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Nottingham City Council
Health Scrutiny Committee

Date: Thursday 16 July 2020

Time: 10.00 am

Place: Remote - To be held remotely via Zoom - https://www.youtube.com/user/NottCityCouncil

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

Director for Legal and Governance

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

1 Apologies for absence

2 Declarations of interest

3 Minutes 3 - 8
To confirm the minutes of the meeting held on 12 March 2020

4 Covid-19 Pandemic

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(b) Changes to NHS Services 13 - 20
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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 at Ground Floor Committee Room - Loxley House, Station Street, Nottingham, NG2 3NG on 12 March 2020 from 10.00 am - 11.38 am

Membership

Present	**Absent**
Councillor Georgia Power (Chair)	Councillor Samuel Gardiner
Councillor Maria Joannou	Councillor Phil Jackson
Councillor Dave Liversidge	Councillor Kirsty Jones
Councillor Lauren O`Grady	Councillor Angela Kandola
Councillor Anne Peach	Councillor Cate Woodward (Vice-Chair)

Colleagues, partners and others in attendance:

Councillor Adele Williams	-	Portfolio Holder for Adult Care and Local Transport
Beth Carney)		Clinical Commissioning Group (CCG)
Matthew Lawson)		
Ajanta Biswas	-	Healthwatch Nottingham and Nottinghamshire
Laura Wilson	-	Senior Governance Officer
Catherine Ziane-Pryor	-	Governance Officer

49 Membership

It is noted that Councillor AJ Matsiko is no longer a member of the Committee.

50 Apologies for absence

Councillor Samuel Gardiner - personal
Councillor Phil Jackson - unwell
Councillor Kirsty Jones - unwell
Councillor Angela Kandola – work commitments
Councillor Cate Woodward – unwell

51 Declarations of interest

None.

52 Minutes

The minutes of the meeting held on 13 February 2020 were confirmed as a true record and signed by the Chair.

53 Discussion with the Portfolio Holder for Adult Care and Local Transport

Councillor Adele Williams, Portfolio Holder for Adult Care and Local Transport, delivered a presentation on the Adult Care aspect of her portfolio, and highlighted the following points:

a) Nottingham has a rapidly increasing population of 329,200, which is predicted to increase to 342,000 in 2026 and, whilst the population increases, the Revenue Support Grant has fallen from £126m in 2013/14 to £25m in 2020/21, which is a reduction of 80% with no further budgetary commitment from Central Government to support the restructure of Social Care going forward;

b) the largest proportion of the Adult Care budget is spent on older people, followed by mental health care, and care for learning disabilities;

c) Nottingham is the 11th most deprived area in England and experiences higher levels of poorer health, including limiting long term illness or disability, and lower employment rates than the national average;

d) the City Council's vision for Adult Social Care includes:

i. a life outside statutory services where possible;
ii. for citizens to live in their own home / have their own tenancy;
iii. for citizens to be well connected to their communities, have access to training, leisure and employment opportunities;

e) the 'Better Lives' and 'Community Together' programmes have been established with a preventative approach to adults entering the Social Care system, or at least with reducing need by building resilience within citizens' own community environment. This is further supported by the 'significant 7' staff training tool to help identify patient deterioration and address it to prevent admission to A&E or residential care homes, and support re-ablement;

f) with the aim to reduce residential care wherever possible for the benefit of citizens, and to meet budget restraints, citizens are to be better supported to live independent lives in their own homes with more control on their circumstances. This has included trialling the 'Nottingham Pathway' model of enablement support;

g) the transition for young people into Adult Social Care is to be made much smoother and aims to ensure that, where possible, they are able and supported, if necessary, to live independently in the community, including in shared houses;

h) the Council Plan 2019 to 2023 proposes to:

- develop the commitment to Nottingham being a dementia friendly city;
- protect from cuts frontline Social Workers;
- reduce the number of people experiencing loneliness and social isolation by 10%;
- set up a council-owned care company to improve quality of care and conditions of those caring;

i) the establishment of a council-owned care company is still in the early stages and a care delivery model is yet to be determined, but several options are being considered;

j) with regard to protecting cuts to front line Social Workers, there is an ongoing issue with recruiting and retaining Social Workers, but the intention is to encourage a 'home-grown' approach whereby there is the opportunity for existing care providers to develop and progress their careers;

k) partnership working is well-established and to be further progressed with the Primary Care Network (PCN) to be embedded in local community teams, with the local care model delivering efficiency and service improvements.

Questions from the committee were responded to as follows:

l) it is acknowledged the several private care homes have gone out of business, but this was primarily due to the oversupply of residential care places, which was unsustainable. When a care home is closing a team from the Council works with the home to focus on transition (including from hospital care) and re-ablement;

m) preventative care is hugely beneficial to citizens and the overall health service, but is costly to the social care budget. More funding is required at the right place and at the right time for preventative measures which, overall, will provide savings. If social care receiving citizens are admitted to hospital, they are less likely return to the same level of independent living which is not good for the citizen and results in a significant financial impact on social care budgets. The overall care budget for a citizen is from public money so there needs to be closer co-ordination of funding across the broader elements of healthcare, particularly where more complex needs are to be met;

n) the business case for the council owned care company is predicted to be presented next year, possibly on an 'arm's-length' basis;

o) whilst the PCNs are considered local, they cover a much larger area than is proposed for the local social care teams which, dependent on need, are likely to cover an area of no more than a few streets. Citizens must have a high level of autonomy and consideration is required to facilitate local connections within the resources available. There are proposals for panels of care providers, including Social Workers and Occupational Therapists, to determine the level of care package to be made available for each service user. Ideally there would be a base for carers and care receivers to access, but without an overburden of process. The have been suggestions that social care is returned to the responsibility of the NHS, but local councils have a better understanding of local communities;

p) Nottingham City Homes and the City Council have jointly created a partly supported living Mental Health Complex in Top Valley, which has proved a great success, with a further complex proposed for the Clifton area. It is hoped that this model can be expanded more broadly across the city.

