Nottinghamshire County Council

Health Scrutiny Committee

Tuesday, 10 September 2019 at 10:30

County Hall, **West Bridgford, Nottingham, NG2 7QP**

AGENDA

Notes

(1) Councillors are advised to contact their Research Officer for details of any Group Meetings which are planned for this meeting.

(2) Members of the public wishing to inspect "Background Papers" referred to in the reports on the agenda or Schedule 12A of the Local Government Act should contact:-

Customer Services Centre 0300 500 80 80

(3) Persons making a declaration of interest should have regard to the Code of Conduct and the Council's Procedure Rules. Those declaring must indicate the nature of their interest and the reasons for the declaration.

Councillors or Officers requiring clarification on whether to make a declaration of interest are invited to contact Noel McMenamin (Tel. 0115 977 2670) or a colleague in Democratic Services prior to the meeting.

(4) Councillors are reminded that Committee and Sub-Committee papers, with the exception of those which contain Exempt or Confidential Information, may be recycled.

(5) This agenda and its associated reports are available to view online via an online calendar - http://www.nottinghamshire.gov.uk/dms/Meetings.aspx

Nottinghamshire County Council

minutes

HEALTH SCRUTINY COMMITTEE

Tuesday 23 July 2019 at 10.30am

Membership

Councillors

Keith Girling (Chair)
Richard Butler
Errol Henry
David Martin
Liz Plant
Kevin Rostance (Items 1-5 inclusive)
Steve Vickers
Stuart Wallace
Muriel Weisz
Yvonne Woodhead
Martin Wright (Vice-Chair)

Councillors in attendance

Boyd Elliott
John Longdon

Officers

Martin Gately	Nottinghamshire County Council
Noel McMenamin	Nottinghamshire County Council

Also in attendance

Ajanta Biswas	Healthwatch Nottingham and Nottinghamshire
Daniel Burdett	NHS Property Services
James Bray	NHS Property Services
Lucy Fitzhugh	NHS Property Services
Mark Swain	NHS Property Services
Lucy Dadge	Greater Nottingham CCG
Dr Keith Girling	Nottingham University Hospitals Trust
Dr Jonathan Brewin	Nottinghamshire Healthcare Trust
Dr Deb Wildgoose	Nottinghamshire Healthcare Trust

1. MINUTES

The minutes of the last meeting held on 18 June 2019, having been circulated to all Members, were taken as read and were signed by the Chair

2. APOLOGIES

Sarah Collis. - Healthwatch Nottingham and Nottinghamshire

The following temporary change of membership for this meeting only was reported:

- Councillor Errol Henry had replaced Councillor Kevin Greaves.

3. DECLARATIONS OF INTEREST

None.

4. NHS PROPERTY SERVICES

James Bray, Daniel Burdett, Lucy Fitzhugh and Mark Swain, Senior Asset and Facilities Managers at NHS Property Services, introduced the item, providing an overview of the services provided by the organisation, its values and achievements and headline points from its Operational Plan going forward.

The Committee had previously raised concerns in respect of the role of NHS Property Services in the Whyburn Practice in Hucknall, and noted that a separate update specifically on the Practice was scheduled for October 2019.

The following points were made during a wide-ranging discussion:

- The settlement in respect of the Whyburn Practice was the subject of a confidentiality clause and could not be discussed in detail;

- It was explained that between 2013 and 2015, NHS Property Services applied the costing structures applicable during Primary Care Trust stewardship of GP practices, which did not reflect true cost. A true cost model was introduced in 2016, while NHS Property Services moved to a ‘market rent’ model in 2016/17, based upon independent market valuations;

- Attendees advised that they became involved with the Whyburn Practice in September 2018, and were not aware that there had been an ongoing dispute for 5 years;

- Some NHS Property Services customers had been unhappy with these changes, which and had refused to engage meaningfully with the changes introduced by the organisation. For its part, the organisation acknowledged that its direct engagement with customers was initially not as robust as it was now;

- While the National Audit Office (NAO) had identified almost £700 million debt remained outstanding to NHS Property Services, there was no intention that

this would be written off, rather, the organisation would work with customers to explain that the charges were valid and seek to recoup arrears;

- While recognising the significant cultural changes in NHS property management in recent years, GP practices were businesses and there needed to be a realisation that it was reasonable for tax payers to expect true costs to be recouped. All Priority 1 and Priority 2 customers in debt would be subject to face-to-face interviews by end September 2019;

- 6% of the organisation's property portfolio was currently vacant, which was low by sector standards. Better charging would secure more optimum use of available space, with non-viable properties decommissioned and sold off or relet;

- Previously hidden costs, such as carrying out essential periodic electrical safety testing, now needed paying by customers, and this culture change had been problematic. It was pointed that engagement was a two-way process, and the organisation was always willing to respond positively to engagement from customers. The organisation's website was much more streamlined in respect of customer contact;

- The organisation's representatives stated that they would not send bailiffs in to properties in arrears, but they would welcome some form of enhanced enforcement powers to increase leverage with resistant customers;

- A rolling Estates Strategy Review was under way, and would consider where there was surplus/insufficient capacity as part of a robust evidence-based exercise;

- It was confirmed that Hardship Funds were available, but required practices to provide accounts details, so uptake was low;

- NHS Property Services agreed that it was not appropriate to bill customers for use of utilities that they didn't use, but pointed out that they were responsible for over 1.8 million data input points, and some errors, while regrettable, were inevitable.

The Chair thanked Mr Bray, Mr Burdett, Ms Fitzhugh and Mr Swain for their attendance at the meeting, and asked for an update in July 2020.

5. NOTTINGHAM TREATMENT CENTRE

Lucy Dadge, Executive Director for Commissioning, Greater Nottingham CCGs and Dr Keith Girling, Medical Director, Nottingham University Hospitals trust (NUH) introduced the report, providing an update on handover arrangements for the Nottingham Treatment Centre from Circle Health Group to the NUH.

Ms Dadge and Dr Girling made the following points:

- Both Circle and NUH had worked very closely and under stringent time pressures to ensure a smooth service transfer by the transfer date of 29 July

2019, covering buildings and equipment, staffing levels, patient records, and a raft of other areas;
- TUPE arrangements were well in hand, with around 600 Circle staff expected to transfer to NUH imminently;
- The CCG was working closely with NUH to ensure that the very complex logistical challenges involved in transferring services were being addressed.

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The following points were made in discussion:

- Both the CCG and NUH were aware of correspondence to the Committee from the Circle Health Group, raising several clinical and operational risks, and advising that the CCG and NUH had not yet advised Circle of mitigations being put in place to mitigate those risks. In response, Dr Girling explained that it was the CCG, as commissioner, that required and received the necessary assurances, and not the soon-to-be former service provider;

- A key focus for NUH was on providing a seamless transition on Day One post-transition. The smooth operation of the Patient Administration System was essential, and NUH would continue to have access to the old system in case of difficulties. Also, the contract for the current outsourced pharmacy had been extended by 3 months to ensure continuity of service;

- It was acknowledged that there were around 90 ad hoc staff – not full-time equivalents - from a variety of sources other than NUH and Circle whose transition had proved difficult, primarily because NUH could not contact them directly because of GDPR requirements. More than half had agreed to continue working under the new arrangements, with half of the remainder expected to remain as well;

- NUH would seek to reduce reliance on a large number of ad hoc staff for service delivery going forward and confirmed that the temporary closure of the Short Stay Unit was not as a result of uncertainty over cover from this cohort of staff;

- The NUH acknowledged that there were issues in respect of pensions arrangements for a small number of staff, which the Trust was committed to resolving. It was also pointed out that TUPE arrangements did not have a time limit, but rather could only be changed through the offer and acceptance of revised contract arrangements for affected staff;

- The CCG confirmed that whoever had been successful in the bid process would have been expected to deliver innovation and service transformation;

- A phased replacement plan was in place for the scanning equipment being transferred to NUH, but this would not affect short-term transition arrangements.

The Chair thanked Ms Dadge and Dr Girling for their attendance at the meeting, and requested that they provided an update at the Committee's January 2020 meeting.

6. NOTTINGHAMSHIRE HEALTHCARE TRUST CQC INSPECTION

Dr John Brewin, Chief Executive and Dr Deb Wildgoose, Interim Head of Nursing, Nottinghamshire Healthcare Trust introduced the report, providing information on the Care Quality Commission's findings arising from its inspection of the Healthcare Trust, the the actions being taken to address shortcomings identified and explaining how actions and improvements will be assured.

In his introduction, Dr Brewin acknowledged that the inspection report was fair, reasonable and an accurate reflection in respect 'safety' responsiveness' and 'leadership' of services requiring improvement.

A number of points were raised in the discussion which followed:

- Dr Brewin identified lack of clear leadership, lack of clarity of purpose and poor levels of communications, engagement and trust with staff as key areas to improve, and that the Trust's Quality Committee would be reporting regularly to the Trust's Board on progress to address these areas;

- Dr Brewin agreed with Committee members that improvement could only be delivered in an environment free from fear of retribution for raising issues of concern;

- Dr Brewin accepted the criticism that the Trust had been too insular in its approach, had not fully engaged with the Health and Wellbeing Board and had stopped being a learning organisation by not tapping into staff's knowledge and expertise;

- A new Executive Team with clear responsibilities was being assembled, and it was expected that by the end of 2019 around two-thirds of Board members would have been replaced;

- Regular meetings with CQC were taking place so that improvements were being tracked and that future inspection outcomes would not come as a surprise to the Trust

- The Trust had a strong track record of patient engagement but was less competent in engaging with the wider public. Engagement in all areas of the Trust's work was central to its changing its organisational culture, and would help improve other areas, including staff retention.

The Chair thanked Drs Brewin and Wildgoose for their attendance and invited them to attend the Committee's February 2020 meeting to provide an update on delivering the improvements required.

7. WORK PROGRAMME

The Committee agreed the following amendments to the work programme, arising from the meeting:-

NHS Property Services

Add to July 2020 meeting

Nottingham Treatment Centre

Add to January 2020 meeting

Nottinghamshire Healthcare Trust Inspection Follow-up

Add to February 2020 meeting.

The meeting closed at 12.56pm.

CHAIRMAN

Nottinghamshire County Council

Report to Health Scrutiny Committee

10 September 2019

Agenda Item: 4

REPORT OF THE CHAIRMAN OF HEALTH SCRUTINY COMMITTEE

NATIONAL REHABILITATION CENTRE

Purpose of the Report

1. To allow the Health Scrutiny Committee to receive the latest information regarding the National Rehabilitation Centre (NRC).

Information

2. The National Rehabilitation Centre (NRC) is a new facility for injured military personnel in the South of Nottinghamshire at the Stanford Hall Estate. Construction started in 2015 for the facility and the centre began treating its first patients at the end of 2018. The NRC is a world class centre of clinical excellence that will contribute to the redesign and improvement of rehabilitation services across the region. Patients from across the East Midlands, including from Nottinghamshire, will benefit from this development, as well as injured service personnel.

3. Dr Amanda Sullivan, Chief Officer, Nottinghamshire CCG, Lucy Dadge, Chief Commissioning Officer and Hazel Buchanan, Director of Operations will attend the Health Scrutiny Committee to brief Members on engagement that has taken place regarding the NRC and answer questions as necessary. A written briefing is attached as an appendix to this report. Further appendices contain findings from qualitative research with patients and carers, an Equality Impact Assessment and a Travel Impact Analysis.

4. Members will wish to consider carefully the impact of the NRC on already existing services and their patients (e.g. the 24 beds at Linden Lodge on the City Hospital site currently expected to transfer to the NRC). Within the briefing document the Health Scrutiny Committee is specifically asked to consider the nature and extent of further engagement and consultation required with the public in relation to this service change. Members will also wish to form a view on the associated issue of whether or not this change represents a substantial variation or development of service.

RECOMMENDATION

That the Health Scrutiny Committee:

1) Consider and comment on the information provided.

2) Schedule further consideration as necessary.

Councillor Keith Girling
Chairman of Health Scrutiny Committee

For any enquiries about this report please contact: Martin Gately – 0115 977 2826

Background Papers

Nil

Electoral Division(s) and Member(s) Affected

All

1.0 Introduction

A strategic planning document called a pre-consultation business case (PCBC) has been developed for the National Rehabilitation Centre (NRC) and outlines the case, in preparation for engagement, for a regional clinical facility which is one part of the National Centre. The PCBC is an initial stage in an extended programme of work that includes building a new facility.

The NRC is a proposal for a new rehabilitation facility that sits alongside the Defence Medical Rehabilitation Centre, at Stanford Hall Rehabilitation Estate (SHRE) near Loughborough and is planned to open Spring 2023. The NRC is a catalyst for the transformation of rehabilitation services across the whole pathway.

The NHS proposal has been made possible through a donation of land and approval from the Government for capital funding for the clinical facility. The NRC will have state of the art facilities including 63 clinical beds, a research and innovation hub and training and education centre. It is expected that the NRC will help to address a current gap in rehabilitation by increasing capacity in the East Midlands including treating a wider cohort of patient conditions.

Other than for capital, there is no additional funding for the NRC and therefore, one of the aims of the programme is that it must be affordable to both the commissioners and providers, taking account of current funding flows. The finance case indicates that this requires transferring beds from Nottingham University Hospitals NHS Trust (City and QMC campuses), releasing acute beds currently occupied by medically fit rehabilitation patients, and transferring patients directly to rehab instead of repatriating them back to an acute bed and overall shorter lengths of stay. Opportunities will be further refined within the context of reviewing and transformation across the whole pathway.

The NRC is an opportunity to create a high-quality centre of rehabilitation excellence in the East Midlands. The provision of more intensive rehabilitation across a wider cohort of patients will improve patient outcomes. There is a deficit in rehabilitation capacity across the East Midlands and the NRC is an opportunity to start to address this and improve access to services.

Focussed patient engagement has been carried out and this will be expanded on as the clinical model and financial case are further developed. It is also planned that ongoing developments will be supported through co-designing rehabilitation services with patients, citizens, service users and carers alongside clinicians and specialists. The Health Scrutiny Committee is asked to consider the nature and extent of further engagement and consultation required with the public in relation to this service change.

Background

The Defence Medical Rehabilitation Centre (DMRC) opened in 2018. The Stanford Hall Rehabilitation Estate was conceived from the outset as a facility where serving defence personnel and NHS patients could all benefit from a bespoke state of the art environment for rehabilitation where facilities and expertise could be shared. The Duke of Westminster purchased the Stanford Hall estate solely for this intention and has passed the site into the ownership of a charitable trust, Black Stork Charity. The vision for the National Rehabilitation Centre for NHS patients is in three parts:

- a regional clinical unit and national centre of excellence
- a national training and education centre
- a national research and innovation hub.

Co-location with the defence centre would mean that NHS patients would benefit from access to facilities and equipment at the DMRC which are not available anywhere else in the UK.

In October 2018 the Government announced the allocation of £70m capital funding on the basis that it is spent to create an NHS facility at Stanford Hall. In November 2018 planning consent was received for the NRC.

