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Our ref: MH/MH09-14/jo'k

September 2014

Dear Frank & Mary

Impact of 2013 changes to emergency care in Cheltenham

Following the consideration of the 12 month review by the Gloucestershire Health & Care Overview & Scrutiny Committee on Monday, I remain very disappointed by the quality of statistics and information presented to councillors and stakeholders in the local community relating to the changes to the emergency department at Cheltenham General Hospital introduced last year which ended blue light admissions to Cheltenham General Hospital Emergency Department between 8pm and 8am and diverted them to the ED at Gloucestershire Royal Hospital.

Because this letter is very critical of the report - and therefore by implication of the Trust and CCG who jointly prepared it - I would like to emphasise that I have always found both of you as senior officers very open, professional and accommodating in your dealings with me and I genuinely appreciate that.

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This letter contains a number of Freedom of Information requests designed to fill in the gaps I believe have been left in the information provided and I am taking the slightly unusual step of copying this letter to a number of people for their information and possible further comment:

- The Secretary of State, as I believe he should be aware of the failing this report reveals in the system of overview and scrutiny put in place by the NHS Act. Lay councillors on the HCOSC cannot be expected to properly scrutinise the local NHS if they are not given adequate and full information.
- The Office of National Statistics, who might want to comment on the quality of the statistical presentation in the 12 month review.
- Monitor, since the poor presentation and sometimes straightforwardly misleading interpretation of incomplete statistics in this report may raise wider questions about accurate presentation of information and statistics by the Trust.

Below are listed the reasons for my concerns with the 12 month review report and the consequent FoI request in each case:

Waiting times

The monthly percentages of patients admitted or discharged within four hours for each emergency department (Cheltenham and Gloucester) are shown on p12 of the report. As in the 6 month review, there is no before/after comparison for a whole year so it is impossible from these statistics to see the impact of the changes. The traffic light colour coding used in the 6 month review has also been removed so that it is isn't immediately clear that while Cheltenham has hit the 95% national target in every month in the last year except, narrowly, in February 2014 (94.37%), Gloucester has missed it in every month except July 2014, often by much larger margins. The report offers no real interpretation of this serious situation and draws no conclusion from this about the capacity of GRH ED to cope with the changes that have taken place.

FOI question 1:

What were the monthly percentages of patients admitted or discharged within four hours at the ED in a) Cheltenham and b) Gloucester in each of the months for which statistics are available since July 2011?

Patients leaving EDs without being seen

Pp 13-14 of the report show the percentage of patients leaving EDs without being seen – now across the whole trust and not broken down by ED. The

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report claims that the figure 'initially decreased significantly and then increased again... before decreasing again' but in Figure 7 on p14 the trend line from August 2013 when the change happened is clearly upwards.

FOI question 2:
What are the percentages of patients leaving EDs without being seen at a) Cheltenham and b) Gloucester in each month since July 2011?

FOI question 3:
Using the graph in the 12 month review showing the percentage of patients leaving EDs without being seen, show the annual statistical trend line since August 2013

Mortality data 1: geographical impact
In my original consultation submission and presentation to the CCG board in July 2013 I presented academic evidence[1] that mortality might increase for emergency admissions from Cheltenham and east Gloucestershire, from where there would be an increase in distance to the emergency department of at least 5km. On p15, as in the 6 month review and despite the questions raised then, no differentiated data between the east and west of the county has been presented so we have no idea whether the situation has got worse for people in the east of the county or not and the reassuring text of the report is therefore misleading.

FOI question 4:
What are the numbers of deaths in Trust EDs for each month since July 2011 for:

a) **persons with home postcodes GL1-6 and GL8-19**
b) **persons with home postcodes GL7, GL20 and GL50-56**

[1] http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2464671/ Methods: We undertook an observational cohort study of 10, 315 cases transported with a potentially life-threatening condition (excluding cardiac arrests) by four English ambulance services to associated acute hospitals, to determine whether distance to hospital was associated with mortality, after adjustment for age, sex, clinical category and illness severity. Results: Straight-line ambulance journey distances ranged from 0 to 58 km with a median of 5 km, and 644 patients died (6.2%). Increased distance was associated with increased risk of death (odds ratio 1.02 per kilometre; 95% CI 1.01 to 1.03; p<0.001). This association was not changed by adjustment for confounding by age, sex, clinical category or illness severity. Patients with respiratory emergencies showed the greatest association between distance and mortality.

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Mortality data 2: impact by risk group

In my original consultation submission and presentation to the CCG board in July 2013 I raised the issues of differential impacts on high risk groups (including increasing health inequalities as in one case – high risk of child admissions – the risk reflected multiple indices of deprivation). The report devotes only 138 words to mortality in general and doesn't include any analysis at all of the impact on higher risk groups.

FOI question 5:

What are the numbers of deaths in Trust EDs for each month since July 2011 which have occurred amongst persons with home postcodes GL7, GL20 and GL50-56 and which were associated with the following:

a) **Appendicitis**
b) **Asthma**
c) **Perforated ulcers**
d) **Acute peritonitis**

FOI question 6:

What are the numbers of deaths in Trust EDs for each month since July 2011 which have occurred amongst the following:

a) **People over 75 from areas of Cheltenham with high risk of accident and emergency admissions amongst elderly people, eg Charlton Kings ward (SOA areas E01022109-112)**
b) **Children under 5 and under 17 from areas of Cheltenham with high risk of accident and emergency admissions amongst children, eg Hesters Way, Oakley, St.Peter's and Springbank wards (SOA areas E01022120-123, E01022131-134, E01022155-162)**

Complaints

On pp16-18, the report states that complaints about emergency care are '*consistently* lower than the preceding year'. First of all, again, none of the data is differentiated by geographical location so the impact of the change on one side of the county would be impossible to see. The chart on p17 appears to show they were actually higher than the previous average in July, September, October and November 2013, February and July 2014 although it is not completely clear which year the blue average line has been derived from. It is called in the text 'the monthly average (taken from the last financial year's total)' and the average value does match the data points shown for financial 2013/14. But then this would include five months *after* the change had taken place in August 2013. A better baseline set of data would have been financial 2012/13 or better still the year to July 2013.

FOI question 7:

How many complaints about the EDs in a) Cheltenham and b) Gloucester have been received in each month since July 2011

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Recruitment

In the original 2013 NHS consultation document[2], it was stated that 'Since 2009, the Trust has repeatedly attempted to recruit to reach the [College of Emergency Medicine]'s recommended minimum number of 10 Emergency Medicine consultants per site covering 16 hours/day. The Trust currently has 11 consultants working across the *two sites* (i.e. fewer than 6 per site)'.

The 12 month review report, p7, confirms that in 2012/13, the actual number of ED consultants was 10 in 2011/12 and 11 in 2012/13. But it gives the *establishment* numbers for those same years as 10 and 12 respectively. So either the 12 month review is wrong and the trust really did have a massive 45% shortfall in consultant staffing against an establishment of 20 – much worse than neighbouring trusts - or the original consultation document was wrong and the establishment was never 20 and the recruitment shortfall was at most 8% (ie one post) - comparable to neighbouring trusts.

FOI Question 8:

What was the emergency consultant establishment of the trust in financial 2011/12 and 2012/13?

FOI Question 9:

How many emergency consultant posts were advertised in financial 2011/12 and 2012/13?

Yours sincerely

Martin Horwood MP
Member of Parliament for Cheltenham

Encl: Gloucestershire County Council Health and Care Overview and Scrutiny Committee 12 month review

c.c: The Rt Hon Jeremy Hunt MP
Secretary of State for Health
Department of Health
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SW1A 2NS

[2] Your NHS: Right Care, Right Time, Right Place (2013) p8

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Gloucestershire
Clinical Commissioning Group

Reconfiguration Report to the Health and Care Overview and Scrutiny Committee

August 2014

Contents

1. Executive Summary

1.1. Report Purpose

This report provides a final review of the Cheltenham and Gloucester Emergency Department (ED) reconfiguration one year since its launch in July 2013. It is based upon performance indicators and the outcome of a workshop held with clinical, managerial and lay representatives from: Gloucestershire Hospitals NHS Foundation Trust (GHFT), Gloucestershire Clinical Commissioning Group (GCCG), Healthwatch Gloucestershire and South West Ambulance Service NHS Foundation Trust (SWAST).

1.2. Summary Findings

The report reviews seven key questions to assess the reconfiguration against its original intentions. It finds:

- Supervision of doctors has significantly improved as a result of the reconfiguration and the Trust is no longer at risk of losing its trainee doctors.
- The predictions of the number of patients the change would affect were broadly correct.
- Waiting times in departments have generally improved and are better than the England average. CGH performance consistently exceeds the national target. Performance at GRH has improved but does not consistently meet the target.
- Mortality appears to have reduced and there have been no adverse incidents as a result of the change.
- Patient experience has improved with less complaints and more compliments.
- There has been some increase in the number of transfers and diverts of patients between sites which remains a concern and is the subject of focussed efforts to minimise unnecessary disruption. With a two site model and increased specialisation transfer between sites will be inevitable. The priority is to minimise transfers and ensure, when required, the process is safe and efficient.

1.3. Lessons learnt

The two workshops reviewing this reconfiguration (6 and 12 month) have identified some key lessons in the event of any future change:

- The main lesson is that some residents of Gloucestershire have misunderstood the reconfiguration and believe Cheltenham General Hospital Emergency Department to have shut which is incorrect – it remains open during the day and to patients walking in and to GP referrals overnight. There is a need for stronger communication from all organisations to ensure messages are communicated effectively.
- Clinical leadership of the change meant it was more meaningful to the public and ensured it was focussed on improving care.
- There has been good partnership working between the Council and Health and Care organisations in Gloucestershire to deliver this complicated change.

1.4. Conclusion

This final report reviewing the reconfiguration has found it has achieved the majority of its objectives and importantly has ensured good doctor training and supervision and improved care.

Key lessons from this change and the review are being taken forward by the health community. There remains a firm commitment by GHFT and GCCG that there will be a strong and vibrant future for both Cheltenham General and Gloucestershire Royal Hospitals.

2. Context for this review

In July 2013, changes were made to the flow of emergency ambulances between Cheltenham and Gloucester. Patients arriving between 2000- 0800 were taken to Gloucestershire Royal Hospital rather than Cheltenham General Hospital. This change was the result of trying to ensure good quality care for patients arriving by ambulance out of hours due to local and national difficulties in recruiting enough doctors to provide cover for two Emergency Departments out of hours. This change and the rationale for it are explained in more detail in section three below.

This change was supported by Gloucestershire Health and Care Overview and Scrutiny Committee (HOSC) on condition of regular reviews for the first year after reconfiguration to understand the change's impact and to ensure it delivered the intended benefits for the population of Gloucestershire. This is the last of these reviews and is based on the findings from all previous reviews and is also based on the discussion of the changes and their impacts at a workshop held in August 2014 that involved managerial, clinical and lay representatives from:

- Gloucestershire Hospitals NHS Foundation Trust (GHT),
- South Western Ambulance Service NHS Foundation Trust (SWAST),
- Healthwatch Gloucestershire and
- NHS Gloucestershire Clinical Commissioning Group (GCCG)

It is important to note that this reconfiguration was focussed on improving care for patients requiring urgent treatment out of hours. Our priority, as stated during the consultation in 2013, was, and is, to ensure that the sickest patients are seen by very skilled specialist staff when they need to be.

