

# verve

## REPORT

North West London Orthopaedic  
services engagement

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## CONTENTS

EXECUTIVE SUMMARY	3
1. INTRODUCTION	5
1.1 BACKGROUND	5
1.2 AIMS AND OBJECTIVES	6
1.3 VERVE	7
1.4 THIS REPORT	7
3. METHODOLOGY	8
3.1 ABOUT QUALITATIVE RESEARCH	8
3.2 DESIGN	8
3.3 RECRUITMENT	8
3.4 FIELDWORK	9
3.4.1 Community events	9
3.4.2 Focus groups and interviews	9
3.5 ANALYSIS	9
4. FINDINGS	11
4.1 THE NEED FOR CHANGE	11
4.1.1 Understanding the need for change	11
4.1.2 Concerns expressed	11
4.2 BARRIERS TO CARE	12
4.2.1 Being lost in the system	12
4.2.2 The importance of Face-to-face appointments	12
4.2.3 The digital divide	12
4.2.4 Travel to Central Middlesex Hospital	13
4.2.5 Lack of access to therapies	13
4.2.6 Access people with disabilities	14
4.2.7 Other concerns	14
4.3 PATIENT CHOICE	15
4.4 PRACTITIONERS' VIEWS	15
4.5 WHAT GOOD LOOKS LIKE	16
4.5.1 Timely, appropriate, co-ordinated and effective	16
4.5.2 Interactions with clinicians	16
4.5.3 Communications	16
4.5.4 Continuity of care	17
4.5.5 Access	17
4.5.6 Additional needs	17
5. DISCUSSION AND RECOMMENDATIONS	18
6. APPENDICES	20
6.1 FLYER	20



6.2	DEMOGRAPHICS OF PARTICIPANTS	21
6.3	RESEARCH MATERIALS	24
6.3.1	Topics discussed in Community Event breakout groups	24
6.3.2	Topics discussed in Focus Groups and Telephone Interviews	24
6.4	QUESTIONS FROM PARTICIPANTS	25



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## EXECUTIVE SUMMARY

The North West London Integrated Care System (NWL ICS) offers orthopaedic services at eight hospitals across its patch. The orthopaedic and musculoskeletal (MSK) teams across North West London believe that waiting times - which increased due to the Covid-19 pandemic – need to be reduced, care should be more patient focussed and health inequalities need to be reduced by levelling up to provide the best standards for all patients. Using lessons learned during the pandemic and building on models in place in other parts of London, NWL ICS's orthopaedic and musculoskeletal teams have proposed changes to improve services in the future.

This engagement work, undertaken by Verve, gathered feedback on the proposed approach for improvement from people across North West London in a series of focus groups, telephone interviews and two online community events.

Seventy eight people took part in the engagement – having been recruited by contacting stakeholders and community groups in the area.

The engagement showed that:

- People understood the need to reduce waiting lists, and were grateful work was being done to enable this. There was an appetite for change to happen quickly so that waiting lists did not continue to grow
- People did not usually understand the complexities of NHS systems
- The model proposed, including one centre for routine surgeries, was generally welcomed, however some concerns were expressed:
  - People were worried that the plans could result in a two tier system from two perspectives:
    - could fast tracking routine surgery be detrimental to people with more complex needs?
    - would increasing the use of digital technologies leave behind people who could not use them?

Several barriers to care were identified, including:

- Being lost in the system
- Not having face-to-face appointments especially for diagnosis and being starting physiotherapy
- The digital divide for people unable or unwilling to use technology
- Travel to and parking at hospitals
- Lack of access to therapies

For most people having a choice of where to have routine surgery (and possibly having to travel further) was less important than shorter waiting times.

Practitioners who took part in the engagement felt that the plans were too focussed on secondary care and raised concerns about whether in the future more people would be referred to them, for example for physiotherapy, as they were already having capacity problems.

Participants thought that good care needed to be timely, appropriate, co-ordinated and effective. They had further suggestions relating to interactions with clinicians, communications, continuity of care, access and taking account of people's additional needs.

Our recommendations include:

- Ensuring clarity of communications by reducing unnecessary detail, providing explanations of terminology and reducing jargon
- Being clear about how the changes will benefit all patients, not just those eligible for routine surgery
- Offer more explanation about the proposed hub, and how it will work and how and where patients having routine surgery will be offered pre and post operative care
- Explain what choices people will have
- Give more detail about care co-ordination
- In the next stage of consultation ensure the inclusion of groups who are potentially disproportionately or differentially affected by the changes, people who would be eligible for routine surgery and people from all boroughs in NWL

