



NOTTINGHAM CITY COUNCIL
HEALTH SCRUTINY COMMITTEE

Date: Thursday 12 September 2019

Time: 10.00 am

Place: Ground Floor Committee Room - Loxley House, Station Street, Nottingham,
NG2 3NG

Councillors are requested to attend the above meeting to transact the following business

Corporate Director for Strategy and Resources

Senior Governance Officer: Laura Wilson **Direct Dial:** 0115 876 4301

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|----------|---|-----------|
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IF YOU NEED ANY ADVICE ON DECLARING AN INTEREST IN ANY ITEM ON THE AGENDA, PLEASE CONTACT THE GOVERNANCE OFFICER SHOWN ABOVE, IF POSSIBLE BEFORE THE DAY OF THE MEETING

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NOTTINGHAM CITY COUNCIL

HEALTH SCRUTINY COMMITTEE

MINUTES of the meeting held in the Ground Floor Committee Room - Loxley House, Station Street, Nottingham, NG2 3NG on 11 July 2019 from 10:01am to 12:28pm

Membership

Present

Councillor Georgia Power (Chair)
Councillor Cate Woodward (Vice Chair)
Councillor Samuel Gardiner
Councillor Phil Jackson
Councillor Maria Joannou
Councillor Kirsty Jones
Councillor Dave Liversidge
Councillor Lauren O'Grady
Councillor Anne Peach

Absent

Councillor Merlita Bryan
Councillor Angela Kandola
Councillor AJ Matsiko

Colleagues, partners and others in attendance:

Andrew Chatten	- Director of Estates and Facilities, Nottingham University Hospitals Trust
Esther Gaskill	- Head of Quality for Primary Care, Nottingham City Clinical Commissioning Group
Duncan Hanslow	- Programme Director, Nottingham and Nottinghamshire Integrated Care System
Adrian Mann	- Governance Officer
Sarah Mayfield	- Screening and Immunisation Manager, NHS England
Kate McCandlish	- Assistant Locality Director, Nottingham City Clinical Commissioning Group
Dr Hugh Porter	- Chair, Nottingham City Clinical Commissioning Group
Angela Potter	- Programme Director, Nottingham and Nottinghamshire Integrated Care System
Professor Mandie Sunderland	- Chief Nurse, Nottingham University Hospitals Trust
Zena West	- Senior Governance Officer
Kerrie Woods	- Head of Primary Care Contracting, NHS England

9 APOLOGIES FOR ABSENCE

Councillor Merlita Bryan	- Council business
Councillor Angela Kandola	- unspecified
Councillor AJ Matsiko	- unwell

10 DECLARATIONS OF INTERESTS

None.

11 MINUTES

The minutes of the meeting held on 13 June 2019 were confirmed as a true record and signed by the Chair.

12 GP PROVISION IN NOTTINGHAM

Esther Gaskill, Head of Quality for Primary Care at Nottingham City Clinical Commissioning Group (CCG); Kate McCandlish, Assistant Locality Director at Nottingham City CCG; Dr Hugh Porter, Chair of Nottingham City CCG; and Kerrie Woods, Head of Primary Care Contracting at NHS England, gave a verbal report on the Care Quality Commission's (CQC) recent inspection and actions relating to the Beechdale Medical Group. The following points were discussed:

- (a) in January, the Government published the NHS Long Term Plan, which includes a new contract for GPs and establishes the Primary Care Networks. These networks group GP practices together to cover a geographical catchment containing 30-50,000 people to encourage collaborative and integrated working between GPs, and to develop links between GPs and other care services over time. There are eight Networks covering the City. These seek to align with social care and community provision areas and match ward boundaries roughly, though not always exactly. There is a rising demand for GP services and, as practices in urban environments tend to be smaller and find it more difficult to recruit staff, investment is needed to create effective economies of scale;
- (b) the Beechdale Medical Group contains four surgeries with their own individual contracts, but all four contracts are with the same provider. All of the surgeries were inspected by the CQC in March and three were rated 'good', with the Strelley surgery rated as 'requires improvement'. The CQC carried out a follow-up inspection of Strelley in early May and, following a further visit on 20 May, it identified serious concerns relating to the management of the surgery's triage process (which was not felt to provide robust enough assurances for patient safety), and to the GPs' available capacity and oversight procedures;
- (c) within two days, the CQC submitted a letter identifying its concerns and requiring that corrective measures were taken. The practice agreed an action plan and implementation timetable with the CQC. However, when the CQC returned to the surgery on 4 June, it felt that the action plan had not been implemented within the agreed timetable, so patients were still at risk. Following further discussions with the surgery on 7 June, the CQC was not satisfied that the practice was able to address its serious safety concerns adequately, so it closed the surgery with immediate effect;
- (d) the 4,600 patients on the surgery's register were contacted by text message and letter, and information was distributed by the other practices in the Group, local hospitals and through the media, so 2,900 of the patients are now registered at the next surgery most accessible and convenient for them, even if this is outside the Group. Emergency care, prescribing and district nursing provision is in place with other care providers and pharmacies, and the Nottingham City GPs' Alliance is able to access the surgery's clinical records system;

- (e) due to the CQC's safety concerns, the triage system used at Strelley was discontinued at all practices within the Group. The CQC then re-inspected the other three practices and, on 28 June, raised serious patient safety concerns at the Boulevard surgery relating to its treatment facilities, clinical cover, leadership and infection control. Following discussions, the CQC did not close the surgery, but treatment delivery was stopped and transferred elsewhere as a temporary measure;
- (f) the final CQC reports will be published shortly. Independent clinical reviews will be undertaken at the Strelley and Boulevard surgeries, with an assurance matrix developed to address the significant safety issues identified by the CQC. Consideration is being given to the merger of Boulevard with another practice. Work is being carried out with the Beechdale Medical Group and the local Medical Council to explore the issues and identify how service provision can be improved and made sustainable. The closure of any surgery is very disruptive to patients and does involve some risk to their safety, so steps are being taken to address the acute issues and then establish effective provision in the area for the future, in consultation with citizens, following the publication of the CQC reports.

RESOLVED to:

- (1) note the information provided;**
- (2) request further information on the distribution of surgeries and Primary Care Networks within Nottingham (maps shared with the first publication of the minutes).**

13 CLEANLINESS AT NUH TRUST HOSPITALS

Andrew Chatten, Director of Estates and Facilities at Nottingham University Hospitals Trust (NUH), and Professor Mandie Sunderland, Chief Nurse at NUH, presented a report on the current progress made by the Trust in improving standards of cleanliness at its hospital sites. The following points were discussed:

- (a) the cleaning of NUH hospitals was brought in-house during 2017, with 420 full-time equivalent roles in place (up from 383 in 2017) and an annual budget of £250-300,000, which is intended to ensure that all cleaning staff have the right training and resources. Cleaning staff are salaried on the NHS wage structure and receive at least the living wage (as suggested by the Living Wage Foundation). Engagement has been carried out with front-line cleaning staff so that they form a consistent part of the ward teams. A vision for excellence is in place and the same cleaning methodology, with an associated audit process, is used across the Trust. Currently, it is intended to use in-house cleaning for the long-term;
- (b) a two-part improvement plan is in place. For Part 1, further improvements will be carried out during 2019/20 within the existing budget, including a focus on training and the deployment of resources in high-risk facilities, with clear management responsibilities for defined areas. Part 2 will be implemented from 2020/21 and will focus on achieving compliance with the upcoming 2019 national standards and moving to a position where the total cleaning hours meet the needs of the hospital fully;

- (c) following the changes since 2017, there have been fewer patient complaints in relation to hospital cleanliness, NHS Improvement (Regulatory) has given the Trust hospitals a 'green' rating, and the Patient Led Assessment of the Care Environment scores have improved. Patients, nurses and cleaners are also involved in the Cleaning Board;
- (d) Clostridium difficile (C. diff) is an infection that can increase if a hospital environment is not kept clean and, following the improvements since 2017, infection rates are at their lowest on record, with 68 cases in 2018/19 (against a maximum target of 90). Only two cases of methicillin-resistant Staphylococcus aureus (MRSA) have been recorded in over 1 million patients, and only one of the patients acquired the infection while in the hospital. However, the rates of an infection known as Carbapenem-resistant Enterobacteriaceae (CRE) are increasing across the UK. CRE can often be picked up by people who have been in hospital in Asia or Eastern Europe and there is only one antibiotic currently available to combat the infection, so a screening programme has been put in place. There is a continued strong focus on environmental cleaning to mitigate the spread of infection and a programme of surveillance and audit is in place;
- (e) the Ward Sisters have a responsibility for ensuring general cleanliness and are coordinating well with cleaning staff. A cleanliness manual has been produced to ensure that all staff are aware of their responsibilities. Information is communicated to visitors in a number of ways, including through the media and in-hospital posters, to raise awareness for the prevention of bringing infections into the hospital – and staff should be prepared to challenge visitors who are visibly unwell;
- (f) the Care Quality Commission's 2019 inspection report did identify a need for a greater consistency of cleanliness levels in some areas, which can be a challenge due to the size of NUH's holdings and the age of some of the buildings. Scores are still lower than expected against the national standards, but there has been sustained improvement and every effort will be made to attain the new 2019 standards. Continual monitoring is in place through monthly Integrated Performance Reports to the NUH Board.

RESOLVED to note the positive progress made by the Nottingham University Hospitals Trust in improving standards of cleanliness at its hospital sites.

14 FLU IMMUNISATION PROGRAMME

Sarah Mayfield, Screening and Immunisation Manager at NHS England, presented a report on the performance of the 2018/19 seasonal flu immunisation programme and the effectiveness of the work undertaken to improve uptake rates. The following points were discussed:

- (a) immunisation vaccination is one of the most effective interventions to mitigate harm from flu and reduce the pressures on health and social care. Increasing uptake in clinical risk groups is important because of the greater risk of flu leading to serious illness or death, while flu during pregnancy may be associated with perinatal mortality, prematurity, smaller neonatal size, lower birth weight and an

increased risk of complications for the mother. Nationally, approximately 600 people die from flu per year, including 16 children, and it is a contributory factor to 50,000 other winter deaths. Vaccination of health and social care workers is vital to protect them and reduce the risk of them spreading flu to their patients, service users, colleagues and family members;

- (b) for 2018/19, the groups eligible for a free flu vaccination were all children aged 2-9 (who had received the live attenuated influenza vaccine (LAIV)), all primary school-aged children in former primary school pilot areas for LAIV, those aged six months to under 65 years in clinical risk groups, pregnant women, those aged 65 years and over, those in long-stay residential care homes, and carers;
- (c) higher levels of flu activity were observed in 2018/19, particularly during November, December and January. The main impact of flu was seen in older adults (with a number admitted to hospital as a result), and a consistent pattern of outbreaks in care homes occurred. Vaccinations are provided through GPs, schools and pharmacies, and the impact on GPs was high during the months of November to January. Unfortunately, as vaccines are only provided by GPs to registered patients, they are not easily accessible to the homeless, so a new service is being developed to reach these vulnerable people;
- (d) the flu vaccine uptake in 2018-19 in England was slightly lower than the 2017-18 season, with over 65 year-olds down from 72.9% to 72%, under 65 year-olds in a pre-defined clinical risk group down from 49.7% to 48% and pregnant women down from 47% to 45.2%. This decline may have been contributed to by a delay in some of the vaccines being distributed. However, uptake in the Childhood Flu Programmes increased slightly. In Nottingham, vaccination uptake is continuing to increase in level towards that of the national average and the targets required to achieve 'herd immunity';
- (e) monthly flu planning meetings are underway, with local flu assurance plans in place and training packages for health care professionals available in the run-up to flu season 2019/20. Flu vaccine uptake data will be reviewed on a monthly basis at GP level and a pilot is underway to increase child uptake at practices. The School Age Immunisation Programme will continue to vaccinate in schools for reception to year 4, while information letters have been sent to parents of 2-3 year-olds. Flu messages will be promoted nationally by Public Health England and NHS England, and will be filtered to local communications teams. A nationally commissioned pharmacy flu service is in place and services continue to be commissioned at the Nottingham University Hospitals NHS Trust (NUH) for pregnant women and 'at risk' patients. NUH, Nottinghamshire Healthcare NHS Foundation Trust and Nottingham City Council are responsible for the vaccination of front-line staff;
- (f) overall, the 2018/19 flu programme was successful, with more vaccines being delivered nationally and locally than in previous years. However, Nottingham City saw a decrease in flu vaccination uptake in most cohorts compared to last year, so NHS England and Nottingham City Council are working together and in conjunction with other stakeholders to bring about further improvement, including increasing the take-up amongst children.

RESOLVED to note the positive results of the 2018/19 flu vaccination programme and the work being carried out to improve uptake for 2019/20.

15 ICS CLINICAL SERVICES STRATEGY

Duncan Hanslow and Angela Potter, Programme Directors at Nottingham and Nottinghamshire Integrated Care System (ICS), presented a report on the proposed Clinical Services Strategy. The following points were discussed:

- (a) nationally, there are 14 ICSs, which have collective responsibility for managing care resources, delivering NHS standards and improving the health of the population. Each ICS has been set up to make the best of existing resources to achieve good care outcomes sustainably and consistently, achieve the best outcomes, implement coherent decision-making and processes to plan and deliver care across the system, focus on the needs of individuals and population groups, and establish objectives and incentives for better collective decisions based around population needs;
- (b) the developing Clinical Services Strategy recognises that the care system needs to change in its totality, rather than just in its individual elements, to achieve sustainability and viability at the right scale, sizing and estate, in the context of an ever-increasing demand on services. Long-term planning is required over a 5-10 year timeframe to justify and sustain capital investment and introduce a partnership strategy which integrates with other changes across the whole system;
- (c) the Strategy intends to define a place-based model of care; establish the levels of standardisation or autonomy at different levels of the system; provide a long-term and sustainable healthcare model for Nottingham and Nottinghamshire; embed personalised care, prevention and early intervention; and provide a strategy in sufficient quality to enable a Pre-Consultation Business Case for any service change that emerges;
- (d) the Strategy is underpinned by extensive engagement, including consideration of system engagement over the last 2-3 years, conversations and workshops with local patient groups (including engagement between patients and clinicians), 'confirm and challenge' sessions with staff on the high-level clinical model and future needs of the workforce, co-production of end-to-end care pathways in service reviews with systematic involvement of patients at every stage, involvement of the voluntary and community sector in service reviews, and engagement with system partners and stakeholders;
- (e) the clinical model will be based on six core principles and will cover healthy living, living well, episodic crisis care, managing illness and end of life. Preventing ill health is a major priority and the commissioning processes need to ensure that the right resources are available to achieve effective results in this area. Some existing service locations are important care hubs, so future planning (through the service review process and engaging with patients and the public) will be carried out in the context of these fixed points, which include Kingsmill Hospital, Queen's Medical Centre Nottingham, Newark Hospital, Rampton Hospital and Wells Road Centre Nottingham. Measures are in place to secure the best value from existing

facilities under Local Improvement Finance Trust and Private Finance Initiative agreements for the remainder of the contract periods;

- (f) there is no target to reduce the number of existing services or care professionals, as demand is projected to outstrip the available budget and a sustainable financial structure is needed. However, rationalisation work will be carried out to ensure that patients are not required to provide the same information each time they access a different service in the overall care system, and further links will be put in place between care professionals to improve communication regarding patients. The right balance must be struck between multi-disciplinary and specialist teams for addressing patients with complex care needs, so that the right care can be delivered in the right place. Budget concerns can sometimes drive service decision-making on care, so it is a key priority to see that the available resources are deployed effectively to an ethos of personalising care;
- (g) a minimum of twenty service reviews have been identified in the context of the clinical model developed within this draft Strategy, and the priority reviews are underway for cardio-vascular disease, respiratory problems, frailty, children and young people, colorectal services, and maternity and neonates. The final Strategy will not be resolved until all of the reviews and consultations have been concluded, after the autumn. All of the ICSs are sharing knowledge in the creation of their Strategies, but there are particular local issues for which each ICS needs to develop tailored solutions;
- (h) there is a separate work stream, strategy and review process for mental health, which has its own particular emphases. However, the mental health work stream will be connected back to the other areas to create the overall care strategy once the review and consultation work has been concluded.

