Report March 2023

Assessment of North West London's proposed elective orthopaedic care centre against all six of the Mayor's Tests

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Summary of proposal

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

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

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

1 https://gettingitrightfirsttime.co.uk/

2 North West London Joint Health Overview & Scrutiny Committee meeting pack, 7 December 2022: shorturl.at/wGPQ3

Context

As of September 2022, the total NWL elective orthopaedic waiting list stood at just over 15,000 patients. The PCBC estimates that of these, just under 2,500 were waiting for elective orthopaedic surgeries that are within the scope of the proposed changes. At present, average waiting times from the decision to admit for surgery for elective orthopaedic patients at NWL hospitals ranges between 11 and 19 weeks for day case surgeries and 14 to 35 weeks for inpatient surgeries.

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

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

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

In January 2023, The Nuffield Trust assessed the proposals – as set out in the PCBC – against the first four of the Mayor's 'six tests' for major service reconfigurations. That analysis was used by the Mayor to inform his response to the PCBC, which was broadly positive but sought some changes and clarifications, particularly with respect to healthcare inequalities and staffing.

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

In March, following the publication of the Consultation Report[4] and the availability of the London Clinical Senate's review of the proposals, we completed tests five and six. On March 15 the final pre-publication version of the Decision-Making Business Case (DMBC) was made available to the GLA and Nuffield Trust in order to review changes made since the PCBC and in light of the Mayor's earlier response, as well as the public consultation and input from the Clinical Senate.

This final report from The Nuffield Trust supplements the original report on the first four tests with tests five and six and adds further commentary (in red) indicating where NWL NHS has changed its plans since the PCBC or has otherwise responded to issues raised during the consultation period.

4 Available at: https://www.nwl-acute-provider-collaborative.nhs.uk/-/media/website/nwl-acute-provider-collaborative/documents/nwl-eoc-consultation/nwl-elective-surgery-consultation-report-final.pdf?rev=d3dc29180fd34296a03afeb94b2c24ac

Test 1: Health inequalities and prevention of ill health

Background	Commentary
Supplementary questions 1&2, do proposals: 1. *Set out the health inequalities issues in their local population?* 2. *Consider their impact on health inequalities in a systematic, documented way?*	The PCBC appears to frame the proposed changes and the associated improvements in in-scope elective orthopaedic surgery as necessarily falling under the national "CORE20PLUS5" policy to focus on the "most deprived 20%" of the population, as it presents statistics showing disproportionate take up of such surgery in the most deprived group. By implication, this group would also be the main beneficiaries of improvements (including shorter waiting times and improved clinical outcomes) resulting from the reconfiguration.
The PCBC sets out the population health challenges for NWL and describes musculoskeletal (MSK) disorders as one of the most common comorbidities amongst the most deprived quintile of the population, as defined by the national Index of Multiple Deprivation (IMD 2019) although this is not quantified or explored in any detail. The PCBC further notes the recent NHS England CORE20plus5 framework, which identifies the most deprived quintile as "the key target cohort for health interventions".	
The PCBC then goes on to state that in 2021, patients from "the most deprived quintile of the North West London population"[5] made up 37 percent of NWL patients undergoing orthopaedic procedures (and 39 per cent in 2019).	The statistics presented require some clarification. The 37-39% figure is derived from an analysis using Carstairs deprivation scores which are reliant on data from the 2011 census and are considered to be poorly suited to London as they use the lack of car ownership, and only male (rather than male and female) unemployment as markers of relative deprivation.[6] Indeed, based on 2019 population estimates, approximately 38% of the NWL population resides in neighbourhoods which the Carstairs measure would categorise as within the "most deprived 20% of England" – roughly proportionate to elective orthopaedic hospital episodes involving patients from the same neighbourhoods.[7] This provides an indication of the lack of suitability of the Carstairs measure to London and further suggests that elective orthopaedic activity in NWL is not disproportionately focused on the poorest fifth of the population, but is merely in line with a crude measure of population share.
Additional analysis presented in the PCBC further claims that while only around 2% of the NWL population live in neighbourhoods falling within the 10% most deprived nationally (under the Index of Multiple Deprivation) patients living in these neighbourhoods account for 6% of elective orthopaedic activity.	

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

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

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

Background	Commentary
	As with the Carstairs analysis, the IMD analysis presented in the PCBC suggests a significant "pro-deprivation" skew in elective orthopaedic activity in NWL, which would be remarkable if correct, as nationally, patients living in the most deprived deciles are underrepresented in elective hospital admissions in general, and in particular for elective orthopaedic admissions[8]. However, The Nuffield Trust has been unable to replicate the findings by national IMD decile reported in the PCBC. Instead, The Nuffield's Trust analysis of elective orthopaedic activity involving patients resident in NWL postcode areas in 2019 and 2021 suggests activity rates were broadly in-line with crude population shares, with some indication of higher than expected activity rates for patients living in areas that fall within the two least deprived deciles nationally – which increased further in 2021 – and lower than expected rates in decile 4 (which falls within the second most deprived quintile nationally).[9]

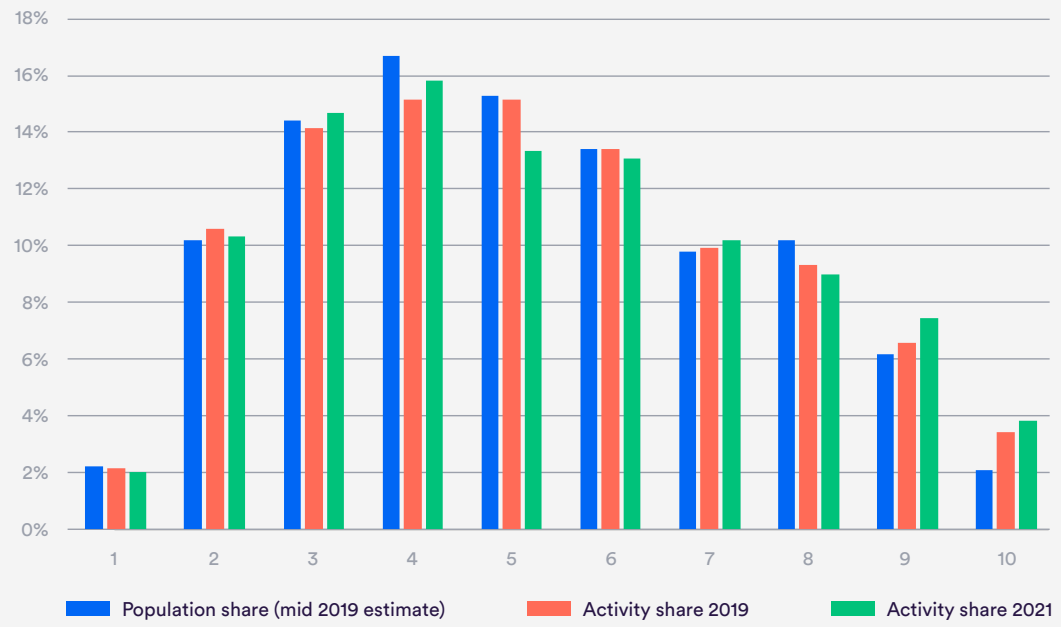
8 For national figures on admitted patient care, see https://digital.nhs.uk/data-and-information/publications/statistical/hospital-admitted-patient-care-activity. Elective orthopaedic specific rates for England were explored in unpublished background analysis by the Nuffield Trust and are indicative.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

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

Background

Commentary

Figure 1: Proportion of elective trauma & orthopaedic spells in NWL, 2019 and 2021, by national IMD decile and population share (1 = most deprived)

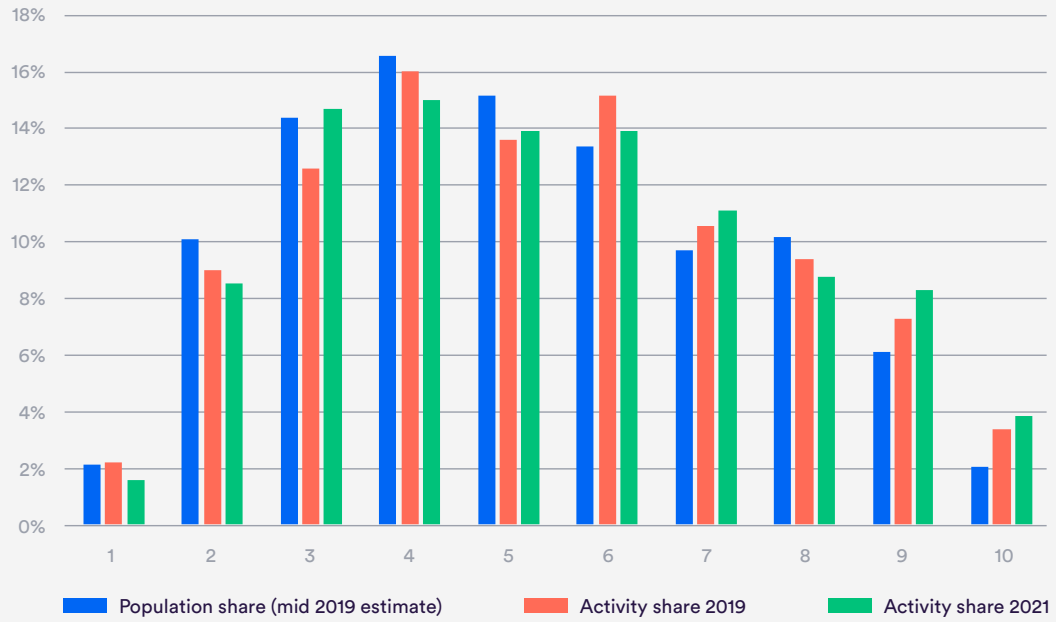


Source: Hospital Episode Statistics; ONS mid-year population estimates for 2019; IMD 2019. Nuffield Trust analysis using elective spells for admitted patient care where treatment specialty is "110" (trauma & orthopaedics). IMD 2019 scores are at LSOA level for patient residence and activity is NWL commissioner-based (ie excludes patients treated in NWL hospitals but commissioned by non-NWL NHS commissioners). Population estimates for 2021 are not yet available at LSOA level. However there were only very minimal changes in national IMD decile population share between 2019 and 2020.

