Nottinghamshire County Council

Health Scrutiny Committee

Tuesday, 26 January 2021 at 10:30

Virtual meeting, **https://www.youtube.com/user/nottscc**

AGENDA

1	Minutes of meeting held on 15 December 2020	1 - 8
2	Apologies for Absence	
3	Declarations of Interests by Members and Officers:- (see note below) (a) Disclosable Pecuniary Interests (b) Private Interests (pecuniary and non-pecuniary)	
4	Dementia Strategy Update - Nottingham University Hospital	9 - 12
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6	Work Programme	143 - 148

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 15 December 2020 at 10.30am

COUNCILLORS

Keith Girling (Chairman)
Martin Wright (Vice-Chairman)

Richard Butler	Kevin Rostance
John Doddy	Stuart Wallace **A**
Kevin Greaves	Muriel Weisz
David Martin	Yvonne Woodhead
Liz Plant	

SUBSTITUTE MEMBERS

Councillor John Longdon substituted for Councillor Richard Butler

Officers

Martin Gately	Nottinghamshire County Council
Noel McMenamin	Nottinghamshire County Council

Also in attendance

Lucy Anderson	Nottingham & Nottinghamshire CCG
Julie Attfield	Bassetlaw CCG
Ajanta Biswas	Healthwatch Nottingham & Nottinghamshire
Lucy Dadge	Nottingham & Nottinghamshire CCG
Ruth Gadd	Nottinghamshire Healthcare Trust
Idris Griffiths	Bassetlaw CCG
Julie Hankin	Bassetlaw CCG
Dr James Hopkinson	Nottingham & Nottinghamshire CCG
Lucy Jones	Public Health, Nottinghamshire County Council
Joe Lunn	Nottingham & Nottinghamshire CCG
Dr Nick Page	General Practitioner
Rachel Lees	Nottinghamshire Healthcare Trust
Catherine Pritchard	Public Health Nottinghamshire County Council
Ann Wright	Nottinghamshire Healthcare Trust
Emma Wilson	NHS England – Yorkshire & Humber

1. MINUTES OF MEETING HELD ON 10 NOVEMBER 2020

The minutes of the meetings held on 10 November 2020, having been circulated to all Members, were taken as read and were signed by the Chair.

2. APOLOGIES

Councillor Stuart Wallace (Council business)

3. DECLARATIONS OF INTEREST

None.

The Chair agreed to re-order the agenda to accommodate NHS representatives' availability, with items taken in the order recorded below.

4. DENTISTRY AND ORTHODONTIC PROVISION IN BASSETLAW

Emma Wilson, Head of Co-commissioning, NHS England Yorkshire and Humberside introduced the report, which provided an update on the provision of dentistry and orthodontic services in Bassetlaw.

The report highlighted current dental provision in Bassetlaw, and explained the impact of the Covid-19 pandemic on services Because current national infection control guidance was in place, only a reduced capacity service, covering triage and pain relief, were currently in place. Check-ups and preventative work were not currently happening.

During discussion, a number of issues were raised and points made:

- It was acknowledged that under the current national contract there were gaps in respect of targeted provision for specific groups. NHS England had begun work on flexible commissioning for children under 5 years and those in care homes over the age of 75. However, there were very rigid funding mechanisms in place around units of dental activity, and these presented a barrier to developing a more flexible model;

- It fell to individual dental practices to best understand it's own capacity to deliver services in the current climate, and to prioritise patient need accordingly. Practices reported a range of different competing issues, but there had been an increase in reactive as opposed to planned dental work;

- It was acknowledged that there was an ongoing challenge to access NHS dentistry services, and Ms Wilson was not in a position to say what current backlog was in respect of accessing treatment. However, patients would not be removed from NHS registers to failing to attend for regular check-ups, given that these weren't being delivered;

- It was confirmed that all frontline dental staff were in the early cohort for receiving the Covid-19 vaccine, but there would be no change 'on the ground' until current standard operating procedures were changed. This was unlikely to take place before significant progress had been made on mass immunisation;

- It was confirmed that property and estate reconfigurations in view of the challenges presented by the pandemic were on NHS England's radar;

- the Committee welcomed news that there was an active workstream in place to take forward flexible commissioning, not just for children and those in care homes, but other specific hard-to-reach groups. The Committee asked that a further update be provided in one year's time.

The Chair thanked Ms Wilson for her attendance and contribution to discussions,

6. GP MENTAL HEALTH REFERRALS

The Committee considered a report and received a brief presentation highlighting the steps in place to identify and make interventions with patients at risk of suicide.

- Dr Nick Page provided a GP perspective, explaining that depression and anxiety were commonplace, and that it would not be possible to mitigate against all suicides. He acknowledged that it was very difficult to make an assessment during a 10-minute appointment, and that other underlying issues such as alcohol and drug use could mask and/or be catalysts for mental health crises.

- Ann Wright and Ruth Gadd from the Nottinghamshire Healthcare NHS Trust elaborated on the work of the Crisis Resolution and Home Treatment teams, which provided 24-hour assessment and home treatment intervention to those that would otherwise have been admitted to hospital. These teams worked closely with third sector providers such as Framework, Mind and CGL and had recently benefitted from increased resource.

- Lucy Jones and Cath Pritchard from the Public Health Team in Nottinghamshire County Council provided an explanation of the multiagency collaboration and partnership working arrangements in place within the Integrated Care System. It was explained that a joint City/County Suicide Prevention Strategy and Plan was already in place, and sought to reduce suicide and self-harm by improving mental health within the population and targeting known high-risk groups

- It was reported that funding of £209,000 had been secured to support Wave 4 suicide prevention, and that learning from the established Derbyshire suicide prevention model was being taken forward in Nottingham and Nottinghamshire.

A number of issues were raised and points made during discussion:

- A Committee member expressed the view that individuals still fell through the system, citing a constituent's experience of being in a custody suite over the

course of a weekend while physical and mental health needs remined unmet. This led to the resident entering the court system;

- A Committee member asked that Crisis Team contact details and criteria should be shared with councillors so that they were readily contactable, and that expectations could be better managed;

- It was explained that it wasn't just the Crisis team who could respond - individuals could also self-refer via the Mental Health Helpline;

- The Suicide Prevention Steering Group would be looking to define risk across the system over the next 12 months, with a range of external partners such as councillors, Police, East Midlands Ambulance Service informing the process;

- The view was expressed that a lot of work on multiple strands to suicide prevention was being pulled together and confidence was expressed that significant positive change would be made in forthcoming 12 months, notwithstanding the impact of Covid-19;

- CAMHS data was being monitored very closely in the wake of social isolation arising from Covid restrictions. While self-harm rates had risen, suicide rates were lower than in the same period 2 years previously;

- In view of the development currently in place to take forward a number of areas for action, the Committee requested an update on the roll-out of the Plan in 12 months.

The Chair thanked all the representatives for their attendance and contribution to discussions.

7. NHS BASSETLAW CLINICAL COMMISSIONING GROUP – IMPROVING LOCAL SERVICES - COMMISSIONING

Idris Griffiths of Bassetlaw CCG, assisted by Julie Attfield and Dr Julie Hankin, also of the CCG, introduced the report and presentation, which provided a further briefing on improvements to local health services in Bassetlaw, with a focus on improving adults' and older people's inpatient mental health services.

The report and presentation highlighted the following points:

- A key driver for change was that current provision comprised mixed wards of a size that exceeded guidance of the Royal College of Psychiatrists and featured dormitory accommodation, which breached current quality guidance. Provision also catered for both organic and functional patients, which again countered good practice;

- A potential solution identified was the creation of an Adult Mental Health inpatient unit for mid-Notts and Bassetlaw patients at Sherwood Oaks, and for a similar inpatient facility for older people at Millbrook;

- Pre-engagement activity had been carried out and engagement planning was progressing well. The Committee's comments on proposed engagement activity were invited;

- Engagement was to take place in January and February 2021 and, following independent analysis and verification, the CCG would make its decision in March 2021. No changes to inpatient mental health care would be made until the process was complete.

During discussion, the following points were made:

- Assurance was provided that waiting times were satisfactory and improving, and that patients were seldom signposted out-of-area. Similarly, access to community services was operating well;

- It was confirmed that the preferred solution would provide 8 beds more than current provision, which would help with any spike in demand arising from the Covid-19 pandemic. The increased capacity would help practitioners provide the appropriate response in a most timely way possible;

- It was confirmed that commissioners were aware of the major developments scheduled to take place near to the Sherwood Oaks site;

- It was also confirmed that engagement data will be considered in its entirety, and that addressing the transport and related issues was implicit within the Plan.

The Chair thanked Mr Griffiths, Ms Attfield and Dr Hankin for their attendance and contributions to the discussion.

5. EQUITY OF ACCESS TO GP SERVICES

The Committee considered a report and received a presentation, detailed in the agenda, on the equitable access to primary care in Nottinghamshire. Lucy Dadge, Joe Lunn and Dr James Hopkinson from the Nottingham and Nottinghamshire CCG were in attendance

Mr Lunn, Associate Director of Primary Care at Nottingham and Nottinghamshire CCG gave the presentation, which was published with the agenda, and highlighted the following:

- Arising from the most recent access review, primary care networks were required to provide extended hours access in the form of additional clinical appointments;

- Among the core requirement detailed in the presentation was the provision of additional weekday and weekend provision, increased use of digital approaches, better access to the wider system and an overhaul of practice websites to ensure patients had access to comprehensive information;

- Covid-19 had driven a sharp increase the use of telephone and video consultation, although face to face consultation still accounted for over 50% of all activity;

- The roll-out of 2021-22 contracts was to be delayed by 6 months to 10 October 2021, with extensions in that period to be covered by existing 2020-2021 arrangements;

- Appointment activity was in line with similar activity levels in 2019, following a sharp drop during the first national lockdown.

During discussion, the following points were made:

- The CCG was aware of the significant new housebuilding activity taking place in Hucknall, and addressing future need will need to form part of the relevant primary care network strategy. However, this was not a question of building new small practices, but of harnessing innovation and existing capacity to provide increased patient choice;

- In response to the view that very little Section 106 monies were accessed to provide additional health provision, CCG representatives indicated that in their experience there were barriers to access to this funding that was not of the health sector's making;

- CCG representatives advised that they were trying to secure 15-year contracts for all 10 Alternative Provider Medical Services contracts during re-procurement, and would be able to advise the Committee of re-procurement outcomes in due course;

- In response to Committee member's concerns about variations in service, CCG representatives advised that monitoring through PALS and Healthwatch helped keep commissioners sighted on variations. It was acknowledged however that the response to Covid-19 particularly during the first lockdown period was less uniform that had subsequently been the case.

The Chair thanked Ms Dadge, Mr Lunn and Dr Hopkinson for their attendance.

8. EAST MIDLANDS COUNCIL EVENT – SCRUTINY RESET AND RECOVERY WORKSHOP

The Committee approved the attendance of 4 members (2 Conservative, 1 Labour and 1 Ashfield Independent) at a future Scrutiny Reset and Recovery workshop event.

9. WORK PROGRAMME

In view of a critical Care Quality Commission report on Maternity Services at NUH, it was agreed that this be added to the Work Programme.

The Chairman also undertook to speak to Planning colleagues about the use of Section 106 monies to fund health provision, to determine the appropriate forum to consider the issue.

Subject to this, the Work programme was approved.

The meeting closed at 1:50pm.

CHAIRMAN

Nottinghamshire County Council

Report to Health Scrutiny Committee

26 January 2021

Agenda Item: 4

REPORT OF THE CHAIRMAN OF HEALTH SCRUTINY COMMITTEE

DEMENTIA STRATEGY UPDATE – NOTTINGHAM UNIVERSITY HOSPITAL

Purpose of the Report

1. To provide a briefing on Dementia Strategy at Nottingham University Hospital (NUH).

Information

2. The strategy describes NUH's priorities for developing Dementia services during 2019 – 2022 and details their commitment to work with patients, carers, the local community and staff to review, develop and monitor dementia care across a range of priority workstreams including end of life care and training.

3. Dr Ali Aamer, Consultant, Health Care of Older People and Katie Moore, Head of Patient Public Involvement at NUH will attend the Health Scrutiny Committee to brief Members and answer questions.

4. A briefing from NUH is attached as an appendix to this report.

5. Members are requested to consider and comment on the information provided and schedule further consideration, if necessary.

RECOMMENDATION

That the Health Scrutiny Committee:

1) Consider and comment on the information provided.

2) Schedules further consideration, if 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

Nottingham University Hospitals NHS Trust

Dementia Strategy Update Report For Health Scrutiny Committee Meeting January 26th 2021

Purpose of this report

This report provides a brief overview and update of our Dementia Strategy work.

Introduction

In November 2018 the Quality Assurance Committee approved the 2019/22 Delivering Excellence in Dementia Care Strategy. This strategy supports our vision to be outstanding in health outcomes and patient and staff experience and aims to respond to the national Dementia Strategy 'Living Well with Dementia' (2009) to:

- Raise awareness and understanding
- Early diagnosis and support
- Living well with Dementia

The strategy describes our priorities for developing Dementia services during 2019 – 2022 and describes our commitment to work with our patients, carers and local community and our staff to review, develop and monitor our Dementia care in the following priority work streams:

- Coming into hospital
- Ongoing care in hospital
- Leaving hospital
- End of life care
- People, training and culture

A Dementia Steering Group, chaired by the Trust's Lead for Dementia supported by five work-stream leads and representatives from Divisions and Departments meets monthly to guide, monitor and implement the strategy. Patient /Carer involvement is via variety of sources and groups including Alzheimer's Society,Dementia Action Alliance, internal and external patient and carer groups.

Current Situation

We are currently in the process of implementing Year 2 of our Dementia Strategy. Due to staff and resources being diverted to respond to COVID-19 have resulted in the suspension of some of the Dementia Strategy work. However significant progress has still been made in many areas in particular:

- Achievement of 70% compliance mandatory training target in October.
- Completion of Kings Fund Environmental Dementia Audit in ward areas in May/June enabling us to identify the following priority environmental issues for action in Q3/Q4 calendars and clocks, signage within wards and around the Trust, handrails, artwork/points of interest, labelling hot and cold taps
- Preparation for the development of the electronic Dementia assessment in Nerve Centre with Digital Services anticipating to commence work on this in January 2021 and develop it ready for go live by the end of March 2021.
- Examples of areas we have not made as much progress are research and system wide changes around information sharing.

- The many examples of kind, compassionate care demonstrated by our staff and local community has helped us to support and care for patients with Dementia and their carers during the pandemic and demonstrated a commitment to supporting and further

developing excellence in Dementia care. For example therapy staff supported by a Wellspring's Musician (funded by Arts Council COVID-19) provided one to one cognitive therapy and a range of music for patients.

- In line with national visiting restrictions in response to COVID-19 patients have not always had access to their carers during this period. However significant efforts were put in place to minimise distress and promote communication virtually and a range of resources rapidly developed and promoted directly to patients and carers and also made available on our website.Current guidance does now enable patients to have access to their carers and support is given to ensure this can be done in accordance with our infection control and safety policies and guidance.
- We have reviewed our year 2 strategy milestones and work plan in light of COVID-19 and at the moment we continue to work towards the actions below .Incorporating these actions in to our recovery and restoration plans as appropriate will support achievement of our year 2 Dementia Strategy Milestones.
    - Development and implementation of an electronic dementia and delirium screening tool
    - Promoting carer involvement and support
    - Information sharing between primary and secondary care
    - Further Development of dementia friendly environments
    - Improving information and processes around discharge
    - Promoting and training staff in the use of RESPECT forms
    - Staff and Volunteer training.
- We remain active members of the Nottingham and Nottinghamshire Integrated Care System Dementia Steering Group.
- There is a need to continually review and adapt as appropriate our Dementia Strategy work in response to COVID-19, local community and system wide requirements.

Conclusion

Although progress has been limited due to the effects of COVID -19 there has been some good progress towards achievement of the Dementia Strategy year 2 milestones. Staff training has increased and awareness has been raised internally about the need to increase and improve our care and facilities to best meet the needs of patients with Dementia and their carers. Strong links have been made within the local community and NUH has remained an active partner in the Nottingham and Nottinghamshire Integrated Care System. There is a need to continually review and adapt our Dementia Strategy work as appropriate in response to COVID-19, local community and system wide requirements.

Recommendation

The Overview and Scrutiny Committee is invited to receive, note and comment on our Dementia Strategy work undertaken and planned across the Trust in support of delivering patient centred Dementia care.
https://www.nuh.nhs.uk/nuh-dementia-strategy

Nottinghamshire County Council

Report to Health Scrutiny Committee

26 January 2021

Agenda Item: 5

REPORT OF THE CHAIRMAN OF HEALTH SCRUTINY COMMITTEE

TOMORROW'S NUH

Purpose of the Report

1. To provide a further briefing on the development of service at Nottinghamshire University Hospital (NUH) following the award of seed money from the the Department of Health Social Care's Health Infrastructure Plan 2 (HIP2).

Information

2. This topic was previously on the agenda of the Health Scrutiny Committee on 10 November 2020, when Members heard that the initiative provided the opportunity to transform the Trust's critical infrastructure, as well as its approach to care provision, while addressing health inequalities and spurring economic regeneration. Some of the potential changes over time could include the consolidation of emergency services, the establishment of a Women and Children's Centre, and having physically separate emergency and elective provision.

3. On 21 November 2020, the commissioners launched a public engagement exercise on the proposals to transform hospital services in Nottingham. The findings from this engagement are set out in Appendix 2 (Pre-engagement Findings Report).

4. Lucy Dadge, Chief Commissioning Officer, Nina Ennis, Associate Director of Programme Delivery and Lewis Etoria, Head of Insights and Engagement, Nottingham and Nottinghamshire Clinical Commissioning Group, as well as Phil Britt, Tomorrow's NUH Programme Director, NUH will attend the Health Scrutiny Committee to brief Members and answer questions.

5. Members are requested to consider and comment on the information provided and schedule further consideration.

RECOMMENDATION

That the Health Scrutiny Committee:

1) Consider and comment on the information provided.

2) Schedules further consideration.

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

Reshaping Health Services in Nottinghamshire and Tomorrow's NUH

Briefing for Health Overview and Scrutiny Committee

26 January 2021

In November 2020 we updated the Committee on the Tomorrow's NUH programme of work. This work aims to access HIP2 Government funding to invest in our local hospital services so that they are better set up to meet people's needs and improve people's health and wellbeing. Tomorrow's NUH is part of a programme of work we are calling Reshaping Health Services in Nottinghamshire, which draws together projects that aim to transform local health services.

At our last briefing to the Committee in November 2020 we described how we were developing a case for change that would enable us to access significant Government funding to invest in the hospital services and estate provided by NUH. We described the process of developing a Pre Consultation Business Case (PCBC), and undertaking pre consultation engagement, that will inform a full public consultation currently planned for summer 2021.

Since that time we have undertaken a programme of patient and public engagement to inform the development of our proposals. We have also undertaken work to develop a clinical model that will underpin our proposals. This briefing provides a summary of the feedback we have received to date and of our work to develop options for a public consultation.

Pre consultation engagement

Our engagement to date has included:

- A virtual events programme comprising 3 events, attended by 34 participants in total
- A programme of focus groups for in depth discussions with people with lived experience of cancer services; maternity services and urgent care, attended by 11 participants in total
- A survey gathering feedback on the outline clinical model developed for the programme, with a total of 415 responses
- A stakeholder reference group, chaired by Healthwatch, comprised of patient and public representatives
- Stakeholder engagement through organisations' boards and forums e.g. NHS provider organisations
- Engagement with key patient involvement forums through their existing meetings e.g. support groups for heart, cardiac and respiratory patients; Maternity Voices Partnership; Notts Deaf Wellbeing Action Group and more
- Outreach engagement, supported by Healthwatch, targeting specific patient cohorts, which were
    - Black, Asian, Minority Ethnic and Refugee (BAMER)
    - People with long term conditions/poor health outcomes
    - People with a disability
    - Frail older people

- Maternity service users
- Young people
- Lesbian, Gay, Bisexual and Transgender (LGBT).

A briefing document was developed to support this work and is included at appendix 1. This provides detail on the outline clinical model.

The headlines from the engagement to date are summarised within the engagement reports included at appendix 2 and appendix 3.

Work to develop options for consultation

Our engagement will inform the development of options for our planned public consultation. These options will set out our final model for hospital services, including how they are integrated with wider primary care, community and preventative services. It will also set out which services will be delivered from which locations.

As part of this work we are undertaking a thorough options appraisal process that takes into account clinical and financial considerations, as well as what patients and the public have told us. We are also undertaking detailed impact assessments on our proposals so that the public can be properly informed of the impact of each option we consult on.

Our final proposals for where we think services should be located will take into account:

- **The best clinical model for services**, particularly where services need to be located together. For example, we know that it is best for our maternity services to be alongside our emergency care services.
- **The impact on our patients**, and their views and preferences. This includes involving patients in our options appraisal process and making sure that the process considers the feedback we have received through our engagement.
- How to design services so that they have the best possible impact on **reducing health inequalities**.
- **Financial considerations** to ensure we achieve the best value from the money available.
- **The options we have for sites, buildings and equipment**, considering the locations we are already using.

The full list of criteria that we will apply to assess each option we consider in our shortlist is included at Appendix 4. We call these our ‘desirable criteria’ – they are the things each option needs to get right if our programme is to be successful. These criteria have been developed in partnership with patients, through the programme’s Stakeholder Reference Group.

We are working with clinicians and other stakeholders through a series of workshops to establish a shortlist of options. We are also involving our Stakeholder Reference Group in this process.

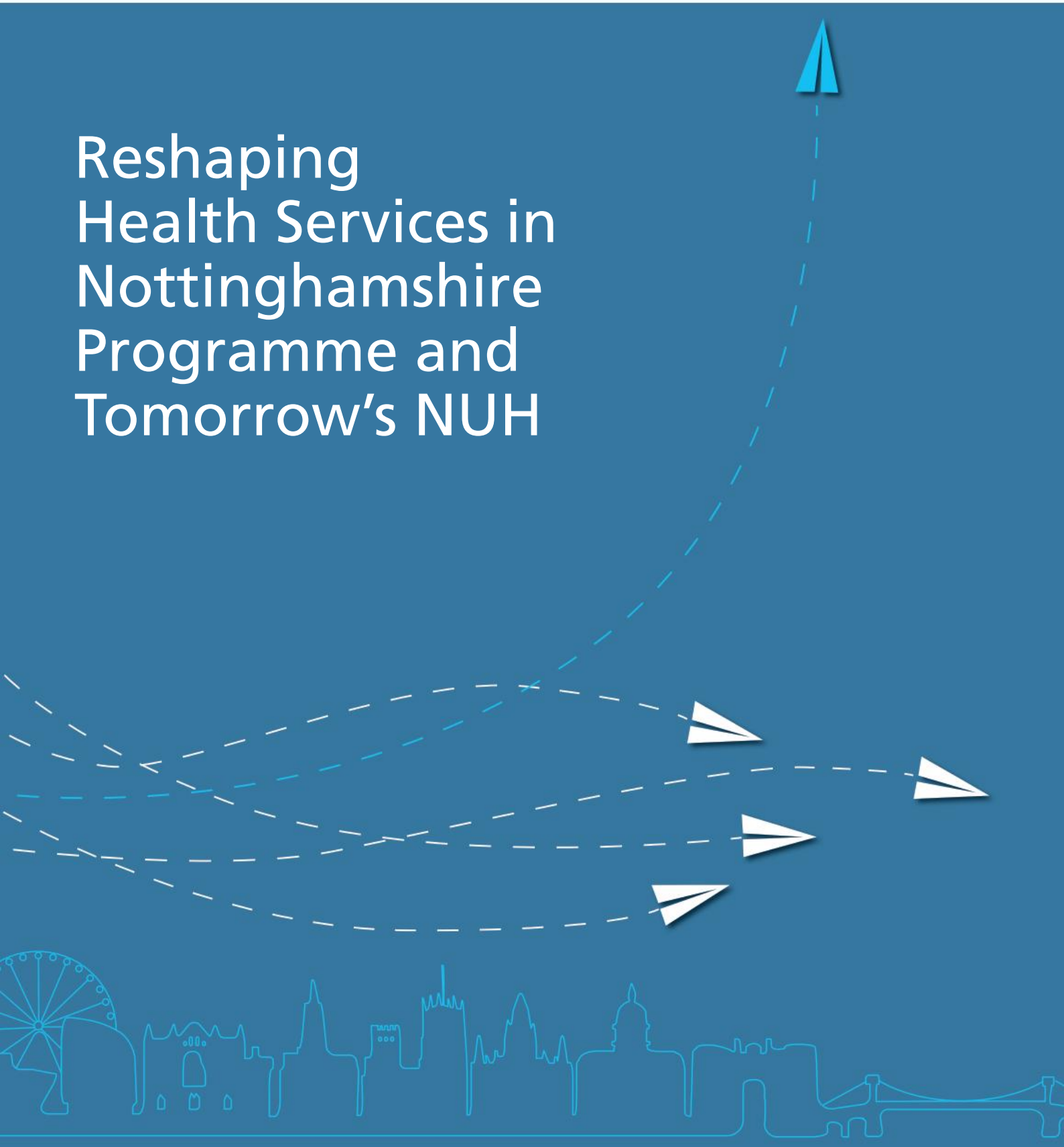
Next steps

Throughout January we will be working with clinicians, our Stakeholder Reference Group and other stakeholders to establish and evaluate a set of options for which services will be located where

Following this we will be developing a consultation plan and Consultation Document which will form the basis of a public consultation, planned for summer of this year. We will continue to engage with the Committee throughout this process.

NHS
Nottingham and Nottinghamshire
Clinical Commissioning Group

Reshaping Health Services in Nottinghamshire Programme and Tomorrow's NUH



Public Engagement
Stakeholder briefing

Who are we?

The Nottingham and Nottinghamshire Clinical Commissioning Group (CCG) is an NHS organisation led by local GPs. The CCG is responsible for understanding the health care needs of the population of Nottingham and Nottinghamshire and planning and paying for healthcare services. This includes listening to, and acting on, feedback from local people to make sure that services meet local need.

What are we doing?

Nottingham and Nottinghamshire Clinical Commissioning Group (CCG) is undertaking a two-month phase of public engagement on proposals to transform hospital services in Nottingham. These proposals are part of what we are calling Reshaping Health Services in Nottinghamshire. This plan aims to secure Government funding to invest in our local hospital services so that they are better set up to meet people's needs and improve people's health and wellbeing.

The part of our plan that we are talking to the public about is called Tomorrow's NUH, focused on services provided by Nottingham University Hospitals (NUH) NHS Trust. This involves all the health and care organisations in our area working together to create hospital services that meet the needs of local people now and in the future.

Why are we doing this?

The NHS in Nottingham and Nottinghamshire has an ambition to transform health and care services so that people living in our area live longer, healthier and happier lives. We know that our hospital services aren't currently set up in the right way for us to achieve this ambition. That is why we want to secure Government funding to invest in local services, facilities and buildings. Nottingham and Nottinghamshire has already been earmarked as an area that can be allocated significant additional funding for hospital services. To secure this funding we need to show that we have a plan for how we will use it to improve the health and wellbeing of local people. To do this we need to set out our case for change. Our case for change is a roadmap of the changes we need to make to our local services. We are talking to people about what those changes might look like and what they might mean for local people.

What happens next?

Next year we will be finalising a set of options for changes to hospital services and will put those options to local people in a public consultation. Before we do that, we want to involve people in developing our proposals. Working with doctors, nurses and health professionals across our area, we have started to identify the things we think we need to change. We are now talking to local people about those ideas.

What are we talking to local people about?

Over the coming months, we will be talking to patients, carers and families who may be affected by the changes we want to make. This public engagement is supported by Healthwatch and endorsed by our local health and care organisations. We will be holding a series of events, focus groups and a survey to share our ideas and gather views on:

This is very much the start of a conversation. We will consider the feedback from patients, carers and the public alongside clinical and financial considerations before developing a final set of options and proposals. These options will form part of a public consultation next year.

How can I have my say?

We have a series of engagement opportunities offering opportunities for the public to give their views find out more and ask questions.

Complete the online survey at:
https://www.surveymonkey.co.uk/r/RHSNtnuh2020

To request a paper copy of the questionnaire, or if you have any other queries regarding this engagement exercise, please email NECSU.engagement@nhs.net or call 0115 971 3592.

Public engagement events

To hear first-hand from clinical leaders, register to attend one of the following virtual events.

Event	Dates	Times	Register to attend
1	Tuesday 8 December	2.30-3.30pm	http://RHSNengagement.eventbrite.com
2	Tuesday 8 December	6-7pm	http://RHSNengagement.eventbrite.com
3	Friday 11 December	10-11am	http://RHSNengagement.eventbrite.com

Join a discussion group

We will also be running a series of discussion groups to explore the issues raised in the proposals in further detail. Simply email us to book your place on a discussion group.