## 1. INTRODUCTION

### 1.1 BACKGROUND

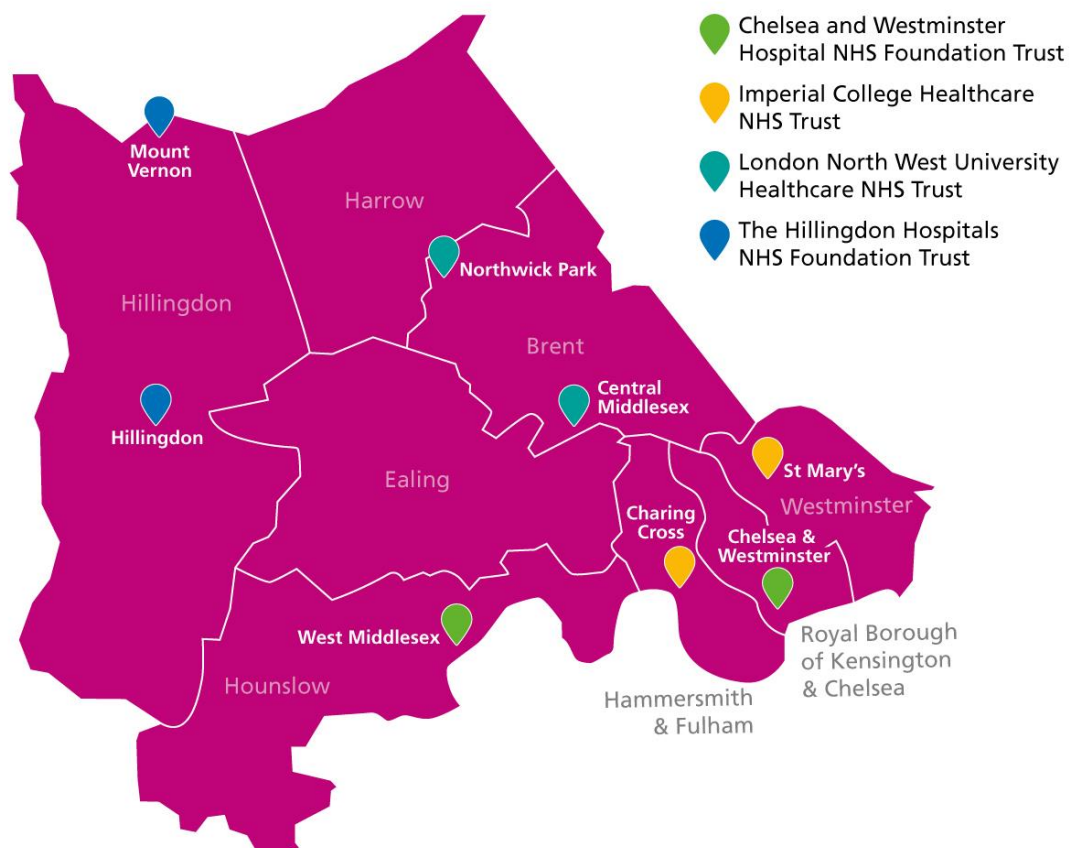
The North West London Integrated Care System (NWL ICS) covers the boroughs of Brent, Ealing, Hammersmith & Fulham, Harrow, Hillingdon, Hounslow, Kensington & Chelsea and Westminster.

Approximately 2.2 million people live in the eight boroughs.

NWL ICS provides hospital, community health and general practices services, including the following NHS acute trusts:

- Chelsea & Westminster Hospital
- The Hillingdon Hospitals
- Imperial College Healthcare
- London North West University Healthcare

Orthopaedic services are offered at eight hospitals:



Several issues led the orthopaedic teams across North West London to look at how orthopaedic services are currently delivered:

The Covid-19 pandemic had a negative impact on waiting lists for orthopaedic surgery, with more than 12,000 people currently waiting for orthopaedic care; the proportion of people waiting more than 52 weeks for care has increased by more than a quarter during the pandemic. Waiting for treatment can have adverse effects on quality of life, making it harder for people to go about their day-to-day activities. Further, conditions may get worse over time making them harder to treat and recover from.

NWL ICS is also keen to ensure that care is more patient focussed. Previous engagement revealed that patients with bone and joint problems had several concerns: frustration with long waiting times between initial assessment and surgery and when attending appointments; having to chase follow up appointments; worrying about having their surgery re-scheduled; communication problems such as lack of co-ordination between GPs and hospital services and being given confusing information; and some patients, including elderly people and those with disabilities, find travel to appointments problematic. The overall message was that patients wanted more control over their care, which they wanted to be organised in clear, consistent and straightforward ways.

NWL ICS has some excellent clinical outcomes for orthopaedic surgery, including low readmission and 're-replacement' rates for knee and hip surgery. However, this varies across the hospitals and it is known that some patients face inequalities in accessing care and have poorer health outcomes – particularly patients who are elderly, those who have disabilities, people from more deprived areas and those from Black, Asian and other minoritised groups. The aim for the future is to level up to the best standards for all patients.

To prepare for the future of orthopaedic services NWL ICS wish to reduce waiting lists, make the most of digital and other technological advances – whilst ensuring that no one is left behind, and attract and retain staff.

Using lessons learned during the pandemic and building on models in place in South West London NWL ICS's orthopaedic and MSK teams are working towards a plan to improve services in the future.

## 1.2 AIMS AND OBJECTIVES

The aims of this engagement exercise were to gather feedback on the proposed approach for improvement and to identify thematically any issues which need to be considered as the programme progresses.

