Reshaping Health Services in Nottinghamshire Programme and Tomorrow's NUH

Pre-engagement Findings Report

January 2021

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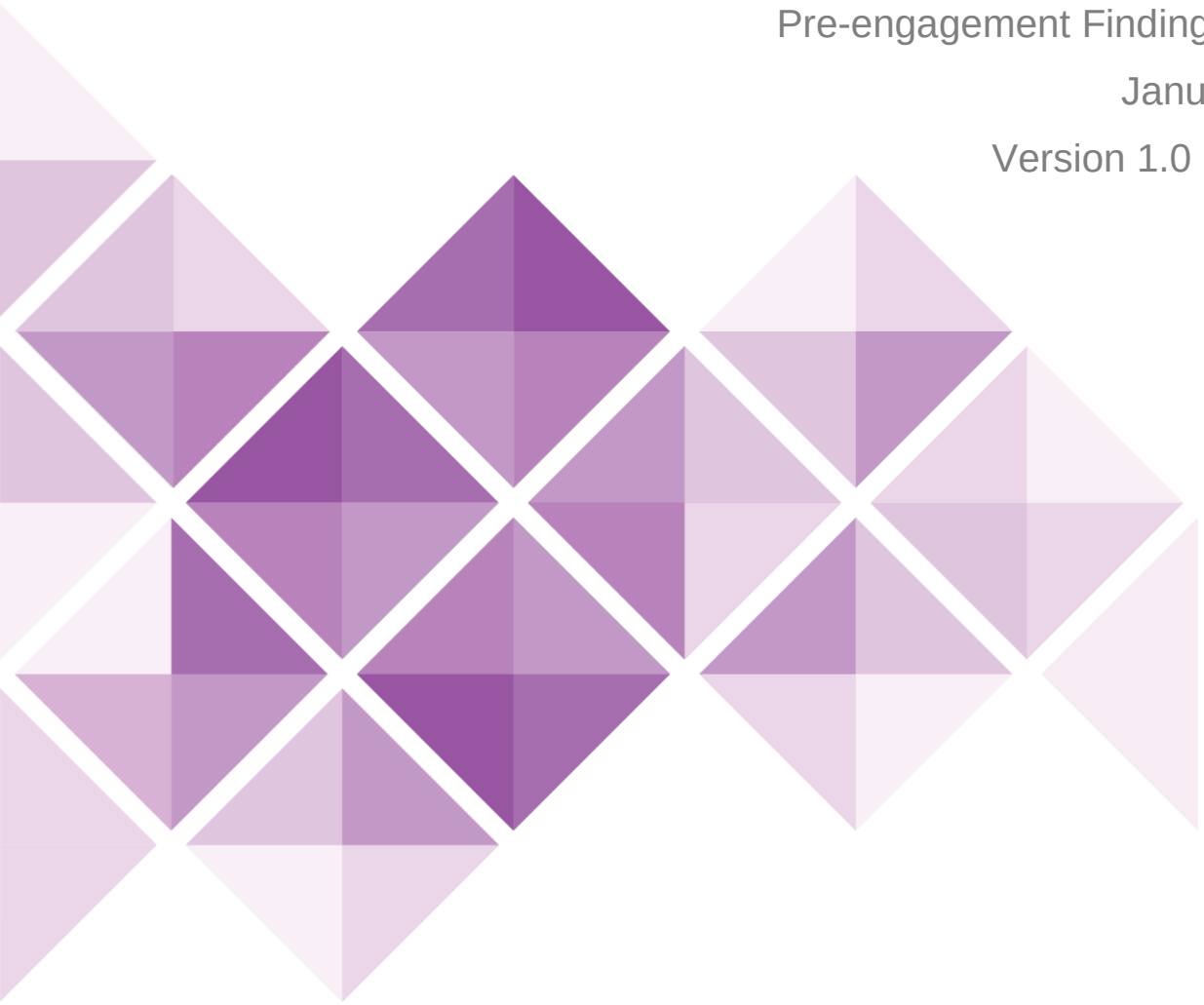

