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NLP Planned Orthopaedic Surgery for Adults

Stage 3

Supplementary Report on Mitigations

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Please note:

The NLP Planned Orthopaedic Surgery Review Stage 3 (Post-consultation) Equalities Impact Assessment and Supplementary Mitigations Workshop reports are both based on information, insight and analysis gathered before the COVID-19 pandemic lockdown in March 2020.

Both were completed in July 2020 and take reports take account of changes due to the pandemic where these relate directly to the model of care for elective surgery and/or configuration of services.

However, the scope for the Impact assessment is limited to proposals on which NLP consulted the public during Spring 2020 and not wider system changes proposed for orthopaedic surgery or the MSK pathway.

1.   ABOUT THIS SUPPLEMENTARY REPORT

1.1   BACKGROUND

This report is supplementary to the Stage 3 report[1] and specifically discusses the outcomes of the workshop held in July 2020 where stakeholders were presented with a shortlist of mitigations to consider whether they were valid, and if so, how they could be taken forward.

The disruption caused by Covid-19 meant that plans for a face-to-face stakeholder workshop had to be changed to an on-line workshop, which took place in July 2020, after drafts of the Stage 3 report were first circulated.

A key requirement for Stage 3 of the IHIEIA was to produce a proportionate, manageable, high impact and practical approach to developing plans for maximising benefits and mitigating potential negative impacts on people sharing the nine protected characteristics set out in the Equality Act 2010, residents from socially deprived backgrounds and those with caring responsibilities.

Throughout the whole process of thinking about service change for adult elective orthopaedic surgery, working with stakeholders on what a new service could look like and how it might work, NLP have engaged with the public, with groups and with stakeholders to take into account views from all interested parties.

From the very earliest stages lists of practical suggestions were compiled, and, where possible, mitigations were built into the model for change. For example, early engagement suggested that having someone on hand who understood the system would be very valuable for some potentially vulnerable people, and the role of care coordinator became part of the service change model.

1.2   METHODOLOGY

1.2.1   PROPOSED ACTIONS AND MITIGATIONS - SOURCES

For this final element of the IHIEIA we have revisited all suggestions for mitigations from all sources, including:

- Pre-consultation engagement
- Stages 1 and 2 of the IHIEIA
- A stakeholder workshop during Stage 2 of the IHIEIA
- The transport analysis
- The consultation process - including
    - interviews with carers, transgender people and BAME people
    - telephone interviews with stakeholders and the public

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[1] NLP Planned Orthopaedic Surgery for Adults - Stage 3 Post-consultation Updated Integrated Health Inequalities and Equalities Impact Assessment (S.Clegg, C.Caseley July 2020)

- engagement and meetings with local residents, including those specifically targeted at groups identified in Stage 2 of the IHIEIA
- direct responses to the consultation process
- survey questions on whether people thought the proposed changes would particularly affect any groups of people.

A longlist of one hundred and eighty-eight (188) suggestions was compiled from all of the above-mentioned sources. The list was reduced by removing comments which did not contain suggestions (for example, the answers to the survey question very often contained a comment which was not a mitigation, such as 'I have elderly parents'), or expressed a concern but did not present a potential mitigation (for example, travel to Chase Farm Hospital was often cited as being difficult from some areas of NCL, but often people did not say what would help to make it easier).

It should be noted that, where people had identified problems but not mitigations, other groups or individuals had offered suggestions for mitigations on the same points.

