NHS
Gloucestershire
Clinical Commissioning Group

Governing Body

Extraordinary Meeting to be held at 2pm on Thursday 18th July 2013
Board Room, Sanger House, Brockworth, Gloucester, GL3 4FE

No.	Item	Lead	Recommendation
1	Apologies for Absence	Chair	
2	Declarations of Interest	Chair	
3	Your NHS – Right Care, Right Time, Right Place 2013 - Maintaining high quality, specialist services. Outcome of Consultation and Plans for Implementation.	Mark Walkingshaw	Approval
4	Public Questions	Chair	
Date and time of next meeting: Thursday 25th July 2013 at 2pm in Board Room at Sanger House			

Questions should be sent in advance to the Associate Director of Corporate Governance: alan.potter1@nhs.net by 12 noon on Monday 15th July 2013. Questions must relate to items on the agenda.

Please note: there is very limited parking available at Sanger House and all spaces must be booked in advance. If parking is required by members of the public, please e-mail Alan Potter (as above) to establish if there are any visitor spaces available.

NHS
Gloucestershire
Clinical Commissioning Group

Agenda Item 3

Governing Body

Governing Body Meeting Date	18th July 2013
Title	Your NHS – Right Care, Right Time, Right Place 2013 - Maintaining high quality, specialist services. Outcome of Consultation and Plans for Implementation.
Executive Summary	The report: - Summarises the proposed changes and the case for change. - Outlines the outcome of the public consultation on proposals for change in; • Emergency and urgent medical care. • Medical specialties (Gastroenterology, Cardiology and Respiratory Medicine). • Paediatric day cases. - Summarises key points from the report of the National Clinical Advisory Team (NCAT). - Summarises implementation plans prepared by Gloucestershire Hospitals NHS Foundation Trust (GHNHSFT).
Key Issues	**Consultation** Consultation proposals prepared and presented by GHNHSFT clinical leaders. Proposals approved for engagement by NHS South, Strategic Health Authority and local NHS commissioners. Three month public consultation undertaken, consultation activity led by local NHS commissioners. Outcome of Consultation Report prepared and discussed by Gloucestershire Health and Care Overview and Scrutiny Committee (HCOSC); all proposals supported by

	HCOSC with qualifications relating to the emergency and urgent care service change proposal. **National Clinical Advisory Team (NCAT) Report** NCAT visit May 2013. NCAT report received June 2013. NCAT support all service change proposals, making recommendations to support implementation. With regards to the Urgent and Emergency Care proposal, consideration of possible increased mortality with extra distance for ambulance travel, NCAT conclude that benefits outweigh the risks. **Implementation** There is a complex programme of implementation required by GHNHSFT ahead of any changes. Preparatory work has been undertaken by a Reconfiguration Programme Board involving GHNHSFT managers, clinicians and local commissioners. This work is being led by Dr Sally Pearson, Director of Clinical Strategy, supported by a full time project manager. One of the drivers for change, a requirement to introduce more appropriate rotas to support training, comes into effect from 1st August 2013.
Risk Issues	Key risks relate to quality of implementation against which an implementation plan has been developed (supported by a full time project manager). With regards to the Urgent and Emergency Care proposal, the greater risk would be not reconfiguring the departments, given the significant quality implications of not bringing together specialist emergency medicine doctors out of hours.
Financial Impact	An initial financial impact assessment carried out by Gloucestershire Hospitals NHS Foundation Trust (GHNHSFT) has highlighted potential capital and revenue cost pressures. These are

	being refined in the current phase of planning.
Legal Issues (including NHS Constitution)	Public consultation activity carried out as required by Section 14Z2, Health and Social Care Act 2012. CCGs have a duty to make arrangements to involve patients and the public at various specified stages, of the commissioning process, including in decisions affecting the operation of commissioning arrangements *"where implementation would have an impact on the manner in which services are delivered or the range of services available".*
Impact on Health Inequalities	An Equality Impact Assessment screening was carried out on all the proposals, prior to consultation. The outcome of the public consultation will be used to inform implementation planning.
Impact on Equality and Diversity	An Equality Impact Assessment screening was carried out on all the proposals, prior to consultation. The outcome of the public consultation will be used to inform implementation planning.
Impact on Sustainable Development	No impact identified.
Patient and Public Involvement	Three month public consultation undertaken 1 February – 3 May 2013. Outcome of Consultation Report published and discussed with Gloucestershire County Council Health and Care Overview and Scrutiny Committee (HCOSC) on 4 June 2013. Outcome of Consultation Report available at Appendix 1.
Recommendation	The Governing Body is asked to: • Consider the outcome of the 'Your NHS – Maintaining High Quality Specialist Services' consultation. • Reaffirm 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. • Endorse Gloucestershire Hospitals NHS Foundation Trust's implementation plans for the 2013 Your NHS service changes.
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Sponsoring Director (if not author)	Mark Walkingshaw Deputy Accountable Officer/Director of Commissioning Implementation NHS Gloucestershire Clinical Commissioning Group

Governing Body

18 July 2013

Your NHS – Right Care, Right Time, Right Place 2013 Maintaining high quality, specialist services Outcome of Consultation and Plans for Implementation

1 Introduction

1.1 This report provides an update to the NHS Gloucestershire Clinical Commissioning Group (GCCG) Governing Body on:

- The outcome of the public consultation on proposals for change in:

  Emergency and urgent medical care.
  Medical specialties (Gastroenterology, Cardiology and Respiratory Medicine).
  Paediatric day cases.

- Summarises key points from the report of the National Clinical Advisory Team (NCAT).

- Gloucestershire Hospitals NHS Foundation Trust's (GHNHSFT) plans for implementation of changes to services at Cheltenham General (CGH) and Gloucestershire Royal (GRH) Hospitals.

2. Your NHS – Consultation, Proposals and Case for Change

2.1 Engagement and consultation with the public, under the banner of 'Your NHS' has been undertaken in Gloucestershire since 2010. These service change proposals are the third phase of 'Your NHS' engagement and consultation.

2.2 **Phase 1**: Your NHS: Maintaining Quality Improving Efficiency, took place in the winter of 2010 and communicated a vision of health care for the future.

Phase 2: Your NHS: Right Care: Right Time: Right Place, conducted during the summer of 2011, presented specific proposals for stroke care, first outpatient appointment for symptomatic breast care, major trauma and emergency paediatric assessment.

Phase 3: Your NHS: Maintaining High Quality Specialist Services. Three month public consultation took place during February through to early May 2013. The proposals and brief case for change are summarised below:

2.2.1 Emergency and urgent medical care

The proposed change relates to 999 ambulances at night (8pm-8am) attending GRH only from 1 August 2013. There is no change to walk-in 'minors' or GP-reviewed admissions at either CGH or GRH.

The key reasons for proposing this change is the significant challenge in securing sufficient specialist medical staff to cover two Emergency Departments. As has been recognised nationally, "the speciality of emergency medicine is currently facing critical workforce shortages in many areas in England. This problem is sufficient to potentially threaten the reliable delivery of urgent and emergency services" (College of Emergency Medicine Taskforce 2012).

These workforce issues are acute in Gloucestershire – it is nationally recommended that there should be ten Emergency Medicine Consultants per site to ensure safe care. Currently, due to difficulty recruiting, there are only eleven consultants working across both Gloucester and Cheltenham Emergency Departments.

In addition, there is a shortage nationally and locally of middle grade doctors. Again, the national recommendation is for eight middle grade doctors per site. However, again due to difficulty recruiting, there are only seven point five across the two sites in Gloucestershire. Due to this shortage, there is an increasing need for more junior staff to fill the gaps in rotas, which is unacceptable in terms of patient safety and in terms of the Severn Deanery's expectations of junior doctor training.

The Severn Deanery have required GHNHSFT to address this issue by the 1st August 2013 or risk the reallocation of existing junior doctor posts to other departments.

By bringing specialist emergency medical staff together at night time, there are a number of benefits:

- Early senior assessment and decision making, which will benefit the sickest patients.
- More robust senior medical cover, round the clock.

2.2.2. Medical specialties – Gastroenterology & Hepatology, Cardiology and Respiratory (or thoracic medicine)

The proposed changes are that:

- Gastroenterology and Hepatology concentrate the majority of beds for planned (non-urgent) inpatient care at CGH, whilst keeping a service for patients with bleeding from the gut and other critical conditions at GRH.
- Cardiology improve the county's Cardiac Intervention Unit at CGH by providing more space in the Hartpury Suite.
- Respiratory concentrate the service for the majority of long-term conditions at CGH. A number of beds would be retained at GRH for patients with emergency respiratory conditions.

The case for these services changing has been developed by the clinical teams providing these services identifying opportunities to improve the quality of care by bringing together specialist staff skills currently split across sites.

The Gastroenterology proposal will free up beds at GRH for increased emergency medicine and trauma cases and retain the key parts of the gastroenterology service required on site for those emergencies. Concentrating the majority of beds at CGH will support the bringing together of specialist expertise.

The Cardiology proposal will provide more recovery beds, which will reduce delays for patients needing these complex

procedures. It will also improve patient experience through ensuring that the extended Hartpury Suite has separate male and female facilities.

The Respiratory proposal will enable a functional redistribution of the beds between the two sites and support the bringing together of specialist expertise for the care of patients.

2.2.3. **Paediatric day cases**

The proposal is that all elective (non-urgent) day case surgery (excluding ophthalmology) and medical interventions will be based in a purpose designed Paediatric Day Unit at GRH.

The case for change for these changes focuses on a number of factors around improving the quality of care:

- There is a shortage of specialist doctors and nurses to care for children; by bringing together the day-case services, a sustainable model for the future can be established.
- The Care Quality Commission's review of Children's Services indicated that the Trust has a red rating against two standards focussed on surgeons and anaesthetists carrying out a small number of procedures per year. The more frequently a clinician carries out a procedure, the better the outcome for a patient.
- Currently children treated in the day surgery unit at GRH are treated in a separate bay but still close to adults. The proposed new paediatric unit at GRH would be staffed only by children's doctors, nurses and play specialists in a child and family friendly environment, totally separate from adult facilities.

2.3. These proposals for change were presented to the NHS Gloucestershire Primary Care Trust Board on 30 January 2013. The Board *"agreed the recommendation to approve the proposals outlined for service change at GHNHSFT for public engagement."*

2.4 The local NHS commissioning organisation[1] led the public consultation on these proposals. The consultation ran from 1 February 2013 to 3 May 2013, a period of just over three months to accommodate Bank Holidays.

3. Outcome of the Consultation

3.1 The Outcome of Consultation Report can be found at Appendix 1. This report can also be found on the GCCG website.http://www.gloucestershireccg.nhs.uk/wp-content/uploads/2012/03/Your-NHS-2013-Outcome-of-Consultation-Report-FINAL.pdf

3.2 The first part of the Outcome of Consultation Report includes information about the background to the consultation, consultation activities undertaken - both public and staff, communications activities undertaken, numbers of public and staff contacts, demographic information about those completing the consultation survey questionnaire and details of two petitions received. The second part of the Outcome of Consultation Report sets out the themes from feedback received, providing responses to that feedback and recording the impact of the consultation and subsequent actions identified.

3.3 The NHS Gloucestershire CCG Governing Body meeting received an update on the Outcome of Consultation during the closed session of its meeting on 30 May 2013.

3.4 The Outcome of Consultation Report was presented to the Gloucestershire Health and Care Overview and Scrutiny Committee at its meeting on 4 June 2013. Representation from NHS Gloucestershire Clinical Commissioning Group included the Accountable Officer, the Deputy Clinical Chair and the Associate Director of Patient and Public Engagement. GHNHSFT were represented at this meeting by the Chair, Chief Executive, Director of Clinical Strategy, Dr Tom

[1] During the period of the public consultation NHS Gloucestershire Primary Care Trust was succeeded on 1 April 2013 by NHS Gloucestershire Clinical Commissioning Group as the commissioner for Gloucestershire for secondary care services provided by Gloucestershire Hospitals NHS Foundation Trust

Llewellyn and Dr Markus Hauser.

3.5 There was considerable discussion amongst members of the Committee, particularly in relation to the emergency and urgent care proposals.

3.6 The recommendation from the Committee to GHNHSFT and GCCG was that:

The Health and Care Overview and Scrutiny Committee agreed to support all the service changes but with qualifications relating to the emergency and urgent care service change proposal. The qualifications were:

- *that performance information must be provided to the Committee on a monthly basis (including ambulance handover times, patient numbers etc);*
- *that there are formal reviews after 6 and 12 months to ascertain whether expected outcomes are being achieved;*
- *that the reviews included looking at mortality figures;*
- *that the outcome of these reviews to be received at a committee meeting(s).*

Both GCCG and GHNHSFT recognise these qualifications and will report back to HCOSC on this basis.

3.7 GHNHSFT Trust Board received an update report at its meeting at the end of June 2013. The Board discussed the outcome of the public consultation and the recently received National Clinical Advisory Team (NCAT) report.

4. Summary of National Clinical Advisory Team (NCAT) Report

4.1 On 15 May 2013, representatives from the National Clinical Advisory Team (NCAT) visited GHNHSFT. NCAT provides a pool of clinical experts to support, advise and guide the NHS on local service reconfiguration proposals to ensure safe effective and accessible services for patients. Gloucestershire Clinical Commissioning Group and GHNHSFT jointly commissioned the review, to provide external clinical assurance of the proposals. Their final report

was received on 10 June 2013 (Appendix 2).

