London Clinical Senate

FINAL

Advice on proposals for adult elective orthopaedic services in North Central London

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v1.8

Independent advice on proposals for adult elective orthopaedic services in North Central London

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Approved by:	**Dr Mike Gill, London Clinical Senate Council Chair, on behalf of the London Clinical Senate**
Date:	**31st October 2019**

AIMS OF THE REPORT:

North Central London Partners in Health and Care are proposing to reconfigure orthopaedic elective services in North Central London. This report has been developed in response to their request for advice on the following areas:

- Whether the new model of care will deliver safe, effective intervention that significantly improves patient experience and outcomes
- Whether there is sufficient evidence that the change proposed is justified in terms of clinical efficacy and patient experience
- That there is sufficient alignment with the wider musculoskeletal pathway to ensure patients experience seamless care across the system
- Our approach demonstrates the future demand is adequately addressed and sustainable services developed
- Our workforce plans will ensure patients can access the right treatment at the right time
- Our plans for digital innovation will facilitate seamless care across organisation boundaries
- That there are no unintended consequences for clinical services that are out of scope but key dependencies within the review (spinal surgery, paediatric surgery and trauma services)

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1. Executive summary

North Central London Partners in Health and Care (NCL Partners) are a partnership of health and care organisations from the five London boroughs of Barnet, Camden, Enfield, Haringey and Islington. NCL Partners are proposing to transform elective orthopaedic care and have asked the London Clinical Senate to provide advice on their proposals. This report sets out our findings, advice and recommendations.

Currently, orthopaedic surgery is delivered at ten separate north central London NHS and independent sector sites. The NCL Partners pre-consultation business case (PCBC) outlines that while many of the services are of good quality, there is unwarranted variation in the quality of care provided. These issues are not unique to north central London. A national work programme initiated by the report "*Getting it Right First Time*" (GIRFT)[1] has explored the delivery of planned orthopaedic care across England and identified many opportunities for improvement.

The reconfiguration proposals aim to improve care, provide better patient experience and efficiency through ring-fencing orthopaedic services on a smaller number of sites with co-located support services, in fit-for-purpose buildings. They seek to achieve this by a single network for orthopaedic services across north central London with two dedicated state of the art orthopaedic surgical centres and local convenient outpatient facilities.

The Clinical Senate was asked to provide advice and agreed to focus on seven issues, and in response, we set up an independent review team to formulate the advice. This included clinical members with expertise in orthopaedic care, in key services that support delivery of orthopaedic care and members who represented the patient and public voice. Collectively, the team brought substantial knowledge and experience to advise on the proposals presented to us and I am very grateful to them all for the time they committed and for the thoughtful and constructive way in which they considered the many points we debated.

The core part of the review involved a panel meeting and discussion with clinicians and representatives of patients and the public in north central London who have been involved in developing the proposals and/or could be affected by them. I am grateful to everyone who took time to meet or speak with us and for the openness with which they shared their views. This allowed us to explore issues, opportunities and concerns about the case for change and the proposed mode of care in some depth, and to triangulate what we heard with supporting documentation we received. I would also like to thank the North Central London Partners in Health and Care for their support in organising the not insignificant logistics of this session.

The senate panel's role was to explore, examine, clarify and challenge where it felt warranted. We developed key lines of enquiry to help fully explore the main areas.

The panel found that there was a clear case for change, based on national best practice and consideration of the local issues. However, they also identified areas where work could be developed, and generated 23 recommendations for NCL Partners to consider as they refine plans and develop the consultation business case. A summary of our findings against each of the seven themes is provided below

[1] https://gettingitrightfirsttime.co.uk

i. Whether the new model of care will deliver safe, effective intervention that significantly improves patient experience and outcomes

The panel considered there was extensive evidence, locally and nationally to support the separation of elective and urgent care. They believe that the proposed model has the potential to deliver safer and more effective interventions and improve patient experience.

ii. Whether there is sufficient evidence that the change proposed is justified in terms of clinical efficacy and patient experience

The panel agreed that there was enough evidence to justify the proposed change and considered that the potential to realise these improvements was not possible with the current configuration.

The patient and public representatives joining the panel day were clear that patient information literature was a priority, and the panel recommends ongoing liaison and involvement with patients and public regarding the service model and the literature to support this. The panel believe that patient perception and choice will steer the success of this model.

iii. That there is sufficient alignment with the wider musculoskeletal pathway to ensure patients experience seamless care across the system

The panel recognise the work that has been undertaken to develop the musculoskeletal pathway and note that there is opportunity to learn and scale up pockets of innovative practice from north central London. However, the panel also recognised further development of the pathway is needed. This includes clarity regarding triage; admission; High Dependency Unit beds; and rehabilitation as well as consideration to the role of care navigators/ coordinators throughout the system. Some of these areas were identified by north central London in the pre-consultation Business Case[2] as requiring further attention.

iv. Our approach demonstrates the future demand is adequately addressed and sustainable services developed

Although the review panel expressed some reservations about the accuracy of growth predictions, the panel 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.

The panel considered that an effective MSK pathway was critical to mitigating against avoidable growth in activity and recommended measuring the rate of conversion to intervention from outpatient appointments to assist with planning and projections.

v. Our workforce plans will ensure patients can access the right treatment at the right time

[2] Pre consultation business case p93

The panel heard that workforce plans were underway and recognised that the model offered the potential for training opportunities and staff retention, which would in turn enable patients to access the right treatment at the right time.

The panel considered that further workforce planning engaging all professions and grades of staff would be essential going forwards. The panel believed that the recruitment and input of senior allied health professionals and senior nurses to the network board would be critical in addressing this.

The review panel welcomed the introduction of a new role to support patients navigate the new care pathway for orthopaedic services and noted that the *South West London Elective Orthopaedic Centres* are looking to implement a similar role. However, as recognised by the NCL Team[3] further development and clarity is required to standardise the role and expectations, to maximise its effectiveness.

vi. Our plans for digital innovation will facilitate seamless care across organisation boundaries

The panel recognised significant investment into a health management tool to enable the sharing of patient information across all providers. They encourage NCL to continue this work and recommended exploring the potential for shared booking to be available across the system in due course.

vii. That there are no unintended consequences for clinical services that are out of scope but key dependencies within the review (spinal surgery, paediatric surgery and trauma services)

The review panel were satisfied that the impact on interdependencies had been reviewed and was being mitigated but considered that the wider position of associated financial flows, gains and losses should be addressed across the whole system. The panel recommends that commissioners and providers consider managing the financial impact of gains and losses across the whole health and social care system in north central London to enable future sustainability.

The panel would like to thank the team who presented to us the proposals on the review day. While we have included some recommendations which we think will help improve the proposals further, the panel were supportive of the proposals. We understand that action on some of the recommendations is already underway.

Dr Mike Gill
Chair of the Review Panel and Chair of the London Clinical Senate Council on behalf of the Review Panel

[3] Pre-consultation business case, p 93

2. Background

The Sustainability and Transformation Plans for north central London outlines the intention to improve planned care, and within this, orthopaedic care.

The pre-consultation business case developed by North Central London Partners articulates the ambition to deliver to their population the best possible experience of orthopaedic services. NCL Partners note that there is unwarranted variation in outcomes, inconsistent access, challenges in attracting and retaining the appropriate workforce and that opportunities for training and research are not maximised. In addition, the pre-consultation business case observes that waits for surgery are long. In 2018/19 an average of 10 planned operations were cancelled each week with over 96% of these cancellations happening on the day of surgery.

