



**Nottingham City CCG Strategy Development  
Report on Engagement Activities**

**November 2016**

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## **1. Executive summary**

### **1.1 Background and approach**

Nottingham City CCG is in the process of developing a new commissioning strategy for 2016-20. To inform its strategy, the CCG is conducting a wide-ranging programme of engagement with stakeholders, patients, community groups and members of the public.

The engagement activity comprised an event with stakeholder organisations; an online and offline survey with 620 responses; 14 facilitated face-to-face discussions with key communities (e.g. carers, disabled people, elderly people etc.); a stand at six community events and a toolkit which allowed other partners and stakeholders to run their own engagement events.

The purpose of the engagement was to understand the communities' healthcare priorities, their response to the draft strategy, and their views on how the strategy could be delivered.

### **1.2 Emerging findings and recommendations to consider**

Survey respondents were asked how far they agreed or disagreed that the ambitions and priorities proposed for the strategy were the right ones for the people of Nottingham City. An overwhelming majority of the 324 respondents who were asked this question agreed that these were the right strategic ambitions, with 94% agreeing overall, of which over half (57%) strongly agreed. Of those who disagreed, concern largely focused around the impact of financial cuts and the ability of the CCG to achieve the aims. Some felt that there should be more explicit mention of the wider determinants of health and the need for effective joint working with other partners.

There was also strong consensus across the facilitated face-to-face discussions with community groups on their healthcare priorities and there was broad support for the draft strategy. In particular, participants saw the focus on mental health, and on prevention, tailored education, and an integrated approach to mental and physical health, positively. However, participants would have liked to see a focus on improving GP services reflected in the draft strategy. Access to primary care was also a strong theme in the survey responses.

There are a number of actions for Nottingham City CCG to consider based on the feedback from the survey and the facilitated discussions with some of the city's different communities. Most of these recommendations cut across the delivery themes (prevention, diagnosis, treatment, self-care), the commissioning priorities (mental health, cancer, long-term conditions, musculo-skeletal disorders) and the

communities. However, there are some that are specific to a theme, priority or community.

The proposed actions are as follows:

### ***1.2.1 Improved access to GP services***

Actions for the CCG to consider in relation to access to GP services include:

- Improved booking systems and processes – to ensure patients can get through on the telephone, that there are call-waiting systems to allow them to wait to speak to a receptionist and that let them know where they are in the queue.
- Offering and promoting alternatives to standard GP appointments, such as telephone appointments, or appointments with nurse practitioners.
- Increasing the number of GP appointments available to cut waiting times.
- Improved consistency between GPs and common standards to ensure all GPs have similar processes and systems in relation to appointments and bookings systems.
- Offering and promoting extra time and support in GP appointments for people who need it, e.g. because of a learning disability, complex or multiple issues, or because they need an interpreter.

### ***1.2.2 Encouraging prevention and self-care by providing better information and support***

Actions for the CCG to consider in relation to prevention and self-care include:

- Reviewing the effectiveness of current health promotion activities and explore new ways of getting the message across.
- Ensure that health promotion materials are tailored to the audiences in question.
- Work with partners to promote and support self-help groups.

### ***1.2.3 Widening and promoting alternative access points***

The CCG could also consider offering more alternatives to the GP as the first point of contact, and promoting existing alternatives, e.g.:

- Better promotion of NHS 111, pharmacy services (especially advice and diagnostics), and self-referral services for physiotherapy and counselling.
- Widespread training for other support workers and professionals to raise awareness, educate, spot early signs, support and signpost. In particular, the CCG should consider working more with Voluntary and Community Sector groups to identify opportunities for connecting with communities in greatest need, and use these channels to spread messages and promote services.

#### ***1.2.4 More inclusive and empathetic services***

The CCG could explore how it can promote improved cultural competence amongst all healthcare professionals so that they can understand, assess and respond to the needs of the communities included in this report.

It is suggested that the initial focus is on GPs, as most comments about cultural competence were focused on GPs. Improved understanding and awareness is especially recommended concerning transgender issues, Deaf people and the healthcare needs and eligibility of Asylum Seekers and Refugees.

It is proposed that the CCG works with community groups and the Voluntary and Community Sector to help it improve healthcare professionals' understanding and to identify knowledge gaps.

#### ***1.2.5 Improved access to mental health***

The CCG could consider a number of actions to improve access to mental health services:

- Quicker referrals into mental health services.
- Shorter waiting lists for mental health services.
- More holistic health assessments at all points along the patient pathway: all healthcare professionals could broaden their assessments to include mental health as well as physical health, and signpost and refer patients where necessary.
- Improved specialism in primary care: greater knowledge amongst GPs of mental health conditions, treatments and medication. This could be achieved by blanket increase in GP knowledge, or by increasing the number of GPs with a mental health specialism.
- Easier access to bridging treatments, e.g. talking therapies while waiting for specialist care (including gender identity services, cancer care and specialist mental health services).
- More – and better promoted – self-referral services.

#### ***1.2.6 Communicating the final, agreed strategy***

There was a call for the CCG to communicate the feedback on the engagement activity and to explain to community groups and stakeholder organisations how this feedback is translated into the final, agreed strategy. The CCG needs to ensure that it does this effectively as there was some strength of feeling that this has not always happened in the past.

## **2. Background, objectives and methodology**

### **2.1 Background**

Nottingham City Clinical Commissioning Group (CCG) is a local NHS organisation, which was created by the Health and Social Care Act 2012. All GP practices in Nottingham work together as a CCG to buy most of the services that they refer their patients on to such as hospital, mental health and community services.

As part of the CCG's planning for commissioning services, work has started to develop a new strategy for 2016-2020. The previous commissioning strategy period ended in March 2016, although commissioned healthcare services are continue as normal. To support the development of the new strategy, a programme of engagement is underway with stakeholders, partners, patients and the public to ensure the priorities agreed are appropriate and reflective of the health needs in Nottingham City.

The engagement activity comprised:

- An event with stakeholder organisations.
- An online and offline survey.
- Facilitated face-to-face discussions with key communities (e.g. carers, disabled people, elderly people etc.)
- A stand at six community events run by the Council.
- A toolkit that allowed other partners and stakeholders to run their own engagement events.

### **2.2 Overview of approach**

This report outlines the feedback from the quantitative survey, the facilitated sessions with community groups and the events facilitated by other partners and stakeholders. Separate reports have been provided on the initial event with stakeholders which took place prior to the launch of the engagement programme and also a more detailed report of the community group feedback.

#### ***2.2.1 The quantitative survey***

Nottingham City CCG published the information document on their website on the 3rd<sup>th</sup> May 2016, with details of how to take part in the engagement exercise. The closing date for responses was 12<sup>th</sup> August 2016.

An online survey was available on the Nottingham City CCG website. To raise awareness of the activity a marketing campaign was launched using print, social media, local media and local voluntary sector networks.

Nottingham City CCG also attended six community events, where local residents were encouraged to either fill in the online questionnaire or complete a hard copy on the day.

The events were:

- 4 May 2016 – Arkwright Meadows Community Gardens Spring Event, Meadows.
- 8 July 2016 – Market Square, Nottingham.
- 25 June 2016 - St Ann's, Nottingham.
- 28 July 2016 – Southglade Park Live 2016 Event, Bulwell.
- 30 July 2016 – Sneinton Festival, Sneinton.
- 9 August 2016 – Picnic in the Park, Clifton.

A shorter version of the questionnaire was produced for use at the events to facilitate completion. The full version and the shorter version of the questionnaire are provided in Appendix 3.

### ***Breakdown of survey responses***

In total, 620 completed survey responses were received. The majority were completed on paper (314), with the remaining 306 completed online.

Two versions of the questionnaire were used. A longer questionnaire was available online (306 completed) and completed on paper by an additional 23 respondents, making a total of 329. Attendees of the six Community Events completed a shorter, more simplified questionnaire (291 completes).

A demographic breakdown of survey respondents is provided in Appendix 2 and the full survey feedback is provided in Appendix 1.

### ***2.2.2 Facilitated community sessions***

The objectives of these sessions were to:

- Understand patient and public priorities for the future.
- Inform the development of the Strategy through helping to identify targeted actions for each commissioning priority.

Many groups were recruited and organised by existing statutory and voluntary organisations. Some sessions were organised as part of existing meetings or sessions, and some were set up outside of routine meetings. Group discussions differed in length, and ranged from 1-2 hours, depending on the time available and the needs of participants. Tailored discussion guides were developed for each group, and the generic version – along with handouts about the CCG and its strategy – are included in Appendix 3.

The following sessions, facilitated by Community Research, were conducted:

<b>Audience (organisation that arranged)</b>	<b>Number of participants</b>	<b>Date held</b>
Lesbian, gay and bisexual (LGB) community also including some transgender people (Nottinghamshire Rainbow Heritage)	11	9 May 2016
People with learning disabilities (Splat, Vox)	5	10 May 2016
Black Caribbean community (Self Help Nottingham)	18	17 May 2016
Transgender community (Notts Trans Hub)	6	17 May 2016
People with mental health conditions (Nottinghamshire Healthcare NHS Trust)	7	23 May 2016
South Asian community (Self Help Nottingham)	16	24 May 2016
Black African communities (Self Help Nottingham)	21	26 May 2016
Women (Nottingham Women's Centre)	7	3 June 2016
Students (University of Nottingham)	9	9 June 2016
Asylum seekers and refugees (Notts Refugee Forum)	36	10 June 2016
Mothers with young families (Small Steps, Big Changes)	9	14 June 2016
Carers (Carers Federation)	7	15 June 2016
Homeless Service User Forum (Sea Participation)	5	8 July 2016
Homeless people (Framework HA)	6	12 July 2016

A breakdown of the make-up of participants by personal characteristics (including age, disabilities, gender identity, race, sex, and sexual orientation) is included in Appendix 2.

Key themes emerging from the community group feedback have been summarised in Section 3 of this report. A fuller report of this feedback is available in a separate, more detailed report.

