Nottingham and Nottinghamshire ICS

Women's Health

Clinical and Community Services Strategy

FINAL V3.1 October 2020

This information has been placed in the public domain in order to benefit patients across the country as we believe the experience and approach may be useful for others, however we request that acknowledgement to the work in Nottinghamshire is made and referenced in all materials. This helps us to understand the wider impact benefits of our programme. Please cite 'this work has been informed by the Nottingham and Nottinghamshire ICS' when referencing.

Contents

1. Executive Summary

The Integrated Care System (ICS) ambition across Nottinghamshire is to both increase the duration of people's lives and to improve the quality of those additional years, allowing people to live longer, happier, healthier and more independently into their old age. The aim of the Clinical and Community Services Strategy (CCSS) is to support the system to achieve this by shifting the focus of our health and care delivery from reactive, hospital based treatment models to a pro-active approach of prevention and early intervention, delivered in people's homes or in community locations where this is appropriate with a long term view of beyond 5 years.

In England, women's health conditions represents 4% of all outpatient attendances, with 3,690,908 outpatient attendances in 2017/18. Benign conditions account for the large number of referrals to specialist women's health services. The Royal College of Obstetricians and Gynaecologists (RCOG) state that there are geographical and socio-economic variations in service provision and access to specialist women's health services. Improving referral processes and existing pathways to ensure they reflect best practice and increasing awareness and use of these pathways can reduce unwarranted variation in the way decisions are made and ensure that patients see the right person, in the right place, first time. This also supports the management of increased demand for services and long waiting times for routine appointments experienced by women's health services.

The women's health pathway has interdependencies across sexual health, fertility, obstetrics and uro-gynaecology. Screening is an important consideration to support reduction in morbidity and mortality, with mortality from cervical cancer reducing by 80% where screening programmes exist. Women of lower socio-economic groups are at higher risk, therefore screening coverage is important, with only 67% uptake of screening in Nottingham City. Sexually Transmitted Infection and unintended pregnancy remains a significant public health challenge, with up to 50% of all pregnancies thought to be unintended at conception, with the use of emergency contraception in Nottingham twice the national rate. Opportunities exist to transform the provision of contraception, with a person-centred approach to discussions regarding family planning and coordination of provision. Self-care is another important opportunity for the women's health pathway, with education on condition management increasing satisfaction, but also creating capacity in the system.

The transformation opportunities for the women's health pathway supports the NHS Long Term Plan (LTP) ambitions which makes strong reference to prevention, the delivery of care closer to home by the right person, right time and with personalised care business as usual.

This women's health service review has been undertaken as part of the ICS CCSS work stream. It has been supported by clinical experts and stakeholders in the development of place based service models for the future, to support the long term needs of our existing citizens. The review also focuses on embedding prevention in our population over the next 5-10 years, by shifting our culture from one of illness to one of healthier lifestyles and self-care.

The strategy identifies major stages in the women's health patient's journey and stresses a need to reorganise the way in which these services are delivered, from prevention through to longer term support for those at highest risk or those living with women's health conditions. A whole pathway approach in the provision of women's health services is crucial in order to maximise the clinical outcome for patients, their quality of life and experience of women's health services.

Key themes have been identified along with key transformational opportunities and potential impacts have been developed which include: prevention strategies to promote healthy living and independence; improved access to services to address risk factors; enhanced community services to improve access and early intervention; optimal hospital service in balance with community offer; system pathway with access to a multi-professional workforce to deliver a sustainable and evidence-based service model.

A transformational 'Bridge to the Future' highlights current service offers across the ICS and identifies some potential long term next steps that can be taken to achieve the identified opportunities with proposed timelines and the expected outcome for our citizens of Nottinghamshire.

The recommended next steps are vital in keeping the momentum of change in the future offer of improved prevention and better health for our citizens; providing the right tools for our population to support their wellbeing; providing strong communication links for our staff is vital to enable them to provide the best care for our citizens; the most appropriate models of care in acute settings, neighbourhood and home need to be provided equitably across the ICS and be provided using best evidence, flexibly and in a patient centred way for them to fulfil their maximum potential throughout their lifetime.

2. Introduction

Background and Purpose	In Nottinghamshire we have made great progress in improving people's health and wellbeing. Today, we can treat diseases and conditions we once thought untreatable. However, our health and care system faces change and this will impact on our services, for example, the growing prevalence of long-term health conditions places new strains on our system. There is inequality evident in both the location of services and in access to services. In some areas, it is easier to access a GP professional than in others, or to find things to do to enable citizens to stay active and fit. The ICS ambition across Nottinghamshire is to both increase the duration of people's lives and to improve those additional years, allowing people to live longer, happier, healthier and more independently into their old age. The requirement for a CCSS came from the recognition that to achieve this ambition the system has to change as a whole, rather than just in its individual acute, primary care, community and social care elements. It is recognised that only by working together to describe changes in how care is provided across the system, rather than through individual organisations, will we deliver the scale of change required.
The ICS Clinical and Community Services Strategy	The aim of the CCSS is to support the system to achieve this by shifting the focus of our health and care delivery from reactive, hospital based treatment models to a pro-active approach of prevention and early intervention. This should be delivered closer to people's homes or in community locations where this enables better prevention, more supported self-care and earlier intervention to support citizens. The Strategy recognises that achieving this change is a long term programme that will be delivered over the next 5 years and beyond. This is also to enable a necessary long term investment in the health and care buildings and infrastructure in the system. An overall CCSS whole life model framework has been developed to focus on the need to support people through their lives from living healthy, supporting people with illness and urgent and emergency care through to end of life care. Citizens can experience different parts of the system at different stages in their lives. With the development of the overall Strategy framework the next phase of work is to review the 20 areas of service across the ICS that collectively form approximately 80% of the volume of clinical work in the ICS. This will ensure that overall the Strategy is described as a coherent whole and generates a programme of change for the whole ICS. This review of Women's Health Services is one such review and is part of the second phase of work.
NHS Long Term Plan	The NHS LTP is clear that to meet the challenges that face the NHS it will increasingly need to be more joined up and coordinated in its care; More proactive in the services it provides; More differentiated in its support offer to its individuals. The ICS has focused on describing 5 areas of focus for the delivery of the NHS LTP. These requirements are reflected in each of the service reviews that collectively will describe the CCSS **1. Prevention and the wider determinants of health -** More action on and improvements in the upstream prevention of avoidable illness and its exacerbations **2. Proactive care, self management and personalisation -** Improve support to people at risk of and living with single and multiple long term conditions and disabilities through greater proactive care, self-management and personalisation **3. Urgent and emergency care -** Redesign the urgent and emergency care system, including integrated primary care models, to ensure timely care in the most appropriate setting **4. Mental health** - Re-shape and transform services and other interventions so they better respond to the mental health and care needs of our population **5. Value, resilience and sustainability -** Deliver increased value, resilience and sustainability across the system (including estates)