Focus groups	Dates	Time	Register to attend
Group 1	9 December 2020	11am-12pm	
Group 2	10 December 2020	10-11am	
Group 3	10 December 2020	2-3pm	

These virtual events will take place via Microsoft Teams and joining instructions will be shared once you have registered.

Visit our website: **https://nottsccg.nhs.uk/RHSN/**
Call: **0115 971 3592**
Email: **NECSU.engagement@nhs.net**

Our plans for the future of our hospital services

To truly make a difference to people's health and wellbeing we know that we need a plan that describes how all of our hospital services will work together. That is why we are starting to set out what we call our outline clinical model. This is the plan that provides an overview of how we might set up all our services, guided by what senior doctors and nurses need to do their job.

NUH has achieved national and international recognition for many of its specialist services and are at the forefront of many research programmes. However, the current hospital infrastructure is not set up to deliver the ambitions we have for services in Nottingham and Nottinghamshire. The two large hospital sites that currently exist, Nottingham City Hospital and Queens Medical Centre (QMC), were designed at a different time to care for fewer patients with different needs to patients today.

Our vision for hospital services in the future is set out below, including what this will mean for local people.

What do we want to do?

We want our hospitals in the future to provide more specialist services (e.g. operations) and to provide more routine services (e.g. follow up appointments for ongoing conditions) in communities near to where people live. We also want to provide more routine services remotely, using phone calls and digital technology, where people are able to access these and where it is appropriate to do so. We want to create modern hospitals with the best possible facilities that our patients and staff deserve.

We want to relocate some services so that patients who need access to emergency or specialist care can get it quickly and safely. This would mean some services currently provided over two or more sites would be provided at one only, but that the care would be better.

We want to separate our elective care services (planned operations like new hips, knees and cataract surgery) from our emergency care services so that pressure on emergency services doesn't result in cancelled operations.

What will this mean for people?

This outline clinical model will mean that:

People would come to hospital less frequently and only if they required specialist care – for example emergency support, inpatient beds or operating theatres. The care people need in between their hospital appointments may happen in a local community setting or over the phone.

Some of the services currently provided in hospital would be provided in a community setting or remotely - this would mean most people have less far to travel for routine care such as follow up appointments for ongoing health problems.

Our hospital buildings and facilities would be more up-to-date and provide better care.

We would provide all of our acute maternity services on one site, so that they are co-located with emergency and specialist services.

All our emergency care services would be on one site, providing access to specialist services that patients may need without having to travel between sites by ambulance.

Planned operations would take place in a dedicated centre, separate from our emergency care services. This would protect planned operations from pressures in emergency care, where admissions to hospital through A&E often mean that we need to cancel operations.

What we want to know

Do you support our overall model?

What benefits do you think this model would bring for you and your family?

What concerns do you have about the model we have set out?

Our plans for emergency care

Emergency care is care for life threatening illnesses or accidents which require immediate or intensive treatment.

We currently provide emergency care services at both the QMC and City Hospitals. This means that when a patient arrives at A&E and needs input from certain specialties, for example, respiratory, cardiology, they need to be transferred by ambulance to the City Hospital for that care. This can add unnecessary delays to getting the care they need.

To ensure all of our patients get access to the right care when they need it, we want to explore the option of combining all emergency care services on one site, where they can be available 24 hours a day, seven days a week. This would mean, for example, that emergency services for stroke patients are on the same site as A&E.

What do we want to do?

We want to bring together all our emergency services on one site, alongside the specialist services that emergency care patients often need – for example services that help people with heart attacks. This would align us with the ambitions set out in the NHS Long Term Plan.

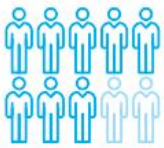
We want to reduce admissions to hospital for people who can be cared for safely elsewhere, by providing alternatives to care on a hospital ward. We would do this by providing Same Day Emergency Care, where patients can be assessed, treated and go home on the same day and by developing 'hot clinics' where patients who are able to can return home to be treated the following day.

We want to develop more community-based services that support people with long-term conditions so that they do not become so ill that they need to come to hospital.

We want to provide more joined-up emergency care, with mental health teams and social care support within our emergency care departments.

What will this mean for people?

We believe that making these changes will mean that:



Less people are admitted to hospital from A&E as we will have alternative ways of treating patients who don't need a hospital bed.

People are less likely to need to access emergency care services, as we will provide more community services to keep people well.

People with additional health or support needs who access emergency care will receive support specialist teams, for example mental health teams.

People will not stay in hospital longer than they need to. With input from mental health teams, social care and others we will work to discharge patients when they are able to go home.

Patients will not be transferred between sites to receive their urgent treatments

What is Same Day Emergency Care?

Same Day Emergency Care (SDEC) facilities are typically open 12-14 hours a day, seven days of week. Patients who arrive at A&E with conditions that can be quickly assessed, diagnosed and treated are transferred to the SDEC area where they are seen, treated and discharged the same day rather than being admitted to a hospital ward. This means patients can receive specialist care quickly and avoid long, unnecessary stays in A&E and avoid admission to a hospital bed.

Example:

Mr Smith arrives at A&E struggling with his severe cellulitis, which is a potentially serious skin infection. As he needs intravenous antibiotics, which have to be infused directly into his blood, he is admitted to a ward. He is monitored overnight and discharged the following day.

With Same Day Emergency Care Mr Smith would immediately be transferred out of A&E to a clinic to receive his antibiotics. He would be monitored and discharged the same day and be able to access the clinic directly if he begins to feel unwell again.

He would have to be admitted to a ward as he needs intravenous antibiotics. This means that he needs to be on a ward so that the antibiotics can be infused directly into his blood.

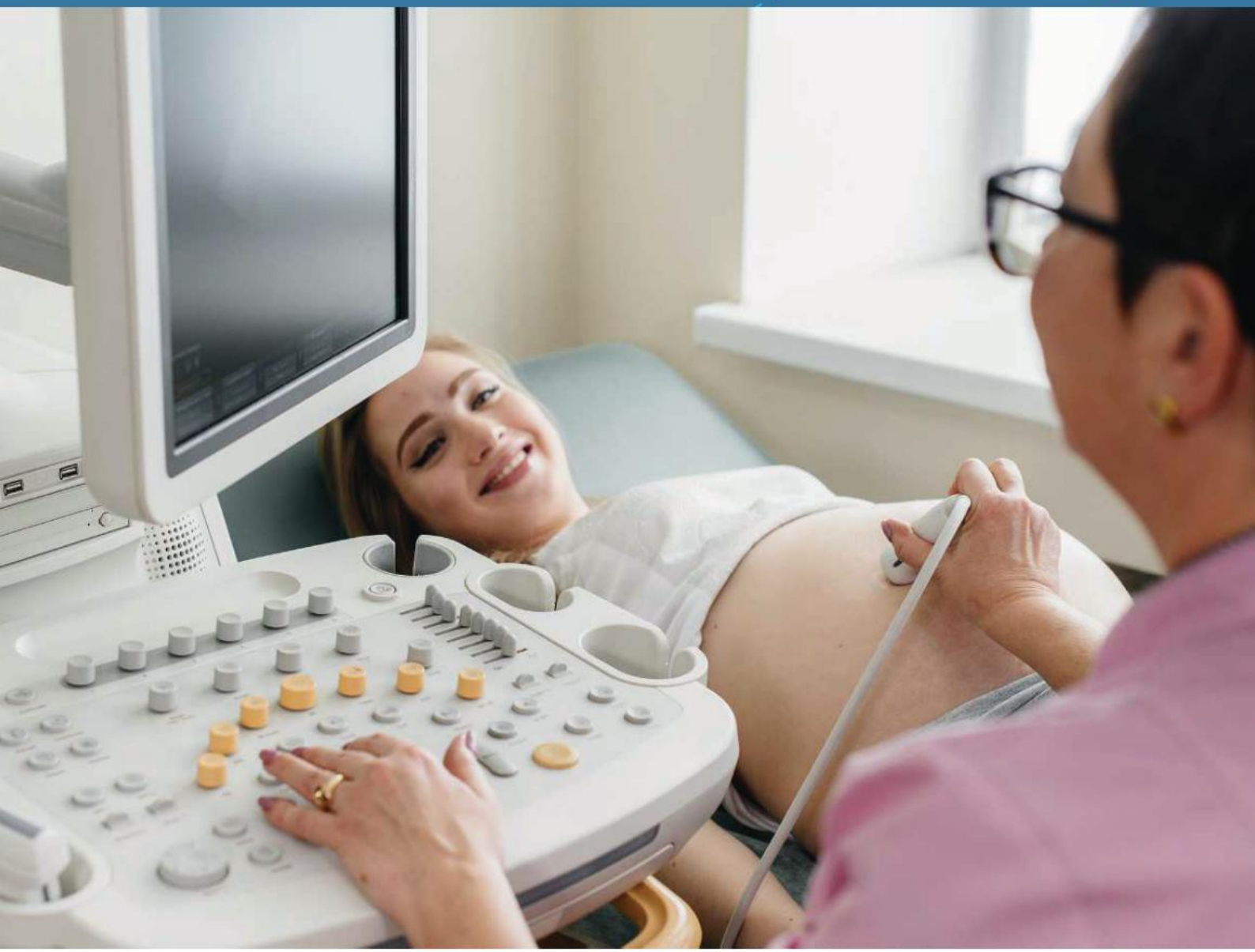
What we want to know

Do you support the model we are starting to develop?

What benefits do you think these changes would bring for you and your family?

What concerns do you have about the plans we have set out?

If you have accessed emergency care, what has your experience been like and what would you like to have been done differently?



Our plans for family care

Family care is care and services that are specific to women and children's health. It includes maternity care.

Our current women and children's services are split across the QMC and City hospitals and the community. Having our services split across sites means that we are not able to provide the same access to the services that work together to provide care for women and children. This results in transfers between sites and delays for women and children to the getting the care they need.

To provide the best, safest care for women and children we are exploring how we would bring services together into a single site as a women and children's hospital.

What do we want to do?

We want to bring together all hospital women and children's services, including maternity and neo-natal services, in a single women and children's hospital. We believe that the best place for this clinically would be next to our adult emergency services to provide easy access to specialist care. This would reduce the need to transfer women and children across our sites and reduce the need to transfer very young and sick babies out of our area.

In the future we want some of our children's services to be provided in our hospitals and some to be provided in other locations like a community clinic or GP surgery. We want to make sure that children are seen in the location most suitable for their health needs and, where appropriate, we will provide care and advice over the phone. We want to make sure that mental health services are available to children when and where they need them.

We want to provide services in modern, purpose built spaces that are designed for children and help reduce the fear they may have about coming to hospital.

What will this mean for people?

We believe that making these changes will mean that:

Women who access maternity care in hospital will be seen at a women and children's hospital.

Other services for women and children will also be provided at a single women and children's hospital.

This will mean less choice in location for services, but better care provided in a bespoke facility.

Women and children will be easily able to access specialist services that they may need without needing to be transferred across sites.

We will have our staff, doctors and nurses working with women and children all in the same place.

We will provide more services for women and children in community settings, like clinics and GP Practices.

Women will have better access to psychological and mental health support during and after their pregnancies.

What we want to know

- Do you support the model we are starting to develop?
- What benefits do you think these changes would bring for you and your family?
- What concerns do you have about the plans we have set out?

If you have accessed women and children's care, what has your experience been like and what would you like to have been done differently?

Our plans for adult elective care

Elective care is care that is planned in advance rather than emergency treatment. Elective care involves planned specialist medical care or surgery including things like knee, hip or cataract operations.

Our planned and emergency services are currently alongside each other. As pressure on emergency services grows and takes over more wards and beds it sometimes impacts our ability to carry out planned operations. This means that we end up cancelling operations because there are no theatres or beds available in intensive care or on our wards. This is not the experience we want to give our patients.

Our vision for planned care is that it should be delivered from dedicated facilities which are separated from our emergency work so as to reduce the risk of cancelled operations and reduce length of stay.

What do we want to do?

An important part of our plans is to create a dedicated planned care centre which will allow us to separate planned care from emergency care. At the moment, our emergency care services and planned care services sit side-by-side. A dedicated planned care centre away from emergency care would help to protect planned operations from cancellations.

We want to provide more elective care in community settings, where it is appropriate to do so. For example, we want to provide more flexible and accessible options for the care people need following an operation so that they don't have to come into hospital unless it is necessary. This could mean that some care is provided via advice, through a GP appointment or remotely via a phone call.

We want to make more use of remote consultations, making use of digital technology and phone consultations, where people are able to access care in this way. This may mean that follow up appointments after surgery and other appointments that don't require face-to-face contact are provided remotely.

What will this mean for people?

We believe that making these changes will mean that:

Less people need to come to hospital for planned care. Some appointments before and after an operation may be carried out in community settings or over the phone or using video technology, where it is appropriate to do so. This will mean less travel, reduced costs and less time out of their lives for the majority of people.

People will receive better care when they need to come to hospital, in a facility dedicated to care for patients who are having planned procedures. As this unit would be separate from emergency patients there would be fewer cancellations for patients.

How do emergency care pressures affect planned operations for patients?

As our A&E department becomes busier, particularly during winter, we have to admit more and more patients to hospital beds where they need emergency care. Sometimes these are beds that were earmarked for a planned operation. As pressure on our hospitals can increase very quickly, this means we sometimes have to cancel operations at late notice and sometimes more than once. This causes distress to patients and disruptions to their lives.

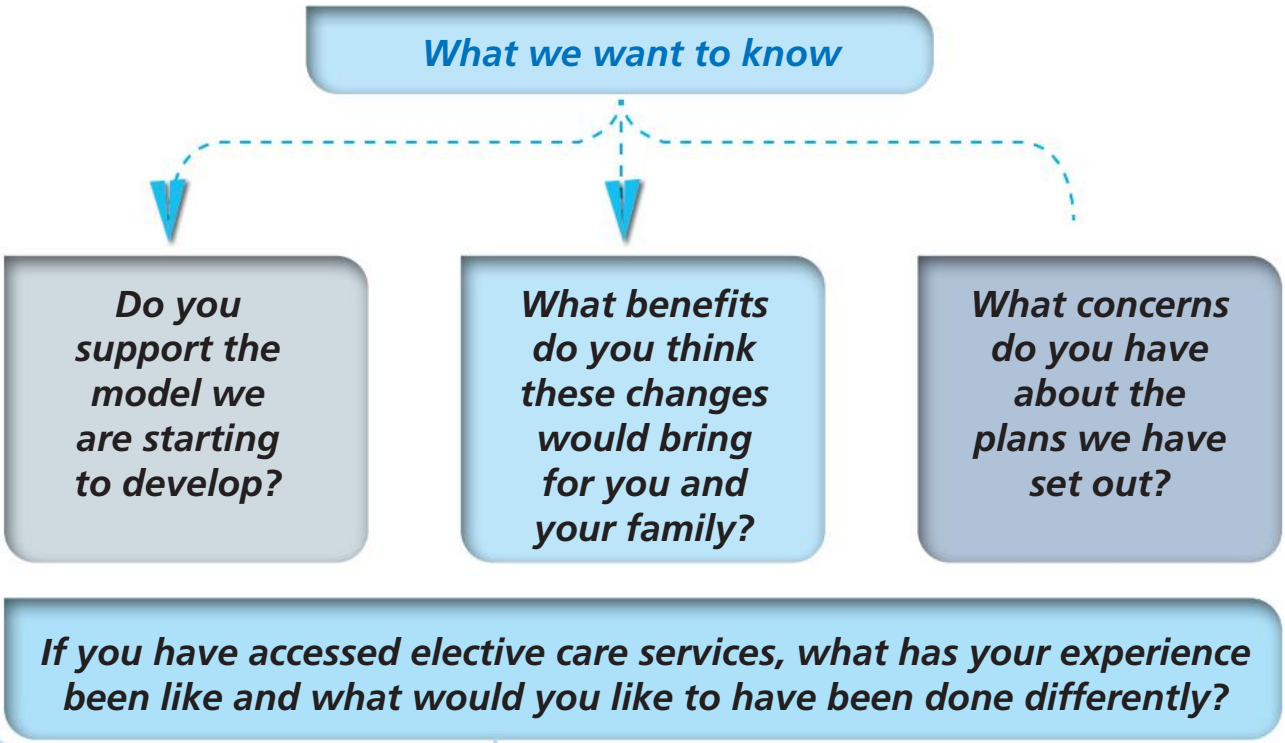
Example:

Mr McNamara is referred to hospital for a knee replacement and placed on a waiting list. He receives a letter with a planned date for his operation. Two days before his operation is due to take place he receives a phone call to cancel his operation. It is winter, the busiest time of year for the hospital, and because of the number of patients arriving at A&E who need a hospital bed there is no bed available for Mr McNamara.

Mr McNamara has his operation rescheduled for a few weeks later but, again, he receives a phone call two days before his operation to cancel it.

The operation does finally go ahead, although nearly two months after the original appointment was made and after two late-notice cancellations.

With a separate planned care centre, Mr McNamara would have chosen a date for his operation. He would have attended the centre for assessment before his operation and the operation itself would have taken place first time.



Our plans for cancer care

Cancer care is the diagnosis and treatment for patients with cancer. Patients are seen and treated in a planned way as well as sometimes being admitted as an emergency.

We currently provide cancer care services across the QMC, City Hospital and where our doctors provide some of our cancer services at other hospitals such as Kings Mill.

We would like to bring our cancer services together, alongside other specialist services that cancer patients sometimes need and with access to critical care.

What do we want to do?

We will have a focus on early diagnosis of cancer. Rolling out community health and screening programmes, we will make sure that more cancers are diagnosed early. This will increase people's chances of surviving. We will particularly focus on communities with traditionally low uptake of screening programmes.

We will provide more cancer services in community settings. Support for people before and after an operation or treatment may be provided outside the hospital, making services more accessible and closer to home for most people.

We will co-locate our specialist cancer services with other specialist services. This will mean that cancer patients have access to all the specialist areas of medicine they may need at any time.

What will this mean for people?

We believe that making these changes will mean that:

People will have a greater chance of surviving cancer, as we will detect and diagnose more quickly.

We will reduce health inequalities, through prevention and screening programmes that focus on those at greatest risk of cancer.

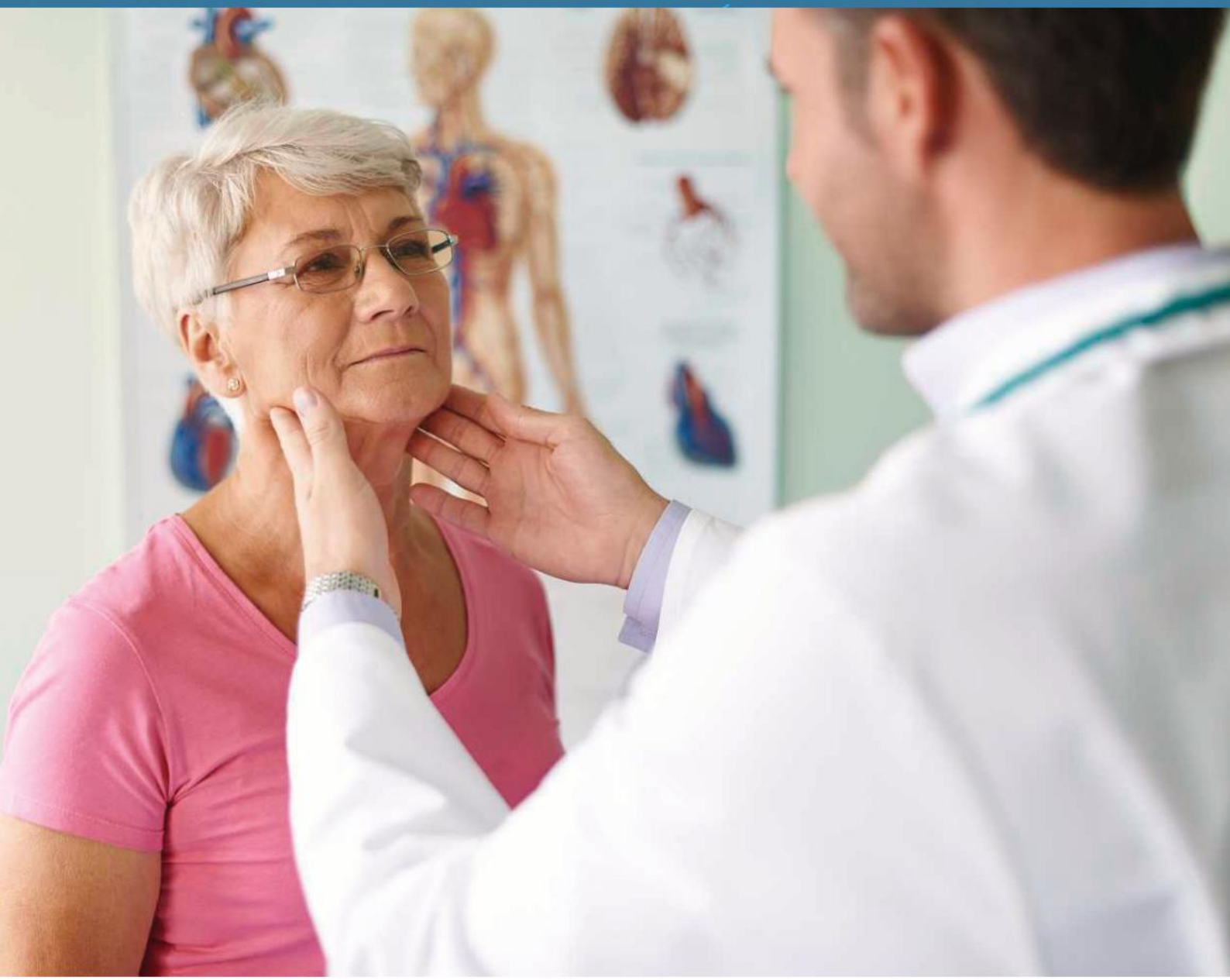
People requiring ongoing cancer care will be able to access care outside of hospital and closer to their homes.

Local people will have access to the best cancer care, as our specialist cancer services will be at the forefront of research and innovation.

What we want to know

- Do you support the model we are starting to develop?
- What benefits do you think these changes would bring for you and your family?
- What concerns do you have about the plans we have set out?

If you have accessed cancer care, what has your experience been like and what would you like to have been done differently?



Our plans for outpatient care

Outpatient care or ambulatory care is medical care provided on day-case basis, where patients are treated and discharged the same day without the need to stay in hospital overnight.

Outpatient care services are currently provided at the QMC including in the Treatment Centre, City Hospital, Ropewalk House and in some community settings.

We want to provide outpatient care that is more flexible and more convenient for patients, providing opportunities to access care outside of hospital.

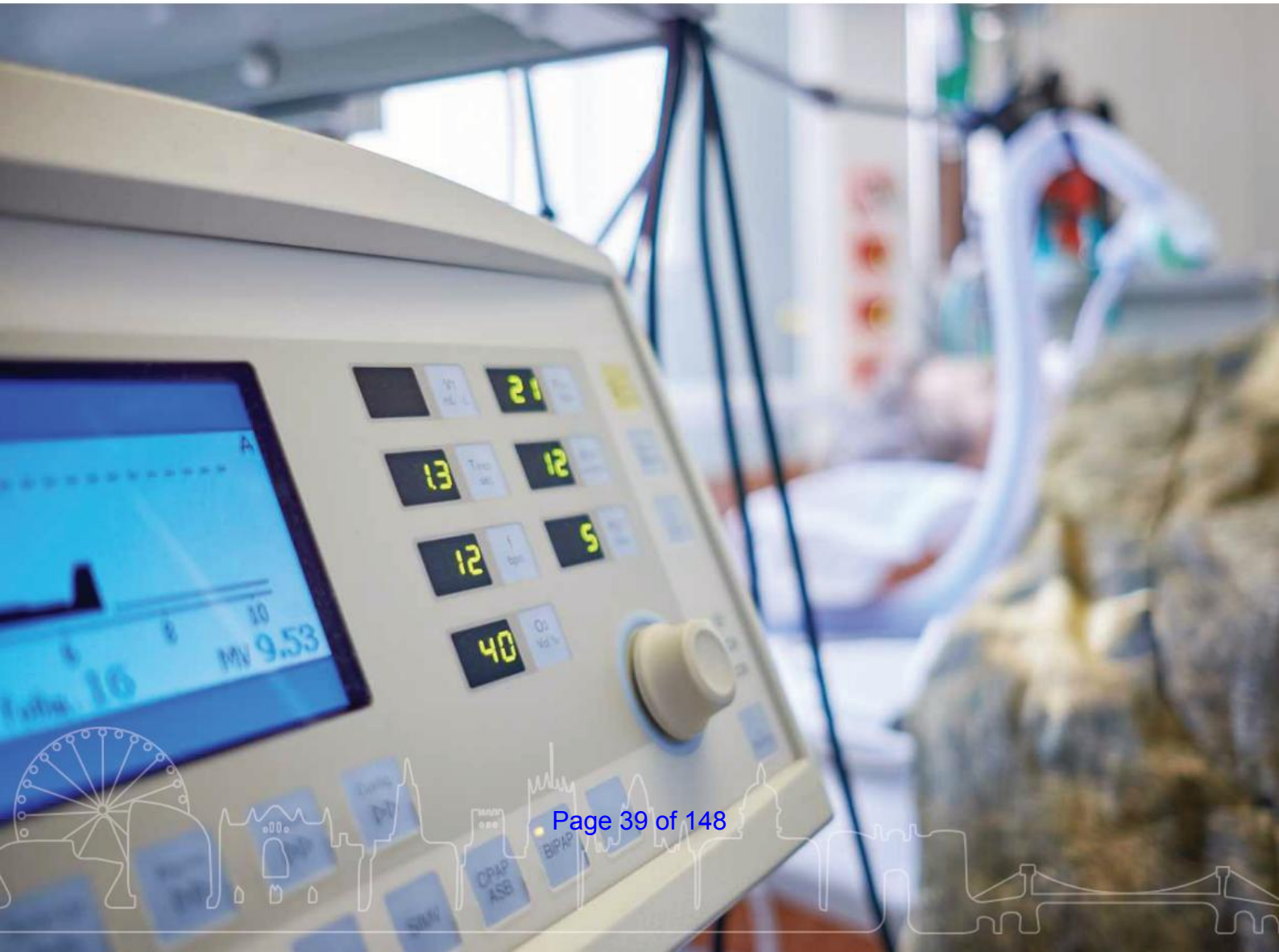
What do we want to do?

We want to provide less outpatient care in hospital and more in community settings or in people's homes or in community clinics or GP surgeries. We want to increase choice and flexibility for patients in when and where they receive care.

We want our teams to work flexibly, providing care at different locations across our area so that patients can access specialist doctors and nurses outside of hospital.

Remote Home Ventilator Monitoring

Typically a patient issued with a home ventilator will attend hospital regularly to review how well it is working. The Lancashire and South Cumbria Long Term Ventilation Service provides a remote ventilator monitoring service. This enables doctors to look at data on the effectiveness of the ventilator without the patient needing to come into hospital for appointments. This has saved patients' time, days off work and travel costs.



What will this mean for people?

We believe that making these changes will mean that:

People are less likely to have their outpatient appointment at hospital, and will have more flexibility and choice about when and where they receive their care.

Follow-up appointments will be more flexible, with patients able to initiate follow ups rather than having routine appointments.

Some care will be provided remotely – for example where patients have specialist equipment that can be monitored using technology.

What we want to know

Do you support the model we are starting to develop?

What benefits do you think these changes would bring for you and your family?

What concerns do you have about the plans we have set out?

If you have accessed outpatient care, what has your experience been like and what would you like to have been done differently?

