London Clinical Senate

Advice on proposals for adult elective orthopaedic services reconfiguration in North West London: case for change, clinical models, and the development of potential solutions.

London Clinical Senate Council Report

7th March 23

Chair's Introduction

On behalf of the London Clinical Senate I am pleased to share the final report of the London Clinical Senate Council's review of North West London Elective Orthopaedic service reconfiguration proposals.

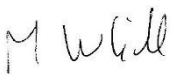
I would like to thank North West London colleagues for their drive and passion to secure these improvements for patients. Significant work has been undertaken to develop these proposals which are grounded in national recommendations and best practice.

My thanks also to members of the senate council and subject matter experts who contributed their time and expertise to undertake this important review. Their breadth and wealth of experience has been instrumental in developing this report, in which we have endeavoured to provide a constructive and rounded perspective.

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

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

We wish North West London colleagues success in their ambition to improve the care and outcomes for their local population.



Mike Gill

Chair, London Clinical Senate Council

Contents

1) Request to the London Clinical Senate

North West London Integrated Care Board (ICB) and North West London Acute Provider Collaborative (APC) approached the London Clinical Senate in August 2022 with a request to provide independent clinical advice on proposals for the reconfiguration of adult routine elective inpatient orthopaedic services in North West London (NWL). The senate received a written request for advice and held a discussion with NWL ICB and APC programme leads.

Their proposal was to consolidate adult routine elective inpatient orthopaedic surgery onto one site, rather than have separate provision at NHS across NWL, as is currently the case. The drivers for this change are to:

- Reduce unwarranted variation in the quality of care provided.
- Improve patient access and experience.
- Gain efficiency benefits through ring-fencing orthopaedic services with co-located support services, in fit-for-purpose buildings.

Central Middlesex Hospital was identified as the preferred site for the proposed centre. Capital monies had been identified and secured; a stage 2 assurance meeting was anticipated in early October.

2) Approach to the review

Representatives from the London Clinical Senate and NWL discussed the scope of the senate review and agreed the approach in the Terms of Reference (Appendix A).

It was agreed that the London Clinical Senate meeting of 27th September 2022 would host the review and would be chaired by Mike Gill, Chair of the London Clinical Senate council.

To ensure a complete and independent panel, all London Clinical Senate council members were asked to declare their interests and to confirm their availability for the meeting. Members considered conflicted did not contribute to the review.

Additional subject matter expertise was secured in orthopaedic surgery and anaesthetics to complement and extend the panel membership. Provision was made for senate council members to contribute electronically if they were unavailable on the day (Appendix B).

Upon receipt of a draft Pre-Consultation Business Case (Appendix C) as well as other supporting documentation from North West London, draft Key Lines of Enquiry (KLOE) were produced by the senate council chair. These were developed with reference to the *London Clinical Senate Principles* and the 5 NHS key tests for changes which are outlined in the Terms of Reference. The primary focus of the senate's review was the *Clear clinical evidence base.* However, consideration was also given to *Strong patient and public engagement* with input from the patient and public voice members on the panel.

Feedback on the KLOE were sought electronically from panel members, and, aside from a small addition to ensure sufficient focus on workforce, these were accepted (Appendix D).

In the period between agreeing the KLOE and the panel review, the North West London team continued to refine the Pre Consultation Business Case (PCBC) to improve flow and readability. Given that documentation had previously been circulated, and on the understanding that changes were predominantly on presentation rather than content the senate panel review focussed on the original version provided.

The format of the review was a presentation from the North West London team, followed by questions from the review panel and finally an opportunity for the panel to deliberate and draw together its conclusions (Appendix E).

3) Key Lines of Enquiry

The discussion and consideration of the review panel against the Key Lines of Enquiry is detailed below; the recommendations (section 4) emerge from this.

3.1 Does the clinical case for change clearly articulate the rationale and provide enough evidence that the change is justified in terms of efficacy, patient experience and inequalities?

3.1.1 The London Clinical Senate review panel considered that there was a clear overarching case for change for the development of an elective orthopaedic centre (EOC).

3.1.2 The NWL proposals align with national best practice recommendations. As detailed in the PCBC, the *"vision for a NWL EOC is consistent with the model recommended by GIRFT and the British Orthopaedic Association. The centre should reduce unwarranted variation in care for patients"* (PCBC, 2.1, p7).

3.1.3 There are also demonstrable benefits of this model from elsewhere in London. South West London have been running such a model for some time and North Central London have recently consulted upon and implemented EOCs. NWL may learn valuable insights from these services regarding introducing, operationalising, and iterating an EOC.

3.1.4 During the review meeting, NWL presented six key local drivers for change:

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

3.1.5 They also articulated that the proposal would enable the full potential of the Central Middlesex hospital site to be maximised and advised that capital monies had been secured.

3.1.6 The overarching challenges were well articulated in the presentation. However, further local data and evidence connecting the national, strategic, and demographic context to the locally planned quality outcomes and performance indicators is important. Further granularity in modelling of activity levels, growth and pathways would provide an even more compelling case for change. Including some of the data provided in the presentation received by the panel into the PCBC would be beneficial, for example:

"There are over 15,000 people currently waiting for orthopaedic care in NWL hospitals with the total PTL for T&O growing by 16% between May and August 2022…. NWL has a longer waiting time before clearing the Orthopaedic waiting list for T&O than four out of five of the ICS areas in London" (Presentation, Intro and Background, p8).

3.1.7 There is evidence of some patient and public involvement, which NWL indicated they intend to develop and strengthen. Increasing engagement was welcomed by the panel.

3.1.8 The panel noted that reducing inequalities was a key driver of change and they considered that this will require further thought and attention to ensure the ambition of more equitable access and outcomes are realised. This will include more detail on specific actions and monitoring the achievement of these. The panel were pleased to hear that NWL are planning to incorporate this going forward.

3.2 Has there been sufficient engagement with Stakeholders?

3.2.1 The panel found there has been a positive start to stakeholder engagement, particularly given the pace at which work has been progressing. They noted the consultation plan included in appendix 11 of the documents referenced groups with protected characteristics.

However, with a population of approx. 2.2mil across 8 boroughs it is essential that wider and deeper engagement is undertaken during consultation, and that the messages emerging from this are considered and responded to with actions taken on known risks.

Considering the engagement of different population groups in turn:

3.2.2 Public and patients. The panel found that there had been engagement in areas: *"Seventy-eight people took part in the engagement in total, 36 in community events and 42 in focus groups and interviews. All fieldwork took place in June 2020."* (PCBC Appendix 8, 3.4). Further engagement of the public living in the area using the service as well as those that are particularly affected is recommended.

The findings from this engagement showed*:*

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

- *People did not usually understand the complexities of NHS systems*
- *The model proposed, including one centre for routine surgeries, was generally welcomed, however some concerns were expressed:*
- *People were worried that the plans could result in a two tier system from two perspectives:*
    - *could fast tracking routine surgery be detrimental to people with more complex needs?*
    - *would increasing the use of digital technologies leave behind people who could not use them?*

Several barriers to care were identified, including:

- *Being lost in the system*
- *Not having face-to-face appointments especially for diagnosis and being starting physiotherapy*
- *The digital divide for people unable or unwilling to use technology*
- *Travel to and parking at hospitals*
- *Lack of access to therapies"* (PCBC Appendix 8, Executive Summary).

As indicated above, the panel wishes to see the response and approach to managing this engagement incorporated into the PCBC.

3.2.3 Providers. Engagement is ongoing. The panel were aware that the success of the service is contingent on the level of support and commitment from each organisation and recommends that attention is paid to this. Similarly, engagement of all staff will be critical to ensure that the systems and flows work operationally.

3.2.4 Workforce. The panel noted that there have been a series of meetings and workshops with staff and were advised that orthopaedic and MSK teams across NWL are collaborating through the NWL MSK Network Group on this and several projects. The numbers engaged with, however, are less clear, and the panel considered that staff initial feedback should be considered and responded to: *"Practitioners who took part in the engagement felt that the plans were too focussed on secondary care and raised concerns about whether in the future more people would be referred to them, for example for physiotherapy, as they were already having capacity problems"* (PCBC Appendix 8, Executive Summary).

Against this context, ongoing involvement of the workforce in design as well as greater involvement with Health Education England (HEE) is recommended.

