



**NOTTINGHAM NORTH AND EAST CCG
RUSHCLIFFE CCG
NOTTINGHAM WEST CCG**

NUH Service Review

Joint Health Overview and Scrutiny
Committee – March 2017

This paper provides an overview of consideration that was taken in establishing plans for patient and public engagement along with whether a service change was substantial.

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1. Introduction

CCGs have a duty to act efficiently, effectively and economically and in order to do this, we are continually reviewing and planning services to meet the needs of the local population and to secure value for money. The Nottingham University Hospitals NHS Trust (NUH) service reviews are an element of this. This programme included reviews of 30 separate services and has been carried out to ascertain whether they are being provided to a specification, in the most appropriate setting and whether they are delivering best value for money. For some services, the reviews highlighted that specifications, information on patient outcomes and activity was not available.

This paper outlines the detail for south Nottinghamshire for those services where it was proposed that they were moved into a community setting. The paper includes criteria considered in relation to whether a proposal was deemed to be a substantial variation and a summary of the service user, carer, public and clinical engagement carried out. The paper also includes timescales and any plans for transition.

Proposals were agreed in the NHS Nottingham North and East, Rushcliffe and Nottingham West Governing Bodies on the 10 February 2017. The outcomes of the decisions are included for each service listed in section 2.

1.1 Establishing whether a service change is substantial.

The planning for patient and public engagement, along with whether a service change was substantial, is based on the proportionality of a service and the nature of the proposal. To do this, the CCG balances its duty to make arrangements to involve with its duty to act efficiently, effectively and economically. In relation to the NUH service review, decisions on the nature and extent of public involvement were considered for each service independently in order to take account of specific circumstances and proportionality.

Generally, in order to assess whether a service is substantial, the following criteria will usually be taken into consideration:

Access – in terms of level of inconvenience, reduction or increase in service due to change of location or opening times

Patient Outcomes – impact on patient outcomes, speed of recovery, impact on ability to lead a full life, impact on person's health, level of comfort

Service Delivery – changes in physical environment, impact on how other services are delivered, impact on system

No. of Patients – patient numbers, proportion of population affected

Cost – cost of existing service, level of savings, impact on system

A decision that a proposed change is substantial may be dependent on one area only, or a combination of criteria.

It is not possible to assign specific parameters to define substantial within each of the criteria, however a key element for consideration is the impact on patient outcomes. Proportionality is assessed against the impact on the patient as well as the breadth and type of services commissioned and the size of the service.

1.2 Engagement

For all services engagement was carried out with clinicians, patients/service users, carers and the general public. It was not possible to contact service users directly through NUH and therefore the CCGs reached out through Practice Patient Groups, CCG web-sites, Facebook, Twitter, self-help groups, voluntary sector organisations, libraries, Surestart Centres, post offices.

For all services, it is not possible to determine a percentage of service users who responded for one or more reasons as follows: The CCG is unable to hold personal details; the number of service users is not always known; CCGs do not have access to the lists of service users.

Engagement plans were informed by legal advice and adhered to the statutory requirements of CCGs. In some cases, engagement is ongoing and this is outlined below.

The Equality Impact Assessments can be found in appendix 1 and demographics in appendix 2.

2. Service Changes

2.1 Pain

The Governing Bodies approved the decision to procure a new service, adhering to NICE guidance. The procurement of the service will address fragmentation and provide equity in care across Greater Nottingham. Patient and clinical feedback has been considered in relation to the final specification and has impacted on the commissioning decision and how transition is managed from the existing to new service.

2.1.1 Overview of Proposal

As part of establishing the specification, an evidenced based review of the clinical and cost effectiveness of interventions currently used was conducted by Public Health colleagues and in conjunction with the Core Standards for Pain Management in the UK (Faculty of Pain Medicine Oct 2015), NICE guidance and SIGN (Scottish Intercollegiate Guidelines Network) guidance. This provided a clear way forward to define the proposal in order to improve the consistency and quality of services for patients across the area.

More specifically, in relation to the service itself it was proposed that care be delivered through a three level system:

Level One

Primary care services from GPs, community pharmacists, community psychological therapies, pain self-help organisations/groups and community based physical and psychological therapies.

Level Two

Community based services offering a multi-disciplinary team approach to pain management including specialist physical and psychological therapies, evidence based interventions such as exercise programmes and access to self-help resources.

The Level Two service will consist of a multi-disciplinary team that can assess all referrals, and manage patient's physical, psychological and social needs associated with pain.

It will ensure patients experiencing chronic pain are appropriately managed in a community environment. Patients requiring secondary care can be referred into an appropriate hospital setting when they need specialist interventions and will then be

transferred back to a community setting (if necessary) once Level Three intervention is complete. Injections will be provided in line with NICE guidance and it will be patient choice with respect to whether they go to the hospital or to a community provider to have their injections.

Level Three

Secondary care service for patients requiring surgery or procedures that require an acute care setting. Referrals to this service must be in line with the agreed service pathway

The use of a “never discharged but not followed up” policy will be adopted to enable long term follow up of patients at set points as agreed with the patient. This enables the patient to self-refer back into the service directly when agreed changes in their condition are noted or if the patient/carer/family need to seek advice to assist in self-management.

All patients will have a comprehensive treatment plan. This will enable colleagues across services to talk to the patient regarding their care plan using common language that everyone understands.

For times of crises, the treatment plan will include a clear explanation of the circumstances where it is expected that patients will need to access services, including how to manage flare ups and how the pain services can help in these situations as opposed to patients having to make a decision whether to contact their GP practice or attend Emergency Departments.

Reducing the fragmentation of the current pathway for patients with chronic pain and ensuring more standardisation in the treatment of patients will reduce duplicating or overlapping service provision and the consequent extra payment for the same or similar service. Therefore, it is in keeping with our duty to act effectively, efficiently and economically ensuring value for money.

2.1.2 Assessment of Substantial

Access - Patient choice for locations will increase with the implementation of a community service. Services will be less fragmented. Patients will continue to receive psychological, physical, social support through the service. Services will be in different locations.

Patient Outcomes - Outcomes and patient experience will be at minimal, the same as existing service in relation to impact on a person's health, ability to lead the same quality of life. Service will be delivered in line with NICE guidance – evidence based and outcomes. Therefore, our expectation is that outcomes and experience will improve through services that are patient centred, rather than organisational centred, with ease of access and an evidenced based specification.

Service Delivery - Service model is based on current service delivery and will not impact on range of services or manner of delivery. Same services as currently available will be provided. An additional step of Cognitive Behavioural Therapy will be available for patients. Removal of duplication. Elements of care that need to be provided in a hospital setting will continue to do so. It is not expected that there will be a detrimental impact on other services as a result of the proposal.

Number of Patients – 483 patients access pain management team. 2714 patients per year access the back pain service. (This is the total number and so more than those that will be accessing the newly commissioned service)

Cost – Total cost of services at NUH is £798k

Summary – the change was agreed as not being substantial as patient outcomes will remain the same or improve due to clear levels of care, treatment plans and crisis management. The proposal outlined that patients will receive the same care that they currently receive. Size of service is proportionately small.