Background	Commentary

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

Figure 2: Proportion of elective hip and knee procedures in NWL in 2019 and 2021 by national IMD decile and population share (1 = most deprived)

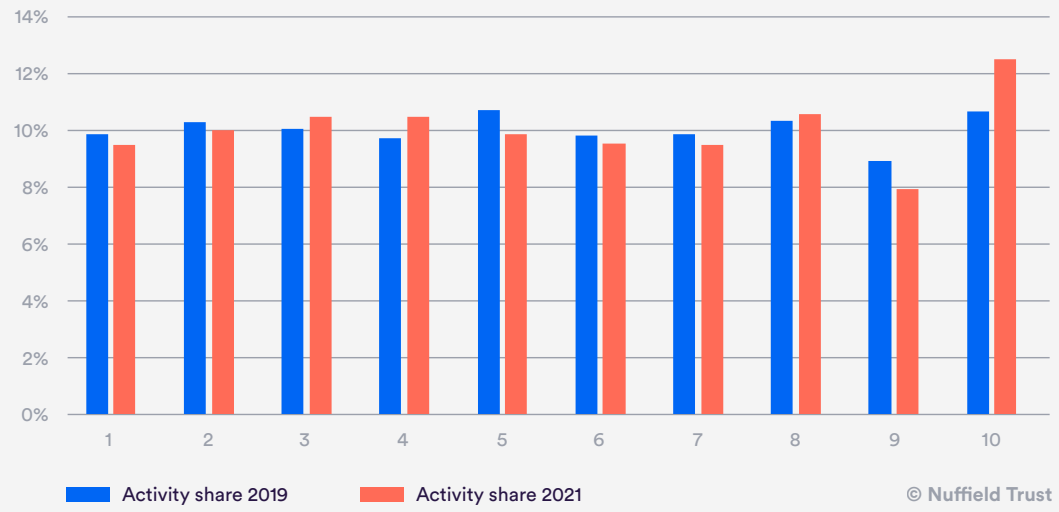


Source: Hospital Episode Statistics; ONS mid-year population estimates for 2019; IMD 2019. Nuffield Trust analysis using elective episodes for admitted patient care, with a procedure code W37 through to W42, which span hip and knee replacements including revisions. Hospital Episode Statistics data (years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

Background	Commentary
	This analysis of crude activity rates is only indicative. A thorough analysis of potential inequalities in elective orthopaedic activity rates would need to account for the different age structures of each population decile (with the least deprived deciles having a higher proportion of over 65 year olds, for example, but also longer healthy life expectancies); higher levels of private healthcare use in the least deprived deciles; and significantly higher rates of clinical risk factors relevant to the need for elective orthopaedic surgery– including higher rates of obesity – in the more deprived deciles.[10] There is a tendency in the PCBC to refer to "the most deprived 20% of the NWL population" when actually what is being presented is the much smaller proportion of the NWL population that falls within the 20% most deprived neighbourhoods in England as a whole, which in NWL comprises just 12% of the population, when assessed against the IMD for 2019. While the CORE20PLUS5 policy instructs health systems to pay particular attention to the most deprived 20% nationally, a systematic exploration of health inequalities at an ICS level would also require an interrogation of healthcare access and outcomes relative to local social inequalities, in order to ascertain if a social gradient is present in healthcare. By way of illustration, the below presents NWL commissioned elective trauma and orthopaedic episodes by patient IMD scores, which have been ranked into deciles relative to NWL, rather than England as a whole. In this presentation, the expected share of activity for each group – all other factors being equal – would be 10%, if activity was in line with population share.

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

Figure 3: Trauma and orthoapedic elective episodes in NWL 2019 and 2021, by NWL-specific IMD deciles (1 = most deprived)



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

Background	Commentary
	This analysis of crude activity rates suggests that the share of elective T&O activity consumed by patients living in the poorest 10% of NWL fell between 2019 and 2021 while the share consumed by the least deprived 10% in particular grew. This crude data would again need adjusting to take account of different age and underlying needs within each population decile before a fuller understanding of any inequities could be ascertained. The indicative nature of these crude activity rates notwithstanding, they do cast significant doubt on the claim in the PCBC that elective orthopaedic surgery in NWL is currently skewed towards the most deprived population group and the implication that benefits stemming from the proposals will similarly accrue disproportionately to that group. At best, the crude activity rates suggest activity shares are only broadly in line with population share. Given the higher MSK disease burden the PCBC highlights as present in the most deprived groups, it may be that an activity rate only proportionate to population share in those groups is indicative of unmet need. There is therefore a risk that the choice of deprivation indicator and analytical approach used in the PCBC has distorted both an understanding of current inequalities in access to elective orthopaedic surgery in NWL as well as of the likely distribution of benefits resulting from the proposed changes, which are intended to both reduce waiting times and improve clinical outcomes (for example through reduced surgical infections – a key benefit stemming from the separation of emergency and elective surgery). This potential distortion is a concern because it may mean opportunities to address existing inequities and to ensure a fairer distribution of benefits from the proposals (or from parallel initiatives) have not been fully explored. As the burden of MSK disease is disproportionately experienced in more deprived groups, changes to the MSK pathway that disproportionately benefit better off groups will, without mitigating action elsewhere, increase inequalities, including against the Mayor's key measure of Healthy Life Expectancy.[11]

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

Background	Commentary
	The Decision Making Business Case sets out a revised inequalities impact assessment, which rightly dispenses with the Carstairs analysis queried above, and uses a method to assess elective orthopaedic activity rates in each of the national IMD deciles along similar (although not identical) lines to the method used by The Nuffield Trust. This method concludes that although activity rates are marginally higher in the most deprived deciles, this is not statistically significant. This brings NWL's understanding of the likelihood of under-utilisation of elective orthopaedic care among more deprived groups – as well as minoritised ethnic groups – close to our own understanding, particularly when coupled with analysis of a higher level of MSK disease in these groups. An allied concern is that the proposed NWL EOC is conceived as a "high volume low complexity" hub which will not be co-located with emergency care facilities. As such, the PCBC is clear that patients with multiple comorbidities – particularly those with conditions that are poorly managed – and/or have ASA scores[12] of 3 or above – will be ineligible for treatment at the proposed EOC. A recent retrospective analysis of high volume low complexity (HVLC) surgical hubs in London found that before the pandemic, approximately 25% of elective orthopaedic patients were classified as ASA 3 or 4– indicating a level of complexity which would currently exclude patients from the scope of the proposed EOC at Central Middlesex[13]. By the time of the analysis (completed in 2021) the proportion had increased to around 35% although it is not yet known if this increase is temporary and due to patients being deconditioned through long waits, or if the marked increase is likely to be sustained, as part of a demographic shift. In either event, the proportion of patients ineligible for treatment at the EOC is likely to be substantial and more needs to be known about these patients, their relevant characteristics (including, but not limited to those protected under the 2010 Equality Act) their needs and the likely outcomes they can expect from their elective surgeries in NWL, including waiting times.

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

13 "Equality and Health Inequalities Impact Assessment: High volume low complexity surgical hubs – Orthopaedics" – Health Innovation Network South London and Imperial College Health Partners, Dec 2021

Background	Commentary
Supplementary questions 3&4, do proposals: *3. Ensure that services do not become less accessible to vulnerable groups?* *4. Ensure that unwarranted variations in outcomes do not worsen?* The proposed EOC will be for "high volume, low complexity" cases	As the incidence of multi-comorbidities increases significantly with deprivation (and also with old age)[14] it would be reasonable to expect that, all other factors being equal, the cohort of patients eligible to be treated at the EOC would likely be less deprived than those deemed ineligible. While the PCBC does acknowledge that patients ineligible for treatment at the EOC will be less likely to benefit directly from reduced waiting times, it claims they would still experience "equal" clinical outcomes compared to patients treated in EOCs. As the chief clinical benefit to treatment in a ring-fenced EOC is lower rates of complications such as surgical site infections due to the separation of elective and emergency care[15], it is unclear how this benefit will be secured by elective patients who continue to be treated in non-ringfenced theatres and wards. It is relevant to note in this regard that while South West London's EOC is widely regarded as a successful "high volume low complexity hub", the aforementioned 2021 retrospective equity analysis found that in the first three months of 2021, South West London patients falling into the poorest national IMD quintile made up just 4% of elective orthopaedic patients treated in the area (with no patients coming from the poorest 10%). While it is not clear what population denominators are relevant to this unpublished study,[16] this is likely to represent a significantly lower than expected share of activity relevant to population size. More analysis is needed to establish the impact of HVLC hubs on equitable access to care, including the impact on patients with more complex needs who do not qualify for treatment in these centres. It is important to stress that an unequal distribution of the direct benefits resulting from the proposals are not in themselves a reason to reject or devalue them. However, where implicit trade-offs have been made between different patient and demographic groups (as well as between competing NHS priorities, such as health equity, waiting times, and limited resources) it would be useful to set these out, as doing so can help inform discussions and investment decisions about other related services, where there may be an opportunity to address or mitigate the imbalance in benefits and outcomes.