3.1.5 Commissioners. The work to date has primarily been driven through an acute provider collaborative. At the time of the review, involvement with commissioners was underway as one of the first collaborative programmes with the NWL ICB. Additional leadership from commissioners will be essential to ensure that statutory duties regarding consultation are fulfilled.

3.1.6 Primary care. Engagement could be stronger here. The panel considered that there is significant benefit in engaging colleagues to ensure effective end to end pathways.

3.3 Will the proposed clinical model deliver safe, effective, high quality orthopaedic care to improve experience of patients and clinical outcomes in NW London?

3.3.1 In general, the panel considered that the proposed clinical model had the potential to deliver safe, effective, and high-quality orthopaedic care; the proposals are consistent with best practice which has been implemented locally, nationally, and internationally. Further detail is needed to ensure that the proposal can actualise this potential and to fully evaluate whether the intended quality improvements are likely to be met.

3.3.2 Progress regarding modelling assumptions was more evident in the presentation to the panel than the PCBC which they reviewed. A section on activity modelling in the NWL presentation articulated:

- *"Historic inpatient and day care activity from all north west London elective orthopaedic providers (excluding spinal surgery, ASA 3, 4, 5s and Revisions) in north west London was used as a basis for the demand model.*
- *Activity data from 2021 and 2022 were not considered due to COVID-19 pandemic effects. Considering that in 2019 waiting lists in north west London had been relatively stable, this activity was used as a proxy for demand.*
- *Demand was forecast to 2030 utilising 2019 data adjusted for patient demographic-specific population change as per 2020 GLA Housing Led Population Growth Projections.*
- *Impact of other demand-influencing factors – such as the changes in BMI, local orthopaedic demand influencing initiatives and changes in utilisation of the private*

sector – were considered non-trivial to model and thus not included in demand forecasts.

- *Demand converted into theatre requirements based on 49 surgery weeks per year:*
  - *10 planned surgical sessions per 4 hour theatre list per week for weekdays*
  - *2 planned surgical sessions per 4 hour theatre list at weekends (Saturday only, 60% of theatres).*
- *Inpatient: 2 cases per 4-hour list*
- *Day case:*
  - *Y1 - 4 cases per 4-hour list*
  - *Y2 onwards - 5 cases per 4-hour list*
- *Using expert opinion, length of stay was set to Model Hospital top decile (average 2.3 days LOS) and bed utilisation was set to 90%.*
- *The number of theatres required has been rounded up to the nearest 0.5 of a theatre. Sensitivity analysis has been completed to test the robustness of the number of cases per session."* (Presentation, p26)

3.3.3 The review panel considered that it is important for NWL to now develop a fuller benchmark/ baseline with clear denominator and numerator on areas such as reduction of waiting times, revision rates, length of stay, readmissions, infection rates and litigation. They recommend that this work continues with input from stakeholders, both for clarity within the business case as well as the effective development and monitoring of operational plans. This will enable the fullest response to implementing mitigating actions against known risks. For example, the review panel identified that the modelling assumptions of 12.5 x 4-hour sessions per theatre weekly and productivity of 2 x inpatient cases/list was ambitious and could only be realised through the planned staffing levels being achieved and realising efficiencies.

3.4 Is the model integrated into the wider musculoskeletal (MSK) pathway to ensure patients can access the right care at the right time?

3.4.1 The review panel were advised that NWL envisage the service as part of wider developments to the MSK pathway:

"The MSK pathway is under development and due to be reprocured. The development of the EOC is a key element of NWL's plans to align and standardise the whole MSK pathway and the EOC proposal is an advance project of a wider programme of MSK improvements." (PCBC, 3.2, p35)

And that

"One of North West London ICS's priorities is to strengthen out-of-hospital care and it has developed borough based health and care partnerships with integrated leadership. These borough teams are using population health data to target care where it is needed most. They are aiming to ensure consistent, high-quality, integrated care across north west London, placing more focus on prevention, management of long-term conditions and improved access and outcomes for people with mental health needs, learning disabilities and autism." (Presentation, Integration with MSK across NWL, p21)

The review panel welcomed this whole system approach, noting that pathways must start in primary care with effective and standardised entry points to reduce inequality. They observed that as the EOC activity will focus primarily on American Society of Anesthesiology (ASA) patient categories 1-2. The more specialist provision such as that offered by the Royal

National Orthopaedic will not be central to this work. The panel welcomed the focus on local integration with primary care and local authorities.

3.4.2 Detailed work to develop and demonstrate the whole pathway is now required. As noted against KLOE 2, engagement with Primary Care should be further developed. Similarly, engagement with Local Authorities operational teams will be critical regarding discharge pathways. The panel observed that to date Local Authority interactions have been focussed on Health Overview and Scrutiny Committees and Joint Overview and Scrutiny Committees. Detail on post-operative re admission rates and transfers will also be important; the panel were advised that these pathways are in place and therefore they would benefit from further articulation in the case for change.

3.4.3 As the pathway work is more fully developed and refined, the panel considered quality indicators should be incorporated, as they are currently light. This will integrate with the discussion against KLOE 3 regarding clear benchmarking and outcome data.

3.4.4 The panel are aware that there is a clear ambition to reduce inequalities and an overarching plan to address this:

"capacity created in other north west London 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" (Presentation, Executive Summary, p2).

Detailed modelling and mapping will be essential to provide assurance that an overall reduction in waiting list numbers and times is not at the detriment of patients with greater orthopaedic, general health, or care needs. Demonstrating a comprehensive understanding of the complexity of patient tracking list management and providing a focus on swifter treatment for patients with the greatest need has the potential to positively reduce inequalities in care and outcomes. The panel wish to see plans to this effect demonstrated clearly in future work.

3.5 Will there be any adverse impact or unintended consequences on areas with key dependencies?

Consider the financial modelling in relation to the clinical services. What are the plans for stranded costs and risk share, to ensure that unintended consequences to other services are avoided?

3.5.1 The panel noted that the scope of the proposals excluded paediatric, trauma and spinal surgery, which are covered by networked approaches to care. Surgery for patients with greater complexity and co morbidities, is planned to be co located with a full range of services on the sites e.g., intensive care and critical care. The panel did not note any issues regarding care groups for elderly care, plastics, vascular and neurology as orthopaedic services will still be present on the acute hospitals and thus continue to contribute to such pathways as appropriate (e.g., Fracture Neck of Femur)

3.5.2 An important benefit of a senate review is the perspective of a multi-disciplinary panel of experts across health and social care to highlight any potential unintended consequences of a proposed service improvement.

The key areas where the panel felt there was potential for unintended consequences were health inequalities and workforce. These issues are noted below, explained more fully under KLOEs 4 and 6, and feature in the recommendations:

- Health inequalities. In developing an EOC there is inadvertent risk to waiting times, care, and outcomes for patients with greater complexity (see KLOE 4). Ensuring effective access to "waiting well" and pre-assessment will be important, as will a full Equality Impact Assessment with associated timed action plan.
- Workforce. There is a risk that staff working primarily at the EOC become de-skilled and that sites across the pathway that attract outer rather than inner London weighting (which supports the financial business case) may be more challenging to staff.

The panel also noted an issue of stranded costs, which they considered to be best addressed through financial assessment in the NHSE assurance process.

3.6 Do workforce plans ensure patients can access the right treatment at the right time?

3.6.1 Workforce challenges across the NHS continue to grow and are as applicable to NWL as they are elsewhere.

The overall view of the panel was that the plans were more likely to encourage rather than discourage recruitment. They noted that the model offers opportunities for improved training and that British Orthopaedic Association (BOA), and British Orthopaedic Trainee Association (BOTA) are on record to supporting the proposal.

3.6.2 However, there may remain very significant workforce challenges including:

- Recruiting sufficient operating department practitioners
- Recruiting and retaining unqualified staff, as many will progress to qualifications leading to high turnover
- Therapy recruitment pipeline especially for Occupational Therapists
- Pressures on anaesthesia workforce which risks lists being cancelled
- Orthopaedics being the highest risk speciality for trainees to progress

Many of these are acknowledged by NWL:

"The biggest gaps in the existing workforce are for qualified (28.7 wte) and unqualified (26.8 wte) nursing, whilst other roles are known to be 'hard to fill' and so as well as exploring all conventional routes to recruitment, we will, through the NWL 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." (PCBC, 5.4, Recruitment and Retention, p65)

3.6.3 It was noted NWL have asked all trusts to complete a workforce data collection return using a consistent set of principles to identify the whole-time equivalent establishment currently required to deliver the transferring activity, as well as whole time equivalent staff in post as part of intelligence gathering to inform planning.