### ***2.2.3 Other community sessions***

A tool-kit was produced to allow community organisations and groups to run their own engagement sessions. This included background on the engagement, a list of key questions and information on how to feed back people's views. A copy of the toolkit is provided in Appendix 3. Sessions run were:

- Events on 8<sup>th</sup> July and 15<sup>th</sup> July run by Nottinghamshire Deaf Society.
- A discussion on 12<sup>th</sup> July by Victoria & Mapperley PPG.
- A discussion on 15<sup>th</sup> July 2016 at Claremont Primary and Nursery School run by the CCG.

Written feedback was provided by the Homelessness Prevention Strategy Implementation Group (SIG).

The feedback from these groups has been incorporated into Section 3 and into the separate, detailed report of the community group findings.

## **2.3 Note on the report**

### ***The survey reporting***

It should be noted that the engagement exercise was open to anyone who chose to respond. As this was an engagement exercise rather than sample based research and those who chose to respond are, by their very nature, self-selecting, the results cannot be extrapolated and assumed to represent the views of the population as a whole.

All the verbatim comments in response to the questionnaire have been coded into a number of categories so the results could be quantified. This process, by its nature, distils and summarises the responses, but in an engagement exercise it is important that the rich detail of the full comments is not lost. All tables in this report should therefore be read in conjunction with the verbatim comments. A selection of comments has been included; full lists of all comments are available separately to this report on request.

The report includes some analysis of differences by demographic characteristics where findings are notably or significantly different. It should be noted that – given the sample sizes – some of these comparisons may be indicative, rather than statistically significant. The report makes it clear when differences are significant, and when they are indicative.

The figures quoted in the tables are percentages unless otherwise stated. Base sizes on which percentages are calculated are provided at the bottom of the chart or table. Percentages may not sum to 100% in all instances on account of rounding or because respondents gave multiple responses to some questions.

### ***The community groups***

Participants were recruited via voluntary and community sector organisations and many were members of support or self-help groups. Many participants had complex conditions and some had a number of different health issues. As a result, in some groups, participants had greater knowledge or experience of the issues being discussed that we might expect from members of the general public.

In some groups, there were support workers present. Some participants needed support to express themselves and communicate, and in these cases support

workers and interpreters were involved. However, it should be stressed that the views included in this report come from participants, and not from professional groups or supporters, unless expressly stated.

### 3. Key findings

#### 3.1 Response to the draft Strategy

Respondents in the online and longer paper survey (329 respondents) were given a summary of the overall ambitions of the CCG's strategy for 2016-2020. These were described as follows:

- To increase the number of years that local people live in good health, meaning that people are healthier for longer.
- To reduce the health inequalities, meaning that the health of those who have the worst health in the city is improved.
- To support local people to improve their own health.

Respondents were asked how far they agreed or disagreed that these ambitions were the right ones for the people of Nottingham City. An overwhelming majority who were asked this question **agreed that these were the right strategic ambitions**, with 94% agreeing overall, of which over half (57%) strongly agreed.

Linked to this, 12% of respondents who gave a reason for their agreement emphasised their support of the commitment to reducing health inequalities. There was widespread recognition that Nottingham has challenges associated with health inequalities and that this urgently needed to be addressed. Healthcare professionals were significantly more likely to mention this (15%).

*"I feel very strongly that class and wealth should not influence how long a person lives or how healthy their lives are."*

**Healthcare professional**

All survey respondents were given a summary of the conditions that NHS Nottingham City CCG proposes to focus on to try to achieve its ambitions. These were described as follows:

- Mental health.
- Cancer.
- Long Term Conditions (Diabetes, Stroke, Heart Disease, Respiratory Illness, Liver Disease.)
- Musculoskeletal Disorders (injuries or pain in the body's joints, ligaments, muscles, nerves, tendons, and structures that support limbs, neck and back.)

**The quantitative feedback supports the priority conditions selected by NHS Nottingham City CCG.** A wide range of other health conditions and issues were mentioned as potential priorities by small percentages of respondents. The largest number of mentions was for Dementia/Alzheimer's with 21 respondents

(3% of those that answered) asking for this to be included within the priority conditions, followed by 20 mentioning obesity.

There was also support for the four themes for delivery at the community group sessions, particularly the focus on prevention, tailored education, early intervention, and an integrated approach to mental and physical health.

While there was support for focusing prevention interventions on high risk groups, some participants questioned how 'high risk' will be defined. Amongst mental health service users and representatives of homeless people, there is a concern that the risk threshold will be set too high. This concern is based on perceptions of high thresholds for accessing some existing support and treatments. Deaf people queried the definition of mental health and asked if there is a better and clearer way of describing what is included.

One patient group felt that the Strategy should explicitly mention children, carers, obesity, and family especially in relation to mental health and the rising number of people with complex health needs. They felt that there should be a reference to a holistic approach, which links the strategy with Housing/Education/Social Care strategy. They also noted that the current austerity regime will make the delivery of any Strategy more challenging as it could be detrimental to those at risk of health exclusion.

The Homeless Prevention SIG welcomed the focus on prevention but noted funding cuts to early intervention services. They called for more focus on people at high risk of poor health, particularly those who are vulnerable, and who lead 'chaotic lives', who struggle to navigate and access health services. They also called for more joined up working between health, homelessness and substance misuse at a strategic level and greater valuing of small providers.

## 3.2 Emerging themes

There are a number of overarching themes that are evident from the survey and community group feedback that cut across the delivery themes (prevention, diagnosis, treatment, self-care) and the commissioning priorities (mental health, cancer, long-term conditions, musculo-skeletal disorders.) These are outlined below:

### 3.2.1 Improved access to GP services

In nearly every community discussion group, participants raised **issues with getting GP appointments**. They talked about having narrow windows of time when they could try and book appointments, repeatedly phoning to try and get through, long waits for appointments or no available appointments when they needed them. Many participants talked about the stress and anxiety of trying to get a GP appointment as a result of these difficulties.

*"I find often when I need to see a GP, I might go in at 7.50 or 8.00 in the morning and there's no appointments left because they are just overrun. I know they're stretched to the hilt, I know they're supposed to have five to 10 minutes, but there's a problem."*

**Women's group**

*"I have to ring [the GP] up, I've been putting off my phone calls for like three weeks now just because I can't get through in the morning, there's no queuing system or anything."*

**Mothers of young families group**

The issue of GP access was also raised by survey respondents - 8% spontaneously suggested that the CCG should consider improving primary care access when thinking about prevention and 17% when thinking about diagnosis.

*"Appointments are difficult to get and take all morning. Why would you queue if there might not be a problem? Come back in two weeks is often repeated and many don't bother. It needs to be easier to be screened and something like routine blood/urine tests for example whenever you see the nurse or doctor rather than make another appointment. Online so you can get information at the time you are worried and book online."*

**Survey respondent - member of the public**

A minority of participants said that their GPs had better systems, such as call waiting systems and telephone appointments, and other participants felt these ideas would ease pressures at their surgeries.

In some community groups, people reported that they (or others in their community) had been **refused access to GP services** or that GPs had refused to treat them:

- Some Asylum Seekers said they knew of a number of people who had been told they could not register with a practice because of their status.
- In the group with homeless people, participants said they couldn't register with a GP surgery because they had no fixed address, and that – as a result – they had to use walk-in services or drop-in services at homeless shelters or day centres. They said that this meant they faced long waits (at walk-in centres) and short appointments.

*"I find it wrong that, if you're on the streets, you can't register with a doctor. You have to register with a homeless doctor at the day centre... or you have to go to the walk-in centre and wait three and a half hours."*

**People who are homeless**

- A number of Transgender people said that some health professionals refuse to treat Transgender patients. Instead they refer them to specialist services, even for issues not related to gender identity.

*"At the moment you get a mixture of doctors actually refusing to treat patients at all, Trans patients that is, even though the clinic has actually told them what to do in writing."*

#### **Transgender Community group**

All community groups felt that a **10-minute appointment slot was not sufficient** for the GP to understand their needs, particularly given different cultural expectations and communication needs. As a result, people in these communities felt that they were not always listened to, that they were sometimes 'fobbed off', and that they were at risk of misdiagnosis or not being diagnosed at all. Those with mental health conditions felt that they needed longer GP appointments so that the link between physical and mental health could adequately be explored and understood.

Given the focus on access to – and experience of – GP services, participants made a number of suggestions for improvements. These included:

- Greater use of alternative contact with GPs, e.g. via telephone appointments, and drop-in sessions.
- Longer GP appointment times, with more thorough assessment or medical examination.
- Longer appointments for people with complex needs and extra needs e.g. people with learning disabilities, Deaf people, people with multiple health needs, and people who need translators. They also suggested greater use of interpreters and communication aids, such as communication books and health passports.

*"Maybe [have] longer appointments where you can talk about all of your symptoms and understand the person as a holistic thing, which links in with both mental and physical health."*

#### **Students group**

*"Just because the person speaks the language, it doesn't mean they understand the health issue. Also, the translation is not working, and [people] don't get any extra time if [you need] a translator."*

#### **Black African communities group**

- Practical support to attend screening, particularly for parents with young children.

*"They should give us some kind of appointment first thing in the morning, if you're a single parent and you've got a child but you still need a smear test or you need your breast checked or you need something intimate and personal."*

### **Parents with young families group**

- Greater specialism in GP services (especially in mental health and transgender issues), and GPs working together to signpost and cross-refer to healthcare professionals with a particular interest or specialism.
- Choice of GP outside of the catchment area for those who are transient, e.g. homeless people.

*"When you move around, especially when it comes to a mental health thing and you move area you have to change your GP, which is not fair to the person that's really feeling comfortable with one GP."*

### **People who are homeless**

Other specific suggestions were:

- GP practices encouraging patients to have annual screening - well man/women checks.
- Greater use of emails to patients alerting them to GP and local health services.
- GP practices putting on health promotion events.
- Easier access to GP surgeries in evenings and w/e.
- Promotion of Nurse Practitioner as first point of contact.
- More locally-based diagnostic services.
- Training for GPs (and their receptionists) on how to deal with different audiences e.g. Trans people, Deaf people, transient populations, vulnerable groups.

