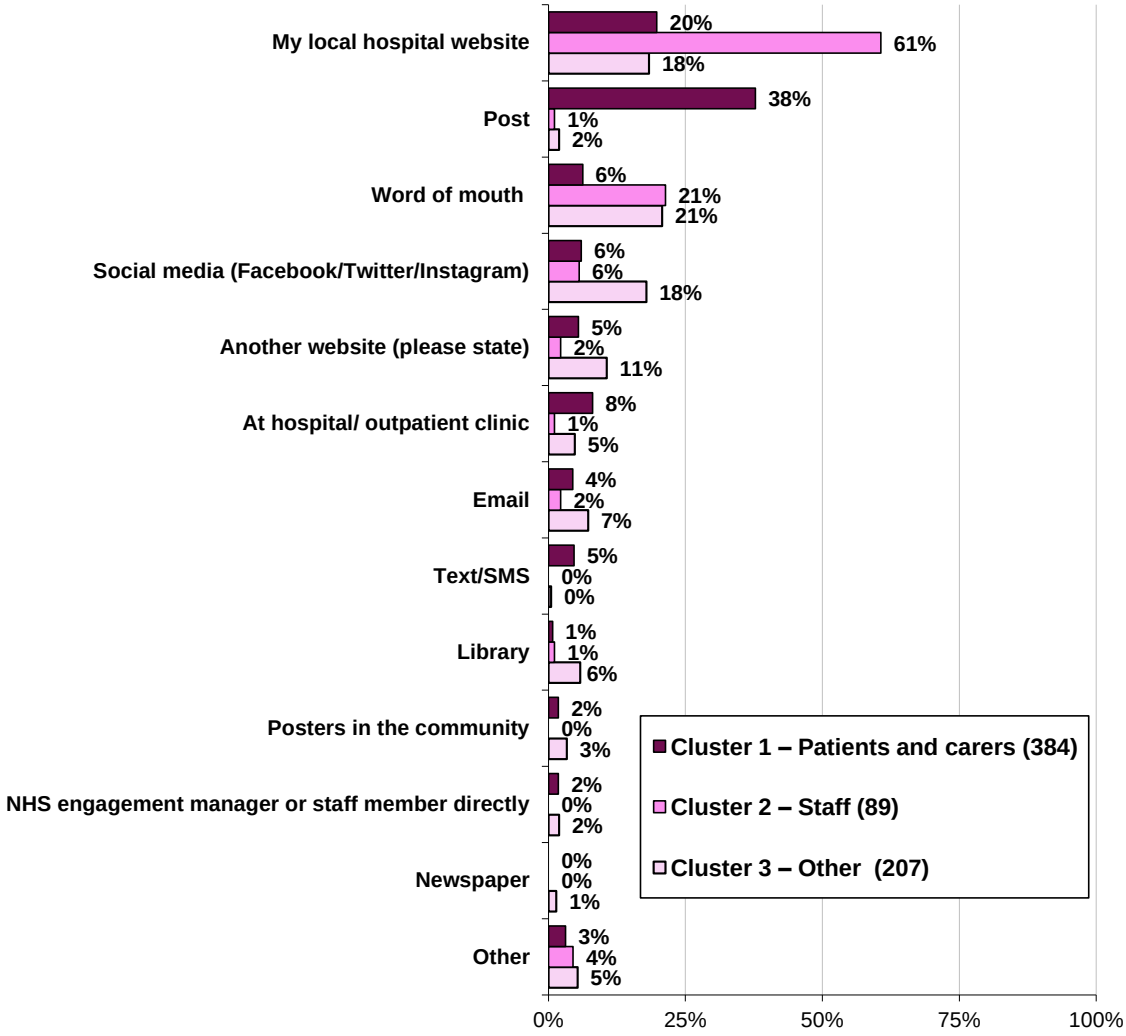
How people heard about the consultation



Source: Verve Communications 2023

Base: All who gave a valid response (682)

How people heard about the consultation – by clusters



Source: Verve Communications 2023

Base: All who gave a valid response

4.7 APPENDIX - COMMUNITY OUTREACH

The NHS consultation team engaged with groups and organisations across North West London. The following tables, supplied by the team, shows the groups and organisations visited by the team, the protected characteristics of the groups and the numbers of people who attended the outreach meetings and all of the community organisations contacted during the consultation.

4.7.1 COMMUNITY MEETINGS MAPPED TO PROTECTED CHARACTERISTICS

Date	Time	Name of Group	Protected characteristic represented	Venue	Borough	Number attended
27/10/22	11.00 - 12.30	Ethiopian Women's group	Race, religion, sex, disability	MBR office	Westminster, RBKC, Hammersmith & Fulham	1
27/10/22	9.00 - 10.00	Harrow Community Leader Touchpoint	Carers, race, areas of deprivation, disability	Online MS Teams meeting	Harrow	15
01/11/22	10.00 - 12.00	KCSC	Race, religion	Kensington Town hall, Horton street, Westminster	Westminster	45
1/11/22	9.00 - 15.00	United Anglo-Caribbean Society	Race, sex	Face-to-face engagement	Ealing	8
08/11/22	13.00 - 14.00	Brent, Harrow, Hillingdon Healthwatch meeting	All	Online MS Teams meeting	Brent, Harrow, Hillingdon	5
08/11/22	10.00 - 12.00	Hounslow Integrated Care Patient & Public Engagement (ICPPE) Committee meeting	Age	Online MS Teams meeting	Hounslow	25
09/11/22	09.00 - 09.45	Internal staff huddle	Internal Hounslow NHS and council staff	Online MS Teams meeting	Hounslow	38
10/11/22	10.00 - 13.00	Quality Food supermarket - Southall	Race, religion	Face-to-face engagement	Ealing	14
11/11/22	10:30	Marylebone Bangladeshi association	Race, religion	Telephone conversation	Westminster, Hammersmith & Fulham, RBKC	1
14/11/22	12.00 - 13.00	Healthwatch	Mixed patients and local residents	Online MS Teams meeting	Hammersmith & Fulham	Approx. 5
14/11/22	12.00 - 13.00	H&F Health Care Partnership – better working together	Race - A range of ethnic backgrounds and patient	Online MS Teams Meeting	Hammersmith & Fulham	11

			representatives, CVOs			
15/11/22	10.00 - 11.00	Building trust project	Race - Black community and protected characteristics	Online MS Teams Meeting	Hammersmith & Fulham	16
17/11/22	11.00 - 12.00	Brent Health Matters Stakeholder Forum	Brent community and BHM colleagues - all	Online MS Teams meeting	Brent	10
21/11/22	11.00 - 12.00	Community Champion Project Leaders	Mixed ethnicity and – deprived local residents	Face-to-face engagement	Hammersmith & Fulham	Approx 6
22/11/22	18.00 - 20.00	Hyde Park Estates Association	Age	Abasto restaurant, 55-57 Connaught St, W2 2BB Westminster	Westminster	Approx. 20 people
23/11/22	13.30 - 15.30	BME Health Forum	Race, religion, sex	Paddington Arts, 32 Woodfield Rd, London	Cross-sector	Approx. 30 people
23/11/22	13.30 - 15.30	BME Health Forum - Interpret and Advocacy service	Race, religion - Black, Asian and ethnic minority Ethnicity: Other white, Middle eastern, North African, Black African, Asian	Face-to face-engagement	Westminster, Hammersmith & Fulham, RBKC	25
28/11/22	2.30 - 3.00	Patient and carer participation group	Age	Online MS Teams meeting	Brent, Ealing and Harrow	Approx. 10
05/12/22	11.00 – 12.30	POPS Health Forum, SOBUS	Age, disability	Online MS Teams meeting	Hammersmith & Fulham	26
15/12/22	13.00 - 15.00	Collaborative space engagement meeting	Race, religion - BAME, Patient representatives, residents, CVOs	Hybrid - Online MS Teams meeting and face-to-face engagement	Westminster, RBKC	17
17/01/23	11.00 - 12.30	Harrow Community Engagement, Wealdstone Library	Area of deprivation	Face-to-face engagement	Harrow	15
17/01/23	13.00- 14.00	Harrow Community Engagement, Pinner library	Area of deprivation	Face-to-face engagement	Harrow	15
17/01/23	15.00 - 16.00	Harrow Community Engagement, Greenhill library	Area of deprivation	Face-to-face engagement	Harrow	15

4.7.2 COMMUNITY ORGANISATIONS CONTACTED

The consultation team provided the following information about the organisations they contacted.

Name of group	Protected characteristic group represented	Borough(s)
CVS Brent	All - carers, areas of deprivation, age, disability	Brent
Man Down Project	Areas of deprivation	Brent
Romanian and East European Hub	Race, areas of deprivation, carers	Brent and Harrow
Iraqi Welfare Association	Race	Cross-sector
Brent Health Matters	All, areas of deprivation, age, race	Brent
Brent Mencap	Carers, areas of deprivation, disability	Brent
Asian Women Centre	Race, age, carers	Brent
Brent Local Authority (incl. all councillors)	All	Brent
Harrow Local Authority (incl. all councillors)	All	Harrow
Hillingdon Local Authority (incl. all councillors)	All	Hillingdon
Ealing Local Authority (incl. all councillors)	All	Ealing
Hammersmith & Fulham Local Authority (incl. all councillors)	All	Hammersmith & Fulham
Hounslow Local Authority (incl. all councillors)	All	Hounslow
Kensington & Chelsea Local Authority (incl. all councillors)	All	Kensington & Chelsea
Westminster Local Authority (incl. all councillors)	All	Westminster
Ashford Place	Mental Health and carers, age, areas of deprivation	Brent
Almis Association	Race, carers, areas of deprivation	Brent
SAAFI	Race, carers, areas of deprivation	Brent
Brent Multi Faith Forum	Religion/faith	Brent
Romanian Culture and Charity Together	Race, carers, areas of deprivation	Brent and Harrow
Mind, Brent, Harrow, Hillingdon	Carers	Brent, Harrow and Hillingdon
French African Association	Race	Brent
Harrow Carers	Carers	Harrow
Brent Harrow Deaf United Club	Disability, carers	Harrow and Brent
Harrow Youth Foundation	Carers, areas of deprivation	Harrow
Harrow Citizen Advisory Bureau	All, areas of deprivation	Harrow
Horizon Youth Action	Race	Harrow
Harrow Hestia Cove Cafe	Areas of deprivation	Harrow
Harrow Association of Somali Voluntary Organisations (HASVO)	Race, religion, carers, areas of deprivation	Harrow
Voluntary Action Harrow	All	Harrow

Name of group	Protected characteristic group represented	Borough(s)
Hillingdon Autistic Care Society [HACS]	Carers, disability	Hillingdon
Hillingdon Alliance of Residents' Associations	All	Hillingdon
Ruislip Residents Association and Northwood Residents' Association	All	Hillingdon
Austin and Silverdale Road Residents Association	All	Hillingdon
Cowley Mill Road (West) Residents' Association	All	Hillingdon
Hillingdon Asian Women's Group	Race	Hillingdon
Refugees in effective and active partnership REAP	Race, areas of deprivation	Hillingdon
Eastcote Residents' Association	All	Hillingdon
Garden City Estates Residents' Association	All	Hillingdon
Harefield Tenants and Residents' Association	All	Hillingdon
High Point Village Residents' Association	All	Hillingdon
Hillingdon Association of Council (Domestic) Leaseholders	All	Hillingdon
Ickenham Residents' Association	All	Hillingdon
North Uxbridge Residents' Association	All	Hillingdon
Northwood Hills Residents' Association	All	Hillingdon
Oak Farm Residents' Association	All	Hillingdon
Hayes Town Partnership	All	Hillingdon
Uxbridge Community Association	All	Hillingdon
Connaught Residents' Association	All	Hillingdon
Warren Park Residents' Association	All	Hillingdon
Yiewsley and West Drayton Town Centre Action Group	All	Hillingdon
South Ruislip Resident's' Association	All	Hillingdon
Disability Association Hillingdon (DASH)	Disability	Hillingdon
Hillingdon Parent Carer Forum	Carers	Hillingdon
H4ALL	All	Hillingdon
Hillingdon Mind	Mental health	Hillingdon
Age UK Hillingdon	Age	Hillingdon
Middlesex Association for the Blind, Hillingdon	Disability, carers	Hillingdon
Hillingdon Women's Centre	Sex	Hillingdon

