Gloucestershire Hospitals
NHS Foundation Trust

PUBLIC BOARD AGENDA

Meeting: **Trust Board meeting**

Date/Time: Thursday 11 March 2021 at 12:30

Location: Microsoft Teams

	Agenda Item	Lead	Purpose	Time	Paper
	Welcome and apologies (RdC)	Chair		12:30	
1.	Declarations of interest	Chair			
2.	Minutes of the previous meeting	Chair	Approval		YES
3.	Matters arising	Chair	Approval		
4.	Chief Executive Officer's report	Deborah Lee	Information	12:35	YES
5.	Fit For the Future decision making business case * *12:45 intro* * *12:55 Patient* * *13:20 staff* * *13:35 governor* * *13:45 debate and decision*	Simon Lanceley	Approval	12:45	YES
	BREAK			14:20	
6.	Trust risk register	Emma Wood	Approval	14:30	YES
	FINANCE AND DIGITAL				
7.	Digital Aspirant programme	Mark Hutchinson	Approval	14:35	YES
8.	Finance report	Karen Johnson	Assurance	14:40	YES
9.	Assurance report of the Chair of the Finance and Digital Committee	Rob Graves	Assurance	14:50	YES
	PEOPLE AND ORGANISATIONAL DEVELOPMENT				
10.	People and Organisational Development Report	Emma Wood	Assurance	15:00	YES
11.	Assurance report of the Chair of the People and Organisational Development Committee	Balvinder Heran	Assurance	15:10	YES
	QUALITY AND PERFORMANCE				

12.	Quality and Performance report	Steve Hams / Felicity Taylor-Drewe / Mark Pietroni	Assurance	15:20	YES
13.	Temporary service changes	Simon Lanceley	Approval	15:30	YES
14.	Assurance report of the Chair of the Quality and Performance Committee	Alison Moon	Assurance	15:40	YES
	STANDING ITEMS				
15.	Minutes of the Council of Governors held on 16 December 2020	Chair	Information	15:50	
16.	Governor questions and comments	Chair			
17.	New risks identified	Chair			
18.	Any other business	Chair			
CLOSE				16:00	

Date of the next meeting: Thursday 8 April 2021 at 12:30 via MS 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	**Executive Directors**
Claire Feehily Rob Graves Marie-Annick Gournet Balvinder Heran Alison Moon Mike Napier Elaine Warwicker	Deborah Lee, Chief Executive Officer Emma Wood, Director of People and Deputy Chief Executive 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 Mark Pietroni, Director of Safety and Medical Director
Associate Non-Executive Directors	

Rebecca Pritchard Roy Shubhabrata	

Gloucestershire Hospitals
NHS Foundation Trust

DRAFT - MINUTES OF THE TRUST BOARD MEETING HELD VIA MICROSOFT TEAMS THURSDAY 11 FEBRUARY 2021 AT 12:30

THESE MINUTES MAY BE MADE AVAILABLE TO THE PUBLIC AND PERSONS OUTSIDE THE TRUST AS PART OF THE TRUST'S COMPLIANCE WITH THE FREEDOM OF INFORMATION ACT 2000

PRESENT:		
Peter Lachecki	PL	Chair
Deborah Lee	DL	Chief Executive Officer
Rachael de Caux	RdC	Chief Operating Officer
Claire Feehily	CF	Non-Executive Director
Marie-Annick Gournet	MAG	Non-Executive Director
Rob Graves	RG	Non-Executive Director and Deputy Chair
Steve Hams	SH	Joint Director of Quality and Chief Nurse
Balvinder Heran	BH	Non-Executive Director
Mark Hutchinson	MH	Chief Digital and Information Officer
Alison Moon	AM	Non-Executive Director
Mike Napier	MN	Non-Executive Director
Mark Pietroni	MP	Director of Safety and Medical Director & Deputy Chief Executive Officer
Elaine Warwicker	EWa	Non-Executive Director
Carole Webster	CW	Joint Director of Quality and Chief Nurse
Emma Wood	EW	Director of People and Organisational Development & Deputy Chief Executive Officer
IN ATTENDANCE:		
James Brown	JB	Director of Engagement
Margaret Coyle	MC	Chief of Service, Division of Surgery (For 028/21)
Sim Foreman	SF	Trust Secretary
Steve Perkins	SP	Director of Operational Finance
Simon Pirie	SPi	Guardian for Safe Working (For 027/21)
Rebecca Pritchard	RP	Associate Non-Executive Director
Ian Quinnell	IQ	Associate Director – Strategic Planning & Transformation
Roy Shubhabrata	RS	Associate Non-Executive Director
Felicity Taylor-Drewe	FTD	Deputy Chief Operating Officer
APOLOGIES		
Karen Johnson	KJ	Director of Finance
Simon Lanceley	SL	Director of Strategy and Transformation
MEMBERS OF THE PUBLIC/PRESS/STAFF/GOVERNORS:		
There were five Governors and one member of the public present.		

ACTION

020/21 DECLARATIONS OF INTEREST

SF reported on new declarations received from CF and SH which would be recorded on the Register on Interests;

- CF as a Trustee of the Brandon Trust and
- SH as Independent Registered Nurse for Surrey Heartlands CCG.

SP declared an interest as a Trust appointed Director of Gloucestershire Managed Services (GMS).

RESOLVED: The Board NOTED the new declarations of interest from CF and SH and that there were NO declarations in relation to

the business of the meeting.

021/21 MINUTES OF THE PREVIOUS MEETING

RESOLVED: The Board APPROVED the minutes of the meeting held on Thursday 14 January 2021.

022/21 MATTERS ARISING

There were none.

023/21 CHAIR'S UPDATE

The Chair presented a paper to update on and seek approval for continued flexible governance arrangements. It was noted that the Trust had flexed the guidance, to provide for the continuation of governor meetings and the Chair thanked all executive colleagues who had supported these. The Trust would continue to streamline agendas of Board and Committee meetings and to convene virtual meetings.

RESOLVED: The Board NOTED the update on governance arrangements, APPROVED the continuation of measures to provide proportionate governance and oversight whilst the Trust response to the pandemic continues and DELEGATED decision making on use of virtual meetings and streamlining agendas to the Chair and Chief Executive.

024/21 CHIEF EXECUTIVE OFFICER'S REPORT

DL presented the report remarking how much is still happening within the Trust beyond the response to COVID. Although the numbers had dramatically reduced there were 75 COVID patients being cared for, (including seven in Critical Care). Suppression of transmission was being aided by the lockdown and the vaccination programme, but there remained a need for continued focus to avoid a "bounce" in cases and the government guidance on 22 February was awaited. Gloucestershire was at the top of the national league table for vaccinations and DL had heard stories and received emails outlining what it truly meant to be people to receive their first dose.

The continued work on the Digital programme had allowed the Trust to provide safer and higher quality care during the pandemic as a result of the launch of early warning observations (e-obs). Building on this, the Trust had been awarded Digital Aspirant status in recognition of its ambition and the delivery of the programme to date, which would provide £6m to expedite digital activities.

DL commended the Endoscopy Training Academy for their work to train and develop the future workforce and providing a solution to future challenges.

Apprenticeship week had received lots of great feedback and shown a strong programme was in place across the Trust. There were great examples of people changing tack in their careers through an

apprenticeship alongside those people joining the workforce for the first time.

DL drew attention to additional Fit For the Future (FFtF) materials which are going live through February 2021, ahead of the decision at the March 2021 Board meeting where there will hopefully be a patient and staff story linked to FFtF.

DL reported the hospitals' charity was about to launch the Green Spaces Appeal to build a garden of commemoration at Gloucestershire Royal Hospital (GRH) which would enshrine the dandelion theme of the "Every Name a Person" initiative in the garden and be open to staff, patients and visitors as a tranquil place for rest and reflection.

DL highlighted tremendous work to reduce the number of Healthcare Support Worker (HSW) vacancies towards zero (usually 90-100 vacancies). There was £190k government funding to support a creative and innovative approach to recruitment in areas of high unemployment post-COVID and to draw in those that do not have the typical entry requirements but who, with support, would make fantastic HSWs.

EWa asked if lower levels of vaccine uptake were being seen within any specific groups. DL replied that a vaccine equity group had been established across the Integrated Care System (ICS) to target and understand lower uptake amongst certain groups given there is both local and national evidence of reduced uptake in some groups e.g. those from Black African and Black Caribbean ethnicities. SH added that over 5,000 colleagues in the Trust had been vaccinated, which was lower than annual flu performance levels and a sensitive and professional webinar focused on BAME colleagues had received lots of views. DL explained that the peer vaccination programme used for flu would hopefully increase the uptake. SH assured that the Trust did not waste a vaccine wherever possible and considerable thought was being given to how to increase staff uptake.

RG thanked DL for the report which provided him, as a NED, with assurance that she was close to the details whilst also looking ahead to the future. This was echoed by AM who added her assurance about operational pressures and the ability to transform services to respond to them. AM asked if there were areas where DL would like improvements to be faster. DL reflected the potential for conflict between staff groups where some may be better "rested" than others but both are pivotal to a single service and noted we will need to navigate this carefully on a service by service basis. She said she was impatient to see our approach to communicating with patients who are waiting but knew this was underway and a paper on this is due at the May 2021 Board.

RS asked how the c50% staff vaccination uptake compared to other trusts and SH explained that the complexity of the data collection process meant the Trust could only view its own. However, SH updated from discussions with his peers in other trusts that we were "in the pack" and stressed formal benchmarks were not available but uptake within GHFT was comparable to GHC.

ACTION

RESOLVED: The Board NOTED the Chief Executive Officer's report.

025/21 TRUST RISK REGISTER

EW presented the report and confirmed there were NO closed risks or risks where scores had reduced, but there were five new entries; one related to workforce, three related to theatres and one related to strategic programmes. EW confirmed the Risk Management Group had reviewed the risks and provided a brief synopsis of each as follows:

- Workforce risk related to not having sufficient staff to comply with statutory requirements related to Liberty Protection Safeguards (LPS) by 01 April 2022.
- Three theatre risks related to ventilation failure interrupting service, lighting failure and total power supply failure and would be addressed and mitigated through theatre refurbishment.
- The final new risk was from strategy and transformation related to a planned service reconfiguration being delayed due to the possibility of public consultation.

RG commended the quality of the report commenting it improved each month. RG asked in relation to the workforce risk and the Mental Capacity Act, was it a case of availability of qualified staff or resources? CW confirmed it related to skills and the time taken to build these up and also have sufficient numbers of staff to cover a seven day service. DL confirmed the Executive Team were discussing a number of intolerable risks on the 8th March 2021 and would consider whether the Trust process for agreeing investments was agile enough given these risks and the delayed operational planning process.

CF enquired on the level of confidence in the responsive of the risk management process to mapping staff availability over the coming three to six months (in terms of resting people and having cover) and any sense of Brexit related supply chain and distribution issues for pharmaceutical or other supplies.

SH responded on the first point explaining that there were thrice daily reviews of ward coverage to ensure sufficient nursing cover. SH added that the strategic review of nursing had looked ahead for the next six months and confirmed there was good coverage. MP seconded this for medical coverage.

RdC confirmed she chaired weekly meetings to consider EU exit issues affecting the Trust and stakeholders and there were no supply issues.

RdC also assured that the theatre risks were mitigated as far as practicable to limit the risk of cancellations to patients. All three risks would be address through the prioritisation of capital next year for the theatre refurbishment programme over the next two to three years.

RESOLVED: The Board NOTED the report and the changes to the Trust Risk Register.

026/21 QUALITY AND PERFORMANCE REPORT

RdC advised the recent COVID surge had impacted on both urgent and elective care performance and although de-escalation work was underway, significant pressures were still expected particularly on four hour wait in the Emergency Department arising from the impact of beds removed for social distancing, on flow.

RdC expressed her pride and gratitude to colleagues continuing to deliver cancer services including mutual aid to other trusts.

Whilst there were a significant number of 52 Week Waiters (52WW) to receive care as part of the recovery process, the Trust would continue to prioritise those patients with the highest clinical priority for treatment as well as developing plans for increasing the proportion of routine care delivered as part of recovery.

SH advised nosocomial transmission was now decreasing as a result of the restoration of social distanced beds. Work was also underway with AM and through the Quality and Performance Committee (QPC) to respond to the Ockenden review and there was an increase in the number of maternity metrics in the report to support this. The data showed that women's experience of maternity care had also started to improve as partners and supporters had been able to participate in care.

MP advised the latest Hospital Standardised Mortality Ratio (HSMR) data showed it returning to normal range. MP also explained the first data on COVID mortality had been published and the Trust's rates were at the lower end of the national average. The detailed date would be presented to QPC and Board in due course.

DL noted the highly preventable deaths related to VTE and that this indicator had never been green, albeit the bar was high at 95%. This was due to be reviewed at QPC later in the month.

CF was encouraged by the HSMR information and asked if anything was being flagged in relation to patients with Learning Disabilities (LD) such as higher incidence of admissions and anything more we can do to improve care. SH said that there were currently a number of outbreaks in LD homes across the county and the vaccination uptake was lower than expected amongst this group and this was being followed up by Public Health colleagues at Gloucestershire County Council. SH reminded and assured the Board that all deaths of patients with LD were subject to LeDeR reviews.

CF asked a supplementary question to ascertain if more could be done to support the LD homes. SH felt the situation had settled and the Trust was providing Infection Prevention and Control (IPC) support for the whole system. DL advised that Gloucestershire deaths of LD patients were lower than the South West region, which itself was lower than the national average for England. DL said the mortality and admission data would be refreshed after Q4, and reported to QPC. **SH**

RG asked for a future meeting if it would be possible to present the dashboard position to show how the most problematic areas track to

recovery rates rather than the end point of national standards. RdC replied that between waves the Trust used a separate set of metrics but the future reporting was expected to change on publication of the national planning guidance e.g. the 52 week wait standard was unlikely to be a key measure.

RESOLVED: The Board RECEIVED the report as ASSURANCE that the Executive Team and Divisions fully understood the levels of delivery against performance standards and had action plans to improve the position where warranted.

027/21 GUARDIAN REPORT ON SAFE WORKING

SPi presented the report for the period October to December 2020 advising there were 107 exception reports (down from 146) with no fines levied. The low number of vacancies was also encouraging.

The Junior Doctor Forum meeting had taken place virtually and there had been positive feedback on food vouchers and accommodation post-shift.

SPi was now reinforcing the need to monitor the logging of exception reports and reinvigorate access to rest breaks to keep things sustainable.

The Chair asked if there were any positive benefits to junior doctors from their experience of working during COVID and how they could be captured and shared. SPi replied that the key areas were how quickly work patterns changed and adapted, the team approach (citing MP as a great role model) and the importance of Chief Registrars. There had been some challenges related to the pace of change where patients move or doctors are redeployed more frequently.

EWa asked if SPi had a sense of what was NOT being reported given the longer hours currently being worked and what the 107 exception reports were telling us. SPi advised he would expect 100-150 reports per quarter and the length of time worked as not showing as a significant issue. He felt there might be fewer reports on access to breaks and the knock on effect of fatigue, which was being promoted again as something that should be reported.

MP shared learning from the Royal College of Physicians which had challenged the perception that junior doctors were cosseted and had shown that their work and efforts through COVID had dispelled this as they had gone above and beyond what was expected of them.

SPi advised this would be his penultimate or final report in his capacity as the Guardian for Safer Working and expressed his appreciation for the ability to have direct access to the Board. The Board thanked SPi and congratulated him on his new role as Chief of Service for Women's and Children's from April 2021.

RESOLVED: The Board was ASSURED that the exception reporting

process was robust and the Junior Doctor Forum was functioning well and discharging its duties accordingly.

028/21 TRAUMA & ORTHOPAEDIC PILOT UPDATE

MP presented the report for information and advised it would be part of Fit For the Future (FFtF) decision making business case information. The pilot had moved elective orthopaedic care to Cheltenham General Hospital (CGH) and trauma to Gloucestershire Royal Hospital (GRH) and had delivered improvements. MC explained that COVID had disrupted orthopaedic and elective trauma work but urgent trauma had continued. This service had been the hardest hit by COVID and the orthopaedic team had responded by helping colleagues across the Trust and shown themselves to be a great group of professionals supporting both critical care services and the vaccination hub.

MC advised since 2017 the pilot had delivered benefits for emergency and elective care with an additional 200 patients per year receiving treatment and the one site model for orthopaedics delivering better outcomes and reduced length of stay (LoS) e.g. hips reduced from five to six days to three days. There were also benefits from seven day cover and an on-call staff member with no other duties being more accessible to trainees. MC confirmed that there was sufficient evidence from the pilot for the Division to support the change on a permanent basis. The Chair thanked MC and congratulated her on her appointment as Chief of Service before inviting questions.

MN noted that a number of things had changed over the past three years and asked to what extent other developments may have contributed to the changes and improvements, to ensure the pilot improvements would not have happened anyway. MP advised she was confident this was not the case and the elective improvements spoke for themselves given the improvements came so quickly after the changes. It was similar for trauma where there had been sustained performance despite an increased workload.

DL noted the RED indicator on theatres related to capacity and demand and sought assurance that there was a plan to move this to GREEN or if the Trust needed to do more. MC replied there had been investment in the transfer team and the Trust had looked at exemplars and a recovery plan against trajectories had been agreed as part of the Executive review process.

AM commended an excellent paper and raised a number of points:

- Noting all the comparisons were against national averages, AM suggested the Trust could weave in comparison to best performing trusts.
- Was there confidence that the changes were future proofed to deal with increased demand?
- What patient evaluation of the process had taken place?
- What might QPC as the assurance committee see in future on time to theatre, as a RED indicator amongst a sea of GREEN.

MC advised that some patient experience evaluation had taken place but the reduction in cancellations had been a helpful surrogate alongside rehab in the community and orthopaedic operating day case capacity. AM suggested evaluation was formally built into future pilots beyond FFtF. MC agreed that more could be done in this space and was acknowledged and in train.

RESOLVED: The Board NOTED the latest performance of the T&O Pilot and that the report will form part of the additional information to be considered on 11 March 2021 when the FFTF Decision Making Business Case (DMBC) will be presented.

029/21 ASSURANCE REPORT OF THE CHAIR OF THE QUALITY AND PERFORMANCE COMMITTEE

AM presented the report from the meeting held on 27 January 2021 confirming it had been a pared down agenda with a risk-based focus. AM highlighted the openness in the meeting from colleagues on the pressures being faced and efforts going into keeping services and staff going, as well as the recovery. AM alerted the Board that it was likely the metrics reported in the coming months would reflect the current pressures but the Committee had received good assurance on the use of escalation areas and the processes supporting them as well as plans to get back out of them.

Ambulance handover times were longer than typical but the Committee were assured that the right patients were being offloaded at the right times in the right order.

Discussion on system working had shown improved discharges amongst other areas and AM stressed the importance of partnerships cannot be overstated.

AM advised there had been recognition that some colleagues and departments had been focused on operational delivery AND improvements citing the continued strong improvement in cancer services and the 13 months since the last MRSA case as examples of this.

The Committee have started to look at maternity services and AM had met with both SH and CW, in her capacity as the lead NED for this area.

A new Quality and Performance report will be introduced in April 2021 with a shadow version coming the March meeting.

The Chair advised that many Trusts had not maintained their quality and performance committee meetings during the pandemic to the extent that this Trust had, and thanked AM and QPC members for their continued focus, discussion and challenge.

RESOLVED: The Board RECEIVED the report as assurance of the scrutiny and challenge undertaken by the Quality and Performance Committee.

ACTION

030/21 TRUST STATEMENT ON MODERN SLAVERY

SF presented the paper which included the Statement of Modern Slavery for 2019/20 and an update on the work in the current year.

RESOLVED: The Board NOTED the ongoing work taking place across the Trust to ensure that slavery and human trafficking is not taking place in any of its supply chains, and in any part of its own business and APPROVE the updated statement on Modern Slavery.

031/21 ASSURANCE REPORT OF THE CHAIR OF THE AUDIT AND ASSURANCE COMMITTEE

The report was taken as read and CF highlighted the focused discussion on risk management had shown the quality and completeness of understanding within the Trust.

CF also reported there had been a Governor development session which had been well attended and provided a good sense of the opportunity to support risk management in the Trust.

RESOLVED: The Board RECEIVED the report as assurance of the scrutiny and challenge undertaken by the Audit and Assurance Committee.

032/21 ASSURANCE REPORT OF THE CHAIR OF THE ESTATES AND FACILITIES COMMITTEE

MN presented the report and highlighted the Committee had received assurance that GMS staff affected by stress and strains of the pandemic had access to the same support services as Trust staff.

The Committee had also discussed security arrangements and the role of porters in dealing with violence and aggression (V&A). Conversations on this were ongoing and linked to findings from the V&A internal audit.

The Committee had market tested costs of the overall work of the Strategic Site Development (SSD) programme to address the financial challenge of increased costs and both EFC and FDC will be monitoring on an ongoing basis.

RESOLVED: The Board RECEIVED the report as assurance of the scrutiny and challenge undertaken by the Estates and Facilities Committee.

033/21 FINANCE REPORT

SP updated the Month 9 (M9) position showed a £1.1m deficit with a £900k improvement due to the underperformance of elective activity, as a consequence of the second wave of COVID. The Trust had delivered 98% of planned activity in month although the levels were lower than M8.

The year to date (YTD) position was £4m ahead of plan, again due to the underperformance of elective activity and the forecast outturn position was improved at £3.9m (although it had not moved in month). SP updated on the need to bridge COVID and recovery in the final quarter and the Trust will work with system partners to further improve the outturn.

The balance sheet position showed the Trust holding high levels of cash although these would reduce in March, as they related to the timing of a payment.

The M9 capital position was £3.5m away from expenditure position and a detailed review of the £7.7m underspend had taken place to either get schemes back on track or bring them forward. The Board heard there was a high degree of confidence in the ability to deliver the capital programme following discussions at the January meeting of the Infrastructure Delivery Group.

DL asked SP for his view on where the year-end position might settle. SP replied that there were ongoing discussions with NHSE/I focused on a system basis but they wanted as much certainty as possible. SP felt the Trust would be able to deliver its position despite lost income, a nationally mandated annual leave adjustment and the ongoing GENMED HMRC issues. DL highlighted to the Board that a number of these factors were beyond the Trust's control.

The Chair asked how well the finance teams were managing and coping. SP acknowledged that, like everyone else, people got fatigued and missed being with people working side by side, but overall there had been a great response with some colleagues more suited to remote working than others. SP stated the new "normal" would be different but the team were a credit to work with.

RESOLVED: The Board RECEIVED the contents of the report as a source of ASSURANCE that the financial position is understood and under control.

034/21 DIGITAL REPORT

MH updated that the Digital team had supported operational and IPC colleagues with the introduction of the COVID alert system to replace a manual system. The team were about to embark on some interesting work with the Onward Care Team to reach outside the organisation and prepare for early discharges. This will include work with Gloucestershire Health and Care NHS Foundation Trust to provide access to our system this week and further join up care.

In relation the implementation of the Electronic Patient Record (EPR), the next two weeks would see the go live of Sunrise in Women's and Children's followed by rollout of the Emergency Care Data Set (ECDS) at CGH A&E at end of March and GRH over the summer. MH acknowledged and recognised the challenge of rolling this out in a high pressure environment but the benefits would be huge, as it would provide a complete a record as possible for the whole patient journey

from ED to discharge and would be a key contributor to safety.

MH also highlighted the digital support provided to the vaccination programme, the strain placed on the IT helpdesk as a result of the number of people working remotely and Information Governance updates in the report.

RP was pleased to hear about the EPR and see practical examples of it being used and asked if there was a way of capturing and communicating the improvements such as time saved, safety metrics etc. MH advised that benefits were reported to the Finance and Digital Committee (FDC) but his team were working to try and share the stories and benefits for staff and patients such as MUST assessments. Time and motion studies had been undertaken to capture the time saved from EPR. The regular meeting of staff would be the forum to identify benefits and MH and SP would try and capture and record these. MH explained the benefits differed for wards, consultants and matrons etc. and he would try show them through the different lenses. He was keen to articulate the benefits but flagged to the Board that it might be that 2019 and 2022 are compared due to the impact of COVID on 2020 and 2021.

Further to the CEO's report, the Chair asked MH to explain the Digital Aspirant programme and elaborate what it means for the Trust. MH explained historically Global Digital Exemplars and a smaller number of "fast follower" Trusts had received funding to allow them to develop further and faster and create blue prints for others but this had widened the digital gap between trusts. A new Digital Aspirant status had been established which the Trust had been awarded due to us demonstrating delivery and ambition. The Trust would receive £6m over three years and have an opportunity to share our experience and learn from others. MH hoped to link with the whole ICS for this work. The Trust was required to match this £6m, and this decision was going through approvals but given this was only a third of recent years' spend he was hopeful of securing this.

The Chair asked if there was a system dimension to Aspirant status. MH replied that although it was Trust focused there was clear connection to how partner organisation data was surfaced in the EPR in the hospital.

RS asked if the £6m was earmarked or the Trust was able to spend as it wished. MH advised that five year capital programme was designed to move the Trust from level zero to level six (seven being the maximum) and the £6m linked to this. There were some headings against the funds and these would be shown in governance reports.

BH stated this was great news and national recognition of the Trust not only doing well, but being able to help others catch up too and support hospital at home care to reduce time in hospital. BH asked if there were plans to streamline the system and entry points to enable a single view of the patient for community, acute and primary care. MH confirmed the ICS Executive had requested a plan for this and this would be reported to FDC as part of ICS updates. MH highlighted the need for striking a balance in using the right system properly without switching people off. Discussions were taking place on whether to use the Continuity of Care

Maturity Model (CCMM) as a system metric.

DL reminded the Board not to underestimate the value of the Trust having an executive digital lead on the Board, whereas the other two NHS system partners have Finance Directors with IT in their portfolio and suggested it would be helpful for NEDs with expertise (from these organisations) to get involved in the ICS level discussions.

RESOLVED: The Board NOTED the contents of the report as a source or INFORMATION and ASSURANCE.

035/21 ASSURANCE REPORT OF THE CHAIR OF THE FINANCE AND DIGITAL COMMITTEE

The report was taken as read and RG updated from discussions on wider system issues which had confirmed communication links had been established, working and view positively. The Committee had also looked at the specific issue of the decarbonisation programme.

The finance discussion was as per SP's report and the Committee were assured on the activity and lower levels of spend. The Capital position was again as reported and the Committee had specifically noted progress to recoup underspend.

In relation to budget setting, RG expressed sympathy to colleagues affected by the challenge of uncertainty related to planning guidance.

The Digital review had looked at both short and long term projects covering upcoming deployments and some future issues including changes to the Microsoft system. The Committee would receive a full Digital Aspirant update at the next meeting.

RESOLVED: The Board RECEIVED the report as assurance of the scrutiny and challenge undertaken by the Finance and Digital Committee.

036/21 GOVERNOR QUESTIONS AND COMMENTS

AT welcomed the new Associate NEDs and felt it was a great meeting. He had been encouraged by the views on the recovery of services and the need for transparency and openness with both patients and public. AT liked the continuity of care model and also welcomed the focus on VTE and pointed it out performance had never been "GREEN" prior to DL's arrival.

AT queried the risk related to power outage in theatres and the time to resolve it. RdC explained it was one of a trio of risks that would all be addressed over one to two years. DL added that whilst the risk had manifested, it had done so without a catastrophic outcome.

037/21 NEW RISKS IDENTIFIED

There were none.

		ACTION
038/21	**ANY OTHER BUSINESS**	

There were no items of any other business.

DATE AND TIME OF THE NEXT MEETING

The next Trust Board meeting will take place at 12:300 on Thursday 11 March 2021 via Microsoft Teams

[Meeting closed at 14:52]

Signed as a true and accurate record:

Chair
11 March 2021

Gloucestershire Hospitals
NHS Foundation Trust

PUBLIC BOARD – MARCH 2021

CHIEF EXECUTIVE OFFICER'S REPORT

1 Operational Context

1.1 Since my last report, the Governments plans for easing lockdown restrictions have been published. I personally welcome the cautious approach being taken, which affords for the impact of each phase of easing to be assessed and judged. I am keen to remind everyone that the current low rates of circulating virus are the result of lockdown and, until we can be confident that vaccine uptake and community immunity is sufficiently great to avoid a rebound, we are not yet on the home straight but to quote a favourite Chief Nurse "the light is getting brighter, and the tunnel is getting shorter"

1.2 Recognising the "no sooner than" approach to the various dates for each phase, colleagues are, however, pleased to finally have some basis upon which to plan – the group of staff who will hopefully be able to leave shielding on the 21st March are at the forefront of my mind, some of whom have been shielding for 12 months; supporting the successful return of this group is a key priority for the organisation.

1.3 As the rates of community transmission continue to fall the number of COVID positive patients in our hospitals is also reducing significantly with less than 30 inpatients now in our care and new admissions each week, down to single figures. The numbers of non-COVID patients in our care continues to rise and this will increasingly be the case as we begin to restore routine operating and other services. Given the increasingly low rates of circulating virus and the continued progress of the COVID vaccination programme, we have now commenced a phased increase of our bed base by restoring some of the beds removed to support social distancing which, in turn, will enable us to re-establish our surgical wards commencing 3rd March 2021. There is a very detailed plan and a similarly cautious approach is being taken to ensure that we do not run the risk of any upturn in hospital transmission rates.

1.4 National guidance on the expected approach to recovery is still awaited but the Trust continues to develop its own plans. The current focus is arranging the treatment for all those patients who are prioritised in Priority Group 2 (P2) i.e. do not require immediate emergency surgery but should be treated within a month; these are typically cancer patients or those for whom non-cancer related urgent surgery is necessary. There are currently 812 patients categorised as P2, all of whom will be treated by the end of March and with sufficient capacity to then treat this group in "real time" going forward. Considerable work is now underway to develop recovery plans for the 7,800 patients awaiting elective procedures, 2234 of whom have waited more than 52 weeks to date. Positively, our use of local independent sector capacity has increased considerably in the last month and some pathways are being primarily directed there, from primary care e.g. hernia pathway. A detailed recovery plan will, subject to receiving national guidance, will be presented to May Board.

1.5 Very positively, the vaccination programme in Gloucestershire remains a huge success with the County featuring top of the national leader board having delivered c230,000 first doses to people in the priority groups 1-9; this represents 44% of the eligible population with 100% of those aged 75 and over having been vaccinated, 94% of those aged 74 to 65 vaccinated and 92% of those deemed clinically extremely vulnerable (CEV). Vaccine supply is set to increase considerably from w/c 15th March

and, assuming this happens, we are confident of achieving the next milestone on the 15 April of having vaccinated all those in Joint Committee on Vaccinations and Immunisations (JCVI) Priority Groups 1-9. The Integrated Care System has established a Vaccine Equity Group to oversee uptake in those groups where "vaccine hesitancy" or other barriers to access are evident. Staff vaccination is progressing within the Trust but not as quickly as we would like; reflecting lower uptake in the general population, staff from Black Caribbean and Black African groups have lower uptake than the Trust as a whole. We can also differential access amongst professional groups. Plan to address this are well advanced, including using some of our successful strategies from recent flu campaigns, such as Peer Vaccinators.

1.6 Subsequent to last month's update, the Care Quality Commission (CQC) undertook their targeted inspection of the Trust's approach to Infection, Prevention and Control during the week commencing the 15th February. The inspection encompassed a review of data, policies and procedures; meetings with staff and an onsite visit to various areas of the Trust. Whilst the formal written report is awaited, the informal feedback was very positive with the themes of strong leadership, high staff engagement and innovation being of note.

1.7 System partners in the County have continued to work collaboratively to reduce the numbers of patients whose discharge from hospital is delayed but this remains one of the greatest constraints to improved performance and care quality, throughout the Trust. Despite best efforts, the numbers of patients whose discharge remains delayed is constantly between 120 to 150 and as such the Gloucestershire system is now in the bottom quartile of Trusts nationally and the worse performing in the South West Region. The system is currently working with the Emergency Care Intensive Support Team (ECIST) to better understand the root causes of this problem, help with capacity planning and identify the immediate high impact changes that we can make. Resolving this issue remains the most significant operational challenge facing the Trust.

1.8 On Tuesday 2nd March, the Trust and Gloucestershire Health and Care Foundation Trust (GHC) presented proposals to the Gloucestershire Health Overview and Scrutiny Committee for the extension of the current temporary service changes introduced in response to the pandemic. These changes will remain in place for a final three months, until 30th June 2021, to enable detailed plans to be developed. As part of this proposal that Trust has confirmed the re-opening of the Aveta Birthing Unit at Cheltenham General Hospital w/c 8th March and the restoration of Cheltenham A&E to the pre-pandemic Consultant Led Service 8am to 8pm and Nurse led unit overnight, by not later than the 1st July 2021.

2 Key Highlights

2.1 On Thursday 4th March, the Governors Quality Group received a presentation from Emergency Medicine Consultant Dr Faye Noble, GHC Operational Lead for Mental Health Jim Welch and Trust Involvement Lead, Anna Rarity describing the challenges encountered in trying to deliver high quality care to patients presenting to the Emergency Department (ED) with **mental health problems**. It is a long time that a discussion has had such an impact on those who were privy to it. These colleagues are the core of a recently established Mental Health Working Party whose aim is to improve the experience and outcomes for those with mental health problems, attending A&E. Of particular note, was the influence of the input to this group from Experts By Experience - patients with lived experience of using our services, who are now actively engaged in co-designing care that meets their needs and the needs of patients like them. There is much to do and it is clear that this patient group do not get best care on every occasion, but the commitment to change that was palpable

amongst this group. I look forward to lending my personal support to this group along with other members of the Board and Council of Governors.

2.2 Linked to this work, is the commitment to develop a wider T**rust strategy for vulnerable people,** including those with mental health conditions whether they present in crisis to our A&E or are one of the 30% of patients in our care at one time, who will have a serious mental illness.

2.3 March's Board meeting will be a seminal meeting in our aim to realise the vision set out in our ***Fit for the Future Programme.*** Many of the issues that the vision will address, if supported, have been the subject of debate for a decade of more and as such the magnitude of the meeting should not be understated. The final decision will be made by the Gloucestershire Clinical Commissioning Group at their meeting on the 18th March. I especially pleased that the Board will hear from a patient and staff who will be positively impacted by these proposals.

2.4 This month saw the publication of the national **Workforce Race Equality Scheme** data (collected in October 2019) which sadly paints a depressing picture of the limited progress on this agenda and of note the likelihood of minority ethnic candidates being appointed from NHS shortlists is at its lowest rate so far recorded while other key race equality indicators have not improved over time. The Trust has now received not only the key findings from the work recently undertaken by external consultants DWC but also their key recommendations. The Board will spend its development session next month considering the findings, recommendations and agreeing next steps.

2.5 Having heard last month about our successful Digital Aspirant Award, the Trust Board will be asked to sign off this programme at its March meeting, which will transform our digital capabilities of the Trust over the next five years. However, day to day progress also continues with the rollout of our electronic patient record – Sunrise EPR – which continues at pace and is now being used in all inpatient wards across our hospitals. At the end of February, Women's and Children's inpatients went live with order communications platform, which means they are now requesting and reviewing most pathology and radiology tests using Sunrise. Despite never having used Sunrise before, colleagues have responded brilliantly and have already embraced the new way of working with very few paper requests now coming through to our laboratories, one week after implementation. Next to go live are theatres and outpatients – watch this space! Finally, at the end of March, Cheltenham Emergency Department (ED) will go live with full EPR functionality, moving the majority of paperwork onto the systems. Whilst this is a huge change for staff, the benefits to doing this are huge. Full support and training is in place to ensure a smooth a transition as possible, including additional staffing and support throughout the go live period. Gloucestershire Royal ED will follow in late June 2021.

2.6 The hospitals' charity launched our exciting new project, the **Green Spaces Appeal** to build a garden of commemoration at Gloucestershire Royal Hospital site in memory of all those who died during the pandemic, as well as celebrating the incredible contribution of staff. The launch attracted considerable media interest including a star performance from Emma Wood, Director of People and OD. Donations are already flooding in for those who want to secure their own wire dandelion – big or small. The garden will hopefully be finished towards the end of April.

2.7 This month I had the pleasure of joining the inaugural meeting of the **Gloucestershire Cancer Institute Appeal Board**, established under the Chairmanship of local business woman Diane Savoury. The Board heard about the hospital charity's plans to

raise £10m in the next three to five years, to enable us to realise our vision of an oncology centre that is befitting of the quality of care delivered from inside it. The Board comprising a number of "high profile" local people will be finalising its approach to fundraising and commencing the private phase of its appeal, later this year.

2.8 As reported last month, under a national initiative to eliminate all **Health Care Support Worker** (HCSW) vacancies by the end of March 20201, the Trust has received national funding to recruit an additional 90 HCSWs and I have been especially impressed with the promotional materials developed to attract people from different walks of life. The Trust is being innovative and inclusive in its approach to not only recruiting the best but ensuring it fulfils its aim to support reduction in social inequalities through its approach to local recruitment and a diverse workforce reflects the communities we serve. A video featuring a wide range of our existing HCSWs has been produced to capture the different motivations for them joining the Trust, in this role – truly inspiring.

2.9 Although not central to patients (who typically just want to know that their NHS is in good hands) this month there has been considerable focus nationally and locally on the proposed changes **to** integrated care systems (ICS), set out in last month's White Paper entitled **Integration and innovation: working together to improve health and social care for all**. *One Gloucestershire* is well placed to move ahead quickly with the vision set out and as such has been selected as a "test bed" to work with regional and national teams on the implementation plans. Mary Hutton, ICE Accountable Officer is our representative in these discussions. More to follow on this agenda in the months ahead.

2.10 Finally, the Trust's growing reputation as an "employer of choice" has resulted in a strong field of applicants for the soon to be vacant Chief Operating Officer role. Seven candidates will be put through their paces over two days, involving a wide range of stakeholders – internal and external. An appointment will hopefully be made by the end of the month.

Deborah Lee
Chief Executive Officer

5 March 2021

Gloucestershire Hospitals NHS
NHS Foundation Trust

Trust Public Board – 11 MARCH 2021
Microsoft Teams, Commencing at 12:30

Report Title
Fit For The Future: Decision Making Business Case

Sponsor and Author(s)	
Author:	Simon Lanceley, Director of Strategy and Transformation
Sponsor:	Deborah Lee, Chief Executive

Executive Summary

Purpose

To secure Trust Board approval for the Fit For the Future (FFTF) Decision Making Business Case (DMBC).

Background

- Following the HOSC meeting on 22nd October, the FFTF public consultation process commenced and ran to January 2021.
- FFTF consultation proposals focussed on five specialist services: Acute Medicine (Acute Medical Take), General Surgery, Image Guided Interventional Surgery (IGIS), Vascular Surgery, Gastroenterology and Trauma and Orthopaedics.
- Post consultation, a range of additional information has been published to respond to feedback and is available here: https://www.onegloucestershire.net/yoursay/fit-for-the-future-developing-specialist-hospital-services-in-gloucestershire/
- The DMBC is the result of over two years of evidence development, assurance, engagement, consultation and review of proposals that addresses the case for change and delivers the next phase of our centres of excellence clinical model.
- The Outcome of Consultation report is a key document to be considered and is included as an appendix. This report includes the key points from the two Citizens Jury outputs (Jurors report and Jury report). Trust Board reviewed the interim report in January 2021.
- The FFTF consultation has been monitored by the Consultation Institute, under its Consultation Quality Assurance Scheme. The Institute has confirmed that the exercise has fully met its requirements for good practice. There are six stages, or gateways, of the Quality Assurance process: Scope and Governance; The Project Plan; Consultation Document Review; Mid-Point Review; Closing Review; Final Report.
- Taking into account the feedback received during consultation, the DMBC consists of 7 Resolutions that Board is asked to approve:

  Resolution #1: Formalise 'Pilot' Configuration for Gastroenterology inpatient services at CGH

  Resolution #2: Formalise 'Pilot' Configuration for Trauma at GRH and Orthopaedics at CGH

  Resolution #3: Centralise Emergency General Surgery at GRH

  Resolution #4: An Image Guided Interventional Surgery (IGIS) 'Hub' at GRH and a 'Spoke' at CGH

  Resolution #5: Centralise Vascular Surgery at GRH

Resolution #6: Centralise Acute Medicine (Acute Medical Take) at GRH

Resolution #7: Planned General Surgery. The recommendation is that work should continue to develop the option that would deliver:

- Planned High Risk Upper Gastrointestinal (GI) and Lower Gastrointestinal (Colorectal) surgery at Gloucestershire Royal Hospital
- Planned complex and routine inpatient and day case surgery in both Upper and Lower GI (Colorectal) at Cheltenham General Hospital.

FFTF programme gateways:

Gateway #1: *Trust Board – 13/8, approval to submit PCBC to NHSE -* ***COMPLETED***

Gateway #2: *South West Clinical Senate Panel – 20/8, confirmation all shortlisted options are clinically viable -* ***COMPLETED***

Gateway #3: *NHSE/I Stage 2 Assurance – 1/10, 5 of 5 statutory tests passed -* ***COMPLETED***

Gateway #4: *Trust Board – 8/10, approval to proceed to public consultation -* ***COMPLETED***

Gateway #5: *HOSC – 22/10, approval to proceed to public consultation –* ***COMPLETED***

Gateway #6: Trust Board – 11/3, Approval of Decision Making Business Case (DMBC) incorporating outcome of public consultation.

Gateway #7: Gloucestershire CCG Governing Body – 18/3, Approval of Decision Making Business Case (DMBC) incorporating outcome of public consultation.

Recommendations

Trust Board is asked to:

1. **Approve** the x7 DMBC resolutions as defined in the DMBC
2. **Approve** the Decision Making Business Case (DMBC) v2.0
3. **Approve** the programme proceeding to implementation.

Impact Upon Strategic Objectives

Delivers the 'Centres of Excellence' objective and supports delivery of 'Outstanding Care'

Impact Upon Corporate Risks

C2784 – Risk of formal legal challenge to the process we have used to develop and consult on our service reconfiguration proposals. Throughout the FFTF programme expert advice has been sought and followed. As far as it is possible to do so (and as supported by the recent commissioned legal review of our PCBC and consultation materials and DMBC), we believe we have done all we can to mitigate the risk of a successful challenge.

The FFTF consultation has been monitored by the Consultation Institute, under its Consultation Quality Assurance Scheme. The Institute has confirmed that the exercise has fully met its requirements for good practice.

The programme has at each stage acted in line with statutory duties and our assessment of best practice, supported by regular advice from the Independent Reconfiguration Panel (IRP), commissioned legal advice and best practice shared by the Consultation Institute. It should be noted that this position is based on the assessment of risk against known precedents and that this risk cannot ever be completely mitigated to zero.

Regulatory and/or Legal Implications

As a clinical reconfiguration programme Fit for the Future carries a risk of legal challenge. This is well understood and the processes adopted by the programme and set out in the business case are designed deliberately to ensure transparency of decision making and clarity that discussions and suggestions are subject to evaluation of impact and public engagement and consultation where required. Our approach throughout the programme has been grounded in expert advice as set out

above.
Equality & Patient Impact
A comprehensive independent Impact Assessment report has been completed for the preferred solutions. An independent Integrated Impact Assessment (IIA) identified Gloucestershire population groups that could be most affected by the proposals and the consultation was designed to ensure we heard from these groups.

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

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

Date the paper was presented to previous Committees						
Quality & Performance Committee	**Finance & Digital Committee**	**Audit & Assurance Committee**	**People and OD Committee**	**Remuneration Committee**	**Trust Leadership Team**	**Other (specify)**
	25/2/21				04/03/2021	S&T Delivery Group 16/2 ICS Executives 4/03 Council of Governors 17/2

Outcome of discussion when presented to previous Committees
• Agreement for DMBC to proceed to next gateway

One Gloucestershire
Transforming Care, Transforming Communities

NHS

Decision Making Business Case Version 2.0

March 2021

SUBJECT TO DECISION MAKING

Fit for the Future

Developing specialist hospital services in Gloucestershire

Contents

Document Control

Author:	Micky Griffith, Programme Director, Fit for the Future
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Version	Date	Author/Reviewer	Comments
1.1	02/11/20	Micky Griffith	Created draft structure
1.2	25/01/21	Micky Griffith	Sections 2,3,4 & 8
1.3	14/02/21	Micky Griffith	Sections 7 & 9
1.4	22/02/21	Micky Griffith	Sections 5 & 6
1.5	25/02/21	Micky Griffith	Incorporate reviewer feedback (internal & external)
2.0	04/03/21	Micky Griffith	Incorporate legal feedback, ICS & TLT Feedback

Document Distribution:

Forum/Audience	Date	DMBC v#	Comments
NHSE&I	19/02/21	1.2	Draft for 1st check-in meeting
NHSE&I	01/03/21	1.5	Draft for 2nd check-in meeting
ICS Executives	01/03/21	1.5	
GHNHSFT TLT	04/03/21	1.5	
GHNHSFT Board	11/03/21	2.0	
CCG Governing Body	11/03/21	2.0	
Publication onto website	04/03/21	2.0	

1 Executive Summary

1.1 Strategic Statement

We, the health and social care organisations in Gloucestershire, have committed to working together as an Integrated Care System (ICS) to improve the health of local people by prioritising prevention and self-care, and ensuring we deliver the right care in the right place at the right time.

Prioritising self-care and prevention means that we are using our data to understand the health needs of local people, and working to improve long-term health and wellbeing. Health and wellbeing is influenced by more than just health services so, as an ICS, we work as an active partner in the public sector to improve health through better housing, better education, better employment, better transport and keeping people safe.

Evidence and experience tell us that people can find it harder to improve their own health or to access our services when they have other challenges in their lives. These include living with deprivation, disability, or a mental health condition. Our commitment is that we will ensure our services are easier to access for people with health inequalities; both ensuring our services recognise and deliver parity of esteem for mental health and provide additional support when people need it.

Delivering the right care in the right place at the right time means that when care can be delivered at home or close to home, it will be. When people need to come to a centre to get care, our aim is to minimise the distance needed to travel to get there, as it can be hard to get around our county particularly with a long-term health condition.

Sometimes however, we will need to prioritise achieving a better health outcome over trying to minimise travel for people. Health care for some conditions is increasingly high-tech and needs expensive equipment and highly trained staff to keep pace with the best in the world. When specialist care is needed our aim is to increasingly deliver this through *Centres of Excellence*; centralised services where we can consolidate skills and equipment to provide the very best care. Sometimes these centres will be outside Gloucestershire but, where possible, as an ICS we will develop our specialist services so we can provide specialist care in our county.

Underpinning all of this is our strong commitment to listen to what matters to people, and to join up our data and information to understand how to meet local needs in the best way. Through our broader ICS engagement programme, we have heard that the care experience is better the more we can plan around individuals and carers' needs (personalisation) and when we use new ways to help support care, like using digital technology, to help plan and manage more care journeys. We have heard that travel and access concerns people, but that generally people are prepared to travel a little further to access better health outcomes where it is clearly demonstrated that this will be achieved.

The NHS has made significant improvements in recent years, but continuing to improve health outcomes, health care and ways of working is a challenge in the context of the resources we have available and the growing needs of our local population. Living within our means to make the best use of every Gloucestershire pound means a commitment to work together to put the patient first in everything we do, developing our workforce, and streamlining our services and organisations where possible to ensure everything we deliver is as efficient as it can possibly be.

Fit for the Future is part of the One Gloucestershire vision focussing on the medium- and long-term future of specialist hospital services at Cheltenham General Hospital and Gloucestershire Royal Hospital. The NHS in Gloucestershire is ambitious for the people of the county. We want to provide world class, leading edge specialist hospital care for patients that is comparable with the best in England.

To achieve these things and to make the most of developing staff skills, precious resources and advances in medicine and technology, we plan to change some of the ways we provide some of our specialist hospital services at Gloucestershire Royal and Cheltenham General, and make best use of our hospital sites. This move towards creating *Centres of Excellence* at the two hospitals is not new and this approach reflects the way a number of other services are already provided.

It is the Programme's recommendation to the Board of Gloucestershire Hospitals NHS Foundation Trust (GHNHSFT) and the Governing Body of Gloucestershire Clinical Commissioning Group (GCCG) that the following resolutions should be considered for agreement and approval, taking into account all the evidence that has been made available, on the basis that they represent the most appropriate solution to address the case for change and are supported by regulatory assurance.

- **Resolution #1**: Formalise 'pilot' configuration for Gastroenterology inpatient services at CGH, to make this a permanent change
- **Resolution #2**: Formalise 'pilot' configuration for Trauma at GRH and Orthopaedics at CGH, to make this a permanent change
- **Resolution #3**: Centralise Emergency General Surgery at GRH
- **Resolution #4**: Develop an Image Guided Interventional Surgery (IGIS) 'Hub' at GRH and a 'Spoke' at CGH
- **Resolution #5**: Centralise Vascular Surgery at GRH
- **Resolution #6**: Centralise Acute Medicine (Acute Medical Take) at GRH
- **Resolution #7**: Planned General Surgery. The recommendation is that further work should begin to deliver a new option.

This Decision-Making Business Case (DMBC) sets out the rationale for proceeding with these resolutions in the context of the extensive work that has been undertaken through the Fit for the Future Programme. This includes taking account of the outcome and findings of the recent consultation process that formally closed in December 2020, the additional information, the enhanced integrated impact assessment and the findings of the Citizens' Jury held in February 2021.

2 Background and Case for Change

2.1 Purpose and scope of DMBC

This Decision Making business case (DMBC) is concerned with the configuration of hospital services across Gloucestershire Hospitals NHS Foundation Trust (GHNHSFT), specifically between Gloucestershire Royal Hospital (GRH) and Cheltenham General Hospital (CGH).

This DMBC is based on the evidence compiled in the pre-consultation business case, feedback from consultation and further evidence compiled post-consultation. This DMBC reviews the outcomes from the consultation report and seeks to ensure that progress to decision-making and implementation is fully informed by detailed analysis of consultation outcomes.

The DMBC will present and summarise the extensive work completed to date, with the following purposes in mind:

- To present our response to the FFTF consultation;
- To demonstrate that options, benefits and impact on service users have been considered; and
- To confirm the recommendations for service change in order to enable decision- makers to determine if these proposals should be implemented

This DMBC is not concerned with the developments for the Forest of Dean Hospital; a separate proposal for this has been developed and presented to decision- makers as required.

2.2 Intended audiences and their decision-making roles

This DMBC is written by the Gloucestershire Fit for the Future Programme for the following audiences:

- The Governing Body of Gloucestershire Clinical Commissioning Group (CCG) which will decide whether the proposed service changes should be implemented based on the evidence presented. The CCG is the legally accountable Consulting Authority so has final responsibility for approving next steps.
- The Board of the Gloucestershire Integrated Care System (ICS), who will be asked to provide their support and ensure that the proposals are compatible with our shared system strategy.
- The Board of Gloucestershire Hospitals NHS Foundation Trust (GHNHSFT) who will confirm organisational level support for the proposed changes to clinical services including formal approval of the case in terms of finance, workforce and implementation plans.
- NHS England and Improvement (NHSE&I) who have already assured that the Fit for the Future Programme has satisfied the government's four tests and NHS England's test for proposed bed changes; the NHS England 'Beds Test' (where appropriate).
- The Gloucestershire Health Overview and Scrutiny committee (HOSC) who will scrutinise the final proposals in line with their responsibilities.

For the purposes of transparency, the final draft of this DMBC will be made available publicly, but the document is not written with a public audience in mind.

2.3 Document status

This document has been written at a point in time, reflecting information (including sources and references accessed) as of the date of publication. The document, including its related analysis and conclusions, may change based on new or additional information which is made available to the programme.

Until published this is a confidential document for discussion purposes and any application for disclosure under the Freedom of Information Act 2000 should be considered against the potential exemptions contained in s.22 (Information intended for future publication), s.36 (Prejudice to effective conduct of public affairs) and s.43 (Commercial interests). Prior to any envisaged disclosure under the Freedom of Information Act, the parties should discuss the potential impact of releasing such information as is requested.

The involved NHS bodies understand and will comply with their statutory obligations when seeking to make decisions that will have an impact on the provision of care services.

2.4 The process we are undertaking

2.4.1 *One Gloucestershire Integrated Care System*

The One Gloucestershire Integrated Care System (ICS) is a partnership between local NHS and care organisations committed to turning the NHS Long Term Plan (LTP) into action for the benefit of local people and our dedicated workforce. Our expectations of healthcare, the demands on health services and the incredible progress made in development of staff skills, medicine and technology mean that we need to continue to adapt to support healthy lives and transform care to meet the needs of people into the future.

Our Vision

To improve health and wellbeing of our population, we believe that by all working better together - in a more joined up way, and using the strengths of individuals, carers and local communities - we will transform the quality of support and care we provide to all local people.

Our Integrated Care System priorities are to:

- Place a greater emphasis on personal responsibility, prevention and self-care, supported by additional investment in helping people to help themselves
- Place a greater emphasis on joined up community-based care and support, provided in patients' own homes and in the right number of community centres, supported by specialist staff and teams when needed
- Continue to bring together specialist services and resources into *Centres of Excellence* that deliver a greater separation of emergency and planned care, and, where possible reduce the reliance on inpatient care (and consequently the need for bed-based services) across our system by repurposing the facilities we have in order to use them more efficiently and effectively in future.
- Develop new roles and ways of working across our system to make best use of the workforce we have, and bring new people and skills into our delivery system to deliver patient care
- Have a continued focus on ensuring parity of esteem for mental health.

As part of our response to the NHS LTP and commitment to the public in Gloucestershire, when patients have serious illness or injury that requires specialist care, we believe they

should receive treatment in centres with the right specialist staff, skills and equipment by delivering care that is fit for the future. Our *Fit for the Future Programme* includes looking at how we can develop outstanding specialist hospital care in the future across the Cheltenham General and Gloucestershire Royal Hospital sites; our *Centres of Excellence*.

2.4.2 *Pre-Consultation Business Case*

To develop the Pre-Consultation Business Case, the Fit for the Future programme agreed principles, processes and governance to support the required decision-making. The development of the PCBC was clinically-led, informed by engagement with key stakeholders and the public, and involved working with partners across Gloucestershire. The PCBC can be found at: Fit for the Future: Developing specialist hospital services in Gloucestershire – OneGloucestershire.net

Three key processes supported the development of the pre-consultation business case:

2.4.2.1 The development of the clinical model

The Fit for the Future Programme has, from the outset, had a clear process in place to develop its clinical models through a combination of innovative ways to involve local people and staff (from a survey and 'drop in' events, independently facilitated workshops, an engagement hearing, a citizens jury (#1 Jan 2019) and culminating in an inclusive and transparent solutions appraisal process), a clear governance structure and agreed and delivered outputs.

This has been a structured, clinically-led process to develop potential new approaches for services, the details of which are presented in the PCBC, and comprises:

- Building a clear Case for Change;
- Defining evaluation criteria;
- Developing best practice care pathways and models of care; and
- A transparent solutions appraisal process

Our vision is for a single hospital on two sites, linked by the A40 'corridor', providing the very best care, experience, safety and outcomes for local people.

To date, the hospital's two sites have sometimes been seen as a problem, but we believe they present a huge opportunity to develop our vision of *Centres of Excellence* providing outstanding specialist care where more patients can be treated, waiting times are lower, patient experience is improved and patient outcomes are amongst the best. We aim to maximise the opportunities of the two-site configuration of our acute hospitals through a greater separation of emergency and planned care:

- Separating facilities for emergency care (from planned care) would ensure that, for patients with a life- or limb-threatening emergency, the right facilities and staff would always be available to give the best possible chance of survival and recovery.
- Getting it right could improve patients' chances of survival and recovery, reduce the amount of time they have to spend in hospital, and sometimes even avoid a hospital stay altogether.
- Having separate facilities for planned care (from emergency care) could reduce the number of operations that get cancelled when beds or operating theatres are needed for the most unwell patients who arrive in ED and need urgent operations or treatment

We are not proposing a full hot (emergency)/cold (planned) split across the hospital sites in our county, so the clinical models retain a 24/7 front door (ED/ED+MIIU) and ITU on both sites. Importantly, many patients and families who have to travel out-of-county specialist centres could be treated locally in the county.

We know how important Cheltenham General Hospital Accident & Emergency (A&E) Department is to the people who live in the east of the county; in particular Cheltenham. We agree it is an important part of the future for local health services. We have publicly committed to the future of the Accident and Emergency (A&E) Department in Cheltenham. The service will remain consultant-led and there will be no change to the (pre-COVID-19) opening hours.

2.4.2.2 Public and stakeholder engagement

The Fit for the Future (FFTF) programme has engaged inclusively, innovatively and constructively with our internal and external stakeholders, most importantly with the residents of Gloucestershire and users of our services. In doing so we believe we have met the requirements of NHSE&I Guidance:

- Robust public involvement;
- To be proactive to local populations;
- To be accessible and convenient;
- To take into account different information and communication needs, and;
- To involve clinicians.

The FFTF public and staff engagement programme started in August 2019 to seek views on the future provision of urgent and specialist hospital care in Gloucestershire. All feedback received was collated into a comprehensive Output of Engagement report (Appendix 2 of the PCBC) that has been used to inform the development of our potential solutions for future local NHS services.

2.4.2.3 The solution development process

These are the steps we followed:

Step 1

A 'long list' of potential solutions for *Centres of Excellence* was put together by local NHS staff and clinicians. The long list included 1,297 possible variations for how the specialist services could be organised across the two hospitals in Cheltenham and Gloucester.

Steps 2 & 3

The long list was reduced to a 'medium list' of 29 variations by testing all the potential solutions against a number of key factors called 'hurdle criteria', and also by testing how well the potential solutions could work together. Simply put, each potential solution had to get over the first few hurdles for it to pass the test to carry on to the next stage.

For those options that cleared these hurdle criteria, the next stage was to consider whether they made sense in combination as 'clinically viable' models. This stage was carried out by a wide range of hospital staff who work across the services on a day-to-day basis. Each potential solution which passed this stage was then considered in more detail using a set of 'evaluation criteria' developed using feedback received during the Fit for the Future Engagement and tested at the first Fit for the Future Citizens' Jury (#1).

The remaining 29 potential solutions were grouped into 8 combinations of services (clinical models). The purpose of doing this was to present a range of service combinations that represented the different ways services could be delivered. This enabled them to be more-

easily compared and evaluated against each other, but did not remove any potentially viable solutions from consideration.

Steps 4 - 6

A series of solutions appraisal workshops took place in public. Members of the public, including some Jury Members and Healthwatch Gloucestershire representatives[1], joined clinicians and other NHS and care staff to look in detail at the medium list of potential solutions. Using the evaluation criteria (see below), the workshops reduced the medium list to a short list, which was subject to external review by the South West Clinical Senate before the final shortlisted options went forward to public consultation.

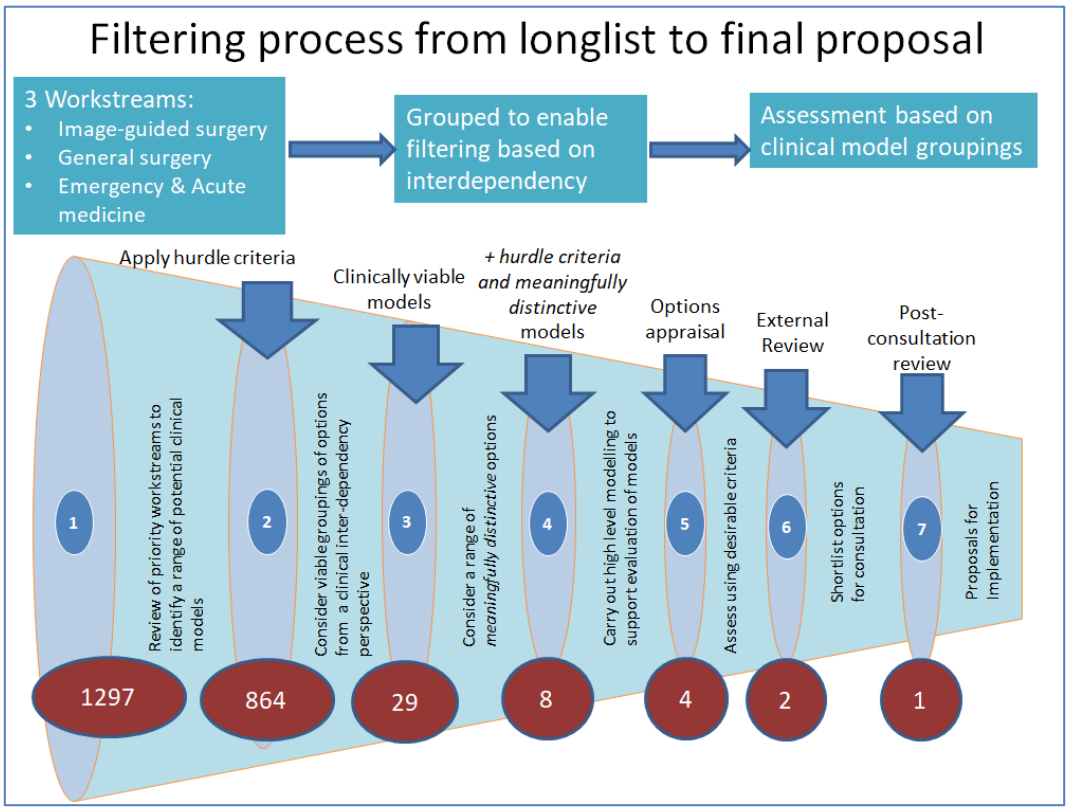
Details of steps 1-6 can be found in the PCBC.

Step 7

Prior to the consultation, the work, including patient, public and staff engagement, had not produced a preferred option for the location of planned Lower GI (colorectal) General Surgery; centralised at either CGH or GRH. Therefore, both options were included in the public consultation (see section 2.6).

Following consultation, an options appraisal process was undertaken using consultation feedback and the desirable criteria domains (see section 4.2.3) to confirm a preferred option.

The diagram below illustrates the stages of our solutions development process.



The six desirable criteria domains listed below were used at steps 4 and 7.

- Quality of care
- Deliverability
- Strategic fit
- Access to care
- Workforce
- Acceptability

[1] Observers were also in attendance including members of Restore Emergency At Cheltenham General Hospital (REACH) campaign

2.4.3 *Consultation*

The Fit for the Future public and staff consultation started on 22 October 2020 and ran until 17 December 2020. The consultation was quality assured by The Consultation Institute[2]

2.4.3.1 Aims of the consultation

The aim of the consultation was to seek the public's views on the proposals in order to inform decision-makers on the acceptability (or otherwise) of the proposed options for service change. The consultation activities therefore aimed to ensure Gloucestershire residents, and people in neighbouring areas who use services in Gloucestershire, were aware of and understood the proposed options for change, by providing information in clear and simple language in a variety of formats. In this way we heard people's views on the proposed reconfiguration of hospital services at GRH and CGH. Decision-makers in the One Gloucestershire system will use evidence from the consultation feedback to inform their decision-making as they discharge their various roles (see section 2.2 for description of roles).

2.4.3.2 Key areas of work and outputs

There have been a number of innovative ways the NHS has involved local people and staff during the consultation, from online events, to a 'socially distanced' Information Bus Tour and a door-to-door mail-drop of an information leaflet delivered by Royal Mail to all households in Gloucestershire. We undertook over 75 virtual and face-to-face events and we received over 700+ survey responses. All the feedback also informed the refresh of the integrated impact assessment (see section 5).

Details of the consultation process can be found in the section 3.1 and in the Final Output of Consultation report in Appendix 1.

2.4.3.3 Impact of Coronavirus (COVID-19) on the consultation

Our consultation plans were designed to deliver a 'socially distanced' consultation, taking into account the impact of COVID-19 on conducting face-to-face consultation activities, in line with NHSE&I guidance issued in August 2020 (*Good practice for stakeholder engagement on service change and reconfiguration during COVID-19* and the *Short guide to socially distanced engagement*). Opportunities for 'virtual' and e-consultation were a key, but not exclusive, part of our consultation methodologies; details of which can be found in section 3.1.2.

Although not directly linked to the longer term proposals set out for consideration in the FFTF programme or the consultation, it should be noted that, in response to the COVID-19 pandemic, GHNHSFT implemented a number of temporary service changes aimed at separating (as much as possible) services caring for COVID-19 and non-COVID-19 patients. Whilst Fit for the Future is not about the COVID-19 temporary changes made in 2020, some of the medium to long term changes proposed relate to some of the same clinical services where temporary changes had to be made in order to keep our hospitals safe.

[2] A UK based not-for-profit organisation specialising in best practice public consultation & stakeholder engagement.

2.4.4 *Decision-making business case*

Following the end of the consultation, the programme has carried out extensive work to understand the evidence and feedback that has been received through consultation. The feedback and responses from the public and stakeholders have been used within this DMBC to inform the development of our final proposals for change.

The process to bring together this evidence and feedback involved several stages, including:

- Collation of the feedback and evidence from consultation into an Interim Output of Consultation report[3];
- Development of the refreshed integrated impact assessment;
- Review and deliberation of consultation findings;
- Development of further analysis and evidence to understand the views and potential effects emerging from consultation; and
- The decision-making process.

This is further described below.

2.4.4.1 Development of the Final Output of Consultation report

The report (Appendix 1) is divided into two parts: Part 1 provides background information about the Fit for the Future Programme, the co-development of the consultation proposals and the consultation planning and activities. Part 2 provides a summary of the feedback received during the consultation. The final section of the report is an evaluation of the consultation activity. There is also a summary of activity post-publication of the Interim Output of Consultation report and signposting to new items.

There are elements of feedback which will be relevant and of interest to all readers and these are presented in the main body of the report. All feedback received can be found in a series of Appendices; all of which are available online[4]. These Appendices include all comments collated during the consultation, including copies of individual submissions received, in addition to the Fit for the Future survey responses.

Some respondents may have answered the formal consultation survey as well as giving feedback in other ways, such as sending a letter or participating in a discussion event. All feedback received has been read and categorised into themes e.g. access, workforce and quality. The theming of the qualitative feedback received through the FFTF survey presented in the report has been undertaken by members of the One Gloucestershire Communications and Engagement Group using SmartSurvey.

2.4.4.2 Development of the DMBC Integrated Impact Assessment

To understand the impacts of the proposals and inform decision-making an Integrated Impact Assessment (IIA) was commissioned from Mid and South Essex University Hospitals Group Strategy Unit. The baseline and pre-consultation IIA were integral to the PCBC and this has been refreshed following the public consultation to take account of:

- Findings from the public consultation process;
- Additional analysis undertaken; and

[3] The Interim Output of Consultation report was published on 11/01/21. The final report was published on 04/03/21

[4] Fit for the Future: Developing specialist hospital services in Gloucestershire – OneGloucestershire.net

- New data sources that have been made available since the publication of the interim report.

Details can be found in section 5 and the full report in Appendices 2a, 2b & 2c.

2.4.4.3 Review and deliberation of consultation findings

The programme team has been through an extensive process of 'socialising', sharing and discussing the consultation findings with a wide range of groups to inform the development of our final proposals for change. This has included:

- Presentation of consultation report and discussion of findings at:
    - Gloucestershire Health Overview and Scrutiny Committee (HOSC)
    - GHNHSFT Board
    - ICS Board and Executives
    - GCCG Governing Body
    - GHNHSFT Council of Governors
    - Citizens' Jury (#2)
    - GHNHSFT Clinical Advisory Group and Service & Transformation Group
    - FFTF IIA Reference Group
- Compilation of key consultation themes and issues that have been taken account of by the DMBC (see section 3.2)
- Engagement with relevant stakeholders to respond to consultation themes and issues.
- Consideration of the impact of consultation findings on service proposals
- Consideration of the impact of further evidence on service proposals

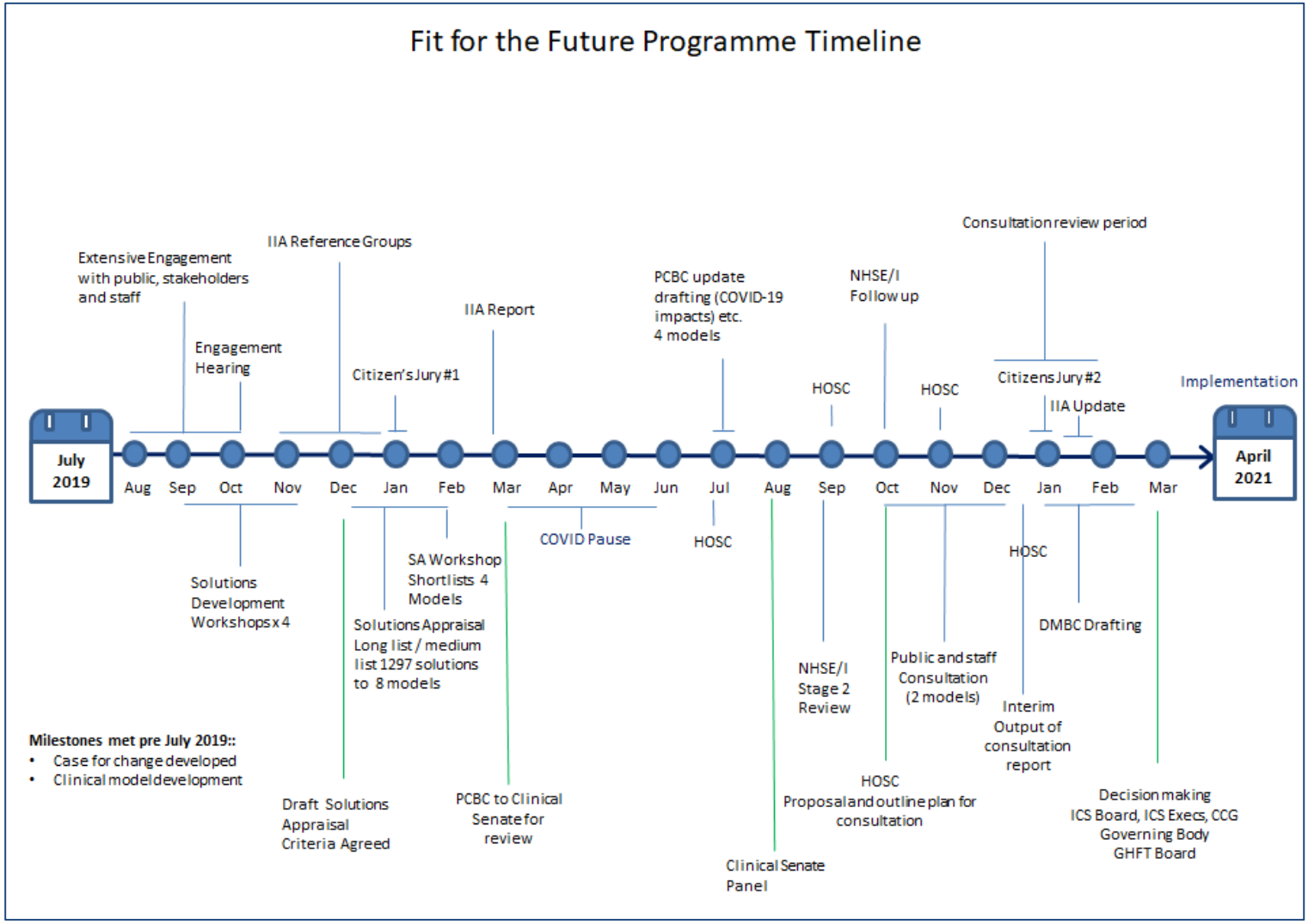
2.4.4.4 Development of further evidence

Within this DMBC, we have used the feedback from consultation to inform the development of our final proposals and solutions. Given this feedback, we have spent particular time reviewing and developing further evidence across a number of areas including Trauma and Orthopaedic and General Surgery. This evidence is summarised in Section 4.

2.4.4.5 Decision-making process

Within this DMBC, we have used the feedback from consultation to help us identify the preferred solutions for our population. This DMBC includes a detailed description of how we have considered the evidence in Section 4. Details of the decision-making process can be found in section 7

2.4.5 *Fit for the Future timeline*



2.5 Case for change

Gloucestershire Hospitals NHS Foundation Trust was formed in 2002 by the merger of Gloucestershire Royal NHS Trust, responsible for GRH, and East Gloucestershire NHS Trust, responsible for CGH. Since that time, several changes have been implemented to offer patients the benefits of improved access and outcomes.

The hospitals are centrally located within the county and are only 8 miles apart. Developing as two district general hospitals has enabled the evolution of two acute hospitals with their own unique characteristics originally serving different parts of Gloucestershire, but, with the development of more complex health interventions, the smaller scale of duplicated services has resulted in patients having to travel to partners in larger regional centres in Oxford, Bristol and Birmingham for more specialist services. For patients who are treated in-county, a hospital covering two sites can dilute the effectiveness of the available resources, compromising quality, productivity and staff recruitment and retention.

The Trust believes that there are both challenges to face and exciting opportunities waiting to be seized. There are challenges to some services related to managing a workforce to stretch across two hospital sites, and splitting specialist high tech equipment across both hospitals does not make best use of resources. The expectations of healthcare, the demands on health services and the incredible progress made through science and technology have dramatically changed the environment, which means that healthcare services need to evolve and change too. The advances in healthcare and staff skills mean that many more services can be provided in people's own homes, in GP surgeries and in the community. There are also real opportunities to take advantage of advances in specialist hospital services. We want our local services to be *Centres of Excellence.*

2.5.1 *Why improvements to current provision are needed*

In the context of the national and county-wide picture of growing demand, improved technology and workforce supply challenges, the Trust's current configuration leads to specific clinical (quality), workforce and financial challenges which were detailed in the PCBC and are summarised below:

2.5.1.1 Clinical Challenges

- 3 in 10 Emergency General Surgery patients have suspected gallstones. Currently less than 50% see an Upper GI specialist (rated 15 on Trust risk register; issues due to staffing challenges working across two sites).
- At times, senior surgical decision-makers are in theatre and unavailable to review patients waiting for specialist surgical assessment in ED or Surgical Assessment Unit, leading to delays in treatment.
- Emergency General Surgery admissions to CGH are not compliant with the South West Clinical Senate's 2017 review requirement for access to a Surgical Assessment Unit, or a 24-hour CEPOD[5] list. There is also no access to ultrasound scans at weekends.
- Shared specialty access to emergency theatres (both sites) can lead to extended 'time to theatre', leading to sub-optimal Emergency General Surgery care (rated 15 on Trust risk register).
- National standards recommend all Acute Medicine patients to undergo a consultant review within 14 hours of arrival. An NHSE&I 7-Day Service self-assessment showed that

[5] National confidential enquiry into patient outcomes and death

67% of patients were seen by a consultant within 14 hours during weekdays, whilst at the weekend this dropped to 48%.

- Every year around 600 patients travel outside of Gloucestershire for image-guided surgical procedures e.g. Cardiology Primary Percutaneous Coronary Intervention (PPCI) that could be offered in-county with the right staff and equipment.
- Existing dispersed configuration of facilities for image-guided surgery reduce our capacity to offer minimally-invasive techniques. There is clear evidence that these can reduce the need for more invasive surgery, reduce the physiological insult to patients and thereby reduce complications and hospital stays.

2.5.1.2 Workforce Challenges

- In a 7-month period in 2019, 15% of shifts for Emergency General Surgery were not covered (390 shifts out of 2,599). Rota gaps have increased by 46% in three years (rated 16 on Trust risk register)
- The Trust has a 43% vacancy rate for acute medical physicians. This is based on an establishment of 14 consultants, with only 8 posts filled.
- GI surgical trainees have reported negative feedback about workload and training environment. If this situation does not improve, the Deanery could withdraw trainees from the GI service in Gloucestershire, impacting further on workforce and safety of care (rated 15 on Trust risk register)
- Due to a shortage of radiologists, we are not compliant with The Royal College of Radiologists' recommendation that provision of a robust 24/7 Interventional Radiology service should be a "priority for all acute hospitals".
- Since May 2019 we have advertised three times for locum and twice for substantive interventional cardiologist recruitment, and have only successfully recruited 1 locum in this time. There are similar challenges with recruiting cardiac catheter lab nurses.

2.5.1.3 Financial Challenges

- Repatriation of patients going out of county for minimally-invasive techniques would bring £460,000 additional income to the county with the potential for this to increase over time.
- The Trust's imaging equipment is recorded on the risk register as being out of date. Work is underway to develop a business case for a Managed Equipment Service contract worth £46m over 15 years to replace and maintain obsolete kit, but decisions are required on where to install the equipment for optimal productivity and improved patient outcomes.
- Image-guided surgery is currently offered in three separate sites in GHNHSFT, driving up the cost of equipment and storage, e.g. £80k consumables waste in 2017/18
- Workforce challenges outlined above lead to high agency and locum costs

2.5.1.4 Performance Challenges

The key performance measures as at December 2019 (at the end of our baseline period) which indicate the need for improvements are:

- Emergency Department (ED) 4 hour target at 83.47%, which although in line with agreed trajectory is short of the national 95% target
- Bed occupancy rate of 95.4% (average) compared with a desired occupancy of <92%

- Rate of emergency admission is slightly higher than peer group[6]
- Over 400 operations cancelled on the day for non-clinical reasons in the most recent 12-month period
- Activity income lost to patients travelling out of area for their procedure
- Staff turnover rate over 11% 2019/20

2.5.2 *Learning from Coronavirus (COVID-19) Temporary Changes*

As stated in Section 2.4.3.3 GHNHSFT implemented a number of temporary service changes in response to the pandemic. In some cases, the temporary changes relate to some of the same clinical services included in our FFTF proposals. Whilst the implementation and context are markedly different to that planned under FFTF changes there have been a number of positive effects on service risks resulting from the temporary changes; these include:

- Reduction in the risk of sub-optimal staffing caused by a combination of insufficient trainees, senior staff and increased demand resulting in compromised trainee supervision
- Reduction in risk to patient safety caused by insufficient senior surgical cover
- Reduction in risk of sub-optimal care for patients with specialist care and other sub-specialty care conditions caused by lack of ability to create sub-specialty rotas
- Reduction in risk of sub-optimal care for emergency surgical patients requiring surgical treatment caused by limited day time access to emergency theatres

2.5.3 *FFTF Proposal Benefits*

In addressing the case for change our proposals are aimed at delivering the following:

What we want to achieve	Benefits
Improved health outcomes…	...ensuring patients are treated by the right specialist team (doctors, nurses and other healthcare professionals) with timely access to treatment and care
Reduced waiting times and fewer cancelled operations…	…leading to a more reliable and positive experience for patients and their families
Timely assessment and decision-making from senior health professionals when you arrive at hospital…	…leading to prompt diagnosis, treatment and recovery
Right staff in the right place at the right time including senior doctors – 24 hours a day, 7 days a week…	…leading to better, safer care with shorter hospital stays while attracting and keeping the very best staff

[6] GHFT is 32% ROA compared with 30% national (2018)

Support for joint working between doctors, nurses and therapists, including links to related services and equipment…	…to avoid the need for more visits and hospital stays
Specialist staff seeing enough patients to maintain their specialist skills…	…so they can provide the very best care and outcomes for patients
Create flagship centres for research, training and learning	…attracting and keeping the best staff in Gloucestershire and ensuring you have access to ground-breaking treatments
Make best use of scarce resources including staff and specialist equipment…	…staff are in the right place, right time, first time to care for patients.

2.6 Consultation proposals

Feedback from engagement showed there is support to continue to develop a *Centre of Excellence* approach, which reflects the way a number of inpatient services are already concentrated in one place – such as oncology (cancer care) in Cheltenham and children's services in Gloucester. For our hospitals, we want to see two thriving, vibrant sites with strong identities with both providing world class treatment.

As we continue to organise services, we believe that one hospital should focus more on emergency care and one hospital should focus on planned care and oncology. This concentration in one place, or *Centre of Excellence*, should help to ensure that the right facilities and specialist staff are always available to give people the best treatment and care, to help reduce the number of planned operations cancelled when beds or operating theatres are needed for the most urgently unwell patients. We want to strike the right, but often difficult, balance between having two world class *Centres of Excellence* in Gloucestershire and providing local access to services.

The consultation proposals were as follows:

- A *Centre of Excellence* for Acute Medicine (Acute Medical Take) at GRH
- An Image Guided Interventional Surgery (IGIS) 'Hub' at GRH and a 'Spoke' at CGH
- A *Centre of Excellence* for Vascular Surgery at GRH
- A *Centre of Excellence* for Gastroenterology inpatient services at CGH
- *Centres of Excellence* for Trauma at GRH and Orthopaedics at CGH.

In addition, the consultation included two proposals for General Surgery which differed in the configuration of planned Lower GI (colorectal) surgery - centralise to CGH or centralise to GRH; these were:

- Create a General Surgery centre of excellence at Gloucestershire Royal Hospital (GRH) comprising a centralised Emergency General Surgery service alongside the already-centralised planned Upper Gastrointestinal (GI) service and a newly-centralised planned Lower GI (colorectal) service. Planned day case Upper and Lower GI (colorectal) surgery would be centralised at CGH

Or

- Centralise Emergency General Surgery at GRH alongside the already-centralised planned Upper GI service and create a *Centre of Excellence* for Pelvic Resection at Cheltenham General Hospital (CGH) comprising a newly-centralised planned Lower GI (colorectal) service alongside Gynae-oncology and Urology. Planned day case Upper and Lower GI (colorectal) surgery would be centralised at CGH.

In these two proposals, the configuration for three service areas is the same: Emergency General Surgery at GRH, planned Upper GI at GRH and day case Upper and Lower GI at CGH.

Key Points

- **The One Gloucestershire ICS is committed to turning the NHS Long Term Plan (LTP) into action for the benefit of local people and our dedicated workforce.**
- **The services included within the DMBC should not be seen in isolation from all the other developments that support the delivery of our LTP.**
- **In Gloucestershire, splitting resources across two hospital sites contributes to quality, workforce, financial and performance issues which affect patient outcomes and staff recruitment and retention and efficient use of resources.**
- **Clinicians have been at the centre of our case for change which is based on the best available evidence.**
- **There is a clear evidence base that greater separation of planned and emergency (elective and non-elective) services in hospitals contributes to improved outcomes for patients and more effective use of resources.**
- **There are strong quality and safety drivers to support proposed changes to the Emergency General Surgery service.**

3 Feedback from Public Consultation

The Fit for the Future public and staff consultation started on 22 October 2020 and ran until 17 December 2020. The planning and delivery of the consultation was supported by a wide range of external groups including:

- The Consultation Institute: The consultation process has been Quality Assured by The Consultation Institute (tCI) with each stage of the consultation planning and activity formally signed-off by a tCI Assessor, ensuring a totally independent assessment of the consultation process.
- Inclusion Gloucestershire: Assisted with the development of Easy Read materials.
- Gloucestershire County Council's Digital Innovation Fund Forum: supported early planning for online activities and assisted with awareness-raising of the consultation to potentially digitally excluded groups.
- Friends from the Friendship Café in Gloucester City: Supported awareness raising within and survey completion by diverse communities.
- Healthwatch Gloucestershire (HWG): HWG Readers' Panel reviewed an early draft of the full consultation booklet and made suggestions for changes, which were incorporated into the final version.
- Know Your Patch (KYP) Coordinators: KYP allowed us space on agendas to share information at online meetings during October and November 2020 to promote the consultation.
- District/Borough Councils and Retail partners: Supported the 'socially distanced' visits of the Information Bus (outside of Lockdown 2) to locations with maximum footfall across the county. District and Borough Councils also hosted members' seminars to discuss the Fit for the Future consultation.
- Local media: Gloucestershire Live, BBC Radio Gloucestershire and GFM Radio
- Others: Many other groups and individuals have helped to raise awareness of the consultation such as GHNHSFT Governors, staff-side representatives, hospital volunteers and community and voluntary sector organisations such as homelessness support charities.

3.1 Overview of Consultation

The consultation approach has been informed by the experience of managing earlier extensive engagement activities. The approach and detailed plan for communications and consultation responded to feedback from those engagement activities, including from the NHSE&I Assurance process.

Equality, diversity, human rights and inclusion are at the heart of delivering personal, fair and diverse health and social care services. All commissioners and providers of health and social care services have legal obligations under equality legislation to ensure that people with one or more protected characteristics are not barred from access to services and decision-making processes.

Our aim with this consultation was to reach a good representation of the local population, whilst making sure we hear from those groups who might be most affected by the proposed changes. We worked closely with Mid and South Essex University Hospitals who, due to their recognised expertise in this area, were commissioned to undertake the Integrated Impact Assessment. This work helped us to identify which particular groups might be

affected, enabling us to actively seek out the views of people in those groups, set out below, during the consultation to gain a better understanding of the potential impact on them and to identify ways to lessen any potential negative effects:

- Black, Asian and Minority Ethnic (BAME) communities, in particular people aged over 65
- People with mental health conditions
- Over 65s who are more likely to have long term conditions such as cardiovascular disease, obesity or diabetes
- Frail older people who are more likely to experience falls
- People from BAME communities who are living with a long-term condition
- People living with a disability (includes physical impairments; learning disability; sensory impairment; mental health conditions; long-term medical conditions).
- Adult Carers and Young Carers
- Homeless people
- Gypsy/Traveller communities
- LGBTQ+ people
- People living in low income areas.

The targeted activities are described in section 3.1.2, the consultation responses in section 0 and the potential impact in section 5.

3.1.1 *Consultation materials*

In developing the materials for the consultation, we undertook an Equality and Engagement Impact Analysis (EEIA) to identify issues pre-consultation and took action ahead of consultation. This is presented in the table below:

Issue identified	Consultation Action
Less information, less jargon and easy read	The Consultation booklet was reviewed by the Healthwatch Gloucestershire Lay Readers Panel. An Easy Read version of the consultation booklet and survey was produced by Inclusion Gloucestershire. A summary version of the consultation booklet was produced.
Accompanying glossary recommended	There is an accompanying glossary in the full consultation document (which is available in print and online).
Further engagement to address the homogeneity of participants	Targeted opportunities for consultation with protected characteristic groups identified through the Impact Analysis e.g. via the Homeless Healthcare Team, Carers Forum etc. Alternative formats of all consultation materials available on request. Contract in place with telephone (and face to face) interpreters, incl. BSL and for written translation.
Paper surveys should be replicated as online surveys	Surveys were available online in regular and easy read formats. People were also offered assistance to complete surveys over the telephone.
Different marketing messages required to encourage online participation for 'always'	All forms of media, print, broadcast, and social media were used. An awareness-raising leaflet was delivered to all households by Royal Mail in Gloucestershire telling them

(compete with other opportunities), 'seldom' (relevance, links to pandemic interests) and 'never' online (other opportunities or assistance required).	about the consultation and how they could get involved.
Liaise with community leaders to hold specific workshops within the BAME communities with community support for interpreters	We contacted local groups, including BAME communities to arrange culturally-appropriate opportunities for participation in the consultation e.g. Information Bus visit to Gloucester Mosque at their invitation [Unfortunately we were unable to attend the Mosque visit due to COVID-19 Lockdown 2 restrictions. However, we liaised with local community leaders about alternative ways to promote the consultation, including WhatsApp and interview on local Community Radio]
Use creative and interactive dialogue methods	We used a range of methods: Online, face-to-face (socially distanced), telephone, written.
Online consultations prove to be most successful when used in conjunction with offline methods such as telephone structured interviews/market research techniques/managed exhibitions	We hosted online activities, chat forums and live discussions recorded on YouTube [In response to feedback after the first Live discussion, broadcast was moved to Facebook Live for better reach]. We invited people to call us to leave a message to book telephone interviews. We toured our Information Bus to all localities in the county.
Online forums should be moderated	The Forum function of the Get Involved in Gloucestershire online participation platform is independently moderated. The Gloucestershire Live Facebook events were hosted by an independent chair and questions were moderated.
Varying the times of online events	Events were held at different times of day and different days of the week
Events, e.g. workshops, no longer than 2 hours	All scheduled events were no longer than 90 minutes, with online events mostly lasting 30-45 minutes. Most events were online, and we make it clear that participants could get up to have a comfort/refreshment break
Some individuals or groups feel more comfortable sharing their thoughts on their own platforms, rather than official channels designed explicitly for themed discussions.	We offered to use the platforms, which worked best for the individual or group: Zoom, FaceTime, Microsoft Teams, and WebEx – We completed DPIA (Data Protection Impact Assessments) for any new platforms requested. We also offered more traditional methods such as telephone calls
Target groups identified through the IIA	Representatives from the groups identified in the IIA were contacted to discuss methods to facilitate participation in the consultation. Example: Advice from the Homeless Healthcare Team, Age UK, Carers Hub

The programme developed a wide range of materials for the consultation, including:

- Consultation Booklet (Long)
- Consultation Booklet (Short)
- Consultation Booklet (Easy Read)
- A consultation questionnaire/survey (online and hard copy)
- Range of videos (with local clinicians explaining each of the service proposals)
- Door-to-Door awareness raising leaflet (delivered by Royal Mail)
- Display materials
- Frequently asked questions

3.1.2 *Consultation activities*

A range of communications and consultation channels were used during the Fit for the Future consultation. Full details of the activities can be found in Appendix 1 and a summary list is provided below:

- Fit for the Future Surveys
- Door-to-Door awareness raising leaflet (delivered by Royal Mail)
- Gloucestershire Media: Live social media partnership (@GlosLiveOnline)
- Gloucestershire Hospitals: Facebook Live (@GlosHospitals)
- Hardcopy engagement booklets
- 'Your Say' area on the One Gloucestershire Health website and Get Involved in Gloucestershire online participation platform
- Further engagement to address the homogeneity of participants
    - Young people
    - Adult Carers and Young Carers
    - Gypsy/Traveller communities
    - LGBTQ+ people
    - Gloucestershire Patient Participation Group (PPG) Network
- NHS Information Bus Tour
- Cuppa and Chats
- Media releases and stakeholder briefings
- Social media
- Facebook
- Twitter
- Media advertising
- Other surveys and petitions

3.1.3 *Post-consultation additional information*

During the period between the end of public consultation and completion of the DMBC, we have continued to work on the ongoing development of our proposals, which has resulted in a number of further pieces of information being made available to decision-makers. To ensure transparency is maintained, the FFTF Consultation Team contacted local people, groups and stakeholders who participated in the consultation and for whom we had contact

details (email or postal address) letting them know about the additional information and inviting them to request this information via online links to documents or printed copies as they became available. All of the additional information was posted at www.onegloucestershire.net/yoursay.

This additional information and any further comments received in relation to it have been incorporated into the final Output of Consultation report and this DMBC. The additional information included:

- Fit for the Future Citizens' Jury (#2) – Jurors report (and recordings of presentations)
- Citizens' Jury (#2) report – includes detail of the Jury process
- Final Output of Consultation report
- Recommendation regarding the preferred location for colorectal surgery
- The Consultation Institute Quality Assurance Assessment
- Updated Trauma and Orthopaedic Pilot Evaluation

3.1.4 *Staff communication and engagement*

Four main programmes of internal communication and engagement were rolled out to staff. Full details of the activities can be found in Appendix 1 and a summary list is provided below:

- Corporate communications:
    - Video communication
    - Global emails
    - Intranet
    - Website
- Staff online discussion forum
- Staff drop-in sessions
- Staff ambassadors

The Fit for the Future consultation has been regularly promoted to all staff working at NHS Gloucestershire Clinical Commissioning Group and in GP practices, Primary Care Networks and the Local Medical Committee via the Primary Care Bulletin. The consultation was promoted at a meeting of the countywide Primary Care Clinical Network Clinical Directors.

3.1.5 *Other stakeholder communication and engagement*

Full details of the activities can be found in Appendix 1 and a summary list is provided below:

- Elected Representatives
    - Members of Parliament
    - Gloucestershire County Council (GCC)
    - District and Borough Councils
- REACH Campaign

3.1.6 *Consultation review*

3.1.6.1 The Consultation Institute's assurance process

The Consultation Institute (tCI) has assured the consultation. The tCI assurance process includes 6 checkpoints at different stages of a consultation. The tCI assurance process for this consultation will conclude following tCI review of the Final Output of Consultation report.

3.1.6.2 Citizens' Jury

A second Citizens Jury, independently facilitated by Citizens Juries CIC, was held in January 2021 to consider the consultation process and approach, to highlight key themes. 18 independently-recruited jurors representative of local communities from a broad range of demographics, received evidence from a range of witnesses, recorded their observations and made their recommendations to decision-makers of the NHS organisations involved. This includes key feedback about the way the consultation process has been delivered, and reflections on how we can further improve and develop our consultation methods in the future. These are included within the Jurors' report (Appendix 3a), and the response from the local NHS with respect to the FFTF consultation is included in the Final Output of Consultation report (Appendix 1).

The key recommendations of the Citizens Jury are included below for decision-makers. The full recommendations are included as an Annex to this document and also then in full with a complete NHS response in the Appendix 1. The Jurors worked together to identify the key messages that are important for the NHS Governing Bodies to hear about the FFTF public consultation. Only those that were supported by a majority of the jury are included in the table below. Their reasoning is given in the middle column of the table. A suggested NHS Response is given in the right hand column to support decision-makers deliberations.

Something still missing, needs to be addressed, or requires further clarification re: the FFTF consultation	Why It Matters	NHS Response
We are concerned regarding the number of Royal Mail mailshots actually delivered to homes and wonder if there are better ways to market the initial engagement process, to get more people to know about the consultation, and hopefully contribute to the results. *16 Yes votes / 2 No votes)*	This will get more peoples' opinions and a better representation of the people in Gloucestershire, and would help us to know the majority have had a chance to be part of the consultation.	Jurors were very interested in the impact of the 'door to door' leaflet drop. Concerned that it had either not been delivered on gone unnoticed amongst other items of post. It should be noted that the leaflet was only one aspect of the communications and our approach included a range of other methods such as paid for social media advertising were used and had a wide reach (see section 2.4 of the Output of Consultation report).

The Covid-19 pandemic has changed our way of life considerably - it would have helped for the FFTF consultation to incorporate a response to the pandemic in their presented material. *(15 Yes votes / 3 No votes)*	This matters because the plans drawn up before the pandemic may not be relevant anymore and the pandemic directly affects the day-to-day running of the services.	The consultation materials included a section about the Covid-19 Temporary changes (page 5 in the main consultation booklet). The DMBC also considers the impact of the pandemic on delivery of services during the pandemic and in the future. We are confident that our proposals take account of the future requirements of our services in light of our experiences during the pandemic
We have been assured that the golden thread of patient experience is the reason for this project, but there is nothing about that in the proposals. It is important that at the same time as any re-organisation of medical services, there is a review of the way patients are treated, their dignity and the facilities offered associated with new medical proposals. There is always something about this in external audits. *(16 Yes votes / 2 No votes)*	It's about the patients!	We are considering our next steps with regards to how to further involve local people in our work to develop the detail on the FFTF implementation plans if decisions are made to proceed with changes, especially with regards to our focus on improving the patient experience.

Statements that received 50% of votes "Yes" are included in the table below.

Something still missing, needs to be addressed, or requires further clarification re: the FFTF consultation	Why It Matters	NHS Response
Why Inclusion Gloucestershire was told in mid-2019 that there wasn't enough time to produce more easy read information booklets? *(9 Yes votes / 9 No votes)*	This is important because it might've meant that the disabled population had a better representation and may have led to different results and views on FFTF.	We will follow this comment up with Inclusion Gloucestershire, with whom we work on a regular basis, and who produced the Easy Read Consultation Booklet and Survey for the 2020 consultation. Inclusion Gloucestershire were crucially involved with recruiting participants with a wide range of protected characteristics to take part in the independently facilitated workshops during the FFTF Engagement in 2019.
Data is missing that would give information of how many leaflets were actually delivered by Royal mail. *(9 Yes votes / 9 No votes)*	This matters because it would give more data to know that as many households as possible had received the leaflets that were commissioned to be delivered by Royal Mail (297k).	We will follow up with Royal Mail to discuss their methods for confirming delivery of leaflets to households and their reporting.

The following is an extract from the Jury report: Overall, the jury:

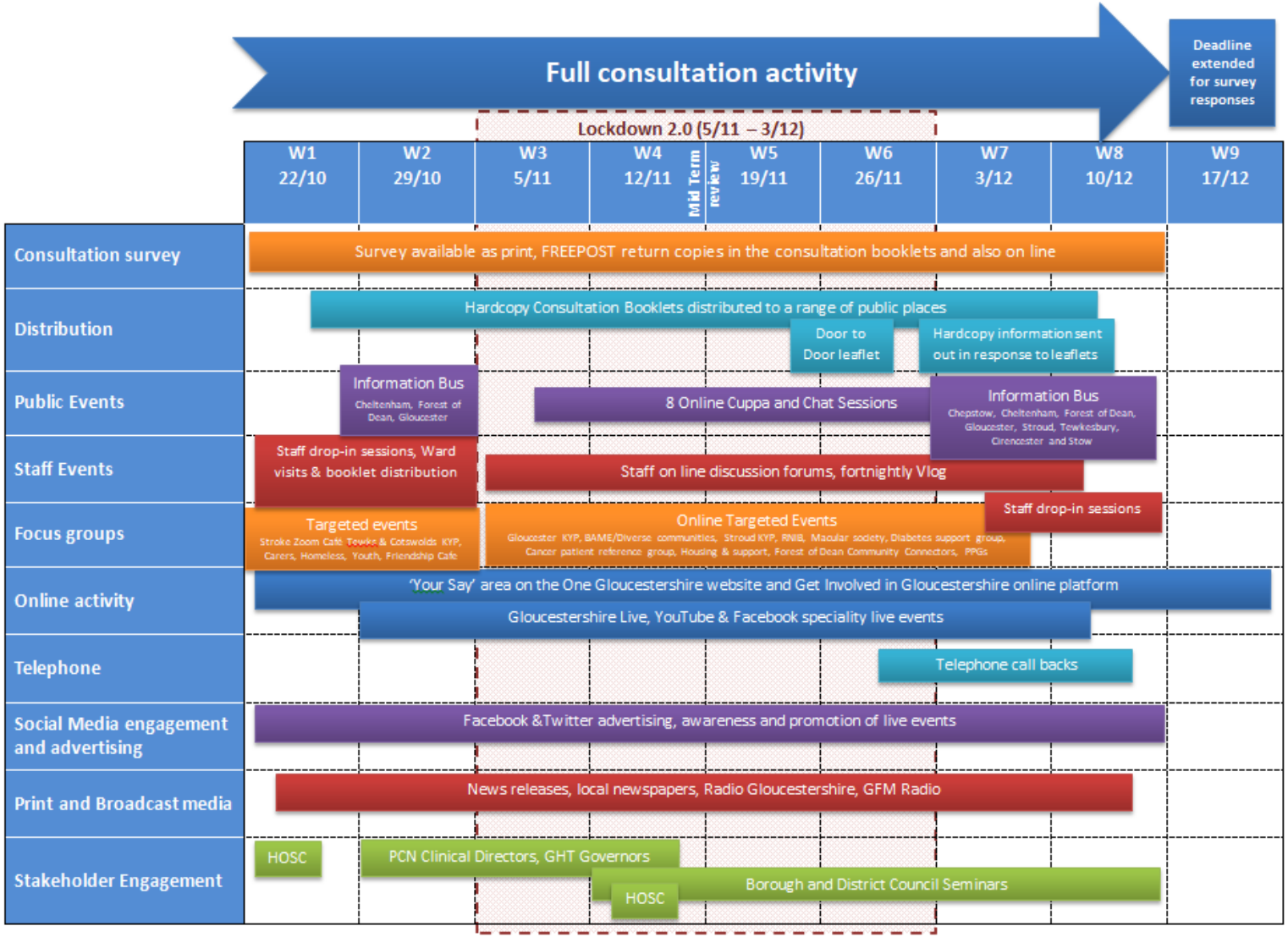
- Was neither confident nor not confident that the consultation process enabled the public to contribute meaningfully to decision making;
    - Gaining in confidence from the clear, concise language and limited jargon in materials
    - Losing confidence from running the consultation during the pandemic thus reducing participation;
- Was more confident than neutral that the information provided as part of the consultation enabled residents to be adequately informed about the proposed service changes thanks to use of plain English and information made accessible across multiple platforms;
- Overall, the jury considered the most important findings from the consultation to be:
    - Though 713 completed surveys may appear unsatisfactory to the general public, it is approximately double the number predicted by sample size calculation software;
    - Respondents did not necessarily reflect the demographics of the county: a significant number of the survey results came from Cheltenham;

    - There are concerns from both staff and patients about bed numbers and the increase of patients to Gloucestershire Royal which is already deemed to be overstretched.
- And a jury majority wanted the NHS Governing Bodies to know:
    - They were concerned about the number of Royal Mail mailshots actually delivered to homes and wondered if there were better ways to market the initial engagement process
    - It would have helped if the FFTF consultation materials incorporated a response to the pandemic;
    - That the proposals should have focused more on patient experience.

Ongoing involvement

The FFTF Programme Team and Consultation Team are grateful to the Jurors for their commitment to the two weeks process. After the conclusion of the Jury we sent a letter to Jurors via Citizens Juries c.i.c. thanking them and encouraging them to continue to be involved in local health services; at the time of writing several have been in touch.

3.1.7 *Consultation activity timeline*



3.2 Summary of Consultation Findings

Feedback to the consultation was received in two main ways:

1. Fit for the Future survey (Main and Easy Read) responses 713 Surveys received (this included 110+ Freepost paper surveys, 1 telephone survey and the remainder online).
2. Other correspondence/written responses

3.2.1 *Demographic information - surveys (Main and Easy Read)*

Demographic information about respondents was collected by the Fit for the Future surveys. Not everyone who responded to the survey completed any/all of the demographic questions; overall average of 82% completed (range across all questions of 75-86%). However, the analysis of the responses indicates that a diverse range of respondents from all protected characteristic groups, and those identified in the Independent Integrated Impact Assessment have provided feedback to the consultation. Full details can be found in Appendix 1 but in summary:

- Proportionally more people from Cheltenham completed the survey (25% of survey respondents compared to the proportion of Gloucestershire population resident in Cheltenham postcodes -18%)
- More women than men completed the survey (55% / 39%)
- Good age range of respondents from Under 18 to Over 75 years
- Between a quarter and a third of responses came from health and social care staff
- Over 20% of responses came from people who considered themselves to have a disability
- Over a quarter of respondents were unpaid carers
- 15% of respondents were not white British

3.2.2 *Survey feedback*

The Fit for the Future analysis includes both quantitative and qualitative responses.

The qualitative feedback from completed surveys and correspondence has been categorised into a series of themes under the following headings (A to Z):

- Access
- Capacity
- Centres of excellence/ clinical model
- Diversity
- Efficiency
- Environment
- Facilities
- Integration
- Interdependency
- Patient Experience / Staff Experience
- Pilot
- Quality
- Resources
- Specialist Skills
- Technology
- Transport
- Travel
- Workforce

All written feedback received (redacted for personally identifiable information e.g. names) can be found in the appendices to the Output of Consultation report.

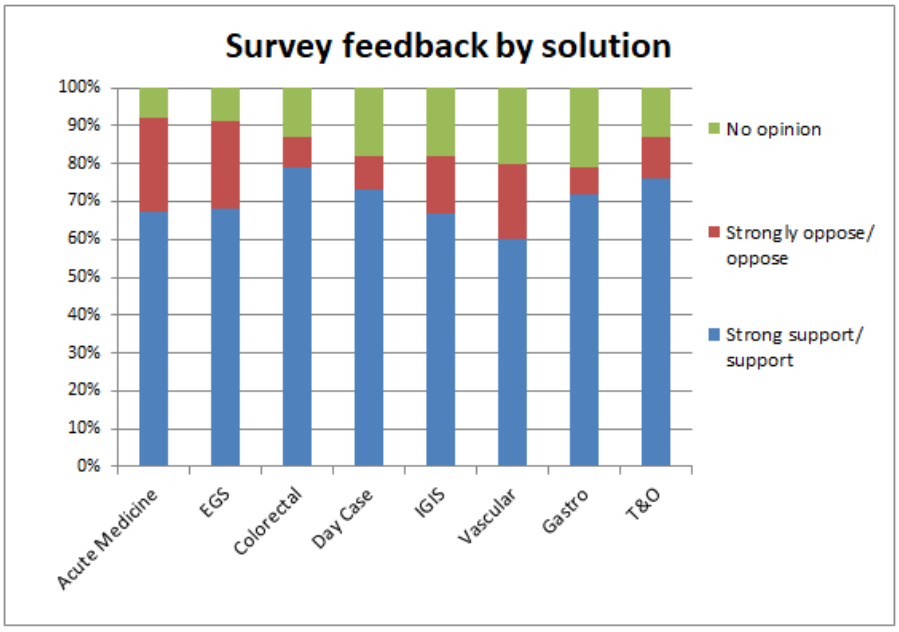
3.2.3 *Feedback by consultation proposal*

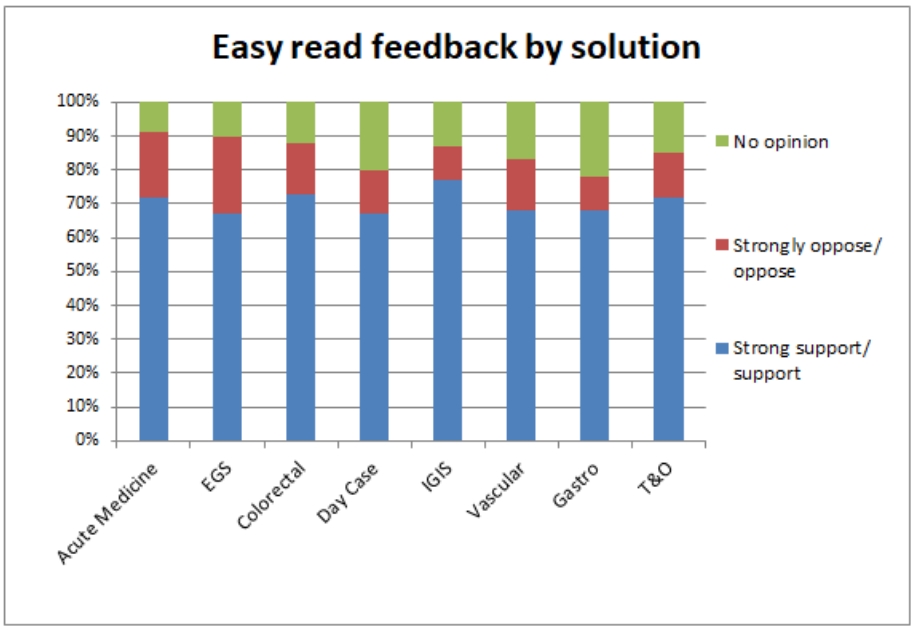
The Final Output of Consultation report provides detailed analysis and presentation of both quantitative and qualitative responses for all consultation proposals, including a selection of qualitative free text responses to illustrate the range of feedback received. It is not the intention of the DMBC to repeat this but rather to focus on the identified themes and specific issues that need to be highlighted to decision-makers and the responses are provided in section 4.

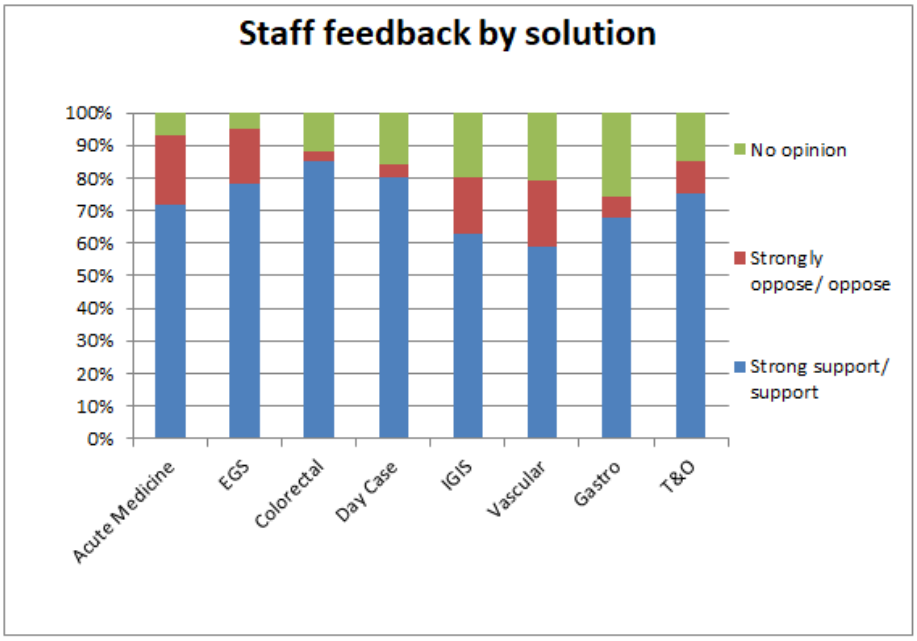
3.2.3.1 Summary of quantitative responses

The table below summarises the quantitative responses by consultation proposal. These are presented for all responses to the survey, staff responses to the survey and all responses to the Easy Read.

Proposal	Strong support/ support			Strongly oppose/ oppose			No opinion		
Group	Survey	Staff	Easy	Survey	Staff	Easy	Survey	Staff	Easy
Acute Medicine to GRH	68%	72%	72%	25%	21%	19%	8%	7%	9%
Emergency General Surgery to GRH	68%	78%	67%	23%	17%	23%	9%	5%	10%
Centralise Planned Colorectal	79%	85%	73%	8%	3%	15%	13%	12%	12%
General surgery Day Cases to CGH	73%	80%	67%	9%	4%	13%	18%	16%	20%
IGIS hub at GRH, spoke at CGH	67%	63%	77%	15%	17%	10%	18%	20%	13%
Vascular Surgery to GRH	60%	59%	68%	20%	20%	15%	20%	21%	17%
Gastroenterology to CGH	72%	68%	68%	7%	6%	10%	21%	26%	22%
Trauma at GRH and Orthopaedics at CGH	76%	75%	72%	11%	10%	13%	13%	15%	15%







Targeted activities aimed to extend the reach of the consultation and to collect data on all protected groups, as recommended in earlier Equality Impact Assessments. Analysis of the survey responses shows there is a broad representation of most groups (response by consultation proposals are presented in the sections below).

Analysis of responses by various demographics, e.g. age, gender, health and care professionals, does not show any significant variation compared with the overall themes, and these are presented graphically for each of the consultation proposals in the sections below. The groups are listed in the table overleaf, and, whilst numbers in some groups are small, it does provide some further information relating to the individuals responding to the survey. It should also be noted that not everyone who responded to the survey completed any/all of the demographic questions (a range across all questions of 75-86%). However, the data presented overleaf indicate the diversity of respondents.

Group	#	Graph axis descriptor
Over 66 years of age	156	> 66 yrs.
Over 66 years of age living with a disability (includes physical impairments; learning disability; sensory impairment; mental health conditions; long-term medical conditions).	60	> 66 yrs. & disability
Black, Asian and Minority Ethnic (BAME)	39	BAME
Black, Asian and Minority Ethnic People living with a disability (includes physical impairments; learning disability; sensory impairment; mental health conditions; long-term medical conditions).	5	BAME & disability
Adult Carers and Young Carers	135	Carers
People living with a disability (includes physical impairments; learning disability; sensory impairment; mental health conditions; long-term medical conditions).	126	Disability
LGBTQ+	19	LGBTQ+
People with mental health conditions and people with learning disability	23	MH & LD
People who live in 12 most deprived wards in Gloucestershire	128	12 wards

3.2.3.2 Qualitative feedback applicable to all consultation proposals

A number of issues identified through the qualitative analysis were applicable to all consultation proposals whilst others were specific to a particular service proposal. This section will present the universally-applicable feedback and followed by the feedback by individual service proposal.

The analysis of the qualitative feedback followed a review of each of the many thousand individual free text comments made by the ~600 long & short survey (only) responses to the 12+ questions in the survey. The review included categorisation of all comments into a series of themes (listed in section 3.2.2) and the identification of issues that needed to be addressed. The findings of this analysis are presented in this section.

The top five categorised themes across all consultation proposals analysed by comments in support or in opposition to the proposals, are listed below:

In support of proposals	In opposition to proposals
Centres of Excellence / clinical model	*Centres of Excellence* / clinical model
Interdependency	Travel
Travel	Facilities
Specialist Skills	Interdependency
Capacity	Capacity

The analysis would indicate that there is high recognition of *Centres of Excellence* / clinical model by survey respondents, as well as the importance of interdependency of services. A common concern shared by respondents (particularly those opposed) related to access to services. Those in support of proposals understood the benefits of proposals on availability/access to specialist skills (that is a key part of the case for change).

The Final Output of Consultation report (and its annexes) provides all the free text comments submitted as part of the consultation. Rather than repeat this, the DMBC has formulated a list of issues from all the comments received that need to be addressed as part of the response to the consultation. These are presented in this section and addressed in section 4.

The importance of both quantitative and qualitative feedback to the decision-making process is clear and well understood by the decision-makers and both are described in the Final Output of Consultation report and this DMBC. As part of this information we have analysed the proportion of respondents providing free text comments for each of the consultation proposals and this is provided for each service proposal.

The issues applicable to all consultation proposals are listed in the table below.

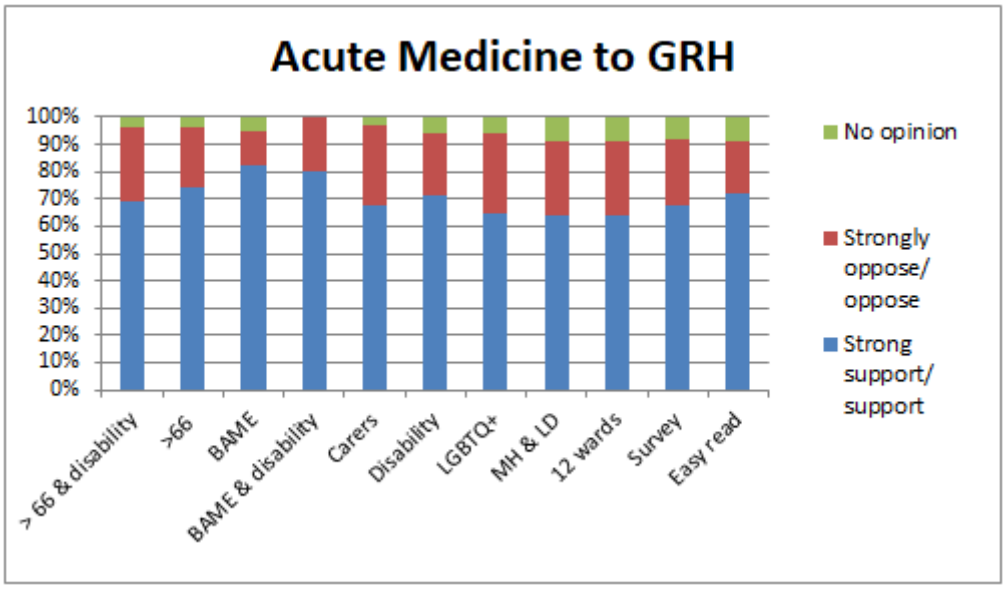
Theme	Issue
COVID-19	Consultation should not have taken place during pandemic
	COVID -19 response – retain improvements to process or service
	COVID-19 has highlighted the need resilience planning for future pandemics
Access/ Travel	Car parking capacity
	Improvements required to public transport services to both GRH and CGH
	Increased patient and carer travel time
	Impact on disadvantaged groups contributes to increasing health inequalities
	Improve communication to the public regarding the location and availability of services
	Greater visibility and support given to people needing to claim travel expenses for hospital visits
	Requests for more outreach services to the homeless, in particular in Cheltenham
	Additional services provided in-county to avoid out-of-county travel
Capacity	Make the most of the CGH site
	Impact of population growth on proposals
	Bed modelling and access to theatres and wards
Facilities	Build a new hospital
	Make better use of virtual technologies
	Make better use of community hospitals
Efficiency	Being done to save money
	Improve recruitment and retention
Quality	Develop a training hospital
	Use the opportunity to improve services
	Hospital discharges
Integration	Work in partnership with community, primary care and the voluntary sector

3.2.3.3 A *Centre of Excellence* for Acute Medicine (Acute Medical Take) at GRH

Quantitative

- 67.6% (Easy read: 72.1%) of survey respondents either strongly supported or supported the proposal
- 24.9% (Easy read: 18.6%) of survey respondents either strongly opposed or opposed the proposal
- 7.6% (Easy Read: 9.3%) of survey respondents had no opinion
- 72.0% of staff respondents either strongly supported or supported the proposal
- 66.2% of respondents excluding staff either strongly supported or supported the proposal

The responses by various demographics are presented in the chart below, with the survey and easy read responses included for comparison.



Qualitative

The top categorised themes for comments made by respondents to the long and short survey (only) on Acute Medicine (Acute Medical Take) analysed by comments in support or in opposition to the proposals, are listed below:

In support of proposals	In opposition to proposals
Centres of Excellence / clinical model	*Centres of Excellence* / clinical model
Specialist Skills	Travel
Access	Capacity
Capacity	Access
Travel	

The proportionality analysis for Acute Medicine (Acute Medical Take) at GRH is provided below.

# of responses	Proportionality
# of quantitative responses	596
# of qualitative responses	299 (51% of quantitative responses)
Support	181 (60% of qualitative responses)
Oppose	112 (38% of qualitative responses)
Neutral	6 (2% of qualitative responses)

In addition to issues applicable to all consultation proposals, the following were specific to Acute Medicine (Acute Medical Take) at GRH.

Theme	Issue
Access	Ambulance response times
Capacity	Bed capacity/ numbers at GRH
	Emergency Department (A&E) capacity at GRH
	Intensive Care capacity at GRH
Efficiency	Ensuring sufficient "flow" through GRH and support to the hospitals 'back door' as this is as important as the 'front door'
Quality	Plans to ensure patients are not moved multiple times between sites or wards at each site, particularly older patients and those with dementia.
	Provision of emergency medical care to support the inpatient population at Cheltenham
	Care of patients presenting with mental health problems

Summary

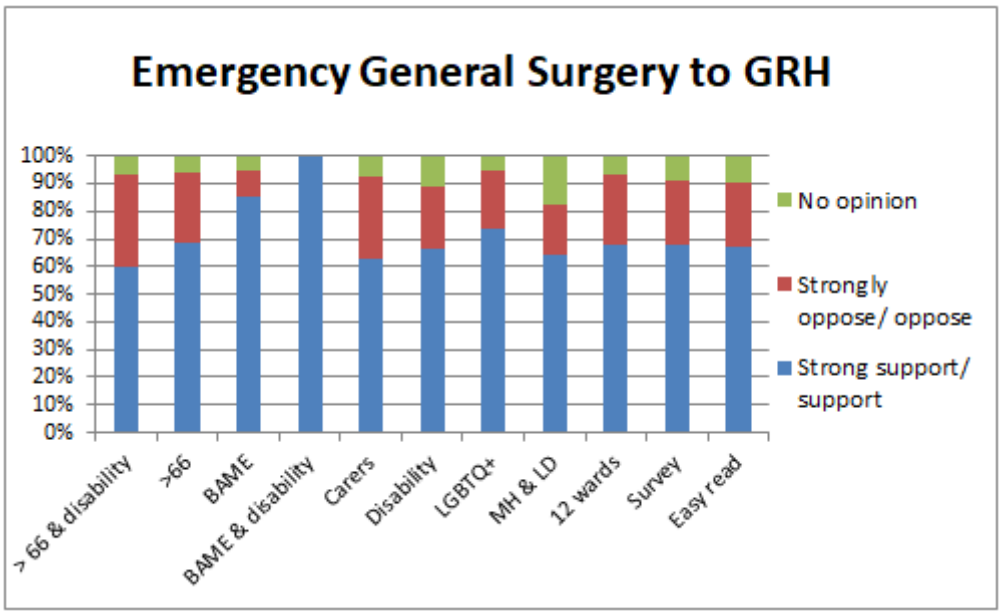
- Numerically well supported across all demographics
- High recognition of centres of excellence/ clinical model
- Recognition of requirement for specialist skills
- Patient and carer travel impact concerns
- Concerns regarding capacity at GRH
- Information required on medical cover at CGH
- Information required on ambulance response times

3.2.3.4 A *Centre of Excellence* for Emergency General Surgery at GRH

Quantitative

- 68.3% (Easy read: 66.7%) of survey respondents either strongly supported or supported the proposal
- 23.4% (Easy read: 23.0%) of survey respondents either strongly opposed or opposed the proposal
- 8.2% (Easy Read: 10.3%) of survey respondents had no opinion
- 77.6% of staff respondents either strongly supported or supported the proposal
- 65.0% of respondents excluding staff either strongly supported or supported the proposal

The responses by various demographics are presented in the chart below, with the survey and easy read responses included for comparison.



Qualitative

The top categorised themes for comments made by respondents to the long & short survey (only) on Emergency General Surgery at GRH analysed by comments in support or in opposition to the proposals, are listed below:

In support of proposals	In opposition to proposals
Centres of Excellence / clinical model	*Centres of Excellence* / clinical model
Specialist Skills	Travel
Workforce	Capacity
Interdependency	
Travel	

The proportionality analysis for Emergency General Surgery at GRH is provided below.

# of responses	Proportionality
# of quantitative responses	546
# of qualitative responses	249 (46% of quantitative responses)
Support	147 (59% of qualitative responses)
Oppose	95 (38% of qualitative responses)
Neutral	7 (3% of qualitative responses)

In addition to issues applicable to all consultation proposals, the following were specific to Emergency General Surgery at GRH.

Theme	Issue
Access	Ambulance response times
Quality	Patient transfers between CGH and GRH
	Infection control

Summary

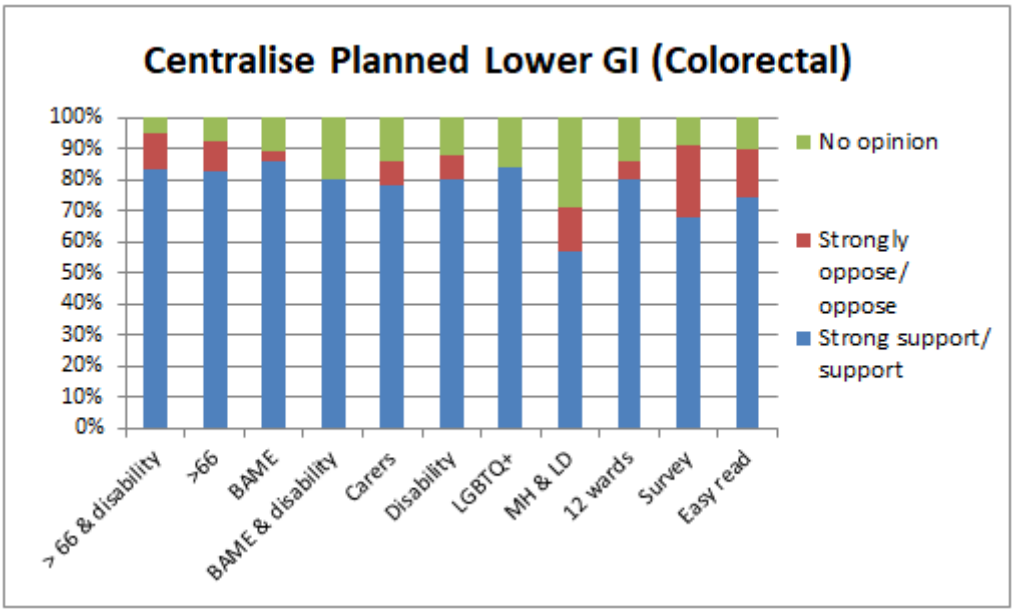
- Numerically well supported across all demographics
- High recognition of centres of excellence/ clinical model
- Recognition of requirement for specialist skills and workforce
- Patient and carer travel impact concerns
- Information required on ambulances and site transfers

3.2.3.5 A *Centre of Excellence* for Planned Lower GI (colorectal) General Surgery

Quantitative

- 79.1% (Easy read: 72.9%) of survey respondents either strongly supported or supported the proposal
- 7.8% (Easy read: 20.3%) of survey respondents either strongly opposed or opposed the proposal
- 13.1% (Easy Read: 12.4%) of survey respondents had no opinion
- 85.3% of staff respondents either strongly supported or supported the proposal
- 76.8% respondents excluding staff either strongly supported or supported the proposal

The responses by various demographics are presented in the chart below, with the survey and easy read responses included for comparison.



Qualitative

The top categorised themes for comments made by respondents to the long & short survey (only) on Planned Lower GI (colorectal) General Surgery analysed by comments in support or in opposition to the proposals, are listed below:

In support of proposals	In opposition to proposals
Centre of Excellence/ clinical model	Centre of Excellence/ clinical model
Interdependency	Travel
Workforce	Workforce
Travel	Interdependency

The proportionality analysis for Planned Lower GI (colorectal) General Surgery is provided below.

# of responses	Proportionality
# of quantitative responses	536
# of qualitative responses	216 (40% of quantitative responses)
Support	168 (78% of qualitative responses)
Oppose	29 (13% of qualitative responses)
Neutral	19 (9% of qualitative responses)

In addition to issues applicable to all consultation proposals, the following were specific to Planned Lower GI (colorectal) General Surgery.

Theme	Issue
Interdependency	Impacts on other surgical specialties including gynae-oncology
	Co-location with Emergency General Surgery
	If centralisation of Emergency General Surgery at GRH then all elective surgical activity is centralised at CGH[7]
	Planned upper and lower GI surgery should be moved to CGH[8]

Summary

- Numerically very well supported across all demographics
- High recognition of centres of excellence/ clinical model
- Recognition of interdependencies with other services
- Patient and carer travel impact concerns
- Request for additional planned care at CGH

[7] This is addressed in section 4.3 "Alternative Suggestions"

[8] This is addressed in section 4.3 "Alternative Suggestions"

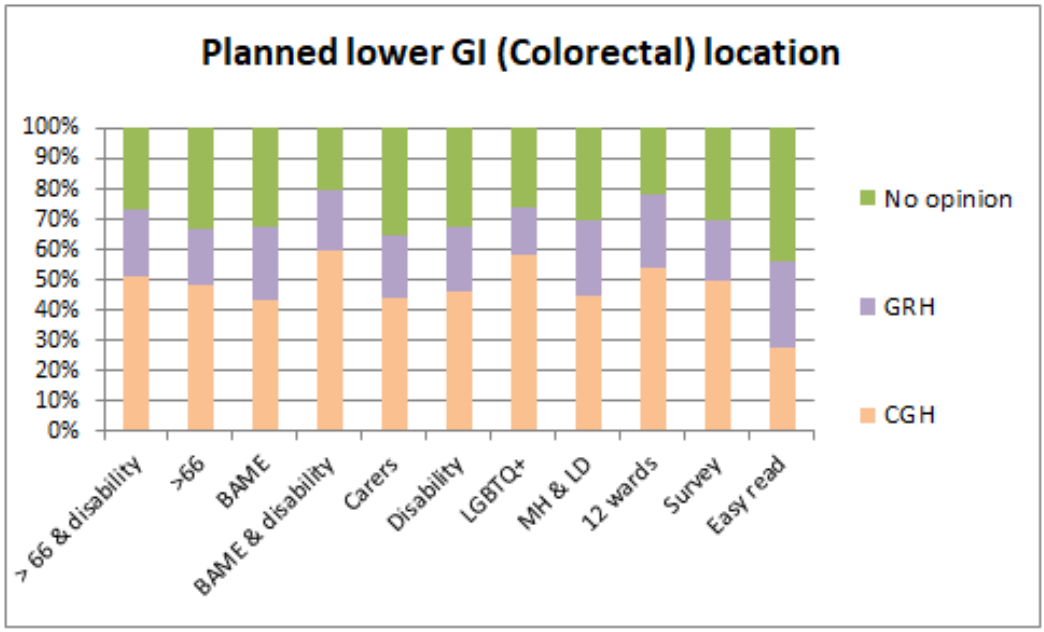
3.2.3.6 Location of Planned Lower GI (Colorectal)

The consultation also asked respondents to provide feedback on the location of the proposed centralised Planned Lower GI (Colorectal) service, either to CGH or GRH.

Quantitative

Group	CGH	GRH	No opinion
All survey responses	50%	20%	30%
Easy Read	28%	28%	44%
Staff	57%	13%	30%
East postcodes	61%	14%	25%
West postcodes	41%	29%	30%
12 most deprived wards	54%	24%	22%

The responses by various demographics are presented in the chart below, with the survey and easy read responses included for comparison.



Qualitative

The Final Output of Consultation report provides a considerable number of qualitative responses grouped by those in support of CGH, in support of GRH and neutral; the themes include:

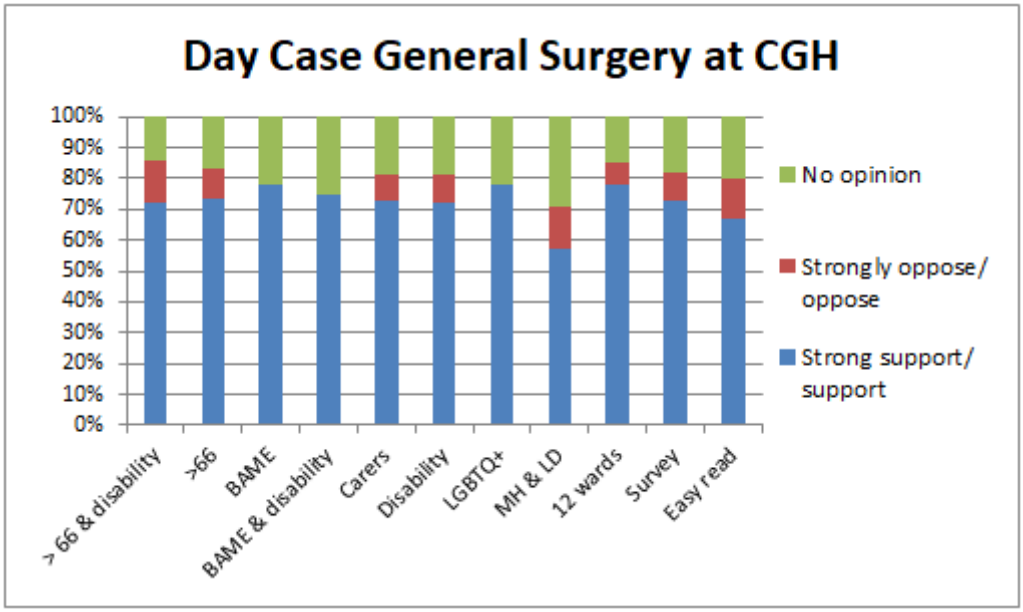
In support of CGH	Neutral	In support of GRH
Ease of access from east of county	Keep service on both sites	GRH facilities better
Co-location with urology, gynae-oncology, oncology and gastroenterology inpatient care	Decision should be based on resources/ capacity available	Elective days-case/short stay surgery in a dedicated unit in CGH. Resectional lower GI surgery co-located with Emergency General Surgery in GRH.
Separate planned and unplanned care (geographically)	Build a new hospital	Experienced high quality of care at GRH
Experienced high quality of care at CGH	Priority is centralised service	Link to Emergency General Surgery at GRH
CGH for all planned activity		Locate with major acute service at GRH
Develop centre of excellence for pelvic resection		Public transport availability better
Link with day cases		Ease of access from west of county
Utilising theatres at CGH		

3.2.3.7 A *Centre of Excellence* for planned day case Upper and Lower GI (colorectal) surgery at CGH

Quantitative

- 73.5% (Easy read: 67.5%) of survey respondents either strongly supported or supported the proposal
- 8.5% (Easy read: 13.3%) of survey respondents either strongly opposed or opposed the proposal
- 18.0% (Easy Read: 19.3%) of survey respondents had no opinion
- 79.6% of staff respondents either strongly supported or supported the proposal
- 71.2% of respondents excluding staff either strongly supported or supported the proposal

The responses by various demographics are presented in the chart below, with the survey and easy read responses included for comparison.



Qualitative

The proportionality analysis for planned day case Upper and Lower GI (colorectal) surgery at CGH is provided below.

# of responses	Proportionality
# of quantitative responses	528
# of qualitative responses	183 (35% of quantitative responses)
Support	134 (73% of qualitative responses)
Oppose	22 (12% of qualitative responses)
Neutral	27 (15% of qualitative responses)

In addition to issues applicable to all consultation proposals, the following were specific to planned day case Upper and Lower GI (colorectal) surgery at CGH.

Theme	Issue
Facilities	Delivery of day case surgery in community hospitals[9] as well as acute hospitals

Summary

- Numerically very well supported across all demographics
- Concerns regarding potential impact on use of community hospitals for day surgery

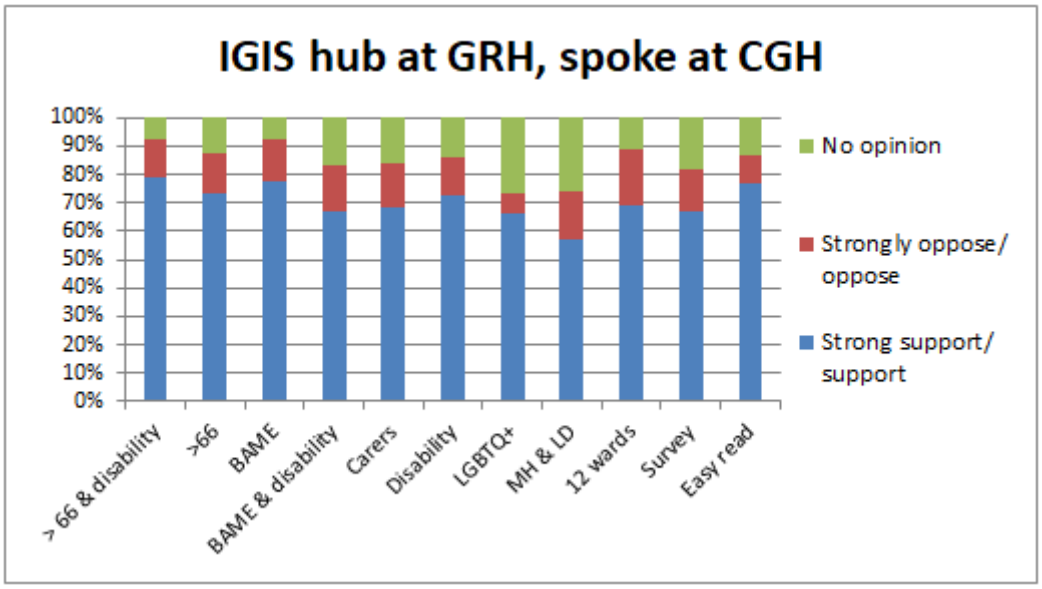
[9] This is addressed in section 4.3 "Alternative Suggestions"

3.2.3.8 An Image Guided Interventional Surgery (IGIS) 'Hub' at GRH and a 'Spoke' at CGH

Quantitative

- 66.5% (Easy read: 76.5%) of survey respondents either strongly supported or supported the proposal
- 15.4% (Easy read: 9.9%) of survey respondents either strongly opposed or opposed the proposal
- 18.1% (Easy Read: 13.6%) of survey respondents had no opinion
- 63.1% of staff respondents either strongly supported or supported the proposal
- 67.8% of respondents excluding staff either strongly supported or supported the proposal

The responses by various demographics are presented in the chart below, with the survey and easy read responses included for comparison.



Qualitative

The top categorised themes for comments made by respondents to the long & short survey (only) on Image Guided Interventional Surgery (IGIS) 'Hub' at GRH and a 'Spoke' at CGH analysed by comments in support or in opposition to the proposals, are listed below:

In support of proposals	In opposition to proposals
Centres of Excellence / clinical model	*Centres of Excellence* / clinical model
Technology	Facilities
Interdependency	Interdependency
Travel	Travel
Facilities	

The proportionality analysis for Image Guided Interventional Surgery (IGIS) 'Hub' at GRH and a 'Spoke' at CGH is provided below.

# of responses	Proportionality
# of quantitative responses	520
# of qualitative responses	183 (35% of quantitative responses)
Support	114 (62% of qualitative responses)
Oppose	47 (26% of qualitative responses)
Neutral	22 (12% of qualitative responses)

In addition to issues applicable to all consultation proposals, the following were specific to an Image Guided Interventional Surgery (IGIS) 'Hub' at GRH and a 'Spoke' at CGH.

Theme	Issue
Facilities	Interventional radiology hub should be located at CGH[10]
	More information on hub and spoke model
Quality	More information regarding impact on cardiology services

Summary

- Numerically supported across all demographics
- High recognition of centres of excellence/ clinical model
- High recognition of technology and equipment required
- Positive aspect of reduced out of county travel
- Concerns regarding use of existing CGH facilities and equipment

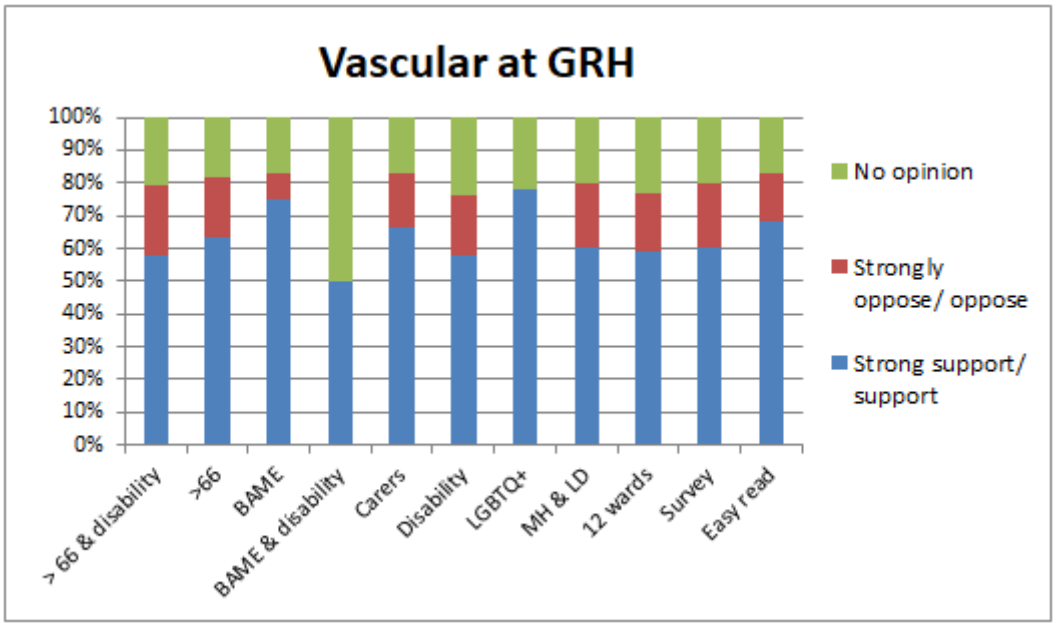
[10] This is addressed in section 4.3 "Alternative Suggestions"

3.2.3.9 A *Centre of Excellence* for Vascular Surgery at GRH

Quantitative

- 60.3% (Easy read: 68.4%) of survey respondents either strongly supported or supported the proposal
- 20.0% (Easy read: 15.2%) of survey respondents either strongly opposed or opposed the proposal
- 19.9% (Easy Read: 17.8%) of survey respondents had no opinion
- 58.9% of staff respondents either strongly supported or supported the proposal
- 60.8% of respondents excluding staff either strongly supported or supported the proposal

The responses by various demographics are presented in the chart below, with the survey and easy read responses included for comparison.



Qualitative

The top categorised themes for comments made by respondents to the long & short survey (only) on Vascular Surgery at GRH analysed by comments in support or in opposition to the proposals, are listed below:

In support of proposals	In opposition to proposals
Interdependency	Facilities
Centres of Excellence / clinical model	*Centres of Excellence* / clinical model
Facilities	Capacity
Travel	Travel
Capacity	Interdependency

The proportionality analysis for Vascular Surgery at GRH is provided below.

# of responses	Proportionality
# of quantitative responses	516
# of qualitative responses	174 (34% of quantitative responses)
Support	92 (53% of qualitative responses)
Oppose	60 (35% of qualitative responses)
Neutral	22 (12% of qualitative responses)

In addition to issues applicable to all consultation proposals, the following were specific to Vascular Surgery at GRH.

Theme	Issue
Capacity	Ward and theatre accommodation for vascular services at GRH.
	Utilisation of the Interventional Radiology/ Hybrid theatre at CGH
Quality	Emergency and elective vascular surgery should be split[11]

Summary

- Numerically supported across all demographics
- Recognition of interdependencies with other services
- Recognition of centres of excellence/ clinical model
- Concerns regarding facilities available at GRH

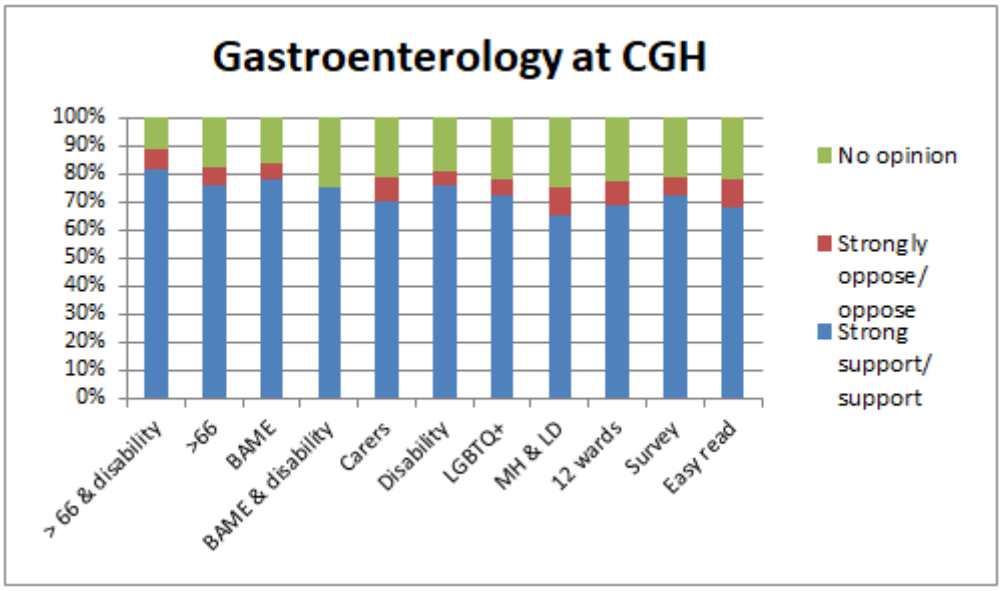
[11] This is addressed in section 4.3 "Alternative Suggestions"

3.2.3.10 A *Centre of Excellence* for Gastroenterology inpatient services at CGH

Quantitative

- 72.0% (Easy read: 68.4%) of survey respondents either strongly supported or supported the proposal
- 6.7% (Easy read: 10.1%) of survey respondents either strongly opposed or opposed the proposal
- 21.4% (Easy Read: 21.5%) of survey respondents had no opinion
- 68.1% of staff respondents either strongly supported or supported the proposal
- 73.4% of respondents excluding staff either strongly supported or supported the proposal

The responses by various demographics are presented in the chart below, with the survey and easy read responses included for comparison.



Qualitative

The top categorised themes for comments made by respondents to the long and short survey (only) on Gastroenterology inpatient services at CGH analysed by comments in support or in opposition to the proposals, are listed below:

In support of proposals	In opposition to proposals
Centres of Excellence / clinical model	Travel
Interdependency	*Centres of Excellence* / clinical model
Specialist Skills	Interdependency
Travel	

The proportionality analysis for Gastroenterology inpatient services at CGH is provided below.

# of responses	Proportionality
# of quantitative responses	510
# of qualitative responses	148 (29% of quantitative responses)
Support	122 (82% of qualitative responses)
Oppose	16 (11% of qualitative responses)
Neutral	10 (7% of qualitative responses)

In addition to issues applicable to all consultation proposals, the following were specific to Gastroenterology inpatient services at CGH.

Theme	Issue
Quality	Care of Gastroenterology inpatients on GRH wards

Summary

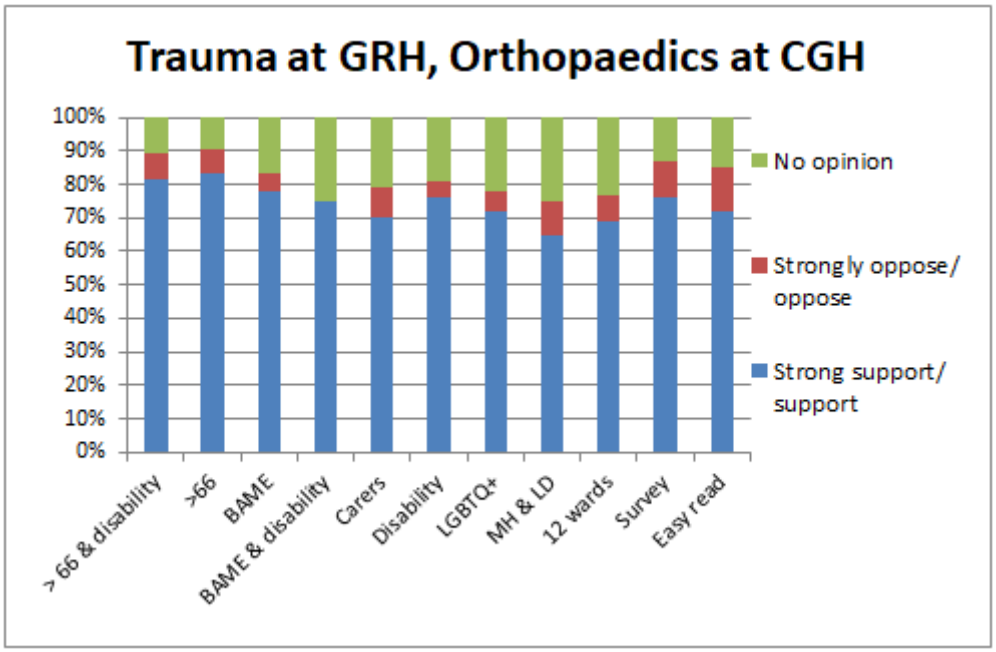
- Numerically very well supported across all demographics
- High recognition of centres of excellence/ clinical model
- Recognition of interdependencies with other services
- Information required regarding service available at GRH

3.2.3.11 *Centres of excellence* for Trauma at GRH and Orthopaedics at CGH

Quantitative

- 76.0% of survey respondents either strongly supported or supported the proposal
- 10.5% of survey respondents either strongly opposed or opposed the proposal
- 13.5% of survey respondents had no opinion
- 75.4% of staff respondents either strongly supported or supported the proposal
- 76.3% of respondents excluding staff either strongly supported or supported the proposal
- Easy read had two questions:
    - Trauma: 70.5% support / 12.8% oppose / 16.7% no opinion
    - Orthopaedics: 73.1% support / 14.1 oppose / 12.8% no opinion

The responses by various demographics are presented in the chart below, with the survey and easy read responses included for comparison.



Qualitative

The top categorised themes for comments made by respondents to the long & short survey (only) on Trauma at GRH and Orthopaedics at CGH analysed by comments in support or in opposition to the proposals, are listed below:

In support of proposals	In opposition to proposals
Centres of Excellence / clinical model	*Centres of Excellence* / clinical model
Efficiency	Pilot
Pilot	Travel
Travel	Capacity
Capacity	

The proportionality analysis for Trauma at GRH and Orthopaedics at CGH is provided below.

# of responses	Proportionality
# of quantitative responses	513
# of qualitative responses	182 (35% of quantitative responses)
Support	130 (71% of qualitative responses)
Oppose	33 (18% of qualitative responses)
Neutral	19 (11% of qualitative responses)

In addition to issues applicable to all consultation proposals, the following were specific to Trauma at GRH and Orthopaedics at CGH.

Theme	Issue
Quality	Pilot evaluation should be presented for scrutiny prior to considering any proposals for a permanent reorganisation
	Management of orthopaedic trauma patients

Summary

- Numerically very well supported across all demographics
- High recognition of centres of excellence/ clinical model
- Request for pilot information to be made available to decision-makers
- Concerns regarding capacity available at GRH

3.3 Alternative suggestions to proposals

The consultation survey included the following question: *Do you have any alternative suggestions for how any of the services covered in the consultation could be organised?*

We also received alternative suggestions submitted in individual correspondence. Full details of all responses can be found in Appendix 1. The table below summarises the suggestions for each service proposal and where applicable to the overall FFTF consultation proposals.

Consultation proposal	Alternative
Applicable to all	Develop centres of excellence on both hospital sites
	Build a new hospital
Image Guided Interventional Surgery (IGIS)	The Interventional Radiology hub should be located at CGH and a spoke at GRH
	Interventional cardiology service could be equally placed at either CGH or GRH
Vascular Surgery	Emergency and elective vascular surgery should be split
	Vascular surgery should remain at CGH.
General Surgery	If centralisation of Emergency General Surgery at GRH then all elective surgical activity is centralised at CGH
	Planned upper and lower GI surgery should be moved to CGH

The response to the alternative suggestions is provided in section 4.3.

3.4 Further areas for consideration

The consultation created an opportunity for the public to provide comments on a range of issues other than those services subject to consultation. Members of the consultation team spoke to participants about matters unrelated to the Fit for the Future proposals, and we received feedback through the survey and individual responses. Other subjects included the national and local response to the Coronavirus pandemic, including practical questions about COVID-19 testing and vaccination, and general comments about services such as primary care (GP) services and mental health services.

Included within these were a number of areas that the respondents would like the NHS in Gloucestershire to consider, and, whilst outside of the Fit for the Future programme, we will carry forward these areas of interest into future work we will do on FFTF in the next phase; they are summarised in the table below and commented on in section 4.4.

Further areas for consideration
• Create a Centre of Excellence for cancer at Cheltenham
• Consider plans for head injuries, chest surgery - including cardiac or neurosurgery.
• Integration of Social Services and the NHS.
• Further develop Care of the Elderly services at CGH.
• Improve the interface with social care services to support patient flow
• Increase the services offered at community hospitals
• Consider centralising other services
• Reinstate Type-1 A&E 24/7 at CGH
• Supporting patients at home, rather than admitting them to hospital.

It should be noted that there were a significant number of messages of thanks to health and care staff and other frontline workers for their efforts during the pandemic.

3.5 Limiting negative impacts

The consultation survey included the following question: *If you think any of our proposals could have a negative impact on you and your family, how should we try to limit this?*

The Final Output of Consultation report (Appendix 1) provides examples of the responses and summarises the mitigations to limit potential negative impacts of centralisation of specialist hospital services as follows and responded to in section 4:

- Retain services on both sites
- Improve patient communications
- Improve integration between hospitals, community services and GP practices
- Reduce the number of patient transfers between acute hospitals
- Build a new acute hospital on a single site
- Improve public transport
- Speed up payment of eligible travel claims
- Encourage more staff to work in Gloucestershire

3.6 Independent Integrated Impact Assessment – consultation review feedback

The Independent Integrated Impact Assessment (IIA) can be found in section 5 and Appendices 2a, 2b & 2c, and is updated to take account of consultation feedback. A summary of their findings is presented below.

- Overall feedback from the consultation was very positive, with the majority of respondents supporting the proposed changes. Feedback from the consultation identified some overall themes.
- **Quality of care** and reduced cancellations and waiting times were perceived to be the benefits of the proposed changes from consultation feedback. These were often the reasons for the high percentage of respondents supporting the changes. Many respondents reported the rationale for the changes were clear.
- **Travel** was identified as theme, particularly for those over 65, those with disabilities and carers. Respondents were concerned about the travel times to the hospital sites from where they live and traffic across the county. Feedback also identified concerns regarding the travel between sites and if public transport is sufficient.
- Those with disabilities and those over 65 and those with long term-conditions identified concerns regarding **transfers** between hospital sites and wards during treatment. This cohort also identified concerns around patients who are very unwell requiring transfer for emergency treatment. This was highlighted in regards to elective colorectal centralisation and Emergency General Surgery centralisation to Gloucestershire Royal Hospital. Some feedback questioned if high risk procedures should be carried out where Emergency General Surgery is centralised.
- **Parking** was identified as an issue for patients, particularly at Cheltenham Hospital, which could become exacerbated by centralisation of elective work.
- **Capacity** was questioned by respondents, with many questioning if the hospitals can cope with the increased demand brought about by centralising services.

- **Both sites** acting as centres of excellence was a suggestion by many respondents who felt that the county was too large to have one centre of excellence located at one site. Some raised concerns regarding the growing population, whereas, others felt that the centralising of services would optimise care quality, increased staff retention and learning for staff which would result in reduced waiting times and cancellations.
- **Community hospitals** were mentioned within feedback, questioning how they will interact with the new models of care.
- Many felt that this could also be a good opportunity to **modernise** areas within the sites as part of this proposal.
- **Subsidised transport** could be explored as many respondents fed back on the cost of transport between hospital sites and home.
- Request to increase **Homeless Outreach**, particularly in Cheltenham. Feedback from the Homelessness Forum and Housing and Support Forum identified that those who are homeless or rough sleeping do not tend to travel outside of their immediate area and so travelling further for medical care may be difficult.
- Many respondents commented that centralising services would support **staff retention** and encourage recruitment.
- **Care quality** was viewed as a benefit by many respondents who felt centralising services would optimise care. Some commented that they were happy to travel for optimised care or that location was less important compared to quality.

Our response to these themes is included in section 4.

3.7 Continued public and stakeholder engagement

As a result of consultation, we have identified a number of areas for ongoing public and stakeholder engagement.

3.7.1 *Planned General Surgery*

As detailed in section 4.2.3 the recommendation following the options appraisal for planned lower gastrointestinal (colorectal) surgery services was that further work should begin with the General Surgery team to define a new, emerging option that includes planned upper gastrointestinal surgery. As this service was not part of the FFTF public consultation there will need to be additional patient, public and stakeholder engagement.

3.7.2 *Citizens' Jury recommendations*

The Jury made recommendations about the public consultation process and information, and about the most important things for the NHS governing bodies to consider from the public responses to consultation. These are included within the Jurors' report (Appendix 3a), and the response from the local NHS with respect to the FFTF consultation is included in the Final Output of Consultation report (Appendix 1).

In response to the Jury observations, the NHS in Gloucestershire has identified a number of considerations/action to support future communications and engagement, including:

- How the input of past, current, and future users of services under consultation and patient experience can be emphasised more in engagement and consultation materials.
- Consider additional methods for signposting to outcomes of earlier engagement activity.
- Pursue further opportunities to promote participation in less well represented districts.
- Establish a 'lay/public' reference group to be involved with reviewing implementation plans for changes approved by decision-makers.
- Investigate 'sampled' market research as an alternative option to consider in future.

3.7.3 *Locality Reference Groups*

As part of the ongoing development of our public engagement and consultation strategy, GCCG is considering expanding the number of locality reference groups across the county. Currently we have a Forest of Dean Locality Reference Group made up of public representatives and community partners with a wide range of interests in healthcare in the Forest of Dean. The group has worked with us to develop our engagement with the local community and have actively contributed to our consultations.

The opportunity to have a process of ongoing engagement with our communities at a locality level to share both the challenges facing health and social care and potential solutions will be extremely valuable.

Key Points

- **The 'socially distanced' consultation and our response are assured by the Consultation Institute.**
- **We targeted particular groups identified in our Integrated Impact Assessment.**
- **We undertook an Equality and Engagement Impact Analysis to identify issues pre-consultation.**
- **The programme developed a wide range of materials and used a variety of channels, including new consultation methods such as live social media events.**
- **Post-consultation a number of additional documents were published.**
- **713 main survey and easy read responses were received.**
- **Consultation proposals were numerically well supported across all demographics.**
- **Qualitative responses identified a range of issues to be addressed, a number of alternative suggestions and some areas for consideration.**

4 Addressing the themes from Consultation

As detailed in section 3.2, following the end of the public consultation there has been an extensive programme to review the findings of the consultation to ensure conscientious consideration[12] of the feedback to inform the recommendations contained within this DMBC.

The outcome of this consideration will be presented using a similar structure[13] as used in Section 3.2:

- Addressing themes applicable to all consultation proposals;
- Addressing themes by individual consultation proposal;
- Responding to alternative suggestions to proposals, and;
- Responding to areas for further consideration

In many cases, our response to feedback from consultation includes reference to either current or proposed activities that seek to address the issues identified. To assist readers of the document, these have been highlighted using the following- Action

4.1 Addressing themes applicable to all consultation proposals

Consultation should not have taken place during pandemic

The decision to proceed to consultation at this point in time was carefully considered and the CCG discussed the approach with NHSE&I, who, as part of the formal process assured the consultation strategy, plan and documentation, and also with The Consultation Institute, which has been providing advice regarding the consultation planning. Neither organisation indicated that a delay to commencing consultation was necessary, or that continuing during the pandemic would compromise our ability to meet our statutory duties for consultation.

The areas of concern mentioned by those respondents with concerns about the consultation taking place during the pandemic can be summarised as:

- The NHS should focus on dealing with COVID-19
- The consultation risked confusing patients and the public, cutting across the key messages and clarity on what needs to be done to fight COVID-19
- The public and other stakeholders may well not be able to focus and give in-depth feedback given they will be focussed on other issues
- We really don't know what the 'new normal' will be and therefore the proposals being consulted upon might no longer be the right ones.

We did pause the programme through the period of the first wave (March - June 2020), but an assessment undertaken of the risks of proceeding were considered to be outweighed by the risks of continuing to pause. A number of services were (and remain) operating under temporary change agreements and this situation perpetuates uncertainty for staff and the public.

We were clear that undertaking the consultation did not put any of our service delivery at risk as the staff involved in the consultation processes are not directly engaged in service delivery. A small amount of clinical time was used to support the consultation but this was

[12] Gunning Principle #4: "conscientious consideration' must be given to the consultation responses before a decision is made.

[13] In some cases the response is presented in more than one sub-section.

outside of patient contact hours for those staff who were involved, typically being senior clinicians who also have management responsibilities factored into their 'day jobs'.

We understood that people were busy and might find it hard to focus on the issues set out in this consultation, but believe the response indicates that this was addressed by offering a comprehensive range of consultation materials, and opportunities to contribute – including online and face-to-face. As detailed in section 2.4.3 we delivered a 'socially distanced' consultation taking account of the needs of groups identified though impact analysis; activities and taking into account the factor of digital exclusion with alternatives to online participation.

In respect of 'future proofing' our proposals, we believe that these are the right proposals for development of our hospitals services whether or not COVID-19 is circulating at high or low levels. We wished to firm up our permanent arrangements to give certainty to our staff and the public. Uncertainty over the previous period has, at times, led to speculation in the media / on social media about which services are likely to be subject to change due to this expected consultation, causing significant concern at times for staff and local residents. We did not believe that perpetuating this uncertainty was in the best interests of either group. We tested our proposals against a number of future scenarios and, in all cases, the proposals remain valid.

Finally, when the UK Government announced a 2nd lockdown in England on 31/10/20 (to run from 05/11/20-02/12/20), an assessment of those activities that would be affected was undertaken. As our plans had been designed to deliver a "socially-distanced" consultation, any activities, such as the Information Bus visits and staff drop-ins, were rescheduled and all were provided once lockdown had ended. Following detailed impact assessment the decision was made to continue with the confirmed consultation schedule.

COVID -19 response – retain improvements to process or service

Action

GHNHSFT has put in place a systematic and inclusive process to identify improvements that have been developed as a result of the pandemic that includes an assessment of whether they should be retained. These include improvements to operational processes, ways of working and patient experience, staff health & wellbeing and communication. Whilst the details of these still require further work, examples include:

- A significant increase in 'virtual' outpatient appointments eliminating the need for many patients to travel and creating space on our hospital sites including reducing the pressure on car parking. Benefit of video and telephone consultations to some autistic patients who otherwise struggle in the hospital environment.
- Improved staff health, wellbeing and support, with the potential benefits in terms of sickness absence, retention and recruitment.
- A shift to relatively high levels of home and remote working across a wide range of staff groups, departments and roles (clinical and non-clinical), with potential effects on staff wellbeing and opportunities for more efficient use of our buildings and estate.
- Frequency of laboratory results
- T&O taking and treating minor injuries from ED, and T&O follow-ups by phone/video
- PPE Safety officer role
- Lung Function team video
- Rapid refresher sessions

- Home enteral feeding team videos
- Ophthalmology triage

COVID-19 has highlighted the need resilience planning for future pandemics

Action

As a result of the pandemic, GHNHSFT put in place a number of temporary COVID-19 service changes, some of which relate to a number of the consultation proposals. Whilst the temporary changes were made as a result of the pandemic, there are a number of key principles that can be considered as part of resilience planning for future pandemics, including:

- To separate COVID-19 and non-COVID-19 pathways by site and by pathway to reduce risk of COVID-19 transmission to and between patients and staff.
- To use our two hospital sites to achieve this by making CGH the focus for planned/elective operating, cancer care and non-COVID-19 diagnostic imaging and GRH as the 'front door' for acute emergency medical and emergency surgical pathways.
- To centralise key points of entry including the Emergency Department, Acute Medical Take and Emergency General Surgery so we can better control flow into hospital and separate three key pathways: COVID-19 positive, suspected COVID-19 and non-COVID-19 patients.
- To designate the Intensive Care Unit (ICU) at CGH as a non-COVID-19 unit - this is a key dependency for cancer and planned care.

Our model of care is focused on delivery in the next decade, whereas it may take several years before the longer-term impacts of COVID-19 are understood and how these effects will affect our response to pandemics and the impact on future health service requirements. A joint letter from The Health Foundation, The King's Fund and the Nuffield Trust to the Health and Social Care Select Committee discussed four main challenges:

- the need to understand the full extent of unmet need;
- the public's fear of using NHS and social care services needs to be reduced;
- looking after and growing the workforce; and
- wider reconfiguration and improvement of the health and social care system.

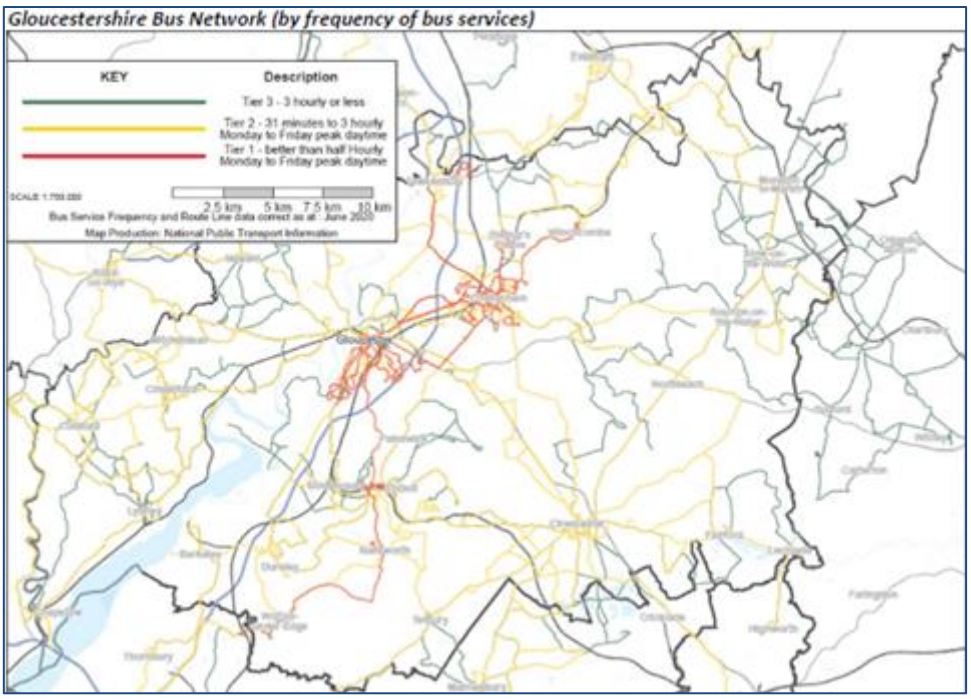
Improvements required to public transport services to both GRH and CGH

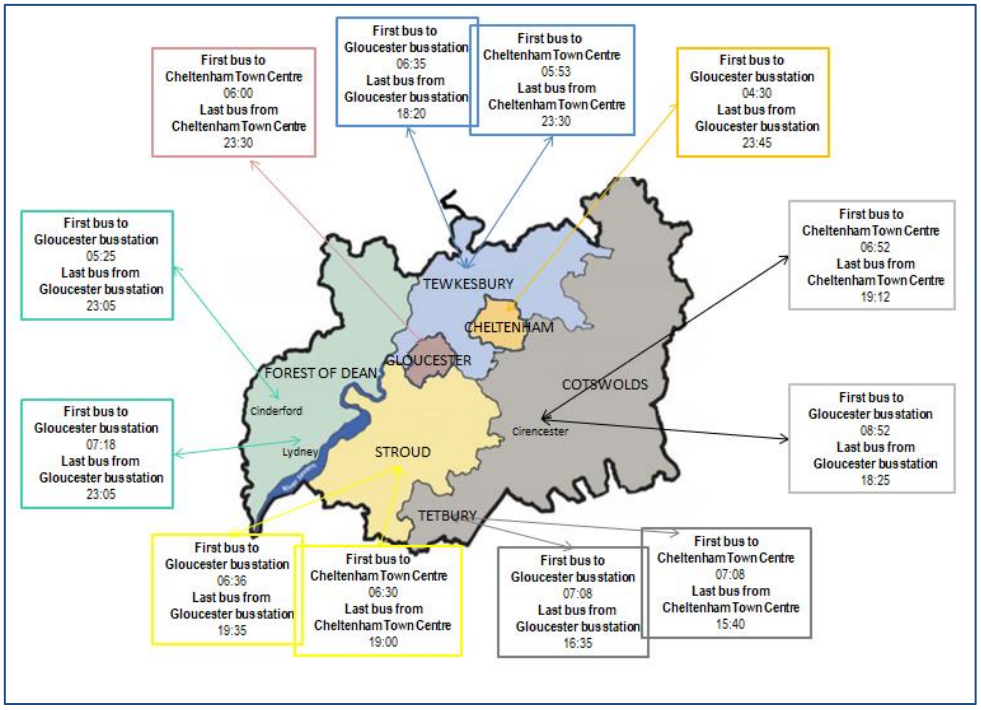
Action

Gloucestershire County Council (GCC) leads the Local Transport Plan which has public transport as one of its key themes. Although public transport has been identified as an issue there a range of services in place and proposals to improve access, details in Appendix 4 and summarised below:

- GCC spend approx. £2.5 million a year on subsidised bus routes across the county. This remains a significant investment in public transport especially as in recent years some Councils have dramatically scaled back their funding.
- The Local Transport Plan is currently being refreshed up until 2041 which will set out strategic ambition for bus travel this sets out a commitment to making GP surgeries accessible with 45 minutes.

- The average journey time by train between Cheltenham Spa and Gloucester is 10 minutes. On an average weekday, there are 60 trains travelling between Cheltenham Spa and Gloucester.
- GCC provides £0.5 million per year in annual grants to support community transport providers, as this is an important provider of transport for vulnerable people. Dial-A-Ride is a bookable door-to-door transport service for those people who do not have their own transport and are unable to use public transport. The following community and Voluntary transport providers operate in Gloucestershire:
    - Connexions – county wide
    - Lydney Dial-A-Ride
    - Cotswold Friends
    - Newent Dial-A-Ride (Shepard House).
- Non-Emergency Patient Service exists for people who are eligible. These services provide free transport to and from hospital.
- GCC is progressing the Thinktravel Total Transport portal which will bring community, voluntary and public transport together under one platform, making accessible transport available to a wider audience who may not previously have considered these options as a travel choice.
- GHNHSFT works closely with a range of partners on transport planning services including GCC.
- GCC currently operates three Park & Ride facilities.
- The 99 bus service connects GRH, Gloucester Bus station, Arle Court Park and Ride, Cheltenham Town Centre and CGH. This service runs 06:35 – 19:50 Mon – Fri every 30 mins. This service is free to staff with a valid permit and a charge is made to the public.
- The bus network does have key routes linking Gloucester, Cheltenham and key towns, with services running on a regular basis during peak hours (see maps below).





Weekday bus services (first and last) to Gloucester and Cheltenham

Action

Car parking capacity

We appreciate the difficulties that can occur during peak times at both hospital sites. The Trust has worked hard over the last few years to increase the provision of public parking at sites. However, the position of the two sites means that there is minimal spare land capacity to further increase provision of public parking spaces and most of the available land will be used to develop clinical services and building for delivering healthcare services.

As detailed later in this section, we have significantly increased the availability of telephone and video call appointments (particularly for outpatients) and have a target of 30% reduction in on-site outpatient activity. This will reduce the number of visitors to our sites and create more car parking capacity for inpatients, their carers and visitors.

In respect of disabled parking the two hospital sites have a large number of accessible parking spaces throughout the patient and visitor car parks. Disabled users may park for free in accessible spaces across the two hospital sites and, where these designated disabled spaces are not available, blue badge holders attending the hospital for the purposes of attending an appointment or supporting/visiting patients receiving medical care on site; may park in other parking spaces on site for the duration of their visit to the hospital without charge, but must display their up-to-date disabled parking permit.

Increased patient and carer travel time

The PCBC provided full details of the travel impact on patients and carers including the methodology, travel impact maps and numbers by locality and model component. This analysis will be updated relating to planned General Surgery (see section 4.2.3) but a summary from the PCBC is provided below:

	Positive (decrease 20+ mins)	Neutral (+/- 20mins)	Negative (increase 20+ mins)
#	1,663	19,468	3,254
%	6.9%	79.8%	13.3%

In the IIA (section 5), the effects are quantified based on the number of patients likely to be affected by the proposed change, the duration/period of impact and then identifies the overall probability of the impact being beneficial or adverse. Effects are quantified using a combination of data collected by the FFTF programme regarding the total number of patients and patient subsets and paired with evidence review of the impacts based on literature and open source data.

Impact on disadvantaged groups contributes to increasing health inequalities

Action

The Gloucestershire ICS is working together to reduce inequalities (i.e. reducing the differences in health, care and life chances based on where people live or their social circumstances), and looking at how we can improve outcomes for our most vulnerable children, including those with additional needs, disabilities and illnesses.

The Integrated Impact Assessment (IIA) provided in section 5 includes a Health Inequalities Impact Assessment that identifies and assesses health inequalities and the impact of the proposed changes for the local community. The aims of a health inequalities impact assessment include identifying and addressing factors which would reduce health inequalities, specifically with regard to access and outcomes.

As detailed in section 3.1 the consultation targeted groups as informed by the PCBC IIA including BAME communities, LGBQT+, gypsy/traveller community, mental health and learning disability groups, frail elderly, long-term condition groups, low income areas, people living with a disability, adult and young carers, young people and the homeless.

GHNHSFT has also established an Involvement Network to ensure that we are able to engage with local people and make our services more accessible to diverse communities. The Trust works with a large number of community and voluntary organisations to improve the engagement and two-way flow of information for local people.

Improve communication to the public regarding the location and availability of services

Action

GHNHSFT provides a range of information to the public on how, where and when to access services. This includes the Trust's website and partner websites (e.g. GCCG, NHS website), patient information leaflets, events and forums, through social media, and through partner organisations. In addition, the Trust works with a large number of community and voluntary organisations to improve the engagement and two-way flow of information for local people. The NHS in Gloucestershire has established an Involvement Network to ensure that we are able to engage with local people and make our services more accessible to diverse communities, and the Trust is always interested to listen to views from staff and local

people on how we can continue to improve access to information. Some examples of GHNHSFT ongoing work includes:

- The Friendship Café is part of our Gloucestershire Hospitals Voluntary & Community Sector Involvement Network, through which we disseminate and receive information.
- Working in partnership with GARAS (Gloucestershire Action for Refugees and Asylum Seekers) on a funding bid.
- Engagement is planned with the traveller community. A funding application has been made to NHS Charities Together for a Community Outreach Worker in order to make a positive impact in this area.
- Appointment of an Arts Coordinator who will be specifically focused on outreach work with black, Asian and other ethnic minorities.
- Work is also ongoing on cultural diversity within the Better Births Programme and it is hoped that links here will also improve our relationships with more diverse communities.
- The Cancer Team has also made significant progress in this area and links and networks will be shared across GHNHSFT services.

Greater visibility and support given to people needing to claim travel expenses for hospital visits

Action

GHNHSFT offers reductions and exemptions to car parking charges for some categories of carers, visitors and patients. Furthermore, those on a low income or benefits may be able to reclaim transport costs to and from the hospital or other NHS premises, through the Healthcare Travel Cost Scheme (HTCS). Information can be found on the Trust website which includes the leaflet HC11.

We recognise that, as with many means-tested benefits, the process can be confusing particularly where the eligibility criteria are complex and constantly changing. The GHNHSFT PALS team is aware of the process and do support and sign post patients and clinicians to the process and availability. The help with travel costs page is promoted prominently on the platform and accessible via the search functionality and navigation.

Requests for more outreach services to the homeless, in particular in Cheltenham

Action

GHNHSFT have reached out to the Housing & Support Forum and Gloucester Homelessness Forum to engage with those who are homeless or currently rough sleepers. Rates of homelessness are slightly higher in Gloucester than surrounding areas, and this group have a significant requirement for trauma services.

There is increased focus in the Involvement Team on working with people who experience health inequalities and are disadvantaged. Strong relationships have been built with two homelessness focused groups, the Cheltenham Housing & Support Forum and Gloucester Homeless Forum. Additionally, relationships have been established with Cheltenham Open Door, a charity which works to relieve poverty, hardship and social or emotional distress. Through engagement and consultation, we worked with ELIM and our Homelessness Specialist Support Nurse to ensure the homeless people/rough sleepers had a voice in Fit for the Future and further outreach work is planned.

Additional services provided in-county to avoid out-of-county travel

Action

Our consultation proposals for IGIS include the repatriation of patients currently travelling out-of-county for IGIS procedures. By centralising IGIS it improves the ability for this provision to expand, increasing the potential for more patients to be treated in the county, overall reducing travel for some patients. Within the scope of the IGIS service proposals are the current 115 patients who undergo various Interventional Radiology procedures mostly delivered in Birmingham and Oxford, with a few in Bristol, and some as far away as Leeds

In addition to the patients directly benefitting, our IGIS service proposals will contribute towards other initiatives aimed at repatriating patients, including:

- 250 Percutaneous coronary intervention (PCI) / Primary percutaneous coronary intervention **(**PPCI) patients - These almost all go to Bristol. This activity is contained within the separate GHNHSFT PPCI business case.
- 60 trans-catheter aortic valve implantation (TAVI) patients – Currently performed in Bristol. This is a future opportunity to deliver more activity in Gloucestershire.
- >300 Electro Physiology patients - nearly all go to Bristol. This is a future opportunity to deliver more activity in Gloucestershire

Build a new hospital

The NHS in Gloucestershire recognises that the UK government has announced a new hospital building programme and that the Gloucestershire 2050 vision includes having a new hospital as a goal for the future. We will continue to work to secure investment in the county however the delivery timescale (10-12 years i.e. beyond 2030) and the costs (on average half-billion pounds[14]) of a new hospital would create a significant delay to the improvements we want to make. We do not want to stand still in the interim and our FFTF plans determine the use of our two hospital sites for the next 10-15 years whereas any new hospital construction would take place in the 20-30-year timeframe. The current national Health Infrastructure Plan runs to 2030 with hospitals already identified, and it does not include a significant development for Gloucestershire.

Make better use of virtual technologies

Action

The One Gloucestershire ICS is committed to turning the NHS Long Term Plan (LTP) into action for the benefit of local people and our dedicated workforce. An important element of this are objectives that develop information technology, including virtual, to deliver improvements for patients and staff.

Examples include:

Long Term Plan Objective	Delivery
Introduce more telephone and video call appointments.	In response to COVID-19, there has been a significant increase in 'virtual' outpatient appointments (video and telephone). We expect to be able to retain the benefit of the recent 'step change' into the future

[14] For example, Bristol's Southmead Hospital opened in 2014 at a cost of £430m

Continuing to develop our secure electronic system which GPs can use to ask hospital specialists questions and receive responses	The roll out of CINAPSIS, which provides GPs with the ability to speak directly to a consultant and discuss whether a patient needs to be seen by the A&E department or admitted as an inpatient, and if so which hospital to refer to. These communications are improving the co-ordination of the admissions pathway for patients.
	We also have links with GPs via an email system called 'Advice and Guidance' where specialists can advise and GPs can implement the best treatment
Innovative and best use of technology to support our staff and our population	A shift to relatively high levels of home and remote working across a wide range of staff groups, departments and roles (clinical and non-clinical), with potential effects on staff wellbeing and opportunities for more efficient use of our buildings and estate.

Action

Make better use of community hospitals

The consultation proposal is for day case Upper and Lower GI activity currently undertaken at GRH and CGH to be centralised at CGH. The consultation proposal does not include any changes to the delivery of day cases at any of the county's community hospitals.

GHC is fully committed to working with system partners to continue to offer a wide and varied range of local services within each community hospital. However, there are no plans to extend the number of sites that offer minor surgery in the community hospitals. All community hospitals work in partnerships with acute hospital providers (predominately GHNHSFT) to deliver a wide range of outpatient and diagnostic services.

We acknowledge that, during COVID-19 there has been some service disruption with some services moving to different locations – this has been a particular feature at North Cotswold Hospital where services have moved between George Moore clinic and the main hospital site to ensure COVID-19 secure environments and better utilisation of the space available. These changes are temporary, and we aim in the longer term to reinstate services back to the original locations.

As of March 2021 GHNHSFT is working with GP referrers to encourage patients having certain day surgery procedures to have their operation at one of the state-of-the-art community hospital theatre settings in Stroud, Tewkesbury or Cirencester. The day surgery is performed by the same consultant-led specialist team. Patients who choose to have their surgery in these locations can take advantage of benefits including easier parking, shorter waiting times, a quieter environment and a location that may be closer to home.

Action

Make the most of the Cheltenham General Hospital (CGH) site

The FFTF proposals deliver a greater separation of emergency and planned care, and are built on establishing a centre of excellence for emergency, urgent and paediatric care at GRH and planned care and oncology at CGH. This approach enables CGH to focus more, but not exclusively, on planned care whilst maintaining the pre-COVID-19 Accident and Emergency (A&E) Department in Cheltenham with a consultant-led service and no change to the opening hours and the provision of Same Day Emergency Care. FFTF also proposes no change to the availability of outpatient services at CGH.

Our proposals will mean medical and surgical specialties on the CGH site will have reliable access to beds, theatres, day surgery and diagnostics resulting in fewer cancelled operations. Grouping these planned care services together also means we will also be able to improve and standardise our pre- and post-operative care pathways, ensure the necessary equipment is always available, and enable us to rapidly adopt new innovations and best practice, for example robotic surgery or new treatment methods. As part of our strategy, there are approved plans to provide two new theatres and a day surgery suite at CGH.

Impact of population growth on proposals

The impact of population growth is detailed in section 6 and uses 2018 subnational population projections from the Office of National Statistics (ONS). We have reviewed the age-group, gender and locality profiles of patients for each of the consultation proposals and applied the appropriate growth rates to our baseline activity to assess the impact of cumulative growth for the period 2021 to 2031.

Whilst the ONS projections are recognised as the usual source for growth assumptions, it should be noted that they were published in 2018 and pre-date the Coronavirus (COVID-19) pandemic. As detailed in the PCBC, our consultation proposals are to deliver our case for change over the medium to long-term and we have therefore, in agreement with NHSE&I, excluded impact of COVID-19 from our baseline data, staffing models, resource requirements and finances. However, at the time of writing, the third wave (and lockdown) continues and it is not practicable to reliably estimate the medium-term impact on planned and unplanned activity; only that it is likely to be different from projections made prior to the pandemic.

Action

Bed modelling and access to theatres and wards

Full details are provided in section 9.5.

Being done to save money

Change in the NHS is often associated with saving money and for a small number of respondents it was assumed this was the case for FFTF. Section 6 provides details of the economic and financial analysis of these proposals including investment in staff funded by the repatriation of activity being undertaken outside of the county. Overall the aim is to be cost-neutral and the proposals will deliver a wide range of benefits (see Appendix 5), allowing us to be more efficient and effective through reductions in waste and duplication.

Improve recruitment and retention

Action

In section 2.5 we describe the reasoning behind our proposals (the Case for Change) where the splitting of resources across two hospital sites contributes to quality, workforce, financial and performance issues which affect patient outcomes and staff recruitment and retention. We are already seeing the benefit of being able to communicate our clinical strategy and ambition as part of the FFTF programme, and have seen an increase in application rate for key clinical roles, particularly at consultant level.

Develop a training hospital

Action

Driving Research is one of GHNHSFTs 10 Strategic Objectives and includes the ambition to become an accredited University Hospital Trust which we believe will increase our capacity and capability to deliver best care for everyone.

GHNHSFT is already a research active Trust providing innovative and ground-breaking treatments, where staff from all disciplines contribute to the collective evidence base which should enable the Trust to become one of the best University Hospitals in the UK. This is being progressed through a number of routes, including Research 4 Gloucestershire, which is a system-wide group with representation from GHNHSFT, GHC, University of Gloucester, Cobalt, CCG and Primary Care.

Use the opportunity to improve services

Action

The centralisation of services at either CGH or GRH is the enabler for the delivery of service improvements and the way we address the issues described in the case for change. Full details of these service improvements were provided in the PCBC and are summarised below:

	Benefit
Improved patient outcomes	• Better access to emergency theatres • Increased number of ED attendances managed by SDEC[15] • Length of Stay reductions • Improved senior surgical review • Reduction in trauma admissions • Reduction in surgical cancellations.
Improved patient experience	• Improved access to sub specialty treatment and equity of care • Reduction in cancellations. • Consistent provision of consultant review • Improved patient pathway and patient experience • Improved access • Improved robustness of Out of Hours service • Reduced rates of mortality and morbidity • The provision of a protected dedicated Elective Unit

[15] Same Day Emergency Care (sometimes referred to as Ambulatory Care)

	Benefit
Improved staff experience	• Improvement in staffing workload • Daily Ward/Board Round for Trauma patients • Improved access to specialist Trauma and Orthopaedic clinicians for advice • Improved rota fulfilment • Workforce deployment efficiencies • Reduction in expired IR inventory • Earlier access to 'in reach' advice from other specialties • Standardisation of pathways • More responsive to GP requests
Improved staff recruitment and retention	• Enhanced staff training and support • Improved Junior Doctor training • Staff health and wellbeing

Action

Hospital discharges

There are a number of schemes in place to support patients on discharge from hospital. The Out of Hospital service, provided by Age UK, offers support to older patients who are preparing to leave hospital or have recently been discharged home. GHNHSFT's Enhanced Discharge Service supports patients discharged on "Pathway 0" (home with no formal health or social care input) with a welfare check telephone call 24 hours post-discharge. The service is provided by a clinician who can provide assurance and advice on all aspects of care (e.g. medication management, community referrals, mental health and wellbeing support), to ensure they have the confidence and tools they need to continue their recovery at home.

There are also two leaflets available for patients on discharge: the 'Your hospital discharge' leaflet explains why they are being discharged from hospital and what they can expect after their discharge, including contact details for the Onward Care Team; the 'Staying safe and well at home' leaflet identifies a range of community services who can offer practical support and guidance to patients, as they continue their recovery in the comfort of their own home; these include carer and voluntary sector support as well as mental health and wellbeing resources. Please see Appendix 6. These discharge arrangements are unchanged as a result of the FFTF proposals.

There is a discharge lounge, staffed by nurses, to cater comfortably for people who are waiting to be collected. If a patient is brought to hospital as an emergency in an ambulance and, after assessment and treatment does not need to be admitted, the ambulance service will not be able to take them home as they supply an emergency service only. However staff will help patients to contact family, friends or taxi services as required. Where patients do qualify for patient transport, this will be arranged. There is a shuttle bus that runs between the two hospitals, which also makes stops in the centres of Cheltenham and Gloucester and the Arle Court Park and Ride. This service runs from 6.35am to 7.50pm, Monday to Friday.

Looking ahead, Healthwatch Gloucestershire (HWG) is currently working on a project to gather patient experience around hospital discharge. Their aim is to identify what works well and what needs to be improved for patients and their carers to deliver a more seamless transition between discharge services. HWG are working with GHNHSFT to contact patients and carers, and have attended our carers Hospitals Reflections & Experience Group to

gather information. We look forward to hearing the outcome of this work and the recommendations that HWG propose.

Work in partnership with community, primary care and the voluntary sector

Action

As an integrated care system, our vision is for every person in every community across Gloucestershire to receive really good care and support, when they need it, as close to home as possible. We want to support people to remain independent for longer, reducing the need for hospital stays, and assisting people to return home from hospital sooner.

GP surgeries are working together in groups, called Primary Care Networks (PCNs), alongside a range of community partners, voluntary and community groups and local people, they can provide better care and access to services, closer to people's homes.

Some of the current and proposed improvements include:

- GP surgeries working together to offer more appointments in the daytime, evening and weekends.
- Introducing more health experts to work in, or with, local GP surgeries to provide care and free-up GP time e.g. clinical pharmacists, physiotherapists, paramedics and mental health workers.
- Making use of technology to increase digital access to primary care including online appointment booking and online and telephone GP consultations.
- Continuing to develop Integrated Community Teams, working alongside Primary Care Networks.
- Bringing together hospital and community respiratory teams so people have a better experience of care.
- Joining-up physical and mental health services to improve support and outcomes for people
- Working with partners in fire, housing, leisure, police and education to improve the health and wellbeing of people across Gloucestershire.
- Working together in a more joined-up way to support people living with and beyond cancer across the county.
- The development of Integrated Locality Partnerships (ILPs) as a partnership of senior leaders of providers and local government, supporting clinically-led integration, developing multidisciplinary workforce models and involving staff and residents in decisions, to keep people in the community and out of hospital.

The ICS has an Enabling Active Communities & Individuals Board which specifically focuses on fostering partnerships and building collaboration between the statutory, community and voluntary sector – this is at a county, district and neighbourhood level. Our close working with a broad range of voluntary and community organisations includes: Cheltenham Housing & Support Forum; Cheltenham Open Door; Dementia UK; Friendship Café; Gloucester Homeless Forum; Gloucestershire Action for Refugees and Asylum Seekers; Gloucestershire Hospitals Voluntary & Community Sector Involvement Network; Gloucestershire LGBT+ partnership; Gloucestershire Patient Participation Group; Inclusion Gloucestershire; Know Your Patch; and Suicide Crisis.