Actions for the CCG to consider in relation to access to GP services include:

- Improved booking systems and processes – to ensure patients can get through on the telephone, that there are call-waiting systems to allow them to wait to speak to a receptionist and that let them know where they are in the queue.
- Offering and promoting alternatives to standard GP appointments, such as telephone appointments, or appointments with nurse practitioners.
- Increasing the number of GP appointments available to cut waiting times.
- Improved consistency between GPs and common standards to ensure all GPs have similar processes and systems in relation to appointments and bookings systems.
- Offering and promoting extra time and support in GP appointments for people who need it, e.g. because of a learning disability, complex or multiple issues, or because they need an interpreter.

### 3.2.2 Encouraging self-care and prevention by providing better information and support

Many survey respondents to the online survey/longer questionnaire spontaneously emphasised the importance of a holistic approach to prevention and intervention support which would stop people from becoming unwell in the first place. Respondents were asked for their views on what the CCG needs to think about when planning for better prevention. 30% of respondents across all stakeholder types mentioned the **need to give people more advice and support** to help them achieve healthy lifestyles. Many emphasised the importance of educating people and raising awareness of the consequences of an unhealthy lifestyle.

*"I think that you are missing something which is to educate people who are currently making bad health choices or who are in danger of making bad health choices to be equipped with the tools or know where to find tools to help them make better choices"*

**Survey respondent - member of the public**

In most groups, participants felt that people need improved awareness and support to lead healthier lifestyles. There was a particular focus on diet, and some on exercise. Many participants acknowledged that they, their families and their communities need to improve their diet and become more active, but they feel that there are multiple barriers to doing so

Participants who were part of like-minded community groups reported the benefits of getting involved in activities that they organised, such as trips, exercise sessions and self-help groups. Some participants in BME and women's groups said they had taken part in specific health education programmes (such as on diet, activity and diabetes). However, other participants reported that they had not heard of any health promotion or education at their community groups (e.g. Asylum Seeker & Refugee community; people with learning disabilities).

People in the LGB community and people with learning disabilities said there were **too few targeted or appropriate resources and materials** on healthy living (especially for people with learning disabilities) and sexual health (explicit in the LGB group, implied in the Learning Disabilities group.) Deaf people mentioned inaccessible information meaning that it can be difficult for them to know how to lead healthy lifestyles or know what to look for in terms of symptoms of illnesses, such as cancer. They preferred information in simple English, supported by visual representations.

Participants were keen to see the following:

- Greater use of 'prescriptions with a difference' (i.e. social prescribing) to refer people onto community activities and self-help groups. A number of

participants across the groups felt they had benefited from membership of community groups and from referrals for gym membership and healthy eating classes. They felt this was particularly valuable in addressing social isolation, improving lifestyle behaviours, and improving mental wellbeing.

- Health education starting in schools and colleges and taken outside of the GP surgery to less threatening environments, for example more events like Healthfest or better use of technology.
  - A PPG indicated that if, for example, the CCG wished to set up health information events PPGs could provide support in advertising, transport where appropriate and support at the event.

*"Use of technology e.g. Apps to help. Set workplace challenges e.g. pedometers to walk around the world. Get people talking about self-care in a fun and entertaining way. Schemes like Park Life (City Council) and This Girl Can are excellent. Promote the benefits. Support and encourage social movements/ innovations such as Dementia Friendly Communities. Other places have made small investments for one year for Dementia Friendly Community Workers who have set up groups, engaged with businesses, communities and created a supportive, self-care culture, potentially reducing demand on services and encouraging prevention."*

**Survey respondent replying on behalf of an organisation or group**

*"Why can't we have education days somewhere so that people who suffer with certain conditions can go and be talked to about the conditions and how to self-manage?"*

**Survey respondent replying on behalf of an organisation or group**

*"Finding different ways of reaching people who don't always engage - taking advice and screening out into the community, for example mobile screening units at school gates, local events, market square, etc."*

**Survey respondent - member of the public**

Participants in all groups and survey respondents felt there was **real value in community and self-help groups** helping people understand their conditions and manage them.

*"We are social animals, we don't self-care, we need the pack in order to look after ourselves. So I think this emphasis on self-care, it's a very neoliberal individualistic model and actually there needs to be more focus on support and community care."*

**Transgender Community group**

*"Helping people find an appropriate self-help group, and reminding them they don't have to 'Do it alone'. Talking and being with similar sufferers is encouraging, as long as the group has professional guidance."*

**Survey respondent - member of the public**

*"Self-care is about having somebody to support you, to help you understand your condition, to help you to understand what you can do to help yourself, but to also recognise that when you're in the place I'm in, I don't want to exercise, I don't want to lose weight, I don't want to do anything... When you feel nothing, you've got [to have] somebody there to say 'come on, I'll come with you'."*

**Mental Health Service user group**

Participants placed particular value on groups run by people who know their community and have specialist knowledge about issues and needs they will have. There was a strong feeling that efforts to improve the effectiveness of prevention and self-care strategies need to be appropriate for the audience in question.

*"Systems and mechanisms currently in place to reduce health inequalities are inadequate and in themselves need vast improvement. Support people to improve their own health: The mechanisms for self-improvement exclude significant numbers/group and communities e.g. web-based self-help tools."*

**Respondent replying on behalf of an organisation or group**

*"Historically, prevention strategies have been very "middle class". I'm not sure this approach works well in all areas...Nottingham has high levels of poverty/deprivation and so it's not a good idea to suggest "people eat the right things" or "go to the gym" if these things are unaffordable. There are also high crime levels in some parts of the city which may prevent people feeling safe to go out by themselves to do things. However, you do have some amazing free facilities around the city and it might be worth working with community organisations to do walks etc..."*

**Survey respondent - member of the public**

BME communities, LGB community and women called for local, affordable, and culturally appropriate activities. Parents (especially mothers) across all groups stressed the importance of providing childcare to enable them to take part in activities. People with learning disabilities said they would need significant support to get involved in more activities, for example, more hours with support workers, and physiotherapists for support with exercise.

One patient group suggested that there should be increased funding for groups that support specific high risk audiences, such as SureStart, Notts Mums and Framework HA. The Homelessness Prevention SIG specifically mentioned the importance of preserving unique and specialist services, like services for gypsies and travellers, DV midwives and housing/health hospital co-ordinators.

Participants stressed the importance of these support groups being targeted for particular communities – they feared that they might not be welcome at more mainstream support groups, that people in these groups would not understand their culture, or that these groups might not be able to accommodate extra or different communication needs. Some participants worried about prejudice and discrimination in mainstream support groups:

*"With the media-bashing of immigrants, it makes us self-conscious when we go out there. I wouldn't go to a [mainstream] support group"*

**Asylum Seeker and Refugee community group**

*"R is a community health advocate. She basically puts herself out. If anybody has got a story to tell and she knows about it, she will try and help that person and put that person in the right direction... anything to do with health and it's community based, she will try and help it... The GPs don't understand. They're not from our community, they don't try and find out how our community works, R is somebody from the community."*

**Caribbean Community group**

There was a call for **greater promotion of existing groups** (both to members of the public and to healthcare professionals), and resourcing to set up and support further groups, amidst concern that some of these groups and services had been lost due to funding cuts.

*"There's so many support groups that don't require money that are around and if you're linking them in with an information campaign would be really good."*

**Students group**

*"We need to work out who (i.e. which groups of people/which issues) can be most helped by peer support and roll it out further. Look at how this can be supported through the Looking After Each Other programme."*

**Homelessness Prevention SIG**

There was also widespread agreement that to achieve this would involve:

- Investment: more services, more appropriately trained healthcare professionals, improved access to primary care.
- Multi-agency coordination: because implementing prevention strategies which are targeted at those most at risk needs to involve a wide range of agencies who are able to identify and reach those most in need.

Actions for the CCG to consider in relation to prevention and self-care include:

- Reviewing the effectiveness of current health promotion activities and explore new ways of getting the message across.
- Ensure that health promotion materials are tailored to target audiences.
- Work with partners to promote and support self-help groups.

### 3.2.3 Widening and promoting alternative access points

The **importance of widening and promoting alternative health access points** was highlighted by survey respondents - when asked what the CCG should consider in terms of treatment, 6% spontaneously mentioned that treatment needed to be delivered within the community and at a local level rather than within more distant secondary care settings. Health professionals were more vocal about this with 13% of them emphasising the importance of this.

*"Stop NUH being the focus for care - people need to be re-educated to use services appropriately. Having everything at NUH encourages people to use this as a one-stop shop. Giving adequate resource to community services so that people can be supported with the health and social care needs. Support initiatives that enable rather than produce dependency. Use alternative models - community based projects in partnership with voluntary sector and CCGs - for example using chaplaincy teams to work with clinicians in the community to provide spiritual / psychological support."*

**Survey respondent - member of the public**

At the community groups, participants viewed the GP as the first port of call when they had symptoms or signs of illness. Parents of young families discussed alternative routes to services – such as pharmacists, NHS 111, and self-referral services. However, few participants knew of these or had used them, and there was little mention of them in other group discussions (apart from Deaf people mentioning the need to improve how the 111 service works for them, particularly ensuring sufficient interpreters and the interpreter video relay service).

*"The diagnosis is always with the GP; he seems to be the golden boy. And then we wonder why he's so busy and you can't get an appointment!"*

### **Black African communities group**

Many participants felt that their **trusted community groups could play a bigger role** in helping people spot early signs and as a first port-of-call for help. A patient group suggested that health checks could be conducted in the work place or in education institutions.

People from BME communities, the homeless community and people with learning disabilities felt that there was an opportunity for their support workers to receive training to raise awareness and spot early signs.

