Nottinghamshire County Council

Health Scrutiny Committee

Tuesday, 14 January 2020 at 10:30

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

AGENDA

Notes

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

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

(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 3 December 2019 at 10.30am

Membership

Councillors

Martin Wright (Vice-Chair)
Richard Butler
John Doddy
Sybil Fielding
Kevin Greaves
John Longdon
David Martin
Mike Pringle
Kevin Rostance
Stuart Wallace
Muriel Weisz

Officers

Martin Gately	Nottinghamshire County Council
Noel McMenamin	Nottinghamshire County Council

Also in attendance

Ian Bayne	Independent Person
Catherine Burn	Bassetlaw Community Voluntary Services
Amy Callaway	Nottinghamshire Integrated Care System
Anne Crompton	Nottingham University Hospitals Trust
Dr Keith Girling	Nottingham University Hospitals Trust
Steve Jennings-Hough	Adult Social Care and Public Health

1. MINUTES

The minutes of the meetings held on 15 October 2019 and 8 November 2019, having been circulated to all Members, were taken as read and were signed by the Chair

2. APOLOGIES

The following change of membership for the remainder 2019-2020 was reported:

- Councillor John Doddy had replaced Councillor Steve Vickers.

The following temporary changes of membership for this meeting only were reported:

- Councillor John Longdon had replaced Councillor Keith Girling
- Councillor Sybil Fielding had replaced Councillor Liz Plant
- Councillor Mike Pringle had replaced Councillor Yvonne Woodhead.

3. DECLARATIONS OF INTEREST

None.

4. NHS ENGLAND'S SOCIAL PRESCRIBING MODEL

Amy Callaway, Programme Manager, Universal Personalised Care, Nottinghamshire Integrated Care System, Steve Jennings-Hough, Transformation Manager, Adult Social Care and Public Health, and Catherine Burn, Director, Bassetlaw Community Voluntary Services introduced the item, providing a briefing on the roll-out of social prescribing, that is, non-clinical activities and interventions to assist people of all ages manage their health and well-being.

NUH representatives made the following points:

- Social prescribing was a key component in the drive by NHS England to deliver Universal Personalised Care by 2023/24, with over 1,000 trained social prescriber link workers being appointed nationally by 2020/2021;
- The benefits of social prescribing included improved self-esteem, empowerment and confidence, a resulting reduction in social isolation and in symptoms of anxiety and depression, and reduced levels of reliance on health and social care services;
- Social prescribing was seen to reduce demand for GP and Accident and Emergency services by an average 28% and 24% respectively;
- Funding was available for 1 Link Worker per Primary Care Network, but Clinical Commissioning Groups had discretion to fund additional Link Worker posts, and further posts would be rolled out in time.

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

- While referral for social prescribing was initially via GPs, self-referral was expected to be available in 2020/2021;
- Assurance was provided that the model in Bassetlaw was delivered by a highly-skilled and competent voluntary and community sector, with all appropriate training and safeguarding practices in place;
- Each link worker would have a caseload with the intention being to identify and signpost support/need, as well as to build personal resilience, over the course of a period of up to 3 months;
- A Peer Network for link workers was being established to share expertise and insights;
- It was acknowledged that voluntary and community sector capacity was a risk to the model, and was very much to the forefront of commissioners' and

providers' thinking in terms of the sustainability of the model in the medium term;
- The social prescribing model was not designed specifically to reduce GP prescription costs. However, it would be possible to track the impact of social prescribing on the prescribing of drugs over time;
- Ms Callaway undertook to share the Integrated Care Provider Shared Local Plan with the Committee.

The Chair thanked Ms Burn, Ms Callaway and Mr Jennings-Hough for their attendance at the meeting,

5. NOTTINGHAM UNIVERSITY HOSPITALS TRUST (NUH) IMPROVEMENT PLAN UPDATE

NUH representatives Dr Keith Girling, Medical Director, and Anne Crompton, Associate Director of Quality and Safety, introduced the item, providing an update on the delivery of the NUH Implementation Plan drawn up following the inspection conducted by the Care Quality Commission in late 2018 and early 2019

Dr Girling and Ms Crompton highlighted the following points:

- 2 of the 7 core services inspected in late 2018/early 2019 were rated as 'requiring improvement' – urgent and emergency care at QMC and maternity care at QMC and City, while an overall rating of 'requires improvement was given for the Safe domain;
- The inspection highlighted one Must Do action in respect of documentation on Do Not Attempt Cardiopulmonary Resuscitation decisions, and 54 Should Do actions;
- Progress on the Must Do action has not proceeded at the required pace, and further targeted intervention is currently taking place. 26 of the 54 Should Do actions, have been delivered or are on track, 13 actions would require significant investment to deliver, while the remaining 15 actions are not on track, but are the subject of a recovery plan;
- Progress was being monitored by an oversight group under the Chie Nurse, which reported regularly at senior Committee and Board level within the Trust. The mechanisms in place have been were reviewed by Internal Audit colleagues and found to offer significant assurance.

A number of points were made during discussion:

- The Committee expressed its dissatisfaction with the poor level of detail provided in the presentation. The absence of a briefing paper, or any information in respect of the Should Do actions, prevented the Committee from fulfilling in a meaningful way its statutory function to deliver effective health scrutiny;
- Dr Girling and Ms Crompton offered their apologies for the lack of information provided and undertook to send through more detailed information, particularly in respect of the Should Do list of actions which still required further action;

- A Committee member suggested that a traffic light system of identifying where action was and was not required against the Should Do actions would be useful;
- It was explained that failure to act upon the Should Do actions drew no further sanctions from the Care Quality Commission, as long as the Trust could demonstrate that no direct harm came to patients;
- Failure to address Must Do actions could lead to an Improvement Notice being issued, but would not happen in this case as the Trust was fully engaged in addressing the identified shortcoming;
- The view was expressed that the decision not to resuscitate was taken only after very careful consideration. Difficulties emerged when the patient had neither the required mental capacity nor identified next-of-kin to take the decision on the patient's behalf.

The Chair thanked Dr Girling and Ms Crompton for their attendance at the meeting and requested a further update at the Health Scrutiny Committee's June 2020 meeting.

6. WORK PROGRAMME

Subject to agreeing to consider the NUH Improvement Plan update at its June 2020 meeting, the Committee's Work Programme was approved without substantive discussion.

The meeting closed at 12:31pm.

CHAIRMAN

Nottinghamshire County Council

Report to Health Scrutiny Committee

14 January 2020

Agenda Item: 4

REPORT OF THE CHAIRMAN OF HEALTH SCRUTINY COMMITTEE

NOTTINGHAM TREATMENT CENTRE

Purpose of the Report

1. To consider the briefing provided by Nottingham University Hospitals (NUH) on the performance of Nottingham Treatment Centre.

Information

2. The Nottingham Treatment Centre was on the agenda of the Health Scrutiny Committee in July 2019, when Members heard the following points:

   - Both Circle and NUH had worked very closely and under stringent time pressures to ensure a smooth service transfer by the transfer date of 29 July 2019, covering buildings and equipment, staffing levels, patient records, and a raft of other areas;
   - TUPE arrangements were well in hand, with around 600 Circle staff expected to transfer to NUH imminently;
   - The CCG was working closely with NUH to ensure that the very complex logistical challenges involved in transferring services were being addressed.

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

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

3. Dr Keith Girling, Medical Director, NUH will attend the Health Scrutiny Committee to provide briefing and answer questions as necessary.

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

5. Members may wish to consider when to schedule further consideration of this issue.

RECOMMENDATION

That the Health Scrutiny Committee:

1) Consider and comment on the information provided.

2) Schedules further consideration, as necessary.

Councillor Keith Girling
Chairman of Health Scrutiny Committee

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

Background Papers

Nil

Electoral Division(s) and Member(s) Affected

All

Update on the transfer and mobilisation of the Treatment Centre to Nottingham University Hospitals NHS Trust

Introduction

Nottingham University Hospitals' (NUH's) priority has been to maintain safety, quality of care and to maximise service continuity from day one whilst completing the mobilisation of the Treatment Centre Services previously delivered by Circle. These have now been successfully transferred two months ahead of the original seven month plan and are now being delivered wholly by NUH.

As part of the mobilisation, over 500 colleagues transferred their employment from Circle to NUH and, along with this transfer, the mobilisation also included the establishment of new IT systems and transfer of patient appointments to NUH's patient administration system. This involved a data transfer of 44,642 existing patient bookings for outpatient appointments and surgery. The service delivery mobilisation has been successfully managed and governed via our weekly Treatment Centre Mobilisation Board and Treatment Centre Steering Group from the end of May to November.

This paper is to update the Health Scrutiny Committee on the completion of the mobilisation activities including the delivery of the services, IT systems and staff transfer, whilst confirming that planning activity has now switched from implementation to delivery of the transformation plan from November 2019, including maximising the use of the inpatient beds. This exciting transformation work will be governed by the Treatment Centre Transformation Board in conjunction with a joint Board set up with our CCG colleagues to ensure we can rapidly deliver our new initiatives across the Nottingham and Nottinghamshire health and care system.

Mobilisation and Transformation Update

The successful delivery of all the areas below is due to the excellent collaborative working relationships that were established with our new TC Division colleagues before the transfer of services on the 29th July and which enabled swift response and delivery of all the key areas well ahead of the original timelines. The key areas of progress have been:

1. Quality and Governance:

The Treatment Centre has been registered with the CQC as a site and full compliance achieved. NUH Data systems and processes have been fully enabled to allow reporting of patient safety and quality issues whilst integrating the TC team into NUH governance structure including attendance at the Nurse Management Board and Quality and Safety Committee by the lead nurse.

We ensured the Friends and Family test (FFT) and reporting arrangements were quickly rolled out along with developing a single point of access for PALs and complaints.

Initially on mobilisation from Circle Health to NUH in August 2019, the Treatment Centre's quality and assurance team had 19 complaints and 65 PALS enquiries. The majority of complaints and enquires centred around the communication to patients about the transfer and the effect this would have on their care. There was also concern regarding the availability of equipment for particular surgeries.

Over the first 1-3 months there was a reduction in these types of concerns and enquiries due to the implementation of our mobilisation plans which have ensured services are now being delivered in line with patients expectations. In November 2019, NUH received 10 complaints and 25 PALS enquiries about the Treatment Centre which all differ in theme. This represents a reduction from the level of complaints before the Treatment Centre was handed across to NUH as the team are now resolving patients' enquiries locally as systems and services have been implemented and are working. Please note there has been an increase in PALS enquiries compared to pre mobilisation which we monitor closely.

The Treatment Centre quality and assurance team has embedded NUH's processes and policy in regard to complaints and PALS, and work closely, offering support Trust-wide, with the patient experience team.

It is important to note that the performance of the key elective constitutional standards were largely unaffected by the addition of the Treatment Centre to the Trust following our joint reporting of the elective standards commenced in October following full validation of Treatment Centre data.

The combined RTT performance was just under 92% at the end of October with both sites achieving similar results. There are currently no reportable 52 week waiters. The 6 week diagnostic standard just failed in October; however, Treatment Centre activity improved the overall performance. The combined PTL is now circa 45,000 following the amalgamation of the two separate PTLs.

NUH performance against key cancer constitutional standards changed with the addition of the Treatment Centre activity. We reported a combined position against cancer standards from August. The inclusion of Treatment Centre data caused a decline in performance against the cancer two-week GP referral to first outpatient standard with combined performance of 92.1% against 93% target in August. In October performance recovered to be above standard at 93.4%. Cancer 62-day urgent referral to treatment (adjusted) performance remains below the 85% standard for both the Treatment Centre and the former NUH elements; the combined position is slightly stronger following the inclusion of the Treatment Centre pathways with reported performance of 80% in October.

To date, there are no TC risks evident on the Trust's Significant Risk Register and a full and final review of all TC risks is expected to be completed by end of December 2019 which will include alignment of all TC risks into NUH registers.

A number of other key areas will be changed as part of the transformation plan which includes:

1. The Complaints Policy at NUH is under review and will be fully embedded by April 2020. The TC is part of the review group who will complete this work.
2. A programme of defibrillation replacement will improve and align the equipment to that provided in NUH.
3. The development and deployment of a single quality schedule with CCG colleagues which we intend to implement in April 2020.

2. Premises:

NHS Property Services have granted the Trust a tenancy at will of the TC building for a period of 6 months to ensure we had full access to the building from day 1 and in order that we can finalise and agree the lease, under-lease and sub under-leases in an appropriate way and mitigate any risks associated with the handover of the building to the NHS.

3. Equipment:

The Trust has committed £5.6m capital monies to replace essential equipment. This comprises £2.1m to buy the equipment, fixtures and fittings in the building from Circle Nottingham Ltd; £0.9m on upgrading ICT network, telephony and computer equipment to current NUH standards; £1.3m replacing critical items of medical equipment which were at the end of their useful life, including almost £1m for endoscopy equipment; and £1.2m on instrumentation for operating theatres. The Trust is currently in the process of the procuring key diagnostic equipment, including a new MRI and CT scanner, in addition to replacing endoscopy stacks and scopes, which will ensure we have state of the art diagnostic capability at the TC. The equipment used previously was over 10 years old and towards the end of its functional life.

A mobile CT continues to be used to help support delivery of services whilst we finalise the deployment new MRI and CT scanners.

4. People:

We have, as stated previously, successfully carried out the rapid TUPE transfer of around 500 colleagues into NUH. Previously the medical workforce to support patient activity had been highly reliant on "ad-hoc" medical staff who were contracted on a sessional basis (circa 85 individuals). In the short term (9 months) we have agreed to extend many of these arrangements and a working group has been set up that is led by the TC Division, fully supported by HR and Finance teams, to ensure we have a robust process in place by the 31st March 2020 to appoint to substantive Trust posts which will minimise or remove the need for these arrangements in order that we can deliver consistent high quality care from NHS employed colleagues. Some of the posts have already been replaced by substantive appointments whilst some of the work has been incorporated into existing NUH consultant job plans and in some cases work has been transferred from consultants to appropriately trained and qualified doctors in training or specialist nurses.

5. IT Systems:

Despite the extremely challenging timescales to set up new systems and integrate the existing systems across the TC, this was completed on 6th October for both the telephony and computer systems, well in advance of our extremely challenging target date of 31st October. This fulfilled our commitment to the CCG to reduce the time to mobilise this extremely complicated task from 7 to 3 months. The incumbent had previously advised the CCG that this switch could take up to 12 months. It was only possible to deliver this work with the excellent cooperation between the NUH ICT team and the TC operational team.

As part of the transfer of patient data, a number of patients had their appointment date and time rescheduled. Each patient received an individual letter about these changes, and all have been successfully reappointed.

6. Activity including inpatient beds:

As previously advised, inpatient activity at the Treatment Centre was paused during August. This was recommenced in September for patients requiring only a planned one night stay. This has meant that patients having elective orthopaedic joint replacements have been transferred to the City hospital, however, there have been no other significant changes in activity in the first three months. There have also been a number of "coding and counting" amendments due to the change in provider, which has, for example reduced the number of chargeable new attendances.

The future of providing orthopaedic joint replacements at the Treatment Centre is still being considered and a trial joint replacement list was successfully undertaken at the Treatment Centre during November.
All clinics remain well utilised in terms of the proportion of slots being booked. In total some 87.9% of the activity plan has been delivered in the first four months since transfer of services to NUH.

