NHS

Leicester, Leicestershire and Rutland Planned Care Policies

Patient and Public Engagement Report
20th August – 26th September 2018

A partnership of:

- Leicester City Clinical Commissioning Group
- West Leicestershire Clinical Commissioning Group
- East Leicestershire and Rutland Clinical Commissioning Group

Background

Planned care is the term used to describe the non-emergency operations and treatment that are carried out in hospital and in the community, with appointments arranged in advance. Some examples of these are hip and knee replacements, operations to correct a cataract, joint injections and varicose vein surgery.

This report details the engagement activity that took place between the 20th August and 26th September 2018 with patients, carers and members of the public on 101 policies that describe when and how planned care operations and treatment are carried out. Policies are used by health professionals to give clear guidance on when a referral should be made for treatment in hospital.

Our local doctors have looked at a range of policies to decide whether they are suitable for patients in Leicester, Leicestershire and Rutland. Following the review, it was agreed that:

- 49 existing policies will not be changed
- 2 existing policies will be changed so that patients receive better care. Any treatment that is given will be based on best medical advice and be the right decision for their individual medical problem.
- 50 new policies will be introduced. These new policies simply describe what is already happening in Leicester, Leicestershire and Rutland although they do not currently have a formal policy in place. It means that from now on it will be clearer which operations and treatment will be carried out and it will be fair for everyone.

The policies cover the following areas of medicine:

- Dermatology: problems with the skin
- Ear, nose and throat
- Gastroenterology: related to the stomach and intestines
- General surgery: a wide range of surgery which includes: surgery of the stomach and intestines; breast problems; kidney, pancreas and liver transplantation; trauma to the abdomen and thorax; certain skin problems and general childhood surgery
- Gynaecology: Related to the female reproductive system, how it works, disorders and diseases
- Imaging: taking pictures of the inside of the body. For example x-ray, ultrasound and MRI scans
- Maxillofacial: related to the mouth and jaw
- Neurology: related to the brain and nervous system
- Ophthalmology: related to the eyes
- Orthopaedics: related to the bones, joints and muscles in the body

- Paediatric surgery: related to children
- Pain
- Plastics: plastic surgery and enhancing appearance with or without surgery
- Podiatry: related to the feet, ankles and lower legs
- Respiratory: related to the lungs
- Urology: In women – related to the kidneys, ureters, bladder. In men, also related to the prostate and penis.
- Vascular: related to the heart and blood system
- plus a small number of other policies.

Why were we doing this?

It is important to have policies in place so that doctors have clear guidance on treatments and to make sure that decisions are made consistently and in the same way for each patient. This was not about "rationing" or reducing access to treatment.

We want to make sure that patients only have procedures, such as operations, where we know that this will be effective for their particular medical problem and circumstances. Any procedure carries a small risk of complications, so we need to know that a treatment is right and will help the patient. Policies also make sure that NHS resources are used in the best possible way and are used fairly for everyone.

We wanted to know whether patients were aware of these policies and understood them, whether they had any questions about them and if there was anything else that they thought should be included.

This work was led by the three NHS clinical commissioning groups (CCGs) responsible for planning and buying health services for local people, in partnership with local hospitals, GPs, public health and patient representatives.

Methodology

The three CCGs undertook a five-week engagement exercise to gather public opinion on the proposals. The feedback would help to:

• Educate people about planned care services and highlight the existing, new and proposed changes to 101 of the policies
• Listen to any concerns about any of the policies and made any amendments or adjustments where possible
• Allow the CCGs to determine whether people are generally in support of the policies before making any changes
• Understand any impacts on the changes so that they could be addressed or mitigated.

We put together a briefing document entitled ‘Planned Care Policies in Leicester, Leicestershire and Rutland’ which explained in detail the background of the project, the list of affected policies and the proposed changes. This document can be found on the Leicester City CCG website. Information was given about how to offer feedback, which included website links, a phone number, freepost address and public events. The policies could be viewed on the Leicester City CCG website on behalf of all 3 CCGs.

The document was circulated across Leicester, Leicestershire and Rutland via email to stakeholders as identified though a stakeholder mapping exercise. These included GP surgeries, hospital clinics, charities, patient support groups, Patient Participation Groups, public memberships and the voluntary sector. Local organisations were asked to circulate wider to their networks wherever possible utilising a variety of methods, and alternative formats were available on request. Attention was paid to the 9 equality strands to ensure a wide range of communities would have an opportunity to take part and face to face meetings were offered to groups on request. This method of distribution was repeated later during the engagement period.