4.2 Addressing themes by individual consultation proposal

4.2.1 *A Centre of Excellence for Acute Medicine (Acute Medical Take) at GRH*

Ambulance response times

Since the publication of the PCBC, the FFTF programme has worked closely with the South Western Ambulance Service NHS Foundation Trust (SWASFT) and Operational Research in Health (ORH) Limited to model the "blue light" ambulance travel impact for **all** of the consultation proposals. The impact was assessed for both the ambulance incident response times and the Call to Hospital times. In summary:

- **Patients attending GRH:** an average of 15.7 patients per day would be conveyed to GRH where previously they had attended CGH
- **Patients attending GWH[16]:** an average 1.7[17] patients per day would be conveyed to GWH where previously they had attended CGH. These are for incidents on the border of Gloucestershire and Wiltshire.
- **Response Performance:** to maintain current Category 1, 2, 3 and 4 performance would require approximately 16-18 hours/day of additional ambulance capacity.
- **Call to Hospital time:** the average (mean) and 90th percentile[18] increase is ~ 7 minutes. Research evidence from a variety of countries, including UK, Scandinavia and the US, reviewing mortality associated with changes in travel, have observed that increases of the order of 10 minutes have an undetectable effect. Further evidence can be found in the PCBC.

Provision of emergency medical care to support the inpatient population at Cheltenham

Action

The proposed deteriorating patient model consists of expanding the Acute Care Response Team (ACRT) to 24/7 on both sites, and providing them with on-site resident ITU consultant support overnight in Cheltenham. The ACRT are specialists in deteriorating patients regardless of specialty or site. They would be led in each site by a band 8a Advanced Clinical Practitioner (ACP) supported by a band 7. For immediate life-threatening issues overnight in Cheltenham, the ACRT practitioners would be supported by a resident Intensive Care Consultant. There would also be a resident junior intensive care doctor onsite.

Alongside the ACRT, there will also be a foundation doctor and a resident medical registrar on the CGH site 24/7 to provide emergency medical care for patients.

We have made a public commitment to maintain the A&E department at CGH. The department will continue to provide consultant-led A&E services 8am to 8pm and a nurse-led service from 8pm to 8am. Under the FFTF proposals, the same day emergency care service at CGH (which is provided by Acute Medicine and is consultant-led) will extend from 8am to 6pm, Mon to Fri to 8am to 8pm Mon to Fri.

Bed capacity/ numbers at GRH

Action

Full details are provided in section 9.5

[16] Great Western Hospitals NHS Foundation Trust, Swindon.

[17] Based on 2019/20 activity and using SWASFT catchment analysis, however the choice of hospital will be determined using a range of factors at the time of the incident.

[18] Indicates the impact for the majority of incidents

Emergency Department (A&E) capacity at GRH

Action

GHNHSFT has recently obtained full planning approval as part of plans to transform facilities at both the CGH and GRH sites. Under the plans, there is an extension and reconfiguration to the emergency department at Gloucestershire Royal Hospital, which will improve streaming and patient flow, plus provide additional minors, majors and resus capacity. This work will be completed by July 2023.

Intensive Care capacity at GRH

Action

Full details are provided in section 9.5

Ensuring sufficient "flow" through GRH and support to the hospital's 'back door' as this is as important as the 'front door'

Action

In line with national challenges, 'flow' through Gloucestershire hospitals has been significantly affected by the COVID-19 pandemic. High numbers of COVID-19 positive patients and increases in the acuity of admissions have driven up the average length of stay and constricted flow. In addition, 160 inpatient beds have been removed as part of infection prevention and control measures, increasing space between beds to reduce nosocomial infection rates. However, GHNHSFT have been able to maintain flow through robust pathways and improved communication between partners and providers. The establishment of the Transfer of Care Bureau, a multi-agency, multi-disciplinary team of health and social care workers, has streamlined the patient referral process, facilitating more timely discharges, and the new 'Home First' pathway (for patients who need formal support from health and/or social care to recover at home) has been instrumental in enabling patients to return home with the support they need to recover. The provision of post-discharge services, such as the Enhanced Discharge Service (a telephone welfare check 24 hours post-discharge) and voluntary sector support have also enabled patients to return home to continue their recovery sooner. These initiatives will continue post-pandemic.

Recent improvement to the interface with social care services to support patient flow have included Adult Social Care (ASC) and Brokerage staff having access to electronic patient records held at GRH and CGH. Aligned with this, the ASC team is sent a daily report of any acute hospital patients who may have a social care need post-discharge. This preliminary notification of potential need allows social care colleagues to engage with patients to facilitate early conversations pertaining to onward care. By including patients in decisions relating to their care, plans can be agreed ahead of discharge; improving patient experience, promoting better flow and providing a smooth transfer of care.

Plans to ensure patients are not moved multiple times between sites or wards at each site, particularly older patients and those with dementia.

As part of FFTF programme, we are identifying the number of beds required on both sites in order to support the proposed changes. We are also developing protocols to ensure that the best care is provided on both sites, and that patients are not moved unnecessarily. In addition, our CINAPSIS system is helping GPs to have conversations with Consultants to determine if a patient needs to be seen in A&E or admitted as an inpatient, and, if so, which hospital they should refer to.

The Same Day Emergency Care service (also known as an ambulatory care service) is provided at both hospitals. There are no plans to change this model. This is a consultant-led service, which is provided Monday to Friday from 8am to 6pm at CGH and Monday to Friday

8am to 11pm and the weekend 8-9pm at GRH. Under FFTF the proposal is to extend the opening hours at CGH to 8pm.

For patients with dementia, we have implemented a protocol to ensure they are not be moved, or only moved under extreme circumstances. This protocol is also supported by having dedicated staff training that will improve the care experience for our patients with dementia/ cognitive impairment, and will help to reassure family / carers that staff are aware of the impact a hospital admission can have on the person. An Admiral Nurse has been appointed, in partnership with Dementia UK, who leads on care, training and treatment of those with dementia. She is available for families and carers affected by dementia in both of our hospitals, and for staff that require support and guidance in caring for people with dementia during their hospital stay.

Care of patients presenting with mental health problems

Action

There are no proposed changes to the current configuration of mental health liaison services, which will still be provided on both sites. However, the centralisation of the acute medical take will support continued development of 'Core 24' requirements and enable timely support and intervention for patients with the greatest need. Following the successful award of national transformation funds, the Gloucestershire Health and Care NHS Foundation Trust (GHCFT) Mental Health Liaison Service is now on the verge of compliance with Core 24 standards. A Cheltenham-based service is currently under development and the investment monies will be used to further improve patient experience and care across both hospital sites. By 2022, we will have onsite services for both hospital sites, which are able to respond proactively and positively to any mental health need.

The GHNHSFT Emergency Department Mental Health Working Party is already progressing with a focused work plan to improve the quality of care and experience of those patients in mental health crisis that attend our Emergency Departments. This collaborative and proactive group is comprised of multiple health care professionals involved in developing and delivering acute mental health services, and recently was joined by two Experts by Experience who are supported by the Involvement Team.

Although the inception of the group pre-dates the recent 2020 report from Healthwatch Gloucestershire, its focus and aims are very much in line with addressing the issues that it raised. These include development of a mental health training programme rolled out to every front-line team member in the Emergency Department, an internal myth-busting campaign led by our Experts by Experience, redesign and redevelopment of the physical spaces within the Emergency Department where mental health assessment takes place, and a particular focus and spotlight on young people's mental health services, to name but a few of the planned initiatives. This comprehensive quality improvement programme is very much a priority for the Trust for the year ahead

We are also continuing to work with Suicide Crisis and people with lived experiences in our Strategic Site Development work, which includes an extension of mental health rooms in our new Emergency Department, with plans to include a sensory room for children and young people.

4.2.2 *A Centre of Excellence for Emergency General Surgery at GRH*

Ambulance response times

Since the publication of the PCBC, the FFTF programme has worked closely with the South Western Ambulance Service NHS Foundation Trust (SWASFT) and Operational Research in Health (ORH) Limited to model the "blue light" ambulance travel impact for **all** of the consultation proposals. The impact was assessed for both the ambulance incident response times and the Call to Hospital times. In summary:

- **Patients attending GRH:** an average of 15.7 patients per day would be conveyed to GRH where previously they had attended CGH
- **Patients attending GWH[19]:** an average 1.7[20] patients per day would be conveyed to GWH where previously they had attended CGH. These are for incidents on the border of Gloucestershire and Wiltshire.
- **Response Performance:** to maintain current Category 1, 2, 3 and 4 performance would require approximately 16-18 hours/day of additional ambulance capacity.
- **Call to Hospital time:** the average (mean) and 90th percentile[21] increase is ~ 7 minutes. Research evidence from a variety of countries, including UK, Scandinavia and the US, reviewing mortality associated with changes in travel, have observed that increases of the order of 10 minutes have an undetectable effect. Further evidence can be found in the PCBC.

Patient transfers between CGH and GRH

As part of FFTF programme, we are identifying the number of beds required on both sites in order to support the proposed changes. We are also developing protocols to ensure that the best care is provided on both sites and that patients are not moved unnecessarily. In addition, our CINAPSIS system is helping GPs to have conversations with Consultants to determine if a patient needs to be seen in A&E or admitted as an inpatient, and, if so, which hospital they should refer to. Data shows that the tool has achieved the following;

- 22% of referrals were retained in Primary Care avoiding a hospital visit
- 7% were referred to an alternative hospital service
- 51% were able to be sent direct to an assessment unit avoiding the Emergency Department (ED).
- 20% were directed to the Emergency Department
- Therefore, 80% of calls did not result in an Emergency Department visit.

The Same Day Emergency Care service (also known as an ambulatory care service) is provided at both hospitals. There are no plans to change this model. This is a consultant-led service, which is provided Monday to Friday from 8am to 6pm at CGH and Monday to Friday 8a.m. to 11p.m. and the weekend 8a.m. to 9p.m. at GRH. Under FFTF the proposal is to extend the opening hours at CGH to 8pm.

This DMBC includes the additional costs of transferring patients between hospitals by ambulance. It is anticipated that GHNHSFT will require between three and four ambulances

[19] Great Western Hospitals NHS Foundation Trust, Swindon.

[20] Based on 2019/20 activity and using SWASFT catchment analysis, however the choice of hospital will be determined using a range of factors at the time of the incident.

[21] Indicates the impact for the majority of incidents

per day to provide inter-site transfers. This is based on the assumption that approx. 7-8 patient journeys/ vehicle / day.

Infection control

Action

The Trust has not had a patient acquire a MRSA blood stream infection (bacteraemia case) since September 2019; nationally there was a mandatory zero tolerance approach to MRSA bacteraemias. For *Clostridioides difficile* infections from April 1st 2020 to January 31st 2021 GHNHSFT had 56 apportioned cases; when compared with April 1st 2019 to January 31st 2020 with 87 Trust-apportioned cases; this represents a 43.3% reduction in the number of cases of Trust-apportioned *C. difficile.*

The Infection Prevention and Control Team have developed a new tool called the COVID Assurance Framework (CAF) to help wards and department assess against the COVID IPC guidance as a source of internal assurance that quality standards are being maintained. It is also to be used to help us to identify any areas of risk and show the corrective actions taken in response to maintain the safety of both patients and staff.

All wards and departments are required to complete a weekly COVID Assurance Framework audit against COVID IPC practices such as cleaning, personal protective equipment use etc. Results presently demonstrate good compliance to practices across both hospital sites and for those areas that require improvements; action plans have been implemented to support improvement

4.2.3 *A Centre of Excellence for Planned Lower GI (colorectal) General Surgery*

As detailed in section 2.6, the consultation included two options for Planned Lower GI (colorectal) General Surgery, either as part of a General Surgery centre of excellence at GRH or as part of a centre of excellence for Pelvic Resection at CGH. On Thursday 4th February, the Trust Leadership Team (TLT) at Gloucestershire Hospitals NHS Foundation Trust explored in detail the configuration options against six domains: Quality of Care; Access to Care; Deliverability; Workforce; Strategic Fit and Acceptability.

The discussion benefited from presentations followed by a question and answer session, with clinical leads from the multi-disciplinary General Surgery team. Both proposals had better outcomes for patients at their heart and many benefits. However, it was evident as a result of the debate that there was an alternative, potentially even better option, that includes the best elements from the two options presented and notably the opportunity to deliver more planned elective surgery at CGH than either of the two options consulted on. This opportunity to treat more patients in a centre of excellence for planned surgical care was also something that came through the consultation feedback (with over 40 references to increasing planned care at CGH) from both public contributors and staff.

The recommendation was that further work should begin with the General Surgery team to define this new, emerging option. The focus will be to explore the opportunity to deliver:

- Planned “High Risk” Upper Gastrointestinal (GI) and Lower Gastrointestinal (Colorectal) surgery at Gloucestershire Royal Hospital
- Planned complex and routine inpatient and day case surgery in both Upper and Lower GI (Colorectal) at Cheltenham General Hospital

The General Surgery team will now work together to define ‘high risk’ and it is important to note that risk doesn’t equal complexity. A complex operation on an otherwise fit and well patient could be categorised as ‘low risk’ where as a relatively routine operation on a patient with other underlying health conditions could be categorised as ‘high risk’.

From the outset of this process, the ICS partners have been clear that consultation feedback is an essential part of informing the decision-making process and this outcome demonstrates the influence of the public and staff voice on the shape of health services in the county. As a result it is important that more time is taken to explore the new option for Planned General Surgery (for details of the recommendation please see section 8).

Impacts on other surgical specialties including gynae-oncology

Action

The impact on other surgical specialties was a key consideration in the recommendation by TLT (see above) to request the development of an alternative proposal for planned General Surgery and in particular that TLT would want gynae-oncology to remain at CGH, and need assurance this can be achieved.

Co-location with Emergency General Surgery

Action

The potential benefit for a cohort of planned General Surgery patients to be co-located with Emergency General Surgery service at GRH was a key consideration in the recommendation by TLT (see above) to request the development of an alternative proposal.

TLT welcomed the re-introduction of planned upper GI into the Fit for the Future programme with more planned care activity being delivered at CGH. In the options assessment process, TLT wanted to better understand the pathway for 'high risk' colorectal and upper GI patients. TLT also wanted to better understand how the planned care ward could operate at CGH, given complex surgery would continue to be managed at CGH.

It should be noted that any proposed changes to the location of planned Upper GI services would be subject to further public and staff involvement.

4.2.4 *A Centre of Excellence for planned day case Upper and Lower GI (colorectal) surgery at CGH*

As described in section 4.2.3, the consultation included two options for inpatient Lower GI (colorectal), but in both cases the only consultation option for planned day case (Upper and Lower GI) is to centralise at CGH. Whilst the principle underpinning this proposal remains unchanged, the recommendation from TLT is to review all planned General Surgery in order to develop a single new option. For details of the recommendation please see section 8.

Delivery of day case surgery in community hospitals as well as acute hospitals

The consultation proposal is for day case Upper and Lower GI activity currently undertaken at GRH and CGH to be centralised at CGH. The consultation proposal does not include any changes to the delivery of day cases at any of the county's community hospitals.

As of March 2021 GHNHSFT is working with GP referrers to encourage patients having certain day surgery procedures to have their operation at one of the state-of-the-art community hospital theatre settings in Stroud, Tewkesbury or Cirencester. The day surgery is performed by the same consultant-led specialist team. Patients who choose to have their surgery in these locations can take advantage of benefits including easier parking, shorter waiting times, a quieter environment and a location that may be closer to home.

4.2.5 *An Image Guided Interventional Surgery (IGIS) 'Hub' at GRH and a 'Spoke' at CGH*

More information on hub and spoke model

The term 'hub and spoke' is used to describe a model of service delivery which arranges assets into a main site (the hub), complemented by secondary site(s) - the spoke(s). The 'hub' is the centralised provision of the service where the largest throughput of activity and where complex procedures are undertaken 24/7. The 'spoke' or 'spokes' are satellite services typically providing services in a more planned way i.e. booked in advance, away from the primary service hub.

In our IGIS proposals we would locate the cardiac cath labs, two Interventional Radiology (IR) labs and the vascular hybrid theatre facility at the main hub in GRH, to support the 24/7 ED, Acute Medicine, Emergency General Surgery, trauma, hyper-acute stroke and vascular services. The spoke site at CGH would retain one interventional lab which will support oncology and urology patients and provide some day-case Interventional Radiology procedures.

We believe the hub and spoke model will provide us with the critical mass of staff and equipment required to reap the benefits of centralisation, whilst still allowing us to provide elective and day case IGIS procedures in Cheltenham to support oncology and urology services which have already been centralised at Cheltenham.

Our consultation proposal for the centralisation of IGIS to a hub at GRH and spoke at CGH will improve the efficiency and effectiveness of our staff resources.

More information regarding impact on cardiology services

The consultation proposals only include Interventional Cardiology services and exclude medical cardiology. Interventional cardiology forms part of our Image-Guided Interventional Surgery (IGIS) proposals that have been jointly developed by collaborative working of all the services directly involved. Interventional cardiology and Interventional Radiology use similar equipment, similarly-trained support staff and similar recovery processes post-operatively. By co-locating these services to create a new 24/7 hub, we will be able to maximise the use of the support staff and equipment across the two services. This is an innovative, but not unprecedented, solution that we believe has the potential to put GHNHSFT amongst the best in the country for providing a full range of endovascular and interventional services, and our proposals have strong clinical support.

We are looking to identify which services might form part of Phase 2 of FFTF, and inpatient medical cardiology services could be included within Phase 2, but this is subject to a full exploration of possible configuration options and a detailed assessment of the impact and benefits associated with each, and consideration of the requirements to both engage and consult with the public and approval by NHSE&I and South West Clinical Senate support.

4.2.6 *A Centre of Excellence for Vascular Surgery at GRH*

Ward and theatre accommodation for vascular services at GRH

Action

It is important to distinguish between the proposals for service change contained within FFTF consultation proposals and the temporary changes implemented in 2020 that were necessary to manage the impact of COVID-19. If approved, the FFTF proposals will be implemented as part of a planned and coordinated programme and aligned with GHNHSFTs Estates Strategy, Strategic Site Development (SSD) programme and capital expenditure plans. This will allow us to phase the implementation of the proposals contained within

FFTF, ensuring that the necessary facilities and infrastructure are in place to support the reconfiguration of services. This will include:

- Investment in the theatres at GRH to provide a vascular environment at least comparable to that already in Cheltenham. We would convert existing theatre facilities at GRH to a full Hybrid IR-Theatre facility ensuring there is no reduction in the quality of the facilities provided to allow complex endovascular procedures to be undertaken.
- The FFTF programme moves more elective surgical activity to CGH which frees up capacity at GRH some of which can be utilised for emergency list use.
- The impact of the FFTF proposals on bed capacity across CGH and GRH has been calculated to ensure it does not create unmanaged 'bed pressures' at either site. Additional capacity at GRH will be provided through the Strategic Site Development (SSD) programme. 41 additional beds at GRH as well as improved day case theatre facilities at CGH will be provided over the next two years through the SSD programme.
- A dedicated vascular ward space for this patient group to ensure services are allocated a sufficient number of beds and other facilities to manage their patient throughput, and that these beds are within an appropriate environment which supports the delivery of excellent care

Utilisation of the Interventional Radiology/ Hybrid theatre at CGH

In 2007, the decision was taken to centralise Vascular Surgery and an options appraisal was undertaken to consider the benefits of centralisation at either CGH or GRH, with CGH selected as the preferred location. A hybrid theatre facility was installed at CGH in 2013 at a cost of ~ £3m, of which £1.8m was required to convert existing facilities to a Hybrid Theatre and the remaining £1.2m related to the purchase and installation of equipment.

The consultation proposals include relocation of the Vascular Hybrid theatre to GRH. The existing Hybrid Theatre at CGH is now 8 years old and the equipment will be approaching planned end of life (typically 10 years for this type of equipment), when the FFTF Phase 1 proposals are implemented and will therefore require replacement. Whilst we acknowledge that replacing this equipment in its current location would be the cheapest solution, we also need to ensure the facility is located in the right place for the expected lifecycle of the equipment being installed. We have taken into account key clinical adjacencies to ensure the location of this highly specialised equipment will be optimised for the future.

To operate a Hybrid Theatre, a multidisciplinary team, including radiographers, is required to utilise the Hybrid theatre as a true endovascular facility. In its current location, limited availability of radiographers at CGH has been a continual challenge restricting our ability to operate this facility as a full hybrid theatre, and reducing the expected benefits from the investment. Our consultation proposal for the centralisation of IGIS to a hub at GRH and spoke at CGH will improve the efficiency and effectiveness of our staff resources.

A hybrid theatre at CGH cannot be fully utilised without both the necessary surgical teams and clinical support staff required to operate it. By locating this facility alongside the IGIS Hub, we will improve the availability of these critical support staff, such as radiographers which are required to operate this facility as a 'Hybrid', and perform endovascular surgery. If the consultation proposals are confirmed, the existing Hybrid Theatre at CGH will be redeveloped to provide additional standard theatre capacity.

4.2.7 *A Centre of Excellence for Gastroenterology inpatient services at CGH*

Care of Gastroenterology inpatients on GRH wards

Although the current Gastroenterology Pilot ward is based at CGH, the service has kept a daily (7/7) Consultant-led referral service at Gloucester. All Gastroenterology patients at GRH can be seen daily as there is an on-call consultant and registrar at GRH who provide a timely opinion to patients coming into ED at GRH. There is also emergency endoscopy cover for both sites. Patients who require assessment and short-term treatment can be seen at GRH and those requiring a longer stay for a more complex condition will be transferred to the specialist ward at CGH. We have two pathways for Gastroenterology patients who are admitted to GRH; patients requiring ongoing Gastro care are moved promptly to CGH and others can continue to be seen on a daily basis at GRH as there is still have a service on both sites.

4.2.8 *'Centres of excellence' for Trauma at GRH and Orthopaedics at CGH*

Pilot evaluation should be presented for scrutiny prior to considering any proposals for a permanent reorganisation

Action

The Trauma and Orthopaedic (T&O) pilot was introduced on 20th October 2017. Prior to the pilot both trauma surgery and planned orthopaedic surgery was carried out at GRH and CGH. Under the pilot, all orthopaedic trauma surgery is now carried out at GRH and as much planned orthopaedic surgery as possible, e.g. hip and knee replacements is carried out at CGH. The T&O service has sole use of 8 theatres (4 at CGH and 4 at GRH), all of which have laminar flow (special high flow air conditioning which minimises the incidence of deep joint infection). As the theatre infrastructure was improved, all elective (planned) arthroplasty (joint replacement surgery) was transferred to CGH however approximately 30% of elective orthopaedic surgery remains at GRH.

As part of the FFTF programme, details including the clinical evidence for the proposal (both desktop and from the pilot), patient and staff (including junior doctor quality panels) experience, an options appraisal assessing the pilot vs. reverting to the previous configuration, and benefits realisation information were included in the FFTF Pre-Consultation Business Case (PCBC). The proposal was also assessed as part of the South West Clinical Senate review.

An updated evaluation report (see Appendix 7) has now been drafted by the T&O team with support from the FFTF Programme Team; it was reviewed by the GHNHSFT Surgical Board and members of the T&O Board received an updated draft of the report and their comments were incorporated. The report was presented and reviewed in public at both the GHNHSFT Board (11/02/21) and Gloucestershire Clinical Commissioning Group (CCG) Governing Body (18/02/21).

A copy of the report (TO-Pilot-Update_-Feb-21.pdf) was published on 08/02/21, and communicated to stakeholders as part of the wider post-consultation updated information (see section 3.1.3). The report was also provided to the Gloucestershire Health Overview & Scrutiny Committee.

The purpose of the report was to provide a systematic evaluation of the T&O pilot structured around the 10 key objectives of the pilot (using the latest available data sets), and latest performance is summarised below:

- 6 of 10 objectives have been achieved
- 3 of 10 objectives show much improved performance
- 1 of 10 objectives has not been achieved.

The objective of the pilot was to address the following areas:

- Co-location of arthroplasty (joint replacement) surgery to allow standardisation of pathways.
- Elective patient operations were often cancelled for emergency (trauma) patients; particularly when complex sub-specialty surgery was required.
- Elective patient operations were often cancelled when the hospitals had periods of high demand.
- Trauma patients did not always receive a timely review by a senior decision-maker in ED because the on-call consultant and registrar could be scheduled to work either in theatre or clinic at the same time. This exacerbated waiting times in ED and at the time of implementation of the pilot Gloucestershire Hospitals were in special measures for poor performance in achieving the 4 hour ED target.
- Once admitted the senior review of trauma patients was variable (depending on the admitting consultant's timetable); this often led to patients staying in hospital longer than necessary.
- There was no routine ward/board Round for Trauma patients which meant delay for patients but also lost opportunity for supervision of junior doctors with poor trainee feedback.
- Junior doctor training, feedback was variable
- Junior doctor recruitment was problematic

The report also makes recommendations for the ongoing monitoring and evaluation of performance of the T&O service and future large-scale service changes.

The publication and review of the evaluation report has provided the opportunity for decision-makers to assess the performance of the pilot and to make recommendations for the ongoing monitoring and evaluation of the service, including regular updates to the GCCG Governing Body.

Management of Orthopaedic Trauma patients

Action

An evaluation report (see Appendix 7) was completed and was presented and reviewed in public at both the GHNHSFT Board (11/02/21) and Gloucestershire Clinical Commissioning Group (CCG) Governing Body (18/02/21), and a copy of the report was published on 08/02/21 at (TO-Pilot-Update_-Feb-21.pdf).

A number of the objectives of the pilot address issues specifically related to Trauma patients including: Trauma patients did not always receive a timely review by a senior decision maker in ED because the on call consultant and registrar could be scheduled to work either in theatre or clinic at the same time; once admitted the senior review of Trauma patients was variable (depending on the admitting consultant's timetable) which often led to patients staying in hospital longer than necessary; inability to cope with Trauma referrals to fracture clinic; and there was no routine Ward/Board Round for Trauma patients which meant delay

for patients but also lost opportunity for supervision of junior doctors with poor trainee feedback.

The pilot achieved these objectives:

- There is now a consultant and registrar as well as a foundation doctor to give an immediate response
- There is now an on-call consultant and Registrar who do not have other duties and so are available for immediate consultation
- There is now a 7-day-a-week Ward/Board round for all Trauma patients
- There is now a new Trauma triage service in place to assist with growing demand

One of the pilot objectives was to improve time to theatre for Trauma patients (at GRH), and the evaluation report categorises this as "Not Achieved" and provides details behind this and the plans in place to improve performance. These plans include more theatre lists being made available at Cirencester Hospital and some non-complex Trauma surgery is undertaken there. In addition, more day cases from the remaining elective work at GRH have been transferred to Cirencester Hospital to create more theatre space within GRH theatres for Trauma patients. There is a further plan to utilise one of the new day surgery theatres at CGH that are to be developed as part of the SSD Programme for Orthopaedics. This will enable the service to further reorganise elective lists and create theatre space at GRH for additional Trauma surgery. The report also makes recommendations for the ongoing monitoring and evaluation of performance of the T&O service and future large-scale service changes.

4.3 Responding to alternative suggestions to proposals

Develop "centres of excellence" on both hospital sites

The feedback from the consultation included a large number of comments describing the excellent care and treatment received by respondents at both CGH and GRH, and requests to leave services unchanged at both sites and thus avoiding any travel impact for patients. Delivering the right care in the right place at the right time means that when care can be delivered at home or close to home, it will be. Sometimes, however, we will need to prioritise achieving a better health outcome over trying to minimise travel for people. Health care for some conditions is increasingly high tech and needs expensive equipment and highly trained staff to keep pace with the best in the world. When specialist care is needed, our aim is to increasingly deliver this through *Centres of Excellence*; centralised services where we can consolidate skills and equipment to provide the very best care. Sometimes these centres may be outside Gloucestershire, but, where possible, as an ICS we will develop our specialist services so we can provide specialist care in our county.

We have clearly heard that travel and access concerns people, but that generally people are prepared to travel a little further to access better health outcomes where it is clearly demonstrated that this will be achieved. As described in section 2.5.1, maintaining these services on both sites is increasingly creating pressures for workforce, quality and safety as resources become ever more stretched to cope with increasing demand. At times, this means services can be compromised in terms of their potential to develop the same standard of specialist care across both sites.

Details of the patient, staff, efficiency and effectiveness benefits can be found in Appendix 5 which directly or indirectly support our ICS objectives set out in our response to the NHS LTP including:

- Ensuring people with specialist health conditions can access outstanding hospital care
- Delivering high quality, joined-up services with the right care, staff skills and equipment in the right place
- Delivering care that is fit for the future through the development of outstanding specialist hospital care in the future across the CGH and GRH sites
- Developing and supporting our workforce and meeting the challenge of recruiting and keeping enough staff with the right skills and expertise.

The process of short-listing options (see section 2.4.2.3) included a detailed assessment of the option to continue to provide these services at both sites, and, following the solutions appraisal workshop these were discounted. Full details can be found in PCBC at: Fit for the Future: Developing specialist hospital services in Gloucestershire – OneGloucestershire.net

Build a new hospital

The NHS in Gloucestershire recognises that the UK government has announced a new hospital building programme and that the Gloucestershire 2050 vision includes having a new hospital as a goal for the future. We will continue to work to secure investment in the county however the delivery timescale (10-12 years i.e. beyond 2030) and the costs (on average half-billion pounds[22]) of a new hospital would create a significant delay to the improvements we want to make. We do not want to stand still in the interim and our FFTF plans determine the use of our two hospital sites for the next 10-15 years whereas any new hospital construction would take place in the 20-30-year timeframe. The current national Health Infrastructure Plan runs to 2030 with hospitals already identified, and it does not include a significant development for Gloucestershire.

The Interventional Radiology hub should be located at CGH and a spoke at GRH

The option to centralise 24/7 Image-Guided Interventional Surgery hub to CGH and the spoke at GRH was identified during the solutions development phase of the FFTF programme (Solution B4); however it was deemed non-viable in combination with the proposal to centralise acute medical take at GRH (Solution A3). This was due to the clinical linkage between the acute medical take and Interventional Cardiology – if the Acute Take was on one site and the 24/7 IGIS hub on a separate site, there is a risk that 'chest pain' patients routed to the 24/7 IGIS hub that did not need Interventional Cardiology but the services of Acute Medicine would need to be transferred between sites, presenting an unacceptable delay to emergency care. When the process described in section 2.4.2.3 determined that centralising the acute medical take at GRH as the only Acute Take option to proceed beyond shortlisting, the option to locate the IGIS Hub at CGH was therefore discounted.

Emergency and elective vascular surgery should be split

The consultation proposal is to relocate the vascular arterial centre and inpatient bed base to GRH. This will mean that complex endovascular surgery and vascular surgery requiring an overnight stay in hospital will take place in the safest environment, with other emergency services available to assist at the same location 24/7 should complications arise. This model allows patients requiring overnight stay following surgery to also be cared for by nurses experienced in vascular care. Although much of the unscheduled admissions for vascular surgery might be considered 'urgent' rather than a true emergency, during the 12-month

[22] For example, Bristol's Southmead Hospital opened in 2014 at a cost of £430m

baseline period used to model FFTF activity, 49 patients were admitted to vascular surgery on an emergency pathway and went to theatre within 12 hours. The vast majority of this surgery was conducted outside of normal working hours. Of those 49 emergency patients admitted to vascular surgery, 36 were admitted to theatre within 4 hours.

A full separation of all elective and emergency vascular activity would require vascular inpatient facilities at both GRH and CGH. Even planned elective vascular surgery carries risk. If inpatient vascular surgery was undertaken at CGH, an emergency response may be required for post-surgical complications. This would therefore require emergency OOH vascular support at both hospital sites, which would significantly reduce our ability to provide robust and timely emergency vascular intervention.

Approximately one third of surgical interventions undertaken in vascular surgery are conducted as day cases. Elective day case procedures will continue to be undertaken at CGH in the new Day Surgery unit, allowing these vascular patients to benefit from the Centre of Excellence for Elective Care. We will also continue to provide some day case surgery at Community Hospital locations.

There has also been some confusion regarding the Vascular GIRFT[23] report published in June 2020, which was a general national report for the restarting of vascular activity during the COVID-19 pandemic. It recommends clearly defined, separate pathways for emergency (potentially COVID-19 positive) and elective (COVID-19 negative) patients. It did not recommend these being on separate sites, only that providers should explore all options in the local health system if separation of these patients is not possible within their own estate.

The option of vascular surgery remaining at CGH was assessed by the South West Clinical Senate Clinical Review Panel (CRP) on 20/08/20. The panel was a key element of the NHSE&I Stage 2 Assurance process in relation to Test 3 (a clear, clinical evidence base). In respect of vascular surgery, the panel was opposed to a split site option for inpatient vascular surgery.

Vascular surgery should remain at CGH.

The FFTF Programme put in place a rigorous 7-step process to evaluate options prior to consultation (see section 2.4.2.3). The option of vascular surgery remaining at CGH was discounted at Step #6 following the South West Clinical Senate Clinical Review Panel (CRP) on 20/08/20. The panel was a key element of the NHSE&I Stage 2 Assurance process in relation to Test 3 (a clear, clinical evidence base). In respect of vascular surgery, the panel noted:

- The model with colocation of vascular services with the IGIS hub at GRH was supported, to support co-dependencies with the IGIS hub, Trauma and diabetes for best patient care
- Vascular surgery at CGH would require a separate middle/junior medical on call rota and it is unlikely that this could be staffed
- Colocation with diabetes, IGIS hub and Trauma make GRH favourable for vascular delivery whereas there is less validity for colocation with the IGIS spoke
- The CRP was opposed to a split site option for vascular surgery

Following this external review, internal discussions were held with clinical teams and through the GHNHSFT and GCCG governance structures, particularly in relation to the panel's concerns regarding the sustainability of the staffing model required to provide safe

[23] Getting It Right First Time (GIRFT) is an NHS improvement programme.

and robust OOH vascular service at CGH, in conjunction with centralisation of EGS to GRH. The PCBC also included evidence that vascular surgery should be considered an urgent care service and services reconfigured to reflect this, with the Vascular Society of Great Britain recommending that 'designated [vascular] arterial centres are co-located with major Trauma centres or Trauma units.

On the basis of the CRP and evidence presented, the decision was taken to withdraw the option of vascular surgery at CGH from the proposed public consultation.

If centralisation of Emergency General Surgery at GRH then all elective surgical activity is centralised at CGH

Action

As detailed in section 4.2.3, when the Trust Leadership Team (TLT) at GHNHSFT explored in detail the configuration options for Lower GI (colorectal) surgery, it was evident as a result of the debate that there was an alternative, potentially even better option, that includes the best elements from the two options presented and notably the opportunity to deliver even more planned elective surgery from the Cheltenham Hospital site.

The recommendation was that further work should begin with the General Surgery team to define this new, emerging option. The focus will be to explore the opportunity to deliver:

- Planned High Risk Upper Gastrointestinal (GI) and Lower Gastrointestinal (Colorectal) surgery at Gloucestershire Royal Hospital
- Planned complex and routine inpatient and day case surgery in both Upper and Lower GI (Colorectal) at Cheltenham General Hospital

From the outset of this process, the ICS partners have been clear that consultation feedback is an essential part of the decision-making process and this outcome demonstrates the influence of the public and staff voice on the shape of health services in the County. As a result, it is important that more time is taken to explore the new option for Planned General Surgery (for details of the recommendation please see section 8).

Planned upper and lower GI surgery should be moved to CGH

Action

As detailed in section 4.2.3, when the Trust Leadership Team (TLT) at GHNHSFT explored in detail the configuration options for Lower GI (colorectal) surgery, the discussion included consideration of planned Upper GI activity to be undertaken at CGH. The recommendation was that further work should begin with the General Surgery team to define this new, emerging option. The focus will be to explore the opportunity to deliver:

- Planned High Risk Upper Gastrointestinal (GI) and Lower Gastrointestinal (Colorectal) surgery at Gloucestershire Royal Hospital
- Planned complex and routine inpatient and day case surgery in both Upper and Lower GI (Colorectal) at Cheltenham General Hospital

From the outset of this process, the ICS partners have been clear that consultation feedback is an essential part of the decision-making process and this outcome demonstrates the influence of the public and staff voice on the shape of health services in the county. As a result it is important that more time is taken to explore the new option for Planned General Surgery (for details of the recommendation please see section 8).

It should be noted that any proposed changes to the location of planned Upper GI services would be subject to further public and staff involvement.

4.4 Responding to areas for consideration

Create a Centre of Excellence for Cancer at Cheltenham

Action

While it is not yet using the label, our Cancer Services already effectively functions as a 'Centre of Excellence' on the Cheltenham General Hospital site. This centre serves a population of just under a million people with a catchment area stretching from Powys to Stroud. It is staffed by 14 consultant clinical oncologists, 3 consultant medical oncologists, consultant nurses, consultant radiographers, cancer-specific nurse specialists, specialist therapy teams, radiographers, psychologists and allied health professionals. The clinical teams deliver state of the art radiotherapy, systemic anti-cancer therapy and supportive therapy within outpatient and day case settings, and also within a thirty bedded specialist inpatient unit. With a satellite unit in Hereford and a nationally unique mobile chemotherapy unit, we are able to care for patients closer to home across this wide geography.

We have plans in place to develop these services into a Centre of Excellence, The Gloucestershire Cancer Institute, with three broad programmes of work:

- Improving patient experience through Living With and Beyond Cancer, and a patient experience group.
- Modernising services through best practice service developments, integration of advanced care and treatment, and implementing genomics to enhance diagnostics and targeted treatment. We are also reviewing the estate and facilities we deliver our services from.
- Operational delivery including projects to advance earlier diagnoses and adopt best practise

Beyond the technical delivery of cancer treatment, the centre prides itself on an ethos of holistic, patient-centred, multi-disciplinary care. We are now at the threshold of being able to deliver Stereotactic Ablative Radiotherapy (SABR) and widening the reach of cancer research and trials. And after many years of work, we now have tangible momentum towards our vision of improved facilities and a new brand—for this centre of excellence on the Cheltenham site, whose staff work tirelessly to serve patients in Gloucestershire and beyond.

Consider plans for head injuries, chest surgery - including cardiac or neurosurgery.

Specialties including neurosurgery, cardiothoracic surgery, burns and spinal injuries units are highly specialised but have relatively low numbers of patients who need the services. For this reason they are undertaken in regional centres where highly complex work is undertaken. There are no plans to make GHNHSFT a regional centre or to provide these specialised services. However there are links with all regional specialised units and plans in place to repatriate patients back to Gloucestershire and in many cases provide ongoing care within the region.

Integration of the NHS and Social Services

Action

Fit for the Future is a programme of the One Gloucestershire Integrated Care System (ICS), which is a partnership between local NHS and social care organisations committed to turning the NHS Long Term Plan (LTP) into action for the benefit of local people and our dedicated workforce. In an integrated care system, NHS organisations, in partnership with

local councils and others, take collective responsibility for managing resources, delivering NHS care, and improving the health of the population they serve.

As a person's care may be provided by several different health and social care professionals across different providers people can experience health and social care services that are fragmented, difficult to access and not based around their (or their carers') needs. People benefit from care that is person-centred and co-ordinated within healthcare settings, across mental and physical health and across health and social care. Being an Integrated Care System has allowed us to work together and coordinate services more closely, to make real, practical improvements to people's lives. For staff, improved collaboration helps make it easier to work with colleagues from other organisations and make better use of the information we have about local people's health, allowing us to provide care that is tailored to individual needs. To support this we have:

- Strong joint commissioning across Gloucestershire County Council and NHS Gloucestershire CCG, including disabilities, older people, children and families.
- Worked across health, education and social care to support young people who have complex additional needs as they move from childhood to adulthood
- Provided local health and social care professionals shared access to patient electronic records, making patient care safer, more efficient and cost effective
- Placed greater emphasis on prevention and self-care, and joining-up services, community support and information across health and social care.
- Created joint posts, for example a Director of Integration at Gloucestershire CCG and Gloucestershire County Council.

Finally, at the time of writing there are ongoing discussions at national and regional level regarding the next steps in the development of ICSs that opens up a discussion with the NHS and its partners about how ICSs could be embedded in legislation or guidance. This builds on the route map set out in the NHS Long Term Plan, for health and care joined up locally around people's needs. It signals a renewed ambition for how we can support greater collaboration between partners in health and care systems to help accelerate progress in meeting our most critical health and care challenges.

Integrated Care Systems have allowed organisations to work together and coordinate services more closely, and to make real, practical improvements to people's lives. For staff, improved collaboration can help to make it easier to work with colleagues from other organisations, and systems can better understand data about local people's health, allowing them to provide care that is tailored to individual needs.

By working alongside councils, and drawing on the expertise of others such as local charities and community groups, the NHS can help people to live healthier lives for longer, and to stay out of hospital when they do not need to be there.

Further develop Care of the Elderly services at CGH

Action

GHNHSFT is currently developing its strategy for Care of the Elderly (COTE) Services, which will continue to provide COTE services on both hospital sites. Our planned initiatives include developing a direct admissions pathway to the Frailty Assessment Service (FAS)/Care of the Elderly, which will reduce waits in the emergency/urgent care pathways, and enable patients to be seen by experts as quickly as possible. We are also planning to develop an enhanced frailty service at CGH, with access to 'hot' clinics, to support admission avoidance and reduce length of stay.

The Trust is also working with GHCFT on a number of initiatives including redesigning the step-down pathway from acute to community hospital rehabilitation and improving access to community beds. We are currently working on enabling FAS (managed by GHNHSFT) and the Integrated Assessment Team (managed by GHCFT) to work more closely together, to improve patient experience and make better use of our combined resources. They are embracing a philosophy of, "Why not home, why not today?"; with the objective of minimising time spent in hospitals.

Improve the interface with social care services to support patient flow

Action

Recent improvement to the interface with social care services to support patient flow have included Adult Social Care (ASC) and Brokerage staff having access to electronic patient records held at GRH and CGH. Aligned with this, the ASC team is sent a daily report of any acute hospital patients who may have a social care need post-discharge. This preliminary notification of potential need allows social care colleagues to engage with patients to facilitate early conversations pertaining to onward care. By including patients in decisions relating to their care, plans can be agreed ahead of discharge; improving patient experience, promoting better flow and providing a smooth transfer of care.

Information essential to the continued delivery of care and support is also recorded in the Single Referral Form, developed by GHNHSFT to ensure that critical patient information is communicated and transferred to the relevant health and care partners on discharge. This form is saved to the patient's electronic record, and includes details of the agreed discharge pathway.

Increase the services offered at community hospitals

GHC is fully committed to working with system partners to continue to offer a wide and varied range of local services within each community hospital. All community hospitals work in partnerships with acute hospital providers (predominately GHNHSFT) to deliver a wide range of outpatient and diagnostic services.

We acknowledge that during COVID-19 there has been some service disruption with some services moving to different locations – this has been a particular feature at North Cotswold Hospital where services have moved between George Moore clinic and the main hospital site to ensure COVID-19 secure environments and better utilisation of the space available. These changes are temporary, and we aim in the longer term to reinstate services back to the original locations.

As of March 2021 GHNHSFT is working with GP referrers to encourage patients having certain day surgery procedures to have their operation at one of the state-of-the-art community hospital theatre settings in Stroud, Tewkesbury or Cirencester. The day surgery is performed by the same consultant-led specialist team. Patients who choose to have their surgery in these locations can take advantage of benefits including easier parking, shorter waiting times, a quieter environment and a location that may be closer to home.

Consider "centres of excellence"/ centralising other services

Action

The *Centres of Excellence* approach is concerned with configuration of adult acute specialties, i.e. where departments, beds and operating (theatres/day unit) resources are located. This is a large-scale change which we are approaching in three phases. This DMBC relates to the first phase and summarised in section 2.6.

The second phase of *Fit for the Future* will review critical dependencies and enablers associated with the preferred option(s) for the Phase 1 specialties. This could include:

- Clinical support services
- Care of the elderly, medical cardiology, acute stroke, respiratory, nuclear medicine
- Review of any remaining elective Orthopaedics on the GRH site that are not linked to services already centralised at GRH, namely Trauma and paediatrics
- Further adult medical/surgical specialties are in Phase 3 for consideration in light of specialty strategic aims, critical dependencies, developing clinical models for each hospital site and operational capacity.

The phases will not necessarily be implemented sequentially. We are seeking clarity on the preferences for the Phase 1 'sentinel' models before we widen the scope of our clinical model development.

Reinstate Type-1 A&E 24/7 at CGH

We know how important Cheltenham General Hospital Accident & Emergency (A&E) Department is to the people who live in the east of the county; in particular Cheltenham. We agree it is an important part of the future for local health services and we have publicly committed to the future of the Accident and Emergency (A&E) Department in Cheltenham. The service will remain consultant led and there will be no change to the pre-Covid-19 opening hours.

The option of a Type 1 provision overnight, 8pm to 8am, at CGH was ruled out at solutions appraisal stage. For full details please see the Pre Consultation Business Case (Fit for the Future: Developing specialist hospital services in Gloucestershire – OneGloucestershire.net).

Supporting patients at home, rather than admitting them to hospital

Action

As a system, our aspiration is to continue to shift the emphasis away from hospital care and towards supporting people to live independently in their own homes. We will do this by offering personalised care where the person and their family/carers are truly able to take more control of their health and well-being.

We fully recognise that there are times when people may need specialist care or support in an inpatient setting. When people do need hospital care due to acute or complex healthcare needs, then we want this to be accessed in the least restrictive environment to meet their individual needs. Our services support people throughout their recovery pathway, enabling people to return safely to their homes and communities.

4.5 New evidence

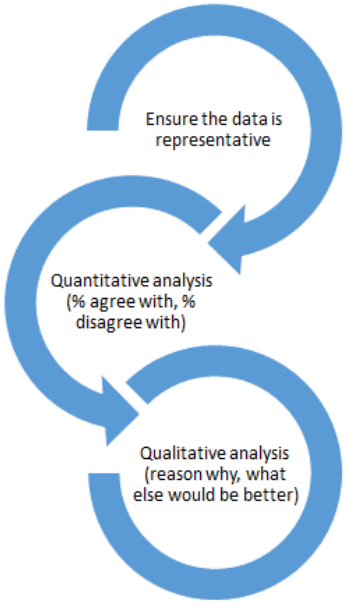
In addition to the qualitative and quantitative feedback received during consultation there are four pieces of new evidence that decision-makers will consider and have influenced the recommendations presented in section 8.

4.5.1 *Enhanced independent Integrated Impact Assessment*

An independent Integrated Impact Assessment (IIA) was a key part of the Pre Consultation Business Case and used the number of people impacted to identify the scale, evidence from literature to determine whether the change would have more positive or adverse impacts and if so, for how long and then an overall assessment was made based on the **scale of the impact, duration of the impact** and therefore the overall **likelihood of the impact.**

Following consultation a process of incorporating consultation feedback into the IIA is undertaken utilising:

- Minutes from engagement events and meetings
- Surveys/ questionnaires sent out to public and patients
- Staff feedback



The process involves breaking down the feedback from the consultation into questions specific to each proposed change and then cohorting the responses e.g. the number of over 65s who agree with proposed change

The IIA (See Appendices 2a, 2b, & 2c) is then enhanced to include **consultation outputs** and **impact based on consultation**. The recommendations are then updated.

Impact of new evidence on our understanding of the options

Details of the recommendations are provided in section 5 and Appendices, and include the following areas:

- Communications
- Delivery of care
- Transport and Accessibility
- On-going patient and public engagement
- COVID-19 pandemic temporary service change learning

How we have listened and the impact of new evidence on decision-making

The impact of the enhanced IIA includes, but not limited to, the following:

- **Planned General Surgery:** It is recommended to explore the possibility of adapting the model of elective colorectal to alleviate some concerns regarding the potential cross-site transfer of high-risk patients. Evidence review suggests there are some clinical benefits to elective colorectal being centralised in GRH with Emergency General Surgery; however, consultation feedback suggests that overall patients would prefer centralisation at CGH, and for this to be extended to other specialties. In order to accommodate patient preference, optimise care and alleviate concerns regarding transfer, it is recommended to explore a model where elective colorectal is

centralised at CGH, but with high-risk patients attending GRH to receive their colorectal treatment. Our response is detailed in section 4.2.3.

- **Virtual appointment:** It is recommended to explore what could be moved to virtual appointment where possible to reduce the need for patients and carers to travel for outpatient appointments. Our response is detailed in section 4.1.
- **Public transport**: It is recommended a review of public transport is conducted to understand if there are limitations, to disseminate information regarding travel to patients to make journey planning easier, and to ensure patients and carers are aware of what services are available. Our response is detailed in sections 4.1 & 7.2.2
- **Proactive engagement**: Ensure sufficient time, resource and focus is allocated to engagement with a range of groups. Our response is detailed in sections 4.1 & 3.7.
- **Communication:** Providing detailed information about what to expect as a patient attending Cheltenham A&E, what is meant by a spoke model for IGIS at Cheltenham, how do the changes link with community hospitals, and how will the hospitals continue to manage demand in the new models. Our response is detailed in sections 4.1 & 7.2.2

4.5.2 *Information regarding Lower GI (colorectal) surgery*

As described in section 4.2.3, GHNHSFTs Leadership Team explored in detail the configuration options regarding Lower GI (colorectal) surgery. As part of this evaluation, information (See Appendix 8) was developed to assess each option against six domains: Quality of Care; Access to Care; Deliverability; Workforce; Strategic Fit and Acceptability.

One of the options (Option B) was an 'acuity'-based model with 'high acuity' colorectal centralised at GRH and 'low acuity' colorectal and upper GI centralised to CGH. The proposal included the development of a number of centres at CGH including:

- Centre for Biliary Disease
- Centre for Pelvic Floor Disease
- Centre for Bariatric Surgery
- Centre for Early Rectal Cancer

Impact of new evidence on our understanding of the options

The TLT discussion concluded that there was an alternative, potentially even better, option that includes the best elements from the two options presented and notably the opportunity to deliver even more planned elective surgery from the Cheltenham General Hospital site.

How we have listened and the impact of new evidence on decision-making

The recommendation was that further work should begin with the General Surgery team to define this new, emerging option. The focus will be to explore the opportunity to deliver:

- Planned High Risk Upper Gastrointestinal (GI) and Lower Gastrointestinal (Colorectal) surgery at Gloucestershire Royal Hospital
- Planned complex and routine inpatient and day case surgery in both Upper and Lower GI (Colorectal) at Cheltenham General Hospital

This opportunity to treat more patients in a centre of excellence for planned surgical care was also something that came through the consultation feedback (with over 40 references to planned care at CGH) from both public contributors and staff.

The changes to the consultation proposals for planned General Surgery are detailed in section 8. It should be noted that any proposed changes to the location of planned Upper GI services would be subject to further public and staff involvement.

4.5.3 *Updated Trauma and Orthopaedic Pilot Evaluation*

As described in section 4.2.8 an updated pilot evaluation report (see Appendix 7) was drafted by the T&O team with support from the FFTF Programme Team. It has been reviewed by the GHNHSFT Surgical Board, T&O Board, GHNHSFT Board and GCCG Governing Body. The report was published and communicated to stakeholders as part of the wider post-consultation updated information.

Impact of new evidence on our understanding of the options

The purpose of the report was to provide a systematic evaluation of the T&O pilot structured around the 10 key objectives of the pilot (using the latest available data sets). A number of the objectives of the pilot address issues specifically related to Trauma patients. The pilot achieved these objectives:

- There is now a consultant and registrar as well as a foundation doctor to give an immediate response
- There is now an on-call consultant and Registrar who do not have other duties and so are available for immediate consultation
- There is now a 7-day-a-week Ward/Board round for all trauma patients
- There is now a new Trauma triage service in place to assist with growing demand

One of the Pilot objectives was to improve time to theatre for Trauma patients (at GRH) and the evaluation report categorises this as “Not Achieved” ad provides details behind this and the plans in place to improve performance. These plans include more theatre lists being made available at Cirencester Hospital, and some non-complex Trauma surgery is undertaken there. In addition more day cases from the remaining elective work at GRH have been transferred to Cirencester Hospital to create more theatre space within GRH theatres for Trauma patients. There is a further plan to utilise one of the new day surgery theatres at CGH that are to be developed as part of the SSD Programme for Orthopaedics. This will enable the service to further reorganise elective lists and create theatre space at GRH for additional Trauma surgery.

How we have listened and the impact of new evidence on decision-making

The publication and review of the evaluation report has provided the opportunity for decision-makers to assess the performance of the pilot and to make recommendations for the ongoing monitoring and evaluation of the performance of the T&O service, including regular updates to the GCCG Governing Body.

The evaluation report was also reviewed by the South West Clinical Senate, and a number of suggestions were made to support the ongoing delivery of the service.

The consultation proposal to retain Trauma (emergency Orthopaedics) at GRH and the majority of elective (planned) Orthopaedics at CGH remains unchanged (see section 8).

4.5.4 *Ambulance response times*

Since the publication of the PCBC, the FFTF programme has worked closely with the South Western Ambulance Service NHS Foundation Trust (SWASFT) and Operational Research in Health (ORH) Limited to model the "blue light" ambulance travel impact for **all** of the consultation proposals.

Impact of new evidence on our understanding of the options

The impact was assessed for both the ambulance incident response times and the Call to Hospital times. In summary:

- **Response Performance:** to maintain current Category 1, 2, 3 and 4 performance would require approximately 16-18 hours/day of additional ambulance capacity.
- **Call to Hospital time:** the average (mean) and 90th percentile[24] increase is ~ 7 minutes. Research evidence from a variety of countries, including UK, Scandinavia and the US, reviewing mortality associated with changes in travel, have observed that increases of the order of 10 minutes have an undetectable effect.

How we have listened and the impact of new evidence on decision-making

The new evidence supports the consultation proposals, and these remain unchanged (see section 8).

Key Points

- **The DMBC provides a comprehensive response to themes applicable to all consultation proposals, to themes applicable to individual consultation proposals, to alternative suggestions and to areas for further consideration**
- **In many cases our response to feedback from consultation includes reference to either current or proposed activities that seek to address the issues identified**
- **The DMBC responds to new evidence**

[24] Indicates the impact for the majority of incidents

5 Integrated Impact Assessment

This assessment has been completed by **Mid and South Essex NHS Foundation Trust ("MSE") Strategy Un**it in conjunction with the Fit for the Future Programme team. Impact analysis, as part of the evaluation of the two pilot changes (Gastroenterology and Trauma & Orthopaedic inpatient services) has been undertaken locally; this IIA summary document will incorporate findings from both IIAs and includes some text included elsewhere in the DMBC.

5.1 Executive summary

Context

MSE Strategy Unit and Partners were engaged as an independent expert provider by Gloucestershire Integrated Care System (ICS) to undertake an independent Integrated Health Inequalities and Equality Impact Assessment (IHIEIA) of the proposed development of centres of excellence and the resulting proposed relocation of services at GRH and CGH.

Purpose

Through the IHIEIA, the commissioners wanted to ensure that any decisions made by them would support advancing equality and ensure fairness by removing barriers, engaging patients and community and delivering high quality care. This would also help ensure that the commissioners continue to meet their responsibilities under Section 149 of the Equality Act 2010, and demonstrate due regard to the need to eliminate discrimination, harassment, victimisation and any other conduct that is prohibited under the Equality Act; to advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it; and to foster good relations between persons who share a relevant protected characteristic and persons who do not share it. The IHIEIA also helps to ensure that the commissioners continue to meet the duty to reduce inequalities between patients with respect to their ability to access health services, and to reduce inequalities between patients with respect to the outcomes achieved for them by the provision of health services, as set out in s.14T of the NHS Act 2006.

Process

Evidence review, data analysis and feedback from engagement and the consultation feedback, including opinion surveys, panel discussions and focus groups, were considered by the Strategy Unit team to summarise both positive and negative impacts of the proposed changes for people with protected characteristics, as outlined by the Equality Act 2010, the impact on other health inequalities and the general health impact.

The Consultation asked all respondents whether they were in support, neutral or opposed to each proposed change and their reasons, including any alternative ideas or other comments. The feedback from this has been incorporated into the overall assessment of impact.

5.1.1 *Summary of Impact*

The IIA specifically focused on the impact of the proposed changes. The impacts are quantified based on the scale of patients likely to be affected by the proposed change, the duration of the impact e.g. short, medium or long term and this then identifies the overall probability of the impact being beneficial or adverse. Impacts are quantified using a combination of data collected by the Trust regarding the total number of patients and patient subsets and paired with evidence review of the impacts based on literature and open source data. All neutral impacts have been removed from the summary. A detailed

summary of this process is included in the Annex – (Appendix 2b), which includes all data and evidence-based review. The impacts are broken down into two visuals shown overleaf. Figure 1 represents the overall impact of each model and figure 2 represents the impact of each individual proposed solution that makes up a model. The key indicates the nature of the impact. Where there are moderate adverse impacts, these have been highlighted within the document and recommendations have been made.

5.1.2 *Summary of Proposals*

As detailed in section 4.2.3 the recommendation following the options appraisal for planned Lower Gastrointestinal (Colorectal) surgery services was that further work should begin with the General Surgery team to define a new, emerging option that includes planned upper gastrointestinal surgery. Once defined, an IIA will be undertaken but in the meantime the IIA includes the impact of both elective colorectal consultation proposals, with all other services are identical:

- Model D proposes elective colorectal to be centralised at Cheltenham General Hospital (CGH)
- Model E proposes elective colorectal to be centralised at Gloucestershire Royal Hospital (GRH)

Key	Description
Significant Positive Impact	The positive impact is significant despite small adverse impacts
Significant Positive Impact Moderate Adverse Impact	The positive impacts outweigh the adverse impacts, however the adverse impacts have been identified and recommendations made to mitigate against these
Significant Adverse Impact	The adverse impact is significant and despite positive impacts it is not clear that the adverse impacts are outweighed by the positive impacts
Neutral Impact (no significant change)	No significant change identified for this cohort

		Model D	Model E
Protected Characteristics	Age	Significant Positive Impact Moderate adverse impact	Significant Positive Impact
	Disability	Significant Positive Impact Moderate adverse impact	Significant Positive Impact Moderate adverse impact
	Gender	Significant Positive Impact	Significant Positive Impact
	Pregnancy	Neutral Impact (no significant change)	Neutral Impact (no significant change)
	Martial Status	Neutral Impact (no significant change)	Neutral Impact (no significant change)
	Ethnicity	Significant Positive Impact	Significant Positive Impact
	Sexual Orientation	Neutral Impact (no significant change)	Neutral Impact (no significant change)
	Religion	Neutral Impact (no significant change)	Neutral Impact (no significant change)
	Gender Reassignment	Neutral Impact (no significant change)	Neutral Impact (no significant change)
Health Inequalities	Deprivation	Significant Positive Impact Moderate adverse impact	Significant Positive Impact Moderate adverse impact
	Looked After Children	Neutral Impact (no significant change)	Neutral Impact (no significant change)
	Carers and Unpaid Carers	Significant Positive Impact Moderate adverse impact	Significant Positive Impact Moderate adverse impact
	Homelessness	Significant Positive Impact	Significant Positive Impact
	Substance Abuse	Neutral Impact (no significant change)	Neutral Impact (no significant change)
	Mental Health	Significant Positive Impact Moderate adverse impact	Significant Positive Impact Moderate adverse impact
Health Impact	Cardiovascular Disease	Significant Positive Impact Moderate adverse impact	Significant Positive Impact
	Diabetes	Significant Positive Impact	Significant Positive Impact
	Neurological Conditions	Significant Positive Impact Moderate adverse impact	Significant Positive Impact Moderate adverse impact
	Falls among the elderly	Significant Positive Impact	Significant Positive Impact
	Overweight and Obese	Significant Positive Impact	Significant Positive Impact

Figure 1 Summary of Proposals

Proposal Summary

All proposals include the following changes:

- Centralise Acute Medicine to GRH
- Centralise Emergency General Surgery to GRH
- Centralise General Surgery/GI day cases to CGH
- 24/7 Image Guided Interventional Surgery (IGIS) hub and Vascular surgery to GRH with IGIS spoke at CGH
- Gastroenterology at CGH
- Trauma at GRH and Orthopaedics at CGH

These are all significantly positive changes that outweigh the adverse impacts identified. The adverse impacts identify that centralising emergency surgery to Gloucestershire Royal means that patients who deteriorate (e.g. day case patients) at CGH or attend A&E but require emergency surgery may need to be transferred. This has been considered adverse for those who are most vulnerable to deterioration such as those over 65. There were 6,176 emergency admissions to General Surgery last year (Feb 19 to Jan 20), 4,215 of which were at GRH. It is estimated; however, that ~6 patients per day in total will be affected by the new arrangements (1,961 in total) and overall 93% of patients' journeys will remain within +/- 20 mins of their existing journey.

It is also estimated that there will be significantly less than 1 patient per day needing to be transferred in an emergency as a result of inpatient deterioration, and a Standard Operating Procedure will be put in place for this event. This means the impact is relatively small and outweighed by the positive clinical outcomes. Emergency General Surgery care would be improved by providing a dedicated team on the Surgical Assessment Unit, which would review all patients presenting on the same day. This would reduce delays to review, improving patient safety. Evidence suggests patients who are seen quicker have reduced admissions and increased self-care post treatment. The Local IIA found a small adverse impact for those in deprived areas with regards to the proposed change to gastroenterology. This is an important consideration in terms of transport and access.

Coronavirus (COVID-19)

As part of GHNHSFT's COVID response the Trust has been monitoring the patients attending CGH A&E who require a transfer to GRH. On average, during the pandemic, 2 General Surgery patients per week were transferred to GRH, 17 in total between 1st April and 18th June 2020. It is also important to note, it is estimated that significantly less than 1 patient per day will require a transfer as a result of inpatient deterioration.

Model D

In Model D the same adverse impact identified above also relates to elective colorectal surgery patients, who will be centralised to CGH. This means this cohort will also need to be considered as potentially at risk of needing to be transferred if they deteriorate. This risk, however, is estimated to impact significantly less than 1 patient per day, meaning this is outweighed by the positive clinical outcomes of having a centralised clinical response to elective surgeries such as this. By centralising some elective surgery, quality of care could be improved as a result of co-location with other relevant specialties. There is also a reduced

risk of cancellations for patients as they will have access to a ring fenced service. Day case operations e.g. Gastroenterology patients, are currently cancelled frequently due to the need for emergency beds, therefore, by separating elective and emergency there is dedicated resource reducing the number of cancellations for patients.

Coronavirus (COVID-19)

As part of GHNHSFT's COVID response, the Trust temporarily consolidated vascular emergency and elective inpatient pathways to GRH whilst day case venous patients remained at CGH. This temporary change was only implemented in June 2020 and, therefore, the impact on vascular patients is still being monitored. In a 12-month period approximately 500 inpatients would move from CGH to GRH, and approximately 750 day case procedures would continue at CGH.

Model E

Model E has the least adverse impacts identified. This model co-locates IGIS and vascular and centralises elective colorectal surgery with Emergency General Surgery at GRH. The adverse impacts for Model E are reflected in the adverse impacts for all models.

Please see a more detailed look at each individual proposed change overleaf;

5.1.3 *Summary of Proposed Solutions*

The following table shows the impact assessment of each proposed change on patient cohorts. The IIA for Gastroenterology and Trauma and Orthopaedics were completed locally within the Trust using a slightly different methodology to Mid and South Essex Foundation Trust's IIA. This is because they were pilots and the local IIA assesses the impacts slightly differently. They have been included in this table to show the overall summary of the findings.

		Mid and South Essex Foundation trust IIA						Local IIA	
		A3 - Centralise acute medicine to GRH	B2 - IGIS hub and vascular centralised to GRH	C3 - EGS centralised to GRH	C11 - GI day cases to CGH	C5 - Elective colorectal to CGH	C6 - Elective colorectal to GRH	Gastroenterology to CGH	Trauma to GRH and Orthopaedics to CGH
Protected Characteristics	Age	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact Moderate adverse impact	Significant Positive Impact Moderate adverse impact	Significant Positive Impact	Significant Positive Impact Moderate adverse impact	Significant Positive Impact Moderate adverse impact
	Disability	Significant Positive Impact Moderate adverse impact	Significant Positive Impact Moderate adverse impact	Significant Positive Impact Moderate adverse impact	Significant Positive Impact Moderate adverse impact	Significant Positive Impact Moderate adverse impact	Significant Positive Impact Moderate adverse impact	Significant Positive Impact Moderate adverse impact	Significant Positive Impact Moderate adverse impact
	Gender	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact	Neutral Impact (no significant change)	Significant Positive Impact
	Pregnancy	Neutral Impact (no significant change)	Neutral Impact (no significant change)	Neutral Impact (no significant change)	Neutral Impact (no significant change)	Neutral Impact (no significant change)	Neutral Impact (no significant change)	Significant Positive Impact Moderate adverse impact	Significant Positive Impact
	Martial Status	Neutral Impact (no significant change)	Neutral Impact (no significant change)	Neutral Impact (no significant change)	Neutral Impact (no significant change)	Neutral Impact (no significant change)	Neutral Impact (no significant change)	Neutral Impact (no significant change)	Neutral Impact (no significant change)
	Ethnicity	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact
	Sexual Orientation	Neutral Impact (no significant change)	Neutral Impact (no significant change)	Neutral Impact (no significant change)	Neutral Impact (no significant change)	Neutral Impact (no significant change)	Neutral Impact (no significant change)	Neutral Impact (no significant change)	Neutral Impact (no significant change)
	Religion	Neutral Impact (no significant change)	Neutral Impact (no significant change)	Neutral Impact (no significant change)	Neutral Impact (no significant change)	Neutral Impact (no significant change)	Neutral Impact (no significant change)	Neutral Impact (no significant change)	Neutral Impact (no significant change)
	Gender Reassignment	Neutral Impact (no significant change)	Neutral Impact (no significant change)	Neutral Impact (no significant change)	Neutral Impact (no significant change)	Neutral Impact (no significant change)	Neutral Impact (no significant change)	Neutral Impact (no significant change)	Neutral Impact (no significant change)
Health Inequalities	Deprivation	Significant Positive Impact Moderate adverse impact	Significant Positive Impact Moderate adverse impact	Significant Positive Impact Moderate adverse impact	Significant Positive Impact Moderate adverse impact	Significant Positive Impact Moderate adverse impact	Significant Positive Impact Moderate adverse impact	Great Adverse Impact	Significant Positive Impact Moderate adverse impact
	Looked After Children	Neutral Impact (no significant change)	Neutral Impact (no significant change)	Neutral Impact (no significant change)	Neutral Impact (no significant change)	Neutral Impact (no significant change)	Neutral Impact (no significant change)	Neutral Impact (no significant change)	Neutral Impact (no significant change)
	Carers and Unpaid Carers	Significant Positive Impact Moderate adverse impact	Significant Positive Impact Moderate adverse impact	Significant Positive Impact Moderate adverse impact	Significant Positive Impact Moderate adverse impact	Significant Positive Impact Moderate adverse impact	Significant Positive Impact Moderate adverse impact	Significant Positive Impact Moderate adverse impact	Significant Positive Impact Moderate adverse impact
	Homelessness	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact	Neutral Impact (no significant change)	Neutral Impact (no significant change)
	Substance Abuse	Neutral Impact (no significant change)	Neutral Impact (no significant change)	Neutral Impact (no significant change)	Neutral Impact (no significant change)	Neutral Impact (no significant change)	Neutral Impact (no significant change)	Significant Positive Impact Moderate adverse impact	Significant Positive Impact
	Mental Health	Significant Positive Impact Moderate adverse impact	Significant Positive Impact Moderate adverse impact	Significant Positive Impact Moderate adverse impact	Significant Positive Impact Moderate adverse impact	Significant Positive Impact Moderate adverse impact	Significant Positive Impact Moderate adverse impact	Significant Positive Impact Moderate adverse impact	Neutral Impact (no significant change)
Health Impact	Cardiovascular Disease	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact Moderate adverse impact	Significant Positive Impact Moderate adverse impact	Significant Positive Impact Moderate adverse impact	Significant Positive Impact	Not assessed	Not assessed
	Diabetes	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact	Neutral Impact (no significant change)	Neutral Impact (no significant change)
	Neurological Conditions	Significant Positive Impact Moderate adverse impact	Significant Positive Impact Moderate adverse impact	Significant Positive Impact Moderate adverse impact	Significant Positive Impact Moderate adverse impact	Significant Positive Impact Moderate adverse impact	Significant Positive Impact Moderate adverse impact	Neutral Impact (no significant change)	Neutral Impact (no significant change)
	Falls among the elderly	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact Moderate adverse impact	Significant Positive Impact Moderate adverse impact
	Overweight and Obese	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact

Figure 2: Summary of proposed changes

5.2 Post-Consultation feedback

Full details can be found in Appendices 2a, 2b and 2c. Overall feedback from the consultation was very positive, with the majority of respondents supporting the proposed changes. Feedback from the consultation identified some overall themes;

Quality of care and reduced cancellations and waiting times were perceived to be the benefits of the proposed changes from consultation feedback. These were often the reasons for the high percentage of respondents supporting the changes. Many respondents reported the rationale for the changes were clear.

Travel was identified as a theme, particularly for those over 65, those with disabilities, and carers. Respondents were concerned about the travel times to the hospital sites from where they live and traffic across the county. Feedback also identified concerns regarding the travel between sites, and if public transport is sufficient.

Those with disabilities and those over 65 and those with long term conditions identified concerns regarding **transfers** between hospital sites and wards during treatment. This cohort also identified concerns around patients who are very unwell requiring transfer for emergency treatment. This was highlighted in regards to elective colorectal centralisation and Emergency General Surgery centralisation to GRH. Some feedback questioned if high-risk procedures should be carried out where Emergency General Surgery is centralised.

Parking was identified as an issue for patients, particularly at Cheltenham Hospital, which could become exacerbated by centralisation of elective work.

Capacity was questioned by respondents. Many questioned if the hospitals can cope with the increased demand brought about by centralising services.

Both sites acting as centres of excellence was a suggestion by many respondents who felt that the county was too large to have one centre of excellence located at one site. Some raised concerns regarding the growing population, whereas, others felt that the centralising of services would optimise care quality, increased staff retention and learning for staff, which would result in reduced waiting times and cancellations.

Community hospitals were mentioned within feedback, questioning how they will interact with the new models of care.

Many felt that this could also be a good opportunity to **modernise** areas within the sites as part of this proposal.

Subsidised transport could be explored as many respondents fed back on the cost of transport between hospital sites and home.

Request to increase **Homeless Outreach**, particularly in Cheltenham. Feedback from the Homelessness Forum and Housing and Support Forum identified that those who are homeless or rough sleeping do not tend to travel outside of their immediate area and so travelling further for medical care may be difficult.

Many respondents commented that centralising services would support **staff retention** and encourage recruitment.

Some respondents had questions regarding the inpatient care at GRH for Gastroenterology patients. This is also the case in relation to how the spilt of Trauma and Orthopaedics looks in practice.

Care quality was viewed as a benefit by many respondents who felt centralising services would optimise care. Some commented that they were happy to travel for optimised care or that location was less important compared to quality.

5.2.1 *Recommendations based on evidence review and consultation feedback*

Communication

1. The need for further communication has been identified through consultation feedback. Providing detailed information about what to expect as a patient attending Cheltenham A&E, what is meant by a spoke model for IGIS at Cheltenham, what will remain available at both sites in relation to Trauma and Orthopaedics split and Gastroenterology centralisation, how do these changes link with community hospitals, and how will the hospitals continue to manage demand in the new models, are some examples.
2. Communications will be needed to explain the benefits and mitigate public perceptions of additional risks to patient and visitor wellbeing. Ensure sufficient time, resource and focus is allocated to engagement with a range of groups on travel impacts, both planned and emergency, and for families and visitors as well as patients. Staff travel may also be a factor.
3. Emphasising to the public that current A&E services at CGH will be maintained is important to alleviate concerns around its closure. Feedback from over 65s emphasises the need to ensure all patients are aware of their local A&E and where to go in the event of an emergency. There are concerns around whether they will need to learn the route to a new A&E so ensuring they know A&E is still available at CGH and what to do in the event of an emergency is important.
4. Explaining how specialist staff are spread across the two sites will be beneficial in alleviating concerns around accessibility to specialist care equally across the county.

Delivery of care

5. It is recommended to explore the possibility of adapting the model of elective colorectal to alleviate some concerns regarding the transfer of high-risk patients. The evidence review suggests there are clinical benefits to elective colorectal being centralised in GRH with Emergency General Surgery, however consultation feedback suggests that overall patients would prefer centralisation at CGH. In order to accommodate patient preference, optimise care and alleviate concerns regarding transfer, it is recommended to explore a model where elective colorectal is centralised at CGH but with high-risk patients attending GRH to receive their colorectal treatment.
6. Explore if increasing outreach services for those who are homeless is needed and would be beneficial.
7. It is recommended to explore what could be moved to virtual appointment, where possible to reduce the need for patients and carers to travel for outpatient appointments.
8. As part of the design of services, consultation feedback suggested that this could be an opportunity to modernise areas of the sites.

Transport and Accessibility

9. Assess the parking at each site, including availability of disabled parking bays to understand if this will be negatively impacted by the changes.
10. It is recommended a review of public transport is conducted to understand if there are limitations, to disseminate information regarding travel to patients to make journey planning easier and ensure patients and carers are aware of what services are available.
11. It is recommended to conduct a review of transport options, including subsidised options for transport which can be disseminated to patients to ensure they are aware of all the options they can access.
12. High quality signposting, good quality wheelchair access and interactive information for those with sensory impairments will be necessary to help patients navigate this change. Both sites will already have facilities in place for patients with disabilities, but it is important to ensure these are optimised and, where possible, co-designed with representative organisations and patients with disabilities.
13. It is recommended to work closely with local transport providers and the local authority to understand their forward plans for transport and the impact this will have on the reconfiguration proposals.
14. When centralising services it is important to assess if there is an appropriate number of disabled parking bays to accommodate increases in demand of, for example, specific elective procedures. Engagement with patients with disabilities can help to identify the perceived challenges and what is required.
15. Moving sites can be a challenge for patients with a sensory impairment who may be familiar with their local hospital site but may be required to travel to the other site. Additional support may be needed to help patients navigate this change; engagement through representative organisations for sensory impairments and disabilities would be beneficial to understand the best way to offer support.

5.2.2 *Potential Positive Impacts*

- Centralising acute medicine enhances patient safety, improves outcomes and reduces length of stay as it allows for more patients to be seen by a senior reviewer within 14 hours of arrival, 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 change and its benefits.
- By centralising the IGIS hub patients will now have a 24/7 service available to them. By co-locating this with the county's Trauma hub patients are more likely to receive emergency intervention faster. By co-locating with vascular the Trust is creating a multi-disciplinary approach to management of primary angioplasty which can improve patient outcomes. 68% of Interventional Cardiology patients and 66% of vascular patients last year were over 65, meaning this cohort is significantly impacted by this change and its benefits.
- The centralisation of services will also mean quality of care and expertise will be enhanced, which is particularly beneficial to patients with long term conditions or co-morbidities which are prevalent in patients with disabilities, those aged >65 and some BAME communities.
- By centralising services, patients will have reduced waiting times, fewer cancellations and fewer unplanned overnight stays. Timely appointments with fewer cancellations mean patients can more effectively plan their travel (e.g. pick up and drop off times if

they are not driving themselves). This will benefit all patients, including those with disabilities who may need to plan travel in advance.

- Reduced unplanned overnight stays may help to limit anxiety and unfamiliarity, particularly important for patients with a learning disability.
- Having a more consistent workforce can make a significant positive impact to patients, specifically those with learning disabilities or from a minority group as consistency allows for ongoing communication with a familiar team and helps build trust for patients.
- 25% of Gloucester city's population are living in deprived areas, approx. 32,000 people. Therefore, centralising Emergency General Surgery, Trauma, Acute Medicine and IGIS to the GRH provides improved access to the right specialists to manage the care of this higher risk community. Deprivation is linked to co-morbidities and poorer health outcomes, therefore, centralising services to form different hubs with co-located specialities across both sites with enhanced quality of care and reduced waiting times will benefit all those living in deprivation across the county.
- The centralisation of services will provide more comprehensive and co-located specialised care, which could be beneficial for carers who are caring for someone with multiple conditions. Centralisation also means services will be ring-fenced, ensuring fewer cancellations, reduced waiting times and improved clinical outcomes, resulting in improved self-care. These benefits will help to support carers to reduce their time attending hospital with the person they are caring for and improve the health outcomes of both the person they are caring for and, in turn, potentially their own health.
- There are 79 people registered with Gloucestershire's Homeless Healthcare Team and it has been identified this cohort are most likely to use A&E and community care services and evidence suggests those who are homeless are more likely to have multiple health conditions. Given rates of homelessness are slightly higher in Gloucester than surrounding areas; centralising Emergency General Surgery to GRH provides improved access to the right specialists to manage the care of homeless people who present with multiple conditions.
- There is a strong association between physical health and mental health. People with long-term conditions, such as diabetes or cardiovascular disease, have significantly raised rates of depression, anxiety and other mental health problems. Evidence suggests they receive poorer quality care than those with a single condition.[25] 1.2% of all A&E attendances last year were for those with mental health conditions, the large majority of these attended GRH A&E. Therefore by centralising services, patients with comorbidities could receive a better quality of specialist care as they will be treated with a multi-disciplinary approach. .
- Diabetes tends to be prevalent with other co-morbidities such as, heart conditions, meaning that this cohort is likely to be impacted by the centralisation of services as they are likely to use several different services due to having multiple conditions. Thus, centralising services will improve their quality of care by reducing waiting times, faster diagnostics and a multi-disciplinary approach to multiple conditions.
- By centralising services, new and innovative training opportunities will be available to staff which will positively impact moral, help to retain existing staff and attract new staff. The co-location of catheter labs with Interventional Radiology improves the

[25] https://www.kingsfund.org.uk/projects/mental-health-and-long-term-conditions-cost-co-morbidity

opportunity to develop innovative nursing and technician roles that would not have been possible before.

- Although the inpatient gastroenterology ward is currently based at CGH there is full access to gastroenterology services at GRH; with 7-day-per-week emergency endoscopy provision and a rostered gastrointestinal consultant and registrar at GRH to assess patients who are referred either from ED or other specialist areas ensuring the same level of emergency care is available at both sites.
- Outpatient gastroenterology and orthopaedic clinics are unaffected, and will be maintained at Cheltenham General, Gloucestershire Royal and community Hospitals creating no impact on travel times.
- Despite some patients from the west of the county having to travel further for elective (planned) orthopaedic surgery the move of planned orthopaedic care to CGH has enabled the provision of ring-fenced wards with an 80% lower chance of cancellation due to emergency trauma patients requiring the attention of specialist staff.
- The way the inpatient beds are organised for trauma and orthopaedics (in the pilot) includes 17 single rooms at CGH and 18 at GRH, which gives flexibility to maintain privacy and dignity.
- Rates of homelessness are slightly higher in Gloucester than surrounding areas; this group have a significant requirement for trauma services and so the centralisation of trauma services there will benefit this cohort.

5.2.3 *Potential Adverse Impacts*

- A centralised hub for IGIS will provide the capacity and capability to provide specialist centralised care for these patients. It is important to consider patients having interventional surgery are often more complex and can be higher risk, often with other co-morbidities and long-term conditions such as cardiovascular conditions. Engagement with staff at Gloucestershire Hospitals Foundation Trust identified some concerns that patient safety may be compromised by having IGIS and vascular separate, as this could result in some complex and emergency vascular patients needing to transfer; identified vulnerable groups are patients who have had a mini stroke or patients with carotid artery disease.
- If Emergency General Surgery is centralised to GRH, people attending A&E at CGH or patients (e.g. day cases and elective colorectal) deteriorating and needing Emergency General Surgery may need to be transferred to GRH. Patients over 65 are most vulnerable to deterioration, and currently 40% of General Surgery patients are over 65, meaning they are disproportionately impacted by this. Currently, however, it is only 6 per day in total who will be impacted by the new arrangements, with significantly less than 1 patient per day needing transfer in an emergency as a result of inpatient deterioration. This means the impact is relatively small and outweighed by the positive clinical outcomes.
- GI day case patients are generally lower acuity and so are less likely to deteriorate; however, in the event a patient does deteriorate they may need to be transferred to GRH. Patients over 65 are more likely to experience co-morbidities and other health conditions and therefore could be more vulnerable to needing transfer; however, transfer as a result of deterioration is already indicated to be low and infrequent. This is outweighed, however, by reduction in waiting times, enhanced quality of care and a reduction in the number of patients who are required to stay overnight unplanned as a result of a late start.

- Feedback from staff and patients suggests parking can be a challenge at both sites. This could prove challenging for patients with a disability who will require a disabled parking bay or drop off point if the demand increases beyond what is currently available as a result of centralising services. Moving sites can also be a challenge for patients with a sensory impairment who may be familiar with their local hospital site but may be require travel to the other site. Additional support may be needed to help patients navigate this change.
- The new proposed models will mean that deteriorating patients may need to be transferred depending on the site they attended and their condition. For patients with a physical, sensory or learning disability, this may mean additional support with transport arrangements on their return home as they may not drive. It is important to note this will likely be in unique circumstances and outweighed by the clinical benefits of centralising services
- Carers and unpaid carers are likely to experience the clinical benefits of better quality of care for the patient, shorter waiting times and specialist services working in a multi-disciplinary approach which could help to reduce their number of hospital visits. It is possible, however, in some instances a carer may need to attend both sites based on the proposed changes (although unlikely), or in the event the patient deteriorates, they may need to transfer to GRH for emergency surgery if they are currently at CGH. These events have been estimated to happen for significantly less than 1 patient a day, meaning that, the benefits outweigh the risks for carers.
- Enhanced clinical outcomes outweigh the negative impacts of travel for the majority of cohorts; however, it is important to consider the possible impact of additional cost in travel for some either through fuel costs or public transport fares for all patients, but particularly considering those in low income households. It is important to consider that this is outweighed by enhanced clinical outcomes as centralising services will likely reduce waiting times and therefore parking fees and in all the proposed solutions, ~80% of all patients impacted will see a neutral impact in travel (a change +/-20 mins).
- There are some patients who attend A&E at CGH who may need to transfer to GRH for admission. This has been mitigated by working with the Ambulance Service to ensure that patients who are likely to require admission are taken directly to GRH. Senior orthopaedic doctor input is available for patients in A&E at both CGH and GRH and there is a process in place to transfer patients who require admission.

5.2.4 *Travel Impacts*

To Patients

- Patients may need to travel to a different site for their treatment in the future. Travel analysis has suggested that approximately 80% of all patients will see minimal change in their journey (+/- 20 mins). This equates to approximately 20,000 people and on average 7% will have a shorter journey, just over 1,600 people
- On average, 13% of patients of the services contained within these proposals will have a negative travel impact. The largest negatively impacted cohorts are those who under the proposals would need to travel to GRH for acute medicine and those travelling to CGH for elective colorectal if this are to be centralised in CGH.
- Gloucestershire Hospitals Trust have assessed the evidence around the extra distance some patients may need to travel in the event of an emergency and the evidence suggests the distance would not impact negatively on mortality or the clinical outcomes of patients.

- By centralising services, a number of patients would see significant reductions in their travel times as they could now be treated locally, whereas at present Primary PCI patients are travelling to other hospitals, such as Bristol, for their treatment.
- There are also currently patients travelling out of county for IGIS procedures. By centralising IGIS it improves the ability for this provision to expand, increasing the potential for more patients to be treated in-county, overall reducing travel for some patients. Within the scope of the IGIS service proposals are the current 115 patients who undergo various Interventional Radiology interventions mostly delivered from Birmingham and Oxford, a few from Bristol, and some travel as far as Leeds. In addition to the patients directly benefitting, our IGIS service proposals will contribute towards to other initiatives aimed at repatriating up to a further 600 patients.

To Staff

- It is important to consider the impact increased travel can have on child care provision or caring responsibilities of staff.
- Despite some staff required to travel more, centralising General Surgery day cases will reduce the number of visits a patient makes which creates more capacity for staff.
- Currently there are challenges in filling rotas, sickness absence and use of agency staff to combat this. This puts staff under pressure and impacts morale. The proposed solutions aim to give staff more dedicated time by making processes more efficient. Some changes will bring teams together and result in less travel and as teams become bigger there will be more opportunity for flexibility of staff. By centralising some emergency and elective cohorts the environment improves for workforce as they have more dedicated capacity, fewer cancellations and less late starts and by creating an IGIS hub, this creates new opportunities for staff to train and develop new specialist skills as well as to attract and retain more staff

Key Points

- **The IIA is an independent assessment that supports decision-making by evaluating the impact of the proposals, informing public debate and supporting decision-makers to meet their Public Sector Equality Duty and their duty to reduce inequalities.**
- **Consultation feedback has been incorporated into the overall assessment of impact.**
- **The consultation proposals are all significantly positive changes that outweigh the adverse impacts identified**
- **The IIA includes recommendations based on evidence review and consultation feedback**

6 Economic and Financial Analysis

6.1 Introduction

The economic and financial analysis has been developed by the Fit for the Future Programme team working with GHNHSFT clinical divisions, reporting to the GHNHSFT Director of Finance, and in collaboration with the Gloucestershire Integrated Care System (ICS) Directors of Finance (DoF) group which comprises DoFs from GHNHSFT, GCCG and GHCFT.

The programme team included GHNHSFT Finance team, information analysts, a Senior HR Business Partner for Workforce Transformation, an Associate Director of Finance from NHS South, Central and West CSU (SCW), as well as the FFTF Programme Director and Programme Managers.

6.2 Methodology

Full details of the methodology and approach can be found in the PCBC. Since the publication of the PCBC, we have undertaken the following activities:

- Re-validation of clinical model workforce requirements.
- Re-confirmed with NHSE&I the decision to exclude impact of COVID-19 from our baseline data, staffing models, resource requirements and finances; baseline period remains Feb 2019-Jan 2020.
- Responded to impact of consultation feedback and new evidence on consultation proposals.
- Review of Downside Risks and modelling of new evidence.
- Modelling impact of growth on consultation proposals.

6.3 Consultation feedback and new evidence

6.3.1 *Planned General Surgery*

As described in section 4.2.3, GHNHSFTs Leadership Team undertook an appraisal for the configuration options regarding Lower GI (colorectal) surgery, and concluded that there was an alternative, potentially even better, option that includes the best elements from the two options presented and notably the opportunity to deliver even more planned elective surgery from the Cheltenham Hospital site. The recommendation was that further work should begin with the General Surgery team to define this new, emerging option for all planned General Surgery. The changes to the consultation proposals for planned General Surgery are detailed in section 8.

As this work will take place in Q1-Q2 2021/22 (see section 9.7.4), and is yet to confirm the activity and staffing requirements, for the purposes of this DMBC the decision has been made to use the higher costs associated with PCBC Model D (4.4): Elective/ planned colorectal surgery centralised to CGH. This included two additional Advanced Nurse Practitioners compared to Model E (5.4).

All other consultation proposals remain unchanged, and therefore no changes have been made to the service revenue or costs.

6.3.2 *South Western Ambulance Service NHS Foundation Trust (SWASFT)*

As described in the PCBC and in section 4.2.1, the FFTF programme has worked closely with SWASFT and Operational Research in Health (ORH) Limited to model the "blue light" ambulance travel impact for **all** of the consultation proposals. The impact was assessed for both the ambulance incident response times and the Call to Hospital times. From a financial impact perspective, the key findings are:

Patients attending GWH[26]: the modelling indicates an average 1.7 patients per day would be conveyed to GWH where previously they had attended CGH (these are for incidents on the border of Gloucestershire and Wiltshire), and is based on 2019/20 activity and using SWASFT catchment analysis. However, the choice of hospital will be determined using a range of factors at the time of the incident.

The financial scale of impact will depend on the actual number of GWH ED attends, the admission conversion rates, the average LoS and therefore the resultant tariff needing to be paid. The impact will also be determined by the contract currency (PbR, block or blended) in place at the time of implementation (2022/23 for Acute Take).

For the purposes of the DMBC a proportion of the potential impact is included as a cost/charge (£250,000) and the remainder is included as a Downside Risk (see below).

Response Performance: to maintain current Category 1, 2, 3 and 4 performance would require approximately 16-18 hours/day of additional ambulance capacity. This analysis will form part of the contract discussions with GCCG and SWASFT. It should be noted that activity numbers are not modelled to change but the resources required to deliver the modelled activity is likely to.

For the purposes of the DMBC, the item remains a Downside Risk but, subject to the above, no financial value has been included.

6.3.3 *Workforce*

Following the re-validation of the clinical models and taking into account the assumptions described in section 6.3.1 above, the financial analysis includes the FTE changes listed below:

	Registered Nurse (FTE)	Non-Registered Nurse(FTE)	Medical Staff (FTE)	Total (FTE)
Emergency and Acute Medicine	0.28	-4.56		**-4.28**
Emergency General Surgery	2.00		2.00	**4.00**
ACRT/Deteriorating Patient	6.80	0.90	-5.60	**2.10**
IGIS	8.32	0.80	1.72	**10.84**
	17.40	**-2.86**	**-1.88**	**12.66**

[26] Great Western Hospitals NHS Foundation Trust, Swindon.

6.3.4 *Downside risks*

Financial Risk	Unadjusted Impact	Likelihood	Consequence	Risk-adjusted Impact	Narrative
Inability to achieve income from additional specialised commissioning activity	£463,600	M	M	£111,813	£300k represents the recurrent cost pressure to SW Spec Comm, as detailed in GHFT/SW Spec Comm joint paper 21/08/20 Adjusted 30Sep-01Oct20 to take account of letter of support and adjusted risk values of specific procedures
Impact of inter-site transfers still to be confirmed - see note f in Surgery tab	£0	H	H	£0	Current expectation is that additional transport requirement will be 3-4 vehicles per day; at current contract value, 3.5 vehicles is ~£350k - **now included within main case for Surgery**
Deteriorating Patient / Acute Care Response Team - junior doctor savings to be identified	£1,069,616	L	L	£84,890	Confidence that these specific posts in the establishment will be identified, but leaving £85k in to reflect ~1.0 of 12.6WTE not coming to fruition
Contingency for staff moves within 'Surgery' element: Colorectal, Upper GI, Emergency Surgery, Day Surgery, T&O	£307,953	L	L	£40,000	Although £30.8m (623.8WTE) is the baseline of the in-scope teams within the 'Surgery' element, the size of the teams whose contractual position is likely to change (ie those not already considered to be 'Trustwide' is £4m (104.5WTE), so contingency has been adjusted to ~1% of this amount
Managed Equipment Service - 5% overspend on IGIS I&E element (if capital scheme, this would be capital charges)	£95,000	L	L	£0	Any overspends would have to be met from within service budgets, as part of usual financial monitoring and approval processes
We continue to work with SWAST (and their modelling partners, ORH) to calculate the financial effect to them of up to 6,554 ambulance arrivals per year at CGH moving to GRH (or other sites, such as GWH, Swindon) If this was new activity, SWAST's contract value would be increased by 50% of the contract value / contractual activity per unit, which for Gloucestershire CCG would be £134 per additional unit of activity for	£878,236	L	M	£0	As there is no new activity, simply redirected activity. Subject to ongoing discussions GCCG and SWASFT
Modelling for SWASFT by ORH has determined that 1.7 ambulance conveyances a day currently arriving at CGH would move to GWH as a result of FftF changes at CGH. This would reduce the A&E activity and subsequent non-elective admissions at GHFT and increase them at GWH, leading to an expectant reduction in income from GCCG to GHFT as the income follows the activity to GWH	£872,249	H	H	£622,249	Impact to be confirmed (for both system and GHNHSFT).
	£3,686,654			**£858,952**	

6.3.5 *Growth*

Our assessment of the impact of population growth uses 2018 subnational population projections from the Office of National Statistics (ONS). We have reviewed the age-group, gender and locality profiles of patients for each of the consultation proposals and applied the appropriate growth rates to our baseline activity to assess the impact of cumulative growth for the period 2021 to 2031. The table below details the mathematical impact of predicted growth for the period 2021-2031; with no growth mitigations in place.

Service	Average Length of Stay	Additional Bed Requirement	Current Bed Base	Required Bed Increase
Cardiology	7.2	9	22.9	41%
Gastroenterology	9.1	8	11.3	75%
Vascular	6.6	5	19.3	25%
General Surgery	3.5	10	55.1	18%
Trauma & Orthopaedic	4.0	16	106.7	15%
TOTAL		**49**	**215.3**	**23%**

The management of growth demand is a consistent and ongoing objective within the ICS to ensure that hospital appointments and admissions are appropriate as well as the year-on-year efficiencies within GHNHSFT to deliver productivity improvements.

Whilst the ONS projections are recognised as the usual source for growth assumptions, it should be noted that they were published in 2018 and pre-date the Coronavirus (COVID-19) pandemic. As detailed in the PCBC, our consultation proposals are to deliver our case for change over the medium to long-term and we have therefore, in agreement with NHSE&I, excluded impact of COVID-19 from our baseline data, staffing models, resource requirements and finances.

Given the multi-factorial nature of COVID-19 effects and uncertainty as to their impacts, the DMBC has not attempted to inflate resource demand (e.g. bed numbers) based on an unmitigated position. If these proposals are approved and the programme shifts to implementation over the next two years, decisions will take account of the position at the time, and the developing pandemic recovery paradigm. At the time of writing, the third wave (and lockdown) continues, and it is not practicable to reliably estimate the medium-term impact on planned and unplanned activity; only that it is likely to be different from projections made prior to the pandemic.

6.4 Revenue Impact

The financial assumptions are based on the following service configurations:

- **GRH**: centralised Acute Medical Take, Emergency General Surgery, 24/7 Image-Guided Interventional Surgery hub including the Vascular arterial centre and Trauma.
- **CGH**: centralised Orthopaedics, Gastroenterology, Image-Guided Interventional Surgery spoke and the Acute Care Response Team.
- **TBC**: Planned General Surgery using the **cost base** for CGH

£'000	Baseline	Proposal
Revenue Costs		
Clinical Services	£112,148	£113,218
Non-Clinical Costs	£4,940	£4,961
Building Running Costs	£0	£0
Other Revenue Costs	£24,282	£24,558
Total Revenue Costs	**£141,371**	**£142,737**
Additional Costs		**£1,367**
Additional Income		
Additional specialised commissioning activity		£(464)
Reduction due to increased GWH activity		£250
Total Additional Income		**£(214)**
Net Recurrent Revenue Impact		**£1,153**
WTE change		**12.66**
Transitional Costs		
Hybrid Theatre enabling building works - now included within overall MES programme		£0
Moves and enabling works for colorectal		£0
Total Transitional Costs - Non-Recurrent Revenue Impact		**£0**

£'000	Proposal
Net Recurrent Revenue Impact	**£1,153**
WTE change	**12.66**
Non-Cash-Releasing Benefits	**£817**
Cash-Releasing Benefits	**£27**
Net Recurrent Revenue Impact After Benefits (excluding risks)	**£309**
Risk-adjusted Impact	**£859**
Risk-Adjusted With Benefits	**£1,168**

6.5 Phasing

£'000	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8
Recurrent Costs								
Acute		(48)	(115)	(115)	(115)	(115)	(115)	(115)
ACRT			397	397	397	397	397	397
DCC			0	0	0	0	0	0
IGIS		233	559	559	559	559	559	559
Surgery	526	526	526	526	526	526	526	526
TOTAL	**526**	**711**	**1,367**	**1,367**	**1,367**	**1,367**	**1,367**	**1,367**
Recurrent Income								
Acute		104	250	250	250	250	250	250
ACRT			0	0	0	0	0	0
DCC			0	0	0	0	0	0
IGIS		(193)	(464)	(464)	(464)	(464)	(464)	(464)
Surgery	0	0	0	0	0	0	0	0
TOTAL	**0**	**(89)**	**(214)**	**(214)**	**(214)**	**(214)**	**(214)**	**(214)**
Net Recurrent Position								
Acute	0	56	135	135	135	135	135	135
ACRT	0	0	397	397	397	397	397	397
DCC	0	0	0	0	0	0	0	0
IGIS	0	40	96	96	96	96	96	96
Surgery	526	526	526	526	526	526	526	526
TOTAL	**526**	**622**	**1,153**	**1,153**	**1,153**	**1,153**	**1,153**	**1,153**
Transitional Costs								
Acute	0	0	0	0	0	0	0	0
ACRT	0	0	0	0	0	0	0	0
DCC	0	0	0	0	0	0	0	0
IGIS	0	0	0	0	0	0	0	0
Surgery	0	0	0	0	0	0	0	0
TOTAL	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Annual Cost	**526**	**622**	**1,153**	**1,153**	**1,153**	**1,153**	**1,153**	**1,153**

£'000	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8
Benefits								
Acute	0	(60)	(144)	(144)	(144)	(144)	(144)	(144)
ACRT	0	0	0	0	0	0	0	0
DCC	0	0	0	0	0	0	0	0
IGIS	0	(70)	(169)	(169)	(169)	(169)	(169)	(169)
Surgery	(531)	(531)	(531)	(531)	(531)	(531)	(531)	(531)
TOTAL	**(531)**	**(662)**	**(844)**	**(844)**	**(844)**	**(844)**	**(844)**	**(844)**
Benefits-Adjusted Annual Cost	**(6)**	**(40)**	**309**	**309**	**309**	**309**	**309**	**309**
Risk-Adjusted Impact								
Acute	0	0	622	622	622	622	622	622
ACRT	0	0	85	85	85	85	85	85
DCC	0	0	0	0	0	0	0	0
IGIS	0	0	112	112	112	112	112	112
Surgery	40	40	40	40	40	40	40	40
TOTAL	**40**	**40**	**859**	**859**	**859**	**859**	**859**	**859**
Annual Cost Including Benefits and Risks	**34**	**(0)**	**1,168**	**1,168**	**1,168**	**1,168**	**1,168**	**1,168**

Key Points

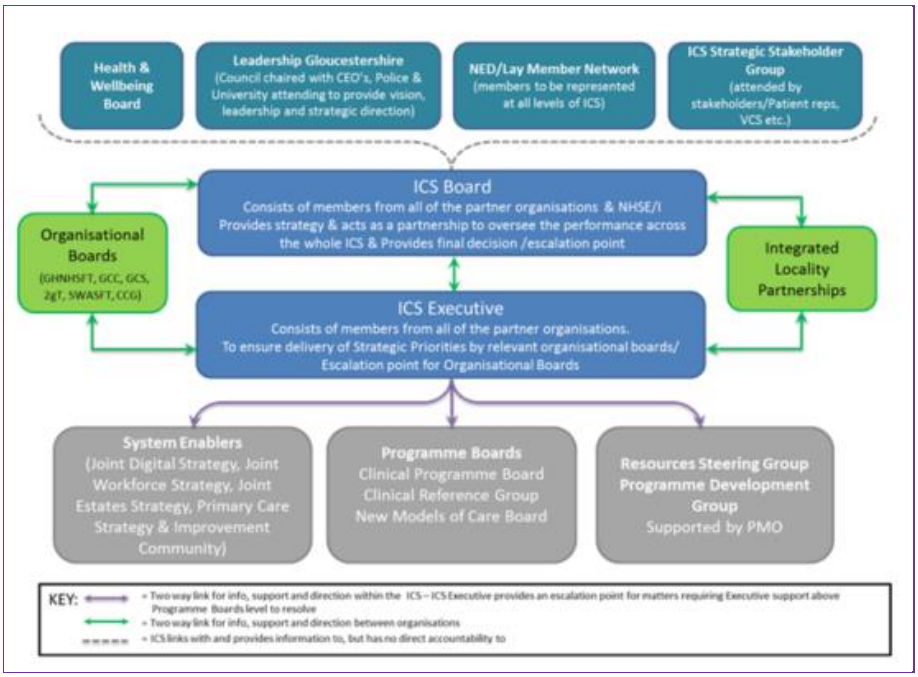
- **We have completed a re-validation of clinical model resource requirements**
- **We have responded to impact of consultation feedback and new evidence on consultation proposals**
- **We have undertaken a review of Downside Risks and re-modelling of impact where appropriate**
- **We have undertaken detailed benefits realisation planning to ensure the expected outcomes for patients, staff and the health economy are deliverable**
- **Our proposals after benefits are within a financial tolerance for which the system would be able to prioritise funding accordingly. The profile of the spend also allows opportunity to deliver further benefits, and the expectation within the system is that the identification and quantification of additional benefits will make our proposals (at least) cost neutral**

7 Governance and Decision Making

7.1 Gloucestershire Integrated Care System (ICS)

Gloucestershire is coterminous as a footprint and has strong partnerships already in place, as demonstrated by our success at working together as Integrated Care System. We have a strong commitment from all of our system partners to move forwards with this new way of working, and believe it will be pivotal to support us to deliver against our challenging performance, financial and delivery objectives more quickly, as embodied by the scale of the proposals for change set out in these proposals.

ICS partnerships continue to need to operate within the existing statutory framework[27], which means that the CCG, Gloucestershire County Council and NHS Trusts (GHNHSFT and GHCFT), remain the statutory accountable bodies within the health and care system. We propose that our organisations will continue to work within our Memorandum of Understanding (MoU) which sets out the principles of collaboration between partners, and which will be the vehicle for the collective delivery of this transformational change at pace and scale. A schematic of the ICS collaboration model is provided below.



The concept of *Centres of Excellence* is consistent with the strategic intent of the ICS. The core purpose of the ICS is to:

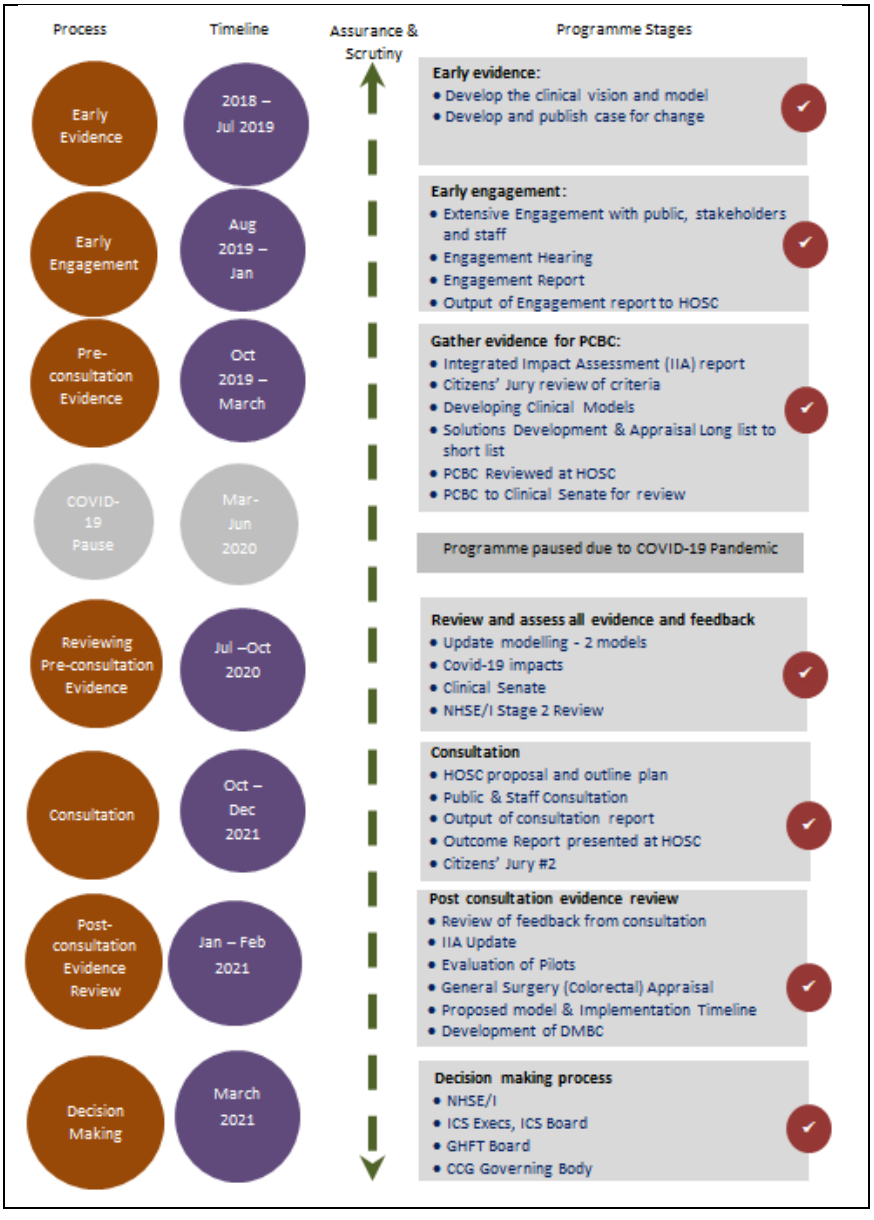
- Maximise ownership and the pace of transformation and associated developments.
- Maximise the value gained from the Gloucestershire NHS and social care pound.
- Reduce areas of service duplication.
- Minimise transactional costs.

[27] As of Feb 2021 there are ongoing discussions at national and regional level regarding the next steps in the development of ICSs

7.2 Internal assurance

The Fit for the Future Programme is overseen by the Gloucestershire ICS, and is embedded into both system and individual organisational governance structures. Regular reports are taken to the ICS Board and ICS Executives, and also to CCG Governing Body, GHNHSFT and GHCFT Trust Boards, as well as system and Board sub-committees.

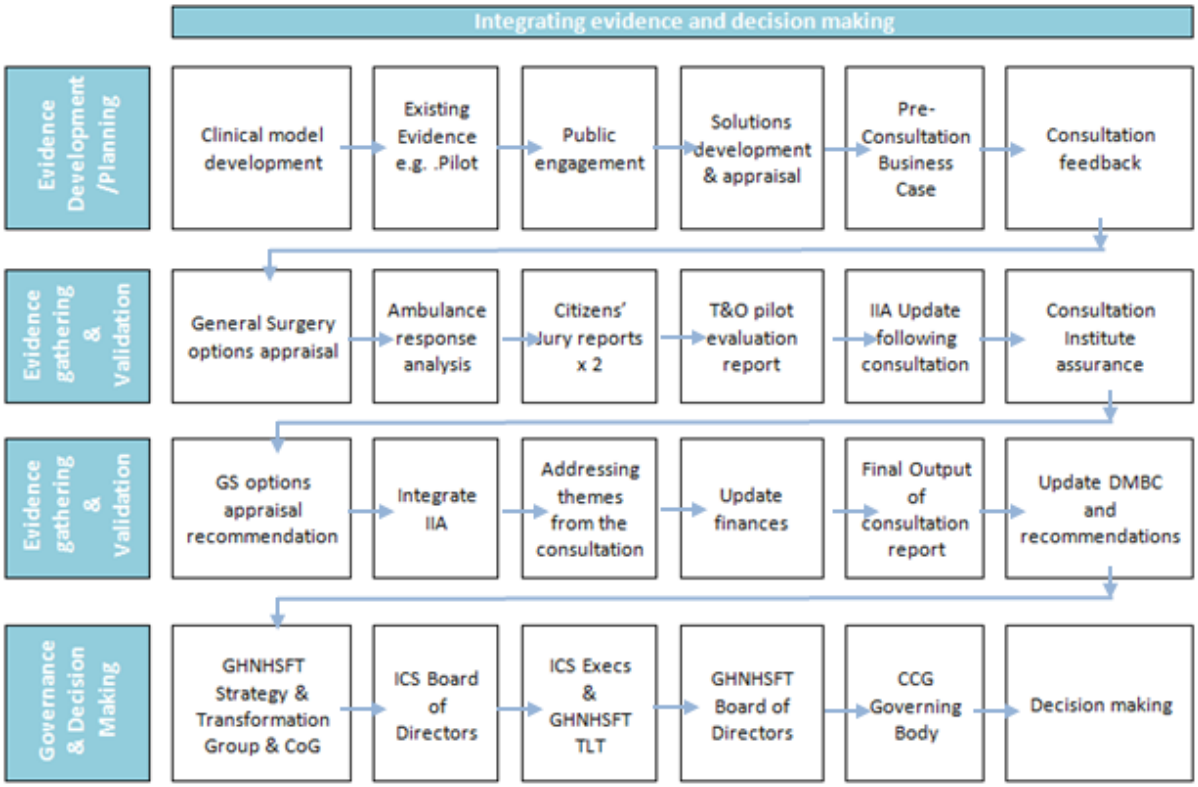
The programme management arrangements are overseen through the Fit for the Future Programme Development Group (PDG), including oversight of the Programme Director, the Programme Managers Group, FFTF Communications and Engagement and activity and financial modelling. Investment is provided by the system to ensure that there are central programme resources in place to ensure delivery of programme objectives.



This DMBC is the result of over two years of evidence development, assurance and review of proposals to deliver a solution that addresses our case for change and delivers our clinical model.

7.2.1 *Process for decision-making*

The consultation proposals were approved as part of the Pre-Consultation Business Case by the ICS, GHNHSFT Board and GCCG Governing Body in October 2020. As detailed in section 2.4.4.3 the consultation feedback and findings, as well as additional information, have been reviewed and discussed by the ICS, GHNHSFT and the CCG. The process of evidence gathering, validation and decision-making is provided below:



As set out in the national guidance on service change in the NHS[28] the CCG's statutory responsibilities includes their duty to lead engagement and consultation on any planned service change in their local systems. In this case Gloucestershire CCG leads engagement and consultation on behalf of the One Gloucestershire Integrated Care System (ICS). The CCG is the decision-making body with regards to any decision to move to consultation on any particular topic, the decision to consult is confirmed in partnership with the Health Overview and Scrutiny Committee of the County Council (HOSC).

The decision-makers in this regard will be the Board of Gloucestershire Hospitals NHS Foundation Trust and the Governing Body of NHS Gloucestershire Clinical Commissioning Group. Independent assurance of the proposals is provided by our regulator NHS England & Improvement, who will ensure that our proposals can be safely and appropriately implemented within available resources.

The timescales for DMBC approval are as follows:

- ICS Executives 04/03/21
- GHNHSFT Board 11/03/21(in public)
- CCG Governing Body 11/03/21 (in public)

[28] https://www.england.nhs.uk/publication/planning-assuring-and-delivering-service-change-for-patients

7.2.2 *Impact of consultation feedback on decision-making*

Within section 4, each theme / issue or alternative identified in section 3 is addressed with an explanation or clarification, and either a description of ongoing or planned action or why alternatives have been discounted. The PCBC had considered the vast majority of the themes/ issues raised during consultation.

Although there is only a single instance where consultation feedback and new evidence has a material impact on a consultation proposal (Planned General Surgery), and therefore on decision making, there are a number of issues identified for consideration/action as part of either ongoing service improvement or FFTF implementation.

Details of the recommendations can be found in section 8 and the implementation plans in section 9.

7.3 External assurance

7.3.1 *NHSE&I*

NHS England and Improvement (NHSE&I) conduct system-level approval on all business cases that need to go to consultation and have been involved in the Fit for the Future Programme from the outset (details are available in the PCBC). The Stage 2 assurance checkpoint took place on 03/09/20, and was confirmed in respect of the "5 tests" in advance of our public consultation (see Appendix 9). We continue to be in regular contact with NHSE&I and had DMBC checkpoint meetings on 24/02/21 and 02/03/21.

As part of the Stage 2 process there were a number of subject areas within the DMBC that required further clarification in the DMBC. These are described below.

Bed capacity during implementation

Full details including the phasing of bed requirements throughout the implementation are provided in section 9.5

Clinical workforce recruitment

The details of the staff requirement (Full Time Equivalents) to deliver the consultation options are provided in the PCBC and for a programme of this scale are relatively small as the majority of the changes are due to centralisation of services; staff can be redeployed and there are consolidation efficiencies. The (net) change in clinical workforce for the consultation proposals is described in the table below:

Role	FTE
Registered Nurse	+10.60
Non Registered Nurse	-3.76
Medical staff	+3.72
Total	**+10.56**

Details of the implementation phasing of the consultation options is presented in section 9, with the impact on recruitment being to benefit from consolidation efficiencies at the start and with the recruitment in the latter stages. This provides time for a planned, phased approach to recruitment to be applied; with identified sources of pipeline and any marketing/advertising identified and planned. Identified pipeline/sources in terms of workforce supply include: redeployment of existing staff (ensuring we support and equip those identified staff to undertake any such move); external recruitment via a dedicated recruitment campaign; international recruitment; and recruitment advertising sources

include various forms of social media, professional publication and journals, national and local press, trust intranet and NHS jobs.

In section 2.5 we describe the reasoning behind our proposals (the Case for Change) where the splitting of resources across two hospital sites contributes to quality, workforce, financial and performance issues which affect patient outcomes and staff recruitment and retention. We are already seeing the benefit of being able to communicate our clinical strategy and ambition as part of the FFTF programme, and have seen an increase in application rate for key clinical roles at GHNHSFT, particularly at consultant level.

Finally, in addition to the above, our proposed deteriorating patient model consists of expanding the Acute Care Response Team (ACRT) to 24/7 on both sites. The (net) change in clinical workforce is described in the table below:

Role	FTE
Registered Nurse	+6.8
Non Registered Nurse	+0.9
Medical staff	-5.6
Total	**+2.1**

Analysis and response to the public consultation

This DMBC, in conjunction with the Final Output of Consultation report (Appendix 1), provides the feedback and analysis from the consultation (section 3), and our responses to this is provided in section 4.

Clinical consensus on the chosen Colorectal Surgical Service Model

The outcome of the General Surgery options appraisal is provided in section 4.2.3 and the recommendation (section 8) is that further work should begin with the General Surgery team to define a new option that includes the best elements from the two options presented and, notably, the opportunity to deliver even more planned elective surgery from the Cheltenham Hospital site. The additional work undertaken since the clinical review panel has identified significant areas of consensus (relating to over 90% of the patient activity), and this will be built on in the coming months as the detail of the new option are developed and finalised. This can be tested at the clinical review panel.

7.3.2 *South West Clinical Senate*

Details of the South West Clinical Senate Clinical Review Panel (including the full report) can be found in the PCBC. The FFTF Programme has continued to engage with the Clinical Senate, including request for participation in the General Surgery options appraisal and agreement to review the T&O Evaluation report. As noted in section 4.2.3, proposed changes to the location of planned Upper GI services are due to be subject to further public and staff involvement, and would include further clinical review by the South West Clinical Senate.

7.4 Information Governance (IG) issues and privacy impact assessment

Following specialist IG advice, the Data Protection Impact Assessment (DPIA) has been drafted on the basis that the current phase of the FFTF Programme is focusing on a DMBC, and there should be no change to any patient pathways and patient data flows. At no time will any patient identifiable data be held by the programme. The data that will be held by the programme during the next phase are as follows –

- Project Management documentation

- Programme Governance documentation
- Consultations documentation and feedback

The current DPIA is presented in Appendix 10 and will be adapted for each the phase of the programme, including implementation.

It should be noted that all the proposals that form part of this DMBC are not intended to change the provider of the services nor are there changes to clinical systems or record-keeping specific to the FFTF Programme; any changes would be subject to a separate DPIA process.

The DPIA describes:

- the data, data flows, and retention period
- any data protection and privacy risks identified
- the risk management measures agreed

Key Points

- **The Fit for the Future Programme is overseen by the Gloucestershire ICS and is embedded into both system and individual organisational governance structures**
- **The concept of *Centres of Excellence* is consistent with the strategic context of the ICS.**
- **NHSE&I have assured these proposals and confirmed the "5 tests" have been met.**
- **This DMBC is the result of over two years of evidence development, assurance and review of proposals to deliver a solution that addresses our case for change and delivers our clinical model**
- **There is only a single instance where consultation feedback and new evidence has a material impact on a consultation proposal (Planned General Surgery) and therefore on decision making**
- **There are a number of issues identified for consideration/action as part of either ongoing service improvement or FFTF implementation.**

8 Recommendations

The Programme has reviewed the feedback from consultation and the additional evidence developed as part of this DMBC. This has shown that there is clear public support for our case for change, and how public feedback has been taken into account to shape our proposals going forward. For two of our consultation proposals we recommend that additional work be carried to further enhance the benefits of our clinical model.

As an ICS we believe these proposals will deliver robust improvements against the issues set out in our case for change, and will improve health outcomes for our local population across a range of measures.

We recognise that there will be significant work to implement our proposals (see section 9), which will include areas identified through consultation as well as the IIA recommendations.

8.1 Resolutions to be agreed

It is the Programme's recommendation to the Board of the Gloucestershire Integrated Care System (ICS), the Board of Gloucestershire Hospitals NHS Foundation Trust (GHNHSFT) and the Governing Body of Gloucestershire Clinical Commissioning Group (CCG) that the following resolutions should be considered for agreement and approval, taking into account all the evidence that has been made available, on the basis that they represent the best solution to address the case for change.

- **Resolution #1**: Formalise 'pilot' configuration for Gastroenterology inpatient services at CGH, to make this a permanent change
- **Resolution #2**: Formalise 'pilot' configuration for Trauma at GRH and Orthopaedics at CGH, to make this a permanent change
- **Resolution #3**: Centralise Emergency General Surgery at GRH
- **Resolution #4**: Develop an Image Guided Interventional Surgery (IGIS) 'Hub' at GRH and a 'Spoke' at CGH
- **Resolution #5**: Centralise Vascular Surgery at GRH
- **Resolution #6**: Centralise Acute Medicine (Acute Medical Take) at GRH

- **Resolution #7**: Planned General Surgery. The recommendation is that work should continue to develop the option that would deliver:
    - Planned High-Risk Upper Gastrointestinal (GI) and Lower Gastrointestinal (Colorectal) surgery at GRH
    - Planned complex and routine inpatient and day case surgery in both Upper and Lower GI (Colorectal) at CGH

*High-risk to be defined by General Surgery team as part of further work.

9 Implementation

9.1 Introduction

Our *Fit for the Future Programme,* which incorporates *Centres of Excellence,* is a large scale, long-term change programme which will be delivered over a number of years. This DMBC contains our Phase 1 'sentinel' models before we widen the scope of our clinical model development, and the three FFTF phases (as described in the PCBC) will not necessarily be implemented sequentially. Furthermore, the implementation of the recommendations will be completed in stages over the next two years.

The proposed service changes are to deliver our case for change over the medium- to long-term, and we have therefore, in agreement with the Regulator, excluded the impact of the recent COVID-19 pandemic from our baseline data, staffing models, resource requirements (beds, DCC, theatres etc.) and finances, as this would have had the result of significantly understating usual activity levels for emergency and planned care services. As described in section 4.1 we believe that these are the right proposals for development of our hospitals services whether or not COVID-19 is circulating at high or low levels.

That being said, the context for our proposals has changed as a result of the pandemic and this was made visible within our PCBC and was central to our "socially-distanced" consultation. Whilst we have the benefit of lessons learned from the COVID-19 temporary changes and opportunities to test some service improvements, it has to be recognised that the medium-term impact of the pandemic on service demand, operational processes and resource utilisation (e.g. socially distanced beds on wards and theatre throughput) has yet to be fully established at the time of writing, but, given the long-term nature of the FFTF programme, we are confident that it can be developed during implementation to ensure safe and sustainable delivery. We are of the view that the suppression of demand seen during the pandemic is unlikely to be sustained over the longer term, and that our assumption of activity returning to 'normal' levels is the appropriate one to base our future models on.

Details of our phased implementation are provided in section 9.5.2, but they are summarised below:

- **Stage 1 - Implemented following decision-making**: these are services that are currently already in place, such as the Trauma and Orthopaedics and Gastroenterology pilots (Resolutions #1 & #2) and Emergency General Surgery (Resolution #3).
- **Stage 2 - Implemented following additional activities**: these are the planned General Surgery services (Resolution #7), where further work (including public engagement and external approval) will be required prior to implementation.
- **Stage 3 - Implemented following completion of other enabling workstreams**: these are services that require enabling work to be completed, for example, estates work, recruitment and training, procurement and installation of equipment. (Resolutions #4, #5, #6 & #7).

Given the scale, complexity and extended timescales of the FFTF programme, this DMBC is not a final implementation plan for all the service change recommendations, but a decision to proceed will cement the strategic direction for these services to allow resources (internally and externally) to be made available to enact the proposed changes in full. Prior to the completion of the public consultation and the final decision-making process, the FFTF programme has been mindful of the need to avoid pre-determination such that some implementation details remain to be confirmed.

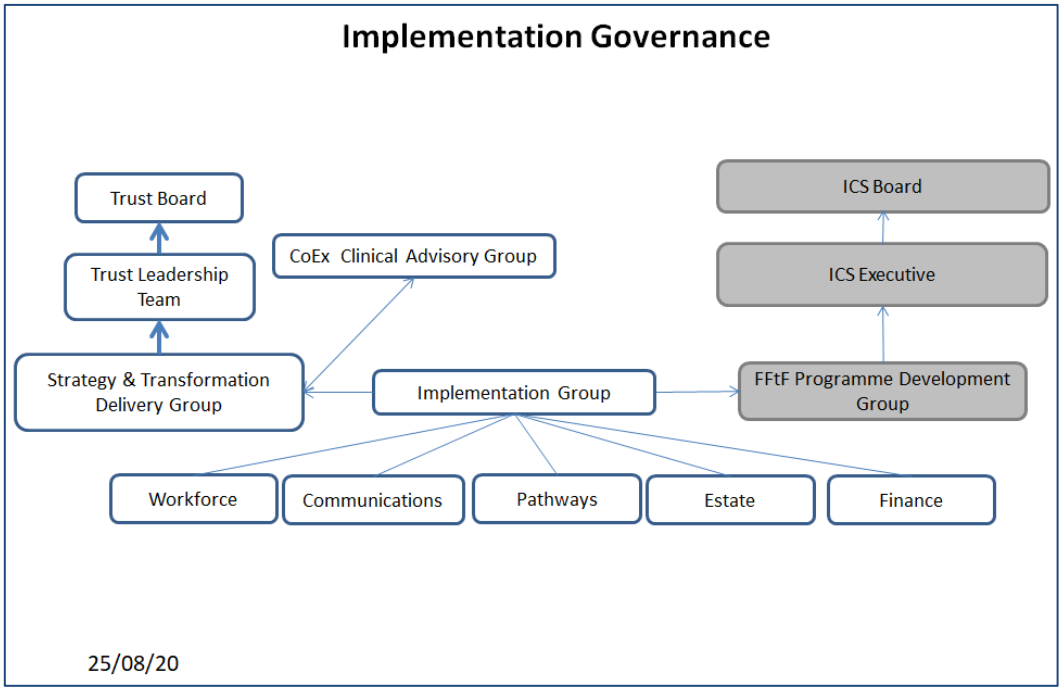
9.2 Governance arrangements for implementation

Formal governance arrangements are required to steer and govern the process of service reconfiguration and development of the FFTF programme; to deliver this we will have a dedicated FFTF Implementation Group that is embedded within existing ICS structures. This will:

- Meet monthly to provide direction, ensure effective co-ordination, resolve issues and manage risks and interdependencies;
- Include representation from GHNHSFT, Gloucestershire CCG, service users and their representatives, and other key stakeholders and leads for each of the workstreams;
- Appoint a senior responsible officer to take on overall accountability for the implementation relating to service changes. They will be responsible for ensuring effective working relationships with the wider sector in planning and implementing changes.
- Agree and monitor performance metrics to track and manage progress against key milestones.
- Align to enabling and other key programmes, for example GHNHSFT Strategic Site Development (SSD) Programme, procurement and installation of new equipment.

A number of workstreams will be established (as presented below) to lead on both the planning and development required to support changes to service provision, as well as the transactional processes of change. Governance arrangements will have clear links within the wider Gloucestershire ICS and individual organisational governance structures to ensure that implementation plans across all areas are aligned.

A robust risk management framework will be implemented to ensure that the principles of measuring, managing and reporting risk are maintained.



9.2.1 *Clinical workstreams*

It is envisaged that there will be a number of clinical workstreams, based on the recommendations, but we recognise the interdependencies between them, and will design our structures to avoid silo working. These will be finalised when the detailed implementation plan is completed.

Each Workstream will be responsible for planning the service transformation and reconfiguration programme, and will report to the Implementation Group. These workstreams will focus on:

- Finalisation of clinical pathways e.g.
    - Development of direct admission pathways, particularly to CGH, and protocols with system partners;
    - Development of enhanced same day emergency care pathways and capacity in CGH;
    - Other 'patient flow' work to support reduced bed occupancy.
- How service reconfiguration will be phased, where will there be dual running and when transition and implementation would occur;
- Management structures, workforce considerations and governance including policies and protocols.
- Full implementation of the 'deteriorating patient' model

9.2.2 *Non-clinical workstreams*

There will be a number of non-clinical workstreams to support the clinical workstreams in implementing the finalised service model and will include (but not limited to):

- Workforce – recruitment and training to support new models of care;
- Estates ensuring direct links to GHNHSFTs estates strategy;
- Equipment;
- Communication and stakeholder engagement; and,
- Finance.

9.3 Monitoring the realisation of benefits

Details of the benefits are provided in Appendix 5, and will be further developed as part of the implementation programme; a summary is provided below:

	Benefit
Improved patient outcomes	• Better access to emergency theatre • Greater capacity to cope with higher levels of demand. • Increased number of ED attendances managed by SDEC • Reduced time to 'be seen' by a gastroenterologist • Reduction in length of stay. • Improved senior surgical review • Reduction in Trauma admissions • Reduction in surgical cancellations.

	Benefit
Improved patient experience	• Improved access to sub specialty treatment and equity of care • To implement ERAS • Reduction in cancellations due to bed pressures. • Consistent provision of consultant review within 14 hours of arrival • Improved patient pathway and patient experience • Improved access • Reduction in patient travel • Reduction in inter-site transfers • Improved robustness of OOH service • Improved rates of mortality and morbidity • Improved access to renal ward • Greater capacity to cope with higher levels of demand. • Achieve the 6-week wait diagnostic target. • Improvement of patient experience. • Improved access to sub-specialty treatment • The provision of a protected dedicated Elective Unit
Improved staff experience	• Improvement in staffing workload • Daily Ward/Board Round for Trauma patients • Improved access to specialist Trauma and Orthopaedic clinicians for advice • Greater capacity to cope with higher levels of demand • Decrease in the number of violence and aggression incidents • Improved access to adjacent specialty advice • Workforce deployment efficiencies • Reduction in expired IR inventory • Earlier access to 'in reach' advice from other specialties • Standardisation of pathways
Improved staff recruitment and retention	• Improvement in trainee environment • Workforce benefits • Enhanced staff training and support • Improved recruitment and retention • Improved Junior Doctor training • Workforce benefits
Improved efficiency and effectiveness (cash releasing and growth avoidance/non-cash releasing)	• Improved senior surgical review • The provision of a protected dedicated Surgical Unit • Reduce the admission rate. • Reduction in length of stay • Workforce efficiencies • Increased revenue • Reduction in spend by no longer outsourcing private services. • Standardisation of Theatre Equipment • Achieve compliance with Regulatory Bodies. • More responsive to GP requests • Increase Efficiency

The FFTF Implementation Group will be responsible for monitoring delivery of benefits and will work closely with GHNHSFT clinical divisions and the SSD Programme. To ensure benefits are not double-counted the FFTF Programme has compared these with other improvement programmes, for example the SSD benefits realisation plans, which is presented below:

			Of which already within GSSD		New / Unclaimed benefits	
	Cash-Releasing Benefit	Growth avoidance/ Non Cash-Releasing Benefits	Cash-Releasing Benefit	Growth avoidance/ Non Cash-Releasing Benefits	Cash-Releasing Benefit	Growth avoidance/ Non Cash-Releasing Benefits
Emergency and Acute Medicine	£793,886	£3,134,353	£793,886	£2,990,210	£0	£144,143
Emergency General Surgery	£0	£314,382	£0	£0	£0	£314,382
Elective Colorectal Inpatient Surgery	£0	£93,054	£0	£49,800	£0	£43,254
General Surgery Day Cases	£150,000	£173,477	£150,000	£0	£0	£173,477
IGIS	£27,000	£142,147	£0	£0	£27,000	£142,147
Total	**£970,886**	**£3,857,414**	**£943,886**	**£3,040,010**	**£27,000**	**£817,404**

9.3.1 *When will benefits be realised?*

The phasing of the benefits is correlated with the implementation stages and included in the financial analysis (section 6).

9.4 Workforce

The details of the staff requirement (Full Time Equivalents) to deliver the consultation options are provided in the PCBC and for a programme of this scale are relatively small, as the majority of the changes are due to centralisation of services; staff can be redeployed and there are consolidation efficiencies.

Details of the implementation phasing of the consultation options is presented in section 9, with the impact on recruitment being a benefit from consolidation efficiencies at the start, and with the recruitment in the latter stages. This provides time for a planned phased approach to recruitment to be applied. As requested by NHSE&I a summary of clinical workforce requirements and recruitment plans are presented in section 7.3.1.

9.5 Beds, Theatres and Dept. of Critical Care (DCC)[29]

9.5.1 *Beds*

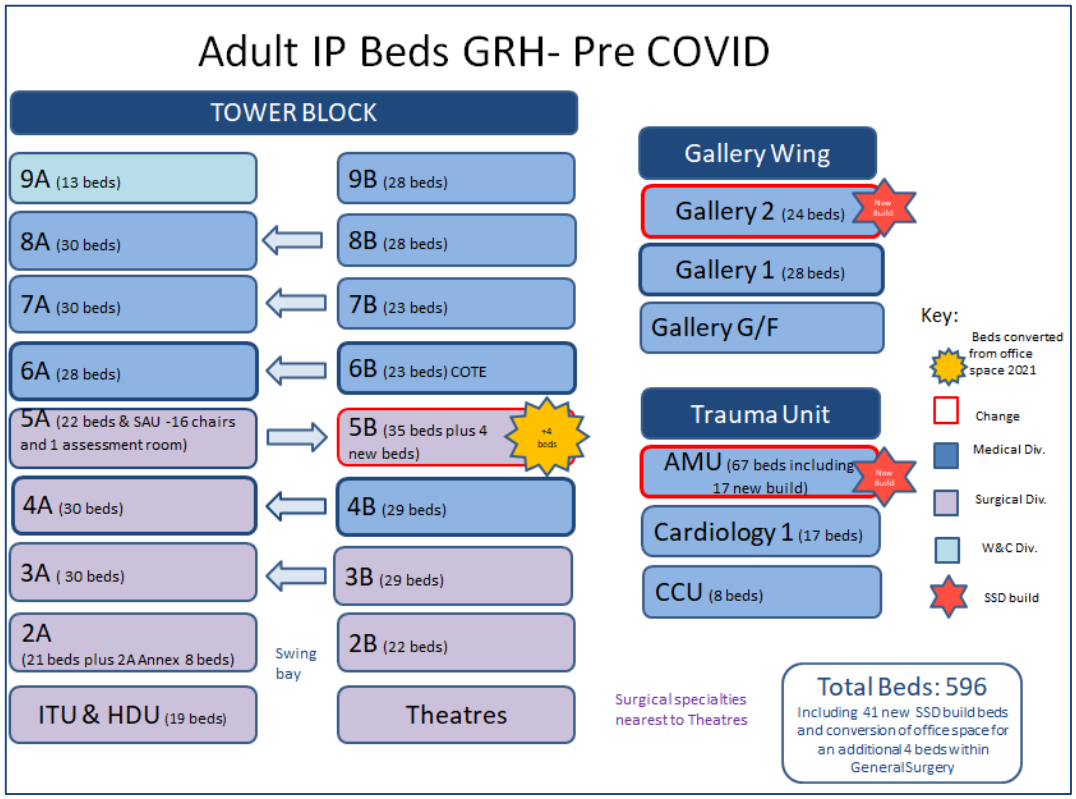
As highlighted in the introduction to this section, in agreement with the Regulator, our activity and resource baseline (Feb 2019-Jan 2020) was deliberately selected to exclude the impact of COVID-19 from our data, and therefore all our analysis and resource modelling does not include the current COVID-19 temporary changes, future pandemic impact on suppression of usual service demand or current COVID-19 infection control protocols e.g. socially distanced beds on wards; currently GHNHSFT have reduced bed number by ~ 160.

Given the multi-factorial nature of COVID-19 effects and uncertainty as to their impacts, the only reasonable option is to exclude it, and therefore the bed number analysis presented below reflects a pre-COVID point in time, and the impact of our recommendations is calculated using pre-COVID demand. If these proposals are approved and the programme shifts to implementation over the next two years, decisions will take account of the position at the time and the developing pandemic recovery paradigm, including defining the new baseline number of inpatient and critical care beds that will include any requirement to maintain infection control measures.

[29] GHNHSFTs Critical Care service is known as Dept. of Critical Care (DCC)

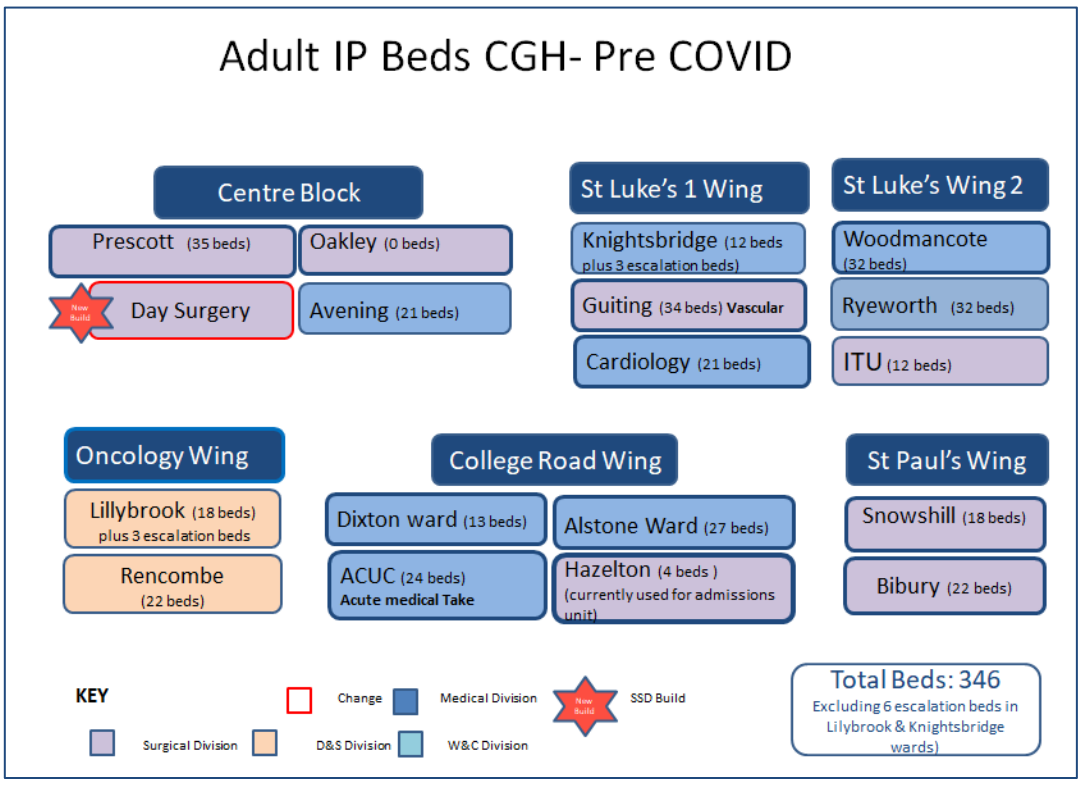
Adult in-patient beds at GRH

The diagram below illustrates the total adult in-patient beds at GRH, the ward locations and configurations and the additional beds (41) delivered by the SSD programme.



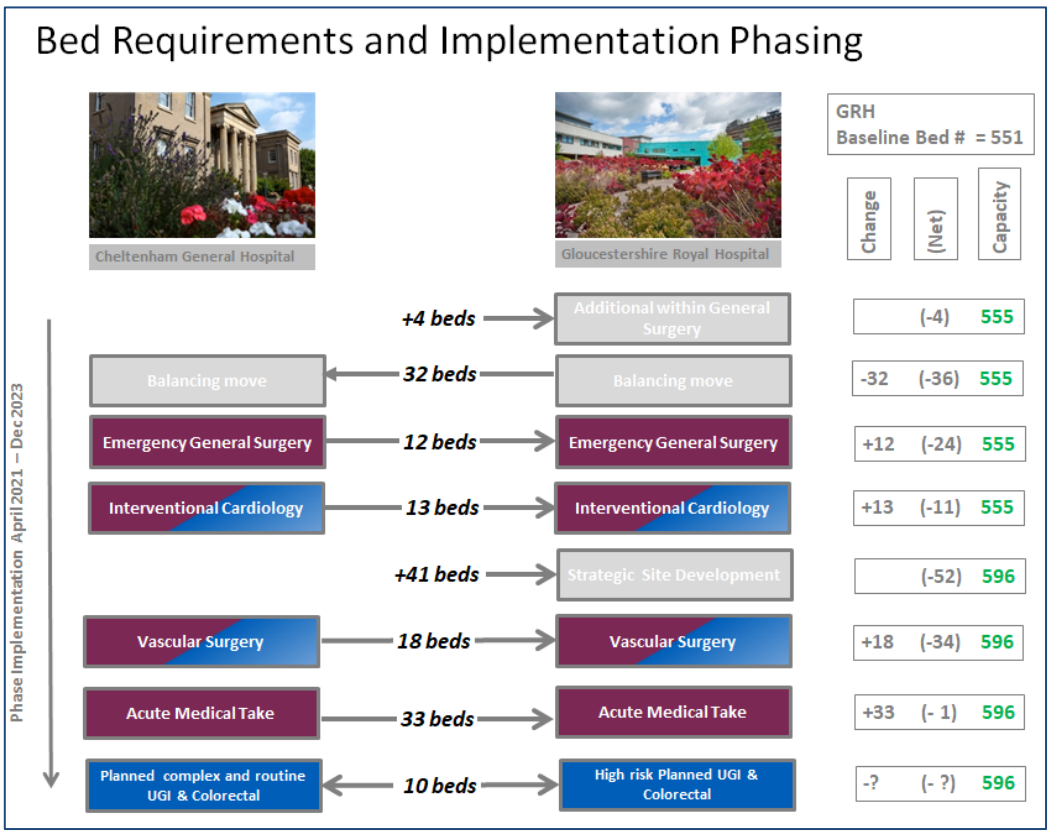
Adult in-patient beds at CGH

The diagram below illustrates the total adult in-patient beds at CGH, the ward locations and configurations and the day surgery unit delivered by the SSD programme.



Impact of recommendations at GRH

The diagram below sets out the requirements for each of the service recommendations and the overall impact on bed capacity at GRH.



Key

	Description	Beds
GS Beds	As part of COVID temporary centralisation of EGS to GRH additional beds	4
Balancing Move	There are number of options being considered for service moves to CGH e.g. an acute stroke pilot to test if the improvements to SSNAP[30] metrics are correlated with the COVID temporary re-location to CGH; enhancements to the frailty service offer at CGH.	32
Emergency General Surgery	The modelled bed requirement= 22 beds. Centralisation has delivered LOS reductions ~ 4 beds. As part of COVID temporary centralisation of EGS, beds in a section of the ward were converted from recliner chairs to provide SAU (#6).	12
Interventional Cardiology	Once the Catheter-lab work is completed and new equipment at GRH in Sept 21 Interventional Cardiology can move to GRH	13
Strategic Site Development	Additional capacity Acute Medical Unit (17 beds), separate Acute Medical Initial Assessment (AMIA) and Gallery Ward (24 beds)	41
Vascular Surgery	Relocation following enabling programmes – SDDP, equipment etc.	18
Acute Medical Take	Relocation following completion of enabling programs. Ongoing work to increase patients seen at CGH includes development of direct admission pathways and protocols; development of enhanced same day emergency care pathways and capacity in CGH; and the required DCC capacity	33
Planned General Surgery	Modelled bed requirement for UGI & LGI = 10 beds. Ongoing work to develop a new model will determine the allocation of beds for high risk patients at GRH. Likelihood is that highest proportion of beds will be at CGH	0-10

[30] Sentinel Stroke National Audit Programme

It should be noted that any proposed changes to the location of planned Upper GI services would be subject to further public and staff involvement. Similarly, any proposals for permanent reconfigurations from Phase 2 that would enable delivery of a balanced beds and operating model would be subject to further public engagement and consultation.

9.5.2 *Theatres*

There is increased emergency and planned theatre capacity required for the proposed recommendations.

At GRH there is an emergency theatre that runs 24/7 for all surgical specialties, so, with EGS at GRH, more emergency theatre requirement is required to provide a second list Mon-Fri from 08.00 to 18.00. This will require theatre nursing staff and anaesthetic staff and is included in our workforce and financial modelling.

When Vascular is relocated to GRH, further emergency theatre capacity would be required. The plan is to use some of the previous CGH emergency list to extend the second emergency list to 08.00 to 20.00 M-F, but additional staff are required to run the second list at GRH on a Saturday and Sunday 08.00-20.00 (is included in our workforce and financial modelling).

The original CGH emergency list is for a half-day list every day and an on-call team at night. The half-day emergency list will be reallocated to provide extended lists for urology to undertake their urgent work and to accommodate vascular emergencies at GRH. The on-call team will be retained at CGH for other emergency out-of-hours surgery at CGH. There is no capital requirement as GHNHSFT has sufficient Theatre capacity e.g. Theatre 2 is available at GRH.

In addition, more day cases from the remaining elective work at GRH have been transferred to Cirencester Hospital to create more theatre space within GRH theatres for Trauma patients.

Investment in the theatres at GRH will provide an environment at least comparable to that already in Cheltenham. We would convert existing theatre facilities at GRH to a full Hybrid IR-Theatre facility, ensuring there is no reduction in the quality of the facilities provided to allow complex endovascular procedures to be undertaken.

There is a further plan to utilise one of the new day surgery theatres at CGH that are to be developed as part of the SSD Programme for Orthopaedics. This will enable the service to further reorganise elective lists and create theatre space at GRH for additional Trauma surgery.

As part of the SSD investment CGH will benefit from better day case surgery facilities with the development of two additional theatres and a Day Surgery Unit.

9.5.3 *Dept. of Critical Care (DCC)*

DCC capacity modelling has been completed and work to date indicates an additional expected requirement for DCC beds on the GRH site in the range of 3 critical care beds aligned to the centralisation of the Acute Take (in Q3 2022/23). The modelling is based on the following assumptions:

- Based on data from 2016 – 2018 so assumes no change in delayed discharges
- Based on average 70% Critical Care bed occupancy rates
- All patients from the planned care speciality transferring to CGH will move to CGH Critical Care with the exception of those acutely admitted directly from GRH Emergency Department or Acute Medical Unit
- All patients repatriated from other providers will go to Critical Care at CGH.

As noted earlier, the medium-term impact of COVID-19 on service demand and efficiency is yet to be fully defined, but lessons from the pandemic have included that there may be requirement to factor in a cohort of ongoing circulating background COVID with a cohort of patients who may require additional DCC capacity. The intended solution is to build more DCC beds in Gloucester, with the appropriate number of side rooms, funded through the national programme to increase ITU capacity; GHNHSFT have already undertaken a feasibility study. The implementation timeline for acute medical take does provide time to assess the model assumptions and the legacy of COVID-19, and identify and deliver in full the modelled requirement for new DCC provision. This will be a key stop / go decision point for the implementation programme to confirm at the point that the Acute Take is scheduled to centralise.

9.6 Implementation risks

The implementation programme will use a risk management framework aligned to the corporate risk management protocols and recorded on a programme risk register. The risks associated with implementation predominantly relate to the identification of location for services displaced by Catheter Lab development at GRH, options considered for service moves to CGH to facilitate full implementation of FFTF phase 1 (~ 32 beds) and DCC capacity.

9.7 Outline programme implementation plan

As summarised in the introduction to this section, the implementation of the recommendations contained within this DMBC will be completed in stages over the next two years (on the basis that resolutions are approved in March 2021).

9.7.1 *Stage 1 - Implemented following decision making*

The first group of recommendations will be the formalisation of 'Pilot' configurations where no further actions are required prior to implementation; these are:

- **Resolution #1**: Gastroenterology inpatient services at CGH from 01/04/2021.
- **Resolution #2**: Trauma at GRH and Orthopaedics at CGH from 01/04/2021.

As detailed in section 9.2.1, as with all clinical services, there are ongoing service improvement activities which will continue post-implementation.

The next recommendation to be implemented is **Resolution #3**: Centralise Emergency General Surgery at GRH, which is currently a Coronavirus (COVID-19) temporary service change (see section 2.5.2) and is already centralised on the GRH site, and it will therefore be formalised as a permanent service change from 1st April 2021.

9.7.2 *Stage 2 - Implemented following additional activities*

As described in section 4.5.2 and recommended in section 8, the proposal for all planned General Surgery (**Resolution #7**) is that further work should begin to develop a new option to deliver:

- Planned High Risk Upper Gastrointestinal (GI) and Lower Gastrointestinal (Colorectal) surgery at GRH
- Planned complex and routine inpatient and day case surgery in both Upper and Lower GI (Colorectal) at CGH

The work will begin following decision-making, is expected to last up to six months and will be dependent on the scale of public engagement required once the clinical model has been

defined. The additional work will include modelling of theatre and bed requirements across both sites and any other dependencies for implementation. Until such time as the clinical model development is complete, we have assumed implementation will be linked to SSD (2022/23). Furthermore, the 'Deteriorating Patient' model (24/7 ITU consultation & ACRT) will be fully established from December 2022.

Whilst the new clinical model will be subject to Clinical Senate and NHSE&I approval, some elements e.g. planed day cases centralised to CGH, have already been externally assured and through public consultation, so could be implemented earlier as theatre capacity allows.

9.7.3 *Stage 3 - Implemented following completion of enabling workstreams*

Implementation is dependent on a number of enabling workstreams, including:

- Changes to the Trust estate – delivered through the Trust Strategic Site Development Programme;
- Workforce – recruitment and training to support new models of care, for example expansion of the Trust's Acute Care Response Team (ACRT);
- Procurement and installation of new equipment – new Cardiac Cath Labs, additional Interventional Radiology equipment; and,
- Clinical Pathways design – to support direct admit pathways for example.

The 'IGIS hub' is enabled by capital investment as part of the phased implementation of the Trust Estates Strategy. Full implementation of the IGIS and vascular proposals require us to locate the cardiac catheter labs, establish an additional Interventional Radiology (IR) labs and the vascular hybrid theatre facility at the main hub in GRH.

On the basis that resolutions are approved in March 2021, our implementation plan includes:

- Catheter-Lab Pre-enabling: Jan 2021 to Jun 2021
- Catheter-Lab relocation (IGIS Phase 1): Apr 2021 to Oct 2021
- Additional IR Lab (IGIS Phase 2): Oct 2021 to Apr 2022
- Hybrid theatre at GRH (IGIS Phase 3): Apr 2022 to Oct 2022
- IGIS 24/7 Hub enabling works and displacements: Apr 2021 to May 2022

In term of making changes to the Trust estate, independent to the Fit for the Future programme and subject to a completely separate internal and external NHS England & Improvement and Department of Health and Social Care assurance process, GHNHSFT has obtained full planning approval as part of plans to transform CGH and GRH as part of a £40m investment. Under the plans CGH will benefit from better day case surgery facilities with the development of two additional theatres and a Day Surgery Unit.

GRH will benefit from an improved Emergency Department and acute medical care facilities designed to speed up diagnosis, assessment and treatment. There will be a redesigned outpatients and fracture clinic accommodation for orthopaedic outpatients, additional x-ray capacity and a programme of ward refurbishment. This investment will help to relieve crowding ED during busy periods which is something both patients and staff have flagged as a priority. As part of this programme the bed capacity at GRH will be increased.

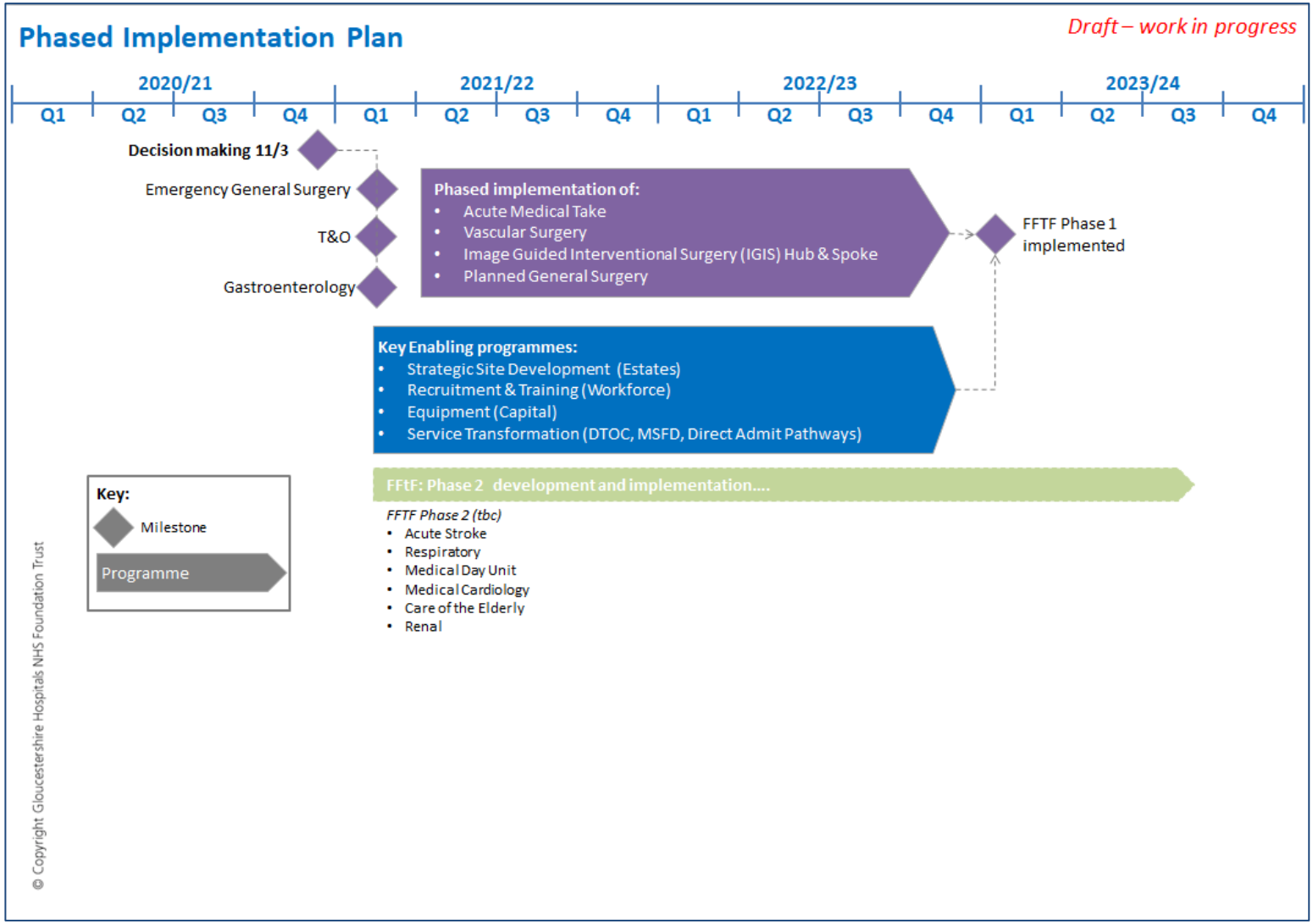
The final business case is now navigating through the various NHSE/I and DHSC checkpoints with construction work due to commence during the summer of 2021 with beds/wards being available from Oct 2022/23, theatres Jan 2023 and ED Apr 2023. On the basis of these

delivery timescales our recommendations for the following will be implemented in a phased approach from decision-making through to 2022/23:

- **Resolution #4**: An Image Guided Interventional Surgery (IGIS) 'Hub' at GRH and a 'Spoke' at CGH
- **Resolution #5**: Centralise Vascular Surgery at GRH
- **Resolution #6**: Centralise Acute Medicine (Acute Medical Take) at GRH
- **Resolution #7**: Planned General Surgery

9.7.4 *Implementation timetable*

A Gantt chart outlining the implementation described above can be found overleaf.


Phased Implementation Plan
Draft – work in progress
2020/21
2021/22
2022/23
2023/24
Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4
Decision making 11/3
Emergency General Surgery
T&O
Gastroenterology
Phased implementation of:
• Acute Medical Take
• Vascular Surgery
• Image Guided Interventional Surgery (IGIS) Hub & Spoke
• Planned General Surgery
FFTF Phase 1 implemented
Key Enabling programmes:
• Strategic Site Development (Estates)
• Recruitment & Training (Workforce)
• Equipment (Capital)
• Service Transformation (DTOC, MSFD, Direct Admit Pathways)
Key:
Milestone
Programme
FFtF: Phase 2 development and implementation....
FFTF Phase 2 (tbc)
• Acute Stroke
• Respiratory
• Medical Day Unit
• Medical Cardiology
• Care of the Elderly
• Renal
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9.8 Communication and engagement plan

One Gloucestershire partners will formally publish the Fit for the Future Decision Making Business Case (DMBC) on 4 March 2021, ahead of the CCG Governing Body meeting on 11 March 2021.

The aim of the communications and engagement plan (Appendix 11) is to ensure staff, community partners, the public and media receive information on the outcome of the decision-making process and next steps in a timely and appropriate way.

There are a number of communication and engagement objectives, including:

- To provide clear, consistent and accurate information
- To support the NHS to communicate the outcome and the changes
- To ensure relevant audiences receive the information in the right order e.g. staff first
- To ensure effective media and social media arrangements are in place.

The communications and engagement plan includes a number of key stakeholders that need to be engaged and supported as decisions are made and communicated.

Key Points

- **The proposed service changes are to deliver our case for change over the medium-to long-term**
- **Our phased implementation will be in three stages**
- **The FFTF Implementation Group will be responsible for monitoring delivery of benefits**
- **Our plans detail the bed requirements and phasing**
- **Our implementation timetable starts in April 2021 and runs through to 2022/23.**

10 Appendices

Appendix 1: Final Output of Consultation Report See separate document
Appendix 2a: Integrated Impact Assessment Post-Consultation See separate document
Appendix 2b: Annex IIA Post-Consultation See separate document
Appendix 2c: Annex IIA Post-Consultation (Pilots) See separate document
Appendix 3a: Citizens' Jury - Jurors' report See separate document
Appendix 3b: Citizens' Jury - Jury report See separate document
Appendix 4: Public Transport Information See separate document
Appendix 5: Benefits Realisation See separate document
Appendix 6: Discharge documents See separate document
Appendix 7: T&O Pilot Evaluation See separate document
Appendix 8: Planned General Surgery information See separate document
Appendix 9: NHSE&I Stage 2 Assurance letter See separate document
Appendix 10: Data Protection Impact Assessment See separate document
Appendix 11: Communications and Engagement Plan See separate document

Appendix 12: Glossary of Terms and Abbreviations

24/7	Twenty-four hours-a-day, seven days-a-week
A&E	Accident and Emergency department (also known as Emergency Department (ED)).
ACRT	Acute Care Response Team
Case for Change	The case for change is the document that sets out why things need to change within local health and care services to make sure they are fit for the future.
Centres of Excellence (CoEx)	The development of the two main hospital sites. Part of the Fit for the Future Programme
CEPOD	A permanently staffed operating theatre that can run on a 24 hour basis
CGH	Cheltenham General Hospital
CINAPSIS	A referral system that makes it easy for clinicians to communicate between healthcare organisations
Citizens' Jury (CJ)	A Citizens' Jury is a small group of selected citizens, representative of the demographics in the area, that come together to reach a collective decision or recommendation through informed deliberation.
Cobalt	Medical imaging centre in Cheltenham
COTE	Care of the Elderly
COVID-19/ Coronavirus	COVID-19 is a new illness that affects lungs and airways. It is caused by a virus called coronavirus.
Deanery	A regional organisation responsible for postgraduate medical and dental training
DCC	Department of Critical Care
Dial-A-Ride	Dial-A-Ride is a bookable door-to-door transport service for those people who do not have their own transport and are unable to use public transport.
DMBC	Decision-Making Business Case prepared following consultation, to support in making a final decision on service change. It will consider all the responses to the consultation
ELIM	Christian Church in Cheltenham
ED	Emergency Department
EGS	Emergency General Surgery
FAS	Frailty Assessment Service
FFFT	Fit for the Future Programme
Friendship Café	Provides youth & community-based activities in Gloucester and surrounding areas
GCCG/CCG	Gloucestershire Clinical Commissioning Group. CCGs are the GP-led bodies responsible for planning and investing in many local health and care services, including the majority of hospital care and stroke services.
GHC	Gloucestershire Health & Care NHS Foundation Trust - Formed in

	2019 by the merger of 2gether Trust and Gloucestershire Care Services
GHNHSFT/GHFT	Gloucestershire Hospitals NHS Foundation Trust
GI	Gastrointestinal (a planned gastrointestinal service is sometimes referred to as upper GI and a planned colorectal service is sometimes referred to as lower GI).
GIRFT	Getting It Right First Time programme is helping to improve the quality of care within the NHS by bringing efficiencies and improvements.
GRH	Gloucestershire Royal Hospital
GWH	Great Western Hospital
Healthwatch Gloucestershire (HWG)	An independent service which exists to speak up for local people on Health and Social Care in Gloucestershire
Health & Social Care Select Committee	A Departmental Select Committee of the British House of Commons
HOSC	Health overview and scrutiny committee (HOSC) - A committee of the relevant local authority, or group of local authorities, made up of local councillors who are responsible for monitoring, and, if necessary, challenging health plans.
Hot and Cold Split	Emergency Care (Hot) and Planned Care (Cold)
ICS	Gloucestershire Integrated Care System Bringing together NHS providers and commissioners and local authorities to work in partnership in improving health and care
IGIS	Image Guided Interventional Surgery
IIA	Integrated Impact Assessment. The purpose of the Integrated Impact Assessment is to explore the potential positive and negative consequences of the proposals. It includes a Health Impact Assessment (HIA), Travel and Access Impact Assessment, Equality Impact Assessment (EqIA) (in which the impacts of the proposals on protected characteristic groups and deprived communities are assessed) and Sustainability Impact Assessment.
Inclusion Gloucestershire	A charity run by disabled people for disabled people
ITU	Intensive Treatment Unit
Know Your Patch (KYP)	Aims to bring organisations together in order to raise awareness of the good work taking place in Gloucester
MIIU	Minor Injury & Illness Unit
Local Transport Plan	The Local Transport Plan (LTP) sets the long-term transport strategy for Gloucestershire up to 2031. It aims to influence how and when people choose to travel so that individual travel decisions do not cumulatively impact on the desirability of Gloucestershire as a place to live, work and invest
NHS Long Term Plan (LTP)	The NHS Long Term Plan sets out priorities for the NHS over the next ten years

NHSE&I	NHS England and NHS Improvement came together on 1 April 2019 as a new, single organisation
Nuffield Trust	An independent health think tank aiming to improve the quality of health care in the UK by providing evidence-based research and policy analysis and informing and generating debate
Operational Research in Health (ORH)	ORH is a management consultancy that uses advanced Operational Research (OR) techniques to support resource planning in the public sector.
One Gloucestershire	The working name given to the partnership between the county's NHS and care organisations to help keep people healthy, support active communities and ensure high quality, joined-up care when needed
Office of National Statistics (ONS)	The UK's largest independent producer of official statistics and the recognised national statistical institute of the UK
PALS	Patient Advisory and Liaison Service
PCBC	Pre-Consultation Business Case. The document which presents the business case for any changes to services on which the CCGs agree to consult. It shows that CCGs have properly considered the options, undertaken pre-consultation engagement, submitted to the required scrutiny, and met the four tests and three conditions required by the Secretary of State.
PPCI/PCI	Primary Percutaneous Coronary Intervention. A coronary angioplasty is a procedure used to widen blocked or narrowed coronary arteries
PPE	Personal Protective Equipment
REACH	The REACH campaign was founded to secure the re-establishment of a full 24/7 Accident and Emergency department at Cheltenham General Hospital. The campaign has expanded to keep a watching brief on the related A&E services
SmartSurvey	Online survey tool that can analyse results graphically
South West Clinical Senate	Established to be a source of independent, strategic advice and guidance to commissioners and other stakeholders
SWASFT	South West Ambulance Service Foundation Trust
The Consultation Institute (tCI)	A UK based not-for-profit organisation specialising in best practice public consultation & stakeholder engagement
TLT	Trust Leadership Team
T&O	Trauma and Orthopaedics
The King's Fund	An English health charity that shapes health and social care policy and practice and provides NHS leadership development
The Health Foundation	An independent charity committed to improving health care for people in the UK

One Gloucestershire
Transforming Care, Transforming Communities

NHS

Fit for the Future

Developing specialist hospital services in Gloucestershire

Final Output of Consultation Report

Final Output of Consultation Report

Contents

Fit for the Future Output of Consultation Report

Executive Summary

Fit for the Future: Developing specialist hospital services in Gloucestershire

Consultation Key Facts

- Consultation proposals focussed on five specialist services: Acute Medicine (Acute Medical Take), General Surgery: Upper and Lower Gastrointestinal (including Emergency General Surgery), Image Guided Interventional Surgery (including Vascular Surgery), Gastroenterology inpatient services and Trauma and Orthopaedic inpatient services.
- Approximately 5000 Consultation booklets distributed across the county.
- 297,000 door-to-door leaflets distributed, generating 1700+ requests for information
- 75+ consultation events.
- More than 1000 socially distanced face-to-face contacts with members of the public/over 350 staff.
- 20+ Facebook posts with a reach of over 140,000 with over 1,500 'engagements' which included over 1,000 clicks on the link in the post.
- 35+ tweets generated over 30,000 impressions and almost 800 engagements.
- 700+ Fit for the Future surveys completed [110+ paper copies received, 1 telephone survey completed; the remainder being online].

Fit for the Future Survey responses

Acute Medicine (Acute Medical Take)

Preferred option to develop: A 'centre of excellence' for Acute Medicine (Acute Medical Take) at Gloucestershire Royal Hospital.

- 67.61% (Easy read: 72.09%) strongly supported or supported the proposal
- 24.83% (Easy read: 18.6%) strongly opposed or opposed the proposal

Emergency General Surgery

Preferred option to develop: to develop: A 'centre of excellence' for Emergency General Surgery at Gloucestershire Royal Hospital.

- 68.31% Fit for the Future survey respondents strongly supported or supported the proposal. Easy read survey respondents: 66.67% strongly supported or supported the proposal
- 23.44% Fit for the Future survey respondents strongly opposed or opposed the proposal. Easy read survey respondents: 22.99% strongly supported or supported the proposal

Planned Lower GI (colorectal) surgery

Preferred option to develop: to develop: A 'centre of excellence' for Planned Lower GI (colorectal) general surgery at Cheltenham General Hospital (CGH) or Gloucestershire Royal Hospital (GRH).

- 79.1% Fit for the Future survey respondents strongly supported or supported the proposal. Easy read survey respondents: 72.84%) strongly supported or supported the proposal.
- 7.83% Fit for the Future survey respondents strongly opposed or opposed the proposal. Easy Read survey respondents: 14.81% strongly opposed or opposed the proposal.

Where do you think we should do planned Lower GI (Colorectal) General Surgery?

- 50.76% Fit for the Future survey respondents chose Cheltenham General Hospital. 27.50% Easy Read respondents chose Cheltenham General Hospital.
- 20.27% Fit for the Future survey respondents chose Gloucestershire Royal Hospital. 27.50% Easy Read respondents chose Gloucestershire Royal Hospital.
- 30.30% Fit for the Future survey respondents had no opinion. 45% Easy Read respondents had no opinion.

Planned day case, Upper and Lower GI

Preferred option to develop: to develop: A 'centre of excellence' for planned day case Upper and Lower GI (colorectal) surgery at Cheltenham General Hospital (CGH).

- 73.49% Fit for the Future survey respondents strongly supported or supported the proposal. (Easy read respondents: 67.47% strongly supported or supported the proposal.
- 8.52% Fit for the Future survey respondents strongly opposed or opposed the proposal. Easy read respondents: 13.25% strongly opposed or opposed the proposal.

Image Guided Interventional Surgery (IGIS) including Vascular Surgery

Preferred option to develop: to develop: A 24/7 Image Guided Interventional Surgery (IGIS) 'Hub' at Gloucestershire Royal Hospital and a 'Spoke' at Cheltenham General Hospital.

- 66.54% Fit for the Future survey respondents strongly supported or supported the proposal. Easy read respondents: 76.54%) strongly supported or supported the proposal.
- 15.39% Fit for the Future survey respondents (Easy read: 9.88%) strongly opposed or opposed the proposal. Easy read respondents: 9.88% strongly opposed or opposed the proposal.

Vascular Surgery

Preferred option to develop: to develop: A 'centre of excellence' for Vascular Surgery at Gloucestershire Royal Hospital.

- 60.27% Fit for the Future survey respondents strongly supported or supported the proposal. Easy read respondents: 68.35% strongly supported or supported the proposal.
- 19.97% Fit for the Future survey respondents strongly opposed or opposed the proposal. Easy read respondents: 15.19% strongly opposed or opposed the proposal.

Gastroenterology inpatient services

Preferred option to develop: A 'centre of excellence' for Gastroenterology inpatient services at Cheltenham General Hospital.

- 71.96% Fit for the Future survey respondents strongly supported or supported the proposal. Easy read respondents: 68.35% strongly supported or supported the proposal.
- 6.67% Fit for the Future survey respondents strongly opposed or opposed the proposal. Easy read respondents: 10.13% strongly opposed or opposed the proposal.

Trauma and Orthopaedics (T&O) inpatient services

Preferred option to develop: to develop: Two permanent 'centres of excellence' for Trauma at Gloucestershire Royal Hospital and Orthopaedics at Cheltenham General Hospital.

- 76.02% Fit for the Future survey respondents strongly supported or supported the proposal
- 10.53% Fit for the Future survey respondents strongly opposed or opposed the proposal

The Easy read survey was divided into two questions:

Trauma:	Support: 70.51%	Oppose: 12.82%	Not sure: 16.67%
Orthopaedics:	Support: 73.08%	Oppose: 14.10&	Not sure: 12.82%

Themes

Responses to the consultation focussed on the following themes: **Access; Capacity; Diversity; Efficiency; Environment; Facilities; Interdependency; Integration (with primary and community services); Patient Experience / Staff Experience; Pilot; Quality; Resources; Transport; and Workforce.**

Who got involved?

In terms of the reach of the consultation, demographic information is known about those survey respondents who chose to provide 'About You' information in their survey responses. There is a broad representation of groups in responses to the survey. There is extended reach through the targeted activities, which ensured voices from all groups identified in the Independent Integrated Impact Assessment had an opportunity to be heard e.g. carers, homeless people, Black, Asian and Minority Ethnic communities.

During the consultation, participants took the opportunity to access information, ask questions and comment on the national and local response to the coronavirus pandemic. Many people expressed their gratitude to NHS and care staff and recognised Gloucestershire's diverse communities' collective acts of support for colleagues, friends, families and neighbours.

A detailed summary of feedback received can be found in Part 2. All feedback received can be found in the online Appendices to this Report.

Summary of activity post publication of Interim Output of Consultation Report and signposting to NEW items in this Report

Interim Output of Consultation Report (see Annex 1 Section 9.1)

The Fit for the Future Consultation period ended on 17 December 2020. Preparation of the Interim Output of Consultation Report took place between 21 December 2020 and 3 January 2021. The Report was published week commencing 4 January 2021.

All feedback received during the consultation period was included within the Interim Output of Consultation Report and Appendices at https://www.onegloucestershire.net/wp-content/uploads/2021/01/FFTF-IOOC-Report.pdf

The Interim Output of Consultation has been discussed at various meetings, including:

- Gloucestershire Health Overview and Scrutiny Committee – 12 January 2021
- Gloucestershire Hospitals NHS Foundation Trust Board – 14 January 2021
- One Gloucestershire Integrated Care System Board – 21 January 2021
- NHS Gloucestershire Clinical Commissioning Group Governing Body – 28 January 2021

Citizens' Jury – 19-28 January 2021(see Annex 1 Section 9.2)

The Fit for the Future Citizens' Jury #2 took place via Zoom for eight days from 19 to 22 January and 25 to 28 January from 1pm-5.30pm each day.

Citizens' Juries c.i.c. was commissioned by NHS Gloucestershire as independent facilitators of two Citizens' Juries associated with the Fit for the Future Programme. The brief for Jury #2 was to design and run a citizens' jury looking at the public consultation. Jurors heard from 11 witnesses who described what good NHS public consultation processes look like, how to interpret public consultation results, the local approach to the Fit for the Future

consultation, local community perspectives on the Fit for the Future consultation and the Output of consultation; focussing particularly on the characteristics of respondents and differences between different groups responses to the consultation as well as main themes and areas for consideration arising from the feedback to the consultation.

Further detail of the Fit for the Future Citizens' Jury #2 can be found in Annex 1.

A 'centre of excellence' for Planned Lower GI (colorectal) general surgery

The FFTF Consultation included two options for Planned Lower GI (colorectal) general surgery, either as part of a General Surgery centre of excellence at GRH or as part of a centre of excellence for Pelvic Resection at CGH.

On 4 February 2021 the Gloucestershire Hospitals NHS Foundation Trust Leadership Team (TLT) explored in detail the configuration options.

Further detail can be found in Annex 1 Section 9.4 and in the Decision Making Business Case (DMBC).

Additional Information (see Annex 1 Section 9.4)

https://www.onegloucestershire.net/wp-content/uploads/2021/02/FFTF2020-Additional-Information-002.pdf

A number of additional documents, which will be considered by decision makers in March 2021, became available during February and March 2021. The FFTF Consultation Team contacted local people, groups and stakeholders who participated in the Fit for the Future consultation last year and for whom we have contact details (email or postal address) and inviting them to request information to be sent to them for comment.

Further detail can be found in Annex 1.

Additional written responses received (see Annex 1 Section 9.5 and Appendix 2.1)

Additional responses were received from three groups and seven respondents to the 'Additional Information' (see above).

The Final REACH Survey was published on 14 January 2021
https://www.reachnow.org.uk/reach-publish-results-of-their-fit-for-the-future-survey/

Further detail can be found in Annex 1.

INTRODUCTION

Fit for the Future Consultation

Purpose of this Report

The Fit for the Future Interim Output of Consultation Report is intended to be used as a practical resource for **One Gloucestershire** partners; to provide them with information about how the public, community partners and staff feel about the Fit for the Future proposals for change in order to inform their decision making in 2021. One Gloucestershire is a partnership between the county's NHS and care organisations to help keep people healthy, support active communities and ensure high quality, joined up care when needed.

The NHS partners of One Gloucestershire are:

- NHS Gloucestershire Clinical Commissioning Group (CCG)
- Primary care (GP) providers
- Gloucestershire Health and Care NHS Foundation Trust (GHC)
- Gloucestershire Hospitals NHS Foundation Trust (GHT)
- South Western Ambulance Services NHS Foundation Trust (SWAST)

This Report will form part of the evidence considered by a second independently facilitated Citizens' Jury, to be held in January 2021. This Report will be shared widely across the local health and care community and is available to all on the One Gloucestershire website www.onegloucestershire.net and on the online participation platform Get Involved in Gloucestershire https://getinvolved.glos.nhs.net

This interim report will be updated before decisions are made to include: the output of the Citizens Jury#2; the outcome of the Elective Lower Gastrointestinal (GI) (colorectal) surgery location discussions; the output of the updated independent Integrated Impact Assessment and other relevant information received. The updated report will be published on the One Gloucestershire website (link above) and shared with decision makers in order for them to give conscientious consideration to all relevant information prior to making decisions about the proposals.

One Gloucestershire partners are invited to consider the feedback from consultation and indicate how it has influenced their decision making. Full details of the next steps for the Fit for the Future Programme can be found in Section 1.4.

This Report has been prepared by the One Gloucestershire Communications and Engagement Group. This report is produced in both print and on-line (searchable PDF) formats. For details of how to obtain copies in other formats please turn to the back cover of this Report.

We would like to thank everyone who has taken the time to share their views and ideas.

Making the best use the information provided in this Report

This report is divided into two parts: Part 1 provides background information about the Fit for the Future Programme, the co-development of the consultation proposals and the consultation planning and activities. Part 2 provides a summary of the feedback received during the consultation. The final section of this report is an evaluation of the consultation activity. This report is supported by a series of online Appendices.

There are elements of feedback which will be relevant and of interest to all readers; these can be easily found in the main body of the report.

All feedback received can be found in a series of online Appendices. These Appendices include all comments collated during the consultation, including copies of individual submissions received, in addition to the FIT FOR THE FUTURE survey responses.

The theming of the qualitative feedback received through the Fit for the Future survey presented in this report has been undertaken by members of the **One Gloucestershire** Communications and Engagement Group using SmartSurvey.

Some respondents may have answered the formal consultation survey as well as giving feedback in other ways, such as sending a letter or participating in a discussion event. All feedback received has been read and coded into themes such as: 'access', 'workforce' and 'quality'. Please note that individual's comments may cover more than one theme.
All qualitative feedback received by representatives of **One Gloucestershire** partners during the consultation period is available in the online Appendices. The information provided in this report and Appendices will be used by decision makers to 'conscientiously consider'[1] all feedback received.

Appendices

All appendices are available at: www.onegloucestershire.net

Appendix 1: Survey responses by specific groups:

i) Full survey
ii) Easy Read
iii) Feedback from targeted groups (identified through independent Integrated Impact Assessment) from Full survey[2]
   a. BAME
   b. Over 66 living with a disability
   c. BAME living with a long term condition
   d. People living with a disability
   e. People with mental health problems and/or learning difficulties

[1] One of the Gunning Principles that have formed a strong legal foundation from which the legitimacy of public consultations is often assessed.
[2] Due to the smaller number of responses to the Easy Read survey, further analysis by demographic has not been completed in order to avoid potentially identifying individuals.

f. Unpaid Carer
g. People who identify as LGBTQ+
h. People who live in 12 most deprived wards in Gloucestershire (Indices of Deprivation 2019)
i. Staff
j. Public and Community Partners
k. Postcodes from East of county
l. Postcodes from West of county

Appendix 2: Other Correspondence

Appendix 2.1: Additional responses received

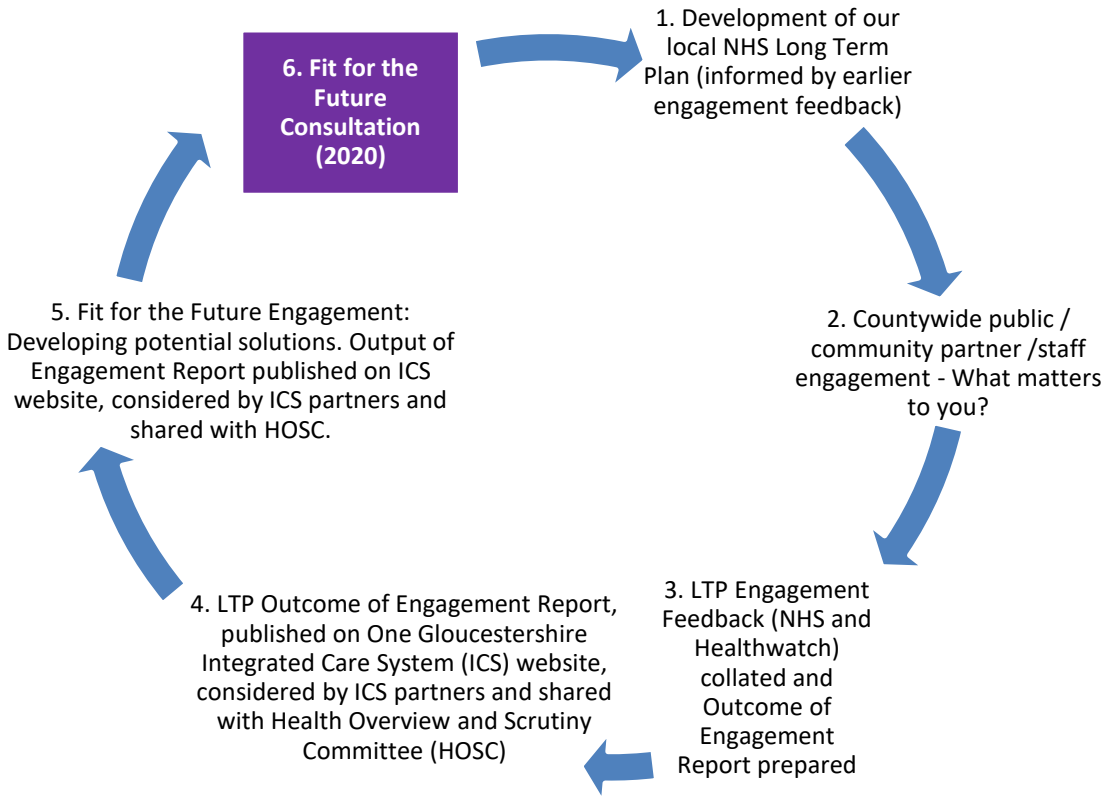
Appendix 3: Glossary

PART 1

1. Background

Over the last few years the NHS in Gloucestershire Fit for the Future programme has been involving local people and staff in looking at potential ways to develop specialist hospital services in Gloucestershire. Through this process the 'centres of excellence'[3] approach has been designed.

Through the earlier Fit for the Future Engagement in 2019 and during earlier conversations about the NHS Long Term Plan in 2018, the NHS in Gloucestershire has been involving staff, patients, local people and the public in looking at a number of services and developing potential 'solutions'. The Fit for the Future Consultation is the latest element of the engagement cycle[4] to develop the Gloucestershire response to the NHS Long Term Plan, which began in 2018.



[3] Centres of excellence: bringing staff, equipment and facilities together in one place to provide leading edge care and create links with other related services and staff.

[4] Previous engagement activities can be found at: www.onegloucestershire.net/yoursay/

The aims of the Fit for the Future programme are to:

- Improve health outcomes
- Reduce waiting times and ensure fewer cancelled operations
- Ensure patients receive the right care at the right time in the right place
- Ensure there are always safe staffing levels, including senior doctors available 24/7
- Support joint working between services to reduce the number of visits you have to make to hospital
- Attract and keep the best staff in Gloucestershire.

To achieve these things and to make the most of developing staff skills, precious resources and advances in medicine and technology, the Fit for the Future programme looks at how some specialist hospital services at Gloucestershire Royal and Cheltenham General could be configured to make best use of both hospital sites. This move towards creating 'centres of excellence' at the two hospitals is not new and this approach reflects the way a number of other services are already provided e.g. Cancer Services in Cheltenham and Children's services in Gloucester.

1.1 What the Fit for the Future consultation is about

The purpose of the consultation was to seek views on the future provision of five specialist hospital services in Gloucestershire:

- Acute Medicine (Acute Medical Take). This is the coordination of initial medical care for patients referred to the Acute Medical Team by a GP or the Emergency Departments and where decisions are made as to whether patients need a hospital stay.

- Gastroenterology inpatient services; medical care for stomach, pancreas, bowel or liver problems.

- General Surgery conditions relating to the gut. Specifically, emergency general surgery, planned Lower Gastrointestinal (GI) (colorectal) surgery and day case Upper and Lower GI surgery.

- Image Guided Interventional Surgery (IGIS) including vascular surgery. IGIS is where the surgeon uses instruments with live images to guide the surgery.

- Trauma and Orthopaedic inpatient services (T&O) diagnosis and treatment of conditions relating to the bones and joints.

1.2 What the Fit for the Future consultation is not about

Cheltenham General Hospital Accident & Emergency (A&E) Department

A public commitment has been made to the future of the Accident and Emergency (A&E) Department in Cheltenham. The service will remain consultant led and there will be no change to the opening hours. The proposals for change described in the Fit for the Future consultation do not include the A&E Department at Cheltenham General Hospital, post pandemic, the department will revert to being a 7-day consultant led A&E unit between 8am and 8pm and a nurse led unit between 8pm and 8am. This is the A&E service model that has been in place at Cheltenham since 2013.

COVID-19 Temporary Changes

Fit for the Future is not about the COVID-19 temporary changes made in 2020. However, some of the medium to long term changes proposed relate to some of the same clinical services where temporary changes have had to be made recently in order to keep our hospitals safe.

Outpatients, Community and Primary Care Services

The focus of this consultation is five specialist inpatient services provided at Cheltenham General and Gloucestershire Royal Hospitals. No changes to outpatient, community or primary care services are included within this consultation.

1.3 Consultation process

The Fit for the Future public and staff consultation started on 22 October 2020 and ran until 17 December 2020.

There have been a number of innovative ways the NHS has involved local people and staff during the consultation, from online events, to a 'socially distanced' Information Bus Tour and a door-to-door mail-drop of an information leaflet delivered by Royal Mail to all households in Gloucestershire. Full details of the consultation process can be found in Section 2.

1.4 Completing the communication, engagement and consultation for the Fit for the Future programme

Citizens' Jury

A second Jury, independently facilitated by Citizens Juries CIC, was held in January 2021 to consider the feedback from this consultation. 18 independently recruited jurors (not the same jurors who participated in Jury #1), representative of local communities from a broad range of demographics, received evidence from a range of witnesses, recorded their observations and made their recommendations for the local NHS to consider. This included key feedback from the consultation process, which will be taken into account when making a final decision on the future configuration of the five specialty acute hospital services. The

Citizens' Jury was hosted online; audio recordings of the plenary sessions were available on request from Citizens Juries CIC, witness presentation recordings and slides were available on the One Gloucestershire website https://www.onegloucestershire.net/yoursay/fit-for-the-future-developing-specialist-hospital-services-in-gloucestershire/ . Further detail is included in Section 9 Annex 1.

Elective Lower Gastrointestinal (GI) (colorectal) surgery – no preferred option proposed in the consultation

The Fit for the Future consultation did not propose a preferred option for Elective Lower Gastrointestinal (GI) surgery; two options were described. The next step was to consider one of the two options for this service; to co-locate at either CGH or GRH to take forward for a decision.

This was carried out at the beginning of February 2021 and is a two stage process. Firstly an appraisal by the Trust Leadership Team of Gloucestershire Hospitals NHS Foundation Trust using the feedback from consultation to obtain a recommendation, with the option chosen by the Trust Board and then a final decision made by the NHS Gloucestershire Clinical Commissioning Group Governing Body in March 2021 (see **Decision** below). The following information was reviewed:

- Feedback from the Public Consultation
- Citizen's Jury #2 output
- Presentations on the two options
- Pre-Consultation Business Case and attachments
- Financial Information
- Beds and resource requirements
- Workforce plans including rotas

Further detail can be found in Annex 1 Section 9.4 and in the Decision Making Business Case (DMBC)Annex 1.

Consultation review period

There is a consultation review period, where Gloucestershire Hospitals NHS Foundation Trust and NHS Gloucestershire Clinical Commissioning Group carefully consider all of the feedback.

Decision

A final decision will be made about the Fit for the Future proposals at the CCG Governing Body meeting on 11 March 2021. This will be live streamed on the internet.

Process of implementation

If the proposals set out in this consultation are supported by the Governing Body of the Clinical Commissioning Group; then the Emergency General Surgery, Gastroenterology and Trauma & Orthopaedics inpatient services changes will be made permanent. The timescale

for other changes will be determined by a number of factors such as estates, staff recruitment and training. The Fit for the Future Programme structure will remain in place with programme and project managers working with clinical staff within the specialties to develop and then deliver detailed implementation plans. Plans to involve local people in the implementation and evaluation process are being developed.

1.5 Providing feedback to you on the consultation and decisions

The feedback from the consultation, the recommendations and observations of the Citizens' Jury and the final decision made by the CCG Governing Body will be published at: www.onegloucestershire.net/yoursay and shared on the online participation platform Get Involved in Gloucestershire https://getinvolved.glos.nhs.uk

2. Our approach to communications and consultation

2.1 Working with others

The planning and delivery of the Fit for the Future consultation has been supported by many external groups:

- The Consultation Institute: The consultation process, including this Interim Output of Consultation Report, has been Quality Assured by The Consultation Institute[5]. A Consultation Institute Advisor worked with the Fit for the Future programme, acting as a critical friend; each stage of the consultation planning and activity was formally signed-off by a Consultation Institute Assessor, ensuring a totally independent element in the consultation process. On 4 March 2021 we were pleased to receive the following assurance from The Consultation Institute: "*This consultation has been monitored by the Consultation Institute, under its Consultation Quality Assurance Scheme. The Institute is happy to confirm that the exercise has fully met its requirements for good practice*". The six stages, or gateways, of the Quality Assurance process are:
    - Scope and Governance
    - The Project Plan
    - Consultation Document Review
    - Mid-Point Review
    - Closing Review
    - Final Report

5 https://www.consultationinstitute.org/services/quality-assurance/ https://www.consultationinstitute.org/wp-content/uploads/2019/12/Quality-Assurance.pdf

- Inclusion Gloucestershire: Assisted with the development of Easy Read materials.
- Gloucestershire County Council's Digital Innovation Fund Forum: Informed early planning for online activities and assisted with awareness-raising of the consultation to potentially digitally excluded groups.
- Friends from the Friendship Café in Gloucester City: Supported awareness raising and survey completion within diverse communities.
- Healthwatch Gloucestershire (HWG): HWG Readers Panel reviewed an early draft of the full consultation booklet and made suggestions for changes, which were incorporated into the final version. A HWG representative will be a member of the independent Oversight Panel for the second Fit for the Future Citizens' Jury.
- Aneurin Bevan Health Board (ABHB): ABHB facilitated the translation of the summary consultation booklet into Welsh, and facilitated an Information Bus visit to Chepstow Hospital in Monmouthshire to enable residents living close to the Wales England Border, who might access services in Gloucestershire the opportunity to find out more about the consultation.
- Know Your Patch (KYP) Coordinators: KYPs allowed us space on agendas to share information at online meetings during October and November 2020 to promote the consultation.
- District/Borough Councils and Retail partners: Supported the 'socially distanced' visits of the Information Bus (outside of Lockdown 2) to locations with maximum footfall across the county. District and Borough Councils also hosted members' seminars to discuss the Fit for the Future consultation.
- Local media: Gloucestershire Live, BBC Radio Gloucestershire and GFM Radio
- Others: Many other groups and individuals have helped to raise awareness of the consultation such as Trust Governors, staff-side representatives, hospital volunteers and community and voluntary sector organisations such as homelessness support charities.

Thank you to everyone who has supported this consultation.

2.2 Equality and Engagement Impact Analysis (EEIA)

Equality, diversity, Human Rights and inclusion are at the heart of delivering personal, fair and diverse health and social care services. All commissioners and providers of health and social care services have legal obligations under equality legislation to ensure that people with one or more protected characteristics[6] are not barred from access to services and decision making processes.