4.2 The majority of the report focusses on the proposal relating to emergency and urgent care. The NCAT report makes it clear that in their view: *"the present arrangements for Emergency Care are unsustainable".* In particular the NCAT report recognises the concerns regarding possible increased mortality with extra distance for ambulance travel, concluding on page 12 of the NCAT report that the: *"benefits of the change greatly outweigh any risks".*

4.3 In conclusion the NCAT report supports all of the Your NHS Phase 3 proposals and makes useful recommendations, which are reflected in the GHNHSFT implementation plan.

4.4 NCAT have requested a brief report updating on progress made by 1 September 2013.

5 Summary of Implementation Plans

5.1 Following the support from the Health and Care Overview and Scrutiny Committee, the clinical teams within GHNHSFT have been developing the implementation plan for these proposals. The priority is to ensure that the revised emergency care pathway is in place by 1 August to meet the requirements of the Severn Deanery to amend the working practices and levels of supervision for doctors in training in the emergency department.

5.2 Key elements of the implementation plan are set out below:

Emergency and Urgent Care Pathway

- Finalisation of medical and nursing rotas for ED staff to support the revised pathway through the emergency departments at both GRH and CGH. This includes formalising the emergency nurse practitioner rota at CGH.
- Finalisation of clinical pathways for all specialities between 8pm and 8am.
- Agreement on joint protocols with South West Ambulance Service.
- Creation of an Acute Assessment Area at CGH.

This will require some estates work and the relocation of some wards on the CGH site.

- Finalisation of medical and nursing rotas for acute medicine staff to support the revised pathway for GP reviewed admissions at CGH.

Medical Specialities

- Allocation of additional beds for Gastroenterology at CGH.
- Finalisation of clinical pathways for Gastroenterology.
- Finalisation of medical and nursing rotas for Gastroenterology staff to support the revised pathway across the county.
- Finalisation of clinical pathways for Respiratory Medicine.
- Creation of additional recovery beds for cardiology interventions at CGH (this cannot happen until paediatric day case changes are implemented).

Paediatric Day-cases

- Completion of the Paediatric Day Unit at GRH.
- Transfer of paediatric day case activity from CGH to GRH.

General

- An internal and external Communication Plan.
- Creation of business case to support any capital or revenue allocations required to support the implementation.
- Clarification of any contractual changes with commissioners.
- Maintaining a risk register for the implementation
- Establishing monitoring approach to support reporting to Board, commissioners and HCOSC.

5.3 A full time project manager has been appointed by GHNHSFT to oversee delivery of this project and a monthly Reconfiguration Programme Board, with representation from Gloucestershire CCG, continues to monitor progress against the implementation plan.

6. Recommendation(s)

6.1 The Governing Body is asked to:

- Consider the outcome of the 'Your NHS – Maintaining High Quality Specialist Services' consultation.

- Reaffirm 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.

- Endorse Gloucestershire Hospitals NHS Foundation Trust's implementation plans for the 2013 Your NHS service changes.

7. Appendices

- Appendix 1: Outcome of Consultation Report

Your NHS 2013
Outcome of Consulta

- Appendix 2: National Clinical Advisory Team (NCAT) Report

NCAT Report -
Gloucestershire Hospi

Gloucestershire NHS
Health Community

Your NHS **Right Care, Right Time, Right Place**

2013

Outcome of Consultation Report

Proposals for change

Maintaining high quality, specialist services

Contents

This report, and other information about the consultation, is available on line at the **NHS Gloucestershire Clinical Commissioning Group** website, **Feedback** page under **Closed engagement or consultations** http://www.gloucestershireccg.nhs.uk/?page_id=15

For copies of this report in other formats please contact:
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1. Introduction

Your NHS – Right Care, Right Time, Right Place 2013 Maintaining high quality, specialist services

The need for change

The NHS in Gloucestershire is working together to develop innovative plans to address the challenges facing the NHS locally.

In the early part of 2013, the Gloucestershire Health Community presented for public consultation three new service change proposals:

- Emergency and urgent medical care
- Medical specialties – Gastroenterology & Hepatology, Cardiology and Respiratory (or thoracic medicine)
- Paediatric day cases.

Each of the proposals was developed by clinicians working within the services.

Public consultation about these service change proposals began on 1 February 2013 and concluded on 3 May 2013.

This Outcome of Consultation Report presents the background to the 'Your NHS' proposals, describes the consultation methodology used, summarises the public response and sets out the Gloucestershire Health Community response to the feedback received.

Impact of consultation

The primary aim of the consultation was to enable as many individuals and groups as wanted, easy access to information about the service change proposals and the opportunity to comment upon them and ask questions to inform their response.

Most frequently asked questions are highlighted in this Report and responses are provided alongside. In addition to specific questions, all comments, and suggestions, received have been considered by the Gloucestershire Health Community and actions in response have been identified.

This report identifies the key themes from the feedback as being access to information, access to services (ranging from access to specialist doctors to availability of public transport) and impact on the ambulance service. No alternatives to the proposals, which addressed the issues set out in the consultation, were received. However, respondents identified several areas where action could be taken to mitigate the impact of the proposed changes.

The following actions have been identified:

- Continue to work with South West Ambulance Service NHS Trust (SWAST) to ensure no significant impact on their response times
- Ensure access to more information on transport options
- Information to the public on distribution of services between CGH and GRH and how to access services
- Progress with planning for implementation
- Progress with monitoring arrangements

2. Background to 'Your NHS'

Engagement and consultation with the public, under the banner of 'Your NHS', has been undertaken in Gloucestershire since 2010. To provide context for the current proposals for change, in this section of the report the background to 'Your NHS' is set out. The current service change proposals are the third phase of 'Your NHS' engagement and consultation.

Phase 1: 'Your NHS: Maintaining Quality, Improving Efficiency' (2010)

Phase 1 of the 'Your NHS: Maintaining Quality, Improving Efficiency' engagement programme took place during the Autumn and Winter of 2010. It communicated a future vision for development of local health services.

Feedback received showed public support for:

- the continued development of community based services – reducing the number of patients having to go into the large hospitals when this is right for the patient and reducing the length of hospital stays where appropriate;
- continuing the work which had already been done to improve the quality and accessibility of community mental health services e.g. promoting self help, increasing access to psychological therapy and providing community based treatment;
- only funding procedures (treatments) and drugs where there is strong evidence of clinical benefits to the patient; and
- looking at how some specialist hospital services are provided in the future in Gloucestershire to ensure safe, quality services. Providing follow-up care and support as locally as possible.

Phase 2: ‘Your NHS: Right Care, Right Time, Right Place’ (2011)

Following the completion of Phase 1, the NHS in Gloucestershire prepared for Phase 2 of communication and engagement activity, which involved setting out four specific proposals for change and seeking feedback from local residents, community partners and staff. The proposals for service development presented during the Phase 2 engagement period were consistent with the feedback received during Phase 1.

Phase 2 Proposals for change (2011)

Specific proposals for change relating to four services were presented during Phase 2 during the summer of 2011 under the title: 'Your NHS: Right Care, Right Time, Right Place':

- Stroke Care
- First outpatient breast care appointment for symptomatic patients
- Care for People with Major Trauma
- Emergency Paediatric Assessment

Following a three month period of comprehensive public and staff engagement, all four service change proposals were supported unanimously by the Health, Community and Care Overview and Scrutiny Committee (HCCOSC), who felt that the *"proposals demonstrated benefits and logic".*

Update on Phase 2 (2011) proposals for change

The following service changes have since been successfully implemented:

- Paediatric (child) emergency assessments to GRH 2011
- Major Trauma (multiple, very serious injuries) to Bristol (Trauma Centre) and GRH (Trauma Unit) 2012
- Stroke and Transient Ischemic Attack (mini strokes) to GRH 2012
- First outpatient Breast Care appointments for symptomatic patients, Thirlestaine Court, CGH 2012

3. Phase 3: Your NHS: Right Care, Right Time, Right Place 2013 Proposals for change: Maintaining high quality, specialist services.

The following sections of this Outcome of Engagement Report relate to Phase 3: ***Your NHS: Right Care, Right Time, Right Place 2013 Proposals for change: Maintaining high quality, specialist services.***

Phase 3 has involved three month public consultation relating to three service change areas:

- **Emergency and urgent medical care**
  - No change to walk-in 'minors' or GP-reviewed admissions at either CGH or GRH. The proposed change relates to 999 ambulances at night (8pm-8am) attending GRH only from 1 August 2013.

- **Medical specialties – Gastroenterology & Hepatology, Cardiology and Respiratory (or thoracic medicine)**
  - The gastroenterology and hepatology proposal is to concentrate the majority of beds for planned (non-urgent) inpatient care at CGH, whilst keeping a service for patients with bleeding from the gut and other critical conditions at GRH.
  - The cardiology proposal is to improve the county's cardiac intervention unit at CGH by providing more space in the Hartpury Suite.
  - The respiratory proposal is to concentrate the service for the majority of long term conditions at CGH. A number of beds would be retained at GRH for patients with emergency respiratory conditions.

- **Paediatric day cases**
  - The proposal is that all elective (non-urgent) day case surgery (excl. ophthalmology) and medical interventions be based in a purpose designed paediatric day unit at GRH.

Development of the Phase 3 service change proposals

Each of the proposals was developed by clinicians working within the services supported by managers. Development work commenced during summer 2012, with the start of public consultation on 1 February 2013.

Table 1: Pre-Consultation activity

Date	Activity	Notes
June - October 2012	• Specialty work-stream meetings and workshops	• Proposals developed
October – November 2012	• Gloucestershire Hospitals NHS	• Proposals discussed

	Foundation Trust (GHNHSFT) Main Board • Clinical Priorities Forum[1]	
December 2012	• Shadow Clinical Commissioning Group (CCG) & NHS Gloucestershire (NHSG) Executives • Cheltenham GP locality group • NHS Reference Group (HCCOSC and Local Involvement Network (LINk) representatives) [2]	• Proposals discussed • GHNHSFT clinicians discussed proposals with Cheltenham GPs • Advance presentation of change proposals and plans for communication and engagement. Plans endorsed by the NHS Reference Group.
January 2013	• Strategic Health Authority (SHA) NHS Gateway Review process assurance • Shadow CCG approval • GHNHSFT Board & Governors • NHS Gloucestershire Board approval	• Presentation of change proposals and plans for communication and engagement. Plans endorsed by SHA. • Proposals approved for engagement by Shadow CCG, GHNHHSFT Board and NHSG Board
3 month public consultation commences		
February 2013	• HCCOSC Meeting	• Presentation of change proposals and plans for communication and engagement. Plans endorsed. Activity designated as Public Consultation.

Consideration of the terms *'engagement'* and *'consultation'*?

Plans for engagement with the public regarding the service change proposals were developed by NHS Gloucestershire (NHSG) and Gloucestershire Hospitals NHS Foundation Trust (GHNHSFT). Traditionally, in

[1] **Clinical Priorities Forum** – membership secondary and primary care clinicians working in Gloucestershire

[2] **NHS Gloucestershire Reference Group**
An outcome of Phase 1: 'Your NHS: Maintaining Quality, Improving Efficiency' was the establishment of the NHS Reference Group. The purpose of the Reference Group is to provide a forum for informal and confidential discussions between NHS Gloucestershire, NHS provider organisations (e.g. Gloucestershire Hospitals NHS Foundation Trust) and representatives from the Health, Community and Care Overview and Scrutiny Committee and Gloucestershire Local Involvement Network (LINK), about potential service developments. The Group builds on the existing productive working relationship between Gloucestershire Health Community and stakeholders and supports our shared goal of 'no surprises'.
The NHS Reference Group does not replace any functions undertaken by the full HCCOSC or LINk in relation to service developments. Instead the group augments the existing process for determining the significance of proposed changes by providing a forum for discussing issues at an exploratory stage.

Gloucestershire, the NHS commissioning organisation[3] has led engagement and consultation activity regarding service change proposals on behalf of the Gloucestershire Health Community.

The engagement plan was discussed with the NHS Reference Group in December 2011 and with the Strategic Health Authority in January 2012 and finally with the Gloucestershire County Council Health, Community and Care Overview and Scrutiny Committee (HCCOSC) in February 2013. At the meeting of the HCCOSC the activities described in the Engagement Plan were approved. However, the HCCOSC concluded that the activity should be referred to as 'consultation', rather than 'engagement'. This amendment did not materially change the nature, nor the practical arrangements for the activities planned; it related only to the title of the activity. No further consultation activity was requested by HCCOSC over and above that already described in the approved engagement plan.

However, renaming of the activity 'consultation' triggered the involvement of the National Clinical Advisory Team, which has a national role as part of the NHS Gateway Review Process. The National Clinical Advisory Team (NCAT) provides a pool of clinical experts to support, advise and guide the NHS on local service reconfiguration proposals to ensure safe, effective and accessible services for patients.

NHS South West Strategic Health Authority had traditionally undertaken the first part of the Health Gateway Review Process in this region. This review took place in January 2013 when the proposals passed through the Gateway and were approved for public engagement (see Table 1 above).

Following the decision at the HCCOSC meeting in February 2013 renaming the activity 'consultation' rather than 'engagement', the Gloucestershire Health Community, in discussion with the Strategic Health Authority, invited NCAT to review the proposals. A visit of the NCAT took place on 15 May 2013.