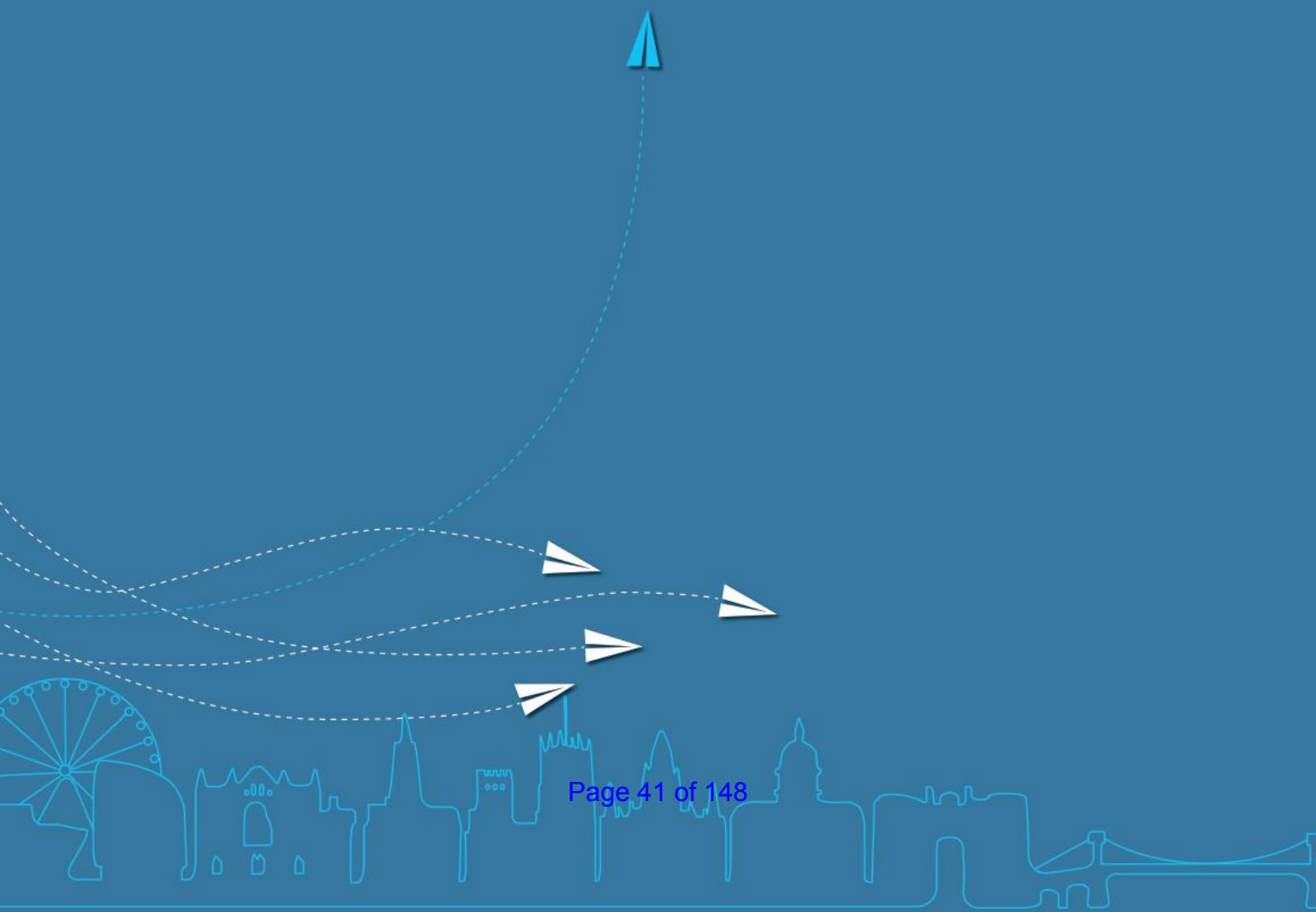
NHS
Nottingham and Nottinghamshire
Clinical Commissioning Group

Contact us

Please call us on: **0115 971 3592**.

Email: **NECSU.engagement@nhs.net**

To request this document in an alternative format please contact us using the details above.



Reshaping Health Services in Nottinghamshire Programme and Tomorrow's NUH

Pre-engagement Findings Report

January 2021

Version 1.0 (DRAFT)

Table of Contents

Executive Summary

Introduction

On 21 November 2020, NHS Nottingham and Nottinghamshire Clinical Commissioning Group (CCG) launched a public engagement on proposals to transform hospital services in Nottingham.

These proposals form part of what is called Reshaping Health Services in Nottinghamshire Programme, which aims to secure Government funding to invest in local hospital services so that they can be better set up to meet the needs of the local population, whilst improving people's health and wellbeing.

The part of the plan, which the engagement period focused on, is 'Tomorrow's NUH' – the services provided by Nottingham University Hospitals (NUH) NHS Trust.

The aim of the engagement was to gather the opinions of members of the public on the initial proposals developed by the CCG about the future of hospital services.

In total, 527 individuals participated in the engagement that took place between 21 November and 15 December 2020 – by either completing an online survey, attending an engagement event/focus group, or providing a response to the promotion of the engagement on social media.

Key findings

Survey respondents showed **strong support** for the model of future hospital services in Nottingham with 80% **strongly/slightly** supporting the draft plans.

More specifically, respondents showed the greatest support for the initial plans developed for cancer care (84%), adult elective care (82%) and emergency care (80%) with support for the plans for outpatient and family care slightly lower at 79% and 76% respectively.

Although a lack of detail in the proposals made it difficult for some to assess the pros and cons of what is being proposed (e.g. where services will be delivered and how they will be staffed/resourced) a number of themes were identified in terms of the perceived benefits and concerns that individuals had about the model of hospital services.

Benefits of the overall model

- *Care closer to home:* providing easier and more convenient access, particularly for those with disabilities/long-term conditions and the elderly.
- *Reduced need to travel to hospital through the provision of more localised services and use of digital appointments:* saving time, reducing costs and helping patients to avoid the parking difficulties at congested hospital sites.
- *Centralisation of emergency, maternity and cancer care resources and expertise:* streamlining services, improving efficiency, increasing capacity and delivering more focused care to patients. Page 45 of 148

- *Separation of adult elective care from emergency care:* resulting in less interruptions to planned specialist medical care or surgery and the associated inconvenience and stress that goes alongside this.
- *Improved access to specialist care:* providing faster and easier access for individuals to get the care that they need.
- *Improved patient outcomes and experiences through better, safer care.*
- *Use of digital consultations:* providing quicker/easier access through less unnecessary hospital visits; a particular benefit for those with childcare issues/work commitments/disabilities.
- *Less time spent in hospital:* through reduced hospital admissions and more community-based/digital appointments.
- *Access to care in the right place with reduced need to transfer patients between sites:* eliminating the stress and anxiety associated with this.
- *Access to more modern, purpose-built facilities.*

Concerns of the overall model

- Location and accessibility of the hospital and community services, with concerns about the appropriateness of venues, public transport access, travel costs and parking facilities.
- Use of, and reliance on digital consultations with concerns about the difficulties that some patient groups will face in using these (i.e. the elderly, those with learning difficulties and/or those without the technology/skills), their effectiveness and appropriateness, as well as patients having strong preferences for face-to-face communication.
- Issues about how appropriate staffing levels in hospital and the community (in light of current shortages) as well as concerns about deskilling/reduced training opportunities, travel implications and reluctance to change.
- Delivery of care within the community with specific concerns about:
    - The dilution of specialist care
    - The reduced quality of care that patients will receive in the community by less experienced/specialist staff
    - Community services (including primary care) being overstretched and under-resourced and unable to cope with the added pressure
    - The challenges associated with joining-up services to ensure patient flow and continuity of care (i.e. administration, communication and information and communications technology).
- Ability to implement changes including potential disruption to services and timeline.

- Cost/financial implications – questions were asked about the affordability of the model and whether community services will be funded sufficiently to deliver service improvements.
- Other concerns included decreased patient choice, privatisation of NHS services, and the space available for transferred/relocated services as well as perceptions that the exercise is a cost-cutting one aimed at reducing services/staff/beds – relocating care to the community.

Next steps

The feedback from this engagement will be used by the CCG, alongside clinical and financial considerations, to develop a final set of options for changes to hospital services, which will be put forward to local people in a formal public consultation in 2021.

1 Introduction

On the 21 November 2020, NHS Nottingham and Nottinghamshire Clinical Commissioning Group (CCG) launched a public engagement on proposals to transform hospital services in Nottingham.

These proposals are part of what is called Reshaping Health Services in Nottinghamshire Programme, which aims to secure Government funding to invest in local hospital services so that they can be better set up to meet the needs of the local population, whilst improving people's health and wellbeing.

The part of the plan, which the engagement focuses on, is 'Tomorrow's NUH' – the services provided by Nottingham University Hospitals (NUH) NHS Trust.

Over the past months, NHS Nottingham and Nottinghamshire CCG have been working with doctors and health professionals from across the area to identify what needs to change concerning hospital services. The aim of the current engagement is to share these early ideas with the public.

Feedback from this engagement will be used by the CCG, alongside clinical and financial considerations, to develop a final set of options for changes to hospital services, which will be put to local people in a formal public consultation in 2021.

2 Methodology

2.1 Overview

The aim of the engagement was to gather the initial thoughts of members of the public on the proposals to transform hospital services in Nottingham. Different engagement methods were used to engage with the public, including an online survey, engagement events and focus groups.

The engagement took place from 21 November to 15 December 2020 and promoted via a dedicated webpage on the CCG's website. A briefing was also shared with local NHS partners and stakeholders. In addition, the engagement was promoted on social media, advertised in the Nottingham Evening Post and via digital advertisements at nottinghampost.com.

2.2 Consultation survey

Members of the public, NHS staff, carers and stakeholders were invited to complete an online survey developed to gather opinion on the proposals. Paper and easy-to-read versions were made available. In total, 415 individuals provided a response to the survey.

A summary of the key demographics of this sample can be found in Section 3.0 with a full breakdown available within the Appendix.

2.3 Engagement events

Three engagement events were staged for people to give feedback about the proposals and ask any questions they had to CCG representatives. Due to social distancing guidelines, these were conducted online via Microsoft Teams.

At the start of each event, attendees were given an overview of TNUH and the outline clinical model by;

- Amanda Sullivan; Accountable Officer for Greater Nottingham and Mid Nottinghamshire CCG

- Dr James Hopkinson; Clinical Chair of NHS Nottingham North and East CCG.

Attendees were then given the opportunity to ask questions or provide any comments they had about the proposals using the chat function.

In total, 34 individuals attended the online events, the breakdown of which is shown in the table below.

***Table**: Engagement event - attendance*

Event	Date	Time	No. of attendees
Event 1	Tuesday 8 December 2020	2.30 - 3.30pm	11
Event 2	Tuesday 8 December 2020	6.00 - 7.00pm	11
Event 3	Friday 11 December 2020	11.00 - 12.00am	12

2.4 Focus groups

Individuals were given the opportunity to discuss their thoughts about the proposals for three of the services - emergency care, family care and cancer care.

A discussion guide was developed for each group to ensure that key questions were addressed and with permission of the participants, the groups were audio recorded and an anonymised transcript produced for analysis purposes.

In total, 11 individuals participated in the online focus groups, the breakdown of which is shown in the table below.

***Table**: Focus group - attendance*

Service	Date	Time	No. of attendees
Emergency care	Wednesday 9 December 2020	11.00 - 12.00am	5
Family care	Thursday 10 December 2020	10.00 - 11.00am	2
Cancer care	Thursday 10 December 2020	2.00 - 3.00pm	4

2.5 Additional responses

Some 67 individuals made a comment in response to the social media activity promoting the engagement.

2.6 Total sample

In total 527 individuals participated in the engagement, by either completing the online survey, attending an engagement event/focus group or providing a response to the promotion of the engagement on social media.

2.7 Analysis and reporting

J. Harvey Research Ltd was commissioned to analyse the findings of the engagement. The specific methods applied to analyse the findings were:

- Qualitative analysis: the findings from the engagement events and focus groups are constructed on an approach where the data from the session notes is analysed and responses grouped into themes that most closely represent the views expressed. Qualitative data does not allow for commentary on the specific number of times comments are made within these themes.

- Quantitative analysis: the survey was structured to include both closed and free text (open) questions giving respondents the opportunity to comment on the proposals in more detail. All free text responses were assigned a code, and codes grouped into categories to allow a quantitative representation of the feedback. For all questions, responses have been presented as a proportion of the number of individuals who responded to each question.

  It is important to note, that respondents to the survey are self-selecting, representing the views of those who wanted to give their views. This is very important opinion but cannot be treated as statistically reliable.

3 Survey sample

3.1 Demographics

In total, 415 individuals responded to the survey; the demographics of which are summarised below, with a full breakdown available in the Appendix.

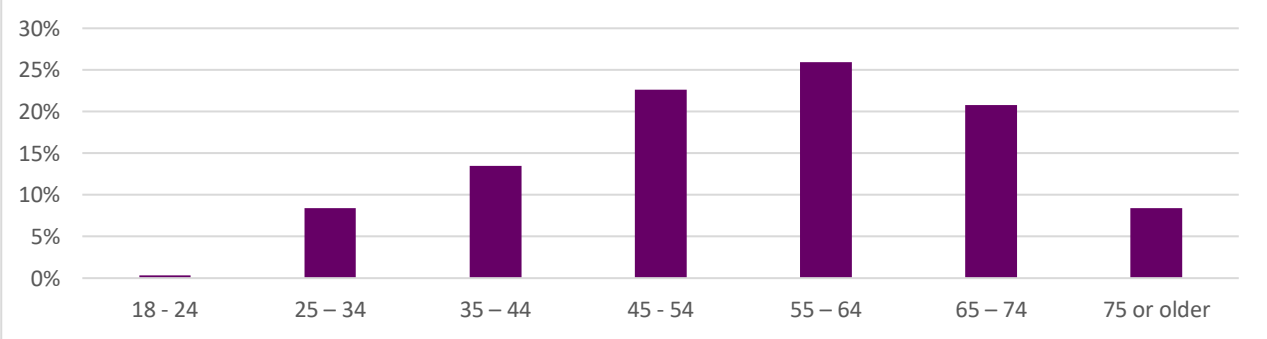
- Most respondents were from Rushcliffe (21%), Broxtowe (19%) or Nottingham City (17%), with smaller proportions from Gedling (14%), Newark and Sherwood (10%), Ashfield (7%) and Mansfield (4%). The remaining 8% were from another area.

***Table**: Location of respondents (N=279)*

	%
Rushcliffe	21%
Broxtowe	19%
Nottingham City	17%
Gedling	14%
Newark & Sherwood	10%
Other	8%
Ashfield	7%
Mansfield	4%

- The majority were female (80%), whilst 19% were male and 1% other; nearly all indicated that their gender matched their sex registered at birth (99%).
- The age profile of respondents is shown in the figure below, with most aged between 55 to 64 years (26%), 45-54 years (23%) and 65-74 years (21%) and smaller proportions 35-44 years (13%), 75 or older (9%) and 25-34 years (8%).

***Figure**: Age distribution of respondents (N=274)*



- The vast majority were White British (92%) and heterosexual/straight (93%).
- Just over half indicated that they had a disability, long-term illness or health condition (53%), whilst 3% were currently pregnant or had been in the last year.
- Most were married (66%), whilst 11% were single, 9% divorced/civil partnership dissolved and 8% cohabitating. Smaller proportions were separated (2%),

widowed or a surviving partner from a civil partnership (2%) or in a civil partnership (1%).

- Half indicated that they had caring responsibilities (49%).
- Most stated that they were Christian (54%) or did not have a religion (41%).

Most responded to the survey as a member of public (76%) or a member of NHS staff (31%). Smaller proportions responded as a carer (5%) or a stakeholder (1%).

***Table**: How individuals responded to the survey (N=415)*

	%
As a member of the public	76%
As a member of NHS staff	31%
As a carer	5%
As a stakeholder	1%
Rather not say	1%

**Participants were able to select more than one response hence the total does not equal 100%*

4 Plans for the future of hospital services

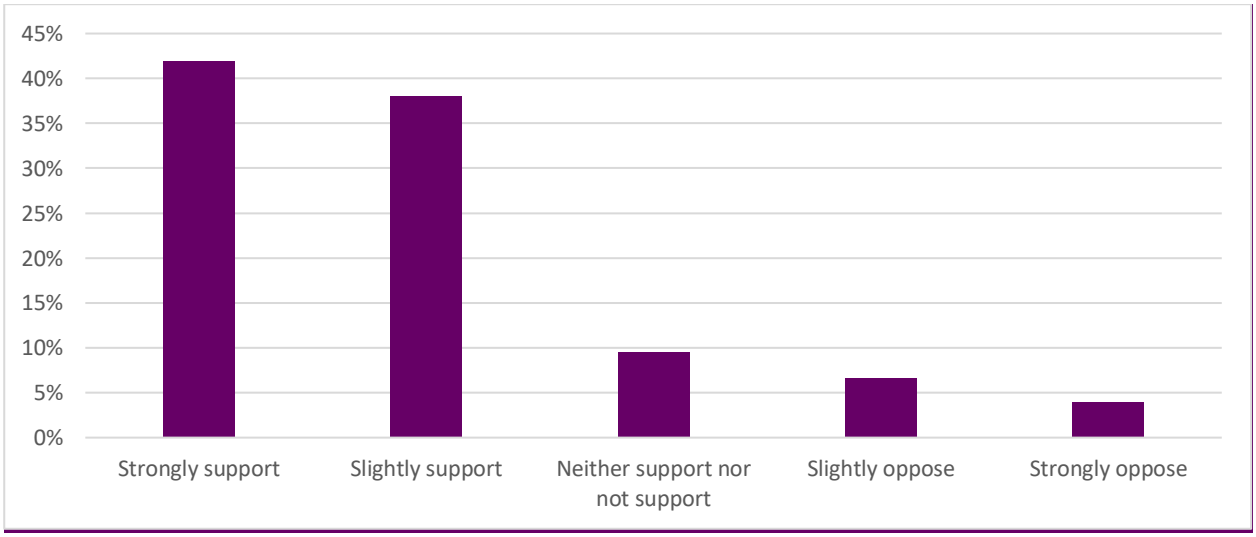
Individuals were provided with the following information about the proposed future of hospital services.

> We want our hospitals in the future to provide more specialist services and to provide more routine services in communities near to where people live. We also want to provide more routine services remotely, using phone calls and digital technology, where people are able to access these and where it is appropriate to do so. We want to create modern hospitals with the best possible facilities that our patients and staff deserve.
>
> We want to relocate some services so that patients who need access to emergency or specialist care can get it quickly and safely. This would mean some services currently provided over two or more sites would be provided at one only, but that the care would be better.
>
> We want to separate our elective care services (planned operations like new hips, knees and cataract surgery) from our emergency care services so that pressure on emergency services does not result in cancelled operations.

4.1 Survey feedback

Most survey respondents support the overall model of hospital services with 42% providing their strong support and 38% their slight support. Furthermore, 10% neither support nor oppose it, 7% slightly oppose and 4% strongly oppose it.

***Figure**: To what extent do you support the overall model? (N=410)*



The benefits that this model would bring to respondents and their families are shown in the table below; the key ones relating to care being delivered closer to home, reduced need to travel to hospital, the provision of centralised emergency, maternity and cancer care services as well as a dedicated facility separating adult elective care from emergency care.

'Local access to certain procedures will benefit communities much better. Not having to go to hospital might be less scary'

'Less travel to hospital, where it is too busy for me to cope with. It is also unaffordable to park at hospitals. Having to go out less and have appointments over the phone would very much benefit me, as I am disabled'

'Dedicated care for routine and emergency care gives me confidence the hospitals would run smoothly'

***Table**: What benefits do you think this model would bring for you and your family? (N=350)*

	%
Care closer to home - providing easier and more convenient access, particularly for those with disabilities/long-term conditions and the elderly	21%
Reduced need to travel to hospital - saving time, reducing costs and helping patients to avoid the parking difficulties at congested hospital sites	21%
No benefits / negative comment	18%
Concentration of resources and expertise (i.e. emergency, maternity and cancer care) – streamlining services, improving efficiency, increasing capacity and delivering more focused care	15%
Separation of adult elective care from emergency care – reducing cancellations and the associated inconvenience/stress that goes with this	15%
Improved access to specialist care – providing faster/easier access	13%
Other benefit, including: - Future proofing local NHS services - Patient clarity – simplicity and understanding - Patient-centred care - Improved working environments - Co-ordination between hospital and community services	11%
Other comment, including lack of detail within the proposal and benefits dependent on factors such as the location of services	9%
Better, safer care with improved patient outcomes and experiences	7%
Use of digital consultations – providing quicker/easier access by reducing unnecessary hospital visits; a particular benefit for those with childcare issues/work commitments/disabilities	5%
Less time spent in hospital i.e. waiting in busy clinics, reduced hospital admissions	4%
Delivery of care in the right place with reduced need to transfer patients between sites – eliminating the stress and anxiety associated with this	4%

Access to modern, purpose-built facilities	3%

In contrast, the concerns that respondents had about the overall model are shown in the table below. The key ones related to the location and accessibility of the hospital and community services, the use of and reliance on digital consultations, staffing and the dilution of specialised care into the community, which is not felt to be able/equipped to take on the extra demand - potentially resulting in more fragmented and reduced quality of care.

'One specialist A&E for the whole of Nottingham is not enough, it needs to be central and equidistant for all to access fairly'

'Sometimes when you have regular appointments at the hospital you feel like you've been checked over properly if you see the consultant face-to-face'

'Diluting services to the community reduces staff sharing specialisms and patients getting the best care. Telephone consultations miss symptoms which the patients may not consider relevant - a visual face-to-face consultation is so important'

***Table**: What concerns do you have about the model? (N=353)*

	%
Location and accessibility of the hospital and community services - with concerns about the appropriateness of venues (especially for those with disabilities), public transport access, travel costs and parking facilities.	24%
Use of, and reliance on digital consultations – with concerns about difficulties in access for some patient groups (i.e. elderly, those without the technology), their effectiveness/appropriateness, as well as patients having strong preferences for face-to-face.	19%
Other concern, including: - Hospital closure - Implications for elective care patients if emergency care is required - Reduced flex through the separation of elective care - More inpatient/hospital focus required - Suitability for all - Lack of consideration for capacity issues - Ongoing care for patients with long-term conditions being delivered remotely - Access to clinical support services e.g. radiology, pathology - Increased transfer of patients - Too much time/money spent on moving services	15%
Staffing - concerns were raised with regards to ensuring appropriate levels of suitably qualified staff in the hospital and the community in light of current shortages as well as deskilling, travel implications and reluctance to change.	12%
Delivery of care within the community with concern relating to: - The dilution of specialist care - The reduced quality of care that will be received in the community by less experienced/specialist staff - Community services (including primary care) being overstretched and under-resourced and unable to cope with the added pressure	11%

- The challenges associated with joining-up services to ensure patient flow and continuity of care (i.e. administration, communication and ICT).	
No concerns/positive comment	8%
Ability to implement changes including potential disruption to services and timeline.	6%
Cost-cutting exercise to reduce services/staff/beds and 'push care out to the community' as well as distrust for NUH management.	4%
Cost/financial implications with questions asked about the affordability of the model and whether community services will be funded sufficiently to deliver service improvements.	4%
Decreased patient choice	4%
Other comment including lack of detail about the proposal i.e. location of hospital/community services.	4%
Privatisation	3%
Other comment, including importance of engaging with staff, tackling inappropriate A&E use and improving transport links.	3%
Space available for transferred/relocated services with concern that hospital and community estates are not fit for purpose.	3%
Model hinders multi-disciplinary working	2%

4.2 Feedback from the engagement events

The following summarises the questions asked and comments made by the 34 individuals who attended the three online engagement events.

4.2.1 Discussion themes

Planning and leadership

- Query over the development of the model - evidence base/involvement of NUH staff in the formulation of ideas.

  'In building these plans, do you start from 'a clean sheet of paper' - what we would like if starting afresh; rather than starting from our existing facilities and how they can be modified/developed?'

- Suggestion that leadership by the Integrated Care System (ICS) may be more appropriate – due to uncertainty of the future of CCGs.

- Timeline to achieve plans – with concerns about how realistic they are.

  'I can only see this exercise taking place on a piecemeal basis so what is the timescale we are looking at? 15-20 years seems the most likely at the moment'

- Suggestion to focus initially on those services that are delivered better in the community e.g. dermatology and diabetes, to release capacity in secondary care.

- Past poor experience of transferring services into the community i.e. dietetic services and the impact on adult oncology patients.

Benefits of the overall model

- Sensible rationale.

  'It makes sense to rationalise maternity to one site, we are very lucky to have 2 major centres at the moment'

- Increased convenience for patients.

  'Being able to do follow-up visits in the community or online is good. It's often a lot of time and inconvenience for patients to go in for a 5 minute appointment'

- Reduced carbon footprint of NUH buildings, staff and patients – opportunities to link with NUH environmental policy.

- Covid-19 supports separation of adult elective care.

  'The inability to do this has had a detrimental impact on so many people'

- Opportunity to transfer budgets from secondary care into primary care/community care/social care/voluntary sector to support the model.

Concerns about the overall model

Location and accessibility	- Accessibility issues of merging services on one site. - Access to services in the community can be more difficult than a hospital site. - Queries over plans for the location of the centralised services and what would replace the services at the current sites. - Queens Medical Centre (QMC) and City Hospital campuses are both very congested – concern about space available for new/transferred services. - Importance of considering access, transport and parking availability of sites
Cost/financial implications	- Query as to whether investment will be made in a new build or renovation/repair of existing facilities. - Considerable investment needed to develop community/primary care services - estate not fit for future service developments. - Potential duplication of model due to the separation of elective care and the transfer of services to the community. - Importance of ensuring resources are available to support mental health teams within A&E.
Delivery of care within the community	- Continuity of care with transition from hospital to community care. - Impact on overstretched and under-resourced primary care, community and social care services. - Increased pressure on Primary Care Networks – query over their involvement in planning. - Potential privatisation: whether services moving to the community will be to existing NHS services or private providers.
Staffing	- Staffing issues – in light of current shortages.

	- Impact of separation of elective and emergency care on clinical staff. - Importance of engaging with staff re: changes to work practices, staff redeployment, new equipment etc. and ensuring recruitment, retention and an increase in training places.
Other	- Lack of clarity within the proposal makes it difficult to comment - Capacity issues will remain – safety valve of being able to delay elective will be lost. - Continuity of care whilst services are relocated. - Reduced patient choice. - Concern if elective surgery suddenly becomes an emergency. - Impact on service provision by cross boundary links.

Other considerations

- Importance of engaging with protected characteristic groups and use of plain English within all communications.

- Opportunities for members of the public to stay involved in the programme.

- Patient and staff resistance to change.

- Absence of Healthcare of the Older Person within the plans.

- Importance of provision of emergency mental health services in close association with physical emergency care.

- Plans for the future configuration for allied health services.

- Inclusion of the Treatment Centre.

- Opportunity to look at new roles and responsibilities and which are best placed to deliver the service.

- Links with the new rehabilitation facility at Stanford Hall Estate/consideration of rehabilitation and recovery following general surgery.

5 Plans for emergency care

Individuals were provided with the following information about the plans for emergency care in Nottingham.

What do we want to do?

We want to bring together all of our emergency services on one site, alongside the specialist services that emergency care patients often need – for example services that help people with heart attacks. This would align us with the ambitions set out in the NHS Long Term Plan.

We want to reduce admissions to hospital for people who can be cared for safely elsewhere, by providing alternatives to care on a hospital ward. We would do this by providing Same Day Emergency Care, where patients can be assessed, treated and go home on the same day and by developing 'hot clinics' where patients who are able to can return home to be treated the following day.

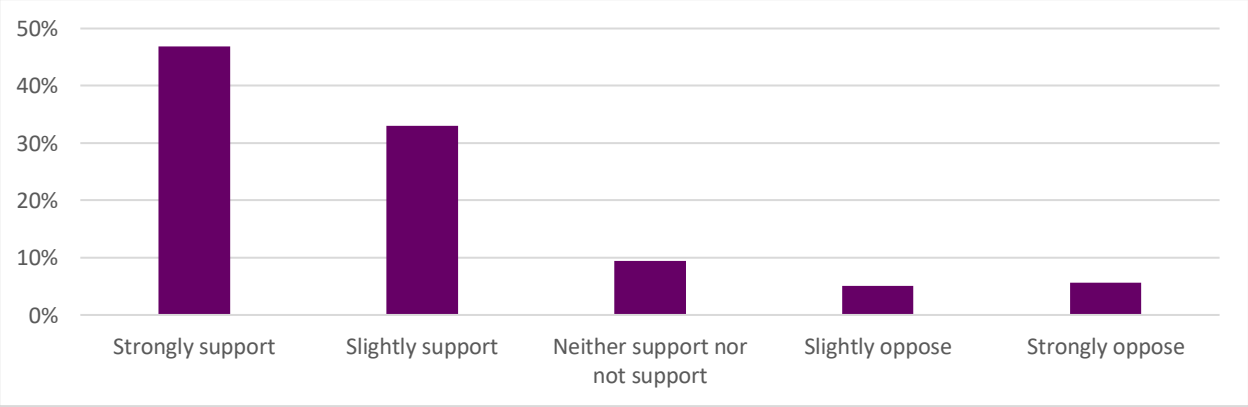
We want to develop more community-based services that support people with long-term conditions so that they do not become so ill that they need to come to hospital.

We want to provide more joined-up emergency care, with mental health teams and social care support within our emergency care departments.

5.1 Survey feedback

Most survey respondents support the model that is starting to be developed for emergency care with 47% providing their strong support and 33% their slight support. Furthermore, 9% neither support nor oppose it, 5% slightly oppose and 6% strongly oppose it.

***Figure**: To what extent do you support the model we are starting to develop for emergency care? (N=339)*



The benefits that this model would bring to respondents and their families are shown in the table below. As can be seen, the largest number of respondents indicated that the model would have no benefit to them or their family and/or provided a negative comment. These are addressed separately in the next survey question.