Patients were invited to have their say as part of the engagement in one of the following ways;

• Fill in the survey online
• Call the Leicester City CCG engagement team to request hard copies of individual policies, the engagement document and surveys
• Attend a public event to hear more about planned care services and discuss the policies with clinical and non-clinical NHS staff

Posters were displayed in local hospital clinics and two visits to the hip and knee clinics were arranged to discuss the changes to this particular policy with patients. Copies of the documents were taken to attended events for local distribution. The information was also made available via social media channels (Twitter and Facebook) to reach out to a wider audience along with a podcast where a lead clinician explained what the engagement was about and how people could get involved. A press release was sent to all local media and coverage included reports in the Leicester Mercury and on radio stations Smooth and Capital.

Dependent on reception of the initiative, a flexible approach would enable the CCGs to react accordingly, in addition to the above proactive communications.

Findings from completed surveys

We received 10 completed surveys from members of the public on the policies, 3 of which we received in hardcopy. A total of 8 of the 10 responders stated they were

female, 7 were aged 60-75 and 8 out of 10 stated they had a disability (6 were long term conditions or diseases). The full equality monitoring responses are as below:

Gender
Male (2)
Female (8)

Age
35-59 (3)
60-75 (7)

Has your gender changed since birth?
Yes (1)
No (8)
(1 did not answer this question)

Do you consider yourself to be disabled?
Yes (8)
No (2)

Disabilities stated:
Mental health condition or disorder (1)
Partial or total loss od hearing (2)
Long standing illness or disease (6)
Physical impairment (2)

Ethnicity
White British (7)
Prefer not to say (2)
(1 did not answer this question)

Religion or belief
No religion (2)
Christian (6)
Prefer not to say (2)

Sexual orientation
Heterosexual (9)
Prefer not to say (1)

Of the 10 completed surveys we received, comments were made about the following policies:

Cataracts (2)

"Although visual acuity is mentioned as a criteria, nothing is stated regarding macular degeneration. If a patient is suffering from either wet or dry types, should they not be treated earlier as this will enable ophthalmologists and doctors to assess the severity, treatment or worsening of the condition." Female, 60-75, White British

Ear wax removal (1)

"Pleased that this procedure will continue to be available when criteria is met"
Male, 60 – 75, White British

Hip and knee replacement (3)

"Why are these being restricted or treatment with held (sic),when patients who have already had one relaced (sic)and have been told by their consultants on more than one occasion in their after care time that they need to get the other one done,but on going to their GP are told that they have to go through extremely useless physio treatment first.They have been on it and are a lot worse off than when they started and are going rapidly down hill due to the extreme pain it caused,but STILL cannot get the GP to put them forward." Female, 60-75, ethnicity not stated

"Frailty of the patient is not mentioned (eg existing osteoporosis) as to assessing the need for the surgery nor the likelihood of the patient hurting themselves should they fall as a consequence of another condition eg epilepsy. Both these should be considered as although the patients may be referred sooner, it may save the primary care service money as they could be in hospital a lot longer if the surgery was delayed." Female, 60 – 75, ethnicity not stated

"I am still left wondering what has changed because the Threshold criteria fits in with my treatment. Yet I know a lady whose BMI is either the same or higher than mine, can get about without walking aids and is younger than me and is getting or has had by now a knee replacement. In my case both my knees are worn and even with walking aids are causing my hips to wear faster. Why such a difference in treatment? I am not complaining as I am grateful for our NHS and will continue to support it, but it would be nice to know why?" Male, 60-75, White British

Screening for Obstruction sleep apnoea (1)

"I understand sleep apnoea may cause seizures in some people. Please could you include this as a possible reason for allowing screening" Female, 60-75, White British

Utero vaginal prolapse (1)

No comments made

2 responders skipped this question.

Findings from public events

We held three events across Leicester, Leicestershire and Rutland to support the discussions about the proposed policy changes. At these events patients, carers and members of the public could come and learn more about the policies and other changes that we might make to local services in the future.

The events took place on the following dates and people were asked to register in advance:

Date	Location	Time	Attendance numbers
Tuesday 18th September	Falcon Hotel, 7 High St E, Uppingham, Oakham LE15 9PY (RUTLAND)	3pm to 6pm	5
Thursday 20th September	Voluntary Action LeicesterShire, 9 Newarke Street, Leicester, LE1 5SN (LEICESTER CITY)	10am -1pm	8
Thursday 20th September	Ramada Hotel, 22 High Street, Loughborough, Leicestershire, LE11 2QL (LEICESTERSHIRE)	3pm to 6pm	3

Each event was attended by a range of NHS clinical and non-clinical staff who were there to present and answer any questions. The event focused on planned care services in general, the projects that are taking place and the planned care policies.

