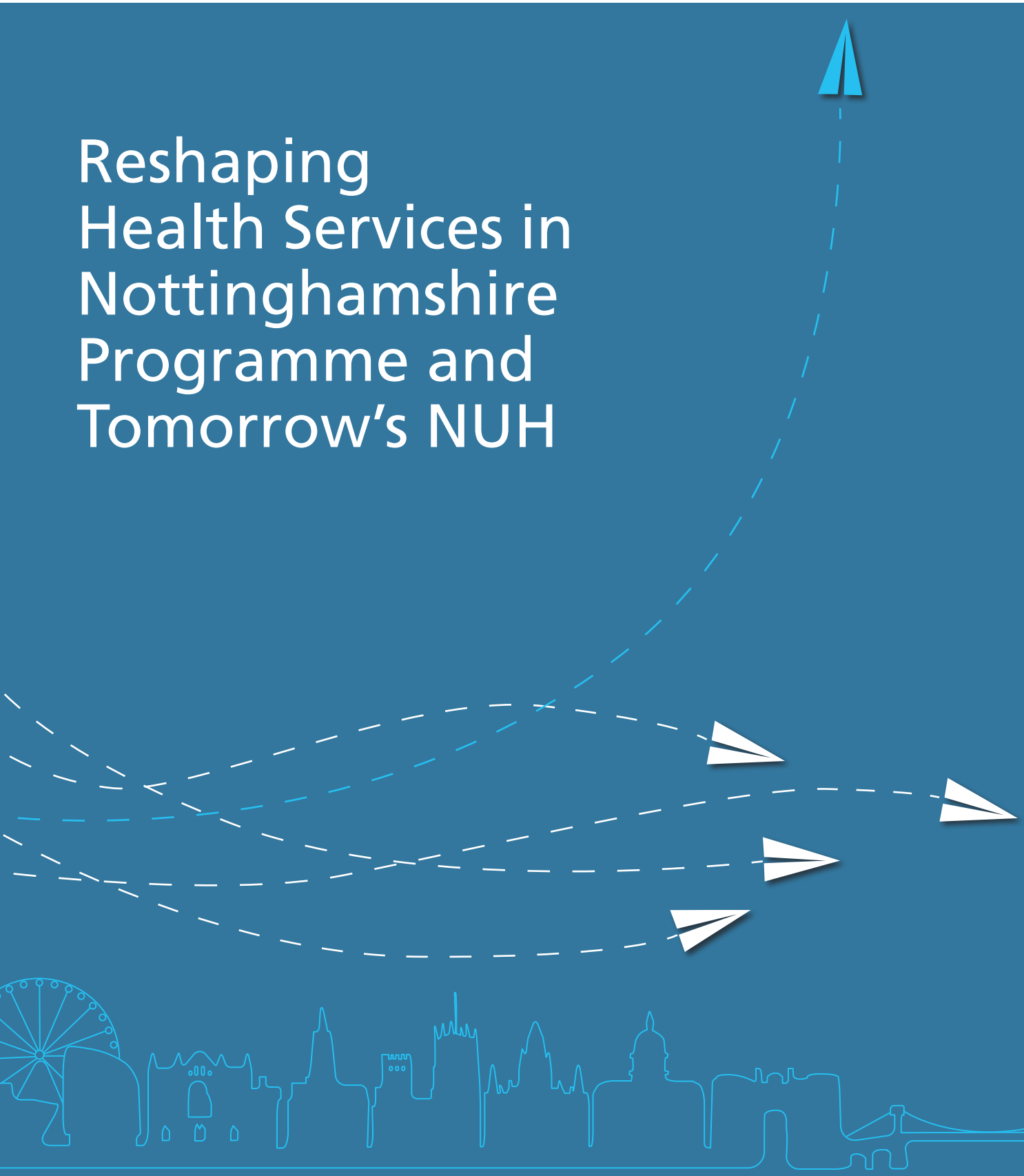
NHS
Nottingham and Nottinghamshire
Clinical Commissioning Group

Reshaping Health Services in Nottinghamshire Programme and Tomorrow's NUH



Public Engagement

Stakeholder briefing

Who are we?

The Nottingham and Nottinghamshire Clinical Commissioning Group (CCG) is an NHS organisation led by local GPs. The CCG is responsible for understanding the health care needs of the population of Nottingham and Nottinghamshire and planning and paying for healthcare services. This includes listening to, and acting on, feedback from local people to make sure that services meet local need.

What are we doing?