RESOLVED to:

- (1) note the current progress in developing a new Clinical Services Strategy by the Nottingham and Nottinghamshire Integrated Care System (ICS);**
- (2) request that updates are returned to the Committee by the ICS on the findings of the individual service reviews.**

16 HEALTH SCRUTINY WORK PROGRAMME

Zena West, Senior Governance Officer, presented the proposed work programme for the 2019/20 municipal year, as per the agenda. The Nottingham and Nottinghamshire Integrated Care System has asked to give a presentation to the Committee on the local impact of the new NHS Long-Term Plan at a future meeting, which will be scheduled when possible.

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HEALTH SCRUTINY COMMITTEE
12 SEPTEMBER 2019
LOCAL IMPLICATIONS OF THE NHS LONG TERM PLAN
REPORT OF HEAD OF LEGAL AND GOVERNANCE

1 Purpose

- 1.1 To receive information on the local implications of the NHS Long Term Plan.

2 Action required

- 2.1 To consider the information provided and provide feedback, prior to the Local System Plan being published.

3 Background information

- 3.1 On 7 January 2019 the Government and the NHS published the Long Term Plan for the NHS. The plan sets out the ambitions and plans for the NHS in England for the next ten years.
- 3.2 Following the publication of the plan, each local area has been asked to develop their own plan for the implementation of the national strategy. In Nottingham and Nottinghamshire this is being led by the Integrated Care System (ICS) in partnership with the Clinical Commissioning Groups, the hospital and provider Trusts and Local Authorities. Representatives from the ICS will be attending the meeting to present the local plan.
- 3.3 In order to support the development of the local plan for Nottingham and Nottinghamshire, the Committee is being consulted on its contents prior to its publication.

4 List of attached information

- 4.1 Briefing note from ICS.

5 Background papers, other than published works or those disclosing exempt or confidential information

- 5.1 None.

6 Published documents referred to in compiling this report

- 6.1 NHS Long Term Plan.

7 Wards affected

- 7.1 All.

8 Contact information

- 8.1 Laura Wilson
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**Integrated
Care System**
Nottingham & Nottinghamshire

healthwatch
Nottingham & Nottinghamshire

Long Term Plan Engagement Integrated Insights Report

Nottingham and Nottinghamshire Integrated Care System

August 2019

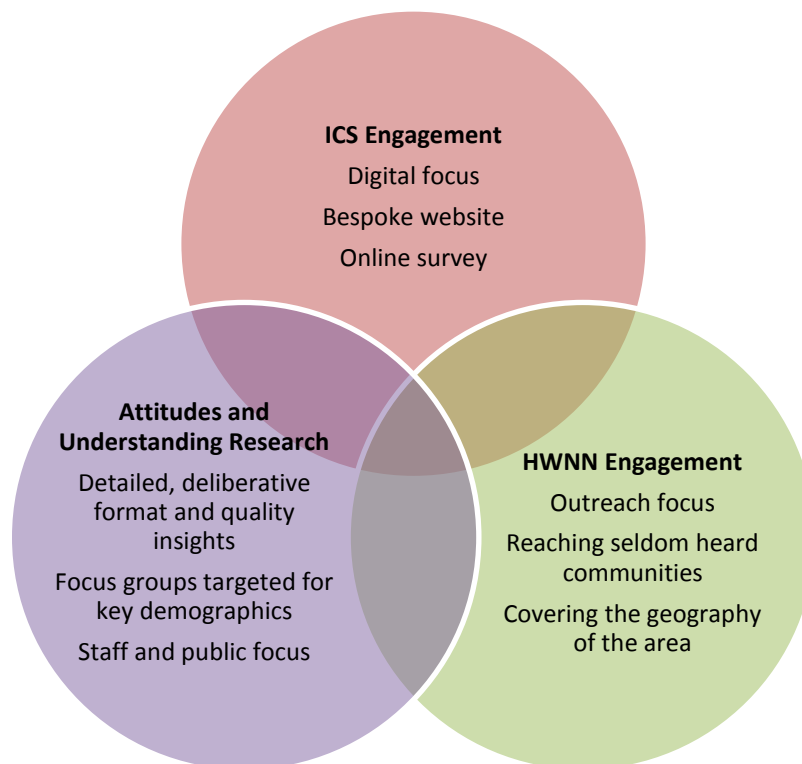
Section 1 – Background

- 1.1 On 7 January 2019 the new Long Term Plan for the NHS was published. This plan sets out the ambitions of the NHS in England for the next ten years and received widespread support upon its publication.
- 1.2 Following the publication of the plan, each local area has been asked to develop their own local plan setting out how they will implement the national strategy. In Nottingham and Nottinghamshire this is being led by the Integrated Care System (ICS) in partnership with the local Clinical Commissioning Groups (CCGs), the hospital and provider Trusts and Local Authorities.
- 1.3 The NHS Long Term Plan was developed with a high level of engagement with clinical experts and other stakeholders, patients and the public.
- 1.4 To support the implementation of the Long Term Plan, each local area was asked to undertake engagement with their populations to understand what matters to local people in their health services and to inform the development of a local system plan.
- 1.5 Healthwatch England, the organisation that supports local Healthwatch organisations, worked closely with the NHS to coordinate a programme of national engagement. We have worked in partnership with Healthwatch Nottingham and Nottinghamshire (HWNN) to undertake an extensive programme of engagement with local people. This engagement has explored some of the key themes in the NHS Long Term Plan and sought to understand what matters to people in their health and health services. This report details the findings of that engagement and sets out how we will ensure that they inform our local system plan.
- 1.6 We have spoken to over 1,000 people across Nottingham and Nottinghamshire in our engagement about topics such as mental health, urgent care, health prevention and more. These conversations with local people have given us a wealth of insight that will help us improve local services and deliver the national NHS Long Term Plan in a way that reflects what matters to people.

Section 2 – Our approach

- 2.1 The Nottingham and Nottinghamshire ICS has worked in partnership with Healthwatch Nottingham and Nottinghamshire (HWNN) to deliver an extensive programme of public engagement on the NHS Long Term Plan.
- 2.2 Our approach includes:
- a) Public engagement by the ICS communications and engagement team, through digital and face-to-face channels
 - b) Public engagement by HWNN through face-to-face channels
 - c) Understanding and Attitudes Research by social research agency Britain Thinks, delivered through a series of focus groups with staff and members of the public.
- 2.3 The elements above form the key parts of our engagement approach. While each element includes a different focus, the programme is underpinned by core themes and questions. This model is summarised below in figure 1.

Figure 1 – model for engagement



- 2.4 The core theme underpinning each element of our engagement was exploring what matters to local people, in the context of the NHS Long Term Plan

ambitions. Each element focused engagement around the priorities within the NHS Long Term Plan.

- 2.5 Central to our approach are a number of ‘trade-off’ questions. These questions are designed to generate debate and challenge assumptions around some of the core elements of the Long Term Plan – for example digital innovation or personalisation. Our trade-off questions ask people to consider how important a potential priority area is, when considered in direct competition with a competing priority. For example, people are asked to rank the importance of preventing ill health versus the importance of treating ill health. These trade-offs are hypothetical and intended to generate debate.
- 2.6 Within all of our engagement we have discussed the priorities within the NHS Long Term Plan in three ways:
- a) Understanding how important each priority is to people;
 - b) Understanding what matters most to people within each priority
 - c) Discussing the priorities in terms of hypothetical ‘trade-offs’ e.g. investment in prevention versus investment in treatment, to generate debate.
- 2.7 We also asked people ‘What do you think is the best thing about the NHS?’ to understand people’s priorities without prompting or context.
- 2.8 The following areas were discussed as priorities within the NHS Long term Plan:
- Urgent and emergency care
 - Mental health
 - Finances and efficiency
 - Prevention
 - Digital innovation
 - Personalisation
 - Children and young people’s health
 - Supporting our workforce
 - Major health conditions.
- 2.9 We talked to a wide range of partners and stakeholders to gain input into our engagement approach. This included conversations with our engagement partner HWNN; our ICS Board members; neighbouring systems; local voluntary and community sector (VCS) partners; NHS Confederation; local MPs and Local Authorities.

ICS Team engagement

- 2.10 The ICS Team engagement focused on engagement through digital channels.
- 2.11 A bespoke website was developed to support the engagement with a campaign run over three months, focusing on local activity linked to the priorities within the Long Term Plan. The campaign drove traffic to the website, which contained news articles and case studies of local interest.
- 2.12 The survey developed to generate feedback was housed within the website. It was developed in partnership with HWNN, who focused on outreach activity to promote the survey and generate responses.
- 2.13 The ICS Team also attended local community events to promote the survey and gather feedback. Detail of those events can be seen in the appendix.

HWNN engagement

- 2.14 HWNN engagement focused on engagement through face-to-face channels and aimed to reach as broadly across the ICS area as possible. This included targeted engagement with:
 - Carers
 - Parents of young children
 - People with long-term conditions
 - Homeless people
 - People experiencing mental health issues.
- 2.15 HWNN particularly focused on reaching communities that are seldom heard and people experiencing health problems or likely to experience poor health outcomes. Over 25% of respondents to the HWNN engagement identified themselves as carers and over half identified as having a disability.
- 2.16 Additional focus group discussions were held by HWNN targeting older people and people who are LGBT. Detail of all of these face-to-face events can be seen in the Appendix 2.

Understanding and Attitudes Research

- 2.17 The ICS commissioned social research agency Britain Thinks to undertake research on attitudes towards and understanding of the priorities within the NHS Long Term Plan, with a focus on what matters to local people.

2.18 The Understanding and Attitudes Research was structured around the same priority areas and key trade-off questions as the ICS and HWNN engagement. It included three key target groups:

- a) Health and care professionals
- b) Heavy service users
- c) Light service users

2.19 A mix of telephone interviews, face-to-face interviews and focus group were deployed across the research. These methods aimed to generate in-depth, meaningful insight and add more context and understanding to the survey results.

2.20 The findings of the engagement will inform the development of our local system plan. We have a broad programme of local stakeholder engagement planned to share the findings of our engagement; discuss how to reflect those findings in our local system plan; and share our local system plan as it develops, gaining input along the way.

2.21 Table 1 below summarises the delivery of engagement across all elements.

Table 1 – summary of engagement by approach

Focus of engagement	Engagement activity/outputs	Value added
ICS Team Engagement		
Engagement through digital channels	Bespoke website with 3,200 visitors over the engagement period	High number of responses to survey across digital channels
Campaign focus	Online survey with 405 responses	High level of engagement with campaign through digital channels
	Outreach engagement at 7 community events	Numbers reached by Long Term Plan conversation far in excess of engagement respondents
	Social media reach of >70,000	
HWNN Engagement		
Outreach engagement targeting seldom heard communities	Outreach engagement with 610 survey responses	Reach into communities across Nottingham and Nottinghamshire
	40 community events attended	Trusted engagement partner enabling the ICS to reach into communities
		Expertise in engagement design



Focus of engagement	Engagement activity/outputs	Value added
Attitudes and understanding Research		
In-depth research targeting professionals, heavy service users and light service users	<p>27 tele-depth interviews with GPs; nurses; consultants; junior doctors; allied health professionals; public health professionals; social care staff</p> <p>10 at-home interviews with heavy service users with complex long-term conditions</p> <p>4 focus groups with light service users</p>	<p>In depth conversations with staff and the public enabling detailed insights to be generated</p> <p>Adding context and depth to the survey findings</p>
Summary		
<p>1015 Survey responses</p> <p>47 Community events</p> <p>58 in-depth interviews/focus groups participants</p> <p>3,200 website visitors</p> <p>Social media reach of >70,000</p>		

Section 3 – Summary of findings

3.1 There were clear and common themes that emerged from all these sources of input. The key insights drawn collectively are summarised below.

3.2 Public views about priorities and pressures within the system are strongly influenced by the national media narrative on the NHS or on personal experience of services

3.2.1 Alongside a significant amount of pride in the local NHS, there is a perception that services are under pressure. This explains the widespread public support identified for urgent and emergency care and mental health. Even those with no experience of these services rank them as important or very important.

3.2.2 The public also see their experience of one service as indicative of the whole NHS, so experiences of long waits for GP services or urgent and emergency care are interpreted as indicators of pressure across the whole system.

3.3 People mostly value having a free at the point of need healthcare model, frontline staff and the accessibility of services within the NHS

3.3.1 Both the ICS and HWNN elements of the engagement opened with the question ‘What do you think is the best thing about the NHS?’ This has provided useful insight into public perceptions about the NHS, which have been reinforced in the Understanding and Attitudes Research.

3.3.2 Overwhelmingly, people value the free at the point of need model as the best thing about the NHS.

3.3.3 Where the workforce are cited as the best thing about the NHS, this is usually focused on front-line staff with compassion, dedication and helpfulness the qualities that people value.

3.3.4 Many people also cite the accessibility of services as the best thing about the NHS, in particular equity of access and fairness e.g. ‘it’s for everyone’.

3.3.5 It should be noted that the free at the point of need model does not, of course, apply to much of social care and therefore care needs to be taken when emphasising this strength of feeling when talking about integrated care.

3.4 There is widespread support for urgent and emergency care and mental health, which are among the system's top priorities

3.4.1 The public are highly supportive of prioritising urgent and emergency care and mental health. There is a perception among both staff and the public that more focus is needed on mental health.

3.5 While there is public support for a focus on finance and efficiency, this is not as significant as support for other areas

3.5.1 While many people rated finance and efficiency as important or very important, support for other system priorities was significantly higher. Support for focusing on finance and efficiency also needs to be considered alongside public and staff concerns about system pressures and perceptions of diminishing resources and cutbacks.

3.5.2 This can be seen in wider national research including this from the King's Fund (<https://www.kingsfund.org.uk/blog/2019/05/public-and-nhs-funding>) where 83% of survey respondents felt that there was a major or severe funding problem in the NHS. The majority (58%) said they would be willing to accept an increase in taxes to fund the NHS and 75% opposed means testing.

3.6 People are broadly supportive of a focus on preventative activity, with some reservations

3.6.1 There is widespread support for focusing on prevention of ill health among both staff and the public. Among the public however, there are some reservations. People still view treatment for health problems as a priority and would be concerned if resources were viewed to be being taken away from this area. People also highlight the limits of preventative interventions, citing that not all health problems are preventative and that people cannot always be encouraged to change their behaviour.

3.7 There are mixed and ambiguous views about personalisation, choice and control

3.7.1 In being asked to consider personalisation, choice and control in health people felt that these things were highly dependent on context. This is reinforced by previous engagement carried out by HWNN on shared decision making. Both engagement on the Long Term Plan, and previous work by HWNN highlights that people do not always understand these terms – particularly those who are not 'health literate'.

3.8 There is only lukewarm support for digital innovation in healthcare and a lack of understanding of the value of digital technology to improve access

3.8.1 Of all the areas of healthcare covered within the engagement there was the least understanding of, and support for, digital innovation to improve access. While there is a correlation between respondents age and their level of support for digital innovation in healthcare, with those over working age less likely to be supportive, it remains the least supported and least understood of all areas covered among all groups.

3.9 The public are mostly uninterested in hearing about system change

3.9.1 The public have little appetite for hearing about system change and transformation, unless it directly affects how they access care. They perceive the biggest challenges to the NHS to be difficulty accessing services, a loss of high performing services and hit-and-miss quality of care. For access to services people are mostly referring to A&E and their GP.

3.10 Staff are concerned about diminishing resources and increasing demand

3.10.1 Staff see an increasing demand for healthcare alongside diminishing resources. They highlight short-term thinking and pressure on staff as the net effects of this. Staff are interested in seeing investment in more effective and efficient ways of working.

3.10.2 Where staff are particularly interested in knowing more about system change they will be very proactive in seeking out information. For those with limited interest in these matters, they want to hear about what it means for them directly in their job and expect to hear it from their line manager or professional association.

Section 4 – Detailed findings

What matters to people in Nottingham and Nottinghamshire?

- 4.1 Within the survey used in the HWNN and ICS engagement, the first question that was asked was ‘What do you think is the best thing about the NHS. Responses against this question are shown below in table 2.

Table 2 – ‘What do you think is the best thing about the NHS?’

Theme	% of responses	No. of responses*
Free at the point of need	46%	468
Staff/workforce	18%	182
Accessibility	16%	159
High quality services	9%	96
Variety of services	4%	44

**combined data across HWNN and ICS engagement*

- 4.2 Of the 807 people who responded to the question the majority (47%) cited free at the point of need healthcare as the best thing about the NHS. Staff and workforce (18%) and accessibility (16%) were the next most common responses.
- 4.3 HWNN note that a general theme within the responses to this question was that people felt secure knowing that the NHS was in place and that they were reassured they would receive a good standard of care from staff. A high level of trust in healthcare professionals was identified across all engagement approaches, with HWNN and Britain Thinks stating that many people trust professionals to make decisions about their care and treatment.
- 4.4 Britain Thinks identified a high level of pride in the local and national NHS in the Understanding and Attitudes Research, particularly in comparison to the health systems in other countries.

