Honesty Equality Accountability Respect Teamwork

Putting patients at the HEART of everything we do

NHS
London North West University Healthcare
NHS Trust

North West London Elective Orthopaedic Centre Full Business Case:

Appendix 1 – Draft Clinical Strategy

(Clinical Cabinet 2023)

Abstract

We will provide the best patient care and experience, continuously improve clinical outcomes, and become a place of work that supports our team to excel.

System vision

Introduction

This document sets out the overarching clinical strategy for Elective Orthopaedic Surgery. The strategy reflects national guidance and best practice and helps meet – and align – a number of strategic priorities for the north west London ICS and the acute provider collaborative.

The strategy aims to describe the direction of travel for elective orthopaedic services focusing on the establishment of an elective orthopaedic centre within the sector. The strategy outlines the clinical cabinet ambition to provide:

- Continuity of care across organisational boundaries
- Continuous improvement leading to high-quality clinical outcomes
- Equitable and inclusive access to care
- Collaboration and engagement with patients
- High-quality education, training and experience for staff

The strategy is structured in line with strategic planning guidance, is evidence based and has been co-produced with the clinical cabinet team. It outlines the strategic context, current arrangements and the sets the direction of travel for service transformation.

Strategic Context

Musculoskeletal (MSK) conditions affect almost one third of the population, that is over 20million people, symptoms can have a significant impact on people's quality of life and independence. Up to 30% of consultations in general practice are related to MSK conditions[1], the service sees an ever-increasing demand for services as people live longer with complex health needs. While most patients can be initially managed with education, self-care and within primary care, orthopaedic referrals from primary care continue to rise by 7-8% each year and there is a growing demand for operative treatments; according to the 2017 Global Burden of Disease study, musculoskeletal conditions were the biggest contributor to global disability. Orthopaedic procedures make up 26% of all surgical procedures and there are no signs of demand abating. Unaddressed, it is anticipated that demand will quickly outstrip resources and capacity. Recent research funded by the Scottish government indicates that if no action is taken then patients listed for hip or knee replacement surgery in 2022 may have to wait up to 7-years to undergo their surgery. New more efficient and effective ways of working are required. An integrated approach across healthcare is required to ensure patients are managed in the right place at the right time across north west London, and that we make the best use of our resources for our patients. Elective surgical services currently face significant pressures competing with surges in demand for unplanned care and, following the COVID-19 pandemic, unacceptably long waits. The NHS approach to tackling the additional challenges created by the COVID-19 pandemic, is set out in The NHS Delivery Plan [2]for tackling the COVID-19 backlog of elective care, by:

[1] NHSE https://www.england.nhs.uk/elective-care-transformation/best-practice-solutions/musculoskeletal/
[2] https://www.england.nhs.uk/coronavirus/publication/delivery-plan-for-tackling-the-covid-19-backlog-of-elective-care/

- increasing health service capacity, including through the physical separation of elective from urgent and emergency services to improve the resilience of elective delivery as well as service efficiency
- prioritising diagnosis and treatment, reducing the maximum length of time that patients wait for elective care and treatment

- transforming the way we provide elective care, including by increasing activity through dedicated and protected surgical hubs
- providing better information and support to patients, including to prepare for surgery in the best way possible.

The GIRFT programme for Trauma and Orthopaedics [3]is well established and evidenced, orthopaedics was the pilot specialty when the improvement programme was launched in 2015. The methodology was subsequently developed and applied to numerous other surgical specialties. The GIRFT programme supports local health and care systems to develop 'high volume low complexity' (HVLC) surgery services. It advocates the development of standardised pathways and adoption of best practice, as well as pooling of capacity and resources. This includes "establishing and maintaining ring-fenced elective capacity at a system level for HVLC procedures, adopting 'hub' models where appropriate". This approach has been evidenced to produce tangible benefits for the quality of care and patient outcomes, performance and efficiency and financial sustainability for patients.

North west London ICS has established a number of multidisciplinary and system-wide CRGs to support elective care recovery and service transformation through review of emerging clinical evidence and best practice. The Orthopaedic CRG, set up in 2020 aims to support collaborative improvement across areas of care and works closely with the wider north west London MSK network. The CRG, taking into consideration the best practice and outstanding outcomes from neighbouring elective orthopaedic surgical centres, identified the need to transform orthopaedic surgical care and to align with, and improve of community MSK pathways. The CRG's key recommendations for orthopaedic surgical care include:

- developing a centre of excellence and networked working for high volume, low complexity orthopaedic care which provides reliable and efficient surgical pathways that deliver a high-quality experience for patients and staff through rigorous application of best practice and continuous learning
- providing dedicated, ring-fenced NHS operating theatres and beds for patients requiring elective orthopaedic surgery
- ensuring rehabilitation support is in place for patients after surgery.

The approach to orthopaedic surgical care will be supported by and integrated across the sector with community musculoskeletal services that will ensure a seamless pathway which is well understood by and accessible to patients, carers and healthcare professionals. A key feature of this will be to ensure that access to high-quality care equitable so that most care is delivered close to the patient, whether in the community or in a patient's local hospital.

To support the recovery of elective care guidance was also issued by the British Orthopaedic Association on restoring elective orthopaedic services. The separation of elective services from emergency services has long been seen as a key aspiration to improving quality and productivity, as set out in an NHSE presentation to lead providers in 2020 which summarised the benefits of a separation of services providing:

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

- less fragmented services and improved patient navigation
- improved patient experience
- shorter stays, waits, and lower risk of cancellation
- improved outcomes and a reduction in unwarranted variation in patient care and revision rates
- improved specialisation to enable training, research and availability of advanced treatment
- reciprocal benefits to emergency and acute care provision.

The success of this approach is well evidenced and demonstrated in the results achieved in centres which have adopted this pattern of working, notably the SWLEOC where separating the activity from the emergency activity being undertaken across the region and even in the host trust, has been identified as key to the success of the model over the past 18 years.

Current Arrangements

Service Provision

Adult trauma and orthopaedic care are currently provided by all four acute trusts in north west London in a total of eight hospitals. The increased pressures on healthcare services as a result of an ageing population, COVID-19 pandemic and the resulting delays in elective care and increases in unplanned care have meant that elective orthopaedic surgery is often de-prioritised, none of the eight hospitals are currently in a position to provide ring-fenced beds for elective orthopaedic patients. This means that these services can never function efficiently, and the service is unreliable for patients and frustrating for staff. Patients deteriorate clinically while they wait for extended periods, they may come to harm, they cannot contribute functionally or economically to society, and they have a very poor experience.

Lead provider for orthopaedic care

To support collaborative and coordinated working across acute providers, especially in terms of elective care recovery, a lead provider model is being implemented for key surgical specialties in many