2.1.3 Service User, Carer and Public Engagement

Engagement was carried out in two stages in order to both inform the proposal and to receive feedback on the proposal itself and commissioning intentions.

Stage 1 - The first stage of engagement included national patient experience and outcomes, existing local feedback received over the past year (in relation to engagement and patient experience feedback), specific focus groups and patient surveys. 60 patient surveys were completed and 33 people attended focus groups, 20 of whom were patients or carers. The demographics in relation to the survey are included in appendix two.

Service users were asked the following questions:

What would a good pain service feel like?

What mattered to you most throughout your treatment/whilst using the service?

How easy is it to access current services?

What is the follow up care like for this service?

A summary of the feedback related to the importance of a personal/tailored service, the importance of the service in providing freedom from pain and improved quality of life, continuum of care is important taking into consideration the physical and psychological effects of pain, importance of staff who are sympathetic and understand patient needs, importance of knowledgeable staff, importance of service supporting independence and control for individual patients.

Stage 2 – A summary of the proposal was provided for people to comment on. The proposal considered feedback from stage 1. People could comment through the web-site, by email, telephone or in writing. 65 responses were received.

A summary of the feedback is as follows:

Substantial concerns on not having access to injections

Services allow individuals to maintain activities of daily living

All areas of therapy need to be together

Concerns on how equipment will be accessible in and across different community venues

Stage 3 – Focus groups are being held with service users who currently have injections in order to understand more fully their physical, psychological and social needs relevant to service delivery.

2.1.4 Clinical Engagement

At the time of developing the proposal, it was not possible to meet with NUH clinicians.

However, robust clinical engagement was sought by involving the following:

- Asking local providers, including NUH to nominate clinicians who could be involved with the work
- The Clinical Senate circulating their wider membership to ask for people who would be prepared to support the reviews
- Approaching key individuals or organisations relevant for the service e.g. Local Optometrist Committee, Chartered Society of Physiotherapy, specialist advisors

- Clinical engagement events were held for some service areas

During stage 2 outlined above, all clinical feedback was considered as part of the decision making process. Consultants and staff within the service provided direct feedback.

A summary of clinical feedback highlighted the experience required for the team, this cohort of patients are vulnerable with physical, psychological and social difficulties, chronic and lasting pain is complex and context sensitive, evidence based management is required that differs from other conditions and requires specialist skills.

2.1.5 Next Steps and Transition

Following consideration of the feedback alongside other criteria, a decision was made to commission a community based service in line with NICE guidance. The service is currently out to tender with the requirement that the new service will be live 15 July 2017. There will be a mobilisation period and how this is managed will depend on the outcome of the procurement process. Any risks will be managed through the mobilisation and transition period. As part of the mobilisation, clinical reviews will be carried out where relevant with existing service users and in order to manage the transition to treatment in line with NICE guidance.

2.2 Neuro Services

The Governing Bodies approved the decision to continue to commission the brain injury and neuro assessment services from NUH. Discussions will be held with NUH on how best to remove duplication and gain efficiencies i.e. through feedback it was highlighted that there is a cohort of patients who are accessing neuro services should be accessing other rehabilitation services. Patient and clinical feedback has been considered in relation to the final specification and has impacted on the commissioning decision to leave the service at NUH.

2.2.1 Overview of Proposal

There are 3 services provided at NUH which serve very similar patient groups:

- Neuro assessment service – this provides outpatient services for patients who have a neurological diagnosis, are under the care of a consultant physician and have specific treatment goals. Specifically the service provides assessment of clinical and psychological needs, identifies and treats or manages problems, and helps co-ordination of services to achieve an integrated, seamless and cost-efficient plan to achieve rehabilitation goals and care.
- Brain injury service – this provides an outpatient service for patients who have had a documented Glasgow Coma Scale Score of 12 or less for at least 30 minutes which requires admission to hospital, and a definite, documented, traumatic brain injury. Specifically it provides interdisciplinary assessment and treatment to patients who present with complex physical and/or cognitive deficits resulting from neurological conditions and who require on-going therapy. Patients are offered an appointment for an initial assessment which results in the patient's goals/focus for neuro rehabilitation and professionals required being identified
- Neuro re-ablement - this service is designed to rehabilitate and enable patients for a wide range of conditions following their admission to hospital. Specifically it facilitates complex discharges and promote earlier discharges , provides rehabilitation in the patient's home, and provides specialist neurological rehabilitation for a wide range of conditions

The proposal was to commission a community based neuro rehabilitation service with the aim of providing the same services and patient outcomes that are currently provided.

The proposal aims to provide a high quality, equitable specialist community neuro-rehabilitation service to reduce the impact of both physical and psychological impairments, maximise independence, reduce mortality and prevent avoidable complications.

The proposed service includes assessment of patients who are referred and confirmation through a multi-disciplinary team whether the patient requires interventions for 16 weeks in relation to a long-term neurological condition or 12 to 14 months for a traumatic or acquired brain injury.

It is proposed that where clinically appropriate for the service, patients will commence on a 16 week or 12 to 14 month community treatment and rehabilitation programme provided by a multi-disciplinary team.

It was proposed that the service provides each patient with a senior expert clinician as their case manager who will oversee the delivery of the plan

It was proposed that by bringing together services that are currently delivered separately there is opportunity to review the overall staffing levels and skill mix whilst still ensuring high quality services are delivered. The aim is that patients will receive intensive but time limited rehabilitation after which they will be referred to community services for the continuation of the rehabilitation programme if required.

2.2.2 Assessment of Substantial

Access – Access would be through a community hub. The proposal included care in the community and in people's own homes.

Patient Outcomes - Outcomes and patient experience will be the same as existing service in relation to the impact on a person's health, flexibility, rehabilitation.

Service Delivery - Service model is based on current service delivery and will not impact on range of services or manner of delivery. Same services as currently available will be provided. It is not expected that there will be a detrimental impact on other services as a result of the proposal.

Number of Patients – Traumatic brain injury is 35-40 new referrals per year. Neuro assessment is 276 referrals per year.

Cost – Total cost of services at NUH is £411k

Summary – the change was agreed as not being substantial as patient outcomes will remain the same or improve due to clear levels of care, treatment plans and crisis management. The proposal outlined that patients will receive the same care that they currently receive. Size of service is proportionately small.

2.2.3 Service User, Carer and Public Engagement

Engagement was carried out in two stages in order to both inform the proposal and to receive feedback on the proposal itself and commissioning intentions.

Stage 1 - The first stage of engagement included national patient experience and outcomes, existing local feedback received over the past year (in relation to engagement and patient experience feedback), specific focus groups, one to one interviews and patient surveys. 40 patient surveys were completed and 19 people attended focus groups and/or were interviewed on a one to one basis. Demographic details in relation to the survey are included in appendix 2.