Members of the committee expressed concern on the following issues:

q) there are still significant number of un-safe hospital discharges across the sector when the emphasis is placed on pursuing savings. This has to be addressed with increased co-ordination between providers and ensuring that appropriate support, including care plans with occupational therapists and Social Workers are in place prior to discharge;

r) although there is a commitment to protect frontline services such as Social Workers, 10 Social Worker posts in Adult Social Care have been lost in the past year. There are national problems with recruiting and retaining Social Workers, who also experience high levels of sickness. There needs to be better understanding of these issues and for them to be addressed;

s) Social Workers are often expected to comment and advise on areas of re-ablement which come under the medical remit of Occupational Therapists. Social Workers are not equipped to make medical decisions and it is unfair and inefficient to expect them to do so. Occupational Therapists are able to identify specific need and recommend appropriate responses;

t) the Loneliness Strategy tends to focus on older people with little reference to young people and their needs. Low-level loneliness needs to be addressed as part of a council-wide agenda throughout the city.

Resolved to note the update and record the thanks to Councillor Adele Williams for her attendance.

54 Gluten Free Food Prescriptions

Matthew Lawson, Senior Medicines Management Dietician, from the CCG, was in attendance to update the committee following gluten free food being withdrawn from prescription during December 2018.

Some members of the committee expressed concern that the cost of gluten free bread from supermarkets was excessive, starting at £2 per loaf, adding that concerns continued that people on a low income may find it particularly difficult to maintain a gluten free diet and therefore their health.

The following points were highlighted and responses provided to members questions:

a) following public consultation, which included GPs and clinical groups, gluten free food was withdrawn from prescription to align practice with the approach taken in the Greater Nottinghamshire area;

b) the withdrawal of prescription availability is now in line with other autoimmune conditions such as diabetes, in that specialist foods are not available on prescription and patients are encouraged to manage the condition through lifestyle changes;

c) to date there have been very few complaints on the withdrawal, prior to which GPs were briefed on the support and education available for people with coeliac disease, to ensure they are able to maintain a gluten free diet;

d) there are clinical risks for people with coeliac disease who do not follow gluten free diet, however, people need to take responsibility for themselves and manage the condition through lifestyle changes. There are more gluten-free alternatives available in supermarkets than ever before and there are plenty of naturally gluten-free foods and products available;

e) patients still have access to dietary advice and support and the saving of £160,000 which has been achieved from the withdrawal of prescription gluten free foods, can now be used to raise awareness and support education services and advice, including the gluten free workshop, following a diagnosis of coeliac disease, or if dietary discipline issues or misunderstanding occur;

f) there is also additional support and advice available from Coeliac UK and other organisations;

g) although prescriptions for gluten free foods have overall been withdrawn, where individual GPs feel there is a significant need for particularly vulnerable citizens, they are able to provide a limited selection of gluten-free food on prescription. However, this is monitored and education in nutrition considered the preferable route;

h) patient feedback, and complaints, if received, will continue to be monitored.

Resolved to note the update, included the added emphasis on education and lifestyle change, and to thank Matthew Lawson for his attendance.

55 Over the Counter Medication Prescriptions

Beth Carney, Associate Chief Pharmacist in Medicines Management, from the CCG, was in attendance to update the Committee on the impact of withdrawing over-the-counter medication from prescription.

The following points were highlighted and responses provided to the committee's questions:

a) prior to withdrawing over-the-counter medication from prescription, there had been broad consultation and consideration of the availability of self-care medication;

b) over-the-counter medication prescriptions were withdrawn in November 2018 for items where there is no evidence of clinical benefit, such as for lozenges for a sore throat, and pain medication for short term problems, etc;

c) approximately £109,000 has been saved since November 2018 , with only two patient complaints, although this will continue to be monitored;

d) it is not known how many patients have been affected, but GPs maintain prescribing discretion for particularly vulnerable patients;

e) some medication which is required for long term prevention or treatment, such as aspirin for blood thinning and long-term painkillers, continue to be prescribed.

Members of the committee added that for patients paying for prescriptions, sometimes the cost of the prescription was significantly higher than the over-the-counter price.

Resolved to note the update, and thank Beth Carney for her attendance.

56 Work Programme 2020/21 Development and 2019/20 Work Programme

Laura Wilson, Senior Governance Officer, presented a report on some potential issues for scrutiny by the Committee for the 2020/21 municipal year. Committee members identified the following as important issues to address:

- actions in the city with regard to ward health profiles;
- self-harm, with focus on young people;

- adult mental health crisis services;
- review of the response to the coronavirus;
- an update on the takeover of the treatment centre (scheduled for July 2020);
- general dental care, including continuity and availability of care;
- an update on GP service provision and GP Access

Resolved to schedule the above topics for consideration in the 2020/21 municipal year.

57 Work Programme 2019/20

Laura Wilson, Senior Governance Officer, presented the proposed work programme for the remainder of the municipal year, and highlighted the request for members to volunteer to participate in working groups to consider the Quality Accounts for Nottingham University Hospitals NHS Trust, Nottinghamshire Healthcare NHS Foundation Trust, CityCare and East Midlands Ambulance Service NHS Trust.

Resolved to

1) to approve the work programme for the remainder of the 2019/20 municipal year;

2) establish working groups to consider and provide comments on the Quality Accounts for Nottingham University Hospitals NHS Trust, Nottinghamshire Healthcare NHS Foundation Trust, CityCare and East Midlands Ambulance Service NHS Trust.

Health Scrutiny Committee
16 July 2020

The Impact on Nottingham

Report of the Head of Legal and Governance

1 Purpose

1.1 To receive information on the impact the Covid-19 pandemic has had on Nottingham city.

2 Action required

2.1 To consider the information provided, use it to inform questioning, and decide issues for future scrutiny.

3 Background information

3.1 This meeting will provide the Committee with an overview of the impact of the pandemic on Nottingham city, to enable the Committee to decide on areas for future scrutiny.

3.2 Public Health representatives will be at the meeting to present the information and answer queries from the Committee.

4 List of attached information

4.1 Report from the Director of Public Health.

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

8.1 Laura Wilson
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COVID-19 in Nottingham City

1. Background

The World Health Organisation (WHO) declared COVID-19 an infectious disease, caused by the newly discovered Coronavirus, a pandemic on 11th March 2020. Most people infected with the COVID-19 virus experience a mild to moderate respiratory illness and recover without requiring special treatment. Older people, and those, with underlying medical problems are more likely to develop serious illness. At this time there are no vaccines for COVID-19.