Name of group	Protected characteristic group represented	Borough(s)
Borough Based Partnership PPE meeting	Community	Hounslow
Network PPG	Network PPG Chairs and vice chairs	Hounslow
Age UK Hounslow	Age	Hounslow
Liesel Angel Trust	Age	Hounslow
Centre for Armenian Information & Advice	Race, religion	Hounslow
Ealing and Hounslow CVS	All	Hounslow
TAHA	Race, religion	Hounslow
The Asian Health Agency	Race, religion	Hounslow
Disability Network Hounslow	Disabled	Hounslow
Rethink Mental Illness	All	Hounslow
Bait – U – Noor (Mosque)	Religion/faith	Hounslow
Asian Family Counselling Service	Race, religion	Hounslow
Calvary Free Grace Baptist Church	Religion	Hounslow
Ghanaian Community Forum	Race, religion	Hounslow
Nepalese Ladies Community London Borough of Hounslow	Race, religion	Hounslow
Sunrise Radio	Race, religion	Hounslow
Polish Radio	Race, religion	Hounslow
Quality Foods Southall	Community	Ealing
Home - London Development Trust (Acton Gardens Community Centre)	All	Ealing
Engagement Oversight Group Ealing (includes VCS)	Voluntary community sector organisations	Ealing
Ealing Library	All	Ealing
Ealing Town Hall	All	Ealing
Dominion Centre	All	Ealing
Ealing shopping centre	All	Ealing
Superdrug Ealing	All	Ealing
Boots the Chemist Ealing	All	Ealing
Ethiopian Women's group	All	Westminster, RBKC, Hammersmith & Fulham
Kensington and Chelsea social Council	All	Westminster, RBKC, Hammersmith & Fulham
POPS health forum, Sobus	All	Hammersmith & Fulham
Marylebone Bangladeshi Association	All	Westminster, RBKC
Collaborative space engagement meeting	All	Westminster, RBKC, Hammersmith & Fulham
H&F Health Care Partnership – better working together	All	Hammersmith and Fulham
BME Health Forum - Interpret and advocacy service	All	Westminster, RBKC, Hammersmith & Fulham

Name of group	Protected characteristic group represented	Borough(s)
Healthwatch	All	Brent, Harrow, Hounslow, Ealing, Hillingdon, Westminster, Hammersmith & Fulham, Kensington & Chelsea
Community Champion project leaders	All	Hammersmith and Fulham
Building Trust project	All	Hammersmith and Fulham
French African Women's Association	All	Westminster, RBKC, Hammersmith and Fulham
Hammersmith & Fulham Save Our NHS	All	Hammersmith & Fulham
Ealing Save our NHS	All	Ealing
Brent Patient Voice	All	Brent

4.7.3 OTHER ORGANISATIONS CONTACTED WITH A REQUEST FOR FORMAL FEEDBACK

Name of organisation
London Councils
Greater London Authority
Care Quality Commission
Sobus
Academy of Medical Royal Colleges
Royal College of Anaesthetists
Royal College of Chiropractors
Royal College of Emergency Medicine
Royal College of General Practitioners
Royal College of Intensive Care Medicine
Royal College of Nursing
Royal College of Physicians
Royal College of Surgeons
Royal Society of Medicine (orthopaedics section)
Royal Society of Acute Medicine
British Orthopaedic Association
Faculty of Intensive Care Medicine
Faculty of Sport and Exercise Medicine
Society for Acute Medicine
Academy of Medical Sciences
Association of Clinical Societies
Medical Schools Council
British Society of Rehabilitation Medicine
British Chiropractic Association

Name of organisation
Institute of Osteopathy
National Axial Spondyloarthritis Society
Royal Osteoporosis Society
Health Education England (London)
GIRFT
Kings Fund
Nuffield Trust
Primary Care Rheumatology and MSK Medical Society
National Orthopaedic Alliance
Arthritis and Musculoskeletal Alliance
Arthritis Action

4.8 APPENDIX – DEMOGRAPHICS OF PARTICIPANTS IN THE QUALITATIVE RESEARCH

The following table shows the demographic data of the eighteen people who completed a form after taking part in qualitative fieldwork.

Category Total respondents: 18	Sub-category	Frequency
Age group		
	11-15	0
	16-18	0
	19-24	0
	25-34	0
	35-44	0
	45-54	4
	55-64	6
	65-79	4
	80+	4
	Prefer not to say	0
Gender		
	Female	12
	Male	6
	Non-binary	0
	In another way	0
Gender ID same as at birth		
	Yes	18
	No	0
	Prefer not to say	0
Do you consider yourself to have a disability?		
	Yes	6
	No	11
	Prefer not to say	1
Ethnicity		
	White: Welsh/English/Scottish/NI/British	1
	White: Irish	0
	White: Gypsy or Irish Traveller	0
	White: Any other White background	3
	Mixed: White and Black Caribbean	0
	Mixed: White and Black African	0

Category	Sub-category	Frequency
	Mixed: Any other mixed background	0
	Asian/Asian British: Indian	4
	Asian/Asian British: Pakistani	0
	Asian/Asian British: Bangladeshi	0
	Asian/Asian British: Any other Asian background	1
	Black or Black British: Black-Caribbean	0
	Black or Black British: Black-African	6
	Black or Black British: Any other Black background	0
	Other ethnic background: Chinese	0
	Other ethnic background: Any other ethnic group	1
	Prefer not to say	1
Religion or belief: Total of 20 (more than 1 option chosen by some participants)		
	No religion	3
	Buddhist	0
	Christian	10
	Hindu	4
	Jewish	0
	Muslim	3
	Sikh	0
	Atheist	0
	Any other religion	0
	Prefer not to say	0
Sexual orientation		
	Heterosexual	14
	Gay	0
	Lesbian	0
	Bisexual	0
	None of the above	2
	Prefer not to say	1
How did you hear about this consultation?		
	My local hospital website	0
	Another website	0
	Newspaper	0
	Posters in the community	1
	Social media	0

Category	Sub-category	Frequency
	Word of mouth	4
	Don't know	0
	Other	8

4.9 RESPONSES FROM ORGANISATIONS

THE ROYAL BOROUGH OF
KENSINGTON
AND CHELSEA

Healthier North West London
By email: nhsnwl.eoc@nhs.net

Date: 19 January 2023

Dear Healthier North-West London team,

Re: Public consultation on Improving planned orthopaedic inpatient surgery in North-West London

We welcome the acknowledgement by Healthier North-West London that we can achieve significant positive impacts on the lives of our residents through collaboration across health, the local authority, and other partners. We also recognise the significant challenges facing our residents with increases in demand for services. It is therefore right that we consider different models of care, building on best practice, to support people to access the services they need, when they need them, to genuinely improve health outcomes for residents.

As a local authority, being an advocate and representative of our residents, we welcome the opportunity to comment on your pre-consultation business case and planned consultation.

At a time when residents are facing increased challenges with the current cost-of-living crisis and existing travel challenges due to regular travel strikes and bus route changes, we are concerned about residents having to travel out of the borough for inpatient orthopaedic care surgery, taking more time away from paid work and with increased travel costs. Additionally, we know that car ownership is relatively low in Kensington and Chelsea, so we are concerned about resident and their supports relying on public transport to travel to clinical appointments.

We would urge you to work with the Council on supporting local employment and apprenticeship pathways, to keep local residents in local jobs in healthcare, and to continue consulting with our residents throughout this process in a way that is meaningful to them. Additionally, with the Integrated Care System now in place, we would like to see meaningful engagement of our Joint Health and Wellbeing Board in decision-making processes such as these.

We look forward to continued collaboration with you as this project progresses, and to our residents being consulted and informed as to any changes to their care provision.

Yours faithfully,

Councillor Sarah Addenbrooke
Lead Member for Adult Social Care and Public Health
The Royal Borough of Kensington and Chelsea

City of Westminster

Proposal Response

Subject: Orthopaedic In-Patient Surgery NW London Proposal

Approved by: Chair, Children, Adult Public Health and Voluntary Sector Policy & Scrutiny Committee

Date: 17 January 2023

Summary Response from the Committee Meeting 5 December 2022

Following a presentation provided to the Committee by Raymond Anakwe (Medical Director for Imperial College Healthcare NHS Trust) and Mick Fisher (Head of Strategic Communications & Stakeholder Relationships| Imperial College Healthcare NHS Trust) on the plans to improve orthopaedic in-patient surgery and care in north west London, the Committee reviewed and considered the following topics:

- The consultation process to date, including feedback from service users, the community, and partners, and the programme for the remainder of the consultation period.
- The importance of a joined-up approach between patient care services across the borough.
- The current waiting lists for orthopaedic care and the issues with addressing the backlog of patients in the borough.
- The costs to patients in travelling for treatment and the plans to transport patients between services, including, the possible involvement with voluntary services to facilitate assistance for patients.
- Targeting minority groups or vulnerable residents, understanding their specific needs, building confidence, and ensuring they are supported through other services such as, childcare, the voluntary sector, and translators.
- The complimentary, digital aspect of the service to improve communication with patients, including, online discussion and follow-up with medical staff, and addressing the issues around patients that are not digitally confident.
- How follow-on treatment like physiotherapy will take place.

The committee highlighted the below points were areas for further consideration:

- Wasted travel time for staff, the travel distance for patients and the plans to address these issues with the opening of the Orthopaedic In-Patient Surgery in NW London.

- Concerns were raised about whether patients were able to choose to attend the proposed Orthopaedic In-Patient Surgery in NW London.
- Whether consideration will be given to other personal requirements of patients.

The Chair and Committee support the plans and recommendations made by Imperial College Healthcare NHS Trust for the Orthopaedic In-Patient Surgery in NW London.

IMPROVING PLANNIED ORTHOPAEDIC INPATIENT SURGERY IN NORTH WEST LONDON

RESPONSE FROM HAMMERSMITH AND FULHAM SAVE OUR NHS (HAFSON)

INTRODUCTION

This is HAFSON's response to the consultation papers about improving planned orthopaedic surgery in NW London.

We have read all the published documents, attended at least one of the engagement events organised by Imperial Trust, contributed to a discussion on the proposals at the H&F Health and Social Care Scrutiny Panel, received written comments from supporters and discussed our draft at a HAFSON general meeting.

We recognise the context from which the proposals have emerged: close collaborative work between trusts during the Covid pandemic; the alarming backlog of patients awaiting orthopaedic treatment; and the evidence that high volume, low complexity treatment at specially designed hubs with dedicated staff could speed up treatment of patients and reduce waiting lists. We also note, as the published papers make clear, that current orthopaedic services show significant weaknesses across trusts in NW London. The papers also admit that currently there is insufficiently joined-up care across primary, community and acute services and that care is not always sufficiently focused on the needs of patients.

HAFSON welcomes the fact that broad consultations to test the proposals for a new orthopaedic hub have taken place.

HAFSON endorses the proposal in general terms as we recognise that this could help tackle the backlog and begin to structure a more coherent patient experience.

However, we also have a number of important concerns which we believe need to be addressed as the proposal is taken forward.

EQUALITY, ACCESS AND QUALITY ISSUES

The papers make a strong case for situating the proposed hub at Central Middlesex Hospital rather than at any of the alternative sites considered, such as Mount Vernon. We think, overall, this is the right choice.

Travel

NW London has a population of more than 2 million people spread over a very wide area. Whatever site is chosen may be easy to get to for some people but will cause travel difficulties for many other patients and their visitors. NW

London has a slightly older population, a somewhat poorer population and a greater ethnic mix than other parts of London; and also has a very large number of people living in deprivation. These groups will be a significant number of those needing orthopaedic care.

For many patients, Central Middlesex (CMH) has poor public transport links and people from the above groupings are less likely than others to have access to private transport. There are no train or tube stations near CMH. And although there are good bus links from several parts of NW London, very many people may require several bus changes to get to the site. It will also be an unfamiliar site to very many people.

Travel is therefore an important access and equality issue. Taxi fares will be beyond the means of many. We note in the papers that there is mention, on p. 58 of the full business case, of developing a shuttle bus service to get patients to and from home hospitals. We endorse this proposal as a possible positive solution to many of the above travel problems. We would also suggest that it would enable properly trained staff to be in attendance to assist patients, post-surgery, to return safely to their homes. In support of this, we know of taxis being used when patients have had to struggle to get from a taxi into their own homes without trained assistance. Getting home safely, post-surgery, poses its own problems which need to be considered in planning transport solutions.

The development of, for example, a shuttle bus system could also help the trusts meet their green targets.