Service users were asked the following questions:

What would a good neuro service (brain injury, assessment, reablement) feel like?

What mattered to you most throughout your treatment/whilst using the service?
What would you like to change in relation to neuro services?
How easy is it to access current services?
What is the follow up care like for this service?

A summary of the feedback related to the need for immediate and ongoing aftercare following a brain injury, the importance and need for an understanding of their condition and its impact, services need to be linked to community and voluntary sector support for when an individual returns home, lack of knowledge by both general and health professionals on the needs of people with brain injuries, social aspects of care are very important, peer groups are very important.

Stage 2 – A summary of the proposal was provided for people to comment on. The proposal considered feedback from stage 1. People could comment through the web-site, by email, telephone or in writing. 150 responses were received. Two further focus groups were held and 70 people attended these. A petition was also started and comments from this were considered as part of the feedback (the petition related to CCGs stopping brain injury services which was not part of the proposal).

A summary of the feedback is as follows:

The service must recognise patient needs and how an individual is responding to care – flexibility in care plans
The proposal does not reflect the differences in care required for traumatic brain injury vs long term condition
The services requires specialist skills and equipment
The proposal needs to reflect how the service gives people their life back
Continuity of care is very important in relation to how quickly an individual recovers

2.2.4 Clinical Engagement

At the time of developing the proposal, it was not possible to meet with NUH clinicians. However, robust clinical engagement was sought by involving the following:

- Asking local providers, including NUH to nominate clinicians who could be involved with the work
- The Clinical Senate circulating their wider membership to ask for people who would be prepared to support the reviews
- Approaching key individuals or organisations relevant for the service e.g. Local Optometrist Committee, Chartered Society of Physiotherapy, specialist advisors
- Clinical engagement events were held for some service areas

During stage 2 outlined above, all clinical feedback was considered as part of the decision making process. Consultants and staff within the service provided direct feedback.

A summary of the clinical feedback included concerns that the specification did not take into consideration reablement and the needs of patients with traumatic brain injuries versus long term conditions, highlighted that there is a need for flexibility in length and intensity in treatment, working from one base is beneficial to facilitate inter-disciplinary working, including access to equipment.

2.2.5 Next Steps and Transition

Following consideration of the feedback alongside other criteria, a decision was made to keep the neuro services at NUH. This has had positive responses from patients and clinicians.

Commissioners are working with NUH on the structure and design of the services going forward from July onwards. Any risks will be identified through this mobilisation process.

2.3 Dietetics

The Governing Bodies approved the decision to continue to procure new integrated dietetics services. This includes notice being provided to both NUH and Health Partnerships. The procurement of an integrated service will allow for a structured and consistent approach across south Nottinghamshire. Patient and clinical feedback on the proposal related to concerns on ongoing dietetic care for certain conditions. This has been updated and is reflected in the revised specification and included as part of the invitation to tender.

2.3.1 Overview of Proposal

Nottingham University Hospitals (NUH) provides a Dietetics Outpatients service which treats adults and children. The aim of the service is to treat the nutritional consequences of disease through a variety of nutritional interventions. For many of the pathways, patients are seen as part of the multidisciplinary team (MDT) clinic and are generally seen on the same day as the Consultant and other members of the team. In other cases, where a dietitian does not sit in the MDT clinic, referrals are managed in a stand-alone clinic or when they come to NUH for their treatment. The service also offers telephone contacts to appropriate patients.

The service accepts referrals for the following conditions/ reasons renal, diabetes, obesity, cancer, HIV, Cystic Fibrosis, Gastroenterology conditions (e.g. Coeliac Disease), Paediatrics specific conditions (Metabolic, Allergy, Failure to thrive).

In addition to the NUH dietetics service, there is also a community dietetic service provided by Community Health Partnerships. They may see patients for similar conditions and provide community based clinics, group sessions and home visits.

Due to the nature of long term conditions managed by the Dietetics Outpatient team, service users may vary between requiring specialist management within secondary care, and when more stable could be managed within the community setting, closer to home.

At present, it is difficult to flow between the two services and settings. Therefore the proposal is for a single provider (or group of providers working together) to provide an integrated dietetic service to deliver all non-inpatients dietetics.

The proposal is for an integrated dietetic service with the aim that it will provide the following:

- A structured and consistent approach to dietetic management through multidisciplinary working, promoting effective and integrated working relationships with the clinicians within the acute setting, community services and Primary Care.
- The aim that the most appropriate clinician, setting and intervention are identified and offered at the outset of treatment. This is reviewed during the patients care and is adjusted as clinically appropriate.
- A movement towards specialist staff delivering services closer to home and up-skilling of community staff to see a more complex case mix.
- A broader offer of delivery methods, to include group sessions, improved access to self-care information and greater use of technology.

2.3.2 Assessment of Substantial

Access – Service provision will continue to be community and hospital based. Access will be improved through clearer patient journeys and removal of duplication of services across providers.

Patient Outcomes - Outcomes and patient experience will be the same as existing services, if not improved through a clearer patient journey and removal of fragmentation. Therefore, our expectation is that outcomes and experience will improve through services that are patient centred, rather than organisational centred

Service Delivery - Service model is based on current service delivery and will not impact on range of services or manner of delivery. Duplication will be removed and specialist skills will be maintained within an integrated service. It is not expected that there will be a detrimental impact on other services as a result of the proposal.

Number of Patients – Not available – contacts over a year were 133 for the community service and 3638 for the acute service.

Cost – Total cost of services is £584k

Summary – the change was agreed as not being substantial as patient outcomes will remain the same due to the proposal using the same service model as is currently provided. Services will be provided in the most appropriate clinical setting ie community or hospital based and in the majority of **circumstances** this will be the same as current arrangement.

2.3.3 Service User, Carer and Public Engagement

Engagement was carried out in two stages in order to both inform the proposal and to receive feedback on the proposal itself and commissioning intentions.

Stage 1 - The first stage of engagement included existing local feedback received over the past year (in relation to both engagement and patient experience feedback), patient surveys and one to one discussions. 10 people commented on dietetics.

Service users were asked the following questions:

What would a good dietetics service feel like?
What mattered to you most whilst using the service?
What would you like to change in relation to dietetic services?
How easy is it to access current services?

A summary of the feedback related to patients lacking confidence about their condition, referrals being refused/rejected and the patient being sent back to their GP – resulting in patients not being seen by any of the dietetics services commissioned. Lack of clarity from the services as to which patients they are treating resulting in service not working well and pathways not being clear, better education and information of dietary needs are needed.

Stage 2 – A summary of the proposal was provided for people to comment on. The proposal considered feedback from stage 1. People could comment through the web-site, by email, telephone or in writing. 52 responses were received.

A summary of the feedback is as follows:

Assurance that support will continue for babies/children with PKU, including during periods of illness.

Concerns as to whether the service will have specialist knowledge around certain conditions
To have specialist knowledge including of renal patients.