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

15 https://gettingitrightfirsttime.co.uk/surgical_specialties/orthopaedic-surgery/

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

Background	Commentary
	The DMBC has provided useful clarification on the benefits expected for the wider cohort of patients beyond those eligible for treatment at the EOC. These entail a broad benefit from the efficiencies gained through the consolidation of low complexity orthopaedic surgery, as well as a more specific benefit through the freeing up of resources at "home" hospitals as staff and theatre time is shared between fewer patients. The realisation of this benefit may have implications for the overall financial savings projected, and so we address it in our supplementary comments in test three. The DMBC also includes a table of KPIs that will be used to track benefits realisation as the EOC is implemented. This includes two KPIs to reduce waiting times and waiting list size for the Low Volume High Complexity patient cohort (cared for by the wider Acute Provider Collaborative) by similar proportions to the expected benefits for patients in the High Volume Low Complexity cohort (treated in the EOC). This is positive. However at present, while there are care quality KPIs (for example 30 day readmission rates, PROMS scores and revision rates) for patients treated in the EOC, there do not appear to be mirroring quality KPIs for the non-EOC cohort. In order to help ensure the benefits of the EOC are shared more widely and transparently, it would be useful if the Final Business Case included quality KPIs for the high complexity cohort of patients also.
The PCBC flags risks to the stability of urgent and emergency care services at surrounding hospitals.	A risk that is particularly pertinent to the trade-offs entailed in competing NHS priorities and pressures is noted throughout the PCBC as the risk to urgent and emergency care services at "referring" hospitals, if staffing arrangements at the EOC lead to a depletion of available staff for emergency care. This is explored in more detail in the bed test below. However, as emergency care is disproportionately consumed by patients from the poorest quintile (while elective care is under-consumed by the same group) this operational and resource risk also poses a risk to healthcare equity. Nationally, in 2019, 24.4% of all emergency admissions were of patients living in the poorest quintile of the population, whereas only 16.1% were of patients living in the least deprived quintile. The DMBC includes KPIs to track staff turnover and vacancy rates. However these appear to apply only to the EOC and so do not address concerns that recruitment (or transfer) to the EOC may be at the cost of staffing levels elsewhere in NWL. We discuss this further in Test two.
Travel The PCBC assesses whether or not situating the proposed EOC at CMH might exacerbate healthcare access inequalities by making travel times for	While travel times under the preferred location (CMH) will be shortest for the poorest neighbourhoods, these are defined in the travel analysis within the PCBC as the "CORE20" group, which comprise (under IMD 2019) 12% of the NWL population. It is not clear what the impact will be on relative deprivation

Background	Commentary
patients deemed particularly vulnerable to healthcare inequalities longer than the general population. The analysis shows that the CMH location will offer the shortest median travel time by car and the second shortest median travel time by public transport for all NWL residents, although all residents will need to travel through the ULEZ to access the site, incurring a charge if their vehicle is non-compliant. It is notable that the median travel times to CMH by both public and private transport are expected to be lowest from the poorest neighbourhoods.	beyond this group – that is, on the further 8% of the NWL population who do not live in the most deprived neighbourhoods nationally, but who, together with the "CORE20" neighbourhoods, make up the most deprived 20% of NWL neighbourhoods. It is also unclear how the assessed future travel times differ from current travel times from the highlighted neighbourhoods, which may be an important factor to consider alongside an analysis of any current inequalities in elective orthopaedic surgery, as what is relevant to obstacles to accessing care is not just how one group's travel times (and costs) might differ from another's, but perhaps more importantly, the differing abilities of different groups to absorb or tolerate travel time and costs.[17] The PCBC notes that some patients travelling by car will need to pay the ULEZ charge (if their vehicles are non-compliant) as well as substantial car parking charges. Travel cost as well as time are factors which will need to be examined in more detail through the public consultation, paying particular attention to low income groups and groups who may struggle to travel longer distances – such as disabled people, older people and those who do not speak English and so may find it harder to navigate public transport. In order to explore how travel issues affect access inequalities (including how they affect patient decisions to seek elective care) it is vital that the consultation involve people who are not currently and have never been elective orthopaedic patients, as well as those who are already on the waiting list or who are receiving care. Concerns about travel times have been flagged by local councillors. In particular, councillors sitting on Hammersmith and Fulham's Health and Adult Social Care Policy and Accountability Committee have raised concerns about transport, with some proposing that the ICS provides a dedicated transport service to alleviate potential inequalities. Councillors on the same committee have also raised concerns about the potential over-reliance of virtual clinics both in the proposed model and more generally since the Covid-19 pandemic as a potential source of inequalities and poorly coordinated care.[18]

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

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

Background	Commentary
	The DMBC reflects that NWL have taken seriously concerns raised by the Mayor, councillors and the public during consultation about travel time and cost and the impact this may have on healthcare inequalities. The DMBC includes a revised travel analysis that takes into account journey cost as well as complexity, and focuses on archetype journeys patients living over 45 minutes from CMH in a deprived neighbourhood might typically need to make. This analysis has resulted in NWL giving more recognition to the risk that long, costly and complex travel times and journeys might serve as a barrier to healthcare access for those with scarce resources and as a result has developed a three step travel solution for the EOC. This entails universal access to proactive travel option advice and assistance/facilitation (for example taxis booked, but not paid for) as steps one and two for all patients, and as step three, a free transport offer to qualifying patients. Patient qualification for free travel provision is described in the DMBC as follows: *"If, on assessment, patients can't rely on friends or family for support with getting to their appointment and they have mobility challenges or live at a distance that would require them to navigate a long, complex journey on public transport that may be costly, travel support will be booked to and from the centre at no charge."* NWL anticipate that around 30% of patients treated at the EOC will qualify for free transport – around 1,540 patients a year. It also anticipates the initiative will reduce projected savings by around £100,000, based on an average spend of £80 per patient assisted in this way.[19] This is a significant change in the original proposals and one that can be expected to both mitigate some of the risk of increased access inequalities as a result of the establishment of the EOC and also reduce existing inequalities. However, the success of the initiative in reducing access inequalities will rest on uptake of the benefit amongst the intended cohort of patients – namely those experiencing economic deprivation for whom travel costs may serve as an impediment to accessing care. For uptake to reach its intended target cohort of patients, eligibility criteria should be clear and well publicised. At present it is not clear from the DMBC if all patients facing "costly" journeys will qualify for this support (including those who may have the means to fund their own travel) or if the support is intended for use by those on low incomes/limited resources. Clarity on this point may help ensure the initiative is understood and used by the intended recipients while also ensuring costs do not escalate beyond what is needed to remove barriers to care access for deprived groups. A clearer articulation of the eligibility criteria for this support would be useful in the FBC.

19 Details provided by Carnall Farrar, March 15, 2023. The £80 per patient is based on the current costs of patient transport

Background	Commentary
	Initiatives designed to widen access to outpatient clinics are likely to help reduce healthcare inequalities, for example if they lessen inequalities driven by low-wage or insecurely employed patients finding it harder to take time of work (or caring responsibilities) to access appointments (provided they are made available alongside face-to-face appointment options for the cohort of the population that experiences difficulties using or accessing technology). However research by the Institute of Fiscal Studies suggests that significant inequalities in follow-up outpatient activity persist, even when inequalities in working-time flexibility are controlled by focusing on retired patients. In a 2020 study, the IFS found that retired patients with the highest educational attainment level attended 17% more outpatient appointments than patients with the lowest educational attainment level, after adjusting for need[20]. This suggests that nationally there is a stark social gradient in patient abilities to seek and take up outpatient care, even after the impact of loss of earnings has been removed or limited.
Supplementary question 5, do proposals set out specific, measurable goals for narrowing health inequalities and mechanisms for achieving this, for example through credible plans to make services more accessible to vulnerable groups (and/or to) reduce unwarranted variation in outcomes?	As Joint School is conceived as playing a key role in preparing patients for procedures ("pre-habilitation") this will be a key area for NWL to monitor to ensure equitable access to the entire surgical pathway. Due to the higher incidence of comorbidities in both the most deprived group as well as in the Black Caribbean group, well-resourced and readily accessible pre-habilitation care, through outpatient clinics and community services will be particularly significant to these groups, especially if they can improvement the management of comorbidities and thus lower patient ASA risk scores. More information on specific plans for this would be useful.
The revised elective orthopaedic pathway will include investment in virtual outpatient clinics including "joint school" appointments to prepare patients for surgery. To address the digital divide, outpatient appointments will also be available face-to-face at their current local hospital.	Focus groups undertaken as part of the public consultation provided some useful insight into patient and public perceptions of inequalities in elective orthopaedic surgery. This included the view that such surgery is for the "middle-class" in so far as the pathway requires patients to engage in (and have time for) exercise/physiotherapy, and a further view that the benefits of orthopaedic surgery and wider MSK pathway are poorly understood among some minoritised ethnic groups. It would be beneficial to see these issues addressed more directly in the FBC, including setting out how NWL providers will ensure Joint School and related pre- and post-operative care is, and is seen as, accessible to all members of the community, including those who do not speak English as a first language or who face other challenges in maximising their outcomes from care.

