National Clinical Advisory Team - NCAT

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NCAT review

Gloucestershire Hospitals NHS Foundation Trust;
Gloucestershire NHS Clinical Commissioning Group

Date of visit 15 May 2013

Venue(s): Cheltenham General Hospital

NCAT Visitors: Dr Irving Cobden, Consultant Physician
Mr Jim Wardrope, Consultant in Emergency Medicine

Introduction:

NCAT was asked to provide clinical assurance of the plans for a proposed reconfiguration of services across the two acute hospitals in Gloucestershire run by Gloucestershire NHS Foundation Trust, namely Cheltenham General Hospital and Gloucestershire Royal Hospital. The specific changes relate to 3 main clinical services:

- Urgent and Emergency Care
- Paediatric Day Cases
- Medical Specialties - Gastroenterology, Respiratory Medicine and Cardiology.

The review was commissioned by the Trust and Gloucestershire CCG. Originally a public consultation process had been described as an "engagement" by the SHA. It is unusual for the proposals to have been out to public consultation in advance of the NCAT review, and the results of the consultation are expected to be published in June.

Background to Review

GHNHSFT runs services on two acute hospital sites, Cheltenham General Hospital and Gloucestershire Royal Hospital, serving a catchment population of between 650 e 750,000. The two acute hospitals are approximately 9 miles apart; "blue light" ambulance journey time is around 14 minutes. Ambulance journey times around the county are of a similar order of magnitude. A shuttle bus service runs half-hourly

between the hospitals. There are 9 Community Hospitals all providing some Minor Injury Unit services although only Stroud and Cirencester operate 24/7 and X-Ray provision varies between sites.

A number of service reconfigurations across the two acute sites have already taken place over previous years. These include:

- Interventional Cardiology – Hartpury Suite, CGH
- Maternity and Gynaecology – GRH
- Opthalmology -CGH
- Paediatric Inpatients and Assessment Unit – GRH
- Adult Urology –CGH
- Stroke and TIA – GRH
- Vascular Surgery (imminent – network with Swindon) - CGH

The Foundation Trust was authorised in 2004. From May to December 2012, the Trust was under Special Measures by Monitor relating particularly to its performance against the Emergency Care standard. There has been previous input from the Intensive Support Team for Emergency Care which visited in January 2012.
NHS Gloucestershire CCG took over commissioning from NHS Gloucestershire PCT / Cluster in April and is co-terminus with its predecessor organisation.

The Case for Change

1. Emergency Care

   Both hospitals currently provide a traditional A&E service although some patients diagnosed with specific acute problems such as stroke, myocardial infarction, maternity and major trauma are taken directly to relevant services on one site only. Patients with major trauma (other than stabilisation at GRH if necessary) or needing emergency coronary intervention out of hours are taken to Bristol.
   There are approximately 70,000 Emergency Department attendances at GRH and 50,000 at CGH.

   There are a number of difficulties in sustaining the present model, including staffing issues and the drivers for improvement in patient safety and clinical standards. It is recognised that emergency care should no longer be provided by

unsupervised junior doctors: this means that a greater presence of Consultant and Middle Grade doctors is required to staff Emergency Departments.

To provide the necessary levels of Consultant presence there should in theory be 10 doctors per site; there are presently 11 across the two sites. The middle grade is similarly under-provisioned with 7.5 doctors across the sites instead of 16. Recruitment is described as challenging. There is a national shortage of seniors and of middle grades wishing to train in Emergency Medicine

Consultants split their time between hospitals and try to provide on-site support from 8am -9pm.The gap in middle-grades is presently covered inappropriately by doctors of insufficient experience, mainly ACCS doctors. A visit by Severn Deanery in December 2012 highlighted the difficulties this placed on the junior doctors and required a solution to be found by August 1st 2013. Failure to comply could result in withdrawal of these junior posts.

2. Paediatric Day cases

   At present day case children's surgery and medical / diagnostic investigations are carried out at both acute hospitals. At CGH there is a dedicated children's facility which supports elective surgery on 2 days a week (307 patients in 2011-12) and medical investigations 2 days per week (468 patients in 2011-12). There is also specialist paediatric nursing support for Dental lists and Ophthalmology.