The longlist was reduced to seventy-seven (77) problems and mitigations, which contained some duplication, particularly around transport issues, and which were incorporated together to produce the list presented in the next section.
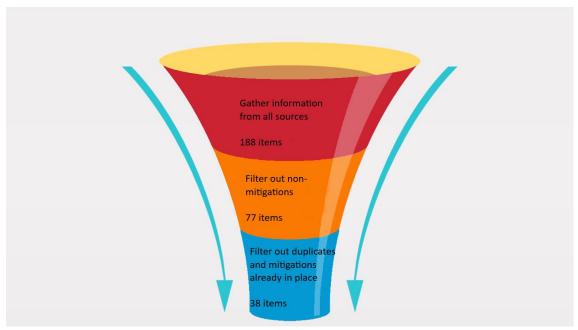

Diagram of process for filtering from full longlist to mitigations for consideration

1.2.2 THE WORKSHOP

The online workshop of stakeholders was convened on 15 July 2020, and attended by:

- Patient representatives
- A GP representative
- Patient representatives
- Healthwatch representatives
- Diversity and Inclusion lead from NCL CCG
- Representatives from:
  - UCLH
  - Royal Free Hospital
  - Whittington Health
  - North Middlesex Hospital
- The NLP Programme team
- The Verve team.

Participants were split into three 'break-out' groups to discuss mitigations, with a view to deciding whether the mitigations were viable and who should take responsibility for taking them forward. Each group had a facilitator and a note taker.

1.2.3 SHORTLIST OF MITIGATIONS

The shortlist of 38 mitigations discussed in the workshop is set out for reference in Appendix A.

In preparation for the workshop, it was clear that many of the proposed mitigations overlapped, either in seeking to solve similar – or related – issues, or through proposing similar solutions or accountabilities for action.

The mitigations were therefore clustered around similar topics, as shown in Appendix A, to enable a more coherent set of discussions by the Workshop groups. Practical approaches to solutions identified during the discussion were collected into the overarching mitigations set out in s2.1.

There were distinct responsibilities at two key levels:

1. Network level
   This would comprise mitigations covering the entire North London patch, and relate to "system-level" policies, work best undertaken once at scale and shared, or engagement with regional delivery partners (e.g. TfL).

2. Partnership level
   This would comprise mitigations delivered by the Northern and Southern partnerships – likely to be operational processes consistently applied across each partnership – but where the detailed approach to meeting agreed standards may differ between them.

In the next section we present the overarching mitigations identified in the workshop and where responsibility for them should lie.

2. CONCLUSIONS FROM THE WORKSHOP

Whilst the list of thirty eight mitigations were generally thought by stakeholders to be important it became clear from their discussions that there were ways in which many of the mitigations could be combined into themes of work, for example, by systematically gathering information about patients' needs at an early stage of a referral, their varying needs could be addresses wherever possible.

We have called these work themes 'overarching mitigations'. Stakeholders thought that the mitigations should be in place when the centres were established.

Some mitigations were considered to require system level, network, responsibility across the whole of the five boroughs; in some instances this was because higher level negotiations would be needed, such as discussions with TfL about bus routes, whilst in others it was to ensure consistency across the networks and avoid duplication of effort. Other mitigations were thought to be best dealt with at local, partnership, level, that is, in the North and South partnerships.

Generally, the stakeholders thought it was important to ensure the mitigations were in place at the outset of the elective centres. The exceptions to this were negotiating with TfL about bus routes to hospitals (which it was assumed would take a long time) and the ongoing need for training on the needs of some vulnerable groups.

Some of the suggested mitigations were partially in place, but the workshop felt that good practice, such as Carers' Passports should be implemented across the whole network.

In this section we discuss the overarching mitigations, where responsibility for them should lie, and end the section with issues for further consideration

2.1 OVERARCHING MITIGATIONS

2.1.1 IDENTIFYING PATIENT NEEDS

An overarching theme from the workshop was the need for the early identification of needs of patients, such as those having caring responsibilities, those with disabilities of all kinds and transgender people. Stakeholders thought that identifying the needs of people as early as possible would go a long way to making their patient journey as smooth as possible. To this end, we recommend that, at partnership level, a method is devised for collecting data from patients at the referral stage, or at the triage stage, to gather as much information as possible about their needs.