The NCAT visit was very constructive, with NCAT representatives having the opportunity to discuss the service change proposals with local secondary and primary care clinicians. At the time of writing this Outcome of Consultation Report the NCAT report has not been received. It is anticipated that a first draft of the NCAT report will be available by the end of May/early June 2013.

Considerations regarding the timing of the consultation period

Much consideration was given to the timing of the three month public consultation. The Gloucestershire Health Community makes it clear in the plans and briefings supporting the consultation activity that there are time constraints associated in particular with the Emergency and urgent medical

[3] During the period of the public consultation NHSG Primary Care Trust was succeeded on 1 April 2013 by NHS Gloucestershire Clinical Commissioning Group (GCCG) as the commissioner for Gloucestershire for secondary care services provided by GHNHSFT.

care proposals related to the rotation of junior doctors in training in August 2013. There are specific expectations of the training body, The South West Deanery, regarding supervision arrangements for those doctors in training, which must be resolved by August 2013.

Advice was sought from the SHA, Gloucestershire County Council democratic services and legal departments and the HCCOSC Chair regarding the implications of starting consultation in the run up to a pre-election period, continuing through the pre-election period and ending the consultation period shortly after the date of the local county elections.

The consensus was that the consultation should start on 1 February and continue for three months. To mitigate any concerns regarding the engagement of locally elected representatives, all Party Leaders, county and district, were invited to attend a stakeholder briefing, attended by clinical representatives from GHNHSFT and the NHS commissioners. One party leader chose to attend this event. In addition, GCC provided contact details for all prospective county council candidates in April 2013 and a communication was sent by the NHS commissioner to all candidates by the commissioner advising them of the consultation proposals. One prospective candidate acknowledged receipt and requested further information.

Public Consultation activity

A broad range of consultation methods were used to promote and facilitate feedback from patients, the public, local stakeholders, including elected representatives, and staff. These included:

- Engagement booklets including feedback form (print/on line)
- Countywide media advertising
- Invited stakeholder events *(sent to over 680 individual and group contacts including Local Medical Committee, elected representatives, patient and carer representatives, black and minority ethnic /BME groups, community and voluntary groups)*
- Community, service user and carer presentations
- Targeted group awareness raising
- Public drop-ins / Info Bus
- Staff briefings

Details of the public and staff consultation activities are set out in Table 2 and Table 3 below.

Table 2: Public Consultation activity timeline

Activity Number	Day	Date	Time	Engagement Activity	Venue	Est. number
1	Fri	08/02/2013	10am	Extraordinary HCCOSC Meeting	Shire Hall, Gloucester	31
2	Thur	19/02/2013	5pm	Meeting with group/party leaders	Prout Room, Sanger House, Gloucester Business Park, GL3 4FE	1
3	Wed	20/02/2013	9am - 5pm	Public Drop-in	Eastgate Shopping Centre, Gloucester	50
4	Thur	21/02/2013	11am - 2pm	Public Drop-in	Moreton Area Centre, Moreton in Marsh, GL56 0AZ	8
5	Thur	21/02/2013	3.00 - 4.30pm	Stakeholder Event /Cancelled few bookings (15.2.2013)	Moreton Area Centre, Moreton in Marsh, GL56 0AZ	0 cancelled, no bookings received
6	Sat	23/02/2013	10.30 - 12.00	Stakeholder Event	Sandford Education Centre, Cheltenham, GL53 7PX	15
7	Mon	25/02/2013	6.00 - 7.30pm	Stakeholder Event	Sanger House, Gloucester Business Park, GL3 4FE	16
8	Tues	05/03/2013	7.00 - 9.00pm	Forest Health Forum	Bream Community Centre, Bream, GL15 6JW	21
9	Thur	07/03/2013	10am - 1pm	Public Drop-in	Co-op, Dockham Road, Cinderford, GL14 2AQ	20
10	Mon	11/03/2013	2.00 - 3.30pm	Stakeholder Event	Forest Hill's Golf Club, Mile End Road, Coleford, GL16 7QD	5
11	Fri	15/03/2013	12.30 - 3.30pm	Public Drop-in	Bishop's Walk Shopping Centre, Cirencester, GL7 1JH	15
12	Fri	15/03/2013	10.30 - 12.00	Stakeholder Event	Bingham Gallery, Dyer Street, Cirencester, GL7 2PP	7
13	Sat	16/03/2013	10am - 3pm	Public Drop-in	Beechwood Arcade, 123 High Street, Cheltenham, GL50 1DQ	25
14	Mon	18/03/2013	4.00 - 7.00pm	Public Drop-in	Morrisons, Tewkesbury , GL20 8AB(Bus)	5
15	Mon	18/03/2013	3.00 - 4.30pm	Stakeholder Event	Holy Trinity Church Hall, Oldbury Road, Tewkesbury, GL20 5NA	8
16	Tues	19/03/2013	10.30 - 12.00	Stakeholder Event	Subscription Rooms (Ballroom), Kendrick Street, Stroud, GL5 1AE	10
17	Tues	19/03/2013	2.00 - 5.00pm	Public Drop-in	Tesco, Stratford Road, Stroud, GL5 4AG (Bus)	5
18	Wed	20/03/2013	4pm - 6pm	FT Members Event	Sandford Education Centre, Cheltenham	76
19	Thur	21/03/2013	11 - 2pm	Public Drop in	St Edwards Hall, The Square, Stow on Wold GL54 1AF	8

20	Tues	26/03/2013	4 - 7pm	Public Drop in	Tesco, Lydney	25
21	Wed	27/03/2013	10am - 1pm	Public Drop in	The Bull Inn, Fairford[4]	0
22	Wed	03/04/2013	3 - 6pm	Public Drop in	Churchdown Community Centre[5]	4
23	Fri	05/04/2013	4 - 7pm	Public Drop in	Tithe Barn, Bishop's Cleeve, Cheltenham[6]	2
24	Mon	08/04/2013	4.30pm	Stroud Youth Council x 3 (8/4, 15/4, 30/4)	Ebley Mill, Stroud	15
25	Sat	13/04/2013	10 - 3pm	Public Drop in	GL1Leisure Centre	35
26	Mon	15/04/2013	11 - 2pm	Public Drop in	Tesco, Cirencester	20
27	Tues	16/04/2013	10 - 12pm	DROP	Redwell Centre, Matson[7]	5 (incl one via Skype)
28	Thur	18/04/2013	10 - 1pm	Public Drop in	Corn Exchange, Tewkesbury Town Council, High Street, Tewkesbury GL20 5AL	6
29	Fri	19/04/2013	11 - 3pm	Public Drop in	Cheltenham High Street (Bus)	25
30	Mon	22/04/2013	11 - 2pm	Public Drop in	Moreton Area Centre, Moreton in Marsh, GL56 0AZ	7
31	Tues	23/04/2013	2 - 5pm	Public Drop in	Sainsbury, Dursley (Bus)	5
32	Wed	24/04/2013	12-1pm	Carers Forum	Guildhall, Gloucester (59 carers of adults, 30 parent carers)	89
33	Wed	01/05/2013	7.30pm	Winchcombe Town Council	Abbey Fields Community Centre, Winchcombe	45
						Total: 606

[4] This event was arranged in response to a request from Fairford Hospital League of Friends
[5] This event was arranged in response to a request from an elected representative
[6] This event was arranged in response to a request from a Practice Participation Group
[7] This event was arranged in response to an invitation from DROP

Table 3: Staff Consultation activity timeline

Activity number	Day	Date	Time	Event	Est. number
34	Fri	01/02/2013	10.30 – 11.30	Redwood Education Centre, GRH	80
35	Fri	01/02/2013	12.30 – 13.30	Sandford Education Centre, CGH	85
36	Thur	14/02/2013	12.30 - 1.30	Lecture hall, Sandford Education Centre	51
37	Fri	15/02/2013	12.30 – 13.30	Lecture hall, Redwood Education Centre	11
38	Tues	05/03/2013	12.30 – 1.30	Lecture Hall, Sandford Education Centre CGH	32
39	Mon	25/03/2013	12.00 – 1.00	G2, Redwood Education Centre GRH	9
40*	Tues	02/04/2013	12.30 – 1.30	Lecture Hall, Sandford Education Centre CGH	Cancelled
41*	Fri	05/04/2013	12.30 – 1.30	Lecture Hall, Redwood Education Centre GRH	Cancelled
**The final two staff events (40 and 41) were cancelled following a global email to gauge interest receiving fewer than 5 booking confirmations for each. GHNHSFT recognised that meetings were difficult for many staff to attend, and were approached by one person to ask if GHNHSFT could prepare a podcast. As an alternative, Frequently Asked Questions were submitted to both Dr Tom Llewellyn, ED Consultant, and Dr Miles Wagstaff, Paediatric Consultant, on film and these were made available to view on the GHNHSFT intranet.*					
				Total: 268	
				Combined Total (public and staff): 877	

Communications activity to support the public consultation

The communications activities undertaken by the NHS commissioner and GHNHSFT to support the consultation are detailed below.

Communications activities undertaken by the NHS commissioning organisation

Stakeholder Briefing

- 31 January 2013 - Briefing sent to MPs, HCCOSC members, local NHS Chairs and Chief Executives, District/County Council leaders.
- 31 January 2013 – details of consultation email notification sent to commissioner stakeholder database (680 contacts).
- 29 April 2013 – 'Last Chance' reminder email sent to commissioner stakeholder database (680 contacts).

GP briefing /E-bulletin

- 31 January 2013 – Initial briefing sent
- 27 February 2013 – Link to consultation included in GP e-bulletin
- 1 May 2013 – 'Last Chance' reminder email sent

Printed consultation booklets

- 10,000 copies of Long guide with freepost feedback form
- 17,000 copies of Short Guide with freepost feedback form
- These were distributed to:
    - Gloucestershire Hospitals NHS Foundation Trust
    - Community Hospitals
    - GP Surgeries
    - Pharmacies
    - District Councils
    - Libraries
    - LINk/Gloucestershire Rural Community Council

Website:

Information about the consultation and online feedback form published on the NHS Gloucestershire website pre 01/04/2013 and, with a banner divert to the Gloucestershire Clinical Commissioning Group website post 01/04/2013.

Placing of advertorial on consultation/event advertising:

- Gloucestershire Echo and Gloucester Citizen: 4, 5 & 6 February 2013 (proposals in depth – 1 proposal per day)
- Gloucestershire Echo and Gloucester Citizen – w/c 18 February 2013 (events and signposting to consultation)
- Wilts & Glos Standard, Cotswold Journal – w/c 18 February 2013 (events and signposting to consultation)
- Stroud News & Journal – 20 February 2013 (Leaders Column – promoting the consultation and Stroud public event)
- The Forester and Forest Review – w/c 25 February 2013 (events and signposting to consultation)
- Gloucester Citizen and Gloucestershire Echo – 27 and 28 March 2013 (events and signposting to the consultation)
- Gloucester Citizen and Gloucestershire Echo: 5 April (feature based on re-stating key elements of the emergency and urgent care proposal following petition misinformation (‘A&E Closure’) and signposting to the consultation).

Mail shot – Posters advertising drop-in dates:

- February – Posters sent to Practice Managers, Pharmacies, Libraries, Children’s Centres, District/County Council buildings

Twitter/Facebook – promotion of the consultation and events

- 1, 18 February 2013
- 22 March 2013
- 9, 19 April 2013

Communications activities undertaken by GHNHSFT

Staff Meetings

- Gloucester – 1, 15 February, 25 March 2013
- Cheltenham – 1, 14 February, 5 March 2013

Staff emails

- Links to consultation materials and meeting dates sent– 31 January, 6, 12 February, 1, 19, 21, 27 March

Staff Newsletter

- 4 page article in February 2013 edition
- Page in April 2013 edition

GHNHSFT Members

- 4 pages in Spring 2013 Members' Involve (newsletter)
- Open meeting - 20 March 2013

Website:

Information about the consultation and online feedback form published on the GHNHSFT website with a direct link to the NHSG website pre (01/04/2013) with a banner divert to the Gloucestershire Clinical Commissioning Group website (post 01/04/2013).

GHNHSFT Governors:

- Presentation sent on 31 January 2013
- Stakeholder briefing and consultation materials sent on 31 January 2013
- Discussed at Governors meeting 11 March 2013

Twitter (GHNHSFT):

Date	Message with link to consultation material
22/3/13	RT NHS Glos consultation message
27/3/13	RT NHS Glos consultation message
9/4/13	A&E Proposal
9/4/13	A&E Proposal
10/4/13	Link to A&E advertorial
11/4/13	reply to question – with link to engagement document
11/4/13	reply to question
17/4/13	Link to proposals
24/4/13	Link to proposals
25/4/13	Reply to questions
30/4/13	Link to proposals and feedback
3/5/13	Last day for feedback

Facebook:

Date	
9/4/13	Link to advertorial plus photo
30/4/13	Link to CCG consultation page

Consultation statistics summary

The following represent the numbers of individual responses/attendances by category recorded during the consultation period:

- On line and print surveys
  - **239** Surveys completed and received
- Written responses and emails
  - **10**
- Hosted Stakeholder Presentations
  - **61** stakeholders took part
- Foundation Trust member event
  - **76** members attended
- Elected representative events
  - **92** members attended (incl. public attendees at meetings in public)
- Community / Service User / Carers Events
  - **115** community representatives/service users/carers took part
- Public Drop-Ins
  - **265** visitors over 18 events
- Staff events
  - **268** staff attended over 6 events
- Media
  - Readership of all local newspapers and listeners to local radio

Total recorded contacts: 1126

Petitions

Two petitions were created linked to this consultation.