   At GRH there is no dedicated paediatric day-case facility but the children's inpatient beds and assessment unit with all relevant staff are on site. There were 1159 surgical procedures and 324 medical cases in the corresponding time-frame. The former patients are admitted to a dedicated bay within the Adult Surgical Day Unit. The latter are seen in the assessment unit inpatient facility. Neither of these arrangements is particularly appropriate and the reduction in paediatric training grades makes it difficult to cover multiple sites of working.

   The CQC Children's Services Review raised concerns about the number of surgeons and anaesthetists reporting low numbers of cases per year on children which would suggest a need to concentrate expertise in a smaller number of operators.

3. Gastroenterology, Respiratory and Cardiology.
   At present both sites deliver these medical specialty services although coronary intervention is delivered at CGH only in the Hartpury suite. This facility has problems of capacity and patient environment. A redistribution of services in the other specialties would enhance senior input and provide greater support for both complex specialty cases and the acute and emergency patients, whilst maintaining support from the specialties on both sites.

Proposals

Emergency Care

Three main options had been considered for the future:

i. Do nothing – this was felt to be untenable
ii. Remove all ED Medical Staff at CGH 24/7 and concentrate senior support to the GRH site, but retain admissions for relatively stable GP admissions to CGH. This was felt to require major changes to the ED and Acute Medicine footprint with strained capacity at GRH; it was felt to lack support clinically and almost certainly from the public and was a “step too far”.
iii. Remove all ED Medical staff at CGH at night - otherwise as ii. This was the preferred proposal and was the model taken to public consultation.

The consultation proposal is to change the model of Emergency and Acute Care in Gloucestershire. Between the hours of 8 p.m. and 8 a.m. most emergency ambulances will go to Gloucester Royal Hospital Emergency Department. Cheltenham General Hospital will continue to receive direct GP admissions and will also operate an Emergency Nurse Practitioner service for walk-in patients. It is expected that all orthopaedic trauma admissions will be centralised at night on GRH. This is being considered for General Surgery but no decision has yet been reached. The expected outcome is to produce a robust Emergency Service with enhanced senior support that meets the requirements of best clinical practice and for training, whilst maintaining clinical services locally for the vast majority of patients who attend as urgent or emergency cases.

Paediatric Day Cases

The proposal is to develop a dedicated paediatric elective day unit at GRH staffed by children’s nurses and play specialists and to carry out all elective day surgery and

medical investigations in this unit. Ophthalmological children's day surgery will continue at CGH and both sites will maintain an outpatient service.

The expected outcome is that children will receive their day-care in an appropriate child-friendly environment, by paediatric trained staff with adequate volumes of experience for surgeons and anaesthetists.

Gastroenterology, Respiratory and Cardiology Services

For Gastroenterology, the plan is to concentrate the main elective inpatient bed-base at CGH whilst retaining an area for acute patients such as GI bleeds at GRH. The expected outcome is that this will facilitate the management of the complex GI patients coupled with the creation of a "GI Physician of the Week" at CGH, freed of other duties, who will support the Gastroenterology ward and also provide in-reach to Acute Medicine and support for other GI problems in the hospital. There will be a "GI physician of the day" rota for the acute facility at GRH.

For Respiratory, the original intention was to concentrate the more long-term complex and chronic patients e.g. lung cancer, COPD whilst the most acutely unwell e.g. respiratory failure requiring non-invasive ventilation (NIV) at GRH.

For Cardiology, the expected outcome is to achieve a better environment for patients and to expedite the transfer of patients from other areas and sites who require interventional cardiology such as PCI, permanent pace-maker insertion etc. Primary (emergency PPI) will continue on a Monday –Friday 9-5p.m. basis with patients being taken by ambulance to Bristol at other times as now.

Documents Received: See appendix 1

We also received copies of presentations given on the day and a copy of the Emergency Care Intensive Support Team's report from June 2012.

People met: See appendix 2

We visited the Emergency Department, Acute Medical Assessment and Admission areas and passed by the Critical Care and Children's Day Unit at CGH.

Views expressed

- There have been a number of reconfigurations of services over recent years so the process is not a strange one to the Trust, GPs or the general public. Perhaps the most controversial change was the unification of in-patient children's beds to the GRH site but that seems well-accepted now. Clinicians, both Hospital Consultants and the CCG and its GP members, seem to be very supportive of the changes although there are one or two dissenting voices.