*"If I had mental health issues I'd go to an LGBT supporter. I wouldn't have to explain that bit to them, I'm just dealing with my mental health issues. So straight away you've cut out half the pressure because you don't have to explain that, you just go and deal with your mental health."*

### **LGB Community group**

Some participants – especially in BME groups – suggested community-based regular health checks, particularly for those more at risk, whether because of their culture, lifestyle or family history. Some also felt that screening opportunities should be taken out to their communities, for example in community centres.

In a number of groups, participants said that people in their communities are less likely to travel to receive services due to confidence, practical barriers or motivation (such as people with mental health issues, parents with young children, people who are Asylum Seekers and Refugees, and some BME communities). They said it was important to provide services closer to home for these communities. A patient group felt that more services provided locally in the community was important for all types of patients.

The Homelessness Prevention SIG mentioned the difficulty people who are homeless or in unstable housing situations will have accessing mainstream services and called for the CCG to consider commissioning routes for people who can't access universal healthcare. For example, there could be a mental health response in hostels.

A number of participants suggested targeted intervention at key stress points in people's lives (such as family breakdown, bereavement, job loss, and financial

problems) to assess mental health needs, for example working with other agencies such the Citizen's Advice Bureau.

*"Knowing that you could go to the pharmacy to have an MOT, get your blood pressure checked... it doesn't need to be a doctor that does that."*

**Parents with young families group**

*"Self-referral could help with mental health as well. You could self-refer, because a lot of people think they have mental health issues and just knowing that you could bypass the doctor and just go and speak to a Therapist [would help]."*

**Parents with young families group**

Younger participants talked about the opportunity to **use technology to greater effect** to aid diagnosis, for example:

- Wider promotion of signs and symptoms of common illness and diseases (including mental health). Students suggested using technology or an app as a symptom checker.
- Using technology to help patients to communicate all issues at once to healthcare professionals who are seeing them for the first time. Students suggest this would avoid people with complex conditions having to repeat their story every time, and would encourage healthcare professionals to take a 'whole-person' approach to understanding a person's needs.
- An improved system for sharing test results (including when tests are negative) to ensure patients receive timely results that are easy to understand, and information on what this means.

The CCG could consider offering more alternatives to the GP as the first point of contact, and promoting existing alternatives, e.g.:

- Better promotion of NHS 111, pharmacy services (especially advice and diagnostics), and self-referral services for physiotherapy and counselling.
- Widespread training for other support workers and professionals to raise awareness, educate, spot early signs, support and signpost. In particular, the CCG should consider working more with Voluntary and Community Sector groups to identify opportunities for connecting with communities in greatest need, and use these channels to spread messages and promote services.

### 3.2.4 More inclusive and empathetic services

Respondents across all types of stakeholder identified the importance of delivering support that genuinely understands, and therefore delivers, what different communities need. Some perceived that not enough effort had been made historically to reach particular people and communities in the most motivating ways appropriate to them. A number of respondents had specific comments to make about institutional barriers within the public health/health promotion/healthcare sector which prevented services from providing advice and support in the best way possible.

*"Far too many teams are made up of the same cohorts e.g. white ethnicity, care professionals. The city doesn't need any more people or approaches that are institutionalised and which create further barriers to access. A person of age or different ethnicity is neither stupid or unable to process information, the care sector continues with the same people and same backwards approach."*

**Survey respondent - member of the public**

People in all communities also said that healthcare professionals did not always understand or meet their specific needs. Many examples relate to GPs, but other healthcare professionals were also mentioned. Some of the examples people gave include:

- People from many discussion groups (including Black, Asian and Minority Ethnic communities, carers, parents and asylum seekers and refugees) felt that their GP did not take time to understand them and were often dismissive of their concerns.
- Members of the African community added that standard appointment times were not long enough when they needed an interpreter. They also felt that their GPs lacked cultural understanding of African mentality, lifestyles and turn of phrase.
- Transgender people said that appointments were often taken up with explaining what it means to be Transgender, even when appointments were unrelated to gender issues.
- People with learning disabilities described experiences where healthcare professionals did not take time to explain things, or talked to their support worker instead of to them.
- Some in the LGB community said that their GPs had told them that lesbians did not need cervical smear tests, and members of the Transgender community said they had been offered inappropriate screening, or not offered screening they needed.

- Mental health service users and Transgender people felt that many GPs did not understand their conditions, with particular concerns about their expertise in different types of medication for mental health conditions.
- Transgender people and people with learning disabilities described situations where healthcare professionals attributed unrelated healthcare issues to their Transgender status or learning disability.

*"I have had GP appointments where it's been 10 minutes, and eight minutes of that has been explaining to them what being transgender is when it's not necessarily why I've turned up. In fact, that has come up as a sizeable topic of conversation in appointments for my son, who is not transgender and really it wasn't of relevance."*

**Transgender Community group**

*"There's a lack of understanding of the needs of LGB people and there's a lack either specific services or culturally competent services for LGB people."*

**LGB Community group**

People with learning disabilities said that some of them are almost entirely reliant on support workers, but often have limited time with them. They rely on support workers to have the time to raise issues, to help them with checking for signs, to book appointments, and to help them get to an appointment. On top of this, people with learning disabilities said they need to have confidence in the support worker, and depend on them to (have the time to) act on the individual's concerns.

*"We always have to take staff with us and it all depends if you've got the time to go."*

**People with learning disabilities group**

Deaf people talked about the need to improve the provision of British Sign Language interpreters (ensuring that they are booked when needed, are gender matched when appropriate, they have relevant training and they are better equipped to deal with delays in clinics.) Deaf people felt strongly that Deaf people have the right to the same access to the services that hearing people benefit from, noting that health service providers should be implementing in full the requirements of the Accessible Information Standard<sup>1</sup>.

As well as lack of understanding of their lives and needs, some participants described situations where they – or people they knew – had experienced

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<sup>1</sup> <https://www.england.nhs.uk/ourwork/accessibleinfo/>

prejudice or discrimination from health services because of their race, sexual orientation, status or identity. Examples include:

- LGB partners not being treated with the same respect and level of involvement as heterosexual partners.
- Transgender people and people who are homeless being told that their treatment was very expensive.
- Caribbean people receiving misdiagnoses relating to cancer and mental health.
- People using mental health services not being treated with dignity and respect.
- Deaf people having fewer treatment options available to them and a poorer patient experience than hearing people.
- A person with (mild) learning disabilities having a 'do not resuscitate' order placed over them without their involvement or consent when they were being treated for stomach cancer.
- Women who are Asylum Seekers being treated differently or poorly because of their status as Asylum Seekers.

*"Three years ago my partner broke his hip... The treatment was excellent but at one stage... a doctor or consultant came along with a train of junior doctors behind him and said 'this man is a homosexual'."*

**LGB Community group**

*"I ...told my physio that I was getting civil partnered just because I was excited and she immediately discharged me. I'm 99% sure I wasn't ready to be discharged, I just think she didn't want to put her hands on me...I was very naïve to think that I could actually tell somebody that I was getting married, like a normal person would. ...No, not if you're gay."*

**LGB Community group**

*"[Using mental health services] I felt very like a non-entity, like I didn't matter. Like I was just a problem, rather than a human being with feelings."*

**Women's group**

*"When I was in the detox unit, they say things like, 'People like you are costing us £500 per night'... You get looked down on like we're the scum of the earth."*

**People who are homeless**

As a result, a number of participants worried that they could face prejudice and misunderstanding in the health service when going for treatment. For some

people, there is particular anxiety about possible care when they do not have capacity or become dependent:

*"What about acceptance? I'm talking of end of life care basically. It kind of scares me a bit... in 20/30 years' time... is healthcare provision going to be advanced enough in that time to be able to cope with a Trans person...? Is adequate respectful care going to be provided, or are we still going to be having this battle in 20 or 30 years' time? I'm really worried actually."*

### **Transgender Community group**

This was a particularly strong theme from the Transgender community, and they urged the CCG to support the implementation of the recent GMC guidelines on Trans Healthcare<sup>2</sup> following the publication of the House of Commons Women and Equalities Committee on Transgender Equality<sup>3</sup>.

The CCG could explore how it can promote improved cultural competence amongst all healthcare professionals so that they can understand, assess and respond to the needs of the communities included in this report.

It is suggested that the initial focus is on GPs, as most comments about cultural competence were focused on GPs. Improved understanding and awareness is especially recommended with regards to transgender issues, Deaf people and the healthcare needs and eligibility of Asylum Seekers and Refugees.

It is proposed that the CCG works with community groups and the Voluntary and Community Sector to help it improve healthcare professionals' understanding and to identify knowledge gaps.

### **3.2.5 Improved access to appropriate mental health services**

When asked to comment on the priority areas in the draft Strategy, 11% of survey respondents (but 20% of those answering the longer questionnaire) spontaneously welcomed the prioritisation of mental health. A greater proportion of respondents replying on behalf of an organisation/group (22%) and healthcare professionals (24%) mentioned this particular aspect in comparison to members of the public (14%).

*"I feel mental health has been overlooked for a number of years and the awareness is not there. By making this a priority area I feel that more people will understand what is happening and will therefore be able to*

<sup>2</sup> <http://www.gmc-uk.org/guidance/28851.asp>.