To meet these aims the people were invited to attend two online community events, one of eight focus groups (seven online and one in person) or be interviewed by telephone. The engagement was designed to:

- Identify patient and public views on the case for change and the positives and negatives relating to a centre for routine surgery
- Understand the likely impacts of the plan, particularly on people sharing protected characteristics or otherwise at risk of health inequalities

The engagement will be used to inform the more detailed proposals for the next stage of the process to enable the development of a high-quality consultation.

## 1.3 VERVE

Verve is an independent full-service agency specialising in supporting NHS organisations in delivering transformation and change.

Verve was commissioned by North West London Integrated Care System to undertake engagement with people living in its patch for early stage discussions about the future of orthopaedic and musculoskeletal services. This document has been produced independently by Verve and represents our own analysis and recommendations.

We are grateful for the assistance and support of NWL ICS colleagues, the wider group of stakeholders and the residents of North West London who took part in the engagement. We would especially like to thank the community groups who helped us to recruit people to the focus groups, particularly Kensington and Chelsea Over 50s Forum<sup>1</sup> who arranged for a facilitator to visit a specially convened meeting to talk to some of their members and the Hear Women GarGar Foundation<sup>2</sup> who recruited members to fill an online focus group.

## 1.4 THIS REPORT

This is an independent report written by Verve.

The report describes the methodology used, the findings of the engagement and presents recommendations based on the findings. Anonymised quotations are used in the report to illustrate points made.

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<sup>1</sup> <https://www.kensingtonandchelseaforum.org.uk/>

<sup>2</sup> <http://www.hearwomen.org/>



## 3. METHODOLOGY

### 3.1 ABOUT QUALITATIVE RESEARCH

This engagement used qualitative methods to ensure that people's views and experiences could be explored in detail.

The aim of qualitative research is to define and describe the range of emergent issues and to explore linkages, rather than to measure their extent. The use of qualitative methods means that we do not collect, or report, on the numbers of people holding particular views or experiences.

### 3.2 DESIGN

The engagement exercise was designed to hear the views of people about orthopaedic and MSK services in North Central London. Two online community events, eight focus groups (seven online and one in person) and four telephone interviews took place in June 2022. Seventy eight people took part in the engagement.

### 3.3 RECRUITMENT

NWL ICS compiled a list of stakeholders and community groups who were sent information about the engagement, including a flyer with a brief outline of the purpose of the work and details of how to book on to the community events (see Appendices).

Recruitment to the community events was via Eventbrite – people could connect via an URL or a QR code and book on to either of the two dates offered. Sign ups were capped at 50 per event to allow for attrition to a capacity of 40 at each event. Both events reach the cap of 50 sign ups. Some people contacted the Verve after the cap was reached and were invited to take part in a focus group instead of a community event.

Verve compiled a supplementary list of community organisations across the eight boroughs. NWL ICL emailed all community organisations introducing the project and Verve. Verve's specialist recruiter followed up with emails and phone calls inviting the community organisations to promote the focus groups and community events to their members.

Two community groups each recruited enough of their members to fill a focus group: the Kensington and Chelsea Over 50s Forum arranged a special meeting and invited a Verve facilitator to run the meeting as a focus group in person as their members could not use technology to attend online sessions; and the Hear Women GarGar Foundation recruited enough of their members to fill an online focus group. We are grateful to all who helped with our recruitment.

People who took part in focus groups and telephone interviews were offered a £20 gift voucher as a thank you for taking part.

## 3.4 FIELDWORK

Seventy eight people took part in the engagement in total, 36 in community events and 42 in focus groups and interviews. All fieldwork took place in June 2020. All the questions asked by participants during the fieldwork are collated in the Appendices and will be used by the NWL ICS team to formulate a set of FAQs for the next stage of the work.

Many participants said they were grateful for the opportunity to take part in the engagement – one person said:

*“It’s important for us to know that you are listening to us”*

### 3.4.1 COMMUNITY EVENTS

The online community events were designed to give people the opportunity to listen to clinicians talk about why they thought change was needed to orthopaedic and MSK services, what the changes might look like and what benefits they saw the changes bringing. After the presentations the participants split into small groups, with a Verve facilitator, to give their thoughts and views; facilitators used a short topic guide to lead the discussions (see Appendices). Each small group formulated questions to take back into a final plenary session to put to a panel of clinicians. The groups were offered the opportunity to ask questions about the information they had heard in the presentations and about their own bone and joint problems, if they had any. People could also use the Zoom chat function to leave comments and ask questions. Whilst some people commented about their own bone and joint problems the questions asked all related to the information from the presentations. The community events were 90 minutes long.

### 3.4.2 FOCUS GROUPS AND INTERVIEWS

Eight focus groups and four interviews were held. Seven focus groups were online and 1 was face-to-face. Verve facilitators undertook all the fieldwork. Facilitators explained why change was thought to be needed, what the changes might be, and what benefits the changes could bring and used a topic guide to lead the discussions (see Appendices). The focus groups were approximately 90 minutes long. Telephone interviews used the same topic guide and lasted between 20 and 45 minutes.