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Executive Summary

Introduction

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

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

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

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

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

Key findings

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

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

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

Benefits of the overall model

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

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

Concerns of the overall model

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

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

Next steps

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

1 Introduction

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

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

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

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

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

2 Methodology

2.1 Overview

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

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

2.2 Consultation survey

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

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

2.3 Engagement events

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

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

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

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

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

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

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

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

2.4 Focus groups

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

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

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

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

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

2.5 Additional responses

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

2.6 Total sample

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

2.7 Analysis and reporting

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

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

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

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

3 Survey sample

3.1 Demographics

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

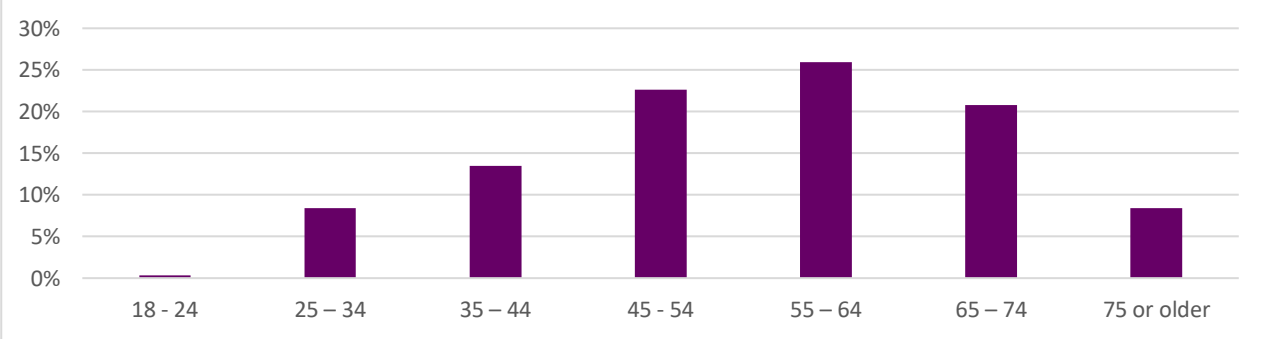
- Most respondents were from Rushcliffe (21%), Broxtowe (19%) or Nottingham City (17%), with smaller proportions from Gedling (14%), Newark and Sherwood (10%), Ashfield (7%) and Mansfield (4%). The remaining 8% were from another area.

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

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

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

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



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

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

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

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

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

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

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

4 Plans for the future of hospital services

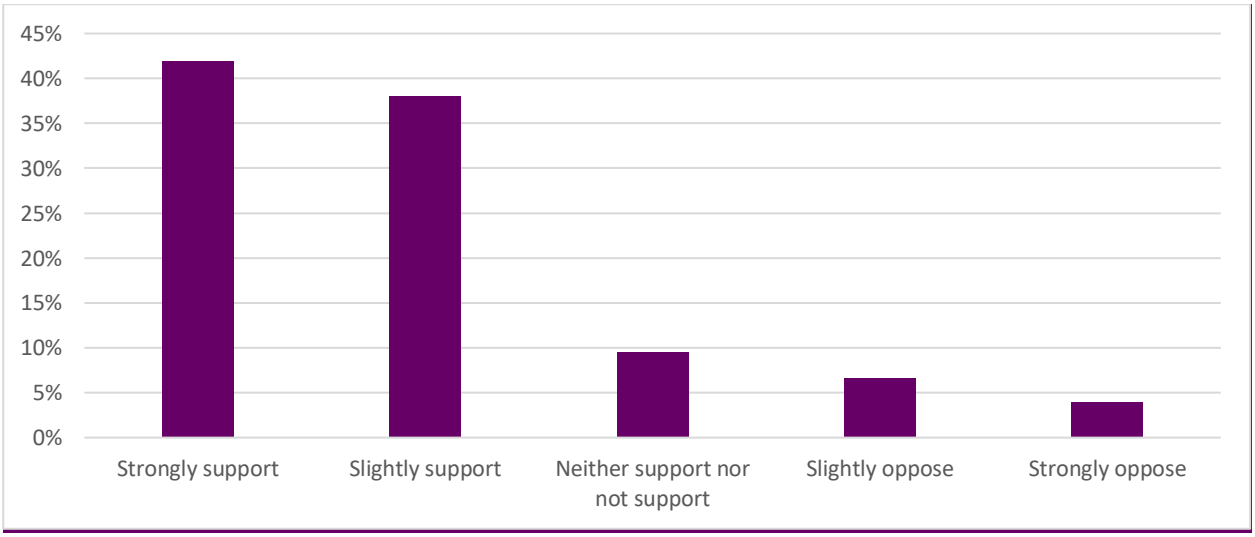
Individuals were provided with the following information about the proposed future of hospital services.