The first petition [Petition 1] was organised by the office of Martin Horwood MP, it was entitled:

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

1,228 names and addresses were collected through the e-petition at http://www.surveymonkey.com/s/6FBMKLJ or using form published in the Liberal Democrat newspaper the Cheltenham Courier, with data from both entered on the Liberal Democrat Connect database.

Petition 1 was delivered to the offices of Gloucestershire Clinical Commissioning Group on 29 April 2013.

The second petition [Petition 2] was organised by Ms Margaret Allen, it was entitled:

Please save Cheltenham General Hospital A & E from closing because the nearest hospital is 10 miles away in Gloucester. We as local people need the accident and emergency department in Cheltenham as it could be life threatening.

7519 names were collected through this on-line petition at the HM Government e-petition website http://epetitions.direct.gov.uk/petitions/45279

Petition 2 has not, at the time of writing this Outcome of Consultation Report, been submitted to the Gloucestershire Health Community as part of the consultation feedback. There has been no recorded contact with Ms M Allen.

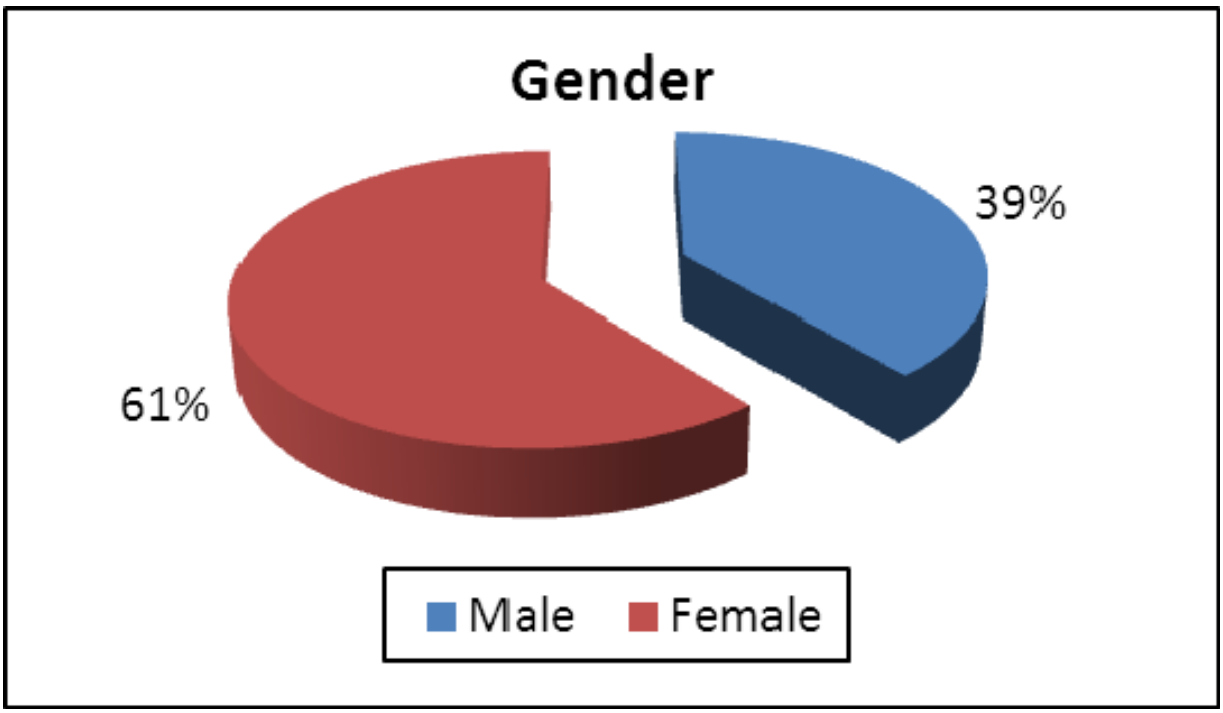
The NHS commissioner made contact with the HM Government e-petitions department to discuss Petition 2 using the on-line 'feedback' facility on the HM Government e-petitions website as soon as the commissioner became aware of the petition on 09/04/2013.

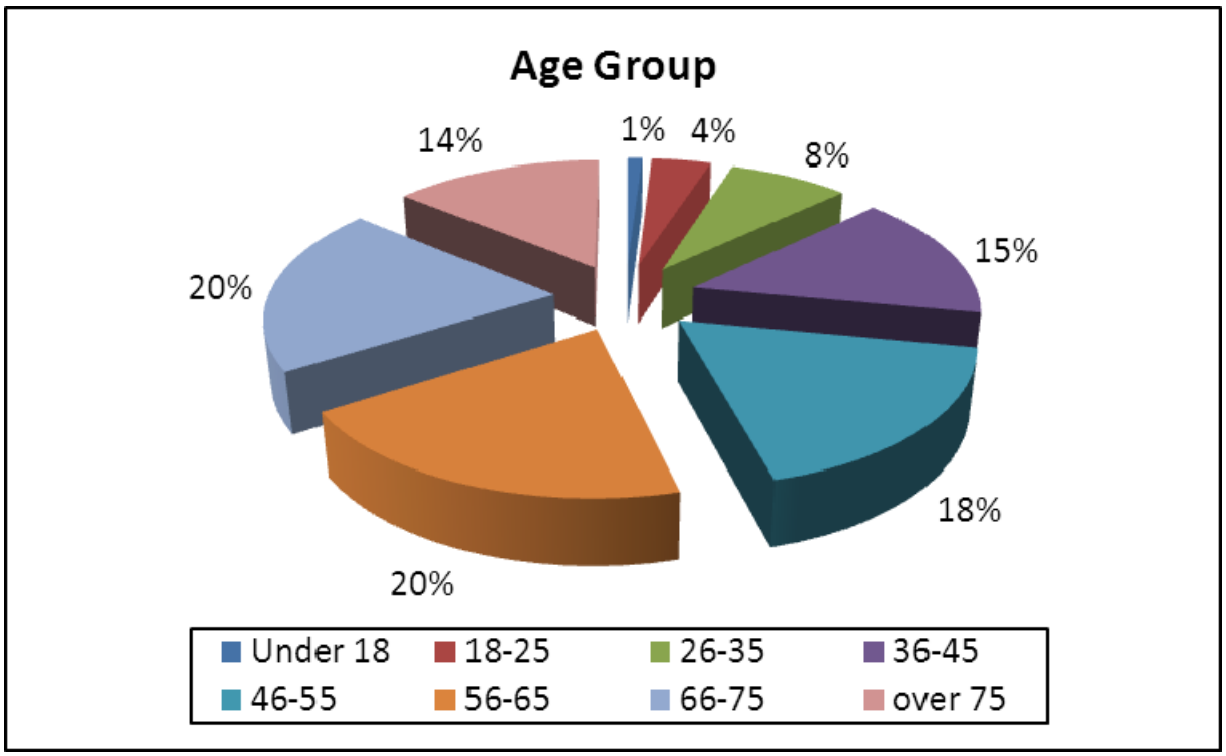
The NHS commissioner wished to register concern regarding the inaccuracy of the petition title and to seek an opportunity to add a comment to the e-petition page providing accurate information about the proposal. It was not possible to amend the site before the petition deadline. Petition 2 closed on 1 May 2013. At the time of preparing this Outcome of Consultation Report the Department of Health has not responded to Petition 2.

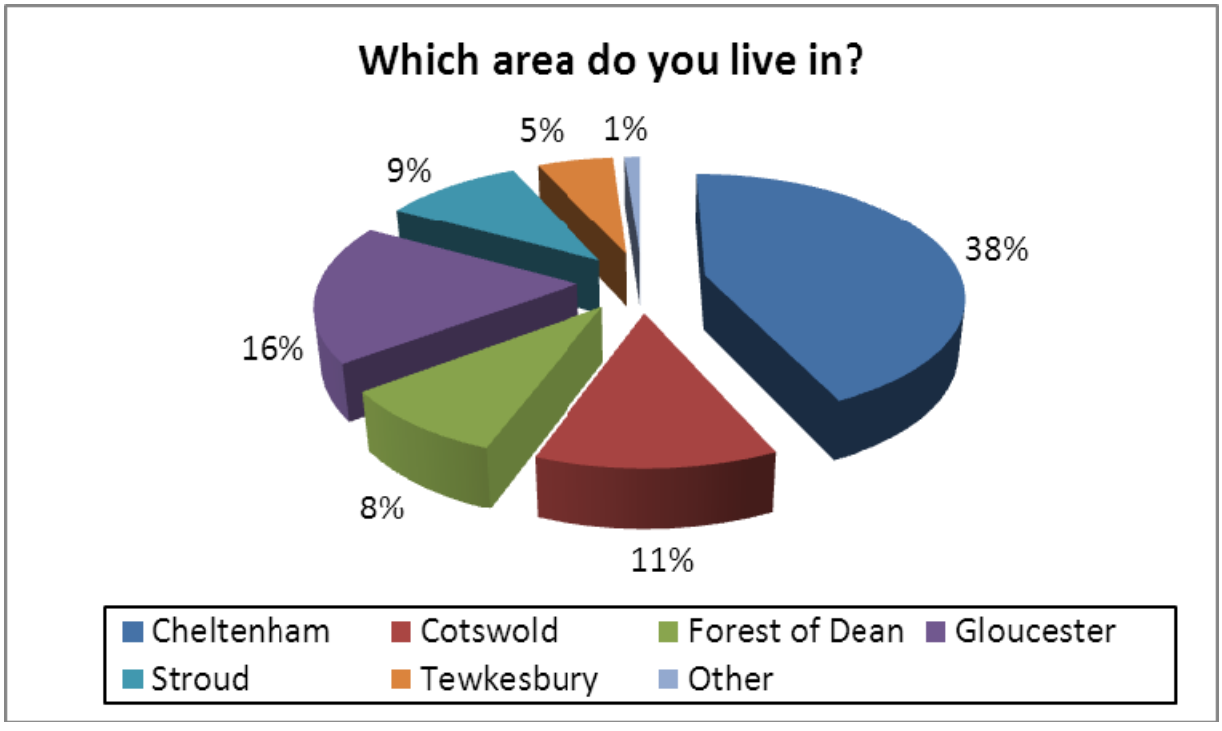
4. Demographic information

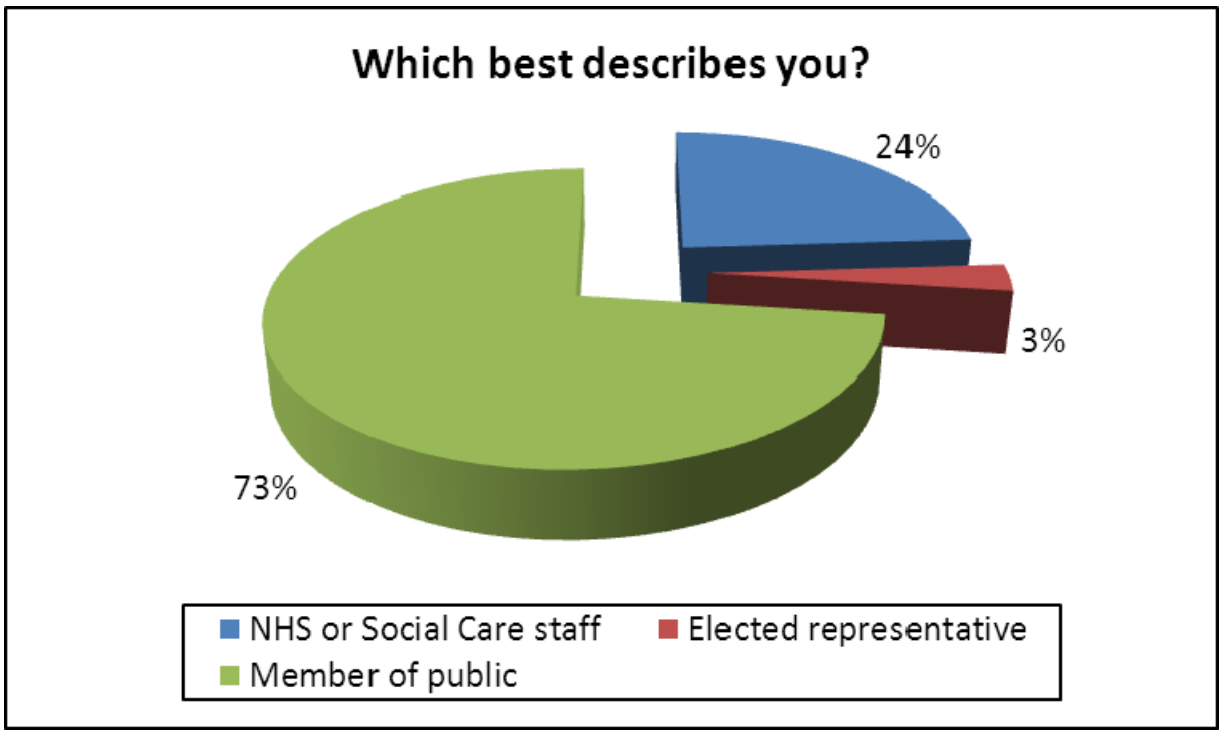
Demographic information was collected from responders to the online and print surveys. Completion of this information was optional. The following charts illustrate the demographic information collected.