7. Transformation:

We are now at the next stage of delivering the transformation plans as described in our original bid with both commissioner colleagues and system partners. Figure 1 below represents the journey we are on:

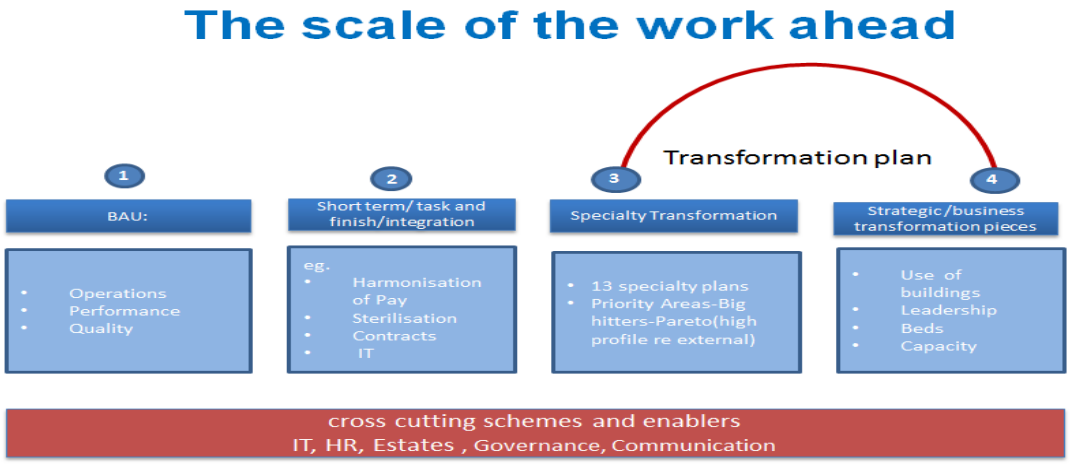


FIG 1

From November, we have an NUH executive-led decision-making Board which will run alongside a new joint board with our CCG colleagues. These groups will have oversight and accountability for the delivery of the Transformation Plans. These Boards will bring together the Divisional and TC leads to drive delivery of the transformation portfolio, direct and prioritise key Gateway-level programmes of work and resolve key delivery issues/risks that are System or Trust-wide and cross Divisions.

This Board will also enable initiatives across the organisation that could help in improving the pathways for the patient whilst ensuring their care is integrated across all parts of their pathway of care.

The executive leads will have a clear line of sight on delivery and assurance issues across Quality, Finance, Performance and Delivery, Strategic Plan Implementation and contractual obligations whilst ensuring alignment of the program with both the system and organisational policy, including HR, IR and IT policies.

Next Steps on the Transformation:

During November and the first week of December the specialties have been presenting their transformation plans on a rolling programme to ensure we can improve and deliver them in line with, or quicker than, the original timescales.

A template is being used to ensure each team can provide the relevant information to enable the Board to make an appropriate decision on the priority of the plans that will support the improved delivery of these care pathways.

8. Summary:

Following our successful fast tracked mobilisation we have, as stated, now focused our attention on implementing the transformation aspects of our successful bid, working with our clinical and system leaders. We intend to continue sharing good practice and learning between NUH and the Treatment Centre and the wider system to further integrate and improve the services we provide for our citizens and their families.

Dr Keith Girling
Medical Director
09.12.19

NHS
Nottingham
University Hospitals
NHS Trust

Nottinghamshire County Council

Report to Health Scrutiny Committee

14 January 2020

Agenda Item: 5

REPORT OF THE CHAIRMAN OF HEALTH SCRUTINY COMMITTEE

ACCESS TO GP APPOINTMENTS

Purpose of the Report

1. To consider the briefing provided by NHS Nottinghamshire commissioners on patient access to GP appointments.

Information

2. Members have previously raised concerns regarding ease of access to GP appointments across Nottinghamshire, and equity of access in different Districts and Boroughs. Nottinghamshire commissioners have therefore provided to the Health Scrutiny Committee content from the NHS Digital Interactive Dashboard highlighting GP patient ratios and data from selected GP survey patient experience themes (Overall Experience and Experience of Booking Appointments). The data indicates high levels of satisfaction in line with the national experience.

3. Members will wish to thoroughly explore the issue of patient experience and satisfaction; including action being taken to address the small number of practices who are providing poor experience to their patients.

4. Lucy Dadge, Chief Commissioning Officer, Nottingham and Nottinghamshire CCG and Dr James Hopkinson, Clinical Chair will attend the Health Scrutiny Committee to provide briefing and answer questions as necessary.

5. The aforementioned information from NHS Digital is attached as an appendix to this report. In addition, the attendees will make a PowerPoint presentation to the committee.

6. Members may wish to consider when to schedule further consideration of this matter, if further issues are identified during the course of the meeting.

RECOMMENDATION

That the Health Scrutiny Committee:

1) Consider and comment on the information provided.

2) Schedules further consideration, as necessary.

Councillor Keith Girling
Chairman of Health Scrutiny Committee

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

Background Papers

Nil

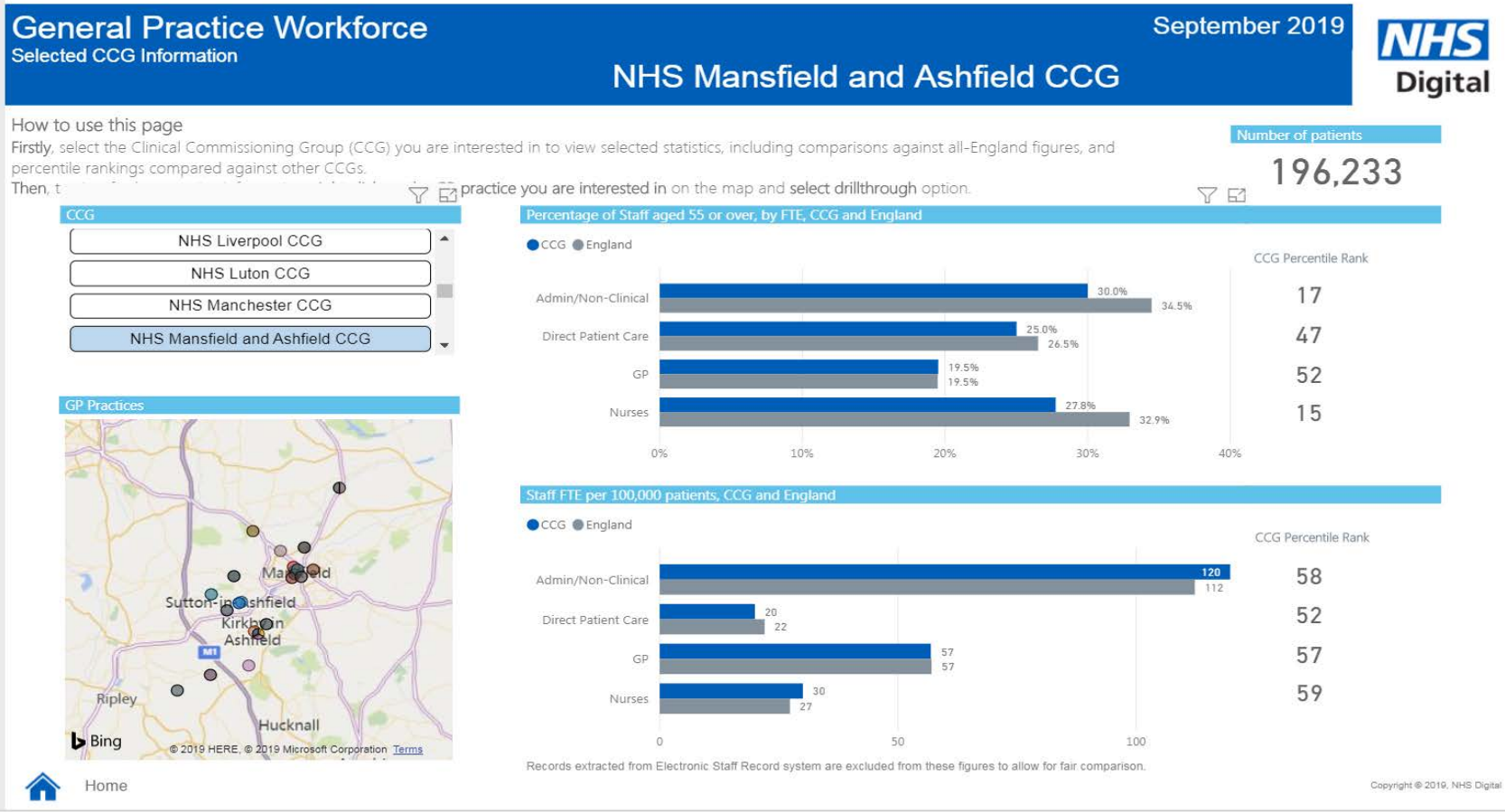
Electoral Division(s) and Member(s) Affected

All

GP Access slides – compiled from General Practice Interactive Dashboard & GP Patient Survey Data

On behalf of the six Clinical Commissioning Groups
in Nottingham and Nottinghamshire

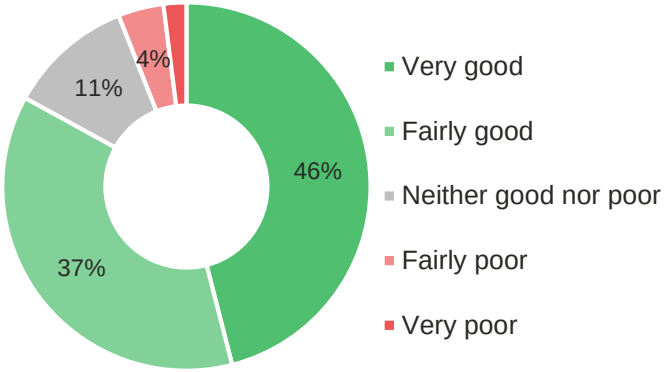
For consideration by the Nottinghamshire County Council
Health and Scrutiny Committee



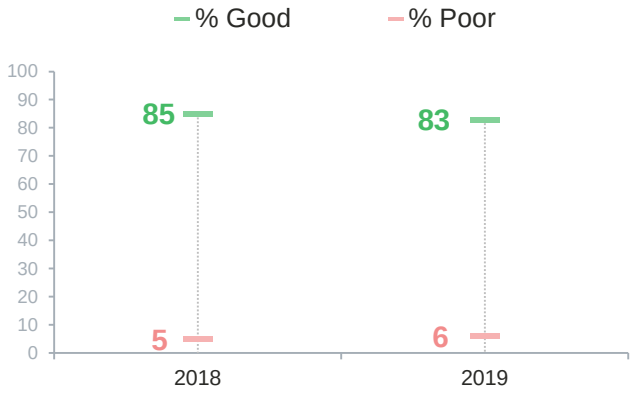
Overall experience of GP practice

Q31. Overall, how would you describe your experience of your GP practice?

CCG's results



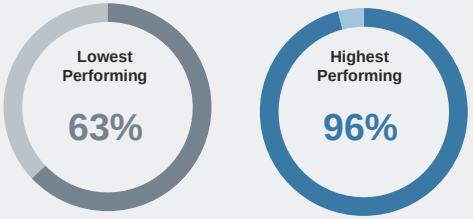
CCG's results over time



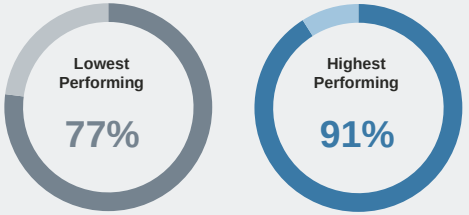
Comparison of results

CCG	National
83%	83%
Good	Good
6%	6%
Poor	Poor

Practice range in CCG – % **Good**



Local CCG range – % **Good**



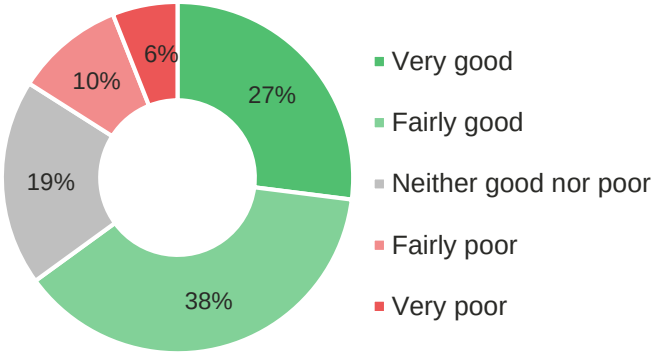
Base: All those completing a questionnaire: National (760,037); CCG 2019 (2,808); CCG 2018 (2,918); Practice bases range from 81 to 137; CCG bases range from 1,402 to 13,580

%Good = %Very good + %Fairly good
%Poor = %Very poor + %Fairly poor

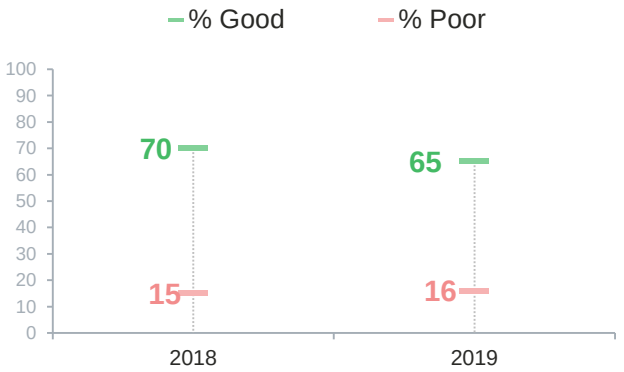
Overall experience of making an appointment

Q22. Overall, how would you describe your experience of making an appointment?