2. Local Context

At the time of writing, there have been 1,172 lab-confirmed positive cases in Nottingham City across all settings (pillars 1 and 2). This information is updated daily and made publically available by Public Health England (PHE). This equates to 354 positive cases per 100,000 residents, lower than the overall England rate of 439.1 and the second lowest of the English core cities. As with the national picture, the daily number of new cases in Nottingham peaked in mid-April has been in continual decline since.

The first COVID-19 deaths in Nottingham were in the week ending 27 March 2020. In total (up to 26 June 2020) there have 231 COVID-19 deaths in Nottingham City (data published by ONS). The majority of these have occurred in hospital (58%) but a significant number have also occurred in care homes (36%). As with positive cases the number of COVID-19 deaths peaked in mid-April (44 deaths in the week ending 17 April 2020) and has continually declined since this point. In the three most recent weeks for which data has been available there have been 3 COVID-19 deaths in Nottingham City per week.

3. Disparities in the risk and outcomes of COVID-19

It has been clear since the early stages of the pandemic that the health impacts are likely to be unequal, and to exacerbate pre-existing health inequalities. This was confirmed by a PHE review into the disparities in the risk and outcomes of COVID-19. Disparities have been observed in relation to a number of factors, the largest of which is age. Nationally, and locally, the highest number of cases and deaths have continued to be seen in the older age groups, in particular in the 85+ age group.

The risk of becoming seriously ill or dying with COVID-19 is also greater for black and minority ethnic groups. PHE's 'Beyond the data' report discusses the role of factors associated with ethnicity including occupation, population density, use of public transport, household composition and housing conditions in COVID-19 transmission, and of inequalities in pre-existing health conditions.

Differences have also been observed in relation to deprivation and occupation.

The national evidence and information is being combined with local intelligence to inform a framework for action that builds on Nottingham's existing assets, to reduce health inequalities both in relation to COVID-19 and beyond.

4. Nottingham's response to COVID-19

The Nottingham and Nottinghamshire Local Resilience Forum has been at the forefront of the multi-agency response to COVID-19 across the City and County. The nature and scale of the pandemic has required the Council and partners to reallocate resource at pace.

This includes, but is not limited to;

- Establishing local arrangements to make sure urgent needs for Personal Protective Equipment could be met in a timely way, including a centralised ordering and distribution system.
- Ensuring sufficient and accessible local testing capacity colleagues for key workers and the wider community.
- Working closely with external care and support providers to provide a range of support.
- Provision of shelter for rough sleepers to ensure they were able to socially distance and self-isolate as per the national guidance.
- Establishing the Customer Services Hub, enabling citizens to raise requests for help. Since March 2020 over 2,000 requests have been received, over 2,000 emergency food parcels delivered and over 70 volunteers recruited. Over 17,000 citizens identified as shielding by the Government or as socially vulnerable by local GPs were also proactively contacted and offered support.

5. NHS Test and Trace and Local Outbreak Control Plan

As we move past the peak, and lockdown measures are eased, the focus has shifted to containing the disease through testing and tracing. Nationally this is delivered through the NHS Test and Trace programme, which contacts individuals with a positive test result, identifies their close contacts and advises them to self-isolate for a 14 day period.

This is complemented at the local level through the local authority led development and delivery of Local Outbreak Control Plans. Nottingham City's plan, published on 30 June 2020, is available on the Council's website. The plan sets out how the Council and partners will mitigate the risk of and manage any further outbreaks of COVID-19.

Key features of the Plan include the ongoing local surveillance of key data indicators and local 'soft' intelligence brought together at a daily Outbreak Cell, identification of potential 'high-risk' or complex settings and the production of Incident Management Plans for these to enable a swift response should it be required, and the establishment of Local Outbreak Control Engagement Boards to ensure effective communication with local communities.

6. Conclusion

COVID-19 has had significant impacts, beyond the impact on the health of those directly affected and the impact on the family and friends of those who have sadly died as a result. Lockdown has impacted the population's mental health, as well as had an economic impact both on individuals and the wider economy as a whole. Children and young people have been impacted by school closures, with inequalities likely to be evident. These impacts will continue to felt over the longer term and easing of lockdown will bring new challenges. As we move into recovery it is important that the reduction of health inequalities plays a central role. Whilst these challenges should not be underestimated Nottingham's strong partnership approach means it is well placed to tackle them.

Health Scrutiny Committee
16 July 2020

Changes to NHS Services

Report of the Head of Legal and Governance

1 Purpose

1.1 To receive information on the changes made to NHS services to respond to the Covid-19 pandemic.

2 Action required

2.1 To consider the information provided, use it to inform questioning, and decide whether any further scrutiny is required.

3 Background information

3.1 Several changes to services have been made to NHS services over the last few months to respond to the Covid-19 pandemic.

3.2 The Committee have been kept informed of the changes via emails from the Clinical Commissioning Group (CCG). Representatives from the CCG will be present at the meeting to discuss the changes in more detail and answer queries from the Committee.

4 List of attached information

4.1 Briefing notes from the Clinical Commissioning Group detailing the service changes.

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

8.1 Laura Wilson
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Changes to services to support the Covid-19 response

Briefing for Health Overview and Scrutiny Committee

8 June 2020

Dear Colleagues,

You will be aware that as a commissioner of local health services we have been working closely with NHS Providers and other bodies in our response to Covid-19. Part of this work involves making changes to local services to manage the increased demand on our hospitals.

Some of the changes we have made have been mandated nationally, for example reducing face-to-face appointments and postponing the provision of some non-urgent services. Other changes have been made by the local system, in response to locally specific circumstances. This includes local implementation of national guidance, for example where staffing levels are becoming unsafe for a non-urgent service to continue.

The degree of pressure on the system and the rapid pace at which we have had to respond to protect the safety and welfare of patients and staff has meant that it has not always been possible to notify the Local Authority of changes that, in normal times, you would be consulted on. In the main, changes have been made by providers to manage workforce and operational pressures and to maintain patient safety. They have not been commissioned by the CCG.

We have provided retrospective briefings on a number of temporary service changes, discharging our statutory duty to notify the Local Authority of substantial change to a health service. We have now compiled a full list of all service changes that have been made in response to the Covid-19 pandemic and have included this with this briefing.

Over the next two weeks we will be undertaking analysis to identify which of the changes need to be reversed as soon as it is safe to do so, and which we are considering making permanent. The latter will include changes that have been made that are aligned to the ambitions in the NHS Long Term Plan and have made a positive impact on health outcomes.