## 3.5 ANALYSIS

Qualitative methods produce many hours of recordings from events, focus groups and interviews. In this engagement there were 2 community events and 8 focus groups of 90 minutes and four telephone interviews of approximately 30 minutes.

The researchers involved in the fieldwork used their notes and recordings to synthesise the material thematically.

At the end of the fieldwork the researchers and the analyst have a debriefing session where they discussed the main themes arising out of the engagement and any outliers.



The analyst familiarised themselves with all the data and themes, looking for similarities and differences. There is constant checking between analysis and original data to check for veracity.

The report is based on the findings from the thematic analysis.

## 4. FINDINGS

The findings represent the views of participants analysed and presented thematically. Where particular types of people held a view, or where there are outlying views we make clear how and why they differ.

### 4.1 THE NEED FOR CHANGE

#### 4.1.1 UNDERSTANDING THE NEED FOR CHANGE

People understood that waiting lists had increased during the pandemic and that there was a need to reduce them; they welcomed the work being done to enable this to happen. There was a call for the proposed changes to happen quickly so that waiting lists would start to reduce sooner rather than later.

More people expressed positive opinions about the potential changes than Verve have seen in similar engagement exercises.

People were positive about the idea of centralised provision of routine orthopaedic care, saying that it was a good way of maximising staff usage and developing clinical expertise. One participant said:

*"It seems a good idea to centralise it so that everything gets fed in to one area and can be dished out with shorter waiting lists, because otherwise it's only going to get worse and at the moment I just can't see that it can carry on the way it is"*

For many people having a shorter wait for surgery outweighed any inconvenience of travelling to a hospital further from their home.

#### 4.1.2 CONCERNS EXPRESSED

Some concerns were raised about having to travel further for surgery by people who would have longer or more difficult journeys, for example a group of people from Kensington & Chelsea worried about how they would get to Central Middlesex Hospital. However, this group was mainly made up of older people, some with complex health problems, who would be unlikely to be offered 'routine' surgery, and some could see the benefit for other people.

Parking at Central Middlesex Hospital was deemed to be bad, including for blue badge holders, and concerns were expressed about how people would get there if they could not use public transport.

Some people questioned whether the waiting times for physiotherapy would be reduced, as well as the waiting times for surgery.

Concerns were expressed about whether the plans could result in a two tier system on two counts: questions were asked about whether patients having routine surgery would be fast tracked to the detriment of people with more complex needs; and people worried that a move to more digital and technological systems would leave behind people who could not interact in this way.

## 4.2 BARRIERS TO CARE

### 4.2.1 BEING LOST IN THE SYSTEM

Generally people who had experience of secondary care praised it highly. However, people said that the pathway to getting secondary care was problematic. Many described a disconnect between GPs and other services – with difficulties getting referrals to physiotherapy, occupational therapy and secondary care. A participant said:

*"There's no proper line of communication between the GP and the hospital and it just leaves you in the dark"*

Many people had experienced poor co-ordination of services and being 'left in limbo', not knowing where they were in the system, and not knowing to whom they could talk to progress their treatment or to find out what was happening. A participant said:

*"Just being discharged home from one borough to another, the communication isn't good. Things take time to be connected and people can sometime wait 2-3 weeks for a physio"*

One participant wrote their own care plan and visited each team involved in her care, copying all of them into emails because there had been no communication between the teams until the patient took control.

People had also experienced long waits between appointments, again, meaning that they felt lost in the system.

### 4.2.2 THE IMPORTANCE OF FACE-TO-FACE APPOINTMENTS

For many people not having face-to-face appointments was a concern. Some had experienced being diagnosed with a bone or joint problem over the telephone and had been given physiotherapy exercises by phone or email. This led to worries about whether diagnoses were correct, whether exercises were being done properly or could be doing more harm than good. A participant who had been diagnosed in a telephone call said:

*"On the basis of the phone call, I got sent some exercises, which then I had to log on online to get to. I just wanted an email with some exercises, but more than that, not seeing someone f2f is worrying"*

For most people having a face-to-face appointment for diagnosis and initial physiotherapy sessions was desirable and increased their confidence that they were getting the right care. A participant said:

*"If it means either constantly waiting in the unknown or somebody doing something, to physically see somebody, I'd hire a jet. I'm prepared to do whatever it takes for someone to actually look at my knee, rather than try to describe it over the phone to a GP"*

### 4.2.3 THE DIGITAL DIVIDE

Some people liked the idea of having access to information about their condition and their patient journey in an app or by other digital means. When Joint School was explained during the community events several people thought this was a very good idea and would overcome the feeling of being lost in the system. However, many people were anxious about care being

provided remotely or digitally for a variety of reasons: some people did not have access to the internet, nor a smart phone; some people were not confident of their abilities to use apps or technology generally, even if they had the means to do so; people who were blind or had vision impairments were concerned about whether apps or other offers would work with their technology such as screen readers; and some people simply did not want to engage digitally.