With respect to identifying the opportunity this could offer, a series of reports in recent years have assessed the level of services for patients who have a rehabilitation need and outcomes from rehabilitation and these have established the following:

- the UK and particularly the East Midlands are underprovided for in relation to current need – in the East Midlands rehabilitation bed provision is at 33% of the level recommended by the British Society of Rehabilitation Medicine (BSRM)
- there is wide unwarranted variation in how rehabilitation is provided across the country and that rehabilitation is often uncoordinated
- owing to the under provision and lack of a coordinated pathway, patients endure long waits for access to rehabilitation and often need to be repatriated' to their local district general hospitals or Trauma Units from a Major Trauma Centre, to wait for a specialist rehabilitation bed to become available
- there is a substantial body of trial-based evidence and other research to support both the effectiveness and cost-effectiveness of specialist rehabilitation.[1]
- early transfer to specialist centres and more intense rehabilitation programmes are cost-effective[2,3], particularly in the small group of people who have high care costs due to very severe brain injury[4,5,6].
- despite their longer length of stay, the cost of providing early specialist rehabilitation for patients with complex needs is rapidly offset by longer term savings in the cost of community care, making this a highly cost-efficient intervention[7].
- for those patients who did receive specialist rehabilitation there was evidence of functional improvement in the vast majority (94%)
- that rehabilitation has been demonstrated to be very cost effective within a healthcare system. With a mean length of stay of 65 days, at a cost of £39,398 and reduced ongoing healthcare cost per patient of £536 per week, the cost of rehabilitation was found to be recouped within 17 months, with savings on ongoing healthcare costs of just over £500,000 per patient over their lifetime.

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[1] Turner-Stokes L, Disler PB, Nair A, Wade DT. Multi-disciplinary rehabilitation for acquired brain injury in adults of working age. Cochrane Database of Systematic Reviews July 2005, 20(3): Cd004170. Updated 2015.

2 Andelic N, Bautz-Holter E, Ronning P, Olafsen K, Sigurdardottir S, Schanke AK, Sveen U, Tornas S, Sandhaug M, Roe C: Does an early onset and continuous chain of rehabilitation improve the long-term functional outcome of patients with severe traumatic brain injury? Journal of Neurotrauma 2012, 29: 66–74.

3 Bai Y, Hu Y, Wu Y, Zhu Y, He Q, Jiang C, Sun L, Fan W: A prospective, randomized, single-blinded trial on the effect of early rehabilitation on daily activities and motor function of patients with hemorrhagic stroke. Journal of Clinical Neuroscience 2012, 19: 1376–1379.

[4] Turner-Stokes L, Paul S, Williams H: Efficiency of specialist rehabilitation in reducing dependency and costs of continuing care for adults with complex acquired brain injuries. Journal of Neurology, Neurosurgery and Psychiatry 2006, 77: 634–639.

[5] Turner-Stokes L: Cost-efficiency of longer-stay rehabilitation programmes: can they provide value for money? Brain Injury 2007, 21: 1015–1021.

[6] Oddy M, da Silva Ramos S: The clinical and cost-benefits of investing in neurobehavioural rehabilitation: a multi-centre study. Brain Injury 2013, 27: 1500–1507.

[7] Turner-Stokes L, Williams H, Bill A, Bassett P, Sephton K: Cost-efficiency of specialist inpatient rehabilitation for working-aged adults with complex neurological disabilities: a multicentre cohort analysis of a national clinical data set. BMJ Open 2016, 6 :e010238

- the UK lags behind many other countries, with 50%-60% of people returning to work after a major injury after 6 months in Europe and the USA, while in the UK the figure is just 37%.
- there is also a disparity in performance between UK defence personnel performance and overall performance with 85% of military patients returning to military duties, against the overall, average UK figure of 37% at 6 months post-injury.
- the findings from several studies in the past few years, and the defence model such as that provided at the DMRC, all support early intervention and ensuring that patients are in the right setting for the appropriate stage in their recovery, particularly in the realm of return to work. Integrated service models have proved the most efficient, especially if associated with some degree of flexibility.
- this data indicates that there is an opportunity to dramatically improve outcomes for patients, including return to work rates. The benefits of a high-quality rehabilitation service with the capacity to provide early interventions, focused on work outcomes for people with ill health are significant:

    - reductions in sick leave and lost work productivity by more than 50%
    - savings in healthcare costs by two thirds
    - savings in disability benefits by 80%
    - reductions in permanent work disability and job loss by 50%
    - societal benefits by supporting people optimize functional capacity.

The overall provision of rehabilitation in the East Midlands is currently 85 beds. This is entirely provided for neurological patients. There is currently no provision for complex orthopaedic injuries and minimal provision for patients with amputations. The British Society of Rehabilitation Medicine (BSRM) recommends rehabilitation provision of between 45 and 65 beds per million people, or 60 per million excluding stroke services. With a population of 4.6million people and taking a mid-point of 55 beds per million, this would indicate an overall requirement for 253 beds, indicating a shortfall of 168 rehabilitation beds across the region or, put another way, only 33% of the recommended level of provision is currently being provided in the region with the busiest Major Trauma Network.

The Facilities

The proposed NHS facility at the NRC would contain 63 beds, comprising 40 neurological and major trauma rehabilitation beds (a net increase of 16), 18 new complex MSK rehabilitation beds and 5 new rehabilitation beds for other patients. This represents a net increase of 39 rehabilitation beds for the region. It is expected that the NRC would treat circa 800 patients per year.

Patients and clinicians at the NRC will have full access to the Stanford Hall Rehabilitation Estate which has been designed to optimise rehabilitation with recreational facilities, hand cycle tracks and trim trails. The NHS will also have access to state of the art equipment including Computer Aided Rehabilitation Environment (CAREN - The CAREN system enables patients with a disability to practice real-life situations in a safe and controlled environment, leading to improved physical stamina, better cognitive skills, dual tasking and improved confidence), Gait Lab, Prosthetics Lab, x-ray, MRI, Hydrotherapy Pool. It is expected that the facilities will facilitate the sharing of knowledge and expertise across the defence medical service and the NHS, driving forward rehabilitation practices.

Recognising the importance of friends and family in a patient's recovery, the plans include overnight accommodation for visitors.

2.0 Proposed Clinical Model

2.1 Overview

The National Rehabilitation Centre will be able to provide rehabilitation for a wider group of patients than at present through criteria that are no longer based on specific clinical conditions. Therefore, this supports the need to consider the clinical model in the context of the full pathway and patient journeys for rehabilitation.

The proposed criteria for admission to the NRC are the following:

- patients who have a rehabilitation need and potential
- patients who are able to cope with an intensive rehabilitation programme
- patients who could potentially benefit from occupational and vocational rehabilitation

Patients will be assessed for rehabilitation services at the NRC through a single point of referral staffed by Consultants from Trusts across the East Midlands Trauma Network. By having the single point of referral, individuals can be considered for other units where they may not benefit from rehabilitation at the NRC which will ensure that all patients are treated in the most appropriate unit relative to their needs. This will help to manage activity efficiently and ensure that patients' are receiving the right care, right time, right place.

Patients will benefit from a comprehensive range of rehabilitation services provided by a multidisciplinary team of specialists. Services will be provided for the following conditions:

- Major trauma
- Neurosciences
- Neurological
- Complex MSK
- Traumatic amputees
- Severely deconditioned patients

The NRC's rehabilitation programme will enable patients to benefit from a more intensive treatment regime delivered six days per week and including a mixture of group and 1:1 sessions. Patients will benefit from out of hours access to two gyms that will allow patients to continue their own rehabilitation outside formal sessions, supported by a non-clinical member of staff. The grounds and other shared DMRC facilities will also contribute to patients' efforts to rehabilitate.

Patients will also benefit from an increase in speciality care. Clinicians in the NRC will be fully focused on rehabilitation and they will benefit from the knowledge sharing with other, equally focused, clinicians from both the NRC and the DMRC.

A new staffing model has been developed with an increased emphasis on use of rehabilitation assistants and exercise therapists. The model for other staff is broadly consistent with existing staffing levels but the way those staff are used will be changed in line with the group work set out above. Another change is the introduction of the trusted assessor. This principle has been introduced to ensure that an assessment made in one unit is accepted by the next.

Whilst it is intended to provide NHS patients with access to facilities in the DMRC not available within NHS services, it is not envisaged that patients in the defence and NHS facilities would ever receive treatment in the same place at the same time. NHS staff would treat NHS patients and be responsible for them whilst on DMRC premises.

Early planning for discharge and return to life and work will be offered at the NRC, enabling the transition from inpatient rehabilitation to home and community based services, if required, to be timely and smooth.

2.2 Clinical Senate Recommendations

Within the NHS, Clinical Senates have been established as a source of independent and objective clinical advice and guidance to local health and care systems, to assist them to make the best decisions about healthcare for the populations they represent.

On the 29th July a Clinical Senate Panel was held to review the proposal and in particular, the clinical model for the NRC. The Senate highlighted that the NRC represents a tremendous opportunity and asset for the region which has the potential to address a significant rehabilitation gap.

The Clinical Senate have provided four recommendations will be taken forward to further develop the service specification and clinical model.

Recommendation 1 - It was recommended that an objective tool for assessment of patients (referral criteria) should be developed and underpinned by clinical policies to ensure there is equity both across clinical conditions and different patient groups.

Recommendation 2 - It was recommended that a clear workforce plan should be developed detailing the staffing required and subsequent training, which should focus on a greater need for a rehabilitation workforce and alternative roles. This should include scientific staff and how specialties such as neuropsychiatry would be accessed.

Recommendation 3 - It was recommended that a detailed discharge planning process is developed with a secure and clear exit pathway, which ensures there is a smooth interface with community provision and ongoing rehabilitation.

Recommendation 4 **-** It was recommended that further detailed cost benefit analysis needed to be undertaken, which should include metrics such as Disability Adjusted Life Years (DALY); a measurement of the gap between current health status and an ideal health situation where the entire population lives to an advanced age, free of disease and disability. It was also recommended that work is undertaken to audit currently occupied rehabilitation beds against those admission criteria.

3.0 Impact Assessments

A travel impact analysis and equality impact assessment have been carried out and the findings from these will be explored further through ongoing engagement. The Impact Assessments are attached.

3.1 Travel Impact Analysis (TIA)

The travel impact analysis was done on the basis of lower super output areas (LSOA) across Nottinghamshire, Derbyshire, Lincolnshire and Leicestershire, with the assumption that patients were treated in the nearest hospital to that LSOA. This showed that patients live on average 10.7 miles from the nearest hospital and this can vary from 3.2 miles on average for Leicester City patients to 39 miles for those from South Lincolnshire.

If all patients were instead treated at the proposed National Rehabilitation Centre, most people would have to travel further to visit patients. Patients would be treated on average just under 25 miles from home – a further 13.9 miles compared to the nearest current hospital. Patients live on average 20 minutes by car from their nearest current site and this would increase to 39 minutes for a single journey to the NRC. It would take two hours and five minutes on average to travel to the NRC by public transport.

The TIA highlights that planning for the National Rehabilitation Centre aims to transfer “patients to a rehabilitation bed in a timely way, reducing the number of patient moves, reducing the overall length of

stay for the cohort of patients and gaining improved outcomes". Reducing patient moves and the overall length of stay should mitigate some of the impact of longer travel times for visitors. There will be three family rooms available at the National Rehabilitation Centre. These facilities will offer the potential for reduced visitor travel, especially if priority is given to those living furthest from the National Rehabilitation Centre.

The Programme Team are considering four areas in planning which will help to mitigate the additional journey times including the following:

1. The design of the facilities includes three family rooms available at the National Rehabilitation Centre. These facilities will offer the potential for reduced visitor travel, especially if priority is given to those living furthest from the National Rehabilitation Centre.
2. There will be ample and free visitor parking on site.
3. There will be high speed broad band to facilitate facetime and skype.
4. Negotiations are underway with the highways agency and bus companies to improve public transport links.

3.2 Equality Impact Assessment (EIA)

The EIA highlighted that there is significant potential to improve clinical outcomes, reduce disability and address geographical inequalities in the East Midlands. Risks to equality were outlined in the EIA and the following recommendations were provided as mitigations. The recommendations have been included in the PCBC.

- Develop explicit referral criteria that state that paid employment is not the only form of vocational and occupational benefit, and that unpaid care, family support, volunteering and social engagement must also be considered.
- Support referring hospitals with training to address unconscious bias so that, on a case by case basis, older adults, people with existing disabilities (physical, sensory and learning) but a high level of motivation and ability to benefit and others who may be vulnerable to being discriminated against (e.g. people who are addicted to drugs) are considered for rehabilitation in a fair and consistent manner.
- Provide ongoing advice and support for referring hospitals on a case by case basis, so that people who may benefit but have a pre existing disability, older adults and other vulnerable people can be discussed.
- Proactively reach out to people with protected characteristics and people in ESD2 inclusion groups during the public consultation for the NRC and take action on their concerns.
- Negotiate public transport access to the site with local public transport providers.
- Use the patient cohort and research expertise at the NRC to identify and address equality issues, such as concerns raised that women are under treated due to unconscious biases around their pain response or need for rehabilitation, and other equality issues raised in the literature or during consultation.
- Ensure that the NRC and referring hospitals seek appropriate translation services when necessary.
- Take steps to address the spiritual needs of patients, where requested, by forming links with local faith communities.

4.0 Engagement

Three focus groups, telephone interviews were carried out and on-line feedback received. A discussion guide was provided on-line and to participants in order to elicit feedback in relation to the following:

- Experiences of current rehabilitation services
- What elements of rehabilitation services are most valued and what could be improved
- Views on the proposed changes as outlined in the Transforming Rehabilitation Services paper
- The potential impact of these changes from a patient perspective and ways of addressing these

The conclusions from the engagement demonstrated that patients really value the rehabilitation services that they have received from the NHS. In particular, the quality of care and attention provided by staff appears to be most appreciated by all patient groups.

Most patients were very receptive to the proposals for a National Rehabilitation Centre as outlined in the Transforming Rehabilitation Services paper. The idea of receiving care "all in one place" was appealing as well as having access to the latest technologies and therapies. The biggest concern for many was losing access to the personal connections they had made with staff who had cared for them. People wanted reassurances that these members of staff would still be in their roles as part of their changes and / or could have access to them. The idea of building new relationships with new teams was a bit daunting for some.

There was some scepticism expressed by a small number of participants who did not think that the plans would be viable in the long-term and that existing services should be invested in instead.

Most people were willing to travel further if necessary to access better services. However, they wanted to make sure that it would also be easy for their families to visit them and affordable for them. This was a particularly important issue for younger patients.

The small number of people who felt they would not travel further to access services at the proposed National Rehabilitation Centre cited convenience and familiarity with the services they received by people they trusted as the main reasons for not doing so.

Many participants recognised the opportunities that having one centre with access to the latest research and expertise provided by a national education centre presented particularly in terms of improving their health outcomes more quickly.

