Our Healthier South East London
Improving health and care together

NHS

Committee in Common: Minutes

Thursday 16 March, 13.00 – 14:30
Chapter Room, Southward Cathedral, SE1
Chair: Paul Minton

Members in Attendance

Paul Minton	Independent Chair
Andrew Bland	Southwark CCG CO
Jonty Heaversedge	Southwark CCG Chair
Richard Gibbs	Southwark Governing Body Member
Andrew Eyres	Lambeth CCG CO
Adrian McLachlan	Lambeth CCG Chair
Martin Wilkinson	Lewisham CCG CO
Marc Rowland	Lewisham CCG Chair
Ray Warburton	Lewisham CCG (for Rosemarie Ramsey)
Mark Chueng	Bromley CCG (for Angela Bhan)
Nikita Kanani	Bexley CCG
Annabel Burn	Greenwich CCG CO
Ellen Wright	Greenwich CCG Chair
James Wintour	Greenwich Governing Body Member
Sarah Blow	Bexley CCG CO
Andrew Parson	Bexley CCG Chair
Mary Currie	Bexley Governing Body Member
John King	Patient and Public Voice
Terry Bamford	Healthwatch
Mark Edginton	NHS England

Other Attendees:

Mark Easton	OHSEL Programme Director
Daniel Moore	PwC
Paul Brown	Patient and Public Voice
Ian Fair	Patient and Public Voice
Olivia O'Sullivan	Save Lewisham Hospital Campaign
Barry Quirk	Lewisham Local Authority
John Moxham	Kings College Hospital
Sola Afuape	Lewisham CCG
Richard Walker	Speaking up Southwark

Apologies:

Jane Fryer	NHS England
Matthew Trainer	NHS England
Rosemarie Ramsey	Lewisham Governing Body Member
Angela Bhan	Bromley CCG CO
Sue Gallaher	Lambeth Governing Body Member
Harvey Guntrip	Bromley Governing Body Member

---

1. **Welcome and apologies:**

1.1 Paul Minton welcomed the committee and outlined the role of the group.

1.2 Committee members reviewed the declarations of interest and noted a number of inaccuracies. Changes to the declarations were verbally communicated to the group and it was **agreed** to review and publish a revised declaration of interest on the OHSEL website.

2. Brief public questions

2.1 Oliva O'Sullivan from the save Lewisham Hospital campaign made the following point: In reference to the SWLEOC model presentation at the Planned Care Reference Group on 16 March she felt that such an entity may result in privatisation. This concern was echoed by the wider Save Lewisham Hospital Group members.

2.2 In response, Sarah Blow confirmed the SWLEOC was collectively owned by the NHS Trusts in South West London. A similar collaborative model would be pursued in SEL.

3. Establishment agreement

3.1 Question from Ray Warburton regarding the role of NHSE. Mark Easton, explained that legal advice confirmed that NHSE isn't authorised to be a voting member of the group. However, NHSE have been important partners in the OHSEL programme and parts of the programme are jointly chaired. They are therefore important partners and should be welcome at the group. Mark Edington confirmed that legislation means that they cannot be a voting member. Their role will be as an observer and as a conduit to NHSE to facilitate the work in SEL.

3.2 The group **agreed** to approve the establishment agreement.

4. Planned Care Orthopaedics

4.1 It was confirmed that the CIC would not be making any decisions regarding sites or locations for a future service but rather the case for change and evaluation criteria which will support the next phase of the process.

Case for change

4.2 James Wintour felt that the paper itself didn't make the case for moving towards a consolidated model. Further financial metrics about improved cost, infection and requirements regarding ring-fencing could be included to make a stronger case. Sarah Blow agreed but confirmed that this was a case for change - rather than a case for consolidation which is one option for an alternative model. Further information will be included in the final business case.

4.3 Ray Warburton confirmed that it is important to make a like-for-like comparison in terms of infection rates. This was supported by Jonty Heaversedge who also explained differences in readmission rates as this is strongly influenced by case mix (the complexity of patients who have procedures at that site). It was **agreed** that additional data and analysis would be sought on these specific issues.

4.4 Adrian McLachlan asked about how day case was being considered. Sarah Blow confirmed that this was currently out of scope but noted that medical advances could mean that there are more day-case procedures in the future.

4.5 The CIC **agreed** that there is a need to explore a new model for elective orthopaedic care in SEL.

Emerging model

4.6 Mary Currie asked if there is a workforce strategy as part of the full business case. Sarah Blow reminded the group that we are still at an early stage of the process. However, workforce has regularly been raised as an important issue specific points raised include; clinicians working across multiple sites, training education and recruitment. A full workforce strategy will come at a later stage but, presently, providers have been asked to consider alternative workforce models and lessons from SWLEOC who have developed new roles

4.7 Richard Giibbs asked how trauma and day case will continue to be sustainable at base hospitals. Sarah Blow confirmed that these services will be retained and planned accordingly. Furthermore, this model will enable improved job planning as elective and trauma time will be ring-fenced.