Once we have undertaken this initial assessment we will discuss with you the viability of adopting some of the changes permanently, subject to the usual procedures for considering changes to services.

We are providing the full list of service changes now in the spirit of transparency and to support future discussions with you on potential areas that we may want to consider and/or consult on for permanent change.

We want to reassure you that any temporary service change made in response to Covid-19 will be done so with the safety and care of patients at the centre of our decision-making.

For more information please contact:

Amanda Sullivan

Accountable Officer

amanda.sullivan7@nhs.net

List of service changes made to support the Covid-19 response

All changes have been made to support a number of principles for care:

- Ensuring adequate hospital and intensive care capacity for patients who need acute care as a result of Covid-19
- Keeping staff and patients safe in healthcare environments (including cohorting of infected patients, infection prevention and control and workforce deployment)
- Reducing face-to-face contacts where care can safely be delivered via alternative methods
- Supporting the most vulnerable members of the population.

Primary Care

Description of change	Briefing issued
Introduction of Clinical Management Centres (CMCs) to allow general practice to function effectively during the COVID-19 outbreak.	Y 4/4/2020
Introduction of a new GP operating model including greater use of remote working; phone and video consultations; suspension of routine non-urgent appointments	N
Enhanced support to care homes from GP Practices	N

Urgent Care

Description of change	Briefing issued
Development of a single discharge pathway	N
Relocation of the primary care element of the Urgent Treatment Unit (UTU) at QMC to Platform 1, Upper Parliament Street	N
Temporary overnight closure of Newark Urgent Treatment Centre (UTC) from 22:00 – 09:00 from 6 April. A further extension has been proposed due to ongoing workforce pressures – we will provide a separate briefing on this.	Y 3/4/2020
NUH are developing plans to transfer hyper acute stroke services from Nottingham City Hospital to QMC, to support winter planning and infection prevention and control measures - we will provide a detailed briefing on this when we have further information	N

Mental Health

Description of change	Briefing issued
Open access all age 24/7 crisis line set up	N
Reduction or suspension of face-to-face contact and increased use of phone and video consultations and online resources for the following: Crisis Teams; Local Mental Health teams; Community Mental Health Teams; CAMHS; Kooth; Sharp; Harmless project	N
Temporary use of Haven House crisis house as a step down unit to support discharge (change now reversed)	Y 28/4/20
Recovery College services suspended and staff deployed to other areas	N
CAMHS support to schools via in-reach	N
Alexander House locked rehabilitation service designated as an isolation unit, with patients transferred to the Orion Unit at Highbury Hospital	N

Planned Care

Description of change	Briefing issued
Block Contracts established with Independent Sector providers to create additional bed capacity	N
Move from face-to-face to virtual clinics for outpatient services where appropriate	N
Postponement of all non-urgent elective operations	N
Suspension of community non-obstetric ultrasound service	N
NUH suspended faecal sample testing	N
SFH Suspension of termination of pregnancy service – service to recommence from 9 June (community service continued)	N
Temporary suspension of home births service by SFHT and NUH - NUH have since re-established a restricted home births service	Y 13/5/20

Children and Young People

Description of change	Briefing issued
Integrated Community Children and Young People's Healthcare Programme: Routine reviews of respiratory conditions delayed except for at risk patients; routine referrals delayed; therapy services delivered by video conferencing or phone.	N
Out of hospital community services stopped except clinical priority services; child protection medicals; phone advice and urgent referrals	N
Rainbows Childrens Hospice: Respite Short Breaks suspended; family support services by video and phone; adult day care suspended	N

Community care

Description of change	Briefing issued
Community Orthoptics service suspended all non-essential face-to-face services and increased use of video and phone consultation	N
Community diabetes nursing teams suspended clinics and education courses	N
Face-to-face community rehabilitation suspended, except for patients who have had recent elective surgery; fractures or those with acute and complex needs	N
Neuro rehabilitation - Chatsworth Unit patients discharged to community provision and inpatient function temporarily closed to admissions	N
Community podiatry and podiatric surgery services suspended, except for high risk patients	N
Community services provided by Primary Integrated Community Services (PICS) suspended all non-essential face-to-face interventions	N
Community MSK groups suspended	N
Community specialist nursing service suspended	N

Changes to community pain management services, including suspension of face-to-face consultations; greater use of video and phone consultations and suspension of steroid injections	Y 18/5/20

Health Scrutiny Committee
16 July 2020

National Rehabilitation Centre – Updated Consultation Plan

Report of the Head of Legal and Governance

1 Purpose

1.1 To receive information on the updated consultation plan in relation to the National Rehabilitation Centre (NRC).

2 Action required

2.1 To consider the updated consultation plan and provide feedback, where necessary.

2.2 To note the proposal to carry out a public consultation on the proposals, for a period of 8 weeks, from 27 July 2020.

3 Background information

3.1 At its meeting on 16 January 2020 Lewis Etoria, Nottingham and Nottinghamshire Integrated Care System, and Hazel Buchanan, Clinical Commissioning Group, provided an update on consultation activities focusing on a new rehabilitation centre, since attending September 2019 meeting of the Committee, and provided the following information:

a) a high demand for rehabilitation services had been identified in the East Midlands, and as there was no national strategy and the land had been made available with a guaranteed ring fenced funding of £70 million for construction, this provided a good opportunity;

b) existing rehabilitation services were based at Nottingham City Hospital's Linden Lodge, but the current building required a substantial amount of investment and maintenance and could not be adapted to facilitate modern medical approaches;

c) nationally, the NHS approach towards rehabilitation was focused only on neurological, but this proposal would enable a broader treatment model to be provided, including complex fractures, mental health and every element of rehabilitation, including acting as a hub for community focused services;

d) patients would be able have access to the defence site's facilities including a hydrotherapy pool, a simulator, an MRI scanner and x-ray facilities;

e) although there was likely to be a transfer of existing staff and services, additional posts such as Rehabilitation Instructor and Case Manager would be established as part of the broader model;

f) travel to the site for visitors (not patients) had previously been raised as a concern, but there would be free parking on site, a bus to and from Nottingham City Centre, and discussions were underway with the voluntary community transport teams, whilst other options would continue to be explored;

g) consultation would start on 9 March 2020 for a period of 6 weeks and comment invited on issues, including patient isolation due to the location, travel and access for family and visitors visiting patients at the site.

h) concerns around travel to the sites were acknowledged so some outpatient appointments would be held at City Hospital once patients had been discharged back into the community;

i) every patient would have a Case Manager who would help and support patients back into society, including forward planning for benefits applications, housing issues and adaptations and, where necessary, connecting with social workers and linking with wrap-around services, ensuring that everything required was in place in time for discharge;

j) if the proposals were accepted, the new facility could be open and functioning by April 2024;

k) once consultation was concluded, the findings would be scrutinised, it was anticipated that a recommendation would be presented to the governing body in May 2020.