Some people, while supportive of the proposals, still felt that "it sounded too good to be true". It was felt that more information was needed about: The types of services patients could access; Clarity about what would happen to existing services; The costs to the patients and their families / visitors; How the Centre would be financed in the long-term not just the short-term.

The full report is attached.

5.0 Finance Case

The Finance Case describes the impact of the 63 bed facility and the corresponding proposed activity model. The capital required for the research and innovation hub and education and training centre will be considered as part of the Strategic Outline Case. Revenue options for these elements of the facility have not been incorporated in the finance case at this stage.

The finance case has been developed to understand the likely impact from the provision of a net increase of 39 specialist rehab beds across the East Midlands and associated transfers of agreed activity and beds from the system.

It has taken into account the known capital and revenue consequences at this stage from the increase in specialist rehab provision and decrease in acute beds.

The basis of the proposal and the financial case has been made on the following assumptions:

- The current activity and resources from the 24 beds at Linden Lodge will transfer to the NRC from the current site at City Hospital. Linden Lodge is in need of considerable repair and backlog maintenance liabilities of £673k have been identified.
- The current activity and resources from 34 Trauma/MSK/Neuro inpatient beds at NUH will transfer to NRC.
- The remaining 5 beds of activity will be filled from other sources across the system and most likely to be: referrals from other acute providers, repatriation from NHS funded private sector activity or step down from other level 1 or 2a specialist rehab units.

Further work will be carried out on the financial case as there remains a revenue pressure and therefore a gap in funding. This will be done in the context of a review of the whole pathway for rehabilitation. In order to ensure that the NRC is affordable additional direct cash releasing benefits will need to be identified to offset either provider or commissioner costs to fund the preferred option.

6.0 Conclusion

The NRC proposal will deliver a step change in the provision of rehabilitation services in the East Midlands, including as a catalyst for the transformation of rehabilitation services and in providing the opportunity for a regional centre of excellence with best practice and advances being rolled out nationally. The NRC will have the capability to achieve the following benefits:

- creating a high-quality centre of rehabilitation excellence
- addressing a clear deficit in rehabilitation capacity
- improving access to services
- improving outcomes and the patient experience through a new clinical model
- be future ready, able to respond to changes in future service needs and models
- reducing pressures on the acute bed base
- reducing pressures on primary and community health services
- reducing system financial pressures and provide a saving to the health and social care system and wider economy by:
    - reducing waits in acute beds
    - reducing the overall length of inpatient stay
    - delivering better outcomes will reduce the need for ongoing health and social care costs
    - returning more people back to work will contribute significantly to the economy through taxes and increased spend of individuals
    - reducing the burden on family members to be main carers
- returning people to work and active lives
- helping patients benefit from clinical, education and training and research and innovation synergies
- improving recruitment, retention, education, training and skills for clinical staff
- improving research and innovation

The proposal has been more fully defined through the Pre-Consultation Business Case and work continues to take the finance case and clinical model through the next phase in preparation for the decision making business case. As a result there are further, more detailed decisions to be made and ongoing involvement will be carried out, in addition to the engagement and/or consultation on the Pre-Consultation Business Case. It is important that the next phase of engagement includes co-designing rehabilitation with patients, citizens, service users and carers alongside clinicians and specialists.

Next Steps

The Health Scrutiny Committees are requested to consider the proposal on its stated merits and give consideration of requirements at this stage with regard to the CCG's statutory duties for involvement of patients in implementing major service change.

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Findings from qualitative research with patients and carers

July 2019

Contents

1 Background

The NHS has an ambitious vision to transform rehabilitation services in the East Midlands and to establish a world-class centre of excellence for rehabilitation in the region. As part of developing the business case for this, *Transforming Rehabilitation Services* was produced in April 2019 - a paper outlining the plans for transforming rehabilitation services and seeking the views of patients and their families to shape the proposals for the new services.

Patients, carers and other people with an interest in rehabilitation services from across the region have been encouraged to have their say on this issue over a two month period of engagement.

As part of the engagement process, an independent research agency, The Campaign Company (TCC), was commissioned to carry out focus groups and depth interviews with patients across the East Midlands who are currently undergoing rehabilitation or who have recently used rehabilitation services following neurological, musculoskeletal or major trauma.

This report sets out the findings from this qualitative research.

2 Our approach

The overarching aim of the research was to obtain qualitative insight, through focus groups, on patients' experiences of rehabilitation services in the region and their views on the proposals for change.

Focus groups were conducted in NHS or community venues with key patient groups in the following areas:

- **Linden Lodge, Nottingham** – a specialist Neurological Rehabilitation Unit at Nottingham City Hospital which caters for a wide range of neurological conditions for patients across East Midlands (10 participants – 8 patients and 2 carers)
- **East Midlands Major Trauma Centre, Nottingham** – established at Queen's Medical Centre, this Major Trauma Centre is for patients who have multiple injuries that could result in death or a serious disability such as severe head injuries, gunshot wounds or injuries from road accidents (8 participants – 4 patients at focus group and 4 telephone interviews with patients)
- **Headway Derby** – a community-based charity, working closely with the local NHS and Derby City Council, to provide a range of support and development services for brain injured people, their families and carers in Derbyshire. (8 participants – 5 patients and 3 carers/support workers)

A discussion guide was developed for the groups to specifically elicit the following insight:

- Experiences of current rehabilitation services
- What elements of rehabilitation services are most valued and what could be improved
- Views on the proposed changes as outlined in the *Transforming Rehabilitation Services* paper
- The potential impact of these changes from a patient perspective and ways of addressing these

Since it could not be assumed that participants had read the *Transforming Rehabilitation Services* paper, each session also included a contextual presentation of the proposed plans for a National Rehabilitation Centre, as outlined in the paper. This allowed participants to have an informed discussion about the proposals.

It should be noted that qualitative research such as this captures perceptions and attitudes rather than quantifiable data. The aim of this is to accurately capture and assess the range of points put forward rather than to quantify the number of times specific themes or comments were mentioned. Larger amounts of data are needed to analyse information quantitatively and to ensure these are representative of the population.

Relevant NHS commissioners and providers carried out the recruitment for these groups. Their help in enabling these groups is appreciated and we are extremely grateful for the active participation of all patients and carers who took the time to share their views to inform this research.

3 Findings from patient and carer insight

This section of the report provides an overview of the findings from the three focus groups and supplementary telephone interviews. Any differences by type of service or patient groups is noted where relevant.

3.1 Experiences of rehabilitation services

"The staff here are wonderful – I wouldn't have been able to get through this without them"

"I'm just so grateful – everything I've needed I've received. Ok – so there are some things that could have been better like the food and communications sometimes but I can't complain"

"Being so close to home was important for me because it meant my Mum and Dad could see me every day

All participants were current or recent long-term users of rehabilitation services so were able to speak knowledgeably about their experiences at their current facility and other places in the East Midlands (eg Leicester Royal Infirmary and Royal Derby Hospital). where they had received care.

All participants really valued the services that they had received during their rehabilitation. The friendly and attentive staff were mentioned most often as being the most important element of care that they valued. Also important to some was location and convenience particularly for their visiting families. This was particularly important for younger patients who had to stay in hospitals.

The elements of care or services that people felt could be improved included:

- Food – a number of people reported that their families used to have to bring them meals from outside on a regular basis
- Access to more 'modern' equipment – some people said that in places were there was only one or two scanners (for example), they often had to wait – especially if one of the machines had broken down
- Access to different treatment and therapies – eg hydrotherapy, emotional support, physiotherapy
- Better communication about care – especially between teams

- Better wheel chair access on all sites
- Better social facilities eg TV, internet access

3.2 Initial views about the National Rehabilitation Centre

"It sounds absolutely great. Everything in one place – and all the equipment would be new probably. Why wouldn't you want that?"

"Having access to specialist staff and the latest research is really important. I would feel my husband was really getting the best care"

"I've seen the Defence place on the news – it looks really good. And everyone knows that the military has all the latest treatments".

"It sounds too good to be true – what's the catch?"

Most participants thought that the idea of a National Rehabilitation Centre was really good. Some were particularly taken by the idea that patients in the East Midlands would have first access to it.

The most attractive features appeared to be the ability to access high quality care, treatment, equipment and expertise all in one place. Both patients and carers felt this would speed up the process of rehabilitation. Patients at the Major Trauma Centre and patients with musculoskeletal injuries particularly highlighted the importance of access to high quality physiotherapy and related services. Access to hydro-pools, cycle tracks and gym equipment were particularly important to them.

People also felt that having a national training and education centre located at the same site as well as research facilities could only benefit patients in the long-term since they would have access to both expertise and research innovations first.

Some people who had heard of the Defence Medical Rehabilitation Centre and had followed its development on the news mentioned the attractive setting, the latest equipment (including a golf course) and were pleased that the proposed National Rehabilitation Centre would be aligned to this.

There was some scepticism though from a few participants. Some felt that there had to be some hidden costs for patients/their visitors and/or that patients would ultimately

bear the cost of this in the long-term. Others felt that money allocated to this should be spent on improving existing rehabilitation services that patients were familiar with.

3.3 The impact of the proposals on patients

"I only live down the road so it wouldn't be as convenient for me or my family, but if it meant I got access to the latest treatment, the best doctors, and get better more quickly then I definitely would be willing to travel further for my care"

"I would want to know that the staff that look after me here would be at the new place – trust doesn't get built overnight. I wouldn't go there if there were new teams."

"It would be a tragedy if this place had to close down because of the new Centre".

The main impact or concern of the proposals raised by participants was losing access to trusted and familiar staff. Many people were concerned that the people currently providing their care would not transfer to the new Centre and that they would have the be treated by new unfamiliar teams. Questions were also asked about what would happen to existing rehabilitation services once the new National Rehabilitation Centre was established.

Travel was not an issue for most patients – for some it would be closer than where they were currently accessing services and others were willing to travel a bit further to get access to high quality care. Travel and location was an issue for others – some lived very close to their current services so travelling to the National Rehabilitation Centre would be more expensive and inconvenient for them. Others felt that it would be very inconvenient for their families / carers. They wanted assurances that provision for families to stay with the patient (especially younger patients) were available and that costs such as parking and travel could be subsidised.

Patients with multiple conditions (eg head injuries and orthopaedic needs) who currently had to see different doctors and support teams felt these proposals would be of huge benefit to them and their carers and would save them a lot of time currently spent "waiting and travelling".

People wanted more detail or clarity about a number of other issues, in addition to those previously mentioned such as the future of current services and staff, including:

- The types of services patients could access
- The number of extra patients seen and the number of extra staff available
- Whether children and young people would have access to educational support
- How the Centre would become financially viable in the long-term

4 Conclusions

It is clear that patients really value the rehabilitation services that they have received from the NHS. In particular, the quality of care and attention provided by staff appears to be most appreciated by all patient groups.

Most patients were very receptive to the proposals for a National Rehabilitation Centre as outlined in the *Transforming Rehabilitation Services* paper. The idea of receiving care "all in one place" was appealing as well as having access to the latest technologies and therapies. The biggest concern for many was losing access to the personal connections they had made with staff who had cared for them. People wanted reassurances that these members of staff would still be in their roles as part of their changes and / or could have access to them. The idea of building new relationships with new teams was a bit daunting for some.

There was some scepticism expressed by a small number of participants who did not think that the plans would be viable in the long-term and that existing services should be invested in instead.

Most people were willing to travel further if necessary to access better services. However, they wanted to make sure that it would also be easy for their families to visit them and affordable for them. This was a particularly important issue for younger patients.

The small number of people who felt they would not travel further to access services at the proposed National Rehabilitation Centre cited convenience and familiarity with the services they received by people they trusted as the main reasons for not doing so.

Many participants recognised the opportunities that having one centre with access to the latest research and expertise provided by a national education centre presented particularly in terms of improving their health outcomes more quickly.

Some people, while supportive of the proposals, still felt that "it sounded too good to be true". It was felt that more information was needed about:

- the types of services patients could access
- clarity about what would happen to existing services
- the costs to the patients and their families / visitors
- how the Centre would be financed in the long-term not just the short-term.

Imogen Blood &
Associates

Proposed National Rehabilitation Centre in East Midlands:

Equality Impact Assessment

June 2019

Introduction

Our approach

This short report presents the findings and recommendations of a high-level Equality Impact Assessment of the Pre-Consultation Business Case for the National Rehabilitation Centre at Stanford Hall, near Loughborough.

The assessment was conducted during June 2019 by the independent consultancy Imogen Blood & Associates (IBA).

Imogen Blood and Sarah Chalmers-Page of IBA, who have extensive expertise of Equality, Diversity and Inclusion and the NHS – reviewed the following documents:

- Pre-consultation Business Case (PCBC) for the National Rehabilitation Centre (NRC)
- Stage 2 Clinical Assurance Evidence Pack

Telephone meetings were held between senior leaders in the team working on the NRC and Imogen Blood. These allowed clarification of points in the document and the scope of the Equality Impact Assessment (EIA).

At the current time, workforce is outwith the scope of this document.

Purpose and status of Equality Impact Assessment (EIA)

Under the Public Sector Equality Duty (PSED) (S.149 of the Equality Act 2010), a public authority such as a Clinical Commissioning Group, must, in the exercise of its functions, have due regard to the need to:

- Eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;
- Advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it; and
- Foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

The following characteristics are protected under the Act:

- age;
- disability;
- gender reassignment;
- marriage and civil partnership;
- pregnancy and maternity;
- race;
- religion or belief;
- sex;
- sexual orientation.

In addition, the NHS Equality Delivery System applies to CCGs and NHS England commissioning decisions. It is a set of outcomes covering patient care, access, and experience which adds to the protected characteristics a number of 'Inclusion Health groups', including (NHS 2013):

- People who are homeless
- People who live in poverty
- People who are long-term unemployed
- People in stigmatised occupations (such as women and men involved in prostitution)
- People who misuse drugs
- People with limited family or social networks
- People who are geographically isolated

What is an EIA and why conduct one?

An Equality Impact Assessment ("EIA") is an analysis of a proposed organisational policy, or (in this case) a change to the way in which services are delivered, which assesses whether plans are likely to have a disparate impact on persons with protected characteristics.(House of Commons Library 2018, p.23).

Although not explicitly required by law, EIAs are one way in which a public authority can demonstrate its compliance with the PSED:

- They can help an authority to evidence that it has considered potential equality impacts systematically and can help it to identify the actions it can take to promote equality of opportunity.
- EIAs allow authorities to pre-empt and mitigate potential 'indirect discrimination', in which a practice, policy or rule which applies to everyone in the same way but has a worse effect on some people than others.

The proposed change

The National Rehabilitation Centre (NRC) aims:

> 'To create the first National Rehabilitation Centre in England, bringing together experts in the field to deliver best practice, train our future workforce and research in the field to maximise the advances in technology and engineering to benefit this patient group'. (PCBC, v2)

The core aims of the service are:

- To reduce delays in accessing care and increase capacity to treat patients. The proposed centre will treat around 800 patients a year.
- To improve outcomes by increasing the intensity of rehabilitation, with improved return to work or other social outcomes.
- To improve facilities, equipment and knowledge through co location with the defence facility.

