North Central London Adult Elective Orthopaedic Services Review

Nuffield Trust assessment against the Mayor's six tests

Sally Gainsbury, Senior Policy Analyst (*tests 1 to 6*)
Nigel Edwards, Chief Executive (*tests 1 to 4*)
Helen Buckingham, Director of Strategy (*tests 5 and 6*)
Simona Baracaia, Public Health Registrar (*test 1*)
Rebecca Rosen, Senior Fellow (*test 1*)

nuffieldtrust

Summary of proposed changes

The North Central London Adult Elective Orthopaedic Services Review is a set of proposals developed by the five North Central London (NCL) CCGs and five NCL NHS provider trusts currently providing adult elective orthopaedic surgery in north central London, who have all come together as part of North London Partners in Health and Care (NLP).

The proposals involve splitting and ring fencing orthopaedic elective (planned) inpatient surgery away from non-elective (emergency) care. There is significant evidence such a model will improve care by reducing infection rates, increasing surgeon experience and by reducing patient waiting times and cancelled operations, which occur when elective procedures are unable to go ahead due to post-operative beds being utilised by emergency patients.

The proposals are for two dedicated Elective Orthopaedic Centres (EOC): one in the north of the patch, already based and running with spare capacity at Chase Farm Hospital. That scheme will be run as a partnership between the Royal Free London group of hospitals and North Middlesex Hospital. In the south, a partnership between University College London Hospitals (UCLH) and Whittington Health will oversee patient care at a new EOC based near Euston road as part of UCLH's "phase 4" development. Both EOCs are also expected to treat a small number of patients who would currently be treated at the Royal National Orthopaedic Hospital in Stanmore.

Orthopaedic surgeons would remain employed by their current "base" hospitals and would split their time (and rotas) between emergency trauma surgery at their base, and elective in-patient surgery at the EOC. Outpatient appointments and post-operative outpatient follow-up would remain at the base hospitals. Day-case surgery would continue to be offered at Whittington Health and North Middlesex as well as the two elective inpatient centres. A crucial part of the model is to retain co-dependent clinical services (such as emergency trauma care services) at base hospitals.

Note: The black text is the initial background and information to support the application of the first four tests. This analysis was undertaken in May 2020, revised in August 2020 and published by the Greater London Authority on 15 September 2020 and remains unchanged. The blue text is additional background and commentary added following the publication of the Decision-Making Business Case on 17 September 2020. This information supports the final application of all six tests.

Test 1: Health inequalities and prevention of ill health

The impact of any proposed changes on health inequalities has been fully considered at an STP level. The proposed changes do not widen health inequalities and, where possible, set out how they will narrow the inequalities gap. Plans clearly set out proposed action to prevent ill-health.

Background	Commentary
What are the relevant health inequalities in NCL? NLP commissioned independent consultants to undertake two separate but related sets of equality impact assessments. The first, undertaken in two stages by the consultancy firm Verve, was an overarching equality assessment which aimed to identify groups living in the NCL area who experienced, or were at risk of experiencing, negative health inequalities in respect of musculoskeletal health and elective orthopaedic surgery [3]. These inequalities are taken to mean avoidable and unfair differences in both access to healthcare and health status. A third report [7] was commissioned and was reviewed in draft form for this analysis. The final version of the third report has now been published. The starting point for the first assessment was the 9 protected characteristics under the 2010 Equality Act , which were further supplemented, at NLP's request, to include economically deprived people and those with caring responsibilities. These were the groups initially considered at risk of health inequalities and/or being impacted negatively by the proposed changes. The assessment used official statistics, where available, to identify where these different at-risk groups live within the NCL area. It also reviewed some of the national and international literature on musculoskeletal health to ascertain how each of the different groups might have differing needs for orthopaedic surgery – for example evidence that older people have	It is not clear if the literature used to identify inequalities and inequities experienced by the 11 groups in relation to musculoskeletal health and elective orthopaedic surgery has been explored in a systematic way. A systematic approach might have started with a literature review and consultation with orthopaedic surgeons. This could have explored the epidemiology of conditions and/or risk factors most relevant to elective orthopaedic surgery – for example osteoarthritis as opposed to osteoporosis, which is repeatedly mentioned in the impact assessment despite having far less relevance to elective hip and knee replacements than osteoarthritis. A systematic approach to understanding clinical risk factors relevant to the need for elective orthopaedic surgery would have given the analysts confidence to then use existing national and local NHS data sets to explore the prevalence of those diseases and risk factors across the NCL population as a whole, and within the 11 groups in particular. This data is available in GP disease registers, Public Health England's CCG profiles and Hospital Episode Statistics. Together with an analysis of actual rates of elective orthopaedic surgery within the specific groups, such an approach would have given NLP a firm understanding of the current status of local health inequalities and health inequities relevant to the musculoskeletal health and elective orthopaedic surgery. Such an analysis could explore, for example, for different demographic and geographic groups within NCL: • actual vs expected diagnoses of relevant diseases and disorders – to see if there is evidence to suggest the health needs of some are being missed or overlooked • prevalence of relevant risk factors (e.g. obesity or osteoarthritis) – to see if some groups face a disproportionate need for relevant preventative or secondary healthcare

1 The protected characteristics of the 2010 Equalities Act are, in alphabetical order: age; disability; gender reassignment; marriage and civil partnership; pregnancy and maternity; race; religion or belief; sex; sexual orientation. The equality impact assessments wrongly refer to the protected characteristic of sex as "gender". This conflation of sex (a biological category) and gender (a social construct or norm) is common but unhelpful, particularly in discussions around health service where biological differences between males and females often determine different health needs and outcomes.

Background	Commentary
a higher rate of musculoskeletal disease than younger people; and how inequalities in access to healthcare and in healthcare outcomes exist between groups – for example that people in the Black and minority ethnic group tend receive surgical treatment later on in the development of their disease, indicating an inequality in access to relevant healthcare.	• actual vs expected rates of elective orthopaedic surgery – to see if access and referral rates between different groups reflects the level of need found within those groups • variation in waiting times and cancellations – to see if some groups experience poorer and less timely access to healthcare • variation in Patient Reported Outcome Measures following elective orthopaedic surgery – to see if outcomes after surgery are poorer for some groups than others While the impact assessment maps where populations within the 11 groups are particularly dense and makes some reference to UK-wide evidence on relevant health inequalities for these groups, it does not establish whether or to what extent those national findings are present within NCL. For example, the impact assessment refers to England-wide research pointing to unmet need in elective orthopaedic surgery amongst people from ethnic minorities. However, it does not assess if this is a factor in NCL, and if so, to what extent. This makes it hard for the analysis to be used as a firm basis for exploring how inequalities might be reduced or eliminated, or how they might be impacted by the proposed changes. NLP describe their assessment of health inequalities within NCL as “high level”, as opposed to drawn from a granular analysis of the actual position using relevant local data. They query how a more granular approach would strengthen their analysis [B13]. The Mayor may also want to consider if the transparency of a baseline analysis of actual existing local inequalities might be a useful starting point for designing and then monitoring policies aimed at reducing and eliminating inequalities. NLP have further commented that an analysis of underlying inequalities in musculoskeletal health is beyond the scope of their impact assessments on proposed changes to elective orthopaedic surgery [B16]. However, it is reasonable to expect a thorough analysis of health inequalities experienced at one particular point in a healthcare pathway to address wider determinants of health which might be addressed at other, “earlier” stages in that pathway, or in related pathways (for example prevention). It is also unclear how inequalities in elective orthopaedic care can be systematically addressed without an understanding of the factors influencing different patient groups to present (or to not present) with a differing need for that care – which would include some analysis of inequalities in wider musculoskeletal health.

Background	Commentary
How is the likely impact of proposals on at-risk groups considered? For the second phase of the over-arching impact assessment a small team of analysts considered how each of the 11 groups first identified as at risk might be sub divided into a total of 30 groups (for example "disability" was divided into 13 different disability categories, such as mobility, or sensory disabilities) to ensure the specific needs of each sub group were considered [4]. The analysts then identified 16 "change points" in the proposals (e.g. changes in surgery location as well as changes in the pathway) and considered how those changes might affect patients in each of the 30 sub-groups. Through this process, the analysts reduced the original long list of 11 equality groups and protected characteristics to six groups or characteristics which were "scoped in" for further assessment on the basis that they encompassed residents who were more likely to be impacted – positively or negatively - by the proposed changes. These characteristics were: age, disability, gender reassignment, race/ethnicity, carers, socio-economic deprivation. Potential impacts for those six groups were then discussed during a workshop involving NHS commissioners, clinicians, patients and representatives from each of the scoped-in groups. The workshop concluded that while all equality groups could expect to experience benefits from the proposed changes, one negative change was identified – longer, more complicated and more expensive travel times to proposed Elective Orthopaedic Centres. The analysis drawn from the workshop found this negative change was most likely to be experienced by people from four of the original 11 at-risk groups: • people with physical and learning disabilities and those with mental health problems • certain ethnic groups, in particular Black people and people of Turkish descent • unpaid carers • people experiencing economic deprivation.	The impact assessment found largely positive impacts from the changes proposed, with the exception of increased travel time and distance to elective care centres. However, the assessment focused only on the impact on patients requiring elective orthopaedic care. One of the key features of the proposals is the separation of elective and emergency orthopaedic care, which will involve substantial changes to clinical rotas and staffing patterns. Surgeons will be required to work across two or more sites (the elective centre and their home "base hospital"), and elective centres (EOCs) will need their own dedicated theatre and ward staff. In the context of clinical staff shortages across the NHS in general, and in London in particular, it is important that new posts at EOCs are not filled at the expense of staffing levels at base hospitals, that will continue to be needed to care for emergency patients. As emergency care is disproportionately used by poorer communities [B1] any deterioration in staffing levels for emergency care in base hospitals would exacerbate health inequalities. NLP will monitor this situation closely, but it remains a risk, which is also flagged under the beds test. The Mayor may want to seek assurances from NLP that staffing levels and capacity for emergency care at base hospitals do not deteriorate as a result of the development of the EOCs.