Although we have concentrated on the needs of patients, some consideration of the travel needs of visitors also needs attention, taking the above into account. It is worth noting that many of the patients will be elderly and having visitors will be a significant factor in recovery.

Similar travel difficulties may be faced by staff accessing this site. Due to increased cost of living, rent etc., staff tend to live close to transport links to hospitals. Thus, increasing their journey times to the new hub may make recruitment and retention more difficult.

Choice

We understand that patients needing low complexity treatment may be able to choose to be treated at the proposed hub or at their home hospital. There needs to be greater clarity about the consequences of any choices that individual patients might make. And any consequences for patients who do not meet the 'low complexity' threshold and therefore would anyway remain at

the home hospital. Many 'low complexity' patients may be white and affluent and it is not clear that, in itself, the hub will help poorer and minority ethnic patients. More detailed analysis of equalities impact would be welcome here.

More explicit explanation is needed on how pressure on home hospital lists might be dealt with if large numbers choose to stay with the home trust – both for the low complexity cases and for high complexity cases. If many low complexity patients choose to remain with their home hospital, will this make the viability of the hub questionable?

Digital

HAFSON understands the very real advantages of digital developments in medical treatment both for patients and for staff. However, the papers seem to adopt the position that this is the default position in dealing with patients – with the only example given, Samira, being entirely dependent on digital.

But many patients do not have the requisite technology, cannot afford the technology, lack digital competence or confidence, may have language issues etc. Additionally, it is often older people who develop orthopaedic problems and who also can lose competence in digital matters as part of the ageing process. It is not just older people – poor vision, impaired hearing etc can make use of mobile technologies very difficult. Patients should not be forced to use this technology when they feel uneasy about its use. Patient choice is vitally important here and digital, however welcome, should not be the default position. Equality of access is a key issue here.

Patients who are uneasy with digital modes should not be made to feel that they should have to apologise for their choice.

More complex cases

The proposals give welcome detail about how the hub could speed up access to treatment, improve the quality of treatment by having a highly trained staff based there, but it says little about how the hub might also lead to improvements to treatment for patients with more complex conditions who will remain at their home hospital. It would be helpful to have more detail on how the hub is expected to also facilitate improvements for those with more complex needs.

Community MSK

The papers make clear that there is recognition that there are fundamental difficulties, particularly from a patient point of view, with existing MSK services. HAFSON would concur with this assessment, particularly in relation to services in H&F. We have, over several years, received more complaints and concerns about poor quality of treatment, unfocused treatment, long unexplained delays between treatments, little follow up, generic advice rather than specific advice relating to an individual problem, about the absence of any treatment plan, about only being dealt with by phone (and not only during the height of covid), about incorrect information … and more.

We therefore welcome the proposal that there is to be a new procurement process initiated soon. We recommend that the new MSK service is fully integrated into a high quality and, above all, coherent service with clear institutional links to both primary and acute services and with a transparent management structure accountable to both the ICB and to the public which it should serve. However, given the widespread dissatisfaction with the current service, we strongly recommend that any new service needs to start from patient experience and needs to be co-produced from the outset, so that a system that is fit for patient need can be developed. This may help prevent conditions developing that may require surgery at a later date. (It is only this week that some of us have been able to see a 'Business Case' for MSK services across NW London which is wholly systems-based and no recognition whatever of patient experience etc.)

Coherence across NHS services

The business case points to gaps, delays, failures to send on appropriate information, marginalisation of the patient etc in a very complex system. However, at the end of the paper there is no detail as to how all the key elements of the orthopaedic service, with patient experience at its centre, is to be brought together in a coherent way – to include primary, secondary and community services. This needs further early development.

Ongoing co-design

We welcome the fact that the proposed orthopaedic service is being envisaged as a co-designed model. We recommend that the new service retains key features of co-design as services will need to evolve to meet changed demographics and new treatment demands. This is of great importance in that members of the most deprived communities who make a large proportion of those using orthopaedic services rarely have a voice in the development of NHS services.

STAFFING

The papers are clear that staffing the hub will present its own challenges. Given the national shortages of staff in this area, is it clear that the proposed hub can recruit and retain sufficient highly trained staff so that the hub can function fully from November 2023, and that the services to remain at home trusts are not undermined?

It seems clear career development, academic research, teaching possibilities etc for staff working at both the hub and at home trusts will be a draw i.e. that consultants and other doctors will have clear career development possibilities. However, from the papers, it does not seem clear that such opportunities to develop careers and develop skills will be available to all staff since it seems that nursing and therapy staff are to be appointed to the hub and will therefore have fewer opportunities for broadening of skills.

We are aware that many of these issues are for 'staff side' consultation.

GOVERNANCE AND MANAGEMENT

The outline graphic on p.84 of the full business case is quite bare. We would welcome much more detail on how in practice such a complex structure might work and how the hub will be held accountable to the general public.

Management on both a strategic and a day-to-day level

We have several questions here.

How will the hub be managed on a day-to-day level given that many of the leading surgical staff (i.e. consultants and accompanying junior doctors etc) will be in attendance, presumably on a rota basis, from their home trusts?

Who will take responsibility for deployment, scheduling etc of such staff? And who will supervise the quality of their work?

As there will be a team of staff working permanently at the hub, as well as staff coming to work from home trusts, how will day-to-day oversight of the work be undertaken? If there is disagreement or conflict between hub staff and staff from the different home trusts, how is this to be managed? It needs to be noted that the actual 'teams' will be changing on a frequent basis and this could lead to tensions.

Will the site be wholly managed, on a day-to-day level, by CMH management? Or will there be a separate management structure? And how will this relate to the home trusts? Will there be dedicated partnership meetings to ensure coherence of approach and full staff commitment to the hub. This whole issue of management of the hub needs significant fleshing out.

To work, the hub will need public trust. We feel that the publication of a clear management structure would be helpful and reassuring.

Finally, we note that mention is made of the transfer of patient electronic records between different parts of the system. We would, with appropriate data protection safeguarding, be very much in favour of this – but will this be in place by November 2023?

FINANCE

The funding for setting up a new hub seems to be clearly organised and detailed. And there is some fairly clear data on the ongoing costs for the first few years of operation – not least while the large backlog is being tackled. However, given the continuing high rate of inflation, is it clear that there will be sufficient money available for all the necessary estate investment required for the hub to function as an orthopaedic site?

If the backlog is successfully tackled, the papers provide no clear information on possible patient numbers in future years that would guarantee that the hub would be viable. We recognise that, given population changes, there may not be a 'steady state' as such, but we think it is important to see figures for

possible patient numbers and ongoing costs, therefore, for the hub for the future. We raise this issue because, in H&F, there has previously been the failure of a 'flagship' hospital, Ravenscourt Park Hospital, which was forced to close because of lack of demand for services – a victim of its own success.

A further query about financing of the hub: we know that there is an outstanding PFI contract at CMH. Could this act as a financial drag on the viability of the hub, or will the financing of the hub be kept entirely separate?

Given the specialism of the hub, we would seek reassurances that the service would remain a fully publicly owned and provided NHS service and that there would be no intention at any time to sell the hub to private providers. We know that stand-alone facilities with narrow specialisms are particularly attractive to private investment. We would very strongly resist any moves in this direction. In the mid-2000s, hundreds of millions of pounds were invested in establishing new 'Independent Sector Treatment Centres' to treat the simplest elective cases. These were NOT a success, cost the NHS a great deal of money, and were then shut down. We need assurances that the hub will not be taken in that direction.

CONCLUSION

It would be useful and reassuring for the public to get feedback on the issues that have been raised during the consultation period – on both the outcomes of the consultation AND answers to issues that have been raised both by individuals and by any organisations that have responded.

We think the above issues are important but we raise them in the context of broad support for the proposed hub.

Jim Grealy, Chair, HAFSON

Merril Hammer, Secretary, HAFSON

London Borough of Hammersmith & Fulham
Governance and Scrutiny
Hammersmith Town Hall,
King Street, London, W6 9JU

For the attention of Prof. Tim Orchard, Chief Executive Officer, Imperial College Healthcare NHS Trust

C/o Mick Fisher, Head of Strategic Communications & Stakeholder Relationships

Dear Tim,

Health and Adult Social Care Policy and Accountability – response to Improving Planned Orthopaedic Inpatient Surgery In North West London consultation

The committee at its meeting on 16 November 2022 (draft minutes are attached as an appendix) received a proposal to consolidate orthopaedic services at an elective orthopaedic centre (EOC). This plans to deliver inpatient surgery by establishing a hub at Central Middlesex hospital. An elective orthopaedic hub could efficiently manage a large volume of cases with clinically low complexity. The committee notes the details of the consultation and welcomes the Trusts efforts and commitment to engaging with community stakeholders and residents to ensure that their views are considered in shaping the proposal.

The committee agrees with your view that the integral concerns of residents and stakeholders need to be alleviated and the following points explore the key areas of our concern:

1. Pre and post operative care patient pathways

   Operationally, procedures would be undertaken at Central Middlesex hospital, with follow-up treatment pathways identified locally. The committee feels that clear signposting to the options and post operative care pathways is important as it informs individual decision making about which route is most appropriate for their circumstances. There should be continuity of care between the procedure and post operative care and given that this will be potentially delivered from two sites – the EOC and a local site, there must be robust framework in place so that patients are aware of treatment options throughout their care. Local signposting to post-operative support and rehabilitation should ensure that every patient understands what their support looks like and how to access it.

   Supporting patient choice is fundamental but there is a balance to be sought between the effective management of resources and the provision of accessible services so that there is no disadvantage to the "patient" should they choose to refuse a fast-track elective option.

2. Transport

There was strong agreement during the committee's discussion that public transport links from the borough to Central Middlesex hospital were a concern and members concurred with your view that an imaginative and sensible approach was needed. The committee recognises that pre-operative patient transport is distinct from post operative patient transport. Cross borough public transport links are not good and traffic congestion throughout the day can vary significantly. Travel costs and transportation were known to negatively impact marginalised and economically vulnerable groups. Dealing with the consequences of an untreated health conditions and the combined stresses of an impending procedure and concerns about transport difficulties are not ideal and could in some cases exacerbate symptoms or impede recovery.

The proposal is intended to provide an efficient clinical solution, but this should not be delivered at the further expense of those groups that are already experiencing hardship. As part of its cost of living response, the council is delivering support via the Household Support Fund. Would it be feasible for the Trust to explore a similar solution to ensure equitable and supported access to services by meeting any treatment related travel costs incurred.

Any patient transport solution will require considerable innovation and the committee would urge the Trust to continue to explore the feasibility of establishing a patient dedicated service that could be developed across the NWL sector.

3. Clinical Expertise

The concentration of clinical expertise at Central Middlesex could impact on local diagnostic services and the committee welcome assurances that local capabilities will be unaffected. The need for strict patient protocols to identify suitable candidates for fast-tracked elective surgical care means that not all patients will be eligible. Recruitment and workforce retention in the NHS are a concern and concentrating clinical expertise on one site infers that there may be additional pressures on local provision which will remain in place as an option. The committee would welcome more detail about how EOC will be provisioned given the current known pressures on clinical staffing and what the impact on localised provision might be once expertise is centralised at the EOC.

4. Digital Inclusion

Some communities experience difficulties in engaging with digital goods and services through lack of knowledge, access to the internet or a suitable device. Prompted by a response to the pandemic, the move to digitise has been fast and there is a concern that groups who struggle to be digitally included will be further excluded unless there are alternative in-person options, both in terms of treatment and the communication of information. The committee welcome the implementation of any measures that can ensure that those who are most affected by digital inclusion are not further

disadvantaged. The committee would particularly support measures which would proactively reach out to underrepresented communities.

The EOC proposals are a welcome solution to the challenge of addressing the significant backlog of orthopaedic cases across NWL. The fast-track hub model approach of tackling high volume low complexity procedures, coupled with robust clinical assurance has the potential to ensure that treatment is offered before the condition of those awaiting treatment further deteriorate. However, the advantages of this configuration could be further enhanced if patient transport and travel issues can be suitably resolved.

In addition, there needs to be clear access to information and signposted patient pathways, including initial, localised diagnostics and post-operative recovery. The patient voice is sometimes excluded from the process of shaping and informing "new" services. Removing barriers to information, listening to the patient voice, and combining this with broad engagement across a range of diverse communities is essential if health inequalities are to be resolved.