Some of the potential needs of patients identified in the mitigations were:
- The needs of carers – including timing of appointments
- Disabilities - including mental health, dementia, physical disabilities, long term conditions (e.g. diabetes), learning disabilities
- Be clear if a patient needs help from specialist dementia nurses

- Include an assessment of capacity – if patient lacks capacity a best interest decision should be completed
- Identify whether a person would like their carer to stay overnight
- Identify if a patient would benefit from a care coordinator
- Identify whether family/carers should be included in plans
- Be clear whether patients need help with transport
- Identify any communication needs - including large print, BSL, translation, easy read etc.

This is unlikely to be an exhaustive list.

Partnership responsibility – producing the means for gathering the data, ensuring the system is used and using the data as a basis to understanding and meeting patients' needs.

Network responsibility – assuring that the system is in place.

2.1.2 PATIENT HELD DOCUMENTS
Carers' Passports, Carers' Packs and My Health Matters Passports were in place were valued by those who had them and used them. The stakeholders considered that these should be available throughout the partnership to ensure consistency across the networks.

Partnership responsibility – ensuring patient held documents are available.

2.1.3 THE CARE COORDINATOR ROLE
Stakeholders felt it was important that there was an appropriate and joined up framework for the role of care coordinator to ensure consistency within partnerships, and across the network in terms of training.

Partnership responsibility, but linked with network – ensuring care coordinators are trained to know what help is available or how to find out what is available.

2.1.4 ACCESSIBLE INFORMATION
Several potential mitigations related to communications and information materials. Stakeholders considered that materials and communications should be agreed at partnership level to ensure consistency across both networks. It was suggested that communications materials should be tested with Healthwatch and patient groups. Elements which should be agreed include:
- Translations
- Large print versions of communications
- Easy read versions of communications
- Pictures/diagrams to be used in consultations.

Network responsibility for production of some materials, e.g. high level information about operations, policy on agreed sets of diagrams etc.

Partnership responsibility for using materials produced at network level and production of local level materials, e.g. videos on hospital walk-arounds, how things work within the partnership.

2.1.5 LEADING AT NETWORK LEVEL

At network level stakeholders considered that there were three major roles:

- Leading on cross partnership issues to ensure consistency and to avoid duplication of effort – examples of this were deciding on infographics to be used, producing high level information which can be used in both partnerships etc.
- Leading on high level negotiations, for example with TfL on transport routes and with partnership organisations
- Ensuring that mitigations are in place in the partnerships in a timely manner

Network responsibility to ensure consistency, avoid duplication of effort, lead on high level negotiations and ensure mitigations are in place in partnerships.

2.2   ISSUES FOR FURTHER CONSIDERATION

Some issues were identified as needing further thought – these were:

- Specialist dementia nurses are not available on-site at non-acute hospitals; therefore consideration needs to be given to referring patients with dementia to elective centres.

- The use of minibuses to shuttle patients between hospitals was not thought to be useful as most journeys will be to/from home and either the base hospital or elective surgery centre, but a shuttle between both sites would be relatively little used. Stakeholders noted there are patient transport services to which access has been amended as a response to the pandemic. It was suggested that eligibility criteria should be well publicised, and other relevant schemes promoted (such as the GoodSAM / Volunteer Responder scheme currently in place).

- A potential mitigation for vulnerable patients to be offered planned surgery at a familiar hospital was not considered to be viable, however, stakeholders thought that the focus should be on familiarising patients with the hospital they would be going to, either by visiting or watching a video. It was considered that need for this should be picked up in the data capture on referral.

- A potential mitigation about training medical teams about gender reassignment and the need to discuss patients' needs before surgery was thought to be partially met, however stakeholders acknowledged that more training might be needed, and this might take some time to develop and put in place.

- Some of the potential mitigations are partially in place, but stakeholders felt it was important to ensure that there remains consistent implementation across each partnership, for example, assistive signage such as lines on floors etc. where new facilities are developed.

- Stakeholders thought that consideration should be given about how to share learning within and between partnerships.

APPENDIX A – INITIAL LIST OF MITIGATIONS

As shown in the previous section a shortlist of 38 potential mitigations was put before the workshop, clustered by 'break-out' group.