NCL Partners propose a system to:

- *Create enough capacity for now and in the future*
- *Separate emergency and planned care to avoid cancellations and minimise infections*
- *Ensure that we have enough trained staff with the right skills to deliver the service*
- *Ensure that operations are successful by giving access to top quality pre- operative and post-operative education and care*
- *Provide consistent care that uses learning from other services around the country*
- *Ensure equality of access for all residents who need an operation*[4]

They undertook stakeholder engagement to influence and inform the plans. This included inviting eligible organisations in north central London to submit a proposal to deliver adult elective orthopaedic services in NCL either as a base hospital, an elective centre or both. The deadline for these was 5th July 2019, and two joint proposals were received from:

- North Middlesex University Hospital NHS Trust and the Royal Free London NHS Foundation Trust
- University College London Hospitals NHS Foundation Trust and the Whittington Health NHS Trust

An option appraisal panel reviewed and assessed these options and from this identified a preferred model of care. The preferred model is intended to build upon these proposals with oversight by an NCL orthopaedic network. At the time of the review, the NCL options appraisal panel had identified that further work was needed over September and October 2019 to develop the detail of the preferred service model, in particular:

- *How patients who develop complications or require re admission would be managed*
- *Assurance around the management of some complex patients at base hospitals*
- *Details of overnight cover arrangements and day time staffing model in both proposed elective centres*
- *Royal Free to provide assurance that level 2 HDU capacity would be in place at Chase Farm and operational at the start of the new model becoming operational*
- *Further work would be undertaken to ensure a single proposition around:*
    - *Detail of integration for post-operative community care*

[4] Extracted from pre-consultation business case, section 1.2 p8

- *Role of care navigators/ coordinators*
- *Requirements for digital interoperability prior to go live- including the need for Image sharing as part of the One London programme of an NCL solution depending on timescales*
- *Transport/ access discharge arrangements*
- *Whittington and Royal Free to provide additional information about the proposed - model of care and arrangements for spinal patients, prior to further discussions involving the spinal network*[5]

3. Scope of advice requested

The London Clinical Senate was asked to give advice in a formal review of the pre-consultation business case on seven issues:

i. *Whether the new model of care will deliver safe, effective intervention that significantly improves patient experience and outcomes*

ii. *Whether there is sufficient evidence that the change proposed is justified in terms of clinical efficacy and patient experience*

iii. *That there is sufficient alignment with the wider musculoskeletal pathway to ensure patients experience seamless care across the system*

iv. *Our approach demonstrates the future demand is adequately addressed and sustainable services developed*

v. *Our workforce plans will ensure patients can access the right treatment at the right time*

vi. *Our plans for digital innovation will facilitate seamless care across organisational boundaries*

vii. *That there are no unintended consequences for clinical services that are out of scope but key dependencies within the review (spinal surgery, paediatric surgery and trauma services)*[6]

4. Formulation of advice

4.1 Review process

The Clinical Senate Council established an independent review team to consider the case for change, the proposed model of care and to formulate the advice requested. This was chaired by Dr Mike Gill, Clinical Senate Council Chair.

[5] Pre consultation business case, section 8.7 p93
[6] Clinical Senate Application, NCL Partners, March 2019

Overall membership (see section 8.2 of this report) included clinicians with expertise in orthopaedics, rehabilitation, general practice, older people's care, critical care, social care, and two members from the Clinical Senate's patient and public voice group.

Clinical membership was multi-professional, including medical, nursing and allied health professional expertise. To ensure independence, care was taken to ensure that members of the review team had not been involved in developing the proposals and worked in other areas of London. All members were asked to formally declare interests and no conflicts were identified (see section 8.4 of this report).

The review team considered a range of documentation provided by the North Central London Partners in Health and Social Care team (see section 8.1 of this report), and they then held a teleconference to discuss views and findings from the information and evidence provided. This was held on 18th September 2019. During this call members discussed and agreed the key lines of enquiry (KLOEs), highlighting issues they wished to explore further. These are detailed in the table below, and cross reference to all areas the review panel were asked to give advice on:

Key Line of Enquiry	Cross Reference to request for advice	Areas to question or explore
1) Does the clinical case for change clearly articulate the rationale and provide enough evidence that the change is justified in terms of efficacy and patient experience?	ii	1. The case for change is clearly articulated and current challenges and shortcomings are demonstrated with relevant data. 2. What is the driving the change? (clinical safety, quality, standards, workforce, royal college guideline) 3. What evidence is this based on? (demographic, population change) 4. Have public and patient been listened to and responded to? 5. Explore numbers and projection modelling and basis for growth estimation.
2) Has there been sufficient engagement with Stakeholders?		What has been the engagement and input from: 1. Public and patients 2. Providers 3. Workforce 4. Commissioners 5. Primary Care?[7]
3) Will the proposed clinical model deliver safe, effective, high quality orthopaedic care to improve experience of patients	i	1. Will the intended quality indicators be achieved by the proposed clinical model? i.e. Waiting times, Revision rates, Length of stay, Readmissions, Infection rates, Litigation.

[7] Note that the initial list of KLOEs highlighted some stakeholders, and fuller breakdown has been given following the review panel.

and clinical outcomes in NCL? and outcomes in NCL?		2. Exploration of modelling, specialisation, skills and competencies, co dependencies, casemix and threshold, patient flows, capacity. 3. Exploration of general direction- reducing the need for outpatient appointments and increasing surgical capacity. Diagnostic services, conversion rates from outpatient appointment to intervention, outpatient activity.
4) Is the model integrated into the wider musculoskeletal (MSK) pathway to ensure patients can access the right care at the right time?	iii	1. How does the proposed model sit with the wider MSK pathway? 2. Where does the Royal National Orthopaedic Hospital/ Stanmore fit in the pathway? 3. Consider primary and secondary care pathways and if required post-operative readmissions and transfer from elective to Intensive Care Unit. 4. What engagement and planning has taken place with the Local authority regarding the discharge pathway 5. What are the plans for quality indicators? 6. Consider complex orthopaedics and patients with complex needs.
5) Will there be any adverse impact or unintended consequences on areas with key dependencies?	vii	1. Explore regarding: • Critical care • Trauma • Paediatric orthopaedic services • Spinal surgery • Elderly care • Plastics • Vascular • Neurology • Intensive care 2. Consider the financial modelling in relation to the clinical services. What are the plans for stranded costs and risk share, to ensure that unintended consequences to other services are avoided?
ENABLERS **6) Do workforce plans ensure patients can access the right treatment at the right time?**	v	1. Is there a coherent and realistic workforce strategy that addressed the role of all health professionals- nursing, AHPs 2. Are the workforce plans sustainable? 3. How can negative impact/ distortion of other workforce areas be avoided.

7) Will plans for digital innovation facilitate seamless care across organisation boundaries?	vi	
SUSTAINABILITY **8) Does the approach demonstrate the future demand is adequately addressed and sustainable services developed?**	iv	

The central part of the review process involved a review day, at which the review panel received presentations from a range of stakeholders in north central London who had been involved in developing the proposals and/or who could be affected by them. The review panel was held on 25th September 2019 (see section 8.3 for agenda).

This report presents the review teams findings, conclusions and advice drawing from the overall process. The advice provided is the unanimous view of all members.

4.2 Limitations

The advice from this review provides a clinical and service user perspective on the case for change and the proposed model for elective orthopaedic care in north central London.

The North Central London pre-consultation business case and the terms of reference that were agreed with the panel focus on the configuration of elective surgery. The panel are mindful that the orthopaedic surgery model sits as part of the wider musculoskeletal pathway, which is critical for ensuring that the right patients are referred for surgery and those that do have surgery have access to optimal rehabilitation. The panel highlights key elements of the orthopaedic framework that require attention, whilst the focus is concentrated on the model for elective orthopaedic surgery.

NCL Partners provided a large amount of information to inform this review. The review panels advice is based on the information seen and discussions held with stakeholders from NCL as noted above. The review team has sought to triangulate the two wherever possible.

There is a note in the pre-consultation business case that further work is required for all four providers to contribute to the preferred service model[8]. This is acknowledged in section 2 of this report, and further suggestions regarding these areas are included in the report recommendations.

[8] Pre-consultation business case section 8.7, p93

5. Review findings against key lines of enquiry

This section of the report provides an account of the panel's exploration against the key lines of enquiry. These have informed the panel's response to the 7 areas that North Central London asked for advice on and the recommendations therein.

5.1 The case for change

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

5.1.1 The case for change is clearly articulated and current challenges and shortcomings are demonstrated with relevant data

The panel recognised that the proposal was driven by an aspiration to improve equity, improve outcomes, recruit and retain workforce and enable innovation including training and research. The panel were persuaded by the case for change[9]. They also tested whether the intended outcomes could be achieved without reconfiguration, for example, by applying standard guidelines across the system. However, they were convinced that the quality improvement outcomes were best met through the described reconfiguration which ringfenced elective surgery and aligned specialist dedicated staff.

5.1.2 What is driving the change? E.g. clinical safety, quality, standards, workforce, royal college guidelines

The pre-consultation business case has a sound evidence base for change[10] and draws on clear evidence from a variety of sources. These include *Getting it Right First Time (GIRFT), Royal Colleges, Kings Fund, Dalton Review,* the *Long Term Plan* and *Right Care.*

5.1.3 What evidence is this based on? E.g. demographic, population change

The North Central London case for change refers to the evidence base and applies this in the local context.[11] The panel felt that the arguments were sound.

5.1.4 Have public and patient been listened to and responded to?

The *Initial Equalities Analysis*[12] provided by north central London to the review panel provided a good account of the different demographic issues in the North and South of the patch. The panel welcomed that a stage 2 *Equalities Impact Assessment* was planned, which would look at the impact of the proposals.