- A comprehensive public consultation was undertaken by the CCG from February 1st to May 3rd. Early results presented from the consultation process seemed to be reasonably supportive for most of the changes but the full report of the results is awaited.

- Two petitions were organised against the proposed reconfiguration, in particular the Emergency Care changes. One by the MP for Cheltenham, which asked the Trust to "reconsider the changes", received 1228 signatures. A HMG on-line petition which asked for votes "against the closure of Cheltenham A&E" (sic) received 7,519 signatures. The CCG is in discussion with HMG as the "closure of Cheltenham A&E" is not what is being proposed.

<u>Urgent and Emergency Care</u>

- Transport for patients and relatives could be an issue although for emergency care the numbers would be relatively small. For relatives and suitable elective patients, there is a shuttle bus between hospitals every 30 minutes from 7.45 a.m. till 6.30 p.m. with a proposal for a later finish of 10 p.m. Parking is described as reasonable at GRH with an increase in space due to a multi-storey car park; the hospital is also said to be close to trains and buses. Parking at Cheltenham is not so good and applications to expand parking have been rejected so far. The hospital is also not quite so handy for train and bus services.

- The question has been raised about possible increased mortality due to longer journey times in the "blue-light" situation. We were not told of any major concerns expressed by South West Ambulance although the extra

distance for some patients at night could take a crew and vehicle away from their locality for an extra length of time. Data suggests an average of 14-16 extra journeys to GRH instead of CGH during the hours 8pm-8am if all 999 patients were taken to GRH.

- Concerns about ambulance waits at hand-over seem to be more of an issue. It is probable that a small number of elderly frail patients from the Cheltenham catchment area who might otherwise be suitable for discharge might have to stay in overnight if taken to Gloucester Royal.
- Ambulances can take patients to M.I.U.s around the county. The question of whether some 999 patients are suitable to be taken to CGH for management in the Acute Medicine Unit, subject to agreed protocols, was discussed.
- Trauma activity at night is small, perhaps 1-2 patients being diverted and the very rare transfer of a walk-in patient from CGH, the example given being a dislocated shoulder.
- General surgical emergencies will continue on both sites at present.
- GP out of Hours at CGH is located close to the ED in Fracture Clinic and operates till 11pm. There is a proposal to increase the hours to cover more of the night.

Paediatric Day cases

- The major benefits highlighted were the concentration of surgical and anaesthetic skills, the improvement in support to the patients of a service which has seen reduced numbers of trainees and the proximity to the in-patient bed base. There was mention of political sensitivities around the retained day facility (Battledown Unit) at CGH. This space is only used for paediatric day cases two days per week and could be used with advantage for other clinical services. We understand that paediatric outpatient services will continue on both sites as at present.

Medical Specialties

- For all specialties it was considered that moving the more long-term or complex patients to CGH would help free up space on the GRH site for the increased numbers of 999 patients at night requiring admission.
- The issues highlighted for Gastroenterology were those of focusing senior input by making CGH the main bed-base for complex GI inpatients and by having a “bleed bay” at GRH to back up the emergency system.

- For respiratory, since the original proposals were put forward, there has been a reconsideration and recognition that NIV will be needed to continue at both sites.
- The importance of enhancing the Hartpury Unit facilities for Cardiac intervention were highlighted; there were space and funding problems that prevented the unit being on the same site as the (extra) 999 ambulances.

Discussion and analysis

1. Urgent and Emergency Care

The vast majority of the discussion centred on the proposed changes to Urgent and Emergency Care

The main driver for change is that staffing two units 24/7 is already critical and the threatened withdrawal of junior posts in ACCS and GP training would lead to collapse of sustainable rotas. There is a national crisis in ED staffing and it is highly unlikely that enough doctors with the right training and experience could be found to fill gaps left by trainees. An ill staffed service at both sites would not deliver safe care. Concentration of senior staff at one site would mean that all patients brought by ambulance would be assured experienced clinical decision makers in the ED 24/7.

There is growing evidence senior staff in the ED at night reduce admissions to hospital and improve patient management.