Patients will be referred to the service based on clinical need, avoiding the current geographical variations in care. Access will widen from neurological patients to include major trauma, complex MSK, traumatic amputees, incomplete spinal cord injury and severely deconditioned patients. These additional patient groups are currently cared for in acute beds but do not benefit from treatment in specialist rehabilitation facilities. Rehabilitation aims to enable people to return as far as possible to their day to day lives and roles.

The centre will share facilities and learning with the UK defence medical services, whose Rehabilitation Centre is co-located at Stanford Hall Rehabilitation estate in state of the art, bespoke new facilities, some of which the NHS patients will be able to share. This includes the hydrotherapy pool, diagnostics equipment such as X ray and MRI, highly sophisticated gait lab and a virtual reality Computer Aided Rehabilitation Environment (CAREN). Such facilities are currently not available on the NHS; currently, defence returns 85% of trauma patients to duty, compared to 35% of people returning to work in the civilian population. Although the populations may not be directly comparable, the UK also lags behind the USA and Europe on return to work (NSCARI report cited in PCBC). This report also acknowledged that rehabilitation provision for patients is not adequate in England.

The proposed NHS facility at the NRC would contain 63 beds, comprising 40 neurological rehabilitation beds, 19 complex MSK beds and four traumatic amputee rehabilitation beds. It would treat 796 patients per year. Part of the proposal is that 25 beds at Linden Lodge (where the estate is no longer at the required standard and there is no space to expand) are moved to the NRC. 18 beds for MSK rehab may also be relocated to the NRC. It is expected that the proposal will be cost neutral due to the relocation of rehab beds, improved lengths of stay for rehab and better outcomes for patients which in turn, will reduce demand on services over the longer term.

The population of the East Midlands

Life expectancy and healthy life expectancy in the East Midlands are lower than the average for England (Public Health England 2017). In terms of deprivation, levels are lower than the English average (PCBC v2) but there is a significant urban-rural divide (with deprivation higher in the urban areas), which means that this should be included in the equality analysis where possible. In Rutland, males and females live 10.7 and 14.6 years respectively in ill health, whereas in Nottingham City they live 20.1 and 24.2 years in ill health (Public Health England 2017). There are also pockets of significantly poorer health outcomes in the former coalfields in Leicestershire and along the Lincolnshire coast.

The Global Burden of Disease data quoted in Public Health England (2017) indicate the most common risk factors for years lived in disability in the East Midlands are obesity, alcohol and drug use, poor diet, occupational risks and smoking.

Overview of key themes highlighted in the EIA

NB: In the remainder of the report, we have highlighted mitigations, questions and recommendations in italics.

Opportunities to advance equality of opportunity through the NRC

Narrowing inequalities through reducing disability and improving clinical outcomes

The NRC will improve outcomes for patients, which should benefit all groups accessing the centre. The concentrated patient cohort will also allow for research, which will benefit patients across the UK and beyond. The NCASRI final report on the provision of specialist rehabilitation following major trauma found that only 40% of patients in major trauma centres identified as needing specialist rehabilitation received it, but of those who did receive it, 94% showed signs of functional improvement. This indicates that there is a need for the NRC and that it will reduce impairments.

The NRC will aim to return people to their usual activities (such as work or caring), rather than facilitate a safe discharge as soon as it is medically possible. This will draw from the defence model of intensive rehabilitation to facilitate a return to duties. This will reduce long term disability and dependence, and in turn reduce the risk of family members becoming carers.

There is evidence that patients benefit from taking part in research, and that services can be improved by patients being involved in service improvement and development (e.g. NIHR Involve 2019; NICE 2019).

The public involvement on these proposals should include people from a range of backgrounds, and proactively reach out to people who are within the EDS2 Inclusion Groups or who have a protected characteristic, to ensure that their perspectives are included in the development of the services.

Reducing geographical inequalities in care and outcomes

The PCBC indicates that there are currently wide variations in waiting time and service based on the area of the East Midlands that a patient is treated in. These are not clinically justified. The NRC will reduce this unfair variation, and therefore reduce inequality based on location.

Practice learning, research and development

The NRC views the ability to increase the profile of rehabilitation as a medical specialty as a critical success factor. The centre will offer posts, training posts and rotations to doctors, nurses and AHPs. The training posts will not only encourage people to work at the NRC, but will also allow people who choose to work elsewhere after training to take specialist knowledge and understanding out into the wider NHS. This will further raise standards for patients and reduce variation in practice.

Shared learning with defence medical services could improve outcomes for all patient groups, through understanding the more intensive model of rehabilitation and what proportion of the difference between the defence return to duties of 85% and the NHS patients return to work of 35% can be reduced, and what is an artefact of a different population. It is this co-location with and access to some of the specialist defence rehabilitation facilities that should help narrow these inequalities and improve outcomes for civilians.

A concentrated cohort of patients will facilitate research into trauma and rehabilitation, which could benefit patients with all protected characteristics and across the whole UK. For example, there is evidence that men are taken as the norm in research and this can lead to women being misunderstood or under treated (Samulowitz 2018; Wiklund 2016); studies done in the NRC could have large enough sample sizes for women to be treated as a category for analysis and any differences to be explored.

Opportunity to design a new-build, purpose-built facility

The fact that the NRC will occupy a purpose-built facility creates a number of opportunities to promote equality of access and experience for different protected characteristic groups, *assuming these are fully considered at the design stage*. The centre should be designed to the highest access standards (including staff and research spaces as well as public-facing spaces), and should also consider acoustics, dementia-friendliness, lighting and psychologically informed approaches in layout, signage, interior design, etc. Making sure that free and/or disabled parking, multi-faith prayer spaces, single rooms, visiting family/ breast-feeding spaces, etc are designed in from the outset should promote equality for a range of protected characteristics amongst the patients, visitors and workforce.

Access to the parkland and other facilities on the site will allow patients from across the East Midlands to experience the benefits of green space, which has been shown to improve recovery outcomes (Houses of Parliament 2016). This will particularly benefit patients from urban areas, and those who do not have access to transport to the countryside.

Possible risks for equality of opportunity through the NRC

NB: Mitigations and considerations moving forwards are included in italics.

Understanding of Vocational or Occupational Benefit

One of the criteria for referral to the service is based on vocational and occupational benefit. It is essential that referring hospitals are clear that this does not just refer to paid employment, but also to wider life, including social roles and leisure pursuits. If referring hospitals mistakenly or unconsciously take a narrower definition, this could potentially discriminate against people who are undertaking unpaid work (carers, people raising children, retired adults who are volunteering and living independently in the community and who are in good physical health), or people who are not currently employed (homeless people, unemployed people, people in the “gig economy” whose work is irregular and hard to document), and others perceived, albeit unconsciously, to have lower social status.

Referring hospitals should be offered advice in how to avoid making broad assumptions about who will benefit, all staff should be trained in equalities and unconscious biases, and supervision and mentorship should include reflection about how referral decisions are made and what unconscious biases could be affecting decisions.

Risk of increased travel

Although patients will not be making repeated journeys to the new centre, because they will be inpatients, their families may be affected by changes to travel. In some cases they will benefit from the centre being closer. In others, such as patients who live close to the existing Linden Lodge at Nottingham City Hospital, they may be travelling further. Nottingham City Hospital is served by public transport. The NRC will have ample free car parking and is served by a bus route which runs between Nottingham and Loughborough every 20 minutes. We understand that there are plans to explore an additional bus route with the Highways Authority.
The NHS should continue to negotiate with public transport providers and the Highways Authority, in response to the forthcoming findings of the travel analysis to maximise ease of access for those visitors dependent on public transport.

However, the Linden Lodge cannot be refurbished to provide the clinical benefits of the NRC, and so staying in the current location without substantial capital investment is not an option. The NRC will be providing some facilities for families to stay on site, and arrangements with public transport providers should enable people who do not have a car to visit their family or friends who are patients.

Equality Considerations for Protected Characteristics and Health Inclusion Groups

Gender

Seventy percent of major trauma patients are men. This is based on case mix and will not need to be mitigated.

Historically, women may not have had their needs understood or met in areas such as pain management (Samulowitz 2018; Wiklund 2016) and as such may have been under treated.
The National Centre could use its expertise and large patient cohort to develop protocols that would prevent this, work with referring units to ensure that unconscious biases are addressed and potentially commission research into whether women experience rehabilitation in a different way from men.

Women are more likely than men to be working part time, or to be working as unpaid carers or providing unpaid childcare.
As vocational and occupational benefit is part of the referral criteria, it must be made very clear to referring hospitals that caring responsibilities are a vocation and an occupation.
This, combined with the male majority case mix for the centre, means that women are more likely to be visiting the centre and may be at more risk of becoming carers, depending on the outcomes of rehabilitation. These issues are picked up in more detail under the section on carers below.

Sexual Orientation, Gender Re-assignment and Gender Identity

Sexual Orientation and Gender re-assignment are protected characteristics and non-binary people are protected from discrimination regardless of whether they have had, are undergoing, or plan to make a medical and legal transition, or not.

Long hospital stays can be a stressful time for people who identify as trans or non-binary, and for gay, lesbian and bisexual patients. It is positive that all patients at the new facility will be in single rooms, as this should reduce the risk of harassment by other patients, or the risk of people being placed in a ward that does not fit with your gender identity, and should afford privacy to trans people and to patients with visiting same sex partners. This will be an improvement over staying in a traditional bay in a local hospital.

Age

It is positive that age is not an explicit criterion for referral to the centre, and older adults should not be discriminated against if they could benefit from rehabilitation. However, there is a risk of referring hospitals making assumptions about older people's likely benefit based on stereotypical views of older people as already weaker, less able to stick with an intensive programme or lacking in vocation or occupation.
The Centre should work with referring hospitals to make sure they understand that some older adults may benefit from rehabilitation and be motivated enough and physically fit enough to benefit, on a case by case basis.

Analysis of UK TARN data (Herron et al 2017) has identified the different types of needs which older people – as group – may have for rehabilitation compared to younger people. The findings of this study suggest that older patients with traumatic injuries will often benefit from being managed in an environment that is also capable of dealing with their complex needs. However, they will benefit from early assessment of their needs by senior decision-makers and specialist older people's physicians. The NRC proposal, which should widen choices and ensure that pathways are determined by clinical need stands to benefit this group, provided that the NRC does not have the (unintended) impact of reducing quality in existing acute hospital settings (early thinking is that it should improve quality by reducing patient numbers); and that there is effective, early clinical decision-making, free from unconscious bias about age. We understand that the major trauma centre will have regular input from ortho-geriatricians, and that speciality reviews can be requested as required.

Younger adults are more likely to be in RTAs as pedestrians or cyclists, and this affects injury severity and type (Department for Transport 2018). The co-location with the Defence Medical Rehabilitation Centre (DMRC) may improve services for younger adults (aged under 25), through greater familiarity with the effects of life changing injuries in younger people, and more experience with a model that aims to return younger people to demanding work.

Race/ Ethnicity and migrants

People from Black, Asian and Minority Ethnic (BAME) backgrounds are more likely to derive their household income from work (Cabinet Office 2017), more likely to be in poor quality and overcrowded housing that would be difficult to adapt to the needs of a disabled resident (Cabinet Office 2017), and more likely to experience a severe occupational injury

(Mekkodathil 2016) than people from white ethnic backgrounds. If the degree and impact of impairments and the need for adaptations can be reduced, there may particularly positive impacts for these groups.

One in five people from Pakistani and Bangladeshi backgrounds do not speak English well or at all (Cabinet Office 2017), and this is more likely for women and older adults. This could make it harder to discuss referral and the likelihood of benefitting from rehabilitation with patients in this group, and they may struggle to advocate for themselves if their English is not fluent. *Referring hospitals should ensure that they use appropriate translation services when discussing the option of a referral to the NRC.*

It should also be noted that worldwide, migrants are more vulnerable to occupational injury than other groups (Mekkodathil 2016) and that migrants may be particularly benefited from having a service that aims to return them to work, since they may have reduced eligibility to UK disability benefits.

Religion and Belief

People who have experienced a life-changing injury and who are receiving intensive rehabilitation may need spiritual support, as well as mental health support, especially if they already have a faith that is important to them.
The diverse spiritual needs of patients should be taken into account, and links should be built with local faith communities to help provide appropriate spiritual support those patients that would benefit from this.

Physical disability and sensory impairment

The centre will reduce impairments and their impact through improving clinical outcomes for people with rehabilitation needs, and by reducing variation in treatment. Extending rehabilitation from neurological patients to people who have had traumatic amputations, major trauma or complex orthopaedic surgery will reduce variation in outcomes and provide more people with the chance to avoid long-term disability.

Care must be taken that people with pre-existing disabilities or sensory impairments, who have been living previously independent lives and who could still benefit from intensive rehabilitation, are not excluded from rehabilitation based on inaccurate assumptions about how much they could benefit from it.
Referring hospitals should be offered advice on how to assess whether people with pre-existing disabilities or sensory impairment would benefit from intensive rehabilitation, and avoid unconscious bias about their likely quality of life gains and independence.

Learning Disability

People with learning disabilities may be less likely to be in traditional paid employment and health professionals may make assumptions about their likely benefit and quality of life. This group may also experience barriers in relation to communication and self-advocacy, both when the decision about whether to refer to NRC is being made and within the

unfamiliar environment of the unit. The Centre will have family rooms available, which should enable family members to come and provide support.
As mentioned under other headings, *referring hospitals must be clear that paid employment is not the only occupational or vocational outcome, and that people with learning disabilities must be assessed on a case by case basis to see if they could benefit.*

Mental Health

The provision of mental health support as part of the model of care will help support patients to adapt to life changing injuries and decrease the risk of long term psychological harm preventing people returning to work.

Pregnancy, Maternity and Parenthood

Pregnancy is a protected characteristic. Parenthood is not, but is another potential source of inequality. This service provides some rooms for family to stay on site. This may be particularly beneficial to parents, who would otherwise not see their families as often during their stay, and may help to maintain family bonds. This in turn may reduce familial anxiety, and benefit the children of people who require rehabilitation.

Carers

This service will benefit carers through reducing the long-term dependency of patients.

The main risk for carers, relates to additional travel time to come and visit loved ones. This is likely to impact particularly on those living in poverty, those who do not have access to a car and/or those living in rural areas. A travel analysis is being conducted, and it will be important to use the findings of this to plan mitigations, e.g. seeking to influence public transport providers.

The provision of rooms on site should reduce anxiety for family members who would otherwise not have been able to see patients during their rehabilitation (e.g. adults who live in the East Midlands and whose families live elsewhere; this may be particularly beneficial to younger adults such as students). The provision of free and plentiful accessible parking will benefit carers, especially those who are on low incomes and/or have health problems or impairments themselves.