[6] It is against the law to discriminate against someone because of: age; disability; gender reassignment; marriage and civil partnership; pregnancy and maternity; race; religion or

The consultation has been informed by the experience of managing earlier extensive engagement activities. The approach and detailed plan for communications and consultation was informed by feedback from those engagement activities, including feedback from NHSE/I Assurance process.

Extract from NHSE/I Assurance Process feedback in relation to communications and engagement:

- The engagement output report shows that the team have really given people every opportunity to take part in the engagement programme and the resulting output report is very extensive. Full credit for openness and transparency
- Would benefit from an accompanying glossary to explain all the inevitable acronyms and terminology sprinkled throughout people's quotes
- The engagement for Fit for the Future described in the PCBC and engagement output report was proportionate, targeted and had due regard for protected groups. From feedback received, the system is in a good place to know what the county as a whole think and the locations where the most negatively impacted populations live
- Further engagement to address the homogeneity of participants in Phase 1.
- In response to COVID-19 restrictions the Strategy and Plan has been designed to support a 'socially distanced' consultation. It includes an Appendix/Briefing which summarises recent advice and guidance regarding online consultation, sets out assumptions and considerations and makes the following observations and conclusions, which will be taken into account during the consultation:
- Consideration to be paid to online deliberation and engagement are those you should pay attention to regardless of whether engagement is face to face or online. Things such as feeling safe, ensuring transparency and that participants have the facts to be able to make an informed decision would apply regardless of how you engage.
- Online consultations prove to be most successful when used in conjunction with offline methods such as telephone structured interviews/market research techniques/managed exhibitions.
- Two-way direct communication is crucial in creating meaningful dialogue – video conferencing software (Zoom, Microsoft Teams etc.) can facilitate this.
- Online forums should be moderated to keep discussion topics organised and to keep participants safe.
- Think about varying the times of online events – avoid excluding working age participants.
- Online events should be no longer than 2 hours and comfort breaks should be scheduled.
- Use creative and interactive dialogue methods for online and offline activities.
- Paper surveys should be replicated as online surveys.

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belief; sex, sexual orientation. These are called protected characteristics. https://www.equalityhumanrights.com/en/equality-act/protected-characteristics

- Some individuals or groups feel more comfortable sharing their thoughts on their own platforms, rather than official channels designed explicitly for themed discussions.
- Different marketing messages required to encourage online participation for 'always' (compete with other opportunities), 'seldom' (relevance, links to pandemic interests) and 'never' online (other opportunities or assistance required).

The FIT FOR THE FUTURE proposals for change have not been implemented as they are subject to this consultation. Two of the services in scope for the consultation are currently piloting the proposed changes and have been evaluated.

The impact of potential changes

We have worked with independent analysts from Mid and South Essex University Hospitals to complete an Integrated Impact Assessment (which covers Health Inequalities and Equality) of the proposed development of 'centres of excellence' for the specialist services described in the Fit for the Future consultation. This can be found at www.onegloucestershire.net/yoursay

The analysis considered a wide range of information, including feedback from the Engagement, to describe how different groups of people who are likely to access and experience health services, could be impacted by the proposed changes for each of the combinations of specialist services. Impact analysis, as part of the evaluation of the two pilot changes (Gastroenterology and Trauma & Orthopaedic inpatient services) has been undertaken locally with the support of the Local Authority Public Health Department. A Lay Reference Group made up of patient, public and VCS representatives was established to support the Impact Analysis and Solutions Appraisal activities.

In addition to the independent Integrated Impact Assessment (IIA) of the proposals, an Equality and Engagement Impact Analysis (EEIA) of the planned consultation activities has also been undertaken.

2.2.1 Groups potentially impacted, issues identified and actions taken

Our aim with this consultation was to reach a good representation of the local population, whilst making sure we hear from those groups who might be most affected by the proposed changes. We sought out the views of people from the groups, set out below, during the consultation to gain a better understanding of the potential impact on them and to identify ways to lessen any potential negative impacts:

- Black, Asian and Minority Ethnic (BAME) communities, in particular people aged over 65
- People with mental health conditions
- Over 65s who are more likely to have long term conditions such as cardiovascular disease, obesity or diabetes
- Frail older people who are more likely to experience falls
- People from BAME communities who are living with a long term condition
- People living with a disability (includes physical impairments; learning disability; sensory impairment; mental health conditions; long-term medical conditions).

- Adult Carers and Young Carers
- Homeless people
- Gypsy/Traveller communities
- LGBTQ+ people
- People living in low income areas.

2.2.2 Issues identified pre-consultation in the EEIA and action taken ahead of consultation

Less information, less jargon and easy read

The Consultation booklet was reviewed by the Healthwatch Gloucestershire Lay Readers Panel. An Easy Read version of the consultation booklet and survey was produced by Inclusion Gloucestershire. A summary version of the consultation booklet was produced.

Accompanying glossary recommended

There is an accompanying glossary in the full consultation document (which is available in print and online).

Further engagement to address the homogeneity of participants

Targeted opportunities for consultation with protected characteristic groups identified through the Impact Analysis e.g. via the Homeless Healthcare Team, Carers Forum etc. Alternative formats of all consultation materials available on request. Contract in place with telephone (and face to face) interpreters, incl. BSL and for written translation.

Paper surveys should be replicated as online surveys

Surveys were available on line in regular and easy read formats. People were also offered assistance to complete surveys over the telephone.

Different marketing messages required to encourage online participation for 'always' (compete with other opportunities), 'seldom' (relevance, links to pandemic interests) and 'never' online (other opportunities or assistance required).

All forms of media, print, broadcast, and social media platforms were used. An awareness raising leaflet was delivered to all households by Royal Mail in Gloucestershire telling them about the consultation and how they could get involved.

Liaise with community leaders to hold specific workshops within the BAME communities with community support for interpreters

We contacted local groups, including BAME communities to arrange culturally appropriate opportunities for participation in the consultation e.g. Information Bus visit to Gloucester Mosque at their invitation [Unfortunately we were unable to attend the Mosque visit due to Covid-19 Lockdown 2 restrictions. However, we liaised with local community leaders about alternative ways to promote the consultation, including WhatsApp and interview on local Community Radio[7]]

Use creative and interactive dialogue methods

We used a range of methods: Online, face-to-face (socially distanced), telephone, written.

Online consultations prove to be most successful when used in conjunction with offline methods such as telephone structured interviews/market research techniques/managed exhibitions.

We hosted online activities, chat forums and Live discussions recorded on YouTube [In response to feedback after the first Live discussion, broadcast was moved to FaceBook Live for better reach]. We invited people to call us to leave a message to book telephone interviews. We toured our Information Bus to all localities in the county and to the Mosque in Gloucester [see note above].

Online forums should be moderated

The Forum function of the Get Involved in Gloucestershire online participation platform is independently moderated. The Gloucestershire Live Face Book Events were hosted by an independent chair and questions were moderated.

Varying the times of online events

Events were held at different times of day and different days of the week

Events, e.g. workshops, no longer than 2 hours

All scheduled events were no longer than 90 minutes, with online events mostly lasting 30-45 minutes. Most events were online and we make it clear that participants could get up, have a comfort/refreshment break

Some individuals or groups feel more comfortable sharing their thoughts on their own platforms, rather than official channels designed explicitly for themed discussions.

We offered to use the platforms, which worked best for the individual or group: Zoom, Face Time, Microsoft Teams, Webex – We completed DPIA (Data Protection

[7] https://gloucesterfm.com/ 7 December 2020, Community Link Show – repeated 8 December 2020

Impact Assessments) for any new platforms requested. We also offered more traditional methods such as telephone calls.

Target groups identified through the IIA

Representatives from the groups identified in the IIA were contacted to discuss methods to facilitate participation in the consultation. Example: Advice from the Homeless Healthcare Team, Age UK, Carers Hub

The Fit for the Future consultation was open to all with activities designed to facilitate feedback from as wide a cross-section of the local community as possible. The full EEIA can be found via the following link:
https://www.onegloucestershire.net/wp-content/uploads/2020/10/Equality-and-Engagement-Impact-Assessment-FINAL-1.pdf

The Pre Consultation Business Case independent Integrated Impact Assessment can be found via the following link: https://www.onegloucestershire.net/wp-content/uploads/2020/12/Appendix-14a_Annex_IIA.pdf

The independent Integrated Impact Assessment will be updated to take into account the response to consultation. The updated assessment will be included in the Decision Making Business Case, which will be available on the One Gloucestershire website.2.3

2.3 Covid 19: A socially distanced consultation

A traditional consultation process would include many of the methods described below, such as producing information, hosting discussion events and developing surveys.
One factor to be taken into account with this consultation was the reduced opportunity to engage with people face-to-face due to pandemic public health restrictions. Therefore a largely 'socially distanced' consultation was planned. In order to maximise opportunities to raise awareness of the consultation and opportunities to get involved the following methods were used.

2.4 Communications: Developing understanding and supporting Fit for the Future consultation

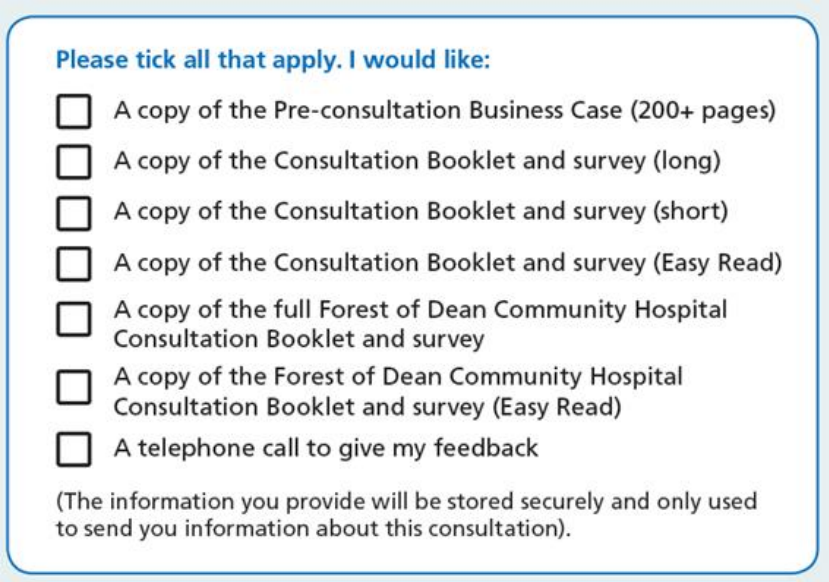
A range of communications and consultation methodologies were used during the Fit for the Future consultation. This section describes the wide ranging approach taken to promoting the *Fit for the Future* consultation and the range of involvement opportunities.
In summary:

Door to Door awareness raising leaflet

The NHS commissioned the Royal Mail to deliver a leaflet to all households in Gloucestershire. One Gloucestershire commissioned Royal Mail to deliver297,000 Fit for the

Future leaflet to all Gloucestershire postcodes. Where residents have chosen Royal Mail Door to Door opt out, they will not have received this information[8]

This was a key method for ensuring that people not able to access materials on-line were able to engage with the consultation. The leaflet included brief information about the Fit for the Future consultation and also the Forest of Dean Community Hospital consultation; which has been running concurrently[9]. The mailer included a freepost reply slip to request information or a telephone call.


Please tick all that apply. I would like:

- ☐ A copy of the Pre-consultation Business Case (200+ pages)
- ☐ A copy of the Consultation Booklet and survey (long)
- ☐ A copy of the Consultation Booklet and survey (short)
- ☐ A copy of the Consultation Booklet and survey (Easy Read)
- ☐ A copy of the full Forest of Dean Community Hospital Consultation Booklet and survey
- ☐ A copy of the Forest of Dean Community Hospital Consultation Booklet and survey (Easy Read)
- ☐ A telephone call to give my feedback

(The information you provide will be stored securely and only used to send you information about this consultation).

- 1,743 requests for information were received (1,286 items posted, all other items were sent by email). Many people requested more than one item or documents relating to both live consultations.
    - Fit For the Future (1,248)
        - Long 226 (162 sent by post)
        - Short 587 (415 sent by post)
        - Easy Read 256 (193 sent by post)
        - Pre Consultation Business Case 180 (132 sent by post)
    - Forest of Dean Community Hospital (495)
        - Long 308 (239 sent by post)
        - Easy Read 187 (145 sent by post)
- 116 requests for telephone call backs
    - Fit for the Future (83)
    - Forest of Dean Community Hospital (33)

[8] https://www.royalmail.com/sites/default/files/D2D-Opt-Out-Application-Form-2015.pdf

[9] Details of the Forest of Dean Community Hospital Consultation can be found at: https://www.fodhealth.nhs.uk/consultation/

Media releases and stakeholder briefings

This included:

- launch materials – media release and stakeholder briefing
- media statements reinforcing key messages and involvement opportunities
- a further open stakeholder letter sent to community stakeholders by email including Patient Participation Groups, local authorities, voluntary and community organisations
- Foundation Trust Membership communications promoting the consultation

Hardcopy engagement booklets

Approximately 5,000 booklets were widely distributed to a range of public places including Cheltenham General and Gloucestershire Royal Hospitals, community pharmacies, GP surgeries and libraries. The booklets included the survey and information detailing the ways people could get involved.

'Your Say' area on the One Gloucestershire Health website and Get Involved in Gloucestershire online participation platform

All consultation materials can be found at: Fit for the Future: Developing urgent and hospital care in Gloucestershire: https://www.onegloucestershire.net/yoursay/ Get Involved in Gloucestershire is an online participation space where anyone can share views, experiences and ideas about local health and care services. Information about the consultation including activities can be found at https://getinvolved.glos.nhs.uk/fit-for-the-future

Further engagement to address the homogeneity of participants

Targeted opportunities for consultation with protected characteristic groups were identified through the Equality and Engagement Impact Analysis e.g. via the Homeless Healthcare Team, Carers Forum etc. Alternative formats of all consultation materials available on request. Contract in place with telephone (and face to face) interpreters, incl. BSL and for written translation. An introduction to the Consultation, with information about support to enable people to participate, was sent to Talking Newspapers

Social media

Social media was used extensively to support the consultation and planned activity covered topics such as promotion of how people could get involved, films, Information Bus Tour and Cuppa and Chat events, promotion of the booklet and survey, and promotion of the online clinical discussions.

Facebook

During the engagement there were a total of 22 Facebook posts from the One Gloucestershire account, with a total reach of 91, 141[10]. There were 5,555 'engagements' with these posts (i.e. actions such as comments, likes or shares) of which 444 clicked the links in the post. There were also three sponsored boosts across the period of the consultation, including a post to launch the consultation, our intro to Fit for the Future video, and to promote the Q&A sessions. Each of these posts also linked to the One Gloucestershire website. This achieved a total reach of 142,512* with 1,793 'engagements' which included 1,016 clicks on the link in the post.

Twitter

During the engagement period there were 38 tweets and retweets from the One Gloucestershire account, with a total of 30,088 impressions. There were 791 'engagements' with these tweets (i.e. actions such as link clicks, retweets, likes, or comments) of which 97 were retweets and 107 were clicks through to the One Gloucestershire website. Activity on Twitter covered the themes referred to in the Facebook section above.

Media Advertising

As well as the methods described above, the initial Information Bus events were advertised in local media titles including Gloucester Citizen, Gloucestershire Echo, The Forester, Wilts & Glos Standard, Stroud News & Journal, Cotswold Journal and Gloucestershire Gazette. We also took out sponsored digital adverts with the titles listed above, which went out via their websites and social media channels. These pushed people to the main Fit for the Future consultation page where people could find our documents, videos and details for how to get involved online or offline.

[10] It is important to note that the total reach across all posts will include many people who saw more than one of our posts. However, on each post, reach only includes each individual once, even if they saw a post multiple times.

2.5 Staff communication and engagement

Gloucestershire Hospitals NHS Foundation Trust staff

Four main programmes of internal communication and engagement were rolled out to support staff.

1) Corporate communications:

Video communication to all staff: Executives regularly updated staff on the programme of work as part of the fortnightly Vlog shared with all staff and hosted on the Trust intranet. To enable greater uptake the intranet has also been made mobile friendly so staff can keep up to date via their own personal device at a time of their choosing.

Key statistics:

- Total page views: 3,242
- unique views: 2,786
- Average time on Vlog: 09m:16s

Global emails: As well as video format, programme leads regularly updated staff on developments in written format via global emails which go out to all staff 3 times a week. This messaging regularly linked back to the intranet page where staff could find out more and were actively encouraged to complete the online survey. Unfortunately due to restrictions with Outlook software there's no tracking device that enables tracking of email updates. However, intranet tracking is available and is covered in the next section.

Intranet: The intranet was used a platform to share all the latest information including opportunities for staff to get involved, learn more about the programme and how to complete the online survey.

Key statistics:

- Total page views: 795
- Unique page views: 647
- Average time on page: 04:39

Website: In addition to the main website platform (onegloucestershire.net), the Hospitals Trust also uploaded an information update (media release) to its website (www.gloshospitals.nhs.uk).

Key statistics:

- Total page views: 394
- unique views: 339
- average time on page: 02:32

2) Staff online discussion forum

Throughout the consultation staff were offered 3 dedicated online sessions to learn more about the programme. Typically each session would include an introduction, overview of the programme, the case for change and the opportunity each afforded. The sessions were clinically supported and executive lead. Staff were invited to participate and ask live questions which were shared and answered.

Monday, 2nd November: x 4 participants
Tuesday, 8th December: x 6 participants
Monday, 14th December: No participants

3) Staff drop in sessions

Information points were established at busy thoroughfares across the hospitals. These were staffed on 10 separate occasions for three hours throughout the period of the consultation. This qualitative approach was designed to understand in more detail the views of staff. Consultation booklets were also distributed widely in staff areas across both Cheltenham General and Gloucestershire Royal Hospital. Total number of contacts made with staff: 351

Themes that emerged:

- Awareness levels varied: some staff were well informed and knowledgeable while others less so
- Anecdotally awareness levels appeared to increase throughout the consultation
- There was some confusion in relation to COVID temporary/emergency changes and long-term strategic proposals for changes as part of Fit for the Future

From those staff, who were engaged, the following themes emerged:

- Broadly there was support for the centres of excellence vision
- Staff understood the benefits of a greater separation between emergency and elective services across both sites
- Staff could point to inefficiencies and duplication which didn't optimise opportunities for better patient care and staff working

- There was a level of anxiety in relation to bed modelling and access to theatres, equipment and wards
- Staff had preferences over which site they preferred to work
- Staff wanted to continue to work within the same team

4) Staff ambassadors

Clinical and managerial leaders supported the programme within their divisions and teams and were encouraged to take the message to them as part of the consultation programme. Clinical and managerial leaders were reminded of the importance of this responsibility during regular corporate and clinical leadership meetings such as the Trust's Leadership Team meeting. By having ambassadors widely dispersed across the hospitals they acted as touch points and support pillars for clinical colleagues, administrative and managerial staff.

Primary care (GP practices) and NHS Gloucestershire Clinical Commissioning Group (CCG)
The Fit for the Future consultation has been regularly promoted to all staff working at NHS Gloucestershire Clinical Commissioning Group and in GP practices, Primary Care Networks and the Local Medical Committee via the Primary Care Bulletin. The consultation was promoted at a meeting of the countywide Primary Care Clinical Network Clinical Directors.

2.6 Other stakeholder communication and engagement

Elected Representatives

Members of Parliament
Regular MP briefings have taken place prior to and during the Fit for the Future consultation period.

Gloucestershire County Council (GCC)
Gloucestershire County Council Health Overview and Scrutiny Committee Members have received regular updates on the Fit for the Future programme and consultation. Consultation materials have been available to elected members and staff.

District and Borough Councils
A series of Fit for the Future Members Seminars have taken place across the county. Following presentations, members had the opportunity to participate in Question and Answer sessions.

REACH Campaign

A series of meetings were held throughout the consultation with representatives of REACH[11]. These meetings provided an opportunity to share information and to respond to questions. During the consultation period REACH produced an alternative survey to the NHS Fit for the Future survey. Details of the REACH survey and responses to it as presented in the REACH Survey Interim Report were shared with the Fit for the Future consultation team at the end of December 2021 and can be found in Part 2. Details of the Final Reach Survey Report published in January 2021 can be found in 5.1.1 and Annex 1.

2.7 Public Consultation Activities

Gloucestershire Media: Live social media partnership (@GlosLiveOnline)

Underpinning the 'socially distanced' approach to consultation was a new and ground breaking partnership with local media stakeholder Gloucestershire Media. In terms of the format six half hour productions were broadcast live via Glos Media's Facebook channel (as well as Glos Hospitals Facebook channel) during peak period. Chaired by an independent figure well-known in the local community and presented as a Q&A public session with hospital clinicians, the sessions were broadcast at 12.30pm each Wednesday (from 4th November – 9th December).

Each session focussed on each of the individual service proposals under the Fit for the Future public consultation programme e.g. Acute Medicine, Gastroenterology inpatient services, Trauma & Orthopaedics, General Surgery and Image Guided Interventional Surgery. The exception to that was the first broadcast which went out as a COVID special on 4th November. The strength of the broadcasts was the level of clinical representation and participation. Under the partnership arrangement other local media outlets including the BBC were given access to the content produced as well as access to the hospitals and clinicians.

[11] https://www.reachnow.org.uk/ extract from website:

The REACH (Restore Emergency At Cheltenham General Hospital) campaign was launched by Cheltenham Chamber of Commerce, which is now working with local businesses, local residents and other campaign groups 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."

Gloucestershire Media: Live social media partnership (@GlosLiveOnline) Analytics:

Table 1 (analytics of the broadcast)

Platform	Date	Subject	Reach	Comments	Likes	Shares	Views
Facebook	11/11/2020	Gastroenterology Inpatient Services	Glos Live: 49,500 Glos Hos: 14,366	74 23	54 29	7 17	10,000
	18/11/2020	Acute Medicine	Glos Live: 58,000 Glos Hos: 3,187	69 16	54 31	7 5	11,000
	25/11/20	T&O	Glos Live: 20,000 Glos Hos: 3,789	36 25	23 27	3 6	6,000
	02/12/2020	General Surgery	Glos Live: 16,000 Glos Hos: N/A	17 N/A	27 N/A	2 N/A	6,500
	09/12/2020	IGIS	Glos Live: 33,234 Glos Hos: 3,900	29 0	54 28	1 5	8,800

Table 2 (analytics of the promotional material)

Platform	Date	Subject	Reach	Comments	Likes	Shares
Facebook	10/11/2020	Gastroenterology	28,800	60	16	6
	11/11/2020	Gastroenterology	20,300	19	34	4
	17/11/2020	Acute Medicine	27,700	44	15	2
	24/11/2020	T&O	14,400	41	7	1
	01/12/2020	General Surgery	11,000	0	3	2
	04/12/2020	T&O	30	1	9	2
	08/12/2020	IGIS	8,000	0	7	2

Gloucestershire Hospitals: Facebook live (@GlosHospitals)

Running parallel to the Gloucestershire Media partnership described above was the Hospitals Trust's own Facebook live production. Clinically led and executive supported, all 7 sessions were broadcast live via the Trust's Facebook channel. In a similar way to the Gloucestershire Media productions, each session was dedicated to an individual service proposal and led by those specialist clinicians. Typically each session would include an introduction, overview of the service, the case for change and the opportunity each afforded. The public were invited to participate and ask live questions which were shared and answered.

Gloucestershire Hospitals: Facebook live (@GlosHospitals): Analytics:

Platform	Date	Subject	Reach	Comments	Likes	Shares	Views
Facebook	02/12/2020	Acute Medicine	18,277	5	24	2	2.5k
	03/12/2020	Gastroenterology Inpatient Services	3,099	0	11	4	1.4k
	03/12/20	General Surgery	2113	1	5	1	970
	04/12/2020	IGIS	3,072	9	8	14	1.4k
	04/12/2020	T&O	30	1	9	2	1.4k
YouTube*	02/11/2020	Acute Medicine	N/A	1	3	N/A	146

* The Hospitals Trust switched from YouTube to Facebook in response to increased audiences and greater accessibility. The Trust ran an additional broadcast on Acute Medicine to ensure the full sequence of service proposals had been broadcast.

Gloucestershire Patient Participation Group Network

https://getinvolved.glos.nhs.uk/ppg-network

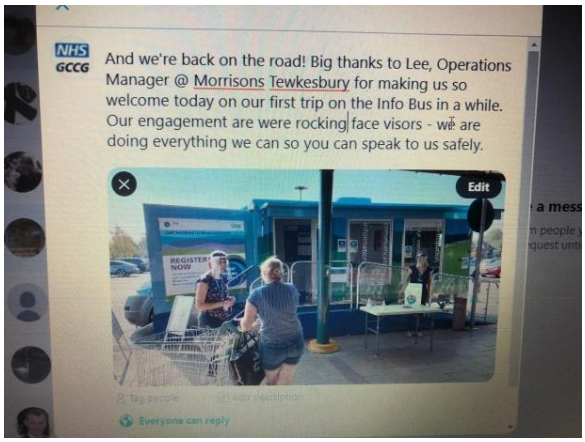
All GP practices in England are required to have a patient participation group. The Gloucestershire PPG Network is organised by Gloucestershire Clinical Commissioning Group (CCG). It is designed to provide a space for PPG members from across the county to share their experiences with one another in order for each PPG to learn and continue to provide an effective role in their practice.

NHS Gloucestershire CCG involves PPG members in engagement and consultation work, provides support to PPG's on an individual basis and also provides opportunities for PPG's to learn and develop. In addition, NHS Gloucestershire CCG hosts a quarterly network meeting. However, during the current pandemic this has moved to holding meetings virtually using MS Teams. An Extraordinary PPG Network meeting to focus solely on the Fit for the Future and Forest of Dean new community hospital consultations attended by 25 PPG members was held in November 2020.

NHS Information Bus Tour

The Information Bus aims to facilitate partnership working, offering information and activities which support self-care, health and wellbeing and self-management across the communities of Gloucestershire. The Bus is also used a consultation resource to support engagement with the public to inform service planning and design.

Prior to the launch of the consultation, the Bus was used during September 2020 to promote the new Get Involved in Gloucestershire online participation platform.



An Information Bus Tour to raise awareness of the consultation, to gather views and answer questions commenced on 2 November 2020. Unfortunately due to new Covid-19 restrictions introduced from 5 November 2020, planned Information Bus Dates originally planned for November 2020 were cancelled. However all these dates were re-provided in December once lockdown in England ended and Gloucestershire moved into Tier 2. Three events had been held prior to lockdown. The Bus was used as a venue for Covid-19 staff testing while it was off the road.

The Bus recommenced its Tour on 1 December 2020 in Chepstow, Monmouthshire (where lockdown was not in place) and in Cheltenham on 3 December 2020.

Chepstow Hospital

Tesco, Tewkesbury Road Cheltenham

Gloucester Quays

During the consultation 433 people visited the Information Bus. See Section 2.10 for details of all Information Bus Tour dates.

Cuppa and Chats

When the Information Bus Tour was paused in November 2020, locality and countywide online 'Cuppa and Chats' were set up to replace the socially distanced face-to-face visits planned. These took the form of a short presentation (including showing of an information film) followed by a shared discussion.

The sessions were initially organised as Microsoft Teams meetings, in response to feedback from public participants, the sessions were moved to an alternative platform, Zoom, more frequently used by community partners.

8 'Cuppa and Chats' were hosted reaching 44 participants.

Targeted activities

In addition to the main consultation activities, the consultation sought feedback from groups identified in the independent Integrated Impact Assessment. Details of how we have engaged these groups in the consultation can be found below in section 2.8.

Fit for the Future Surveys

Two surveys (standard and Easy Read) were developed by the NHS to support the FIT FOR THE FUTURE engagement. These were available as print, FREEPOST return copies in the engagement booklets and also on line at:
https://www.onegloucestershire.net/yoursay/fit-for-the-future-developing-specialist-hospital-services-in-gloucestershire/
and
https://getinvolved.glos.nhs.uk/fit-for-the-future

A total of 713 Fit for the Future surveys have been received. This included 110+ Freepost paper surveys, 1 telephone survey with the remainder online.

Other surveys and petitions

REACH created an alternative survey to gather views to inform their response to the Fit for the Future consultation proposals.
[Extract from REACH website) https://www.reachnow.org.uk/

REACH launch their Fit for the Future Survey **(19 November 2020)**

REACH are concerned that the One Gloucestershire Fit for the Future survey that forms part of the consultation has been constructed in such a manner that the results can be used to justify a decision that the respondents would not have supported. Because of this REACH have chosen to launch their own survey, to gather the real preferences of those local people in Gloucestershire and surrounding areas, who will be affected by these proposals.

"We believe it is vital that the public can actively engage in this consultation. We are not convinced that the One Gloucestershire survey enables the public to express clear responses to some of the key points, which is why we have chosen to produce our own Fit for the Future survey.

"We would encourage as many people as possible to take part in our survey and allow their views to be heard. We will be making the results of this survey public and will be sharing them with One Gloucestershire. To help the general public understand some of the fairly complex issues involved we have also produced a non- medical persons' guide to some of the key points"

The interim results from the REACH survey were shared with the One Gloucestershire Communications and Engagement Team before Christmas 2020 and are included in the detailed summary of consultation feedback in Part 2 of this report. REACH has also provided a formal response to the consultation which can be found in the online appendices.

The Final Report of the REACH Survey was published on 14 January 2021. Further detail of this survey can be found at 5.1.1 and at Annex 1. The Final REACH Survey Report can be found in full at Appendix 2.1.

Petitions

At the time of writing the Interim Report no petitions relating to Fit for the Future have been received by NHS partners of One Gloucestershire.

2.8 Consulting people with protected characteristics and others identified in the Independent Integrated Impact Analysis

The consultation took two main routes to reach, gather and record views from people with protected characteristics and others identified in the independent Integrated Impact Analysis:

- promoting the formal consultation routes and encouraging participation. The consultation survey asks for respondents to provide demographic information (see Part 2)
- proactive consultation with targeted groups. The consultation team contacted groups across Gloucestershire using existing well established networks and Your Circle https://www.yourcircle.org.uk/, which is a local online directory to help you

find your way around care and support and connect with people, places and activities in Gloucestershire. The following describes activities undertaken to encourage participation from these groups and themes from their responses to the consultation where possible without identifying individual's responses.

Black, Asian and Minority Ethnic (BAME) communities, in particular people aged over 65

There are a number of responses to the survey from people from BAME communities (39 people identified as: White Other, Asian or Asian British, Black or Black British, Chinese, Mixed who complete the 'About you' survey questions). A small number of respondents from BAME communities also indicated they were aged over 66. Members of the consultation team worked with Friends from the Friendship Café in Gloucester City to supported awareness raising and survey completion within diverse communities. Information about the consultation was shared with the members of the Impact of COVID-19 on BAME Community/Groups Gloucestershire Task and Finish Group. Consultation materials were shared with the Gloucestershire VCS Alliance BAME/Diverse Communities Forum. An interview on the Community Link Programme on Gloucester FM Radio promoted the consultation to listeners. Gloucester FM community radio station, has an emphasis on local issues, information, advice and music reflecting Gloucestershire's multi-cultural community https://gloucesterfm.com/

People with mental health conditions [and learning disabilities]

There is a good response to the survey from people who indicated they have a disability (including mental health problem or learning disability). During the consultation, members of the consultation team attended all Know Your Patch meetings across the county to promote Fit for the Future and the Get Involved in Gloucestershire online participation platform. Know Your Patch builds networks for those working with individuals and groups to help people stay independent for longer and to lead full and happier lives. Know Your Patch has a network of organisations in each district in Gloucestershire. These networks meet quarterly for networking and discussion and communicate through email bulletins and updates. These networks help connect VSCE and statutory organisations together for effective partnership working https://knowyourpatch.co.uk/networks/ Information about the consultation was also shared with the Mental Health and Learning Disability Partnership Boards.

The online appendices includes reports of the responses from all survey respondents, who completed the 'About You' questions in the survey, who stated they had a mental health problem or a learning disability.

Over 65s who are more likely to have long term conditions such as cardiovascular disease, obesity or diabetes

There is a good response to the survey from people aged 66 and over, and also from people who indicated they have a disability. Staff from Gloucestershire Health and Care NHS Foundation Trust, working in Cardiac Rehabilitation, have been provided with consultation materials. The Gloucestershire Heart Support Group, HeartSmart (Cirencester), Heart to Heart Exercise Group and Where the Heart Is Group, were provided with information about the consultation to share with members of their groups. Visits were made to the Cardiac Ward and Coronary Care Unit at Cheltenham General Hospital and Gloucestershire Royal

Hospital to provide awareness raising flyers, summary booklets and full booklets for clinical staff to share with patients who were well enough to read of them. Information about the consultation was also shared via email with 20 members of the Gloucester Diabetes Support Group and at a Gloucestershire Stroke Zoom Café attended by 5 members.

Frail older people who are more likely to experience falls

The activities described above for Over 65s with long terms conditions apply to this group as well. Contact was also made with the local branch of Age UK to promote the consultation.

The online appendices provide a report of the responses from all survey respondents, who completed the 'About You' questions in the survey, who are over 66 and who stated they had a disability.

People from BAME communities who are living with a long term condition

There is a proportional response to the survey from people from BAME communities. A small number of respondents from BAME communities also indicated they had a disability.

As referenced above, members of the consultation team worked with Friends from the Friendship Café in Gloucester City to supported awareness raising and survey completion within diverse communities.

Information about the consultation was shared with the members of the Impact of COVID-19 on BAME Community/Groups Gloucestershire Task and Finish Group. An interview on the Community Link Programme on Gloucester FM Radio promoted the consultation to listeners. Gloucester FM community radio station, has an emphasis on local issues, information, advice and music reflecting Gloucestershire's multi-cultural community https://gloucesterfm.com/

GFM Studio

The online appendices provide a report of the responses from all survey respondents, who completed the 'About You' questions in the survey, who are from BAME communities and who stated they had a disability.

People living with a disability (includes physical impairments; learning disability; sensory impairment; mental health conditions; long-term medical conditions)

There is a good response to the survey from people who indicated they have a disability. As above, during the consultation, members of the consultation team attended all Know Your Patch meetings across the county to promote Fit for the Future and the Get Involved in Gloucestershire online participation platform.

Know Your Patch builds networks for those working with individuals and groups to help people stay independent for longer and to lead full and happier lives. Know Your Patch has a network of organisations in each district in Gloucestershire. These networks meet quarterly for networking and discussion and communicate through email bulletins and updates. These networks help connect VSCE and statutory organisations together for effective partnership working https://knowyourpatch.co.uk/networks/

Information about the consultation was also shared with the Learning Disability Partnership Board and Physical Disability and Sensory Impairment Partnership Board who have a total of 179 members between them. Information about the consultation was directly targeted by the Integrated Disabilities Commissioning Hub to 31 members involved of the Building Better Transport Links (BBTL) group, who are looking at better transport arrangements for people with disabilities. The consultation also targeted people with visually impairment through representatives from the Sight Loss Council, the Macular Society and Royal National Institute for the Blind; following their advice information was sent to Gloucestershire's network of talking newspapers and Fit for the Future VLOGs, as well as written updates, were added to social media channels.

The online appendices provide a report of the responses from all survey respondents, who completed the 'About You' questions in the survey, who stated they had a disability.

Young people

The Gloucestershire Hospitals NHS Foundation Trust Youth Group held a discussion group about the Fit for the Future consultation proposals. Members were encouraged to visit the Get Involved in Gloucestershire online participation platform. 2 Youth Ambassadors created short films, which were shared on social media, to encourage young people to get involved. One member of the Youth Group sent a formal written response to the consultation.

Adult Carers and Young Carers

There is a good response to the survey from people who indicated that (unpaid) they look after, or give any help or support to family members friends, neighbours or others because of either a physical or mental health need or problems related to old age. During the consultation members of the consultation team attended carers group meetings to talk about the Fit for the Future consultation including Gloucestershire Hospitals NHS Foundation Trust Carers Hospitals Reflections and Experience Group and YACTION – Young Adult Carers Group. The groups both emphasised the importance of good clear

communications around any proposed changes and the need to work closely and in partnership with carers.

YACTION in action, we talked about Fit for the Future, while together we crafted Christmas decorations.

The online appendices provide a report of the responses from all survey respondents, who completed the 'About You' questions in the survey, who stated they were unpaid carers.

Homeless people (and rough sleepers)

Homelessness is not a characteristic the survey collects. Therefore, in order to ensure the feedback from homeless people can be identified, enhanced targeted activity has taken place to raise awareness of Fit for the Future and Get Involved in Gloucestershire; and to collect feedback specific to the consultation proposals and any other issues of importance to homeless people. Members of the consultation team have attended several meetings of groups who support homeless people in Gloucestershire: Gloucester Homeless Forum, Cheltenham Housing & Care Forum, Cheltenham Open Door, Cheltenham Housing Aid Centre and also engaged with the Homeless Specialist Nurse.

Summary of feedback: - *Requests were made for more outreach services, in particular in Cheltenham and for the local NHS to ensure that, whichever hospital vulnerable people were admitted to, they are treated well and with dignity.*

Gypsy/Traveller communities

Members of the consultation team met with the Travellers' Welfare Officer to discuss the Fit for the Future consultation proposals. General comments about the experience of travelling families of Gloucestershire NHS service related to the attitude of NHS staff to travelling families, in particular from ward staff when visiting family members in hospital.

LGBTQ+ people

There is a good response to the survey regarding sexual orientation, with a small number of respondents describing themselves as LGB. No respondents to the survey, who completed the 'About You' questions stated that they did not identify with the gender they were

registered with at birth. 1 respondent to the survey, who completed the 'About You' questions stated they were transgender. Information about the consultation was shared with the members of the Gloucestershire LGBT+ partnership and there was an opportunity to raise awareness of the consultation when the NHS Information Bus supported the LGBTQ+ partnership as a mobile venue during Hate Crime week in September 2020.

The online appendices provide a report of the responses from all survey respondents, who completed the 'About You' questions in the survey, who identified as LGBTQ+ [The combined number is greater than 10]

People living in low income areas

Low income is not a characteristic the survey collects. However, there is information within local data which records indices of deprivation and shows which areas of the county are most likely to be low income areas. Extract from Inform website: https://inform.gloucestershire.gov.uk/deprivation/overview/

> *The Indices of Deprivation 2019 are national measures based on 39 indicators, which highlight characteristics of deprivation such as unemployment, low income, crime and poor access to education and health services. The 2019 indices offer an in-depth approach to pinpointing small pockets of deprivation. Each indicator was based on data from the most recent time point available. Using the latest data available means there is not a single consistent time point for all 39 indicators.* https://inform.gloucestershire.gov.uk/media/2094524/gloucestershire_deprivation_2019_v13.pdf
>
> *….There are 12 areas of Gloucestershire in the most deprived 10% nationally for* the overall IMD. [9 of the 12 are in Gloucester District Council: GL1, GL2 and GL4 postcode areas, 2 in Cheltenham GL50 and GL51 and 1 in the Forest of Dean GL14.
>
> 1. *Podsmead 1 Gloucester 621 (n=national rank out of 32,844 small areas or neighbourhoods called Lower-layer Super Output Areas in England[12])*
> 2. *Matson and Robinswood 1 Gloucester 735*
> 3. *Westgate 1 Gloucester 1,183*
> 4. *Kingsholm and Wotton 3 Gloucester 1,456*
> 5. *Westgate 5 Gloucester 1,579*
> 6. *St Mark's 1 Cheltenham 2,178*
> 7. *Moreland 4 Gloucester 2,221*
> 8. *St Paul's 2 Cheltenham 2,368*
> 9. *Cinderford West 1 Forest of Dean 2,729*
> 10. *Tuffley 4 Gloucester 2,801*
> 11. *Matson and Robinswood 5 Gloucester 2,948*
> 12. *Barton and Tredworth 4 Gloucester 3,126*

12 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/835115/IoD2019_Statistical_Release.pdf

Employment status is one of the indices of deprivation. Information available on the Inform website the latest available unemployment data for October and November 2020 indicates that Barton and Tredworth ward in the GL1 postcode of Gloucester has the highest claimant rate (Job Seekers Allowance and Universal Credit) in Gloucestershire. https://inform.gloucestershire.gov.uk/media/2102589/unemployment-bulletin-147-oct-20.pdf and https://inform.gloucestershire.gov.uk/media/2103578/unemployment-bulletin-148-nov-20.pdf

The Fit for the Future consultation survey collects top level postcode information (first part of the postcode e.g. GL16 or GL3) to avoid potential for identifying individual survey respondents.

The online appendices provide a report of the responses from all survey respondents, who completed the 'About You' questions in the survey, who stated they lived in the GL1 postcode area and who lived in GL1, GL2, GL4, GL50, GL51 and GL14.

2.8.1 Updated Integrated Impact Analysis post consultation

The independent Integrated Impact Assessment has been updated following the consultation taking into account consultation feedback and recommendations made. This is described in detail at Section 5.2 of the FFTF Decision Making Business Case - extract below:

> ***Post Consultation feedback***
>
> *Overall feedback from the consultation was very positive, with the majority of respondents supporting the proposed changes. Feedback from the consultation identified some overall themes;*
>
> ***Quality of care** and reduced cancellations and waiting times were perceived to be the benefits of the proposed changes from consultation feedback. These were often the reasons for the high percentage of respondents supporting the changes. Many respondents reported the rational for the changes were clear.*
>
> ***Travel** was identified as theme, particularly for those over 65, those with disabilities and carers. Respondents were concerned about the travel times to the hospital sites from where they live and traffic across the county. Feedback also identified concerns regarding the travel between sites and if public transport is sufficient.*
>
> *Those with disabilities and those over 65 and those with long term conditions identified concerns regarding **transfers** between hospital sites and wards during treatment. This cohort also identified concerns around patients who are very unwell requiring transfer for emergency treatment. This was highlighted in regards to elective colorectal centralisation and Emergency general surgery centralisation to*

Gloucestershire Royal Hospital. Some feedback questioned if high risk procedures should be carried out where emergency general surgery is centralised.

***Parking** was identified as an issue for patients, particularly at Cheltenham Hospital, which could become exacerbated by centralisation of elective work.*

***Capacity** was questioned by respondents. Many questioning if the hospitals can cope with the increased demand brought about by centralising services.*

***Both sites** acting as centres of excellence, was a suggestion by many respondents who felt that the county was too large to have one centre of excellence located at one site. Some raised concerns regarding the growing population. Whereas, others felt that the centralising of services would optimise care quality, increased staff retention and learning for staff which would result in reduced waiting times and cancellations.*

***Community Hospitals** were mentioned within feedback, questioning how they will interact with the new models of care.*

Many felt that this could also be a good opportunity to modernise areas within the sites as part of this proposal.

***Subsidised Transport** could be explored as many respondents fed back on the cost of transport between hospital sites and home.*

*Request to increase **Homeless Outreach**, particularly in Cheltenham. Feedback from the Homelessness Forum and Housing and Support Forum identified that those who are homeless or rough sleeping do not tend to travel outside of their immediate area and so travelling further for medical care may be difficult.*

*Many respondents commented that centralising services would support **staff retention** and encourage recruitment.*

Some respondents had questions regarding the inpatient care at Gloucester Royal Hospital for Gastroenterology patients. This is also the case in relation to how the spilt of trauma and orthopaedics looks in practice.

***Care Quality** was viewed as a benefit by many respondents who felt centralising services would optimise care. Some commented that they were happy to travel for optimised care or that location was less important compared to quality.*

2.9 District/Borough Council Member Seminars

Representatives from One Gloucestershire NHS partners attended a series of District/Borough Council Member Seminars. Discussions were on the following themes:

Centres of Excellence approach

- Impact of centralisation of services on patient access and choice
- Impact of proposals on planned operations being cancelled in future
- Centres of Excellence – positive separation of planned and urgent care, potential to reduce reliance on private sector for planned procedures
- Centralisation: NHS benefits (efficiency) balanced against impact on the public (social costs)
- Ambulances need to know which hospital to bring patients to
- Hospitals are only one part of the patient journey, they need to work in partnership with community and primary care and the voluntary sector
- One Gloucestershire borders many counties and Wales, consider cross-border flow of patients

Cheltenham General Hospital A&E Department

- Confirmation requested regarding A&E arrangements a Cheltenham General Hospital reverting to pre-Covid service and clarification of what the pre-Covid arrangements were.
- Covid temporary changes – challenges with Ambulance delayed at Gloucestershire Royal Hospital (GRH) and capacity at GRH.

Communications

- Patients understanding of which services are provided at each hospital now and in the future
- Communications and Public Relations more innovation needed to meet diverse communities' requirements
- The public need to know which services are available, where and at what times of the day and night
- Level of Clinical support for the proposals

Sustainability/Estates

- How hospitals keep up to date with new developments/treatments
- The plans for increasing 7 day working
- Consideration should be given to building one new Acute General Hospital for Gloucestershire – more efficient

Transport/Access/Rurality

- Centralising services results in longer travel times for patients and visitors
- Rural transport infrastructure poor in county
- Ambulance response times in rural areas of the county

2.10 Consultation events activity timeline

Week	Activity	Number engaged with	Protected Characteristic (where applicable)
22 –28 October	Health Overview and Scrutiny Committee (HOSC)	15	
	Stroke Zoom Café	5	Disability
	Get Involved in Gloucestershire (GIG) with Gloucestershire Hospitals NHS Foundation Trust (GHT) Governors	6	
29 October – 4 November	Tewkesbury Know Your Patch (KYP)	13	Multi Voluntary Community Sector (VCS)
	Information bus – Cheltenham, High Street	55	
	Information bus – Cinderford, Co-Op (Forest of Dean)	22	
	Information bus – Gloucester, Quays	37	
	Stroud and Berkeley Vale Patient Participation Group (PPG)	16	
	Acute Medicine Clinical Q&A YouTube Live	15	
	GIG with GHT Governors	6	
	GHT Carers focus group	15	Carers
	Gloucester Homeless Forum (professionals/VCS)	30	Homeless
	GHT Youth Group	18	Age, young adults
	Primary Care Network (PCN) Clinical Directors	16	Health Professionals
	Cotswolds KYP	27	Multi VCS
	Friendship Café	4	BAME
	GHT Staff drop ins and ward visits	134	Health Professionals
	GHT staff online discussion forum	4	Health Professionals
5 – 11 November	KYP Gloucester	38	Multi VCS
	PPG Network	25	

	Stroud and Berkeley Vale PPG	16	
	GHT staff online discussion forum	6	Health Professionals
	GHT Governors	15	
	Gloucestershire Live Gastroenterology Inpatient service (Facebook Live)	10,000 views Combined reach - 63,866	
12 – 18 November	Cuppa and Chat - Stroud (using Microsoft Teams)	2	
	Forest of Dean Locality Reference Group	13	
	Cuppa and Chat – Cotswolds (using Microsoft Teams)	3	
	HOSC	15	
	Forest of Dean Community Connectors/KYP	17	VCS organisations; housing associations
	BAME/Diverse communities Forum (VCS Alliance)	Online link sent	BAME
	KYP Stroud	49	Multi VCS
	Cheltenham Borough Council Members Seminar	21	
	Gloucestershire Live Acute Medicine (Facebook Live)	11,000 views Combined reach – 61,187	
	RNIB (SW Facebook group)	up to 2500 followers	Disability
	Macular society Gloucestershire meeting	9	Disability
	Gloucester diabetes support group	20	Disability
	Cancer Patient Reference Group	13	Disability
	Cuppa and Chat – Tewkesbury (using Zoom)	6	
19 – 25 November	Cuppa and Chat - Forest of Dean (using Zoom)	10	
	GHT reflections and experience group	15	
	Housing and Support Forum	24	Health Inequalities
	Gloucester City Council Members Seminar	14	

	Cuppa and Chat – Cheltenham (using Zoom)	7	
	Gloucestershire Live Trauma & Orthopaedics (Facebook Live)	6,000 views Combined reach – 23,789	
26 November – 2 December	Information bus - Chepstow	17	
	Alney Practice PPG	12	
	Cuppa and Chat – Gloucester (using Zoom)	7	
	BAME C19 Task and Finish Group	12 and information sent to full membership	BAME
	Forest of Dean District Council briefing	14	
	Acute Medicine Clinical Q&A Facebook Live	2,500 views Reach – 18,277	
	Gloucestershire Live General Surgery (Facebook Live)	6,500 views Combined reach – 16,000 (not on GHT Facebook page)	
3– 9 December	Tewkesbury Borough Council briefing	10	
	Information bus –Cheltenham, High Street	31	
	Information bus – Cheltenham, Tesco	12	
	Cuppa and Chat – Fit for the Future (using Zoom)	7	
	Information bus – Lydney, Newerne Street car park (Forest of Dean)	32	
	Gastroenterology Clinical Q&A Facebook Live	1,400 views Reach 3,099	
	Cuppa and Chat - Forest of Dean	2	
	Information bus – Gloucester, Quays	17	
	Information bus – Gloucester, Tesco St Oswald's Road	24	
	General Surgery Clinical Q&A Facebook Live	970 views Reach – 2,113	
	Information bus – Stroud, Tesco	25	
	Image Guided Interventional Surgery (IGIS) Clinical Q&A Facebook Live	1,400 views Reach – 3,072	
	Trauma & Orthopaedics Clinical Q&A Facebook Live	1,400 views Reach – 3,000	

	Information bus – Cirencester Market Place (Cotswolds)	37	
	Forest of Dean PCN	19	
	Information bus – Stow Market Place (Cotswolds)	58	
10 -17 December	Information bus – Tewkesbury, Spring Gardens car park	28	
	Cotswold District Council	11	
	Information bus - Coleford Clock Tower (Forest of Dean)	38	

2.11 **Post consultation activity timeline**

21 December 2020 – 3 January 2021	Preparation of Interim Output of Consultation Report
12 January 2021	Health Overview and Scrutiny Committee - Presentation of Interim Output of Consultation Report
14 January 2021	Gloucestershire Hospitals NHS Foundation Trust Board - Presentation of Interim Output of Consultation Report
21 January 2021	One Gloucestershire Integrated Care System Board - Presentation of Interim Output of Consultation Report
28 January 2021	NHS Gloucestershire Clinical Commissioning Group Governing Body - Presentation of Interim Output of Consultation Report
19-28 January 2021	Fit for the Future Citizens' Jury #2
4 February 2021	Gloucestershire Hospitals NHS Foundation Trust – Trust Leadership Team recommendations regarding aA 'centre of excellence' for Planned Lower GI (colorectal) general surgery
From w/c 1 February	Additional Information published https://www.onegloucestershire.net/wp-content/uploads/2021/02/FFTF2020-Additional-Information-002.pdf Deadline for further comments 25 February 2021.
2 March 2021	Health Overview and Scrutiny Committee – update on post consultation activity.

PART 2

3. Responses to the consultation

Feedback to the consultation was received in two main ways:

- Fit for the Future survey (Main and Easy Read) responses 713 Surveys received (Paper copies: 81 Fit for the Future Survey and 32 Fit For the Future Easy Read)
- Other correspondence/written responses

The qualitative feedback from completed surveys and correspondence has been grouped into a series of themes under the following headings (A to Z):

- Access
- Capacity
- Diversity
- Efficiency
- Environment
- Facilities
- Interdependency
- Integration (with primary and community services)
- Patient Experience / Staff Experience
- Pilot
- Quality
- Resources
- Transport
- Workforce

All written feedback received (redacted for personally identifiable information e.g. names) can be found in the online appendices.

3.1 Demographic information

Respondents to the Fit for the Future surveys (Main and Easy Read)

Demographic information about respondents was collected by the Fit for the Future surveys. Monitoring of equality data requires a two-stage process: data collection and analysis. Gathering good equality data supports legislative requirements in that it aids prevention of discrimination. This is why it is really important to provide an explanation that the process is worthwhile and necessary.

The Fit for the Future survey included the following statement:

> *About You: Completing the "About You" section [of the survey] is optional, but the information you give helps to show that people with a wide range of experiences and circumstances have been involved. Your support with this is really appreciated.*

The Fit for the Future Easy Read survey included the following statement:

> *About You: You don't have to fill in this information, but it will help us know that we have asked a lot of different people what they think about our ideas.*

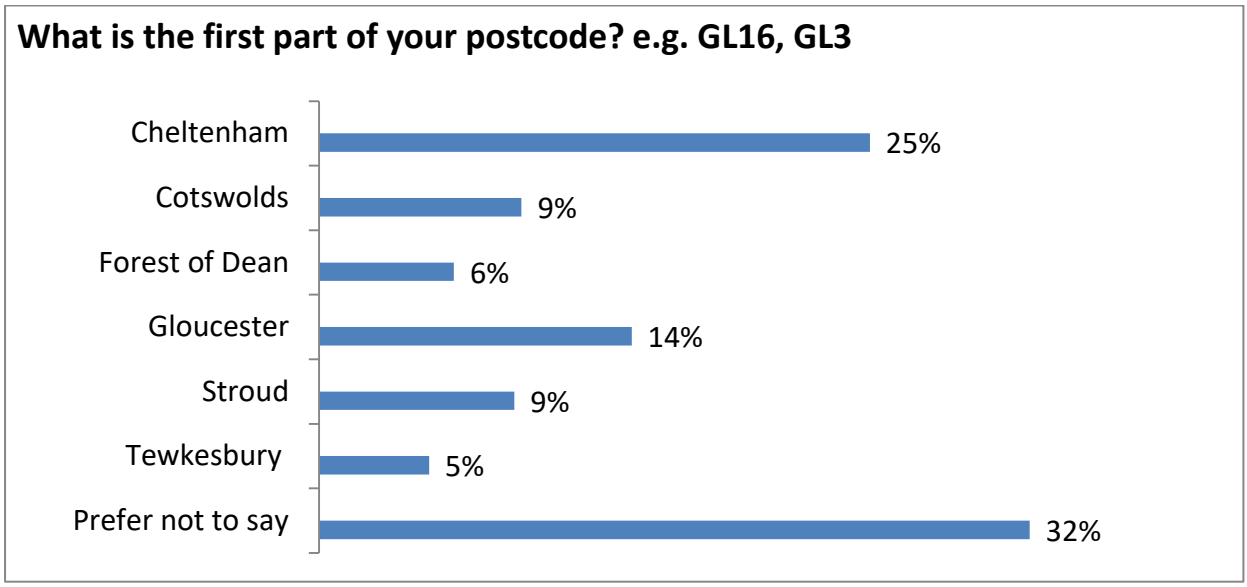
Not everyone who responded to the survey completed any/all of the demographic questions. However, the data presented below indicates that a diverse range of respondents from all protected characteristic groups, and those identified in the Independent Integrated Impact Assessment have provided feedback to the consultation.

Targeted activities aimed to extend the reach of the Consultation and collect data on all protected groups, as recommended in earlier Equality Impact Assessments. Analysis of the survey responses shows there is a broad representation of most groups. Initial analysis of responses by various demographics, e.g. age, gender, health and care professionals, does not show any significant variation compared with the overall themes. The independent Integrated Impact Assessment will be updated to take into account the response to consultation. The updated assessment will be included in the Decision Making Business Case, which will be available on the One Gloucestershire website.

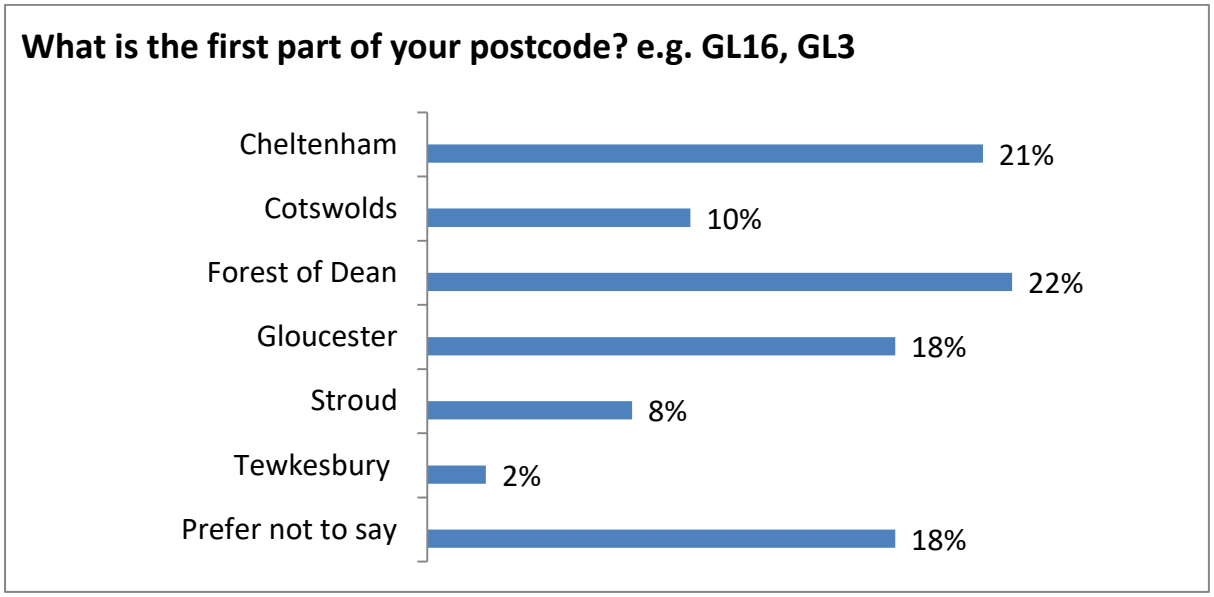
The level of support for each proposal from staff and public is included in the summary information below. Further information about targeted engagement with some of these groups can be found in Section 2.8.

Demographic Information about Fit for the Future surveys (Main and Easy Read) respondents

Fit for Future Survey



Fit for Future Survey Easy Read



Fit for the Future Survey

Which age group are you:			
		Response Percent	Response Total
1	Under 18	1.65%	8
2	18-25	2.06%	10
3	26-35	10.91%	53
4	36-45	12.35%	60
5	46-55	18.72%	91
6	56-65	22.22%	108
7	66-75	18.93%	92
8	Over 75	11.32%	55
9	Prefer not to say	1.85%	9
		answered	486
		skipped	138

Fit for the Future Survey Easy Read

Which age group are you:			
		Response Percent	Response Total
1	0 - 18	1.27%	1
2	18-25	1.27%	1
3	26-35	1.27%	1
4	36-45	3.80%	3
5	46-55	8.86%	7
6	56-65	20.25%	16
7	66-75	43.04%	34
8	75+	20.25%	16
9	Not saying	0.00%	0
		answered	79
		skipped	10

Fit for the Future Survey

Are you:				
			Response Percent	Response Total
1	A health or social care professional		29.57%	144
2	A community partner		1.64%	8
3	A member of the public		62.63%	305
4	Prefer not to say		6.16%	30
			answered	487
			skipped	137

Fit for the Future Survey Easy Read

Are you:				
			Response Percent	Response Total
1	Someone who works in health or social care		7.50%	6
2	A member of the public		88.75%	71
3	Not saying		3.75%	3
			answered	80
			skipped	9

Fit for the Future Survey

Do you consider yourself to have a disability? (Tick all that apply)			
		Response Percent	Response Total
1	No	72.16%	350
2	Mental health problem	4.54%	22
3	Visual Impairment	2.89%	14
4	Learning difficulties	0.41%	2
5	Hearing impairment	5.36%	26
6	Long term condition	17.32%	84
7	Physical disability	4.74%	23
8	Prefer not to say	3.09%	15
		answered	485
		skipped	139

Fit for the Future Survey Easy Read

Do you have a disability - tick the ones that describe you.			
		Response Percent	Response Total
1	No	50.00%	37
2	Mental health problem	9.46%	7
3	Problems with your sight	9.46%	7
4	Learning difficulties	4.05%	3
5	Problems with your hearing	14.86%	11
6	A health problem you have had for a long time like asthma, diabetes, or something else	36.49%	27
7	Physical disability	8.11%	6
8	Not saying	1.35%	1
		answered	74
		skipped	15

Fit for the Future Survey

Do you look after, or give any help or support to family members, friends, neighbours or others because of either a long term physical or mental ill health need or problems related to old age? Please do not count anything you do as part of your paid employment.			Response Percent	Response Total
1	Yes		28.30%	135
2	No		67.51%	322
3	Prefer not to say		4.19%	20
			answered	477
			skipped	147

Fit for the Future Survey Easy Read

Do you look after, or give any help and support that you don't get paid for, to other people because they are ill or older?			Response Percent	Response Total
1	No, I don't		75.68%	56
2	Yes, I do		22.97%	17
3	Not saying		1.35%	1
			answered	74
			skipped	15

Fit for the Future Survey

Which best describes your ethnicity?			
		Response Percent	Response Total
1	White British	84.71%	410
2	White Other	3.72%	18
3	Asian or Asian British	2.48%	12
4	Black or Black British	0.62%	3
5	Chinese	0.00%	0
6	Mixed	0.62%	3
7	Prefer not to say	7.23%	35
8	Other (please specify):	0.62%	3
		answered	484
		skipped	140

Other (please specify): (3)

1	Why is this relevant to the survey
2	European
3	White English

Fit for the Future Survey Easy Read

Please can you tell us which of the groups in our list best describes you? This is called ethnicity.			
		Response Percent	Response Total
1	White British	93.59%	73
2	White Other	1.28%	1
3	Asian or Asian British	1.28%	1
4	Black or Black British	0.00%	0
5	Chinese	0.00%	0
6	Mixed	1.28%	1
7	Not saying	2.56%	2
		answered	78
		skipped	11

Fit for the Future Survey

Which, if any, of the following best describes your religion or belief?				
			Response Percent	Response Total
1	No religion		39.38%	191
2	Buddhist		0.41%	2
3	Christian (including Church of England, Catholic, Methodist and other denominations)		48.04%	233
4	Hindu		0.41%	2
5	Jewish		0.41%	2
6	Muslim		1.65%	8
7	Sikh		0.00%	0
8	Other		1.44%	7
9	Prefer not to say		8.25%	40
			answered	485
			skipped	139

Fit for the Future Survey Easy Read

Please tick if you have any of these religions or beliefs				
			Response Percent	Response Total
1	None		19.74%	15
2	Buddhist		0.00%	0
3	Christian		71.05%	54
4	Hindu		0.00%	0
5	Jewish		0.00%	0
6	Muslim		0.00%	0
7	Sikh		0.00%	0
8	Other		1.32%	1
9	Not saying		7.89%	6
			answered	76
			skipped	13

Fit for the Future Survey

Are you:				
			Response Percent	Response Total
1	Male		38.76%	188
2	Female		54.64%	265
3	Transgender		0.21%	1
4	Prefer not to say		6.39%	31
			answered	485
			skipped	139

Fit for the Future Survey Easy Read

Can you say about your gender? Tick the one that describes you.				
			Response Percent	Response Total
1	Male		49.37%	39
2	Female		48.10%	38
3	Transgender		0.00%	0
4	Non-binary		1.27%	1
5	Not saying		1.27%	1
			answered	79
			skipped	10

Fit for the Future Survey

Do you identify with your gender as registered at birth?			
		Response Percent	Response Total
1	Yes	93.81%	455
2	No	0.00%	0
3	Prefer not to say	6.19%	30
		answered	485
		skipped	139

Fit for the Future Survey Easy Read

Are you the same gender you were born with?			
		Response Percent	Response Total
1	Yes	94.74%	72
2	No	2.63%	2
3	Not saying	2.63%	2
		answered	76
		skipped	13

Fit for the Future Survey

Which of the following best describes how you think of yourself?			
		Response Percent	Response Total
1	Heterosexual or straight	86.21%	419
2	Gay or lesbian	1.85%	9
3	Bisexual	1.65%	8
4	Other	0.21%	1
5	Prefer not to say	10.08%	49
		answered	486
		skipped	138

Fit for the Future Survey Easy Read

Can you say how you think of yourself?			
		Response Percent	Response Total
1	Heterosexual or straight	90.79%	69
2	Gay or lesbian	1.32%	1
3	Bisexual	1.32%	1
4	Other	0.00%	0
5	Not saying	6.58%	5
		answered	76
		skipped	13

Fit for the Future Survey

Are you currently pregnant or have given birth in the last year?			
		Response Percent	Response Total
1	Yes	1.46%	7
2	No	68.75%	330
3	Not applicable	24.17%	116
4	Prefer not to say	5.63%	27
		answered	480
		skipped	144

Fit for the Future Survey Easy Read

Are you pregnant or had a baby in the last year?			
		Response Percent	Response Total
1	Yes	0.00%	0
2	No	52.56%	41
3	Not saying	1.28%	1
4	This question doesn't apply to me	46.15%	36
		answered	78
		skipped	11

4. Survey Feedback

This section sets out the survey feedback received about each of the specialist services (Acute Medicine, Gastroenterology inpatient services, General Surgery (emergency general surgery, planned Lower Gastrointestinal [GI] / colorectal surgery and day case Upper and Lower GI surgery), Image Guided Interventional Surgery (IGIS) including Vascular Surgery, and Trauma and Orthopaedics (T&O) inpatient services).

The Fit for the Future survey included two types of questions:

- **Quantitative** questions, which offer a choice for the respondent e.g.

  Acute Medicine (Acute Medical Take)
  Please tell us what you think about our preferred option to develop: A 'centre of excellence' for Acute Medicine (Acute Medical Take) at Gloucestershire Royal Hospital.
    - *Strongly support*
    - *Support*
    - *Oppose*
    - *Strongly oppose*
    - *No opinion*
- and **Qualitative** questions which invite the respondent to write a comment

  Please tell us why you think this, e.g. the information you would like us to consider:

As mentioned previously, the qualitative feedback from completed surveys and correspondence has been grouped into themes under the following headings (A to Z):

- Access
- Capacity
- Diversity
- Efficiency
- Environment
- Facilities
- Integration (with primary and community services)
- Interdependency
- Patient Experience / Staff Experience
- Pilot
- Quality
- Resources
- Transport
- Workforce

In this report, illustrative quotations have been selected from the free-text responses from the survey for each of the proposals and other correspondence received. All free text

responses and other correspondence can be found in the online appendices at: https://www.onegloucestershire.net/yoursay/fit-for-the-future-developing-specialist-hospital-services-in-gloucestershire/

4.1 Acute Medicine (Acute Medical Take)

Preferred option to develop: A 'centre of excellence' for Acute Medicine (Acute Medical Take) at Gloucestershire Royal Hospital.

- 67.61% (Easy read: 72.09%) of all survey respondents either **strongly supported** or **supported** the proposal
- 24.83% (Easy read: 18.6%) of survey respondents either **strongly opposed** or **opposed** the proposal
- 7.55% (Easy Read: 9.3%) of survey respondents had **no opinion**

- 72.03% of staff respondents either **strongly supported** or **supported** the proposal
- 66.23% of respondents excluding staff either **strongly supported** or **supported** the proposal

Fit for the Future Survey

Please tell us what you think about our preferred option to develop: A 'centre of excellence' for Acute Medicine (Acute Medical Take) at Gloucestershire Royal Hospital.			Response Percent	Response Total
1	Strongly support		36.07%	215
2	Support		31.54%	188
3	Oppose		11.24%	67
4	Strongly oppose		13.59%	81
5	No opinion		7.55%	45
			answered	596
			skipped	28

Fit for the Future Survey Easy Read

What do you think about having the service for Acute Medicine (Acute Medical Take) at Gloucestershire Royal Hospital? Acute medicine is treatment and assessment for things like very bad headaches, chest pain, pneumonia or asthma			Response Percent	Response Total
1	Good idea		72.09%	62
2	Bad idea		18.60%	16
3	Not sure		9.30%	8
			answered	86
			skipped	3

Qualitative Themes: Acute Medicine (Acute Medical Take)

The following quotes are from survey responses either supporting or opposing the preferred option.
The quotes included below are illustrative of key themes in the feedback received regarding Acute Medicine:

Themes in the responses to the proposal relating to Acute Medicine are (A-Z):
Access; Capacity; Efficiency; Interdependency; Patient Experience; Quality; Resources; Transport; and Workforce.

Acute Medicine (Acute Medical Take)

Preferred option to develop: A 'centre of excellence' for Acute Medicine (Acute Medical Take) at Gloucestershire Royal Hospital.

- 67.61% (Easy read: 72.09%) of survey respondents either **strongly supported** or **supported** the proposal
- 24.83% (Easy read: 18.6%) of survey respondents either **strongly opposed** or **opposed** the proposal
- 7.55% (Easy Read: 9.3%) of survey respondents had **no opinion**

Supporting the proposal	Opposing the proposal
It's a rational use of limited resources. Concentration of specialist people, and specialist kit, absolutely makes sense, and research shows that it produces better outcomes. [Quality, Resources, Workforce]	*I do not think that Gloucester Royal Hospital will cope with all the acute services that you wish to base there. They cannot cope with the influx of patients at the moment particularly at night. These plans do not improve patient experience they merely allow the trust to attempt to save money* [Capacity, Resources, Patient Experience]
Creating CoEs across the county will inevitably create a good deal more traversing of the county for patients. I can empathise with the desire to make best use of resources. [Access,	*Damaging effect on the local community, as it disproportionately affects vulnerable individuals with protected characteristics. Concerns about bed space at GRH. Concerns about a bottleneck effect at GRH - if you double the amount of traffic, you need to double the width of the road, ALL roads,*

Resources]	*leading in and out. Leading on to concerns about the lack of funding for SWAS [Ambulance Service] as per their financial outlook to provide the additional ambulance service coverage. Flawed notion of attracting high quality staff from a business/management perspective. Gloucestershire's market has competitors in Bristol, Birmingham (to an extent), Oxford, and of course London. Centralised services will not enable GHNHSFT to outcompete these, leaving us with 'the best of the rest'. This would have been the case whether centralisation occurred or not, thus centralisation itself is a moot point. Flawed concept of 'extra time' to care. This will inevitably lead to cost savings (perhaps instructed by ministers, and not immediately) by reducing staff numbers to provide current levels of care, only now at one site. [Capacity, Transport / Access, Staff/Resources]*
Having a centre of excellence for acute medicine at GRH makes a lot of sense, but it is important to reflect on what centre of excellence might be appropriate for CGH, perhaps chronic or ongoing care? I think it is very important to ensure that CGH is not appear to be downgraded and is valued as a site for quality care provision.[Quality]	*Cheltenham and surrounding villages and other small towns in Gloucestershire deserve to have their own "Acute Medical Take" at CGH. Travelling is difficult enough in Gloucestershire and Gloucester Royal Hospital has very inadequate and expensive parking. This is a very busy tourist town with many festivals bringing thousands of people to the town and it is a very poor decision to only have a centre of excellence in Gloucester. We need our own A & E and also our own Acute Medical Take I am not opposed to Gloucester having its own centre but both places should be treated the same. Gloucester is a very large county stretching from the borders of Wales to the edge of Oxfordshire and Worcestershire.* [Transport / Access]
Makes absolute sense to have a Centre of excellence. Paramedics and GP's will know where to take and send	*I believe CGH should offer equal services to GRH and not all resources*

associated patients rather than pot luck between two options. [Efficiency, Quality]	*diverted to Gloucester.* [Access]
I agree with this ONLY if the A&E at Cheltenham is maintained at the same level they were pre-COVID. [Access]	*The preferred option would mean that people living in the east of Gloucestershire would have to travel further for urgent medical care.* [Transport / Access]
All acute services including the ED and both takes should be on a single site (GRH) to allow for CGH to be developed into a major elective cancer surgery hub. [Quality]	*I think it should be split between the 2 hospitals so that you can go to the nearest hospital to where you live. I see no reason that both hospitals cannot have enough or share staff so that this can happen* [Transport / Access, Staff/Resources]
The idea of creating centres of excellence at both of the two excellent large hospitals in Gloucestershire makes sense. It is worth remembering that the other specialist inpatient services, which have already centralised at either CGH or GRH e.g. cancer services at CGH and children's services at GRH, are working really well for patients. [Interdependency]	*The provision for Emergency, consultant led 24/7 care on the East of the County is essential for best outcomes for the aging population given how overcrowded Glos A&E is. Therefore anything which doesn't re-provide the highest tier of A&E at CGH puts patients at more immediate risk of poor outcomes IMO.* [Quality and Capacity]
Centralisation of this speciality will ensure that the clinicians with the right skills are always available. It will reduce risks to the public and reduce the need for potential transfer either to another facility or out of county. [Quality]	*It worries me hugely that the town the size of Cheltenham already hasn't got 24/7 Consultant Led A&E services. This seems another plan to reduce this even further. I worry about increased time to get emergency help for my children and elderly parents by having to travel to another town.* [Quality, Transport / Access]

Having centres of excellence is ideal providing it does reduce waiting time, and ensures operations are not cancelled. All expertise in one place so if second opinion is needed there is someone to consult immediately without the necessity of a follow up visit somewhere else. [Quality]	
After having experienced 'in patient ' services at both CGH and GRH on two separate occasions resulting from pneumonia. I would fully support the objective of developing a 'centre of excellence' at GRH. The disadvantage of extra travelling for Cheltenham residents is outweighed by the improved facilities, better use of and more focused staff. [Quality]	
Presume staffing a single acute centre is easier than two, making the care it can provide more consistent and 'guaranteed'. Only reason my response is 'Support' and not 'Strongly Support' is the extra 10 miles I would need to travel. [Quality, Transport/Access]	
I believe that there must be economies of scale in forming specialist centres. One whole is more beneficial than two halves in this case. This should mean savings in the cost of staff, equipment, spares and consumables, after an initial cost to physically create the unit. Some may get emotional about losing a service in 'their' area, but as a relative newcomer to the area, the hospitals are physically so close together, with good transport links between the two, I would consider the benefits to	

outweigh this. [Staff/Resources]	
With stretched specialised NHS resources concentrating particular but different Specialists at each hospital makes sense. I am also reassured that A&E will remain at Cheltenham hospital as we live in Bourton-on-the-Water so need to be confident that the closeness of A&E in Cheltenham in an emergency provides a much better chance of survival rather than going all the way to far side of Gloucester from here. [Transport/Access]	

Neutral and other correspondence examples

Neutral

A centre of excellence is a title conferred on a centre by other institutions and is not something you can simply decide to be. Aspiration to excellence is essential but not if this is considered zero sum - i.e. we can aspire to be a centre of excellence in A and therefore B will not be excellent. Also there are currently services which are already considered excellent: does the Trust know what these are and do the various plans consider that aspiring to excellence in one domain might strip and already considered excellent service of its status?

REACH survey

"It is hard to imagine a General Hospital without acute medical beds. Cheltenham is a General Hospital, it needs to supply beds for both surgical and medical patients. Removing medical beds from Cheltenham is essentially downgrading this hospital and masking it less important, like asset stripping!"

It is admirable to want to keep all your experts on one site. However, I fear the sheer numbers of people needing to be seen at any one venue are not practicable. Better, surely to see people at two sites, meaning they can be treated in half the time. If in a critical condition, then surely any extra waiting time endangers the patient. That includes transit time.

International evidence shows centres of excellence provide better care for patients. It also helps to recruit the best people to work there. If you have a serious heart attack in Gloucestershire at present you may be diverted to Bristol as this is where the best treatment is available. What is

wrong with wanting that here in Gloucester."

Other correspondence

Centralisation of the acute medical service onto a single site at Gloucestershire Royal Hospital (GRH) will place very significant pressure on bed availability, even with the planned expansion of the acute admissions unit at GRH.
For any acute medical centralisation to be successful, the Trust must make every effort to transfer elective activity to CGH.

Given the close links set out in the consultation document between the Emergency Departments and the acute medical beds, and if Cheltenham A&E is indeed to reopen, there seems an obvious risk of this proposal … failing the test of the criteria of transfer of patients between sites and travel times and risk which will inevitably be higher if an acutely ill patient has to be transferred between Cheltenham ED to an acute medical bed in Gloucester to be admitted.

…any proposal under Fit for the Future regarding acute medicine must ensure adequate twenty four hour provision of emergency medical care to support the inpatient population in Cheltenham as well as the ED on the east side of the county… …Whilst REACH would prefer to see the option of a continuing acute medical take at Cheltenham, REACH recognises the need for future resilience planning to allow local healthcare to continue in case of any future pandemic or health emergency.

I feel that emergency care should be predominantly at GRH and planned day cases should mainly take place at CGH. This would in my opinion make the best use of resources including staff as well as equipment.

The only useful comments I can make relate to Cheltenham where we live. I therefore have of course a natural predilection to use a Cheltenham hospital in preference to one in Gloucester for any purpose…especially emergency treatment.

4.2 General Surgery (emergency general surgery, planned Lower Gastrointestinal [GI] / colorectal surgery and day case Upper and Lower GI surgery)

4.2.1 Emergency General Surgery

Preferred option to develop: to develop: A 'centre of excellence' for Emergency General Surgery at Gloucestershire Royal Hospital.

- 68.31% (Easy read: 66.67%) of all survey respondents either **strongly supported** or **supported** the proposal
- 23.44% (Easy read: 22.99%) of survey respondents either **strongly opposed** or **opposed** the proposal
- 8.24% (Easy Read: 10.34%) of survey respondents had **no opinion**

- 77.62% of staff respondents either **strongly supported** or **supported** the proposal
- 65.01% of respondents excluding staff either **strongly supported** or **supported** the proposal

Emergency General Surgery

Fit for the Future Survey

Please tell us what you think about our preferred option to develop: A 'centre of excellence' for Emergency General Surgery at Gloucestershire Royal Hospital.			Response Percent	Response Total
1	Strongly support		35.71%	195
2	Support		32.60%	178
3	Oppose		10.62%	58
4	Strongly oppose		12.82%	70
5	No opinion		8.24%	45
			answered	546
			skipped	78

Fit for the Future Survey Easy Read

What do you think about having the service for Emergency General Surgery at Gloucestershire Royal Hospital? These are emergency operations on the gut which is where you digest food			Response Percent	Response Total
1	Good idea		66.67%	58
2	Bad idea		22.99%	20
3	Not sure		10.34%	9
			answered	87
			skipped	2

Qualitative Themes: Emergency General Surgery

The following quotes are from survey responses either supporting or opposing the proposal. The quotes included below are illustrative of key themes in the feedback received regarding Emergency General Surgery services. Themes in the responses to the proposal relating to Emergency General are (A-Z): Access; Capacity; Efficiency; Interdependency; Patient Experience; Quality; Resources; Transport; Workforce

Emergency General Surgery

Preferred option to develop: Preferred option to develop: to develop: A 'centre of excellence' for Emergency General Surgery at Gloucestershire Royal Hospital.

- 68.31% (Easy read: 66.67%) of survey respondents either **strongly supported** or **supported** the proposal
- 23.44% (Easy read: 22.99%) of survey respondents either **strongly opposed** or **opposed** the proposal
- 8.24% (Easy Read: 10.34%) of survey respondents had **no opinion**

Supporting the proposal	Opposing the proposal
It [Gloucestershire Royal Hospital] *is bigger hospital and easy for access (not confusing as opposed to CGH which is a maze and patients are constantly lost).* [Access, Patient Experience]	*This would further reduce/support the case for reducing the provision of the highest tier of A&E at CGH (East) so should not be considered*. [Access]
If acute care services are to be centred at GRH it makes sense for the emergency general surgery to also be at GRH to avoid transfers of very sick patients. [Interdependency]	*There needs to be more than one centre as GRH may be unavailable through a disaster, infection or overloading. Currently GRH A&E is too busy.* [Capacity]
This is important BUT is not and should not be seen as mutually exclusive to a centre of excellence in pelvic resection. [Interdependency]	*There should be surgery facilities at both sites, and both should be "excellent". Transferring emergency patients to GRH wastes precious time and could risk lives.* [Quality]

Skilled teams can provide care needed People may have to travel, but for a good outcome it is worth it. [Access/Travel, Quality]	*According to the Royal College of Surgeons "Patients requiring emergency surgical assessment or treatment are among the most unwell patients in the NHS. Often elderly, frail and with significant other health problems, the risk of death or serious complication is unacceptably high." This means the increasing unacceptable the risk to patients of making them travel from east of Cheltenham travel through the town and a further 10 miles to GRH.* [Quality, Access]
More efficient use of staff. The more surgeries completed the better the surgeons become and so patient outcomes should improve. [Efficiency, Quality]	*Cheltenham is a General hospital and should have surgical beds, including emergency surgery. What sort of hospital would Cheltenham become if medical patients and surgical emergencies were transferred to GRH. This is exercise is about downgrading Cheltenham, which currently has the facilities to offer high quality care. This will have an impact on the A&E department, essentially turning it into a minor injuries unit.* [Quality]
It is a good idea, except… that as we are on the edge of the county Gloucestershire is further away. [Access]	*Many people from Cheltenham and North Gloucestershire would die on the way to Gloucester Royal. The traffic at many times of the day is appalling in Gloucester. You seem to be considering Cheltenham as a small village when in fact it has a population of 112,700. When you include the Cotswolds it rises to 196,300. With the regular increases of population throughout the year this should surely make a difference to your decision.* [Quality, Access/Transport]
Better to have emergency care in one place with a full team of experts. Planned surgery can then take place at Cheltenham. [Quality]	*Having all your 'specialist' staff in one area may be better and more cost effective for you but as always it's the patients who suffer. Traveling to and from Gloucester is not easy for those without their own transport. Even if the patient is transported to Gloucester by ambulance, once discharged they*

	have still got to find their own way home, probably still feeling very unwell. They may not have friends with a car or have sufficient funds to cover the cost of a taxi, which leaves the bus, if it is running and if it is not full - not very good for infection control following surgery. There is also historically a poor reputation for infection control at GRH. I would not feel confident going there for anything serious. [Access/Transport, Quality]
To centralise services, staff, expertise and equipment at one site. If this ensures that planned surgery is protected and not impacted by emergencies, then I would strongly support this option. [Efficiency, Quality]	*The key word is Emergency. All emergencies should be treated as close as possible to the point at which the emergency was recognised. Unnecessary travel is best avoided and may introduce stress to the detriment of the patient.* [Access/Transport, Quality]
Improve patient outcomes, centralised care with specialists available to review patients as all based at Gloucester. Staff morale and retention. Improve care of patients including access to SAU and patient flow. Reduce cancellation of specific surgical procedures. Improve quality of care provided. [Quality, Workforce]	*The current system, with surgery at both hospitals, is better for anyone who: has money issues lacks transport has complex needs of any type I understand the desire to group services together for the NHS' logistical sake, but for anyone who struggles, in any way, being themselves in another town or having their loved ones in another town creates complications and unhappiness as mentioned in my previous answer. By doing this, you prioritise those with money, time and head space to cope with these extra complications, and disadvantage anyone who struggles in any way.* [Access/Transport, Resources]
If emergency treatment is performed at one hospital, GRH, it leaves planned surgery at the other, CGH, not liable to interruption for emergency surgery. [Quality]	*As with all your proposals to centralise services the problem is that of access for patients and their families. Whilst many have access to private transport a very large minority do not and they are frequently the elderly and less*

	financially secure. For these people centralisation poses a major difficulty in accessing your services unless you propose to offer free transport between the sites. Even for those with private transport difficulties in accessing parking at either site pose difficulties and high costs. [Access/Transport]
A centre of excellence is essential and you shouldn't spread your resources. The hospitals are close enough that no areas should be disadvantaged. [Access/Transport, Resources, Quality]	
Specialisation usually leads to higher quality service and the attraction of most able doctors. [Quality, Workforce]	

Neutral and other correspondence examples

REACH SURVEY

So, essentially work that was performed at 2 sites is now all going to be at GRH alone. Does that mean staffing is still the same as if catering for the needs of 2 hospitals but just at GRH or more likely the poor sods at GRH will be doing double the work they originally would have done. Whilst houses continue to be built and the population continue to expand. This is cost cutting surely whilst stretching I presume an already stretched workforce.

Centralising may be easier for people delivering the service, but means patients nearly always have to travel greater distances. This can mean extreme discomfort for some, me included, but a lot more stress for patients…

This will allow a fully staffed surgical team to manage these patients. They should not have to wait to be seen until a doctor can leave the operating theatre.

Other correspondence

Centralisation of emergency general surgery and the acute medical onto a single site at GRH may increase bed pressure in that unit. If centralisation proceeds for emergency general surgery at GRH it is vital that all elective activity is centralised at CGH, so that elective patients can be treated without disruption from emergency bed pressures or indeed future pandemics.

It seems to me that option C3 – centralising emergency general surgery in Gloucester – can accord with good practice but if and only if it is combined with Option C5 and C11 to centralise planner lower GI surgery and day case general surgery at Cheltenham.

I feel that we should establish a General Surgery Centre of Excellence at GRH with centralised Emergency General Surgery alongside centralised planned Upper GI service and newly centralised planned Lower GI Service. Planned day case for both upper and lower GI surgery to be centralised at CGH.

4.2.2 (i) Planned Lower GI (colorectal) surgery

Preferred option to develop: to develop: A 'centre of excellence' for Planned Lower GI (colorectal) general surgery at Cheltenham General Hospital (CGH) or Gloucestershire Royal Hospital (GRH).

- 79.1% (Easy read: 72.84%) of all survey respondents either **strongly supported** or **supported** the proposal
- 7.83% (Easy read: 20.27%) of survey respondents either **strongly opposed** or **opposed** the proposal
- 13.06% (Easy Read: 12.35%) of survey respondents had **no opinion**

- 85.31% of staff respondents either **strongly supported** or **supported** the proposal
- 76.84% respondents excluding staff either **strongly supported** or **supported** the proposal

Planned Lower GI (colorectal) surgery

Fit for the Future Survey

Please tell us what you think about our preferred option to develop: A 'centre of excellence' for Planned Lower GI (colorectal) general surgery at Cheltenham General Hospital (CGH) or Gloucestershire Royal Hospital (GRH).			Response Percent	Response Total
1	Strongly support		44.59%	239
2	Support		34.51%	185
3	Oppose		4.66%	25
4	Strongly oppose		3.17%	17
5	No opinion		13.06%	70
			answered	536
			skipped	88

Fit for the Future Survey Easy Read

What do you think about having the planned Lower GI (Colorectal) General Surgery in one hospital? These are planned, not emergency, operations on the lower part of the gut.			Response Percent	Response Total
1	Good idea		72.84%	59
2	Bad idea		14.81%	12
3	Not sure		12.35%	10
			answered	81
			skipped	8

4.2.2 (ii) Planned Lower GI: Location

Fit for the Future Survey

In supporting our preferred option to create a single site 'centre of excellence', where do you think a 'centre of excellence' for Planned Lower GI (colorectal) general surgery should be developed?			Response Percent	Response Total
1	Cheltenham General Hospital (CGH)		50.76%	268
2	Gloucestershire Royal Hospital (GRH)		20.27%	107
3	No opinion		30.30%	160
			answered	528
			skipped	96

Fit for the Future Survey Easy Read

Where do you think we should do planned Lower GI (Colorectal) General Surgery? These are planned, not emergency, operations on the lower part of the gut.			Response Percent	Response Total
1	Cheltenham General Hospital		27.50%	22
2	Gloucestershire Royal Hospital		27.50%	22
3	Don't mind		45.00%	36
			answered	80
			skipped	9

Qualitative Themes: Planned Lower GI (colorectal) Surgery

The following quotes are from survey responses either supporting or opposing the proposal. The quotes included below are illustrative of key themes in the feedback received regarding Planned Lower GI (colorectal) Surgery. Themes in the responses to the proposal relating to Planned Lower GI (colorectal) Surgery are (A-Z): Access; Capacity; Efficiency; Facilities; Interdependency; Patient Experience; Quality; Resources; Transport and Workforce.

Planned Lower GI (colorectal) Surgery

Preferred option to develop: A 'centre of excellence' for Planned Lower GI (colorectal) general surgery at Cheltenham General Hospital (CGH) or Gloucestershire Royal Hospital (GRH).

- 79.1% (Easy read: 72.84%) of survey respondents either **strongly supported** or **supported** the proposal
- 7.83% (Easy read: 20.27%) of survey respondents either **strongly opposed** or **opposed** the proposal
- 13.06% (Easy Read: 30.30%) of survey respondents had **no opinion**

Supporting the proposal	Opposing the proposal
Based on my support for emergency care at Gloucester, presumably it would make room at Cheltenham for this area of non-urgent operations. [Capacity, Facilities]	*You should be able to go to nearest hospital for treatment, staff should be split between the 2 hospitals if necessary so this can be done.* [Access]
Good to have a centre of excellence. Attracts staff and makes good effective use of both equipment and staff. [Workforce, Efficiency]	*Lower GI surgical provision impacts on other surgical specialties including gynae oncology. Gynaecology is linked to Obstetrics, an acute specialty based in Gloucester. Acute gynaecology, including acute gynae oncology admissions, is based in Gloucester hospital. It is not possible to move this acute provision as the registrars cross cover Gynaecology and Obstetrics when on shifts. Moving gynae oncology with Lower GI to Gloucester would provide better training and ward safety for patients*.[Interdependency]

Please bear in mind any treatments taken prior to appointments which may make a long journey very difficult. [Patient Experience]	*It is easier for elderly, disabled, and very sick people to travel to their nearest hospital. Some of the people in this category will not be able to either drive themselves or travel on public transport. An unfamiliar environment may be distressing for them, and it may be more difficult for their families to visit if they are further away. Therefore, all procedures should be available in all hospitals, not in one centre.* [Access/Transport]
I have had fantastic service and a colorectal resection at GRH. This started with the Bowel Cancer Screening at Stroud Hospital, and two operations at GRH, with follow up care. The care and dedication of all the staff at GRH has been exemplary, and I am so grateful to them! Of course if CGH was chosen, as long as the staff moved also, then the service would be just as excellent. A slight fear I have that when I think merge and provide an ever better service', the accountants hear 'merge, provide the same service, and cut costs'. The latter really would be a betrayal of trust. [Quality, Patient Experience, Resources]	*Unless there is a shortage of staff with the correct expertise I do not see why a single centre of excellence in Gloucester is a fair option for Cheltonians. It's a long journey and a real challenge for elderly patients - visiting and collection of discharged patients becomes far more challenging especially for those restricted to public transport.* [Access/Transport, Staff, Resources]
Need to locate the planned specialties into CGH if emergency medicine and surgery are going to GRH. [Interdependency]	
Separating emergency from planned services should prevent cancellations and create the right number of beds for the planned procedures. Co-locating with other pelvic services makes sense as I suspect they often need to work together. [Patient Experience, Capacity, Interdependency]	
GRH surgical bedspace already limited; conversely beds	

available at CGH for increased surgical work. Transfer to all planned colorectal work to GRH would increase already high pressure on surgical bed availability. Centralising lower GI at CGH would make use of existing surgical cover and surgical nursing staff with less bed pressures than at GRH. Benefits to be had from concentrating all colorectal lists at a single site - CGH the obvious option as currently has less bed pressure than GRH but still has required surgical and nursing expertise. Gastroenterology already at CGH which would benefit those patients who need input from gastro medics whilst under care of Lower GI surgeons. [Capacity, Quality, Patient Experience)	
Gloucestershire Royal is the most modern of the two hospitals and parts of the Cheltenham Hospital are 200 years old and unsuitable for 21st century health care provision. The most recent blocks in College Road Cheltenham could be used to complement the services provided at the Gloucester base. [Facilities]	
Having experienced this service, I know that the present set-up works well. CGH is already a centre of excellence for cancer, colorectal surgery is integral to that service, it makes common sense to fully embed this at CGH. Further, I am aware that moving this service to GRH is not popular with staff and could result in the loss of crucial expertise. Staff retention is a critical issue at all times - conserve what you have. [Patient Experience,	

Workforce, Resources]	
Specialist staff in one place should mean collaboration in terms of quickly dealing with patient problems. Quick treatment/ diagnosis of Crohn's can reduce the need for surgery, less time off work and a better quality of life! [Workforce, Quality]	
Neutral and other correspondence examples	
Neutral *It has been mooted for some time, so that GRH would become the 'hot' hospital, while CGH would take 'cold surgery'. This seems to have been an accepted version of things to come, so it is no surprise, and for me, there is no good reason to oppose* *All planed surgery should be subject of a centre of excellence, at both hospitals, not just Lower GI* **REACH survey** *It would be sensible to have this service at CGH with gynaecological oncology.* *Whilst there may be a case for centralising at Cheltenham - certainly not at GRH - this could only be considered in the light of decisions made on other issues. There seems to me the danger of progressively demoting Cheltenham as a centre of excellence, but there has also to be regard to the needs of patients in the west of the county.* *After opposing centralisation for the first 2 at Gloucester and Cheltenham is my local hospital I can't agree for the people of Gloucester having the same problem of getting to Cheltenham.* **Other correspondence** *Elective major colorectal surgery should be centralised onto a single site at CGH. This centralisation will help to create a large elective Cancer Hospital, with reference to pelvic surgery.*	

Where do you think we should do planned Lower GI (Colorectal) General Surgery?

- 50.76% (27.50% Easy Read) survey respondents chose Cheltenham General Hospital
- 20.27% (27.50% East Read) of survey respondents chose Gloucestershire Royal Hospital
- 30.30% (45% Easy Read) had no opinion
- Staff:
    - Cheltenham General Hospital (CGH) 56.64%
    - Gloucestershire Royal Hospital (GRH) 13.29%
    - No opinion 30.07%
- Public and Community Partners:
    - Cheltenham General Hospital (CGH) 48.14%
    - Gloucestershire Royal Hospital (GRH) 22.37%
    - No opinion 30.85%

Cheltenham General Hospital	Neutral	Gloucestershire Royal Hospital
As I have mentioned, public views will revolve how location, for example, will affect the individual. CGH is closer to me than GRH so this is obviously my choice. That is naive and there are many many far more important factors that should determine the location. I really don't understand how public consultation on this matter assists the process.	Remain with both sites as both large populations. Travelling to either site difficult if not in either town/ city. Keep both therefore quicker and more local access. Helps reduce carbon and, safety) health risks involved in traveling	GRH is a larger site, has better facilities and is more accessible for visitors. I have had surgery in CGH in the past and felt the facilities were poor and the care was lacking. It is also very difficult for visitors to find somewhere to park.
Having benefited from this excellent service, and still under their care, I would really like the service in Cheltenham to be bolstered. I live at the extreme Northern tip of the county, and Gloucester Hospital would have been a nightmare for family visits, and for me getting home from the multiple operations I have had. Given the fantastic care I had at Cheltenham, I would be keen for it not to be moved	I believe that you are wrong in trying to decide one place against the other hospital. Gloucester Royal is full to capacity and often difficult to reach because of its situation. The best solution would be to build a new hospital at Staverton and put any "centres of excellence" there. This idea, whilst not likely to ever be considered, would be a perfect solution. There is plenty of space at Staverton and the surrounding land. Sites at Gloucester and Cheltenham could be then be sold at a huge profit	I live in Stroud and find it easier to get to GRH and easier to park the car.
1. co-located with other pelvic cancer services (urology, gynae-oncology) 2. co-located with	Whichever site has best capacity of operating theatres and staffing for this proposal	I think it makes more sense to have surgical units for upper and lower GI surgery in one

oncology 3. co-located with gastroenterology inpatient care 4. Protected bedbase from emergency admissions (if going with the emergency hub in GRH) and allows screened admissions only in the covid era 5. Ease of access to HDU / ITU for all planned major resections 6. Separated (geographically) elective v emergency care as recommended by a) GIRFT, b) Current President of the RCS Eng (Prof Neil Mortensen) c) external senate review		location
To co-locate with urology and gynae-oncology. By taking elective lower GI from GRH space would be freed up for other needs.	Again, it doesn't matter which site, so long as the service is there and available and ensure capacity and effective care for Gloucestershire residents. In my mind it would make sense to have a particular specialist treatment at both sites i.e. GRH is centre of excellence for XX and CGH is centre of excellence for YY. So that one or other site does not become defunct.	Greater diversity in Gloucester
A strong case has been made for both. On balance I think CGH.	Care needs to be taken in assessing the user demographic to make a suitable choice. Ideally it would be in the centre of the most common user base.	I think a centre of excellence, a single one would benefit the local and wider community by being situated in Gloucester.

If the 24hr A&E is at GRH, then the planned surgery to be at CGH.	Very important to have separate sites for emergency and elective surgery for better patient experience and outcome	I understand that there can some crossover between Upper and Lower GI* and this suggests to me that collocating them would be wise provided that there is sufficient space and facilities at GRH. *Last year I had emergency Lower GI surgery carried out at CGH by an Upper GI consultant (excellent outcome!)
CGH should be the site for all planned activity	Both hospitals should have their own colorectal services.	I know the GRH team are fantastic, but have had no dealings with CGH.
I believe it would be sensible to try and ensure that CGH takes on planned / elective surgery with lower risks involved, and that GRH is responsible for caring for emergency surgery. However, I also appreciate that this could result in specialist surgical cover required across both sites rather than just covering one and could be confusing for the public if there is general surgery offered at both sites.	Keep both hospitals operating as hospitals for all services. This centre of Excellence "concept" is in my opinion RUBBISH. Stop pretending that you are offering a better service when you are diluting what is already available	If you think upper GI surgery needs to be on the same site as emergency general surgery, surely the same should apply to colorectal surgery. If you are struggling to run the general surgery service on two sites at the moment why would you want to set a service that continues to run general surgery on two sites?
I think that the 'reputation' of Cheltenham Hospital needs to be preserved if emergencies go to Gloucester, even if in a new way, so putting excellent planned	Crucial item for me is that there is an equal balance between what is in Cheltenham and what is in Gloucester....with equal numbers of essential services in each. It must not be	All major General surgery located with acute services makes common sense.

operations in Cheltenham would be good.	Gloucester is the centre with bits in Cheltenham	
Due to other specialities already doing pelvic surgery in this hospital. Surely a 'centre of excellence' would allow surgeons to assist and advise each other when required.	As it is planned surgery the patient can arrange transport beforehand so I don't see any issues	It makes sense for all GI (lower and upper) services to be in one hospital
Would seemingly make best sense to locate this at CGH to create a centre of excellence for pelvic resection; and to keep this surgery service entirely separated from the pressures of the Emergency General Surgery at GRH (as suggested in the consultation booklet)'	we live in Stroud - now my son has transitioned into adult IBD services we have had infusions in GRH, consultant appointment in GRH and MRI in Chelt - the travel relatively easy for us so wherever means staff travelling less.	I would like Gloucester to be a better option for care, this should be improved so that it is more viable than having to travel to Cheltenham to visit people.
Calmer atmosphere. Better patient experience.	Although my own experience has been of having colorectal surgery at GRH, I think location for this is less important than concentrating the expertise at one centre.	[GRH] Better parking for staff and visitor options more mid-way for Forest patient and visitors. Near to train links.
It would appear logical to have all cancer services on one site and given Cheltenham's preeminent role in cancer treatment then all related services should be located there,	I've put no opinion because transport is about the same for both, and planning a service is a complex task that looks at a wide range of information. I trust One Gloucestershire to make a good choice.	Just because it is the nearest hospital to where I live, I should imagine anyone living near to Cheltenham would choose the Cheltenham one as their option
most of the issues are probably cancer related so it makes sense to put this in	At the moment, both CGH and GRH seem to have a Planned Lower GI general surgery	It seems likely that management of complications would be best on the site with

Cheltenham with the existing unit - although the buildings at Cheltenham are in dire need of refurbishment and modernising	facility. I think the decision on which location to invest more excellency should mostly be focused on statistic and medical opinion, such as estimated time of arrival from one location to the hospital; percentage of local and not local patients who come to the hospital; accessibility to the yard; transportation accessibility etc. While Cheltenham could be more easily accessible, in my opinion, GRH offers facilities on Upper GI general surgery, which could contribute to the treatment of exceptional patients who may need assistance with both.	the most robust emergency cover
If the plan is to have the Day Case focussed at CGH it would seem to be sensible to have the rest of the GI provision on the same site	a cold, elective hospital allows access to beds, ITU, and allows all the relevant surgical specialities to work closely together to deliver excellent care. The removal of colorectal surgery from CGH would mean that urology and gynae-oncology may not be able to stay, which would put more pressure on GRH	As above, the premises at Gloucester are superior and those at Cheltenham have fallen way behind. In my view Cheltenham should have constructed a new hospital to replace Cheltenham General in the hospital building boom of the 1990s and early 2000s when a large number of towns and cities constructed new hospitals, such as Worcester, Swindon, Birmingham, Stratford -on-Avon, Hereford, Taunton, etc. etc. Cheltenham missed out then and a new replacement for Cheltenham General is unlikely now

Consultants and staff are fed up. Colorectal worked at Cheltenham before stop fixing things that aren't broken. Wasting good theatres, what's the point in not using something we already have. And you have amazing nurses and HCAs with colorectal experience in Cheltenham that will not go to Gloucester.	On your facebook live session the consultant said that 12 out of 15 consultants supported this model, shouldn't you be listening to what the experts think as they provide the service and should know how it works.	Elective days-case/short stay surgery in a dedicated unit in CGH. Resectional lower GI surgery co-located with emergency general surgery in GRH.
This builds on already established reputation and allows other interdependent excellent services to continue to flourish because they have ongoing on site, immediate lower GI surgical support. Removing lower GI surgical support from CGH would diminish urological, gynaecological oncology, gastroenterology and oncology services. Specifically gynaecological oncology simply could not operate in the same way and all ovarian cancer surgery would need to move to GRH to facilitate appropriately supported radical surgery within any governance framework	Either. But a Centre of excellence makes sense.	Needs to be co-located with the emergency general surgery service.

4.2.3 Planned day case, Upper and Lower GI

Preferred option to develop: to develop: A 'centre of excellence' for planned day case Upper and Lower GI (colorectal) surgery at Cheltenham General Hospital (CGH).

- 73.49% (Easy read: 67.47%) of all survey respondents either **strongly supported** or **supported** the proposal
- 8.52% (Easy read: 13.25%) of survey respondents either **strongly opposed** or **opposed** the proposal
- 17.99% (Easy Read: 19.28%) of survey respondents had **no opinion**

- 79.58% of staff respondents either **strongly supported** or **supported** the proposal
- 71.24% of respondents excluding staff either **strongly supported** or **supported** the proposal

Fit for the Future Survey

Please tell us what you think about our preferred option to develop: A 'centre of excellence' for planned day case Upper and Lower GI (colorectal) surgery at Cheltenham General Hospital (CGH).				
			Response Percent	Response Total
1	Strongly support		38.07%	201
2	Support		35.42%	187
3	Oppose		5.11%	27
4	Strongly oppose		3.41%	18
5	No opinion		17.99%	95
			answered	528
			skipped	96

Fit for the Future Survey Easy Read

What do you think about having the service for General Surgery Day Cases (Upper and Lower GI) at Cheltenham General Hospital? These are operations on the gut which is where you digest your food. People have their operation and go home the same day.				
			Response Percent	Response Total
1	Good idea		67.47%	56
2	Bad idea		13.25%	11
3	Not sure		19.28%	16
			answered	83
			skipped	6

Qualitative Themes: Planned day case Upper and Lower GI (colorectal) surgery

The following quotes are from survey responses either supporting or opposing the proposal. The quotes included below are illustrative of key themes in the feedback received regarding Planned day case Upper and Lower GI (colorectal) surgery. Themes in the responses to the proposal relating to Planned day case Upper and Lower GI (colorectal) surgery are (A-Z): Access; Capacity; Efficiency; Facilities; Interdependency; Quality; Resources and Workforce.

Planned day case Upper and Lower GI (colorectal) surgery

Preferred option to develop: A 'centre of excellence' for planned day case Upper and Lower GI (colorectal) surgery at Cheltenham General Hospital (CGH).

- 73.49% (Easy read: 67.47%) of survey respondents either **strongly supported** or **supported** the proposal
- 8.52% (Easy read: 13.25%) of survey respondents either **strongly opposed** or **opposed** the proposal
- 17.99% (Easy Read: 19.28%) of survey respondents had **no opinion**

Supporting the proposal	Opposing the proposal
There aren't enough staff to go around, so we need to make best use of those we have. [Resource/Workforce]	*Don't like the single site option, would like both hospitals to offer as many treatments as possible* [Access].
Cheltenham already has this function so it would be sensible to maintain this service. [Efficiency]	*Why not at both, this involves improving Cheltenham at the expense of Gloucester.* [Access]
This type of surgery is at most risk of cancellation when emergency pressures are high. We should have access to protected facilities so these operations are not cancelled. This will be good for CGH as more planned surgery will be performed there than in GRH. [Patient Experience, Capacity]	*This is a bad decision and the people of the forest of dean and Monmouth deserve better.* [Access]

One of your consultants proposed a model for low risk patients which included patients staying in hospital for one or two nights having their operation in Cheltenham to reduce the risk of cancellation. This sounds like a good idea as long as there is capacity. [Patient Experience, Capacity]	*This proposal is another way of saying that CGH becomes a hospital for day case surgery only, chiefly benign conditions, i.e. not a proper hospital in the sense that is understood by most people. Since there is not room for all inpatient GI surgery on the site, to embrace this option is a sure fire way of ensuring that the malignant bowel surgery would have to be moved elsewhere (GRH), which is probably why it has been packaged up this way. Is CGH envisaged as a proper cancer hospital or not? If it is, then the malignant bowel surgery should take place there and not benign day case procedures instead.* [Capacity]
Would require better facilities at Cheltenham general in my opinion hospital dated and tired in appearance. [Facilities]	*I don't support having only one centre for anything, given the size and demographic of Glos.* [Access]
I have experience of this and know that the process is well embedded in CGH, with highly skilled specialists. Further, this type of surgery is usually directly associated with colorectal surgery e.g. stoma loop reversal, it makes sense for the surgeon who created the loop to reverse it thus maintaining continuity. [Interdependency]	*As with all your proposals to centralise services the problem is that of access for patients and their families. Whilst many have access to private transport a very large minority do not and they are frequently the elderly and less financially secure. For these people centralisation poses a major difficulty in accessing your services unless you propose to offer free transport between the sites. Even for those with private transport difficulties in accessing parking at either site pose difficulties and high costs.* [Access/Transport]
On the focus of Cheltenham General Hospital as an elective centre this fits well. The pelvic centre of excellence with the arthroplasty, gyno and urinary would all work well together although it may reduce the General Surgery pool slightly at GRH.	*It needs to be Gloucester more central for Gloucestershire.* [Access]

[Interdependency]	
Having an excellent readily available service that treats me even if I have to travel is preferred to waiting and perhaps getting a second class service because of a dilution of resources/service simply to accommodate operating on both sites. It is 7 miles not travelling to the moon. [Patient Experience, Quality, Access]	
If planned centre of excellence for lower GI general surgery will be in Cheltenham it is only sensible for day cases upper and lower surgery to be there also. [Interdependency]	
Neutral and other correspondence examples	
Neutral *Concentration in one centre is the most important issue.* *Day case can be done anywhere* **REACH survey** *These day procedures should remain dispersed throughout all the hospitals to reduce demand on a centralised location, freeing up resources for more critical procedures. Dispersal of the service will serve local communities much better and help to ensure the viability of the community hospitals. It seems unnecessary to centralise this service and, (forgive me), appears a bit of a sop to CGH after proposed removal of so many of their services.* *Spreading the workload of minor procedures over many local sites seems sensible and popular with the public who prefer to travel to their nearest site.*	

4.3 Image Guided Interventional Surgery (IGIS) including Vascular Surgery

Preferred option to develop: to develop: A 24/7 Image Guided Interventional Surgery (IGIS) 'Hub' at Gloucestershire Royal Hospital and a 'Spoke' at Cheltenham General Hospital.

- 66.54% (Easy read: 76.54%) of all survey respondents either **strongly supported** or **supported** the proposal
- 15.39% (Easy read: 9.88%) of survey respondents either **strongly opposed** or **opposed** the proposal
- 18.08% (Easy Read: 13.58%) of survey respondents had **no opinion**

- 63.12% of staff respondents either **strongly supported** or **supported** the proposal
- 67.81% of respondents excluding staff either **strongly supported** or **supported** the proposal

4.3.1 IGIS Hub and Spoke

Fit for the Future Survey

A 24/7 Image Guided Interventional Surgery (IGIS) 'Hub' at Gloucestershire Royal Hospital and a 'Spoke' at Cheltenham General Hospital.			Response Percent	Response Total
1	Strongly support		32.69%	170
2	Support		33.85%	176
3	Oppose		8.85%	46
4	Strongly oppose		6.54%	34
5	No opinion		18.08%	94
			answered	520
			skipped	104

Fit for the Future Survey Easy Read

What do you think about having a 24 hour 7 days a week IGIS Hub at Gloucestershire Royal Hospital and an IGIS Spoke at Cheltenham General Hospital? A Hub is the main place something happens, and a Spoke is linked to the Hub. IGIS is Image-guided Interventional Surgery. This is where cameras are used inside the body so the surgeon can see what is going on.			Response Percent	Response Total
1	Good idea		76.54%	62
2	Bad idea		9.88%	8
3	Not sure		13.58%	11
			answered	81
			skipped	8

4.3.2 Vascular Surgery

Preferred option to develop: to develop: A 'centre of excellence' for Vascular Surgery at Gloucestershire Royal Hospital.

- 60.27% (Easy read: 68.35%) of all survey respondents either **strongly supported** or **supported** the proposal
- 19.97% (Easy read: 15.19%) of survey respondents either **strongly opposed** or **opposed** the proposal
- 19.77% (Easy Read: 17.72%) of survey respondents had **no opinion**

- 58.86% of staff respondents either **strongly supported** or **supported** the proposal
- 60.8% of respondents excluding staff either **strongly supported** or **supported** the proposal

Fit for the Future Survey

A 'centre of excellence' for Vascular Surgery at Gloucestershire Royal Hospital.				
			Response Percent	Response Total
1	Strongly support		29.26%	151
2	Support		31.01%	160
3	Oppose		9.50%	49
4	Strongly oppose		10.47%	54
5	No opinion		19.77%	102
			answered	516
			skipped	108

Vascular Surgery

Fit for the Future Survey Easy Read

What do you think about having the Vascular Surgery at Gloucestershire Royal Hospital? Vascular is about blood vessels				
			Response Percent	Response Total
1	Good idea		68.35%	54
2	Bad idea		15.19%	12
3	Not sure		17.72%	14
			answered	79
			skipped	10

Qualitative Themes: Image Guided Interventional Surgery (IGIS).

The following quotes are from survey responses either supporting or opposing the proposal. The quotes included below are illustrative of key themes in the feedback received regarding Image Guided Interventional Surgery (IGIS). Themes in the responses to the proposal relating to Image Guided Interventional Surgery (IGIS) (A-Z): Access; Efficiency; Facilities; Interdependency; Quality; Resources and Workforce.

Image Guided Interventional Surgery (IGIS)

Preferred option to develop: A 24/7 Image Guided Interventional Surgery (IGIS) 'Hub' at Gloucestershire Royal Hospital and a 'Spoke' at Cheltenham General Hospital.

- 66.54% (Easy read: 76.54%) of survey respondents either **strongly supported** or **supported** the proposal
- 15.39% (Easy read: 9.88%) of survey respondents either **strongly opposed** or **opposed** the proposal
- 18.08% (Easy Read: 13.58%) of survey respondents had **no opinion**

Supporting the proposal	Opposing the proposal
I believe it is good to have different hospitals with different specialisms. This will also promote inter hospital information exchange. I presume Cheltenham would be a spoke and therefore provide back up. [Efficiency]	*Heart attack patients need treatment at closest hospital this would be better than using Bristol but should be available on both sites.* [Access]
The major IGIS is acute related often so should be with the trauma and stroke unit. However, Cheltenham General Hospital as a spoke would allow elective investigations and pelvic and oncology to occur. [Interdependency]	*I would not support anything being moved from Cheltenham to Gloucester.* [Access]
Important to rationalise and make optimum use of very	*Most cases are already performed in Cheltenham and it should be the main Hub because it already has a new purpose built facility costing several*

expensive and latest equipment. [Efficiency, Resources]	*millions. It would be hugely wasteful to remove this service from Cheltenham.* [Facilities, Resources]
Such a move would avoid duplication of expensive equipment. The proposal refers to a 24/7 hub, my support is conditional on this meaning availability 24 hours a day 7 days a week. [Efficiency, Access]	*Vascular services currently at CGH with IGIS, alongside urology, cardiology and cancer services. GRH is run down with tower block wards which are not suitable for all these services.* [Interdependency, Facilities]
If EGS and Acute Medical Take are located at GRH, then it makes good sense to make GRH the hub for IGIS. It would also seem sensible for there to be a 'spoke' at CGH to work alongside oncology, urology and other specialisations there. [Interdependency]	*Extreme nature of emergency IGIS means the time delay going from Cheltenham to Gloucester would be far too risky re. Loss of life to a patient who may, for example's sake, live just across the road from CGH.* [Access, Quality]
Have had heart surgery and this would have helped me at the time and taken away the need to attend Oxford. Great for bringing the specialists to Gloucestershire to work. Open up the service to more charitable funds. [Patient Experience, Access, Resources]	*I do not understand why, following the presumed logic elsewhere in this consultation why the IGIS service needs a 'hub and spoke model'. There is no convincing argument made for this on any rationalisation, financial, staffing or any other basis. Just create a centre of excellence based on sensible criteria and get on with it.* [Efficiency, Resources]
Key point of focus at GRH. It is unclear to me why you would want a spoke at CGH. Resources staff and equipment would be split. Imaging equipment requires ongoing maintenance programme better focused at one location. [Efficiency, Resources]	
Centralised approach is good. The equipment needed to undertake these investigations are often expensive, particularly	

the imaging equipment. Staffing levels are often difficult to maintain and are often difficult to recruit. State of the art equipment will help to attract highly trained staff. [Resources, Workforce]	
I support this on the basis that fewer people would need to travel outside of the county for treatment. We need to start thinking 'Gloucestershire' when considering these matters. If people are having to travel further beyond county boundaries then it makes sense to centralise some services here. That said good to see there would be an IGIS spoke at CGH to support specialties there. [Access]	
Appears to be specialist treatment needing expensive specialist equipment operated by experts. Given this seems better to centralise as one service - some people may travel a little further but far fewer would need to travel out of county at evenings/weekends. Going to hospital unexpectedly (or even planned) is not a good experience so removing a longer journey with some of the complications this can lead to seems a beneficial step. [Access, Patient Experience]	
Neutral and other correspondence examples	
Strongly support the concept but if this is elective work wouldn't it be sensible to base it at cgh and have a spoke at grh? *This set up should be in the best site for the overall plan. IGIS is an increasingly import part of urgent clinical care so it makes sense to create a hub and spoke approach.*	

There is a …rationale for locating imaging-led services at Cheltenham which is the presence there of the Cobalt charity's unique Imaging Centre…which they say 'have increased patient comfort, shorter scanning times and deliver superior image quality'.

Qualitative Themes: Vascular Surgery

The following quotes are from survey responses either supporting or opposing the proposal. The quotes included below are illustrative of key themes in the feedback received regarding Vascular Surgery. Themes in the responses to the proposal relating to Vascular Surgery (A-Z): Access; Capacity; Diversity; Facilities; Interdependency; Patient Experience; Quality; Resources and Workforce.

Vascular Surgery

Preferred option to develop: A 'centre of excellence' for Vascular Surgery at Gloucestershire Royal Hospital.

- 60.27% (Easy read: 68.35%) of survey respondents either **strongly supported** or **supported** the proposal
- 19.97% (Easy read: 15.19%) of survey respondents either **strongly opposed** or **opposed** the proposal
- 19.77% (Easy Read: 17.72%) of survey respondents had **no opinion**

Supporting the proposal	Opposing the proposal
Better facilities and car-parking at GRH. [Facilities, Access]	*I think Vascular should remain at CGH. Only a relatively short time ago much investment was made to establish a centralised service at CGH. Going forward with future phases of Fit for the Future there will be a need to have established services at CGH and this is one that could fit and not compromise safety.* [Resources, Quality]
Having Vascular surgery at GRH will mean that vascular surgery will be able to support the emergency services better.	*Provide services at both hospitals, provides for the two large population sites and better for outlying areas. Provides back up for either place. Better*

[Interdependency]	*for patients requiring emergency support.* [Access, Quality]
Why not? The importance is that the unit exists and is available 24/7 as and when. [Access, Patient Experience]	*I feel emergency and elective vascular surgery should be split so that emergency work is aligned with the surgical take whilst elective work continues at CGH. This will ensure there is critical care capacity available to support the elective work otherwise there is likely to be an ever increasing pressure on ICU beds at GRH.* [Interdependency, Capacity]
BME communities have higher rates as diversity to Cheltenham and Gloucester - GRH is perfectly placed. [Access, Diversity]	*This should be in CGH where the available beds are, and where there is the state of the art interventional theatre.* [Capacity, Facilities]
Vascular is predominantly a service where patients can be suffering from a life threatening event (AAA) that requires immediate intervention in a theatre designed for this type of surgery. I think splitting Vascular across two sites will provide a sparse clinical cover across two sites rather than strong cover on one site. I can see the intrinsic link between IGIS and Vascular and therefore wherever the IGIS hub is, Vascular should be centralised to and vice versa. [Interdependency, Workforce]	*The wards at GRH are not fit for practice. They are overcrowded, beds too close together increasing the infection risk. The tower block appears generally dirty. Your report reads that if you live in a deprived area (25% of Gloucester population) you will get preferential treatment on your door step and blow the rest of the county. Given that most vascular issues occur in the over 65 age group and these people are spread out across the county if you live at Morton/Bourton area East Gloucestershire, you won't stand much chance of survival.* [Facilities, Access, Diversity]
This should be concentrated at Gloucestershire Royal and it is not asking too much for patients needing such procedures to have them carried out at Gloucester. [Access]	*Vascular surgery carries a burden of heavy emergency list use, often at unpredictable times. This has impacted the emergency theatre provision at GRH such that, even with an extra emergency theatre and consultant anaesthetist on site, access to emergency surgery in a timely fashion has deteriorated for all specialties. CGH would be well placed in terms of facilities and aftercare provision to re-accommodate vascular surgery after the recent experimental transfer to GRH. The fully equipped and recently*

	provisioned IR theatre at CGH is currently lying fallow much of the time and is superior to anything available in GRH. [Capacity, Facilities]
I believe that some thought should be given to maintaining some 'low risk' non urgent vascular capability for some elective vascular surgery at Cheltenham General Hospital. [Access]	*I appreciate that these skills cannot be shared between too sites but for emergencies people living in many of the remote parts of Gloucestershire they need quicker access to a hospital and Gloucester is far from us.* [Access]
Hard to have IGIS at GRH and vascular at CGH so makes sense. [Interdependency]	
You need the technology to do this and therefore would be good to be in Gloucestershire. Need to have the wards set up for this close to the theatres. Will pull in staff and money by having a centre of excellence. Increase the number of specialist nurses. [Resources, Workforce]	

Neutral and other correspondence examples

This service was previously being managed well at CGH but if it not possible to split elective e.g. IGIS and emergency vascular surgery then I believe it would be preferable to keep it on the GRH emergency site and then consider the "spoke" option at CGH for the elective surgery. Splitting this service will have an impact on the intensity / quality of Therapy those patients will receive unless additional funding is provided to support splitting this service across sites.

It depends where other surgical specialties are cited.

REACH survey

"Given the installation of a £2.5 million facility at CGH six years ago it would be hard to justify moving the centre now.

I understand that vascular surgery was recently transferred from CGH to GRH as an 'emergency COVID measure'; staff and accommodation were drastically reduced. I can see no reason why this service should not be reinstated at CGH as soon as possible, It is a nonsense to waste the valuable and well regarded vascular operating theatre.

Other correspondence

The majority of arterial vascular surgery is elective, it would seem entirely reasonable that this should be located at the elective Centre of Excellence at the CGH.

4.4 Gastroenterology inpatient services

Preferred option to develop: A 'centre of excellence' for Gastroenterology inpatient services at Cheltenham General Hospital.

- 71.96% (Easy read: 68.35%) of all survey respondents either **strongly supported** or **supported** the proposal
- 6.67% (Easy read: 10.13%) of survey respondents either **strongly opposed** or **opposed** the proposal
- 21.37% (Easy Read: 21.52%) of survey respondents had **no opinion**

- 68.08% of staff respondents either **strongly supported** or **supported** the proposal
- 73.44% of respondents excluding staff either **strongly supported** or **supported** the proposal

Fit for the Future Survey

A permanent 'centre of excellence' for Gastroenterology inpatient services at Cheltenham General Hospital.				
			Response Percent	Response Total
1	Strongly support		39.41%	201
2	Support		32.55%	166
3	Oppose		3.92%	20
4	Strongly oppose		2.75%	14
5	No opinion		21.37%	109
			answered	510
			skipped	114

Fit for the Future Survey Easy Read

What do you think about us carrying on doing Gastroenterology at Cheltenham General Hospital after the pilot? Gastroenterology is where tests or treatment are needed for the stomach, bowel, liver and pancreas for things like Crohn's Disease and stomach ulcers				
			Response Percent	Response Total
1	Good idea		68.35%	54
2	Bad idea		10.13%	8
3	Not sure		21.52%	17
			answered	79
			skipped	10

Qualitative Themes: Gastroenterology Inpatient Services

The following quotes are from survey responses either supporting or opposing the proposal. The quotes included below are illustrative of key themes in the feedback received regarding Gastroenterology inpatient services. Themes in the responses to the proposal relating to Gastroenterology inpatient services are (A-Z): Access; Capacity; Interdependency; Quality; Resources; Staff experience; Transport and Workforce.

Gastroenterology Inpatient Services

Preferred option to develop: A 'centre of excellence' for Gastroenterology inpatient services at Cheltenham General Hospital.

- 71.96% (Easy read: 68.35%) of survey respondents either **strongly supported** or **supported** the proposal
- 6.67% (Easy read: 10.13%) of survey respondents either **strongly opposed** or **opposed** the proposal
- 21.37% (Easy Read: 21.52%) of survey respondents had **no opinion**

Supporting the proposal	Opposing the proposal
This has been piloted successfully and seems a sensible balance between the two hospitals. [Access, Quality]	*As with all your proposals to centralise services the problem is that of access for patients and their families. Whilst many have access to private transport a very large minority do not and they are frequently the elderly and less financially secure. For these people centralisation poses a major difficulty in accessing your services unless you propose to offer free transport between the sites. Even for those with private transport difficulties in accessing parking at either site pose difficulties and high costs.* [Access / Transport]
Efficient use of resources, access to specialist staff at all times, no waiting for them to travel from GRH to CGH and vice-versa. The total patient capacity must still remain the same (and hopefully higher!), not reduce as a result. [Access, Capacity,	*Both hospitals need a centre of excellence due to the size of the population and the location of the services.* [Access]

Workforce, Resources]	
I am in support of this if it means that all the specialists are in one place. I do have concerns about the lack of parking facilities at CGH - especially if patients are being asked to travel from further afield to attend this site. [Access, Facilities]	*Despite gastro inpatients being at CGH currently, gastro inpatients are still seen on GRH wards and do not get the care they need from the gastro team. Patients either need to be moved promptly so the care of the patient is not impacted, or have a service at both sites.* [Quality]
Only if lower GI surgery is co-located - rapid senior surgical review with alacrity ensures that decisions for surgery are correctly timed and that non-surgical interventions are not pursued too long; if all one has is a hammer then everything looks like a nail. [Interdependency]	
Got to move something to CGH to balance the shift to GRH. Aligns well to elective services generally centralising to CGH. [Interdependency]	
Links with upper /lower GI as well as colorectal and cancer based surgeries, this is a no brainer as it would all fit together and enable this centre of excellence aim. [Interdependency]	
Gastroenterology experience has been demonstrably improved by the recent pilot. Less violence and aggression on the ward, less non-gastro (general medicine) patients using specialised beds and better staff satisfaction from cohorting our clinical capacity onto a single site. [Quality, Staff experience]	
A centre of excellence would benefit both staff, services delivered and patient care. [Quality, Staff/Resources]	
Neutral and other correspondence examples	
I support the proposals to change and think the information provided presents a strong case. However, throughout the consultation document I	

see little or no reference to: a) How staff are to be retained, trained, recruited and afforded. b) No reference to any improvements to process or service instigated as part of the response to Covid -19 which will be retained as Best Practice moving forward. c) Limited reference to the way that services will be re-modelled in line with international Best Practice. There is limited information given for example on the use of telemedicine, telephone consultation and follow up, health education in primary care, transfer of services into community settings, conversations to higher day case rates, better streaming through outpatients (and ED). The proposals appear to deal with the issue of duplication of services across two sites and consequent rationalisation and whilst this is to be welcomed, of itself, it does little to illustrate how the models of care can or will change. Similarly there is no financial analysis (that I can see) with the documentation provided. In an increasingly stretched NHS, this must be a consideration for services to be long term sustainable.

I feel this service could be led from either hospital and the service continue I the hospital why change for change sake . Save money and develop leadership on either site and share good practice online

REACH survey

Patients always benefit from a joined up approach to care and specialists on the same site makes for a less stressful experience

Other correspondence

Retain Gastroenterology Services at CGH as this fits with the Centre of Excellence model

4.5 Trauma and Orthopaedics (T&O) inpatient services

Preferred option to develop: to develop: Two permanent 'centres of excellence' for Trauma at Gloucestershire Royal Hospital and Orthopaedics at Cheltenham General Hospital.

- 76.02% of all survey respondents either **strongly supported** or **supported** the proposal
- 10.53% of survey respondents either **strongly opposed** or **opposed** the proposal
- 13.45% of survey respondents had **no opinion**
- Easy read had two questions:
    - Trauma: 70.51% support / 12.82% oppose / 16.67% no opinion
    - Orthopaedics: 73.08% support / 14.10 oppose / 12.82% no opinion

- 75.35% of staff respondents either **strongly supported** or **supported** the proposal
- 76.28% of respondents excluding staff either **strongly supported** or **supported** the proposal

Fit for the Future Survey

Two permanent 'centres of excellence' for Trauma at Gloucestershire Royal Hospital and Orthopaedics at Cheltenham General Hospital.

			Response Percent	Response Total
1	Strongly support		44.44%	228
2	Support		31.58%	162
3	Oppose		7.41%	38
4	Strongly oppose		3.12%	16
5	No opinion		13.45%	69
			answered	513
			skipped	111

Trauma and Orthopaedics (T&O) inpatient services

The Easy Read Survey separated out the Trauma and Orthopaedic proposal into two questions:

Fit for the Future Survey Easy Read - Trauma

What do you think about us carrying on doing Trauma Surgery at Gloucestershire Royal Hospital after the pilot? Trauma Surgery is where people need operations after they have been injured in an accident.

			Response Percent	Response Total
1	Good idea		70.51%	55
2	Bad idea		12.82%	10
3	Not sure		16.67%	13
			answered	78
			skipped	11

Fit for the Future Survey Easy Read – Planned Orthopaedics

What do you think about us carrying on doing Planned Orthopaedics at Cheltenham General Hospital after the pilot? Planned Orthopaedics are operations for things like hip replacements and knee surgery.

			Response Percent	Response Total
1	Good idea		73.08%	57
2	Bad idea		14.10%	11
3	Not sure		12.82%	10
			answered	78
			skipped	11

Qualitative Themes: Trauma and Orthopaedics (T&O) inpatient services

The following quotes from survey responses are from survey responses either supporting or opposing the proposal. The quotes included below are illustrative of key themes in the feedback received regarding Trauma and Orthopaedics (T&O) inpatient services. Themes in the responses to the proposal relating to Trauma and Orthopaedics (T&O) inpatient services (A-Z): Access; Capacity; Efficiency; Facilities; Interdependency; Patient Experience; Pilot; Quality; Resources; Transport; Workforce

Trauma and Orthopaedics (T&O) inpatient services

Preferred option to develop: Two permanent 'centres of excellence' for Trauma at Gloucestershire Royal Hospital and Orthopaedics at Cheltenham General Hospital.

- 76.02% of survey respondents either **strongly supported** or **supported** the proposal
- 10.53% of survey respondents either **strongly opposed** or **opposed** the proposal
- 13.45% of survey respondents had **no opinion**
- Easy read had two questions:
    - Trauma: 70.51% support / 12.82% oppose / 16.67% no opinion
    - Orthopaedics: 73.08% support / 14.10 oppose / 12.82% no opinion

Supporting the proposal	Opposing the proposal
Separating trauma and planned surgery proven model, elsewhere, in terms of bed base, theatre capacity and managing infection rates. [Efficiency, Quality]	*Trauma needs unambiguous and fast treatment. I've no idea where/when I can go to CGH so I'd call an ambulance rather than go by car. What a stupid waste of resources.* [Patient Experience]
This is something that I believe is already pretty much established with GRH being the trauma site and CGH being the elective site. [Efficiency]	*I am concerned that having these two sited at different hospitals will result in increased patient transfers due to the overlap of specialities.* [Access/Transport]
This principle is sound - to concentrate emergencies on one site	*Both hospitals have the population to support a centre of excellence- this is*

and orthopaedics on the other and it will help the ambulance service to direct patients to the appropriate site. [Efficiency]	*just stealing Cheltenham hospital services away which has been happening by stealth over recent years!* [Access]
This scenario has been in place for some time and seems to work well. Keeping elective patients away from acute admissions is vital to minimise the risk of prosthetic joint infections.[Efficiency, Quality]	*The pilot study at GRH regarding Trauma has not been publicly scrutinised. I gather it has not been successful due to pressure on beds and operating time, consequently causing delays to surgery. It would not be sensible or responsible to continue this service at GRH. Orthopaedics at CGH on the other-hand has performed better.* [Pilot, Capacity, Patient Experience]
Ok, need to give county spread. But Cheltenham not so easily accessible and very difficult for family and visitors without a car.... Cheltenham has a very limited evening bus service e.g. from Stroud. [Access, Transport]	*From things I have heard about Trauma & Orthopaedics I am not convinced the T&O Pilot study has gone as well as the Hospital Trust has claimed. I should like to see the full report of the Trial, before forming a judgement on this. I am not opposed to most elective orthopaedic surgery being done on one site and most trauma orthopaedics being done on the other, to minimise disruption to elective orthopaedic procedures, but Trauma Orthopaedics is fundamental to a fully functioning A&E Department, not least because it is not always obvious until x-rayed whether an injury is a broken bone or a soft-tissue injury. At least some trauma orthopaedic capacity should be retained on both sites.* [Pilot, Quality]
If elective T&O operations are low risk then basing them on a site away from emergencies makes sense as there will be a reduced chance of cancellation. Trauma is best location near the main A&E. [Capacity, Patient Experience]	*Trauma and orthopaedics should stay together at GRH.* [Interdependency]
As someone who is on the waiting list for a knee replacement and living in Cheltenham being able to keep a permanent 'centre	*No there should be one centre to concentrate all resources in one place, unless one is for emergencies and one for electives. Two sites would dilute*

of excellence' at Cheltenham General would be good. [Patient Experience, Access]	*this.* [Efficiency]
Separating out emergency trauma and elective orthopaedics makes sense as it again puts the planned care in CGH which will be a calmer hospital and more suitable for that type of services, and the emergency services can have their centre of excellence at GRH. Again, having the centres of excellence is a sensible way forward, and the pilot seems to have worked well. [Facilities, Quality]	*Trauma and orthopaedic need to go together. It would be VERY confusing to split them. You've GOT to start treating this as one hospital over 2 sites; not 2 different hospitals. EVRRYTHING trauma and orthopaedic at Gloucester.* [Efficiency]
Much like with previous service responses I believe that by keeping Trauma linked with Orthopaedics will inevitably lead to Orthopaedics losing out because acute patients (trauma) has to take priority for beds, theatre space and staffing requirements. This allows the massive Orthopaedics service to properly deliver aside from the constraints put on them through sharing bed and staff capacity with Trauma. [Quality, Capacity]	*If it is a trauma case, it is quite possibly an ambulance admission and GRH cannot cope now. All ambulances go to GRH and then orthopaedics would have to be transferred to CGH, increased cost, risk, time and staff.* [Capacity, Resources/Workforce]

Neutral and other correspondence examples

Don't know why we need two centres. Probably better to have everyone on one site rather than spreading resources more thinly across two sites.

Because the two are so closely linked, why not have one Centre of Excellence in one place?

REACH survey

The Trust must see the results of the Pilot Study first, before making any further decisions on this. It would be reckless to proceed before any

further facts, information and recommendations have been gleaned and shared with the public. Patient care and health could be compromised and it would be negligent for the Trust to allow GRH to continue when it is currently not coping with demand. Quality of care over quantity of patients seen is of paramount importance.

No if the pilot study has shown delays and pressure on beds then I think it would be very unwise to make Gloucester the place for Trauma services. If they do, then all orthopaedic trauma will end up there, (road traffic accidents for example). This means Cheltenham A&E will no longer be used for this purpose, essentially downgrading the A&E department at Cheltenham and making it a minor injuries unit. Again what sort of A&E will Cheltenham have?

Other correspondence

We would hope that the GHNHSFT will publish comparative outcome data regarding the management of fractured neck of femur, lower limb and ankle fractures, and upper limb fractures for further scrutiny. Data for these key performance groups of trauma patients should be made available for both hospitals prior to the institution of the T&O Pilot Scheme, as well as outcome data during the pilot period. The success or otherwise of this Pilot Scheme should be judged on objective outcome data.

4.6 Impact of our proposals on you and your family

The following quotes from survey responses illustrate the impacts (positive and negative) identified by respondents to the survey: Access; Environmental; Facilities/Car Parking, Outpatients, Patient Experience; Quality; and Safety.

The predominant impact identified from respondents from all areas of the county is **Access** to centralised services; whether at Cheltenham General Hospital or Gloucestershire Royal Hospital. Therefore, a significant number of examples of this impact have been selected below. Frequently respondents have linked Access with either expected improvement in quality of services or deterioration in quality of services. Several respondents highlight **Environmental** aspects of increased travel.

I do not believe they would impact negatively, the distance between the two centres is not very far, if it was an emergency the patient would be blue lighted anyway. I would rather get the best possible care than decisions being made on geography. If as a plus this means that patients may not need to be sent out of county this is huge benefit. [Access, Quality]

My wife and I are both in our 80s and moved from a rural location in 2019 as we anticipate a point at which we will not own a car. We deliberately bought a property within walking distance of CGH. We have already found it necessary to travel to Gloucester for X-ray and my wife was admitted for emergency treatment late on a Saturday evening. I had to return home to collect her essential medication and was able to do so in the car. This would have been particularly difficult without our own transport. [Access]

Any proposal that fails to deliver the full restoration of 24/7 type-1 consultant-led A&E services at CGH, will make it considerably more difficult to access emergency health care for me and my family. [Access]

Removal of services from Cheltenham would make it very difficult for people of North Cotswolds who depend very strongly on Cheltenham. [Access]

Minimal impact currently - may involve slightly longer travel dependent on outcome. Applies to services that would move to GRH. [Access]

As someone of working age with access to independent transport, I think this is a positive move for me. However, I am concerned about the social practical impacts for people who are dependent on public transport, elderly, need support to travel, more financially disadvantaged. [Access]

I live in the Forest of dean so any move to Cheltenham will put 30 minutes extra on my journey. Maybe longer when you consider how difficult it is to park in Cheltenham. [Access]

Difficulty in getting to Cheltenham general hospital, public transport links poor or non-existent. [Access]

We live on the border in Herefordshire but our nearest GP surgery is in Gloucestershire where we access services. Having to travel to Cheltenham is too far. [Access]

I live in Moreton-in-Marsh and I am not able to drive. Gloucester is a foreign country! Oxford or Worcester is easier to reach. Any suggestion of concentrating services at GRH is therefore bad news. Only super specialist services should be located here. [Access]

Any medical treatment should be available at a local hospital. It is wrong to expect patients who are obviously ill to travel to long distances for treatment. Ecologically it is also better for a few medical staff to move between hospitals than for large numbers of patients to travel. [Access, Environmental]

If the services are not at both units this would mean further travel and time. It also means for Carers there days would be more disrupted getting patients to appointments in larger units. [Access]

I have multiple disabilities and cannot drive or travel on public transport. If I ever need any of the services covered in this proposal, I want them to be as close as possible to my home. It is easier for elderly, disabled, and very sick people to travel to their nearest hospital. An unfamiliar environment may be distressing for them, and it may be more difficult for their families to visit if they are further away. I will not be the only person in this category who is not able to either drive themselves or travel on public transport. Therefore, all procedures should be available in all hospitals, not in one centre. This feedback relates to all the services. [Access]

My view is that centres of excellence would be a positive proposal. Negative could be transport/parking etc. issues in either getting to hospital, or for visitors. A free green shuttle between the sites would help with this. But really transport issues are far down the line when compared to top class treatment. [Access, Transport, Environment]

Both hospitals pretty much equidistant for us and are over thirty mins away, so no change for us. [Access]

Obviously because I live in the forest of Dean it would be better for my family to have all resources staff and centres of excellence at Gloucester but Cheltenham needs to have its own centres of excellence. [Access]

As a Gloucester based family it is always easier for us to go to GRH. However, I would prefer to travel a bit further to a centre of excellence. [Access, Quality]

There could be more travel for patients depending on the proposals, but clearly the aim is for people to have world class care and I personally would be prepared to travel a bit more and not be so territorial. It's your health that matters at the end of the day. Also, some of the proposals like IGIS should mean fewer people having to travel out of county which is a good thing. [Access, Quality]

As a resident of Cheltenham I am happy to travel if it means better care. I just want the right people in the right place to look after my family if they are unwell. [Access, Quality]

Car parking is an issue at CGH, assurances need to be made that relatives are able to park, to be able to transport and visit their relatives.
The estate has to be able to support the changes to the centres of excellence along with staffing and support services. [Facilities/Car Parking]

I imagine most opposition to the proposals will come from those who live significantly closer to one hospital or the other. We are fortunate in living more or less halfway between the two. Despite it being easier, therefore, for me to agree to the proposals, I do feel strongly that rationalisation of provision is important. [Access, Efficiency]

As long as the clinic appointments are in the same place I think it will have very little impact on my family. [Outpatients]

I am concerned that scarce resource (pathology, radiology, social work etc.) is diverted to GRH leaving a second rate services that would not be able to safely support any centre of excellence (including oncology) based in CGH. [Quality/Safety]

A possible positive impact would be an increased likelihood of a successful outcome of any treatment in the future. [Quality]

Because we live in the very south of the county to a certain extent these changes will have very little impact on us as we are pretty much as far away from one hospital as the other. The time taken to get to either of them is about the same, and as there is no public transport to either hospital, it doesn't really matter for any of the services at either hospital. However, I know that having centres of excellence can generally improve patient outcomes, which is

why I support the developments of the centres of excellence. At the moment some trauma and emergencies from our area are dealt with at Southmead, so if GRH and CGH can become superior centres of excellence, then perhaps we would be more likely to be treated in county. I would rather battle the traffic into Cheltenham or Gloucester than Bristol. [Access]

Creating a major elective hub at CGH is likely to be beneficial to my family. This would allow good access to intensive care if needed and reduce the risk of hospital acquired infection. [Quality]

My family and I could be affected positively by services being centralised because we would get the treatment we need in time by highly motivated trained staff. [Quality]

All proposals would have a positive impact on me and my family. I don't care where I or my loved ones are treated. If any one of us had an extremely unusual condition requiring us to travel to London for treatment, we would do it. It therefore makes no difference to me whether I have to travel to Cheltenham or to Gloucester for treatment, as long as the service is good, well-staffed with enough of the right staff and capacity available is all I care about. [Quality, Access]

4.7 Limiting negative impact

The following quotes from survey responses illustrate suggestions for limiting negative impacts identified by respondents to the survey [Access; Communications, Integration; Reduce patient transfers; Single Site, Transport, Travel Claims; and Workforce.]

Survey respondents shared the following mitigations to limit potential negative impacts of centralisation of specialist hospital services.

- Retain services on both sites
- Improve Patient Communications
- Improve integration between hospitals, community services and GP practices
- Reduce the number of patient transfers between Acute hospitals
- Build a new Acute Hospital on a Single Site
- Improve public transport
- Speed up payment of eligible Travel Claims
- Encourage more staff to work in Gloucestershire

As far as possible try to maintain urgent/emergency/acute facilities at both sites while splitting care not in those categories into centres of excellence across the two sites. [Access]

I cannot understand why it seems the Trust struggles with employing adequate staff for both hospitals. Gloucestershire is a beautiful county, more and more people are leaving cities and moving into the countryside, like the Cotswolds and Cheltenham is the home of the 'festivals' after all! So providing more staffing and investing in equipment etc should be a priority for both hospitals. Why do staff have to cover both sites? The two hospitals are separate sites and should continue to provide equal facilities because Gloucestershire is such a large growing county. [Workforce]

Work with the transport services. [Access, Transport]

It is important that free public transport is available for patients between the two hospitals, so that (for example) people living in Cheltenham are not financially disadvantaged by having to travel to GRH, if they do not have a car. [Access, Transport]

Make all services available in all hospitals. If this is not possible, then there should be excellent hospital or volunteer transport which is suitable for individual patients with a variety of disabilities including severe allergies (I cannot travel in standard hospital transport or on public transport because of allergies to perfumed products from laundry detergent to standard toiletries.) [Access]

24 transport links (99 bus useful but only mon-fri) between CGH and GRH. Cheaper parking if patient needs transfer from/to CGH/GRH. [Access, Transport]

Easier travel; more car parking spaces and lower charges for parking. Move to a paperless system so there is no need to transfer paper notes and images between sites - practical experience at both hospitals show lost notes are very common. [Access, Transport, Car Parking]

You really need to have a "Southmead" in the Golden Valley area. And you need to consider better bus services to both sites for general public to reduce car parking requirements and problems. [Single site, Transport]

Finding ways to minimise the need to transfer patients between sites is important. Communication about any changes that are made and why they are necessary always helps. [Reduce patient transfers, Communications]

Greater visibility and support given to people needing to claim travel expenses for hospital visits. Citizens Advice Stroud ran a campaign about this 3-4 years ago, surveying the hospitals and surgeries to see how visible the information was and how easy to claim. The

procedure for making a claim and receiving payment was poor. Stressed relatives need immediate assistance. They should not have to wait a month to be reimbursed. [Travel Claims]

Get it Right First Time. Direct to FAS/ COTE bed. Another specialist COTE ward at CGH (although difficult to recruit to this area) Discussion with community partners: keep Community Hospital and Bed Based Rehab beds for patients needing these services to speed transfers out of acute hospital. Blocking beds in the community blocks up our ' back door' and our beds perpetuating the problem of flow. [Integration]

Better 'advertising' of which conditions and situations are for which hospital so we can make decisions without convoluted calls to 111. [Communications]

Try leadership and staff support for both units from one hospital. Sharing good practice teams can meet online. [Workforce]

4.8 Anything else you want to tell us

The following quotes from survey responses illustrate other comments made by respondents to the survey:

Bring back Cheltenham A&E full-time and with full services as soon as Covid restrictions are lifted.

My hope would be that by making these changes the local service will be made better and the cancelling of planned procedures is significantly reduced.

Just think more about travel access, parking facilities and best of all getting appointments and blood tests done promptly. The Cotswolds is treated as a backwater by Glos NHS

More free car parking at GRH and CGH.

If would help if other bodies such as Glos Highways and bus companies could be persuaded to consider better road access and enhanced public transport facilities to reduce difficulties in trying to access two sites.

I would be interested to know what consideration One Gloucestershire have given to inclusion in terms of practical access to the hospital sites e.g. public transport providers, charities with volunteer drivers, support groups in disadvantaged areas.

Given the health inequalities which have been demonstrated through the Covid-19 situation, it is vital to me that these considerations are given a platform in any changes, else we risk worsening inequalities already present. As well as the patient, this can impact visitors, whose support can positively bolster outcomes for a patient.
Also, there is no mention of the impact on ambulance services, but presumably there will be an impact in terms of transfers needed (not just when ambulance first called to patient, but also transfers between GRH and CGH). I am wondering how this has been assessed?
Thank you for appreciating the importance of having an A & E service in Cheltenham to local people, I am really pleased this is reflected in the plan.

Build a new County Hospital between Gloucester and Cheltenham, or focus development on the Gloucester site. Improve access (sheltered pedestrian links) to Gloucester rail and bus stations.

The shuttle bus between CGH and GRH is a great asset in relation to access to services. A commitment to its future would be good to hear. It would also be good to hear that discussions are being held to see whether the bus route could include a stop at Park and Ride at Cheltenham Racecourse. Decision makers should consider evaluation of services changes if implemented and the involvement of patients, carers and VCS in the evaluation.

Keep up the good work. Will be interested in the result of survey. Any plans for head injuries, chest surgery - including cardiac or neurosurgery, so these still go to Bristol of John Radcliffe, Oxford. Guess if you live west of the M5 you want all in GRH, east of the M5 CGH. There are of course major incidents to remember where anything and everything can turn up.

I understand and agree with your reasons for wanting to change things in these two big hospitals, but I would urge you to also consider our more rural hospitals (Cirencester, Stroud etc.) when it comes to where funds go. I would hate these to be underfunded at the expense of these changes.

The public's primary concern about the reconfiguration of specialist services within the hospital relate to the convenience and accessibility of services and the long term sustainability of a Type 1 A&E Department in Cheltenham. Of some of these proposals are implemented it is difficult to see how a full Type 1 A&E Department would be sustainable in the long term. This is despite the reassurances the Hospital Trust has repeatedly been given. It is these proposals which have undermined staff and public confidence in the Hospital Trust's sincerity over the re-opening of Cheltenham A&E and its long term future.

If you centralise more long queue and parks, waste cancelled appointments staff on sick holidays etc. As more money was used in covid 19. We have to think weekly and keep NHS

going for years to come. Electric chargers at hospital while wait for o/patient and visitors. Cars in come for hospital?

Refreshing to see such an in depth review and consultation. How about integration of Social Services and the NHS next?

Whatever decision is made, the correct and additional staff numbers must be allocated. You cannot simply move the patient workload (currently split over two sites with two teams) to one site with only that sites pre-existing team numbers. This will be a recipe for failure / disquiet. Working in a small speciality which centralised 10 or so years ago the benefits are huge for us.

Improving continuity of care, reducing outliers and improving communication with families might be improved if a balance in activity across the hospitals is achieved.

These are excellent consultation proposals but miss one very important heading - THE CUSTOMER CARE EXPERIENCE. Visits to both major hospitals are still very poor experiences. Everyone does their best with awful facilities and it's time we moved from a 1958 experience to 2020.

I would like to see a very positive statement, and concrete proposals for the better care of patients presenting with mental health problems in ED. This has been a long ongoing concern, how will Fit for the Future ensure that mental health is given proper consideration?

I worry about the link and relationship between these proposals and GP services. GP services need to be as much a part of this as the hospitals and the hospitals cannot do this in isolation of community services. I can see part of the proposal is to enable more joined up working but this has to work in practice with collaboration and cooperation across the services. While I have experienced fantastic GP services in Gloucestershire (up to about 10 years ago). Unfortunately I have also experienced some poor GP service provision in Gloucestershire, which has deteriorated over the last 8 to 10 years. My biggest concern is that if the GP services are not joined up with these proposals, this will not be able to succeed.

I have been watching this play out for years and too much time and negative energy has been spent which has hampered the development of all specialties in both hospitals. I am utterly fed up with it.

Inappropriate and dangerous hospital discharges happen regularly, particularly at GRH. I hope these changes will help reduce these. Mental health support is very poor, particularly in GRH, I hope the cost and staff savings can be used to provide better mental health support for patients with mental ill health.

I feel that emergency care should be predominantly at GRH and planned day cases should mainly take place at CGH. This would, in my opinion, make the best use resources including staff as well as equipment. As I want to pursue a career in Medicine, I was interested to learn about the positive experience the pilots have made on the working lives of junior doctors.

I used to work for the department of health. The fashion for building new hospitals would alternate between big is beautiful and small is beautiful on a 10 year cycle. The result was that all current buildings was out of step with prevailing thinking. Health trusts need to resolve this conundrum and ensure a successful balance between specialist and locally delivered hospital based options.

Just ensure that the investment needed to provide these changes properly and not half hearted is there for all services involved including those that are sometimes overlooked. There is no point picking a service up and moving it to one side of the county or other if you don't use this opportunity to actually improve it.

A future proof plan for reduced waiting times, reduced hospital stay, access to cutting edge skills and equipment along with optimal training of junior staff and attracting the best must be a positive move.

Invest in your nursing staff as you do with every other professional group. Pay them more and develop their skills. This is the only way you will be seriously considered as addressing the recruitment and retention crisis.

I find taking part in the survey stimulating and support the developments.

Do not ignore the publics opinion we have a right to choose where we have our care.

5. Other correspondence/written responses

9 written responses were received during the consultation (A-Z).

- Cheltenham Borough Council [Access, Capacity, Interdependency + commitment to Cheltenham General Hospital A&E]
- Cllr Martin Horwood, Liberal Democrat, Cheltenham Borough Council [Capacity, Access, Pilot + timing of consultation]
- Leckhampton with Warden Hill Parish Council [Capacity, Access, Pilot + timing of consultation]
- REACH: Restore Emergency At Cheltenham General Hospital campaign (including REACH survey interim report) [Capacity, Access, Interdependency, Facilities, Quality, Pilot + commitment to Cheltenham General Hospital A&E] – Summary of REACH Survey responses below.
- Tewkesbury Borough Council [Access + commitment to Cheltenham General Hospital A&E]
- 4 x members of the public [#1: Quality, Resources, Workforce, Facilities, Staff Experience, Pilot. #2: Workforce. #3: Quality, Patient Experience. #4: Efficiency, Resources, Capacity, Workforce]

10 email responses were received from members of the during the consultation from members of the public

[#1. Efficiency, Resources. #2: Access, Resources. #3: Patient Experience, Access, Resources, Facilities, Integration (use North Cotswolds Community Hospital). #4: Integration (use North Cotswolds Community Hospital), Access. #5: Access, Integration (use North Cotswolds Community Hospital). #6: Access. #7: Access + commitment to Cheltenham General Hospital A&E Department. #8: Access, Patient Experience. #9: Interest in Stroke services. #10: Copy of Member of the Public Letter 4: Efficiency, Resources, Capacity, Workforce].

Further information about Additional responses received can be found in Annex 1 Section 9.5.

5.1 REACH Survey – summary interim results

The REACH Report on Interim Results (17 December) has been shared with the Fit for the Future consultation team and can be found in full in the online appendices.

The REACH survey asked different questions to those in the Fit for the Future Survey and Fit for the Future Easy Read Survey.

The REACH survey number of responses or demographics of respondents have not been shared with the Fit for the Future consultation team at the time of writing the Interim Output of Consultation Report (published w/c 4 January 2021)[13]. . Summary results (EXTRACTS from the REACH Interim Report] regarding each specialist services are proposals are as follows:

Acute Medical Take: NHS Preferred option to develop: A 'centre of excellence' for Acute Medicine (Acute Medical Take) at Gloucestershire Royal Hospital.
REACH survey question: Do you agree with the Trust's preferred option of centralising acute emergency medical patients on to the GRH site?
EXTRACT: The public response has been overwhelming, indicating that the people do not support centralisation of the acute medical take or emergency admissions at GRH.

Emergency General Surgery: NHS Preferred option to develop: A 'centre of excellence' for Emergency General Surgery at Gloucestershire Royal Hospital**.**
REACH survey question: Do you agree with the Trust's preferred option of centralising acute emergency general surgical patients on to the GRH site?
EXTRACT: Public opinion is again not in favour of centralising emergency general surgery onto the GRH site. Only a small minority support One Gloucestershire's preferred option.

Planned Lower GI (colorectal) general surgery: NHS Preferred option to develop: A 'centre of excellence' for Planned Lower GI (colorectal) general surgery at Cheltenham General Hospital (CGH) or Gloucestershire Royal Hospital (GRH).
REACH survey question: Do you agree with the Trust's preferred option of centralising planned lower gastrointestinal/colorectal patients onto a single hospital site?
EXTRACT: Public opinion on this issue was split. Notably a significant minority of people were neutral on this topic, as they believed that this should be available at both sites, or that answering this depended on the outcome of the emergency surgery debate. It would appear that the public would ideally prefer to have services as close as possible to home, whether this might be for emergency or elective care.

[13] The Final Reach Survey Report was published on 14 January 2021. It states that: "the findings from this survey are based upon 335 full or partial survey responses". Further detail about the Final REACH Survey report can be found at 5.1.1 and in Annex 1 Section 9.5

Supporters of this proposal, however, indicated that this should be centralised in Cheltenham as part of the Cancer Centre.

Location of Planned Lower GI (colorectal) general surgery: NHS No preferred option.

REACH survey question: If you do agree that it would be sensible to centralise planned lower gastrointestinal/colorectal patients onto a single hospital site, which hospital would best deliver this service?

EXTRACT: Supporters of centralising colorectal planned patients onto one site overwhelmingly indicated that Cheltenham should be the preferred site for such a proposal. Many respondents cited the importance of co-locating colorectal surgery with the Cancer Centre and patients with other cancer requiring colorectal expertise e.g. .gynaecological and urological cancer patients. Some patients were neutral on this question, but this may reflect the respondents to the previous related question, who were not persuaded about centralisation.

Planned day case Upper and Lower GI (colorectal) surgery: NHS preferred option to develop: A 'centre of excellence' for planned day case Upper and Lower GI (colorectal) surgery at Cheltenham General Hospital.

REACH survey question: Do you agree with the Trust's preferred option of centralising planned day case upper and lower gastrointestinal patients onto the CGH site, as opposed to continuing day surgery in community hospitals and the two main hospitals?

EXTRACT: Public opinion clearly opposes the centralisation of daycase surgery at CGH. The public wants to have daycase surgery performed as close to home as possible, with the community hospitals. This would seem perfectly reasonable, as the delivery of daycase surgery in community as well as acute hospitals is entirely appropriate patients.

Image Guided Interventional Surgery (IGIS): NHS preferred option to develop: A 24/7 Image Guided Interventional Surgery (IGIS) 'Hub' at Gloucestershire Royal Hospital and a 'Spoke' at Cheltenham General Hospital.

REACH survey question: Where do you believe that the main interventional radiology centre or "hub" should be located in?

EXTRACT: A clear majority of the public replies indicate that the main centre or hub for interventional radiology should be at Cheltenham. The respondents indicating "no opinion" generally said that this service should be provided at both hospitals. The Proposal from One Gloucestershire is for a "hub and spoke" model. Public opinion indicates that the main centre or "hub" should be at Cheltenham with a smaller service or "spoke" at Gloucester.

Vascular Surgery: NHS preferred option to develop a 'centre of excellence' for Vascular Surgery at Gloucestershire Royal Hospital.

REACH survey question: Where do you believe that the main vascular interventional radiology/surgery centre should be located in?
EXTRACT: The overwhelming public response is that the interventional vascular centre should remain at Cheltenham, maximising the use of the state of the art hybrid interventional operating theatre at CGH.

INTERVENTIONAL CARDIOLOGY [question not included in the Fit for the Future Survey and Fit for the Future Easy Read Survey]
REACH survey question: Where do you believe that the main cardiac interventional radiology/surgery centre should be located in?
EXTRACT: The public response was evenly split between having interventional cardiology at both sites or at Cheltenham alone.

INPATIENT VASCULAR SURGERY [question not included in the Fit for the Future Survey and Fit for the Future Easy Read Survey]
REACH survey question: Where do you believe that the main vascular inpatient surgery centre should be located in?
EXTRACT: The overwhelming public response is that inpatient vascular surgery should remain at Cheltenham, so that the state of the art hybrid vascular theatre can be used properly. The public do not believe that spending more money to replicate this facility at Gloucester represents value for taxpayers' money.

Gastroenterology inpatient services: NHS preferred option to maintain a permanent 'centre of excellence' for Gastroenterology inpatient services at Cheltenham General Hospital.
REACH survey question: Where do you believe that the gastroenterology inpatient service should be located in?
EXTRACT: The vast majority of respondents indicated that the single site gastroenterology inpatient site should be located in Cheltenham. Many cited that this is sensible, as it would be sited alongside the cancer centre in Cheltenham. Those who expressed no opinion indicated their preference for this service to continue on both sites.

Trauma and Orthopaedic inpatient services: NHS preferred option to maintain two permanent 'centres of excellence' for Trauma at Gloucestershire Royal Hospital and Orthopaedics at Cheltenham General Hospital.
REACH survey question: Do you believe that One Gloucestershire should be considering any proposals until the results of the "Pilot Study" are made public for proper scrutiny?
EXTRACT: There was overwhelming public opinion that the results of the "Pilot Study" on Trauma and Orthopaedics should be presented for scrutiny prior to considering any proposals for a permanent reorganisation. The public believe that One Gloucestershire

should be transparent and share the data about trauma surgery outcomes for proper scrutiny.

REACH survey question: Last but not least do you agree that the "Pilot Study" arrangement with Trauma based in Gloucester and planned orthopaedic surgery based in Cheltenham should continue as a permanent reorganisation, without the formal results of the "Pilot Study" being revealed?

EXTRACT: The public believe that the proposal to make a permanent reconfiguration along the lines of the "Pilot Study" should not be enacted until the results of the "Pilot" have been fully evaluated. Fewer than 5% of the respondents believe that it would be appropriate to proceed on such a basis.

5.1.1 Final REACH Survey

The final REACH Survey Report, which received 335 full or partial responses was published on 14 January 2021. It can be found at: https://www.reachnow.org.uk/reach-publish-results-of-their-fit-for-the-future-survey/ The Final REACH Survey can be found in full at Appendix 2.1.

Extract from the REACH website:

> ***Survey findings***
>
> *REACH has recognised that the proposals in Fit for the Future are complex and will have a wide-ranging permanent impact on healthcare provision in our County. The implications of centralising emergency care have not, we believe, been explained fully to the public by One Gloucestershire. The concept of excellent care is indeed laudable, and REACH recognises the challenges of staffing as well as the impact of advances in patient care.*
>
> *Nevertheless, the public have overwhelmingly stated that they would prefer, in general, care closer to home. The public understand that there are significant bed pressures at GRH, which would be amplified further by centralising of acute medicine and emergency surgery at GRH. The public know that One Gloucestershire cannot squeeze the proverbial "quart into a pint pot."*
>
> *The large number of extra inpatient beds required at GRH from the centralisation of emergency medicine and surgery are very substantial and are unlikely to be offset by proposals such as centralising day surgery at Cheltenham. The public are rightly concerned that these proposals may downgrade Cheltenham and that proposals to centralise day surgery at Cheltenham might be regarded as a "sop" to public opinion. REACH believes that the excellent facilities and dedicated staff at both hospitals should be used efficiently and that happy and fully engaged staff will then provide the best care and service to the people of our County.*

If One Gloucestershire wishes to proceed with its proposals to centralise emergency care at Gloucester in spite of public opinion, REACH believes that as much elective (planned) major surgery should occur at Cheltenham, in order to utilise the beds, nursing expertise and importantly the excellent intensive care unit at Cheltenham. This public survey has shown that if there were to be a centralisation of colorectal surgery and the vascular service, both these services should be located in Cheltenham.

REACH was also concerned about the portrayal of Image Guided Interventional Surgery as a single specialty, when in fact this concept covers many disciplines. After explaining this to the public in non-medical language, the public have indicated that this should be located at Cheltenham. The exception being cardiac intervention, where the public indicated that this could be on both sites or at Cheltenham.

Michael Ratcliffe MBE, Chairman of REACH concluded:

"Through these findings, the public has made their feelings very clear indeed and we urge One Gloucestershire to take these into consideration during their deliberations.

The launch of Fit for the Future during the worst pandemic in living memory has caused much concern among the public and REACH. The Government and healthcare community are concerned that we are likely to experience further future pandemics, and that the COVID virus may mutate significantly.

This COVID pandemic has wrought havoc to our healthcare system and caused the delay and cancellation of non COVID related healthcare for millions of people. REACH believes that any proposal for the future must include resilience planning for future pandemics. One Gloucestershire's Fit for the Future proposals include no proposals to render our local healthcare system more robust and we would exhort our healthcare leaders to re-examine the proposals in the light of the catastrophic events of the last 9 months".

5.2 Other comments received during the consultation

(Not directly related to the Fit for the Future consultation proposals)

During the consultation, members of the consultation team spoke to participants about matters unrelated to the Fit for the Future proposals. Other subjects included the national and local response to the Coronavirus pandemic, including practical questions about Covid-19 testing and vaccination; the timing of the consultation taking place during a pandemic; feedback about services such as primary care (GP) services and mental health services.

The final subject to report was the significant number of messages of thanks to health and care staff and other frontline workers for their efforts to maintain services during the pandemic.

5.3 Additional written responses received post-consultation

Additional responses post-consultation were received from:

- Healthwatch Gloucestershire: A letter providing observations on the consultation process and feedback, encouraging decision makers to take into account any concerns raised and to consider recommendations from the FFTF Citizens' Jury #2 for future engagement and consultation approaches
- Gloucestershire Primary Care Network Clinical Directors: A letter of support for the Fit for the Future Proposals for change
- 55 Clinical Staff from Gloucestershire Hospitals NHS Foundation Trust: A letter of support for Cheltenham General Hospital to become a centre of excellence for inpatient planned care for: Pelvic Cancer and Pelvic Disease, Lower Gastrointestinal Disease and Inpatient Oncology. We received five letters and two emails, two of which were relating to the New Hospital in the Forest of Dean closed consultation. One requesting we no longer contact them in relation to the Fit for the Future: developing specialist hospital services project.
- Further responses to the Additional Information: We received five letters and two emails, two of which were relating to the New Hospital in the Forest of Dean closed consultation. One requesting we no longer contact them in relation to the Fit for the Future: developing specialist hospital services project.

Additional written responses received can be found in full at Appendix 2.1

6. Addressing themes from the Consultation

This Interim Output of Consultation Report is one of a number of key documents that decision makers utilise (and which are made available to the public), when assessing service change proposals. To support 'conscientious consideration'[14] decision makers should be able to provide evidence that they have taken consultation responses into account. As part of this process, the Decision Making Business Case (another of the key documents utilised by decision makers), will include significant content from the consultation. In addition to summarising the consultation process it will also include:

- A summary of consultation findings
- Analysis of consultation responses including any alternative suggestions to the proposals
- New evidence from the consultation and the impact of this on the proposals
- An updated Integrated Impact Assessment that includes feedback from the consultation

This information is a crucial part of determining the final proposals that are included in the Decision Making Business Case (DMBC) for consideration by decision makers. Further work will be completed to ensure decision makers are able to take a proportional view based on the quantitative and qualitative responses.

Sections 3 and 4.7 have already identified key themes and mitigations to limit potential negative impacts that will be need to be addressed by the DMBC. The table below lists some of the specific topics, identified from all sources of consultation responses that will need to be considered and responded to as part of the post-consultation, pre-decision making process. As with all consultations there are a range of issues identified commensurate with the differing views of those responding to the consultation.

Theme	Topic
Access	• Establish Centres of Excellence on both sites (GRH & CGH) • Improve communication regarding location of services • Ambulance response times and capacity • Car parking • Public transport including Park & Ride and Inter-site" 99" bus service • Travel expenses claim process • Practical travel support to access services for those disadvantaged groups and impact on health inequalities • Additional services provided in-county to avoid out-of-county travel

[14] One of the Gunning Principles that have formed a strong legal foundation from which the legitimacy of public consultations is often assessed.

Capacity	• GRH capacity including beds and Emergency Department • Making the most of the CGH site • Impact of population growth on proposals • Impact of COVID-19 on separation of emergency and elective surgical services • Use of virtual technologies to support services
Facilities	• New hospital • Use of the hybrid theatre at CGH • Use of community hospitals to support services
Integration	• Increased co-operation with other regional hospitals • Partnership with community and primary care and the voluntary sector • Integration of Social Services and the NHS • Care of patients presenting with mental health problems in Emergency Department
Interdependencies	• Access to theatres • Colorectal surgery and emergency general surgery co-located • Separation of elective and emergency vascular surgery • Co-location of colorectal surgery with gynaecology and urology at CGH • Interventional radiology hub at CGH and spoke at GRH • Centralise all IGIS at GRH, no requirement for a spoke at CGH.
Pilot	• Publication of Trauma and Orthopaedic pilot evaluation information
Quality	• Training hospital • More information on infection control • Plans to improve services once re-located • Medical cover at CGH

6.1 Decision Making Business Case

Purpose and scope of DMBC

The Fit for the Future Decision Making business case (DMBC) is concerned with the configuration of hospital services across Gloucestershire Hospitals NHS Foundation Trust (GHNHSFT), specifically between Gloucestershire Royal Hospital (GRH) and Cheltenham General Hospital (CGH).

The DMBC is based on the evidence compiled in the pre-consultation business case, feedback from consultation and further evidence compiled post-consultation. The DMBC reviews the outcomes from the consultation report and seeks to ensure that progress to

decision-making and implementation is fully informed by detailed analysis of consultation outcomes.

The DMBC presents and summarises the extensive work completed to date, with the following purposes in mind:

- To present our response to the FFTF consultation;
- To demonstrate that all options, benefits and impact on service users have been considered; and
- To confirm the recommendations for service change to enable decision makers to determine if these proposals should be implemented

The DMBC includes the following sections pertaining to the Consultation:

- Feedback from Public Consultation
- Overview of Consultation
- Summary of Consultation Findings
- Alternative suggestions to proposals
- Further areas for consideration
- Limiting negative impacts
- Independent Integrated Impact Assessment – consultation review feedback
- Continued public and stakeholder engagement
- Addressing the themes from Consultation
- Addressing themes applicable to all consultation proposals
- Addressing themes by individual consultation proposal
- Responding to alternative suggestions to proposals
- Responding to areas for consideration
- New evidence

The DMBC will be considered by the Governing Body of NHS Gloucestershire Clinical Commissioning Group on 11 March 2021. At this meeting decisions will be made about the Fit for the Future proposals for change.

7. Questions and Answers

Throughout the consultation a range of questions have been received from a variety of sources e.g. online discussion groups, Information Bus Tour, survey free text responses. The following questions (and responses) are representative of frequently asked questions.

Question	Response
Acute Medicine (Acute Medical Take)	
How are you going to ensure GRH will be able to cope with the increase in patients?	Fit for the Future is a long term strategic plan, which would take a number of years to implement. We are also investing in new facilities at both hospitals which will increase the number of patients we can look after. As part of the programme we are reviewing bed numbers across both sites to ensure that they align with the proposed change in services. If approved additional acute medicine beds would be provided at GRH.
If you move Acute Medicine, surely you will end up closing the A&E department?	We have made a public commitment to maintain the A&E department at CGH. The department will continue to provide Consultant Led A&E services 8 a.m. to 8 p.m. and a Nurse Led service from 8 p.m. to 8 a.m. This model of care has been in place at Cheltenham A&E since 2013. Under the Fit for the Future proposals, the same day emergency care service at CGH (which is provided by acute medicine and is consultant led) would extend from 8am to 6pm, Mon to Fri to 8am to 8pm Mon to Fri.
Are you closing the Acute Care Unit (ACU) in Cheltenham?	Under the Fit for the Future proposals this service would move from CGH and form part of an expanded Acute Medical Unit at GRH.
Presume staffing a single acute centre is easier than two making the care it can provide more consistent and 'guaranteed'. Is this the case?	Yes this is correct and a key driver for the change. Moving the acute medical take to one site would mean we have greater flexibility to cover staff rotas and provide a sustainable service.
Aspiration to excellence is essential but not if this is considered zero sum - i.e. we can	Our proposals are focused on creating Centres of Excellence at both hospital sites;

aspire to be a centre of excellence in A and therefore B will not be excellent. How are you proposing to ensure this does not happen?	for planned care and cancer at CGH and for emergency care, paediatrics and obstetrics at GRH. Through the centralisation of specialist services we would be able to utilise our resources (staff, buildings and equipment) in a more effective, efficient and sustainable way.
There are currently services which are already considered excellent: does the Trust know what these are and do the various plans consider that aspiring to excellence in one domain might strip an already considered excellent service of its status?	The Fit for the Future proposals aim to build on our services which are already considered excellent, for example cancer care at CGH and paediatrics and obstetrics at GRH, by using the same approach of centralisation of highly specialist services which allows us to utilise our resources (staff, buildings and equipment) in a more effective, efficient and sustainable way. There are no plans to change those services but rather learn from their experience to ensure that we have excellent services for the population we serve.
We know that to give patients a good experience at the 'front door' we have to have an efficient 'back door'. How are you going to support the hospitals 'back door' as this is as important as the 'front door'?	Fit for the Future focuses specifically on specialist services provided by the GHFT which includes the admission and discharge of affected patients. However, the Trust continues to work in collaboration with our local integrated care system to improve end to end care pathways across a wide range of services; this work is ongoing and complementary to the Fit for the Future programme.
We know that moving older patients and particularly patients with dementia multiple times is not good for their recovery. How can we make this better for this cohort of patients?	We are fully aware of this risk and do our utmost to minimise any unnecessary ward moves in patients with delirium and dementia unless the clinical situation or operational pressures make this imperative Our Staff are trained in supporting the care of patients living with dementia and aim to work in partnership with carers and relatives. We use a butterfly symbol to make all members of the team aware that a patient needs extra support. The butterfly

	symbol may be on the patient's medical notes and/or on their hospital identity wristband. We also support 'John's campaign.
What plans do you have to ensure patients are not moved multiple times between sites, or indeed, wards at each site?	As part of Fit for the Future programme we are identifying the number of beds required on both sites in order to support the proposed changes. We are also developing protocols to ensure that the best care is provided on both sites and that patients are not moved unnecessarily. In addition our Cinapsis system is helping GPs to have conversations with Consultants to determine if a patient needs to be seen in A&E, or admitted and if so which hospital to refer to.
Currently, the acute medicine facilities are woeful. What investment are you putting in to improve the acute medicine facilities?	Separate to Fit for the Future the Trust has a capital development plan to improve the space and layout of the Same Day Emergency Care and Acute Medical Unit facilities at GRH.
What are you offering Cheltenham to ensure it doesn't suffer as a town because you have made Gloucester your focus?	Our proposals are focused on creating Centres of Excellence at both hospital sites; for planned care and cancer at CGH and for emergency care, paediatrics and obstetrics at GRH. Through the centralisation of specialist services we would be able to utilise our resources (staff, buildings and equipment) in a more effective, efficient and sustainable way. Separate to Fit for the Future the Trust has a capital development plan to provide two new theatres and a day surgery suite at CGH. Fit for the Future proposes no change to the availability of outpatient services at CGH and we have made a public commitment to maintain the A&E department at CGH. The department will continue to provide Consultant Led services 8 a.m. to 8 p.m. and a Nurse Led service from 8 p.m. to 8 a.m.

	This model of care has been in place at Cheltenham A&E since 2013. Under the Fit for the Future proposals, the same day emergency care service at CGH (which is provided by acute medicine and is consultant led) would extend from 8am to 6pm, Mon to Fri to 8am to 8pm Mon to Fri. It is anticipated that Fit for the Future proposed changes would impact approx. 20-30 people a day i.e. these patients would need to travel to or be taken to GRH for their acute care.
Will the centralisation of the Acute Medicine take improve access to mental health services?	Similar to centralising acute medicine onto one site, the mental health team supporting acute medical patients would be able to concentrate their team that supports these patients onto one site giving them greater flexibility to deliver these services.
Are you going to increase the bed capacity at Gloucester so that it can cope?	Fit for the Future is a long term strategic plan, which will take a number of years to implement as it will require changes to estate (including ward and theatre capacity), workforce and equipment. As part of the programme we are reviewing bed numbers across both sites to ensure that they align with the proposed change in services.
How are you involving support services e.g. Pathology and Pharmacy in the planning?	Support services requirements have been factored into the design of our proposals and were included in the process of developing and appraising the Fit for the Future solutions.
Dropping off close to entrances is difficult, particularly A&E and finding a parking space is difficult at GRH. What are your plans, if any, to improve and increase the access and parking facilities at GRH?	As part of the capital development programme at GRH, access to the A&E department will be improved. Whilst there are currently no plans to increase parking spaces we regularly review the provision of public transport to help improve access to

	our hospitals.
Why has Cardiology not been considered in any of these plans?	Interventional Cardiology is included in this consultation (as part of the Image Guided Interventional Surgery (IGIS) service. Non interventional cardiology could be included in any future phase of Fit for the Future.
There are far too many elderly patients as outliers across the hospital; another care of the elderly ward would be beneficial. Are you considering the use of beds at CGH?	As part of Fit for the Future programme we are modelling the number of beds required on both sites to support the proposed changes. This modelling focuses on activity by specialty rather than existing bed numbers. The aim will be to avoid patients having to be admitted as 'outliers' to the wards of other specialties.
Gastroenterology inpatient services	
Has the recent pilot trialling this been successful?	Yes very. The service has been able to provide a better patient experience as patients are treated by the right specialists at the right time. Clinicians have been able to concentrate on sub-specialty work and have increased the number of endoscopy sessions and clinics. The pilot has worked well for junior doctor who have been able to undertake the specialist training required and improves staff retention and recruitment.
What are the results / outcomes of the recent pilot trailing this?	As above
Despite gastro inpatients being at CGH currently, gastro inpatients are still seen on GRH wards and do not get the care they need from the gastro team. Will you move patients to CGH to get the specialist care they need and care is not impacted?	Although the Gastro ward is based at CGH, there is an on call consultant and registrar at GRH to give timely opinion to patients coming into ED at GRH and also patients who require assessment and short term treatment can be seen at GRH. However if a longer stay for a more complex condition is required the patent will be transferred to the specialist ward at CGH.
Will there be some gastroenterology presence at GRH also?	As above
Would it not be better suited at GRH where other acute medical care is taking place?	As explained above there are clinicians at both sites, the transfer to CGH is only for

	those who need specific and complex gastrointestinal specialty care.
Do both hospitals not need a centre of excellence due to the size of the population and the location of the services? Will CGH be able to cope with demand for this service?	Gloucestershire Hospitals is a very large Trust but the number of patients who require treatment as an in-patient in gastroenterology is relatively small and co-locating the In-patient team on one site enables the provision of the best service.
Will colorectal surgery is also be located at CGH? Without this it will leave Gastroenterology exposed.	There are two options for colorectal surgery, one at CGH and one at GRH. In either option there would be a daily senior gastroenterology clinical team at both sites and so liaison with the colorectal team would continue whichever site colorectal is based.
Will you consider having continuing support for Gastroenterology services at Cirencester hospital?	Endoscopy and outpatient clinics, where most treatment is carried out will remain unchanged and continue to be provided at community hospitals.
Will Emergency Gastroenterology patients be admitted to ED at CGH once it's reopened? Otherwise you don't have a 'centre of excellence. You will have patients on both sites.	The ED at CGH is closed temporarily as a result of the COVID epidemic and the plan is to restore the previous service. The plan is for patients to be able to access the service at both sites.
Will Pathology be taken into account with these decisions? - especially Blood Transfusion	It is essential when services are re-organised that all support services are included as no service can run without input from colleagues. Before making the changes task and finish groups are implemented to involve all services that will be affected so that we have the assurance that they are able to provide the support. The pilot has run for 2 years and the service is running well.
Will this be a Proper centre of excellence? If you want to have a centre of excellence EVERYTHING to do with that area of medicine needs to be there, no half measures.	The Specialist ward at CGH will be a centre of excellence for patients with complex conditions and the team will be co-located to provide this. However it is important that those who require out-patient or short stay assessment and treatment have access to treatment nearer to home at CGH, GRH and

	Community Hospitals.
Describe centre of excellence as this term is being overused in the survey?	When specialist care is needed our aim is to increasingly deliver this through 'Centres of Excellence', centralised services where we can consolidate skills and equipment to provide the very best care. Sometimes these centres may be outside Gloucestershire, but where possible as an Integrated Care System we think it would benefit patients to develop our specialist services so we can provide specialist care in our county.
Will this service be easily accessible?	Yes patients would be assessed at both CGH and GRH EDs and out-patient clinics and endoscopy clinics would be maintained at all sites including community hospitals.
Is this not already in place?	The pilot was started 2 years ago but consultation is being sought to make this move permanent.
General Surgery (emergency general surgery, planned Lower Gastrointestinal [GI] / colorectal surgery and day case Upper and Lower GI surgery)	
How would you support those that need emergency surgery at CGH?	The proposal is for all emergency surgery to be located at GRH. If an ambulance is called the paramedics would review and would take the patient directly to GRH. If patients 'walk in' to CGH ED and need to be reviewed or referred to the surgical team there are existing Standard Operating Processes in place depending on how poorly the patient is.
Are patients that require emergency general surgery fit to travel between sites?	As above.
Why can there not be this service offered at CGH too?	There are a number of very high risks involved with continuing to provide emergency general surgical services at both sites, they are: • There are not enough junior (trainee) doctors to cover rotas on both sites and there is negative feedback from trainees about their workload. • In a 7 month period in 2019 15% of

	shifts (390) for emergency surgery were not covered. Gaps in rotas have increased by 46% in three years. • At times senior doctors are in theatre an unavailable to review you if you are waiting for specialist assessment in the ED or surgical assessment unit. This leads to delays. All these issues would be resolved by moving to one site.
Will the bed capacity at GRH be able to cope with this? How will you ensure surgical patients are not outliers on other wards?	Bed capacity is being modelled; services would not be moved permanently before bed capacity is established.
Will GRH A&E be able to cope with the increase in emergencies?	The service has moved as part of the COVID changes and already we have seen the ED process improve with higher percentage of patients seen quickly. This is because there is a dedicated senior team of clinicians that are not rostered to be in theatre and can give a specialist opinion. There is also a surgical assessment unit to provide timely assessment and treatment, which means patients often don't need to be admitted to a bed.
Will there still be surgical cover at CGH even after centralisation?	There will still be surgery carried out at CGH, urology, gynae-oncology, elective orthopaedics, breast surgery and day surgery. Elective colorectal surgery is being discussed as part of the programme with options for centralisation at either CGH or GRH. There will still be an out of hours theatre team on call at CGH, to provide care for patients who need to return to theatre with complications. There are Standard Operating Processes in place to ensure a patient is reviewed by or referred to the surgical team depending on how poorly the patient is.
By making this change will you be able to protect planned surgery and reduce the	Yes, particularly for those who are planned to have day case surgery as in times of very

number of cancellations especially those cancelled on the day?	high demand sometimes it is necessary to use beds in the day surgery ward at GRH for in-patients. By moving this work to CGH where a new designated day surgery ward and two new theatres are to be built, this should reduce cancellations and improve patient experience.
How many will this change affect per year – i.e. how much emergency general surgery is performed each year?	In the year Feb 2019 to Jan 2020, 5,782 people underwent emergency general surgery. Of these 1,753 were carried out at CGH. An impact assessment has been undertaken to assess the travel impact, it shows: • For 74 patients who had emergency surgery at CGH the transfer to GRH would be positive • For 1,342 patients who had emergency surgery at CGH the transfer to GRH would be neutral • For 337 patients who had emergency surgery at CGH the transfer to GRH would be negative
How are you going to increase the bed availability at GRH to manage this?	Fit for the Future is a long term strategic plan, which would take a number of years to implement. We are also investing in new facilities at both hospitals which will increase the number of patients we can look after. As part of the programme we are reviewing bed numbers across both sites to ensure that they align with the proposed change in services.
How are you going to ensure CGH theatre staff maintain their skills in emergency surgery?	Many staff work on both sites already and often this is done to gain experience in different fields. When the final decisions are made all affected staff would be involved in discussion to assess the best area for them to work with regard to their personal situation and training and experience.
How will you minimise the number of times patients are moved between each hospital or between wards at each hospital?	For people undergoing elective (planned) surgery, the site would be specified. For those who are emergency admissions; if they

	arrive by ambulance they would be taken to GRH directly. The patients that may need to travel are those who 'walk in' to ED at CGH and after assessment are found to require hospital admission. These patients will be transferred to GRH.
Will there be enough parking at GRH for the increase in people going there?	There is more car parking available on the GRH site as the Trust gained permission to build a multi storey car park. On the GRH site there are a total of 11 car parks providing 1,854 car parking spaces, of which 532 are public, 1208 staff and 87 spaces available for blue badge holders (DDA). On the CGH site there are a total of 11 car parks providing 741 car parking spaces, of which 192 public, 437 staff and 40 Oncology patient car parking spaces with 56 spaces for blue badge holders.
What are the financial implications of this move?	There are no changes anticipated to income or workforce and so the financial impact is neutral
How are you going to measure if this change has been successful in improving patient and staff experiences and outcomes?	There are a wide range of quality, outcome, patient and staff performance measures that are monitored to assess the impact of any changes. In addition there are currently 5 items on the GHFT Risk Register with regard to emergency general surgery which would be monitored; they are: • A risk of unsafe surgical staffing caused by a combination of insufficient trainees and excessive work patterns. • A risk of patient safety caused by insufficient senior surgical cover resulting in delayed senior assessment and treatment. • A risk to safe service provision caused by an inability to provide an appropriate training environment leading to poor trainee feedback which could result in a reduction in

	trainees and therefore adversely impacting on the workforce. • A risk of sub-optimal care for patients with gall-bladder disease and other sub-specialty conditions caused by a lack of ability to create a sub-specialty rota which could result in inequitable care and different clinical outcomes. • A risk of sub-optimal care caused by the limited day time access to emergency theatres resulting in an increased length of stay and poor patient experience.
Why can't you build a new hospital in the middle?	Over a billion pounds would be required and although Gloucestershire County Council does have this as a goal for the future, it would take 12-15 years to deliver. It in meantime we need to provide the best care with the resources that we currently have.
Will you consider the support services when you make this change for example Pathology?	This is a really important point, no service can move without the support of other services. During the months before the start of the pilot weekly task and finish meetings were held with all associated services, pathology, pharmacy, therapy, theatre, nursing, radiology and the emergency department to ensure that SOPs were in place and rotas etc. had been amended to reflect the changes.
How will you ensure resilience when you have an outbreak of Norovirus or Covid and have to shut wards?	This would not change, sadly these outbreaks can and do occur at either site. There is a dedicated infection control team who advise on a daily basis with the optimal way to segregate and treat patients who have or are exposed to these infections.
Have you been working with the ambulance service when looking at these changes?	Yes, we have been working closely with the ambulance trust to ensure that all options are deliverable.
What will there be about CGH to attract anybody to work there, if surgery is removed	There are no proposals to remove surgery from CGH altogether. Surgery for urology,

from Cheltenham altogether?	gynae-oncology, elective orthopaedics, breast surgery and day surgery will be based at CGH. Elective colorectal surgery is being discussed as part of the programme with options for centralisation at either CGH or GRH.
Which hospital is safer, Gloucester or Cheltenham?	Both are safe, all service moves are carefully considered and safety is of paramount importance. If the executive team and external agencies are not reassured that a proposal is safe, it would not be considered.
Haven't you already made the decision about where you are going to locate services?	There is a preferred option for emergency surgery which is at GRH and for day surgery at CGH. These recommendations come after significant work to assess the best options by assessing the patient benefits of co-locating services. As there was not a preferred option for elective colorectal surgery, either CGH or GRH, both were included in the consultation; the feedback of which is carefully considered before decisions are made on any permanent changes.
Image Guided Interventional Surgery (IGIS) including Vascular Surgery	
Are you going to invest in the theatres at GRH to provide an environment at least comparable to that already in Cheltenham?	Yes. We would convert theatre capacity at GRH to a 'hybrid theatre' facility to allow complex endovascular procedures to be undertaken. The existing hybrid facility at CGH would be converted to a standard theatre.
How are you going to ensure there are enough beds at GRH to manage the extra demand?	Fit for the Future is a long term strategic plan, which would take a number of years to implement. We are investing in new facilities at both hospitals which will increase the number of patients we can look after; for example 41 additional beds at GRH as well as improved day case theatre facilities at CGH.
Are you planning to invest in the ward space for this patient group if this change goes ahead?	Absolutely. It would be important to ensure services are allocated a sufficient number of beds to manage their patient throughput, and that these beds are within an

	appropriate environment which supports the delivery of excellent care.
Why did you invest in a hybrid theatre in Cheltenham to then decide to move the service?	In 2007 the decision was taken to centralise Vascular Surgery. At that time an options appraisal was undertaken to consider the benefits of centralisation at either CGH or GRH. CGH was selected as the preferred location. The proposal we are now consulting on to relocate the Vascular arterial centre (regional hub) to GRH is in consideration of the current and proposed configuration of services. Critical to this is the relationship with general surgery, the benefits of centralising emergency general surgery at GRH, and the requirement for general surgery staff to form part of the on-call surgical rotas for Vascular Surgery. The Hybrid facility in CGH was installed in 2013, and the technical equipment within it is now reaching its planned end of life.
Will the proposed change mean that planned vascular surgery is less likely to be cancelled?	The proposals are to relocate the vascular arterial centre and inpatient bed base to GRH. This would mean that complex endovascular surgery and vascular surgery patients requiring an overnight stay in hospital would take place in the safest environment, with other emergency services available to assist at the same location 24/7 should complications arise. Approximately one third of surgical interventions undertaken in vascular surgery are conducted as day cases. Elective day case procedures would be undertaken at CGH in the new Day Surgery unit, allowing these vascular patients to benefit from the Centre of Excellence for Elective Care.
Do these proposals cover all of vascular or are you going to split emergency and planned between the two hospitals?	These proposals would move all emergency vascular work to GRH. Any vascular procedure requiring an overnight stay would also be undertaken at GRH, as well as complex surgery and endovascular surgery

	requiring the hybrid theatre facility. Approximately one third of our vascular procedures are undertaken as day cases and these would be conducted at the new Day Surgery unit at CGH.
Why are you centralising vascular at GRH and leaving cardiology at CGH?	Interventional cardiology is part of the Fit for the Future Phase 1 scope and it is proposed this is located at GRH with vascular surgery. The wider cardiology service is expected to form part of the Fit for the Future Phase 2. All configuration scenarios will be considered during this process and appraised in order to determine the preferred configuration.
Trauma and Orthopaedics (T&O) inpatient services	
1. Trauma and orthopaedic need to go together. It would be VERY confusing to split them. You've GOT to start treating this as one hospital over 2 sites; not 2 different hospitals. EVERYTHING trauma and orthopaedic at Gloucester. How will this work across 2 sites with transferring patients and ambulance admissions? And 2. Because the two are so closely linked, why not have one Centre of Excellence in one place? 3. Why are these separated at two sites? Are they not related, so should be together on one site?	The orthopaedic service has always been divided into two categories, trauma and elective (planned) surgery. Although there are some similarities the two work quite differently and have completely separate wards (even on the same site). The reason for this is that for many orthopaedic operations, for example joint replacements need ultra clean environments to prevent infection, so the elective wards are ring-fenced for this group alone and patients have stringent tests for MRSA, MSSA and COVID 19 before admission. Separating facilities for emergency care (from planned care) would ensure that, if you have a life or limb threatening emergency, the right facilities and staff would always be available to give you the best possible chance of survival and recovery. Conversely separating the elective (planned) surgery would mean a smaller chance of cancellation at short notice. It would also be impossible to have the whole service on one site as the infrastructure does not allow this. 8 laminar flow theatres would be required on one site.
I think it makes sense to have trauma on one	This is a very important point. The pilot was

site but there needs to be adequate orthopaedic cover for the other site. Will this happen?	started at the end of 2017. The majority of the out of hours team will be working with the unscheduled or Trauma site. However it is essential that the elective site is also fully covered. There is a separate doctor rota at the elective site together with a team of dedicated nurses, therapists, pharmacists, radiographers and extended scope practitioners. In the early days of the pilot we also started a daily ward round for elective patients as we felt there was a gap in service provision.
Will sites be able to cope with capacity?	Yes, the service is very large and was previously spread across the site so was able to refine the service within the existing footprint.
Are both sites fit for purpose?	Yes, but centralising the service onto separate sites is really just the beginning; it provides the foundation to build for the future. For example the service has continued to evolve with Enhanced Recovery after Surgery work and rationalisation of surgical equipment in elective surgery and the implementation of a Trauma Assessment & Treatment Unit within Trauma services
Has the recent pilot trialling this been successful?	Yes, many things have improved for example: Trauma: • Now there is a review of every trauma patient 24/7. • There is always a senior orthopaedic surgeon available to respond to patients in ED. • The feedback from junior doctors regarding training is much improved Elective: • There are significantly fewer cancellations • There are increased volumes of hip and knee surgery (until theatre refurb in 2019 and COVID in 2020)

	• Changes have facilitated improvements in ERAS. However the service continues to evolve and improve with the provision of Trauma Assessment & Treatment Unit and responding to the needs of the patients and staff.
Will Pathology to be taken into account with these decisions - especially Blood Transfusion?	This is a really important point, no service can move without the support of other services. During the months before the start of the pilot weekly task and finish meetings were held with all associated services, pathology, pharmacy, therapy, theatre, nursing, radiology and the emergency department to ensure that SOPs were in place and rotas etc. had been amended to reflect the changes.
Only makes sense if full A&E restored at Cheltenham?	There is a national trauma network in place. For Gloucestershire the Trauma Centre is in Bristol but Gloucestershire Royal Hospital (GRH) is designated a Trauma unit. Therefore the only patients attending Cheltenham General Hospital (CGH) for a trauma injury will be those who 'walk in' or those that the ambulance teams have assessed can be managed at CGH. There are well established operational policies in place to manage any patients that need to be transferred from CGH to GRH for admission.