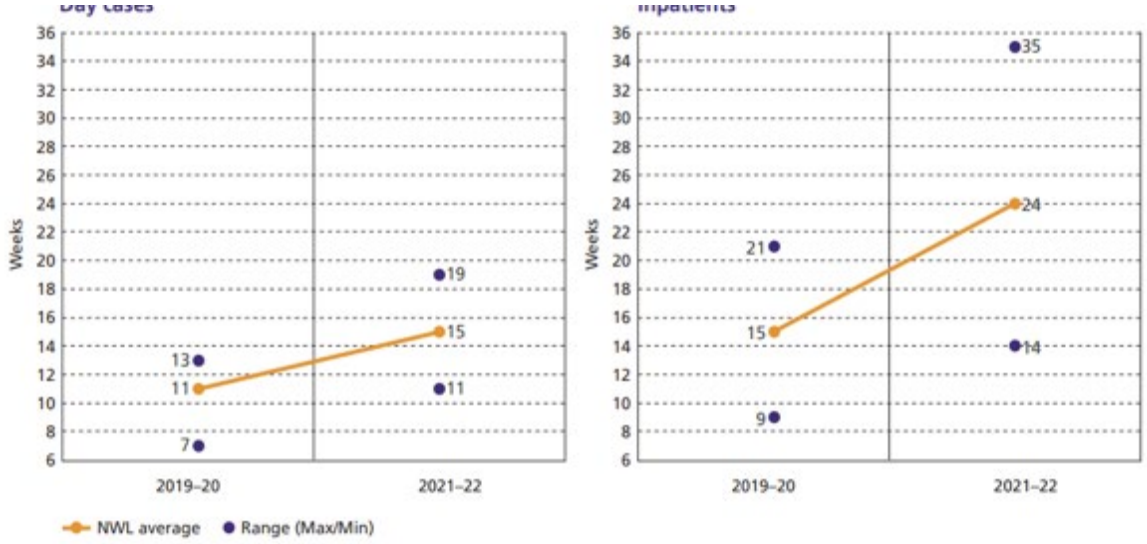
integrated care systems. north west London ICS has set draft principles to guide the creation and development of a lead provider role, which sees the lead provider selected and appointed at a system level, for orthopaedics London north west Hospitals Trust has been selected and holds responsibility for:

- engaging clinical and managerial leaders across all providers in a system
- coordinating and having oversight of waiting lists so that a system population has equity of access to care, based on clinical priority and waiting time
- oversight of clinical outcomes and productivity at a system level and using the system's continuous improvement methodology to reduce any unwarranted variation
- participating in the London Clinical Panel to agree best practice standards in clinical outcomes and productivity for the specialty

Performance

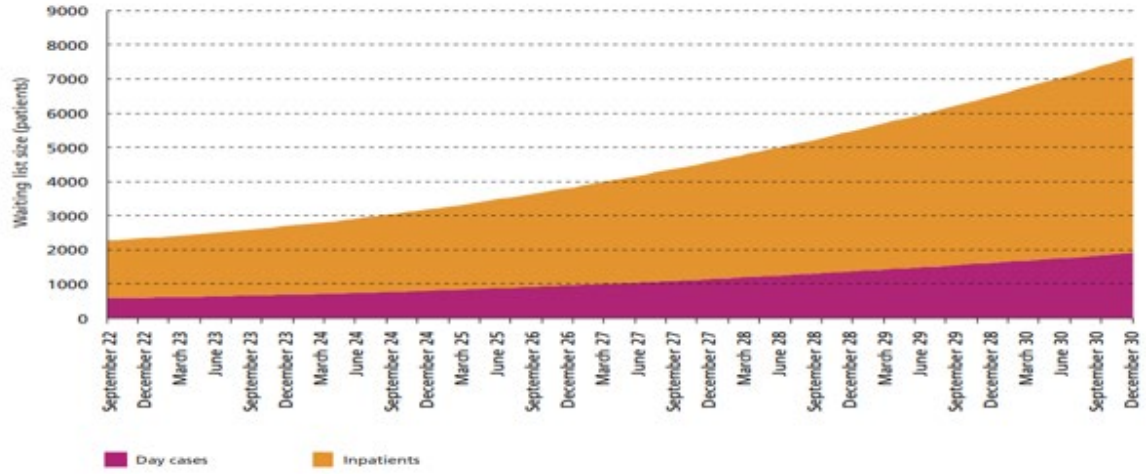
Over 15,000 people were waiting for orthopaedic care in north west London hospitals as at the end of September 2022. This includes all patients waiting for outpatient appointments, diagnostics or surgical procedures. This total patient waiting list for orthopaedics care did reduce in size compared to pre-COVID-19 numbers as elective services largely shut down, patients did not attend hospital for anything other than urgent care and patients were reluctant to travel to hospital. However, as we see this demand return, the waiting list has been growing – increasing by 22% in the last 6 months alone.

North west London orthopaedics breakdown of average DTA to treatment waiting times (Source: Public Consultation Business Case, 2022)



Demand for services in north west London will become particularly challenging over the next few years, as modelling shows that the number of people needing orthopaedic surgery will increase exponentially by 2030 if activity levels remain the same. Without intervention, the north west London orthopaedic waiting lists will continue to grow faster than the existing capacity to provide care

North west London orthopaedic surgery Patient Tracking List (PTL6) growth to 2030, with activity levels unchanged (north west London elective orthopaedic centre in-scope procedures and ASA grades only) Source: Public Consultation Business Case, 2022



Challenges

The four key challenges experienced by the service are outlined in this chapter. These challenges are the key drivers for change.

1. Growing demand and increasing waiting times
2. Clinical outcomes
3. Insufficiently joined-up care
4. Staff recruitment and challenges

Growing demand and increasing waiting times

The north west London orthopaedics waiting list has been rising with a c22% increase in the last 6 months as the disrupted demand during COVID-19 returns – currently standing at over 15,000 patients waiting for care. Of the total number of patients waiting, the number waiting for surgery has increased sharply since COVID-19, there are almost 200 patients who have been waiting for over a year. Without

intervention, the north west London orthopaedic waiting lists will continue to grow faster than the existing capacity to provide care. Patients deteriorate clinically while they wait for extended periods, they may come to harm, they cannot contribute functionally or economically to society and they have a very poor experience.

Elective orthopaedic surgical services will focus on consistent, improved and sustained performance. Even though procedures like hip or knee replacements are not usually considered to be time critical, waiting for treatment can have an extremely negative impact on quality of life and many conditions can worsen over time, making treatment and recovery harder. While many of the levers for preventing and mitigating MSK disorders sit outside the control of acute hospitals and even the wider NHS, elective orthopaedic surgical services should deliver fast, high-quality care, particularly to older patients and patients from more deprived backgrounds as they have proportionately more demand for elective orthopaedic care. This may be directly through an elective orthopaedic centre itself – which would take patients in order of clinical need from across the whole of north west London – or by freeing up more orthopaedic surgery capacity on sites where patients with more complex needs can be treated.

Clinical Outcomes

The table below shows the performance of the four hospitals in north west London against key quality indicators. As is evident, the majority of the performance analysis shows north west London hospitals performing at or below third quartile performance, demonstrating significant scope for improvement. There is also inconsistent performance, highlighting scope for uniformly consistent performance at improved levels. There are aspects of national guidance, inferior quality outcomes, financial inefficiencies and variations in clinical practice and standards where there are clear opportunities to offer an improved service for patients across north west London and to use our resources more efficiently.

North west London performance for elective orthopaedic care using 'model hospital'*

data and PROMs by trust (Source: Public Consultation Business Case, 2022)

KPI	Imperial	LNWH	ChelWest	Hillingdon/ MVH	Sector average
5 year revision rate hips	Q3	Q1	Q4	Q4	Q3
5 year revision rate knees	Q4	Q2	Q1*	Q4	Q3
PROMS – OKS	Q4*	Q4*	Q2	Q4*	Q4
PROMS – OHS	Q2	Q3	Q3	Q4	Q3
PROMS Eq5d hips	Q2	Q3	Q2	Q4	Q3
PROMS Eq5d knees	Q3	Q4	Q2	Q4	Q3
Length of stay hips	Q3	Q2	Q1	Q1	Q2
Length of stay knees	Q4	Q3	Q2	Q1	Q3
Cost per WAU orthopaedic surgery	Q4	Q3	Q1	Q3	Q3
Readmission rate knee	Q1*	Q4	Q4	Q4	Q3
Readmission rate hips	Q1*	Q1	Q4	Q4	Q2
Implants – cemented/hybrid hips in over 70s	Q4	Q4	Q3	Q4	Q4
Average	Q3	Q3	Q3	Q4	Q3

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

The potential for improvement, as well as variation, is particularly demonstrated when quality data for elective orthopaedic care is analysed to show which of the north west London trusts, if any, sit in the top decile or quartile for performance. No more than one north west London acute provider achieves top decile or top quartile performance for any group of indicators. No north west London trust achieves top decile performance for patient reported outcome measures (PROMs)8, length of stay, implants, readmission rate or revision rate. There are clear opportunities to improve the care that is provided for patients in north west London so that better, safer and high-quality care can be expected by and delivered for all.