3. Approach and Scope

Approach	This strategy has been developed through an open and inclusive process which weaves together the expertise of clinicians and care experts with commissioners and citizens in determining the future shape of services across the system. There have been a variety of stakeholder and service user events to develop a clinical and community services model. An extensive system wide piece of work is taking place across a minimum of 20 services. The CCSS Programme Board have reviewed these services against a range of quantitative and qualitative criteria and agreed the second phase of six service reviews. These include; Women's Health; Eye Health; Skin Health; Diabetes; Heart Health and Urgent Care. Due to lockdown following the outbreak of the pandemic, Coronavirus Disease 2019 (COVID19), it was decided to postpone Heart Health and Urgent Care, which will be resumed in-line with clinical commitments I response to the pandemic. This document discusses the approach, scope, the key issues and potential transformational opportunities within Women's Health services across the ICS. Health, social care, public health and the voluntary sectors have all been considered through reviewing the current service offer across the ICS. The service review was taken over approximately 24 weeks with engagement with stakeholders across the ICS. An evidence review pack was developed which considered national and local best practice to inform the development of potential themes and new models of care where transformational change may take place across the ICS in the future.
Scope	**In scope:** The women's health service represents 4% of all outpatient (OP) attendances. Benign gynaecology includes a range of conditions and accounts for the large number of referrals to specialist women's health services. In considering the transformation of services it is important to account for the interdependencies with obstetrics, sexual health, fertility and uro-gynaecology. Whilst the review focusses on women's health (age 13+), it is important to consider couples when developing transformation proposals for sexual health and fertility. Therefore, the main conditions considered in this review are: • Menstrual bleeding • Urinary incontinence • Menopause • Cervical polyps • Endometriosis • Pelvic Inflammatory Disease (PID) • Polycystic Ovary Syndrome (PCOS) • Persistent pelvic pain • Vulval disease (including skin disease and pain) • Persistent visceral pain e.g. bladder pain syndrome • Pelvic organ prolapse • Sexual Health (including sexual infections and contraception) • Fertility **Not in scope:** HIV infection and an established diagnosis of gynaecological cancer was agreed to sit outside the scope of this review, although it was agreed recommendations could be fed through this process.
Engagement	The Women's Health service review has been supported by a tailored Women's Health Steering Group involving stakeholders and clinical experts from across the ICS. They have provided expert advice, guided, confirmed and challenged assumptions throughout the period of review and connected to other workstreams. This group has formed part of the governance process along with the CCSS Programme Board. Stakeholders involved in the Women's Health service review included, Clinicians, Allied Health Professional (AHP), Nurses, Heads of Service, Social Care, Public Health, Commissioners and others to be proactively involved in re-evaluating current service offers across the ICS, in developing potential themes and agreeing transformational change for the future Clinical and Community Services Strategy. Previous patient engagement, undertaken by Healthwatch, has enabled confirm and challenge assumptions and play an active part in the co-design of any future service changes across the ICS.

4. Contents

Strategy Development	This Strategy Document consists of five key elements. These have been developed through a process of design and iteration at steering group meetings. The strategy has been developed with reference to the Evidence Review document and the pre-existing patient engagement.
Priorities for Change	The work of the Steering Group identified four key areas of focus that need to change in the ICS for Women's Health care. These were based on a review of the current issues facing the ICS and the views of the Steering Group.
Proposed Future Care System	Following the evidence review at subsequent steering group meetings, attendees started to develop the future care system for Women's Health to address the Priorities for Change. The future care system is described against two dimensions • **Location** split between - Home (usual place of residence) – Acute Hospital with 24/7 medical presence – Neighbourhood representing all community/primary care and ambulatory care settings • **Urgency** split between - **Emergency/Crisis** requiring a service provided 24/7 to avoid crisis or risk to life – **Urgent** requiring a service 7/7 but not 24/7 to meet urgent care needs – **Planned/Scheduled** reflecting any arrangement where an appointment is agreed between a professional and a citizen The intention of the system model is to focus future care delivery closer to home and also with greater levels of scheduled care to best use the available resources and reduce demand on urgent and emergency care services. The new system to address the Priorities for Change is presented for each location and then summarised overall for the ICS.
Transformation Proposal	The Transformation proposal described the key initiatives or programmes that are required to deliver this new model. Namely, • **Priority** – What is the priority of the initiative in the view of the steering group and workshop attendees • **Alignment** – At what level of the system should we aim for a consistent approach for each initiative? In most instances this is ICS level where with the greater value is perceived to be in an overall consistent approach. However there are some instances where the recommendation is for delivery to be at Integrated Care Provider (ICP) level where. Alternatively, it is at Primary Care Network (PCN) level where differential delivery would benefit the needs of very local populations • **Enabling Requirements** – What is required to enable each Programme to deliver? This includes workforce, technology, estate or service configuration. There are also requirements of culture or finance and commissioning to allow the system to work together differently • **Benefits and Costs** – Where available, the key benefits of the initiative at system level are summarised
Service Vision	The 'Bridge to the Future' was generated at a further virtual steering group meeting. It summarises the current challenges for the women's health system in the ICS now (Priorities for Change), what the ambition is and the outline steps to get there. Progress with the 'Bridge to the Future' and the partnering vision can be returned to with stakeholders as the work develops to review progress.

Women's Health Key Themes and Areas of Priority

Prevention & Self Care

- Prevention of high risk factors e.g. screening, vaccination, obesity
- Contraception
- Education

Referral and Access

- Diagnostics
- Referral Process
- Intervention

Pathway

- Consistent evidence based practice guidelines
- Service Model
- Pre-optimisation and role of the Acute Hospital

Whole System Approach

- Expertise in the right place
- Communities of Practice
- Succession Planning and Innovative Roles

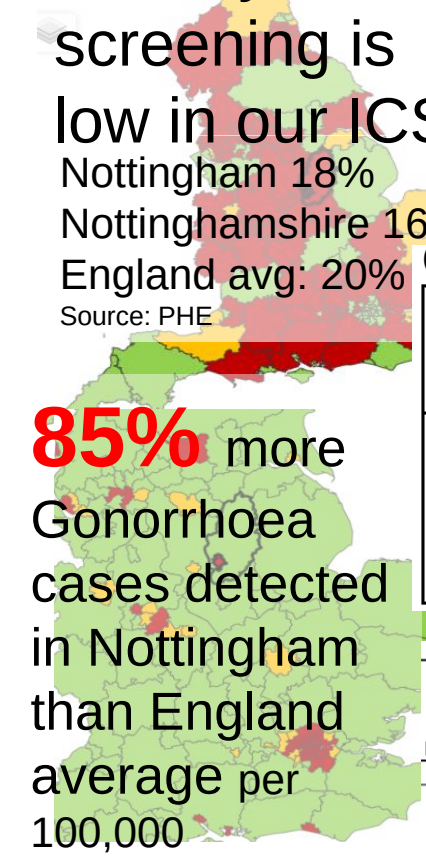
Priorities for Change - Infographics

Integrated Care System
Nottingham & Nottinghamshire

www.healthandcarenotts.co.uk @NHSNottingham

Chlamydia screening is low in our ICS.

Nottingham 18%
Nottinghamshire 16%
England avg: 20%
Source: PHE



85% more Gonorrhoea cases detected in Nottingham than England average per 100,000
Source: PHE

1 in 3 25-49yr olds in Nottingham are **overdue a smear test.**
(1 in 4 nationally) NHS Digital

CERVICAL SCREENING SAVES LIVES

99.8% of cervical cancer is preventable. Cancer Research UK

Smoking doubles women's risk of cervical cancer
NHS.co.uk

Cervical Screening:

Source:NHS Digital

CCGName	Age 25 - 49 2019/20 Q4 Eligible	Screened	Coverage	Additional people to screen to reach 80%	Rank	Age 50 - 64 2019/20 Q4 Eligible	Screened	Coverage	Screeening to reach 80%	Rank
NHS RUSHCLIFFE CCG	20,423	17,056	84%		1/191	12,426	10,513	85%		1/191
NHS NOTTINGHAM WEST CCG	17,235	13,798	80%		5/191	9,618	7,849	82%		3/191
NHS NOTTINGHAM NORTH AND EAST CCG	22,901	18,605	81%		2/191	13,309	10,740	81%		4/191
NHS NOTTINGHAM CITY CCG	62,666	43,439	69%	6,694	146/191	24,476	18,914	77%	667	73/191
NHS NEWARK & SHERWOOD CCG	20,562	15,938	78%	512	27/191	12,758	10,186	80%	21	8/191
NHS MANSFIELD AND ASHFIELD CCG	31,657	23,910	76%	1,416	60/191	17,238	13,576	79%	215	27/191

Sexual Health Attends:

Thousands

Region & Local Authority c	Total Activities [1]	Contraceptive care (excl. emergency contraception)	STI related care	Emergency contraception	Sexual health advice	Pregnancy related (excl. ultrasound scan)	Ultrasound scan	Abortion related	Cervical screening	Psychosexual therapy / referral	Implant removal	IUS removal	IUD removal	PMS and menopause related care [2]	Alcohol brief intervention	Other [3]
Nottingham	55.8	19.0	16.0	1.2	12.7	3.4	0.1	0.0	0.1	0.1	0.9	0.3	0.3	0.1	0.0	1.6
Nottinghamshire	57.6	24.7	11.3	0.9	13.6	2.6	0.1	0.0	0.1	0.0	1.8	0.7	0.3	0.1	0.0	1.3

Nottingham Community gynaecology

73% of patients want screening, diagnostics & treatment on the same day.
Healthwatch patient engagement

2 in 5 children age 10-11 in Nottingham City are overweight, obese or severely obese
PHE Fingertips

Obese 14 year old girls are **61%** more likely to have **Polycystic Ovary Syndrome** at age 31.
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4103796/

Priorities for Change - Infographics

50% of pregnancies unintended at conception.