8. Evaluation

8.1 Considerations and learning points for future engagement and communication activities

Our approach to evaluating the effectiveness of our consultation activities locally is to apply a well-known quality improvement methodology, using an iterative process: Plan, Do, Study, Act (PDSA cycle) https://improvement.nhs.uk/documents/2142/plan-do-study-act.pdf

We have applied the following evaluation framework.

Engagement (and Consultation), Experience and Inclusion Evaluation Framework developed by The Science and Technologies Facilities Council has developed a useful engagement evaluation framework, https://stfc.ukri.org/files/corporate-publications/public-engagement-evaluation-framework/ We have adapted this to support the STUDY element in our Engagement, Experience and Inclusion PDSA Cycle		
Dimension	Definition	Response
Inputs	Engagement (and Consultation), experience and inclusion inputs include the time, skills and money that are invested into delivering engagement activities.	A comprehensive Fit for the Future communications and consultation plan was developed to support the consultation activity. This plan, assured by NHS England/Improvement and independently by The Consultation Institute, set out the approach to communications and consultation. In response to pandemic restrictions, the plan was developed to support a 'socially distanced' consultation. This included the development of more online methods such as the new Get Involved in Gloucestershire online participation platform; independently chaired Gloucestershire Media @GlosLiveOnline discussions and Gloucestershire Hospitals NHS Foundation Trust Facebook Live produced clinical discussions. The plan was evaluated using an Engagement and Equality Impact Assessment https://www.onegloucestershire.net/wp-content/uploads/2020/10/Equality-and-Engagement-Impact-Assessment-FINAL-1.pdf
Outputs	Engagement (and consultation), experience and inclusion outputs are the activities we	Over 75 engagement events were held. The majority of events were held on line. The Information Bus Tour were socially distanced face to face events. Approximately 5000 information booklets were produced and distributed in local communities.

	undertake and the resources that we create.	A door to door drop of 297,000 delivered information to households in Gloucestershire. This resulted in over 1,700 requests for information. This was a key method for ensuring that people not able to access materials on-line were able to engage with the consultation. Feedback received did include comments on the Fit for the Future communications and consultation process itself. Feedback received was a mixture of positive and negative comments. An example of learning from feedback of this kind from the earlier Fit for the Future engagement was the suggestion to use of QR codes on future publications to allow people to link quickly to website materials. A QR code was added to the Fit for the Future consultation materials.
Reach	Reach has two main elements: The number of people engaged, this includes attendance at events, completion of surveys, social media interaction etc. The types or diversity of people engaged.	Total face-to-face contacts was more than 1000 (public) and more than 350 staff. More than 700 Fit for the Future surveys completed. There were 22 Facebook posts with a reach of over 90,000. 38 tweets generated over 30,000 impressions and over 750 engagements. We do not routinely collect demographic information about individuals participating in events/drop-ins etc. Demographic information was collected through our survey, but these questions were optional and consequently were not always completed. However, the demography of the county is considered during consultation planning and events/meetings targeted to reach a wide range of communities of interest and those groups identified though the independent Integrated Impact Assessment.
Outcomes	Outcomes are the way that audiences respond to the engagement, experience and inclusion activity – completed event evaluation forms, independent observation	The consultation has been independently Quality Assured by The Consultation Institute. A Consultation Institute Advisor worked with the Fit for the Future programme, acting as a critical friend; each stage of the consultation planning and activity was formally signed-off by a Consultation Institute Assessor, ensuring a totally independent element in the consultation process. The six stages, or gateways, of the Quality Assurance process are: • Scope and Governance • The Project Plan • Consultation Document Review • Mid-Point Review* • Closing Review

	reports	• Final Report *The Mid-Point Review considered the efficacy of the consultation activities to date and those planned for the second half of the consultation period to identify any potential gaps in opportunities for participation. Prior to the Mid-Point review Covid-19 Lockdown#2 necessitated the postponement of some Information Bus Tour Dates, alternative locality online 'Cuppa and Chats' were arranged to provide opportunities for geographically based participants to discuss the consultation proposals. The Information Bus Tour recommenced after the end of Lockdown#2. The consultation team also discussed responding to requests for additional information with The Consultation Institute see Annex 1 Section 9.4 for detail of Additional Information process.
Processes	Processes are the way we work to plan, develop and deliver our engagement, experience and inclusion activities. They include our approaches to quality assurance and following good practice.	See above The Consultation Institute Quality Assurance process. Inclusion Gloucestershire: Assisted with the development of Easy Read materials. Gloucestershire County Council's Digital Innovation Fund Forum: Informed early planning for online activities and assisted with awareness-raising of the consultation to potentially digitally excluded groups. Friends from the Friendship Café in Gloucester City: Supported awareness raising and survey completion within diverse communities. Healthwatch Gloucestershire (HWG): HWG Readers Panel reviewed an early draft of the full consultation booklet and made suggestions for changes, which were incorporated into the final version. A HWG representative will be a member of the independent Oversight Panel for the second Fit for the Future Citizens' Jury. Aneurin Bevan Health Board (ABHB): ABHB facilitated the translation of the summary consultation booklet into Welsh, and facilitated an Information Bus visit to Chepstow Hospital in Monmouthshire to enable residents living close to the Wales England Border, who might access services in Gloucestershire the opportunity to find out more about the

		consultation. Know Your Patch (KYP) Coordinators: KYPs allowed us space on agendas to share information at online meetings during October and November 2020 to promote the consultation. District/Borough Councils and Retail partners: Supported the 'socially distanced' visits of the Information Bus (outside of Lockdown 2) to locations with maximum footfall across the county. District and Borough Councils also hosted members' seminars to discuss the Fit for the Future consultation. Local media: Gloucestershire Live, BBC Radio Gloucestershire and GFM Radio Others: Many other groups and individuals have helped to raise awareness of the consultation such as Trust Governors, staff-side representatives, hospital volunteers and community and voluntary sector organisations such as homelessness support charities.

8.2 ACT (following Fit for the Future engagement)

The following actions were undertaken following feedback received during the FIT FOR THE FUTURE engagement to support future communications and engagement associated with FIT FOR THE FUTURE Programme:

Inclusion Gloucestershire participants identified the following areas for us to consider to improve engagement further (extract from Inclusion Gloucestershire Engagement Report):

- Less information, less jargon and easy read copies of all information.
- From our experience, people who represent the seldom heard groups tend to need more time and preparation to support them to engage. It would have been helpful to have had at least two weeks research time prior to each area workshops.
- Workshops to be held later in the morning to enable people who use public transport to use their bus passes.
- Workshops to be held in the actual areas and at times that people can attend. For example: Tewkesbury was held in Highnam for 09.00am, Stroud and Berkley Vale held in Nailsworth for 09.00am and North Cotswolds was held in Cirencester for 09.00am.
- Some people from the BME communities were not able to engage in the workshops due to a language barrier. Going forward it might be more beneficial to liaise with community leaders to hold specific workshops within the BME communities with community support for interpreters. We know that there are many barriers for people from the BME communities accessing health care. For many, they don't know how to ask for the health care that they need or struggle to understand treatment options.

- For One Gloucestershire to go out to community groups such as the Inclusion Hubs for those who need to go at a slower pace and for a wider group of people to be included in the process.

8.3 ACT (following Fit for the Future consultation)

The following actions will be undertaken following feedback received during the Fit for the Future consultation to support future communications and engagement:

- The consultation targeted the **visually impaired** people through representatives from the Sight Loss Council, the Macular Society and RNIB. The following suggestions were shared with the consultation team in order for them to reach more people with Visual Impairment:
    - Place adverts in Talking newspapers
    - Use BBC local radio
    - Focus on promotion of telephone line and ability to order large print copies of the booklet
    - Focus on voice based/telephone based contact as most of people with visual impairment don't use desktops/laptops and rely on mobile phones.

- The consultation targeted the **homeless people;** the consultation team now has established good links with homelessness charities in Gloucestershire, these networks should be maintained and development further through links with the Gloucestershire Hospitals NHS Foundation Trust Homeless Specialist Nurse.

- The consultation targeted **travelling communities;** the consultation team now has established good links with the County Council Traveller Welfare Officer. Plans to improve communications for travelling communities about local NHS services are planned for 2021.

- The consultation used more **online participation methods** than ever before. These proved to be very popular with groups who may not have engaged with consultations before and facilitated easier access to more people who may not have previously been willing or able to attend face to face events. The One Gloucestershire Communications and Engagement Sub Group will review the current online methods available and consider opportunities for maximising their use for future engagement and consultation activities; in particular use of a range of online platforms will be explored to maximise choice and access.

8.3.1 ACT (following Citizens' Jury #2)

The following actions will be undertaken in response to observations made by the Fit for the Future Citizens' Jury #2 to support future communications and engagement, we will:

- consider the use of 'incentives' to participate: financial would be prohibitive on a countywide scale, we have tried prize draws in the past but these made no difference to response rates.

- think about how to maximize impact of postage options e.g. inclusion of NHS information with other door to door communications distributed by ICS partners e.g. District Council Council Tax News or The Local Answer.
- consider how, in future plans we could better balance the description of the 'all public/staff' activities.
- think about how the input of past, current, and future users of services under consultation and patient experience can be emphasized more in engagement and consultation materials.
- investigate 'Sampled' market research as an alternative option to consider in future – but note that sample size of this kind would be a smaller number of responses than general survey response rate.
- pursue further opportunities to promote participation in less well represented districts.
- review the CCG Engagement and Experience Strategy to incorporate Jury findings.
- consider additional methods for signposting to outcomes of earlier engagement activity.
- continue to work with Inclusion Gloucestershire and others to develop Easy Read documents to a high standard and review methods to increase awareness of Easy Read.
- ensure that the purpose of background documents which are made public is clearly described e.g. a technical document part of the national NHS assurance/planning process.
- develop and further raise awareness of GIG across Gloucestershire with the aim of encouraging local people to register to keep up to date with involvement opportunities.
- make the Decision Making Business Case available in the public domain'.
- establish a 'lay/public' reference group to be involved with reviewing implementation plans for changes approved by decision makers.
- consider how we explain the assurance and scrutiny process associated with consultation. The Consultation Institute Quality Assurance conclusions will be considered and any opportunities for future engagement and consultation identified will be investigated.
- continue to recognize the value of analysis of free text/qualitative feedback and actively seek innovations to maximize the impact of this important engagement and consultation data.
- make available decision making documents in the public domain on the One Gloucestershire Website and the Get Involved in Gloucestershire online participation space and share these with participants to the consultation (for whom we have contact details
- continue to investigate innovative opportunities to communicate with local people, building on the new media online/social media partnerships developed during the FFTF programme to date.

9. Annex 1:

Activity post publication of Interim Output of Consultation Report

9.1 Interim Output of Consultation Report

The Fit for the Future Consultation period ended on 17 December 2020. Preparation of the Interim Output of Consultation Report took place between 21 December 2020 and 3 January 2021. The Report was published week commencing 4 January 2021.

All feedback received during the consultation period was included within the Interim Output of Consultation Report and Appendices

Report: https://www.onegloucestershire.net/wp-content/uploads/2021/01/FFTF-IOOC-Report.pdf

and Appendices can be found at: https://www.onegloucestershire.net/yoursay/fit-for-the-future-developing-specialist-hospital-services-in-gloucestershire/

- Appendix – 1.1 – Full survey report
- Appendix – 1.2 – Easy read survey report
- Appendix – 1.3 – Responses by demographics:
    - 1.3.a – BAME
    - 1.3.b – Over 66 with disability
    - 1.3.c – BAME with disability
    - 1.3.d – Disability
    - 1.3.e – Mental health problems and learning difficulties
    - 1.3.f – Carers
    - 1.3.g – LGBT+
    - 1.3.h – 12 most deprived wards
    - 1.3.i – Healthcare professionals
    - 1.3.j – Public and community partners

- 1.3.k – Postcodes from East
- 1.3.l – Postcodes from West

- Appendix – 2 – Other Correspondence
- Appendix 2.1 Additional Responses Received is added to the Final Output of Consultation Report Appendices.
- Appendix – 3 – Glossary

9.1.1 Presentations

The Interim Output of Consultation has been discussed at various meetings, including:

- Gloucestershire Health Overview and Scrutiny Committee – 12 January 2021
- Gloucestershire Hospitals NHS Foundation Trust Board – 14 January 2021
- One Gloucestershire Integrated Care System Board – 21 January 2021
- NHS Gloucestershire Clinical Commissioning Group Governing Body – 28 January 2021

9.2 Citizens' Jury – 19-28 January 2021

Citizens' Juries in Gloucestershire

The NHS in Gloucestershire seeks to be innovative in its approach to engagement and consultation. We aim to ensure that potential solutions for service development are coproduced with local people and staff, and evaluated during an Engagement Phase; which is followed by Consultation before any final decisions are made. Our approach to communications and consultation and how we work with others is set out in Section 2 of this Report. Part of our local approach in recent years has been to incorporate Citizens' Juries into our engagement and consultation plans.

Few NHS organisations have experience of using this deliberative process as an element of engagement and consultation and consequently we have been invited to talk about the method at NHS England Master Classes and by The Consultation Institute. We have previous experience of commissioning two Citizens' Juries. The first considered the location for a new community hospital for the Forest of Dean. The second Jury formed a key element of the Fit for the Future (FFTF) Engagement in 2019.

Fit for the Future Citizens' Jury #1

FFTF Jury #1 considered feedback from the Fit for the Future public and staff engagement, together with evidence on the need for change across Gloucestershire's two main hospital sites – Cheltenham General and Gloucestershire Royal. Jurors considered staff and public feedback including survey findings, outputs from events, service workshops and the engagement hearing. They also heard evidence from expert witnesses on the need for change, access to services and best clinical practice. After careful assessment of the information, Jurors made recommendations about their priorities for three specialist services and gave their views on the centres of excellence approach. The Report of the FFTF Jury #1 can be found at https://citizensjuries.org/wp-content/uploads/2020/02/Jurors-Report-1.pdf

Fit for the Future Citizens' Jury #2

FFTF Citizens' Jury #2 took place via Zoom for eight days from 19 to 22 January and 25 to 28 January from 1pm-5.30pm each day. Citizens' Juries c.i.c. was commissioned by NHS Gloucestershire as independent facilitators of two Citizens' Juries associated with the Fit for the Future Programme. The brief for Jury #2 was to design and run a citizens' jury looking on the public consultation. Jurors heard from 11 witnesses who described what good NHS public consultation processes look like, how to interpret public consultation results, the local approach to the Fit for the Future consultation, local community perspectives on the Fit for the Future consultation and the Output of consultation; focussing particularly on the characteristics of respondents and differences between different groups responses to the consultation) as well as main themes and areas for consideration arising from the feedback to the consultation. More detail can be found in the jury specification published on the Citizens Juries c.i.c. website at: https://citizensjuries.org/wp-content/uploads/2021/02/Jury-specification.pdf

The online jury process was led by skilled facilitators: Kyle Bozentko and Sarah Atwood of the Jefferson Center. The Jefferson Center is a sub-contractor to Citizens Juries c.i.c. The Jefferson Center is a non-partisan, non-profit civic engagement organization specializing in the design and implementation of deliberative processes with global partners and clients on a range of policy topics.

On Day 1 of the Jury, Jurors were advised that Citizens' Juries c.i.c. had been commissioned by NHS Gloucestershire Clinical Commissioning Group as independent facilitators of the Jury.

How to access the FFTF Citizens' Jury #2 proceedings

In order to protect the identity and privacy of jury participants, it was not possible to watch the jury proceedings live. However, slides and audio recordings of the presentations by the expert witnesses were made available. The schedule outlining what happened each jury day

is available at: https://www.onegloucestershire.net/wp-content/uploads/2021/01/4-Planned-schedule-3.pdf

All presentation slides and audio files of the presentations can be found at: https://www.onegloucestershire.net/yoursay/fit-for-the-future-developing-specialist-hospital-services-in-gloucestershire/citizens-jury/

Audio recordings of plenary sessions of the jury, including question and answer sessions between jury members and the witnesses, were made available on request. Citizens Juries c.i.c. and the Jefferson Center aim to protect the privacy and identity of the jury participants. Protecting the identity of participants is more difficult if audio recordings of jury members speaking are widely shared. Therefore, to request audio file(s), individuals must first complete this online agreement form to not share the audio data.

Thank you to Citizens' Jury c.i.c. for preparing the downloadable files.

Full details of the Fit for the Future Citizens' Jury #2 can be found at: https://www.onegloucestershire.net/yoursay/fit-for-the-future-developing-specialist-hospital-services-in-gloucestershire/citizens-jury/ and

https://citizensjuries.org/gloucestershire-hospitals-consultation-2021-jury/

Independent Oversight Panel

The witness slides and other materials were reviewed prior to the Jury by an oversight panel who were briefed to check that the jury was being provided with a fair balance of relevant information. The oversight panel members, chosen for their interest in the topic and lack of conflict of interest in any particular jury outcome, were: Karen Newbiggin, Reader in Healthcare Policy and Management, Health Services Management Centre, University of Birmingham; Ben Stokes, Chair of Health and Wellbeing Board, South Gloucestershire Council; and Helen Webb, Healthwatch Gloucestershire Manager.

The oversight panel reviewed the jury specification, the expert witness brief, the juror agreement, and the slides of all witnesses. Changes were made to documents as a result, including the slides of witnesses before the jury began. Each panel member completed a short questionnaire at the end of the process assessing the potential bias and giving their reasoning.

Citizens Juries c.i.c. appointed the independent oversight panel.

About the participants (Jurors)

The participants were recruited by Citizens Juries c.i.c. during November and December 2020. The 18 adults selected broadly reflect Gloucestershire residents in relation to age, sex, ethnicity, educational attainment, geographical district, and employment status.

Extract from Jury Report: https://citizensjuries.org/wp-content/uploads/2021/02/FFTF-Consultation-Citizens-Jury-Report-Jan-2021-v1.pdf

Jury recruitment

In total, 332 people applied to be part of the jury. They applied by entering their personal details, including relevant demographics, into an on-line survey. Candidates were shortlisted based on their demographics alone using an algorithm supplied by the Sortition Foundation. Shortlisted candidates had a brief telephone or Zoom interview so that any ineligible candidates (e.g. current NHS professionals) could be identified and excluded. Some jurors were recruited by email or word of mouth, but the majority came through the "Indeed" jobs website. In order to guard against any bias from using a jobs website, the sample was controlled for employment status to ensure the majority were employed or self-employed. Each juror was paid £480 for eight afternoons. Paying participants is an important way to limit self-selection bias. One week before the jury, 18 jurors and three reserves had been recruited. The jury demographics were all within target ranges, broadly reflecting the population of Gloucestershire (in 2011 census) in terms of age, gender, ethnicity, and educational attainment, District (in Gloucestershire), and employment status. One person withdrew just before the jury began, and two people withdrew during the first two jury days, all because of unforeseeable changes to personal circumstances. The three reserve jurors were able to step in. Despite these late withdrawals a good demographic mix was still achieved. The geographical distribution of the 18 jurors across Gloucestershire was affected by the late withdrawals but there was still a fair spread (see map below). There were 4 jurors from Cotswold District, all chosen at random, but by chance none was from the north of the District.

Jury Output

The Citizens' Jury produced two reports: The Jurors' Report and The Citizens' Jury Report.

The Jurors' Report

The Jurors' Report is a report from the 18 members of the citizens' jury. The report was constructed using the words of the jury members, from statements they prepared together. A draft version was reviewed and agreed by jury members as part of the jury process on 28 January before being reformatted, published online and distributed to members of the jury.

https://www.onegloucestershire.net/wp-content/uploads/2021/02/Fit-for-the-Future-Citizens-Jury-Jurors-Report-v1.pdf

The following are extracts from the Jurors' Report about their experience as a Juror:

Everyone's opinions were taken into consideration and time was given to discuss individually and together to enable us to make the decisions in the report fairly.

I think that the effectiveness of the Jury over the past 2 weeks is in some degrees reflected by the whole consultation process and information that has been shared with all of the jury and how important a role that the jury plays its part and that because of the way the Jury process was delivered it has made a substantial contribution to the whole FFTF Consultation Process.

That we have listened to and seen the presentations from witnesses and experts, we have raised issues and questions for clarification directly with them at the time and that we have duly considered the issues that were directly involved in relation to the process and collectively with the assistance from experts and facilitators delivered a report that we believe to be fair and unbiased with points and recommendations for your consideration.

Considering we are going through a pandemic the efforts and lengths that were made to get the information out about the consultation was still made despite the pandemic. I do feel that the public was made aware of their best ability and we as jurors were led through the process. Considering I've never done this before in this way, it has definitely taught me something new meeting and grouping with like minded people of all ages and backgrounds and helped to get through this new way of working and communicating.

It was thorough and professionally conducted. Everything was open and transparent. Expert presentations covered every aspect of the jury deliberations. The organisers have been exemplary in every aspect. I have every confidence this experience will enhance my learning adventure.

Everyone's opinions were taken into consideration and time was given to discuss individually and together to enable us to make the decisions in the report fairly.

The Citizens' Jury Report

The Citizens' Jury report includes additional information (e.g. on jury recruitment) was produced by Citizens Juries c.i.c and published in February 2021. This Report is prepared as a report for the commissioners https://citizensjuries.org/wp-content/uploads/2021/02/FFTF-Consultation-Citizens-Jury-Report-Jan-2021-v1.pdf

FFTF Citizens' Jury #2 questions and conclusions

The jury were informed about the questions they were exploring, partly through the expert witnesses who gave presentations and answered questions posed by the jurors. Jurors were given time to work together and deliberate amongst themselves before reaching their conclusions. To reach their conclusions, the jury members worked together to answer important questions about consultation.

The jury made recommendations about the public consultation process and information, these observations are about the general characteristics of any consultation and consultation materials rather than specific comments about the FFTF consultation. Jurors then make observations about the most important things for the NHS governing bodies to consider from the public responses to the FFTF Consultation.

The section below considers each Jury question in turn and provides responses from the local NHS. Each NHS Gloucestershire engagement and consultation activity is evaluated using an Engagement, Experience and Inclusion PDSA (Plan, Do, Study, Act) cycle. Where further actions are proposed in response to Jurors' observations which could influence the process of future engagement and consultation these can be found in Section 8 of the Final Output of Consultation Report.

Q1. How good was the FFTF consultation process?

Q1a. What are the characteristics of a good consultation process?

Jurors agreed the important characteristics of a good consultation process and why it matters based on the evidence that they heard and their deliberations. These characteristics would apply to any consultation.

Quality / Characteristic of a Strong or Good Consultation Process	**Why It Matters (how this quality or characteristic helps us gauge consultation quality or results, etc.)**	**NHS Response in relation to the FFTF consultation**
Consultation seeks to incorporate guidance from relevant bodies, involves a wide variety of the public in its decisions, engages with all sections of society, including groups that are harder to hear, and is inclusive regarding location, access, and geography. - *16 votes*	- It is important to ensure all members of the public have the chance to have their say because everyone should be able to have the information available to be able to make an informed decision. - Shows that the consultation attempts to reach as many of the public as possible and aims to make sure changes made are in the best interest of as many people as possible.	Leaflets promoting the consultation were sent to all Gloucestershire households using Royal Mail. Information available on dedicated webpages and a new online participation platform https://getinvolved.glos.nhs.uk/ and promoted through a door to door mailer to all households, organic and regular paid for (sponsored) social media, print media, a countywide Bus Tour and an extensive programme of online participation events, including innovative media partnerships. All information available on request in different formats. There was a mix of summary and more detailed information. In response to the door to door leaflet – over 1500 requests for consultation information were received.

Process uses clear, concise and targeted information and materials. - *11 votes*	- This explains why proposed changes are necessary, informs the public with reasonings behind the decisions, and enables the public to evaluate the proposals and make informed decisions.	Public facing consultation materials (full version and short guide) written using plain English. A full glossary was included in the consultation booklet (based on a previous recommendation from the engagement phase). Healthwatch Readers' Panel and The Consultation Institute reviewed content and made suggestions for improvement prior to publication. Easy Read consultation materials prepared by Inclusion Gloucestershire.
Consultation is conducted in accordance with the Gunning Principles and process lasts a proportionate amount of time during formative stages of proposal development. - *5 votes*	- Demonstrates that the process has taken into account the relevant information over a timescale that does it justice and is based on previous experience and best practices.	Consultation materials setting out the proposals for change, how they were developed and the rationale for change were published and promoted (see above) for consideration. Consultation period was from October to December 2020; this was preceded by a 3 month period of Engagement in 2018/19. After the end of the Consultation, 3 months were allowed for analysis of consultation feedback prior to consideration and decision making in March 2021. The Consultation Institute Quality Assurance of the consultation states: *This consultation has been monitored by the Consultation Institute, under its Consultation Quality Assurance Scheme. The Institute is happy to confirm that the exercise has fully met its requirements for good practice.*
Process allows scrutiny from relevant media, local government, public representatives and the public. - *3 votes*	- This shows broad oversight of the consultation process.	Consultation timing and timescales including time allowed for consideration of consultation feedback approved by NHS England and Gloucestershire County Council Health Overview and Scrutiny Committee.

Jurors agreed the important characteristics of a weak consultation process and why it matters based on the evidence that they heard and their deliberations. These characteristics would apply to any consultation.

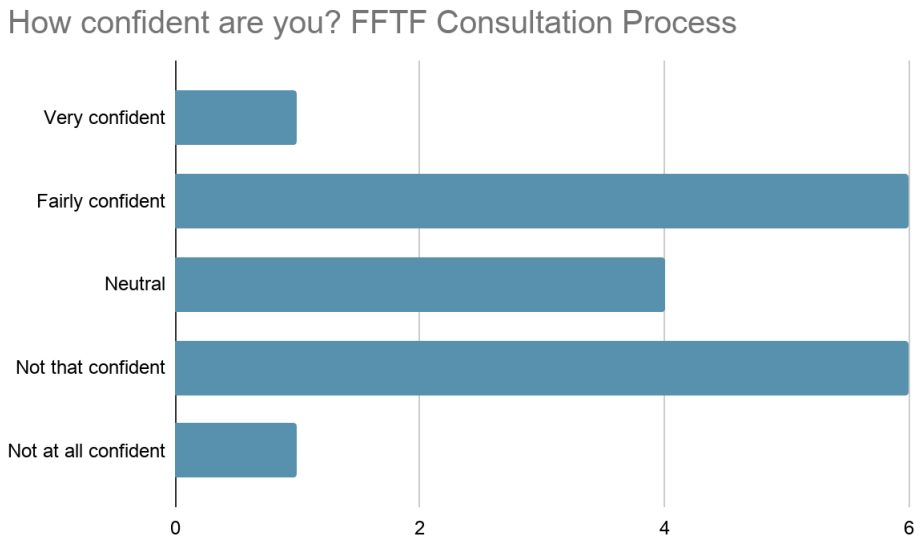
A response from the local NHS with respect to the FFTF consultation has been added in the table below.

Quality / Characteristic of a Weak or Poor Consultation Process	Why It Matters (how this quality or characteristic helps us gauge consultation quality or results, etc.)	NHS Response
The consultation process is not inclusive or there is a failure to consult the right people and those who are affected by service changes. - *8 votes*	- This matters because the CCG serves the whole of the county and needs to take account of differing medical needs across the whole county. - This matters because the ones who will be impacted by the decisions should be involved and different groups should be consulted appropriately. - This matters because evidence informing the proposals may be misleading and consultation results may be biased if based only on certain brackets of the public.	The FFTF Programme and Consultation was informed by an independent Integrated Impact Assessment (IIA). The Consultation process was designed to ensure that protected characteristic groups and others identified in the IIA had an opportunity to get involved with the consultation and have their say. Details of the approach to consulting people identified in the IAA can be found in Section 2.8 of the Output of Consultation Report.
Responses not analysed or responded to properly. - *8 votes*	- This demonstrates that the decision makers think the public's views are not important and could cause people to lose confidence in	Responses to the FFTF consultation are summarised in Part 2 of the Output of Consultation Report. Unusually for NHS organisations, all consultation responses (redacted for personally identifiable information) are published by NHS Gloucestershire. These can be found in the online Appendices at https://www.onegloucestershire.net/yoursay/fit-for-the-future-developing-specialist-hospital-services-in-gloucestershire/

	these services and the NHS.	After the end of the Consultation, 3 months were allowed for consideration of consultation feedback prior to decision making in March 2021. The development of the FFTF Decision Making Business Case (DMBC) has taken into account feedback from the consultation. The DMBC is available on the One Gloucestershire website.
There is not sufficient time for the consultation process. - *7 votes*	- This could make it so that not enough information will be gathered to make an informed decision and people won't have a chance to participate.	Consultation period was from October to December 2020; this was preceded by a 3 month period of Engagement in 2018/19. After the end of the Consultation, 3 months were allowed for consideration of consultation feedback prior to decision making in March 2021. Consultation timing and timescales including time allowed for consideration of consultation feedback approved by NHS England and Gloucestershire County Council Health Overview and Scrutiny Committee.
Not enough information is provided to the public about the consultation process and relevant changes. - *6 votes*	- This matters because it is vitally important to provide enough quality information to make an informed decision.	Information was available in printed documents and on dedicated webpages and a new online participation platform https://getinvolved.glos.nhs.uk/ and promoted through a door to door mailer to all households, organic and regular paid for (sponsored) social media, print media, a countywide Bus Tour and an extensive programme of online participation events, including innovative media partnerships. All information available on request in different formats. There was a mix of summary and more detailed information. In response to the door to door leaflet – over 1500 requests for consultation information were received.
Information not communicated effectively, not presented clearly and contains jargon. - *3 votes*	- This may lead to the public being confused or misinformed and not able to fully understand the proposed changes.	Public facing consultation materials written using plain English and a full glossary was included in the consultation booklet (based on a previous recommendation from the engagement phase). Healthwatch Readers' Panel reviewed content and made suggestions for improvement prior to publication. Easy Read consultation materials prepared by Inclusion Gloucestershire.
Proposals not developed transparently. - *3 votes*	- This matters because it may weigh the outcome in favour of a certain group or party.	The consultation was preceded by a 3 month period of Engagement in 2018/19. During this time. This engagement was an opportunity to talk about ways services could be organised so that local people can benefit from two thriving specialist hospitals in the future in Cheltenham and Gloucester. OVER 3300 local people participated in planned activities – but the focus of engagement is not about numbers it is

		about receiving qualitative feedback from a broad range of people. 1230 FFTF online surveys completed, 28 Public Drop in Events, 12 Independently facilitated workshops and Engagement Hearing and FFTF Citizens' Jury #1. This was followed by a solutions appraisal process held in public attended by a mix of public and NHS participants. The FFTF Output of Engagement Report can be found at: https://www.onegloucestershire.net/wp-content/uploads/2020/01/FFTF-Output-of-Engagement-Report.pdf

Q1b. Based on what you have learned, how confident are you that the consultation process has allowed all residents to contribute meaningfully to the decision-making process?



Jurors collectively identified and ranked reasons that made them confident that the consultation process has allowed residents to contribute meaningfully to the decision-making process.

Reasons to be confident that the consultation process has allowed residents to contribute meaningfully to the decision-making process.	**NHS Response**
Clear, concise language and limited jargon in materials - *11 votes*	Public facing consultation materials (full version and short guide) written using plain English. A full glossary was included in the consultation booklet (based on a previous recommendation from the engagement phase). Healthwatch Readers' Panel reviewed content and made suggestions for improvement prior to publication. Easy Read consultation materials prepared by Inclusion Gloucestershire.
Range of platforms and options for participating and responding - *9 votes*	Information was available in printed documents and on dedicated webpages and a new online participation platform https://getinvolved.glos.nhs.uk/ and promoted through a door to door mailer to all households, organic and regular paid for (sponsored) social media, print media, a countywide Bus Tour and an extensive programme of online participation events, including innovative media partnerships. All information available on request in different formats. Responses could be made using online and freepost surveys, letters, telephone interviews or face to face (socially distanced), online discussion forums and live streamed clinical discussions using Facebook live.
Variety of versions of documents with varying detail was provided - *8 votes*	Consultation materials setting out the proposals for change, how they were developed and the rationale for change were published and promoted (see above) for consideration. There was a mix of summary and more detailed information. In response to the door to door leaflet – over 1500 requests for consultation information were received. Easy Read consultation materials prepared by Inclusion Gloucestershire. All information available on request in different formats.

Significant effort made to reach and involve harder to hear groups - *6 votes*	The FFTF Programme and Consultation was informed by an independent Integrated Impact Assessment (IIA). The Consultation process was designed to ensure that protected characteristic groups and others identified in the IIA had an opportunity to get involved with the consultation and have their say. Details of the approach to consulting people identified in the IAA can be found in Section 2.8 of the Output of Consultation Report.
Process allowed for scrutiny from multiple outside bodies - *5 votes*	NHS England assured the FFTF Programme and consultation process. The Gloucestershire Health Overview and Scrutiny Committee received regular briefings about the FFTF Programme and consultation. The consultation was Quality Assured by The Consultation Institute.
Number of responses statistically acceptable based on software - *4 votes*	The NHS witness to the Jury discussed sample size. For a population of 65000 (approx. pop. of Gloucestershire) a sample size of 384 is acceptable. More than 700 responses to the FFTF survey were received.
Incorporated guidance from relevant outside bodies - *3 votes*	NHS England assured the FFTF Programme and consultation process. The consultation was Quality Assured by The Consultation Institute.
Conducted in accordance to Gunning Principles - *3 votes*	The consultation was Quality Assured by The Consultation Institute. The assurance process includes a review of the consultation project plan which addresses the Gunning Principles. The NHS Gloucestershire CCG Engagement and Experience Strategy: An open culture: a strategy for engagement and experience sets out our commitment to listen to the views of our local communities and involve people in the planning, development and evaluation of services. https://www.gloucestershireccg.nhs.uk/about-you/strategy-and-reports/ This strategy refers explicitly to the Gunning Principles.
Staff were given options for participating in process - *3 votes*	30% of survey responses were from staff. Section 2.5 of the Output of Consultation Report describes the staff communication and engagement activities.
NHS engagement staff (B. Parish) answered questions and presented confidently - *2 votes*	The FFTF consultation team were pleased to be invited to present information to the Jury and to participate in thoughtful question and answer sessions.
Carried out over a timely and appropriate timescale	Consultation timing and timescales including time allowed for consideration of consultation feedback approved by NHS England and Gloucestershire County Council Health Overview and Scrutiny

- *0 votes*	Committee.
Open and inclusive process - *0 votes*	The consultation was open to all. All consultation documents were made available either on line or print and in other formats on request. Details of consultation activities focusing on protected characteristic groups identified through the independent Integrated Impact Assessment can be found in Section 2.8 of the Output of Consultation report.

Jurors collectively identified and ranked reasons that made them not confident that the consultation process has allowed residents to contribute meaningfully to the decision-making process.

Reasons to not be confident that the consultation process has allowed residents to contribute meaningfully to the decision-making process.	**NHS Response**
Conducting consultation during Covid-19 pandemic compressed timeline, made it more difficult to participate, limited options for engagement and reduced quality - *12 votes*	We designed a social distanced consultation. NHS England assured the FFTF Programme and consultation process. The Gloucestershire Health Overview and Scrutiny Committee received regular briefings about the FFTF Programme and consultation. The consultation was Quality Assured by The Consultation Institute. Acknowledge that for some individuals participation might have been more difficult, for others the innovative use of online methods proved to be more accessible (a diverse response overall)
Marketing and advertising strategy did not raise awareness of consultation – *10 votes*	Information was available in printed documents and on dedicated webpages and a new online participation platform https://getinvolved.glos.nhs.uk/ and promoted through a door to door mailer to all households, organic and regular paid for (sponsored) social media, print media, a countywide Bus Tour and an extensive programme of online participation events, including innovative media partnerships. All information available on request in different formats. Responses could be made using online and freepost surveys, letters, telephone interviews or face to face (socially distanced), online discussion forums and live streamed clinical discussions using Facebook live.

Relying on Royal Mail Postal leaflet as primary outreach led to reduced awareness and participation - *9 votes*	Jurors were very interested in the impact of the 'door to door' leaflet drop. Concerned that it had either not been delivered on gone unnoticed amongst other items of post. The NHS did not rely only on the Royal Mail postal leaflet – see above box. However, the leaflet did generate a large number of requests for hardcopy information (it also promoted the availability of information online). In response to the door to door leaflet – over 1500 requests for consultation information were received. It should be noted that countywide distribution of the Royal Mail postal leaflet started nearly two months before the Citizens' Jury was held.
Overemphasis on targeted groups may have reduced awareness among and participation among general public - *8 votes*	We certainly put a lot of emphasis on the IIA identified groups.
Input of past, current, and future users of services under consultation and patient experience not emphasised in materials - *5 votes*	We certainly involved service users during the 'engagement' phases of FFTF and signposted the engagement activity within the consultation activities.
Use of self-selecting survey to gather responses may have decreased number of people who participated - *4 votes*	Self-selection bias is always a problem with open surveys.
Large percentage of responses were from Cheltenham and less representation from Gloucestershire overall could bias results - *2 votes*	Cheltenham and east of county responses generally at higher for activities of this kind. Activities were targeted in all districts – face to face and dedicated 'district' online activities.
Unclear whether or not and how CCG will utilise the results of the Citizens' Jury in decision-making - *2 votes*	A initial response to the Citizens' Jury conclusions is included in the Final Output of Consultation Report [HERE]. This will form part of the Decision Making Business Case (DMBC) considered by decision makers in March 2021.
Feedback from community groups may not have been	This is included in the DMBC 'considerations' section.

responded to or may have disregarded - *1 vote*	
Alternative options for service changes not clearly communicated in materials - *1 vote*	This was in the engagement documentation. This could have been promoted more in the public facing consultation documentation but there is a balance between level of detail, length of documents and signposting to other resources.
REACH organisation has given a very negative opinion - *0 votes*	We are in regular contact with REACH – more than 5 times during the consultation. We plan to invite REACH to participate in any implementation planning and evaluation (if proposals are approved) together with other local stakeholders. We will continue to meet with REACH on a regular basis.

Q2. How good was the consultation information?

Q2a. What are the characteristics of good consultation information?

Jurors considered the most important characteristics of good or strong consultation information based on the evidence that they heard and our deliberations.

Quality / Characteristic of Strong or Good Consultation Information	**Why It Matters (how this quality or characteristic helps us gauge consultation quality or results, etc.)**	**NHS Response**
Clear and consistent presentation of information using "Plain English." - *10 votes*	- Demonstrates an understanding by the process organisers that they acknowledge what is required by the service users and that information is being shared among the public. - Matters because participants need to properly understand the proposed changes so they can make	Public facing consultation materials (full version and short guide) written using plain English. A full glossary was included in the consultation booklet (based on a previous recommendation from the engagement phase). Healthwatch Readers' Panel and The Consultation Institute reviewed content and made suggestions for improvement prior to publication. Easy Read consultation materials prepared by Inclusion Gloucestershire.

	relevant contributions and understand the information they are asking to opinionate on. - Matters because overly complicated language/ technical jargon can be off putting/confusing to some people and be difficult for those w/disabilities and dyslexia, etc.	
Information is accessible across multiple platforms and tailored to specific audiences. - *9 votes*	- To ensure it reaches a wide audience, allowing as many people to be aware of it as possible and because different audiences will have differing capacities to understand and feedback on information	Information was available in printed documents and on dedicated webpages and a new online participation platform https://getinvolved.glos.nhs.uk/ and promoted through a door to door mailer to all households, organic and regular paid for (sponsored) social media, print media, a countywide Bus Tour and an extensive programme of online participation events, including innovative media partnerships. Full consultation booklet, short guide, door to door leaflet and also Easy Read consultation materials prepared by Inclusion Gloucestershire. All information available on request in different formats. Responses could be made using online and freepost surveys, letters, telephone interviews or face to face (socially distanced), online discussion forums and live streamed clinical discussions using Facebook live.
Data is accurate, specific, and up-to-date or responsive when appropriate. - *7 votes*	- Demonstrates that the consultation is credible and reliable.	The consultation documents included accurate and up to date information. More detailed information was included in supporting documents such as the Pre Consultation Business Case and Appendices.

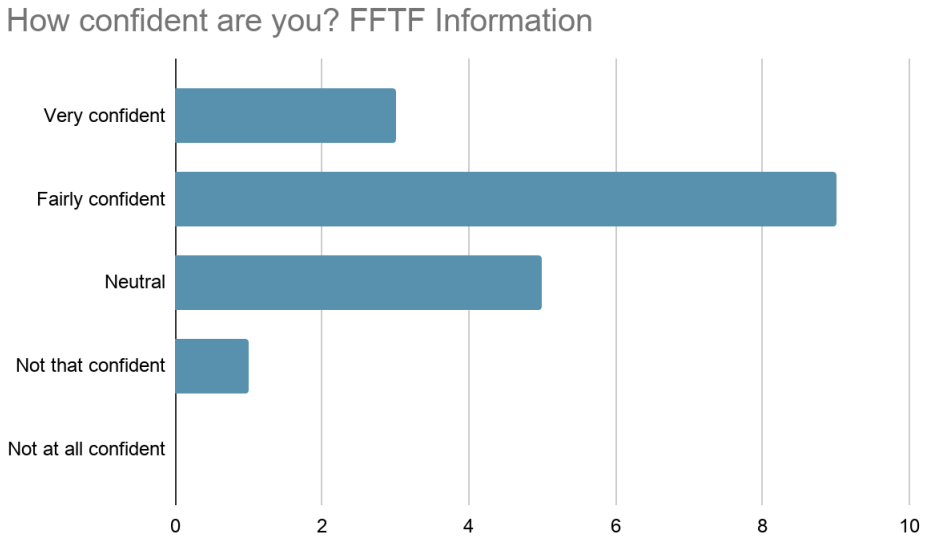
A good consultation should include other arguable alternatives and reasons they were not considered. - *5 votes*	- This is the only Gunning Principle directly related to consultation information so it is important that it is adhered to in the consultation.	The FFTF Consultation was preceded by a 3 month period of Engagement in 2018/19. During this time. This engagement was an opportunity to talk about ways services could be organised so that local people can benefit from two thriving specialist hospitals in the future in Cheltenham and Gloucester. OVER 3300 local people participated in planned activities – but the focus of engagement is not about numbers it is about receiving qualitative feedback from a broad range of people. 1230 FFTF online surveys completed, 28 Public Drop in Events, 12 Independently facilitated workshops and Engagement Hearing and FFTF Citizens' Jury #1. This was followed by a solutions appraisal process held in public attended by a mix of public and NHS participants. The FFTF Output of Engagement Report can be found at: https://www.onegloucestershire.net/wp-content/uploads/2020/01/FFTF-Output-of-Engagement-Report.pdf The main FFTF Consultation booklet described How we involved staff and local people in developing potential solutions for change and how those potential solutions for developing new 'centres of excellence' were developed and considered. This information is on pages 15 – 19. The shortlisted potential solutions are included in tables in each service section, together with their 'scores'. The PCBC describes the engagement process in detail – setting out the evaluation of alternative potential solutions and how preferred options were selected.
Any proposed changes include rationale and supporting evidence. - *4 votes*	- Otherwise people won't understand why the changes are needed / what problems the changes are designed to address.	The Consultation booklets (and online information) include the following sections: What is Fit for the Future about and what are its aims? Fit for the Future Vision summarizing what we want to achieve and the benefits. Each service section includes Challenges and Opportunities and What we think the proposed changes would mean for local people.

Jurors considered the most important characteristics of weak or poor consultation information based on the evidence that they heard and their discussions.

Quality / Characteristic of Weak or Poor Consultation Information	**Why It Matters (how this quality or characteristic helps us gauge consultation quality or results, etc.)**	**NHS Response**
Information or data in consultation materials is inaccurate, incorrect, incomplete or insufficient. - *17 votes*	- This matters because it will lead to an incorrect judgement because the audience may not fully understand the issues or the potential impacts which would limit the success of the whole consultation process.	The consultation documents included accurate and up to date information. More detailed information was included in supporting documents such as the Pre Consultation Business Case and Appendices.
Consultation materials are not available in accessible formats or information is too detailed, dense, or lengthy. - *8 votes*	- This matters because the process should be as inclusive as is practically possible and information should be accessible to everyone - including people who don't have much spare time. - People need to be able to find and access all information offered.	Public facing consultation materials (full version and short guide) written using plain English. A full glossary was included in the consultation booklet (based on a previous recommendation from the engagement phase). Healthwatch Readers' Panel and The Consultation Institute reviewed content and made suggestions for improvement prior to publication. Easy Read consultation materials prepared by Inclusion Gloucestershire.
Information could be construed as ambiguous or misleading to the general public. - *8 votes*	- This matters because it will lead to an incorrect judgement and may be counterproductive.	Healthwatch Readers' Panel reviewed content and made suggestions for improvement prior to publication. Also see above box.
Information is poorly written or not presented clearly. - *2 votes*	- This matters because it could lead to confusion and questions not being answered correctly, resulting in misinformed and	Healthwatch Readers' Panel reviewed content and made suggestions for improvement prior to publication.

	irrelevant data.	Easy Read consultation materials prepared by Inclusion Gloucestershire. The Consultation Institute Quality Assurance process reviewed all consultation materials.

Q2b. Based on what you have learned, how confident are you that the information provided through the consultation enabled residents to be adequately informed about the proposed service changes?



Jurors ranked the reasons that made them CONFIDENT that the information provided through the consultation enabled residents to be adequately informed about the proposed service changes.

Reasons to be confident that the information provided through the consultation enabled residents to be adequately informed about the proposed service changes.	**NHS Response**
Uses "plain English" and provides supplemental glossary to explain jargon - *15 votes*	Public facing consultation materials written using plain English. Healthwatch Readers' Panel reviewed content and made suggestions for improvement prior to publication. The Glossary was a 'learning' action from the earlier Engagement.
Information was accessible across multiple platforms and formats - *14 votes*	Information was available in printed documents and on dedicated webpages and a new online participation platform https://getinvolved.glos.nhs.uk/ and promoted through a door to door mailer to all households, organic and regular paid for (sponsored) social media, print media, a countywide Bus Tour and an extensive programme of online participation events, including innovative media partnerships. Detail can be found in pages 23-34 of the output of consultation report Full consultation booklet, short guide, door to door mailer and also Easy Read consultation materials prepared by Inclusion Gloucestershire. All information available on request in different formats. Responses could be made using online and freepost surveys, letters, telephone interviews or face to face (socially distanced), online discussion forums and live streamed clinical discussions using Facebook live.
Included the rationale for why proposed changes were being considered and the reasons these changes would be beneficial - *10 votes*	The Consultation booklets (and online information) include the following sections: What is Fit for the Future about and what are its aims? Fit for the Future Vision summarizing what we want to achieve and the benefits. Each service section includes Challenges and Opportunities and What we think the proposed changes would mean for local people.
Information provided was	The consultation documents included accurate and up to

informative, factual, accurate, and up-to-date - *5 votes*	date information. More detailed information was included in supporting documents such as the Pre Consultation Business Case and Appendices.
Information was shared through print, online platforms, face-to-face interactions, and by telephone - *4 votes*	Information was available in printed documents and on dedicated webpages and a new online participation platform https://getinvolved.glos.nhs.uk/ and promoted through a door to door mailer to all households, organic and regular paid for (sponsored) social media, print media, a countywide Bus Tour and an extensive programme of online participation events, including innovative media partnerships. Full consultation booklet, short guide, door to door mailer and also Easy Read consultation materials prepared by Inclusion Gloucestershire. All information available on request in different formats. Responses could be made using online and freepost surveys, letters, telephone interviews or face to face (socially distanced), online discussion forums and live streamed clinical discussions using Facebook live.

Jurors ranked the reasons that made them not confident that the information provided through the consultation enabled residents to be adequately informed about the proposed service changes.

Reasons to not be confident that the information provided through the consultation enabled residents to be adequately informed about the proposed service changes.	**NHS Response**
Alternatives to proposals not easy to find in consultation, nor explanation of why alternative options were not chosen or available to preferred options - *16 votes*	The main FFTF Consultation booklet described How we involved staff and local people in developing potential solutions for change and how those potential solutions for developing new 'centres of excellence' were developed and considered. This information is on pages 15 – 19. The shortlisted potential solutions are included in tables in each service section, together with their 'scores'. The PCBC describes the engagement process in detail – setting out the evaluation of alternative potential solutions and how preferred options were selected.
Methods used to distribute information (and solicit feedback) was inadequate - *11 votes*	The approach to a 'socially distanced' consultation was extensive and included traditional methods such as media advertising, online information, organic and regular paid for (sponsored) social media advertising, an extensive programme of online participation events, including innovative media partnerships, a countywide Bus Tour and included investment in more extensive distribution of printed information than previous engagement and consultation activities i.e. the leaflet to all households.
Continuing the consultation during COVID-19 pandemic hindered advertisement of information - *11 votes*	As above, the local NHS made use of traditional methods to communicate about the consultation, as well as other a range of other/ additional channels of communication. During the consultation period there was a lot of focus on the NHS due to the pandemic response, and in many instances this drew attention to the consultation (heightened awareness of NHS services).
Easy Read materials and survey were difficult to access and did not provide enough relevant information about proposed	The Easy Read materials were made available online and were available on request in print form. 256 people requested the Easy Read Booklet and Survey in response to the household leaflet. The Easy Read

changes - *9 votes*	materials were prepared by Inclusion Gloucestershire using the information contained in the main consultation booklet. In addition to inviting people to use the Easy Read materials to inform and provide feedback the opportunity to request a telephone interview was also available; 83 people requested telephone calls.
Information was poorly written, too dense, or contained too much jargon for the average reader - *1 vote*	Jurors indicated that they felt the public facing FFTF material were well written and did not contain jargon (see above). The local NHS has been keen to make public all relevant documents, some of which are technical. There is an important differentiation between public consultation materials and materials that we have, in the interests of transparent decision making, made available to members of the public. For instance the Pre Consultation Business Case (PCBC) is an outline appraisal of the proposals, and is not a finished article. It is a document we have made available in public but it was not written as a public facing document. By its' nature it is a technical document, given the spread of issues we are required to cover to meet the assurance domains set out by our regulator NHS England.

Q3. What are the most important findings from the FFTF consultation results?

Jurors ranked what they thought are the most important findings that they identified from the responses to the consultation in the table below. The main reasons for each choice are shown in the right-hand column.

Important Findings from FFTF consultation results for NHS Governing Bodies to consider	**Why It Matters**	**NHS Response**
It is important to know that although the number of 713 completed surveys appears to be a small countywide response, this is approximately double the number survey models recommend. The Fit For the Future consultation group were happy with the overall response, double than what was predicted with response software. However, due to the population being approx 650,000, the number of completed surveys may appear unsatisfactory to the general public. - *11 votes*	- Suggests the general public is pretty apathetic and the FFTF are happy not pushing to get the numbers higher in all age demographics. Whilst some members of the jury felt it was a low number. - This helps us to know that the response rate, and therefore results, is robust enough to base decisions. This is because it shows that most areas were represented.	We use a range of methods to raise awareness of engagement and consultation opportunities. In 2020, shortly before the start of the FFTF consultation we launched Get Involved in Gloucestershire (GIG) https://getinvolved.glos.nhs.uk/ Get Involved in Gloucestershire is an online participation space where people can share their views, experiences and ideas about local health and care services. The public's input will help inform and influence the decisions local NHS organisations make.

There was a range of respondents however this did not necessarily reflect the demographics of the county. A significant number of the survey results came from Cheltenham with relatively small proportions from elsewhere. - *10 votes*	- This demonstrates that the consultation results captured different sections of the community (including 20% from people who considered themselves to have a disability), but some groups were under-represented (few responses from under 45 year olds). - This is important because it could mean that the consultation results are inappropriately biased toward Cheltenham where evidence has suggested there is concern that the hospital in Cheltenham may be closed. The survey results may therefore be skewed and biased in favour of proposed changes and therefore do not reflect the views of the residents of Gloucestershire as a whole.	We actively encourage participation from people living and working in all parts of Gloucestershire and from across all demographics. For the FFTF Programme there has been increased interest during both the Engagement and the Consultation from people living in Cheltenham postcode areas. There is significant interest in services provided at Cheltenham General Hospital (CGH). The local NHS continues to make public commitments to the positive future for CGH as a 'centre of excellence'. Overall respondents to the FFTF survey were more supportive of all proposals for change than in opposition to them. All 'groups' of respondents were also more supportive than in opposition to the proposals for change. Details can be found in the Appendices to the Output of Consultation Report https://www.onegloucestershire.net/yoursay/fit-for-the-future-developing-specialist-hospital-services-in-gloucestershire/
There are concerns from both staff and patients about bed numbers and	- A plan should have been provided to ensure concerns were heard and addressed as well	NHS organisations are required to consult on outline proposals, and this occurs prior to development of a decision making business case (DMBC). All feedback received during consultation is used to inform the development

the increase of patients to GRH which is already deemed to be overstretched (pre-Covid-19). - *8 votes*	as potential negative effects on other areas of the hospital are mitigated against.	of the Decision Making Business Case (DMBC). When NHS decision makers convene in public to take decisions on the DMBC for FFTF they will consider a range of information that will include, but will not be limited to: • Quality of care: To evaluate clinical effectiveness, patient outcomes, patient and carer experience, continuity of care, the quality of the care environment, self-care, patient transfers, travel time impact and the management of risk. • Access to care: To evaluate the impact on patient choice, simplifying the offer to patients, travel burden for patients, carers and families, waiting times, supporting the use of new technology to improve access, improving or maintaining service operating hours and locations, impact on equality and health inequalities and accounting for future changes in population size and demographics. • Deliverability: To evaluate the expected time to deliver, meeting relevant national, regional or local delivery timescales, access to the required staffing capacity and capability, support services, premises / estates (including beds) and technology to be successfully implemented. • Workforce: To evaluate the impact on workforce capacity / resilience, optimising the efficient and effective use of clinical staff, cross-organisational working across the patient pathway, flexible deployment of staff and the development of innovative staffing models, staff health and wellbeing, recruitment and retention, maintaining or improving the availability of trainers, enabling staff to maintain or enhance their capabilities/ competencies, the travel burden for staff and clinical supervision. • Acceptability: To into account the feedback from engagement and consultation on the proposals for change • Affordability: resources impact of the change proposals and a plan for

		investment as required / any anticipated savings
Despite the level of participation being deemed as sufficient, we feel it is not representative. - *7 votes*	- The results are not a true representation of the population of Gloucestershire because of the low response rate.	As above: We actively encourage participation from people living and working in all parts of Gloucestershire and from across all demographics.
The overall level of support for the proposals was around 70% for all options from the general public and staff that responded to the survey and staff consultation. - *6 votes*	- This suggests the proposals are acceptable to the general public and the NHS staff.	Overall respondents to the FFTF survey were more supportive of all proposals for change than in opposition to them. All 'groups' of respondents were also more supportive than in opposition to the proposals for change. Details can be found in the Appendices to the Output of Consultation Report https://www.onegloucestershire.net/yoursay/fit-for-the-future-developing-specialist-hospital-services-in-gloucestershire/
Service users were not properly targeted or identified. - *5 votes*	- It would have been as important, if not more important, to see this information as the stats from target groups as 'lived' experience could prove invaluable.	The FFTF Programme and Consultation was informed by an independent Integrated Impact Assessment (IIA). The Consultation process was designed to ensure that protected characteristic groups and others identified in the IIA had an opportunity to get involved with the consultation and have their say. Details of the approach to consulting people identified in the IAA can be found in Section 2.8 of the Output of Consultation Report. Survey feedback from targeted groups can be found in the Output of Consultation Appendices: https://www.onegloucestershire.net/yoursay/fit-for-the-future-developing-specialist-hospital-services-in-gloucestershire/
It is important to know that deciding whether to go ahead with the consultation during a pandemic was carefully	- This matters because benefits to completing the consultation process were identified that outweighed any pandemic effect.	The consultation was Quality Assured by The Consultation Institute. The conclusions of their assurance of the consultation process will be published when received. Consultation timing and timescales including time allowed for consideration of consultation feedback approved by NHS England and Gloucestershire County Council Health Overview

considered by the consultation team with the help from external organisations such as the Consultation Institute. - *3 votes*		and Scrutiny Committee.
Open text feedback from the consultation uses the language of the proposals such "Centres of Excellence." - *2 votes*	- This demonstrates that respondents understood the narrative/proposals in the FFTF consultation informational texts and therefore the results reflect informed understanding of the options.	We carefully review the free text/qualitative feedback to the consultation. Secondary more detailed analysis of the freetext feedback does show frequent use of the phrase 'centres of excellence' and further analysis of the free text feedback shows understanding of the concept of centralizing specialist services in one place (a 'centre of excellence' even when the phrase is not used.
Proposals and public response are scrutinized both internally and externally and that all aspects and potential adverse impacts are considered. - *1 vote*	- To assure the public that results are analysed and presented in accordance with law and processes and they are reassured that any concerns raised have been considered and addressed.	After the end of the Consultation, 3 months were allowed for consideration of consultation feedback prior to decision making in March 2021. The DMBC includes a response to the themes/suggestions from feedback to the consultation. The DMBC will be considered at meetings of the Trust and the Clinical Commissioning Group in March 2021. These meetings will be held in public and the DMBC and the decisions of these meetings will be published in the public domain.
The data appears to show a lot of support for the movement of Planned Lower GI surgery and Gastroenterology inpatient services to Cheltenham General Hospital. - *1 vote*	- This is important to note because the majority of respondents to the survey were from Cheltenham postcodes which may give false data and sway the results in favour of the planned	Cheltenham and east of county responses generally at higher for activities of this kind. Activities were targeted in all districts – face to face and dedicated 'district' online activities. We actively encourage participation from people living and working in all parts of Gloucestershire and from across all demographics. For the FFTF Programme there has been increased interest during both the Engagement and the Consultation from people living in Cheltenham postcode areas. There is significant interest in

	proposals.	services provided at Cheltenham General Hospital (CGH). The local NHS continues to make public commitments to the positive future for CGH as a 'centre of excellence'. Overall respondents to the FFTF survey were more supportive of all proposals for change than in opposition to them. All 'groups' of respondents were also more supportive than in opposition to the proposals for change. Details can be found in the Appendices to the Output of Consultation Report https://www.onegloucestershire.net/yoursay/fit-for-the-future-developing-specialist-hospital-services-in-gloucestershire/

Q3a. What are the most important findings from the consultation for the NHS Governing Bodies to consider (such as impact on local community, and suggestions to reduce any negative impacts)? Why?

Q4. Any other messages for the Governing Bodies?

The Jurors worked together to identify other messages that are important for the NHS Governing Bodies to hear about the FFTF public consultation. Only those that were supported by a majority of the jury are included in the table below. Their reasoning is given in the middle column of the table and the NHS Response is given in the right hand column.

Something still missing, needs to be addressed, or requires further clarification re: the FFTF consultation	**Why It Matters**	**NHS Response**
We are concerned regarding the number of Royal Mail mailshots actually delivered to homes and wonder if there are better ways to market the initial engagement process, to get more people to know about the consultation, and hopefully contribute to the results. *16 Yes votes / 2 No votes)*	This will get more peoples' opinions and a better representation of the people in Gloucestershire, and would help us to know the majority have had a chance to be part of the consultation.	Jurors were very interested in the impact of the 'door to door' leaflet drop. Concerned that it had either not been delivered on gone unnoticed amongst other items of post. It should be noted that the leaflet was only one aspect of the communications and our approach included a range of other methods such as paid for social media advertising were used and had a wide reach (see section 2.4 of the Output of

		Consultation Report). The leaflet did generate a large number of requests for hardcopy information (it also promoted the availability of information online). In response to the door to door leaflet – over 1500 requests for consultation information were received. It should be noted that countywide distribution of the Royal Mail postal leaflet started nearly two months before the Citizens' Jury was held.
The Covid-19 pandemic has changed our way of life considerably - it would have helped for the FFTF consultation to incorporate a response to the pandemic in their presented material. *(15 Yes votes / 3 No votes)*	This matters because the plans drawn up before the pandemic may not be relevant anymore and the pandemic directly affects the day-to-day running of the services.	The consultation materials included a section about the Covid-19 Temporary changes (page 5 in the main consultation booklet). The DMBC also considers the impact of the pandemic on delivery of services during the pandemic and in the future. We are confident that our proposals take account of the future requirements of our services in light of our experiences during the pandemic.
We have been assured that the golden thread of patient experience is the reason for this project, but there is nothing about that in the proposals. It is important that at the same time as any reorganisation of medical services, there is a review of the way patients are treated, their dignity and the facilities	It's about the patients!	We are considering our next steps with regards to how to further involve local people in our work to develop the detail on the FFTF implementation plans if decisions are made to proceed with changes, especially with regards to our focus on improving the patient experience.

offered associated with new medical proposals. There is always something about this in external audits. *(16 Yes votes / 2 No votes)*		

Statements that received 50% of votes "Yes" are included in the table below.

Something still missing, needs to be addressed, or requires further clarification re: the FFTF consultation	**Why It Matters**	**NHS Response**
Why was Inclusion Gloucestershire told in mid 2019 that there wasn't enough time to produce more easy read information booklets? *(9 Yes votes / 9 No votes)*	This is important because it might've meant that the disabled population had a better representation and may have led to different results and views on FFTF.	We will follow this comment up with Inclusion Gloucestershire, with whom we work on a regular basis, and who produced the Easy Read Consultation Booklet and Survey for the 2020 consultation. Inclusion Gloucestershire were crucially involved with recruiting participants with a wide range of protected characteristics to take part in the independently facilitated workshops during the FFTF Engagement in 2019.
Data is missing that would give information of how many leaflets were actually delivered by Royal mail. *(9 Yes votes / 9 No votes)*	This matters because it would give more data to know that as many households as possible had received the leaflets that were commissioned to be delivered by Royal Mail (297k).	We will follow up with Royal Mail to discuss their methods for confirming delivery of leaflets to households and their reporting.

The following is an extract from the Jury Report:

Overall, the jury:

- *Was neither confident nor not confident that the consultation process enabled the public to contribute meaningfully to decision making;*

    - *Gaining in confidence from the clear, concise language and limited jargon in materials*
    - *Losing confidence from running the consultation during the pandemic thus reducing participation;*
- *Was more confident than neutral that the information provided as part of the consultation enabled residents to be adequately informed about the proposed service changes thanks to use of plain English and information made accessible across multiple platforms;*

Overall, the jury considered the most important findings from the consultation to be:

- *Though 713 completed surveys may appear unsatisfactory to the general public, it is approximately double the number predicted by sample size calculation software;*
- *Respondents did not necessarily reflect the demographics of the county: a significant number of the survey results came from Cheltenham;*
- *There are concerns from both staff and patients about bed numbers and the increase of patients to Gloucestershire Royal which is already deemed to be overstretched.*

- *And a jury majority wanted the NHS Governing Bodies to know:*
    - *They were concerned about the number of Royal Mail mailshots actually delivered to homes and wondered if there were better ways to market the initial engagement process*
    - *It would have helped if the FFTF consultation materials incorporated a response to the pandemic;*
    - *That the proposals should have focused more on patient experience.*

Ongoing involvement

The FFTF Programme Team and Consultation Team are grateful to the Jurors for their commitment to the two weeks process. After the conclusion of the Jury we sent a letter to Jurors via Citizens Juries c.i.c. thanking them and encouraging them to continue to be involved in local health services; at the time of writing several have been in touch.

9.3 A 'centre of excellence' for Planned Lower GI (colorectal) general surgery

The FFTF Consultation included two options for Planned Lower GI (colorectal) general surgery, either as part of a General Surgery centre of excellence at GRH or as part of a centre of excellence for Pelvic Resection at CGH.

On 4 February 2021 the Gloucestershire Hospitals NHS Foundation Trust Leadership Team (TLT) explored in detail the configuration options against six domains: Quality of Care; Access to Care; Deliverability; Workforce; Strategic Fit and Acceptability, taking into account feedback from the Consultation. The following extract from the FFTF Decision Making Business Case (DMBC) is a summary of the discussions and recommendation:

The discussion benefited from presentations followed by a question and answer session, with clinical leads from General Surgery. Both proposals had better outcomes for patients at their heart and many benefits. However, it was evident as a result of the debate that there was an alternative, potentially even better option, that includes the best elements from the two options presented and notably the opportunity to deliver even more planned elective surgery from the Cheltenham Hospital site. This opportunity to treat more patients in a centre of excellence for planned surgical care was also something that came through the consultation feedback (with over 40 references to planned care at CGH) from both public contributors and staff.

The recommendation was that further work should begin with the General Surgery team to define this new, emerging option. The focus will be to explore the opportunity to deliver:

- *Planned High Risk Upper Gastrointestinal (GI) and Lower Gastrointestinal (Colorectal) surgery at Gloucestershire Royal Hospital*
- *Planned complex and routine inpatient and day case surgery in both Upper and Lower GI (Colorectal) at Cheltenham General Hospital*

From the outset of this process, the ICS partners have been clear that consultation feedback is an essential part of the decision making process and this outcome demonstrates the influence of the public and staff voice on the shape of health services in the County. As a result it is important that more time is taken to explore the new option for Planned General Surgery.

9.4 Additional Information

https://www.onegloucestershire.net/wp-content/uploads/2021/02/FFTF2020-Additional-Information-002.pdf

A number of additional documents, which will be considered by decision makers in March 2021, became available during February and March 2021. The FFTF Consultation Team contacted local people, groups and stakeholders who participated in the Fit for the Future consultation last year and for whom we have contact details (email or postal address) to let them know about the additional information and inviting them to request information to be sent to them for comment. Information about the additional information was also sent to 161 people registered with the Get Involved in Gloucestershire (GIG) online participation space. Letters (440) and emails (603 + 161 to GIG members) were sent on 2nd February 2021 to a total of 1,204 people. This included those that had returned the Fit for the Future mailer (884), had expressed an interest in being kept involved (59) or part of our PPG Network (112).

If anyone had any comments on the additional information, or anything else they wished to draw to decision-makers attention, they were invited to email: glccg.participation@nhs.net or write to our FREEPOST address. The deadline for additional feedback was 25 February 2021. We asked anyone to contact us if they felt unable to send additional comments to us before this date. All additional information, and any further comments received are summarised below and will be used to inform the Decision Making Business Case (DMBC).

The totals numbers of items being sent or requesting each document is:

Documents (A-Z)*	**Numbers****
Citizens Jury – Jurors' Report	621
Addressing themes for the consultation (in the DMBC)	13
Citizens Jury Report – includes detail of the Jury process	17
Decision Making Business Case (DMBC)	22
Output of Consultation Report (FINAL) (Appendix to DMBC)	17
Recommendation regarding the preferred location for colorectal surgery	18
The Consultation Institute (tCI) Quality Assurance Assessment	11
Updated Trauma and Orthopaedic Pilot Evaluation	17
Updated independent Integrated Impact Assessment (IIA) (in the DMBC)	16

*All of this additional information was posted at www.onegloucestershire.net/yoursay

**we received six return forms requesting information, however, they did not include a name or address so we could not send these.

9.5 Additional responses received

Additional responses were received from:

- **Healthwatch Gloucestershire:** A letter providing observations on the consultation process and feedback, encouraging decision makers to take into account any concerns raised and to consider recommendations from the FFTF Citizens' Jury #2 for future engagement and consultation approaches
- **Gloucestershire Primary Care Network Clinical Directors:** A letter of support for the Fit for the Future Proposals for change
- **55 Clinical Staff from Gloucestershire Hospitals NHS Foundation Trust:** A letter of support for Cheltenham General Hospital to become a centre of excellence for inpatient planned care for: Pelvic Cancer and Pelvic Disease, Lower Gastrointestinal Disease and Inpatient Oncology.
- **REACH Survey – Final Report:** The final REACH Survey, published on 14 January 2021 can be found at: https://www.reachnow.org.uk/reach-publish-results-of-their-fit-for-the-future-survey/

Extract from the REACH website:

Survey findings

REACH has recognised that the proposals in Fit for the Future are complex and will have a wide-ranging permanent impact on healthcare provision in our County. The implications of centralising emergency care have not, we believe, been explained fully to the public by One Gloucestershire. The concept of excellent care is indeed laudable, and REACH recognises the challenges of staffing as well as the impact of advances in patient care.

Nevertheless, the public have overwhelmingly stated that they would prefer, in general, care closer to home. The public understand that there are significant bed pressures at GRH, which would be amplified further by centralising of acute medicine and emergency surgery at GRH. The public know that One Gloucestershire cannot squeeze the proverbial "quart into a pint pot."

The large number of extra inpatient beds required at GRH from the centralisation of emergency medicine and surgery are very substantial and are unlikely to be offset by proposals such as centralising day surgery at Cheltenham. The public are rightly concerned that these proposals may downgrade Cheltenham and that proposals to centralise day surgery at Cheltenham might be regarded as a "sop" to public opinion. REACH believes that the excellent facilities and dedicated staff at both hospitals should be used efficiently and

that happy and fully engaged staff will then provide the best care and service to the people of our County.

If One Gloucestershire wishes to proceed with its proposals to centralise emergency care at Gloucester in spite of public opinion, REACH believes that as much elective (planned) major surgery should occur at Cheltenham, in order to utilise the beds, nursing expertise and importantly the excellent intensive care unit at Cheltenham. This public survey has shown that if there were to be a centralisation of colorectal surgery and the vascular service, both these services should be located in Cheltenham.

REACH was also concerned about the portrayal of Image Guided Interventional Surgery as a single specialty, when in fact this concept covers many disciplines. After explaining this to the public in non-medical language, the public have indicated that this should be located at Cheltenham. The exception being cardiac intervention, where the public indicated that this could be on both sites or at Cheltenham.

Michael Ratcliffe MBE, Chairman of REACH concluded:

"Through these findings, the public has made their feelings very clear indeed and we urge One Gloucestershire to take these into consideration during their deliberations.

The launch of Fit for the Future during the worst pandemic in living memory has caused much concern among the public and REACH. The Government and healthcare community are concerned that we are likely to experience further future pandemics, and that the COVID virus may mutate significantly.

This COVID pandemic has wrought havoc to our healthcare system and caused the delay and cancellation of non COVID related healthcare for millions of people. REACH believes that any proposal for the future must include resilience planning for future pandemics. One Gloucestershire's Fit for the Future proposals include no proposals to render our local healthcare system more robust and we would exhort our healthcare leaders to re-examine the proposals in the light of the catastrophic events of the last 9 months".

- **Further responses to the Additional Information**

We received five letters and two emails, two of which were relating to the New Hospital in the Forest of Dean closed consultation. One requesting we no longer contact them in relation to the Fit for the Future: developing specialist hospital services project.

Additional written responses received can be found in full at Appendix 2.1

10. Copies of this report

This report is available on the One Gloucestershire website at:
https://www.onegloucestershire.net/yoursay/
and on the online participation platform Get Involved in Gloucestershire
https://getinvolved.glos.nhs.uk

Print copies of the report can be obtained from the NHS Gloucestershire Clinical Commissioning Group Engagement and Experience Team by calling:
Freephone 0800 0151 548
or email: GLCCG.participation@nhs.net

To discuss receiving this information in large print or Braille please ring **0800 0151 548.**

To discuss receiving this information in other formats please contact:

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PALS, NHS Gloucestershire Clinical Commissioning Group, Sanger House, 5220 Valiant Court, Gloucester Business Park Gloucester GL3 4FE

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Fit for the Future, Sanger House, 5220 Valiant Court,
Gloucester Business Park, Gloucester GL3 4FE

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One Gloucestershire
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NHS

Integrated Impact Assessment

Appendix 2a

March 2021

SUBJECT TO DECISION MAKING

Fit for the Future

Developing specialist hospital services in Gloucestershire

Contents

1 Integrated Impact Assessment

This assessment has been completed by **Mid and South Essex NHS Foundation Trust ("MSE") Strategy Un**it in conjunction with the Fit for the Future Programme team. Impact analysis, as part of the evaluation of the two pilot changes (Gastroenterology and Trauma & Orthopaedic inpatient services) has been undertaken locally; This IIA summary document will incorporate findings from both IIAs.

1.1 Executive summary

Context

MSE Strategy Unit and Partners were engaged as an independent expert provider by Gloucestershire Integrated Care System (ICS) to undertake an independent Integrated Health Inequalities and Equality Impact Assessment (IHIEIA) of the proposed development of centres of excellence and the resulting proposed relocation of services at Gloucestershire Royal Hospital (GRH) and Cheltenham General Hospital (CGH).

Purpose

Through the IHIEIA the commissioners wanted to ensure that any decisions made by them would support advancing equality and ensure fairness by removing barriers, engaging patients and community and delivering high quality care. This would also help ensure that the commissioners continue to meet their responsibilities under Section 149 of the Equality Act 2010 and demonstrate due regard to the need to eliminate discrimination, harassment, victimisation and any other conduct that is prohibited under the Equality Act; advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it; and foster good relations between persons who share a relevant protected characteristic and persons who do not share it. The IHIEIA also helps to ensure that the commissioners continue to meet the duty to reduce inequalities between patients with respect to their ability to access health services reduce inequalities between patients with respect to the outcomes achieved for them by the provision of health services, as set out in s.14T of the NHS Act 2006.

Process

Evidence review, data analysis and feedback from engagement and the consultation feedback, including opinion surveys, panel discussions and focus groups, were considered by the Strategy Unit team to summarise both positive and negative impacts of the proposed changes for people with protected characteristics, outlined by the Equality Act 2010. This included impact on other health inequalities and impact on general health.

The Consultation asked all respondents whether they were in support, neutral or opposed to each proposed change and their reasons, including any alternative ideas or other comments. The feedback from this has been incorporated into the overall assessment of impact.

1.1.1 *Summary of Impact*

The IIA specifically focused on the impact of the proposed changes. The impacts are quantified based on the scale of patients likely to be affected by the proposed change, the duration of the impact e.g. short, medium or long term and this then identifies the overall probability of the impact being beneficial or adverse. Impacts are quantified using a combination of data collected by the Trust regarding the total number of patients and patient subsets and paired with evidence review of the impacts based on literature and open source data. All neutral impacts have been removed from the summary. A detailed summary of this process is included in the Annex – (Appendix 2b), which includes all data

and evidence based review. The impacts are broken down into two visuals shown overleaf. Figure 1 represents the overall impact of each model and figure 2 represents the impact of each individual proposed solution that makes up a model. The key indicates the nature of the impact. Where there are moderate adverse impacts, these have been highlighted within the document and recommendations have been made.

1.1.2 *Summary of Proposals*

As detailed in the Decision-Making Business Case (DMBC), the recommendation following the options appraisal for planned Lower Gastrointestinal (Colorectal) surgery services was that further work should begin with the General Surgery team to define a new, emerging option that includes planned upper gastrointestinal surgery. Once defined, an IIA will be undertaken but in the meantime the IIA includes the impact of both elective colorectal consultation proposals, with all other services are identical:

- Model D proposes elective colorectal to be centralised at Cheltenham General Hospital (CGH)
- Model E proposes elective colorectal to be centralised at Gloucestershire Royal Hospital (GRH)

Key	Description
Significant Positive Impact	The positive impact is significant despite small adverse impacts
Significant Positive Impact Moderate Adverse Impact	The positive impacts outweigh the adverse impacts, however the adverse impacts have been identified and recommendations made to mitigate against these
Significant Adverse Impact	The adverse impact is significant and despite positive impacts it is not clear that the adverse impacts are outweighed by the positive impacts
Neutral Impact (no significant change)	No significant change identified for this cohort

		Model D	Model E
Protected Characteristics	Age	Significant Positive Impact Moderate adverse impact	Significant Positive Impact
	Disability	Significant Positive Impact Moderate adverse impact	Significant Positive Impact Moderate adverse impact
	Gender	Significant Positive Impact	Significant Positive Impact
	Pregnancy	Neutral Impact (no significant change)	Neutral Impact (no significant change)
	Martial Status	Neutral Impact (no significant change)	Neutral Impact (no significant change)
	Ethnicity	Significant Positive Impact	Significant Positive Impact
	Sexual Orientation	Neutral Impact (no significant change)	Neutral Impact (no significant change)
	Religion	Neutral Impact (no significant change)	Neutral Impact (no significant change)
	Gender Reassignment	Neutral Impact (no significant change)	Neutral Impact (no significant change)
Health Inequalities	Deprivation	Significant Positive Impact Moderate adverse impact	Significant Positive Impact Moderate adverse impact
	Looked After Children	Neutral Impact (no significant change)	Neutral Impact (no significant change)
	Carers and Unpaid Carers	Significant Positive Impact Moderate adverse impact	Significant Positive Impact Moderate adverse impact
	Homelessness	Significant Positive Impact	Significant Positive Impact
	Substance Abuse	Neutral Impact (no significant change)	Neutral Impact (no significant change)
	Mental Health	Significant Positive Impact Moderate adverse impact	Significant Positive Impact Moderate adverse impact
Health Impact	Cardiovascular Disease	Significant Positive Impact Moderate adverse impact	Significant Positive Impact
	Diabetes	Significant Positive Impact	Significant Positive Impact
	Neurological Conditions	Significant Positive Impact Moderate adverse impact	Significant Positive Impact Moderate adverse impact
	Falls among the elderly	Significant Positive Impact	Significant Positive Impact
	Overweight and Obese	Significant Positive Impact	Significant Positive Impact

Figure 1 Summary of Proposals

Proposal Summary

All proposals include the following changes,

- Centralise Acute Medicine to GRH
- Centralise Emergency General Surgery to GRH
- Centralise General Surgery/GI day cases to CGH
- 24/7 Image Guided Interventional Surgery (IGIS) hub and Vascular surgery to GRH with IGIS spoke at CGH
- Gastroenterology at CGH
- Trauma at GRH and Orthopaedics at CGH

These are all significantly positive changes that outweigh the adverse impacts identified. The adverse impacts identify that centralising emergency surgery to Gloucestershire Royal means that patients who deteriorate (e.g. day case patients) at CGH or attend A&E but require emergency surgery may need to be transferred. This has been considered adverse for those who are most vulnerable to deterioration such as those over 65. There were 6,176 emergency admissions to General Surgery last year (Feb 19 to Jan 20), 4,215 of which were at GRH. It is estimated; however, that ~6 patients per day in total will be affected by the new arrangements (1,961 in total) and overall 93% of patient's journeys will remain within +/- 20 mins of their existing journey.

It is also estimated that there will be significantly less than 1 patient per day needing to be transferred in an emergency as a result of inpatient deterioration and a Standard Operating Procedure will be put in place for this event. This means the impact is relatively small and outweighed by the positive clinical outcomes. Emergency General Surgery care would be improved by providing a dedicated team in the Surgical Assessment Unit who would review all patients presenting on the same day. This would reduce delays to review, improving patient safety. Evidence suggests patients who are seen quicker have reduced admissions and increased self-care post treatment. The Local IIA found a small adverse impact for those in deprived areas with regards to the proposed change to gastroenterology. This is an important consideration in terms of transport and access.

Coronavirus (COVID-19)

As part of GHNHSFT's COVID response the Trust has been monitoring the patients attending CGH A&E who require a transfer to GRH. On average, during the pandemic, 2 General Surgery patients per week were transferred to GRH, 17 in total between 1st April and 18th June 2020. It is also important to note, it is estimated that significantly less than 1 patient per day will require a transfer as a result of inpatient deterioration.

Model D

In Model D the same adverse impact identified earlier also relates to elective colorectal surgery patients, who will be centralised to CGH. This means this cohort will also need to be considered as potentially at risk of needing to be transferred if they deteriorate. This risk, however, is estimated to impact significantly less than 1 patient per day, meaning this is outweighed by the positive clinical outcomes of having a centralised clinical response to elective surgeries such as this. By centralising some elective surgery, quality of care could be improved as a result of co-location with other relevant specialities. There is also a reduced

risk of cancellations for patients as they will have access to a ring fenced service. Day case patients, e.g. Gastroenterology patients, are currently cancelled frequently due to the need for emergency beds, therefore, by separating elective and emergency there is dedicated resource reducing the number of cancellations for patients.

Coronavirus (COVID-19)

As part of GHNHSFT's COVID response the Trust temporarily consolidated vascular emergency and elective inpatient pathways to GRH whilst day case venous patients remained at CGH. This temporary change was only implemented in June 2020 and, therefore, the impact on vascular patients is still being monitored. In a 12 month period approximately 500 inpatients would move from CGH to GRH and approximately 750 day case procedures would continue at CGH.

Model E

Model E has the least adverse impacts identified. This model co-locates IGIS and vascular and centralises elective colorectal surgery with Emergency General Surgery. The adverse impacts for Model E are reflected in the adverse impacts for all models.

Please see a more detailed look at each individual proposed change overleaf;

1.1.3 *Summary of Proposed Changes*

The following table shows the impact assessment of each proposed change on patient cohort. The IIA for Gastroenterology and Trauma and Orthopaedics were completed locally within the Trust using a slightly different methodology to Mid and South Essex Foundation Trust's IIA. This is because they were pilots and the local IIA assesses the impacts slightly differently. They have been included in this table to show the overall summary of the findings.

		Mid and South Essex Foundation trust IIA						Local IIA	
		A3 - Centralise acute medicine to GRH	B2 - IGIS hub and vascular centralised to GRH	C3 - EGS centralised to GRH	C11 - GI day cases to CGH	C5 - Elective colorectal to CGH	C6 - Elective colorectal to GRH	Gastroenterology to CGH	Trauma to GRH and Orthopaedics to CGH
Protected Characteristics	Age	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact Moderate adverse impact	Significant Positive Impact Moderate adverse impact	Significant Positive Impact	Significant Positive Impact Moderate adverse impact	Significant Positive Impact Moderate adverse impact
	Disability	Significant Positive Impact Moderate adverse impact	Significant Positive Impact Moderate adverse impact	Significant Positive Impact Moderate adverse impact	Significant Positive Impact Moderate adverse impact	Significant Positive Impact Moderate adverse impact	Significant Positive Impact Moderate adverse impact	Significant Positive Impact Moderate adverse impact	Significant Positive Impact Moderate adverse impact
	Gender	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact	Neutral Impact (no significant change)	Significant Positive Impact
	Pregnancy	Neutral Impact (no significant change)	Neutral Impact (no significant change)	Neutral Impact (no significant change)	Neutral Impact (no significant change)	Neutral Impact (no significant change)	Neutral Impact (no significant change)	Significant Positive Impact Moderate adverse impact	Significant Positive Impact
	Martial Status	Neutral Impact (no significant change)	Neutral Impact (no significant change)	Neutral Impact (no significant change)	Neutral Impact (no significant change)	Neutral Impact (no significant change)	Neutral Impact (no significant change)	Neutral Impact (no significant change)	Neutral Impact (no significant change)
	Ethnicity	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact
	Sexual Orientation	Neutral Impact (no significant change)	Neutral Impact (no significant change)	Neutral Impact (no significant change)	Neutral Impact (no significant change)	Neutral Impact (no significant change)	Neutral Impact (no significant change)	Neutral Impact (no significant change)	Neutral Impact (no significant change)
	Religion	Neutral Impact (no significant change)	Neutral Impact (no significant change)	Neutral Impact (no significant change)	Neutral Impact (no significant change)	Neutral Impact (no significant change)	Neutral Impact (no significant change)	Neutral Impact (no significant change)	Neutral Impact (no significant change)
	Gender Reassignment	Neutral Impact (no significant change)	Neutral Impact (no significant change)	Neutral Impact (no significant change)	Neutral Impact (no significant change)	Neutral Impact (no significant change)	Neutral Impact (no significant change)	Neutral Impact (no significant change)	Neutral Impact (no significant change)
Health Inequalities	Deprivation	Significant Positive Impact Moderate adverse impact	Significant Positive Impact Moderate adverse impact	Significant Positive Impact Moderate adverse impact	Significant Positive Impact Moderate adverse impact	Significant Positive Impact Moderate adverse impact	Significant Positive Impact Moderate adverse impact	Significant Adverse Impact	Significant Positive Impact Moderate adverse impact
	Looked After Children	Neutral Impact (no significant change)	Neutral Impact (no significant change)	Neutral Impact (no significant change)	Neutral Impact (no significant change)	Neutral Impact (no significant change)	Neutral Impact (no significant change)	Neutral Impact (no significant change)	Neutral Impact (no significant change)
	Carers and Unpaid Carers	Significant Positive Impact Moderate adverse impact	Significant Positive Impact Moderate adverse impact	Significant Positive Impact Moderate adverse impact	Significant Positive Impact Moderate adverse impact	Significant Positive Impact Moderate adverse impact	Significant Positive Impact Moderate adverse impact	Significant Positive Impact Moderate adverse impact	Significant Positive Impact Moderate adverse impact
	Homelessness	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact	Neutral Impact (no significant change)	Neutral Impact (no significant change)
	Substance Abuse	Neutral Impact (no significant change)	Neutral Impact (no significant change)	Neutral Impact (no significant change)	Neutral Impact (no significant change)	Neutral Impact (no significant change)	Neutral Impact (no significant change)	Significant Positive Impact Moderate adverse impact	Significant Positive Impact
	Mental Health	Significant Positive Impact Moderate adverse impact	Significant Positive Impact Moderate adverse impact	Significant Positive Impact Moderate adverse impact	Significant Positive Impact Moderate adverse impact	Significant Positive Impact Moderate adverse impact	Significant Positive Impact Moderate adverse impact	Significant Positive Impact Moderate adverse impact	Neutral Impact (no significant change)
Health Impact	Cardiovascular Disease	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact Moderate adverse impact	Significant Positive Impact Moderate adverse impact	Significant Positive Impact Moderate adverse impact	Significant Positive Impact	Not assessed	Not assessed
	Diabetes	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact	Neutral Impact (no significant change)	Neutral Impact (no significant change)
	Neurological Conditions	Significant Positive Impact Moderate adverse impact	Significant Positive Impact Moderate adverse impact	Significant Positive Impact Moderate adverse impact	Significant Positive Impact Moderate adverse impact	Significant Positive Impact Moderate adverse impact	Significant Positive Impact Moderate adverse impact	Neutral Impact (no significant change)	Neutral Impact (no significant change)
	Falls among the elderly	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact Moderate adverse impact	Significant Positive Impact Moderate adverse impact
	Overweight and Obese	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact

Figure 2: Summary of proposed changes

1.2 Post Consultation feedback

Full details can be found in Appendices 2a, 2b and 2c. Overall feedback from the consultation was very positive, with the majority of respondents supporting the proposed changes. Feedback from the consultation identified some overall themes;

Quality of care and reduced cancellations and waiting times were perceived to be the benefits of the proposed changes from consultation feedback. These were often the reasons for the high percentage of respondents supporting the changes. Many respondents reported the rational for the changes were clear.

Travel was identified as theme, particularly for those over 65, those with disabilities and carers. Respondents were concerned about the travel times to the hospital sites from where they live and traffic across the county. Feedback also identified concerns regarding the travel between sites and if public transport is sufficient.

Those with disabilities and those over 65 and those with long term conditions identified concerns regarding **transfers** between hospital sites and wards during treatment. This cohort also identified concerns around patients who are very unwell requiring transfer for emergency treatment. This was highlighted in regards to elective colorectal centralisation and Emergency General Surgery centralisation to GRH. Some feedback questioned if high risk procedures should be carried out where Emergency General Surgery is centralised.

Parking was identified as an issue for patients, particularly at Cheltenham Hospital, which could become exacerbated by centralisation of elective work.

Capacity was questioned by respondents. Many questioning if the hospitals can cope with the increased demand brought about by centralising services.

Both sites acting as centres of excellence, was a suggestion by many respondents who felt that the county was too large to have one centre of excellence located at one site. Some raised concerns regarding the growing population. Whereas, others felt that the centralising of services would optimise care quality, increased staff retention and learning for staff which would result in reduced waiting times and cancellations.

Community Hospitals were mentioned within feedback, questioning how they will interact with the new models of care.

Many felt that this could also be a good opportunity to **modernise** areas within the sites as part of this proposal.

Subsidised Transport could be explored as many respondents fed back on the cost of transport between hospital sites and home.

Request to increase **Homeless Outreach**, particularly in Cheltenham. Feedback from the Homelessness Forum and Housing and Support Forum identified that those who are homeless or rough sleeping do not tend to travel outside of their immediate area and so travelling further for medical care may be difficult.

Many respondents commented that centralising services would support **staff retention** and encourage recruitment.

Some respondents had questions regarding the inpatient care at Gloucester Royal Hospital for Gastroenterology patients. This is also the case in relation to how the spilt of Trauma and Orthopaedics looks in practice.

Care Quality was viewed as a benefit by many respondents who felt centralising services would optimise care. Some commented that they were happy to travel for optimised care or that location was less important compared to quality.

1.2.1 *Recommendations based on evidence review and consultation feedback*

Communication

1. The need for further communication has been identified through consultation feedback. Providing detailed information about what to expect as a patient attending Cheltenham A&E, what is meant by a spoke model for IGIS at Cheltenham, what will remain available at both sites in relation to Trauma and Orthopaedics split and Gastroenterology centralisation, how do these changes link with community hospitals and how will the hospitals continue to manage demand in the new models, are some examples.
2. Communications will be needed to explain the benefits and mitigate public perceptions of additional risks to patient and visitor wellbeing. Ensure sufficient time, resource and focus is allocated to engagement with a range of groups on travel impacts, both planned and emergency, and for families and visitors as well as patients. Staff travel may also be a factor.
3. Emphasising to the public that current A&E services at CGH will be maintained is important to alleviate concerns around its closure. Feedback from over 65s emphasises the need to ensure all patients are aware of their local A&E and where to go in the event of an emergency. There are concerns around whether they will need to learn the route to a new A&E so ensuring they know A&E is still available at CGH and what to do in the event of an emergency is important.
4. Explaining how specialist staff are distributed across the two sites will be beneficial in alleviating concerns around accessibility to specialist care equally across the county.

Delivery of care

5. It is recommended to explore the possibility of adapting the model of elective colorectal to alleviate some concerns regarding the transfer of high risk patients. Evidence review suggests there are clinical benefits to elective colorectal being centralised in GRH with Emergency General Surgery, however, consultation feedback suggests that overall patients would prefer centralisation at CGH. In order to accommodate patient preference, optimise care and alleviate concerns regarding transfer, it is recommended to explore a model where elective colorectal is centralised at CGH but with high risk patients attending GRH to receive their colorectal treatment.
6. Explore if increasing outreach services for those who are Homeless is needed and would be beneficial.
7. It is recommended to explore what could be moved to virtual appointment where possible to reduce the need for patients and carers to travel for outpatient appointments.
8. As part of the design of services, consultation feedback suggested that this could be an opportunity to modernise areas of the sites.

Transport and Accessibility

9. Assess the parking at each site, including availability of disabled parking bays to understand if this will be negatively impacted by the changes.
10. It is recommended a review of public transport is conducted to understand if there are limitations, to disseminate information regarding travel to patients to make journey planning easier and ensure patients and carers are aware of what services are available.
11. It is recommended to conduct a review of transport options, including subsidised options for transport which can be disseminated to patients ensuring they are aware of all the options they can access.
12. High quality signposting, good quality wheelchair access and interactive information for those with sensory impairments will be necessary to help patients navigate this change. Both sites will already have facilities in place for patients with disabilities but it is important to ensure these are optimised and co-designed where possible with representative organisations and patients with disabilities.
13. It is recommended to work closely with local transport providers and the local authority to understand their forward plans for transport and the impact this will have on the reconfiguration proposals.
14. When centralising services it is important to assess if there is an appropriate number of disabled parking bays to accommodate increases in demand of, for example, specific elective procedures. Engagement with patients with disabilities can help to identify the perceived challenges and what is required.
15. Moving sites can be a challenge for patients with a sensory impairment who may be familiar with their local hospital site but may be required to travel to the other site. Additional support may be needed to help patients navigate this change; engagement through representative organisations for sensory impairments and disabilities would be beneficial to understand the best way to offer support.

1.2.2 *Potential Positive Impacts*

- Centralising acute medicine enhances patient safety, improves outcomes and reduces length of stay as it allows for more patients to be seen by a senior reviewer within 14 hours of arrival, 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 change and its benefits.
- By centralising the IGIS hub patients will now have a 24/7 service available to them. By co-locating this with the County's Trauma hub patients are more likely to receive emergency intervention faster. By co-locating with vascular the Trust is creating a multi-disciplinary approach to management of primary angioplasty which can improve patient outcomes. 68% of Interventional Cardiology patients and 66% of vascular patients last year were over 65, meaning this cohort is significantly impacted by this change and its benefits.
- The centralisation of services will also mean quality of care and expertise will be enhanced, particularly beneficial to patients with long term conditions or co-morbidities which are prevalent in patients with disabilities, those aged 65 and some BAME communities.
- By centralising services, patients will have reduced waiting times, fewer cancellations and less unplanned overnight stays. Timely appointments with fewer cancellations means patients can more effectively plan their travel (e.g. pick up and drop off times if

they are not driving themselves). This will benefit all patients, including those with disabilities who may need to plan travel in advance.

- Reduced unplanned overnight stays may help to limit anxiety and unfamiliarity, particularly important for patients with a learning disability.
- Having a more consistent workforce can make a significant positive impact to patients, specifically those with learning disabilities or from a minority group as consistency allows for ongoing communication with a familiar team and helps build trust for patients.
- 25% of Gloucester city's population are living in deprived areas, approx. 32,000 people. Therefore centralising Emergency General Surgery, Trauma, acute medicine and IGIS to the GRH provides improved access to the right specialists to manage the care of this higher risk community. Deprivation is linked to co-morbidities and poorer health outcomes, therefore, centralising services to form different hubs with co-located specialities across both sites with enhanced quality of care and reduced waiting times will benefit all those living in deprivation across the County.
- The centralisation of services will provide more comprehensive and co-located specialised care, which could be beneficial for carers who are caring for someone with multiple conditions. Centralisation also means services will be ring fenced, ensuring fewer cancellations, reduced waiting times and improved clinical outcomes, resulting in improved self-care. These benefits will help to support carers to reduce their time attending hospital with the person they are caring for and improve the health outcomes of both the person they are caring for and, in turn, potentially their own health.
- There are 79 people registered with Gloucestershire's homeless healthcare team and it has been identified this cohort are significantly most likely to use A&E and community care services and evidence suggests those who are homeless are more likely to have multiple health conditions. Given rates of homelessness are slightly higher in Gloucester than surrounding areas; centralising Emergency General Surgery to GRH provides improved access to the right specialists to manage the care of homeless people who present with multiple conditions.
- There is a strong association between physical health and mental health. People with long-term conditions, such as diabetes or cardiovascular disease, have significantly raised rates of depression, anxiety and other mental health problems. Evidence suggests they receive poorer quality care than those with a single condition.[1] 1.2% of all A&E attendances last year were for those with mental health conditions, the large majority attended GRH A&E. Therefore by centralising services, patients with comorbidities could receive a better quality of specialist care as they will be treated with a multi-disciplinary approach. .
- Diabetes tends to be prevalent with other co-morbidities such as heart conditions, meaning that this cohort is likely to be impacted by the centralisation of services as they are likely to use several different services due to having multiple conditions. Thus centralising services will improve their quality of care by reducing waiting times, faster diagnostics and a multi-disciplinary approach to multiple conditions.
- By centralising services new and innovative training opportunities will be available to staff which will positively impact moral, help to retain existing staff and attract new staff. The co-location of catheter labs with Interventional Radiology improves the

[1] https://www.kingsfund.org.uk/projects/mental-health-and-long-term-conditions-cost-co-morbidity

opportunity to develop innovative nursing and technician roles that would not have been possible before.

- Although the inpatient gastroenterology ward is currently based at CGH there is full access to gastroenterology services at GRH; with 7 day per week emergency endoscopy provision and a rostered gastrointestinal consultant and registrar at GRH to assess patients who are referred either from ED or other specialist areas ensuring the same level of emergency care are available at both sites.
- Outpatient gastroenterology and orthopaedic clinics are unaffected and will be maintained at Cheltenham General, Gloucestershire Royal and Community Hospitals creating no impact on travel times.
- Despite some patients from the west of the county having to travel further for elective (planned) orthopaedic surgery the move of planned orthopaedic care to CGH has enabled the provision of ring-fenced wards with 80% lower chance of cancellation due to emergency trauma patients requiring the attention of specialist staff.
- The way the inpatient beds are organised for trauma and orthopaedics (in the pilot) includes 17 single rooms at CGH and 18 at GRH which gives flexibility to maintain privacy and dignity.
- Rates of homelessness are slightly higher in Gloucester than surrounding areas; this group have a significant requirement for trauma services and so the centralisation of trauma services there will benefit this cohort.

1.2.3 *Potential Adverse Impacts*

- A centralised hub for IGIS will provide the capacity and capability to provide specialist centralised care for these patients. It is important to consider patients having interventional surgery are often more complex and can be at higher risk, often with other co-morbidities and long term conditions such as cardiovascular conditions. Engagement with staff at Gloucestershire Hospitals Foundation Trust identified some concerns that patient safety may be compromised by having IGIS and vascular separate as this could result in some complex and emergency vascular patients needing to transfer, identified vulnerable groups are patients who have had a mini stroke or patients with carotid artery disease.
- If Emergency General Surgery is centralised to GRH, people attending A&E at CGH or patients (e.g. day cases and elective colorectal) deteriorating and needing Emergency General Surgery may need to be transferred to GRH. Patients over 65 are most vulnerable to deterioration and currently 40% of General Surgery patients are over 65, meaning they are disproportionately impacted by this. Currently, however, it is only 6 per day in total will be impacted by the new arrangements, with significantly less than 1 patient per day needing transfer in an emergency as a result of inpatient deterioration. This means the impact is relatively small and outweighed by the positive clinical outcomes.
- GI day case patients are generally lower acuity and so are less likely to deteriorate; however, in the event a patient does deteriorate they may need to be transferred to GRH. Patients over 65 are more likely to experience co-morbidities and other health conditions and therefore could be more vulnerable to needing transfer; however, transfer as a result of deterioration is already indicated to be low and infrequent. This is outweighed, however, by reduction in waiting times, enhanced quality of care and a reduction in the number of patients who are required to stay overnight unplanned as a result of a late start.

- Feedback from staff and patients suggests parking can be a challenge at both sites. This could prove challenging for patients with a disability who will require a disabled parking bay or drop off point if the demand increases beyond what is currently available as a result of centralising services. Moving sites can also be a challenge for patients with a sensory impairment who may be familiar with their local hospital site but may be required to travel to the other site. Additional support may be needed to help patients navigate this change.
- The new proposed models will mean that deteriorating patients may need to be transferred depending on the site they attended and their condition. For patients with a physical, sensory or learning disability, this may mean additional support with transport arrangements on their return home as they may not drive. It is important to note this will likely be in unique circumstances and outweighed by the clinical benefits of centralising services
- Carers and unpaid carers are likely to experience the clinical benefits of better quality of care for the patient, shorter waiting times and specialist services working in a multi-disciplinary approach which could help to reduce their number of hospital visits. It is possible, however, in some instances a carer may need to attend both sites based on the proposed changes (although unlikely), or in the event the patient deteriorates, they may need to transfer to GRH for emergency surgery if they are currently at CGH. These events have been estimated to happen for significantly less than 1 patient a day, meaning that, the benefits outweigh the risks for carers.
- Enhanced clinical outcomes outweigh the negative impacts of travel for the majority of cohorts; however, it is important to consider the possible impact of additional cost in travel for some either through fuel costs or public transport fares for all patients, but particularly considering those in low income households. It is important to consider that this is outweighed by enhanced clinical outcomes as centralising services will likely reduce waiting times and therefore parking fees and in all the proposed solutions, ~80% of all patients impacted will see a neutral impact in travel (a change +/-20 mins).
- There are some patients who attend A&E at CGH who may need to transfer to GRH for admission. This has been mitigated by working with the Ambulance Service to ensure that patients who are likely to require admission are taken directly to GRH. Senior orthopaedic doctor input is available for patients in A&E at both CGH and GRH and there is a process in place to transfer patients who require admission.

1.2.4 *Travel Impacts*

To Patients

- Patients may need to travel to a different site for their treatment in the future. Travel analysis has suggested that approximately 80% of all patients will see minimal change in their journey (+/- 20 mins). This equates to approximately 20,000 people and on average 7% will have a shorter journey, just over 1,600 people
- On average, 13% of patients using the services contained within these proposals will have a negative travel impact. The largest negatively impacted cohorts are those who under the proposals would need to travel to GRH for acute medicine and those travelling to CGH for elective colorectal if this are to be centralised in CGH.
- GHNHSFT have assessed the evidence around the extra distance some patients may need to travel in the event of an emergency and the evidence suggests the distance would not impact negatively on mortality or the clinical outcomes of patients.

- By centralising services, a number of patients would see significant reductions in their travel times as they could now be treated locally, whereas at present Primary PCI patients are travelling to other hospitals, such as Bristol, for their treatment.
- There are also currently patients travelling out of county for IGIS procedures. By centralising IGIS it improves the ability for this provision to expand, increasing the potential for more patients to be treated in-county, overall reducing travel for some patients. Within the scope of the IGIS service proposals are the current 115 patients who undergo various Interventional Radiology interventions mostly delivered from Birmingham and Oxford, a few from Bristol, and some travel as far as Leeds. In addition to the patients directly benefitting, our IGIS service proposals will contribute towards to other initiatives aimed at repatriating up to a further 600 patients.

To Staff

- It is important to consider the impact increased travel can have on child care provision or caring responsibilities of staff.
- Despite some staff required to travel more, centralising General Surgery day cases will reduce the number of visits a patient makes which creates more capacity for staff.
- Currently there are challenges in filling rotas, increased sickness absence, and increased use of agency staff to combat this. This puts staff under pressure and impacts morale. The proposed solutions aim to give staff more dedicated time by making processes more efficient. Some changes will bring teams together and result in less travel and as teams become bigger there will be more opportunity for flexibility of staff. By centralising some emergency and elective cohorts the environment improves for workforce as they have more dedicated capacity, fewer cancellations and less late starts and by creating an IGIS hub, this creates new opportunities for staff to train and develop new specialist skills as well as to attract and retain more staff

1.3 Integrated Impact Assessment (IIA) – background information

1.3.1 *Context – Fit for the Future and Proposed options*

The Fit for the Future (FFTF) Programme was developed by health partners in Gloucestershire to support achievement of the NHS Long Term Plan's ambitions and in commitment to the public in Gloucestershire. As partners in Gloucestershire's health and care system, we believe patients who have serious illness or injury that requires specialist care, should receive treatment in centres of excellence, equipped with the right specialist staff, skills, resources and technology so they can by deliver care that is fit for the future.

The FFTF Programme (previously called "One Place"), strives to develop outstanding specialist hospital care across the Cheltenham General and Gloucestershire Royal hospital sites. These will be "Centres of Excellence" for planned care and treatment, and for emergency care respectively. Our vision is for a single hospital on two sites, linked by the A40 'corridor', providing reliable and high quality care and experience, safely and that delivers the best possible outcomes for local people.

To date, GHNHSFT has faced some challenges describing a clear future for services, However, the Trust believes there is a huge opportunity to develop centres of excellence providing outstanding specialist care where more patients can be treated, waiting times are lower, patient experience is improved and patient outcomes are amongst the best.

This programme seeks to maximise the opportunities of hospital care being delivered from two sites, by achieving the benefits of a separation of elective and emergency provision with one site focusing more on planned care and one more emergency-driven care site. This is unlikely, due to the needs of our population and critical co-dependencies, to be fully achieved, so any future clinical model will retain a 24/7 front door (ED/ED+MIIU) and ITU on both sites.

A summary of the proposed changes to services is as follows:

Clinical pathway group	Ref	Solutions Descriptor	Model D (4.4)	Model E (5.4)
Acute medicine	A3	Centralise acute medicine to GRH	✓	✓
Image guided interventional surgery	B2	IGIS hub and vascular centralised to GRH	✓	✓
General Surgery	C3	EGS centralised to GRH	✓	✓
	C5	Elective colorectal to CGH	✓	
	C6	Elective colorectal to GRH		✓
	C11	GI daycases - CGH	✓	✓
Gastroenterology Trauma & Orthopaedics	Gastro 1	Centralised CGH	✓	✓
	T&O 1	Split O=CGH/T=GRH	✓	✓
**Enabler - Deteriorating patient model			✓	✓

1.3.2 *Why Integrated Impact assessment (IIA)?*

An integrated impact assessment supports decision making by evaluating the impact of a proposal, informing public debate and supporting decision makers to meet their Public Sector Equality Duty and their duty to reduce inequalities.

The assessment was achieved by undertaking and combining three different methods reflecting best practice guidance summarised in figure 1.

In relation to equality, these responsibilities include assessing and considering the potential impact which the proposed service relocation could have on people with characteristics that have been given protection under the Equality Act, especially in relation to their health outcomes and the experiences of patients, communities and the workforce. With reference to health and health inequalities, the responsibilities include assessing and considering the

impact on the whole of the population served by the relevant statutory bodies and identifying and addressing factors which would reduce health inequalities, specifically with regard to access and outcomes.

1.3.3 *What is included in the IIA?*

NHS partners in Gloucestershire commissioned the MSE Strategy Unit and Partners in February 2020 to:

- Undertake and complete a full Integrated Health Inequalities and Equality Impact Assessment (IIA) prior to the consultation process of the FFTF programme's proposed changes.
- Provide recommendations based on the evidence review conducted as part of the IIA to inform an action plan developed and owned by commissioners and the *One Gloucestershire* Integrated Care System
- Ensure the report contains evidence that decision-making arrangements will pay due regard to equalities and inequalities issues and the Brown principles[2].
- The assessment uses techniques such as evidenced based research, engagement and impact analysis to understand the impact of change on the population, the impact on groups with protective characteristics and the impact on accessibility and quality of services. The aim of the report is to understand and assess the consequences of change whilst maximising positive impacts and minimising negative impacts of the proposed change.

This IIA is made up of 3 chapters:

- Equality Impact Assessment
- Health inequalities impact assessment
- Health impact assessment

1.3.4 *Applicable Standards and Principles*

Key legal principles and guidance recognised and referenced as part of this document are:

- s.149 - Public Sector Equality Duty (PSED) of the Equality Act 2010.
- Equality and Human Rights Commission's paper (2012).
- Brown Principles[3].
- The Public Services (Social Value) Act 2012.
- The Autism Act 2009.
- The Children's Act 2004.
- Section 14T and 13G of the NHS Act 2006
- Commissioner duties as set out in Section 14 of the National Health Service Act 2006
- NHS Five Year Forward View and NHS Long Term Plan.
- The NHS Constitution

[2] [2] R. (Brown) v. Secretary of State for Work and Pensions [2008] EWHC 3158 at paras 90-96.

[3] R. (Brown) v. Secretary of State for Work and Pensions [2008] EWHC 3158

1.3.5 *What is the scope of this IIA?*

Patients covered

- The current and future patients from GHNHSFT.
- The population served by One Gloucestershire ICS
- Population/communities covered
- The overall population of Gloucestershire

Workforce

The current workforce at Gloucestershire Royal Hospital (GRH) and Cheltenham General Hospital (CGH)

1.3.6 *The IIA Methodology*

This IIA process includes an evidence review, data analysis and linking with outputs from stakeholder engagement to identify potential impacts of proposals on key groups. Each aspect had specific focus areas as listed below:

An **evidence review** of health issues and the risk factors for the specific patient/client groups impacted by the move as well as general population. This will ensure all population groups with the potential to be impacted are considered.

Descriptive analysis of the current patient population and health landscape within England. This includes specific emphasis on areas covered by CCGs relevant to Gloucestershire. This analysis has been used to establish an understanding of the scale of impact. This ensures the response to the impact is proportional to its scale.

Comparative analysis to assess whether different groups of the patient population/staff population, namely those that fall under protected characteristics, are disproportionately impacted by the proposed changes. This is done within the context of equality and diversity, health inequalities and population health impact. For each category of assessment, themes are used to assess impact following a description of the effect using evidence/data, whether it was positive or negative and would be difficult to remedy or be irreversible.

Assessing future demand for the service and potential impact upon different groups of the patient and workforce population in the context of equality and diversity, health inequalities and population health impact.

Iterative process combining information gathered from engagement activity conducted with the local population such as opinion surveys, panel discussions and focus groups carried out by GHNHSFT and the findings from the consultation.

The Consultation asked all respondents whether they were in support, neutral or opposed to each proposed change and their reasons, including any alternative ideas or other comments. The feedback from this has been incorporated into the overall assessment of impact.

The consultation analysis can be broken down into 3 steps.

- Step 1: assessment of the representation of respondents
- Step 2: quantitative analysis of the consultation feedback
- Step 3: Qualitative analysis of feedback from respondents to capture themes which inform recommendations.

Each impact was prioritised based on:

- **Probability** of the impact occurring (using a decision matrix combining scale and duration)
- **Scale** of those impacted
- **Public opinion** through consultation
- **Duration** of the impact e.g. short, medium or long term

1.3.7 *The IIA assumptions and limitations*

Patients who have attended GRH, CGH and community provision have been used to identify potentially impacted patients and scale of impact.

The population of Gloucestershire as a county has been used to identify population health needs and inequalities of those who may be impacted by the proposed changes.

Population growth projections are based on ONS 2011 Census and current scenarios thus by default the analysis will assume that current trends will remain constant.

The overall impact of travel has been assessed considering both staff and patients feedback through engagement. Travel analysis for patients has been provided by Gloucestershire Commissioning Support Unit.

1.3.8 *How to read the IIA*

There are 3 chapters in the IIA;

- Equality Impact Assessment
- Health inequalities impact assessment
- Health impact assessment

Each chapter will start with a summary of the positive impacts and negative impacts followed by evidence based recommendations related to these impacts. The impacts of each solution has been assessed and then aggregated up to assess the impact of each proposed model of change.

1.4 Equality Impact assessment: the impact on groups with protected characteristics

Equality impact assessment is a tool which identifies and assesses impacts on a range of affected groups of people with characteristics protected under the Equality Act 2010, namely: age; gender, disability; gender reassignment; marriage and civil partnership; pregnancy and maternity; race and ethnicity; religion and belief; and sexual orientation.

The aim of an Equality Impact Assessment (EIA) is to establish the differential impact of a policy, such as in this case the development of centres of excellence and the proposed relocation or centralisation of services within Gloucestershire, on these groups. It also considers the potential measures which could reduce any negative impacts, especially in relation to health outcomes and the experiences of patients, carers, communities and the workforce. It also seeks to identify opportunities to better promote equality and good relations.

Protected characteristics considered in the analysis as per Equality Act 2010:

- **Age**: a reference to a person of a particular age group, for example this includes older people; middle years; early years; children and young people.
- **Sex**: a reference to a man or a woman.
- **Gender reassignment**; a reference to a person who is to undergo, is undergone or has undergone a process (or part of a process) for the purpose of reassigning the person's sex by changing physiological or other attributes of sex
- **Disability**: includes people with physical or mental impairments where the impairment has a substantia and long terms adverse effect on the individual's ability to carry out normal day-today activities e.g. people with learning disability; sensory impairment; mental health conditions; long-term medical conditions.
- **Marriage and civil partnership**: people who are married or in a civil partnership.
- **Pregnancy and maternity**: women before and after childbirth; breastfeeding.
- **Race**: a reference to people of a particular racial group.
- **Religion or belief**: a reference to people of a particular religion or belief.
- **Sexual orientation**: a person's sexual orientation towards persons of the same sex; persons of the opposite sex or person of either sex.

1.4.1 *Summary of impacts on people with protected characteristics*

		A3 - Centralise acute medicine to GRH	B2 - IGIS hub and vascular centralised to GRH	C3 - EGS centralised to GRH	C11 - GI day cases to CGH	C5 - Elective colorectal to CGH	C6 - Elective colorectal to GRH	Gastroenterology to CGH	Trauma to GRH and Orthopaedics to CGH
Protected Characteristics	Age	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact Moderate adverse impact	Significant Positive Impact Moderate adverse impact	Significant Positive Impact	Significant Positive Impact Moderate adverse impact	Significant Positive Impact Moderate adverse impact
	Disability	Significant Positive Impact Moderate adverse impact	Significant Positive Impact Moderate adverse impact	Significant Positive Impact Moderate adverse impact	Significant Positive Impact Moderate adverse impact	Significant Positive Impact Moderate adverse impact	Significant Positive Impact Moderate adverse impact	Significant Positive Impact Moderate adverse impact	Significant Positive Impact Moderate adverse impact
	Gender	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact	Neutral Impact (no significant change)	Significant Positive Impact
	Pregnancy	Neutral Impact (no significant change)	Neutral Impact (no significant change)	Neutral Impact (no significant change)	Neutral Impact (no significant change)	Neutral Impact (no significant change)	Neutral Impact (no significant change)	Significant Positive Impact Moderate adverse impact	Significant Positive Impact
	Martial Status	Neutral Impact (no significant change)	Neutral Impact (no significant change)	Neutral Impact (no significant change)	Neutral Impact (no significant change)	Neutral Impact (no significant change)	Neutral Impact (no significant change)	Neutral Impact (no significant change)	Neutral Impact (no significant change)
	Ethnicity	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact
	Sexual Orientation	Neutral Impact (no significant change)	Neutral Impact (no significant change)	Neutral Impact (no significant change)	Neutral Impact (no significant change)	Neutral Impact (no significant change)	Neutral Impact (no significant change)	Neutral Impact (no significant change)	Neutral Impact (no significant change)
	Religion	Neutral Impact (no significant change)	Neutral Impact (no significant change)	Neutral Impact (no significant change)	Neutral Impact (no significant change)	Neutral Impact (no significant change)	Neutral Impact (no significant change)	Neutral Impact (no significant change)	Neutral Impact (no significant change)
	Gender Reassignment	Neutral Impact (no significant change)	Neutral Impact (no significant change)	Neutral Impact (no significant change)	Neutral Impact (no significant change)	Neutral Impact (no significant change)	Neutral Impact (no significant change)	Neutral Impact (no significant change)	Neutral Impact (no significant change)

Gastroenterology and Trauma and Orthopaedics were assessed locally through a local IIA.

1.4.2 *Potential Positive Impacts*

- Centralising acute medicine enhances patient safety, improves outcomes and reduces length of stay as it allows for more patients to be seen by a senior reviewer within 14 hours of arrival, 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 change and its benefits.
- By centralising the IGIS hub patients will now have a 24/7 service available to them. By co-locating this with the County's Trauma hub patients are more likely to receive emergency intervention faster. By co-locating with vascular the Trust is creating a multi-disciplinary approach to management of primary angioplasty which can improve patient outcomes. 68% of interventional cardiology patients and 66% of vascular patients last year were over 65, meaning this cohort is significantly impacted by this change and its benefits.
- The centralisation of services will also mean quality of care and expertise will be enhanced, particularly beneficial to patients with long term conditions or co-morbidities which are prevalent in patients with disabilities, those aged 65 and some BAME communities.
- By centralising services, patients will have reduced waiting times, fewer cancellations and less unplanned overnight stays. Timely appointments with fewer cancellations means patients can more effectively plan their travel (e.g. pick up and drop off times if they are not driving themselves). This will benefit all patients, including those with disabilities who may need to plan travel in advance.
- Reduced unplanned overnight stays may help to limit anxiety and unfamiliarity, particularly important for patients with a learning disability.

Coronavirus (COVID-19)

As part of GHNHSFT's response the Trust temporarily consolidated vascular emergency and elective pathways to GRH; this has allowed the Trust to monitor the impact on patients and staff whilst optimising patient care during these unprecedented times. The Trust can use this learning to help inform planning for the future.

1.4.3 *Recommendations based on evidence Review and Consultation feedback*

1. High quality signposting, good quality wheelchair access and interactive information for those with sensory impairments will be necessary to help patients navigate this change. Both sites will already have facilities in place for patients with disabilities but it is important to ensure these are optimised and co-designed where possible with representative organisations and patients with disabilities.

2. Explaining how specialist staff are distributed across the two sites will be beneficial in alleviating concerns around accessibility to specialist care equally across the county.

3. It is recommended a review of public transport is conducted to understand if there are limitations, to disseminate information regarding travel to patients to make journey planning easier and ensure patients are aware of what services are available.

4. It is recommended to work closely with local transport providers and the local authority to understand their forward plans for transport and the impact this will have on the reconfiguration proposals.

5. It is recommended to explore the possibility of adapting the model of elective colorectal to alleviate some concerns regarding the transfer of high risk patients. Evidence review suggests there are clinical benefits to elective colorectal being centralised in Gloucestershire Royal hospital with emergency general surgery, however, consultation feedback suggests that overall patients would prefer centralisation at CGH. In order to accommodate patient preference, optimise care and alleviate concerns regarding transfer, it is recommended to explore a model where elective colorectal is centralised at CGH but with high risk patients attending GRH to receive their colorectal treatment.

6. Communication has been identified as an area of improvement based on feedback. Providing detailed information about what to expect as a patient attending Cheltenham A&E, what is meant by a spoke model for IGIS at Cheltenham, how do these changes link with community hospitals and how will the hospitals continue to manage demand in the new models, are some examples.

7. Assess the parking at each site, including availability of disabled parking bays to understand if this will be negatively impacted by the changes.

1.4.4 *Potential adverse Impacts*

- A centralised hub for IGIS will provide the capacity and capability to provide specialist centralised care for these patients.
- If emergency general surgery is centralised to GRH, people attending A&E at CGH or patients (e.g. day cases and elective colorectal) deteriorating and needing emergency general surgery may need to be transferred to GRH. Patients over 65 are most vulnerable to deterioration and currently 40% of general surgery patients are over 65, meaning they are disproportionately impacted by this. Currently, however, it is only 6 per day in total will be impacted by the new arrangements, with less than 1 patient per day needing to be transferred in an emergency as a result of inpatient deterioration. This means the impact is relatively small and outweighed by the positive clinical outcomes.

- GI day case patients are generally lower acuity and so are less likely to deteriorate; however, in the event a patient does deteriorate they may need to be transferred to GRH. Patients over 65 are more likely to experience co-morbidities and other health conditions and therefore could be more vulnerable to needing transfer; however, transfer as a result of deterioration is already indicated to be low and infrequent. This is outweighed, however, by reduction in waiting times, enhanced quality of care and a reduction in the number of patients who are required to stay overnight unplanned as a result of a late start.
- Feedback from staff and patients suggests parking can be a challenge at both sites. This could prove challenging for patients with a disability who will require a disabled parking bay or drop off point if the demand increases beyond what is currently available as a result of centralising services. Moving sites can also be a challenge for patients with a sensory impairment who may be familiar with their local hospital site but may be required to travel to the other site. Additional support may be needed to help patients navigate this change.
- The new proposed models will mean that deteriorating patients may need to be transferred depending on the site they attended and their condition. For patients with a physical or learning disability, this may mean additional support with transport arrangements on their return home as they may not drive. It is important to note this will likely be a rare occurrence and therefore outweighed by the clinical benefits.

Coronavirus (COVID-19)

Following the temporary change of Emergency General Surgery to GRH, the Trust has been monitoring the patients attending CGH A&E/MIU who require a transfer to GRH; on average 2 general surgery patients per week were transferred to GRH, 17 in total between 1st April and 18th June 2020.

1.4.5 *Recommendations based on evidence review and consultation feedback*

- It is recommended residents and service users over 65s and BAME communities are engaged with, to explain the reasons for centralising IGIS and the implications for co-locating vascular with IGIS from a clinical outcomes perspective.
- Identifying to the public that current A&E services at CGH will be maintained is important to alleviate concerns around its closure. Feedback from over 65s emphasises the need to ensure all patients are aware of their local A&E and where to go in the event of an emergency. There are concerns around whether they will need to learn the route to a new A&E so ensuring they know A&E is still available at CGH and what to do in the event of an emergency is important.
- Liaise with the local authority and transport services regarding public transport options for people who may need to use public transport to travel between hospital sites or access a different site from their home.
- When centralising services it is important to assess if there is an appropriate number of disabled parking bays to accommodate increases in demand of, for example, specific elective procedures. Engagement with patients with disabilities can help to identify the perceived challenges and what is required.
- Moving sites can be a challenge for patients with a sensory impairment who may be familiar with their local hospital site but may be required to travel to the other site. Additional support may be needed to help patients navigate this change, engagement through representative organisations for sensory impairments and disabilities would be beneficial to understand the best way to offer support.
- It is recommended patients with disabilities are part of the co-design where possible, looking at specific challenges such as disabled access and transport for those who do not drive. Engagement with representative organisations and support groups would also be needed to understand how to support patients with learning disabilities who may need to travel to a different site.
- It is recommended a review of public transport is conducted to understand if there are limitations, to disseminate information regarding travel to patients to make journey planning easier and ensure patients are aware of what services are available.
- It is recommended to work closely with local transport providers and the local authority to understand their forward plans for transport and the impact this will have on the reconfiguration proposals.
- It is recommended to explore the possibility of adapting the model of elective colorectal to alleviate some concerns regarding the transfer of high risk patients. Evidence review suggests there are clinical benefits to elective colorectal being centralised in Gloucestershire Royal hospital with emergency general surgery, however, consultation feedback suggests that overall patients would prefer centralisation at CGH. In order to accommodate patient preference, optimise care and alleviate concerns regarding transfer, it is recommended to explore a model where elective colorectal is centralised at CGH but with high risk patients attending GRH to receive their colorectal treatment.
- Communication has been identified as an area of improvement based on feedback. Providing detailed information about what to expect as a patient attending Cheltenham A&E, what is meant by a spoke model for IGIS at Cheltenham, how do

these changes link with community hospitals and how will the hospitals continue to manage demand in the new models, are some examples.

- Assess the parking at each site, including availability of disabled parking bays to understand if this will be negatively impacted by the changes.

Coronavirus (COVID-19)

It is recommended that the impact of any COVID-19 pandemic temporary service changes are assessed based on staff and patient experience, access to care and quality and timeliness of care to ensure that the learning from the pandemic is reflected in any future reconfiguration decisions. This will also include considerations around the zoning of patients to ensure segregated pathways for COVID and non-COVID patients to ensure patient safety.

1.5 Health Inequalities Impact Assessment

The Health inequalities impact assessment identifies and assesses health inequalities and the impact of the proposed changes for the local community. The aims of a health inequalities impact assessment include identifying and addressing factors which would reduce health inequalities, specifically with regard to access and outcomes.

The World Health Organisation (WHO) defines health inequities or health inequalities as *'avoidable inequalities in health between groups of people within countries and between countries.'* Such inequities arise from inequalities within and between societies. According to the WHO, *'social and economic conditions and their effects on people's lives determine their risk of illness and the actions taken to prevent them becoming ill or treat illness when it occurs.'*

Unlike the protected characteristics listed in the Equality Act 2010, there are no specific groups identified in Section 14T of the NHS Act 2006 in relation to the duty to reduce health inequalities. However, research has identified that a range of groups and communities are at greater risk of poorer access to health care and poorer health outcomes[4]. Groups other than those that have protected characteristics as defined in the Equality Act 2010 who face health inequalities:

- Looked after and accommodated children and young people.
- Carers: paid/unpaid; family members.
- Homeless people or those who experience homelessness: people on the street; those staying temporarily with friends/family; those in hostels/B&Bs.
- People with addictions and substance misuse problems.
- People who have low incomes.
- People living in deprived areas.
- People living in remote, rural and island locations.
- People with enduring mental ill health.
- People in other groups who face health inequalities.

Summary of impacts of health inequalities

The gastroenterology and trauma and orthopaedics IIA was carried out locally.

		A3 - Centralise acute medicine to GRH	B2 - IGIS hub and vascular centralised to GRH	C3 - EGS centralised to GRH	C11 - GI day cases to CGH	C5 - Elective colorectal to CGH	C6 - Elective colorectal to GRH	Gastroenterology to CGH	Trauma to GRH and Orthopaedics to CGH
Health Inequalities	Deprivation	Significant Positive Impact Moderate adverse impact	Significant Positive Impact Moderate adverse impact	Significant Positive Impact Moderate adverse impact	Significant Positive Impact Moderate adverse impact	Significant Positive Impact Moderate adverse impact	Significant Positive Impact Moderate adverse impact	Small Adverse Impact	Significant Positive Impact Moderate adverse impact
	Looked After Children	Neutral Impact (no significant change)	Neutral Impact (no significant change)	Neutral Impact (no significant change)	Neutral Impact (no significant change)	Neutral Impact (no significant change)	Neutral Impact (no significant change)	Neutral Impact (no significant change)	Neutral Impact (no significant change)
	Carers and Unpaid Carers	Significant Positive Impact Moderate adverse impact	Significant Positive Impact Moderate adverse impact	Significant Positive Impact Moderate adverse impact	Significant Positive Impact Moderate adverse impact	Significant Positive Impact Moderate adverse impact	Significant Positive Impact Moderate adverse impact	Significant Positive Impact Moderate adverse impact	Significant Positive Impact Moderate adverse impact
	Homelessness	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact	Neutral Impact (no significant change)	Neutral Impact (no significant change)
	Substance Abuse	Neutral Impact (no significant change)	Neutral Impact (no significant change)	Neutral Impact (no significant change)	Neutral Impact (no significant change)	Neutral Impact (no significant change)	Neutral Impact (no significant change)	Significant Positive Impact Moderate adverse impact	Significant Positive Impact
	Mental Health	Significant Positive Impact Moderate adverse impact	Significant Positive Impact Moderate adverse impact	Significant Positive Impact Moderate adverse impact	Significant Positive Impact Moderate adverse impact	Significant Positive Impact Moderate adverse impact	Significant Positive Impact Moderate adverse impact	Significant Positive Impact Moderate adverse impact	Neutral Impact (no significant change)

[4] https://www.england.nhs.uk/wp-content/uploads/2019/01/ehia-long-term-plan.pdf

1.5.1 *Potential Positive impacts*

25% of Gloucester city's population are living in deprived areas, approx. 32,000 people. Therefore centralising emergency general surgery, acute medicine and IGIS to the GRH provides improved access to the right specialists to manage the care of this higher risk community. Deprivation is linked to co-morbidities and poorer health outcomes, therefore, centralising services to form different hubs with co-located specialities across both sites with enhanced quality of care and reduced waiting times will benefit all those living in deprivation across the County.

The centralisation of services will provide more comprehensive and co-located specialised care, which could be beneficial for carers who are caring for someone with multiple conditions. Centralisation also means services will be ring fenced, ensuring fewer cancellations, reduced waiting times and improved clinical outcomes, resulting in improved self-care. These benefits will help to support carers to reduce their time attending hospital with the person they are caring for and improve the health outcomes of both the person they are caring for and, in turn, potentially their own health.

There are 79 people registered with Gloucestershire's homeless healthcare team and it has been identified this cohort are significantly most likely to use A&E and community care services and evidence suggests those who are homeless are more likely to have multiple health conditions. Given rates of homelessness are slightly higher in Gloucester than surrounding areas; centralising emergency general surgery to GRH provides improved access to the right specialists to manage the care of homeless people who present with multiple conditions.

There is a strong association between physical health and mental health. People with long-term conditions, such as diabetes or cardiovascular disease, have significantly raised rates of depression, anxiety and other mental health problems. Evidence suggests they receive poorer quality care than those with a single condition.[5] Therefore by centralising services patients with comorbidities could receive a better quality of specialist care. In Particular, emergency services where the majority of patients with mental health conditions are already attending as 1.2% of all A&E attendances last year were for mental health conditions, the large majority attending GRH A&E.

Rates of homelessness are slightly higher in Gloucester than surrounding areas; this group have a significant requirement for trauma services and so the centralisation of trauma services there will benefit this cohort.

Coronavirus (COVID-19)

In light of the COVID-19 pandemic, some patient groups may now be further impacted by the need to self-isolate for 14 days prior to an elective admission to hospital. Homeless patients, for example, may find this challenging and may be unable to self-isolate. Those with long term health conditions may be shielding and reluctant to attend hospital due to concerns regarding COVID-19 and families in low income households, those who are self-employed or those who have recently been made redundant may feel unable to self-isolate prior to a hospital visit as they are financially unable to take the time off from work. This could result in some patient cohorts not attending hospital for the treatment they need.

[5] https://www.kingsfund.org.uk/projects/mental-health-and-long-term-conditions-cost-co-morbidity

1.5.2 *Potential adverse Impacts*

Carers and unpaid carers are likely to experience the clinical benefits of better quality of care for the patient, shorter waiting times and specialist services working in a multi-disciplinary approach which could help to reduce their number of hospital visits. It is possible, however, in some instances a carer may need to attend both sites based on the proposed changes (although unlikely), or in the event the patient deteriorates, they may need to transfer to GRH for emergency surgery if they are currently at CGH. These events have been estimated to happen for less than 1 patient a day, meaning that, the benefits outweigh the risks for carers.

Enhanced clinical outcomes outweigh the negative impacts of travel for the majority of cohorts; however, it is important to consider the possible impact of additional cost in travel for some either through fuel costs or public transport fares for all patients, but particularly considering those in low income households. It is important to consider that this is outweighed by enhanced clinical outcomes as centralising services will likely reduce waiting times and therefore parking fees and in all the proposed solutions, ~80% of all patients impacted will see a neutral impact in travel (a change +/-20 mins).

There are a number of patients with identified needs for whom it is important to ensure access to services is equitable, for example 25% of the Gloucester city population living in deprived areas and the rates of homelessness being slightly greater in Gloucester.

Coronavirus (COVID-19)

Consider how some patient cohorts are impacted by the need to self-isolate prior to an elective admission and consider how these cohorts could be supported to follow the social distancing rules. Offer virtual appointments and explain the process of attending hospital to patients so they understand how they will be kept safe during their hospital visit (zoning, COVID and non-COVID separation, PPE etc.).

1.5.3 *Recommendations based on evidence review and consultation feedback*

1. It is recommended a review of public transport is conducted to understand if there are limitations, to disseminate information regarding travel to patients to make journey planning easier and ensure patients and carers are aware of what services are available.

2. It is recommended to conduct a review of transport options, including subsidised options for transport which can be disseminated to patients ensuring they are aware of all the options they can access.

3. Explore if increasing outreach services for those who are Homeless is needed and would be beneficial.

4. It is recommended to explore what could be moved to virtual appointment where possible to reduce the need for patients and carers to travel for outpatient appointments.

1.6 Health Impact Assessment

The Health impact assessment (HIA) identifies and assesses health outcomes, service impacts and workforce impact of the proposed changes for the local community. The aims of a health impact assessment include assessing and considering the impact on the whole of the population served by the relevant statutory bodies and identifying and addressing factors which would reduce health inequalities, specifically with regard to access and outcomes.

HIA emerged as the recommended tool for maximising the health of the population through embedding health in all policies with the publication of the Gothenburg consensus. The framework, which was produced by the World Health Organization [WHO] European Centre for Health Policy, was underpinned by four core values: sustainable development, equity, democracy and the ethical use of evidence[6].

Based on an initial scoping exercise and evidence review we identified the main aspects within the context of health and the wider determinants of health that potentially have the greatest impact Gloucestershire's proposed changes. These are:

1. Cardiovascular Disease
2. Diabetes
3. Falls in the elderly
4. Overweight and Obesity

1.6.1 *Summary of impacts of the health assessment*

The gastroenterology and trauma and orthopaedics IIA was conducted locally.

		A3 - Centralise acute medicine to GRH	B2 - IGIS hub and vascular centralised to GRH	C3 - EGS centralised to GRH	C11 - GI day cases to CGH	C5 - Elective colorectal to CGH	C6 - Elective colorectal to GRH	Gastroenterology to CGH	Trauma to GRH and Orthopaedics to CGH
Health Impact	Cardiovascular Disease	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact Moderate adverse impact	Significant Positive Impact Moderate adverse impact	Significant Positive Impact Moderate adverse impact	Significant Positive Impact	Not assessed	Not assessed
	Diabetes	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact	Neutral Impact (no significant change)	Neutral Impact (no significant change)
	Neurological Conditions	Significant Positive Impact Moderate adverse impact	Significant Positive Impact Moderate adverse impact	Significant Positive Impact Moderate adverse impact	Significant Positive Impact Moderate adverse impact	Significant Positive Impact Moderate adverse impact	Significant Positive Impact Moderate adverse impact	Neutral Impact (no significant change)	Neutral Impact (no significant change)
	Falls among the elderly	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact Moderate adverse impact	Significant Positive Impact Moderate adverse impact
	Overweight and Obese	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact

1.6.2 *Potential Positive Impacts*

Diabetes tends to be prevalent with other co-morbidities such as, heart conditions, meaning that this cohort is likely to be impacted by the centralisation of services as they are likely to use several different services due to having multiple conditions. This means centralising services will improve their quality of care by reducing waiting times, faster diagnostics and a multi-disciplinary approach to conditions.

Obesity is often linked to a large number of co-morbidities which mean obese patients are significantly more likely to be impacted by the proposed changes. The movement of services could result in specialist care being provided in one place leading to a better quality of care.

[6] https://globalizationandhealth.biomedcentral.com/articles/10.1186/1744-8603-10-13

Patients who fall regularly are one of the cohorts more likely to be impacted by the proposed changes as they will usually attend hospital more than other cohorts in the population. 1,812 people per 100,000 in Gloucestershire are admitted to hospital due to falls. This cohort may benefit from the centralisation of services in the same way as over 65s because frailty can correlate with age, see "Age" section of the EQIA.

1.6.3 *Recommendations based on evidence review and consultation*

- It is recommended a review of public transport is conducted to understand if there are limitations, to disseminate information regarding travel to patients to make journey planning easier and ensure patients and carers are aware of what services are available.
- It is recommended to conduct a review of transport options, including subsidised options for transport which can be disseminated to patients ensuring they are aware of all the options they can access.
- Explore if increasing outreach services for those who are Homeless is needed and would be beneficial.
- It is recommended to explore what could be moved to virtual appointment where possible to reduce the need for patients and carers to travel for outpatient appointments.
- It is recommended to explore the possibility of adapting the model of elective colorectal to alleviate some concerns regarding the transfer of high risk patients. Evidence review suggests there are clinical benefits to elective colorectal being centralised in Gloucestershire Royal hospital with emergency general surgery, however, consultation feedback suggests that overall patients would prefer centralisation at CGH. In order to accommodate patient preference, optimise care and alleviate concerns regarding transfer, it is recommended to explore a model where elective colorectal is centralised at CGH but with high risk patients attending GRH to receive their colorectal treatment.

Coronavirus (COVID-19)

It is important to consider a number of patients with long term health conditions are likely to be shielding due to the COVID-19 pandemic. Therefore, it is important to explain clearly to patients and their relatives the pathways for COVID and non-COVID patients so they understand the safety procedures in place should they need to attend hospital during this time.

1.7 Public and Staff Engagement (Pre-consultation)[7]

The key concerns for patients are around access to specialist care regardless of where they live, time to assessment and overall waiting times and the availability of services locally so there is not an inequality in service provision.

Engagement from the public suggests BAME communities feel it is vitally important services remain close to patients who need it most. This cohort identified the need to see a specialist

[7] for more detail please see Appendix 2b & 2c

at their earliest opportunity and some think that centres of excellence are a good idea to promote specialist care.

Feedback from people over 65 confirmed that there are concerns around access to specialist staff in a timely manner.

Both Staff and the public expressed some concerns about GRH being able to cope with an increase in emergency admissions with staff looking at it from a facilities and resource perspective, and the public considering waiting times and parking.

Feedback from people over 65 confirmed that there is concern around transport. Specifically they highlighted the impact on family and friends of travelling to a different hospital, the surrounding area and how to get there. This cohort also criticised public transport reliability. This point was emphasised by those living outside of both Gloucester and Cheltenham where transport is perceived to be more complicated.

Feedback indicated that the public are more concerned with travel times than distances when it comes to care but also indicated that for some parts of the county it can take an hour to attend hospital if the proposed changes take place and this will result in increased fuel costs on top of parking charges.

Overview of local engagement

More than 3,300 face-to-face contacts were made across local communities during the FFTF Engagement period. In addition, staff working across NHS and care organisations were actively encouraged to participate in the engagement. Consequently a total of 2482 surveys were completed, with feedback also captured through workshops and other engagement events.

An overview of the feedback received during the engagement period was included in PCBC. Feedback was received from across the county with targeted engagement through a series of workshops. The workshops were supported by Inclusion Gloucestershire (a local user-led organisation whose aim is to reduce health inequalities) who helped to recruit members of the public as experts in their own lives to participate, and provide a balance of opinion, in discussions with NHS clinicians and professionals. Those who attended the workshops disclosed demographic information relating to:

- Age – including a young carer
- Disability – physical disability, Autism and learning disabilities
- Race – individuals from different BAME communities
- Religion or belief
- Substance misuse
- Sexual orientation
- Those who are socially isolated

Demographic information was also collected via the survey, although not everyone provided the full range of information. From the information collected, approx. 38% of respondents were aged over 65 yr., with approx. 25% declared a disability or long term condition and 87% described themselves as White British. This is comparable to demographic information about the county (Source: Inform Gloucestershire).

In addition, engagement undertaken regarding the NHS Long Term Plan targeted our diverse communities. In partnership with Healthwatch Gloucestershire, a series of drop-ins and workshop style events were held with local communities of interest: the elderly; patients with disabilities and long term conditions; those with poor mental health and learning

disabilities; carers; LGBT+ representatives; young people not in employment, education or training (NEET) and representatives from the BAME communities. Feedback relevant to FFTF noted that people felt the most important elements of their care were:

- Support is available as close to home as possible;
- Quality of care/expertise and continuity of care;
- Choice and timeliness of appointments;
- Reduced cancellations of appointments and operations.

1.8 Next steps

The independent Integrated Impact Assessment (IIA) undertaken has identified the potential for people with certain protected characteristics, health inequalities and health impacts to be adversely impacted by some of the proposals. Our proposed consultation (see DMBC) was developed to respond to the findings of the IIA and the IIA itself has been updated post-consultation to take account of consultation feedback and the impact upon people with protected characteristics. A final list of recommendations has been provided based on the evidence review and analysis of the IIA, public engagement pre consultation and feedback post consultation. The recommendations will now help to drive decision making around the implementation of proposed changes and considerations that need to be made that identified through this process.

Full details of the IIA can be found in Appendix 2b and 2c

1. Annex: Integrated Impact Assessment

A key commitment for the Fit for the Future programme is to deliver the requirements for Service Change as set out in Delivering Service Change for Patients (NHS England, 2018). An important component of this is delivery of an Integrated Impact Assessment on proposed solutions. This document contains all analysis conducted to determine the impacts of each proposed change.

2. Contents

3. Equality Impact Assessment

3.1. Key Findings

Public and staff Engagement

- Engagement from the public suggests BME communities feel it is vitally important services remain close to patients who need it most. This cohort identified the need to see a specialist at their earliest opportunity and some think that centres of excellence are a good idea to promote specialist care.
- The key concerns for patients are around access to specialist care regardless of where they live, time to assessment and overall waiting times and the availability of services locally so there is not an inequality in service provision.
- Over 65s have also expressed concerns around access to specialist staff in a timely manner.
- Both Staff and the public expressed some concerns about Gloucestershire Royal Hospital (GRH) being able to cope with an increase in emergency admissions with staff looking at it from a facilities and resource perspective and the public considering waiting times and parking.
- Over 65s expressed concerns around transport. Specifically they highlighted the impact on family and friends and the unfamiliarity of a different hospital, the surrounding area and how to get there. This cohort also criticised public transport reliability. This point was emphasised by those living outside of both Gloucester and Cheltenham where transport is perceived to be more complicated.
- Feedback indicated that the public are more concerned with travel times than distances when it comes to care but also indicated that for some parts of the county it can take an hour to attend hospital if the proposed changes take place and this will result in increased fuel costs on top of parking charges.

Consultation Feedback

Feedback from the consultation identified some overall themes highlighted by those with protected characteristics.

Travel was identified as concern, particularly for those over 65 and those with disabilities. Respondents were concerned about the travel times to the hospital sites from where they live and traffic across the county. Feedback also identified concerns regarding the travel between sites and if public transport is sufficient.

Those with disabilities and those over 65 identified concerns regarding **transfers** between hospital sites and wards during treatment. This cohort also identified concerns around patients who are very unwell requiring transfer for emergency treatment. This was highlighted in regards to elective colorectal centralisation and Emergency general surgery centralisation to GRH. Some feedback questioned if high risk procedures should be carried out where emergency general surgery is centralised.

Parking was identified as an issue for patients, particularly at Cheltenham General Hospital (CGH), which could become exacerbated by centralisation of elective work.

Capacity was identified as a concern by respondents. Many questioning if the hospitals can cope with the increased demand brought about by centralising services.

Both sites acting as centres of excellence, was a suggestion by many respondents who felt that the county was too large to have one centre of excellence located at one site. Some raised concerns regarding the growing population. Whereas, others felt that the centralising of services would optimise care quality, increased staff retention and learning for staff which would result in reduced waiting times and cancellations.

Community Hospitals were mentioned within feedback, questioning how they will interact with the new models of care.

Many felt that this could also be a good opportunity to **modernise** areas within the sites as part of this proposal.

Potential Positive Impacts

Centralising acute medicine enhances patient safety, improve outcomes and reduce LOS as it allows for more patients to be seen by a senior reviewer within 14 hours of arrival, 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 change and its benefits.

By centralising the IGIS hub patients will now have a 24/7 service available to them. By co-locating this with the County's Trauma hub patients are more likely to receive emergency intervention faster. By co-locating with vascular the Trust is creating a multi-disciplinary approach to management of primary angioplasty which can improve patient outcomes. 68% of interventional cardiology patients and 66% of vascular patients last year were over 65, meaning this cohort is significantly impacted by this change and its benefits.

The centralisation of services will also mean quality of care and expertise will be enhanced, particularly beneficial to patients with long term conditions or co-morbidities which are prevalent in patients with disabilities, those aged 65 and some BME communities.

By centralising services, patients will have reduced waiting times, fewer cancellations and less unplanned overnight stays. Timely appointments with fewer cancellations means patients can more effectively plan their travel (e.g. pick up and drop off times if they are not driving themselves). This will benefit all patients, including those with disabilities who may need to plan travel in advance.

Reduced unplanned overnight stays may help to limit anxiety and unfamiliarity, particularly important for patients with a learning disability.

Recommendations based on evidence Review

1. It is recommended that BME communities, particularly those vulnerable to long term conditions are involved in the consultation to feedback their views of the proposed changes and their perceived challenges. BME patients and those aged over 65 are disproportionately represented in the vascular patient cohort, meaning that engagement was these groups around the proposed changes to the vascular hub would be beneficial.

2. Proactive engagement will be needed to explain the benefits and mitigate public perceptions of additional risks to patient and visitor wellbeing. Ensure sufficient time, resource and focus is allocated to engagement with a range of groups on travel impacts, both planned and emergency, and for families and visitors as well as patients. Staff travel may also be a factor.

3. High quality signposting, good quality wheelchair access and interactive information for those with sensory impairments will be necessary to help patients navigate this change. Both sites will already have facilities in place for patients with disabilities but it is important to ensure these are optimised and co-designed where possible with representative organisations and patients with disabilities.

4. Explaining how specialist staff are distributed across the two sites will be beneficial in alleviating concerns around accessibility to specialist care equally across the county.

5. It is recommended a review of public transport is conducted to understand if there are limitations, to disseminate information regarding travel to patients to make journey planning easier and ensure patients are aware of what services are available.

6. It is recommended to work closely with local transport providers and the local authority to understand their forward plans for transport and the impact this will have on the reconfiguration proposals.

7. It is recommended to explore the possibility of adapting the model of elective colorectal to alleviate some concerns regarding the transfer of high risk patients. Evidence review suggests there are clinical benefits to elective colorectal being centralised in GRH with emergency general surgery, however, consultation feedback suggests that overall patients would prefer centralisation at CGH. In order to accommodate patient preference, optimise care and alleviate concerns regarding transfer, it is recommended to explore a model where elective colorectal is centralised at CGH but with high risk patients attending GRH to receive their colorectal treatment.

8. Communication has been identified as an area of improvement based on feedback. Providing detailed information about what to expect as a patient attending CGH A&E, what is meant by a spoke model for IGIS at CGH, how do these changes link with community hospitals and how will the hospitals continue to manage demand in the new models, are some examples.

9. Assess the parking at each site, including availably of disabled parking bays to understand if this will be negatively impacted by the changes.

Potential Negative Impacts

A centralised hub for IGIS will provide the capacity and capability to provide specialist centralised care for these patients. By retaining vascular at CGH, the service is maintained in the location where a higher proportion of patients are over 65. However, patient safety may be compromised by having IGIS and vascular separate, resulting in some complex and emergency patients needing to travel. It is also unclear the impact this will have on vascular and if this impact could be negative. Patients most impacted by this are those over 65 as they are more likely to have heart disease and make up over 60% of the vascular patient cohort. The impact to vascular and the impact on patient safety has been identified by Gloucestershire Hospitals NHS Foundation Trust, however, this impact has yet to be quantified by clinicians.

If emergency general surgery is centralised to GRH, people attending A&E at CGH or patients (e.g. day cases and elective colorectal) deteriorating and needing emergency general surgery may need to be transferred to GRH. Patients over 65 are most vulnerable to deterioration and currently 40% of general surgery patients are over 65, meaning they are disproportionately impacted by this. Currently, however, it is only 6 per day in total will be impacted by the new arrangements, with less than 1 patient per day need to be transferred in an emergency as a result of inpatient deterioration. This means the impact is relatively small and outweighed by the positive clinical outcomes.

GI day case patients are generally lower acuity and so are less likely to deteriorate; however, in the event a patient does deteriorate they may need to be transferred to GRH. Patients over 65 are more likely to experience co-morbidities and other health conditions and therefore could be more vulnerable to needing transfer, however, transfer as a result of

deterioration is already indicated to be low and infrequent. This is outweighed, however, by reduction in waiting times, enhanced quality of care and a reduction in the number of patients who are required to stay overnight unplanned as a result of a late start.

Feedback from staff and patients suggests parking can be a challenge at both sites. This could prove challenging for patients with a disability who will require a disabled parking bay of drop off point if the demand increases beyond what is currently available as a result of centralising services. Moving sites can also be a challenge for patients with a sensory impairment who may be familiar with their local hospital site but may be required to travel to the other site. Additional support may be needed to help patients navigate this change.

The new proposed models will mean that deteriorating patients may need to be transferred depending on the site they attended and their condition. For patients with a physical or learning disability, this may mean additional support with transport arrangements on their return home as they may not drive. It is important to note this will likely be a rare occurrence and therefore outweighed by the clinical benefits.

Recommendations based on evidence review

1. It is recommended residents and service users over 65s and BME communities are engaged with to explain the reasons for centralising IGIS and the implications for keeping vascular separate or co-locating it with IGIS from a clinical outcomes perspective.

2. It is recommended those over 65 are engaged with regarding the proposed centralisation of emergency general surgery as 60% of the cohort are over 65. It is important to consider the impact for patients deteriorating at CGH who may need to be transferred, particularly those over 65 who may have more difficulty travelling around the county e.g. visitors such as relative who may be relying on public transport and who may have health conditions themselves. It is also recommended to consider if there will be repatriation plans for patients who started at CGH.

3. Identifying to the public that current A&E services at CGH will be maintained is important to alleviate concerns around its closure. Feedback from over 65s emphasises the need to ensure all patients are aware of their local A&E and where to go in the event of an emergency. There are concerns around whether they will need to learn the route to a new A&E so ensuring they know A&E is still available at CGH and what to do in the event of an emergency is important.

4. Any change involving emergency transport will need to be part of engagement as this could result in access concerns.

5. Liaise with the local authority and transport services regarding public transport options for people who may need to use public transport to travel between hospital sites or access a different site from their home.

6. When centralising services it is important to assess if there is an appropriate number of disabled parking bays to accommodate increases in demand of, for example, specific elective procedures. Engagement with patients with disabilities can help to identify the perceived challenges and what is required.

7. Moving sites can be a challenge for patients with a sensory impairment who may be familiar with their local hospital site but may be required to travel to the other site. Additional support may be needed to help patients navigate this change; engagement through representative organisations for sensory impairments and disabilities would be beneficial to understand the best way to offer support.

8. It is recommended patients with disabilities are part of the co-design where possible, looking at specific challenges such as disabled access and transport for those who do not drive. Engagement with representative organisations and support groups would also be needed to understand how to support patients with learning disabilities who may need to travel to a different site.

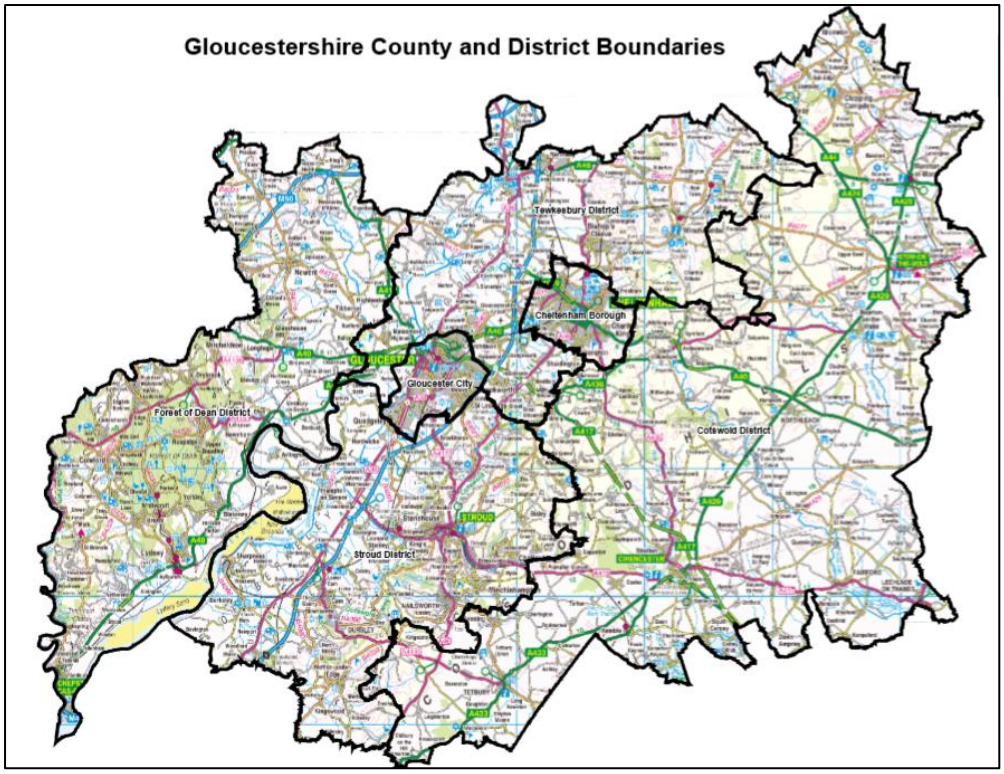
4. EQIA analysis

Public bodies have a legal duty to eliminate unlawful discrimination, to advance equality of opportunity and to have particular regard to the impact of potential service changes on defined segments of the population – known as those with 'protected characteristics'. The main protected characteristics defined in legislation and national guidance are:

1. Age
2. Disability
3. Sex
4. Pregnancy
5. Marital status
6. Race
7. Sexual orientation
8. Religion
9. Gender reassignment

Catchment Area

Gloucestershire covers 6 districts: Gloucester, Stroud, Forest of Dean, Tewkesbury, Cheltenham and Cotswold (see map below).This report will use this geography for analysing prevalence within the population to supplement analysis of specific patient cohorts identified through hospital data.



4.1. Age

The age of an individual, combined with additional factors including other 'protected characteristics' may affect their health and social care needs. Individuals may also experience discrimination and inequalities because of their age. Analysis of the 2008 European Social Survey in 2012 found that age discrimination was the most common form of prejudice experienced in the UK, affecting both younger and older people, with 28% of respondents saying they had experienced prejudice based on age.

Assuming current population trends continue, the population in Gloucestershire will rise by 44,300 between 2016 and 2026, from 623,100 to 667,400 (an increase of 0.7% per annum). The dominating feature of the population projections is the sharp increase in population in the age group 65 or over. These changes mean that by 2041, the proportion of people in the county who are aged 65 or over will have risen from 20.8% to 28.9%, and the proportion of people aged 85 or over will have risen from 2.9% to 5.5%. Population projections in the older age categories far exceed national averages (see Table 1).

Table 1: ONS Subnational Population Projections for Gloucestershire, the districts and England by age group, 2016 to 2041

	0-19			20-64			65+		
	Number of people		% change	Number of people		% change	Number of people		% change
	2016	2041	2016 to 2041	2016	2041	2016 to 2041	2016	2041	2016 to 2041
Cheltenham	26,500	27,200	2.6%	69,100	67,200	-2.7%	21,900	33,600	53.4%
Cotswold	17,600	18,400	4.5%	47,000	44,500	-5.3%	21,500	33,500	55.8%
Forest of Dean	18,300	19,600	7.1%	46,700	45,200	-3.2%	20,200	32,100	58.9%
Gloucester	32,100	35,200	9.7%	75,600	80,600	6.6%	20,800	35,300	69.7%
Stroud	26,200	28,600	9.2%	65,400	67,100	2.6%	25,800	40,400	56.6%
Tewkesbury	19,800	22,800	15.2%	49,300	52,100	5.7%	19,500	32,100	64.6%
Gloucestershire	**140,600**	**152,000**	**8.1%**	**353,000**	**356,700**	**1.0%**	**129,700**	**206,700**	**59.4%**
England	13,107,000	13,672,900	4.3%	32,278,400	33,285,800	3.1%	9,882,800	14,993,600	51.7%

EQIA summary for Age

Proposed Change	Scale of Potential impact	Evidence of Potential Impact and potential duration	Consultation Outputs	Impact based on consultation	Nature of potential impact and recommendations
A3 - Centralise acute medicine to GRH	**Large Scale Impact** The proportion of people in the county who are aged 65 or over will rise from 20.8% to 28.9% and the proportion of people aged 85 or over will rise from 2.9% to 5.5% by 2040. Population projections in the older age categories far exceed national averages. As part of the centralisation of acute medicine there will likely be an increase at GRH from CGH. There were 7,415 admissions between Feb 19 and Jan 20 for acute medicine at CGH. 67% were over the age of 65.	**Long Term Impact** Long term conditions are more prevalent in those over the age of 65 making this cohort more likely to access services and may require extra provision and support to do so. The acute medical problems of older people are often similar to those of younger adults but the presentation can be atypical or there can be a number of co-existing problems that make diagnosis difficult. In these patients a minor illness can lead to deterioration[1]. This commonly leads to admission into acute medicine, making this cohort likely to be impacted by the centralisation of acute medicine. Centralising acute medicine enhances patient safety, improve outcomes and reduce LOS as it allows for the co-ordination of tests and input from different specialist teams. It is also best practice for acute medicine patients to undergo consultant review within 14 hours of arrival in hospital. By centralising a finite workforce the Trust will be able to offer more consistent provision of senior reviewers which will increase the number of patients being reviewed within 14 hours, improving clinical outcomes for patients and associated with increased discharges.	141 people over 66 responded to the survey with regards to centralised acute medicine. In total for all those who responded to this question in all patient cohorts, 233 respondents were from the East and 179 the West of the county.	74% of those over 65 support the proposal to centralise of acute medicine to GRH and a further 3.5% had no opinion. Where respondents agreed, they felt that consolidating skill into one centre was sensible. Where respondents were opposed, they expressed concerns around travel to GRH and felt both hospitals should have equal skill and offer the same services. Feedback around the importance of avoiding multiple moves between sites and wards for older patients.	**Overall Impact : Positive** **Large Positive Impact** Centralising acute medicine enhances patient safety, improve outcomes and reduce LOS as it allows for more patients to be seen by a senior reviewer within 14 hours of arrival, associated with increased patient discharges and improved clinical outcomes. **Small Negative Impact** Patients over 65 may need further support to access services in the new location if their journey becomes longer and they are less familiar with the centralised location. Respondents to the consultation over 65 expressed concerns regarding travel times and travel options. Liaising with local transport e.g. through local authority partners to provide information about transport options for those over 65 and to understand more about transport plans over the next 5 to 10 years to understand if there is any plans to expand current transport options in the future. Plans to ensure patients are not moved multiple times between sites or wards at each site, particularly older patients and those with dementia.

[1] Lawson P, Richmond C. 13 Emergency problems in older people. Emergency Medicine Journal 2005;22:370-374.

B2 - IGIS hub and vascular centralised to GRH	**Moderate Scale Impact** There were 1,855 Interventional cardiology procedures and 944 vascular surgeries at CGH between Feb 19 and Jan 20. 68% of interventional cardiology patients were over 65 and 66% of vascular patients. Considering that in addition to this, over a fifth of the population of GRH and CGH is over 65, this cohort is likely to be the most impacted.	**Long Term impact** Evidence suggests aging has a remarkable effect on the heart and arterial system, leading to an increase in Cardiovascular Disease including atherosclerosis, hypertension, myocardial infarction, and stroke [2]. As the population of over 65s in GRH and CGH is predicted to rise from a fifth to over a quarter by 2040, this suggests a significant number of patients receiving services will be over 65. By centralising the image-guided interventional surgery (IGIS) 'hub' to GRH including vascular this will enable a 24/7 for patients which is not currently offered. Many IGIS interventions are time critical and there, outcomes for patients will be improved by locating the hub at the County's trauma unit because it will reduce the time to intervention in many emergencies. By co-locating IGIS and vascular, interventional radiology and interventional cardiology The Trust is taking a multi-disciplinary approach to the management of primary angioplasty. There is significant evidence to suggest that patient outcomes could improve as a result of this approach.	142 people over the age of 65 responded to the survey regarding this proposed model of care. In total for all those who responded to this question in all patient cohorts, 230 respondents were from the East and 179 the West of the county.	73% of those over the age of 60 support the proposal to have an IGIS hub in GRH and a spoke site at CGH Those who agreed with a hub at GRH supported the consolidation of expensive equipment and skills to one site. 64% of respondents support a centre for vascular surgery at GRH and 19% had no opinion.	**Overall Impact: Positive** **Large Positive Impact** By centralising the IGIS hub patients will now have a 24/7 service available to them. By co-locating this with the County's Trauma hub patients are more likely to receive emergency intervention faster. By co-locating with vascular the Trust is creating a multi-disciplinary approach to management of primary angioplasty which can improve patient outcomes. The co-location will also promote a multi-disciplinary approach to angioplasty, most common in those over 65[3]. **Small Negative Impact** Data suggests a number of patients accessing vascular services will be over 65 and required to travel to GRH where they may have been travelling to CGH previously. 73% of those over 65 supported an IGIS hub and spoke model at GRH with the spoke at CGH. A smaller majority (64%) also supported a vascular surgery centre at GRH. It is recommended to provide more detailed information about hub and spoke, explaining how a spoke site will be used and in what circumstances a patient attends a spoke site.

[2] Lakatta EG, Levy D. Arterial and cardiac aging: major shareholders in cardiovascular disease enterprises, part I: aging arteries: a "set up" for vascular disease. Circulation. 2003;107:139–146
[3] https://www.nhs.uk/conditions/Coronary-angioplasty/

C3 - EGS centralised to GRH	**Moderate Scale Impact** It is estimated this will mean 2,812 patients in total may be subject to change, approximately 8 a day. 2080 patient episodes would move from CGH to GRH 732 patient episodes would move from GRH to CGH. General surgery activity data states that approximately 38% of patients seen at GRH are aged 65+ and the proportion is even higher at CGH at 42%; using general surgery activity as a proxy, this would imply that regarding EGS approximately 278 patients will move from CGH to GRH and 874 Patients will move from CGH to GRH. A total of 1,152 aged over 65 will be impacted by solution C3 which is 40% of the estimated 2,812 overall patients impacted.	**Long Term Impact** The population aged 65 and over are much more likely suffer with long term conditions and ill health in general thus the older populations are more likely to be accessing services and more likely to require extra provision and support to access the services. By 2039 the proportion of over 65s is expected to rise to by 25% (ONS). This demographic shift has been accompanied by an increase in the prevalence of multiple and often complex long-term conditions. The number of people in England with three or more long-term conditions is projected to increase by 1 million people. As the older population grows, so too will the number of surgical patients carrying additional risk factors and requiring more multi-professional and multidisciplinary support. Research into 154 hospital sites shows 60% of EGS patients were over 65.[4] Centralising emergency general surgery to GRH will result in greater availability for staff to discuss patients and see surgical assessment unit patients quicker. Evidence suggests patients who are seen quicker have reduced admissions and increased self-care post treatment.	140 people over 65 responded to this the survey regarding this care model. In total for all those who responded to this question in all patient cohorts, 231respondents were from the East and 179 the West of the county.	68% supported the proposal to centralise EGS to GRH. Those who supported the proposal supported the consolidation of skills and expertise on one site and increase capacity for planned at CGH. Those who opposed did not supported both sites offering different emergency general surgery offers and felt both sites should have the same emergency offer.	**Overall Impact: Positive** **Large Positive Impact** EGS care would be improved by providing a dedicated team on SAU which would review all patients presenting on the same day. This would reduce delays to review, improving patient safety. Evidence suggests patients who are seen quicker have reduced admissions and increased self-care post treatment. It is estimated 40% of the patient cohort impacted by this change will be over 65. **Small Negative Impact** Patients attending A&E at CGH or inpatients deteriorating and needing emergency general surgery may need to be transferred, however, this is less than 1 patient per day at present so this impact is relatively small overall but moderate for the patient as they may be moved, however, they will receive a high quality service due to centralisation. It is recommended those over 65 are engaged with as 60% of the emergency general surgery cohort are over 65. It is important to consider the impact for patients deteriorating at CGH who may need to be transferred, particularly those over 65 who may have more difficulty travelling around the county e.g. visitors such as relative who may be relying on public transport and who may have health conditions themselves. It is also recommended to consider if there will be repatriation plans for patients who started at CGH.

[4] Watson R, Crump H, Imison C, Currie C and Gaskins M (2016) Emergency general surgery: challenges and opportunities. Research Report. Nuffield Trust.

					Clarity around the pathway for a patient at CGH requiring emergency general surgery may be helpful as well as information regarding what can be provided in A&E at CGH in the new model. It may also be beneficial to discuss co-design with organisations such as age UK.
C11 - GI day cases to CGH	**Moderate Scale Impact** In this solution (including the impacts of all changes that will co-occur with this solution in the overall model) it is estimated, 4349 patients in total may be subject to change, approximately 16 a day. 2535 patients would move from CGH to GRH 1814 patients would move from GRH to CGH Based on the prevalence of over 65s as a proxy, up to 42% of patients are over 65. This is disproportionately high compared to other age ranges.	**Medium Term Impact** Gastrointestinal (GI) changes in the elderly are common. While some changes associated with aging GI system are physiologic, others are pathological and particularly more prevalent among those above age 65 years[5]. By centralising GI day cases to CGH there will be dedicated unit which increases quality of care and in turn will improve clinical outcomes. Patients are currently cancelled frequently due to the need for emergency beds, therefore, by separating elective and emergency there is dedicated resource reducing the number of cancellations for patients.	138 people over 65 responded to a question regarding this care model. In total for all those who responded to this question in all patient cohorts, 223 respondents were from the East and 178 the West of the county.	73% of respondents aged over 65 supported the proposal to centralise GI day case at CGH. Were respondents agreed, they supported the centralisation of specialise resources. Where respondents opposed, they did not support that the hospitals would offer different services and felt they should offer the same due to the size of the county and population size. Impact of population growth on proposals was a theme.	**Overall Impact: Positive** **Large Positive Impact** There will be dedicated unit which increases quality of care and in turn will improve clinical outcomes. By separating elective and emergency there is dedicated resource reducing the number of cancellations for patients. **Moderate Negative Impact** GI day case patients are generally lower acuity overall in this cohort and so are less likely to deteriorate; however, in the event a patient does deteriorate they may need to be transferred to GRH. This is potentially outweighed by the reduction in the number of patients who are required to stay overnight unplanned as a result of a late start in procedures. Patients over 65 are more likely to experience co-morbidities and other health conditions and therefore could be more vulnerable to needing transfer. It is recommended to provide examples of

[5] Dumic, I., Nordin, T., Jecmenica, M., Stojkovic Lalosevic, M., Milosavljevic, T., & Milovanovic, T. (2019). Gastrointestinal Tract Disorders in Older Age. *Canadian journal of gastroenterology & hepatology*, *2019*, 6757524. https://doi.org/10.1155/2019/6757524

					what the patient pathways will look like for an emergency and an elective patient so the differences are clear. Information regarding travel times and transport options across the County may also be beneficial for carers and relatives who have concerns regarding travel, based on respondents over 65.
C5 - Elective colorectal to CGH	**Moderate Scale Impact** GRH conducted 910 colorectal surgeries in Feb 19 to Jan 20. 42% were over the age of 65. This means over 65s will be disproportionately impacted by the centralisation to CGH.	**Long Term Impact** With the increase in life expectancy comes an increase in the number of elderly people with colorectal diseases; as the incidence of colorectal carcinomas increases with advancing age.[6] The population of over 65s in Gloucestershire is increasing from a fifth to over a quarter by 2041 and therefore an increase in demand for colorectal could be seen. By centralising elective colorectal surgery, quality of care could be improved as a result of co-location with other relevant specialities such as medical gastroenterology. There is also a reduced risk of cancellations for patients as they will have access to a ring fenced service.	In total 140 people over 65 answered questions related to this care model. 73% of those aged over 65 support the proposal for a centre of excellence for planned colorectal surgery. In total for all those who responded to this question in all patient cohorts, 227 respondents were from the East and 176 the West of the county.	49% of those over 65 think this centre of excellence should be located at CGH; please note a third had no opinion. Approximately half of all respondents in each cohort supported the proposal for the centre of excellence to be located at CGH rather than GRH. Comments largely focused on the convenience of the centre based on their own location of residence. Where respondents supported the proposal, they were supportive of the concept of a centre of excellence and felt that developing that on one site was sensible. Where respondents were not	**Overall Impact: Positive** **Large Positive Impact** By centralising the service with relevant specialities quality of care will improve and there will be fewer cancellations as a result of better access. Consultation results suggest that patients over 65 with a disability would prefer the service was centralised at CGH. **Moderate Negative Impact** The Proposed relocation to CGH may impact negatively on travel for patients who would have previously attended GRH. This may be a challenge for patients over 65 who may find travel more difficult and therefore it is important to engage with this cohort. If elective colorectal surgery is centralised to CGH then arrangements will need to be made for deteriorating patients who may need to be transferred to Gloucestershire for emergency general surgery, if centralised. This will impact on visitors and carers who may be reliant on public transport and who may have health conditions themselves.

[6] 1. de Rijke JM, Schouten LJ, Hillen HF, Kiemeney LA, Coebergh JW, van den Brandt PA. Cancer in the very elderly Dutch population. Cancer. 2000;89:1121–1133.

				supportive, they were concerned that hospitals should be equally resourced and the overall perception reflected that they felt a movement in resources were a reduction in resources.	It is recommended to engage with those over 65 regarding the impact of centralising services and the potential for transfer in the event of deterioration to understand how best to support visitors and carers in travelling to another site. It is also recommended to consider this cohort have concerns around the centralisation of emergency care and the separation from elective care e.g. in the case of colorectal patients. Another option may need to be considered for more high risk colorectal patients.
C6 - Elective colorectal to GRH	**Moderate Scale Impact** CGH conducted 584 colorectal surgeries and 49% were over 65. This means over 65s will be disproportionately impacted by the centralisation to GRH.	*Evidence as listed above.*		73% of those aged over 65 support the proposal for a centre of excellence for planned colorectal surgery. 19% of those over 65 felt the centre of excellence should be located at GRH. Please note, this is 25 people and 45 had no opinion (33%). A third of all respondents did not have an opinion on which site the centre of excellence was located. Comments largely focused on the convenience of the centre based on their own location of residence. Where respondents supported the proposal, they were supportive of the concept of a centre of excellence and felt that developing that on	**Overall Impact: Positive** **Large Positive Impact** Although a smaller percentage of patients are over 65 in GRH's general surgery cohort, The centralised services will improve access to the right specialists without the need to travel, however, data suggests this cohort is smaller in GRH than CGH, so more over 65s will need to travel in this proposed solution. This is outweighed by the benefit of having elective colorectal co-located with Emergency general surgery (if this is to go ahead) as then patients will not need to travel in the event of deterioration, something patients over 65 could be more vulnerable to. **Moderate Negative Impact** The Proposed relocation to GRH may impact negatively on travel for patients who would have previously attended CGH. This may be a challenge for patients over 65 who may find travel more difficult and therefore it is

				one site was sensible. Where respondents were not supportive, they were concerned that hospitals should be equally resourced and the overall perception reflected that they felt a movement in resources were a reduction in resources.	important to engage with this cohort. Consultation results suggest that patients over 65 would prefer the service was centralised at CGH. Therefore it is important to establish a clear plan describing the patient pathway in the event of an emergency if a patient were to be transferred from CGH. It is also recommended to consider this cohort have concerns around the centralisation of emergency care and the separation from elective care e.g. in the case of colorectal patients. Another option may need to be considered for more high risk colorectal patients.

4.2. Disability

Dementia, learning disabilities and physical disabilities have all been considered under this category.

Learning Disabilities: Estimated projections suggest that in 2019 there will be approximately 11,825 people aged 18+ living with a learning disability in Gloucestershire equating to 2.3% of the adult population. Of this group, about 2,400 are estimated to have moderate or severe learning disabilities, equating to 0.5% of the adult population.

Disabilities: According to the 2011 Census, 16.7% of Gloucestershire residents reported having a long term limiting health problem or disability. At a household level, 24.2% of households had at least one person with a long-term limiting health problem or disability.

Dementia: Only 12% of people with dementia have no comorbidities. 40% have 1-2 and 48% have 3 and a quarter of hospitals beds are occupied by patients with dementia over the age of 65.

Sensory Impairment: A sensory impairment is something that affects your hearing, vision or both your hearing and vision. Most people accessing support because of a sensory impairment are over 55 years and population projections suggest this will increase. They often experience multiple long term conditions which can impact on accessing health care services. Several services are on offer to sensory impaired people in the county including Gloucestershire Deaf Association who provide British Sign Language (BSL) Interpreters in our health care settings.

EQIA summary for Disability

In total for all those who responded to the consultation survey across all patient cohorts, there were more respondents from the East, approx. 230 respondents compared to the West of the county where there were approx. 175 respondents.

Model	Scale of Potential impact	Evidence of Potential Impact	Consultation Outputs	Impacts from Consultation	Nature of Potential Impact and recommendations
A3 - Centralise acute medicine to GRH	**Moderate Scale Impact:** 16.7% of Gloucestershire residents reported having a long term limiting health problem or disability. Approximately 11,825 people aged 18+ living with a learning disability in Gloucestershire equating to 2.3% of the adult population.	**Long Term Impact** People with a physical or learning disability will require increased provision and assistance to access services and are at a higher risk of requiring services, especially those with multiple long term conditions.	124 people with a disability answered questions regarding this care model.	71% of respondents supported the centralisation of acute medicine, 72% for those using the easy read. Those who agreed supported the efficiency benefits of centralising. Those who opposed had concerns regarding travel and the distance in traffic. Respondents with disabilities were concerned about limited transport options, particularly from rural areas or areas further from Gloucester.	**Overall Impact: Positive** **Large Positive Impact** By centralising services, patients will have reduced waiting times, fewer cancellations and less unplanned overnight stays. Timely appointments with fewer cancellations means patients can more effectively plan their travel (e.g. pick up and drop off times if they are not driving themselves). The centralisation of services will also mean quality of care and expertise will be enhanced, particularly beneficial to patients with long term conditions or co-morbidities which are prevalent in patients with disabilities. Reduced unplanned overnight stays may help to limit anxiety and unfamiliarity, particularly important for patients with a learning disability.

B2 - IGIS hub and vascular centralised to GRH			124 people with a disability answered questions regarding this care model.	71% support the proposal for an IGIS hub and spoke model, 77% for those using the easy read. Those who supported the hub model supported the avoidance of duplication, centralising specialist service provision and staff retention. Those opposed, had concerns regarding resources spread across the county and some residents being too far away from the hub site. 57% support vascular surgery at GRH but nearly a quarter had no opinion.	**Moderate Negative Impact** Feedback from staff and patients suggests parking can be a challenge at both sites. Therefore, by centralising services it is important to assess if there is an appropriate number of disabled parking bays to accommodate increases in demand of, for example, specific elective procedures. The new proposed models will mean that deteriorating patients may need to be transferred depending on the site they attended and their condition. For patients with a physical or learning disability, this may mean additional support with transport arrangements on their return home as they may not drive. Moving sites can also be a challenge for patients with a sensory impairment who may be familiar with their local hospital site but may be required to travel to the other site. Additional support may be needed to help patients navigate this change. High quality signposting, good quality wheelchair access and interactive information for those with sensory impairments will be necessary to help patients navigate this change. Both sites will already have facilities in place for patients with disabilities but it is important to ensure these are optimised. It is recommended that those with a disability are involved in the consultation to understand their needs and perceived challenges. It is also recommended that local transport providers are engaged with to understand if there are transport options running between the two hospitals and frequency of these. Explore the possibility of modernising areas within sites if needed. Indicate how the proposed plans with work alongside
C3 - EGS centralised to GRH			123 people with a disability answered questions regarding this care model.	66% support EGS centralisation to GRH, 67% for those using the easy read Those who supported, commented on planned surgery being less likely to be interrupted by emergency surgery. Those who opposed had concerns around parking being difficult and around coverage across the whole county.	
C11 - GI day cases to CGH			121 people with a disability answered questions regarding this care model.	72% of people with a disability supported GI day case at CGH, 67% of those using the easy read, and 19% had no opinion. Those who supported put	

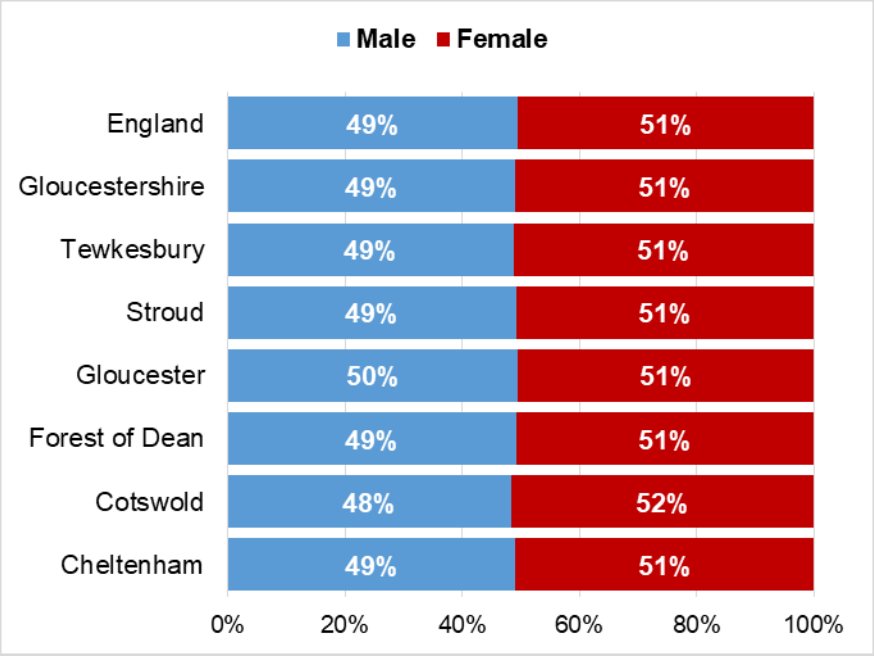
				emphasis on quality of care and centralising skills. Those opposed had concerns around CGH parking facilities and accessibility.	community provision such as community hospitals.
C5 - Elective colorectal to CGH				79% of those with a disability support the proposal for a centre of excellence, 73% of those using the easy read. 47% of those with a disability felt the centre of excellence should be at CGH 21% of those with a disability felt the centre of excellence should be at GRH Those who supported expressed that reducing duplication was important. Those who opposed had concerns around centralising to one site for the population size the hospitals serve. Make better use of community hospitals was also a theme from feedback.	
C6 - Elective colorectal to GRH					

4.3. Gender

The sex of an individual, combined with additional factors such as living alone, may affect their health and social care needs. Individuals may also experience discrimination and inequalities because of their sex. A report by the European Social Survey found 24% of respondents had experienced prejudice based on their sex. Discrimination on the grounds of sex was reported by more respondents than discrimination based on ethnicity.

The overall population split by sex in Gloucestershire is slightly skewed towards females, with males making up 49.1% of the population and females accounting for 50.9%. In Gloucestershire in 2017, 52.9% of people aged 65-84 were female, whilst for people aged 85+ the difference was more marked with females accounting for 64.6% of the total population. This situation is also reflected at district, regional and national level. As a result of this, 71% of single pensioner households are shown to be headed by a woman. It is worth highlighting that women were more likely than men to be living in a household without access to a car.

Figure 1: population by proportion of males and females within the catchment area, Gloucestershire and England.



EQIA Summary for Gender

In total for all those who responded to the consultation survey across all patient cohorts, there were more respondents from the East, approx. 230 respondents compared to the West of the county where there were approx. 175 respondents. More females answered the survey, approx. 260 females and 180 males.

Model	Scale of Potential impact	Evidence of Potential Impact	Consultation Outputs	Impacts from Consultation	Nature of Potential Impact and recommendations
A3 - Centralise acute medicine to GRH	**Large Scale Impact** There were 7,415 admissions between Feb 19 and Jan 20 for acute medicine at CGH. 54% were female, suggesting changes to acute medicine may slightly disproportionately impact females.	**Long Term Impact** It is difficult to determine the driver behind why more females are treated in acute medicine in CGH, however, it could be because although there is a gynaecology department in CGH, Obstetrics is in Women's and Children in GRH. Therefore this demand could be skewed by females of pregnancy age. Pregnant women can present to any acute hospital service at any time during their pregnancy or the postpartum period, which is up to 12 months post-delivery. Women may present with acute medical problems that need to be managed differently because of pregnancy, or may present with obstetric syndromes[7].	262 females and 182 males answered questions in relation to this care model.	73% of females and 72% of males support centralised acute medicine at GRH. Those who supported saw benefits in centralising and improvements in quality of care. Those opposed at concerns around increasing travel times for unwell patients and felt there should be two acute medical sites at both locations. There were also comments regarding how GRH would accommodate the additional acute medical demand.	**Overall Impact: Positive** **Large Positive Impact** It is evident that males are disproportionately impacted in some cohorts and females in others, however, the centralisation of services and the separation of elective and emergency where possible in these proposed changes will improve quality of care, create opportunities for enhanced training and understanding of patient's conditions as a result of co-located specialities and therefore improve clinical outcomes for patients. **Small Negative Impact** It is possible that males could be disproportionately impacted if vascular was to remain at CGH and IGIS to centralise at GRH as 69% of interventional cardiology patients were male. This could mean that is a patient needs to be moved to the vascular hub at CGH from GRH evidence suggests they are more likely to be

[7] https://www.rcplondon.ac.uk/guidelines-policy/acute-care-toolkit-15-managing-acute-medical-problems-pregnancy

B2 - IGIS hub and vascular centralised to GRH	**Moderate Scale Impact** There were 1,855 Interventional cardiology procedures and 944 vascular surgeries at CGH between Feb 19 and Jan 20. 69% of interventional cardiology patients were male and vascular was only marginally more male.	It is estimated that around 1.4 million people in the UK have survived a heart attack, approx.1 million men and 380,000 women. There are currently 2.3 million people living with Coronary heart disease in the UK, 1.5 million are men[8]. Therefore males may be disproportionately impacted by changes to cardiology and vascular services.	257 females and 184 males answered questions in relation to this care model.	70% of females and 70% of males supported a hub and spoke model for IGIS where IGIS is at GRH and the spoke at CGH. Those in support felt the rational was clear and understood the need to centralise expressive equipment and resources. Those who opposed had concerns around patient safety if patients who are very unwell need to be transferred to the other site. They also felt this should be offered at both sites. 66% of females and 60% of males support vascular surgery at GRH. Comments from some respondents question if more services are being centralised to GRH compared to CGH and question how this model works with hospital care in Oxford.	male; however, this is likely to be less than 1 patient per day and the clinical outcomes are likely to outweigh this. It is recommended that a clear outline of how patients will be transferred in emergencies for each pathway are completed so patients can understand what will happen and ensure all the appropriate safety measures are in place. It must also be helpful to consider repatriation options for patients transferred, if not already doing so.

[8] https://www.bhf.org.uk/what-we-do/our-research/heart-statistics

C3 - EGS centralised to GRH	**Moderate Scale Impact** General surgery activity data states that approximately 54% of patients seen at GRH are female and 52% at CGH. Using general surgery activity as a proxy, this could suggest females may be slightly disproportionately impacted by this, however, the difference in gender is very small.	**Long Term Impact** There is no evidence to suggest that males or females are more likely to use EGS services in GRH. The overall population of general surgery patients are 52% female, however, there is no evidence to suggest females are more likely to receive emergency general surgery.	260 females and 181 males responded to questions regarding this care model.	73% of females and 70% of males support the centralisation of EGS to GRH. Those who support this, commented on the need have single site if this improves care quality and safety. There was also support if this reduces waiting times and cancellations for planned surgery. Those opposed have concerns regarding the time it would take to transfer a patient in an emergency due to the size of the county. Comments also reflected concerns around how patients get home following discharge if they live near Cheltenham.
C11 - GI day cases to CGH	**Moderate Scale Impact** In this solution (including the impacts of all changes that will co-occur with this solution in the overall model) it is estimated, 4349 patients in total may be subject to change, approximately 16 a day. 2535 patients would move from CGH to GRH 1814 patients would move from GRH to CGH.	**Medium Term Impact** There is no evidence to suggest that males or females are more likely to use EGS services in GRH. The overall population of general surgery patients are 52% female, however, there is no evidence to suggest females are more likely to receive emergency general surgery. Evidence does suggest, however, that, as compared to men with IBS, women with IBS are more likely to report additional functional gastrointestinal (GI) conditions including globus, dysphagia, bloating,	256 females and 181 males responded to questions regarding this care model.	79% of females and 75% of males support GI day case to CGH. Those who support commented on day case beds being ring-fenced, resulting in fewer cancellations. Those opposed, commented on the need for day case to be available at both sites to save patients travelling.

	Using general surgery as a proxy we know that 54% of patients at GRH who would attend CGH in the proposed change are female. Suggesting females could be disproportionately impacted by this.	constipation, fecal incontinence and pelvic floor dysfunction[9]. This could suggest women may be more likely to report concerns and seek treatment.		
C5 - Elective colorectal to CGH	**Moderate Scale Impact** GRH conducted 910 colorectal surgeries in Feb 19 to Jan 20. There were slightly more males than females in this patient cohort (51%) but very marginal.	**Long Term Impact** Evidence suggests differences in gender across colorectal cancer. The overall incidence is higher in men, with an earlier age distribution, however, important sex differences exist in anatomical site. There were relatively small differences in screening uptake, route to diagnosis, cancer staging at diagnosis. Women are more likely to present as emergency cases, with more men diagnosed through screening and two-week-wait[10].	253 females and 182 males responded to questions regarding this care model.	83% of females and 81% of males support elective colorectal being centralised. Those in support commented elective pathways not being disturbed by emergency pathways through things like cancellations. Some respondents commented on whether there still needs to be some emergency capacity at both sites. 52% of females and 48% of males support this at CGH. Please note over a quarter of females and a third of males did not have an opinion.
C6 - Elective colorectal to GRH	**Moderate Scale Impact** CGH conducted 584 colorectal surgeries. 53% of this patient cohort were male.	Evidence same as above		

[9] Cain et al (2009) Gender Differences in Gastrointestinal, Psychological, and Somatic Symptoms in Irritable Bowel Syndrome, Dig Dis Sci, 54(7) 1542–1549.
[10] White, A., Ironmonger, L., Steele, R.J.C. et al. A review of sex-related differences in colorectal cancer incidence, screening uptake, routes to diagnosis, cancer stage and survival in the UK. BMC Cancer 18, 906 (2018). https://doi.org/10.1186/s12885-018-4786-7

4.4. Pregnancy

The Equality Act protects women who are pregnant, have given birth in the last 26 weeks (non-work context) or are on maternity leave (work context) against discrimination in relation to their pregnancy.