Those who could see the benefits, identified that there would be a reduced need to transfer patients between sites, a concentration of emergency care resources and expertise on one site, more prompt access to better and safer emergency care as well as patients having to spend less time in hospital.

'Not having to be transferred across sites if someone has a stroke or heart attack'

'One-stop shop for emergency care, delivering efficiency and effectiveness where it is most required. Saving lives'

'Access to emergency care when needed would be better and more streamlined'

***Table**: What benefits do you think these changes would bring for you and your family? (N=292)*

	%
No benefits/negative comment	21%
Reduced need to transfer patients between sites - providing quicker access to specialist care, reducing stress/anxiety and improving outcomes.	19%
Concentration of emergency care resources and expertise on one site delivering a more streamlined service with benefits to both staff and patients (i.e. more focused care, improved working environment).	17%
Faster/more prompt access to treatment	15%
Less time spent in hospital through reduced hospital admissions - freeing up beds.	11%
Better, safer emergency care improving patient outcomes and experiences.	11%
Greater provision of localised services - reducing travel time and improving preventative care.	8%
Other comment, including lack of detail within the proposal.	5%
Good/sensible model	3%
Investment in teams to support patients i.e. mental health and social care.	3%
Simplicity and understanding for patients	2%
Decreased pressure on A&E / the acute hospital	2%
Other benefit, including: - Separation of elective care - Better follow-ups - 24/7 service - Less stress for patients	2%

In contrast, the wide range of concerns expressed about the plans are summarised in the table below. The key issues are the location and accessibility of the centralised emergency care service and the community services, the dilution of specialist care into the community, which is not felt to be able/equipped to take on the added pressure. In addition: patients discharged from hospital too quickly and without the adequate care in place as well as the cost/financial implications of the changes.

'Where the hospital for emergency care will be based? How easy will it be for family members to visit especially if they have to use public transport?'

'That the community will not be able to cope as they do not have enough staff or equipment'

'That people may be forgotten as there won't be enough health care workers in the community'

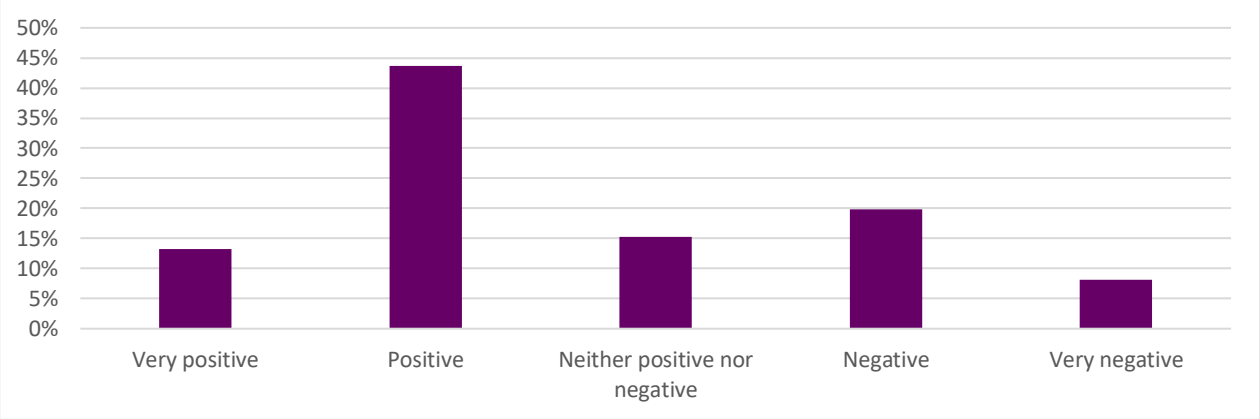
***Table**: What concerns do you have about the plans we have set out? (N=291)*

	%
Location and accessibility of the centralised emergency care service as well as the community services with concern about the impact of increased travel time in emergencies and the additional strain that will place on ambulance services.	16%
Delivery of care within the community with concern relating to: - The dilution of specialist care - The reduced quality of care that will be received in the community by less experienced / specialist staff - Community services (including primary care) being overstretched and under-resourced and unable to cope with the added pressure - The challenges associated with joining-up services to ensure patient flow and continuity of care (i.e. administration, communication and ICT).	16%
Other concern, including: - More staff and patient movement - Lack of 24/7 support in the community - Lack of consideration of inappropriate A&E use - Lack of holistic care focus - Hospital closure - Evidence for model - Isolation of some specialist services.	14%
No concerns/positive comment	12%
Patients being discharged too quickly from hospital without adequate community and/or social care support in place, resulting in decreased care and readmissions.	12%
Cost/financial implications - with questions being asked about whether sufficient investment will be made in community services, social care and mental health to support the model as well as the cost implications of re-structuring and the duplication that the model brings.	11%
Cost-cutting exercise to keep people out of hospital and reduce services/staff/beds as well as distrust with NUH management.	9%
Staffing - with concern about the additional staff needed to ensure appropriate levels of qualified staff in hospital and the community in light	7%

of current shortages as well as difficulties in attracting new staff, deskilling and reluctance to change.	
Other comment including lack of detail within the proposal i.e. location of hospital and community services.	10%
Ability to implement changes including potential disruption to services and timeline.	6%
Space available including additional pressure on transport infrastructure and parking.	5%
Confusion for patients in knowing where/how to access care	2%

Just under half of the overall sample had accessed emergency care services in Nottingham for themselves or a family member in the last two years (47%). Of these, 57% described their experience as very positive or positive, whilst 15% described it as neither positive nor negative and 28% negative or very negative.

***Figure**: How would you describe your experience? (N=197)*



Respondents provided a wide variety of suggestions as to what would have improved the care they received, the key ones being shorter waiting times, better communication and information, increased staffing and more pleasant waiting areas.

***Table**: Is there anything that could have improved your experience? (N=153)*

	%
Shorter waiting times including waits for triage, treatment, X-ray/other diagnostics and ward beds.	33%
Other improvement, including: - Less errors / misdiagnosis - Non-urgent patients being given the option to return home whilst they wait for surgery - Security of staff and patients - Separation of elective care - More mental health beds.	18%
Communication including more information about waiting times and improved communication between staff/staff and patients.	14%
Increased staffing	12%
Better waiting areas including improved signage and separate areas dependent on need i.e. mental health, learning disabilities.	10%
More up-to-date facilities including smaller bays/more cubicles for privacy, access to food and drink.	9%

Improved staff attitude – staff to show more compassion and empathy, and to listen to patients' needs.	7%
Improved standard of care	7%
More localised care to address inappropriate A&E use and provide care closer to home.	6%
Better co-ordination between services i.e. A&E, 111, primary and social care.	6%
Better parking including reduced charges and drop-off points.	3%
Less transfers to different wards / other hospitals	3%
Other comment	1%

5.2 Focus group feedback

Five participants took part in the emergency care focus group - all of which were members of the public and represented patient groups.

There was consensus among participants that the proposal would be beneficial in terms of *'having everything on one site'* to reduce duplications and reduce movement across the city for patients to receive the care that they need. Furthermore, it was generally agreed that having completely separate areas for emergency and elective care would be very positive.

Participants found it difficult to be more specific about the benefits without more detail about the proposal *'we need more concrete plans so that we can comment properly'.*

Although participants could see the overall benefit in principle, participants did have concerns about the challenges these changes may also present. These were largely in relation to the following.

- *Capacity:* there were concerns that neither of the proposed sites have the space available for all services to be brought together in one place.

- *Accessibility:* participants commented that due to capacity issues, car parking would be a problem at either site, especially at City Hospital where there are no tram and bus services.

- *Pressure on community care:* it was agreed that bed blocking was a key issue *'you see ambulances sitting outside emergency departments, as beds are not free'* and that increased community care was needed to reduce people using A&E. However, there was also the concern that community resources are drained and would not be able to meet the increased demand and support patients adequately *'care is better for them in the hospital setting instead of the community'.*

Participants wanted to know how long the whole process would take to complete and felt that the transformation of services needed to be done in a certain order, as well as encompassing other care sectors; *'there's no point in creating a new site until we improve community and social care'.*

The importance of this was felt in terms of both prevention; to reduce the need for A&E by improving care in the community, and aftercare to support people when they leave hospital to reduce readmissions.

The needs of certain population groups was also felt to be missing from the proposal, including those with mental health problems, who would need *'their own, separate discreet part'* of the hospital so that they do not feel overwhelmed in the busy areas, and the elderly who are felt to be at an increased risk of needing emergency care.

For those participants who had received emergency care themselves, or for their family members in the previous two years, it was felt that although the overall standard of care received was good, basic care was lacking, as staff simply did not have enough time.

Participants agreed that this proposal provided an opportunity to make services better; however training, resources and investments would be needed. It was also felt that basic education of the public to understand which conditions do require emergency treatment and those that can be treated elsewhere, would also need to be incorporated to support the overall plans.

6 Plans for family care

Individuals were provided with the following information about the plans for family care in Nottingham.

What do we want to do?

We want to bring together all hospital women and children's services, including maternity and neo-natal services, in a single women and children's hospital. We believe that the best place for this clinically would be next to our adult emergency services to provide easy access to specialist care. This would reduce the need to transfer women and children across our sites and reduce the need to transfer very young and sick babies out of our area.

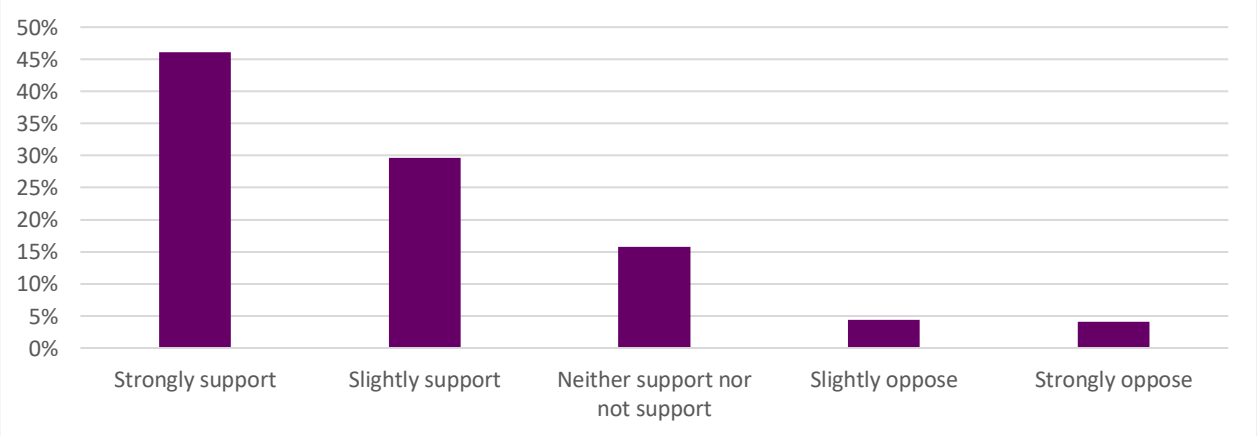
In the future, we want some of our children's services to be provided in our hospitals and some to be provided in other locations like a community clinic or GP surgery. We want to make sure that children are seen in the location most suitable for their health needs and, where appropriate, we will provide care and advice over the phone. We want to make sure that mental health services are available to children when and where they need them.

We want to provide services in modern, purpose built spaces that are designed for children and help reduce the fear they may have about coming to hospital.

6.1 Survey feedback

Most survey respondents support the model that is starting to be developed for family care with 46% providing their strong support and 30% their slight support. Furthermore, 16% neither support nor oppose it, 4% slightly oppose and 4% strongly oppose it.

***Figure**: To what extent do you support the model we are starting to develop for family care? (N=317)*



When asked to identify the benefits that the model would bring to respondents and their families, a variety of factors were discussed; the key ones being the concentration of resources and expertise all one site and better, safer care for women and children.

'Seamless ongoing care. Reduction in disparity between the two sites'

'It would be better than it is now. The Care Quality Commission has called the present maternity service at the QMC and City Hospital as inadequate and in need of improvement'

'Could make access to better care easier'

***Table**: What benefits do you think these changes would bring for you and your family? (N=240)*

	%
Concentration of resources and expertise on one site - streamlining services, improving/addressing staffing issues, reducing duplication and providing a single point of access and a consistent standard of care.	32%
No benefits/negative comment	21%
Better, safer care - improving outcomes for women and children	15%
Other comment including lack of detail within the proposal i.e. location of the centralised and community services and the need for involvement of Primary Care Networks.	10%
Increased access to care – providing quicker, easier and more convenient access.	7%
Provision of more localised care - reducing the need to travel	7%
Good/sensible model	6%
Less transfer between sites - ensuring mothers and their babies are treated on the same site	6%
Access to on-site emergency care	3%
Simplicity and understanding for patients	3%
Other benefit, including: - Holistic approach - Improved supervision of midwives	2%
Access to more modern / purpose built facilities	2%
Improved mental health support	2%

The concerns that respondents have about the plans for family care are shown in the table below. The key ones relate to the location and accessibility of the centralised family care service and the community services, reduced patient choice and the dilution of specialist care into the community, which is not felt to be able/equipped to take on the added pressure.

'Maternity services and children's services should be in two main locations so that people living south and north of the city do not have to travel far'

'You blatantly plan to cut beds / staff and decant patients into less qualified and less well staffed primary care which has been shown to fail'

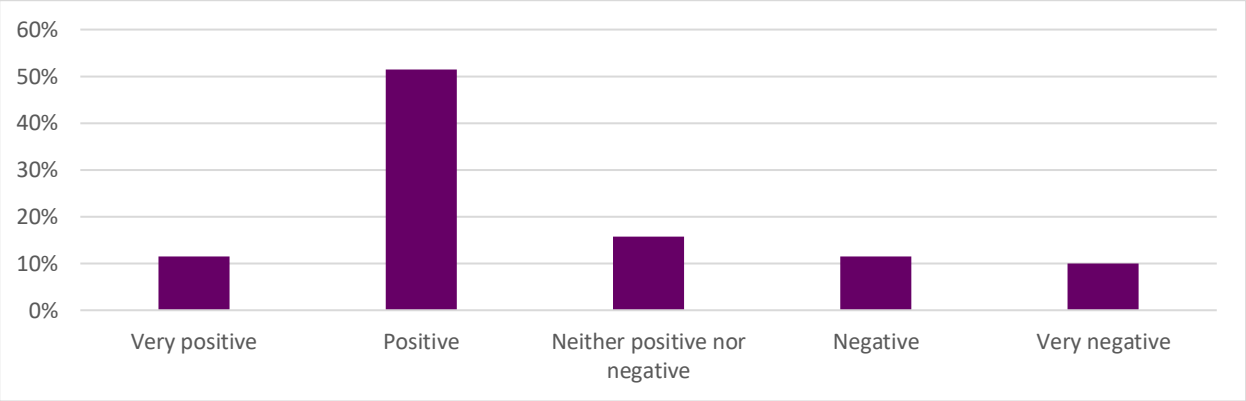
'People will not like the lack of choice, distance to travel'

***Table**: What concerns do you have about the plans we have set out? (N=254)*

	%
Location and accessibility of the centralised family care service and the community services with concern about the impact of increased travel time for women in labour	27%
No concerns / positive comment	23%
Other concern, including: - Waste of money constantly restructuring services - Less personalised care - Privatisation - The integration of women and children's services might be traumatic for some (i.e. those who have suffered miscarriages) - Changes impacting on existing good teams / services - Effectiveness of model - Staff involvement in decision-making - Patient confusion - Reliance on digital consultations.	12%
Reduced patient choice regarding location of care and birthing options with concern about those who may have experienced a poor service at one location.	8%
Delivery of care within the community with concern relating to: - The dilution of specialist care - The reduced quality of care that will be received in the community by less experienced / specialist staff - Community services (including primary care) being overstretched and under-resourced and unable to cope with the added pressure - The challenges associated with joining-up services to ensure patient flow and continuity of care (i.e. administration, communication and ICT).	7%
Space available - with concern that hospital and community estates are not fit for purpose.	6%
Cost-cutting exercise to reduce hospital services/staff/beds and push care into the community, as well as distrust for NUH management.	6%
Cost/financial implications - with questions asked about what funding will be available to invest in community services (including mental health), and whether the model will be more expensive to operate than how it is currently, resulting in a poorer service.	6%
Staffing – with concern about the additional staff needed to ensure the appropriate levels of qualified staff within hospital and community services.	4%
Ability to implement changes including potential disruption to services and timeline.	4%
Other comment including lack of detail within the proposal i.e. location of the centralised and community services, the need to consider children with special needs and the absence of genetic services from the plans.	4%
Terminology – the use of the term 'women and children's services' was felt to be inappropriate and exclude men/lone fathers/the non-binary community/other guardians.	4%
Access to other specialities – resulting in patient transfer / delays in treatment (i.e. neurosurgery, children's radiotherapy, bone densitometry)	3%

Just 16% of the overall sample had accessed women and children's care in Nottingham for themselves or a family member in the last two years. Of these, 63% described their experience as very positive or positive, whilst 16% rated it as neither positive nor negative and 21% negative or very negative.

***Figure**: How would you describe your experience? (N=70)*



When asked what could have improved their experience, a wide variety of suggestions were provided; the key ones being staff attitude, reduced waiting times/lists, more qualified staff and up-to-date, family friendly facilities.

***Table**: Is there anything that could have improved your experience? (N=49)*

	%
Other suggestion, including: - Better birthing facilities i.e. availability of pools - Greater support for breastfeeding / menopause - Use of digital consultations - Parking - Access for disabled patients - Electronic / paper records that patients and health professionals can add to	39%
Staff attitude – staff to show greater compassion and empathy, and listen to patients' needs	14%
Reduced waiting times / lists	14%
More qualified staff	14%
More up-to-date, family friendly facilities with increased privacy, green spaces and better laid out waiting areas	14%
A centralised service	8%
Better mental health support ante-/postnatally and following trauma	8%
Services closer to home / within local communities	6%
Better administration and communication	6%
Specific homebirth service / greater availability of home-birthing team	4%
Integrated, joined-up services	4%
Continuity of care including option for community midwife to be present at hospital consultations (in person or digitally)	4%
Improved discharge process	4%

6.2 Focus group feedback

Two participants took part in the focus group discussing the proposed changes to family care in Nottingham. Both participants were members of the public and represented patient / stakeholder groups.

Participants could clearly see the benefits of bringing all women and children's services together in one place. They further acknowledged that it is important to have local community access for aspects such as appointments and antenatal classes, as this would provide a better service for patients being closer to home.

However, participants recognised that the process of change would be challenging and further highlighted some specific concerns about the proposal. Primarily this was around space and accessibility in relation to parking at hospital sites, which are thought to be of particular concern to this service with visiting friends and family increasing demand.

Balancing the priorities of different services within one setting was also highlighted as a concern, acknowledging that careful planning is required *'to ensure the chaos of the emergency department doesn't interfere with the calm needed on maternity wards.'*

Furthermore, it was strongly felt that family care needs to be looked at in the wider context of the health and care system as opposed to being addressed as an isolated service.

Finally, participants stressed the importance of communication and public engagement, enforcing the key role that the opinions of the public should play in the development of the plans. It was also felt that any relaying of information to the public about service changes needs to be delivered sensitively.

7 Plans for adult elective care

Individuals were provided with the following information about the plans for adult elective care in Nottingham.

What do we want to do?

An important part of our plans is to create a dedicated planned care centre which will allow us to separate planned care from emergency care. At the moment, our emergency care services and planned care services sit side-by-side. A dedicated planned care centre away from emergency care would help to protect planned operations from cancellations.

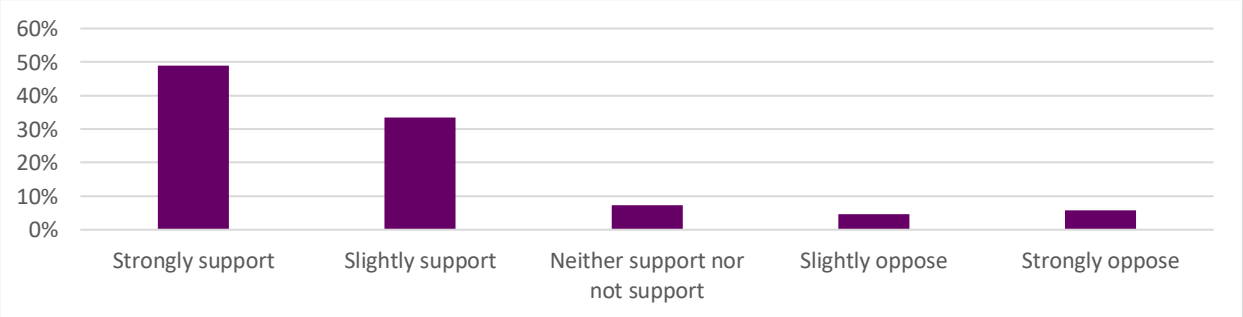
We want to provide more elective care in community settings, where it is appropriate to do so. For example, we want to provide more flexible and accessible options for the care people need following an operation so that they do not have to come into hospital unless it is necessary. This could mean that some care is provided via advice, through a GP appointment or remotely via phone call.

We want to make more use of remote consultations, making use of digital technology and phone consultations, where people are able to access care in this way. This may mean that follow up appointments after surgery and other appointments that don't require face-to-face contact are provided remotely.

7.1 Survey feedback

Most survey respondents support the model that is starting to be developed for adult elective care with 49% providing their strong support and 33% their slight support. Furthermore, 7% neither support nor oppose it, 5% slightly oppose and 6% strongly oppose it.

***Figure**: To what extent do you support the model we are starting to develop for adult elective care? (N=299)*



The key benefits that this model would bring to respondents and their families were identified as the delivery of a more seamless service with less cancellations/interruptions, reduced travel through the provision of more localised care and digital appointments as well as more prompt access to elective care (i.e. reduced waiting lists).

'Reduction in cancellations due to fluctuations in emergency care'

'Less stressful for the patient and no need to go to hospital for pre-care'

'Less crowding in the hospital, quicker response (hopefully)'

***Table**: What benefits do you think these changes would bring for you and your family? (N=241)*

	%
Delivery of a more seamless service with less interruptions / cancellations - reducing stress and anxiety for patients	26%
No benefits / negative comment	15%
Less travel with an associated reduction in cost	15%
More prompt access to elective care with reduced waiting lists	14%
More localised and improved access to elective care	11%
Dedicated facility for elective care – streamlining, improving efficiency and providing more focused patient care	8%
Less time spent in hospital i.e. waiting in busy clinics	7%
Better care and outcomes through an improved service	7%
Use of digital appointments – increasing convenience and reducing travel costs	6%
Other benefit, including: - Reduced pressure on A&E / the acute hospital - Less stress for the patient - Patient focus	6%
Good / sensible idea	5%
Other comment, including lack of clarity about the proposal	5%

In contrast, the key concerns that respondents have about the plans relate to the use of and reliance on digital consultations, staffing and being able to ensure appropriate resource levels in the elective care facility, on the acute site and within the community - as well as the transfer of care into the community, which may potentially reduce the standard and continuity of care that patients will receive.

'Separating elective from ED is in theory a wonderful idea, but allows people to become de-skilled at complex and emergency theatre/recovery/anaesthetics'

'Many staff posts are unfilled. All sites will have to be covered for emergency care. It is likely that staff will spend a lot of time driving between sites. Elective cases who develop an emergency will have to transfer sites anyway, or all sites would have to be covered which there are not enough staff for'

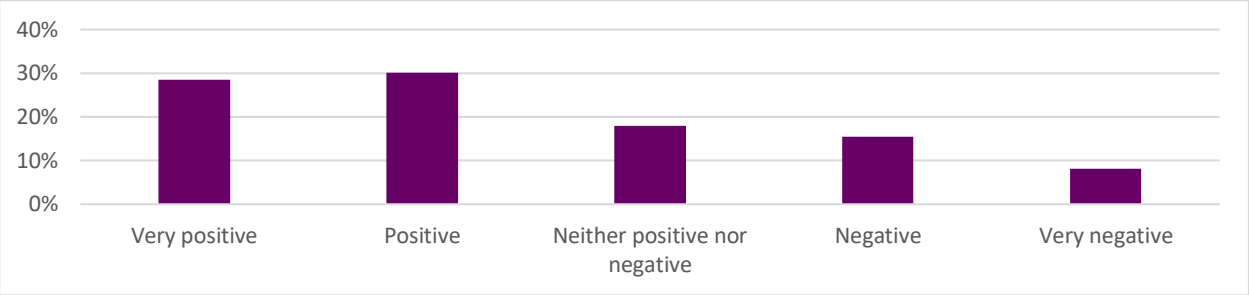
'Are you planning to make GP surgeries more like mini hospitals? I cannot think this will be cost effective and do you have enough GP's to take on more work? GP's are leaving the profession as some say there is too much work as it is'

***Table**: What concerns do you have about the plans we have set out? (N=244)*

	%
Use of, and reliance on digital appointments - with concerns about difficulties in access for some patient groups, their effectiveness/appropriateness and as well as some patients having strong preferences for face-to-face communication, particularly when meeting surgical staff/ teams.	25%
No concerns/positive comment	16%
Staffing - with concerns about ensuring appropriate levels in the elective care facility, on the acute site and within the community in light of current shortages as well as deskilling/reduced training opportunities, splitting staff between sites and reluctance to change.	11%
Delivery of care within the community with concern relating to: - The reduced standard of care that will be received in the community by less experienced/specialist staff - Community services (including primary care) being overstretched and under-resourced and unable to cope with the added pressure - The challenges associated with joining-up services to ensure patient flow and continuity of care (i.e. administration, communication and ICT)	10%
Other concerns, including: - Importance of staff and patient engagement - Ineffective model - Lack of support for day cases - Reduced patient choice - Space available i.e. extra theatre space - Increased responsibility placed on patients - Patients being discharged too quickly.	10%
Ability of the service to respond to patient complications and manage complex patients i.e. access to emergency/intensive care.	9%
Cost/financial implications - with questions being asked about whether the model will be affordable with the additional facilities/staffing required and what investment will be made in community services to make them fit for service development.	8%
Location and accessibility of the elective care facility and community services.	7%
Other comment, including lack of detail within the proposal i.e. location of the dedicated facility and community services and the importance of complementary therapies/healthcare education in schools/local phlebotomy service.	6%
Cost-cutting exercise to reduce hospital services/staff/beds and push care into the community, as well as distrust for NUH management	4%
Plans do not address wider capacity issues i.e. A&E relies on the flexibility of elective care.	4%
Privatisation	4%
Ability to implement changes including potential disruption to services and timeline.	3%

Approximately a third of the overall sample had accessed adult elective care services in Nottingham for themselves or a family member in the last two years (28%). Of these, 58% described their experience as very positive or positive, whilst 18% rated it as neither positive nor negative and 24% negative or very negative.

***Figure**: How would you describe your experience? (N=123)*



The key improvements suggested by respondents related to shorter waiting times and improved efficiency, better communication, greater integration of hospital and community services and more up-to-date facilities.

***Table**: Is there anything that could have improved your experience? (N=82)*

	%
Shorter waiting times / improved efficiency	18%
Better communication; between staff, different hospital departments, services as well as with patients (importance of clear, consistent information).	13%
Other suggestion, including: - Improved standard of care - Option for face-to-face appointments - More holistic care focus - Attitude of staff in private sector to NHS patients.	12%
Greater integration of hospital and community services to reduce fragmentation of care.	9%
More up-to-date hospital facilities including food, signage, privacy and access for disabled patients.	7%
Separation of elective care to reduce cancellations.	6%
Care provided during the Covid-19 pandemic i.e. increased waiting times and cancellations.	5%
Staff attitude – staff to show greater compassion and empathy, and listen to patients' needs.	5%
Reduced reliance on outsourcing of services	5%
Greater availability of, and cheaper parking	5%
Improved aftercare i.e. helplines, more detailed physiotherapy follow-ups	5%
Continuity of care – ensuring access to the same health professional/teams so patients don't have to repeat their medical history.	4%
Local access to services including phlebotomy.	4%
Less reliance on digital consultations; respondents had negative experiences of these and/or felt they were impersonal.	4%
More qualified staff	4%

8 Plans for cancer care

Individuals were provided with the following information about the plans for cancer care in Nottingham.

What do we want to do?

We will have a focus on early diagnosis of cancer. Rolling out community health and screening programmes, we will make sure that more cancers are diagnosed early. This will increase people's chances of surviving. We will particularly focus on communities with traditionally low uptake of screening programmes.