<sup>3</sup> <http://www.publications.parliament.uk/pa/cm201516/cmselect/cmwomeq/390/390.pdf>

*help more efficiently. I feel that GPs should receive more training with regards to mental health.”*

**Survey respondent replying on behalf of an organisation or group**

In every community group session, there was a **consensus that mental health should have a higher priority and parity with physical health** in terms of profile, funding and services. In part, participants wanted to see a greater focus on mental health because they felt that their communities were at higher risk of poor mental health. They raised a number of causes of poorer mental health in their communities:

- **Prejudice and bullying:** in nearly all groups<sup>4</sup>, people talked about the impact of stigma, prejudice and bullying that they face or fear in their daily lives. They talked about the stress that this causes when they go out and about, meet new people, and go to new places.
- **Social isolation:** a number of people said that they spend long periods of time alone, either because of their fear of prejudice, or because of their responsibilities in the home (e.g. carers, parents and South Asian Women), or because of low motivation and poor health (mental and physical). People with learning disabilities said that some people in their community rely on support workers to go out, but may only have a few hours support a week. As a result, much of their time is spent alone in their rooms.
- **Loss of social and family networks:** in some groups, people said that their family and social networks had been broken or lost, for example due to immigration and geographical distance (BME communities; Asylum Seekers and refugees; students), or due to changes in circumstances or identity (LGB people; Transgender people; homeless people).
- **Life changes and stresses:** parents, students, carers, recent immigrants, homeless people, and people going through gender transition treatment talked about the stress that life changes create.
- **Personal turmoil** about sexuality and gender identity: LGB people and Transgender people talked about the inner turmoil that comes with dealing with one's sexual orientation and gender identity.
- **Trauma:** Asylum seekers and refugees, homeless people and Transgender people all talked about traumatic experiences of physical and emotional abuse and violence experienced by people in their communities.
- **Drug and alcohol dependency:** homeless people, LGB and Transgender people all talked about higher levels of drug and alcohol use in their communities. They said that this is often triggered by mental health issues, but that it can lead to poorer mental health, too.

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<sup>4</sup> People with learning disabilities, LGB people, Transgender people, people from Black and Minority Ethnic (BME) groups, people who are asylum seekers, people with mental health problems and homeless people

*"You've got a community [LGB&T] that are experiencing ongoing oppression and that can lead to complex trauma. They may have had less easy attachments growing up because of being different and that can lead to complex trauma. They're at high risk of experiencing violence, bullying, sexual abuse, and that leads to trauma. They're more likely to be marginalised and unsupported in their communities and that takes away the protective factor for trauma. So an awful lot of the reasons why we have drug issues, drink issues, risky behaviour, all these other things there's often a trauma history at the root of it. So back to early intervention for people who have experienced trauma would, to me, wipe out a huge amount of the problems, health problems with LGB people."*

**LGB Community group**

*"If we went out we would only have so many hours with the staff.  
...And if you go out, you get bullied, don't you?  
...Picked on, bullied. There's a lot of work that needs to be done around prejudice."  
"So people are already having things stacked up against them because of their disabilities."*

**People with Learning Disabilities group**

However, widespread positivity for the prioritisation of mental health was also combined with some criticism about the inadequate provision of mental health services currently.

Several groups (including the Transgender, Asylum Seeker and Refugee, women, mental health services users and student groups) spontaneously raised issues of delays in access to mental health services. They also said that there were no 'bridging' treatments (such as talking therapies) while they were waiting for psychological therapy, and that there were risks of people's mental health deteriorating further as a consequence.

*"If somebody turned round and said 'you've got cancer but we're not going to see you for 10 months', or some other chronic illness, there'd be uproar. But for something that could probably save a fortune of side effects from some sort of [mental] illness, like IBS or whatever..."*

**Mental health services user group**

*"I think [waiting times are] a big thing, waiting times are killing people, literally killing people."*

**Students group**

Some also talked about a lack of certainty in not knowing how long they would have to wait.

*"Quite often you're on a list but when you've got mental health issues you want continuity and certainty. If you're waiting for something and you don't know when it's coming, ...you get stressed... 'Is it coming, isn't it coming, am I still on the list?'. It's that stress of not knowing."*

**Mental health services user group**

There was also concern that the referral thresholds for mental health services were often too high, and that people have to be at crisis point before they receive services.

*"I've been told in as many words that I would have to have a crisis before I get referred. ...If you are already in fragile health that can be devastating. It was life threatening in my case."*

*"It's not that our doctors don't care, it's just that they have to jump through so many hoops."*

*"I'm now having to pay for counsellors because I've been going through the NHS now for four years and it's going nowhere, it's just waiting list after waiting list... I'm in a very lucky position that my parents can afford that but I am completely draining all of their resources and they will be broke by the time that I'm finished."*

**Students group**

*"When you get into crisis people coming running, 'oh, he's unwell', but in the community there's not enough."*

**Mental health service users group**

Some participants who had experience of services – especially mental health services – had experienced gaps in the system, staff turnover and a lack of join-up in the system across professional boundaries and geographical areas.

*"The problem is also that you see a psychiatrist and you'll see them for a period of up to 18 months, after that then they move onto another position and then you've got to restart with that other psychiatrist of the bedding in with them and getting to know them and then, again, it comes back to 18 months we're moving around again."*

**Mental Health Services User group**

A number of participants talked about problems with continuity when people move between different parts of the country or from outside of the UK. Students

and people who are Asylum Seekers described situations where they had a diagnosis and treatment plan from their previous home, but healthcare professionals would not continue with the treatment. As a result, they said they were forced to start at the beginning of the process to get a diagnosis.

Various groups mentioned the transition between Child and Adolescent Mental Health Services and Adult Mental Health Services. Some of those who had experienced the transition felt it was too sudden, that they had not been supported enough, and that there was too little consistency.

A number of participants reported that some services (especially mental health services) stop too suddenly, without an effective follow-up. They felt that this was not good for the patient, and ended up costing the NHS more money because it is easier for people to relapse or end up at a crisis point.

*"From what I've experienced with depression, sometimes I think you're left to self-care too much. Like you've got tablets so now you'll be fine, and it's like, 'Come for a check-up in eight weeks' time', when actually that person isn't coping on the tablets and, because you've told them come back in eight weeks' time, that they feel, 'I should be fine'."*

**Parents with young families group**

*"[There should be] ongoing support, not dropping you at the end of it, 'oh right, you've received your course of treatment, bye bye', and you end up falling off the edge of the cliff and it all starts back at square one again... Even if it's just like once a month, once a week, even just as simple as a quick phone call or a text message or an email saying 'how you doing? How's everything going?'."*

**Students group**

Participants also called for a wider range of treatment options for mental health issues, e.g. emotional freedom therapy, motivational techniques, personal development courses and greater use of initiatives such as Story Shop and Recovery College.

The CCG could consider a number of actions to improve access to mental health services:

- Quicker referrals into specialist services.
- Shorter waiting lists for mental health services.
- More holistic health assessments at all points along the patient pathway: all healthcare professionals could broaden their assessments to include mental health as well as physical health, and signpost and refer patients where necessary.
- Improved specialism in primary care: greater knowledge amongst GPs of mental health conditions, treatments and medication. This could be achieved by blanket increase in GP knowledge, or by increasing the number of GPs with a mental health specialism.
- Easier access to bridging treatments, e.g. talking therapies while waiting for specialist care (including gender identity services, cancer care and specialist mental health services).
- More – and better promoted – self-referral services.

In a small number of groups, participants expressed some frustration and cynicism about the engagement process. In the Deaf people, Transgender, LGB and Caribbean community groups, people felt that they had been saying the same things for a number of years, but there was little sign that things were changing as a result.

*"None of this is very new... these conversations have been going on for at least my whole life, so we all know what a lot of the issues are but, unfortunately... we keep getting back... more of the same and not more of what we think should be happening"*

**LGB Community group**

*"Large organisations like the CCG team always seem to come out into the community and pick our brains, sucking our brains and give us little back in return. So if they want really to be seen to be really wanting to engage with us, then get some of us into the Boardrooms so we can help make those decisions."*

**Caribbean community group**

*"Many people felt that the feedback to services doesn't work, that services have been told about difficulties Deaf people experience but nothing has changed. The system for complaining or feeding back is not fully accessible for Deaf people..."*

**Deaf people toolkit response**

This frustration with engagement exercises, which ask the same questions as previous surveys but without action being taken, was also mentioned by a small number of survey respondents.

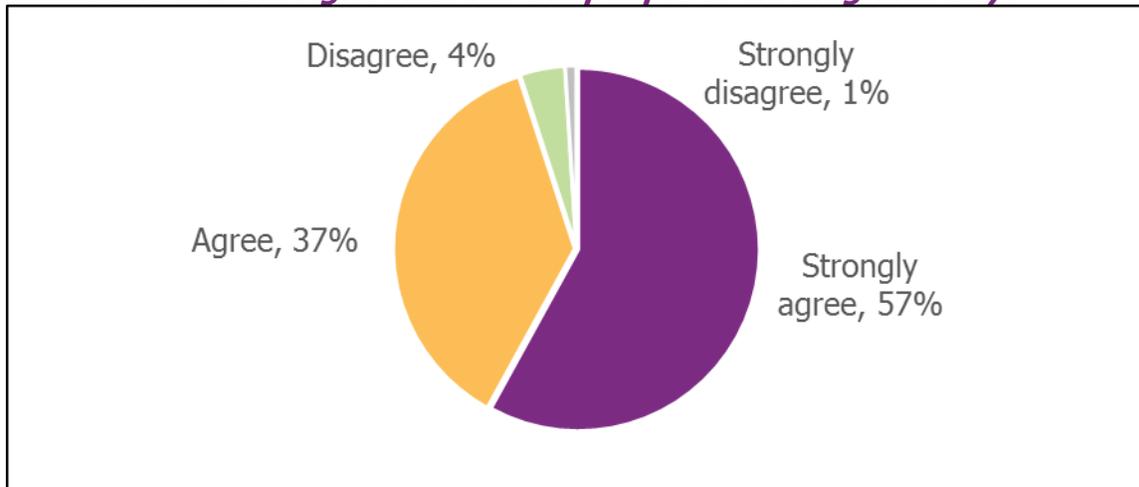
Overall, two fifths (43%) of survey respondents asked to see an electronic copy of the final report on the engagement activities and 28% indicated that they would like to join NHS Nottingham City CCG's patient panel to regularly engage on health related issues and services within the City

There was a call for the CCG to communicate the feedback on the engagement activity and to explain to community groups and stakeholder organisations how this feedback has been translated into the final, agreed strategy. The CCG needs to ensure that it does this effectively as there was some strength of feeling that this has not always happened in the past.