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

Background	Commentary
	One emerging form of good practice with regards to inequalities in access to outpatient appointments is the monitoring of "did not attends" by factors such as deprivation and ethnicity. This can provide insights into the accessibility of services for different groups as well as guide targeted and measurable action on addressing access inequalities.[21] KPIs included in the DMBC include monitoring of DNAs for the EOC but it is not clear if this will include a breakdown by key equity groups such as ethnic group and deprivation level. It is notable that at present, none of the KPIs proposed for the proposed scheme relates to healthcare equity. Although the DMBC makes several references to the ongoing re-procurement of the MSK pathway, and the intention to embed equity metrics within that, there are still currently no KPIs for the EOC scheme which measure or set equity ambitions. It is not clear why this is the case. The starting point to addressing this would be a more comprehensive analysis of existing rates of access to elective orthopaedic surgery, relative to need, to identify unwarranted gaps and establish appropriate means to close them and measures of progress in doing so.

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

Bed test

Background	Commentary
Supplementary question 1: Do proposals maintain/increase current bed capacity? The PCBC envisages a substantial increase in bed and theatre capacity at CMH, from 13 dedicated inpatient beds at 2019 levels to 41 by 2024. This will represent a marked increase in bed capacity available for elective orthopaedic patients in NWL, as beds at CMH will be ringfenced for this activity only, whereas current practice is for this capacity to be frequently absorbed in dealing with surges in emergency admissions, leading to elective care cancellations. Beds and theatre slots at other NWL hospitals "freed up" by the transfer of inpatient elective orthopaedic patients to CMH are expected to remain open but be made available for other forms of care (including emergency care and more complex elective orthopaedics). The productive use of these beds (and the staffing capacity which goes with them) will be a challenge and will be considered under the finance test.	While dedicated clinical capacity for dealing with elective orthopaedic activity that is in-scope (that is, surgery for patients with an ASA score at or below 2 and who do not require spinal or revision procedures) is set to increase under the proposals, there is substantial uncertainty about clinical capacity for related and co-dependent services, including trauma and paediatric care; elective orthopaedic care for out-of-scope conditions and multi-morbid patients; and also for in-scope activity that will remain at patients' "local" hospitals (for example outpatient clinics and therapists). At present, such activity makes use of beds and clinical capacity that the proposals will see strictly ringfenced and moved to CMH. This creates a risk and uncertainty for those co-dependent services and the PCBC is unclear how much clinical capacity will transfer to CMH and how much will remain and be available for continued use by the NWL healthcare system. Regardless of decisions over funding for the remaining capacity, the chief concern will be staff availability to maintain service safety and sustainability. This uncertainty is flagged at several points throughout the PCBC which notes the risk that "residual services" at Chelsea and Westminster, Imperial and Hillingdon hospitals trusts may be "denuded" of relevant staff if the establishment of the EOC was to lead to a reduction of staff available to work at these "referring" hospital trusts. The concern was also been raised by Hammersmith and Fulham councillors.[22] This risk is three-fold: 1. Recruitment into EOC posts might come at the cost of staffing levels in surrounding hospitals. The PCBC envisages that EOC recruitment will lead to additional staffing levels across NWL. However, this may prove overly optimistic for some staff groups. 2. For some staff groups at referring hospitals, there may not be sufficient elective orthopaedic patients left – or a sufficient case mix of activity left – to sustain local services and retain staff. The PCBC flags this risk in particular in relation to some allied health professional staff working with elective and emergency care patients at The Hillingdon Hospital;

22 LBHF, Health and Adult Social Care Policy and Accountability Committee Draft Minutes Wednesday 16 November 2022 http://democracy.lbhf.gov.uk/documents/g7304/Printed%20minutes%2016th-Nov-2022%2019.00%20Health%20and%20Adult%20Social%20Care%20Policy%20and%20Accountability%20Committ.pdf?T=1.

Background	Commentary
Although the proposals do not include any reduction in bed or clinical capacity over all, they will involve a substantial shift in clinical resource from "referring" hospitals to CMH, to staff the new EOC. The PCBC estimates that in total, the EOC will require a staff of 351, including 243 nurses and 53 doctors. Some of these staff will transfer permanently to the CMH from other NWL trusts while others (particularly consultants) will "follow" their patients to CMH when they receive their inpatient procedure, but will continue working also at their current hospitals (where they will treat day case patients, run outpatient clinics and work emergency care rotas). NWL is also clear that a substantial component will need to be additional staff, but flags that qualified and unqualified nursing posts are currently particularly hard to fill.	3. The provider collaborative is yet to complete its workforce modelling and baseline analysis of its current workforce establishment. This means the PCBC does not provide any detail on what proportion of time staff currently working at "referring hospitals" spend dealing with "in scope" activity that will be transferred to the EOC, and what proportion of their working time is spent on out-of-scope activity, including surges in emergency admissions. This information is vital to the safe and sustainable staffing of services – both in and out-of-scope. The PCBC states that this data collection is ongoing and will be used to monitor staffing levels at referring trusts. This is vital information that should be made transparent before any final decision is made on the proposals. Transparent metrics should also be developed so this risk can be monitored throughout any implementation of the EOC model. Until this work is completed and made transparent, it is unclear whether or not the proposals will lead to an over-all reduction in clinical capacity in NWL hospitals as there is a risk they will increase capacity for low complexity elective care at the price of reduced capacity or resilience for higher complexity care, urgent and emergency care and other related services.[23] The DMBC updates some of the assumptions made about sourcing staff for the EOC. In particularly, following the analysis of workforce data returns, the DMBC notes that the Provider Collaborative has been unable to identify a group of non-medical staff whose principal purpose is delivering the activity that will transfer to the EOC. The DMBC therefore states that at this point, there are no plans to require such staff to transfer to the EOC. Rather, such staff will be given the opportunity to apply for new roles at the EOC. The DMBC describes this change to rely on "direct recruitment" to the EOC as entailing an increase in the staffing risk for the EOC itself but a decreased staffing risk for "home" hospitals. It is useful that NWL has undertaken this analysis. However, it appears that regardless of the distribution of risk between the EOC and "home" hospitals, the intelligence that there is not a dedicated "HVLC" elective orthopaedic staff that can readily transfer to the EOC increases the overall net risk with regards to staffing levels in NWL's acute hospitals as a whole, compared to the assumptions made at the PCBC stage. This is perhaps reflected in the updated and more detailed risk register for the scheme, which now places

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

Background	Commentary
	staff shortages on the threshold of a medium and high risk to the successful implementation of the EOC, alongside a new detailed risk that the EOC itself may be heavily reliant on expensive agency staff. It is not clear why a shift from staff transfers to the EOC to recruitment to the EOC would lessen the risk of exacerbating staff shortages at "home" hospitals, as such hospitals are likely to be the source of staff recruited into the EOC. This will need further work in the FBC. While the KPIs for the scheme include monitoring staff vacancies and turnover rates, theses appear to only apply to the EOC itself, rather than assessing the impact of the EOC on recruitment and retention at home hospitals – including but not limited to staff currently engaged in elective orthopaedic care. For some staff groups – particularly consultants – staffing levels will be contingent on service ability to offer attractive job plans, including opportunities to develop through an appropriate mix of patients, and to undertake research. These issues will need to be explored further under test 5. Pay rates – in particular the difference between inner and outer London weighting - may also be a factor and this is explored in test 3 below. The proposals also flag the potential use of new clinical roles – including advanced clinical practitioners. These roles require careful planning and supervision to ensure safe practice[25] and there are currently uncertainties around the future regulatory framework for them. Successful introduction of the roles will require detailed consultation with the wider clinical team.
Supplementary question 2: Do any proposed bed closures meet at least one NHSE common sense condition The relevant NHSE test is for proposals to do one or more of the following[24]:	The PCBC does not present explicit mitigations to bed closures as its base case is that staffing levels for non-transferred services will be maintained. However a potential mitigation would be increased efficiencies for in-scope activity, which would mean that activity could be carried out with relatively lower staffing requirements than at present (or that increased activity could be achieved on relatively static staffing levels).