1 in 13 women terminate a pregnancy within a year of giving birth

BMJ Sexual Reproductive Health

Over **50%** of couples resume sexual activity by 6 weeks' postpartum

£1 spent on contraception saves **£11** in healthcare

https://www.fpa.org.uk/sites/default/files/economics-of-sexual-health.pdf

NHS Digital

COLPOSCOPY DATA Name of unit	Referrals 2018/19	No. apts 2018/19	Attends (%)	DNA (%)
England	**182,304**	**403,074**	***71.2***	***7.9***
East Midlands	**12,276**	**26,472**	***72.3***	***8.4***
Circle - Treatment Centre	1,464	4,212	*52.5*	*6.3*
Nottingham City Hospital	1,016	2,492	*84.7*	*9.6*
King's Mill Hospital	961	1,807	*78.7*	*11.5*
Newark Hospital	160	298	*79.5*	*16.4*

Gaps in middle grade rotas are reported by approximately **90%** of units

The Royal College of Obstetricians and Gynaecologists, 2017)

CCG data

	OUTPATIENT APPOINTMENTS 2014/15	2015/16	2016/17	2018/19	2019/20
QMC	9,587	10,970	3,036	11,296	10,577
CITY	9,123	9,300	9,661	8,741	8,654
CIRCLE	15,258	16,449	16,072	13,466	4,100
TREATMENT CENTRE	-	-	-	-	2,218
KINGS MILL HOSPITAL	18,847	20,109	21,695	18,567	19,407
NEWARK HOSPITAL	1,625	1,619	1,912	2,338	2,245
PICS	-	-	-	-	1,672
PRIVATE (IN ICS)	2,767	3,158	4,358	4,479	5,141
OTHER	2,139	2,228	2,124	1,968	1,704
	59,346	63,833	58,858	60,855	55,718

Emergency Gynae Surgery (required in 1 hour) 2019	
NUH:	25
SFHFT:	66

NUH & SFHFT

CCG data

	2015/16	2016/17	2017/18	2018/19	2019/20
CIRCLE	**1938**	**1835**	**1700**	**954**	**277**
Daycase	1799	1649	1464	788	218
Elective	139	186	236	166	59
NUH	**4445**	**4060**	**3952**	**3601**	**3591**
Daycase	1146	1068	1038	546	859
Elective	1409	1365	1176	1142	946
Emergency	1890	1627	1738	1913	1786
SFHFT	**5757**	**5678**	**5203**	**3123**	**3113**
Daycase	3717	3354	2973	557	480
Elective	619	635	608	547	491
Emergency	1421	1689	1622	2019	2142
OTHER	**998**	**1143**	**1028**	**1010**	**1070**
Daycase	499	607	568	569	646
Elective	317	363	307	272	276
Emergency	182	173	153	169	148
Grand Total	**13138**	**12716**	**11883**	**8688**	**8051**

Nottingham citizens use emergency contraceptives at **TWICE** the England rate.

Sexual Reproductive Health Services NHS Digital

64% of Gynae Advice and Guidance at NUH is given within a 2 day timeframe.

73% of women successfully continued with **pessary self-management** at six months following gynae education programme

NHS England gynacology elective care handbook

5. Priorities for Change

The review identified 4 key areas of focus highlighting potential areas of change which include:

- Prevention and Self-Care (with emphasis on education, awareness and optimising prevention and self-care strategies whilst improving access to consistent and equitable services to address risk factors including screening and provision of contraception).
- Referral and Access (delivering an optimal community model, with access to triage, advice & guidance, diagnostic offer and a pathway delivered with the appropriate workforce with relevant expertise, with consideration to mental health, to support early intervention).
- Pathway (ensuring optimal hospital services aligned with community offer, with defined pathways for the range of women's health conditions elective and emergency pathways on the same site aligned with community offer, see and treat service model and pre-operative pathway for elective procedures).
- Whole System Approach (Development ow workforce to deliver women's health services with the principles of right person, right time, opportunities for joint working to support succession planning and utilisation of skills and experience in the system, integrated technology to support system working).

Prevention and Self-Care	Prevention of women's health conditions is improved by better understanding of health promotion and condition management. The NHS LTP makes a commitment to supporting prevention, including the top 5 risk factors (smoking, diet, high blood pressure, obesity, alcohol and drug use). Addressing these risk factors can prevent a number of women's health conditions including, cervical cancer, Poly Cystic Ovary Syndrome (PCOS), infertility and pelvic organ prolapse. Education on other lifestyle and health factors such as, sexual behaviour, personal hygiene, physical activity, heavy lifting and antibiotic use provide further opportunities to reduce women's health conditions. The risk of developing a women's health condition is increased by the wider determinants of health, such as socio-economic status, and should be considered when developing prevention strategies. Screening and vaccination programmes provide important opportunities to prevent ill health. All women under 25 who are sexually active or when they change their partner are recommend to be tested for sexually transmitted infections (STIs), including chlamydia. In the ICS, 15-24 year old women have below average uptake of this testing. Human Papilloma Virus (HPV) infection is the main risk factor for cervical cancer, causing 99.7% of cases. Vaccination is given to girls aged 12 to 13 years and since the programme started HPV infections have reduced by 86% in England, significantly reducing future cervical cancer rates. The programme is now being extended to boys to reduce other cancer risk associated with HPV infection. Cervical screening is recommended every 3 years for women aged 25 to 49 years and every 5 years for women aged 50 to 64 years. Current uptake of screening varies across the ICS, with only 67% uptake in women aged 25 to 49 years in the city. Opportunities exist to consider home screening e.g. You Screen, to complement existing programmes and increase coverage, especially where there is higher risk e.g. deprived communities. Nationally, 50% of pregnancies are unintended. 80% of contraception provision is via the general practitioner (GP), but emphasis remains on oral methods. Opportunities exist to consider online provision of contraception, with successful models in place. Long Acting Reversible Contraception (LARC) is highly effective in reducing unintended pregnancies. In the ICS LARC uptake is higher than the national average, despite this there is still a higher proportion of women using emergency contraception, twice the national average. A high number of unintended pregnancies occur less than 12 months after birth, accounting for 1 in 13 termination of pregnancies. An opportunity exists to discuss and insert LARC in the ante-natal setting and at the time of childbirth to reduce unintended pregnancies. Improved education and awareness of the general population helps to prevent women's health conditions and promote self-care. ICS agreement on consistent and trusted information on trusted sites, such as the NHS App, incorporating Patient Knows Best (PKB), can lead to improved signposting. Sexual health services in the ICS deliver education activities in a range of settings and in collaboration with voluntary sectors to reach vulnerable groups, targeting health promotion to reduce inequalities. Education of healthcare professionals (HCP) to deliver consistent and evidence based practice (EBP) will support successful outcomes through greater knowledge and skill in supporting people in addressing risk factors , treatment and self-care for women.