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

4.1 Survey feedback

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

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



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

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

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

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

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

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

Access to modern, purpose-built facilities	3%

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

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

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

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

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

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

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

4.2 Feedback from the engagement events

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

4.2.1 Discussion themes

Planning and leadership

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

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

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

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

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

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

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

Benefits of the overall model

- Sensible rationale.

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

- Increased convenience for patients.

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

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

- Covid-19 supports separation of adult elective care.

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

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

Concerns about the overall model

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

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

Other considerations

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

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

- Patient and staff resistance to change.

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

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

- Plans for the future configuration for allied health services.

- Inclusion of the Treatment Centre.

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

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

5 Plans for emergency care

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

What do we want to do?

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

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

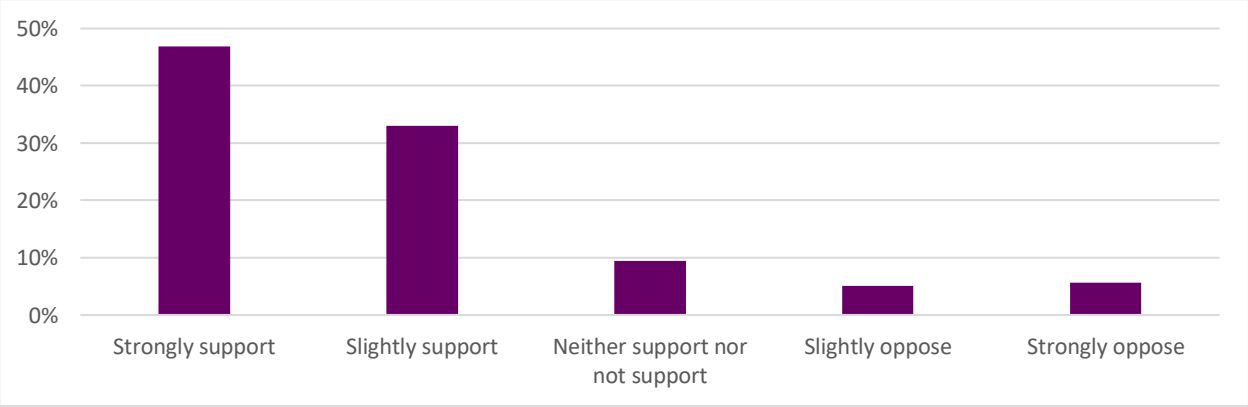
We want to develop more community-based services that support people with long-term conditions so that they do not become so ill that they need to come to hospital.