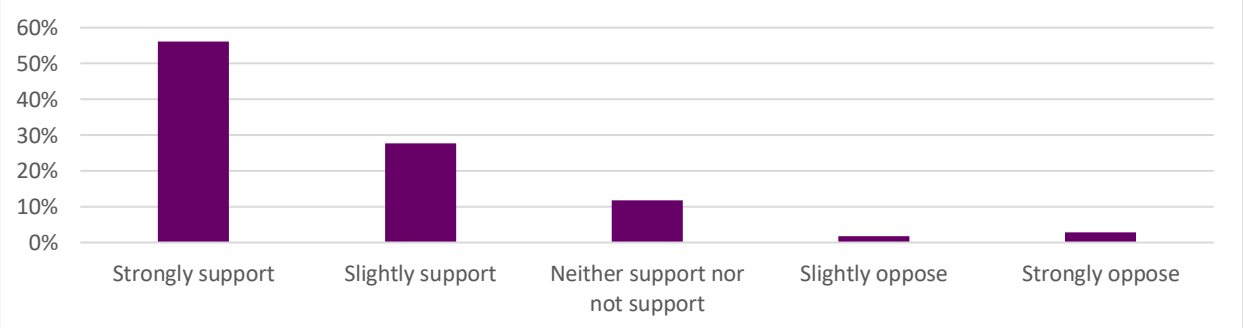
We will provide more cancer services in community settings. Support for people before and after an operation or treatment may be provided outside the hospital, making services more accessible and closer to home for most people.

We will co-locate our specialist cancer services with other specialist services. This will mean that cancer patients have access to all the specialist areas of medicine they may need at any time.

8.1 Survey feedback

Most survey respondents support the model that is starting to be developed for cancer care with 56% providing their strong support and 28% their slight support. Furthermore, 12% neither support nor oppose it, 2% slightly oppose and 3% strongly oppose it.

***Figure**: To what extent do you support the model we are starting to develop for cancer care? (N=289)*



The benefits that the model would have for respondents and their families are categorised in the table below; the key ones being the focus on earlier diagnosis through increased health and screening programmes, improved patient outcomes through better care and support, reduced travel through the provision of more localised care and the concentration of resources and expertise on one site.

'More prompt diagnosis of cancer and therefore better outcomes from treatment'

'Cancer care at the centre of the patients' needs, all in one place. Better outcomes'

***Table**: What benefits do you think these changes would bring for you and your family? (N=216)*

	%
Focus on earlier diagnosis	22%
Improved patient outcomes through better care and support	22%
Concentration of resources and expertise on one site – streamlining and providing a single point of access to specialist cancer care.	18%
Reduced travel through the provision of more localised care – making service access less onerous for patients, particularly those feeling ill/tired.	18%
No benefits/negative comment	15%
Improved access to cancer care – providing faster and easier access	11%
Other comment, including lack of detail about the proposal and the evidence supporting the plans.	6%
Other benefit, including: - Services at the forefront of research and innovation - Model builds on the excellent services currently provided - Less isolation for patients - Better multi-disciplinary approach to care - Modern facilities.	6%
Suggestion, including: - Nursing/care service to support patients at home - Improved testing including thermal imaging - Better access to treatments e.g. hyperbaric/high dose oxygen therapy - Chemotherapy services at Newark Hospital.	2%
Good model / change needed	2%

In contrast, the key concerns that respondents have about the plans relate to the location and accessibility of the centralised and community services, as well as the dilution of specialist care into the community which is not felt to be able / equipped to take on the added pressure, potentially reducing the standard and continuity of care that patients will receive.

'This is, yet again, a cost cutting model and patients will have to travel further to get treatment if it's just in one centre'

'Community services are not up to the job. GPs are bad at cancer diagnosis. The 2 week referral has been a life saver'

'Will there be enough support in the community? Will it make inequalities worse? Is there money in the community? Will specialists forget patients in the community?'

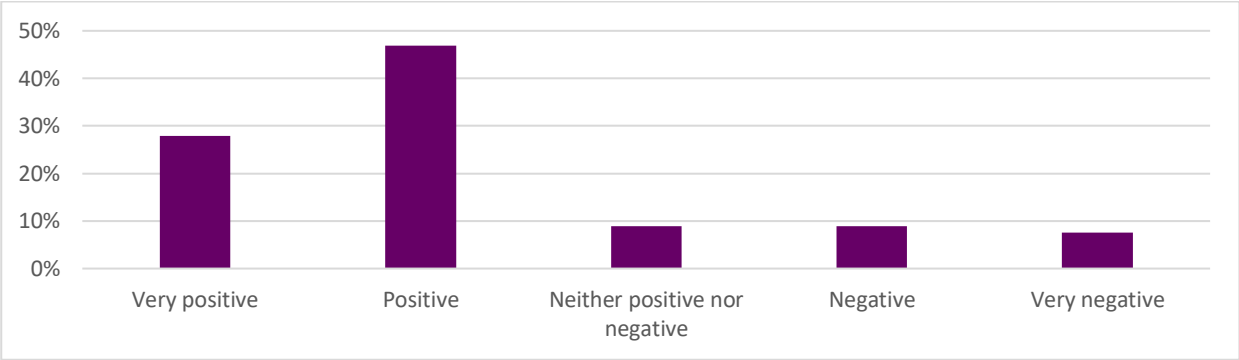
***Table**: What concerns do you have about the plans we have set out? (N=203)*

	%
No concerns/positive comment	28%
Location and accessibility of the centralised site and community services - with concern that some patients will have to travel a long distance to access the centralised service causing additional stress / anxiety.	15%
Other concern, including: - Waste of purpose-built facilities - Longer waits/delays - Too much focus on location/estate - Staff and patient engagement vital - Space available - Privatisation - Confusion for patients - Appropriateness of digital consultations - Reduced capacity/fewer beds	15%
Delivery of care within the community with concern relating to: - The dilution of specialist care - The reduced standard of care that will be received in the community by less experienced / specialist staff - Community services (including primary care) being overstretched and under-resourced and unable to cope with the added pressure - The challenges associated with joining-up services to ensure patient flow and continuity of care (i.e. administration, communication and ICT).	13%
Cost/financial implications - questions were asked about whether the model will be affordable with the additional facilities / staffing required and what investment will be made in community services to make them fit for service development.	8%
Staffing - concerns were raised about whether there are sufficient staff available to deliver the model, in addition to deskilling and reluctance to change.	6%
Other comments including lack of detail within the proposal and the absence of family involvement/prevention/access to imaging and interventional radiology/Maggie's Cancer Care Service within the proposal.	5%
Role of GPs in the cancer pathway - concerns were raised about the difficulty patients have in making appointments with their GP, GPs misdiagnosing or not recognising early cancer symptoms and/or refusing tests/delaying referrals	3%
Suggestion, including: - Cancer survival support - More holistic approach required.	3%
Cost-cutting exercise to reduce hospital services / staff / beds and push care into the community, as well as distrust for NUH management.	3%
Difficulties in accessing other specialist support services not co-located/directly linked.	3%

Improved screening required for all, not just low uptake areas, including better recognition of cancer symptoms	2%
Ability to implement changes including potential disruption to services and timeline	2%

Approximately a fifth of the overall sample (19%) had accessed cancer care in Nottingham for themselves or a family member in the last two years. Of these, 75% described their experience as very positive or positive, whilst 9% rated it as neither positive nor negative and 17% negative or very negative.

***Figure**: How would you describe your experience? (N=79)*



Aspects of the service that respondents thought could be improved are listed in the table below, with staff attitude, care provided during the Covid-19 pandemic, integration between departments / consultants and with primary care, patient communication and waiting times all being identified as key areas for improvement.

***Table**: Is there anything that could have improved your experience? (N=53)*

	%
Staff attitude - staff to show greater compassion and empathy, and listen to patients' needs.	17%
Care provided during the Covid-19 pandemic was felt to have resulted in reduced monitoring, cancellation of appointments, new treatments not being considered and increased use of digital appointments which some felt were unsatisfactory and excluded loved ones.	13%
Other suggestion, including: - More holistic care focus - Quicker primary care referrals - Centralised care - Less errors/misdiagnosis - Patient access to digital records - Greater recognition of individual needs - More reliable and patient friendly scheduling of appointments.	13%
Better integration of departments / consultants and with primary care	11%
Improved patient communication including text reminders for all appointments, ensuring letters are all written in layman terms and open and honest communication.	11%
Reduced waiting times including elimination of delays whilst receiving chemotherapy.	9%

Continuity of care to reduce the risk of conflicting advice being received.	6%
Improved screening programmes	6%
Better standard of care including more care in hospice settings.	6%
Options for face-to-face appointments	4%
Improved physical environments e.g. waiting rooms.	4%
Greater availability of, and cheaper parking	4%
More community based follow-up	4%
Better support for patients with less reliance on charities for information and facilities for patients to talk with others in the same situation.	4%

8.2 Focus group feedback

Four participants took part in the focus group discussing the proposed changes to cancer care. Three participants were members of the public and one was an employee within the diagnosis service. All participants had experience of cancer care services as a patient themselves or through family members.

Participants could see the benefit of bringing together cancer services and aligning these with emergency and critical care to improve communication, 'join up' services and reduce the need to travel between different sites. Participants had experienced issues in these areas within the last two years via their own or their family members' experiences so could particularly see the benefit of the proposal in addressing these.

Participants felt there were *'huge benefits'* to screening in the community with agreement that services such as these *'don't need to be done at a large hospital site'*. It was generally felt that by making screening more accessible to people and closer to their homes, the number of people that take part would increase.

Participants had concerns about capacity at the QMC and the City Hospital, as neither sites were felt to have enough space to accommodate this service. There were also concerns about access to both of these locations, as public transport links and car parking facilities were felt to be lacking.

Participants did see the value of services being offered in the community and wanted to see more concrete plans for this in the proposal, including how services would be better integrated. Staffing issues and resources were also felt to be important factors, but absent from the current plans.

It was suggested that engagement with patients, particularly gaining feedback from *'those currently undergoing treatment',* is needed to help shape the plans for this service. It was also noted that carers *'often don't have a voice',* with their needs also requiring consideration.

9 Plans for outpatient care

Individuals were provided with the following information about the plans for outpatient care in Nottingham.

What do we want to do?

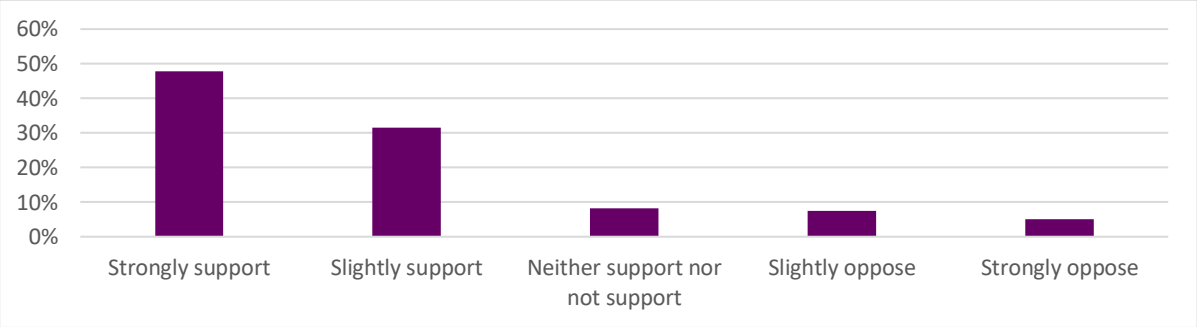
We want to provide less outpatient care in hospital and more in community settings or in people's homes or in community clinics or GP surgeries. We want to increase choice and flexibility for patients in when and where they receive care.

We want our teams to work flexibly, providing care at different locations across our area so that patients can access specialist doctors and nurses outside of hospital.

9.1 Survey feedback

Most survey respondents support the model that is starting to be developed for outpatient care with 48% providing their strong support and 31% their slight support. Furthermore, 8% neither support nor oppose it, 8% slightly oppose and 5% strongly oppose it.

***Figure**: To what extent do you support the model we are starting to develop for outpatient care? (N=280)*



The benefits that the model would have for respondents and their families are categorised in the table below; the key ones being improved accessibility and reduced travel requirements through the provision of more localised care, as well as increased choice and flexibility for patients.

'Travel stress to a hospital site would be avoided, and hopefully the proposals will ensure patients do not have an unacceptable wait'

'More access to local provision and increased choice'

'Possibly less travel and less time spent in the huge outpatient department'

'Embracing technology that has been available for years - and used by the private sector for a long time!'

***Table**: What benefits do you think these changes would bring for you and your family? (N=232)*

	%
Increased accessibility through more localised care with less travel.	43%
Increased patient choice and flexibility	21%
No benefits/negative comment	16%
Less visits to/time spent in hospital – helping patients to avoid the parking difficulties at congested hospital sites and/or long waits in the outpatient department.	11%
Other comment, including lack of detail about who (i.e. which health professionals) will provide care, the location of community services and the evidence supporting the model.	10%
More prompt access to care	5%
Use of digital technology to help manage chronic conditions and provide consultations remotely.	5%
Other benefit, including: - Beneficial for more independent patients - Reduced DNAs - More responsive approach to local care needs.	3%
Improved patient outcomes through a better service	2%
Good/sensible model	1%

In contrast, respondents expressed a number of concerns about the model, specifically with regard to the dilution of care and expertise into less well equipped / resourced community services, the location and accessibility of the community services as well as the use of and reliance on digital consultations and the onus placed on patients to manage their own care.

'Whenever I've had a community outpatient's appointment it's been a nightmare to find an appointment at a place I can get to and the booking system is incredibly unhelpful. For many disabled people - knowing where you're going and what to expect - is really important. Community outpatient appointments can be all over the place and it's disruptive and distressing. Some outpatient activities need to stay at hospital. Have fun taking my blood in the Tesco community room!'

'Will the level of expertise and continuation to care be available in the new set up? Also, if patients are able to arrange their own follow ups rather than have routine appointments, will there be a catch-all to ensure that check-ups are not missed e.g. if a patient forgets or doesn't know how often they should be seen?'

'Less likely to actually see someone you know and who knows about your case'

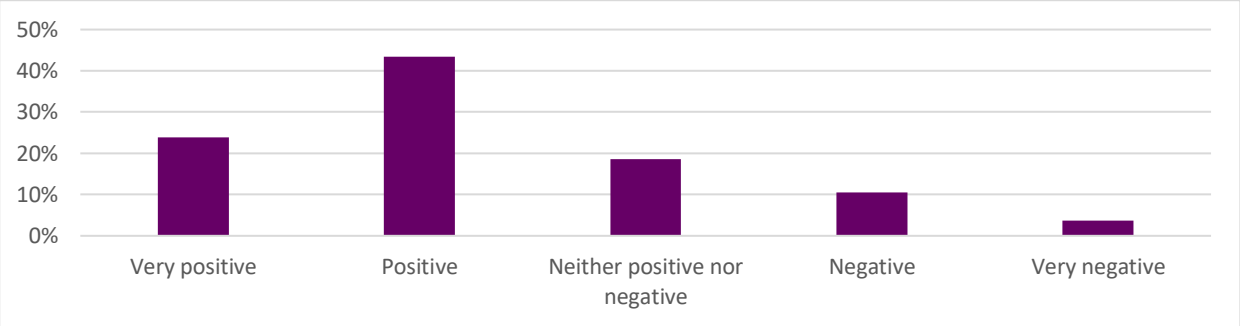
***Table**: What concerns do you have about the plans we have set out? (N=228)*

	%
Delivery of care within the community with concern relating to: - The dilution of care and expertise - The reduced quality of care that will be received in the community by less experienced / specialist staff - Community services (including primary care) being overstretched and under-resourced and unable to cope with the added pressure	26%

- The challenges associated with joining-up services to ensure patient flow and continuity of care (i.e. administration, communication and ICT).	
No concerns / positive comment	16%
Location and accessibility of the service - with concern that some patients will experience greater difficulties in accessing community services as opposed to a large hospital site (i.e. poor public transport, inadequate parking facilities).	11%
Other concerns, including: - Reduced patient choice - Availability of appointments - Confusion for patients - Waste of money / reverting back to old ways of working - Privatisation - Equality in access - Increasing patient expectations.	11%
Use of, and reliance on digital consultations - with concerns about the difficulties that some patient cohorts will face (i.e. the elderly, those without the technology / skills to use them), their effectiveness/ appropriateness as well as patient preferences for face-to-face.	9%
Onus placed on patients to initiate their own follow-up appointments - with concern that patients 'won't bother'/'won't understand'/experience too many difficulties in making an appointment, resulting in a reduced standard of care/issues being missed.	9%
Limited access to diagnostics/specialist equipment/support services i.e. phlebotomy/other specialist teams (including allied health professionals) preventing multi-disciplinary working and resulting in patients being referred to hospital.	8%
Cost/financial implications - questions were asked about whether the model will be affordable and what investment will be made in community services to make them fit for service development.	7%
Other comment including lack of detail within the proposal and the need for a 'joined-up' programme across the ICS/system wide consistency with the technology used (i.e. for digital consultations)/ providing each patient with a responsible clinician to oversee their care	7%
Staffing - concerns were raised about whether sufficient qualified staff are available to deliver the model, resistance to change and the impact of the changes on staff i.e. increased travel.	7%
Cost-cutting exercise to reduce hospital services/staff/beds and push care into the community, including distrust for NUH management.	4%
Ability to implement changes including potential disruption to services and timeline.	2%
Staff / public engagement required	2%

Just under half of the overall sample had accessed outpatient care in Nottingham for themselves or a family member in the last two years (46%). Of these, 67% described their experience as very positive or positive, whilst 19% rated it as neither positive nor negative and 15% negative or very negative.

***Figure**: How would you describe your experience? (N=189)*



Factors suggested to have improved respondents' experiences included better administration and communication, reduced waiting times for appointments / treatments increased patient choice as well as more localised care and improved/cheaper parking.

***Table**: Is there anything that could have improved your experience? (N=107)*

	%
Improved administration and communication – ensuring that patients are kept informed and given all the information they require (i.e. aftercare advice and contact telephone numbers) so that they don't have to chase their referrals.	24%
Reduced waiting times for appointments/treatments including clinics running on time	19%
Other suggestion, including: - Less crowded waiting areas - Familiarity of private organisations with the local area - Updated equipment - More holistic care focus - Making allowances for time to travel.	13%
Increased patient choice with regards to appointment times/locations with options for face-to-face consultations.	9%
More localised care to reduce travel requirements and improve access.	8%
Greater availability of, and cheaper parking	8%
Staff attitude - staff to show greater compassion and empathy, and listen to patients' needs.	4%
Improved communication and shared systems between different trusts / services (including primary care).	4%
Improved access to facilities for those with disabilities, including the importance of considering the appropriateness of community venues.	4%
I**ncreased use of digital consultations**	3%
Increased staffing with more qualified staff	3%
Standard of care including continuity of care	3%
Better pharmacy facilities	2%

10 Other responses - social media

In total 101 comments were made in response to the promotion of the engagement survey on social media, however only 71 of these were considered relevant (these comments were provided by 67 people).

As posts are directly identifiable, these were anonymised and summarised within the categories - positive, negative and other/neutral.

10.1 Positive comments

In total 26 positive comments were recorded and covered the following themes:

- Caring and dedicated staff

  'Been at hospital this year for operations and appointments and was well looked after, all the staff were friendly and caring'

  'I think all the staff, nurses, doctors, surgeons and everyone else at the City Hospital are brilliant. I have had several operations there and they were wonderful'

- Excellent standard of care

  'I have had excellent care and been seen, when required, since I became ill in April, despite the pandemic and the problems it's caused!'

  'My husband has had excellent treatment for blood cancer this year and I had 3 operations on a broken leg and I have no complaints. The treatment we had was, and still is excellent.'

- Live saving treatments

  'Saved my life. Amazing.'

  'I have water on the brain. I still have my appointments. QMC saved my life'.

Other positive comments included feeling safe and being seen straightaway.

10.2 Negative comments

Some 35 negative comments were recorded and mainly covered the following themes:

- Poor standard of care

  'If I ever have a stroke, there is no way I want to end up on your stroke ward, saw enough when my brother was in'

- Poor communication

  'Need to improve communication from the ward to relatives, especially when visiting is not allowed'

  'My wife sat in QMC for 2 hrs waiting for a cancer operation, to be told 'oh has no-one told you your operation is cancelled''

- Delays / cancellations in surgery and treatments

  'My husband has 2 fractures of his spine he has been waiting 7 months for 2 operations. He is in so much pain, he spends 24 hours a day sitting on the settee, and he can't go to bed because the pain is so bad. He has tried all kinds of different painkillers including pain patches, nothing works. He's hardly eating, he can't sleep. When is something going to be done about this? They keep going on the NHS being open to all patients yet people are suffering. They told my husband his operations were top priority yet they are doing nothing to help him.'

- Issues with staffing

  Comments relating to staff seemed to be split with individuals either commenting that there are not enough staff; *'Biggest problem! Too many chiefs and not enough Indians!!'* and others stating that they often witnessed staff just standing around.

  'I visited four times at the height of pandemic, nurses and doctors just wondering around doing nothing, some of the nurses complained about being bored and having nothing to do, yes your ICU is busy as you are at this time every year but please remember there are other illnesses that need urgent treatment too'

- Lack of basic facilities

  'My dad ended up in the QMC because the diabetic foot clinic was closed due to COVID and an ulcer went undetected. On the ward there was no visiting, no TV, no radio, no newspapers. He felt each day was like a week. For goodness sake put the simple things in place'

- Lack of basic care

  '*Some wards are run brilliantly others not so, I think they all need more nurses/health care workers though, when it came to dinner time many were left without food or given cold food as not enough staff to feed everybody that needed help - basic care!'*

Other negative comments related to staff not having the skills to be able to care for individuals with learning and/or physical disabilities and services not providing follow-up appointments or using digital consultations when it was felt that these should have been face-to-face.

10.3 Other / neutral comments

A total of 10 other/neutral comments were recorded and are summarised as follows:

- Improved accessibility of services is required i.e. through the provision of better transport infrastructure

- Removal of car parking charges.

- A greater focus on prevention.

- Further education and training opportunities for nurses.

11 Conclusion

The findings from the public engagement show that there is strong support for the model of future hospital services in Nottingham with 80% of survey respondents strongly / slightly supporting the draft plans. More specifically, respondents showed the greatest support for the initial plans developed for cancer care (84%), adult elective care (82%) and emergency care (80%), whilst support for the plans for outpatient and family care was slightly lower at 79% and 76% respectively.

Although some found it difficult to assess the potential advantages/disadvantages of what is being proposed (due to the lack of detail), a number of consistent themes emerged in terms of the benefits and concerns of the overall model as well as the plans for each of the services i.e. family care, emergency care, cancer care, adult elective care and outpatient care.

It is thought that the model of future hospital services will benefit individuals by improving accessibility to specialist services through the provision of more localised care and the use of digital consultations - reducing the need for individuals to travel to hospital, increasing convenience, lowering costs and helping patients to avoid the parking difficulties at congested hospital sites.

Furthermore, the centralisation of emergency, maternity and cancer care resources and expertise is thought to provide the advantages of streamlining services, improving efficiency, increasing capacity and delivering more focused care to patients. In contrast, the separation of adult elective care from emergency care will ensure a seamless service for those undergoing planned treatment/surgery with less chance of cancellations/interruptions to their care.

Other potential benefits include more prompt access to specialist care, improved patient outcomes and experiences, access to care in the right place and in more modern, purpose-built facilities, as well as patients spending less time in hospital (i.e. reduced hospital admissions).

However, a number of concerns were expressed about the plans. These were specifically with regard to the location and accessibility of the hospital and community services, the use of and reliance on digital consultations, staffing and the dilution of care into ill-equipped and overstretched community services with concerns that patients will receive more fragmented and reduced quality of care from less experienced staff.

Other concerns included the ability to implement changes without causing disruption, the cost and financial implications of the changes as well as perceptions that the exercise is aimed at cutting costs by reducing services, staff and beds.

The feedback from this engagement will be used by the CCG, alongside clinical and financial considerations, to develop a final set of options for changes to hospital services which will be put forth to local people in a formal public consultation in 2021.

12 Appendix

12.1 Demographic breakdown of survey respondents

***Table**: Age (n=274)*

Response	%
18-24	0%
25-34	8%
35-44	13%
45-54	23%
55-64	26%
65-74	21%
75+	9%

***Table**: Gender (n=273)*

Response	%
Female	80%
Male	19%
Other	1%

***Table**: Gender identity match sex registered at birth (n=272)*

Response	%
Yes	99%

***Table**: Pregnant or had child in the last year (n=274)*

Response	%
Yes	3%
No / not applicable	97%

***Table**: Marital status (n=264)*

Response	%
Married	66%
Single	11%
Divorced or civil partnership dissolved	9%
Cohabiting	8%
Separated	2%
Widowed or a surviving partner from a civil partnership	2%
In a civil partnership	1%

***Table**: Disability, long-term illness or health condition (n=264)*

Response	%
Yes	53%
No	47%

***Table**: Caring responsibilities (n=279)*

Response	%
None	51%
Primary carer of a child or children (under 2 years)	3%
Primary carer of a child or children (between 2 and 18 years)	16%

Primary carer of a disabled child or children	2%
Primary carer or assistant for a disabled adult (18+ years)	4%
Primary carer or assistant for an older person or people (65 years +)	12%
Secondary carer	10%

***Table**: Race / ethnicity (n=259)*

Response	%
White: British	92%
White: European	3%
Other	1%
Asian / British Asian: Indian	1%
White: Irish	1%
Mixed Race: Black & White	1%
Mixed Race: Asian & White	<1%

***Table**: Sexual orientation (n=244)*

Response	%
Heterosexual or straight	93%
Bisexual	2%
Gay man	2%
Other	2%
Asexual	1%

***Table**: Religion (n=253)*

Response	%
Christian	54%
No religion	41%
Other religion	3%
Humanist	2%
Hindu	1%

12.2 Engagement event transcripts

12.2.1 Engagement Event #1 - Tuesday 8 December (2.30pm)

Attendee: Do I take it that these proposals are more about this being seen as a funding bid to Government?

It's a very good question and I did emphasise the opportunity to get funding. But I do think that it is more around making sure that we are able to develop and improve our hospital services as part of the wider NHS, linking in with the community services. But in order to be able to do some of those things that we want to do, we do need some investment in the buildings. There are some aspects of some of the buildings that are probably preventing us from taking some of those further steps. I think the funding is more of a backdrop and an opportunity to bring this all together. I think the key thing we will focus on is how we can improve things and how the clinical services work going forward. And then in order to attract the funding and the investment we really want in our local area. The funding is an opportunity but really our focus will be on making the best use of that and how we make the clinical services work as best they can.

Attendee: I understood that the government funding was for hospital estate. Does it include the extra funding that would be needed to develop the community and GP services?

The Government announcement was around the hospital. What we would be doing is aligning that with all the other aspirations and things that we are trying to do with general practice, with the primary care networks and the community services. And then we will look at that in the round. It may be that we have to put in some additional bids around some of those community aspects. But there are also things we can do differently with some of the existing estates that we have. But we will need to look at all of it in the round. And as the whole system, make those choices around where best we can do it. But the focus of this work is really on the hospitals in terms of the funding for the buildings.

Attendee: Are you going to re-arrange the current estate or is the CCG thinking more in terms of having a separate specialist hospital site i.e. as in Birmingham metropolitan hospital, where two sites are being merged into one?

The answer is everything's on the table. We're right at the very beginning of this process and we're considering all options, so everything you describe could be possible outputs. There have been no hard decisions made yet.

Attendee: What will be the impact on GP practices?

We're in this process where we're trying to design what everything will look like and the whole process. So the aim should be to make healthcare throughout the whole system more straight forward, more streamlined. So the aim should be that every part of the system improves. At the moment there is no specific impact on general practice

because we haven't described what it is we're going to create apart from this ambition that we're describing to you.

Attendee: Do you have an idea of how much it will cost to make the structural changes to buildings and what will be needed on an on-going basis to make sure that those structural changes can be appropriately utilised, i.e. if you were given the capital - will you have the funding for other changes?

What we're doing as part of the development of the process is we're looking very closely, with colleagues in NUH, to try and make sure our proposals are deliverable and affordable, and before we come out and consult with you we will need to make sure that that is the case. Because obviously we do not want to consult on something that we then find we can't deliver or make promises we cannot fulfil. Therefore, we will work that through, and in fact we are actively working that through at the same time as developing clinical proposals about sites. We will be given an affordability limit in terms of the capital, so we will do all of those things together.

Attendee: During previous review of NUH services, there has been drive to transfer some services to community. However this process was carried out at times without full understanding of the services in question. For example: dietetic services were reviewed with a push to provide these services to patients in the community, specifically for adult oncology patients. It would result in these patients attending the hospital site for treatment daily, but being unable to receive any dietetic care on the hospital campus.

We're trying to create a clinical case for change for everything that is changing or that could potentially change through this process, with the aim clearly to make things better, not, as you describe, to leave holes in care. So at this point everything's on the table. There are focus groups being set up where people can discuss and challenge what the potential proposals might be, so that we can try and end up with the right outcome.

Attendee: The rationale for what's being proposed seems very sensible. What about the practicalities such as 1) the QMC campus is already very congested, so how can we create the space there for new or transferred services; and 2) what about car parking - and/or other ways of providing access?