CCG's results



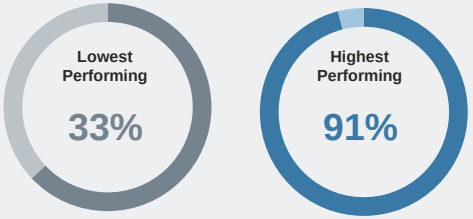
CCG's results over time



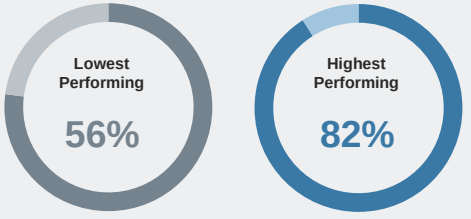
Comparison of results

	CCG	National
	65%	67%
	Good	Good
	16%	16%
	Poor	Poor

Practice range in CCG – % **Good**

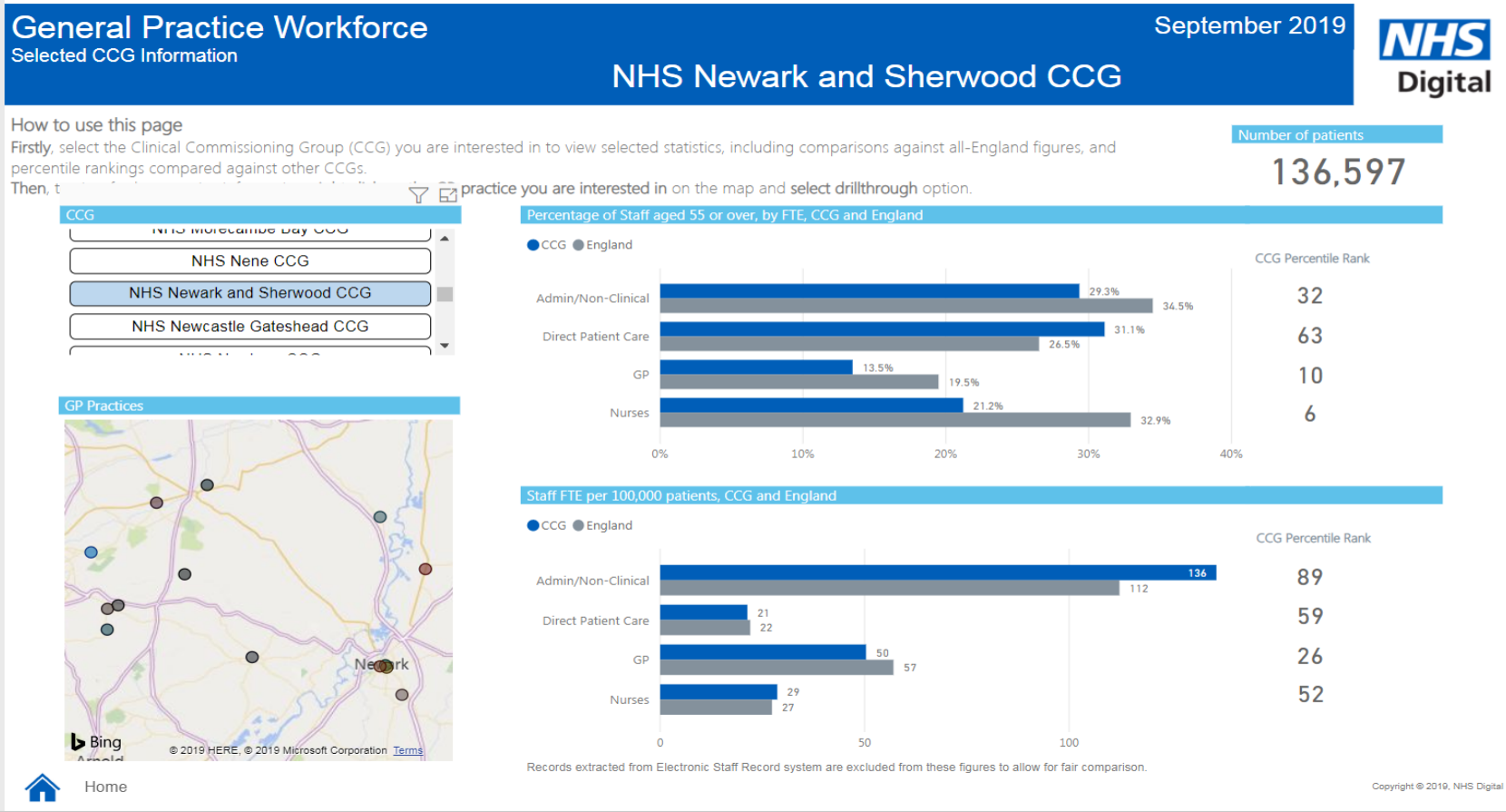


Local CCG range – % **Good**



Base: All who tried to make an appointment since being registered: National (705,310); CCG 2019 (2,625); CCG 2018 (2,688); Practice bases range from 77 to 128; CCG bases range from 1,304 to 12,671

%Good = %Very good + %Fairly good
%Poor = %Very poor + %Fairly poor


General Practice Workforce
Selected CCG Information
September 2019
NHS Newark and Sherwood CCG
NHS Digital
How to use this page
Firstly, select the Clinical Commissioning Group (CCG) you are interested in to view selected statistics, including comparisons against all-England figures, and percentile rankings compared against other CCGs.
Then, t practice you are interested in on the map and select drillthrough option.
Number of patients
136,597
CCG
NHS Nene CCG
NHS Newark and Sherwood CCG
NHS Newcastle Gateshead CCG
GP Practices
Newark
Bing
© 2019 HERE, © 2019 Microsoft Corporation Terms
Percentage of Staff aged 55 or over, by FTE, CCG and England
CCG England
CCG Percentile Rank
Admin/Non-Clinical 29.3% 34.5% 32
Direct Patient Care 31.1% 26.5% 63
GP 13.5% 19.5% 10
Nurses 21.2% 32.9% 6
0% 10% 20% 30% 40%
Staff FTE per 100,000 patients, CCG and England
CCG England
CCG Percentile Rank
Admin/Non-Clinical 136 112 89
Direct Patient Care 21 22 59
GP 50 57 26
Nurses 29 27 52
0 50 100
Records extracted from Electronic Staff Record system are excluded from these figures to allow for fair comparison.
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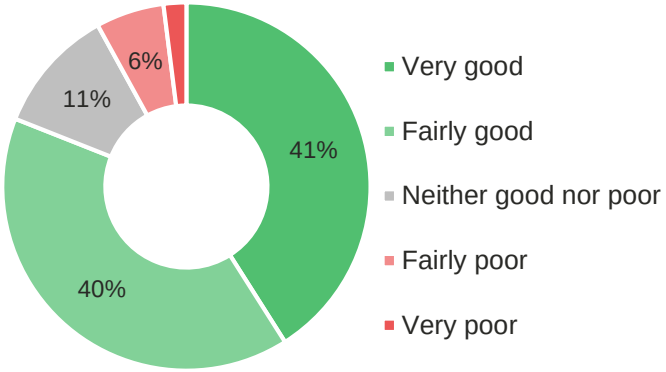
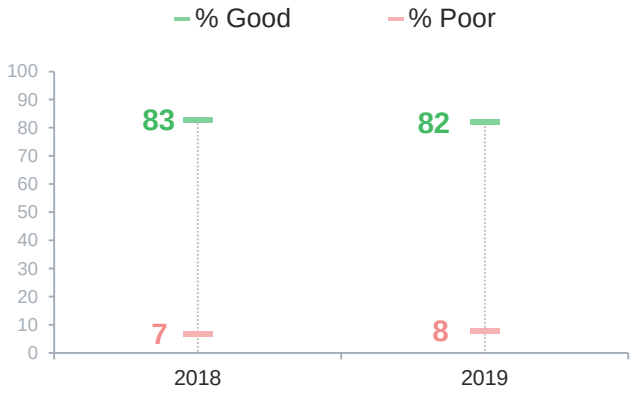
Overall experience of GP practice

Q31. Overall, how would you describe your experience of your GP practice?

CCG's results



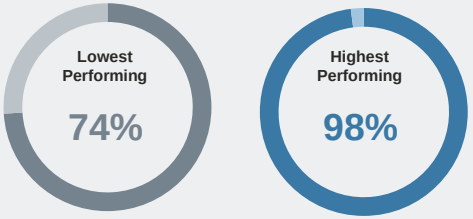
CCG's results over time



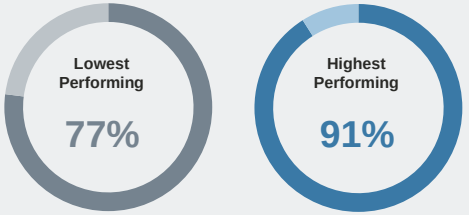
Comparison of results

	CCG	National
	82%	83%
	Good	Good
	8%	6%
	Poor	Poor

Practice range in CCG – % **Good**



Local CCG range – % **Good**



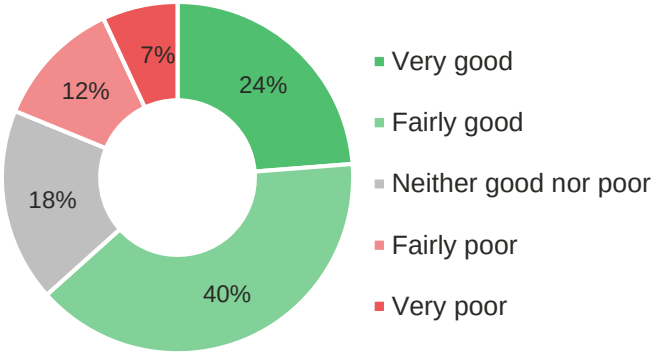
Base: All those completing a questionnaire: National (760,037); CCG 2019 (1,609); CCG 2018 (1,537); Practice bases range from 100 to 143; CCG bases range from 1,402 to 13,580

%Good = %Very good + %Fairly good
%Poor = %Very poor + %Fairly poor

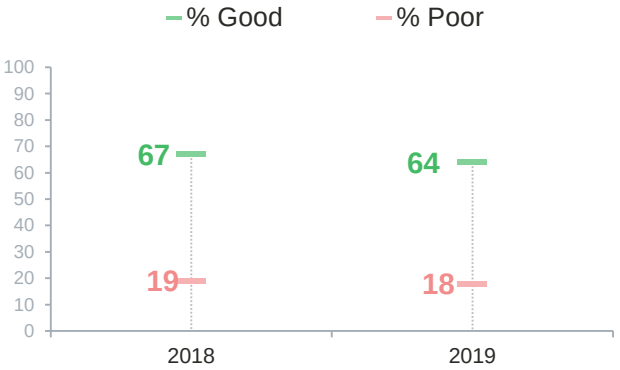
Overall experience of making an appointment

Q22. Overall, how would you describe your experience of making an appointment?

CCG's results



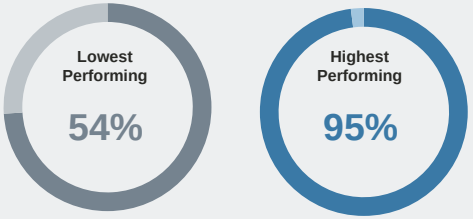
CCG's results over time



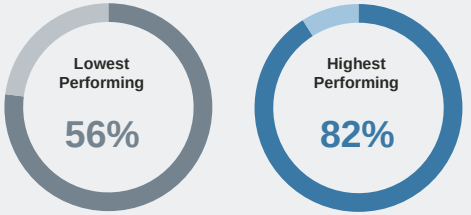
Comparison of results

	CCG	National
	64%	67%
	Good	Good
	18%	16%
	Poor	Poor

Practice range in CCG – % **Good**

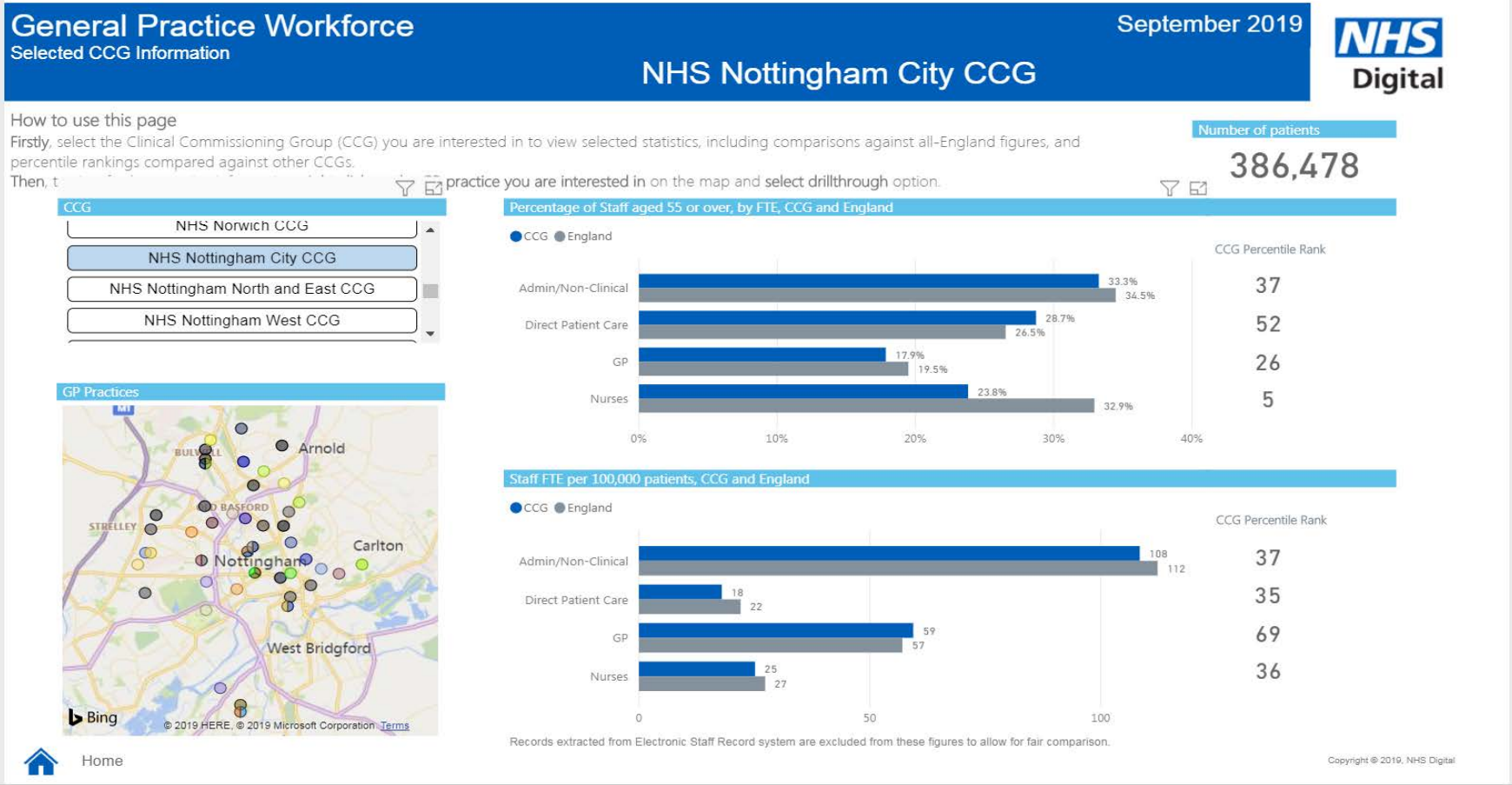


Local CCG range – % **Good**



Base: All who tried to make an appointment since being registered: National (705,310); CCG 2019 (1,494); CCG 2018 (1,448); Practice bases range from 94 to 134; CCG bases range from 1,304 to 12,671

%Good = %Very good + %Fairly good
%Poor = %Very poor + %Fairly poor


General Practice Workforce
Selected CCG Information
September 2019
NHS Nottingham City CCG
NHS Digital
How to use this page
Firstly, select the Clinical Commissioning Group (CCG) you are interested in to view selected statistics, including comparisons against all-England figures, and percentile rankings compared against other CCGs.
Then, t practice you are interested in on the map and select drillthrough option.
Number of patients
386,478
CCG
NHS Norwich CCG
NHS Nottingham City CCG
NHS Nottingham North and East CCG
NHS Nottingham West CCG
GP Practices
Arnold
Carlton
Nottingham
West Bridgford
Bing
© 2019 HERE, © 2019 Microsoft Corporation Terms
Percentage of Staff aged 55 or over, by FTE, CCG and England
CCG England
CCG Percentile Rank
Admin/Non-Clinical 33.3% 34.5% 37
Direct Patient Care 28.7% 26.5% 52
GP 17.9% 19.5% 26
Nurses 23.8% 32.9% 5
0% 10% 20% 30% 40%
Staff FTE per 100,000 patients, CCG and England
CCG England
CCG Percentile Rank
Admin/Non-Clinical 108 112 37
Direct Patient Care 18 22 35
GP 59 57 69
Nurses 25 27 36
0 50 100
Records extracted from Electronic Staff Record system are excluded from these figures to allow for fair comparison.
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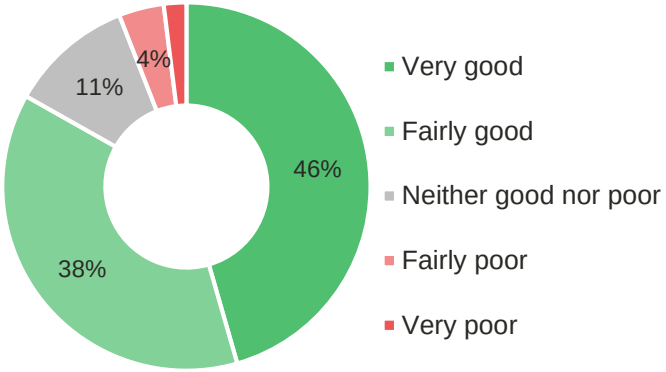
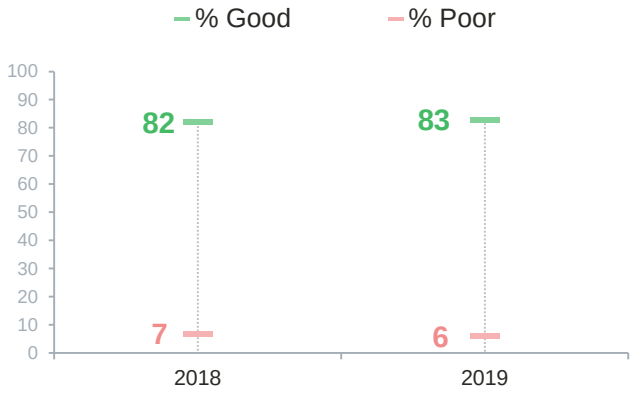
Overall experience of GP practice

Q31. Overall, how would you describe your experience of your GP practice?