3.6.4 The panel strongly recommend that further work is undertaken on workforce planning to ensure education, training and sustainability and that Health Education England should be involved as a major stakeholder. There is risk that without a clear and coherent plan, the proposed benefits of the case for change will not be realised. This was acknowledged by NWL who will seek to take on board this feedback.

3.6.5 Finally, the review panel noted that as well as the workforce plan addressing risk, there was real potential to promote the opportunities afforded by the model e.g.

- The model can provide experience as well as competence for trainees, with the potential for individuals to grow in interest and confidence in the speciality.
- Experience in NCL was that the trainees loved the model, it provided a fantastic educational tool, and they appreciate the opportunity to continue training throughout the Covid pandemic.

3.7 Will plans for digital innovation facilitate seamless care across organisation boundaries?

3.7.1 The review panel considered that digital innovation to facilitate an effective patient pathway and care across boundaries was critical. This should include waiting well and pre-assessment and follow up. Opportunities for sharing information will be crucial to standardising the pathways over the whole Integrated Care System.

3.7.2 The panel noted that NWL is working effectively in this area, and it will be important that the capacity and capability is optimised. Important and promising work is underway, and it was positive to see digital capability included as part of the selection criteria for the preferred site.

3.7.3 During the presentation, NWL showed a clear direction of travel for digital:

"To optimise effective delivery of the elective orthopaedic centre as a system hub, a single method for sharing information across the patient pathway to improve patient flow and utilisation of capacity at all stages of the pathway is required. The opportunities provided by the Care Co-ordination Solution (CCS) currently being deployed across acute providers can support the management of the patient pathway, including the safe transfer of care to a surgical hub (i.e. elective orthopaedic centre). The CCS solution is PAS/EPR agnostic and provides a shared space within North West London ICS that can be accessible based on 'purposes' or 'role based' access. There are also developments within North West London ICS to leverage the same technology and provide a consistent reporting solution across the sector covering financial and operational performance, quality of care and workforce. There is an opportunity within the elective orthopaedic centre to pilot the CCS and quantify benefits.

Cerner development of a North West London ICS level facility is under review, this could support elective orthopaedic centre as an ICS proof-of-concept for transferring the management of the patients care within the facility, with full transparency of the clinical record for patients on Cerner. Though Cerner is currently built at a Trust level, remote monitoring has already been set up at an ICS level. This could provide benefits to the elective orthopaedic centre once Cerner is available at the proposed location and would future proof for other ICS ways of working.

These are part of the North West London Digital Roadmap implementation." (Presentation, Digital, p31)

The panel support the direction of travel and encourage NWL to work hard to operationalise the potential to maximise the effectiveness of the service and pathway for patients.

3.8 Does the approach demonstrate the future demand is adequately addressed and sustainable services developed?

3.8.1 An elective orthopaedic surgery model was supported by the senate review panel as being an appropriate service configuration going forwards. This offers the advantage of providing ringfenced surgery which can continue when pressures on the wider NHS might otherwise adversely impact it, for example, EOCs enabled elective surgery to continue through the Covid pandemic.

3.8.2 However, learning from elsewhere in London is that the numbers of ASA1 and 2 cases can be relatively small. The panel discussed that South West London Elective Orthopaedic Centre (SWLEOC) is on its 4th or 5th operational model since implementation. This underpins that a good understanding of data and modelling at development and an agile approach to implementation is critical to ensure that the service model effectively meets needs and is sustainable. The panel noted and supported the flexible approach planned by NWL.

3.8.3 Further detail of this modelling, as referenced elsewhere, would enable the senate to provide a more specific assessment of sustainability. However, the panel did note the proposed level of theatre utilisation was higher than the current best utilisation in the sector. Thus, it is important to ensure that plans are realistic as well as ambitious and an achievable implementation plan should be developed.

3.8.4 Regarding environmental sustainability, the panel particularly encourage NWL to explore the use of electric vehicles and fleet between sites. They also recommend seeking input and feedback from Greener NHS Integrated Care System teams to ensure that best practice is optimised, and due consideration is given to all aspects of environmental sustainability.

4) Recommendations

The specific recommendations emerging from the review panel's deliberation of the key lines of enquiry are detailed below.

4.1 General

In general, the case for change is clear and the evidence for the changes improving outcomes including patient experience and efficiency is good. This is supported by these changes now taking place across London and nationally.

The senate review panel were aware that they considered a draft Pre-Consultation Business Case and recognise that there will be further engagement. As this is iterated, the panel recommends:

- Ensuring that the document is clear to non-specialists, patients and public e.g., inclusion of definitions or glossary for key terms such as High Volume, Low Complexity.
- Referencing the specific evidence base for the models e.g., the specific *Getting it Right First Time* (GIRFT) recommendations.
- Measuring inputs and benefits on the components of the whole pathway and their effectiveness. This granularity will be important as NWL develop the service and review whether anticipated improvements have been delivered.
- Quantifying assertions e.g., what is the current cancellation rate for surgery and what is the ambition for reduction? How will the model improve care to those from deprived backgrounds?
- Including case descriptions of the patient journey to articulate the model and changes, such as before and after examples.
- Providing detail on the roles of stakeholders represented in the site based steering group.

4.2 Specific recommendations

4.2.1 Continue developing commitment to the Business Case across all organisations to ensure that when implementation challenges occur these can be managed collaboratively. It is important that clinicians embrace and promote the new pathways with patients to ensure optimal use and benefits.

4.2.2 Provide clearer detail on how these changes fit into an overall plan for Trauma and Orthopaedics in NWL to allow a better view of the resilience of the entire system. This could include: the capacity at the base hospitals for day cases; paediatrics; patients with a higher risk American Society of Anesthesiology (ASA) score and link to the overall elective recovery programme with digital waiting lists.

4.2.3 Undertake further work to standardise the Musculoskeletal pathways across the ICS, including "waiting well" and pre-assessment. This will be important from an equality perspective.

4.2.4 Include the pathways for managing unexpected deterioration on the elective orthopaedic site in the consultation business case. These will need to be tested for the higher volumes that may be required with the introduction of the Elective Orthopaedic Centre. For example, this would include a plan for emergency vascular surgery for the rare arterial injuries that can complicate routine surgery.

4.2.5 Describe more fully potential infection prevention and control improvements.

4.2.6 Consider if plans for extending treatment to some patients in ASA3 level would be viable and how that might take place safely.

4.2.7 Develop and implement plans to track and monitor patient outcomes across the whole pathway including patients not treated at the centre. Actively respond where necessary as the changes take place.

4.2.8 There is a risk that the PTL might be adversely impacted for patients with greater complexity. To ensure resilience: identify risk and have plans to actively mitigate the potential adverse impact on outcomes, waiting times, variation between sites etc. This may include ring fencing beds, theatre space etc. for ASA 3-5 cases to be seen in acute hospitals throughout the year.

4.2.9 Ensure that the post implementation evaluation framework/ key performance indicators include specific reference to inequalities and that these refer to the drivers for change. This should be in addition to the Getting it Right First Time, Length of Stay and Patient Recorded Outcomes Measures.

4.2.10 Provide further detail on the number of theatres and theatre efficiency plans including long days and weekend working. This is particularly important given that the current utilisation modelling exceeds the current best utilisation rate in the sector.

4.2.11 The current plan is that day cases undertaken at the new centre are from the “local” population only (i.e., those close to the Elective Orthopaedic Centre). Day cases can add to efficiency of capacity as “fillers” in operating lists. To facilitate this, expanding the “local” population definition may need to be considered.

4.2.12 Consider planning if the numbers of lower risk procedures decrease given:

a) patient behaviour with some seeking operations via independent sector
b) deterioration of those patients remaining on the waiting list reducing numbers of ASA 1&2 patients who can be treated at the Elective Orthopaedic Centre

4.2.13 Health Education England trainers and trainees should be involved to ensure education and training is central to plans and that these deliver improved training as

well as improved services. There should be focus on opportunities to develop competencies for trainees.