Concerns have been raised during the consultation that patients will be at risk of increased mortality due to the extra travel distance. The main source for this concern is the paper by Nichol et al from the EMJ in 2007. A number of relevant safety issues that need to be addressed were discussed.

Ambulance patients 8pm-8am

It is estimated that an average of 16 patients per night might need transfer to GGH. At times both CGH and GGH might operate bypass to the other site so the net change of transfer will be less. Ambulance protocols will reduce this number.

GP referred ambulance cases will be received in an acute assessment area staffed mainly by acute medicine. Those patients brought under protocol would be seen in the same area except AAA where the patient would be taken to vascular surgery. There is a possibility that some patients with critical illness (such as cardiac arrest) could be brought to the ED resuscitation room.

Crucial discussions to be finalised included agreement on how patients beginning journeys close to 20:00 will be managed, the effects of increased journey time to GGH on response times, and the provision for transfer from CGH for walk in patients requiring more acute care. Agreement of protocols, for direct admission of patients with defined conditions to acute medicine/vascular surgery/ cardiac arrest was also discussed. This will require agreement by acute medicine, general surgery and anaesthesia regarding the response required to staff the resuscitation room, if an unstable patient is being brought by the ambulance service.

The walk in (ENP) service at CGH 8pm- 8am

Emergency Nurse Practitioners, experienced triage nurses and other nurses will provide the service for walk-in patients. There are currently 20 ENPs across both sites. They deal mainly with minor injury. There is a training programme in minor illness assessment, advanced paediatric life support (APLS), care of patients with head injury and for those under the influence of alcohol. Discussions are on-going regarding the rotation of staff to cover nights.

The ENPs will be able to discuss care with the ED senior staff at Gloucester and have x-rays reviewed via PACS. They will also be able to discuss patients with the ED consultant at handover at 08:00. The quality of the training programme and its extreme urgency was highlighted.

Patient Safety at the 20.00 watershed

There are plans to have EM and AM consultant presence up to 20:00. They will ensure as many patients as possible are treated and admitted or discharged before 20:00. There will continue to be ED doctors in the department until 22:00 and ED nurses 24/7.Operational procedures are being developed to ensure smooth handover. For the ambulance service an important consideration will be the handling of patients whose journeys commence just before the 20.00 watershed.

The CCG, Primary Care and Out of Hours

The CCG and its members are strongly supportive of the changes but recognise that the role of Primary Care in helping to deliver urgent and Emergency Care is crucial. We were assured that movement of appropriate patients between the OOH centre and ED is easy in either direction. We were also informed that the receptionist can signpost patients to the most appropriate service e.g. injuries to the ED and minor ailments to OOH.

Patient Flows – Acute Medical Unit

Enthusiastic and willing clinicians staff the Acute Assessment and Short Stay areas at CGH but the system is hampered by the multiple areas currently delivering its functions. Proposals to rationalize the footprint are well developed and the opportunity was raised of taking some of the proposed ambulance diverts at night, where clinical protocols can be developed, an example being for patients with long-term conditions, particularly when they are well known to CGH services. There is an integrated discharge team facilitating patient discharge home but difficulties arise when flows onward into specialty wards are blocked: significant numbers of medical patients may be boarded onto non-medical wards. Some patients stay on the Acute Medical Unit longer than the generally-accepted maximum of 48-72 hours. We were informed that the Ambulatory Care facility carries out a number of non-emergency treatments such as iron infusions.

Patient Flows – Medical Specialties

Lengths of stay have improved in some specialties but not in others. Integration of working with Acute Medicine, for example daily in-reach to the unit by specialty opinion, is not optimally developed. The implementation of brief business / board rounds on Specialty wards early in the day by a senior opinion, recognized as crucial to timely discharge, is patchy.

Trauma and Orthopaedics

Numbers at night were confirmed as small with an average of 1 patient per night being transferred or diverted to GRH. Discussions centred on patients with injuries such as a dislocated shoulder who might walk into CGH: there is no on-site middle grade but ENPs could be upskilled. Conscious sedation by ED staff remains controversial with differing views from the anaesthetic team to the ED team about safety out of theatre.