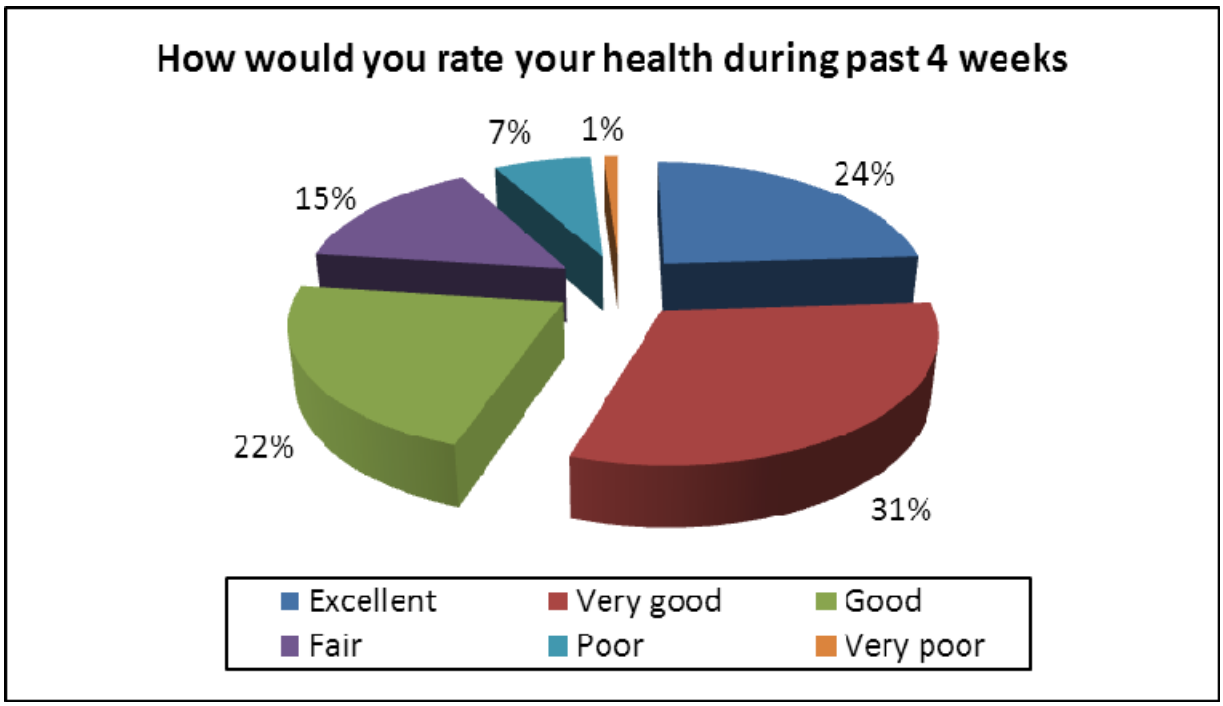
Demographic information about individuals who responded to the consultation in other ways e.g. attending an event, visiting a public drop-in, is not collected. However it should be noted that a range of consultation events were targeted at specific groups e.g. Youth Forum, disability rights group, Carers Forum.

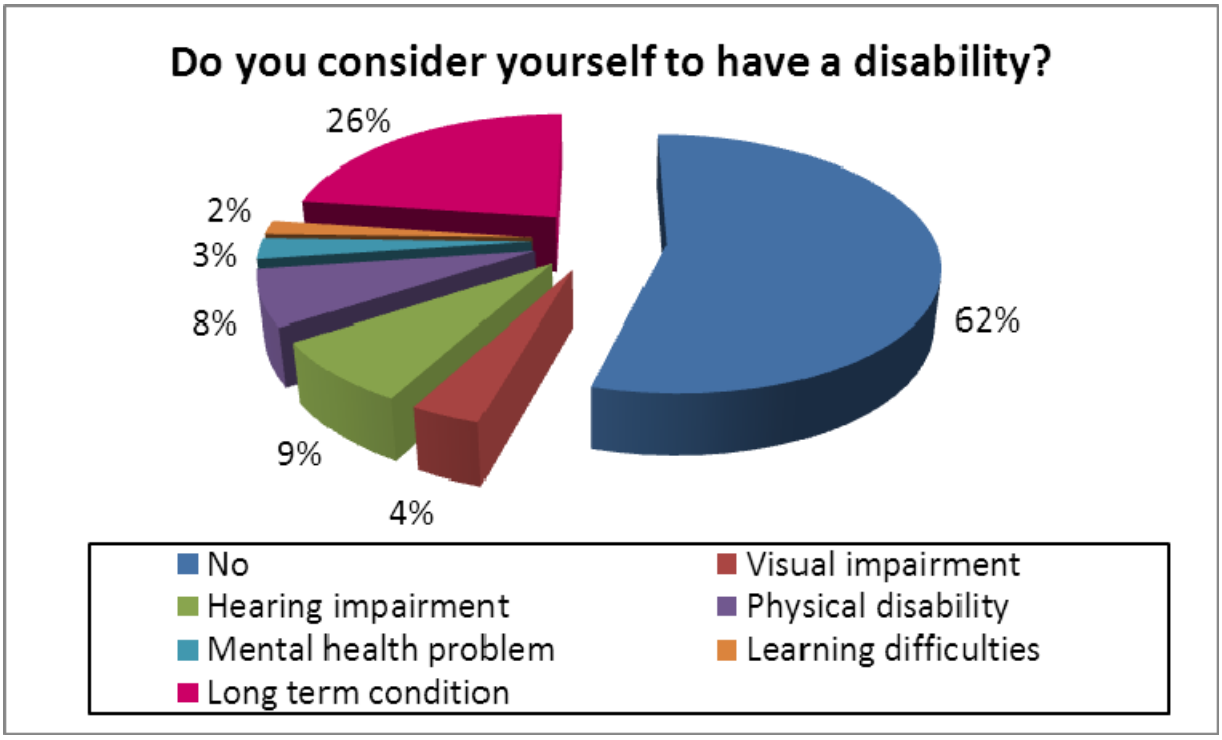


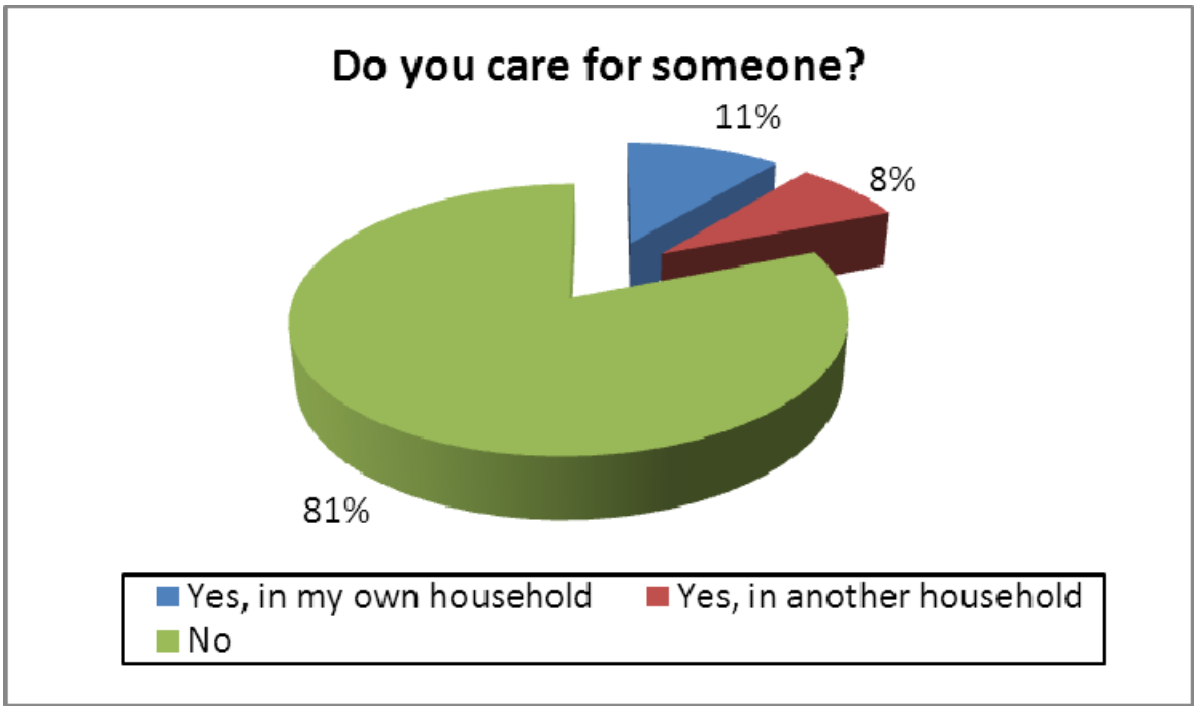

Age Group
1%
4%
8%
15%
18%
20%
20%
14%
Under 18
18-25
26-35
36-45
46-55
56-65
66-75
over 75

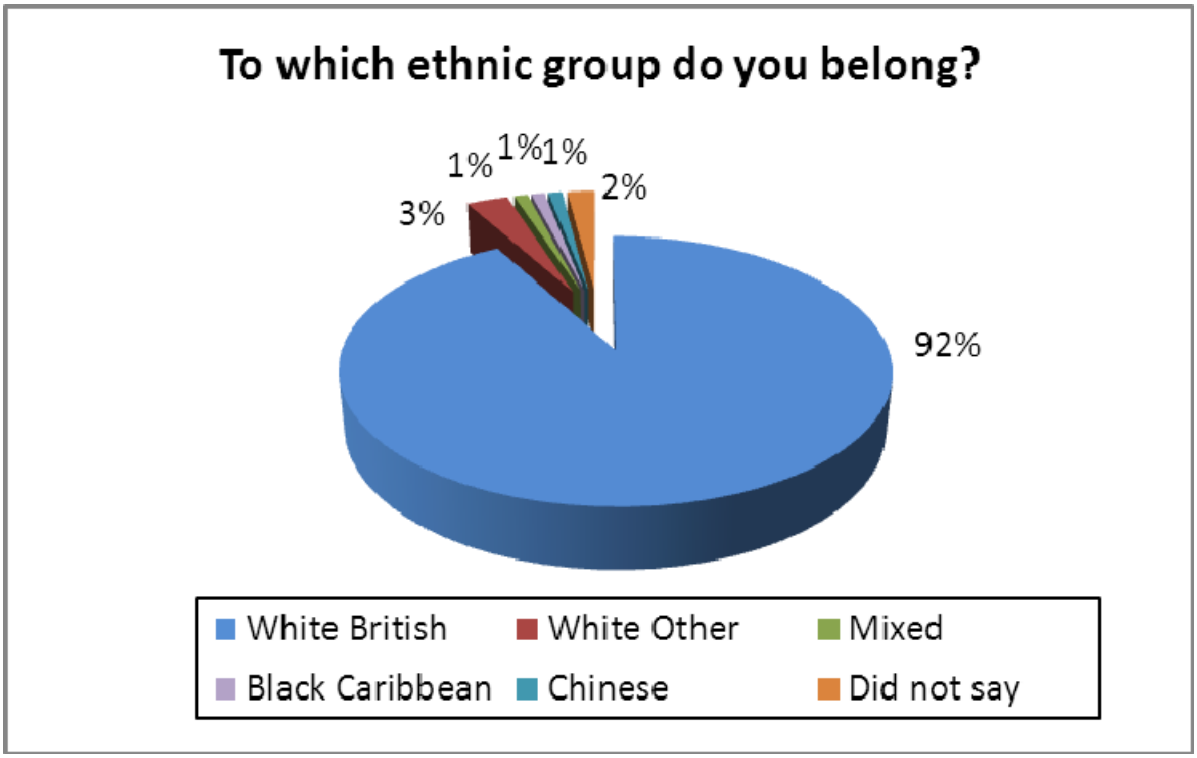

Which area do you live in?
5%
1%
9%
38%
16%
8%
11%
Cheltenham
Cotswold
Forest of Dean
Gloucester
Stroud
Tewkesbury
Other


Which best describes you?
24%
3%
73%
NHS or Social Care staff
Elected representative
Member of public


How would you rate your health during past 4 weeks
7%
1%
24%
15%
22%
31%
Excellent
Very good
Good
Fair
Poor
Very poor


Do you consider yourself to have a disability?
26%
2%
3%
8%
9%
4%
62%
No
Visual impairment
Hearing impairment
Physical disability
Mental health problem
Learning difficulties
Long term condition


Do you care for someone?
11%
8%
81%
Yes, in my own household
Yes, in another household
No


To which ethnic group do you belong?
1%
1%
1%
2%
3%
92%
White British
White Other
Mixed
Black Caribbean
Chinese
Did not say

5. Responses to the consultation

The responses received to the consultation are summarised in this section of the Outcome of Consultation report.