4.2.14 While the review panel felt the plans were more likely to encourage rather than discourage recruitment, there should be exploration of opportunities for different ways of working particularly where there are national and regional initiatives.

4.2.15 Consider staff rotation. The panel heard little about rotating staff to ensure that they would not solely focus on ASA1 and 2 categories of patients and risk becoming deskilled. There was mention of staff passports and further description on how this would work in practice would be helpful.

4.2.16 The Elective Orthopaedic Centre site attracts outer London weighting. Some staff currently receive inner London weighting. This is presented as a potential for cost savings; it should be considered and discussed further with staff groups as there may be implications for workforce flexibility.

4.2.17 Financial evaluation will review and assure regarding the potential for stranded costs. However, mitigations for any potential stranded services from workforce challenges should be also described.

4.2.18 Include further details on digital plans, including apps described in the model patient pathways, to support patients through the whole pathway and mitigations for potential digital exclusion.

4.2.19 Continue work to assure interoperability of information systems is in place to support the whole patient pathway.

4.2.20 Provide more detail on environmental sustainability plans and opportunities including how the whole pathway can be made more sustainable by reducing overall transport burden e.g., through standardised local pathways for preassessment and follow up plus use of electric vehicles etc.

4.2.21 It is noted that a full inequalities impact assessment is still in progress. As this is developed:

a) Integrate the Equalities Impact Assessment into the document going forward, providing a clear response to issues raised through this and stakeholder engagement.
b) Ensure that there is parity of service improvement for all patients and that any risks to achieving this are mitigated during and after consultation. For example, more

complex patients in ASA grades 3-5 could be disadvantaged if pressures on local hospitals disrupt elective activity, and other populations with lower ASA grades may have to travel further.

c) Consider how the economically deprived populations, which are associated with more complex co-morbidities and social care needs may indirectly benefit from the changes as they may not always receive direct benefit from the Elective Orthopaedic Centre.
d) Describe how the proposed model can improve access to care for patients who could not be treated at Elective Orthopaedic Centre. For example, those with multiple complexities and co morbidities, adults with vulnerabilities and where there may be safeguarding concerns.

5) Conclusion

The London Clinical Senate review panel supports the proposals for a North West London Elective Orthopaedic Centre on the Central Middlesex site. This is based on reviewing the documentation and presentations made to the review team. There is a clearly articulated case for change and a background evidence base which supports the quality and outcome improvements anticipated by the changes.

The review team have made recommendations which may further enhance the proposals. These are intended to strengthen the proposals and promote the improvement of the whole pathway in all patient groups (not just those directly affected by the proposals).

Tracking outcomes and measuring the improvement of all patient groups is strongly recommended going forward with specific attention to inequalities.

Finally, we note implementation from go ahead to steady state is anticipated within 1 year. The panel considered that a key risk. Experience from panel members indicates that it can take up to 2 years to implement such changes fully. Sharing experience from colleagues who have implemented similar changes recently may might help mitigate this risk.

6) Glossary

ACP	Acute Provider Collaborative
BOA	British Orthopaedic Association
BOTA	British Orthopaedic Trainee Association
ASA	American Society of Anesthesiology
EOC	Elective Orthopaedic Centre
EPR	Electronic Patient Record
GIRFT	Getting it Right First Time
HEE	Health Education England
ICB	Integrated Care Board
KLOE	Key Lines of Enquiry
MSK	Musculo Skeletal
NWL	North West London
PCBC	Pre Consultation Business Case
T&O	Trauma and Orthopaedics
PAS	Patient Administration Systems
SWLEOC	South West London Elective Orthopaedic Centre

Appendix A- Terms of Reference

London Clinical Senate

INDEPENDENT CLINICAL REVIEW: TERMS OF REFERENCE

Title: Advice on proposals for adult elective orthopaedic services reconfiguration in North West London: case for change, clinical models and the development of potential solutions

Sponsoring Organisation: North West London ICB and NWL Acute Provider Collaborative

Clinical Senate: London Clinical Senate

NHS England regional or team: NHS England and NHS Improvement (London)

Terms of reference agreed by:

Dr Mike Gill, Chair, London Clinical Senate Council

on behalf of the London Clinical Senate and

Dr Roger Chinn, Chelsea and Westminster Foundation Trust Chief Medical Officer and NWL Acute Provider Collaborative Chief Medical Officer lead.

on behalf of North West London ICB, which included Chelsea and Westminster Foundation Trust, Imperial Healthcare NHS Trust, The Hillingdon Hospitals Foundation Trust and London North West University Healthcare NHS Trust.

Date: 22nd September 2022

1. **Aims of the review and advice requested**

North West London ICS have asked the London Clinical Senate to provide independent advice on proposals to reconfigure adult elective orthopaedic services in North West London (NWL). The proposals set out to transform elective services across the NWL ICS footprint.

Currently elective orthopaedic surgery is delivered at separate NWL NHS and independent sector sites. While many of the services are of good quality, there is unwarranted variation in the quality of care provided and the reconfiguration proposals aim to provide improvements in care, better patient experience and efficiency benefits through ring-fencing orthopaedic services on a smaller number of sites with co-located support services, in fit-for-purpose buildings.

The London Clinical Senate has been asked to provide advice in a formal review of the pre-consultation business case (PCBC) (stage 2 review). The panel will review the draft PCBC in advance of its submission to NHSE and NHSI in accordance with the major service change assurance processes. The review will be inclusive of all clinically related elements, which would include but not be limited to shortlisted service configuration solutions and clinical models.

2. Scope of the review

Planning, assuring and delivering service change for patients (NHS England, November 2015) requires NHS England to be assured that any proposal for major service change or reconfiguration satisfies four tests set by the Government in 2010:

Strong public and patient engagement

Consistency with current and prospective need for patient choice

Clear, clinical evidence base

Support for proposals from commissioners

The Clinical Senate's advice focuses mainly but not exclusively on the third test. In 2017 the NHS Chief Executive introduced a 5th new patient care test for hospital bed closures, which if relevant will also be reviewed clinically.

The timing of the review of the PCBC is critical; the review will be undertaken by considering a draft of the PCBC as opposed to the final document submitted for NHSE and NHSI assurance. Focus will be predominantly on the clinical elements. This planned approach will enable North West London ICS to make best use of Clinical Senate advice and recommendations, revising and integrating them where appropriate into the final version of the PCBC, prior to the assurance process.

The Clinical Senate Council has also agreed a set of principles which it believes are essential to improving quality of care and outcomes. The Council seeks evidence of, and promotes, these principles in the issues it considers and the advice that it provides. The issues are:

Promoting **integrated working across health and across health and social care** and ensure a seamless patient journey

Being **patient-centred and co-designed** (this includes patient experience, patient involvement in development and design of services)

Reducing **inequalities** (this involves understanding and tackling inequalities in access, health outcomes and service experience, between people who share a protected characteristic and those who do not and being responsive to the diversity within London's population. It includes all inequalities e.g. between people who share a protected characteristic and those who do not, as well inequalities that may arise from geography and deprivation.

Demonstrating **parity of esteem between mental and physical health** for people of all ages

Supporting **self-care** and **health and wellbeing**

Improving **standards and outcomes** (these include use of evidence and research, application of national guidance, best practice and innovation)

Ensuring **value** this includes issues such as affordability, cost effectiveness and efficiency, long term sustainability, implications for service users and the workforce and consideration of unintended consequences.

Demonstrate how **environmental sustainability and moves to carbon neutral** are included in plans and developments. This includes reference to the National ambition to reach carbon Net zero by 2040 and the London Health Board to ensure that every Londoner breathes safe air.

3. Review Panel

The Chair of the London Clinical Senate Council (Dr Mike Gill) will co-chair the review, potentially with another council member.

Membership of the review panel will reflect a multi-professional panel with expertise in the services and pathways being considered. Subject to agreement with the Chair, membership will include expertise independent of North West London that are unrelated to the changes proposed. Advice on membership will be sought from the London Clinical Senate Council and Forum members with relevant expertise, and professional bodies as necessary.