24 https://www.england.nhs.uk/wp-content/uploads/2018/03/planning-assuring-delivering-service-change-v6-1.pdf

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

Background	Commentary
A) Demonstrate that sufficient alternative provision, such as increased GP or community services, is being put in place alongside or ahead of bed closures, and that the new workforce will be there to deliver it; B) Show that specific new treatments or therapies, such as new anti-coagulation drugs used to treat strokes, will reduce specific categories of admissions; C) Where a hospital has been using beds less efficiently than the national average, that it has a credible plan to improve performance without affecting patient care (for example in line with the Getting it Right First Time programme).	The PCBC indicates that activity and capacity modelling has been premised on a bed occupancy rate of 90% for the EOC and the achievement of an average length of stay of 2.3 days – upper quartile performance for the NHS as a whole. At present LNW Trust (which runs CMH) appears in the second and third quartile of England-wide performance for hip and knee replacement lengths of stay, whereas NWL's overall performance is 3.7 days for knee replacements and 3.4 days for hip replacements. This suggests that the EOC will need to see a marked decrease in NWL's average length of stay if it is to meet the assumptions within the activity and capacity modelling. Performance metrics for five established EOCs in England presented in the PCBC show a range of performance on length of stay, ranging from EOCs in South West London, Royal Cornwall and Lincoln all achieving upper quartile length of stays for hips and knees, but EOCs in Gloucester and Nottingham performing at below national average. The DMBC has included a range of productivity and care quality KPIs that will track how well the EOC is able to achieve the stated ambitions and benefits. The PCBC states that activity growth assumptions have been based on the GLA's population projections to 2029. Correspondence from NWL ICS to the GLA further explains that these projections have been weighted in line with the age breakdown in NWL elective trauma and orthopaedic activity in 2019, which saw the largest shares of activity in patients aged between 55 and 79. This produces a projected increase in demand of around 19% by 2029.[26] NWL states that the proposed EOC will be able to cater for this level of demand increase in in-scope activity, with potential for activity levels to increase above this level if day case rates increase and the EOC were able to run theatres 7 days a week.[27] It is not yet clear how capacity to deal with out-of-scope demand and activity will be affected by the changes, or how the trajectory of demand for such activity might differ (or not) from the trajectory of demand for in-scope activity.

26 The PCBC uses the GLA's housing-led population projections https://data.london.gov.uk/dataset/housing-led-population-projections. The 19% weighted demand increase referenced here is based on Nuffield Trust's calculations, using age weights provided by NWL ICS and the GLA's population projections.

27 Personal communication NWL ICS to GLA, January 2023

Background	Commentary
Supplementary question 3: Does revised bed modelling take full account of the latest demographic projections? *Supplementary question 4: Have the proposals used the NHS bed capacity modelling tool?*	For context, NHS England's current target is that overall elective capacity increase to 130% of pre-pandemic levels by 2024-25 and to permanently sustain the level of emergency care capacity put in place over winter 2022/23 (the equivalent of 7,000 beds nationally).[28] By contrast, NWL's plans are for elective orthopaedic activity to increase to 110% of pre-pandemic levels by 2024 and for this to be partly achieved by strictly ringfencing clinical capacity that is currently used to deal with surges in demand for emergency care. It may be that other factors not made explicit in the PCBC mean that NWL faces a smaller challenge than the national challenge implied by NHS England. Alternatively, it may be that locally (as well as nationally) available staffing and financial resources are insufficient to meet national goals. More clarity on NWL's position on this would be useful.

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

Test 3: Financial investment and savings

Background	Commentary
Supplementary question 1: Have plans secured capital and revenue investment to deliver in full, and are the sources of funding credible? The PCBC future reports that the EOC can be established at the CMH with £9.4m in capital investment, which is fully funded in the local acute capital programme. By way of illustration of the capital cost relative to revenue returns, the PCBC anticipates annual revenue savings once the EOC is fully established in the region of £4m.	The preferred location of the EOC is Central Middlesex Hospital, which is ran by London North West University Healthcare NHS trust which includes the Brent Emergency Care and Diagnostic Centre (BECaD) which was completed in 2007 under a Private Finance Initiative scheme. Out of 10 existing NHS local sites considered for the scheme, only one other – Mount Vernon Hospital, situated on the outer northern edge of the ICS geography – fit with the clinical criteria required for the scheme; namely the ability to strictly separate elective and non elective patients. As Mount Vernon Hospital is currently unable to absorb additional patient volumes without significant disruption and investment, it was rejected as an option (the site was also viewed as posing more travel difficulties than others). By contrast, CMH has historically been underused, and despite the name, its BECaD does not undertake emergency care (with the exception of an Urgent Treatment Centre for minor injuries and illnesses) as the hospital's A&E was closed in 2014. Under the terms of the PFI contract, the Trust is currently paying in the region of £12m a year in charges, connected both to the borrowing and build costs, but also for ongoing services such as cleaning and facilities management. PFI contracts typically last in the region of 30 years and in CMH's case, charges are uplifted each year through reference to a price index linked to inflation.[29] The PCBC reports that bed occupancy at CMH is currently at only 50%. The establishment of an EOC at CHM therefore presents an opportunity for the NHS to better use assets it is already contractually committed to paying for over many years. There are a number of material uncertainties in NHS funding and finance at present that are not unique to NWL but which make projections of future cost and income difficult. This includes an approximate 30% increase in elective care unit costs between 2019-20 and 2020-21 reflecting both the increased costs of the pandemic but also lower activity rates see since that time.[30]

29 LNW NHS Trust annual accounts, 2021-22 https://www.lnwh.nhs.uk/download.cfm?doc=docm93jijm4n9889

30 Nuffield Trust analysis of NHS National Cost Collection data 2020-21, https://www.england.nhs.uk/publication/2020-21-national-cost-collection-data-publication/

Background	Commentary
	The figures used in the PCBC model do not use these higher actual unit costs, but instead uplift 2019-20 costs by around 3%. Actual costs and savings in year one and two of the EOC will depend on how fast each trust and hospital site is able to reduce its cost base down to pre-pandemic levels.
Supplementary question 2: Are plans to make efficiency savings sufficiently detailed and credible? The ~£4m annual savings are estimated using 2019/20 NHS reference costs (and patient-level costing data from individual trusts) which are uplifted to current prices to give a "no change" total cost of relevant orthopaedic care in NWL of £33m. Modelling for the PCBC anticipates that efficiencies gained through the establishment of the EOC – including moving to upper quartile performance on length of stay – will reduce the total cost to £29.6m, with savings to be distributed between the four trusts.	Planning guidance for 2023-24 has stated that the contract default for elective care activity for the next two years is that it will be funded on a unit cost basis, with reference to the national tariff[31s]. Funding on a unit cost basis may provide some stability for elective care providers, but may also expose the commissioning budget to pressures should activity growth outstrip funding growth. As the elective orthopaedic case mix will substantially change at referring hospitals in particularly, this could also expose those trusts to financial pressures – for example if national tariff prices do not reflect the average cost of units of that activity – bearing in mind that patients remaining at referring hospitals are likely to be of a higher complexity and with longer than average length of stays. The provider collaborative will need to grapple with these issues and develop sufficiently flexible mechanisms for ensuring that unforeseen changes in the distribution of costs and savings, as well as unavoidable higher costs where they occur, are appropriately covered. A more significant overall risk is the £17m of worth of elective orthopaedic activity that is proposed to move from Imperial College Healthcare Trust, The Hillingdon Hospitals Foundation Trust and Chelsea and Westminster Hospital Foundation Trust to the EOC ran by LNW NHS Trust. Although the PCBC models anticipates that activity can be performed at a lower cost at the EOC, realising those potential savings ICS-wide will be dependent on the three "referring" trusts being able to either export the full cost of those patients out of their own cost bases when the activity is moved (which would typically involve transferring staff) or productively re-use it for other forms of patient care. Their ability to do this represents the largest financial risk in the plans and is acknowledged in the PCBC. In the current funding context in particularly, it is important to note that re-purposed hospital capacity will not only need to be actively employed in patient care, but will need to be done so in a way that is fully funded. By way of understanding the relative significance of this ~£17m cost to the NWL health economy, it is the equivalent of just under 0.5% of the Integrated Care Board's recurrent resource allocation for 2022-23, at a time when core ICB funding allocations are flat in real terms.