Nottingham and Nottinghamshire Clinical Commissioning Group (CCG) is undertaking a two-month phase of public engagement on proposals to transform hospital services in Nottingham. These proposals are part of what we are calling Reshaping Health Services in Nottinghamshire. This plan aims to secure Government funding to invest in our local hospital services so that they are better set up to meet people's needs and improve people's health and wellbeing.

The part of our plan that we are talking to the public about is called Tomorrow's NUH, focused on services provided by Nottingham University Hospitals (NUH) NHS Trust. This involves all the health and care organisations in our area working together to create hospital services that meet the needs of local people now and in the future.

Why are we doing this?

The NHS in Nottingham and Nottinghamshire has an ambition to transform health and care services so that people living in our area live longer, healthier and happier lives. We know that our hospital services aren't currently set up in the right way for us to achieve this ambition. That is why we want to secure Government funding to invest in local services, facilities and buildings. Nottingham and Nottinghamshire has already been earmarked as an area that can be allocated significant additional funding for hospital services. To secure this funding we need to show that we have a plan for how we will use it to improve the health and wellbeing of local people. To do this we need to set out our case for change. Our case for change is a roadmap of the changes we need to make to our local services. We are talking to people about what those changes might look like and what they might mean for local people.

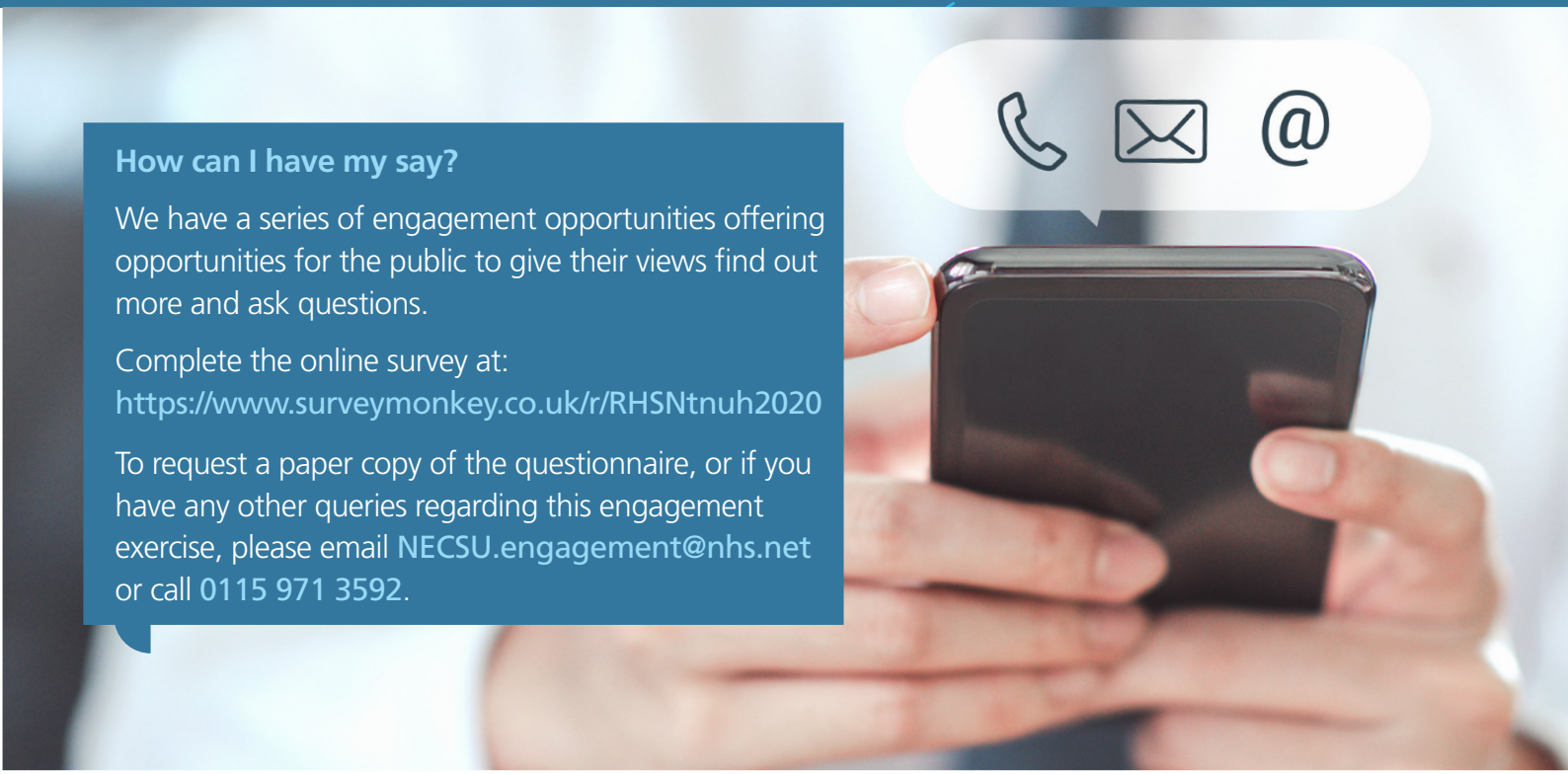
What happens next?