Referral and Access	Locally, across the Nottingham and Nottinghamshire ICS, referrals are triaged to support a reduction in the number of cases going to secondary care. Despite this a significant number of referrals are still being sent to secondary care resulting in appointment slots issues (ASIs) and longer waiting times. RCOG recommends improved processes to reduce unwarranted variation in service delivery, with standardised referral processes that reflect best practice The use of structured templates using NHS e-Referral (e-RS), with explicit referral criteria, advising where to direct patients and with accompanying information, including signposting, can support prompt and consistent onward referral. Further development of triage by a suitable qualified clinician, optimising templates for women's health and education of GPs can support further reductions in referrals to secondary care. The option of returning the referral to the referrer is also in place via Advice and Guidance (A&G). However, only 64% of A&G requests are completed within 2 days. This excludes sexual health as the vast majority of referrals are patient directed with self-referral. The current model of triage and A&G is led by a consultant supporting the community women's health service. Opportunities exist to consider the development of a GP with extended role (GPwER) to enhance specialist knowledge and skills and support consistent triage and A&G for women's health. This will support the ambition to further reduce referrals directed to hospital outpatient clinics, reducing waiting times and appointment slot issues (ASIs). The NHS LTP makes a commitment to developing fully integrated community based healthcare with multi-disciplinary teams (MDT) working across primary and hospital sites. This is endorsed by RCOG advising that an integrated model of care maximises women's health outcomes, with clear pathways for women's health conditions and access to MDTs working across settings to support early diagnosis and intervention. Local patient engagement, conducted by Healthwatch, concluded that 73% of women in the ICS would like screening, diagnostics and treatment on the same day. Locally in city and south a community women's health model has been developed, with further opportunity to extend the model across the ICS. Delivery of specialist clinics in the community that can deliver diagnostics, treatment and care that would traditionally take place in the hospital requires consideration to the range of diagnostic tests available and access to MDT specialist skills, which is currently not in place across the ICS. Learning from COVID-19 pandemic has shown that virtual consultation can complement this model and meet the LTP ambitions to reduce outpatient attendances by 30% in the next 5 years.
Pathway	Optimal community provision can address the lack of capacity in secondary care, improve processes in outpatients and support the variation in length of stay (LoS) for procedures often considered day cases. RCOG recommends that pathways should be developed which are patient centred and based on evidence based practice, with a robust clinical governance structure to support development and implementation of best practice for women's health across settings. This supports clearly defined services, seamless transition of care and minimises fragmentation. Pathway delivery should support holistic care across the range of women's health services, including gynaecology, sexual health and fertility, as well as access to MDT specialist skills and defined links with other specialities, such as colo-rectal surgery, pain management and dermatology. Alignment of assessment and treatment with diagnostics will support a see and treat model. Locally, pathways are not always clearly defined or meet best practice guidance to optimise seamless care across settings with access to the appropriate skills. This provides an opportunity to enhance pathways to deliver an integrated model across community and secondary care. The coordination and delivery of high quality emergency and elective women's health services requires organisational infrastructure, appropriate workforce, theatre capacity, diagnostics and specialist services. Locally, 71% of emergency cases at NUH and 85% of emergency cases at SFH have a LoS of less than I day. At NUH in the last year 25 gynaecology procedures requiring theatre within 1 hour were performed, with 66 at SFH. During COVID-19 NUH has seen a 70% reduction in emergency admissions through access to a consultant in the emergency department (ED). At the same time the number of elective inpatient (IP) cases are declining, with 79% of elective cases a day case at NUH and 59% at SFH. The changing models of care, long term decline in IP activity, alignment with ED and workforce challenges provides an opportunity to streamline emergency and elective care to support improved outcomes, reductions in admissions, shorter length of stay and sustainable solutions for the workforce. In the UK, mortality following surgery is less than 1%, of these deaths 80% are defined as high risk and represent 10% of surgical workload. Enhanced Recovery After Surgery (ERAS) is an evidence based intervention which optimises surgical outcome without increasing complications. It is based on the delivery of pre operative counselling, peri-operative and post operative interventions. Delivery of ERAS supports reductions in length of stay (LoS), readmissions and increased patient satisfaction. The ICS has developed peri-operative care transformation with consideration to a holistic approach, universal assessment and access to intervention based on risk, underpinned by shared decision-making and signposting to lifestyle interventions. Consideration of this will support delivery of ERAS enabling movement back to the community, reducing LoS.

Whole System Approach	An optimal women's health pathway requires access to appropriate skills and experience across settings to deliver high quality treatment and care to women. Locally, there are opportunities to develop expertise across the ICS to provide access and meet the ambition of treatment and care delivery by the right person, right place, first time. The NHS LTP highlights the need to enhance multi-professional involvement in the MDT. An example of this is the role of physiotherapists as first-point-of-contact practitioner, which can have a vital role in faster diagnostics and earlier intervention in the community. Pelvic, Obstetric and Gynaecological Physiotherapy (PGOP) state that physiotherapy is the most cost effective intervention for treating mild to moderate incontinence and prolapse. Locally, direct referral to physiotherapy is not accessible consistently, with opportunities to directly refer and consider self-referral to reduce variation and improve outcomes and cost effectiveness. Advanced Level Practitioners (ACPs) provide a further opportunity to increase access to appropriate skills within an MDT. The RCOG recommends a clinical network approach to support optimal care delivery across community and secondary care. This is based on a MDT with appropriate skills and competencies working together to optimise service delivery and minimise fragmentation. It also supports coordinated involvement from multiple teams supporting treatment and care for women. Locally, and as highlighted above, skills and capacity to deliver this approach is not consistently accessible or supported by effective ways of communicating to support shared-decision making across multiple teams in different settings. The development of integrated technology solutions, with visible and accessible information and opportunities to discuss remotely provides an opportunity to develop a local clinical network. Nationally 90% of units report gaps in middle grade doctors, presenting a local challenge to succession planning and developing and maintaining skills and expertise for women's health. The majority of units practice in obstetric and gynaecology fields, but 20-30% practice one field. Locally, NUH operates predominately in one field, but SFH as combined obstetrics and gynaecology. The development of a clinical network, as described above, can support future consideration to joint working across the ICS including, for example, joint appointment and on call rotas, to support optimal outcome and safety and sustainability for the workforce. The development of extended non-medical roles to support specific tasks e.g. diagnostics, pessary fitting, provides a further opportunity to address potential gaps in the medical workforce. The GP Forward View makes a commitment to greater use of non-medical clinicians is primary care to improve access and capacity in the system, harnessing skills and expertise to improve outcome and deliver care by the right person, right place, first time.

6. Proposed future care system

Home

Planned/Scheduled

Prevention and Self-care – High Risk Factors, Contraception, Education

- Stronger prevention and education strategy – range of media e.g. social media, NHS App, consistent and trusted information in a well governed manner.
- Advice on lifestyle risk factors - smoking cessation, flu vaccines, messages on diet for gut health and bowel health, exercise , including pelvic floor muscle exercise, chronic coughing risks.
- Vulnerable groups – young, teenage pregnancies, socio-economic groups, diverse ethnics, domestic/ sexual abuse.
- Cervical screening kits for home testing – reach vulnerable groups
- STI screening at home – extension of existing provision – possible self-testing/ swabbing with virtual support.
- Online contraception provision – person-centred
- Role of 3rd sector in providing advice and support on self-care

Sustainable by:

- Improved support and understanding of risks allows early prevention
- Improved access to services to support prevention , self-care and independence
- Increased signposting to support self-care

Referral and Access – Diagnostics, Referral Process, Intervention

- Maximising the efficiency of the service – increase virtual offer
- Develop systems to aid patient understanding of services available , access to advice and information to support signposting to appropriate service
- HCP knowing when interaction F2F is required – increase opportunities to work virtually.
- Opportunities for self-referral – building on option already available for sexual health

Sustainable by:

- Reduced outpatient attendances
- Increased self-care and independence

Pathway – Evidence-based Practice, Service Model, Pre-optimisation

- Opportunity for virtual OPA – providing access to several professions and right expertise without attendance in clinic setting
- This can help making decisions on whether patients can stay at home or need to come in.
- Partnership working and joint appointments to provide access to several professions/expertise

Sustainable by:

- Improves outcomes through access to specialist advice and early intervention
- Reduced outpatient attendances

Whole System Approach – Expertise in the right place, Communities of practice, Succession planning and innovative roles

- Needs good consistent IT (from home across to acute settings). e.g. local diagnostic or imaging being transferred to acute clinician for review and virtual follow up.
- 3-way connection to patients – social services, primary and secondary care – reducing number of steps to progress care

Sustainable by:

- Promoting access to specialist advice, early intervention and supporting self-care

Urgent – 24 hours

Prevention and Self-care

- Access to emergency contraception online
- Support for sexual abuse/ assault – urgent response support – can support be provided at home – access to support line

Sustainable by:

- Provides quick response enables earlier intervention and support to avoid crisis services

Emergency/Crisis – 4 hours

Prevention and Self-care

- 999 when immediate help &support – police and/ or ambulance

Sustainable by:

- Provides quick response enables earlier intervention and support to avoid crisis services

Colour KEY to information source: Steering Group Evidence Document/ Guideline Patient Engagement

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6. Proposed future care system

Neighbourhood

Planned/Scheduled

Prevention and Self-care – High Risk Factors, Contraception, Education

- Engage with hard to reach groups across the ICS e.g. .travelling community, sex workers, BAME groups. Continue engagement in schools, colleges and universities.
- Contraceptive - increase support in anti-natal care for choices to be implemented closely following birth.
- Streamline provision of contraception – including for non-contraceptive purposes, delivering access closer to home
- Abortion Care sits outside NHS (unless complex medical history). Develop a smoother pathway with closer links

