Gloucestershire Clinical Commissioning Group (CCG)
Governing Body

Minutes of the Extraordinary Meeting held on Thursday 18th July 2013
in the Board Room, Sanger House, Gloucester GL3 4FE

Present:		
Dr Helen Miller	HM	Clinical Chair
Dr Steve Allder	SA	Secondary Care Specialist
Marion Andrews-Evans	MAE	Executive Nurse and Quality Lead
Dr Caroline Bennett	CBe	GP Liaison Lead
Julie Clatworthy	JC	Registered Nurse
Alan Elkin	AE	Lay Member – Patient and Public Engagement
Dr Malcolm Gerald	MGe	GP Liaison Lead
Dr Martin Gibbs	MGi	GP Liaison Lead
Colin Greaves	CG	Lay Member - Governance
Mary Hutton	MH	Accountable Officer
Cath Leech	CL	Chief Finance Officer
Dr Hein Le Roux	HLR	GP Liaison Lead
Dr Andy Seymour	AS	Deputy Clinical Chair
Sarah Scott	SSc	Deputising for the Interim Director of Public Health
Mark Walkingshaw	MW	Deputy Accountable Officer
Dr Jeremy Welch	JW	GP Liaison Lead
Margaret Willcox	MWi	Director of Adult Social Care
In attendance:		
Dr Sally Pearson	SP	Director of Clinical Strategy - GHNHSFT
Dr Tom Llewellyn	TL	Emergency Medicine Consultant - GHNHSFT
Keith Scott	KS	Director of Operations - SWAST
Becky Parish	BP	Associate Director Patient and Public Engagement
Alan Potter	AP	Associate Director Corporate Governance
Fazila Tagari	FT	Board Administrator
There were 10 members of the public present.		

1 Apologies for Absence

Valerie Webb, Dr Will Haynes, Dr Charles Buckley and Rob Rees.

2 Declarations of Interest

2.1 No declarations of interest were received.

3 Introduction from the Clinical Chair

3.1 HM welcomed representatives from Gloucestershire Hospitals NHS Foundation Trust to the meeting: Director of Clinical Strategy, Dr Sally Pearson and Emergency Medicine Consultant, Dr Tom Llewellyn. She also welcomed members of the public who were in attendance.

3.2 HM reminded those present that the meeting of the Governing Body was a meeting in public, rather than a public meeting. Questions from the public had been submitted in advance and using the Chair's discretion, these would be responded to earlier in the agenda.

3.3 HM explained that the aim of the meeting was for Governing Body members to look afresh at the 2013 Your NHS service change proposals and review the implementation plans, taking into account all of the information before them. This included consideration of the outcome of consultation report, the National Clinical Advisory Team report and the recommendations and qualifications of the county's Health and Care Overview and Scrutiny Committee.

3.4 The meeting would also consider the Equality Impact Assessment completed by Gloucestershire Hospitals NHS Foundation Trust as part of the former Strategic Health Authority Gateway Review.

3.5 Governing Body members were then advised that at the end of the discussion they would be asked whether they wished to reaffirm commissioner support for the service changes and endorse the implementation plans subject to review and discussion at the meeting.

3.6 HM indicated that she would ask the Deputy Accountable Officer and Director of Commissioning Implementation, (MW) to introduce the paper.

3.7 Following this, HM indicated that she would invite SP and TL to make any additional points concerning the Foundation Trust's implementation plans before inviting questions from the Governing Body members.

3.8 HM concluded by stating that there would then be a response to the public questions that were submitted in advance before further discussion and moving to consideration of the recommendations.

4 <u>Your NHS – Right Care, Right Time, Right Place 2013 – Maintaining high quality specialist services, Outcome of Consultation and Plans for Implementation.</u>

4.1 MW introduced the report to the Governing Body which summarised the proposed changes and the case for change and provided an update on the outcome of the public consultation on the proposed changes.

4.2 MW noted that members would be aware that these proposals for change represent the third phase of the 'Your NHS changes' - a process which began 3 years ago.