CCG's results



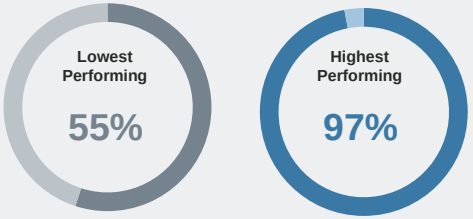
CCG's results over time



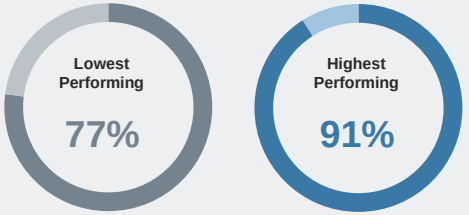
Comparison of results

	CCG	National
	83%	83%
	Good	Good
	6%	6%
	Poor	Poor

Practice range in CCG – % **Good**



Local CCG range – % **Good**



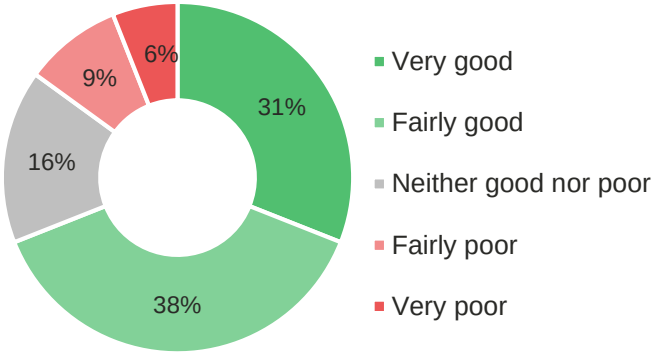
Base: All those completing a questionnaire: National (760,037); CCG 2019 (5,283); CCG 2018 (5,185); Practice bases range from 22 to 133; CCG bases range from 1,402 to 13,580

%Good = %Very good + %Fairly good
%Poor = %Very poor + %Fairly poor

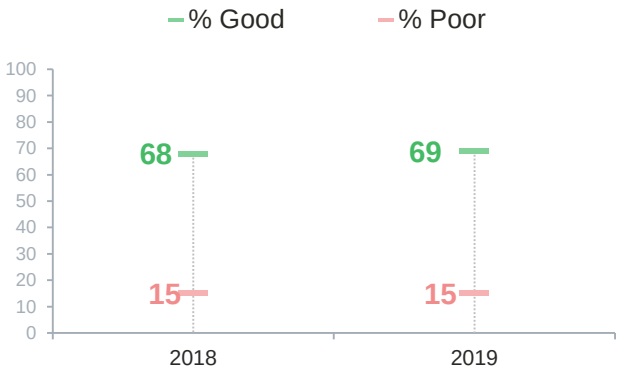
Overall experience of making an appointment

Q22. Overall, how would you describe your experience of making an appointment?

CCG's results



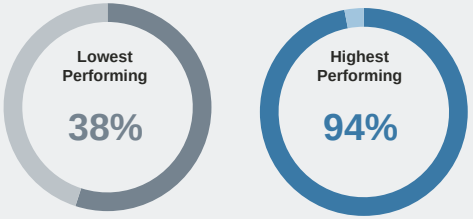
CCG's results over time



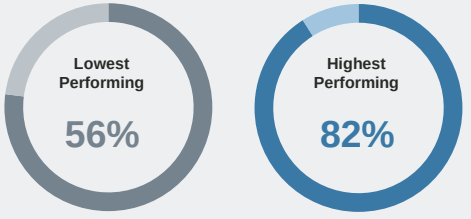
Comparison of results

	CCG	National
	69%	67%
	Good	Good
	15%	16%
	Poor	Poor

Practice range in CCG – % **Good**

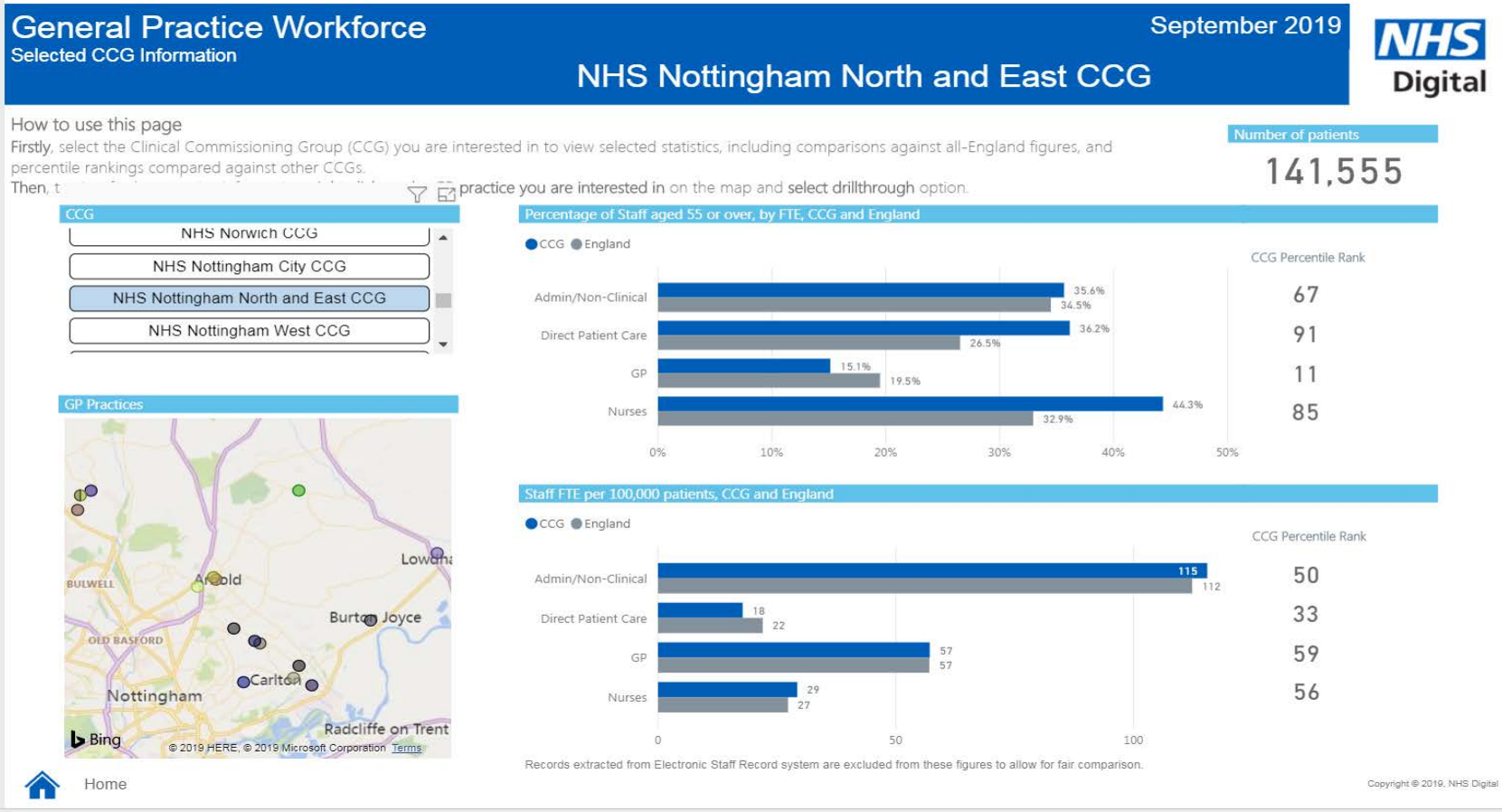


Local CCG range – % **Good**



Base: All who tried to make an appointment since being registered: National (705,310); CCG 2019 (4,868); CCG 2018 (4,769); Practice bases range from 20 to 125; CCG bases range from 1,304 to 12,671

%Good = %Very good + %Fairly good
%Poor = %Very poor + %Fairly poor


Microsoft Power BI
app.powerbi.com/view?r=eyJrIjoiNmY4NGNiMWQtMGVkZi00MzU2LThiZGMtMTFlZjY2NGE0NTZmIiwidCI6IjUwZjYwNzFmLWJiZmUtNDAxYS04ODAzLTY3Mzc0OGU2MjllMiIsImMiOjh9
General Practice Workforce
Selected CCG Information
September 2019
NHS Nottingham North and East CCG
NHS Digital
How to use this page
Firstly, select the Clinical Commissioning Group (CCG) you are interested in to view selected statistics, including comparisons against all-England figures, and percentile rankings compared against other CCGs.
Then, t
practice you are interested in on the map and select drillthrough option.
Number of patients
141,555
CCG
NHS Norwich CCG
NHS Nottingham City CCG
NHS Nottingham North and East CCG
NHS Nottingham West CCG
GP Practices
BULWELL
Arnold
Lowdham
Burton Joyce
OLD BASFORD
Carlton
Nottingham
Radcliffe on Trent
Bing
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Percentage of Staff aged 55 or over, by FTE, CCG and England
CCG England
CCG Percentile Rank
Admin/Non-Clinical 35.6% 34.5% 67
Direct Patient Care 36.2% 26.5% 91
GP 15.1% 19.5% 11
Nurses 44.3% 32.9% 85
0% 10% 20% 30% 40% 50%
Staff FTE per 100,000 patients, CCG and England
CCG England
CCG Percentile Rank
Admin/Non-Clinical 115 112 50
Direct Patient Care 18 22 33
GP 57 57 59
Nurses 29 27 56
0 50 100
Records extracted from Electronic Staff Record system are excluded from these figures to allow for fair comparison.
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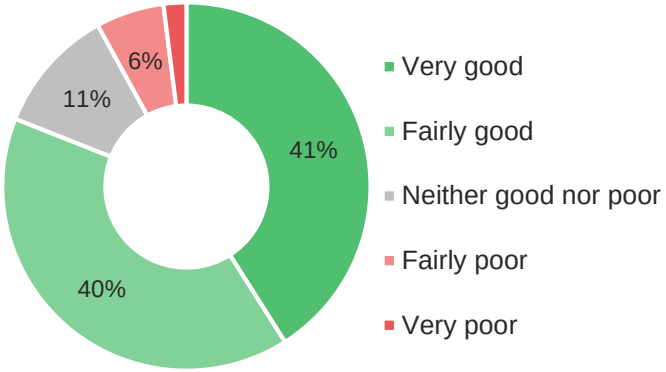
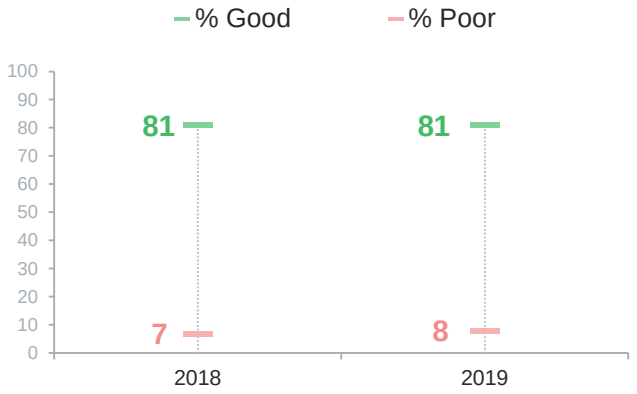
Overall experience of GP practice

Q31. Overall, how would you describe your experience of your GP practice?

CCG's results



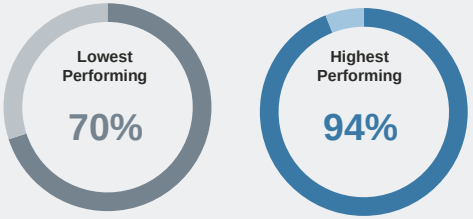
CCG's results over time



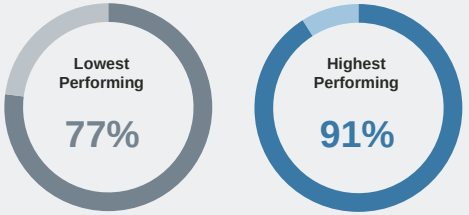
Comparison of results

	CCG	National
% Good	81%	83%
	Good	Good
% Poor	8%	6%
	Poor	Poor

Practice range in CCG – % **Good**



Local CCG range – % **Good**



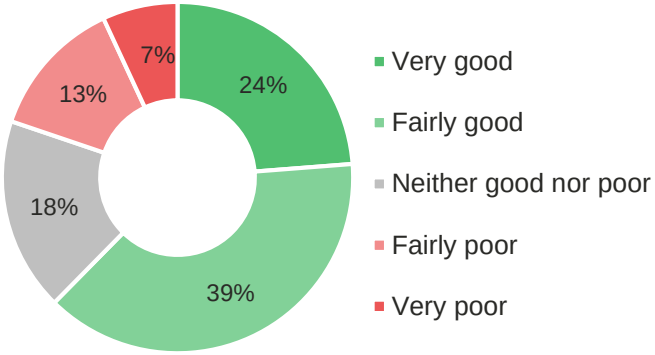
Base: All those completing a questionnaire: National (760,037); CCG 2019 (1,919); CCG 2018 (2,250); Practice bases range from 94 to 134; CCG bases range from 1,402 to 13,580

%Good = %Very good + %Fairly good
%Poor = %Very poor + %Fairly poor

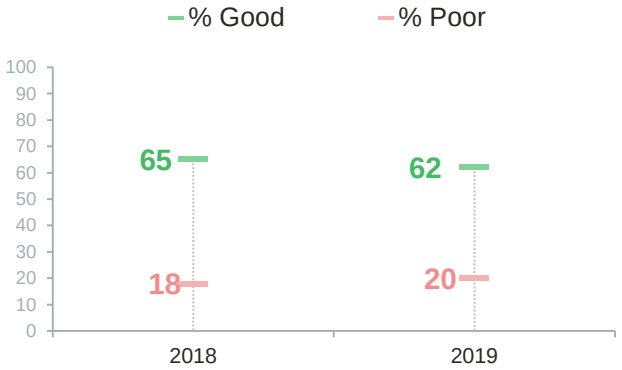
Overall experience of making an appointment

Q22. Overall, how would you describe your experience of making an appointment?

