Public Board - 2 June 2020

02 June 2020, 11:00 to 12:00
MS Teams

Agenda

Agenda

1. Declarations of interest

Peter Lachecki

2. Temporary Service Change to support next phase response to COVID-19 pandemic

Simon Lanceley

02.0 - Temp Service Change_COVID-19 Phase 2_Cover Sheet.pdf (3 pages)

02.1 - Temp Service Change_COVID19 Phase 2_Board June20.pdf (24 pages)

3. Any other business

Peter Lachecki

Gloucestershire Hospitals
NHS Foundation Trust

PUBLIC BOARD AGENDA

Meeting: **Trust Board meeting**

Date/Time: Tuesday 2 June 2020 at 11:00

Location: Microsoft Teams

	Agenda Item	Lead	Purpose	Time	Paper
	Welcome and Apologies	Chair		11:00	
1.	Declarations of Interest	Chair			
2.	Temporary Service Change to support next phase response to COVID-19 pandemic	Simon Lanceley	Approval		YES
3.	Any Other Business	Chair			
CLOSE				12:00	

Date of the next meeting: Thursday 11 June via Microsoft Teams.

Public Bodies (Admissions to Meetings) Act 1960 "That under the provisions of Section 1 (2) of the Public Bodies (Admissions to Meetings) Act 1960, the public be excluded from the remainder of the meeting on the grounds that publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted."

Due to the restrictions on gatherings during the COVID-19 pandemic, there will be no physical attendees at the meeting. However members of the public who wish to observe virtually are very welcome and can request to do so by emailing ghn-tr.corporategovernance@nhs.net at least 48 hours before the meeting. There will be no questions at the meeting however these can be submitted in the usual way via email to ghn-tr.corporategovernance@nhs.net and a response will be provided separately.

Board Members

Peter Lachecki, Chair

Non-Executive Directors

Claire Feehily
Rob Graves
Balvinder Heran
Alison Moon
Mike Napier
Elaine Warwicker

Associate Non-Executive Director

Executive Directors

Deborah Lee, Chief Executive Officer
Emma Wood, Director of People and Deputy Chief Executive Officer
Rachael de Caux, Chief Operating Officer
Steve Hams, Director of Quality and Chief Nurse
Mark Hutchinson, Chief Digital and Information Officer
Karen Johnson, Director of Finance
Simon Lanceley, Director of Strategy & Transformation

Marie-Annick Gournet Mark Pietroni, Director of Safety and Medical Director

Gloucestershire Hospitals
NHS Foundation Trust

PUBLIC MAIN BOARD – JUNE 2020

Report Title
Temporary Service Change to support next phase response to COVID-19 pandemic
Sponsor and Author(s)
Authors: Simon Lanceley, Director of Strategy & Transformation **Prof. Mark Pietroni,** Director of Safety and Medical Director **Prof. Steve Hams,** Director of Quality and Chief Nurse **Dr. Rachael De Caux,** Chief Operating Officer **Karen Johnson**, Director of Finance **Sponsor:** Simon Lanceley, Director of Strategy & Transformation
Executive Summary

PURPOSE

To secure Board approval for the proposed temporary service changes as part of the Trust's response to the next phase of the COVID-19 pandemic. Of note, this approval is subject to further scrutiny of the financial impact of the proposed changes.

PROPOSALS

Recommendation 1: Pandemic Next Phase Service Changes

That the service changes listed in Section 3.2 of the accompanying paper are implemented as emergency (temporary) service changes, in line with the Memorandum of Understanding (MOU) agreed with Gloucestershire Health Overview and Scrutiny Committee, as part of the Trust's response to the next phase of the COVID-19 pandemic, including Cheltenham Emergency Department facility becoming a Minor Injury and Illness Unit (MIIU), operating 8am to 8pm 7-days a week.

Work is ongoing with respect to finalising the model for vascular services and the recommended option will be presented to Board on 2 June.

Recommendation 2: Implementation timeline

The emergency (temporary) service changes are implemented in a phased approach with some enabling moves happening in w/c 1 June (subject to Board approval) and changes to CGH ED, the Acute Medical Take and Vascular services happening on Tuesday 9 June, subject to:

- Board approval of recommendation 1.
- Confirmation on 2 June that any key dependencies linked to the recommended option for vascular services can be in place before the 9 June, for example essential equipment required to support the emergency pathway - an interventional radiology (IR) enabled C-arm.
- Confirmation that an affordable financial plan underpins the proposals and has been agreed with Divisions.

Recommendation 3: Financial Plan

Due to its complexity, it has not been possible to conclude the financial planning to support Board approval on 2 June. The Board is requested to delegate approval of the financial plan to an extraordinary single item Finance Committee on Wednesday 3 or Thursday 4 June.

BACKGROUND

Proposals presented to Trust Board on 14 May were approved in principle, subject to gathering feedback from a wider group of staff, governors and external stakeholders. This feedback is summarised in Sections 6 and 7.

Following further work by clinical teams and discussions at the COVID-19 Task & Finish group, some proposals have been refined since 14 May; see Section 3.2 of the paper for final proposals.

Key points to note:

- This proposal reflects our response to the next phase of COVID-19 and is built upon NHS England's recovery framework.
- All changes enacted as part of this second phase will be implemented as temporary emergency service change, in line with the Memorandum of Understanding (MOU) agreed with Health Overview and Scrutiny (HOSC).
- Changes will be enacted for an initial three monthly period at which point the ongoing necessity will be reviewed, again in line with the requirements of the MOU and prevailing national guidance.
- Proposed implementation timescale is:
  - 3rd June onwards (subject to Board approval): a number of enabling ward and service moves
  - 9th June:
    - CGH ED facility becomes MIIU 7-days per week 8am to 8pm.
    - All 999 and undifferentiated GP referrals would be centralised at GRH.
    - Acute Medical Take moves to GRH.
    - Vascular option to be confirmed on 2 June.
    - Urology 999 front door pathway would move to GRH, planned and non-COVID pathways would remain at CGH.
    - Radiology services at CGH would be focused on outpatient care and support a largely non-COVID bed base and ambulatory access.
- Further work is required on the financial plan to support these proposals and Board will be updated on progress with this plan on 2 June.
- A robust internal and external communication plan will be implemented if these proposals are approved and this is summarised in Section 14 including significant campaign to raise public awareness of the changes to Cheltenham Emergency Department.

Recommendations

Board is asked to APPROVE the recommendations supported by Trust Leadership Team on 29 May subject to satisfactory scrutiny of the associated financial plan.

Impact Upon Strategic Objectives

The changes in this paper are temporary in order to mitigate COVID-19 risks and are not linked to any longer term strategic objective.

Impact Upon Corporate Risks

Changes described in this paper, will support the mitigation of two key COVID-19 risks:

- **C3169MDCOVID** - Risk of the Trust being unable to deliver its usual range of comprehensive, high quality services with consequent impact on patient safety, experience and staff wellbeing due to COVID-19 Pandemic.
- **M3182COVID** - The avoidable risk of exposure to the COVID-19 virus due to patient not being admitted to a cohort ward, designated for potential or confirmed COVID-19 patients.

Regulatory and/or Legal Implications

None of these changes are considered pre-emptive of any future substantial service change which will remain subject to public consultation.

Equality & Patient Impact

A Quality Impact Assessment (QIA) and Equality Impact Assessment (EIA) has been completed and mitigating actions identified, see Section 10 and 11.

Resource Implications			
Finance	X	Information Management & Technology	X
Human Resources	X	Buildings	X

Action/Decision Required							
For Decision		For Assurance		For Approval	**X**	For Information	

Date the paper was presented to previous Committees						
Quality & Performance Committee	**Finance Committee**	**Audit & Assurance Committee**	**Workforce Committee**	**Remuneration Committee**	**Trust Leadership Team**	**Other (specify)**
					29 May 2020	COVID-19 T&F Group
Outcome of discussion when presented to previous Committees						
For recommendations to proceed to Board for approval.						