There were 6,739 live births in Gloucestershire in 2016. Table 2 shows the age of mothers at the delivery of their baby in five year age bands), the highest proportion of deliveries were to women aged 30 to 34 continuing the trend of later motherhood. Births to mothers aged 25-29 and 30-34 account for a slightly higher proportion of total births in Gloucestershire than they do nationally, whilst those to mothers aged under 25 account for a slightly lower proportion.

At district level, Gloucester and the Forest of Dean have a higher proportion of births to mothers aged under 20 (4.0% and 3.6% respectively) than Gloucestershire and England. Cheltenham, Cotswold and Stroud have a higher proportion of births to mothers aged 35+ than Gloucestershire and England.

Table 2: % of births by age of mother

	Total number of live births	% of total births by age of mother						
		under 20	20-24	25-29	30-34	35-39	40-44	45+
Cheltenham	1,328	2.0	10.6	24.4	36.3	21.5	5.1	0.2
Cotswold	730	1.5	10.5	25.2	34.2	22.6	5.3	0.5
Forest of Dean	844	3.6	15.8	32.5	29.5	15.2	3.3	0.2
Gloucester	1,768	4.0	16.2	31.6	31.6	13.7	2.7	0.3
Stroud	1,094	1.9	10.3	28.6	34.3	19.7	4.8	0.3
Tewkesbury	975	1.9	11.7	31.4	33.8	17.5	3.5	0.1
Gloucestershire	**6,739**	2.6	12.8	29.1	33.3	17.9	4.0	0.3
England	663,157	3.2	14.6	28.0	31.8	18.1	4.0	0.3

EQIA Summary for Pregnancy

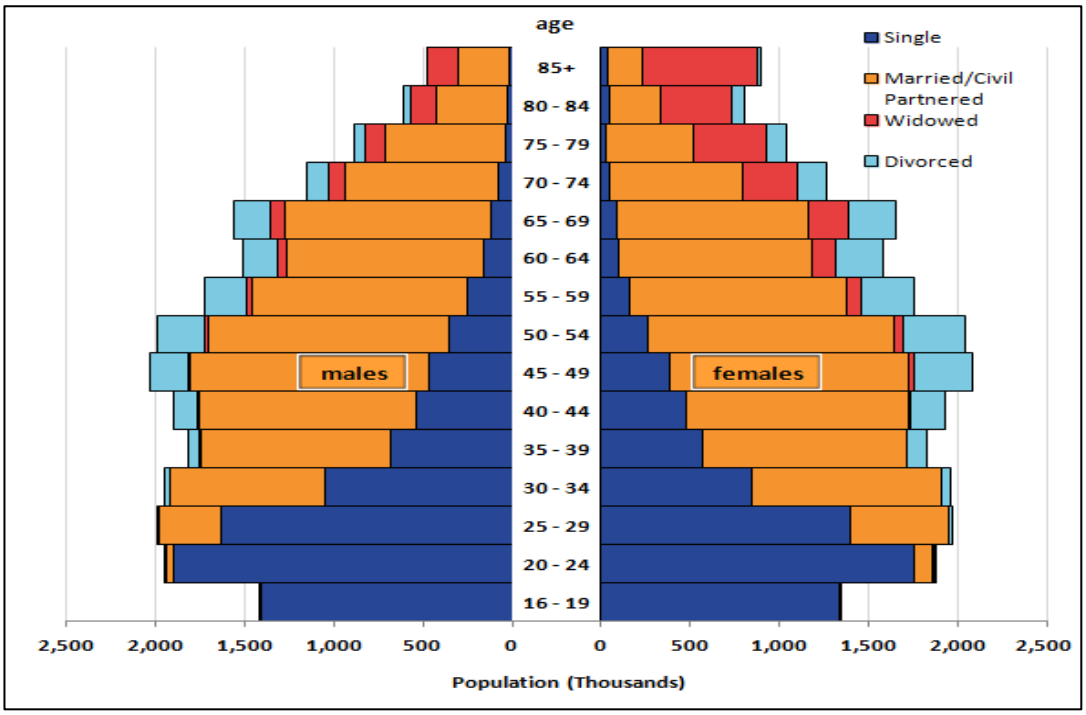
In total for all those who responded to the consultation survey across all patient cohorts, there were more respondents from the East, approx. 230 respondents compared to the West of the county where there were approx. 175 respondents.

Model	Scale of Potential impact	Evidence of Potential Impact	Consultation Outputs	Impacts from Consultation	Nature of Potential Impact and recommendations
A3 - Centralise acute medicine to GRH B2 - IGIS hub and vascular centralised to GRH C3 - EGS centralised to GRH C11 - GI day cases to CGH C5 - Elective colorectal to CGH C6 - Elective colorectal to GRH	**Moderate Scale Impact** There were 6,739 live births in Gloucestershire in 2016; Gloucester and the Forest of Dean have a higher proportion of births to mothers aged under 20 (4.0% and 3.6% respectively) than Gloucestershire and England. Cheltenham, Cotswold and Stroud have a higher proportion of births to mothers aged 35+ than Gloucestershire and England.	**Long Term Impact** There is currently limited data to determine any impact of the changes for women during pregnancy.	There is nothing in the consultation document to suggest significant concerns from those pregnant or regarding pregnancy in relation to these models of care.	There is nothing in the consultation document to suggest significant concerns from those pregnant or regarding pregnancy in relation to these models of care.	**Overall Impact: Neutral** Proposed changes to services are expected to maintain current inclusive support service approach. It is recommended to engage with a representative distribution of the population, to include those pregnant or new parents.

4.5. Marital status

According to the latest data from the ONS, the majority (50.6%) of the population in England and Wales aged 16 and over in 2015 were married and this is similar in Gloucestershire. The next largest group within the population were single, never married or civil partnered (34.5%). The population who were divorced or widowed made up a smaller proportion of the total population at 8.1% and 6.5% respectively. The smallest group within the population were those who were civil partnered, making up 0.2% of the population aged 16 and over in 2015.

Figure 2: Population Estimates (aged 16 and over) by marital status, age group and sex, 2015



EQIA Summary for Marital Status

In total for all those who responded to the consultation survey across all patient cohorts, there were more respondents from the East, approx. 230 respondents compared to the West of the county where there were approx. 175 respondents.

Model	Scale of Potential impact	Evidence of Potential Impact	Consultation Outputs	Impacts from Consultation	Nature of Potential Impact and recommendations
A3 - Centralise acute medicine to GRH	**Moderate scale Impact** As part of the centralisation of acute medicine there will likely be an increase at GRH from CGH. There were 7,415 admissions between Feb 19 and Jan 20 for acute medicine at CGH. 46% of acute medicine patients are married, 16% single and 9% widowed. A large number not stated	There is currently limited data to ascertain any impact of the changes for those who are from any particular marital status.	There is no significant evidence from consultation feedback to suggest this patient cohort is significantly impacted.	There is no significant evidence from consultation feedback to suggest this patient cohort is significantly impacted.	**Overall Impact: Neutral** Proposed changes to services are expected to maintain current inclusive support service approach. It is recommended to engage with a representative distribution of the population to include those who are married, divorced, widowed, single and separated.
B2 - IGIS hub and vascular centralised to GRH	**Moderate scale Impact** There were 1,855 Interventional cardiology procedures and 944 vascular surgeries at CGH between Feb 19 and Jan 20. 49% of interventional cardiology patients and 45% of vascular patients at CGH are married.				

C3 - EGS centralised to GRH	**Moderate Impact:** General surgery activity data states that approximately 36% of patients seen at GRH are married compared to 44% at CGH. Using general surgery activity as a proxy, this suggests patients are most likely to be married.
C11 - GI day cases to CGH	**Moderate Impact:** In this solution (including the impacts of all changes that will co-occur with this solution in the overall model) it is estimated, 4349 patients in total may be subject to change, approximately 16 a day. 2535 patients would move from CGH to GRH 1814 patients would move from GRH to CGH Using general surgery as a proxy we know that 36% of patients at GRH who would attend CGH in the proposed change are married.
C5 - Elective colorectal to CGH	**Moderate scale Impact:** GRH conducted 910 colorectal surgeries in Feb 19 to Jan 20. 39% of patients were married at GRH.

C6 - Elective colorectal to GRH	**Moderate Impact:** CGH conducted 584 colorectal surgeries and 43% of patients at CGH were married				

4.6. Ethnicity

The prevalence of ethnic minorities in Gloucestershire is lower than national averages at 4.6% of the population from Black and Minority Ethnic (BME) backgrounds; this figure increased to 8.4% when the Irish, Gypsy or Irish Traveller and 'other White' categories were included[11].

Based on data, from the Gloucestershire county council population profile, amongst people aged 65 and over, 58.5% of Asian/Asian British people and 56.7% of Black African/Caribbean/Black British people had a long-term health problem/disability compared with 48.9% of White British people. Amongst the Gloucestershire population of all ages, people of Gypsy or Irish Traveller origin were much more likely to be in poor health than other ethnic groups (15.9% of Gypsy/Irish Travellers compared with 4.6% of White British people).

[11] https://inform.gloucestershire.gov.uk/media/2087689/equality-profile-2019-final.pdf

EQIA Summary for Ethnicity

In total for all those who responded to the consultation survey across all patient cohorts, there were more respondents from the East, approx. 230 respondents compared to the West of the county where there were approx. 175 respondents.

Model	Scale of Potential impact	Evidence of Potential Impact	Consultation Outputs	Impacts from Consultation	Nature of Potential Impact and recommendations
A3 - Centralise acute medicine to GRH	**Large Scale Impact** As part of the centralisation of acute medicine there will likely be an increase at GRH from CGH. There were 7,415 admissions between Feb 19 and Jan 20 for acute medicine at CGH. 4% were BME	**Long Term Impact** In Gloucestershire amongst people aged 65 and over, 58.5% of Asian/Asian British people and 56.7% of Black African/Caribbean/Black British people had a long-term health problem/disability compared with 48.9% of White British people.	39 people who are BAME responded to questions regarding this care model.	82% of BAME respondents supported the centralisation of acute medicine to GRH. Respondents questioned if this would increase demand at GRH and how GRH would accommodate this demand. Those in support, commented ton reduced waiting times and quality of care offered. Those opposed had concerns regarding the A&E capability at CGH if acute medicine were to be at GRH.	**Overall Impact: Positive** **Large Positive Impact** Centralised services ensure the best quality care is made available to patients and will benefit patients with complex or long term needs, which correlates with some BME patient cohorts. The co-location of relevant specialist services improves training and enhanced understanding of patient conditions, leading to better clinical outcomes and improving access to services with fewer cancellations. **Small Negative Impact** Some patient cohorts are disproportionately from BME communities such as vascular patients. Therefore, changes to the vascular hub will impact on this

B2 - IGIS hub and vascular centralised to GRH	**Moderate Scale Impact** There were 1,855 Interventional cardiology procedures and 944 vascular surgeries at CGH between Feb 19 and Jan 20. 4% of cardiology patients and 5% of vascular patients at CGH are BME. This is disproportionately higher than the overall BME population of Gloucestershire at 4.6% BME.	Research suggests South Asians are more likely to develop coronary heart disease than white Europeans. Those who are African or African Caribbean are at higher risk of developing high blood pressure and having a stroke than other ethnic groups and all are more likely to develop diabetes than the rest of the population[12]. Therefore, BME patients are likely to be impacted by this proposed change.	38 people who are BAME responded to questions regarding this care model.	74% of BAME respondents supported the proposal for an IGIS Hub and spoke model with the spoke at CGH. Some respondents commented on the risks related to transferring patients between sites. 75% of BAME respondents support vascular surgery at GRH.	cohort, particularly if this results in further travel or the possibility of requiring a transfer from one site to another, however, this is only in a very small number of circumstances. It is recommend that information regarding travel times and repatriation between sites is made clear to help residents and patients understand more about the transfer process and how frequently transfers are to happen. Having patient representatives as an integral part of the co-design of services is crucial to ensure there is wide representation from those with the conditions that are being impacted. Particularly considering that for some of the conditions being impacted, there are disproportionate numbers of BAME patients.
C3 - EGS centralised to GRH	**Moderate Scale Impact:** General surgery activity data states that approximately 8% of patients seen at GRH are BME compared to 6% at CGH. Using general surgery activity as a proxy, this suggests BME patients are disproportionately impacted.		39 people who are BAME responded to questions regarding this care model.	85% of BAME respondents support the centralisation of EGS. Those in support thought the proposal was clear and commented on the benefits of reduced waiting times and less cancellations. Those opposed, commented on the	

[12] https://www.bhf.org.uk/informationsupport/risk-factors/ethnicity

				increased demand to GRH and the risks associated with transferring patients between sites.	
C11 - GI day cases to CGH	**Moderate Scale Impact:** In this solution (including the impacts of all changes that will co-occur with this solution in the overall model) it is estimated, 4349 patients in total may be subject to change, approximately 16 a day. 2535 patients would move from CGH to GRH 1814 patients would move from GRH to CGH. Using general surgery as a proxy we know that 8% of patients at GRH who would attend CGH in the proposed change are BME. This suggests BME patients are disproportionately impacted.		37 people who are BAME responded to questions regarding this care model.	78% of BAME respondents supported day case GI at CGH. Some respondents commented if all GI should stay together, others commented that separating emergency and elective has benefits.	

C5 - Elective colorectal to CGH	**Moderate Scale Impact:** GRH conducted 910 colorectal surgeries in Feb 19 to Jan 20. 4% were BAME patients.		36 respondents who are BAME responded to questions regarding this care model.	85% of those who are BAME support the proposal for a centre of excellence 43% of BAME respondents felt the centre of excellence should be at CGH 24% of BAME respondents felt the centre of excellence should be at GRH Please note 11% had no opinion. Those in support commented on the clear rational for centralising services. Those opposed, commented on the need for specialist services at both sites.	
C6 - Elective colorectal to GRH	**Moderate Scale Impact:** CGH conducted 584 colorectal surgeries in Feb 19 to Jan 20. 5.6% were BAME patients. This is disproportionately high compared to the population of BAME which is 4.6%.				

4.7. Sexual orientation

People who are lesbian, gay or bisexual (LGB) are more likely to have experienced depression or anxiety, attempted suicide or had suicidal thoughts and self-harmed than men and women in general[13]. LGB population aged over 55 are more likely than heterosexual people over 55 to live alone and are more likely than heterosexual people to say that they expect to rely on health and social care providers as they get older.[14] The prevalence of the LGB population in Gloucestershire is estimated to be around 5% - 7%[15].

[13] Stonewall, 2015, Mental Health, Stonewall health briefing
http://www.stonewall.org.uk/sites/default/files/Mental_Health_Stonewall_Health_Briefing__2012_.pdf Accessed 18/12/2017
Stonewall, 2011, Lesbian, Gay and Bisexual People in Later Life.
www.stonewall.org.uk/sites/default/files/LGB_people_in_Later_Life__2011_.pdf Accessed 18/12/201

[15] https://inform.gloucestershire.gov.uk/media/2087689/equality-profile-2019-final.pdf

EQIA Summary for sexual Orientation

In total for all those who responded to the consultation survey across all patient cohorts, there were more respondents from the East, approx. 230 respondents compared to the West of the county where there were approx. 175 respondents.

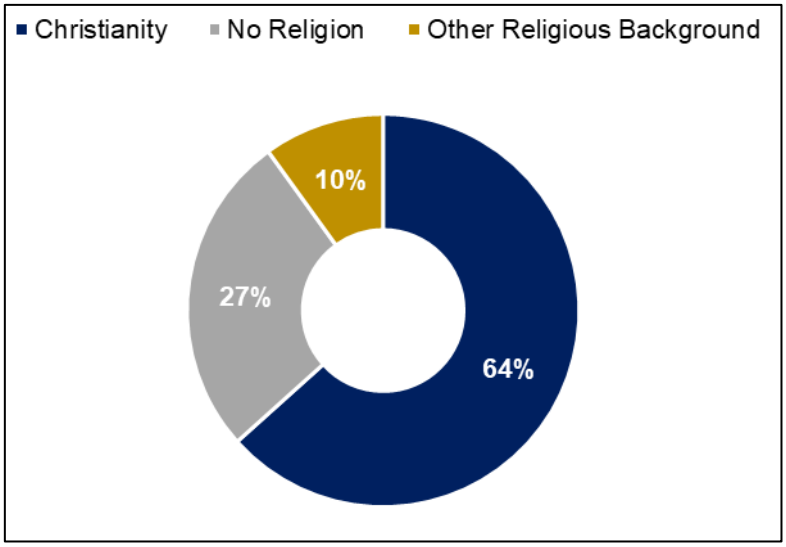
Model	Scale of Potential impact	Evidence of Potential Impact	Consultation Outputs	Impacts from Consultation	Nature of Potential Impact and recommendations
A3 - Centralise acute medicine to GRH	**Small- Moderate Scale Impact** The LGBTQ+ community is estimated to form 5% - 7% of the Gloucestershire population.	**Long Term Impact** According to the Stonewall survey, 13% of LGBTQ+ people have experienced some form of unequal treatment from healthcare staff because they are LGBTQ+ and 23% have witnessed it. This includes 32% of trans people and 24% of Asian LGBTQ+ people who have experienced unequal treatment.	19 respondents who are LGBT+ responded to questions regarding this care model.	58% of LGBT+ respondents supported the centralisation of acute medicine Some respondents commented on concerns regarding the distance for those living further from Gloucester, others	**Overall Impact: Neutral** Proposed changes to services are expected to maintain inclusive support service approach. It is recommended to ensure LGBTQ+ communities are included in the consultation and are able to feed back their views as changes to health care settings can be challenging to patients who may already feel healthcare is unequal (as shown in the Stonewall survey).
B2 - IGIS hub and vascular centralised to GRH			18 respondents who are LGBT+ responded to questions regarding this care model.	55% of LGBT+ respondents supported an IGIS hub and spoke model with CGH as the spoke. However, 39% had no opinion. 78% supported vascular surgery at GRH.	
C3 - EGS centralised to GRH			19 respondents who are LGBT+ responded to questions regarding this care model.	74% of LGBT+ respondents supported EGS centralised to GRH. Some respondents commented they felt CGH still needed to have adequate emergency care.	
C11 - GI day cases to CGH			18 respondents who are LGBT+ responded to questions regarding this care model.	78% of LGBT+ respondents support GI day case at CGH.	
C5 - Elective colorectal to CGH			19 respondents who are LGBT+ responded to questions regarding this care model.	84% of LGBT+ respondents supported the centralisation of elective colorectal. 58% felt this should be CGH and 26% had no opinion.	
C6 - Elective colorectal to GRH					

4.8. Religion

According to the 2011 Census, 63.5% of residents in Gloucestershire were Christian, making it the most common religion. This was followed by no religion which accounts for 26.7% of the total population.

Gloucestershire has a higher proportion of people who are Christian, have no religion or have not stated a religion than the national figures. In contrast it has a lower proportion of people who follow a religion other than Christianity, which reflects the ethnic composition of the county.

Figure 3: Gloucestershire population broken down by religious background



At district level:

- Cheltenham had the lowest proportion of people who are Christian at 58.7% of the total population; this was lower than the county and marginally lower than the national figure.
- Cotswold had the highest proportion of people who follow Christianity.
- Cheltenham had the highest proportion of Buddhists, Hindus and people who have no religion.
- At 3.2% of the total population Gloucester had the highest proportion of Muslims.
- Stroud had the highest proportion of people who follow an "Other Religion" and of people who did not state their religion.

EQIA Summary for Religion

In total for all those who responded to the consultation survey across all patient cohorts, there were more respondents from the East, approx. 230 respondents compared to the West of the county where there were approx. 175 respondents.

Model	Scale of Potential impact	Evidence of Potential Impact	Consultation Outputs	Impacts from Consultation	Nature of Potential Impact and recommendations
A3 - Centralise acute medicine to GRH	**Small Scale Impact** As part of the centralisation of acute medicine there will likely be an increase at GRH from CGH. There were 7,415 admissions between Feb 19 and Jan 20 for acute medicine at CGH. 60%cute medicine patients were Christian and 7% have no religion.	**Long Term Impact** Approximately 64% of the Gloucestershire population are from a Christian background and almost 27% have no religion. Only estimated 10% of the population has other religious backgrounds.	There is no significant evidence from consultation feedback to suggest this patient cohort is significantly impacted.	There is no significant evidence from consultation feedback to suggest this patient cohort is significantly impacted.	**Overall Impact: Neutral** It is important to ensure an evenly represented group feedback through the consultation, meaning that religions are represented when feeding back views. Many patients did not state their religion and so it is difficult to know how different religions are impacted which is why it is important to ensure the consultation captures feedback from all religions. As an example some patients will want reassurance that they can request the gender of their doctor for religious reasons
B2 - IGIS hub and vascular centralised to GRH	**Small Scale Impact** There were 1,855 Interventional cardiology procedures and 944 vascular surgeries at CGH between Feb 19 and Jan 20. 48% of interventional cardiology patients and 33% of vascular patients at CGH are Christian. 0.7% are Muslim and a large proportion did not state their religion.				

C3 - EGS centralised to GRH	**Small Scale Impact** General surgery activity data states that approximately 45% of patients seen at GRH are Christian compared to 53% at CGH. 0.4% of patients are CGH were Hindu and a further 0.4% Muslim.
C11 - GI day cases to CGH	**Small Scale Impact** In this solution (including the impacts of all changes that will co-occur with this solution in the overall model) it is estimated, 4349 patients in total may be subject to change, approximately 16 a day. 2535 patients would move from CGH to GRH 1814 patients would move from GRH to CGH Using general surgery as a proxy we know that 45% of patients at GRH who would attend CGH in the proposed change are Christian and 1% are Muslim.
C5 - Elective colorectal to CGH	**Small Scale Impact** GRH conducted 910 colorectal surgeries in Feb 19 to Jan 20. 42% of patients were Christian, the large majority remaining stated they had no religion or did not state their religion.

C6 - Elective colorectal to GRH	**Small Scale Impact** CGH conducted 584 colorectal surgeries in Feb 19 to Jan 20. 51% of patients were Christian, the large majority remaining stated they had no religion or did not state their religion.				

4.9. Gender reassignment

The Equality Act 2010 protects transgender people. It is therefore important this is clearly understood and followed within the organisation, for both patients and staff who are transgender.

Transgender people are more likely to report mental health conditions and to attempt suicide than the general population[16]. Transgender people encounter significant difficulties in accessing and using health and social services[17]. Numbers of people identifying as transgender across the county is increasing with current estimates at 0.6% people aged 16 and over[18].

[16] House of Commons Women and Equalities Committee, 2016, Transgender Equality . www.publications.parliament.uk/pa/cm201516/cmselect/cmwomeq/390/390.pdf Accessed 24/01/2019
[17] Stonewall (2015) Unhealthy Attitudes www.stonewall.org.uk/sites/default/files/unhealthy_attitudes.pdf Accessed 24/01/2019
[18] https://inform.gloucestershire.gov.uk/media/2087689/equality-profile-2019-final.pdf

EQIA Summary for Gender Re-assignment

In total for all those who responded to the consultation survey across all patient cohorts, there were more respondents from the East, approx. 230 respondents compared to the West of the county where there were approx. 175 respondents.

Model	Scale of Potential impact	Evidence of Potential Impact	Consultation Outputs	Impacts from Consultation	Nature of Potential Impact and recommendations
A3 - Centralise acute medicine to GRH	**Small Scale Impact** The estimated prevalence of gender re-assignment is 0.6% in Gloucestershire.	There is limited evidence regarding the impact to those who have undergone gender reassignment, however, impacts may mirror those of sexual orientation (see above)	There is no significant evidence from consultation feedback to suggest this patient cohort is significantly impacted.	There is no significant evidence from consultation feedback to suggest this patient cohort is significantly impacted.	**Overall Impact: Neutral** Proposed changes to services are expected to maintain inclusive support service approach. It is recommended to ensure transgender people are included in the consultation
B2 - IGIS hub and vascular centralised to GRH					
C3 - EGS centralised to GRH					
C11 - GI day cases to CGH					
C5 - Elective colorectal to CGH					
C6 - Elective colorectal to GRH					

5. Health Inequalities Impact Assessment

5.1. Key Findings

Consultation Feedback

Travel was identified as concern, particularly for carers. Respondents were concerned about the travel times to the hospital sites from where they live and traffic across the county. Feedback also identified concerns regarding the travel between sites and if public transport is sufficient. Some respondents mentioned if technology could be utilised to deliver virtual appointments, avoiding travel.

Subsidised Transport could be explored as many respondents fed back on the cost of transport between hospital sites and home.

Request to increase **Homeless Outreach**, particularly in Cheltenham. Feedback from the Homelessness Forum and Housing and Support Forum identified that those who are homeless or rough sleeping do not tend to travel outside of their immediate area and so travelling further for medical care may be difficult.

Many respondents commented that centralising services would support **staff retention** and encourage recruitment.

Potential Positive impacts

25% of Gloucester city's population are living in deprived areas, approx. 32,000 people. Therefore centralising emergency general surgery, acute medicine and IGIS to GRH provides improved access to the right specialists to manage the care of this higher risk community. Deprivation is linked to co-morbidities and poorer health outcomes, therefore, centralising services to form different hubs with co-located specialities across both sites with enhanced quality of care and reduced waiting times will benefit all those living in deprivation across the County.

The centralisation of services will provide more comprehensive and co-located specialised care, which could be beneficial for carers who are caring for someone with multiple conditions. Centralisation also means services will be ring fenced, ensuring fewer cancellations, reduced waiting times and improved clinical outcomes, resulting in improved self-care. These benefits will help to support carers to reduce their time attending hospital with the person they are caring for and improve the health outcomes of both the person they are caring for and, in turn, potentially their own health.

There are 79 people registered with Gloucestershire's homeless healthcare team and it has been identified this cohort are significantly most likely to use A&E and community care services and evidence suggests those who are homeless are more likely to have multiple health conditions. Given rates of homelessness are slightly higher in Gloucester than surrounding areas; centralising emergency general surgery to GRH provides improved access to the right specialists to manage the care of homeless people who present with multiple conditions.

There is a strong association between physical health and mental health. People with long-term conditions, such as diabetes or cardiovascular disease, have significantly raised rates of depression,

anxiety and other mental health problems. Evidence suggests they receive poorer quality care than those with a single condition.[19] Therefore by centralising services patients with comorbidities could receive a better quality of specialist care. In Particular, emergency services where the majority of patients with mental health conditions are already attending as 1.2% of all A&E attendances last year were for mental health conditions, the large majority attending GRH A&E.

Potential Negative Impacts

Carers and unpaid carers are likely to experience the clinical benefits of better quality of care for the patient, shorter waiting times and specialist services working in a mutli-disciplinary approach which could help to reduce their number of hospital visits. It is possible, however, in some instances a carer may need to attend both sites based on the proposed changes (although unlikely), or in the event the patient deteriorates, they may need to transfer to Gloucestershire Royal for emergency surgery if they are currently at CGH. These events have been estimated to happen for less than 1 patient a day, meaning that, the benefits outweigh the risks for carers.

Enhanced clinical outcomes outweigh the negative impacts of travel for the majority of cohorts, however, it is important to consider the possible impact of additional cost in travel for some either through fuel costs or public transport fares for all patients, but particularly considering those in low income households. It is important to consider that this is outweighed by enhanced clinical outcomes as centralising services will likely reduce waiting times and therefore parking fees and in all the proposed solutions, over half of all patients impacted will see a neutral impact in travel (a change +/-20 mins).

Evidence Based Recommendations

1. It is recommended a review of public transport is conducted to understand if there are limitations, to disseminate information regarding travel to patients to make journey planning easier and ensure patients and carers are aware of what services are available.

2. It is recommended to conduct a review of transport options, including subsidised options for transport which can be disseminated to patients ensuring they are aware of all the options they can access.

3. Explore if increasing outreach services for those who are Homeless is needed and would be beneficial.

4. It is recommended to explore what could be moved to virtual appointment where possible to reduce the need for patients and carers to travel for outpatient appointments.

[19] https://www.kingsfund.org.uk/projects/mental-health-and-long-term-conditions-cost-co-morbidity

6. HIIA analysis

6.1. Deprivation

In general, Gloucestershire is not a very deprived county; looking at the 151 upper-tier authorities, Gloucestershire has a rank of 126, putting it in the least deprived quintile for overall deprivation. An average IMD rank for each of the six districts in Gloucestershire shows that even the most deprived district (Gloucester City) falls in the middle quintile (middle 20%) for deprivation out of 326 English authorities. Tewkesbury, Cotswold, and Stroud districts are in the least deprived quintile, with Cheltenham in the second least deprived quintile. However there are pockets of deprivation and 13 areas of Gloucestershire are in the most deprived 10% nationally. These 13 areas account for 20,946 people (3.4% of the county population). Comparison of data between 2015 and 2019 indicates that there have been minimal changes to the increase/ decrease in levels of deprivation in the county[20].

Figure 17 shows that Gloucester City has the highest proportion of population living in the most deprived quintile at around 25% and this is 2.5 times higher than the equivalent proportion for Cheltenham (10%).

Deprivation: Inequality in life expectancy

According to the latest available data, men who reside in the least deprived IMD quintile in Gloucestershire live 8.4 years longer on average compared to those who live in the most deprived areas; this is statistically similar to the regional average of 7.4 years but significantly better than the national average of 9.5 years (see Figure 18)[21].

The inequality in life expectancy among females also showed a similar trend with women living in the least deprived quintiles of Gloucestershire living 5.4 years longer on average than their counterparts living in the most deprived areas; this was significantly better than the national average but similar to the regional rates (see Figure 22).

[20] https://inform.gloucestershire.gov.uk/media/2094524/gloucestershire_deprivation_2019_v13.pdf
[21] https://fingertips.phe.org.uk/search/life%20expectancy#page/0/gid/1/pat/6/par/E12000009/ati/102/are/E10000013

Figure 16: Overall Index of Multiple Deprivation 2019 Map of Gloucestershire by IMD 2019 Quintile[22].

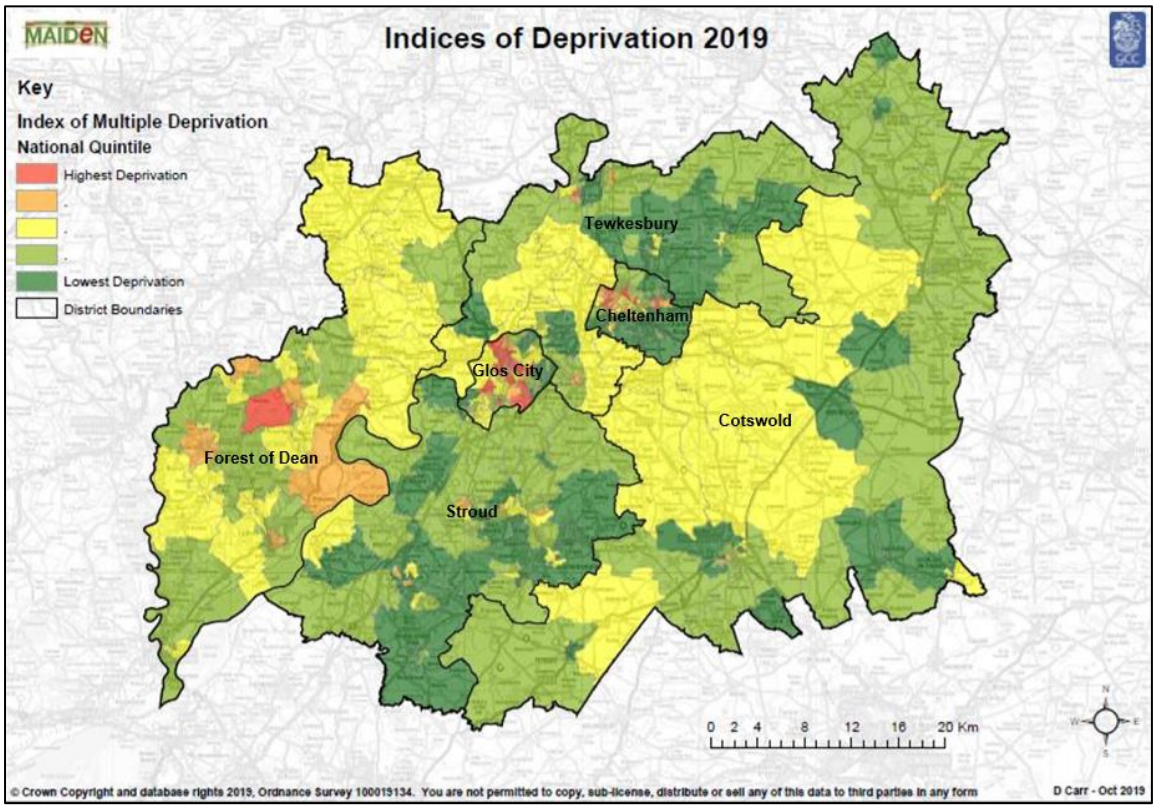
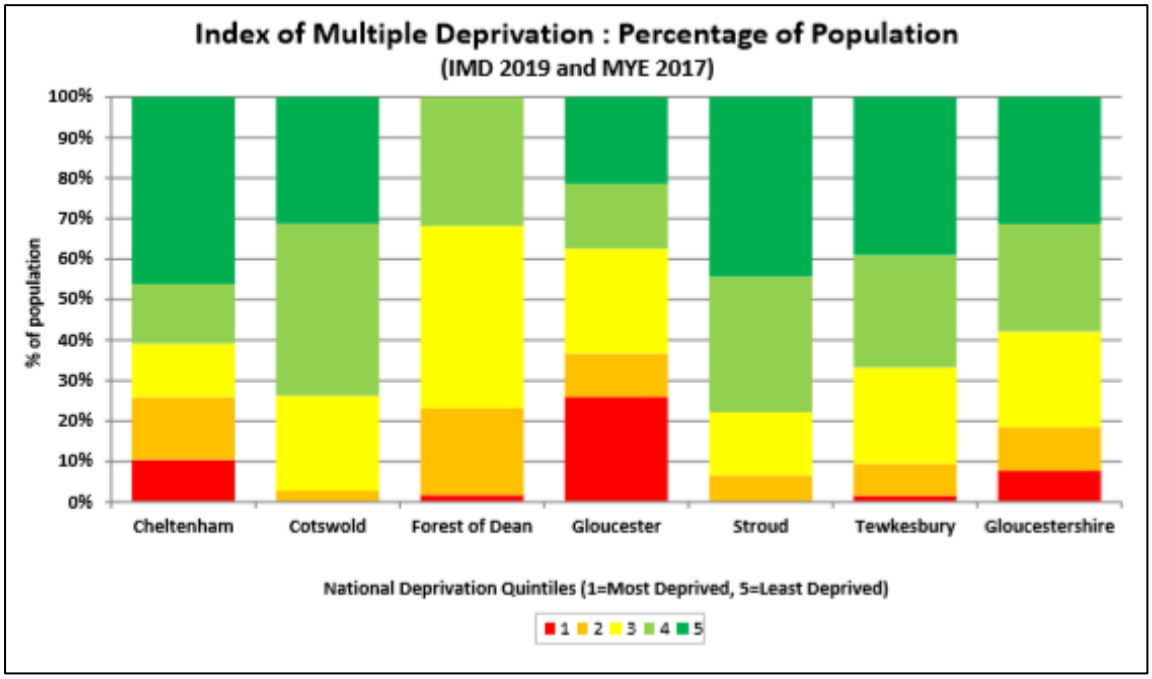


Figure 17: Overall Index of Multiple Deprivation 2019 – Percentage of Population by Quintile and District.



[22] https://inform.gloucestershire.gov.uk/media/2094524/gloucestershire_deprivation_2019_v13.pdf

Figure 21: Graph showing number of years of inequality in life expectancy among males living in the most deprived and least deprived IMD quintiles; 2016-2018[23]

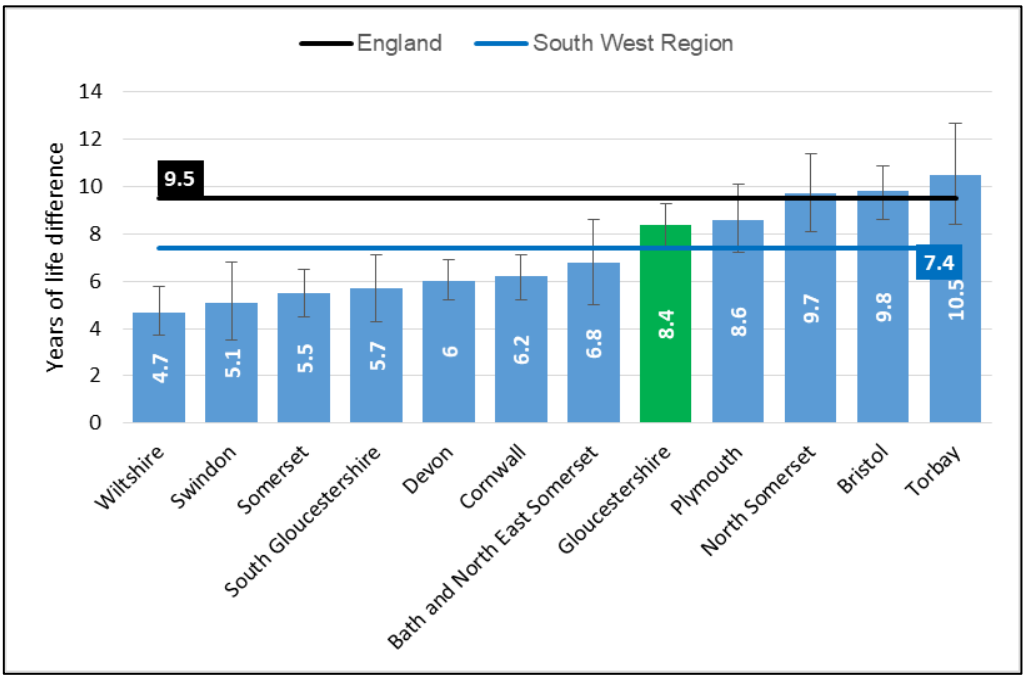
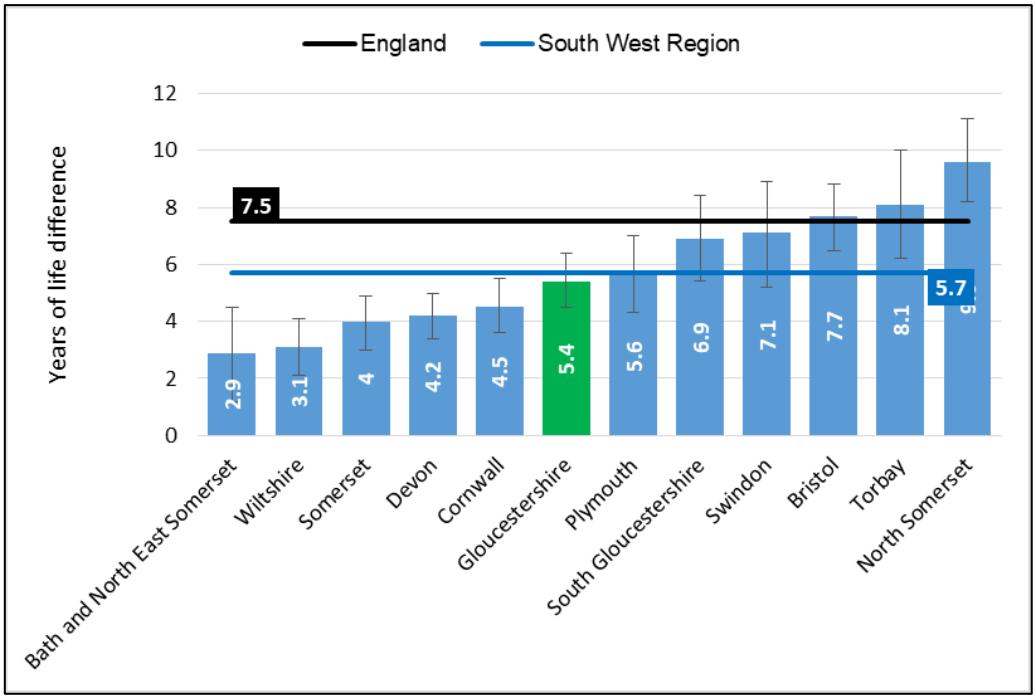


Figure 22: Graph showing number of years of inequality in life expectancy among females living in the most deprived and least deprived IMD quintiles; 2016-2018



23 https://fingertips.phe.org.uk/search/life%20expectancy#page/0/gid/1/pat/6/par/E12000009/ati/102/are/E10000013

HIIA summary for Deprivation

In total for all those who responded to the consultation survey across all patient cohorts, there were more respondents from the East, approx. 230 respondents compared to the West of the county where there were approx. 175 respondents.

Proposed Change	Scale of Potential impact	Evidence of Potential Impact	Consultation Outputs	Impact based on consultation	Nature of potential impact and recommendations
A3, B2, C3 and C6 Centralise/move various services to GRH	**Large Scale Impact** Approximately 7.7% of the Gloucestershire population live within the most deprived IMD quintile which equates to just over 48,000 people being potentially impacted. At a district level, Gloucester city has the highest proportion of its population living in the most deprived areas (25%) equating to approximately 32,500 people; this is followed by Cheltenham (11,700), Forest of Dean (2,600) and Tewkesbury (1,800). None of the areas within Stroud nor Cotswold fall under the most deprived quintile. Overall, an estimated 72% of the population living in the most deprived areas appear to live closer to GRH (based on district level map information) and this equates to around 35,000 people.	**Long Term Impact** The lack of affordability for private vehicles in low-income households, combined with limited public transport services in many peripheral social housing estates, considerably exacerbates the problem (of inequalities to healthcare) in many parts of the UK[24] People in the most deprived areas in England can expect to have two or more health conditions at 61 years, which is 10 years earlier than people in the least deprived areas, according to research carried out by the Health Foundation[25] The more deprived areas in both England and Wales experienced a higher number of deaths from leading causes such as heart diseases, chronic respiratory diseases and lung cancer than less deprived areas[26]	128 people in the 12 most deprived wards responded to questions regarding these care models.	64% of those living in the 12 most deprived wards supported the centralisation of acute medicine at GRH 68% of those living in the 12 most deprived wards supported EGS at GRH. 80% of those living in the 12 most deprived wards supported centralisation of elective colorectal. 55% thought this should be at CGH. 78% of those living in the 12 most deprived wards supported GI day case at CGH. 63% of those living in the 12 most deprived wards supported an IGIS hub and spoke model with CGH being the spoke. 60% also supported vascular surgery at GRH and just under a quarter had no opinion.	**Overall Impact: Positive** **Large Positive Impact** Given that around 35,000 people, accounting for 72% of the population living in the most deprived areas live closer to GRH; centralising/moving services to GRH provides improved access to the right specialists to manage the care of those living in the most deprived areas. Services will be providing specialist care where residents are more likely to have multiple conditions. In the event proposed change B2 were to happen, vascular services would also be centralised to GRH. Based on research, those in deprived areas are more at risk of conditions that may benefit from specialised vascular services and this area has the highest proportion of residents in deprivation. In the event that the proposed change "B3" were to happen, vascular services would still remain in CGH and would not be centralised, benefiting the deprived population in Cheltenham whilst still

[24] Lucas et al, 2019; Inequalities in mobility and Access in the UK Transport System: Evidence Review: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/784685/future_of_mobility_access.pdf
[25] https://www.health.org.uk/news-and-comment/news/people-in-most-deprived-areas-of-england-develop-multiple-health-conditions-10-years
[26] https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/articles/howdoesdeprivationvarybyleadingcauseofdeath/2017-11-01

					providing other specialist services (IGIS) closer to the higher proportion of deprived residents in Gloucester. **Moderate Negative Impact** However, patients who live in the most deprived areas nearer to CGH (approx. 13,000) may need further support to access services in the new location if their journey becomes longer and they are less familiar with the centralised location. Engaging with lower income areas within Gloucester City is important to understand if they currently struggle to access healthcare and if they think the proposed centralisations and movement of services from CGH to GRH will improve their access to healthcare. It is recommended that residents are made aware of transport options for low income families both from the hospital and from local transport services. This includes opportunities for subsidised travel.
C5, C11 services to CGH (or in the case of B3 to keep vascular at CGH)	**Large Scale Impact** Approximately 7.7% of the Gloucestershire population live within the most deprived IMD quintile which equates to just over 48,000 people being potentially impacted. At district level, Gloucester city has the highest proportion of its population living in the most deprived areas (25%) equating to approximately 32,500 people; this is followed by Cheltenham (11,700), Forest of Dean (2,600) and Tewkesbury (1,800). None of the areas within Stroud nor Cotswold fall under the most deprived quintile. Overall, an estimated 72% of the population living in the most deprived areas live closer GRH (based on a map view of these areas being geographically closer) and this equates to around 35,000 people.	**Long Term Impact** Inequalities in the provision of transport services are strongly linked with where people live, and the associated differences in life expectancy, access to employment, healthcare, education, are all influenced by deprivation. The lack of affordability for private vehicles in low-income households, combined with limited public transport services in many peripheral social housing estates, considerably exacerbates the problem in many parts of the UK[27]		Some respondents have concerns around access and transport to a site further from where they live. Some have concerns that the county is too large for centralised services. Those in support have stated they are happy to travel for care that is optimised whilst others think both sites should be centres of excellence. Greater visibility and support given to people needing to claim travel expenses for hospital visits was a theme from the feedback.	

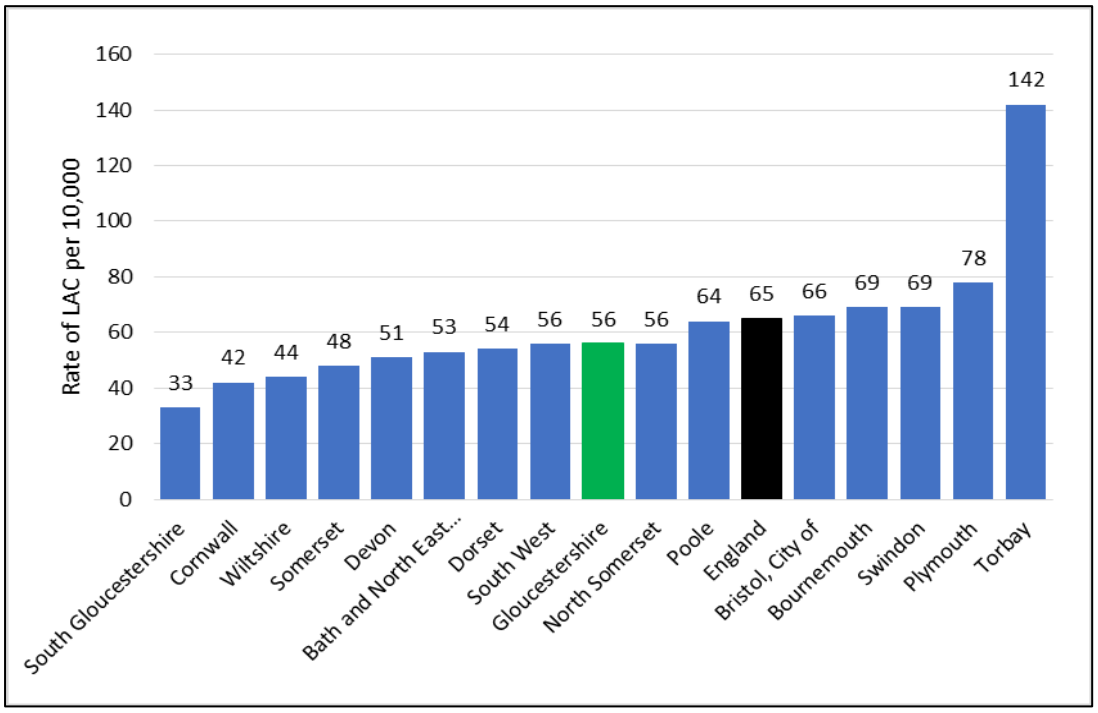
[27] Lucas et al, 2019; Inequalities in mobility and Access in the UK Transport System: Evidence Review: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/784685/future_of_mobility_access.pdf

6.2. Looked After Children (LAC)

According to data from the department for Education, there are just under 80,000 children who are in care in England. Most are taken into care over fears of abuse or neglect. They are vulnerable to health inequalities, and exhibit significantly higher rates of mental health issues, emotional disorders (anxiety and depression), hyperactivity and autistic spectrum disorder conditions[28].

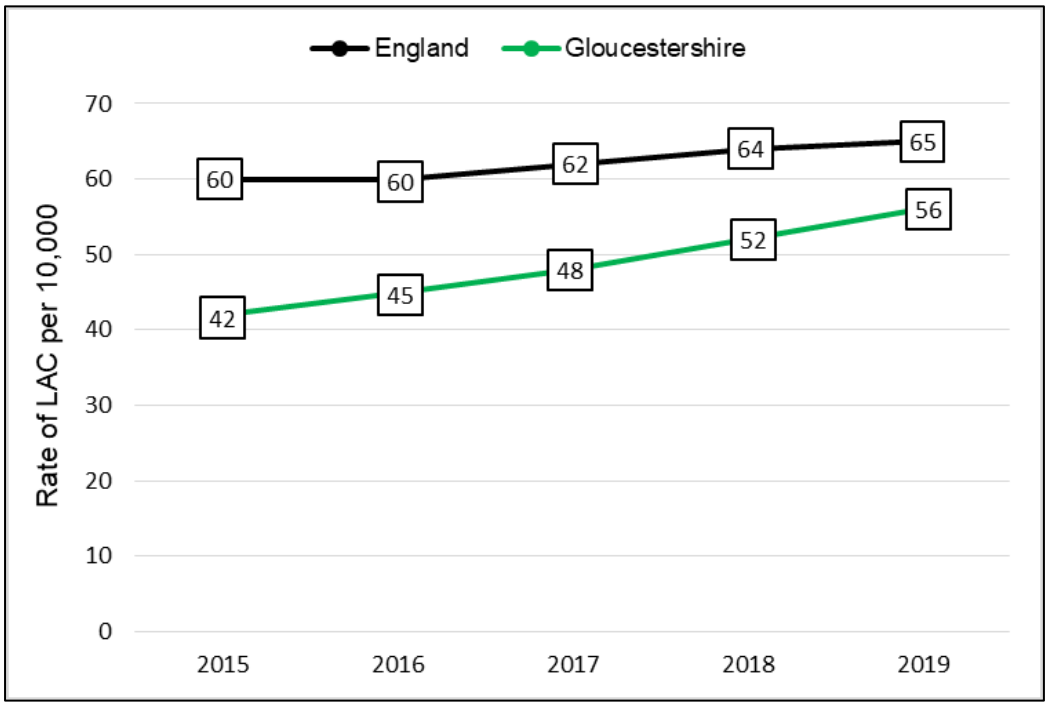
In Gloucestershire there were 718 looked after children in 2019; this equated to a rate of 56 per 10,000 persons, which is lower than England (65 per 10,000); however it is worth noting that the rate of LAC has increased by a third from 2015 to 2019[29] (see Figure 18).

Figure 18: Graph showing the rate of looked after children per 10,000 in local authorities in the South West region and national rate, 2019



[28] https://www.rcpch.ac.uk/resources/looked-after-children-lac
[29] https://www.gov.uk/government/statistics/children-looked-after-in-england-including-adoption-2018-to-2019

Figure 19: Graph showing the rate of looked after children per 10,000 in Gloucestershire and England rate, 2015 to 2019



HIIA summary for Looked After Children (LAC)

In total for all those who responded to the consultation survey across all patient cohorts, there were more respondents from the East, approx. 230 respondents compared to the West of the county where there were approx. 175 respondents.

Model	Scale of Potential impact	Evidence of Potential Impact	Consultation Outputs	Impacts from Consultation	Nature of Potential Impact and recommendations
A3 - Centralise acute medicine to GRH B2 - IGIS hub and vascular centralised to GRH C3 - EGS centralised to GRH C11 - GI day cases to CGH C5 - Elective colorectal to CGH C6 - Elective colorectal to GRH	**Small Scale Impact** In Gloucestershire there were 718 looked after children in 2019; this equated to a rate of 56 per 10,000 persons, which is lower than England (65 per 10,000); however it is worth noting that the rate of LAC has increased by a third from 2015 to 2019	**Long Term Impact** There is limited evidence regarding the impact to those who are looked after children; however evidence suggests that they are vulnerable to health inequalities, and exhibit significantly higher rates of mental health issues, emotional disorders (anxiety and depression), hyperactivity and autistic spectrum disorder conditions[30].	There is no significant evidence from consultation feedback to suggest this patient cohort is significantly impacted.	There is no significant evidence from consultation feedback to suggest this patient cohort is significantly impacted.	**Overall Impact: Neutral** Proposed changes to services are expected to maintain current inclusive support service approach. It is recommended to consult with a representative distribution of the population.

[30] https://www.rcpch.ac.uk/resources/looked-after-children-lac

6.3. Carers and Unpaid Carers

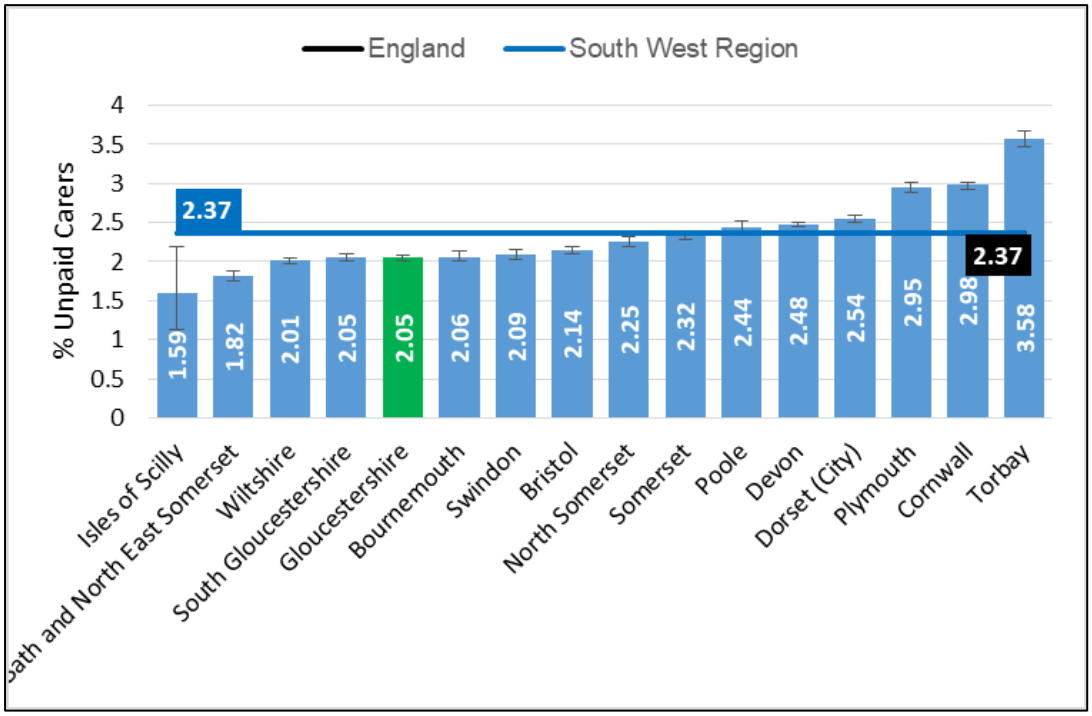
Increasing numbers of people are living with complex health needs and disabilities and require help with everyday activities. These people are often cared for, informally and unpaid, by family, friends, and neighbours.

Around 6.5 million carers in the UK provide care worth an estimated £57 billion to £100 billion per year. The number varies across the UK with a higher proportion of carers in Wales and Northern Ireland[31].

Providing unpaid care can affect carers' education, employment, relationships, household finances, health and well-being. Effects on carers tend to worsen with the more care provided. Support for carers can be provided by a range of organisations, such as employers and governments, and it can include financial, employment-related, respite care, and emotional and social support. Some carers, such as those from ethnic minorities, can find it difficult to access support. Respite breaks, training, and counselling can improve carers' mental health and reduce stress.

There is very little publically available data on the prevalence of unpaid and paid carers; according to the 2011 census the prevalence of unpaid carers within the Gloucestershire population was 2.05% and this was significantly lower than both regional and national averages (2.37%).

Figure 20: Graph showing the prevalence of unpaid carers in local authorities in the South West region and national rate, 2011 census



[31] https://researchbriefings.files.parliament.uk/documents/POST-PN-0582/POST-PN-0582.pdf

HIIA Summary for carers and unpaid carers

In total for all those who responded to the consultation survey across all patient cohorts, there were more respondents from the East, approx. 230 respondents compared to the West of the county where there were approx. 175 respondents.

Model	Scale of Potential impact	Evidence of Potential Impact	Consultation Outputs	Impacts from Consultation	Nature of Potential Impact and recommendations
A3 - Centralise acute medicine to GRH B2 - IGIS hub and vascular centralised to GRH C3 - EGS centralised to GRH	**Small Scale Impact** According to the 2011 census the prevalence of unpaid carers within the Gloucestershire population was 2.05% and this was significantly lower than both regional and national averages, however, unpaid carers are likely to be under-represented.	**Long Term Impact** Caring responsibilities can have an adverse impact on the physical and mental health, education and employment potential of those who care, which can result in significantly poorer health and quality of life outcomes. These in turn can affect a carer's effectiveness and lead to the admission of the cared for person to hospital or residential care. 84% of carers said that caring has had a negative impact on their health and evidence suggests there is a 23% increased risk of stroke for spousal carers. Carers attribute their health risk to a lack of support, with 64% citing a lack of practical support.[32]	135 carers responded to questions regarding these care models.	69% of carers supported the centralising of acute medicine to GRH. 63% of carers supported centralising EGS to GRH. 78% of carers supported centralising elective colorectal. 44% thought this should be a CGH and 36% had no opinion. 73% of carers supported GI day case at CGH. 65% of carers supported an IGIS hub and spoke model with CGH as the spoke and 19% had no opinion. 67% supported vascular surgery at GRH. Those in support of proposed centralisations to GRH felt this was the right location as centre of the county.	**Overall Impact: Positive** **Large Positive Impact** The centralisation of services will provide more specialist care which could be beneficial for carers who are caring for someone with multiple conditions. The waiting times will be reduced and fewer cancellations will help to support carers who often have to plan and make arrangements. Overall, centralised services will provide shorter lengths of stay, faster diagnostics and minimised waiting times which will help carers who have to attend hospital regularly. It will also result in ring fenced services which means more access to services and therefore better health outcomes for the patient and improved self-care. **Moderate Negative Impact:** If, however, centralisation results in extended travel time or a more complex journey, this could lead to carers finding this more challenging. Carers may have to attend a different site or even both sites and contend with the challenges that come with this, for example, parking which is reportedly a challenge from engagement with the public. It is also possible that carer and patient may need to transfer to another site in the event of patient deterioration in certain circumstances. This is in a very small number of circumstances, however.

[32] https://www.england.nhs.uk/commissioning/comm-carers/carer-facts/

				Some carers expressed concerns regarding travelling to GRH from other parts of the county. Increased patient and carer travel time was a theme.	It is recommended that carers are part of the co-design with a specific interest in understanding what practical support may be required to help them navigate changes, specifically around disability access, travel information and required facilities.
C11 - GI day cases to CGH					
C5 - Elective colorectal to CGH					
C6 - Elective colorectal to GRH					

6.4. Homelessness

The number of rough sleepers identified by the Ministry of Housing, Communities and Local Government are extremely small in Gloucestershire identifying just 19 people. Therefore this report will look at the impact to those statutorily homeless. This is identified as the count of households who are living in temporary accommodation provided under the homeless legislation.

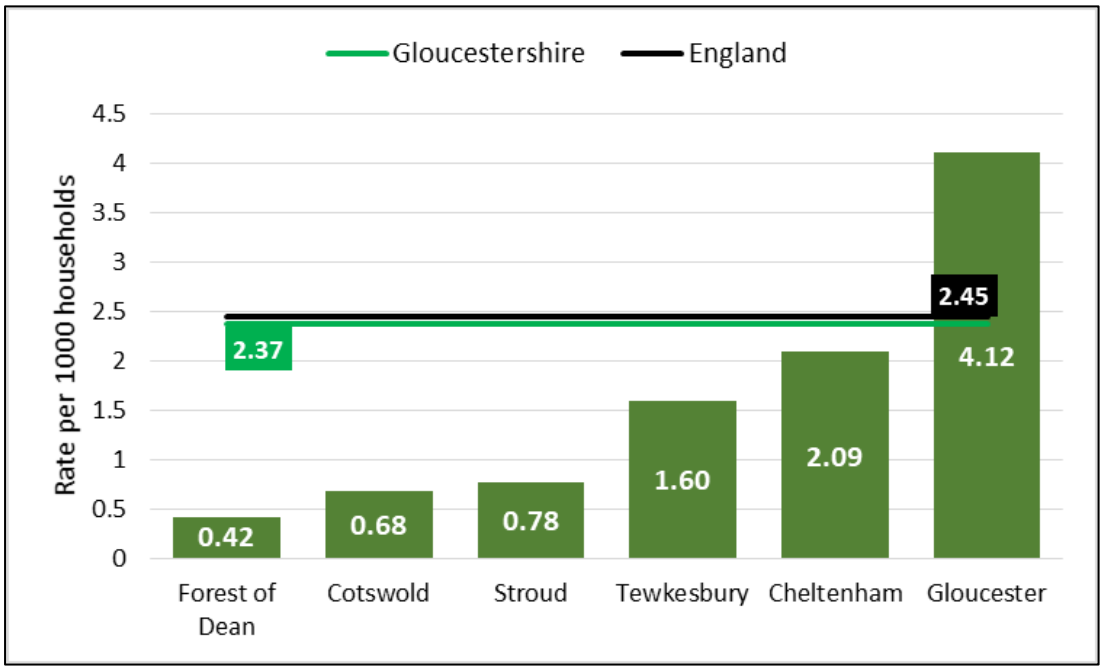
As such, statutorily homeless households contain some of the most vulnerable members of our communities and are at a higher risk of long term conditions, mental health, smoking and various other illnesses, thus this cohort require a higher provision of care[33]. Being homeless also comes with a higher risk of delayed discharge from hospital, lengthening stays or cause repeated admissions to hospitals[34].

Numerous risk factors are associated with the likelihood of someone becoming homeless, and these broadly fall under individual circumstances and the wider forces. The risks range from drug and alcohol issues, bereavement, or experience of the criminal justice system, to the wider determinants of health such as inequality, unemployment, and housing supply and affordability[35]

The rate of homelessness in Gloucestershire varies substantially by district. The highest rates are seen in Gloucester with 219 households accepted as homeless, equating to a rate of 4.12 per 1000 households; this is significantly higher than both county and national rates and double the rate of Cheltenham at 2.09 (see Figure 22).

[33] Morton , Jane. Primary Health Care (2014+); London Vol. 27, Iss. 8, (Sep 2017): 25. DOI:10.7748/phc.2017.e1289
[34] https://publichealthmatters.blog.gov.uk/2018/02/09/the-inequalities-of-homelessness-how-can-we-stop-them-dying-young/
[35] https://publichealthmatters.blog.gov.uk/2018/02/09/the-inequalities-of-homelessness-how-can-we-stop-them-dying-young/

Figure 22: Graph showing rate of acceptances per 1000 households in Gloucestershire districts compared with Gloucestershire and national averages, 2017/18



Locally sourced data provided by NHS Gloucestershire Clinical Commissioning Group and Gloucestershire County Council indicates there are 40 rough sleepers in Gloucestershire currently.

Gloucester 17, Cheltenham 9, Cotswold 7, Forest of Dean 3, Stroud 2 and Tewkesbury 2.

There are also 79 people registered with Gloucestershire's Homeless Healthcare team. This group are more likely to be male and are far younger than the overall CCG cohort. This cohort used A&E and community care services more, as well as mental health services.

HIIA summary for Homelessness

In total for all those who responded to the consultation survey across all patient cohorts, there were more respondents from the East, approx. 230 respondents compared to the West of the county where there were approx. 175 respondents.

Proposed Change	Scale of Potential impact	Evidence of Potential Impact	Consultation Outputs	Impacts from Consultation	Nature of potential impact and recommendations
A3, B2, C3 and C6 Centralise/move various services to GRH	**Small Scale Impact** On average 2.37 per 1000 households are homeless in Gloucestershire. In Cheltenham 108 households are accepted as homeless, in Tewkesbury this figure is 61 households and in Cotswold 26. This means approx. 195 homeless may currently be living closer to CGH and therefore could be impacted by the proposed move of services to GRH from CGH (based on a map view of these areas being geographically closer) There are 79 people registered with the Homeless Healthcare team.	**Long Term Impact** Homeless people are at a higher risk of long term conditions, mental health, smoking and various other illnesses, thus this cohort require a higher provision of care[36]. Being homeless also comes with a higher risk of delayed discharge from hospital, lengthening stays or cause repeated admissions to hospital[37]. Those known to Gloucestershire's homeless healthcare team are more likely to be male and are far younger than the overall CCG cohort. This cohort used A&E and community care services more, as well as mental health services.	Minutes from the Gloucester Homeless Forum and the Housing and Support Forum**.**	Feedback from those representing those who are homeless in the Gloucester Homeless Forum and Housing and Support Forum expressed concerns about how the proposals will meet the needs of the vulnerable clients that attend Cheltenham Open Door who have very complex needs and MA also discussed concerns about how people rough sleeping often don't like to leave the immediate area and travel for appointments. Feedback also suggests requests for more outreach services to the homeless, in particular in Cheltenham.	**Overall Impact: Positive** **Large Positive Impact** Given rates of homelessness are slightly higher in Gloucester; a centralising/moving services to GRH provides improved access to the right specialists to manage the care of homeless people who present with multiple conditions. Services in these solutions will be located near the highest proportion of homeless people in Gloucestershire, improving access to specialist care without additional travel. Homeless people are more likely to have long term conditions and multiple conditions which means centralising and co-locating services will provide support for more complex needs such as these.

[36] Morton , Jane. **Primary Health Care (2014+); London** Vol. 27, Iss. 8, (Sep 2017): 25. DOI:10.7748/phc.2017.e1289
[37] https://publichealthmatters.blog.gov.uk/2018/02/09/the-inequalities-of-homelessness-how-can-we-stop-them-dying-young/

C5 and C11 move various services to CGH (or in the case of B3 to keep vascular at CGH)	**Small Scale Impact** The highest rates of homelessness acceptances are seen in Gloucester with 219 households accepted as homeless, equating to a rate of 4.12 per 1000 households; this is significantly higher than both county and national rates and double the rate of Cheltenham at 2.09. In addition to this Stroud has 39 homeless households and Forest of Dean 15. Making the assumption that these areas are closer to GRH, there are approximately 273 homeless who may be impacted by the proposed move of some services to CGH. (based on a map view of these areas being geographically closer)	**Long Term Impact** Homeless people are some of the most vulnerable and needy members of our communities and are at a higher risk of long term conditions, mental health, smoking and various other illnesses, thus this cohort require a higher provision of care. Being homeless also comes with a higher risk of delayed discharge from hospital, lengthening stays or cause repeated admissions to hospitals.			**Small Negative Impact** Patients who are homeless, especially those from outside of Gloucester district may need further support to access services in the new location if their journey becomes longer and they are less familiar with the centralised location. It is recommended that organisations that advocate for homeless people locally such as Cheltenham Open door and others, are part of the co-design around transport and repatriation of those who are homeless to understand the pathway of care and how that impacts on homeless people or rough sleepers if they are required to travel out of their local area. Explore if there are more outreach opportunities for homeless people and if this is needed.

6.5. Substance Abuse

There is evidence to suggest that young people who use recreational drugs run the risk of damage to mental health including suicide, depression and disruptive behaviour disorders. Regular use of cannabis or other drugs may also lead to dependence. Among 10 to 15 year olds, an increased likelihood of drug use is linked to a range of adverse experiences and behaviour, including truancy, exclusion from school, homelessness, time in care, and serious or frequent offending[38].

Patients with substance use disorder diagnoses, specifically those with drug use-related diagnoses, have higher rates of recurrent acute care hospital utilisation than those without substance use disorder diagnoses[39].

The age standardised hospital admissions due to substance misuse in Gloucestershire is among the lowest in the South West region at 38 per 100,000 persons; lower than both regional and national rates, although there is a lack of data to determine statistical significance or comparisons. The age standardised mortality rate due to substance misuse is highest in the district of Gloucester with a rate of 7 per 100,000 over the period from 2016 to 2018; this is significantly higher than both Gloucestershire and England rates. All other districts had a rate similar to national and county rates or lower.

Figure: Age standardised rate of hospital admissions due to substance misuse per 100,000 within local authorities within the South West region compared with regional and national rates, 2018/19

[38] Schlossarek S et al U: Psychosocial Determinants of Cannabis Dependence: A Systematic Review of the Literature. Eur Addict Res 2016;22:131-144.
[39] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6034987/

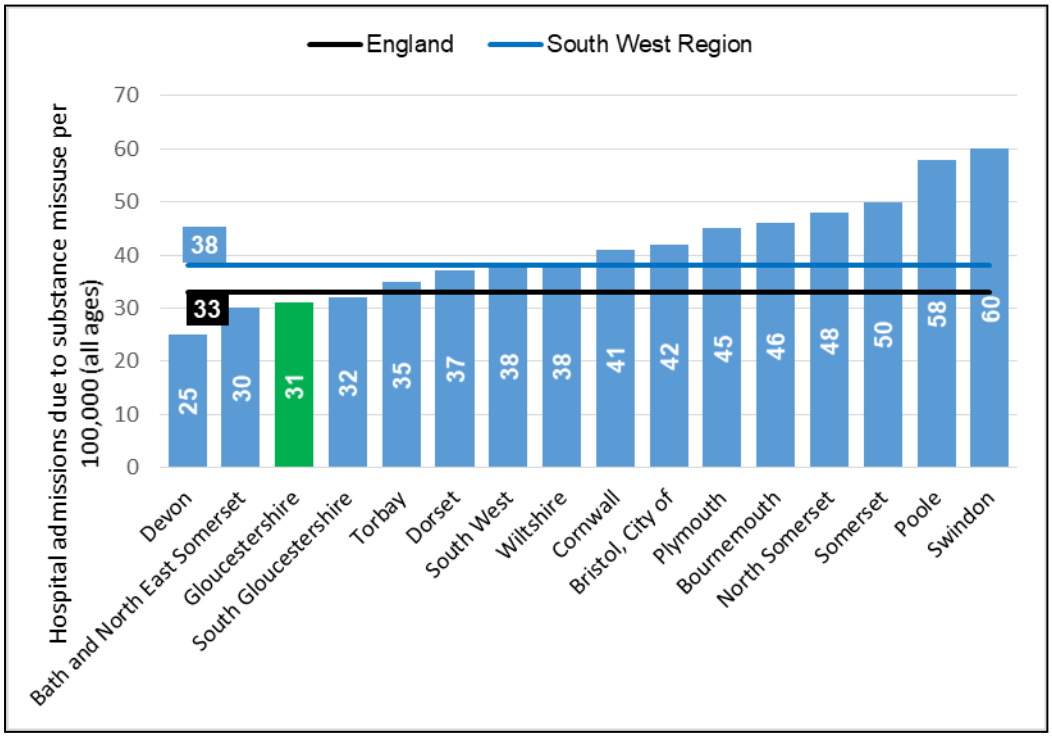
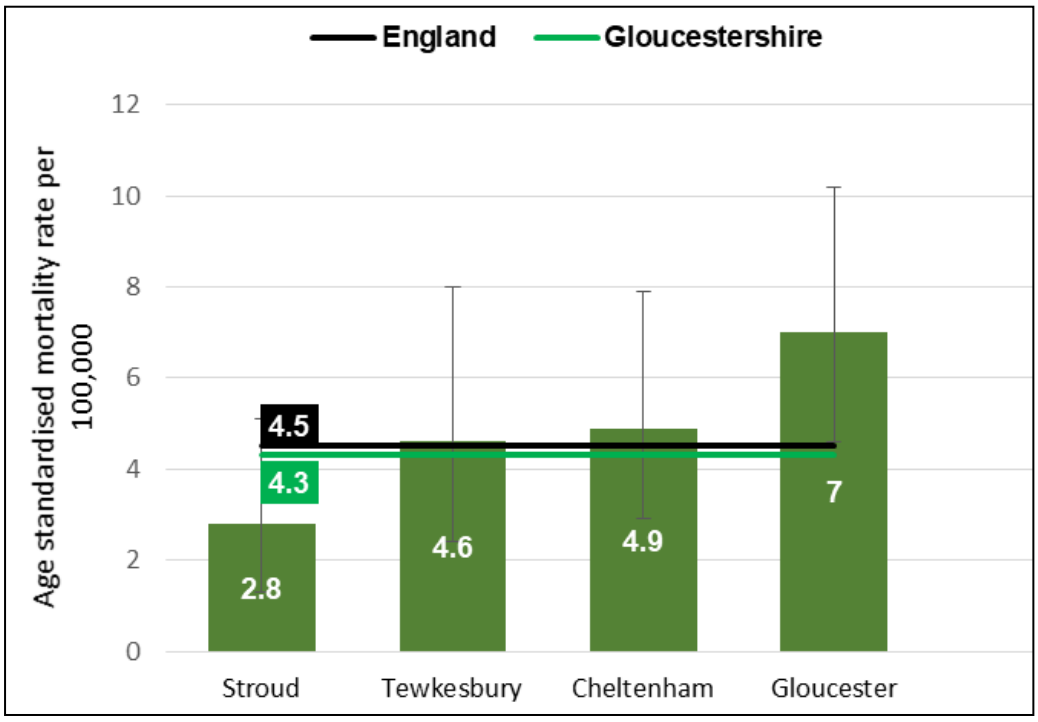


Figure: Age standardised mortality rate due to substance misuse per 100,000 within Gloucestershire districts, compared with county and national rates, 2016 - 2018



*Numbers were too low for Cotswold and Forest of Dean

HIIA Summary for Substance Misuse

In total for all those who responded to the consultation survey across all patient cohorts, there were more respondents from the East, approx. 230 respondents compared to the West of the county where there were approx. 175 respondents.

Model	Scale of Potential impact	Evidence of Potential Impact	Consultation Outputs	Impacts from Consultation	Nature of Potential Impact and recommendations
A3 - Centralise acute medicine to GRH B2 - IGIS hub and vascular centralised to GRH C3 - EGS centralised to GRH C11 - GI day cases to CGH C5 - Elective colorectal to CGH C6 - Elective colorectal to GRH	**Moderate Scale Impact** The age standardised hospital admissions due to substance misuse in Gloucestershire is among the lowest in the South West region at 38 per 100,000 persons; lower than both regional and national rates; however mortality rates suggest that the district of Gloucester City has the highest rates of deaths due to substance misuse, significantly higher than county and national averages.	**Long Term** Patients with substance use disorder diagnoses, specifically those with drug use-related diagnoses, have higher rates of recurrent acute care hospital utilisation than those without substance use disorder diagnoses[40].	There is no significant evidence from consultation feedback to suggest this patient cohort is significantly impacted.	There is no significant evidence from consultation feedback to suggest this patient cohort is significantly impacted.	**Neutral Impact** Proposed changes to services are expected to maintain current inclusive support service approach.

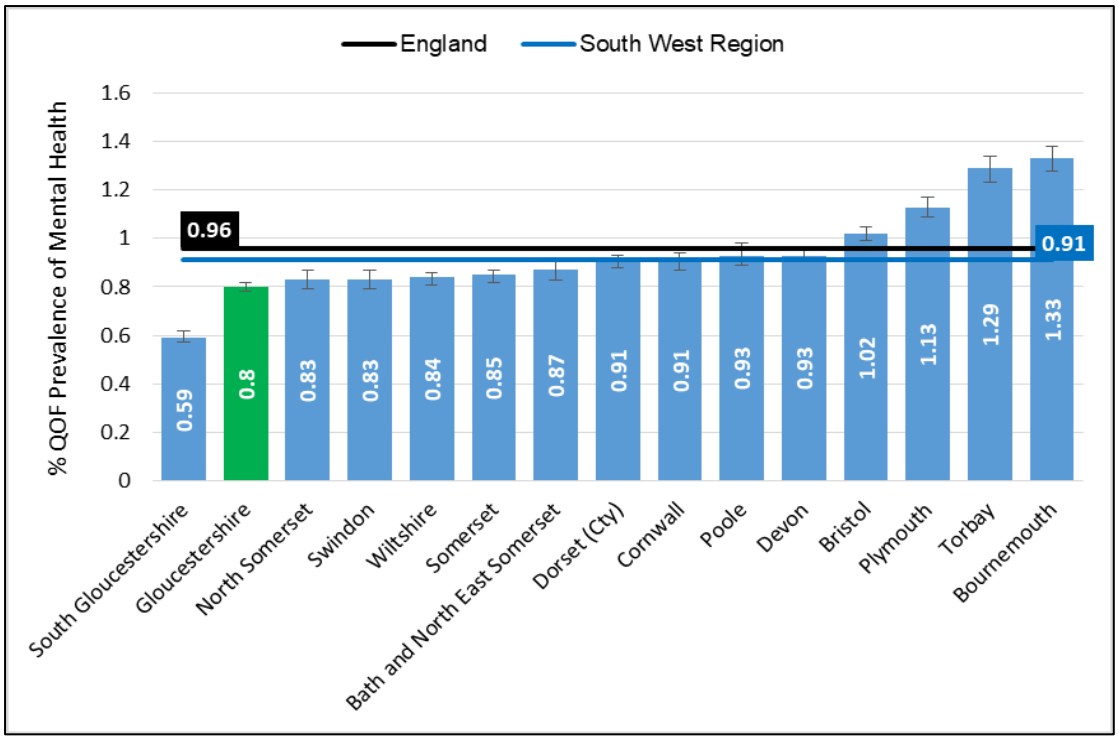
[40] Walley et al (2012) Acute care hospital utilization among medical inpatients discharged with a substance use disorder diagnosis. J Addict Med. 2012 Mar;6(1):50-6. doi: 10.1097/ADM.0b013e318231de51

6.6. Mental Health

The prevalence of mental health disease within the GP practice registered population within Gloucestershire is among the lowest in the South West region at 0.8%; significantly lower than both regional and national averages (see Figure 24).

During 2018/19, 351 people attended CGH ED and 1447 attended GRH with a mental health issue. This total of 1798 across the 2 sites equates to 1.2% of all attendances during this year. This data clearly demonstrates that more people attend GRH than CGH with mental health related issues.

Figure 24: Graph showing QOF prevalence of the registered population with a mental health disease in local authorities in South West compared to regional and national averages 2015/16 to 2017/18



HIIA Summary for Mental Health

In total for all those who responded to the consultation survey across all patient cohorts, there were more respondents from the East, approx. 230 respondents compared to the West of the county where there were approx. 175 respondents.

Model	Scale of Potential impact	Evidence of Potential Impact	Consultation Outputs	Impacts from Consultation	Nature of Potential Impact and recommendations
A3 - Centralise acute medicine to GRH	**Moderate Scale Impact** The prevalence of mental health disease within the GP practice registered population within Gloucestershire is among the lowest in the South West region at 0.8%; significantly lower than both regional and national averages, however, a number of mental health conditions are undiagnosed or underrepresented. During 2018/19, 351 people attended CGH ED and 1447 attended GRH with a mental health issue. This total of 1798 across the 2 sites equates to 1.2% of all attendances during this year. This data clearly demonstrates that more people attend GRH than CGH with mental health related issues.	**Long Term Impact** There is a strong association between mental and physical ill health. People with long-term conditions, such as diabetes or cardiovascular disease, have significantly raised rates of depression, anxiety and other mental health problems. Evidence suggests that many of these people receive poorer quality care than those with a single condition.[41]	22 respondents with mental health conditions answered questions in relation to these care models	62% of those with a mental health condition supported centralised acute medicine 62% of those with a mental health condition supported EGS centralised to GRH and 19% had no opinion. 57% of those with a mental health condition supported centralised elective colorectal and 29% had no opinion. 50% supported it at CGH and 35% had no opinion. 57% of those with a mental health condition supported GI day case at CGH and 29% had no opinion. 62% of those with a mental health condition supported an IGIS hub with a spoke at CGH and 19% had no opinion. 60% supported vascular surgery at GRH and 20% had no opinion. Some benefits identified through	**Overall Impact: Positive** **Large Positive Impact** By centralising services patients with comorbidities could receive a better quality of specialist care. Particularly emergency services where the majority of patients with mental health conditions are already attending. **Moderate Negative Impact** Patients with anxiety disorders and other mental health disorders which may be exacerbated by change in routine or need to travel may find these challenging. It is recommended those with mental health conditions and organisations supporting those with mental health conditions form part of the design of services, particularly considering the impact of travel or a new environment on those with mental health conditions that may be exacerbated by these changes.

[41] https://www.kingsfund.org.uk/projects/mental-health-and-long-term-conditions-cost-co-morbidity

				feedback were around the increased likelihood of seeing a specialist on first appointment rather than being redirected and quality of care optimised. Some respondents expressed concerns around capacity at one site by centralising services.	
B2 - IGIS hub and vascular centralised to GRH					
C3 - EGS centralised to GRH					
C11 - GI day cases to CGH					
C5 - Elective colorectal to CGH					
C6 - Elective colorectal to GRH					

7. Health Impact Assessment

7.1. Key Findings

Consultation Feedback

Care Quality was viewed as a benefit by many respondents who felt centralising services would optimise care. Some commented that they were happy to travel for optimised care or that location was less important compared to quality.

Those over 65 with disabilities and those with long term conditions had concerns regarding the potential need to **transfer** some patients for emergency treatment who may be very unwell.

Potential Positive Impacts

Diabetes tends to be prevalent with other co-morbidities such as, heart conditions, meaning that this cohort is likely to be impacted by the centralisation of services as they are likely to use several different services due to having multiple conditions. This means centralising services will improve their quality of care by reducing waiting times, faster diagnostics and a multi-disciplinary approach to conditions.

Obesity is often linked to a large number of co-morbidities which mean obese patients are significantly more likely to be impacted by the proposed changes. The movement of services could result in specialist care being provided in one place leading to a better quality of care.

Patients who fall regularly are one of the cohorts more likely to be impacted by the proposed changes as they will usually attend hospital more than other cohorts in the population. 1,812 people per 100,000 in Gloucestershire are admitted to hospital due to falls. This cohort may benefit from the centralisation of services in the same way as over 65s because frailty can correlate with age, see "Age" section of the EQIA.

Potential Negative Impacts

In the event that the proposed change "B3" were to happen, vascular services would still remain in CGH and would not be centralised. By having IGIS separate from vascular this could result in compromised patient safety and could result in patients needed to be transferred if they are vulnerable to deterioration such as those with cardiovascular disease. This may also impact on what cardiovascular disease patients receive in the vascular hub at CGH. The impact of the separation of vascular on patient safety is not yet known but has been raised as a concern by staff, and therefore remains a concern for patients vulnerable to deterioration or those with complex heart conditions. The impact to vascular and the impact on patient safety has been identified by Gloucestershire Hospitals NHS Foundation Trust, however, this impact has yet to be quantified by clinicians.

Evidence Based Recommendations

- It is recommended a review of public transport is conducted to understand if there are limitations, to disseminate information regarding travel to patients to make journey planning easier and ensure patients and carers are aware of what services are available.
- It is recommended to conduct a review of transport options, including subsidised options for transport which can be disseminated to patients ensuring they are aware of all the options they can access.
- Explore if increasing outreach services for those who are Homeless is needed and would be beneficial.
- It is recommended to explore what could be moved to virtual appointment where possible to reduce the need for patients and carers to travel for outpatient appointments.
- It is recommended to explore the possibility of adapting the model of elective colorectal to alleviate some concerns regarding the transfer of high risk patients. Evidence review suggests there are clinical benefits to elective colorectal being centralised in GRH with emergency general surgery, however, consultation feedback suggests that overall patients would prefer centralisation at CGH. In order to accommodate patient preference, optimise care and alleviate concerns regarding transfer, it is recommended to explore a model where elective colorectal is centralised at CGH but with high risk patients attending GRH to receive their colorectal treatment.

HIA analysis

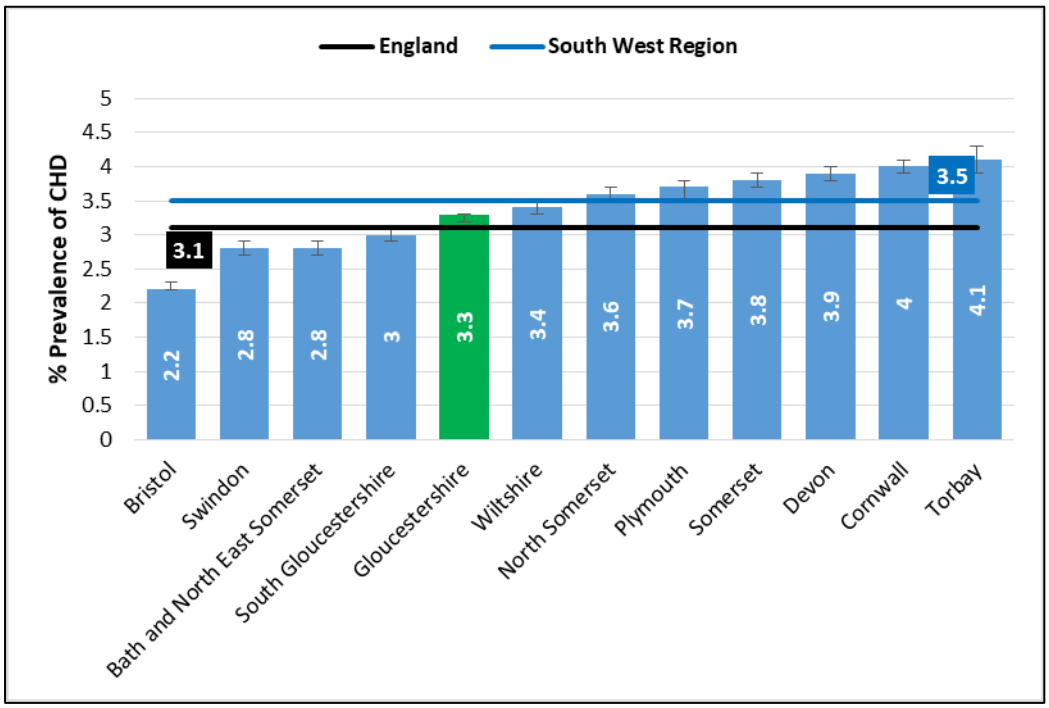
7.2. Cardiovascular disease

Cardiovascular disease (CVD) is responsible for 26% of all deaths in the UK. This equates to approximately 160,000 deaths each year or an average of 435 people each day and at least 42,000 of these deaths occur prematurely. [42] There are multiple risk factors for cardiovascular disease; these include old age, ethnicity, deprivation, gender, smoking, obesity etc.[43]

The more deprived areas in both England and Wales experienced a higher number of deaths from leading causes including cardiovascular and other related conditions than less deprived areas.[44]

The prevalence of cardiovascular disease within the GP practice registered population within Gloucestershire is 3.3%, which is significantly lower than the regional average (3.5%) but significantly higher than the national average (3.1%) see Figure 25.

Figure 25: Graph showing QOF prevalence of chronic heart disease in the registered population in local authorities in South West compared to regional and national averages, 2017/18



[42] https://www.heartuk.org.uk/downloads/heart-uk-state-of-the-nation-report-2018.pdf
[43] https://ada.com/cardiovascular-disease-risk-factors/
[44] https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/articles/howdoesdeprivationvarybyleadingcauseofdeath/2017-11-01

HIA summary for Cardiovascular disease

In total for all those who responded to the consultation survey across all patient cohorts, there were more respondents from the East, approx. 230 respondents compared to the West of the county where there were approx. 175 respondents.

Proposed Change	Scale of Potential impact	Evidence of Potential Impact	Consultation Outputs	Impacts from Consultation	Nature of potential impact and recommendations
A3, B2, C3 and C6 Centralise/move various services to GRH	**Large Scale Impact** The prevalence of cardiovascular disease within the GP practice registered population within Gloucestershire is 3.3%, which is significantly lower than the regional average (3.5%) but significantly higher than the national average (3.1%). Over the period between April 2018 and March 2019, there was a total of 3,783 cardiology/vascular patients seen across GRH and CGH; 3,334 (88%) of these patients were seen at CGH. While there is insufficient data to ascertain whether there is a higher prevalence of cardiovascular patients living nearer to CGH compared to GRH; it can be denoted that the vast majority of cardiology patients are currently seen at CGH and proposed changes are most likely to impact this cohort.	**Long Term Impact** There are multiple risk factors for cardiovascular disease; these include old age, ethnicity, deprivation, gender, smoking, obesity etc.[45] The more deprived areas in both England and Wales experienced a higher number of deaths from leading causes including cardiovascular and other related conditions than less deprived areas.[46] Approx. 35,000 people, accounting for 72% of the population living in the most deprived areas live closer to GRH; centralising/moving services to GRH provides improved access to the right specialists to manage the care of those living in the most deprived areas who are at a higher risk of cardiovascular disease.	81 respondents with Long term conditions responded to questions regarding these care models.	73% of those with a long term condition supported acute medicine centralised to GRH. 69% of those with a long term condition supported EGS centralised to GRH and 10% had no opinion. 84% of those with a long term condition supported the centralisation of elective colorectal. 48% felt it should be at CGH. 74% of those with a long term condition supported GI day case at CGH. 73% of those with a long term condition supported and IGIS Hub with the spoke at CGH and 52% supported vascular surgery at GRH with 30% having no opinion. Feedback regarding colorectal raised concerns regarding transfers of very unwell patients	**Overall Impact: Negative** **Large Positive Impact:** In the event proposed change B2 were to happen, vascular services would also be centralised to GRH. Based on research, those in deprived areas are more at risk of conditions that may benefit from specialised vascular services and this area has the highest proportion of residents in deprivation. The centralisation of services will result in cardiovascular patients experiencing reduced waiting times, less cancellations and improved clinical outcomes as a result of the co-location of specialities. **Large Negative Impact** In the event that the proposed change "B3" were to happen, vascular services would still remain in CGH and would not be centralised. This could result in less optimised patient safety and could result in patients needed to be transferred. This may impact on what

[45] https://ada.com/cardiovascular-disease-risk-factors/
[46] https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/articles/howdoesdeprivationvarybyleadingcauseofdeath/2017-11-01

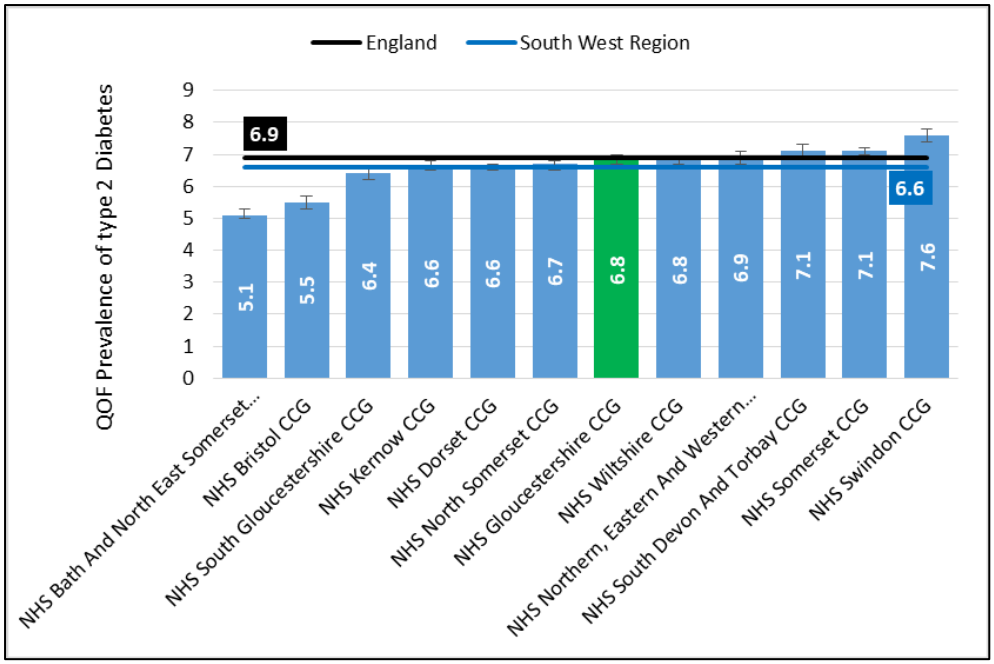
				and the time required for transfer impacting on patient outcomes. Feedback also expressed concerns around the impact centralising acute medicine will have on the A&E offer at CGH.	vascular patients receive at CGH also. The impact of the separation of vascular on patient safety is not yet known, and therefore remains a concern for patients vulnerable to deterioration or those with complex heart conditions. Until the impact is quantified, this remains high. It is recommended that patient pathways regarding transfer are made clear so patients can understand the impact of transfer in the event of being unwell. An assessment of travel times between sites in an emergency may also be beneficial
C5, C11 services to CGH (or in the case of B3 to keep vascular at CGH)	**Large Scale Impact** The prevalence of cardiovascular disease within the GP practice registered population within Gloucestershire is 3.3%, which is significantly lower than the regional average (3.5%) but significantly higher than the national average (3.1%). Over the period between April 2018 and March 2019, there was a total of 3,783 cardiology/vascular patients seen across GRH and CGH; 449 (12%) of these patients were seen at GRH.	As above			

7.3. Diabetes Mellitus

Research suggests that those living in the most deprived areas within the UK are 2.5 time more likely to be suffering from Diabetes.[47] Those suffering from diabetes also have a high likelihood of coming from a BME background; Type 2 Diabetes is up to 6 times more likely in people of South Asian descent and 6 times more likely among Afro-Caribbean's.[48]

The prevalence of Type 2 Diabetes within the GP practice registered population within Gloucestershire is similar compared to the South West region and national average at 6.8% (see Figure 26).

Figure 26: Graph showing QOF prevalence of the registered population with a Diabetes Mellitus in local authorities in South West compared to regional and national averages, 2017/18



[47] https://www.diabetes.org.uk/about_us/news_landing_page/uks-poorest-twice-as-likely-to-have-diabetes-and-its-complications
[48] *Association of glycaemia with macrovascular and microvascular complications of Type 2 diabetes: prospective observational study* British Medical Journal 2000; 321: 405-412.

HIA summary for Diabetes Mellitus

In total for all those who responded to the consultation survey across all patient cohorts, there were more respondents from the East, approx. 230 respondents compared to the West of the county where there were approx. 175 respondents.

Model	Scale of Potential impact	Evidence of Potential Impact	Consultation Outputs	Impacts from Consultation	Nature of Potential Impact and recommendations
A3 - Centralise acute medicine to GRH B2 - IGIS hub and vascular centralised to GRH C3 - EGS centralised to GRH C11 - GI day cases to CGH C5 - Elective colorectal to CGH C6 - Elective colorectal to GRH	**Small Scale Impact:** The prevalence of Type 2 Diabetes within the GP practice registered population within Gloucestershire is similar compared to the South West region and national average at 6.8%	**Long Term Impact** There is limited evidence regarding the impact to those who are Diabetics; however, evidence suggests that those living in the most deprived areas within the UK are 2.5 time more likely to be suffering from Diabetes.[49] Those suffering from diabetes also have a high likelihood of coming from a BME background; Type 2 Diabetes is up to 6 times more likely in people of South Asian descent and 6 times more likely among Afro-Caribbean's.[50] This cohort may face challenges and perceived challenges in access to services in general, especially those within BME background[51]	81 respondents with Long term conditions responded to questions regarding these care models.	73% of those with a long term condition supported acute medicine centralised to GRH. 69% of those with a long term condition supported EGS centralised to GRH and 10% had no opinion. 84% of those with a long term condition supported the centralisation of elective colorectal. 48% felt it should be at CGH. 74% of those with a long term condition supported GI day case at CGH. 73% of those with a long term condition supported and IGIS Hub with the spoke at CGH and 52% supported vascular surgery at GRH with 30% having no opinion. Feedback regarding colorectal raised concerns regarding transfers of very unwell patients and the time required for transfer impacting on patient outcomes. Feedback also expressed concerns around the impact centralising acute medicine will have on the A&E offer at CGH.	**Overall Impact: Positive** **Positive Impact** Diabetes is prevalent with other co-morbidities such as, heart conditions, meaning that this cohort is likely to be impacted by the centralisation of services as they are likely to use multiple services due to having multiple conditions. This could mean centralising services will improve their quality of care and enhance clinical outcomes. It is recommended to use existing forums to engage with patients with long term conditions and also to engage with representative organisations for long term conditions such as diabetes.

[49] https://www.diabetes.org.uk/about_us/news_landing_page/uks-poorest-twice-as-likely-to-have-diabetes-and-its-complications
[50] *Association of glycaemia with macrovascular and microvascular complications of Type 2 diabetes: prospective observational study* British Medical Journal 2000; 321: 405-412.
[51] https://bmjopen.bmj.com/content/6/11/e012337

7.4. Neurological Conditions

The number of people living with neurological conditions in England is rising and will continue to increase. This is due in part to advances in neonatal healthcare meaning more children with neurological conditions survive beyond birth and into adulthood. Public Health England's 2018 Neurology Mortality reports show that number of deaths in England relating to neurological disorders rose by 39% over 13 years, while deaths in the general population fell by 6% over the same period.[52]

According to the NHS & CQC 2017 Adult Inpatient Survey, Patients with neurological conditions reported poorer experiences for confidence and trust, respect and dignity, respect for patient-centred values and overall experience of care. In response to the NHS 2016 patient experience survey, just 41% (n=2,132) of patients described the health services they received for their neurological condition as 'good' or 'excellent'.[53]

The 2013-14 NHS England survey of patients of GP practices found that people with long-term neurological conditions have the lowest health-related quality of life of any long-term condition.[54]

The prevalence of neurological conditions among the registered population is similar in Gloucestershire compared with the South West Region and National rates at 8.8%.

The rate of hospital admissions for epilepsy among under 19s is 87.5 per 100,000; this is statistically similar to the South West regional average (71.5) but statistically higher than the national average (70.6) by a small margin.

Figure 27: Graph showing prevalence neurological conditions among the registered population in local authorities in South West compared to regional and national averages, 2017/18

[52] Public Health England (2018) Deaths associated with neurological conditions in England 2001 to 2014: Data analysis report. Available online at https://www.gov.uk/government/publications/deaths-associated-withneurological-conditions
[53] The Neurological Alliance (2017): Falling short: How has neurology patient experience changed since 2014? Available online at http://www.neural.org.uk/store/assets/files/668/original/Neurological_Alliance__Falling_Short_-_How_has_neurology_patient_experience_changed_since_2014.pdf
[54] The Neurological Alliance (2017): Falling short: How has neurology patient experience changed since 2014? Available online at http://www.neural.org.uk/store/assets/files/668/original/Neurological_Alliance__Falling_Short_-_How_has_neurology_patient_experience_changed_since_2014.pdf

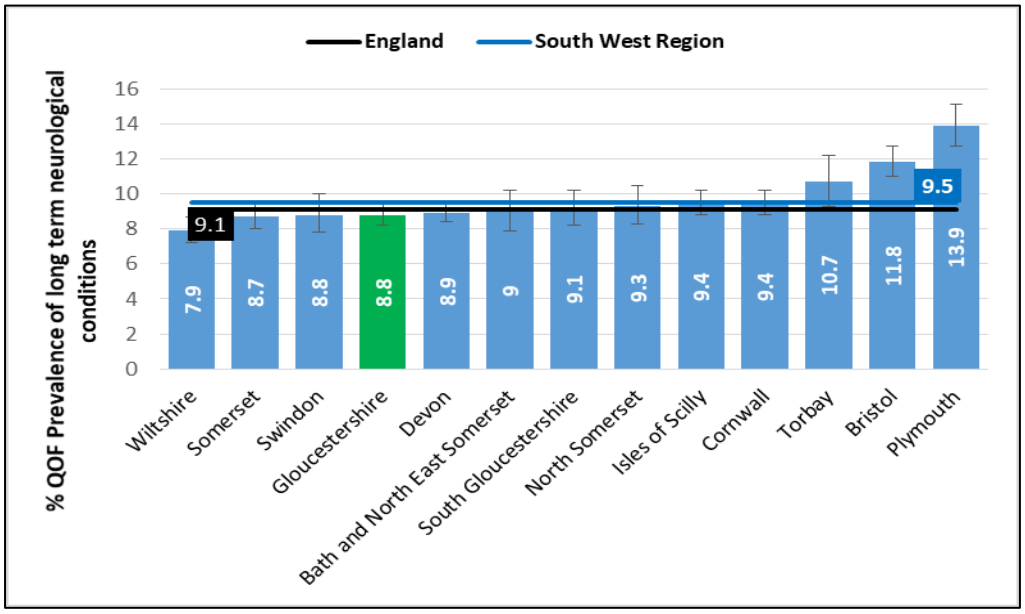
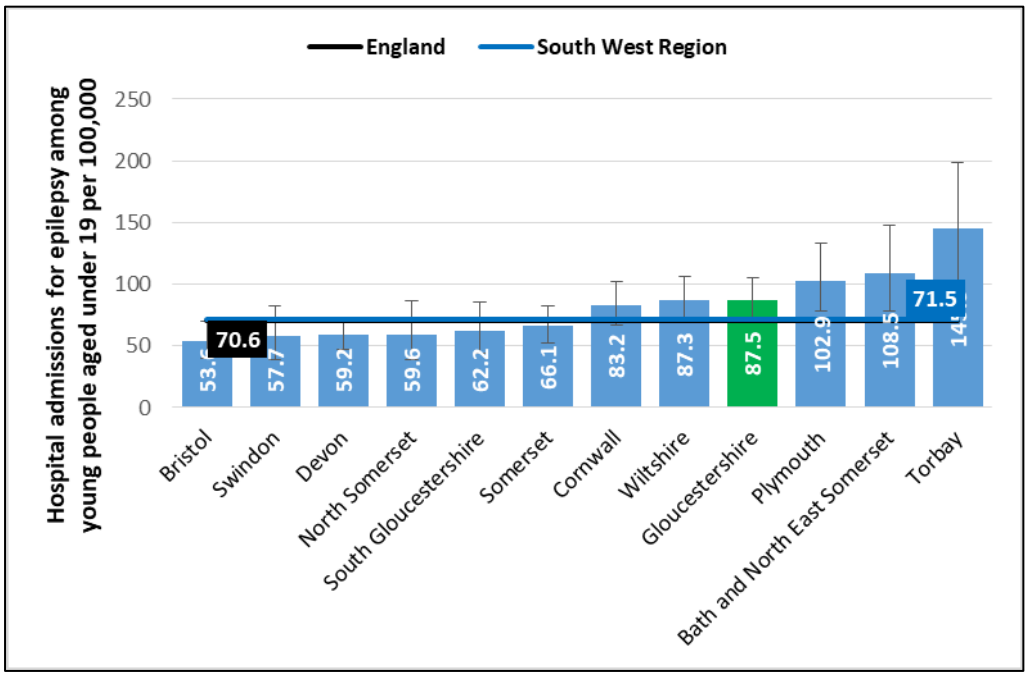


Figure 28: Graph the rate of hospital admissions for epilepsy among under 19s per 100,000 in local authorities in South West compared to regional and national averages, 2016/17



HIA summary for Neurological Conditions

In total for all those who responded to the consultation survey across all patient cohorts, there were more respondents from the East, approx. 230 respondents compared to the West of the county where there were approx. 175 respondents.

Model	Scale of Potential impact	Evidence of Potential Impact	Consultation Outputs	Impacts from Consultation	Nature of Potential Impact and recommendations
A3 - Centralise acute medicine to GRH B2 - IGIS hub and vascular centralised to GRH C3 - EGS centralised to GRH C11 - GI day cases to CGH C5 - Elective colorectal to CGH C6 - Elective colorectal to GRH	**Moderate scale Impact:** The prevalence of neurological conditions among the registered population is similar in Gloucestershire compared with the South West Region and National rates at 8.8%. The rate of hospital admissions for epilepsy among under 19s is 87.5 per 100,000; this is statistically similar to the South West regional average (71.5) but statistically higher than the national average (70.6) by a small margin. Over the period between April 2018 and March 2019, there was a total of 1,042 neurology patents seen at GRH and 644 (62%) of these patients lived closer to GRH than CGH thus if services were to be moved from GRH to CGH, this cohort is most likely to be impacted.	**Long Term Impact** According to the NHS & CQC 2017 Adult Inpatient Survey, Patients with neurological conditions reported poorer experiences for confidence and trust, respect and dignity, respect for patient-centred values and overall experience of care. In response to the NHS 2016 patient experience survey, just 41% (n=2,132) of patients described the health services they received for their neurological condition as 'good' or 'excellent'.[55] The 2013-14 NHS England survey of patients of GP practices found that people with long-term neurological conditions have the lowest health-related quality of life of any long-term condition.[56]	81 respondents with Long term conditions responded to questions regarding these care models.	73% of those with a long term condition supported acute medicine centralised to GRH. 69% of those with a long term condition supported EGS centralised to GRH and 10% had no opinion. 84% of those with a long term condition supported the centralisation of elective colorectal. 48% felt it should be at CGH. 74% of those with a long term condition supported GI day case at CGH. 73% of those with a long term condition supported and IGIS Hub with the spoke at CGH and 52% supported vascular surgery at GRH with 30% having no opinion. Feedback regarding colorectal raised concerns regarding transfers of very unwell patients and the time required for transfer impacting on patient outcomes. Feedback also expressed concerns around the impact centralising acute medicine will have on the A&E offer at CGH.	

[55] The Neurological Alliance (2017): Falling short: How has neurology patient experience changed since 2014? Available online at http://www.neural.org.uk/store/assets/files/668/original/Neurological_Alliance__Falling_Short_-_How_has_neurology_patient_experience_changed_since_2014.pdf

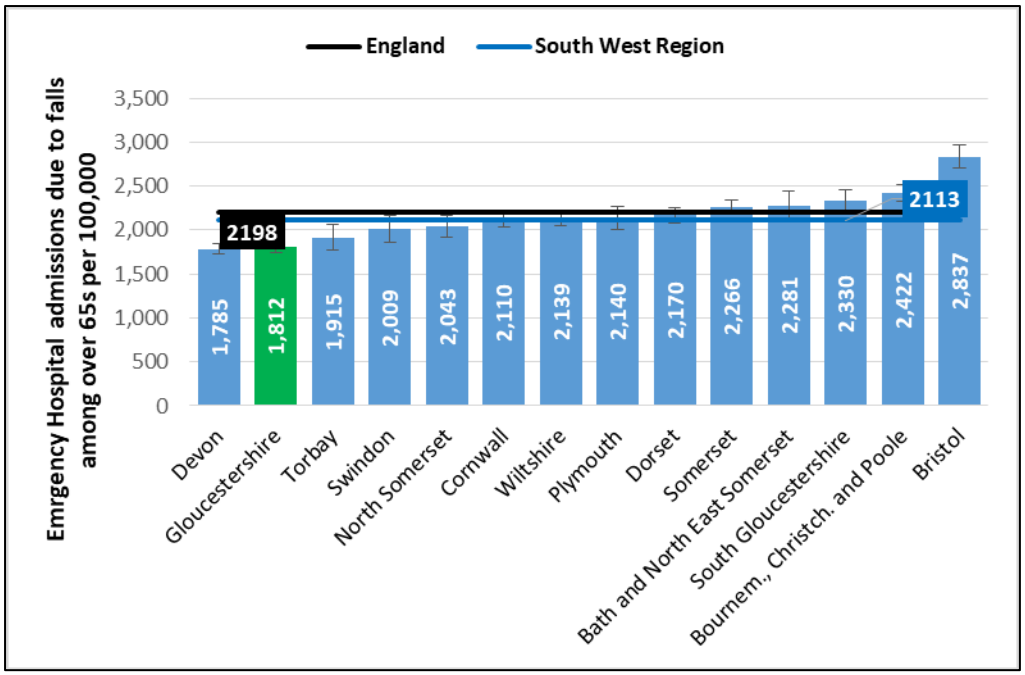
[56] The Neurological Alliance (2017): Falling short: How has neurology patient experience changed since 2014? Available online at http://www.neural.org.uk/store/assets/files/668/original/Neurological_Alliance__Falling_Short_-_How_has_neurology_patient_experience_changed_since_2014.pdf

7.5. Falls among the elderly

A rapidly ageing population means that doctors in all specialties are likely to encounter older people with falls. Falls in the elderly are common and associated with major morbidity and mortality. Falls cause injuries, fractures, loss of confidence and independence, depression and death. Recurrent falls and fear of falling are the most common reasons for an older person to require nursing home care. An initial fall may be a manifestation of an acute illness and may be the only presenting feature. However, it is known that an index fall is a risk for future falls and approximately half of those who fall once are likely to do so again.[57]

The rate of emergency hospital admissions due to falls among those aged over 65 per 100,000 in Gloucestershire is among the lowest in the South West region; a rate of 1,812 per 100,000 at Gloucestershire makes it significantly lower than both regional and national averages.

Figure 29: Graph the rate of emergency hospital admissions due to falls among over 65s per 100,000 in local authorities in South West compared to regional and national averages, 2018/19



[57] https://www.rcpe.ac.uk/sites/default/files/anderson.pdf

HIA summary for falls among the elderly

In total for all those who responded to the consultation survey across all patient cohorts, there were more respondents from the East, approx. 230 respondents compared to the West of the county where there were approx. 175 respondents.

Model	Scale of Potential impact	Evidence of Potential Impact	Consultation Outputs	Impacts from Consultation	Nature of Potential Impact and recommendations
A3 - Centralise acute medicine to GRH B2 - IGIS hub and vascular centralised to GRH C3 - EGS centralised	**Large Scale Impact:** The rate of emergency hospital admissions due to falls among those aged over 65 per 100,000 in Gloucestershire is among the lowest in the South West region; a rate of 1,812 per 100,000 at Gloucestershire makes it significantly lower than both regional and national averages.	**Long Term Impact** Falls cause injuries, fractures, loss of confidence and independence, depression and death. Recurrent falls and fear of falling are the most common reasons for an older person to require nursing home care. An initial fall may be a manifestation of an acute illness and may be the only presenting feature. However, it is known that an index fall is a risk for future falls and approximately half of those who fall once are likely to do so again.[58] This cohort focuses on those aged over 65; see "Age" section of the EQIA (pages 5-10). Although it is to be noted that this cohort is a particularly vulnerable subset of the elderly population, hence more provision of care needs to be given.	58 people over the age of 65 with a disability answered questions regarding these care models.	69% of those over 65 with a disability supported the centralisation of acute medicine 60% of those over 65 with a disability supported EGS at GRH and 21% strongly opposed this. 83% of those over 65 with a disability supported the centralisation of elective colorectal, 52% supporting it at CGH and 29% with no opinion. 73% of those over 65 with a disability supported GI day case at CGH. 75% of those over 65 with a disability supported the IGIS hub and spoke model with spoke at CGH, 58% supported vascular surgery at GRH and 21% had no opinion. Respondents in support commented on the location being less important if the care is "excellent". Some respondents had concerns around the transfer of patients in an emergency to GRH from CGH. Travelling around the county was also a	**Overall Impact: Positive** **Positive Impact** Patients who fall regularly are likely to be a cohort impacted by the proposed changes as they will likely attend hospital more than other cohorts in the population. 1,812 people per 100,000 in Gloucestershire are admitted to hospital due to falls. This cohort may benefit from the centralisation of services in the same way as over 65s because frailty correlates with age, see "Age" section of the EQIA (pages 5-10). It is recommended to engage through existing forums with patients Or via representative organisations for frailty and falls. It is recommended to conduct some analysis to understand the travel offer in the area and how vulnerable patients can be supported in this. It is also recommended to consider this cohort have concerns around the centralisation of emergency care and the separation from elective care e.g. in the case of colorectal patients. Another option may need to be considered for more high risk colorectal patients.

[58] https://www.rcpe.ac.uk/sites/default/files/anderson.pdf

to GRH				concern for some.	
C11 - GI day cases to CGH					
C5 - Elective colorectal to CGH					
C6 - Elective colorectal to GRH					

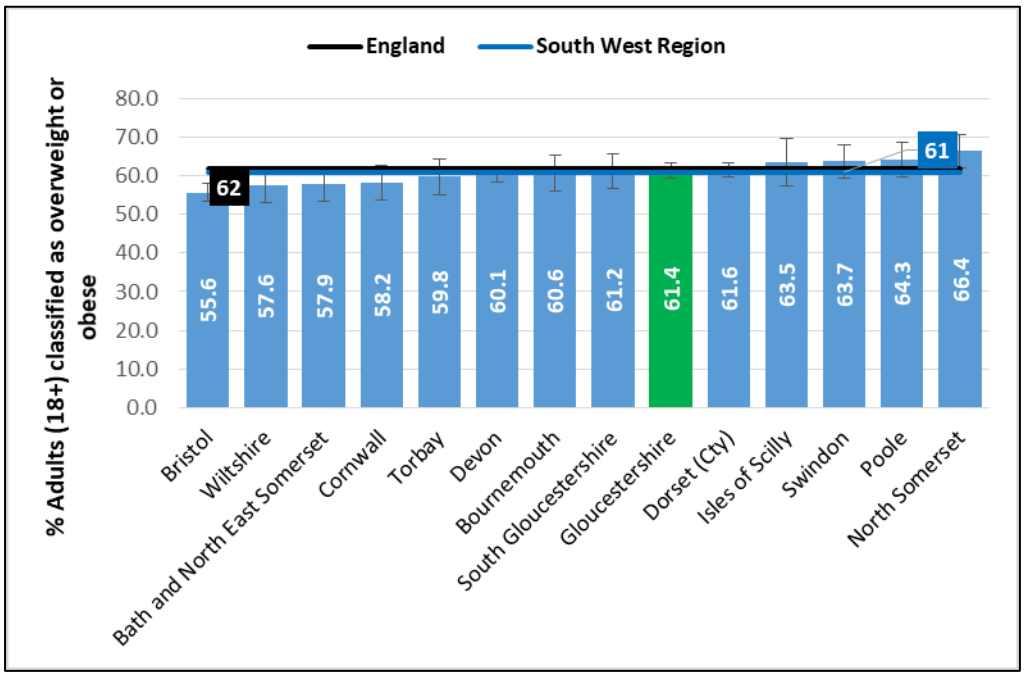
7.6. Overweight or Obese

Excess weight and obesity is a risk factor for various health conditions, including type 2 diabetes, high blood pressure, cardiovascular disease, fatty liver disease, various cancers and kidney disease.[59]

Overweight and obese individuals are less likely to access healthcare and are less likely to receive evidence-based and bias-free healthcare when they do engage according to various studies.[60][61][62]

The prevalence of overweight and obesity in Gloucestershire if 61.4%; this is similar to both regional and national rates.

Figure 30: Prevalence of overweight and obese among the population aged 18 and over in local authorities in South West compared to regional and national averages, 2018/19



[59] https://www.niddk.nih.gov/health-information/weight-management/health-risks-overweight

[60] Aldrich T., Hackley B. (2010). The impact of obesity on gynecologic cancer screening: an integrative literature review. J Midwifery Womens Health 55, 344–356. 10.1016/j.jmwh.2009.10.001 [PubMed] [CrossRef] [Google Scholar]

[61] Forhan M., Salas X. R. (2013). Inequities in healthcare: a review of bias and discrimination in obesity treatment. Can. J. Diabetes 37, 205–209. 10.1016/j.jcjd.2013.03.362 [PubMed] [CrossRef] [Google Scholar]

[62] Phelan S. M., Burgess D. J., Yeazel M. W., Hellerstedt W. L., Griffin J. M., van Ryn M. (2015). Impact of weight bias and stigma on quality of care and outcomes for patients with obesity. Obes. Rev. 16, 319–326. 10.1111/obr.12266 [PMC free article] [PubMed] [CrossRef] [Google Scholar]

HIA summary for Overweight and Obesity

In total for all those who responded to the consultation survey across all patient cohorts, there were more respondents from the East, approx. 230 respondents compared to the West of the county where there were approx. 175 respondents.

Model	Scale of Potential impact	Evidence of Potential Impact	Consultation Outputs	Impacts from Consultation	Nature of Potential Impact and recommendations
A3 - Centralise acute medicine to GRH B2 - IGIS hub and vascular centralised to GRH C3 - EGS centralised to GRH C11 - GI day cases to CGH C5 - Elective colorectal to CGH C6 - Elective colorectal to GRH	**Large Scale Impact:** The prevalence of overweight and obesity in Gloucestershire is61.4%; this is similar to both regional and national rates.	**Long Term Impact** Research suggests statistically significant associations for overweight with the incidence of type II diabetes, cancer, cardiovascular diseases asthma, gallbladder disease, osteoarthritis and chronic back pain[63]. Overweight and obese individuals are less likely to access healthcare and are less likely to receive evidence-based and bias-free healthcare when they do engage according to studies.[646566] Evidence suggests that this cohort may face challenges and perceived challenges in access to services in general and also are at a higher risk of mobility related barriers.[67]	81 respondents with Long term conditions responded to questions regarding these care models.	73% of those with a long term condition supported acute medicine centralised to GRH. 69% of those with a long term condition supported EGS centralised to GRH and 10% had no opinion. 84% of those with a long term condition supported the centralisation of elective colorectal. 48% felt it should be at CGH. 74% of those with a long term condition supported GI day case at CGH. 73% of those with a long term condition supported and IGIS Hub with the spoke at CGH and 52%	**Overall Impact: positive** Obesity is often linked to a large number of co-morbidities which mean obese patients are more likely to be impacted by the proposed changes. The movement of services could result in specialist care being provided in one place leading to a better quality of care. It is recommended to engage through existing forums with patients Or via representative organisations.

[63] Guh, D.P., Zhang, W., Bansback, N. *et al.* The incidence of co-morbidities related to obesity and overweight: A systematic review and meta-analysis. *BMC Public Health* **9,** 88 (2009). https://doi.org/10.1186/1471-2458-9-88

[64] Aldrich T., Hackley B. (2010). The impact of obesity on gynecologic cancer screening: an integrative literature review. J Midwifery Womens Health 55, 344–356. 10.1016/j.jmwh.2009.10.001 [PubMed] [CrossRef] [Google Scholar]

[65] Forhan M., Salas X. R. (2013). Inequities in healthcare: a review of bias and discrimination in obesity treatment. Can. J. Diabetes 37, 205–209. 10.1016/j.jcjd.2013.03.362 [PubMed] [CrossRef] [Google Scholar]

[66] Phelan S. M., Burgess D. J., Yeazel M. W., Hellerstedt W. L., Griffin J. M., van Ryn M. (2015). Impact of weight bias and stigma on quality of care and outcomes for patients with obesity. Obes. Rev. 16, 319–326. 10.1111/obr.12266 [PMC free article] [PubMed] [CrossRef] [Google Scholar]

[67] https://www.ncbi.nlm.nih.gov/pubmed/20059707

				supported vascular surgery at GRH with 30% having no opinion. Feedback regarding colorectal raised concerns regarding transfers of very unwell patients and the time required for transfer impacting on patient outcomes. Feedback also expressed concerns around the impact centralising acute medicine will have on the A&E offer at CGH.	

Appendix 14b: Integrated Impact Assessment
Inpatient Gastroenterology and Trauma and Orthopaedics

1. Introduction

A key commitment for the Fit for the Future programme is to deliver the requirements for Service Change as set out in Delivering Service Change for Patients (NHS England, 2018). An important component of this is delivery of an Integrated Impact Assessment (IIA) on proposed solutions. This document contains the analysis conducted to determine the impacts of the two pilot studies which have been evaluated as successful, so our approach to the IIA is to assess the impact of these pilots being reversed; these are.

- In October 2017 Trauma was centralised to Gloucestershire Royal Hospital and elective Orthopaedics to Cheltenham General Hospital.
- In November 2018, Gastroenterology inpatient services were centralised to Cheltenham General Hospital

This report is to be read in conjunction with Annex II (Appendix 14a) prepared by the Strategy Unit at NHS Mid and South Essex University Hospitals Group.

Contents

2. Impact Assessment Key Findings

2.1 Positive Impacts

Gastroenterology

The majority of gastroenterology patients are in the 18 to 64 year age range. However, there are a number of patients with identified needs. With 25% of Gloucester city population living in deprived areas and the rates of homelessness being slightly greater in Gloucester it was important to ensure that access to the service was equitable. Although the inpatient ward is currently based at Cheltenham General Hospital there is full access to gastroenterology services at GRH; with 7 day per week emergency endoscopy provision and a rostered gastrointestinal consultant and registrar at Gloucestershire Royal Hospital to assess patients who are referred either from ED or other specialist areas ensuring the same level of emergency care are available at both sites.

Outpatient clinics are unaffected and will be maintained at Cheltenham General, Gloucestershire Royal and Community Hospitals creating no impact on travel times.

Trauma & Orthopaedics

25% of Gloucestershire city population are living in deprived areas, approximately 32,000 people. Therefore, centralising trauma (emergency orthopaedics) to Gloucestershire Royal Hospital provides improved access to the right specialists to manage the care of this higher risk community.

Rates of homelessness are slightly higher in Gloucester than surrounding areas; this group have a significant requirement for trauma services.

As part of the initiative a trauma triage service was set up. This means that anyone who comes into the Emergency Department at Cheltenham General Hospital, Gloucestershire Royal Hospital or any of the Minor Injury Units will have an independent review of their case notes and X-rays by a senior orthopaedic surgeon, 7 days a week. This enables the service to prioritise those requiring immediate treatment. Those that do not need to attend the hospital again are contacted by Advanced Nurse Practitioners to give advice by telephone. This prevents unnecessary journeys to hospital which is especially helpful for the elderly or those with physical disability or learning difficulty.

Despite some patients from the west of the county having to travel further for elective (planned) orthopaedic surgery the move of elective care to Cheltenham General Hospital has enabled the provision of ring-fenced wards with 80% lower chance of cancellation due to emergency trauma patients requiring the attention of specialist staff.

The way the inpatient beds are organised now (in the pilot) includes 17 single rooms at Cheltenham General Hospital and 18 at Gloucestershire Royal Hospital which gives flexibility to maintain privacy and dignity, allowing segregation of gender and availability of single rooms for those with learning disabilities etc.

Outpatient clinics are unaffected and will be maintained at Cheltenham General, Gloucestershire Royal and Community Hospitals creating no impact on travel times.

2.2 Negative Impacts

During the period of the pilot the impact of the change has been monitored and where necessary mitigations have been put in place to address negative impacts identified.

Gastroenterology

There are some patients who will attend Gloucestershire Royal Hospital who may require a longer stay and therefore need to transfer to Cheltenham General Hospital for admission. There is a process in place to transport these patients.

There are some patients with long term conditions that may need multiple admissions and some of these will live in the west of the county requiring a longer journey. However the dedicated ward environment, specialist team and improved outcomes resulting from care provided by the specialist team mitigates the additional journey time.

Trauma & Orthopaedics

There are some patients who attend A&E at Cheltenham General Hospital who may need to transfer to Gloucestershire Royal Hospital for admission. This has been mitigated by working with the Ambulance Service to ensure that patients who are likely to require admission are taken directly to Gloucestershire Royal Hospital. Senior orthopaedic doctor input is available for patients in A&E at both Cheltenham General and Gloucestershire Royal Hospitals and there is a process in place to transfer patients who require admission.

Not all elective (planned) orthopaedic surgery is undertaken at Cheltenham Hospital due to theatre capacity constraints. The planned services that remain at Gloucestershire Royal Hospital are those with the strongest clinical links to trauma e.g. spinal services. A ring-fenced separate ward area has been created at Gloucestershire Royal Hospital which included a £200,000 estates renovation.

3. Equality Impact Assessment (EQIA)

3.1 Age

By 2040 the proportion of people in the county who are aged 65 or over will rise from 20.8% to 28.9% and the proportion of people aged 85 or over will rise from 2.9% to 5.5%. Population projections in the older age categories far exceed national averages.

EQIA Summary for Age

Proposed Change	Scale of Potential impact	Evidence of Potential Impact and duration	Potential Impact if changes reversed
Formalise Gastroenterology Pilot	**Long term Impact** 1135 people are admitted per year for gastroenterology treatment only 8 are age 17 or under. 588 are aged 18-64 years and 544 are over the age of 65 years. It is recognised that those at the upper end of this age band may use adult services. Broadly speaking, older people are more likely to have underlying long term health conditions, more likely to attend A&E and are more likely to be admitted to acute care than younger people. As a result older people may benefit disproportionately from an improved service. However, previous engagement work has suggested that older people tend to raise transport and access issues more often than younger people so concentrating services on one site may impact this group more	**Overall Impact : Positive** **Large Positive Impact** Centralising gastroenterology enhances patient safety, improve outcomes and reduce LOS as it allows for more patients to be seen by a senior reviewer which is associated with increased patient discharges and improved clinical outcomes. **Potential Small Negative Impact** Prior to the changes it was thought that Patients over 65 may need further support to access services in the new location if their journey becomes longer and they are less familiar with the centralised location. However, this has not been raised in the patient feedback.	**Overall Impact : Negative** **Large Negative Impact** Centralising gastroenterology enhances patient safety, improve outcomes and reduce LOS as it allows for more patients to be seen by a senior reviewer with increased patient discharges and improved clinical outcomes. **Small Positive Impact** Patients over 65 may need further support to access services in the new location if their journey becomes longer and they are less familiar with the centralised location. However this has not been demonstrated

Formalise Trauma & Orthopaedic Pilot	8248 people are admitted per year for treatment within the Trauma and Orthopaedic service 489 are age 17 or under. 3866 are aged 18-64 years and 3894 are over the age of 65 years. Within the Trauma and Orthopaedic services there are two groups of elderly patients who use the service. Those are the patients who suffer from deteriorating conditions i.e. arthritis and require planned joint replacement and those who sustain injury associated with frailty for example fractured neck of femur. While the service under discussion is an adult service with the paediatric services remaining unchanged and therefore the 0-19 age group will NOT use these services, it is recognised that those at the upper end of this age band may use adult services. Broadly speaking, older people are more likely to have underlying long term health conditions, more likely to attend A&E and are more likely to be admitted to acute care than younger people. As a result older people may benefit disproportionately from an improved service. However, previous engagement work has suggested that older people tend to raise transport and access issues more often than younger people so concentrating services on one site may impact this group more	**Overall Impact : Positive** **Large Positive Impact** Centralising elective orthopaedic services to CGH enhances patient safety, improve outcomes and reduce LOS. Centralising trauma to GRH: Hip fractures are managed by the trauma service now based at Gloucestershire Royal Hospital during the pilot. These patients almost always arrive by ambulance straight to Gloucestershire Royal Hospital where there is a specialist ward staffed with both orthopaedic and care of the elderly specialist doctors and a team of highly specialised nursing and therapy staff in a ward with a therapy room and modifications for those with dementia. **Potential Small Negative Impact** Prior to the changes it was thought that Patients over 65 may need further support to access services in the new location if their journey becomes longer and they are less familiar with the centralised location. However, this has not been raised in the patient feedback.	**Overall Impact : Negative** **Large Negative Impact** Decentralising planned orthopaedic services will lead to increased cancellations and poorer outcomes. For trauma services there would not be a centralised service to provide timely surgical provision **Small Positive Impact** Patients over 65 may find it easier to attend for surgery nearer to home. Although it should be noted that outpatient care remains unchanged, including community sites.

3.2 Disability

Dementia, learning disabilities and physical disabilities have all been considered under this category.

Learning Disabilities: Estimated projections suggest that in 2019 there will be approximately 11,825 people aged 18+ living with a learning disability in Gloucestershire equating to 2.3% of the adult population. Of this group, about 2,400 are estimated to have moderate or severe learning disabilities, equating to 0.5% of the adult population.

Disabilities: According to the 2011 Census, 16.7% of Gloucestershire residents reported having a long term limiting health problem or disability. At a household level, 24.2% of households had at least one person with a long-term limiting health problem or disability.

Dementia: Only 12% of people with dementia have no comorbidities. 40% have 1-2 and 48% have 3 and a quarter of hospitals beds are occupied by patients with dementia over the age of 65.

Sensory Impairment: A sensory impairment is something that affects your hearing, vision or both your hearing and vision. Most people accessing support because of a sensory impairment are over 55 years and population projections suggest this will increase. They often experience multiple long term conditions which can impact on accessing health care services. Several services are on offer to sensory impaired people in the county including Gloucestershire Deaf Association who provide British Sign Language (BSL) Interpreters in our health care settings.

EQIA summary for Disability

Proposed Change	Scale of Potential impact	Evidence of Potential Impact and duration	Potential Impact if changes reversed
Formalise Gastroenterology Pilot	**Long term Impact** Forest of Dean is the only district locally that exceeds the national average in terms of the proportion of residents living with a disability. People with disabilities may have an increased risk of developing secondary conditions that are more likely to result in the need for acute care. Evidence shows that people with learning disabilities have poorer health than the general population, much of which is avoidable, and that the impact of these health inequalities is serious; people with learning disabilities are three times as likely as people in the general population to have a death classified as potentially avoidable through the provision of good quality healthcare. Men with learning disabilities die on average 13-20 years younger than men in the general population and women with learning disabilities die on average 20-26 years younger than women in the general population. These inequalities result to an extent from the barriers which people with learning disabilities face in accessing health care. Studies suggest that people with a disability are also more likely on average to have negative experiences of using acute hospital services due to a	**Overall Impact : Positive** **Large Positive Impact** Centralising gastroenterology enhances patient safety, improve outcomes and reduce LOS as it allows for more patients to be seen by a senior reviewer which is associated with increased patient discharges and improved clinical outcomes. **Small Negative Impact** Patients with disabilities need to travel further for inpatient admission although this has not been raised in patient feedback.	**Overall Impact : Negative** **Large Negative Impact** Reversal of the changes will lead to a poorer service for all patients including those with disabilities, with deteriorating patient outcomes and greater LOS. **Small positive Impact** Patients with disabilities may find it easier to have inpatient care nearer to home

Formalise Trauma & Orthopaedic Pilot	perceived lack of understanding and sensitivity to their disability, and generally "being treated differently". For example, in a recent national survey, 33% of A&E patients with a mental health condition and 31% with a learning disability said they were not reassured by staff when distressed. This is compared with 21% of A&E patients without a disability. Communication issues have also been highlighted particularly for people with a sensory disability. For example, in a survey of deaf people in Manchester, nearly half (46%) had considered complaining about their experience in A&E, with communication difficulties being the main reason. Providing services from a calmer, site with a shorter overall length of stay may well benefit those with disabilities as they may be more affected by such factors than the general population. Overall, given the evidence around increased need in this population, it is possible that people will disabilities will benefit more from an improved service with faster access to specialists and a more streamlined provision than the general population. However, if modifications around adequate access and/or staff's understanding of the diverse needs of this group are not met then this section of the population could be disadvantaged. In addition, moving services to Cheltenham is further from the Forest of Dean where the highest proportion of those with disabilities lives. This represents a potential dis-benefit if not mitigated	**Overall Impact : Positive** **Large Positive Impact** Centralising trauma and orthopaedics enhances patient safety for all patients. The current 17 single rooms at Cheltenham General Hospital and 18 at Gloucestershire Royal Hospital which gives flexibility to maintain privacy and dignity, allowing availability of single rooms for those with learning disabilities etc. **Small Negative Impact** Patients with disabilities need to travel further for inpatient admission although this has not been raised in patient feedback.	**Overall Impact : Negative** **Large Negative Impact** Reversal of the changes will lead to a poorer service for all patients including those with disabilities and the bed configuration may need to change. **Small positive Impact** Patients with disabilities may find it easier to have inpatient care nearer to home

3.3 Gender

The sex of an individual, combined with additional factors such as living alone, may affect their health and social care needs. Individuals may also experience discrimination and inequalities because of their sex. A report by the European Social Survey found 24% of respondents had experienced prejudice based on their sex. Discrimination on the grounds of sex was reported by more respondents than discrimination based on ethnicity.

The overall population split by sex in Gloucestershire is slightly skewed towards females, with males making up 49.1% of the population and females accounting for 50.9%. In Gloucestershire in 2017, 52.9% of people aged 65-84 were female, whilst for people aged 85+ the difference was more marked with females accounting for 64.6% of the total population. This situation is also reflected at district, regional and national level. As a result of this, 71% of single pensioner households are shown to be headed by a woman. It is worth highlighting that women were more likely than men to be living in a household without access to a car.

EQIA Assessment for gender:

Proposed Change	Scale of Potential impact	Evidence of Potential Impact and duration	Potential Impact if changes reversed
Formalise Gastroenterology Pilot	**Long term Impact** There is no conclusive evidence to suggest that access to and experience of acute hospital care differs solely on the basis of a person's sex. While there are slightly more women in the population, men are marginally more likely to require unplanned care and so overall the effect is likely to be neutral. In terms of staff impact nursing staff is more likely to be female so centralisation on CGH site may have impact on family commitments. The gastroenterology service admits 1135 patients a year of which 517 (45.6%) are female and 544 (54.4%) are male.	**Overall Impact :** There have not been any impacts identified specific to gender within this service	**Overall Impact :** There have not been any impacts identified specific to gender within this service

Formalise Trauma & Orthopaedic Pilot	**Long term Impact** As part of the centralisation of trauma and Orthopaedic inpatients there will be an increase at CGH from GRH. There is no conclusive evidence to suggest that access to and experience of acute hospital care differs solely on the basis of a person's sex. While there are slightly more women in the population, men are marginally more likely to require unplanned care. In terms of staff impact nursing staff is more likely to be female so centralisation on CGH site may have impact on family commitments The trauma and orthopaedic service service admits 8248 patients a year of which 4418 (53.5%) are female and 3830 (46.5%) are male.	**Overall Impact : Positive** **Positive Impact** Centralising trauma and orthopaedics enhances patient safety for all patients. The current bed configuration is 17 single rooms at Cheltenham General Hospital and 18 at Gloucestershire Royal Hospital which gives flexibility to maintain privacy and dignity, allowing segregation of gender	**Overall Impact : Negative** **Negative Impact** Reversal of the changes will lead to a poorer service for all patients and the possibility that the bed configuration may change.

3.4 Pregnancy

The Equality Act protects women who are pregnant, have given birth in the last 26 weeks (non-work context) or are on maternity leave (work context) against discrimination in relation to their pregnancy.

There were 6,739 live births in Gloucestershire in 2016. The highest proportions of deliveries were to women aged 30 to 34 continuing the trend of later motherhood. Births to mothers aged 25-29 and 30-34 account for a slightly higher proportion of total births in Gloucestershire than they do nationally, whilst those to mothers aged under 25 accounts for a slightly lower proportion.

At district level, Gloucester and the Forest of Dean have a higher proportion of births to mothers aged under 20 (4.0% and 3.6% respectively) than Gloucestershire and England. Cheltenham, Cotswold and Stroud have a higher proportion of births to mothers aged 35+ than Gloucestershire and England.

EQIA Assessment for Pregnancy

Proposed Change	Scale of Potential impact	Evidence of Potential Impact and duration	Potential Impact if changes reversed
Formalise Gastroenterology Pilot	There are no changes to current pregnancy, maternity or neonatal services. There is no identified evidence to indicate that pregnant women and mothers of new-born children have disproportionate of differential needs in relation to acute hospital services. However, the majority of inpatient gastroenterology services will now be located on the opposite site to the obstetrics and paediatrics service. It is envisaged that the hot consultant cover will be able to provide specialist input to any obstetric/maternity patients on the GRH site to ensure they are not disadvantaged.	**Overall Impact : Positive** **Large Positive Impact** Centralising gastroenterology enhances patient safety, improve outcomes and reduce LOS as it allows for more patients to be seen by a senior reviewer which is associated with increased patient discharges and improved clinical outcomes. **Small Negative Impact** There will be a negligible impact on those who have recently given birth	**Overall Impact : Negative** **Large Negative Impact** Changing the service back would decrease patient safety, improve outcomes and reduce LOS. **Small Negative Impact** There will be a negligible impact on those who have recently given birth

Formalise Trauma & Orthopaedic Pilot	There are no changes to current pregnancy, maternity or neonatal services. There is no identified evidence to indicate that pregnant women and mothers of new-born children have disproportionate of differential needs in relation to trauma and orthopaedic services.	**Overall Impact** **Large Positive Impact** Elective surgery is planned and therefore patients who have given birth in the last 26 weeks who require orthopaedic admission at CGH have time to organise the resources required. It is far more likely that someone in this category may sustain trauma and require admission to GRH. This is significantly positive as all Women's and Children's services are located on this site.	**Overall Impact : Negative** **Large Negative Impact** Changing the service back would decrease patient safety, improve outcomes and reduce LOS. For trauma patients it would separate this patient group from on-site Women's and Children's facilities

3.5 Marital status

According to the latest data from the ONS, the majority (50.6%) of the population in England and Wales aged 16 and over in 2015 were married and this is similar in Gloucestershire. The next largest group within the population were single, never married or civil partnered (34.5%). The population who were divorced or widowed made up a smaller proportion of the total population at 8.1% and 6.5% respectively. The smallest group within the population were those who were civil partnered, making up 0.2% of the population aged 16 and over in 2015.

EQIA Assessment for Marital Status:

Proposed Change	Scale of Potential impact	Evidence of Potential Impact and duration	Potential Impact if changes reversed
Formalise Gastroenterology Pilot Formalise Trauma & Orthopaedic Pilot	**Long term Impact** This protected characteristic applies to workforce matters. Geographical distribution of people with the varied characteristics is not known at small area scale. It is not envisaged that centralisation of services will have an impact	**Overall Impact : Neutral** There is currently limited data to ascertain any impact of the changes for those who are from any particular marital status.	**Overall Impact : Neutral** There is currently limited data to ascertain any impact of the changes for those who are from any particular marital status.

3.6 Ethnicity

The prevalence of ethnic minorities in Gloucestershire is lower than national averages at 4.6% of the population from Black and Minority Ethnic (BME) backgrounds; this figure increased to 8.4% when the Irish, Gypsy or Irish Traveller and 'other White' categories were included.

Based on data, from the Gloucestershire county council population profile, amongst people aged 65 and over, 58.5% of Asian/Asian British people and 56.7% of Black African/Caribbean/Black British people had a long-term health problem/disability compared with 48.9% of White British people. Amongst the Gloucestershire population of all ages, people of Gypsy or Irish Traveller origin were much more likely to be in poor health than other ethnic groups (15.9% of Gypsy/Irish Travellers compared with 4.6% of White British people).

EQIA Assessment for Ethnicity:

Proposed Change	Scale of Potential impact	Evidence of Potential Impact and duration	Potential Impact if changes reversed
Formalise Gastroenterology Pilot and Formalise Trauma & Orthopaedic Pilot	**Long term Impact** Studies of secondary care usage have found that ethnicity is a significant predictor of acute hospital admission with BAME group's overall being more likely to access emergency services than the general population. Previous national surveys show higher levels of dissatisfaction with NHS services amongst some minority ethnic groups. Patients from Pakistani, Indian and Bangladeshi backgrounds report poorer experiences than patients from other white and BAME groups. In addition, cultural factors can mediate access to acute hospital care. Nationally, it has been reported that minority ethnic communities may have poor access to health services for reasons including language barriers, lack of culturally sensitive services and negative attitudes about communities. Conversely there is also evidence of how some members of BAME groups, particularly recent migrants, may be disproportionately more likely to access acute hospital services, owing to a lack of awareness of local primary care provision. For example, recent research by Dudley CCG highlighted that a disproportionately high proportion of BAME attendees at A&E were not registered with a local GP and so had no other access route	**Overall Impact : Positive Large Positive Impact** Centralised services ensure the best quality care is made available to patients and will benefit patients with complex or long term needs, which correlates with some BME patient cohorts. The co-location of relevant specialist services improves training and enhanced understanding of patient conditions, leading to better clinical outcomes and improving access to services with fewer cancellations.	**Overall Impact : Negative** **Large Negative Impact** Reversing the centralisation of services would negatively impact patient safety, improve outcomes and LOS

	to health services. The district with the highest proportion of BAME residents is Gloucester meaning that travel distances to specialist services are likely be longer for this group. However, recent CCG engagement has suggested seeing the right specialist is more important to people than where they see them. Overall, improvements to services configuration and delivery may therefore have a disproportionate benefit to BAME communities due to a higher service usage and the facts they may be more negatively impacted by current service design issues.		

3.7 Sexual orientation

People who are lesbian, gay or bisexual (LGB) are more likely to have experienced depression or anxiety, attempted suicide or had suicidal thoughts and self-harmed than men and women in general[1]. LGB population aged over 55 are more likely than heterosexual people over 55 to live alone and are more likely than heterosexual people to say that they expect to rely on health and social care providers as they get older. The prevalence of the LGB population in Gloucestershire is estimated to be around 5% - 7%[2].

Proposed Change	Scale of Potential impact	Evidence of Potential Impact and duration	Potential Impact if changes reversed
Formalise Gastroenterology Pilot and Formalise Trauma & Orthopaedic Pilot	**Long Term Impact - Neutral** The LGBTQ+ community is estimated to form 5% - 7% of the Gloucestershire population. A major recent UK survey found that this group on average report poorer levels of general health. Research into this group's experiences of accessing healthcare indicates that they have more negative experiences, on average, than heterosexual patients and may also face specific challenges associated with disclosing their sexuality and being visited by friends and same-sex partners in healthcare settings. One of the few studies to have included findings specifically on this group's experiences of acute hospital services highlighted instances of discrimination and reported that 70% of gay and bi men felt they were treated with respect and dignity in A&E compared to 78% of the general population. The absence of current data makes the impact hard to assess although based on current findings a reduced length of stay may have a disproportionately beneficial impact on this group.	**Overall Impact – Neutral** According to the Stonewall survey, 13% of LGBTQ+ people have experienced some form of unequal treatment from healthcare staff because they are LGBTQ+ and 23% have witnessed it. This includes 32% of trans people and 24% of Asian LGBTQ+ people who have experienced unequal treatment. We anticipate that changes to this patient group would be negligible.	**Overall Impact: Neutral** We anticipate that changes to this patient group would be negligible.

[1] Stonewall, 2015, Mental Health, Stonewall health briefing http://www.stonewall.org.uk/sites/default/files/Mental_Health_Stonewall_Health_Briefing__2012_.pdf Accessed 18/12/2017
Stonewall, 2011, Lesbian, Gay and Bisexual People in Later Life. www.stonewall.org.uk/sites/default/files/LGB_people_in_Later_Life__2011_.pdf Accessed 18/12/201
[2] https://inform.gloucestershire.gov.uk/media/2087689/equality-profile-2019-final.pdf

3.8 Religion

According to the 2011 Census, 63.5% of residents in Gloucestershire were Christian, making it the most common religion. This was followed by no religion which accounts for 26.7% of the total population.

Gloucestershire has a higher proportion of people who are Christian, have no religion or have not stated a religion than the national figures. In contrast it has a lower proportion of people who follow a religion other than Christianity, which reflects the ethnic composition of the county.

At district level:

- Cheltenham had the lowest proportion of people who are Christian at 58.7% of the total population; this was lower than the county and marginally lower than the national figure.
- Cotswold had the highest proportion of people who follow Christianity.
- Cheltenham had the highest proportion of Buddhists, Hindus and people who have no religion.
- At 3.2% of the total population Gloucester had the highest proportion of Muslims.
- Stroud had the highest proportion of people who follow an "Other Religion" and of people who did not state their religion.

EQIA assessment for Religion

Proposed Change	Scale of Potential impact	Evidence of Potential Impact and duration	Potential Impact if changes reversed
Formalise Gastroenterology Pilot Formalise Trauma & Orthopaedic Pilot	**Small Scale Impact** No evidence has been identified to indicate that this group has significant differential or disproportionate needs in relation to acute hospital services like gastroenterology or T&O. It is envisaged that best practice around provision for people with religious or other beliefs will continue to be provided over both sites so access will be unchanged.	**Long Term Impact** No impact Both CGH and GRH have a team of Chaplains who provide spiritual and pastoral care and support for all faiths to help people find strength comfort and meaning at what can be a very difficult time in their lives.	**Overall Impact: Neutral** No impact Both CGH and GRH have a team of Chaplains who provide spiritual and pastoral care and support for all faiths to help people find strength comfort and meaning at what can be a very difficult time in their lives.

3.9 Gender Reassignment

The Equality Act 2010 protects transgender people. It is therefore important this is clearly understood and followed within the organisation, for both patients and staff who are transgender.

Transgender people are more likely to report mental health conditions and to attempt suicide than the general population[3]. Transgender people encounter significant difficulties in accessing and using health and social services[4]. Numbers of people identifying as transgender across the county is increasing with current estimates at 0.6% people aged 16 and over[5].

EQIA assessment for Gender reassignment

Proposed Change	Scale of Potential impact	Evidence of Potential Impact and duration	Potential Impact if changes reversed
Formalise Gastroenterology Pilot Formalise Trauma & Orthopaedic Pilot	**Impact: Neutral** The estimated prevalence of gender re-assignment is 0.6% in Gloucestershire. There is a paucity of data both on the size of this group within Gloucestershire and on health service use or experience. One study of this group's experiences of health services in general has identified certain barriers, including a lack of access to knowledgeable, competent, and trans-friendly providers. Service reconfiguration alone is unlikely to impact this although a reduced length of stay and ongoing wider trust activity around LGBT+ inclusivity may have a positive impact on this group.	**Overall Impact: Neutral** There is limited evidence regarding the impact to those who have undergone gender reassignment, however, impacts may mirror those of sexual orientation	**Overall Impact: Neutral** Proposed changes to services are expected to maintain inclusive support service approach.

[3] House of Commons Women and Equalities Committee, 2016, Transgender Equality. www.publications.parliament.uk/pa/cm201516/cmselect/cmwomeq/390/390.pdf Accessed 24/01/2019

[4] Stonewall (2015) Unhealthy Attitudes www.stonewall.org.uk/sites/default/files/unhealthy_attitudes.pdf Accessed 24/01/2019

[5] https://inform.gloucestershire.gov.uk/media/2087689/equality-profile-2019-final.pdf

4. Health Inequalities Impact Assessment (HIIA)

25% of Gloucester city's population are living in deprived areas, approx. 32,000 people. Deprivation is linked to co-morbidities and poorer health outcomes, therefore, centralising services to form different hubs with co-located specialities across both sites with enhanced quality of care and reduced waiting times will benefit all those living in deprivation across the County.

The centralisation of services provides more comprehensive and co-located specialised care, which could be beneficial for carers who are caring for someone with multiple conditions. Centralisation also means services will be ring fenced, ensuring fewer cancellations, reduced waiting times and improved clinical outcomes, resulting in improved self-care. These benefits help to support carers to reduce their time attending hospital with the person they are caring for and improve the health outcomes of both the person they are caring for and, in turn, potentially their own health.

There are 79 people registered with Gloucestershire's homeless healthcare team and it has been identified this cohort are significantly most likely to use A&E and community care services and evidence suggests those who are homeless are more likely to have multiple health conditions. Given rates of homelessness are slightly higher in Gloucester than surrounding areas; centralising services to Gloucestershire Royal Hospital provides improved access to the right specialists to manage the care of homeless people who present with multiple conditions.

There is a strong association between physical health and mental health. People with long-term conditions, such as diabetes or cardiovascular disease, have significantly raised rates of depression, anxiety and other mental health problems. Evidence suggests they receive poorer quality care than those with a single condition.[6] Therefore by centralising services patients with comorbidities could receive a better quality of specialist care. In Particular, emergency services (such as Trauma), where the majority of patients with mental health conditions are already attending as 1.2% of all A&E attendances last year were for mental health conditions, the large majority attending Gloucestershire Royal Hospital A&E.

[6] https://www.kingsfund.org.uk/projects/mental-health-and-long-term-conditions-cost-co-morbidity

4.1 Deprivation

In general, Gloucestershire is not a very deprived county; looking at the 151 upper-tier authorities, Gloucestershire has a rank of 126, putting it in the least deprived quintile for overall deprivation. An average IMD rank for each of the six districts in Gloucestershire shows that even the most deprived district (Gloucester City) falls in the middle quintile (middle 20%) for deprivation out of 326 English authorities. Tewkesbury, Cotswold, and Stroud districts are in the least deprived quintile, with Cheltenham in the second least deprived quintile. However there are pockets of deprivation and 13 areas of Gloucestershire are in the most deprived 10% nationally. These 13 areas account for 20,946 people (3.4% of the county population). Comparison of data between 2015 and 2019 indicates that there have been minimal changes to the increase/ decrease in levels of deprivation in the county[7].

Gloucester City has the highest proportion of population living in the most deprived quintile at around 25% and this is 2.5 times higher than the equivalent proportion for Cheltenham (10%).

HII Assessment for Deprivation

Proposed Change	Scale of Potential impact	Evidence of Potential Impact and duration	Potential Impact if changes reversed
Formalise Gastroenterology Pilot	**Long term Impact** Approximately 7.7% of the Gloucestershire population live within the most deprived IMD quintile which equates to just over 48,000 people being potentially impacted. At a district level, Gloucester city has the highest proportion of its population living in the most deprived areas (25%) equating to approximately 32,500 people; this is followed by Cheltenham (11,700), Forest of Dean (2,600) and Tewkesbury (1,800). None of the areas within	**Overall Impact : Small Negative** **Small Negative Impact** The lack of affordability for private vehicles in low-income households, combined with limited public transport services in many peripheral social housing estates, considerably exacerbates the problem (of inequalities to healthcare) in many parts of the UK[8] Engaging with lower income areas within Gloucester City is important to understand if they currently struggle to access healthcare at CGH	**Overall Impact : Negative** **Negative Impact** Decentralising Gastroenterology services will lead to greater cancellations and poorer outcomes **Small Positive Impact** Some patients may find travel easier

[7] https://inform.gloucestershire.gov.uk/media/2094524/gloucestershire_deprivation_2019_v13.pdf
[8] Lucas et al, 2019; Inequalities in mobility and Access in the UK Transport System: Evidence Review: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/784685/future_of_mobility_access.pdf

Formalise Trauma & Orthopaedic Pilot	neither Stroud nor Cotswold fall under the most deprived quintile. Overall, an estimated 72% of the population living in the most deprived areas appear to live closer to GRH (based on district level map information) and this equates to around 35,000 people.	**Overall Impact : Positive** **Positive Impact** The deprivation level is higher around Gloucester and this group of patients are more likely to require the unplanned services. This with trauma services based at GRH the impact is positive. **Small Negative Impact** The lack of affordability for private vehicles in low-income households, combined with limited public transport services in many peripheral social housing estates, considerably exacerbates the problem (of inequalities to healthcare) in many parts of the UK[9]	**Overall Impact : Negative** **Negative Impact** Decentralising planned orthopaedic services will lead to greater cancellations and poorer outcomes. For trauma services there would not be a centralised service to provide timely surgical provision **Small Positive Impact** Patients find it easier to attend for surgery nearer to home. Although it should be noted that outpatient care remains unchanged, including community sites.

4.2 Looked after children

According to data from the department for Education, there are just under 80,000 children who are in care in England. Most are taken into care over fears of abuse or neglect. They are vulnerable to health inequalities, and exhibit significantly higher rates of mental health issues, emotional disorders (anxiety and depression), hyperactivity and autistic spectrum disorder conditions[10].

There is no change to children's service for either gastroenterology or Trauma and Orthopaedics. All inpatient children's services remain at GRH.

[9] Lucas et al, 2019; Inequalities in mobility and Access in the UK Transport System: Evidence Review: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/784685/future_of_mobility_access.pdf

[10] https://www.rcpch.ac.uk/resources/looked-after-children-lac

4.3 Carers or unpaid carers

Increasing numbers of people are living with complex health needs and disabilities and require help with everyday activities. These people are often cared for, informally and unpaid, by family, friends, and neighbours. Around 6.5 million carers in the UK provide care worth an estimated £57 billion to £100 billion per year. The number varies across the UK with a higher proportion of carers in Wales and Northern Ireland[11].

Providing unpaid care can affect carers' education, employment, relationships, household finances, health and well-being. Effects on carers tend to worsen with the more care provided. Support for carers can be provided by a range of organisations, such as employers and governments, and it can include financial, employment-related, respite care, and emotional and social support. Some carers, such as those from ethnic minorities, can find it difficult to access support. Respite breaks, training, and counselling can improve carers' mental health and reduce stress.

There is very little publically available data on the prevalence of unpaid and paid carers; according to the 2011 census the prevalence of unpaid carers within the Gloucestershire population was 2.05% and this was significantly lower than both regional and national averages (2.37%).

HII Assessment Carers

Proposed Change	Scale of Potential impact	Evidence of Potential Impact and duration	Potential Impact if changes reversed
Formalise Gastroenterology Pilot and Formalise Trauma & Orthopaedic Pilot	**Long term Impact** According to the 2011 census the prevalence of unpaid carers within the Gloucestershire population was 2.05% and this was significantly lower than both regional and national averages, however, unpaid carers are likely to be under-represented.	**Overall Impact : Neutral** There is currently limited data to ascertain any impact of the changes for those who are carers.	**Overall Impact : Neutral** There is currently limited data to ascertain any impact of the changes for those who are carers.

[11] https://researchbriefings.files.parliament.uk/documents/POST-PN-0582/POST-PN-0582.pdf

4.4 Homelessness

The number of rough sleepers identified by the Ministry of Housing, Communities and Local Government are extremely small in Gloucestershire identifying just 19 people. Therefore this report will look at the impact to those statutorily homeless. This is identified as the count of households who are living in temporary accommodation provided under the homeless legislation.

As such, statutorily homeless households contain some of the most vulnerable members of our communities and are at a higher risk of long term conditions, mental health, smoking and various other illnesses, thus this cohort require a higher provision of care[12]. Being homeless also comes with a higher risk of delayed discharge from hospital, lengthening stays or cause repeated admissions to hospitals[13].
Numerous risk factors are associated with the likelihood of someone becoming homeless, and these broadly fall under individual circumstances and the wider forces. The risks range from drug and alcohol issues, bereavement, or experience of the criminal justice system, to the wider determinants of health such as inequality, unemployment, and housing supply and affordability[14]

The rate of homelessness in Gloucestershire varies substantially by district. The highest rates are seen in Gloucester with 219 households accepted as homeless, equating to a rate of 4.12 per 1000 households; this is significantly higher than both county and national rates and double the rate of Cheltenham at 2.09 (see Figure 22).

Locally sourced data provided by NHS Gloucestershire Clinical Commissioning Group and Gloucestershire County Council indicates there are 40 rough sleepers in Gloucestershire currently- Gloucester 17, Cheltenham 9, Cotswold 7, Forest of Dean 3, Stroud 2 and Tewkesbury 2.

There are also 79 people registered with Gloucestershire's Homeless Healthcare team. This group are more likely to be male and are far younger than the overall CCG cohort. This cohort used A&E and community care services more, as well as mental health services.

[12] Morton , Jane. Primary Health Care (2014+); London Vol. 27, Iss. 8, (Sep 2017): 25. DOI:10.7748/phc.2017.e1289
[13] https://publichealthmatters.blog.gov.uk/2018/02/09/the-inequalities-of-homelessness-how-can-we-stop-them-dying-young/
[14] https://publichealthmatters.blog.gov.uk/2018/02/09/the-inequalities-of-homelessness-how-can-we-stop-them-dying-young/

Proposed Change	Scale of Potential impact	Evidence of Potential Impact and duration	Potential Impact if changes reversed
Formalise Gastroenterology Pilot and Formalise Trauma & Orthopaedic Pilot	**Long term Impact** The highest rates of homelessness acceptances are seen in Gloucester with 219 households accepted as homeless, equating to a rate of 4.12 per 1000 households; this is significantly higher than both county and national rates and double the rate of Cheltenham at 2.09. In addition to this Stroud has 39 homeless households and Forest of Dean 15. Making the assumption that these areas are closer to GRH, there are approximately 273 homeless who may be impacted by the current pilot location of services at CGH. The Gloucestershire Public Health Team have completed but not yet published a homeless heath needs assessment. Findings suggest the homeless population are higher than average users of acute services. Barriers to people who are homeless receiving good care were reported in a recent study to be around insensitive, impersonal or unkind behaviour from service providers, not receiving the support they felt was needed, and lack of communication between multiple providers .	**Overall Impact : Neutral** There is currently limited data to ascertain any impact of the changes for those who are homeless	**Overall Impact : Neutral** There is currently limited data to ascertain any impact of the changes for those who are homeless

4.5 Substance Abuse

There is evidence to suggest that young people who use recreational drugs run the risk of damage to mental health including suicide, depression and disruptive behaviour disorders. Regular use of cannabis or other drugs may also lead to dependence. Among 10 to 15 year olds, an increased likelihood of drug use is linked to a range of adverse experiences and behaviour, including truancy, exclusion from school, homelessness, time in care, and serious or frequent offending[15].

Patients with substance use disorder diagnoses, specifically those with drug use-related diagnoses, have higher rates of recurrent acute care hospital utilisation than those without substance use disorder diagnoses.

The age standardised hospital admissions due to substance misuse in Gloucestershire is among the lowest in the South West region at 38 per 100,000 persons; lower than both regional and national rates, although there is a lack of data to determine statistical significance or comparisons. The age standardised mortality rate due to substance misuse is highest in the district of Gloucester with a rate of 7 per 100,000 over the period from 2016 to 2018; this is significantly higher than both Gloucestershire and England rates. All other districts had a rate similar to national and county rates or lower.

HII Assessment – Substance Abuse

Proposed Change	Scale of Potential impact	Evidence of Potential Impact and duration	Potential Impact if changes reversed
Formalise Gastroenterology Pilot	**Long term Impact** Those with drug and alcohol problems tend to be high users of gastroenterology services as a result of the complications arising from drug and alcohol abuse. As a result improved services are likely to benefit this group. As for other groups transport may be an issue where this characteristic co-exists with poverty.	**Overall Impact : Positive** **Large Positive Impact** Centralising gastroenterology enhances patient safety, improve outcomes and reduce LOS as it allows for more patients to be seen by a senior reviewer which is associated with increased patient discharges and improved clinical outcomes. **Potential Small Negative Impact** Prior to the changes it was thought	**Overall Impact : Negative** **Large Negative Impact** Centralising gastroenterology enhances patient safety, improve outcomes and reduce LOS as it allows for more patients to be seen by a senior reviewer with increased patient discharges and improved clinical outcomes.

[15] Schlossarek S et al U: Psychosocial Determinants of Cannabis Dependence: A Systematic Review of the Literature. Eur Addict Res 2016;22:131-144.

		that Patients with substance misuse may need further support to access services in the new location if their journey becomes longer and they are less familiar with the centralised location. In the patient feedback this has not been evidenced.	
Formalise Trauma & Orthopaedic Pilot	Patients with substance use disorder diagnoses, specifically those with drug use-related diagnoses, have higher rates of recurrent acute care hospital utilisation than those without substance use disorder diagnoses	**Large Positive Impact** Patients who undertake substance abuse will be more prevalent in the Gloucester area which gives best access for this patient group	**Impact Negative** Reversing the pilots would reduce the benefits of centralisation.

4.6 Mental Health

The prevalence of mental health disease within the GP practice registered population within Gloucestershire is among the lowest in the South West region at 0.8%; significantly lower than both regional and national averages.

During 2018/19, 351 people attended CGH ED and 1447 attended GRH with a mental health issue. This total of 1798 across the 2 sites equates to 1.2% of all attendances during this year. This data clearly demonstrates that more people attend GRH than CGH with mental health related issues.

HII Assessment – Mental Health

Proposed Change	Scale of Potential impact	Evidence of Potential Impact and duration	Potential Impact if changes reversed
Formalise Gastroenterology Pilot and Formalise Trauma & Orthopaedic Pilot	**Small Scale Impact** The prevalence of mental health disease within the GP practice registered population within Gloucestershire is among the lowest in the South West region at 0.8%; significantly lower than both regional and national averages, however, a number of mental health conditions are undiagnosed or underrepresented.	**Long Term Impact** No impact identified	**Overall Impact: Neutral** No impact identified

4.7 Diabetes Mellitus

Research suggests that those living in the most deprived areas within the UK are 2.5 time more likely to be suffering from Diabetes.[16] Those suffering from diabetes also have a high likelihood of coming from a BME background; Type 2 Diabetes is up to 6 times more likely in people of South Asian descent and 6 times more likely among Afro-Caribbean's.[17]

The prevalence of Type 2 Diabetes within the GP practice registered population within Gloucestershire is similar compared to the South West region and national average at 6.8%.

HII Assessment- Diabetes Mellitus

Proposed Change	Scale of Potential impact	Evidence of Potential Impact and duration	Potential Impact if changes reversed
Formalise Gastroenterology Pilot and Formalise Trauma & Orthopaedic Pilot	**Neutral Impact** Both CGH and GRH have a team of Diabetic specialists who provide support to services at both sites	**Long Term Impact** No impact	**Overall Impact: Neutral** No impact

[16] https://www.diabetes.org.uk/about_us/news_landing_page/uks-poorest-twice-as-likely-to-have-diabetes-and-its-complications

[17] ***Association of glycaemia with macrovascular and microvascular complications of Type 2 diabetes: prospective observational study*** British Medical Journal 2000; 321: 405-412.

4.8 Neurological Conditions

The number of people living with neurological conditions in England is rising and will continue to increase. This is due in part to advances in neonatal healthcare meaning more children with neurological conditions survive beyond birth and into adulthood. Public Health England's 2018 Neurology Mortality reports show that number of deaths in England relating to neurological disorders rose by 39% over 13 years, while deaths in the general population fell by 6% over the same period.[18]

According to the NHS & CQC 2017 Adult Inpatient Survey, Patients with neurological conditions reported poorer experiences for confidence and trust, respect and dignity, respect for patient-centred values and overall experience of care. In response to the NHS 2016 patient experience survey, just 41% (n=2,132) of patients described the health services they received for their neurological condition as 'good' or 'excellent'.[19]

The 2013-14 NHS England survey of patients of GP practices found that people with long-term neurological conditions have the lowest health-related quality of life of any long-term condition.[20] The prevalence of neurological conditions among the registered population is similar in Gloucestershire compared with the South West Region and National rates at 8.8%. The rate of hospital admissions for epilepsy among under 19s is 87.5 per 100,000; this is statistically similar to the South West regional average (71.5) but statistically higher than the national average (70.6) by a small margin.

HII Assessment- Neurological Conditions

Proposed Change	Scale of Potential impact	Evidence of Potential Impact and duration	Potential Impact if changes reversed
Formalise Gastroenterology Pilot and Formalise Trauma & Orthopaedic Pilot	**Neutral Impact** Both CGH and GRH have a team of neurology specialists who provide support to services at both sites	**Long Term Impact** No impact	**Overall Impact: Neutral** No impact

[18] Public Health England (2018) Deaths associated with neurological conditions in England 2001 to 2014: Data analysis report. Available online at https://www.gov.uk/government/publications/deaths-associated-withneurological-conditions

[19] The Neurological Alliance (2017): Falling short: How has neurology patient experience changed since 2014? Available online at http://www.neural.org.uk/store/assets/files/668/original/Neurological_Alliance__Falling_Short_-_How_has_neurology_patient_experience_changed_since_2014.pdf

[20] The Neurological Alliance (2017): Falling short: How has neurology patient experience changed since 2014? Available online at http://www.neural.org.uk/store/assets/files/668/original/Neurological_Alliance__Falling_Short_-_How_has_neurology_patient_experience_changed_since_2014.pdf

4.9 Falls among the elderly

A rapidly ageing population means that doctors in all specialties are likely to encounter older people with falls. Falls in the elderly are common and associated with major morbidity and mortality. Falls cause injuries, fractures, loss of confidence and independence, depression and death. Recurrent falls and fear of falling are the most common reasons for an older person to require nursing home care. An initial fall may be a manifestation of an acute illness and may be the only presenting feature. However, it is known that an index fall is a risk for future falls and approximately half of those who fall once are likely to do so again.[21]

The rate of emergency hospital admissions due to falls among those aged over 65 per 100,000 in Gloucestershire is among the lowest in the South West region; a rate of 1,812 per 100,000 at Gloucestershire makes it significantly lower than both regional and national averages.

HII Assessment- Falls among the elderly

Proposed Change	Scale of Potential impact	Evidence of Potential Impact and duration	Potential Impact if changes reversed
Formalise Gastroenterology Pilot	**Long term Impact** Older people may benefit disproportionately from an improved service. However, previous engagement work has suggested that older people tend to raise transport and access issues more often than younger people so concentrating services on one site may impact this group more	**Overall Impact : Positive** **Positive Impact** Centralising gastroenterology enhances patient safety, improve outcomes and reduce LOS **Potential Small Negative Impact** Prior to the changes it was thought that Patients over 65 may need further support to access services in the new location if their journey becomes longer and they are less familiar with the centralised location. In the patient feedback this has not been raised.	**Overall Impact : Negative** **Negative Impact** Centralising gastroenterology enhances patient safety, improve outcomes and reduce LOS. **Small Positive Impact** Patients over 65 may need further support to access services in the new location if their journey becomes longer and they are less familiar with the centralised location. However this has not been demonstrated

[21] https://www.rcpe.ac.uk/sites/default/files/anderson.pdf

Formalise Trauma & Orthopaedic Pilot	The Trauma and Orthopaedic services are directly affected by patient falls as many patients who are admitted after falling are seen by the trauma team.	**Overall Impact : Positive** **Large Positive Impact** Centralising trauma to GRH: Hip fractures are managed by the trauma service now based at Gloucestershire Royal Hospital during the pilot. These patients almost always arrive by ambulance straight to Gloucestershire Royal Hospital where there is a specialist ward staffed with both orthopaedic and care of the elderly specialist doctors and a team of highly specialised nursing and therapy staff in a ward with a therapy room and modifications for those with dementia. **Potential Small Negative Impact** Patients who fall in CGH and require surgical orthopaedic treatment will be transferred to a trauma ward at GRH.	**Overall Impact : Negative** **Large Negative Impact** For trauma services there would not be a centralised service to provide timely surgical provision **Small Positive Impact** Patients who fall in CGH and require surgical orthopaedic treatment would no longer be transferred.

4.10 Overweight or obese

Excess weight and obesity is a risk factor for various health conditions, including type 2 diabetes, high blood pressure, cardiovascular disease, fatty liver disease, various cancers and kidney disease.[22]

Overweight and obese individuals are less likely to access healthcare and are less likely to receive evidence-based and bias-free healthcare when they do engage according to various studies.[232425]

The prevalence of overweight and obesity in Gloucestershire is 61.4%; this is similar to both regional and national rates.

HII Assessment – overweight and obese

Proposed Change	Scale of Potential impact	Evidence of Potential Impact and duration	Potential Impact if changes reversed
Formalise Gastroenterology Pilot and Formalise Trauma & Orthopaedic Pilot	**Neutral Impact** Obesity is often linked to a large number of co-morbidities which mean obese patients are more likely to be positively impacted by the centralisation of services resulting in specialist care being provided in one place. They would be negatively impacted if these services reverted to their original configuration.	**Overall Impact : Positive** **Positive Impact** Centralisation of specialist services improves clinical outcomes for patients with co-morbidities.	**Overall Impact : Negative** **Negative Impact** Centralising gastroenterology enhances patient safety, improve outcomes and reduce LOS. For trauma services there would not be a centralised service to provide timely surgical provision

[22] https://www.niddk.nih.gov/health-information/weight-management/health-risks-overweight

[23] Aldrich T., Hackley B. (2010). The impact of obesity on gynecologic cancer screening: an integrative literature review. J Midwifery Womens Health 55, 344–356. 10.1016/j.jmwh.2009.10.001 [PubMed] [CrossRef] [Google Scholar]

[24] Forhan M., Salas X. R. (2013). Inequities in healthcare: a review of bias and discrimination in obesity treatment. Can. J. Diabetes 37, 205–209. 10.1016/j.jcjd.2013.03.362 [PubMed] [CrossRef] [Google Scholar]

[25] Phelan S. M., Burgess D. J., Yeazel M. W., Hellerstedt W. L., Griffin J. M., van Ryn M. (2015). Impact of weight bias and stigma on quality of care and outcomes for patients with obesity. Obes. Rev. 16, 319–326. 10.1111/obr.12266 [PMC free article] [PubMed] [CrossRef] [Google Scholar]

Fit for the Future (FFTF) Public Consultation
January 2021 Citizens' Jury
Jurors' Report

A report produced with the 18 members of the citizens' jury assessing the 2020 FFTF public consultation process and information, and making recommendations about the most important outcomes of the consultation

February 1, 2021

Commissioned by:

Designed and delivered by:

citizens juries

Jefferson Center

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1. Preface

About this report

This is a report from the 18 members of the citizens' jury who met online over eight afternoons between 19 and 28 January 2021 to hear evidence from a wide variety of witnesses, to deliberate together, and to make recommendations about the 2020 public consultation on Fit for the Future (FFTF). FFTF is a programme from Gloucestershire NHS organisations ("One Gloucestershire") which proposes changes to how certain specialist hospital services are organised across the two main sites: Gloucestershire Royal and Cheltenham General Hospitals. The report was constructed using the words of the 18 jury members, from statements they prepared together. A draft version was reviewed and agreed by jury members as part of the jury process on 28 January before being reformatted, published online and distributed to members of the jury.

A citizens' jury report with additional information (e.g. on jury recruitment) will be produced by Citizens Juries c.i.c. and published online during February 2021.

1. Statement to NHS Governing Bodies and Public

At the conclusion of the jury, participants chose to share the following about their experience and collective work assessing the Fit For the Future consultation process, information, and results:

Everyone's opinions were taken into consideration and time was given to discuss individually and together to enable us to make the decisions in the report fairly.
It is important to know that the jury has worked as a cohesive unit to give truthful feedback to processes etc regarding FFTF in order to improve the process (where needed) going forward.
Without much knowledge initially about what a Citizens' Jury does, I feel there should be one in every decision making process now! Not only does it add transparency to a process but it hopefully provides either valuable insight or analysis as well.
I think that the effectiveness of the Jury over the past 2 weeks is in some degrees reflected by the whole consultation process and information that has been shared with all of the jury and how important a role that the jury plays its part and that because of the way the Jury process was delivered it has made a substantial contribution to the whole FFTF Consultation Process.
This gave me the opportunity to engage with jury members drawn from a broad spectrum of the community. I was pleasantly surprised how quickly the members gelled and interacted positively and courteously with each other and achieved outstanding outcomes. This experience has been very exhilarating and totally rewarding. Thank you to the organisers and professionals who helped us understand and achieve an outstanding finale and result.
It is important for the NHS Governing Bodies to know that I am pleased I was able to take part and have an input in this FFTF consultation. The public should be aware that there is a lot of unseen processes and in-depth research that take place in order to come to a final decision on proposed changes.
I would like to say that I would've preferred to have taken part in the actual process and been able to have my opinion on the changes heard but feel taking part in the jury means that maybe next time a process like this happens it will be more broadly advertised so that myself and the rest of the public get to put their opinions forward. I also hope that our opinions on the process make a difference as we did spend a lot of time deliberating. I found the facilitators extremely helpful and the witness speakers knowledgeable and passionate.
It is important to know that the work we've done together as a jury has been done in a fair way, giving a diverse group of individuals the chance to share their opinions, listen to others, and work together. The information we were given and the presentations we heard were useful, professional and comprehensive. The process was also excellently handled. Not only has the jury itself been excellently designed, facilitated and made to be interesting and enjoyable, but it demonstrates how robust an approach the NHS takes to their public consultations. It has given me more confidence in the NHS and their commitment to engage the public in various ways.
A jury containing a cross section of Gloucestershire public were given enough information to form a view on the actual consultation process used by FFTF giving everyone an equal platform to discuss their own views and listen to others to form an educated opinion for our conclusion, all very well led by a system laid out and well communicated by our organisers, in lead up and during this process.
We received informative briefs and information to assist with our decisions. The jury had a fair chance to discuss together but answer independently.
We have listened to and questioned expert witnesses, both internal to the NHS and external to the NHS. This included the FFTF consultation team, staff representatives, voluntary groups and experts in the consultation process. We have had lots of information to help us deliberate on the FFTF process and information and come to our conclusions. The Citizens' Jury has been professionally organised and

facilitated to make it an enjoyable and stimulating experience.
We've been able to read a lot of information, listen to a lot of witnesses and deliberate effectively on the process and I hope the governing body will appreciate this. As a juror I now feel very informed and encouraged that our voices will hopefully be listened to as part of the decision-making process. The organisers have been very efficient, welcoming and friendly and have kept us all motivated throughout. I would definitely recommend them to any organisation looking to go through a similar process.
It was a systematic process which gave you a framework to think through the questions and information presented by FFTF. The group work was a great place to test your own personal conclusions, questions and clarify information. The facilitators were very neutral in their approach and encouraged full group participation. They always gave room for questions and were very respectful. I felt that by the end of the time, when we were asked to draw conclusions on the process FFTF followed, I had been well equipped to answer the questions posed. It would have been helpful to have a greater understanding of the influence of the jury on the final decisions or following processes. In some areas more time would have made the jury a more comfortable experience although I am not sure if that would have impacted my personal conclusions. It was hard work but very worthwhile and enjoyable.
It is possible for a jury to examine and decide on substantial matters if it is set up and run properly like the one we have just completed.
That we have listened to and seen the presentations from witnesses and experts, we have raised issues and questions for clarification directly with them at the time and that we have duly considered the issues that were directly involved in relation to the process and collectively with the assistance from experts and facilitators delivered a report that we believe to be fair and unbiased with points and recommendations for your consideration.
Considering we are going through a pandemic the efforts and lengths that were made to get the information out about the consultation was still made despite the pandemic. I do feel that the public was made aware of their best ability and we as jurors were led through the process. Considering I've never done this before in this way, it has definitely taught me something new meeting and grouping with like minded people of all ages and backgrounds and helped to get through this new way of working and communicating.
It was thorough and professionally conducted. Everything was open and transparent. Expert presentations covered every aspect of the jury deliberations. The organisers have been exemplary in every aspect. I have every confidence this experience will enhance my learning adventure.
We've discussed and analysed all of the consultation material, and come up with other ways of looking at the consultation information from a variety of perspectives.
The jury members were from all ages, locations, backgrounds and sexes who came together as individuals to make the best informed decisions as a group that they could make on the evidence available to them over a two week period. The written information was supported by verbal presentations with the opportunity to question and clarify information supplied. This enabled focused conclusions to be reached on the factual information supplied. The facilitators were most efficient in keeping the timetable on track and clarifying uncertainties. It was an interesting, stimulating experience.

2. The jury questions and recommendations

The questions for the citizens' jury, and our answers/recommendations are set out below. The jury questions are *in italics*. Our answers explain, in our own words, what we thought about the FFTF public consultation process and information, and what we think are the most important things that emerge from the consultation responses from the public. We voted to prioritise what we considered to be most important of our ideas, and the numbers of votes are shown throughout section 2 (often votes exceed 18 in total because we were given more than one vote each).

The process we went through to reach our conclusions is described in section 3.

Q1. How good was the FFTF consultation process?

We heard evidence from an expert witness on what a good public consultation process and good consultation information should look like (see section 3). We used this information and deliberated together to answer Q1a and Q2a. With further oral expert evidence and access to the public consultation documentation, we were able to work together to answer Q1b and Q2b about how confident we are in the public consultation process and information.

Q1a. What are the characteristics of a good consultation process?

The table below sets out what we agreed are the most important characteristics of a good consultation process based on the evidence that we heard and our deliberations.

Quality / Characteristic of a Strong or Good Consultation Process	**Why It Matters (how this quality or characteristic helps us gauge consultation quality or results, etc.)**
Consultation seeks to incorporate guidance from relevant bodies, involves a wide variety of the public in its decisions, engages with all sections of society, including groups that are harder to hear, and is inclusive regarding location, access, and geography. - *16 votes*	- It is important to ensure all members of the public have the chance to have their say because everyone should be able to have the information available to be able to make an informed decision. - Shows that the consultation attempts to reach as many of the public as possible and aims to make sure changes made are in the best interest of as many people as possible.
Process uses clear, concise and targeted information and materials. - *11 votes*	- This explains why proposed changes are necessary, informs the public with reasonings behind the decisions, and enables the public to evaluate the proposals and make informed decisions.
Consultation is conducted in accordance with the Gunning Principles and process lasts a proportionate amount of time during formative stages of proposal development. - *5 votes*	- Demonstrates that the process has taken into account the relevant information over a timescale that does it justice and is based on previous experience and best practices.
Process allows scrutiny from relevant media, local government, public representatives and	- This shows broad oversight of the consultation process.

the public. - *3 votes*	

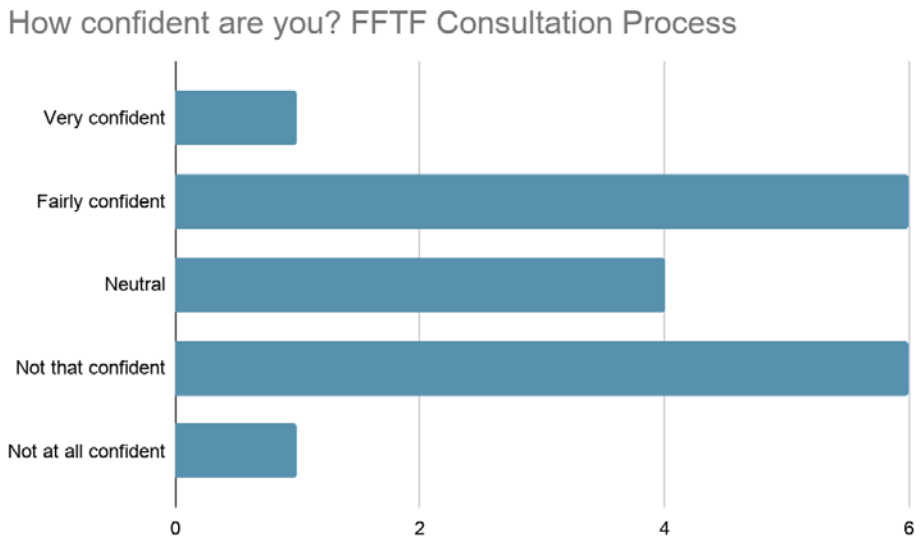
The table below sets out important characteristics of a weak or poor consultation process based on the evidence that we heard and our deliberations.

Quality / Characteristic of a Weak or Poor Consultation Process	**Why It Matters (how this quality or characteristic helps us gauge consultation quality or results, etc.)**
The consultation process is not inclusive or there is a failure to consult the right people and those who are affected by service changes. - *8 votes*	- This matters because the CCG serves the whole of the county and needs to take account of differing medical needs across the whole county. - This matters because the ones who will be impacted by the decisions should be involved and different groups should be consulted appropriately. - This matters because evidence informing the proposals may be misleading and consultation results may be biased if based only on certain brackets of the public.
Responses not analysed or responded to properly. - *8 votes*	- This demonstrates that the decision makers think the public's views are not important and could cause people to lose confidence in these services and the NHS.
There is not sufficient time for the consultation process. - *7 votes*	- This could make it so that not enough information will be gathered to make an informed decision and people won't have a chance to participate.
Not enough information is provided to the public about the consultation process and relevant changes. - *6 votes*	- This matters because it is vitally important to provide enough quality information to make an informed decision.
Information not communicated effectively, not presented clearly and contains jargon. - *3 votes*	- This may lead to the public being confused or misinformed and not able to fully understand the proposed changes.
Proposals not developed transparently. - *3 votes*	- This matters because it may weigh the outcome in favour of a certain group or party.

Q1b. Based on what you have learned, how confident are you that the consultation process has allowed all residents to contribute meaningfully to the decision-making process? [Very confident/Fairly confident/Neutral/ Not that confident/Not at all confident]

Our votes on this question are shown in the table below.

Answer Choices	Responses	Percentage
Very confident	1	5.56%
Fairly confident	6	33.33%
Neutral	4	22.22%
Not that confident	6	33.33%
Not at all confident	1	5.56%
TOTAL	18	100%



- *What are the most important reasons to be confident [that the consultation process has allowed all residents to contribute meaningfully to the decision-making process]?*

  We collectively identified and ranked reasons that made us confident that the consultation process has allowed residents to contribute meaningfully to the decision-making process.

Reasons to be confident that the consultation process has allowed residents to contribute meaningfully to the decision-making process.
Clear, concise language and limited jargon in materials - *11 votes*
Range of platforms and options for participating and responding - *9 votes*
Variety of versions of documents with varying detail was provided - *8 votes*
Significant effort made to reach and involve harder to hear groups - *6 votes*
Process allowed for scrutiny from multiple outside bodies - *5 votes*
Number of responses statistically acceptable based on software - *4 votes*
Incorporated guidance from relevant outside bodies - *3 votes*

Conducted in accordance to Gunning Principles - *3 votes*
Staff were given options for participating in process - *3 votes*
NHS engagement staff (B. Parish) answered questions and presented confidently - *2 votes*
Carried out over a timely and appropriate timescale - *0 votes*
Open and inclusive process - *0 votes*

- *What are the most important reasons to not be confident [that the consultation process has allowed residents to contribute meaningfully to the decision-making process]?*

  We collectively identified and ranked reasons that made us not confident that the consultation process has allowed residents to contribute meaningfully to the decision-making process.

Reasons to not be confident that the consultation process has allowed residents to contribute meaningfully to the decision-making process.
Conducting consultation during Covid-19 pandemic compressed timeline, made it more difficult to participate, limited options for engagement and reduced quality - *12 votes*
Marketing and advertising strategy did not raise awareness of consultation - *10 votes*
Relying on Royal Mail Postal leaflet as primary outreach led to reduced awareness and participation - *9 votes*
Overemphasis on targeted groups may have reduced awareness among and participation among general public - *8 votes*
Input of past, current, and future users of services under consultation and patient experience not emphasised in materials - *5 votes*
Use of self-selecting survey to gather responses may have decreased number of people who participated - *4 votes*
Large percentage of responses were from Cheltenham and less representation from Gloucestershire overall could bias results - *2 votes*
Unclear whether or not and how CCG will utilise the results of the Citizens' Jury in decision-making - *2 votes*
Feedback from community groups may not have been responded to or may have disregarded - *1 vote*
Alternative options for service changes not clearly communicated in materials - *1 vote*
REACH organisation has given a very negative opinion - *0 votes*

Q2. How good was the consultation information?

Q2a. What are the characteristics of good consultation information?

The table below sets out the most important characteristics of good or strong consultation information based on the evidence that we heard and our deliberations.

Quality / Characteristic of Strong or Good Consultation Information	Why It Matters (how this quality or characteristic helps us gauge consultation quality or results, etc.)
Clear and consistent presentation of information using "Plain English." - *10 votes*	- Demonstrates an understanding by the process organisers that they acknowledge what is required by the service users and that information is being shared among the public. - Matters because participants need to properly understand the proposed changes so they can make relevant contributions and understand the information they are asking to opinionate on. - Matters because overly complicated language/ technical jargon can be off putting/confusing to some people and be difficult for those w/disabilities and dyslexia, etc.
Information is accessible across multiple platforms and tailored to specific audiences. - *9 votes*	- To ensure it reaches a wide audience, allowing as many people to be aware of it as possible and because different audiences will have differing capacities to understand and feedback on information
Data is accurate, specific, and up-to-date or responsive when appropriate. - *7 votes*	- Demonstrates that the consultation is credible and reliable.
A good consultation should include other arguable alternatives and reasons they were not considered. - *5 votes*	- This is the only Gunning Principle directly related to consultation information so it is important that it is adhered to in the consultation.
Any proposed changes include rationale and supporting evidence. - *4 votes*	- Otherwise people won't understand why the changes are needed / what problems the changes are designed to address.

The table below sets out the most important characteristics of weak or poor consultation information based on the evidence that we heard and our discussions.

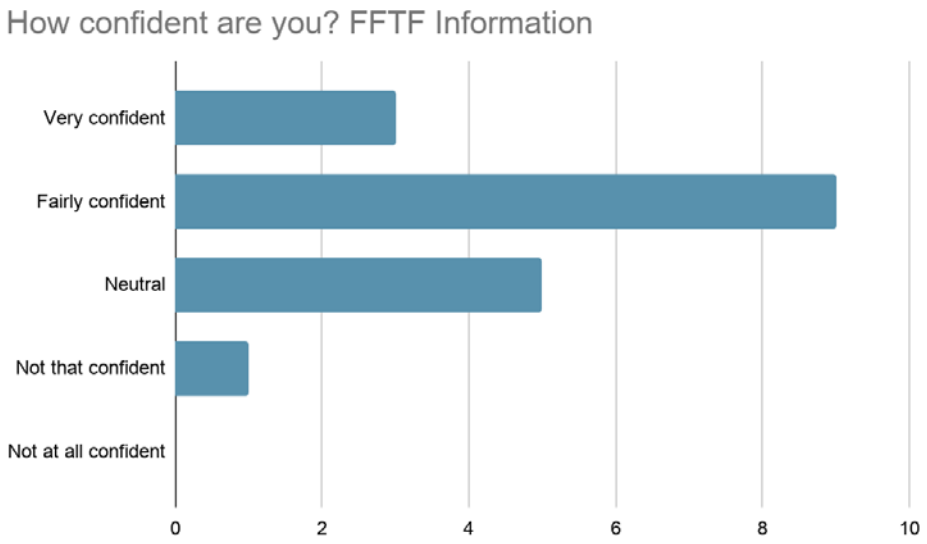
Quality / Characteristic of Weak or Poor Consultation Information	Why It Matters (how this quality or characteristic helps us gauge consultation quality or results, etc.)
Information or data in consultation materials is inaccurate, incorrect, incomplete or insufficient. - *17 votes*	- This matters because it will lead to an incorrect judgement because the audience may not fully understand the issues or the potential impacts which would limit the success of the whole

	consultation process.
Consultation materials are not available in accessible formats or information is too detailed, dense, or lengthy. - *8 votes*	- This matters because the process should be as inclusive as is practically possible and information should be accessible to everyone - including people who don't have much spare time. - People need to be able to find and access all information offered.
Information could be construed as ambiguous or misleading to the general public. - *8 votes*	- This matters because it will lead to an incorrect judgement and may be counterproductive.
Information is poorly written or not presented clearly. - *2 votes*	- This matters because it could lead to confusion and questions not being answered correctly, resulting in misinformed and irrelevant data.