3.2 Due to the Covid-19 pandemic, the consultation was postponed 3 and a briefing was provided to Committee members in April 2020 seeking views on running the public consultation without face-to-face contact.

3.3 Committee members provided comments and feedback on the proposal to undertake the consultation through non-contact methods, which hae been considered and the consultation plan has been revised to respond to the issues raised.

3.4 The comments from the Committee and the responses to them are included in the attached briefing note, and a representative from the CCG will be in attendance at the meeting to discuss the proposals.

4 List of attached information

4.1 Briefing note from the CCG and updated consultation plan.

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 reports and minutes – September 2019 and January 2020.

7 Wards affected

7.1 All.

8 Contact information

8.1 Laura Wilson
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NHS Rehabilitation Centre – Update to the Nottingham City Health Scrutiny Committee July 2020

Briefing

1. We updated the Committee on our proposals for establishing an NHS Rehabilitation Centre at the Stanford Hall Estate, which hosts the Defence Medical Rehabilitation Centre (DMRC), in September 2019 and January 2020.
2. We previously notified the Committee of our intention to launch a public consultation on these proposals in March 2020. Due to the Covid-19 pandemic, this consultation was postponed.
3. In April 2020 we provided a briefing to the Committee, seeking views on running the public consultation without face-to-face contact. In that briefing we noted that we had sought specialist advice from the Consultation Institute and legal advice from our Solicitors, Browne Jacobson, on the feasibility of delivering the consultation in a lockdown and/or social distancing context, without any face-to-face engagement. The consensus of that advice was that removing face-to-face engagement from the exercise does not weaken it or effect its validity for use in the decision-making process
4. The Committee provided comments and feedback on our proposal to undertake the consultation through non-contact methods. We have considered these, and revised our Consultation Plan to mitigate the issues raised. We have included our updated Consultation Plan with this briefing. We have also provided specific responses to the comments received from the Committee on a non-contact approach to consultation below.
5. In light of the mitigations we outline in our plans and in the information below, we wish to formally notify the Committee of our intention to hold a public consultation on our proposals, for a period of 8 weeks, from 27 July 2020.

Comments received from the Committee and the CCG's response

On an issue such as this everyone in the region should be consulted by letter. Failing this, local transport charities should be consulted to get their views on the travel to and from the centre.

The cost of writing to every household in Nottingham and Nottinghamshire on this proposal would be prohibitive, and not proportionate to the impact on the local population. We have considered the need to ensure we reach as many people as possible however, and have put additional resources into promotion and awareness raising, including:

- Paid for press advertising in Nottingham and Nottinghamshire and in the surrounding areas
- Paid for social media advertising
- Commissioning additional materials to promote the consultation, such as a short animation.

We have also retained Healthwatch as a delivery partner in this project, who will undertake targeted engagement by phone with some of our most vulnerable and marginalised communities.

Are there plans to have any paper versions of questionnaires etc. which participants could request? If not it could be worth considering as some people will not have internet access and may prefer to participate that way?
People can complete a questionnaire online, in hard copy or over the phone. We have a phone line set up to receive requests for hard copies or telephone completion.

Is there any particular reason it needs to go ahead whilst we are on lockdown? Are there time constraints for example?
The Covid-19 pandemic is likely to be restrictive for some time, and there is no certainty of when public gatherings would be allowed to take place. This means that postponement until social distancing is relaxed is currently indefinite.

The current proposal is also based on the premise that there is insufficient specialist rehabilitation bed capacity in the East Midlands, with the NHS Rehabilitation Centre able to provide significant health benefits. We are therefore keen to proceed with the consultation if there are no reasons it cannot be delivered meaningfully.

We are also mindful that the proposal for a new rehabilitation facility came about as a result of a government capital allocation some time ago following the donation of land to the NHS. Although The Black Stork Charity have contributed £7m of enabling activities they have indicated that the offer of land is not open indefinitely and the timely outcome of our consultation and commissioning decisions is required.

Given that this is an amended procedure, which may or may not hit teething problems, could the consultation period be extended?
We have extended the consultation period from 6 weeks to 8 weeks. We have also put in place regular monitoring of responses; website hits; social media reach and other metrics to ensure that the consultation is reaching a large number of people.

Will Healthwatch still be included?
Yes, Healthwatch are involved and will be delivering targeted engagement. As with the core consultation they will be using non-contact methods. Healthwatch have already demonstrated their ability to reach across our vulnerable communities in lockdown, having undertaken a remote engagement exercise on the impact of Covid-19 on different communities.

How will responses that are not paper-based be captured? Will there be recording of phone conversations or will people be expected to fill in an online response on a website after the interview/forum?
We have set up a comprehensive engagement log that will capture feedback across all channels. We will try and direct people to the questionnaire where possible but will also accept feedback provided over the phone, in writing and by email. We will record all feedback within our engagement log.

People should not be excluded from the consultation who can't participate in phone and/or virtual interviews for whatever reason.
We are offering a range of feedback channels – postal, phone, online.

Face-to face interviews are problematic at the moment, but the difficulties are not insurmountable.
Given the current Government guidance on Covid-19 infection risk and social distancing, we do not feel it would be appropriate to undertake face-to-face engagement.

Is there any room for flexibility, i.e. to carry out phone or online interviews "where at all possible"?
Yes – we are offering online, phone or postal completion to all.

An online approach does 'weaken the exercise' in that it will inevitably exclude some people, and any responses could depend on how the questions are asked.
We have taken legal and procedural advice on our proposed approach. The consensus of this advice is that the approach does not weaken the exercise, as long as appropriate mitigations are in place. We have carefully considered the feedback of the Committee in drawing up our plans.