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

Background	Commentary
	The DMBC has provided useful clarification in response to points raised by the Mayor and The Nuffield Trust under test one above – in relation to the need to ensure resources moved to the EOC are not at the expense of resources currently used to care for patients ineligible for care at the EOC (for example because they require complex orthopaedic surgery, or care under separate, but co-dependent clinical specialties). The DMBC states that the intention is that non EOC patients will also see improvements in their care quality and waiting times, as clinical capacity freed-up at "home" hospitals by the transfer of "High Volume, Low Complexity" activity to the EOC, will instead be available for patients that remain. A similar point is made in the DMBC with relation to revised assumptions about staffing, as staff will no longer be required to transfer to the EOC, in part because the data collection on staffing revealed that it was not possible to identify staff groups solely dedicated to transferring activity. While these clarifications are welcome and reassuring with respect to patient equity and safety, it is not clear why they have not led to revisions in the projected savings from the EOC, as they entail that it will be significantly harder to remove costs from home hospitals than assumed at the PCBC stage, beyond the marginal savings which might be made by reducing reliance on temporary staffing – which is referenced in the revised finance section in the DMBC. It is possible that providers may still envisage a similar level of financial benefits, if, for example, it is planned that capacity freed up by activity transferring to the EOC is income-generating – as the DMBC suggests is currently being scoped. However any assumptions on income generation will need to be clear and agreed with NWL NHS commissioners.
The PCBC outlines a number of financial risks which the plans face if assumptions about staff pay rates, use of agency staff, and clinical efficiencies prove overly optimistic	The total downside risk modelled is for costs to be £7.9m higher than anticipated, which exceeds the total £4m modelled savings in the base case. However the PCBC states that the ICS is confident that not all these risks would materialise, or that where they to, they would be significantly less extensive in value. The following risks are briefly set out in the PCBC: Staff pay and London weighting: the modelled savings assume that staff working at the EOC are paid the outer London weighting, as is currently the case for all LNW Trust staff. However, as some of these staff will transfer from NWL trusts that currently attract the inner London pay weighting, it is possible

Background	Commentary
	that the EOC will only be able to recruit and retain staff if it pays at the inner London weighting rate also. If this were the case, the PCBC states that ICS-wide costs would be in the region of £0.8m higher. There is a further risk referenced in the bed test above that higher pay rates paid at the EOC might undermine recruitment and retention at other "outer London" hospitals, including other, non EOC services ran by LNW Trust. Use of agency staff: The PCBC anticipates a 14% workforce gap at the EOC, of which 10% would be filled using bank staff and 4% using agency staff. It models a maximum risk of £2.8m higher costs if all of the vacancies were alternatively filled with agency staff, which are more costly than bank staff. Length of stay reductions: The PCBC assumes an average length of stay at the EOC of 2.3 bed days. The PCBC anticipates that for every 0.2 days excess above the average length of stay target, the EOC will face additional ward staff costs of £0.2m, up to £1.3m higher than planned costs if average length of stay at the EOC is 3.5 days. Theatre utilisation: If theatre utilisation rates do not meet GIRFT case-per-theatre session standards, the PCBC models higher costs of up to £2m, representing the cost of "waiting list initiatives" such as overtime theatre sessions. However the PCBC states there is a high confidence of meeting GIRFT theatre productivity standards due to the relatively low-complexity of patients who will be treated at the EOC. The DMBC has made a modest reduction in the projected savings of £106,000 to reflect the anticipated cost of the enhanced patient transport scheme. This is a prudently assumption. We have noted in Test 1 that the scheme might best serve its intended purpose, as well as make best use of NHS funding, if it was made clearer that the scheme is intended for patients with low incomes/financial means.

Test 4: Social care impact

Background	Commentary
The PCBC does not set out how the proposals will affect adult social care services, either operationally or financially.	This is a gap in the plans that needs to be filled. At a minimum, plans need to consider: 1. Current discharge destinations of elective orthopaedic patients treated at the four hospital trusts and differences between the HVLC cohort and more complex patients; 2. Current adult social care capacity (including reablement and home equipment services) within NWL boroughs and gaps within this; 3. How the plans to substantially increase elective orthopaedic activity and change the location of surgery will increase and change the profile of demand for post-operative adult social care services in the area; 4. How demographic changes (including the aging population but also increased longevity in people with life-long disabilities) will also change the shape of demand for adult social care and elective orthopaedic surgery; 5. How existing and future modelled shortfalls in social care support can be addressed; 6. What the optimal integration of adult social care into the elective orthopaedic pathway (including pre-operating care and "pre-habilitation") looks like and what is needed to achieve this; 7. A down-side scenario whereby gaps in social care support are not filled, modelling the impact this will have on both the EOC and elective orthopaedic activity and the other hospitals (for example delayed transfers of care impacting on ability to undertake elective activity and increased inequalities if more complex patients are unable to access pre-operative support and pre-habilitation) Further, the plans envisage a substantial shift in patients from multiple NWL hospitals to CMH for their operations. This is likely to require CMH to develop relationships with significantly more adult social care departments and providers than it has at present. It is not clear if the workforce model for the EOC includes the capacity to do this. NWL have made some efforts to address the gaps identified in the PCBC with regards to adult social care. Some of their data analysis has been limited by data availability issues around adult social care, which are not unique to NWL. This includes uncertainty on the proportion of patients requiring domiciliary homecare after elective orthopaedic surgery. However NWL have stated that they believe this number is low – particularly for the low complexity cohort of patients that will be treated at the EOC.

Background	Commentary
	The DMBC now includes a section setting out the EOC's approach to discharge. This includes identify as early as possible in a patient's pathway (ideally before admission) which patients may require additional support at discharge, including re-enablement care. The DMBC also confirms that CMH has a discharge hub which currently works with its three surrounding local authorities, and this will be expanded to all eight NWL local authorities when the EOC is established. The hub will then act as a single point of referral for EOC patients from all eight NWL boroughs for social care, community rehabilitation and bedded rehabilitation. The DMBC further introduces a care navigator role into the workforce plan for the EOC, which might provide further assistance for patients requiring social care support before and after discharge.
The Equalities Impact Assessment notes research finding that single and widowed patients are more likely than those living with a potential carer to be discharged from orthopaedic surgery into long-term residential nursing care, rather than into their own home. Such patients also experience longer lengths of stay	This point is noted in the Equalities Impact Assessment as it is viewed as potentially relevant to the protected characteristics of "marriage and civil partnership", with the assessment proposing that experience against marital status be monitored as the plans are implemented. However the point requires more direct consideration in the care pathway as it highlights the centrality of social care and support for optimal post operative recovery.[32] This is especially the case for female patients who are more likely to be widowed and/or without adequate unpaid carer support at home and who make up the larger proportion of elective orthopaedic patients. Concerns about patients living alone, or with additional needs were raised during the public consultation and are set out in test 6.

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

Test 5: Clinical support

Background	Commentary
Overarching test: Proposals demonstrate widespread clinical engagement and support, including from frontline staff. We have assessed the proposals against each of the 4 sub-headings below, basing our analysis on the Consultation Report prepared by Verve Consulting and published on the Provider Collaborative website[33s] and the Report of the London Clinical Senate. *Supplementary test 1: [The proposals]... include a demonstrable, robust clinical case for change, including an improvement in both quality of care and outcomes* The report from the London Clinical Senate states clearly that in the Senate's view there is a "clear overarching case for change for the development of an elective orthopaedic centre (EOC)" while making a number of recommendations for further consideration. The Senate notes that further action is required to ensure that the potential benefits offered by the new model of care are realised in practice. The recommendations from the Senate are consistent with recommendations made in our previous report on tests 1-4, in particular in relation to modelling, pathway design, workforce planning and healthcare inequalities.	The Clinical Senate underlines the importance of setting clear baselines and benchmarks for a range of activity and quality indicators, in order to ensure "clarity within the business case as well as the effective development and monitoring of operational plans [and to] enable the fullest response to implementing mitigating actions against known risks." In relation to health and healthcare inequalities, the Senate highlights the need to continue to monitor outcomes for patients not in scope for the EOC, stating: "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." The need to ensure equity and sufficient capacity for patients whose comorbidities place them beyond the scope of the EOC was also flagged in test 1 and test 2 of our original review and the Clinical Senate recommends that NWL state more clearly how patients who are more deprived and therefore more likely to require higher complexity care will benefit from the changes, even if not directly through the EOC itself. As noted under test one and two, the DMBC responds in part to the concern about equity for patients out of scope, whom the DMBC asserts will also experience benefits from the changes. However, these concerns expressed would be more fully addressed if KPIs attached to the proposed changes included direct monitoring of care quality and staffing levels for patients and pathways out of scope. The Senate also references the need to undertake more detailed work on the whole pathway for musculoskeletal care "noting that pathways must start in primary care with effective and standardised entry points to reduce inequality." The DMBC states that the wider community MSK pathway is currently being reprocured and that equity and integration are key considerations for the development of those services.

33 https://www.nwl-acute-provider-collaborative.nhs.uk/-/media/website/nwl-acute-provider-collaborative/documents/nwl-eoc-consultation/nwl-elective-surgery-consultation-report-final.pdf?rev=d3dc29180fd34296a03afeb94b2c24ac

Background	Commentary
	On workforce, the Senate notes potential benefits, but also major risks – in particular around the need to develop a robust workforce plan. The Senate's report states: "there is risk that without a clear and coherent plan, the proposed benefits of the case for change will not be realised." Although the Senate recognises that the proposed service model should generally aid recruitment, it highlights six specific challenges: • 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 • High drop-out rates in orthopaedic speciality training The Senate also notes that "There is a risk that staff working primarily at the EOC become de-skilled" as they will focus on lower complexity cases. The Senate recommended that this risk be considered when rotas were designed, to ensure staff retained a balance set of skills, but also warned that recruitment and retention across the pathway could be differentially affected by pay considerations, as some sites attracted inner London weighting while others did not. The DMBC now assumes that staff will be recruited specifically to work in the EOC rather than being transferred from elsewhere. However, as raised under test two, in all likelihood those staff will already be working in the NWL area, and so this does not address the concerns raised by the Clinical Senate about staff shortages. It is currently not clear how concerns about deskilling will be addressed. Finally, the Senate highlights the need for all healthcare interventions and policies to continuously monitor demand and how demographic changes might affect that, stating: "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."
Supplementary test 2: [Proposals] have the support of local primary and secondary care clinicians, including but not limited to those whose services/ patients will be directly affected	The Senate's report states that engagement with primary care "could be stronger" and that "the panel considered that there is significant benefit in engaging colleagues to ensure effective end to end pathways." The Senate report noted that more detail was needed on work NWL says it has already done engaging with Local Authority adult social care operational teams, particularly around discharge pathways, as well as on readmission rates and transfers with other hospitals and NHS care providers.