4.3 The proposals for change within this phase were consulted upon between February and May this year and relate to maintaining high quality specialist services for our population. As commissioners, the CCG and its predecessor organisation, NHS Gloucestershire, led the consultation process on these changes.

4.4 The proposed changes are based upon evidence produced by clinicians on how to best organise services for patients – from the beginning the proposals were very much developed by the clinical teams who deliver these services for the population of Gloucestershire.

4.5 MW indicated that the service changes relate to 3 key areas outlined below:

Emergency and urgent medical care - Services at Cheltenham General Hospital at night time (between the hours of 8pm and 8am). The changes allow the bringing together of specialist emergency medicine doctors on the Gloucestershire Royal Hospital site. MW noted that, as well as the clinical case for making this change, there is a real urgency because of the very challenging workforce issues within emergency medicine - including the supply and supervision of junior doctors.

Medical specialties - identifying opportunities to improve the quality of care by bringing together the skills of specialist staff currently split across hospital sites. In particular within Gastroenterology, Hepatology, Cardiology and Respiratory services.

Paediatric day case surgery - in particular the proposals mean that elective day case surgery and medical interventions will be based in a purpose designed Paediatric Day Unit on the Gloucestershire Royal Hospital site.

4.6 MW stated that the key elements of the implementation plan for these changes were set out at section 5.2 of the report. Member's attention was drawn to two key documents, the content of which was summarised in the report and provided in full as appendices.

4.7 Appendix 1 of the report outlined the outcome of consultation report, which as well as setting out how the consultation was undertaken and the responses received, also set out the suggestions received during the consultation and response to these.

4.8 MW highlighted that this report was presented to the Gloucestershire Health and Care Overview and Scrutiny Committee on 4th June 2013. This resulted in that committee supporting all of the service changes, subject to the qualifications set out in section 3.6 of the paper. MW stated that the qualifications were recognised and accepted by both the CCG and GHNHSFT.

4.9 The second key document, which was provided as Appendix 2 was the report from the National Clinical Advisory Team. This team, made up of clinical experts, was asked to provide clinical assurance of the plans. MW noted that the NCAT also supported the proposed changes and in particular emphasised that, in their view, the present arrangements for emergency care were unsustainable because of the workforce issues.

4.10 MW requested the Governing Body to approve the recommendation outlined at Section 6.1 of the report.

4.11 SP and TL were then invited by HM to comment on the implementation plans for these changes.

4.12 SP reaffirmed to Governing Body members that following the outcome from the HCOSC, the Trust have been reviewing the implementation plans to enable the proposed changes.

4.13 SP advised that the deadline had been set by the Severn Deanery to demonstrate more acceptable levels of supervisory controls for junior doctors than the current arrangement. It was noted that comprehensive engagement has been undertaken and continues regarding the implementation plans, including input from the CCG and South West Ambulance Trust (SWAST).

4.14 In response to a question by AE on why these changes needed to be made now, TL advised the timescales were determined by the Severn Deanery by their request to alter the current supervision system of junior staff. It was noted the present system is currently covered by more junior staff. Failure to comply with the Deanery's request could result in withdrawal of these junior posts by the Deanery.

4.15 JC sought assurance that the decision reflected all the issues from the consultation and the HCOSC meeting. BP advised that the outcome of consultation report identifies the key themes from the consultation responses and also includes the suggestions made and response to these suggestions from GHNHSFT and GCCG. Members noted the following examples of actions being taken in response to the suggestions made:

- Increase the operating hours of the shuttle bus between CGH and GRH.
- Consider options for providing free or reduced rate parking permits to volunteer drivers.
- Informing families with young children on what transport options are available.

BP advised that the HCOSC had supported the proposals and noted there will be further formal reviews after 6 and 12 months to ascertain whether expected outcomes are being achieved.

4.16 KS confirmed SWAST are working closely with the GHNHSFT and reviewing the varying travel distances between patient transfers. KS advised that ambulance crews are experienced in diverting patients to other areas and was confident that mechanisms are in place to support these changes.

4.17 CG enquired why temporary specialist emergency staff are not recruited and was advised by TL there is a national shortage of candidates for these posts and that this position is not likely to improve in the short term. Members were advised that recruitment was challenging due to the unsociable working hours and that there was no temporary fix.