Gloucestershire Hospitals
NHS Foundation Trust

PUBLIC TRUST BOARD – 2 JUNE 2020

TEMPORARY SERVICE CHANGES TO SUPPORT NEXT PHASE RESPONSE TO COVID-19

1. Introduction

This paper describes the temporary service changes the Trust proposes to implement as part of its response to the next phase of the COVID-19 pandemic.

Proposals have been developed by Specialty and Divisional Teams and refined and challenged through the weekly COVID-19 Task and Finish Group Chaired jointly by The Director of Safety & Medical Director and Chief Operating Officer. Proposals and key dependencies, for example cross-site transport, equipment and communication plans have been further developed through Directors Operational Assurance Group (DOAG).

If supported, these proposals would:

- limit the risk of transmission of the virus to patients and staff during the next phase of the pandemic,
- enable restoration of many of the services paused in response to Phase 1 of the pandemic, increasing the volume of cancer surgery, planned care and specialist diagnostic activity, especially to those patients who are most vulnerable,
- give confidence to our local population that both our hospitals are safe places to visit.

Proposals were approved in principle by Trust Board on 14 May subject to gathering feedback from a wider group of staff and external stakeholders to be considered at an extraordinary Trust Board on 2 June where final proposals will be considered. This feedback is summarised in Sections 6 and 7.

At a meeting of the Trust Leadership Team (TLT) on 29 May it was agreed this paper should proceed to Board for final approval subject to finalisation and scrutiny of the underpinning financial plan.

2. Key Principles Informing the Proposals

The following principles have been used to inform the design of the proposed temporary service changes:

- To build on the success of our phase 1 response by continuing to separate COVID and non-COVID pathways by site and by pathway to reduce risk of COVID transmission to and between patients and staff.
- To use our two hospital sites to achieve this by making Cheltenham General the focus for elective operating, cancer care & non-COVID diagnostic imaging and Gloucestershire Royal as the ‘front door’ for acute emergency medical and emergency surgical pathways.
- To centralise our key points of entry including the Emergency Department,

acute medical take and emergency general surgery so we can better control flow in to our hospitals and separate four key pathways: COVID positive, suspected COVID, possible COVID and non-COVID patients.

- To designate the Intensive Care Unit (ICU) at Cheltenham General as a non-COVID unit - this is a key dependency for increasing cancer and planned care operating in this second phase. Note this will include the ability to accommodate a COVID positive patient by exception, in the available side rooms.
- To design a model of care to accommodate both a continuation of the current level of COVID-positive patients as well as a possible second surge.
- To develop a recovery model that promotes public confidence in our services to ensure that the public recognises that both our hospitals are safe places to come to receive acute hospital services.
- To ensure our plans are in line with direction set by South West Regional Team and NHS England, namely:
    - Recovery programmes at institution level should complement system strategy and the longer term vision
    - A much greater separation between urgent and elective work by site and pathway
    - A way of operationalising segregation between COVID and non COVID
    - Virtual by default unless good reasons not to
    - Triage/single points of access/resources and control at the front end of pathways
    - Guidance provided in *Operating framework for urgent and planned services in hospital settings during COVID-19*, NHS England, May 2020.

3. Proposed Changes

3.1. Phase 2 Service Changes

Appendix 1a and 2a show the current configuration of inpatient and day case services at Cheltenham General Hospital (CGH) and Gloucestershire Royal Hospital (GRH). Appendix 1b and 2b show the configuration of services at CGH and GRH should the proposed temporary service changes be approved for implementation.

3.2. Summary of Proposals

- CGH Emergency Department (ED) facility would become a Minor Injury and Illness Unit (MIIU), it is the view of the clinical team that the MIIU should be open 7-days a week, 8am to 8pm - see Section 3.3 below.
- CGH MIIU would be supported by a Medical Consultant led Ambulatory Emergency Care (AEC), service operating Monday to Friday, 8am to 6pm, to see differentiated GP referrals and to enable previously discharged patients to be followed up in CGH.
- All 999 and undifferentiated GP referrals would be centralised at GRH. This would include centralising the Acute Medical Take to GRH.
- Acute Stroke Unit (ASU) would move to CGH. The Hyper Acute Stroke Unit

(HASU) would remain at GRH, and Stroke Rehab at The Vale Community Hospital.

- Transfer a greater proportion of non-COVID-19 Cardiac patients to Cardiac Care Unit (CCU) at CGH.
- The ICU at CGH would be designated as a non-COVID unit. Note a protocol is in place for the management of infectious patients through the use of side rooms on the unit should a COVID positive patient need to be admitted in extremis.
- Extended use of the Private Sector (Winfield and Nuffield) for non COVID planned care (subject to national agreement).
- Benign Gynaecology day case activity would move to CGH.
- Recommended option for vascular services to be confirmed. Option 1: Emergency and elective inpatient pathways would move to GRH, daycase venous service would remain at CGH. Option 2: The emergency front door for vascular services would move to GRH but all other services remain at CGH.
- Urology 999 front door pathway would move to GRH, planned and non-COVID pathways would remain at CGH.
- Radiology services at CGH would be focused on outpatient care and support a largely non-Covid bed base and ambulatory access.

3.3. Cheltenham ED/ MIIU

To control the flow of emergency patients into our hospitals during the next phase of the pandemic we are proposing to flow all 999 and undifferentiated GP referrals to GRH. Differentiated GP referrals would continue to be managed at CGH by the Ambulatory Emergency Care Service where possible and appropriate.

If 999 and undifferentiated GP referrals transfer to GRH two options for Cheltenham ED have been considered;

Option 1: CGH ED facility to operate as a Minor Injury & Illness Unit (MIIU) 24/7

Option 2: CGH ED facility to operate as an MIIU from 8am to 8pm (last patient accepted at 8pm but unit would be staffed until 10pm)

Under both options Cheltenham MIIU would continue to be staffed by emergency nurse practitioners, registered nurses and senior doctors to see patients with minor injury and illness and would respond to any emergency patient who walks-in during the proposed opening hours in keeping with any MIIU. With respect to activity, pre COVID-19 the average was 7 patients per night and this has reduced to an average of 4 patients per night.

Under Option 1 we would continue to staff CGH MIIU overnight and ask staff to continue to cover work additional hours, but accept that this is likely to result in further rota gaps at both CGH and GRH and undoubtedly impact on staff well-being and resilience.

Under Option 2 we could operate Cheltenham MIIU from 8am to 8pm and move the overnight CGH staff to GRH to help close rota gaps, reduce staff overtime requirements and provide a more sustainable and resilient service.

The preference of our clinical teams and the recommendation supported by TLT is Option 2, due to the following reasons:

- To safely separate COVID and non COVID emergency patients we have

increased capacity in GRH ED by 85%. This equates to an additional 16 COVID spaces made up of resuscitation areas, majors trolleys and cubicles.

- To manage these additional 16 spaces, while adhering to strict infection control procedures, requires an additional 32 staff, a combination of Registered Nurses and Health Care Assistants (HCAs).
- During Phase 1 of the COVID-19 pandemic, we have had to ask staff to work additional hours including more frequent evening and weekend working to cover two departments out of hours. This arrangement has been in place for 3 months and is not resilient or sustainable as we move into the next stage of this pandemic.
- Staffing CGH MIIU overnight requires four staff, including specialist nursing which if not open, could be deployed to alleviate some of the shortages at GRH.
- Our ability to sustainably staff both sites is also impacted by sickness on what is already a national shortage of registered nursing workforce, equating to 22 WTE across the ED departments.
- Our team of Emergency Nurse Practitioners already work across GRH and CGH to provide 24/7 cover with a registered nursing shortfall.
- The medical workforce is equally challenged, to cover both sites safely with a shortfall of Junior and middle grade doctors.
- To improve the use of onsite radiography overnight, the resident radiographer at CGH would move, in line with the proposed MIIU opening hours, and support the acute take in GRH, maximising efficiency of the radiology workforce.