Lewis Etoria
Head of Insights and Engagement
July 2020

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NHS Mansfield and Ashfield Clinical Commissioning Group

NHS Newark and Sherwood Clinical Commissioning Group

NHS Nottingham City Clinical Commissioning Group

NHS Nottingham North and East Clinical Commissioning Group

NHS Nottingham West Clinical Commissioning Group

NHS Rushcliffe Clinical Commissioning Group

Consultation Plan

NHS National Rehabilitation Centre

June 2020

1. Introduction

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

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

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

This plan has been updated to reflect how we would carry out the consultation during restrictions on contact due to the Covid-19 pandemic.

2. Background to the consultation

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

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

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

3. Aims and objectives

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

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

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

Our high-level objectives are:

- Ensure that our consultation is transparent and meets statutory requirements and best practice guidelines
- Undertake significant and meaningful engagement with local stakeholders, building on the findings of our pre-consultation engagement activity by using a range of digital, 1-1 telephone and hardcopy survey engagement methods
- Clearly articulate the implications, impact and benefits of our proposals
- Create a thorough audit trail and evidence base of feedback
- Collate, analyse and consider the feedback we receive to make an informed decision.

It is worth noting that although this plan describes the approach we will take for a consultation without face-to-face activity, the aims and objectives remain the same and we are confident we can achieve them by providing alternative methods of engagement.

4. Principles for the consultation

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

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

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

- Make sure our methods and approaches are tailored to specific audiences as required
- Identify and use the best ways of reaching the largest amount of people and provide opportunities for vulnerable and seldom heard groups to participate
- Provide accessible documentation suitable for the needs of our audiences, including easy read
- Offer accessible formats including translated versions relevant to the audiences we are seeking to reach
- Undertake equality monitoring of participants to review the representativeness of participants and adapt activity as required

- Use different virtual/digital methods or direct and 1-1 telephone activity to reach certain communities where we become aware of any underrepresentation
- Arrange our engagement activities so that they cover the local geographical areas that make up Nottingham and Nottinghamshire
- Arrange meetings in accessible venues and offer interpreters, translators and hearing loops where required
- Inform our partners of our consultation activity and share our plans.

In light of the restrictions currently in place as a result of the Covid-19 pandemic, we have sought professional and legal advice on whether we can realistically undertake this consultation at this time. The consensus of this advice, from the Consultation Institute and Browne Jacobson Solicitors respectively, is that removing face-to-face engagement from the consultation does not weaken the exercise and would mean that the consultation would still be valid for use in the decision-making process. This advice is based on the consultation finding suitable alternative methods to face-to-face engagement.

5. Resources

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

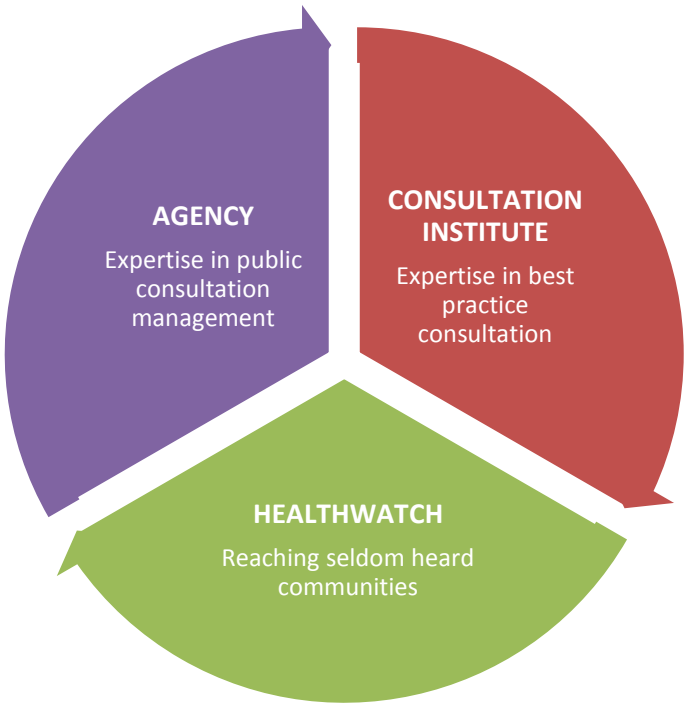
- Overall management and delivery of the consultation (agency support)
- Analysis and reporting of findings (agency support)
- Specialist advice and guidance (Consultation Institute)
- Community engagement and targeting of seldom heard communities (Healthwatch).

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

6. Strategic approach

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

Figure 1



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

As we are unable to undertake face-to-face engagement, our approach will instead focus on hard copy and online survey responses; telephone interviews and events and focus groups run virtually through video conferencing software. In light of this, we will provide the following to maximise participation:

- **Video and other visual resources to support the Consultation Document**
- **Paid-for Facebook advertising to boost completion of the survey**
- **Press advertising to boost completion of the survey**
- **Freepost address for return of hard copy surveys**
- **A phone line for people to request a call-back for telephone completion of the survey.**

7. Key milestones

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

Table 2

Phase	Action	Date	Lead
PHASE 1 - Pre consultation assurance			
	National Finance Director sign off	By 26/05	CCG
	Consultation Doc and plan to County for comment and feedback	By Fri 26/06	CCG
	Feedback on approach from Health Scrutiny Committees	Fri 03/07	CCG
	Formal notification to Health Scrutiny Committees of intention to consult	Fri 10/07	CCG
	Extra-ordinary Governing Body meeting to approve consultation	Tue 21/07	CCG
PHASE 2a - Public consultation			
	Public consultation period	Mon 27/07 – Fri 18/09	Agency
PHASE 2b - Resolving outstanding issues from PCBC + building info for DMBC			
	Workshop 1 - Clinical model	Fri 19/06	CCG
	Workshop 2 - Activity assumptions	Fri 26/06	CCG
	Workshop 3 - Workforce	Fri 10/07	CCG
	Workshop 4 - Finance / contracting model	Fri 17/07	CCG
PHASE 3 - Consideration of consultation findings			
	Analysis and reporting	Mon 21/09 – Fri 02/10	Agency
	Circulate Report from Consultation	Fri 09/10	CCG
	CCG Governing Body – Update on consultation findings	Wed 07/10	CCG
	Findings Consideration Panel	Fri 09/10	CCG
	Findings Consideration Panel	Fri 23/10	CCG
PHASE 4 - Finalisation and approval of DMBC			
	Draft DMBC completed	Mon 26/10 – Fri 06/11	CCG
	CCG Prioritisation and Investment Committee review draft	Wed 11/11	CCG
	Clinical Senate review draft	TBC	CCG
	DMBC Finalised	Mon 09/11 - Tue 17/11	CCG
	DMBC to GB for papers deadline	Wed 25/11	CCG
	Governing Body sign off	Wed 02/12	CCG

8. Summary of findings from pre-consultation activity

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

Phase 1 patient engagement

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

Clinical and stakeholder engagement

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

Staff engagement

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

Travel Impact Analysis (TIA)

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

Equality Impact Assessment

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

Findings

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

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

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

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

Phase 2 patient engagement

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

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

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

9. Summary of consultation activity

Pre-launch

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

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

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

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

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

Launch and consultation period

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

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

We will supplement our online engagement with targeted telephone interviews for affected groups e.g. Linden Lodge patients. While we are able to use online conferencing facilities to hold public events and small group workshops and focus groups, we will also provide opportunity for those who are directly affected to talk to us 1-1.