The review panel will seek advice from other independent experts on specific issues if indicated. The review panel will not include anyone who has been involved in the development of the proposals being considered or associated with the bodies.

All review panel members will be required to formally declare any interests (which will be noted in the review report) and sign a confidentiality agreement.

4. Method

In determining the review approach and formulating advice the Clinical Senate Council and Review Panel will draw on the following, which includes guidance on testing an evidence base:

Clinical Senate Review Process: Guidance Notes, NHS England, August 2014

NHS England's Service Change Toolkit

Planning, assuring and delivering service change for patients, NHS England, March 2018

The review is expected to involve the following steps:

Step 1: **Establish the review panel**

Step 2: **Brief the review panel** and circulate key documentation for desk-top assessment (the proposed schedule of documentation is on page 4)

Step 3: Hold a **review panel meeting/teleconference** to:

- agree the overall methodology that will be applied to formulate the advice
- share desk-top assessment findings
- identify issues that need to be explored, clarified or validated to assist in formulating the advice
- agree any further information/documentation that the review panel members agree to be required to inform the review

Step 4: Hold an expert **review panel** to undertake the following:

- Meet and discuss the proposals/solutions with stakeholders (commissioners and providers) involved in their development to explore key lines of enquiry
- Provide an opportunity for stakeholders impacted by the proposals to share views with the review panel
- Debate findings within the review panel and finalise conclusions
- Identify any outstanding issues and agree the process for following-up (and further review panel discussion as agreed necessary)

Step 5: **Prepare a report** setting out overall findings, conclusions, advice and any recommendations; this will be circulated to the review panel.

Hold a meeting/teleconference with the review panel to discuss the draft report content and agree any amendments.

Step 6: Once agreed by the review panel**, share the report with the Clinical Senate Council** who will:

Ensure the terms of reference have been met

Comment on any specific issues where identified by the review panel

Agree that the report can be issued

Subject to the schedule of Council meetings the Senate Council Chair may undertake this on the Council's behalf.

Step 7: **Issue the report and advice**.

5. Documentation required

In formulating advice the review panel will review documentation that has both informed and been developed by commissioners and the providers. North West London ICS will make relevant documentation available to the review panel. Where possible relevant sections/pages of documents should be highlighted where the whole document does not apply to the proposals or context of a Clinical Senate review.

The documentation that will inform this review is anticipated as follows. Excluding those marked with an asterisk*, documents will be provided by North West London ICS. Further requirements may be confirmed following establishment of the review panel.

- The draft Pre-Consultation Business Case (PCBC)
- The Case for Change (rationale for the proposed change and evidence base)
- Proposed clinical models (description, rationale and evidence base)
- Supporting activity and workforce data and modelling, patient flows and pathways, patient transport, performance against key quality indicators benchmarking data/patient experience data – available information should be provided initially and any further specific requests will be discussed
- Relevant CQC inspection and GIRFT reports
- Schedule of evidence and best practice that have informed the proposals
- Equality impact assessment
- NWL ICB plans if available
- Relevant Trust Clinical Strategies
- Process used to develop the proposals including staff, service user and public involvement

- Summary of outcomes of patient and public engagement
- Summary of outcomes of stakeholder engagement, including neighbouring trusts and services
- Programme risk log

The review panel will formulate the advice requested based on consideration and triangulation of the documentation provided, discussion with key stakeholders and panel members' knowledge and experience. The advice will be provided as a written report.

6. Risks

It is essential that the processes through which the Clinical Senate formulates advice are robust and the approach outlined is designed to do this. Recruiting the appropriately experienced review panel members who are available on the key dates set for the review and ensuring adequate time to prepare for key activities are the most critical elements and pose the greatest risk. Every effort will be made to mitigate this risk.

7. Reporting arrangements

The review panel will report to the Clinical Senate Council who will agree the report and be accountable for the advice contained in the final report.

The Clinical Senate Council will submit the report to the sponsoring organisation and this advice will be considered as part of the NHS England assurance process for service change proposals.

8. Report

A final draft report setting out the advice will be shared with the sponsoring organisation to provide an opportunity for checking factual accuracies prior to completion. Comments/corrections must be received within 5 working days.

9. Communication and media handling

North West London ICS (and partner bodies) will be responsible for publication and dissemination of the report. The expectation is that it will be made publicly available as soon as possible following completion. The Clinical Senate will post the report on their website at a time agreed with the sponsoring organisation.

Communication about the clinical review and all media enquiries will be dealt with by the sponsoring organisation.

If helpful, the Clinical Senate will support the sponsoring organisation in presenting the review's findings and explaining the rationale for the advice provided e.g. at a key stakeholder meeting subject to discussion and availability of review panel members.

<u>Disclosure under the Freedom of Information Act 2000</u>

The London Clinical Senate is hosted by NHS England and NHS Improvement and operates under its policies, procedures and legislative framework as a public authority. All the written material held by the Clinical Senate, including any correspondence sent to us, may be considered for release following a request to us under the Freedom of Information Act 2000 unless the information is exempt.

10. Resources

The Clinical Senate will recruit review panel members and cover members' reasonable expenses. It will also provide management support to the review panel, including coordinating all communication relating to the review, documentation sharing, meeting organisation and report production.

The sponsoring organisation will identify a named contact to coordinate the provision of documentation and any other information requested and to assist in coordinating stakeholders' participation in the review at a local level. The sponsoring organisation will also organise accommodation for meetings and the review panel day.

If during the course of the review the review panel identifies any additional requirements to formulate the advice requested, the review Chair or Clinical Senate Senior Project Manager will, if necessary, discuss these with the sponsoring organisation and may seek resources for this.

11. Accountability and Governance

The review panel is part of the London Clinical Senate accountability and governance structure.

The Clinical Senate is a non-statutory advisory body and will submit the review report and its advice on the proposals to the sponsoring organisation. The sponsoring organisation remains accountable for decision making. The review report may draw attention to specific issues, including any risks, which the Clinical Senate believes the sponsoring organisation should consider or address.

If the Clinical Senate identifies any significant concerns through its work which indicate risk to patients it will raise these immediately with relevant senior staff in the organisation(s) involved. Please note that depending on the nature of the issues identified the Clinical Senate Council may be obliged to raise these with the relevant regulatory body(ies). Should this situation occur, the Clinical Senate Council Chair will advise the Chief Executives, Clinical Leads and Chief Officers of the provider and commissioning organisations involved.

12. Functions, responsibilities and roles

The **sponsoring organisation** will:

- Provide the review panel with the case for change, draft PCBC, options/solutions appraisal and relevant background and current information, identifying relevant best practice and guidance and other documentation requested. Background information may include, among other things, relevant data and activity, internal and external reviews and audits, impact assessments, relevant workforce information and population projections, evidence of alignment with national, regional and local strategies and guidance (e.g., NHS Constitution and outcomes framework, Joint Strategic Needs Assessments, Sustainability and Transformation Plan, CCG delivery plans and commissioning intentions). Information requested for this review is detailed on page 4. Additional requests may be made as the review progresses.
- Respond within the agreed timescale to the draft report on matters of factual inaccuracy.
- Undertake not to attempt to unduly influence any members of the review panel during the review.
- Submit the final report to NHS England for inclusion in its formal service change assurance process.

The **London Clinical Senate Council and the sponsoring organisation** will:

- Agree the terms of reference for the clinical review, including scope, timelines, methodology and reporting arrangements.

The **London Clinical Senate Council** will**:**

- Appoint a review panel which may be formed of members of the Senate, external experts, and/or others with relevant expertise.
- Endorse the terms of reference, timetable and methodology for the review.
- Consider the review recommendations and report (and may wish to make further recommendations).
- Provide suitable support to the review panel.
- Submit the final report to the sponsoring organisation.

The **review panel** will:

- Undertake its review in line with the methodology agreed in the terms of reference.
- Submit the draft report to the London Clinical Senate Council for comment, consider any such comments made and incorporate relevant amendments into the report. Review panel members will subsequently submit a final draft of the report to the London Clinical Senate Council.
- Keep accurate notes of meetings.