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

(Source: Public Consultation Business Case, 2022)

Insufficiently joined-up care

NHS acute trusts in north west London receive generally positive feedback from patients about their planned orthopaedic care, in particular that staff are caring, kind and helpful. Patients are less positive about their experience of the healthcare system. In particular, patients with experience of MSK and orthopaedic services report frustration with long waiting times between their initial assessment and surgery or while attending their appointments, having to chase up for their follow-up appointments or feeling worried due to re-scheduling or cancellations.

During engagement activities, patients and the public highlighted that there should be a standardised community pathway which would complement improvements to the elective care model. They are concerned that it is easy for patients to become 'lost' in the system before and after referral or admission to hospital. Some patients face inequalities in accessing care and have poorer health outcomes as a result. This is particularly the case for patients who are elderly, have disabilities, are from deprived areas and from black, Asian and other minority ethnic groups. For example, previous engagement has shown elderly or disabled patients often say travel to appointments is a problem. Patients highlight communication problems, such as a lack of coordination between GPs and hospital services or confusing information. Many patients want more control over their care and would like the health system to organise services in a way that is clearer and more consistent and straightforward. Innovative 'one stop shop' models of care, such as 'joint weeks' or 'mass clinics', which save everyone's time, are popular with patients and clinicians but it is often difficult to organise resources in this way and they are often prone to disruption due to surges in unplanned demand.

With the wider community MSK pathway under review, and due to be re-procured, by the north west London Integrated Care Board, there is a real opportunity to create more joined-up care across primary, community and acute services and promote integrated patient pathways across elective orthopaedics.

Staff recruitment and retention challenges

Recruitment and retention of skilled and engaged staff is one of the biggest challenges facing the NHS. Key issues include:

- providing a greater range of training and career development opportunities, including new roles, such as advanced clinical practitioners and care navigators
- making it easier for staff to move across roles and partner employers, with common approaches to ways of working
- increasing resilience, including through greater appropriate cover
- reducing sickness and absence rates
- increasing more flexible working
- reducing the use of bank and agency through more effective cover of the rotas with permanent staff
- ensuring trainees and students have access to the highest quality education and training.

Model of Care

Vision for Elective Orthopaedic Surgery

The vision is to advance clinical excellence and share best practice worldwide. The service aims to provide the best patient care and experience, continuously improve patient outcomes, and become a place of work that supports team members to excel. To deliver this, we will establish an elective orthopaedic centre that is fully embedded and integrated within the wider patient musculoskeletal pathways so that improved end-to-end care is delivered for patients with musculoskeletal (MSK) disorders across north west London. This will involve close collaborative working with adjacent services and providers across north west London. This includes primary and community care, secondary care and social care providers.

Patients who need day case surgery or complex surgery or those who have additional health risks will be offered surgery in their 'home' hospital that currently provides orthopaedic surgical care. Patients who require routine inpatient surgery (ASA I and II) will be prepared for surgery by their 'home' hospital and referred to a dedicated elective orthopaedic centre for their surgery by their 'home' hospital team. The end-to-end responsibility of surgical care will remain under the surgical team based at their 'home' hospital to help ensure a seamless experience. If they have their surgery at the elective orthopaedic centre, their 'home' surgical team will travel with them to undertake the surgery, supported by the centre's permanent clinical support team.

A model of care that includes an elective orthopaedic centre that offers low complexity, inpatient, orthopaedic surgery in a purpose-designed centre of excellence that is completely separated from emergency care services offers several benefits that have been evidenced in national guidance and have demonstrated that:

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

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

The Clinical Model

The delivery of the clinical model is centred around 4 core principles. It is acknowledged that it will require not insignificant adjustment to working patterns and relationships but focusing on these core principles serves to support decision making which means that the selected model will deliver the intended benefits while remaining patient centred and responsive to the feedback that we have received during consultation and after careful consideration.

The Elective Orthopaedic Centre will:

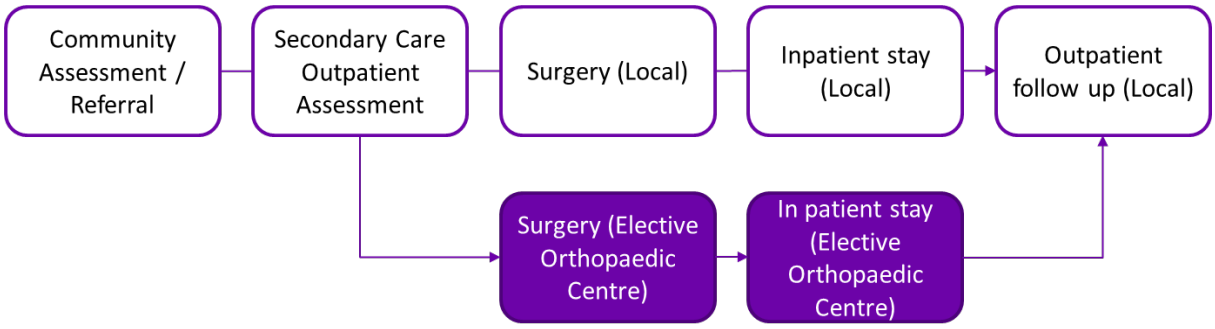
- Deliver clinical excellence and continuity of care
- Deliver care that reflects a culture of continuous improvement and is evidence based
- Be a product of co-production and will be fully integrated with wider community musculoskeletal pathways
- Deliver efficient, high-quality care with a focus on equitable access and excellent patient outcomes for all patients across north west London

This will be facilitated by:

- Ongoing collaboration and engagement reflecting respect for and insights from patient choice, preferences and staff feedback
- The use of digital technology to support patient access, information and education
- A commitment to high-quality research, training and education
- Efficient and effective operational processes
- A commitment to active audit, and clinical governance processes with active monitoring and reporting

The clinical model will offer a seamless integrated journey for the patient through preoperative care and treatments, whether undertaken in hospital or the community through assessment, surgery and rehabilitation. Technology and digital design will be used to facilitate this and to enhance communication and information sharing between clinicians and different elements of the pathway. This will empower patients and carers to access their own information and records. Examples include a shared electronic patient record, shared digital imaging, the remote collection of patient outcome measures, the development of virtual and online educational materials for patients and carers and over time the development of a virtual pre-assessment platform to support local provision via home trusts.

The Patient Journey



Community assessment and referral into secondary care

The clinical model and patient pathway involves referral from a community provider to the local hospital trust at a time when secondary care expertise is judged to be helpful or desired and/or when surgical treatment is being considered.

Secondary care outpatient assessment

Once surgery is agreed on through shared decision making, patients will undergo preoperative assessment. Patients will be listed for surgery at their local hospital, eligible patients (ASA 1 and 2) will be added to the patient waiting list for the Elective Orthopaedic Centre to have their surgery and perioperative care conducted there.

Pre-habilitation, preoperative physiotherapy and patient education

These will be provided either in the local home trust for the patient or in the community close to home.

Inpatient care

The inpatient pathway will be protocolised to support best practice and standardised efficient pathways. Ward-based care will be provided by daily senior grade surgeon ward rounds and a resident on-ward junior doctor presence supported by (specialist) nurses and therapists providing multidisciplinary post-operative care.