We will commission our local Healthwatch to undertake engagement to reach communities who are vulnerable and seldom heard. This activity will be shaped to respond to the Equality Impact Assessment (EIA) carried out on our proposals. This will be delivered primarily through telephone and online methods.

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

10. Channel and methods

Audience	Method
Service users affected by proposals	Targeted engagement online events/focus groups; feedback via telephone; briefings through existing forums and groups; media; social media
General public	Media; social media
Staff	Staff briefing document; Trust's internal communication channels; media; social media
Health Scrutiny Committees	Formal presentations; phone and online briefings (Chairs); media; social media
MPs and Councillors	Stakeholder briefings; media; social media
Local, regional and national charities representing patients affected by proposals	Direct letter inviting feedback in writing; Stakeholder briefings; media; social media
Local VCS	Stakeholder briefings; media; social media
GPs	GP newsletters; stakeholder briefings
Media	Proactive press release; stakeholder briefing

Key messages and FAQs are included at Appendix 1.

11. Consultation document and supporting materials

The following will be developed to support the consultation:

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

12. Capturing feedback, analysis and reporting

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

- On-line/Digital and hardcopy/paper Survey responses
- Qualitative responses through direct emails, feedback forms and telephone calls
- Transcripts of virtual/on-line focus group discussions
- Minutes of meetings
- Letters
- Petitions
- Direct social media messages.

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

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

13. Meeting our legal duties on equality and health inequalities

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

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

In developing our Consultation Plan we have:

- Given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a

relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it; and
- Given regard to the need to reduce inequalities between patients in access to, and outcomes from healthcare services and to ensure services are provided in an integrated way where this might reduce health inequalities.

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

To respond directly to the recommendations in the EIAs we have commissioned Healthwatch to undertake targeted engagement with a range of groups during the consultation. They will undertake this engagement using 1-1 telephone interviews and an on-line survey specifically tailored for the groups identified within the EIA. This engagement will focus specifically on how a person's specific needs, identity or characteristics may affect their experience of inpatient rehabilitation services, and thus what mitigations we need to consider in our plans.

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

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

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

- Age
- Disability
- Race
- Religion and belief
- Sex
- Sexual orientation.

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

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

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

Appendix 1 – Key messages and FAQs

Regional Rehabilitation Centre consultation

Key messages

- The NHS in the East Midlands is consulting on the opportunity to create an NHS Rehabilitation Centre [the Centre], part of the vision for a National Rehabilitation Centre on the Stanford Hall Rehabilitation Estate, near Loughborough.
- This represents a £70m investment by the government in the rehabilitation facilities on the Stanford Hall Rehabilitation Estate which is already developing a reputation for rehabilitation expertise
- Patients and public can have their say on this opportunity from 8 June 2020 to 17 July 2020
- This presents an opportunity for the NHS to transform rehabilitation services in the region by creating a specialist regional clinical facility on the Stanford Hall Rehabilitation Estate and at the same time take advantage of the state-of-the-art facilities used for the military in the Defence Medical Rehabilitation Centre.
- There is currently a shortage of beds for specialist rehabilitation in the East Midlands.
- The opportunity will mean that in-patient rehabilitation services will be available for individuals who have had a complex fracture following an injury. Currently in-patient rehabilitation is available in the regional for neurological patients only.
- The opportunity will increase access to more rehabilitation beds with all the services and staff patients need under one roof.
- We believe that the services proposed will provide better outcomes for patients and, crucially, help them get back to their lives sooner because they will receive intensive rehabilitation.
- To transform services there will be change, and in this case the proposal is to transfer services from Linden Lodge at Nottingham City Hospital to the centre.
- It is easy for the public to have their say on the opportunity by completing either an online survey or by attending events staged across the county. More information is available online at: [add link to website].

Q&A (for spokespeople and to inform statements to media)

Q1. What are you asking the public to consult on?

We are consulting on whether or not to take forward the opportunity to create a £70m NHS Rehabilitation Centre on the Stanford Hall Rehabilitation Estate.

The Centre would be co-located with the Defence Medical Rehabilitation Centre.

The owner of the Stanford Hall Rehabilitation Estate is prepared to provide the land needed for the NHS facility at no cost. Planning permission has already been granted for the construction of this facility and detailed designs have been developed. The Ministry of Defence has agreed to share the advanced facilities in the DMRC with the NHS. This will mean NHS patients would be treated at the estate, but in a separate facility from military personnel.

Q2. Who is behind the consultation?

NHS Nottingham and Nottinghamshire Clinical Commissioning Group (CCG) are proposing to commission rehabilitation services to be provided at the regional rehabilitation centre. This would be an NHS-run facility, separate to the military rehabilitation service and building, but providing NHS patients with access to state-of-the-art facilities (for example a hydrotherapy pool).

Q3. Where will the centre be located?

Stanford Hall Rehabilitation Estate is located near Loughborough. It is 13 miles from Nottingham, 4 miles from Loughborough, 32 miles from Mansfield, 19 miles from Leicester and 47 miles from Lincoln.

Q4. Why do you think this is needed?

The NHS believes that an NHS Rehabilitation Centre could deliver better outcomes for patients with the development of a strategy that includes rehabilitation for a range of complexities and injuries and reduced delays to access services.

There are a number of reasons for the recommended change to services, which we have set out in the public consultation:

- Creating a high-quality centre of rehabilitation excellence
- Contributing to a deficit in rehabilitation capacity
- Improving access to services
- Improving outcomes and the patient experience through a new clinical model
- Ability to respond to changes in future service needs and models
- Reducing pressures on the acute bed base.