For people who could not, or did not want to, engage digitally there was a fear that online services would replace face-to-face services, and this was seen as unacceptable. For these participants there was a view that being directed to digital services was being 'fobbed off'. Many of the participants who felt they could not engage digitally were older people, but there were also concerns from some people for whom English is not their first language. One person said:

*"I feel we're being brushed off to the far corners"*

#### **4.2.4 TRAVEL TO CENTRAL MIDDLESEX HOSPITAL**

It should be noted that many of the people who took part in the engagement were unlikely to be offered routine orthopaedic surgery at Central Middlesex Hospital as they had co-morbidities; during all sessions there were explanations about the hub being used for routine surgery for people who were very unlikely to need more than a minimum hospital stay, consequently, some views about travel relate to problems for people with disabilities and co-morbidities.

People who knew Central Middlesex Hospital said that parking is bad and felt that this would need to be improved. There were also concerns about getting to the hospital by public transport, and participants pointed out that people with bone and joint problems can find walking difficult, so proximity to public transport was important. A participant said:

*"The problem is when you have got bone and joint pain, transport is difficult, walking is difficult"*

People who had used patient transport for hospital appointments reported several problems, for example, transport arriving on time – or being very early and then having a long wait at the hospital, or not turning up at all. One person had experienced difficulties because she was a wheelchair user – she had once been refused patient transport because of her wheelchair and at other times she had been 'tied' into the front seat – she said:

*"They tie me up like a fly in a spider's web. I had to travel in the front seat like that and was crying with pain"*

#### **4.2.5 LACK OF ACCESS TO THERAPIES**

There were some concerns expressed about whether there would be sufficient aftercare if people are discharged from hospital very soon after an operation – people asked whether services such as physiotherapy would be able to cope with the proposed changes.

People thought that free or reduced cost gym memberships should be available for people with bone and joint problems, saying that this would encourage people to do their physiotherapy exercises and possibly become generally fitter. There was a perception that there was a lack of gym facilities for older people.

Some women prefer women only sessions in gyms and swimming pools, and participants reported that there were very few of these available. Women from some ethnic backgrounds found this particularly problematic.

#### **4.2.6 ACCESS PEOPLE WITH DISABILITIES**

Wheelchair users reported that waiting areas and consulting rooms were often too small for wheelchair users – they might be able to get into a consulting room but they could not manoeuvre their chair once in there. Waiting areas were too small, particularly if there was more than one wheelchair in there at a time. Beds and examination couches often did not go down far enough for wheelchair user to transfer onto them. There was a lack of hoists, for example, for people needing MRI scans.

People with vision impairments said their needs were often not taken into account by healthcare professionals – for example they might need more time in an appointment. People said that if they needed support to find their way in hospitals they sometimes had to wait too long to be assisted to their appointment.

People with vision impairments who use assistive technologies on their smartphones or other devices sometimes find that health related software is not compatible meaning they cannot use the apps etc.

#### **4.2.7 OTHER CONCERNS**

Participants did not like going to clinics where all patients had been given the same appointment time, saying that it led to long wait times in clinics and very busy waiting rooms. This was thought to be for the benefit of the providers rather than the patients, and there was a call for a more patient-centred approach. One patient said:

*“They say patients come first and yet they say everyone come in at the same time because it's more convenient for them. They ask everyone to be there at 7a.m. If you come from further afield you'd have to get up at 3a.m.”*

Some people expressed a concern that if they made a complaint their care would be compromised, meaning that they either did not make a complaint or they waited until their care was over. They were not reassured by information from hospitals and care providers about complaint handling procedures and felt that there was a need for an independent moderator to ensure a more arms' length approach.

People with extra needs, including disabilities, co-morbidities, caring responsibilities and language needs thought that the system in general needed to support them better, not least by finding out at the beginning of their patient journey what their needs were and accommodating them as much as possible throughout their care.

Patients sometimes felt that hospitals did not have enough time to properly involve them in their own care, which led to people feeling that they were not able to discuss care options or be part of the decision making process.

### 4.3 PATIENT CHOICE

The potential changes to orthopaedic and MSK services in North West London would see routine surgery offered on one site only, at Central Middlesex Hospital, rather than across eight hospitals across the patch as it is now. Participants discussed whether effectively reducing their choice of where to go for routine surgery in this way was a problem. Generally people did not consider a lack of choice of location for routine surgery to be a problem, saying that a reduction in waiting times and other benefits such as very experienced clinical teams outweighed not being able to choose a hospital, possibly one closer to home.

Some people wondered whether there would be other opportunities for choice, for example, choosing which consultant or surgeon they would see if they were referred to the hub. For some participants this would be important, and they would like to have information about clinicians to enable them to make a choice.

People who had had surgery in the past said they would prefer to go to hospitals where they had already received care from, saying that they thought the clinical teams would understand their condition better and there would be continuity of care. For some people treatment in familiar surroundings was important and was likely to lead to them feeling they had some control over their care.