The **review panel members** will undertake to:

- Commit fully to the review and attend/join all briefings, meetings, interviews, panels etc. that are part of the review (as defined in the methodology).
- Contribute fully to the process and review report.
- Ensure that the report accurately represents the consensus of opinion of the review panel.
- Comply with the confidentiality agreement and not discuss the scope of the review nor the content of the draft or final report with anyone not immediately involved in it.
- Declare to the review panel Chair any conflict of interest prior to the start of the review and/or any that materialise during the review.

13. Contact details of key personnel coordinating the review process

For the London Clinical Senate:

Emily Webster, London Clinical Senate Senior Programme Manager emilywebster@nhs.net

For North West London Partners

Victoria Medhurst, Assistant Director, Surgical Hubs Victoria.Medhurst@nhs.net

Appendix B- Membership of London Clinical Senate Council and North West London presentation Panel

London Clinical Senate Review Panel

Name, Job title and Biography	Register of Interests
Dr Michael Gill (Panel Chair) ***Chair, London Clinical Senate, Consultant Physician (Care of Elderly and General Medicine)*** ***Non -Executive Director Homerton University Hospital NHS Foundation Trust*** Dr Mike Gill is an experienced senior Medical Leader. He has been practicing as a Consultant Physician (Care of Elderly and General Medicine) since 1989. He is a Non-Executive Director at Homerton University Hospital NHS Foundation Trust and subject matter expert for a Health Education England Frailty Clinical Fellow Programme. Mike has many years of board level experience as a Medical Director. Most recently he was *Medical Director at Health 1000: The Wellness Practice*, a new type of GP surgery which looked after patients with multiple medical conditions in their own homes. Prior to this he had been a Medical Director for over 12 years at Newham University Hospital NHS Trust, Barking, Havering and Redbridge University Hospitals NHS Trust, Associate Medical Director at Barts Health and Interim Medical Director at the Homerton University Hospital Foundation Trust. He was also a member of NICE Acute Medical Emergencies Guideline Committee and an elected fellow on the Council of the Royal College of Physicians 2014-17. Other roles Mike has undertaken include Joint Clinical Director for the Health for North East London programme and Honorary Clinical Director for Elderly Care at NHS London.	No conflicts declared
Mr Dimpu Bhagawati (Review Subject Matter Expert) ***Clinical Lead for Spinal Surgery, Consultant Orthopaedic & Spinal Surgeon, Bedfordshire Hospitals NHS Foundation Trust.*** Mr Dimpu Bhagwati works at Bedfordshire hospitals NHS Foundation trust, and is a local lead for the North West Thames Regional Spinal Network.	No conflicts declared. Interests noted: Private practice Sits on the HCA spinal Council (unpaid) Director of Blue Riband Reporting Limited. Further information supplied and available on request.

Lucy Brett, (**London Clinical Senate Patient Public Voice Representative)** **Deputy Chair, London Clinical Senate Patient and Public Voice Group** Lucy is an author, editor and communications and engagement professional with a background in journalism, production and media regulation, and a clear commitment to raising the concerns and voices of underrepresented groups. Her writing (as Luce Brett) has appeared in print and online including in The Guardian, The New York Times, Huff Post, The Sun, The Daily Mail and she has spoken about women's health, birth injury and taboo health conditions on national radio and many international podcasts. As an advocate for patient inclusion in healthcare Lucy is also a Patient Insight Partner for Versus Arthritis and a member of the charity's Research Advisory Group for Rare Diseases, helping bring patient concerns into the heart of research strategy. She has a keen interest in taboo conditions, speaking widely on incontinence including at IUGA and on behalf of the World Federation of Incontinence and Patients, contributing to NICE guidelines, judging the 2021 BMJ awards category for Women's Health as a patient experience advisor, writing for the BMJ and Patient Safety Learnings, and working via the senate with London Maternity Services on online patient information.	No Conflicts declared Interests noted: Patient at UCLH, Whittington and North Middlesex. On the research Advisory Group for inflammatory arthritis and rare diseases at Verus Arthritis, which is dormant. Not currently on reviews.
Adrian Capp, (**London Clinical Senate Council Member)** ***Head of Therapy, The National Hospital for Neurology & Neurosurgery, University College London Hospitals NHS Foundation Trust.*** Adrian qualified as a physiotherapist from Pinderfields College of Physiotherapy in 1994 following which he worked in the North West of England and then in New Zealand. He joined UCLH in 2001 as a senior physiotherapist in neurosurgery followed by a range of clinical and senior health management roles. In 2005 he graduated with a MSc in Adult Critical Care from Imperial College London. Adrian was involved in the implementation of the London Stroke Strategy and has been a member of both the London Strategic Clinical Network for Stroke and the NHSE Specialist Commissioning Clinical Reference Group for Specialist Rehabilitation. Recently Adrian has been involved in the implementation of an electronic health record system to support transformational care provision and has an interest in digital health, technology, and informatics to improve care delivery both within organisations and across healthcare systems. As an active supporter of the allied health professional agenda Adrian is keen to raise the profile of how allied health professionals can transform the delivery of care within the NHS and to challenge traditional ways of working and historical boundaries.	No conflicts declared

Miss Lila Dinner, **(Review Subject Matter Expert)** ***Consultant Anaesthetist, National Hospital for Neurology and Neurosurgery, University College London Hospitals.*** ***Regional Clinical Director Anaesthetics, London Elective Surgery Recovery and Transformation Programme.*** ***Deputy Chief Executive, Chief Medical Officer, Responsible Officer and CCIO, Royal National Orthopaedic Hospital NHS Trust.***	No conflicts declared Interests noted: Responsible Officer Appraiser, NHS England – paid Consultant Anaesthetist, Royal Free London 2001 – 2019 Divisional Director for Surgery and Associated Services, Royal Free London 2017-2019 (Chair of Clinical Pathways Group, Surgery; RFL SRO for NCL Elective Orthopaedic Centre submission) Anaesthetics Training Programme Director, HEE 2005-2017 Lead Regional Adviser, Royal College of Anaesthetists 2015-2017
Dr Deepak Hora, (London Clinical Senate Council Member) ***GP, NHS North Central London ICS Acute Commissioning and Outpatient Transformation lead, Camden Primary Care Development lead, Camden and Islington borough Named GP Adult Safeguarding.*** Dr Dee Hora brings extensive experience in clinical leadership, commissioning, and large-scale service re-design, and is currently involved in a number of transformation projects across North Central London. Dee qualified from Imperial College in 2007 and was awarded the Fraser Rose Medal for Outstanding performance on completion of her GP training in 2012. During her GP training, she was involved in a multi-agency project to improve access to health services and health education/advocacy for homeless adolescents in Camden and Islington. In response to the Government's Troubled Families Agenda, Dee provided clinical leadership to Camden council around service delivery for complex, vulnerable families with a high burden of mental health, substance misuse, domestic abuse and social care needs. This led to re-design of existing Children and family services, strengthening communication and engagement with Primary care, and facilitating the introduction of Early Help services into Secondary care settings as part of a clinical innovation project. As Clinical Lead for Domestic abuse, she has delivered training to health practitioners to increase recognition of victim survivors and introduced an advocacy support service in Primary care, Secondary	No conflicts declared Interests noted: Camden CCG Clinical Lead Planned Care and Adult Safeguarding Named GP North Central London Clinical Lead Planned Care Medigold Health GP – clinical work Haverstock healthcare adhoc clinical work North West London Individual Funding request panel member – ad hoc Camden Clinical Assessment service GP assessor Clinical Lead for Pathfinder Domestic Abuse Project with Camden and Islington Domestic Abuse Services GP ad hoc work Clinical lead work