Socio-economic deprivation

People who live in areas of socioeconomic deprivation are more likely to have road traffic accidents , more likely to be in occupations that have high incidences of occupational injury (World Health Organisation Europe 2009) and more likely to be the victims of violence (World Health Organisation Europe 2009) and therefore may benefit highly from this service. They are also more likely to be casually employed, and therefore not to have sickness pay, critical injury insurance etc. This makes return to work rather than discharge home with ongoing needs a positive outcome for this group.

More socioeconomically deprived families may be disproportionately disadvantaged if transport costs are higher to visit the NRC than to remain in local pathways, and this may

influence them to seek care closer to home even if the outcomes may not be as good. As mentioned above, this can be mitigated with provision of free car parking, negotiating bus routes that include the NRC, and with facilities for families to stay on site where this is needed.

People using alcohol and other drugs harmfully and/or experiencing homelessness

Members of these 'Health Inclusion' groups experience a heightened risk of traumatic injury, due to being victims of crime, involved in RTAs or other accidents while under the influence and/or sleeping rough, and amputation, where they have been injecting.

These groups are at risk of unconscious bias during the assessment process, and there is a risk that NRC is not offered since assumptions are made that the individual will not be sufficiently motivated or does not have enough rehabilitation potential to warrant a referral. Whilst patients in this group may decide that they do not want to undergo an intensive rehabilitation programme, especially at a distance from their current networks, it is important that these options are presented and discussed fairly and honestly. For some, the opportunity to attend NRC may be a turning point.

Conclusions and recommended next steps

The centre has significant potential to improve clinical outcomes, reduce disability and address geographical inequalities in outcome for patients in the East Midlands. There is no evidence that the risks to equality outlined above cannot be successfully mitigated.

Recommendations

1) Develop explicit referral criteria that state that paid employment is not the only form of vocational and occupational benefit, and that unpaid care, family support, volunteering and social engagement must also be considered.

2) Support referring hospitals with training to address unconscious bias so that, on a case by case basis, older adults, people with existing disabilities (physical, sensory and learning) but a high level of motivation and ability to benefit and others who may be vulnerable to being discriminated against (e.g. people who are addicted to drugs) are considered for rehabilitation in a fair and consistent manner.

3) Provide ongoing advice and support for referring hospitals on a case by case basis, so that people who may benefit but have a pre existing disability, older adults and other vulnerable people can be discussed.

4) Proactively reach out to people with protected characteristics and people in EDS2 inclusion groups during the public consultation for the NRC and take action on their concerns.

5) Negotiate public transport access to the site with local public transport providers.

6) Use the patient cohort and research expertise at the NRC to identify and address equality issues, such as concerns raised that women are under treated due to unconscious biases around their pain response or need for rehabilitation, and other equality issues raised in the literature or during consultation.

7) Ensure that the NRC and referring hospitals seek appropriate translation services when necessary.

8) Take steps to address the spiritual needs of patients, where requested, by forming links with local faith communities.

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Partners in improving local health

National Rehabilitation Centre: Travel Impact Analysis

National Rehabilitation Centre

East Midlands Region

July 2019

Report Specification

Recipients

National Rehabilitation Centre, East Midlands.

Data Source

Sources

Data was originally provided from the Secondary Uses Service by NHS England following a request from the National Rehabilitation Centre Programme Team. Revised data for the 2018 calendar year was later provided by the East Midlands Major Trauma Centre to more closely reflect patients who might use the National Rehabilitation Centre. It covers finished inpatient rehabilitation episodes taking place during this period.

Travel distances and times are calculated using this data and analysed using fastest path algorithms.

Geography

This report covers patients using inpatient rehabilitation services at Nottingham University Hospitals NHS Trust, University Hospitals of Leicester NHS Trust, Derby Teaching Hospitals NHS Foundation Trust and United Lincolnshire Hospitals NHS Trust sites.

Data Receipt

Data was supplied on 14 June 2019 to provide a basis for agreeing assumptions and drafting a scope for the work. Final data was supplied on 10 July 2019 from which all analysis in this report is taken.

Production

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Completion Date

This draft was completed 18 July 2019

Saved in

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Contents

Executive Summary

This report estimates the current travel distance and time undertaken by people visiting patients who require rehabilitation services in the East Midlands region. It also models potential changes in distances and time if rehabilitation services are established at a new National Rehabilitation Centre located on the Stanford Hall Rehabilitation Estate near Loughborough.

The methodology used combines industry standard, multi-modal transport travel distance algorithms which optimise journeys to the nearest hospital site in terms of the shortest distance / time by private transport means or shortest time only by public transport.

The East Midlands region provided data on patients using inpatient rehabilitation services covering the calendar year 2018. To ensure patient confidentiality, aggregate data has been supplied. This data was restricted to numbers of patients and total length of stay of patients normally resident in each Lower Super Output Area (LSOA).

Total days spent in rehabilitation services per LSOA were used to estimate the number of visits made by friends and family to the nearest existing site and the total distance / time that this took. This method was then applied to model travel distances and journey times to the proposed new location for rehabilitation services at Stanford Hall Rehabilitation Estate.

There were 1296 episodes of rehabilitation in 2018, excluding 35 episodes where the patient's location was not available in the data provided. These episodes involved 19224 bed days (approximately 2745 weeks of care). The average length of stay in rehabilitation for this cohort was 24 days.

It is unlikely that all of these cases would transfer to the NRC. However, this pool of potential users has been included in the analysis as criteria and pathways for admission to the NRC have not been fully established.

Patients live 10.7 miles from the nearest current site on average but this can vary from 3.2 miles on average for Leicester City CCG patients to 39 miles for those from South Lincolnshire CCG.

If all patients were instead treated at the proposed National Rehabilitation Centre, most people would have to travel further to visit patients. Patients would be treated on average 25 miles from home – a further 13.9 miles compared to the nearest current hospital.

Patients from North and North East Lincolnshire CCGs would face the greatest impact, travelling more than 40 miles further to the NRC on average. It should be noted, however, that there are relatively few patients from these CCGs and the total additional miles travelled per year would be less than for most other CCGs. More patients from Lincolnshire East and West CCGs were included in the dataset and these patients would face longer journeys on average. In contrast, West Leicestershire CCG patients would travel fewer miles compared to their nearest current site.

Patients live on average 20 minutes by car from their nearest current site. This would increase to 39 minutes for a single journey to the NRC.

Travelling by public transport, journey times to the current nearest hospital are considerably longer than by private transport (an hour on average). Most people would incur greater travel time to reach the NRC by public transport (an additional 66 minutes on average) with people from the Lincolnshire CCGs particularly affected.

There could be significant impact for some people visiting patients using rehabilitation services if all rehabilitation services are transferred to the National Rehabilitation Centre.

A small number of people, for example some of those from the Lincolnshire CCGs, would be particularly adversely affected. It is recommended that consideration is given to the availability of alternatives to treatment at the National Rehabilitation Centre for people living furthest from the proposed site. Providing choice in the location of rehabilitation services will be particularly important for visitors who do not have access to a car.

Introduction

1.1 Background

The East Midlands region plans to develop the first National Rehabilitation Centre to be located on the Stanford Hall Rehabilitation Estate (SHRE) near Loughborough.

Whilst it is anticipated that rehabilitation services will be improved if this development is agreed, it is important to consider the travel implications arising from moving services to a new location. The East Midlands region has a requirement to understand more about the journeys people make to visit patients where they are currently treated and any differences which would be experienced if they are treated at the National Rehabilitation Centre.

1.2 Purpose of Report

This report provides detail on current and potential changes in travel distance/time for people visiting patients who require rehabilitation services.

Methodology

2.1 Scope and data sources

The scope of this study was agreed with the Programme Director, National Rehabilitation Centre. The study is restricted to estimated changes in travel incurred by people visiting patients who require inpatient rehabilitation services.

The specialties and patients which may move to a National Rehabilitation Centre are neurosciences, complex musculo-skeletal, major trauma, amputee and incomplete spinal cord injury patients.

Patients using the National Rehabilitation Centre are expected to come from the East Midlands (Nottinghamshire, Derbyshire, Lincolnshire and Leicestershire).

The East Midlands region provided data on patients using inpatient rehabilitation services covering the calendar year 2018. To ensure patient confidentiality, aggregate data was supplied. This data was restricted to numbers of patients and total length of stay of patients normally resident in each Lower Super Output Area (LSOA). LSOAs are a geographic area designed to improve the reporting of small area statistics in England and Wales. The minimum LSOA population is 1000 and the mean is 1500.

2.2 Rehabilitation sites

The following sites were included in the modelling:

- Nottingham University Hospitals NHS Trust (NUH) – QMC and City Hospital Sites – NG7 2UH, NG5 1PB
- University Hospitals of Leicester NHS Trust (UHL) – LE1 5WW
- Derby Teaching Hospitals NHS Foundation Trust (DTH) - DE22 3NE and London Road site DE1 2QY
- United Lincolnshire Hospitals NHS Trust (ULH) – LN2 5QY
- Proposed site of the National Rehabilitation Centre using LE12 5QW.

2.3 Travel Impact Analysis modelling

The travel implications of historical and current use of existing rehabilitation services was modelled using data supplied by commissioners on the numbers of patients by LSOA and their total length of stay.

As detailed postcode data for patients using rehabilitation services is not available, the population weighted centroid for each LSOA was used as a proxy for the patient's home address. The population weighted centroid is produced by the Office for National Statistics and provides a single summary reference point within the LSOA based on the distribution of the population in the LSOA[1]. The easting and northing of this centroid was then used to enable travel distances to each rehabilitation site to be calculated.

Travel distances to each rehabilitation site were calculated using shortest / fastest path algorithms originally devised by Edsger Wybe Dijkstra[2]. These algorithms form the basis for most methods of calculating travel time / distance. It was assumed that patients in each LSOA were treated in the nearest hospital to that LSOA.

Proprietary speed datasets were used to provide an estimate of drive times for private transport. Public transport travel times were also modelled and make allowances for arriving at a bus stop and the onward journey after alighting from a bus.

Total days spent in rehabilitation services per LSOA were used to estimate the number of visits made by friends and family and the total distance and time that this took.

This method was then applied to provide travel distances and journey times to the proposed new location for rehabilitation services at Stanford Hall Rehabilitation Estate. Differences arising from this change were then reported.

[1] Population Weighted Centroids Guidance. Office for National Statistics https://www.arcgis.com/sharing/rest/content/items/b20460edf2f3459fa7d2771eacab51fc/data

[2] Dijkstra's algorithm https://en.wikipedia.org/wiki/Dijkstra%27s_algorithm

2.4 Patient Confidentiality

No patient identifiable data has been made available to the researchers undertaking this study. Aggregate data at LSOA level has been used to model likely travel scenarios.

2.5 Assumptions and Limitations

It is understood that the prime focus of this study is to assess visitor journeys. The commissioner has specified an average frequency of visits of three times per week which is used alongside the patients' length of stay to calculate the number of journeys made.

As the address of visitors is not recorded, it is assumed that visitors live at the same location as the patient.

As detailed postcode data is not available, travel distances are calculated from the population centroid of the LSOA where the patient is normally resident. Whilst this approach can only provide an approximation of actual travel distances, it is felt that this methodology provides the best balance between assessing the likely travel impact and maintaining patient confidentiality.

As the hospital that the patient attended is not available in the data set to be used, it is assumed that patients in each LSOA were treated in the nearest hospital to that LSOA. This may underestimate the travel incurred using current services.

To calculate travel times, road speeds adjusted for typical traffic speeds at a specified time of day were used. As the relevant visiting times for each site were not known, all journeys were set to start at 1.30pm on a Wednesday. It is not possible to ascertain if all roads were available at the time of travel or if there were any temporary delays, eg due to accidents.

The dataset supplied included 35 patients with no LSOA identified. 9 of these patients had no fixed abode. The others were due to an invalid home address being recorded. These records have been excluded from this study as travel details cannot be calculated. These records account for 2.6% of the dataset so this is unlikely to affect the findings.

It was not possible to identify public transport routes for 31 patients. These have been excluded from the public transport modelling.

Results

3.1 Baseline

The dataset supplied included 35 patients with no LSOA identified. 9 of these patients had no fixed abode. The others were due to an invalid home address being recorded. These records have been excluded from this study as travel details cannot be calculated. These records account for 2.6% of the dataset so this is unlikely to affect the findings.

There were 1296 episodes of rehabilitation in 2018. These episodes involved 19224 bed days (approximately 2745 weeks of care). The average length of stay in rehabilitation for this cohort was 24 days.

Figure 1 shows where patients who received rehabilitation services in 2018 normally live. There were four patients who lived more than 100 minutes by car from the nearest hospital. As their inclusion would require a less detailed scale, they have been excluded from the map below.

Figure 1 Home location of patients using rehabilitation services 2018:

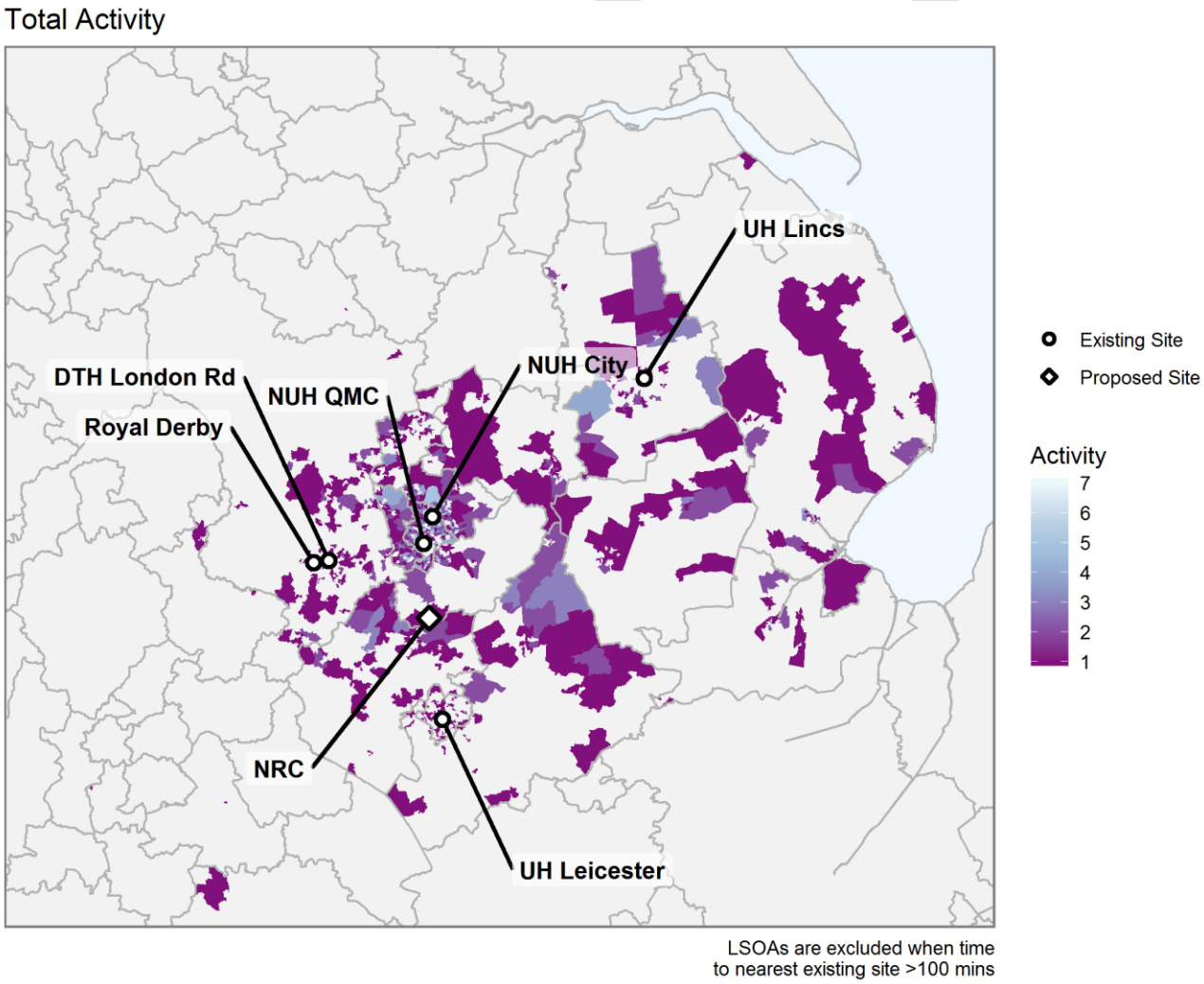


Table 1 shows rehabilitation activity in 2018 by the responsible CCG. As the hospital used was not included in the dataset, it is assumed that patients used the nearest hospital which will probably underestimate current travel. This shows that the Nottingham and Southern Derbyshire CCGs make greatest use of the services covered in this report. Patients live 10.7 miles from the nearest hospital on average but this can vary from 3.2 miles on average for Leicester City patients to 39 miles for those from South Lincolnshire CCG.