Participants with complex needs also preferred to have care in familiar surroundings, where they had been seen before, whether for orthopaedic/MSK care or for other conditions. Again, there was a perception that continuity of care would be better, their patient records would be readily available and clinical teams would understand their conditions and needs. A participant said@  
*"Continuity is very important, having someone who understands you, your history, your pain, who knows whether things are changing over time. You get tired of telling your story all the time, you just want someone who knows you."*

For many people it was important to be able to choose whether they used technology or not – even if they had the means to do so. Many older people did not want to be made to embrace technology to access care and felt that they would almost certainly miss out in some ways if this happened – for example, by not being able to use apps, respond to messages or download exercise instructions. There was a fear that establishing technology as the way forward would create a two tier system, with those unable or unwilling to use it 'going to the bottom of the pile'. Further, views were expressed by some participants that the quality of healthcare would diminish if more were delivered digitally. A participant said:

*"I'm wary of the drive towards using technology to replace interactions with healthcare professionals... I think this will inevitably reduce the quality of healthcare you receive"*

### 4.4 PRACTITIONERS' VIEWS

Information about the community events was sent to many stakeholders across North West London. Some service providers chose to attend the community events and their views about the possible changes to services are presented separately in this section.



Practitioners expressed a concern that the plans seemed to mainly relate to secondary care; they questioned how services such as physiotherapy and occupational therapy fitted into the scheme. There was a strong view expressed that there were already capacity issues for therapies across the whole pathway and they questioned what would be done about this as at the moment most cases practitioners saw were complex, adding in routine patients for after-care would increase their workload. One person said:

*"I think they may have a rose-tinted opinion of what we can offer in the community. There's a lot of stress in the system currently. A lot has to happen prior to a patient getting to the elective hub and that needs to be looked at"*

Questions were raised about whether GPs had a good understanding of alternatives to surgery, with practitioners expressing the view that a lack of understanding led to patients being pushed towards a surgery pathway as a default.

Practitioners thought that polyclinics were needed to give access to a variety of services such as mental health, obesity clinics, exercise and therapies. Further, practitioners were of the view that there was need for primary and secondary care to work more closely together.

## 4.5 WHAT GOOD LOOKS LIKE

People discussed what good care looked like.

### 4.5.1 TIMELY, APPROPRIATE, CO-ORDINATED AND EFFECTIVE

The most important things people identified were that care should be timely, appropriate, co-ordinated and effective. That is, waiting times should be as short as possible, they should be referred to appropriate services, care should be co-ordinated by providers and the outcomes of care should be good.

Other elements which contributed to good care were:

### 4.5.2 INTERACTIONS WITH CLINICIANS

- Face-to-face appointments, especially at the time of diagnosis and first appointments with physiotherapists to ensure patients understand what they are being asked to do, and are doing exercises correctly
- Clinicians working with patients to include them in decisions about care – and taking time to explain care to patients, and listening to concerns and complaints
- Good communications between clinicians and with patients
- Being treated with respect and in a friendly way

### 4.5.3 COMMUNICATIONS

- Being kept informed about what is happening – and understanding what the care pathway is
- Clear, jargon free communications

- Easy to use and easy to understand systems, for example, how to reschedule appointments
- Having systems in place so patients do not have to explain their conditions and circumstances at each appointment

#### **4.5.4 CONTINUITY OF CARE**

- A holistic approach from diagnosis onwards, with support all along the care pathway
- Continuity of care – by seeing the same clinicians at appointments
- Pain management should be offered whilst people are waiting for operations

#### **4.5.5 ACCESS**

- Good access, including public transport links and good parking – including for people with disabilities. It was suggested that a shuttle bus could operate between hospitals to alleviate travel issues and higher travel costs
- If travelling further for surgery pre and post operative care should be close to home
- Having good information about how to get to hospitals, how parking works – including costs and how payments are made, and transport routes – including proximity of stations and bus stops

#### **4.5.6 ADDITIONAL NEEDS**

- Ensure that additional needs are understood and accommodated, for example, checking whether people with vision impairments can use apps and other technology with screen readers and other assistive devices

## 5. DISCUSSION AND RECOMMENDATIONS

People tended to be supportive of the plans outlined in the engagement, and welcomed the work being done to reduce waiting lists – there was an appetite for change to happen quickly. There was a relatively positive response to the idea of a centre for routine planned surgery. Some concerns were expressed about the disconnect along the current pathway, including difficulties getting referrals and being 'lost' in the system – and people hoped a new system might sort some of these issues out. A strong negative response was heard from many people about the over-reliance on digital technologies. Some fears were expressed that the plans could result in a two tier system on two counts – if routine cases are fast tracked for care to the detriment of more complex cases and people being left behind if they could not use technology.

Generally people did not understand the complexities of NHS systems, and often found explanations of how they work confusing – this included which Trusts provide care, what primary and acute care was, who commissioners were, the acronyms used, how systems worked together and why some care appears to be delivered by private providers. It is important to note that for many people understanding the intricacy of the system is far less important than being in receipt of good care – as discussed above the most important elements identified as crucial to good care were that it is timely, appropriate, co-ordinated and effective.