The committee commends the Trusts efforts to engage with the community, voluntary sector and stakeholders. This commitment that has been actively supported by the council through sharing information about the consultation across council communication channels and its wider network of partner organisations.

Kind regards,

Cllr Natalia Perez

Councillor for White City

Chair of Health and Adult Social Care Policy and Accountability Committee
London Borough of Hammersmith & Fulham

Appendix – Draft minutes of the Health and Adult Social Care Policy and Accountability Committee, 16 November 2022

MAYOR OF LONDON

Helen Pettersen
Regional Director for London
NHS England

Penny Dash
Chair
North West London Integrated Care System

Matthew Swindells
Joint Chair
North West London Acute Hospitals

Rob Hurd
Chief Executive Officer
North West London Integrated Care System

Date: 19 January 2023

Dear Helen, Penny, Matthew and Rob,

I want to start by thanking the North West London Integrated Care System team for their helpful engagement with the process to apply my six tests to the proposals for 'Improving planned orthopaedic inpatient surgery in north west London'. This has supported my team to better understand the proposed changes and the objectives and analysis behind them.

As Mayor, I have committed to using my influence and role as a political leader to champion, challenge and collaborate with the NHS and other health partners on behalf of all Londoners. As part of this role, I have developed six tests to apply to all major health and care transformation and reconfiguration programmes. These tests are designed to help me challenge the NHS to demonstrate that major changes are in the best interests of all Londoners.

In November 2022, I reviewed and refreshed my six tests. However, given that the public consultation for these proposals was launched before the six tests were refreshed, I am assessing them against the previous version of the tests. Those tests cover:

- health inequalities and the prevention of ill health
- hospital beds
- financial investment and savings
- social care impact
- clinical support
- patient and public engagement.

In November 2022, I commissioned the Nuffield Trust to carry out an independent expert review of the proposed changes against the six tests. I have used this analysis to inform my position on the proposals. A copy of this review is attached to this letter.

This letter sets out my view on the proposed changes against the first four of my tests. Following the publication of the consultation report and final plans in the forthcoming decision-making business case (DMBC), I will share my final position on the proposed changes against all six tests.

City Hall, Kamal Chunchie Way, London E16 1ZE
mayor@london.gov.uk • london.gov.uk • 020 7983 4000

MAYOR OF LONDON

Overall, I am broadly supportive of the proposed changes. They represent a significant opportunity to improve patient outcomes, reduce waiting times, tackle the elective care backlog and deliver care more efficiently. The model of care being developed has the potential to be adapted and emulated by both other systems and other types of service across London, to the great benefit of patients. However, in part because of the major potential these changes hold, it is crucial to ensure that the benefits they generate for the health of Londoners and towards efforts to reduce health inequalities are optimised. It is in that spirit that I share my position on the proposals at this stage of their development.

To allow me to support the DMBC, I would like to draw your attention to several key points for you to consider during the next phase of developing the proposals. In particular, the final plans should:

- Account for the potential risks of widening health inequalities that are identified in the Nuffield Trust review, and offset these risks with actions to improve equity in elective orthopaedic care in north west London.
- Put forward a detailed workforce plan that addresses the risk that shifting staff to the new elective orthopaedic centre (EOC) could reduce capacity in surrounding hospitals and services.
- Show how capacity freed up by the shift in activity to the EOC will be used or redeployed, in order to realise the potential savings associated with the proposed changes.
- Set out a detailed consideration of the impact of the changes on social care services in north west London.

Test 1: Health inequalities and the prevention of ill health

The pre-consultation business case (PCBC) for the proposals claims that elective orthopaedic surgery use in north west London is currently skewed towards the most deprived population group, and implies that, since their use of these services is disproportionately high, improvements to elective orthopaedic care generated by the proposed changes will disproportionately benefit this group. However, indicative analysis by the Nuffield Trust suggests that the share of elective orthopaedic surgery in north west London used by the most deprived parts of the population is broadly in line with population size, rather than being disproportionately high. This would mean that, at best, the activity rate is proportionate to the relative level of need in that population group. However, given that the PCBC for these proposals identifies a higher musculoskeletal disease burden in the most deprived groups, this proportion of activity may in fact indicate a relatively high level of unmet need for elective orthopaedic care. This entails a risk that the changes will disproportionately benefit less deprived groups, and thereby widen health inequalities. Given this, the DMBC should revisit this analysis to ensure that the risk of widening health inequalities is appropriately considered and mitigated.

The proposed new EOC is a 'high volume low complexity' hub, where patients with multiple comorbidities, particularly if these are poorly managed, will be ineligible for treatment. Since the incidence of multiple comorbidities increases significantly with deprivation, there is a substantial risk that the group of patients eligible for treatment at the new centre will be less deprived than those deemed ineligible. This would appear to mean that the benefits generated by the creation of the new centre, such as improved clinical outcomes and reduced waiting times, would accrue disproportionately to less deprived parts of the north west London population. In this respect, the proposed changes risk widening health inequalities. The PCBC argues that patients ineligible for treatment at the new EOC will experience equal clinical outcomes. However, since the chief clinical benefit of the changes appears to be that treatment in the new centre will involve lower rates of

City Hall, Kamal Chunchie Way, London E16 1ZE
mayor@london.gov.uk • london.gov.uk • 020 7983 4000

complications, more evidence is needed to explain how patients treated outside of the centre will experience improved clinical outcomes. As things stand, this risk should be offset by wider actions to improve healthcare equity in orthopaedic care in north west London. These actions should be clearly set out in the DMBC, alongside health inequality metrics and targets for the scheme.

It is positive that analysis in the PCBC shows that median travel times to the new EOC by both car and public transport are lowest for the most deprived groups in north west London. However, it is crucial to understand differences in travel costs, as well as travel times, associated with the proposed changes, and I would want to see evidence on this in the DMBC. I am pleased to see the commitment in the PCBC to pay particular attention to the travel needs of patients and carers from deprived areas and to explore solutions to support affordable access. Attention should also be paid to the needs of groups who may struggle to travel long distances, such as disabled people, older people and those who do not speak English.

Test 2: Hospital beds

The proposed changes will involve a significant increase in bed and theatre capacity for elective orthopaedic patients in north west London, as well as opening up bed capacity for other forms of care in hospitals from which inpatient elective orthopaedic care will be transferred to Central Middlesex Hospital (CMH). However, I note that analysis by the Nuffield Trust suggests that without further actions in addition to those set out in the proposals, demand for elective orthopaedic care in north west London will continue to outstrip NHS capacity.

The proposed changes involve a substantial shift in clinical resource from surrounding hospitals to CMH, in order to staff the new centre. This risks diminishing clinical staff levels in those hospitals, as well as destabilising interdependent services, including emergency care – potentially leading to an effective reduction in bed capacity for other forms of care. Since more deprived groups disproportionately use emergency care, such an impact on emergency care would generate a health inequalities risk. These risks are helpfully raised in the proposal documentation published to date.

However, given the gravity of the risks, I would anticipate that the DMBC will include a more detailed workforce plan that sets out how the risks will be addressed and monitored over time, including mechanisms for tracking the effects of the changes on capacity in surrounding hospitals.

Test 3: Financial investment and savings

I welcome the fact that the EOC can be established at CMH with capital investment that is fully funded in the local acute capital programme. It is also positive that this change would enable the NHS to more efficiently use assets at CMH that it is already contractually committed to paying for, and that annual revenue savings of £4m are anticipated once the centre is fully established.

Under the proposals, £17m of elective orthopaedic activity is being moved from three north west London trusts to the new centre at CMH. For the potential ICS-wide savings of this shift to be realised, these three trusts will need to either be able to export the full cost of the 'referred' patients out of their own cost bases when activity is moved, or re-use existing capacity for other forms of patient care in a way that is fully funded. The PCBC rightly acknowledges this as a critical challenge, but the DMBC should set out in detail how this challenge will be addressed – including outlining how, where costs cannot be exported, capacity will be redeployed or activity reduced.

City Hall, Kamal Chunchie Way, London E16 1ZE
mayor@london.gov.uk • london.gov.uk • 020 7983 4000

MAYOR OF LONDON

Test 4: Social care impact

One of my priorities for any major service change is that the impact on adult social care is well considered. I note that the PCBC does not set out how the proposed changes will affect adult social care services. This should be considered in detail in the DMBC. It is important that this includes modelling of the expected impact of the changes over time on the size and profile of demand for local social care services, as well as setting out how risks associated with potential shortfalls and inequalities in social care support will be monitored and mitigated. Given the shift in patients from multiple boroughs to CMH, it is also important that the DMBC sets out appropriately resourced plans to develop relationships between CMH and the full range of adult social care services that it will be working with if the EOC is established.

Thank you for the opportunity to comment on the proposals. I will be publishing this letter on the Greater London Authority website in the next few days. I plan to share my final position against all six tests once I have reviewed the consultation report and the revised proposals that will follow in the DMBC.

Yours sincerely,

Sadiq Khan
Mayor of London

Cc: Geoff Alltimes, Independent Chair, London Estates and Infrastructure Board
Dr Roger Chinn, Chief Medical Officer, Chelsea and Westminster Hospital NHS Foundation Trust
Dr Michael Gill, Chair, London Clinical Senate
Toby Lambert, Executive Director of Strategy and Population Health, North West London Integrated Care System
Martin Machray, Executive Director of Performance, NHS England – London
Dr Chris Streather, Medical Director, NHS England – London

City Hall, Kamal Chunchie Way, London E16 1ZE
mayor@london.gov.uk • london.gov.uk • 020 7983 4000

Nuffield Trust assessment of North West London's proposed elective orthopaedic care centre against the first four of the Mayor's Tests. January 2023

Summary of proposal:

The establishment of an Elective Orthopaedic Centre (EOC) at Central Middlesex Hospital, which will operate as a stand-alone "High Volume, Low Complexity" surgical hub, with a strict separation of elective from emergency care. Such a separation is recommended in the "Getting it Right First Time" literature and national programme[1] and follows a widely-regarded example of good practice in SWL (based at Epsom hospital). Such EOCs are viewed both cost and clinically effective (allowing more standardisation to best practice, lower length of stay (LOS) and more productive use of theatre time) with better outcomes for patients, primarily in the form of shorter waiting times (as theatre slots are not cancelled due to emergency demand surges) and lower rates of complications (due to fewer site infections – as theatres and wards are not shared with emergency patients who cannot always be screened for infections).

In the NWL case, Central Middlesex has been selected as a preferred site for the centre because it does not have an emergency department at all, meaning the elective ring-fence will not be undermined. Further, CMH has unused physical capacity to open additional theatre slots and beds.

Under the proposed operating model, all NWL elective orthopaedic inpatients requiring "high volume, low complexity" surgical procedures will receive their operation at the EOC in Central Middlesex. For comparison, there were approximately 4,200 such procedures carried out in NWL NHS hospitals in 2019, of which around 3,700 were carried out on NWL residents.[2] Those who have higher complexities (measured in terms of multi comorbidities) will continue to have their operations at their existing hospitals. Day case procedures, spinal surgery and hip and knee revisions (when an original joint replacement is replaced or revised for a second time) would also be out of scope for the EOC with procedures remaining at their current locations, where clinical teams will specialise in emergency care and higher complexity elective orthopaedics. Patients will continue to attend pre and post operative assessments and outpatient clinics at their current local hospitals (with an increased emphasis on virtual clinics) with consultants "following" their patients to the EOC to perform surgeries.

Context:

As of September 2022, the total NWL elective orthopaedic waiting list stood at just over 15,000 patients. The PCBC estimates that of these, just under 2,500 were waiting for elective orthopaedic surgeries that are within the scope of the proposed changes. At present, average waiting times from the decision to

[1] https://gettingitrightfirsttime.co.uk/
[2] North West London Joint Health Overview & Scrutiny Committee meeting pack, 7 December 2022: shorturl.at/wGPQ3

admit for surgery for elective orthopaedic patients at NWL hospitals ranges between 11 and 19 weeks for day case surgeries and 14 to 35 weeks for inpatient surgeries.

The PCBC envisages the establishment of the EOC will reduce waiting times by around 7 weeks for inpatients and by 8 weeks for day cases by October 2025.