HCOSC members have identified that following the changes to the Emergency Department over night at Cheltenham General Hospital there remain, amongst some members of the local population, residual concerns regarding the future of the two acute hospitals in the county. Gloucestershire Clinical Commissioning Group and Gloucestershire Hospitals NHS Foundation Trust are committed to a vibrant future for both Cheltenham General Hospital and Gloucestershire Royal Hospital (see Appendix B).

3. What changes have been made and why?

In February 2013 the Health community in Gloucestershire proposed changes to the local emergency care system with the aim of maintaining high quality safe services against the backdrop of difficulties recruiting specialist emergency care doctors. These were set out in the NHS Gloucestershire Clinical Commissioning Group (GCCG) led public consultation document *"Your NHS – Right Care, Right Time, Right Place."* (see Appendix C)

The proposals were supported by the National Clinical Advisory Team in their report following consideration of the proposals. Given this and the outcome of consultation, the Health and Care Overview and Scrutiny Committee gave their support to the changes following agreement over review and on-going scrutiny arrangements including:

a) that performance information must be provided to the committee on a monthly basis (including ambulance handover times, patient numbers etc)

b) that there were formal reviews after 6 and 12 months to ascertain whether expected outcomes are being achieved

c) that the reviews included looking at mortality figures

d) that the outcome of these reviews be received at committee meeting (s)

The proposed changes to the emergency departments were introduced on 29 July 2013. Since that date between 8pm and 8am seriously ill patients arriving by ambulance have been taken to Gloucestershire Royal Hospital (GRH) Emergency Department (ED) rather than Cheltenham General Hospital (CGH) ED. Ambulance crews are allowed to admit a small selected group of patients directly to the acute medical ward (AAA) in Cheltenham. These are stable patients who fulfil strict clinical criteria.

There is no change for walk-in patients or for patients referred by their GP. Between 8pm and 8am the department at Cheltenham is staffed by Emergency Nurse Practitioners (ENPs) under the supervision of a Medical Consultant. If a patient arrives at the department and their presenting condition cannot be treated by the ENPs, the patient can be transferred to the new Acute Assessment Area (AAA) in Cheltenham where they will be assessed by a medical team.

It is important to note alongside this reconfiguration the ongoing national review of Urgent Care led by Sir Bruce Keogh, which aims to improve the quality of urgent care and minimise unnecessary demand on hospitals. Further guidance on national strategy on urgent care has recently been published, and GCCG and the wider health community will engage with the public, partners and the Health and Care Overview and Scrutiny Committee in taking forward any implications of this for Gloucestershire.

4. Impact of the Change

This section outlines answers to several key questions posed by the HCOSC and against which the reconfiguration's implementation has been assessed. Where relevant, performance data is included to support the answer to the question.

4.1. Has the supervision of junior doctors improved?

The emergency department is staffed by three groups of medical staff: junior doctors who have recently qualified and generally require significant supervision, middle grade doctors who are more senior and can work more independently and who supervise the juniors, and consultants who are the most senior doctors leading the department. As well as medical staff, emergency departments are staffed with nursing, therapy and administrative staff.

One of the main objectives of the service changes was to improve the coverage and the supervision of junior doctors which had been highlighted as a significant concern by the Severn Deanery. The reconfiguration has achieved this by concentrating middle grade doctors on the GRH site overnight enabling better supervision. Positive feedback has been received from both junior doctors and the Severn Deanery confirming that this result has been delivered. Severn Deanery undertook a re-audit of the supervision of doctors after reconfiguration and stated:

> *"The general perception is that the reconfiguration of the Emergency Medicine Departments has taken place in a smooth fashion. The previous issues around the rota have been addressed. The rota is now said by the trainees to be well managed and working very well."*
>
> *Severn Deanery Review of ED, November 2013*

Previously GHFT was at risk of having its trainee doctors withdrawn by the Severn Deanery due to limited supervision, which would have caused serious issues with medical cover in ED. By improving their supervision GHFT can continue to train junior doctors locally and maintain a safe emergency service. Furthermore the Deanery have decided there is no need to return specifically to re-audit ED as there are no current concerns or issues.

Despite improved junior and middle grade coverage due to centralisation of rotas at night, it should be noted that vacancies still exist at the middle grade level – which is the key challenge area – as illustrated below there will be only 7 whole time equivalents in post against a requirement for 10. The Trust is focussed on recruiting to these vacancies and undertakes targeted recruitment, incentives and offers flexibility. However, given the need for these posts to work nights and weekends, they remain difficult to recruit to. This local problem is reflected on a national scale leading the College of Emergency Medicine to report recently that 383 of the 699 specialist registrar posts in A&E nationally have been left vacant over the past three years.

Figure 1. Doctor staffing against establishment 11/12 to 14/15 (projected)

Period	Establishment – junior doctors	Actual numbers of ED junior doctors *(mix of newly qualified doctors to doctors deciding on their career path)* in post	Establishment – middle grade	Actual numbers of ED middle staff in post whole time equivalent (WTE)	Establishment – ED Consultant	Actual numbers of ED Consultant staff in post
2011/12	21	20 *(unable to appoint to 21 – applicants had insufficient qualifications to meet standard required)*	10	7	10	10
2012/13	21	19 *(unable to appoint to 21 – applicants had insufficient qualifications to meet standard required)*	10	5	12	11
2013/14	21	20 *(unable to appoint to 21 – applicants had insufficient qualifications to meet standard required)*	10	8 WTE (9 job shares) 2.0 WTE Vacancies	14	14
2014/15 projected	21	20 19 - Aug '15 *(One year Severn Deanery pilot (Post shared between ED and Anaesthetics expires August 2015 – to be evaluated)*	10	6.7 WTE *(11 job shares)* 3.3 WTE Vacancies	15	15 *(Dr Heather Clark commences Oct '14)*

Whilst middle grades remain the main problem in Gloucestershire's Emergency Departments, there has been a move from 11 consultants in post to 15 being in post currently. Some of these additional consultants are currently working night shifts to cover the middle grade vacancies. The current establishment of middle grades is that required to staff one ED overnight. To return to two fully functioning EDs overnight would require 16 middle grade staff. Given the local and national recruitment difficulties there is no prospect of this being achieved in the foreseeable future.

4.2. Have the number of ED attendances changed?

Whilst admissions to GHFT have remained relatively static, there has been a small increase in attendances at Emergency Departments in Gloucestershire over the last year (for example from August 2012 – July 2013 there were 121,643 attendances whereas this year there have been 123,433). This increase has largely been during the late afternoon and early evening in the working age population with minor injuries particularly in the Gloucester and Cheltenham areas. Whilst overall there has been an increase, attendances at CGH have decreased from 49,432 to 44,703 following the reconfiguration. A reduction in attendances was anticipated for ambulances which has been realised, albeit below the anticipated number of cases. However, it was not anticipated that the number of walk-ins and GP referrals would be reduced and therefore this suggests the public have misunderstood the reconfiguration and some are now no longer attending CGH when they could (as walk-ins and GP referrals are unaffected by the change). It is worth noting that the AAA opened in November 2013 and accepted certain ambulance cases which would have previously been sent to GRH between August 2013 and October 2013. This is reflected in the mode of conveyance chart for GRH.

The issue of misunderstanding among the public in relation to the opening times of the ED at CGH was discussed at both the Six Month and Twelve Month Reviews. There is a perception among some people in the community that Cheltenham ED has shut either completely or during the out-of-hours period. Both GHFT and GCCG have worked hard to make the public aware that Cheltenham has remained open for GP referrals and walk-ins out of hours and it is only seriously ill patients transported by ambulance that must be routed to Gloucester. Further steps have been taken by GHFT since the six monthly review to reinforce that message and help raise levels of public awareness. This has included numerous press and media opportunities including TV and radio; in particular extended coverage from the ED on radio Gloucestershire earlier in August 2014; digital promotion as well as social media messaging.

Following initial implementation of the changes, GHT developed clinical protocols with SWAST to enable an increased direct admission to the Acute Assessment Area (AAA) at Cheltenham for stable patients with certain conditions. The AAA is located away from ED but is intended as a base where medical reviews of patients can still take. The medical cover is provided by the acute medical teams covering Cheltenham wards.

The revised clinical protocols with the AAA have enabled 241 patients to be treated in Cheltenham rather than transferring out of hours to GRH.

Figure 2. ED attendances by site (2013/14 represented by bars and 2014/15 represented by dashes)