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

5.1 Survey feedback

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

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



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

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

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

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

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

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

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

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

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

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

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

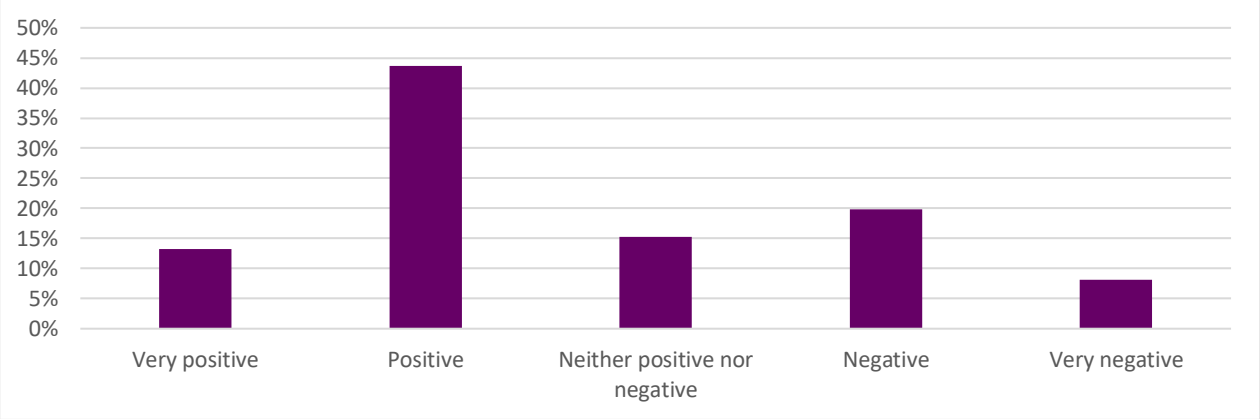
***Table**: What concerns do you have about the plans we have set out? (N=291)*

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

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

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

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



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

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

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

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

5.2 Focus group feedback

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

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

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

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

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

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

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

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

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

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

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

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

6 Plans for family care

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

What do we want to do?

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

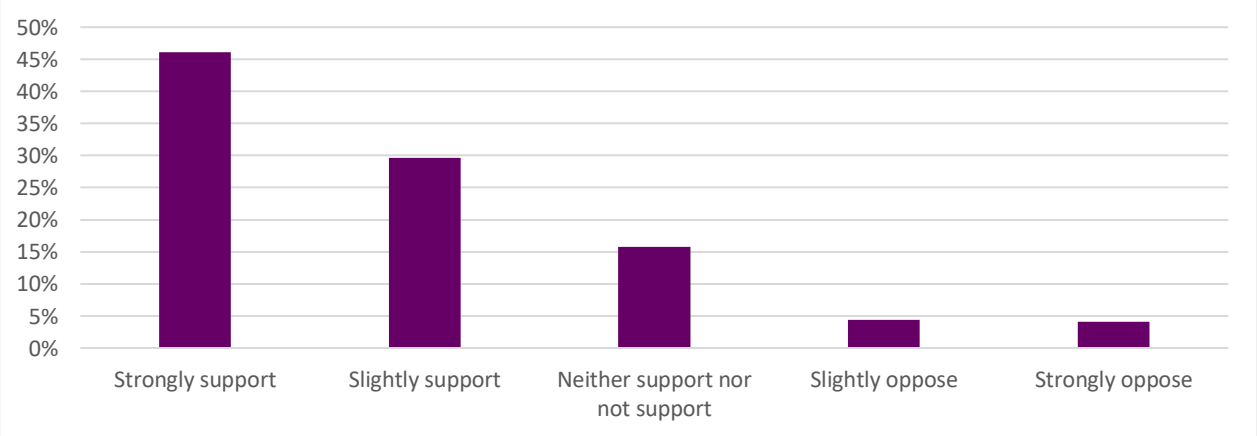
In the future, we want some of our children's services to be provided in our hospitals and some to be provided in other locations like a community clinic or GP surgery. We want to make sure that children are seen in the location most suitable for their health needs and, where appropriate, we will provide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

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

6.1 Survey feedback

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

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



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

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

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

'Could make access to better care easier'

