MAYOR OF LONDON

Helen Pettersen
Interim Regional Director for London
NHS England

Dr Penny Dash
Chair
North West London Integrated Care System

Date: 20 March 2023

Matthew Swindells
Joint Chair
North West London Acute Hospitals

Rob Hurd
Chief Executive
North West London Integrated Care System

Dear Helen, Penny, Matthew and Rob,

I want to start by again thanking the North West London Integrated Care System team for their engagement with the process to apply my six tests to the proposals for 'Improving planned orthopaedic inpatient surgery in north west London'. Now that the Decision-Making Business Case (DMBC) for these proposals has been published, I am writing to set out my position against all six of my tests. This builds on and updates my consideration of the first four tests, which I shared with you on 19 January 2023.

As Mayor of London, I am committed to championing, challenging and collaborating with the NHS and other health partners on behalf of all Londoners. As part of this, I have developed six tests to apply to all major health and care transformation programmes. These tests are designed to help me challenge the NHS to demonstrate that major changes are in the best interests of all Londoners.

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

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

In November 2022, I commissioned the Nuffield Trust to carry out an independent expert review of the proposals for 'Improving planned orthopaedic inpatient surgery in north west London' against the six tests. I have used this analysis to inform my position on the proposals. A copy of the review is attached to this letter.

Overall, I remain broadly supportive of the proposals. They continue to represent an opportunity to improve patient outcomes, reduce waiting times, tackle the elective care backlog and deliver care

more efficiently. Since my last letter, progress has been made in developing the proposals to better tackle health inequalities, plan how the new service will link with social care, and respond to patient and public feedback.

To help ensure that the potential benefits to Londoners that these proposed changes hold are fully realised, I would also like to draw your attention to several key points for you to consider during the next phase of their development and implementation. In particular, as the proposals are taken forward, I would encourage:

- Further action to ensure that pre- and post-operative care is, and is seen as, accessible to everyone needing elective orthopaedic care.
- Detailed workforce planning to address risks around potential staff shortages, informed by ongoing staff engagement.
- The adoption of additional metrics and targets relating to equity, care quality outside of the proposed elective orthopaedic centre (EOC), and the effect of the changes on capacity in surrounding hospitals.
- Close ongoing engagement with local authorities to ensure robust planning around social care.

Test 1: Health inequalities and the prevention of ill health

I am pleased to see that the analysis of the potential impact of the proposed changes on health inequalities has been strengthened since my last letter, taking account of the findings of the independent review that I commissioned from the Nuffield Trust. This will help facilitate better-informed action on health inequalities.

I welcome the action that has been taken around the potential health inequalities impact of the changes to patient travel associated with the proposals. This was a concern that I raised in my last letter alongside several other respondents to the public consultation, and it is clear that these concerns have been taken seriously by the team developing the proposals. I am pleased to see that there will be universal access to proactive travel advice and support with arranging transport, as well as a free transport offer for qualifying patients that is anticipated to cover 30% of those treated at the EOC. This has real potential to help reduce health inequalities. To fully realise this potential, it will be important to ensure that those qualifying for the free transport offer are aware of it and easily able to take it up.

The proposed new EOC is a 'high volume low complexity' hub. Patients with co-morbidities, particularly if these are poorly managed, will be ineligible for treatment here. In my last letter I noted that, since rates of multiple co-morbidities increase significantly with deprivation, it was likely that the group of patients eligible for treatment at the EOC would tend to be less deprived than those deemed ineligible. This would mean that, if care improved more for those treated in the EOC than for those treated outside of the EOC, the changes could lead to widening health inequalities. For that reason, I asked for more information about how patients treated outside of the EOC would benefit from the proposed changes. The DMBC provides useful clarification of these intended benefits, particularly those coming from increases in capacity in other hospitals resulting from moving low complexity care to the EOC. The adoption of key performance indicators around waiting times and waiting list sizes outside of the EOC will support efforts to ensure that improvements are fairly distributed between those treated in and those treated outside of the EOC. However, I would encourage this to be taken further through the adoption of additional metrics and targets relating to care quality for patients treated outside of the EOC, as well as relating directly to equity.