Q2b. Based on what you have learned, how confident are you that the information provided through the consultation enabled residents to be adequately informed about the proposed service changes?
[Very confident/Fairly confident/Neutral/ Not that confident/Not at all confident]

Our votes on this question are shown in the table below.

Answer Choices	Responses	Percentage
Very confident	3	16.67%
Fairly confident	9	50.00%
Neutral	5	27.78%
Not that confident	1	5.56%
Not at all confident	0	0.00%
TOTAL	18	100%



- *What are the most important reasons to be confident?*

  We ranked the reasons that made us CONFIDENT that the information provided through the consultation enabled residents to be adequately informed about the proposed service changes.

Reasons to be confident that the information provided through the consultation enabled residents to be adequately informed about the proposed service changes.
Uses "plain English" and provides supplemental glossary to explain jargon - *15 votes*
Information was accessible across multiple platforms and formats - *14 votes*
Included the rationale for why proposed changes were being considered and the reasons these changes would be beneficial - *10 votes*
Information provided was informative, factual, accurate, and up-to-date - *5 votes*
Information was shared through print, online platforms, face-to-face interactions, and by telephone - *4 votes*

- *What are the most important reasons to not be confident?*

  We ranked the reasons that made us not confident that the information provided through the consultation enabled residents to be adequately informed about the proposed service changes.

Reasons to not be confident that the information provided through the consultation enabled residents to be adequately informed about the proposed service changes.
Alternatives to proposals not easy to find in consultation, nor explanation of why alternative options were not chosen or available to preferred options - *16 votes*
Methods used to distribute information (and solicit feedback) was inadequate - *11 votes*

	Continuing the consultation during COVID-19 pandemic hindered advertisement of information - *11 votes*
	Easy Read materials and survey were difficult to access and did not provide enough relevant information about proposed changes - *9 votes*
	Information was poorly written, too dense, or contained too much jargon for the average reader - *1 vote*

Q3. What are the most important findings from the FFTF consultation results?

Q3a. What are the most important findings from the consultation for the NHS Governing Bodies to consider (such as impact on local community, and suggestions to reduce any negative impacts)?

- *Why?*

We ranked what we think are the most important findings that we identified from the responses to the consultation in the table below. The main reasons for each choice are shown in the right-hand column.

Important Findings from FFTF consultation results for NHS Governing Bodies to consider	Why It Matters
It is important to know that although the number of 713 completed surveys appears to be a small countywide response, this is approximately double the number survey models recommend. The Fit For the Future consultation group were happy with the overall response, double than what was predicted with response software. However, due to the population being approx 650,000, the number of completed surveys may appear unsatisfactory to the general public. - *11 votes*	- Suggests the general public is pretty apathetic and the FFTF are happy not pushing to get the numbers higher in all age demographics. Whilst some members of the jury felt it was a low number. - This helps us to know that the response rate, and therefore results, is robust enough to base decisions. This is because it shows that most areas were represented.
There was a range of respondents however this did not necessarily reflect the demographics of the county. A significant number of the survey results came from Cheltenham with relatively small proportions from elsewhere. - *10 votes*	- This demonstrates that the consultation results captured different sections of the community (including 20% from people who considered themselves to have a disability), but some groups were under-represented (few responses from under 45 year olds). - This is important because it could mean that the consultation results are inappropriately biased toward Cheltenham where evidence has suggested there is concern that the hospital in Cheltenham may be closed. The survey results may therefore be skewed and biased in favour of proposed changes and

	therefore do not reflect the views of the residents of Gloucestershire as a whole.
There are concerns from both staff and patients about bed numbers and the increase of patients to GRH which is already deemed to be overstretched (pre-Covid-19). - *8 votes*	- A plan should have been provided to ensure concerns were heard and addressed as well as potential negative effects on other areas of the hospital are mitigated against.
Despite the level of participation being deemed as sufficient, we feel it is not representative. - *7 votes*	- The results are not a true representation of the population of Gloucestershire because of the low response rate.
The overall level of support for the proposals was around 70% for all options from the general public and staff that responded to the survey and staff consultation. - *6 votes*	- This suggests the proposals are acceptable to the general public and the NHS staff.
Service users were not properly targeted or identified. - *5 votes*	- It would have been as important, if not more important, to see this information as the stats from target groups as 'lived' experience could prove invaluable.
It is important to know that deciding whether to go ahead with the consultation during a pandemic was carefully considered by the consultation team with the help from external organisations such as the Consultation Institute. - *3 votes*	- This matters because benefits to completing the consultation process were identified that outweighed any pandemic effect.
Open text feedback from the consultation uses the language of the proposals such "Centres of Excellence." - *2 votes*	- This demonstrates that respondents understood the narrative/proposals in the FFTF consultation informational texts and therefore the results reflect informed understanding of the options.
Proposals and public response are scrutinized both internally and externally and that all aspects and potential adverse impacts are considered. - *1 vote*	- To assure the public that results are analysed and presented in accordance with law and processes and they are reassured that any concerns raised have been considered and addressed.
The data appears to show a lot of support for the movement of Planned Lower GI surgery and Gastroenterology inpatient services to Cheltenham General Hospital. - *1 vote*	- This is important to note because the majority of respondents to the survey were from Cheltenham postcodes which may give false data and sway the results in favour of the planned proposals.

Q4. Any other messages for the Governing Bodies?

Q4. Is there anything else about the consultation that a majority of the jury would like the NHS Governing Bodies to consider in the decision-making process?

Why?

We worked together to identify other messages that are important for the NHS Governing Bodies to hear about the FFTF public consultation. Only those that are supported by a majority of the jury are included in the table below. Our reasoning is given in the right-hand column of the table.

Something still missing, needs to be addressed, or requires further clarification re: the FFTF consultation	**Why It Matters**
We are concerned regarding the number of Royal Mail mailshots actually delivered to homes and wonder if there are better ways to market the initial engagement process, to get more people to know about the consultation, and hopefully contribute to the results. *16 Yes votes / 2 No votes)*	This will get more peoples' opinions and a better representation of the people in Gloucestershire, and would help us to know the majority have had a chance to be part of the consultation.
The Covid-19 pandemic has changed our way of life considerably - it would have helped for the FFTF consultation to incorporate a response to the pandemic in their presented material. *(15 Yes votes / 3 No votes)*	This matters because the plans drawn up before the pandemic may not be relevant anymore and the pandemic directly affects the day-to-day running of the services.
We have been assured that the golden thread of patient experience is the reason for this project, but there is nothing about that in the proposals. It is important that at the same time as any reorganisation of medical services, there is a review of the way patients are treated, their dignity and the facilities offered associated with new medical proposals. There is always something about this in external audits. *(16 Yes votes / 2 No votes)*	It's about the patients!

Statements that received 50% of votes "Yes" are included in the table below.

Something still missing, needs to be addressed, or requires further clarification re: the FFTF consultation	**Why It Matters**
Why was Inclusion Gloucestershire told in mid 2019 that there wasn't enough time to produce more easy read information booklets? *(9 Yes votes / 9 No votes)*	This is important because it might've meant that the disabled population had a better representation and may have led to different results and views on FFTF.

Data is missing that would give information of how many leaflets were actually delivered by Royal mail. *(9 Yes votes / 9 No votes)*	This matters because it would give more data to know that as many households as possible had received the leaflets that were commissioned to be delivered by Royal Mail (297k).

3. The jury process: what we heard and did

This section describes what we did over the eight days of the citizens' jury: from 13.00 to 17.30 each day on 19-22 January, and then 25-28 January. We heard from a range of expert and community witnesses. We asked questions and collectively captured important information after each presentation. The brief for each presenter is given below but a full set of slides and audio of the presentations are available for download at: https://www.onegloucestershire.net/yoursay/fit-for-the-future-developing-specialist-hospital-services-in-gloucestershire/citizens-jury/.

Day 1: Context setting

The event began with introductions by jury members, and to the citizens' jury process and deliberation. This was led by the process designers and facilitators Kyle Bozentko and Sarah Atwood from the Jefferson Center.

We then heard from Micky Griffith, the Programme Director of the NHS's "Fit for the Future" programme. He had been asked to set the context for the jury:

- Why has the jury been called?
- Who has commissioned it?
- What is the subject of the jury?
- What are the main steps that have led up to this jury, and when did they happen?
- Where are we now and what steps will follow the jury to lead to decisions being made?
- Why do the results of the jury matter, and how will they be used?

Day 2: What is "Fit for the Future"?

We heard from Prof. Mark Pietroni, Director for Safety and Medical Director, Gloucestershire Hospitals NHS Foundation Trust. He had been briefed to explain:

- What is "Fit for the Future," an "integrated care system," and the Centres of Excellence approach?
- Why are changes to hospital services being proposed?
- In summary, what are the main service changes being proposed?

Day 2: What does a good NHS public consultation process look like?

Frances Newell, Senior Programme Lead (community involvement), NHS England was briefed to address:

- What does the law and national guidance require from a NHS public consultation?
- What features would a good NHS public consultation process have?
- What features might a poor NHS public consultation process have?
- Any other relevant points about public consultation processes.

Day 2: What does good NHS public consultation information look like?

Frances Newell also gave the presentation on good consultation information:

- What information does the law and national guidance require to be included in a NHS public consultation?
- What would be the features of good information content in a NHS public consultation?
- What might be the signs of poor information in a NHS public consultation?
- Any other relevant points about public consultation information.

Day 3: What has the FFTF engagement and consultation process been?

This presentation was made jointly by two representatives from Gloucestershire Clinical Commissioning Group: Micky Griffiths, Programme Director, Fit for the Future & Becky Parish, Associate Director Engagement and Experience. Their brief was:

- What steps did the NHS in Gloucestershire go through up to the end of engagement?
- What steps did the NHS in Gloucestershire go through from engagement up to the end of the public consultation?
- What has the NHS in Gloucestershire done (with relevant metrics) during the public consultation to make these consultation materials accessible?
- What activities were carried out to encourage local people to respond and what mechanisms were available to people to respond?
- Following the public consultation, what steps will be taken before the governing bodies make decisions?

As a group we determined "What's Important for our Neighbours to Know" regarding the steps NHS Gloucestershire undertook for the Fit for the Future consultation process:

What's Important to Know re: FFTF Process
FFTF used a range of communications on a variety of different platforms for accessibility along with a diversity of approaches and targeted outreach to involve different groups and ensure inclusion of seldom heard or hard to reach groups.
External groups were contacted to provide input and be involved in planning, in proposal development, and the consultation process itself.
FFTF appears to have taken steps to ensure the process is done according to procedure and that public were able to shape the process and that the feedback would be incorporated meaningfully (eg the public were asked what mattered to them and these were incorporated into process; FFTF worked with the Consultation Institute for advice).
There were methods for internal and external scrutiny of the materials and process.
A low level of response was deemed a success from various engagement activities.
FFTF adjusted the consultation process in response to COVID-19.
Members of NHS staff have been (heavily) engaged in the process.

Day 3: What information has NHS Gloucestershire provided for the public consultation?

Becky Parish also gave this presentation addressing the following questions:

- What are the main public consultation documents, and what purpose does each of them serve?
- What purpose does each serve?
- Is there anything in particular that jurors should be aware of when reviewing the documents?

As a group we determined "What's Important for Our Neighbours to Know" regarding the information NHS Gloucestershire provided for the public consultation process:

What's Important to Know re: FFTF Information
There were a variety of informational documents available and different ways for people to access the consultation information, on various platforms (including methods such as callbacks).
It is important to know the total number of or amount of requests for various types of information and the response rates for various approaches.
Many people were seemingly unaware of the consultation and did not access/receive any information (including the NHS leaflet) and did not respond to any surveys or participate in any of the engagement options.
FFTF responded to Covid-19 by adjusting how information was provided to try to ensure people had access to the information.
It is important to know how successful response rate/s are determined based on the population and targets and to know whether or not these were met.

Day 4: Community perspectives: what were the strengths and weaknesses of the public consultation?

Five representatives from the local community were invited to speak to the jury on what they perceived to be the strengths and weaknesses of the consultation. Each gave a short presentation followed by questions from the jury. The presentations were given by:

- Dr Russell Peek, Consultant Paediatrician and Medical and Dental Staff Governor, Gloucestershire Hospitals NHS Foundation Trust (speaking about consultation with staff)
- Julius Marstrand and Chris Hickey, REACH (Restore Emergency At Cheltenham General Hospital)
- Trevor Rawlinson, Church St Medical Patient Participation Group Chair
- Angela Gilbert, Community Development Team Managers, Know Your Patch
- Vicci Livingstone-Thompson, Director, Inclusion Gloucestershire.

As a group we determined some of the most important strengths of the Fit for the Future consultation process and information after hearing from community members and deliberating:

Strengths of FFTF Consultation
Efforts were made to ensure accessibility and inclusion by engaging a wide range of Gloucestershire residents as well as among seldom heard groups (eg working with community groups) so everyone could have input.
Community groups were involved in sharing, distributing or communicating consultation information to, and engaging with, target groups across the county.
Community groups were involved in planning the consultation process and developing the proposals.
NHS staff were represented or involved at all stages throughout the process.
Information was made available on multiple platforms and across various formats (online, phone, print) for residents to learn about the process and share their views.
Lots of information was available and materials had different levels of detail.
FFTF attempted to respond to Covid-19 by adjusting how people learned about or participated in the consultation.
Patient experience was included as a consideration.

As a group we determined some of the most important weaknesses of the Fit for the Future consultation process and information after hearing from community members and deliberating:

Weaknesses of FFTF Consultation
The Covid-19 pandemic interrupted the process and made it more difficult for people to participate, decreased overall participation/response rates, and limited opportunities for community groups to be engaged.
Information was unclear, was too technical and didn't properly provide rationale for changes or the potential impacts of changes on patients and staff.
It is unclear if all staff were equally involved and whether or not various relevant Unions (medical and non medical) were consulted or involved.
Some groups who were engaged to plan or contribute to the consultation may have had suggestions, feedback or changes overlooked or disregarded and consultation was less inclusive.
Information was not easily available to enough people and not heavily advertised enough for people to know about the consultation.
Low awareness of the consultation and low participation numbers and response rates among Gloucestershire residents.
Negative views from community groups (such as REACH) may not have been fully included in the consultation process and information.

Patient experience (eg treatment pathways) and users not fully included as a component of the consultation materials.
Reliance on digital and electronic communications may have excluded some from participating.
The time period of the consultation process may not have allowed enough time for residents to participate.

Day 5: Jury Study Time, Review of Fit for Future Consultation Materials, and Deliberations

Day 6: What can we learn and where should we be cautious when interpreting public consultation results?

Richard Stockley, Head Of Research, Surrey Heartlands Health & Care Partnership (NHS) & Surrey County Council presented information to help us more effectively interpret and assess consultation results, finding, and information. He was briefed to give a presentation addressing the following:

- What can we learn from the results of a public consultation?
- What are we unable to learn from a public consultation?
- Why might public consultation results not reflect the views of the local population (e.g. self-selection bias)?
- What are the important questions to ask to test how well the results reflect the views of the local population?
- Any other relevant points about interpreting consultation results.

As a group we determined some important things to consider when interpreting results:

Interpreting Consultation Results Responses
It is important to know whether responses reflect a broad cross section of society or if responses represent particular groups when interpreting results to understand if the consultation provides a full snapshot of the public.
It is important to consider how different groups and the general public are targeted, and why, in order to gather responses from those groups appropriately to ensure that consultation has been effective.
It is important to ensure that the questions being asked are not leading, loaded or weighted towards a certain response and include explanation of alternative options. This is crucial because misleading questions can produce skewed results which encourage confidence among decision makers where it shouldn't exist and not provide all relevant information.
It is useful to consider the number of survey responses received (response rates) so we can be confident that the results are giving an overall snapshot of the population.
It is important that the consultation includes existing, past, and future users of the

services to be affected because this gives perspective from members of the community that will possibly be affected by any changes.

Day 6: What were the results of the NHS Gloucestershire public consultation?

Becky Parish presented a summary of the responses to the public consultation. The full report was in the ring binders sent to jury members. The brief for this presentation was:

- Who / how many people responded?
- Did the mix of people responding closely match the Gloucestershire population in relation to:
    - Where people live?
    - Other key demographics such as age, gender, ethnicity etc.?
- What groups were over-represented and under-represented/missing?
- What were the main results?
- Was there a clear pattern in any of the results suggesting that particular views came from particular groups of people?
- Were there marked differences between staff and public responses?
- What were some of the main themes from free-text responses?
- Were there public responses received from other organisations?

Day 7: Jury Study Time, Review of Fit for the Future Consultation Materials and Interim Output of Consultation Report, and Deliberations

Day 8: Deliberation and report writing (this report)

Appendix 1: Messages to our neighbours

When asked about what they would want to share with their family, friends, and neighbours about their experience on the jury, participants shared the following:

That it is a positive and worthwhile experience and the website address to apply!
It is important to know that the jury was conducted in such a way that every member was able to get their thoughts and views heard.
It is important for people to know that the jury was made up of people from different ages, genders, ethnic and personal backgrounds, making it a very broad opinionated group. Also the amount of detail we were supplied with to enable us to make our decisions was excellent.
I have found the experience to be what I expected overall but have been really impressed with how things have worked so smoothly online. I will actually be taking away some things too - particularly how much more constructive it has been to work in smaller groups, then coming together as it has allowed people who wouldn't normally speak up to feel engaged and confident.
How refreshing it is that 18 people with nothing obvious in common are able to come up with very similar reactions and answers to questions put to the jury i.e. how similar and sensible we all are when it comes down to it.
Important for them to know that it is an in-depth process where there are no constraints to sharing your views/opinions/concerns. That (hopefully) the opinions/concerns of the jury are taken on board by the various groups/committees going forward, not only for the FFTF plan but future consultations.
I found the whole process very interesting and enjoyable, I have learned a lot about the way the NHS tries to get the public involved. Disappointed that this was the first time I had heard of this process though as I think it is in everyone's interest to get involved in anything relating to the NHS. I also found the hosts very welcoming and incredibly nice.
Been a fun and interesting process, learning lots about what's happening moving forward with NHS Gloucestershire, having not known about it before the jury. Found different peoples' views interesting on matters I may not have thought about. Liked the Zoom model rather than the face-to-face, felt it put people at ease working from home, and easy to focus on the task at hand.
I have been very impressed with how much work has gone into the preparation and organisation of the jury. The variety of people selected has been great and from different areas and backgrounds, all really nice people. All the presentations from witnesses were interesting and informative and helped a great deal with our deliberations. The time goes very quickly!
I am extremely impressed by my experience with the jury. Not only has the jury itself been excellently planned, facilitated and made to be enjoyable, but it demonstrates how robust an approach the NHS takes to their public consultations. It has given me confidence in the NHS and their commitment to engage the public. I would also say that the jury has been very interesting, I feel I have gained new skills and had the chance to work with a wonderful group of people!
They know that I was in consultation with a group discussing matters to do with the NHS health service and the way forward. They were glad to know I had something to occupy my mind, body & soul during the past 2 weeks.
I have enjoyed the experience being part of the Jury service for the last 2 weeks, it has been very interesting and informative to understand from the presentations and witness statements, working with people on the Jury that until this time, for me I did not know them previously, a very good mix of people from a variety of backgrounds with different viewpoints and perspectives, this enhanced the value and experience and enabled me to evaluate my own viewpoints and perspectives to come to what I think were good evaluations and decisions.

That we were all unknown to each other and we all had our own views which we were able to express and compare with each other respectfully and with due consideration. As a result we were able to put forward constructive responses both favourable and unfavourable for consideration by the Gloucester Health Trust FFTF commissioning body.
The Citizens' Jury has been a stimulating and fun experience. It has taken a lot of concentration but has been managed in a professional and encouraging way. All members of the jury are encouraged to participate during the discussions and I have found my peers to be supportive and accepting of differing opinions.
Very engaging work with a very good step by step process to get to a clear end point - by the end you could see how all the steps got us to a conclusion. It was really helpful to hear different views and perspectives on issues and tasks. It enabled a well-rounded approach and challenged any preconceived ideas. It may have been helpful to have a little more time getting to know each other. It was hard to judge how much influence this process will have on the decision or work of FFTF going forward. Although it still felt worthwhile. Timing was sometimes pushed however some of the group work could have been more efficient. It was a worthwhile experience.
To know it was a learning experience for us all, made us all think differently about what we were discussing as time went on.
It was not about the proposals but about the correct process was conducted and more than sufficient and appropriate information was delivered to the public. Moreover it allowed us to receive a variety of witness statements and the opportunity for Q and A, clarity and clearing any misunderstandings.
That the jury were able to make evidence-based decisions that the CCG should have regard to and that the Citizens' jury was not merely a rubber stamping exercise.

Fit for the Future (FFTF) Public Consultation
January 2021 Citizens' Jury
Jury Report

15 February 2021

Commissioned by:

Designed and delivered by:

citizens juries

Jefferson Center

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Management Summary

The NHS in Gloucestershire has developed a "Centres of Excellence" approach which could mean that certain services currently provided at both Gloucestershire Royal and Cheltenham General Hospitals will be re-organised and may be provided from a single centre in future. Proposals for change were published as part of One Gloucestershire's Fit for the Future consultation and responses sought from the Gloucestershire public and local NHS staff between October and December 2020. A citizens' jury was held online in January 2021 about the public consultation; this is the report of that citizens' jury.

The citizens' jury was designed and carried out by Citizens' Juries c.i.c. in partnership with the Jefferson Center (the founders of the citizens' jury method). A Jury Commissioning Group of representatives from the NHS in Gloucestershire oversaw the project and set the questions which the jury tackled but not involved in the jury process design. The jury design and materials were reviewed in advance for potential bias by an independent oversight panel.

The jury of 18 citizens, broadly reflecting the Gloucestershire public, was recruited through advertising and came together on Zoom for eight afternoons between 19 and 28 January 2021. They heard evidence from a total of 12 expert and community witnesses about the public consultation processes and information, and deliberated together to answer the questions they were set. The jury worked extensively in small groups, developing and refining their conclusions which are captured in a separate Jurors' Report.

Overall, the jury:

- Was neither confident nor not confident that the consultation process enabled the public to contribute meaningfully to decision making;
    - Gaining in confidence from the clear, concise language and limited jargon in materials
    - Losing confidence from running the consultation during the pandemic thus reducing participation;
- Was more confident than neutral that the information provided as part of the consultation enabled residents to be adequately informed about the proposed service changes thanks to use of plain English and information made accessible across multiple platforms;
- Overall, the jury considered the most important findings from the consultation to be:
    - Though 713 completed surveys may appear unsatisfactory to the general public, it is approximately double the number predicted by sample size calculation software;
    - Respondents did not necessarily reflect the demographics of the county: a significant number of the survey results came from Cheltenham;
    - There are concerns from both staff and patients about bed numbers and the increase of patients to Gloucestershire Royal which is already deemed to be overstretched.
- And a jury majority wanted the NHS Governing Bodies to know:
    - They were concerned about the number of Royal Mail mailshots actually delivered to homes and wondered if there were better ways to market the initial engagement process[1];
    - It would have helped if the FFTF consultation materials incorporated a response to the pandemic;
    - That the proposals should have focused more on patient experience.

[1] Note that the jury heard that the mailshot was one of a range of communication methods used including social media, radio, local newspapers etc.

Report of the jury

Between 19 and 28 January 2021, 18 people from across Gloucestershire met online for a "citizens' jury". The task for these citizens was to tackle a set of jury questions about the public consultation on Fit for the Future, One Gloucestershire's programme proposing potential changes to certain specialist hospital services.

Over eight afternoons (each 1 – 5.30PM), the citizens heard from, and asked questions of, 12 witnesses and carried out group exercises to explore the jury questions. The jury deliberated and found answers to the jury questions together about:

- how confident they were in the public consultation process and the information that was distributed about the proposed service changes
- what they considered to be the most important findings from the public and staff responses to the consultation
- messages that a majority of the jury wanted to send to One Gloucestershire Governing Bodies.

The 18 jury members were selected randomly from 332 applicants to broadly represent the demographic mix of Gloucestershire (according to the 2011 census) in terms of age, gender, ethnicity, educational attainment, employment status and county district.

This report explains why the jury was held, how it was designed, how the jurors were recruited, what they did, the jury's answers to the jury questions, and the results of the end-of-jury questionnaires completed at the end of the last day.

The report from the jurors themselves, and many detailed documents about the jury can be found at https://citizensjuries.org/gloucestershire-hospitals-consultation-2021-jury/. Witness slides and recorded presentations are at: https://www.onegloucestershire.net/yoursay/fit-for-the-future-developing-specialist-hospital-services-in-gloucestershire/citizens-jury/.

Why the citizens' juries were run

This was the second of two citizens' juries about the Fit for the Future programme in Gloucestershire, the first being in January 20220. Both were commissioned by NHS Gloucestershire Clinical Commissioning Group on behalf of One Gloucestershire. One Gloucestershire is an "integrated care system" which aims to provide more joined-up care for NHS patients. It comprises seven partner organisations: Gloucestershire County Council; Gloucestershire Care Services NHS Trust; Gloucestershire Health & Care NHS Foundation Trust; NHS Gloucestershire Clinical Commissioning Group; Gloucestershire primary care providers; and South West Ambulance Service NHS Foundation Trust. One Gloucestershire has developed a "Centres of Excellence" approach to providing specialist services from Gloucestershire's two main hospitals (Gloucestershire Royal and Cheltenham General Hospitals). This approach aims to organise resources and services across the two hospital sites so as to enable better and more efficient patient care.

One Gloucestershire must consult the public about any significant changes to services, and is doing this as part of its "Fit for the Future" Programme. A public and staff engagement exercise was carried out through autumn 2019, to inform the development of "potential solutions" – changes to some specialist hospital services, and to develop evaluation criteria for assessing these potential

solutions. The citizens' jury in January 2020 contributed to this process.

A public consultation about the change proposals was run between October and December 2021. As the public consultation took place during the Covid-19 pandemic, face-to-face events were restricted. A leaflet about the consultation was delivered door-to-door across Gloucestershire and a variety of information booklets were distributed providing varying degrees of detail. Public and staff feedback was captured using a variety of methods including online surveys, social media, and drop-in events.

The citizens' jury was carried out in order to inform the cross-section of the public on the jury about the public consultation process, information and responses, and ask the jury a variety of questions to assess the process and information. The outputs from the jury were designed to inform the decision makers as they consider the case for implementing a set of potential service change solutions carried into the 2020 public consultation.

An earlier citizens' jury was carried out in January 2020 to gain public feedback on the approach and service changes being considered by One Gloucestershire to inform what change proposals were chosen. A report and other documents about the 2020 jury can be found at: https://citizensjuries.org/371-2/.

Planning and designing the citizens' jury

The January 2021 citizens' jury was planned, designed and refined over a period of approximately six months by Citizens' Juries c.i.c. and the Jefferson Center (with the exception of the jury questions which were set by the commissioners of the jury). The main aspects of the jury design were:

- the jury questions;
- the jury demographics and recruitment approach;
- the brief and selection of individuals to act as expert witnesses;
- the brief and selection of individuals to act as members of the oversight panel;
- the programme of jury activities across the five days; and
- the design of the questionnaires completed at the end of the jury.

The design documentation is published and available at:

https://citizensjuries.org/gloucestershire-hospitals-consultation-2021-jury /

Bias, both conscious and unconscious, is a risk to consider in planning citizens' juries.[2] For example, it is very difficult to know what constitutes "impartial information" or balanced argument, and almost every design choice, even down to a bullet point on a presenter's slide, could be challenged on grounds that it might manipulate the citizens' jury towards one outcome or another.

Bias can be monitored and minimised but not eliminated. To monitor and minimise bias on this project, an oversight panel was appointed to review the jury design and materials, and report potential bias. They were chosen to be people with relevant topic knowledge, and no conflict of interest in the outcome of the jury. Members of the panel each completed a bias evaluation form after the jury, published at: https://citizensjuries.org/gloucestershire-hospitals-consultation-2021-jury/.

The end of jury questionnaire also asked about bias.

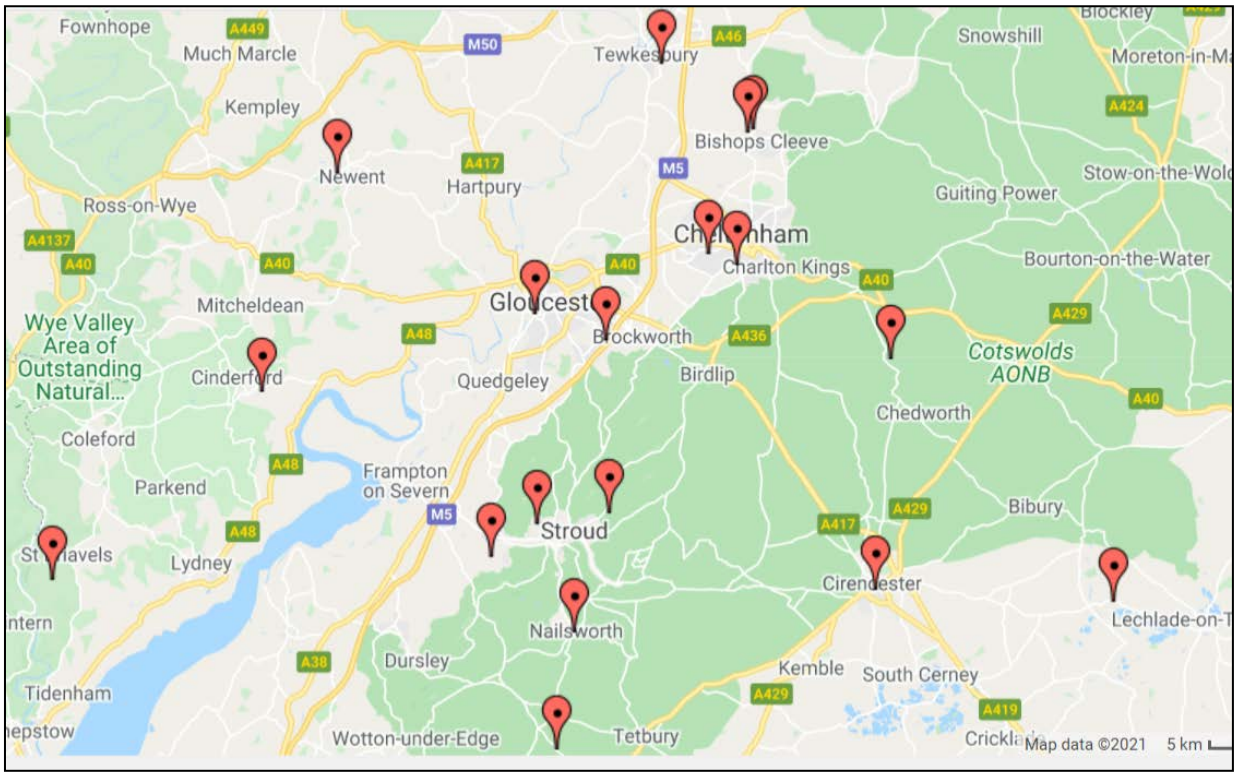
Other design controls used to monitor and minimise bias included:

- The commissioners of the jury were involved in setting the jury questions and advising on NHS witnesses but were independent from the design of the jury process and outcomes;
- The jury worked with independent facilitators from the Jefferson Center to construct and agree their own Jurors' Report of their findings; and
- The detailed jury design and results documentation were published.

Jury recruitment

In total, 332 people applied to be part of the jury. They applied by entering their personal details, including relevant demographics, into an on-line survey. Candidates were shortlisted based on their demographics alone using an algorithm supplied by the Sortition Foundation. Shortlisted candidates had a brief telephone or Zoom interview so that any ineligible candidates (e.g. current NHS professionals) could be identified and excluded. Some jurors were recruited by email or word of mouth, but the majority came through the "Indeed" jobs website. In order to guard against any bias from using a jobs website, the sample was controlled for employment status to ensure the majority were employed or self-employed. Each juror was paid £480 for eight afternoons. Paying participants is an important way to limit self-selection bias.

One week before the jury, 18 jurors and three reserves had been recruited. The jury demographics were all within target ranges, broadly reflecting the population of Gloucestershire (in 2011 census) in terms of age, gender, ethnicity, and educational attainment, District (in Gloucestershire), and employment status. One person withdrew just before the jury began, and two people withdrew during the first two jury days, all because of unforeseeable changes to personal circumstances. The three reserve jurors were able to step in. Despite these late withdrawals a good demographic mix was still achieved. The geographical distribution of the 18 jurors across Gloucestershire was affected by the late withdrawals but there was still a fair spread (see map below). There were 4 jurors from Cotswold District, all chosen at random, but by chance none was from the north of the District.



The jury process and jurors' report

The jury took place online using Zoom from 19 to 22 January, and from 25 to 28 January 2021 (13.00 to 17.30 each day) with:

- Two facilitators: Kyle Bozentko and Sarah Atwood of the Jefferson Center
- 12 expert witness presentations (a mix of expert and community witnesses);
- Group exercises and deliberation; and
- The Jurors' Report in the jurors' words, and the End-of-jury questionnaire, produced on the end of day five.

The jury met in private to protect the identity and privacy of jury participants from people recording and publishing their images and voices through the internet. For this reason, the transparency of the jury design and process is particularly important. The outline jury schedule and the slides and audio recordings from expert witnesses are published on the One Gloucestershire webpage dedicated to the jury. More detailed jury documents are available on the Citizens Juries c.i.c. website.

A full description of the 12 witness presentations, plus the questions posed to the jury and their conclusions, are set out within the Jurors' Report. The results are expressed in their own words using the outputs of the group work over the two weeks. The Jurors' Report was shown to, and agreed by, the jury on the final day of the jury. It was collated by the jury facilitators and contains the main conclusions of the jury in the jurors' own words plus a summary of each day's activities. The jurors were led page-by-page through the report, which was displayed to the group on Zoom, to gain the jurors' acceptance that it fairly represented their work and conclusions. The report was formatted and the final version published by Citizens Juries c.i.c. without external review on 1 February 2021, two working days after the jury ended.

Jury questions and answers

The jury was charged with tackling the six questions set out in in Appendix B. In order to provide reasoned answers to those questions, the jurors listened to witness presentations, asked questions of those witnesses, and deliberated together in small groups in Zoom breakout rooms throughout the week. Their answers were developed and prioritised through group work, other than for questions 1b and 2b ("how confident are you…?") where results were achieved through individual online voting.

The full jury results are published in the Jurors' Report. The summary below aims to capture the main answers to the jury questions (but see the Jurors' Report for the full detail including the reasoning behind priorities). Unlike the full Jurors' Report, it only includes reasoning that was supported by at least a third of the jury (i.e. a minimum of 6 votes). Each juror had multiple votes so the total votes often exceed 18. The narrative reasoning in the tables below is taken directly from the Jurors' report and is in the words of the jurors.

The jury questions are shown below *in italics*.

Q1. How good was the FFTF consultation process?

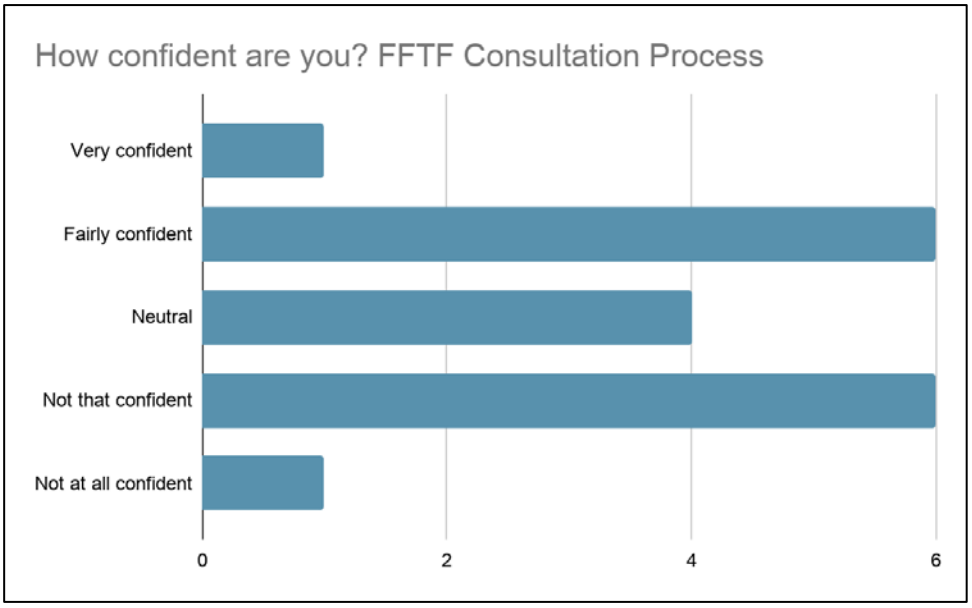
In order to enable the jury to assess the quality of the FFTF consultation process, they heard evidence from an expert witness about what constitutes a good consultation process and developed their own thinking on this question (set out below).

Q1a. What are the characteristics of a good consultation process?

Quality / Characteristic of a Strong or Good Consultation Process	Why It Matters
Consultation seeks to incorporate guidance from relevant bodies, involves a wide variety of the public in its decisions, engages with all sections of society, including groups that are harder to hear, and is inclusive regarding location, access, and geography. - *16 votes*	- It is important to ensure all members of the public have the chance to have their say because everyone should be able to have the information available to be able to make an informed decision. - Shows that the consultation attempts to reach as many of the public as possible and aims to make sure changes made are in the best interest of as many people as possible.
Process uses clear, concise and targeted information and materials. - *11 votes*	- This explains why proposed changes are necessary, informs the public with reasoning behind the decisions, and enables the public to evaluate the proposals and make informed decisions.

Q1b. Based on what you have learned, how confident are you that the consultation process has allowed all residents to contribute meaningfully to the decision-making process?
[Very confident/Fairly confident/Neutral/ Not that confident/Not at all confident]

The results indicate that overall the jury was neither confident nor not confident about the consultation process with a symmetrical split in voting:



- *What are the most important reasons to be confident [that the consultation process has allowed all residents to contribute meaningfully to the decision-making process]?*

Reasons to be confident that the consultation process has allowed residents to contribute meaningfully to the decision-making process.
Clear, concise language and limited jargon in materials - *11 votes*
Range of platforms and options for participating and responding - *9 votes*
Variety of versions of documents with varying detail was provided - *8 votes*
Significant effort made to reach and involve harder to hear groups - *6 votes*

- *What are the most important reasons to not be confident [that the consultation process has allowed residents to contribute meaningfully to the decision-making process]?*

Reasons to not be confident that the consultation process has allowed residents to contribute meaningfully to the decision-making process.
Conducting consultation during Covid-19 pandemic compressed timeline, made it more difficult to participate, limited options for engagement and reduced quality - *12 votes*
Marketing and advertising strategy did not raise awareness of consultation - *10 votes*
Relying on Royal Mail Postal leaflet as primary outreach led to reduced awareness and participation - *9 votes*
Overemphasis on targeted groups may have reduced awareness among and participation among general public - *8 votes*

2. How good was the consultation information?

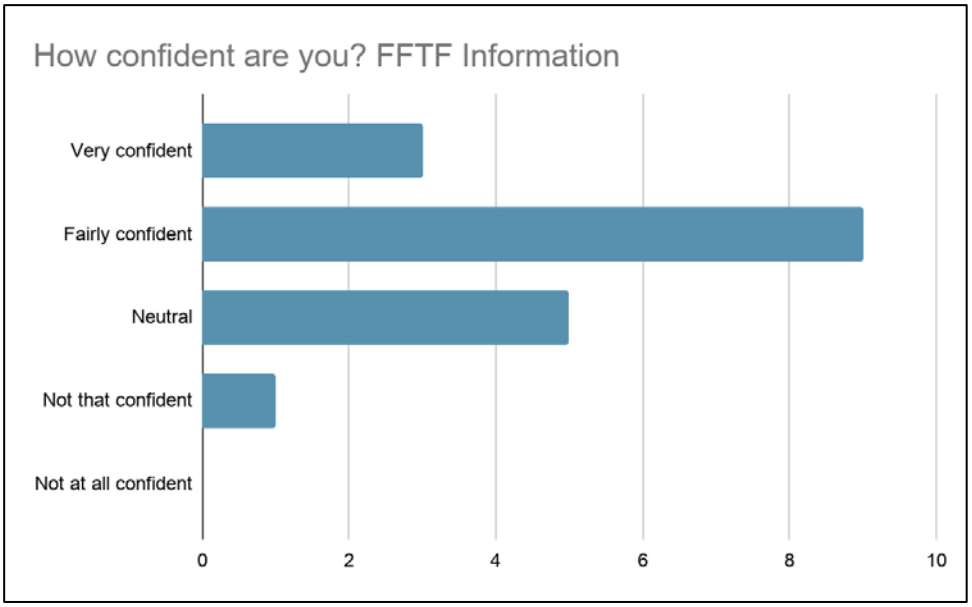
In order to enable the jury to assess the quality of the FFTF consultation information, they heard evidence from an expert witness about what constitutes a good consultation information and developed their own thinking on this question (set out below).

2a. What are the characteristics of good consultation information?

Quality / Characteristic of Strong or Good Consultation Information	Why It Matters
Clear and consistent presentation of information using "Plain English." - *10 votes*	- Demonstrates an understanding by the process organisers that they acknowledge what is required by the service users and that information is being shared among the public. - Matters because participants need to properly understand the proposed changes so they can make relevant contributions and understand the information they are asking to opinionate on. - Matters because overly complicated language/ technical jargon can be off putting/confusing to

	some people and be difficult for those w/disabilities and dyslexia, etc.
Information is accessible across multiple platforms and tailored to specific audiences. - *9 votes*	- To ensure it reaches a wide audience, allowing as many people to be aware of it as possible and because different audiences will have differing capacities to understand and feedback on information
Data is accurate, specific, and up-to-date or responsive when appropriate. - *7 votes*	- Demonstrates that the consultation is credible and reliable.

2b. Based on what you have learned, how confident are you that the information provided through the consultation enabled residents to be adequately informed about the proposed service changes?
[Very confident/Fairly confident/Neutral/ Not that confident/Not at all confident]



- *What are the most important reasons to be confident?*

Reasons to be confident that the information provided through the consultation enabled residents to be adequately informed about the proposed service changes.
Uses "plain English" and provides supplemental glossary to explain jargon - *15 votes*
Information was accessible across multiple platforms and formats - *14 votes*
Included the rationale for why proposed changes were being considered and the reasons these changes would be beneficial - *10 votes*

- *What are the most important reasons to not be confident?*

Reasons to not be confident that the information provided through the consultation enabled residents to be adequately informed about the proposed service changes.
Alternatives to proposals not easy to find in consultation, nor explanation of why alternative

options were not chosen or available to preferred options - *16 votes*
Methods used to distribute information (and solicit feedback) was inadequate - *11 votes*
Continuing the consultation during COVID-19 pandemic hindered advertisement of information - *11 votes*
Easy Read materials and survey were difficult to access and did not provide enough relevant information about proposed changes - *9 votes*

Q3. What are the most important findings from the FFTF consultation results?

Q3a. What are the most important findings from the consultation for the NHS Governing Bodies to consider (such as impact on local community, and suggestions to reduce any negative impacts)?

- *Why?*

Important Findings from FFTF consultation results for NHS Governing Bodies to consider	**Why It Matters**
It is important to know that although the number of 713 completed surveys appears to be a small countywide response, this is approximately double the number survey models recommend. The Fit For the Future consultation group were happy with the overall response, double than what was predicted with response software. However, due to the population being approx 650,000, the number of completed surveys may appear unsatisfactory to the general public. - *11 votes*	- Suggests the general public is pretty apathetic and the FFTF are happy not pushing to get the numbers higher in all age demographics. Whilst some members of the jury felt it was a low number. - This helps us to know that the response rate, and therefore results, is robust enough to base decisions. This is because it shows that most areas were represented.
There was a range of respondents however this did not necessarily reflect the demographics of the county. A significant number of the survey results came from Cheltenham with relatively small proportions from elsewhere. - *10 votes*	- This demonstrates that the consultation results captured different sections of the community (including 20% from people who considered themselves to have a disability), but some groups were under-represented (few responses from under 45 year olds). - This is important because it could mean that the consultation results are inappropriately biased toward Cheltenham where evidence has suggested there is concern that the hospital in Cheltenham may be closed. The survey results may therefore be skewed and biased in favour of proposed changes and therefore do not reflect the views of the residents of Gloucestershire as a whole.
There are concerns from both staff and patients about bed numbers and the increase of patients	- A plan should have been provided to ensure concerns were heard and addressed as well as

to GRH which is already deemed to be overstretched (pre-Covid-19). - *8 votes*	potential negative effects on other areas of the hospital are mitigated against.
Despite the level of participation being deemed as sufficient, we feel it is not representative. - *7 votes*	- The results are not a true representation of the population of Gloucestershire because of the low response rate.
The overall level of support for the proposals was around 70% for all options from the general public and staff that responded to the survey and staff consultation. - *6 votes*	- This suggests the proposals are acceptable to the general public and the NHS staff.

4. Any other messages for the Governing Bodies?

Is there anything else about the consultation that a majority of the jury would like the NHS Governing Bodies to consider in the decision-making process?

Something still missing, needs to be addressed, or requires further clarification re: the FFTF consultation	**Why It Matters**
We are concerned regarding the number of Royal Mail mailshots actually delivered to homes and wonder if there are better ways to market the initial engagement process, to get more people to know about the consultation, and hopefully contribute to the results. *16 Yes votes / 2 No votes)*	This will get more peoples' opinions and a better representation of the people in Gloucestershire, and would help us to know the majority have had a chance to be part of the consultation.
The Covid-19 pandemic has changed our way of life considerably - it would have helped for the FFTF consultation to incorporate a response to the pandemic in their presented material. *(15 Yes votes / 3 No votes)*	This matters because the plans drawn up before the pandemic may not be relevant anymore and the pandemic directly affects the day-to-day running of the services.
We have been assured that the golden thread of patient experience is the reason for this project, but there is nothing about that in the proposals. It is important that at the same time as any reorganisation of medical services, there is a review of the way patients are treated, their dignity and the facilities offered associated with new medical proposals. There is always something about this in external audits. *(16 Yes votes / 2 No votes)*	It's about the patients!

Jury questionnaire results

All jury members completed a daily feedback questionnaire at the end of the first seven jury days. When asked whether staff were conducting themselves in a neutral manner, over 99% of responses from jurors over the seven days were either "very satisfied" or "satisfied" with over

80% being “very satisfied”. Participants also responded each day on whether they agreed that they were being allowed to fully participate in the process. Satisfaction rates were again very high (97%) but slightly lower than those around staff neutrality.

The 18 jurors completed a fuller end-of-jury questionnaire at the end of the jury. The full questionnaire design and the results are available at: https://citizensjuries.org/gloucestershire-hospitals-consultation-2021-jury/. An end-of-day bias questionnaire was also completed by jury members and the results of these are available on the same webpage.

Three questions in the end-of-jury questionnaire concerned potential bias.

When asked “Did you ever feel that the expert witnesses (other than the community representatives on Friday) tried to influence you towards particular conclusions?”

- 11 said “not at all”;
- 5 said “perhaps occasionally”
- 2 said “sometimes”
- No one answered “often” or “very often”.

On the organisers:

- 17 jurors said that the facilitators exhibited no bias (one said “perhaps occasionally”); and
- Similarly, 17 said that no one else outside the jury exhibited bias
- 17 said they were given a fair balance of information (one said there was “some bias” in information presented).

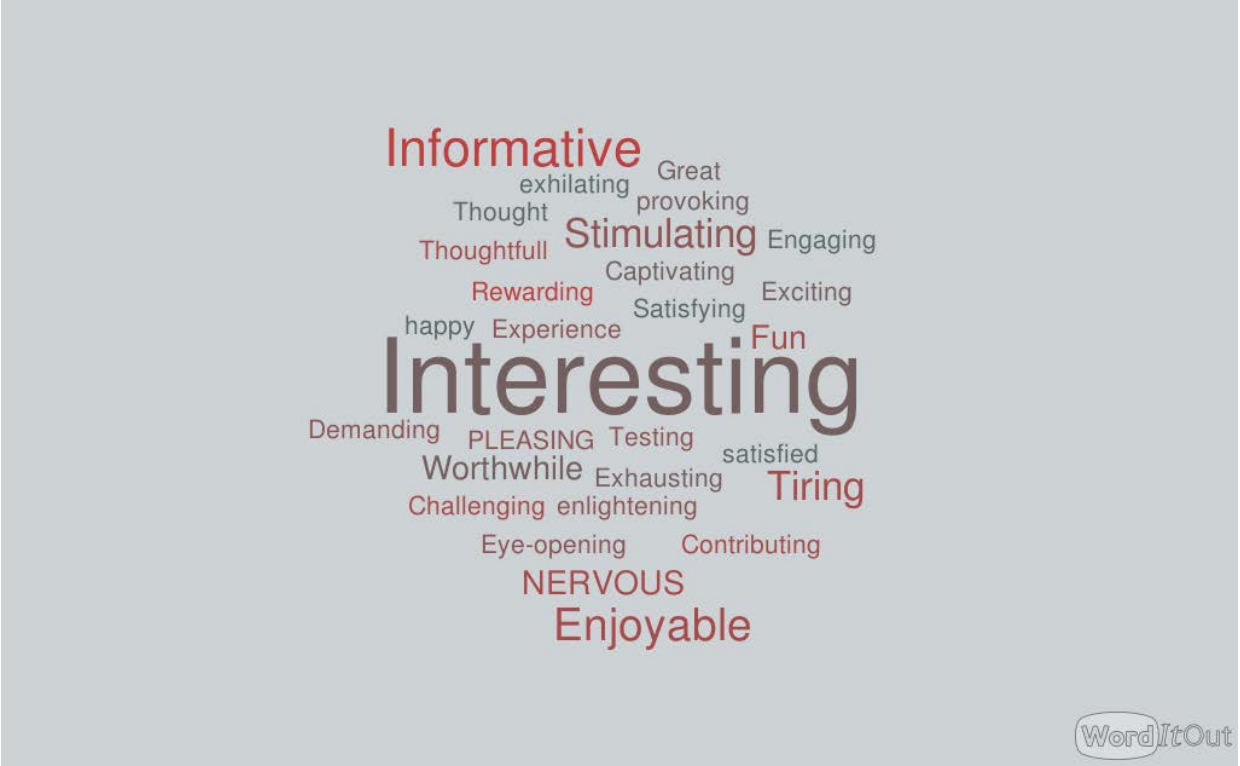
When asked “How easy or difficult did you find doing the jury remotely and online?”

- 12 said “very easy”
- 4 said “mostly easy”
- 2 said “neither easy nor difficult”
- No one said it was “mostly difficult” or “very difficult”.

Asked how interesting they found the jury (on a five point scale from “very interesting” to “very dull”), 17 jurors said they found it “very interesting”, and one said “mostly interesting”.

In another question, each jury member was asked to provide three words to sum up their experience of the jury. The words of the 18 jury members are constructed in a “word cloud” below (large words were said more often).

“Word cloud” of jurors’ experience of the citizens’ jury



Appendix 1: further information about the juries

The Citizens' Jury Method

Like much public policy, assessing a public consultation about how specialist services should be delivered across two hospitals is complex with a lot of information and many arguments to consider. Surveys and focus groups provide useful information about what the public thinks, but they are not mechanisms to inform people. A citizens' jury can tell policymakers what members of the public think once they become more informed about a policy problem. In a citizens' jury, a broadly representative sample of citizens are selected to come together for a period of days, hear expert evidence, deliberate together, and reach conclusions about questions they have been set. The method was devised by Dr Ned Crosby in 1971. He went on to set up the Jefferson Center, which produced the Citizens' Juries Handbook[3], the method followed by Kyle Bozentko and Sarah Atwood of the Jefferson Center when designing and running the jury in Gloucestershire in partnership with Citizens Juries ci.c.

Citizens' Juries are a form of "deliberative democracy", based on the idea that individuals from different backgrounds and with no special prior knowledge or expertise can come together and tackle a public policy question. A citizens' jury is a particularly relevant method for informing public bodies making value judgements. Melbourne City Council appointed a citizens' jury to determine how to allocate its A$5 billion budget, and the council is implementing virtually all of the jury's recommendations. A Citizens' Assembly (the same method but with more participants than a citizens' jury) was commissioned by the Irish government on whether to change the Irish Constitution on abortion recommended change, leading directly to the national referendum on the subject. Mostly citizens' juries or assemblies *inform* policy decisions, although there are examples of these bodies being constituted to *make* decisions.

Witnesses

Witnesses were chosen to provide relevant information to the members of the jury to enable them to answer the jury questions. Each witness gave a presentation and then answered questions posed by the jurors.

The expert witnesses were issued with a brief prior to preparing their presentations. The witness brief is published at: https://citizensjuries.org/gloucestershire-hospitals-consultation-2021-jury/. The witness slides were reviewed in advance to check for potential bias by the oversight panel. The panel identified whether changes were "required" or "advisory". All "required" changes, and most "advisory" changes were made prior to the start of the jury.

Date	Witness presentation topic	Witness
19 Jan	Where are we now, how did we get here and what happens next?	Micky Griffith, One Gloucestershire (NHS)
20 Jan	a) What is Fit for the Future (FFTF)?	a) Prof. Mark Pietroni, One Gloucestershire (NHS)

	b) What does a good NHS consultation process look like? c) What does good consultation information look like?	b) Frances Newell, NHS England c) Frances Newell, NHS England
Jan 21	a) What has the FFTF engagement and consultation process been? b) What information has the NHS provided for the public consultation?	a) Micky Griffith and Becky Parish, One Gloucestershire (NHS) **b)** Becky Parish, One Gloucestershire (NHS)
Jan 22	What in your view were the strengths and weaknesses of the FFTF public consultation?	Five separate presentations from community representatives all on same topic: Russell Peek, Staff Governor, Gloucestershire Hospitals NHS Foundation Trust Chris Hickey and Julius Marstrand, REACH Angela Gilbert, Know Your Patch Networks Trevor Rawlinson, Patient Participation Group from Church Street Medical Practice Vicci Livingstone-Thompson, Inclusion Gloucestershire
Jan 26	a) What can we learn and where should we be cautious when interpreting consultation results? b) What were the results of the consultation?	a) Richard Stockley, Surrey Heartlands Health and Care Partnership b) Becky Parish, One Gloucestershire (NHS)

The oversight panel

The oversight panel was appointed by Citizens Juries c.i.c. to help monitor and minimise bias. The panel reviewed the citizens' jury design, and much of the detailed jury documentation, including the end-of-jury questionnaire, and the slides from the presentations by the expert witnesses, including the video produced by the NHS to be presented alongside Mark Pietroni's slides. Issues identified by the panel were marked as either "advisory" or "required" and fed back to presenters resulting in changes to these materials where appropriate. The three oversight panel members, chosen for their lack of conflict of interest in any particular jury outcome, were:

- Karen Newbiggin, Reader in Healthcare Policy and Management, Health Services

Management Centre, University of Birmingham;
- Ben Stokes, Chair of Health and Wellbeing Board, South Gloucestershire Council;
- Helen Webb, Healthwatch Gloucestershire Manager.

The brief for the oversight panel is available at: https://citizensjuries.org/gloucestershire-hospitals-consultation-2021-jury/ Each member of the oversight panel completed a questionnaire about bias, published at the same webpage.

Two panel members was "fully satisfied" and one panel member was "mostly satisfied" that the jury was designed with the *aim* of minimising bias. Two of the three panel members were "mostly satisfied" that this aim was achieved, and one was "fully satisfied".

Citizens' jury project team and commissioners

The project manager was Malcolm Oswald, Director of Citizens Juries c.i.c. and an Honorary Research Fellow in Law at The University of Manchester. He worked closely with the jury commissioners, the jury facilitators, oversight panel, and expert witnesses. Kyle Bozentko, Executive Director of the Jefferson Center and his colleague Sarah Atwood led the jury design process and facilitated the juries. Chris Barnes and Amanda Stevens recruited and supported the jurors.

The juries were commissioned and paid for by NHS Gloucestershire Clinical Commissioning Group. A Jury Commissioning Group comprising Micky Griffith, Becky Parish, Ellen Rule, Simon Lanceley, all from One Gloucestershire oversaw the project and particularly the setting of the jury questions. Malcolm Oswald provided three-weekly highlight reports to the Jury Commissioning Group, and had liaison meetings with Becky Parish and Micky Griffith through the project.

Appendix 2: The Jury Questions

The jury was tasked with responding to a number of questions set out below. The jury was designed to prepare, inform and otherwise enable the jurors to provide reasoned answers to these questions (the latter being set out in full in the Jurors' Report).

The questions for the citizens' jury are:

1. How good was the FFTF consultation process?

1a. What are the characteristics of a good consultation process?

1b. Based on what you have learned, how confident are you that the consultation process has allowed all residents to contribute meaningfully to the decision-making process?

[Very confident/Fairly confident/Neutral/ Not that confident/Not at all confident]

- What are the most important reasons to be confident?
- What are the most important reasons to not be confident?

2. How good was the consultation information?

2a. What are the characteristics of good consultation information?

2b. Based on what you have learned, how confident are you that the information provided through the consultation enabled residents to be adequately informed about the proposed service changes?

[Very confident/Fairly confident/Neutral/ Not that confident/Not at all confident]

- What are the most important reasons to be confident?
- What are the most important reasons to not be confident?

3. What are the most important findings from the FFTF consultation results?

3a. What are the most important findings from the consultation for the NHS Governing Bodies to consider (such as impact on local community, and suggestions to reduce any negative impacts)?

- Why?

4. Any other messages for the Governing Bodies?

Is there anything else about the consultation that a majority of the jury would like the NHS Governing Bodies to consider in the decision-making process?

Appendix 3: Bibliography

1. Armour, A., *The citizens' jury model of public participation: a critical evaluation*, in *Fairness and competence in citizen participation*. 1995, Springer. p. 175-187.
2. Jefferson Center. *The Citizens' Jury Handbook*. 2004 [cited 09 Feb 2016].

DMBC Appendix 5: Travel Analysis

Summary

The 99 bus service connects Gloucester Hospital, Gloucester Bus station, Arle Court Park and Ride, Cheltenham Town Centre and Cheltenham General Hospital. This service runs 06:35 – 19:50 Mon – Fri every 30 mins. This service is free to staff with a valid permit and a charge is made to the public.

The 94 bus operates between Gloucester bus station and Cheltenham Promenade. Services commence at 04:30 and operate until 00:20 Monday to Friday. This service runs every 15 mins at peak times and every 30 mins at other times. On a Saturday the service runs from 04:30 – 00:20 - every 20 mins at peak times. On a Sunday the service commences at 06:00 and runs until 23:27 - every 30 mins during peak times.

Current services to/from hospitals:

- Service 24 – Late night journeys between Cinderford and Gloucester – 23:10
- Service 22 – Between Gloucester-Cinderford-Coleford – 23:06
- Service 41 – Between Tewkesbury (Ashchurch / Northway) and Cheltenham – 23:30
- Service D/E – Cheltenham / Hatherley / Bishop's Cleeve – 23:02
- Service 98 – Between Gloucester – Longford - Churchdown – Cheltenham – 23:40
- Service 66 – Between Stroud, Stonehouse and Cheltenham – 19:00

During the week the last bus from Gloucester to key towns is at:

- Cheltenham – 23:45
- Tewkesbury – 18:20
- Stroud – 19:35
- Dursley – 17:53
- Cirencester – 18:25
- Tetbury – 16:35
- Coleford – 23:05
- Lydney – 23:05

All will have a connection with the 99 bus. Although the final 99 bus service runs from GRH at 19:45 arriving at Gloucester bus station at 19:50.

During the week the last bus from Cheltenham to key towns is at:

- Gloucester – 23:30
- Tewkesbury – 23:30
- Stroud – 19:00
- Dursley – 16:53*
- Cirencester – 19:12
- Tetbury – 15:40
- Coleford – 22:05*
- Lydney – 22:05*

All will have a connection with the 99 bus. Although the final 99 bus service runs from CGH at 19:46 arriving at Clarence Parade at 19:50.

The Gloucestershire County Council lead Local Transport Plan (LTP has bus travel as one of its key themes and although perceived as poor the bus network does have key routes linking up Gloucester, Cheltenham and key towns that run on a regular basis during peak hours as seen in appendix 5.

At the moment, GCC spend roughly £2.5 million a year on subsidised routes across the county. This remains a significant investment in public transport especially as in recent years some Councils have dramatically scaled back their funding.

The LTP is currently being refreshed up until 2041 which will set out strategic ambition for bus travel this sets out a commitment to making GP surgeries accessible with 45 minutes.

The average journey time by train between Cheltenham Spa and Gloucester is 10 minutes. On an average weekday, there are 60 trains travelling from Cheltenham Spa to Gloucester.

The following stations in Gloucestershire have services with direct trains to Cheltenham and Gloucester

- Stroud
- Kemble
- Stonehouse
- Cam & Dursley

- Ashchurch for Tewkesbury
- Lydney
- Moreton-in-Marsh also has trains that run to Gloucester & Cheltenham although a change is required.

The following community and Voluntary transport providers operate in Gloucestershire.

- Connexions – County wide
- Lydney DAR
- Cotswold Friends
- Newent DAR (Shepard House).

A Non-Emergency Patient Service exists for some people are eligible. These services provide free transport to and from hospital for people who have a medical need for it.

GCC currently operates three Park & Ride facilities. It owns the Park & Ride at:

- Waterwells – For Gloucester
- Arle Court – For Cheltenham
- Cheltenham Racecourse – For Cheltenham

Age UK Survey - People were asked to indicate their main form of transport from a list of options and nearly half of respondents were drivers 49.37 % responded that it was by a vehicle driven by me

*No specific service. Allowing an hour to travel to Gloucester to connect at Gloucester bus station.

Subject area	Narrative	Link	Appendix
99 Bus GRH – CGH	This service links staff and passengers to Gloucestershire Royal and Cheltenham General Hospitals (GRH & CGH) five days a week (Monday to Friday excluding Bank Holidays).This service is funded by the NHS.	Link to service timetable - https://www.gloshospitals.nhs.uk/about-us/news-media/press-releases-statements/new-99-shuttlebus-service-launches/	Appendix 1 Service timetable

	Bus stops Cheltenham: • Clarence Parade - Buses serving this stop include: D, E, F, 99, 94U, 94X • North Street Stop 18 (by Primark) - Bus serving this stop: 99, F • Albion Street - Buses serving this stop include 99, 606 & 606S, B, F, 801 • Cheltenham General Hospital, College Road • Arle Court Park and Ride *St James St (on the return loop from Gloucester to Cheltenham only) The service runs 06:35 – 19:50 Mon – Fri. Gloucester: • Gloucester Bus Station, Market Parade • Gloucestershire Royal Hospital, Tower Block entrance For staff: Travel is free on display of a valid staff ID card (GHNHSFT). However, a £1 fare is applicable to staff joining the service at Arle Court Park and Ride (this includes car parking). For the public: • CGH to GRH: Single: £3.30 Return: £5 • Cheltenham town centre to CGH: Single: £1.50 Return: £2 • GRH to CGH: Single: £3.30 Return: £5 • Gloucester bus station to GRH: Single: £1.50 Return: £2 Please see appendix 1 for the service timetable.		

94 Bus service between Gloucester and Cheltenham	Travel between Gloucester and Cheltenham 7 days per week. Services commence at 04:30 between Cheltenham and Gloucester until 00:20 Monday to Friday. This service runs every 15 mins at peak times and every 30 mins at other times. On a Saturday the service runs from 04:30 – 00:20 on every 20 mins at peak times. On a Sunday the service commences at 06:00 and runs until 23:27 every 30 mins during peak times. Please see appendix 2 for the service timetable.	94 timetable https://tiscon-maps-stagecoachbus.s3.amazonaws.com/Timetables/West/2021/94.pdf https://tiscon-maps-stagecoachbus.s3.amazonaws.com/Timetables/West/2020/94041020.pdf	Appendix 2 Service timetables
Moovit travel analysis to GRH	Travel analysis using the Moovit website indicates that GRH is relatively well connected to the local network and that several services that pass near to GRH. The appendices indicated 'live' end to end travel times at a point in time.	Moovit urban mobility app https://moovitapp.com/ How to get to GRH from various locations and indicative travel times– https://moovitapp.com/index/en-gb/public_transportation-Gloucestershire_Royal_Hospital-South_West-site_8864255-2106	

Moovit travel analysis to CGH	Travel analysis using the Moovit website indicates that CGH is relatively well connected to the local network and that the several services that pass near to CGH. The appendices indicated 'live' end to end travel times at a point in time.	Moovit urban mobility app https://moovitapp.com/ How to get to CGH from various locations and indicative travel times https://moovitapp.com/index/en-gb/public_transportation-Cheltenham_General_Hospital-South_West-site_8870204-2106	
Buses that stop at GRH and CGH	Current services to/from hospitals • Services 94 and 10 still operate evening services between Gloucester and Cheltenham and prior to pandemic they appeared to be working well. • Service 24 – Late night journeys between Cinderford and Gloucester • Service 22 – Between Gloucester-Cinderford-Coleford • Service 41 – Between Tewkesbury (Ashchurch / Northway) and Cheltenham • Service D/E – Cheltenham / Hatherley / Bishop's Cleeve • Service 98 – Between Gloucester – Longford - Churchdown – Cheltenham • Service 66 – Between Stroud and Stonehouse		

First and last bus analysis from GRH	Analysis of the first and last bus home from • Cheltenham • Tewkesbury • Stroud • Dursley • Cirencester • Tetbury • Coleford • Lydney Please see appendix 3 for a summary and appendix 4 for a travel map.		Appendix 3 Analysis matrix Appendix 4 Analysis map
Bus strategy / LTP	General Bus routes can be commercial – run by a company. In this case, the route needs to bring in enough revenue from passengers to make it viable/sustainable for that operator without receiving any subsidy funds from GCC. If a route is required for a community but is not commercially viable, the route can be subsidised. This is where a local authority (in our case, Gloucestershire County Council) pays an operator what is required to provide the route. We use a fully compliant tendering process to ensure best and most efficient use of public funds. At the moment, GCC spend roughly £2.5 million a year on subsidised routes across the county. This remains a significant investment in public transport especially as in recent years some Councils have dramatically scaled back their funding.	Local transport plan	Appendix 5 Gloucesters hire bus network (by frequency of services) Appendix 6 Tiered services with differing funding streams

	As the car has become more popular in rural areas (no scheduling is required), especially in the evenings, some bus users have moved to using their cars rather than hard-to-reach public transport. As such, some commercial bus services have reduced their journey number (per day), due to decreased revenue, and for those routes that are subsidised, the council has to maintain or increase subsidy to cover the decreasing revenue. Aims and objectives: The purpose of continuing to maintain and develop the bus network is three-fold: • To support the economy and growth by providing access to facilities and services for people with no alternative. • To support efficiency within society and the economy by offering travel choice for people with private transport. • To support measures to promote health and fitness and care for the environment. Frequency of offer: Frequency of services does differ across the County and this is demonstrated in appendix 5. Although, it should be noted the areas that receive a tier 1 or tier 2 service which tend to be commercially or part commercially viable services. Funding: Bus services are subject to a 3 tier funding system – • Core Services – High frequency (ie no GCC funding). • Intermediate – Frequent bus services (mix of commercial and subsidised services). • Supported services – (infrequent and mostly subsidised).		

	From the draft LTP: • *It is important for GCC to direct its financial resources effectively with the aim of improving the commercial viability of the network through the provision of complementary services and specific services that meet particular policy objectives, such as avoiding social exclusion or isolation. Access to education and training, employment, non-emergency health care and essential (food) shopping are considered priorities*. Any significant changes to funding or the allocation of funding would be considered a 'Key Decision' and would be subject to a process that included consultation. LTP priority - below is the LTP priority relating to bus travel. LTP PI-10 - Maintain bus passenger access. Outputs from this indicator will assist in understanding the impacts of LTP Policy Documents 1 Public & Community Transport. This indicator reports access by public transport within 45 minutes to GP surgeries it provides a good proxy for network coverage as GP surgeries tend to be located close to other local services. The target is to maintain level of access to GP services and facilities by public transport within 45 minutes. Please see appendix 5 which provides an overview of the Gloucestershire bus network and appendix 6 which provides some more detail around funding of the busses in the County.		

Train travel between Gloucester and Cheltenham	The average journey time between Cheltenham Spa and Gloucester is 10 minutes. On an average weekday, there are 60 trains travelling from Cheltenham Spa to Gloucester. The journey time may be longer on weekends and holidays. • The first train weekday train from Gloucester is at 04:17 and the last train at 00:56. • The first weekday train from Cheltenham is at 04:56 and the last train at 23:03. • The fastest journey time by train is 8 minutes.	Timetable information is available here – https://www.thetrainline.com/train-times/gloucester-to-cheltenham-spa	
Train travel in Gloucester-shire	The following stations with trains to Cheltenham and Gloucester • Stroud • Kemble • Stonehouse • Cam & Dursley • Ashchurch for Tewkesbury • Lydney • Moreton-in-Marsh also has trains between Gloucester & Cheltenham although a change is required.	More details on local train times can be found here - https://www.thetrainline.com/	
Local Transport Plan (LTP)	Gloucestershire County has a responsibility to have a Local Transport Plan (LTP). The LTP sets out the long term transport strategy between 2015 and 2031. To put the LTP into context please see. The LTP draws together 6 connecting place based strategies and is currently undergoing a refresh, the refresh will look forward to 2041 and it is now in a draft format. The draft vision is: 'A resilient transport network that enables sustainable economic growth by providing travel choices for all, making Gloucestershire a better place to live, work and visit'	Links to the LTP document https://www.gloucestershire.gov.uk/transport/gloucestershires-local-transport-plan-2015-2031 Connecting places strategies https://www.gloucestershire.gov.uk/transport/gloucestershires-local-transport-plan-2015-2031/connecting-places-strategies-cps/	

	In delivering the LTP, funding is achieved from various sources who are all stakeholders in the decision making process. Appendix 7 sets out how the plan is funded, appendix 8 its proposed objectives and 9 the context of the document and who feeds into the process of creating the plan.		Appendix 7 LTP funding sources Appendix 8 LTP Objectives Appendix 9 LTP context.
Community & Voluntary travel	Healthwatch Gloucestershire is not a transport provider but signposts to community and Voluntary transport providers. The main groups are: • Connexions – County wide • Lydney DAR • Cotswold Friends • Newent DAR (Shepard House). GCC provides £0.5 million per year in annual grants to support community transport providers, as this is often the last line of access to public transport for vulnerable people. It is an LTP aspiration that there may be opportunities to protect and enhance community transport through a Total Transport approach. This would draw together the resources deployed on various types of specialist provision, including non-emergency patient transport and school transport47. Such integration will provide economies of scale by linking together different passenger demands and increasing utilisation of existing vehicles.	Voluntary Groups https://www.gloucestershire.gov.uk/transport/community-transport/	

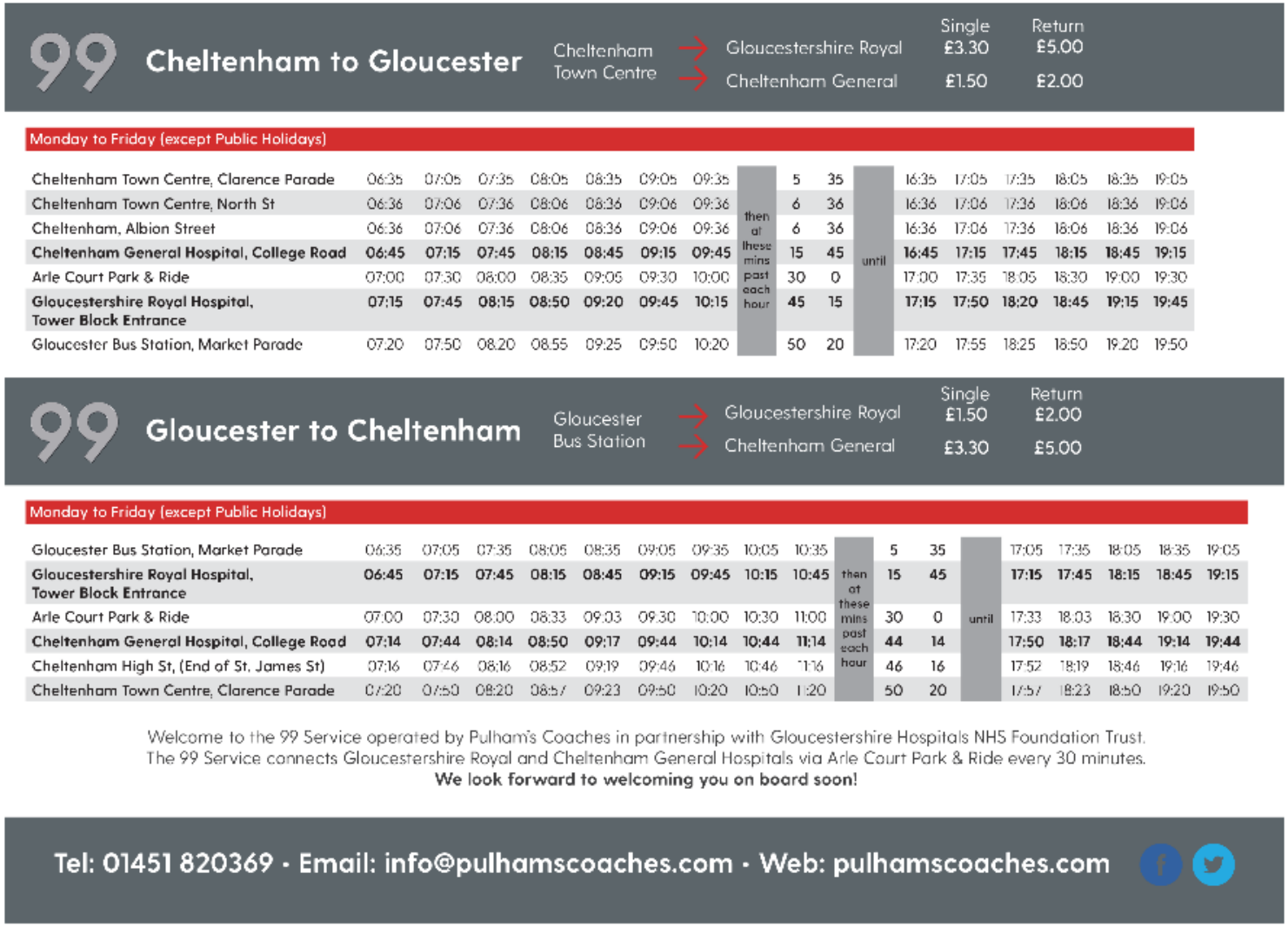
	GCC is progressing this idea through the Thinktravel Total Transport portal which will bring community, voluntary and public transport together under one platform, making accessible transport available to a wider audience, that previously have not considered these options as a travel choice. This could include better integration of the funding and delivery of patient care transport, demand responsive community transport services and car or lift-share schemes. There is a need to clarify the training and permit requirements for those providing shared services.		
Non-Emergency Patient Transport Services	Non-emergency patient transport services Some people are eligible for non-emergency patient transport services (PTS). These services provide free transport to and from hospital for people who have a medical need for it. The NHS determines that patients are eligible for free non-emergency transport when: • The medical condition of the patient is such that they require the skills or support of PTS staff during the journey and where it would be detrimental to the patient's condition or recovery if they were to travel by other means: and/or • The patient's medical condition impacts on their mobility to such an extent that they would be unable to access healthcare or it would be detrimental to the patient's condition or recovery to travel by other means. In Gloucestershire this transport is provided by E-zec Medical Transport Services Ltd. If you think you might be eligible to receive non-emergency patient transport, call The Patient Transport Advice Centre (PTAC) direct on 01278 726968.		

	You will be asked some questions about yourself or the person you are booking transport for and they will be able to tell you if you/they are eligible. PTAC's assessment will be based on Department of Health Guidelines. If you are eligible they will take some further details to make sure the right type of transport and support is provided and will take your booking.		
Park & ride	GCC currently operates three Park & Ride facilities. It owns the Park & Ride at: • Waterwells – For Gloucester • Arle Court – For Cheltenham And has a facility at: • Cheltenham Racecourse – For Cheltenham Services run between 07:00 and 19:00 Monday – Saturday and 08:30 and 18:00 on a Sunday.	Cheltenham Racecourse https://www.stagecoachbus.com/promos-and-offers/west/cheltenham-park-and-ride https://www.gloucestershire.gov.uk/transport/park-ride-gloucester-and-cheltenham/	
Age UK	In the spring of 2019 we conducted further engagement activity with older people across Gloucestershire, asking about their experiences of living in the county and how it could be better. The purpose of this activity was to provide further clarity to our initial focus group findings, by gaining insight from a larger number of older people across Gloucestershire. Key findings: It is easy for me to get around and access the activities I do and the services I need.		

	Respondents were asked to indicate how far they agree or disagree with this statement. • 57.5% agreed or strongly agreed that it is easy for them to get around • 27.7% disagreed or strongly disagreed. What is your main form of transport? People were asked to indicate their main form of transport from a list of options and nearly half of respondents were drivers. • 49.37 % responded that it was by a vehicle driven by me • 11.72 % responded that it was a vehicle driven by a friend or relative • 6.28 % responded that it was a vehicle driven by a partner • 23.43 % responded that the bus was the main form of transport • The remainder of the responses were a mixture of walking 13.8% and taxi, train and bicycle		
COVID 19	It should be noted that travel timetables have been amended to adjust to passenger demand which has changed through Lockdowns, working from home and general changes in behaviour due to COVID-19. In general the first and last services each day have not been removed from service timetables.		

Appendix 1

99 Service timetable



99 Cheltenham to Gloucester

Cheltenham Town Centre → Gloucestershire Royal — Single £3.30 — Return £5.00
Cheltenham Town Centre → Cheltenham General — Single £1.50 — Return £2.00

Monday to Friday (except Public Holidays)

Cheltenham Town Centre, Clarence Parade	06:35	07:05	07:35	08:05	08:35	09:05	09:35	then at these mins past each hour	5	35	until	16:35	17:05	17:35	18:05	18:35	19:05
Cheltenham Town Centre, North St	06:36	07:06	07:36	08:06	08:36	09:06	09:36		6	36		16:36	17:06	17:36	18:06	18:36	19:06
Cheltenham, Albion Street	06:36	07:06	07:36	08:06	08:36	09:06	09:36		6	36		16:36	17:06	17:36	18:06	18:36	19:06
Cheltenham General Hospital, College Road	**06:45**	**07:15**	**07:45**	**08:15**	**08:45**	**09:15**	**09:45**		15	45		**16:45**	**17:15**	**17:45**	**18:15**	**18:45**	**19:15**
Arle Court Park & Ride	07:00	07:30	08:00	08:35	09:05	09:30	10:00		30	0		17:00	17:35	18:05	18:30	19:00	19:30
Gloucestershire Royal Hospital, Tower Block Entrance	**07:15**	**07:45**	**08:15**	**08:50**	**09:20**	**09:45**	**10:15**		**45**	**15**		**17:15**	**17:50**	**18:20**	**18:45**	**19:15**	**19:45**
Gloucester Bus Station, Market Parade	07:20	07:50	08:20	08:55	09:25	09:50	10:20		50	20		17:20	17:55	18:25	18:50	19:20	19:50

99 Gloucester to Cheltenham

Gloucester Bus Station → Gloucestershire Royal — Single £1.50 — Return £2.00
Gloucester Bus Station → Cheltenham General — Single £3.30 — Return £5.00

Monday to Friday (except Public Holidays)

Gloucester Bus Station, Market Parade	06:35	07:05	07:35	08:05	08:35	09:05	09:35	10:05	10:35	then at these mins past each hour	5	35	until	17:05	17:35	18:05	18:35	19:05
Gloucestershire Royal Hospital, Tower Block Entrance	**06:45**	**07:15**	**07:45**	**08:15**	**08:45**	**09:15**	**09:45**	**10:15**	**10:45**		**15**	**45**		**17:15**	**17:45**	**18:15**	**18:45**	**19:15**
Arle Court Park & Ride	07:00	07:30	08:00	08:33	09:03	09:30	10:00	10:30	11:00		30	0		17:33	18:03	18:30	19:00	19:30
Cheltenham General Hospital, College Road	**07:14**	**07:44**	**08:14**	**08:50**	**09:17**	**09:44**	**10:14**	**10:44**	**11:14**		**44**	**14**		**17:50**	**18:17**	**18:44**	**19:14**	**19:44**
Cheltenham High St, (End of St. James St)	07:16	07:46	08:16	08:52	09:19	09:46	10:16	10:46	11:16		46	16		17:52	18:19	18:46	19:16	19:46
Cheltenham Town Centre, Clarence Parade	07:20	07:50	08:20	08:57	09:23	09:50	10:20	10:50	11:20		50	20		17:57	18:23	18:50	19:20	19:50

Welcome to the 99 Service operated by Pulham's Coaches in partnership with Gloucestershire Hospitals NHS Foundation Trust.
The 99 Service connects Gloucestershire Royal and Cheltenham General Hospitals via Arle Court Park & Ride every 30 minutes.
We look forward to welcoming you on board soon!

Tel: 01451 820369 · Email: info@pulhamscoaches.com · Web: pulhamscoaches.com

Appendix 2

94 Service timetable

94 from Gloucester to Cheltenham

Stagecoach

from 16 January 2021

Mondays to Fridays

	94	94	94	94	94	94	94X	94	94	94	94X	94	94	94X	94	94	94	94	at these mins past each hour	94	94	94	94	until	94	94	94	94	94	94	94	94X	94	94
Gloucester Market Parade [M]	0500	0530	0600	0630	0645	0700	0712	0715	0730	0745	0747	0800	0815	0822	0830	0845	0900	0915		30	45	00	15		1430	1445	1500	1515	1530	1545	1600	1607	1615	1630
Longlevens Elmbridge Road	0508	0538	0608	0638	0653	0708	0720	0723	0738	0753	0755	0808	0823	0830	0838	0853	0908	0923		38	53	08	23		1438	1453	1508	1523	1538	1553	1608	1615	1623	1638
Churchdown Hare & Hounds	0515	0545	0615	0645	0700	0715	-	0730	0745	0800	-	0815	0830	-	0845	0900	0915	0930		45	00	15	30		1445	1500	1515	1530	1545	1600	1615	-	1630	1645
GCHQ Benhall Gloucester Road	0525	0555	0625	0655	0710	0725	0730	0740	0755	0810	0805	0825	0840	0840	0855	0910	0925	0940		55	10	25	40		1455	1510	1525	1540	1555	1610	1625	1625	1640	1655
Cheltenham Promenade	0535	0605	0635	0705	0720	0735	0740	0750	0805	0820	0815	0835	0850	0850	0905	0920	0935	0950		05	20	35	50		1505	1520	1535	1550	1605	1620	1635	1635	1650	1705

	94X	94	94	94	94X	94	94	94	94	94	94	94	94	94	94	94	94	at these mins past each hour	94	94	until	94	94
Gloucester Market Parade [M]	1642	1645	1700	1715	1717	1730	1745	1800	1815	1830	1845	1900	1915	1935	1955	2015	2045		15	45		2315	2345
Longlevens Elmbridge Road	1650	1653	1708	1723	1725	1738	1753	1808	1823	1838	1853	1908	1923	1943	2003	2023	2053		23	53		2323	2353
Churchdown Hare & Hounds	-	1700	1715	1730	-	1745	1800	1815	1830	1845	1900	1915	1930	1950	2010	2030	2100		30	00		2330	2400
GCHQ Benhall Gloucester Road	1700	1710	1725	1740	1735	1755	1810	1825	1840	1855	1910	1925	1940	2000	2020	2040	2110		40	10		2340	0010
Cheltenham Promenade	1710	1720	1735	1750	1745	1805	1820	1835	1850	1905	1920	1935	1950	2010	2030	2050	2120		50	20		2350	0020

94 from Cheltenham to Gloucester

Stagecoach

from 16 January 2021

Mondays to Fridays

	94	94	94	94	94	94	94	94	94X	94	94	94	94X	94	94	94X	94	94	94	94	at these mins past each hour	94	94	94	94	until	94	94	94	94	94	94	94	94X
Cheltenham Promenade [3]	0430	0500	0530	0600	0615	0630	0645	0700	0713	0715	0730	0745	0748	0800	0815	0823	0830	0845	0900	0915		30	45	00	15		1430	1445	1500	1515	1530	1545	1600	1608
Arle Court	0438	0508	0538	0609	0624	0639	0654	0710	0723	0725	0740	0755	0758	0810	0825	0833	0840	0855	0910	0925		40	55	10	25		1440	1455	1510	1525	1540	1555	1610	1618
Churchdown Hare & Hounds	0445	0515	0545	0616	0631	0646	0701	0718	-	0733	0748	0803	-	0818	0833	-	0848	0903	0918	0933		48	03	18	33		1448	1503	1518	1533	1548	1603	1618	-
Longlevens Elmbridge Road	0450	0520	0550	0621	0636	0651	0706	0726	0733	0741	0756	0811	0808	0826	0841	0843	0856	0911	0926	0941		56	11	26	41		1456	1511	1526	1541	1556	1611	1626	1628
Gloucester Market Parade	0457	0527	0557	0630	0645	0700	0715	0735	0742	0750	0805	0820	0817	0835	0850	0852	0905	0920	0935	0950		05	20	35	50		1505	1520	1535	1550	1605	1620	1635	1637

	94	94	94X	94	94	94	94X	94	94	94	94	94	94	94	94	94	at these mins past each hour	94	94	until	94	94	94
Cheltenham Promenade [3]	1615	1630	1643	1645	1700	1715	1718	1730	1745	1800	1815	1830	1850	1910	1930	2000		30	00		2230	2300	2330
Arle Court	1625	1640	1653	1655	1710	1725	1728	1740	1755	1810	1825	1840	1900	1920	1940	2010		40	10		2240	2310	2340
Churchdown Hare & Hounds	1633	1648	-	1703	1718	1733	-	1748	1803	1818	1833	1848	1908	1928	1948	2018		48	18		2248	2318	2348
Longlevens Elmbridge Road	1641	1656	1703	1711	1726	1741	1738	1756	1811	1826	1841	1856	1916	1936	1956	2026		56	26		2256	2326	2356
Gloucester Market Parade	1650	1705	1712	1720	1735	1750	1747	1805	1820	1835	1850	1905	1925	1945	2005	2035		05	35		2305	2335	0005

94 from Gloucester to Cheltenham

Stagecoach

from 16 January 2021

Saturdays

							until/at these mins past each hour				until								at these mins past each hour			until		
Gloucester Market Parade [M]	0500	0530	0600	0630	0650	0710		30	50	10		1630	1650	1710	1730	1750	1815	1845		15	45		2215	2245	2345
Longlevens Elmbridge Road	0508	0538	0608	0638	0658	0718		38	58	18		1638	1658	1718	1738	1758	1823	1853		23	53		2223	2253	2353
Churchdown Hare & Hounds	0515	0545	0615	0645	0705	0725		45	05	25		1645	1705	1725	1745	1805	1830	1900		30	00		2230	2300	2400
GCHQ Benhall Gloucester Road	0525	0555	0625	0655	0715	0735		55															2240	2310	0010
Cheltenham Promenade	0535	0605	0635	0705	0725	0745		05															2250	2320	0020

94 from Cheltenham to Gloucester

Stagecoach

from 16 January 2021

Saturdays																										
Cheltenham Promenade [3]	0430	0500	0530	0600	0620	0640	until at these mins past each hour	00	20	40	until	1700	1720	1740	1800	1830	until at these mins past each hour	00	30	until	2100	2130	2200	2300
Arle Court	0438	0508	0538	0610	0630	0650		10	30	50		1710	1730	1750	1810	1840		10	40		2110	2140	2210	2310
Churchdown Hare & Hounds	0445	0515	0545	0618	0638	0658		18	38	58		1718	1738	1758	1818	1848		18	48		2118	2148	2218	2318
Longlevens Elmbridge Road	0450	0520	0550	0626	0646	0706		26	46	06		1726	1746	1806	1826	1856		26	56		2126	2156	2226	2326
Gloucester Market Parade	0457	0527	0557	0635	0655	0715		35	55	15		1735	1755	1815	1835	1905		35	05		2135	2205	2235	2335

94 from Gloucester to Cheltenham

Stagecoach

from 16 January 2021

Sundays & Bank Holiday Mondays																				
Gloucester Market Parade [M]	0630	0730	0815	0845	0915	then every 30 minutes at	45	15	until	1645	1715	1745	1815	1900	then every 60 minutes at	00	until	2300
Longlevens Elmbridge Road	0636	0736	0823	0853	0923		53	23		1653	1723	1753	1823	1906		06		2306
Churchdown Hare & Hounds	0640	0740	0830	0900	0930		00	30		1700	1730	1800	1830	1910		10		2310
Arle Court P&R	-	-	-	0910	0940		10	40		1710	1740	-	-	-		-		-
GCHQ Benhall Gloucester Road	0647	0747	0840	0913	0943		13	43		1713	1743	1810	1840	1917		17		2317
Cheltenham Promenade	0657	0757	0850	0923	0953		23	53		1723	1753	1820	1850	1927		27		2327

94 from Cheltenham to Gloucester

Stagecoach

from 16 January 2021

Sundays & Bank Holiday Mondays																				
Cheltenham Promenade [3]	0600	0700	0730	0800	0830	0900	0930	then every 30 minutes at	00	30	until	1600	1630	1700	1730	then every 60 minutes at	30	until	2230
Arle Court	0608	0708	0740	0810	0840	0910	0940		10	40		1610	1640	1710	1738		38		2238
Arle Court P&R	-	-	-	-	-	0912	0942		12	42		1612	1642	1712	-		-		-
Churchdown Hare & Hounds	0615	0715	0748	0818	0848	0921	0951		21	51		1621	1651	1721	1745		45		2245
Longlevens Elmbridge Road	0620	0720	0756	0826	0856	0929	0959		29	59		1629	1659	1729	1750		50		2250
Gloucester Market Parade	0627	0727	0805	0835	0905	0938	1008		38	08		1638	1708	1738	1757		57		2257

Key

△ School days only

– Stop not served

Appendix 3

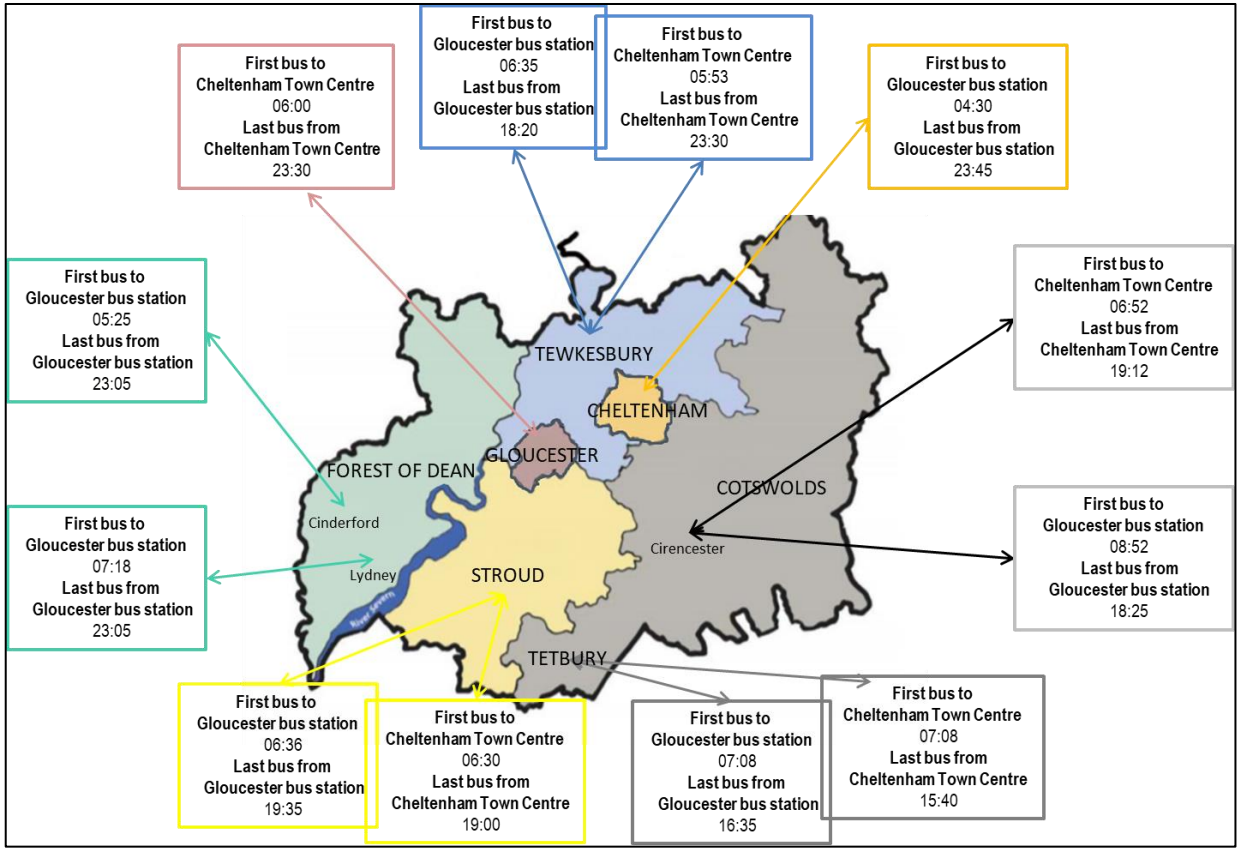
Analysis matrix

Gloucester						
	First bus to Gloucester (weekday)	Last Bus from Gloucester (weekday)	First bus to Gloucester (Saturday)	Last Bus from Gloucester (Saturday)	First bus to Gloucester (Sunday)	Last Bus from Gloucester (Sunday)
Cheltenham	04:30 (Service 94)	23:45	04:30	23:45	06:00	23:00
Tewkesbury	06:35 (Service 71)	18:20	07:55	18:30	N/A	N/A
Stroud	06:36 (63)	19:35	07:38	19:35	08:38 (Service 66)	17:25 (Service 66)
Dursley	06:38 (Service 60)	17:53	06:38	17:53	08:40	16:43
Cirencester	08:52	18:25	09:35	18:15 (via Chelt)	10:17 (via Chelt)	16:15 (via Chelt)
Tetbury	07:08 (Service 69 then 63)	16:35 (Service 63 then 69)	07:08 (Service 69 then 63)	16:25 (Service 63 then 69)	N/A	N/A
Coleford	05:25 (Service 22)	23:05	05:55	23:05	08:55	16:30
Lydney	07:18 (Service 23)	23:05	08:18	23:05	10:18	14:30

Cheltenham						
	First bus to Cheltenham (weekday)	Last Bus from Cheltenham (weekday)	First bus to Cheltenham (Saturday)	Last Bus from Cheltenham (Saturday)	First bus to Cheltenham (Sunday)	Last Bus from Cheltenham (Sunday)
Gloucester	06:00 (Service 94)	23:30	06:00	23:00	06:30	22:30
Tewkesbury	05:53 (Service 41)	23:30	06:13	23:30	07:28	19:22
Stroud	06:30 (Service 66)	19:00	07:45	19:00	08:45	17:40
Dursley	No Direct bus need to catch bus to Gloucester, as above, then Service 94 to Cheltenham					
Cirencester	06:52	19:12	07:17	19:07	08:17	17:07
Tetbury	07:08 (Service 69 then 66)	15:40 (Service 66 then 69)	07:08 (Service 69 then 66)	15:40 (Service 66 then 69)	N/A	N/A
Coleford	No direct route, need to catch bus to Gloucester, as above, then service 94 to Cheltenham.					
Lydney						

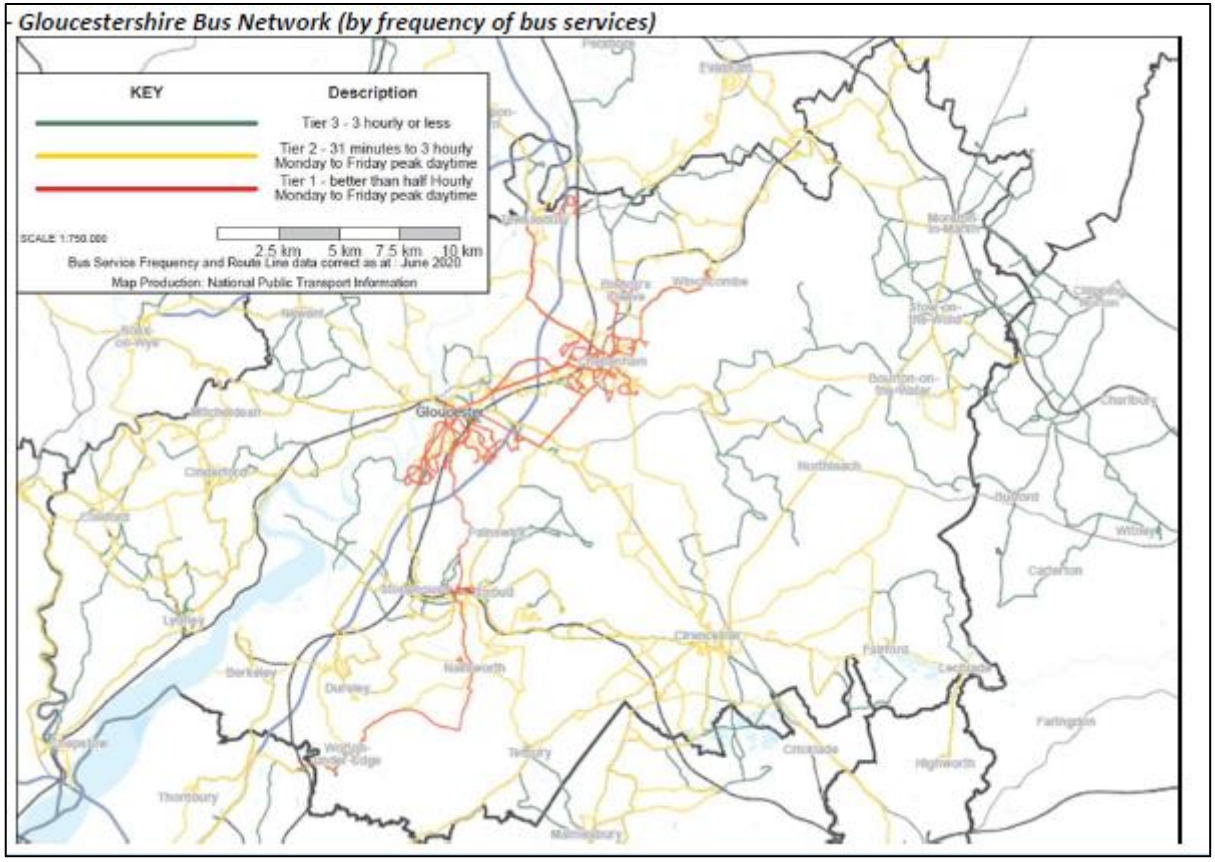
Appendix 4

Analysis map



Appendix 5

Gloucestershire bus network (by frequency of services)



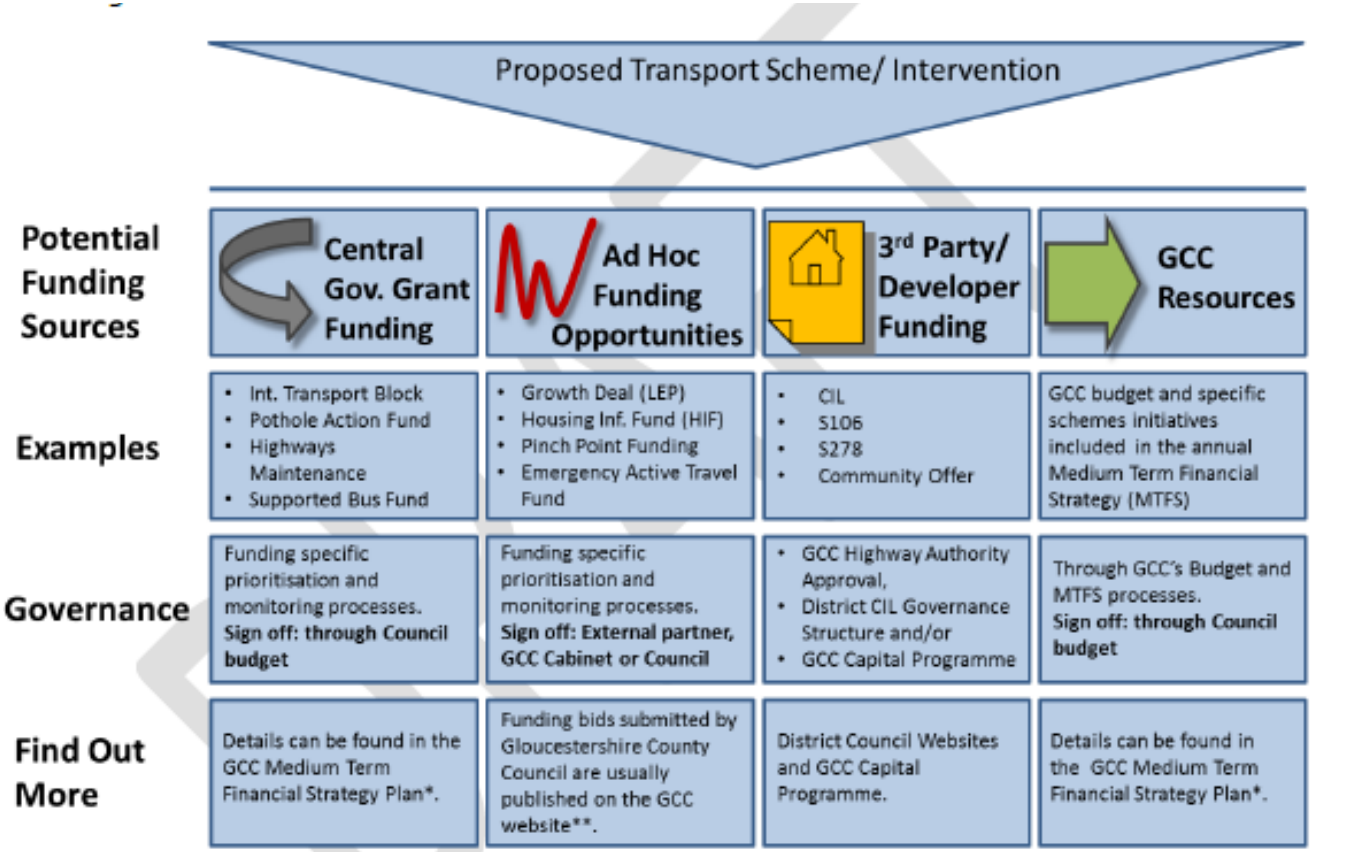
Appendix 6

Tiered services with differing funding streams

Core Services (Tier 1)	High frequency core bus services (mostly commercial), on a route that is one or more of: • Commercially operated (i.e. no GCC subsidy) • High frequency (one bus every 30 minutes or less) • High use (a minimum of 250,000 passenger trips per year) • Inter-urban (operating between 2 urban areas of at least 20,000 population) • Intra-urban (operating entirely within an urban area of at least 20,000 population)
Intermediate (Tier 2)	Frequent bus services (mixture of commercial and subsidised), on a route that is one or more of: • Partially commercial (GCC subsidises a maximum of 50% of the route) • Medium frequency (one bus every 31-180 minutes) • Medium use (50,000-250,000 passenger trips per year) • Part urban (serves at least one urban area of at least 10,000 population)
Supported Services (Tier 3)	Supported bus services (infrequent and mostly subsidised), on a route that does not meet any tier 1 or 2 criteria, likely to include: • Majority or entirely subsidised • Low frequency (2 buses per day or less) • Low use (under 50,000 passenger trips per year) • Rural (no urban centres of at least 10,000 population)

Appendix 7

LTP funding sources



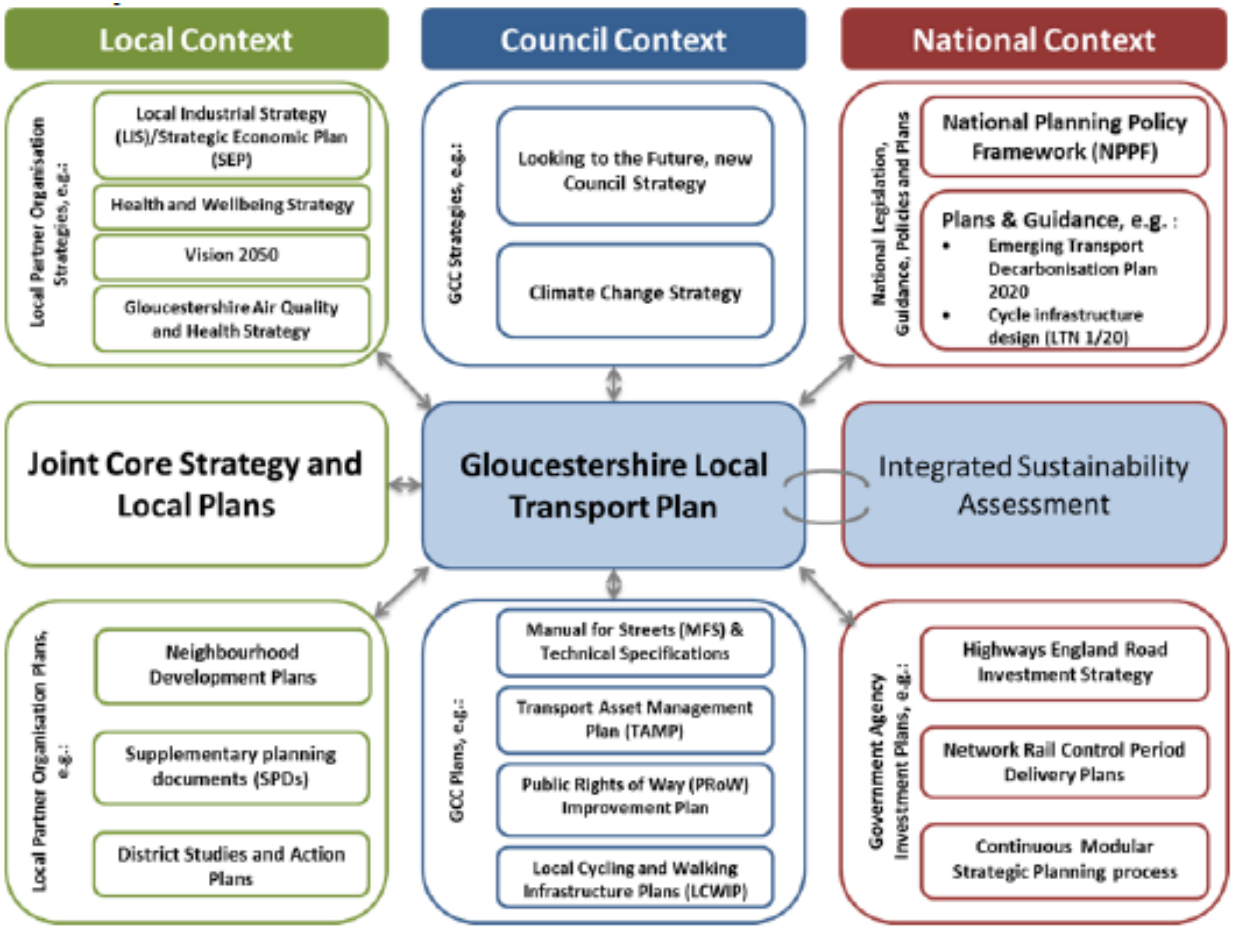
* https://www.gloucestershire.gov.uk/council-and-democracy/performance-and-spending/budget-and-medium-term-financial-strategy/
** https://www.gloucestershire.gov.uk/council-and-democracy/performance-and-spending/bids-and-progress-reports/

Appendix 8

LTP Objectives

Appendix 9

LTP context



Benefit Realisation Plans (22/09/2020)

This document presents the proposed benefits that are planned as a result of the proposed service changes in the Fit for the Future Programme (Phase 1). These plans will be developed through the business case process the baseline and outcome metrics are confirmed prior to implementation[1].

The identified benefits include:

- Improved patient outcomes
- Improved patient experience
- Improved staff experience
- Improved staff recruitment and retention
- Improved efficiency and effectives ness (cash releasing)
- Improved efficiency and effectives ness (non-cash releasing)

[1] It should be noted that Gastroenterology and T&O are currently pilots and therefore the benefits are those that have accrued as a result of their implementation.

Benefits Realisation- Emergency General Surgery (EGS) (C3)

Desired benefit pre change	Stakeholders impacted	Enablers required to realise benefit	Outcomes Displayed if benefit realised	Current (Pre-COVID) Baseline measure	Who is Responsible?	Target date	Learning / Indications from Temporary COVID 19 Changes
Improvement in staffing workload – Risk S2275- Risk of sub-optimal staffing caused by a combination of insufficient trainees and increased demand resulting in compromised trainee supervision, excessive work patterns and impacting on the ability to run safe and high quality surgical rotas	Patients Junior doctors Deanery Consultants	Reallocation of workload by centralising the emergency service. Rota redesign	Enhance training and support for staff. Retention and possible increase of trainee doctors Increasing registrar presence at GRH to 2 to enable better support and workload	Risk (S2275) Score: **Extreme Risk** 16- Workforce 12- Statutory 10- Finance In a 7 month period in 2019 15% of EGS shifts were not covered (390 out of 2599) Rota gaps increased by 46% over the past 3 years	Surgical Division	First quarter 2021/22	Rotas are still not optimal as covering CGH in a non-sustainable rota; however the new rota has shown marked improvement with significantly improved resilience and a reduction in locum shifts. Risk (S2275) has been reviewed following temporary co-location at GRH Score: **Moderate Risk** 6- Workforce 6- Statutory 6- Finance Opportunity to reduce locum spend but yet to be quantified.
Improvement in trainee environment- Risk S3035 to safe service provision caused by an ability to provide an appropriate training environment leading to poor trainee feedback which could result in a reduction of trainee allocation impacting further upon workforce and safety of care	Patients Junior doctors Deanery Consultants	Reallocation of workload by centralising the emergency service. Rota redesign	Retention and possible increase of trainee doctors	Risk (S3035) Score: **Extreme Risk** 15- Workforce Deanery feedback is poor.	Surgical Division	First quarter 2021/22	Rotas are still not optimal as covering CGH in a non-sustainable rota; however already there is a marked improvement with trainees now able to continue operating alongside consultants without being interrupted to review patients who require admission or escalation. Risk (S2275) has been reviewed following temporary co-location at GRH Score: **High Risk** 9- Workforce
Improved senior surgical review. Risk S2930-Insufficient senior surgical cover resulting in delayed senior assessment and delays to urgent treatment for patients- Risk to patient safety	Patients Junior doctors Deanery Consultants	Reallocation of workload by centralising the emergency service. Rota redesign	Ability to assess patients in a timely way resulting in faster assessment and treatment for patients	Risk (S2930) Score: **Extreme Risk** 15- Quality 12- Safety 10- Statutory	Surgical Division	First quarter 2021/22	Following the temporary centralisation of EGS, data collected by the Surgical Assessment unit has shown that the waiting time has reduced markedly with an increase of 81% to 93% of patients reviewed within 4 hours Score: **Moderate Risk** 4- Quality 4- Safety 4- Statutory

Desired benefit pre change	Stakeholders impacted	Enablers required to realise benefit	Outcomes Displayed if benefit realised	Current (Pre-COVID) Baseline measure	Who is Responsible?	Target date	Learning / Indications from Temporary COVID 19 Changes
Improved access to sub specialty treatment and equity of care. Risk S3036 shows sub-optimal care for patients with conditions requiring specific care (upper or lower GI) caused by inability to provide sub-specialty rotas and resulting in inequitable are and different clinical outcomes	Patients	In the proposals there are plans to have two consultants on call one upper and one lower GI	The on call arrangements described would ensure that patients requiring subspecialty expertise receive it in a timely way	Risk (S3036) Score: **Extreme Risk** 15- Quality	Surgical Division	First quarter 2021/22	Following the temporary centralisation of EGS the new on call arrangements have been trialled enabling a reduction in delay to theatre and better continuity of care. Score: **Moderate Risk** 6- Quality
Better access to emergency theatre. Risk S3038- A risk of sub-optimal care with delays for patients requiring surgical treatment caused by limited day time access to emergency theatres resulting in increased length of stay and poor patient experience	Patients Junior doctors Consultants	To increase emergency theatre provision to one 24 hrs a day and a second 08.00-18.00	To allow more timely surgery and avoid working after 20.00hrs on patients who should receive surgery during normal working hours (national guidance)	Pre COVID baseline- During February 2020; 42 operations were carried out between the hours of 20.00 to 08.00 Risk (S2930) Score: **Extreme Risk** 16- Quality 9- Safety	Surgical Division	First quarter 2021/22	April- August 2020; 152 operations were carried out between the hours of 20.00 to 08.00 (an average of 30 a month) This shows a reduction of 40%. It is anticipated that this would further improve if the vascular surgical team are not sharing the emergency theatre as they have during the COVID period Risk (S2930) Score: **High Risk** 12- Quality 9- Safety
The provision of a protected dedicated Surgical Unit. If the wards are not ring-fenced other patients' sometimes medical patients are accommodated on the surgical ward and in turn surgical patients are then outliers in other wards. This makes the care more difficult for the on-call team.	Patients Junior doctors Consultants	To ring-fence wards 5A and 5B.	This will create a dedicated area for General Surgery including a Surgical assessment Unit which will improve patient care.	Pre COVID baseline- There were 41.9 beds used for emergency surgical outliers in the 4 months prior to COVID November 2019-Feb 2020. An average of 10.5 beds a month	Surgical Division	First quarter 2021/22	During the COVID changes from April-August 2020 there were 33 outliers. An average of 6.6 a month

Desired benefit pre change	**Stakeholders impacted**	**Enablers required to realise benefit**	**Outcomes Displayed if benefit realised**	**Current (Pre-COVID) Baseline measure**	**Who is Responsible?**	**Target date**	**Learning / Indications from Temporary COVID 19 Changes**
To Reduce the admission rate. By providing improved senior review for emergency patients in ED or the Surgical Assessment Unit. Currently in theatre whilst the other is available to support junior staff in the assessment of emergency patients. This will avoid unnecessary admission. The rate of emergency Admission is 9.7% higher than peer groups.	Patients Hospital capacity	By having two consultants on call, one will be in theatre whilst the other is available to support junior staff in the assessment of emergency patients.	Improved patient pathway and patient experience The plan is to reduce the admission rate by 20%- 455 admissions but this is non-cash releasing (~£314,000)	Pre COVID baseline- To reduce the number of admissions. In the year prior to COVID March 2019 to Feb 2020 there were 6895 admissions. An average of 574.6 a month	Surgical Division	First quarter 2021/22	Emergency Surgery admissions from April to August 2020 were 2277 An average of 455.4 a month. Indicating a drop in admissions of 21%
Achieve compliance with Regulatory Bodies. Currently emergency theatre provision at CGH does not comply with NCEPOD regulations as there is not dedicated emergency theatre provision 24/7	Patients All Staff Trustwide	Patients	Compliance with NCEPOD recommendations	Emergency theatre provision at CGH does not comply with NCEPOD regulations as there is not dedicated emergency theatre provision 24/7	Surgical Division	First quarter 2021/22	Proposed Theatres provision at GRH is compliant with NCEPOD recommendations

Benefits Realisation- Centralisation of elective colorectal (lower GI) services to one site (C5 & C6).

Desired benefit pre change	**Stakeholders impacted**	**Enablers required to realise benefit**	**Outcomes Displayed if benefit realised**	**Current (Pre-COVID) Baseline measure**	**Who is Responsible?**	**Target date**
The provision of a protected dedicated Surgical Unit. If the wards are not ring-fenced other patients' sometimes medical patients are accommodated on the surgical ward and in turn surgical patients are then outliers in other wards. This makes the care more difficult for the on-call team.	Patients Junior doctors Consultants	To ring-fence ward	This will create a dedicated area for colorectal surgery which will improve patient care.	Pre COVID outlier baseline- There were 7.9 bed days with outlying colorectal patients in the 6 months prior to COVID Sept 2019-Feb 2020. An average of 1.3 a month	Surgical Division	First quarter 2021/22
Greater capacity to cope with higher levels of demand. Demand for healthcare is increasing due to population growth	Patients Regulatory targets-18 week pathway	To centralise elective colorectal surgery	A centralised service will provide more capacity and increased levels of efficiency to support higher levels of demand Additional 16 Inpatient cases PA x £4,159 per average PbR income. Total increased income of £43,254 Non-cash releasing	Number of elective inpatient episodes. From March 2019 to Feb 2020 were 166, an average of 14 a month.	Surgical Division	First quarter 2021/22
To implement ERAS (enhanced recovery after surgery) programme	Patients Consultants Nursing Staff	To centralise elective colorectal surgery	A single site will facilitate the standardisation of practice which will give clear pathways resulting in better patient, nursing and junior doctor experience LoS reduction of one day per case; 166 cases PA x cost of a day in hospital £300 gives a total saving of £49,800. However this is already included in the SSDP (Surg 05)	Length of stay and patient feedback	Surgical Division	First quarter 2021/22
Workforce benefits	Consultants Nursing Staff Junior Doctors	To centralise elective colorectal surgery	It is anticipated that centralisation will enhance the training and support offered to staff. It will also form closer working relationships and peer support.	Deanery feedback is currently poor. Nursing feedback to be recorded	Surgical Division	First quarter 2021/22

Benefits Realisation- Centralisation of General Surgery (upper and lower GI) day cases to CGH (C11)

Desired benefit pre change	**Stakeholders impacted**	**Enablers required to realise benefit**	**Outcomes Displayed if benefit realised**	**Current (Pre-COVID) Baseline measure**	**Who is Responsible?**	**Target date**
Reduction in cancellations due to bed pressures. Currently approximately 55% of upper and lower GI day surgery cases are performed at GRH. As GRH hosts more emergency work, peak pressures on beds can result in the cancellation of non-urgent day cases.	Patients	To move elective day cases for both upper & lower GI to CGH.	Improved patient experience Each cancellation means that theatre is not utilised. A theatre sessions costs approx. £2,000 to staff and there are approximately 4 cases in each session (£500 per case and there is an assumption 300 cancellations in GS can be prevented. There will be a saving of £150K PA	Over 400 cancellations for non-clinical reason were recorded in the past year the majority of these were day cases.	Surgical Division	First quarter 2021/22
Greater capacity to cope with higher levels of demand. Demand for healthcare is increasing due to population growth	Patients Regulatory targets- 18 week pathway	To centralise elective general surgery day cases	A centralised service will provide more capacity and increased levels of efficiency to support higher levels of demand If there is an increase of 10% there will be an additional 62 cases PA x the average cost of a day case £4,159. (£167,000)	Number of elective day case episodes. In the year from February 2019 to January 2020 were 622, an average of 52 per month.	Surgical Division	Second quarter 2021/22
Reduction in length of stay. Day surgery principles are fundamental to modern patient care	Patients	To centralise elective general surgery day cases	Shortened length of stays improves outcomes and earlier mobilisation reduces the risk of hospital acquired infections and venous thromboembolism If an hour is removed from every procedure, this will give 30 bed days. A reduction of £9,000 (assuming that the cost of a bed day is £300). However this is already included in the SSDP business case (Surg 05)	The British Association of Day Surgery (BADS) has listed an index of listed procedures that are optimally done as a day case. The BADS target is to undertake 95% of these cases as day surgery. The target for general surgery at Gloucestershire Hospitals is currently 75%	Surgical Division	Fourth quarter 2021/22
Standardisation of pathways. High volume, non-complex cases are particularly suited to geographical separation	Patients Consultants Nursing Staff	To centralise elective general surgery day cases	A single site will facilitate the standardisation of practice which will give clear pathways resulting in better patient, nursing and junior doctor experience	Patient feedback via FFT	Surgical Division	Second quarter 2021/22

Workforce benefits	Consultants Nursing Staff Junior Doctors	To centralise elective general surgery day cases	It is anticipated that centralisation will enhance the training and support offered to staff. It will also form closer working relationships and peer support.	Deanery feedback is currently poor. Nursing feedback to be recorded	Surgical Division	First quarter 2021/22

Benefits realisation – Centralising Acute Medicine (A3)

Desired benefit	Stakeholders impacted	Enablers required to realise benefit	Outcomes displayed if benefits realised	Current baseline measure	Who is responsible?	Target date
Increased number of ED attendances managed by SDEC on both sites– avoiding admission	Patients attending ED	Redistribution of medical registrars across sites Extended use of CINAPSIS Extending opening hours of SDEC in CGH (from 6pm to 8pm Mon-Fri)	CGH - Reduction in AEC associated admissions with a LOS of <24hrs, reducing number of admissions by 1,416 GRH – 40% of acute medical take managed by SDEC Non-cash releasing benefits included in SSDP (£1.3m)	CGH - AEC associated admissions with LOS of <24hrs is 1416 GRH – 29% of acute medical take managed by SDEC	Medical Division	First quarter after implementation
Consistent **provision of consultant review within 14 hours of arrival**	Acute Medical admissions	Centralised acute medical take rota	90 % of inpatients reviewed within 14 hours of arrival. Reduction in ALOS on AMU to 1.4 days Non-cash releasing benefits included in SSDP (£1.56m), potential additional £144,000	% patients assessed within 14 hours on weekdays 67% and 48% at weekends 25660 admissions to ACUC and AMU LOS – current baseline shows for AMU 0.86. SSDP assumptions – ACUC baseline 1.3, AMU baseline 1.2	Medical Division	First quarter after implementation
Earlier access to 'in reach' advice from other specialties	Acute medical patients, acute medical team	Acute medical take centralised at GRH, improving co-location with other specialties	Earlier assessment of acute medical patients, leading to: Reduction in admissions Reduction in LOS on AMU to 1.4 days	See above	Medical Division	First quarter after implementation

Desired benefit	Stakeholders impacted	Enablers required to realise benefit	Outcomes displayed if benefits realised	Current baseline measure	Who is responsible?	Target date
Enhanced **staff training and support**	All staff of all professional groups	Where specialities are centralised this will enhance the training and support offered to staff	Forges closer working relationship and peer support. Mentors affords easier access to those they are mentoring and vice versa Avoids forced duplication of training provision Management support more accessible Improved staff morale Natural progression to meet demands of a developing service new roles/ways of working Positive impact on patient care Reduction in staff turnover by 2% Reduction in agency / locum costs Cash and non-cash releasing benefits included in GSSD (£913,000)	Medical Division turnover is 13.31%	Medical Division	Assess success 6 & 12 months post implementation National NHS Staff Survey
Improved recruitment and retention – medical and nursing staff and overall staff satisfaction	Medical and Nursing Staff	New rotas to support a centralised acute take. Creation of more attractive job roles and training opportunities Overall impact of improved morale health and we being	Improved staff satisfaction/morale will make Acute Medicine a more attractive place to work. Not only improve retention of staff thus reducing number of vacancies but act as a magnet to attract new staff thus reducing reliance upon agency. Better able to support staff in terms of flexible working Reduction in number of vacancies Reduction in staff turnover by 2% by the end of the second year following implementation Maintain GMC NTS GIM overall scores using GRH scores as baseline Staff Survey – improvement to staff motivation to England Average Reduction in workforce risk register scores (M, 2434, Emer, - The risk of reduced safety, patient experience and quality of care due to inability to recruit and retain qualified nursing staff across Unscheduled Care – scored 8-12)	43% vacancy rate for acute medical consultant physicians Medical Division turnover is 13.31% Workforce risks reduced to 4-6	Medical Division	Third quarter post implementation Turnover – at end of 2nd year 2%

Desired benefit	Stakeholders impacted	Enablers required to realise benefit	Outcomes displayed if benefits realised	Current baseline measure	Who is responsible?	Target date
Workforce efficiencies through centralising acute medical beds	Nursing staff	Creation of a centralised acute medical unit	Reduction in 5.8 wtes (inclusive of additional costs to extend SDEC at CGH)			Third quarter from date of implementation
Improved patient pathway and patient experience	Patients	All of the above plus direct admission protocols	Increased number of direct admissions to CGH avoiding the need for admission via the ED. Improved Family and Friends scores % who would recommend the service to England Average	Currently 2120 direct admissions to CGH	Medical Division	Second quarter from implementation

Benefits Realisation – IGIS

Desired benefit	Stakeholders impacted	Enablers required to realise benefit	Outcomes displayed if benefits realised	Current baseline measure	Who is responsible?	Target date
Improved access to interventional radiology for patients on an emergency pathway	Acute medicine, Interventional Radiology	Establishment of 24/7 IGIS Hub, Centralisation of the acute take to GRH	Improved patient outcomes - Reduction in mortality - Reduction in morbidity - Reduced LoS	- Trustwide mortality rate for patients admitted on emergency pathway - Unable to baseline morbidity rate - Trustwide average LoS for patients admitted on emergency pathway = 5.6 days	Radiology	2024 (following full establishment of the 24/7 IGIS hub
Improved access to adjacent specialty advice for second opinion / clinical advice	Interventional Radiology, Vascular Surgery, Cardiology	Establishment of 24/7 IGIS Hub, relocation of cath labs, relocation of hybrid theatre	Improved patient outcomes - Reduction in mortality - Reduction in morbidity Not expected to be a statistically measurable difference	- Trustwide mortality rate for patients admitted on emergency pathway - Unable to baseline morbidity rate	Radiology, Cardiology, Vascular Surgery	2024 (following full establishment of the 24/7 IGIS hub
Improved recruitment and retention – medical and nursing staff	Radiographers, Radiologists, cardiologists, surgeons, nursing	Establishment of the 24/7 IGIS Hub	Reduction in agency spend Reduction in staff vacancies Reduction in staff turnover Reduction in risk rating for D&S2051Rad Datix (Risk of a reduced radiology service due to increase in vacancy and turnover rate of skilled Radiographic staff) = target score of 8 or below	D&S2051Rad Datix current score = consequence 4 x Likelihood 3 = 12	Radiology, Cardiology, Vascular Surgery	2024 (following full establishment of the 24/7 IGIS hub

Desired benefit	Stakeholders impacted	Enablers required to realise benefit	Outcomes displayed if benefits realised	Current baseline measure	Who is responsible?	Target date
Workforce deployment efficiencies through consolidation of radiology locations	Radiographers	Co-location of hybrid theatre and IGIS Hub	Reduction in radiographic equipment downtime resulting from staff shortages Non-cash releasing benefit 20 x £2,077 (£54,000)	IR suites have been closed on approximately 20 occasions a year as a result of radiographers being unavailable. Had facilities not have been out of action on occasion because of breakdowns this figure would be much higher.	Radiology	2024 (following full establishment of the 24/7 IGIS hub
Improved patient pathway and patient experience for emergency patients requiring cardiac input	Cardiology inpatients, emergency admissions, E-zec	Relocation of the cath labs	Reduction in inter-site transfers for emergency cardiac interventions. Estimate reduction of 62% inter-site transfer (NCRB ~£25,000) Average LoS reduction of 0.5 days for each inter-site transfer avoided (NCRB £39,000) Resulting in improved patient experience	Between Feb19-Jan20 678 Patients were admitted at GRH on an emergency pathway and required inter-site transfer to CGH to access the cath labs	Cardiology	2021 (following relocation of cath labs)
Improved patient pathway for patients requiring urgent vascular input	Emergency admissions	Relocation of Vascular surgery, Centralisation of the acute take to GRH	Undifferentiated emergency admissions will have access to vascular care without the need to transfer to CGH Thereby improving the patient experience and reducing time to intervention Reduction in inter-site transfers for vascular inpatients admitted via the other site (NCRB ~£3,400)	Vascular patients admitted via GRH (this will need to offset by the number of vascular patients admitted via CGH) – Between Feb19-Jan20 64 patients were admitted as vascular inpatients via GRH ED. Unable to effectively measure expected change in patient experience	Vascular Surgery	2024 (following full establishment of the 24/7 IGIS hub
LoS reduction resulting from new IR procedures replacing open surgery	Patients, Surgical division, Interventional radiologists	Commissioned to undertake new activity / agreement to undertake activity under the QE MDT	See bed impact detail NCRB - 62 beds days @ £276 (£11,000)	As detailed in bed impact	Interventional Radiology	Subject to commissioner approval

Desired benefit	Stakeholders impacted	Enablers required to realise benefit	Outcomes displayed if benefits realised	Current baseline measure	Who is responsible?	Target date
Reduction in expired IR inventory resulting from consolidated IR locations	Interventional Radiology	Co-location of hybrid theatre and IGIS Hub	Reduction in expired stock. Target of 33% reduction (moving from 3 sites to 2) = dispose of less than £53k CRB £27,000	During 2017/18 £80k of IGIS consumable stock had to be disposed of	Radiology	2024 (following full establishment of the 24/7 IGIS hub
Increased revenue resulting from repatriated activity	Interventional Radiology	Commissioned to undertake new activity / agreement to undertake activity under the QE B'Ham MDT	£463,590 in potential additional revenue (as detailed in financial modelling)	£0	Radiology	Subject to commissioner approval
Reduction in patient travel resulting from repatriated activity	Gloucestershire patients	Commissioned to undertake new activity / agreement to undertake activity under the QE B'Ham MDT	Improved patient experience Avoided requirement for Gloucestershire patients to travel out of County to receive their care.	N/A	Radiology	Subject to commissioner approval
Reduction in inter-site transfers resulting from same site location of vascular and dialysis services	Vascular inpatients, E-zec	Relocation of vascular surgery to GRH	Improved patient experience No inter-site transfers required for vascular inpatients requiring dialysis. NCRB 146 x £60 (£8,760)	During the six month period of July 2019 – December 2019 72 site transfer-and-return journeys were undertaken for vascular inpatients requiring dialysis = 146 transfer and return journeys / annum	Vascular Surgery	2024 (following full establishment of the 24/7 IGIS hub

Desired benefit	Stakeholders impacted	Enablers required to realise benefit	Outcomes displayed if benefits realised	Current baseline measure	Who is responsible?	Target date
Improved robustness of OOH interventional radiology service resulting from radiologist vacancies	Radiology	Establishment of 24/7 IGIS Hub	Reduction in score of datix risk D&S1636Rad (Risk of non-availability of OOHs interventional radiology service) Target score of 9 or less	D&S1636Rad datix score = consequence 3 x likelihood 4 = 12	Radiology	2024 (following full establishment of the 24/7 IGIS hub
Improved mortality and morbidity rates within interventional cardiology	Cardiology	Relocation of the cath labs to GRH and centralisation of the acute take	Reduction in morbidity and mortality for the PPCI 24/7 programme and ACS treatment	Tbc	Cardiology	2024 (following relocation of the cath labs and centralisation of the acute take
Improved access to renal ward for vascular opinion	Renal inpatients	Relocation of vascular AC to GRH	Better access to fistula patients by vascular consultants. Improved access to a vascular opinion. Quicker review of patients. Not expected to produce measureable benefit	N/A	Vascular / Renal	Following relocation of vascular service

NB: These Pilots have been implemented therefore benefits realised are in the Baseline

Benefits Realisation- Centralisation of Gastrointestinal Medicine

Desired benefit pre change	**Stakeholders impacted**	**Enablers required to realise benefit**	**Outcomes Displayed if benefit realised**	**Current (Pre-COVID) Baseline measure**	**Who is Responsible?**	**Target date**
Greater capacity to cope with higher levels of demand. Demand for healthcare is increasing due to population growth	Patients Regulatory targets- 18 week pathway	To centralise patients from two sites to one dedicated unit	A centralised service is more efficient freeing clinicians to provide more clinic and endoscopy capacity	Additional endoscopy lists a week. Post pilot the service is regularly achieving 5.6 additional endoscopy lists a week	Medical Division	Fourth quarter 2018/19
Reduction in spend by no longer outsourcing private services. Before the pilot the service was unable to keep up with demand necessitating the use of private providers to undertake endoscopy procedures	Patients Regulatory targets- 18 week pathway	To centralise patients from two sites to one dedicated unit	By becoming more efficient (as described above) the service would no longer need to 'outsource' to private providers	The annual cost to GHNHSFT before the pilot was £660K. Since the pilot it has not been necessary to 'outsource' endoscopy services.	Medical Division	Fourth quarter 2018/19
Achieve the 6 week wait diagnostic target. Before the pilot the service was unable to achieve the target of 6 weeks for endoscopy even with the use of private providers to undertake endoscopy procedures	Patients Regulatory targets- 18 week pathway	To centralise patients from two sites to one dedicated unit	By becoming more efficient (as described above) the service would no longer need to 'outsource' to private providers	To achieve the 6 week diagnostic target. Pre pilot the service was unable to achieve the target of 6 weeks for endoscopy even with the use of private providers to undertake endoscopy procedures Post pilot the trust has achieved the 6 week target	Medical Division	Fourth quarter 2018/19
Reduced time to 'be seen' by a gastroenterologist. This refers to a request via e-referral	Patients	A 'consultant of the day' rota to be established	A 'consultant of the day' rota to be established to provide support for two 'high acuity beds' at GRH and provide referrals in a more timely way	Pilot target was that all patients should be seen within 24 hours. Pre pilot results 24-48 hours Post pilot results 6-12 hours	Medical Division	Fourth quarter 2018/19
Decrease in the number of violence and aggression incidents within the service.	Patients All Staff	Improvement of the time taken to assess patients	The system described above will enable patients to be reviewed earlier and prevent delays which lead to agitation	A decrease in reported incidents involving violence and aggression within the service. Before pilot there were an average of 8.5 a month After the pilot there were an average of 1.6 a month	Medical Division	Fourth quarter 2018/19

Desired benefit pre change	**Stakeholders impacted**	**Enablers required to realise benefit**	**Outcomes Displayed if benefit realised**	**Current (Pre-COVID) Baseline measure**	**Who is Responsible?**	**Target date**
Reduction in length of stay.	Patients	To centralise patients from two sites to one dedicated unit	Shortened length of stays improves outcomes and earlier mobilisation reduces the risk of hospital acquired infections and venous thromboembolism	Monitor Length of stay. Reports show fluctuation in length of stay. However because there are more patients being seen quickly on admission and discharged home straight from the Acute Medical Ward the previous shorter stay admissions are no longer required.	Medical Division	Fourth quarter 2018/19
More responsive to GP requests	Patients GPs Consultants	Provide an 'Advice and Guidance' service to GPs	Direct communication between GPs and consultants enables best care for patients which can either result in the prevention of an Inpatient admission or a more streamlined admission where the patient is admitted directly to the gastro ward	Monitor the number of requests. Since the start of the pilot the gastroenterology service receives between 120 and 150 GP requests for help in managing this patient group.	Medical Division	Fourth quarter 2018/19
Improvement of patient experience.	Patients	To centralise patients from two sites to one dedicated unit	A single dedicated unit will provide timely admission to a ward staffed by an expert team of nurses and doctors	Patient feedback via FFT (Friends and Family Test) Prior to pilot results: Positive 79%, Negative 6.98% After pilot results: Positive 91.49%, Negative 2.13%	Medical Division	Fourth quarter 2018/19
Improved Junior Doctor training	Junior Doctors	To centralise patients from two sites to one dedicated unit	Improved access to teaching ward rounds. Manageable workload. Increase opportunities to attend endoscopy sessions and clinics.	Monitor deanery feedback	Medical Division	Fourth quarter 2018/19
Workforce benefits	Consultants Nursing Staff	To centralise patients from two sites to one dedicated unit	It is anticipated that centralisation will enhance the training and support offered to staff. It will also form closer working relationships and peer support.	Monitor Feedback: Consultant feedback overwhelmingly positive, able to concentrate on their own specialty. Nursing feedback agreed that the changes gave patients the correct environment with the right expertise.	Medical Division	Fourth quarter 2018/19

Benefits Realisation- Trauma & Orthopaedics

Desired benefit pre change	**Stakeholders impacted**	**Enablers required to realise benefit**	**Outcomes Displayed if benefit realised**	**Current (Pre-COVID) Baseline measure**	**Who is Responsible?**	**Target date**
Improved senior surgical review. Prior to the changes there were often prolonged waits for senior Orthopaedic Opinion because the on-call team might be undertaking other duties, for example working in clinic or theatre.	Patients Junior doctors Consultants	Re-allocation of service by centralising the trauma service and rota redesign to have a designated on-call Consultant and registrar without other commitments	Ability to assess patients within 30mins of being contacted by ED; resulting in faster assessment and treatment for patients	Number of patients seen within 30 mins of ED request.	Surgical Division	Third quarter 2017/18
Reduction in trauma admissions. Delays in getting a senior orthopaedic opinion in ED (as above) could also lead to a higher number of patients being admitted than necessary.	Patients Junior doctors Consultants	Re-allocation of service by centralising the trauma service and rota redesign to have a designated on-call Consultant and registrar without other commitments	Reduce trauma admissions as patients will no longer be admitted unnecessarily due to delayed senior opinion.	Number of trauma admissions; bed days for trauma patients have been difficult to calculate accurately however we believe that bed days are reduced as we are able to prevent unnecessary admissions from ED. Trauma beds have been reduced by 5.	Surgical Division	Fourth quarter 2017/18
Daily Ward/Board Round for Trauma patients. Prior to the changes post op follow up was variable as clinicians who were responsible for patients may be timetabled elsewhere making daily consultant review impossible	Patients Junior doctors Deanery Consultants	Re-allocation of service by centralising the trauma service and altering the on call rotas. There is now one designated on-call Consultant and registrar who will undertake a daily ward and board round	All trauma patients to receive a **daily senior review** by the on-call consultant 7 days a week	100% of patients reviewed daily by a Consultant, every day.	Surgical Division	Third quarter 2017/18
Improved access to sub specialty treatment Sometimes there was inability to provide timely sub-specialty surgery for complex trauma. This was because timetables for complex subspecialty trauma surgery were not evenly rostered.	Patients	There are two all day trauma theatres 7 days a week. Every day a surgeon who is able to undertake hip arthroplasty is allocated to one theatre and there is a rota for other specialist surgery i.e. upper limb, and foot and ankle in the other theatre	Reduced waits for complex surgery	Reduced delays for complex surgery	Surgical Division	Third quarter 2017/18

Desired benefit pre change	Stakeholders impacted	Enablers required to realise benefit	Outcomes Displayed if benefit realised	Current (Pre-COVID) Baseline measure	Who is Responsible?	Target date
Improvement in trainee environment- to provide an appropriate training environment leading to poor trainee feedback which could result in a reduction of trainee allocation impacting further upon workforce and safety of care	Patients Junior doctors Deanery	Reallocation of workload by centralising the trauma service and redesigning the rotas.	Retention and possible increase of trainee doctors	Deanery feedback: Foundation Year 2 Feedback was 'requires' improvement prior to the pilot and 'good' post changes. Registrar feedback remains good and it has been easier to recruit Trust Doctors.	Surgical Division	Third quarter 2017/18
Improved access to specialist trauma and orthopaedic clinicians for advice. By providing a trauma triage service	Patients ED & MIU Clinicians Consultants Junior Doctors	Set up an advice service where referrals and X-rays are reviewed.	This enables the expedition of prioritised urgent cases and those who do not need further face to face appointments can be contacted by extended scope practitioners to give advice. Therefore avoiding unnecessary visits.	**Every GP and MIIU trauma referral** now triaged by a senior decision maker, patients are prioritised with urgent cases seen sooner		Third quarter 2017/18
The provision of a protected dedicated Elective Unit. It is essential that elective orthopaedic wards are ring-fenced to prevent deep joint infection	Patients Junior doctors Consultants	To ring-fence elective orthopaedic wards: Alstone, Dixton, Hazelton and 2A Annex	This will create a dedicated area for elective orthopaedic patients which is essential to provide the best environment to achieve low rates of infection and best post-operative care	Surgical Site infection rates are to be monitored.	Surgical Division	Third quarter 2017/18
Greater capacity to cope with higher levels of demand. Demand for healthcare is increasing due to population growth	Patients Regulatory targets- 18 week pathway	To centralise elective orthopaedic arthroplasty surgery	A centralised service will provide more capacity and increased levels of efficiency to support higher levels of demand	Monitor the number of procedures: In comparison with the year prior to the pilot and first year afterwards. The overall number of elective procedures went up by 310, 10% representing an additional £1.656 M income. Of these higher proportions were joint replacements. Hip replacement increased by 20% and Knee replacement by 19%. In the following year the number reduced slightly as one of the theatres was refurbished and out of action for 6 months.	Surgical Division	Third quarter 2018/19

Desired benefit pre change	Stakeholders impacted	Enablers required to realise benefit	Outcomes Displayed if benefit realised	Current (Pre-COVID) Baseline measure	Who is Responsible?	Target date
Reduction in surgical cancellations. Previously elective cases were cancelled for trauma, in particular complex trauma.	Patients	To separate the elective orthopaedics and trauma services	Previously elective cases were cancelled for trauma, in particular complex trauma. With allocated sub-specialty trauma sessions this should be markedly reduced.	Monitor Cancellations. In the first 14 months post pilot cancellations on the day were reduced by 55% and cancellations for urgent trauma were reduced by 80%	Surgical Division	Third quarter 2018/19
Increase Efficiency (ERAS- enhanced recovery after surgery programme**)** A single site will facilitate the standardisation of practice which will give clear pathways resulting in better patient, nursing and junior doctor experience	Patients	Patients Consultants Nursing Staff	To centralise elective orthopaedic (arthroplasty) surgery	Monitor length of stay. In the past year length of stay for hip replacement has reduced by 20%	Surgical Division	Third quarter 2018/19
Standardisation of Theatre Equipment. Theatre staff can be familiar with all equipment used which increases safety and there are financial savings associated with buying in larger quantities	Patient safety and Financial benefit	To centralise both trauma and elective orthopaedic surgery	A single site will facilitate the standardisation of equipment which will enable a more streamlined and efficient Theatres experience and may result in reduction in purchase costs.	Monitor spends on equipment particularly high cost items like hip and knee prostheses. Work has been undertaken to standardise implants used resulting in a reduction in spend of £750K	Surgical Division	Fourth quarter 2017/18

HM Government

NHS

Your hospital discharge: going home

This leaflet explains why you are being discharged from hospital and what you might expect after your discharge.

Why am I being discharged from hospital?

You are being discharged from hospital as your health team have agreed that you are now able to return home.

Why can't I stay in hospital?

It is important that our hospitals are able to look after people that need hospital care. Due to this, once you no longer need care in hospital, as decided by the health team looking after you, you will be discharged. It is always our priority to discharge you to the best possible place to support your recovery.

You will not be able to remain in hospital if you choose not to accept the care that is being offered to you.

What can I expect?

Your health team will discuss discharge and transport arrangements with you (and a family member, friend or carer if you wish).

If you require care and support when you get home, this will be arranged.

What if I need additional care?

If you need more care now than when you came into hospital, your clinical assessment team will arrange for additional care to be provided free of charge **FOR 1 - 6 WEEKS, depending on the level of care you require**. This does not mean that you are entitled to 6 weeks of care. After this time you may be required to pay for **SOME** or **ALL** of your health/social care costs.

Who can I contact?

After you have been discharged, if you have any concerns or need to speak to someone about your care, you can call **0300 422 4224** to be re-directed to your specialist hospital team.

You are a patient under the care of:

_____

www.nhs.uk

HM Government

NHS

Your hospital discharge: another place of care

This leaflet explains why you are being discharged from hospital and what you might expect after your discharge.

Why am I being discharged from hospital?

You are being discharged as your health team have agreed that you are now able to continue your recovery in another care setting, outside of hospital.

Why can't I stay in hospital?

It is important that our hospitals are able to look after people that need hospital care. Due to this, once you no longer need care in hospital, as decided by the health team looking after you, you will be discharged. It is always our priority to discharge you to the best possible place to support your recovery. You will not be able to remain in hospital if you choose not to accept the care that is being offered to you.

What can I expect?

Your discharge and transport arrangements will be discussed with you (and a family member or carer if you wish) and you will be discharged with the care and support you need to a bed in the community.

It is possible that you may be moved more than once after your discharge. This is because we will be trying to find the best place for your ongoing care. Your health team are here to answer any questions you might have.

What if I need additional care?

If you need more care now than when you came into hospital, your clinical assessment team will arrange for additional care to be provided free of charge **FOR 1 - 6 WEEKS, depending on the level of care you require**. This does not mean that you are entitled to 6 weeks of care. After this time you may be required to pay for **SOME** or **ALL** of your health/social care costs.

Who can I contact?

After you have been discharged, if you have any concerns or need to speak to someone about your care, you can call **0300 422 4224** to be re-directed to your specialist hospital team.

You are a patient under the care of:

_____

www.nhs.uk

One Gloucestershire
Transforming Care, Transforming Communities

NHS

Gloucestershire Carers Hub
The Carers Emergency Scheme

If you are being looked after by an unpaid carer, such as a member of your family or a friend, your carer can register with The Carers Emergency Scheme to ensure that your care will continue, even when they are unexpectedly prevented from looking after you.

There are two ways in which The Carer's Emergency Scheme can support you when your carer cannot; with interim emergency care provision from someone you know or short term support from professional healthcare workers.

If you have family, friends or neighbours who would be willing to provide the necessary care and support without prior notice, we would encourage them to register with the scheme so you can receive the help you need from someone you know.

If your family and friends live away or are unable to provide unplanned care, you can also register to receive free support from experienced care workers for up to 48 hours (72 over a bank holiday). This gives time for family, friends or other relevant organisations to consider your care requirements and discuss your options with you.

To find out more about the scheme or about what other free support Gloucestershire Carers Hub can offer you, visit **www.gloucestershirecarershub.co.uk**
email **carers@peopleplus.co.uk**
or call **0300 111 9000**

Gloucestershire Carers Hub is a commissioned service by Gloucestershire County Council and NHS Gloucestershire Clinical Commissioning Group.

If you have hospital equipment on loan that you no longer need, please call **01452 520438** to arrange a collection.

One Gloucestershire
Transforming Care, Transforming Communities

NHS

Your hospital discharge: **Staying safe and well at home**

There are a number of people who can help you stay safe and well at home following your recent stay in hospital. As well as offering help and advice, they can provide practical support and guidance on a number of issues. In some instances you may also be contacted by a member of the hospital discharge team once you are home, who can signpost you to appropriate services

Gloucestershire Community Help Hub

01452 583519 - Mon to Fri, 9am to 5pm

www.gloucestershire.gov.uk/helphub

As you adjust to life at home, you may need help with everyday tasks – particularly if you have to stay home more than usual. The Gloucestershire Help Hub works with local councils and police as well as health and social care services to support people. The Help Hub can signpost you to appropriate community resources support available to you.

In some instances, there might already be a group you can get in touch with; you can find further information at **www.yourcircle.org.uk** or by calling **01452 583519**. If you are Clinically Extremely Vulnerable, you can register for support at **https://www.gov.uk/coronavirus-shielding-support**

Age UK Gloucestershire

www.ageuk.org.uk/gloucestershire

Age UKG Out of Hospital Team: 01452 420937/420928 - Mon to Fri, 9am to 5pm

If you are over 65, Age UK's Out of Hospital Team can support you and your family as you continue your recovery at home, helping you to maintain your independence following your time in hospital. The team can provide essential information and signposting to help you find what you need at this time.

Age UKG Help Team: 01452 422660/Option 1 - Mon to Fri, 10am to 3pm

If you're over 50 and need advice or guidance on something that is affecting you, Age UK's Help Team can provide support and assistance on a wide range of issues.

Let's Talk

0800 073 2200

www.talk2gether.nhs.uk

It's normal to feel anxious after an illness or injury, but this can sometimes become overwhelming; particularly if you have limited contact with others. Let's Talk can offer help and advice on how to manage your mental health and improve your wellbeing to support your recovery.

Trauma and Orthopaedic Evaluation: Pre and Post Pilot - Draft

Executive Summary

The Trauma and Orthopaedic pilot was introduced on 20th October 2017. The pilot centralised all trauma surgery to GRH and the majority of elective orthopaedic surgery to CGH.

Trauma and Orthopaedic inpatient services have been part of the recent Fit for the Future (FFTF) public consultation focussing on the medium and long term future of specialist hospital services at Cheltenham General Hospital and Gloucestershire Royal Hospital. The consultation proposal was to maintain two 'centres of excellence' for Trauma at Gloucestershire Royal Hospital and Orthopaedics at Cheltenham General Hospital.

As part of the FFTF programme details including the clinical evidence for this proposal (both desktop and from the pilot), patient and staff (including junior doctor quality panels) experience, an options appraisal assessing the pilot vs. reverting to the previous configuration and benefits realisation information were included in the FFTF Pre-Consultation Business Case (PCBC). The proposal was also assessed as part of the South West Clinical Senate review.

The purpose of this report is to provide a systematic evaluation of the Trauma and Orthopaedic pilot to be included as part of the FFTF decision making process as well as additional performance information. The report is structured around the 10 key objectives of the pilot (using the latest available data sets) and latest performance is summarised below:

- 6 of 10 objectives have been achieved
- 3 of 10 objectives show much improved performance
- 1 of 10 objectives has not been achieved.

#	Pilot objective	Description	Current position	Outcome
1.	**Co-location of arthroplasty (joint replacement) surgery**	To improve standardisation of pathways.	All arthroplasty at CGH and ERAS pathway and standardisation of prostheses	Achieved
2.	**Reduced cancellation of elective patients for trauma patients**	Cancellations frequent, particularly when complex sub-specialty surgery was required	There are still cancellations when there are peaks in trauma demand but significantly fewer	Much improved
3.	**Reduced cancellation of elective patients when beds used for other specialties**	Elective patients were often cancelled when the hospitals had periods of high demand.	There are still cancellations in times of high demand but significantly fewer	Much improved
4.	**Timely review of trauma patients by a senior decision maker to reduce wait times in ED**	On call consultant and registrar could be scheduled to work either in theatre or clinic at the same time.	Now there is a consultant and registrar as well as a foundation doctor to give an immediate response	Achieved
5.	**Timely review of admitted trauma**	On call consultant and registrar could be	There is now an on-call consultant and Registrar	Achieved

#	Pilot objective	Description	Current position	Outcome
	patients by a senior decision maker	scheduled elsewhere and were not always available for immediate consultation	who do not have other duties and so are available for immediate consultation	
6.	**Implement regular senior review for trauma inpatients**	There was no routine Ward/Board Round for trauma patients which meant delay for review	Now there is a 7 day a week Ward/Board round for all trauma patients	Achieved
7.	**Respond to rapid increase in trauma referrals to fracture clinic**	Increase in demand just prior to the pilot leading to unacceptable delays	New trauma triage service in place to assist with growing demand	Much Improved
8.	**Improve time to theatre for trauma patients**	There was a delay in getting some patients to theatre, especially during peaks in demand	Although the care for trauma patients is now standardised, this remains an issue to be resolved.	Not achieved
9.	**Address poor junior doctor feedback**	Access to senior colleagues was difficult as timetables prevented regular supervision	There is now a consultant and registrar available for supervision and regular training sessions	Achieved
10.	**Improve junior doctor recruitment**	Filling junior doctor posts was often difficult	The service is now fully staffed	Achieved

The main section of the report provides the context, data and details underpinning the assessment for each of the objectives but it is worth noting that:

- Given the length of the pilot period (over 3 years), there have been significant external changes which have impacted on the service and these are explained in the report.
- Despite work to increase the efficiency of the trauma service, the increase in demand has exacerbated the difficulty of 'time to operation' especially when there are peaks in demand.
- Patients with fractured neck of femur will be (correctly) prioritised for surgery before those with wrist fractures. However this increase leads to a pressure on theatre resource particularly as each fractured neck of femur patient will require 2 to 3 hours in the operating theatre. Growth in hip fractures since 2009 has grown 21% an average year on year increase of 3.8%.
- The trauma team have been working to maximise theatre efficiency and also convert some theatre lists from elective to trauma. More theatre lists have been made available at Cirencester Hospital and some non-complex trauma surgery is undertaken there. In addition more day cases from the remaining elective work at GRH have been transferred to Cirencester Hospital to create more theatre space within GRH theatres for Trauma patients. There is a further plan to utilise one of the new day surgery theatres at CGH that are to be developed as part of the £39.5M Strategic Site Development Programme for orthopaedics. This will enable the service to further reorganise elective lists and create theatre space at GRH for additional trauma surgery.

In summary, the pilot achieved the vast majority of its objectives and has made a positive impact on patients. The team are working to achieve all objectives, to make the best use of the opportunities provided by the Strategic Site programme and to continuously improve the service. The report also includes lessons learned and recommendations for future implementation monitoring and evaluation.

Introduction

Background

The Trauma and Orthopaedic (T&O) pilot was introduced on 20th October 2017. Prior to the pilot service change, both trauma surgery and planned orthopaedic surgery was carried out at Gloucestershire Royal Hospital (GRH) and Cheltenham General Hospital (CGH).

Under the pilot, all orthopaedic trauma surgery is now carried out at GRH and as much planned orthopaedic surgery as possible e.g. hip and knee replacements is carried out at CGH. The T&O service has sole use of 8 Theatres (4 at CGH and 4 at GRH) all of which have laminar flow (special high flow air conditioning which minimises the incidence of deep joint infection). As the theatre infrastructure was fixed, all elective (planned) arthroplasty (joint replacement surgery) was transferred to CGH however approximately 30% of elective orthopaedic surgery remains at GRH.

The paediatric (children's) wards are in GRH and therefore paediatric surgery must remain there. There are some sub-specialties where there are links with trauma surgery. As the transfer of the remaining elective surgery is dependent on suitable theatre provision at CGH, there are plans in place to utilise one of the new day surgery theatres at CGH that are to be developed as part of the £39.5M Strategic Site Development Programme for orthopaedics. This will enable the service to undertake all elective adult day surgery at CGH and create theatre space at GRH for additional trauma surgery.

Fit for the Future

Trauma and Orthopaedic inpatient services have been part of the recent Fit for the Future (FFTF) public consultation focussing on the medium and long term future of specialist hospital services at Cheltenham General Hospital and Gloucestershire Royal Hospital. The consultation proposal was to maintain two 'centres of excellence' for Trauma at Gloucestershire Royal Hospital and Orthopaedics at Cheltenham General Hospital.

The FFTF Pre-Consultation Business Case (PCBC) provided extensive information on the performance of the pilot, including:

- Published clinical evidence
- T&O service key performance indicators
- T&O service improvements
- Lessons learnt and areas for improvement
- Patient and staff experience including junior doctor quality panels
- Results of the options appraisal assessing the T&O pilot vs. reverting back to the previous configuration and,
- Benefits realisation information

The proposal was also assessed as part of the South West Clinical Senate review of all FFTF proposals; in summary the senate stated that:

- The pilot has shown that the service works, with clear pathways in place and good staffing, since 2017.
- There is an effective handover and regular ward round at GRH. On call consultant provides support to any out of hours issues at CGH and over weekend.

All documents can be found at Fit for the Future: Developing specialist hospital services in Gloucestershire – OneGloucestershire.net.

Purpose of the Report

The purpose of this report is to provide a systematic evaluation of the Trauma and Orthopaedic pilot to be included as part of the FFTF decision making process as well as additional performance information. The report is structured around the 10 key objectives of the pilot, using the latest available data sets. Given the length of the pilot period (now over 3 years), it is worth noting there have been significant changes which have impacted on the service and these are explained in the sections below.

The objective of the pilot was to address the following areas:

- Co-location of arthroplasty (joint replacement) surgery to allow standardisation of pathways.
- Elective patients were often cancelled for emergency (trauma) patients; particularly when complex sub-specialty surgery was required.
- Elective patients were often cancelled when the hospitals had periods of high demand.
- Trauma patients did not always receive a timely review by a senior decision maker in ED because the on call consultant and registrar could be scheduled to work either in theatre or clinic at the same time. This exacerbated wait times in ED and at the time of implementation of the pilot Gloucestershire Hospitals were in special measures for poor performance in achieving the 4 hour ED target.
- Once admitted the senior review of trauma patients was variable (depending on the admitting consultant's timetable); this often led to patients staying in hospital longer than necessary.
- There was no routine Ward/Board Round for trauma patients which meant delay for patients but also lost opportunity for supervision of junior doctors with poor trainee feedback.
- Junior doctor training, feedback was variable with better supervision and workload
- Junior doctor recruitment was problematic

Three of the pilot KPIs performance form part of the Trust's Quality Performance Report that is presented monthly at Trust Public Board; performance against the national 4 hour ED standard, the percentage of fractured neck of femur patients treated with 36 hours and the percentage of fractured neck of femur patients meeting best practice criteria.

Governance and Assurance

This report was drafted by the T&O team with support from the FFTF Programme Team.

A draft of the report has been reviewed by the GHNHSFT Surgical Board.

Members of the T&O Board received an updated draft of the report and their comments are incorporated.

The report will be presented and reviewed in public at both the GHNHSFT Board and Gloucestershire Clinical Commissioning Group (CCG) Governing Body; prior to formal FFTF decision making. A copy of the final report will be provided at https://www.onegloucestershire.net/yoursay/

The report will also be provided to the Gloucestershire Health Overview & Scrutiny Committee, who last had a T&O update in May 2019.

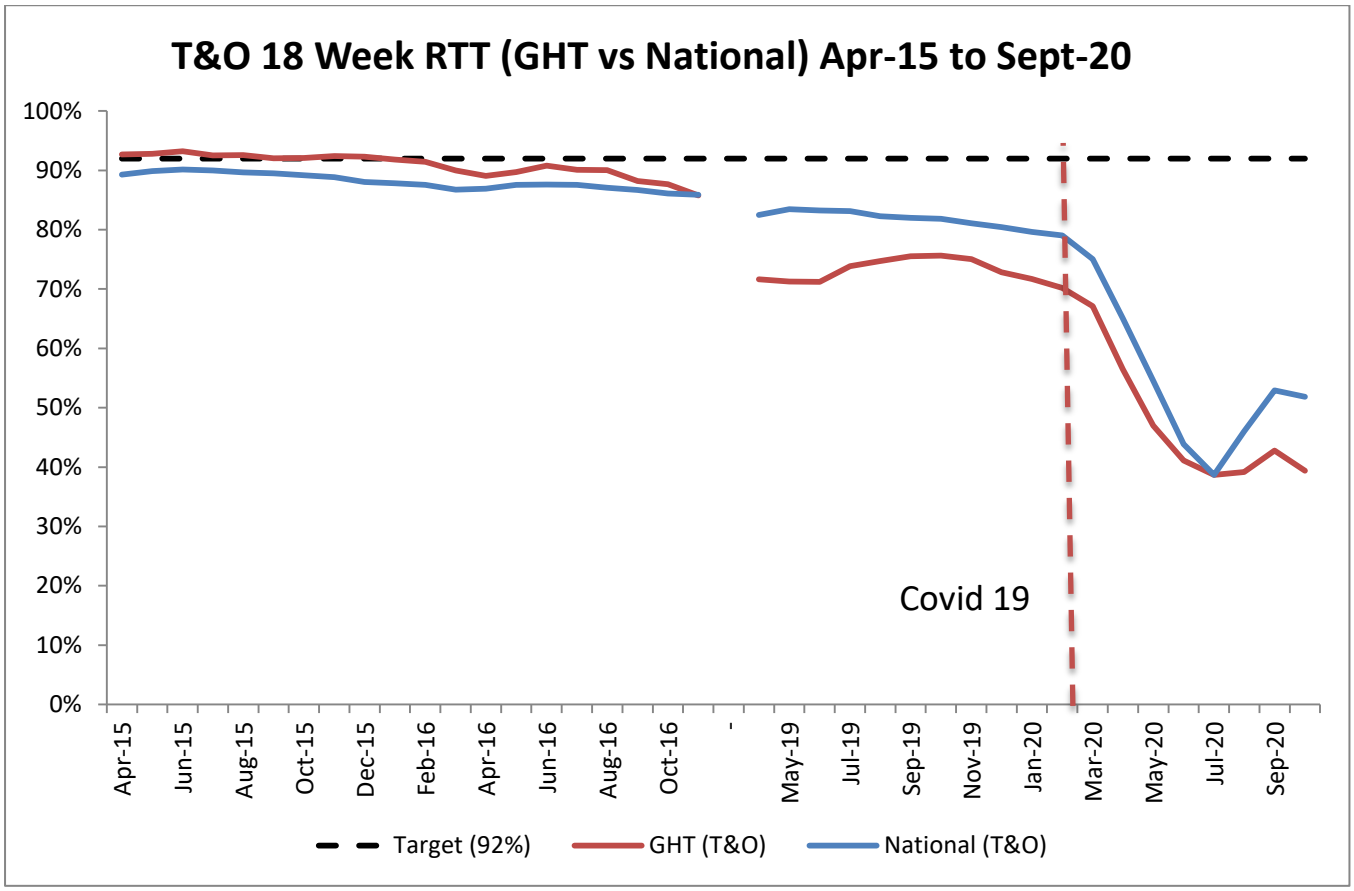
Elective Orthopaedic Data

Over the past three years since the beginning of the pilot there have been many changes, including implementation of a new Patient Administration System (PAS), a six month refurbishment of one of the laminar flow theatres at CGH, a new referral system and the impact of the COVID 19 pandemic in 2020 which has resulted in elective work being reduced and orthopaedic staff diverted to treat patients with COVID 19 and support non-COVID areas at CGH and GRH.

When the new PAS was implemented not all data links to the Business Intelligence team were completed and it was very difficult to obtain data and in particular to go back a year before the start of the pilot to establish a performance baseline. A new pre-pilot dataset is now available which has closed some of these gaps and is included in the sections below.

18 week target:

There is a national 18 week target from referral to treatment for all elective surgery, detailed in the graph below. Before the pilot and it can be seen that the orthopaedic service was achieving the target (95%) during 2015 but dropped to 85.8% by the end of 2016. This was due to closure of elective wards during peaks of high activity (bed pressures).

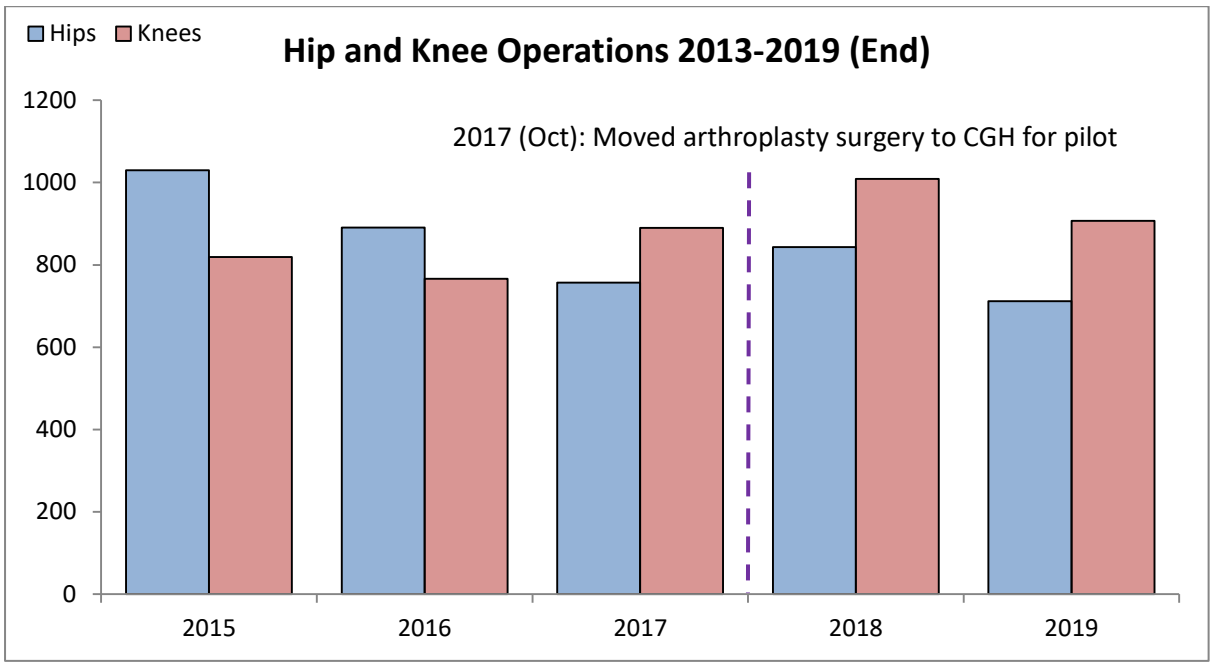


It should be noted that from November 2016 to April 2019 the Trust was unable to report the 18 week target data. A new IT system was implemented and during this time the data was not deemed sufficiently reliable.

Hip and Knee Arthroplasty Replacement Surgery:

This data has been presented by the BI team who have identified patients who have elective arthroplasty surgery. **It should be noted that during 2019 the service were without one of the arthroplasty theatres for 6 months whilst it was refurbished (*)**.

Type of operation	2015	2016	(20th Oct pilot) 2017	2018	2019
Hips	1030	891	757	843	712
Knees	819	766	890	1009	907
Grand Total	1849	1657	1647	1852	*1619



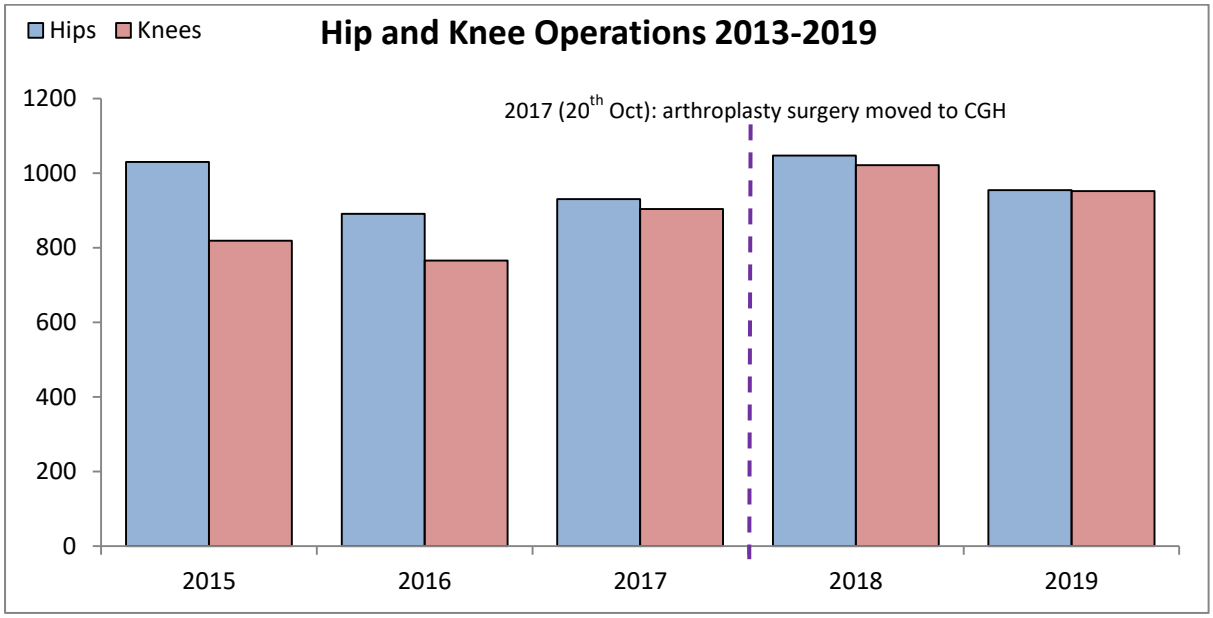
2018/19: On block contract

2018: One theatre at CGH close for refurbishment (6 months) and 3 theatres (3 weeks)

Hip and Knee Operations recorded by the National Joint Registry:

It will be noted that these are different from those in the report compiled by the BI team however they include hip arthroplasty undertaken for trauma patients as well as elective surgery.

Type of operation	2015	2016	(20th Oct h/c split) 2017	2018	2019
Hips	**1030**	**891**	**931**	**1047**	**955**
Knees	**819**	**766**	**904**	**1022**	**952**
Grand Total	**1849**	**1657**	**1835**	**2069**	**1907**



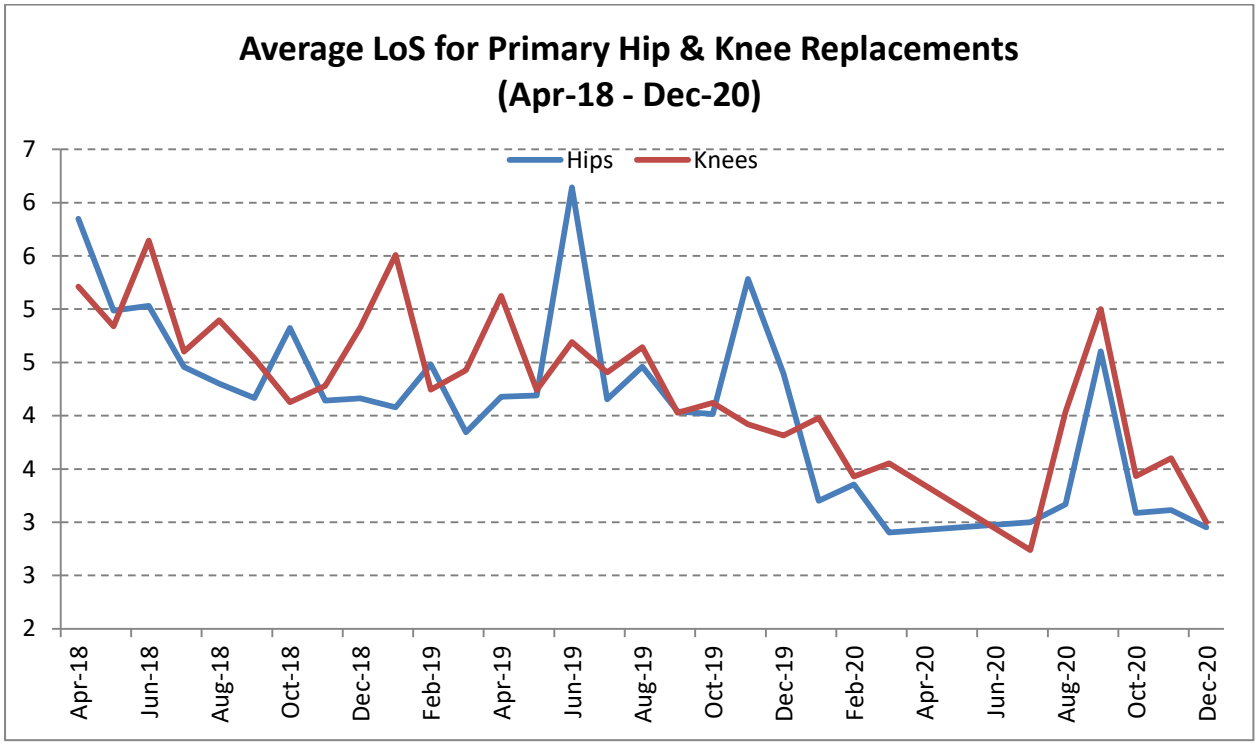
Objective #1: Enhanced Recovery after Surgery (ERAS)

#	Issue	Description	Current position	Outcome
1.	**Co-location of arthroplasty (joint replacement) surgery**	To improve standardisation of pathways.	All arthroplasty at CGH and ERAS pathway and standardisation of prostheses	Achieved

By relocating the arthroplasty (joint replacement) surgery on one site the service established a multidisciplinary ERAS working group in 2018. In a year they were able to save 1741 bed days, 726 days after hip arthroplasty and 1015 after knee arthroplasty by:

- Establishing an audit programme
- Link nurses for ERAS established in all departments
- Starting Pre-op Carbohydrate drinks
- Monthly review of readmissions to look for trends
- Increased patient involvement
- Patients have access to a post op advice line/ wound service which is well utilised
- Established staff education programmes
- Working with infection control team to produce a new protocol for post-op wound care
- Stopped using Diamorphine in spinal anaesthetic which reduces the incidence of nausea /vomiting and post-op dizziness.

Length of Stay[1]



[1] Data source: ERAS reporting – orthopaedic dashboard.

Length of Stay

Type	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Hips Ave. LoS	5.9	5.0	5.0	4.5	4.3	4.2	4.8	4.1	4.2	4.1	4.5	3.8
Knees Ave. LoS	5.2	4.8	5.6	4.6	4.9	4.5	4.1	4.3	4.8	5.5	4.2	4.4
Total primary Hip/Knee	112	137	124	151	127	125	159	146	108	97	105	120

Type	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Hips Ave. LoS	4.2	4.2	6.1	4.2	4.5	4.0	4.0	5.3	4.4	3.2	3.4	2.9
Knees Ave. LoS	5.1	4.2	4.7	4.4	4.6	4.0	4.1	3.9	3.8	4.0	3.4	3.6
Total primary Hip/Knee	112	132	61	123	124	122	138	110	86	105	87	50

Type	Apr-20[2]	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20
Hips Ave. LoS	-	-	-	3.0	3.2	4.6	3.1	3.1	3.0
Knees Ave. LoS	-	-	-	2.7	4.0	5.0	3.4	3.6	3.0
Total primary Hip/Knee	0	0	0	55	64	62	67	51	37

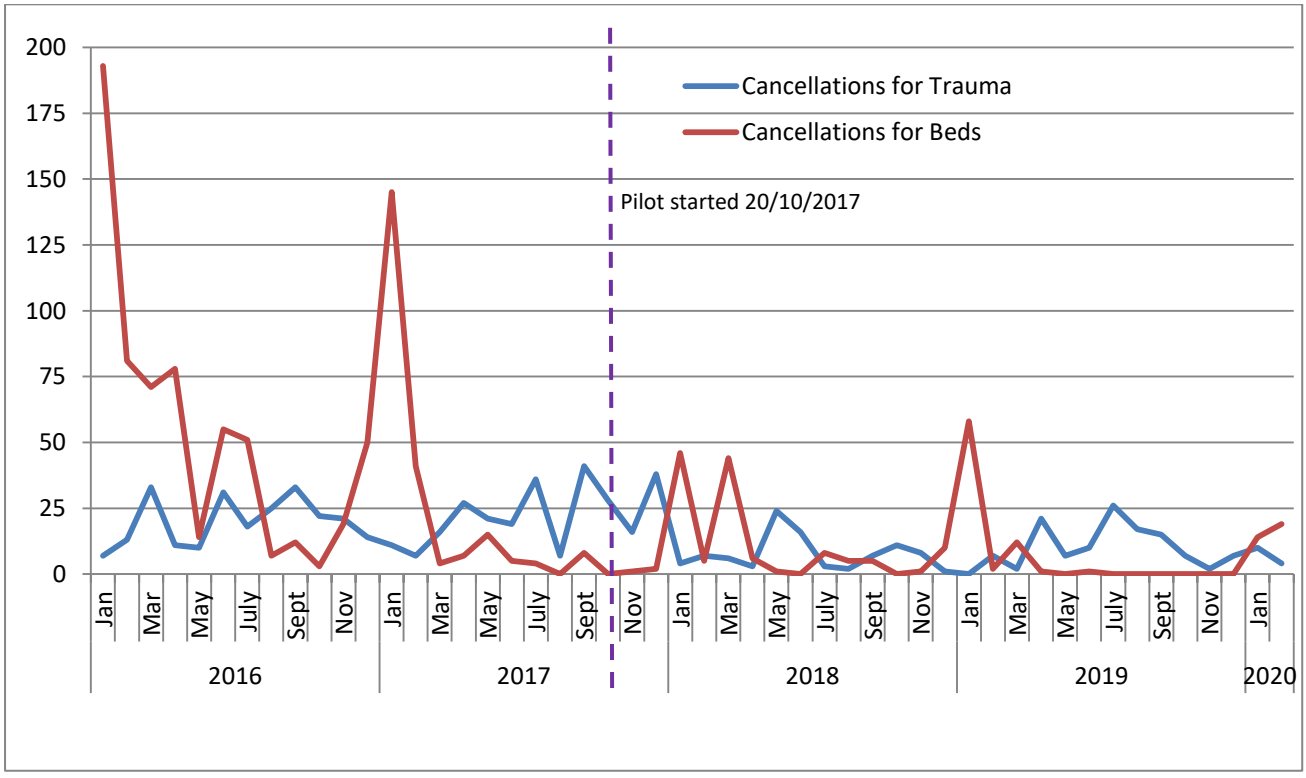
[2] No activity recorded Apr20-Jun20 as a result of Covid-19

Objectives #2 & #3: Cancellation of Elective operations

#	Issue	Description	Current position	Outcome
2.	**Cancellation of elective patients for trauma patients**	Cancellations frequent particularly when complex sub-specialty surgery was required	There are still cancellations when there are peaks in trauma demand but significantly fewer	Much improved
3.	**Cancellation of elective patients when beds used for other specialties**	Elective patients were often cancelled when the hospitals had periods of high demand.	There are still cancellations in times of high demand but significantly fewer	Much improved

There are a number of reasons why elective surgery is cancelled but by far the most common are because there is an emergency (trauma) or urgent case or in times of high activity when there are bed pressures. Data can be taken from the system but only cancellation on the day of surgery is recorded and this was started in 2017. This data is not particularly helpful as the service makes every effort to cancel before the day of surgery if they are aware that surgery cannot go ahead to try and reduce the impact on patients as much as possible. To find these figures an audit of the manual system has been carried out.

Cancellation of orthopaedic surgery (by hospital) for either trauma/urgent case or bed pressures:



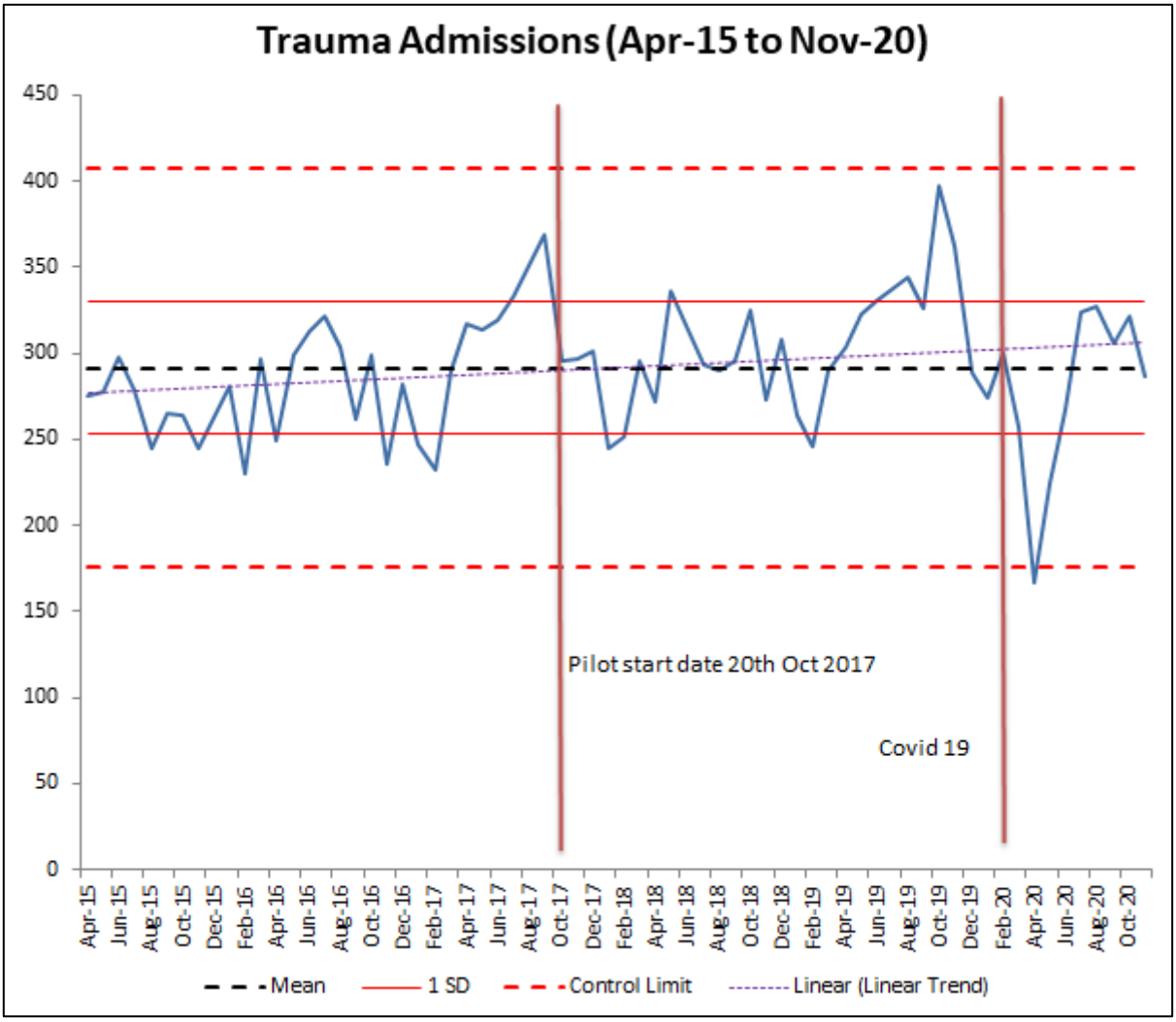
The red line shows cancellation for beds and although there are still peaks where bed pressures necessitate the reallocation of wards, the trend is positive. Likewise the cancellations for trauma, shown in blue, decreased although the chart shows a rise in 2019. It should be noted that this data includes cancellations for urgent elective (planned) patients as well as emergency trauma patients. 2020 data has not been shown as the service has been significantly affected by the COVID 19 pandemic and comparison would not be appropriate.

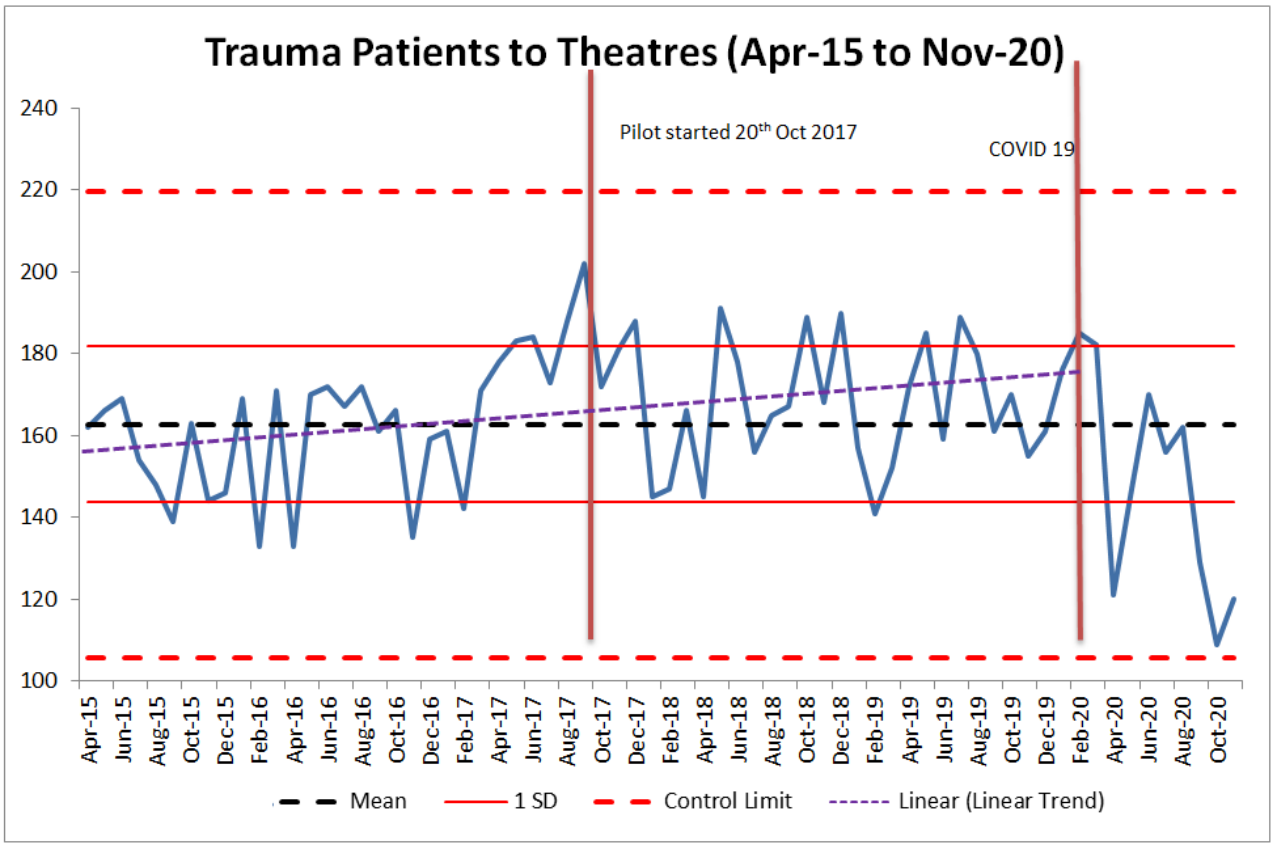
Objective #4: Trauma

#	Issue	Description	Current position	Outcome
4.	**Trauma patients did not always receive a timely review by a senior decision maker which exacerbated wait times in ED**	On call consultant and registrar could be scheduled to work either in theatre or clinic at the same time.	Now there is a consultant and registrar as well as a foundation doctor to give an immediate response	Achieved

Trauma Admissions:

Trauma admissions have always fluctuated throughout the year but the gradual trend has been an increase apart from a marked drop in attendances during the COVID 19 lockdown from March to July 2020. The linear admission growth since the beginning of 2017 can be seen in the graphs below the first giving numbers of admissions and the second the growth rates (the red line until the end of 2019 and the blue line including the COVID 19 drop in patient presentation).





The graph above shows changes over the years in the number of trauma patients who required surgery.