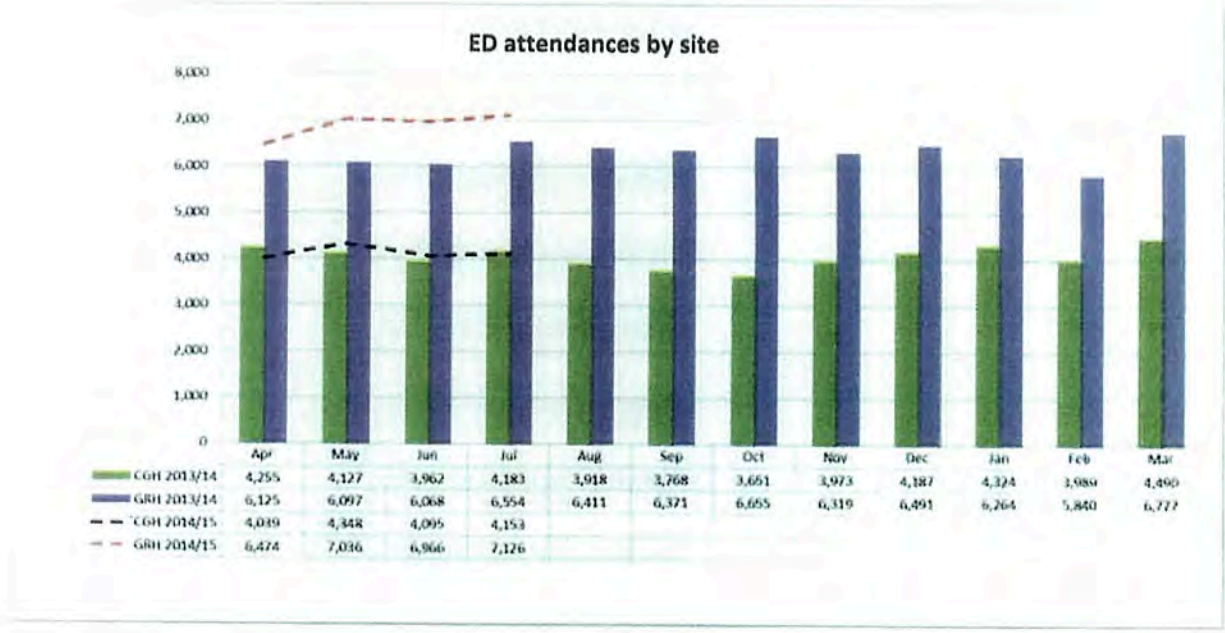
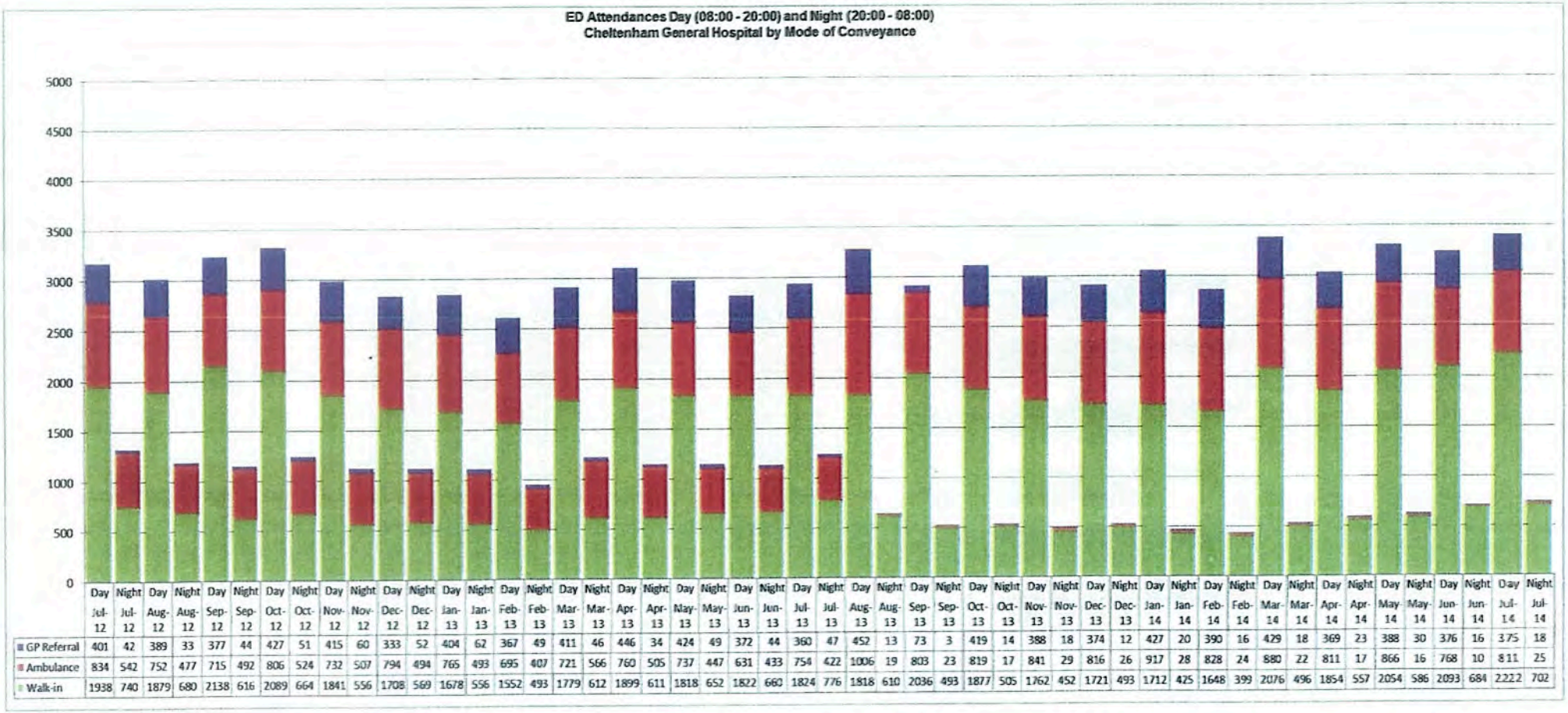


Figure 2 above shows that ED attendances at CGH in 14/15 (black dashed line) have remained close to the same level of where they were prior to the change, with an initial dip in August September and October 13/14. Overall there has been a rise in attendances at GRH in 14/15 (red dashed line).

4.3. Were predictions about the number of patients likely to be affected correct?

GHFT predicted that on average 16 patients a night (between 8pm and 8am) would be taken to GRH by ambulance instead of going to CGH and this is supported by a review of data since the changes happened. 16 additional patients a night over the course of a year totals an anticipated 5,840 additional patients. In reality, GRH saw less than that – an additional 4,948 (comparing the same period, Aug 12-Jul13 with Aug 13-Jul14). This shift in ambulance attendances to Gloucester from Cheltenham is illustrated in figure three below where the shift can be seen taking place from August 2013 (as the red part of the bar reduces at Cheltenham and increases at Gloucester).

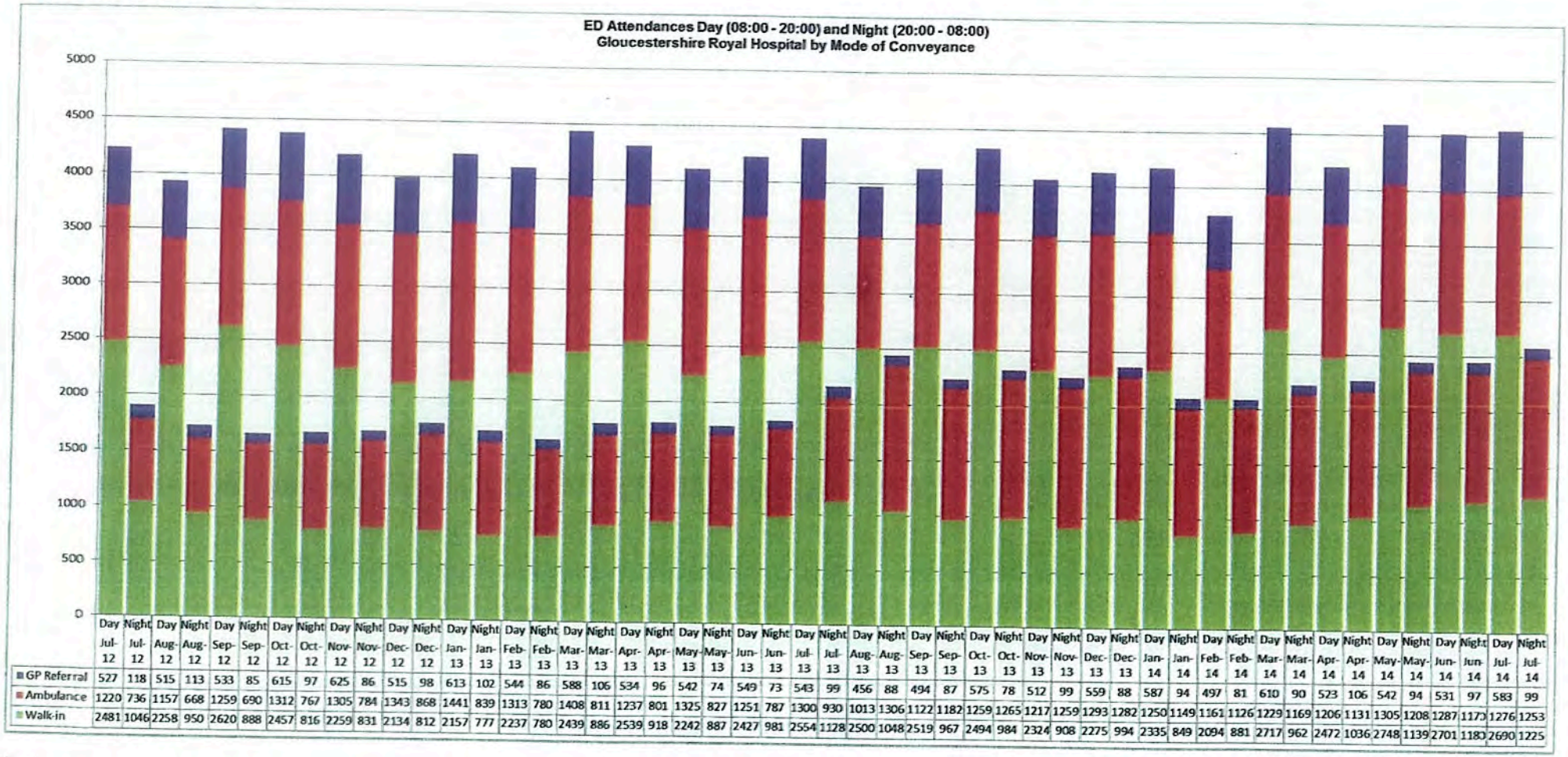
Figure 3. ED attendances at Cheltenham and Gloucester EDs by Means of Arrival



	Day Jul-12	Night Jul-12	Day Aug-12	Night Aug-12	Day Sep-12	Night Sep-12	Day Oct-12	Night Oct-12	Day Nov-12	Night Nov-12	Day Dec-12	Night Dec-12	Day Jan-13	Night Jan-13	Day Feb-13	Night Feb-13	Day Mar-13	Night Mar-13	Day Apr-13	Night Apr-13	Day May-13	Night May-13	Day Jun-13	Night Jun-13	Day Jul-13	Night Jul-13	Day Aug-13	Night Aug-13	Day Sep-13	Night Sep-13	Day Oct-13	Night Oct-13	Day Nov-13	Night Nov-13	Day Dec-13	Night Dec-13	Day Jan-14	Night Jan-14	Day Feb-14	Night Feb-14	Day Mar-14	Night Mar-14	Day Apr-14	Night Apr-14	Day May-14	Night May-14	Day Jun-14	Night Jun-14	Day Jul-14	Night Jul-14
GP Referral	401	42	389	33	377	44	427	51	415	60	333	52	404	62	367	49	411	46	446	34	424	49	372	44	360	47	452	13	73	3	419	14	388	18	374	12	427	20	390	16	429	18	369	23	388	30	376	16	375	18
Ambulance	834	542	752	477	715	492	806	524	732	507	794	494	765	493	695	407	721	566	760	505	737	447	631	433	754	422	1006	19	803	23	819	17	841	29	816	26	917	28	828	24	880	22	811	17	866	16	768	10	811	25
Walk-in	1938	740	1879	680	2138	616	2089	664	1841	556	1708	569	1678	556	1552	493	1779	612	1899	611	1818	652	1822	660	1824	776	1818	610	2036	493	1877	505	1762	452	1721	493	1712	425	1648	399	2076	496	1854	557	2054	586	2093	684	2222	702

(Where a GP has referred but the patient has arrived by ambulance, they have been counted in the ambulance figures).

Figure 3 continued.



	Day Jul-12	Night Jul-12	Day Aug-12	Night Aug-12	Day Sep-12	Night Sep-12	Day Oct-12	Night Oct-12	Day Nov-12	Night Nov-12	Day Dec-12	Night Dec-12	Day Jan-13	Night Jan-13	Day Feb-13	Night Feb-13	Day Mar-13	Night Mar-13	Day Apr-13	Night Apr-13	Day May-13	Night May-13	Day Jun-13	Night Jun-13	Day Jul-13	Night Jul-13	Day Aug-13	Night Aug-13	Day Sep-13	Night Sep-13	Day Oct-13	Night Oct-13	Day Nov-13	Night Nov-13	Day Dec-13	Night Dec-13	Day Jan-14	Night Jan-14	Day Feb-14	Night Feb-14	Day Mar-14	Night Mar-14	Day Apr-14	Night Apr-14	Day May-14	Night May-14	Day Jun-14	Night Jun-14	Day Jul-14	Night Jul-14
GP Referral	527	118	515	113	533	85	615	97	625	86	515	98	613	102	544	86	588	106	534	96	542	74	549	73	543	99	456	88	494	87	575	78	512	99	559	88	587	94	497	81	610	90	523	106	542	94	531	97	583	99
Ambulance	1220	736	1157	668	1259	690	1312	767	1305	784	1343	868	1441	839	1313	780	1408	811	1237	801	1325	827	1251	787	1300	930	1013	1306	1122	1182	1259	1265	1217	1259	1293	1282	1250	1149	1161	1126	1229	1169	1206	1131	1305	1208	1287	1173	1276	1253
Walk-in	2481	1046	2258	950	2620	888	2457	816	2259	831	2134	812	2157	777	2237	780	2439	886	2539	918	2242	887	2427	981	2554	1128	2500	1048	2519	967	2494	984	2324	908	2275	994	2335	849	2094	881	2717	962	2472	1036	2748	1139	2701	1180	2690	1225

(Where a GP has referred but the patient has arrived by ambulance, they have been counted in the ambulance figures).