I suppose we're kind of earlier than you've described. There's been no decision about where positions will be or where services will merge to or from. The current set up we have is as you've described it – it is very congested at the QMC campus. We will need to look at solutions for car parking and peoples' access to buildings. But these are all on the table to be discussed and nothing is set in stone yet.

Attendee: How do you plan to balance transferring care to the community, without disrupting continuity of care for patients?

Attendee: With the emphasis being on doing whatever is possible in the community how does this work across budgets? Is there any potential to transfer budgets from secondary care into primary care/social care/voluntary sector to support this?

I think what we're aiming to do. We would call it integrated care. When we are planning how pathways will work through services, it is to work with community and hospital staff together a lot more than we have traditionally – and general practice as well. So when we're designing it, we should do it so there's much more of a smoother handover across the pathways, so there's more of a team approach, rather than a separate hospital and community approach. And that is therefore linked to how the budgets work, and we are looking at how we can rearrange our budgets so they go into the whole programme areas of work and that would then help with teams to come together across community and hospital services to work effectively as one team, and to make sure patients go in the right place and that the money can support that.

There is some areas where we've started to do that with some services. One is around end of life care, one is around MSK conditions. They are very successful in bringing a whole range of providers together and then thinking about being really very joined up in a more coordinated approach. So we'll be building that in to any thoughts about the links between hospital and community. And that's really why we're treating this as one big programme of work because we know how important those things are.

Attendee: Delivering certain services within the community sounds very attractive, but do we need to be careful we don't create more problems - e.g. someone living in East Leake might well find it easier to get to the QMC than to get to a clinic in, say Gamston.

The short answer is yes – we need to not create more problems – you're absolutely right that's a key thing that we need to make sure we are focussing on.

Attendee: Isn't there a shortage of GPs? Will you realistically be able to transfer more care out to GPs?

I am a GP and there is nothing in these proposals that's aiming to put more care out for GPs to do. This is about moving care into primary care, and primary care doesn't mean GPs do it, so we could be talking about surgical follow ups done in community clinics or GP surgeries, We could be talking about orthotic reviews that are currently done in secondary care being done in community settings. We could be talking about services being delivered in peoples' homes. But this is about where this is happening, not who. So specifically we're not trying to move extra work from secondary care into general practice.

Attendee: Where still needs capacity in GP's? If the work is done in GP's it need rooms and facilities.

Absolutely and there's a national ambition around trying to increase the number of GPs and we are working actively with colleagues in Health Education England and others to

try and really promote bringing trainee GPs into the area and then retaining them and giving them that support to stay in this area. We do want and need more GPs in general anyway. But what we're also doing is we've got primary care networks which is groups of GPs working together which can help the resilience of practices as some of them really have a small number of people, so small changes in workforce can have a big impact. We are also recruiting different types of professionals out in the primary care networks as well to do with social prescribing and pharmacists and others to support general practice as a whole. So the workforce won't only be general practitioners, it's often not GPs who are doing some of the work, but we are looking to expand the types of professionals who work in those settings and that will be important.

Everything that we're looking at that requires space will have to be delivered and considered as part of the round. So we can't plan to move services into the community if there's nowhere to move them to. So it's all part of the same process that we're going through to try and look at what can be done.

Attendee: The government does not seem keen to build new hospitals, preferring to provide capital for development of existing sites. Both our major sites are space constrained. Does anybody, at this stage, have any idea how transferred services can be fitted in at, say, QMC

Yes it's a good observation and I think what we'll need to do as we work up these proposals is we'll look at what sites are available there and if there are any other options as well. And then if we are moving things, think about how clinical services need to be grouped together to be most effective. So if its emergency services there'll be certain things that will need to be in one place together, but it might mean that other things could move to a different site. One of the things that James mentioned was we think will be part of this is more separation of emergency services from planned services, and thinking can we free-up any space on a site as and when we need to, be either making different groupings of services as well as use of some of the digital technology and more community settings as well. It is something we will absolutely have to work through properly before we're able to put any firm proposals out.

Attendee: How will you ensure continuity of services while they are relocated from e.g. QMC to City? The Debenhams building might make a good and accessible community venue!!

So every service change we do – we will have to create an operational plan about how we're going to do that – for exactly that purpose – to ensure continuity of care across the service. So I think on a speciality by speciality basis or even on a ward by ward, depending on what we're moving, will need a clear operational plan to ensure that that takes place.

Just to say we will have to look at how accessible the sites are as well, so with public transport links and other things. So we do look at that side of things as well. We will consider accessibility when we're looking at options around sites.

Attendee: I can only see this exercise taking place on a piecemeal basis so what is the timescale we are looking at? 15-20 years seems the most likely at the moment.

In terms of how we develop these proposals there is quite a tight timescale which James mentioned so we will need to do quite a lot of detailed work I think as these questions are illustrating and put some firm proposals out next summer to be discussed, and then by the spring of the following year to be making a decision on exactly the way forward. We will need to keep to those timescales around the development of the proposals and firming them up, and making a decision on those in order to attract the funding. And given the complexity that comes out in the questions, we are going to have to do a lot of detailed work between now and the summer in terms of the proposals, but then also working through how they might become a reality and then there would be the programme. Realistically we are going to have to do it in a phased way, and again that would be something in terms of feasibility and phasing that we would need to work through in more detail. There is a relatively tight timescale in order to secure that funding so we'll be aiming to do that. Yep the implementation period will be over a longer period of time and we'll have to get transition plans in place and the building works etc. So yes we are talking years in terms of the full implementation.

Attendee: Rehab is a very important aspect of healthcare.... and probably under-resourced at present. To what extent does the new facility at Stanford Hall fit into our plans?

It absolutely is part of our plans, in fact only last week the CCG Governing Body made the firm decision following the consultation that we would proceed in commissioning that service there. It's not just about the rehabilitation centre at Stanford Hall because one of the things we've been doing is thinking very carefully about how that works with other services because people will have a period of time when they need that very intensive inpatient rehabilitation for certain things, but they'll also need the rehabilitation to continue when they go home and make sure those services link. So NUH will be the provider of that, and that will be very much linked, as it currently is, around the major trauma centre at NUH, as well as some of the other services. It's very much part of our plans and it will be a bit of a national test I think in terms of how we develop rehabilitation services. So it will be a pivotal area where we can develop and learn, and then with the idea being that we will be able to roll that out. But yes I agree that rehabilitation has probably not had the focus it needs up and down the country actually that it needs, and I think that was a really good first step.

Attendee: Creating provision for emergency and planned care could require duplication of provision with in the hospitals e.g. ICU bed provision across the piece. This is only one example there will be many more examples. Moving

services to the community will also be duplication of provision, all this has to convince the patients and give them confidence in the future.

That clearly is a key consideration for us about what can we do to minimise duplication and what are the right groupings of specialties and services that we put together. You're absolutely right there are risks of duplication so therefore we need to be making sure we're looking at those to make sure we're picking the right specialities to put together to minimise those risks and to improve our efficiency.

Attendee: I hope lessons have been learnt and no services will be given to private sector e.g. elective care

Our job is to make sure people can access a whole range of NHS services. I think we do have to think about what overall capacity we've got to deliver NHS services. So for example in Covid, NUH hospitals as well as Sherwood hospitals has worked very closely with private hospitals in the area to keep as many services going as we can through Covid and there's obviously waiting lists that have built up a little bit over the time of Covid. So I think we want to use all the available capacity that we can to get as much NHS care as we can. So yes it's a point well made. I think in the NHS England the whole policy area nationally is developing around the need to tender things – so I think we are moving into some very different times now.

Attendee: What about rehabilitation and recuperation following general surgical recovery rather than major trauma. This is sadly lacking at the moment.

The idea of the new rehab unit that we are building – well we've literally just commissioned – is aiming to rehabilitate those most in need. So it's not specifically for major trauma alone. So it should be for recovery for the people that need rehabilitation and recuperation across the board, and it should all be part of a pathway leading back into their own homes doing their active daily living and work. So yes this is something we are looking at actively and trying to work on.

Attendee: Some services are delivered better in the community such as dermatology, diabetes etc. will you be focussing on these earlier to release capacity in secondary care. E.g. is there a hierarchy in which services are being looked at first.

All the services are on the table and I'm sure as we work through this process some services will stand out as being easier to move or being more obvious to move earlier. I'm sure these will be the things we start to roll out first. I'm sure there will be a natural process where that happens. We haven't actually created a hierarchy or a plan to do that as yet, but you're absolutely right.

Attendee: How will the abolition of CCGs affect this programme?

At the moment that is one of two options that are being engaged on. And in any event, even though it is the preferred option of NHS England, it's also very clear in that document that commissioning, that CCGs statutory duties, in the event that CCGs are

abolished, that they would be deployed through the integrated care system statutory bodies. So the commissioning functions that take place in systems would remain and would be executed differently. And that would take place from April 2022 so the CCG will conduct the consultation next year and then depending on what happens with legislative change, that process will continue in the successor body, whatever that is. But the core commissioning functions will continue to exercised, just differently in systems.

Attendee: In building these plans, do you start from 'a clean sheet of paper' - what we would like if starting afresh; rather than starting from our existing facilities and how they can be modified/developed?

What we've tried to do is build in the evidence about what works best, the clinical standards, things that people are raising – trying to bring that all together. But what we will need to do is when we have firm proposals is to have built in a bit of a fresh look actually, alongside thinking about what's feasible, what's affordable, what we would be able to do with the land estate etc. So it will be a fresh look, not just thinking about the existing buildings, but then some practicalities put around that, around what is going to be feasible and affordable. So it would be a bit of a combination of all of them by the time we get to the final proposals.

12.2.2 Engagement Event #2 – Tuesday 8 December (6.00pm)

Attendee: Carbon footprint of NUH buildings, staff and patients would also be reduced with these plans in lots of ways, which is great. It seems it would be good to connect this work to NUH environmental policy.

That's a really good point. Though the capital build will be more in the NUH area of responsibility I do think that's absolutely right and we will need to factor that in as we are developing the model of how the services work, how people access the services, the locations and buildings. So absolutely we do need to link the carbon footprint in with these developing proposals. It's a really good point and an opportunity for us.

Attendee: If you separate Elective and Emergency care, how are you going to separate clinical staff? Surely both use the same clinicians in many cases? What is the evidence supporting this route?

Attendee: Putting more care into the Community means more pressure on the PCN's - don't they need to be a core part of this planning? Otherwise it looks like NUH are pushing work into other parts of the system

So we're right at the beginning of this process - we are planning what and which services we would or could separate and what would be more efficient and safer to keep together. So this is all part of the planning stage. And you're absolutely right – where there's key things that the same staff would work across then it makes more sense for them to stay together. That is part of the discussions that's happening so we are planning that in and are having those discussions live.

Yes PCNs do need to be a core part of this planning and they will be consulted and involved and also just to make the point, moving more care into the community doesn't necessarily mean the PCNs doing it. I'm talking about the environment where that's happening so NUH staff working in the community should be happening as well. So if follow up needs to happen from an operation for example, it doesn't necessarily mean that if it's done in the community it's done by the PCNs.

Attendee: So has this been modelled on another NHS Trust and if so, can you share where you have performed your research please?

Attendee: When mentioning moving some services out in the community, is this to existing NHS services and how does the funding work there? Can you confirm it will not be into private firms?

This is at the very early stages of developing the proposals ahead of the consultation when we've looked at this in more detail. But I think these ideas have come largely from clinicians working in the area and it's about some of the benefits that have been found in terms of the proposals. So what we will be doing in this next phase is doing exactly that – looking at the modelling, looking at the research, looking at how the workforce would work. There'll be some areas where it works better consolidating teams in a hospital in other areas with the development of digital technology and other sort of

different ways of teams working together. Because one of the other aspects of this work is to develop ways of working which mean that hospital staff, community staff, general practitioner staff, all work more as a team and share information much more, so that people can move between the services better. So it's come from ideas from people who work elsewhere and say it works differently and better elsewhere but our next stage is to model that and do the proper research so that when we have developed the proposals more firmly we will have that full evidence base. But as I say these are things that have come from clinicians.

In terms of the funding what we are looking to do differently with budgets is to put our budgets more together across a whole pathway – whether it's the hospital or the community and then think about how providers can work together to use that pot of money in a more streamlined way. And that might mean some of the money moves around a little bit as well. So the funding would do that. And what we'll be doing is looking at NHS services so that they continue to be our prime area. All of these things will need groups of providers working together in a way that brings all of the NHS together differently going forward.

Attendee: Comment (not really a question). Being able to do follow-up visits in the community or online is good. It's often a lot of time and inconvenience for patients to go in for a 5 minutes appointment.

Absolutely. I think we need to make it as streamlined and simple for a patient's time, convenience, carbon footprint – everything lines up then doesn't it? So it can be done and it works – it works very well. We just need to be very mindful about who it works well for, and where it works – so we get it right.

Attendee: I was under the impression that elective and emergency were already separated, certainly in orthopaedics where all elective moved to City some while ago? Definitely support this approach to maintain elective care.

It is true that we have created an elective hub for orthopaedics but actually orthopaedics is probably the exception that proves the rule. Across most of the other hospitals we haven't separated in the same way.

Attendee: What is the time-line to achieve these plans?

Yes so this is our initial engagement, gathering all the thoughts and ideas, We intend to bring those into formal proposals that we would consult on over the summer next year (June to August) and then consider all the feedback, work that up into really quite detailed proposals that we know we could enact, and then make a decision on that in the spring of 2022 with a view then to summer onwards of that year starting to roll forward some of the changes. We are aware that with the government funding, we will need to stick to those decision making timelines so that we don't lose the opportunity for the investment.

Attendee: Are you planning on having focus groups on specific areas/with communities of identity, such as services for disabled people?

We have three focus groups taking place this week. And there'll be details of how to join them at the end session.

Attendee: Will you be working directly with NUH PPI volunteers to gather feedback in tis pre-consultation phase?

I thinks that's really essential as those volunteers are really close to some of those specific services so absolutely yes we'll make sure that we build that into the plans. We've got plans to engage with a big range of stakeholders but we'll specifically make sure we pay attention to that.

Attendee: Agree that more joined up working across the NHS will be needed - in which case shouldn't this work be led by the ICS rather than NUH?

Yes I think that's absolutely right, this is not just about the hospital building although that is the capital funding and that's where there's an opportunity to modernise the estate. That's really why we've developed the Reshaping Healthcare in Nottinghamshire programme – for that exact reason. It is about integrated care. So the CCG has the responsibility to develop the proposals and to do the public consultation part of it, but it's done very much with integrated care system (ICS) partners, and in fact we're just setting up a stakeholder board, which across the whole ICS as we develop these proposals. So I think it is a point well-made and it very much will be a whole system working together.

Attendee: Have equality impact assessments been undertaken on these proposals?

At the moment, these aren't proposals - yet. So before they go to consultation all those processes will be in place. So at the moment we're just at the stage of creating ideas and testing them. So before we move forward they will be – but they haven't been.

Attendee: Can the Treatment Centre now be included in the NUH strategy? It is a really pleasant environment compared to a lot of other buildings.

We will be considering the use of the whole of the estate including community settings as well, in terms of how is all fits together and how it works, so yes.

Attendee: Are there any outline plans for the location of the new estate - e.g. where would a new Women's' and Childrens hospital be sited and what would replace it at the current sites.

So at the moment we're looking at creating options appraisals for where estates might be or which bits might be where. So we're not yet at the stage to have an outline plan for a location – it's still being discussed.

Attendee: It's great that mental health emergency services is being included in the plans, as long as resources are there to support this.

I agree – it's really essential we join all of that up. And mental health investment is one of the national priorities – there are rules around it if you like, making sure we're building on those services. Our understanding is there will be national funding that is designated to making sure than mental health emergency services work effectively as part of the wider system in hospital and in alternative environments.

Attendee: This all sounds practical and positive. Will we be able to stay involved throughout the process?

Yes very much so. We will continue to engage with people as we develop the proposals further. What we'll do is make sure that we're publishing and advertising opportunities. There will be more specific detailed focus groups and conversations around the specifics of the clinical service areas that James highlighted so there should be plenty of opportunity going forward.

Attendee: It is difficult to get to services based at the Rope Walk if you are dependent on public transport - it would be useful if this could be addressed.

I think that's a key part of this whole debate. It's about access and people getting to the care they need – so I think that's definitely in the mix and is going to be addressed in all of the plans. It's too early to know where Rope Walk will sit in our plans. It's part of the options we will discuss about what will happen where, but certainly the concept of access to where will be involved.

Attendee: At this early stage there's a fondness for a certain kind of language. I.e. people move seamlessly.

We want all parts of the NHS to work together so that if you need care you don't notice what organisation carers work for. You just get to the services that you need without having to worry about whether they're NUH or social workers or the community district nurse or whatever. So it's really very much about trying to make sure that the NHS works together and with social care. So it doesn't really matter if you are on the receiving end of care, it's not relevant to you which organisation people work for. But yes and 'streamline' services as well. It's trying to avoid duplication so that people don't have to keep repeating themselves every time they go to a different service. So that's really what we're trying to do.

Attendee: Will there be any investment in new build or just renovation/repair?

We're working through that at the moment. There'll be an indicative amount of money that the government says plan along those lines. We will be looking at this with a fresh pair of eyes but there'll be an affordability limit on that, so that will have an impact on that. We'll have to work that through and see.

Attendee: I understand why merging services like maternity is being suggested but can also see a lot of opposition to taking this away from one or other site as it's a long way to travel e.g. from the south of the city to City Hospital or from Sherwood to QMC with the traffic issues we have around the ring road if you're in a hurry. Is access, transport and car parking availability going to be considered during this process?

Yes I think what we'll need to do as we look at that and think about it more carefully. As I say that has come from the clinical teams actually and there are issues about women travelling between sites and being sent between sites. We will need to work through any potential proposals around that and think about travel time and we'll model all that through so when we consult we can be clear in the proposal what that will mean in terms of travel times and access and other things so that people can take a view.

The answer is yes, it absolutely accessibility to all services and how patients are going to get there is part of the process.

Attendee: There will always be resistance to change, but it must make sense to rationalise maternity to one site. We are very lucky to have 2 major centres at the moment.

So we're making the clinical case and you're right there will always be resistance to change and there will always be people who oppose plans as well as those who support them but we're going to try and make decisions around all these services about what's in the best interest of the patients as a whole, and we'll do that by going through the consultation process and taking advice from clinicians, patients and all of the above to try and make sure that we get it right because it's really, really important.

Attendee: Are there any plans to recruit more staff as I understand staffing issues may be a problem already?

Certainly, we are working, again as a whole system, looking at the workforce requirements for the NHS going forward, and within that there are plans to expand the workforce. Obviously, that depends on getting good quality trained staff through. I don't know if that is specific to maternity or not, but there certainly are plans to increase staff in maternity.

Attendee: Is merging and moving maternity to one site will affect the birth options for families?

If we had one maternity unit rather than two is would reduce our birth options from two to one for people who are having hospital births. But the trade-off hopefully is that we manage to have a wider range of options and a larger rota and more provision for emergency care and all the inherit benefits you can get from staffing one larger unit. Therefore, it's getting that balance right isn't it, and that's what we are debating.

I think we'd still retain though, the choices of type of care – so midwifery led care, obstetric led care for people with particular risks, or home births. So I don't think having one site would stop this as some people do go into hospital and have quite midwifery led births, water births, that kind of thing. So I don't think we'd change the overall types of birth but obviously if there was one site it would be in one location rather than two locations so in once sense that would affect people's choice of where to go. There's certainly no discussion or thoughts that the actual types of birth would be impacted by that.

Attendee: Presumably this will be an opportunity to look at new roles and responsibilities too and which role is best placed to deliver the service. Is this in the scope of this project?

We would certainly consider that as part of it. We'd be looking at clinical models and how clinical services would work and how they would operate, so that would certainly be part. Obviously if we had new roles that would have a lead-in time, but that would all be part of the considerations, yes.

12.2.3 Engagement Event #3 - Friday 11 December (10.00am)

Attendee: I am the chair of the Trade Union Health and Safety Reps Group at NUH. The Health and Safety Reps have asked me to remind you that there is a legal responsibility to consult with the Union Health and Safety Reps over any changes to work practices, staff redeployment any new equipment etc.

I'm happy to endorse that and a point well-made and something we will need to factor into as we develop the proposals.

Attendee: A lot of the community estate is not fit for current services never mind any future service developments

Yes, we are aware there is a mixture of community estates. What we will be doing in the programme is looking at that and I think also there is some community estate where there is more opportunity than we are currently maximising as well. There is also the possibility of reshaping how some of the services work around people at home and providing more care in that way either digitally or in person and how different teams work together differently to join things up a bit. In a way for patients, it shouldn't really matter which organisations people work for. But it is certainly something we are aware of and we will build into our thinking and it may be that there is another pot of money that we try and apply for, we're putting bids together around community estate as well, so we will look at in the round.

Attendee: The pandemic has shown how vital it is to safeguard elective surgery, the inability to do this has had a detrimental impact on many people. It sounds like so many services are being located in one place/site, what do you envisage being located on the other non-emergency care NUH site?

There's no hard decisions been made, the conversations are very much around elective surgery, outpatients and some of the investigations. Some of those things may not

need be located with the emergency sites so they could have a dedicated unit so we have a very smooth and easy stream for patients to navigate.

Attendee: If an elective session suddenly becomes an emergency, how will this be supported if they are in separate areas?

So the answer is, the elective care setting will have, for example, all the technology and people there that can manage emergencies so anaesthetists will be present, all the medical teams required to deliver the care for those elective services. So I don't think there is an issue about not being able to provide emergency care, the issue is there won't be responding to external emergency care that is coming in which is unpredictable.

Attendee: Separation of emergency and elective services. Will there not still be a capacity issue?

What's really important is the demand-capacity modelling which we are undertaking at the minute for all of our services, so when we finally get to a point of having our plans developed, we can understand the capacity needed for all of those services so we are able to meet it.

Attendee: Older people form a huge % of the hospital population, including patients living with the dementia? Why is there no mention of Healthcare of the Older Person in any of the documents?

It is a good point, it perhaps is not explicit enough in that sense, but it's very much when we talk about overall health needs and people living longer with more conditions, dementia is a really critical one, we will definitely be including that as we develop the detail going forward more and obviously looking at best practice around that as well. I think it's a point well made, and I think as we work through the detail more, we will need to be more explicit and detailed around that.

Attendee: Will there be a dedicated stroke unit with emergency care as we know how important it is to be quickly diagnosed and treated , and will the rehabilitation after care also be on the same site, if not, how will it be linked with the community and charity's like stroke association?

So I think this is really important in demonstrating why it's important that we start doing these processes because there has been huge steps forward in stroke care particularly the care we need to do or can do very quickly. We're planning to have a hyper acute stroke service, which is the very quick stroke service which potentially includes operating on people to actually remove clots from their brain before damage has taken place as well. All of the acute services is planned to be co-located at the emergency site. The rehabilitation of stroke may happen separately, again this is not all set out in stone at all, but there may be cross overs with our new estate that we are planning out in Stanford with the rehabilitation service, so there will be dedicated stroke services, dedicated rehabilitation services and possibly in more than one site. The key bit is making sure we link the most important bits together so the emergency service is right next to where we deliver the emergency stroke care.

Attendee: HCOP medicine is as much a specialty as cancer.

Attendee: It's all very well in an ideal world to separate emergency from elective,

when overloaded though, the safety valve of being able to delay elective is vital but not possible if they are separated.

I think this is a really important point and one we have been discussing quite a lot at the moment. First of all, what I would say when we talk about separation of our planned emergency activity, that does not always mean that that would be on a different site, so we are looking at separation of elective from emergency on the same site and also looking at separation on different sites. As James has said, we haven't yet made any decisions on this and we are looking at these plans in quite a lot of detail and the issue you flag here, is one which we are looking at quite hard to understand the different merits of those options as we go forward.

Attendee: When services in the community are discussed, it's hard to comment about these without knowing where they will be located. It can be very difficult to travel on public transport, e.g. Beeston to Hucknall, which have been put together in Mental Health etc. Accessibility is key.

It is a really good point, as we are developing the proposals and are developing them more firmly, so we can see any impacts ahead of any, if you like, formal consultation, this will be something that we very much take into account. We do look at travel times accessibility as well with a view to health inequalities making sure that some of the really vulnerable people that needs services the most can access them. Accessibility will be something we are looking at very much as we develop these proposals further.

Attendee: Do you envisage much of the old estate at City hospital being demolished and replaced by new builds? I was thinking mostly about hospital design and services.

We are at the stage where we have not made decisions about the site. So it's a little bit hard to answer that question, but I suppose it has the potential to be true, I wouldn't like to say yes or no to it at this stage, it's too early.

Attendee: One of the services currently missing is the provision of emergency mental health services in close association the physical emergency care, will this in future be provided by one trust?

So I absolutely agree with that observation, I do think we need to more closely align mental and physical health. I'm not sure whether it will be provided by one trust, but what we are very much encouraging, which will run alongside this is for providers to work more closely so they can actually join together clinical teams where that is the right thing to do for the patients. A big area of that is mental health and physical health, so what we will be looking to do is join up how those services work together, whether that's through a contract that says they work together or one trust or what they call a lead provider arrangement, we would need to work through it but we are very much promoting and developing that joint working around that and the best locations for those as well. The emergency department isn't always the right location, I know it can be a bit of a default for people presenting with mental health emergencies as well as physical health but there are other alternatives to that which we are developing alongside this programme as well.

Attendee: With regard to discharge and care in the community, there is a lack of capacity in social care to provide services in patients' homes. How will this be addressed?

So clearly this is an issue and it's an ongoing issue particularly as our population are getting more elderly and we are working closer and closer with our social care colleagues and aligning our services to try and maximise what we can achieve with limited budgets so it is definitely on the radar and something that is being planned but it is slightly separate to how we are designing our estate, but it clearly a key factor in how we manage our estates and how it is going to work.

It is something that we are very much working closely on in terms of our joint working as we have gone through COVID actually, that's helped us cement those relationships and we are looking at very flexible ways of trying to provide that care, so it is very much a work in progress.

Attendee: What about impact on service provision by cross boundary links e.g. Derby?

So as we start to develop these proposals, we are engaging with our neighbouring counties so Lincolnshire, Leicestershire, Derbyshire so we will work with NHS colleagues across the borders to look at any potential impacts. It's too early to say at this stage what they may be but they are very much engaged in the process.

Attendee: Will some of the funding obtained for community services be shared with charities and 3rd sector that support long term care for those for example rebuilding lives after stroke?

Again, this sort of links back to what I was saying around physical and mental health emergency services. We are looking to develop providers working more closely together so collaboration of providers which does include the third sector very much. Some of that will be attached to the Primary Care Networks' social prescribers who can link in with different third sector providers for particular vulnerable groups. We are trying to very much make sure that is joined up and it is very inclusive of the third sector as well in terms of how budgets are put together and all of that, so again a work in progress which will very much run alongside this work.

Attendee: For those who do not know Consultation is covered in the Brown Book Safety Representatives and Safety Committees Regulations 1977.

Thank you very much for that.

Attendee: Are you gathering learning from the impact of the pandemic on service provision? What we know now is that a pandemic could happen again.

Yes we are. I think some of that is positive learning around the strength or partnerships and how we can build on that going forward across the different parts of the services. The other aspect of that is, we have learnt more and there could be another pandemic and I think it's made it more in people's minds so one of things which Phil may want to add about, is making sure any new buildings are quite flexible in how they could be used so they could be flexed differently to provide intensive care or other needs depending on the nature of the pandemic. I think having more flexibility in the hospital estate has been really raised as key learning.

I can just add, so we have done things in different ways during the pandemic and we have explored learning and we have done it really quickly so we have had an increased use in IT for example and how we can consult remotely. Some of it works really really well, some it we are aware works less well and we are sort of at a time where we are reflecting on what stuff we will keep as its just better than what we did before or what stuff is stuff we do when we under pressure and difficulties and all of those thoughts will drive what we build, because depending on what we think is the most efficient and the safest way for the future will determine what we need so Amanda is talking about the flexibility of estates, but what we are also learning is that actually if we are going to do a lot of stuff remotely, we need good IT systems that can connect people where that is appropriate. All of those things are being considered and affecting the design of our physical estate so our physical estate is designed for the services we need to deliver.

Attendee: What about support on discharge from hospital?

This is an area where I think COVID has helped us to deliver stronger relationships and stronger understanding across different parts of the NHS. We now have a combined discharge team with leadership across the whole system, hospitals, communities, social care. We have got kind of a more flexible and more timely way of discharging patients. There is still more to do but it has moved on quite a bit so what happens now more is that nurses and social workers and doctors from across hospitals, communities, join together as early on as possible to plan the best discharge support and location for those patients. Now we have always done that to some extent, but I think it is more joined up and I think it's reaping some benefits in that decisions are able to be made more quickly now than they were so we will continue to build on that and then what we are also doing is to make sure that when people do go from hospital the offers are as flexible as possible, looking at different roles of health and care working together more flexibly. Again, that will be work that runs parallel to this to make sure we build on the learning and the types of care available when people leave hospital.