Care and Mental health services in Camden and Islington which has significantly improved outcomes for victim survivors. She has contributed her health expertise to the All Party Parliamentary Group for Domestic Violence and Abuse. Dee is passionate and motivated to improve services and reduce inequality for vulnerable patients through her role as Named GP for Adult Safeguarding (Camden and Islington).	
Diane Jones, (London Clinical Senate Council Member) ***Chief Nursing Officer, NHS North East London, Part of North East London Health and Care Partnership.*** Diane started her career as a student Nurse in the NHS in 1992, she is currently the Chief Nursing Officer for NHS North East London Integrated Care Board. Diane has worked as a Nurse and Midwife across London and continues to maintain clinical practice. Prior to her current role, Diane has been a Consultant Midwife before transition to a Director of Midwifery post prior to senior commissioning roles. Diane is a non executive Director / Trustee of Group B Strep Support (GBSS) charity. Diane is a system leader and senior responsible officer for a number of programmes across North East London Integrated health and care partnership/system. She has significant experience in safeguarding, transformation, governance, and risk management. Whilst Diane's expertise lies within midwifery, she is also passionate about quality improvement, workforce race equity and population wellbeing across all health and care services. Diane has previously been a Care Quality Commission (CQC) specialist advisor for governance, Maternity and Safeguarding. Her strength is leading teams and coaching others to realise their potential.	No conflicts declared. Interests noted: Chief Nursing Officer: NHS North East London Integrated Care Board (NEL ICB) Paid Non Executive / Trustee: Group B Step Support (GBSS) Charity. Unpaid Nursing & Midwifery Council (NMC) registrant part 1 and 2 Honorary contract as a Midwife with Homerton Healthcare Trust and Barts Health
Dr Michael Holland, (London Clinical Senate Council Member) *(stepped down from council Nov 22)* ***Medical Director South London and Maudsley NHS Foundation Trust (at the time of the review)*** Dr Michael Holland took up post as Chief Executive of the Tavistock and Portman NHS Foundation Trusts in November 22. Dr Michael Holland is currently Executive Medical Director at South London and Maudsley NHS Foundation Trust and works as a Liaison Psychiatrist at Guy's hospital. He is also Co-Clinical Director for London Mental Health network, a visiting senior fellow at London School of Economics and Executive Fellow at King's Business School. He has been a Non-Executive Director at Recovery Focus. He was previously Deputy Medical Director and Chief Clinical Information Officer and led the implementation of Revalidation within the organisation. Prior to this he was a Fellow at the NHS Institute for Innovation and Improvement where he worked on the development of resources for the use of SBARD within Mental Health and helped to set up and deliver Leading Improvement in Patient safety for Mental Health services within the UK. He has also worked as an Improvement	No conflicts declared. Interests noted (at the time of the review): South London and Maudsley NHS Foundation Trust London School of Economics Medical Director at SLaM NHS FT Senior Fellow at London School Economics – teach on MSc and work on consulting assignments with LSE.

Advisor to the Improvement programmes delivered in NHS South West and NHS South. He became a Rehabilitation Consultant in 2003 at South London and Maudsley NHS Trust, having finished his SpR training within the Trust. He had previously completed his SHO training on the St George's rotation.	
Richard Leigh, (London Clinical Senate Council Member) ***Consultant Podiatrist, Royal Free London NHS Foundation Trust, Council Member, The Royal College of Podiatry*** Richard Leigh is Consultant Podiatrist at the Royal Free Hospital. He is visiting Professor to PSMU. He specialises in acute foot care, especially conditions related to diabetes, vascular pathology and neurological problems and continues to research and publish in these and other lower limb related fields. Richard is a Director and Council Member of the Royal College of Podiatry. He is chair of the English Diabetes Footcare Network and also chairs the Diabetes and At Risk Foot Expert Reference Group for London and the South East. He is clinical lead for NHSE (London) and co-chairs the London Foot Care Network and the Work-stream for NHSE (London).	No conflicts declared Interests noted: Consultant Podiatrist Royal Free London NHS Foundation Trust. (unpaid) Chair of the English Diabetes Footcare Network. (unpaid) Chair South East and London Diabetes and At Risk Foot Expert Reference Group for the Royal College of Podiatry. (unpaid) Co-Chair NHS England (London) SCLG Diabetic Foot Subgroup. (unpaid) Clinical Lead for NHS London Diabetes Footcare Group (1 PA per week). Member Health Education England HNCEL representing podiatry education for London (unpaid) Member Royal College of Podiatry Professoriate Group (unpaid) Small amount of private practice in podiatry (The London Clinic – paid). (Further information supplied and available on request.)
Prof. Geeta Menon (London Clinical Senate Council Member) ***Postgraduate Dean, South London Health Education England.***	No conflicts declared Interests noted:

Professor Geeta Menon is a Consultant Ophthalmic Surgeon at Frimley Health NHS Foundation Trust in Surrey. In addition to high-volume cataract surgery, she has developed a major interest in medical retina, including research particularly novel treatments for age-related macular degeneration. She is the Postgraduate Dean for Health Education England across South London since April 2018. She is the Lead Dean for Cancer and Diagnostics. She is the Clinical Director for NIHR Clinical Research Network in Kent, Surrey and Sussex. She won the coveted RCP-NIHR award of Excellence for research leadership in the NHS in 2017. She is involved in the VISION 2020 links programme and set up Diabetic Retinopathy Screening in Zambia. She has extended this programme to St Lucia and Northern India. She won the 'Excellence in Patient Care Award' hosted by the Royal College of Physicians (RCP) for outstanding clinical activity that contributes to excellent patient care overseas.	Postgraduate Dean Health Education England across South London Consultant Ophthalmic Surgeon at Frimley Health NHS Foundation Trust – Paid Clinical Director for Kent Surrey and Sussex Clinical Research Network - Paid
Mr Sam Oussedik, (Review Subject Matter Expert) ***Clinical Lead for Trauma and Orthopaedics University College London Hospitals NHS Foundation Trust.*** Sam Oussedik is a Consultant Orthopaedic Surgeon and Clinical Lead for Trauma & Orthopaedics at University College London Hospitals NHS Trust. He represented UCLH through the advisory process leading to the opening of the dedicated Elective Orthopaedic Centre at Grafton Way. Through his role as Director of Surgical Education at UCLH, Sam has also led the provision of HEE funded simulation courses for Orthopaedic trainees across London. He has published on the response to Covid and the problems facing the recovery of Elective services	No conflicts declared Interests noted: Paid consultant to Stryker Editorial Board Member the Bone & Joint Journal Paid clinical governance lead for the Lister Hospital, Chelsea.
Dr David Parkins (London Clinical Senate Council Member.) ***London Clinical Senate Council Member. Optometrist and Chair of the London Eye Health Network NHS, England (London)*** Dr David Parkins is Chair of the London Eye Health Network (NHS England) and a registrant member of the General Optical Council (UK regulator for optical professions). David was President of the College of Optometrists (2014-2016) and Chair of the Clinical Council of Eye Health Commissioning (2015-2017, Vice-Chair 2017-2021). As Chair of a Professional Executive Committee of a Primary Care Trust, and Assistant Director of Quality in a Clinical Commissioning Group, he has had extensive experience in commissioning, patient safety, and quality assurance. His research interests include service improvement and redesign, and unwarranted variation in clinical decision making and its impact on outcomes.	No conflicts declared Interests noted: Eye Health Network Chair (paid). Registrant Council Member General Optical Council. UK regulator (paid)

Mr Zameer Shah (Review Subject Matter Expert) ***Consultant Orthopaedic & Trauma Surgeon Kings Health Partners. Clinical Lead for Orthopaedics, Guy's & St. Thomas' Hospitals, Kings Health Partners***	No conflicts declared Consultant Orthopaedic Surgeon GSTT NHS Trust Clinical Lead for Orthopaedics
Peter West (London Clinical Senate Patient Public Voice Representative) ***Chair, London Clinical Senate Patient and Public Voice Group*** Peter West is a retired health economist and health researcher who spent his career working with and for the NHS and health sector manufacturers on a wide range of planning and cost-effectiveness studies. He has carried out studies of health care across the UK, the Republic of Ireland, Australia and a number of developing countries. He is the author of three books on health economics and the NHS and co-authored a report on the NHS reforms, the "purchaser-provider split", in 2008. He has worked for a wide range of NHS bodies, the NHS regulator (the predecessor of the Care Quality Commission) and the King's Fund. Peter has experience on the Board of an NHS Hospital Trust and an NHS Community and Mental Health Trust from different times in his career. He is currently a trustee of Princess Alice Hopsice, Esher, a provider of inpatient and community end-of-life care and support.	No conflicts declared
Gladys Xavier (London Clinical Senate Council Member- contributed electronically) ***Director of Public Health and Commissioning, London Borough of Redbridge*** Gladys joined London Borough of Redbridge in 2014 as the Director of Public Health and Commissioning. She is responsible for public health and social care commissioning and the provision of a wide range of services to improve and protect the health and wellbeing of the residents. Prior to this she worked as the Deputy Director of Public Health in the NHS. She began her career in the NHS as a registered nurse and went on to work in different specialities including Haematology, Gynaecology and Coronary Care. She was appointed as the first nurse consultant in public health for London and worked for the Health Protection Agency. She is registered as a Generalist Specialist in the UK Public Health Register (UKPHR) and is a Faculty of Public Health approved education supervisor for public health and GP registrars.	No conflicts declared