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[9] Pre-consultation business case, section 1.2, p8
[10] Pre-consultation business case section 4.1 p27
[11] Pre-consultation business case, section 4.2 and 4.3, p29-42
[12] Initial Equalities Analysis, Verve 2018

The panel considered strong endeavours had been made to engage with patients, public and Local Authorities. They encourage this to be further built upon to ensure the model is developed as effectively as possible and that the fuller pathway of admission and aftercare is worked through with key stakeholders.

5.1.5 Explore numbers and projection modelling and basis for growth estimation

The draft pre-consultation business case asserts:

"Underlying demand is forecast to increase by an average of 1.5% per year in north central London. This equates to an additional 2,149 procedures between 2017 and 2029, a rise of 17.5%.

Changes being introduced to the MSK pathway are anticipated to reduce demand by around 1,000 procedures over the next five years.

The net increase in activity is therefore forecast to be 1,148 procedures (9.5%)"[13]

The panel explored these figures and felt the assertion that changes to the musculoskeletal (MSK) pathway would reduce the number of procedures was debatable. The panel considered that an effective MSK pathway should delay the need for surgery, reduce the number of referrals to secondary care, improve conversion to intervention rates and provide accessible high-quality rehabilitation. The panel welcomed the development of an effective MSK pathway to reduce the number of inappropriate referrals and free up secondary care capacity to manage increase in procedures. However, the consensus was that the number of procedures is likely to increase in line with changing demographics. Anecdotal evidence from SE London is that volumes have increased by 5-7% per year, and whilst there was a dip after new MSK screening started, activity volumes all seemed to return within 1-2yrs. The panel therefore encourage NCL partners to review and clarify their projections.

The panel noted that the proposed model allows for the physical capacity to expand the elective centres. Whilst there is currently no further funding or staffing available to manage any expansion, the panel considered that the potential to do so was more likely, rather than less likely post reconfiguration.

The panel heard that the proposed model would affect approximately 1,000 patients each year or 8% of the total activity. This was broken down as:

- 400 inpatient operations a year moving from North Middlesex to Chase Farm
- 350 inpatient operations a year moving from Whittington to UCLH
- 400 day cases a year moving from UCLH to Whittington
- This is against a total of 12,000 operations across NCL

Conclusion

The panel were persuaded by a clear case for change. It clearly articulates the rationale and provides enough evidence that the change is justified in terms of efficacy and patient experience.

[13] Pre-consultation business case, section 4.3.1, p30

To further strengthen the case, the panel recommends consideration of the wider musculoskeletal pathway into which this sits to ensure that the intended benefits can be maximised. It also recommends NCL partners review net activity projections to ensure that they are as realistic as possible (recommendation12).

5.2 Stakeholder engagement

Has there been sufficient engagement with Stakeholders?

5.2.1 What has been the engagement and input from the public and patients?

The panel were pleased to discuss the proposals with a range of patient representatives from north central London. Although the demographic mix of the group in attendance at the senate panel discussion was somewhat limited, it was clear that NCL had sought obtain views from a variety of stakeholders. Working with local Healthwatch groups, resident representatives had been secured to serve on the programme board and attend clinical design workshops. During the engagement phase of the programme a wide range of community organisations were contacted to gain feedback on the case for change, with specific effort given seldom heard groups identified from the initial desktop *Equality Impact Assessment*. For the options appraisal exercise, half of the decision-making panel was patient representatives, who were identified through a comprehensive recruitment campaign delivered via voluntary sector organisations, Healthwatch and CCG partners.

The representatives we spoke to considered that the programme team had been inclusive and responsive. They articulated some outstanding concerns but felt confident that the programme team were listening and would continue to involve them in developing solutions.

The panel heard from the patient group representatives that the public are not completely satisfied with the way the service currently operates and are hopeful that the proposals will give an opportunity to gain consistency across the area. The public/ patients would like to see:

- A reduction in late cancellations which cause huge distress and upheaval such as with work and childcare.
- Response to the concerns raised about travel from some parts of Camden to Chase Farm; they cited a workshop where to discuss travel in relation to the review, during which potential mitigations had been discussed.
- Standardised and clear information across all north central London. One representative suggested using the literature from the Royal Orthopaedic Hospital as a best practice example. The panel were pleased to note that this has informed the work of network around patient education.
- Improvements and standardisation re: physiotherapy and aftercare which varies between hospitals.
- Better advanced planning on the care available at discharge (e.g. support for those living alone and needing to manage stairs)
- Care coordinator/ navigator to support patients navigate the system as their experience of different organisations and agencies varies
- Communication with the wider public

5.2.2 *What has been the engagement and input from providers?*

The panel appreciated the strong engagement with the providers, noting that the orthopaedic departments and networks had co created the service models put forward.

5.2.3 *What has been the engagement and input from Workforce?*

The panel explored the extent to which the workforce has been engaged. The overarching sense was that good progress had been made with the engagement of medical staff. However, they considered engaging executive or deputy to executive level nursing and allied health professional (AHP) staff at to bring clinical, strategic and operational knowledge to the proposal was needed. The panel consider that swift recruitment to these posts on the network board is essential and welcomed NCLs commitment to do so.

5.2.4 *What has been the engagement and input from Commissioners?*

The panel heard of solid foundations of commissioner engagement. Orthopaedic care is highlighted in the planned care workstream within NCL Sustainability and Transformation Plans (STPs). Discussion of the proposed changes have taken place at North London Clinical Commissioning Groups (CCG) Joint Commissioning Committee (JCC) for just under two years. The panel understand that the Directors of Adult Social Services and elected lead members for health and social care have been briefed and their views had been fed into the formal evaluation of the pre consultation engagement. In addition,a written briefing had been provided to local authority partners as well as briefings to the NLP Engagement Advisory Board, which includes all five local authorities. information has been sent via *Adult social care briefings* and the *Engagement advisory board.*

5.2.5 *What has been the engagement and input from Primary Care?*

Primary care representatives gave their endorsement and support to the proposals in the afternoon session.

Conclusion

The panel were satisfied with the stakeholder engagement that has taken place. They welcomed the inclusive approach that north central London adopted from the outset. The panel considered it was important for NCL Partners to continue to build on this firm foundation. They suggest that NCL Partners gain public and patient input to the networks update of patient information literature, as well as making quality improvement metrics available to patients (recommendation 2). The panel also recommends rapidly securing senior nursing and allied health professional representation on the network board (recommendation 13).

5.3 Clinical model

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

5.3.1 *Will the intended quality indicators be achieved by the proposed clinical model? i.e. waiting times, revision rates, length of stay, readmissions, infection rates, litigation*

The pre-consultation business case[14] details the quality indicators against which the proposed clinical model intends to secure improvements: waiting times, cancellations, length of stay, infection rates, emergency readmissions, revisions, patient reported outcomes. The panel considered that these were appropriate and that the application of the model would assist in them being met.

The panel considered that the next phase of work would be for NCL to explore how to build in the quality indicators into standard operating procedures and collect them digitally (recommendation 1).

5.3.2 Exploration of modelling, specialisation, skills and competencies, co-dependencies, case mix and threshold, patient flows, capacity

The panel heard from NCL Partners that steps to improve quality in line with national benchmarks will continue across all sites. They felt that the context in which this sits (see section 5.4) will be critical to ensuring the benefits are maximised and the capacity is managed most effectively. They also considered it would be important for senior nurses and allied health profession also to test the model from a multi-disciplinary team perspective (See section 5.6).

In addition, the panel explored in more detail the impact of separating elective and urgent care. Whilst neither of the base sites in the model are major trauma centres, the panel wanted to explore the impact of subspecialisation of elective care on staffing. The panel were advised that there would be enough junior and senior medical staff to cover trauma, however, the panel reflected on experience from SE London which suggests that trauma skill levels particularly for subspecialty work can be difficult. Therefore, the panel anticipate that flexibility between teams will be needed to address this.
The panel were informed that there had been in a reduction in the number of surgeons undertaking a low volume of cases. This, although separate to the key focus of the review is notable insofar as it has been raised through the GIRFT programme as having the potential to improve safety. The panel considered that the proposed reorganisation would almost certainly make this process easier.

Additionally, the panel considered that attention should be given to the whole multi-disciplinary 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.

The panel considered that effective multi-disciplinary team meetings (MDTs) would be critical to the success of the network and queried the current position and future. The review team were advised that:

- Southern hub - MDTs happening at present in purpose-built space with teleconferencing facilities. Meetings typically take place fortnightly, although microbiology is presented weekly for revisions.