Attendee: Where are facilities/resources going to come from? GPs are already really overstretched?

I can certainly acknowledge it because I'm a GP and I would agree that we are fairly overstretched at the moment and there is a lot of interesting challenges, particularly looking forward to the vaccination for COVID. The reality is that, this isn't an attempt to move care from hospitals into GP surgeries for GP's to do, this is about trying to deliver the right care in the right place so it may be that follow-ups for after surgery for example, may happen by the hospital staff but delivering it from a local clinic, local to where they live. So this isn't an attempt to move workload into GPs it's an attempt to spread delivery of service close to where people are and make things more efficient for people across the board.

Attendee: How will Allied Health Services be configured in the future?

Attendee: Are we able to have a copy of today's recordings please?

Unfortunately we are not able to share the recording for data protection reasons but we will be providing the slides on the proposal website.

Attendee: Will the difficulties in transport links across the county be factored in, East Leake to QMC/City is easier than East Leake to say Keyworth?

So part of developing our proposals for consultation will be what we conduct a travel time analysis so we will be looking at the amount of time it takes, which build in the transport links, so they will work out average times from different parts of the patch.

Attendee: Regarding transport we have to remember that a lot of staff use public transport to get to work.

Attendee: All of this will only work if there is sufficient staff. What will be done alongside to ensure recruitment, retention and an increase in training places?

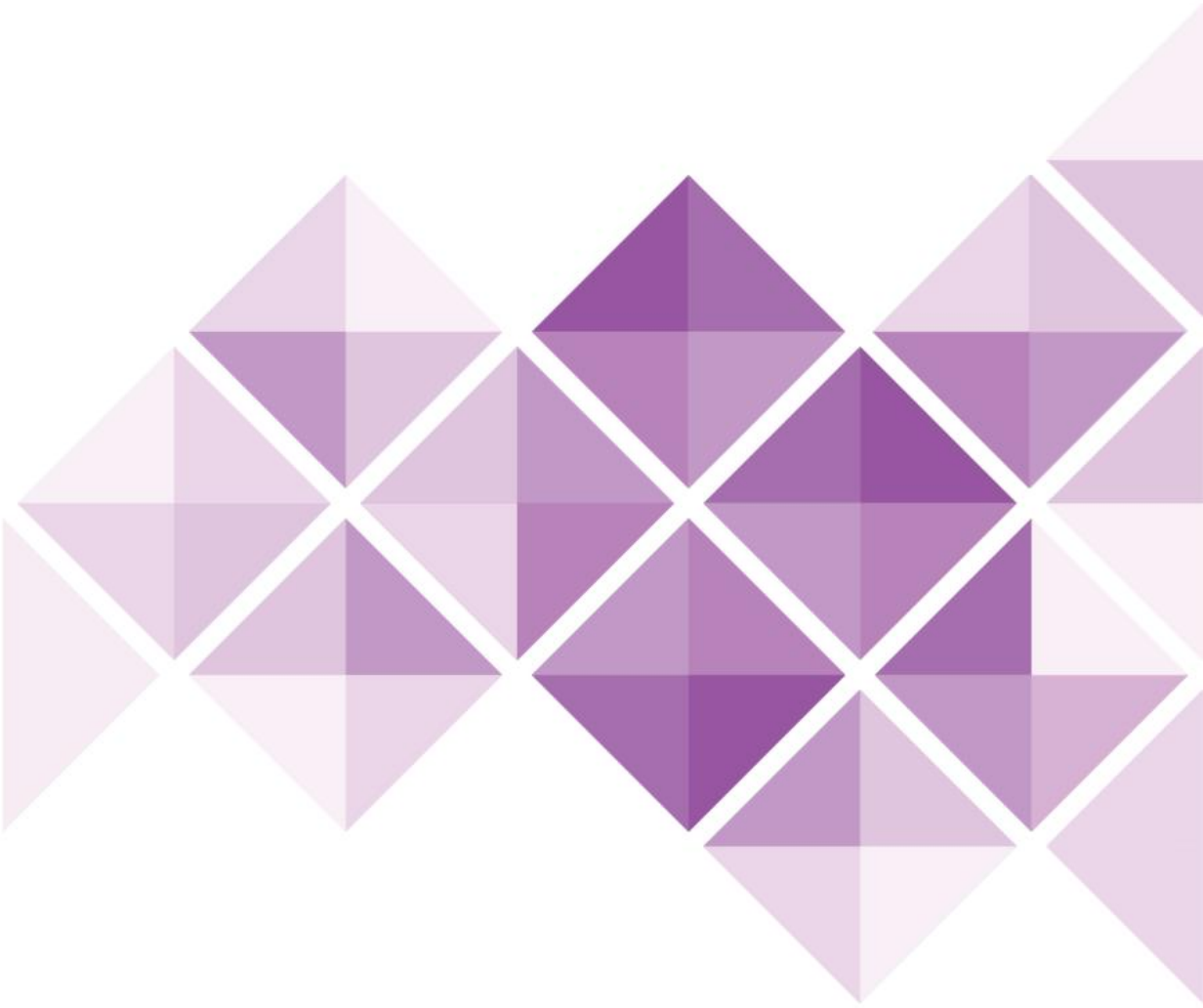
There is work going on across the system, the integrated care system around workforce planning and modelling for different types of care going forward so we have got a workstream running alongside. That's not to ignore the fact that there are recruitment difficulties in some areas. We are going through that workforce work, to attract as much of the workforce into Nottingham and Nottinghamshire as much as we can but we do recognise that there are shortages in some areas so we will have to do what we can to maximise that. Again working through some of the ideas around benefits, the benefits of separating elective and emergency care, we would need to build that in and look at that with the teams at NUH and as Phil said, they are looking in a lot of detail of how that could work operationally. The suggestion that came from the clinical teams, this is something they have seen work elsewhere really well, we would work close with the teams and I think there may be some efficiencies in there in people not having to travel across sites. So we would look at it in the round what might help or what might make things more challenging.

Attendee: Is there a plan to employ more professionals? If operations are going on in say the elective surgery and emergency surgery at the same time, aren't you going to need more professionals?

See above.

Attendee: I completed the survey and found it to be very wordy, is there an aphasia friendly one that could be shared please for those who have difficulty reading and digesting information?

We have produced easy read versions of the survey. We're also providing paper copies of the survey and we are very happy to go through the survey over the phone if that is easier for people to do.



healthwatch
Nottingham & Nottinghamshire

Tomorrow's NUH

(Nottingham University Hospitals)

January 2021

Commissioned by

Nottingham and Nottinghamshire Integrated Care System

Pre-publication draft - only for Health Scrutiny Committee

'If they want to change services to that extent, you've got to change the whole structure of the clinicians that they've got available, the number, the specialties, and the services in the community as well.'

Comment from respondent

Contents

Who are Healthwatch Nottingham & Nottinghamshire?

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.

We have 3 key roles:

Scrutiny of local health and care commissioners to ensure that they: listen to the public, provide excellent care, provide quality signposting and are totally transparent

Make a difference: We collect & provide insight from patients & communities, and use these to make recommendations to improve services for the public. We will then scrutinise how this insight helps to influence improvements.

To work in partnership across local, regional and national networks of Healthwatch and the CQC to ensure big issues/opportunities are acted upon & best practice is shared, whilst ensuring that our independence is maintained

Why is it important?

You are the expert on the services you use, so you know what is done well and what could be improved.

Your comments allow us to create an overall picture of the quality of local services. We then work with the people who design and deliver health and social care services to help improve them.

How do I get involved?

We want to hear your comments about services such as GPs, home care, hospitals, children and young people's services, pharmacies and care homes.

You can have your say by:

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Executive summary

Nottingham University Hospitals (NUH) are developing plans for changes to hospital services and will put options to local people in a public consultation later in 2021. Nottingham and Nottinghamshire Clinical Commissioning Group (CCG) wanted to find out local people's views on the proposed changes to NUH and commissioned Healthwatch Nottingham and Nottinghamshire (HWNN) to involve people in developing these proposals. The work of HWNN complemented consultation carried out by the CCG and aimed to gather the views of people from more vulnerable groups. The questions HWNN were seeking to answer on behalf of the CCG were:

- What people think of the plans
- How they might be impacted, positively and negatively
- Other relevant comments they may have

HWNN gathered the views of 150 people across Nottingham and Nottinghamshire in December 2020, focusing on people from specific cohorts including:

- Black, Asian, Minority Ethnic and Refugee (BAMER)
- People with long term conditions/poor health outcomes
- People with a disability
- Frail older people
- Maternity service users
- Young people
- Lesbian, Gay, Bisexual and Transgender (LGBT)

The findings are discussed under six headings in line with the six sections in the survey. They are summarised below.

People were very positive about the idea of modernising the hospitals; receiving emergency treatment at one hospital; better mental health care - especially in A&E; care closer to home, meaning less travel to busy hospital sites; separating emergency and elective care, if this meant fewer operations would be cancelled; more and better cancer screening and the use of online and telephone consultations where appropriate.

At the same time, people highlighted negative points about the plans, particularly about how they would be resourced, in terms of money, staffing and space in the community; how the changes would be implemented; the potential fragmentation of care; changes to the current model of women and children's services; and the extent to which remote consultations would be successful and the attention given to the needs of specific groups such as BAMER and people with disabilities.

In summary: *'if they want to change services to that extent, you've got to change the whole structure of the clinicians that they've got available, the number, the specialties, and the services in the community as well.'*

Recommendations

The recommendations are drawn from the comments received and will require more detailed work as plans develop.

- Provide/publish responses to the questions posed by the survey participants
- Ensure that the staffing for the proposed models is sufficient to meet demand
- Ensure that primary care has the capacity to meet the increased responsibilities
- Ensure that both face to face and online appointments are offered to give fair access for all
- Ensure good communication between different parts of the healthcare system, reducing the need for people to give information again
- Ensure that the changes are clearly communicated to patients and the public before and as they are implemented
- Provide mental health services in A&E, alongside sufficient mental health emergency care in the community
- Carry out further exploration with maternity service users and families with young children about a combined hospital for Women and Children
- Work with community groups, build relationships, and respond to concerns from e.g. BAMER, people with disabilities
- Cultural matters need to be given consideration e.g. interpreter services and home visits where a woman alone may need a chaperone

Introduction

In March 2021 Nottingham University Hospitals (NUH) will be finalising a set of options for changes to hospital services and will put those options to local people in a public consultation. HWNN were commissioned by Nottingham and Nottinghamshire Clinical Commissioning Group (CCG) to gather local people's views to inform the development of the proposals. The CCG wanted to find out people's views on proposed changes and improvements to NUH. The questions they were seeking to answer were:

- What people think of the plans
- How they might be impacted, positively and negatively
- Other relevant comments they may have

The aim of this pre-consultation engagement was to generate options. The work of HWNN complements this by reaching more vulnerable communities.

The engagement ran between 1 December and 18 December 2020 with HWNN conducting our survey between these dates and was publicised on the Healthwatch website http://hwnn.co.uk/t-nuh. The CCG will consult again when plans have been developed later in 2021.

Background

The Government published a New Hospital Building Programme in September 2020 and NUH was one of 27 Trusts given the go ahead to develop plans for improving and modernising hospital facilities. It is hoped these plans will bring better health services for local people.

To ensure that they take this opportunity the CCG has developed the Reshaping Health Services in Nottingham Programme. Central to this is *Tomorrow's NUH* – a programme of work to design and create hospital services that will meet the needs of the population now and in the future. One of the reasons for these changes is that the current hospital infrastructure is out of date. The two large hospital sites that currently exist (Queen's Medical Centre and City Hospitals) were designed at a different time to care for fewer patients with different needs to patients today.

The proposed approach would result in:

- Hospitals being used mainly for services such as emergency care and operations; most other services such as follow up appointments would be done closer to home.
- Patients being able to have an appointment online using a computer, tablet or by phone.
- Most care being provided at one hospital site, making it better, safer and quicker.
- Planned operations being provided at a separate site to emergency care.

This would mean:

- Fewer visits to hospital and more care at home or close to home.
- More investment in hospitals to make them more modern and with better equipment.
- Providing a special women and children's hospital, to give mothers and babies better care.
- All emergency care services would be on one site, providing access to specialist services that patients may need without having to travel across sites by ambulance.
- Planned operations would take place in a dedicated elective care centre, separate from emergency care services. This would help protect elective care from emergency pressures, and reduce the number of cancelled operations.

NUH is in the early stages of this process and is outlining the future vision for services set out in six clinical pathways: Emergency Care, Family Care, Elective Care, Cancer Care, Outpatient Care, and Ancillary Services.

Work has begun with the clinical teams on developing the operating model which will:

- Enable the provision of the right care in the right location, transform services and meet the commitments made in the Clinical and Community Services Strategy 2020
- Address issues that remain from merging two separate organisations, which impacts on ability to deliver modern care. This is due to services being split across sites or duplicated and spreading staff and equipment too thinly.
- Support clinical best practice and fulfil NUH's role as a regional centre
- Fix the parts of the ageing estate that have received little or no investment and do not meet the needs of services to deliver modern healthcare.

The CCG will consult again on more detailed plans later in 2021.

Our approach

The CCG commissioned HWNN to engage with people across Nottingham and Nottinghamshire (excluding Bassetlaw) from specific cohorts including:

- BAMER
- People with long term conditions/poor health outcomes
- People with a disability
- Frail older people
- Maternity service users
- Young people
- LGBT

Healthwatch worked with the CCG to develop a more accessible version of the survey. The survey was circulated electronically to individuals, groups and via the HWNN website http://hwnn.co.uk/t-nuh and an offer was also made to interview respondents by phone. The survey comprised comments and a rating scale. Responses were entered onto a secure SNAP survey link. This data was downloaded and analysed for themes and trends.

Three online focus groups were held with:

- Mixed group (6)
- Young people (10)
- Substance users (8)

Focus group discussions were recorded, sent for transcription and then analysed to identify themes. Some adaptations were needed to successfully run a virtual focus group and this learning has been incorporated into HWNN's approach.

Tables showing the demographics of the respondents are included at the end of the report in Appendix 1. The demographics showed that:

- Age – 6 young people aged 16-24 and 33 older people aged 65+ responded
- Disability – 138 people had an illness or impairment (this includes people who may have more than one)
- Parents with young children- 15 people said they were either pregnant or had children under 5 years old
- BAMER- 68 people (46.8%) of respondents were BAMER
- Religion or belief – 54 people (37%) were Christian, 43 people (29%) were Muslim and 29 (20%) said that they had no religion.
- Sex – men were under-represented 27 (18%) and as a group who often have poorer health outcomes HWNN would wish to increase this in the future
- Sexual orientation – 9 people were homosexual

In total, 150 residents responded to the engagement and 145 people completed the demographics questions. Of those, 55.2% (n=80) were from Nottingham City and 42.7% (n=62) from Nottinghamshire.

Of these, 24 people took part in focus groups, 32 had telephone interviews and 94 completed online surveys.

Summary of findings

The findings are discussed under six headings in line with the six sections in the survey.

Tables showing the rating scales for each plan are included at the end of the report in Appendix 2. The rating scales suggest overall support for the plans, however the value of this report is in the more detailed responses in the survey and from the focus groups. These raised many questions and concerns.

People were very positive about the idea of modernising the hospitals; receiving emergency treatment at one hospital; better mental health care - especially in A&E; care closer to home, meaning less travel to busy hospital sites; separating emergency and elective care, if this meant fewer operations would be cancelled; more and better cancer screening and the use of online and telephone consultations, where appropriate.

At the same time, people highlighted negative points about the plans, particularly about how they would be resourced, in terms of money, staffing and space in the community; how the changes would be implemented; the potential fragmentation of care; changes to the current model of women and children's services; and the extent to which remote consultations would be successful and the attention given to the needs of specific groups such as BAMER and people with disabilities.

In summary: *'if they want to change services to that extent, you've got to change the whole structure of the clinicians that they've got available, the number, the specialties, and the services in the community as well.'*

1. Plans for the future of Hospital Services

The plans are for hospitals mainly to concentrate on operations with follow up appointments being done closer to home or remotely by other NHS services.

There was positive support for the plans: *'Great to hear work is being done to modernise our health service'* and: *'These plans seem a really good idea. On the face of it they would help patients to be treated quicker and more efficiently.'*

However, overall, participants identified more issues than benefits to this proposed model with the main one being around resourcing. People made negative comments about whether the plans could be delivered: *'I worry that they are over-promising to be able to deliver locally.'*; *'It sounds great but does it really happen?'* and one person concluded: *'This sounds like a great idea but there needs to be extremely strong and effective back-up plans to help transition the services especially in the early stages.'*

Concerns included:

Whether there would be enough specialists to staff this approach: *'I think it would push a lot of care back into primary care, I think there's a danger that specialists will not be as readily available'* and *'if you're talking about people delivering home services to the individuals who need it more, are they going to have enough staff basically?'* Another person said: *'All too often, services are moved to the community without the correct staffing levels to mirror hospital care and services.'*

Whether the number of available appointments would be reduced due to the additional travelling time for staff who need to visit multiple sites: *'the consultants themselves are not now based in the hospital, they have to go to say Riverside or Mary Potter. They're not seeing as many patients either because they're having to spend a lot of time travelling around the community.'*

Whether there would be sufficient parking at primary care sites: *'the area where I live in Nottingham West, we have a lovely Care Centre at Stapleford, but parking is absolutely dreadful. It's just as bad in places like Park House at Carlton.'*

Whether the existing hospital shuttle bus would be big enough to carry additional patients travelling between sites: *'those little buses won't be able to cope with the demand of extra people needing to use them to get from one site to the other'*

How easy it would be to make these appointments given the current challenges of getting a GP appointment: *'primary care services are already pushed to the limit, they don't have the capacity or the resources to take on these extra outpatient appointments.'*

Whether the process of making these appointments would lead to: *'tying up emergency services'* with calls.

Quality of care

Participants also expressed concern whether this new model would impact on the quality of care, for example, lack of continuity of care and ensuring the plans do not disadvantage certain groups.

Lack of continuity of care: *'Follow up appointments in the community sound great but there is an issue of continuity of care - if you are having to explain your individual particular story to someone fresh every time you see them it is very draining.'* and *'what's actually happened is that now I don't see a regular consultant. I see a different consultant every time as I have in the last two years. Every time I see him, I have to go through everything that I've been through previously.'* There were concerns about: *'how you achieve continuity of care - although [a] multiple team approach can work it's often fraught with difficulty. Lack of communication between healthcare professionals is a key reason for time wasted.'*

Ensuring that the plans don't disadvantage some groups of people: *'In principle the plans are good but need to ensure this new approach does not negatively impact certain groups and exclude them to increase or perpetuate inequalities in health.'*

Feasibility of online services

Several people questioned the feasibility of online services. For example, they said that:

The approach might not be suitable for everyone: *'It would be helpful if you provided a clear strategy for those who … have English as a second language.'* And another respondent said: *'I worry that it will exclude some people who are not online.'* Therefore whilst: *'that sounds great, there needs to be an option for face-to-face appointments as well as online.'*

Remote consultations might not be able to identify some conditions: *'Depending on your condition an online consultation wouldn't always work and vital elements could get missed'* and *'it's all very well doing appointments over the phone, but say you've got to have hernia surgery, or gallbladder surgery, or whatever it happens to be, the consultant needs to look at it and actually physically examine the area where it is so he can see what he's doing.'*

Some patients might not be able to express themselves or health professionals might not be able to read body language remotely in order to support diagnosis: *'a lot of people like to have a face-to-face appointment rather than have it online and everything, because sometimes people find it hard to express themselves'* and *'I feel like with therapy, and just psychological health, online doesn't really do the job as well, because it's very hard to read body language or what the person is feeling.'*

Not everyone has the IT or can afford it: *'not everybody's got technology to have an appointment online, what's going to happen to all of them people that's not got the technology to be able to do that?'* and *'not everybody can afford it.'*

Conclusion

A range of concerns were raised by participants about whether there are enough resources in the community to deliver this model (both specialist and general community services e.g. GPs) as well as how appropriate remote appointments are for all. If patients could be offered options of treatment locations and methods (face to face, online etc.) tailored to the individuals needs that would be preferable.

2. Plans for Emergency Care

Plans for Emergency Care would mean care being delivered in one place, so there would be no need for patients to move hospital, and, where possible having follow up appointments and treatment closer to home so patients do not have to come back into hospital. There would also be a specialist mental health team working in A&E.

There was definitely support for receiving treatment in one place. *'Not having to be moved once in hospital really appeals because I have often been transferred from QMC to City Hospital for respiratory care.'* Other respondents said: *'A good idea. It's disturbing to be moved from one place to another'* and *'this is real progress; I think of my father being admitted 14 times into hospital in his final year, being shunted from one hospital to another over and over. This created terrible anxiety for him and me.'*

There was mixed support for emergency care at home. *'I like the notion of trying to be kept out of A&E to be helped before going into hospital. Having been into A&E a few times in your life it's quite scary, it's frantic and a bit impersonal'* and *'it would be great to be able to get emergency care at home if possible! Saves journeys when you are not well.'* However other people felt that*: 'Surely 'emergency' requires specialist support in hospital'* and were concerned about safety: *'I wouldn't want to be left at home if it wasn't safe.'*

Other positive comments made were:

Overnight stays may be reduced, *'I think what appeals to me is that less people will be needing to stay in hospital every night'*

People may not have to come back for an additional appointment and risk missing it, *'if this is somebody who's rough sleeping or vulnerably housed, they're not going to come back necessarily, if we could get all of that done in one go, that would be really useful'*

Whether support for domestic abuse could be provided as well, *'we need more specialist services such as those for domestic violence and other issues, not just for mental health. Will they be able to pick up these other conditions as well as mental health?'*

How the model would be resourced

A number of respondents had concerns about how the model would be resourced, for example they felt that:

Care at home could increase costs: *'It sounds good but how is it possible to implement this to treat people at home? Will it increase the cost?'*

The model might stretch specialist services as a variety of staff would be required in one place: *'if somebody needs, let's say, a scan or needs a different kind of doctor, would all of them be at the same hospital and how plausible will it be to have all those people, let's say for example, five or six doctors who are of different professions at the same time and at the same place?'*

The hospital might not be able to provide the specialist care required for some cohorts: *'I'm conscious to the fact that lupus and supercell and those illness that are particular to the community, I'm not sure how that's going to be covered'* and, *'people such as alcohol and drug workers and mental health*

workers, will they only be available during office hours?' Taking account of issues such as: *'provision in ED of support for different communication needs for people with different learning abilities, visual or hearing problems or different languages and need for interpreters.'* Also that the service: *'should offer female staff where possible as Muslim women may prefer this.'*

More patients coming into one hospital might require more discharge staff, *'discharging patients is an issue because they can be delayed, which causes bed blocking, you will need more staff to be available to discharge patients and take care of their social care needs.'*

Mental health care

Mental health care was seen as a gap in A&E and there was a lot of support for providing this, for example:

Having specialist mental health staff in the emergency department. *'I feel that a lot of focus needs to be put on mental healthcare and therefore this sounds promising'* and *'Mental health professionals in emergency centres are long overdue…I have been in emergency units and it has been obvious that [some people] are suffering from mental health and dementia and they take up an inordinate amount of time'* and *'it sounds more holistic by including mental health.'*

Staff having more training in mental health: *'I don't think enough care is available for patients with mental health issues, as nurses are only trained in physical health and not mental health.'*

It would be better for young people who might be diagnosed earlier with mental health issues: *'for example, a 16-year-old goes into the hospital, things could be picked up at a younger age is what I'm trying to say instead of it progressing into late adult.'*

It would be better to have mental health services in the same hospital as A&E so you could be seen straight away: *'some of our most vulnerable clients, if we get them in, it's a really good opportunity whilst they're there to try and put all those things in place at the same time'* and *'this has happened with the 'everyone in' thing for COVID where we got all the rough sleepers into hotels. It's been a really great opportunity to get everything working in one place, for some people, that's been really, really good. It's been the first time in years that they've had everything dealt with at once. If we could do that in the hospital, it would be fantastic'*

There was a lack of mental health care generally and it was important to talk more with people with mental health issues: *'I worry about the massive mental health issues, about the delivery of mental health emergency care in the community - will the service be available at the right level of funding'* and: *'you really need to talk to the people with mental health problems.'* One person said: *'my point is that there's got to be more mental health. I mean instead of having it in A&E why's it not separate? Why is there a not a section of the hospital for that anyway, emergency mental health section because sometimes it can be uncomfortable for that person where you're going into the emergency department, you've got people with broken legs and stuff, and you're having a mental breakdown.'*

Ensuring there is enough mental healthcare in the community: *'The plans sound good in principle but I worry that if lots of healthcare professionals are focusing on emergency care in hospitals, will people in the community be able to access e.g. mental health care?'*

Conclusion

In order to provide emergency care in one hospital, more follow up treatment closer to home, and additional mental health services both in A&E and in the community, careful consideration of resourcing is needed. However if it can be managed participants supported this model as it would provide a 'one stop shop' and a holistic approach to treating the whole individual.

3. Plans for Family Care

Plans for Family Care would bring all women and children's care together in one hospital and more services would be provided closer to home.

People did support care closer to home: *'Nearer to home is good. Having to cart older children into hospital with you for appointments is difficult and can be stressful'* and: *'I like the idea of having other care during and after pregnancy by doctors, nurses, social care and mental health in GP surgeries and clinics, closer to home. My sister had to go to hospital to have her baby vaccinated but it would have been better nearer home.'*

There was mixed support for services being on one site. Some people liked the idea: *'I think this idea of the one hospital is so much easier and much less stressful if you are needing family services and already have young children'* and: *'The family plans sound the ideal answer to some of the problems families are experiencing at the moment, for example domestic abuse.'*

Others were concerned about there being less choice. It was felt that women needed greater options around pregnancy.: *'I think the women during pregnancy should be given way more options and they shouldn't kind of be rolled into one big thing'* and *'What I think could be a problem for a pregnant woman is being denied the choice of hospital because I think women want to be given a choice.'* One person was concerned that this could bring poorer outcomes: *'Less choice can mean centralisation of care that is proven to bring poorer birth outcomes.'*

It was felt that a single site would not be suitable for everyone, for example a different environment is needed for women and children*, 'I feel like women also need some time and space, and especially, if they're pregnant. Children would need a different environment to feel comfortable, and women need a different environment.'* Services needed to be sensitive for example *'…imagine a situation where a woman was being treated and that treatment meant she couldn't have children and wanted to…'* and: *'…cases where a baby will be stillborn or will be born with Downs syndrome should be private…'* And one person said: *'I wouldn't want to be in the same unit as maternity if I was there for something else.'*

Several people stressed the importance of access to care for specific groups including men and BAMER: *'What does women and children's services mean as it needs to be inclusive of fathers and single parents and parents of the same sex?'* and *'There are few if any details on how the proposals have considered the unique needs of BAME groups or other vulnerable groups i.e. those with a disability.'*

Other concerns that were raised were whether there would be sufficient resources if everything was under one roof, *'if we just merge everything, wouldn't the staff be really overloaded with issues focused on children and also women?'*; whether people would still be able to see another doctor for a second opinion if everything was provided in one hospital and the needs pf children with mental health problems: *'It's very important that they give a high priority to mental health services for children because the harm that mental health problems can cause children can live with them for the rest of their lives unless they are helped quickly.'*

Conclusion

Participants expressed a preference for the current model where women had a choice of hospitals and where women and children were treated at different sites; the reasons given were that people's needs were different and this would give choice. Doubts were also raised about the resource implications. In order to understand these issues better we suggest further exploration is done with maternity service users and families with young children.

4. Plans for Elective Care (Planned operations)

Plans for Elective Care would mean care being delivered at a different hospital to A&E services and where possible having follow up appointments and treatment closer to home following the operation, so patients don't have to come into hospital.