Non-Panel Members present

Name and Job title	Role
Gillian Foreshew, Business Support Coordinator, London Clinical Network and Clinical Senate, NHS England – London	Minutes
Maisie Nair Business Support Assistant for Clinical Networks, Medical Directorate, NHS England – London	IT and Logistics
Dr Bhavi Trivedi Deputy Director, London Clinical Networks and London Clinical Senate, NHS England- London	Observer
Emily Webster Senior Programme Manager, London Clinical Senate	Report production

Presentation panel from North West London

Name	Job title
Roger Chinn (Chair)	Chelsea and Westminster Foundation Trust Chief Medical Officer and NWL Acute Provider Collaborative Chief Medical Officer lead
Martina Dinneen	Programme Director, Elective Orthopaedic Centre
Dinesh Nathwani	Consultant Knee Surgeon and Hon Senior Clinical Lecturer, Imperial College Healthcare NHS Trust; NWL CRG Sector Lead for Trauma & Orthopaedics; NWL Co-Chair of MSK Clinical Network
Raymond Anakwe	Consultant Hand, Wrist and Elbow Surgeon, Medical Director, Imperial College Healthcare NHS Trust
Charlie Sheldon	Chief Nurse, North West London Integrated Commissioning Board
Imran Sajid	GP and Musculoskeletal Clinical lead

Appendix C- Papers shared with the London Clinical Senate Review Panel

Papers shared with the London Clinical Senate and viewed by the review panel prior to the pre meet are listed below, providing the file name of the document:

Pre-Consultation Business Case: 220909 Draft for distribution NWL ortho PCBC v.0.6 v2.docx (Referred to as Pre Consultation Business Case or PCBC in the report body)

Template for requesting advice from the London Clinical Senate VM edit

PCBC Appendices

Appendix 1_ GIRFT slide deck plus case studies June 22

Appendix 2_EOC Sensitivity Model v6.0

Appendix3_EHIA EOC LNWH Format 20220517v10 inc action detail 20220906

Appendix 4_Quality Impact Assessment

Appendix 5_EOC Travel Analysis v1.5

Appendix 6_Nov2021 service option workshop

Appendix 7_THH Estates_Strategy_Feb 2022

Appendix 8_Verve public engagement analysis

Appendix 9_ Public Engagement log

Appendix 10_Stakeholder Engagement log

Appendix 11_Consultation Plan

Appendix 12_ EOC Consultation Document Draft

Appendix 13_Risk Register PCBC NWL EOC Final Draft

Appendix 14_Orthopaedic Hub Financial Appendices

Appendix 15_ Value for Money Model -LNWH (R1K) EOC TIF bid 22-23 FINAL Updates for 30 Yr Projection

Appendix 16_DPIA- S2209021155- Elective Orthopaedic Centre 6 Sept 22

Papers shared with the review panel the day prior to the review and/ or presented at the review are listed by their file name below:

- LCS presentation v4 (Referred to as Presentation in the report body)
- NW_London_Integrated_Care_System_presentation_slides
- 1912 STP clinical strategy (NWL)
- 2022 03 31 NW London- System Development Plan (Draft) v1.6

Appendix D- Key Lines of Enquiry

London Clinical Senate

London Clinical Senate Council Review: Advice on proposals for adult elective orthopaedic services reconfiguration in North West London: case for change, clinical models and the development of potential solutions

Clinical Senate Key Lines of Enquiry v0.2

Key Line of Enquiry	Areas to question or explore
1) Does the clinical case for change clearly articulate the rationale and provide enough evidence that the change is justified in terms of efficacy, patient experience and inequalities?	1. Is the case for change clearly articulated and current challenges and shortcomings are demonstrated with relevant data? 2. What is the driving the change? (clinical safety, quality, standards, workforce, royal college guideline) 3. What evidence is this based on? (demographic, population change) 4. Have public and patient been listened to and responded to? 5. Explore numbers and projection modelling and basis for growth estimation. 6. Explore how the case for change considers and improves inequalities.
2) Has there been sufficient engagement with Stakeholders?	What has been the engagement and input from: 1. Public and patients 2. Providers 3. Workforce 4. Commissioners 5. Primary Care?
3) Will the proposed clinical model deliver safe, effective, high quality orthopaedic care to improve experience of patients and clinical outcomes in N W London?	1. Will the intended quality indicators be achieved by the proposed clinical model? i.e. Waiting times, Revision rates, Length of stay, Readmissions, Infection rates, Litigation. 2. Exploration of modelling, specialisation, skills and competencies, co dependencies, casemix and threshold, patient flows, capacity. 3. Exploration of general direction- reducing the need for outpatient appointments and increasing surgical capacity. Diagnostic services, conversion rates from outpatient appointment to intervention, outpatient activity.

4) Is the model integrated into the wider musculoskeletal (MSK) pathway to ensure patients can access the right care at the right time?	1. How does the proposed model sit with the wider MSK pathway? 2. Do other providers like the Royal National Orthopaedic Hospital/ Stanmore fit in the pathway? 3. Consider primary and secondary care pathways and if required post-operative readmissions and transfer from elective to Intensive Care Unit. 4. What engagement and planning has taken place with the Local authority regarding the discharge pathway 5. What are the plans for quality indicators? 6. Consider complex orthopaedics and patients with complex needs.
5) Will there be any adverse impact or unintended consequences on areas with key dependencies?	1. Explore regarding: • Critical care • Trauma • Paediatric orthopaedic services • Spinal surgery • Elderly care • Plastics • Vascular • Neurology • Intensive care 2. Consider the financial modelling in relation to the clinical services. What are the plans for stranded costs and risk share, to ensure that unintended consequences to other services are avoided?
ENABLERS **6) Do workforce plans ensure patients can access the right treatment at the right time?**	1. Is there a coherent and realistic workforce strategy that addressed the role of all health professionals- nursing, AHPs 2. Are the workforce plans sustainable? 3. How can negative impact/ distortion of other workforce areas be avoided? 4. Are the education and training plans appropriate?
7) Will plans for digital innovation facilitate seamless care across organisation boundaries?	
SUSTAINABILITY **8) Does the approach demonstrate the future demand is adequately addressed and sustainable services developed?**	

Appendix E- Review Panel Agenda

London Clinical Senate Council Review: Advice on proposals for adult elective orthopaedic services reconfiguration in North West London: case for change, clinical models and the development of potential solutions			NHS London Clinical Senate	
Date: Tuesday 27th September 2022			**Time:** 5:25-7:00pm	
	Time	**Description**	**Papers**	**Lead**
1.	5.20-5.25pm	Review panel convene		Mike Gill, Chair of London Clinical Senate
2.	5.25-5.30pm	Review panel pre-meet • Welcome to senate council and subject matter expert panel • Key task/advice requested • Timeline and key activities • Conflicts of interest declaration and confidentiality agreement • Notes	• Terms of Reference • Request for Advice • Key Lines of Enquiry • Confidentiality and Register of Interest	Mike Gill, Chair of London Clinical Senate
3.	5.30-5.50pm *(NWL join meeting)*	Presentation: North West London Adult Elective Orthopaedic Services Review	**Presentation** to be given on the day	Roger Chinn, CWFT Chief Medical Officer and NWL APC CMO lead. NWL Acute Provider Collaborative With colleagues
4.	5.50-6.10pm	Questions and discussion with North West London representatives	All documentation including PCBC and appendices	Mike Gill, Chair of London Clinical Senate
5.	6.10-6.55pm *(NWL leave meeting)*	Panel discussion and deliberation	All documentation-including PCBC and appendices	Mike Gill, Chair of London Clinical Senate
6.	6.55-7.00pm	Wrap up and next steps • Written report and advice-accuracy and timeline • NHSE Stage 2 assurance checkpoint		Mike Gill, Chair of London Clinical Senate