3.4. Cheltenham General Hospital Medical and Surgical Cover

During the day, CGH will continue to be supported by an on-site medical team comprising consultants, medical registrar and junior doctors, surgical team and ITU Consultants. Overnight in CGH medical cover will be provided by a 7-day resident medical SpR and the CGH ICU will continue to be 24/7 supported by an on call ITU Consultant. Surgical cover will be provided by a resident FY1 and mid-grade surgical trainee. The Acute Care Response Team (ACRT) will also continue to be the first point of contact for ward teams concerned about deteriorating patients overnight.

Note the recommended option for vascular services will impact on this model.

3.5. All 999, undifferentiated GP referrals and acute medical take to GRH

ED admissions will be solely through GRH, patients may be transferred to CGH as appropriate. ED staff will continue to work across both sites to maintain skill sets.

Paediatric ED will remain in the Paediatric Assessment Unit (PAU) at GRH. A Minor Injury Unit (MIU) service will continue to be provided by the Orthopaedics team at GRH.

3.6. Acute Stroke Unit services will move to CGH

Hyper Acute patients will be admitted through GRH ED. Post Hyper Acute phase and once COVID swab results are confirmed, patients will be transferred to the ASU at CGH, for onward care and acute rehabilitation.

3.7. Cardiology services will remain at both CGH and GRH

Transfer .a greater proportion of non-COVID-19 Cardiac patients to Cardiac Care Unit (CCU) at CGH.

3.8. ICU at CGH to be designated as Non-COVID

The development of a non-Covid site at CGH is proposed, which would include the provision of a non-Covid Intensive Care Unit (ICU). This is directly linked to the ability to reduce the risk of Covid emergency patients requiring Critical Care to egress into the CGH site.

In terms of patient safety and experience, this will enable those patients that are non-Covid, including post-operative surgical patients, to be cared for in a non-Covid ICU. In enabling the creation of the unit in this way, a further benefit will allow for the continuation of complex surgery during a potential second surge.

The proposed change would also benefit the GRH site, allowing flexibility should there be a requirement to increase Covid positive beds on the GRH ICU without initially affecting other areas.

The last benefit is to the ICU staff: continuing the existing model of rotating staff allows for staff to have days when they are not subject to the wearing of full PPE as required for the Covid positive patients.

There are two risks attached to the implementation of a non-Covid ICU: both are low risk and mitigated. The first risk is that there would still be the possibility of having a critically unwell Covid positive patient admitted to the unit, albeit unlikely: the unit has a protocol in place for the management of infectious patients through the use of side rooms on the unit.

The second risk is that the CGH ICU is under-utilised: to mitigate this, we will ensure that the numbers of patients are monitored daily in conjunction with the GRH ICU and should this occur, we will reduce staff accordingly as we do in normal operational practice.

3.9. Extended use of the Independent sector

Under the current National Contract (currently under review), we are working with the Independent Sector for the provision of additional capacity: locally we are using the Winfield and the Nuffield to increase our elective work.

This has two main benefits: -

- Continued management and treatment of our surgical patients (to support delivery of our cancer and urgent patients)
- Provision of additional capacity on our acute site for those patients requiring more complex surgery.

The risks of not having the continued use of the Independent Sector would include increased limitations on our ability in the acute sites to undertake the full range of urgent and cancer work, (due to the case-mix/acuity of patients in conjunction with the volume of cases). The additional IS support is integral in ensuring that we can treat our patients locally according to their treatment plan.

3.10. Vascular Surgery

Option 1

The provision of an emergency vascular service is proposed to be on the GRH site alongside the provision of the main emergency take. The provision of a safe vascular site to receive emergencies alongside the overall objective to reduce the incidence of Covid 19 into the CGH site mean that the vascular service is proposed to move to the GRH site (for arterial patients only).

The main risk is moving away from the provision of the hybrid theatre located in CGH. Alternative and modern kit has been sourced and reviewed as an alternative, noting the hybrid theatre will need capital replacement in the next couple of years. This solution has the additional benefit of providing two locations of appropriate kit.

Outpatient and Day Case Vascular work will be undertaken within the CGH site to ensure efficient use of resources. The theatre allocation in GRH would enable greater efficiency from the vascular team to address elective waiting times.

Option 2

An alternative proposal is the retention of the service on the CGH site, apart from the initial admission of any arterial emergencies out of hours who will attend GRH. This option supports the separation of Covid and non-Covid pathways. The intention is to stabilise the patient on the GRH site overnight before transferring them in the morning to CGH. Patients requiring emergency vascular services during the day will be admitted to the CGH site.

The risks to this option include the ability to design a safe overnight surgical rota for vascular patients on the CGH site, a Vascular rota that delivers 7-day Consultant cover at GRH for emergency admissions supported by agreed Standard Operating Procedures (SOPs)

Both options require additional kit to support the emergency pathway - an interventional radiology (IR) enabled C-arm.

3.11. Urology

Although the intention is to admit emergency patients onto the GRH site to support the separation of Covid and non-Covid pathways, the volume of urology emergencies is low enough to leave the Urology Service on the CGH site. Urology emergencies (999) will be received on the GRH site. Where patients are known to services, they can be received and accepted, after triage, into a newly-established CGH Urology Assessment Unit (UAU).

The main benefit of this move is to separate out the non-Covid and Covid pathways to allow for the continuation of elective work, with the benefit of continued low length of stay for the cancer patients having robotic-assisted surgery. The majority of urology patients are in the over 70 age bracket and this supports their care being delivered on a non-Covid site with minimal risk of exposure. This option also supports the diagnostic capacity on both sites.

In terms of risks, there will be emergency 999 patients brought to the GRH site that would need to be subsequently transferred to the CGH site, but these are low numbers, (estimated to be around 1 to 2 patients per day). Provision has been

identified to care for the patients on a surgical ward prior to transfer to the CGH site. There may also be the requirement to care for a Covid positive patient on the CGH site who requires specialty urological care: these patients will be managed in side rooms as confirmed by Infection Control.

3.12. Benign Gynaecology day cases

Benign Gynaecology day cases can be operated on flexibly across both sites, and will be able to support theatre scheduling accordingly. The only risk is the development of a late post recovery complication that may require the patient to be transferred to GRH for review by the single site on-call team.

4. Other Options Considered & Discounted

The following service configurations and pathways were considered by Specialties, Divisions and COVID-19 Task & Finish Group but discounted, as none of these options maximises the use of our two sites by enabling us to do as much cancer and planned care imaging and operating as possible **and** provide a mostly non COVID site that reduces the risk for shielding and other vulnerable patients:

A. Status quo: maintain 999, GP referrals and acute medical take on both sites
Reason discounted: would require us to maintain four different streams for emergency patients (COVID, non-COVID, suspected COVID and possible COVID), which is complex, results in patients being admitted to the incorrect specialty bed, is not possible to replicate on both sites due to the additional staffing requirements, makes it difficult to maintain a non COVID ICU at CGH impacting on cancer and planned care operating capacity.

B. 999, GP referrals & acute medical take to Cheltenham General Hospital
Reason discounted: limited capacity of CGH Emergency Department and Acute Care Unit, imaging capacity at CGH is lower than at GRH, Stroke, Trauma & Paediatrics already centralised to GRH, layout of CGH ICU would require it to be COVID-19 only impacting on cancer and planned care operating capacity,

C. Acute medical take centralised to GRH, no change to CGH ED
Reason discounted: retains four different streams for emergency patients at CGH so discounted for reasons listed in #1 Text

D. Retain Vascular and Urology 'front door' pathways at CGH
Reason discounted: would result in COVID and non-COVID patients being admitted to specialty wards and ICU at CGH, impacting on cancer and planned care operating capacity

E. Cancer and all planned care to Independent Sector hospitals
Reason discounted: Insufficient theatre capacity and a lack of ICU support for complex post-operative patients in these hospitals to manage all elective work. It would also result in having four different streams for emergency patients at CGH and GRH (COVID, non-COVID, suspected COVID and possible COVID).