“My neighbour collapsed on a bank holiday – they said you’ll wait a while, and then the ambulance was there within 3 minutes. You can’t do better than that.”

- 4.5 Within responses highlighting accessibility as the best thing about the NHS, it is often the principles of fairness and equity of provision that are highlighted as most important. Within the Understanding and Attitudes Research, light service users tended to prioritise reducing waiting times for A&E and their GP as the most important things to address.

Top local priorities for health and care

4.6 The survey used within the HWNN and ICS engagement explained that three areas were being considered as priorities for health and care locally:

- Mental health - Improving mental health services and treating mental ill health as important as physical health
- Urgent and emergency care - Making sure that emergency services such as A&E are quick and easy to access
- Finances - Making sure taxpayers' money is used as efficiently as possible and that we stick to our budgets.

Our Understanding and Attitudes Research also used these areas to prompt discussions about people's priorities for health and care.

4.7 Responses to this question within the survey are shown below in table 3.

Table 3 – 'Please tell us how important each of the following are to you'

Theme	% of responses rating as very important	% of responses rating as important	% of responses rating as important or very important	No. of responses rating as important or very important*
Urgent and emergency care	79%	19%	98%	806
Mental health	70%	24%	94%	772
Finance and efficiency	50%	33%	84%	688

*combined data across HWNN and ICS engagement

4.8 Most people who responded to this question felt that urgent and emergency care (98%) and mental health (94%) were either important or very important. Our Understanding and Attitudes Research highlights that the national media narrative is highly influential in people's views of local health services. It is therefore expected that areas receiving significant media attention are thought to be important.

"I do know that A&E is at crisis point. It's all over social media, people put up their experiences, on the news there are people being left in hallways. People who have died at home because ambulances aren't able to get to them."

- 4.9 People who have had personal experience of mental health services highlighted confusing referrals, long waiting times and a particular struggle for young peoples' services and support for carers.
- 4.10 Finance and efficiency was seen as important or very important by 84% of respondents to the question. While this demonstrates public support for this area as a priority it should be noted that other priorities (see below) were more widely supported. It should also be noted that both staff and the public perceive that the system is under pressure and that resources are diminishing – so a focus on further reducing budgets or making further efficiencies will be seen as unwelcome and unpopular.
- 4.11 It is worth noting the gap between these three areas in the proportion of people who rated them as *very important*. While urgent and emergency care and mental health were rated as very important by 79% and 70% of respondents respectively, finance and efficiency was rated as very important by 50%. This highlights that finance and efficiency is seen as less of a priority than other areas.

Other priorities for health and care

- 4.12 The survey then explained that the local health and care system had a further set of other priorities for focus over the next five years and asked people how important they thought these areas are:
- Preventing ill health - More action on the things that create poor health such as smoking, alcohol and unhealthy eating
 - Children and young people's health - More action on services for children and young people including mental health services, maternity services and treating illnesses
 - Major health conditions - Better care for the major health conditions in our society such as cancer, diabetes and stroke - for example faster diagnosis and better treatment
 - Supporting our workforce - Making sure we have the right number of doctors, nurses and social care workers in the right places and that they have the right skills to provide what people need
 - Digital innovation in healthcare - Using things like Skype for appointments to help you get better access to your GP.
- Again, these were used as prompts in our Understanding and Attitudes Research for discussions around priorities.

- 4.13 Responses to this question within the survey are shown below in table 4.

Table 4 – ‘Please tell us how important each of the following are to you’

Theme	% of responses rating as very important	% of responses rating as important	% of responses rating as important or very important	No. of responses rating as important or very important*
Supporting our workforce	79%	20%	99%	805
Major health conditions	72%	28%	99%	783
Children and young people’s health	64%	34%	98%	753
Preventing ill health	48%	48%	95%	702
Digital innovation in healthcare	31%	43%	55%	444

*combined data across HWNN and ICS engagement

- 4.14 All the listed priority areas were overwhelmingly seen as important or very important, with the exception of digital innovation in healthcare (55%). Digital innovation was also the least supported area within the trade-off questions. Considering the areas ranked as *very important* by people, workforce (79%) and major health conditions (72%) have much more public support than the other areas. Less than half of respondents thought that preventing ill health or digital innovation are very important.
- 4.15 Beyond using Skype for appointments the public struggle to see other areas where digital technology can improve access. There is also some suspicion in investing in what is seen to be new as there is a perception that existing services are under-resourced. People are also concerned about those that are not comfortable using digital technology and the risk of system failures, or perceptions that existing or previous digital services have not performed well.
- 4.16 There is a correlation between the age of respondents and their level of support for digital innovation in healthcare. Of respondents of working age, 59% rated digital innovation as important or very important. For non-working age respondents this fell to 46%.

“Some people haven’t got internet. The people who use services the most – the elderly, young children. So investing in [Skype appointments] might not work”



- 4.17 Among the public, the prioritisation of support for the workforce is interpreted to mean either more front-line staff or staff being able to spend more time with patients.

“Nursing staff and GPs are worth their weight in gold”

- 4.18 Children and young people’s services and treatment for major health conditions were seen as strengths of the local area’s health services, with the exception of mental health.
- 4.19 Preventing ill health was viewed positively by both staff and the public, although comments within the survey used by HWNN and the ICS and discussions within the Understanding and Attitudes Research indicate some reservations about focusing on prevention at the detriment of treatment. The limits of public health campaigns, in particular, are seen as caveats in prioritising prevention.

“Everybody already knows all that. Everybody knows how to live a healthy life, it's whether you choose to or not, it's up to the individual. Yes they should still advertise walking and quitting smoking and all that. But nobody wants it shoved in their face 24/7.”

Choices about health and care investment

- 4.20 The survey used by HWNN and the ICS asked people which they felt was more important for the local health and care system to deal with, out of a series of two opposing choices. People were asked which was more important to focus on between:

Preventing people becoming ill - Keeping people fit and well so they are less likely to become ill

Choice and control - Letting people manage their own health and wellbeing and choice of treatment

Investing in digital technology for healthcare - Using things like Skype for appointments to help people get better access to their GP

OR

OR

OR

Treating people when they become ill - Making sure that people who become ill have the best possible treatment

The best possible care and treatment without having to choose - Doctors and other health professionals deciding what is best for people and making sure it is provided

Investing in buildings and equipment for healthcare - Investing in the buildings and equipment used at locations where people go to for urgent healthcare

These hypothetical trade-offs were also used to stimulate debate in our Understanding and Attitudes Research.

- 4.21 HWNN and the ICS collected the data for this question in different ways. Within the HWNN survey, these questions were formatted as multiple-choice with respondents able to choose either of the trade-off choices or a neutral answer. Within the ICS survey, respondents were able to use a manual sliding scale of 0-100 to indicate *how much more important* they felt one choice was than another.
- 4.22 Tables 5 – 7 below show the responses for the ICS and HWNN surveys separately. Within the ICS survey results, the number and proportion of respondents showing a **strong** preference for one choice within a trade-off question are shown within the table. A ‘strong’ preference is one where the response is at least 75% towards one choice. The HWNN results show the proportion of people selecting one option or another. The number of responses shown against each option within the Healthwatch results is therefore higher than the ICS results, which only includes response at each end of a sliding scale.

Table 5 – Preventing people becoming ill or treating people when they become ill

Which is more important to you?	HWNN data		ICS data	
	% of responses selecting this option	No. of responses	% of responses stating a strong preference	No. of responses
Preventing people becoming ill	40%	243	27%	108
Treating people when they become ill	39%	237	26%	104

- 4.23 Presenting a choice between prevention and treatment generated a similar numbers of strong responses for each option.

Table 6 – Choice and control or the best possible care and treatment without having to choose

Which is more important to you?	HWN data		ICS data	
	% of responses selecting this option	No. of responses	% of responses stating a strong preference	No. of responses
Choice and control	30%	182	21%	87
The best possible care without having to choose	40%	246	25%	101

- 4.24 There were slightly more strong responses for the best possible care without having to choose compared to strong responses for choice and control in healthcare.
- 4.25 The Understanding and Attitudes Research highlighted some important nuances in perceptions of choice and control. Both light and heavy service users are satisfied with their current level of choice and control. However, people who are working and have families express a desire for more choice in terms of flexibility of appointments. Social care staff are more likely than NHS staff to view choice and control positively, and highlight the benefits it can bring for older people and those with long-term conditions.
- 4.26 A previous HWNN project engaged with people who do not traditionally engage with shared decision making and discussions around choice and control. It found that these participants were in favour of shared decision making in health as long as a number of conditions were met, including having the confidence and time to ask questions about choices; having trust in healthcare professionals; understanding the language being used; having the mental capacity to make a choice, understanding the benefits and risks and being listened to.

Table 7 – Investing in digital technology for healthcare or investing in buildings and equipment for healthcare

Which is more important to you?	HWN data		ICS data	
	% of responses selecting this option	No. of responses	% of responses stating a strong preference	No. of responses
Investing in digital technology	10%	63	12%	47



Investing in buildings and equipment	61%	371	32%	128

- 4.27 There is limited public and staff support for investing in digital innovation versus other areas. This gap is starker when people are asked to choose between investment in digital innovation and investment in buildings and equipment. As highlighted, people struggle to identify areas where digital technology could improve access.

Section 5 – Key lessons learned and next steps

5.1 The key lessons learned through our engagement on the Long Term Plan are:

- People value a free at the point of need model for healthcare as the best thing about the NHS and plans should reassure people that this will be protected for the future
- The public are supportive of prioritising mental health services and urgent and emergency care.
- People feel that we should prioritise supporting our workforce and view front-line staff as one of the best things about the NHS.
- People are concerned about pressure on services and would like to see improvements in waiting times for access.
- People recognise finance and efficiency as important, but also view services as under pressure and under-funded. It will be important to reassure people that decisions on investment and disinvestment are robust and underpinned by long-term thinking.
- The public are supportive of action to prevent ill health, but see this as less as a priority than other areas and need reassurance that treating ill health will not be deprioritised
- Digital innovation to improve services was the least supported of all potential priority areas discussed and there is work to do to take the public with us if we wish to accelerate the use of digital technology in health services.
- Support for choice and control is dependent on context and this area merits further engagement.

5.2 A wide programme of engagement with key bodies, forums and organisations across the local health and care system is planned. This work will help us in feeding the findings of our Long Term Plan engagement into our local system plan.

5.3 We recognise that further engagement will be required within specific areas of our local plan and this will be carried out within our Integrated Care Providers, who will be tasked with implementing the plan.

Appendix 1 – What Matters to You Survey



What matters to you in health and care?

Make sure your voice is heard

In January the NHS launched its Long Term Plan, which sets out its ambition to make sure everyone has the best start in life, receives world class care for major health problems and gets the support they need to age well.

To help us deliver the aims of the Long Term Plan locally, we'd like your views to help shape our local plan.

Whether it's your opinion on the plan's priorities, or how you and your family get health advice, support and services – please join the conversation. You're at the heart of everything we do, so we want to make sure your voice is heard.

You can give us your feedback through this short survey.

Completing the survey

For each question please tick clearly inside the box that is closest to your views using a black or blue pen. Don't worry if you make a mistake; simply cross out the mistake and put a tick in the correct box. Please do not write your name or address anywhere on the survey. All information will be kept strictly confidential and in accordance with the Data Protection Act 1998 and associated protocols.

This survey is available to complete here or by visiting our website:

<https://nottswatmatterstoyou.co.uk/>

Please return this form either by email to julie.andrews12@nhs.net

or by post to:

Freepost RTGE-CRAT-BABH

NHS Mansfield & Ashfield CCG

Birch House

Mansfield

NG21 0HJ

Please call 0115 804 3925 if you require:

- Any further information
- Support to complete this survey
- Copies of the information and survey in different languages and formats

Q1. What do you think is the best thing about the NHS?

Our top priorities for health and care in Nottingham and Nottinghamshire

We believe that the biggest challenges for health and care in Nottingham and Nottinghamshire over the next 5 years are **mental health**; **urgent and emergency care** and **finance and efficiency**.

We want to know if you agree or disagree that these should be our top priorities.

Q2. Please tell us how important each of the following are to you

	Not important at all	Not very important	Neither unimportant or important	Important	Very important
Mental health - Improving mental health services and treating mental ill health as important as physical health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Urgent and emergency care - Making sure that emergency services such as A&E are quick and easy to access	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Finance and efficiency - Making sure taxpayers' money is used as efficiently as possible and that we stick to our budgets	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Please tell us more about any areas you feel strongly about					

Our priorities for health and care in Nottingham and Nottinghamshire

The following is a list of other areas we may want to prioritise over the next 5 years.

Q3. Please tell us how important each of the following are to you

	Not important at all	Not very important	Neither unimportant or important	Important	Very important
Preventing ill health - More action on the things that create poor health such as smoking, alcohol and unhealthy eating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Children and young people's health - More action on services for children and young people including mental health services, maternity services and treating illnesses	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Major health conditions - Better care for the major health conditions in our society such as cancer, diabetes and stroke - for example faster diagnosis and better treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Supporting our workforce - Making sure we have the right number of doctors, nurses and social care workers in the right places and that they have the right skills to provide what people need	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Digital innovation in healthcare - Using things like Skype for appointments to help you get better access to your GP	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Please tell us more about any areas you feel strongly about					



Choices about health and care in Nottingham and Nottinghamshire

We want to know what matters to you in health and care. Please tell us which of the following things is more important to you.

Q4. Which is more important for the NHS and social care to deal with?

Preventing people becoming ill - Keeping people fit and well so they are less likely to become ill	Don't know	Treating people when they become ill - Making sure that people who become ill have the best possible treatment
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Please tell us why you feel this way		

Q5. Which is more important for the NHS and social care to deal with?

Choice and control - Letting people manage their own health and wellbeing and choice of treatment	Don't know	The best possible care and treatment without having to choose - Doctors and other health professionals deciding what is best for people and making sure it is provided
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Please tell us why you feel this way		



Q6. Which is more important for the NHS and social care to deal with?