Objectives #5 & #6: Senior Review

#	Issue	Description	Current position	Outcome
5.	**The senior review of admitted trauma patients from ED was variable**	On call consultant and registrar could be scheduled elsewhere and were not always available for immediate consultation	There is now an on-call consultant and Registrar who do not have other duties and so are available for immediate consultation	Achieved
6.	**Regular senior review for trauma patients**	There was no routine Ward/Board Round for trauma patients which meant delay for review	Now there is a 7 day a week Ward/Board round for all trauma patients	Achieved

Objective #7: Trauma Triage

#	Issue	Description	Current position	Outcome
7.	**Inability to cope with trauma referrals to fracture clinic**	Increase in demand just prior to the pilot leading to unacceptable delays	Now new trauma triage service in place to assist with growing demand	Much Improved

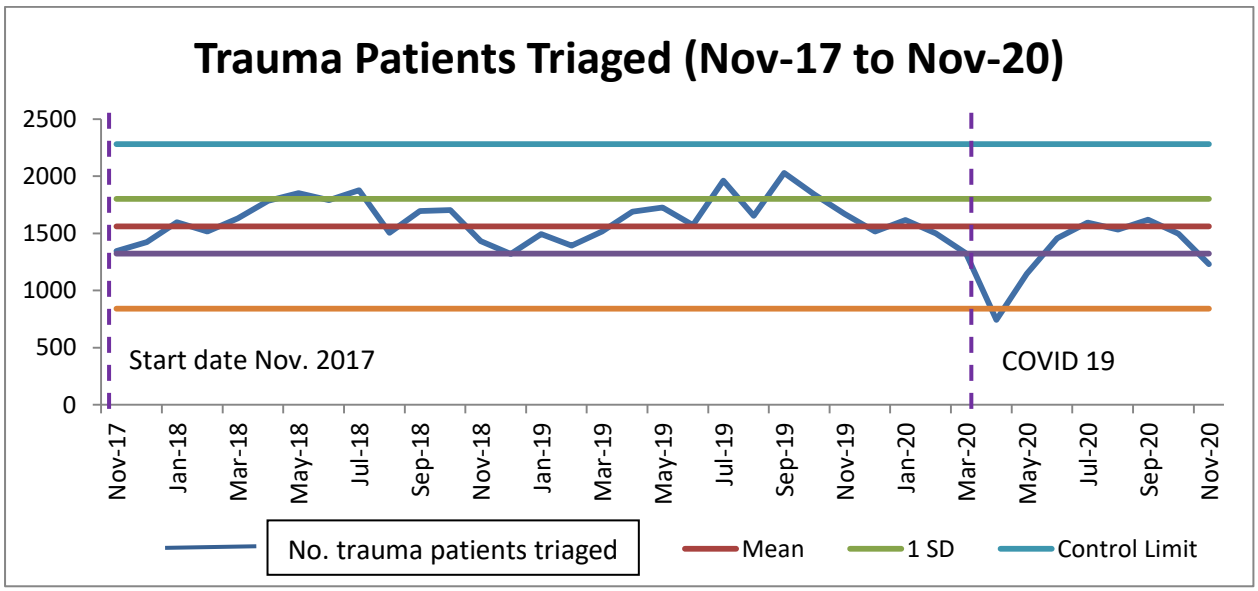
At the beginning of 2017 the number of trauma patients requiring opinion from the orthopaedic surgeons had risen, this was in part due to the retirement of the specialist who oversaw the community hospitals minor injury units (MIU) team and there was insufficient pre-planning to take account of the likely impact as a result of a change in the pathway.

The system prior to the pilot was that all patients that came into the ED and were not immediately admitted but referred on to the orthopaedic team and (from 2017) community MIUs were given an appointment in fracture clinic. Ideally this was within 48 hours; at this appointment the surgeons would assess whether surgery was required and plan the treatment regime. However the demand on this service was unsustainable with an increasing number of referrals resulting in a longer wait for an appointment in fracture clinic which could mean that the decision of whether surgery was needed was delayed and the resulting surgery.

In order to resolve this concern a trauma triage system was set up. In this service all patients who would be previously referred to the fracture clinic were referred into a virtual clinic. Every day the on-call trauma team review the referrals and allocates patients to either be admitted immediately, seen at fracture clinic immediately or if that is not necessary at an appropriate interval.

There are also patients who do not need to come into fracture clinic, these patients are telephoned by the specialist nurse trauma co-ordinators who advise on the best management; these patients are also given a number to call an open appointment in case they have concerns. In this way we can insure that those who require immediate treatment receive it and also minimise unnecessary visits to hospital.

The trauma triage started in November 2017 when **1,344** patients were triaged. As all trauma numbers do fluctuate but there was a marked rise in referrals towards the end of 2019 with a peak in September 2019 of **2,018** referrals.



Objective #8: Trauma waiting times

#	Issue	Description	Current position	Outcome
8.	**Improve time to theatre for trauma patients**	There was a delay in getting some patients to theatre, especially during peaks in demand	Although the care for trauma patients is now standardised, this remains an issue to be resolved.	Not achieved

There is a daily meeting of all trauma staff, on call team, operating team, trauma co-ordinators, junior doctors and Theatre staff. At this meeting the patients awaiting surgery are prioritised and allocated a theatre slot. Upper limb trauma was chosen as a metric for the pilot as many patients in this group will wait at home and be admitted when there is a theatre slot.

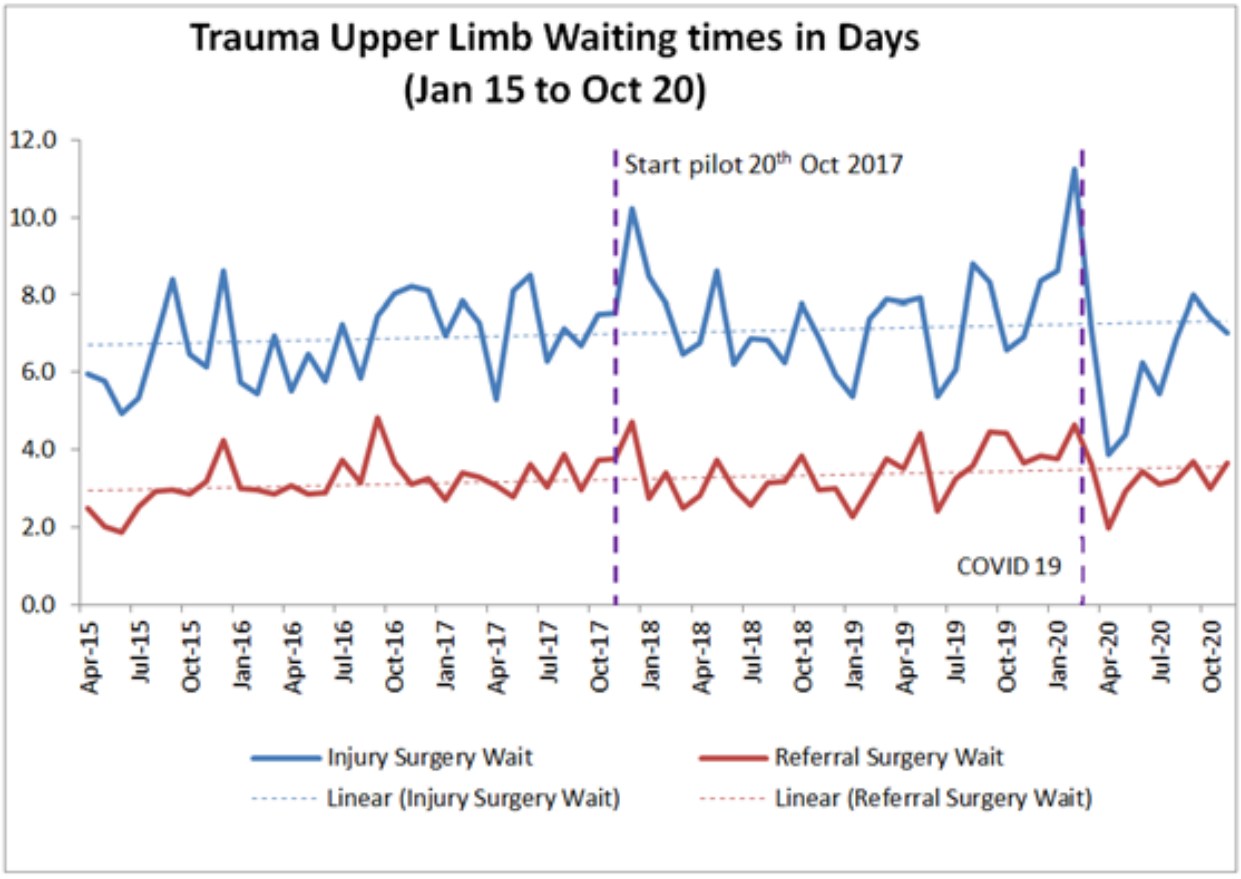
Guidance from the BSSH (British Society for Surgery of the Hand) is that all hand injuries should be triaged within 72 hours and be taken to surgery within 7 days. For specific fractures of the distal radius the British Orthopaedic Association Audit Standards for Orthopaedics gives a 72 hour target for review and surgical intervention, if appropriate.

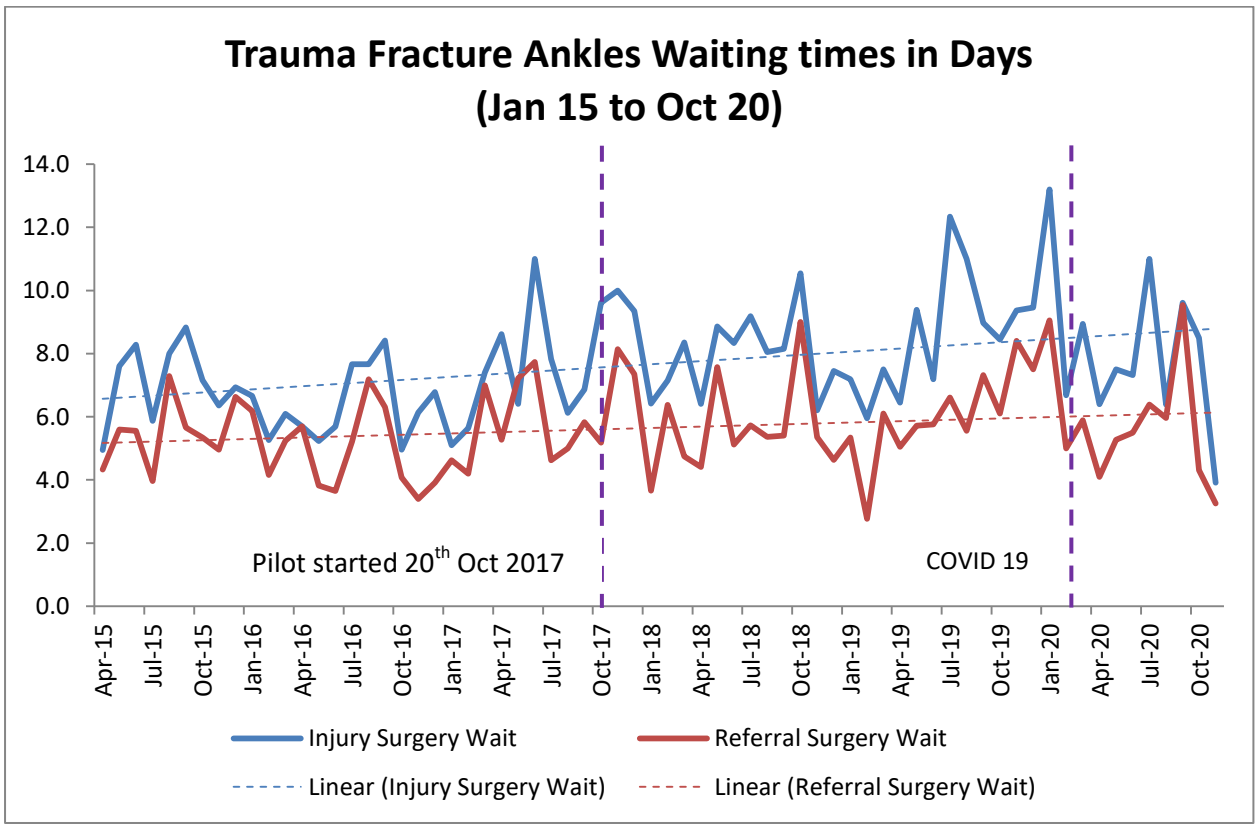
Using the British Society for Surgery of the Hand (BSSH) standard of 7 days for surgery as the benchmark, and assessing performance for upper limb trauma, the BSSH standard was achieved:

- In 1 of the 4 quarters (25%) pre pilot (October to September 2017)
- In 4 of the 9 quarters (44%) post pilot, but pre Covid-19 (October 2017 to January 2020)
- In 2 of the 4 quarters (50%) post Covid-19

Although not part of the original set of pilot objectives, time to surgery for wrist fractures is now included on the monthly orthopaedic dashboard for monitoring.

The trauma team have been working to maximise theatre efficiency and also convert some theatre lists from elective to trauma. There is a plan to utilise one of the new day surgery theatres at CGH that are to be developed as part of the strategic site development programme for orthopaedics. This will enable the service to undertake all elective adult day surgery at CGH and create theatre space at GRH for additional trauma surgery.


Trauma Upper Limb Waiting times in Days
(Jan 15 to Oct 20)
12.0
10.0
8.0
6.0
4.0
2.0
0.0
Start pilot 20th Oct 2017
COVID 19
Apr-15
Jul-15
Oct-15
Jan-16
Apr-16
Jul-16
Oct-16
Jan-17
Apr-17
Jul-17
Oct-17
Jan-18
Apr-18
Jul-18
Oct-18
Jan-19
Apr-19
Jul-19
Oct-19
Jan-20
Apr-20
Jul-20
Oct-20
Injury Surgery Wait
Referral Surgery Wait
Linear (Injury Surgery Wait)
Linear (Referral Surgery Wait)


Trauma Fracture Ankles Waiting times in Days
(Jan 15 to Oct 20)
14.0
12.0
10.0
8.0
6.0
4.0
2.0
0.0
Pilot started 20th Oct 2017
COVID 19
Apr-15
Jul-15
Oct-15
Jan-16
Apr-16
Jul-16
Oct-16
Jan-17
Apr-17
Jul-17
Oct-17
Jan-18
Apr-18
Jul-18
Oct-18
Jan-19
Apr-19
Jul-19
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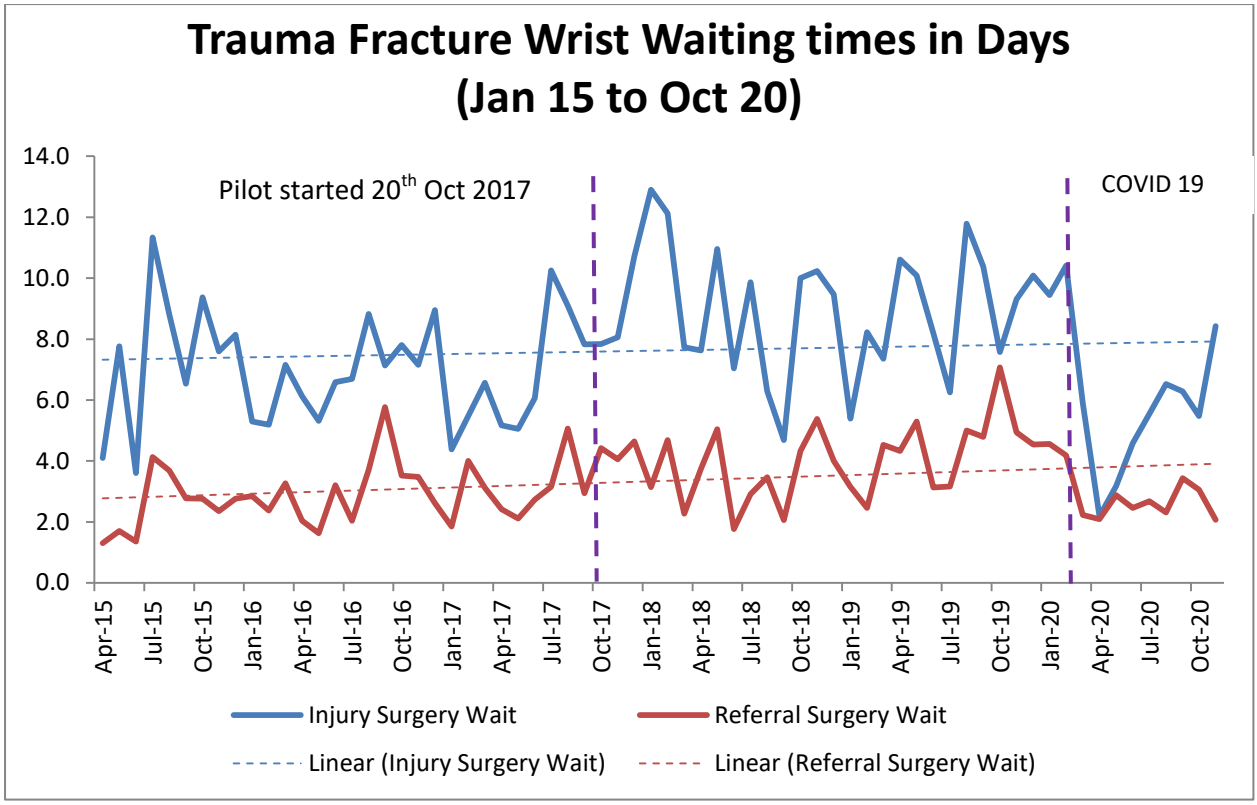
Jan-20
Apr-20
Jul-20
Oct-20
Injury Surgery Wait
Referral Surgery Wait
Linear (Injury Surgery Wait)
Linear (Referral Surgery Wait)



Objectives #9 & #10: Junior Doctors

#	Issue	Description	Current position	Outcome
9.	**Poor junior doctor feedback**	Access to senior colleagues was difficult as timetables prevented regular supervision	There is now a consultant and registrar available for supervision and regular training sessions	Achieved
10.	**Junior doctor recruitment**	Filling junior doctor posts was often difficult	The service is now fully staffed	Achieved

Performance measures outside of pilot objectives

In addition to the 10 Objectives that were key drivers for change in the original Pilot (described above), there are a number of additional performance metrics associated with the Trauma and Orthopaedic services and these are described below.

Fractured Neck of Femur Data

There is a national database to record data for people suffering from fractured neck of femur. This is because hip fracture is very common – almost 68,000 people were admitted into hospital with a fractured hip last year. The majority of these patients are very frail and suffering from complex medical conditions. The database was set up due to a national variation in quality and outcomes. Up to a third of people who fractured their hip died within the year and a third of patients did not return to their previous place of residence i.e. their own home or care home within 30 days of discharge from hospital.

The national data base was set up as there was national variation in mortality (deaths within 30 days of admission to hospital). High quality, safe care requires the coordinated approach of a multidisciplinary team who are committed to implementing care that research has shown will produce the best outcomes. All data shown is published nationally.

Care of fractured neck of femur patients was undertaken at both CGH and GRH hospitals until October 2017. Although after 2013 when CGH ED became 24/7 A&E (nurse-led 8pm–8am), all patients who were brought by ambulance would be taken to GRH. Ambulance is the usual way for these patients to arrive at hospital.

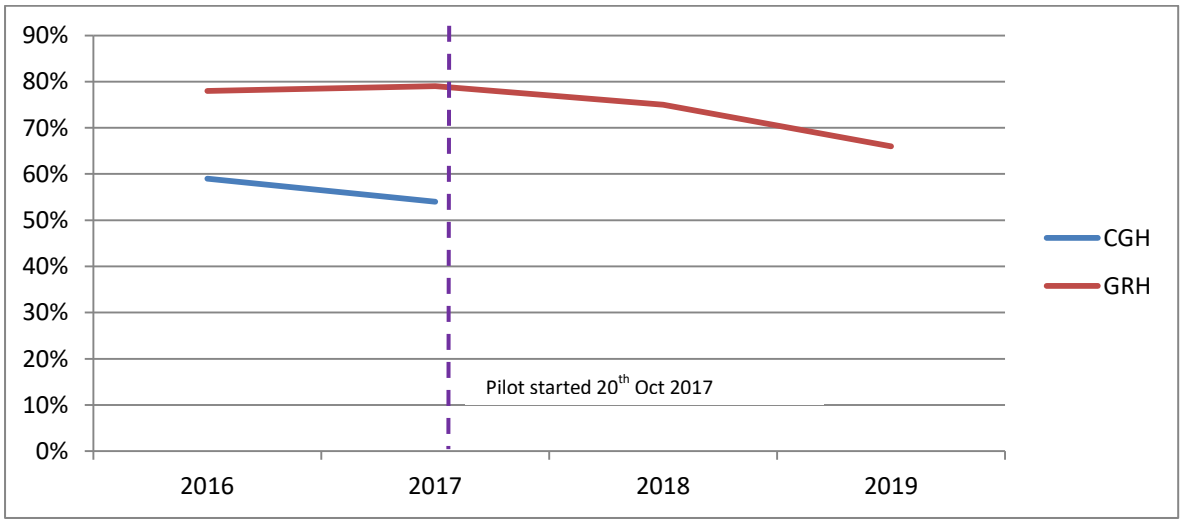
We have publicly committed to the future of the Accident and Emergency (A&E) Department in Cheltenham. Once the COVID-19 temporary changes are reversed the service will remain consultant led and there will be no change to the pre-COVID opening hours.

Best Practice Tariff (fracture neck of femur):

A national 'Best practice tariff' was also implemented which is achieved if individual patient care complies with the following key performance indicators:

- Surgery within 36 hours of admission
- Assessment by senior member of the Care of the Elderly Team (consultant/SAS/ST3+)
- AMTS on admission (a nationally validated assessment of mental cognition)
- Delirium assessment undertaken post operatively
- Nutrition assessment undertaken
- Falls assessment undertaken.
- Bone protection medication reviewed

Achievement of Best Practice tariff at Gloucestershire Hospitals 2016-2019[3]



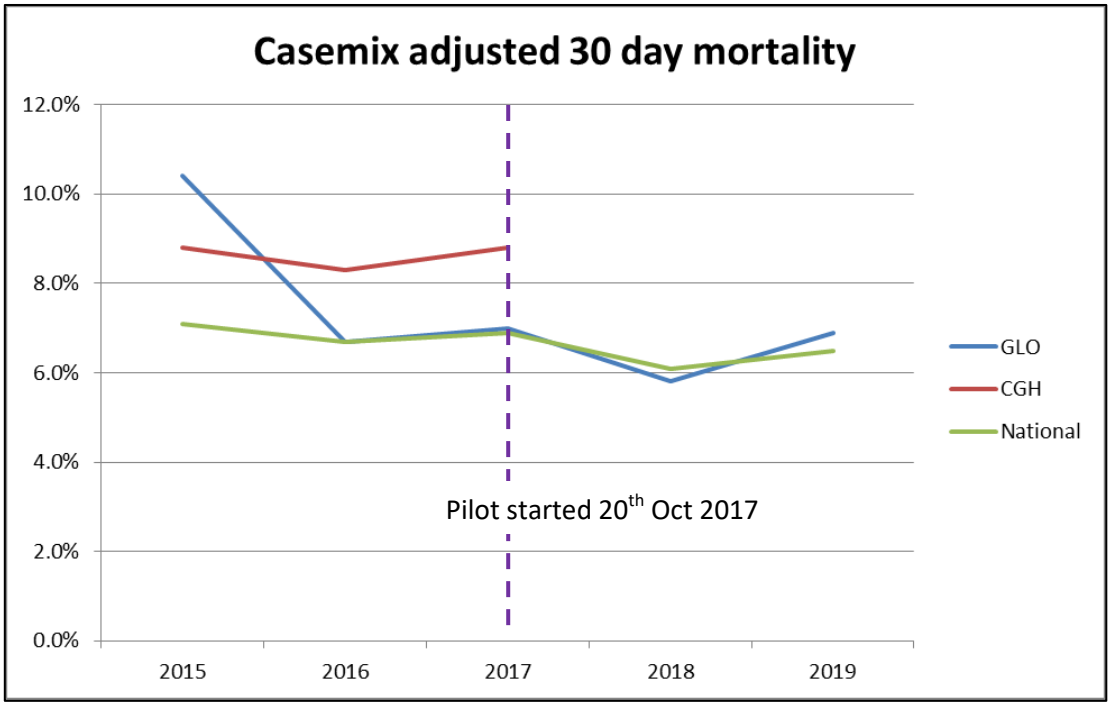
[3] Data for 2020 not yet available due to end of year adjusted mortality rate validated by national team

The achievement of the best practice tariff required co-ordination from a dedicated multidisciplinary team which was difficult to provide on two sites as there is a national shortage of ortho-geriatricians. The impact of theatre capacity on performance is dealt with elsewhere in the report.

Mortality

The National Hip Fracture database collects data to show the percentage of deaths within 30 days of admission to hospital with a fracture neck of femur. The raw data is collected and is then validated and case mix adjusted to indicate the level of medical complexity for each patient. This may mean that the raw data percentage rises if complexity is low and drops if complexity is high. This is done to enable equitable benchmarking between organisations. Validation is completed by the national group at the end of each year

Mortality within 30 days for fractured neck of femur patients in Gloucestershire:[4]



Year	GRH	CGH	National
2015	10.4%	8.8%	7.1%
2016	6.7%	8.3%	6.7%
2017	7.0%	8.8%	6.9%
2018	5.8%	0	6.1%
2019	6.9%	0	6.5%

It will be noted that the mortality percentage was high and reached a peak in 2015 at GRH (10.4%) and at CGH levels were lower (8.8%) but above national average (7.1%). A considerable amount of work was commenced to resolve this issue. A multidisciplinary team was established in

[4] Data for 2020 not yet available due to end of year adjusted mortality rate validated by national team

Gloucestershire including the Orthopaedic Trauma Lead Consultant, Care of the Elderly Consultant, Anaesthetic Consultant, ED Consultant, Nursing ANP, Ward Nurses, Physiotherapists, Junior Doctors, Pharmacists and General Manager to address the issues. The team also joined the Scaling up for safety National project to share the lessons learnt from a hip fracture quality improvement programme.

The improvement team undertook a pathway review, altering processes in ED, Anaesthetic protocols, surgical implants used and management on the wards, including a dedicated nutritional nurse. As a result of this work the mortality rate at GRH dropped to 6.7% the national level for that year whilst CGH was 8.3%.

This improvement took place before the reconfiguration pilot. However one of the aims was to bring the improved service to all patients and maintain the improvements in care. In 2018 the year after pilot was initiated mortality for all fractured neck of femur patients had improved even further to 5.8% better that the national average at 6.1% (see table above).

The overall validated mortality percentage rose to 6.9% in 2019 slightly higher than the national average at 6.5%. However it was noted that the percentage increased sharply towards the end of the year and there was concern within the service, the reason for this rise is multifactorial and not always easy to identify but there was concern that that it may be due to competition for theatre space.

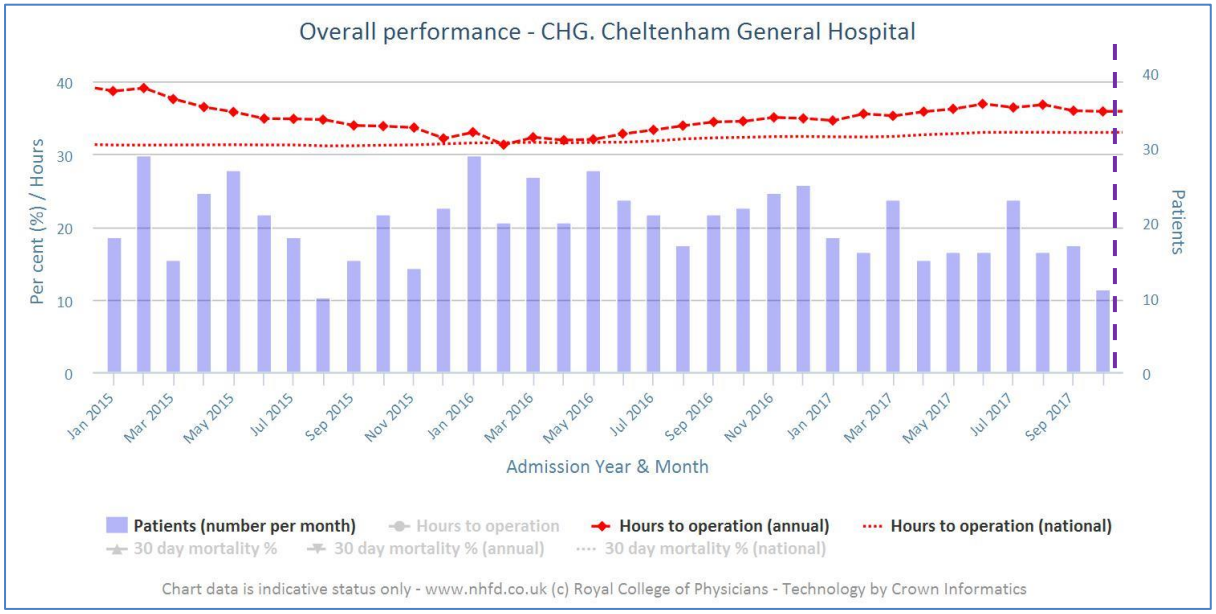
Validated data for 2020 is not yet available and figures for this year will be affected by the March *and November/December* COVID spikes. Over the last few months 30 day crude mortality has plateaued at approx. 7%

Length of time to Theatre

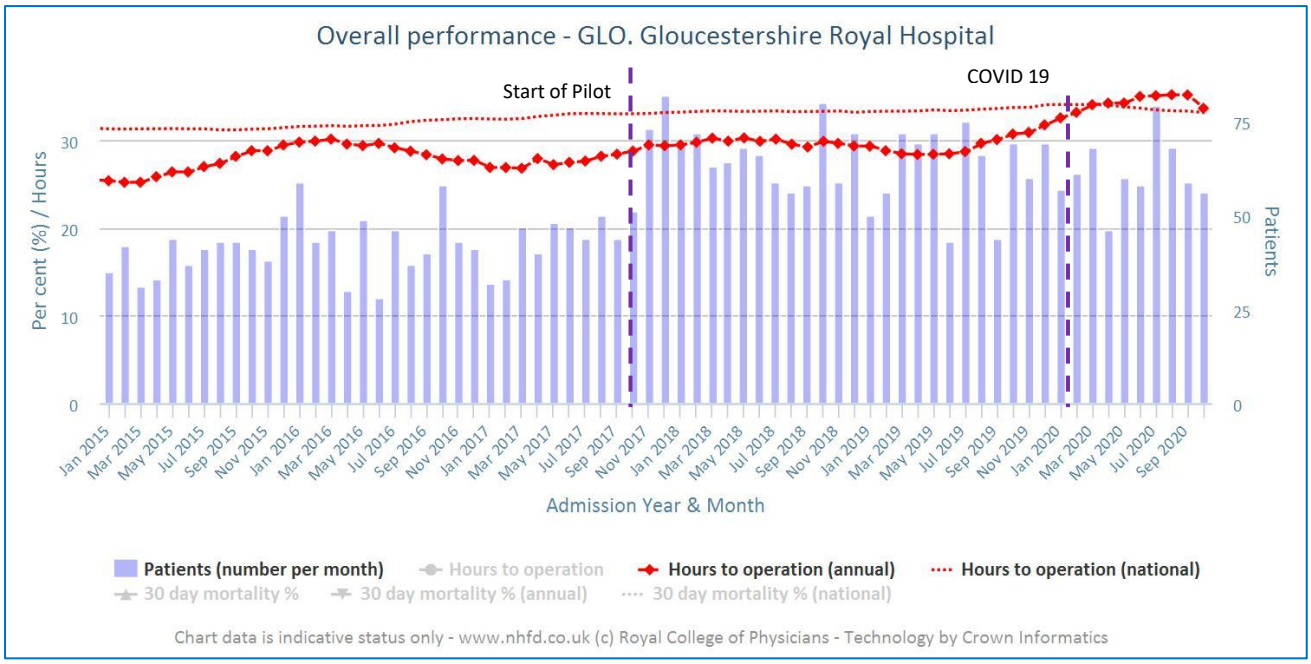
This information reflects the length of time from admission to surgery; the target is within 36 hours. The reason that early surgery is important is that research shows better mortality and morbidity outcomes. Also surgical intervention is a good form of pain control. The majority of patients receive a fascia iliac local block (local anaesthetic is injected into the hip area) in ED which gives good pain control for up to 24 hours, if patients do not go to theatre within this time they are assessed and a second block is given if appropriate. This was part of the pilot and has been very effective. There will be a small percentage of patients who after assessment are not taken to theatre, this will only be in cases where death is imminent and the surgical intervention would be inappropriate.

The two graphs below are taken from the nationally published data, the block graphs show the number of patients admitted with Fractured Neck of femur. The diamond line graph shows the average length of time for patients to be taken to theatre and the dotted line shows the national average time to take patients to theatre.

Graph to show the number of patients and time to Theatre at CGH 2015-2017 (until 20th October 2017):



Graph to show the number of patients and Time to Theatre at GRH 2015-2020:



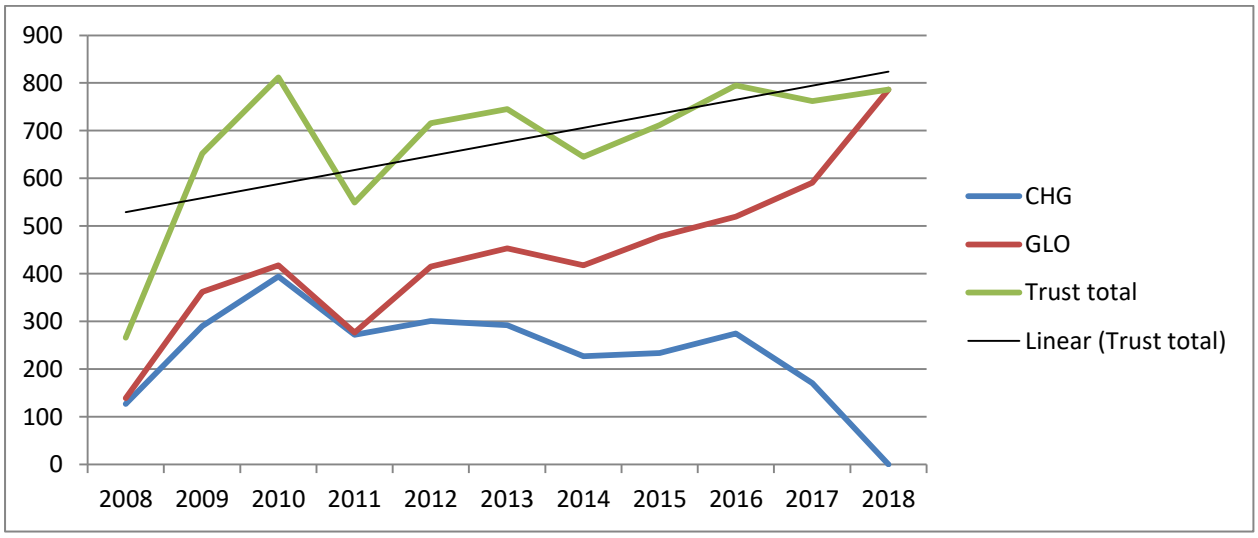
As demonstrated, the time to theatre at CGH was consistently longer than the national average. There were two reasons for this; before the pilot there was only one half day list at CGH and the trauma surgery was carried out by a timetabled surgeon, this did not provide the flexibility to provide sub-specialty care. For example if the surgeon that day was a specialty in upper limb procedures they may not be best placed to operate on a patient with a hip fracture and the hip fracture patient would have to wait until a suitable surgeon was rostered or cancel a patient who was booked to undergo an elective procedure on the list of a surgeon with appropriate sub-specialty.

In the pilot there are a minimum of two full day trauma theatre lists every day, 7 days a week and the lists are structured in a way to ensure that there is access to complex sub-specialty surgery as required.

The graphs show that whilst we were unable to get patients with fractured neck of femur to theatre within the target timescale at CGH, since the start of the pilot it has been possible to maintain a time to surgery that is better than the national average. There was an adverse rise towards the end of 2019 and 2020 as mentioned above (in mortality) and measures have been taken to re-allocated theatre lists, the improvement is also charted.

As previously mentioned, more theatre lists have been made available at Cirencester Hospital and some non-complex trauma surgery is undertaken there. In addition more day cases from the remaining elective work at GRH have been transferred to Cirencester Hospital to create more theatre space within GRH theatres for Trauma patients. There is a further plan to utilise one of the new day surgery theatres at CGH that are to be developed as part of the £39.5M Strategic Site Development Programme for orthopaedics. This will enable the service to further reorganise elective lists and create theatre space at GRH for additional trauma surgery.

Growth in referrals for Fractured Neck of Femur



Continuous Improvement

A physical service move will not solve all issues but will provide a building block for change. Over the last three years there have been a number of new innovations.

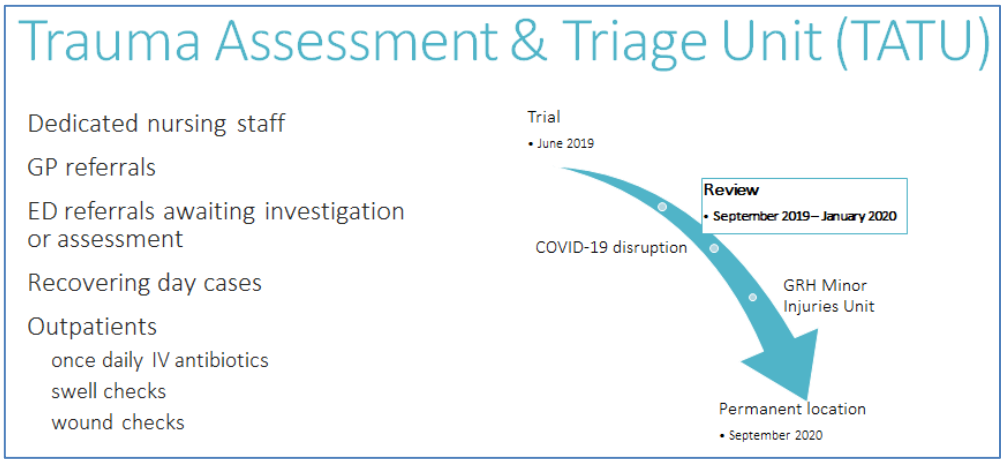
- Within the elective service a ward round was set up at CGH to support the junior doctors and work is ongoing with ERAS and standardisation in surgery.
- Wards at CGH have been ring-fenced in accordance with infection control regulations and further work to undertake pre-operative testing for MSSA in addition to MRSA has been set up.
- The anaesthetic team have set up a new cell salvage service to enhance patient care.
- Theatre lists are well utilised although the service was without an elective theatre for six months in 2019 whilst necessary refurbishment was carried out and as part of the same refurbishment without three theatres for 3 weeks.
- A musculoskeletal triage service was put in place in July 2019. This is going well with regular MDTs between advanced practitioners and surgeons. As a result, and as expected, this has

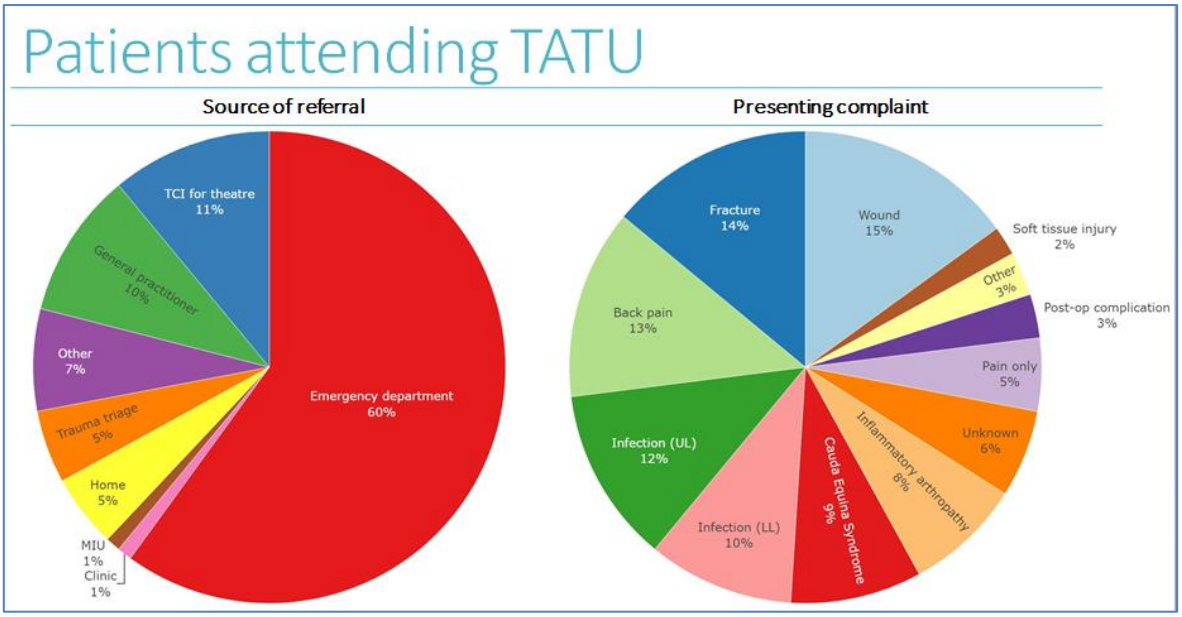
resulted in a lower number of referrals to outpatients but a higher conversion rate. The lower referral rate has allowed the service to undertake the delayed follow ups that had accumulated during the difficult IT system implementation; although unfortunately there will be significant delays in treatment in after the COVID 19 Pandemic.

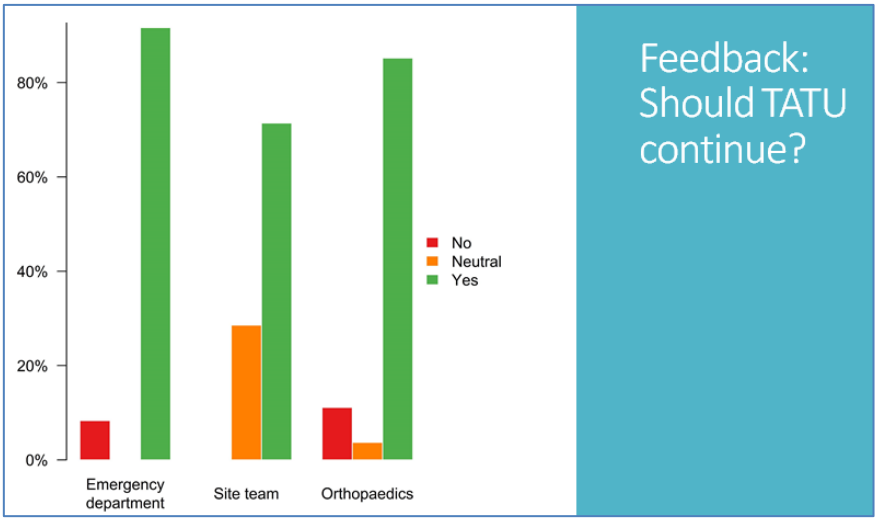
- Within the Trauma service we have seen a significant rise in demand which has shown a pressure in 2019 with a delay to theatre recorded and a rise in cancellations for trauma cases.
- There have been a number of innovative changes with a Trauma Assessment & Treatment unit now in place to help patient flow from ED. Details and feedback of this trial are recorded below:

Despite work to increase the efficiency of the trauma service, the increase in demand has exacerbated the difficulty of time to operation especially when there are peaks in demand. Growth in demand is in particular for fractured neck of femur and wrist fractures; patients with fractured neck of femur will be (correctly) prioritised for surgery before those with wrist fractures. However the increase leads to a pressure on theatre resource particularly as each fractured neck of femur patient will require 2 to 3 hours in the operating theatre. With this in mind a simple comparison of data may not tell the whole story but work is ongoing to review theatre requirements and ensure that theatre utilisation and productivity are optimised.

Trauma Assessment & Treatment Unit (TATU)







TATU has now been made permanent and has made a major contribution to keeping the service running throughout the COVID pandemic.

COVID 19 Changes

Another change undertaken during the COVID pandemic is that orthopaedic staff have worked within the minor injuries area at GRH. The benefits have been:

- A reduction of the 1st on call workload
- An ability to access a second senior decision maker immediately and process referrals to trauma triage by ANPs immediately
- The availability to undertake minor ops (freeing up valuable time / resources from main theatres)
- The ability to triage to come back to fracture clinic e.g. at 10days instead of within 72hrs.

Whether this continues after the COVID pandemic is to be reviewed.

Lessons Learned

- **Theatre modelling:** The modelling for the required theatre time in GRH for trauma did not fully identify the ongoing requirement and this resulted in sub-optimal capacity and did not enable all the expected benefits to be realised.
- **Monitoring of the Pilot**: the monitoring processes in place did not create a sufficiently robust feedback loop so that deliverability issues[5], for example ring fenced beds for elective orthopaedic care, waiting times and repatriation of work lost to the independent sector, were not addressed during the pilot period.

Recommendations

As demonstrated in the report, the Trauma and Orthopaedic pilot had a set of clear objectives that aimed to improve patient outcomes and experience, respond to increasing demand, support recruitment and retention and improve efficiency; and the T&O team continue to develop the service and innovate. It is recognised, however, that the monitoring of the pilot could have been enhanced and a list of considerations for future service change implementation governance is listed below:

- Apply Plan-Do-Study-Act (PDSA) approach to ensure expected benefits are monitored and reviewed and actions taken to rectify
- Identify evaluation forum which receive regular updates (e.g. quarterly) and where deliverability issues are resolved / escalated to e.g. Specialty Board, Divisional Board, TLT etc.
- Confirm the performance metrics to be used to assess success and present in easily understood format e.g. dashboard and to include quality metrics pre and post pilot
- Allocate responsibility for evaluation to nominated clinical, operational and programme staff.

[5] A number of these are addressed in the report

Fit for the Future

Planned General Surgery

The consultation included two options for Planned Lower GI (colorectal) General Surgery, either as part of a General Surgery centre of excellence at GRH or as part of a centre of excellence for Pelvic Resection at CGH. On Thursday 4th February, the Trust Leadership Team (TLT) at Gloucestershire Hospitals NHS Foundation Trust explored in detail the configuration options against six domains: Quality of Care; Access to Care; Deliverability; Workforce; Strategic Fit and Acceptability.

The discussion benefited from presentations followed by a question and answer session, with clinical leads from the multi-disciplinary General Surgery team. Both proposals had better outcomes for patients at their heart and many benefits. However, it was evident as a result of the debate that there was an alternative, potentially even better option, that includes the best elements from the two options presented and notably the opportunity to deliver more planned elective surgery at CGH than either of the two options consulted on. This opportunity to treat more patients in a centre of excellence for planned surgical care was also something that came through the consultation feedback (with over 40 references to increasing planned care at CGH) from both public contributors and staff.

The recommendation was that further work should begin with the General Surgery team to define this new, emerging option. The focus will be to explore the opportunity to deliver:

- Planned “High Risk” Upper Gastrointestinal (GI) and Lower Gastrointestinal (Colorectal) surgery at Gloucestershire Royal Hospital
- Planned complex and routine inpatient and day case surgery in both Upper and Lower GI (Colorectal) at Cheltenham General Hospital

The General Surgery team will now work together to define ‘high risk’ and it is important to note that risk doesn’t equal complexity. A complex operation on an otherwise fit and well patient could be categorised as ‘low risk’ where as a relatively routine operation on a patient with other underlying health conditions could be categorised as ‘high risk’.

Copies of the two presentations are provided overleaf.

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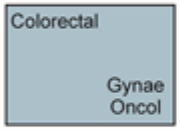
Combined in-patient planned care model for Colorectal surgery at CGH
–
developing Centres of Excellence delivering Fit for the Future

NHS
Gloucestershire Hospitals
NHS Foundation Trust

What is the vision?

Single dedicated inpatient unit (ward) for colorectal surgery – joint working with gynaecological oncology



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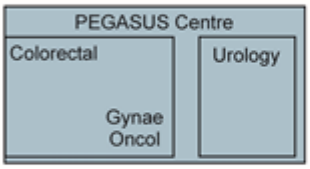
What is the vision?

Development of a flagship centre of lower abdominal and pelvic surgery - 'PeGasUs Centre'



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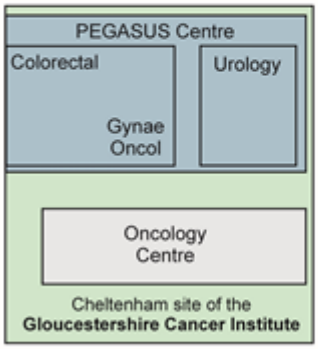
What is the vision?

Enhanced on-site working with the Oncology Centre – supporting the CGH part of the 'Gloucestershire Cancer Institute'



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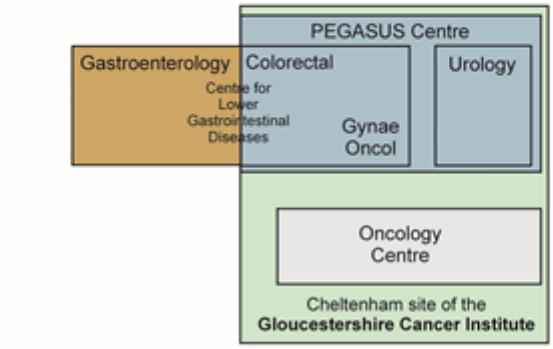
What is the vision?

Development of a single site centre for in-patient lower gastrointestinal disease



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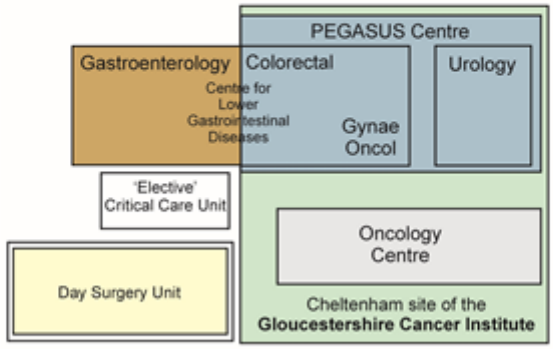
Gloucestershire Hospitals
NHS Foundation Trust

What is the vision?

Optimising the use of resources on both Trust sites
Augmenting the delivery of Emergency General Surgery at GRH



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Who for?

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What evidence?

NHS England
Innovation

NHS
South West
Clinical Senate

Royal College of Surgeons
ADVANCING SURGICAL CARE

G I R F T
GETTING IT RIGHT FIRST T

Public - Partners - Staff
2:1 - 2:1 - 4:1

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Trauma & Orthopedics - pilot
Emergency General Surgery ('trial')
Urology and Gastroenterology - pilot

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- Truly separate Centres of Excellence for Emergency and Elective Care
- Facilities dedicated to the different needs of the patients and staff
- Realising the true potential of a twin site Trust to deliver Fit for the Future
- Fully supported by all external opinion

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Future Vision for Gastrointestinal Surgery

Centre of Excellence for High Acuity Care
Centre of Excellence for Planned Care

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Who are we?

- Gastrointestinal (GI) Surgery – part of General Surgery
- One team, many parts, all dependent upon each other

- Changes to one part of our service impact on the whole of our service

What do we do?

High Acuity Care

- Emergency General Surgery (EGS)
- Elective major surgery patients
  - Significant risk of becoming unwell during admission
  - Increased risk of requiring a return to theatre
  - Greater risk of needing imaging (CT scans)
  - Higher risk of needing interventional radiology (IGIS)

Planned Care

- Inpatient short stay
- Day case surgery
  - Higher volume
  - Lower acuity
  - Lower risk of complications

This is **80%** of patients undergoing planned surgery

Why do we need to change?

NHS Gloucestershire Hospitals NHS Foundation Trust

- **Patient Safety**
  - High intensity workload
  - Difficulty staffing safe rotas for high acuity care across two sites
- **Inequality of patient care**
  - Variation in subspecialist input
- **Cancellation of planned care**
  - Lack of beds for high volume, lower acuity cases
  - Loss of income

Our Future Department of Gastrointestinal Surgery

Centre of Excellence for High Acuity Care

EGS

Elective major surgery

OG cancer
CR cancer
IBD

10% return to theatre
1 every 10 or 11 days

Centre of Excellence for Planned Surgery

Inpatient short stay

Weight loss surgery
Rectal prolapse surgery
Early rectal cancer

Day case patients

Laparoscopic cholecystectomy
Hernias
Haemorrhoids/fistulas

Lower risk of complications

This represents **80%** of patients undergoing planned GI surgery

Create the Environment

Centre of Excellence for High Acuity Care

- Dedicated SAU
- Dedicated ward for emergency admissions
- Separate dedicated elective major gastrointestinal surgery ward

Centre of Excellence for Planned Care

- Specialist unit with dedicated theatre for day case gastrointestinal surgery
- Dedicated ward for short stay gastrointestinal patients
- 5-day unit

Allow our staff to flourish

- Improved well-being and resilience
  - Redistribution of staff to improve workload
  - Better work-life balance
  - Not reliant on good-will

- Better supervision and training of medical staff
- Fantastic training environment – Nursing, AHP, PAs

- Career development and New Roles
  - ANPs, ERAS, nutrition team

What does this mean for our patients?

- **Safety**
  - Patients undergoing high acuity surgery will be looked after by a fully staffed, on site surgical service 24/7
  - Increased continuity of care
- **Subspecialist GI consultant review every day**
- **Operation at the right time**
  - Fewer cancellations of planned cases
  - Fewer complaints
  - Improved Patient Experience

Trust Strategy 2019 to 2024

Our Purpose — To improve the health, wellbeing and experience of the people we serve by delivering outstanding care every day

Our Vision — Best Care for Everyone

Our Values

- Caring
- Listening
- Excelling

Our GI Surgery Service
Centres of Excellence and Fit for the Future

Centre of Excellence for High Acuity Care

- Centre for Emergency General Surgery
- Centre for GI Resections
- Centre for Robotic Surgery

Centre of Excellence for Planned Surgery

- Centre for Biliary Disease
- Centre for Pelvic Floor Disease
- Centre for Bariatric Surgery
- Centre for Early Rectal Cancer

A VISION FOR EXCELLENCE

Quality of care ✓
Comprehensive safe cover for all our patients
7-day subspecialty GI review

Workforce ✓
Fully staffed rotas, wellbeing, sustainable
Multi-professional development
Integrated working

Access to Care ✓
Same care for everyone
Service development
Uses both sites
Minimal risk of cancellation

Strategic fit ✓
Greater separation of planned and high acuity care
Progressive model allowing all aspects of the service to flourish

Deliverability ✓
Staffing, theatres and beds in place
Rotas to maximise training opportunities

Acceptability ✓
First options appraisal
Engagement process
Fits with national guidance

Summary

NHS
Gloucestershire Hospitals
NHS Foundation Trust

- Addresses our drivers for change
- Creates the Safest Environment
- Vision for how all our staff can reach their potential

Leading to:

- The Best Care and the Best Outcomes for all our Patients

NHS
Gloucestershire Hospitals
NHS Foundation Trust

A Model Fit for the Future

Trust Strategy

Our Vision

- Patient safety at its core
- Right patient, right place, right time
- Delivering excellence

Elizabeth O'Mahony
Regional Director South West
NHS England and NHS Improvement
South West House
Blackbrook Park Avenue
Taunton
TA1 2PX

Telephone: 01823 361338
Email: e.omahony@nhs.net

7 October 2020

Mary Hutton
CCG Accountable Officer &
One Gloucestershire ICS Lead

Via email: mary.hutton1@nhs.net

Dear Mary

Stage 2 Assurance of the Gloucestershire Centres of Excellence (CoEx) Proposals

My thanks to you and the CoEx team for the extensive work on the CoEx Pre-Consultation Business Case and the constructive manner in which you have addressed the points arising from discussions with our SW service reconfiguration assurance panel on 3 September and then the follow-up meeting on 1 October 2020.

Statement of Assurance

Following consideration of the evidence presented and the discussion at the assurance meetings on 10 August, 27 August, 3 September and 1 October 2020, it is concluded that this scheme is Fully Assured against the four Key Tests, and the Finance and Best Practice requirements:

Test	Panel finding
Test 1 - Strong Public & Patient Engagement / Stakeholder Engagement	Fully Assured
Test 2 - Consistency with current & prospective need for Patient Choice	Fully Assured
Test 3 - Clear Clinical Evidence Base	Fully Assured
Test 4 - Support from Clinical Commissioners	Fully Assured
Test 5 - NHS Beds Test	Not Applicable***
Financial Assurance	Fully Assured
Implementation Plan	Fully Assured

****Note: At the Stage 2 Panel Meeting on 3 September, Gloucestershire ICS confirmed that there is no overall change in hospital bed numbers in their CoEx proposals. As a result of this it was agreed that the NHS Beds Test is Not Applicable in relation to the CoEx proposals.*

There has been extensive independent expert review of the FFtF CoEx proposals by the SW Clinical Senate Clinical Review Panel (CRP). The CRP Report was issued on 20 August 2020. I understand that at the Stage 2 follow up meeting on 1 October, Gloucestershire colleagues shared their appreciation for the Senate's further support through their additional independent clinical review of the colorectal staffing model.

As a result, the GHFT Medical Director and the FFtF team confirmed their confidence in the safety and deliverability of the two options for colorectal proposals - either centralising elective colorectal to CGH or to GRH.

The final PCBC is due to be reviewed and approved by GHFT Board and the GCCG Governing Body on 8 October and the considerations will include:

- The actions taken in response to the CRP's feedback, especially in respect to vascular and colorectal.
- The legal advice received by the team confirming that no issues have been identified about moving forward to consultation.

For the avoidance of doubt, my agreement to proceed to public consultation does not constitute approval or sign-off for:

- Capital expenditure or confirmation of capital availability. This is a particularly significant point given the constrained national capital funding position.
- Control totals for the trusts or surplus/deficit for the CCG for future years.
- Any other funding beyond routine allocations

I wish you and colleagues every success in taking forward these proposals.

Yours sincerely

Elizabeth O'Mahony
Regional Director South West

cc:

Glos ICS:	NHSE/I:
Deborah Lee	Rachel Pearce
Ellen Rule	Laura Nicholas
Micky Griffith	Christina Button
Mark Pietroni	David Halpin
Anthony Dallimore	Ellie Devine
Becky Parish	Sharon Kingscott
Karen Johnson	Jane Appleton
Catherine Leech	

NHS
Gloucestershire
Clinical Commissioning Group

Data Protection Impact Assessment (DPIA)

Project title	Fit For the Future Programme – Engagement & Consultation phase
DPIA Reference no. (from IG Lead)	DPIA079a This update 09/02/21 – updated text highlighted in yellow.
DPIA prepared by (project lead)	Mark Woodward - Project Manager – Fit For the Future

1. Summarise the project or change, including the benefits

For completeness the DPIA is being refreshed to reflect the programme moving into the DMBC phase and the subsequent implementation phase. The updated text is highlighted in yellow.

The Fit For the Future (FFtF) Programme sits as part of our One Gloucestershire ICS strategy. This sets out our ambitions to deliver a step change for health and social care in Gloucestershire. Our Vision is to:

- Place a far greater emphasis on personal responsibility, prevention and self-care, supported by additional investment in helping people to help themselves
- Place a greater emphasis on joined up community based care and support, provided in patients' own homes and in the right number of community centres, supported by specialist staff and teams when needed
- Continue to bring together specialist services and resources in to 'Centres of Excellence', where possible reducing the reliance on inpatient care (and consequently the need for bed based services) across our system by repurposing the facilities we have in order to use them more efficiently and effectively in future
- Develop new roles and ways of working across our system to make best use of the workforce we have, and bring new people and skills into our delivery system to deliver patient care

  Have a continued focus on ensuring Parity of Esteem for Mental health

The programme has recently completed a 'Solutions Appraisal' process and has a shortlist of solutions that it wishes to progress through an iterative Pre Consultation Business Case (PCBC) process. The PCBC will be presented to the ICS and partner organisations (v1), the Clinical Senate (v2), NHSE/I (v3) and then HOSC (v4). Should the PCBC be approved then it is anticipated that a solution(s) will be subject to a public consultation in 2020.

This DPIA covers the Solutions Appraisal phase of the programme, drafting of the PCBC and the period up until the end of any consultation process.

The Programme was paused in the Spring of 2020 due to the system response to COVID-19 until June when the PCBC v4 was refreshed. It is planned that the Consultation phase will commence following the 22nd October HOSC meeting. The DPIA will then be refreshed for the Decision Making Business Case phase of the programme.

2. Describe the data, data flows, and retention period. If this is a trial or pilot project, include the criteria, process and data that will be used for evaluating its outcome

The FFtF Programme is currently focusing on a PCBC and then a consultation process so there should be no change to any patient pathways and patient data flows during the current phase of the programme.

At no time will any patient identifiable data be held by the programme.

The data that will be held by the programme is as follows –

Project Management

- TOR's for working groups and Programme Governance groups
- Agenda's for meetings
- Action notes from meetings
- Minutes from meetings
- Risk and issues log for the programme
- Project plans
- Communication and consultation strategy and plan
- Highlight reports

Programme Governance

- PCBC and appendices
- Integrated Impact Assessment (IIA)
- Travel Impact Assessment (TIA)
- Date Protection Impact Assessment (DPIA)

Consultation documentation

- Consultation documentation e.g. – leaflets
- Consultation online / paper based surveys
- Staff consultation
- Public consultation
- Citizens Jury documentation
- Letters
- Emails
- Feedback extracted from the Engagement HQ system (non-patient identifiable data)

Data Flows –

- Project Management

Project management documentation will be issued by the FFtF programme office by way of email from NHS email accounts or from the generic Fit For the Future email account. All email accounts are controlled by user name and password protection. The recipients will predominantly have NHS email accounts.

The Project Management documentation will contain project team members' names and job titles and be stored on the CCG's network and the FFtF Programme MS Teams shared storage area. The MS Teams shared storage area is subject to a national DPIA / information Governance arrangements.

The CCG's network access is controlled through Line Managers authorising access to certain areas of the network based on employees needs to access the folders.

The above data will be stored on the CCG's network and the MS Teams shared storage area for the lifetime of the programme and any challenge period. The data will then be archived in line with the

CCG's data retention policy.

- Programme Governance

The PCBC document and appendices will not contain any patient or staff member identifiable information other than the authors. Summary data will be included as well as anonymised quotes from stakeholders.

The PCBC will have an Integrated Impact Assessment (IIA), which is being created by Mid & South Essex University Hospitals Group. Various non patient identifiable data sets have been sent via NHS email to Mid & South Essex University Hospitals Group who will in turn create an assessment. The aim of the reports is to understand the current services and assess the consequences of any change whilst maximising the positive impacts and minimising negative impacts of the proposed change. The majority of the information provided is considered as 'in the public domain'. The IIA will be appended to the PCBC.

The PCBC will also contain a number of Travel Impact Assessments (TIA) as appendices which are being created by the Commissioning Support Unit (CSU) using non patient identifiable data sets. The data has been sent to the CSU using the NHS email system. When completed the impact assessments will be stored on the CCG network and form part of the PCBC.

The PCBC will also contain a South West Ambulance Service (SWAST) impact assessment. The modelling to develop the impact assessment will be completed by ORH Management Consultancy who currently undertake all of the SWAST transport modelling. A contract is currently in place between SWAST and ORH for data transfer and management.

A contract will be put into place between GHFT (the data controller) and ORH for modelling the impacts of potential hospital service reconfigurations on SWAST resources.

The contract will be appropriate to the low level of risk in sending this data, using an encrypted service to an existing SWAST contractor. The following data will be provided to ORH as part of the Fit For the Future Programme –

- SWAST ID / incident number
- Arrival time at a location

The data will be sent to ORH NHS mail [SECURE] email and ORH will extract this data using the egress end to end encryption email service.

It is anticipated that the data will be sent on a single occasion. The data will then be manipulated by ORH and it will be presented back in a spatial format using licensed base maps.

The spatial mapping will then be agreed as appropriate for inclusion in the PCBC by the FFTF Programme Director.

The draft and final versions of the PCBC will be stored on the CCG's network and the ultimately the MS Teams shared storage area. The document will be shared to the Programme team and stakeholders using NHS mail.

The PCBC and appendices will be stored on the CCG's network and the MS Teams shared storage area for the lifetime of the programme and any challenge period. The data will then be archived in

line with the CCG's data retention policy.

- Consultation Documentation

An online questionnaire has been used as part of the Solutions appraisal process to allow invited attendees to answer a set of questions in advance of the event. Respondents could provide a name and attendee role if they wished to do so when completing the survey. This data is held in the third party Smart Survey system. Smart Survey is based in Tewkesbury, Gloucestershire and all data is stored on servers which are located in the UK. The physical location of the servers is something that formed part of the procurement evaluation criteria.

A hyperlink to the survey was emailed to attendees from the Fit For the Future email account using the bcc option.

When the questionnaire was completed summary reports were generated from the system and used to analyse feedback. The summary reports are stored on the CCG network.

It is planned that a similar questionnaire will be used during the Consultation phase of the programme and a similar process will be followed.

Due to the impacts of COVID-19 pandemic the approach to the consultation phase of the programme has been reviewed and the Communication and Consultation plan has been updated.

During the Consultation process stakeholders will be encouraged to provide feedback through the following methods –

Online consultation and feedback using the online participation platform: Get involved Gloucestershire https://getinvolved.glos.nhs.uk
Media and Social media promotions which will encourage feedback
QR codes linked to consultation materials and surveys to provide feedback
Online information – booklets & FAQ's
Ad hoc emails
Ad hoc letters
Roadshows
Virtual Citizens' Jury

The online participation platform: the Get involved Gloucestershire will be used to collect and manage non-identifiable patient demographic data provided through feedback during the Consultation period.

Data that is collected will be held on the Bang the Table (system developers) system servers in the UK. The CCG's Patient Engagement team will then be able to extract required data through its data analytics reporting functionality. Any reports that are extracted will be stored on the CCG's M Drive or MS Teams shared storage area.

Access to the online participation platform: the Get involved Gloucestershire system will be controlled by username and password protection and will be limited to the CCG's Patient Engagement team.

Following the consultation exercise the data will be held in the online participation platform: the Get involved Gloucestershire for a period in line with the CCG's retention schedules.

A range of non-identifiable demographic data will be collected throughout the consultation process via online and paper based surveys. It will also be possible to complete the survey at one of the roadshows (Information Bus Tour) that are planned.
The surveys can be completed by any stakeholder and posted back to the CCG by Freepost, at one of the roadshows or online. When collated the paper survey data will be input into the online participation platform: the Get involved Gloucestershire and then shredded.
All emails relating to the consultation process will be administered through the Engagement Team's online participation platform: the Get involved Gloucestershire generic email account. Access to this account is through Line Manager authorisation and user name and password protection.

Should a letter be received then this is scanned and the hard copy shredded. The letter is then held on the Patient Engagement team 'M' drive together with any response. The letter is stored in accordance with the team's retention schedule.

In January 2020 an independently facilitated Citizens' Jury took place and it is planned that another Citizens' Jury, this time facilitated virtually, will be held in the winter of 2021. The Citizens Jury process is operated by a Company Called Citizens Juries CIC who administered the event. This resulted in the CCG not holding any attendee identifiable data.

The Programme is now in the Decision Making Business Case (DMBC) phase. The non-identifiable patient demographic data collected during the consultation will be presented in the DMBC.

It is not planned to change the data, data flows or retention periods during the DMBC phase or the next phase of the programme which will be implementation.

3. What is the lawful basis for processing the personal data under GDPR/DPA 2018? (refer to IG Lead or NHS Digital guidance, particularly sections 5 and 6)

For processing Personal Data:
GDPR 6(1)(e) – the processing is necessary for the performance of a task carried out in the exercise of official authority vested in the controller by the NHS Act 2006.

For processing Special Category Data (e.g. health):
No special categories of personal data will be processed.

4. Relevant stakeholders who have been consulted about data protection and privacy risks (name, role)

Ellen Rule – Director of Transformation
Tony Ware – Information Governance Manager
Micky Griffith - Fit For the Future Programme Director
Becky Parish – Associate Director Engagement and Experience
Caroline Smith – Senior Manager Engagement & Inclusion
Anthony Dallimore – Associate Director Communications

5. Describe any data protection and privacy risks identified

- Risk 1 – Unauthorised access to lists of individuals names and job titles and email addresses contained on ToR's, action log, minutes etc.
- Risk 2 – Unauthorised access to surveys completed through the Smart Survey / Engagement HQ systems via hacking the site or accessing the summary reports generated by the system.
- Risk 3 - Unauthorised access to 'hard copy' surveys completed.
- Risk 4 – That paper copy completed surveys or hand delivered letters are delivered to the wrong CCG department.
- Risk 5 – Unauthorised access to the ORH data transfer or business systems containing

- SWAST ID number
- Arrival time at a location

6. Describe the risk management measures agreed (what, why, who, when)**, including how they will be implemented**

- Risk 1 – Access to the network will only be available to those with a CCG user account with approved access by a line manager to the Fit For the Future filing structure and Fit For the Future email account which both have user name and password protection in place.
- Risk 2 – Access to the Smart Survey / Engagement HQ systems will be limited to the Engagement Team this will be controlled through user name and password protected accounts.
- Risk 3 – Hard copy surveys will be stored by members of the CCG's Engagement & Experience team and only made available to Programme Team members on request with a business need for the hard copy forms.
- Risk 4 – Ensure that a procedure is agreed with those responsible at the CCG for post opening and distribution.
- Risk 5 – The data will be sent to ORH using an NHS.net email account and the egress encrypted file transfer service. ORH will only allow access to its systems using user name and password protection and the data will be stored on the ORH servers in line with the ORH data retention schedules.

7. Approved and signed off by the GCCG IG Lead (Tony Ware)

T Ware. 10/3/20. Updated version DPIA079a approved, by email dated 15/10/20

This update 9/2/21 approved by email dated 17/2/21

8. Approved and signed off by the relevant Director (name, signature, role, date)

Previously Ellen Rule, Director of Transformation and Service Redesign, approved DPIA079a on 27/10/20.

Date: 19th February 2021

9. Does this DPIA need to be reviewed? If yes, when?

For completeness the DPIA is being refreshed to reflect the programme moving into the DMBC phase and the subsequent implementation phase.

Communications and Engagement Plan Publication of the Fit for the Future DMBC

1. Background

One Gloucestershire partners will formally publish the Fit for the Future Decision Making Business Case (DMBC) on 4 March 2021, ahead of the CCG Governing Body meeting on 11 March 2021.

This business case will set out resolutions for the service proposals following the Fit for the Future consultation:

- Acute Medicine (specifically acute medical take)
- Gastroenterology inpatient services
- General Surgery (Emergency General Surgery, *Planned Lower Gastrointestinal [GI]/colorectal surgery and day case Upper and Lower GI surgery)
- Image Guided Interventional Surgery (IGIS) including Vascular Surgery
- Trauma and Orthopaedic (T&O) inpatient services.

This follows the consultation review period, which included careful consideration by Gloucestershire Hospitals NHS Foundation Trust and NHS Gloucestershire CCG, of the output of consultation report, the Citizens' Jury reports and public, staff and stakeholder comments following publication of additional information.

*The DMBC will also include a resolution for Planned General Surgery that recommends that further work is done to define a new option to deliver:

- Planned High Risk Upper Gastrointestinal (GI) and Lower Gastrointestinal (Colorectal) surgery at Gloucestershire Royal Hospital
- Planned complex and routine inpatient and day case surgery in both Upper and Lower GI (Colorectal) at Cheltenham General Hospital.

Local people and staff will be given the opportunity to be involved.

2. Aim

The aim of the communications and engagement plan is to ensure staff, community partners, the public and media receive information on the outcome of the decision making process and next steps in a timely and appropriate way.

3. Objectives

There are a number of communication and engagement objectives, including:

- To provide clear, consistent and accurate information
- To support the NHS to communicate the outcome and the changes
- To ensure relevant audiences receive the information in the right order e.g. staff first
- To ensure effective media and social media arrangements are in place.

4. Key Messages

General

- The Fit for the Future consultation was about exploring how best to provide a number of specialist hospital services across the Cheltenham General and Gloucestershire Royal Hospital sites in the future and to ensure Gloucestershire is at the leading edge of healthcare

- The consultation feedback shows there was more support overall than opposition to strengthen the 'centres of excellence' approach to care, which reflects the way a number of inpatient services are already concentrated in one place, such as cancer care in Cheltenham and children's services in Gloucester

- We want to see two thriving hospital sites in Cheltenham and Gloucester, both providing world class treatment and care

- For services, the aim is to improve health outcomes for patients, reduce waiting times and the number of cancelled operations and ensure people see the right specialist to meet their needs at the right time

- It's about ensuring there are always safe staffing levels, including senior doctors available 24/7, teams have the best equipment and facilities and we support joint working across services

- We are also keen to create flagship centres for research, training and learning – attracting and keeping the best staff in Gloucestershire and provide more specialist services in the county to enable people to receive care locally rather than travelling further afield

- We know how important the Cheltenham General Hospital A&E Department is to people who live in the east of the county; in particular Cheltenham. We have publicly committed to a 24 hour A&E department in Cheltenham (nurse led, 8pm to 8am)

- The temporary COVID-19 emergency service changes are designed to support the delivery of healthcare in the context of the operational challenges presented by the COVID-19 pandemic

  Whilst some of the temporary changes relate to the same clinical services included in the Fit for the Future consultation, the Fit for the Future programme remains the mechanism for agreeing any permanent, substantive changes to specialist hospital services for the benefit of patients.

The consultation

- We aimed to deliver a comprehensive consultation that sought to gather views from a wide cross section of the local population and our staff

- We were keen to go the extra mile to ensure we reached and received feedback from our diverse local communities and workforce using innovative methods, which responded to the challenges brought by the pandemic

- Our consultation approach was informed by independent advice from The Consultation Institute (TCI) and we used a variety of methods and channels to inform and consult on-line, in person, by post and by phone. As part of this advice, TCI also reviewed all consultation processes – documents, approach and survey

- As part of the consultation review period, all feedback was carefully considered before decisions were made

- We have demonstrated that we are always open to embracing new methods to provide opportunities for participation to as many people as wish to get involved.

5. Key Stakeholders and timings

There are a number of key stakeholders that need to be engaged and supported as decisions are made and communicated:

Time	Stakeholder	Purpose	Method
Monday 1 March 2021	NHS England – regional comms	Provide an overview of the decision making process and communication arrangements	Verbal briefing
Wednesday 3 March 2021	Staff within the services affected	Notification that the DMBC/recommendations will be published on 4 March ahead of the CCG Gov Body meeting and where the papers can be found. Communicate the recommendations, decision making process and potential next steps	Verbal briefing Develop Q/A based on questions received and publish
Wednesday 3 March 2021	Strategic Stakeholders: MPs, HWG, HOSC, District Councils	As above. Provide notification of where the papers and recommendations will be published, decision making process and potential next steps	Written briefing
Wednesday 3 March 2021	Dedicated briefing to Alex Chalk, MP and Richard Graham MP	As above. Provide notification of where the papers and recommendations will be published, decision making process and potential next steps	Virtual Briefing
Thursday 4 March	Media	Reactive statement in place	Media statement
Thursday 4 March	Publish information	Provide a link to the DMBC/Board papers from www.onegloucestershire.net/yoursay Ensure links across CCG and Trust websites are in place	On-line
Thursday 11 March	All Governors & Board Members	Briefing to inform stakeholders of the outcome of the CCG Governing Body meeting and next steps	Written briefing

Thursday 11 March	Staff briefing	Briefing to inform staff affected of the outcome of the CCG Governing Body meeting and next steps	Verbal and written briefing
Thursday 11 March	Strategic Stakeholders: MPs, HWG, HOSC, District Councils, Healthwatch Gloucestershire	Briefing to inform stakeholders of the outcome of the CCG Governing Body meeting and next steps	Written briefing
Thursday 11 March	Dedicated briefing to Alex Chalk, MP and Richard Graham MP	Briefing to inform them of the outcome of the CCG Governing Body meeting and next steps	Verbal briefing
Thursday 11 March	Trust and CCG PALS & Volunteers	Briefing and where to direct queries for further information	Written briefing
Thursday 11 March	Dedicated briefing to REACH	If not in attendance at the meeting, briefing to inform them of the outcome of the CCG Governing Body meeting and next steps	Verbal briefing
Thursday 11 March	Media/public	Issue media release	Media release
Thursday 11 March	Public	Issue social media post with video talking head from GHFT Medical Director?	Social media post with video content
Friday 12 March	Consultees	Communication/letter to all those who took part in the consultation (who supplied contact details) informing them of the outcome of decision making with a link to the papers online	Letter based on stakeholder briefing

6. Media statement

To follow

7. Social Media Posts

To follow

8. Internal comms

To follow

9.

Risks and mitigations

There are a number of risks that need to be considered:

Risk	Mitigation
Misinformation on social media channels regarding the decisions	A proactive watching brief on social media channels will enable any misinformation to be quickly addressed and responded to
Media receive accurate information on the decisions made	Appropriate proactive and reactive media arrangements in place
Information online is out of date	One Gloucestershire, GIG, Trust and CCG sites checked from 3 March 2021-12 March 2021

Gloucestershire Hospitals
NHS Foundation Trust

Public Trust Board – 11 March 2021
Microsoft Teams – Commencing at 12:30

Report Title
TRUST RISK REGISTER (TRR)
Sponsor and Author(s)
Author: Lee Troake, Corporate Risk, Health & Safety Sponsor: Emma Wood, Deputy CEO and Director of People and OD
Executive Summary

Purpose
The Trust Risk Register enables the Board to have oversight, and be assured of, the active management of the key risks within the organisation.

Key issues to note

- One additional risk was agreed for entry on to the Trust Risk Register by Risk Management Group (RMG) in February 2021:

  C2984COOEFD - Risk of harm to patients, staff and visitors from hazardous floor conditions and damaged ceiling tiles as a result of multiple and significant leaks in the roof of the Orchard Centre, Gloucestershire Royal Hospital

  Score: Safety C4 x L3= 12, Quality C4 x L3 =12, Statutory C3 x L3 = 9, Reputational C3 x L3 = 9, Business C3 x L3 = 9, Finance C3 x L3 = 9, Environmental C3 x L3=9

  Following this risk being entered on to the Trust Risk Register, capital was allocated to the Orchard Centre roof and work has been encompassed in on-going repairs to the Centre. This will significantly reduce the risk once the work has been completed.

- A risk already on the Trust Risk Register (TRR) was downgraded by the RMG but remains on the TRR:

  This risk was reviewed following an improvement in the inpatient transmission rate and 2 weeks with no nosocomial cases within the Trust.

  C3223COVID - The risk of nosocomial infection, prolonged hospitalisation and death to patients, the risk of illness to staff affecting safety and quality

  Score: Safety was C5 x L4 = 20 **reduced to C5 x L3 = 15**, Quality was C5x L5=25 **reduced to C4 x L3 = 12,** Workforce C4 x L5=20 **reduced to C4 x L2 = 8**, Statutory C3 x L3=9

There were no proposed upgrades or closure of risks on the Trust Risk Register.

Recommendations
To note this report.
Impact Upon Risk – known or new
The RMG / TRR identifies the risks which may impact on the achievement of the strategic objectives
Equality & Patient Impact
Potential impact on patient care, as described under individual risks on the register.
Resource Implications

Finance			**x**	Information Management & Technology			
Human Resources				Buildings			**x**
Action/Decision Required							
For Decision		For Assurance	X	For Approval		For Information	X
Date the paper was presented to previous Committees							
Divisional Board		**Trust Leadership Team**		**Other (Specify)**			
		March 2021		Risk Management Group February 2021			
Outcome of discussion when presented to previous Committees							
Risk approved for entry onto the Trust Risk Register.							

Ref	Inherent Risk	Controls in place	Action / Mitigation	Highest Scoring Domain	Consequence	Likelihood	Score	Current	Date Risk to be reviewed by	Approval status
M2353Diab	The risk to patient safety for inpatients with Diabetes whom will not receive the specialist nursing input to support and optimise diabetic management and overall sub-optimal care provision.	1)E referral system in place which is triaged daily Monday to Friday. 2)Limited inpatients diabetes service available Monday - Friday provided by 0.80wte DISN funded by NHSE additional support for wards is dependent on outpatient workload including ad hoc urgent new patients.	Business case draft 2 to be submitted Business case to be submitted Demand and Capacity model for diabetes Liaise with Steve Hams to raise this diabetes risk onto TRR	Safety	Moderate (3)	Likely - Weekly (4)	12	8 -12 High risk	25/06/2021	Trust Risk Register
S2579Th	The Risk to patients safety and experience of being unable to safely complete procedures across multiple theatres resulting from mains power failure combined with generator failure	Generator back up system and generator checks On site Estates team x5 UPS units in the affected theatre areas across both sites. x3 in GRH and x2 in CGH. These units will successfully run a stacking system for 30 minutes in order for a surgeon to safely bring the procedure to a controlled stop or to assist until the generator/power has been restored. Potential for moving patient between theatres to ensur esafety Theatre refurbishment programme - Theatres being equipped as per HBM as part of a refurbishment plan Annual service contract for existing UPS and annual check at GRH	support Estates in delivery of the theatre refurbishment programme Work with manufacturers to obtain UPS specifically designed for use on endoscopic stacks Gather evidence of power failure incidents for theatres identify national standards for requiring UPS Creation of action plan to upgrade/replace UPS Plan for theatre in the event of mains & UPS failure	Safety	Catastrophic (5)	Rare - Less than annually (1)	5	4 - 6 Moderate risk	12/02/2021	Trust Risk Register
C3089COOEFD	Risk of failure to achieve the Trust's performance standard for domestic cleaning services due to performance standards not being met by service partner.	1. Domestic Cleaning Services are currently provided by the Service Partner with defined performance standards/KPIs for functional areas in the clinical & non-clinical environment. (NB. Performance Standards/KPIs are agreed Trust standards that marginally deviate from guideline document 'The National Specifications for Cleanliness in the NHS – April 2007'); 2. Cleaning Services are periodically measured via self-audit process and performance is reported against the agreed Performance Standards/KPIs to the Contract Management Group (bi-monthly, every two months); 3. Scope of Cleaning Service currently agreed with the Service Partner includes – Scheduled & Reactive Cleaning, Planned Cleaning, Barrier Cleaning, Deep Cleaning and other Domestic Duties; 4. Provision of an Ad-hoc cleaning service is provided by the Service Partner with defined rectification times for the functional areas; 5. Cleaning activities and schedules are noted as being agreed at local levels (e.g. departmental/ward level) between Trust and Service Partner representatives.	Review, Assess and enact agreed future actions/controls	Quality	Major (4)	Likely - Weekly (4)	16	15 - 25 Extreme risk	05/04/2021	Trust Risk Register
C2817COO	Tower block ward ducts / vents have built up dust and debris over recent years.	Funding for cleaning now secured; Schedule for cleaning drawn up to be undertaken in the summer months where wards can be decanted to day surgery areas, allowing cleaning to take place at weekends.	Duct cleaning only possible when ward is fully decanted. Implement ward closure programe to provide access to undertake the works. Ward 3B being assessed for ability to undertake works this Summer	Safety	Catastrophic (5)	Rare - Less than annually (1)	5	4 - 6 Moderate risk	29/07/2021	Trust Risk Register
C2970COOEFD	Risk of harm or injury to staff and public due to dilapidation and/or structural failure of external elevations of Centre Block and Hazelton Ward Ceiling – resulting in loose, blown or spalled render/masonry to external & internal areas.	1) Snapshot' visual survey undertaken from ground level to establish the scope of the loose, blown or spalled render and masonry to the external elevations of the building & any loose material removed (frequency TBC); 2) Heras fencing has been put up to isolate persons from the areas of immediate concern; 3) Areas of concern being monitored (frequency TBC). (All Controls to be reviewed and confirmed as active & appropriate).	Refurbish the roof outside and make safe To undertake a comprehensive structural survey of the external elevations of Centre Block to identify all areas requiring repair or replacement and to undertake those works Planning permission for investigatory works	Safety	Catastrophic (5)	Rare - Less than annually (1)	5	4 - 6 Moderate risk	05/04/2021	Trust Risk Register
C2669N	The risk of harm to patients as a result of falls	1. Patient Falls Policy 2. Falls Care Plan 3. Post falls protocol 4. Equipment to support falls prevention and post falls management 5. Acute Specialist Falls Nurse in post 6.Falls link persons on wards 7. Falls monitored and reported at the Health and Safety Committee and the Quality and Performance Committee 8. Falls management training package	Discussion with Matrons on 2 ward to trial process Develop and implement falls training package for registered nurses develop and implement training package for HCAs #Litle things matter campaign Discussion with matrons on 2 wards to trial process Review 12 hr standard for completion of risk assessment Alter falls policy to reflect use of hoverjack for retrieval from floor review location and availability of hoverjacks Set up register of ward training for falls	Safety	Major (4)	Possible - Monthly (3)	12	8 -12 High risk	31/03/2021	Trust Risk Register

C2984COOEFD	Risk of harm to patients, staff and visitor from hazardous floor conditions and damaged ceilings as a result of multiple and significant leaks in the roof of the Orchard Centre GRH, (E51), Wotton Lodge (E58), Chestnut House	•Wet floor signs are positioned in affected areas •Existing controls/mitigating actions as referenced in 'Control in Place' including provision of additional domestic staff on wet days to keep floor clear of water (e.g. dry, signage, etc.) •Some short term patch repairs are undertaken (reactive remedial action); •Temporary use of water collection/diversion mechanism in event of water ingress •Risk assessment completed in 2019 and again in 2020 – issue escalated to Executive team •Options provided to TLT regarding building in June 2019	Long term repairs to roofs needed GRH To revise specification and quote for Orchard Centre roof repairs to include affected area. Urgently provide quote and whether can be done this financial year to KJ / Finance Discuss at Infrastructure Delivery Group whether there is sufficient slippage in the Capital Programme for urgent repairs to the Orchard Centre Roof	Safety	Major (4)	Possible - Monthly (3)	12	8 -12 High risk	05/04/2021	Trust Risk Register
C3169MDCOVID	Risk of the Trust being unable to deliver or maintain its usual range of comprehensive, high quality services with consequent impact on patient safety, experience and staff wellbeing due to the second wave of COVID-19 Pandemic and winter pressures.	Winter pressure plan in place• RED ED flip / RED surge Plan• Empty two green bays on 8a to create red capacity• Paediatrics red area • Following National Guidance across all domains / reviewing guidance and applying according to local circumstances• Fit testing programme • PPE training provision, training, information and PPE Safety Officers / social distancing guardians• Action cards published for staff• Pathways for trauma for COVID and non COVID for all specialties• COVID testing on admission, testing on day 5• Outbreak MDT meetings - clinical staff, ICP and Safety• COVID Secure programme & working group• Provision of social distancing materials / guidance and PPE• All staff to wear masks if within 2m of others• Patients to be required to wear mask if away from bed space (and can tolerate it)• Paediatrics and Obstetrics – both have clear pathway for COVID or non COVID problem patients• Gynaecology – early pregnancy and miscarriage is being managed through OP where possible• Limited public access to hospital• Telephone triage support to ED to reduce wait times e.g. OMF• Prescriptions (FP10s) e-mailed direct to community Pharmacies• Patient belongings and letters drop-off service• Family and friends helpline • Continued provision of critical / mandatory training• Rapid refresher training sessions for nurses• Revised training programme• Virtual meetings to support governance framework / statutory requirements• Workforce Hub and specialist staff support network• New psychological support services and link workers• Revision of medical rotas to ensure staffing supports activity, recruitment of volunteer workforce, redeployment to areas of greatest need, retired staff returning• All rotas can be revised to a 12 hour rota for juniors if needed• Clinical and non-clinical home working – with access to EPR, scans, results, email, datix, VPN etc.• Daily staff updates with key messages and links to key resources• Extended childcare offer• Subsidised food and drink • Emergency accommodation offer • Going the Extra Mile (GEM) postcards to say thank you, quickly• Cross-site parking permits• Staff / family member pillar 1 testing for those self-insolation commenced to support return to work• Specialist Platinum COVID19 on-call rota composed of CEO and Exec Tri• Senior Nurse cover until 8pm and 24/7 Nurse Director on call• Outpatient appointments moved from face to face to video conference where possible• Initial telephone triage of 2 week wait referrals to identify patients that can go 'straight to test' without a face to face appointment • Microbiologist resource – are providing a 1 in 5 rota and the out of hours service. Lab results available hourly• Cancellation of non-urgent elective work to reduce demand on anaesthetics team if required• Digital solutions to allow continuation of routine OP work where workforce permits• Stress testing of key infrastructure as part of contingency planning e.g. max Oxygen capacity at both sites• Community hospital eligibility criteria expanded resulting in reduced DTOC and >21d LOS• Pharmacy service continuity plans• Multiple diagnostics arranged for the same day to support one-stop outpatient appointments • Use of Private Provider facilities in extremis• Usage of Private Provider Bed Stock to gain additional capacity • Working closely with Community and Social care partners• Use of Microsoft teams for all staff to connect • specialty transition and recovery planning• Ophthalmology has changed its triage service to 7 days a week from 8am-8pm • Additional resources in the form of bank, student nurse volunteers • Exploration of use of national charity funds for long term health issues• Deployment hub• Weekly psychological briefing for execs• Weekly hub analysis for trends• Proactive communication to vulnerable groups – BAME and shielded • Use of additional Government funding to support incident response• Charity Fundraising to publicise GHFT efforts	Establish IMT to manage response	Quality	Major (4)	Likely - Weekly (4)	16	15 - 25 Extreme risk	28/02/2021	Trust Risk Register
F2895	There is a risk the Trust is unable to generate and borrow sufficient capital for its routine annual plans (estimated backlog value £60m), resulting in patients and staff being exposed to poor quality care or service interruptions as a result of failure to make required progress on estate maintenance, repair and refurbishment of core equipment and/or buildings.	1. Board approved, risk assessed capital plan including backlog maintenance items; 2. Prioritisation and allocation of cyclical capital (and contingency capital) via MEF and Capital Control Group; 3. Capital funding issue and maintenance backlog escalated to NHSI; 4. All opportunities to apply for capital made; 5. Finance and Digital Committee provide oversight for risk management/works prioritisation; 6. Trust Board provide oversight for risk management/works prioritisation; 7. GmS Committee provide oversight for risk management/works prioritisation; 8. Prioritisation of Capital managed through intolerable risk process 2019-20 – Complete 30/4/19 and revisited periodically through Capital contingency funds; 9. On-going escalation to NHSI for Capital Investment requirements – Trust recently awarded Capital Investment for replacement of diagnostic imaging equipment (MR, CT and mammography) in October 2019, SOC for £39.5 million Strategic Site Development on GRH and CGH sites approved September 2019, Trust recently rewarded emergency Capital of £5million for 19/20 from NHSI.	1. Prioritisation of capital managed through the intolerable risks process for 2019/20 Ongoing escalation to NHSI and system	Environmental	Major (4)	Likely - Weekly (4)	16	15 - 25 Extreme risk	26/02/2021	Trust Risk Register
			To set up SD guardians							

C3253PODCOVID	Risk to the health of staff working in the healthcare setting who are extremely clinically vulnerable, clinically vulnerable or BAME and are at increased risk of a more serious outcome or fatality as a result of contracting COVID-19 infection.	1. Risk assessment templates provided to managers to support a personal risk assessment for each member of staff within these groups 2. Managers will be asked to confirm with the hub that the assessment has been completed 3. Assessments will be kept on personal files 4. Extremely clinically vulnerable staff to work from home 5. Clinically vulnerable staff to work from home or a suitable low risk environment 6 IT resources provided to enable remote working 7. DSE equipment available to work from home 8. Home working policy 9 Social distancing guidelines and toolkit developed 10. Risk assessment templates provided to support social distancing risk assessment 11. Social Distancing guardians 12. PPE available to all staff 13. Hand gel and masks on all public entrances 14. Inpatients now wear masks where possible 15. IPC working with outbreak areas / daily outbreak meetings 16. Continual comms on social distancing	Risk Assessment Audit for NHSE/I	Workforce	Moderate (3)	Possible - Monthly (3)	9	8 -12 High risk	31/03/2021	Trust Risk Register
C3224COOCOVID	Risks to safety and quality of care for patients with increased waiting in relation to the services that were suspended or which remain reduced	• RAG rating of patients in clinical priorisation & Clinical Harm Reviews • Movement of the acute take from CGH to GRH (see issues outlined in gaps below) ED dept at CGH will operate as a minor injuries unit, all emergency patients are managed through GRH. This will enable CGH to manage planned patients who have tested negative to COVID. • All emergency surgery will move to GRH. Vascular emergency patients will move from CGH to GRH. 50% of benign Gynaecology elective day cases will transfer from GRH to CGH. Some Upper GI urgent activity may also move to CGH (Hot laparoscopic Cholecystectomy), if additional theatre capacity is required. • Use of BI models to underpin next phases in medicine – impact on AMU / ACUC • 9a will come in to Medicine and there will be clear pathways to move Elderly Care and Stroke to CGH • Respiratory bed base will be at GRH with a HOT Respiratory Consultant at CGH • Cardiology has an allocation of 17 beds at GRH due to acute specialty and all elective activity to go to CGH. • Hot PCI's will go directly to CGH and managed in side rooms pending swabs, supported by a Respiratory nurse to give full review of patients at CGH • Have assessed impact of move to GRH based on patient numbers and acuity in MIU at CGH overnight • Overnight staffing of MIU to be moved to GRH to increase GRH ED resilience • AEC presence 8am-8pm at CGH / triage via Cinapsis • Red Oncology – after patients are triaged on the helpline they will go to GRH if suspect red. If confirmed COVID they will not have chemo and will stay under medical beds at GRH. If Haematology is the primary issue they will move to Knightsbridge. • limit emergency admissions through to CGH as predominantly NON COVID Site • Green ITU established at CGH • Optimise elective activity whilst maintaining COVID beds and ready to take another surge	Incremental step up of elective activities, including through the independent sector Continued review of clinical waiting lists	Safety	Major (4)	Possible - Monthly (3)	12	8 -12 High risk	31/03/2021	Trust Risk Register
C3431S&T	The risk is that planned reconfiguration of Nuclear medicine and Lung Function is considered to be 'substantial change' and therefore subject to formal public consultation.	Feasibility study underway to explore alternative locations for Nuclear Medicine and Lung Function. Work underway to determine whether centralising Nuclear Medicine to CGH (preference of the service) and establishing a hub and spoke model for Lung Function meets the criteria for 'substantial service variation'	Develop case for change for Nuclear Medicine & Lung Function	Business	Catastrophic (5)	Possible - Monthly (3)	15	15 - 25 Extreme risk	16/02/2021	Trust Risk Register
M2613Card	The risk to patient safety as a result of lab failure due to ageing imaging equipment within the Cardiac Laboratories, the service is at risk due to potential increased downtime and failure to secure replacement equipment.	Modular lab in place from Feb 2021 Maintenance was extended until April 2021 to cover repairs Service Line fully compliant with IRMER regulations as per CQC review Jan 20. Regular Dosimeter checking and radiation reporting.	This has been worked up at part of STP replace bid. Submission of cardiac cath lab case Procure Mobile cath lab	Safety	Major (4)	Possible - Monthly (3)	12	8 -12 High risk	26/02/2021	Trust Risk Register
D&S2517Path	The risk of non-compliance with statutory requirements to the control the ambient air temperature in the Pathology Laboratories. Failure to comply could lead to equipment and sample failure, the suspension of pathology laboratory services at GHT and the loss of UKAS accreditation.	Air conditioning installed in some laboratory (although not adequate) Desktop and floor-standing fans used in some areas Quality control procedures for lab analysis Temperature monitoring systems Temperature alarm for body store	Review performance and advise on improvement Review service schedule A full risk assessment should be completed in terms of the future potential risk to the service if the temperature control within the laboratories is not addressed	Statutory	Major (4)	Likely - Weekly (4)	16	15 - 25 Extreme risk	31/03/2021	Trust Risk Register

		Contingency plan is to transfer work to another laboratory in the event of total loss of service, such as to North Bristol	A business case should be put forward with the risk assessment and should be put forward as a key priority for the service and division as part of the planning rounds for 2019/20.							
C1850NSafe	The risk of safety to patients, staff and visitors in the event of any adolescent 12-18yrs presenting with significant mental illness, behavioural, emotional and social difficulties, with potentially self harming and violent behaviour whilst on the ward. Patient's stay at GHT is prolonged whilst waiting assessment and a place of safety with an Adolescent Mental Health (Tier 4) facility or foster care placement.	1. The paediatric environment has been risk assessed and adjusted to make the area safer for self harming patients with agreed protocols. 2. Relevant extra staff including RMN's are employed via and agency during admission periods to support the care and supervision of these patients. 3. CQC\commissioners have been made formally aware of the risk issues. 4. Individual cases are escalated to relevant services for support . 5. Welfare support for staff available - decompression sessions can be given to support staff after difficult incidents 6. Designated social work allocated by CCG	Develop Intensive Intervention programme Escalation of risk to Mental Health County Partnership Escaled to CCG	Safety	Moderate (3)	Likely - Weekly (4)	12	8 -12 High risk	31/12/2020	Trust Risk Register
C2719COO	The risk of inefficient evacuation of the tower block in the event of fire, where training and equipment is not in place.	All divisions now taking accountability to ensure fire training and evacuation being undertaken and evidence; Records kept at local level as per fire safety standards to includes: fire warden training, e-learning, fire drills and location of fire safety equipment: Fire safety committee now established; Training needs and equipment are identified; Training programs launched to include drills using an apprenticeship model: see one, do one, teach, one for matrons (to be distributed out to staffing); Education standardisation documentation established for all areas; Localised walkabouts arranged with fire officer (Site team prioritised); Consistent messaging cascaded at the site meeting for training and compliance.	Monitoring and ensure all areas received the approrpaite training and drills to evaucate patients safely	Safety	Catastrophic (5)	Rare - Less than annually (1)	5	4 - 6 Moderate risk	31/03/2021	Trust Risk Register
C1798COO	The risk of delayed follow up care due outpatient capacity constraints all specialities. (Rheumatology & Ophthalmology) Risk to both quality of care through patient experience impact(15)and safety risk associated with delays to treatment(4).	1. Speciality specific review administratively of patients (i.e. clearance of duplicates) (administrative validation) 2. Speciality specific clinical review of patients (clinical validation) 3. Utilisation of existing capacity to support long waiting follow up patients 4.Weekly review at Check and Challenge meeting with each service line, with specific focus on the three specialties 5.Do Not Breach DNB (or DNC)functionality within the report for clinical colleagues to use with 'urgent' patients. 6. Use of telephone follow up for patients - where clinically appropriate 7. Additional capacity (non recurrent) for Ophthalmology to be reviewed post C-19 8. Adoption of virtual approaches to mitigate risk in patient volumes in key specialties 9. Review of % over breach report with validated administratively and clinically the values 10. Each speciality to formulate plan and to self-determine trajectory. 11. Services supporting review where possible if clinical teams are working whilst self-isolating.	1. Revise systems for reviewing patients waiting over time 2. Assurance from specialities through the delivery and assurance structures to complete the follow-up plan 3. Additional provision for capacity in key specialiities to support f/u clearance of backlog	Quality	Moderate (3)	Almost certain - Daily (5)	15	15 - 25 Extreme risk	31/03/2021	Trust Risk Register
C2819N	The risk of serious harm to the deteriorating patient as a consequence of inconsistent use of NEWS2 which may result in the risk of failure to recognise, plan and deliver appropriate urgent care needs	Ongoing education on NEWS2 to nursing, medical staff, AHPs etc o E-learning package o Mandatory training o Induction training o Targeted training to specific staff groups, Band 2, Preceptorship and Resuscitation Study Days o Ward Based Simulation o Acute Care Response Team Feedback to Ward teams o Following up DCC discharges on wards • Use of 2222 calls – these calls are now primarily for deteriorating patients rather than for cardiac arrest patients • Any staff member can refer patients to ACRT 24/7 regardless of the NEWS2 score for that patient • ACRT are able to escalate to any department / specialist clinical team directly • ACRT (depending on seniority and experience) are able to respond and carry out many tasks traditionally undertaken by doctors o ACRT can identify when patient management has apparently been suboptimal and feedback directly to senior clinicians	Monthly Audits of NEWS2. Assessing completeness, accuracy and evidence of escalation. Feeding back to ward teams Development of an Improvement Programme	Safety	Major (4)	Possible - Monthly (3)	12	8 -12 High risk	30/10/2020	Trust Risk Register
S2424Th	The risk to business interruption of theatres due to failure of ventilation to meet statutory required number of air changes.	Annual Verification of theatre ventilation. Maintenance programme - rolling programme of theatre closure to allow maintenance to take place External contractors	Write risk assesment Update busines case for Theatre refurb programme Agree enhanced checking and verification of Theatre ventilation and engineering. meet with Luke Harris to handover risk implement quarterly theatre ventilation meetings with estates gather finance data associated with loss of theatre activity to calculate financial risk	Business	Major (4)	Likely - Weekly	16	15 - 25 Extreme risk	12/02/2021	Trust Risk Register

		Prioritisation of patients in the event of theatre closure review of infection data at T&O theatres infection control meeting	investigate business risks associated with closure of theatres to install new ventilation review performance data against HTML standards with Estates and implications for safety and statutory risk calculate finance as percente of budget Creation of an age profile of theatres ventilation list Action plan for replacement of all obsolete ventilation systems in theatres		Major (4)	(4)				
C3084P&OD	The risk of inadequate quality and safety management as GHFT relies on the daily use of outdated electronic systems for compliance, reporting, analysis and assurance. Outdated systems include those used for Policy, Safety, Incidents, Risks, Alerts, Audits, Inspections, Claims, Complaints, Radiation, Compliance etc. across the Trust at all levels.	Risk Managers monitoring the system daily Risk Managers manually following up overdue risks, partially completed risks, uncontrolled risks and overdue actions Risk Assessments, inspections and audits held by local departments Risk Management Framework in place Risk management policy in place SharePoint used to manage policies and other documents	Prepare a business case for upgrade / replacement of DATIX Arrange demonstration of DATIX and Ulysis	Quality	Moderate (3)	Almost certain - Daily (5)	15	15 - 25 Extreme risk	31/03/2021	Trust Risk Register
C2628COO	The risk of regulatory intervention (including fines) and poor patient experience resulting from the non-delivery of appointments within 18 weeks within the NHS Constitutional standards.	The RTT standard is not being met and re-reporting took place in March 2019 (February data). RTT trajectory and Waiting list size (NHS I agreed) is being met by the Trust. The long waiting patients (52s)are on a continued downward trajectory and this is the area of main concern Controls in place from an operational perspective are: 1.The daily review of existing patient tracking list 2. Additional resource to support central and divisional validation of the patient tracking list. 3.Review of all patients at 45 weeks for action e.g. removal from list (DNA / Duplicates) or 1st OPA, investigations or TCI. 4. A delivery plan for the delivery to standard across specialities is in place 5. Additional non-recurrent funding (between cancer/ diagnostics and follow ups) to support the reduction in long waiting 6. Picking practice report developed by BI and theatres operations, reviewed with 2 specialities (Jan 2020) and issued to all service lines (Jan 2020) to implement. Reporting through Theatre Collaborative and PCDG. 7. PTL will be reviewed to ensure the management of our patients alongside the clinical review RAG rating	1.RTT and TrakCare plans monitored through the delivery and assurance structures	Statutory	Major (4)	Likely - Weekly (4)	16	15 - 25 Extreme risk	31/03/2021	Trust Risk Register
C2786NSafe	The risk of insufficient workforce to plan and prepare new arrangement ahead of new statutory requirements as an authorising body for Liberty Protection Safeguards by 1st April 2022, as a result of not having staff trained and processes in place from autumn 2021.	Safeguarding Adults policy DoLS checklist Mental Capacity Act documentation Daily updates between GHFT Safeguarding Adults team and DoLS office. CQC updated with every DoLS outcome. MCA included as a mandatory element in Safeguarding Adults training MCA training has been provided live via MSTeams All divisions have developed MCA improvement plans. QDG are monitoring progress monthly	A Trust MCA/DoLS Delivery Group is being established. Clinical leads being recruited and Divisional leads. DoLS scoping in place. July DoLS awareness month. Support to teams in practice, IT enhancemenst to DoLS applicatiosn process. Divisional improvment plans for MCA MCA and DoLS training included in Safeguarding Adults training Workforce planning	Statutory	Major (4)	Likely - Weekly (4)	16	15 - 25 Extreme risk	29/01/2021	Trust Risk Register
S2917CC	The risk of patient and staff harm and loss of life as a result of an inability to horizontally evacuate patients from critical care	Presence of fire escape staircase Hover-jack to aid evacuation of level 3 patient Fire extinguisher training for staff	Fire extinguisher training Simulation training to evaluate hoverjack and slide sheets Discuss estates option for creating adequate fire escape facilities Purchase of twenty sliding sheets order oxygen cylinder holders Evacuation practice relocation of small O2 cylinders b end of unit	Safety	Catastrophic (5)	Rare - Less than annually (1)	5	4 - 6 Moderate risk	26/02/2021	Trust Risk Register
		RN identified for ambulance assessment corridor 24/7 Identified band 3 24 hours a day for third radiology corridor with identified accountable RN on every shift.Additional band 3 staffing in ambulance assessment corridor 24 hours a day - improvement in NEWS compliance and safety checklist Where possible room 24 to be kept available to rotate patients 9(or identified alternative where 24 occupied) (GPH)8am - 12mn consultant cover 7/7	Complete CQC action plan Compliance with 90% recovery plan Monies identified to increase staffing in escalation areas in E, increase numbers in Transfer Teams, increase throughput in AMIA.							

M2268Emer	The risk of patient deterioration (Safety) due to lack of capacity leading to ED overcrowding with patients in the corridor	Where possible room 24 to be kept available to rotate patients s(or identified alternative where 24 occupied) (GRH)/bam - 12mm consultant cover ??? (GRH) reviewed by fire officers.safety checklist; Escalation to silver/gold on call for extra help should the department require to overflow into the third (radiology) corridor..Silver Ql project undertaken to attempt to improve quality of care delivered in corridor inc. fleeced single use blankets and introduction of patient leaflet to allow for patients to access PALS.90% recovery plan May 2019.adherence. Pitstop process late shifts Mon - Fri to rapidly assess all patient arriving by ambulance - early recognition of increased acuity to prioritise into the department.Establishment of GPAU to stream GP referrals direct into alternative assessment area reducing demand in corridor.	Upgrage risk to reflect ED corridor being used for frequently + liaise with Steve Hams so get risk back on TRR	Safety	Moderate (3)	Likely - Weekly (4)	12	8 -12 High risk	31/03/2021	Trust Risk Register
C3034N	The risk of patient deterioration, poor patient experience, poor compliance with standard operating procedures (high reliability)and reduce patient flow as a result of registered nurse vacancies within adult inpatient areas at Gloucestershire Royal Hospital and Cheltenham General Hospital.	1. Temporary Staffing Service on site 7 days per week. 2. Twice daily staffing calls to identify shortfalls at 9am and 3pm between Divisional Matron and Temporary Staffing team. 3. Out of hours senior nurse covers Director of Nursing on call for support to all wards and departments and approval of agency staffing shifts. 4. Band 7 cover across both sites on Saturday and Sunday to manage staffing and escalate concerns. 5. Safe care live completed across wards 3 times daily shift by shift of ward acuity and dependency, reviewed shift by shift by divisional senior nurses. 6. Master Vendor Agreement for Agency Nurses with agreed KPI's relating to quality standards. 7. Facilitated approach to identifying poor performance of Bank and Agency workers as detailed in Temporary Staffing Procedure. 8. Long lines of agency approved for areas with known long term vacancies to provide consistency, continuity in workers supplied. 9. Robust approach to induction of temporary staffing with all Bank and Agency nurses required to complete a Trust local Induction within first 2 shifts worked. 10. Regular Monitoring of Nursing Metrics to identify any areas of concern. 11, Acute Care Response Team in place to support deteriorating patients. 12, Implementation of eObs to provide better visibility of deteriorating patients. 13, Agency induction programmes to ensure agency nurses are familiar with policy, systems and processes. 14, Increasing fill rate of bank staff who have greater familiarity with policy, systems and processes.	To review and update relevant retention policies Set up career guidance clinics for nursing staff Review and update GHT job opportunities website Support staff wellbing and staff engagment Assist with implementing RePAIR priorities for GHFT and the wider ICS Devise an action plan for NHSi Retention programme - cohort 5 Trustwide support and Implementation of BAME agenda Devise a strategy for international recruitment	Safety	Moderate (3)	Almost certain - Daily (5)	15	15 - 25 Extreme risk	26/02/2021	Trust Risk Register
C2989COOEFD	The risk of patient, staff, public safety due to fragility of single glazed windows. Risk of person falling from window and sustaining serious injury or life threatening injuries. Serious injury from contact with broken glass / shattered windows. Glass shards may be used as a weapon against staff, other patients or visitors. Risk of distress to other patients / visitors and staff if person falls	1. All faults are logged on Backtraq via the Estates Helpdesk either on-line or via the 6800 number and reports are available as necessary; 2. Many windows have a protective film to prevent shards of glass fragmenting and causing harm; 3. Patient Risk Assessments are in place by the Trust for vulnerable patients to ensure that controls are in place locally to minimise and/or mitigating patient contact with windows/glass; 4. Window Restrictors are fitted to all windows which require them and are maintained on an annual PPM schedule by Gloucestershire Managed Services; 5. Window Restrictor Policy in place which is reviewed and updated on a three yearly basis or as required; 6. If a window is broken or damaged it is replaced with a window which has toughened glass and complies with all current legislative requirements (e.g. 6.4mm laminate safety glass tested to provide class 2 level of protection to BS EN 12600, manufactured to BS EN 14449 and/or BS EN ISO 12543-2); 7. Money is made available in the Capital budget for replacement of windows (Note for AM: Accuracy of control/mitigation action to be confirmed).	Replacement, or upgrade of windows. 100 windows need replacing throughout the Tower Block. Decision to be made as to whether each window needs to be replaced, or whether each window is replaced on a ward first at a cost of £30, 000 per ward Review, assess and enact agreed future actions/controls	Environmental	Minor (2)	Almost certain - Daily (5)	10	8 -12 High risk	05/04/2021	Trust Risk Register

C3295COO	The risk of patients experiencing harm through extended wait times for both diagnosis and treatment	Booking systems/processes: Two systems were implemented in response to the covid 19 pandemic. (1) The first being that a CAS system was implemented for all New Referrals. The motivation for moving to this model being to avoid a directly bookable system and the risk of patients being able to book into a face to face appointment. This triage system would allow an informed decision as to whether it should be face to face, telephone or video. To assist, specific covid-19 vetting outcomes were established to facilitate the intended use of the CAS and guidance sent out previously, with the expectation being that every referral be categorised as telephone, video or face to face. (2) The second system was to develop a RAG rating process for all patients that were on a waiting list, including for instance those cancelled during the pandemic, those booked in future clinics, and those unbooked. Guidance processes circulated advising Red = must be seen F2F; Amber = Telephone or Video and Green = can be deferred or discharged (with instructions required). Both systems were operational from end March.Recognising significant loss of elective activity during the pandemic services are required to undertake the above processes and closely review their PTLs. The review process creating both the opportunity of managing patients remotely; identifying the more urgent patients; and deferring or discharging those patients that can be managed in primary care. RTT delivery plans are also being sought to identify the actions available to provide adequate capacity to recover this position.The Clinical Harm Policy has also been reviewed and Divisions undertaking harm reviews as required. Harm reviews suspended aside from Cancer. The RAG process described above has moved into a P category status = all patients are now being validated under this prioritisation on the INPWL - a report has also been provided at speciality level to detail the volume completed	No Further actions	Safety	Major (4)	Likely - Weekly (4)	16	15 - 25 Extreme risk	31/03/2021	Trust Risk Register
M2473Emer	The risk of poor quality patient experience during periods of overcrowding in the Emergency Department	Identified corridor nurse at GRH for all shifts; ED escalation policy in place to ensure timely escalation internally; Cubicle kept empty to allow patients to have ECG / investigations (GRH); Pre-emptive transfer policy Patient safety checklist up to 14 hours Monitoring Privacy & Dignity by Senior nurses Appointment of band 3 HCA's to maintain quality of care for patients in escalation areas. Review of safety checklist to incorporate comfort measures and oxygen checks. Introduction of pitstop trial to identify urgent patient needs including analgesia and comfort measures.	CQC action plan for ED Development of and compliance with 90% recovery plan Winter summit business case Liase with Tiff Cairns to discuss with Steve Hams to get ED corridor risks back up to TRR	Quality	Moderate (3)	Almost certain - Daily (5)	15	15 - 25 Extreme risk	31/03/2021	Trust Risk Register
			Deliver the agreed action fractured neck of femur action plan Develop quality improvement plan with GSIA Review of reasons behind increase in patients with delirium Development of parallel pathway for patients who fracture NOF in hospital Pull together complaints and compliments to understand patient/care views Pull together any complaints or compliments to understand patient/care views for #NOF patients develop joint training and share learning to reduce issues and optimise care discuss admitting patients to 3a with site team create SOP for prioritisation of #NOFs to 3rd floor with intention that other trauma should outlie first restart TATU to help reduce length of stay and improve discharges Identify potential capital works and funding for TATU revisit possibility of Mayhill taking planned trauma revisit community teams administering antibiotics agree targeted approach for high volume conditions engagement activities with staff on ideas for improving LOS Prioritise 3rd floor for ward rounds to aid flow							

S2045T&O	The risk to patient safety of poorer than average outcomes for patients presenting with a fractured neck of femur at Gloucestershire Royal	Prioritisation of patients in ED Early pain relief Admission proforma Volumetric pump fluid administration Anaesthetic standardisation Post op care bundle – Haemocus in recovery and consideration for DCC Return to ward care bundle Supplemental Patient nutrition with nutrition assistant medical cover at weekends OG consultant review at weekends therapy services at weekends Theatre coordinator Golden patients on theatre list Discharge planning and onward referrals at point of admission	creation of new inpatient clerking proforma progress pre op protocols through documentation committee launch pre op protocols early escalation by trauma coordinators of any trauma backlog to prioritise hip fracture patients review of escalation policy and relaunch if necessary creation of snapshot report to aid escalation re educate trainees that if femoral head if not out/guide wire not within 20 mins, requirement to request senior help Need to emphasise with trainees that access available to JUYI/SCR to inform full list of patient medication Feedback on ward care plan audit results and education of trauma coordinators and medical staff of importance feedback on care bundle audit and feedback to nursing teams and junior Drs of importance recruitment into vacant post for nutrition support practitioner good practice re optimisation for nutrition and hydration to be shared outside 3a Audit post op blood taking over weekends investigate options to increase junior orthogeri cover on call junior dr to be supported by 2nd registrar in MIU, freeing up on call Dr to see ward patients explore issue relating to complex patients not being assessed by COTE team before theatre process for escalation of DATIX to junir Dr and escaltion superviserd to aid learning undertake time and motion study of juniors to understand pressures work with HR to develop recruitment and retention plan for trauma nursing review feeback from nursing education programme engagement activities across T&O nursing Explore issues around Gallery ward taking NOF patients with complex needs review TOR for hip fracture mortality meetings Identify staff to undertake silver QI course to develop QI skills	Safety	Major (4)	Possible - Monthly (3)	12	8 -12 High risk	25/06/2021	Trust Risk Register
C2667NIC	The risk to patient safety and quality of care and/or outcomes as a result of hospital acquired C .difficile infection.	1. Annual programme of infection control in place 2. Annual programme of antimicrobial stewardship in place 3. Action plan to improve cleaning together with GMS	1. Delivery of the detailed action plan, developed and reviewed by the Infection Control Committee. The plan focusses on reducing potential contamination, improving management of patients with C.Diff, staff education and awareness, buildings and the envi	Safety	Major (4)	Possible - Monthly (3)	12	8 -12 High risk	31/03/2021	Trust Risk Register
S2537Th	The risk to patient safety & experience due to loss of main theatre lighting impacting on ability to safely complete surgical procedures	Maintenance by Estates and Fulbourn Medical.	Request funding for all obsolete lights Put light risk on the risk register Add Apollo Lights to the risk assessment and MEF request Carry out surveys of the theatres requiring lights Replacement programme Work with estates to produce a list of outstanding lights	Safety	Major (4)	Possible - Monthly (3)	12	8 -12 High risk	12/02/2021	Trust Risk Register

			Identify access to additional lighting in case of failure Action plan for lights replacement To produce risk assessment for light failure							
D&S3103Path	The risk of total shutdown of the Chem Path laboratory service on the GRH site due to ambient temperatures exceeding the operating temperature window of the instrumentation.	Air conditioning installed in some laboratory areas but not adequate. Cooler units installed to mitigate the increase in temperature during the summer period (now removed). *UPDATE* Cooler units now reinstalled as we return to summer months. Quality control procedures for lab analysis Temperature monitoring systems Contingency would be to transfer work to another laboratory in the event of total loss of service (however, ventilation and cooling in both labs in GHT is compromised, so there is a risk that if the ambient temperature in one lab is high enough to result in loss of service, the other lab would almost certainly be affected). Thus work may need to be transferred to N Bristol (compromising their capacity and compromising turnaround times).	Develop draft business case for additional cooling Submit business case for additional cooling based on survey conducted by Capita Rent portable A/C units for laboratory	Quality	Major (4)	Likely - Weekly (4)	16	15 - 25 Extreme risk	01/04/2021	Trust Risk Register
C3223COVID	The risk of nosocomial infection, prolonged hospitalisation and death to patients, the risk of illness to staff affecting safety and quality.	•2m distancing implemented between beds where this is viable •Perspex screens placed between beds •Clear procedures in place in relation to infection control •COVID-19 actions card / training and support •Planning in relation to increasing green bed capacity to improve patient flow rate •Transmission based precautions in place •NHS Improvement COVID-19 Board Assurance Framework for Infection Prevention and Control •H&S team COVID Secure inspections •Hand hygiene and PPE in place •LFD testing – twice a week •72 hour testing following outbreak •Regular screening of patients	CAFF inspections to be progressed	Workforce	Major (4)	Almost certain - Daily (5)	20	15 - 25 Extreme risk	08/03/2021	Trust Risk Register
C1945NTVN	The risk of moderate to severe harm due to insufficient pressure ulcer prevention controls	1. Evidence based working practices including, but not limited to; Nursing pathway, documentation and training including assessment of MUST score, Waterlow (risk) score, Anderson score (in ED), SSKIN bundle (assessment of at risk patients and prevention management), care rounding and first hour priorities. 2. Tissue Viability Nurse team cover both sites in Mon-Fri providing advice and training. 3. Nutritional assistants on several wards where patients are at higher risk (COTE and T&O) and dietician review available for all at risk of poor nutrition. 4. Pressure relieving equipment in place Trust wide throughout the patients journey - from ED to DWA once assessment suggests patient's skin may be at risk. 5. Trustwide rapid learning from the most serious pressure ulcers, RCAs completed within 72 hours and reviewed at the weekly Preventing Harm Improvement Hub.	1. To create a rolling action plan to reduce pressure ulcers 2. Amend RCSA for presure ulcers to obtain learning and facilitate sharing across divisions 3. Sharing of learning from incidents via matrons meetings, governance and quality meetings, Trust wide pressure ulcer group, ward dashboards and metric reporting. 4. NHS collabborative work in 2018 to support evidence based care provision and idea sharing Discuss DoC letter with Head of patient investigations Advise purchase of mirrors within Division to aid visibility of pressure ulcers update TVN link nurse list and clarify roles and responsibilities implement rolling programme of lunchtime teaching sessions on core topics TVN team to audit and validate waterlow scores on Prescott ward purchase of dynamic cushions share microteaches and workbooks to support react 2 red cascade learning around cheers for ears campaign Education and supprt to staff on 5b for pressure ulcer dressings Review pressure ulcer care for patients attending dilysis on ward 7a	Safety	Major (4)	Possible - Monthly (3)	12	8 -12 High risk	31/03/2021	Trust Risk Register

Gloucestershire Hospitals
NHS Foundation Trust

Trust Public Board – 11 March 2021
Microsoft Teams – Commencing at 12:30

Report Title
Digital Aspirant Programme

Sponsor and Author(s)	
Author:	Rebecca McKeever, Digital Finance Business Partner Nicola Davies, Digital Engagement & Change Lead
Sponsor:	Mark Hutchinson, Executive Chief Digital & Information Officer

Executive Summary

Purpose

This paper provides an update on the Trust's successful application to become a Digital Aspirant and seeks the Committee's approval for the funding agreement with NHSX.

Key Issues to Note

- As part of our five-year digital strategy and commitment to reaching HIMSS level 6/7, GHFT expressed an interest in becoming a Digital Aspirant.
- The application included our five-year digital strategy approved by Board in November 2019 and our most recent five-year capital plan proposal (as submitted to Finance & Digital Committee in October 2020).
- In January 2021, we were notified that our application is being supported and would be approved by NHSX.
- This presents us with a £6 million addition to our capital-funding over the next three-years and approval is needed to confirm that GHFT will prioritise future capital spend to ensure we meet our commitment to match-fund (as per the schedule in the document) as part of our existing programme.
- The matched funding requirement for years 1 and 2 is already within the current year and proposed 21/22 capital programme. Year 3 requires a minimum matched funding of £3.3m and a proposed Trust investment of £6.3m, to reflect the total investment required to deliver the programme set out in the strategy and achieve the digital maturity HIMMS level 6/7.
- Digital investment in the last three-years has been broadly one-third of the Trust's capital programme and, therefore, year 3 funding would require a minimum pre-commitment of £3.3m (15.5%) and the £6.3m (29.6%). This is consistent with historic spending levels, assuming the future capital regime is not more restrictive than recent years.

Conclusions

The importance of improving GHFTs digital maturity in line with our five-year strategy has been significantly highlighted throughout the COVID-19 pandemic. Our ability to respond and care for our patients has been greatly enabled by our delivery so far, and becoming a Digital Aspirant will allow this work to continue at pace.

Implications and Future Action Required

The commitments required as part of the Digital Aspirant Programme will be monitored by the Digital Care Delivery Group and Finance & Digital Committee, to provide assurance and oversight.

Recommendations

The Committee is asked to approve the drawdown of the capital award under the Digital Aspirant Programme and, in doing so, approve the minimum pre-commitment of £3.3m from the 2022/23 capital programme and note the level of investment aspired to (£6.3m) as part of the delivery of the wider digital strategy.

Impact Upon Strategic Objectives

This investment, if approved, will be the primary enabler to the digital strategic objective.

Impact Upon Corporate Risks

Progression of the digital agenda will allow us to significantly reduce a number of corporate risks related to the improvement in the safety and reliability of patient care.

Regulatory and/or Legal Implications

Progression of the digital agenda will allow the Trust to provide more robust and reliable data and information to provide assurance of our care and operational delivery.

Equality & Patient Impact

Progression of the digital agenda will improve the safety and reliability of care in the most efficient and effective manner.

Resource Implications

Finance		Information Management & Technology	**X**
Human Resources		Buildings	

Action/Decision Required

For Decision		For Assurance		For Approval	**X**	For Information	

Gloucestershire Hospitals
NHS Foundation Trust

TRUST PUBLIC BOARD – MARCH 2021

DIGITAL ASPIRANT PROGRAMME

1. Purpose of report

Gloucestershire Hospitals Foundation Trust (GHFT) has been invited onto the NHSX Digital Aspirant Programme. As part of the governance and funding agreement process, the Finance & Digital Committee is asked to:

- Approve the Trust's inclusion on the Digital Aspirant Programme.
- Agree to prioritise future capital spend to ensure we meet our commitment to match-fund (as per the schedule in the report) as part of our existing programme.
- Support the formal agreement with NHSX and the programme requirements.

2. Digital Aspirant Programme

The Digital Aspirant Programme was launched by the Health Minister, Matt Hancock, in December 2019 to drive digital change in the NHS. The programme is run by NHSX and was established to provide additional support to organisations that have clearly demonstrated an ability to deliver; as well as an ambition to advance digital maturity in their organisations. Through a matched capital-funding programme, it aims to help organisations to go further, faster.

The Digital Aspirant Programme aims to meet the following national investment objectives:

- Advance the digital maturity of secondary care providers.
- Allow ICS/STPs to harness technology to help realise their transformation goals.
- Enable information to be shared across local healthcare systems, laying the foundations for integrated care.
- Catalyse ICS/STP-level leadership of the digital agenda at a local level.

2.1 GHFT Aspirant Application Timeline

Since outlining and agreeing our five-year digital strategy at the end of 2019, our long-term aspiration has been to become a Global Digital Exemplar Trust. However, the announcement of the NHS Digital Aspirant Programme provided a more realistic opportunity for us to put Gloucestershire on the digital map and publicly declare our intention to become a digital leader.

Following discussions as part of our Senior Leadership team and as part of our journey to HIMSS level 6, we declared an interest to regional colleagues about joining the Aspirant Programme (start of 2020). However, we heard nothing more and the first Aspirants were announced that year. We assumed we had been unsuccessful.

In January 2021, we were notified that NHSX would be keen to support our request to become a Digital Aspirant and we were asked to provide an updated position on our EPR programme, along with an outline of our planned capital programme for the life of the current strategy (2019-2024) (indicative plan as submitted to the Finance & Digital Committee in October 2020). By the end of the month, we were told that we were successful.

This news came as a huge and welcome surprise to the digital team, particularly those in the senior team who had been on a three-year journey to get us back on-track. Digital colleagues in the ICS heard the news first and have played a key part in the successes we have achieved so far; but also the transformation we can achieve in the future, if this is approved.

Both GHT and the wider ICS aspire to deliver long-term strategies that are reliant on digital technology. The model for urgent and elective care requires high quality clinical, capacity and demand information to flow across care settings, sites and providers in as near to real-time as possible. Digital technology, in the form of an EPR, provides fluid access to information for: direct care speed, improved quality, back-office streamlining, quality and continuous improvement, operational planning, self-care promotion and service reconfiguration. All of these benefits enable GHFT and the ICS to maximise limited resources.

Following a significant programme of investment and improvement, we are now on our journey to a core level of digitisation, with infrastructure we can rely on; a successfully recovered PAS and a rapid first deployment of an electronic patient record. There is still so much to do.

3. Capital Funding Commitment

As well as the national recognition, the additional support and expertise we'll receive as part of this programme - and the access to blueprints and learning from others - is going to make a significant difference to our progression.

This opportunity also presents us with a £6 million addition to our capital funding; this is because successful admission to the Aspirant Programme includes match-funding of our capital plans over the next three years.

These numbers are not driven by NHSX, but by our internal expectations of the funding we will need to deliver our commitments successfully. Commitments that have already been set out in our five-year strategy, which was approved at Board level.

In summary:

- Approval is needed to confirm that GHFT will prioritise future capital spend to ensure we meet our commitment to match-fund (as per the schedule in the document below and attached) as part of our existing programme.

- The matched funding requirement for years 1 and 2 is already within the current year and proposed 21/22 capital programme.
- Year 3 requires a minimum matched funding of £3.3m and a proposed Trust investment of £6.3m, to reflect the total investment required, to deliver the programme set out in the strategy and achieve the digital maturity HIMMS level 6/7.
- Digital investment in the last three-years has been broadly one-third of the Trusts capital programme and, therefore, year 3 funding would require a minimum pre-commitment of £3.3m (15.5%) and the £6.3m (29.6%). It is consistent therefore with historic spending levels, assuming the future capital regime is not more restrictive than recent years.

The Agreement is for an award of £6,000,000 capital split over three-years in the following way (subject to the agreement of the F&D Committee and Trust Board);

- £700k in 2020/21 (on-boarding payment)
- £2,000,000 in 2021/22
- £3,300,000 in 2022/23

However, NHSX has made it clear that the allocation of central funding to the Trust does not need to be matched by the Trust either revenue for revenue, capital for capital or even in the same financial years. It is entirely at our discretion how we wish to provide the match-funding. To provide context, the table below shows the total level of capital expenditure over the previous three-years and the provisional capital budget for next year. For comparison, it shows the total GHFT capital spend against the digital (IM&T) spend.

YEAR	TOTAL GHFT (£M)	IM&T (£M)
2018-19	17.9	5.2
2019-20	33.6	9.8
2020-21	38.5	8.6
2021-22 (provisional)	21.8	7.1

Once approved, the Trust will receive an on-boarding payment, with subsequent funding instalments approved by NHSX, once the agreed assurance criteria are met. NHSX will establish payment milestones, subject to delivery of capability and outcomes.

Milestone	Capital £k	Revenue £k	TOTAL £k	Financial Year	Cumulative % of Funding	Due Date
Central Funding						
Central Funding - Onboarding FM1	£700	£0	**£700**	20/21	12%	Feb 2021
Central Funding FM2	£2,000	£0	**£2,000**	21/22	45%	Mar 2021
Central Funding FM3	£3,300	£0	**£3,300**	22/23	100%	Mar 2022
Match Funding						
Match Funding MF1	£2,550	£0	**£2,550**	20/21	20%	Mar 2021
Match Funding MF2	£4,058	£0	**£4,058**	21/22	51%	Mar 2022
Match Funding MF3	£6,300	£0	**£6,300**	22/23	100%	Mar 2023
Match Funding MF4	£0	£0	**£0**	22/23	0%	
Summary by Year					**Annual %**	
20/21 Central Funding	£700	£0	**£700**	20/21	12%	
21/22 Central Funding	£2,000	£0	**£2,000**	21/22	33%	
22/23 Central Funding	£3,300	£0	**£3,300**	22/23	55%	
Total Central Funding	**£6,000**	**£0**	**£6,000**		100%	
20/21 Match Funding	£2,550	£0	**£2,550**	20/21	20%	
21/22 Match Funding	£4,058	£0	**£4,058**	21/22	31%	
22/23 Match Funding	£6,300	£0	**£6,300**	22/23	49%	
Total Match Funding	**£12,908**	**£0**	**£12,908**		**100%**	

4. Project Level Funding

GHFT has a draft digital capital programme that totals £18.9million for years 20/21, 21/22 and 22/23. There is a digital strategy already agreed for 23/24 and 24/25, which will need capital allocations.

5. Assurance and Governance

The Digital Aspirant agreement and milestones will be monitored by the EPR Programme Delivery Group, reported regularly to the Digital Care Delivery Group and overseen by quarterly updates to Finance & Digital Committee.

Under the agreement, the Trust is expected to:

- Build on the work already undertaken on front-line digitisation by employing the GDE/Fast Follower Blueprints.
- Actively employ learning from others.

- Develop relationships with more digitally mature Trusts as proven in the followership model on the GDE programme.

There is a clear obligation on the leadership of the Aspirant organisations to ensure these commitments and undertakings are met. If they are not met, then no further funding will be given, and steps will be taken to recover the funding already given.

6. Conclusions and recommendations

When we first began our recovery journey in 2018, we could never have envisaged being selected for a national digital programme such as this. Digital systems require long-term investment and not just an initial injection of capital. Benefits are realised along the life of a project, as systems are used, embedded and developed by the clinicians themselves. Digital enables savings opportunities across the organisation and any future investment in electronic systems should be seen in that way.

Becoming a Digital Aspirant - whilst requiring a firm commitment to capital funding over the next three-years - does not require any additional funds than those already provisionally planned for, when we committed to our five-year strategy. The risk of not investing in digital will take the Trust back to the place we began our journey in 2018; under scrutiny from NHS England and with no ability to safely and effectively monitor patient care.

The Finance & Digital Committee is asked to approve GHFT's admission to the Digital Aspirant Programme; to support the match-funding already identified in the capital programme for 20/21 and 21/22; and approve the minimum pre-commitment of £3.3m from the 2022/23 capital programme. The Committee is also asked to note the level of investment aspired to (£6.3m) as part of the delivery of the wider digital strategy.

Authors:
Rebecca McKeever, Digital Finance Business Partner
Nicola Davies, Digital Engagement & Change Lead

Presenter: Mark Hutchinson, Executive Chief Digital & Information Officer

Gloucestershire Hospitals
NHS Foundation Trust

Trust Public Board – 11 March 2021
Microsoft Teams - Commencing at 12:30

Report Title
Financial Performance Report **Month Ended 31 January 2021**
Sponsor and Author(s)
Author: Johanna Bogle, Associate Director of Financial Management Sponsor: Karen Johnson, Director of Finance
Executive Summary

Purpose

This purpose of this report is to present the Financial position of the Trust at Month 10 to the Finance and Digital Committee.

Key issues to note

Month 10 overview
At Month 10 we recorded a £0.24m deficit, compared to a planned deficit of £1.63m. This means that we were better than plan by £1.39m. This is as a result of incurring less cost than forecast, due to performing less activity than plan in month.

Our activity was 18% less than our planned level of activity, and down 2% compared to month 9. This was due to the second surge of Covid, which peaked in the Trust in Month 10.

We have not assumed a financial penalty against missing activity targets within our financial position.

Forecast Outturn
We submitted a M7-12 plan that costed the delivery of required activity levels, alongside Winter pressures, but excluding any Covid 2nd surge, at £336m. Due to the improvement against plan in months 7 and 8, and some additional block income from NHSE revisiting their earlier calculation; we have reduced our forecast outturn by £3.9m, which means that we are now forecasting a deficit of £11.6m. This includes an annual leave provision, as required nationally.

There are ongoing discussions both nationally and regionally regarding the ability to fund some of the technical adjustments which is likely to result in an improved position by year end, the ultimate goal will be to achieve breakeven.

Next Year
We are progressing with our budget setting for 21/21. Funding for next year is unknown, but it is likely that system allocations will again play a part and systems will be encouraged to share risk.

Capital
As at M10 the Trust have delivered £18.1m of the capital programme, with a forecast spend (excluding donations and government grants) of £37.4m for the year. Close working with project leads looks to provide continued assurance over the forecasts and seeks to capture the key risks around delivery. A weekly progress update to the Chair of IDG has been established.

Conclusions

The Trust is reporting a year to date deficit of £3.90m, £5.43m better than the planned £9.33m deficit. This position does not include any financial penalties for under-achievement of activity against the elective incentive scheme.

The system forecast deficit is £28.4m for the second half of the year, when there is no retrospective true-up. This does not yet include the improvement to our Trust forecast.

The GHFT deficit forecast for the second half of the year is £11.6m, an improvement of £3.9m since the plan was submitted. This includes an annual leave provision, and the expectation that the Gen Med Vat provision is not supported by NHSE, despite us continuing to push for this to be funded.

Implications and Future Action Required

To continue the report the financial position monthly.

Recommendations

The Committee is asked to receive the contents of the report as a source of assurance that the financial position is understood and under control.

Impact Upon Strategic Objectives

This report updates on our progress throughout the financial year of the Trust's strategic objective to achieve financial balance.

Impact Upon Corporate Risks

This report links to a number of Corporate risks around financial balance.

Regulatory and/or Legal Implications

No issues for regulatory of legal implications.

Equality & Patient Impact

None

Resource Implications

Finance	**X**	Information Management & Technology	
Human Resources		Buildings	

Action/Decision Required

For Decision		For Assurance	**X**	For Approval		For Information	

Date the paper was presented to previous Committees and/or Trust Leadership Team (TLT)

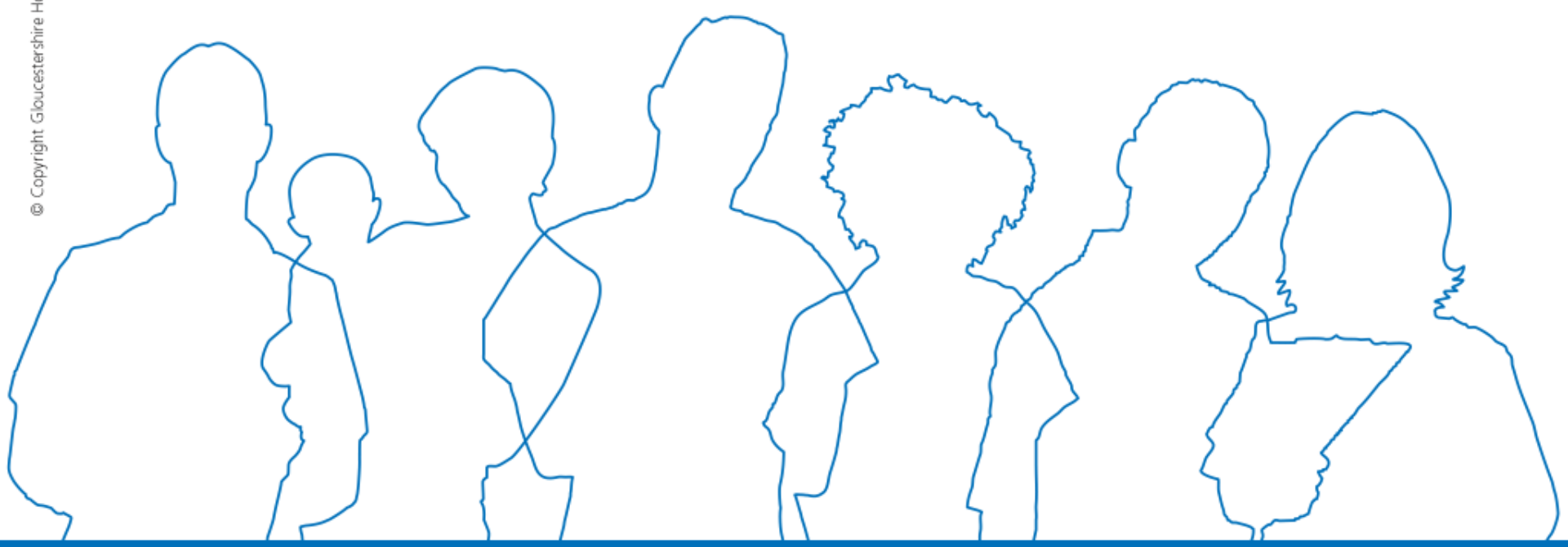
Audit & Assurance Committee	Finance & Digital Committee	Estates & Facilities Committee	People & OD Committee	Quality & Performance Committee	Remuneration Committee	Trust Leadership Team	Other (specify)

Outcome of discussion when presented to previous Committees/TLT

Gloucestershire Hospitals
NHS Foundation Trust

Report to Trust Board

Financial Performance Report
Month Ended 31st January 2021



Director of Finance Summary

Gloucestershire Hospitals NHS Foundation Trust

Month 10 overview

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We have not assumed a financial impact against the elective incentive scheme.

Forecast Outturn

We submitted a M7-12 plan that costed the delivery of required activity levels, alongside Winter pressures, but excluding any Covid 2nd surge, at £336m. Due to the improvement against plan in months 7 and 8, and some additional block income from NHSE revisiting their calculation, we have reduced our forecast outturn by £3.9m, which means that we are forecasting a revised deficit of £11.6m. This includes an annual leave provision, as required nationally. The system forecast has not yet been updated to include the improvement to our Trust forecast.

For Month 10 we have held our current forecast.

Next Year

We are progressing with our budget setting for 21/21. Funding for next year is unknown, but it is likely that system allocations will again play a part and systems will be encouraged to share risk.

Capital

As at M10 the Trust have delivered £18.1m of the capital programme, with a forecast spend (excluding donations and government grants) of £37.4m for the year. Close working with project leads looks to provide continued assurance over the forecasts and seeks to capture the key risks around delivery. A weekly progress update to the Chair of IDG has been established.

Month 10 headlines

Gloucestershire Hospitals
NHS Foundation Trust

Headline	Compared to plan	Narrative	Change from last month
I&E Position YTD is £3.9m.		Overall YTD financial performance is £3.9m. This is £5.4m better than plan.	
Income is £535.4m YTD.		YTD £5.5m better than plan, mainly due to above-plan expected income for private patient activity, and pass-through drugs income and cost not forming part of the plan.	
Pay costs are lower than plan at £340.6m YTD.		YTD this is £1.4m lower than plan. This is due to lower activity than expected, and therefore lower temporary staff costs.	
Non-Pay expenditure is worse than plan at £191.5m.		YTD this is £1.5m worse than plan. This is due to pass-through drugs costs not forming part of the plan, and offsets relevant income over-performance.	
CIP schemes on plan for 20/21.		As long as we are within our overall plan for 2020/21, CIP is delivered for this year. The budget setting process has now started, and will be aiming to identify CIP for 2021/22	
Capital expenditure is £18.1m YTD		Capital spending is £4.8m behind plan YTD but forecasting to spend the full £37.4m by year end.	
The cash balance is £87.38m		Cash is £18.1m ahead of plan, mainly because of our extra month of block income that will be repaid in March.	

Latest forecast position

Gloucestershire Hospitals NHS Foundation Trust

The Trust submitted a deficit planned position for the 20/21 year that amounted to £15.5m.

Our forecast remains as per Month 8 at £11.6m deficit for the year. The favourable variances in Months 9 and 10 will be used to ensure that we are able to afford as much recovery activity in Months 11 and 12 as possible.

Latest Forecast Outturn position - £11.6m deficit

	Original H2 Forecast Outturn 20/21	M7 variance to plan improving Forecast Outturn	M8 Confirmation of additional Block Income	M8 variance to plan improving Forecast Outturn	Revised H2 Forecast Outturn	M1-6 Actuals 20/21	Full Year Forecast 20/21
Income	- 320,566		- 851	- 504	- 321,921	- 316,183	- **638,104**
Pay	212,937			- 1,549	211,388	202,419	**413,807**
Non Pay	123,145	- 1,020			122,125	113,764	**235,889**
Surplus / Deficit	**15,516**	**- 1,020**	**- 851**	**- 2,053**	**11,592**	**-**	**11,592**

YTD True-Up Funding agreed by NHSE

Gloucestershire Hospitals NHS Foundation Trust

For Months 1-6 the Trust was under a retrospective top-up arrangement. This meant that the Trust was expected to breakeven and, in order to do so, had to assume retrospective top-up income equivalent to any overspend. In total for the first half of the year, the Trust applied for £21.9m. This was made up of £15.2m of Covid-19 costs so far this year, plus the Gen Med VAT provision of £4.2m, plus other overspends of £2.5m compared to the nationally-calculated block funding.

NHSE have not yet transacted a true-up provision for Gen Mad VAT – we will continue to push this in discussions with NHSE. All other True-up balances have been paid.

NHSE True-Up Income Position	Value (£'000)
True-Up M01 Paid	1,757
True-Up M02 Paid	1,769
True-Up M03 Paid	3,811
True-Up M04 Paid	3,627
True-Up M05 Initially Applied	6,505
True-Up M05 Rejected - Gen Med VAT	(4,200)
True-Up M05 Rejected - PDC (error in accts corrected)	(733)
True-Up M05 Revised Paid	1,572
True-Up M06 Unvalidated - Repeat of Gen Med	4,200
True-Up M06 Paid	5,145
Grand Total (Revised) True-Up YTD	**21,881**

Financial Position Compared to Plan

Gloucestershire Hospitals NHS Foundation Trust

We are reporting £1.39m better than plan in Month 10. This is predominantly around clinical underspend linked to reduced activity, but is also as a result of better income performance than expected.

Given the current situation with HMRC over the VAT treatment of Gen Med our risk appetite for VAT-related cost saving is diminished. To this end we are reviewing our contracts via GMS and providing against VAT reclaims that may be challenged. To this effect, month 10 includes £0.98m of additional VAT provision.

For the year to date (YTD) we show a favourable variance to plan of £5.43m. Again, this is mainly as a result of reduced activity and higher-than expected income.

Feeding the Month 7 and 8 favourable results through into our forecast, as well as the additional block income NHSE have now awarded us, we are forecasting an improvement against plan by £3.9m, reducing our £15.5m deficit to £11.6m deficit.

	In month Forecast	Actuals M10	In month variance	YTD Forecast	YTD Actuals	Variance to YTD Forecast	Original Full Year Forecast	Adjustments to end M08	Revised Full Year Forecast
Pay	34,586	33,543	1,043	333,425	330,277	3,148	412,056	(1,549)	410,507
Non Pay	18,773	19,621	(848)	181,230	182,563	(1,333)	224,391	(1,020)	223,371
Covid Costs (in envelope)	1,066	1,447	(381)	17,285	17,732	(447)	6,394	0	6,394
Covid Costs (outside envelope)	-	806	(806)	-	1,461	(1,461)	-	0	-
Non-operating Costs	809	750	59	8,215	7,597	618	9,869		9,869
Remove impact of Donated Asset Depreciation	(37)	(37)	0	(371)	(371)	0	(445)		(445)
Total Cost	55,197	56,130	(933)	539,784	539,258	526	652,265	(2,569)	649,696
Run Rate Funding / Billable Income	(53,568)	(55,089)	1,521	(508,571)	(512,018)	3,447	(636,749)	(1,355)	(638,104)
Covid Income (outside envelope)		(805)	805		(1,461)	1,461			
Total (Surplus) / Deficit	**1,629**	**236**	**1,393**	**31,213**	**25,779**	**5,434**	**15,516**	**(3,924)**	**11,592**
True-up Funding	0	0	0	(21,883)	(21,883)	0	0		
Grand Total (Surplus) / Deficit	**1,629**	**236**	**1,393**	**9,330**	**3,896**	**5,434**	**15,516**	**(3,924)**	**11,592**

Activity Position Compared to Plan

Gloucestershire Hospitals NHS Foundation Trust

For Month 10 we delivered 82% of planned delivery. We expected to increase activity by 16% month-on-month, but instead we performed 2% less activity than the previous month. This reduction is attributable to the impact of Covid surge 2 and the impact on our bed base and our elective activity capacity.

The number of beds moved from surgery to medicine to assist with the Covid response is reflected in the surgery under-delivery of activity, where we expected to increase activity 16% month-on-month, but actually reduced by 13%.

Our financial position reflects the associated reduced variable costs of lost activity and contributes towards our position financially being better than plan, although this is to the detriment of our patients and our waiting lists.

Summary Activity Increase Month on Month - BI figures day 5

	Month 9 Plan	Month 9 Actual	Month 9 Variance	Month 10 Plan	Month 10 Actual	Month 10 Variance	Month 10 % of Plan Delivered	MoM increase / (Decrease)	Planned MoM Increase / (decrease) % *	Actual MoM increase / (decrease) %
W&C	9,470	7,639	(1,831)	10,387	7,649	(2,738)	74%	10	10%	0%
Surgery	31,818	26,038	(5,780)	36,865	22,758	(14,107)	62%	(3,280)	16%	(13%)
Medicine	33,768	25,397	(8,371)	35,765	24,363	(11,402)	68%	(1,034)	6%	(4%)
D&S	219,520	227,187	7,667	258,346	224,524	(33,822)	87%	(2,663)	18%	(1%)
Corp (Unid'd)	0	191	191	0	152	152	0%	(39)	0%	(20%)
Total	**294,576**	**286,452**	**(8,124)**	**341,363**	**279,446**	**(61,917)**	**82%**	**(7,006)**	**16%**	**(2%)**

* nB Planned MoM increase was on a starting level of activity not achieved in Month 9

Balance Sheet

Trust Financial Position	Opening Balance 31st March 2020 £000	GROUP Balance as at M10 £000	B/S movements from 31st March 2020 £000
Non-Current Assests			
Intangible Assets	5,851	6,202	351
Property, Plant and Equipment	257,352	260,341	2,989
Trade and Other Receivables	5,889	5,782	(107)
Total Non-Current Assets	**269,092**	**272,325**	**3,233**
Current Assets			
Inventories	9,121	8,697	(424)
Trade and Other Receivables	31,268	26,590	(4,678)
Cash and Cash Equivalents	37,385	87,383	49,998
Total Current Assets	**77,774**	**122,670**	**44,896**
Current Liabilities			
Trade and Other Payables	(79,872)	(86,296)	(6,424)
Other Liabilities	(3,401)	(46,341)	(42,940)
Borrowings	(132,582)	(4,398)	128,184
Provisions	(170)	(170)	0
Total Current Liabilities	**(216,025)**	**(137,205)**	**78,820**
Net Current Assets	**(138,251)**	**(14,535)**	**123,716**
Non-Current Liabilities			
Other Liabilities	(6,484)	(6,171)	313
Borrowings	(40,609)	(37,665)	2,944
Provisions	(2,850)	(2,850)	0
Total Non-Current Liabilities	**(49,943)**	**(46,686)**	**3,257**
Total Assets Employed	**80,898**	**211,104**	**130,206**
Financed by Taxpayers Equity			
Public Dividend Capital	179,302	313,773	134,471
Reserves	29,891	29,891	0
Retained Earnings	(128,295)	(132,560)	(4,265)
Total Taxpayers' Equity	**80,898**	**211,104**	**130,206**

Gloucestershire Hospitals
NHS Foundation Trust

The table shows the M10 group balance sheet and movements from the 2019/20 closing balance sheet.

Current Assets
The movement in inventories relates to pharmacy stock.

Trade and other receivables balances have reduced. This mainly relates to accrued debt which is reflected in the cash position.

Cash has increased by £49.9m; the majority of this relates to the payment we received in April 2020 of an extra month of SLA income. This will be reduced again in March 2021.

Current Liabilities
Trade and other payables have increased by £6.4m. Other liabilities have increased by £42.9m; again this mainly relates to the advance month of SLA income and will reduce in March 2021.

Cash Flow

Gloucestershire Hospitals
NHS Foundation Trust

Cashflow Analysis	Apr-20 £000s	May-20 £000s	Jun-20 £000s	Jul-20 £000s	Aug-20 £000s	Sep-20 £000s	Oct-20 £000s	Nov-20 £000s	Dec-20 £000s	Jan-21 £000s	Forecast Movement February 21 to March 21 £000s	Forecast Outturn £000s
Surplus (Deficit) from Operations	**818**	**954**	**1,035**	**908**	**967**	**92**	**(3,708)**	**2,602**	**(271)**	**(65)**	**(5,028)**	**(1,696)**
Adjust for non-cash items:											**0**	**0**
Depreciation	1,509	1,509	1,509	1,509	1,509	1,509	1,509	1,509	1,509	1,509	**2,898**	**17,988**
Other operating non-cash	0	0	0	0	0	0	0	0	0	0	**1,500**	**1,500**
Operating Cash flows before working capital	**2,327**	**2,463**	**2,544**	**2,417**	**2,476**	**1,601**	**(2,199)**	**4,111**	**1,238**	**1,444**	**(630)**	**17,792**
Working capital movements:												
(Inc.)/dec. in inventories	221	232	(57)	(152)	116	(429)	157	41	(215)	510	**(417)**	**7**
(Inc.)/dec. in trade and other receivables	(4,178)	10,065	(797)	(7,991)	1,749	(2,843)	(4,979)	16,338	2,737	(5,423)	**(12,787)**	**(8,109)**
Inc./(dec.) in current provisions	0	0	0	0	0	0	0	0	0	0	**0**	**0**
Inc./(dec.) in trade and other payables	35,152	(5,229)	(44,038)	7,110	2,503	3,027	3,933	(4,927)	1,119	4,722	**(8,007)**	**(4,635)**
Inc./(dec.) in other financial liabilities	7,099	(4,559)	41,320	(1,168)	2,140	1,665	(4,988)	7,417	(1,687)	(4,299)	**(42,790)**	**150**
Net cash in/(out) from working capital	**38,294**	**509**	**(3,572)**	**(2,201)**	**6,508**	**1,420**	**(5,877)**	**18,869**	**1,954**	**(4,490)**	**(64,001)**	**(12,587)**
Capital investment:												
Capital expenditure	(1,667)	(1,667)	(1,729)	(882)	(1,737)	(2,149)	(1,417)	(4,584)	(807)	(1,021)	**(24,909)**	**(42,569)**
Capital receipts	0	0	0	0	0	0	0	0	0	0	0	**0**
Net cash in/(out) from investment	**(1,667)**	**(1,667)**	**(1,729)**	**(882)**	**(1,737)**	**(2,149)**	**(1,417)**	**(4,584)**	**(807)**	**(1,021)**	**(24,909)**	**(42,569)**
Funding and debt:												
PDC Received	0	0	0	353	0	127,860	0	6,258	0	0	**16,346**	**150,817**
Interest Received	11	0	0	0	0	0	0	0	0	0	**0**	**11**
Interest Paid	0	0	0	0	(658)	(525)	0	0	0	0	**(658)**	**(1,841)**
DH loans - received	0	0	0	0			0	0	0	0	**0**	**0**
DH loans - repaid	0	0	0	0	0	(129,180)	0	0	0	0	**(865)**	**(130,045)**
Finance lease capital	(95)	(95)	(95)	(488)	(488)	(488)	(488)	(488)	(488)	(488)	**(976)**	**(4,677)**
Interest element of Finance Leases	(17)	(17)	(17)	(12)	(12)	(12)	(13)	(13)	(13)	(13)	**(26)**	**(165)**
PFI capital element	(43)	(43)	(43)	(68)	(68)	(68)	(68)	(68)	(68)	(68)	**(136)**	**(741)**
Interest element of PFI	(182)	(182)	(182)	(38)	(38)	(38)	(38)	(38)	(38)	(38)	**(76)**	**(888)**
PDC Dividend paid						0		(1,040)			**(4,204)**	**(5,244)**
Net cash in/(out) from financing	**(326)**	**(337)**	**(337)**	**(253)**	**(1,264)**	**(2,451)**	**(607)**	**4,611**	**(607)**	**(607)**	**9,405**	**7,227**
Net cash in/(out)	**38,628**	**968**	**(3,094)**	**(919)**	**5,983**	**(1,579)**	**(10,100)**	**23,007**	**1,778**	**(4,674)**	**(80,135)**	**(30,137)**
Cash at Bank - Opening	**37,385**	**76,013**	**76,981**	**73,887**	**72,968**	**78,951**	**77,372**	**67,272**	**90,279**	**92,057**	**87,383**	**37,385**
Closing	**76,013**	**76,981**	**73,887**	**72,968**	**78,951**	**77,372**	**67,272**	**90,279**	**92,057**	**87,383**	**7,248**	**7,248**

Recommendations

Gloucestershire Hospitals NHS Foundation Trust

The Committee is asked to:

- Note the Trust is reporting a year to date deficit of £3.90m, £5.43m better than the planned £9.33m deficit. The position does not include any financial penalties for under-achievement of activity against the elective incentive scheme.
- Note that the system forecast deficit is £28.4m for the second half of the year, when there is no retrospective true-up. This does not yet include the improvement to our Trust forecast.
- Note that the GHFT deficit forecast for the second half of the year is £11.6m, an improvement of £3.9m since the plan was submitted. This includes an annual leave provision, and the expectation that the Gen Med Vat provision is not supported by NHSE, despite us continuing to push for this to be funded.

Authors: **Johanna Bogle, Associate Director of Financial Management**

Presenting Director: **Karen Johnson, Director of Finance**

Date: **February 2021**

Gloucestershire Hospitals
NHS Foundation Trust

REPORT TO TRUST BOARD – 11 March 2021

From: The Finance and Digital Committee Chair – Rob Graves, Non-Executive Director

This report describes the business conducted at the Finance and Digital Committee held on 25 February 2021, indicating the NED challenges made and the assurances received and residual concerns and/or gaps in assurance.

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
Financial Performance Report	Review of the month 10 financial position which in-month recorded a £0.24 million deficit compared to a plan pf £1.63 million deficit principally reflecting activity 18% below plan. The year's estimate is now a deficit pf £11.6 million which is £3.9 million less than plan resulting from the continued shortfall in activity and additional block income from NHSE/I following revised calculation.	Had the position changed in respect of penalties for missed activity targets? What is the status of the accounting treatment for GENMED?	No penalties are included in the projections The extra costs are included in the year-end position	
Capital Programme Report	Detailed review of the plans to spend the year's allocated funding of £37.4 million plus £3.8 from donations and government grants. £19.3 remains to be spent in the final 2 months of the year. Review of the draft 21/22	What is the risk that capital will be forfeited at year end though non-completion of projects?	While it is not unusual to have a large unspent balance at this stage of the year it is possible there could be unused capital at year end. Comprehensive monitoring is taking place to minimise this risk	Continued oversight of the spending plans and associated actions

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
	plan – which had yet to be formally notified by the centre.	Does the current significant unspent balance indicate capability and capacity limitations in the Trust?		The trust will consider a more proactive approach to allocating funds from the capital programme capital for project management.
Planning Budget Setting	Update of the current approach to budget setting in the absence of a national framework. Agreement on an approach that sets operating budgets including target cost improvements.	What is the executive view of the indicative Cost Improvement Target? Is there adequate focus on transformation programmes?	Further productivity savings are difficult to achieve making transformation programmes more important Scope to learn from others is limited with the continuing focus on grip & control and recovery.	CIP update planned for March meeting.
Proposed New Ledger	The Committee had previously been advised of the 2022 date when the current finance and procurement system contract will end. The briefing focussed on the considerations associated with replacing this 20+ year old system.	Challenges in an extensive discussion covered: - The need to look beyond system used by partner organisations - What is a realistic timescale? - The approach to securing effective project management expertise - The size and scope of the opportunity and the importance of wide-ranging	Further analysis will take place and the Committee will be kept informed.	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
		initial thinking		
Fit For The Future Decision Making Business Case	A Further update of the evolution of the financial analysis supporting the draft Decision Making Business case.	What is the level of confidence in achieving the risk mitigations?	Detailed explanation of progress and timetable provided assurance and the committee approved the paper.	
Digital Aspirant Funding Agreement	The Trust has been accepted as a "Digital Aspirant". This status brings the benefit of an additional £6million of capital over the next 3 years provided the Trust match funds at 100%.	Is there a risk that the Trust could not match fund this supplementary funding?	The expected level of capital allocation to the Trust and its planned deployment will meet the matching requirement.	Proposed that the Committee has a further review of the long term digital plans.
Integrated Care System Update	Update on the system wide process to prepare for the 21/22 planning round. Clear explanation of the complexities associated with a dynamic situation.		The committee continues to be assured of the high level of communication and co-operation between partner organisations.	

Rob Graves
Chair of Finance and Digital Committee
4th March 2021

Gloucestershire Hospitals
NHS Foundation Trust

Trust Public Board – 11 MARCH 2021
Microsoft Teams, commencing at 12:30

Report Title
People and Organisational Development Report: Performance Dashboard (Abridged) and assurance on management of Employee Relations cases as per Baroness Dido Harding's recommendations
Sponsor and Author(s)
Authors: Alison Koeltgen, Operational Director of People and Organisational Development. Sara Bowen, Human Resources Business Partner & Emma Wood, Deputy CEO and Director of People and Organisational Development Sponsoring Director: Emma Wood, Deputy CEO and Director of People and Organisational Development

Executive Summary

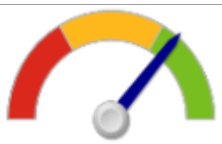
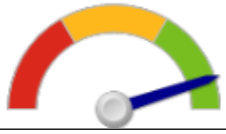
Purpose

This paper is in two halves.

The first is an **abridged** Performance Dashboard highlighting the main operational performance measures monitored by the Trust, and the second is assurance on how the Trust has complied with the recommendations set out by a review chaired by Baroness Harding on Trusts management of Employee Relations cases.

Performance dashboard

The Performance dashboard aligns to the strategic and operational measures identified within the People and Organisational Development Strategy. Key measures detailed within are benchmarked (where appropriate) to Model Hospital Peer rates and University Hospital/ Teaching Peer rate. The indicators include:

Retention, Turnover, Vacancy	
Appraisal	
Mandatory Training	
Sickness Absence	

The dashboard has been reconfigured to focus on exceptions to the overarching performance indicators, with a deep dive into the medical division as requested. Each indicator includes a subset of linked measures set out in the People and OD Strategy, aligning to our long term plan. More detail is provided at Annex 1.

The Board are advised performance is good with the exception of appraisal compliance.

Employee Relations assurance

In May 2019, Baroness Dido Harding wrote to NHS Foundation Trust chairs and chief executives detailing the outcomes of an important piece of work she had undertaken in response to a very tragic event that occurred at a London NHS Trust during 2015 (annex 2)

The People and OD Committee (PODC) have taken assurance at two committee meetings, outcomes reflected in the subsequent chairs reports, that the Trust complies with the principles of best practice when undertaking formal employment relations casework and meets the requirements incumbent upon organisations as articulated in the Baroness Dido Harding report.

The PODC were provided a report on our case management profiles in October 2020 and an update on how the Trust continues to meet the requirements of establishing a just and learning culture in February 2021. The Committee were appraised in October of the 438 formal cases reported in the period 01 April 2019 to 31 March 2020 including detail on reason for the case and protected characteristics of colleagues within processes and outcomes. The report indicated the improvements made in managing cases including improving the timelines of case management (reducing the average time from six months to two). In the period reported the Trust had just one Employment Tribunal case which was successfully defended.

The reports provided assurance on our:

- Adherence to best practice and how the Trust learns from casework;
- Application of rigorous decision making when deciding if we should progress a case or not and the involvement of Divisions in this process;
- Processes to ensure people involved in the application of formal processes are fully trained and competent to carry out their role;
- How we assign sufficient resources and casework to meet timescales;
- How we make decisions relating to the implementation of suspensions/ exclusions;
- Accountability and oversight through the People and OD Delivery Group and Executive Review process;
- Just and learning culture approach involving our diversity network to review cases to ensure we can jointly challenge and identify any cases raised which may suggest inequitable treatment on the basis of a protected characteristic. Processes also allow for a ‘stepping off’ arrangement;
- Our proactive welfare support for colleagues who are party to a formal case including agreeing a specific welfare officer and extending the support through the Peer Supporter Group and the 2020 Hub.

Next steps:

To meet the requirement of the Dido Harding recommendations the PODC will continue to receive updates which will be provided on a quarterly basis to ensure the Board are satisfied that the Trust has:

‘Mechanisms by which comprehensive data relating to investigation and disciplinary procedures is collated, recorded, and regularly and openly reported at board level. Associated data collation and reporting should include, for example: numbers of procedures; reasons for those procedures; adherence to process; justification for any suspensions/exclusions; decision-making relating to outcomes; impact on patient care and employees; and lessons learnt.’

Recommendations
Performance dashboard: It is recommended that the Board are assured that three of the four key indicators are green. It is recognised that appraisal rates will be impacted by the challenges of working through a pandemic, however divisions remain focused in their efforts to improve these rates. Sufficient controls exist to monitor performance against key workforce priorities. Where operational improvements are required, actions are fed into the appropriate work streams, monitored by the People and Organisational Development Delivery Group. Where Divisional exceptions are highlighted this is challenged and monitored through the Executive Review process. **Employment Relations:** This report provides Board level oversight into our people management processes in relation to a Just and Learning culture. The report indicates the progress we have to embed these practices and the means by which the PODC will be appraised of progress.
Impact Upon Strategic Objectives
Performance measures and a just and learning culture link to the delivery of a compassionate, skilful and sustainable workforce, organised around the patient that describes us as an outstanding employer who attracts, develops and retains the very best people.
Impact Upon Corporate Risks
Workforce stability is a critical part of our plans to mitigate the risk associated with the limited supply of key occupational groups such as Nurses, AHPs and Medical staff. We are on track to achieve the measures outlined within our People and OD strategy, whilst recognising the risks and issues associated with turnover in key roles/ departments. Whilst there is no direct impact on corporate risks, a just and learning culture is critical to the safe management of employment matters and impacts on employee experience, engagement, a compassionate workforce and workforce retention. Good case management reduces the risk of Employment Tribunal claims which may result in financial penalties and reputational damage.
Regulatory and/or Legal Implications
The report provides assurance that the Trust are operating in accordance with: NHSI/E requirements Best practice and employment legislation, including the Equality Act. The aspirations of the NHS People Plan.
Equality & Patient Impact
There is a known researched link between employee experience, stability, retention and patient experience. The People and Organisational Development Strategy promotes a culture of 'caring for those who care', who in turn will enhance the experience of our patients.

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

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

Date the paper was presented to previous Committees						
Quality & Performance Committee	**Finance Committee**	**Audit & Assurance Committee**	**People and OD Committee**	**Remuneration Committee**	**Trust Leadership Team**	**Other (specify)**
			N/A for performance report			

			October 2020 and February 2021 for ER assurance			

Outcome of discussion when presented to previous Committees

The Committee were assured in October 2020 that the improvement plan to reduce the time cases take to resolve and consider how to embed just and learning cultures and approach any disproportionate impact of ER processes on BAME candidates was in place.
The Cmmittee were assured in February 2021 that the improvement plan was RAG rated green and progress and data sets would continue to be provided by the People and OD team on a quarterly basis.

WORKFORCE SUSTAINABILITY - Vacancy Factor and Supply Pipelines		
Strategic Measure	**Performance**	**Exception Report**
Reduce Vacancy factor from 9% to 5% (long term plan) reduce by 0.75-1% per annum as a minimum. Improve attraction and pipeline of Nurses – establish a pipeline that looks to improve the supply of Nurses by 5-10% annually.		December's vacancy rate of 6.07% has been calculated from establishment data loaded onto ESR. The % Rate represents 422 vacancies Trust-wide, an increase of two since the November figures reported to PODC in December. We remain on track to meet the long term strategic measure. **Nurse Vacancies** Using ESR establishment data the combined December Staff Nurse/ODP vacancy rate of 15.26%. Registered Nursing & Midwifery as a staff group has a VR rate of 8.87% (203 vacancies). **Medical Staffing** The Medical staffing vacancy rate is reported at 1.43%, translating to a shortfall of 12.9fte. **D&S Division** The current radiography vacancy rate is 15.19%. However, turnover rates are low at 8.75%, meaning the anticipated arrival of ten overseas Radiographers by April 2021 will make a small improvement to this vacancy figure. In addition we welcomed the arrival of our first cohort of Radiography trainees from Gloucestershire University in January 2021 – supporting the specialty workforce plan objectives and improving the long term supply of resource into this area. **Medicine Division** Vacancy rates remain stable within the Division (6.6%), two highest areas of concern being Nursing & Midwifery and Healthcare Scientists.
WORKFORCE SUSTAINABILITY - Turnover		
Reduce Turnover to meet top quartile in model hospital. Aim in year 1 to achieve national median and in year 2 next best peer. By year 5 match best in model hospital peers (moving year on year target) Reduce Health Care Assistant turnover from 15.5% to 10% **by 2024**, by reducing by 1% year on		The rolling annual turnover rate shows a consistent gradual decrease since 2019 and is reported at 9.45%, placing the Trust in the top quartile for retention when benchmarked to the Model Hospital Peer Group. Registered Nurse Retention figures remain consistently higher than Model Hospital Peers **Non-Registered Nurse Turnover** has reduced to 13.44% (from 16.46% in March 2020), keeping us on track to achieve our long term strategic measure of a reduction to 10% by 2024. Funding from NHS England has been received (£190k) to support the recruitment of Health Care Support Workers to help reduce our vacancy position of c90 to as close to zero, as a pipeline of candidates by April 2021 **Medicine Division** has the highest Turnover rate for non-registered nursing staff at 18.2% (35.69 fte

year. Reduce Admin and Clerical turnover from 13% to 10% **by 2024**, by reducing by 0.75% year on year.		leavers).
Operational Measure	**Performance**	**Exception Report**
Appraisal 90%		Trust Appraisal rate is currently 82%, falling below the 90% target. Compliance across all divisions has reduced with the exception of Diagnostic & Specialties. The lowest Divisional Appraisal rate is the **Corporate Division, reporting further decline to 75% compliance.** This is the Division has the highest proportion of staff working from home, however managers have been reminded that whilst virtual (MS Teams) appraisals may not be preferred, they are encouraged, to continue to support our staff.
Statutory/Mandatory Training 90%		Trust compliance overall remains high at 93%, supported by the increased digitalization of programmes using more videos and eLearning. **All divisions have achieved the target of 90%,** ranging from medicine at 91% to 95% by both Corporate and D&S.
Strategic Measure	**Performance**	
Absence rate to meet best peers from model hospital and aim to reduce by 1% per annum		**Non-Covid absence** remains low and below 2019 figures (3.69%). However, with Covid-19 sickness absence out absence rate has increased to 5.41% During 2020 we observed a 7% increase to sickness absence related to mental health. We are preparing our staff support and wellbeing services for a continued increase to this trend during 2021 We are currently shortlisting and interviewing to our new Psychology Link Worker posts, funded by NHS Charities together, whilst we integrate our existing staff support offer into the People and OD Department. In addition we are rolling out further training in TRiM for nominated TRiM Managers and Peer Support staff, whilst we prepare a trauma training package for managers (to be delivered by our new Psychology Link worker staff). As the Trust vaccination programme is rolled out we are observing a significant decrease in Covid associated staff absence. We will be in a position to report on this decrease more accurately at the next Committee, as we validate the absence reporting in arrears.

Annexe 2

Chief Executive and Chair's Office
Wellington House
133-155 Waterloo Road
London SE1 8UG

Tel: 020 3747 0000

To: NHS trust and NHS foundation trust chairs and chief executives

24 May 2019

Dear colleagues

Learning lessons to improve our people practices

I am writing to share with you the outcomes of an important piece of work recently undertaken in response to a very tragic event that occurred at a London NHS trust three years ago.

In late 2015, Amin Abdullah was the subject of an investigation and disciplinary procedure. The protracted procedure culminated in Amin's summary dismissal on the grounds of gross misconduct. Tragically, in February 2016 just prior to an arranged appeal hearing, Amin took his own life. This triggered the commissioning of an independent inquiry undertaken by Verita Consulting, the findings of which were reported to the board of the employing Trust and to NHS Improvement in August 2018. The report concluded that, in addition to serious procedural errors having been made, throughout the investigation and disciplinary process Amin was treated very poorly, to the extent that his mental health was severely impacted. Verita's recommendations were accepted by the Trust, in full, and have largely been implemented.

Subsequently, NHS Improvement established a 'task and finish' Advisory Group to consider to what extent the failings identified in Amin's case are either unique to this Trust or more widespread across the NHS, and what learning can be applied. Comprising of multi-professional stakeholders and subject matter experts representing both the NHS and external bodies, together with an advocate for Amin's partner, the Group conducted an independent analysis of both the Verita findings and several historical disciplinary cases, the outcomes of which had attracted criticism in Employment Tribunal proceedings and judgements. HR directors of provider organisations were advised of the Group's activity and invited to share details of any local experiences and/or examples of measures being taken to improve the management of employment issues.

The analysis highlighted several key themes associated with the Verita inquiry which were also common to other historical cases considered. Principal among these were: poor framing of concerns and allegations; inconsistency in the fair and effective

application of local policies and procedures; lack of adherence to best practice guidance; variation in the quality of investigations; shortcomings in the management of conflicts of interest; insufficient consideration and support of the health and wellbeing of individuals; and an over-reliance on the immediate application of formal procedures, rather than consideration of alternative responses to concerns.

The NHS England and NHS Improvement People Committees in Common received a detailed report on the outcomes of the Advisory Group's activities, which included recommendations that aim to ensure the captured learning is used to best effect in informing positive changes across the NHS. The Committees recognised that, sadly, Amin's experiences are far from unique and acknowledged there needs to be greater consistency in the demonstration of an inclusive, compassionate and person-centred approach, underpinned by an overriding concern to safeguard people's health and wellbeing, whatever the circumstances. This view certainly echoed many of the comments we have received from across the NHS during our recent People Plan engagement.

Some of the proposed recommendations will require further discussion with key stakeholders, including regulatory and professional bodies (in particular, I am keen that consideration and assessment of the 'health' of organisational culture, including aspects relating to the management of workplace issues, is given more prominence in the 'well-led' assessment domain). The majority, though, can be immediately received and applied.

Enclosed with this letter is additional guidance relating to the management and oversight of local investigation and disciplinary procedures which has been prepared based on the Advisory Group's re commendations. You will recognise the guidance as representing actions characteristic of responsible and caring employers and which reflect our NHS values. I would ask that you, your HR team and your Board review them and assess your current procedures and processes in comparison and, importantly, make adjustments where required to bring your organisation in line with this best practice. I would draw your attention to item 7 of the guidance and ask you to consider how your Board oversees investigations and disciplinary procedures. Further, with respect to any cases currently being considered and all future cases, I would ask you to review the following questions (and, where necessary, take corrective action in response):

- Is there sufficient understanding of the issues or concerns, and the circumstances relating to them, to justify the initiation of formal action?

- Considering the circumstances, in the eyes of your organisation and others external to it, would the application of a formal procedure represent a proportionate and justifiable response (i.e. have other potential responses and remedies, short of formal intervention, been fully assessed before being discounted)?

- If formal action is being or has been taken, how will appropriate resources be allocated and maintained to ensure it is conducted fairly and efficiently; how are you ensuring that independence and objectivity is maintained at every stage of the process?

- What will be the likely impact on the health and wellbeing of the individual(s) concerned and on their respective teams and services, and what immediate and ongoing direct support will be provided to them? Further, how will you ensure the dignity of the individual(s) is respected at all times and in all communications, and that your duty of care is not compromised in any way, at any stage.

- For any current case that is concluding, where it is possible that a sanction will be applied, are similar questions being considered?

In highlighting these issues, which I know will be important to you and your teams, I would like to thank all those colleagues who directly contributed to and informed the work completed by the Advisory Group. I would particularly like to acknowledge the endeavours of Amin's partner Terry Skitmore and his advocate Narinder Kapur, without whose dedication and sacrifices the Amin Abdullah inquiry and subsequent development work by NHS Improvement would not have taken place.

I know that we are all keen to ensure we treat our people fairly and protect their wellbeing. Implementing the attached guidance consistently well across the NHS will contribute to that goal. It is tragic that we are learning these lessons after Amin's death, but we owe it to him and the others who have suffered in similar circumstances to act now.

Thank you for your attention to these vital issues.

Best wishes

Baroness Dido Harding
Chair, NHS Improvement

Enclosure:
Additional guidance relating to the management and oversight of local investigation and disciplinary procedures

Copies:
Chair, Care Quality Commission
Chair, NHS Providers
Chair, Nursing and Midwifery Council
Chief Executive, NHS Employers

Additional guidance relating to the management and oversight of local investigation and disciplinary procedures

1. Adhering to best practice
a) The development and application of local investigation and disciplinary procedures should be informed and underpinned by the provisions of current best practice, principally that which is detailed in the Acas 'code of practice on disciplinary and grievance procedures' and other non-statutory Acas guidance; the GMC's 'principles of a good investigation'; and the NMC's 'best practice guidance on local investigations' (when published).
b) All measures should be taken to ensure that complete independence and objectivity is maintained at every stage of an investigation and disciplinary procedure, and that identified or perceived conflicts of interest are acknowledged and appropriately mitigated (this may require the sourcing of independent external advice and expertise).

2. Applying a rigorous decision-making methodology
a) Consistent with the application of 'just culture' principles, which recognise that it is not always appropriate or necessary to invoke formal management action in response to a concern or incident, a comprehensive and consistent decision-making methodology should be applied that provides for full and careful consideration of context and prevailing factors when determining next steps.
b) In all decision-making that relates to the application of sanctions, the principle of plurality should be adopted, such that important decisions which have potentially serious consequences are very well informed, reviewed from multiple perspectives, and never taken by one person alone.

3. Ensuring people are fully trained and competent to carry out their role
Individuals should not be appointed as case managers, case investigators or panel members unless they have received related up to date training and, through such training, are able to demonstrate the aptitude and competencies (in areas such as awareness of relevant aspects of best practice and principles of natural justice, and appreciation of race and cultural considerations) required to undertake these roles.

4. Assigning sufficient resources
Before commencing investigation and disciplinary procedures, appointed case managers, case investigators and other individuals charged with specific responsibilities should be provided with the resources that will fully support the timely and thorough completion of these procedures. Within the overall context of 'resourcing', the extent to which individuals charged with such responsibilities (especially members of disciplinary panels) are truly independent should also be considered.

5. Decisions relating to the implementation of suspensions/exclusions
Any decision to suspend/exclude an individual should not be taken by one person alone, or by anyone who has an identified or perceived conflict of interest. Except where immediate safety or security issues prevail, any decision to suspend/exclude should be a measure of last resort that is proportionate, timebound and only applied when there is full justification for doing so. The continued suspension/exclusion of any individual should be subject to appropriate senior-level oversight and sanction.

6. Safeguarding people's health and wellbeing
a) Concern for the health and welfare of people involved in investigation and disciplinary procedures should be paramount and continually assessed. Appropriate professional occupational health assessments and intervention should be made available to any person who either requests or is identified as requiring such support.
b) A communication plan should be established with people who are the subject of an investigation or disciplinary procedure, with the plan forming part of the associated terms

of reference. The underlying principle should be that all communication, in whatever form it takes, is timely; comprehensive; unambiguous; sensitive; and compassionate.
c) Where a person who is the subject of an investigation or disciplinary procedure suffers any form of serious harm, whether physical or mental, this should be treated as a ‘never event’ which therefore is the subject of an immediate independent investigation commissioned and received by the board. Further, prompt action should be taken in response to the identified harm and its causes.

7. Board-level oversight
Mechanisms should be established by which comprehensive data relating to investigation and disciplinary procedures is collated, recorded, and regularly and openly reported at board level. Associated data collation and reporting should include, for example: numbers of procedures; reasons for those procedures; adherence to process; justification for any suspensions/exclusions; decision-making relating to outcomes; impact on patient care and employees; and lessons learnt.

Gloucestershire Hospitals
NHS Foundation Trust

REPORT TO TRUST BOARD – REPORT TO TRUST BOARD – 11 March 2021

From the People & Organisation Development Committee Chair – Balvinder Kaur Heran, Non-Executive Director

This report describes the business conducted at the People and Organisational Development Committee on 23 February 2021 indicating the NED challenges made and the assurances received and residual concerns and/or gaps in assurance.

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
Risk Register	People and OD Delivery Group are monitoring the increase in mental health absence. The COVID19 related anxiety and depressive disorders risk has not increased. The Trust provision for improving mental health support continues with appointment of new psychology roles and roll out of TRIM. From a service point of view the Trust has good health and wellbeing services for both proactive and reactive purposes.	Will Board receive a staff/people recovery plan alongside the operational recovery plan?	Divisions are thinking and planning recovery and giving thought to how staff may have time to recover. This will be subject to national planning and expectations which are yet to be published.	The Committee were assured that work was on-going to support the increased absence rates linked to mental health and would be kept updated on any issues. People recovery plan will form part of the Board recovery paper scheduled for May.
		Will the rollout of trauma training impact operationally?	Roll out has been fast tracked to meet Divisional demand. There is flexibility of training provision. There will be 24 sessions over 6	Committee assured that training slots and approaches were flexible to work around shifts and availability and Divisions encouraged to nominate staff

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
		How do we help staff before they ask for it?	months (Reaching 250 people). Divisions were asked to nominate people who had capacity to take on this role. There are lots of ways we seek out staff who may need help from TRIM, dedicated resource on resilience training, Peer Supporters, 2020 hub, role of the Team Support Group in determining areas which may be in need of help, proactive deployment of Psychological Link Worker.	where capacity allowed. An update on gaps/Divisions not able to nominate sufficient resources to be provided to the Committee.
Gender Pay Gap	The Trust has an overall Pay gap of 28.6% in favour of males impacted largely by medical grades. The committee were advised on the impact Terms and conditions have in establishing this gap - pay based on length of service, given we have more men with longer service. CEA awards historically favoured those who worked above contract hours which had a disproportionate impact on	Are the national terms and conditions aligned with the Equality Act? 64% of Trainee doctors are female and this may neutralising the gap in time, but many females leave. How can we mitigate that?	The national terms will have had an equality test at point of design. National agenda on changing the terms and conditions is complex. NHS Employers are consulting on new CEA awards and SAS doctor grades where BAME doctors are well represented. There is a lead representing doctors who	Committee assured that the work on the pay gap was being reviewed in line with national guidance and consultations with national bodies would provide greater insight on impact on terms and conditions. Requested that the Committee receive updates on progress.

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
	females. Over the last few years, the Trust has worked with female doctors to apply for CEA awards and proportionately female applicants are now more successful than males. For agenda for change grades the gender pay gap is 3.9% in favour of males.	What are the issues with seniority for females? Why with the percentage of females within the Trust do we have a fewer females in senior leadership roles.	work part time and issues are raised in the Speciality Dr forum. Medical staffing and Education teams provide coaching and support to junior doctors, including education support. SAS Doctors support is best in class and would be a good model to replicate. The issue with seniority of females is being picked up within the Equality, Diversity and Inclusion agenda.	Requested that the Committee receive updates on progress.

Staff Survey Results	The staff survey is under embargo and the committee received a confidential briefing.	Outcomes/action plan to be reported to PODC	
Employee Relations Report	Dido Harding's letter of recommendations from 2019 were discussed and have been met	The committee were assured of the report and the committee asked to see	Case work detail provided to the Committee in October 2020 and will be provided again in April

	Assurance of ER case management is provided through the People and OD Delivery Group governance and will come on a quarterly basis to the People and OD Committee. Key actions outlined in October have progressed and were discussed. A further action has been added regarding the requirement to treat harm from an ER process as a 'never event'.	the data behind case work.	2021 and on a quarterly basis thereafter
Sustainable Workforce Review and Education, Learning and Development	Highlights included: - 268 apprentices a growth of 48 and the range of qualifications have risen from 34 to 41. - Our partnering universities are keen to increase the student numbers and HEE have supported this with funding. GHT made good early progress increasing placements by 30% in 2019/20 to over 650, - Many courses are now run virtually, resulting in time and cost-savings with only a minimal loss of activity – and no loss in quality. - Work force plans are in place - Succession planning for model employer aspirations is under way	What is the impact of the digital agenda – are any staff members being left behind? What are the greatest risks and concerns for the education teams and are you confident with your mitigations?	The Trust is offering blended learning and some training is still face to face but there may be some colleagues that aren't digitally enabled and could struggle with the approach but the objective of the learning teams is to try to provide a mixed approach. Capacity and burnout. Some staff in operational areas and concerned teams are stretched too thinly. Priorities for the next year must be managed including how to evaluate training in a virtual world and how we can research the impact of this.

Board note/matter for escalation

None

Balvinder Kaur Heran
Chair of People and OD Committee, 23 February 2021

Gloucestershire Hospitals NHS Foundation Trust

Trust Public Board - 11 March 2021
Microsoft Teams – Commencing at 12:30

Report Title
QUALITY AND PERFORMANCE REPORT
Sponsor and Author(s)
Author: Felicity Taylor-Drewe, Director Planned Care / Deputy COO Sponsor: Rachael De Caux, Chief Operating Officer
Executive Summary

Purpose

This report summarises the key highlights and exceptions in Trust performance for the January 2020 reporting period.

The Quality and Performance (Q&P) committee receives the Quality Performance Report (QPR) on a monthly basis. The supporting exception reports from Quality; Emergency Care; Cancer and Planned Care Delivery Groups support the areas of performance concerns.

Quality Strategy Improvement Plan
The Covid-19 pandemic continues to impact our services and our improvement programmes' lead quality indicators.

Infection Prevention and Control
Covid 19

Whilst the operational context for the Trust remains challenging, there are signs that the ongoing lockdown has impacted positively on community transmission and, more recently, on admissions to hospital. Following the decision to remove beds from our bed there has been a significant and continued reduction in the rate of nosocomial infections within our hospitals and the risk rating has been reduced accordingly.

Safety Domain - Safety Plan
Metric - never events
There were no new never events reported this month.

Deep Tissue Pressure Ulcers
Increased deconditioning in patients is a contributing factor to an increase in the number of deep tissue injury pressure ulcers acquired as an inpatient being reported in the Trust. On review of the cases, a lack of evidence of pressure ulcer risk assessment and subsequent interventions is also a factor on review of all cases. Cases are reviewed weekly at Preventing Harm Improvement Hub, and a Preventing Harm Council is being launched soon.

Falls
Falls per 1000 bed days have increased due to a number of factors; increased deconditioning, reduced visiting which decreases supervision, inability to fill enhanced care requests, multiple bed moves and transfers including late night. Further diagnostic work is being undertaken currently to support the falls reduction programme. The falls reduction programme is active and all cases with moderate harm or above are rapidly reviewed in Preventing Harm Hub, and the Preventing Harm Council is being launched soon.

Person Centred Care – caring domain

Metric - Friends and Family Test

January 2021 saw the highest positive score for FFT across all surveys since April 2020, with the Trust wide score reported at 93.1%, and all surveys showing a high response rate.

Inpatient and day case

The inpatient FFT score for January has seen a 4% increase to 89.7% positive score; there has also been an increase in the number of responses received, providing more validity to this improvement. There are still areas where we are receiving a lower number of responses each month, which does risk results being skewed either positively or negatively. The Patient Experience team are working with divisions to identify how the FFT scores and other survey feedback is being utilised to inform local improvement plans, and to offer additional routes for gaining patient experience feedback that can challenge or validate some of these scores in areas with lower numbers. This includes running bespoke local surveys to increase insight on areas potentially highlighted in the FFT feedback, as is currently happening in AMU, or to increase numbers or responses to provide a more representative experience. This is ongoing and will be monitored monthly through QDG

Outpatient
The outpatient FFT score for January has seen a slight increase to 94.7% positive score; the outpatient FFT score has been the most stable throughout Covid, having remained at >94% positive score for the last few months. Feedback on outpatient services is also being gathered through the Attend Anywhere remote consultation platform, which is also showing patients are reporting a positive experience of this service. We will continue to monitor and triangulate this data

PALs concerns closed within 5 days
In January, the PALS team closed 86% of cases within 5 days, which is a consistently improving metric since September 2020 when this was added to the QPR for monitoring and assurance. The PALS team are currently managing an increased volume of concerns coming in to the service, as well as supporting the 7 day Patient Support Service for relatives, while we have visiting restrictions in place, meaning the team capacity is stretched. The team have recruited two 3 month FTC PALS Advisors to support with managing this increase in volume while restrictions are in place, and they are due to start mid February which will build more resilience and capacity into the team to manage the increasing cases and increase the number of calls that can be closed within 5 days. There are additional challenges beyond capacity within the PALS team where some calls cannot be closed as we cannot get a response from clinicians due to capacity in wards/departments, and we will continue to work closely with and support divisions around responding to and closing these concerns.

Maternity Improvement Programme
The overarching improvement action plan will be reviewed at February's Q&P meeting, including a review of a number of metrics which have been included into the monthly QPR, based on a gap analysis completed against the Ockendon Report Standards.

Metric - % of women on a Continuity of Carer Pathway
Following additional funding from the CCG, a Continuity of Carer Improvement Plan is being developed to support the Trust reaching the 30% national target for women to be on a continuity of carer pathway

Metric - % C Section rate (Planned and emergency)
Continued diagnostic work is going on in this area

Metric - % of women that have an induced labour
The induction of labour (IOL) rate has triggered "red" this month and highlights the need for work to be done by the Division. The service are currently undertaking deeper diagnostics to understand the cause of the higher rates of induction of labour. They will then deliver an improvement programme designed with colleagues based on these insights.