General Surgery

Presently emergency surgery rotas are maintained at both sites and there is a resident middle-grade (SpR). Both vascular and breast surgeons currently staff the emergency general surgery rota at CGH. Vascular surgery is being centralised at CGH site and the vascular surgeons will no longer take part in the general surgery rota. The vast majority of emergency General Surgery is GI related. There is evidence of a variation in surgical approach to the GI emergencies according to the time of day and day of the week. Sustainability of the emergency rota at CGH was discussed.

The rationalisation of General Surgery to one site (GRH) had been discussed but consensus had not been reached There would be some difficulties of practicalities and space. Advantages would include more layers of senior cover, direct admission to a Surgical Assessment Unit and to making available rapid discussion with an on-call surgeon.

2. Paediatric Day Cases

It is clear that the environment for children in the Day Surgical Unit at GRH is not appropriate for child-friendly care and a new facility will have to be created. The changes proposed are felt to optimize the use of this facility, and provide better care for the children and parents of Gloucestershire. The provision of children's services staff and the concentration of surgical and anaesthetic skills is now recognized as a requirement for safe surgery on children. There will be an element of increased travelling and inconvenience for those from the Cheltenham catchment area.

3. Gastroenterology, Cardiology and Respiratory Medicine

In discussion, the proposals for these specialties were deemed to be less controversial and should be facilitative to the Emergency Care changes. For example, concentrating the more complex patients to the CGH site will help relieve potential increases in bed pressures at GRH. The move to a GI physician of the week at CGH would allow for the daily morning senior rounds that can

contribute greatly to reducing lengths of stay. The expansion of Hartpury Unit should result in more rapid transfer of patients requiring cardiac intervention presently waiting in Acute Medicine and other areas.

Conclusions and Recommendations

1. Emergency and Urgent Care

It is clear that the present arrangements for Emergency Care are unsustainable. The service is already under threat of withdrawal of junior staff.
If no action is taken it is likely that the ED at CGH will have to close on a sporadic unplanned basis. This would cause severe problems across the whole emergency care system with poorer patient experience and possible effect on outcomes. It would make management of the 999 service much more difficult.
We recognise the concerns about possible increased mortality with extra distance for ambulance travel. The main source for this concern is the paper by Nichol et al from the Emergency Medicine Journal in 2007. This paper did note an increase in mortality for severely ill patients travelling long distances of approximately 10 km an extra 1% in mortality for every extra 10km travelled. The authors themselves point out this was only for those patients with severe illness and that there are other limitations to their study.

A practical approach to this information is summarised in “The Way Ahead 2009”, a major policy document from the College of Emergency Medicine:
“Where small/medium EDs are geographically close (within 10km); a more coherent emergency service may be possible by amalgamation. Between 10-20 km the local health communities will have to make a judgement on the balance of risk of having ill patients travel further against the benefits of centralisation”.

In view of the major risks to sustainability of the service, it would seem that the benefits of the change greatly outweigh any risks.

We therefore support the proposal to concentrate ED medical staff at GRH at night and divert 999 ambulances. We would expect the vast majority of patients to notice little change in ED services: and that for a number, clinical care may be improved.

Whilst we were impressed by the amount of collaborative work that has been done and by the commitment of the specialties and CCG in supporting the change, we have a number of issues and recommendations, some of which need to be addressed with some urgency:

Safety and sustainability of the ENP service.

An intensive programme of education is under way to prepare the ENPs. Many of the issues noted below are in progress but given the very tight schedule for change the following issues need to be finalised as soon as possible

1. Training of the ENPs must cover the areas of practice in which some may have less experience of independent practice (minor illness, concussive head injury and the intoxicated patient).

2. Written operational procedures must be agreed with the preferred out of hours provider for referral to out of hours primary care. The provision of out of hours care is currently out to tender by the CCG. It would make great clinical sense to co-locate night primary care near the ED to facilitate care of patients with minor illness (currently co-located up to 23:00).

3. Written operational procedures must be agreed for referral to inpatient services at CGH and for transfer to GRH.

4. There will need to be a sufficient number of ENPs undertaking night work to ensure a sustainable service with contingency to cover unexpected absence.

Patient safety at the 20:00 watershed.

We note the plans to have EM and AM consultant presence up to 20:00. They will try to ensure as many patients as possible are treated and admitted/discharged before 20:00. There will continue to be ED doctors in the department until 22:00 and ED nurses 24/7.

Operational procedures must be developed quickly to ensure smooth handover.