Investing in digital technology for healthcare - Using things like Skype for appointments to help people get better access to their GP	Don't know	Investing in buildings and equipment for healthcare - Investing in the buildings and equipment used at locations where people go to for urgent healthcare
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Please tell us why you feel this way		



Appendix 2 – Demographic breakdown of survey respondents

HWNN engagement

District	No.	Percent
Nottingham City	158	25.9%
Gedling	131	21.5%
Ashfield	83	13.6%
Newark and Sherwood	59	9.7%
Rushcliffe	58	9.5%
Broxtowe	39	6.4%
Mansfield	38	6.2%
Out of area	52	6.9%
Not answered	2	0.3%
Total	610	100.0%

Age Groups	No.	Percent
1 - 15	4	0.7%
16-17	11	1.8%
18-24	24	3.9%
25-34	52	8.5%
35-44	63	10.3%
45-54	95	15.6%
55-64	100	16.4%
65-74	92	15.1%
75-85	56	9.2%
85+	11	1.8%
Not answered	102	16.7%
Total	610	100.0%

Gender	No.	Percent
Female	410	67.2%
Male	181	29.7%
Non-binary	1	0.2%
Not answered	13	2.1%
Prefer not to say	5	0.8%
Total	610	100.0%

Sexuality	No.	Percent
Heterosexual	438	71.8%
Prefer not to say	68	11.1%
Not answered	32	5.2%
Bisexual	27	4.4%
Homosexual	25	4.1%
Asexual	20	3.3%
Total	610	100.0%

Ethnicity	No.	Percent
White	542	88.9%
Not answered	19	3.1%
Prefer not to say	14	2.3%
Mixed/Multiple ethnic	12	2.0%
Black	11	1.8%
Asian	7	1.1%
Other	4	0.7%
South Asian	1	0.2%
Total	610	100.0%

Religion	No.	Percent
Christian	305	50.0%
None	193	31.6%
Prefer not to say	34	5.6%
Other	30	4.9%
Not answered	28	4.6%
Buddhist	8	1.3%
Sikh	4	0.7%
Hindu	3	0.5%
Jewish	3	0.5%
Muslim	2	0.3%
Total	610	100.0%

Carers	No.	Percent
No	426	69.8%
Not answered	28	4.6%
Yes	156	25.6%
Total	610	100.0%



Illness/impairment	No.	Percent
Mental health illness	123	24.4%
Physical impairment	122	24.2%
Hearing impairment	94	18.7%
Visual impairment	58	11.5%
Other	36	7.1%
Prefer not to say	31	6.2%
Learning impairment	21	4.2%
Social/behavioural problems	19	3.8%
Total	504	100.0%

ICS engagement

What is your gender?	No.	%
Female	232	70.1%
Male	95	28.7%
Non binary	1	0.3%
Prefer not to say	3	0.9%
Total	331	

Is your gender identity the same gender you were assigned at birth?	No.	%
Yes	322	97.9%
No	2	0.6%
Prefer not to say	5	1.5%
Total	329	

Is your gender identity the same gender you were assigned at birth?	No.	%
Yes	322	97.9%
No	2	0.6%
Prefer not to say	5	1.5%
Total	329	



What is your ethnicity?	No.	%
Any other Black background	1	0.3%
Any other ethnic group (please specify)	9	2.7%
Any other mixed background	3	0.9%
Any other White background	4	1.2%
Asian or Asian British - Indian	6	1.8%
Asian or Asian British - Pakistani	4	1.2%
Black or Black British - African	1	0.3%
Black or Black British - Caribbean	1	0.3%
Gypsy or Traveller	1	0.3%
Irish	5	1.5%
Mixed - White and Asian	2	0.6%
Mixed - White and Black Caribbean	1	0.3%
White British	292	88.5%
Total	330	

What is your age?	No.	%
Under 18	3	0.9%
18-24	9	2.7%
25-34	44	13.4%
35-44	62	18.8%
45-54	86	26.1%
55-64	67	20.4%
65+	58	17.6%
Total	329	

Do you consider yourself to have a disability?	No.	%
No	254	76.5%
Prefer not to say	13	3.9%
Yes	41	12.3%
Total	332	

What is your sexual orientation?	No.	%
Bisexual	8	2.4%
Gay	12	3.6%
Heterosexual	287	87.2%
Prefer not to say	22	6.7%
Total	329	



What is your religion?	No.	%
Buddhist	6	1.8%
Christian (all denominations)	133	40.7%
Hindu	2	0.6%
Muslim	5	1.5%
None	160	48.9%
Other	18	5.5%
Sikh	3	0.9%
Total	327	


What is your marital status?	No.	%
Civil partnership	11	3.3%
Divorced	22	6.6%
Married	189	56.9%
Prefer not to say	18	5.4%
Separated	8	2.4%
Single	73	22.0%
Widowed	11	3.3%
Total	332	

Women and pregnancy - are you pregnant?	No.	%
No	285	96.0%
Yes	3	1.0%
Prefer not to say	9	3.0%
Total	297	

Appendix 3 – Engagement Log

Date	Activity	Audience	Notes/documents
15/1/19 and ongoing	Email, face-to-face and phone exchanges with South Yorkshire ICS Comms Director to get builds and inputs. (AB and LE)	Sister ICS with adjoining geography (Bassetlaw)	Aligned approach and agreed to co-create generic questions and ensure that timings are dovetailed.
1/2/19 to 7/2/19	Email exchange with NCVS lead to get builds and input. (AB)	Nottingham City Community and Voluntary sector.	No major amends, endorsed approach.
5/2/19	Met with and shared plan with local NHS Confederation representative to get builds and input. (AB)	NHS Confederation regional rep.	No major amends, endorsed approach
15/2/19	Shared overall plan with ICS Board to alignment and agreement on approach to engagement. (AB)	ICS Board members (CEs, Chairs, Councillors).	
26/2/19	Shared summary of LTP and new GP contract and overall engagement plan with ICS Partnership Forum for alignment and specific builds on approach.	Partnership Forum members (see ToR)	
4/3/19	Nottinghamshire County Council – Adult Social Care and Public Health Committee	County Councillors with interest in ASC and Public Health	
26/3/19	Met with Prof Jonathan Tallant to discuss how to enhance levels	Professor of Philosophy,	



Date	Activity	Audience	Notes/documents
	of Trust amongst respondents to the survey to maximise engagement and response rates. Suggested amendments incorporated into survey. (AB)	Nottingham University	
29/3/19	Briefings issued to staff, stakeholders, Councillors and MPs. (AB, LE, JG, TS and others)	Staff, system partners, Councillors, MPs	
1/4/19	ICS Team engagement at 4 Seasons Shopping Centre, Mansfield	Public	
1/4 to 4/4/19	Diabetes Awareness Week activities in QMC; Oak Tree Tesco, Mansfield; Asda, Newark; Idlewells Shopping Centre, Sutton-in-Ashfield, Asda Hyson Green)	Public	https://twitter.com/MandAccg/status/1113087472974659585  Dawn Jameson, Diabetes Manager 1.jj
2/4/2019	Experian initial meeting with Amy Priest, Wellbeing Lead (KH)	Experian staff	Initial meeting to commence building ICS / CCG / Experian information channels and staff engagement opportunities around the Long Term Plan activity.
2/4/19	ICS Team Engagement with CCG Patient and Public Engagement Committee	Public	
3/4/19	ICS Team engagement at diabetes truck, Mansfield	Public	
4/4/19	ICS Team engagement as part of diabetes awareness week, Newark	Public	
4/4/19	ICS Team engagement as part of diabetes awareness week, Sutton-in-Ashfield	Public	



Date	Activity	Audience	Notes/documents
9/04/2019	Connected with Community Gardens managers and volunteers (St Ann's allotments, Clifton Summerwood Lane Gardens and Bulwell Forest Gardens) across City to find out their additional events throughout the summer.	Volunteers and managers but to understand the visitor and footfall across the gardens to see who we can connect with.	
10/4/19	HWNN with LGBT group in Nottingham City	Public	
11/4/19	ICS Team engagement at Tesco Health Event, Ollerton	Public	
12/4/19	HWNN engagement with Citycare Patient Engagement Group	Public	
12/4/19	Coverage of Estates Strategy item from Board (11/4) includes reference to LTP Engagement and has URL	Public	https://www.nottinghampost.com/news/nottingham-news/bold-five-year-plan-upgrade-2752189 and https://westbridgfordwire.com/plans-to-improve-nottinghams-nhs-buildings/
12/4/19	HWNN engagement at Arnold Mental Health Drop-In	Public	
16/4/19	Coverage of City Council rejoining the ICS includes reference to LTP Engagement and has URL	Public	https://westbridgfordwire.com/city-council-rejoins-nottingham-and-notts-health-and-social-care-system/
16/4/19	HWNN engagement in Nottingham City	Public	
16/4/19	HWNN public engagement at 4 Seasons Shopping Centre, Mansfield	Public	

Date	Activity	Audience	Notes/documents
17/4/19	HWNN engagement with Broxtowe diabetes group	Public	
23/4/19	First Patient Impact Group meeting for the Integrated Urgent Care project.	Internal – Mid Notts and Greater Notts	Brief notes taken and agreed to hold future meetings and engagement until Governing Body ratify the latest paper. Added to engagement log here as cross-ICS work and might impact on LTP when finalised.
23/4/19	HWNN engagement with Gedling diabetes group	Public	
24/4/19	First Strategy Workshop with ICS Board, pre-circ includes initial insights from Engagement (AB)	Board Members	
25/4/19	HWNN Focus Group with Growing Bolder, older person's group in Mansfield	Public	
27/4/19	HWNN engagement with Fibromyalgia group	Public	
29/04/19	Summary of social media activity and engagements over first month of the project	Public	
1/5/19	ICS team public engagement in Ollerton	Public	
3/5/19	HWNN engagement at Bullwell Carers Group	Public	
4/5/19	HWNN public engagement in Gedling	Public	
7/5/19	HWNN Focus Group with LGBT Switchboard volunteers	Public	
7/5/19	Trent Barton engagement activity.	Trent Barton staff	https://www.facebook.com/photo.php?fbid=678305389272262&set=pcb.678305425938925&type=3&theater



Date	Activity	Audience	Notes/documents
8/5/19	ICS Team engagement at Ageing Well event, Sherwood	Public	
8/5/19	HWNN drop-in community event in Gedling	Public	
8/5/19	HWNN public engagement in Newark	Public	
9/5/19	HWNN engagement at Gedling Homes community event	Public	
9/5/19	Presented summary of engagement activities so far and initial insights from data gathered.	ICS Board Members	Details and papers here at item 9: http://www.stpnotts.org.uk/media/1737342/icsboardagendapapers20190509.pdf
9/5/19	HWNN engagement at Burton Joyce library	Public	
10/5/19	HWNN focus group with weight management group in Ashfield	Public	
10/5/09	Mention of MP engagement meeting in Alex Norris MP email newsletter	Nottingham North residents	Newsletter attached – see page 4
10/5/19	HWNN engagement with Arnold mental health group	Public	
10/5/19	HWNN public engagement in Gedling	Public	
13/5/19	HWNN engagement in Nottingham City	Public	
13/5/19	HWNN engagement with Kings Mill Hospital Patient Involvement Group	Public	
13/5/19	HWNN engagement at Talk2Us event in Newark	Public	



Date	Activity	Audience	Notes/documents
13/5/19	HWNN engagement in Rushcliffe	Public	
13/5/19	HWNN engagement in Rushcliffe	Public	
14/5/19	HWNN engagement at Nottingham City Carers Roadshow	Public	
14/5/19	HWNN engagement at Ollerton toddler group	Public	
14/05/19	Experian Mental Health awareness week and LTP engagement	Experian staff	
Page 48 14/5/19	Briefing for MPs on ICS, Long Term Plan (and CCG Merger).	Members of Parliament: Norris, Greenwood, Leslie, Coaker. Plus via their staff: Jenrick and Spencer.	
14/5/19	HWNN engagement at Emmanuel House in Nottingham City	Public	
14/5/19	ICS Team engagement at Ashfield Active AGM	Public	
15/5/19	ICS Team engagement at Kings Mill hospital	Public	
15/05/19	Trent Barton Engagement	Trent Barton engagement	
16/5/19	HWNN engagement at Arnold play group	Public	
17/5/19	HWNN engagement at Clifton	Public	



Date	Activity	Audience	Notes/documents
	Carers Roadshow		
17/5/19	Alex Norris MP – mention of engagement meeting in Westminster in constituent newsletter	MPs	
21/5/19	Discussion with Jane Laughton, CEO, HWNN re progress and plan to finalise analysis	Stakeholder	
22/5/19	Partnership Forum – presentation on approach so far and emerging insights. Discussion on how to further propagate survey and ensure wider completion of survey.	Stakeholders	
28/5/19	ICS Team engagement	Clifton	
28/5/19	ICS Team engagement	Bulwell	
30/5/19	City Council Leadership Group	Leader, Deputy Leader, 2x Portfolio Holders, Chief Exec	
5/6/19	County Health and Wellbeing Board	Councillors and wider stakeholders. Cllrs Glynn Gilfoyle, Joyce Bosnjak and colleague from PCC v interested. Esp on Rough Sleeping and MH. Agreed to set up informal	



Date	Activity	Audience	Notes/documents
		workshop in the summer.	
19/6/19	ICS Team engagement at learning disability event	Public	
24/6/19	ICS Team engagement at LGBT event	Public	
25/6/19	Councillors and NEDs Discussion – facilitated by Chris Ham.	Councillors and NEDs. 13x Councillors 5x NEDs	
28/6/19	ICS Team engagement at school event	Public	
29/7/19	Workshop with County H&WB members	15 Councillors (County and District) and other H&WB Members (inc VCS, Police).	
8/7/19	County Adult Social Care and Public Health Committee	11 Councillors	
16/7/19	City Councillor Eunice Campbell – conversation following re-entry of City Council to ICS	City HWBB Chair	
22/7/19	ICS Board Development Session	ICS Board Members	



**Integrated
Care System**
Nottingham & Nottinghamshire

healthwatch
Nottingham & Nottinghamshire

Long Term Plan Engagement Integrated Insights Report Executive Summary Report

Nottingham and Nottinghamshire Integrated Care System

August 2019

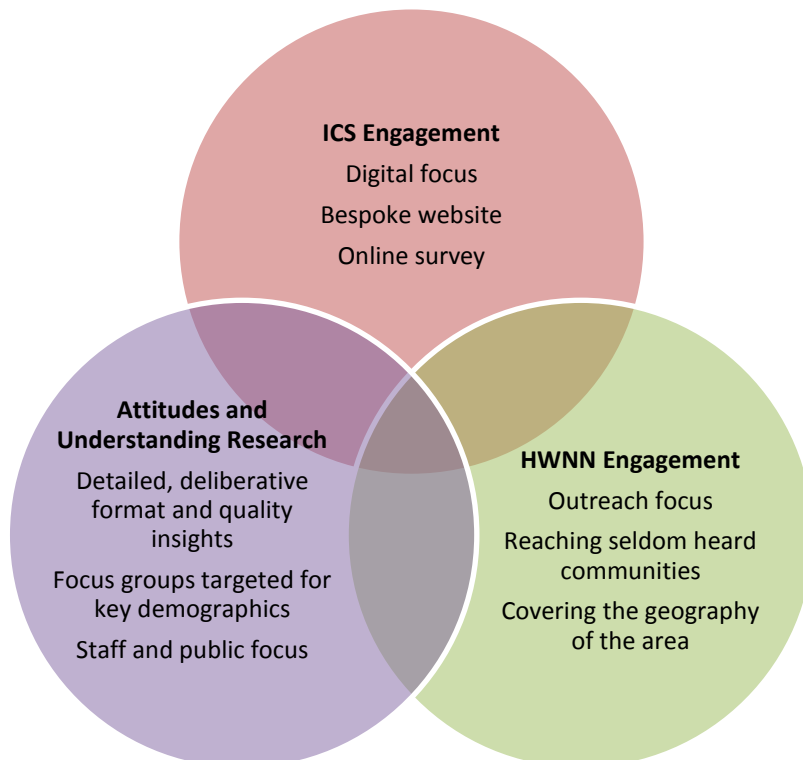
1 Background

- 1.1 On 7 January 2019 the new Long Term Plan for the NHS was published. This plan sets out the ambitions of the NHS in England for the next ten years and received widespread support upon its publication.
- 1.2 Following the publication of the plan, each local area has been asked to develop their own local plan setting out how they will implement the national strategy. In Nottingham and Nottinghamshire this is being led by the Integrated Care System (ICS) in partnership with the local Clinical Commissioning Groups (CCGs), the hospital and provider Trusts and Local Authorities.
- 1.3 The NHS Long Term Plan was developed with a high level of engagement with clinical experts and other stakeholders, patients and the public.
- 1.4 To support the implementation of the Long Term Plan, each local area was asked to undertake engagement with their populations to understand what matters to local people in their health services and to inform the development of a local system plan.
- 1.5 Healthwatch England, the organisation that supports local Healthwatch organisations, worked closely with the NHS to coordinate a programme of national engagement. In Nottingham and Nottinghamshire we have worked in partnership with Healthwatch Nottingham and Nottinghamshire (HWNN) to undertake an extensive programme of engagement with local people. This engagement has explored some of the key themes in the NHS Long Term Plan and sought to understand what matters to people in their health and health services. This report details the findings of that engagement and sets out how we will ensure that they inform our local system plan.
- 1.6 We have spoken to over 1,000 people across Nottingham and Nottinghamshire in our engagement about topics such as mental health, urgent care, health prevention and more. These conversations with local people have given us a wealth of insight that will help us improve local services and deliver the national NHS Long Term Plan in a way that reflects what matters to people.

2 Our approach

- 2.1 The Nottingham and Nottinghamshire ICS has worked in partnership with HWNN Nottinghamshire to deliver an extensive programme of public engagement on the NHS Long Term Plan.
- 2.2 Our approach includes:
- a) Public engagement by the ICS communications and engagement team, through digital and face-to-face channels
 - b) Public engagement by HWNN through face-to-face channels
 - c) Understanding and Attitudes Research by social research agency Britain Thinks, delivered through a series of focus groups with staff and members of the public.
- 2.3 The elements above form the key parts of our engagement approach. While each element includes a different focus, the programme is underpinned by core themes and questions. This model is summarised below in figure 1.