Table 1 Baseline by CCG 2018

CCG	Total Episodes	Average LoS (Days)	Min Distance from Nearest Site (in miles)	Average Distance from Nearest Site (in miles)	Max Distance from Nearest Site (in miles)
NHS EAST LEICESTERSHIRE AND RUTLAND CCG	62	16.4	2.1	15.4	47.4
NHS LEICESTER CITY CCG	59	13.4	1.1	3.2	5.0
NHS LINCOLNSHIRE EAST CCG	51	17.9	10.3	34.4	44.9
NHS LINCOLNSHIRE WEST CCG	60	16.0	0.8	7.0	23.0
NHS MANSFIELD AND ASHFIELD CCG	69	22.1	2.0	13.0	22.5
NHS NEWARK & SHERWOOD CCG	47	22.9	3.2	17.2	24.8
NHS NORTH EAST LINCOLNSHIRE CCG	1	5.0	36.1	36.1	36.1
NHS NORTH LINCOLNSHIRE CCG	2	24.0	15.1	15.1	15.1
NHS NOTTINGHAM CITY CCG	442	36.9	0.5	4.0	99.6
NHS NOTTINGHAM NORTH AND EAST CCG	118	33.3	1.8	4.9	28.4
NHS NOTTINGHAM WEST CCG	118	32.0	2.0	5.7	19.8
NHS SOUTH LINCOLNSHIRE CCG	18	26.6	1.9	39.0	45.3
NHS SOUTH WEST LINCOLNSHIRE CCG	33	13.5	10.2	24.2	30.0
NHS SOUTHERN DERBYSHIRE CCG	140	15.5	0.6	8.6	89.0
NHS WEST LEICESTERSHIRE CCG	76	14.9	5.6	17.5	163.7
Grand Total	**1296**	**24.2**	**0.5**	**10.7**	**163.7**

Table 2 shows the nearest current site for patients and the average, minimum and maximum distances from home. 39% of patients live closest to the NUH City Hospital.

Table 2 Baseline information on nearest current sites:

Nearest Site	Activity 2018	% of Total Activity	Minimum Distance from Nearest Site (in miles)	Average Distance from Nearest Site (in miles)	Maximum Distance from Nearest Site (in miles)
Royal Derby	32	2%	1.8	14.0	94.8
Derby: London Road	121	9%	0.6	7.9	43.0
NUH: City Hospital	509	39%	0.8	6.8	89.0
NUH QMC	337	26%	0.5	9.3	40.7
University Hospital of Leicester	127	10%	1.1	10.8	163.7
United Lincolnshire Hospitals	170	13%	0.8	22.1	45.3
Grand Total	**1296**	**100%**	**0.5**	**10.7**	**163.7**

Table 3 shows the total weeks spent in rehabilitation. It also estimates the number of journeys per year made by relatives or friends visiting patients and the total miles incurred (assuming visitors travel from the patients' home address to the nearest current site). It is assumed that each patient receives three visits per week. Return journeys are counted. Patients from Nottingham City CCG incur the most miles travelled due to greater numbers of cases and a high average length of stay for patients (just under 37 days).

Table 3 Baseline information on total visits to nearest current sites:

Row Labels	Activity 2018	Total LoS in 2018 (weeks)	Total Weeks of Rehabilitation	Estimated Journeys per Year	Estimated Total Miles Travelled by Visitors Per Year
NHS EAST LEICESTERSHIRE AND RUTLAND CCG	62	110	662	10016	18448
NHS LEICESTER CITY CCG	59	94	565	1817	6314
NHS LINCOLNSHIRE EAST CCG	51	100	599	21596	32305
NHS LINCOLNSHIRE WEST CCG	60	96	577	4108	8255
NHS MANSFIELD AND ASHFIELD CCG	69	168	1005	10412	21545
NHS NEWARK & SHERWOOD CCG	47	118	707	11785	19936
NHS NORTH EAST LINCOLNSHIRE CCG	1	1	4	151	231
NHS NORTH LINCOLNSHIRE CCG	2	3	20	308	490
NHS NOTTINGHAM CITY CCG	442	1022	6132	32693	71001
NHS NOTTINGHAM NORTH AND EAST CCG	118	280	1681	7334	19081
NHS NOTTINGHAM WEST CCG	118	265	1589	8113	20711
NHS SOUTH LINCOLNSHIRE CCG	18	53	320	13166	18521
NHS SOUTH WEST LINCOLNSHIRE CCG	33	54	325	8125	12779
NHS SOUTHERN DERBYSHIRE CCG	140	250	1497	12975	25354
NHS WEST LEICESTERSHIRE CCG	76	132	790	16919	26813
Grand Total	**1296**	**2746**	**16473**	**159520**	**301783**

3.2 Modelling National Rehabilitation Centre Travel Impact: Distance

If all patients were instead treated at the proposed National Rehabilitation Centre, most people would have to travel further to visit patients. Patients would be treated on average just under 25 miles from home – a further 13.9 miles compared to the nearest current hospital. Based on people visiting a patient three times per week, this would involve an additional 212,994 miles travelled per year. It should be noted that it is unlikely that all patients would transfer to the NRC so this may be seen as worst case scenario.

As would be expected, the impact on travel will vary considerably depending upon where patients live. The very small number of patients from North and North East Lincolnshire CCGs would face the greatest impact, travelling more than 40 miles further on average. There are relatively few patients from these CCGs and the total additional miles travelled per year would be less than for most other sites. More patients from Lincolnshire East and West CCGs were included in the dataset and these patients would face longer journeys on average. In contrast, West Leicestershire CCG patients would travel fewer miles compared to their nearest current site.

Table 4 demonstrates the potential impact for people visiting patients at the NRC compared to their nearest current hospital.

Table 4 Modelling travel to the NRC:

Row Labels	Activity 2018	Average Distance from Nearest Site (in miles)	Average Distance to New Site (in miles)	Average Difference in miles Travelled compared to current nearest site	Total Additional Miles Travelled Per Year
NHS EAST LEICESTERSHIRE AND RUTLAND CCG	62	15.4	21.3	5.9	3271
NHS LEICESTER CITY CCG	59	3.2	18.1	14.9	8165
NHS LINCOLNSHIRE EAST CCG	51	34.4	69.2	34.8	18057
NHS LINCOLNSHIRE WEST CCG	60	7.0	46.3	39.3	23080
NHS MANSFIELD AND ASHFIELD CCG	69	13.0	31.0	18.1	16936
NHS NEWARK & SHERWOOD CCG	47	17.2	29.6	12.4	9023
NHS NORTH EAST LINCOLNSHIRE CCG	1	36.1	84.2	48.1	202
NHS NORTH LINCOLNSHIRE CCG	2	15.1	59.1	44.0	898
NHS NOTTINGHAM CITY CCG	442	4.0	15.1	11.2	66573
NHS NOTTINGHAM NORTH AND EAST CCG	118	4.9	18.5	13.6	22938
NHS NOTTINGHAM WEST CCG	118	5.7	16.9	11.3	17978
NHS SOUTH LINCOLNSHIRE CCG	18	39.0	47.9	8.9	3253
NHS SOUTH WEST LINCOLNSHIRE CCG	33	24.2	38.0	13.8	4188
NHS SOUTHERN DERBYSHIRE CCG	140	8.6	23.0	14.5	21325
NHS WEST LEICESTERSHIRE CCG	76	17.5	14.0	-3.5	-2894
Grand Total	**1296**	**10.7**	**24.6**	**13.9**	**212994**

The impact of a single journey to the NRC compared to the current nearest site is further examined in Table 5 to show the maximum and minimum changes involved. For a small number of patients, being supported at the NRC could result in a very small increase or even a reduction in travel. However, for some patients, it is likely that other provision would be preferred unless specialist care at the NRC is required.

Table 5 Additional Modelling of travel to the NRC:

Row Labels	Average Distance to New Site (in miles)	Average Difference in miles Travelled compared to current nearest site	Minimum Difference in miles Travelled compared to current nearest site	Max Difference in miles Travelled compared to current nearest site
NHS EAST LEICESTERSHIRE AND RUTLAND CCG	21.3	5.9	-12.2	24.8
NHS LEICESTER CITY CCG	18.1	14.9	8.5	20.8
NHS LINCOLNSHIRE EAST CCG	69.2	34.8	10.2	46.5
NHS LINCOLNSHIRE WEST CCG	46.3	39.3	7.5	48.5
NHS MANSFIELD AND ASHFIELD CCG	31.0	18.1	13.4	24.8
NHS NEWARK & SHERWOOD CCG	29.6	12.4	3.7	24.6
NHS NORTH EAST LINCOLNSHIRE CCG	84.2	48.1	48.1	48.1
NHS NORTH LINCOLNSHIRE CCG	59.1	44.0	44.0	44.0
NHS NOTTINGHAM CITY CCG	15.1	11.2	-12.2	39.7
NHS NOTTINGHAM NORTH AND EAST CCG	18.5	13.6	1.9	20.0
NHS NOTTINGHAM WEST CCG	16.9	11.3	-4.9	15.9
NHS SOUTH LINCOLNSHIRE CCG	47.9	8.9	2.5	16.3
NHS SOUTH WEST LINCOLNSHIRE CCG	38.0	13.8	-2.4	44.0
NHS SOUTHERN DERBYSHIRE CCG	23.0	14.5	0.3	23.3
NHS WEST LEICESTERSHIRE CCG	14.0	-3.5	-13.9	19.6
Grand Total	**24.6**	**13.9**	**-13.9**	**48.5**

3.3 Estimated Travel Time by Car

Journey times for the routes identified have been estimated. These times are based on journeys starting at 1.30pm on a Wednesday and use typical road speeds at that time. These estimates do not account for delays on particular days due to road closures, accidents etc.

Figure 2 provides a map of the estimated travel times to the nearest current hospital. The location of the proposed NRC site is shown for information only.

Figure 2 Estimated Travel Times by Car to the Nearest Current Hospital:

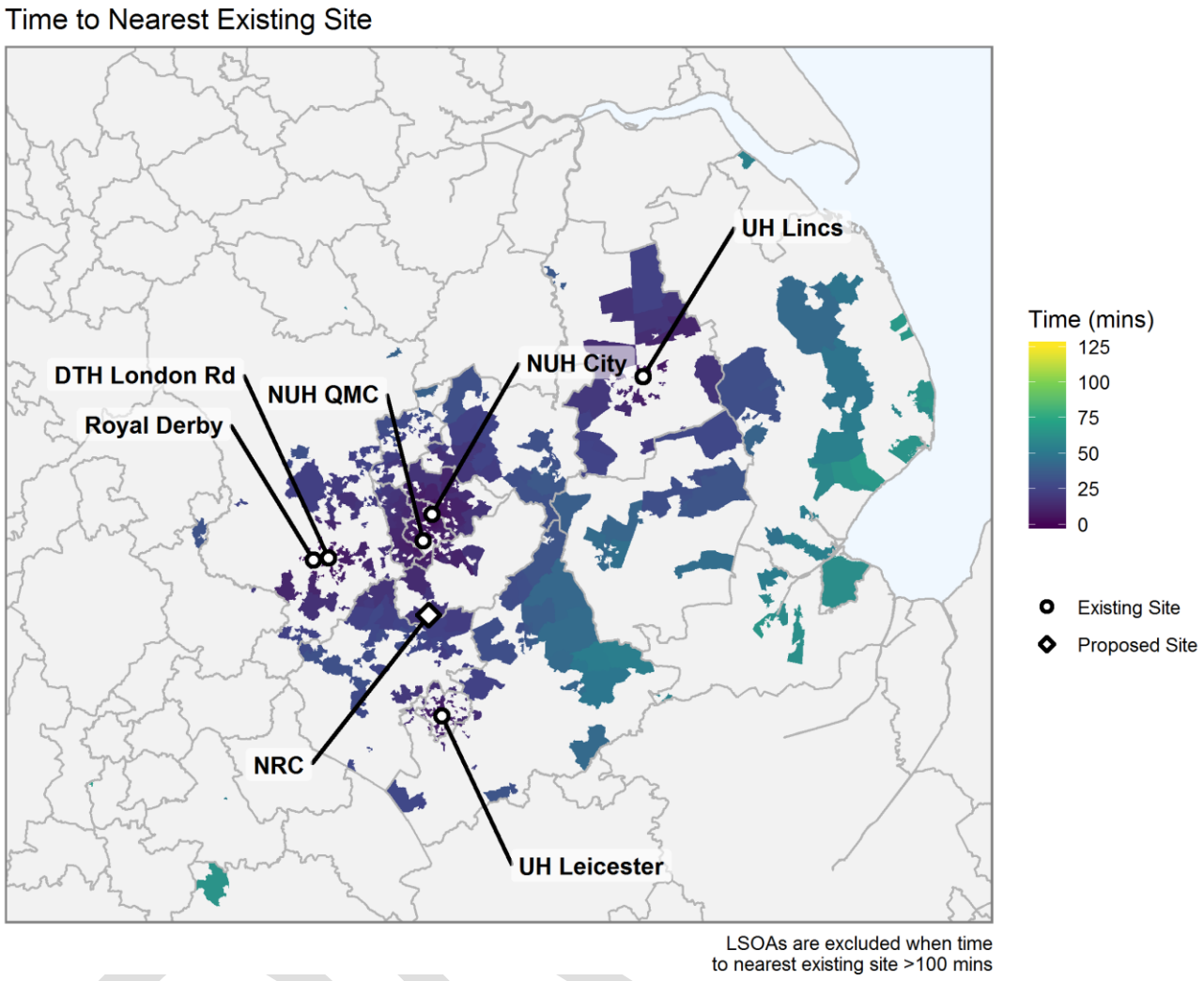


Table 6 shows estimated journey times by car to the current nearest hospital and the difference that would be incurred if the patient was instead treated at the National Rehabilitation Centre. Patients live on average 20 minutes by car from their nearest current site. This would increase to 39 minutes for a single journey to the NRC.