We recommend that for the next stage of the process the NWL ICS team consider the following:

- Ensure that communications are jargon free – including:
  - Clarify what 'routine' surgery is
  - 'Elective surgery' was not understood – consider 'planned surgery' and explain the difference between planned and emergency surgery
  - Explain what musculoskeletal service are
- The case for change document will give a lot of detail about who is involved in the system, how they will work together, financial considerations etc. Assuming this will be available to the public if they wish to read it, consider how much of this sort of detail is needed in the engagement sessions
- Explanations should be provided for terms including:
  - Primary care
  - Acute care
  - Secondary care
- Be clear how the changes will benefit ALL patients, not just those eligible for routine surgery at the hub – explain how people with more complex needs will get their care, and whether there will be any changes directly affecting them
- Explain in more detail why the hub would be sited at a hospital without an A&E

- Explain what will happen if something goes wrong during a routine surgery – how will patients receive extra care they need? For example, would they be taken by ambulance to another hospital?
- Explain in more detail how and where patients receiving routine surgery at the hub will receive pre and post operative care
- Explain whether/where patients will be able to make choices – for example, will patients be able to choose which surgeon they see?
- Explain in detail how care will be co-ordinated between different clinicians and hospitals
- In the consultation stage ensure the following groups are included:
  - Groups potentially differentially or disproportionately impacted, for example transgender people taking hormone therapies and people with some types of disabilities
  - People who would be eligible for routine surgery
  - People from all the boroughs in NWL

## 6. APPENDICES

### 6.1 FLYER

This flyer was sent to contacts across North West London by the NWL ICS team, including colleagues, other service providers and community contacts.



#### Meet our doctors and clinical teams and give us your views and ideas

We are a range of organisations providing hospital, community health and general practice services. We are working together to join up our care and make best use of our combined resources for the benefit of patients and local communities.

We want to improve routine orthopaedic surgery, such as knee or hip replacements, and wider musculoskeletal (MSK) care - bone and joint services including physiotherapy, pain management and rehabilitation. This includes reducing the long waiting times for routine surgery that have built up during the Covid-19 pandemic.

One specific development we are exploring is bringing together much of our routine orthopaedic surgery in one centre for west and north west London. Examples in other parts of the UK have shown that this approach can improve quality as well as enable patients to be treated more efficiently and therefore more quickly.

To help develop our plans, we want to make sure we fully understand the needs and views of patients, carers and local communities and what would make the biggest impact.

With support from Verve Communications, we are running two online events open to anyone living in west or north west London. We are especially keen to involve people who are – or have been – patients with bone and joint problems.

#### At the events:

- We will explore in detail what our services for people with bone and joint problems should look like in the future, taking into account current challenges and opportunities.
- Our doctors, nurses and physiotherapists will run a Q&A session to help increase awareness and understanding of common bone and joint concerns, care and treatment.

We hope you will want to take part!



Just sign up online using the link or QR code here. Or you can call 07898 865743

[nwl-ics-bone-and-joint.eventbrite.com](https://nwl-ics-bone-and-joint.eventbrite.com)

These developments are being led by organisations making up the North West London Integrated Care System, including: Chelsea and Westminster NHS Foundation Trust, Hillingdon Hospitals NHS Foundation Trust, Imperial College Healthcare NHS Trust and London North West University Healthcare NHS Trust and North West London Clinical Commissioning Group

## 6.2 DEMOGRAPHICS OF PARTICIPANTS

Participants were asked to fill in a short online form to collect anonymous demographic data. Seventy-eight people took part in the engagement. Thirty-three filled in the demographic survey. The findings from the survey were as follows:

### Boroughs people lived in:

Brent	4
Ealing	4
Hammersmith & Fulham	9
Harrow	0
Hillingdon	0
Hounslow	0
Kensington & Chelsea	7
Westminster	9
Other	0

### Age groups:

18-24	0
25-34	1
35-44	4
45-54	4
55-64	7
65+	17
Prefer not to say	0

### Gender:

Female	23
Male	10
Transgender	0
Non-binary	0
Prefer not to say	0
Other	0

### Gender the same as the sex assigned at birth:

Yes	30
No	1
Prefer not to say	2

**Sexual orientation:**

Heterosexual	26
Lesbian	0
Gay	0
Bisexual	0
Prefer not to say	4
Other	1
No answer	2

**Ethnic background:**

White	21
Mixed	0
Asian or Asian British	5
Black or Black British	4
Prefer not to say	0
Other	1
No answer	2

**Disabilities or long term health conditions:**

Yes	21
No	9
Prefer not to say	3

**Disabilities or long term health conditions – type:**

Physical disability	16
Speech impairment	0
Mental health condition	9
Blind or impaired vision	0
Deaf or hard of hearing	3
Wheelchair user	6
Learning difficulties	0
Prefer not to say	6

NB: people could choose more than one category so adds to more than 33

## Marital or civil partnership status:

Married	12
Registered civil partnership	0
Never married/registered civil partnership	10
Divorced	2
Separated	0
Widowed	4
Prefer not to say	4
No answer	1

## Religion:

Atheist	0
Buddhist	2
Christian	13
Hindu	0
Jewish	2
Muslim	7
Sikh	0
No religion	6
Other	0
Prefer not to say	3



## 6.3 RESEARCH MATERIALS

### 6.3.1 TOPICS DISCUSSED IN COMMUNITY EVENT BREAKOUT GROUPS

The breakout groups in the community events discussed the presentations they had heard in the opening plenary group.

