healthwatch
Nottingham & Nottinghamshire

Tomorrow's NUH (Nottingham University Hospitals) Report

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Commissioned by

Nottingham and Nottinghamshire Clinical Commissioning Group

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Executive Summary

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

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

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

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

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

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

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

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

Recommendations

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

- Provide/publish responses to the questions posed by the survey participants
- Ensure that the staffing for the proposed models is sufficient to meet demand
- Ensure that primary care has the capacity to meet the increased responsibilities

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

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Introduction

Healthwatch Nottingham and Nottinghamshire (HWNN) is an independent organisation created to gather and represent the views of those who use health and social care services. We use this information to bring about changes in how services are designed and delivered, to make them better for everyone.

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

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

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

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

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Background

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

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

The proposed approach would result in:

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

This would mean:

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

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

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

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

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

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Our approach

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

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

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

Three online focus groups were held with:

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

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

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

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

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

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

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Summary of findings

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

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

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

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

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

1. Plans for the future of Hospital Services

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

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

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

Concerns included:

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

Whether the number of available appointments would be reduced due to the additional travelling time for staff who need to visit multiple sites: *'the consultants themselves are*

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not now based in the hospital, they have to go to say Riverside or Mary Potter. They're not seeing as many patients either because they're having to spend a lot of time traveling around the community.'

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

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

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

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

Quality of care

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

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

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

Feasibility of online services

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

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

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

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

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

Conclusion

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

2. Plans for Emergency Care

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

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

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

Other positive comments made were:

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

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

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

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How the model would be resourced

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

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

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

The hospital might not be able to provide the specialist care required for some cohorts: *'I'm conscious to the fact that lupus and supercell and those illness that are particular to the community, I'm not sure how that's going to be covered'* and, *'people such as alcohol and drug workers and mental health workers, will they only be available during office hours?'* Taking account of issues such as: *'provision in ED of support for different communication needs for people with different learning abilities, visual or hearing problems or different languages and need for interpreters.'* Also that the service: *'should offer female staff where possible as Muslim women may prefer this.'*

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

Mental health care

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

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

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

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

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

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time in years that they've had everything dealt with at once. If we could do that in the hospital, it would be fantastic'

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

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

Conclusion

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

3. Plans for Family Care

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

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

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

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

It was felt that a single site would not be suitable for everyone, for example a different environment is needed for women and children, *'I feel like women also need some time and space, and especially, if they're pregnant. Children would need a different*

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environment to feel comfortable, and women need a different environment'. Services needed to be sensitive for example *'…imagine a situation where a woman was being treated and that treatment meant she couldn't have children and wanted to…'* and: *'…cases where a baby will be stillborn or will be born with Downs syndrome should be private…'* And one person said: *'I wouldn't want to be in the same unit as maternity if I was there for something else.'*

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

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

Conclusion

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

4. Plans for Elective Care (Planned operations)

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

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

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

Remote consultations are easier for some people. *'I queued around for about four hours to see the surgeon and then he basically had a look at the way the stitching was on the*

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operation and said, "Yes, that's fine. You can go home now." I could have sent him a picture of that or I could have gone to my local GP to look at it.'

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

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

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

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

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

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

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

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

Conclusion

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

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5. Plans for Cancer Care

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

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

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

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

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

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

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

The negative points that were raised included,

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

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

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they've got the skills to. I'm not quite sure where the hospital think there's going to be more diagnosis in the community'

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

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

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

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

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

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

Conclusion

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

6. Plans for Outpatient Care

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

The positives that were identified were:

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

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

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

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

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

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

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

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

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

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

Conclusions

People liked the idea of providing more outpatient care at home and in the community because it would reduce travelling time and hospital transportation. Online and telephone support was a good option for e.g. blood pressure and blood sugar monitoring. They also raised concerns about adequate staffing, significant system changes that would need to be

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communicated adequately to the public and risks of providing online appointments which are not accessible to all and may make diagnosis difficult for health professionals.

Questions

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

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

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Conclusions

Main Findings

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

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

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

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

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Recommendations

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

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

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Appendix 1: Demographics of respondents

Note: 5 respondents did not provide any demographics.