4.18 AE requested an example of how specialist expertise in other services has been successfully brought together previously and the benefits that were delivered for the patients. SP responded that GHT has a long history of reconfiguration of services over the last year 20 years. A recent example of reconfiguration included the stroke service changes which was initiated by clinical staff requesting improvements. Following the consultation, the reconfiguration of stroke service resulted in a single stroke unit at GRH. It was noted that national indicator targets were not being achieved prior to reconfiguration, these were now being met.

4.19 HM enquired if there are any issues regarding recruitment to clinical specialities relating to the other service reconfiguration areas, namely Gastroenterology, Cardiology and Respiratory. SP responded that this was a common theme about the availability of specialist staff. The position for other specialist staff was less acute than for emergency care speciality.

4.20 SA requested an update on the headline summary of the NCAT report and its conclusions and was advised that NCAT were supportive of all the proposals and made it clear that the current arrangements for Emergency Care are unsustainable. It was also stated that the report made useful recommendations on which clinicians have reflected in the GHNHSFT implementation plan.

4.21 SSc queried the findings from the Equality Impact Assessment (EIA) and was informed assessment screening was carried out on all the proposals prior to consultation as part of the NHS South West Strategic Health Authority Gateway Process. An EIA was conducted internally by GHNHSFT designed to address the 9 protected characteristics. The EIA had identified people with age and disability to potentially be disproportionately negatively affected by the proposed changes. Plans to address these issues are progressing and mitigating actions are in place.

4.22 In response to a question by AS on the progress of the implementation plan outlined at Section 5.2 of the report, it was noted that the medical and nursing rotas are finalised and the model is based around patient flows. Clinical pathways and protocols have been designed and the only changes relate to the Emergency Medical Practitioner rota. GP admitted patients pathways have been designed in conjunction with SWAST to ensure there are no delays. KS informed members that only 49% of all patients who dial 999 are taken to Emergency Departments with the remainder being recommended to use alternative care pathways. Following telephone triage, 5% are not visited by the ambulance service.

4.23 CG queried the anticipated impact of the changes on mortality rates and noted that the study by Nicholl was an observational study from 1997 to 2001. This paper did note an extra 1% increase in mortality for severely ill patients travelling long distances of approximately 10 km. SP responded that the Nicholl paper does not address the risk of seriously ill patients being taken to a department where there are insufficient senior emergency physicians to provide safe care nor did it reflect changes in performance or new policies that are intended improve care at more distant facilities. It was noted that mortality rates are monitored 12 hours after admittance. Replicating the Nicholl methodology locally would be logistically difficult due to limited measurement and would be highly unlikely to generate results of any statistical significance. Members were advised that stroke morbidity figures have improved since reconfiguration.

4.24 Members were informed of a short delay in the schedule to the completion of the new proposed Paediatric day unit due to estate issues.

4.25 The Governing Body noted the risks of not going ahead with the Emergency and Unscheduled Care Proposal would result in the risk of junior doctors moving to other hospitals outside Gloucestershire.

5 Public Questions

5.1 MH advised the Governing Body that a number of questions had been received in advance from Martin Horwood, the MP for Cheltenham, who was invited to read his questions to the meeting. MH then asked AP to re-read the questions along with the prepared responses as detailed below:

5.2 **Q** **Of the 225 responses to the emergency and urgent medical care consultation questions, how many were from Cheltenham and what was the balance of support for or opposition to the proposals amongst those Cheltenham respondents?**

5.2 **A** Total number of Respondents to Question 5a of the survey regarding the Emergency Department proposal from GL50, GL51, GL52 or GL53 postcode area = 77

Of the 77 responses to Question 5a from the postcode areas above:

Completely agree: 18 (23% of 77)
Partly agree: 18 (23%)
Don't know: 1 (1%)
Not at all: 40 (52%)

5.3 **Q** **What relative weight was given to a) the 225 responses to the formal consultation question on emergency and urgent medical care and b) the 2,400 Cheltenham residents who have so far signed the petition urging a rethink of these proposals?**

5.3 **A** No weighting is used in the Outcome of Consultation Report. The Report is a factual record of the consultation activities undertaken and the responses received.