## Appendix 1 - Survey feedback

### 1.1 Support for the strategy ambitions

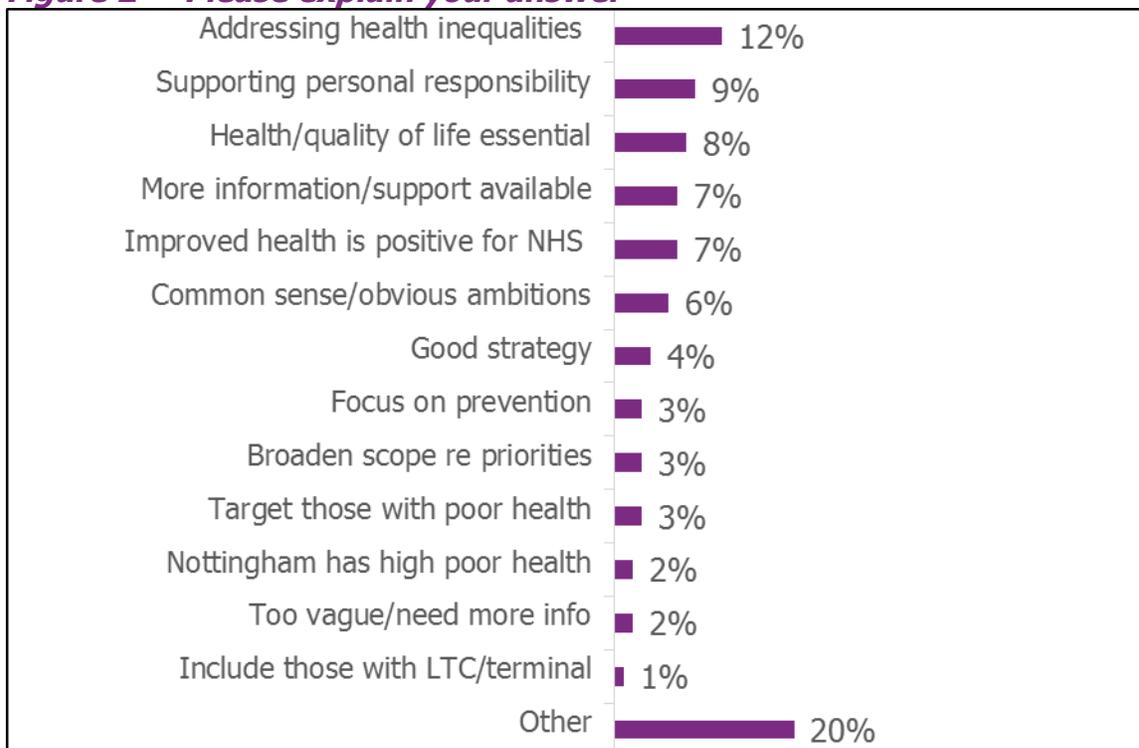
*Figure 1 – 'Overall, how far do you agree or disagree that these ambitions are the right ones for the people of Nottingham City?'*



**Base: All who answered excluding 'don't know' (324)**

### 1.2 Reasons for supporting the ambitions

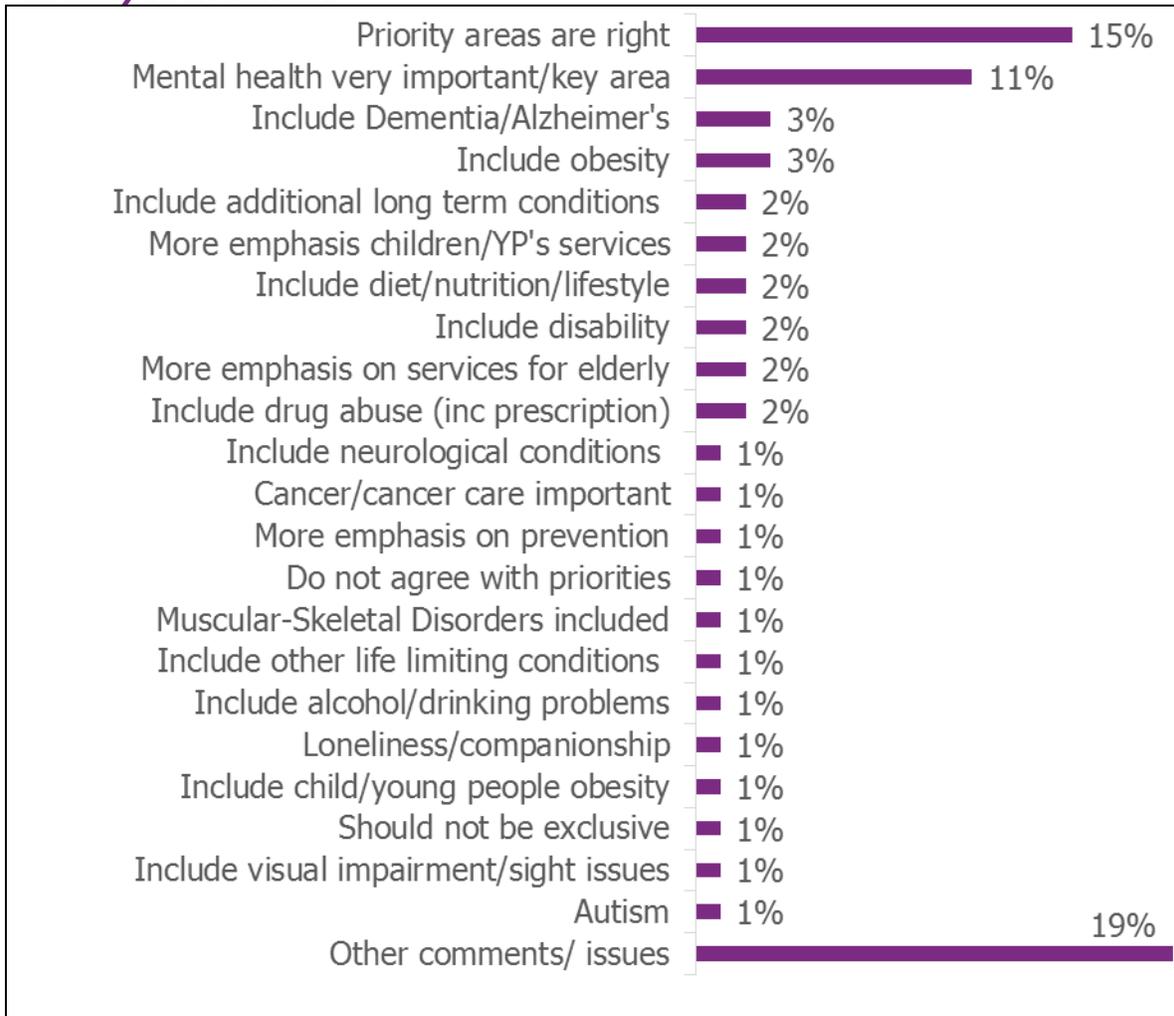
*Figure 2 – 'Please explain your answer'*



**Base: All who answered Q2 (324)**

## 1.4 Response to priority conditions

**Figure 3 – Q4 (Online survey/longer questionnaire) Do you have any comments about these priority areas? Are they right? Is anything missing? AND Q5 (Community Event Questionnaire) Finally, are there any other conditions or priority areas that you would add to the four already mentioned?**



**Base: 620**

### 1.4.4 Other conditions

A wide range of other health conditions and issues were mentioned as potential priorities by small percentages of respondents. The largest number of mentions was for Dementia/Alzheimer's and obesity. Many respondents took the opportunity to argue the case for including other conditions within these priority areas, particularly the Community Event participants. Conditions mentioned included:

- Septicaemia
- Menstrual health, Polycystic Ovary Syndrome, Endometriosis
- HIV and sexual health
- Amputees
- Impact of domestic violence and sexual abuse
- Macular degeneration
- Meningitis
- Arthritis
- Multiple Sclerosis
- Autism
- Asthma
- IBD
- Phenylketoturia
- Diabetes

### 1.5 Better prevention

**Figure 4 – Q5. (Online survey and longer questionnaire) What does the CCG need to think about when planning for better prevention? AND Q1 (Community event questionnaire) What could health services do to help prevent people from becoming ill?**



**Base: 620**

### ***Practical initiatives to deliver support***

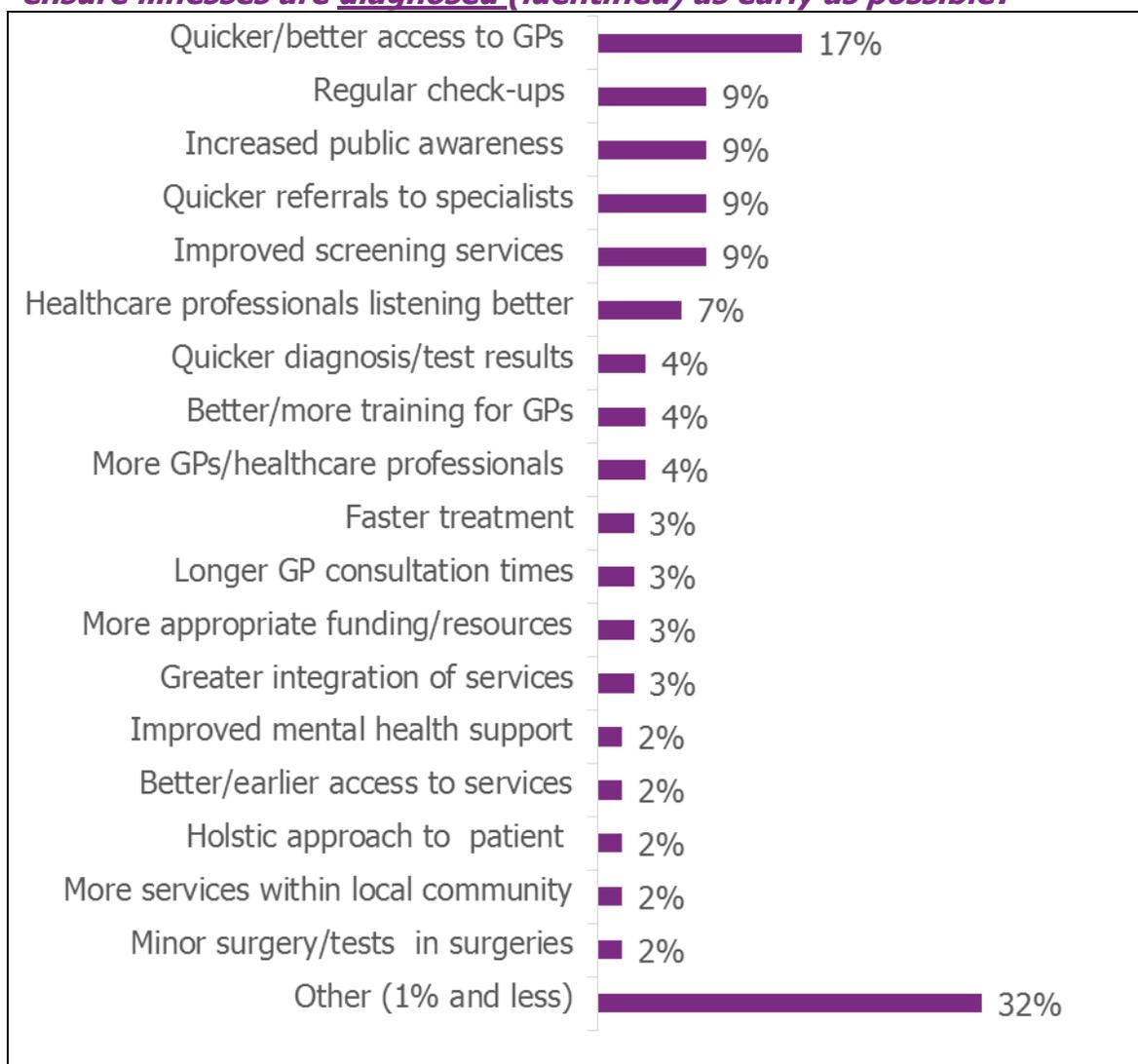
Respondents suggested a wide range of practical initiatives to deliver this support. These included:

- More proactive out-reach: regular check-ups / home visits (for elderly/housebound) to keep people engaged in their health; visits within the workplace/reaching large employers.
- Clubs/clinics aimed at specific conditions/issues e.g. 'well leg club'.
- Free/low cost/subsidised events and activities to keep fit e.g. gym taster sessions, free fitness sessions in parks, Weight Watchers, sports facilities, walking groups, yoga.
- Access to low cost fruit and vegetables; community gardening initiatives.
- Events and groups to help parents cook healthy meals.
- In-home tailored to help to demonstrate how to cook healthy meals quickly and easily.
- Activities to reduce social isolation.
- Support groups to help people with mental health issues.
- Compulsory healthy living education for people receiving benefits.
- More cycle lanes.
- More school sport.
- Support with alcohol reduction and management of drug taking especially cannabis and "legal highs".
- Stop smoking services accessible to everyone.
- Disease prevention: immunisations; antibacterial gel available; more hygienic facilities.

## 1.6 Better diagnosis

### 1.6.1 Overview of what the CCG needs to consider

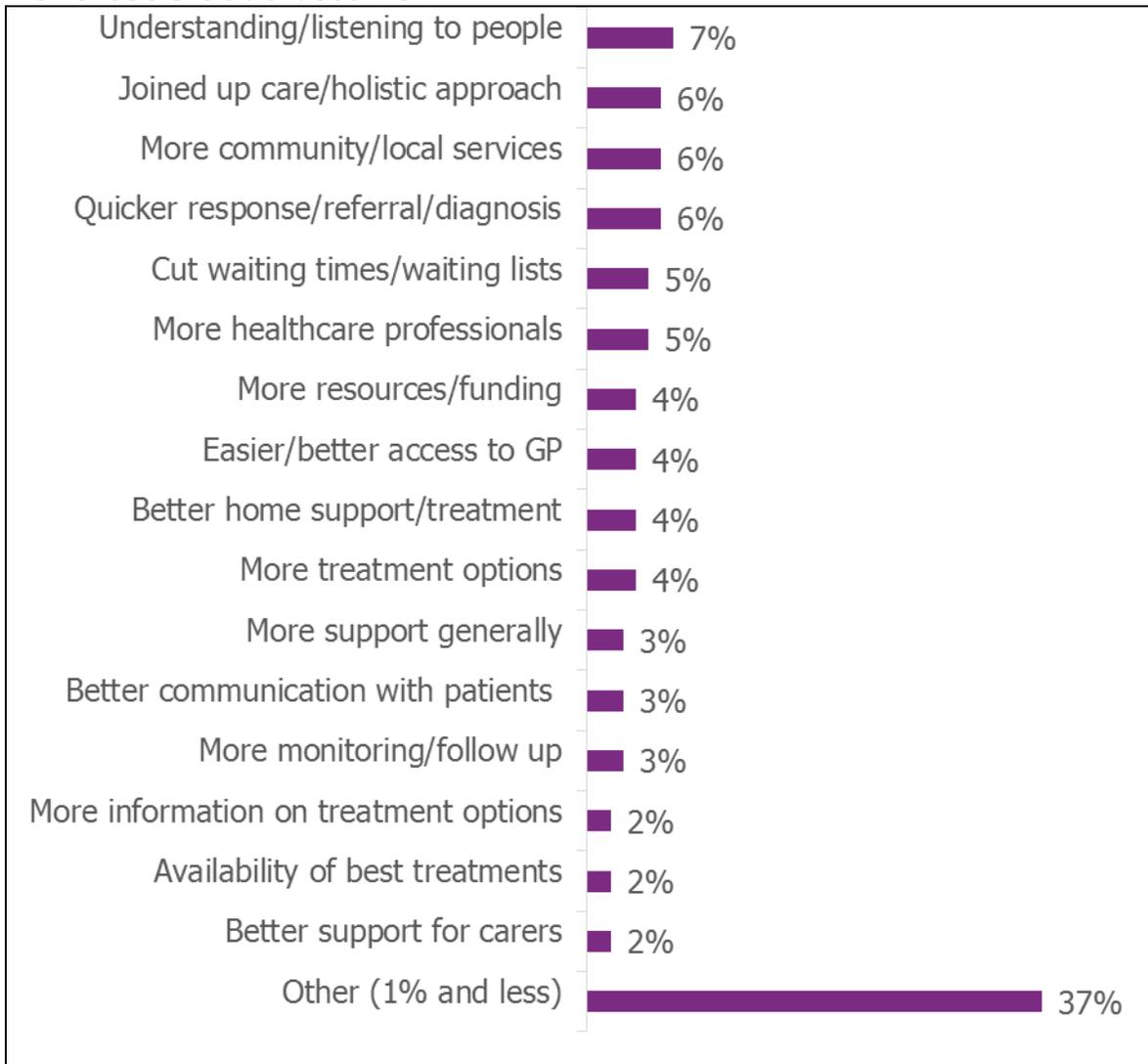
**Figure 5 – Q6. (Online survey and longer questionnaire) What does the CCG need to think about when planning for better diagnosis? AND Q2 (Community event questionnaire) What could health services do to ensure illnesses are diagnosed (identified) as early as possible?**



**Base: 620**

## 1.7 Better treatment

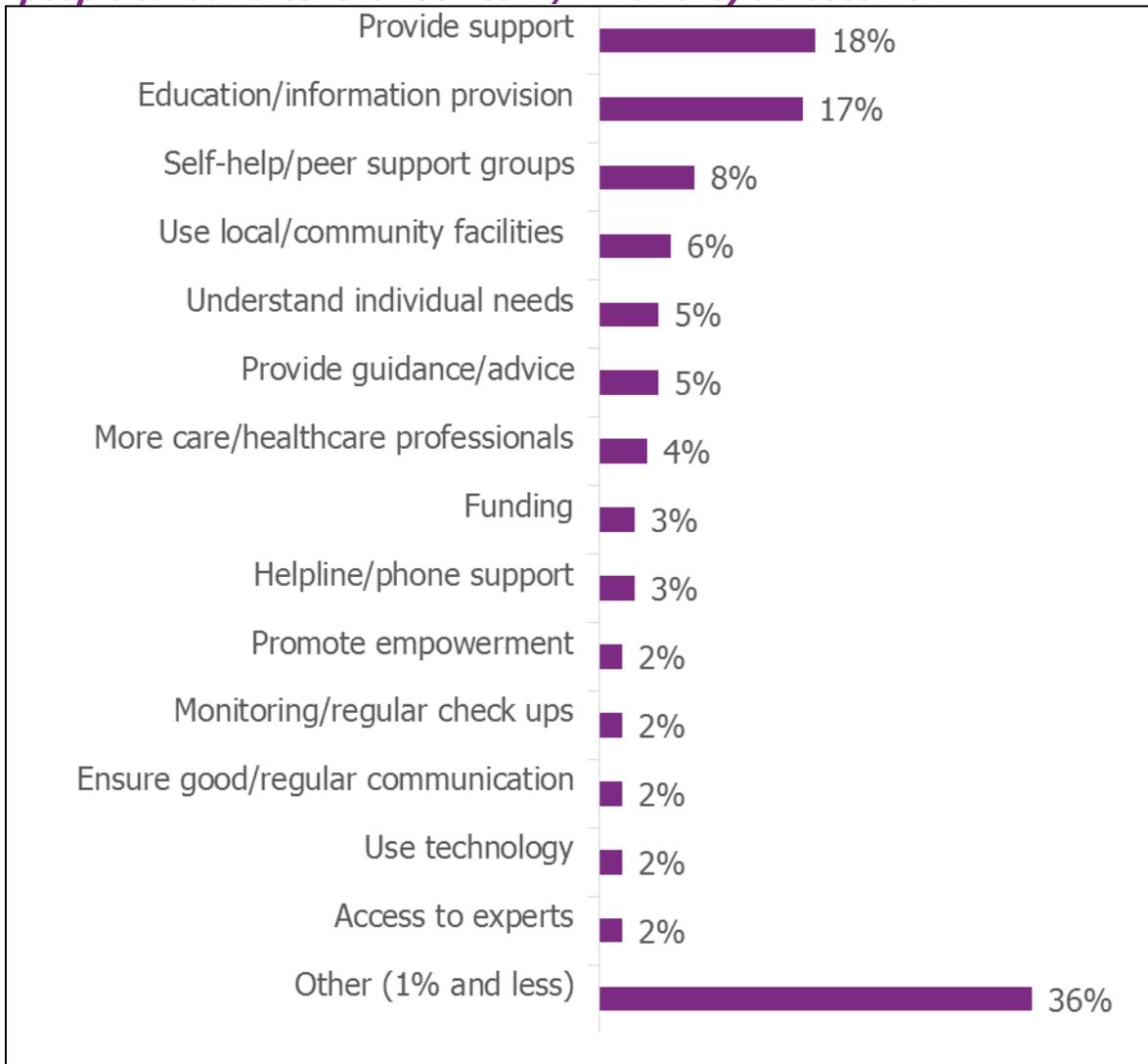
**Figure 6 – Q6. (Online survey and longer questionnaire) What does the CCG need to think about when planning for better treatment? AND Q3 (Community event questionnaire) How could treatment be improved for those that do become ill?**