CCG's results



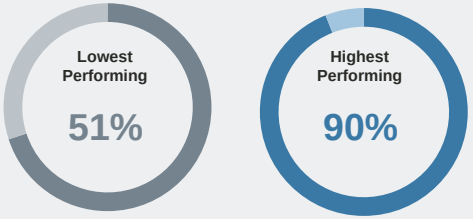
CCG's results over time



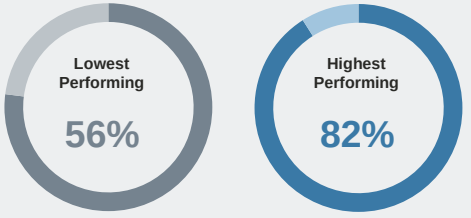
Comparison of results

	CCG	National
	62%	67%
	Good	Good
	20%	16%
	Poor	Poor

Practice range in CCG – % **Good**

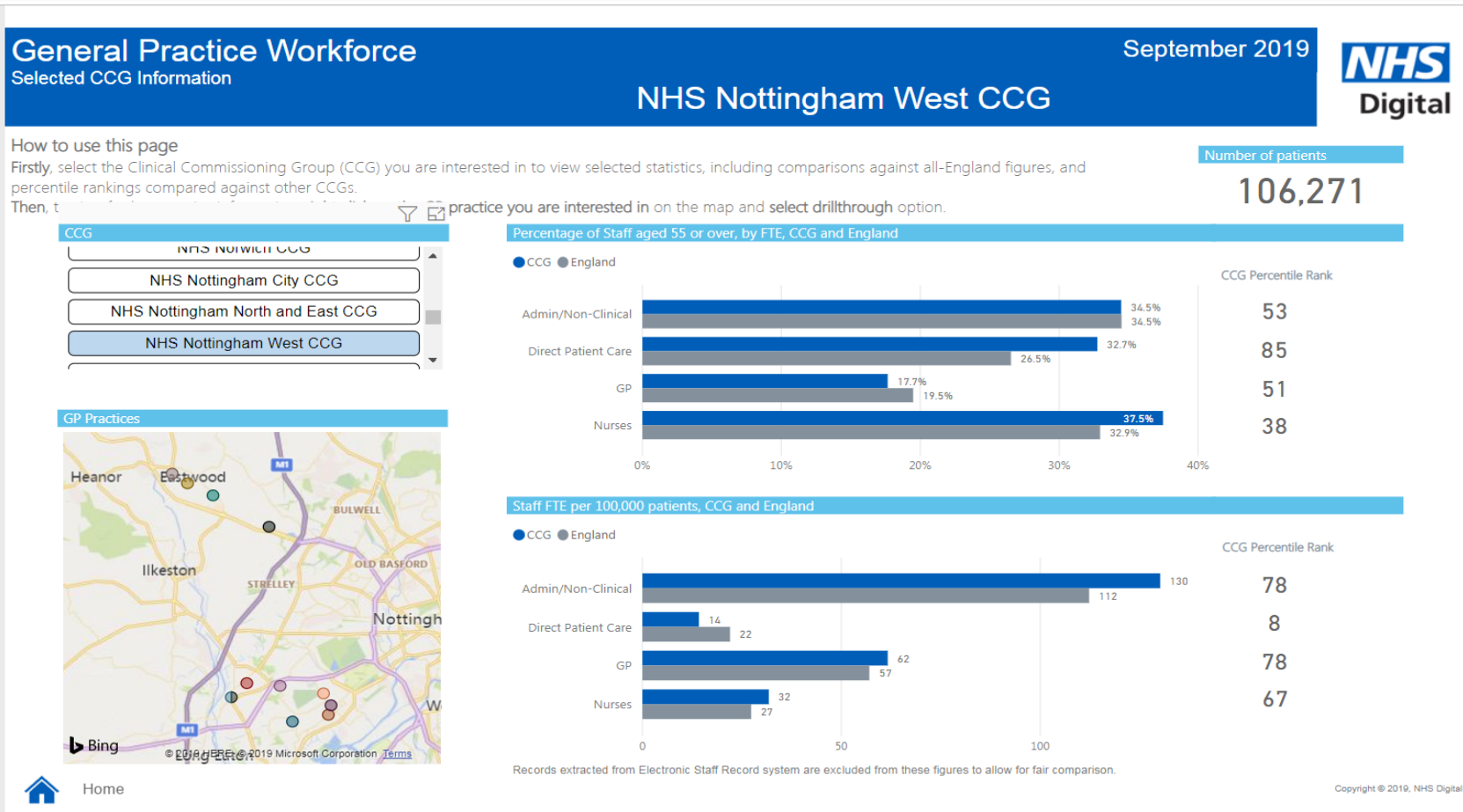


Local CCG range – % **Good**



Base: All who tried to make an appointment since being registered: National (705,310); CCG 2019 (1,788); CCG 2018 (2,086); Practice bases range from 85 to 124; CCG bases range from 1,304 to 12,671

%Good = %Very good + %Fairly good
%Poor = %Very poor + %Fairly poor


Microsoft Power BI
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General Practice Workforce
Selected CCG Information
September 2019
NHS Nottingham West CCG
NHS Digital
How to use this page
Firstly, select the Clinical Commissioning Group (CCG) you are interested in to view selected statistics, including comparisons against all-England figures, and percentile rankings compared against other CCGs.
Then, t practice you are interested in on the map and select drillthrough option.
Number of patients
106,271
CCG
NHS Norwich CCG
NHS Nottingham City CCG
NHS Nottingham North and East CCG
NHS Nottingham West CCG
GP Practices
Heanor
Eastwood
Ilkeston
BULWELL
OLD BASFORD
STRELLEY
Nottingh
M1
Bing
© 2019 HERE, © 2019 Microsoft Corporation Terms
Percentage of Staff aged 55 or over, by FTE, CCG and England
CCG England
CCG Percentile Rank
Admin/Non-Clinical 34.5% 34.5% 53
Direct Patient Care 32.7% 26.5% 85
GP 17.7% 19.5% 51
Nurses 37.5% 32.9% 38
0% 10% 20% 30% 40%
Staff FTE per 100,000 patients, CCG and England
CCG England
CCG Percentile Rank
Admin/Non-Clinical 130 112 78
Direct Patient Care 14 22 8
GP 62 57 78
Nurses 32 27 67
0 50 100
Records extracted from Electronic Staff Record system are excluded from these figures to allow for fair comparison.
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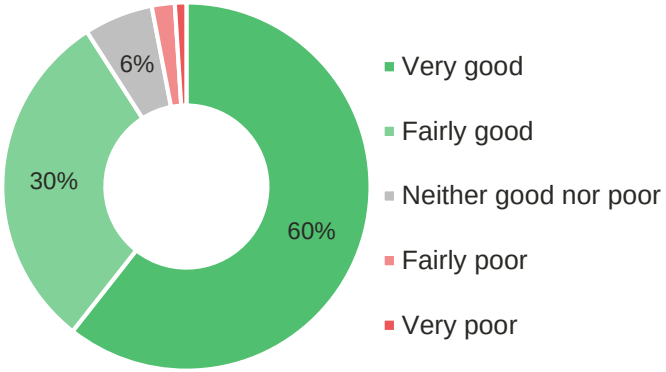
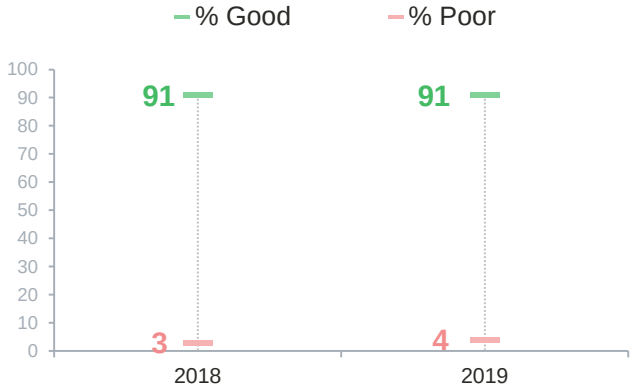
Overall experience of GP practice

Q31. Overall, how would you describe your experience of your GP practice?

CCG's results



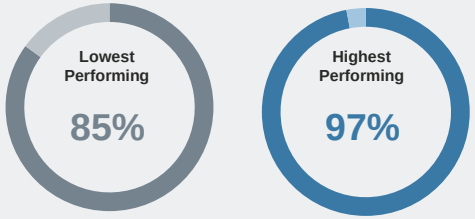
CCG's results over time



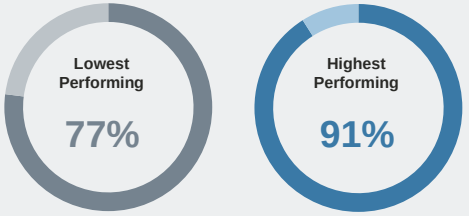
Comparison of results

	CCG	National
	91%	83%
	Good	Good
	4%	6%
	Poor	Poor

Practice range in CCG – % **Good**



Local CCG range – % **Good**



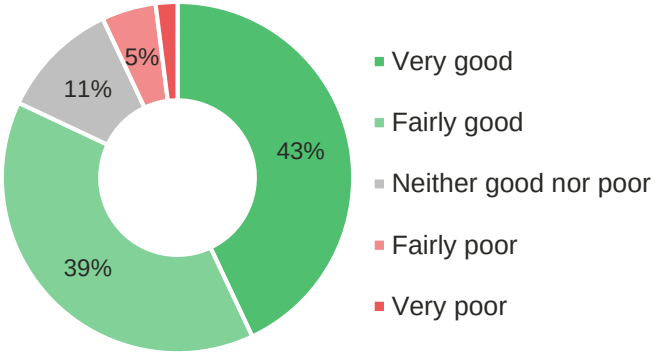
Base: All those completing a questionnaire: National (760,037); CCG 2019 (1,432); CCG 2018 (1,292); Practice bases range from 108 to 133; CCG bases range from 1,402 to 13,580

%Good = %Very good + %Fairly good
%Poor = %Very poor + %Fairly poor

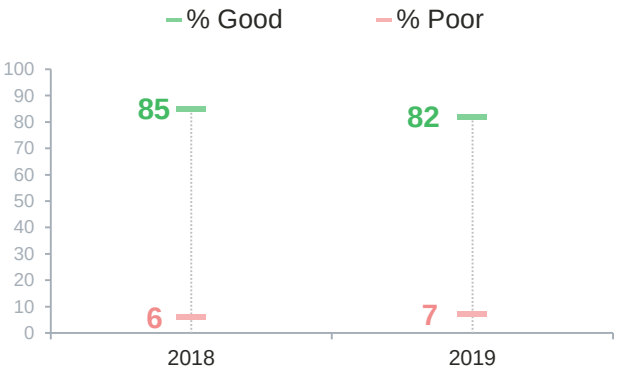
Overall experience of making an appointment

Q22. Overall, how would you describe your experience of making an appointment?

CCG's results



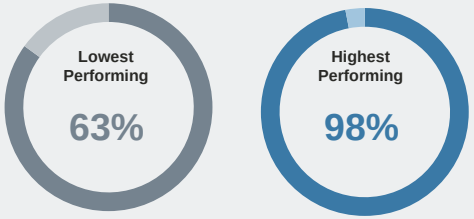
CCG's results over time



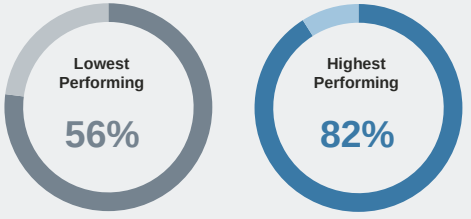
Comparison of results

	CCG	National
	82%	67%
	Good	Good
	7%	16%
	Poor	Poor

Practice range in CCG – % **Good**

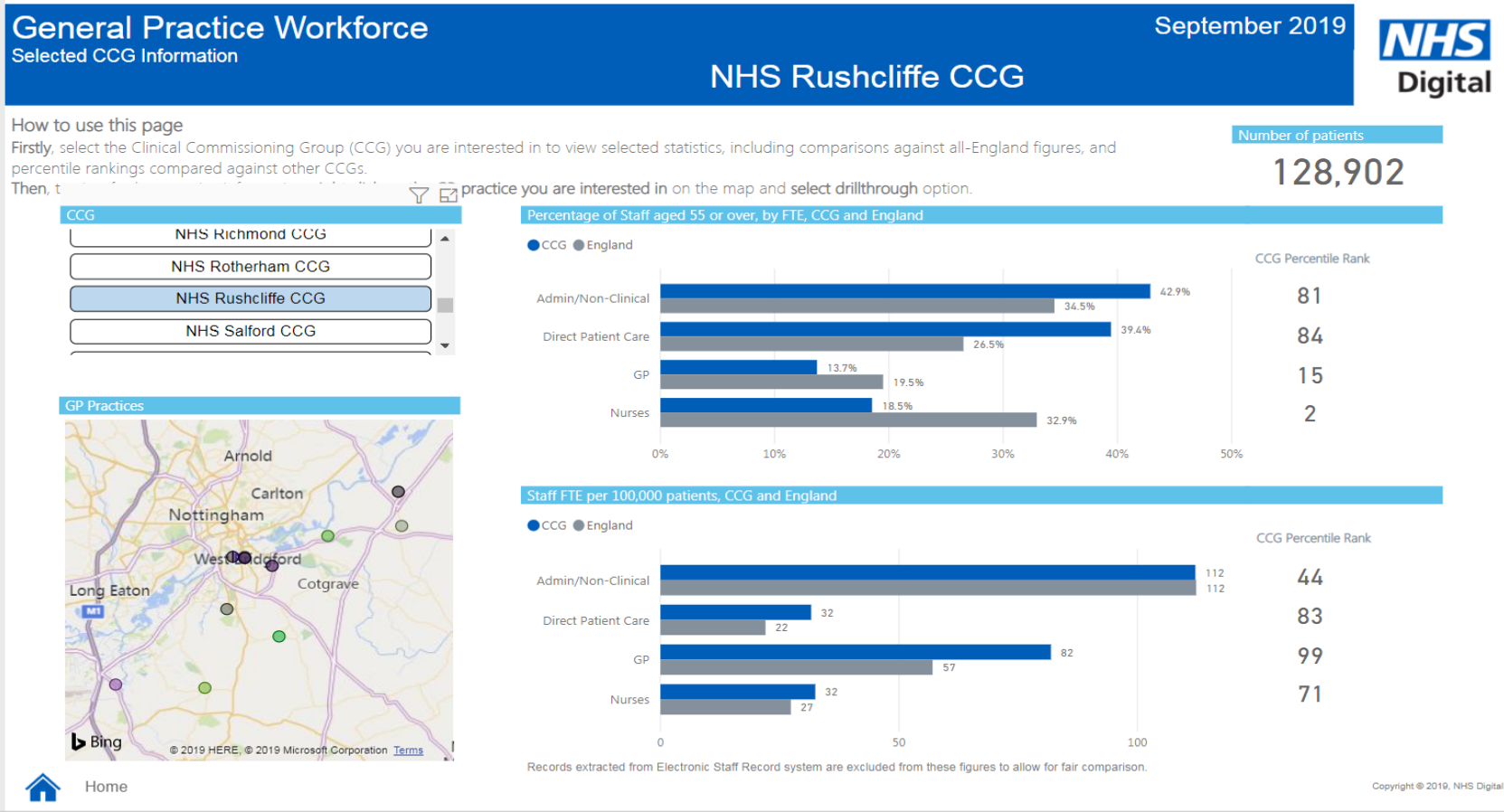


Local CCG range – % **Good**



Base: All who tried to make an appointment since being registered: National (705,310); CCG 2019 (1,331); CCG 2018 (1,188); Practice bases range from 95 to 131; CCG bases range from 1,304 to 12,671