Finally, the public consultation revealed that some members of the public raised concerns about the equal accessibility of elective orthopaedic surgery, for example, due to the time, literacy or English-language skills required to engage in pre- and post-operative care. As the proposals are taken forward, it would be valuable to explore further action to ensure that pre- and post-operative care is, and is seen as, accessible to everyone. Existing plans to embed ongoing patient involvement in the design of both the EOC and the broader care pathway should help with this, and it would be worth setting out and monitoring progress against improvement ambitions.

Test 2: Hospital beds

The proposed changes will increase bed and theatre capacity for elective orthopaedic patients in north west London, as well as open up capacity in hospitals from which elective orthopaedic care will be transferred to the EOC.

However, there is a risk that staff shortages at the EOC prevent this increased capacity from being realised, or that EOC staff are recruited from surrounding hospitals that then experience diminished capacity themselves, potentially destabilising surrounding services. The latter situation could lead to an effective reduction in bed capacity for other forms of care. These risks are reflected in the proposals and risk register for the scheme, and more detailed analysis around the risks has been undertaken since my last letter. Nevertheless, as the proposals are taken forward, it is crucial that detailed workforce planning is undertaken to address these risks, informed by engagement with existing staff. As part of these efforts, it would be valuable to adopt mechanisms for tracking the effects of the changes on capacity in surrounding hospitals.

Test 3: Financial investment and savings

I again welcome the fact that the EOC can be established with capital investment that is fully funded in the local acute capital programme. It is also positive that this change would enable the NHS to more efficiently use assets at CMH that it is already contractually committed to paying for.

I note that the plans continue to anticipate revenue savings of £4m, despite the fact that some elements of the model have changed since my last letter, including plans to transfer staff from home hospitals to the EOC. The DMBC states that providers are now considering how capacity freed up by the transfer of activity to the EOC can be redeployed. It will be important that, where plans effectively involve an increase in overall hospital capacity, the ongoing financial implications for NHS commissioners and the health system as a whole are fully understood and set out.

Test 4: Social care impact

For any major service change, it is crucial that the impact on social care services is well considered. I am pleased to see that, since my last letter, significant efforts have been undertaken to better understand the impact associated with the proposed changes. I recognise that this analysis has been limited by data availability issues around adult social care that extend far beyond north west London. It is positive to see further detail on the proposed approach to discharge, as well as a new commitment to introducing a care navigator role, which could provide further assistance for patients requiring social care support before and after discharge. I would strongly encourage close ongoing engagement with local authorities over the coming phases of the scheme to ensure that planning related to social care is robust, and to build relationships between adult social care services and the EOC.

Test 5: Clinical Support

I was pleased to see that the London Clinical Senate has found there to be a 'clear overarching case for change' for the proposals, which it stated were 'grounded in evidence and best practice'. I note that the London Clinical Senate report sets out a range of recommendations for the programme team to consider as they take the plans forward, in order to ensure that the potential benefits are realised. These recommendations are consistent with many of the points that I have raised elsewhere in this letter in relation to health inequalities, monitoring care quality for patients treated outside of the EOC, workforce planning to address risks associated with staff shortages across north west London, and ongoing engagement with social care services.

I note that support for the proposed changes among staff responding to the public consultation was markedly lower than support among patients and carers. It is welcome that the DMBC outlines plans for further staff engagement on the development and implementation of the proposals, which I hope will help ensure that staff concerns are understood and addressed, as well as informing workforce planning.

Test 6: Patient and public engagement

It is welcome that patient representatives have been meaningfully involved at different stages throughout the development of the proposals, including through the appointment of a lay partner as a permanent member of the programme board. It appears that key concerns raised by members of the public, for example around travel to the EOC and the need for non-digital appointment options and patient communications, have been addressed.

During the public consultation, valuable steps were taken to engage with groups identified in the Equality Health Impact Assessment as being at risk of disproportionate impact by the proposals, such as through bespoke focus groups and interviews. I note that analysis by the Nuffield Trust suggests that further work building on this engagement is worthwhile to better understand and address the needs of these groups, particularly people who are disabled, elderly, from deprived areas or for whom English is a second language. I welcome plans set out in the DMBC for ongoing engagement as the proposals are taken forward, which include patient feedback indicators and are particularly focused on groups who have not been well engaged with in the past. This represents a rich opportunity to understand and address health inequalities and ensure that services meet the needs and priorities of local communities.

Thank you again for the opportunity to comment on the proposals. I will be publishing this letter on the Greater London Authority website in the next few days.

Yours sincerely,

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