Background	Commentary
Impact on travel time, cost and distance Following the equalities impact assessment described above, NLP commissioned consultants Mott McDonald to model expected changes in travel times for patients resulting from the proposed changes [5]. The models looked at travel times for patients now and under the proposed changes, using public transport as well as using private cars or taxis, at different times of the day. The analysis found that the proposed consolidation of elective inpatient surgery at two sites (UCLH and Chase Farm) would result in increased travel times for some NCL residents but would disproportionately affect those from Turkish and Black ethnic communities as well as those from the most economically deprived areas, who would experience both the largest deteriorations in travel times (by both private car and public transport) and the longest travel times as a result. For example, the proportion of Haringey residents able to get to a surgery site within 30 minutes by public transport would reduce from 60% to 30%). There would be similar increases in travel times for Black and Turkish populations concentrated in parts of Enfield, Haringey and Islington. NLP have emphasised that in almost all cases, travel times will increase by around 15 minutes only (ie from a public transport journey under 30 minutes to one under 45 minutes). However, this will result in additional complexities for patients needing to travel to Chase Farm by public transport in particular, leading the transport impact assessment to conclude “some residents may struggle with this journey”. The travel time analysis shows that car travel times would also increase, particularly for patients from the poorest areas of NCL. In those areas, the proportion of patients able to travel to the hospital where their surgery would take place in the space of a 15 minute car (or private taxi) journey would decrease from 81% at present to 24% - a steeper drop than the average change across NCL as a whole where the percentage of patients	As part of the public consultation process and third stage impact assessment [7] an online “mitigations workshop” was held with selected NCL healthcare stakeholders in July 2020 [8]. Stakeholders included both patient groups, the relevant NLP providers and the NLP project team charged with overseeing the proposed changes. The workshop considered over 30 potential mitigations to alleviate problems or concerns identified either during the impact assessment stages or the public consultation. Proposed mitigations relevant to transport were [7]: • work with TfL to provide better, step free, transport links, or provide a minibus, from Oakwood Underground Station, where there is a lift, to Chase Farm Hospital • have a minibus between sites, especially the Royal Free Hospital and Chase Farm Hospital • ensure patients who might need help with transport are identified at the referral/assessment stage, and discuss their needs and any help which might be available to them (for example, whether taxi fares can be reimbursed) • ensure each hospital has specific transport and travel plans available, including public transport routes, step free access availability, and car parking. It is not clear which of the proposed transport mitigations NLP will take forward to implementation. The report stemming from the mitigations workshop [8] notes that stakeholders were sceptical that a minibus between sites would be beneficial to patients, whose main need was for transport between their home and the EOC. Stakeholders also felt that negotiations with TFL around new bus routes could take a long time to complete and it is not clear if more immediate options will be considered in the meantime. While the impact assessment refers to these extra private car travel costs as only a “minor adverse” impact, its quantification of these extra costs is unclear. TFL’s guide on taxi fares suggests that, for “tariff I” travel (5am to 8pm) a 6-13 minute journey could cost between £6.20 and £9.60, whereas a 16-30 minute journey could cost between £16 and £24 – implying that the 15 minute increase in journey times anticipated by the analysis for patients living the poorest parts of NCL could be expected to more than double taxi fare costs. Although the travel analysis has modelled car and public transport travel from across NCL to different elective surgery sites under the current and proposed future model, there is no indication as to what the most common mode of travel is for different groups of patients at present, particularly for their journey home after their operation (where public transport may not be practical for

Background	Commentary
within a 15 minute car journey would reduce from 68% to 28%. Of the protected characteristic groups assessed, car travel times would be worst for black and Turkish populations. The analysis suggests that in all or almost all cases, the increase in travel time would be from a journey of under 15 minutes to a journey of under 30 minutes.	some post-operative patients, for example those who have undergone lower limb surgery). It would be useful to establish this in order to understand what the material change in transport options would actually be, for different patient groups: for example, a 15 minute increase to public transport times, or an increase in taxi fare? Establishing these facts would likely aid the development of strategies and services aimed at mitigating the negative impact of increased travel times, distances, complexity and cost. The modelling does not establish what time of day patients are required to attend for surgery, which may be a particular concern for patients required to attend early in the morning when bus routes are less frequent. The third equality impact assessment [7] which took into account feedback from the consultation stages, proposed that particular focus was given to ensuring appointment times were discussed in advance with patients with carer responsibilities who might find it particularly difficult to schedule being away from those they cared for and therefore seek to minimise that. This was discussed during the mitigations workshop, but it is not yet clear if it will be adopted. While patients would have a choice between two elective care partners (the Northern Partnership of North Middlesex and Royal Free NHS Trusts, and the Southern partnership of UCLH and Whittington Health Trusts) it is not clear if they would be able to opt to split their surgery and after care between the two partnerships – for example, receiving their outpatient care at the Royal Free, which is part of the Northern Partnership but their operation at UCLH, which is part of the Southern Partnership. This may exacerbate travel times for patients asked to travel to Chase Farm EOC, for example, when travel to the UCLH EOC would be quicker – especially those living close to the Royal Free site and receiving their pre- and post-operative care there. The outgoing chair of the NCL Joint Health Overview and Scrutiny Committee has reported unease and concern amongst the local community about worsening travel distances and times for patients. These concerns are exacerbated, the chair reports, by a sense that current patient transport arrangements and travel reimbursement schemes are poorly run, unclear or hard to access. Improving these arrangements could go some way to mitigating some of the risks highlighted in the transport report. The chair feels strongly, after listening to patients and residents, that essential health service reconfigurations will be jeopardised unless travel is made easy, reliable and affordable for all [B4].

Background	Commentary
The care coordinator role The move to a model where a patient's care is shared between two sites – a base local hospital where pre- and post-operative outpatient appointments are carried out, and an elective care centre were only the operation is performed – presents particular risks to patients who might struggle to navigate this additional complexity (for example due to language, visual or hearing impairment, mental health or learning disability). The NLP proposals include introducing a "care coordinator" role based at EOCs to mitigate this concern. Following public consultation, specific recommendations are included in the third stage impact assessment [7] for expanding the care coordinator's role further to include ensuring the needs of patients who are also carers, and of patients who are transgender, are addressed.	The "care coordinator" role is new and may need some iterative development as the model is implemented. There is also a danger that the role becomes over-burdened as a "one stop shop" for mitigating a potentially growing number of foreseen and unforeseen problems as patients are asked to adapt to a model where different parts of their care are given by different providers and on different sites.
Addressing unwarranted variations in outcomes The proposed changes are intended to implement best practice in elective orthopaedic care by separating elective procedures from emergency procedures. The widely recognised potential benefits include: • lower rates of surgical site infection • lower cancelation rates • improved (reduced) waiting times • lower revision rates. As such, the proposed changes have the potential to improve the quality of care for all. However, as discussed above, the impact assessments to date do not explore unwarranted variations in access or outcomes between equality groups under the current configuration of services and so it is not possible to comment on how the plans will address these.	Nationally, there is evidence of socio economic inequality in access to elective hip and knee surgery in the NHS, with poorer patients receiving care at a lower than expected rate, and later in their disease progression [B2]. There is also relevant international research suggesting that outcomes from, and access to, hospital care diminish with distance from hospital provider [B3]. Given the deteriorations expected in travel time, distance and cost for poorer communities in particular, it may be appropriate for NLP to undertake further analysis – perhaps using focus groups – to explore how increased travel time/distance might influence patients, carers and GP referrers. Such analysis could explore the potential impact of travel time/distance/cost on decisions to seek or take up elective orthopaedic surgery, choice of provider, as well as on the patient's experience of elective surgery itself (for example additional hardships in travel). Such analysis might also help inform strategies and services designed to mitigate and reduce inequalities. It should be noted that exacerbated travel times and cost relate only to the inpatient care element of the care pathway as there will be no changes to where patients receive their pre- and post-operative care.

Background	Commentary
Primary prevention While the proposed changes focus almost exclusively on elective secondary care, they are being made in the context of a wider development of the entire musculoskeletal pathway which aims to also improve prevention and patient self-care.	As commented above – a more granular understanding of inequalities in access to, outcomes from and experience of musculoskeletal healthcare in NCL at present would greatly aid the development of effective strategies and services to tackle unwarranted variations in health status and health outcomes between different population groups. Further mitigation to unequal access to orthopaedic elective care (should it be found though a baseline analysis of activity rates under the current configuration of services) could be provided through proactive case finding in primary care to reduce unmet need amongst target groups, as well as improving access to alternative pathways such as physiotherapy. However increasing activity to address unmet need could increase activity rates and therefore costs to NHS commissioners This is considered further on the issue of unmet need in the second test on beds. Obesity is a significant factor in osteoarthritis, associated with both its incidence and progression. In 2018, the average BMI of patients receiving a hip replacement in the UK was 28.7 – falling into the category of "overweight" – while the average BMI of patients receiving a knee replacement was 30.8 – falling into the category of "obese" [B5]. NLP have expressed an ambition to slow the growth in elective orthopaedic surgery, but any strategy to do so must include a public health focus, particularly on reducing obesity rates. Obesity is a disease which disproportionately affects poor and Black and minority ethnic communities. The Decision-Making Business Case (DMBC) states: "It is recognised orthopaedic secondary care services sit within the wider context of the musculoskeletal (MSK) pathway and this pathway would benefit from additional quality improvements to deliver excellent patient outcomes and experience more widely. Optimisation of primary and community intervention is critical for the success of the overall MSK pathway." It further states that the health inequalities assessments undertaken in respect of the elective orthopaedic review, together with local public health data "will underpin service development to ensure equitable services are targeted to the needs to the local NCL population and additional strategies to support at risk and vulnerable patient groups are implemented". As made clear in our original assessment, further analysis of local public health data is needed beyond that presented in the three impact assessments.

Test 2: Hospital beds

Given that the need for hospital beds is forecast to increase due to population growth and an ageing population, any proposals to reduce the number of hospital beds will need to be independently scrutinised for credibility and to ensure these demographic factors have been fully taken into account. Any plans to close beds should also meet at least one of NHS England's 'common sense' conditions

Background	Commentary
Current capacity and activity baseline To assess NLP's proposals against the Mayor's second test, "beds" is considered as a shorthand for both the physical space in hospitals needed to put beds and the clinical staff needed to ensure patients can safely be cared for in these beds. It is important to ensure that proposed service changes will provide sufficient bed and staffing capacity to meet the expected future needs and numbers of patients.	The central tenet of the reconfiguration is to "ring fence" elective orthopaedic surgery away from emergency surgery, as suggested by best practice [B6].
NLP is clear that the central driver for its elective orthopaedic review is to improve care quality, waiting times and patient outcomes, rather than to reduce cost or bed numbers [1].	
The Decision-Making Business Case (DMBC) makes clear that the clinical case for establishing "ring fenced" elective orthopaedic surgery centres has been strengthened by the coronavirus pandemic, where it has been crucial to establish emergency and elective (COVID-19-free) surgery pathways. The DMBC states: "At a time of infection and significant public health concern, providing streamlined, well-coordinated care in protected clean sites should be seen as the exemplar of how elective care is delivered in the post-COVID-19 environment." [20]	NLP's plans to ring fence elective orthopaedic care predates the coronavirus pandemic, but they are likely to support providers in continuing to deliver safe elective care over the coming months when further surges in COVID-19 are expected.
The plans will see a modest increase in the number of beds in NCL's NHS hospitals that are ear marked for adult elective orthopaedic patients from approximately 68 in 2019 to around 79 in 2023. These new beds will be based at the two proposed EOCs, at Chase Farm Hospital to the north and UCLH to the south.	Current practice – where emergency patients are placed in beds originally intended for elective patients, frequently leading to elective orthopaedic surgery being cancelled – means that it is hard to accurately establish how many beds are used to care for the numbers of elective orthopaedic care patients being treated today. Further work – potentially involving bed audits – may be needed to give NLP an accurate picture of their elective orthopaedic bed use under the current model, so they can more accurately forecast how many are likely to be needed in the future and under the proposed new model of care.