4.4. Have the waiting times in Emergency Departments improved?

Performance indicators show how long people wait in EDs and give an understanding of how well they are dealing with demand.

Cheltenham General Hospital achieved the 4 hour target 11 of the 12 months since the changes (just missing in February 2014 with 94.37%) which is a significant improvement on previous years. There are ongoing challenges to achieving the four hour performance target at Gloucestershire Royal Hospital which is being improved through a rigorous action plan and a new system-wide Resilience Group with Chief Executive leadership.

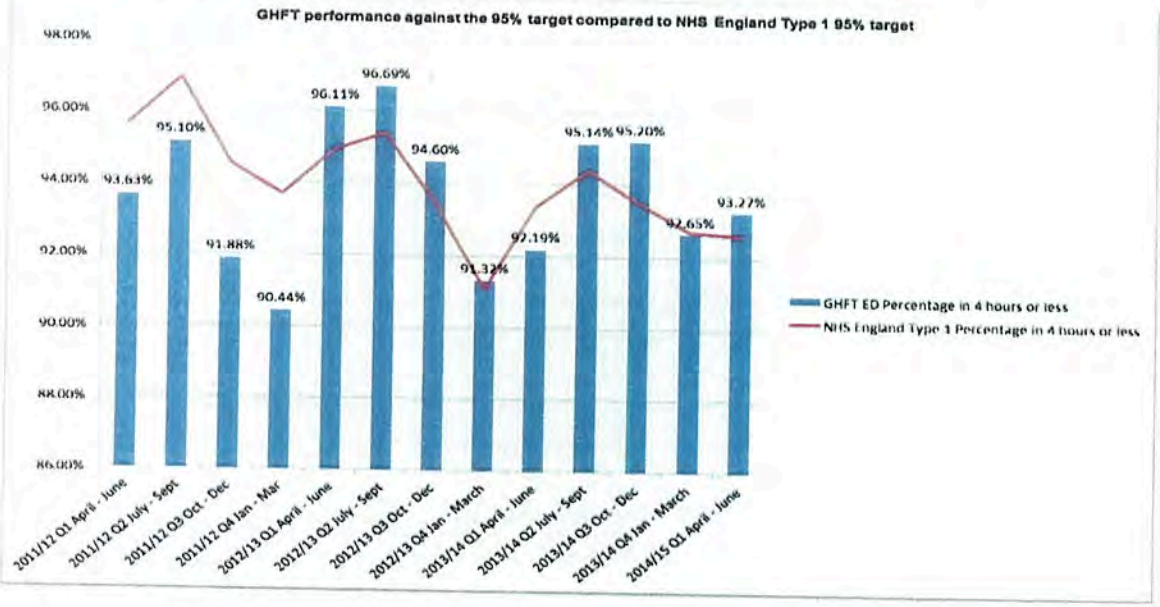
Figure 4. Percentage of patients admitted or discharged within 4 hours (2011/12 - 2014/15)

ED Site	Apr 2013	May 2013	Jun 2013	Jul 2013	Aug 2013	Sep 2013	Oct 2013	Nov 2013	Dec 2013	Jan 2014	Feb 2014
CGH	89.92%	92.54%	95.41%	93.40%	97.24%	97.90%	98.22%	97.31%	97.57%	95.86%	94.37%
GRH	91.33%	90.83%	93.66%	95.45%	93.71%	94.44%	94.43%	93.26%	93.81%	93.18%	90.65%
Total	**90.75%**	**91.52%**	**94.35%**	**94.65%**	**95.05%**	**95.73%**	**95.77%**	**94.70%**	**95.11%**	**94.15%**	**92.00%**

ED Site	Apr 2014	May 2014	Jun 2014	Jul 2014
CGH	97.60%	96.88%	97.14%	95.93%
GRH	91.69%	91.43%	90.09%	89.45%
Total	**93.81%**	**93.39%**	**92.64%**	**91.83%**

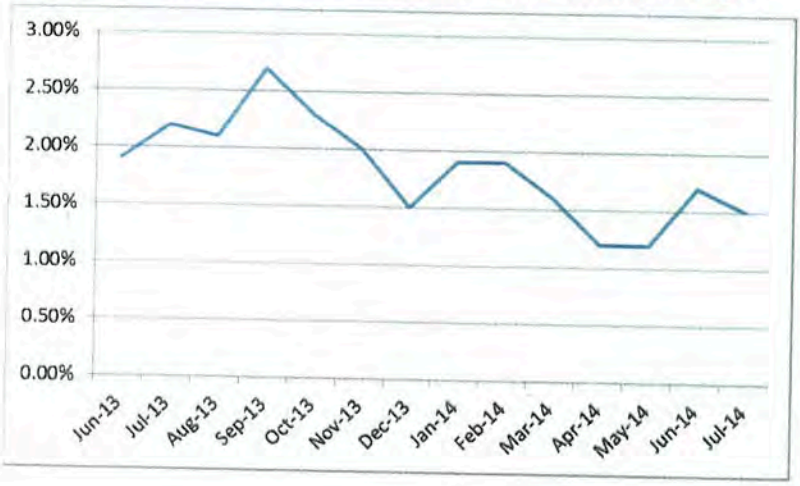
It is important to note however that when reviewed in comparison to national ED performance Gloucestershire is on a par with national peers.

Figure 5. GHT ED performance against national average 2011-2014



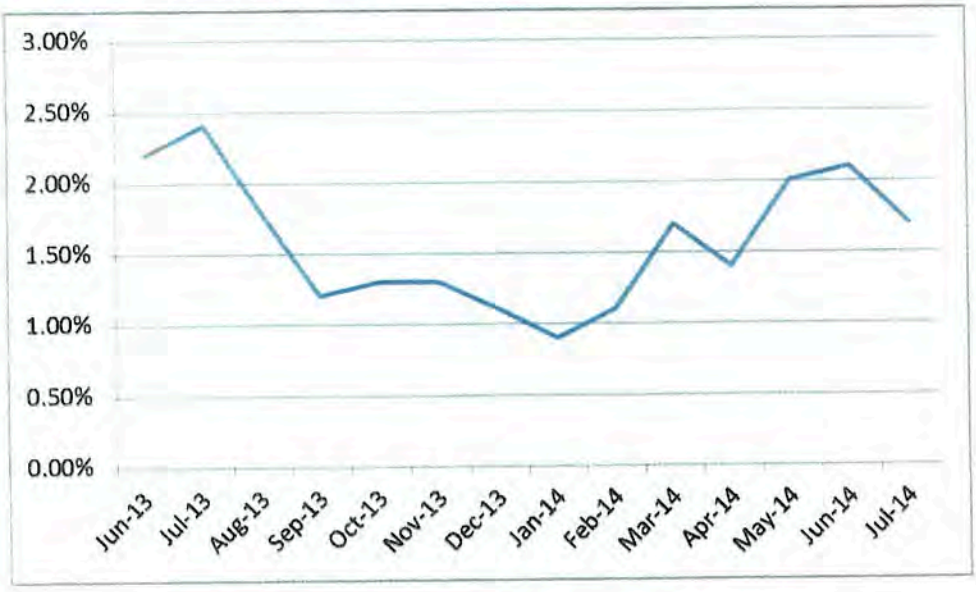
Another key target is to have below 5% of attendances re-attend the ED within 7 days. As can be seen from Figure 6 below, this performance has been improving consistently since the reconfiguration.

Figure 6. Unplanned re-attendance at ED within 7 days



Another key measure focusses on the percentage of patients that leave ED without being seen. As can be seen from Figure 7 below, this initially decreased significantly and then increased again during the time of peak pressures in early 2014, before decreasing again.

Figure 7. Percent of patients that leave ED without being seen



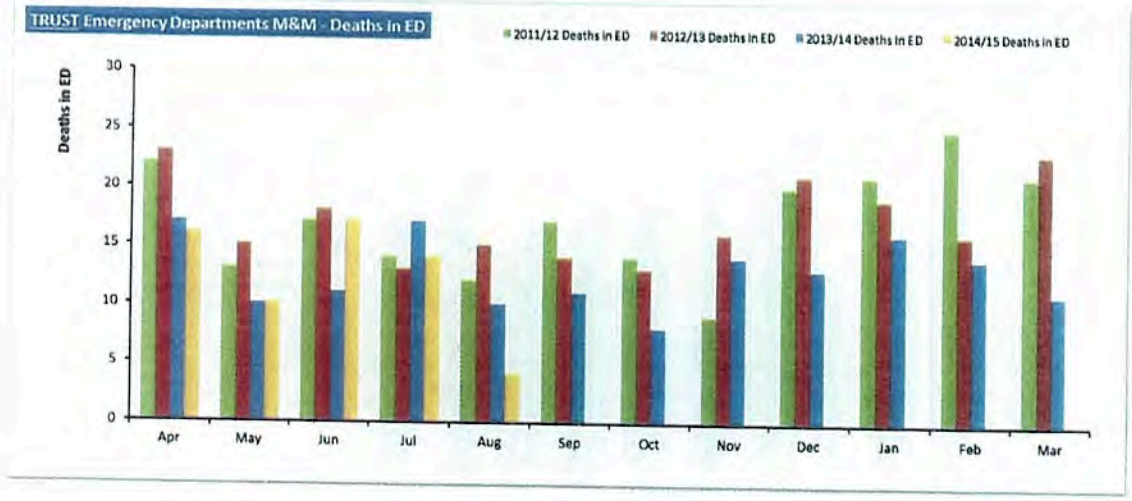
Whilst performance measures such as these are important, quality of care is the key driver of the changes and as such is investigated in more detail below.

4.5. Have the quality of care and clinical outcomes improved?

The key rationale for the reconfiguration when it was introduced in July 2013 was to improve the quality of care that patients received particularly to ensure they were seen and treated by a sufficiently senior doctor. Therefore measures such as complaints, mortality and patient satisfaction are pivotal in understanding if the change delivered its desired results.

The HCOSC, on supporting the reconfiguration, made it a condition that mortality and clinical quality were monitored. To this end, there are regular Morbidity and Mortality Reviews undertaken of any deaths in the Emergency Departments. These have found no emerging concerns since the reconfiguration. Mortality figures year on year are outlined in Figure 8 below, which shows a general trend since August 2013 of fewer deaths per month – in only one month (June 2014) were they higher than the same month in the preceding year. The number of deaths can fluctuate dramatically due to the relatively small numbers involved.