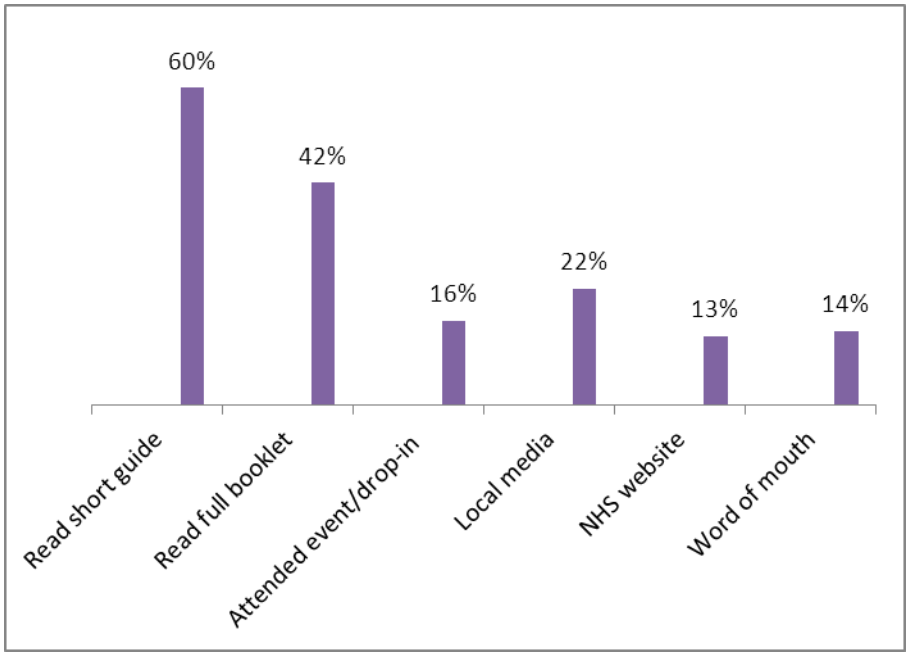
Firstly this section contains information about the views of respondents who used the consultation survey to provide feedback and secondly information about the views of individuals who provided feedback to the consultation in other ways.

5.1 Quantitative responses to the consultation online and print survey

The responses to the questions in the consultation survey were as follows:

Question 1:

How have you obtained information about the proposed changes? (select all that apply)



The totals in this graph add up to more than 100% as respondents were asked to ‘select all that apply’ and many respondents had obtained information in more than one of the ways described.

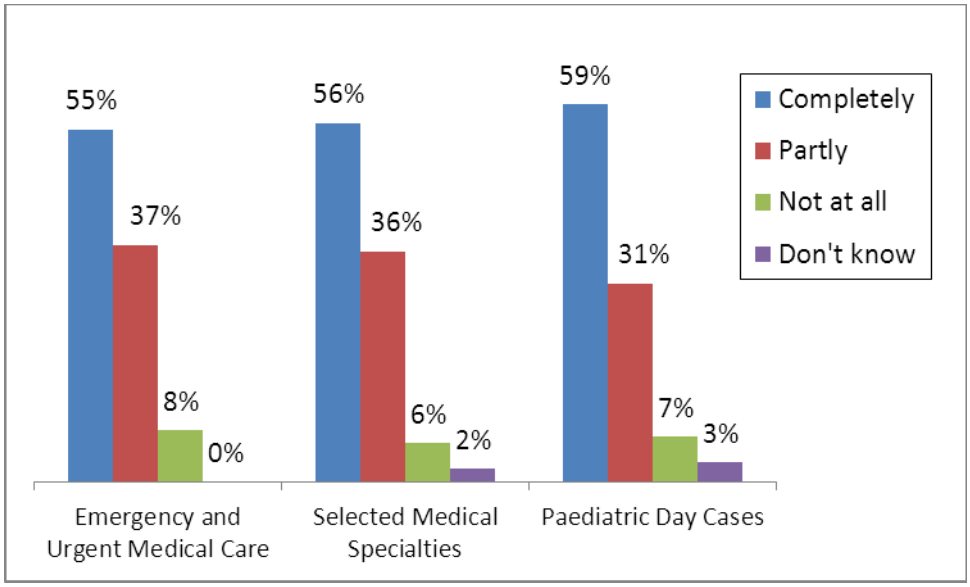
Question 2:

Do you have any suggestions about how else we could make this information available?

Suggestions made in response to this question are included in the qualitative section of this Report.

Question 3:

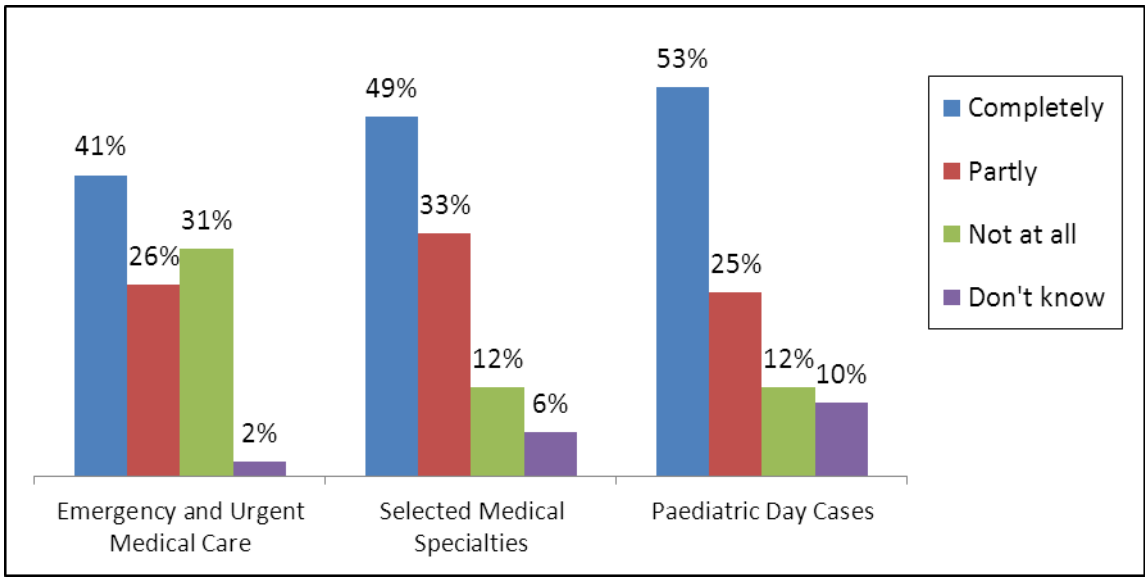
Were you provided with the right information to help you understand and form a view about the proposals for change?



By combining the 'completely' and 'partly' responses to Question 3, it is clear that 90% plus of respondents were either completely or partially satisfied with the information provided. Those respondents who were partially satisfied provided suggestions regarding addition information which would have been useful to them. These are included in the qualitative feedback to Question 2.

Question 4:

Do you agree with the views of clinicians and managers about the proposals for change?



By combining the 'completely' and 'partly' responses to Question 4:

- 67% of respondents agreed completely or partially with the proposal relating to Emergency and Urgent Medical Care. For those who partially agreed with the proposal the most frequent comments related to increased travel times, public transport access, car parking, recruitment of senior doctors and managing demand within the ED at GRH during busy periods. Responses to these comments can be found later in this report.

- 82% of respondents agreed completely or partially with the proposal relating to Selected Medical specialties. For those who partially agreed with the proposal the most frequent comments related to increased travel times, public transport access and access for visitors.

- 78% of respondents agreed completely or partially with the proposal relating to Paediatric Day Cases. For those who partially agreed with the proposal the most common comments related to car parking costs, increased travel times and inconvenience to parents. 10% of respondents did not express an opinion, citing that they did not have children or grandchildren.

Question 5: Please give us your views about the proposals for change

- **Emergency and urgent medical care**
- **Selected Medical Specialties**
- **Paediatric Day Cases**

Views recorded in relation to the proposals for change are included in the qualitative section of this report.

Further comments

Further comments are included in the qualitative section of this report.

5.2 Qualitative responses to the consultation (online and print) survey and letters and emails.

It is important to take into account qualitative feedback as well as the quantitative feedback above. However, it should be recognised, that the analysis of qualitative feedback is more difficult to represent in a written report such as this. In the following section, this report presents a representative sample of the most frequently occurring comments, questions and suggestions received.

It should also be noted that those responders who chose to provide additional comments were significantly more likely to be less positive about the proposals, whilst those responders supporting the proposals frequently choose not to make further comments. Therefore, the comments selected below should be read taking this into account.

Question 2: Do you have any suggestions about how else we could make this information available?

Many comments were received stating that the information provided was clear, well presented and sufficient.

The information is very clear and well set out in the full version of engagement process booklet.

I think that the info provided is sufficient to understand the problems facing the Trust and the need for changes.

More detail would have been information overload. The booklet is simple and concise and presents both the reasons for the changes and the proposals themselves clearly.

Suggestions for how else information could be made available can be found below. Most respondents suggested methods which had already been employed, including advertising in the local media and providing information in GP surgeries and public libraries.

How else we could make information available		
(S)	**Suggestion**	**Response[8]**
S	Send information to schools and colleges	NHS Commissioner response: we will discuss arrangements with Gloucestershire County Council for future engagement / consultation activities.
S	Make presentations to PHSE lessons	NHS Commissioner response: we will discuss arrangements with Gloucestershire County Council for future engagement / consultation activities.
S	Door to door household direct mail drop	On a county-wide basis, this would be a hugely expensive exercise (printing and distribution). However, further consideration will be given to expanding the range of community outlets the information is available from.

The survey asked respondents:

If you felt that other information would be useful, please say what else you would like to know.

Most frequently occurring suggestions were:

- Statements about shortage of specialist staff should be supported by statistically valid data.
- How the ambulance services will cope with ferrying patients between the sites.
- How ambulance services would be improved to compensate for changes in night-time emergency procedures. Evidence that you have considered the problems of people living far away from Gloucester.
- Need to know how the changes, particularly a to A&E are to be managed at GRH, which is regularly at capacity now.
- Clarity about how patients who "walk in" and are subsequently found to have more serious complaint that require admissions will be treated.

[8] Responses provided by GHNHSFT, GCC and GCCG

- More details on staffing particularly in ED proposals. More details on paediatric staffing on new day care unit at GRH and impact on staffing for OPD in CGH.
- Information about the action taken to recruit doctors.
- Information about how much it would cost to implement the changes.
- Information about how these service change proposals fit into the Trust's longer term plans.
- More information about "support in the community".
- Signposting information about transport options between the two hospitals and to the two hospitals from rural areas.
- Information about any increased risk of mortality associated with the proposed changes.
- More detailed information regarding the steps taken to obtain required staff
- Incorporate the views of general practitioners.
- An example of how outcomes (CQC inspections etc) would be better with these changes i.e. red scoring to green/amber
- Comparable data for other hospitals/trusts.
- Include an implementation timescale if possible.
- No information on how many staff were consulted at different grades and how that consultation was carried out.
- More information about the social impact of the proposed changes.

Question 5: Please give us your views about the proposals for change

- **Emergency and urgent medical care**
- **Selected Medical Specialties**
- **Paediatric Day Cases**

In this section this Outcome Report summarises the free text comments made in relation to Question 5 above as well as feedback received by letter and email. Comments and grouped under:

- general comments, suggestions and questions
- comments against the proposals
- comments supporting the proposals

It should be noted that no alternatives to the service change proposals, which addressed the issues set out in the consultation, were suggested. However, respondents identified several areas where action could be taken to mitigate the impact of the proposed changes.

The views of residents with disabilities

The consultation received specific feedback from individuals representing individual residents in Gloucestershire with disabilities. The feedback received suggested that the service change proposals did not in themselves represent a significant negative impact on people with a disability. However, it was stated that access to services for individuals with a disability is more difficult and more could be done to improve access to services across the board and support for individuals with a disability whilst in hospital.

Emergency and Urgent medical care

Summary:

Significantly more comments were recorded regarding the Emergency and Urgent Care Proposals than the other proposals.

Many comments related to the need for clear communication about any changes made. There was concern that people would not understand the changes and people would subsequently be put at risk as a consequence of seeking to access a service at the wrong hospital site. Some comments demonstrated a lack of awareness/understanding about the way that some services are already configured e.g. Stroke care centralised at Gloucestershire Royal Hospital following public engagement in 2011. Respondents queried whether ambulance services had been involved in the development of the proposals for change.

Below are a sample of **comments, suggestions and questions** to illustrate the main themes expressed:

- *It is not good enough to concentrate evening/night time services in one unit unless something is done to deliver much greater space and treatment facilities and improve the movement of patients through A&E in order to avoid backlog of cases coming in.*
- *If patients arrive at GRH during the night, they have no satisfactory way of getting home - this is particularly difficult for elderly and vulnerable patients.*
- *If I had an accident/urgent health issue I'd want to know I was getting the most expert care as quickly as possible and I'd prefer a longer ambulance journey in the first instance to get to GRH than being moved after admission.*

A selection of comments against proposal:

There was much concern that the proposals were the *"thin end of the wedge"* and would lead to eventual closure/downgrading of the Emergency Department at CGH. Respondents also showed scepticism and some saw cost cutting as the motivation for the proposals rather than quality and safety. Many respondents incorrectly thought the proposal was to close the ED at CGH completely.

- *I feel that this is the beginning of the eventual closure of CGH ED.*
- *I believe that there should be full emergency services on both sites to account for the demands of the rural community that spreads way beyond Cheltenham town.*
- *There seems no rational reason for this - there will be the same doctor/patient ratio but with a more limited resource at Gloucester and I therefore do not see the benefit. Conversely patient safety will be compromised by the additional transportation times by paramedics and ambulances.*
- *Lives will be lost.*
- *Cheltenham is an expanding town with another 1000 homes just been approved and growing university population. Even Stroud and Cirencester A&E have a doctor overnight.*
- *Neither ED can cope with current demand so there is no way that GRH would cope with Cheltenham patients.*
- *Gloucester too far from the Cotswolds for patients.*
- *This A&E reduction proposal will be detrimental to the health care of patients in Cheltenham and the Cotswolds who require urgent medical treatment at night that will be delayed by an extended ambulance journey to Gloucester to become an additional demand on an A&E department where the waits can already be too long.*
- *Concerns at potential transfer times to & waiting times in Gloucester at night, difficulty in non-ambulance services accessing A & E and getting home after treatment at night.*
- *More efforts should be put into recruiting the required number of consultants and doctors.*
- *The trust web site does not state it wants to close A&E in Cheltenham.*

A selection of comments supporting the proposal:

There was acknowledgement that if a patient needed to see a more senior doctor in the ED Department the additional travel at night for 999 ambulances from the eastern half of the county was justifiable.