Facilitators in the breakout groups guided the discussions around:

- The case for change
- The opportunities which changes could bring
- Views on a centre offering routine orthopaedic care
- Participants' views on what good care looked like.

In the final part of the discussion participants agreed on questions to be asked in the final plenary.

### 6.3.2 TOPICS DISCUSSED IN FOCUS GROUPS AND TELEPHONE INTERVIEWS

Facilitators briefly explained why change was considered necessary and what the future services might look like. Participants then discussed the following topics in relation to current and future services:

- What good care looks like and what affects people's viewpoints, including their own experiences of what worked well and what could be improved
- Patient choice, and views about one site offering routine orthopaedic care
- Views on travelling, including potentially travelling further for surgery, and what could make things easier for people
- Barriers and enablers in accessing healthcare

## 6.4 QUESTIONS FROM PARTICIPANTS

This section brings together the questions participants asked in the community events (in breakout groups, plenary sessions and Zoom chat) and in the focus groups. The questions are grouped under themes.

### About the model

- How many people will benefit from this?
- What are the criteria for 'routine' surgery?
- Will people be able to choose which surgeon they see?
- Is this project able to carry the clinicians forward to the hub as some might be reluctant to move?

### About the pathway

- What will the new pathway look like? How will it be any different/better than the current pathway? Will it be any quicker?
- Will the pathway mean quicker access to care?
- Where will people's first appointments be?
- What kind of emergency care would be available if there were difficulties with routine operations?
- Where will aftercare happen, including rehab?
- Will community physio/OT pilots continue?

### About the hub

- Do you think these hubs will reduce the length of stay post-operatively and how will you accommodate this if there are complications – e.g. illness, DC planning, step down care etc? What impact will this have on patient flow if patients end up staying longer to recover?
- Has there been follow up with people who participated in the 'trial' hubs during the pandemic? How satisfied were they, what was the recovery time post-surgery, what was the impact on quality of life?
- Will Central Middlesex Hospital be the hub for ALL MSK?
- Will patients with complex/multiple conditions be seen at the hub?
- Will car parking at Central Mid improve? It is terrible at the moment.

### Co-ordination along the pathway and across the system

- Will the care pathway be co-ordinated by SPOC to prevent the patient having to co-ordinate their own care pathway?
- How do you foresee this pathway working with a multitude of different providers across NWL from start to finish of the patient journey given the complexity of the system?
- How will discharge planning work across so many boroughs?
- How will you ensure good communication, including image sharing, between different service providers?

## **About the programme and implementation**

- How will the plans be implemented?
- What are the next steps in the process?
- What are the timelines for getting this up and running?
- How long will it take to set up the new system? When will it happen?
- How soon will the new hub be set up? (The faster the better)
- Do you see a role on Health and Wellbeing boards?
- Will there be pilots for the plans? If so, how will they be implemented? Where will it start? Will it be an iterative process so that you can learn from the pilot?

## **About resources and finance**

- How will this be financed? Where are resources coming from? How is it being set up?
- How much will all this cost?
- How will this hub be achieved on an operational level? Are they taking staff away from existing hospitals?
- If people are fast tracked it creates more demand on physio and OT services as more people will be going through the system – does the current system have capacity?

## **Support along the pathway**

- Is there opportunity for pre-habilitation e.g. physio exercises before surgery to maximise the chance of fast post-op recovery?
- How will you monitor whether people are doing physiotherapy correctly if they have been given exercises by email or over the phone?
- Hackney has a service with a paramedic in a car, could something like this be adapted in North West London for post operative orthopaedic surgery?
- Could you provide free limited gym membership for people to do physiotherapy exercises – in the past there was a scheme for people with arthritis.
- What role will social prescribing have?

## **Condition-specific questions**

- Will gait analysis be available?
- How is osteoporosis part of the plan?
- Can joint replacements be made to last longer?
- Will special equipment on loan be available to all patients?
- How will people with complex conditions fit into the plan – what will the hub do for them?
- In France they offer pelvic care during childbirth – why does this not happen here?
- Can they put a hydro-therapy pool in the Middlesex?

## **Communication and clarity**

- Will the new pathway be transparent so that patients know where they are on the pathway and what to expect will happen next?
- At the moment everything is called a hub – it doesn't mean a lot because there is a lot of confusion

## **About access**

- How is access for people with disabilities, such as parking, going to be managed?
- How will people with hearing impairments be able to access care?
- Will there be fewer remote diagnoses, for example, over the phone?
- I hope you can take feedback seriously because at the moment the system is a rollercoaster.

## **About technology**

- Will there be opportunity for more face-to-face contact with clinicians than there is currently – especially for diagnosis and monitoring?
- How will you work with people who do not have internet connection or smart phones? It looks as though a lot of care will be on mobile apps.
- Paramedics have apps on their tablets which allow them to scan a patient – will this type of facility be available in primary care?