[14] Pre-consultation business case, section 4.3.5, p36-41

- Northern hub - the Royal Free group of hospitals has an MDT structure and the North Middlesex Hospital has been invited to join these arrangements

5.3.3 Exploration of general direction- reducing the need for outpatient appointments and increasing surgical capacity. Diagnostic services, conversion rates from outpatient appointment to intervention, outpatient activity

The panel considered that the number of procedures should continue to increase with the changing demographic, but that the demand for orthopaedic services due to effective triage should decrease. The panel therefore recommend that the rate of conversion to intervention from outpatient appointments should be captured to assist with planning and projections (recommendation 12).

The panel queried whether there were any ambitions for outpatient joint surgery given the growing movement internationally. It was noted that UCLH have piloted day case unicompartmental knee and day case total hip replacement, but this applies to a minority of patients and there are no immediate plans for large scale expansion.

Conclusion

The panel considered that most of the information to address their key lines of enquiry had been effectively articulated in the pre- consultation business case. Through discussion they were assured that this was consistent with the wider direction of travel. They considered the clinical model was straightforward and well evidenced. However, the MSK pathway in which this sits (see section 5.4) will be critical to ensuring the benefits are maximised. They also considered that senior testing of the model from a Multi-Disciplinary Team perspective by senior nurses and Allied Health Professionals was required (see section 5.6).

5.4 Musculoskeletal pathway

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

5.4.1 How does the proposed model sit with the wider MSK pathway?

The panel's primary focus was to consider the service model, separating elective and urgent surgery. However, in line with national guidance, it is important that pathways are via a comprehensive musculoskeletal service to manage referrals and post discharge. The panel sought assurance as to how this service integrates with community triage and rehabilitation services as well as other relevant services such as rheumatology and pain management.

The high-level pathway is described in the pre-consultation business case[15]. The panel heard that several features of the musculoskeletal pathway are different in the north to the south of the patch because of the way the different proposals were developed. In addition, there are examples of pockets of innovative work[16]. The panel welcome the intention to develop the models for consistency and learn from best practice. The panel

[15] Pre-consultation business case, fig.4 p48
[16] Pre-consultation business case 4.3.3 p31-36

recommend that NCL Partners expand on the detail of this pathway, and there is a sustained education programme across the system to ensure that this is effectively understood, communicated and operationalised (recommendations 3-6).

There was discussion at the review day about how to ensure effective and patient centred scheduling of patents, and where pooled lists might effectively be applied to fully utilise capacity. This included discussion about how consenting in clinics might be undertaken with either a named surgeon or a team. The panel recognise that further conversations within NCL providers will be required to decide the best approach.

5.4.2 Where do the Royal National Orthopaedic Hospital/ Stanmore fit in the pathway?

The role of the specialist services of the Royal National Orthopaedic Hospital at Stanmore is largely outside the scope of this review and the service has different access criteria. That said, the wider pathway should take into consideration their role.

5.4.3 Consider primary and secondary care pathways and if required post-operative readmissions and transfer from elective to Intensive Care Unit

The panel understands that there will be access to intensive care at the Royal Free and University College Hospital London in line with other specialisms. However, there is a vision to develop a High Dependency Unit (HDU) for patients that require this post elective surgery at Chase Farm by fully equipping 3 rooms above recovery and staffing these with advanced nursing practitioners. The panel recommends NCL explore this concept and consider the access and transport arrangements. The panel believed that whilst HDU or similar may be ideal, low volumes would make it very costly and it may be that a post anaesthetic care unit is considered. The panel noted that there is not a clear answer to the appropriate patient pathway and observed that many centres operate with robust transfer plans. Areas for consideration are identified in recommendations 7 and 10.

5.4.4 What engagement and planning has taken place with the Local authority regarding the discharge pathway?

The panel noted that engagement had commenced with local authorities around the north central London reconfiguration proposals and pathways. This is critical to ensure a good understanding of the wider services and equipment available in each borough and primary care.

The panel felt it was important that the network influenced the discharge pathway to support people to reach their full potential, given the current lack of clarity and fragmentation identified by NCL. Effective liaison between Local Authorities and primary care at the point of discharge will be essential to minimise the number of readmissions following surgery, see recommendations 8 and 9.

5.4.5 What are the plans for quality indicators?

It is important that as the pathways is developed, the collection points of data for the quality indicators are built in. This is reflected in recommendation 1 of this report.

5.4.6 Consider complex orthopaedics and patients with complex needs

The panel considered that all patients, particularly those with additional vulnerabilities or complex needs would require extra support to navigate the system. There was strong support for a single contact /navigator/coordinator throughout the pathway, especially to address problems arising post discharge. There was good discussion regarding how this would take place and broad agreement that:

- An explanation should be given to the patient about their pathway at the start of their journey
- Every member of staff should be able to articulate the patient journey
- There should be one point of contact to navigate the system and link with clinical teams.
- Community engagement regarding triage and rehabilitation should be considered

NCL identified that care navigators/ coordinators had been included in the PCBC as additional roles. The panel considered that more detail was needed on the scope of these roles, including whether they were clinical or non-clinical and level of seniority, see recommendation 21.

The way in these are funded is yet to be determined e.g. efficiencies through reduction of cancellations. The panel noted that there would be double running as the service was established and that it would be important not to duplicate existing roles.

Conclusion

The wider pathway is important in terms of ensuring that the planning assumptions are correct, quality indicators are realised and that there is ongoing sustainability. The panel considered that a good start had been made to ensuring that the model is integrated into the wider musculoskeletal pathway to ensure patients can access the right care at the right time, and that as NCL themselves identify, ongoing work is needed.

5.5 Adverse impact and unintended consequences

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

5.5.1 Explore regarding: Critical care/ Trauma/ Paediatric orthopaedic services/ Spinal surgery/ Elderly care/ Plastics/ Vascular / Neurology and Intensive care

The review panel explored the model to consider whether there might be adverse impact or unintended consequences on a range of services. They recognised that there is an ongoing debate about medical provision for complex patients on an elective site.

The panel concluded that although there would be less doctors on site with splitting elective orthopaedic centres from urgent care, the impact on critical care and trauma could be mitigated- in part because separate urgent and trauma rotas already exist. They were also persuaded that separating trauma and orthopaedic surgery would offer a better training experience for staff, which in turn should aid recruitment and retention benefit the

rota. The panel were reassured that there had been collaboration with major trauma network and spinal network.

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

Although the panel heard that provider trust boards were working together, the panel felt that outstanding work is needed to finalise the financial implications of how benefits from improved value and productivity would be shared across the system. The panel considered that the new model provided opportunities to improve quality and efficiency e.g. length of stay.

Conclusion

The panel were satisfied that the impact on interdependencies had been reviewed and were being mitigated where necessary but considered that the wider position of associated financial flows, gains and losses should be addressed across the whole system. See recommendation 23.

5.6 Enabler- workforce

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

5.6.1 Is there a coherent and realistic workforce strategy that addressed the role of all health professionals e.g. nursing, allied health professionals?

The panel considered that doctors/ medical staff had been the main focus of workforce plans to date. Although senior nurses have been involved in workshops, the posts on the network board had not yet been recruited. Possibly due to this, there is little detail in the documents regarding the impact on the allied health professional and nursing workforce. The review team were heartened that plans are in place to recruit nurses and allied health professionals onto the board to help ensure that due consideration to these professional bodies is given and heard in this programme and that they can influence the pathway (see recommendations 13, 14 and 20).

5.6.2 Are the workforce plans sustainable?

In broad terms, this model proposes the same number of posts as present but a change in the skill mix. The review team considered the model offered some excellent opportunities for workforce development, and that the vacancy rate, at least in theatres (7-10%) would allow this. The model presents economies of scale and opportunities for realising benefits by working across the wider network, for example care practitioner roles. There is opportunity to engage with training of community-based triage practitioners in a variety of roles such as first contact practitioners and single point of access, which can offer a career structure, rotation and support retention. The panel recommends further consideration to how these might be integrated into the model (recommendation 15).

The panel believes that further attention and consultation would be needed to truly test the effectiveness and sustainability of the plans as well accommodate any rising demand.

5.6.3 How can negative impact/ distortion of other workforce areas be avoided?

There is a potential impact on the role of trainee doctors with the separation of planned and urgent care. It was apparent that the NCL team have considered the impact of the proposed model from a trainer perspective, as well as the logistics, for higher specialty orthopaedic trainees.

The panel were advised that trainees have been part of the discussions at a trust level and welcomed the changes. However, the panel also considered that a wider workforce scope would be important, and this should include the impact on core surgical foundation, anaesthetic and intensive care trainees as well as orthogeriatric services, including physician trainees. The panel recommend consideration of the national Improving Surgical Training (IST) report recommendations. They suggest a helpful approach can be mapping the care pathway and points of care to take to fora with junior doctors. Elsewhere, this has effectively been undertaken by a trainee in a transformation role such as Darzi or Chief Registrar programmes (see recommendations 17-19).