District	No.	Percent
Ashfield	3	2.1%
Bassetlaw	2	1.4%
Broxtowe	15	10.3%
Gedling	21	14.5%
Mansfield	1	0.7%
Newark & Sherwood	7	4.8%
Nottingham City	80	55.2%
Rushcliffe	13	9.0%
Outside of Nottinghamshire	3	2.1%
Total	**145**	**100%**

Table 1 - source all respondents (n=145)

Age Groups	No.	Percent
<16	0	0.0%
16-24	6	4.1%
25-34	13	9.0%
35-44	29	20.0%
45-54	35	24.1%
55-64	24	16.6%
65-74	12	8.3%
75-85	17	11.7%
85+	4	2.8%
Not answered	5	3.4%
Total	145	**100%**

Table 2 - source all respondents (n=145)

Gender	No.	Percent
Female	107	73.8%
Male	27	18.6%
Not answered	9	6.2%
Non-binary	1	0.7%
Prefer not to say	1	0.7%
Total	**145**	**100%**

Table 3 - source all respondents (n=145)

Gender Same as Birth	No.	Percent
Yes	134	92.4%
Not answered	8	5.5%
Prefer not to say	3	2.1%
Total	**145**	**100%**

Table 4- source all respondents (n=145)

Sexuality	No.	Percent
Heterosexual	100	69.0%
Not answered	17	11.7%
Prefer not to say	15	10.3%
Homosexual	9	6.2%
Asexual	3	2.1%
Bisexual	1	0.7%
Total	**145**	**100%**

Table 5 - source all respondents (n=145). Less 0 aged <16

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Ethnicity	No.	Percent
White	71	49.0%
Black	21	14.5%
Asian	17	11.7%
South Asian	14	9.7%
Mixed/Multiple ethnic	6	4.1%
Other	5	3.4%
Arab	5	3.4%
Prefer not to say	3	2.1%
Not answered	3	2.1%
Total	**145**	**100%**

Table 6 - source all respondents (n=145)

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

Table 7 - source all respondents (n145)

Nationality	No.	Percent
British	109	75.2%
Other	16	11.0%
Not answered	12	8.3%
British Asian	2	1.4%
British Pakistani	2	1.4%
Polish	2	1.4%
British Bangladeshi	1	0.7%
Indian	1	0.7%
Total	**145**	**100%**

Table 8 - source all respondents (n=145)

Main Language	No.	Percent
English	134	92.4%
Not answered	5	3.4%
Other	5	3.4%
Polish	1	0.7%
Total	**145**	**100%**

Table 9 - source all respondents (n=145)

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

Table 10 - source all respondents (n=145)

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

Table 11 - source all respondents (n=145)

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

Table 12 - source all respondents (n=145)

Asylum seeker/refugee	No.	Percent
Yes	3	2.1%
Total	**3**	**2.1%**

Table 13 - source all respondents (n=145)

Employment Status	No.	Percent
Part time	39	26.9%
Full time	35	24.1%
Retired	31	21.4%
Unable to work	16	11.0%
Not employed	10	6.9%
Prefer not to say	5	3.4%
Student	6	4.1%
Not answered	3	2.1%
Total	145	100%

Table 14 - source all respondents (n=145)

Illness/impairment	No.	Percent
A long-term health condition	53	36.6%
Physical impairment	24	16.6%
Visual impairment	12	8.3%
Hearing impairment	12	8.3%
Prefer not to say	9	6.2%
Mental health illness	15	10.3%
Learning disability	8	5.5%
Social/behavioural problems	5	3.4%

Table 15 - source all respondents (n=145) - note: this is the number of respondents who have identified per condition.

Disability Count	No.	Percent
Number of respondents	71	49.0%

Table 16 - source all respondents (n=145) - note number of respondents who indicated they had a disability/impairment

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Appendix 2: Rating Scales

1. Plans for Hospital Services

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

2. Plans for Emergency care

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

3. Plans for Family care

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

4. Plans for Elective care

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

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5. Plans for Cancer care

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

6. Plans for Cancer care

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

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