The Centre would provide high quality care, underpinned by leading expertise and best practice, in one of the best facilities in the NHS.

There is a significant opportunity to improve lives, develop leading expertise in rehabilitation and, at the same time, use NHS resources more efficiently.

Q5. What is different about what is proposed and what is already provided in existing NHS hospitals?

Rehabilitation services for neurology patients are provided at hospitals across the East Midlands. The opportunity to create a regional centre that can provide care for patients with fractures as well as many neurological conditions represents a ‘step change’ in the provision of specialist rehabilitation services for patients in the East Midlands.

While a regional rehabilitation centre will expand services, neurological rehabilitation will continue to be provided in hospitals across the region.

Q6. What is the distinction between an NHS regional rehabilitation Centre and a national rehabilitation centre?

The proposed development of an NHS Rehabilitation Centre on the Stanford Hall Rehabilitation Estate is part of a vision for a future National Rehabilitation Centre (NRC). The vision for the NRC is for it to provide a hub for staff development, research and education. This means that it could lead the way in developing and deploying the best techniques for rapid and effective rehabilitation across the NHS.

The ultimate vision for the NRC is for it to be the hub for a network of outstanding NHS rehabilitation services across England.

Q7. What have people said already?

We have spoken to patients, carers, NHS staff, charities and others over two phases of engagement. While people we spoke to were generally positive about the prospect of improved facilities at Stanford Hall, some had some concerns about the impact on rehabilitation services provided at Nottingham City Hospital. Others had concerns about travelling to visit patients at Stanford Hall by public transport.

The engagement we have undertaken has informed the development of our proposals and the focus of our consultation.

Q8. How would patients benefit from being treated at the Centre?

The aim is to support patients in their rehabilitation and recovery following serious injury or illness. There are state-of-the-art facilities wherever you look at Stanford Hall, such as the £1.8m Computer Assisted Rehabilitation Environment which uses virtual reality to track movement, allowing medical experts to correct their gait and work out what areas of their body may be under pressure, or acclimatise them to different conditions.

Q9. What conditions would be rehabilitated there?

A team of expert staff would provide treatment for patients, mainly from the East Midlands, who will have complex and specific needs, including:

- Major trauma following, for example, a road traffic collision or an accident at work
- Neurological problems such as an injury to the brain
- Complex musculoskeletal injury with damage to bones, joints and muscles
- Traumatic amputation
- Incomplete spinal cord injury resulting in paralysis.

Q10. How would families and friends without private transport get to the centre?

The centre would be located on the Stanford Hall Rehabilitation Estate, near Loughborough. The site is serviced by a bus that runs from Nottingham to Loughborough every 20 minutes. The NHS is negotiating with public and voluntary sector transport providers and the Highways Authority to improve bus services to the centre.

Stanford Hall Rehabilitation Estate lies approximately 5 km northeast of Loughborough and is located at the southern tip of the county of Nottinghamshire, on the border with Leicestershire.

Q11. What would the impact be on NHS rehabilitation services in Nottingham and surrounding areas?

The impact will be that a wider cohort of patients have access to specialist rehabilitation services with more beds provided for neurological patients. To achieve this, in-patient specialist rehabilitation in Nottinghamshire will be provided at the regional rehabilitation centre.

Providing rehabilitation services has to be achievable within existing budgets, so that other services are not negatively affected. This would mean relocating existing services from Linden Lodge at the City Hospital in Nottingham to the Centre.

Q12. Will this be better than what is already provided for patients?

Yes. A team of multi-disciplinary staff will be able to provide rehabilitation for patients in purpose-built surroundings with all services under one roof. Patients will be supported throughout their recovery and with access to the facilities and services in a specialist rehabilitation centre and return to their lives sooner. Overall, there will be more rehabilitation beds, so we are increasing capacity to treat patients in the region.

Q13. How would inpatient beds be allocated?

The referral criteria for the Centre would be based on the level of rehabilitation need and the potential of the patient to benefit from treatment.

Patients and families would have a choice on whether to be referred to the Centre or not. Their care would be provided by the NHS no matter what they choose.

Q14. How does it work with a military facility being located on the same estate?

The NHS Rehabilitation Centre will be an NHS facility, co-located with the Defence Military Rehabilitation Centre at the Stanford Hall Rehabilitation Estate. Patients referred to the NHS Rehabilitation Centre would have access to the defence rehabilitation facilities but be treated by NHS staff separate to the military facility.

Q18. Who will work there?

Rehabilitation would be provided by an NHS team that includes medical consultants, junior doctors, nurses, physiotherapists, occupational therapists, speech and language therapists, dieticians, psychologists, case managers, exercise therapists and local authority social workers.

Q19. Could the £70m allocated for the centre be spent on anything else?

No. The funding has been allocated by the government for the construction of a clinical rehabilitation facility on the Stanford Hall Rehabilitation Estate, not for other NHS services. We are consulting on whether or not to take forward this opportunity, including the transfer of existing services to the new facility.

Q20. What would it be like to be a patient at the Centre?

Patients at the Centre will take part in intensive rehabilitation tailored to their needs and aimed at improving functional ability.

For example, a patient with a disorder to their brain and nervous system (neurological) will have one-to-one treatment sessions with rehabilitation experts and have access to specialist facilities such as a hydrotherapy pool and equipment that helps them to adjust and transfer their body weight correctly.

A patient in need of rehabilitation as a result of acute treatment involving bones and muscles (orthopaedic) would benefit with gym sessions and hydrotherapy.

There would be access to state-of-the-art facilities such as a gait analysis laboratory and Computer Aided Rehabilitation Environment, a system that analyses movement in real time, along with a hydrotherapy pool, prosthetic laboratory and access to the entire rehabilitation estate.

The centre will also have two gyms that would allow patients to continue their own rehabilitation outside of formal sessions, supported by members of staff.

While everyone involved in care will be focussed on returning patients to their daily lives, the multi-disciplinary team will be supported by social workers allowing early assessment of home needs in line with any vocational needs to help the discharge process.

Q21. What will the facilities be like at the NHS Rehabilitation Centre?

There will be three wards, plus space for activities and a rehabilitation flat for patients to experience living back at home before being discharged. For visiting families there will be overnight accommodation available.

Ends