Will patients still be able to access specialist dietetics information when they are at the hospital for other treatments i.e. dialysis.

2.3.4 Clinical Engagement

At the time of developing the proposal, it was not possible to meet with NUH clinicians. However, robust clinical engagement was sought by involving the following:

- Asking local providers, including NUH to nominate clinicians who could be involved with the work
- The Clinical Senate circulating their wider membership to ask for people who would be prepared to support the reviews
- Approaching key individuals or organisations relevant for the service e.g. Local Optometrist Committee, Chartered Society of Physiotherapy, specialist advisors
- Clinical engagement events were held for some service areas

During stage 2 outlined above, all clinical feedback was considered as part of the decision making process. Consultants and staff within the service provided direct feedback.

A summary of clinical feedback highlighted the risk of fragmentation, concerns that inpatient dietetics will be de-stabilised due to a shortage of clinical skills, an erosion of skilled workforce in the system, for patients with chronic kidney disease a close link between the consultant and dietetics will need to be maintained, clinical risk due to communication required with different dieticians across the system.

2.3.5 Next Steps and Transition

The service is currently out to tender with the requirement that the new service will be live 15 July 2017. Since announcing the decision, further feedback has been received in relation to the alignment with specialised services which are commissioned by NHS England. There will be a mobilisation period and how this is managed will depend on the outcome of the procurement process. Any risks will be managed through the mobilisation and transition period.

2.4 Complex Rehabilitation/Medicine Day Care/Geriatric Day Care

The Governing Bodies approved the decision to move the service into the community as part of integrated rehabilitation services. This will provide greater access for patients and alignment with other relevant services in particular falls and stroke. Patient and clinical feedback related predominantly to concerns on the removal of a service for patients with Parkinson's. As a result, a specific annex is being written to ensure that Parkinson's patients continue to receive the same level of care.

2.4.1 Overview of Proposal

The Nottingham University Hospitals Rehabilitation Unit (NUHRU) provides specialised comprehensive, multidisciplinary assessment and individualised treatment programmes to meet the goals and needs of frail older out-patients whose needs are too complex to be provided for effectively in community i.e. complex falls patients, early complex stroke patients, Parkinson's Disease patients and complex geriatric patients. Patients are discussed at a multidisciplinary team (MDT) meeting, and a goal-oriented, individualised care plan produced.

The proposal is that the service will be provided in either a community location with specialised equipment or in the home environment.

Referral criteria will remain the same, along with a focus on complex falls and complex neurological conditions including Parkinson's Disease.

It was proposed to deliver rehabilitation for this cohort of patients with the aim of services being integrated. The aim of the proposal is to provide rehabilitation following a multi-disciplinary

team approach with physiotherapy, occupational therapy and social care being provided by a community service. The proposal includes medical review of complex patients within a multi-disciplinary team environment and the aim is that this would also include a community geriatrician service and where complex investigations are needed, these would be requested through secondary care (for example, tilt table testing and imaging). It is proposed that close links with primary care on prescribing and medicines management would support the service model and support for nursing services such as continence care and dietetics support would be provided through community services.

The delivery model will exclude stroke patients where those stroke patients will be cared for by the specialist stroke community service.

2.4.2 Assessment of Substantial

Access – Service provision will be provided in a community setting and integrated with existing services. Therefore services should be more accessible for patients.

Patient Outcomes - Outcomes and patient experience will be the same as existing services, if not improved through the integration with existing services. Therefore, our expectation is that outcomes and experience will improve through services that are patient centred, rather than organisational centred, with ease of access and an evidenced based specification

Service Delivery - Service model is based on current service delivery and will not impact on range of services or manner of delivery. Patients currently accessing the service who have had a fall will be managed through the specific falls services. Patients with Parkinsons will have the same service within existing rehabilitation services. Duplication will be removed and specialist skills will be maintained within an integrated service. It is not expected that there will be a detrimental impact on other services as a result of the proposal.

Number of Patients – 421 patients referred into the service.

Cost – Total cost of service is £1.1m

Summary – the change was agreed as not being substantial as patient outcomes will remain the same due to the proposal using the same service model as is currently provided. Services for patients accessing complex rehab are already provided in the community in relation to falls and stroke. Parkinson's patients will continue to receive the same service in a community setting. The cost of the service will reduce considerably however care to patients will be the same if not improved.

2.4.3 Service User, Carer and Public Engagement

Engagement was carried out in two stages in order to both inform the proposal and to receive feedback on the proposal itself and commissioning intentions.

Stage 1 - The first stage of engagement included existing local feedback received over the past year (in relation to both engagement and patient experience feedback), detail from a national survey on rehab for Parkinson's patients, NHS England patient feedback in commissioning guidance for rehabilitation, interviews with patients at the NUH rehabilitation unit, patient feedback in relation to falls services. Seven responses were received on the survey and eleven patients were interviewed on a one to one basis. Demographic details are included in appendix 2.

Service users were asked the following questions:

What would a good service feel like?
What mattered to you most whilst using the service?
What would you like to change in relation to services?
How easy is it to access current services?

A summary of the feedback included positive patient experience, the service feels more important being provided in a hospital. However, the majority of patients felt that the service did not need to be provided in a hospital. Patients want personalised care which is tailored to them as individuals. A small number of patients saw a doctor. Can see an improvement through the physiotherapy. The service includes the social side i.e. a day out for a half hour appointment. The service can be difficult to access due to attending for a day/half day.

Stage 2 – A summary of the proposal was provided for people to comment on. The proposal considered feedback from stage 1. People could comment through the web-site, by email, telephone or in writing. 39 responses were received.

A summary of the feedback predominantly related to patients with Parkinson's and concerns that the proposal did not cover the current service received. Peer and social support is important, how will community services have the specialist equipment, group exercise is very beneficial, will this compromise patient treatment resulting in more use of drugs.

For this service there will be a stage three for engagement which will cover Parkinson's specifically.

Stage 3 – Two focus groups are being held to discuss the annex for patients with Parkinson's. These are being co-ordinated with the support of Parkinson's UK.

2.4.4 Clinical Engagement

At the time of developing the proposal, it was not possible to meet with NUH clinicians. However, robust clinical engagement was sought by involving the following:

- Asking local providers, including NUH to nominate clinicians who could be involved with the work
- The Clinical Senate circulating their wider membership to ask for people who would be prepared to support the reviews
- Approaching key individuals or organisations relevant for the service e.g. Local Optometrist Committee, Chartered Society of Physiotherapy, specialist advisors
- Clinical engagement events were held for some service areas

During stage 2 outlined above, all clinical feedback was considered as part of the decision making process. Consultants and staff within the service provided direct feedback.

A summary of clinical feedback highlighted the medical and rehab needs of complex patients and concerns as to whether these had been fully considered as part of the proposal, this is a group of patients requiring regular, multi-disciplinary assessment and treatment, concerns on the capability to safely manage heavy equipment in the community.