4.8 Ray Warburton asked about recruitment. Sarah Blow confirmed that surgeons will continue to be employed by base hospitals and will be required to work across different sites. In addition, an improved elective orthopaedic services should improve recruitment and retention.

4.9 Adrian McLachlan asked how information would be shared across sites to avoid any issues arising from pre- and post-operative care across multiple sites. It was agreed that lessons would be drawn from existing consolidated models. Clinicians are currently working through what could be retained at a base hospital.

4.10 Annabel Burn asked whether there was a need to work up more detail regarding a 3 site option and why it should be discounted. Noted that two site model supports the national recommendations from GIRFT. It was **agreed** that some further work is required in relation to this model to explain rationale for discounting. It was also agreed that 3 would be the maximum number of sites.

4.11 Marc Rowland asked whether there would be consolidation within specialities – for example a single site for Knees and one for Hips. This is being explored but there is no confirmed view on this at this stage.

4.12 Mary Currie asked about specialist services and whether low volume specialist activity may be consolidated between surgeons as well as sites. This is the intention of the model which is currently taking place. This would be an expectation of the emerging network and would be supported by publishing surgeon level outcomes and establishment of standards. This is happening at existing consolidating sites such as SWLEOC.

4.13 **Agreed** that a single site model (option 1,2 and 3)should be discounted

4.14 **Agreed** that option 5 and 6 should be continued and option 4 and 7 should be discounted

4.15 **Agreed** that, once further analysis of the 3 site model has been done to make a decision to discount or not.

4.16 **Agreed** that work should continue to develop options through the submission of proposals, evaluation process and pre-consultation business case as described.

Evaluation Criteria

4.17 Andrew Parsons asked about how unintended consequences of residual services would be measured and whether enough detail would be available at the hurdle criteria stage.

4.18 Mark Easton explained some of the pre-work that would need to be done in advance of determining sites/locations for hosts. It was agreed that trusts would need to agree a joint commercial model and operating principles in advance of determining sites.

4.19 James Wintour asked whether the process would need to demonstrate how there would be no impact on A&E. This would need to be demonstrated through the evaluation process. Annabel Burn explained some additional modelling may be available and should be shared through the process.

4.20 Mary Currie asked about the ability of a site to be flexible in terms of scaling up diagnostics as required. In addition when would site management and infrastructure be agreed.

4.21 Annabel Burn asked about finance criteria and whether the assessment would need to show benefit from a SEL perspective across both providers and commissioners. It was recognised that commissioners would need to decide on the level of any additional cost required to deliver.

4.22 Martin Wilkinson asked about the criteria of travel impact and impact on equalities and whether these could be linked in the evaluation.

4.23 Ray Warburton commented that the prime objective of the proposal is to improve patient outcomes for elective orthopaedic care and as such the percentage split afforded to quality in the evaluation should be higher. Jonty Heaversedge suggested that aspects of the non-financial criteria speak to quality of care and as such asked if the overall split of 70% to 30% between the non-financial criteria and financial criteria felt proportionally correct. Ray Warburton suggested that quality should be supported ahead of financial criteria.

4.24 Ray Warburton commented that equality issues should be well understood and suggested that the language used in the equality criteria should be strengthened to say “Does the option promote greater equality” rather than just complying with NHS equality duties

4.25 Adrian McLachlan suggested that the evaluation of clinical quality should be against the aim of aspiring to excellence across all of SEL, not just bringing providers up to average performance. Mark Easton confirmed that the proposals submitted by providers will provide evidence of the delivery of high quality clinical services and how they would intend to implement within an elective orthopaedic centre.

4.26 Mark Easton suggested that minor changes be made to the wording of the criteria following the comments made by the committee in common and that this be circulated to CCG chairs for sign off electronically

4.27 **Agreed** that the categories put forward should be used for evaluation subject to update in wording of criteria being agreed by CCG chairs

4.28 **Agreed** that the 70:30 split between non-financial criteria and financial criteria.

4.29 **Agreed** to the principle of weighting quality criteria higher than financial criteria.

5. Any other business

5.1 Andrew Eyres asked that a briefing note be created by the programme team following today's meeting to be circulated to all CGGs to communicate the decisions made by the committees in common

5.2 John King as chair of the patient and public advisory group (PPAG) gave support to the work that had been done on orthopaedics