If in the unlikely event a patient required critical care, support will be provided if required by the on-site enhanced care unit team. The ECU has a small number of beds and is linked to the Northwick Park Hospital Critical Care unit. This facility is primarily provisioned for LNWH home patients as it is not anticipated that ASA 1 or 2 patients who have been scheduled for routine surgery will routinely need this level of care. There are well-rehearsed SOPs in place for patient transfer to NPH where necessary for post-operative emergency medical or surgical care. Patients will be given contact details and instructions on discharge to access clinical support and advice should this be required. Discharge will be routinely communicated to both the primary care provider and the local hospital trust for the patient.

Outpatient follow-up care

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

A small group of patients may require additional support during their post-operative recovery period. These patients will be identified as early as possible in the pathway. After surgery the discharge hub will act as a single point of referral to the eight north west London boroughs for social care, community rehabilitation and bedded rehabilitation.

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

The Elective Orthopaedic Centre

Recognising that optimising productivity in a mixed trauma and planned surgery environment is challenging, the development of an elective orthopaedic centre as a shared resource for all patients across north west London is underway. All acute trusts will be able to direct suitable patients to the centre, the EOC will provide equitable access to referring trusts and expertise at the centre. Although located on the CMH site, the inpatient beds are ring-fenced and protected from the pressures of urgent and emergency care (and other) pathways.

The ethos of the elective orthopaedic centre is to provide an excellent high-quality service. There will be some patients for whom variation from the clinical model of care is warranted and, in some cases, necessary. For example, there will be a small number of patients where it might be helpful for them to visit the EOC in advance of the day of surgery. Patient choice is important and will be respected as per the NHS Choice Framework.

If at the point of shared decision making to list a patient for surgery, a patient requests an alternative to the elective orthopaedic centre for routine inpatient orthopaedic surgery, a risk benefit assessment would be undertaken with consideration of the patient's clinical status and any protected characteristics that may be relevant.

Day case surgery has been excluded currently to maintain shorter travel distances for patients on

the day of surgery but this will be reviewed as the service develops and matures. Day case surgery and planned orthopaedic surgery for patients graded up to and including ASA 3, provided by London north west University Healthcare NHS Trust will continue to take place in the facilities of the EOC. This surgery already takes place in this facility as it is their 'home' orthopaedic hospital and the necessary support and adjacencies including critical care support have already been put in place to support this work.

The increase in capacity and efficiency offered by the EOC will mean that for some patients who currently need to have their surgical treatment procured, planned and delivered in the private sector, sometimes away from their local environment, their needs will now fall in-scope for the proposed elective orthopaedic centre, and they will be able to access treatment locally, closer to home.

Equity, inclusion, and access

Ensuring everyone can access services on an equal footing is a key priority for the NHS**.** North west London understands that the implementation of an elective orthopaedic centre may disproportionately impact some groups of the population. To understand this impact, as part of its statutory duty to consider reducing inequalities an EHIA and an Integrated Impact Assessment has been carried out. This takes a

systematic and evidenced based approach to considering the likely impact of the change on the different groups of people and sets out the mitigating actions to be included in any service changes.

Some of the actions being taken to reduce health inequalities in NWL MSK pathway include:

1. A strong focus on ensuring equity throughout the development of service changes – we have used the IIA alongside our consultation feedback to identify key challenges and possible responses.

2. People from black, Asian and other minority ethnic communities may be less likely to seek orthopaedic surgery than other groups which the service aims to tackle this through even more detailed waiting list monitoring and improved communications, engagement and support.

3. Potential digital exclusion: the service aims to make the most of digital and other technological advances -which can increase convenience for some patients and avoid potentially painful or complex journeys to hospital -without leaving anyone behind. A roll out of new digital solutions to support the clinical model will include tailored communications and face-to-face service options for patients who do not want –or are not able –to use digital platforms.

4. Patients with more complex needs: review of workforce requirements to ensure the proposed move of routine inpatient surgery to the elective orthopaedic centre would support a greater focus on complex surgery at the other sites. The efficiencies gained from consolidating low complexity care at a centre of excellence would be shared across all four acute trusts for the benefit of all orthopaedic patients.

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

Patient Experience

The service has built up a significant volume of insight about what patients and local communities in north west London want and need from inpatient orthopaedic care and wider MSK services. The ambition is to continue to engage with patients and local communities as the elective orthopaedic centre is established and use this insight to shape the service we offer to patients.

The service aims to provide a high-quality patient experience by ensuring care is provided in line with best practice guidelines, by a skilled multidisciplinary team who provide patient-centred care. Published literature[4][5][6] outlining orthopaedic patient feedback on the aspects of care that impacts their surgical experience along with feedback from our patients underpins the approach that the service adopts:

- Providing care with compassion and empathy
- Providing high-quality patient information to ensure that patients are well informed about their surgical procedure and the expected outcomes.
- Patient education programmes to support patients though their care journey from referral through to treatment
- A multidisciplinary team approach, ensuring patients can share their concerns and receive support from the best placed member of the team
- Post-operative care and effective discharge planning are key in alleviating patient concerns around postsurgical pain and anxiety associated with post-operative living arrangements

Patient feedback both qualitative and quantitative is key to continuous service improvement, there are processes in place to ensure that it is collected, analysed and acted upon across the patient pathway through the elective orthopaedic centre. In addition to this, there will be ongoing engagement with the

[4] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7503134/
[5] https://pxjournal.org/cgi/viewcontent.cgi?article=1348&context=journal
[6] https://www.magmutual.com/learning/article/orthopedic-surgeons-improve-patient-experience/

contacts established through the consultation and engagement completed to date that will also inform the service through implementation.

The model of care and arrangement of elective orthopaedic inpatient surgery services promotes the following patient experience benefits:

- support faster and fairer access for patients who need orthopaedic surgery across northwest London
- prevent conditions from getting worse when waiting a long time for surgery
- mean fewer postponed operations due to urgent and emergency care pressures
- help care to be more joined-up across the whole of the musculoskeletal care pathway
- support more focus on care before and after surgery to help reduce the risks of surgery and enable faster recovery

Improving Quality and Outcomes

How does the service plan to improve outcomes

The benefits that will be delivered by establishing the EOC are best considered through the 6-domains of quality applied to orthopaedic surgery, the approach is outlined here and will be developed through mobilisation and implementation of the elective orthopaedic centre.

1. Safe: Avoiding harm to patients from the care that is intended to help them.

Bringing together an expert team to regularly and routinely undertake elective orthopaedic surgery at scale in the EOC will make this surgery safer for patients. Safe practice is supported by strong well-rehearsed and trained teams working to best practice guidelines and learning from each other. Enhanced safety will be delivered by standardising pathways and protocols. Specifically, standardised protocols around ring-fencing beds, antibiotic prophylaxis, venous thromboprophylaxis, transfusion guidance and early safe post-operative mobilisation will drive up standards for all patients across north west London, achieve compliance with best practice, national standards, and make care safer.

Close monitoring of adherence to standards, performance, and patient outcomes will allow any risks to patient safety or quality to be identified early and to be addressed. Specifically, outcomes will be reviewed in multidiscipinlary team meetings, participation in the national joint registry project and other national audits, participation in the UK Health Security Agency Surgical Site Surveillance for Infection programme. Placing training, and innovation at the heart of the EOC will instil a culture of continuous learning, maintaining best practice and standards to keep patients and staff safe.

The structure, processes, policies, culture and people of the EOC will all lend themselves to supporting a sustainable culture of patient safety, offering all 6 elements of a successful safety management system.