At the end of the consultation period, and at the time of writing the Report, the CCG had received two petitions. The one referred to above is recorded in the Report as the 'first petition [Petition 1]'. It is entitled:

We the undersigned call on Gloucestershire Hospitals NHS Trust to rethink its proposals to downgrade emergency care at Cheltenham General Hospital.

This petition is recorded as having 1,228 signatories. To date no further petition has been received by GCCG nor GHNHSFT.

5.4 **Q** **Is the board aware that no Health and care overview & scrutiny committee members from Cheltenham supported the permanent downgrade of the emergency department at Cheltenham at their meeting on 4 June 2013 and what consideration has been given to this?**

5.4 **A** An accurate record of the HCOSC meeting of 4 June 2013 is available in the minutes of the HCOSC meeting. Councillors questions and comments are recorded by the relevant councillor's name. These minutes were published by Gloucestershire County Council on their website on Monday 17 June 2013.

5.5 **Q** **What evidence has the board seen that the Hospitals Trust has made real efforts to recruit emergency doctors from abroad, for instance by advertising specific posts abroad over specific periods of time, and will they make this evidence public?**

5.5 **A** Jobs are advertised on NHS Jobs and in the BMJ. These can be accessed on-line internationally.

Evidence that this is effective in attracting interest from abroad comes from the fact that most of the applicants (often over 90%) come from abroad only rarely do they fit the criteria for interview.

Representatives from the Trust have previously travelled to interview abroad and recruited staff with a view to training them into the job. None of the doctors reached the correct standard.

5.6 **Q** **What consideration has the board given to the rejection by the trust of the paying of higher salaries for hard-to-recruit posts and is this a general policy or one restricted to emergency medicine?**

5.6 **A** It has been recognised nationally that there are shortages of doctors entering specialist training for emergency medicine, which means that there are not enough people to fill current training posts nor the need for more consultants.

Higher salaries would not solve that core problem, but simply fuel pay inflation as hospitals try to entice scarce staff away from other hospitals. Very quickly other shortage specialities, such as paediatrics, elderly care medicine and acute medicine, would argue that they require the same higher rates of pay.
The result would be a bad deal for the tax-payer as higher wages would result and the fundamental issue of the unattractiveness of some specialities to current young doctors would remain.

5.7 **Q** **What does the board expect the government or Sir Bruce Keogh to recommend in relation to emergency medical recruitment as a result of his review of urgent and emergency services in England?**

5.7 **A** ‘High Quality Care for All, Now and for Future Generations: Transforming Urgent and Emergency Care Service in England’ was published in June 2013.
The publication has 2 parts the Evidence Base, and The Emerging Principles. In the Evidence Base the section on urgent and emergency care workforce highlights the same issues relating to recruitment and the impact of the EWTD as were set out in our consultation material.
The Emerging principles document does not directly address recruitment but does propose that senior emergency physicians should be present until midnight in all 999 ambulance receiving emergency departments

5.8 **Q** **What analysis of the health inequalities impact of these changes has been made, particularly in relation to the neighbourhoods of Whaddon, St.Peter’s, Springbank and Hester’s Way, has this analysis been carried out by a professional qualified in health inequalities analysis and will this analysis be made public?**

5.8 **A** GHNSFT completed an Equality Impact Assessment ahead of the consultation as required as part of the NHS South West Strategic Health Authority Gateway Process. The EIA template focuses on the 9 protected characteristics as defined in The Equality Act 2010. The completed EIA identified two categories 'age' and 'disability' as potentially affected negatively by the proposed changes to emergency and urgent care services.

EIA Extract:

<u>Please detail which aspect of your project may have a negative impact on patients, carers, visitors or staff:</u>

Redistribution of hospital services to centralise specialist functions in one place has the advantage of improving the quality of service, but impacts on travel times for patients, visitors and staff who previously attended their nearest hospital.