The panel noted the following key points at the review day:

- The model works effectively for specialist trainees. The panel suggest further work to test and potentially improve the experience for core trainees to ensure that there is rotation through elective and trauma. The learning needs for less than full time trainees should also be included.

- NCL advised that the model was based on trainees working 1-2 days at different sites and that the tariff would stay at the base hospitals- though the workforce will move on block. Health Education England (HEE) discourage trainees having to work different sites on the same day. The panel were reassured this would not be included in the plans.

- Hospital at night cover was presented as cost neutral by NCL due to the costs going in from a provider perspective regardless of model. However, there was no clear plan for recruitment of locally employed doctors (those not in training) to cover the hospital at night.

- Anaesthetic practitioners - UCLH feedback has been that the down time is frustrating as trainees are seeking to gain competency numbers and solutions are being explored.

Conclusion

The panel considered that the model has the potential to provide positive opportunities for workforce development, benefits to the surgical trainees and to support learning in a way that the current fragmentation does not. However, to realise these benefits it is essential that the workforce strategy continues to be expanded and defined as work progresses, with detailed attention to all professional groups.

5.7 Enabler- digital innovation

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

The panel were informed of a £9m investment into an STP wide digital programme, to provide population health management was underway with *Cerner*. This will provide a minimum data set for all health and social care partners across the STP. There is ongoing work through the One London programme to enable images to be shared across London, this is currently being piloted in east London.

The panel welcomed the support offered to cross site working and effective pathways through digital investment although noted that the system will not allow bookings, and thus work is needed to clarify the patient flow and potentially passporting for staff. These issues are recognised by NCL and we understand that attention is being given to address them.

Conclusion

The panel were heartened to see the progress being made in digital to underpin the effectiveness of the model and the wider MSK pathway. They recommend that the programme plan explores the potential for shared booking to be available across the system to smooth the patient pathway (recommendation 22).

5.8 Sustainability

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

The panel considered that the proposal provided equivalent if not greater assurance of service sustainability and the potential to manage growth than the current configuration.

However, the panel also considered that there could be potential for the numbers and complexity to be greater than anticipated in the modelling, as indicated in section 5.1.5. They advise that the NCL team continually monitor these assumptions with consideration to how growth should be managed if required (see recommendations 11 and 12) . It was noted that growth could be met by the physical provider capacity, but further workforce may be necessary to support this.

The panel were advised that no services were at risk from stranded costs, and NCL partners were focussing on realising efficiencies. There is potential for the identified gains in quality to be used by the network and the STP to manage capacity and growing demand.

Conclusion

The review panel deemed that the new model offers a much more sustainable future for orthopaedic services than the current configuration. The proposal is a clinically and cost-effective way to meet the growing demand. However, they also considered that the proposals should be developed in terms of financial planning to ensure that any gains are shared across the system for the ongoing improvement of the MSK care pathway.

6. Advice and recommendations

Following full exploration of the key lines of enquiry the panel have focussed their views against the seven areas that NCL asked them to consider. Their views and ensuring recommendations are detailed below:

6.1 Model of care

Whether the new model of care will deliver safe, effective intervention that significantly improves patient experience and outcomes

The panel considered 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. The local data presented in the report supports this, and the panel consider that an important next phase is to monitor quality improvement metrics in real time.

The panel also heard from patient representatives that the public are not completely satisfied with the current model of the service. They wish to see consistent information and a reduction in late cancellations. The proposed model gives the opportunity to meet these requests.

The panel recommends:

R1. Quality indicators and improvement metrics are built into the standard operating procedures. Where possible, these are collected digitally

6.2 Evidence

Whether there is sufficient evidence that the change proposed is justified in terms of clinical efficacy and patient experience

The panel considered that there is enough evidence that the proposed change is justified. There is a strong body of evidence underpinning the service model, with outcomes and improvement metrics that can be tracked.

They tested whether outcomes could be improved through the uniform application of standards on the current configuration and were convinced that reconfiguration is warranted (see 5.1 Case for Change, above).

The PPV representatives joining the panel day were clear that clear information and patient literature were a priority to them. The panel were pleased to hear work already progressing within the Network to address this. The panel feel that patient perception and choice will steer the success of this model.

The panel recommends:

R2. Patient information literature is codesigned with patients and improvement metrics are made available to patients.

6.3 Musculoskeletal pathway

That there is sufficient alignment with the wider musculoskeletal pathway to ensure patients experience seamless care across the system

The panel heard that as part of the development of the pre-consultation business case, conversations had been held across the two proposed hubs and had commenced with Primary Care and Local Authorities to embed the elective surgical model within a clear musculoskeletal pathway. The need for a clear pathway was a strong feature of feedback from the public and patient representatives, and an area where the NCL programme team have recognised refinement is required.

The PCBC states that further work over September and October 2019 is needed on the following:

- *How patients who develop complications or require re admission would be managed*
- *Assurance around the management of some complex patients at base hospitals*
- *Details of overnight cover arrangements and day time staffing model in both proposed elective centres*
- *Royal Free to provide assurance that level 2 HDU capacity would be in place at Chase Farm and operational at the start of the new model becoming operational*
- *Further work would be undertaken to ensure a single proposition around:*
    - *Detail of integration for post-operative community care*
    - *Role of care navigators/ coordinators*
    - *Requirements for digital interoperability prior to go live- including the need for Image sharing as part of the One London programme of a NCL solution depending on timescales*
    - *Transport/ access discharge arrangements*
    - *Whittington and Royal Free to provide additional information about the proposed - model of care and arrangements for spinal patients, prior to further discussions involving the spinal network*[17]*.*

The panel encourages full exploration of the areas that NCL have identified.

The panel also recommends:

R3. A sustained education model is developed for stakeholders of the service covering topics such a discharge communication.

R4. Clarifying threshold and trigger points for readmissions

R5. Clarifying the process for readmissions, considering identifying a single contact point through which this is managed.

R6. Learning from the pilots and best practice models already in existence in the borough[18] and considering rolling out for consistency

R7. Liaising with patient transport services and London Ambulance Service regarding transport and discharge arrangements across all sites

R8. Exploring innovative models to support the pathway e.g. joint schools, after care and equipment.

[17] Pre-consultation business case, Section 8.7, p93
[18] Referenced in the pre-consultation business case section 4.3.3, p31-36

R9. Further engaging community MSK triage and rehabilitation services to ensure a safe effective and efficient pathway in and out of secondary care orthopaedic services

R10. Considering the role and specification of beds on the Chase Farm site to clarify the new model of care, commission the model and develop a practical understanding of patient flow. This may include:

- patient criteria e.g. high dependency unit or post anaesthetic care unit
- patient pathway
- anticipated length of stay
- arrangements with patient transport services and London Ambulance Service for patient transfer and emergency conveyancing

6.4 Demand and sustainability

Our approach demonstrates the future demand is adequately addressed and sustainable services developed

The panel recognised NCL projected a net increase of activity to be 1,148 procedures (9.5%. However, they considered this was only realistic and sustainable if the wider system contributed to managing demand and ongoing care.

The Clinical Senate review panel has assessed the plans regarding the future sustainability of the clinical model. The panel considered that the proposal provided equivalent if not greater assurance of service sustainability and the potential to manage growth than the current configuration.

The panel recommends:

R11. 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.

R12. Reviewing activity projections to ensure that they are as realistic as possible. Measure the rate of conversion to intervention from outpatient appointments to assist with planning and projections.

6.5 Workforce

Our workforce plans will ensure patients can access the right treatment at the right time

The panel heard that workforce plans were underway and recognised that the model offered the potential for training opportunities and staff retention, which would in turn enable patients to access the right treatment at the right time.

The panel did not hear anything that was detrimental to the workforce and consider the new model offers potential that the current model does not. That said, the recruitment of senior allied health professionals and senior nurses to the network board is needed to fully work up plans for all professional groups. Although the plans provide assurance of physical capacity, there is less assurance of workforce capacity should activity rise above current levels of projection.

The panel recommends:

R13. Implementing plans to recruit senior allied health professionals and nurses to the network board

R14. Developing and articulating opportunities for all staff, allied health professionals and nursing staff as well as doctors. Consider giving attention to standards; pathways; education; mentoring and preceptorship; rotation; as well as practical employment issues such as parking, childcare and maternity payments.

R15. Considering how roles such as first contact practitioner or single point of access/ triage practitioners might be integrated into the model. Develop a capability framework for these.