- **A safety plan**: A strategic plan and system to identify, eradicate, manage and mitigate risks to patient safety. The EOC will adopt and incorporate the clinical governance and patient safety framework in place at LNWH as the host trust/lead provider for the EOC.
- **Policies, procedures, and processes:** Adopting evidence-based practice and national standards to make care safer and to improve quality of care for all. This includes standards across the whole pathway; for treatment, implant selection, patient preparation, ring-fencing of beds, staffing levels and discharge procedures.
- **Training and induction:** Preparing staff, equipping them with the knowledge, tools and access to perform effectively and to promote patient safety. There is a specific workforce plan for the EOC which addresses this area in detail. A core team of staff will be recruited to the EOC. Surgeons

and trainee surgeons and anaesthetists will attend the EOC on a sessional basis from their home trust. Other staff may be offered the opportunity to undertake rotational specialist placements at the EOC in order to disseminate learning, skills and experience. All staff will undergo training and familiarisation to allow them to function fully and safely in the EOC. Training grade surgeons and anaesthetists will be offered training passports with agreement from their school of training and Health Education England in order to ensure that prior learning and experience is recognised and that they are able to take advantage of the full training opportunity of the EOC.

- **Monitoring**: The EOC will commit to and participate fully in all relevant national audit programmes, the national joint registry, clinical surveillance, patient outcomes reporting as well as a local programme of clinical audit and quality improvement. Knowledge and learning will be shared with the EOC teams but also with local trusts for wider dissemination across north west London.
- **Supervision:** Putting training at the core of the EOC offers a strong lever for safety and quality improvement but also introduces an obligation to have a strong focus on supervision. Surgery and perioperative care in the EOC will be consultant led and trainee involvement will be directly supervised with best clinical and training practice. Supervision on ward areas is equally important and the EOC will have a separate and distinct workforce from the host trust so that the clinical pathways remain protected even during times of pressure on other emergency pathways and so that appropriate staffing and skill mix are maintained to allow excellent clinical care but also excellent training and supervision.
- **Reporting:** The EOC will report performance on quality and safety metrics through the LNWH governance structures but a Partnership board from all acute providers will also have oversight. The Acute Collaborative Board in Common with delegated authority to the Quality Committee will receive reports and have ultimate responsibility for the performance, quality, safety and running of the centre.

2. Effective: Providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit (avoiding underuse and misuse, respectively).

Offering treatments that are evidence based and in line with best practice. Twenty-five percent of the total hip replacement types available in the UK do not have any evidence to support their safety or effectiveness. The EOC will offer surgery using only evidence-based implants, highly rated by the Orthopaedic Data Evaluation Panel. Standardised referral pathways and criteria will mean that treatments are offered and targeted to those patients likely to benefit across NWL so that they are more likely to be effective.

3. Patient-centred: Providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions.

The patient pathways have been considered and designed to align with best practice but also to allow for some necessary variation and differences, to accommodate patient preferences and choice or where patients have additional needs. While the default model of care will mean that patients who are assessed as ASA1 or 2 will be offered surgery in the EOC, it is recognised that for some patients this may be better provided in their local hospital in order to meet specific individual needs. This is anticipated to be a small number of patients and capacity will be maintained in home/local trusts to accommodate these patients locally. The ethos of the centre is to remain patient centred while offering the best care for all patients.

The development of the EOC is an important and major step in advancing high-quality, equitable and patient –centred care for all across north west London. Bringing this clinical work into one centre of excellence will improve care for patients across north west London. Any change can be worrying for patients or staff and the clinical model recognises that progress to standardising pathways and treatments will be gradual with the potential for ongoing and increased benefits for patients and the service.

A good example of the iterative benefits that will be derived from this centre is that initially, surgeons from individual trusts will operate on and be responsible for patients from their own trusts, with a trust-based patient list. This recognises the need to develop patient and staff confidence in the model. Patient and staff groups have both expressed their anxieties about being operated on or followed up by a surgeon from a different hospital.

The evidence from other established centres suggests that we could obtain even greater benefits in efficiency and for equity by consolidating the waiting lists from all 4 acute trusts into one patient list. This would mean that any surgical team could operate on any patient which would allow operating lists to be planned and scheduled with even greater efficiency and improved equity of access. We recognise however, that confidence in the model, surgeons, colleagues and care are just as important as the evidence for the new model of care and that this will take time to develop. The model of care at the EOC will therefore necessarily develop iteratively over time, responding to the needs and preferences of patients and staff over time. The need for the clinical model to develop over time has been shown by the evolution of the South West London EOC (SWLEOC) over the past 18 years as the largest and most productive UK elective Joint Replacement Centre.

4. Timely: Reducing waits and sometimes harmful delays for both those who receive and those who give care.

Establishing the EOC will increase the surgical capacity to address the existing large patient waiting lists and increased referral rates and patient demand. This is an evidence-based approach which has been successful elsewhere. Current data suggests that this is a national problem and that 'doing nothing' will mean that patients in Scotland who are offered surgery today will wait 7-years before they are offered their surgery. NWL is the last London region to develop this model and the available evidence shows that NWL patients are disadvantaged by a lack of capacity. Research undertaken in NWL shows that those patients who wait the longest periods for their treatment report a deterioration in their health and quality of life. At worst, patients waiting over 39-months for hip and knee replacement reported a quality of life 'worse-than-death'.

Moving the surgery for ASA 1 and 2 patients into the EOC will release theatre, ward and critical care capacity in local home trusts that can then be used to offer more timely treatment for those patients who for reason of more complex conditions, comorbidities or who are sicker or frailer, are not eligible for treatment at the EOC. In this way, access to timely treatment is improved for all.

In addition, the elective centre at Charing Cross Hospital has been commissioned by NHS England as a Specialist Major Joint Revision Centre which will offer further opportunities to streamline pathways and to improve timely access to appropriate care across north west London.

5. Efficient: Avoiding waste, including waste of equipment, supplies, ideas, and energy.

Offering high volume low complexity surgery using this model offers proven efficiencies of scale and has been shown to improve quality and patient experience.

6. Equitable: Providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status.

The benefits in this domain are both progressive and cumulative. Improving the timeliness of access to appropriate care is an early (immediate) opportunity and success. As care standards are driven up to uniformly excellent levels, the full range of treatments will become increasingly and equally accessible for all patients across NWL irrespective of personal characteristics. We anticipate that the maturity and sustainability of improvements in equity will develop as the clinical model develops in response to the needs, beliefs, and preferences of our patients.

Improvement interventions, monitoring and engagement

Improvement interventions and monitoring of outcomes will be continuous and will be supported by active and ongoing engagement with patients and carers as well as staff. Identified themes for monitoring and engagement are detailed below, based on GIRFT criteria for high volume low complexity surgery hubs.

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

Benefits Realisation Plan: targeted improvement on key performance indicators

KEY

Activity to remain within home hospitals	Non-LNWH day cases, and ASA 3 and 4 activity, spinal, paediatric and out of area activity. Parallel monitoring to be undertaken across the system for both access and outcomes by the Shadow Partnership Board and through North West London Acute Provider Collaborative quality governance. * Note LNWH day case waiting list will also be monitored by the EOC as part its performance monitoring.
Year 1	12 month period beginning November 2023.
Year 2	12 month period beginning November 2024.
New and developmental KPIs.	Note - some of the additional KPIs relating to transport and patient satisfaction are of necessity work in progress and will need to be baselined prior to opening.