Although we had relatively low attendance at the events we gathered a wide range of feedback from the discussions which gave us new insight into the thoughts of local patients and members of the public about planned care services. Please see Appendix 1 for a full breakdown of all of the feedback.

Feedback on the policies was positive by all attendees and there were no issues raised about the changes made to the two policies that were presented on the day (male circumcision and hips and knee policies). Below are all of the comments captured at the events:

Improving productivity and managing growth - doing things differently to make your money go further

Right staffing levels, right skill mix, making money go further

Consider the military - 10% of Rutland's population!

Hip and knee policy

Pain different for individual people

Findings from visits to hip and knee clinics

A member of staff attended two hip and knee clinics at the Leicester General Hospital to speak directly to out-patients about the proposed changes to the hip and knee policy.

A total of 46 patients were spoken to during the visits, with 17 completing a survey. Of the 17 responses we received in the clinics, 5 of those were male (30%) and 12 were female (70%). The ages ranged from 25 to over 75. A total of 12 (70%) people stated that they were White British, 1 was Caribbean, 1 Indian and 1 Pakistani. 5 (30%) stated that they were disabled.

Most of the responses collected focused on the current service and appointment times rather than the policy however some were applicable to policy development. These additional comments will be fed back to the service providers.

Most of the responders stated that they would prefer to be seen quicker as the delays meant that their condition had worsened. Some of these were however, referring to the time it took to get an appointment in secondary care. Many were in favour of surgery avoidance and a small number agreed that they should try other methods of treatment (such as physiotherapy) before having an operation.

"More physio. What about alternative therapy to prevent replacement" Female, 60-75, White British

“If you know what the problem is, why would you delay surgery?” Female, 60-75, White British

The majority of responders said they would like to been seen elsewhere for their appointments to speed up waiting times and avoid cancellations, and there was a suggestion that GPs could do more in practice.

“The policy needs to give consideration to be seen and treated elsewhere and the waiting times to be reduced” Male, 35-59, Caribbean

It was also stated that it was important that patients were treated as individuals, and that “one size doesn’t fit all”.

Next Steps

The overall responses received from patients, carers and members of the public though the survey and the events were broadly positive and none of the comments received raised any concern for any policy presented. However, each individual comment will be considered before final versions are drafted and presented to each CCG’s Governing Body.

Once agreed the 101 final policies with remain on the Leicester City CCG website for patients to access at any time. The policies will be shared across Leicester, Leicestershire and Rutland health and social care services so that one version will be applied in all instances. Patients are encouraged to have conversations with their GP about their individual circumstances.

As Leicester, Leicestershire and Rutland planned care services develop over time, engagement and consultation may be required on changes to other policies in the future. This process will be managed through the Leicester, Leicestershire and Rutland Clinical Procedure Implementation Group as necessary.

The feedback received at the public events will be presented as a summary to the Planned Care Board and incorporated into the developing plans at an individual project level.

We would like to take this opportunity to express our gratitude and to sincerely thank all of the patients, carers and members of the public who have taken the time to speak to us and provide their views and feedback as part of this engagement.

Appendix 1: Planned care events – Feedback on planned care in the future

Rutland	Leicester City	Leicestershire
Self-care and prevention		
Q1. What can we do to help you, to help yourself?		
Exercise referral a good idea	Self support groups	Use of telephone appointments in GP practices but in a timeslot
Signposting needs to be maintained and updated – single point for information/dissemination	Needs to come from the top down i.e. sugar tax, fat tax (government)	Use skills in the community – what can they offer?
A lot of info – you need to be internet savvy!	Use of voluntary sector i.e. LEAP. Helping each other to help themselves	Walking groups. Tandem bike group
Initiatives are not joined up	Annual check up after 74. Cut off at 65 – feel left out.	Prescribing nurses to do more i.e. they can do some of the appointments
	Self-monitoring: BP, Peak flows, Self management of diabetes, Using technology	Explaining in schools what to expect with health services
	Exercise, social connectivity – create connections	Pharmacies doing more
	5 ways to wellbeing – exercise, connecting with people, learning, volunteering/giving, taking notice/mindfulness	Open sessions at surgeries – regular events
	Wellbeing often not thought about until patients are actually ill: start early, walking, education	Children into adulthood – support stops. Tackle people at school age.
	Information is haphazard – various info in a variety of places.	
Q2. What information would you like, do you need?		
Variety of methods needed for everyone	Use adverts, collaborative approach. Community places, buses, community centres, libraries	Wrong format for blind – higher contrast, simple text, easy read and large print
Those with conditions plus those with an interest	Promotion of these sorts of events a bit late – which reduces ability to join in.	
Maintain existing range of communication	Food manufacturers locally	
	Invitations to events need to	