Based on three return visits per week's stay, it is estimated that people would currently spend over 5,000 hours per year on travel to visit patients receiving inpatient rehabilitation services. This would double to 10,267 hours if all rehabilitation services were located in the NRC. As would be expected from the travel distances shown earlier, people who would currently visit patients from the Lincolnshire CCGs would face the greatest increase in travel times for a single journey (between 44 and 52 additional minutes). However, 30% of all travel time to the NRC would be undertaken by visitors of Nottingham City CCG patients (3059 hours in total).

Table 6 Estimated Travel Time by Car, Current Nearest Site and to NRC:

	Ave. Time to Nearest Site (Single Journey Mins)	Est. Total time travelled per year (hours)	Average Time to New Site (Single Journey Minutes)	Est. Total time travelled per year to New Site (hours)
NHS EAST LEICESTERSHIRE AND RUTLAND CCG	29.0	307	35.9	370
NHS LEICESTER CITY CCG	11.2	105	33.5	310
NHS LINCOLNSHIRE EAST CCG	52.3	538	96.5	942
NHS LINCOLNSHIRE WEST CCG	14.1	138	62.4	606
NHS MANSFIELD AND ASHFIELD CCG	25.8	359	46.2	711
NHS NEWARK & SHERWOOD CCG	28.6	332	45.0	529
NHS NORTH EAST LINCOLNSHIRE CCG	55.0	4	106.0	7
NHS NORTH LINCOLNSHIRE CCG	24.0	8	76.0	26
NHS NOTTINGHAM CITY CCG	9.9	1183	28.5	3059
NHS NOTTINGHAM NORTH AND EAST CCG	12.2	318	35.5	991
NHS NOTTINGHAM WEST CCG	13.9	345	28.6	739
NHS SOUTH LINCOLNSHIRE CCG	56.6	309	76.2	429
NHS SOUTH WEST LINCOLNSHIRE CCG	38.4	213	54.6	296
NHS SOUTHERN DERBYSHIRE CCG	16.6	423	36.1	896
NHS WEST LEICESTERSHIRE CCG	29.9	447	23.7	355
Grand Total	**20.2**	**5030**	**39.4**	**10267**

Travel times to each hospital site vary depending on how close a patient lives to their nearest site and to the NRC. Figure 3 below shows the minimum, maximum journey times plus the interquartile range (middle 50%), and the mean average journey times for patients living closest to their current rehabilitation sites and to the NRC.

There are a minority of patients who face a long travel time to their current nearest site. For example, all patients who live closest to the University Hospital of Leicester live within an hour's drive of the hospital except two patients who live more than two hours away. It is likely that the recorded address of these two patients may not reflect their living arrangements at the time.

75% of patients live within 44 minutes of the NRC travelling by car. However, 10% of current patients live more than 64 minutes from the NRC. 5% would travel more than one hour and 23 minutes by car to reach the NRC.

Figure 3 Range of Travel Times by Car to Nearest Current Hospital & to NRC:

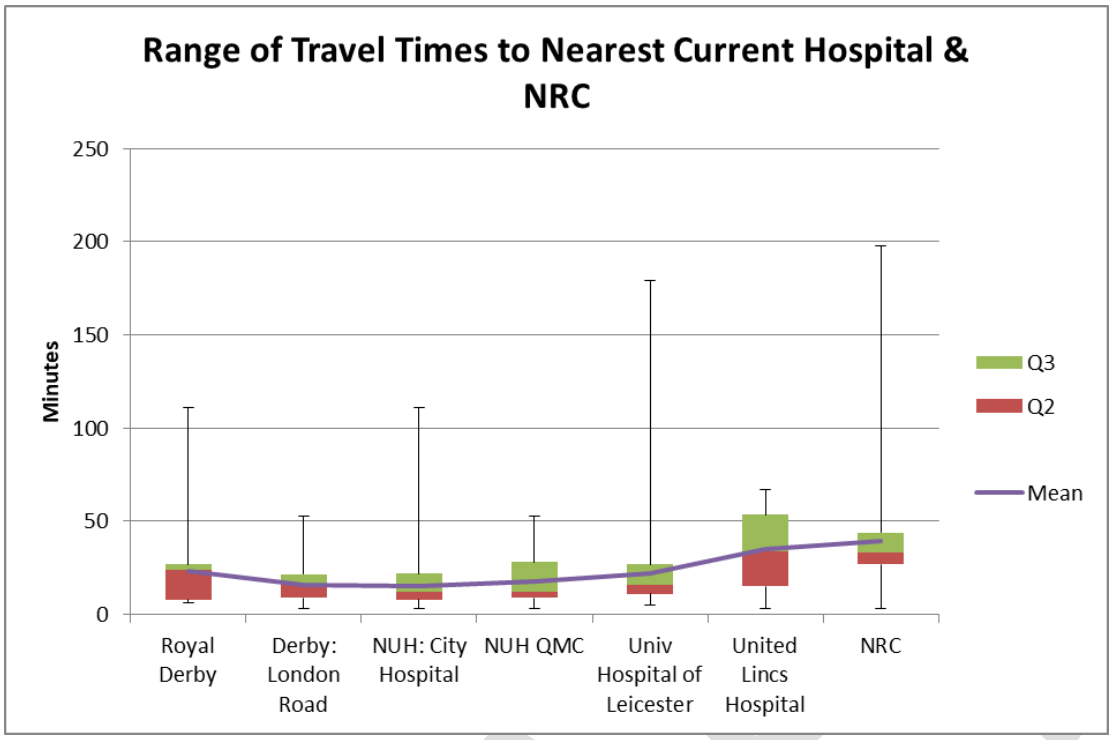
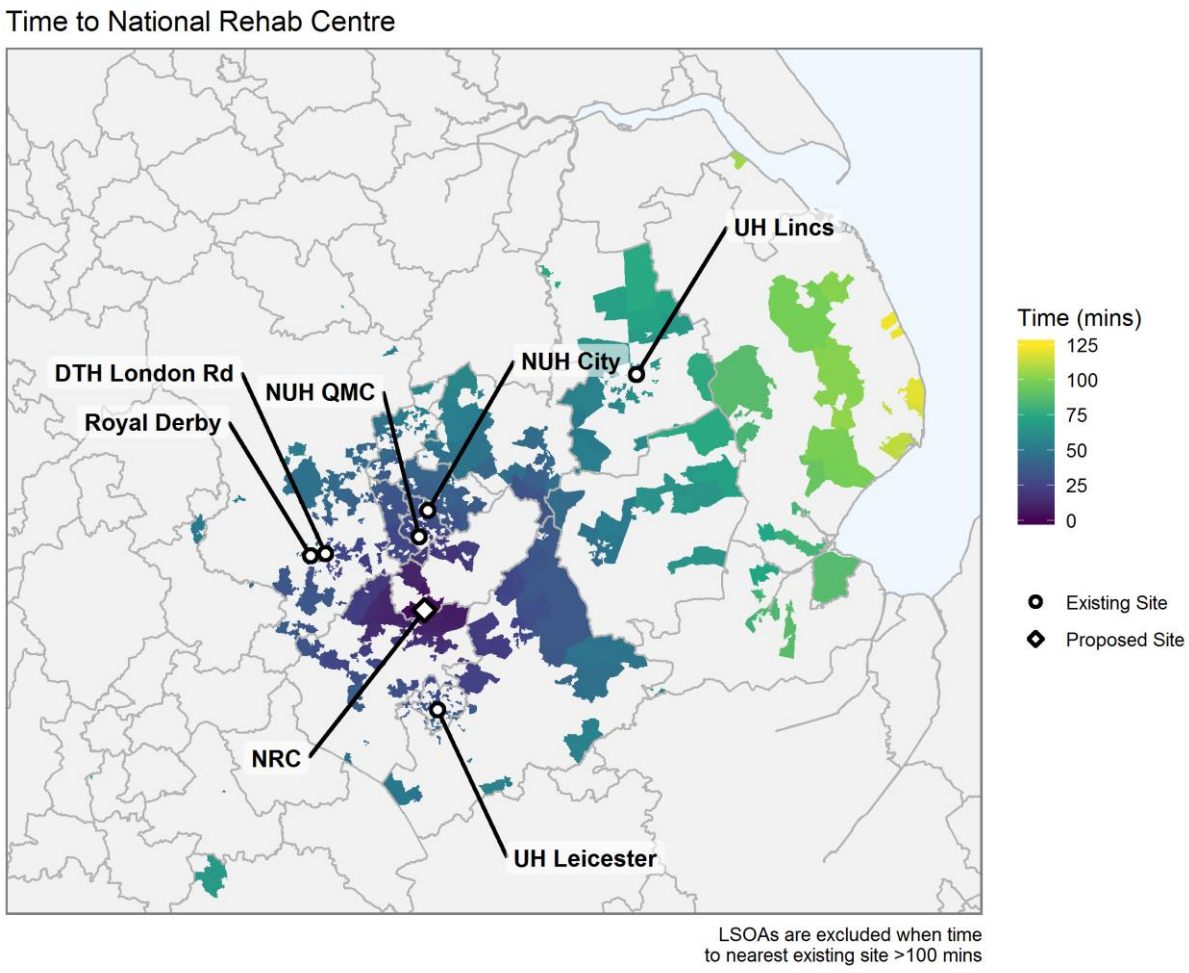


Figure 4 Travel Times by Car to the NRC:



3.4 Estimated Travel Time by Public Transport

Estimated travel time by public transport includes estimated time walking to and from bus / train points. Because the proportion of visitors who would travel by public transport is not known, single journey times only are modelled to provide an indication on the travel impact for those using public transport.

Table 7 shows the average, minimum and maximum times it would take to reach the current nearest hospital by public transport. It can be seen that journey times are considerably longer than by private transport (one hour on average).

Table 7 Estimated Travel Time by Public Transport, Current Nearest Site:

CCG	Ave. Time to Nearest Site (Single Journey Minutes)	Minimum Time to Nearest Site (Single Journey Minutes)	Max Time to Nearest Site (Single Journey Minutes)
NHS EAST LEICESTERSHIRE AND RUTLAND CCG	73	17	168
NHS LEICESTER CITY CCG	42	16	61
NHS LINCOLNSHIRE EAST CCG	125	34	257
NHS LINCOLNSHIRE WEST CCG	50	13	98
NHS MANSFIELD AND ASHFIELD CCG	76	37	108
NHS NEWARK & SHERWOOD CCG	77	47	108
NHS NORTH EAST LINCOLNSHIRE CCG	155	155	155
NHS NORTH LINCOLNSHIRE CCG	86	86	86
NHS NOTTINGHAM CITY CCG	42	10	169
NHS NOTTINGHAM NORTH AND EAST CCG	45	23	86
NHS NOTTINGHAM WEST CCG	39	13	74
NHS SOUTH LINCOLNSHIRE CCG	96	34	131
NHS SOUTH WEST LINCOLNSHIRE CCG	98	49	147
NHS SOUTHERN DERBYSHIRE CCG	54	8	158
NHS WEST LEICESTERSHIRE CCG	78	33	235
Grand Total	**60**	**8**	**257**

Table 8 below shows the average time it would take to travel to the National Rehabilitation Centre by public transport plus the average, minimum and maximum differences in journey times compared with travel to the nearest current site. While a small number of people may benefit from travelling to the NRC (shown in the minimum difference column), the average time to travel to the NRC by public transport would be over two hours. Most people would incur greater travel time (an additional 66 minutes on average) with people from the Lincolnshire CCGs particularly affected.

Table 8 Estimated Travel Time by Public Transport, Current Nearest Site and to NRC:

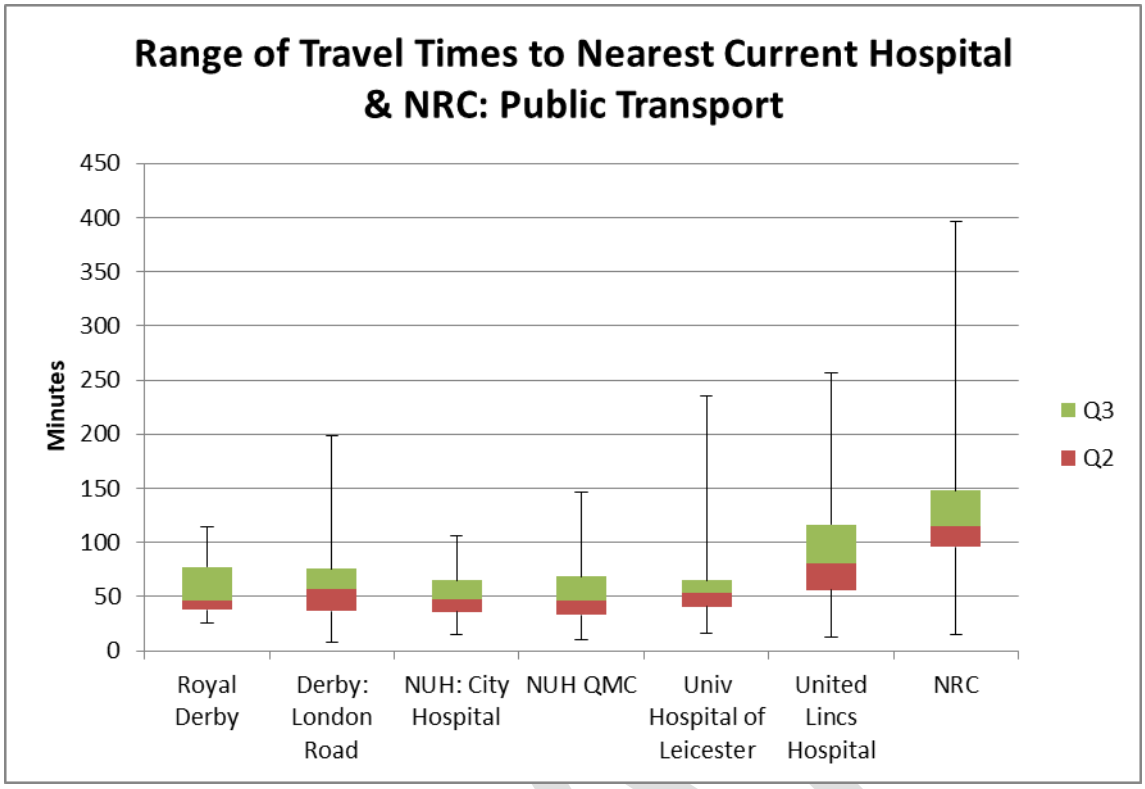
CCG	Ave. Time to Nearest Site (Single Journey Mins)	Average Time to NRC (Single Journey Minutes)	Average Difference To NRC (Minutes)	Minimum Difference To NRC (Minutes)	Max Difference To NRC (Minutes)
NHS EAST LEICESTERSHIRE AND RUTLAND CCG	73	138	65	9	236
NHS LEICESTER CITY CCG	42	132	89	42	209
NHS LINCOLNSHIRE EAST CCG	125	230	105	56	178
NHS LINCOLNSHIRE WEST CCG	50	171	121	63	167
NHS MANSFIELD AND ASHFIELD CCG	76	143	67	31	97
NHS NEWARK & SHERWOOD CCG	77	141	64	41	96
NHS NORTH EAST LINCOLNSHIRE CCG	155	278	123	123	123
NHS NORTH LINCOLNSHIRE CCG	86	244	158	158	158
NHS NOTTINGHAM CITY CCG	42	87	46	-39	109
NHS NOTTINGHAM NORTH AND EAST CCG	45	108	63	28	97
NHS NOTTINGHAM WEST CCG	39	105	66	37	118
NHS SOUTH LINCOLNSHIRE CCG	96	176	80	51	93
NHS SOUTH WEST LINCOLNSHIRE CCG	98	166	68	-2	133
NHS SOUTHERN DERBYSHIRE CCG	54	124	69	30	128
NHS WEST LEICESTERSHIRE CCG	78	117	39	-46	84
Grand Total	**60**	**126**	**66**	**-46**	**236**

Figure 5 below shows the minimum, maximum public transport journey times plus the interquartile range (middle 50%), and the mean average journey times for patients living closest to their current rehabilitation sites and to the NRC.