Background	Commentary
	The DMBC states that although there will be 27 ringfenced EOC beds (up from 21) in the southern partnership (at UCLH) by 2023-24, "initially" there will only be 22 [20].
Activity growth rate assumptions NLP has assessed that underlying demand for elective orthopaedic surgery – measured in terms of the patients likely to need it - will grow by around 1.5% a year over the next decade [1]. This figure broadly reflects projected demographic growth of around 1.3%. However, NLP plans for elective orthopaedic surgery activity (measured in terms of operations a year) to grow at a lower rate of around 0.7% to 1% a year. It is NLP's assumption that elective orthopaedic activity will grow at this slower rate regardless of whether or not the new EOC model is adopted. The Clinical Delivery Model [2] describes NLP's assumption that the underlying rate of growth in demand for elective orthopaedic can be slowed through the application of commissioner policies to manage demand. A key policy in this was originally referred to as "procedures of limited clinical effectiveness" (PoLCE) [B7] but has more recently been reviewed and renamed "evidence based interventions and clinical standards" [B9]. The policy lists procedures (including several orthopaedic procedures such as knee arthroscopy) which NHS commissioners will not routinely fund. In addition NLP expect the London "Choosing Wisely" programme [B8] and the increased use of alternatives to surgery such as physiotherapy [B12] to also result in a slowing of the rate at which demand for elective orthopaedic surgery has been growing.	It should be noted that plans involve moving (sometimes called "repatriating" [B22]) the majority or all of patients who under the current model have their care funded by the NHS but provided in private hospitals. The plans foresee all these patients eventually being treated in NHS hospitals. This is expected to save the NHS money, but will put an additional pressure on the need for beds within NHS hospitals, as private hospital capacity will no longer be used. Figures set out in NLP's May 2019 Clinical Delivery Model suggest local private hospitals currently provide the equivalent of four beds for NHS elective orthopaedic patients. These would need to be matched under the new model if patients were instead cared for in NHS hospitals [2]. Once those four beds are counted as beds currently used by NHS elective care patients, the planned like-for-like increase in beds available for NHS patients is reduced from 11 extra beds to 7 by 2023. As discussed further below in the financial test, the coronavirus pandemic and associated infection prevention and control measures (for example enhanced requirements around deep cleaning facilities between patients) has slowed the rate at which hospitals can treat patients with their current physical and staff capacities. As set out in the DMBC, the NHS has nationally commissioned additional independent sector capacity as a result of the pandemic. The DMBC analysis reduces the original assumption made about the numbers of patients funded by NCL CCGs who could move from the independent sector to the EOCs by 2023-24 by around half, to potentially around 850 patients [20]. This represents a proportion of the total activity currently commissioned from the independent sector by the CCG. NLP explain the reduction is in a part a result of a shift in time scales, caused by the coronavirus pandemic and it is assumed that potentially more activity could flow in subsequent years [B23]. However, some of that reduction is off-set by a new assumption in the DMBC that around 350 NHS patients who are resident outside the NCL commissioning area will be treated in the NLP's EOCs in the future. These patients are currently turned away from the Royal National Orthopaedic Hospital as they do not require specialist care and are treated in hospitals outside the NCL area. Treating these patients in NCL hospitals brings financial benefits to the NCL health economy but will act as a further pressure

Background	Commentary
	on its beds and capacity. A comparison of figures provided in the Clinical Delivery Model [2] PCBC [1] and DMBC [20] suggests that around a third of the growth in elective orthopaedic activity to 2023-24 in NLP's providers (assumed to be around 3.7% higher than the 2019-20 activity baseline – following annual growth of around 0.9%) could be driven by a combination of repatriated patients from private hospitals and patients from outside NCL originally referred to RNOH. How those patients will impact demand for beds will depend on the proportions of patients treated as day cases. NLP have indicated they will work together to avoid a situation where bed capacity is insufficient and to agree principles for determining patient priority [B23]. The 0.7% to 1% growth rate stated in the PCBC represents an increase from the 0.4% rate set out in the earlier Clinical Delivery Model [2]. However, concerns were still raised by the London Clinical Senate about the accuracy of the revised rate [6]. The Senate said it was "debateable" that improvements in the wider musculoskeletal pathway would succeed in reducing growth in demand to below the rate of demographic growth. While the Senate noted that the proposed reconfiguration would be better able to meet growing demand than the existing arrangement, it stated that additional workforce would be needed if activity grew at a higher than planned rate [6]. NHS England "RightCare" analysis published in 2019 shows that three of the five NCL CCGs (Barnet, Camden and Haringey) were spending less than their peers on inpatient care for osteoarthritis patients and have a lower than expected rate of hip and knee replacements. Spending and procedure rates in Islington are higher than expected, while figures for Enfield are inconclusive [B10]. These figures could indicate an under-utilisation or under-supply of elective orthopaedic surgery in parts of the NCL area at present and that attempts to further reduce activity to below the rate of demographic growth could potentially result in residents' healthcare needs not being met. There is a risk that NLP has been over optimistic about the impact its "evidence based interventions and clinical standards policy" [B9] will have. Earlier iterations of the policy have been in place amongst NCL CCGs since 2011.

Background	Commentary
Waiting times NLP envisage that the extra beds and ring fenced nature of the EOCs would over time enable 92% of patients being referred for elective orthopaedic procedures to receive their care within the national 18 week referral-to-treatment target [2]. This would mark an improvement against current performance where only 79% of patients were treated within 18 weeks between January 2018 and 2019 [1].	Although NLP plans for orthopaedic waiting times to return to the national referral to treatment standard (92% treated within 18 weeks of referral) activity rates and commissioner spending assumptions have not been adjusted to allow for the "catch up" needed to meet this (nationally, the 18 week target has not been met since 2016). Even without the impact of Covid-19, such a catch up would likely require both a temporary increase in activity to clear the "backlog" of patients waiting over 18 weeks, as well as a more modest permanent increase in activity to prevent waiting times from growing again. The DMBC states that further work is pending to validate the size of the waiting list following the temporary suspension and slow-down in elective activity due to the coronavirus pandemic [20]. It states that NLP commissioners and providers will work together to address the backlog using a common set of principles for prioritising patients and so minimise variation and inequality between the five boroughs and former CCG areas. The rate at which the waiting list backlog will be addressed will depend in part on national policy and funding which has yet to be clarified. NLP believes there is some capacity at both the proposed EOCs to absorb additional activity growth beyond the ~1% a year currently planned, through the provision of additional beds; additional capacity in operating theatres; making the centres operational 7 days a week; and through further expected efficiencies not currently assumed in the PCBC [B11]. NLP plan to complete a sensitivity analysis on its activity growth rate assumptions as part of its Decision Making Business Case. The DMBC states that the EOC at UCLH may be able to provide up to an additional seven beds above the planned total of 27 by 2023/24, "if required". While such additional capacity will be useful in addressing any excess demand (including that relating to the need to reduce the waiting list backlog) it should be noted that it will need to be funded through additional income to providers from commissioners. The sensitivity analysis will now need to reflect the additional pressures brought by the COVID-19 pandemic, as well as the ongoing uncertainties resulting from the pandemic which may entail that assumptions need to be frequently revisited and revised. On the demand side, consideration will need to be given to the original activity growth rate assumptions, along with an analysis of the now-expanded waiting list for orthopaedic surgery has affected the level of underlying demand. On the supply side, revised modelling will need to consider how on-going Covid infection prevention and control measures have reduced hospital productivity, capacity and the availability of staff. Activity assumptions will also need to consider commissioner affordability and national policy with regards to waiting time standards – for example the expected trajectory for "recovering" the 18 week waiting standard.

Background	Commentary
	It is not clear what adjustments NLP have made to their activity assumptions in the DMBC to reflect the restrictions imposed by the coronavirus pandemic, beyond the slowing of the pace at which NHS patients are repatriated from private hospitals to the EOCs. This is partly because similar (if not worse) capacity constraints would be present in a "do nothing"/"no change" scenario. However further work will still be required to ensure activity levels and expectations are understood and gaps in capacity made clear. The LCS was told that plans for clinical posts would remain static between the current model of care and the proposed new model [6]. However as beds and staff capacity currently ear-marked for elective orthopaedic patients are routinely used instead for emergency patients (leading to cancelations for elective patients) NLP will want to assure themselves that the new EOCs do not in effect subtract from the recruitment and retention of nursing, AHP and theatre staff at base hospitals where they will continue to be needed to care for emergency patients.
Implications for co-dependent hospital services NLP has been mindful of the need to avoid unintended consequences for co-dependent clinical services following the separation and ring fencing of elective orthopaedic surgery, (such as trauma care), which will need to remain at base hospitals. NLP have sought advice and input from the London Clinical Senate on this [6]. The clinical delivery model assumes that emergency orthopaedic surgery rotas are maintained at all sites [2] The Clinical Senate agreed that rotas for orthopaedic surgeons could be designed to ensure sufficient cover at both base hospitals and EOCs to protect emergency care at base hospitals. However, it also urged for greater senior nurse and allied health professional input into the planning and development of proposals.	Recruitment and retention of clinical staff is a critical problem for the NHS in general and so any revised assumptions about workforce numbers will need to consider where additional staff come from, to ensure they do not undermine NHS services elsewhere.

Test 3: Financial investment and savings:
Sufficient funding is identified (both capital and revenue) and available to deliver all aspects of plans including moving resources from hospital to primary and community care and investing in prevention work. Proposals to close the projected funding gap, including planned efficiency savings, are credible.