Figure 8. Mortality data for GHT EDs (August 2014 data goes up to 8th)



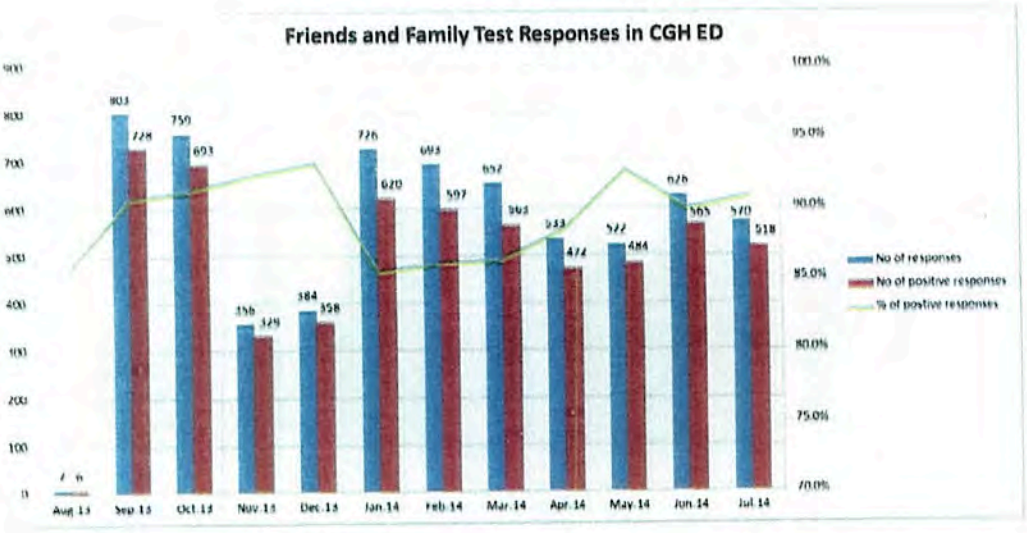
4.6. What has the patient experience been like?

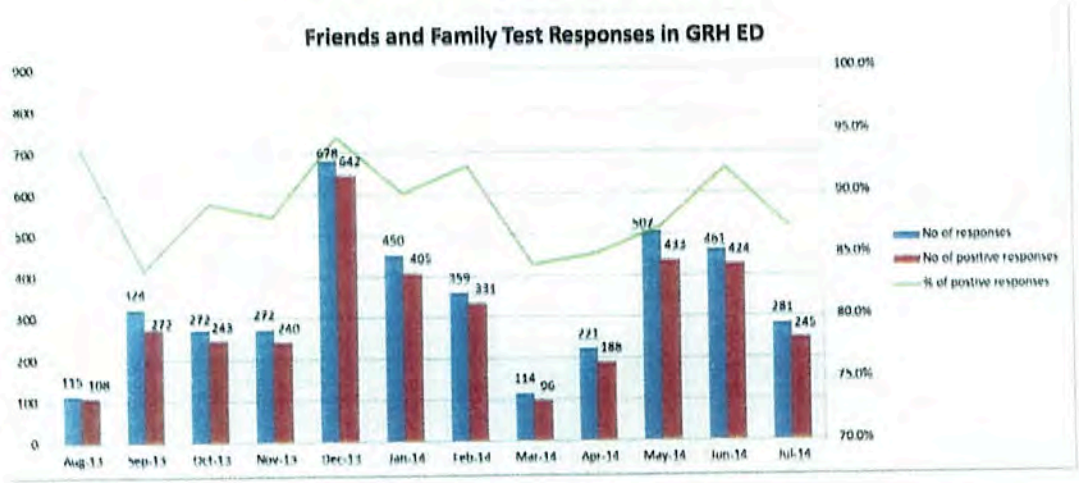
Patient experience is monitored through a number of measures including complaints, compliments, queries to the Patient Advice and Liaison (PALs) service and also through the results of the Friends and Family Test each of which are reviewed below.

4.6.1. The Friends and Family Test

The Friends and Family Test asks patients who have attended the Emergency Department whether they would recommend the Department to their Friends and Family. The results of the Friends and Family Test (which was rolled out in July 2013) are detailed in the table below and show fairly consistent performance and do not evidence deterioration in experience at either site post-reconfiguration. These measures continue to be monitored monthly to ensure patient experience is maintained on both sites.

Figure 9. Friends and Family Performance CGH and GRH





4.6.2. Complaints and queries

The graphs below show the actual number of complaints, concerns and compliments received for the Emergency Division for this and last year along with the monthly average (taken from the last financial year's total). As can be seen from these graphs, the number of complaints are consistently lower than the preceding year, whilst the number of compliments are on the increase. Key trends in the complaints and concerns involve lost property, staff attitude and wait for treatment.

Figure 10. Emergency Care Concerns by month

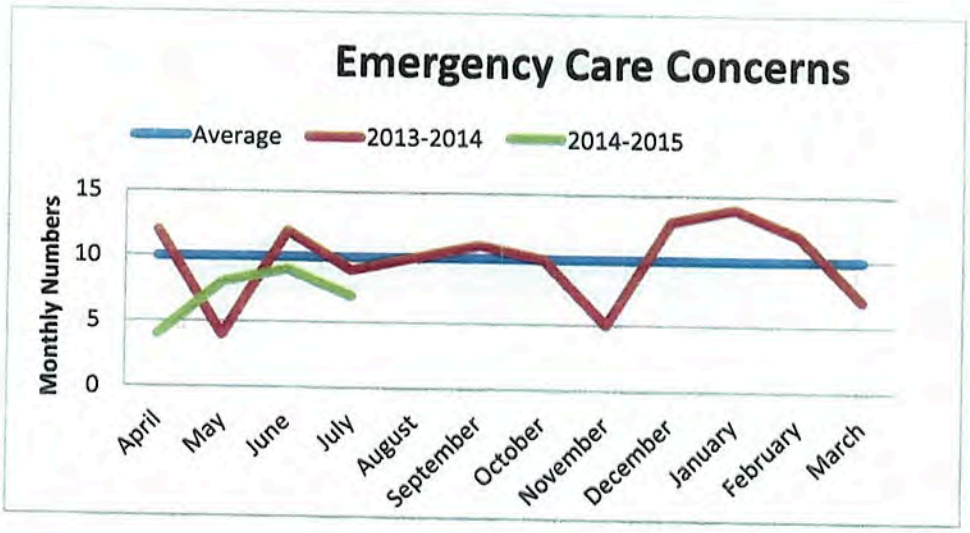


Figure 11. Emergency Care Complaints by month

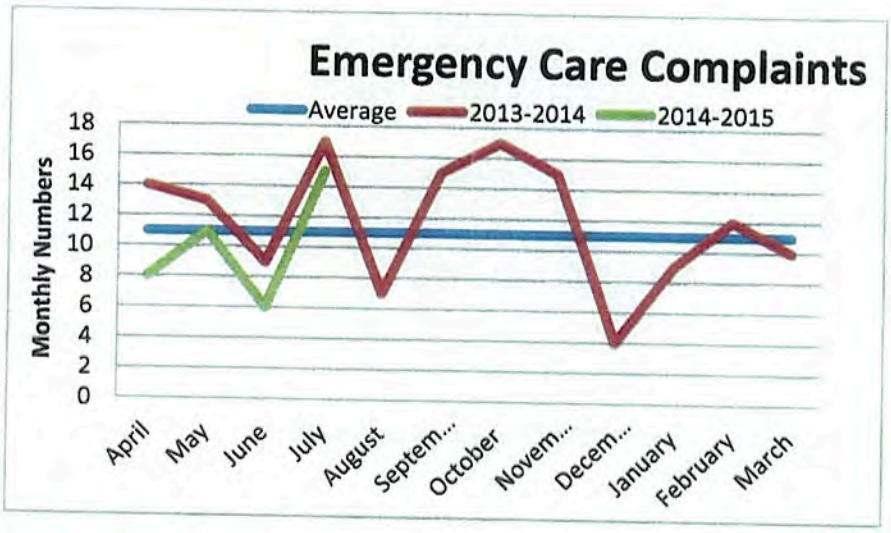
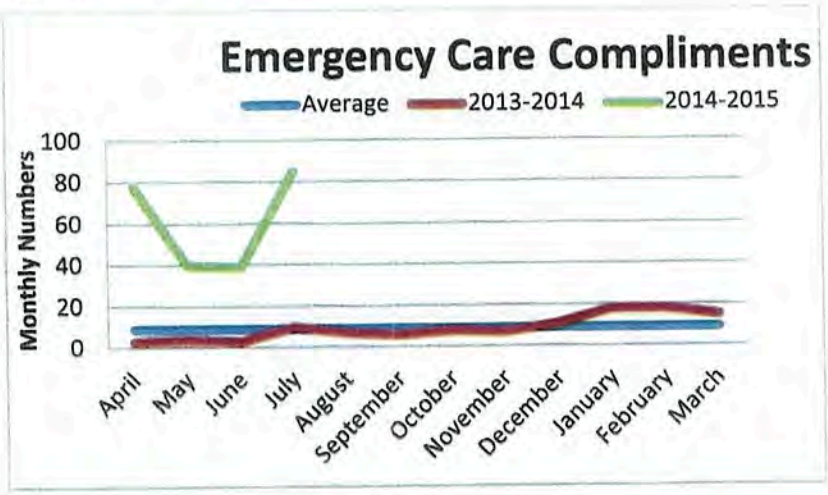


Figure 12. Emergency Care Compliments by month



4.6.3. Healthwatch Gloucestershire feedback

In drawing up the twelve month review of the service reconfiguration, Healthwatch Gloucestershire undertook a detailed review of feedback received pre- and post-reconfiguration. This review informed the workshop and the content of this report. In their report (attached as Appendix A) they make a number of key observations that have been used to inform changes:

- the absolute number of comments is small and focuses less on the reconfiguration and more on the quality of care in ED
- There have been some comments (four) regarding the distance/time to get to hospital from the North Cotswolds
- Waiting time is the main source of comment
- There is public confusion about what changes have happened at Cheltenham and generally in terms of what care is available in the county
- There is a need to communicate clearly across all partners about what services are available and how to access them

4.6.4 Feedback received by GCCG

In addition to the Healthwatch Gloucestershire report, GCCG reviewed patient and public feedback received about the reconfiguration. Despite attending a number of events and 'drop in' Information Bus sessions in the centre of Cheltenham during the last six months, GCCG received little specific feedback on the reconfiguration in the last six months. The only concern noted was from a member of the public who raised concern about the level of urgent care provision in North Cotswolds over weekends and asked for Cheltenham to 'remain open at night'. In addition the REACH (Restore Emergency At Cheltenham Hospital) campaign was launched by Cheltenham Chamber of Commerce. The REACH website states that it is working with local businesses, local residents and other campaign groups such as 38 Degrees and Stroud Against the Cuts to achieve the following objective:

"To have a fully functioning, fully staffed A&E Department operating 24/7 re-instated at Cheltenham

General Hospital, which serves a population of at least 200,000 in Cheltenham, Tewkesbury Borough and the North Cotswolds, at the earliest possible opportunity."

The focus of the REACH campaign is to secure the re-establishment of a full 24/7 Accident and Emergency department at Cheltenham General Hospital to serve the people of that town and the surrounding districts of Gloucestershire.