Next year we will be finalising a set of options for changes to hospital services and will put those options to local people in a public consultation. Before we do that, we want to involve people in developing our proposals. Working with doctors, nurses and health professionals across our area, we have started to identify the things we think we need to change. We are now talking to local people about those ideas.

What are we talking to local people about?

Over the coming months, we will be talking to patients, carers and families who may be affected by the changes we want to make. This public engagement is supported by Healthwatch and endorsed by our local health and care organisations. We will be holding a series of events, focus groups and a survey to share our ideas and gather views on:

This is very much the start of a conversation. We will consider the feedback from patients, carers and the public alongside clinical and financial considerations before developing a final set of options and proposals. These options will form part of a public consultation next year.



How can I have my say?

We have a series of engagement opportunities offering opportunities for the public to give their views find out more and ask questions.

Complete the online survey at: https://www.surveymonkey.co.uk/r/RHSNtnuh2020

To request a paper copy of the questionnaire, or if you have any other queries regarding this engagement exercise, please email NECSU.engagement@nhs.net or call 0115 971 3592.

Public engagement events

To hear first-hand from clinical leaders, register to attend one of the following virtual events.

Event	Dates	Times	Register to attend
1	Tuesday 8 December	2.30-3.30pm	http://RHSNengagement.eventbrite.com
2	Tuesday 8 December	6-7pm	http://RHSNengagement.eventbrite.com
3	Friday 11 December	10-11am	http://RHSNengagement.eventbrite.com

Join a discussion group

We will also be running a series of discussion groups to explore the issues raised in the proposals in further detail. Simply email us to book your place on a discussion group.

Focus groups	Dates	Time	Register to attend
Group 1	9 December 2020	11am-12pm	
Group 2	10 December 2020	10-11am	
Group 3	10 December 2020	2-3pm	

These virtual events will take place via Microsoft Teams and joining instructions will be shared once you have registered.

Visit our website: **https://nottsccg.nhs.uk/RHSN/**
Call: **0115 971 3592**
Email: **NECSU.engagement@nhs.net**

Our plans for the future of our hospital services

To truly make a difference to people's health and wellbeing we know that we need a plan that describes how all of our hospital services will work together. That is why we are starting to set out what we call our outline clinical model. This is the plan that provides an overview of how we might set up all our services, guided by what senior doctors and nurses need to do their job.

NUH has achieved national and international recognition for many of its specialist services and are at the forefront of many research programmes. However, the current hospital infrastructure is not set up to deliver the ambitions we have for services in Nottingham and Nottinghamshire. The two large hospital sites that currently exist, Nottingham City Hospital and Queens Medical Centre (QMC), were designed at a different time to care for fewer patients with different needs to patients today.

Our vision for hospital services in the future is set out below, including what this will mean for local people.

What do we want to do?

We want our hospitals in the future to provide more specialist services (e.g. operations) and to provide more routine services (e.g. follow up appointments for ongoing conditions) 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 doesn't result in cancelled operations.

What will this mean for people?

This outline clinical model will mean that:

People would come to hospital less frequently and only if they required specialist care – for example emergency support, inpatient beds or operating theatres. The care people need in between their hospital appointments may happen in a local community setting or over the phone.

Some of the services currently provided in hospital would be provided in a community setting or remotely - this would mean most people have less far to travel for routine care such as follow up appointments for ongoing health problems.

Our hospital buildings and facilities would be more up-to-date and provide better care.

We would provide all of our acute maternity services on one site, so that they are co-located with emergency and specialist services.

All our emergency care services would be on one site, providing access to specialist services that patients may need without having to travel between sites by ambulance.

Planned operations would take place in a dedicated centre, separate from our emergency care services. This would protect planned operations from pressures in emergency care, where admissions to hospital through A&E often mean that we need to cancel operations.

What we want to know

- ***Do you support our overall model?***
- ***What benefits do you think this model would bring for you and your family?***
- ***What concerns do you have about the model we have set out?***

Our plans for emergency care

Emergency care is care for life threatening illnesses or accidents which require immediate or intensive treatment.