%Good = %Very good + %Fairly good
%Poor = %Very poor + %Fairly poor


Microsoft Power BI
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General Practice Workforce
Selected CCG Information
September 2019
NHS Rushcliffe CCG
NHS Digital
How to use this page
Firstly, select the Clinical Commissioning Group (CCG) you are interested in to view selected statistics, including comparisons against all-England figures, and percentile rankings compared against other CCGs.
Then, t
practice you are interested in on the map and select drillthrough option.
Number of patients
128,902
CCG
NHS Richmond CCG
NHS Rotherham CCG
NHS Rushcliffe CCG
NHS Salford CCG
GP Practices
Arnold
Carlton
Nottingham
Long Eaton
Cotgrave
Bing
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Percentage of Staff aged 55 or over, by FTE, CCG and England
CCG England
CCG Percentile Rank
Admin/Non-Clinical 42.9% 34.5% 81
Direct Patient Care 39.4% 26.5% 84
GP 13.7% 19.5% 15
Nurses 18.5% 32.9% 2
0% 10% 20% 30% 40% 50%
Staff FTE per 100,000 patients, CCG and England
CCG England
CCG Percentile Rank
Admin/Non-Clinical 112 112 44
Direct Patient Care 32 22 83
GP 82 57 99
Nurses 32 27 71
0 50 100
Records extracted from Electronic Staff Record system are excluded from these figures to allow for fair comparison.
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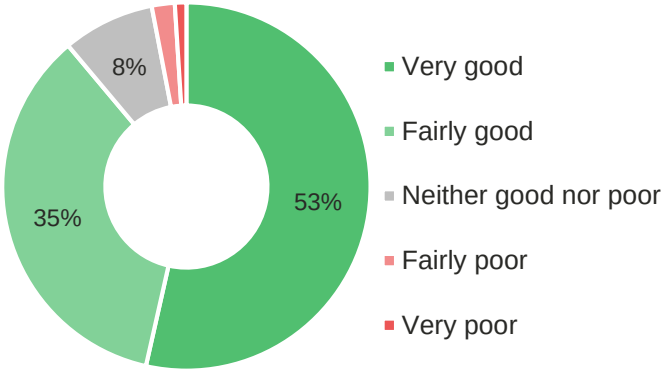
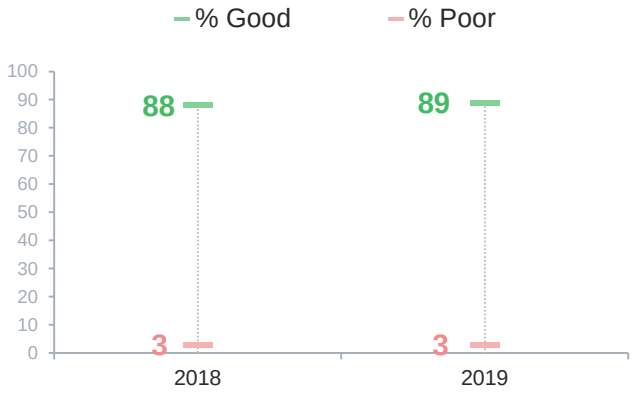
Overall experience of GP practice

Q31. Overall, how would you describe your experience of your GP practice?

CCG's results



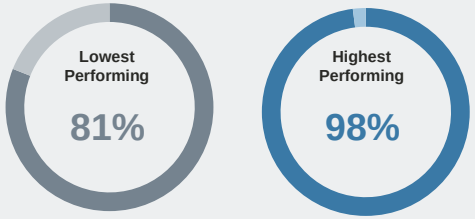
CCG's results over time



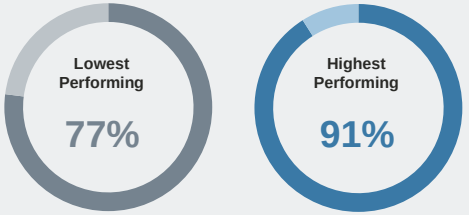
Comparison of results

	CCG	National
	89%	83%
	Good	Good
	3%	6%
	Poor	Poor

Practice range in CCG – % **Good**



Local CCG range – % **Good**



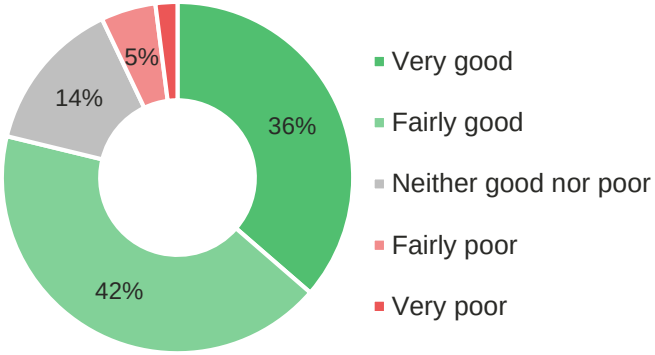
Base: All those completing a questionnaire: National (760,037); CCG 2019 (1,402); CCG 2018 (1,381); Practice bases range from 99 to 139; CCG bases range from 1,402 to 13,580

%Good = %Very good + %Fairly good
%Poor = %Very poor + %Fairly poor

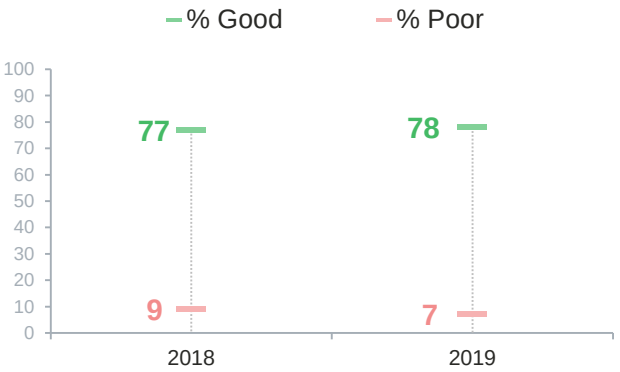
Overall experience of making an appointment

Q22. Overall, how would you describe your experience of making an appointment?

CCG's results



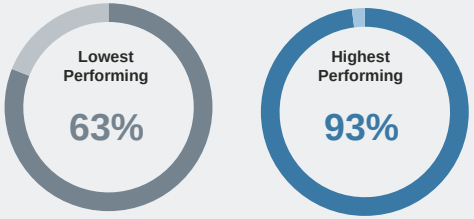
CCG's results over time



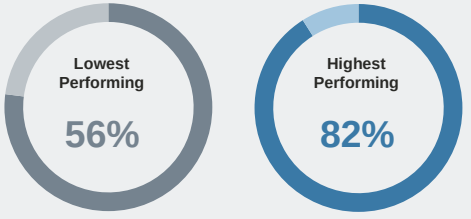
Comparison of results

CCG	National
78%	67%
Good	Good
7%	16%
Poor	Poor

Practice range in CCG – % **Good**



Local CCG range – % **Good**



Base: All who tried to make an appointment since being registered: National (705,310); CCG 2019 (1,304); CCG 2018 (1,306); Practice bases range from 96 to 125; CCG bases range from 1,304 to 12,671

%Good = %Very good + %Fairly good
%Poor = %Very poor + %Fairly poor

Staff FTE per 100,000 patients

CCG	Direct Patient Care	GPs	Nurses
Mansfield & Ashfield	20	57	30
Newark & Sherwood	21	50	29
Nottingham City	18	59	25
Nottingham North & East	18	57	29
Nottingham West	14	62	32
Rushcliffe	32	82	32
England average	**22**	**57**	**27**

Source: General Practice Interactive Dashboard - NHS Digital, September 2019

Patient survey comparison (% 'good')

CCG	Overall Experience of GP Practice	Overall Experience Making an Appointment
Mansfield & Ashfield	83%	65%
Newark & Sherwood	82%	64%
Nottingham City	83%	69%
Nottingham North & East	81%	62%
Nottingham West	91%	82%
Rushcliffe	89%	78%
England average	**83%**	**67%**

Source: GP Patient Survey 2019 - NHS England

Nottinghamshire County Council

Report to Health Scrutiny Committee

14 January 2020

Agenda Item: 6

REPORT OF THE CHAIRMAN OF HEALTH SCRUTINY COMMITTEE

NATIONAL REHABILITATION CENTRE

Purpose of the Report

1. To consider the latest information on the National Rehabilitation Centre relating to consultation and business plan.

Information

2. The National Rehabilitation Centre (NRC) was last on the agenda of the Health Scrutiny Committee on 8 November 2019, when Members heard the following:

- The Pre-consultation Business Case focussed on the clinical element of the NRC, for which funding was available, with the research and education elements to be considered at a later stage;
- A new clinical model, encompassing neurological, musculo-skeletal, orthopaedic and major trauma pathways was envisaged, while the transfer of staff and services from Linden Lodge to the new facility was a key component of the Business Case;
- a series of focus groups had considered the proposals, and over 150 survey responses from staff and patients had been received to date. Engagement outcomes had been very positive, where levels of care and access to high quality services outweighed the consideration of receiving care close to home;
- the 63-bed facility would have overnight accommodation for families, and work was underway to alleviate concerns about public transport and IT connectivity as well as parking provision;

3. Hazel Buchanan, Director of Operations, Greater Nottingham Clinical Commissioning Group will attend the Health Scrutiny Committee to provide briefing and answer questions, as necessary.

4. The draft consultation plan and the amended Equality Impact Assessment are attached as appendices to this report for information.

5. Members may wish to consider when to schedule further consideration of this issue.

RECOMMENDATION

That the Health Scrutiny Committee:

1) Consider and comment on the information provided.

2) Schedules further consideration, as necessary.

Councillor Keith Girling
Chairman of Health Scrutiny Committee

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

Background Papers

Nil

Electoral Division(s) and Member(s) Affected

All

NHS Mansfield and Ashfield Clinical Commissioning Group

NHS Newark and Sherwood Clinical Commissioning Group

NHS Nottingham City Clinical Commissioning Group

NHS Nottingham North and East Clinical Commissioning Group

NHS Nottingham West Clinical Commissioning Group

NHS Rushcliffe Clinical Commissioning Group

DRAFT Consultation Plan

National Rehabilitation Centre

December 2019

1. Introduction

The purpose of the consultation plan is to describe our approach to communications and engagement for the formal public consultation on the development of inpatient rehabilitation services at the Regional Rehabilitation Centre (RRC). The RRC is being developed on the Stanford Hall Rehabilitation Estate, which hosts the Defence Medical Rehabilitation Centre (DMRC) and is a 360-acre countryside estate providing high quality clinical rehabilitation services to defence personnel.

We have already undertaken patient, staff, clinical and wider stakeholder engagement to inform our proposals. This consultation plan sets out how we will undertake a public consultation on a set of options for developing NHS services at the RRC. These options are informed by our pre-consultation engagement activity.

This plan aims to ensure that our public consultation enables those affected by our proposals, and the wider public, to give their views and for those views to be considered in our final model for the RRC. The plan also aims to ensure that our consultation is presented in a way that enables proper, informed consideration of our proposals by clearly articulating the impact of each option under consideration.

2. Background to the consultation

In 2012 there was a breakthrough in the ability to treat serious injury in England with the establishment of 22 trauma centres across the country. These centres have ensured that those who suffer serious injury receive the full range of treatment and care within the shortest possible time. The trauma centres have been an undoubted success with 19% more people now surviving despite having sustained a serious injury.

A Regional Rehabilitation Centre (RRC) is being developed as a centre of excellence in patient care and training and research. Serving patients across the East Midlands the RRC will be created on the Stanford Hall Rehabilitation Estate, which hosts the Defence Medical Rehabilitation Centre (DMRC) and is a 360-acre countryside estate providing high quality clinical rehabilitation services to defence personnel.

Following a period of pre-consultation engagement, which has involved patient, staff, clinical and wider stakeholder engagement, we are launching a public consultation to enable our proposals to be considered prior to implementation. The proposal we are consulting on is informed by that engagement and will be clearly set out in our consultation document.

3. Aim and objectives

We will deliver a best practice consultation, accessing advice and guidance from the Consultation Institute and drawing on our local Healthwatch organisation's access to marginalised and seldom heard communities.

The Consultation Institute will undertake an advice and guidance role, providing feedback on this Consultation Plan, our Consultation Document and other materials. We have worked with the Consultation Institute in an advisory capacity throughout our pre-consultation period.

Our local Healthwatch form part of a task and finish group drawn together to oversee our patient engagement activity throughout our pre-consultation engagement and into the formal consultation period. Healthwatch will be supporting our consultation more directly through the consultation period, providing engagement support to enable us to reach some of our most marginalised and seldom heard communities. The engagement Healthwatch will carry out as part of the consultation responds directly to the Equality Impact Assessment carried out on the proposals.

Our high-level objectives are:

- Ensure that our consultation is transparent and meets statutory requirements and best practice guidelines
- Undertake significant and meaningful engagement with local stakeholders, building on the findings of our pre-consultation engagement activity
- Clearly articulate the implications, impact and benefits of our proposals
- Create a thorough audit trail and evidence base of feedback
- Collate, analyse and consider the feedback we receive to make an informed decision.

4. Principles for consultation

We will undertake our consultation in line with the legal duty on NHS organisations to involve patients and the public in the planning of service provision, the development of proposals for change and decisions about how services operate AND with The Gunning Principles, which are:

- That consultation must be at a time when proposals are still at a formative stage
- That the proposer must give enough reasons for any proposal to permit of intelligent consideration and response
- That adequate time is given for consideration and response
- That the product of consultation is conscientiously taken into account when finalising the decision.

In addition, we will adopt the following principles to ensure best practice:

- Make sure our methods and approaches are tailored to specific audiences as required
- Identify and use the best ways of reaching the largest amount of people and provide opportunities for vulnerable and seldom heard groups to participate
- Provide accessible documentation suitable for the needs of our audiences, including easy read
- Offer accessible formats including translated versions relevant to the audiences we are seeking to reach
- Undertake equality monitoring of participants to review the representativeness of participants and adapt activity as required
- Use different methods or direct activity to reach certain communities where we become aware of any underrepresentation
- Arrange our engagement activities so that they cover the local geographical areas that make up Nottingham and Nottinghamshire
- Arrange meetings in accessible venues and offer interpreters, translators and hearing loops where required
- Inform our partners of our consultation activity and share our plans.

5. Resources

We have accessed external support throughout our pre-consultation activity, working with communications and engagement agencies that specialises in consultation work and with the Consultation Institute. For our public consultation, we will allocate resources according to our strategic approach, seeking external support for:

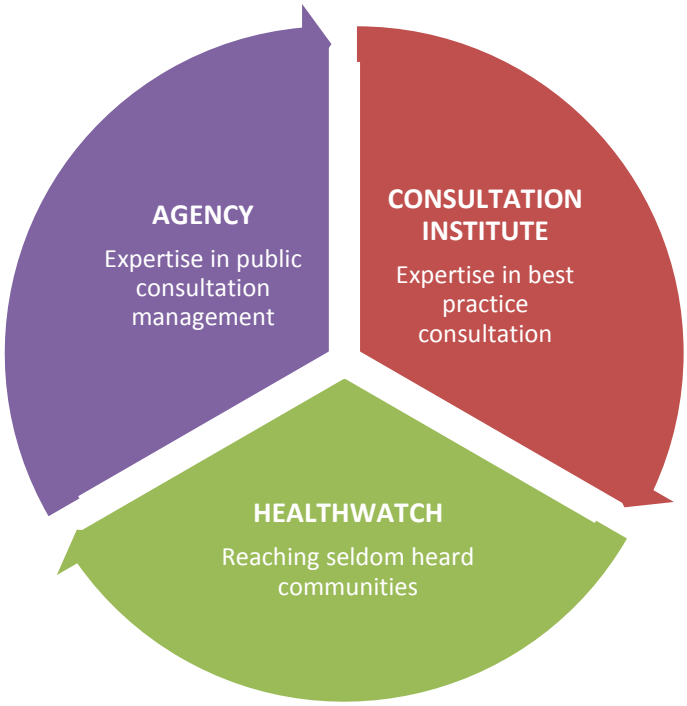
- Overall management and delivery of the consultation (agency support)
- Analysis and reporting of findings (agency support)
- Specialist advice and guidance (Consultation Institute)
- Community engagement and targeting of seldom heard communities (Healthwatch).