4.7. Have the changes impacted on the Ambulance Trust?

At the point of approving the plan, some concerns existed that by sending patients out of hours by ambulance to Gloucester instead of Cheltenham, there may be extra pressures put on the ambulance service that would impact adversely on patient care or performance. This section explores the impact of the reconfiguration on three areas: diverts, transfers, and increased journey time.

Before the detailed analysis, it is important to note SWAST report there have been no adverse incidents involving patients being taken to Gloucester from areas around Cheltenham.

4.7.1. Journey Time

Due to some patients being taken to GRH rather than CGH out of hours, there is an increase in journey time for ambulance journeys from particular areas of the county. As part of the six and twelve month review workshops this issue was discussed with SWAST, who felt that, given the significant number of factors affecting the ambulance trust including weather, patterns of demand and new models of care, this change was not significant enough to affect adversely ambulance performance.

4.7.2. Diverts

In the months immediately following reconfiguration, the ambulance service reported issues with prolonged diverts between sites. Diverts are where patients are taken to a different hospital due to capacity problems at the other hospital – either in the ED of that hospital or due to a shortage of beds. SWAST now report that the number of diverts has reduced and that there is no adverse impact seen on the ambulance service that is considered as significant. Some diverts still continue at a much lower level but these are recognised as a usual part of an acute hospital running over two sites. The increase in diverts during January and February 2014 that can be seen below were due to an outbreak of Norovirus at GRH, which prevented them receiving the usual number of patients.

Figure 13. Diverts from GRH to CGH by month

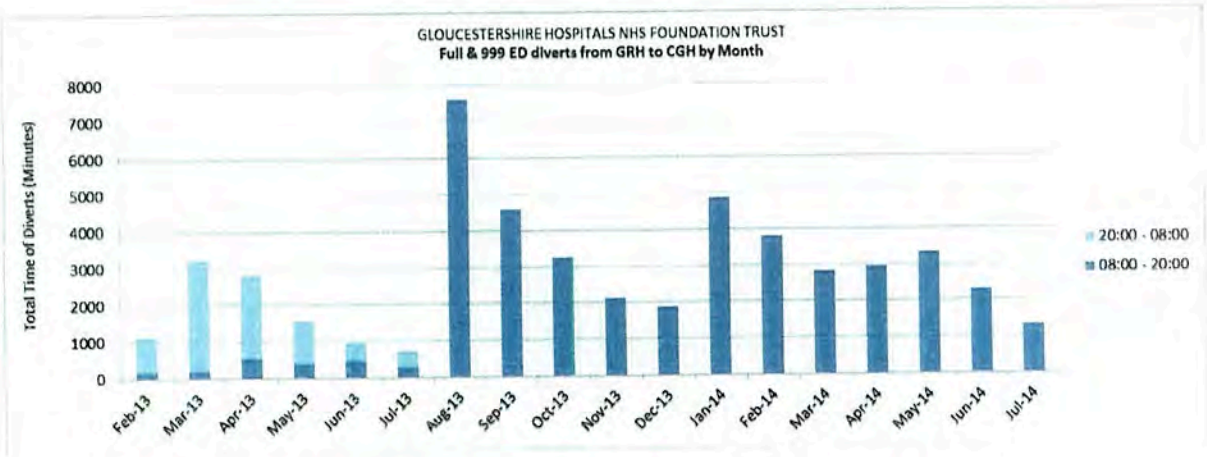
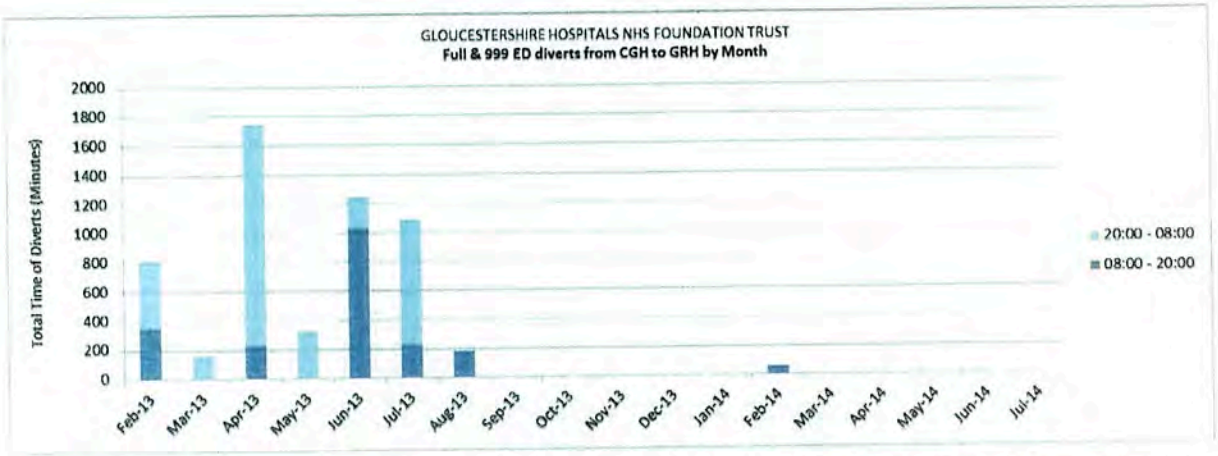


Figure 14. Diverts from CGH to GRH by month

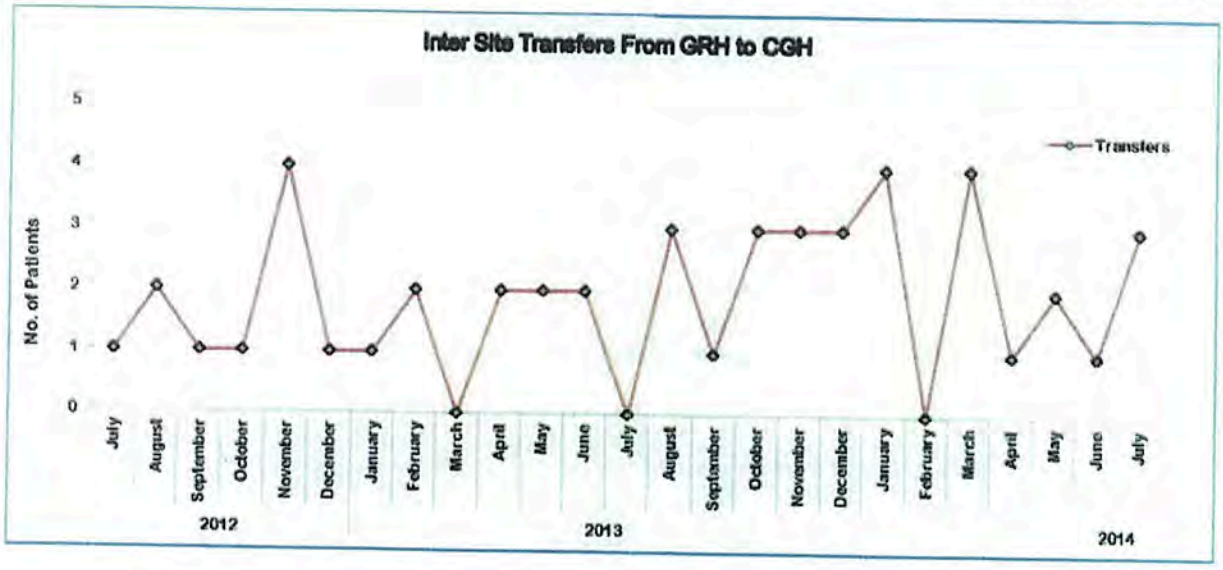


**Please note that the data for CGH to GRH diverts for September 2013 through to January 2014 and March – July 2014 is '0'.*

4.7.3. Transfers

A transfer is where a patient has received some treatment at one site and then requires transfer to another site for ongoing treatment or rehabilitation. As can be seen from the graph below, transfers from GRH to CGH have significantly increased following the reconfiguration. This has been due to a number of factors particularly around the need to transfer some patients appropriately to specialist services running at Cheltenham to ensure they are in the best ward possible for their ongoing care. Another issue is around bed capacity at GRH which, although it has improved since the reconfiguration, is still insufficient for the number of patients going to that site. GHFT is in the process of undertaking a comprehensive bed review to understand longer term changes to bed capacity needed on the Gloucester site and the impact the current configuration of specialties has on transfers.

Figure 15. Inter site transfers from GRH to CGH 2012 to date



5. Consideration of what went well during the reconfiguration and what could have gone better.

In the workshop discussion as part of the twelve month review, there was a reflection on what elements of the reconfiguration and review had gone well and which could have been improved in order to inform future changes. The following key points were noted as having proceeded well:

- The change had delivered real improvement in the quality of care for patients arriving at hospital at night via ambulance
- Doctors felt much happier and the training programme at GHT was no longer in danger
- There was a clear clinical case for change presented and communicated in the consultation document and supporting material and the reconfiguration was clinically led in its rationale
- There was strong cross-community effort to work in the best interests of patient care
- The reconfiguration itself passed without major operational issues and appears to have delivered against the majority of intended objectives
- The impact was as anticipated in terms of numbers of patients affected
- The change had been led through strong partnership working between GCCG, SWAST, and GHFT.

The following areas were also identified that could have been improved:

- Despite proactive and planned communication e.g. through media advertorial and consultation materials, some patients and members of the public perceived the change to be about the closure of CGH ED. This misunderstanding was supported in some media reporting and some messaging from campaign groups. Further communication from the local NHS may have ensured fewer people becoming concerned. As a result, following the

six month review of the change, further public information campaigns were undertaken to help reinforce the new service arrangements and address misunderstanding of the changes amongst some members of the public.

- There is an ongoing need to improve four hour performance at the Gloucester site and this forms a key element of work for the health community

6. Conclusion and future monitoring

- In conclusion, this 12 month review of the reconfiguration has found broadly that the change delivered the intended benefits. Specifically, it has found that whilst some patients raise concerns about travel time, the feedback in the last six months has been minimal.
- Concerns persist around the number of diverts and transfers and these are now monitored by the health community to ensure they are kept as low as possible.
- Mortality in both CGH and GRH Emergency Departments appear to have reduced, although the numbers are small. The number of complaints about ED has reduced.
- GHFT's junior doctor training has been assured and the satisfaction and supervision of junior doctors is now much improved.
- Recruitment of emergency doctors continues to be extremely challenging. The reconfigured night time rotas covering one ED are less onerous on doctors and this has led to improved recruitment but current levels are still below establishment.
- There is a perception amongst some in the community that Cheltenham ED has shut either completely or during the out of hours period; which is inaccurate. Ongoing communication is needed to raise awareness amongst the public that people can attend Cheltenham out of hours and that only ambulance journeys are affected by the reconfiguration. This should be led by GHFT, supported by GCCG and other partners such as the Council to minimise unnecessary concern and inappropriate demand on GRH.

The ongoing performance of ED at both sites and of the Urgent Care System in Gloucestershire will now be monitored via the newly established System Resilience Group, which will include Chief Executives from key organisations and importantly, patient representatives and the Director of Adult Social Services from Gloucestershire County Council. This group will be responsible for monitoring key performance indicators including those above and ensuring decisive action is taken on areas of concern.