We currently provide emergency care services at both the QMC and City Hospitals. This means that when a patient arrives at A&E and needs input from certain specialties, for example, respiratory, cardiology, they need to be transferred by ambulance to the City Hospital for that care. This can add unnecessary delays to getting the care they need.

To ensure all of our patients get access to the right care when they need it, we want to explore the option of combining all emergency care services on one site, where they can be available 24 hours a day, seven days a week. This would mean, for example, that emergency services for stroke patients are on the same site as A&E.

What do we want to do?

We want to bring together all 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.

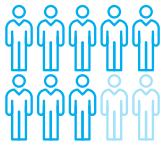
We want to reduce admissions to hospital for people who can be cared for safely elsewhere, by providing alternatives to care on a hospital ward. We would do this by providing Same Day Emergency Care, where patients can be assessed, treated and go home on the same day and by developing 'hot clinics' where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

What will this mean for people?

We believe that making these changes will mean that:

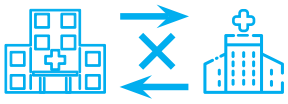


Less people are admitted to hospital from A&E as we will have alternative ways of treating patients who don't need a hospital bed.

People are less likely to need to access emergency care services, as we will provide more community services to keep people well.

People with additional health or support needs who access emergency care will receive support specialist teams, for example mental health teams.

People will not stay in hospital longer than they need to. With input from mental health teams, social care and others we will work to discharge patients when they are able to go home.



Patients will not be transferred between sites to receive their urgent treatments

What is Same Day Emergency Care?

Same Day Emergency Care (SDEC) facilities are typically open 12-14 hours a day, seven days of week. Patients who arrive at A&E with conditions that can be quickly assessed, diagnosed and treated are transferred to the SDEC area where they are seen, treated and discharged the same day rather than being admitted to a hospital ward. This means patients can receive specialist care quickly and avoid long, unnecessary stays in A&E and avoid admission to a hospital bed.

Example:

Mr Smith arrives at A&E struggling with his severe cellulitis, which is a potentially serious skin infection. As he needs intravenous antibiotics, which have to be infused directly into his blood, he is admitted to a ward. He is monitored overnight and discharged the following day.

With Same Day Emergency Care Mr Smith would immediately be transferred out of A&E to a clinic to receive his antibiotics. He would be monitored and discharged the same day and be able to access the clinic directly if he begins to feel unwell again.

He would have to be admitted to a ward as he needs intravenous antibiotics. This means that he needs to be on a ward so that the antibiotics can be infused directly into his blood.

What we want to know

Do you support the model we are starting to develop?

What benefits do you think these changes would bring for you and your family?

What concerns do you have about the plans we have set out?

If you have accessed emergency care, what has your experience been like and what would you like to have been done differently?

Our plans for family care

Family care is care and services that are specific to women and children's health. It includes maternity care.

Our current women and children's services are split across the QMC and City hospitals and the community. Having our services split across sites means that we are not able to provide the same access to the services that work together to provide care for women and children. This results in transfers between sites and delays for women and children to the getting the care they need.

To provide the best, safest care for women and children we are exploring how we would bring services together into a single site as a women and children's hospital.

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.

What will this mean for people?

We believe that making these changes will mean that:

Women who access maternity care in hospital will be seen at a women and children's hospital.

Other services for women and children will also be provided at a single women and children's hospital.

This will mean less choice in location for services, but better care provided in a bespoke facility.

Women and children will be easily able to access specialist services that they may need without needing to be transferred across sites.

We will have our staff, doctors and nurses working with women and children all in the same place.

We will provide more services for women and children in community settings, like clinics and GP Practices.

Women will have better access to psychological and mental health support during and after their pregnancies.

What we want to know

Do you support the model we are starting to develop?

What benefits do you think these changes would bring for you and your family?

What concerns do you have about the plans we have set out?

If you have accessed women and children's care, what has your experience been like and what would you like to have been done differently?

Our plans for adult elective care

Elective care is care that is planned in advance rather than emergency treatment. Elective care involves planned specialist medical care or surgery including things like knee, hip or cataract operations.

Our planned and emergency services are currently alongside each other. As pressure on emergency services grows and takes over more wards and beds it sometimes impacts our ability to carry out planned operations. This means that we end up cancelling operations because there are no theatres or beds available in intensive care or on our wards. This is not the experience we want to give our patients.