There was a lot of support for separating emergency care from planned operations, if this meant that fewer operations would be cancelled. *'If operations are less likely to be delayed or cancelled because the hospital is separate from A & E, then this can only be a good thing.'* It would help to guarantee appointments: *'elective surgery patients get pushed down the waiting list because emergency cases take over and if A&E is separate from elective care there will be an appointment that could be guaranteed'* and *'if they'd got lots of accidents, car accidents, and things like that, quite rightly, those people were taken straight in for operations. What it meant, if you were on elective surgery, you're just getting pushed back all the time'*

It would be good idea as people generally want to be treated as soon as possible to avoid problems escalating. *'It's best to catch people at the earliest opportunity if they [health professionals] see something that needs doing this would enable them to be able to get it done at the earliest opportunity, rather than risk it being cancelled and then maybe something else developing further down the line'*

Remote consultations are easier for some people. *'I queued around for about four hours to see the surgeon and then he basically had a look at the way the stitching was on the operation and said, "Yes, that's fine. You can go home now." I could have sent him a picture of that or I could have gone to my local GP to look at it.'*

Suggestions were made that staffing issues could be helped with volunteer support. *'Maybe you can get people with lived experience and can volunteer to go to see some of the patients and just to check upon them.'*

However there were also doubts about this model, for example:

Whether there would be sufficient staff to deliver the model: *'Will there be enough surgeons to cover both emergency and planned care sufficiently? If not, you might still have the same problem but over multiple sites if the emergency department is to be separated'* and: *'I worry about a hospital with just elective care. What happens when emergencies happen during elective care? Are resources spread too thinly across multiple locations to be able to help in an emergency?'*

Specialists within A&E might not be readily available if elective care was at another hospital: *'I'm really concerned about splitting the A&E from the main hospital, I had to go in for intravenous drugs on one occasion and the nurse who was doing it couldn't do that particular job. She went to A&E and got an A&E nurse, who was an expert in putting intravenous type things.'*

Awareness that this could impact on discharge which needs further work: *'It isn't working at all right now, we would need to see evidence that NUH can get that working, and they have got time to get that working to start out.'*

There were concerns about on line or telephone follow-up: *'Again, a poor city, you are relying on people having certain technology and I think whoever thinks everyone is set up at home with webcams and smart phones needs to spend some time in the community!'* and: *'This will probably disadvantage those who do not have access to online services or do not feel comfortable speaking over the phone… There again seems to be little thought into how disadvantaged communities, i.e. BAME groups will be impacted.'*

The lack of face to face appointments could lead to it being difficult to explain the seriousness of a condition: *'I am visually impaired and unable to use a computer and if I needed an assessment over the telephone and they wanted me to describe what I can see on my wound, I won't be able to as I can't see'* and *'sometimes it's very difficult to-- like if you're on certain benefits, and you have to*

have an assessment done and they want you to do it over the phone, it's very difficult to explain to them your condition, it can have a double impact on whether you get your benefits or you don't get them.'

Whether primary care has the capacity to support this model, *'that's a bit tricky because GPs are taking on so much now that sometimes they can't cope.'*

Conclusion

Participants supported the model if it meant that less elective surgery would be postponed by having it at a different site to Accident and Emergency. However they also recognised that the roles of staff in A&E and elective care sometimes crossed over and that resourcing would need to be carefully considered. People liked care closer to home and could see the benefits of remote consultations however there would still be a need for face to face appointments.

5. Plans for Cancer Care

Plans for cancer care would aim to catch cancer early by checking people in their community at higher risk earlier and providing more cancer services closer to home.

Participants views were mixed as to whether this model would be an improvement on not. On the positive side:

There was support for more and better screening. *'I think this is great, catching cancer early is vital and this means better and earlier screening which means in the long run it is cheaper than trying to treat the cancer at a later stage'* and *'Many communities are not aware of the signs and symptoms of cancer and there is a lot of fear and stigma surrounding cancer as well as the treatments and also outcomes. Barriers to uptake of cancer screening services need to be addressed including racism and ensuring cultural and religious needs of communities are taken account. You can't check people if they don't come forward! So work with groups, build relationships, rapport, trust, listen and respond to concerns without judgement'*

People liked the idea of being cared for closer to home, or at home, where practicable: *'I like cancer treatment for patients to be closer to home to cope with psychological support with families and relatives.'* and *'I think this is a good plan - I think I would want to be at home if at all possible while being treated for cancer, so long as it's appropriate.'* This would prevent patients waiting around: *'The option of been treated at home e.g. chemo would be a positive move as patients would be in their own surroundings instead of having long wait in hospital for their turn.'* And although much cancer treatment would need to take place in hospital: *'after care can be done at home via a zoom meeting or visits by a health professional. People who have had chemotherapy might be too sick to travel to hospital or their loss of hair would make them too self-conscious to leave the house. So care closer to home would suit them better.'*

There would be reduction in travelling time, *'my friend has recently been diagnosed with brain cancer, and she has to go for regular blood tests all the way from Stapleford over to the City.'*

It would be better for sick patients, *'having treatment nearer to home is better as patients do not need to travel especially when they're sick or when they can't get to a relative or friend to take them to hospital.'*

There would be a reduction in the number of different departments that would need to be visited inside hospitals, *'I would say that during my trajectory, there was an awful lot of coming and going to different parts of the whole complex. I did find that very, very confusing'* and *'I think I once one afternoon did 10,000 steps around Nottingham Hospital trying to accompany someone around'.*

The negative points that were raised included,

Resources: *'need more staff resources to provide the care in the community and we have difficulty with the NHS budget already'*

GPs were also found to be key to getting an early diagnosis: *'As long as GPs are up to date with treatments. My dad died with prostate cancer, my brother visited his GP to ask for a test (he is over 50 black Caribbean) they refused because he had no symptoms!! Luckily my brother was able to educate them and get tested'* and *'if you present to [your] GP with any sort of lump or mole, invariably, they refer you to the hospital, they don't actually attempt to diagnose it themselves. Either they don't want to, they don't feel they've got the skills to. I'm not quite sure where the hospital think there's going to be more diagnosis in the community'*

How the NHS would persuade people to be screened, *'how on earth NUH is going to persuade more people to take part in these early screening processes, well, best of British luck because as I said, it's voluntary. It's not mandatory'*

Whether this is practically possible, *'a lot of the drugs that you get for cancer care are hospital-only drugs, they're not available at local pharmacies and GPs don't always have any knowledge about how they interact with other drugs'*

Other points raised were that care in hospital would benefit from separating new patients from returning ones: *'When cancer patients go back to the hospital for chemotherapy, the ones there for the first time should not be mixed with patients whose cancer has returned. It's very stressful and depressing for first-time patients to see from the others that their cancer may come back.'* Also good communication between departments: *'What they're aiming for, like everything else, relies on good communication and on co-operation.'* and: *'Having good communication between departments when working with cancer, e.g. removing large masses, need to talk to plastic surgery too. Patients need help from multiple departments to work together to support the pathways for care.'*

People identified two other important areas to be considered in the plans for cancer.

Hospices: *'There's a need for more hospices to support the families as well as care for the patients instead of keeping them in hospital or leaving them to struggle at home. Hospices have a very positive outlook and have activities for the patients and their families.'*

Palliative care: *'Palliative care has been left out of these plans. It's very important- a lot of men have gone through traumas when their wives are receiving palliative care, for example because of the difficulty in obtaining oxygen at weekends.'*

Conclusion

Generally participants felt that cancer diagnosis and care closer to home was a good model for the patient who would have less travelling time, particularly when they were not feeling well. There were also concerns about staff resources and other services such as palliative care.

6. Plans for Outpatient Care

Plans were to provide more outpatient care in patients' homes, in community clinics or GP surgeries, to give patients more choice when and where they receive care and to let patients get treatment from specialists, doctors, and nurses, without having to go into hospital.

The positives that were identified were:

People did like the idea of care at home, or closer to home: *'I like it as care should be provided at home and close to home.'* And: *'[Not going to hospital] has to be good. This thing of going to the hospital is always a big thing on your mind. As well as the travel, going to this big place with lots of people and waiting around.'* One person gave this example: *'With pain management I was going to St*

Ann's Valley or for physio I went to Sherwood. Fantastic, as this was near to home, easy parking and easy access into the buildings.'

Easier access and avoids hospital transport, *'I've had a family member who was treated over at King's Mill Hospital, had to go there every three weeks for his chemo. The surgeon was begging them to let him do a clinic over at Newark because he had so many patients over there. You're not going there and back to King's Mill. You're just able to walk round to the hospital and go and have an outpatient appointment there at the Eastwood Centre and it's just a lot easier'* and *'I think it's also very good for the hospital and also for the people, because it's really difficult for them to always arrange their transportation to the hospitals and it would be way easier for them as well.'*

Remote and online care was good for certain conditions e.g. blood pressure and blood sugar which could be monitored remotely: *'I like really taking on board tele-medicine. Where you can be checked remotely. You can have a blood pressure monitor that can send details down the phone line. I think that is a really important step to help the NHS make best use of its resources … I would want a bit more support over phone or video to feel more comfortable when not being seen by someone.'*

Participants raised a number of issues with this model which included,

More changes, *'if they want to change services to that extent, you've got to change the whole structure of the clinicians that they've got available, the number, the specialties, and the services in the community as well'*

Reservations about whether the plans could be achieved: *'How would receiving care at home be logistically possible? Wouldn't this mean taking from staff at the hospital?'* and: *'I think that they're going to have to employ a lot more staff because I think that patients are going to have to wait a lot longer if clinicians and staff are going to have to travel to all these different places'* A solution might be: *'I can see that patients will have to accept that if they want to be seen at clinics in specific locations, they will have to be at specific times.'*

Differing cultures might affect care at home: *'There are also cultural practices [that] would need to be taken into account and flexibility with regards health services at home specific to women. It sounds great in principle but may not be in practice.'*

People felt that the internet was not suitable for everyone: *'Sounds good - since COVID and more emphasis on working from home, people think it's good not to have to go out of the home. I worry about the internet, though - how many of us can manage it?'* and: *'I fundamentally disagree with this remote care process, where the doctor relies on looking at a patient on the screen and actually trying to monitor and gauge their health by a screen process. I think that this is a fundamentally bad idea'*

Communicating to people about the changes is a whole system change: *'which has nothing to do with the clinicians, it's to do with the admin people'*

Quality of care: *'This proposal raises questions as to whether quality of service will be maintained. Will this create more burden for relatives?'*

Conclusion

People liked the idea of providing more outpatient care at home and in the community because it would reduce travelling time and hospital transportation. Online and telephone support was a good option for e.g. blood pressure and blood sugar monitoring. They also raised concerns about adequate staffing, significant system changes that would need to be communicated adequately to the public and risks of providing online appointments which are not accessible to all and may make diagnosis difficult for health professionals.

Questions

The CCG is undertaking a pre-consultation and so the information given to enable people to comment is not fully developed. Respondents have therefore raised a number of questions which are summarised below. A lot of people said they really needed a lot more information before they could comment or before they would feel happy that the plans would make a difference.

- How will this be paid for?
- Are they trying to close one of the hospitals? Will there be fewer hospitals?
- Where will the emergency services be?
- Is the women's and children's hospital a full paediatric (unit) too?
- Does women's care include, for example, gynaecology?
- What does 'less choice' mean for women and children's services?
- Will there still be flexibility for face to face consultations?
- Where is 'nearer home' for follow-ups? GP surgeries are already at capacity.
- Will more care closer to home lead to a watering down of expertise?
- Will this actually mean more cancer screening?
- Can cancer care be delivered safely in the community?
- Where does this leave the Treatment Centre?
- How will interpreters be provided?

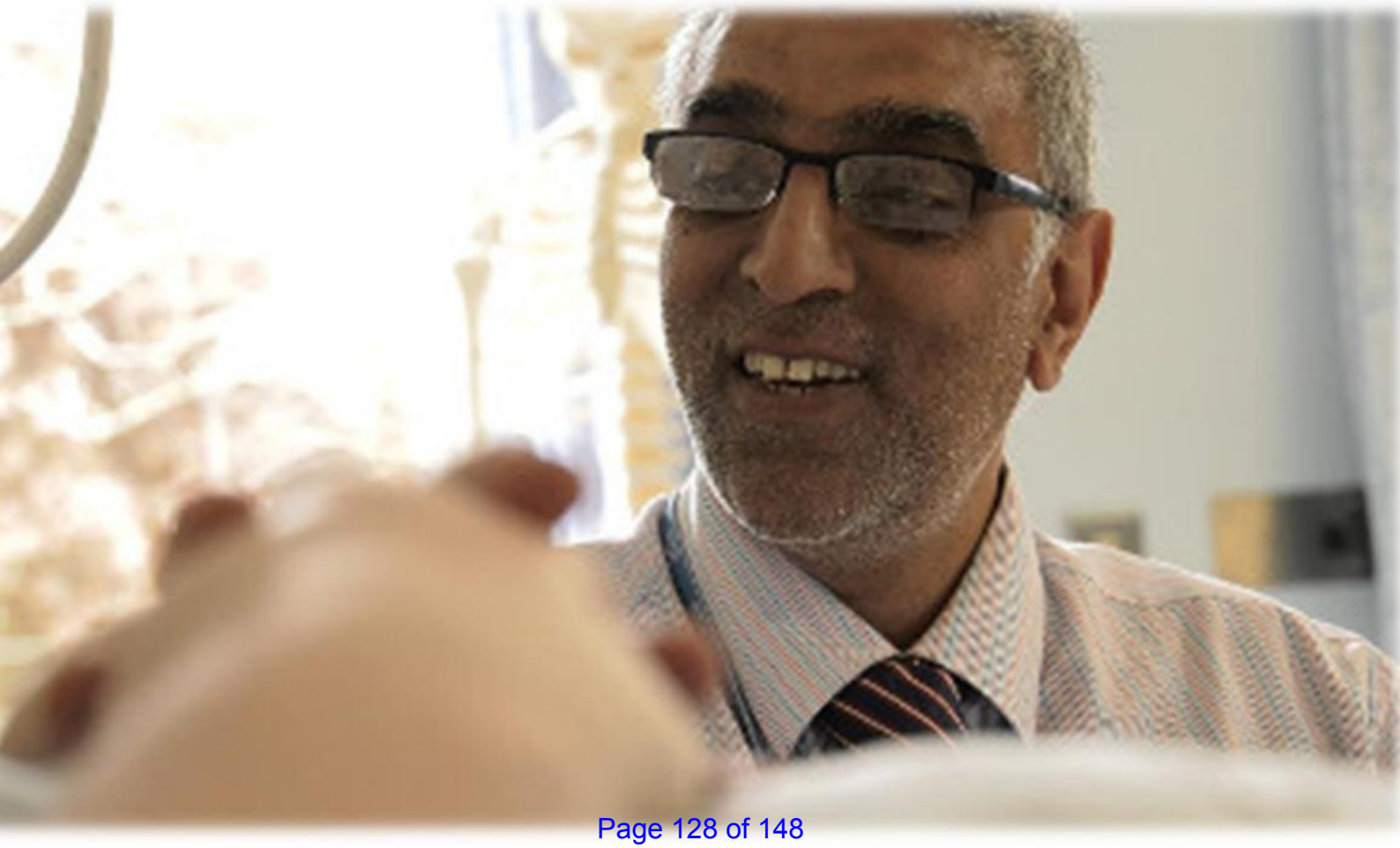
Main Findings

The findings are discussed under six headings in line with the six sections in the survey. They are summarised below.

People were very positive about the idea of modernising the hospitals; receiving emergency treatment at one hospital; better mental health care - especially in A&E; care closer to home, meaning less travel to busy hospital sites; separating emergency and elective care, if this meant fewer operations would be cancelled; more and better cancer screening and the use of online and telephone consultations, where appropriate.

At the same time, people highlighted negative points about the plans, particularly about how they would be resourced, in terms of money, staffing and space in the community; how the changes would be implemented; the potential fragmentation of care; changes to the current model of women and children's services; and the extent to which remote consultations would be successful and the attention given to the needs of specific groups such as BAMER and people with disabilities.

In summary: *'if they want to change services to that extent, you've got to change the whole structure of the clinicians that they've got available, the number, the specialties, and the services in the community as well.'*



Recommendations

The recommendations are drawn from the comments received and will require more detailed work as plans develop.

- Provide/publish responses to the questions posed by the survey participants
- Ensure that the staffing for the proposed models is sufficient to meet demand
- Ensure that primary care has the capacity to meet the increased responsibilities
- Ensure that both face to face and online appointments are offered to give fair access for all
- Ensure good communication between different parts of the healthcare system, reducing the need for people to give information again
- Ensure that the changes are clearly communicated to patients and the public before and as they are implemented
- Provide mental health services in A&E, alongside sufficient mental health emergency care in the community
- Carry out further exploration with maternity service users and families with young children about a combined hospital for Women and Children
- Work with community groups, build relationships, and respond to concerns from e.g. BAMER, people with disabilities
- Cultural matters need to be given consideration e.g. interpreter services and home visits where a woman alone may need a chaperone

Appendix 1: Demographics of respondents

District	Number	Percent
Ashfield	3	2.1%
Bassetlaw	2	1.4%
Broxtowe	15	10.3%
Gedling	21	14.5%
Mansfield	1	0.7%
Newark & Sherwood	7	4.8%
Nottingham City	80	55.2%
Rushcliffe	13	9.0%
Outside of Nottinghamshire	3	2.1%
Total	145	100%

Age Group	Number	Percent
<16	0	0.0%
16-24	6	4.1%
25-34	13	9.0%
35-44	29	20.0%
45-54	35	24.1%
55-64	24	16.6%
65-74	12	8.3%
75-85	17	11.7%
85+	4	2.8%
Not answered	5	3.4%
Total	145	**100%**

Gender	Number	Percent
Female	107	73.8%
Male	27	18.6%
Not answered	9	6.2%
Non-binary	1	0.7%
Prefer not to say	1	0.7%
Total	**145**	**100%**

Gender - Same as birth	Number	Percent
Yes	134	92.4%
Not answered	8	5.5%
Prefer not to say	3	2.1%
Total	**145**	**100%**

Sexuality	Number	Percent
Heterosexual	100	69.0%
Not answered	17	11.7%
Prefer not to say	15	10.3%
Homosexual	9	6.2%
Asexual	3	2.1%
Bisexual	1	0.7%
Total	**145**	**100%**

Ethnicity	**Number**	**Percent**
White	71	49.0%
Black	21	14.5%
Asian	17	11.7%
South Asian	14	9.7%
Mixed/Multiple ethnic	6	4.1%
Other	5	3.4%
Arab	5	3.4%
Prefer not to say	3	2.1%
Not answered	3	2.1%
Total	**145**	**100%**

Religion	**Number**	**Percent**
Christian (all denominations)	54	37.2%
Muslim	43	29.7%
No religion	29	20.0%
Atheist	9	6.2%
Other	4	2.8%
Prefer not to say	3	2.1%
Not answered	2	1.4%
Hindu	1	0.7%
Total	**145**	**100%**

Nationality	Number	Percent
British	109	75.2%
Other	16	11.0%
Not answered	12	8.3%
British Asian	2	1.4%
British Pakistani	2	1.4%
Polish	2	1.4%
British Bangladeshi	1	0.7%
Indian	1	0.7%
Total	**145**	**100%**

Main Language	Number	Percent
English	134	92.4%
Not answered	5	3.4%
Other	5	3.4%
Polish	1	0.7%
Total	**145**	**100%**

Are you a carer for anyone?	Number	Percent
No	113	77.9%
Yes	24	16.6%
Not answered	8	5.5%
Total	**145**	**100%**

Are you a cared for by anyone?	Number	Percent
No	121	83.4%
Yes	17	11.7%
Not answered	7	4.8%
Total	**145**	**100%**

Pregnant/children age < 5	Number	Percent
No	124	85.5%
Yes	15	10.3%
Not answered	5	3.4%
Prefer not to say	1	0.7%
Total	**145**	**100%**

Asylum seeker/refugee	Number	Percent
Yes	3	2.1%
Total	**3**	**2.1%**

Employment Status	Number	Percent
Part time	39	26.9%
Full time	35	24.1%
Retired	31	21.4%
Unable to work	16	11.0%
Not employed	10	6.9%
Prefer not to say	5	3.4%
Student	6	4.1%
Not answered	3	2.1%
Total	**145**	**100%**

Illness/impairment	Number	Percent
A long-term health condition	53	36.6%
Physical impairment	24	16.6%
Visual impairment	12	8.3%
Hearing impairment	12	8.3%
Prefer not to say	9	6.2%
Mental health illness	15	10.3%
Learning disability	8	5.5%
Social/behavioural problems	5	3.4%

Disability Count	Number	Percent
Number of respondents	71	49.0%

Appendix 2: Rating Scales

1. Plans for Hospital Services

Rating	Number	Percentage
I really like them	25	19.8%
I like them	46	36.5%
They're ok	39	31.0%
I don't like them	6	4.8%
I really don't like them	4	3.2%
I don't know	6	4.8%
Total	**126**	**100%**

2. Plans for Emergency Care

Rating	Number	Percentage
I really like them	34	27.0%
I like them	46	36.5%
They're ok	36	28.6%
I don't like them	7	5.6%
I really don't like them	1	0.8%
I don't know	2	1.6%
Total	**126**	**100%**

3. Plans for Family Care

Rating	Number	Percentage
I really like them	31	24.6%
I like them	43	34.1%
They're ok	33	26.2%
I don't like them	8	6.3%
I really don't like them	0	0.0%
I don't know	11	8.7%
Total	**126**	**100%**

4. Plans for Elective Care

Rating	Number	Percentage
I really like them	25	19.8%
I like them	34	27.0%
They're ok	40	31.7%
I don't like them	14	11.1%
I really don't like them	4	3.2%
I don't know	9	7.1%
Total	**126**	**100%**

5. Plans for Cancer Care

Rating	Number	Percentage
I really like them	44	34.9%
I like them	43	34.1%
They're ok	26	20.6%
I don't like them	3	2.4%
I really don't like them	1	0.8%
I don't know	9	7.1%
Total	**126**	**100%**

6. Plans for Outpatient Care

Rating	Number	Percentage
I really like them	31	24.6%
I like them	47	37.3%
They're ok	32	25.4%
I don't like them	8	6.3%
I really don't like them	1	0.8%
I don't know	7	5.6%
Total	**126**	**100%**

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Appendix 4 – Desirable Criteria

Our desirable criteria are the tests we will apply to each of our shortlisted options to assess its suitability. They are grouped under a number of headings, or 'investment objectives', below:

1. **Health Inequalities**

Health inequalities - The extent to which this option contributes to a reduction in health inequalities including increased support services and improved cultural appropriateness.

Accessibility - The extent to which the option allows patients, staff and visitors to access the services whether using public or private transport, in terms of travel time and cost.

Environment - The extent to which the option improves the environmental impact of services.

2. **Quality**

Clinical quality - The extent to which the option provides timely, effective care that prevents people from dying prematurely, enhances quality of life from birth to death and helps people recover from episodes of ill health.

3. **Experience**

Patient experience - The extent to which the option ensures patients and visitors/carers are confident that care is patient centred, they are being treated by the right staff, with dignity and respect, in a fit for purpose environment that they perceive to be accessible.

4. **Clinical Safety**

Safety - The extent to which the option ensures patients are treated safely, with fewer serious incidents, minimum hospital acquired infections and lower excess mortality.

5. Efficiencies

Efficient operation - The extent to which the option enhances patient flow and supports efficient operation of the healthcare system through service redesign.

6. Integration and Alignment

Integration of care - The extent to which this option improves patient journeys through the healthcare system via a focus on collaboration and coordination between secondary and primary/ community care teams and shared pathways that cross care settings.

Alignment with wider health plans - The extent to which this option supports delivery of the ICS strategic priorities and Out of Hospital ambitions (including the Clinical and Community Services Strategy) and the NHS Long Term Plan.

7. Workforce and Sustainability

Staff availability - The extent to which this option can be staffed appropriately, meeting rota requirements, whilst ensuring an appropriate skill mix allowing efficient and effective use of the workforce.

Recruitment and Retention - The extent to which this option will support attracting and retaining the best workforce.

Staff experience - The extent to which the option ensures a good staff experience, with support for staff and volunteers, in a fit for purpose environment to reduce sickness and absence rates.

8. Capacity

Capacity - The extent to which this option is right sized and provides sufficient system wide capacity to meet expected demand for acute and specialist services.

Flexibility - The extent to which this option is future proofed and provides flexibility with the potential to change in response to changing healthcare needs.

9. **Fit for Purpose Estate**

Estate - The extent to which this option reduces backlog maintenance and mitigates critical infrastructure risks.

Adjacencies - The extent to which this option improves clinical adjacencies.

Complexity of build - How challenging is the build of the option, considering the impact on existing services and the local community. What is the mix of new build and redevelopment and what are the delivery risks?

Time to build - Length of time taken to build the option.

10. **Digital**

Digital - The extent to which this option increases resilience of the NUH data infrastructure and increases opportunities for hosting data infrastructure of other system partners.

11. **Research and Innovation**

Research and Innovation - The extent to which this option supports innovation and R&D.

12. **Efficiencies**

Benefit cost ratio - Analysis to determine whether the benefits of the investment outweigh the costs and therefore will deliver value for money value of benefits/ value of costs.

13. **Anchor Institution**

Net Present Social Value - Standard calculation of development cost, plus risk, less benefits to the Trust and the wider economy, over the life of the asset. Includes efficiency benefits, financial risks and phasing of capital costs.

Nottinghamshire County Council

Report to Health Scrutiny Committee

26 January 2021

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 2020/21

Subject Title	**Brief Summary of agenda item**	Scrutiny/Briefing/Update	Lead Officer	External Contact/Organisation
29 September 2020				
Health Trust CQC Improvement Plan	Further Scrutiny of Nottinghamshire Healthcare Trust's improvement plan following last year's CQC inspection.	Scrutiny	Martin Gately	Anne Maria Newham Executive Director for Nursing, AHPs and Quality
Millbrook Service Variation	Improvements to inpatient mental health provision			Sharon Creber, Healthcare Trust
Bassetlaw Hospital Service Variation	Initial briefing on a potential substantial variation of service and engagement/consultation	Scrutiny	Martin Gately	Victoria McGregor-Riley, Bassetlaw CCG
14 October 2020				
NRC Consultation Response	[Final] consideration of responses to the National Rehabilitation Centre consultation	Scrutiny	Martin Gately	Lewis Etoria, Nottinghamshire CCG
10 November 2020				
Tomorrow's NUH	Future development of services at NUH	Scrutiny	Martin Gately	Dr Keith Girling, NUH
COVID-19 Restoration	Further briefing on service changes linked to COVID-19	Scrutiny	Martin Gately	Lucy Dadge, Chief Commissioning Officer, Nottinghamshire CCG
COVID-19 and Mental Health	Mitigation of COVID-19 on mental health, including mental health support for NHS staff	Scrutiny	Martin Gately	CCG/Healthcare Trust TBC
Chatsworth Neurorehabilitation Service (move to community model)	Further briefing on the Chatsworth Neurorehabilitation Service and service development towards a community service.	Scrutiny	Martin Gately	Lucy Dadge, Chief Commissioning Officer, Nottinghamshire CCG

15 December 2020				
Dentistry and Orthodontic Provision (Bassetlaw)	An initial briefing on dentistry in Bassetlaw	Scrutiny	Martin Gately	Emma Wilson, Head of Co-commissioning Debbie Stovin, Dental Commissioning Manager, NHSE
GP Mental Health Referrals	An initial briefing from the CCG and Nottinghamshire Healthcare Trust on the operation of GP mental health referrals.	Scrutiny	Martin Gately	Maxine Bunn, Associate Director of Commissioning, Nottinghamshire CCG
Equity of Access to GPs	An initial briefing on equity of access to GP services across Nottinghamshire	Scrutiny	Martin Gately	David Ainsworth, Locality Director, Nottinghamshire CCG
Bassetlaw Proposals Engagement	Briefing on the planned engagement in relation to the emerging proposals for Bassetlaw	Scrutiny	Martin Gately	Dr Victoria McGregor-Riley, Bassetlaw CCG
12 January 2021				
Rehabilitation Services	A full and detailed briefing on rehabilitation services within Nottinghamshire	Scrutiny	Martin Gately	Lucy Dadge, Chief Commissioning Officer, Nottinghamshire CCG
26 January 2021				
Tomorrow's NUH	Further briefing on future development of services at NUH	Scrutiny	Martin Gately	TBC
Dementia in Hospital	An initial briefing from NUH on dementia services in hospital	Scrutiny	Martin Gately	
9 March 2021				
Frail Elderly at Home and Isolation (TBC)	TBC	Scrutiny	Martin Gately	TBC
Patient Transport Service Performance Update	Latest Performance Information on the PTS	Scrutiny	Martin Gately	TBC

NUH Maternity Services Improvement Plan	An initial briefing on NUH's improvement plan for Maternity Services following last year's	Scrutiny	Martin Gately	TBC
Access to School Nurses	An initial briefing on school nurses and Healthy Family Teams.	Scrutiny	Martin Gately	TBC
Children's Strategic Commissioning	TBC	Scrutiny	Martin Gately	Louise Lester, Consultant in Public Health and Jonathan Gribbin, Director of Public Health
20 April 2021				
Winter Planning (NUH)	Lessons learned from experiences of last winter	Scrutiny	Martin Gately	TBC
East Midlands Ambulance Service Performance	The latest information in relation to performance targets from EMAS.	Scrutiny	Martin Gately	TBC
Allergies in Children	Initial briefing in relation to allergies and epi-pens	Scrutiny	Martin Gately	TBC
8 June 2021				
NHS Property Services and contracts	TBC	Scrutiny	Martin Gately	TBC
13 July 2021				
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
NHS Property Services	TBC	Scrutiny	Martin Gately	TBC
Operation of the Multi-	TBC			

agency safeguarding hub				

Potential Topics for Scrutiny:

Recruitment (especially GPs)

Diabetes services

Air Quality (NCC Public Health Dept)