1. Proactive management from EM/AM to minimise patients waiting admission/treatment in the early evening.

2. Proactive bed management to ensure as few patients as possible are waiting for a bed at 20:00 and then speedy admission for those treated after 20:00

The ambulance service.

1. Discussion on the changes with agreement on how patients beginning journeys close to 20:00 will be managed.

2. Discussion on the effects of increased journey time to GRH on response times.

3. Discussion on the provision for transfer from CGH for walk in patients

4. Agreement of protocols for direct admission of patients with defined conditions directly to acute medicine/vascular surgery/ cardiac arrest. This will require agreement by acute medicine, general surgery and anaesthesia regarding the response required to staff the resuscitation room if an unstable patient is being brought by the ambulance service.

The Clinical Commissioning Group

There are major advantages in locating the out of hours service in or near the ED. Patients would not be confused by a multiplicity of different venues. There would be clinical synergy between the skills of the ENPs and primary care staff.

The contract for provision of out of hours services is currently out to tender. The CCG should give careful consideration to any bid that intends to use the existing of out of hours facilities at CGH. There would need to be clear and compelling reasons to move the out of hours base away from its current position next to the ED.

Key steps at GRH

Improved ED staffing should ensure no deterioration in ED waiting time at GRH but possibly the major risk to patient experience and safety is the potential to have longer waiting times for admission to hospital at GRH. While the numbers of extra patients taken to GRH will be small, the current system allows both hospitals to divert ambulances if one site is under pressure. This flexibility for 999 ambulances will be lost in the new system. The provision of senior staff in the ED at GRH may reduce some admissions but access block to hospital beds is an increasing issue for many EDs

Acute Medicine

The centralisation of the acute assessment area, ambulatory care and short stay unit from its present three areas to one is a crucial enabler to the proposed

reconfiguration. We were unclear when this change of estate could be complete. It must be done as rapidly as is feasible.

Patient Flows

Steps must be taken to maximise bed capacity at both sites. Lengths of stay should be the best that is compatible with clinical safety - at least in the top 25% or better of national figures: to benchmark as “average” is really not that good! Changes to medical specialty working and ensuring prompt discharge are essential, as is the increase in in-reach support to the Acute Medical Unit and the Emergency Department. It is to be hoped that the specialty changes proposed (see below) will facilitate patient flows.

Trauma and Orthopaedics

We support the service description as given but recognize the option of managing the very small number of walk-in (or ambulance) patients with lesser trauma such as shoulder dislocation being managed on the CGH site without transfer.

General Surgery

Whilst recognising the practical and logistic difficulties in centralising emergency surgery to one site we have concerns about the sustainability of the emergency general surgery on two sites, the performance of GI emergency operations by surgeons not routinely carrying out GI elective procedures, and by the variability of possible surgical approaches taken.

In the longer term it is highly unlikely that surgeons appointed to a breast service would have any adequate training or elective practice in GI surgery.

We recommend that the present proposal for “no change” be reconsidered.

2. Paediatric Day Cases

<u>We support the proposal to concentrate Children’s Day Case surgery and Medical Investigation in a new build at the GRH site.</u>

The changes seem eminently sensible and should lead to a better experience and greater safety for children needing Day Case surgical procedures or medical Investigations. The freeing up of space on the CGH site may be a significant enabler to other service improvements.

It will be important to consider access and travel for those families who will need to make the increased journeys necessary.

3. Medical Specialties – Gastroenterology, Cardiology and Respiratory Medicine.

We support the proposed changes, namely the concentration of complex patients to CGH, the management of acute GI bleeding and the modification of the Hartpury Unit as described above.

We strongly urge that senior working in these specialties is increasingly focused on supporting medical emergencies and the Acute Medicine Unit.

Finally, it would be useful for NCAT to receive a brief report updating on progress made in implementing the change and our recommendations, by September 1st.