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

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

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

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

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

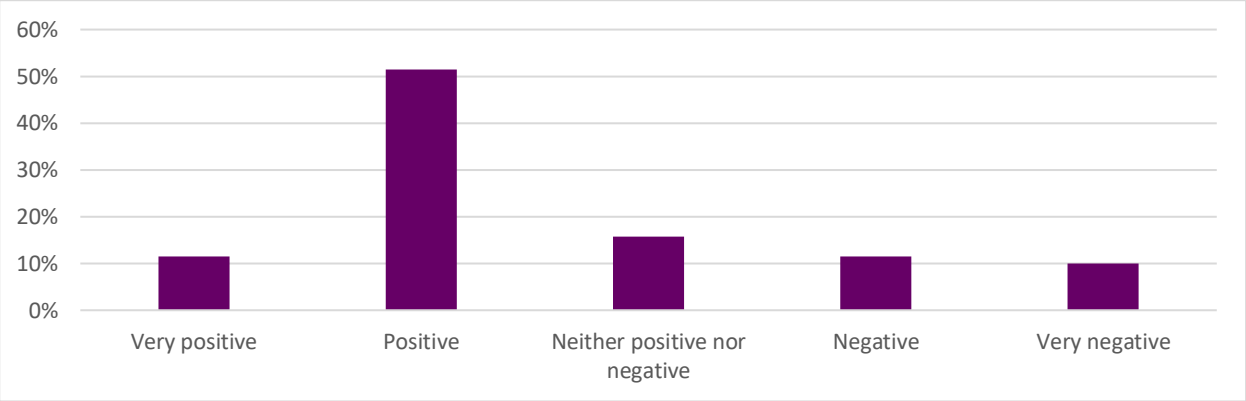
'People will not like the lack of choice, distance to travel'

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

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

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

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



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

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

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

6.2 Focus group feedback

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

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

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

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

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

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

7 Plans for adult elective care

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

What do we want to do?

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

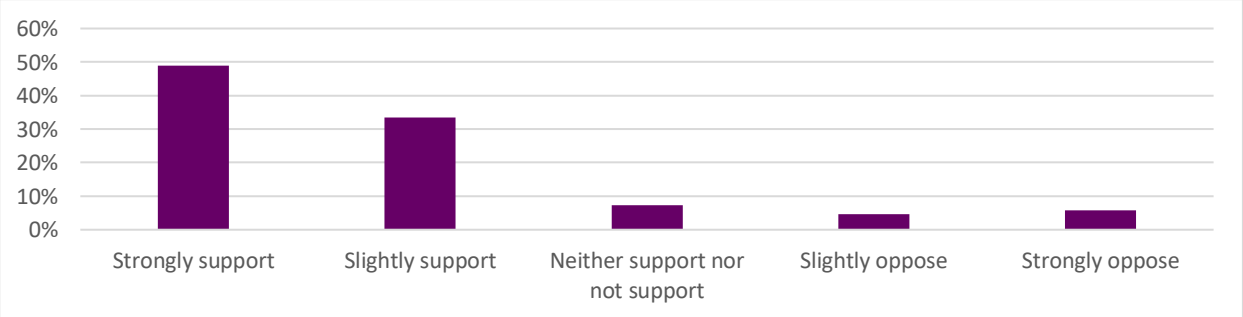
We want to provide more elective care in community settings, where it is appropriate to do so. For example, we want to provide more flexible and accessible options for the care people need following an operation so that they do not have to come into hospital unless it is necessary. This could mean that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

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

7.1 Survey feedback

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

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



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

'Reduction in cancellations due to fluctuations in emergency care'

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

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

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

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

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

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

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

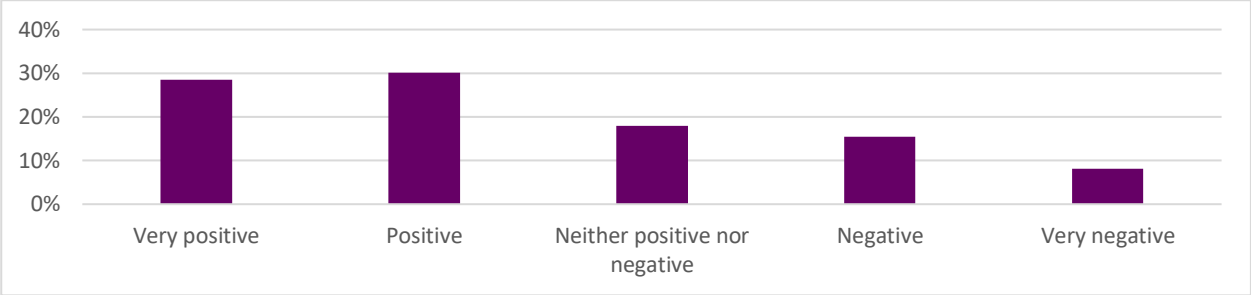
'Are you planning to make GP surgeries more like mini hospitals? I cannot think this will be cost effective and do you have enough GP's to take on more work? GP's are leaving the profession as some say there is too much work as it is'

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

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

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

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



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

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

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

8 Plans for cancer care

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

What do we want to do?