The 'Age' category has been identified as negatively impacted since:
Redistribution of ED & Acute Care will involve a cohort of patients who would historically have been admitted to CGH being admitted to GRH instead, and vice versa in order to manage within the capacity of both hospital sites. This cohort is likely to include a large proportion of old age **patients** who are therefore not admitted to their nearest hospital.

The 'Disability' category has been identified as negatively impacted since travel to and from hospital for admission or as a visitor is hardest for this group, who are therefore disadvantaged more than others by services being reconfigured to a model which centralises specialist services.

<u>Detail how adjustments can be made to your project to eliminate or minimise potential negative impact:</u>

Age & Disability
The issue for both these categories relates to access and travel. This will be addressed as far as possible by:
Emphasising the improved quality of care available
Providing clear and comprehensive instructions on how to reach each hospital including maps, journey times, parking and public transport details
Positive promotion of the '99' bus service between the sites.

In response to the consultation feedback further measures to address transport issues will be introduced e.g. the hours of the 99 Shuttle Bus between CGH and GRH sites will now be extended later into the evening between CGH and GRH.

5.9 **Q** **<u>Are the proposed changes compatible with the Gloucestershire Health & Wellbeing Strategy 2012-2032, Fit for the Future, in relation to its commitment to reducing health inequalities?</u>**

5.9 **A** The Gloucestershire health and social community is committed to reducing health inequalities and the Gloucestershire Health and Wellbeing Strategy and resulting action plan sets out ways in which this will be achieved.

It should be noted that public consultation on the Gloucestershire Health and Wellbeing Strategy in the Winter of 2012 was carried out at the same time as consultation on the partner Gloucestershire 5 year strategy for care: Your Health, Your Care (YHYC). The document highlighted plans to maintain high quality, specialist hospital services. It stated:

"We think the most important things to consider are the medical benefits for the patient and patient safety. We also need to ensure that the right number of specialist staff are available 24 hours a day, 7 days a week."

"As an example, Cheltenham General Hospital and Gloucestershire Royal Hospital will continue to play a key role in providing important services to local people, but we think that the distribution of some services between these two sites may need to change in the future.

5.10 **Q** **What analysis has been made of the health impact on the neighbourhoods of Charlton Kings, Whaddon, St.Peter's, Springbank and Hester's Way which are all identified as 'hot' in terms of emergency admissions risk on MAIDeN, and will this analysis be made public?**

5.10 **A** No analysis has been made of the health impact on the specific neighbourhoods described above as part of these service change proposals. These proposals, developed for quality and clinical safety reasons, relate to all neighbourhoods across the county and we refer you back to the answer concerning the equality impact assessment carried out across the whole population.

Subject to the service change going ahead, we will be drawing up the assessment criteria for the 6 month and 12 month reviews of this service change. It is anticipated that these will include information regarding patients' place of residence which will enable us to monitor the impact on all neighbourhoods.

5.11 **Q** **What is the total number of deaths for the most recent year for which data is available equivalent to the percentage of 6.2% deaths identified in the study by Nicholl and others in the Emergency Medicine Journal (Emerg Med J. 2007 September; 24(9): 665–668), and does the board expect the proposed changes to increase this number as suggested by the study, and if so by how much?**

5.11 **A** Although this study showed an association between distance to hospital and increased risk of mortality the authors identified a number of limitations of the study. Firstly, this is an observational study and inferring causality from the observed associations is fraught with difficulties, primarily as the findings could be attributed to confounding factors that were not controlled for in the study.

Secondly, the study deliberately selected ambulance calls that suggested patients might have life threatening conditions and a high risk of mortality. They advised that their findings should not be applied to the vast majority of patients transported to hospital by ambulance.

Thirdly, the results reflect an association between outcome and distance within the emergency care system as it performed in 1997 to 2001. Changes in performance or new policies that improve care at more distant facilities or improve the effectiveness of pre hospital care could attenuate the potential effect.

This paper does not address the risk of seriously ill patients being taken to a department where there are insufficient senior emergency physicians to provide safe care. Such a study would be unethical.

The relevance of this paper was specifically addressed in the National Clinical Advisory Team Report (page 12).