Appendix 1

Documents Received

- Reconfiguration Project Brief version 4
- Reconfiguration 2012-13 NHSG, updated Jan 2013
- Service Change Readiness Framework
    - ED acute care trauma
    - Medical specialties
    - Paediatric day cases
- HCCOSC Presentation Feb 2013
- HCCOSC Minutes and agendas
- NHSG Board Minutes
- CPF draft notes
- Summary of Patient flows
- Reconfiguration pathway monthly report – Feb 2013
- Workforce
    - Options for August Summary
    - Severn Deanery report
- Public Consultation – Your NHS – full engagement document Feb 2013
- Draft Options Appraisal with comments from IST August 2013

Appendix 2

2013/14 Reconfiguration Programme

National Clinical Advisory Team (NCAT) Assurance Review

Wednesday 15th May 2013, 9am to 4.45pm

Boardroom, 1 College Lawn, Cheltenham, Gloucestershire, GL53 7AN

AGENDA

Time	Item	Lead	Required
9.00am	Welcome, introductions & agenda	Dr S Pearson	All
9.10	Purpose of NCAT visit	NCAT	All
9.20	GHFT drivers for change	Dr S Pearson Dr S Elyan	All
10.00	Consultation approach & outcome	B Parish	All
10.30	Break		
10.45	Proposed clinical model	Specialty Directors	SP, MA, EG, MS, TL, MH, VT, SD
12.00pm	Walk the emergency patient pathway at Cheltenham General Hospital	Dr T Llewellyn	SE, MA, TL
12.45	Working lunch – discussion with Gloucestershire CCG lead GPs	Dr H LeRoux Dr G Mennie	HL, GM, SP, SE, TL, MS, SD
1.30	**Clinical discussion group 1;** Emergency Department & Acute Care	NCAT	MS, TL, SM, RB, SP,SL
2.30	**Clinical discussion group 2;** Emergency Department, Acute Care, Trauma, General Surgery & Paediatrics	NCAT	TL, VT, SD, DDW, MW, PT, BT, AMV, SP,SL
3.15	**Clinical discussion group 3;** Emergency Department, Acute Care, Cardiology, Respiratory & Gastroenterology	NCAT	TL, RA, JB, PK, BH, SP,SL
4.00	Break to allow NCAT team to prepare feedback	NCAT	NCAT
4.20	NCAT feedback	NCAT	All
4.45pm	Close		

Attendees/ invited:

Attendee	Initials	Role
Dr Sally Pearson	SP	Director of Clinical Strategy & Programme SRO
Dr Sean Elyan	SE	Medical Director
Maggie Arnold	MA	Nursing Director
Eric Gatling	EG	Director of Service Delivery
Dr Mark Silva	MS	Chief of Service, Medicine
Mr Aidan Fowler (apologies)	AF	Chief of Service, Surgery
Becky Parish	BP	Associate Director, Patient and Public Engagement (NHS Gloucestershire Clinical Commissioning Group)
Dr Graham Mennie	GM	GP, Cheltenham Locality (NHS Gloucestershire Clinical Commissioning Group)
Dr Hein LeRoux	HL	GP, Stroud Locality, CCG Governing Body (NHS Gloucestershire Clinical Commissioning Group)
Jill Crook	JC	Director of Nursing Banes, Gloucestershire, Swindon & Wiltshire Area Team NHS England
Simon Lanceley	SL	Programme Manager
Dr Tom Llewellyn	TL	Specialty Director, Unscheduled Care
Eddie Minchew	EM	Lead Nurse, Unscheduled Care
Dr Marcus Hauser (apologies)	MH	Clinical Lead, Acute Care
Sue Milloy	SM	Director, Unscheduled Care
Mr Simon Dwerryhouse	SD	Specialty Director, General Surgery
Mr Vinay Takwale	VT	Specialty Director, Trauma & Orthopaedics
Debbie De Wit	DDW	General Manager
Mr Simon Clint (apologies)	SC	Trauma Network Lead
Dr Ananthakrishnan Raghuram	RA	Specialty Director, Respiratory & Renal Medicine
Prof Jonathan Brown	JB	Specialty Director, Cardiology & Gastroenterology
Dr Miles Wagstaff	MW	Consultant Paediatrician
Roger Blake	RB	General Manager, Unscheduled Care
Paula Tambing	PT	General Manager, Paediatrics
Becky Hughes	BH	General Manager, Respiratory & Renal
Phillip Kiely	PK	General Manager, Cardiology
Anne Marie Vicary	AMV	General Manager, Trauma & Orthopaedics
Bernie Turner	BT	General Manager, General Surgery