Sustainable by:

- Improved support and understanding of risks allows early prevention
- Promotes awareness to support self-care and independence
- Improved outcomes and patient experience

Referral and Access – Diagnostics, Referral Process, Intervention

- GPwER to support triage and advice and guidance across system – align with other roles supporting the pathway. Development with consultant support
- Educate GPs on referral and access to A&G.
- Community hubs with access to diagnostics – Phlebotomy, sonography, colposcopy (including mobile units), endometrial biopsy , STI screening.
- Injection clinics in the community with virtual follow up.
- Access to the right expertise in the community to support early intervention – role of GPwER, consultant and other groups e.g. physiotherapy – extending option of direct referral to other members of the MDT- right person, right time
- Patients would prefer screening, diagnostics and treatments on the same day
- Procedures and treatments without the need for extra appointment to talk through
- Access to psychologist, counselling services for fertility, miscarriage, sexual health for high risk behaviour, including psychosexual.
- Access to talking therapies
- Opportunities for self-referral – already exist in some sexual health services, can this be expanded for more of women's health services.
- Complement F2F offer with virtual ways of working manage demand and allow capacity for most vulnerable

Sustainable by:

- Improved outcomes and experience through early intervention and access to specialist advice in the right place at the right time
- Reduces acute attendances through access to specialist advice closer to home
- Supports delivery of consistent and evidence-based advice to support improvements in outcomes

Urgent – 24 hours

Prevention and Self-care

- Access to emergency contraception – through pharmacy, GP, Sexual Health and Secondary Care
- Support for sexual assault victims
- Access to support from social services and mental health teams.

Sustainable by:

- Improved support and understanding of risks allows early prevention
- Promotes awareness to support self-care and independence
- Improved outcomes and patient experience

Emergency/Crisis – 4 hours

Colour KEY to information source: Steering Group Evidence Document/ Guideline Patient Engagement

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6. Proposed future care system

Neighbourhood

Planned/Scheduled	Urgent – 24 hours	Emergency/Crisis – 4 hours

Pathway – Evidence-based Practice, Service Model, Pre-optimisation

- Pre-op assessment and signposting for low and moderate risk - align with high risk in acute and virtual offer in the home
- Service Model – development of GPwER to gain expertise in the community, aligned with other professional groups to deliver the service.
- Pathway to NICE guidance e.g. NICE guidelines 2019 – uro-incontence and prolapse to have a pelvic floor physio in the MDT – consider delivery across settings
- Education to support pathway delivery to evidence-based practice

Sustainable by:

- Improves outcomes through enhanced condition management
- Reduced cancelled procedures
- Reduced length of stay
- Enhanced access to specialist advice closer to home

Whole System Approach – Expertise in the right place, Communities of practice, Succession planning and innovative roles

- Opportunities for joint appointments to maximise access to expertise in the system
- Extended roles to support the pathway including specialist nursing roles (gynaecology, fertility and sexual health).Succession planning also needs to be considered – developing skills and roles
- ACPs – consider role due to loss of junior doctors – 3 years training to masters level
- Physio – extended role, including non medical prescribing e.g. pessary prescribing and fitting. Local / national training packages – tapping into these.
- Maximise nurse associates and non-registered roles e.g. phlebotomy, non-complex consultations, managing results/testing
- Pharmacist – specialist pharmacist prescribing/medication reviews
- Consideration to education for GPs and community teams to prevent urgent attendances.

Sustainable by:

- Improving self-care and condition management through access to specialist skills
- Enhanced specialist skills to deliver interventions
- Reduced hospital appointments
- Enhanced succession planning

Colour KEY to information source: Steering Group Evidence Document/ Guideline Patient Engagement

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6. Proposed future care system

Acute

Planned/Scheduled	Urgent – 24 hours	Emergency/Crisis – 4 hours
Prevention and Self-care – High Risk Factors, Contraception, Education • MECC – raising awareness and addressing lifestyle and signposting – smoking, exercise, diet, STI, sexual health awareness. Holistic conversation – person-centred approach family planning • Continuity of carers to facilitate conversations (cross reference with maternity review), particularly for vulnerable women • Contraception following TOP – consideration of LARC • Post-delivery – conversation and fitting of LARC • Include in service offer access to expertise for secondary prevention e.g. continence e.g. referral to physiotherapy on uro-gynae pathways • Psychological care following injury - wider offer of support for women, including counselling support e.g. fertility Sustainable by: • Promotes awareness to support prevention, self-care , independence and optimal condition management • Improved outcomes and patient experience		
Referral and Access – Diagnostics, Referral Process, Intervention • Consultant triage and use of F12 - directing referrals to scheduled community clinics – consistent approach across the system • Advice and guidance offer embedded across settings • Access to specialist advice e.g. nurse specialist/physiotherapy - with access to direct referral. • One stop diagnostic service to support 2WW pathway • Development of pathways e.g. pelvic pain to ensure access to MDT with specialist skills e.g. physiotherapy, pain management and with links with other services with interdependencies e.g. dermatology • Access to talking therapies • Virtual service offer maximised Sustainable by: • Improved outcomes through early intervention and access to specialist advice • Reduce demand on acute hospitals including reduced waiting times • Improved patient experience	Referral and Access • Diagnostics within 24 hours – urgent slots on lists Sustainable by: • Provides quick response and enables earlier assessment and intervention	Referral and Access • Nurse specialist role/ACP for emergency scanning e.g. early pregnancy assessment – protocol driven Sustainable by: • Provides quick response and enables earlier intervention
Pathway – Evidence-based Practice, Service Model, Pre-optimisation • System agreement on pathway delivery to EBP • Pre-habilitation pathway in place – high risk in acute - maximise virtual offer to support delivery • Agreed and trusted resources to signpost and support virtual offer • Single site for elective and emergency Sustainable by: • Provides quick response and enables earlier assessment and intervention • Increased capacity through single site offer • Reduction in cancelled elective procedures	Pathway • Consultant advice 24/7. • 24/7 US scanning and BHCG and theatre • Single site for urgent/emergency with planned Sustainable by: • Provides quick response and enables earlier assessment and intervention • Enhanced access to expertise • Improved succession planning	Pathway • Emergency theatre within 4 hours Sustainable by: • Provides quick response and enables earlier assessment and intervention
Whole System Approach – Expertise in the right place, Communities of practice, Succession planning and innovative roles • Extended physiotherapy roles Sustainable by: • Improving outcomes by early intervention right person, right time	Whole System Approach • Opportunities for joint working – possible cross system cover Sustainable by: • Provides quick response and enables earlier assessment and intervention • Improved succession planning	

Colour KEY to information source: Steering Group
Evidence Document/ Guideline Patient Engagement

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6. Future Care System – Summary

