North Central London Joint Commissioning Committee

Meeting on 2 May 2019

The following questions were submitted by Mr Martin Blanchard in advance of the committee. The following responses were provided.

1. **We note from the report that you will be using the London Choosing Wisely (LCW) Policy criteria to 'manage demand' for hip and knee replacement (a euphemism for rationing). This we find surprising as, during the very limited PoLCE engagement exercise with the NCL public, we were assured that the basis for changing any referral criteria was only to improve 'evidence-based clinical practice'. However, there has been no consultation at all with people in NCL about adopting LCW criteria to 'manage demand' for surgery. Will NL Partners give an assurance that they will hold a full and frank public consultation with the citizens of North Central London about the wish to ration elective orthopaedic surgery, explaining exactly how they are going to do this and why they wish to do this, while describing the possible clinical consequences and the effects this will have on some people's quality of life?**

   Elective orthopaedic surgery is not being rationed in north London. The number of the number of these surgeries is predicted to rise, in line with the requirements of a growing and ageing population. Overall, demand for orthopaedic surgery is anticipated to increase by 2.2% by 2023 (average increase of 0.38% per annum).

   The policy wording relates to the point at which it is clinically appropriate to have surgery, following shared decision-making between the patient and their clinician, and after first using appropriate non-surgical interventions.

   We can reassure residents that a significant number of local clinicians were involved in reviewing the revised referral thresholds for hip and knee replacement. The changes are based on latest clinical evidence and the input of subject matter experts. We also undertook equality impact assessments to consider any impact for protected groups, which concluded there is no reason why those residents meeting the clinical criteria wouldn't receive the treatment they require.

   We have presented regularly at the NCL Joint Health and Oversight Committee over the past year to ensure we are meeting our duty to communicate and engage with residents on any changes in an appropriate way and continue to work with them with regards to any future updates.

2. In the finances section of the report it states that elective orthopaedic care will require the setting up of a 'Commercial Board' (or Boards) and indeed that the elective centres in NCL will look to take on 'customers' from surrounding areas and Private Hospitals. We understand that it is currently possible for NHS Providers to use 49% of their services to treat 'paying customers' if they wish, and that future financial pressures may make this an attractive proposition for managers. Hip and knee replacement surgery could be seen to represent 'good business'. Will NL Partners assure the citizens of NCL that clinical need will be the only factor taken into consideration when deciding who receives orthopaedic surgery, and that no patients will be able to pay to gain access to elective surgery in our services?

The JCC decided at its January 2019 meeting, that services under the newly configured clinical delivery model will remain within the NHS by way of variations to existing annual contracts; to ensure services are safe and that there are no adverse implications for interdependent orthopaedic trauma services.

The reference to 'commercial principles' relates to how money will be distributed between NHS providers and a 'joint commercial board' would comprise representatives from each NHS service provider. Its purpose would be to ensure financial governance across the NHS system, not the proportion of privately funded patients accepted by each organisation.

At the JCC meeting on 2 May, we received feedback from committee members that the use of the term 'commercial' in the clinical delivery model did not convey the intended purpose of these financial governance arrangements. We were therefore asked to clarify the terminology in the final version of the documents.

3. The Report of the 6th National Audit Project Royal College of Anaesthetists May 2018 states that patients with severe perioperative anaphylaxis should be admitted to Level 3 critical care, and that following resuscitation from cardiac arrest, most patients require vasopressor infusions, with some needing to stay in critical care for more than two days. Given these findings, will patients with what the Report identifies as a 'high risk of an adverse outcome from severe perioperative anaphylaxis'- i.e. older people, obese people, people with an ASA of or above 3, people taking beta-blockers or ACE inhibitors-only receive their elective treatment at a NL Provider with an on-site Level 3 critical care facility capable of providing these longer stays if necessary? This would act to try to avoid the need of ever having to transfer any patient who is critically ill due to perioperative anaphylaxis, between sites.

Under the proposed model of care, all patients undergoing elective orthopaedic surgery will have a comprehensive pre-surgical assessment. Those identified as high risk will be assessed by an anaesthetist to determine individual clinical needs and post-surgery care planning to occur.

Those identified as potentially requiring level 3 critical care intervention prior to surgery will receive surgery at the most appropriate site. For those who require level 3 care unexpectedly post-surgery, there will be appropriate protocols and systems in place to ensure safe transfer to the most clinically appropriate NCL site.

All prospective providers are required to provide level 2 critical care as a minimum. Potential sites for the elective centre may already be co-located with a level 3 critical care facility. Critical care provision will be assessed as part of the options appraisal, with all providers asked to determine the case mix they can safely and effectively manage.