Background	Commentary
The current funding gap Orthopaedic Centres which, as a minimum, would improve the financial position for the NHS as a whole in NCL after two years of operation and with no additional capital or revenue costs for NHS commissioners [2]. The PCBC presents figures showing the expected financial position over 5 years under the current status quo model of care, and the proposed new model. In both cases the activity growth rate is assumed to be the same. The figures suggest that the four trusts that will be partnering under the proposals currently spend around £42.6m a year on providing elective orthopaedic care to NCL residents [1]. Under the current NHS financing regime, where NHS commissioners "purchase" care from providers on behalf of patients according to a national price list or tariff, trusts receive approximately £39m in income for that elective orthopaedic care. The figures presented in the PCBC therefore show an elective orthopaedic care funding gap (or financial loss) for NHS providers of around £3.6m a year. NLP projects that without any changes to the way care is delivered, that £3.6m funding gap will grow to around £4.5m by 2023-24 [1].	The £3.6m loss shown in the financial modelling as the current loss or funding gap experienced by NCL providers in treating elective orthopaedic patients requires some further explanation. The figure is shown in the PCBC for illustrative purposes and is driven in part by including under "elective orthopaedic costs" the costs of maintaining the unused capacity at both the existing Chase Farm EOC and at UCLH's incomplete phase 4 development, even though that capacity is not currently utilised to care for elective orthopaedic patients. This has the effect of inflating the reported costs of elective orthopaedic care under the current model. The rationale for presenting the figures in this way is that the cost of maintaining the currently unused capacity is a cost that is already being born by NHS providers in NCL, which they will need to continue covering regardless of whether the proposed changes for elective orthopaedics are adopted or not. NLP's proposals for elective orthopaedic care represent an attempt to utilise currently unused NHS capacity to meet expected future demand for elective orthopaedic care with minimum additional costs, particularly for capital. However, it is important that ongoing work on the cost implications of the proposals is transparent about how the cost comparisons between the existing and proposed models are made. The DMBC contains substantial revisions to the financial projections. This reflects more detailed and up-to-date information on costs (including "bottom up" costing from theatres and wards) and the impact on costs and capacity of coronavirus and associated infection prevention and control measures. Changes have therefore been made to both to the status quo/no change projections, as well as to projected finances under the proposed changes. The updated projections in the DMBC therefore show that elective orthopaedic care under the status quo arrangement is expected to experience a funding gap this financial year (2020-21) of £6.2m, up from £4.5m anticipated at the time of the PCBC [20]. This funding gap is equivalent to around 16% of the income NLP providers receive to care for elective orthopaedic patients. That gap is now projected to grow to £7.5m under the status quo arrangement by 2023-24 [20].

Background	Commentary
Planned efficiencies from new model The PCBC projects that moving to the proposed new model of elective orthopaedic care will allow the expected £4.5m funding gap by 2023-24 to be reduced to £3.3m. This £1.2m improvement in NHS trust finances would be achieved without extra cost to commissioners, but through a series of modest efficiency gains to reduce provider costs, made possible by the new model of care. The PCBC sets these out as [1]: • more effective bed use, for example patients in higher cost post-surgery beds for shorter periods • economies of scale in procurement, for example of orthopaedic implants • moving services to NHS providers who are already more efficient • reduced cancelled operations	NLP have been prudent in their estimates of potential efficiency savings stemming from the new model of care. For example, the financial assumptions do not include any change to current patient length of stay or an increase to the proportion of patients who are treated as day cases. Improved care quality, with lower infection and readmission rates also has the potential to reduce cost overall. NLP plan to set out further expected efficiencies in the DMBC [B11]. The revised projections show the elective orthopaedic funding gap reducing from £7.5m in 2023-24 under the status quo arrangement to £6.7m under the proposed new model of care [20]. This is a more modest improvement (£804,000 rather than £1.2m) than originally planned at the time of the PCBC, which in part reflects the constraints the coronavirus pandemic has imposed on the ability of NHS providers to increase efficiency – for example through driving up bed utilisation rates. Work continues to identify further efficiency savings which may result from the closer collaboration of NLP providers [20].
Planned additional income and activity for NHS providers In addition to these efficiency gains, proposals include moving, or "repatriating" the majority or all NHS-funded patients who currently choose to have their elective orthopaedic surgery at a private hospital. These patients would instead receive their care at an NCL NHS hospital. The majority of NHS patients currently being treated in private hospitals are resident in Enfield, where patients opt to receive care in a local private hospital under the patient choice policy. Under the proposed change they would most likely have their operation at Chase Farm EOC and be cared for through the northern partnership. Moving these patients from private to NHS hospitals would mean the funding that NHS commissioners currently pay private hospitals to care for those patients would instead be paid to NCL's NHS hospitals. The change would be cost neutral for NHS commissioners as the tariff price paid to	NLP state in the PCBC that over time they would expect patients being treated in the independent sector to have their care in one of the two NHS EOCs. NLP state that it is a result of their revised standards for commissioning adult elective orthopaedic care. These standards include requiring facilities treating NHS patients to have as a minimum a level 2 High Dependency Unit (capable of offering organ support). NLP's proposal is that in the future they will only contract with local providers who meet those standards, which will require contractual changes with private providers. It is anticipated that all or the majority of local private hospitals will not be able to meet the new standards, whereas the EOCs will. NLP have advised that as part of the DMBC they will include a section on the approach to patient choice which will reflect on the feedback to the public consultation [B16]. The financial benefits to the NHS as a result of this change - outlined in the PCBC - are contingent on NHS commissioning funds which are currently flowing to private providers instead being redirected to NHS providers. This will require contractual changes with private providers which means the bulk of the

Background	Commentary
private and NHS hospitals is the same. However, the increased numbers of patients being cared for by the NHS hospitals would allow the hospitals to gain from economies of scale and effectively make a margin on the income they receive for caring for those patients. This would be a net benefit for the NHS as the income would be retained in the NHS rather than in the private sector.	financial benefits currently anticipated are sensitive to the successful phasing and completion of those changes and ensuing discussions. NLP may also need to revise its assumptions about both NHS and private capacity in the light of the ongoing COVID-19 pandemic (for example the anticipated need for the NHS to make use of private sector capacity to address waiting lists and productivity constraints resulting from COVID-19) and consider how these effect the financial modelling, if at all. As a result of capacity constraints imposed by the coronavirus pandemic, the DMBC changes the phasing around the activity shift assumptions from patients within the independent sector by 2023/24 by around half (with additional benefits assumed the following year). This results in a substantially smaller financial benefit to NLP providers: from £721,000 expected at the time of the PCBC to £488,000 in the revised projection. However this "loss" (compared to the original repatriation plans at the time of the PCBC) is more than off-set by the inclusion in the revised financial projections of an additional £354,000 in financial benefit by 2023-24 gained through the importing of new NHS patients who are currently treated in hospitals outside NCL [20]. These patients make up a subset of the 2,700 NHS patients who are referred to the Royal National Orthopaedic Hospital each year but are turned away as they do not require specialist care [20]. They are resident outside NCL and so are funded by CCGs other than NCL CCGs and are currently treated in hospitals outside NCL [21]. NLP have estimated that if a proportion of those patients (around 13%) were treated in the EOCs, this would bring a net financial benefit of around £354,000 a year by 2023-24. The PCBC did note that there was potential for the EOCs to make a financial gain by importing RNOH referrals but noted it would be imprudent to factor that benefit in as it • relied on the "Payment by Results" funding framework which is currently uncertain, and • would not represent a financial benefit to the NHS as a whole [1]. The PCBC anticipated that the financial gain to NCL would be substantially lower (around £109,000 a year) than now forecast in the DMBC.

Background	Commentary
	As noted in the bed test above, there is a danger the importation of NHS patients from outside NCL will detract from NLP's ability to meet the level of demand from its own residents, particularly given the capacity constraints imposed by coronavirus. It is not clear from the DMBC why NLP providers are expected to be able to absorb additional activity stemming from RNOH referrals, but has changed the phasing of the expectations relating to the shift of NCL NHS patients from the independent sector. Although anticipated gains from repatriating patients are significant, the PCBC still projects that NHS hospitals in NCL will make a loss on their elective orthopaedic activity of around £3.3m, or 8% in 2023-24. This suggests a fundamental misalignment between the price paid by NHS commissioners (currently under the NHS tariff) and the cost of treating elective orthopaedic patients – a misalignment which is reflected elsewhere in acute care costs [B14]. If services are to be sustainable, commissioners and providers will need to address this misalignment through either increased cost efficiencies or increased funding. However, the scope for doing this will be limited by available funding and potentially more pressing demands from elsewhere in the system (such as emergency care). Revised financial projections in the DMBC – which include an estimate of the ongoing cost implications of the coronavirus pandemic – show a funding gap after implementation of the new model of £6.7m by 2023-24 [20].
Transitional and additional costs in new model of care Against these financial benefits, the PCBC also estimates headline additional costs associated with the new model of care. These include: • "stranded costs" of beds and staff capacity, which will remain at base hospitals but initially be underutilised when elective orthopaedic surgery moves to EOCs • transition costs to set up or extend EOCs • additional on-going costs to make the currently unused capacity at Chase Farm and UCLH's phase 4 development operational as EOCs – for example the cost of providing additional staff to ensure EOC beds are "ring fenced".	The financial costs and benefits of the new model differ between the two partnerships. Figures presented in the PCBC have pencilled in only modest efficiency gains resulting from the proposed changes of around £260,000 by 2023-24 for the northern partnership. This is because the Chase Farm EOC is already in operation and so the majority of benefits stemming from it would be realised regardless of whether the wider changes were adopted or not. However, this also means the transition and additional operating costs associated with the new model for the northern partnership are also relatively low, as these have either already been incurred or would similarly happen under either scenario.

Background	Commentary
Figures set out in the PCBC show that by the end of the second year of operation (envisaged as 2021-22) the combined benefit of (a) efficiency savings and (b) increased net revenue as a result of repatriating patients from the private sector will be sufficient to off-set the additional operating, stranded and transition costs across the two partnerships. As projected gains gradually increase and transition costs diminish, the PCBC forecasts a net benefit to the two partnerships (spanning 4 NHS hospital trusts) of just under £1.2m by the end of the fourth year (2023-24). This is shown as a reduction in the elective orthopaedic care funding gap that would otherwise be expected that year from £4.5m to £3.3m [1]. As explained above, the revised financial forecast in the DMBC shows a net benefit by 2023-24 of £803,000, reducing the relevant funding gap from £7.5m under the current model of care to £6.7m if proposals are successfully implemented [20]. The five NCL NHS provider trusts and CCGs have signed a memorandum of understanding agreeing the principles upon which future discussions around sharing the cost and benefits of the new model will be based, including the principle of a NCL system-wide view on investment.	Another difference between the partnership is that the northern partnership expects to gain significantly more through the assumed move of patients from private providers (£688,000 in revenue margin in 2023-24- after the cost of treating those patients – compared to just £55,000 for the southern partnership). As noted above, the phasing of assumptions around patients shifting to the NHS from the private sector has been changed. The DMBC forecasts a £435,000 benefit to the northern partnership and a £53,000 benefit to the southern partnership [20]. The off-setting financial benefit of imported RNOH referrals differs between the partnerships. The DMBC forecasts a net £99,000 benefit by 2023-24 to the northern partnership and a £255,000 to the southern partnership [20]. The planned EOC at UCLH in the southern partnership is not yet in operation and will be developed as part of UCLH's ongoing "phase 4" capital programme. Moving elective inpatient orthopaedic patients from Whittington Health to the EOC at UCLH is expected to result in spare capacity at the Whittington, which the PCBC shows will need to be funded as a stranded cost until it is absorbed through additional alternative activity by the third year of operation (2022-23). The model also anticipates higher additional on-going operating costs associated with running the EOC which will not be offset until the third year. There has been a substantial reduction in anticipated transitional costs forecast for the southern partnership between the PCBC and the DMBC, from £1m to just £390,000. The DMBC implies this reworked calculation is "based on the experience of other transformation programmes". The differing cost and transition profiles of the two partnership means that while the additional and transition costs of model across NCL as a whole will be neutral by the second year, this relies on the northern partnership delivering early gains in order to offset the slightly longer transition phase required in the southern partnership. These differences and financial co-dependencies highlight the need for cross-NCL agreement on how the cost and benefits of the new model will be shared. As NLP are fully aware, the NHS financial system is expected to be subject to quite substantial change over the next 3 to 5 years. Much is still uncertain but there is an expectation that the focus of funding will