Benefit Description	KPI theme	Expected benefits	Baseline	Target improvement	By when	Owner
Productivity	Average length of stay - hips	Improved productivity	3.1 – 4.1 days (Model Health - 12 months to end Q2, 2022/23)	Top decile 2.3 days	Year 2	EOC Medical Director
	Average length of stay - knees	Improved productivity	3.2 – 5.7 days (Model Health - 12 months to end Q2, 2022/23)	Top decile 2.3 days	Year 2	EOC Medical Director
	Cases per list – Inpatient	Improved productivity	1.3 – 2.5 cases per list for mixed lists across NWL hospitals (Combined T&O - Model Hospital 2022/23)	GIRFT Target 2 cases per 4 hour list	Year 1	EOC Medical Director
	Cases per list – Day Case	Improved productivity		5 cases per 4 hour list	Year 2	EOC Medical Director
Cost-Effectiveness	Cost per Weighted Activity Unit – All planned Orthopaedic activity	Better use of resources	£368	£351 (2nd Quartile)	Year 2	EOC Managing Director
	Cost per Weighted Activity Unit – Orthopaedic	Better use of resources	£3,569	£3,1633 (2nd Quartile)	Year 2	EOC Managing Director

Benefit Description	KPI theme	Expected benefits	Baseline	Target improvement	By when	Owner
	inpatients and day case activity					
Clinical Outcomes and Experience	Patient reported outcomes PROMS - Oxford hip score	Improved patient satisfaction	3rd Quartile Health gain 21.807 - 23.278	2nd quartile	Year 2	EOC Medical Director
	Patient reported outcomes PROMS Oxford knee score	Reduced burden on primary care	4th quartile Health gain 14.179 - 17.685	2nd quartile	Year 2	EOC Medical Director
	Patient reported outcomes PROMS - Oxford hip Eq5d	Improved patient satisfaction Reduced burden on primary care	3rd quartile Health gain 0.416 - 0.480	2nd quartile	Year 2	EOC Medical Director
	Patient reported outcomes PROMS - Oxford knee Eq5d	Improved patient satisfaction Reduced burden on primary care	3rd quartile Health gain 0.288 - 0.347	2nd quartile	Year 2	EOC Medical Director
	30 day readmission rate - hips	Improved productivity Better outcomes	1.6% – 12.5% (MH - 12 months to end Q2, 2022/23)	Top quartile 4.5%	Year 1	EOC Medical Director
	30 day readmission rate - knees	Improved productivity Better outcomes	2.5% – 12.1% (MH - 12 months to end Q2, 2022/23)	Top quartile 4.5%	Year 1	EOC Medical Director
	Cancellation for (a) clinical reasons	Improved patient satisfaction Better use of resources	1.8% - 3.5% (MH - 12 months to end Q2, 2022/23)	1%	Year 1	EOC Medical Director
	Cancellation for (b) non-clinical reasons	Improved patient satisfaction Better use of resources	3.1% - 8.2% (MH - 12 months to end Q2, 2022/23)	2%	Year 1	EOC Medical Director
	Cemented hip implants > 70 years old	Better outcomes	68.1% - 76% (MH - 12 months to end Q2, 2022/23)	2nd quartile	Year 2	EOC Medical Director
	5 year revision rate - hips	Improved patient satisfaction Reduced burden on primary care Better use of resources	3rd quartile 1.0%	Top quartile 0.5%	Year 6	EOC Medical Director
	5 year revision rate - knees	Improved patient satisfaction Reduced burden on primary care Better use of resources	4th quartile 2.0%	Top quartile 1.0%	Year 6	EOC Medical Director
Patient Access	Reduction in EOC waiting list size for High Volume Low Complexity inpatients	Improved patient satisfaction	Waiting list size as at December 2022.	Reduction of of ~38% by October 2025 Year 2		EOC Managing Director
	Reduction in waiting list size for Low Volume High Complexity inpatients	Improved patient satisfaction	Waiting list size as at December 2022.	Reduction of of ~36% by October 2025		Acute Provider Collaborative
	Reduction in waiting list size for NWL sector day cases*	Improved patient satisfaction	Waiting list size as at December 2022.	Reduction of of ~57% by October 2025		Acute Provider Collaborative
	Reduction in EOC waiting time for High Volume Low Complexity inpatients	Improved patient satisfaction	Waiting list size as at December 2022.	Reduction of ~9 weeks by October 2025		EOC Managing Director

Benefit Description	KPI theme	Expected benefits	Baseline	Target improvement	By when	Owner
	Reduction in waiting time for Low Volume High Complexity inpatients	Improved patient satisfaction	Waiting list size as at December 2022.	Reduction of ~9 weeks by October 2025		Acute Provider Collaborative
	Reduction in waiting time for NWL sector day cases	Improved patient satisfaction	Waiting list size as at December 2022.	Reduction of ~9 weeks by October 2025		Acute Provider Collaborative
Transport	Analysis of patients who DNA	Reduced DNAs		% DNA rate reduction As a subset: % DNA rate reduction of patients who live at long distance/ ++age Target improvement to be agreed by the EOC Management Board and the Shadow Partnership Board.	Year 2	EOC Estates and Facilities Lead
	Continuous review of PTS	Improved access to PTS amongst eligible patients	Baseline to be determined prior to opening.	12% of overall EOC patients who were able to access PTS took up the service. Review assumptions at end of Year 1.	Year 1	EOC Estates and Facilities Lead
	Patient friends and family test	Improved patient satisfaction	Baseline to be determined prior to opening.	Top quartile	Year 2	EOC Estates and Facilities Lead
Patient Satisfaction	Volume and nature of patient complaints	Reduction in number and scope of complaints	Baseline to be determined prior to opening.	Tbc	Year 1	EOC Director of Nursing
	Qualitative patient survey	Improved qualitative assessment	Baseline to be determined prior to opening.	Tbc	Year 1	EOC Director of Nursing
	Qualitative patient feedback	Improved patient satisfaction		Target improvement to be agreed by the EOC Management Board and the Shadow Partnership Board, based on EOC Operational Management Group recommendations Baseline position to be determined based on data for period six months prior to opening the EOC, with initial post-opening survey six months after opening and then continuing six monthly thereafter.	Year 2	
Workforce Impact	Staff satisfaction	Staff engagement	6.9	7.0 (Top quartile, NHS Staff Survey)	Year 2	EOC Director of Nursing
		Staff morale	5.7	5.9 (Top quartile, NHS Staff Survey)	Year 2	EOC Director of Nursing
	Staff recruitment and retention	Low vacancy rates and low turnover	TBC	10% (Agreed by Workforce Workstream)	Year 2	EOC HR Lead

(Source: Decision-Making Business Case DRAFT, 2023)

On-site Facilities and delivery of the clinical model

The clinical model will be delivered at the CMH site which will be expanded to 5 state-of-the-art operating theatres with laminar flow facilities. Currently London north west University Hospitals NHS Trust (LNWH) uses 3-operating theatres to deliver elective orthopaedic surgery including some day surgery cases, this includes patients assessed as ASA3. It is proposed that with the development of the EOC, LNWH will continue to offer surgery for patients graded ASA3 and for some day case procedures. The supporting infrastructure and critical care support is already in place to allow this. Patients being treated by teams from the other 3 trusts will be ASA 1 and 2 only. ASA 3 and 4 patients will undergo treatment locally in their home trusts. The site provides a small number of level 2/3 beds suitable to support the existing ASA 3 patient activity undertaken by LNWH and this can be made available in the unlikely event that an ASA 1 or 2 patient requires a short period of additional support/monitoring. Otherwise, there are well-rehearsed pathways to transfer patients who deteriorate unexpectedly or who require additional support or care to Northwick Park Hospital.

The model for delivery of care will be agreed by the EOC Programme Board and ratified by the Acute Programme Board. The aim is to offer maximum benefits of the new EOC for patients across NWL while avoiding anything that would destabilise LNWH. Four options have been considered.

A. Each Acute provider trust will assume the running of the EOC for a two-week period, scheduling and delivering surgery using all 5 operating theatres with surgical teams attending from the local home trust.
B. LNWH will use one theatre at the CMH to provide ASA 3 and day case surgery and each of the other 3 acute providers will assume the running of the other 4 theatres for a 2-week period.
C. LNWH will use one theatre at the CMH to provide ASA 3 and day case surgery. Each of the acute providers will assume the running of one of the other 4 theatres each day to deliver planned ASA 1 and 2 patient activity in the EOC. This will allocate 2 operating theatres to LNWH each day and one each to Chelsea and Westminster Hospital NHS Foundation Trust, Imperial College Healthcare NHS Trust and Hillingdon Hospital NHS Foundation Trust.
D. LNWH will continue to operate out of 3 operating theatres at the CMH while theatre sessions in the other 2 operating theatres will be scheduled and booked on a rotational basis for the other 3 trusts.