Figure 1 – model for engagement



- 2.4 The core theme underpinning each element of our engagement was exploring what matters to local people, in the context of the NHS Long Term Plan ambitions. Each element focused engagement around the priorities within the NHS Long Term Plan.
- 2.5 Within all of our engagement we have discussed the priorities within the NHS Long Term Plan in three ways:
- a) Understanding how important each priority is to people;
 - b) Understanding what matters most to people within each priority
 - c) Discussing the priorities in terms of hypothetical 'trade-offs' e.g. investment in prevention versus investment in treatment, to generate debate.
- 2.6 We also asked people 'What do you think is the best thing about the NHS?' to understand people's priorities without prompting or context.
- 2.7 We talked to a wide range of partners and stakeholders to gain input into our engagement approach. This included conversations with our engagement partner HWNN; our ICS Board members; neighbouring systems; local voluntary and community sector (VCS) partners; NHS Confederation; local MPs and Local Authorities.
- 2.8 Table 1 below summarises the delivery of engagement across all elements.

Table 1 – summary of engagement by approach

Focus of engagement	Engagement activity/outputs	Value added
ICS Team Engagement		
Engagement through digital channels	Bespoke website with 3,200 visitors over the engagement period	High number of responses to survey across digital channels
Campaign focus	Online survey with 405 responses	High level of engagement with campaign through digital channels
	Outreach engagement at 7 community events	Numbers reached by Long Term Plan conversation far in excess of engagement respondents
	Social media reach of >70,000	
HWNN Engagement		
Outreach engagement targeting seldom heard communities	Outreach engagement with 610 survey responses	Reach into communities across Nottingham and Nottinghamshire
	40 community events attended	Trusted engagement partner enabling the ICS to reach into communities
		Expertise in engagement design

Focus of engagement	Engagement activity/outputs	Value added
Attitudes and understanding Research		
In-depth research targeting professionals, heavy service users and light service users	<p>27 tele-depth interviews with GPs; nurses; consultants; junior doctors; allied health professionals; public health professionals; social care staff</p> <p>10 at-home interviews with heavy service users with complex long-term conditions</p> <p>4 focus groups with light service users</p>	<p>In depth conversations with staff and the public enabling detailed insights to be generated</p> <p>Adding context and depth to the survey findings</p>
Summary		
<p>1015 Survey responses</p> <p>47 Community events</p> <p>58 in-depth interviews/focus groups participants</p> <p>3,200 website visitors</p> <p>Social media reach of >70,000</p>		

3 Summary of findings

- 3.1 There were clear and common themes that emerged from all these sources of input. The key insights drawn collectively are summarised below.
- 3.2 Public views about priorities and pressures within the system are strongly influenced by the national media narrative on the NHS or on personal experience of services**
- 3.2.1 Alongside a significant amount of pride in the local NHS, there is a perception that services are under pressure. This explains the widespread public support identified for urgent and emergency care and mental health. Even those with no experience of these services rank them as important or very important.
- 3.2.2 The public also see their experience of one service as indicative of the whole NHS, so experiences of long waits for GP services or urgent and emergency care are interpreted as indicators of pressure across the whole system.
- 3.3 People mostly value having a free at the point of need healthcare model, frontline staff and the accessibility of services within the NHS**
- 3.3.1 Both the ICS and HWNN elements of the engagement opened with the question 'What do you think is the best thing about the NHS?' This has provided useful insight into public

perceptions about the NHS, which have been reinforced in the Understanding and Attitudes Research.

- 3.3.2 Overwhelmingly, people value the free at the point of need model as the best thing about the NHS.
- 3.3.3 Where the workforce are cited as the best thing about the NHS, this is usually focused on front-line staff with compassion, dedication and helpfulness the qualities that people value.
- 3.3.4 Many people also cite the accessibility of services as the best thing about the NHS, in particular equity of access and fairness e.g. 'it's for everyone'.
- 3.3.5 It should be noted that the free at the point of need model does not, of course, apply to much of social care and therefore care needs to be taken when emphasising this strength of feeling when talking about integrated care.
- 3.4 There is widespread support for urgent and emergency care and mental health, which are among the system's top priorities**
 - 3.4.1 The public are highly supportive of prioritising urgent and emergency care and mental health. There is a perception among both staff and the public that more focus is needed on mental health.
- 3.5 While there is public support for a focus on finance and efficiency, this is not as significant as support for other areas**
 - 3.5.1 While many people rated finance and efficiency as important or very important, support for other system priorities was significantly higher. Support for focusing on finance and efficiency also needs to be considered alongside public and staff concerns about system pressures and perceptions of diminishing resources and cutbacks.
 - 3.5.2 This can be seen in wider national research including this from the King's Fund (<https://www.kingsfund.org.uk/blog/2019/05/public-and-nhs-funding>) where 83% of survey respondents felt that there was a major or severe funding problem in the NHS. The majority (58%) said they would be willing to accept an increase in taxes to fund the NHS and 75% opposed means testing.
- 3.6 People are broadly supportive of a focus on preventative activity, with some reservations**
 - 3.6.1 There is widespread support for focusing on prevention of ill health among both staff and the public. Among the public however, there are some reservations. People still view



Treatment for health problems as a priority and would be concerned if resources were viewed to be being taken away from this area. People also highlight the limits of preventative interventions, citing that not all health problems are preventative and that people cannot always be encouraged to change their behaviour.

3.7 There are mixed and ambiguous views about personalisation, choice and control

3.7.1 In being asked to consider personalisation, choice and control in health people felt that these things were highly dependent on context. This is reinforced by previous engagement carried out by HWNN on shared decision making. Both engagement on the Long Term Plan, and previous work by HWNN highlights that people do not always understand these terms – particularly those who are not ‘health literate’.

3.8 There is only lukewarm support for digital innovation in healthcare and a lack of understanding of the value of digital technology to improve access

3.8.1 Of all the areas of healthcare covered within the engagement there was the least understanding of, and support for, digital innovation to improve access. While there is a correlation between respondents age and their level of support for digital innovation in healthcare, with those over working age less likely to be supportive, it remains the least supported and least understood of all areas covered among all groups.

3.9 The public are mostly uninterested in hearing about system change

3.9.1 The public have little appetite for hearing about system change and transformation, unless it directly affects how they access care. They perceive the biggest challenges to the NHS to be difficulty accessing services, a loss of high performing services and hit-and-miss quality of care. For access to services people are mostly referring to A&E and their GP.

3.10 Staff are concerned about diminishing resources and increasing demand

3.10.1 Staff see an increasing demand for healthcare alongside diminishing resources. They highlight short-term thinking and pressure on staff as the net effects of this. Staff are interested in seeing investment in more effective and efficient ways of working.

3.10.2 Where staff are particularly interested in knowing more about system change they will be very proactive in seeking out information. For those with limited interest in these matters, they want to hear about what it means for them directly in their job and expect to hear it from their line manager or professional association.

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HEALTH SCRUTINY COMMITTEE
12 SEPTEMBER 2019
GENERAL PRACTICE (GP) FORWARD VIEW UPDATE
REPORT OF HEAD OF LEGAL AND GOVERNANCE

1 Purpose

- 1.1 To receive an update on the GP Forward View (GPFV).

2 Action required

- 2.1 To consider the information provided and use it to inform questioning and in relation to the effectiveness of work taking place locally on the GPFV.

3 Background information

- 3.1 At its meeting in February 2019 the Committee heard from Hazel Buchanan and Dr Hugh Porter, from the Nottingham City Clinical Commissioning Group (CCG), about the work taking place to ensure that all citizens had access to good quality GP services now and in the future.

- 3.2 In relation to the GPFV the Committee heard that:

- it was published in April 2016 and committed to an extra £2.4 billion a year to support general practice services by 2020/21;
- 14 initiatives had been launched, 10 of which were led locally by CCGs;
- Nottingham City was working with Nottingham North and East CCG, Nottingham West CCG and Rushcliffe CCG as part of the Greater Nottinghamshire CCGs to support the delivery of the GPFV, sharing best practice and, where possible, delivering schemes at scale;
- one of the main aims of the GPFV was to reverse historic underinvestment in general practice and increase the workforce by 2020/21. A number of schemes were being rolled out under the GPFV to deliver these aims;
- the GPFV recognised the pressures within primary care around difficulties in workforce recruitment and expansion. NHS England and Health Education England (HEE) had set ambitious targets to expand the workforce, backed with additional funding as part of the Sustainability and Transformation package;
- the Nottinghamshire Vocational Training Scheme continued to be well utilised with more trainees going through the recruitment process and the GP fellowship programme also continuing to be a success;
- in addition, the GPFV included a commitment to deliver a major international recruitment drive to attract appropriately trained and qualified GPs from overseas by 2020. NHS England had established a GP International Recruitment Office to organise and run a scaled

up international recruitment programme. This office co-ordinated the recruitment, provided support for and relocation of recruited doctors, working closely with regional and local colleagues and partner organisations. A local framework of approved recruitment, relocation and training companies to support the programme had been developed. The Greater Nottingham CCGs successfully applied to be in wave 3 and aimed to recruit 24 GPs through this scheme;

- a workforce plan had been developed which outlines gaps in provision of clinical staff and how to bridge the gaps and recruit to ensure practices had the staff needed to deliver primary care services. It was key that with a reduced future supply of GPs there was a need to introduce skill mix into the clinical workforce and ensure that GPs caseload was appropriate.

- 3.3 Lynette Daws, CCG, and Dr Manik Arora will be in attendance at the meeting to update the Committee on the progress made on the GPFV in the last 6 months.

4 List of attached information

- 4.1 Briefing note from the CCG.

5 Background papers, other than published works or those disclosing exempt or confidential information

- 5.1 None.

6 Published documents referred to in compiling this report

- 6.1 Health Scrutiny Committee report and minutes from February 2019.

7 Wards affected

- 7.1 All.

8 Contact information

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Primary Care Services in Nottingham City

1. Introduction and Summary

This paper provides the Health Scrutiny Committee with an update on the delivery of The General Practice Forward View (GPFV) in Nottingham City. It provides an update on the initiatives to improve access and quality of services in Nottingham City.

Nottingham City CCG previously included progress with the GPFV in papers to the Health Scrutiny Committee in November 2015, January 2016, February 2018 and February 2019.

2. Primary Care Provision within Nottingham City

There are 50 GP practices in Nottingham City serving a total population of 386,429 registered patients. In the last 6 months three GP practices have closed in the City;

- Strelley Health Centre, part of the Beechdale Medical Group, closed May 2019 following a CQC inspection on 14 and 20 May 2019. CQC identified serious concerns during the inspection and took Urgent Enforcement Action to close the GP practice. Patients have been notified and are registering with other practices. A copy of the published report is available at <https://www.cqc.org.uk/location/1-3169167802>
- Mapperley Park Medical Centre closed June 2019 following the retirement of the single handed GP. Patients have been notified and are registering with other practices.
- Boulevard Medical Centre, part of the Beechdale Medical Group, closed July 2019 following a CQC inspection on 28 June 2019. CQC identified serious concerns during the inspection and took Urgent Enforcement Action to vary the registration of the Beechdale Medical Group to prevent further services being delivered at the Boulevard Medical Centre premise. Patients have been notified of this change and have transferred to Beechdale Surgery, although patients can choose to register with another practice. A copy of the published report is available at <https://www.cqc.org.uk/location/1-3169167634>

3. National and Local priorities

The GPFV was published in April 2016 with a commitment to invest money to support general practice services. Nottingham City has been working with Nottingham North and East CCG, Nottingham West CCG and Rushcliffe CCG as part of the Greater Nottinghamshire CCGs to support the delivery of the GPFV, sharing best practice and where possible delivering schemes at scale.

Through the GPFV, projects have been implemented to improve patient care and access, address workforce and workload challenges, primary care infrastructure and service redesign.

3.1.1 Access GP+

The CCG commissions an additional 182 hours per week, in the evenings and on weekends, to deliver additional primary care services. This is equivalent to over 700 additional appointments per week. The Nottingham City General Practice Alliance (NCGPA) has delivered this service, known locally as GP+ since March 2018. The service provides bookable routine appointments with GPs, Practice Nurses, Clinical Pharmacists and Physiotherapists from their central hub located on Upper Parliament Street, 7 days a week.

During June 2019 2,697 appointments were available, 2,429 appointments were booked (90%) and there were 387 DNAs. NCGPA continues to work closely with practices to maximise utilisation of appointments and reduce DNAs. Patient survey results continue to remain excellent.

Primary Care Patient Offer (PCPO)

The PCPO consists of a set of minimum standards and expectations of good quality primary care service providers. In Nottingham City 40 of the 50 GP practices are participating in this enhanced service. The PCPO includes a range of standards for access and quality.

3.1.2 Workload

During 2017/18 and 2018/19 funding has been used to increase resilience in primary care which includes training for practice managers, reception and clerical training.

The CCG has supported reception and clerical staff with the following training:

Workflow optimisation is an initiative that focusses on training practice administrators to process clinical correspondence such as letters from hospitals and referral services.

The training was rolled out across the City and 45 practices participated in the programme, with 117 members of practice receiving training. This involved training practice administrators on how to handle clinical correspondence, including read code training and techniques on how to log, understand and action correspondence in a safe, confidential and efficient manner. Each practice also had an appointed 'GP champion' who was invited to attend a specialist training session, to ensure they had a strong understanding of how the programme worked and how it could be implemented at their practice.

The programme has been well received in practices, empowering staff to deal with correspondences and reducing the GPs workload. It has resulted in up to 80% of the patient correspondence being processed without the involvement of a GP, freeing up approximately 40 minutes per day per GP and often allows the practice to take speedier action on some issues. An evaluation took place late 2018 which found that across Nottingham City over 1,000 GP hours were released in a year.

NHS England have also developed a GP Workload Tool, this tool sits within practices clinical system and allows practices to review appointment utilisation; patient demographics; multiple appointments/DNAs/cancellations; modes of access; wait times; and next available appointment. Thirty City practices were identified by the national team to test the tool and provide feedback. We have encouraged all our practices to review the information and suggest ways it could support capacity and demand within practice.

3.1.3 Workforce

SignpostingHealth was developed by the NCGPA to help practices deliver 'Active Signposting' training to all GP receptionists.

A total of 388 administration and clerical staff have been trained as 'sign posters' across practices with each practice having a Signposting Champion to lead the initiative locally within the practice. The 'sign posters' help patients get the right help first time and empowering patients to find services and self-care information for themselves in the future.

To support this NCGPA has also developed a website with a directory of services and self-care information. This [website](#) also links to other local health and social care service directorates produced by Nottingham City Council, CityCare and NHS Choices to avoid duplication and confusion for patients.

Resilience funding was made available to practices to develop schemes for the practice to become sustainable and more resilient in a changing environment. Schemes included specialist advice for human resources, for rapid intervention and management support for practices at risk of closure, to align back office functions such as policies and procedures, to support practices to prepare for CQC visits, to implement a standardised approach to health and safety across practices, and to facilitate GP engagement events to support the development of federations.

This also provided opportunities for practice manager development to provide training around change management, effective leadership, building personal resilience, developing coaching skills and supporting, and the establishment of Practice Manager Forums.

The Nottinghamshire GPFV workforce plan was delivered during 2018/19, creating a solid base to move to engagement and workforce planning with the newly established Primary Care Networks. The key aspects of the plan have been about supply, recruitment and retention which have focused on general practitioners but with success in the uptake of clinical pharmacist programme, approval of more fellowships than other areas and the creation of an overarching programme to manage all GP retention strategies.

The workforce plan has a strong alignment with the long term plan in looking to develop and embed new roles, develop flexible roles that meet individuals' career aspirations but also addresses developments to match population health needs with digital champions identified within the GP, nursing and practice manager roles across all Primary Care Networks.

For 2019/20 funding to deliver the GPFV will be at scale on an ICS (Integrated Care System) footprint across Nottinghamshire rather than individual CCGs. A working group including all stakeholders has been established and ideas and suggestions for schemes have been submitted. The working group has reviewed and prioritised the list of schemes with project leads identified to scope schemes in more detail. A summary of schemes is listed in **Appendix A**.

3.1.4 Estates

The four Greater Nottingham CCGs have an approved Estates Strategy which identifies the estates issues in each CCG and the opportunities for development. The strategies produced in 2016 were a requirement to enable each CCG to bid for capital funding from the Estates Transformation and Technology Fund (ETTF) to improve and extend existing buildings.

ETTF has also been used to support business cases for capital investment on new developments and over £4m has been invested in building, extending and improving primary care estate, targeted at boosting capacity in primary care. Nottingham City schemes are listed in **Appendix B**.