Background	Commentary
	shift from individual organisations earning income on a pay-for-volume basis (under the NHS tariff) to a more whole system approach, akin to block and grant funding. While this will present some advantages to system-wide strategic development, it will also present challenges, especially if individual trusts and foundation trusts remain accountable for their own performance. It will also present challenges in terms of adequately tracking funding flows and cost which will be needed to ensure resources are invested where needed.
Capital costs The capital investment required to establish the two planned elective orthopaedic centres has either already been incurred or planned and agreed as part of wider trust developments. In the case of the Northern Partnership, the plans involve filling the currently spare capacity at the Chase Farm elective orthopaedic centre which is already in operation [1, B11]. The Southern Partnership will see clinical space currently under construction on Tottenham Court Road and referred to as UCLH's "phase 4" development configured to accommodate an elective orthopaedic centre. UCLH's phase 4 development predates discussions on elective care reconfiguration and NLP's plans assume that using some of the physical capacity created through the development for an elective orthopaedic centre will not increase the capital costs of those pre-existing plans [1].	Although the capital required to make both EOCs operational has already been committed, and predates plans to reorganised elective orthopaedic care, the more recent plan to commit part of UCLH's phase 4 capital development to elective orthopaedic care could have an impact on how the costs of orthopaedic care in NCL are presented and accounted for. In particular, depreciation and capital charges relating to part of the UCLH phase 4 development could be attributed to the elective orthopaedic service line. Unless properly acknowledged and explained, this could have unintended consequences for how the service is administered and regulated – for example making orthopaedic surgery appear more expensive in comparison to other NHS service lines than it otherwise would.
The DMBC identifies a need for capital investment in digital clinical image sharing between providers. This will be delivered through the OneLondon NCL Imaging Solution Programme at a total cost of around £470,000. Of this, around £250,000 will be provided by the centrally-funded 'One London' digital investment programme with the balance funded in equal shares of £40,000 by the four NCL partnership NHS trusts as well as the RNOH [20].	The DMBC notes the new imaging capabilities will have benefits to services beyond orthopaedics [20].

Test 4: Social care impact

Proposals take into account a) the full financial impacts on local authority services (including social care) of new models of healthcare, and b) the funding challenges they are already facing. Sufficient investment is available from Government to support the added burden on local authorities and primary care.

Background	Commentary
NLP acknowledge that the impact of their proposed changes to elective orthopaedic care on adult social are services in the area has not yet been a primary focus of its work. If plans are progressed after the consultation, then further work in this area will be undertaken.	The implicit assumption has been that elective orthopaedic care does not have as many co-dependencies on adult social care as emergency orthopaedic care. This will need to be tested and care taken to ensure the growing numbers of elderly, disabled and otherwise vulnerable patients receiving elective orthopaedic care are able to be looked after in their own homes after hospital discharge. The London Clinical Senate also expressed a view that greater engagement is needed with social care planners to ensure that discharged patients also have access to appropriate services and equipment to enable them to stay in their own homes and minimise the number of readmissions [6].
The new model of care includes the introduction of "care coordinators" based at EOCs who will help vulnerable patients navigate their way between the different NHS providers of their care as well as adult social care.	It will be important to establish which organisation – the EOC or the base hospital – will be responsible for supporting a patient's access to appropriate adult social care services. Care coordinators may well be suitably placed but will need to develop links and relationships with up to 5 separate NCL London boroughs, as well as with a multitude of NHS acute and community care providers. If this role is to help reduce care complexities and fragmentation for patients, it will be important to ensure it is properly resourced.
A 12 month pilot (due to end September 2020) in Barnet is exploring the potential benefits of a "discharge to assess" programme for non-weight-bearing orthopaedic patients. Under these programmes, an individual's ability to recover in their own home is assessed at home rather than in hospital, with perceived advantages in that patients feel more comfortable and therefore more confident and independent in their own environment [B15]. NLP plans to incorporate the learning from the pilot into its plans for discharge from the elective orthopaedic pathway.	The development of a functioning "discharge to assess" arrangement will require careful capacity planning with adult social care services to ensure the staff needed to undertake assessments at home are available. There may well be substantial differences between the non-weight bearing patient cohort assessed in the pilot and the case mix of patients expected at the EOCs. The DMBC states that the implementation phase of the plans will involve a review of discharge arrangements undertaken by a nominated lead from adult social care [20].

Test 5: Clinical support

Do the proposals demonstrate widespread clinical engagement and support, including from frontline staff?

Background	Commentary
Do the proposals include a demonstrable, robust clinical case for change, including an improvement in both quality of care and outcomes? NLP have proposed a new model of care for elective orthopaedic patients within North Central London. This is in the context of [1]: • rising demand for services with a 9.5% increase in activity forecast to 2029 • growing waiting lists and waiting times for surgery • frequent late notice or last minute cancellations of surgery, with almost all of them on the day of surgery • length of stay is inconsistent with two out of four local providers having higher lengths of stay than the English average • variation in infection, readmission and revision rates across providers. The London Clinical Senate (LCS) review of the proposals prior to consultation concluded that there was a "…strong case for change. There is extensive evidence cited in the pre-consultation business case and orthopaedic experts on the panel recognised that the separation of elective and urgent care has the potential to deliver safer and more effective interventions." [6]	The quality indicators that will be used to measure improvement in practice had not been finalised at the time of the consultation. Both the PCBC [1] and the DMBC, which were supplied for review state that indicators will be developed as part of the implementation process, in partnership with the orthopaedic clinical network. The DMBC includes a proposed 'benefits framework', which identifies a number of metrics of importance to both patients and clinicians. These include process and satisfaction measures, and outcome measures where those are available. Examples of proposed metrics include: • number of cancellations for non-medical reasons • waiting times • patient satisfaction scores • number of emergency readmissions • length of stay • staff satisfaction • proportion of local population out of work due to musculoskeletal issues. The framework as currently drafted does not include baseline performance on the measures and nor, with a few exceptions, have clear improvement targets been set at this stage, although the intended direction of travel is clear.
Do 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 LCS concluded that there had been good engagement with relevant medical staff across the hospitals involved [6]. It also noted that primary care clinicians were supportive of the proposals. However, it noted that there had been relatively less engagement with nursing or Allied Health Professional (AHP) clinicians in the development of the proposals and noted in particular that	It would be useful if NLP could demonstrate how plans have/ will be further developed or finessed following the greater involvement of nursing and AHP representatives in the clinical network.

Background	Commentary
"…attention should be given to the whole multidisciplinary team i.e. operating department practitioners and theatre nurses. As staff will often work in more than one specialty there may be an impact on the existing workforce if staff move to elective centres. Senior nursing and allied health professional involvement in the network board could provide the scrutiny needed to ensure the delivery of a safe staffing model." [6] Subsequent to the LCS review nursing and AHP representatives and leads have been appointed to the clinical network [B17].	
Do the proposal have the support of pan-London clinical bodies – London wide LMCs, London Clinical Senate? As noted above, the LCS has given its support to the proposals, although their report included 23 recommendations to be considered as the plans developed further. The recommendations were grouped under 7 themes. Recommendations include the following [6]: • Model of care: The LCS recommends that quality indicators and improvement metrics are built into the standard operating procedures. Where possible, these are collected digitally. • Evidence: The LCS recommends that patient information literature is co-designed with patients and improvement metrics are made available to patients. • Musculoskeletal (MSK) pathway: The LCS recommends that a sustained education model is developed for stakeholders of the service covering topics such as discharge communication. • Demand and sustainability: The LCS recommends mitigating against avoidable growth in activity by ensuring that interventions are provided to the right patients at the right time, through adhering to recommendations relating to the musculoskeletal pathway. • Workforce: The LCS recommends considering the willingness and availability to flex staff across sites, paying attention to passporting, rota and work schedules.	Both the PCBC [1] and DMBC include an appendix showing progress made against the LCS recommendations, although there is no material difference between the two despite the passage of time. For the most part, the business case states that the recommendations will be taken into account as implementation plans are agreed. This is not in itself unreasonable, as most of the recommendations are essentially practical in nature and do not relate to fundamental concerns with the model.

Background	Commentary
• Digital innovation: The LCS recommends that the Programme plan a time to explore the potential for shared booking to be available across the system to smooth the patient pathway.	
The LCS raised a concern on the activity modelling that underpins the business case (as shared with them in 2019) noting that although changes to the overall MSK pathway may reduce referrals, this would likely be offset by demographic growth. However, the LCS also "…considered that the proposal provides at least equivalent if not greater assurance of service sustainability and the potential to manage growth than the current configuration." [6]	The concern underlines the importance of ensuring that the financial model and risk sharing arrangements are clear and agreed by all parties and that the costs of activity in excess of plans is fully funded. However, as we noted in the earlier beds test, NHS providers' ability to meet demand in excess of plan will be limited by staff availability and new physical constraints stemming from COVID-19 infection control and prevention measures.
It is also worth noting that although the LCS were broadly comfortable with the likely impact on medical staff as a result of splitting emergency and elective care, it was less clear whether the impact on non-medical staff, in particular nursing and AHPs, has been fully worked through.	As noted in our report on the 'beds test', NLP will want to assure themselves that the new EOCs do not in effect subtract from the recruitment and retention of nursing, AHP and theatre staff at base hospitals where they will continue to be needed to care for emergency patients.
Do proposals have the support of local authority social care and other professionals? The acting chair of the Joint Health Overview and Scrutiny Committee for the five NCL local authorities wrote to NLP in mid-September 2020 expressing the committee's support for the proposals and stating "we find that the consultation with local authorities is of sufficiently high quality and meets the standards we expect" [B19].	It would be helpful if NLP could provide further details on how input from local authority colleagues shaped the proposals, including how they have or will address any specific concerns raised and how they will monitor any ongoing impacts on adult social care services and local authorities as they implement the plans.
The letter noted relatively low numbers of carers taking part in the consultation and asked that "specific work be undertaken in the future to identify and gain insights from them due to their importance. Furthermore, we would expect continuous engagement with community, advisory and staff groups to be embedded into the implementation phase of the proposals, allowing for ongoing input into the delivery of the new model of care." [B19]	NLP have already developed a "benefits framework" to track the successful implementation of the new model. It may be useful to work with adult social care colleagues to include within the benefits framework indicators or other measures which would help track and improve the level of integration between health and adult social care services.