Our vision for planned care is that it should be delivered from dedicated facilities which are separated from our emergency work so as to reduce the risk of cancelled operations and reduce length of stay.

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 don't 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 a 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.

What will this mean for people?

We believe that making these changes will mean that:

- Less people need to come to hospital for planned care. Some appointments before and after an operation may be carried out in community settings or over the phone or using video technology, where it is appropriate to do so. This will mean less travel, reduced costs and less time out of their lives for the majority of people.

People will receive better care when they need to come to hospital, in a facility dedicated to care for patients who are having planned procedures. As this unit would be separate from emergency patients there would be fewer cancellations for patients.

How do emergency care pressures affect planned operations for patients?

As our A&E department becomes busier, particularly during winter, we have to admit more and more patients to hospital beds where they need emergency care. Sometimes these are beds that were earmarked for a planned operation. As pressure on our hospitals can increase very quickly, this means we sometimes have to cancel operations at late notice and sometimes more than once. This causes distress to patients and disruptions to their lives.

Example:

Mr McNamara is referred to hospital for a knee replacement and placed on a waiting list. He receives a letter with a planned date for his operation. Two days before his operation is due to take place he receives a phone call to cancel his operation. It is winter, the busiest time of year for the hospital, and because of the number of patients arriving at A&E who need a hospital bed there is no bed available for Mr McNamara.

Mr McNamara has his operation rescheduled for a few weeks later but, again, he receives a phone call two days before his operation to cancel it.

The operation does finally go ahead, although nearly two months after the original appointment was made and after two late-notice cancellations.

With a separate planned care centre, Mr McNamara would have chosen a date for his operation. He would have attended the centre for assessment before his operation and the operation itself would have taken place first time.

What we want to know

Do you support the model we are starting to develop?

What benefits do you think these changes would bring for you and your family?

What concerns do you have about the plans we have set out?

If you have accessed elective care services, what has your experience been like and what would you like to have been done differently?

Our plans for cancer care

Cancer care is the diagnosis and treatment for patients with cancer. Patients are seen and treated in a planned way as well as sometimes being admitted as an emergency.

We currently provide cancer care services across the QMC, City Hospital and where our doctors provide some of our cancer services at other hospitals such as Kings Mill.

We would like to bring our cancer services together, alongside other specialist services that cancer patients sometimes need and with access to critical care.

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.

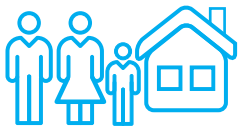
We will co-locate our specialist cancer services with other specialist services. This will mean that cancer patients have access to all the specialist areas of medicine they may need at any time.

What will this mean for people?

We believe that making these changes will mean that:

People will have a greater chance of surviving cancer, as we will detect and diagnose more quickly.

We will reduce health inequalities, through prevention and screening programmes that focus on those at greatest risk of cancer.



People requiring ongoing cancer care will be able to access care outside of hospital and closer to their homes.

Local people will have access to the best cancer care, as our specialist cancer services will be at the forefront of research and innovation.

What we want to know

Do you support the model we are starting to develop?

What benefits do you think these changes would bring for you and your family?

What concerns do you have about the plans we have set out?

If you have accessed cancer care, what has your experience been like and what would you like to have been done differently?

Our plans for outpatient care

Outpatient care or ambulatory care is medical care provided on day-case basis, where patients are treated and discharged the same day without the need to stay in hospital overnight.

Outpatient care services are currently provided at the QMC including in the Treatment Centre, City Hospital, Ropewalk House and in some community settings.

We want to provide outpatient care that is more flexible and more convenient for patients, providing opportunities to access care outside of hospital.

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.

Remote Home Ventilator Monitoring

Typically a patient issued with a home ventilator will attend hospital regularly to review how well it is working. The Lancashire and South Cumbria Long Term Ventilation Service provides a remote ventilator monitoring service. This enables doctors to look at data on the effectiveness of the ventilator without the patient needing to come into hospital for appointments. This has saved patients' time, days off work and travel costs.

What will this mean for people?

We believe that making these changes will mean that:

People are less likely to have their outpatient appointment at hospital, and will have more flexibility and choice about when and where they receive their care.

Follow-up appointments will be more flexible, with patients able to initiate follow ups rather than having routine appointments.

Some care will be provided remotely – for example where patients have specialist equipment that can be monitored using technology.

What we want to know

Do you support the model we are starting to develop?

What benefits do you think these changes would bring for you and your family?

What concerns do you have about the plans we have set out?

If you have accessed outpatient care, what has your experience been like and what would you like to have been done differently?

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Contact us

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