F. Spinal surgery to CGH
Reason discounted: The spinal service maintains all elective and emergency work (four consultants) on the GRH site at present. Moving the elective work to CGH would require an additional spinal consultant in order to support coverage on both sites and this would be challenging to resolve for the duration of the temporary move.

G. Head and Neck Surgery to CGH

Reason discounted: could split service into emergency and elective stream across the two sites, but this would require provision for what is a small service on both sites. As we would be unable to split the existing team, this would result in substantial staff retraining on the CGH site in the short term for what would be a new specialty for them, thereby increasing patient safety risk.

5. Nature of Change

The proposed changes will be implemented in line with the following principles:

- All changes enacted as part of this Second Phase will be implemented as temporary emergency service change, in line with the Memorandum of Understanding (MOU) agreed with Health Overview and Scrutiny (HOSC). This MOU was developed to align to NHS England guidance on emergency service change[1].
- Changes will be enacted on a three monthly basis, at which point the ongoing necessity will be reviewed, again in line with the requirements of the MOU.
- Key externals stakeholders have been continually briefed on how the Trust is responding to the different phases of COVID-19 including emerging proposals for Phase 2, and feedback on these proposals in summarized in Section 5.
- These temporary service changes will be managed and communicated separately to Fit for the Future which remains paused at this current time.
- None of these changes are considered pre-emptive of any future substantial service change which will remain subject to public consultation.

6. Internal Engagement & Feedback

6.1. Staff Engagement

During the development of proposals Managers used team meetings and one to one meetings to understand individual and team preferences on location or specialty, with the objective to accommodate preferences wherever possible i.e. stay on the same ward or site, stay together as a team or stay with the specialty (so move with the service).

Staff are required to work across sites within their service line as such relocation is not anticipated to be an issue. Any individual needs or concerns which need to be accommodated are being raised with the HR Advisory and HR Business Partner team to resolve such as travel issues and child care.

A staff briefing document was provided to Managers to support these conversations and ensure consistency of message. This briefing was also sent to Staff Side for review. Feedback on the proposals was captured on a standard form and is summarised below. A Frequently asked questions (FAQs) was also provided which included the latest guidance and information for COVID-19 related changes and issues on the Trust intranet.

Staff were encouraged to talk to their line manager throughout the process to discuss individual issues or circumstances and where this was not possible or if further support was required staff were encouraged to seek advice from the HR Advisory Service, staff side representative or for staff wellbeing and psychological support

[1] Planning, assuring and delivering service change for patients, NHS England, March 2018 and Joint Working Protocol: When a hospital service or facility closed at short notice, NHS England, December 2017

through the 2020 Hub.

Changes are being managed in accordance with our operational change protocol and do not require formal consultation with staff or their representatives. Twice weekly calls with the HRBP team and Director of People and OD are taking place to discuss matters of concern relating to staff engagement and involvement. These offer an opportunity to understand if the messaging has been adequate and consistent and if there are any issues to implementation. Any inconsistencies or areas of concern are escalated to the Tri and relevant HRBP and the team are proactive in meeting colleagues and staff groups where necessary.

6.2. Staff Feedback

Although there is recognition that the model of care established for Phase 1 of the Pandemic is not suitable for the next phase, and reassurance taken from the level of planning going into the next phase, a number of points were raised by staff:

- Change of location or role
- Concerns changes would become permanent changes
- Questions on the size of some of the proposed areas e.g. acute medical bed base, cardiology bed base at GRH, trauma capacity at GRH
- Frailty Assessment Service not having a fixed base
- Teams reflected on the strong bonds that had been built through Phase 1 and described a degree of loss at the possibility of being disbanded/ reset.
- Some ward teams had improved during Phase 1, e.g. achieving NAAS green status and there was concern around new staff rotations impacting on this performance
- The possibility of needing to travel more frequently between two sites
- How new ways of working would impact on their specific specialty e.g. respiratory.

6.3. Gloucestershire Managed Services (GMS) Feedback

Feedback was received from Domestic Services, Facilities, Linen Services, Operations, Materials Management. Key messages include:

- Broadly neutral/ supportive of the changes.
- Some concern was raised about the future of CGH ED.
- Little concern operationally with any suggested changes.
- The team will continue to adapt as things progress.
- It should be recognised that SLA KPIs may be impacted as a result of workforce challenges and increased demand on reactive arm of the service (Operations).

6.4. Governor Feedback

Members of the Executive Team briefed Governors on the proposals at a session held on 27 May. Governors then discussed the proposals in private and the feedback below was provided by the Lead Governor:

Overall, we are quite content to endorse what you trying to achieve through these proposals. We do not feel especially competent to comment on the detail, though

staff governors were very useful sounding boards for much of what was discussed. On the specific issue of Cheltenham ED, there was again collective endorsement of the general approach, though there was a minority view that was hesitant in endorsing Option 2. The main issue surrounding this - and the other issues - was how well the Trust would manage to communicate its proposals once agreed on. Given the previous commitments to a Cheltenham ED we could see that at some point in the future there may be some difficult questions to address, but the current 'crisis' is clear. Specific questions that were discussed included some on transport and staffing; staff governors were again very useful to help us understand the position.

So, all in all you have our support - and you also have a very appreciative governing body. As you might expect, though, we take our responsibilities seriously, and will be monitoring progress and reviews as and when necessary.

7. External Engagement & Feedback

7.1. External Stakeholders

A stakeholder briefing explaining the proposals and asking for feedback was issued to the following individuals and groups:

- Gloucestershire Clinical Commissioning Group (CCG)
- Gloucestershire Health & Care
- Gloucestershire County Council
- Members of Parliament for Gloucestershire
- Health Overview & Scrutiny Committee
- Restore Emergency At Cheltenham Hospital (REACH)
- Cheltenham Borough Council

A letter of support from the **CCG Governing Bod**y was received on 15 May that also included a number of points of clarification we responded to.

SWAST provided a list of questions relating to the clinical model and pathways for Cardiology (STEMI), Stroke, Vascular, Urology, time critical patients and MIIU acceptance criteria. Responses have been provided to the points raised.

Feedback from **Gloucestershire County Council** focussed on the impact any continued reduction in acute and community hospital beds (due to social distancing) will have on Adult Social Care services and capacity, particularly in relation to supporting 7-day discharge pathways. It was noted the movement of Acute Stroke to CGH could increase Adult Social Care demand at CGH.

REACH responded with a list of questions and a statement. The questions relate to the temporary nature of the changes and ask for a commitment that all changes will be reversed when NHSE has decided the COVID crisis is over. There is one specific question on why elective colorectal and upper GI surgery has not been moved to CGH in line with the objective to separate COVID and non-COVID pathways. The statement relates to the Option 2 CGH MIIU opening hours:

It is understood one of the possible options being considered is the closure of a downgraded CGH A&E at night between 20.00hrs and 08.00hrs. If this is correct then clearly it would be absolutely unacceptable to REACH, Cheltenham and Tewkesbury Borough Councils, the local MPs and virtually 100% of the Parish Councils in North and East Gloucestershire i.e. a populace of circa 260,000, which constitutes almost 50% of the County's population.

7.2. Public Engagement

Due to the difficulties of meeting face to face with patients and the wider public, the Trust worked with Voluntary Care Service organisations to reach out to their networks and seek feedback on our behalf. The same external briefing was issued to the following individuals and groups and followed up with telephone calls:

- Healthwatch Gloucestershire
- Gloucestershire Carers Hub
- Inclusion Gloucestershire
- The Friendship Café
- Atique Miah – Faith Leader at the Trust.