Charts presented in the PCBC suggest that without the proposed changes, the ~2,500 NWL waiting list of in-scope patients will grow to around 7,500 by September 2030. With the changes, data modelled in the PCBC suggests the relevant waiting list will be eliminated in full by 2029. Although the precise activity projections for in-scope patients are not set out clearly in the PCBC, this radical reduction in the waiting list appears to be based on the establishment of the EOC leading to approximately 1,300 more elective orthopaedic inpatients being treated a year in NWL by 2024 than at 2019 levels.[3]

The establishment of the EOC will involve CMH itself treating 3,250 more inpatient elective orthopaedic patients a year by 2024 than at 2019 activity levels, of which figures presented in the PCBC suggest just under 2,900 would currently be expected to be treated at one of the other NWL hospitals, but would instead be transferred to the new EOC.

Test 1: Health inequalities and the prevention of ill health

Background	Commentary	Things for the Mayor to consider (to come)
Supplementary questions 1&2, do proposals: 1. *Set out the health inequalities issues in their local population?* 2. *Consider their impact on health inequalities in a systematic, documented way?*	The PCBC appears to frame the proposed changes and the associated improvements in in-scope elective orthopaedic surgery as necessarily falling under the national "CORE20PLUS5" policy to focus on the "most deprived 20%" of the population, as it presents statistics showing disproportionate take up of such surgery in the most deprived group. By implication, this group would also be the main beneficiaries of improvements (including shorter waiting times and improved clinical outcomes) resulting from the reconfiguration.	

[3] It would be useful if NWL could clarify activity projections (including the split between inpatient and day case procedures). The figures presented in the PCBC are at times confusing, particularly the activity figures and capacity options presented in figure 21.

The PCBC sets out the population health challenges for NWL and describes MSK disorders as one of the most common comorbidities amongst the most deprived quintile of the population, as defined by the national Index of Multiple Deprivation (IMD 2019) although this is not quantified or explored in any detail. The PCBC further notes the recent NHS England CORE20plus5 framework, which identifies the most deprived quintile as "the key target cohort for health interventions".		
The PCBC then goes on to state that in 2021, patients from "the most deprived quintile of the North West London population"[4] made up 37 percent of NWL	The statistics presented require some clarification. The 37-39% figure is derived from an analysis using Carstairs deprivation scores which are reliant on data from the 2011 census and are considered to be poorly suited to London as they use the lack of car ownership, and only male (rather than male and female) unemployment as markers of relative deprivation.[5] Indeed, based on 2019 population estimates, approximately 38% of the NWL population resides in	

[4] In fact, the analysis does not focus on "the most deprived 20% of the NWL population", but rather on the neighbourhoods of NWL that fall within the 20% most deprived in England which ranges between 12% and 38% of NWL, depending on the measure of England-level deprivation used. We address this point further below, but correct the terminology here to avoid confusion.

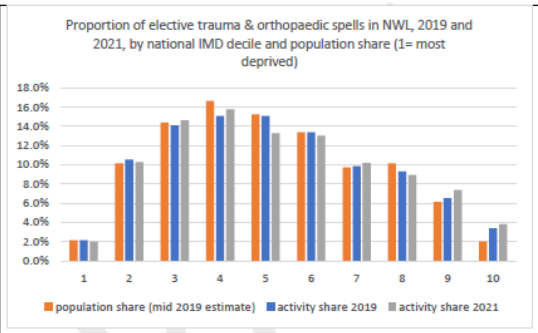
[5] See https://eprints.whiterose.ac.uk/86164/7/DeprivationHealth-Full-18-01-2015.pdf and https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4889779/ and http://s3-eu-west-1.amazonaws.com/statistics.digitalresources.jisc.ac.uk/dkan/files/Townsend_Deprivation_Scores/UK%20Townsend%20Deprivation%20Scores%20from%202011%20census%20data.pdf

patients undergoing orthopaedic procedures (and 39 per cent in 2019). Additional analysis presented in the PCBC further claims that while only around 2% of the NWL population live in neighbourhoods falling within the 10% most deprived nationally (under the Index of Multiple Deprivation) patients living in these neighbourhoods account for 6% of elective orthopaedic activity.	neighbourhoods which the Carstairs measure would categorise as within the "most deprived 20% of England" – roughly proportionate to elective orthopaedic hospital episodes involving patients from the same neighbourhoods.[6] This provides an indication of the lack of suitability of the Carstairs measure to London and further suggests that elective orthopaedic activity in NWL is not disproportionately focused on the poorest fifth of the population, but is merely in line with a crude measure of population share. As with the Carstairs analysis, the IMD analysis presented in the PCBC suggests a significant "pro-deprivation" skew in elective orthopaedic activity in NWL, which would be remarkable if correct, as nationally, patients living in the most deprived deciles are underrepresented in elective hospital admissions in general, and in particular for elective orthopaedic admissions[7]. However, The Nuffield Trust has been unable to replicate the findings by national IMD decile reported in the PCBC. Instead, The Nuffield's Trust analysis of elective orthopaedic activity involving patients resident in NWL postcode areas in 2019 and 2021 suggests activity rates were broadly in-line with crude population shares, with some indication of higher than expected activity rates for patients living in areas that fall within the two least deprived deciles nationally – which increased further in 2021 – and lower than expected rates in decile 4 (which falls within the second most deprived quintile nationally). [8]	

[6] Carstairs scores for Lower Super Output Areas in England were derived from: Wheeler, Benedict (2019). "Carstairs Index 2011 for Lower-layer Super Output Areas" [Data Collection]. Colchester, Essex: UK Data Archive. 10.5255/UKDA-SN-851497 https://reshare.ukdataservice.ac.uk/851497/

[7] For national figures on admitted patient care, see https://digital.nhs.uk/data-and-information/publications/statistical/hospital-admitted-patient-care-activity. Elective orthopaedic specific rates for England were explored in unpublished background analysis by the Nuffield Trust and are indicative. A thorough analysis of inequalities in hospital care would need to take into account differences in need between population groups, including – but not limited to – those indicated by the age profile of individual neighbourhoods.

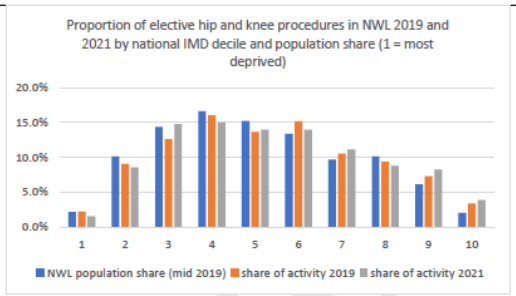
[8] Chart Source: Hospital Episode Statistics; ONS mid-year population estimates for 2019; IMD 2019. Nuffield Trust analysis using elective spells for admitted patient care where treatment specialty is "110" (trauma & orthopaedics). IMD 2019 scores are at LSOA level for patient residence and activity is NWL commissioner-based (ie excludes patients treated in NWL hospitals but commissioned by non-NWL NHS commissioners). Population estimates for 2021 are not yet available at LSOA level. However there were only very minimal changes in national IMD decile population share between 2019 and 2020. Hospital Episode Statistics data (years 2018/19 to 2020/21) Copyright © (2021), NHS Digital. Re-used with the permission of NHS Digital. All rights reserved.



Activity rates for elective hip and knee procedures – which will form the bulk of activity affected by the NWL proposals – indicate a more pronounced and widening differences in activity shares relative to the share of the NWL population that falls into the most and least deprived deciles nationally in 2021. [9]

[9] Chart Source: Hospital Episode Statistics; ONS mid-year population estimates for 2019; IMD 2019. Nuffield Trust analysis using elective episodes for admitted patient care, with a procedure code W37 through to W42, which span hip and knee replacements including revisions. Hospital Episode Statistics data (years 2018/19 to 2020/21) Copyright © (2021), NHS Digital. Re-used with the permission of NHS Digital. All rights reserved.

5

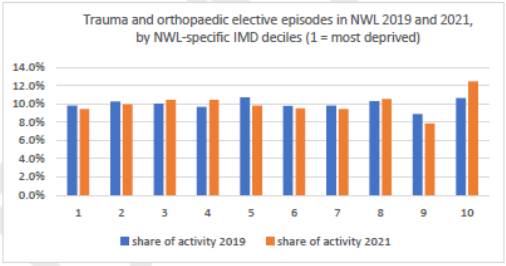


This analysis of crude activity rates is only indicative. A thorough analysis of potential inequalities in elective orthopaedic activity rates would need to account for the different age structures of each population decile (with the least deprived deciles having a higher proportion of over 65 year olds, for example, but also longer healthy life expectancies); higher levels of private healthcare use in the least deprived deciles; and significantly higher rates of clinical risk factors relevant to the need for elective orthopaedic surgery– including higher rates of obesity – in the more deprived deciles[10].

There is a tendency in the PCBC to refer to "the most deprived 20% of the NWL population" when actually what is being presented is the much smaller proportion of the NWL population that falls within the 20% most deprived neighbourhoods in England as a whole, which in NWL comprises just 12% of the population, when assessed against the IMD for 2019.

[10] For more information on MSK risk factors by a variety of social and other variables, see Public Health England's "Fingertips" resource https://fingertips.phe.org.uk/profile/msk

6

	While the CORE20PLUS5 policy instructs health systems to pay particular attention to the most deprived 20% *nationally*, a systematic exploration of health inequalities at an ICS level would also require an interrogation of healthcare access and outcomes relative to local social inequalities, in order to ascertain if a social gradient is present in healthcare. By way of illustration, the below presents NWL commissioned elective trauma and orthopaedic episodes by patient IMD scores, which have been ranked into deciles relative to NWL, rather than England as a whole. In this presentation, the expected share of activity for each group – all other factors being equal – would be 10%, if activity was in line with population share.[11] 	

[11] Chart source: Hospital Episode Statistics; ONS mid-year population estimates for 2019; IMD 2019. Nuffield Trust analysis using elective episodes for admitted patient care where treatment specialty is "110" (trauma & orthopaedics). IMD 2019 scores are at LSOA level with deciles ranked according to the NWL range. NB this analysis focuses on episodes of care under a named consultant, rather that spells in hospital. One spell may consist of multiple episodes. Hospital Episode Statistics data (years 2018/19 to 2020/21) Copyright © (2021), NHS Digital. Re-used with the permission of NHS Digital. All rights reserved.

7

	This analysis of crude activity rates suggests that the share of elective T&O activity consumed by patients living in the poorest 10% of NWL fell between 2019 and 2021 while the share consumed by the least deprived 10% in particular grew. This crude data would again need adjusting to take account of different age and underlying needs within each population decile before a fuller understanding of any inequities could be ascertained. The indicative nature of these crude activity rates notwithstanding, they do cast significant doubt on the claim in the PCBC that elective orthopaedic surgery in NWL is currently skewed towards the most deprived population group and the implication that benefits stemming from the proposals will similarly accrue disproportionately to that group. At best, the crude activity rates suggest activity shares are only broadly in line with population share. Given the higher MSK disease burden the PCBC highlights as present in the most deprived groups, it may be that an activity rate only proportionate to population share in those groups is indicative of unmet need. There is therefore a risk that the choice of deprivation indicator and analytical approach used in the PCBC has distorted both an understanding of current inequalities in access to elective orthopaedic surgery in NWL as well as of the likely distribution of benefits resulting from the proposed changes, which are intended to both reduce waiting times and improve clinical outcomes (for example through reduced surgical infections – a key benefit stemming from the separation of emergency and elective surgery). This potential distortion is a concern because it may mean opportunities to address existing inequities and to ensure a fairer distribution of benefits from the proposals (or from parallel initiatives) have not been fully explored. As the burden of MSK disease is disproportionately experienced in more deprived groups, changes to the MSK pathway that disproportionately benefit better off groups will, without mitigating action elsewhere, increase inequalities, including against the Mayor's key measure of Healthy Life Expectancy[12]. An allied concern is that the proposed NWL EOC is conceived as a "high volume low complexity" hub which will not be co-located with emergency care facilities. As such, the PCBC is clear that	

[12] For a discussion of the evidence linking the elimination of arthrosis (the key diagnosis associated with elective orthopaedic surgery) to tangible increases in Healthy Life Expectancy, see: Ritsuno, Y., Kawado, M., Morita, M. *et al.* "Impact of musculoskeletal disorders on healthy life expectancy in Japan", *BMC Musculoskelet Disord* 22, 661 (2021). https://doi.org/10.1186/s12891-021-04539-4