We recognise the concerns about possible increased mortality with extra distance for ambulance travel. The main source for this concern is the paper by Nicholl et al from the Emergency Medicine Journal in 2007. This paper did note an increase in mortality for every extra 10km travelled. The authors themselves point out that this was only for patients with severe illness and that there are other limitations to their study.

A practical approach to this information was summarized 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 10-20km the local health communities will have to make a judgment on the balance of risk of having ill patients travel further against the benefits of centralisation.

In the conclusions and recommendations section of the National Clinical Advisory Team’s clinical assurance review of Gloucestershire’s emergency and urgent care proposals, it states: “In view of the major risks to the sustainability of the service it would seem that the benefits of the change greatly outweigh the risks”

5.12 **Q** **What comparative analysis has been carried out of the increased mortality risk from the proposed increase in distance travelled suggested by the Nicholl study and any reduced risk of mortality from the proposed centralisation of night-time blue light admissions, has this analysis been carried out by a professional qualified in such analysis, and will the analysis be made public?**

5.12 **A** See answer above.

5.13 **Q** **Has any particular analysis be carried out of the increased risk to people in the following categories from the proposed increase in travel distance: a) appendicitis b) perforated duodenal ulcers c) acute peritonitis d) sub-arachnoid haemorrhages e) asthma and will the impact of the changes on these groups be monitored in terms of mortality or other statistics?**

5.13 **A** No particular analysis for these groups has been carried out. As requested by the H&COSC we will be monitoring mortality, but demonstrating a causal relationship will be difficult.

In terms of the conditions described above each individual would be considered on a case by case basis and it should not be assumed that all such patients would require ambulance transfer to the ED department at Gloucestershire Royal Hospital at night time.

5.14 **Q** **On whose authority did the accountable officer of the CCG sign a joint letter with the chief executive of the Hospitals Trust on 4 June 2013 announcing that the changes would now be implemented and had the board considered the outcome of the consultation exercise at this time?**

5.14 **A** The letter was approved by the CCG Accountable Officer and the Chief Executive of the Hospitals Trust as an update to stakeholders following the meeting of the H&COSC on 4 June. It referred to The Hospitals Trust working to introduce the changes this year and states that 'It is intended that the proposal for emergency care will be introduced in August 2013…'

The draft Outcome of Consultation Report was presented in closed session of the CCG Governing Body on 30 May 2013. The final report was also submitted to GHNHSFT Board on 28 June 2013.

The final report will be presented to the GCCG Governing Body at a meeting on 18 July 2013.

5.15 **Q** **What does the board expect to be the configuration of emergency and urgent medical care in Gloucestershire in a) 2015 and b) 2020?**

5.15 **A** It is not possible to predict this. As with all our services we will continue to monitor the ability of our services to deliver the expected standards and outcomes, particularly as the demands for our services change. If we believe that any further significant changes are required these will be subject to a further consultation process.

There are no plans for further changes to the emergency department in Cheltenham at this time.

5.16 **Q** **What are the objections to making these changes temporary and reviewing them after one year?**

5.16 **A** There are no objections to reviewing the impact of these changes at 6 months and 12 months as required by the H&COSC. The challenge to the proposal to make the changes temporary is that the drivers for the proposals, the lack of medical staffing, will not have changed over this period. The lead in time to improve the supply of ED consultants was set out in the consultation material.

Cheltenham Chamber of Commerce Comments

5.17 MH advised the Governing Body that comments had also been received from Mr Michael Ratcliffe, Chief Executive of the Cheltenham Chamber of Commerce. Mr Ratcliffe was invited to read out the four comments which were as follows:

5.18 Cheltenham has a most vibrant social and cultural night-life. There is an important need for prompt A&E treatment in Cheltenham both before 8pm and equally after 8pm.

5.19 Cheltenham's Festivals continue to grow year by year bringing substantial numbers of overnight visitors to the town. Again prompt A&E attention is regularly required and will increasingly be so as the Festivals grow.

5.20 A residential development for North West Cheltenham, circa 4,500 homes is now being proposed. This will be the first phase of potentially 30,000+ homes to be built in this part of the county. Full A&E facilities on a 24 hour basis are absolutely essential.