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Availability		Acute/ MH Hospital	Neighbourhood	Home
4 hours or less	24/7	• Development of the nurse specialist/ACP role for emergency diagnostics • Access to emergency theatre lists • Joint out of hours emergency care provision to maximise skills and experience across the system and support succession planning		• 999 /111 response for immediate help and support
Urgent Care/ within 24 hours	7 days	• Joint out of hours urgent care provision to maximise skills and experience across the system and support succession planning • Access to urgent diagnostics for early pregnancy, including Ultra Sound and Serum BHCG	• Access to emergency contraception in a range of settings • Access to sexual health advice with appropriate input from social services and mental health teams	• Support for sexual abuse/assault and signposting to advice and support
Scheduled	Appt based	• Consistent triage and advice and guidance offer across the system to redirect referrals to the community where appropriate • Education and support to GP with specific interest to develop skills and experience • Access to specialist advice from other professional groups with extended roles with ability to receive direct referrals from GP e.g. physiotherapy • Pre-operative assessments for high risk patients with anaesthetist, with signposting and referral • One stop see and treat for 2ww referrals, including diagnostics (hysteroscopy) • Access to diagnostics (laparoscopy/MRI) and other specialities to support treatment and condition management e.g. pain management, dermatology, colo-rectal • Inpatient elective and emergency services will be delivered at the same location • System agreement on pathway and workforce delivery to evidence based practice, focus on areas of development e.g. pelvic pain pathway	• Education, signposting and referral to appropriate advice and support, including charity organisations • Providing person-centred family planning and contraception advice at the right time and in a range of settings across the system, including vulnerable groups • Enhancing collaboration between sexual health consultants, GP and Local Authority to support timely and equitable contraception provision • Develop clear pathways between services e.g. termination of pregnancy service • Community gynaecology with GPwER aligned with consultant to support capacity and demand and access to specialist skills across the system • Consistent triage and advice and guidance across the system to support early intervention • Joint appointment across the system to maximise workforce, access to expertise and support equality of provision • Access to phlebotomy, diagnostics (sonography, colposcopy, endometrial biopsy) and treatments (injection clinics) in the community • Multi-professional team embedded in the service model to align with best practice recommendations • Strengthen the role of other professional groups, aligned with GPwER, e.g. ACP, nurse specialists, pharmacists, physiotherapists; developing extended roles with direct referral for assessment, treatment and advice • Pre-operative assessments with signposting and referral, aligned with risk stratification model (low and moderate risk) and shared decision-making principles • Access to counselling and clinical psychologists to support mental health and self-care	• Trusted education and advice to support self-care for women and couples, with consideration to prevention but also family planning • Signposting women and couples to trusted and approved apps and online resources and relevant charity to support self-care • Drive screening closer to home to increase coverage across the system • Access to online contraception • Support vulnerable groups and those with additional needs – providing accessible information and advice for those more vulnerable and their family/carers in an understandable format • Mental health/ social care support at home to support independent living • Virtual appointments allowing connections with multiple professions at home to support decision making and progress care • Access to IT system that facilitates information sharing across the system and into the home

Level of Care

Whole system women's health 3 tier **Education Programme** cutting across the ICS **Med Priority**	Far more needs to be done to raise awareness of the prevention and self-care opportunities linked to women's health, from addressing lifestyle risk factors through to helping people manage their condition. Education for the ICS population on risk factors needs to be made readily available from trusted and approved sources both printed and online (e.g. NHS App). Areas of health inequalities need to be targeted to reach local communities and vulnerable groups . This should include working with charities, voluntary groups and community leaders to reach communities and education provision across a range of locations including schools, colleges and community centres. Providing access to trusted resources for the ICS population and enabling way access (NHS App/PKB) with access to education, advice and support, including form charities and voluntary sector, to support prevention and self-care. Education of patients needs to be person centred and promote shared decision-making and should consider education of women, but also couples when delivering prevention and self-care education linked to sexual health and fertility. Access to information should include should consider signposting to social care and mental health services, voluntary and charity support and when and how to access urgent advice. Education of HCPs will support delivery of EBP and awareness of where to signpost for advice and support. It also provides an opportunity to enhance consistent understanding of the women's health pathway and the development of skills and extended roles. **Impact & Benefit** • Reduction in risk factors and enhanced self-care • Overall economic benefits through prevention and better self-care • Consistent and evidence-based service delivery **Alignment –** For prevention and education a universal approach is required, with alignment across the ICS to ensure consistent and equitable education, signposting and access to services.
Development of c**onsisten**t and **equitable** access to services to address **risk** factors for women and couples , improving coverage across the system e.g. person-centred contraception and family planning advice, screening closer to home **Med Priority**	If prevention and self-care approaches and enhanced education of HCP are to help transform services across the system, then access to consistent and equitable services to address risk factors for women and couples needs to be delivered across all areas. Increasing coverage will deliver significant benefits to vulnerable groups in the ICS and HCP should work with a range of settings e.g. schools, colleges and with public leaders and link workers to reach these communities. Coverage can be further improved by delivering screening closer to home, targeting vulnerable communities to reduce health inequalities. Home screening (including STI) should be widely available and used where appropriate. This will enable a blended approach to screening. The development of an integrated approach to sexual health in its widest sense (STI and contraception) and in planning a family can support delivery of a person/couple-centred approach. Organisation of contraception provision can be enhanced through enhanced collaboration between the GP, sexual health services and the local authority (LA). This includes opportunities to explore ambitions for digital contraception provision and to increase the uptake of LARC. Specific consideration to increasing uptake of LARC uptake through earlier conversations at antenatal appointments and insertion post partum, can significantly reduce the number of unintended pregnancies within 12 months of birth. **Impact & Benefit** • Increased uptake and coverage of screening and vaccination programmes • Person-centred access and provision of contraception, increasing uptake of LARC • Contribution to prevention of women's health conditions • Overall economic benefits through prevention and better self-care **Alignment** – For access to services to address risk factors it is key that a universal approach is taken and alignment across the ICS to ensure equity of coverage

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7. Transformation Proposal

Improving **local access** to Women's Health services through an enhanced **community offer** e.g. triage, advice and guidance community diagnostics and joint appointments **High Priority**	Local access to women's health services through an enhanced community offer needs to be further developed to extend across the ICS, expanding and enhancing the models of care working in the city and south. This includes developing the triage, A&G already in place, but extending support by a suitably qualified clinician. This should consider the development of a GPwER to work alongside the consultant to increase skills in the community and support consistent delivery of A&G within 2 days. Development of an integrated community based healthcare with an MDT with the skills and experience to deliver assessment, diagnostics and treatment, will support early diagnosis and intervention and enhance satisfaction. This requires consideration of the breadth of diagnostics available in the community, with options to develop phlebotomy, sonography, ultra sound, colposcopy, endometrial biopsy and injection therapy. Access to specialist skills requires further development of the MDT e.g. physiotherapy, nursing, with options of direct or self referral to early intervention. Specialist skills should include access to counselling and clinical psychologists to support mental health and self-care. Learning from COVID-19 includes opportunities to extend virtual consultations in to the model to support delivery of care closer to home and reduce the number of face to face appointments. Connection with multiple professionals from the MDT, by developing joint appointments with further enhance access to expertise to optimise outcomes for women across the ICS. **Impact & Benefit** • Reducing fragmentation and delivering care closer to home • Improved outcomes through earlier diagnosis and intervention • Reduction in hospital attendances and waiting times • Economic benefits through earlier intervention **Alignment** – Improving local access to women's health service should be aligned at ICS level to support a consistent and equitable approach.
Optimal **Hospital Women's Health Services** and organisation in balance with community provision to support timely inpatient care e.g. cross hospital working **High Priority**	Whilst enhancing the community women's health offer, consideration needs to be taken to the optimal alignment and organisation of hospital services to support delivering of an integrated women's health service with clearly defined pathways to support seamless transition of care and avoid fragmentation. The pathways should consider alignment of assessment, diagnostics and treatment, with access to other specialities to support a see and treat model, providing holistic care and reduce the number of hospital attendances. Optimal organisation of elective and emergency women's health services provides opportunities to deliver optimal outcomes, reduce admissions, reduce length of stay and support sustainability of the workforce. COVID -19 has resulted in an escalation of plans to co-locate emergency and elective women's health services on one site at NUH to deliver consistent models across Nottingham and Nottinghamshire. Pathway development across the system also provides an opportunity to consider joint working, for example, joint appointments and on call arrangements, in the future to support elective and emergency care. ERAS is an evidence-based intervention proven to reduce LOS, improve outcome and patient satisfaction. Implementation of the ICS peri-operative care transformation will reduce LOS and enable movement back to the community. Delivery can be considered across settings dependent on the level of risk, with access to assessments and signposting in the community for low and moderate risk and higher risk in the hospital setting. **Impact & Benefit** • Reduction in length of stay • Improved patient outcome and experience • Reduction in hospital referral through organisation with community offer • Optimal access to specialist expertise **Alignment –** Optimal hospital services organisation in balance with community provision, should be aligned at an ICS level.

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7. Transformation Proposal

Develop a **multi-professional workforce** and **system pathway** to deliver a sustainable and evidence-based service model for Women's Health for the future e.g. extended roles of other professional groups

High Priority

To deliver an optimal women's health pathway, further development of the MDT is required to support access to appropriate skills and experience across the ICS. This includes specific opportunities to complement existing roles and ensure delivery to evidence based guidelines. Specific opportunities exist linked to diagnostics and earlier intervention through the development of physiotherapy capacity as well as consideration to ACP roles. The ability to directly refer to other members of the MDT will ensure the principles of right person, first time are met.