- *If changing the arrangements at night time preserves the two site Emergency Department service then I support it.*
- *Better to travel for better treatment, particularly if there is earlier senior assessment and decision making when the patient arrives at hospital.*
- *It is important that people get the adequate level of care they require and the theory behind this seems sound given the medical vacancies.*
- *The proposals seem realistic in view of the available resources*
- *Change is clearly needed to make services safe.*

Emergency and Urgent medical care: Suggestions and Questions

Suggestion	Response
Consideration should be given to providing additional hours for support workers to provide personal assistance to individuals with disabilities to take into account accessing services further from home and for when appointment times are delayed.	The amount of time, or personal budget, a disabled person is entitled to depends upon their needs. When those needs are assessed, the Social Worker will take into consideration all of their circumstances, including access to services. If someone has a personal budget and is using that for support, they can decide how to flex their allocation to ensure their personal assistant can help them access appointments or services further from home. If they have chosen to have a service directly provided, their support plan can be flexible if the service user has identified this as a need and they meet the criteria supported by the Council of substantial or critical.
Every effort should be made to avoid delays in hospital for individuals with disabilities who have paid support workers, to enable support workers to remain with the individual until the end of their appointment within their paid working hours.	Every effort should be made to avoid delays in hospital for all patients. If patients with disabilities accompanied by paid support workers make their needs known to our staff we will do our best to accommodate them
Concerning stroke patients - given that the paramedics are already treating these patients for strokes before they arrive, and that A&E itself waits for specialist advice from the stroke unit before sending patients upstairs, I would like to suggest that stroke patients are delivered direct to the stroke unit, thereby avoiding the backlog in A&E (important for these time-critical patients) and reducing the load there.	Our stroke pathway is now well established following the centralisation of this service on the GRH site last year. The paramedics do assess the patients with stroke, and can now deliver some patients direct to the CT scanner to speed their care. The emergency clot busting drugs still need to be given by a senior doctor and this needs to be done in the Emergency Department, but patients are then transferred to the Stroke Unit as fast as possible.
Question	**Response**
I appreciate the issues regarding doctor training. However, what	The emergency nurse practitioners will be able to access advice from the

happens when people "walk in" as they will with complex problems how will they be managed. The public will expect a DGH to have a fully functional emergency dept.	senior doctors in the emergency department in GRH. They will also be able to refer to the acute Physicians and Surgeons in CGH. If a patient's condition cannot be treated in CGH we will arrange their transfer to GRH. We already have operational policies in place to cover this, for instance if a child requiring admission "walks in" to CGH or a person with a urological problem requiring immediate treatment "walks in" to GRH.
If a patient goes to GRH and needs admission will they be transferred to CGH during night to inpatient ward or all admitted to GRH?	Wherever appropriate patients will be admitted to the site at which they presented, most usually to our acute care units. For some patients who require admission to a medical specialty ward it may better for them to be transferred to our other hospital to secure the best treatment. This can happen now in both of our hospitals.
Please clarify long term plans for A&E in Cheltenham.	There are no plans for further changes to the accident and emergency department in Cheltenham. 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.
Why (is) a permanent change being made to deal with temporary recruitment problems?	The recruitment problem is not temporary. There are insufficient doctors in training to fill the required numbers of consultant posts. Because of the length of time it takes to train specialists, this position is unlikely to change before 2020.
Are there enough consultants to provide emergency care at GRH and what will be the availability of "the bay" in ED?	Implementing these proposals will enable us to match the presence of senior doctors to the flow of patients through the department better.
Could lives be lost as a result of the delay in getting to GRH A&E Department?	We recognise the concerns about possible increased mortality with extra distance for ambulance travel. The main source cited 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 of 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, we believe that the benefits of the change greatly outweigh any risks. The most urgent condition we deal with is cardiac arrest and we will still receive these patients in CGH.
It is better to have to travel for a little longer to receive top quality care, rather than Glos NHS trying to cover two centres with only adequate care. I would want to be in receipt of the highest level of expertise. My only concern is how we gain a guarantee that The Ambulance Trust can fully support that transportation requirement.	We have included colleagues in the South West Ambulance Trust (SWAST) in our discussions. They have confirmed that given the geographical area that they cover, the proposal for all 999 ambulances to attend GRH overnight is unlikely to impact on their quality of service or response times. However, if this were to result in an increase in ambulance handover delays then it would have an impact on their response. We will work with colleagues in SWAST to ensure that this does not happen. The changes proposed will reduce

	ambulance handover delays for GP reviewed admissions at CGH, as suitable patients (following pre agreed conditions) will be taken direct to the acute assessment unit. The improved staffing levels and full use of the additional "majors" area at GRH will mitigate the risk of ambulance handover delays increasing at GRH. We will agree with SWAST a period of additional cover after the proposals are implemented to enable us to understand the impact of additional transfers between sites better.
Are the Emergency Nurse Practitioners in ED trained to deal with paediatric accidents and illnesses?	Yes. Their training includes Advanced Paediatric Life Support Training (APLS), minor illness assessment and treatment and the care of patients with minor head injuries.
You keep saying "at night" in reference to A&E cover at night but you don't give a time.	References to "at night" in the consultation material relate to the period 8pm to 8am as stated.
If Gloucester is full or closed for any reason how can A&E be quickly re-instated at Cheltenham and when there is a full scale emergency when sometimes patients are taken to both Hospitals how will Gloucester cope?	We have well established policies and procedures in response to major incidents. These include calling in or diverting from other areas both doctors and nurses. The emergency department in CGH will continue to be available in such incidents. At times of excessive demand at GRH, the opportunity to divert GP reviewed attendances will still exist**.**
Why was GRH chosen as the hospital to receive the Ambulances at night?	The choice of GRH as the site to receive 999 ambulances overnight is to ensure the availability of support from children's and women's services and the major trauma team.
The all singing all dancing General Hospital is no longer a viable option and change is necessary. However in the case of any further reduction in A&E at CGH I believe that great consideration be given to: • effect of multiple casualty incidents on one unit only • can GRH really cope with 40%	Agreed. If further changes to the emergency department at CGH were to be considered, these would be important considerations.

+ increase in throughput • can SW Ambulance Trust provide an acceptable service?	
Have you really tried all options to fill those A&E posts? Foundation trusts have the freedom to pay doctors more if they are proving hard to recruit but recent advertisements by the trust for emergency doctors are on the standard pay scale.	Yes, we believe we have. Whilst it is true that as a Foundation Trust we could deviate from national terms and conditions of service, to do this would have significant implications for us. In practice we have tested our ability to fill our vacancies through paying more by using locum appointments. In 2012/13 we spent £0.7m on ED locum and agency doctors yet despite this we have still been unable to consistently fill the rotas.
Is the Trust pre-empting the current Keogh review of emergency medicine? Surely they should wait to hear his findings before making changes at Cheltenham.	Our proposal to reconfigure emergency services predated the announcement of the Keogh Review and we do not have time to wait for it to be published as we need to have a solution that resolves the risk of withdrawal of training doctors by August 2013. We will review the services in Gloucestershire against the recommendations of the Keogh Review when it is published, as we would with any national policy directive. Our expectation is that these proposals will be consistent with the likely direction of travel that will be reflected in the review.
Is UTOPIA still operating?	The key principle of UTOPIA is for patients to be triaged by a senior decision maker as early as possible to ensure they are put on the right care pathway, first time. This principle has been maintained in the proposed service changes.
As well as lung disease, which emergency cases would be taken to the CGH at night?	Our clinicians are currently in discussion with the ambulance Trust to agree which groups of patients should continue to come to CGH at night in order to access the right care pathway, first time.

Selected Medical Specialities

Summary

Some of the comments received highlight a lack of understanding of the proposals. A clear message will need to be given regarding any changes that are made and about previous changes made e.g. centralisation of Stroke services. GHNHSFT may wish to consider ways to share information about how services are configured across the two sites.

Below are a sample of comments, suggestions and questions to illustrate the main themes expressed:

- *It is not easy to remember, when certain forms of treatment are split between CGH and GRH e.g. Gastroenterology and Respiratory Medicine.*
- *I know we have to be cost effective but this means patients have to be moved from one location to another which has an effect on the patient and families concerned as a lot of people can find travelling very difficult.*
- *This means we can't have a choice of hospital.*
- *During daytime the 99 bus service is superb, but if you live in Glos evening visiting would be difficult for elderly or non-drivers, when most services are at CGH.*
- *The proposed changes here make sense, and secure the future of both CGH and GRH as credible district general hospitals.*

A selection of comments against proposal:

- *With populations increasing it seems illogical that in order to have effective services we have to travel further; demand for and use of local services should be increasing. Decreases in public transport and increased traffic and parking issues result in increasing difficulties accessing services.*
- *I have an on-going degenerative respiratory condition and am likely to be admitted at various times over the next few years. I have seen no sign of community respiratory support to replace hospital care.*
- *I do not wish to be admitted to Cheltenham as:*
    - *1 It is difficult to access from my home area (Forest of Dean) and that of family members (Berkley Vale area. Public transport is very difficult and parking very poor.*
    - *2 Access issues at the hospital for someone with impaired mobility and;*
    - *3 I perceive Cheltenham to be an old, out of date hospital which is unfit for purpose. I would prefer to be treated in a modern, clinically suitable setting.*

Comments supporting the proposal:

- *It does make sense to have centres of excellence and increased skills.*
- *Cardiology one sex wards would be welcome.*
- *Good to have specialist staff skills on one site.*

- *I can definitely see the advantages of centralising services where that would provide the right expertise from staff and better patient outcomes.*
- *Locality versus reassurance of specialisation will always be the crux of this argument.*

Selected Medical Specialties
Suggestions and Questions

Suggestion	**Response**
/	/
Question	**Response**
Does keeping non-urgent gastroenterology de-skill the clinicians if they do not manage any emergencies. How will they manage if a case becomes urgent?	No as the clinicians will operate as a countywide team with all clinicians continuing to treat patients who present as an emergency or for a planned treatment.
In principle I support the proposals. I would be interested to understand the demographic make-up of the two areas (Cheltenham and Gloucester) to understand whether those specialisms are best placed either at Gloucester or Cheltenham, and I'd also be keen to understand whether there is such a thing as 'linked' specialisms would continue to operate successfully if they are split across site (medical expertise not strong here but for example ENT and Respiratory).	We do not think there are any significant differences between the populations of Cheltenham or Gloucester that would influence the location of any of the services included in these proposals. Critical clinical linkages are an essential factor that we take into account whenever we are considering changing the distribution of services between our 2 sites.
Will cardiology services in extended accommodation at CGH be available at weekends?	Not at present. The proposals are to improve the quality of our cardiac interventional service which currently operates between the hours of 9am and 5pm, Monday to Friday.

Paediatric Day Cases

Summary

This service change proposal received the least number of comments. The key theme was access for parents and visitors.

A selection of comments against proposal:

- *It is difficult for mother's to travel distance with children and this can be stressful for both, so I feel Cheltenham should still be used for day treatments.*
- *The children's facilities at GRH are very good; my reservation is whether Gloucester is accessible for all families.*
- *Concentrating skills is important but I have concerns about extra travelling involved for people with young and possibly sick children.*
- *Gloucester is very big and scary for young children. CGH is not.*

A selection of comments supporting the proposal:

- *I feel this is probably best solution as better to have highly experienced specialists dealing with whole service rather than fragmenting across county.*
- *Sounds very positive and well thought out.*
- *I fully support these proposals, as long as the Out Patient services provided at CGH continue to be available with specialist Paediatric Care.*
- *The location is not as important...as the SERVICE received at point of contact.*
- *I think it is a great idea, and if all the children are put together then perhaps they may feel more relaxed with others from their age group in similar situations.*
- *Very supportive of a new children's day surgery unit at GRH, children in an adult day surgery unit is not right.*

Paediatric Day Cases
Suggestions and Questions

Suggestion	Response
Would be better if cheaper parking, as to stay all day with your child is very expensive to park.	We do recognise that parking charges do have an impact on people using our services. The level of charges are influenced by 2 things; firstly a need to recover the cost of providing parking through charges to avoid diverting resources away from delivering healthcare and secondly matching our charges with those charged by the local authorities to prevent our car parks being used by people not attending our hospitals. Arrangements

	are in place to enable people in receipt of benefits to recoup these charges. There is also a reduced rate for frequent visitors. Details are available on the GHNHSFT website at: http://www.gloshospitals.nhs.uk/en/Patients-and-Visitors/Travel-and-Parking/
Question	**Response**
Good to see outpatient services maintained at both sites. Do community hospitals provide children's outpatients?	Yes. Paediatric clinics are provided at Stroud, Berkeley, Lydney, Dilke, Moreton-in Marsh, Bourton on the Water, Tewkesbury, Cirencester and Winchcombe. In addition there are a number of clinics provided at special schools for children with neuro-disabilities.
How will you help Cheltenham families to manage attending GRH without affecting other children in the family group adversely?	Whenever it is practicable to do so we will continue to provide services for children as close to home as possible through our community based services. When attendance at GRH is essential we will always try to schedule this at dates and times that minimise the impact on other children in the family.