5.21 The Chamber feels most strongly that the down-grading of the A&E Department sends a most inappropriate message to new businesses wishing to re-locate to the town.

5.22 Mr Ratcliffe also stated that if the Board knew the pressure was on from December 2012, does the Board feel that it has done sufficient to ensure recruitment has been as effective as it needs to be in light of the MP's comments.

Governing Body Comments and Questions

5.23 AE queried the proportion of emergency cases dealt with at CGH Emergency Department during the day and night and the impact for patients being transferred elsewhere. SP advised that the consultation document quantified an average of 16 patients overnight who would be affected by the changes.

5.24 AE noted that areas of deprivation were distributed throughout the County not only in Cheltenham. Gloucester City and the Forest of Dean were noted to have particular areas of deprivation. It was noted that planning associated with the whole urgent and emergency services in the County was looking at deprivation across the area.

5.25 The Governing Body was advised that a letter had been received by HM from Councillor Steve Jordan of Cheltenham Borough Council on the 17th July 2013. HM read the letter to the meeting as follows:

Dear Helen

I write to express the concerns of Cheltenham Borough Council about the proposed changes to the accident and emergency services at Cheltenham General Hospital.

At the Council meeting on 24th June the following motion was debated and agreed by 28 votes to 1 with 5 abstentions:-

This Council is dismayed at the decision taken by the NHS community in Gloucestershire to permanently divert ambulances overnight between 8pm and 8am from Cheltenham General Hospital to Gloucestershire Royal Hospital.

We are particularly concerned about the potential for increased mortality rates of patients being taken further across the county for emergency care, alongside the impact on waiting times at Gloucestershire Royal Hospital and on ambulance response times. We are also concerned that measures to mitigate access issues for Cheltenham patients being discharged from Gloucester remain uncertain.

In the light of the national review of urgent and emergency care, published on 17th June, this Council agrees to write formally to the Board of the Gloucestershire Clinical Commissioning Group to ask that the decision to downgrade Cheltenham A&E should only be temporary to:

a) allow more time for local and national workforce issues to be addressed and

b) allow the impact of the downgrading to be properly understood by the health community and the County's Health, Community and Care Overview and Scrutiny Committee.

While understanding the difficulties you face locally, a particular concern relates to the proposal to make permanent changes in Cheltenham before the impact of efforts to address concerns about increased workload and lack of recruitment to key posts in A&E are addressed nationally.

I have also attached a copy of the draft minutes of the meeting on 24th June.

5.26 MGi asked whether there was a process which was set out for service reconfigurations of this nature. It was explained that the service change proposals had been discussed with the predecessor commissioning organisation, NHS Gloucestershire, and approved by them for consultation. The proposed changes had also been discussed at GHNHSFT and with the NHS Reference Group and HCOSC which, following the outcome of consultation, had supported all of the service change proposals with qualifications (as previously mentioned). There were no further questions regarding the process.

5.27 The Governing Body confirmed that a letter from Harrison Clark Rickerbys Solicitors, acting on behalf of the Cheltenham Chamber of Commerce, has been received and had been circulated to members.

5.28 MGe noted that there is no indication there is going to be any improvements in recruitment in the short term. The length of time it takes to train specialists, this position is unlikely to change before 2020.

5.29 **RESOLUTION:**

The Governing Body noted and:

- Considered the outcome of the 'Your NHS – Maintaining High Quality Specialist Services' consultation.
- Reaffirmed commissioner support for the service changes following publication and consideration of the outcome of consultation report, the National Clinical Advisory Team (NCAT) report and scrutiny by the County's Health & Care Overview and Scrutiny Committee.
- Endorsed Gloucestershire Hospitals NHS Foundation Trust's implementation plans for the 2013 Your NHS service changes.

6 The meeting closed at 15:37.

7 Date & Time of next meeting: Thursday 25th July 2013 at 2pm in the Board Room at Sanger House.

Minutes Approved by Gloucestershire Clinical Commissioning Group Governing Body:

Signed (Chair):_____ Date:_____