Healthwatch Gloucestershire circulated the proposals to their members and provided the following summary statement:-
We understand the clinical reasons for the proposals and the need to maintain pathways that are rigorously managed in terms of infection control. This is a temporary measure and we would recommend that the Trust clearly sets out the criteria for which the temporary arrangement will end – we do understand that it may be impossible to put a time frame to this. Healthwatch Gloucestershire would also recommend that there are clear and positive communications on these temporary measures and offer our Readers Panel to assist. We would also recommend that the experiences of the public are gathered during this time and would be happy to support this by offering patients the opportunity to talk to Healthwatch Gloucestershire independently and confidentially.

Gloucestershire Carers Hub circulated the proposals to their members and provided the following summary statement:
Gloucestershire Carers Hub values the request from Gloucestershire Hospital NHS Foundation Trust to collect feedback from carers about the proposals for changes to service. We have shared the briefing with carers so that they can respond directly with their views and experiences. During the period of the pandemic response, carers have talked to us about their concerns surrounding healthcare for them and their cared for, who are often among the most vulnerable people. These concerns have been focused on hospital appointments being cancelled or postponed especially oncology services, carers not feeling like hospitals are safe places for them to attend, due to worries about COVID transmission, and confusion over which services are still functioning.
We would support the Trust in proposals that would mean that these concerns were acknowledged, but would also encourage the Trust to ensure that carers are clearly communicated with on the above points with any changes that are made, to give them confidence that they were able to attend their appointments safely.

Inclusion Gloucestershire have commented, recognising that there are both positives and negatives, but are generally supportive of the temporary changes.

Suicide Crisis raised concerns regarding the impact on access to services for people in crisis in the Cheltenham area.

The Friendship Café asked for clarification on the proposals and raised concerns regarding the impact on patient travel. They have also requested no change to the CGH Emergency Departments.

Our Faith Leader at the Trust circulated the proposals to their network and the general feedback was positive and supportive of the temporary measures.

A **Patient Participation Group (linked to a GP surgery)** has provided comments supporting Option 2 for CGH MIIU opening hours, as they believe it makes the best use of resources. They list some concerns and ask that if the proposals are agreed that communication messages are clear and effective.

8. Key Dependencies

8.1. Non-Emergency Patient Transport (NEPT)

These proposals will require an increase in the volume and frequency of cross-site Non-Emergency Patient Transport (NEPT). Capacity modelling has suggested the requirement for 3 vehicles operating 12 hours per day, 7-days per week.

The new NEPT service is a key dependency of the proposed changes and at TLT it was confirmed the procurement process can be completed, a contract awarded and a service in place by the preferred implementation date of 9 June.

8.2. Interventional Radiology (IR) enabled C-Arm

For both vascular options an IR enabled C-arm would be required in GRH to support the emergency pathway.

Discussions are in progress with the supplier to secure loan equipment ahead of proposed 9th June implementation date. The loan equipment will be used until a permanent solution can be procured.

9. Proposed Implementation Timeline

3rd June onwards:

Series of enabling service moves to support separation of COVID and non-COVID pathways into Phase 2, including

- Acute Stroke Unit (ASU) would move to CGH.
- Start to transfer a greater proportion of non-COVID-19 Cardiac patients to Cardiac Care Unit (CCU) at CGH.
- The ICU at CGH would be designated as a non-COVID unit.
- Benign Gynaecology day case activity would move to CGH.

Tuesday 9th June:

- CGH ED facility becomes MIIU 7-days per week 8am to 8pm.
- CGH Extended AEC service established.
- All 999 and undifferentiated GP referrals would be centralised at GRH.
- Acute Medical Take moves to GRH.
- Vascular moves to GRH (if Option 1 supported).
- Urology 999 front door pathway would move to GRH, planned and non-COVID pathways would remain at CGH.
- Radiology services at CGH would be focused on outpatient care and support a largely non-Covid bed base and ambulatory access.

10. Impact Assessment

10.1. Quality Impact Assessments (QIAs)

QIAs have been completed for the changes proposed and identified four key themes:

Theme	Description
Patient/staff safety	Greater ability to separate COVID and non COVID patients, minimising risk of cross infection and the ability to separate high acuity from less complex patients and deliver appropriate care to meet their needs. Consolidating the workforce to reduce the need for temporary staff. Improving waiting times. Consolidation of out of hours imaging working at GRH, reducing risk of lone working in CGH from 10 pm to 8 am
Clinical effectiveness	Reducing clinical variation, through standardisation of pathways and sharing best practice. Through staff rotation across sites, provide the opportunity for increased skills in treating the full spectrum of patient needs. Complex outpatient imaging separated from acute and inpatient activity.
Care	Greater ability to co-ordinate care for COVID and non-COVID patients and to deliver elective, diagnostic and therapeutic activity safely on the non-COVID site- screening prior to admission
Responsiveness	Providing the ability to re-start elective surgery, including less urgent classification of patients for diagnostic and therapeutic activity in a non-COVID environment. These changes will increase equity in experience (with similar pathways) and ring-fence planned surgery and outpatient imaging from urgent care pressures, leading to fewer cancellations and reducing waiting times

The QIA also identified the following risks for which mitigations have been defined:

Risk area	Description	Mitigation
Patient/staff safety	Inability to maintain CGH as a non-COVID site and access to adequate support for deteriorating patients. Transport difficulties in transferring patients. Insufficient imaging capacity/throughput on non-COVID site	Screening and testing all patients prior to admission and implementing the deteriorating patient pathway model. Robust medical, surgical and ICU rota for CGH Pathways and additional transport provision
Clinical effectiveness	Delays in treatment due to ward, theatre and imaging capacity. Inability to provide holistic care for people with multiple-morbidities	Pathways to minimise delays and avoid excess bed days; planning theatre sessions to maximise use and putting in place plans for a consult/review service covering both sites.
Care	Increases health inequalities	Use of the EIA process to ensure that this is monitored and addressed.
Responsiveness	Length of stay increases due to more complex patients being admitted. Delayed responsiveness for walk ins, who are acutely ill and need transfer.	Monitor length of stay throughout and adjust forecasts accordingly. Ensure appropriate staffing skills and pathways in place. Request to referrers to highlight urgency of patients accurately, to

Risk area	Description	Mitigation
	Not meeting imaging target dates due to reduced throughput and patients unwillingness to attend	enable accurate prioritisation of imaging patients.

10.2. Evaluation Criteria

The quality indicators listed below will be used to measure the impact of the changes:

Division	Quality Indicator
Medicine	• Patients are cared for in a safe environment - nomsolcomal infection rate • Improving medical and nursing cover and therefore patient flow and quality of care - staff absence and sickness rates
Surgery	• Increasing elective activity – data on elective activity • Number of wards at CGH remaining non-COVID – swab tests • Achieving 92% bed occupancy rate on surgical wards – hospital data set • Operations cancelled for non-clinical reasons – hospital data set • 7 day service performance (no gap in hospital SMR between weekday and weekend)- hospital data set
Diagnostics and Specialist Services	• Increasing modality activity – hospital data set • Increasing inpatient and ED workload – hospital data set • Compliance with reporting turn-around pathways – hospital data set • Compliance with turn-around times for cancer and RTT patients – hospital data set • Improve rota fill% and impact on vacancies – service held data

These indicators will be assessed weekly through the COVID-19 Task & Finish Group and reported monthly through Divisional Operational Assurance Group and Trust Leadership Team. They will also be reported as part of the 3-month review process defined in the HOSC MOU.

10.3. Impact on National Performance Standards

Two of the key principles behind these proposals are to separate COVID and non COVID pathways where possible to reduce the risk of exposure for patients that require cancer and planned care surgery and to provide resilience so that these services can continue in the event of a second COVID surge.