Background	Commentary
The PCBC states that “The lead member for health and social care (or committee lead) and the directors of adult social services in Barnet, Camden, Enfield, Haringey and Islington have been regularly briefed about the proposals during their development and their input sought.” [1]	
In addition, the relevant local authorities are all members of NLP. The project team state that they have asked for an Adult Social care (ASC) nominee to sit on the Programme Board overseeing the proposals [16] and the DMBC states the commitment to work with ASC colleagues during implementation to ensure they have input into the plans.	
NLP note that the new care co-ordinator role is intended in part to help identify any additional needs a patient may have – including those relating to their discharge and engagement or referral to adult social care services [16].	As noted in the earlier health inequalities test, it will be important to monitor the work load and expectations of the care co-ordinator role as there is a risk it may become over-burdened as a “one stop shop” for mitigating a potentially growing number of foreseen and unforeseen problems in the transition to a new model of care that involves multiple providers.

Test 6: Patient and public engagement

Proposals demonstrate credible, widespread, ongoing, iterative patient and public engagement, including with marginalised groups, in line with Healthwatch recommendations.

Background	Commentary
Did patients/the public/the local Healthwatch influence proposals before they were published for formal public consultation? NLP carried out a pre-consultation engagement in Autumn 2018, which was reviewed in the November 2018 Engagement report [9]. The engagement involved over 500 individuals, including almost 200 patients/members of the public and over 300 healthcare professionals (including the clinical and non-clinical staff of local hospitals and NHS commissioners). Two key themes emerged from the engagement: • concerns over the potential impact on patient travel and the need to evaluate this fully • the need to better define and articulate the clinical case for change and provide assurances around joined up working across the elective orthopaedic care pathway (in particular if discrete parts of care are to be given by different providers) and continuity of care. A detailed transport analysis [5] of the proposals was undertaken as part of the second stage equalities impact assessment (which preceded consultation), which is described in test one above. As a result of this engagement exercise, NLP also developed the concept of the care coordinator, to help patients navigate the new pathway and multiple providers, as well as focus on the needs of particularly vulnerable or complex patients 1]. The consultation documents [1, 10] clearly outline the expected clinical benefits of the change – including a reduction in waiting times and cancellations, as well as better allowing the local NHS to meet growing demand.	NLP carried out pre-consultation engagement. Two key themes emerged, which were around the impact on patient travel and the need to further define and articulate the case for change.

Background	Commentary
Did patients/the public/the local Healthwatch advise on the consultation plan? NLP convened a consultation planning subgroup made up of communications and engagement professionals from NCL providers and commissioners, together with local residents who had become engaged in the plans. All five Healthwatch organisations across NCL were also involved in the design of the consultation questionnaire and additional quality assurance on the consultation was provided by The Consultation Institute [11].	Responses to the consultation [11] indicate these benefits were well understood, although patients were confused about whether the proposals would lead to an increase or decrease in choice. We comment more on this further below.
Did proposals set out sufficient, easily understandable information about, and reasons for the proposals to enable an informed response? Was the consultation well publicised? Proposals were set out in a variety of formats, which made a number of the advantages and disadvantages of the proposals clear to residents and explained how they could get involved in the consultation. Easy read, large print, British Sign Language, and the most commonly spoken non-English language versions were also made available online. (Other translations were available on request but no such requests were made). Off line, hard copies of the full and summary consultation documents, together with large print and easy read documents and posters were displayed in GP practices, outpatient clinics and hospital receptions. News of the proposals was also covered in two local newspapers – Camden New Journal and the Islington Tribune, shortly after the start of the 12 week consultation [11].	Media coverage of the proposed changes was concentrated in newspapers primarily distributed in the southern side of the NCL patch. Considering the negative impact on travel times is expected to disproportionately affect residents living in Enfield and Haringey, public engagement may have been improved through coverage in local newspapers and outlets focused on those areas and communities – for example the Turkish language newspaper Haber, which is based in Green Lanes Haringey.
The Easy read consultation document was prepared by an organisation (A2i) specialising in making information accessible, including to people with learning disabilities [12]. A two minute animated video prominently displayed on NLP's consultation website also provided another way for people to learn about the proposals [13].	The video does not include the results of the travel and inequalities impact assessment. However, the Easy Read consultation leaflet did state that some patients may experience longer travel times and that patients with learning disabilities might find confusing to go to a different hospital [12].

Background	Commentary
The consultation summary document – in effect a leaflet with illustrations and diagrams to help explain the planned changes - was clear that the results from the equalities and transport assessment were that patients living in “some black and minority ethnic communities” and “in the more deprived parts of Enfield and Haringey” could experience longer travel times as a result of the changes. [10] Assurance was given on the consultation methodology by the Consultation Institute, while the process was evaluated by the consultants Participate UK. In their analysis of the consultation and consultation response (including responses to questionnaires) Participate noted there was some confusion as to whether the proposed changes would increase or reduce patient choice of provider, indicating that this aspect of the changes was not clear [11].	Instead of referring to “some black and minority ethnic communities” it may have been better for the summary document to have referred to “some black and Turkish communities” as that more accurately reflects the findings in the analyses and may have resulted in stronger engagement from Turkish residents. Further it is not clear if this information was relayed in the foreign language translations of the summary document. For example, the Turkish translation [14] appears to omit any reference to the finding that the changes would disproportionately affect some communities, and no reference to how one of those communities would be the Turkish one. A number of graphics and illustrations used in the consultation summary leaflet have been inserted into the foreign language translations without changes being made to the embedded English text (see for example the Turkish summary and Somali summary). This will have limited their use to patients and residents with little or no English. [14, 15]. We have already commented in response to test 1 that NLP need to clarify whether or not patients will be able to choose to be cared for by two providers who are not part of the same partnership. If the changes will in effect lead to a reduction in choice for some or all patients, NLP need to spell out why they believe that reduction in choice will be offset by an increase in care quality and efficiency. The DMBC states that the position on choice – including the policy around patients choosing care in a private hospital – will be made clear through documentation provided to GPs for use at the first point of referral [20].
Were local networks used to promote engagement? Was the formal public consultation open for a sufficient period of time? Was it possible to comment verbally via telephone and face to face meetings, as well as in writing? The 12 week consultation was launched on January 13th and closed on 6th April with the consultation plan designed to attempt to ensure groups identified through the inequalities impact assessment as being at risk of additional hardships (predominantly in the form of longer journeys to and from hospital) were engaged. Engagement activities has been deliberately concentrated in the first two months of the consultation, to avoid holding many events during the anticipated pre-election period of the London Mayoral election.	It is hard to assess whether the consultation was successful in reaching sufficient numbers of residents and patients despite the pandemic as no details have been provided about the intended reach in the consultation plan. Translation services were available at a number of events and meetings, including British Sign Language translators who were further available at public meetings, on advance request [10, B23].

Background	Commentary
The latter part of the consultation was affected by the UK moving into lock down as of 23 March. NLP made the decision not to adjust the consultation end date but instead implemented a consultation contingency plan, drawn up with agreement of the outgoing Chair of the JHOSC [B23]. Due to the Coronavirus pandemic, no public meetings and group discussions were held after March 17. This affected a number of planned events and meetings. In place of the cancelled events, NLP carried out telephone interviews with targeted groups, worked with local Healthwatch and third-sector groups to promote further participation and invited feedback online, in writing and verbally on the telephone [11]. In addition to public meetings and outreach sessions, a questionnaire was sent directly to the 800 member NCL resident panel and further distributed through the five Healthwatch organisations and other community groups and services. The same questionnaire was also available online and was used as the basis for collating feedback during interviews and events. Questionnaire design was overseen by the Consultation Institute with the aim of being accessible and in plain English [11].	As noted further below, the consultation struggled to engage residents who identify as Turkish, who make up over 4% of the population in the area as a whole [3]. Analysis of the 2011 census suggests that Turkish-born people (who may also include those who identify as Kurdish) make up the fourth largest ethnic group in both Enfield and Haringey, after white British, African and Caribbean [B18]. The consultation may have been more successful in engaging people from that population had it made more materials – including the questionnaire – available in Turkish. One finding emerging from the consultation was that "there are large black and minority ethnic populations in north London who do not have English as their first language e.g. Turkish." [11]. It should be noted that language forms a barrier both to accessing services but also to engaging in the shaping of those services.s It is questionable whether or not the questionnaire always succeeded in being "plain English". One of the questions aimed at collecting demographic data (needed to ensure the consultation reflected the NCL population, as a means to better tailor the development of services to that population) asked participants: "Is your gender identity the same as the gender you were given at birth?" (having already asked participants their gender) [16]. It is possible this question confused many participants as out of the 595 who took part in the survey, 325 did not answer that question – twice the number who did not answer other demographic questions [11]. It may have been clearer – while remaining respectful to transgendered people – to ask: "What biological sex were you recorded as at birth?" while retaining the possibility for a respondent to select "prefer not to say". As noted in the health inequalities impact assessment [3], the needs for orthopaedic elective care differ between the biological sexes, as they do also between those who have undergone treatment for gender reassignment and those who have not. It is therefore important that where relevant health services continue to collect information on biological sex as well as on gender and gender reassignment.
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? The original consultation plan was designed to attempt to ensure groups identified through the inequalities impact assessment as being at risk of additional hardships as a result of the proposals were engaged in the consultation process, in addition to groups whose voices might not be heard (those with disabilities, health conditions and carers) [11]. In the case	The consultation plan originally hoped to include young (under 16) carers of parents or other relatives but these proved hard to identify [11]. The needs of such carers and their families will need to be further explored and addressed as plans are implemented.