Background	Commentary
It is not clear from either the Senate report or the local consultation report how much support the proposals have from local clinicians, in particular those from primary care or working beyond the direct elective orthopaedic pathway. We note that the proposal was presented to the Senate panel by a cross section of local clinicians, including primary care representatives, and that a number of the local consultation meetings were led by or included presentations from local clinicians.	We also note that the the separate consultation report indicated that where staff responded to the consultation they were noticeably less positive than patients and carers, with only 48% of staff responses agreeing or strongly agreeing to the question "To what extent do you agree with the proposal to develop an elective orthopaedic centre for most routine, inpatient orthopaedic surgery in North West London?" compared to 64% of patient and carer responses. The DMBC has now embedded staff satisfaction as a KPI attached to the implementation and running of the EOC. As the Senate panel notes "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." Further work to understand and address the reasons for the apparent relatively low level of staff support for the proposal may be instructive, and aid the development of a robust workforce plan. The DMBC outlines plans for further staff engagement on the development and implementation of the plans, as well as wider work across NWL providers on improvement staff experience and wellbeing.
Supplementary test 3: [Proposals] Have the support of pan-London clinical bodies – London wide LMCs, London Clinical Senate? The Senate established a panel to review the proposal, which consisted of a range of primary and secondary care clinicians, including representatives of nursing and allied health professionals, as well as patient representatives. The Panel was able to review the clinical strategy for NW London alongside the PCBC and its appendices, and received a presentation from the NWL ICS and Provider Collaborative followed by a question and answer session.	As noted above, the proposal is clearly supported by the London Clinical Senate, but the series of recommendations made by the Senate to ensure that benefits are realised in practice are both reasonable and significant.
Supplementary test 4: [Proposals] have the support of local authority social care and other professionals?	It is worth noting that none of the three local authorities whose responses we have seen have made specific reference to concerns about social care capacity or engagement, but it is implicit within the need to undertake further work on the pre and post-operative pathways. We would recommend that NWL engage explicitly with each local authority affected on the specific impacts on social care as set out in our report on the first four tests.

Background	Commentary
As with supplementary test 2, it is not possible to answer this question with confidence. We note that full responses from three local authorities are included in the consultation report, but that only Westminster explicitly state that they support the proposal. Both Kensington & Chelsea and Hammersmith & Fulham councils have noted the proposals, and all three councils set out areas of concern which they expect to be addressed through future work. These include: • Access & transport • Employment • Patient choice • Health inequalities, including those associated with deprivation • Pre- and post-operative pathways • The workforce plan associated with the proposal • Digital inclusion • Ongoing community engagement	

Test 6: Patient and public engagement

Background	Commentary
Overarching test: Proposals demonstrate credible, widespread, ongoing, iterative patient and public engagement, including with marginalised groups, in line with Healthwatch recommendations. *Supplementary test 1 & 2: Did patients/the public/the local Healthwatch influence proposals before they were published for formal public consultation? Did patients/the public/the local Healthwatch advise on the consultation plan?* Patient representatives are reported to have been involved at different stages in the development of the elective orthopaedic concept – including in defining what "good" care and patient experience looks like – and there is now a lay partner as a permanent member of the programme board to help ensure an effective and consistent approach to patient and public involvement (See Page 13 - Exec summary pre consultation business case). To explore views on a potential elective orthopaedic centre, the Acute Provider Collaborative worked with Verve Communications Limited, to undertake a small engagement programme in summer 2022 (See Appendix 4 of the Pre-consultation Business case). This consisted of focus groups, telephone interviews and two online community events. Seventy-eight people took part in the engagement process. The Pre-Consultation Business Case outlines initial input from patient, public and stakeholder groups (See Page 67 - Engagement)	The central influence of patients and the public on proposals prior to formal public consultation seems to have been in terms of how information was presented within the consultation. The Pre Consultation Business Case includes recommendations based on the engagement programme conducted in summer 2022, which consist in the main of specifying where more or less detail would be helpful. These practical recommendations were subsequently implemented in the consultation proposal materials (See Public Consultation Summary).
Supplementary question 3: Did proposals set out sufficient, easily understandable information about, and reasons for the proposals to enable an informed response?	While the consultation booklet was clear, the webpage which contained all the consultation materials was hard to navigate. It would have been helpful to more clearly set-out what different documents were, so that people could decide if reading them was necessary to make an informed response. For instance, it would have been helpful to position the executive summary of the pre-consultation business case before the full pre-consultation business case which was over 200 pages long.

Background	Commentary
There was an easy read summary of the consultation proposal as well as a consultation summary (Consultation booklet) written for a public audience. The public consultation website also included additional documents that can be downloaded such as the pre-consultation business case.	
Supplementary questions 4&5: Was the formal consultation well-publicised throughout the geographical and other communities in which affected people live, work and spend their time? Were local networks used to promote engagement? A range of community organisations across the London Boroughs were contacted about the consultation (See 4.7.2 of the evaluation report). This was in addition to requesting feedback from other organisations and publicising the consultation online, via social media, within hospitals and in print. Community outreach activities are also outlined in Appendix 4.7 of the evaluation report.	Whilst the consultation was publicised in a variety of ways, 25% of questionnaire respondents reported hearing about the consultation via their local hospital website. The questionnaire respondents are therefore likely to be people who are particularly interested in healthcare, and/or who are already accessing healthcare, as well as being those who are technologically literate.
Supplementary questions 6,7 and 8: Was the formal public consultation open for a sufficient period of time? Was the consultation available via a range of mediums including online and hard copy? Was it possible to comment verbally via telephone and face to face meetings, as well as in writing? The consultation period was open between 19 October 2022 and 20 January 2023 (See Page 2 of consultation evaluation report). The consultation evaluation report highlights that: 'The consultation period ran for 13 weeks, which included the Christmas period. Traditionally, 12 weeks has been considered reasonable for a public consultation process, having originally been proposed in the Code of Conduct.' (See Page 132). The evaluation report notes that consultation information was available online as well as hard copy (See section 2.4.2 Communications.	The public consultation summary document stated that the consultation would be underway for 14-weeks. There is therefore a slight discrepancy with the final time-line of the consultation (13-weeks and 2-days).

Background	Commentary
People could respond via telephone and face to face meetings, as well as in writing.	
Supplementary questions 9 and 10: Were proactive steps taken to engage patients and the public, especially harder-to-reach groups and communities, and those particularly affected by proposals – both directly and through representative groups? Did the consultation yield widespread, detailed public/patient feedback, especially from equalities and hard to reach groups, and those particularly affected by the changes?	As part of the earlier Equality and Health Impact Assessment (EHIA) process, it was also recommended though that groups identified as at risk of experiencing disadvantages were included in the consultation. While there were efforts to do this, it would have been useful if views from these groups were given more prominence in the evaluation report. There were bespoke sessions (focus groups and 1:1 interviews) with groups identified in the EHIA, but the main consultation activity was a questionnaire, which was not widely representative of the EHIA highlighted groups. For instance, the EHIA highlights the impact on Black and Minority Ethnic patients for whom English is a second language. 47% of NWL's population with a known ethnicity are reported to be non-White in the EHIA, but over 70% of the questionnaire respondents were White.
Consultation activities included open meetings and drop-ins, community outreach meetings, staff events, focus groups and interviews, questionnaire, responses from the public by email or telephone and organisational responses. The questionnaire received the highest level of participation, with 807 participants out of a total of 1,959 recorded across all activities.	The DMBC sets out how NWL plans to extend the patient and public engagement it started with the consultation process with ongoing engagement, including on implementation of the plans and governance. This will include the development of patient and community feedback and experience indicators and an ongoing programme of engagement, particularly with groups who have not been well engaged in the past. This is a positive development and NWL should seek to maximise the opportunities to use such engagement to explore drivers of healthcare inequities as well as broader patient experience and outcome concerns.
The Equality Health Impact Assessment identified the following groups in particular as being at risk of disproportionate impact by the proposal (Pg. 9): Elderly patients, Disabled patients, Black and minority ethnic patients for whom English is a second language and Patients from deprived areas	While the questionnaire recorded which borough the respondents lived in, it is not possible to look at consultation responses or involvement by deprivation level. This could have been possible if respondents were asked to give all or part of their postcode when responding. In a separate communication NWL has explained that postcode data was not captured as there were concerns this could identify patients. While such concerns are not insurmountable, alternative means of attributing deprivation levels to respondents are also available, for example asking survey respondents to indicate if they receive any from a given list of income-related benefits. While it was reported that translated materials were available, there is no evidence as to how many (if any) translated materials were requested. The number of respondents who completed the questionnaire was not as many as initially planned for. The aim was 2,000 responses (See Page 6 of the consultation