Performance against nation standards will continue to be impacted during phase 2 of the pandemic which is summarised below:

- The impact on SWAST handover times is unknown as during COVID SWAST have seen dramatic reduction in call outs and conveyance so we do not know post COVID what the activity will be.
- Ambulance patient handover times are likely to be longer to allow for appropriate PPE and social distancing of patients, this will be reflected

nationally.

- 4 hour Emergency Dept. performance will depend on the availability Point of Care Testing (PoCT) and if and how quickly activity returns to pre COVID levels. We have planned on activity returning to 80% of pre COVID levels for the duration of these temporary changes.
- 4 hour performance and patient flow will also be impacted by infection control and social distancing requirements.
- 52 week waits are likely to continue to rise as during phase 2 we will continue to triage patients referred by their GP and treat in order of clinical priority not time order.
- Referral To Treatment (RTT) performance will also continue to be impacted – current performance is 73.6% a drop of 8% from pre COVID which is reflected nationally.
- Planned care constitutional standards are unlikely to be met.
- Cancer performance will continue to be challenging but these proposals will ensure we are able to increase activity and reduce wait times.
- The proposals include establishing a predominantly non COVID diagnostic service at CGH that will speed up access for our most vulnerable patients.

11. Equality Impact Assessment

An Equality Impact Assessment (EIA) was completed to assess the potential impact of the proposed service changes on protected groups and this is summarised in the table below

Fig 1. EIA assessment by division

Protected Group	Medicine		Surgery	
	Disproportionately POSITIVE impact on equality	Disproportionately NEGATIVE impact on equality	Disproportionately POSITIVE impact on equality	Disproportionately NEGATIVE impact on equality
Age: (65+)	●	●		
Race/ethnic group				
Disability		●		
Sexual orientation				
Gender reassignment				
Religion or belief				
Marriage and civil partnership				
Other groups	●			

The Medical Division have assessed that there will be a disproportionately positive impact on people aged 65 and over and on other groups, whilst it has assessed that there will be a disproportionately negative impact on people aged over 65 and people with disabilities and these are described below. The Surgical Division have assessed that there will be no disproportionate impacts on equality.

Potential Positive Impacts

- Patients that have been waiting to access cancer or planned care treatment.
- Reduce anxiety of attending a hospital site to access acute care services for risk of being exposed to COVDI-19.

- Provides non-COVID (Green) imaging and non-COVID (Green) critical care at CGH which is crucial to recovering cancer and elective care operating and recommencing of diagnostic investigations of “vulnerable” patients.
- Restores beds currently closed at Cheltenham General as part of our phase 1 response, supporting patient flow.
- Enables rapid COVID diagnostics through Point Of Care Testing at GRH emergency front door.
- Supports asymptomatic staff testing of Cheltenham workforce on cyclical basis to further reduce transmission risk.
- Centralising the acute medical take enhances patient safety, improves outcomes and reduces the length of stay as it allows more patients to be seen by a senior reviewer more quickly, which is associated with increased patient discharges and improved clinical outcomes. 67% of admissions to acute medicine last year were for over 65s, meaning this cohort is significantly impacted by this temporary change and its benefits.
- 25% of Gloucester City’s population are living in deprived areas, approx. 32,000 people. Therefore centralising acute medicine to GRH provides improved access to the right specialists to manage the care of this higher risk community.

Potential Negative Impacts

- Patients who rely on public transport may need further support to access services in the new location if their journey becomes longer.
- 16.7% of Gloucestershire residents report having a long term limiting health problem or disability. People with a disability or suffering from long term conditions are more likely to require urgent care. Centralising 999 and GP referrals and the acute medical take to GRH will mean that some patients will have to travel further if GRH is not their local hospital.

Recommendations Based on EIA

It is recommended that further engagement is carried out to ensure that the information regarding the proposed short term service changes is clear and that there is ongoing feedback during the period of implementation. Key actions will include:

- Developing easy read materials to promote the changes to people with learning disabilities or where English isn’t their first language.
- Continued working with voluntary and community sector groups to understand the impacts of the changes and how changes can be communicated.
- Continued use of Friends and Family Test to assess impact.
- Use of the CCG Virtual Engagement Platform to engage with more patients and stakeholder groups (available from July).

12. Capacity Modelling

12.1. Medical Division

Modelling to determine the number of medical beds required to support the proposed service changes was based on the following assumptions:

- It does not include a top up for COVID related activity, assumes that the 100% will include an element of COVID bed requirement.
- Assumes that we return to a pre COVID average length of stay and no improvement of the MSfD/DTOC position. The bed requirement would be reduced if we maintained the current MsFD/ DTOC position as our average LOS would be reduced.
- The bed requirement makes no assumptions on occupancy rate
- Makes no assumptions on efficiencies gains from centralising the acute take

The figure below shows the number of beds required to support a single acute medical take at 70%, 85% and 100% of pre-Covid-19 activity levels and confirms the proposed service changes deliver the number of beds required.

Fig 2. Acute medical take bed modelling

Acute Take Bed Requirement

	70%	80%	100%
Average Bed Requirement	46	52	65
Max Bed Requirement	48	55	69

Proposed New Acute Take Bed Base

	Bed base without social distancing	Current Bed Base - with social distancing
9A	18	17
9B	28	20
AMU1	25	25
AMU2	15	13
Total new bed base:	**86**	**75**

Further modelling was completed to determine the number of post-take medical specialty beds required to support the proposed changes and this is shown below.

Fig 3. Post-take bed modelling

Trust

Metric	ADMITTING TFC	
	General Medicine	Other
Medical TFCS	247	42
% Discharged	32.9%	98.8%

Second Episode TFC	General Medicine	Other	
	Total	Total	Total
Accident and Emergency	0	0	0
Cardiology	28	5	33
Dermatology	0	0	0
Diabetic medicine	0	0	0
Discharged	81	41	123
Endocrinology	9	0	10
Gastroenterology	13	2	15
General medicine	42	5	46
Geriatric medicine	85	21	107
Nephrology	21	2	23
Neurology	7	1	8
Respiratory medicine	41	5	46
Rheumatology	0	0	0
TOTAL (excluding Discharged)	247	42	289

12.2. Surgical Division

Bed modelling was undertaken based on actual activity data using the Trust's model with the agreed criteria of occupancy levels based on 95% elective and 92% emergencies. For Option 1 in vascular services, this would result in a requirement of 194 beds against a pre-Covid position of 167 beds on the GRH site.

However, there are a number of restrictions on surgical throughput during this phase of Covid, including reduced theatre throughput due to requirement to wear PPE and reduced bed capacity due to social distancing measures. To that end, the expected activity levels were revised to reduced numbers of 60% elective and 80% emergency of 19/20 actuals. This resulted in a reduction of beds required down to 144 on the GRH site.

Social distancing has reduced the GRH bed base down to 126 surgical beds, so if this remains, further mitigations would be required alongside the existing changes to pathways (such as fractured mandibles). If social distancing measures are adjusted, through the installation of protective screens for example, the surgical bed base would accommodate the proposed moves including Option 1 for vascular services.

13. Financial Impact

13.1. Summary

The next phase of recovery is a complex process and one where the full detail is still being worked through. Board will be updated on progress on 2 June and subject to further Board Committee scrutiny before plans are mobilised.

Communication Plan

Internal

Internal communications will comprise of the following:

- Mangers briefing pack to summarise key changes
- Team meeting/ letter/email as appropriate to those directly affected
- A Vlog with CEO and Medical Director explaining the changes.
- Podcast supported with design illustration/ floor plan of both sites illustrating what services are where
- Intranet updated with Phase 2 including Q&A
- Screensavers
- Email or letter to Governors and FT Members.