2.4.5 Next Steps and Transition

Mobilisation will be carried out between March and June with the transfer to community services taking place in July. Mobilisation includes further service user, carer and public engagement in order to inform the appendix to the contract. Mobilisation will also include meetings between providers in order to discuss the services and transition in detail. This will include any relevant discussions on staff. Discussions to date have not identified any risks.

2.5 Renal Conservative Management

The Governing Bodies approved the decision to continue with the service at NUH and to commission as part of an overall renal service covering home dialysis and renal conservative management. This was as a result of the specialist knowledge required for the service, recognising also that through the review efficiencies were identified.

2.5.1 Overview of Proposal

End of life support through the Conservative Management Home Visiting Service for end stage renal disease. The current service provides advanced care planning, symptom management, practical nursing care, facilitates end of life care and discusses preferred place of care and death.

There are currently other dedicated end of life services provided in the community and therefore the proposal was to move this service to the community with the aim of fully integrated care. It was proposed that this could allow for a greater emphasis on patient outcomes and how to meet these and improved patient and carer experience. The proposed change takes into consideration the removal of duplication in services and as a result, could provide better value for money.

The proposal outlines a case management approach:

Principles include:

- 24 hour nursing care within their own home due to long term chronic disease or as a result of an acute episode of ill health;
- Ongoing case management or rehabilitation as a result of a long term condition(s) or complex needs from multiple conditions.
- Adherence to and provision of evidence of compliance with the NICE quality standard for End of life for adults.

The proposal was that the service will continue to be provided in a patient's own home and the aim of the new model is care co-ordination across other relevant community services.

2.5.2 Assessment of Substantial

Access – Service provision would be the same in that the majority of care would be provided in the patient's own home.

Patient Outcomes - Outcomes and patient experience would be the same as the existing service.

Service Delivery - Service model is based on current service delivery and will not impact on range of services or manner of delivery. Patients would receive the same care predominantly in their own homes. Specialist skills would be the same with access to very specialist knowledge remaining at NUH.

Number of Patients – 77 referrals in one year.

Cost – Total annual cost of service is £31k.

Summary – the change was agreed as not being substantial as patient outcomes will remain the same due to the proposal using the same service model as is currently provided. Service provision would also remain in patient's own home.

2.5.3 Service User, Carer and Public Engagement

Engagement was carried out in two stages in order to both inform the proposal and to receive feedback on the proposal itself and commissioning intentions.

Stage 1 – Due to the specialist nature of the service it was very difficult to reach out to service users and NUH were unable to provide access to patients currently in the service. Previous engagement on end of life services was used to inform the proposal.

Stage 2 - Two comments were received, again reflecting the very specialist nature of the service. The concern was that the proposal focused predominantly on end of life when the service provided a wider spectrum of care. Patients could be with the service for as long as five years.

2.5.4 Clinical Engagement

At the time of developing the proposal, it was not possible to meet with NUH clinicians. However, robust clinical engagement was sought by involving the following:

- Asking local providers, including NUH to nominate clinicians who could be involved with the work
- The Clinical Senate circulating their wider membership to ask for people who would be prepared to support the reviews
- Approaching key individuals or organisations relevant for the service e.g. Local Optometrist Committee, Chartered Society of Physiotherapy, specialist advisors
- Clinical engagement events were held for some service areas

During stage 2 outlined above, all clinical feedback was considered as part of the decision making process. Consultants and staff within the service provided direct feedback.

A summary of clinical feedback highlighted that the service supported complex renal patients requiring specialist skills, provides a specialised system management for patients who are not suitable or do not wish to go on dialysis, end of life is only a small part of the service, if decommissioned NUH would not be able to offer ad hoc telephone advice.

2.5.5 Next Steps and Transition

Commissioners are working with NUH on the structure and design of the services going forward from July onwards. Any risks will be identified through this mobilisation process.

2.6 Chronic Fatigue Syndrome (CFS) Service

The Governing Bodies approved the decision to move the service into the community, ensuring that specialist knowledge on CFS was maintained. The service will be provided in line with NICE guidance and will be part of the pain service which is being procured. Patient engagement emphasised the importance of specialist CFS knowledge as well as peer support for patients.

2.6.1 Overview of Proposal

The current service at Nottingham University Hospitals (NUH) assesses and helps those patients diagnosed with mild to moderate Chronic Fatigue Syndrome (CFS). The service supports patients to develop appropriate strategies for managing their symptoms and improving their quality of life. Patients begin with a therapist or consultant assessment. Patients can be discharged at this point with advice, or they can receive one or more of the following interventions:

- 6-8 individual sessions with an occupational therapist
- 9 week group programme led by appropriate therapists
- 10 -12 individual Cognitive Behavioural Therapy (CBT) or Psychology sessions

The National Institute for Clinical Excellence (NICE) has published guidelines for CFS management which recommend the following:

- Patients and therapists working together
- Cognitive Behavioural Therapy
- Graded Exercise Therapy

NICE highlights that these are the interventions for which there is the clearest evidence of benefit. In addition the guidelines advise that CFS services should provide support if symptoms worsen during treatment and should develop a plan to manage relapses.

It is proposed that this service provides evidence based interventions only, as identified by NICE. The proposal is that a community based service will provide the following:

- Be delivered by a multi-disciplinary team which will include appropriate CFS specialists that can triage all referrals and manage patient's physical, psychological and social needs
- Act as a single point of access for patients with chronic pain or CFS providing a simpler patient journey
- Provide a holistic assessment and management approach for patients with chronic pain or CFS as early as possible in the pathway
- Support patients living with chronic pain or CFS and their nominated carers to:
 - manage their own condition and make decisions about self-care and treatment
 - allow them to live as independently as possible continue care and support (where appropriate) learnt through the service post discharge
- Provide appropriate access points for patients and carers following discharge to support in the management of flare ups and avoid re-entry into the service where possible

As part of the proposal, the group therapy that is currently provided will not continue. It is proposed that this service could be integrated into existing community based physio and rehab services. In order to ensure the specialist skills for CFS continue in the community the specification will include the requirement that clinicians have the competencies required to work with CFS patients.

2.6.2 Assessment of Substantial

Access – Service provision will be provided in a community setting and integrated with existing services. Therefore services should be more accessible for patients.

Patient Outcomes - Outcomes and patient experience will be the same as existing services, if not improved through the integration with existing services. Therefore, our expectation is that outcomes and experience will improve through services that are patient centred, rather than organisational centred, with ease of access and an evidenced based specification

Service Delivery - Service model is based on current service delivery and in line with NICE guidance. Duplication will be removed and specialist skills will be maintained within an integrated service. It is not expected that there will be a detrimental impact on other services as a result of the proposal.

Number of Patients – Number of patients is not available. Over one year there were 77 visits with a consultant, 158 attendances at the CBT course, 449 attendances at group therapy, 251 individual therapy courses and 125 therapy assessments.

Cost – Total annual cost of the service is £135k.