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

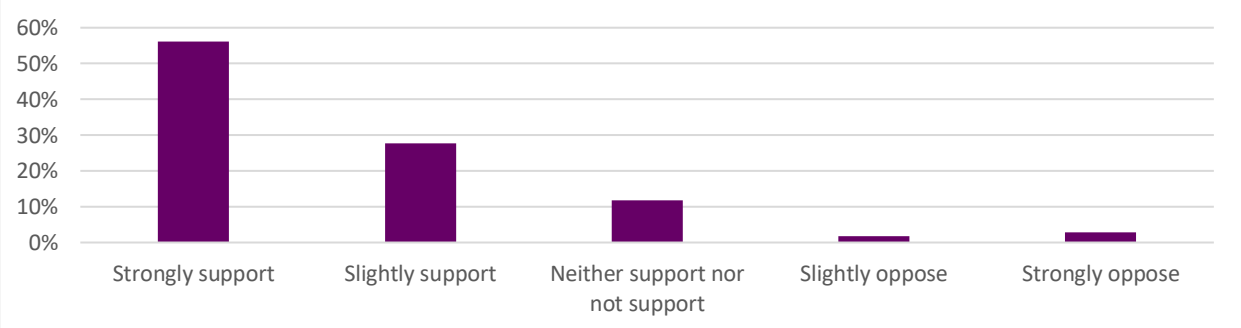
We will provide more cancer services in community settings. Support for people before and after an operation or treatment may be provided outside the hospital, making services more accessible and closer to home for most people.

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

8.1 Survey feedback

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

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



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

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

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

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

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

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

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

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

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

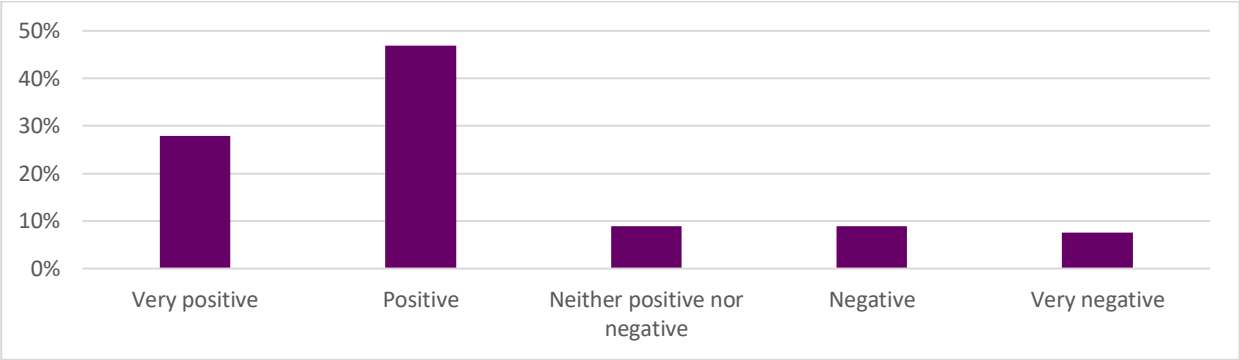
***Table**: What concerns do you have about the plans we have set out? (N=203)*

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

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

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

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



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

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

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

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

8.2 Focus group feedback

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

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

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

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

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

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

9 Plans for outpatient care

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

What do we want to do?