Our internal Communications and Engagement Team will provide coordination to support consultation activity. They will also support the production of materials and delivery of engagement activities.

6. Strategic approach

We will draw on three core areas of support to ensure our consultation meets its objectives. Each of these areas brings a specific benefit to the consultation:

Figure 1



1. Expertise on best practice - Consultation Institute
2. Ability to reach seldom heard communities across Nottingham and Nottinghamshire - Healthwatch
3. Expertise in the management of public consultation – Agency.

7. Key milestones

Table 1 below provides a summary of the key milestones that should be considered as part of the consultation.

Table 2

Milestones/Deliverables	Timescales	Lead
PHASE 1 - Pre-consultation assurance		
NHSE mock assurance panel - **COMPLETE**	31 Oct	CCG
Progress update to Governing Body - **COMPLETE**	7 Nov	CCG
Progress update to County Health Scrutiny Committee* - **COMPLETE** *City HSC cancelled for pre-election period	8 Nov	CCG
NHSE/I Informal Finance Discussion - **COMPLETE**	19 Nov	CCG
Agency appointed	16 Dec	CCG
Agency and C&E Team begin arranging public events, setting up feedback channels and developing Consultation Document and associated materials	16 Dec – 6 Feb	Agency
NHSE/I Checkpoint Meeting	6 Jan	CCG
1st draft Consultation Document and associated materials	13 Jan	Agency
Feedback and redrafting of Consultation Document and associated materials (includes feedback, advice and guidance from Healthwatch and Consultation Institute)	13 Jan – 30 Jan	Agency
All engagement activity and events booked and confirmed	24 Jan	Agency
Final draft Consultation Document	30 Jan	Agency
PCBC and Consultation Document to GB confidential session	6 Feb	CCG
OGSCR meeting	11 Feb	CCG
CFO approval	W/C 17 Feb	CCG
PCBC and final Consultation Document to GB	5 Mar	CCG
PHASE 2 - Public consultation		
Public consultation period	9 Mar – 17 Apr (6 weeks)	Agency
PHASE 3 - Consideration of consultation findings		
Analysis and reporting	17 Apr – 1 May (2 weeks)	Agency
Findings Consideration Panel 1	20 Apr	CCG
Final report on consultation findings	1 May	Agency
Findings Consideration Panel 2	4 May	CCG
Development of final proposals	1 May – 29 May	CCG
Presentation of final proposals to Governing Body	4 June	CCG

8. Summary of findings from pre-consultation activity

We have undertaken the following activity through our pre-consultation engagement period to inform our options for consultation, and this consultation plan:

Phase 1 patient engagement

We have undertaken two periods of patient involvement. For our first round of patient engagement, three focus groups were held in July with patients who are likely to be eligible for treatment at the RRC. These focus groups helped us identify patients' views of our early RRC proposals, patient-identified impacts and concerns. This engagement was specifically targeted for those who would be eligible for inpatient rehabilitation services at the RRC.

Clinical and stakeholder engagement

We presented our early, draft proposals to Health Scrutiny Committees; the regional Clinical Senate and our Governing Bodies.

Staff engagement

Staff who may be affected by the relocation of existing inpatient rehabilitation services have been engaged throughout the pre-consultation period, with fortnightly face-to-face briefings held with staff at Linden Lodge, which may be relocated as part of our proposals. While the relocation of existing services is not yet determined, we have proactively engaged with staff early on who may be affected.

Travel Impact Analysis (TIA)

A TIA was held to identify the impact on patients, carers and families' travel times to the RRC.

Equality Impact Assessment

An EIA was undertaken based on our early, draft proposals. A second EIA was undertaken following patient, clinical and stakeholder engagement and subsequent changes to the PCBC. The EIAs have informed development of our proposals and our approach to engagement and consultation. Equality and health inequalities will be a continuing consideration for our proposals.

Findings

The following were identified as key themes to explore through further engagement:

- The potential benefits for and impact on patients of each option for change
- Views on specific relocation of service proposals
- Levels of support for the options for change
- General views on the RRC, its location and its co-location with a military site
- Feedback on the referral criteria
- Impact on accessibility including travel and visitation
- Impact on and mitigations for potential isolation
- Continuity of care including interdependency with other services
- Discharge planning
- Mental health support.

The following were identified as areas to refine for our pre-consultation business case:

- Refine the financial case
- Clarify how accessibility will be addressed, particularly with regard to travel, visitation and isolation
- Clarify interdependency with wider clinical pathways
- Undertake further analysis of the impact of referral criteria on patient journeys
- Clarify impact on flow and capacity i.e. what we have now and what we are proposing to replace it with
- Provide more detail on access to the defence facilities
- Provide more detail on discharge and links to community services
- Clarify the workforce plan
- Provide more detail on mental health provision
- Describe the procurement implications.

Phase 2 patient engagement

During October we carried out a second round of patient engagement. The purpose of this was to explore the key themes from all of the above in more depth. We held six focus groups specifically targeted to gather feedback from neurological patients, major trauma, complex MSK, traumatic amputees, incomplete spinal cord injury and severely deconditioned patients. A survey was also developed for this period of engagement, which generated 150 responses.

The key themes from the findings of the engagement can be summarised as follows:

- Patients were mostly supportive of the proposals for an RRC, citing the quality of the facilities
- Concern about potential loneliness and isolation, given the remote location of the centre
- Issues with access to the centre, including transport – although parking was seen as a positive, particularly compared to parking facilities for current inpatient rehabilitation services
- Concern about being treated on a military site and uncertainty around how this would work in practice
- Concern that referrals would be cherry-picking of the patients with the best potential for positive outcomes
- Families, carers and partners ability to visit and to stay overnight
- Concern about existing rehabilitation services, including wider outpatient services.

10. Summary of consultation activity

Pre-launch

We will continue with a thorough programme of key stakeholder engagement leading up to the start of the consultation. This includes meetings scheduled with Health Scrutiny Committees; Governing Bodies and staff briefings.

We will issue a stakeholder briefing, proactive press release and social media promotion to share details of the consultation and how people can feedback. We will target local, regional and national charities who represent patients who may be affected by our proposals (e.g. brain injury charities) and encourage them to respond directly to our consultation.

A core consultation document and supporting materials will be developed for the consultation. This will include information about our proposals and a questionnaire to gather feedback. Our consultation document and supporting materials will all be available online, in printed format on request and in other languages and formats as required.

We will develop a bespoke web presence for the consultation, acting as a one-stop-shop for all consultation materials and information. This will provide a simple signposting solution for all our consultation activity.

We will secure external support for the consultation, including expert advice and guidance; overall management and delivery of outreach engagement.

Launch and consultation period

The survey within our consultation document will be available online and in hard copy on request, and for outreach engagement. We will regularly monitor responses and take action to target any groups who are underrepresented.

A series of engagement events will be held with affected patients, charities, families and carers. We will continue an on-going dialogue with patients, drawing insights from previous engagement to inform discussions throughout the consultation.

We will commission our local Healthwatch to undertake community outreach activities to reach communities who are vulnerable and seldom heard. This activity will be shaped to respond to the Equality Impact Assessment (EIA) carried out on our proposals.

The consultation launch will take place in the first week of formal consultation. We will issue briefings to stakeholders and undertake promotional activities through our digital channels and local media.

10. Channels and methods

Audience	Method
Service users affected by proposals	Targeted engagement events/focus groups; briefings through existing forums and groups; media; social media
General public	Media; social media
Staff	Face-to-face briefings; staff briefing document; Trust's internal communication channels; media; social media
Health Scrutiny Committees	Formal presentations; face-to-face briefings (Chairs); media; social media
MPs and Councillors	Stakeholder briefings; media; social media
Local, regional and national charities representing patients affected by	Direct letter inviting feedback in writing; Stakeholder briefings; media; social media

proposals	
Local VCS	Stakeholder briefings; media; social media
GPs	GP newsletters; stakeholder briefings
Media	Proactive press release; stakeholder briefing

11. Key messages

Key messages will be developed through the agency commissioned to support the consultation.

12. Consultation document and supporting materials

The following will be developed to support the consultation:

- Consultation document
- Questionnaire
- Easy-read questionnaire
- Live FAQs document
- Stakeholder briefing
- Staff briefing
- Press release
- Web page housing all consultation information
- Discussion guide for focus groups
- Feedback forms
- Letter to local, regional and national charities
- Phone-line for further information and support in completing questionnaire
- Email address for comments and feedback on proposals
- Range of social media assets promoting the consultation.

13. Capturing feedback, analysis and reporting

We are providing a range of channels, detailed in this plan, to facilitate feedback on our proposals. We will commission an independent organisation to assist in the design of the survey, collation of feedback, analysis and reporting. This will include feedback received through:

- Survey responses
- Qualitative responses through direct emails, feedback forms and telephone calls
- Transcripts of focus group discussions
- Minutes of meetings
- Letters
- Petitions
- Direct social media messages.

There will be an interim analysis report two-weeks into the consultation. The findings of this review will inform action to be undertaken over the final two weeks of the consultation.

Once the formal consultation data input has taken place and the data analysed, we will ensure that all the intelligence is captured into one report. This report will provide a view from staff, public, patients, carers and key stakeholders on the proposals.

14. Meeting our duties on equality and health inequalities

CCGs have separate legal duties on equality and on health inequalities. These duties come from:

- The Equality Act 2010
- The NHS Act 2006 as amended by the Health and Social Care Act 2012

In developing our Consultation Plan we have:

- Given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it; and
- Given regard to the need to reduce inequalities between patients in access to, and outcomes from healthcare services and to ensure services are provided in an integrated way where this might reduce health inequalities.

To inform our proposals and to help shape our pre-consultation engagement and this Consultation Plan, independent Equality Impact Assessments (EIAs) have been carried out in June 2019 and October 2019. This analysis has informed our approach to ensuring we meet our duties under the Equality Act 2010. It has also informed how we consider our duties to reduce health inequalities.

To respond directly to the recommendations in the EIAs we have commissioned Healthwatch to undertake targeted engagement with a range of groups during the consultation. This engagement will focus specifically on how a person's specific needs, identity or characteristics may affect their experience of inpatient rehabilitation services, and thus what mitigations we need to consider in our plans.

Healthwatch will be undertaking engagement with the following Inclusion Health Groups (as defined by the NHS Equality Delivery System):

- Homeless people
- People living in poverty
- People who are long-term unemployed
- People in stigmatised occupations
- People experiencing poor health outcomes

Healthwatch will also be undertaking targeted engagement to help us understand the views of those that share the following protected characteristics:

- Age
- Disability
- Race
- Religion and belief
- Sex

- Sexual orientation.

To ensure the consultation process meets the requirements to evidence that due regard has been paid to our equality duties, all the consultation activity will be equality monitored routinely to assess the representativeness of the views gathered during the formal consultation process. Where it is not possible to gather such data, such as complaints and social media we will record any information provided. Halfway through the consultation we will review responses so far and adapt our approach to seek more feedback from any groups that might not so far have fed back.

Once gathered the consultation data will be independently analysed. At a mid-point in the consultation, analysis will be reported to highlight any under-representation of patients who we believe could be potentially affected by any change in services, and if this is demonstrated further work will be undertaken to address any gaps.

Once complete the analysis will consider if any groups have responded significantly differently to the consultation or whether any trends have emerged which need to be addressed in the implementation stage. This data will also be used as part of the evidence to support the equality impact assessment process which will be carried out simultaneously.

15. Activity Plan

Detailed plan to be developed.

Imogen Blood &
Associates

Proposed National Rehabilitation Centre in East Midlands:

Equality Impact Assessment

Revised: October 2019

Introduction

Our approach

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

The assessment was conducted during June 2019 and reviewed again in October 2019 by the independent consultancy Imogen Blood & Associates (IBA).

Imogen Blood and Sarah Chalmers-Page of IBA, who have extensive expertise of Equality, Diversity and Inclusion and the NHS – reviewed the following documents in June 2019:

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

In October 2019, they reviewed the following additional documents:

- NRC Engagement Events, Interim Report, 25 October 2019, prepared by necs
- Version 15 of the Pre-Consultation Business Case (October 2019), with particular focus on the updated Care Model (S5.2) and the findings of the Travel Impact Assessment (TIA) (S5.4)

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

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

Purpose and status of Equality Impact Assessment (EIA)

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

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

The following characteristics are protected under the Act:

- age;
- disability;
- gender reassignment;
- marriage and civil partnership;

- pregnancy and maternity;
- race;
- religion or belief;
- sex;
- sexual orientation.

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

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

What is an EIA and why conduct one?

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

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

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

The proposed change

The National Rehabilitation Centre (NRC) aims:

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

The core aims of the service are:

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

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

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

The proposed NHS facility at the NRC would contain 63 beds, comprising 40 neurological rehabilitation beds, 19 complex MSK beds and four traumatic amputee rehabilitation beds. It would treat 796 patients per year. Part of the proposal is that Linden Lodge (the rehabilitation unit at Nottingham University Hospitals (NUH)) will close, since the estate is no longer at the required standard and there is no space to expand. 21 of the current 24 beds at Linden Lodge would be moved to the NRC, with 3 rehabilitation beds moving to another location with the NUH campus. 18 beds for MSK rehab may also be relocated to the NRC. It is expected that the proposal will be cost neutral due to the relocation of rehab beds, improved lengths of stay for rehab and better outcomes for patients which in turn, will reduce demand on services over the longer term.

The population of the East Midlands

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

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

Overview of key themes highlighted in the EIA

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

Opportunities to advance equality of opportunity through the NRC

Narrowing inequalities through reducing disability and improving clinical outcomes

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

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

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

Reducing geographical inequalities in care and outcomes

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

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

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

breast-feeding spaces, etc are designed in from the outset should promote equality for a range of protected characteristics amongst patients, visitors and workforce.

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

The importance of designing the building in such a way that it maximises patients' ability to be independent is integral to the proposed Care Model; *however, it is important that accessibility in relation to other protected characteristics (eg. religion, language/ learning ability, etc) is also built in from the outset.*

Possible risks for equality of opportunity through the NRC

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

Admission and assessment

The NRC admission criteria have been revised and refined to reduce the risk of groups of patients being excluded from the opportunity to rehabilitate at the NRC on account of: their geographical location within the East Midlands; the presence of absence of specific clinical conditions; and vocational and occupational benefit. This positive step is in direct response to the previous version of this EIA, which highlighted the risk that assumptions might be made about the value of or potential for 'vocational or occupational benefit' of different protected characteristic and Inclusion Health groups (eg. older people, unpaid carers, people with pre-existing disabilities, people experiencing homelessness or long-term unemployment, those who misuse drugs or work in stigmatised professions).

The revised criteria are clear about:

- how the 'potential to benefit' will be measured objectively (i.e. using the rehab complexity score),
- the justification for exclusions which might otherwise incur indirect discrimination (e.g. a dementia diagnosis, on the basis that a person's other needs cannot be met at NRC); and
- how patient choice and shared decision-making will inform the assessment about whether the patient is willing and able to commit to intensive rehabilitation, and whether this is compatible with their personal functional goals.