Summary – the change was agreed as not being substantial as patient outcomes will remain the and the proposal is in line with NICE guidance providing evidenced base care. Specialist CFS knowledge will be retained and accessibility will include various community settings.

2.6.3 Service User, Carer and Patient Engagement

Stage 1 - The first stage of engagement included existing local feedback received over the past year (in relation to both engagement and patient experience feedback), review of patients feedback in relation to the NICE guidance, focus groups held with patients, patient survey. Demographic details in relation to the survey are included in appendix 2. 18 responses were received via the online survey and 20 people attended focus groups.

Service users were asked the following questions:

What would a good service feel like?
What mattered to you most whilst using the service?
What would you like to change in relation to services?
How easy is it to access current services?

A summary of the feedback included the need for services to have an understanding of CFS (so they can validate, recognise and believe those that are ill), clinicians to have an understanding of the individual, being listened to by caring and empathetic practitioners, GPs to have a better awareness of NICE recommendations, up-to-date treatment methods, capability to support patients at different stages so that patient can “re-programme” themselves, access to a multidisciplinary team is beneficial, flexibility in service delivery, option of group and individual sessions, support for carers is required.

Stage 2 – A summary of the proposal was provided for people to comment on. The proposal considered feedback from stage 1. People could comment through the web-site, by email, telephone or in writing. 16 responses were received.

A summary of the feedback predominantly related to accessibility of the service and the need for flexibility. Group therapy is beneficial in managing the condition. The service does require clinicians with specialist knowledge of CFS. Service users have mixed views on graded exercise therapy. Patients welcome the opportunity to talk to other people with CFS, in particular to discuss their coping mechanisms and how they’ve been able to “re-programme” themselves.

2.6.4 Clinical Engagement

At the time of developing the proposal, it was not possible to meet with NUH clinicians. However, robust clinical engagement was sought by involving the following:

- Asking local providers, including NUH to nominate clinicians who could be involved with the work
- The Clinical Senate circulating their wider membership to ask for people who would be prepared to support the reviews
- Approaching key individuals or organisations relevant for the service e.g. Local Optometrist Committee, Chartered Society of Physiotherapy, specialist advisors
- Clinical engagement events were held for some service areas

During stage 2 outlined above, all clinical feedback was considered as part of the decision making process. Consultants and staff within the service provided direct feedback.

A summary of clinical feedback highlighted concerns on the discontinuation of group therapy and the feeling that NICE guidance is out of date.

2.6.5 Next Steps and Transition

The service is currently out to tender as part of the pain service with the requirement that the new service will be live 15 July 2017. There will be a mobilisation period and how this is managed will depend on the outcome of the procurement process. Any risks will be managed through the mobilisation and transition period. In order to support group therapy going forward, CCGs are working with self-help Nottingham to establish specific CFS groups.

2.7 Motor Neurone Disease (MND) Home Visiting Service

The Governing Bodies approved the decision to move the service from NUH into existing community services. A specific annex to the contract for the provider of community services will ensure that the specialist skills are available to care for patients with MND. Patient feedback emphasised the complexity of disease and the need for multi-disciplinary care which can be provided more effectively through an integrated community service.

2.7.1 Overview of Proposal

The MND Care Co-ordinator provides home visits which include a holistic health, psychosocial and physical review. The main emphasis being on MND symptom management control.

In reviewing this service the proposal took into consideration the view that there is duplication with services provided in the community. It was proposed that if the service was moved out of the acute setting this could allow for improved integration of care and as a result a greater emphasis on patient outcomes.

It was proposed that care will still be provided in a patient's home as required. The proposal is to maintain the current principles of crisis management, rehabilitation, self-management. The following care is provided under the existing service and it is proposed that it will continue with the new service:

- Assessment of oxygen saturation levels
- Swallow assessment
- Nutrition assessment
- Activities of daily living assessment
- Discussion regarding Do Not Resuscitate
- Discuss advance decision to refuse treatment (and put this in place)
- Facilitate end of life care with community teams and GP
- Discuss preferred place of care and death

The proposal included care co-ordination across other relevant community services. It is proposed that links with the acute neurology team will remain.

2.7.2 Assessment of Substantial

Access – Service provision will be provided in a home environment and provide greater integration with existing community services. Therefore services should be more accessible for patients.

Patient Outcomes - Outcomes and patient experience will be the same as existing services, if not improved through the integration with existing services. Therefore, our expectation is that outcomes and experience will improve through services that are patient centred, rather than organisational centred.

Service Delivery - Service model is based on current service delivery with access to the same specialist skills. It is not expected that there will be a detrimental impact on other services as a result of the proposal.

Number of Patients – 17 referrals and 27 contacts over one year.

Cost – Total annual cost of the service is £62k.

Summary – the change was agreed as not being substantial as patient outcomes will remain the same. Access to specialist services will remain, along with care in a patient's own home. Service is very small and therefore, would be beneficial to be part of an integrated service.

2.7.3 Service User, Carer and Public Engagement

Engagement was carried out in two stages in order to both inform the proposal and to receive feedback on the proposal itself and commissioning intentions.

Stage 1 – Due to the specialist nature of the service it was very difficult to reach out to service users and NUH were unable to provide access to patients currently in the service. MND Nottinghamshire asked patients and carers to complete a survey and provided feedback. A national survey on improving MND care was used as well as existing feedback. Demographic details in relation to the CCG survey are included in appendix 2. Four people responded to the online survey. To put this in context, the number of contacts with MND patients recorded in 2015/16 by NUH was 27.

A summary of the feedback included that services can be provided in the community – mobility can be a big problem for MND patients so care in the community is beneficial if it's accessible. Patients with MND have a high regard for the care centre at Queen's Medical Centre with treatment being very personalised to individual patients. Individuals need good access to a range of specialists. Individuals feel it takes too long to get a diagnosis.

Stage 2 - Three comments were received, reflecting the small numbers of patients with this condition. Feedback highlighted that there needs to be the right capacity and capability ensuring skills and expertise to meet the complex needs of patients with MND. Patients need access to a wide range of support and care. Services need to be able to respond and implement care plans quickly and be able to meet the needs relevant to the degenerative nature of the disease.

Stage 3 – Further engagement will be carried out with carers and service users in order to ensure that all factors are considered as part of future service delivery..

2.7.4 Clinical Engagement

At the time of developing the proposal, it was not possible to meet with NUH clinicians. However, robust clinical engagement was sought by involving the following:

- Asking local providers, including NUH to nominate clinicians who could be involved with the work
- The Clinical Senate circulating their wider membership to ask for people who would be prepared to support the reviews
- Approaching key individuals or organisations relevant for the service e.g. Local Optometrist Committee, Chartered Society of Physiotherapy, specialist advisors
- Clinical engagement events were held for some service areas

During stage 2 outlined above, all clinical feedback was considered as part of the decision making process. Consultants and staff within the service provided direct feedback.

A summary of clinical feedback highlighted that a specialist rather than a generic approach to care co-ordination is required, community teams need to work in close partnership with acute sector for integrated pathway, the service must be able to meet NICE quality standards.