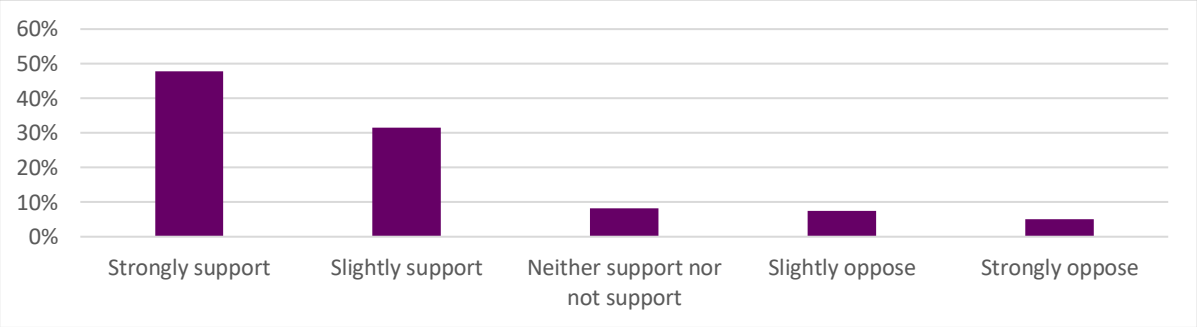
We want to provide less outpatient care in hospital and more in community settings or in people's homes or in community clinics or GP surgeries. We want to increase choice and flexibility for patients in when and where they receive care.

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

9.1 Survey feedback

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

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



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

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

'More access to local provision and increased choice'

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

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

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

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

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

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

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

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

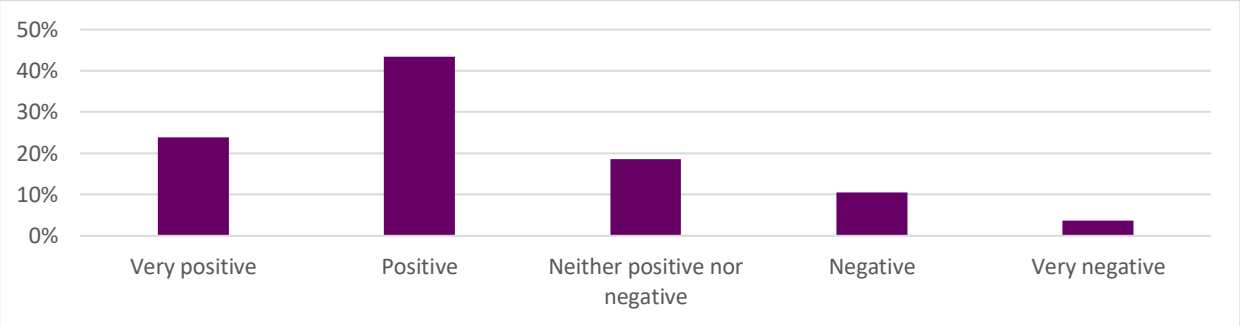
***Table**: What concerns do you have about the plans we have set out? (N=228)*

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

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

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

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



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

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

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

10 Other responses - social media

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

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

10.1 Positive comments

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

- Caring and dedicated staff

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

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

- Excellent standard of care

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

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

- Live saving treatments

  'Saved my life. Amazing.'

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

Other positive comments included feeling safe and being seen straightaway.

10.2 Negative comments

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

- Poor standard of care

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

- Poor communication

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

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

- Delays / cancellations in surgery and treatments

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

- Issues with staffing

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

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

- Lack of basic facilities

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

- Lack of basic care

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

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

10.3 Other / neutral comments

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

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

- Removal of car parking charges.

- A greater focus on prevention.

- Further education and training opportunities for nurses.

11 Conclusion

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

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

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

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

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

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

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

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

12 Appendix

12.1 Demographic breakdown of survey respondents

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

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

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

Response	%
Female	80%
Male	19%
Other	1%

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

Response	%
Yes	99%

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

Response	%
Yes	3%
No / not applicable	97%

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

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

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

Response	%
Yes	53%
No	47%

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

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

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

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

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

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

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

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

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

12.2 Engagement event transcripts

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

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

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

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

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

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

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

Attendee: What will be the impact on GP practices?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Thank you very much for that.

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

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

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

Attendee: What about support on discharge from hospital?

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

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

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

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

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

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

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

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

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

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

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

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

See above.

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

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