Option C is preferred and judged to maximise the benefits of the EOC without destabilising LNWH; efficiencies of scale; bringing teams from across NWL on-site together as a step to closer working, improved quality and safety outcomes; allowing for the development of regular processes, routines and teams working together.

All options will require adjustments to be made to team job plans and these will be agreed through local trust job planning in the first instance. It is recognised that there will be a need for recruitment to achieve the aims of the EOC and it is important to be clear that this model represents an increase in capacity across NWL with obvious benefits rather than a simple transfer of existing work.

Workforce

North west London ICS has set out a People Plan, the vision sets out that our people are able to provide great care for our patients and communities because they have the skills, tools and capacity to do their job and the environments they work in are inclusive and supportive.

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

People Priorities :

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

The workforce model for the elective orthopaedic centre forms part of the workforce redesign priority for the sector. The model aims to provide the elective orthopaedic surgical teams with the skills and structures to deliver new clinical models of care; operate in agile ways using technology and transform operating models for support services.

Elective Orthopaedic Centre Workforce Model

The elective orthopaedic centre will become a centre of excellence by bringing together surgical teams from across north west London to work together to deliver high-quality care. The centre's workforce model focusses on ensuring continuity of care for patients, the opportunity for continuous improvement that can be shared across all contributing hospital teams and enhanced training and teaching opportunities across all disciplines. The scale of the centre and expected number of patients sets a solid foundation for staff to thrive and work together as a team to reduce unwarranted variation in practice, improve clinical outcomes and share their learning and best practice with teams at their home hospitals.

Consultant and anaesthetist staffing model

Each of the four acute trusts will review their funded consultant establishment. Formal team job planning will be required for each team and the new model of care will almost certainly require a reorganisation of the working patterns and structures for consultants. It is recognised that this represents an expansion of capacity across north west London and as such, following job planning, it is anticipated that additional recruitment may be required. Consultants will be responsible and job-planned to contribute to governance at both the EOC and in their home trusts which will facilitate sharing of best practice between the EOC and he home trusts and teams.

Medical non-consultant

Training grade junior doctors will remain based at their home hospitals and will work at the EOC using passporting arrangements agreed with Health Education England., The team will have the opportunity to train within a dedicated surgical centre alongside a team of expert clinicians and dedicated specialist support staff. In addition to training grade doctors, the EOC will provide 24-hour resident medial cover. These posts will be recruited directly to the EOC.

Nursing staffing model

There will be a dedicated nursing team at elective orthopaedic centre that are trained and skilled in orthopaedic care. The team will work collaboratively within the MDT with oversight from the host trust for professional management and support. The centre will enable teams from local home trusts to work collaboratively with them. The centre will offer educational and rotational placement programmes as it is recognised that both support staff retention, provide an attractive opportunity for those looking to

develop their skills and support the ethos of continuous improvement by bringing experience and best practice from home hospitals to the centre and vice versa.

Administrative and Clerical model

There will be a dedicated administrative and clerical team to support EOC patients through their patient journey. This will include booking patients in for their surgery and providing information about the centre, its location and how to get there, signposting patients who need additional support with transportation to the appropriate resources, supporting with coordination and booking of pre-surgery appointments and tests and post-surgery follow-up appointments at the appropriate location. The team will be recruited by the host Trust and managed accordingly, they will work in collaboration with the EOC MDT team and also with their peers at referring the referring trusts to ensure patients have a seamless journey through the centre and back to their local trust.

Allied Health Professionals

A dedicated team will be recruited to support patients during perioperative treatments and immediate recovery, assessments before discharge and liaison with community support if required. The team will work closely with the MDT and with their peers in referring hospitals to ensure a seamless patient journey. The team will also work collaboratively with community MSK teams to ensure patients who need it are supported close to home with any further care needs.

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

As a true centre of excellence, the elective orthopaedic centre will attract the best and brightest talent to work in north west London. This innovative care model, with potential for a range of new roles and ways of working will help to embed best clinical practice and to support ongoing professional development, offering challenging careers with growth opportunities and the right environment to develop real excellence and expertise among the multidisciplinary team. This will directly support staff recruitment and retention. Ensuring the elective orthopaedic centre is part of an integrated, end-to-end pathway together with the other north west London hospitals providing orthopaedic surgical care and with primary and community care partners, will help with wider staff recruitment and retention too.

There are potential advantages for the wider system also. Over time, we anticipate that the EOC will be able to support and offer rotations and placements for nurses and allied health professionals from across the acute provider and community trusts/partners which will help to develop a better understanding of the whole patient pathway for clinicians as well as supporting the development and dissemination of specialist knowledge and skills across the region.

Staff experience

The developing workforce plan for the north west London elective orthopaedic centre aims to support positive staff experience by providing an environment that is purpose built with provisions for staff wellbeing, multidisciplinary team education, training and innovation and supports efficient patient flows.

The elective orthopaedic centre will have a dedicated management team to provide staff with senior support and oversight on a day-to-day basis and will be further supported by the host trust's leadership team. The opportunity for teams across the eight hospitals to attend the centre for learning and training opportunities will further boost staff experience, not just for the EOC staff, but also for their peers at referring hospitals.

The impact of the workforce model that we would hope to see would include:

- Development of consistent ways of working together with north west London-wide clinical protocols driven by the orthopaedic network
- Successful recruitment and retention of staff at the centre and in home hospitals
- Reduced staff sickness and absence rates at the centre
- Development of new roles where appropriate, which are likely to include advanced clinical practitioners and care navigators
- Low bank and agency staff reliance
- Development of north west London support networks including system-wide multidisciplinary team working structures and defined escalation pathways to access clinical expertise for complex patients
- development of a north west London-wide recruitment strategy for orthopaedics that includes education and rotation opportunities for staff to develop enhanced skills and specialisation in orthopaedic care

Training, Education and Research

This innovative model of care has been shown to offer significant opportunities and benefits for training. Consolidating large volumes of routine elective surgery allows for excellent whole team routines, skills and relationships to be developed that enhance the training environment and make care consistently more efficient and safer.

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

In order to achieve this, they will need the usual digital, site and electronic access and permissions to allow them to function. This will be achieved through liaison with HEE and LNWUH to agree training passports for this group of doctors. Training standards and expectations will be identical to those provided in the home trust with the expectation that a trainee can operate under the supervision of their consultant trainer within their competence.

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

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

This flexibility and opportunity will help to address the recognised challenges of recruitment to ‘hard-to-fill' roles, will offer the professional and career challenge and development that supports staff retention and satisfaction. We will, through the north west London Health Academy, utilise, develop and design training and skills programmes with the partnership skills providers to upskill existing staff, and consider the use of alternate roles. There are a number of courses currently available ranging from diploma to masters level across nursing; physician associates; MSK ultrasound; advanced clinical practice, physiotherapy, operating department practice, and a number of entry level apprenticeship courses.

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

Placing training as a core element and expectation will encourage the EOC to continue to aim for the highest standards, to remain reflective and responsive to change, progress and challenge and to embrace true multidisciplinary working. Our commitment to provide an excellent environment for training will

help to make the EOC a great place for all to work, supporting our recruitment, retention and staff wellbeing. The positive impacts of all of these for patient safety are well recognised.