	be publicised earlier and wider and using more mediums. CCgs more proactive about role.	
	Collection of all media/methods. Use luncheon clubs and where people gather	
Q3. What are your thoughts about the use of technology to give people information?		
	Support for those not using the internet	Ages of users – tailor to them
	Remember to use more traditional methods of communication	Consider issues i.e. sight problems in old age
		Good example: Couch to 5k
		Make sure it looks like it is coming from a recognised source
		Use of Alexa, is this possible? I.e. for a food diary. People use food diaries for specific issues
		Encourage people to record things in a diary – non paper version
Primary and community care		
Q1. You are suffering with lower back pain and decide to visit your GP. What is your expectation?		
Physio	Expectation/timescales. Know how long it will take.	Diagnosis, self help. Next steps. Massage available on the NHS
I would want control of decisions	How long will you wait before you go to a GP – about a month	Feel back, watch how you walk. Movement check, recommend massage, then scan.
Patients might only know when there is a problem or they need help	Would want pain management and physio. Then a review	
	Parking – pay before you leave!	
	GP to find out what you want to achieve i.e. ride a bike or run a marathon!	
	Timescales would help people decide – patient choice. Longer wait, more	

	uncertainty	
	Help to manage it – tips, exercise, agree what you want to achieve	
	GP needs to see one month later	
Q2. Your GP asks you to follow some actions before you are referred anywhere else. What are your thoughts and questions?		
Patients may be happy to be referred elsewhere	Procedures to follow. Back pain pathway. If the scan isn't altering the overall management – would it be done?	Information to social support i.e. luncheon clubs. GP or nurse could do this!
Different ages may want different approaches	Reassurance and peace of mind that treatment is right – expectation	Ask what they think the outcome could be.
May be dependent on condition/illness how you want to be treated	More procedures in community. Hospital staff need to know what's around.	Happy to go elsewhere in the community
		Some issues can be caused by excess weight – LEAP service
		'Timebanking' service. Public Health initiative – volunteers sharing skills
Q3. Your GP decides you need an MRI scan. What are your expectations?		
		Some people won't have the confidence to ask questions. Plain English needs to be offered.
		Need to be told what happens in an MRI scan – so you are well informed
		Getting results quickly. Phone GP for results. Find out how long it takes for results to come through
		Need to be told at the time i.e. it will be painful
		You should get a sticker for having it done (like children do)
Secondary Care		
Q1. What influences where you want to be seen?		
Accessibility	Medical staff visit at home, or local clinics (or over the	Known environment, known person (i.e. GP).

	phone) rather than visit a hospital	
Parking	Some may feel hospital is washing their hands of you	Accessible by public transport
Weighing up options ie waiting times vs best place/care/where is good	Managing expectation – reassurance that support is there if you need it.	Hospital hopper doesn't go to the bus station! I have to ask for a lift instead. Link with bus station or park and ride.
	Easy access!!!	
	Telephone follow up if needed	
	Parking issue – cost/time	See people in one hospital (where my notes are)!
Q2. What is important to you about the person that you see about your condition?		
You don't always know the qualifications of staff	Reputation of speciality (best person)	Good bedside manner.
More reassuring to see someone more senior	Education of health professional i.e. Optometrists	Able to explain things simply (not technical language)
Language issue meant information was missed	Clear communication. Be able to ask about experience	Be prepared to reassess at another appointment (things may have changed)
Communication/explanations are key at all levels	Specialist work that goes OOC – could monitoring be done locally?	Interaction of different medication needs considering – holistic approach. Look at person as a whole.
Tailoring approach – care and attention	Knowledge, skills of persons (not always a Dr).	Telephone follow ups a good idea but would want to see someone for at least one follow up appointment.
	Explaination/time/questions answered	They need to wait for you when called at receptions rather than calling and walking off.
	Being given time	Would be happy to see the right person/location for best treatment
Planned care		
Q3. Do you have any suggestions for improvements for planned care services?		
Patient ownership/access rather than just GPs	Plan discharge/support after procedure	People may be worried about reducing hospital referrals.
Sharing information on steps in a pathway	Recovery/rehab in community (nursing/res homes)!	
Realistic timescales	Promote community hospital 'consultant led' appointments	
Managing patient expectations	Simple communication and information at the right level	
GPs need to see information	Continuity of care – see the	

i.e. treatments that have happened in secondary care/conversations	same person	
	Information about individual	
	More and easier access to physios	
	Educate patients other healthcare professionals (other than Drs) – nurses, others, Pharmacists, therapists	