8

Supplementary questions 3&4, do proposals: 3. *Ensure that services do not become less accessible to vulnerable groups?* 4. *Ensure that unwarranted variations in outcomes do not worsen?*	patients with multiple comorbidities – particularly those with conditions that are poorly managed – and/or have ASA scores[13] of 3 or above – will be ineligible for treatment at the proposed EOC. A recent retrospective analysis of high volume low complexity (HVLC) surgical hubs in London found that before the pandemic, approximately 25% of elective orthopaedic patients were classified as ASA 3 or 4– indicating a level of complexity which would currently exclude patients from the scope of the proposed EOC at Central Middlesex[14]. By the time of the analysis (completed in 2021) the proportion had increased to around 35% although it is not yet known if this increase is temporary and due to patients being deconditioned through long waits, or if the marked increase is likely to be sustained, as part of a demographic shift. In either event, the proportion of patients ineligible for treatment at the EOC is likely to be substantial and more needs to be known about these patients, their relevant characteristics (including, but not limited to those protected under the 2010 Equality Act) their needs and the likely outcomes they can expect from their elective surgeries in NWL, including waiting times. As the incidence of multi-comorbidities increases significantly with deprivation (and also with old age)[15] it would be reasonable to expect that, all other factors being equal, the cohort of patients eligible to be treated at the EOC would likely be less deprived than those deemed ineligible. While the PCBC does acknowledge that patients ineligible for treatment at the EOC will be less likely to benefit directly from reduced waiting times, it claims they would still experience "equal" clinical outcomes compared to patients treated in EOCs. As the chief clinical benefit to treatment in a ring-fenced EOC is lower rates of complications such as surgical site infections due to the	

[13] ASA grades are the American Society of Anaesthesiologist's patient classification system, indicating level of complexity linked to the patient's condition and diagnoses, with 1 indicating low complexity. The ASA grading system is standardly used throughout the NHS. For more information, see Anaesthesia UK : ASA Physical Status Classification System (frca.co.uk)

[14] "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

[15] See for example: "The influence of socioeconomic deprivation on multimorbidity at different ages: a cross-sectional study", McLean, G et al., British Journal of General Practice 2014; 64 (624): e440-e447. DOI: 10.3399/bjgp14X680545; and "Inequalities in incident and prevalent multimorbidity in England, 2004–19: a population-based, descriptive study", Head, A., et al, The Lancet, Vol 2 (8), 2021

The proposed EOC will be for "high volume, low complexity" cases The PCBC flags risks to the stability of urgent and emergency care services at surrounding hospitals.	separation of elective and emergency care[16], it is unclear how this benefit will be secured by elective patients who continue to be treated in non-ringfenced theatres and wards. It is relevant to note in this regard that while South West London's EOC is widely regarded as a successful "high volume low complexity hub", the aforementioned 2021 retrospective equity analysis found that in the first three months of 2021, South West London patients falling into the poorest national IMD quintile made up just 4% of elective orthopaedic patients treated in the area (with no patients coming from the poorest 10%). While it is not clear what population denominators are relevant to this unpublished study, [17] this is likely to represent a significantly lower than expected share of activity relevant to population size. More analysis is needed to establish the impact of HVLC hubs on equitable access to care, including the impact on patients with more complex needs who do not qualify for treatment in these centres. It is important to stress that an unequal distribution of the direct benefits resulting from the proposals are not in themselves a reason to reject or devalue them. However, where implicit trade-offs have been made between different patient and demographic groups (as well as between competing NHS priorities, such as health equity, waiting times, and limited resources) it would be useful to set these out, as doing so can help inform discussions and investment decisions about other related services, where there may be an opportunity to address or mitigate the imbalance in benefits and outcomes. A risk that is particularly pertinent to the trade-offs entailed in competing NHS priorities and pressures is noted throughout the PCBC as the risk to urgent and emergency care services at "referring" hospitals, if staffing arrangements at the EOC lead to a depletion of available staff for emergency care. This is explored in more detail in the bed test below. However, as emergency care is disproportionately consumed by patients from the poorest quintile (while elective care is	

[16] https://gettingitrightfirsttime.co.uk/surgical_specialties/orthopaedic-surgery/

[17] The Nuffield Trust has been unable to verify the analytical approach used in this unpublished London-wide study, elements of which are reproduced in the NWL PCBC. In particularly, it is not clear which version of the IMD was used to assign London ICS populations to national deciles. However, under all likely possibilities it seems the most deprived two deciles were underrepresented in South West London's EOC activity. In IMD2010, roughly 1.3% and 6.2% of SWL's population fell into the two most deprived deciles, whereas in IMD 2019, this reduced to 0.7% for the most deprived decile and remained constant for the second most deprived decile.

	under-consumed by the same group) this operational and resource risk also poses a risk to healthcare equity. Nationally, in 2019, 24.4% of all emergency admissions were of patients living in the poorest quintile of the population, whereas only 16.1% were of patients living in the least deprived quintile.	
Travel The PCBC assesses whether or not situating the proposed EOC at CMH might exacerbate healthcare access inequalities by making travel times for patients deemed particularly vulnerable to healthcare inequalities longer than the general population. The analysis shows that the CMH location will offer the shortest median travel time by car and the second shortest median travel time by public transport for all NWL residents, although all residents will need to travel through the ULEZ to access the site, incurring a charge if their vehicle is non-compliant. It is notable that the median travel times to CMH by both public and private transport are expected to	While travel times under the preferred location (CMH) will be shortest for the poorest neighbourhoods, these are defined in the travel analysis within the PCBC as the "CORE20" group, which comprise (under IMD 2019) 12% of the NWL population. It is not clear what the impact will be on relative deprivation beyond this group – that is, on the further 8% of the NWL population who do not live in the most deprived neighbourhoods nationally, but who, together with the "CORE20" neighbourhoods, make up the most deprived 20% of NWL neighbourhoods. It is also unclear how the assessed future travel times differ from current travel times from the highlighted neighbourhoods, which may be an important factor to consider alongside an analysis of any current inequalities in elective orthopaedic surgery, as what is relevant to obstacles to accessing care is not just how one group's travel times (and costs) might differ from another's, but perhaps more importantly, the differing abilities of different groups to absorb or tolerate travel time and costs.[18] The PCBC notes that some patients travelling by car will need to pay the ULEZ charge (if their vehicles are non-compliant) as well as substantial car parking charges. Travel cost as well as time are factors which will need to be examined in more detail through the public consultation, paying particular attention to low income groups and groups who may struggle to travel longer distances – such as disabled people, older people and those who do not speak English and so may find it harder to navigate public transport. In order to explore how travel issues affect access inequalities (including how they affect patient decisions to seek elective care) it is vital that the consultation involve people who are not currently and have never been elective orthopaedic patients, as well as those who are already on the waiting list or who are receiving care.	

[18] For example, a low paid worker on a zero hour contract may find it significantly harder to spend two hours travelling and attending an outpatient appointment than a patient working in a salaried profession. Even if both were required to take unpaid time off work to attend the appointment, the relative hit of this income loss their household disposable incomes would likely differ very widely

be lowest from the poorest neighbourhoods. *Supplementary question 5, do proposals set out specific, measurable goals for narrowing health inequalities and mechanisms for achieving this, for example through credible plans to make services more accessible to vulnerable groups (and/or to) reduce unwarranted variation in outcomes?* The revised elective orthopaedic pathway will include investment in virtual outpatient clinics including "joint school" appointments to prepare patients for surgery. To address the digital divide, outpatient appointments will also be available face-to-face at their current local hospital.	Concerns about travel times have been flagged by local councillors. In particular, councillors sitting on Hammersmith and Fulham's Health and Adult Social Care Policy and Accountability Committee have raised concerns about transport, with some proposing that the ICS provides a dedicated transport service to alleviate potential inequalities. Councillors on the same committee have also raised concerns about the potential over-reliance of virtual clinics both in the proposed model and more generally since the Covid-19 pandemic as a potential source of inequalities and poorly coordinated care.[19] Initiatives designed to widen access to outpatient clinics are likely to help reduce healthcare inequalities, for example if they lessen inequalities driven by low-wage or insecurely employed patients finding it harder to take time of work (or caring responsibilities) to access appointments (provided they are made available alongside face-to-face appointment options for the cohort of the population that experiences difficulties using or accessing technology). However research by the Institute of Fiscal Studies suggests that significant inequalities in follow-up outpatient activity persist, even when inequalities in working-time flexibility are controlled by focusing on retired patients. In a 2020 study, the IFS found that retired patients with the highest educational attainment level attended 17% more outpatient appointments than patients with the lowest educational attainment level, after adjusting for need[20]. This suggests that nationally there is a	

[19] LBHF, Health and Adult Social Care Policy and Accountability Committee Draft Minutes Wednesday 16 November 2022 http://democracy.lbhf.gov.uk/documents/g7304/Printed%20minutes%2016th-Nov-2022%2019.00%20Health%20and%20Adult%20Social%20Care%20Policy%20and%20Accountability%20Committ.pdf?T=1. Other scrutiny committee meetings were monitored over the course of The Nuffield Trust applying the first four tests, however LBHF was the only committee to publish the minutes of relevant meetings

[20] Stoye, G., Zaranko, B., Shipley, M., McKee, M. and Brunner, E.J. (2020), "Educational Inequalities in Hospital Use Among Older Adults in England, 2004-2015" The Milbank Quarterly, 98: 1134-1170. https://doi.org/10.1111/1468-0009.12479

	stark social gradient in patient abilities to seek and take up outpatient care, even after the impact of loss of earnings has been removed or limited. As Joint School is conceived as playing a key role in preparing patients for procedures ("pre-habilitation") this will be a key area for NWL to monitor to ensure equitable access to the entire surgical pathway. Due to the higher incidence of comorbidities in both the most deprived group as well as in the Black Caribbean group, well-resourced and readily accessible pre-habilitation care, through outpatient clinics and community services will be particularly significant to these groups, especially if they can improvement the management of comorbidities and thus lower patient ASA risk scores. More information on specific plans for this would be useful. One emerging form of good practice with regards to inequalities in access to outpatient appointments is the monitoring of "did not attends" by factors such as deprivation and ethnicity. This can provide insights into the accessibility of services for different groups as well as guide targeted and measurable action on addressing access inequalities. [21] It is notable that at present, none of the KPIs proposed for the proposed scheme relates to healthcare equity. The starting point to addressing this would be a more comprehensive analysis of existing rates of access to elective orthopaedic surgery, relative to need, to identify unwarranted gaps and establish appropriate means to close them and measures of progress in doing so.	

[21] See for example https://www.england.nhs.uk/wp-content/uploads/2022/07/B1779-Actionable-Insights-Tackling-inequalities-in-healthcare-access-experience-and-outcomes-guidance-July-202.pdf

Test 2: Hospital beds

Background	Commentary	Things for the Mayor to consider (to come)
Supplementary question 1: Do proposals maintain/increase current bed capacity? The PCBC envisages a substantial increase in bed and theatre capacity at CMH, from 13 dedicated inpatient beds at 2019 levels to 41 by 2024. This will represent a marked increase in bed capacity available for elective orthopaedic patients in NWL, as beds at CMH will be ringfenced for this activity only, whereas current practice is for this capacity to be frequently absorbed in dealing with surges in emergency admissions, leading to elective care cancellations. Beds and theatre slots at other NWL hospitals "freed up" by the transfer of inpatient elective orthopaedic patients to CMH are expected to remain open but be made available for other forms of care (including emergency care and more complex elective orthopaedics). The productive use of these beds (and the staffing capacity which goes with them) will be a challenge and will be considered under the finance test.	While dedicated clinical capacity for dealing with elective orthopaedic activity that is in-scope (that is, surgery for patients with an ASA score at or below 2 and who do not require spinal or revision procedures) is set to increase under the proposals, there is substantial uncertainty about clinical capacity for related and co-dependent services, including trauma and paediatric care; elective orthopaedic care for out-of-scope conditions and multi-morbid patients; and also for in-scope activity that will remain at patients' "local" hospitals (for example outpatient clinics and therapists). At present, such activity makes use of beds and clinical capacity that the proposals will see strictly ringfenced and moved to CMH. This creates a risk and uncertainty for those co-dependent services and the PCBC is unclear how much clinical capacity will transfer to CMH and how much will remain and be available for continued use by the NWL healthcare system. Regardless of decisions over funding for the remaining capacity, the chief concern will be staff availability to maintain service safety and sustainability. This uncertainty is flagged at several points throughout the PCBC which notes the risk that "residual services" at Chelsea and Westminster, Imperial and Hillingdon hospitals trusts may be "denuded" of relevant staff if the establishment of the EOC was to lead to a reduction of staff available to work at these "referring" hospital trusts. The concern was also been raised by Hammersmith and Fulham councillors.[23]	

[23] LBHF, Health and Adult Social Care Policy and Accountability Committee Draft Minutes Wednesday 16 November 2022 http://democracy.lbhf.gov.uk/documents/e7304/Printed%20minutes%2016th-Nov-2022%2019.00%20Health%20and%20Adult%20Social%20Care%20Policy%20and%20Accountability%20Committ.pdf?T=1.