2.7.5 Next Steps and Transition

Mobilisation will be carried out between March and June with the transfer to community services taking place in July. Mobilisation includes further service user, carer and public engagement in order to inform the appendix to the contract. Mobilisation will also include meetings between providers in order to discuss the services and transition in detail. This will include any relevant discussions on staff. Discussions to date have not identified any risks.

3. Conclusion

Patient, service user, public and clinical feedback has informed decisions throughout the process of the NUH service review. Activities have been proportionate and have met statutory responsibilities. Out of 30 services reviewed, five are moving to the community and three of these are out to procurement. Therefore, the overall programme has not had a detrimental impact on other services and/or the system. The five services are Pain, Chronic Fatigue Syndrome, Dietetics, Motor Neurone Disease Home Visiting, Complex Rehab. The programme of work has been a positive step forward and is an example of good commissioning, with the outcome that commissioners and NUH have greater clarity on the services which are now supported by evidenced based specifications.

When considering the services individually against criteria including access, service delivery, patient outcomes, number of patients and cost they are not considered to be substantial or significant. Patient and public engagement has been central to informing the specifications and the commissioning decisions and this has been carried out proportionately to the changes.

Appendix 1 – Equality Impact Assessments

1. Pain Services

No negative impacts on the protected characteristics were identified. There were no concerns identified for other minority populations (eg travellers, sex workers, single parents, those on low income) who may be disadvantaged by the policy or service's operation, or who may receive unequal treatment. The proposal does not directly/indirectly discriminate against any section of the community.

	Negative Impact	Positive Impact	Neutral Impact	Reason(s)
Age			X	The service to be commissioned will continue to provide services with community settings. Therefore this will not adversely impact any group inequitably on the basis of age. The wider implications of this decision to the patient-group as a whole (regardless of Age), are considered within the relevant Quality Impact Assessment.
Disability – including physical, sensory or mental		X		The service to be commissioned will continue to provide services with community settings. Therefore this may positively impact on the basis of disability due to service potentially being provided closer to home. The wider implications of this decision to the patient-group as a whole (including those with Disabilities), are considered within the relevant Quality Impact Assessment.
Gender - including transgender and issues relating to pregnancy and maternity			X	The service to be commissioned will continue to provide services with community settings. This will not adversely impact any group inequitably on the basis of gender. The wider implications of this decision to the patient-group as a whole (regardless of Gender), are considered within the relevant Quality Impact Assessment.
Race/Ethnicity			X	The service to be commissioned will continue to provide services with community settings. This will not adversely impact any group inequitably on the basis of race or ethnicity. The wider implications of this decision to the patient-group as a whole (regardless of race or ethnicity), are considered within the relevant Quality Impact Assessment.
Religion or Belief			X	The service to be commissioned will continue to provide services with community settings. This will not adversely impact any group inequitably on the basis of religion or belief. The wider implications of this decision to the patient-group as a whole (regardless of religion or belief), are considered within the relevant Quality Impact Assessment.
Sexual Orientation – including issues relating to marriage and civil partnerships			X	The service to be commissioned will continue to provide services with community settings. This will not adversely impact any group inequitably on the basis of sexual orientation. The wider implications of this decision to the

				patient-group as a whole (regardless of sexual orientation), are considered within the relevant Quality Impact Assessment.
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2. Neuro Services

No negative impacts on the protected characteristics were identified. There were no concerns identified for other minority populations (eg travellers, sex workers, single parents, those on low income) who may be disadvantaged by the policy or service's operation, or who may receive unequal treatment. The proposal does not directly/indirectly discriminate against any section of the community.

	Negative Impact	Positive Impact	Neutral Impact	Reason(s)
Age			X	The service will cover patients over the age of 16 registered with all CCGs within the NUH consortia. Patients under the age of 16 will be seen within paediatrics and remain under a consultant. There is no impact to specific age groups.
Disability – including physical, sensory or mental		X		We would expect the provider to be able to support the following groups: <ul style="list-style-type: none"> • mobility impaired • physically impaired • citizens with 1 or more long term condition • deaf/hearing impaired • blind/partially sighted • speech impairment • learning disability • citizens with a mental health condition The provider should also have access to translators and people who are able to use sign language. The new specification requires treatments to be delivered in the home as well as in NUH facilities. This enables the provider to meet any additional needs the patient may have, in their own environment. All staff would be appropriately trained to support patients with this long term condition.
Gender - including transgender and issues relating to pregnancy and maternity		X		The provider is expected to have undertaken the necessary training and knowledge to understand these protected characteristics, and is expected not to discriminate or disadvantage any patients based on this characteristic.
Race/Ethnicity		X		The service is not targeted towards any specific race; patients are referred by healthcare professionals (predominantly secondary care) based on the referral criteria outlined in the service specification, which does not indicate any specific race requirements.
Religion or Belief		X		The provider is expected to be sensitive to patients religious and belief needs by supporting them with their preferences e.g. providing female staff for female patients.
Sexual Orientation – including issues relating to marriage and civil partnerships		X		The provider is expected to have undertaken the necessary training and knowledge to understand this characteristic, and is expected not to discriminate or disadvantage any patients based on this characteristic. Spouses and partners will be supported by the provider of this service and appropriately trained to support the patient at home.

3. Dietetics

No negative impacts on the protected characteristics were identified. There were no concerns identified for other minority populations (eg travellers, sex workers, single parents, those on low income) who may be disadvantaged by the policy or service's operation, or who may receive unequal treatment. The proposal does not directly/indirectly discriminate against any section of the community.

	Negative Impact	Positive Impact	Neutral Impact	Reason
Age			X	Neutral impact - The service will continue to be delivered, however the setting may be different.
Disability – including physical, sensory or mental		X		Positive impact - The service will continue to be delivered, however were possible, the service will be delivered from accessible community locations.
Gender – including trans* and issues relating to pregnancy and maternity			X	Neutral impact - The service will continue to be delivered, however the setting may be different.
Race/Ethnicity			X	Neutral impact - The service will continue to be delivered, however the setting may be different.
Religion or Belief			X	Neutral impact - The service will continue to be delivered, however the setting may be different.
Sexual Orientation - including issues relating to marriage and civil partnerships			X	Neutral impact - The service will continue to be delivered, however the setting may be different.

4. Complex Rehab/Medicine Day Care/Geriatric Day Care

No negative impacts on the protected characteristics were identified. There were no concerns identified for other minority populations (eg travellers, sex workers, single parents, those on low income) who may be disadvantaged by the policy or service's operation, or who may receive unequal treatment. The proposal does not directly/indirectly discriminate against any section of the community.