Background	Commentary
of carers, a set of 15 telephone interviews were undertaken to ensure their needs and views were understood [17]. Mid-way through the consultation, survey responses were analysed which led to Participate and NLP deciding additional work was needed to garner responses from transgender people and people from Black, Asian and minority ethnic groups – in particular Turkish people from Haringey [11]. This resulted in the transgender advocacy organisation Gendered Intelligence being asked to lead on the recruitment of transgender people to participate in telephone interviews – following the same structure as the questionnaire [11]. Five such interviews took place, with participants offered a £25 Amazon voucher as an incentive. In addition to this, six transgender advocacy organisations were asked to send formal responses to the consultation on behalf of transgender people [18]. To increase responses from black, Asian and other minority ethnic people (but particularly people from the Turkish community) NLP originally planned to undertake 50 street interviews using the questionnaire [11]. When social distancing guidance made this impossible, the 800-strong Resident's Health Panel database was searched to identify 55 people within the target demographic group, all of whom were contacted, with seven subsequently taking part in telephone interviews [19]. **Did the consultation yield widespread, detailed public/patient feedback, especially from equalities and hard to reach groups, and those particularly affected by the changes?** 27% of survey respondents were current or past service users, and a further 9% were the carers or family members of current service users [11]. 80% of respondents were matched to postcodes described as deprived.	The report summarising the feedback from the five interviews with transgender residents [18] explains that the rationale for specifically targeting transgender people in the consultation is the potentially increased risk of developing osteoporosis experienced by people who receive hormone, and hormone-affecting treatments as part of a gender transition process. However, as noted in the inequalities test, it is not clear why osteoporosis has been identified as a particularly relevant condition for elective orthopaedic surgery as osteoporosis is more commonly associated with frailty fractures which are generally treated as emergency trauma cases and so out of the scope of the proposed changes. This point does not undermine the value of feedback received from the interviewees, which NLP may want to share with other NCL colleagues to inform broader efforts to improve access and care for transgender people across NHS services. It is not clear that the seven interviews were successful in targeting residents from the Turkish community in particular. The resident interview report [19] shows that of the seven people interviewed in this exercise, three identified their ethnicity as African, one as Caribbean and the remaining three did not identify their ethnicity at all, although all had previously identified as being black, Asian or other minority ethnicity at the time of joining the resident's panel. It is also unclear how NLP were able to determine how many people identifying as having Turkish ethnicity responded to the questionnaire, as "Turkish" was not included as an option in the ethnicity monitoring section of the questionnaire [16], despite the equalities impact assessment specifically noting that Turkish communities in Haringey and Enfield were at risk of experiencing additional hardships as a result of the proposed changes [4,5]. NHS organisations across North Central London may want to review the demographic data they collect and hold, as well as their population engagement strategies to ensure they are best able to ascertain and then reflect the needs of the heterogeneous population group who might identify (or be identified as) as Turkish or Turkish-born. Comparing the available demographic information of survey responders to the demography of the NCL area as presented in the equalities impact assessment [3] suggests the survey responses were "over representative" of older people and those with a physical disability, although as such populations have a clear disproportionate need for elective orthopaedic surgery, this "over representation" is likely warranted.

Background	Commentary
	It is hard to know how reflective survey responders were of the overall level of deprivation in the NCL boroughs as no figures for the proportion of NCL households living in deprivation is given in the consultation or associated planning documentation. The overall proportion cited would also depend on the level of granularity selected and definition of deprivation used. It would be useful if NCL could provide a figure for the proportion of households living in poverty using the same measure (which appears to be a 3 or 4 digit postcode match) used in the consultation report [11]. The survey respondents did not fully reflect the ethnic diversity of NCL as a whole. In total, 66% of survey participants indicated they were from a white ethnic background [11], compared to 62% for the NCL area as a whole [3]. Survey respondents describing themselves as either black African and black Caribbean made up 9% of all respondents [11], compared to 13% for the NCL population as a whole [3]. As stated above, it is not possible to ascertain the proportion of survey participants who identified as Turkish as this was not recorded, although the equalities impact assessment found that people identifying as Turkish made up over 4% of the NCL population as whole. A third of all responses were from residents in Enfield [11]. As 230 responses either did not detail a borough or were from outside NCL, this meant there were more responses from Enfield than the other 4 NCL boroughs put together [11]. This is thought to reflect the efforts of Enfield's Healthwatch organisation which was particularly active in promoting the consultation and survey [11]. The skew towards Enfield residents meant that of the respondents answering a question about which was their nearest hospital, the largest proportion – 22% - stated this was the North Middlesex Hospital, followed by 17% who selected Barnet Hospital [11]. Given patients currently attending North Middlesex will be amongst those experiencing a change of provider for inpatient surgery, this skew is not unhelpful, although it would have been preferable to have received more feedback from patients whose local hospital is the Whittington, as those patients would also be relocated. 17% of patients responding to the "local hospital" question said their local hospital was another hospital not on the list [11]. It is not known if these NHS hospitals outside the NCL boundary, or independent hospitals within it.

Background	Commentary
Three quarters of survey respondents overall indicated they agreed with the proposed changes, although there was a lower level of agreement amongst disabled respondents (68%) than non-disabled (81%) [11]. Not surprisingly, patients living nearest to some of the hospitals that will be most affected also had lower levels of agreement with the proposals: 22% of Whittington Health and Royal Free users disagreed with the proposals compared with 8% of overall respondents [11]. Responses indicated that respondents supported the proposals on the understanding they would go some way to reducing waiting times, cancellations and hospital acquired infection rates while improving the quality of care overall and better enabling the local NHS to meet expected future demand [11]. On travel, 54% of respondents indicated they would "happy to travel further to receive the best orthopaedic surgery with my outpatient appointments close to home". 23% indicated they had "have some concerns about potential travel and access issues if services are changed but, I feel that if I needed this kind of care, I would benefit from the proposed changes". A further 18% indicated they "I would prefer all my orthopaedic care, including surgery, to be at my local hospital even if it meant I had to wait longer" [11]. While 30% of overall respondents indicated they did not have concerns about travel, the proportion indicating concerns about travel implications varied considerably between boroughs [11]. Overall, 20% of respondents indicated they had concerns about the cost of travel. Reflecting relative levels of deprivation, this rose to 40% of respondents from Islington and fell to 9% of respondents from Barnet [11]. 28% of respondents overall expressed concern about increased travel complexity (for example having to take two buses). This concern was highest amongst respondents from Islington (55%) and lowest in Camden and Barnet (24%) [11].	It is noteworthy that there was a tendency for survey respondents who were current or past patients, or their families/carers to be less optimistic than those who were not that the proposals would lead to improvements in care quality or capacity [11]. It is important to note that survey respondents indicated their support for the changes when expressed in terms of enabling "the best" orthopaedic surgery [11, 16]. NLP will need to develop a framework for assuring this aspiration is demonstrably delivered.

Background	Commentary
Overall 23% of respondents indicated they were concerned about increased travel time – a figure which was slightly higher in Camden (29%) and lower in Enfield (20%) [11].	
20% of overall respondents indicated "it will be easier for me or my family as public transport options will be improved". This figure was driven by positive responses from Enfield and Barnet residents. By contrast only 5% of Islington residents felt this way [11].	It is not clear why respondents from Enfield and Barnet felt public transport would be improved as there are currently no concrete proposals to do this beyond providing additional information about transport and working with TFL in the longer to improve public transport options to and from Chase Farm Hospital (which is currently assessed by TFL's Public Transport Accessibility Measure as "poor" [5]).
The separate in-depth report on interviews with carers yielded important insights into the concerns and challenges faced by that group [17]. Interviews were focused on the needs and concerns of carers (particularly those caring for elderly or disabled relatives) as potential patients. For example, carers explained their concerns about changes which might increase the time they were away from the relatives they cared for – for example by increasing travel times. They also described the difficulties they faced attending outpatient appointments, especially if such appointments did not run to schedule and they were left waiting for a long time; their anxieties growing about their caring responsibilities at home. Carers also described how concern for the person they cared for could be a factor preventing them from receiving inpatient care or surgery [17].	The report on carers [17] provides valuable insights relevant to both the proposed changes around elective orthopaedic care and beyond. Recommendations to address some issues and concerns are discussed in the next section.
The concerns around access and travel were also highlighted by the JHOSC [B19].	
Have the final proposals been demonstrably modified following patient/ public feedback? The DMBC outlines NLP's response to concerns raised during the consultation process. It is clear that in its view, the consultation process affirmed rather than undermined the proposed new model of care. The DMBC sets out commitments NLP will make to address concerns with regards to:	It is not clear which commitments set out in the DMBC were already part of the plans and which have been either introduced or enhanced as a result. Some of the commitments stop short of proposals and recommendations stemming from the equalities impact assessments, mitigation workshop and consultation process. For example, the mitigations report [8] and third stage equalities impact assessment [7] recommended that patients with caring responsibilities be

Background	Commentary
• **travel:** improving information about travel options; working with TFL to improve public transport links in the longer term and signposting patients with travel or travel cost difficulties to help they may be entitled to (for example with costs) • **tailoring care around specific patient vulnerabilities or needs - such as learning disabilities or caring responsibilities:** Additional needs to be identified at the point of GP referral; recognition that some patients – for example carers – would benefit from being given priority appointment slots to minimise waiting times on the day of their appointment • **clarity around patient choice:** Supplying GPs with information on what choices patients can make, particularly in the context of the planned move away from elective orthopaedic surgery routinely being provided by private hospitals and well as NHS providers • **communication with patients:** Communication issues and needs to be identified at the point of GP referral; care co-ordinator to signpost patients to relevant services for translation/interpretation services for deaf/hearing impaired patients and those who do not speak English; literature to be developed on new services and care model to be available in a range of local community languages.	offered the first appointment slot of the day – to reduce the likelihood of them facing longer than expected waiting times on the day of the appointment. While NLP have recognised the additional needs of patients with caring responsibilities and have stated in the DMBC that "reasonable adjustments [will be] made where possible" it has not committed to implementing the recommendation in full. `
Do the final proposals set out plans for ongoing dialogue with patients and the public as detailed delivery plans are developed and service changes are implemented? The DMBC states that, should proposals be implemented: "There will be a continued dialogue with community organisations that represent groups with protected characteristics throughout implementation and ramp up of the proposed model of care. This will allow for feedback of any concerns of service users around the implementation of the model, and for these to be fed back to implementation teams to take into account." It further notes that patient representatives recruited onto the clinical network would continue to have an important role in monitoring and evaluating the implementation of proposals [20].	It is not reasonable for a small number of patient representatives on the clinical network to hold the full responsibility for ensuring that the needs of patients with many different characteristics are met, and so although their role is a valuable one, NLP will need to demonstrate the impact of the other approaches they intend to adopt through the implementation.

Background	Commentary
The DMBC further outlines a “benefits framework” – overseen by the clinical network - which includes a variety of metrics which will be used to assess whether or not the intended benefits of the new model are being realised. These metrics include patient centred measures such as waiting times and patient satisfaction [20].	As noted in test 5 above, there is currently no baseline data for the benefits framework or details on the expected rate of improvement. It will be important both are spelt out in order to ensure NLP remain accountable to the patients and public it serves. In Test 5 we also propose that NLP work with colleagues in adult social care to include relevant means for assessing how elective orthopaedic services are interacting and integrating with adult social care services.