The development of the NWL EOC has been discussed by and is supported by the national Specialist Advisory Committee for Trauma and Orthopaedic surgery, the body with delegated authority for training in trauma and orthopaedic surgery on behalf of the Joint Royal Colleges of Surgery and the Joint Committee for Surgical Training. The model and proposal is endorsed and felt to offer significant opportunities for improved training with the caveat and requirement that the centre should achieve the GIRFT standards for training in surgical hubs.

Recent data shows that trainees and training in trauma and orthopaedic surgery have been disproportionately affected by the covid-19 pandemic and reduced elective surgery volume. The specialty has the largest proportion of 'outcome 10' assessments at trainee annual competency assessments, where trainees have not been able to achieve the expected standards of operating because of the impact of the covid pandemic. The EOC will offer an important solution for this problem in north west London and will provide future trainees with high volume training in a supervised high volume performance environment.

The model for training has been discussed in more detail with and will be developed in collaboration with Health Education England. The clinical cabinet and workstream have been working with the Schools of Surgery and Anaesthesia to do this and will continue to regularly engage with them as the EOC programme progresses. In addition, the clinical cabinet have agreed to recruit trainee representatives to join the clinical, training and workforce workstreams in order to add their insights. The intention is to place training at the heart of the EOC.

This support is caveated with the requirement for the EOC to be designed and established in line with the GIRFT accreditation criteria which put training at the heart of the centre. The NWL ICB have made this commitment which will benefit clinical training for all specialties and will also support high-quality care.

GIRFT HVLC criteria for hub accreditation including training

Elective Hub Accreditation Criteria-Staff and Training page 1/1)

Headline criteria	Core elements of headline criteria	What we will be looking for	Evidence	CQC KLOE
1. Dedicated & ring-fenced clinical and operational teams	1.a Robust clinical staffing model in place	• *Clear rotational or permanent clinical staffing model in place • *Staff vacancy rates are low or • Hub has, or aims for, 80% substantive staff across all staff groups and on a rolling monthly basis • Hub review the number of additional hours that staff work to ensure staff well being	Self-certification. Rotas Vacancy data. Copy of plans Rotas. Self-certification Self-certification	Effective
	1.b System in place to enable staff to work effectively at hubs sites and to move efficiently between hubs	• *Passporting process & rotational models fully embedded *Induction processes are in place for all staff, including those from other sites and visiting clinicians	Related policies. Conversations with staff during site visit Self-certification	Effective
	1.c Robust ring-fencing applied to hub staff	• *Chief Executive/Exec Tripartite decision required for breaking of ring-fence of hub staff • *Winter/emergency pressures plans in place to avoid hub cancellations	Self-certification. Conversations with staff during site visit Copy of plans	Effective
	1.d.Effective strategy to address future staffing issues & robust staff management processes	• *Plan to address recruitment and retention in place (e.g. networking with neighbouring hubs, rotational or innovative posts) • Plans for role-development and ongoing training • Robust staffing processes such as appraisal, disciplinary etc	Self-certification. Copy of approach and results Copy of plans Copy of policies	Safe
2. Supported training of junior doctors & wider MDT	2.a There are regular, scheduled, training opportunities at the hub for junior doctors, including fellows	• *Dedicated training operating lists to agreed GIRFT ratios (e.g. 8 cataracts per training list v 10 non-training list)	Example theatre lists. Model hospital data. Conversations with staff during visit	Effective
	2.b Hub staff offered regular, relevant continued professional development (CPD) opportunities	• *Systematic training opportunities in place for relevant hub staff	Training records	Effective
3. Strategy & approaches that promote staff well-being	3.a Staff have access to necessary basic facilities and services	• There is sufficient parking and transport arrangements for staff not permanently based at the hub • *Staff access to a dedicated area for breaks / lunch • There is lockable storage and changing facilities are available for hub and non-hub staff • Smart card/relevant logon information for staff not permanently based at the hub is collected in a timely way	Observation during visit. Conversations with staff during site visit Observation during visit Self-certification. Conversations with staff during site visit Conversations with staff during site visit	Effective
	3.b Staff feel safe in their work environment	• *Necessary estates safety checks carried out • Outdoor areas and parking is well lit	Self-certification Observation during visit	Effective
	3.c Staff feel valued and respected in their work environment	• Evidence of regular engagement with staff at all levels with evidence of action taken to address suggestions and comments • Good levels of staff satisfaction	Self-certification of process. Examples of impact Vacancy, sickness and turnover rates. Trend data	Effective

Clinical Governance Overview

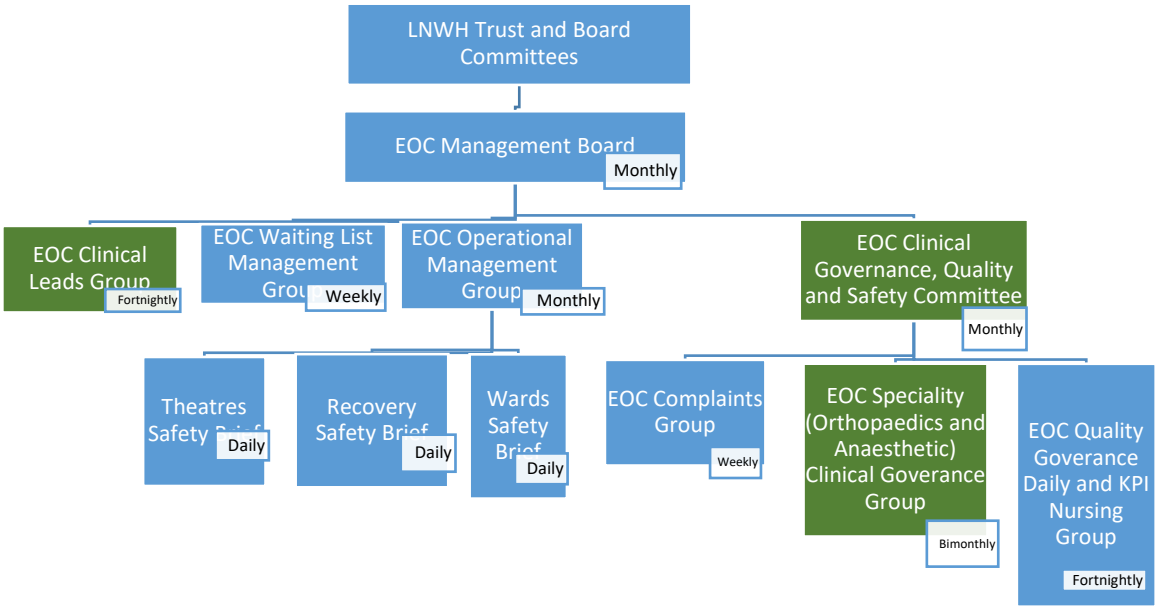
Summary of arrangements

Operationally, the elective orthopaedic centre will be run by LNWH as a stand-alone business unit with its distinct budget, cost centre and service line reporting. In a similar fashion to the LNWH clinical divisions, for governance purposes the elective orthopaedic centre Management Board will report to the Trust Executive Group and upwards to the Trust Board. The elective orthopaedic centre senior leadership team will be members of the Trust Executive Group, and the existing LNWH divisional governance framework will be mirrored by the elective orthopaedic centre.

Clinical leadership will be provided by a medical director and nursing director, the medical director will chair a representative clinical council/management board which will include multidisciplinary representatives from partner trusts. This will be the primary management group for the EOC tasked with delivering the strategic goals of the centre.

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

The EOC will put in place a strong clinical governance framework to support the drive to improve clinical and quality patient outcomes and the patient experience, to maximise efficiency and financial sustainability and to deliver excellence. A culture of continuous learning and improvement will help us to recognise and address any unwarranted variation and poor outcomes early on and to improve the care and access to excellent care that we provide for all patients across north west London. The proposed governance structure is below:



Source: Decision Making Business Case DRAFT, 2023