Development of a clinical network for women's health will support optimal organisation of care across community and hospital settings. This provides opportunities for shared decision-making and optimising the utilisation of expertise across the ICS, with options to consider joint working in the future to support sustainability of the medical workforce. Integration of technology will support the functioning of the network to ensure shared-decision making and effective communication.

Succession planning presents a challenge for the women's health pathway. Opportunities to utilise expertise across multi-professional groups to develop extended roles should be considered; to enhance skills and expertise and provide a solution to potential workforce gaps. This will require consideration to education and training and incorporation within pathway development.

Impact & Benefit

- Improved succession planning of workforce
- Delivery of a seamless service to patients
- Access to right person, right time to optimise outcome
- Reduction in face to face appointments

Alignment – To support delivery of a multi-professional workforce and system pathway, alignment should be at an ICS level to support a sustainable model for women's health**.**

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7. Women's Health Transformation Proposal Summary

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	Priority (High/ Med/ Low)	Alignment (ICS/ ICP/ PCN)	Workforce	Technology	Estate/ Configuration	Finance/ Commissioning	Culture	Benefits (*Less than £20,000 per QALY is cost effective)
Whole system women's health 3 tier **Education Programme** cutting across the ICS for: • ICS Population –to support prevention • HCPs – to support consistent practice • Patients – to support self-management	Med	ICS	-What training is required and who to deliver it -Education delivery added to job plans	-Consistent and approved resources e.g. Apps accessible in a range of settings -Virtual education to MDT -Integration of systems	-Central hub for storage, management and dissemination of information -Community hubs to deliver education, balanced with virtual offer	-Funding for education time within job plans -Funding for IT solutions, including integrated systems, Apps, online content and virtual offer	-Collaboration and connections across the system to support consistency and encourage signposting to advice -Changing culture and mind-set to promote prevention -Consideration to the needs of the community	-Consistent and evidence based service delivery -Increased prevention and self-management -Release clinical time and reduction in unnecessary appointments -Improved clinical outcomes and patient experience
Develop c**onsisten**t and **equitable** access to services to address **risk factors** for women and couples , improving coverage across the system e.g. person-centred contraception and family planning advice, screening closer to home	Med	ICS	-HCP workforce to deliver timely, consistent and equitable access to contraception - Workforce to support ambitions to increase screening coverage closer to home	-Digital first access to STI services -Home screening kits -Online contraception -Technology to support virtual offer	-Community diagnostic hubs -Community settings to improve coverage across communities	-Commissioning of sexual health, access and contraception provision -Commissioning community work to reach vulnerable groups	-Collaboration with 3rd sector -System-wide agreement on contraception across settings -Person-centred provision, choice and care closer to home	-Increased prevention and self-management, including vulnerable groups -Increase in screening coverage -Increased uptake of LARC -Enhanced patient satisfaction and person-centred provision -Improved clinician satisfaction through a streamlined approach, delivering increased coverage in addressing risk factors
Improving **local access** to Women's Health services through an enhanced **community offer** e.g. triage, advice and guidance community diagnostics and joint appointments	High	ICS	-Scope what is available and what is needed across professional roles, including GPwER -Job planning to include education and shared-learning to support pathway delivery	-Video-consultation technology -Access to postal kits -Integrated IT system across settings	-Community hubs accessible to population -Diagnostic hubs and mobile units to extend offer	-Evolve commissioning and tariff to support model -Funding estate/workforce/ technology	-Collaboration, communication and partnership working across the system -Support changes in patient perceptions of where service s ae delivered	-Improved clinical outcome through earlier intervention -Improved patient experience through holistic approach to care - Reducing fragmentation and care closer to home - Reduction in costs – earlier intervention, holistic approach and reduced hospital attendances
Optimal **Hospital Women's Health Services** and organisation in balance with community provision to support timely inpatient care e.g. cross hospital working	High	ICS	-Workforce to deliver pathway and aligned with capacity and demand to support joint working -Specialist nurse role - upskilling to support diagnostics -Pre-operative MDT workforce requirements	-Technology to support diagnostics and streaming surgery -Integrated IT system -Electronic notes -Virtual consultation platform and equipment	-Community hubs for pre-op -Co-location of emergency and elective gynaecology on one site	-Funding for technology -Commissioning and funding to support joint working, including workforce	-Commitment to joint working -Consistent one stop see and treat -Co-production to support evolving service delivery and support change process	-Improved patient outcome and experience -Reduction in length of stay -Reduction in referrals acute setting -Reduced staff travel -Cost benefit through joint working and estate utilisation
Develop a **multi-professional workforce** and **system pathway** to deliver a sustainable and evidence-based service model for Women's Health for the future e.g. extended roles of other professional groups	High	ICS	-Capacity and skill mix to deliver future workforce -Extended roles for other professional groups e.g. physiotherapy -Non registered staff – opportunity to extend roles	-Integrated IT system with connectivity across system -Virtual consultation, platform and equipment	-Estate to co-locate MDT across settings	-Funding and commissioning arrangements to support extended roles, activity planning and capacity to meet demand.	-Removing barriers across professional and organisational boundaries -Commitment to multi-professional working to utilise skills of the workforce	-Improved patient outcome and experience through right person, right time -Better and quicker access and a seamless service to patients -Improved workforce and succession planning -Improved staff satisfaction

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8. Enabling Requirements

Workforce	Enhancing the future health and social care for women's health services, requires the following considerations for workforce: • Widespread training of healthcare professionals (HCPs) to empower them to signpost to appropriate resources and services and provide best practice advice to support self-care and condition management, with a mentorship programme to increase skills and confidence • Cross pathway working (primary, secondary and community care) with specific development and expansion of the multi-professional team to meet best –practice guidance and deliver the recommended service models • Development of a GPwER role with recognition that a training/ development period of 18 months is required to gain accreditation working towards GPwERs • Development of roles to deliver the model and ensure access to the appropriate skills and expertise to support the women's health pathway, including the development of extended roles
Technology	The main areas in which technology can effect transformation for women's health care include: • Developing an integrated IT system for women's health to support visibility of information, where appropriate, across settings to support decision-making and communication with the MDT • Trusted and approved resource development for signposting and self-care, with common understanding amongst HCPs - based on NHS App/PKB. • Increased use of virtual consultations n to deliver care closer to home • Development of digital offer for screening and contraception provision
Estate	• There is an emphasis on delivering women's health care closer to home and accessible more locally, community hub space will be required to support the model e.g. diagnostics, peri-operative care • It is crucial to ensue better local access is made available in some of the more remote areas of higher deprivation or cultural/ethnic diversity • Provision of care closer to home, can help optimise the space footprint required in acute hospital departments, with optimal configuration of elective and emergency services on one site
Culture	• Enhancing collaboration across the ICS to support the development of a clinical network for women's health, ensuring access to expertise and development of a seamless pathway across primary, community and secondary care • Developing an asset based approach – identifying and building relationships with community leaders, charity and voluntary sector to strengthen community working and support equitable access and service delivery to meet the needs of all our citizens • Promoting person-centred care and shared decision-making

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9. Women's Health Services Vision

Women's Health Services Future Vision:

From…		2022/23 Phase 1	2023-2026 Phase 2	2026+ Phase 3	To…
• Inconsistent prevention and self-care strategies in place to disseminate and sign-post to appropriate information • Inconsistent education/ training across the region • Inconsistent access to services to address risk factors, particularly in vulnerable groups	Prevention & Self-Care	-Develop system wide resources for HCP and patients in range of media e.g. NHS App, with awareness campaigns and consideration of vulnerable groups -Scope service to signpost people to, including 3rd sector - Scope screening and contraception offer – including online	-Develop technology to support access to information -3rd sector support defined and utilised consistently -Develop education offer to vulnerable groups -HCP with access to information to support signposting -Implement screening and contraception pathway – person-centred approach	-Patients aware of platforms to access information and use consistently e.g. NH SApp - Embedded education offer -Access to support from third sector readily available -Embedded screening programme – blended offer to increase coverage -Embedded contraception pathway – timely access/local	• Consistent and equitable prevention and self-care through wide-spread public awareness, education and signposting • Consistent evidence-based practice to support prevention, treatment and self-management • System-wide equitable and consistent services to address risk factors, with improved coverage to vulnerable groups
• Inconsistent triage, advice and guidance • Limited access to community diagnostics and joint appointments to utilise expertise in the system • Different IT systems impacting on service delivery across settings • Limited access to services to support mental health and self-care	Referral and Access	-Develop triage, advice & guidance – standardised -Define key roles e.g. GPwER aligned with other workforce to deliver pathway -Develop diagnostic offer and build to one-stop offer aligned with virtual offer -Scope IT systems to support triage, visibility, signposting, virtual offer, information	-Implement triage, advice & guidance -Recruit to workforce to deliver pathway – ensuring alignment of roles -Develop community hubs, diagnostic offer and virtual offer -Implement continuous learning and MDT communication -Implement IT solution connecting exisintg systems	-Established triage and advice & guidance -Operational community hubs, with mobile units for targeted response -Platforms for communicating with patients and with MDT operational and robust - IT Systems truly connected and integrated where possible	• Consistent triage, advice and guidance • Comprehensive community diagnostic offer, with joint appointments to utilise expertise in the system • Integrated IT system to support service delivery across settings • Access to services to support mental health and self-care
• Lack of clarity on pathways between services and across the system • Hospital elective and emergency services delivered on different sites and not aligned with community offer • Multiple hospital attendances to support treatment planning • Inconsistent advice and signposting in advance of elective procedures	Pathway	-Align pathways with community offer – identify gaps and scope requirements e.g. pelvic pain -Build on see and treat models and increase offer aligned with virtual offer -Scope estate and workforce -Scope pre-operative pathway -Build on one site ambition -Scope IT systems and access to information	-Pathway delivered in alignment with community and gaps addressed e.g. pelvic pain -Workforce and MDT arrangements in place -One stop and virtual offer fully implemented -Single site offer in place -Implement system IT solution – visibility and integration where possible	-Working with embedded pathways ad systems, with feedback to ensure continuous improvements -Delivery of Women and Children's hospital	• Clear pathways between services and across the system • Hospital services delivered on the same site and aligned with community offer • One stop see and treat model • Consistent advice and signposting in advance of elective procedures
• Limited opportunities for joint working across acute settings to support utilisation of skills and experience and succession planning • Limited extended non-medical roles to support principles of right person, right time • Lack of integrated technology to support system working	Whole System Approach	-Scope workforce for pathway to develop non-medical roles e.g. advanced practitioner physio/nurse -Identify psychological support as part of MDT -Develop framework to support roles, with clear pathways, training and communication – use this to exploit joint working opportunities across system	-Implement advanced practitioner roles, framework, pathways and referral criteria -Scope joint working opportunities and align with future drivers e.g. ICS waiting lists -Development of technology, training and communication to support MDT working	-Embedded roles with agreed pathways and joint working to optimise access to expertise in the right place/right time -MDT with access to training and support to develop expertise for the future -IT system to support the pathway – connected and integrated where possible	• Opportunities for joint working optimised to support utilisation of skills and experience and support succession planning • Extended non-medical roles to support right person, right time • Integrated technology to support system working

10. Conclusions and Next Steps

Conclusions	The review of women's health services as part of the development of a Clinical and Community Services Strategy for Nottingham and Nottinghamshire ICS has been undertaken using a co-design model where patients, carers and key stakeholders, have collaboratively worked together to shape a vision for the future care system. Although work has progressed quite well working remotely and holding video meetings, further patient engagement would have been beneficial and will be revisited when the system allows this safely. The four key themes for improvement identified are: • Prevention and Self-Care (with emphasis on education, awareness and optimising prevention and self-care strategies whilst improving access to consistent and equitable services to address risk factors including screening and provision of contraception). • Referral and Access (delivering an optimal community model, with access to triage, advice & guidance, diagnostic offer and a pathway delivered with the appropriate workforce with relevant expertise, with consideration to mental health, to support early intervention). • Pathway (ensuring optimal hospital services aligned with community offer, with defined pathways for the range of women's health conditions elective and emergency pathways on the same site aligned with community offer, see and treat service model and pre-operative pathway for elective procedures). • Whole System Approach (Development ow workforce to deliver women's health services with the principles of right person, right time, opportunities for joint working to support succession planning and utilisation of skills and experience in the system, integrated technology to support system working). The review describes a future care system in optimal care settings and with care provided at different levels of urgency and envisages 3 high priority and medium priority programmes to transform care: • **High** – Improving local access to women's health services through an enhanced community offer • **High** – Optimal hospital women's health services and organisation in balance with community provision to support timely inpatient care • **High** – Develop a multi-professional workforce and system pathway to deliver a sustainable and evidence-based service model for women's health for the future • **Medium** – Whole system women's health 3 tier education programme cutting across the ICS • **Medium** – Development of consistent and equitable access to services to address risk factors for women and couples , improving coverage across the system • To achieve these there are a range of enabling requirements for the ICS across workforce, estate, technology, culture and financial systems. Collectively these initiatives can transform and provide long term health improvement and sustainability in the area of women's health care in the Nottingham and Nottinghamshire ICS.
Next Steps	This strategy sets the future direction of development of women's health care in the ICS and it is proposed it will shape future work of the ICS in a number of ways: • The identified priorities and programmes should be used to inform commissioning ICS, ICP and PCN activity • The enabling activities require development and inclusion in the relevant ICS workstreams to inform their work programmes • The impact on estate and configuration changes require inclusion in a programme of pre-consultation business case development alongside the service changes recommended from other reviews. • The aggregate impact of the collective suite of service reviews should be used to shape focus of future service provision in acute and community settings in the ICS

NOTE: In further developing and implementing the proposals set out above as part of our focus, each partner organisation within the ICS will continue to ensure that they comply with their statutory duties and system/organisational governance processes, particularly (but not limited to) those relating to patient and public involvement; equality and inequality analysis

11. List of Abbreviations

ACP	Advanced Level Practitioner	LTC	Long Term Conditions
A&G	Advice and Guidance	LTP	Long Term Plan
AHP	Allied Health Professional	MDT	Multi-Disciplinary Team
App	Application	MECC	Make Every Contact Count
ASI	Appointment Slot Issue	MH	Mental Healthcare
BAME	Black, Asian and Minority Ethnic	Mid Notts.	Mansfield & Ashfield, Newark & Sherwood
CCSS	Clinical and Community Services Strategy	NCH	Nottingham City Hospital
CCG	Clinical Commissioning Group	NHS	National Health Service
COVID-19	Coronavirus Disease 2019	NHSE/I	National Health Service England and Improvement
DNA	Did Not Attend	NICE	National Institute for Health and Care Excellence
EBP	Evidence Based Practice	Notts.	Nottinghamshire
ECR	Electronic Care Record	NUH	Nottingham University Hospitals
ED	Emergency Department	OOH	Out of Hours
ERAS	Enhanced Recovery After Surgery	OP	Outpatient
e-RS	NHS e-Referral	PCOS	Poly Cystic Ovary Syndrome
F2F	Face to Face	PCN	Primary Care Network
FU	Follow up	PCP	Personalised Care Plan
GP	General Practitioner	PH	Public Health
GPwER	General Practitioner with Extended Role	PHE	Public Health England
H&SC	Health and Social Care	PID	Pelvic Inflammatory Disease
HCP	Healthcare Professional	PKB	Patient Knows Best
HIV	Human Immunodeficiency Viruses	PN	Practitioner Nurse
HPV	Human Papilloma Virus	QoL	Quality of Life
IAPT	Improving Access to Psychological Therapies	QIPP	Quality, Innovation, Productivity and Prevention
ICP	Integrated Care Partnership	QMC	Queens Medical Centre
ICS	Integrated Care System	RCOG	Royal College of Obstetricians and Gynaecologists
IP	Inpatient	ROI	Return on Investment
IT	Information Technology	RTT	Request to Treatment
LA	Local Authority	SC	Social Care
LARC	Long Acting Reversible Contraception	SFH	Sherwood Forest Hospitals
LD	Learning Disability	UK	United Kingdom
LoS	Length of Stay		

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12. Data Sources

Data Sources	BMJ Sexual Reproductive Health Cancer Research CCGs Critical Care journal European Journal of Surgery Healthwatch Patient Engagement National Confidential Enquiry into Patient Outcomes and Death (NCEPOD) NHS Digital NHS England Elective Care Handbook NHS website NICE Nottingham University Hospital Public Health England (including Fingertips) Royal college of Obstetricians and Gynaecologists Sherwood Forest Hospital

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