Background	Commentary
	plan) and they achieved just over 800 (n=807 participants). Steps were taken to engage with groups at risk of being disproportionately impacted by the proposal (focus groups and 1-to-1 interviews), but the questionnaire was the main point of engagement and this was not representative of groups highlighted in the EHIA. Detailed feedback was received but there is less emphasis on this in the evaluation report. The consultation evaluation final report draws significantly on the questionnaire results as evidence that the elective orthopaedic centre plans are viewed favourably. There are various challenges with this. Firstly, as already noted above, groups reflected in the Equality Impact Assessment (elderly patients, disabled patients, black and minority ethnic patients for whom English is a second language and patients from deprived areas) are less well represented in the questionnaire responses. Secondly, the results highlight that Hillingdon had a much higher 'disagree' score than any other borough to both the proposals overall and the specific location of the EOC (48% strongly disagreed with the overall proposals and 61% with the proposed location) as well as being the most well-represented borough in the proposal with 28% of all respondents. This is not explored except for brief commentary on possible links to travel concerns. Hillingdon also had the highest proportion of 'other' respondents (43%), representing members of the public and organisations, as opposed to existing or recent patients and their carers or staff groups. More detail on these respondents would have been useful. Thirdly, earlier engagement between NWL NHS and the GLA has noted high orthopaedic demand in Southall, which is poorly linked by public transport to CMH. It was stated that NWL ICS were consulting with this community about how to resolve this. As noted above, the DMBC now includes a detailed transport offer. Technical issues around questionnaire design and analysis may also have impacted the results gained. In the questionnaire, there is a discrepancy between how the questionnaire Likert scale response options are reported in the evaluation report compared to the questionnaire as shown in Appendix 4.1. In the questionnaire, the Likert scale response anchors are reported as ‘Strongly Disagree’ versus ‘Agree Strongly’. This is not best practice. We would normally expect mirroring response anchor scale options, as has been reported in the evaluation report itself. i.e. ‘Strongly Disagree’ versus ‘Strongly Agree’. If the survey questions were presented as per the questionnaire, it is unclear the impact this may have had on people’s likelihood of responding favourably (or otherwise) to the questions posed and subsequently the conclusions that can be drawn from the questionnaire findings.

Background	Commentary
	The evaluation report lacks details regarding how many questionnaire respondents answered 'don't know', or 'prefer not to say' to specific questions. We would recommend including this detail in future reports, or being clear about how respondents who select these answers are represented in reporting. If a large number of respondents selected 'don't know' to specific questions, this would have provided important contextual information when assessing perceptions of the proposal plans. For instance, were there elements of the proposals/survey questions which respondents found hard to answer - possibly because the proposals weren't clear, or alternatively because people could not anticipate how they would be impacted, or possibly because they were from groups who, for example, were less likely to use/need the service (such as under 50 year-olds). The final report also specifies 'all respondents who have a valid answer' as the base. It is unclear whether responses of 'don't know' or 'prefer not to say' are included in the final n-size for each question.
Supplementary tests 11 and 12: Have the final proposals been demonstrably modified following patient/public feedback? Do the final proposals set out plans for ongoing dialogue with patients and the public as detailed delivery plans are developed and service changes implemented? Putting to one side the lack of clarity in the consultation report about questions not answered, the report sets out how a majority of questionnaire respondents agreed that the proposed changes would: • Improve clinical outcomes for both in and out of scope patients (for example by freeing up capacity in local hospitals for more complex cases) • Provide the same high quality care for patients where ever they live in NW London • Reducing waiting times, through the separation of elective from non elective careImprove efficiency and reduce surgery costs • Reduce the likelihood of last minute cancellations – again through the separation of electives and non electives • Help join up care between hospitals, GPs and community services The main concerns about the proposals specified by questionnaire respondents were travel to the Central Middlesex Hospital, the availability of post operative care at home/in the community, and the impact of what has been described as the “digital divide”.	On the impact of digital technology, the consultation report describes how only 48% of questionnaire respondents agreed with the statement that plans to offer more services and communications online would make things “easier for patients”. Concerns about access to, or the impact of, digital technology were further highlighted in open text answers, with 18% of open text responses (the highest proportion) expressing such concerns. Further exploration of this through focus groups revealed a strong desire for alternatives to digital communications and virtual appointments for those who wanted them. This concern has been addressed in the DMBC which is very clear that there will be no “default to digital” and in-person options for outpatient appointments and patient communications will be available. On travel, only 55% of questionnaire respondents agreed with the statement that they would be willing to travel further for “the best orthopaedic surgery” while having outpatient care closer to their home. Worryingly, 34% of respondents outright disagreed with this statement – indicating a risk that, without mitigations, plans to relocate elective surgery could create or exacerbate access inequalities for some groups of patients. Related to this point, the proportion of respondents agreeing and disagreeing with the statement “I would prefer my orthopaedic surgery to be at my local hospital even if it meant I had to wait longer” were very evenly matched (43% agree, 42% disagree). Focus group discussions explored these patient travel concerns further, with participants raising concerns about travel affordability and the impact this would have on disadvantaged groups. Participants also

Background	Commentary
	queried the median travel times set out in the PCBC and pointed out that transport costs had not been considered or presented. They further emphasised that the need for frequent bus changes could be more problematic for some than journey length. The consultation report describes “strong concerns” that travel cost, time and complexity could mean patients unable to drive or afford taxis would be disadvantaged and receive a service “worse than that currently offered”. As noted in Test one, the DMBC has responded to travel concerns by setting out a three step travel solution which offers universal advice and assistance to all, and free travel for those facing particularly difficult or costly journeys to the EOC – expected to comprise up to one third of patients. As set out in our revised commentary to test one, this strong response could be strengthened further by providing clarity on which patients are eligible for such help with travel as this will enable more patients to see that the service has been designed with them in mind. A sizeable portion of questionnaire respondents (70%) indicated they had concerns that people with additional needs – such as dementia or a learning disability – would find it confusing to receive surgery in an unfamiliar hospital. Focus group discussions highlighted concerns for these patients around navigating care across different providers, as well as complicated travel. This concern has been partly mitigated in the DMBC by highlighting the role of “care navigators” who will help patients navigate their care. It seems likely that patients with additional health needs would also qualify for free patient transport as described above. 61% of respondents indicated they were concerned that staff would need to move between hospital regularly. Some focus group participants also expressed concerns about the staffing model for the new centre and the risk it might take staffing resources away from other hospitals and services (including those for patients with higher complexity needs) with some staff participants expressed concern that multisite working could also lead to some skilled staff leaving. This is a risk we flagged in test two and is further addressed in test 5. A focus group with Black and minority ethnic people highlighted a view that people from some ethnic backgrounds are less likely to seek elective surgery as the benefits of it are less well understood in their specific community and the system does not do enough to address this inequality in understanding – both in terms of the benefits of elective surgery and other aspects of the wider MSK pathway such

Background	Commentary
	as physiotherapy. In a similar vein, some focus group participants described how orthopaedic elective surgery was seen as "the most middle-class of surgeries" because pre- and post-operative care required patients to be able to take the time to exercise or undertake physiotherapy. This feedback is significant because it highlights how patient understanding and perceptions of their own candidacy for healthcare is an important element in healthcare inequalities, which can be strongly influenced by the information provided and culture reflected by the service provider. The focus groups also highlighted the role of wider material inequalities in creating obstacles to elective care, with people in jobs without sick pay saying they would not be able to take time off work to recover from procedures.[34] We have set out in test one that it would be useful if the FBC set out how the EOC and wider MSK pathway providers will ensure all aspects of the MSK pathway are accessible to all members of the community. Other significant concerns included wider discharge support, which reflected poor experiences some focus group participants had in the past – for example in accessing community health services. Post-discharge support was a particular concern for older or disabled people living on their own, but there was also a more generalised desire for improved support and care after hospital discharge. As noted in test four, the DMBC has expanded on NWL's approach to support on discharge from the EOC. Participants proposed a range of mitigations to address some of these issues – many focusing on transport, but also post-discharge support and communication with patients (including those who do not speak English or have hearing difficulties). At a meeting on March 8 2023 the North West London Joint Health Overview and Scrutiny Committee provided its feedback on the proposals. This echoed many of the views expressed during the public consultation, with committee members asking the NWL NHS to develop specific proposals and commitments to address transportation and travel concerns. NWL has stated that it has accepted the JHOSC's recommendations.

34 For further information on inequalities in the different steps or domains of healthcare access, see: Gainsbury S and Hutchings R (2022) Review of the Mayor of London's Health Inequalities Test. Research report, Nuffield Trust. https://www.nuffieldtrust.org.uk/research/review-of-the-mayor-of-london-s-health-inequalities-test#response-from-the-mayor-of-london

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