Appendix A: Healthwatch Report to the Reconfiguration Workshop

Report from:

Claire Feehily

Chair, Healthwatch Gloucestershire **1 August 2014**

Twelve Month Review of Reconfiguration Workshop

Summary of comments from August 2013 – June 2014

We have examined individual comments received by Healthwatch Gloucestershire; issues raised in public meetings and engagement events, and themes from partner meetings. All public comments have been shared, verbatim, with CCG and relevant partners as part of our quarterly circulation of information. In turn, such comments have been incorporated within the CCG and provider Trusts' arrangements for considering patient experience of services.

Specific comments

The average number of comments received each month by HWG relating to emergency departments rose by around 30% through the period from July 2013-June 2014. (36 in approx 6 months July - late Jan; 40 in approx 5 months late Jan – June 2014)

The quantity and percentage of comments relating to long waiting times is increasing. 11% (4 of 36) of the comments received from July 2013-January 2014 related to long waiting times; this percentage increased to 25% (10 of 40) for the period of 21 January – 30 June 2014. 20% of these comments (2 of 10) related to waiting times that were for four hours or more.

Overall, for the whole of the period, 18% of comments (14 of 76) related to long waiting times. 5% (4 of 76) of comments related to the distance patients have had to travel in an emergency, particularly from the North Cotswolds area.

General points:

The absolute number of comments has been small. Generally, the focus of comment is less about the reconfiguration between hospital sites than concerns about the quality of experience within the ED service. There has been a small amount of commentary about travelling distance from North Cotswolds. Waiting times is the single biggest theme that is raised and it is increasingly the focus of comments in the second six months when we received specific feedback about waits in excess of 4 hours.

Our sense is that there continues to be public confusion about the status of ED in Cheltenham and we regularly hear incorrect descriptions from the public about the services that are available there. Reconfiguration is also conflated with other speculative comments about the future of Cheltenham and of community hospital services.

This fits with broader patterns of confusion about where the public ought to go for specific types of care and uncertainty about the precise treatment boundaries for primary / community hospital and acute hospital settings

We also have examples where NHS 111 advice on these boundary issues has been confusing or appears to have been wrong.

The problem has perhaps been compounded by "renaming" types of care that the public may know by other names: "reablement"; "rapid response"; "integrated community teams" are terms whose precise meaning may be well understood within the health and care system, but there is a need to improve clarity for the public. Public information appears at times to be fragmented between different providers' websites, leaflets etc, and "in the moment" when people need to make a decision about where to go for treatment, it can be difficult to be certain, especially when GP advice is unavailable.

Our feedback to CCG and providers has been to confirm the need for more coordinated, system-wide clarification of the range and purpose of specific types of provision and their availability in particular places. Thought should be given to where and how to locate, repeat and reinforce such communication messages for different audiences. There has been a very positive reaction to the recent radio coverage for the Hospital Trust. Perhaps system-wide communication could be further developed through this medium.

Claire Feehily

Chair, Healthwatch Gloucestershire

1 August 2014

Appendix B - Comment regarding the 'future of two acute hospitals in Gloucestershire: Cheltenham General Hospital and Gloucestershire Royal Hospital'.

HCOSC members have identified that there remain, amongst some members of the local population, residual concerns regarding the future of the two acute hospitals in the county.

We recognise that these changes to the emergency pathway have led some people to be concerned about the future of our two main hospitals, and Cheltenham General Hospital in particular.

Having two main hospital sites presents both an opportunity and a challenge in moving forward. The two sites offer local access to the largest centres of population in the county and engender a significant degree of local ownership. Providing services on two sites rather than one inevitably leads to duplication of services.

There is a clinical and managerial consensus that the quality and efficiency of our services would improve if we were able to concentrate all services requiring specialist, staff, facilities and equipment onto a single site however this is not an option for the following reasons:

- The cost of building a new hospital is unaffordable in both capital and revenue terms. (Capital £600m: revenue £50m based on a PFI model)
- The greater part of the current assets at Cheltenham and Gloucester (£191m of a total asset value of £228m) would in effect be written off
- Concentration of all acute services in one place – whether on a new site or one of our existing sites – would create major planning problems particularly in relation to public access and traffic management
- Neither of the existing sites is large enough to accommodate the current or predicted demand for services

As a consequence we are committed to developing both of the existing sites with appropriate clinical specialisation on each. This commitment is reflected in a balanced portfolio of investment on both of the hospital sites, including a state of the art interventional radiology theatre to support the specialist vascular service at CGH, investment in a surgical robot to support the specialist urology service at CGH and refurbishment of the theatres on the CGH site.

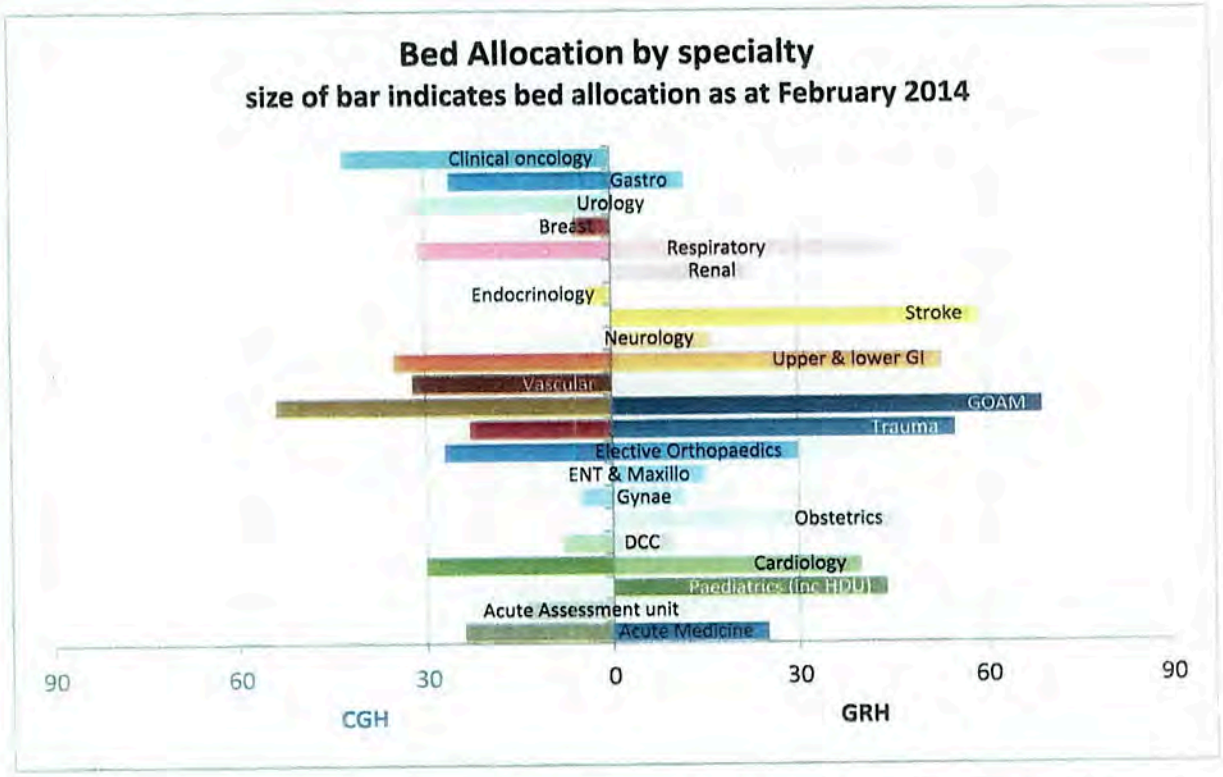
The drive is to deliver services closer to peoples' homes, whenever it is safe and efficient to do so. This means that we will continue to look for opportunities to develop community services, either by delivering them in communities ourselves or supporting others to do so.

There is also a need to respond to new national clinical and patient safety and quality standards. For example, in the recent past clinicians providing stroke services in Gloucestershire put forward proposals for change to the way services could be delivered locally. The stroke clinical teams had recognised that, for those services such as Stroke, which rely upon very specialised staff or equipment, it may not be possible to replicate services in multiple locations whilst maintaining the quality and safety of those services. Following a period of consultation with the public and HCOSC,

these changes to Stroke services were implemented and have delivered the expected improvement in outcomes for patients.

The Trust encourages all clinical teams to take into account the changing context in which they operate. They are encouraged to generate ideas for improvements in quality. A key influence on these discussions going forward will be the outcome of the next stage of the national Urgent and Emergency Care Review led by Sir Bruce Keogh, Medical Director NHS England.

Both Gloucestershire Royal and Cheltenham General Hospitals are vibrant general hospitals. The strategic intention is to preserve both hospitals as facilities for the local population whilst implementing a programme of centralisation of the most specialised services. The graphic below shows the current distribution of services between our sites.



The driver for centralisation of services in every case has been clinically led focussing on the need to maintain or improve the quality and safety of service and outcomes for patients.

Gloucestershire NHS
Health Community

Your NHS Right Care, Right Time, Right Place

2013

Short Guide

Proposals for change

Maintaining high quality, specialist services

You can also feedback online at: www.nhsglos.nhs.uk. Deadline for responses 3 May 2013.

Maintaining high quality, specialist services

The need for change

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

We are committed to providing as many services as possible close to the patient's home, but where very specialist care is needed in the larger hospitals, we continue to look at how best to organise services to maintain quality, ensure safety of patients and achieve the best possible health outcomes for these individuals.

Feedback from local people in 2012 on the Health and Social Care Community's five year Strategy for Care: 'Your Health, Your Care' showed a high level of support for our vision for services in the future. This included:

- Supporting people in their communities – further development of joined up (integrated) community teams to support people in their own homes, including GPs, as well as social care, nursing and physiotherapy
- Development of a 'co-ordinator' role to support people with long term conditions and ensure they receive the advice, support and services they need.

These, and other developments, will help to reduce the traditional reliance on hospital based services.

There was also strong support for maintaining high quality specialist health services in the county.

During the 2010 and 2011, 'Your NHS' engagement process, we put forward proposals for changes to major trauma services, stroke services, emergency paediatric (child) assessment and outpatient breast care services.

There was real recognition of the need for the changes put forward to make the most of the specialist staff, skills and equipment available in the county.

There are a number of benefits to this kind of change including:

- Bringing certain specialist staff together and reducing the risk to patients by having robust medical cover at all times
- Speeding up assessment for patients and decision making about their treatment and onward hospital care
- Improving the links between related services to improve the patient experience and make services more joined up
- Improving the patient environment and developing services and facilities

that are better suited to the needs of the patient

- Clinicians seeing enough patients to maintain their skills. The more frequently a doctor performs a particular treatment or procedure the better the outcome for the patient
- Ensuring consistency of care 24 hours a day, 7 days a week.

Local history of service change

Gloucestershire has a history of successful site and service changes for specialist hospital services. This includes:

- Neutropenia Service (for people suffering severe side effects of cancer treatments) to Cheltenham General Hospital (CGH) 1994
- Interventional Cardiology Service (pinhole surgery for heart conditions) to CGH 1996
- Specialist Ear, Nose and Throat services to Gloucestershire Royal Hospital (GRH) 2000
- Ophthalmology (eye surgery) to CGH 2000
- Paediatric (child) inpatient care to GRH 2006
- Obstetrics (maternity services for women considered 'high risk' during pregnancy), neonatology (care for premature babies) and benign gynaecology (treatment of conditions related to the female reproduction system) to GRH 2011
- Inpatient Urology (treatment of urinary conditions and conditions related to the male reproductive system) to CGH 2011
- 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 Ischaemic Attack (mini strokes) to GRH 2012
- First outpatient Breast Care appointments for symptomatic patients, Thirlestaine Court, CGH 2012
- General and Old Age Medicine (GOAM) – both sites 2012.