**Base: 620**

## 1.8 Better self-care

**Figure 7 – Q7. (Online survey and longer questionnaire) What does the CCG need to think about when planning for better self-care? AND Q4 (Community event questionnaire) What could be done to help support people to look after themselves if / when they do become ill?**



**Base: 620**

## **1.9 Other comments**

At the end of the online survey and longer questionnaire, respondents were invited to add in any other comments that they wished the CCG to hear. 100 respondents made additional comments.

Some broad themes emerged amongst these which are summarised below.

### ***Perception that healthcare is not delivered in a way which meets the public's needs***

- Frustration with lack of access to appropriate healthcare e.g. GP not available or not interested.
- Frustration at medical profession's inability/unwillingness to empower people to be in control of their own healthcare, and their inability to really hear what their patients are telling them.
- Frustration at emphasis within medical profession in prescribing drugs rather than looking more holistically at people's well-being and providing care which supports this.
- Frustration with inflexibility of services which do not deliver care to people in the way that they need to access it e.g. mental health support groups/courses which are only during working hours; temporarily housebound people who do not qualify for home GP visits; drop-in clinics which are not open at weekends.
- Frustration with the lack of funding/referral to alternative therapies.

### ***Issues that the CCG needs to consider***

- Frustration that the CCG is not prepared to make radical change to benefit the public because of institutional barriers and vested interests within the CCG who may be reluctant to change practise.
- Concerns of specific communities that the CCG is not listening to them and not sufficiently aware of most pressing issues impacting upon them: specifically, the LGBT community, BME community, Gypsy-Traveller community, deaf people.
- Concern that the CCG does not adequately recognise the health implication of the high volume of survivors of domestic and sexual abuse living in Nottingham.
- The value of the early intervention in domestic violence IRIS project which is funded by the CCG until 2017.
- The need for more responsive mental health services for traumatised people
- The need to provide better care for the elderly after leaving hospital and to improve in-home care support services generally.
- The need for health services to work in collaboration with other agencies to be effective.
- Concern at the high number of people over 55 with a disability

### ***Frustrations with the NHS: funding, structure, management, practises***

- Concerns about strains on services because of lack of adequate funding, particularly East Midlands Ambulance Service
- Frustration with privatisation of the NHS which leads to perceptions that profit is being put before people's health and contractors are not delivering services appropriately.
- Frustration with the awarding of contracts to large contractors who are unable/unwilling to listen to and to reach out to marginalised groups as well as the smaller, more grass-roots community based organisations would be able to.
- Frustration with waste of NHS resources in discarding unused medical equipment unnecessarily.
- Perception that funding is directed towards management and high bonuses than towards service provision.
- Concern that the NHS is not sufficiently accountable or transparent, and a desire that whistle-blowing when aware of malpractices should be compulsory.

### ***Issues the NHS generally needs to consider***

- The importance of empowering and supporting carers.
- The value of using practice nurses to deliver prevention advice and support.
- The potential for getting prescriptions from a pharmacist rather than via GP.
- The NHS should take advantage of technological advances e.g. Skype consultations, electronic notes.
- NHS should provide free gamete storage for patients undergoing treatment of gender dysphoria.

### ***Specific requests***

- Complementary healthcare clinic in Shenton
- Removal of Fluoride from drinking water

### ***Positive comment about local healthcare***

- Fantastic staff at Maternity Unit

### ***Feedback about the survey***

- Appreciation that the views of organisations/groups had been sought.
- Frustration with engagement exercises like this which ask the same questions as previous surveys but action does not seem to have been taken.

## Appendix 2 - Response breakdown

### *Breakdown of participants at the facilitated community events*

In total, 163 attendees attended the community events facilitated by Community Research. All were asked to complete a demographic monitoring questionnaire and 104 completed responses were received in total. The percentages in the data below calculated on 104 responses i.e. anyone who completed a questionnaire. The skew towards female participants is explained by the fact some sessions (i.e. those with refugees/asylum seekers and South Asian people) were female only to ensure participants felt comfortable giving their views and others were, by definition, women-only (i.e. the group at the Women's Centre and the group of mothers with young families.)

#### **Gender\***

Female	Male	Transgender	Other	Not answered
84	18	5	2	-
81%	17%	5%	2%	-

*\* multiple response allowed*

#### **Age**

Under 24	25 to 39	40 to 69	70+	Not answered
9	28	51	15	-
9%	29%	49%	14%	-

#### **Ethnicity**

White/White British	Mixed	Asian/Asian British	Black/Black British	Other	Not answered
35	5	16	46	1	1
34%	5%	15%	44%	1%	1%

#### **Impairment\***

Learning	Long term illness or physical condition	Mental health condition	Sensory or mobility	Other	Not answered
11	44	30	31	6	37
11%	42%	29%	30%	6%	36%

*\* multiple response allowed*

#### **Religion**

Christianity	Other religion	No religion	Not answered
57	28	15	4
55%	17%	14%	4%

**Sexual identity**

Heterosexual/ straight	Gay	Lesbian	Bi-sexual	Other	Not answered
73	1	1	6	5	18
70%	1%	1%	6%	5%	17%

**Been pregnant or given birth in last 12 months**

Been pregnant or given birth in last 12 months
3
3%

**Carer**

Yes	No	Not answered
32	67	5
31%	64%	5%

**Main language**

English	Other (inc sign language)	Not answered
85	17	2
82%	16%	2%

**Postcode**

NG1	4	4
NG11	2	2
NG14	1	1
NG16	3	3
NG18	2	2
NG2	7	7
NG3	9	9
NG4	2	2
NG5	7	7
NG6	7	7
NG7	21	20
NG8	15	14
NG9	9	9
LN1	1	1
NS	14	13

## Breakdown of respondents to the survey

### Stakeholder type

Total number	Member of the public <sup>5</sup>	Respondent replying on behalf of an organisation or group	Healthcare Professional	All three	Other	Not answered
620	506	54	46	4	7	3
100%	82%	9%	7%	1%	1%	-%

### Gender\*

Female	Male	Transgender	Other	Not answered
421	136	3	4	66
68%	20%	0.5%	1%	11%

\* multiple response allowed

### Age

Under 24	25 to 39	40 to 69	70+	Not answered
33	168	311	36	72
5%	27%	50%	6%	12%

### Ethnicity

White/White British	Mixed	Asian/Asian British	Black/Black British	Other	Not answered
434	22	40	4	66	54
70%	4%	6%	1%	11%	9%

### Impairment\*

Learning	Long term illness or physical condition	Mental health condition	Sensory or mobility	Other	Not answered
7	81	34	58	12	428
1%	13%	5%	9%	2%	69%

\* multiple response allowed

### Religion

Christianity	Other religion	No religion	Not answered
132	55	104	329
21%	9%	17%	53%

<sup>5</sup> Of these, 291 completed questionnaires (47% of the total) were completed at the six community events held in the City

**Sexual identity**

Heterosexual/ straight	Gay	Lesbian	Bi-sexual	Other	Not answered
260	10	8	9	9	324
42%	2%	1%	1%	1%	52%

**Been pregnant or given birth in last 12 months**

Been pregnant or given birth in last 12 months
6
1%

**Carer**

Yes	No	Not answered
118	186	316
19%	30%	51%

**Main language**

English	Other (inc sign language)	Not answered
309	5	306
50%	1%	49%

**Postcode**

NG1	16	3%	NG22	1	0.2%	NG96	1	0.2%
NG11	5	1%	NG23	1	0.2%	S80	2	0.3%
NG14	4	1%	NG24	1	0.2%	S81	1	0.2%
NG16	5	1%	NG25	2	0.3%	DE7	1	0.2%
NG18	2	0.3%	NG27	1	0.2%	NS	332	53.5%
NG2	23	4%	NG32	3	0.5%			
NG3	38	6.1%	NG35	2	0.3%			
NG4	6	1.0%	NG51	1	0.2%			
NG5	49	7.9%	NG52	2	0.3%			
NG6	12	1.9%	NG53	1	0.2%			
NG7	35	5.6%	NG54	2	0.3%			
NG8	28	4.5%	NG59	4	0.6%			
NG9	12	1.9%	NG60	1	0.2%			
NG10	5	0.8%	NG73	1	0.2%			
NG12	2	0.3%	NG74	1	0.2%			
NG15	5	0.8%	NG82	2	0.3%			
NG17	1	0.2%	NG92	1	0.2%			
NG19	2	0.3%	NG93	3	0.5%			
NG21	2	0.3%	NG94	1	0.2%			

## Appendix 3 - Research instruments

### *Survey questionnaires*



Full version.pdf



Shorter version for  
events.pdf

### *Toolkit*



Commissioning  
Strategy 2016 - List

### *Facilitated discussions*



Generic group  
discussion guide.pdf



Community Strategy  
2016 - Handout.pdf