Travel to visit patients using public transport increases journey times considerably. Whilst more than 25% of people live within one hour by public transport of the hospitals currently used, only 3.6% live within one hour of the NRC.

It would take two hours and five minutes on average to travel to the NRC by public transport. This average is affected by some cases with very long travel times. However, the median travel time (the time for half the patients) is still 96 minutes.

Figure 5 Range of Travel Times by Public Transport to Nearest Current Hospital & NRC:



3.5 Other factors for consideration

Planning for the National Rehabilitation Centre aims to transfer "patients to a rehabilitation bed in a timely way, reducing the number of patient moves, reducing the overall length of stay for the cohort of patients and gaining improved outcomes"[3]. Reducing patient moves and the overall length of stay should mitigate some of the impact of longer travel times for visitors.

There will be three family rooms available at the National Rehabilitation Centre. These facilities will offer the potential for reduced visitor travel, especially if priority is given to those living furthest from the National Rehabilitation Centre.

[3] PCBC Synopsis, Miriam Duffy, Programme Director National Rehabilitation Centre.

Conclusions & Recommendations

4.1 Impact on patient journeys

It can be seen that there could be significant impact for some people visiting patients using rehabilitation services if all rehabilitation services are transferred to the National Rehabilitation Centre.

A small number of people, for example some of those from the Lincolnshire CCGs, would be particularly adversely affected. It is recommended that consideration is given to the availability of alternatives to treatment at the National Rehabilitation Centre for people living furthest from the proposed site. Providing choice in the location of rehabilitation services will be particularly important for visitors who do not have access to a car.

Nottinghamshire County Council

Report to Health Scrutiny Committee

10 September 2019

Agenda Item: 5

REPORT OF THE CHAIRMAN OF HEALTH SCRUTINY COMMITTEE

HEALTHWATCH

Purpose of the Report

1. To introduce a presentation on the work and role of Healthwatch and the reviews it has recently undertaken.

Information

2. Healthwatch Nottingham and Nottinghamshire is an independent organisation that helps people get the best from their local health and care services by ensuring the voice of local people is heard by those who design and deliver services.

3. Sarah Collis, the Chair of Healthwatch will attend the Health Scrutiny Committee to deliver the presentation on Healthwatch and its work.

RECOMMENDATION

That the Health Scrutiny Committee:

1) Consider and comment on the information provided.

2) Schedule further consideration, as necessary.

Councillor Keith Girling
Chairman of Health Scrutiny Committee

For any enquiries about this report please contact: Martin Gately – 0115 977 2826

Background Papers

Nil

Electoral Division(s) and Member(s) Affected

All

healthwatch
Nottingham & Nottinghamshire

Health Scrutiny
July 2019

healthwatch
Nottingham & Nottinghamshire

Our Unique Purpose

Healthwatch Nottingham & Nottinghamshire is the independent patient and public champion that holds health and social care services more accountable to their communities for the services they commission and provide.

Our unique overview across the whole of Nottingham and Nottinghamshire, includes commissioning, public health, health inequalities, social care, children and young people. We listen, collect experiences and share insights with those with the power to make change happen.

Our Strategic Approach

To achieve our unique purpose, we fulfill five key roles locally:

- **Facilitate Engagement** by supporting and bringing together early, effective and widespread involvement of communities
- **An Independent Voice** providing the means for people, particularly those who are seldom heard, to express their views and concerns
- **Evidence based Insight** being a local hub for collecting and analysing intelligence and data
- **Influence Change** by linking with and providing compelling feedback to system leaders on sustained improvements
- **Raising Awareness** to information that allows individuals to make informed choices

We are a values based organisation and adhere to our core principles of:

- Being **representative,** enabling all communities have to a meaningful voice
- Supporting the long term **sustainability** of **quality** health and social care services
- Being **responsive** to current concerns and issues raised
- We are accountable to the public by ensuring we are **transparent** in everything we do
- We **add value** by adopting best practice approaches and ensuring our professional standards at all times

The difference we make

- We facilitate targeted improvements in health and social care design and delivery
- We influence care to be patient and public centred
- We support collaboration, co-operation and integration; bring communities and systems closer together
- We facilitate shared aims and promote openness and transparency of change agendas

Key aims of Healthwatch Nottingham and Nottinghamshire are:

1. Making the views and experiences of members of the general public known to health and social care providers;
2. Enabling local people to have a voice in the development, delivery and equality of access to local health and social care services and facilities;
3. The promotion of high standards by health and social care providers
4. Providing training and the development of skills for volunteers and the wider community in understanding, scrutinizing, reviewing and monitoring local health and care services and facilities
5. Hold commissioners and service providers to account

A reminder of why Healthwatch was formed in 2012 and still remains essential

- Healthwatch was created in 2013 under the Health and Social Care Act 2012 to ensure service users are at the heart of health and social care delivery.
- This Act stipulates that local Healthwatch must be independent organisations that are not-for-profits and for run community benefit only.
- They were set up specifically to support the stated intention of increasing patient and public centred care, generating world leading health outcomes, enhancing collaboration and co-operation between health and social care bodies.
- We are an effective, powerful, representative and independent local public and patient voice for all aspects of health and social care services within a community. The local Healthwatch bodies also act to support local views in influencing national policy and practice through Healthwatch England.

Our Priorities 2019-20

1. Priorities of frail elderly and mental health, introducing a focus on young people. Plan and carry out a project on each of these areas in 2019/20
   - Frail elderly – support to manage at home
   - Mental health services for young people

2. Short focus
   - Domestic violence/sexual abuse survivors (Recommissioning)
   - Homeless – access to primary care
   - Mental health and drug/alcohol use (Opportunity Nottingham)
   - Opticians

Presentation will cover the following:

- Projects – what we have completed and what are we working on.
- Activity – what we are currently active in, what our volunteers are participating in.
- Impact – what we are achieving and what difference is it making.

Healthwatch Nottingham & Nottinghamshire Strategic aims 2019-21

Strategic aims
1. Measure and demonstrate our impact to others
2. Extend our reach, representing our local communities, especially the seldom heard
3. Build a responsive and sustainable organisation recognised as a leader in best practice engagement

Nottinghamshire County Council

Report to Health Scrutiny Committee

10 September 2019

Agenda Item:6

REPORT OF THE CHAIRMAN OF HEALTH SCRUTINY COMMITTEE

WORK PROGRAMME

Purpose of the Report

1. To consider the Health Scrutiny Committee's work programme.

Information

2. The Health Scrutiny Committee is responsible for scrutinising substantial variations and developments of service made by NHS organisations, and reviewing other issues impacting on services provided by trusts which are accessed by County residents.

3. The work programme is attached at Appendix 1 for the Committee to consider, amend if necessary, and agree.

4. The work programme of the Committee continues to be developed. Emerging health service changes (such as substantial variations and developments of service) will be included as they arise.

5. Members may also wish to suggest and consider subjects which might be appropriate for scrutiny review by way of a study group or for inclusion on the agenda of the committee.

RECOMMENDATION

That the Health Scrutiny Committee:

1) Considers and agrees the content of the draft work programme.

2) Suggests and considers possible subjects for review.

Councillor Keith Girling
Chairman of Health Scrutiny Committee

For any enquiries about this report please contact: Martin Gately – 0115 977 2826

Background Papers

Nil

Electoral Division(s) and Member(s) Affected

All

HEALTH SCRUTINY COMMITTEE DRAFT WORK PROGRAMME 2019/20

Subject Title	**Brief Summary of agenda item**	Scrutiny/Briefing/Update	Lead Officer	External Contact/Organisation
07 May 2019				
NUH CQC Inspection and Improvement Plan	Initial briefing on outcomes and planning following the CQC inspection	Scrutiny	Martin Gately	NUH
NUH Winter Plans	Briefing on lessons learnt from last winter and future plans	Scrutiny	Martin Gately	NUH
Muscular Dystrophy Pathway	Initial briefing on patient experience in the muscular dystrophy pathway, including the physiotherapy service	Scrutiny	Martin Gately	NUH
Dentistry in Nottinghamshire	An initial briefing on the commissioning of dental services in Nottinghamshire.	Scrutiny	Martin Gately	Laura Burns, NHS England
18 June 2019				
CCG Merger Consultation	Agreement of consultation response to CCG merger.	Scrutiny	Martin Gately	TBC
East Midlands Ambulance Service – Performance and Recruitment Update	An update on the progress by EMAS in filling vacant posts and against key performance indicators.	Scrutiny	Martin Gately	Annette McFarlane, Service Delivery Manager and Keith Underwood, Ambulance Operations Manager for EMAS
Patient Transport Service	The latest performance information on patient transport from the commissioners and Arriva.	Scrutiny	Martin Gately	Neil Moore and Lucy Dadge, Greater Nottingham CCG
23 July 2019				
NHS Property Services	An initial briefing on NHS Property Services and its interaction with tenant/providers.	Scrutiny	Martin Gately	Senior representatives of NHS Property

				Services.
Healthcare Trust CQC Inspection	Briefing on the Trust's improvement plan following recent CQC inspection.	Scrutiny	Martin Gately	Dr John Brewin, Chief Executive, Healthcare Trust
Treatment Centre	An update on the latest position with the procurement of the Treatment Centre.	Scrutiny	Martin Gately	Lucy Dadge, Executive Director Commissioning, Nottinghamshire CCG and Dr Keith Girling, Medical Director, NUH
10 September 2019				
National Rehabilitation Centre	Briefing on the current position.	Scrutiny	Martin Gately	Hazel Buchanan, Nottinghamshire CCG
Healthwatch	Briefing on the recent work of Healthwatch (including reviews).	Scrutiny	Martin Gately	Sarah Collis, Healthwatch
15 October 2019				
Whyburn Medical Practice Update	Update on contract and service provision.	Scrutiny	Martin Gately	Greater Nottingham CCG
Clinical Services Strategy Update	Further briefing on the strategy.	Scrutiny	Martin Gately	Greater Nottingham CCG
Nottinghamshire Healthcare Trust – Adult Services Update (TBC)	An update on a range of issues in Adult Mental Services, including feedback on additional bed spaces at the Highbury Hospital site.	Scrutiny	Martin Gately	Kazia Foster/Sandra Crawford, Healthcare Trust
NHS Long Term Plan	Update on local engagement and how this will inform local plan.	Scrutiny	Martin Gately	Lewis Etoria, Head of Communications, Integrated Care System.

3 December 2019				
NUH Improvement Plan Update	Further consideration of improvement plan following CQC inspection.	Scrutiny	Martin Gately	Dr Keith Girling, Medical Director NUH (TBC)
Muscular Dystrophy Pathway Update	Update following the previous consideration of the pathway in May.	Scrutiny	Martin Gately	Dr Saam Sedehizadeh, NUH (TBC)
Social Prescribing (TBC)	An initial briefing on the benefits of social prescribing.	Scrutiny	Martin Gately	Amy Callaway, Programme Manager, Integrated Care System
East Midlands Ambulance Service – CQC Inspection Report/Improvement Plan (TBC)	A briefing on the recent CQC inspection of EMAS with consideration of the associated improvement plan.	Scrutiny	Martin Gately	Richard Henderson, Chief Executive, EMAS
14 January 2020				
Nottingham Treatment Centre	Update on latest performance from NUH	Scrutiny	Martin Gately	NUH/Nottinghamshire Commissioners
Access to GP Appointments	Initial briefing on an issue of concern	Scrutiny	Martin Gately	Nottinghamshire Commissioners (TBC)
Dentistry Update	Update further to the previous consideration of this issue in May.	Scrutiny	Martin Gately	Laura Burns, NUH
25 February 2020				
Nottinghamshire Healthcare Trust CQC Inspection – Improvement Plan	The latest progress by the Trust against its improvement plan.	Scrutiny	Martin Gately	Dr Brewin, Chief Exec, Nottinghamshire Healthcare Trust
31 March 2020				

19 May 2020				
NUH Winter Plans	Annual consideration of winter planning issues.	Scrutiny	Martin Gately	Caroline Nolan/Rachel Eddie, NUH (TBC)
To be scheduled				
Public Health Issues				
Integrated Care System – Ten Year Plan (TBC)	An initial briefing on the ICS – ten year plan.	Scrutiny	Martin Gately	TBC
Parity of GP Service Coverage across Nottinghamshire				
Dementia Care in Hospital				
The administration of GP referrals				
Access to School Nurses				
Wheelchair repair				
Allergies in Children				
Operation of the MASH				
Mental Health issues (e.g. suicide) and GP referrals.				
Clinical Commissioning Groups' Merger				
Bassetlaw Hospital Update				
Frail Elderly at Home				
Patient Transport Service				

Performance Update (To be scheduled for December 2020)				
NHS Property Services (July 2020)				

Potential Topics for Scrutiny:

Recruitment (especially GPs)

Allergies and epi-pens

Diabetes services

Air Quality (NCC Public Health Dept)

Overview Sessions (To be confirmed)

Nottingham University Hospitals (NUH) – autumn 2019

East Midlands Ambulance Service (EMAS) – autumn 2019

VISITS

Urgent Care Pathway (QMC visit) – autumn 2019

Medium secure mental hospitals – TBC