R16. Considering the development of a workforce strategy that would address any rise in activity.

R17. Undertaking a wider workforce scope, mapping the care pathway and points of care for discussion with a wider forum of surgical trainees.

R18. Considering how core surgical trainees gain exposure in areas other than orthopaedics. Imaginative solutions may be required.

R19. Considering the willingness and availability to flex staff across sites, paying attention to passporting, rota and work schedules.

R20. Identifying within the model whether therapy services will operate 5 or 7 days per week and the workforce implications of this.

In addition, the review panel welcomed the introduction of a new role to support patients navigate the new care pathway for orthopaedic services. The panel noted that the South West London Elective Orthopaedic Centres are now looking to implement a similar role. Further development and clarity is required to standardise the role and expectations, to maximise its effectiveness, and this is already recognised by the NCL Team[19]

The panel recommends:

R21. Fully work up the proposals for care navigators/ coordinators, paying attention to:

- articulating the outcomes of better care coordination within and outside the hospital
- gathering feedback from PPV groups to determine what the need is and therefore influence how this can best be met
- the differing proposed models in the north and the south of the patch and whether these can be standardised
- the role/ parts of role required to address the administrative aspects (perhaps better called a navigator) and which would be clinical i.e. nurse or allied health professional consultant
- development of a role description which includes a clear definition of clinical responsibilities if relevant.
- addressing how the care coordinator role will be funded – especially if it picks up on parts of pre-existing roles
- creating a development framework for these staff, potentially connecting to an apprenticeship programme

[19] Pre- consultation business case, section8.7, p93

- identifying the interface with MDTs to manage patients across primary, secondary and tertiary care pathways
- identifying additional support that may be required for patients with additional vulnerabilities e.g. mental health needs

6.6 Digital innovation

Our plans for digital innovation will facilitate seamless care across organisational boundaries

The panel recognises significant investment into a health management tool to enable the sharing of patient information across all providers. They encourage NCL to continue this work.

The panel recommends:

R22. Programme plan a time to explore the potential for shared booking to be available across the system to smooth the patient pathway.

6.7 Unintended consequences

That there are no unintended consequences for clinical services that are out of scope but key dependencies within the review (spinal surgery, paediatric surgery and trauma services).

The review panel were satisfied that the impact on interdependencies had been reviewed and was being mitigated but considered that the wider position of associated financial flows, gains and losses should be addressed across the whole system.

The panel noted that the future configuration of the NHS is evolving, and attention needs to be paid to the legacy. The PCBC outlines that the overall effect of the proposals is cost neutral; however, stranded costs have been applied to some organisations. This suggests that some organisations gain financially from implementing the proposed model.

The panel recommends:

R23. Commissioners and providers consider managing the financial impact of gains and losses across the health and social care system in north central London to enable future sustainability. This could be enabled by network collaboration.

7. Conclusion

The panel supports the proposals for adult elective orthopaedic services in North Central London as outlined in the Pre-Consultation Business Case subject to the recommendations outlined above.

Report Signed off by: Dr Mike Gill, Chair London Clinical Senate

Report Prepared by: Emily Webster, Senior Programme Manager, London Clinical Senate (Interim)

8. Supporting information

8.1 Information submitted to the review

The following documentation informed the review:

Draft PCBC Documentation

a. North London Partners in Health and Care; Adult Elective Orthopaedic Services: Pre-Consultation Business Case Partnership for orthopaedic excellence: North London, Draft version 0.11 (August 2019)

Care Quality Commission Reports

b. Care Quality Commission; North Middlesex University Hospitals Trust, Inspection Report (September 2018)
c. Care Quality Commission; Royal Free London NHS Foundation Trust, Inspection Report (May 2019)
d. Care Quality Commission; Royal National Orthopaedic Hospital NHS Trust, Inspection Report (March 19)
e. Care Quality Commission; Harley Street at UCH, Quality Report (June 2017)
f. Care Quality Commission; Whittington Health NHS Trust, Inspection Report (February 2018)

Equalities Impact Assessment

g. Verve Communications; Initial Equalities Analysis, Desk Research (August 2018)

North London STP Plans

h. North Central London Sustainability and Transformation Plan; North Central London Sustainability and Transformation Plan – Case for Change (September 2016)
i. North London Partners in Health and Care; Working together for better health and care: our sustainability and transformation plan (June 2017)
j. North London Partners in Health and Care; Planning for better health and care in North London, A public summary of the NCL STP (August 2017)
k. North London Partners in Health and Care; Delivering improved outcomes for North Central London residents: Overview of the STP and delivering the NHS Long Term Plan (August 2019)

Relevant Trust Strategies (Northern)

l. North Middlesex University Hospital NHS Trust; Our Forward View 2019-2024
m. North Middlesex University Hospital NHS Trust; 2018/19 Quality Account (June 2019)
n. Barnet, Enfield and Haringey Clinical Strategy; Programme Board report and recommendation to the Barnet, Enfield and Haringey Clinical Commissioning Group Governing Bodies (September 2013)
o. Royal Free London NHS Foundation Trust; Clinical Strategy Meeting Trauma & Orthopaedic Surgery (September 2018)
p. North Middlesex University Hospital NHS Trust and Royal Free London NHS Foundation Trust; Adult Elective Orthopaedic Services in North London, Pro-forma for provider responses, Submissions of options (July 2019)

Relevant Trust Strategies (Southern)

q. University College London Hospitals NHS Foundation Trust; Cancer and Surgery Facility (Phase 4) (June 2019)

r. University College London Hospitals NHS Foundation Trust; Quality Account 2018/19 (May 2019)
s. Whittington Health NHS Trust; Our Strategy 2019-2024
t. Whittington Health NHS Trust; Quality Account 2017/18 (June 2018)
u. Whittington Health NHS Trust and University College London Hospitals NHS Foundation Trust; Memorandum of Understanding between Whittington Health NHS Trust and University College London Hospitals NHS Foundation Trust (January 2017)
v. Whittington Health NHS Trust and University College London Hospitals NHS Foundation Trust; Licence to Attend (November 2017)
w. Whittington Health NHS Trust and University College London Hospitals NHS Foundation Trust; Adult Elective Orthopaedic Services in North London, Pro-forma for provider responses, Submissions of options (issued May 2019) (July 2019)

Programme Risk Log

x. North Central London STP; NCL STP Adult Elective Orthopaedics Work Stream Risk Register (August 2019)

8.2 Review panel members

- **Dr Mike Gill, Panel Chair and Chair, London Clinical Senate Council**

  Dr Mike Gill is an experienced senior Medical Leader. He has been practicing as a Consultant Physician (Care of Elderly and General Medicine) since 1989.

  From 2014-2018 he was Medical Director at Health 1000: The Wellness Practice, a new type of GP surgery which looked after patients with multiple medical conditions in their own homes. The Practice also supported the care of patients in Nursing Homes. The Nuffield have published evaluations of both services. Prior to this he had been a Medical Director for over 12 years at Newham University Hospital NHS Trust, Barking, Havering and Redbridge University Hospitals NHS Trust, Associate Medical Director at Barts Health and more recently Interim Medical Director at the Homerton University Hospital Foundation Trust. As well as Interim Chair of Council of the London Clinical Senate, Mike is also Chair of Kent and Medway Acute Stroke Services Joint Committee and subject matter expert for a Health Education England Frailty Clinical Fellow Programme.

  He was a member of NICE Acute Medical Emergencies Guideline Committee and an elected fellow on the Council of the Royal College of Physicians 2014-17. Other roles Mike has undertaken include Joint Clinical Director for the Health for North Central and East London programme and Honorary Clinical Director for Elderly Care at NHS London.

  Mike joined the London Clinical Senate Council in June 2013.

- **Richard Ballerand, London Clinical Senate PPV Group Chair**

  Richard M Ballerand is a Franco-British policy advisor and Axolotl Associates partner. Leading his practice's Patient Participation Group, he serves as lay member/reviewer for National Institute for Health Research, National Institute for Health and Care Excellence, and National Data Collaborative for Health and Care. An EMA European patient expert, NIHR CLAHRC NWL improvement leader fellow, and multiple health network member, he has served in various capacities on five London NHS Trusts over the last six years.

A syncretist with economics, strategy, and psychology degrees, and a financial/defence sector background, Richard also travelled widely as a reservist military liaison officer. Former trustee of several charities and think-tanks (e.g. Chelsea Society, Royal Institution and Royal United Services Institute) – some earlier roles include: Zoological Society of London vice-president, Birkbeck College governor, and University of London senator.