Any further comments?

Below is a selection of 'other' comments, suggestions and questions received, which do not refer specifically to one of the three service change proposals. The most frequently occurring further comments not related to specific change proposals were pragmatic.

- *The implementation of these proposals is overdue in my view. This is what management are paid to do! With the NHS under considerable financial pressure it must be managed more effectively. Everything cannot be done on both sites.*
- *There is a real challenge to parking at both hospitals, notably the lack of, and expensive.*
- *Just be resolute. A very long time ago I worked at a northern regional hospital which provided specialist services for a very large area. This was familiar & expected. People just don't like change. Please ensure that families & carers get support to understand the issues for their person & help in travelling to see them.*
- *The main thing is that patients receive good quality care and are treated by experienced specialists in dedicated areas. So it makes sense to centralise services rather than lose them altogether.*
- *With 2 hospitals within 9 miles of each other it makes sense to split services on either site.*

- *I agree that the advances in modern medicine mean greater specialisation and this means all services will not be available on all geographical sites.*

Other suggestions and questions

Suggestion	Response
Make appointments when at hospital if further treatment needed instead of posting it, then people have to phone back as appointment not convenient so further postage and paper.	If a patient needs a follow up appointment within 6 weeks then this is arranged at the time at the outpatient desk. If a follow-up is needed beyond 6-weeks then patients are added to a follow-up pending list. This is to stop the multiple cancellations and re-booking of appointments due to doctors being on leave for example. In our annual patient survey we receive positive feedback on the lack of appointment cancellation and re-booking and we wouldn't want to undo this.
I think the county need to work hard to educate the public to choose the correct service and help them understand that minor illnesses do not need hospital treatment.	Agreed. The NHS is expanding its targeted 'Choose Well' campaign this year and has a comprehensive plan in place for the Autumn and Winter. This includes advice on self-care, use of community pharmacies and other healthcare options.
If the doctors were managed as well as the nurses then we would not be in this position. Nurses have no choice about shift rotation and this should be made compulsory to consultants, if they choose the speciality of emergency medicine then they need to provide a 24 hour service.	This observation is not accurate. Doctors entering the specialty of emergency medicine do recognise the requirement for 24 hour cover and cannot opt out of the rotas required to deliver this. The problem is that fewer doctors in training are choosing emergency medicine as a career. The bulk of our patients come in during the day. To cover nights with consultants would require a significant increase in consultant numbers. Our consultants are not averse to providing night cover if there were sufficient numbers of consultants available.
The hospital needs to promote the specialisation of services - the	This is an excellent suggestion. We will look to do this more effectively

diagram on page 3 of the full consultation booklet is helpful and could be modified to provide information for patients and carers about where services are delivered.	through our patient information and our website, making more use of the diagram referred to.
The message must be got across to the older generation, if these changes go ahead, that if in doubt call 999!	This will be considered as part of a communication programme to support implementation should the proposals be agreed.
Question	**Response**
What happens if the M5/Golden Valley is closed and there is traffic gridlock throughout the area?	Firstly, it should be noted that there are very few patients that need to be rapidly transported to hospital under blue light conditions and therefore the main concern is being able to respond to calls in the first instance. There are currently rare occasions when the Golden Valley is closed and given that the main ambulance base for the Gloucester and Cheltenham areas is located in the industrial estate area of Staverton then contingency arrangements are made. SWASFT have standby points located at both ends of the Golden Valley and have access to the motorway via the police base at Bamfurlong. Given that CGH will only not accept ambulances at night then this will be outside peak traffic flows, if the Golden Valley is closed then other routes such as the M5, Cheltenham Old Rd or the Brockworth bypass can be used. Generally, with the use of blue lights emergency vehicles can proceed through the heaviest of traffic; if necessary a police escort can be requested.
Will you feedback what changes have been incorporated from the engagement/consultation with the public?	Yes, feedback will be provided through the publication of this Outcome of Consultation Report and through regular reporting to the HCOSC.
How will you introduce innovation to improve standards e.g. think outside the box as has occurred in other hospitals?	We are always looking to improve our services. We do this by assessing ourselves against published good practice, comparing ourselves with other providers, encouraging peer review and participating in

	improvement networks such as the South West Patient Safety Programme.
Will the results of this questionnaire by fully available to the public?	This Outcome of Consultation Report will be published on the NHS Gloucestershire Clinical Commissioning Group website.

5.3 Themes from qualitative responses collected through other consultation activities e.g. presentations, public drop-ins.

The commissioner hosted six invitational Stakeholder presentations in districts across the county. Presentations of the specific service change proposals were made by representatives from the NHS commissioner and GHNHSFT were followed by question and answer sessions.

It should be noted that the consultation proposal relating to proposed changes to Emergency and Urgent Care Services generated the highest level of comment amongst stakeholders; and all other respondents to the consultation. Proposals regarding changes to selected medical specialties and paediatric day surgery attracted significantly less discussion.

Below is a summary of the key discussion points:

Access to services

A most common theme at stakeholder events was access to services. Access was a key discussion point across all three service change proposal areas. Discussions related to access to staff, access to transport, equity of access and perceived restrictions to access in terms of opening times and geographical access i.e. centralisation at either CGH or GRH.

A subset of access to services was access to specialist staff

There was general agreement that junior doctors required good quality supervision.

There was general agreement that the recruitment of more senior doctors in A&E was a national issue that must be resolved at that level.

A subset of access to services was transport (public and own) and car parking

Public Transport

Access to public transport, particularly in the rural areas of the county, was a frequent discussion point. Stakeholders reflected a common theme from

respondents to the survey, that the public transport network was not adequate to meet the needs of local residents. This was in terms of area covered and frequency of services. Several suggestions were made about the scheduling of appointments for people with bus passes after 9.30am in order for them to take advantage of free bus travel.

It was noted that evening and weekend discharges from hospital were a concern for those people reliant upon public transport.

There was acknowledgement that the NHS does well to get many local buses to call at CGH, but that public transport from rural areas is often impossible. This situation is worse at night-time.

Ambulance Transport

Stakeholders acknowledged the crucial role played by the ambulance service in ensuring patients are transported to the most appropriate hospital site. Close working between GNHSFT and SWAST in the implementation of service change was recommended.

Volunteer drivers

The contribution made by volunteer drivers was acknowledged. It was noted that the availability of volunteer drivers in the county was reducing. It was also noted that the cost to patients for using volunteer drivers was being affected by the need for volunteer drivers to pay for additional parking hours at CGH and GRH due to appointment delays.

Transport information

Stakeholders noted that people, both patients and staff, were unaware of the full range of public, community and volunteer transport options available.

Hospital parking

Stakeholders were concerned that parking at either hospital could be a problem at the hospital with centralised services.

Other non-access related discussion points:

Individual / family / community responsibility

Stakeholders noted the contribution individual and families could make towards improving their health and wellbeing, thereby reducing demand on NHS and social care services.

Use of community hospital beds and other beds

Stakeholders noted that the reduction in beds within community hospitals could add additional strain to the system during busy periods.

Capacity at GRH Emergency Department

It was noted that GRH ED is already often very busy, concern was expressed that it would not have capacity to receive additional 999 ambulance patients. It was also noted that this was a whole community issue to be resolved.

Paediatric Day Cases

There was broad support for this proposal from stakeholders and the public. A dedicated paediatric team would ensure that CQC standards are met in terms of numbers of paediatric procedures carried out per surgeon, thereby ensuring a safer delivery model.

Consultation and communications activity

Stakeholders enhanced the consultation activity by recommending additional venues to hold public consultation events (public drop-ins, community presentations).

Some concern was raised regarding the timing of the consultation overlapping with the pre-election period [see *Considerations regarding the timing of the consultation period* earlier in this Report.]

Next steps

Stakeholders asked for a review of all changes if/when implemented to monitor for expected outcomes and unintended consequences. Below is a selection of most frequently occurring suggestions and questions raised through other consultation activities.

Suggestions and Questions: From qualitative responses collected through other consultation activities e.g. presentations, public drop-ins, correspondence

Suggestion	Response
The current system means that the NHS is responsible for getting the patient to hospital if unwell. However, it is the patient's responsibility to get themselves home… perhaps the hospital could provide patients with information about some of the charities which provide transport and other transport options.	This is an excellent suggestion which we will pursue. We already provide some information but it can certainly be improved.
Scheduling of appointments should support the use of free public transport.	We can rearrange appointments on an individual basis for those people eligible for and/or restricted to free public transport timetables and patients should contact the booking office to do this.

Could GPs send patients directly to community hospitals?	Yes, GPs frequently send patients to community hospitals closer to where patients live.
Gloucestershire Health Community should consider ways in which information about transport options, including voluntary, can be made available to the public and staff.	This is something that the commissioner has been actively looking at as part of the development of a revised patient transport service specification. We are seeking a single point of access call centre to support individual patients' transport needs.
Gloucestershire Health Community should promote all urgent and emergency service system options more widely.	Agreed. The NHS is expanding its targeted 'Choose Well' campaign this year and has a comprehensive plan in place for the Autumn and Winter. This includes advice on self-care, use of community pharmacies and other healthcare options.
GHNHSFT should consider publicising more clearly which sites provide specific specialties.	This is an excellent suggestion. We will look to do this more effectively through our patient information and our website, making more use of the diagram included in our consultation material which people indicated was helpful.
Revised escalation arrangements during busy periods will be required.	This is correct and they are currently being finalised to share with colleagues across the health community to be reflected in our countywide escalation plans.
GHNHSFT should consider options for providing free or reduced rate parking permits to volunteer drivers.	We are planning to provide free car parking for volunteer drivers in the spaces provided by the demolition of some disused buildings at GRH. Unfortunately the space at CGH is very tight, hence the application for a multi-storey car park (see other response).
Review the operating hours of the 99 shuttle bus between CGH and GRH – explore whether it would be possible to extend the hours later into the evening.	We are actively pursuing extending the hours of operation of the 99 bus to be available between 06.20 and 22.05 with last pick up from CGH at 21.45. (Current last pick up at CGH is 18.55 arriving at GRH 19.20) We have reached agreement with the transport provider Stagecoach, and are waiting for confirmation that the hours of availability of the park and ride facility at Cheltenham Racecourse can be extended.

Question	Response
Stakeholders wanted to know whether a patient attending the Emergency Department at Cheltenham General Hospital at CGH has a right to see a doctor rather than a nurse?	Patients have the right to appropriate care. Nurses will be experienced and will have support from senior acute care doctors.
Can GHNHSFT influence public transport providers?	The provision of public transport is the responsibility of the local authority. GHNHSFT does seek to influence the local travel plans and to ensure that any changes to our services that might have implications for transport providers are highlighted. The Board of GHNHSFT has recently endorsed its own travel plan which will be shared with the County Council.
Can GHNHSFT provide a comfortable lounge for patients to wait following discharge late at night, or following 999 transfer to GRH not resulting in an admission until public, community or volunteer transport is up and running in the morning.	We will look into ways in which we can provide more comfortable waiting areas for people waiting for transport home.
Since the opening of the multi-storey care park at GRH parking has become much easier for patients and visitors. Plans have been submitted to Cheltenham Borough Council for a multi-storey car park on the CGH site. Why have these plans have been rejected by the Borough Council?	The application by VINCI Park was rejected because objections were raised by a number of people including the Lido about light encroachment from the various options submitted.
How will GRH A&E be reconfigured to manage extra demand from 999 ambulances at night?	Seven new A&E majors bays were installed in GRH last year. These are currently funded to open 8 hours per day. Post August these bays will be open 24 hours a day. In additional, changes to Ambulatory Emergency Care clinics will increase the number of patients who can be managed in an outpatient type environment rather than in A&E.
Explore closer working between hospital and community children's services to facilitate earlier discharge and reduce admissions.	This is already happening. There is close inter-agency liaison between the hospital, the children's community nursing team, social services and Children and Young Persons Service (2gether NHS Foundation Trust).

	The team are constantly reviewing whether there are further improvements that could be made to facilitate discharge and reduce admissions further.
If the proposed changes do not work, can the services be returned to the current arrangements?	We are making no structural changes which mean the services could not be returned to the current arrangements but our ability to do this would be limited by the shortage of specialist staff which is the driver for these proposals.

6. Impact of consultation

Taking into account the quantitative and qualitative responses to the: Your NHS: Right Care, Right Time, Right Place 2013 Proposals for change: Maintaining high quality, specialist services communications and consultation programme, the following actions have been identified:

- Continue work with SWAST to ensure no significant impact on their response times
- Ensure access to more information on transport options
- Information to the public on distribution of services between CGH and GRH and how to access services
- Progress with planning for implementation
- Progress with monitoring arrangements

7. Acknowledgements

The following contributors and contributions are noted with thanks:

- GHNHSFT clinical teams
- GHNHSFT management
- NHS Commissioners
- Patient and Public Involvement and Communications staff
- NHS South Strategic Health Authority
- National Clinical Advisory Team
- NHS Reference Group Members (HCCOSC and LINk)
- HCCOSC Members
  and finally
- All respondents to the consultation

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NHS Gloucestershire Clinical Commissioning Group
On behalf of the NHS health community in Gloucestershire

May 2013

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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