It will, nevertheless, be important to support and monitor the implementation of this referral system to ensure that people from different protected characteristic and Inclusion Health groups receive sufficient information and opportunity to make and express their choices and participate in shared decision making. The engagement event facilitated by nec at Linden Lodge suggests that, at present, some rehab patients do not even receive proper explanation of where they are being taken, let alone genuine opportunities for shared decision-making.

This will, therefore, require cultural, workforce and procedural change if staff assumptions (which will be subject to unconscious bias) are not to become a short-cut in practice to effective shared decision-making. Within such a scenario, patients who are older, poorer, do not speak English as a first language, or have alternative lifestyles risk being automatically excluded from the opportunity to consider whether they are willing and able to commit to the programme at the NRC.

Referring hospitals should be offered advice in how to avoid making broad assumptions about who will benefit, all staff should be trained in equalities and unconscious bias, and supervision and mentorship should include reflection about how referral decisions are made and what unconscious biases could be affecting decisions. Shared decision-making should be recorded in writing in the notes, and support tools used where available.

Risk of increased travel

Although patients will not be making repeated journeys to the new centre, because they will be inpatients, their families may be affected by changes to travel. In some cases they will benefit from the centre being closer. However, the TIA shows that the average distance between patients' homes and the NRC is more than double the average distance between their homes and their nearest facility. Since the nearest facilities (with the exception of Linden Lodge in Nottingham) are not being affected by the proposal, patients will only be affected if they choose to attend the NRC. However, the impact on visitors' travel may well influence patients' decision-making regarding whether or not to commit to a stay at NRC. Feedback from the necs engagement events reminds us just how crucial it is to many rehabilitation patients' mental and emotional wellbeing to have their family around them at such a traumatic time.

Patients and their families who live close to the existing Linden Lodge at Nottingham City Hospital (since the majority of the beds from that facility will transfer to the NRC), those living on the Lincolnshire coast (given geography) and those who are reliant on public transport will be impacted the most in terms of travel time to the NRC location. People living in poverty are over-represented in each of these three groups, so mitigation will be important in this area. Linden Lodge cannot be refurbished to provide the clinical benefits of the NRC, and so staying in the current location without substantial capital investment is not an option moving forwards. The current proposals include a plan to retain 3 rehabilitation beds within the NUH campus. Although the assessment for these will be based on clinical need, this provides an alternative option for those who would prefer to stay closer to family and could therefore act as a mitigation.

The proposed NRC site is served by a bus route which runs between Nottingham and Loughborough every 20 minutes. We understand there are plans to explore an additional bus route with the Highways Authority. Concerns were raised by some at the engagement events about safety while walking for/ waiting for buses at the proposed NRC site, given its isolated position. The NRC will have ample free car parking and those family members who drive to visit patients at Linden Lodge contrasted this favourably with the current challenges to park at Nottingham City Hospital.

The NRC will provide facilities for families to stay on site and super-fast broadband so that people can stay in touch with families online. This will benefit families who are able to take up these offers, in relation to their personal circumstances and digital inclusion. Feedback at the engagement events highlighted the importance of the consistent provision of accurate information to families about available facilities. For example, some had not found out that they could save money parking at Linden Lodge by buying a monthly pass.

The NHS should continue to negotiate with public transport providers and the Highways Authority to improve bus services to the NRC. The bus route will need to be adjusted so that buses stop on the site at a sheltered, well-lit stop with seating. The proposed facilities for families at the NRC are positive, but it will be important to ensure that information about them is provided consistently both at the point where patients are deciding whether or not to pursue a referral and at the point of admission to NRC. This information needs to be accessible and to address potential concerns of different protected characteristic groups (e.g. cost, accessibility, privacy and safety, access to food storage/ preparation facilities).

Equality Considerations for Protected Characteristics and Health Inclusion Groups

Gender

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

Historically, women may not have had their needs understood or met in areas such as pain management (Samulowitz 2018; Wiklund 2016) and as such may have been under treated. *The National Centre could use its expertise and large patient cohort to develop protocols that would prevent and respond positively to this, work with referring units to ensure that unconscious biases are addressed and gathering feedback from women patients to better understand and improve their experiences of rehabilitation*.

Women are more likely than men to be working part time, or to be working as unpaid carers or providing unpaid childcare. This, combined with the male majority case mix for the centre, means that women are more likely to be visiting the centre and may be at greater risk of becoming carers, depending on the outcomes of rehabilitation. These issues are picked up in more detail under the section on carers below.

Sexual Orientation, Gender Re-assignment and Gender Identity

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

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

Age

It is positive that age is not an explicit criterion for referral to the centre, and older adults should not be discriminated against if they could benefit from rehabilitation medically and if it fits with their personal functional goals. Older patients are more likely than younger patients to be deemed unsuitable for NRC referral based on either a dementia diagnosis or other clinical complications impacting on their capability to undertake rehabilitation. This is medically justifiable; however, it is important that these decisions are made objectively, communicated to patients and their families where possible and recorded. There is a risk of referring hospitals making assumptions about older people's likely benefit based on their age alone and influenced by stereotypical views of older people as already weaker, less able to stick with an intensive programme or lacking in vocation or occupation which might motivate them to do so.

The Centre should work with referring hospitals to make sure they understand that some older adults may benefit from rehabilitation and will be motivated enough and physically fit enough to benefit, and that these decisions should be made on a case by case basis, informed by objective and specialist medical assessment.

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

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

Race/ Ethnicity and migrants

People from Black, Asian and Minority Ethnic (BAME) backgrounds are more likely to derive their household income from work (Cabinet Office 2017), more likely to be in poor quality and overcrowded housing that would be difficult to adapt to the needs of a disabled resident (Cabinet Office 2017), and more likely to experience a severe occupational injury (Mekkodathil 2016) than people from white ethnic backgrounds. If the degree and impact of impairments and the need for adaptations can be reduced, there may be positive impacts from the proposals for these groups.

However, one in five people from Pakistani and Bangladeshi backgrounds do not speak English well or at all (Cabinet Office 2017), and this is more likely for women and older adults. This could make it harder to discuss referral and the likelihood of benefitting from rehabilitation with patients in this group, and they may struggle to advocate for themselves if their English is not fluent.

Referring hospitals should ensure that they use appropriate translation services when discussing the option of a referral to the NRC.

The BAME population is not distributed evenly across the East Midlands, so the proposal's impacts (both positive and negative) on geographical inequalities can also have an impact on racial inequality. Nottingham City has a large BAME population which accounts for just over one third (35 per cent) of the total population (Sheffield Hallam/ Nottingham City CCG 2015) and those living in the city will be particularly impacted by the proposals, given that the NRC will replace Linden Lodge as the primary specialist rehabilitation provision for the city.

Accessible information regarding transport and overnight stay facilities will – as outlined above – be important to mitigate potential barriers to BAME families taking up the offer of a place at NRC.

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

Religion and Belief

People who have experienced a life-changing injury and who are receiving intensive rehabilitation may need spiritual support, as well as mental health support, especially if they already have a faith that is important to them. It is positive that the Care Model places a high value on the role of mental health, psychological and social support during rehabilitation.

The diverse spiritual needs of patients should be taken into account, and links should be built with local faith communities to help provide appropriate spiritual support to those patients that would benefit from this.

Patients and families (especially those who are using – or considering using – the overnight stay facilities) should be given clear information about how their religious needs will be met within the NRC facility. This should include access to prayer facilities, chaplaincy, dietary needs, washing facilities, and consideration given to modesty and dignity.

Physical disability and sensory impairment

The centre will reduce impairments and their impact through improving clinical outcomes for people with rehabilitation needs, and by reducing variation in treatment. Extending rehabilitation from neurological patients to people who have had traumatic amputations,

major trauma or complex orthopaedic surgery will reduce variation in outcomes and provide more people with the chance to avoid long-term disability.

Care must be taken that people with pre-existing disabilities or sensory impairments, who have been living previously independent lives and who could still benefit from intensive rehabilitation, are not excluded from rehabilitation based on inaccurate assumptions about how much they could benefit from it.

Referring hospitals should be offered advice on how to assess whether people with pre-existing disabilities or sensory impairment would benefit from intensive rehabilitation, and where there might and should not be clinical complications. Awareness raising and training will be important in order to reduce unconscious bias about the likely quality of life gains and independence of those with pre-existing disabilities.

Learning Disability

Some people with learning disabilities will lack the capacity to work towards functional goals within the intensive programme proposed at the NRC, and some will not have sufficient capacity to make the decision to commit to this programme. However, there will be others who will be able to do this, provided they are offered appropriate support in relation to communication and self-advocacy both during shared decision making and throughout the programme. There is a risk that health professionals will either not notice invisible disabilities and therefore not make reasonable adjustments to reduce the barriers experienced or will make assumptions about people's goals and their capacity to achieve them.

The provision of single rooms and family rooms for visitors is likely to be of particular benefit to people with autism and other learning disabilities, who can find unfamiliar and busy environments particularly stressful.

Awareness raising in relation to autism, dyslexia and other learning disabilities is recommended for the NRC workforce and those in referring hospitals in order to promote inclusion during referral and treatment.

Mental Health

Mental health support was voted by those attending the necs engagement events to be their highest priority in relation to rehabilitation. It is positive that this is reflected in the proposed Care Model for the NRC, with provision of psychological and support work support being integral to the programme. This should help support patients to adapt to life changing injuries and decrease the risk of long term psychological harm preventing people returning to work, family, leisure and social life.

Pregnancy, Maternity and Parenthood

Pregnancy is a protected characteristic. Parenthood is not, but is another potential source of inequality. The proposed service provides some rooms for family to stay on site. This may be particularly beneficial to parents, who might otherwise not see their families as

often during their stay, and may help to maintain family bonds. This in turn may reduce familial anxiety, and benefit the children of people who require rehabilitation. Psychological and social work support is a key part of the NRC's Care Model and this should help families cope with the aftermath of trauma and the rehabilitation programme and to prepare for discharge.

Carers

The NRC service should benefit carers through reducing the long-term dependency of patients.

The main risk for carers is in the short term and relates to additional travel time to come and visit loved ones. This is likely to impact particularly on those living in poverty, those who do not have access to a car and/or those living in rural areas.

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

Socio-economic deprivation

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

More socioeconomically deprived families may be disproportionately disadvantaged if transport costs are higher to visit the NRC than to remain in local pathways, and this may influence them to seek care closer to home even if the outcomes may not be as good. As mentioned above, this can be mitigated with provision of free car parking, negotiating bus routes that include the NRC, and with facilities for families to stay on site where this is needed.

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

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

These groups are at risk of unconscious bias during the assessment process, and there is a risk that NRC is not offered since assumptions are made that the individual will not be sufficiently motivated or does not have enough rehabilitation potential to warrant a

referral. Whilst patients in this group may decide that they do not want to undergo an intensive rehabilitation programme, especially at a distance from their current networks, it is important that these options are presented and discussed fairly and honestly. For some, the opportunity to attend NRC may be a turning point.

Conclusions and recommended next steps

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

Recommendations

1) Support referring hospitals with detailed guidance on the referral criteria and training to address unconscious bias so that, on a case by case basis, older adults, people with existing disabilities (physical, sensory and learning) but a high level of motivation and ability to benefit and others who may be vulnerable to being discriminated against (e.g. people who are addicted to drugs) are considered for rehabilitation in a fair and consistent manner. Record and monitor shared decision-making practice and outcomes.

2) Ensure that universal accessibility principles, including consideration of the needs of different protected characteristics groups are built into the design of the building, workforce training, and processes at NRC from the outset.

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

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

5) Provide clear and accessible information for patients' families regarding how to get to the NRC and other facilities, such as the family rooms and broadband, both at referral stages and on admission.

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

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

8) Take steps to address the spiritual and religious needs of patients both in the design of the facility and its services and by forming links with local faith communities.

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Nottinghamshire County Council

Report to Health Scrutiny Committee

14 January 2020

Agenda Item: 7

REPORT OF THE CHAIRMAN OF HEALTH SCRUTINY COMMITTEE

WORK PROGRAMME

Purpose of the Report

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

Information

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

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

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

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

RECOMMENDATION

That the Health Scrutiny Committee:

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

2) Suggests and considers possible subjects for review.

Councillor Keith Girling
Chairman of Health Scrutiny Committee

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

Background Papers

Nil

Electoral Division(s) and Member(s) Affected

All

HEALTH SCRUTINY COMMITTEE DRAFT WORK PROGRAMME 2019/20

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

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

8 November 2019				
National Rehabilitation Centre – Pre-consultation Business Case	Briefing/presentation on the NRC Pre-Consultation Business Case	Scrutiny	Martin Gately	TBC – Senior CCG representatives.
3 December 2019				
NUH Improvement Plan Update	Further consideration of improvement plan following CQC inspection.	Scrutiny	Martin Gately	Dr Keith Girling, Medical Director NUH (TBC)
Social Prescribing	An initial briefing on the benefits of social prescribing.	Scrutiny	Martin Gately	Amy Callaway, Programme Manager, Integrated Care System
14 January 2020				
Nottingham Treatment Centre	Update on latest performance from NUH	Scrutiny	Martin Gately	NUH/Nottinghamshire Commissioners
Access to GP Appointments	Initial briefing on an issue of concern	Scrutiny	Martin Gately	Nottinghamshire Commissioners (TBC)
National Rehabilitation Centre	Consideration of Business Plan and consultation	Scrutiny	Martin Gately	TBC
25 February 2020				
Nottinghamshire Healthcare Trust CQC Inspection – Improvement Plan	The latest progress by the Trust against its improvement plan.	Scrutiny	Martin Gately	Dr Brewin, Chief Exec, Nottinghamshire Healthcare Trust
Dementia in Hospital Update	Update on the latest position regarding patients with dementia at NUH.	Scrutiny	Martin Gately	TBC
Nottinghamshire Healthcare Trust – Substantial Variation of Service	Initial briefing on a substantial variation of service within the Healthcare Trust	Scrutiny	Martin Gately	Dr Brewin, Chief Exec, Nottinghamshire Healthcare Trust

31 March 2020				
Clinical Commissioning Group Merger (TBC)				
National Rehabilitation Centre – Pre-consultation Business Case (TBC)				
19 May 2020				
NUH Winter Plans (TBC)	Annual consideration of winter planning issues.	Scrutiny	Martin Gately	Caroline Nolan/Rachel Eddie, NUH (TBC)
Bassetlaw Hospital Update (TBC)				
To be scheduled				
Public Health Issues				
Muscular Dystrophy Update				
Integrated Care System – Ten Year Plan (TBC)	An initial briefing on the ICS – ten year plan.	Scrutiny	Martin Gately	TBC
Parity of GP Service Coverage across Nottinghamshire				
The administration of GP referrals				
Access to School Nurses				
Wheelchair repair				
Allergies in Children				
Operation of the MASH				
Mental Health issues (e.g. suicide) and GP referrals.				
Muscular Dystrophy	Update following the previous	Scrutiny	Martin	Dr Saam

Pathway Update	consideration of the pathway in May.		Gately	Sedehizadeh, NUH (TBC)
Bassetlaw Hospital Update				
Frail Elderly at Home				
Patient Transport Service Performance Update (To be scheduled for December 2020)				
NHS Property Services (July 2020)				
NHS Long Term Plan (July 2020)				

Potential Topics for Scrutiny:

Recruitment (especially GPs)

Allergies and epi-pens

Diabetes services

Air Quality (NCC Public Health Dept)

Overview Sessions (To be confirmed)

Nottingham University Hospitals (NUH) – autumn 2019

East Midlands Ambulance Service (EMAS) – autumn 2019

VISITS

Urgent Care Pathway (QMC visit) – autumn 2019

Medium secure mental hospitals – TBC