Richard draws on extensive lived experience of the British, French and American healthcare systems, including family advocacy, caring, and care coordination. London based for three decades, he also trained and volunteered as a counsellor. During his doctoral studies he was hit by a car, and sustained several injuries, including a traumatic brain injury, with long-term sequelae. Richard has a special interest in those with invisible disabilities and deficits, and the challenges facing the ex-military and diverse groups.

Richard is the Patient and Public Voice group nominee on the London Clinical Senate Council and joined the Council in September 2019.

- **Andrew Bennett, Consultant MSK Physiotherapist, Epsom and St Helier University Hospitals NHS Trust**

  Andrew is a Consultant Musculoskeletal Physiotherapist within Sutton Health and Care Alliance and Epsom and St Helier NHS Trust. He qualified in 2000 in Leeds, completing specialty training across London as well as a PGcert, PGdip and MSc. He led the successful re design of MSK local services presented nationally and internationally, is a lead for MSK transformation within the South West London Health and Care Partnership and acted an expert specialist for a variety of projects including the recent NIHR Moving Forward themed review. He is an undergraduate and post graduate educator and co-chair of the UK Consultant Physiotherapists group

- **Aileen Buckton, Previous London Association of Directors of Adult Social Services Chair**

  Aileen was previously Director of Adult Social Services at Lewisham, and Chair of the London Association of Directors of Adult Social Services. She was a member of the London Clinical Senate for a number of years.

- **Mr Suresh Chandrashekar, Consultant Orthopaedic Surgeon, Homerton University Hospital NHS Foundation Trust**

  Mr Suresh Chandrashekar is consultant orthopaedic foot and ankle surgeon based at Homerton University Hospitals NHS Foundation trust and Clinical lead for trauma and orthopaedics.

- **Mr Peter Earnshaw, Consultant Orthopaedic Surgeon and Clinical Director of Surgery, Guy's and St Thomas' NHS Foundation Trust**

  Mr Peter Earnshaw is a consultant orthopaedic surgeon based at Guys Hospital. He was Clinical Director of Surgery at GSTT for 15years and is now Clinical Lead for the SE London Elective Orthopaedic Network.

- **Rachael Fergusson, Head of Occupational Therapy (Acting), Guy's and St Thomas' NHS Foundation Trust**

Rachael trained at Otago Polytechnic in New Zealand in 1997 having worked in various clinical areas she has developed a special interest in working with older adults in emergency medicine and has also worked in a number of senior health management roles. In 2006 she graduated with an MSc in Health Sciences from St Georges, University of London.

- **Sally Kirkpatrick, London Clinical Senate PPV Group Member**

  Sally retired from financial consultancy in 2010 and has since been a patient representative across many health organisations including the London Clinical Senate Patient and Public Voice group, her local Healthwatch, her local Clinical Quality boards and the Integrated Urgent Care service in her area. She was a member of the Pan London End of Life Alliance and a board member of the Senate's Helping Smokers Quit (HSQ) programme. Sally is an expert by experience and was a member of the team that redeveloped the mental health wards at her local trust, providing patient and carer input for the architectural design of the building and the individual rooms.

- **Dr Jo Szram, Deputy Postgraduate Dean, HEE South London**

  Jo trained in respiratory and general medicine in Cambridge, Peterborough, Nottingham and North West London. She works in the Occupational Lung Disease Clinic at the Royal Brompton and Harefield NHS Foundation Trust, where she was Director of Medical Education from 2014-9. She was Core Medical Training Programme Director for HEE North West London until 2017.

  Jo has been Deputy Postgraduate Dean, Health Education England (HEE) South London since 2017 and since 2018, the clinical lead for the Physician Specialty Recruitment Office (PSRO) now based in HEE. Most recently she has taken over the Chair of HEE's Leadership Leads group, who work to deliver leadership development to all postgraduate medical trainees and is co-chairing the well-being checking working group as part of HEE's wellbeing oversight board. She is responsible for the South London trainee network and the London fellows' network.

  Jo is an elected Councillor of the Royal College of Physicians (London), and Chair Elect of the National Association of Clinical Tutors (NACT UK). Jo sits on the IMT advisory committee for the federation of royal colleges of physicians training board as quality lead, and HEE's IMT programme board. She is an associate editor of the Future Healthcare Journal and tweets regularly from @lungsatwork.

- **Janet Murat, Divisional Director of Nursing, Anaesthetics, Barking, Havering and Redbridge University Hospitals NHS Trust, September 2015 to date.**

  Janet's current service and operational responsibilities include; 23 Theatres, Day Surgery, Critical Care services covering 52 beds including tertiary Neuro beds , Critical Care Outreach, Pain and Pre-Assessment Services.

- **Dr Mohini Parmar, NWL STP Clinical Lead, Chair NHS Ealing Clinical Commissioning Group and GP Partner Barnabas Medical Centre**

  Mohini has been a practising GP in Ealing for 26 years and is the Senior Partner in a four-partner practice. She has been Chair of Ealing Clinical Commissioning Group since April 2011 and has been leading and facilitating ECCG through this transition phase. Mohini

takes a key role in ensuring clinicians are effectively involved in service design and has worked with other clinical colleagues and the borough team to ensure and promote active engagement with ECCG member practices.

Supported by

- **Emily Webster**
  Clinical Senate Programme Lead (Interim), NHS England and NHS Improvement, London
- **Katie Humphreys**
  Clinical Senate Senior Project Manager, NHS England and NHS Improvement, London

8.3 Review panel enquiry sessions

North Central London Adult Elective Orthopaedic Review
Clinical Senate Review Panel Timetable

Time	Topic	Team presenting/answering questions	KLOE to be addressed
8.30am to 9am	Arrival registration and refreshments for the panel		
9am to 9.30am	Panel pre-meet		
9.30am to 10am	**North Central London Adult Elective Orthopaedic Services Review** Presentation covering: • Our vision • Case for Change • Clinical Delivery Model • Change process and how we have worked together	• ***TEAM LEAD: Professor Fares Haddad (Clinical lead and network chair)*** • Rob Hurd (Joint SRO and Chief Executive of the Royal National Orthopaedic Hospital) • Anna Stewart (Programme Director) • Rosemary Arnold and Helen Andrews, patient representatives on the Programme Board	KLOE 1: Does the clinical case for change clearly articulate the rationale and provide enough evidence that the change is justified in terms of efficacy and patient experience? KLOE 2: Has there been sufficient engagement with Stakeholders?
10am to 11.30am	**Our proposed model of care -** *Partnership for Orthopaedic Excellence: North London*	**Programme team** • ***TEAM LEAD: Rob Hurd (Joint SRO and Chief Executive of the***	KLOE 3: Will the proposed clinical model deliver safe, effective, high quality

	Short presentation to start covering: • Role of the Clinical Network • Northern hub (Royal Free/North Middlesex) • Southern hub (UCLH/Whittington) • Role of the super specialist centre • External clinical input and assurance	***Royal National Orthopaedic Hospital)*** • Professor Fares Haddad (Clinical lead and network chair) • Mr Phil Mitchell (Independent Clinical Adviser, Medical Director SWLEOC) **Royal Free/North Middlesex team** • Mr Philip Arhens (Consultant Orthopaedic Surgeon, Royal Free London) • Dr Prashanth Belavadi (Divisional Clinical Director Surgery, North Middlesex Hospital) • Sam Hoskins (Operations Manager - Trauma and Orthopaedics, Royal Free London) **UCLH/Whittington team** • Mr Sam Oussedik (Consultant Orthopaedic Surgeon, UCLH) • Mr Panos Thomas (Consultant Orthopaedic Surgeon, Whittington Health) • Kate Petts (Deputy Director of Strategy, UCLH) **Workforce implications and broader clinical involvement** • Tom Nettel (HR Director, RNOH and workforce lead) • Andrea Francis (Therapies Lead, Royal Free) • Anna Bruce (Matron UCLH)	orthopaedic care to improve experience of patients and clinical outcomes in NCL? KLOE 4: Is the model integrated into the wider musculoskeletal pathway to ensure patients can access the right care at the right time? NB Bullet points 1 & 2 to be covered in the afternoon session KLOE 5: Will there be any adverse impact or unintended consequences on areas with key dependencies? NB financial dependencies to be covered in the afternoon session KLOE 7: Do workforce plans ensure patients can access the right treatment at the right time