3.1.5 Models of care

Primary Care Networks (PCNs) have been established and configured across the ICS. The overarching aim is that PCNs will be at the heart of health and care provision; improving the wellbeing of our local populations through proactive, accessible, coordinated and integrated health and care services. The PCNs will work to collectively deliver localised care, and also with the ability of at scale working as part of the wider system. Patient ownership, activation and strengthened local communities will play an ever increasing vital role to ensure a comprehensive care offer to our population.

Nottingham City has 8 Primary Care Networks (PCNs), each PCN has a Clinical Director and all but one now has a Deputy Clinical Director. The NCGPA have supported the development of PCNs, providing functions on behalf of each PCN and overarching support in the continual development of the PCNs and Clinical leadership.

4. Conclusion

The CCG will continue to support the ICS and PCNs in the delivery of the requirements outlined in the GPFV to improve access, quality and the sustainability of primary care in Nottingham City.

Lynette Daws, Head of Primary Care – Nottingham City
September 2019

Appendix A – GPFV ICS schemes

PCN organisational development

To facilitate the organisational development of sustainable PCNs that have a shared vision, values, narrative, commitment and ambitions. This will indirectly support GP capacity and resilience but will include engagement of system partners to support system transformation

Group consultations

Group consultations to support practices to become more sustainable and resilient, better placed to tackle the challenges they face now and into the future, and secure continuing high quality care for patients

Health Care Assistant workforce training

To provide a programme of training to maximise utilisation of Health Care Assistant appointments in GP practices

Practice Manager ‘roving’ support

‘Roving’ practice management support to work with practices requiring operational assistance to achieve greater practice business resilience and a consistent approach to key practice business issues

Practice Manager training

The development and delivery of training for aspiring and existing Practice Managers to support GP practice resilience, with alignment to the ‘roving’ Practice Manager support scheme

Senior fellowship programme

To enable GPs to work more flexibly, reduce their sessions, providing the opportunity to undertake work in areas of interest

Fellowship Lite

To enable mid-career GPs to learn additional specialist skills e.g. gynaecology, emergency care etc in a community environment

General practice fundamentals programme (Practice Nursing)

The delivery of a coordinated and centrally delivered training programme for new practice nurses to improve delivery of services and capacity in general practice

Reception and Clerical staff training programme

The training is planned to build on areas such as workflow optimisation, care navigation, signposting health and correspondence management to reduce clinical time through upskilling and empowering administrative teams

Online consultation

Public facing digital services and access to online consultation is a key requirement within the new GP contract to provide a single point of access to digital health and care services

Appendix B - ETTF

ETTF schemes for Nottingham City include:

Family Medical Centre - The extension of the premises to provide additional clinical rooms to increase access and capacity

Strelley Health Centre - The development of an outline business case providing options for building redesign/improvement, this is currently being reviewed

Rise Park Surgery – The extension of the premises to provide additional clinical rooms to increase access and capacity, due diligence is taking place

Bridgeway Practice – The internal reconfiguration of the premises to provide additional clinical rooms to increase access and capacity

Tudor House Medical Practice - The internal reconfiguration of the premises to provide additional clinical rooms to increase access and capacity, due diligence completed and being reviewed

Rivergreen Medical Centre - The internal reconfiguration of the premises to provide additional clinical rooms to increase access and capacity

Sherwood Rise Medical Centre – Improvements to the building, feasibility study completed

Elmswood Surgery - Improvements to the building, feasibility study completed

Derby Road Health Centre - The extension of the premises to provide additional clinical rooms to increase access and capacity, awaiting value for money assessment

Cripps Health Centre – New build, awaiting rent review

Wollaton Park Medical Centre - The internal reconfiguration of the premises to provide additional clinical rooms to increase access and capacity

Hucknall Road Medical Centre - The internal reconfiguration of the premises to provide additional clinical rooms to increase access and capacity

HEALTH SCRUTINY COMMITTEE
12 SEPTEMBER 2019
THE NATIONAL REHABILITATION CENTRE
REPORT OF HEAD OF LEGAL AND GOVERNANCE

1 Purpose

- 1.1 To receive information on the proposals for the National Rehabilitation Centre (NRC).

2 Action required

- 2.1 To consider the nature and extent of further engagement and consultation required with citizens on the introduction of the NRC.

3 Background information

- 3.1 The NRC is a proposal for a new rehabilitation facility that sits alongside the Defence Medical Rehabilitation Centre, at Stanford Hall near Loughborough and is planned to open in Spring 2023.
- 3.2 The NRC will have 63 clinical beds, a research and innovation hub and training and education centre.
- 3.3 It is expected that the NRC will help to address a current gap in rehabilitation by increasing capacity in the East Midlands including treating a wider cohort of patient conditions.
- 3.4 Patient engagement has been carried out and will be expanded on as the clinical model and financial case for the NRC are further developed.
- 3.5 The Committee is asked to consider the nature and extent of further engagement and consultation required with the public in relation to the service change, and representatives from the Clinical Commissioning Group (CCG) will be at the meeting to provide further information,

4 List of attached information

- 4.1 Briefing note and appendices from the CCG.

5 Background papers, other than published works or those disclosing exempt or confidential information

- 5.1 None.

6 Published documents referred to in compiling this report

- 6.1 None.

7 Wards affected

7.1 All.

8 Contact information

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National Rehabilitation Centre

1.0 Introduction

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

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

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

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

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

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

Background

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

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

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

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

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

- the UK and particularly the East Midlands are underprovided for in relation to current need – in the East Midlands rehabilitation bed provision is at 33% of the level recommended by the British Society of Rehabilitation Medicine (BSRM)
- there is wide unwarranted variation in how rehabilitation is provided across the country and that rehabilitation is often uncoordinated
- owing to the under provision and lack of a coordinated pathway, patients endure long waits for access to rehabilitation and often need to be repatriated¹ to their local district general hospitals or Trauma Units from a Major Trauma Centre, to wait for a specialist rehabilitation bed to become available
- there is a substantial body of trial-based evidence and other research to support both the effectiveness and cost-effectiveness of specialist rehabilitation.¹
- early transfer to specialist centres and more intense rehabilitation programmes are cost-effective^{2,3}, particularly in the small group of people who have high care costs due to very severe brain injury^{4,5,6}.
- despite their longer length of stay, the cost of providing early specialist rehabilitation for patients with complex needs is rapidly offset by longer term savings in the cost of community care, making this a highly cost-efficient intervention⁷.
- for those patients who did receive specialist rehabilitation there was evidence of functional improvement in the vast majority (94%)
- that rehabilitation has been demonstrated to be very cost effective within a healthcare system. With a mean length of stay of 65 days, at a cost of £39,398 and reduced ongoing healthcare cost per patient of £536 per week, the cost of rehabilitation was found to be recouped within 17 months, with savings on ongoing healthcare costs of just over £500,000 per patient over their lifetime.

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

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

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

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

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

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

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

- the UK lags behind many other countries, with 50%-60% of people returning to work after a major injury after 6 months in Europe and the USA, while in the UK the figure is just 37%.
- there is also a disparity in performance between UK defence personnel performance and overall performance with 85% of military patients returning to military duties, against the overall, average UK figure of 37% at 6 months post-injury.
- the findings from several studies in the past few years, and the defence model such as that provided at the DMRC, all support early intervention and ensuring that patients are in the right setting for the appropriate stage in their recovery, particularly in the realm of return to work. Integrated service models have proved the most efficient, especially if associated with some degree of flexibility.
- this data indicates that there is an opportunity to dramatically improve outcomes for patients, including return to work rates. The benefits of a high-quality rehabilitation service with the capacity to provide early interventions, focused on work outcomes for people with ill health are significant:
 - reductions in sick leave and lost work productivity by more than 50%
 - savings in healthcare costs by two thirds
 - savings in disability benefits by 80%
 - reductions in permanent work disability and job loss by 50%
 - societal benefits by supporting people optimize functional capacity.

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

The Facilities

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

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

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

2.0 Proposed Clinical Model

2.1 Overview

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

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

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

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

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

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

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

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

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

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

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

2.2 Clinical Senate Recommendations

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

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

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

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

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

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

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

3.0 Impact Assessments

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

3.1 Travel Impact Analysis (TIA)

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

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

journey to the NRC. It would take two hours and five minutes on average to travel to the NRC by public transport.

The TIA highlights that planning for the National Rehabilitation Centre aims to transfer “patients to a rehabilitation bed in a timely way, reducing the number of patient moves, reducing the overall length of stay for the cohort of patients and gaining improved outcomes”. Reducing patient moves and the overall length of stay should mitigate some of the impact of longer travel times for visitors. There will be three family rooms available at the National Rehabilitation Centre. These facilities will offer the potential for reduced visitor travel, especially if priority is given to those living furthest from the National Rehabilitation Centre.

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

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

3.2 Equality Impact Assessment (EIA)

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

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

4.0 Engagement

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

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

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

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

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

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

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

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

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

The full report is attached.

5.0 Finance Case

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

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

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

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

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

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

6.0 Conclusion

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

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

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

Next Steps

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

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Partners in improving local health

National Rehabilitation Centre: Travel Impact Analysis



*National Rehabilitation Centre
East Midlands Region*

July 2019

Report Specification

Recipients

National Rehabilitation Centre, East Midlands.

Data Source

Sources

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

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

Geography

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

Data Receipt

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

Production

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Executive Summary

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

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

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

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

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

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

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

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

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

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

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

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

A small number of people, for example some of those from the Lincolnshire CCGs, would be particularly adversely affected. It is recommended that consideration is given to the availability of alternatives to treatment at the National Rehabilitation Centre for people living furthest from the

proposed site. Providing choice in the location of rehabilitation services will be particularly important for visitors who do not have access to a car.

Introduction

1.1 Background

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

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

1.2 Purpose of Report

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

Methodology

2.1 Scope and data sources

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

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

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

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

2.2 Rehabilitation sites

The following sites were included in the modelling:

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

2.3 Travel Impact Analysis modelling

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

As detailed postcode data for patients using rehabilitation services is not available, the population weighted centroid for each LSOA was used as a proxy for the patient's home address. The population weighted centroid is produced by the Office for National Statistics and provides a single summary reference point within the LSOA based on the distribution of the population in the LSOA¹. The easting and northing of this centroid was then used to enable travel distances to each rehabilitation site to be calculated.

Travel distances to each rehabilitation site were calculated using shortest / fastest path algorithms originally devised by Edsger Wybe Dijkstra². These algorithms form the basis for most methods of calculating travel time / distance. It was assumed that patients in each LSOA were treated in the nearest hospital to that LSOA.

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

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

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

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

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

2.4 Patient Confidentiality

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

2.5 Assumptions and Limitations

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

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

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

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

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

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

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

Results

3.1 Baseline

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

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

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

Figure 1 Home location of patients using rehabilitation services 2018:

Total Activity

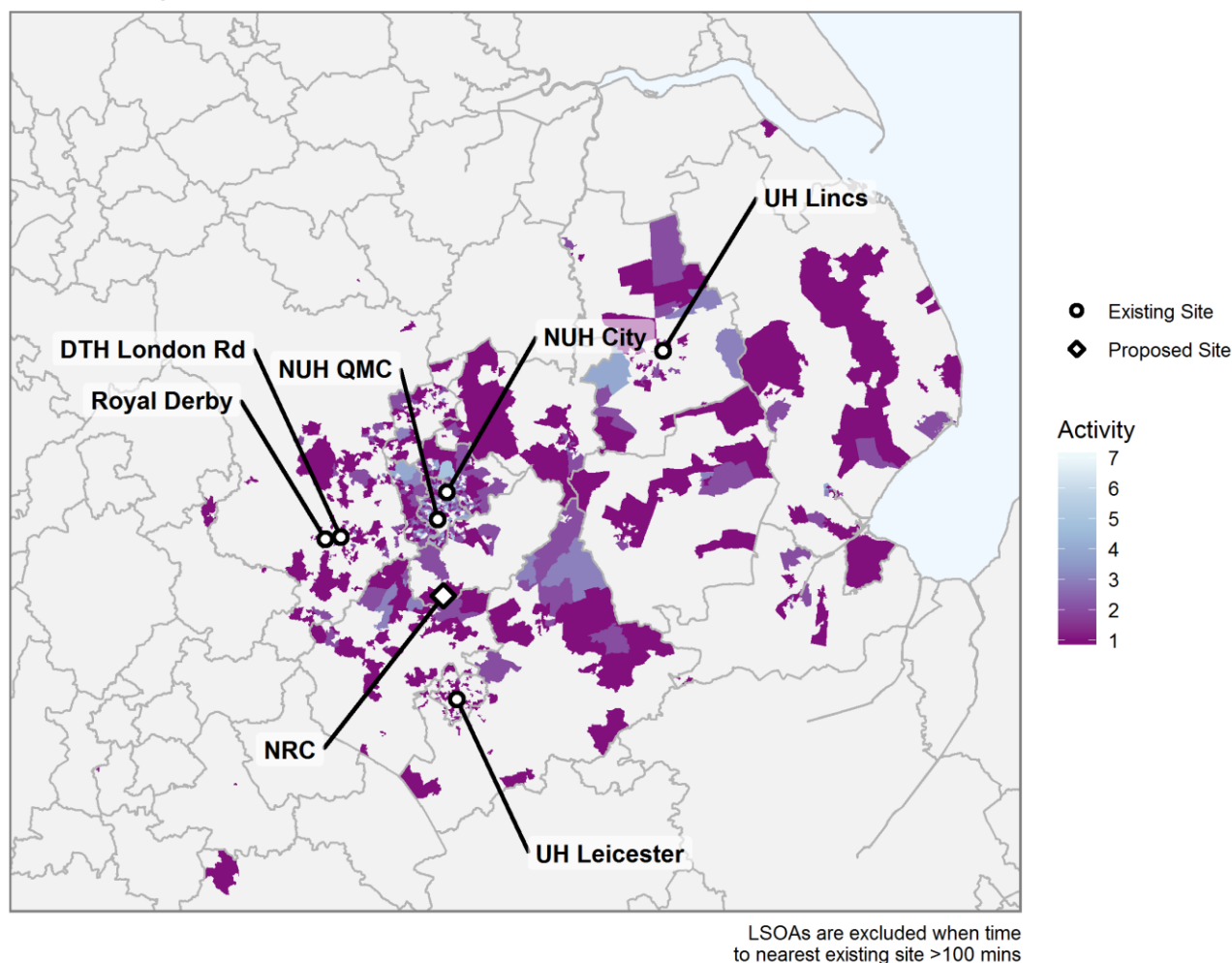


Table 1 shows rehabilitation activity in 2018 by the responsible CCG. As the hospital used was not included in the dataset, it is assumed that patients used the nearest hospital which will probably underestimate current travel. This shows that the Nottingham and Southern Derbyshire CCGs make greatest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

Table 1 Baseline by CCG 2018

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

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

Table 2 Baseline information on nearest current sites:

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

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

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

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

3.2 Modelling National Rehabilitation Centre Travel Impact: Distance

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

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

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

Table 4 Modelling travel to the NRC:

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

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

Table 5 Additional Modelling of travel to the NRC:

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

3.3 Estimated Travel Time by Car

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

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

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

Time to Nearest Existing Site

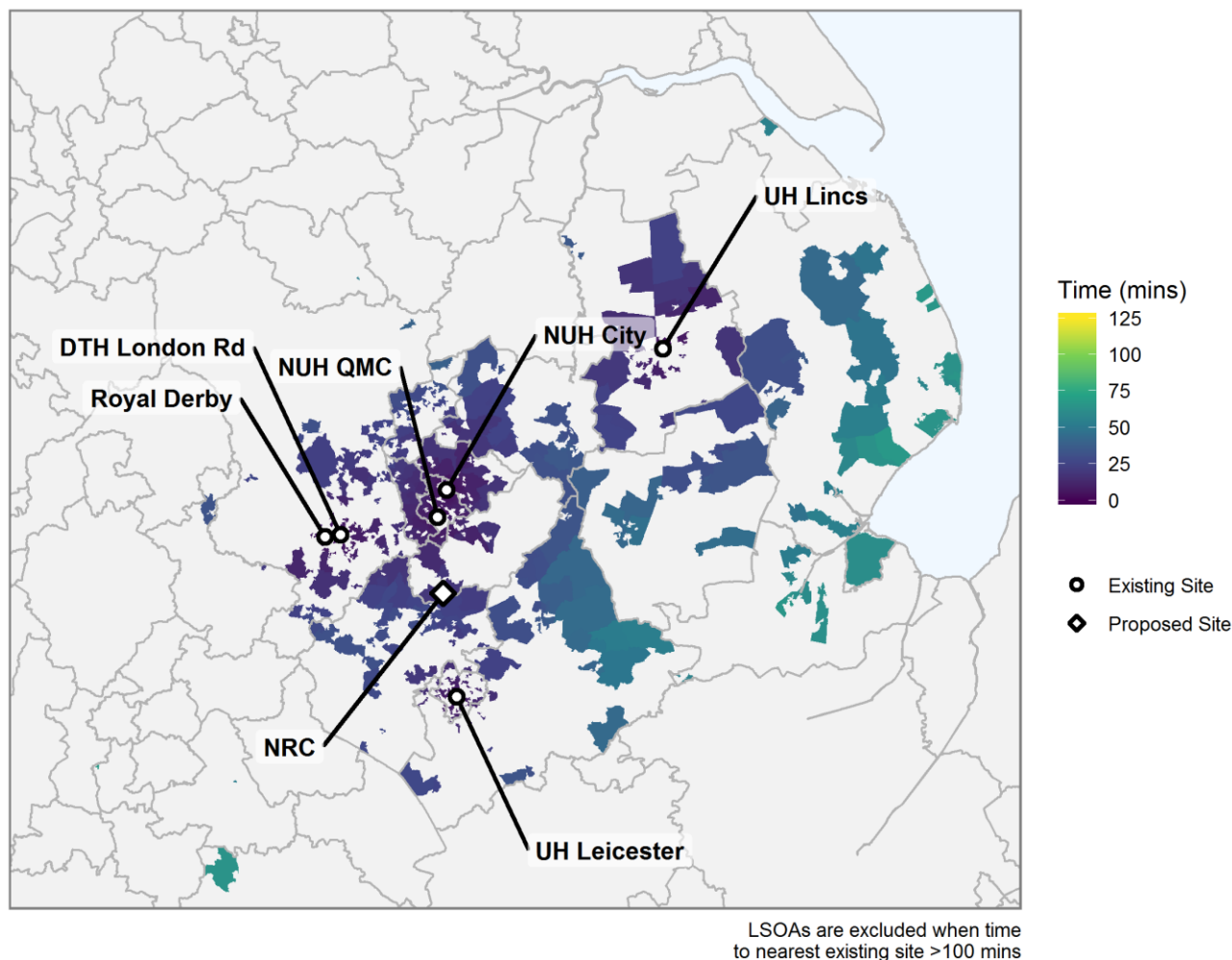


Table 6 shows estimated journey times by car to the current nearest hospital and the difference that would be incurred if the patient was instead treated at the National Rehabilitation Centre. Patients live on average 20 minutes by car from their nearest current site. This would increase to 39 minutes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

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

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

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

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

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

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

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

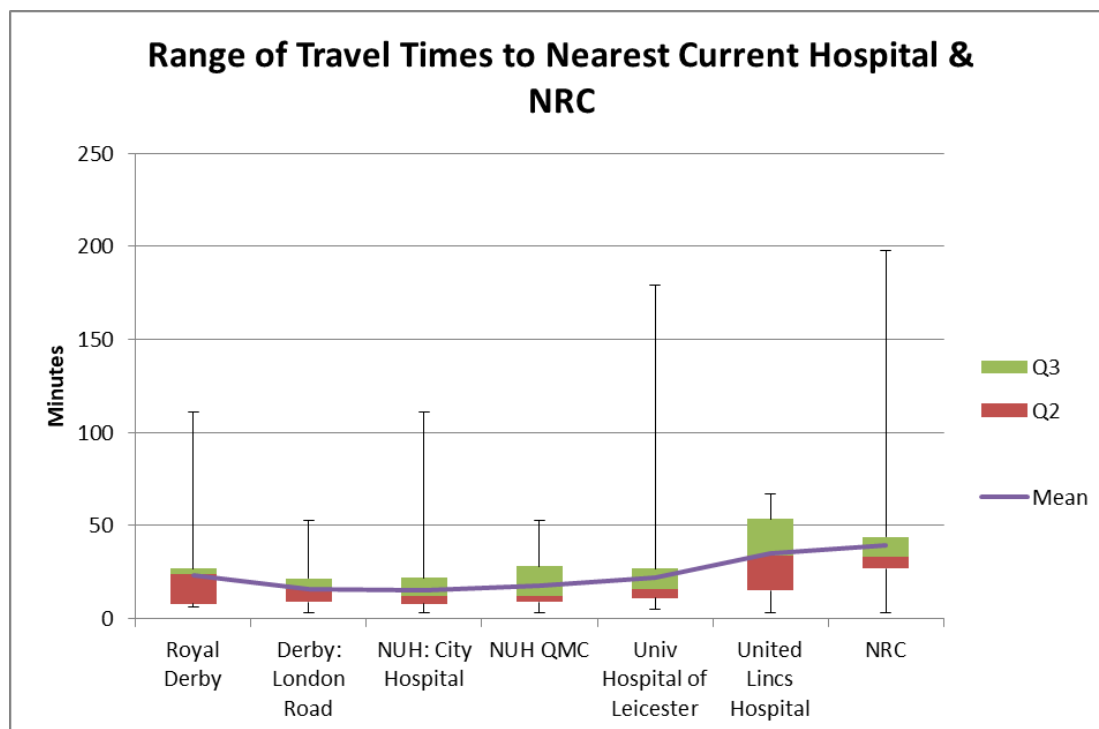
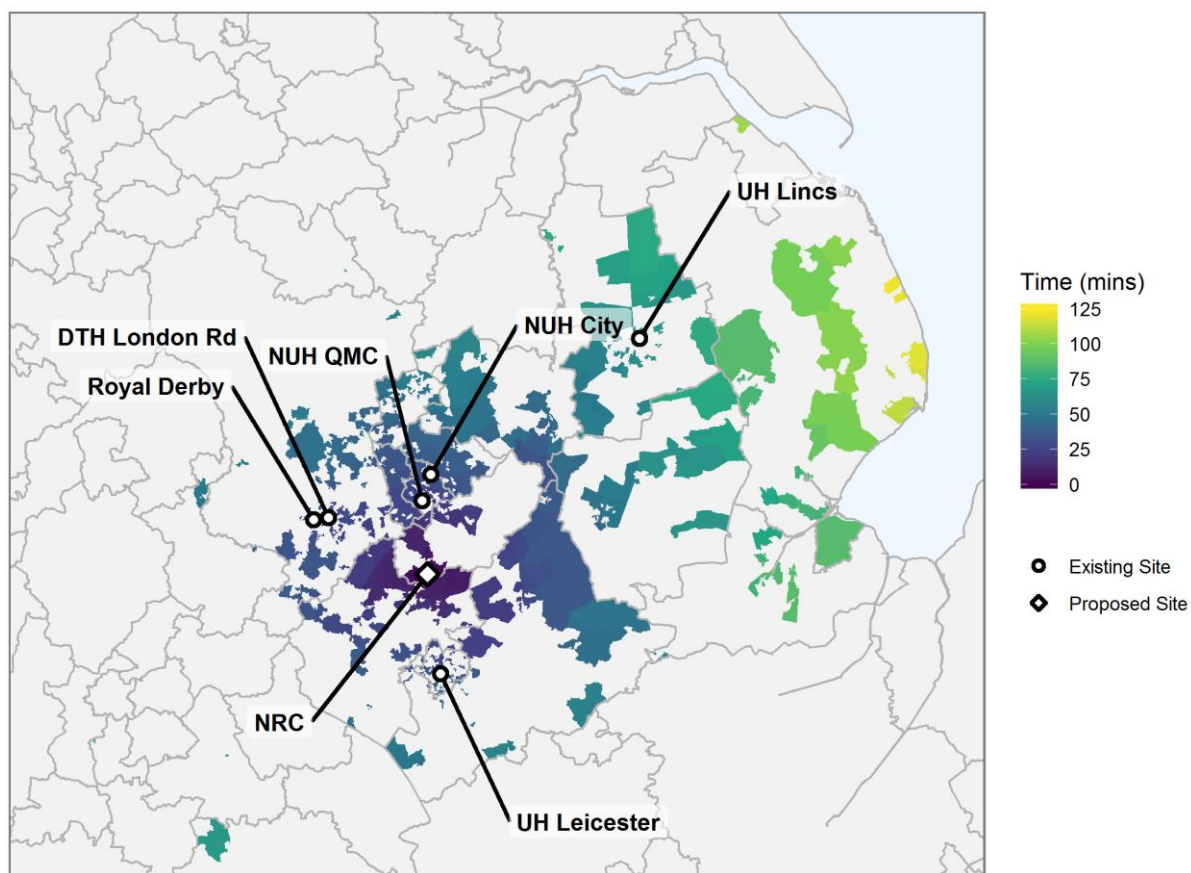


Figure 4 Travel Times by Car to the NRC:

Time to National Rehab Centre



LSOAs are excluded when time to nearest existing site >100 mins

3.4 Estimated Travel Time by Public Transport

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

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

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

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

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

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

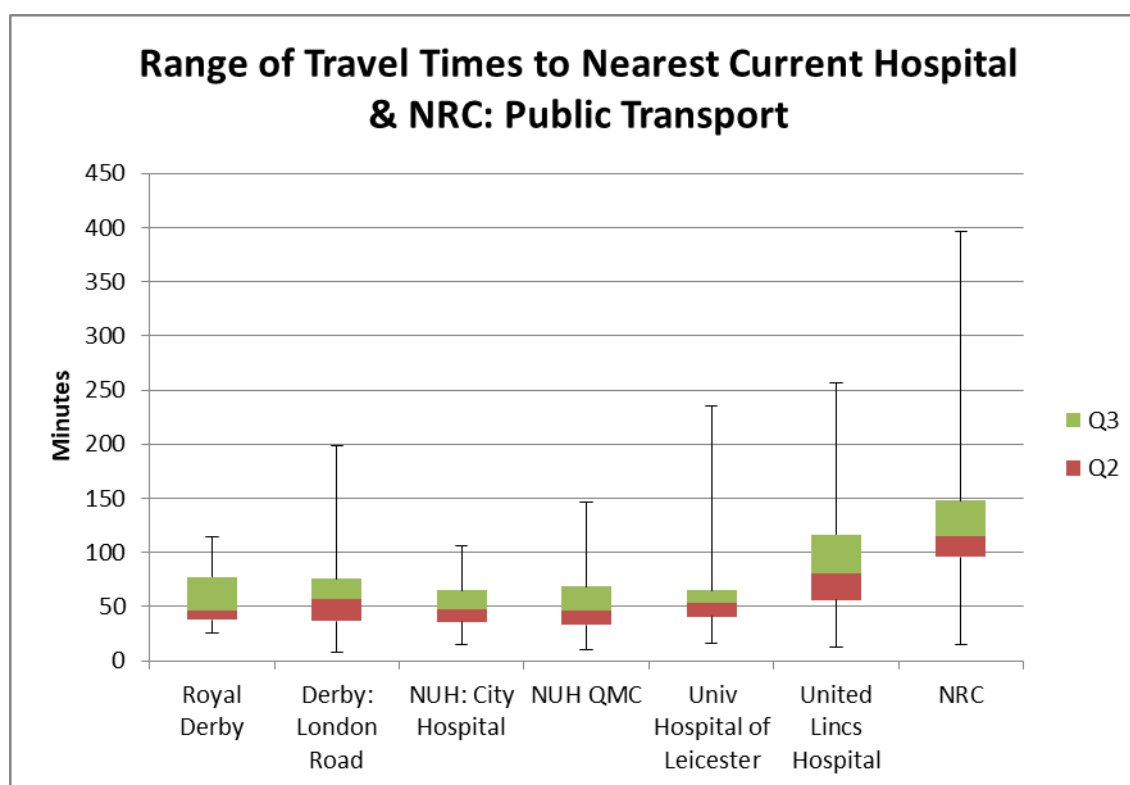
CCG	Ave. Time to Nearest Site (Single Journey Mins)	Average Time to NRC (Single Journey Minutes)	Average Difference To NRC (Minutes)	Minimum Difference To NRC (Minutes)	Max Difference To NRC (Minutes)
NHS EAST LEICESTERSHIRE AND RUTLAND CCG	73	138	65	9	236
NHS LEICESTER CITY CCG	42	132	89	42	209
NHS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

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

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

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

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



3.5 Other factors for consideration

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

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

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

Conclusions & Recommendations

4.1 Impact on patient journeys

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

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

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Proposed National Rehabilitation Centre in East Midlands:

Equality Impact Assessment

June 2019

Introduction

Our approach

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

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

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

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

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

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

Purpose and status of Equality Impact Assessment (EIA)

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

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

The following characteristics are protected under the Act:

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

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

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

What is an EIA and why conduct one?

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

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

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

The proposed change

The National Rehabilitation Centre (NRC) aims:

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

The core aims of the service are:

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

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

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

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

The population of the East Midlands

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

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

Overview of key themes highlighted in the EIA

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

Opportunities to advance equality of opportunity through the NRC

Narrowing inequalities through reducing disability and improving clinical outcomes

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

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

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

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

Reducing geographical inequalities in care and outcomes

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

Practice learning, research and development

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

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

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

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

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

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

Possible risks for equality of opportunity through the NRC

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

Understanding of Vocational or Occupational Benefit

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

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

Risk of increased travel

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

The NHS should continue to negotiate with public transport providers and the Highways Authority, in response to the forthcoming findings of the travel analysis to maximise ease of access for those visitors dependent on public transport.

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

Equality Considerations for Protected Characteristics and Health Inclusion Groups

Gender

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

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

Women are more likely than men to be working part time, or to be working as unpaid carers or providing unpaid childcare.

As vocational and occupational benefit is part of the referral criteria, it must be made very clear to referring hospitals that caring responsibilities are a vocation and an occupation.

This, combined with the male majority case mix for the centre, means that women are more likely to be visiting the centre and may be at more risk of becoming carers, depending on the outcomes of rehabilitation. These issues are picked up in more detail under the section on carers below.

Sexual Orientation, Gender Re-assignment and Gender Identity

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

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

Age

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

The Centre should work with referring hospitals to make sure they understand that some older adults may benefit from rehabilitation and be motivated enough and physically fit enough to benefit, on a case by case basis.

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

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

Race/ Ethnicity and migrants

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

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

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

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

Religion and Belief

People who have experienced a life-changing injury and who are receiving intensive rehabilitation may need spiritual support, as well as mental health support, especially if they already have a faith that is important to them.

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

Physical disability and sensory impairment

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

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

Referring hospitals should be offered advice on how to assess whether people with pre-existing disabilities or sensory impairment would benefit from intensive rehabilitation, and avoid unconscious bias about their likely quality of life gains and independence.

Learning Disability

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

unfamiliar environment of the unit. The Centre will have family rooms available, which should enable family members to come and provide support.

As mentioned under other headings, *referring hospitals must be clear that paid employment is not the only occupational or vocational outcome, and that people with learning disabilities must be assessed on a case by case basis to see if they could benefit.*

Mental Health

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

Pregnancy, Maternity and Parenthood

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

Carers

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

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

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

Socio-economic deprivation

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

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

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

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

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

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

Conclusions and recommended next steps

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

Recommendations

- 1) Develop explicit referral criteria that state that paid employment is not the only form of vocational and occupational benefit, and that unpaid care, family support, volunteering and social engagement must also be considered.
- 2) Support referring hospitals with training to address unconscious bias so that, on a case by case basis, older adults, people with existing disabilities (physical, sensory and learning) but a high level of motivation and ability to benefit and others who may be vulnerable to being discriminated against (e.g. people who are addicted to drugs) are considered for rehabilitation in a fair and consistent manner.
- 3) Provide ongoing advice and support for referring hospitals on a case by case basis, so that people who may benefit but have a pre existing disability, older adults and other vulnerable people can be discussed.
- 4) Proactively reach out to people with protected characteristics and people in EDS2 inclusion groups during the public consultation for the NRC and take action on their concerns.
- 5) Negotiate public transport access to the site with local public transport providers.
- 6) Use the patient cohort and research expertise at the NRC to identify and address equality issues, such as concerns raised that women are under treated due to unconscious biases around their pain response or need for rehabilitation, and other equality issues raised in the literature or during consultation.
- 7) Ensure that the NRC and referring hospitals seek appropriate translation services when necessary.
- 8) Take steps to address the spiritual needs of patients, where requested, by forming links with local faith communities.

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TRANSFORMING REHABILITATION FOR PATIENTS IN THE EAST MIDLANDS

Findings from qualitative research with patients and carers

July 2019

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1 Background

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

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

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

This report sets out the findings from this qualitative research.