There is also a commitment to centralise inpatient vascular surgery (surgery to treat conditions in arteries and veins) to CGH in 2013.

These changes have resulted in bringing together specialist expertise and have improved outcomes for the patient.

For example, since the recent centralisation of Stroke and TIA services, the Hospitals Trust now consistently meets quality of care targets, which were frequently unachievable before.

2013

We have new proposals for change in 2013 to the following services:

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

Each of the proposals has been developed by clinicians working within the services and managers.

As well as this short guide, we have also developed a full engagement booklet, which contains more detailed information (see end of this guide for details on how to read a copy).

Principles

Throughout this guide (and the full engagement booklet) you will see the following symbols that highlight important principles that local clinicians and managers believe are key to the development of services. These symbols represent:


Alternatives to hospital admission


Clinical Benefit


Improving Access and Reducing Unnecessary Delays


Improving Health Outcomes


Patient Safety

Value for Money.

Feedback

We would value your feedback on the proposals described in this guide and we would encourage you to read the full engagement booklet.

You can share your views by completing the Feedback Form at the back of either booklet or you can visit the 'Your NHS' web page at **www.nhsglos.nhs.uk**.

The web page also includes information on a series of Public Drop In events, which will be held over the next few months at locations across the county. You will be able to find out information and talk to NHS representatives about the proposed changes. You can also speak to someone about the events by calling: 0800 015 1548.

Proposals for change

Proposal 1: Emergency and urgent medical care

Our priority is to ensure that the sickest patients are seen by very skilled specialist staff when they need to be.

To do this, we need to ensure that those specialist staff are available to respond to patients and the public 24 hours a day, 7 days a week.

The Hospitals Trust is facing increasing pressures as nationally, recruitment into emergency medicine remains extremely challenging.

Despite numerous attempts, the Trust has not been able to recruit close to the number of recommended doctors in emergency medicine (emergency care consultants and 'middle grade' doctors) it needs to maintain services the way they are currently set up in the county.

From August 2013, there is no guarantee that the Trust will have the number of doctors they currently have so they need to plan responsibly to ensure patient safety.

The changes we are proposing to make at this time relate to services at Cheltenham General Hospital (CGH), at night time only.

Night time is the time when medical staffing levels are the most difficult to deliver and it would be particularly beneficial to bring specialist emergency medicine doctors together on one site.

As part of the proposal, the Emergency Care Centre (within the current Emergency Department) at CGH would be run at night by specially trained nursing staff who are capable of treating the vast majority of walk-in patients.

Doctors (Acute Physicians) would continue to be on site at CGH to receive patients who had previously been reviewed by a GP. However, patients with a critical illness and injury who need treatment from emergency medicine doctors would go to Gloucestershire Royal Hospital (GRH) at night.

If a patient with a critical illness or injury arrives as a 'walk-in' at CGH, they will be assessed in the Emergency Care Centre, receive initial treatment and a decision will be made on whether they can be admitted in to hospital (CGH) under the care of an Acute Physician (Doctor) or transferred by ambulance to GRH.

With this proposal as a whole, the vast majority of patients would continue to access services in the way they do now.

Based on current planning, it is estimated that on average around 16 patients with critical illness or injury would be diverted from CGH to GRH at night time.

By bringing together specialist emergency medicine staff at GRH at night time, the Trust will be able to ensure:

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

The reason for concentrating our resources at GRH at night rather than CGH, is due to the critical links to other services which are based there, such as children's services, high risk maternity services and stroke care.

> "We believe this proposal strikes the right balance between providing excellent specialist clinical care in an emergency and maintaining local access to services whenever possible."
>
> **Emergency Medicine (A&E) Consultant, Dr Tom Llewellyn**

Proposal 2: Selected Medical Specialties

These proposals relate to the following specialist medical services:

Gastroenterology and hepatology – care of patients with problems with their digestive system and/or liver

Cardiology – care of patients with heart problems

Respiratory (or thoracic) medicine – care of patients with breathing and lung conditions such as Chronic Obstructive Pulmonary Disease (COPD), commonly referred to as emphysema.

Currently, both inpatient (when patients stay in hospital) and outpatient (when patients have treatment or see a specialist and then return home) services for these medical specialties are provided at both Cheltenham General Hospital (CGH) and Gloucestershire Royal Hospital (GRH).

The interventional cardiac investigations service (pinhole surgery for heart conditions) is based at CGH only, in the Hartpury Suite.

These proposals, summarised below, do not include centralising any of the

services completely and do not apply to outpatient services which would remain the same as they are today.

Gastroenterology

- The 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 their gastrointestinal tract (gut) and other critical conditions in a single emergency bay at GRH.
  This will free up beds at GRH for increased emergency medicine and trauma cases and retain the key parts of the gastroenterology service required there for those emergencies. Concentrating the majority of beds at CGH will support the bringing together of specialist expertise.

Cardiology

- The proposal is to improve the facilities in the county's cardiac intervention unit at CGH by providing more beds in the unit, which will reduce the delays to patients needing these complex procedures.

  The Trust would also be able to improve the patient experience through more privacy and dignity for patients as the extended unit would have separate male and female facilities.

Respiratory Medicine

- The proposal is to concentrate the service for the majority of long term respiratory conditions (e.g. lung cancer or lung disease) at CGH. A number of beds would be required at GRH for patients with emergency respiratory conditions, such as those requiring ventilation.

  This will free up beds at GRH for increased emergency medicine and trauma cases and retain the key parts of the respiratory service required there for those emergencies. Concentrating a greater proportion of beds at CGH will support the bringing together of specialist expertise.

> "It's an opportunity to further improve the quality of care for our patients and develop a leading edge service by bringing together specialist skills and expertise."
>
> **Consultant in Thoracic (Respiratory) Medicine, Dr Ananthakrishnan Raghuram**

The doctors and nurses providing these services have identified opportunities to improve quality of care by bringing together the specialist staff skills currently split across sites.

The proposals are also in response to the proposed changes for emergency and urgent medical care.

Since the number of emergency patients going to GRH is likely to increase as previously described, other services will need to adjust to ensure there is the space available to meet the needs of these patients.

The changes to medical specialties will help us manage this increase by ensuring that patients with clearly diagnosed medical conditions are admitted directly to the relevant specialist team at CGH.

As well as these proposals, the NHS in Gloucestershire is also developing community services which are helping to reduce reliance on hospital services – providing care in the patient's own home or close to home.

This includes development of a Community Respiratory Team and there is also a comprehensive countywide service in place specialising in community cardiac rehabilitation and heart failure management.

Proposal 3: Paediatric Day Cases

This proposal relates to elective (non-urgent) care for children who need a test or procedure that doesn't involve an overnight stay in hospital, but which cannot be carried out during an outpatient appointment.

The service includes day surgery and procedures such as tests and infusions (delivering drugs by drip) and tests under sedation.

There are comprehensive outpatient services at Cheltenham General Hospital (CGH) and Gloucestershire Royal Hospital (GRH) for children to be assessed and receive the majority of simple tests, such as blood tests, which, under the proposals, would stay the same as they are today.

The proposal is that all elective (non-urgent) paediatric day case surgery (excluding ophthalmology) and medical investigations are based in a purpose designed paediatric day unit on the Gloucestershire Royal Hospital site.

We are proposing these changes for a number of reasons:

- There is a shortage of specialist doctors and nurses to care for children. Bringing together the day case services will ensure we have a sustainable model for the future, with consistent quality of care for all children and their families wherever they live in the county

- The Trust currently has a Care Quality Commission red rating against 2 standards. These relate to the number of surgeons and anaesthetists carrying out a small number of procedures/treatments per year on children aged 29 days to 12 years – the more frequently a clinician carries out a procedure or treats a particular condition, the better the outcome for the patient
- The proposal would reduce the need for children to travel after their operation if they needed specialist follow up care and an overnight stay
- The proposed new day unit would be staffed only by children's doctors and nurses and play specialists in a child and family friendly environment, totally separate from adult facilities
- It's an opportunity to establish a dedicated paediatric theatre with a dedicated paediatric team made up of surgeons, anaesthetists and nurses.

The majority of services for children in the county are based at GRH at the Children's Centre, including emergency and overnight inpatient care.

We believe it would be better for the new day unit to be on the same site, so that children don't have to travel after their procedure if there are complications. Locating the services together means we make the best use of scarce expert resources.

> "Bringing together the day case services will ensure we have a sustainable model for the future."
>
> **Consultant Paediatrician, Dr Miles Wagstaff**

Feedback

The questionnaire which follows is one of a number of ways in which people can express their views as part of the engagement exercise.

This questionnaire is intended to capture a broad view of the response to the proposals set out in the engagement booklet. You may not want to feed back on every proposal, so you need only respond to questions you are interested in.

There are number of other ways in which you can have your say. Full details can be found at: **www.nhsglos.nhs.uk.** You can:

- Complete this questionnaire online at: **www.nhsglos.nhs.uk**
- Send your comments by email to: **consultation@glos.nhs.uk**
- Write to: Caroline Smith, Community Involvement Manager,
  NHS Gloucestershire
  Freepost RRYY – KSGT – AGBR
  Sanger House, 5220 Valiant Court
  Gloucester Business Park, Brockworth GL3 4FE.

  If you are a member of NHS staff, please use the internal post system and return to the Patient and Community Involvement Team at Sanger House.
- Visit the Information Bus when it visits a location near you.
  To view the the Bus schedule visit:
  www.palsglos.org.uk/userfiles/docstore/pdf/Schedule.pdf.
- Attend a public 'Drop In' event.

If you would like assistance to complete this questionnaire or to express your views in any other way please call the Patient Advice and Liaison Service (PALS) on Freephone **0800 015 1548**.

Questionnaire

Please take some time to read through this guide before you complete the questionnaire below.

There is also a full engagement booklet and this is available from: NHS Gloucestershire, Sanger House, 5220 Valiant Court, Gloucester Business Park, Brockworth GL3 4FE, via the website **www.nhsglos.nhs.uk** or call **0800 015 1548** for a copy.

It will help us to capture your views accurately if you mark your answers clearly in a dark coloured ink. If you choose to add your own comments at the end of this questionnaire, please can you ensure that you write clearly and concisely.

Question 1: How have you obtained information about the proposed changes? *(Please select all that apply)*

read the short guide	☐	read the full engagement booklet	☐
attended a Community Event/Public drop-in session			☐
local media	☐	NHS website	☐
Information Bus	☐	word of mouth	☐

other (please give details) .....

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

Question 3: Having read this guide (and the full engagement booklet) do you think you have been provided with the right information to help you to understand and form a view about the proposals for change?

Proposal	Completely	Partly	Not at all	Don't know
Emergency and urgent medical care				
Selected Medical Specialties				
Paediatric Day Cases				

If you felt that other information would be useful, please say what else you would like to know (in the box below)

Question 4: Do you agree with the views of clinicians and managers about the proposals for change?

Proposal	Completely	Partly	Not at all	Don't know
Emergency and urgent medical care				
Selected Medical Specialties				
Paediatric Day Cases				