References

Documents published by North London Partners as part of consultation:

Reference in text	Shorthand name	Full title	Author(s)	Date, where available	URL
1	Pre-consultation Business Case (PCBC)	Adult Elective Orthopaedic Services: Pre-Consultation Business Case Partnership for orthopaedic excellence: North London FINAL DRAFT Version 1.0	North London Partners	December 2019	https://conversation.northlondonpartners.org.uk/wp-content/uploads/2020/01/NCL-Orthopaedic-Review-Pre-Consultation-Business-Case-FINAL.pdf
2	Clinical delivery model	Adult Elective Orthopaedic Services: Clinical Delivery Model and Options Appraisal Process	North London Partners	May 2019	https://conversation.northlondonpartners.org.uk/wp-content/uploads/2020/01/190520_Joint_CDM_OA_Elective_Orthopaedic-v-1-2.pdf
3	Stage 1 equalities assessment	Initial Equalities Analysis Desk research	Verve Communications	August 2018	https://conversation.northlondonpartners.org.uk/wp-content/uploads/2020/01/NLP-EIA-scoping-v12.pdf
4	Stage 2 equalities assessment	NLP Planned Orthopaedic Surgery for Adults Health Inequalities and Equalities Impact Assessment	Verve Communications	December 2019	https://conversation.northlondonpartners.org.uk/wp-content/uploads/2020/01/Verve-NLP-POSA-HIEIA-REPORT-DEC19-1.pdf
5	Equalities travel analysis	Independent Travel and Access Assessment Changes to adult planned orthopaedic services in North Central London	Mott MacDonald	January 2020	https://conversation.northlondonpartners.org.uk/wp-content/uploads/2020/01/NCL-Travel-Analysis-Report-Final.pdf
6	LCS advice to NLP	Advice on proposals for adult elective orthopaedic services in North Central London	London Clinical Senate	November 2019	https://conversation.northlondonpartners.org.uk/wp-content/uploads/2020/01/v1.8-FINAL-Report-for-NCL-Partners.-Advice-on-proposals-for-elective-orthopaedic-care-in-North-Central-London.pdf
7	Stage 3 equalities assessment	Post-consultation Updated Integrated Health Inequalities and Equalities Impact Assessment	Verve Communications	July 2020	https://conversation.northlondonpartners.org.uk/wp-content/uploads/2020/08/North_London_Partners_Orthopaedic_Review_EIA_Stage_3-report-FINAL.pdf
8	Mitigations report	Supplementary Report on Mitigations	Verve Communications	July 2020	https://conversation.northlondonpartners.org.uk/wp-content/uploads/2020/08/North_London_Partners_Orthopaedic_Review_EIA_Stage_3-report_supplementary_workshop_FINAL.pdf

Reference in text	Shorthand name	Full title	Author(s)	Date, where available	URL
9	Engagement report	Engagement evaluation report	Verve communications	November 2018	https://www.northlondonpartners.org.uk/downloads/plans/Adult-elective-orthopaedic-review/End%20of%20engagement%20papers/North%20London%20Partners%20Review%20Group_Summary%20of%20Engagement%20Evaluation.pdf
10	Consultation summary	Consultation summary/leaflet	North London Partners	no date	https://conversation.northlondonpartners.org.uk/wp-content/uploads/2020/01/NLP_Orthopaedic-review_FINAL-1.pdf
11	Consultation report	Proposed Changes to Planned Orthopaedic Care for Adults	Participate UK	September 2020	https://conversation.northlondonpartners.org.uk/wp-content/uploads/2020/08/North_London_Partners_Orthopaedic_Consultation_Report_FINAL.pdf
12	Easy read	Our plan for making planned orthopaedic surgery better	A21	no date	https://conversation.northlondonpartners.org.uk/wp-content/uploads/2020/01/Summary-Document-FINAL-text-Improving-planned-orthopaedic-surgery-for-....pdf
13	Video		North London Partners	No date	https://youtu.be/h69Di-EXdCE
14	Turkish summary		North London Partners	No date	https://conversation.northlondonpartners.org.uk/wp-content/uploads/2020/01/Summary-Document-Improving-planned-orthopaedic-surgery-for-adults-in-north-central-London_Turkish.pdf
15	Somali summary		North London Partners	No date	https://conversation.northlondonpartners.org.uk/wp-content/uploads/2020/01/Summary-Document-FINAL-text-Improving-planned-orthopaedic-surgery-for-adults-in-north-central-London_Somali.pdf
16	Questionnaire		North London Partners	No date	https://conversation.northlondonpartners.org.uk/wp-content/uploads/2020/01/NLP_Orthopaedic-review_Survey_FINAL-1.pdf
17	Carer report	Insight report on carers	Verve Communications	April 2020	https://conversation.northlondonpartners.org.uk/wp-content/uploads/2020/08/North_London_Partners_Orthopaedic_Review_Carers_Interviews.pdf
18	Transgender resident report	Insight report on the views of transgender respondents to the consultation	North London Partners	March 2020	https://conversation.northlondonpartners.org.uk/wp-content/uploads/2020/08/200323-Report-on-insights-from-interviews-transgender-consultees-FINAL.pdf

Reference in text	Shorthand name	Full title	Author(s)	Date, where available	URL
19	Resident report	Insight report on the views of resident health panel members	North London Partners	March 2020	https://conversation.northlondonpartners.org.uk/wp-content/uploads/2020/08/200331-Report-on-insights-from-interviews-with-Resident-Health-Panel-members-FINAL.pdf
20	DMBC	Decision-Making Business Case	North London Partners	September 2020	https://northcentrallondonccg.nhs.uk/wp-content/plugins/download-attachments/includes/download.php?id=1702

Other documents referred to in tests:

Reference in text	Full title	Author(s)	Publisher and date, where available	URL
B1	Population and patient factors affecting emergency department attendance in London	Sally A Hull, Kate Homer, Kambiz Boomla, John Robson and Mark Ashworth	British Journal of General Practice, Online First 2018	https://www.qmul.ac.uk/blizard/ceg/media/blizard/images/documents/ceg-documents/publications/newly-published/AED-attendance-BJGP-SH-2018.pdf
B2	Socio-Economic Inequalities in Health Care in England	Richard Cookson, Carol Propper, Miqdad Asaria and Rosalind Raine	Fiscal Studies, vol. 37, no. 3–4, 2016	https://onlinelibrary.wiley.com/doi/pdf/10.1111/j.1475-5890.2016.12109
B3	Are differences in travel time or distance to healthcare for adults in global north countries associated with an impact on health outcomes? A systematic review	Kelly C, Hulme C, Farragher T, et al	British Medical Journal, 2016	https://bmjopen.bmj.com/content/6/11/e013059.info
B4	Personal communication, Cllr Alison Kelly to Nuffield Trust	Cllr Alison Kelly, chair North Central London Joint Health Overview and Scrutiny Committee	February- March 2020	
B5	2019 16th Annual Report National Joint Registry for England, Wales, Northern Ireland and the Isle of Man	National Joint Registry	2019	https://reports.njrcentre.org.uk/Portals/0/PDFdownloads/NJR%2016th%20Annual%20Report%202019.pdf
B6	A national review of adult elective orthopaedic services in England	Tim Briggs	2015	https://gettingitrightfirsttime.co.uk/wp-content/uploads/2018/07/GIRFT-National-Report-Mar15-Web.pdf
B7	North Central London Procedures of Limited Clinical Effectiveness (PoLCE	NCL Commissioners	2019	https://gps.camdenccg.nhs.uk/cdn/serve/service-downloads/1549382191-d2ab0be3f5085302393a6006b369859e.pdf
B8	London Choosing Wisely	Healthy London Partnership	2020	https://www.healthylondon.org/our-work/london-choosing-wisely/
B9	Evidence Based Intervention and Clinical Standards: Procedures not routinely funded or requiring prior approva	North London Partners	2019	https://www.northlondonpartners.org.uk/downloads/plans/Evidence-Based-Interventions/NCL-PoLCE-Policy-Version-7.1-Issued-April-2019.pdf
B10	RightCare Where to Look data pack: North London Partners in Health & Care STP	NHS England	2019	https://www.england.nhs.uk/rightcare/wp-content/uploads/sites/40/2019/09/cfv-where-to-look-sept-19-North-London-Partners-in-Health-Care-STP-WTL-v2.48.pdf

Reference in text	Full title	Author(s)	Publisher and date, where available	URL
B11	Personal communication NLP-Nuffield Trust		February 2020	
B12	Personal communication NLP-Nuffield Trust		March 2020	
B13	Personal communication NLP-Nuffield Trust		April 2020	
B14	The bottom line: Understanding the NHS deficit and why it won't go away	Sally Gainsbury	Nuffield Trust, 2017	https://www.nuffieldtrust.org.uk/files/2017-11/the-bottom-line-final-nov-amend.pdf
B15	Quick Guide: Discharge to Assess	DHSC/ADASS/NHS England	No date	https://www.nhs.uk/NHSEngland/keogh-review/Documents/quick-guides/Quick-Guide-discharge-to-access.pdf
B16	Personal communication NLP-Nuffield Trust		July 2020	
B17	Personal communication NLP-Nuffield Trust		Early September 2020	
B18	Welfare needs of Turkish and Kurdish communities in London. Final report	Alessio D'Angelo, Ozlem Galip, Neil Kaye/Middlesex University	July 2013	http://sprc.info/wp-content/uploads/2013/07/DayMer-Final-Report-final.pdf
B19	Letter from acting chair of Joint Health Overview and Scrutiny Committee to North London Partners	NCL JHOSC	September 2020	
B21	Telephone briefing with NLP-Nuffield Trust		Mid September 2020	
B22	NHS looks to grab private sector work with major reconfiguration	Health Service Journal	February 2020	https://www.hsj.co.uk/service-design/nhs-looks-to-grab-private-sector-work-with-major-reconfiguration/7026849.article?mkt_tok=eyJpIjoiTkRRMll6WTRZVEl4T0dWbSIsInQiOiJTcFp3aDJZbmxjNTliUDNpU2JvRGIrQTRXR09ldVRDbU1pUU42MEJsTHd5U290dVhvakU5T2VXdm5DSk52U29MOEcwQTFUVk5WYldvUzV3YmViZ1YxRTN 6c25XVU9KZzRmaEZ3VHZyak5Vakw3VkJ6SUw2dGNXRDBKQWc0WFR4ayJ9
B23	Personal communication NLP-Nuffield Trust		Mid September 2020	

Nuffield Trust is an independent health charity. We aim to improve the quality of health care in the UK by providing evidence-based research and policy analysis and informing and generating debate.

59 New Cavendish Street
London W1G 7LP
Telephone: 020 7631 8450
www.nuffieldtrust.org.uk
Email: info@nuffieldtrust.org.uk

Published by the Nuffield Trust.

Design by Soapbox: soapbox.co.uk

nuffieldtrust