External Communications Plan

Category	What
Media	Press release
	Possible media briefing, inviting journalists in
	Scheduled interviews (BBC Radio Gloucestershire and Heart) and advertising
	Full page adverts (GlosLive, So Glos, Citizen, Echo) including a landing page banner.
Web and digital	Social media and pay to boost to reach geographic area if required
	Explainer video explaining benefits/ testimonials (used on website, social, GP surgery screens)
	99 Bus screen advertising
	Specific stakeholder emails or letters: GPs, MPs, councils, care homes, members, charity donors with who we have an ongoing relationship
Print	A5 advert in Local Answer publication which goes to every household in Cheltenham/ North Cotswolds/ Bishops Cleeve
	A5 leaflets or posters for doctors surgeries, pharmacies, post offices, schools, police stations, taxi companies with a particular focus on the Cheltenham area and more sporadic around the rest of Gloucestershire
	Pull-up and A3 posters for ED entrance. Outdoor wobble board
	Changing Internal signage and outdoor signage at CGH A&E.

14. Recommendation

Board is asked to approve the following recommendations:

Recommendation 1: Next Phase Service Changes

The service changes listed below are implemented as emergency (temporary) service changes in line with the MOU agreed with HOSC, as part of the Trust's response to the next phase of the COVID-19 pandemic:

- CGH Emergency Department (ED) facility to become a Minor Injury and Illness Unit (MIIU), open 7-days a week, 8am to 8pm
- CGH MIIU to be supported by a Medical Consultant led Ambulatory Emergency Care (AEC), service operating Monday to Friday, 8am to 6pm, to see differentiated GP referrals and to enable previously discharged patients to be followed up in CGH.

- All 999 and undifferentiated GP referrals to be centralised at GRH. This would include centralising the Acute Medical Take to GRH.
- Acute Stroke Unit (ASU) to move to CGH. The Hyper Acute Stroke Unit (HASU) would remain at GRH, and Stroke Rehab at The Vale Community Hospital.
- To transfer a greater proportion of non-COVID-19 Cardiac patients to Cardiac Care Unit (CCU) at CGH.
- The ICU at CGH to be designated as a non-COVID unit, noting a protocol is in place for the management of infectious patients through the use of side rooms should a COVID positive patient need to be admitted in extremis.
- Extended use of the Private Sector (Winfield and Nuffield) for non COVID planned care (subject to national agreement).
- Benign Gynaecology day case activity to move to CGH.
- Recommended option for vascular services to be confirmed. Option 1: Emergency and elective inpatient pathways would move to GRH, daycase venous service would remain at CGH. Option 2: The emergency front door for vascular services would move to GRH but all other services remain at CGH.
- Urology 999 front door pathway to move to GRH, planned and non-COVID pathways to remain at CGH.
- Radiology services at CGH to focus on outpatient care and support a largely non-Covid bed base and ambulatory access.

Recommendation 2: Implementation timeline
The emergency (temporary) service changes are implemented in a phased approach with some enabling moves happening in w/c 1 June and changes to CGH ED, the Acute Medical Take and Vascular services happening on Tuesday 9 June, subject to:

- Board approval of recommendation 1.
- Confirmation on 2 June that any key dependencies linked to the recommended option for vascular services can be in place before the 9 June, for example essential kit required to support the emergency pathway - an IR enabled C-arm.
- Confirmation an affordable financial plan to support the changes has been agreed with Divisions. Board will be updated on progress with the financial plan on 2 June.

Recommendation 3: Financial Plan
If it has not been possible to bring an affordable financial plan to Board for approval on 2 June, Board is requested to delegate approval of this plan to an extraordinary single item Finance Committee on Wednesday 3 or Thursday 4 June.

Authors:
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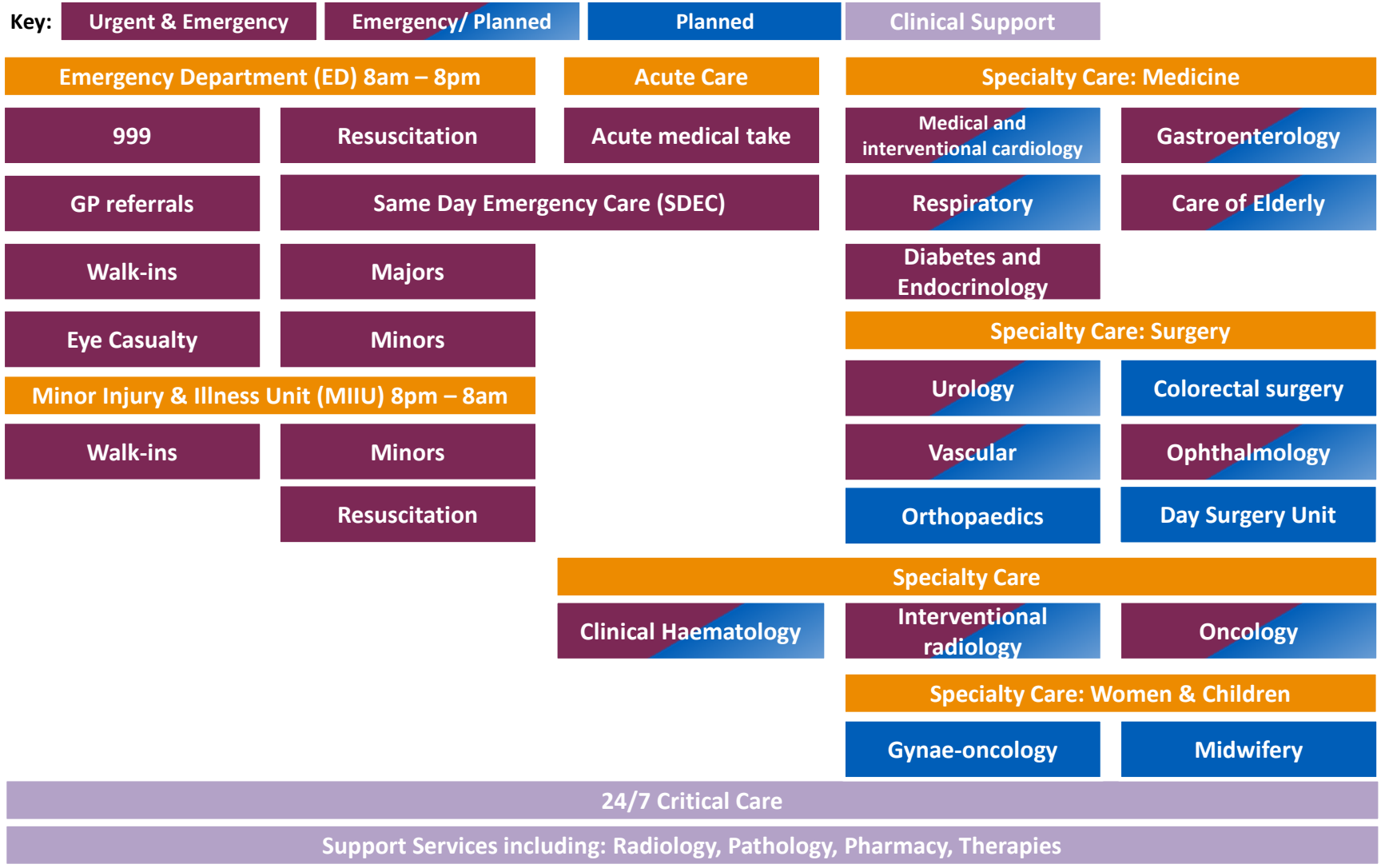
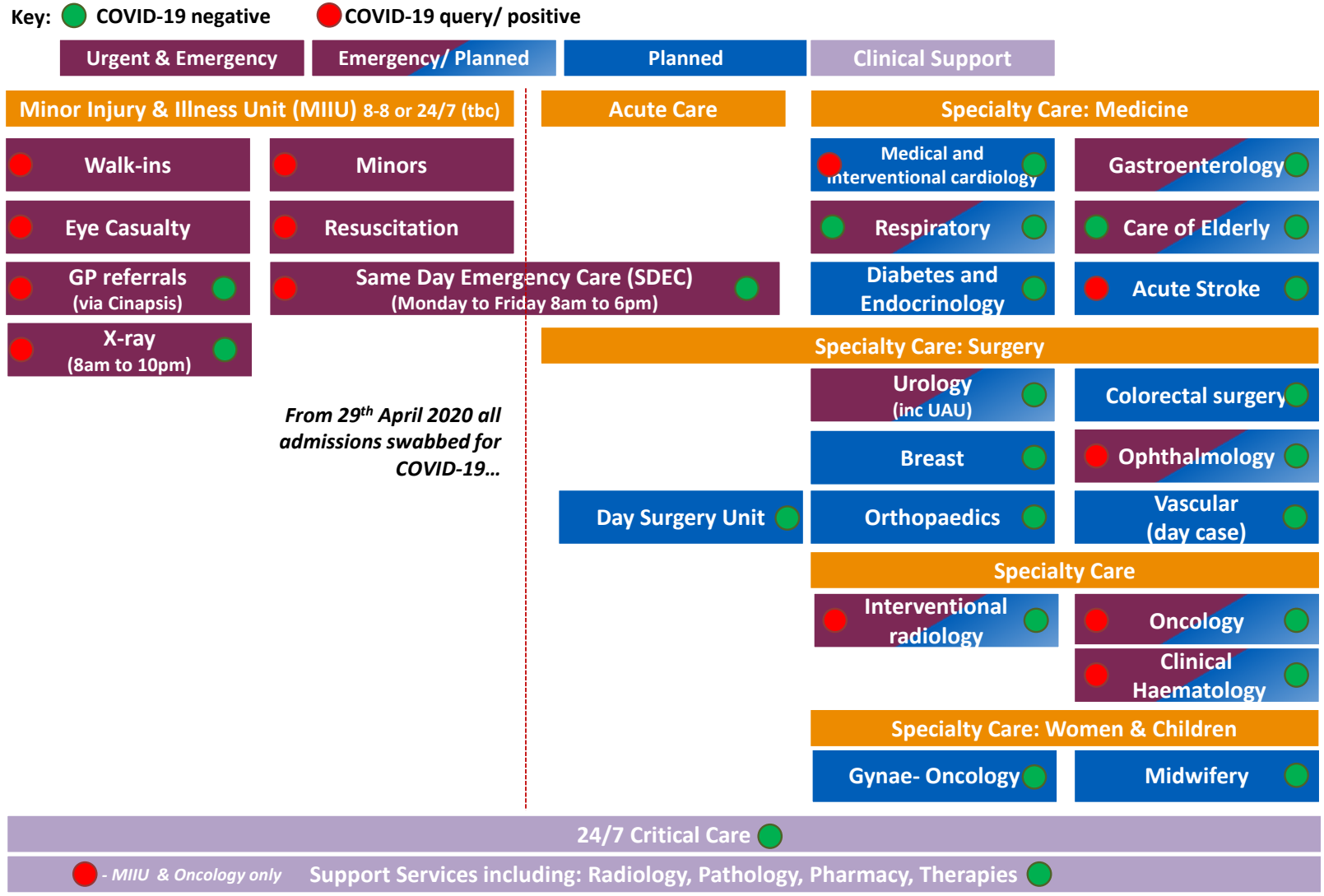
Prof. Steve Hams, Director of Quality and Chief Nurse
Dr. Rachael De Caux, Chief Operating Officer
Karen Johnson, Director of Finance