2 Our approach

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

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

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

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

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

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

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

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

3 Findings from patient and carer insight

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

3.1 Experiences of rehabilitation services

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

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

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

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

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

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

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

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

3.2 Initial views about the National Rehabilitation Centre

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

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

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

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

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

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

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

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

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

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

3.3 The impact of the proposals on patients

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

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

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

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

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

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

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

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

4 Conclusions

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

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

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

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

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

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

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

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

HEALTH SCRUTINY COMMITTEE
12 SEPTEMBER 2019
REDUCING UNPLANNED TEENAGE PREGNANCIES
REPORT OF HEAD OF LEGAL AND GOVERNANCE

1 Purpose

- 1.1 To review work to reduce unplanned teenage pregnancy levels in wards with the consistently highest levels of unplanned teenage pregnancy.

2 Action required

- 2.1 To consider the information provided on the progress being made in reducing unplanned teenage pregnancies in the city.

3 Background information

- 3.1 In line with the national Teenage Pregnancy Strategy, published in 1999, reducing unplanned teenage pregnancies has been a priority in Nottingham for a number of years, with focused activity to reduce teenage pregnancy rates. Over that time there has been a reduction in the teenage pregnancy rate nationally and locally. In Nottingham the target to halve teenage pregnancy by 2020 was met by 2014, but the England under-18 conception rate remains higher than other Western European countries and the rate in Nottingham is still above the national average.
- 3.2 In 2017 the Committee decided to review whether the focus and investment in reducing unplanned teenage pregnancies in Nottingham over the previous 16 years had resulted in a sustainable reduction in teenage pregnancy rates. In March 2017, the Committee reviewed the latest data on teenage conceptions; evidence about risk factors associated with teenage pregnancy; the impact of teenage pregnancy and what works to reduce teenage pregnancy; services available in the Nottingham for prevention and early intervention and support; and current challenges, including the findings of the Joint Strategic Needs Assessment Chapter on teenage pregnancy. The Committee spoke to the Teenage Pregnancy Specialist and the Consultant in Public Health. At that time, the Committee was informed that if numbers continued to fall at the same rate then the City was on track to reduce teenage pregnancy in line with the ambition of the Council Plan. There had been a sustained reduction in levels of unplanned teenage pregnancy but there was still more work to do particularly to address variations across the city, for example, the Committee noted that the Aspley, Arboretum and Bulwell wards consistently had the highest rates of teenage pregnancy in the City.

3.3 The issue was also considered in 2018, when the Committee were informed:

- that it was difficult to know if pregnancies were planned or unplanned, particularly once mothers started to develop a bond as their perception of wanted and unwanted changed, so all teenage conceptions were included in the statistics;
- most data available related to 2013/14-2014/15 with some more recent information up to 2016;
- research showed that the majority of teenage mothers had, and would experience higher levels of deprivation and that they and their children would often experience poorer health and have lower aspirations;
- 2016 data showed that 127 teenage conceptions (13-18 years of age) were recorded in Nottingham which equated to 26.9 conceptions per 1,000 population in that age group. This was a 14% decrease on the 2015 figures;
- nationally there had been a downward trend in conceptions over the last 10 years and this had been mirrored in Nottingham. However, local data showed that conceptions varied during the course of any given year and therefore it was difficult to know if this was a consistent downward trend;
- with regard to teenage conceptions by ward, whilst in 2013-15 Bulwell was ranked as significantly higher than the city average for teenage conceptions, by 2016-17 it was no longer significantly different from the city average and Aspley, Bilborough, Berridge and Arboretum had the highest rates of teenage conceptions and were significantly higher than the city median. This may have been partly due to the focused preventative work taking place in Bulwell or the changing demographics, but careful consideration was on-going to identify and understand the contributing factors;
- it was acknowledged that the demographics of the four wards with significantly higher conception rates have very different populations, deprivation levels and Black, Asian, Minority Ethnic (BAME) and cultural mixes. Unfortunately it was not possible to identify ethnicity and cultural background of the cohort as, due to the small numbers involved, it could enable individuals to be identified. As a result, the information provided could only be anecdotal;
- some cultures encouraged marriage and childbirth at an earlier age and this fed through to the aspirations of young women. However, targeted work to engage with these communities was proving successful and with that comes a focus on raising the aspirations of young women. Where young women in these cultures were identified, sensitive enquiries were made to ensure they had the information and support they needed. The issues and challenges in these cultures were wide ranging and often included a lack of information or understanding of the services available for health, housing, etc and the need for young people to attend educational settings;
- in many instances, if it was considered normal within a family to have children young, then this tended to be a pattern which subsequent generations followed;

- a sexual health survey had been compiled by a sexual health consultant and Marie Cann-Livingstone aimed at young women aged 15-18 years of age, asking them about their experiences of sexual health services. The survey was undertaken face-to-face to ensure that there were no literacy barriers;
- deprivation was the most significant common element of areas with high conception rates and this was usually concentrated in urban environments. Blackpool had the highest rate of teenage conceptions in the country;
- the Council commissioned outreach services to support the most vulnerable young people, including:
 - support for teenage parents to help prevent further pregnancies;
 - ensuring that young mothers had an understanding of the employment training available;
 - access to relationship and sexual health advice and services;
 - GP focused information;
 - the 'C-Card scheme';
- as published statistics were always at least a year to 18 months old, it would be some time before the impact of initiatives became apparent;
- a better understanding was needed as to why young people did and didn't choose to access services which were available to them. The delay in available statistics was hindering progress in ensuring that successful approaches were identified and rolled out faster. Different service providers needed to ensure that the information they held could be used in conjunction with information held by other providers to inform decision making.

3.4 The purpose of this meeting is to review the latest data on levels of teenage pregnancy in the city and how this compares with national comparators, and the work which has taken place over the last year to further reduce unplanned teenage pregnancies in the city.

4 List of attached information

4.1 Briefing note from Marie Cann-Livingstone, Teenage Pregnancy Specialist, and Helene Denness, Public Health Consultant

5 Background papers, other than published works or those disclosing exempt or confidential information

5.1 None.

6 Published documents referred to in compiling this report

6.1 Health Scrutiny Committee minutes and reports, March 2017 and June 2018.

7 Wards affected

7.1 All.

8 Contact information

- 8.1 Laura Wilson
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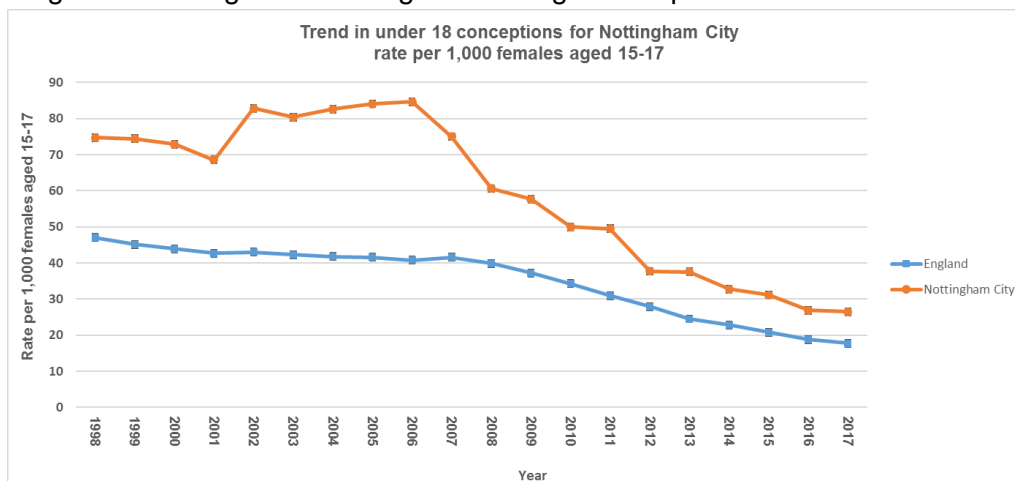
Progress toward reducing unplanned teenage in Nottingham: A report for Nottingham City Council Health Scrutiny Committee

12 September 2019

1 Teenage pregnancy in Nottingham

In Nottingham in 2017, the most recently available annual conception data, there was a decrease in the number of under-18 conceptions from 127 in 2016 to 125 in 2017 – a 1.6% decrease. During this 12 month time period the conception rate decreased from 26.9 per 1000 girls aged 15-17 to 26.5; a 1.5% decrease.

Figure 1: Nottingham and England teenage conception rate trend 1998-2017



Source: Office for National Statistics (2019) 2017 Conception Statistics England and Wales

The Nottingham under-18 conception rate has decreased significantly, by 64.5%, since the baseline year of 1998 when the under-18 conception rate was 74.7 (Figure 1).

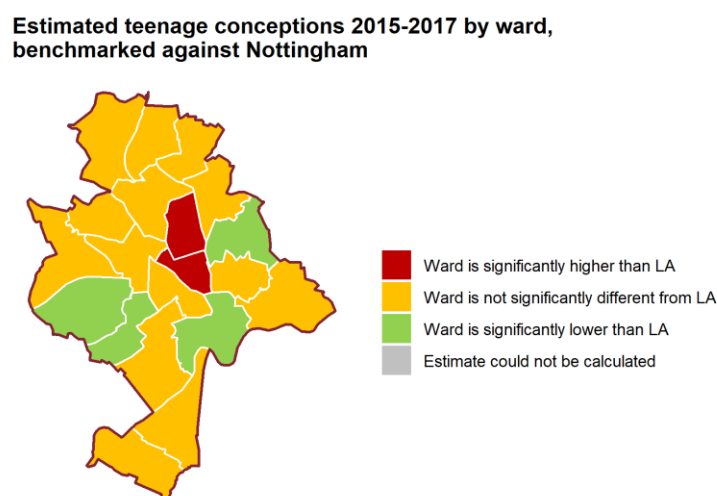
However, Nottingham's under-18 conception rate is still higher than the England average rate of 17.8 conceptions per 1000 girls aged 15-17 in 2017 and the Core Cities average of 23.4 per 1000. Nationally, and locally, around 80% of teenage conceptions are to 16 and 17 year olds and approximately 20% are to 13-15 year olds.

Figure 2 shows the teenage conception rates for individual wards. The aggregated data for the three years from 2015 to 2017 shows that the two wards of Berridge and Arboretum had rates that were significantly higher than the Nottingham average. This has changed from the last data reported, 2014 to 2016, when Berridge, Arboretum, Aspley and Bilborough all had rates significantly higher than the Nottingham average.

Work to tackle unplanned teenage pregnancy in Nottingham is delivered through universal services for children, young people and families as well as through targeted support for those most at risk.

Over the past few years we have directed some of our council commissioned services to work in Aspley due to the stubbornly high rates of teenage conceptions. Therefore, we cautiously hope that the targeting of services is having an impact as, for the first time in many years, Aspley does not have a rate significantly higher than the Nottingham average.

Figure 2:



Source: Public Health England (2019) Estimated ward conception rates for local authorities in England

2 Teenage pregnancy prevention and support services

Primary prevention services

- Nottingham City's Integrated Sexual Health Services for young people deliver accessible and integrated sexual health services within the community offering advice and support whilst offering the full range of contraceptive services.
- The C-Card scheme provides free condoms to young people aged between 13 and 24 at 37 registration points and a further 50 pick-up points across the City.
- General Practitioners provide information and contraception, including Long Acting Reversible Contraception (LARC).
- Pharmacies across Nottingham provide a range of services including emergency contraception and pregnancy testing.
- The Public Health Nursing for school-age children and young people service (formerly known as the School Nursing Service) provides information and practical support through a suite of options including the delivery of 'clinic in a bag'.

- The delivery of effective Relationships and Sex Education (RSE) is encouraged in all schools as an evidence-based approach to reducing teenage pregnancy rates Nottingham City Council.
- Family and Community Teams have staff trained to deliver sexual health, contraceptive and positive relationships advice for young people aged 13-25.

Early intervention and support services

- Termination of pregnancy services include counselling and support whilst making a decision and after the decision has been made.
- Accommodation services for vulnerable teenage parents and their children are available within bespoke self-contained hostel accommodation in the City.
- The Family Nurse Partnership programme provides support and guidance for up to 200 pregnant girls and mothers each year. It is an intensive health visiting programme that visits the teenager from early on in her pregnancy until the child is two years old enabling teenagers to have a healthy pregnancy, improve their child's health and development as well as plan their own futures and aspirations.
- The Education Officer for Teenage Pregnancy provides one-to-one support for pregnant teenagers and teenage parents to engage in education. The officer monitors the participation and attainment of all pregnant teenagers and school-age parents assisting them to overcome barriers.
- The Teenage Pregnancy Midwifery Service is available to support all pregnant under-18s offering flexible one-to-one care for teenage parents to increase self-esteem, promote a sense of self-worth and boost their confidence as parents.

What we have done since the last Scrutiny meeting to reduce teenage pregnancy?

- Mapped service provision at Medium Super Output Area (MSOA) level alongside conception rates. The latest versions of the maps will be available for consideration at the meeting.
- Improved equitable access to relationships and sex education (RSE) and successfully rolled out Nottingham's annual RSE Day nationally.
- Targeted resources toward reducing conceptions in the under-16 age group and within high-rate wards, for example, through meeting with the Heads of high-rate schools.

Marie Cann-Livingstone, Teenage Pregnancy Specialist, Nottingham City Council
Helene Denness, Public Health Consultant, Nottingham City Council
 4 September 2019

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HEALTH SCRUTINY COMMITTEE
12 SEPTEMBER 2019
WORK PROGRAMME
REPORT OF HEAD OF LEGAL AND GOVERNANCE

1 Purpose

- 1.1 To consider the Committee's work programme for 2019/20.

2 Action required

- 2.1 To discuss the work programme for the remainder of the municipal year and make any necessary amendments.

3 Background information

- 3.1 The Committee is responsible for setting and managing its own work programme.
- 3.2 In setting the work programme, the Committee should aim for an outcome-focussed work programme that has clear priorities and a clear link to its roles and responsibilities.
- 3.3 The work programme needs to be flexible so that issues which arise as the year progresses can be considered appropriately.
- 3.4 Where there are a number of potential items that could be scrutinised in a given year, consideration of what represents the highest priority or area of risk will assist with work programme planning.
- 3.5 Changes and/or additions to the work programme will need to take account of the resources available to the Committee.

4 List of attached information

- 4.1 Health Scrutiny Committee 2019/20 Work Programme.

5 Background papers, other than published works or those disclosing exempt or confidential information

- 5.1 None.

6 Published documents referred to in compiling this report

- 6.1 Health Scrutiny Committee reports and minutes.

7 Wards affected

7.1 All.

8 Contact information

8.1 Laura Wilson
 Senior Governance Officer
 0115 8764301
 laura.wilson@nottinghamcity.gov.uk

HEALTH SCRUTINY COMMITTEE WORK PROGRAMME 2019/20

DATE	ITEMS
17 October 2019	<p>Emergency Pathway Transformation Update To update the Committee on implementation of the new Emergency Department entrance</p> <p>Planning for Winter Pressures To update the Committee on the preparation work that is being done for the expected winter pressures</p> <p>Gluten Free Food Prescriptions To update the Committee on the effects of the implementation of the changes</p> <p>Prescribing over the counter Medication To update the Committee on the effects of the implementation of the changes</p> <p>Work Programme To agree the work programme for the remainder of the municipal year</p>
14 November 2019	<p>Treatment Centre Mobilisation A written update on the effects of the implementation of the changes</p> <p>Progress of Targeted Intervention Services To update the Committee on the effects of the implementation of the changes</p> <p>Healthwatch Annual Report To consider the annual report</p> <p>CityCare Provision of Out of Hospital Community Services Contract A review of the provision of the out of hospital community services contract</p> <p>Inpatient Detoxification Services A written update on the effects of the implementation of the new contract</p> <p>Work Programme To agree the work programme for the remainder of the municipal year</p>

DATE	ITEMS
12 December 2019	<p>Homecare Services Model To update the Committee on the implementation of the Homecare Services Model</p> <p>Young People's Mental Health and Wellbeing Services To update the Committee on the progress of the services</p> <p>Work Programme To agree the work programme for the remainder of the municipal year</p>
16 January 2020	<p>Work Programme To agree the work programme for the remainder of the municipal year</p>
13 February 2020	<p>Work Programme To agree the work programme for the remainder of the municipal year</p>
12 March 2020	<p>Work Programme To agree the work programme for the remainder of the municipal year</p>
16 April 2020	<p>Work Programme To discuss ideas for the work programme for the 2020/21 municipal year</p>