Group 1:
- Ensure caring responsibilities are picked up during the referral/assessment process
- Work with carers to make sure that their appointment is at a time which is most appropriate for them, for example, first appointment of the day
- Ensure that enough notice of appointments is given to carers for them to arrange alternative care arrangements
- Offer some 'fixed time' appointments, whereby the patient is guaranteed that they will be seen as near to their appointment time as possible. This would be welcomed by carers, and for people who struggle with long waits, busy environments etc.
- Care coordinators should advise carers on any help which might be available to them, and should actively assist them to access such help
- North Middlesex University Hospital has introduced a Carers' Passport – this should be rolled out across all hospital sites in NCL
- Have people at hospital sites who can help with physical navigation around hospitals
- Arrange visits to unfamiliar sites ahead of appointments to allow people to become familiar with the environment
- Have provision for carers to stay overnight with the people they care for, if the cared for person requires in-patient treatment
- Ensure co-ordination between referring GPs and learning disability nurses at hospitals so that patients with learning disabilities are identified and assisted
- Put in place policies and protocols for ensuring that people with long term conditions such as diabetes are placed first on operating lists to minimise disruption to medicine regimes
- Have clear protocols for identifying patients who would benefit from the support of a care coordinator, including training staff at assessments to ask the correct questions to enable such identification
- When assessing patients ensure that the families and carers of people with conditions such as dementia, mental illnesses and learning disabilities are listened to and included in plans.

Group 2:
- Work with TfL to provide better, step free, transport links, or provide a minibus, from Oakwood Underground Station, where there is a lift, to Chase Farm Hospital
- Have a minibus between sites, especially the Royal Free Hospital and Chase Farm Hospital
- Ensure patients who might need help with transport are identified at the referral/assessment stage, and discuss their needs and any help which might be available to them (for example, whether taxi fares can be reimbursed)
- Ensure each hospital has specific transport and travel plans available, including public transport routes, step free access availability, and car parking
- Use large print for all paperwork, including letters to patients

- Any requirements for help with communications should be identified at the referral stage and made clear to the receiving team so that adequate help will be available at the first appointment
- A range of communications options should be offered, including a range of community languages (although not derived from Google Translate which one respondent deemed inadequate) and plain English. Formats other than written information should be available
- Ease read versions of all information should be available
- Have a reminder system in place for appointments, to ensure that patients know which hospital their appointment is at and where in the building they are going
- Always ensure that people have really understood what is being said to them
- Have staff in hospital who are trained in basic British Sign Language and ensure that there are adequate ways of communicating information to deaf people
- Ensure adequate interpreting services are provided, including utilising already existing language skills amongst staff
- Use pictures, diagrams, and easy read symbols in consultations, for those who need them

Group 3:
- Ensure 'My Health Matters' passports are incorporated into plans for patients with learning disabilities
- Where possible people with severe mental health problems should be fast tracked through the system
- Have specialist dementia nurses available to help and advise on treatment for people with dementia
- An assessment of capacity should be completed at the point of referral; if a patient lacks capacity a best interest decision should be completed and should generate recommendations regarding reasonable adjustments, which should be forwarded with the referral to ensure that the receiving department is aware of the patient's needs
- Vulnerable patients, for example, those with dementia, should be offered planned surgery at a hospital they are familiar with
- Ensure staff, particularly care coordinators, are trained to know what help is available to meet people's needs, or ensure that they know how to find out quickly what help there is
- Make sure that signage is good, easily visible and well lit
- Have lines on floors so people can follow a line to a department
- Have letter coded areas in hospitals
- Medical teams should be trained in transgender awareness, and understand the key elements of care for transgender people, and these needs should be discussed before surgery takes place
- Care coordinators could act as advocates for individual transgender people, liaising with staff about a patient's needs and requirements
- Transgender people should be offered private rooms so that they do not have to choose between being on male or female wards