	Negative Impact	Positive Impact	Neutral Impact	Reason(s)
Age			X	Patients are still entitled to receive alternative community care.
Disability – including physical, sensory or mental		X		The location of more community services will benefit those who find difficulty in travelling.
Gender - including transgender and issues relating to pregnancy and maternity			X	Patients are still entitled to receive alternative community care.
Race/Ethnicity			X	Patients are still entitled to receive alternative community care.
Religion or Belief			X	Patients are still entitled to receive alternative community care.
Sexual Orientation – including issues relating to marriage and civil partnerships			X	Patients are still entitled to receive alternative community care.

5. Renal Conservative Management

No negative impacts on the protected characteristics were identified. There were no concerns identified for other minority populations (eg travellers, sex workers, single parents, those on low income) who may be disadvantaged by the policy or service's operation, or who may receive unequal treatment. The proposal does not directly/indirectly discriminate against any section of the community.

	Negative Impact	Positive Impact	Neutral Impact	Reason(s)
Age			X	The service will be delivered via an alternative pathway in the community. There is no impact to specific age groups.
Disability – including physical, sensory or mental		X		As the service will be decommissioned and patients managed along an alternative community pathway, there is potential for a negative impact on patients with renal failure as they will be managed by general community services rather than clinicians specialising in the management of renal failure. However it was felt that the service is inequitable as patients with other progressive/palliative conditions are already seen by general community services. In addition to this clinical feedback from an existing end of life community service has confirmed that this cohort of patients does not have needs that are over and above what can be managed in the community.
Gender - including transgender and issues relating to pregnancy and maternity			X	Neutral impact - The service will be delivered via an alternative pathway in the community. There is no impact to specific genders.
Race/Ethnicity			X	Neutral impact - The service will be delivered via an alternative pathway in the community. There is no impact to this protected group.
Religion or Belief			X	Neutral impact - The service will be delivered via an alternative pathway in the community. There is no impact to this protected group.
Sexual Orientation – including issues relating to marriage and civil partnerships			X	Neutral impact - The service will be delivered via an alternative pathway in the community. There is no impact to this protected group.

6. CFS

A negative impact was identified for patients with CFS/ME and this is mitigated through the commissioning of the service in line with NICE guidance. Also, through the transition, assurance will be gained that staff have specific training relevant to CFS/ME. No other negative impacts on the protected characteristics were identified. There were no concerns identified for other minority populations (eg travellers, sex workers, single parents, those on low income) who may be disadvantaged by the policy or service's operation, or who may receive unequal treatment. The proposal does not directly/indirectly discriminate against any section of the community.

	Negative Impact	Positive Impact	Neutral Impact	Reason
Age			X	Neutral impact - The service will be delivered via an alternative pathway in the community. There is no impact to specific age groups.
Disability – including physical, sensory or mental	X			As the service will be re-commissioned and patients managed utilising a reduced number of interventions, there is potential for a negative impact on CFS/ME patients.
Gender – including trans* and issues			X	Neutral impact - The service will be delivered via an alternative

relating to pregnancy and maternity				pathway. There is no impact to specific genders.
Race/Ethnicity			X	Neutral impact - The service will be delivered via an alternative pathway. There is no impact to this protected group.
Religion or Belief			X	Neutral impact - The service will be delivered via an alternative pathway. There is no impact to this protected group.
Sexual Orientation - including issues relating to marriage and civil partnerships			X	Neutral impact - The service will be delivered via an alternative pathway. There is no impact to this protected group.

7. Motor Neurone Home Visiting Service

A negative impact was identified in relation to patients with MND and this has been mitigated with inclusion of an appendix to the existing contract with the community provider to ensure that staff have the required skill levels. Further engagement is being carried out to support this. No other negative impacts on the protected characteristics were identified. There were no concerns identified for other minority populations (eg travellers, sex workers, single parents, those on low income) who may be disadvantaged by the policy or service's operation, or who may receive unequal treatment. The proposal does not directly/indirectly discriminate against any section of the community.

	Negative Impact	Positive Impact	Neutral Impact	Reason
Age			X	Neutral impact - The service will be delivered via an alternative pathway in the community. There is no impact to specific age groups.
Disability – including physical, sensory or mental	X			As the service will be decommissioned and patients managed along an alternative community pathway, there is potential for a negative impact on MND patients as they will be managed by general community services rather than clinicians specialising in the management of MND. Although it was felt that the service is inequitable as there is no similar service for people with other progressive conditions
Gender – including trans* and issues relating to pregnancy and maternity			X	Neutral impact - The service will be delivered via an alternative pathway in the community. There is no impact to specific genders.
Race/Ethnicity			X	Neutral impact - The service will be delivered via an alternative pathway in the community. There is no impact to this protected group.
Religion or Belief			X	Neutral impact - The service will be delivered via an alternative pathway in the community. There is no impact to this protected group.
Sexual Orientation - including issues relating to marriage and civil partnerships			X	Neutral impact - The service will be delivered via an alternative pathway in the community. There is no impact to this protected group.

Appendix 2 – Survey Demographics

Gender (7% skipped)

- Male – 35.59%
- Female – 64.41%

Is your gender the same as it was at birth? (40% skipped)

- Yes - 99.13%
- No – 0%
- Prefer not to say - 0.87%

Ethnic origin (13% skipped)

Answer Choices	Responses
White British	89.16%
White Irish	0.00%
Any other White background (including Traveller)	2.41%
White & Black Caribbean	1.20%
White & Black African	0.60%
White & Asian	0.00%
Other mixed	1.20%
Asian/Asian British Indian	1.20%
Asian/Asian British Pakistani	0.60%
Asian/Asian British Bangladeshi	0.00%
Asian/Asian British other	0.00%
Black or Black British Africa	0.60%
Black or Black British Caribbean	0.60%
Black or Black British other	0.60%
Other ethnic group	1.81%
Total	

Age (8% skipped)

Answer Choices	Responses
0-17	0.00%
18-30	6.25%
31-65	56.25%
65 and over	37.50%
Total	

Do you consider yourself to have a disability? (11% skipped)

Answer Choices	Responses	
Yes	25.88%	44
No	40.59%	69
Prefer not to say	3.53%	6
If yes, please specify	30.00%	51
Total		170

Sexual orientation (25% skipped)

Answer Choices	Responses
Heterosexual	79.86%
Gay	1.39%
Lesbian	0.69%
Bisexual	3.47%
Prefer not to say	14.58%
Total	

Religion or belief (15% skipped)

Answer Choices	Responses
No religion	22.16%
Bahai	0.60%
Christian	62.28%
Jain	0.00%
Jewish	0.60%
Hindu	0.60%
Muslim	1.80%
Sikh	0.00%
Prefer not to say	6.59%
Other (please specify)	5.39%
Total	

Marital/ civil partnership status (7% skipped)

Answer Choices	Responses
Single	15.82% 28
Married	63.84% 113
Civil Partnership	2.26% 4
Divorced	6.21% 11
Separated	2.26% 4
Widowed	6.21% 11
Prefer not to say	3.39% 6
Total	177

Are you currently pregnant? (22% skipped)

- Yes - 1.34%
- No - 97.32%
- Prefer not to say - 1.34%