11.30am to 12.15pm	Patient participation	• ***TEAM LEAD: Anna Stewart (Programme Director)*** • Helen Andrews • Noelle Skivington • Pam Hibbs • Yvonne Denny • Stephen Lee	KLOE 1: Does the clinical case for change clearly articulate the rationale and provide enough evidence that the change is justified in terms of efficacy and patient experience? Specifically have public and patient been listened to and responded to?
12.45pm to 2.00pm	Strategic Context for NCL • Fit with future plans – integrated care • Commissioning perspectives – CCG and specialised commissioning • Primary and Community Context of MSK services	**Financial context and modelling** • ***TEAM LEAD: Simon Goodwin (Director of Finance, NCL CCGs)*** • David Stacey (Finance Director North Middlesex Hospital and Chair of the Finance Steering Group for the review) • Geoff Sanford, NEL CSU finance and activity lead **Programme team** • Anna Stewart (Programme Director) **STP context** • Richard Dale (Director of Programme Delivery, North London Partners) • Plus Jo Sauvage (see below) **Wider stakeholder engagement** • Victoria Osborne-Smith – Specialised Commissioning, London **FROM 1.30PM (below)** **Fit with primary and community services and wider MSK pathway**	KLOE 2: Has there been sufficient engagement with Stakeholders? KLOE 5: Will there be any adverse impact or unintended consequences on areas with key dependencies? Particularly to pick up here finance as a dependency KLOE 1: Does the clinical case for change clearly articulate the rationale and provide enough evidence that the change is justified in terms of efficacy and patient experience? Specifically, to pick up here the activity modelling. KLOE 8: Will plans for digital innovation will facilitate seamless care across organisation boundaries KLOE 9: Does the approach demonstrate the future demand is adequately addressed and

		• Dr Dee Hora, North London Partners Planned Care Clinical Lead (Primary Care) • Dr Jo Sauvage, Chair Islington CCG and Co-chair NCL Health and Care Cabinet • Nadine Jeal, Clinical Director, Adult Community Health Services Whittington Health, MSK Advance Practice Physiotherapist, MSK Professional Lead for the Haringey and Islington Wellbeing Partnership	sustainable services developed?
2.00pm to 2.15pm	Wrap up and any closing questions from the day	• ***TEAM LEAD: Professor Fares*** Haddad • Rob Hurd • Anna Stewart	
2.15pm to 5pm	Panel discussion and deliberation		

8.4 Declarations of interests

The London Clinical Senate provides independent and impartial advice. The review panel did not include anyone who has been involved in the development of the proposals on which we are giving advice or who has been involved in, or is likely to be involved in, any part of NHS England's assurance process for these proposals. All review panel members formally declared their interests and no conflicts existed.

8.5 Review terms of reference

INDEPENDENT CLINICAL REVIEW: TERMS OF REFERENCE

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

Sponsoring Organisation: North Central London Partners in Health and Care

Clinical Senate: London Clinical Senate

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

Terms of reference agreed by:

Dr Mike Gill, Chair, London Clinical Senate Council

on behalf of the London Clinical Senate and

Will Huxter, Director of Strategy, Barnet, Camden, Enfield, Haringey and Islington CCGs

on behalf of North Central London Partners in Health and Care

Date: 8th July 2019

Aims of the review and advice requested

North Central London Partners in Health and Care have asked the London Clinical Senate to provide independent advice on proposals to reconfigure adult elective orthopaedic services in North Central London (NCL). The proposals set out to transform elective services across five north London boroughs and CCGs: Barnet, Camden, Enfield, Haringey and Islington.

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

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

Scope of the review

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

Strong public and patient engagement

Consistency with current and prospective need for patient choice

Clear, clinical evidence base

Support for proposals from commissioners

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

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

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

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

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

Reducing **inequalities** (this involves understanding and tackling inequalities in access, health outcomes and service experience, between people who share a protected characteristic and those who do not, and being responsive to the diversity within London's population)

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

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

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

Ensuring **value** (achieving the best patient and population outcomes from available resources)

Review Panel

The Chair of the London Clinical Senate Council will chair the review (Dr Mike Gill).

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

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

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

Method

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

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

NHS England's Service Change Toolkit

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

The review is expected to involve the following steps:

Step 1: **Establish the review panel**

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

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

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

Step 4: Hold an expert **review panel** (1 day) to undertake the following:

- Meet and discuss the proposals/solutions with stakeholders (commissioners and providers) involved in their development to explore key lines of enquiry
- Provide an opportunity for stakeholders impacted by the proposals to share views with the review panel
- Debate findings within the review panel and finalise conclusions

- Identify any outstanding issues and agree the process for following-up (and further review panel discussion as agreed necessary)

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

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

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

Ensure the terms of reference have been met

Comment on any specific issues where identified by the review panel

Agree that the report can be issued

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

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

Documentation required

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

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

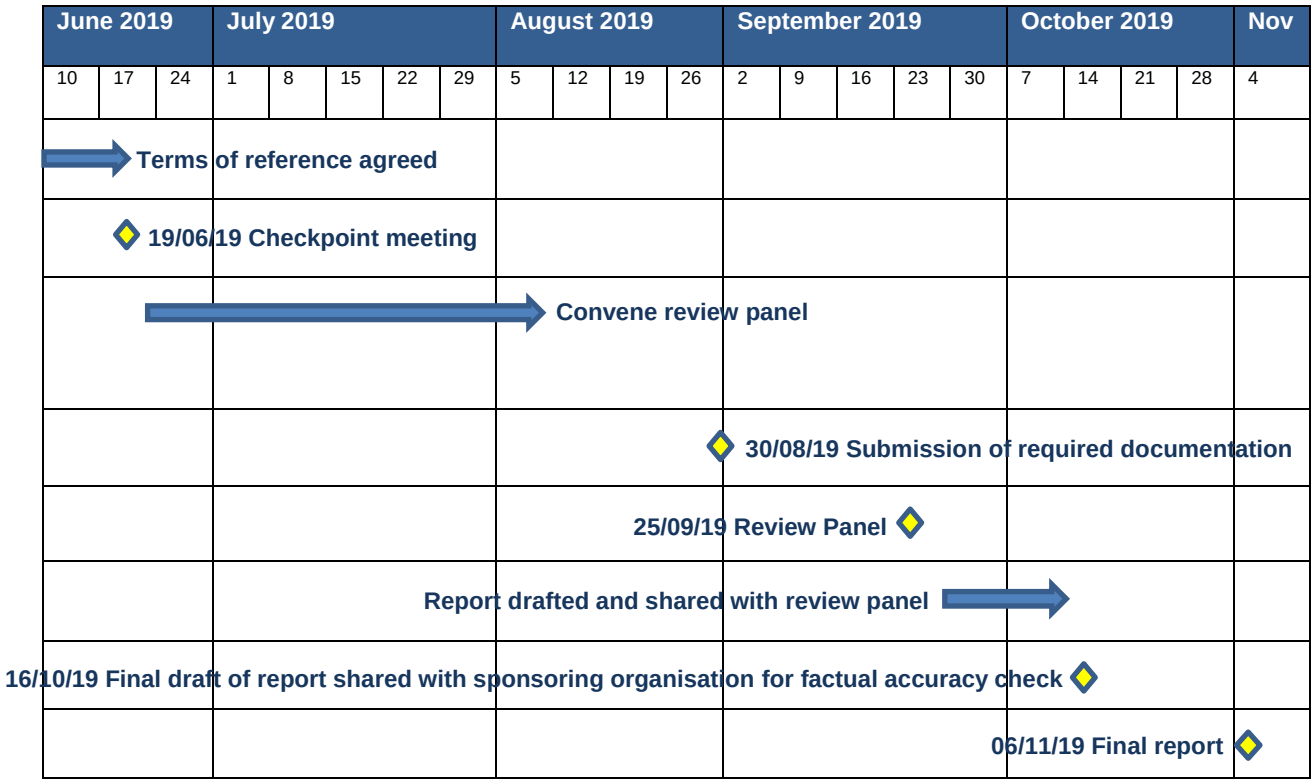
- The draft Pre-Consultation Business Case (PCBC)
- The Case for Change (rationale for the proposed change and evidence base)
- Proposed clinical models (description, rationale and evidence base)
- Supporting activity and workforce data and modelling, patient flows and pathways, patient transport, performance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

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

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

Timeline

The figure below details the milestones in the review process:



Risks

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

Reporting arrangements

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

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

Report

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

Communication and media handling

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

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

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

Disclosure under the Freedom of Information Act 2000

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

Resources

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

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

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

Accountability and Governance

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

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

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

Functions, responsibilities and roles

The **sponsoring organisation** will:

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

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

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

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

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

- Provide suitable support to the review panel.
- Submit the final report to the sponsoring organisation.

The **review panel** will:

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

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

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

Contact details of key personnel coordinating the review process

For the London Clinical Senate:

Katie Humphreys
Senior Project Manager
Email address: katiehumphreys@nhs.net

For North Central London Partners in Health and Care:

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Programme Director
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Final, 23rd December 2019 v 1.8