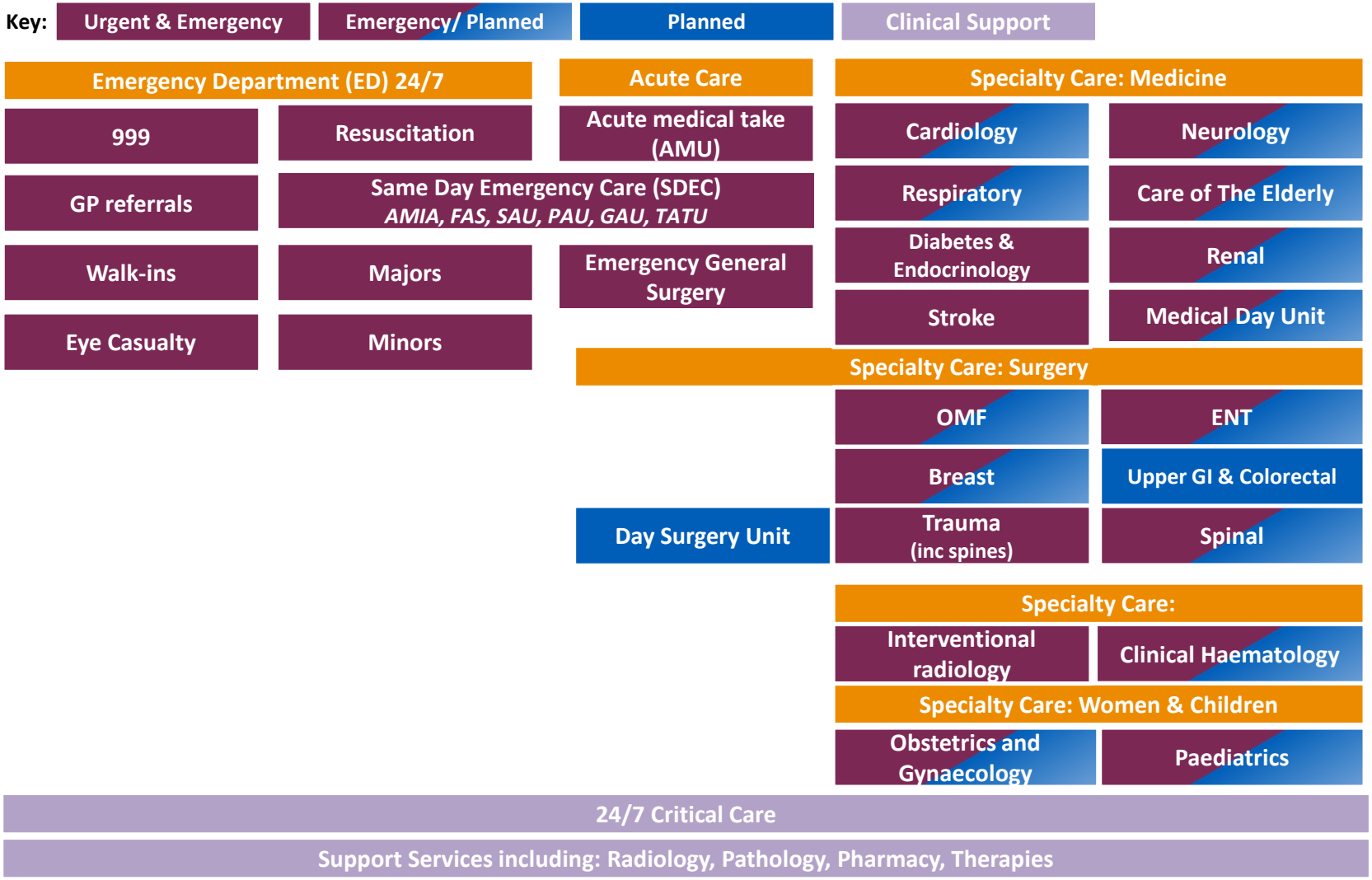
Appendix 1a: Current State: Cheltenham General Hospital - as at 30 April 2020
Includes current pilots and emergency (temporary) service changes, inpatient & day case services only



Appendix 1b: Proposed State: Cheltenham General Hospital – with proposed COVID-19 phase 2 changes
Includes current pilots and emergency (temporary) service changes, inpatient & day case services only



Appendix 2a: Current State: Gloucestershire Royal Hospital - as at 30 April 2020
Includes current pilots and emergency (temporary) service changes, inpatient & day case services only



Appendix 2b: Proposed State: Gloucestershire Royal Hospital – with proposed COVID-19 phase 2 changes
Includes current pilots and emergency (temporary) service changes, inpatient & day case services only