Although the proposals do not include any reduction in bed or clinical capacity over all, they will involve a substantial shift in clinical resource from "referring" hospitals to CMH, to staff the new EOC. The PCBC estimates that in total, the EOC will require a staff of 351, including 243 nurses and 53 doctors. Some of these staff will transfer permanently to the CMH from other NWL trusts while others (particularly consultants) will "follow" their patients to CMH when they receive their inpatient procedure, but will continue working also at their current hospitals (where they will treat day case patients, run outpatient clinics and work emergency care rotas). NWL is also clear that a substantial component will need to be additional staff, but flags that qualified and unqualified nursing posts are currently particularly hard to fill.	This risk is three-fold: 1. Recruitment into EOC posts might come at the cost of staffing levels in surrounding hospitals. The PCBC envisages that EOC recruitment will lead to *additional* staffing levels across NWL. However, this may prove overly optimistic for some staff groups. 2. For some staff groups at referring hospitals, there may not be sufficient elective orthopaedic patients left – or a sufficient case mix of activity left – to sustain local services and retain staff. The PCBC flags this risk in particular in relation to some allied health professional staff working with elective and emergency care patients at The Hillingdon Hospital; 3. The provider collaborative is yet to complete its workforce modelling and baseline analysis of its current workforce establishment. This means the PCBC does not provide any detail on what proportion of time staff currently working at "referring hospitals" spend dealing with "in scope" activity that will be transferred to the EOC, and what proportion of their working time is spent on out-of-scope activity, including surges in emergency admissions. This information is vital to the safe and sustainable staffing of services – both in and out-of-scope. The PCBC states that this data collection is ongoing and will be used to monitor staffing levels at referring trusts. This is vital information that should be made transparent before any final decision is made on the proposals. Transparent metrics should also be developed so this risk can be monitored throughout any implementation of the EOC model. Until this work is completed and made transparent, it is unclear whether or not the proposals will lead to an over-all reduction in clinical capacity in NWL hospitals as there is a risk they will increase capacity for low complexity	

	elective care at the price of reduced capacity or resilience for higher complexity care, urgent and emergency care and other related services.[24] For some staff groups – particularly consultants – staffing levels will be contingent on service ability to offer attractive job plans, including opportunities to develop through an appropriate mix of patients, and to undertake research. These issues will need to be explored further under test 5. Pay rates – in particular the difference between inner and outer London weighting - may also be a factor and this is explored in test 3 below. The proposals also flag the potential use of new clinical roles – including advanced clinical practitioners. These roles require careful planning and supervision to ensure safe practice[25] and there are currently uncertainties around the future regulatory framework for them. Successful introduction of the roles will require detailed consultation with the wider clinical team. The PCBC does not present explicit mitigations to bed closures as its base case is that staffing levels for non-transferred services will be maintained. However a potential mitigation would be increased efficiencies for in-scope activity, which would mean that activity could be carried out with relatively lower staffing requirements than at present (or that increased activity could be achieved on relatively static staffing levels).	
Supplementary question 2: Do any proposed bed closures meet at least one NHSE common sense condition	The PCBC indicates that activity and capacity modelling has been premised on a bed occupancy rate of 90% for the EOC and the achievement of an	

[24] For a wider discussion, see "David Oliver: Could separating NHS "hot" and "cold" inpatient sites work?" BMJ 2021; 374 :n1814 doi:10.1136/bmj.n1814 https://www.bmj.com/content/374/bmj.n1814

[25] https://www.hee.nhs.uk/sites/default/files/documents/multi-professionalframeworkforadvancedclinicalpracticeinengland.pdf

The relevant NHSE test is for proposals to do one or more of the following[22]: A) Demonstrate that sufficient alternative provision, such as increased GP or community services, is being put in place alongside or ahead of bed closures, and that the new workforce will be there to deliver it; B) Show that specific new treatments or therapies, such as new anti-coagulation drugs used to treat strokes, will reduce specific categories of admissions; C) Where a hospital has been using beds less efficiently than the national average, that it has a credible plan to improve performance without affecting patient care (for example in line with the Getting it Right First Time programme). *Supplementary question 3: Does revised bed modelling take full account of the latest demographic projections?*	average length of stay of 2.3 days – upper quartile performance for the NHS as a whole. At present LNW Trust (which runs CMH) appears in the second and third quartile of England-wide performance for hip and knee replacement lengths of stay, whereas NWL's overall performance is 3.7 days for knee replacements and 3.4 days for hip replacements. This suggests that the EOC will need to see a marked decrease in NWL's average length of stay if it is to meet the assumptions within the activity and capacity modelling. Performance metrics for five established EOCs in England presented in the PCBC show a range of performance on length of stay, ranging from EOCs in South West London, Royal Cornwall and Lincoln all achieving upper quartile length of stays for hips and knees, but EOCs in Gloucester and Nottingham performing at below national average. The PCBC states that activity growth assumptions have been based on the GLA's population projections to 2029. Correspondence from NWL ICS to the GLA further explains that these projections have been weighted in line with the age breakdown in NWL elective trauma and orthopaedic activity in 2019, which saw the largest shares of activity in patients aged between 55 and 79. This produces a projected increase in demand of around 19% by 2029.[26] NWL states that the proposed EOC will be able to cater for this level of demand increase in in-scope activity, with potential for activity levels to increase above this level if day case rates increase and the EOC were able to run theatres 7 days a week.[27] It is not yet clear how capacity to deal with out-of-scope demand and activity will be affected by the changes, or how the trajectory of demand for such	

[22] https://www.england.nhs.uk/wp-content/uploads/2018/03/planning-assuring-delivering-service-change-v6-1.pdf
[26] The PCBC uses the GLA's housing-led population projections https://data.london.gov.uk/dataset/housing-led-population-projections. The 19% weighted demand increase referenced here is based on Nuffield Trust's calculations, using age weights provided by NWL ICS and the GLA's population projections.
[27] Personal communication NWL ICS to GLA, January 2023

Supplementary question 4: Have the proposals used the NHS bed capacity modelling tool?	activity might differ (or not) from the trajectory of demand for in-scope activity. For context, NHS England's current target is that overall elective capacity increase to 130% of pre-pandemic levels by 2024-25 and to permanently sustain the level of emergency care capacity put in place over winter 2022/23 (the equivalent of 7,000 beds nationally).[28] By contrast, NWL's plans are for elective orthopaedic activity to increase to 110% of pre-pandemic levels by 2024 and for this to be partly achieved by strictly ringfencing clinical capacity that is currently used to deal with surges in demand for emergency care. It may be that other factors not made explicit in the PCBC mean that NWL faces a smaller challenge than the national challenge implied by NHS England. Alternatively, it may be that locally (as well as nationally) available staffing and financial resources are insufficient to meet national goals. More clarity on NWL's position on this would be useful.	

Test 3: Financial investment and savings

Background	Commentary	Things for the Mayor to consider (to come)
Supplementary question 1: Have plans secured capital and revenue investment to deliver in full, and are the sources of funding credible? The PCBC future reports that the EOC can be established at the CMH with £9.4m in capital investment, which is fully funded in	The preferred location of the EOC is Central Middlesex Hospital, which is ran by London North West University Healthcare NHS trust which includes the Brent Emergency Care and Diagnostic Centre (BECaD) which was completed in 2007 under a Private Finance Initiative scheme. Out of 10 existing NHS local sites considered for the scheme, only one other – Mount Vernon Hospital, situated on the outer northern edge of the ICS geography – fit with the clinical criteria required for the scheme; namely the ability to strictly	

[28] https://www.england.nhs.uk/wp-content/uploads/2022/12/PRN00021-23-24-priorities-and-operational-planning-guidance-december-2022.pdf

the local acute capital programme. By way of illustration of the capital cost relative to revenue returns, the PCBC anticipates annual revenue savings once the EOC is fully established in the region of £4m. *Supplementary question 2: Are plans to make efficiency savings sufficiently detailed and credible?* The ~£4m annual savings are estimated using 2019/20 NHS reference costs (and patient-level costing data from individual	separate elective and non elective patients. As Mount Vernon Hospital is currently unable to absorb additional patient volumes without significant disruption and investment, it was rejected as an option (the site was also viewed as posing more travel difficulties than others). By contrast, CMH has historically been underused, and despite the name, its BECaD does not undertake emergency care (with the exception of an Urgent Treatment Centre for minor injuries and illnesses) as the hospital's A&E was closed in 2014. Under the terms of the PFI contract, the Trust is currently paying in the region of £12m a year in charges, connected both to the borrowing and build costs, but also for ongoing services such as cleaning and facilities management. PFI contracts typically last in the region of 30 years and in CMH's case, charges are uplifted each year through reference to a price index linked to inflation.[29] The PCBC reports that bed occupancy at CMH is currently at only 50%. The establishment of an EOC at CHM therefore presents an opportunity for the NHS to better use assets it is already contractually committed to paying for over many years. There are a number of material uncertainties in NHS funding and finance at present that are not unique to NWL but which make projections of future cost and income difficult. This includes an approximate 30% increase in elective care unit costs between 2019-20 and 2020-21 reflecting both the increased costs of the pandemic but also lower activity rates see since that time.[30] The figures used in the PCBC model do not use these higher actual unit costs, but instead uplift 2019-20 costs by around 3%. Actual costs and savings in year one and two of the EOC will depend on how fast each trust and hospital site is able to reduce its cost base down to pre-pandemic levels.	

[29] LNW NHS Trust annual accounts, 2021-22 https://www.lnwh.nhs.uk/download.cfm?doc=docm93jijm4n9889
[30] Nuffield Trust analysis of NHS National Cost Collection data 2020-21, https://www.england.nhs.uk/publication/2020-21-national-cost-collection-data-publication/

trusts) which are uplifted to current prices to give a "no change" total cost of relevant orthopaedic care in NWL of £33m. Modelling for the PCBC anticipates that efficiencies gained through the establishment of the EOC – including moving to upper quartile performance on length of stay – will reduce the total cost to £29.6m, with savings to be distributed between the four trusts.	Planning guidance for 2023-24 has stated that the contract default for elective care activity for the next two years is that it will be funded on a unit cost basis, with reference to the national tariff[31]. Funding on a unit cost basis may provide some stability for elective care providers, but may also expose the commissioning budget to pressures should activity growth outstrip funding growth. As the elective orthopaedic case mix will substantially change at referring hospitals in particularly, this could also expose those trusts to financial pressures – for example if national tariff prices do not reflect the average cost of units of that activity – bearing in mind that patients remaining at referring hospitals are likely to be of a higher complexity and with longer than average length of stays. The provider collaborative will need to grapple with these issues and develop sufficiently flexible mechanisms for ensuring that unforeseen changes in the distribution of costs and savings, as well as unavoidable higher costs where they occur, are appropriately covered. A more significant overall risk is the £17m of worth of elective orthopaedic activity that is proposed to move from Imperial College Healthcare Trust, The Hillingdon Hospitals Foundation Trust and Chelsea and Westminster Hospital Foundation Trust to the EOC ran by LNW NHS Trust. Although the PCBC models anticipates that activity can be performed at a lower cost at the EOC, realising those potential savings ICS-wide will be dependent on the three "referring" trusts being able to either export the full cost of those patients out of their own cost bases when the activity is moved (which would typically involve transferring staff) or productively re-use it for other forms of patient care. Their ability to do this represents the largest financial risk in the plans and is acknowledged in the PCBC. In the current funding context in particularly, it is important to note that re-purposed hospital capacity will not only need to be actively employed in patient care, but will need to be done so in a way that is fully funded. By way of understanding the relative significance of this ~£17m cost to the NWL health economy, it is the equivalent of	

[31] https://www.england.nhs.uk/wp-content/uploads/2022/12/PRN00021-23-24-priorities-and-operational-planning-guidance-december-2022.pdf and https://www.england.nhs.uk/wp-content/uploads/2022/12/23-25NHSPS-Consultation-A-Policy-proposals.pdf

The PCBC outlines a number of financial risks which the plans face if assumptions about staff pay rates, use of agency staff, and clinical efficiencies prove overly optimistic	just under 0.5% of the Integrated Care Board's recurrent resource allocation for 2022-23, at a time when core ICB funding allocations are flat in real terms. The total downside risk modelled is for costs to be £7.9m higher than anticipated, which exceeds the total £4m modelled savings in the base case. However the PCBC states that the ICS is confident that not all these risks would materialise, or that where they to, they would be significantly less extensive in value. The following risks are briefly set out in the PCBC: Staff pay and London weighting: the modelled savings assume that staff working at the EOC are paid the outer London weighting, as is currently the case for all LNW Trust staff. However, as some of these staff will transfer from NWL trusts that currently attract the inner London pay weighting, it is possible that the EOC will only be able to recruit and retain staff if it pays at the inner London weighting rate also. If this were the case, the PCBC states that ICS-wide costs would be in the region of £0.8m higher. There is a further risk referenced in the bed test above that higher pay rates paid at the EOC might undermine recruitment and retention at other "outer London" hospitals, including other, non EOC services ran by LNW Trust. Use of agency staff: The PCBC anticipates a 14% workforce gap at the EOC, of which 10% would be filled using bank staff and 4% using agency staff. It models a maximum risk of £2.8m higher costs if all of the vacancies were alternatively filled with agency staff, which are more costly than bank staff. Length of stay reductions: The PCBC assumes an average length of stay at the EOC of 2.3 bed days. The PCBC anticipates that for every 0.2 days excess above the average LoS target, the EOC will face additional ward staff costs of £0.2m, up to £1.3m higher than planned costs if average LoS at the EOC is 3.5 days. Theatre utilisation: If theatre utilisation rates do not meet GIRFT case-per-theatre session standards, the PCBC models higher costs of up to £2m, representing the	

	cost of "waiting list initiatives" such as overtime theatre sessions. However the PCBC states there is a high confidence of meeting GIRFT theatre productivity standards due to the relatively low-complexity of patients who will be treated at the EOC.	

Test 4: Social Care Impact

Background	Commentary	Things for the Mayor to consider
The PCBC does not set out how the proposals will affect adult social care services, either operationally or financially.	This is a gap in the plans that needs to be filled. At a minimum, plans need to consider: 1. Current discharge destinations of elective orthopaedic patients treated at the four hospital trusts and differences between the HVLC cohort and more complex patients; 2. Current adult social care capacity (including reablement and home equipment services) within NWL boroughs and gaps within this; 3. How the plans to substantially increase elective orthopaedic activity and change the location of surgery will increase and change the profile of demand for post-operative adult social care services in the area; 4. How demographic changes (including the aging population but also increased longevity in people with life-long disabilities) will also change the shape of demand for adult social care and elective orthopaedic surgery; 5. How existing and future modelled shortfalls in social care support can be addressed; 6. What the optimal integration of adult social care into the elective orthopaedic pathway (including pre-operating care and "pre-habilitation") looks like and what is needed to achieve this; 7. A down-side scenario whereby gaps in social care support are not filled, modelling the impact this will have on both the EOC and elective orthopaedic activity and the other hospitals (for example delayed transfers of care impacting on ability to undertake elective activity and increased inequalities if	

	more complex patients are unable to access pre-operative support and pre-habilitation) Further, the plans envisage a substantial shift in patients from multiple NWL hospitals to CMH for their operations. This is likely to require CMH to develop relationships with significantly more adult social care departments and providers than it has at present. It is not clear if the workforce model for the EOC includes the capacity to do this.	
The Equalities Impact Assessment notes research finding that single and widowed patients are more likely than those living with a potential carer to be discharged from orthopaedic surgery into long-term residential nursing care, rather than into their own home. Such patients also experience longer lengths of stay	This point is noted in the Equalities Impact Assessment as it is viewed as potentially relevant to the protected characteristics of "marriage and civil partnership", with the assessment proposing that experience against marital status be monitored as the plans are implemented. However the point requires more direct consideration in the care pathway as it highlights the centrality of social care and support for optimal post operative recovery.[32] This is especially the case for female patients who are more likely to be widowed and/or without adequate unpaid carer support at home and who make up the larger proportion of elective orthopaedic patients.	

[32] In addition to the recent 2020 research on orthopaedic trauma surgery cited in the PCBC, see also, on elective orthopaedic surgery: de Pablo P, L. E, et al "Determinants of discharge destination following elective total hip replacement", Arthritis Rheum. 2004 Dec 15;51(6):1009-17. doi: 10.1002/art.20818. PMID: 15593323. https://onlinelibrary.wiley.com/doi/epdf/10.1002/art.20818

Consultation Response

North West London NHS Elective Orthopaedic Centre

It is welcome that there will be an increase in healthcare resources directed to orthopaedics and the setting up of a specialist centre to focus on a reduction in the current waiting list for elective surgery in orthopaedics. Not having surgery often means patients have to live with a condition which can cause discomfort and their quality of life is affected.

However, the select committee has a number of concerns and it would like the consultation to consider the following points very seriously at this stage, so we can ensure there are no barriers to access this care for any of our residents, particularly our most vulnerable:

- Transportation, particularly for those using public transport, is a barrier to accessing healthcare and patients in an inner London borough such as the Royal Borough of Kensington and Chelsea will be more likely to face this barrier because they are further away from the proposed site at Central Middlesex Hospital.
- The business case does outline mitigations to transportation barriers such as dedicated transport provision to the centre and encourage people to apply for travel reimbursement, but these need to be explored in more detail as part of the final implementation.
- Some residents in the borough may also be additionally affected because of physical and financial barriers to accessing transport services.
- Patient choice is valued and it is welcome the business case sets out that patients will still have the option to have elective surgery at a local hospital trust rather than travel to the Elective Orthopaedic Centre. However, if it is the case that the local option may take longer than having a procedure done at the Elective Orthopaedic Centre there will need to be careful monitoring of waiting lists at local acute Trusts as part of the implementation.
- The business case acknowledges that deprivation can be a barrier to access to healthcare. The Royal Borough of Kensington and Chelsea has a concentration of deprivation in areas in the north of the borough. However, the demographic spatial analysis, based on the index of multiple deprivation, in the business case shows there are also deprived areas in the south-west and south of the borough as well.

Adult Social Care and Health Select Committee

Royal Borough of Kensington and Chelsea

4.10 APPENDIX – COMPLIANCE WITH STATUTORY GUIDANCE

Requirement	Commentary
Working in Partnership with People and Communities - Statutory Guidance	
1. Ensure people and communities have an active role in decision-making and governance	The consultation provided a range of channels through which people could participate, which included targeted community engagement to reach communities identified as likely to be particularly impacted and bespoke sessions for those groups scoped in through the Equality Impact Assessment. Within this, the consultation programme included structured, facilitated 'deliberative' sessions to ensure that participants were able to test the case for change and model as well as respond to consultation questions, and to actively suggest solutions and mitigations. The main programme governance group includes a lay partner as a formal member.
2. Involve people and communities at every stage and feed back to them about how it has influenced activities and decisions	The consultation engagement built on work undertaken during pre-consultation to inform development of the PCBC. Independent reports analysing and summarising responses were commissioned for decision-making meetings. The pre-consultation engagement report was published in the PCBC. This report is expected to be made public with the decision-making business case, and NHS North West London has indicated that summary versions which include responses to questions asked during the consultation and reports back on decisions of the ICB will be produced.
3. Understand your community's needs, experiences, ideas and aspirations for health and care, using engagement to find out if change is working	During pre-consultation the focus was "what good looks like" while consultation engagement focused more clearly on the clinical model and preferred location. This report contains analysis and insights gathered during the consultation and which focus specifically on: The proposal to develop an elective orthopaedic centre, and The preferred location at Central Middlesex Hospital.

Requirement	Commentary
	The data to inform this was drawn from the extensive consultation engagement programme detailed in this report, which included quantitative and 'free text' responses captured through the questionnaire, as well as comments from structured engagement events across eight boroughs with: Residents and patients Staff Groups sharing protected characteristics or at risk of inequality, prioritised through the Equalities Impact Assessment published with the PCBC. This report lists specific questions asked and practical suggestions ('actionable ideas') collected by Verve and the Collaborative. Although these have not been evaluated or validated, they provide a 'checklist' of potential issues to be considered during decision-making.
4. Build relationships based on trust, especially with marginalised groups and those affected by inequalities	It was recognised that some groups of residents may still find barriers to participation or may bring specific experience or perspectives which it was important to ensure were included and heard during the consultation. The consultation provided an opportunity to further develop relationships, and a wide variety of local groups were approached, informed by the networks maintained by the NHS North West London engagement team. Community outreach activity detailed in this report sets out how NHS North West London and the Collaborative worked together to invite involvement from groups working with marginalised communities and those affected by inequalities.
5. Work with Healthwatch and the voluntary, community and social enterprise sector as key partners	Healthwatch were formally invited to make responses to the consultation. The consultation was supported by community outreach organised at a borough level, engaging with partners in the voluntary and community sector, for example offering to send speakers to local meetings and attending events to encourage people to complete the questionnaire. A list of all groups contacted is appended to this report.

Requirement	Commentary
6. Provide clear and accessible public information	The Collaborative website included a summary of the case for change, clear information about the proposals and the rationale behind them and details of the consultation and how to take part. This information was also contained in a consultation booklet which could be downloaded and was also distributed in print format. At engagement events, clinicians gave scene-setting presentations with a clear and concise slide deck and were on hand to answer any questions. Support was made available to those who needed it to access information or compete the questionnaire. This included: Translated versions or access to interpreters for people for whom English is not a first language or who need a BSL signer The consultation booklet was also available in audio, large print, Easy-Read or Braille formats Support was offered to people with a learning disability or difficulty in communicating. For people interested in understanding the proposals in more depth, the full Pre-Consultation Business Case and an Executive Summary could also be found on the site.
7. Use community-centred approaches that empower people and communities, making connections to what works already	A flexible approach was taken, particularly to engaging seldom heard groups, providing choices for participation to suit them - for example working with and through trusted organisations and organising events where people are, rather than expecting them to "come to us".
8. Have a range of ways for people and communities to take part in health and care services	Given the diverse nature of North West London's population, the consultation engagement was designed to be as accessible as possible and offer a wide range of ways in which people could participate. This included high-profile promotion of events, outreach through community organisations and trusted networks in order to engage patient groups and communities who may otherwise not participate, and flexibility of engagement, for example offering 1:1 interviews. Promotion of the engagement emphasised that feedback was welcome through many different channels, specifically: Questionnaire (online or printed, with Freepost available)

Requirement	Commentary
	Feedback by direct to the Collaborative team via telephone (0203 number) Email to dedicated consultation inbox or post, with Freepost.
9. Tackle system priorities and service reconfiguration in partnership with people and communities	The consultation and this report relate to reconfiguration of orthopaedic surgery in North West London. The approach taken by NHS North West London, working with the Collaborative, to partnership with people and communities during the consultation period is detailed in this report.
10. Learn from what works and build on the assets of all health and care partners – networks, relationships and activity in local places	This was one of the largest service change programmes in North West London since the creation of the ICB, and the first since the establishment of the Collaborative. It was therefore the first 'system-wide' engagement. With the mix of clinical leadership, staff engagement, qualitative and quantitative feedback from residents and targeted outreach to priority groups and communities, the programme benefitted from bringing together networks and relationships for the first time. This has provided a real opportunity to test new ways of working and to learn from each other.
Gunning Principles	
Consultation must take place when the proposal is still at a formative stage	In the pre-consultation period the project benefitted from significant input from stakeholders, staff, and, increasingly, patients and the public. Overall, engagements were considered valuable in aiding development of the proposal for an elective orthopaedic centre. The concerns raised during pre-consultation highlighted the need to fully contextualise information for groups and concerns raised were incorporated into the formal public consultation.
Sufficient information and reasons must be put forward for the proposal to allow for intelligent consideration and response	This report details the information which was developed to inform the consultation, including the formats and support made available for people to participate.
Adequate time must be given for consideration and response	The consultation period ran for 13 weeks, which included the Christmas period. Traditionally, 12 weeks has been considered reasonable for a public consultation process, having originally been proposed in the Code of Conduct.

Requirement	Commentary
The product of consultation must be conscientiously taken into account	The Pre-Consultation Business Case was agreed at the NHS North West London Public Board on 27 September. This consultation engagement report is expected to be included within the Decision-making Business Case and considered by NHS North West London.