Clinical Outcomes and Effectiveness Domain

Dementia Care Improvement Programme - Metric FAIR Test

The manual audit for this indicator shows a consistent performance in screening the 30 case notes sampled, but is still below compliance, and as the Dementia Improvement Plan (DIP) has developed its performance dashboard, it should be noted that the sample size is approximately 10% of monthly dementia admissions. The dementia and delirium pathway process is currently being assessed for approval and discussions taking place to develop the EPR process to support the screening and assessment of delirium and dementia. A review of the Trust's dementia training is taking place to support the clinical pathway. In addition a recent Task & Finish Group as part of the ICS Dementia Steering Group has been established to achieve a one system approach to delirium.

Learning from Deaths Programme
Metric – SHMI and HSMR
Both indicators are now within the expected range.

Performance

During January the Trust did not meet the national standards or Trust trajectories for; A&E 4 hour standard and the 62 day cancer standard. There remains significant focus and effort from operational teams to support performance recovery.

In January 2021, the trust performance against the 4hr A&E standard was 66.82% including system performance was 77.82%.

In respect of RTT, we are reporting 69.8% for January 2021, whilst this is below the national standard; this is within the context of the Covid-19 position. Operational teams continue to monitor and manage the patients through clinical urgency within the capacity constraints.
Our performance against the cancer standard saw non-delivery in delivery for the 2 week standard at 90.1% (un-validated) for January. Indications are that performance for February will meet this standard. Cancer 62 day Referral to Treatment (GP referral) performance for January was 86.2% un-validated and 28 day performance is 77.1%

Key issues to note

The key areas of focus remain the assurance of patient care and safety during this time. Teams across the hospital continue to support each other to offer the best care for all our patients. Further details are provided within the exception reports.
Quality delivery (with the exception of those areas discussed) remains stable, with exception reporting from divisions through QDG for monitoring and assurance.

Recommendations
The Trust Board is requested to receive the Report as assurance that the Executive team and Divisions fully understand the current levels of non-delivery against performance standards and have action plans to improve this position, alongside the plans to clinically prioritise those patients that need treatment planned or un-planned during the pandemic.
Impact Upon Strategic Objectives
Current performance jeopardises delivery of the Trust's strategic objective to improve the quality of care for our patients.
Impact Upon Corporate Risks
Continued poor performance in delivery of the two national waiting time standards ensures the Trust

remains under scrutiny by local commissioners and regulators.

Regulatory and/or Legal Implications
No fining regime determined for 2020 within C-19 at this time, activity recovery aligned with Phase 3 requirements.

Resource Implications			
Finance		Information Management & Technology	
Human Resources		Buildings	

Action/Decision Required							
For Decision		For Assurance	✓	For Approval		For Information	

Date the paper was presented to previous Committees						
Quality & Performance Committee	**Finance & Digital Committee**	**Audit & Assurance Committee**	**People & OD Committee**	**Remuneration Committee**	**Trust Leadership Team**	**Other (specify)**
✓						
Outcome of discussion when presented to previous Committees						

NHS
Gloucestershire Hospitals
NHS Foundation Trust

Quality and Performance Report

Reporting Period January 2021

Presented at February 2021 Q&P and March 2021 Trust Board

Contents

Gloucestershire Hospitals NHS Foundation Trust

Executive Summary

Gloucestershire Hospitals NHS Foundation Trust

The key areas of focus remain the assurance of patient care and safety during this time. Key reductions in non-urgent elective care took place in December and January to support organisational response to Covid-19. This has led to a number of changes and opportunities to deliver patient care in an enhanced way. The Trust through support of IM&T colleagues has continued to embrace remote working with our patients & with Primary Care. For elective care (Cancer; Screening and RTT), all patients are being reviewed and clinically prioritised and national guidance enacted. We are ensuring that we are tracking all patients and that our waiting list size is consummate with those patients requiring secondary care opinion. For unscheduled care the approach has equally been to support the safety and care of our patients to enable them to access specialist emergency care as they need to. Teams across the hospital have supported each other to offer the best care for all our patients.

During January, the Trust did not meet the national standards for 52 week waits, diagnostics and the 4 hour standard.

The Trust performance (type 1) for the 4 hour standard in January was 68.82%, against the STP trajectory of 86.19%. The system did not meet the delivery of 90% for the system in January, at 77.82%.

The Trust did not meet the diagnostics standard for January at 24.59%. We have, as with many services prioritised same day diagnostics and support for patients to be prioritised post clinical review. The achievement of this standard has been majorly impacted by C-19, specifically endoscopy tests. MR and CT have recovered their waiting time position.

The Trust did not meet the standard for 2 week wait cancer at 90.1% in January but did meet the standard for 62 day cancer waits at 86.3%, this is as yet un-validated performance at the time of the report.

For elective care, the RTT performance is 69.67% (un-validated) in January, work continues to ensure that the performance is stabilised. Significant work is underway to reduce our longest waiting patients of over 52 weeks, of which there were 2,237 in January. This is as yet un-validated performance at the time of the report.

Directors Operational Group will review the Unscheduled and Scheduled performance indicators with the Divisions and the wider Executive team.

The Quality Delivery Group (QDG) continues to monitor the performance of the quality metrics with the Divisions providing exception reports. The delivery of any action plans to deliver improvement are also reviewed within the meeting. There are improvement plans in place for any indicators that have consistently scored in the “red” target area.

Performance Against STP Trajectories

Gloucestershire Hospitals NHS Foundation Trust

The following table shows the monthly performance of the Trust's STP indicators for 2019/20. RAG Rating: The STP indicators are assessed against the monthly trajectories agreed with NHS Improvement.
Note that data is subject to change.

Indicator		Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21
Count of handover delays 30-60 minutes	Trajectory	40	40	40	40	40	40	40	40	40	40	40	40	40
	Actual	161	105	105	61	57	88	78	166	140	152	166	333	286
Count of handover delays 60+ minutes	Trajectory	0	0	0	0	0	0	0	0	0	0	0	0	0
	Actual	10	5	2	0	0	5	1	36	21	42	95	440	336
ED: % total time in department – under 4 hours (types 1 & 3)	Trajectory	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%
	Actual	81.02%	82.33%	85.08%	89.93%	88.72%	89.94%	90.05%	83.26%	82.34%	80.21%	79.64%	77.06%	77.82%
ED: % total time in department – under 4 hours (type 1)	Trajectory	86.19%	85.36%	85.79%	85.32%	85.37%	85.17%	85.90%	85.22%	85.61%	85.89%	86.04%	85.99%	86.19%
	Actual	72.45%	72.41%	78.56%	87.46%	85.41%	85.06%	84.46%	73.53%	71.74%	68.96%	69.40%	65.43%	68.82%
Referral to treatment ongoing pathways under 18 weeks (%)	Trajectory	80.30%	80.60%	81.00%	81.00%	81.00%	81.00%	81.00%	81.00%	81.00%	81.00%	81.00%	81.00%	81.00%
	Actual	81.06%	81.41%	81.01%	73.61%	66.53%	59.06%	55.83%	60.07%	66.27%	69.36%	70.06%	68.84%	69.67%
Referral to treatment ongoing pathways over 52 weeks (number)	Trajectory	40	20	0	0	0	0	0	0	0	0	0	0	0
	Actual	28	14	33	156	366	694	1037	1233	1279	1285	1411	1602	2237
% waiting for diagnostics 6 week wait and over (15 key tests)	Trajectory	0.98%	0.98%	0.98%	0.99%	0.99%	0.99%	0.99%	0.99%	0.99%	0.99%	0.99%	0.99%	0.99%
	Actual	1.50%	1.16%	3.16%	41.95%	43.43%	29.54%	26.07%	25.49%	23.00%	17.50%	14.67%	14.04%	24.59%
Cancer – urgent referrals seen in under 2 weeks from GP	Trajectory	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%
	Actual	95.10%	96.10%	95.10%	90.60%	99.10%	98.00%	96.50%	90.80%	95.20%	93.10%	91.60%	93.70%	90.10%
2 week wait breast symptomatic referrals	Trajectory	93.20%	93.20%	93.20%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%
	Actual	96.30%	97.80%	98.40%	87.90%	97.80%	95.70%	96.40%	95.90%	93.40%	97.10%	85.20%	91.80%	70.60%
Cancer – 31 day diagnosis to treatment (first treatments)	Trajectory	96.20%	96.20%	96.20%	96.00%	96.00%	96.00%	96.00%	96.00%	96.00%	96.00%	96.00%	96.00%	96.00%
	Actual	95.50%	94.30%	95.50%	96.60%	96.00%	95.30%	98.10%	96.70%	96.40%	99.30%	99.30%	97.60%	97.70%
Cancer – 31 day diagnosis to treatment (subsequent – drug)	Trajectory	98.00%	98.00%	98.00%	98.00%	98.00%	98.00%	98.00%	98.00%	98.00%	98.00%	98.00%	98.00%	98.00%
	Actual	100.00%	100.00%	100.00%	100.00%	100.00%	94.00%	97.00%	100.00%	100.00%	100.00%	100.00%	98.00%	98.10%
Cancer – 31 day diagnosis to treatment (subsequent – radiotherapy)	Trajectory	95.10%	95.10%	95.10%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%
	Actual	96.70%	97.50%	100.00%	98.30%	96.70%	86.50%	83.00%	98.30%	97.30%	98.70%	94.70%	98.50%	97.40%
Cancer – 31 day diagnosis to treatment (subsequent – surgery)	Trajectory	94.80%	94.80%	94.80%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%
	Actual	98.30%	97.40%	94.10%	98.20%	92.60%	81.30%	78.90%	87.20%	96.20%	96.80%	96.80%	100.00%	93.90%
Cancer 62 day referral to treatment (screenings)	Trajectory	90.60%	90.60%	90.60%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%
	Actual	97.80%	96.70%	94.70%	90.90%	54.50%	60.00%	66.70%	77.80%	88.90%	100.00%	96.80%	100.00%	93.30%
Cancer 62 day referral to treatment (upgrades)	Trajectory	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
	Actual	69.20%	63.60%	76.50%	100.00%	88.90%	73.70%	91.70%	90.00%	91.70%	85.00%	70.80%	61.90%	59.40%
Cancer 62 day referral to treatment (urgent GP referral)	Trajectory	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%
	Actual	68.00%	76.50%	78.20%	78.00%	69.00%	78.00%	85.60%	87.60%	81.50%	84.60%	79.70%	84.80%	86.30%

Summary Scorecard

Gloucestershire Hospitals NHS Foundation Trust

The following table shows the Trust's current monthly performance against the chosen lead indicators within the Trust Scorecard.

RAG Rating: Overall RAG rating for a domain is an average performance of lead indicators against national standards. Where data is not available the lead indicator is treated as red.

Safe

- % of adult inpatients who have received a VTE risk assessment
- Number of never events reported
- Number of trust apportioned Clostridium difficile cases per month
- Number of trust apportioned MRSA bacteraemia
- Safety thermometer – % of new harms

Effective

- % C-section rate (planned and emergency)
- Emergency re-admissions within 30 days following an elective or emergency spell
- Hospital standardised mortality ratio (HSMR)
- Hospital standardised mortality ratio (HSMR) – weekend

Caring

- ED % positive
- Maternity % positive
- Number of breaches of mixed sex accommodation
- Outpatients % positive

Responsive

- % of ambulance handovers that are over 60 minutes
- % waiting for diagnostics 6 week wait and over (15 key tests)
- Cancer 62 day referral to treatment (screenings)
- Cancer 62 day referral to treatment (upgrades)
- Cancer 62 day referral to treatment (urgent GP referral)
- Did not attend (DNA) rates
- ED: % total time in department – under 4 hours (type 1)
- ED: % total time in department – under 4 hours (types 1 & 3)
- Referral to treatment ongoing pathways over 52 weeks (number)
- Referral to treatment ongoing pathways under 18 weeks (%)

Well Led

- % sickness rate
- % total vacancy rate
- % turnover
- Overall % of nursing shifts filled with substantive staff
- Trust total % mandatory training compliance
- Trust total % overall appraisal completion

Demand and Activity

Gloucestershire Hospitals NHS Foundation Trust

The table below shows monthly activity for key areas. The columns to the right show the percentage change in activity from:

1) The same month in the previous year
2) The same year to date (YTD) period in the previous year

Measure	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Monthly (Jan)	YTD
GP Referrals	10,191	9,595	7,888	3,076	3,946	3,185	8,119	7,784	8,181	8,746	7,679	6,937	6,713	-34.1%	-105.7%
OP Attendances	13,634	12,167	10,637	26,018	30,419	40,646	44,330	39,151	49,790	51,948	51,957	46,742	45,157	231.2%	562.3%
New OP Attendances				7,002	8,812	12,052	13,870	12,542	16,179	17,326	16,882	14,025	13,438		
FUP OP Attendances				19,016	21,607	28,594	30,460	26,609	33,611	34,622	35,075	32,717	31,719		
Day cases	7,067	5,304	4,216	1,473	1,786	2,721	3,467	3,109	4,414	4,586	4,396	3,972	3,266	-53.8%	-125.3%
All electives	8,039	6,294	4,966	1,780	2,183	3,252	4,242	3,965	5,366	5,640	5,275	4,599	3,603	-55.2%	-119.5%
ED Attendances	12,624	11,695	9,721	6,861	8,913	9,819	10,957	11,636	10,903	10,279	9,475	9,309	8,290	-34.3%	-67.2%
Non Electives	4,664	4,353	3,874	3,110	3,728	4,205	4,421	4,320	4,495	4,584	4,233	4,202	3,973	-14.8%	-36.1%

Trust Scorecard - Safe (1)

OVERALL SCORE

Note that data in the Trust Scorecard section is subject to change.

	19/20	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	20/21 Q3	20/21	Standard	Threshold
Infection Control																		
COVID-19 community-onset – First positive specimen <=2 days after admission					250	64	9	5	4	18	48	224	193	444	465	810	TBC	
COVID-19 hospital-onset indeterminate healthcare-associated – First positive specimen 3-7 days after admission					68	7	1	1	0	1	3	57	71	42	131	209	TBC	
COVID-19 hospital-onset probably healthcare-associated – First positive specimen 8-14 days after admission					38	1	2	1	0	0	0	55	48	41	103	145	TBC	
COVID-19 hospital-onset definite healthcare-associated – First positive specimen >=15 days after admission					33	4	1	1	1	0	0	57	56	30	113	153	TBC	
Number of trust apportioned MRSA bacteraemia	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	Zero	
MRSA bacteraemia – infection rate per 100,000 bed days	.6	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	Zero	
Number of trust apportioned Clostridium difficile cases per month	97	8	6	5	4	7	2	7	0	4	8	4	4	4	16	56	2019/20: 114	
Number of hospital-onset healthcare-associated Clostridioides difficile cases per month	5	4	6	2	1	4	1	2	6	1	1	2	1	2	4	21	<=5	
Number of community-onset healthcare-associated Clostridioides difficile cases per month	45	4	0	3	3	3	1	5	6	3	7	2	3	2	12	35	<=5	
Clostridium difficile – infection rate per 100,000 bed days	28.8	29.7	21.5	17.6	25.6	38.6	9.9	30.3	0	15.7	29.2	15.8	15.2	19.2	20.2	19.3	<30.2	
Number of MSSA bacteraemia cases	18	1	1	2	1	0	3	1	1	0	1	1	4	1	6	13	<=8	
MSSA – infection rate per 100,000 bed days	5.3	3.3	3.6	7	6.4		14.9	4.3	4	0	3.6	3.9	15.2	3.8	7.6	5.6	<=12.7	
Number of ecoli cases	46	3	3	2	1	3	2	4	3	0	6	3	1	2	10	25	No target	
Number of pseudomona cases	9	3	0	1	0	2	0	0	0	0	0	0	2	0	2	4	No target	
Number of klebsiella cases	18	1	2	1	1	2	0	1	1	1	0	1	0	3	2	10	No target	
Number of bed days lost due to infection control outbreaks	1,264	100	13	0		0	0	4	0	0	5					9	<10	>30

Trust Scorecard - Safe (2)

OVERALL SCORE

	19/20	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	20/21 Q3	20/21	Standard	Threshold
Patient Safety Incidents																		
Number of patient safety alerts outstanding	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	Zero	
Number of falls per 1,000 bed days	6.4	7.1	7	6.4	6	7.9	7.2	7	7.3	7.5	6.9	7.7	8.5	8.6	7.7	7.5	<=6	
Number of falls resulting in harm (moderate/severe)	4	5	5	0	2	4	4	3	4	3	6	6	5	4	17	41	<=3	
Number of patient safety incidents – severe harm (major/death)	6	6	5	2	4	1	5	2	7	4	5	6	7	4	18	45	No target	
Medication error resulting in severe harm	0	0	1	1	0	0	0	0	0	0	0	0	0	0	0	0	No target	
Medication error resulting in moderate harm	2	5	2	1	2	3	2	6	1	2	1	1	1	6	3	25	No target	
Medication error resulting in low harm	12	10	8	11	9	15	7	8	14	14	9	15	8	14	32	113	No target	
Number of category 2 pressure ulcers acquired as in-patient	30	27	12	23	13	15	16	9	24	13	23	28	30	27	81	198	<=30	
Number of category 3 pressure ulcers acquired as in-patient	5	2	3	1	0	1	0	1	3	4	5	3	1	0	9	18	<=5	
Number of category 4 pressure ulcers acquired as in-patient	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	Zero	
Number of unstagable pressure ulcers acquired as in-patient		4	6	3	3	4	7	4	5	9	7	6	4	2	17	51	<=3	
Number of deep tissue injury pressure ulcers acquired as in-patient		5	3	4	4	6	1	2	6	4	12	5	11	6	26	57	<=5	
RIDDOR																		
Number of RIDDOR	35	4	2	2	2	1	5	3	0	2	1	3	3	3	22	14	SPC	
Safeguarding																		
Number of DoLs applied for				33			41	59	38				45	32			TBC	
Total attendances for infants aged < 6 months, all head injuries/long bone fractures					1			18							22		TBC	
Total attendances for infants aged < 6 months, other serious injury					17			30							2		TBC	
Total admissions aged 0-18 with DSH					6			31							34		TBC	
Total ED attendances aged 0-18 with DSH					26			55							181		TBC	
Total number of maternity social concerns forms completed				31			48										TBC	

Trust Scorecard - Safe (3)

OVERALL SCORE

	19/20	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	20/21 Q3	20/21	Standard	Threshold
Safety Thermometer																		
Safety thermometer – % of new harms	97.1%	96.5%	98.1%	97.8%													>96%	<93%
Sepsis Identification and Treatment																		
Proportion of emergency patients with severe sepsis who were given IV antibiotics within 1 hour of diagnosis	67.00%			68.00%			68.00%			74.00%						71.00%	>=90%	<50%
Serious Incidents																		
Number of never events reported	6	1	1	0	0	0	2	0	0	1	0	3	0	0		6	Zero	
Number of serious incidents reported	3	2	3	2	0	0	2	2	5	4	3	4	2	2		24	No target	
Serious incidents – 72 hour report completed within contract timescale	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%	>90%	
Percentage of serious incident investigations completed within contract timescale	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		100%	>80%	
VTE Prevention																		
% of adult inpatients who have received a VTE risk assessment	93.2%	90.1%	94.2%	92.7%		90.1%	94.0%	93.8%	90.7%	87.0%	89.8%	94.6%	91.0%	90.4%	91.8%	91.3%	>95%	

Trust Scorecard - Effective (1)

OVERALL SCORE

	19/20	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	20/21 Q3	20/21	Standard	Threshold
Dementia Screening																		
% of patients who have been screened for dementia (within 72 hours)	0.8%	37.0%	86.0%	74.0%	67.0%	63.0%	68.0%	71.0%	71.0%	79.0%	64.0%	68.0%	68.0%	65.0%		68.0%	>=90%	<70%
% of patients who have scored positively on dementia screening tool that then received a dementia diagnostic assessment (within 72 hours)	29.4%	0.0%	10.0%	0.0%													>=90%	<70%
Maternity																		
% of women on a Continuity of Carer pathway		4.30%	5.00%	4.40%	4.70%	3.00%	0.80%	0.00%	0.00%	0.40%	0.00%	0.00%	0.00%	0.00%	0.00%	0.90%	No target	
% C-section rate (planned and emergency)	28.39%	28.66%	30.23%	28.90%	27.73%	28.82%	25.94%	26.51%	27.80%	31.13%	32.91%	28.09%	34.76%	28.12%	32.01%	29.17%	<=27%	>=30%
% emergency C-section rate	15.74%	13.60%	16.36%	14.48%	12.73%	15.27%	12.08%	12.73%	16.20%	15.14%	19.50%	15.73%	20.09%	15.65%	18.46%	15.48%	No target	
% of women booked by 12 weeks gestation	88.9%	90.3%	89.5%	89.7%	89.6%	93.1%	93.3%	93.0%	92.4%	95.0%	92.3%	95.4%	92.7%	94.2%	93.2%	92.5%	>90%	
% of women that have an induced labour	28.65%	27.20%	28.42%	27.98%	27.50%	28.60%	29.70%	35.49%	31.20%	32.41%	28.72%	32.58%	32.51%	33.91%	31.21%	31.26%	<=30%	>33%
% of women smoking at delivery	10.95%	13.18%	8.64%	12.39%	9.55%	10.97%	11.29%	9.39%	13.80%	11.30%	12.58%	11.24%	11.06%	8.80%	11.65%	11.03%	<=14.5%	
% stillbirths as percentage of all pregnancies > 24 weeks	0.22%	0.21%	0.00%	0.23%	1.14%	0.00%	0.20%	0.42%	0.00%	0.21%	0.83%	0.68%	0.22%	0.25%	0.58%	0.39%	<0.52%	
Mortality																		
Summary hospital mortality indicator (SHMI) – national data	1.1	1.1	1.1	1.1	1.1	1.1	1.1	1.1	1.1	1.1						1.1	NHS Digital	
Hospital standardised mortality ratio (HSMR)	108	99.9	107.2	108	111.3	110.7	107.1	104.6	105.1	104.7	103.9					103.9	Dr Foster	
Hospital standardised mortality ratio (HSMR) – weekend	112.7	104.3	110.9	112.7	117.4	117.5	114.4	110.8	108.8	107.4	105.5					105.5	Dr Foster	
Number of inpatient deaths	1,964	215	167	192	252	126	112	120	143	147	142	182	245	278	569	1,764	No target	
Number of deaths of patients with a learning disability	15	4	0	0	4	2	0	1	3	4	1	1	1	2	3	19	No target	
Readmissions																		
Emergency re-admissions within 30 days following an elective or emergency spell	7.0%	6.6%	6.7%	8.3%	9.5%	8.5%	7.2%	7.9%	8.5%	7.4%	7.8%	8.0%	7.7%		7.8%	7.9%	<8.25%	>8.75%
Research																		
Research accruals		110	98		1,079	633	54	126	350	629	461	578	382				No target	

Trust Scorecard - Effective (2)

OVERALL SCORE

	19/20	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	20/21 Q3	20/21	Standard	Threshold
Stroke Care																		
Stroke care: percentage of patients receiving brain imaging within 1 hour	49.5%	45.2%	56.4%	46.2%	37.0%	53.0%	45.0%	63.5%	60.9%	52.9%	46.6%	54.7%	51.7%	56.1%	51.0%	52.1%	>=43%	<25%
Stroke care: percentage of patients spending 90%+ time on stroke unit	87.7%	88.5%	87.7%	90.4%	88.5%	78.0%	84.0%	95.1%	89.7%	94.3%	71.4%	94.3%	91.4%			83.5%	>=85%	<75%
% of patients admitted directly to the stroke unit in 4 hours	54.80%	38.40%	30.80%	49.30%	49.00%	21.00%	65.00%	74.50%	50.70%	51.60%	34.50%	36.50%	16.10%	24.40%	29.00%	45.00%	>=75%	<55%
% patients receiving a swallow screen within 4 hours of arrival	70.70%	69.20%	71.00%	65.20%	68.00%	76.00%	65.00%	78.60%	59.30%	62.70%	63.50%	64.70%	70.60%	71.80%	66.30%	68.00%	>=75%	<65%
Trauma & Orthopaedics																		
% of fracture neck of femur patients treated within 36 hours	55.7%	73.1%	58.6%	48.6%	75.0%	62.4%	72.7%	56.7%	71.9%	63.6%	60.7%	85.1%	77.0%	75.8%	73.5%	70.2%	>=90%	<80%
% fractured neck of femur patients meeting best practice criteria	54.90%	73.10%	55.20%	48.60%	53.10%	60.60%	70.91%	56.70%	70.20%	62.10%	58.80%	83.00%	73.00%	75.80%	71.60%	66.60%	>=65%	<55%

Trust Scorecard - Caring (1)

OVERALL SCORE

	19/20	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	20/21 Q3	20/21	Standard	Threshold
Friends & Family Test																		
Inpatients % positive	90.7%	90.2%	90.5%	91.1%	90.0%	90.2%	91.9%	87.0%	86.0%	88.7%	86.4%	85.7%	84.8%	89.7%	85.7%	87.9%	>=96%	<93%
ED % positive	82.1%	79.9%	79.2%	79.6%	90.2%	85.8%	86.8%	81.8%	77.2%	73.0%	75.4%	83.7%	77.6%	87.2%	79.2%	80.9%	>=84%	<81%
Maternity % positive	97.4%	100.0%	100.0%	100.0%	97.2%	100.0%	90.2%	100.0%	85.2%	93.9%	88.9%	88.4%	96.7%	98.6%	90.4%	91.9%	>=97%	<94%
Outpatients % positive	93.0%	93.1%	93.0%	94.3%	94.0%	93.6%	93.9%	93.7%	93.5%	92.8%	94.0%	94.1%	94.2%	94.7%	94.1%	93.8%	>=94%	<91%
Total % positive	91.2%	91.4%	91.1%	92.2%	92.9%	91.8%	92.4%	91.3%	90.0%	90.1%	91.7%	92.2%	91.9%	93.2%	91.9%	91.4%	>=93%	<90%
Number of PALS concerns logged										273	312	227	163	137	704		No Target	
% of PALS concerns closed in 5 days										73%	75%	81%	82%	86%	79%		>=95%	<90%
Inpatient Questions (Real time)																		
How much information about your condition or treatment or care has been given to you?	79.00%	81.00%	84.00%	78.00%													>=90%	
Are you involved as much as you want to be in decisions about your care and treatment?	92.00%	93.00%	95.00%	92.00%													>=90%	
Do you feel that you are treated with respect and dignity?	98.00%	99.00%	99.00%	100.00%													>=90%	
Do you feel well looked after by staff treating or caring for you?	99.00%	100.00%	100.00%	99.00%													>=90%	
Do you get enough help from staff to eat your meals?	89.00%	80.00%	96.00%	67.00%													>=90%	
In your opinion, how clean is your room or the area that you receive treatment in?	99.00%	98.00%	98.00%	100.00%													>=90%	
Do you get enough help from staff to wash or keep yourself clean?	96.00%	97.00%	93.00%	86.00%													>=90%	
MSA																		
Number of breaches of mixed sex accommodation	82	2	1	8	6	13	21	23	1	0	0	0	0	2	0	66	<=10	>=20

Trust Scorecard - Responsive (1)

OVERALL SCORE

	19/20	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	20/21 Q3	20/21	Standard	Threshold
Cancer																		
Cancer – 28 day FDS two week wait					53.9%	79.6%	77.9%	79.9%	79.4%	76.1%	77.1%	78.3%	77.8%	76.3%	89.0%	75.2%	TBC	
Cancer – 28 day FDS breast symptom two week wait					91.4%	95.7%	98.6%	99.1%	80.6%	98.3%	77.1%	95.4%	77.8%	97.9%	89.0%	97.8%	TBC	
Cancer – 28 day FDS screening referral					76.0%	50.0%	76.9%	100.0%	78.6%	65.4%	77.1%	61.8%	77.8%	52.8%	89.0%	68.8%	TBC	
Cancer – urgent referrals seen in under 2 weeks from GP	92.5%	95.1%	96.1%	95.1%	90.6%	99.1%	98.0%	96.5%	90.8%	95.2%	93.1%	91.6%	93.7%	90.1%	93.7%	94.3%	>=93%	<90%
2 week wait breast symptomatic referrals	97.5%	96.3%	97.8%	98.4%	87.9%	97.8%	95.7%	96.4%	95.9%	93.4%	97.1%	85.2%	91.8%	70.6%	91.0%	95.2%	>=93%	<90%
Cancer – 31 day diagnosis to treatment (first treatments)	93.4%	95.5%	94.3%	95.5%	96.6%	96.0%	95.3%	98.1%	96.7%	96.4%	99.3%	99.3%	97.6%	97.7%	98.6%	97.6%	>=96%	<94%
Cancer – 31 day diagnosis to treatment (subsequent – drug)	99.4%	100.0%	100.0%	100.0%	100.0%	100.0%	94.0%	97.0%	100.0%	100.0%	100.0%	100.0%	98.0%	98.1%	99.4%	99.4%	>=98%	<96%
Cancer – 31 day diagnosis to treatment (subsequent – surgery)	93.6%	98.3%	97.4%	94.1%	98.2%	92.6%	81.3%	78.9%	87.2%	96.2%	96.8%	96.8%	100.0%	93.9%	99.5%	94.8%	>=94%	<92%
Cancer – 31 day diagnosis to treatment (subsequent – radiotherapy)	94.9%	96.7%	97.5%	100.0%	98.3%	96.7%	86.5%	83.0%	98.3%	97.3%	98.7%	94.7%	98.5%	97.4%	98.7%	97.6%	>=94%	<92%
Cancer 62 day referral to treatment (urgent GP referral)	73.1%	68.0%	76.5%	78.2%	78.0%	69.0%	78.0%	85.6%	87.6%	81.5%	84.6%	79.7%	84.8%	86.3%	84.4%	83.1%	>=85%	<80%
Cancer 62 day referral to treatment (screenings)	95.4%	97.8%	96.7%	94.7%	90.9%	54.5%	60.0%	66.7%	77.8%	88.9%	100.0%	96.8%	100.0%	93.3%	98.5%	91.8%	>=90%	<85%
Cancer 62 day referral to treatment (upgrades)	72.2%	69.2%	63.6%	76.5%	100.0%	88.9%	73.7%	91.7%	90.0%	91.7%	85.0%	70.8%	61.9%	59.4%	73.1%	79.7%	>=90%	<85%
Number of patients waiting over 104 days with a TCI date	170	5	4	3	4	8	8	21	2	3	3	1	0	3	4	50	Zero	
Number of patients waiting over 104 days without a TCI date	407	19	14	20	33	79	66	38	15	8	8	9	13	14	30	269	<=24	
Diagnostics																		
% waiting for diagnostics 6 week wait and over (15 key tests)	3.16%	1.50%	1.16%	3.16%	41.95%	43.43%	29.54%	26.07%	25.49%	23.00%	17.50%	14.67%	14.04%	24.59%	14.04%	24.59%	<=1%	>2%
The number of planned / surveillance endoscopy patients waiting at month end	825	853	803	825	1,035	1,230	1,367	1,465	1,569	1,648	1,665	1,772	1,949	1,969	1,949	1,969	<=600	
Discharge																		
Patient discharge summaries sent to GP within 24 hours	56.5%	58.9%	59.4%	57.7%	55.4%	57.8%	60.1%	60.0%	57.5%	61.2%	60.7%	58.3%	52.3%		57.4%	58.3%	>=88%	<75%

Trust Scorecard - Responsive (2)

OVERALL SCORE

	19/20	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	20/21 Q3	20/21	Standard	Threshold
Emergency Department																		
ED: % total time in department – under 4 hours (type 1)	81.58%	72.45%	72.41%	78.56%	87.46%	85.41%	85.06%	84.46%	73.53%	71.74%	68.96%	69.40%	65.43%	68.82%	67.98%	76.13%	>=95%	<90%
ED: % total time in department – under 4 hours (types 1 & 3)	87.40%	81.02%	82.33%	85.08%	89.93%	88.72%	89.94%	90.05%	83.26%	82.34%	80.21%	79.64%	77.06%	77.82%	79.03%	83.88%	>=95%	<90%
ED: % total time in department – under 4 hours CGH	93.70%	91.50%	93.02%	94.10%	95.42%	96.43%	98.93%	99.85%	99.91%	99.95%	99.84%	99.94%	99.88%	99.92%	99.88%	98.86%	>=95%	<90%
ED: % total time in department – under 4 hours GRH	81.59%	63.30%	64.91%	71.69%	84.28%	80.59%	84.01%	84.46%	73.53%	71.74%	68.96%	69.40%	65.43%	68.82%	67.98%	74.80%	>=95%	<90%
ED: number of patients experiencing a 12 hour trolley wait (>12hours from decision to admit to admission)	2	0	0	1	0	0	0	0	1	0	0	14	36	96	50	147	Zero	
ED: % of time to initial assessment – under 15 minutes	71.2%	68.0%	65.8%	70.1%	80.4%	77.0%	72.7%	72.5%	63.7%	61.3%	66.9%	66.5%	61.3%	64.5%	64.9%	68.2%	>=95%	<92%
ED: % of time to start of treatment – under 60 minutes	31.3%	31.9%	29.0%	40.9%	68.0%	57.5%	52.0%	44.5%	31.4%	30.9%	38.1%	41.8%	40.8%	48.9%	40.2%	44.1%	>=90%	<87%
% of ambulance handovers that are over 30 minutes	2.40%	3.76%	2.76%	2.87%	2.09%	1.74%	2.57%	2.04%	4.17%	3.67%	3.95%	4.59%	8.70%	8.14%	5.77%	4.23%	<=2.96%	
% of ambulance handovers that are over 60 minutes	0.07%	0.23%	0.13%	0.05%	0.00%	0.00%	0.15%	0.03%	0.90%	0.55%	1.09%	2.63%	11.50%	9.57%	5.11%	2.71%	<=1%	>2%
Operational Efficiency																		
Cancelled operations re-admitted within 28 days	74.03%	88.89%	74.07%	74.03%	-120.00%	100.00%	100.00%	94.00%	86.67%	94.74%	95.83%	90.50%	78.30%	14.30%	75.00%	72.60%	>=95%	
Urgent cancelled operations	8	1	1	0	0	0	0	11	2	10	7	4	14	4	33	60	No target	
Number of patients stable for discharge	86	112	101	70	14	33	45	66	68	72	99	84	71	12	254	491	<=70	
Number of stranded patients with a length of stay of greater than 7 days	423	431	427	358	204	213	248	288	332	325	379	392	417	403	396	320	<=380	
Average length of stay (spell)	5.14	5.68	5.36	6.16	5.22	4.49	4.54	4.69	4.66	4.78	4.86	4.79	5.57	6.25	5.06	4.97	<=5.06	
Length of stay for general and acute non-elective (occupied bed days) spells	5.73	6.43	6.07	6.9	5.37	4.75	4.81	5.13	5.15	5.34	5.44	5.43	6.04	6.42	5.63	5.41	<=5.65	
Length of stay for general and acute elective spells (occupied bed days)	2.67	2.42	2.62	2.66	3.74	2.2	2.64	2.47	2.32	2.47	2.59	2.12	2.87	4.38	2.5	2.6	<=3.4	>4.5
% day cases of all electives	85.59%	87.91%	84.27%	84.90%	82.75%	81.81%	83.67%	81.73%	78.41%	82.26%	81.28%	83.34%	86.37%	90.65%	83.50%	82.43%	>80%	<70%
Intra-session theatre utilisation rate	87.20%	86.40%	87.50%	85.60%	91.80%	87.60%	84.05%	87.30%	88.60%	86.70%	85.70%	87.70%	77.40%	79.30%	83.60%	85.10%	>85%	<70%

Trust Scorecard - Responsive (3)

OVERALL SCORE

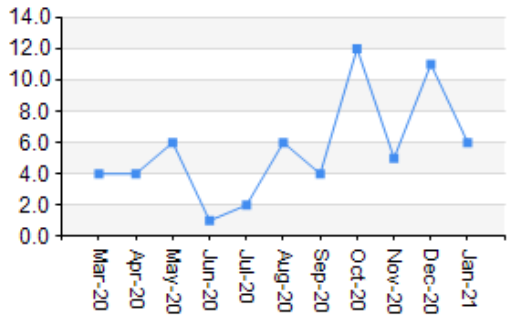
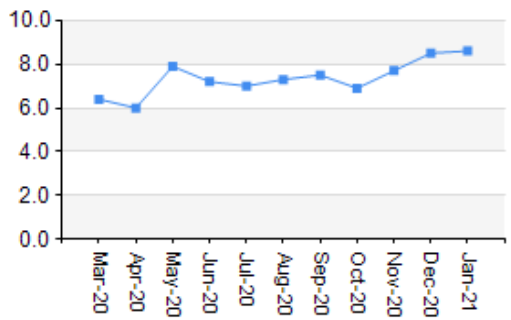
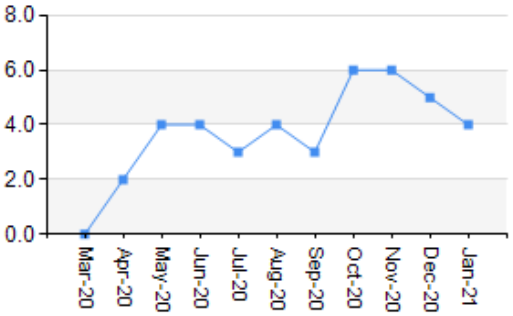
	19/20	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	20/21 Q3	20/21	Standard	Threshold
Outpatient																		
Outpatient new to follow up ratio's	1.88	1.86	1.93	2.04	2.49	2.32	2.28	2.03	1.99	1.94	1.88	1.96	2.15	2.14	1.99	2.08	<=1.9	
Did not attend (DNA) rates	6.90%	6.90%	6.40%	7.80%	4.20%	4.30%	4.70%	5.50%	6.20%	6.50%	6.30%	6.30%	6.50%	6.50%	6.30%	5.80%	<=7.6%	>10%
RTT																		
Referral to treatment ongoing pathways under 18 weeks (%)	81.01%	81.06%	81.41%	81.01%	73.61%	66.53%	59.06%	55.83%	60.07%	66.27%	69.36%	70.06%	68.84%	69.67%	69.43%	69.43%	>=92%	
Referral to treatment ongoing pathways 35+ Weeks (number)	1,833	1,658	1,653	1,833	2,719	3,794	4,967	6,226	7,155	7,748	8,404	8,352	7,256	6,646	8,004	8,004	No target	
Referral to treatment ongoing pathways 45+ Weeks (number)		309	286	334	707	1,197	1,768	2,172	2,724	3,084	3,253	3,035	3,854	4,798	3,381	3,381	No target	
Referral to treatment ongoing pathways over 52 weeks (number)	33	28	14	33	156	366	694	1,037	1,233	1,279	1,285	1,411	1,602	2,237	1,443	1,443	Zero	
Referral to treatment ongoing pathways 70+ Weeks (number)		1	0	0	0	2	5	17	57	77	86	111	163	245	120	120	No target	
SUS																		
Percentage of records submitted nationally with valid GP code	99.7%	99.9%	99.9%	99.9%	100.0%	100.0%	100.0%	100.0%	100.0%							100.0%	>=99%	
Percentage of records submitted nationally with valid NHS number	99.7%	99.8%	99.8%	99.8%	99.8%	99.8%		99.9%	99.9%							99.9%	>=99%	

Trust Scorecard - Well Led (1)

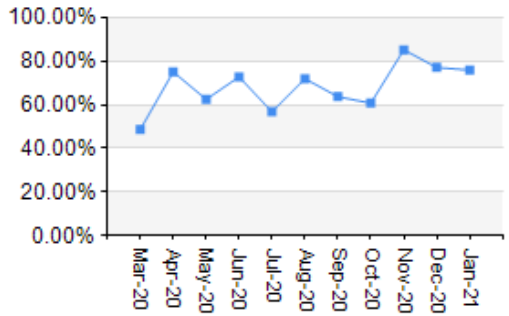
OVERALL SCORE

	19/20	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	20/21 Q3	20/21	Standard	Threshold
Appraisal and Mandatory Training																		
Trust total % overall appraisal completion	82.0%	83.0%	85.0%	85.0%	85.0%	85.0%	78.0%	80.0%	82.0%	84.0%	83.0%	83.0%	82.0%	82.0%	82.0%		>=90%	<70%
Trust total % mandatory training compliance	92%	90%	90%	90%	90%	90%	90%	91%	91%	94%	93%	93%	93%	93%	93%		>=90%	<70%
Finance																		
Total PayBill Spend		30.1	31.6	30.2	32.5	33.8	34.3	33.2	33.9	34.7								
YTD Performance against Financial Recovery Plan		.3	.1	1.5	0	-.1	0	0	0	0								
Cost Improvement Year to Date Variance		-2	-4	-8	0	0	0											
NHSI Financial Risk Rating		3	3	3	3	3	3											
Capital service		4	4	3	3	3	3											
Liquidity		4	4	4	4	4	4											
Agency – Performance Against NHSI Set Agency Ceiling		3	3	3	3	3	3											
Safe Nurse Staffing																		
Overall % of nursing shifts filled with substantive staff	97.40%	99.30%	98.30%				90.52%	100.77%	102.10%	93.82%	96.30%	94.90%	90.64%	90.88%	94.11%	95.00%	>=75%	<70%
% registered nurse day	98.20%	98.50%	98.10%				89.23%	100.82%	101.90%	93.04%	95.49%	94.40%	91.04%	93.76%	93.76%	95.00%	>=90%	<80%
% unregistered care staff day	100.20%	102.10%	100.20%				110.83%	120.86%	117.50%	106.50%	101.36%	102.40%	93.42%	99.20%	99.20%	106.50%	>=90%	<80%
% registered nurse night	95.70%	100.80%	98.60%				92.99%	100.69%	102.60%	95.27%	97.77%	95.90%	89.93%	94.75%	94.75%	96.30%	>=90%	<80%
% unregistered care staff night	106.20%	107.80%	109.70%				112.80%	131.01%	131.70%	114.61%	113.36%	112.00%	97.48%	99.23%	107.90%	113.90%	>=90%	<80%
Care hours per patient day RN	4.7	4.6	4.7				6.2	5.8	5.6	5.2	5.2	5.7	5.4	6.1	5.4	5.6	>=5	
Care hours per patient day HCA	3	2.9	3				4.5	4.2	3.9	3.5	3.4	3.7	3.5	3.9	3.5	3.8	>=3	
Care hours per patient day total	7.7	7.6	7.7				10.8	10.1	9.5	8.6	8.6	9.4	8.9	10.1	9	9.4	>=8	
Vacancy and WTE																		
% total vacancy rate		6.70%	6.15%	6.15%			5.97%	5.14%	7.10%	5.26%	5.74%	6.03%	5.99%	5.57%			<=11.5%	>13%
% vacancy rate for doctors		3.62%	1.24%				4.90%	2.70%	3.27%	1.54%	1.07%	0.37%	1.43%	1.77%			<=5%	>5.5%
% vacancy rate for registered nurses		9.92%	10.26%	10.26%			8.12%	8.44%	8.90%	10.01%	7.76%	9.06%	8.70%	8.80%			<=5%	>5.5%
Staff in post FTE		6351.41	6387.05	6422.86	6421.87	6549.97	6573.86	6485.99	6463.25	6548.39	6557.43	6551.18	6546.28	6560.89			No target	
Vacancy FTE		457.45	418.47	418.47			416.06	358	494.04	365.97	399.63	420.14	417.44	409.32			No target	
Starters FTE		55.75	63.74	44.17	32.81	30.05	57.65	49.45	62.46	151.56	73.19	46.87	52.85	50.64			No target	
Leavers FTE		52.49	36.99	58.37	43.37	46.93	38.57	96.43	106.66	66.41	76.11	68.76	40.52	50.03			No target	
Workforce Expenditure and Efficiency																		
% turnover		11.5%	11.3%	11.1%	10.8%	10.9%	10.4%	10.2%	10.3%	10.3%	9.6%	10.1%	9.5%	9.5%			<=12.6%	>15%
% turnover rate for nursing		11.12%	10.92%	10.73%	10.59%	10.72%	10.14%	9.98%	10.34%	10.10%	9.41%	10.23%	9.61%	9.83%			<=12.6%	>15%
% sickness rate		3.9%	3.9%	3.5%	3.8%	3.8%	3.8%	3.7%	3.7%	3.7%	3.7%	3.7%	3.7%	3.7%			<=4.05%	>4.5%

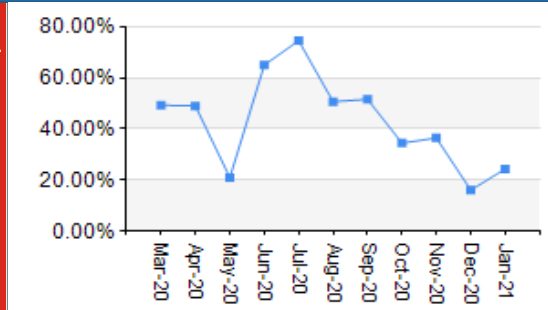
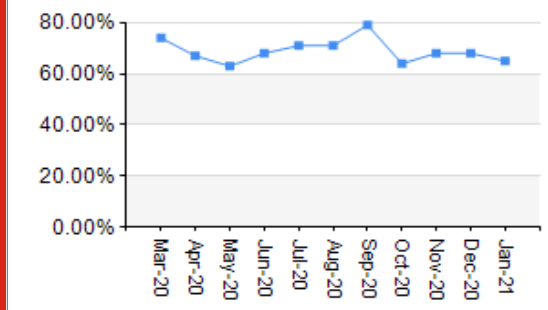
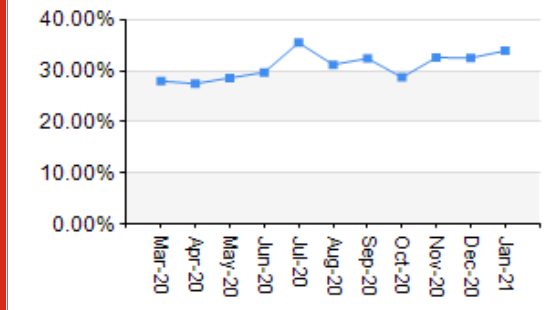
Exception Reports - Safe (1)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Number of deep tissue injury pressure ulcers acquired as in-patient **Standard: <=5**		Increased deconditioning in patients is a contributing factor, lack of evidence of pressure ulcer risk assessment and subsequent interventions is also a factor on review of all cases. Cases are reviewed weekly at Preventing Harm Improvement Hub.	**Deputy Nursing Director & Divisional Nursing Director - Surgery**
Number of falls per 1,000 bed days **Standard: <=6**		Falls have increased due to a number of factors; increased deconditioning, reduced visiting which decreases supervision, inability to fill enhanced care requests, multiple bed moves and transfers including late night. The falls reduction programme is active and all cases with moderate harm or above are rapidly reviewed in Preventing Harm Hub.	**Director of Safety**
Number of falls resulting in harm (moderate/severe) **Standard: <=3**		Falls have increased due to a number of factors; increased deconditioning, reduced visiting which decreases supervision, inability to fill enhanced care requests, multiple bed moves and transfers including late night. The falls reduction programme is active and all cases with moderate harm or above are rapidly reviewed in Preventing Harm Hub.	**Director of Safety**

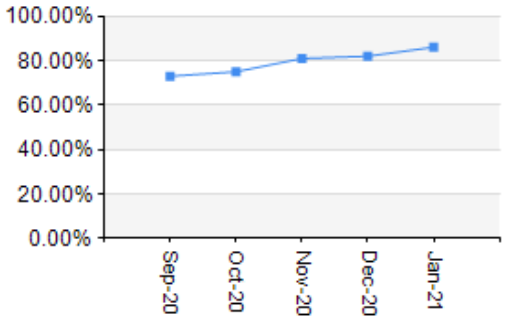
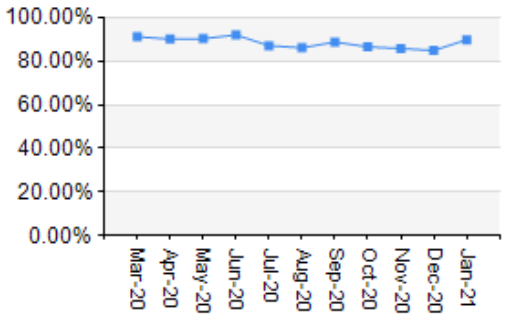
Exception Reports - Effective (1)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
% of fracture neck of femur patients treated within 36 hours **Standard: >=90%**		Although performance against this metric is below standard, it should be noted that only 85-90% of all #NOF patients are expected to be fit enough for surgery within 36 hours. The #NOF pathway has been significantly impacted by the ongoing pressures caused by COVID-19. Since week commencing 14th December, T&O wards have had to be used for Medicine patients which has reduced our capacity for trauma patients. This has led to a significant number of #NOF patients outlying on other wards, which impacts on the efficiency of the pathway, particularly with the latest advice from Infection Control to reduce patient moves to reduce risk of nosocomial infection even when a bed is available on a 'home' ward. Delays to theatre have occurred when high numbers (more than 3-4) of #NOF patients are admitted within a 24-hour period, which happened on a few occasions in the reporting period. The impact of the volume of non NOF trauma cases was such that patients were waiting over two weeks for surgery. This means that morbidity is potentially caused with further delay and it therefore becomes a balance of need for prioritising patients. This has continued into January and there are concerns regarding reducing the capacity for trauma operating from week commencing 18th January with only two lists. Loss of the urgent spinal theatre capacity severely impacts on our wait times for non NOF trauma and #NOF trauma time to theatre due to the length and complexity of cases. It should also be noted that as of 15th January, due to continued pressure on GRH beds, the T&O and Care of the Elderly Team have been asked to identify post-op #NOF patients who can be 'stepped down' to CGH T&O wards. Although the teams will be selective in identifying who will go to CGH, these are generally frail elderly patients with multiple co-morbidities who require several days / weeks in a hospital bed. In GRH, these patients receive daily COTE / specialist Orthogeriatric consultant input, specialist nursing and dedicated nutritional assistant care which cannot be completely replicated in CGH due to availability of staffing whilst mid-pandemic. The T&O pilot was discussed at the Trust's public board in February and this was the only metric not achieved. The T&O Tri have been tasked to submit a recovery plan / trajectory for improvement to Divisional Tri by the end of the month. The specialty Tri have also been tasked to consider a sub-acute community pathway for Trauma patients, working with our system partners.	**Director of Operations - Surgery**

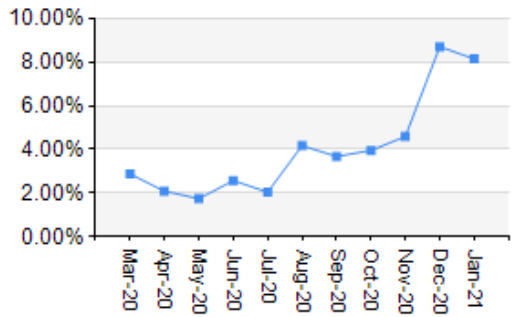
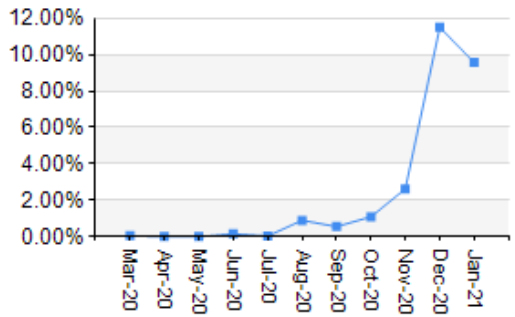
Exception Reports - Effective (2)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
% of patients admitted directly to the stroke unit in 4 hours **Standard: >=75%**		Improvement of 8.30% on December (16.10%). 62 patients breached the target in the month of December. Of these 62: 32 patients were delayed due to lack of HASU beds (shared space with Cardiology) 4 patients were delayed due to an unclear diagnosis which led to them initially being admitted to AMU for further tests. 16 patients experienced a delay in assessment as the Stroke team were not informed by ED. Led to breaches along the rest of the pathway elements 1 patient was an inpatient already 1 patient was admitted from TIA clinic 8 patients had an unknown breach reason listed	**Director of Unscheduled Care and Deputy Chief Operating Officer**
% of patients who have been screened for dementia (within 72 hours) **Standard: >=90%**		The manual audit for this indicator shows a consistent performance in screening the 30 case notes sampled, but is still below compliance, and as the Dementia Improvement Plan (DIP) has developed its performance dashboard, it should be noted that the sample size is approximately 10% of monthly dementia admissions. The dementia and delirium pathway process is currently being assessed for approval and discussions taking place to develop the EPR process to support the screening and assessment of delirium and dementia. A review of the Trust's dementia training is taking place to support the clinical pathway. In addition a recent Task & Finish Group as part of the ICS Dementia Steering Group has been established to achieve a one system approach to delirium.	**Deputy Chief Nurse**
% of women that have an induced labour **Standard: <=30%**		The service are currently doing a data collection exercise to see the reasons for IOL. They will then undertake a QI project to make any improvements which may be necessary to reduce numbers	**Divisional Chief Nurse and Director of Midwifery**

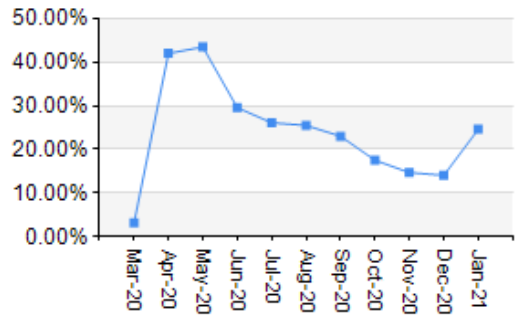
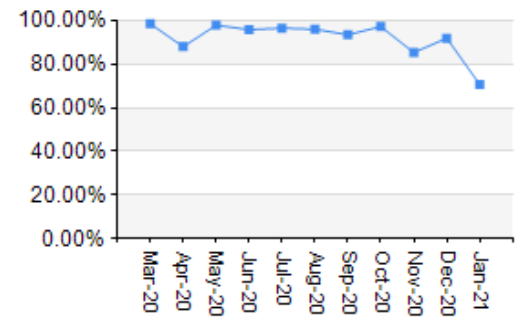
Exception Reports - Caring (1)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
% of PALS concerns closed in 5 days **Standard: >=95%**		The PALS team are continuing to close 86% of cases within 5 days, when they are seeing a huge increase in volume of concerns, enquiries and compliments to manage compared to this time last year, alongside managing calls from relatives via the patient support service. The team have recruited 2 3 month FTC PALS Advisors to support with managing this increase in volume while restrictions are in place, and they are due to start mid February which will build more resilience and capacity into the team to manage the increasing cases.	**Head of Quality and Freedom to Speak Up Guardian**
Inpatients % positive **Standard: >=96%**		The inpatient FFT score for January has seen a 4% increase to 89.7% positive score, and has seen an increase in the number of responses received, providing more validity to this improvement. There are still areas where we are receiving a lower number of responses each month, which does risk results being skewed either positively or negatively. The Patient Experience team are working with divisions to identify how the FFT scores and other survey feedback is being utilised to inform local improvement plans, and to offer additional routes for gaining patient experience feedback that can challenge or validate some of these scores in areas with lower numbers. This includes running bespoke local surveys to increase insight on areas potentially highlighted in the FFT feedback, as is currently happening in AMU, or to increase numbers or responses to provide a more representative experience. This is ongoing and will be monitored monthly through QDG.	**Deputy Director of Quality**

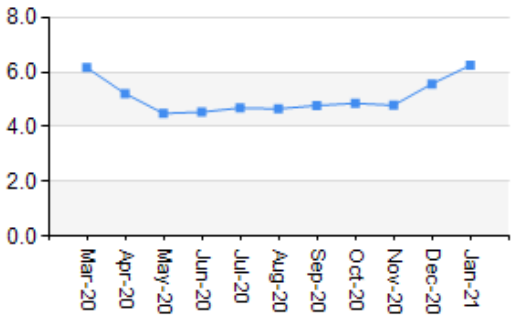
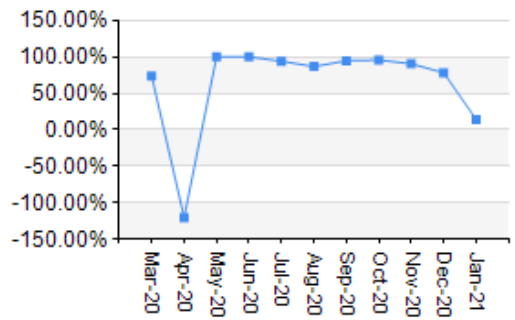
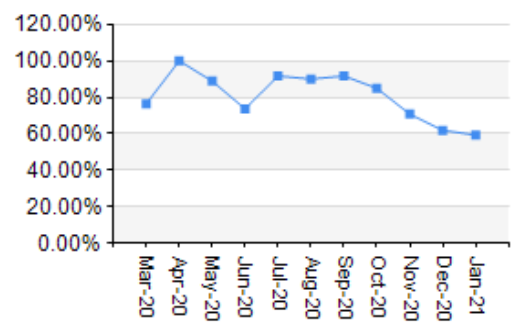
Exception Reports - Responsive (1)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
% of ambulance handovers that are over 30 minutes **Standard: <=2.96%**		A decrease in the number of handovers in January compared to December, however they still remain high. A cohort area was agreed this month which should be used only in the event of a System Wide Major Incident.	**Director of Unscheduled Care and Deputy Chief Operating Officer**
% of ambulance handovers that are over 60 minutes **Standard: <=1%**		A decrease in the number of handovers in January compared to December, however they still remain high. A cohort area was agreed this month which should be used only in the event of a System Wide Major Incident.	**Director of Unscheduled Care and Deputy Chief Operating Officer**

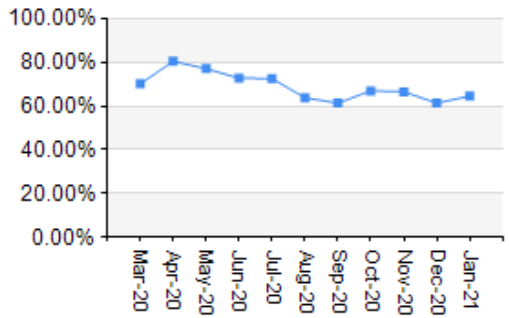
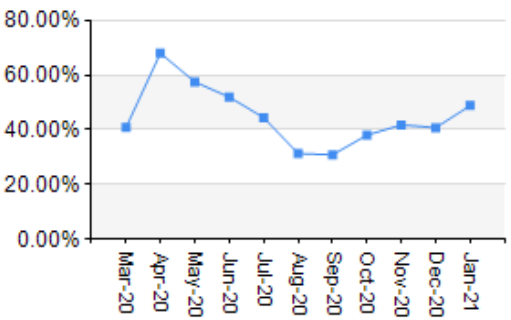
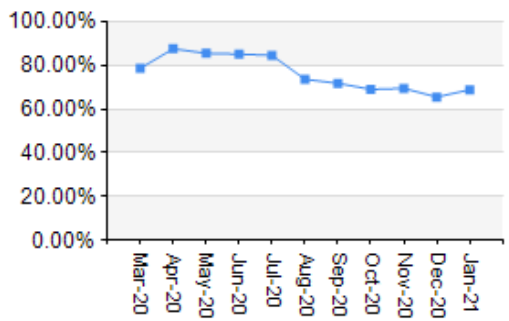
Exception Reports - Responsive (2)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
% waiting for diagnostics 6 week wait and over (15 key tests) **Standard: <=1%**		A full breakdown of diagnostic performance is available within the exception report.	**Deputy Chief Operating Officer**
2 week wait breast symptomatic referrals **Standard: >=93%**		2ww breast symptoms performance (unvalidated) = 70.6% target = 93.0% National performance = 67.0% Performance impacted by outpatient capacity caused by staff sickess in December and high 2ww referral levels. February performance showing clear sign of recovery with 98.2% of patients seen within target (110 seen).	**Director of Planned Care and Deputy Chief Operating Officer**

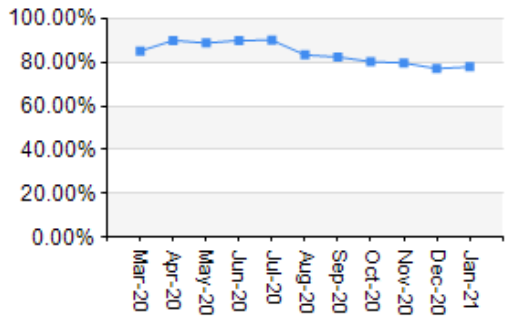
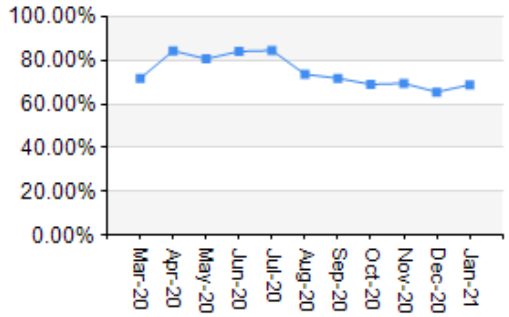
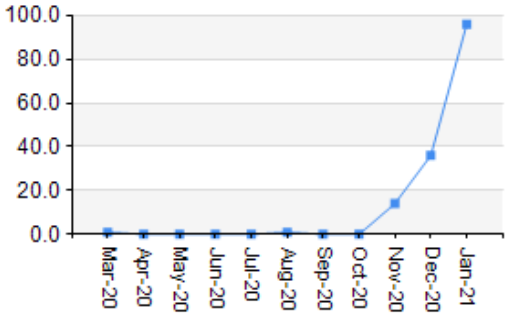
Exception Reports - Responsive (3)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Average length of stay (spell) **Standard: <=5.06**		ALOS under review given the latest surge in January 2020	**Deputy Chief Operating Officer**
Cancelled operations re-admitted within 28 days **Standard: >=95%**		Cancelled operations continue to be reviewed at specialty level and every effort made to reschedule within the 28 days. In December 7 patients were cancelled on the day and could not be rescheduled within 28 days. This included 4 vascular, 1 Upper GI, 1 T&O and 1 Gynae.	**Deputy Chief Operating Officer**
Cancer 62 day referral to treatment (upgrades) **Standard: >=90%**		62 day upgrades performance (unvalidated)= 59.40% target = n/a National performance = 83.5% 16 treatments 6.5 breaches 4 breaches relate to patients not being treated within 24 days following transfer to the Trust for treatment.	**Director of Planned Care and Deputy Chief Operating Officer**

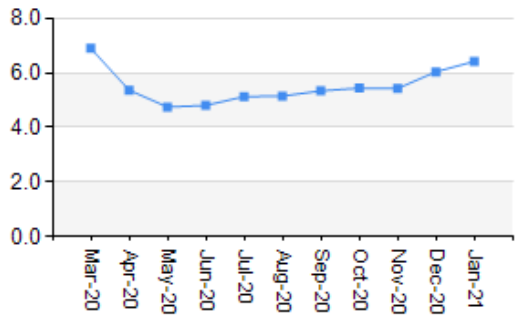
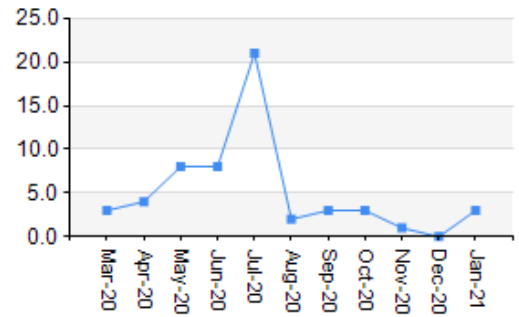
Exception Reports - Responsive (4)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
ED: % of time to initial assessment – under 15 minutes **Standard: >=95%**		Average time to triage reduced this month with the average wait for walk in patients being 17.7 minutes and 22.7 minutes for patients who arrive by ambulance. The pit stop continues the run which allows for rapid assessment and in times of extreme escalation, triage takes place on the ambulance.	**Director of Unscheduled Care and Deputy Chief Operating Officer**
ED: % of time to start of treatment – under 60 minutes **Standard: >=90%**		Median wait to see a Doctor remains within target with an average waiting time of 29 minutes.	**Director of Unscheduled Care and Deputy Chief Operating Officer**
ED: % total time in department – under 4 hours (type 1) **Standard: >=95%**		4-hour performance is 68.82% which is an improvement compared to December which was 65.43%. The average total wait in ED reduced from 239.5 minutes to 234.4 minutes.	**Director of Unscheduled Care and Deputy Chief Operating Officer**

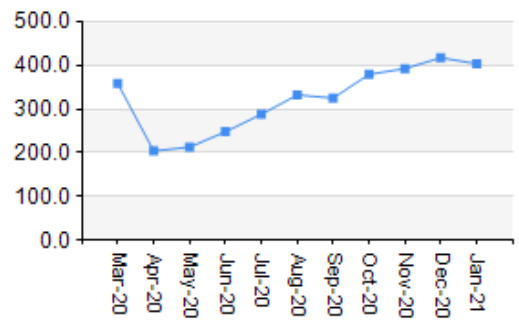
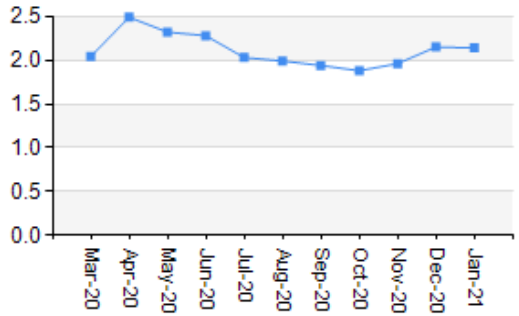
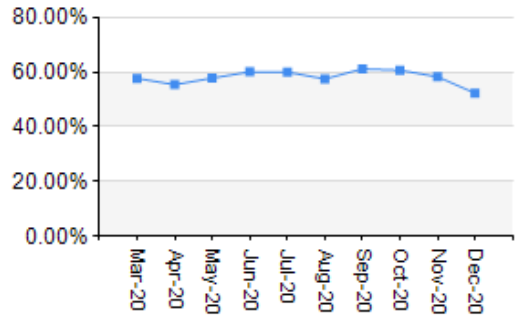
Exception Reports - Responsive (5)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
ED: % total time in department – under 4 hours (types 1 & 3) **Standard: >=95%**		4-hour performance is 77.82% which is an improvement compared to December which was 77.06%. The average total wait in ED reduced from 239.5 minutes to 234.4 minutes.	**Director of Unscheduled Care and Deputy Chief Operating Officer**
ED: % total time in department – under 4 hours GRH **Standard: >=95%**		4-hour performance is 68.82% which is an improvement compared to December which was 65.43%. The average total wait in ED reduced from 239.5 minutes to 234.4 minutes.	**Director of Unscheduled Care and Deputy Chief Operating Officer**
ED: number of patients experiencing a 12 hour trolley wait (>12hours from decision to admit to admission) **Standard: Zero**		There were 96 12 hour DTA breaches in January. This reflects the challenges in the month relating to flow, acuity and Covid.	**Director of Unscheduled Care and Deputy Chief Operating Officer**

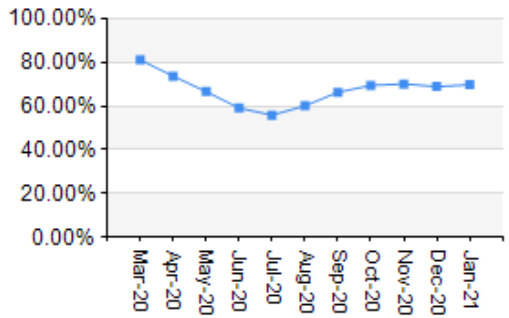
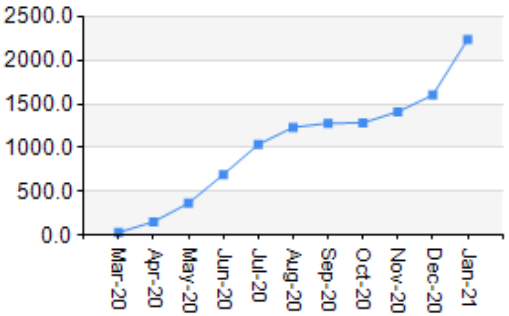
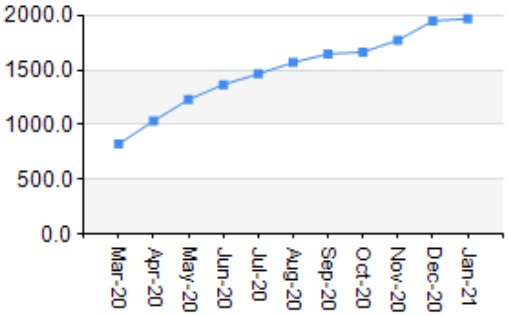
Exception Reports - Responsive (6)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Length of stay for general and acute non-elective (occupied bed days) spells **Standard: <=5.65**		LOS is under review given surge in January of C-19.	**Deputy Chief Operating Officer**
Number of patients waiting over 104 days with a TCI date **Standard: Zero**		Specialty No. Upper GI 2 Skin 1 Urological 1 Lower GI 1 Grand Total 5 Sustained rise in late referrals from neighbouring trusts for treatment (currently 6 patients >104 days). 6 patients are impacted by Covid 19	**Director of Planned Care and Deputy Chief Operating Officer**

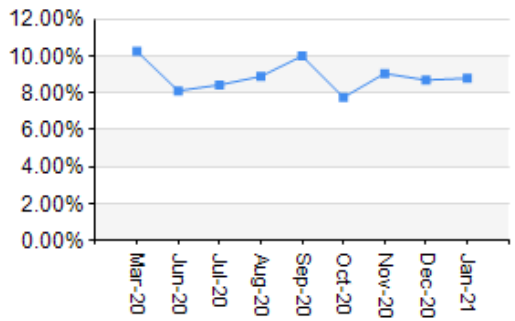
Exception Reports - Responsive (7)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Number of stranded patients with a length of stay of greater than 7 days **Standard: <=380**		LOS is under review given surge in January of C-19.	**Deputy Chief Operating Officer**
Outpatient new to follow up ratio's **Standard: <=1.9**		We continue to measure this metric, but note that Outpatients has been limited during C-19 surge 2 and therefore clinic activity is not at normal levels.	**Director of Unscheduled Care and Deputy Chief Operating Officer**
Patient discharge summaries sent to GP within 24 hours **Standard: >=88%**		Performance remains poor despite efforts to improve, continues to be monitored at executive reviews. Some tail off during covid period. It is likely significant improvement won't be made until discharge summaries are moved to sunrise system, which is work in progress to determine timeline. Efforts continue to drive improvements.	**Medical Director**

Exception Reports - Responsive (8)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Referral to treatment ongoing pathways under 18 weeks (%) **Standard: >=92%**		See Planned Care Exception report for full details. Restoration and recovery has temporarily ceased due to the scale of the second surge, with both inpatient and outpatient services effected. Cancellation of inpatients and reduction of outpatient clinics has resulted in a deterioration of performance. Decembers finalised position was 69.48% and the part validated position for January is currently 69.8%, and anticipated to be 69.9% at submission. As indicated in other metrics the long waiting cohort of patients has risen in recent months.	**Deputy Chief Operating Officer**
Referral to treatment ongoing pathways over 52 weeks (number) **Standard: Zero**		See Planned Care Exception report for full details. Restoration and recovery has temporarily ceased due to the scale of the second surge, with both inpatient and outpatient services effected. Cancellation of inpatients and reduction of outpatient clinics has resulted in a deterioration of performance. Consequently the cohort of long waiting patients has increased in January.	**Deputy Chief Operating Officer**
The number of planned / surveillance endoscopy patients waiting at month end **Standard: <=600**		There has been a deterioration of performance (20) in January following December's performance of 1949. The backlog position is due to COVID-19 pressures on a number of Endoscopy pathways, particularly cancer 2ww and 6ww diagnostic. It is anticipated that pressures will continue on performance as the Endoscopy Units across both sites have been used for inpatient escalation due to COVID demand in January 2021. Recovery planning is anticipated to commence in April 2021.	**Medical Director**

Exception Reports - Well Led (1)

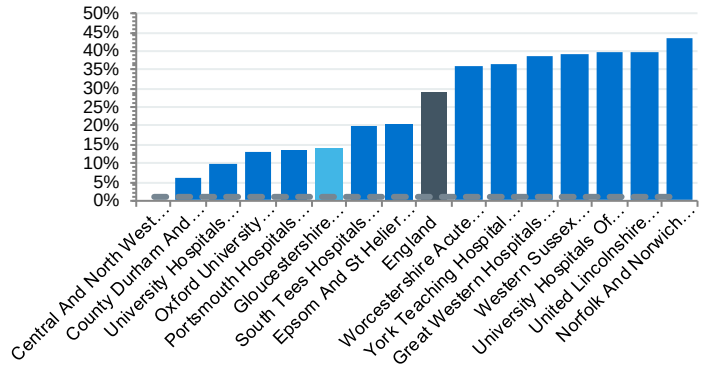
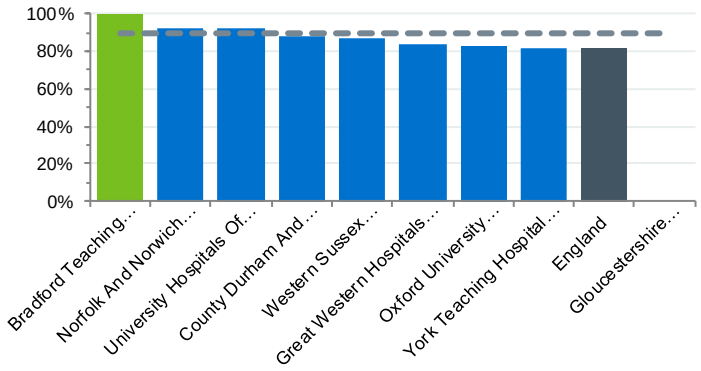
Metric Name & Standard	Trend Chart	Exception Notes	Owner
% vacancy rate for registered nurses **Standard: <=5%**		Registered Nurse vacancies remain above the 5% target, we continue to work with Divisions to reflect accurate vacancy figures and to ensure that our pipeline of supply is prioritised to the area's most in need.	**Director of Human Resources and Operational Development**

Benchmarking (1)

Gloucestershire Hospitals NHS Foundation Trust

Standard **England** **Other providers**
GHT **Best in class***

*Where there is more than one top performing provider, the first in alphabetical order is reported here

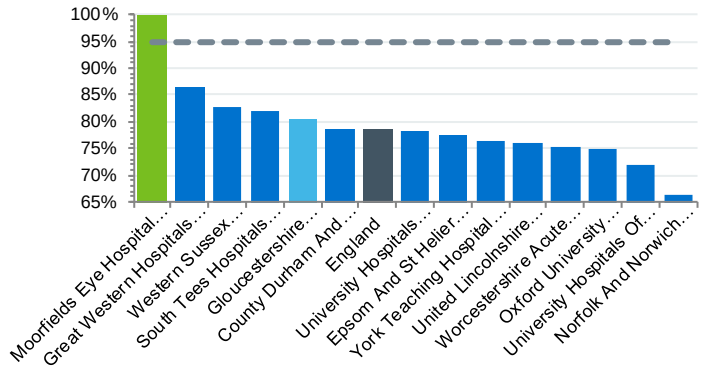
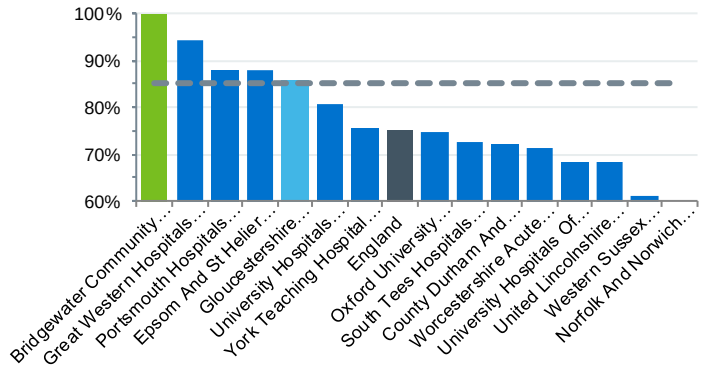
Metric	Period	Peer Group	Rank	Quartile
Diagnostics	December-20		48 / 160	2nd
Dementia	February-20		82 / 82	4th

Benchmarking (2)

Gloucestershire Hospitals NHS Foundation Trust

Standard **England** **Other providers**
GHT **Best in class***

*Where there is more than one top performing provider, the first in alphabetical order is reported here

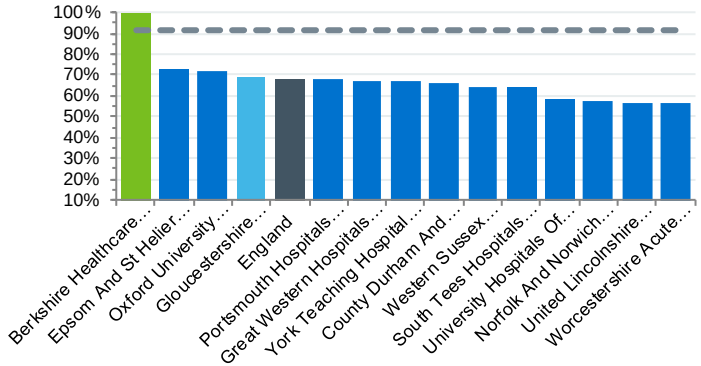
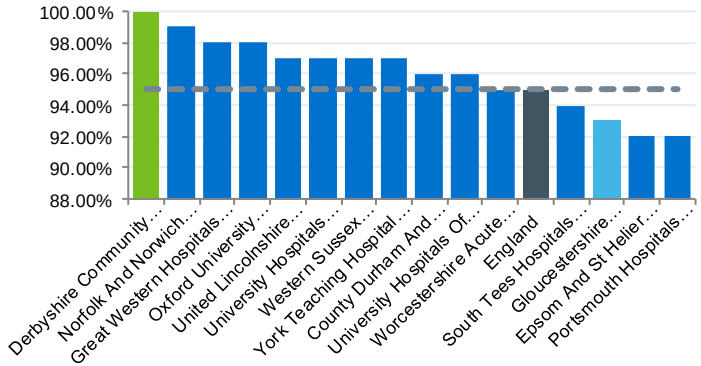
Metric	Period	Peer Group	Rank	Quartile
ED 4 Hour (Type 1 & Type 3)	January-21		47 / 114	2nd
Cancer 62 Days GP Referrals	December-20		25 / 136	1st

Benchmarking (3)

Gloucestershire Hospitals NHS Foundation Trust

Standard **England** **Other providers**
GHT **Best in class***

*Where there is more than one top performing provider, the first in alphabetical order is reported here

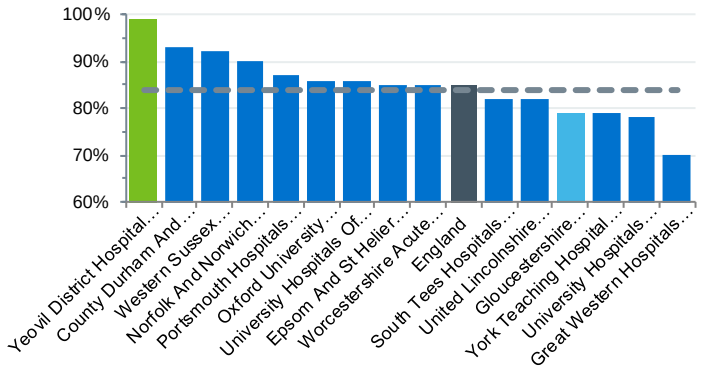
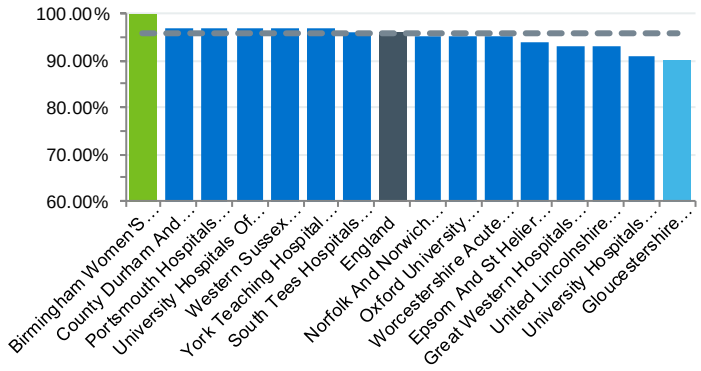
Metric	Period	Peer Group	Rank	Quartile
RTT	December-20		88 / 157	3rd
VTE (published quarterly)	December-19		116 / 149	4th

Benchmarking (4)

Gloucestershire Hospitals NHS Foundation Trust

Standard **England** **Other providers**
GHT **Best in class***

*Where there is more than one top performing provider, the first in alphabetical order is reported here

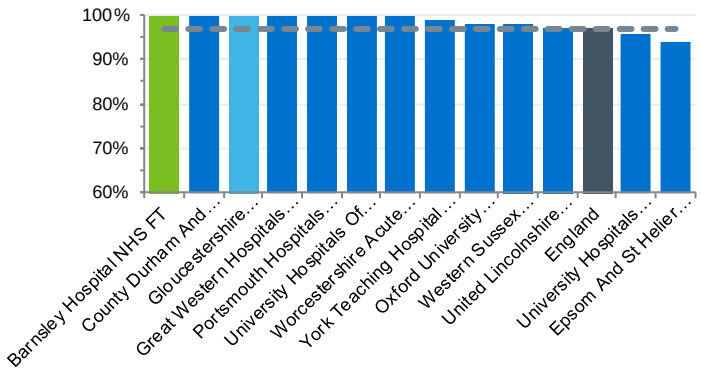
Metric	Period	Peer Group	Rank	Quartile
FFT - ED	February-20		109 / 131	4th
FFT - Inpatient	February-20		135 / 144	4th

Benchmarking (5)

Gloucestershire Hospitals NHS Foundation Trust

Standard **England** **Other providers**
GHT **Best in class***

*Where there is more than one top performing provider, the first in alphabetical order is reported here

Metric	Period	Peer Group	Rank	Quartile
FFT - Maternity	February-20		11 / 117	1st

Appendix A - New Maternity Metrics

	19/20	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	20/21 Q3	20/21	Standard	Threshold
Maternity																		
Total births		474	440	442	438	473	511	481	497	472	482	443	445	408	1,370	4,650		
Number of maternal deaths		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		
Number of births less than 37 weeks		46	26	38	30	41	33	30	43	29	38	21	34	23	93	322		
Number of births less than 34 weeks		14	5	13	6	12	5	6	10	9	8	8	16	6	32	86		
Number of births less than 27 weeks		0	0	1	2	0	2	0	0	2	1	3	2	2	6	14		
% stillbirths as percentage of all pregnancies		0.20%	0.00%	0.20%	1.14%	0.00%	0.20%	0.42%	0.00%	0.21%	0.83%	0.68%	0.22%	0.25%	0.58%	0.39%		
% Massive PPH >1.5 litres		5.3%	4.8%	5.9%	3.9%	4.7%	5.9%	4.8%	3.7%	5.8%	3.8%	4.3%	4.5%	3.9%	4.2%	4.5%	<=4%	
% breastfeeding (initiation)		80.2%	81.1%	80.8%	79.7%	81.4%	76.1%	80.5%	79.7%	77.5%	76.6%	80.8%	80.4%	81.1%	79.2%	79.3%	>=81%	
% breastfeeding (discharge to CMW)		56.5%	55.9%	56.8%	58.0%	61.1%	56.4%	57.8%	57.1%	57.8%	51.7%	59.4%	56.2%	58.5%	55.6%	57.3%		
Saving Babies Lives																		
Percentage of women with a CO measurement ≥4ppm at booking																		
Percentage of women with a CO measurement ≥4ppm at 36 weeks																		
Percentage of women who have a CO level ≥4ppm at booking and <4ppm at the 36 week appointment																		
Percentage of babies <3rd centile born > 37+6 weeks																		
Percentage of stillbirths which had issues associated with Reduced Fetal Movement management identified using Perinatal Mortality Review Tool																		
Percentage of intrapartum stillbirths, early neonatal deaths and cases of severe brain injury where failures of intrapartum monitoring are identified as a contributory factor.																		
Number of maternity and neonatal serious incidents																		
Number of incidents with moderate harm																		
Number of incidents with significant harm																		
New HSIB referrals																		

Gloucestershire Hospitals
NHS Foundation Trust

Quality and Performance Report Statistical Process Control Reporting

Reporting Period January 2021

Presented at February 2021 Q&P and March 2021 Trust Board

Contents

Gloucestershire Hospitals NHS Foundation Trust

Guidance

Gloucestershire Hospitals NHS Foundation Trust

Variation			Assurance		
					
Common cause – no significant change	Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values	Special cause of improving nature or lower pressure due to (H)igher or (L)ower values	Variation indicates inconsistently hitting passing and falling short of the target	Variation indicates consistently (P)assing the target	Variation indicates consistently (F)alling short of the target

How to interpret variation results:

- Variation results show the trends in performance over time
- Trends either show **special cause variation** or **common cause variation**
- **Special cause variation: Orange icons** indicate **concerning** special cause variation requiring action
- **Special cause variation: Blue icons** indicate where there appears to be **improvements**
- **Common cause variation: Grey icons** indicate **no significant change**

How to interpret assurance results:

- Assurance results show whether a target is likely to be achieved, and is based on trends in achieving the target over time
- **Blue icons** indicate that you would expect to **consistently achieve a target**
- **Orange icons** indicate that you would expect to **consistently miss a target**
- **Grey icons** indicate that **sometimes the target will be achieved and sometimes it will be missed**

Source: NHSI Making Data Count

Executive Summary

Gloucestershire Hospitals NHS Foundation Trust

The key areas of focus remain the assurance of patient care and safety during this time. Key reductions in non-urgent elective care took place in December and January to support organisational response to Covid-19. This has led to a number of changes and opportunities to deliver patient care in an enhanced way. The Trust through support of IM&T colleagues has continued to embrace remote working with our patients & with Primary Care. For elective care (Cancer; Screening and RTT), all patients are being reviewed and clinically prioritised and national guidance enacted. We are ensuring that we are tracking all patients and that our waiting list size is consummate with those patients requiring secondary care opinion. For unscheduled care the approach has equally been to support the safety and care of our patients to enable them to access specialist emergency care as they need to. Teams across the hospital have supported each other to offer the best care for all our patients.

During January, the Trust did not meet the national standards for 52 week waits, diagnostics and the 4 hour standard.

The Trust performance (type 1) for the 4 hour standard in January was 68.82%, against the STP trajectory of 86.19%. The system did not meet the delivery of 90% for the system in January, at 77.82%.

The Trust did not meet the diagnostics standard for January at 24.59%. We have, as with many services prioritised same day diagnostics and support for patients to be prioritised post clinical review. The achievement of this standard has been majorly impacted by C-19, specifically endoscopy tests. MR and CT have recovered their waiting time position.

The Trust did not meet the standard for 2 week wait cancer at 90.1% in January but did meet the standard for 62 day cancer waits at 86.3%, this is as yet un-validated performance at the time of the report.

For elective care, the RTT performance is 69.67% (un-validated) in January, work continues to ensure that the performance is stabilised. Significant work is underway to reduce our longest waiting patients of over 52 weeks, of which there were 2,237 in January. This is as yet un-validated performance at the time of the report.

Directors Operational Group will review the Unscheduled and Scheduled performance indicators with the Divisions and the wider Executive team.

The Quality Delivery Group (QDG) continues to monitor the performance of the quality metrics with the Divisions providing exception reports. The delivery of any action plans to deliver improvement are also reviewed within the meeting. There are improvement plans in place for any indicators that have consistently scored in the “red” target area.

Access Dashboard

Gloucestershire Hospitals NHS Foundation Trust

This dashboard shows the most recent performance of metrics in the Access category. Where SPC analysis is not possible the metric is RAG rated against national standards. Exception reports are shown on the following pages.

Key

MetricTopic	MetricNameAlias	Target & Assurance	Latest Performance & Variance	
Cancer	Cancer – 28 day FDS two week wait	TBC	Jan-21	76.3%
Cancer	Cancer – 28 day FDS breast symptom two week wait	TBC	Jan-21	97.9%
Cancer	Cancer – 28 day FDS screening referral	TBC	Jan-21	52.8%
Cancer	Cancer – urgent referrals seen in under 2 weeks from GP	>=93%	Jan-21	90.1%
Cancer	2 week wait breast symptomatic referrals	>=93%	Jan-21	70.6%
Cancer	Cancer – 31 day diagnosis to treatment (first treatments)	>=96%	Jan-21	97.7%
Cancer	Cancer – 31 day diagnosis to treatment (subsequent – drug)	>=98%	Jan-21	98.1%
Cancer	Cancer – 31 day diagnosis to treatment (subsequent – surgery)	>=94%	Jan-21	93.9%
Cancer	Cancer – 31 day diagnosis to treatment (subsequent – radiotherapy)	>=94%	Jan-21	97.4%
Cancer	Cancer 62 day referral to treatment (urgent GP referral)	>=85%	Jan-21	86.3%
Cancer	Cancer 62 day referral to treatment (screenings)	>=90%	Jan-21	93.3%
Cancer	Cancer 62 day referral to treatment (upgrades)	>=90%	Jan-21	59.4%
Cancer	Number of patients waiting over 104 days with a TCI date	Zero	Jan-21	3
Cancer	Number of patients waiting over 104 days without a TCI date	<=24	Jan-21	14
Diagnostics	% waiting for diagnostics 6 week wait and over (15 key tests)	<=1%	Jan-21	24.59%
Diagnostics	The number of planned / surveillance endoscopy patients waiting at month end	<=600	Jan-21	1,969
Discharge	Patient discharge summaries sent to GP within 24 hours	>=88%	Dec-20	52.3%
Emergency Department	ED: % total time in department – under 4 hours (type 1)	>=95%	Jan-21	68.82%
Emergency Department	ED: % total time in department – under 4 hours (types 1 & 3)	>=95%	Jan-21	77.82%
Emergency Department	ED: % total time in department – under 4 hours CGH	>=95%	Jan-21	99.92%
Emergency Department	ED: % total time in department – under 4 hours GRH	>=95%	Jan-21	68.82%

MetricTopic	MetricNameAlias	Target & Assurance	Latest Performance & Variance	
Emergency Department	ED: number of patients experiencing a 12 hour trolley wait (>12hours from decision to admit to admission)	Zero	Jan-21	96
Emergency Department	ED: % of time to initial assessment – under 15 minutes	>=95%	Jan-21	64.5%
Emergency Department	ED: % of time to start of treatment – under 60 minutes	>=90%	Jan-21	48.9%
Emergency Department	% of ambulance handovers that are over 30 minutes	<=2.96%	Jan-21	8.14%
Emergency Department	% of ambulance handovers that are over 60 minutes	<=1%	Jan-21	9.57%
Maternity	% of women booked by 12 weeks gestation	>90%	Jan-21	94.2%
Operational Efficiency	Number of patients stable for discharge	<=70	Jan-21	12
Operational Efficiency	Number of stranded patients with a length of stay of greater than 7 days	<=380	Jan-21	403
Operational Efficiency	Average length of stay (spell)	<=5.06	Jan-21	6.25
Operational Efficiency	Length of stay for general and acute non-elective (occupied bed days) spells	<=5.65	Jan-21	6.42
Operational Efficiency	Length of stay for general and acute elective spells (occupied bed days)	<=3.4	Jan-21	4.38
Operational Efficiency	% day cases of all electives	>80%	Jan-21	90.65%
Operational Efficiency	Intra-session theatre utilisation rate	>85%	Jan-21	79.3%
Operational Efficiency	Cancelled operations re-admitted within 28 days	>=95%	Jan-21	14.30%
Operational Efficiency	Urgent cancelled operations	No target	Jan-21	4
Outpatient	Outpatient new to follow up ratio's	<=1.9	Jan-21	2.14
Outpatient	Did not attend (DNA) rates	<=7.6%	Jan-21	6.50%
Readmissions	Emergency re-admissions within 30 days following an elective or emergency spell	<8.25%	Dec-20	7.7%
Research	Research accruals	No target	Dec-20	382

Access Dashboard

Gloucestershire Hospitals NHS Foundation Trust

This dashboard shows the most recent performance of metrics in the Access category. Where SPC analysis is not possible the metric is RAG rated against national standards. Exception reports are shown on the following pages.

Key

Assurance

- Consistently hit target
- Hit and miss target subject to random
- Consistently fail target

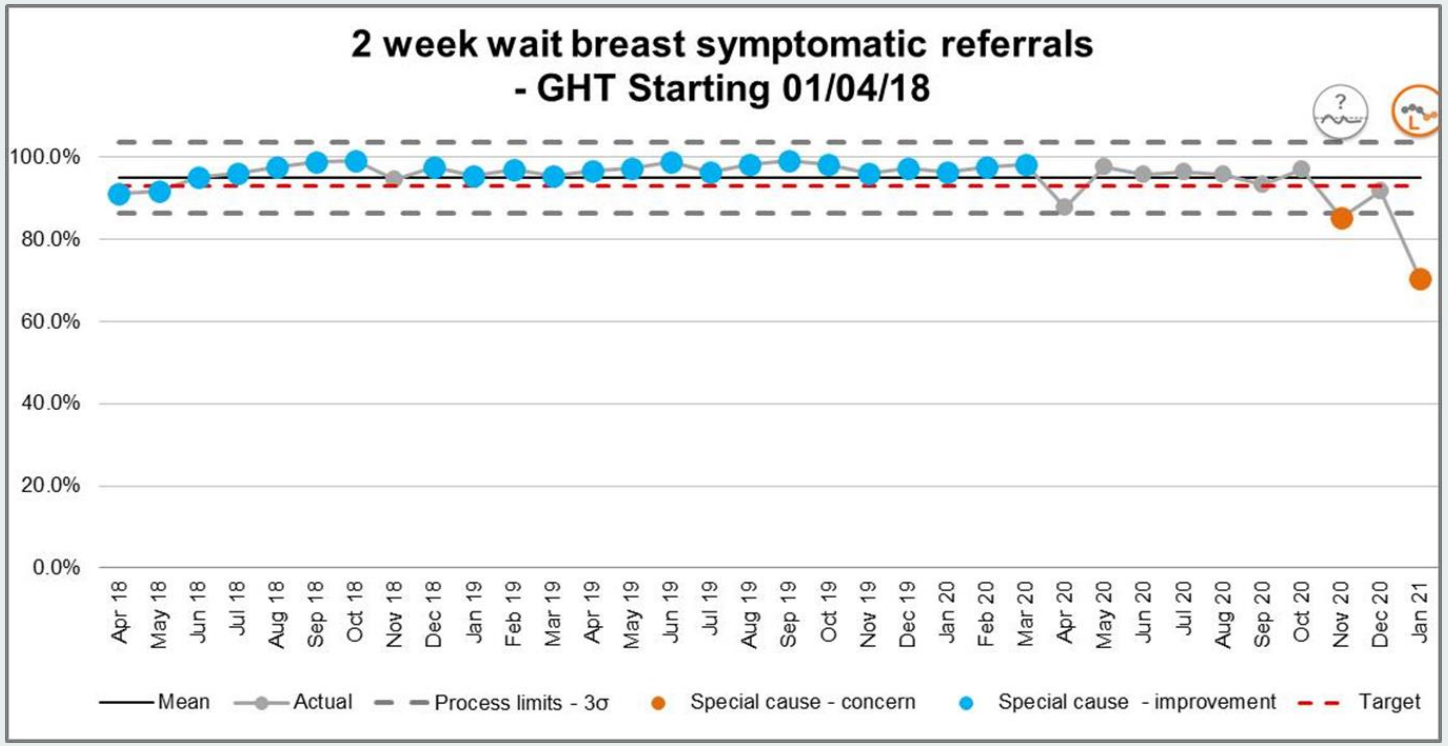
Variation

- Special Cause Concerning variation
- Common Cause
- Special Cause Improving variation

MetricTopic	MetricNameAlias	Target & Assurance		Latest Performance & Variance		
RTT	Referral to treatment ongoing pathways under 18 weeks (%)	>=92%		Jan-21	69.67%	
RTT	Referral to treatment ongoing pathways 35+ Weeks (number)	No target		Jan-21	6,646	
RTT	Referral to treatment ongoing pathways 45+ Weeks (number)	No target		Jan-21	4,798	
RTT	Referral to treatment ongoing pathways over 52 weeks (number)	Zero		Jan-21	2,237	
RTT	Referral to treatment ongoing pathways 70+ Weeks (number)	No target		Jan-21	245	
Stroke Care	Stroke care: percentage of patients receiving brain imaging within 1 hour	>=43%		Jan-21	56.1%	
Stroke Care	Stroke care: percentage of patients spending 90%+ time on stroke unit	>=85%		Dec-20	91.4%	
Stroke Care	% of patients admitted directly to the stroke unit in 4 hours	>=75%		Jan-21	24.4%	
Stroke Care	% patients receiving a swallow screen within 4 hours of arrival	>=75%		Jan-21	71.8%	
SUS	Percentage of records submitted nationally with valid GP code	>=99%		Aug-20	100.00%	
SUS	Percentage of records submitted nationally with valid NHS number	>=99%		Aug-20	99.9%	
Trauma & Orthopaedics	% of fracture neck of femur patients treated within 36 hours	>=90%		Jan-21	75.80%	
Trauma & Orthopaedics	% fractured neck of femur patients meeting best practice criteria	>=65%		Jan-21	75.8%	

Access:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

2ww breast symptoms performance (unvalidated) = 70.6%
Target = 93.0%
National performance = 67.0%

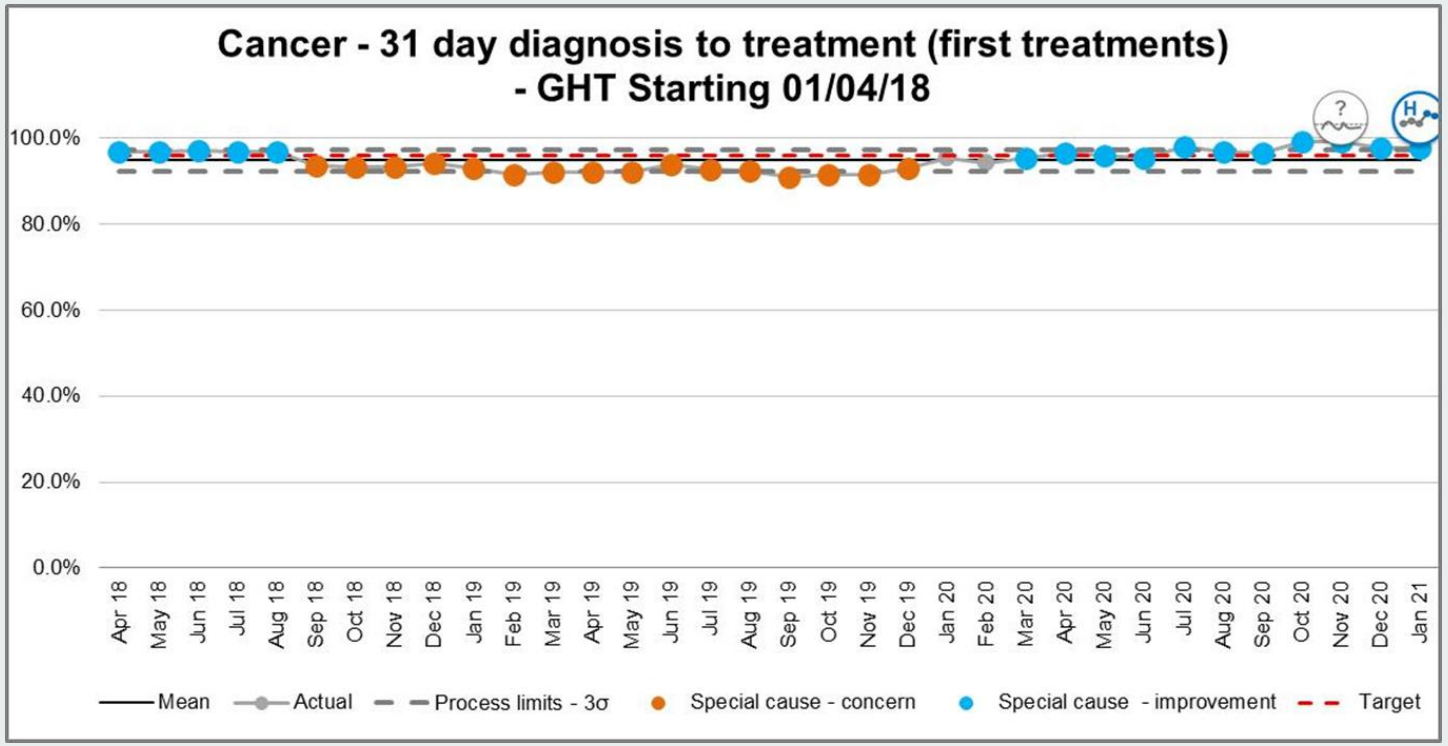
Performance impacted by outpatient capacity caused by staff sickness in December and high 2ww referral levels. February performance showing clear sign of recovery with 98.2% of patients seen within target (110 seen).
- Director of Planned Care and Deputy Chief Operating Officer

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 2 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above the mean.
Run	When there is a run of 7 increasing or decreasing sequential points this may indicate a significant change in the process. This process is not in control. In this data set there is a run of rising points
2 of 3	When 2 out of 3 points lie near the LPL this is a warning that the process may be changing

Access:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

31 day new performance (unvalidated) = 97.4%
Target = 96%
National performance = 96.0%

Currently 97.6% for annual performance 20/21. December will be the ninth month in a row of meeting the standard

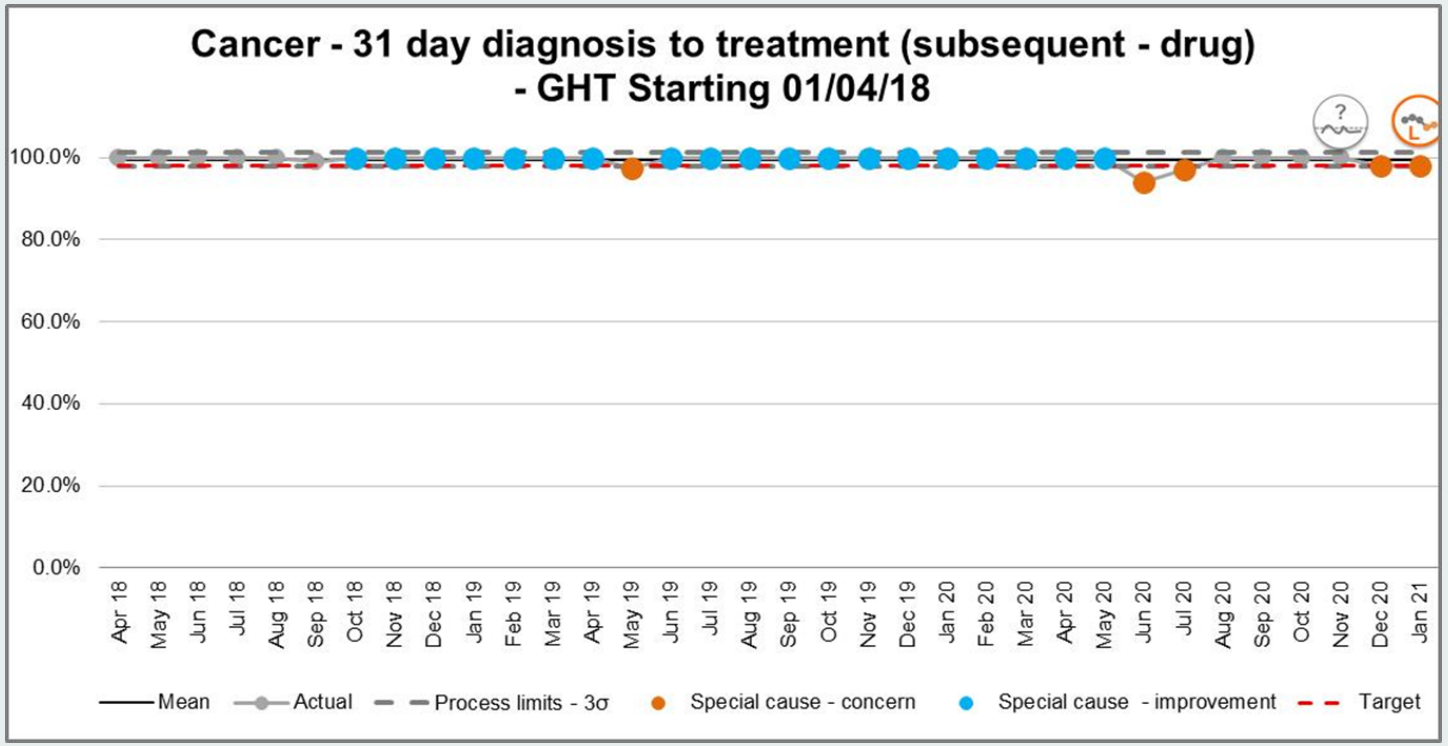
- Director of Planned Care and Deputy Chief Operating Officer

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 5 data points which are above the line. There are 7 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above and below the mean.
2 of 3	When 2 out of 3 points lie near the LPL and UPL this is a warning that the process may be changing

Access:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

31 day subs chemotherapy performance (unvalidated)= 100.0%
Target = 98%
National performance = 99.4%

106 treatments 0 breaches

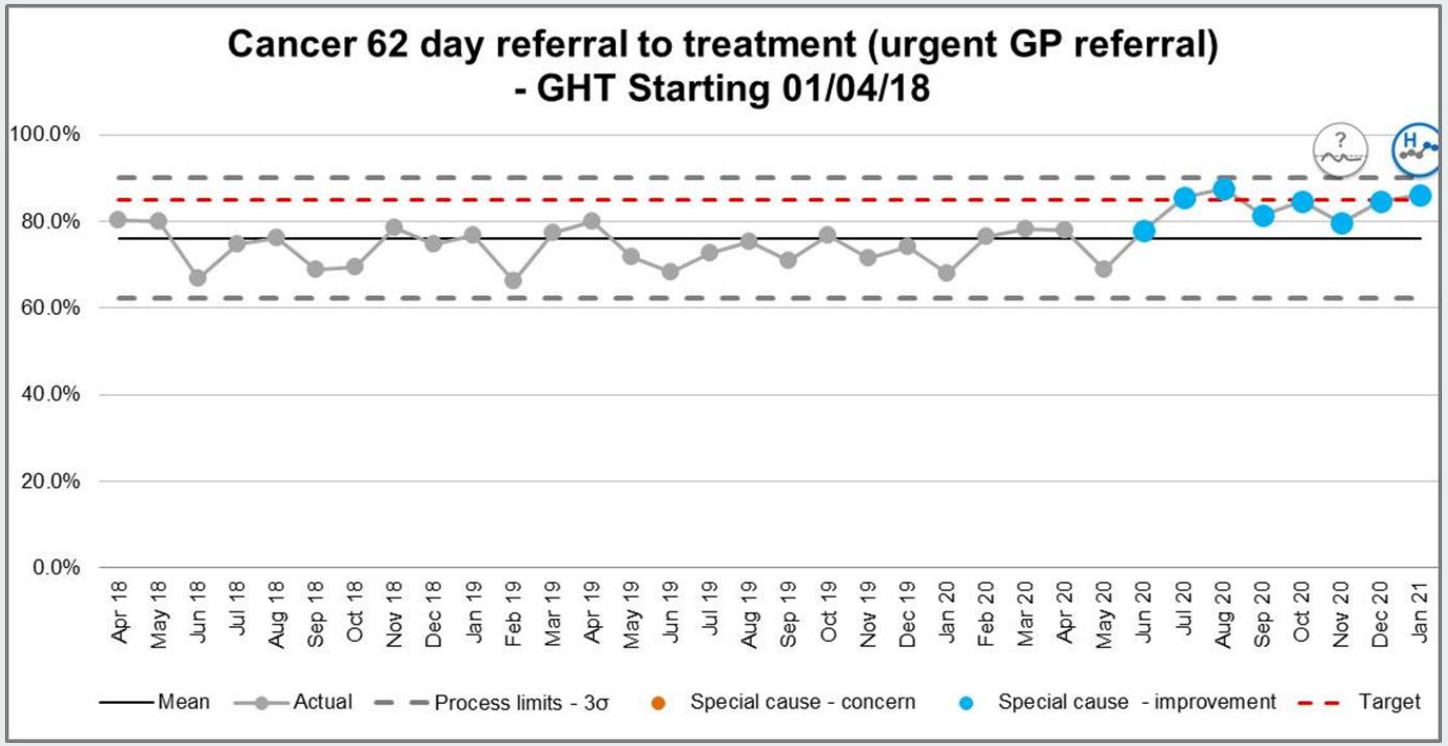
- Director of Planned Care and Deputy Chief Operating Officer

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 3 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above and below the mean.
2 of 3	When 2 out of 3 points lie near the LPL this is a warning that the process may be changing

Access:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

2ww performance (unvalidated) = 90.1%
Target = 93.0%
National performance = 87.5%
1771 date first seens & 176 breaches
A difficult month with the Breast service still recovering from issues in Nov/December. Current breast performance (Feb 21) shows a dramatic improvement with 231 out of 233 first seen within 14 days (99.1%). There were a higher number of patient choice breaches in January relating to the festive period (40 breaches) with 43 breaches relating to patients having target dates between Christmas day and 3rd January 21.
Trust highly probable to meet 2ww standard in February (currently at 96.3% with 1165 patients seen).
2ww activity back up to 19/20 and in some specialties it is well above.
Annual performance currently 94.3%

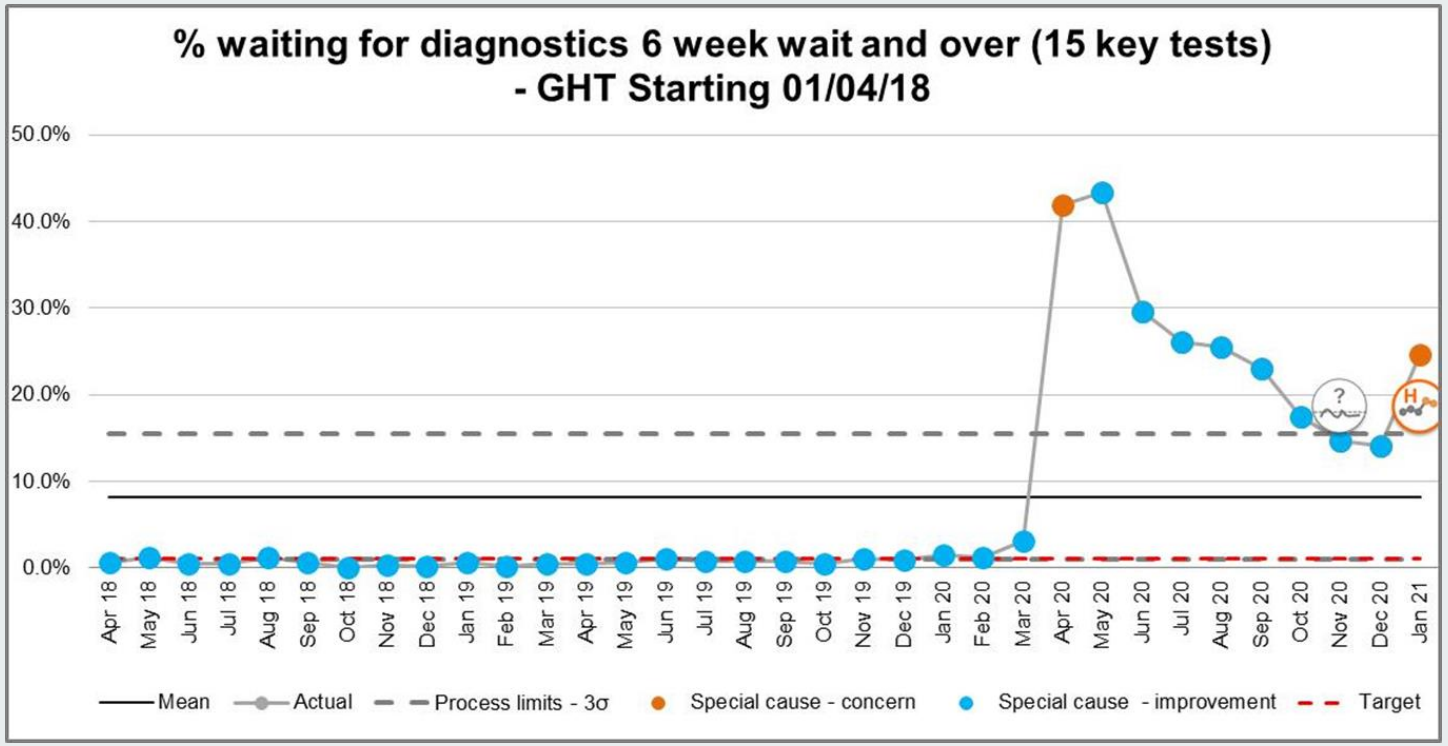
- Director of Planned Care and Deputy Chief Operating Officer

Data Observations

Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a sigificant change in process. This process is not in control. There is a run of points above the mean.
2 of 3	When 2 out of 3 points lie near the UPL this is a warning that the process may be changing

Access:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

A full breakdown of diagnostic performance is available within the exception report.

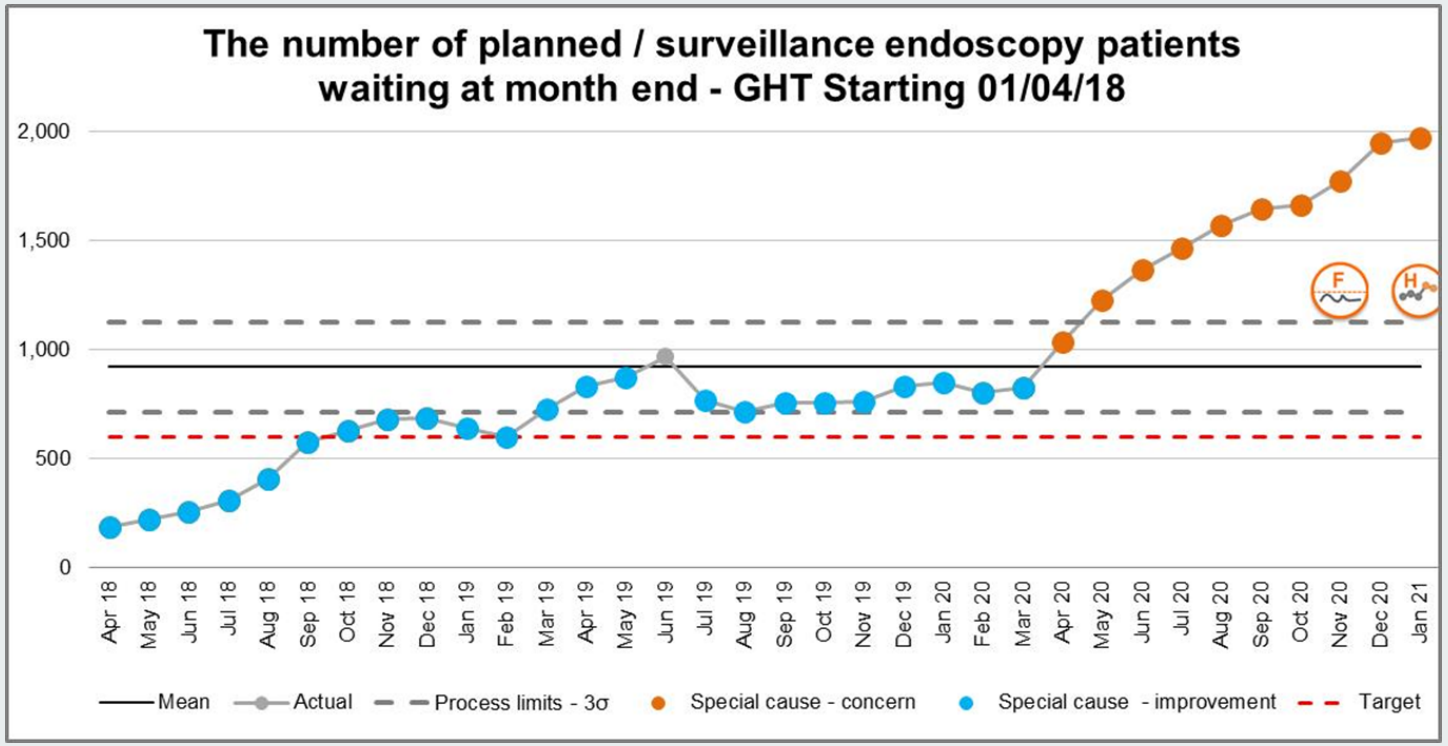
- Director of Unscheduled Care and Deputy Chief Operating Officer

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 8 data points which are above the line. There are 17 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above and below the mean.
Run	When there is a run of 7 increasing or decreasing sequential points this may indicate a significant change in the process. This process is not in control. In this data set there is a run of falling points
2 of 3	When 2 out of 3 points lie near the LPL and UPL this is a warning that the process may be changing

Access:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

There has been a deterioration of performance (20) in January following December's performance of 1949. The backlog position is due to COVID-19 pressures on a number of Endoscopy pathways, particularly cancer 2ww and 6ww diagnostic.

It is anticipated that pressures will continue on performance as the Endoscopy Units across both sites have been used for inpatient escalation due to COVID demand in January 2021. Recovery planning is anticipated to commence in April 2021.

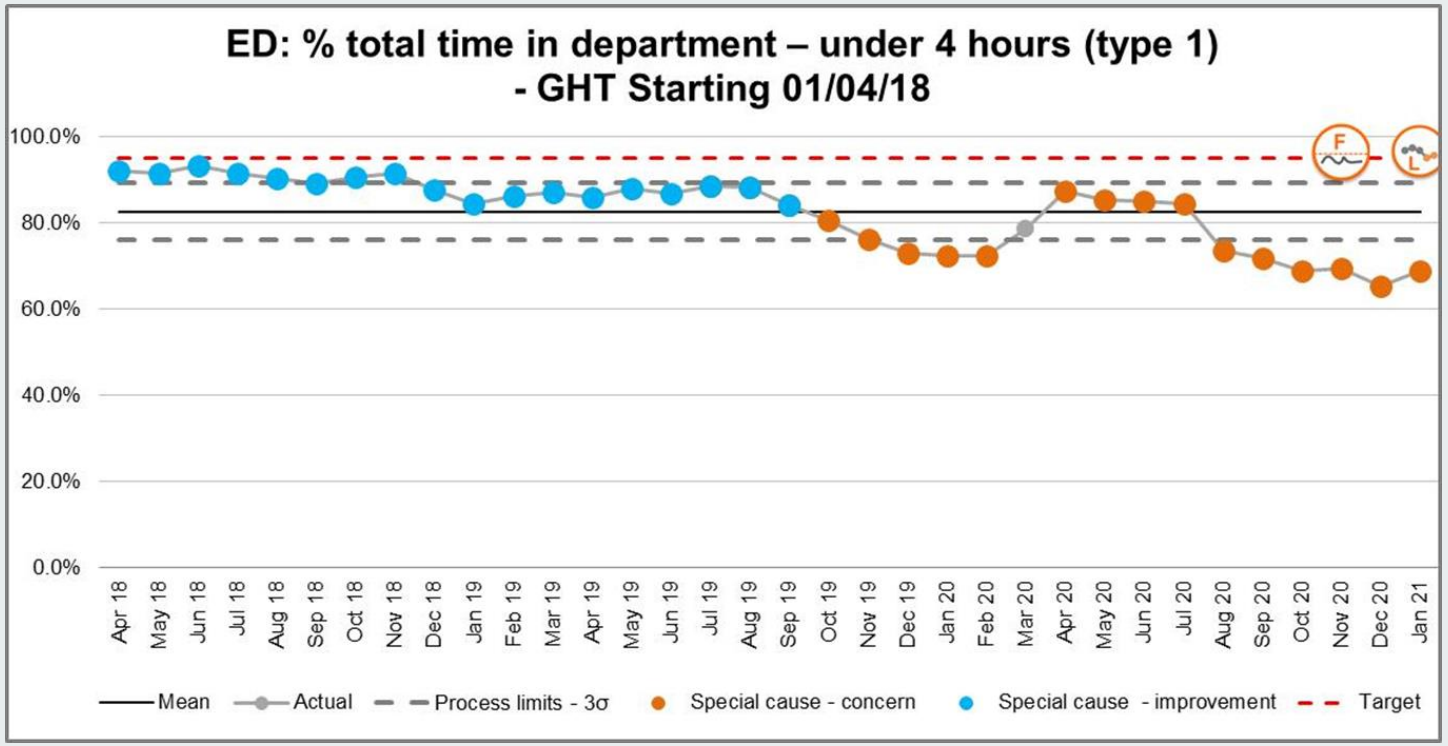
- Medical Director

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 9 data points which are above the line. There are 12 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above and below the mean.
Run	When there is a run of 7 increasing or decreasing sequential points this may indicate a significant change in the process. This process is not in control. In this data set there is a run of rising points
2 of 3	When 2 out of 3 points lie near the LPL and UPL this is a warning that the process may be changing

Access:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

4-hour performance is 68.82% which is an improvement compared to December which was 65.43%. The average total wait in ED reduced from 239.5 minutes to 234.4 minutes.

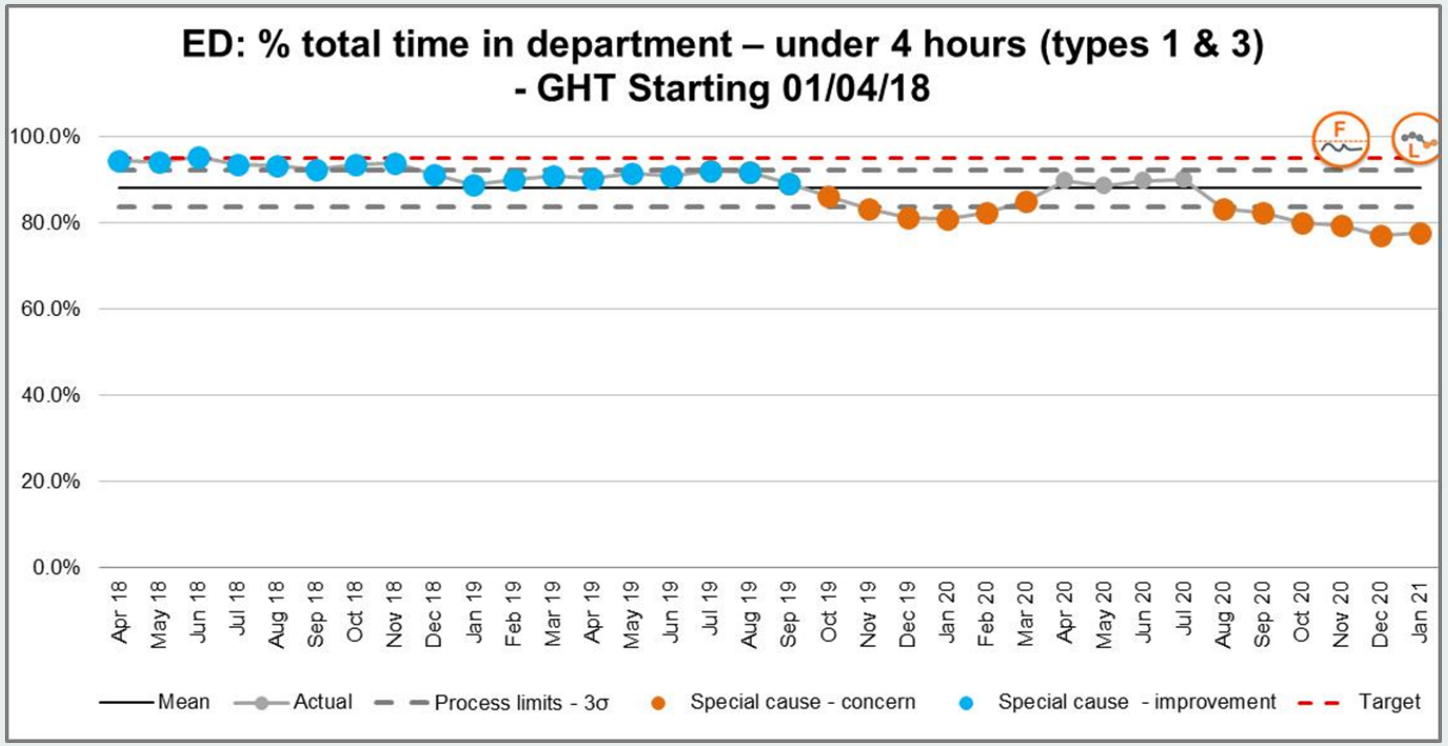
- Director of Unscheduled Care and Deputy Chief Operating Officer

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 7 data points which are above the line. There are 9 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above the mean.
Run	When there is a run of 7 increasing or decreasing sequential points this may indicate a significant change in the process. This process is not in control. In this data set there is a run of falling points
2 of 3	When 2 out of 3 points lie near the LPL and UPL this is a warning that the process may be changing

Access:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

4-hour performance is 77.82% which is an improvement compared to December which was 77.06%. The average total wait in ED reduced from 239.5 minutes to 234.4 minutes.

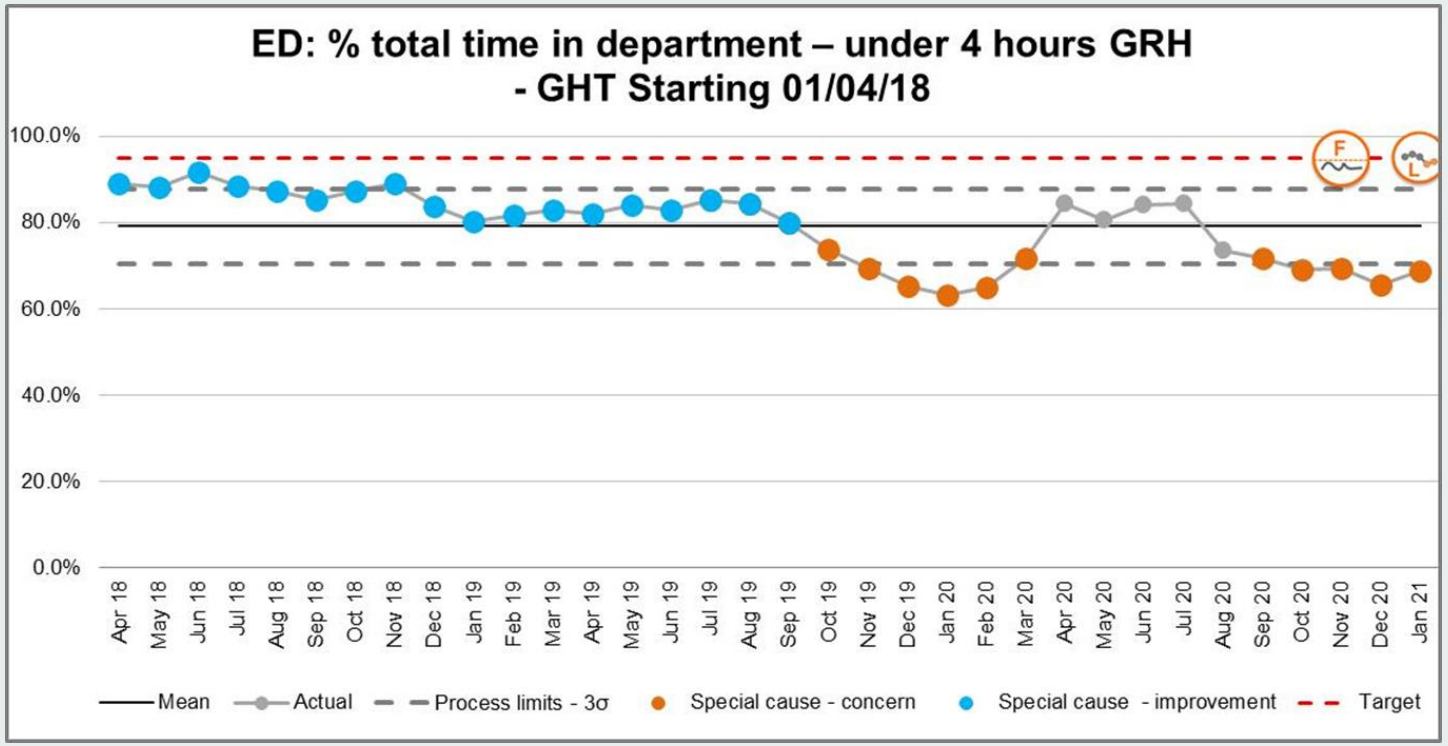
- Director of Unscheduled Care and Deputy Chief Operating Officer

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 8 data points which are above the line. There are 10 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above the mean.
Run	When there is a run of 7 increasing or decreasing sequential points this may indicate a significant change in the process. This process is not in control. In this data set there is a run of falling points
2 of 3	When 2 out of 3 points lie near the LPL and UPL this is a warning that the process may be changing

Access:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

4-hour performance is 68.82% which is an improvement compared to December which was 65.43%. The average total wait in ED reduced from 239.5 minutes to 234.4 minutes.

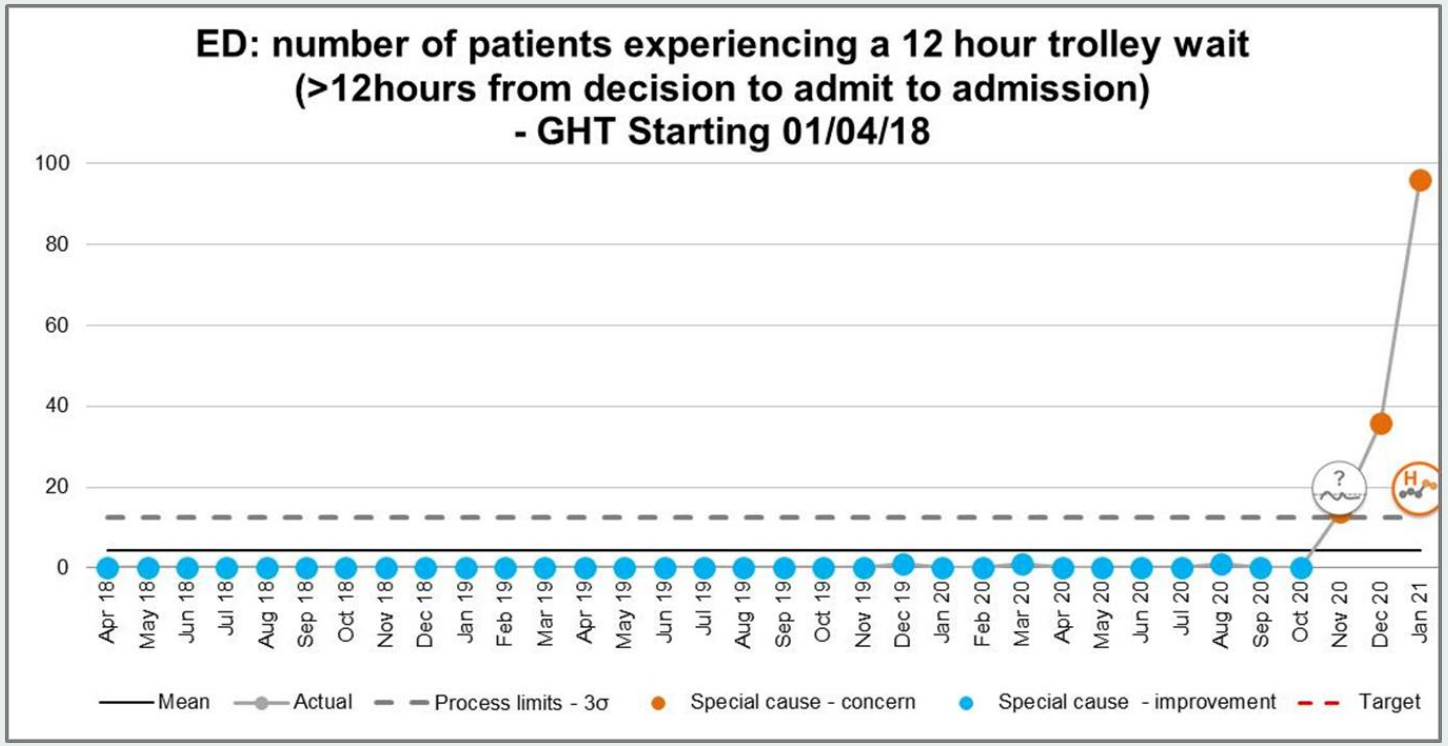
- Director of Unscheduled Care and Deputy Chief Operating Officer

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There is 5 data point which is above the line. There are 8 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above and below the mean.
Run	When there is a run of 7 increasing or decreasing sequential points this may indicate a significant change in the process. This process is not in control. In this data set there is a run of falling points
2 of 3	When 2 out of 3 points lie near the LPL this is a warning that the process may be changing

Access:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

There were 96 12 hour DTA breaches in January. This reflects the challenges in the month relating to flow, acuity and Covid.

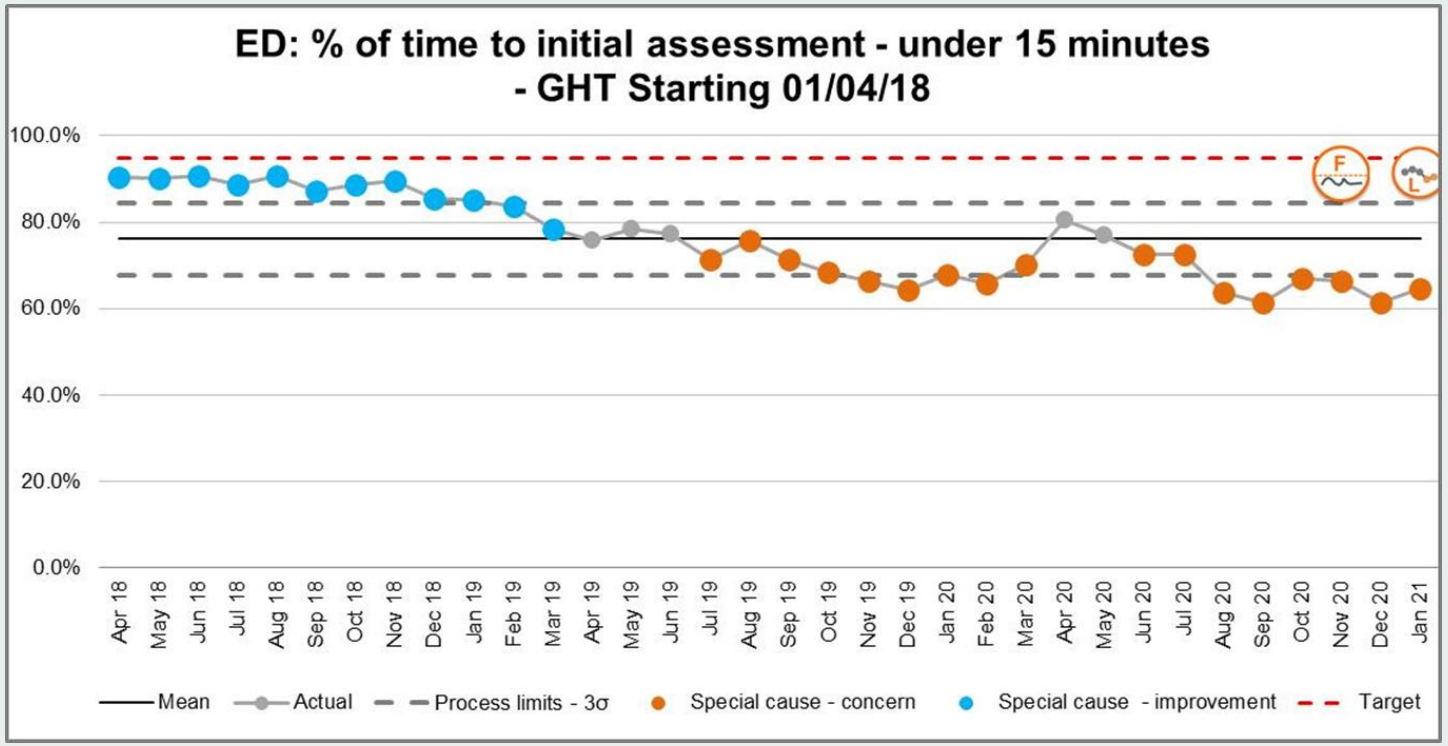
- Director of Unscheduled Care and Deputy Chief Operating Officer

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 3 data points which are above the line.
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points below the mean.
2 of 3	When 2 out of 3 points lie near the UPL this is a warning that the process may be changing

Access:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

Average time to triage reduced this month with the average wait for walk in patients being 17.7 minutes and 22.7 minutes for patients who arrive by ambulance. The pit stop continues the run which allows for rapid assessment and in times of extreme escalation, triage takes place on the ambulance.

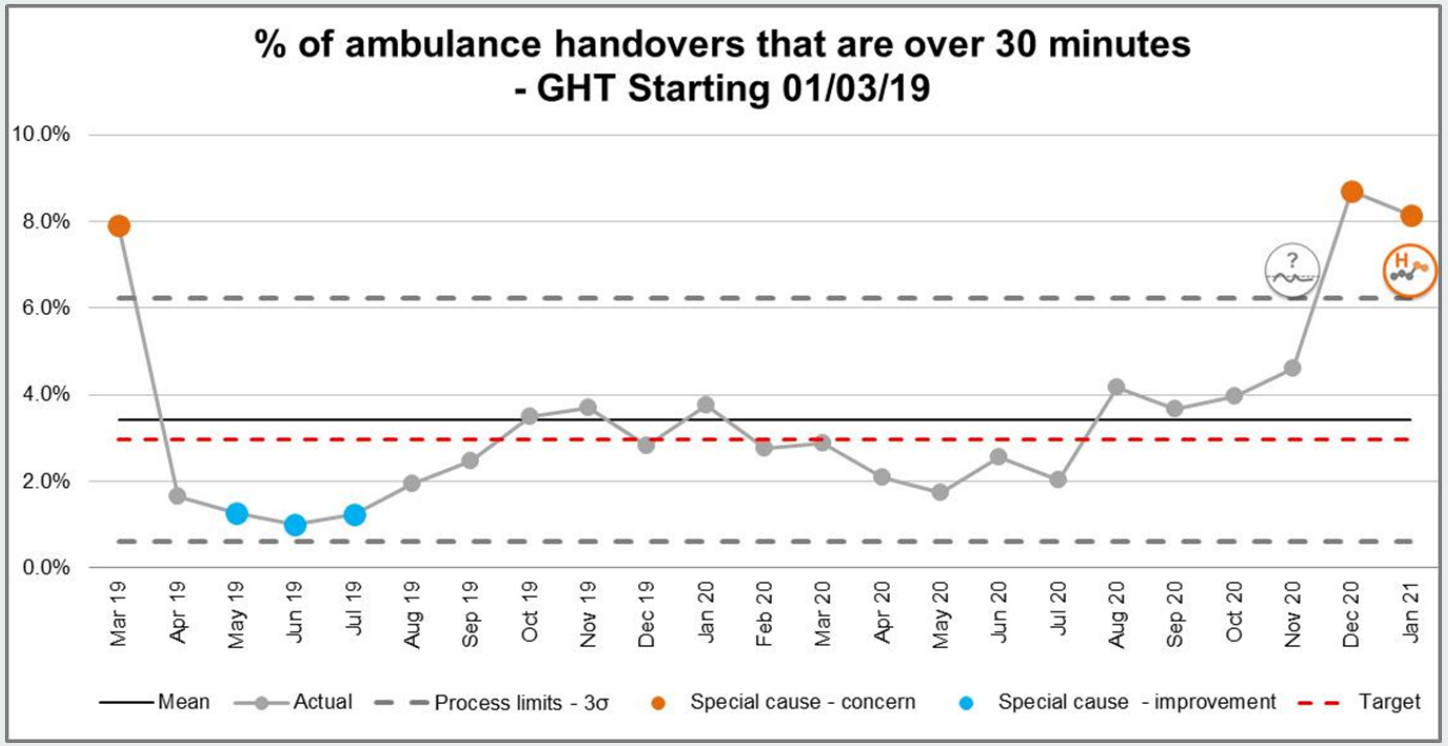
- Director of Unscheduled Care and Deputy Chief Operating Officer

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 10 data points which are above the line. There are 9 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above and below the mean.
2 of 3	When 2 out of 3 points lie near the LPL and UPL this is a warning that the process may be changing

Access:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

A decrease in the number of handovers in January compared to December, however they still remain high. A cohort area was agreed this month which should be used only in the event of a System Wide Major Incident.

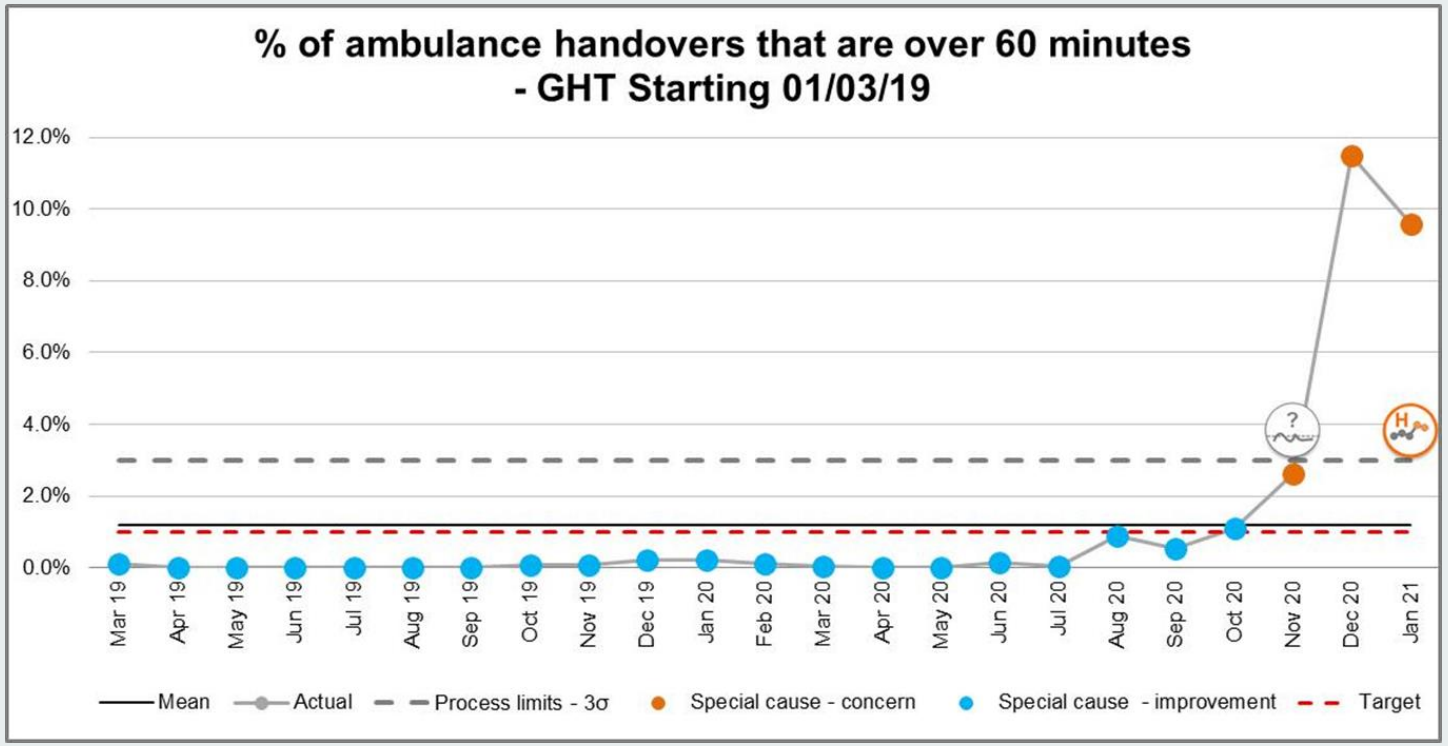
- Director of Unscheduled Care and Deputy Chief Operating Officer

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 3 data points which are above the line.
2 of 3	When 2 out of 3 points lie near the LPL this is a warning that the process may be changing

Access:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

A decrease in the number of handovers in January compared to December, however they still remain high. A cohort area was agreed this month which should be used only in the event of a System Wide Major Incident.

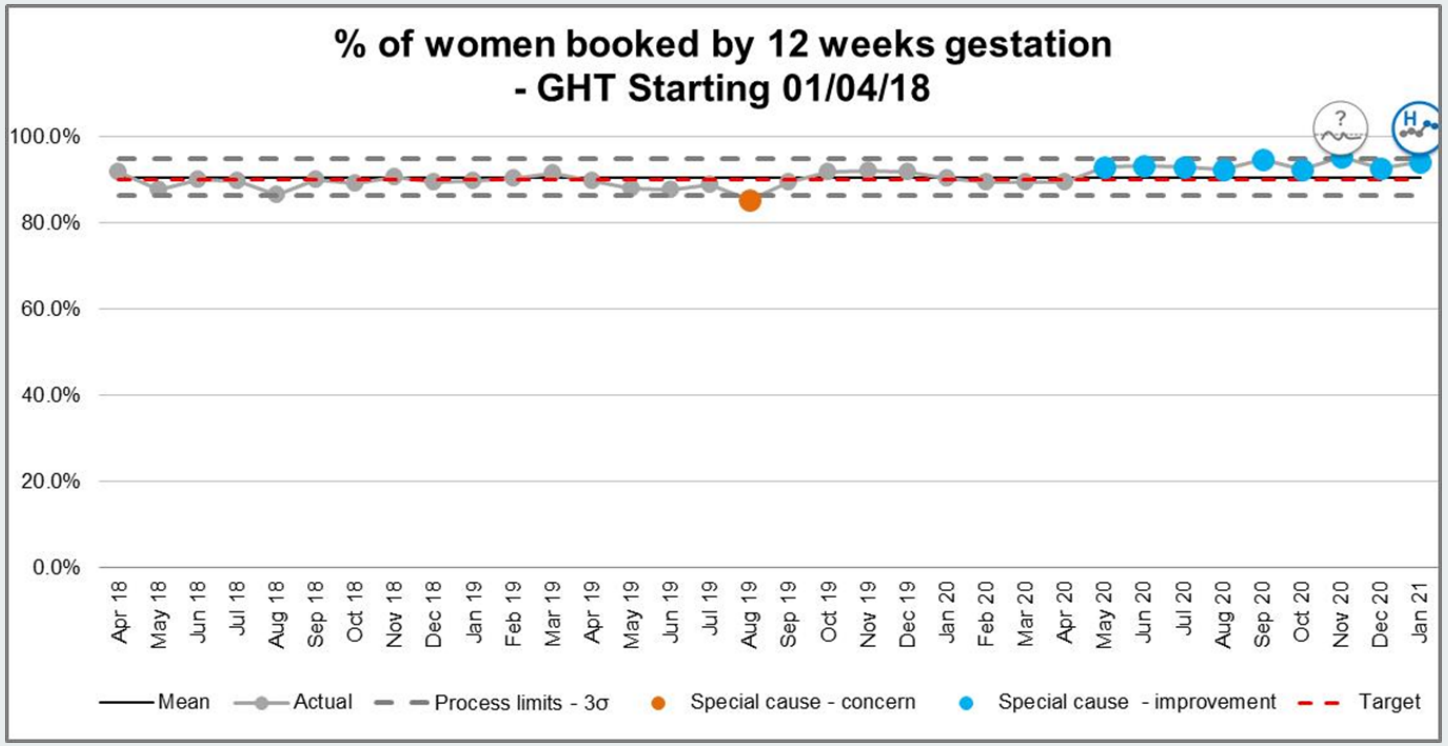
- Director of Unscheduled Care and Deputy Chief Operating Officer

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 2 data points which are above the line.
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points below the mean.
2 of 3	When 2 out of 3 points lie near the UPL this is a warning that the process may be changing

Access:
SPC – Special Cause Variation

Gloucestershire Hospitals
NHS Foundation Trust



Commentary

With the GP surgeries now being more open, women are being referred to the midwifery service in a timely manner. This enables early contact by the community midwife for booking completion by 12 weeks.

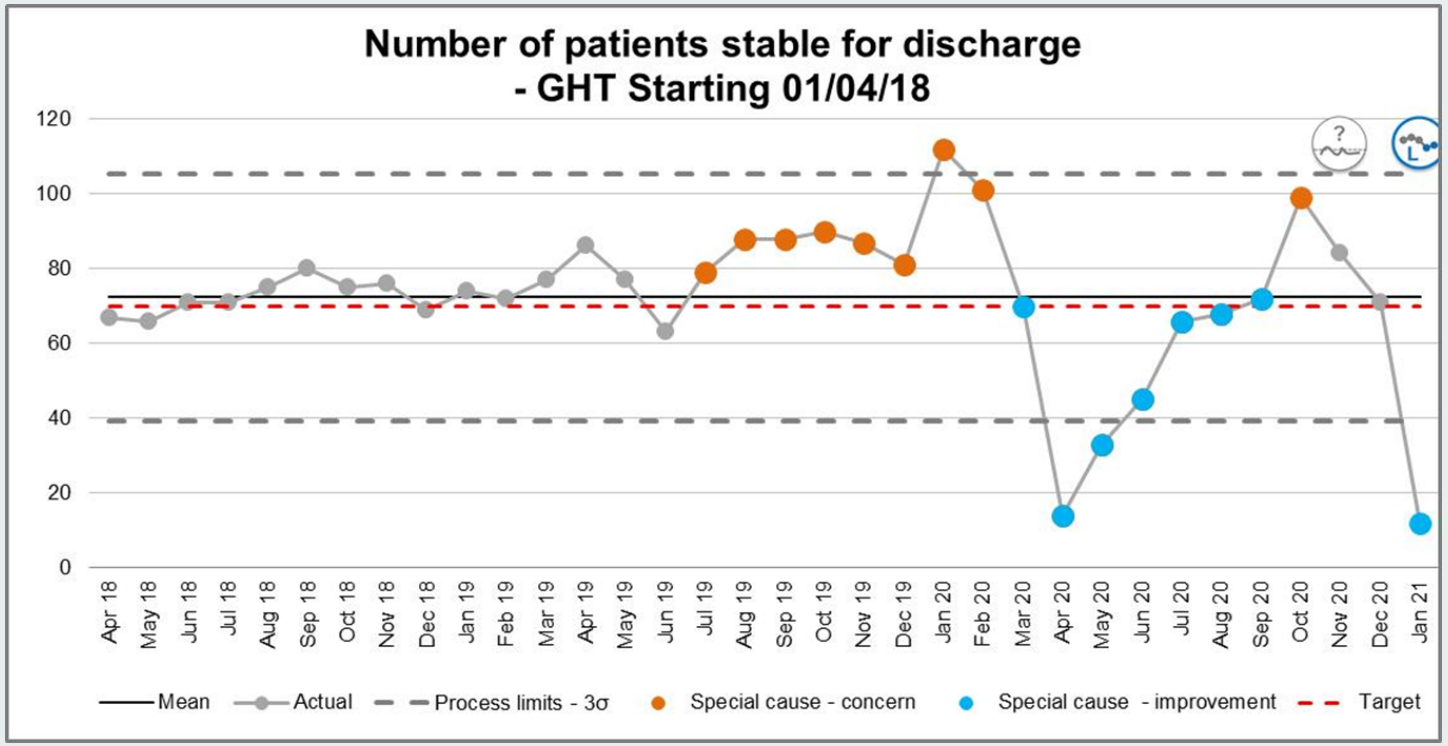
- Divisional Chief Nurse and Director of Midwifery

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There is 1 data point which is above the line. There is 1 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above the mean.
2 of 3	When 2 out of 3 points lie near the UPL this is a warning that the process may be changing

Access:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

Under Review.

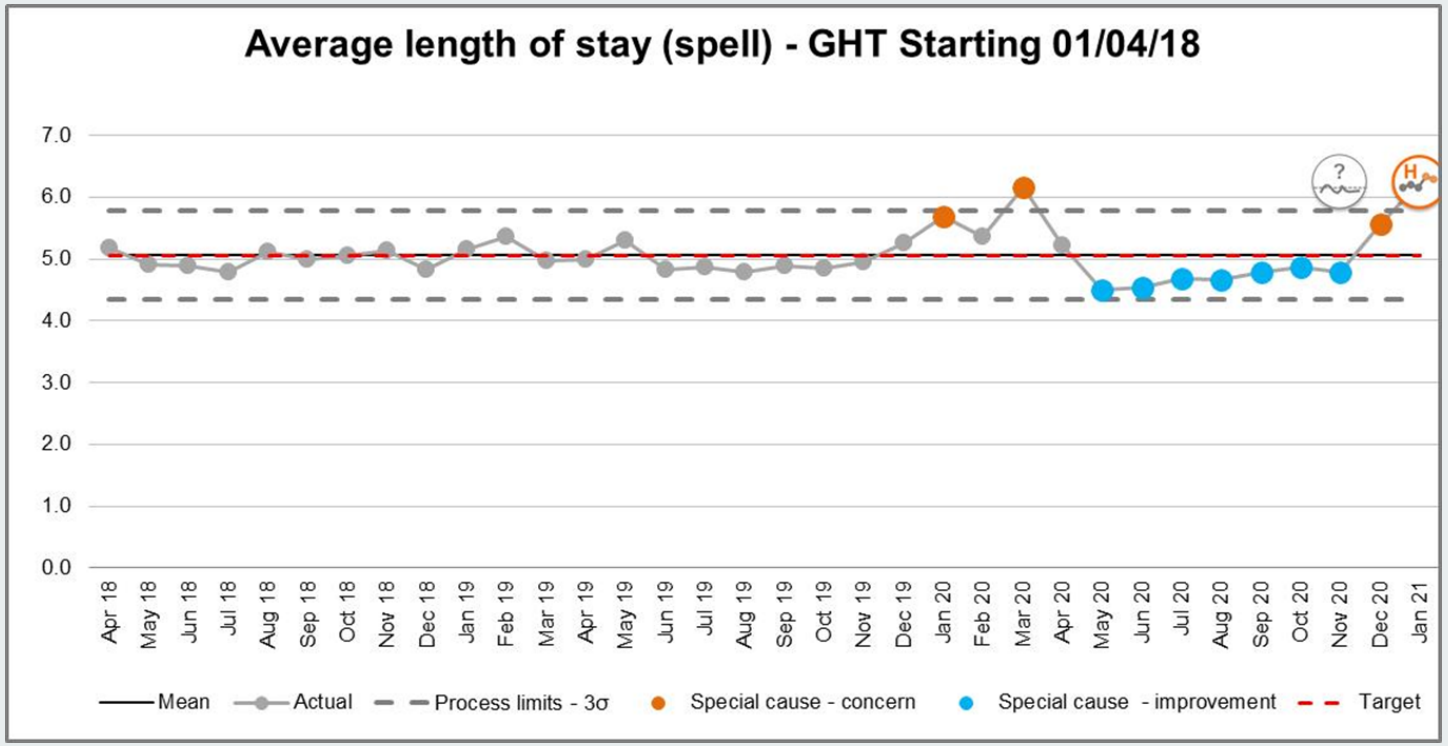
- Head of Therapy & OCT

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There is 1 data point which is above the line. There are 3 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above and below the mean.
Run	When there is a run of 7 increasing or decreasing sequential points this may indicate a significant change in the process. This process is not in control. In this data set there is a run of rising points
2 of 3	When 2 out of 3 points lie near the LPL and UPL this is a warning that the process may be changing

Access:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

ALOS under review given the latest surge in January 2020.

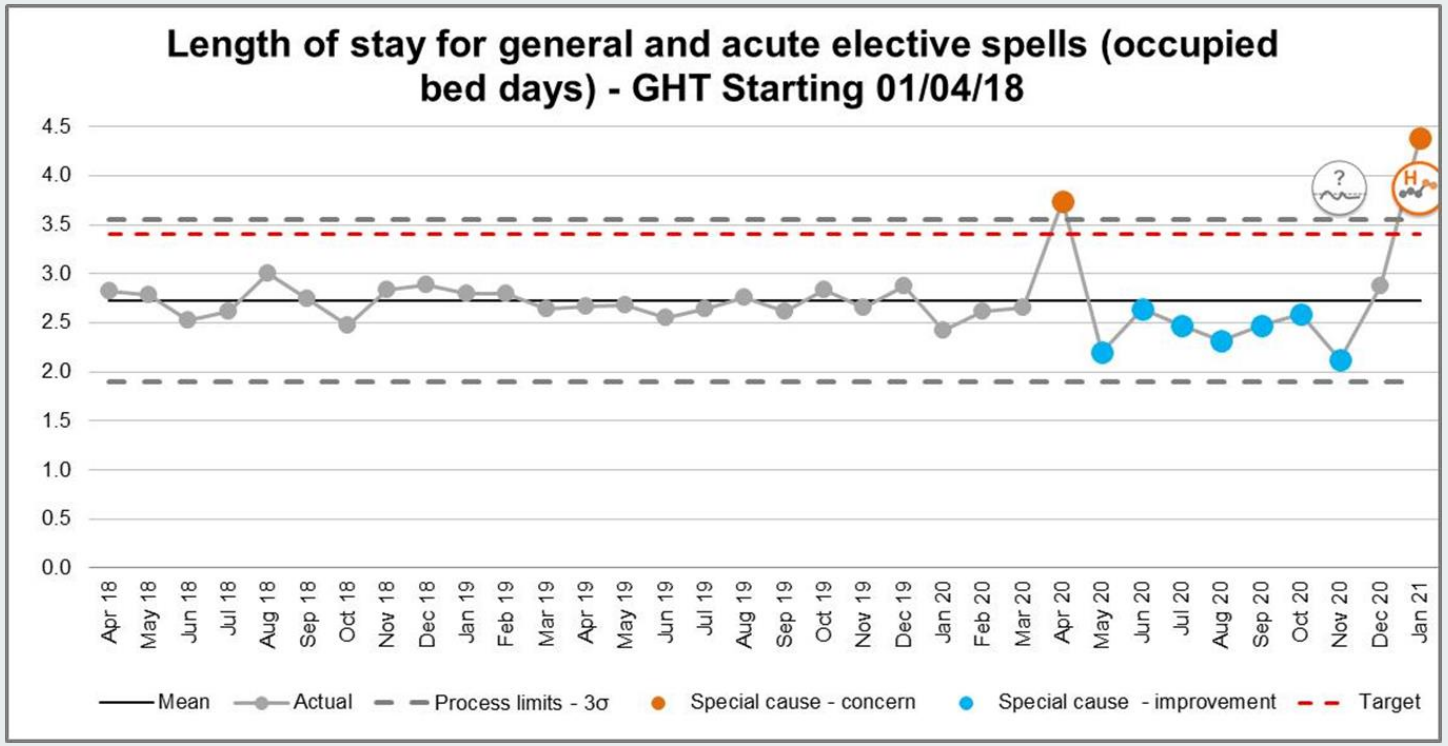
- Deputy Chief Operating Officer

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 2 data points which are above the line.
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points below the mean.
2 of 3	When 2 out of 3 points lie near the LPL and UPL this is a warning that the process may be changing

Access:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

LOS subject to review given the latest surge in January 2020.

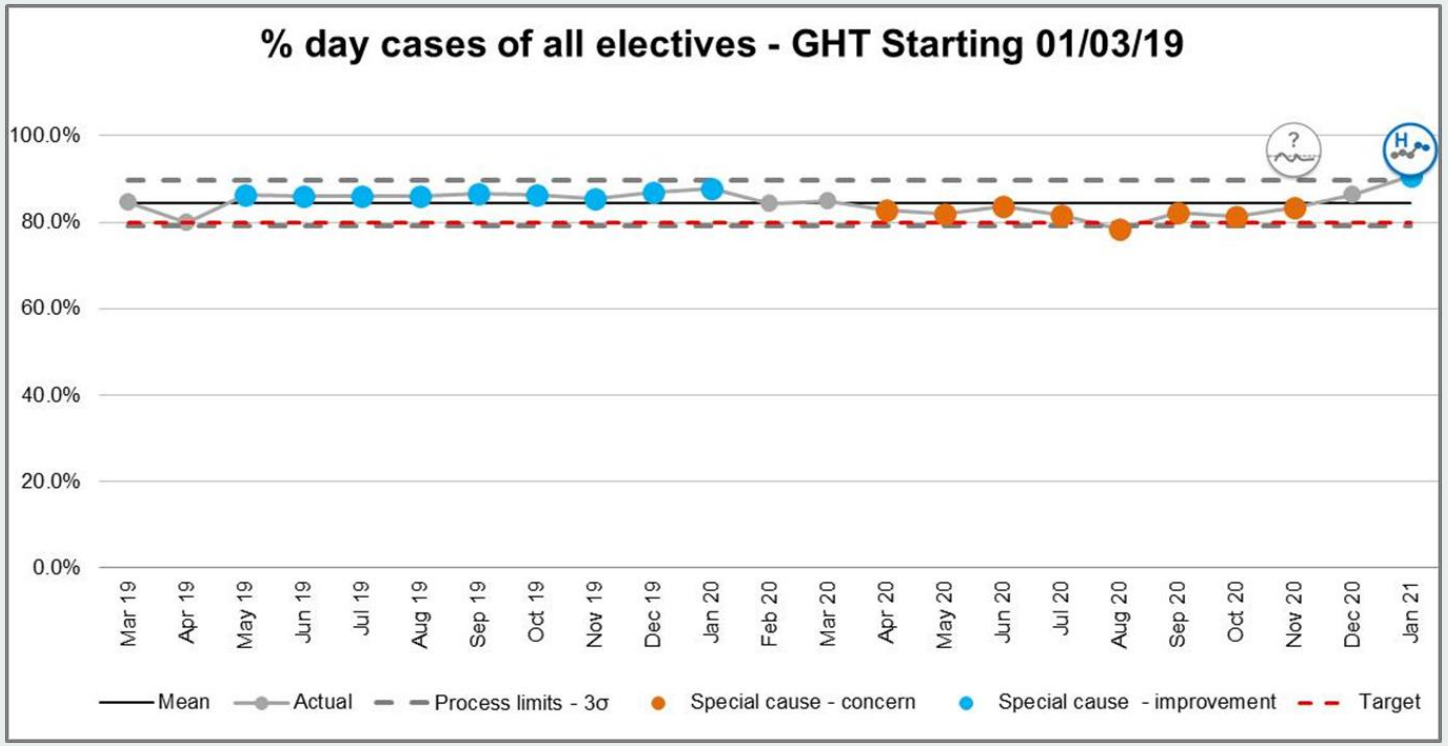
- Deputy Chief Operating Officer

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 2 data points which are above the line.
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points below the mean.
Rule 4	When more than 15 consecutive points lie within the mean +/- 1σ this process is considered to be out of control.

Access:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

Patients are being prioritised on clinical need, therefore this measure is reported but not fully utilised in an evidence base for a restricted elective capacity.

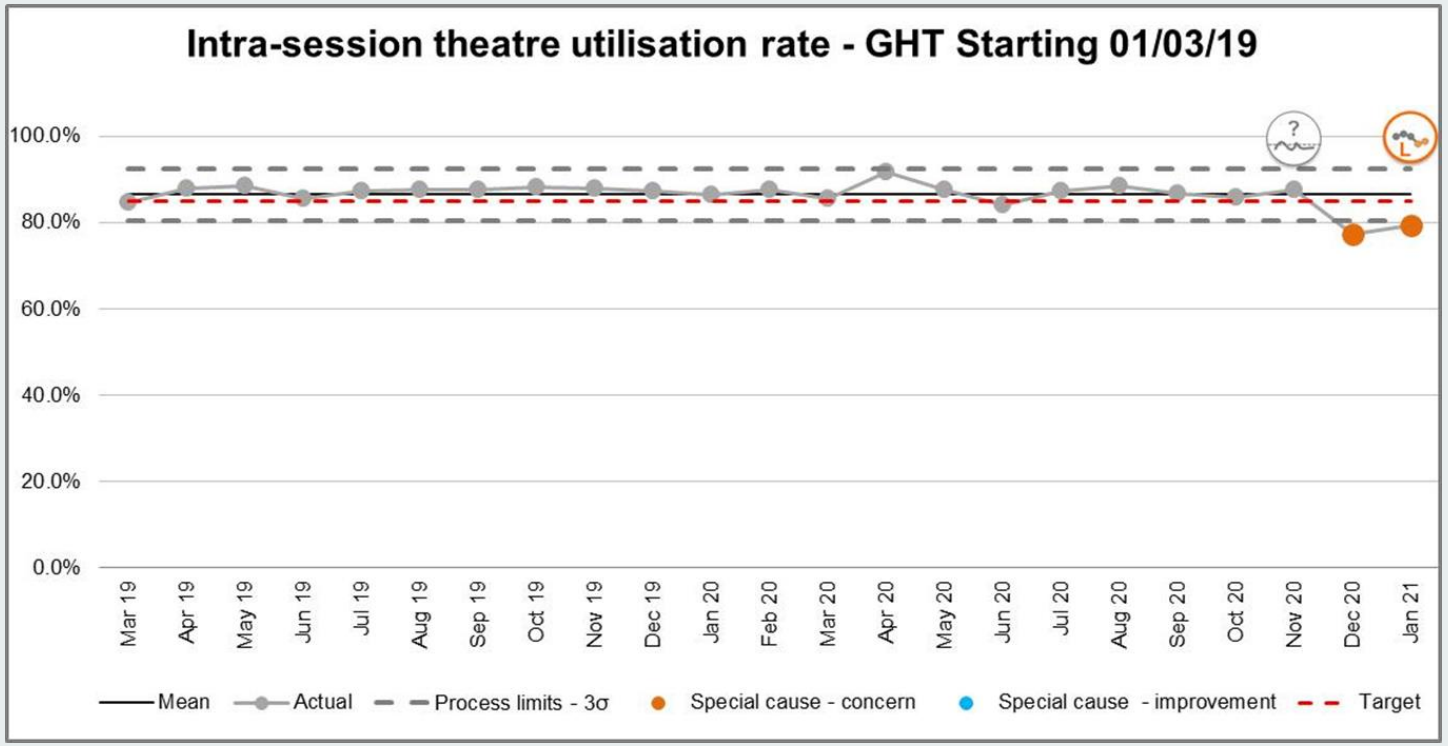
- Deputy Chief Operating Officer

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There is 1 data point which is above the line. There is 1 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above and below the mean.

Access:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

This is limited by the impact of the elective work we have undertaken, which was limited as a result of C-19 activity. Patients were prioritised based on clinical need.

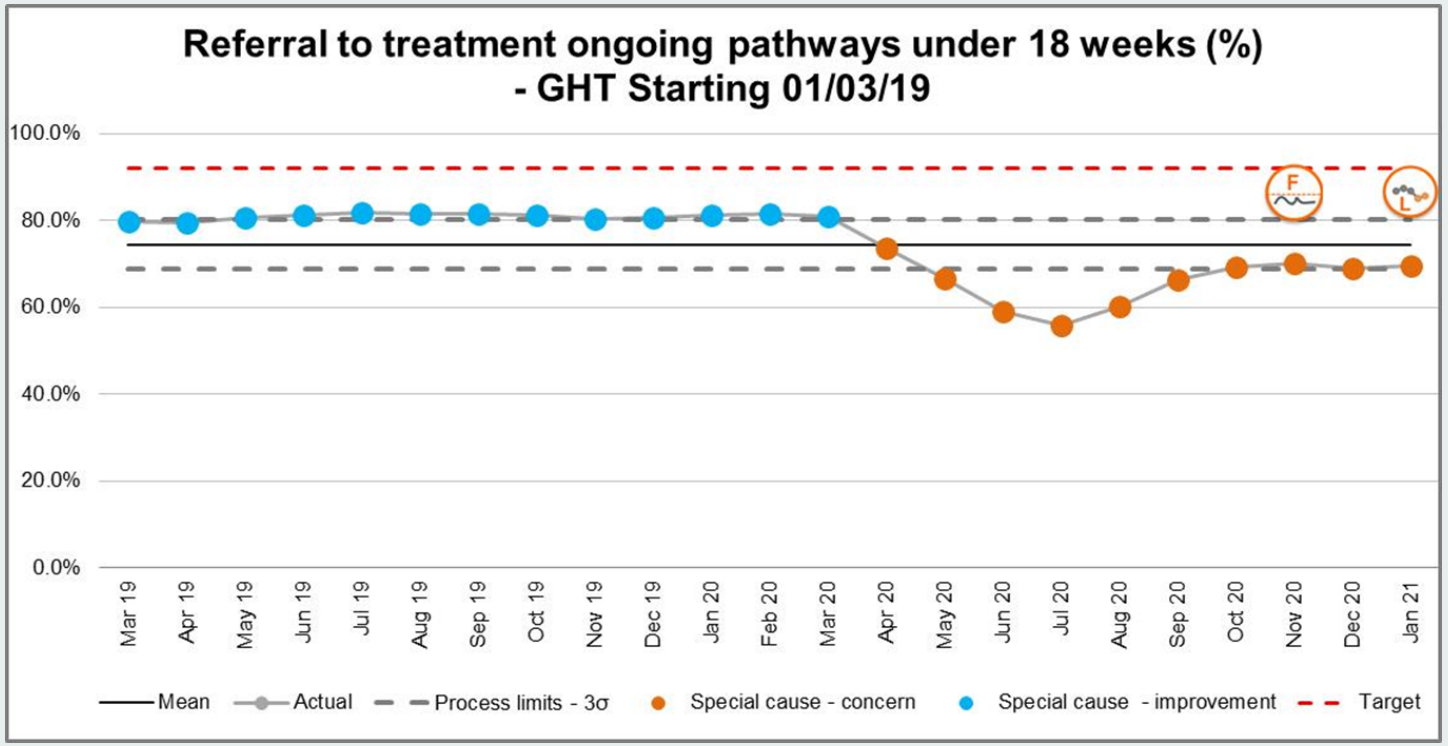
- Director of Operations - Surgery

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 2 data point(s) below the line
2 of 3	When 2 out of 3 points lie near the LPL this is a warning that the process may be changing

Access:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

See Planned Care Exception report for full details. Restoration and recovery has temporarily ceased due to the scale of the second surge, with both inpatient and outpatient services effected. Cancellation of inpatients and reduction of outpatient clinics has resulted in a deterioration of performance. Decembers finalised position was 69.48% and the part validated position for January is currently 69.8%, and anticipated to be 69.9% at submission. As indicated in other metrics the long waiting cohort of patients has risen in recent months.

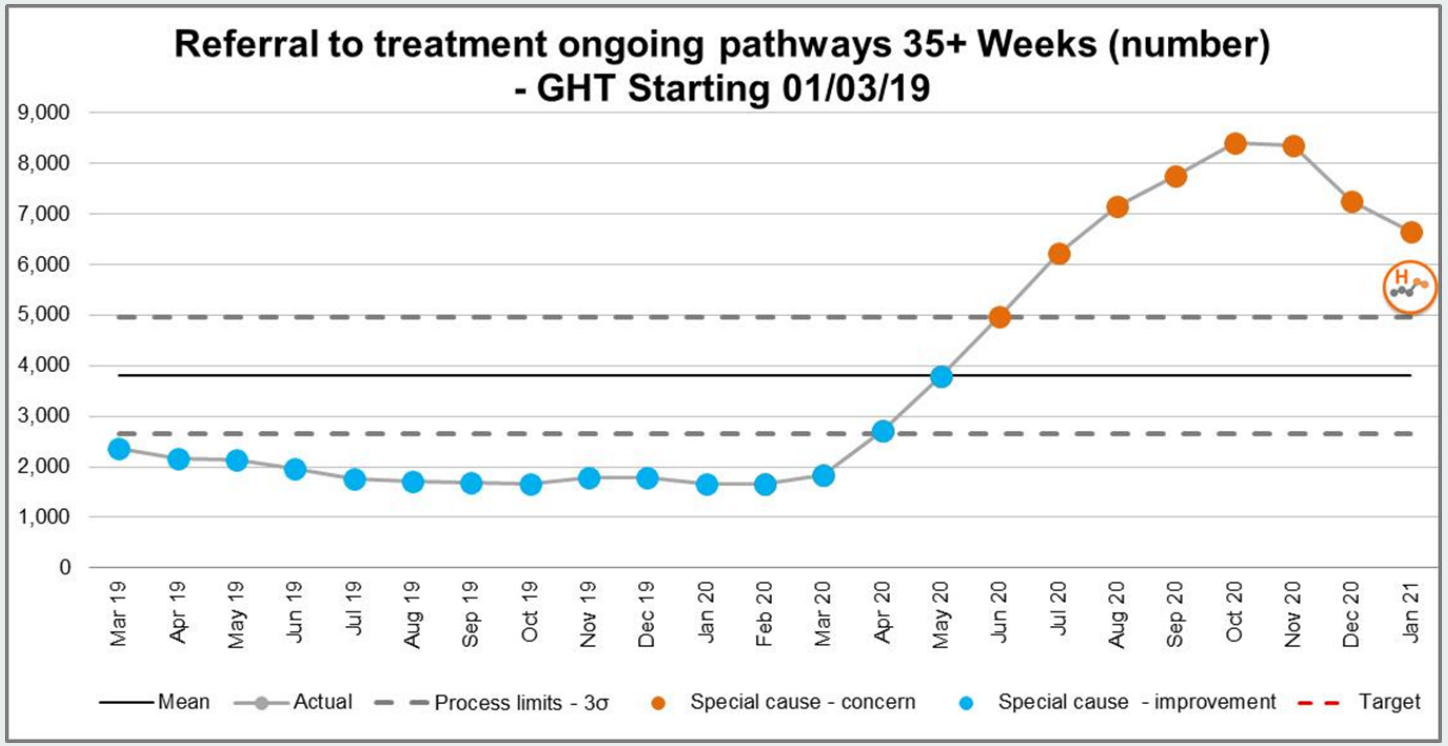
- Deputy Chief Operating Officer

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 11 data points which are above the line. There are 5 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above and below the mean.
2 of 3	When 2 out of 3 points lie near the LPL and UPL this is a warning that the process may be changing

Access:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

Restoration and recovery has temporarily ceased due to the scale of the second surge, with both inpatient and outpatient services effected. Cancellation of inpatients and reduction of outpatient clinics has resulted in an overall deterioration of performance. The cohort of patients over 35+ weeks has dipped for the second consecutive month, although longer waiting patients have increased in January.

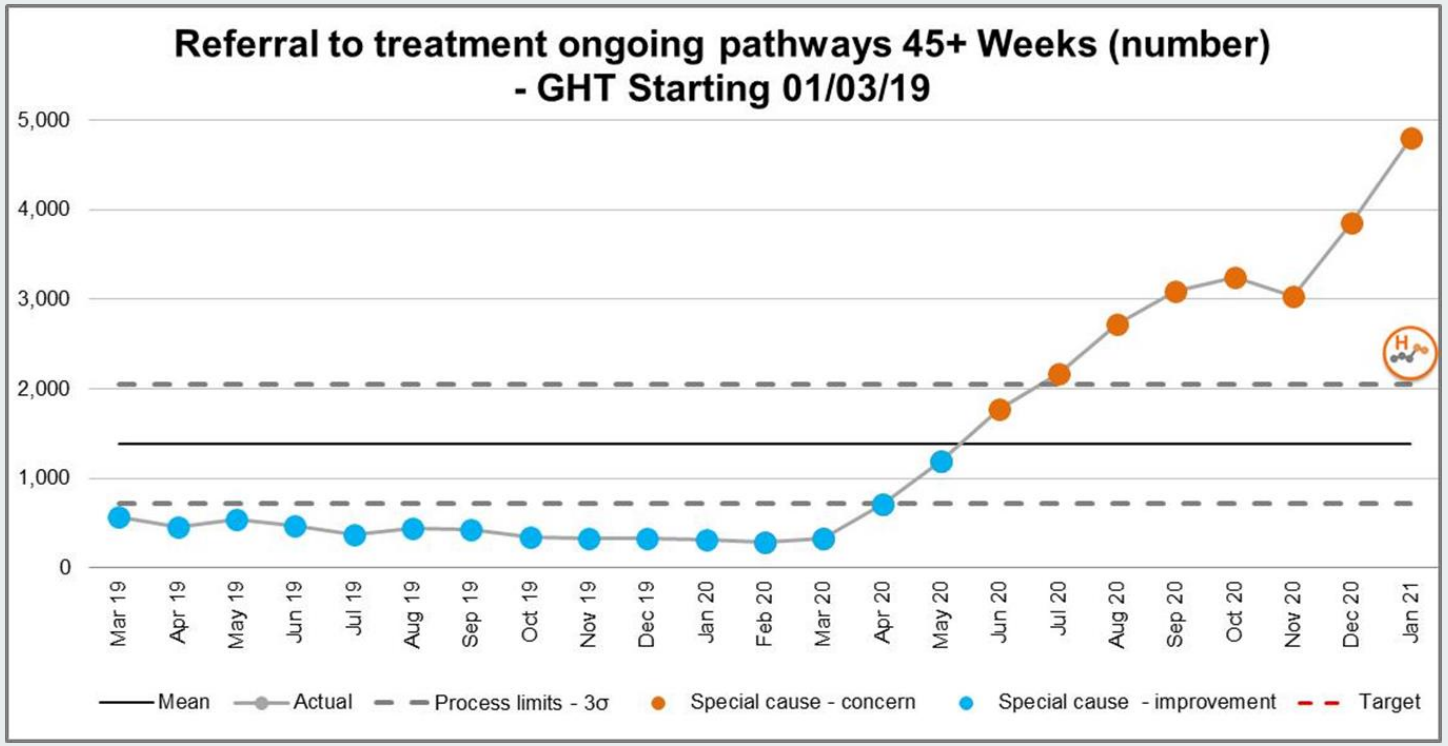
- Deputy Chief Operating Officer

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 8 data points which are above the line. There are 13 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above and below the mean.
Run	When there is a run of 7 increasing or decreasing sequential points this may indicate a significant change in the process. This process is not in control. In this data set there is a run of rising and falling points
2 of 3	When 2 out of 3 points lie near the LPL and UPL this is a warning that the process may be changing

Access:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

Restoration and recovery has temporarily ceased due to the scale of the second surge, with both inpatient and outpatient services effected. Cancellation of inpatients and reduction of outpatient clinics has resulted in a deterioration of performance. Consequently the cohort of long waiting patients has increased in January.

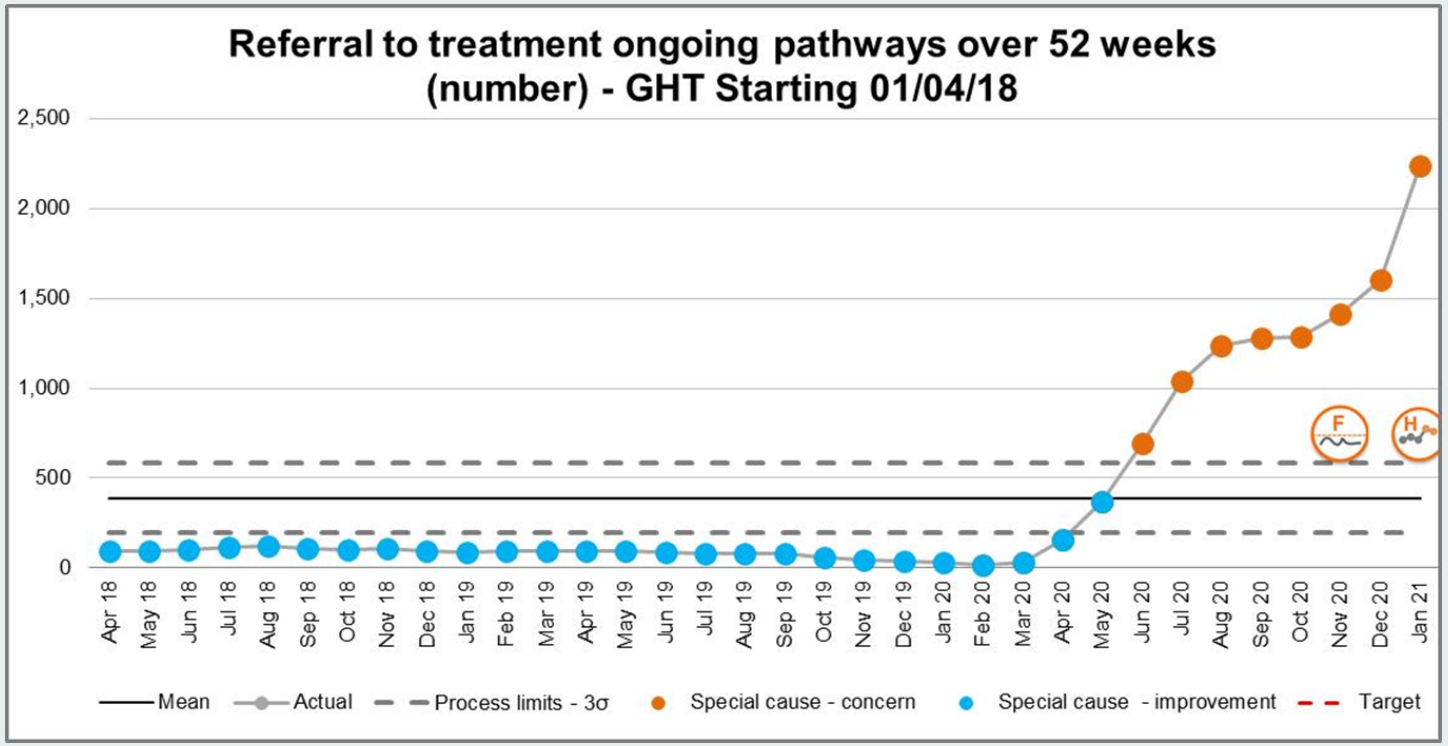
- Deputy Chief Operating Officer

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 7 data points which are above the line. There are 14 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above and below the mean.
Run	When there is a run of 7 increasing or decreasing sequential points this may indicate a significant change in the process. This process is not in control. In this data set there is a run of rising points
2 of 3	When 2 out of 3 points lie near the LPL and UPL this is a warning that the process may be changing

Access:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

See Planned Care Exception report for full details. Restoration and recovery has temporarily ceased due to the scale of the second surge, with both inpatient and outpatient services effected. Cancellation of inpatients and reduction of outpatient clinics has resulted in a deterioration of performance. Consequently the cohort of long waiting patients has increased in January.

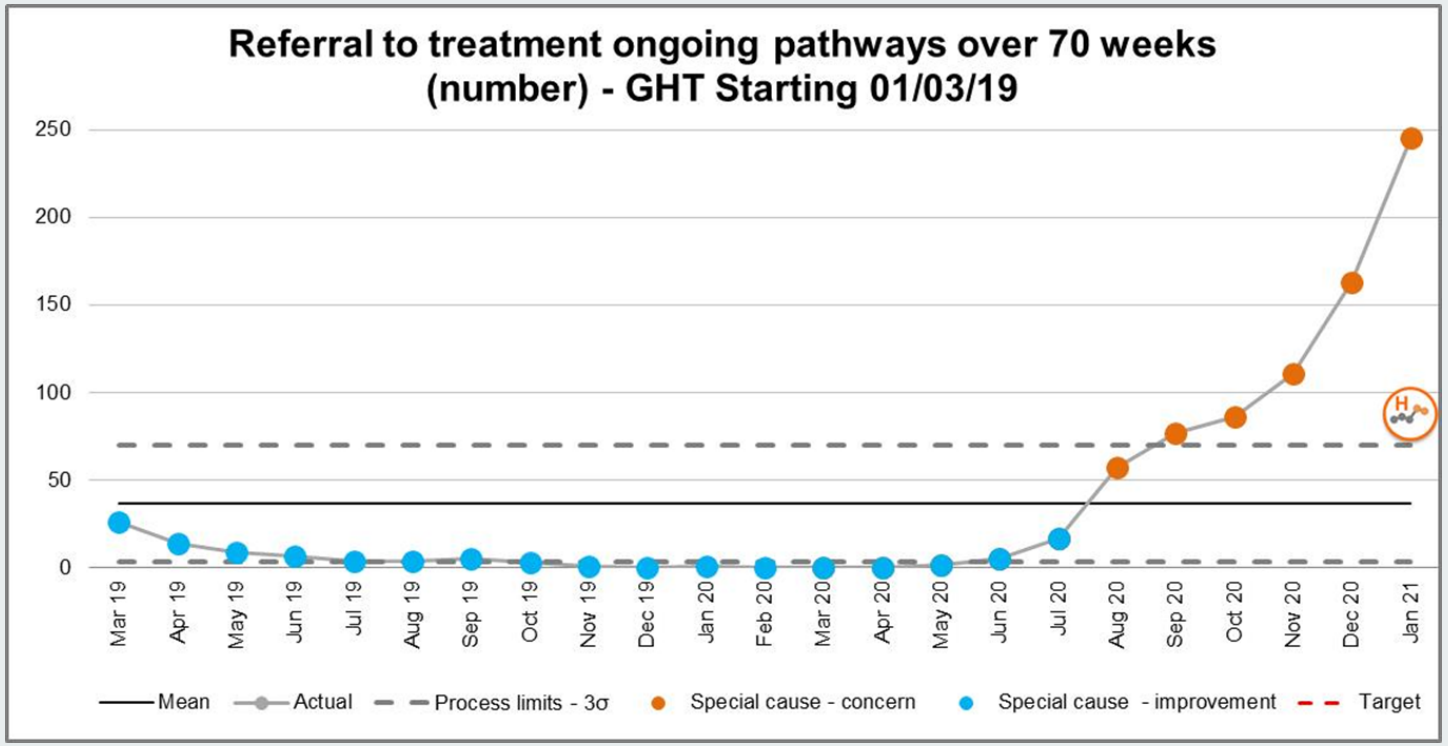
- Deputy Chief Operating Officer

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 8 data points which are above the line. There are 25 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above and below the mean.
Run	When there is a run of 7 increasing or decreasing sequential points this may indicate a significant change in the process. This process is not in control. In this data set there is a run of rising and falling points
2 of 3	When 2 out of 3 points lie near the LPL and UPL this is a warning that the process may be changing

Access:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

Restoration and recovery has temporarily ceased due to the scale of the second surge, with both inpatient and outpatient services effected. Cancellation of inpatients and reduction of outpatient clinics has resulted in a deterioration of performance. Consequently the cohort of long waiting patients has increased in January. P1 patients continue to be TCI'd.
Estimate that approx 95% of inpatients >70 weeks having been clinically validated, with a handful being P2, and the remainder being P3 or P4.

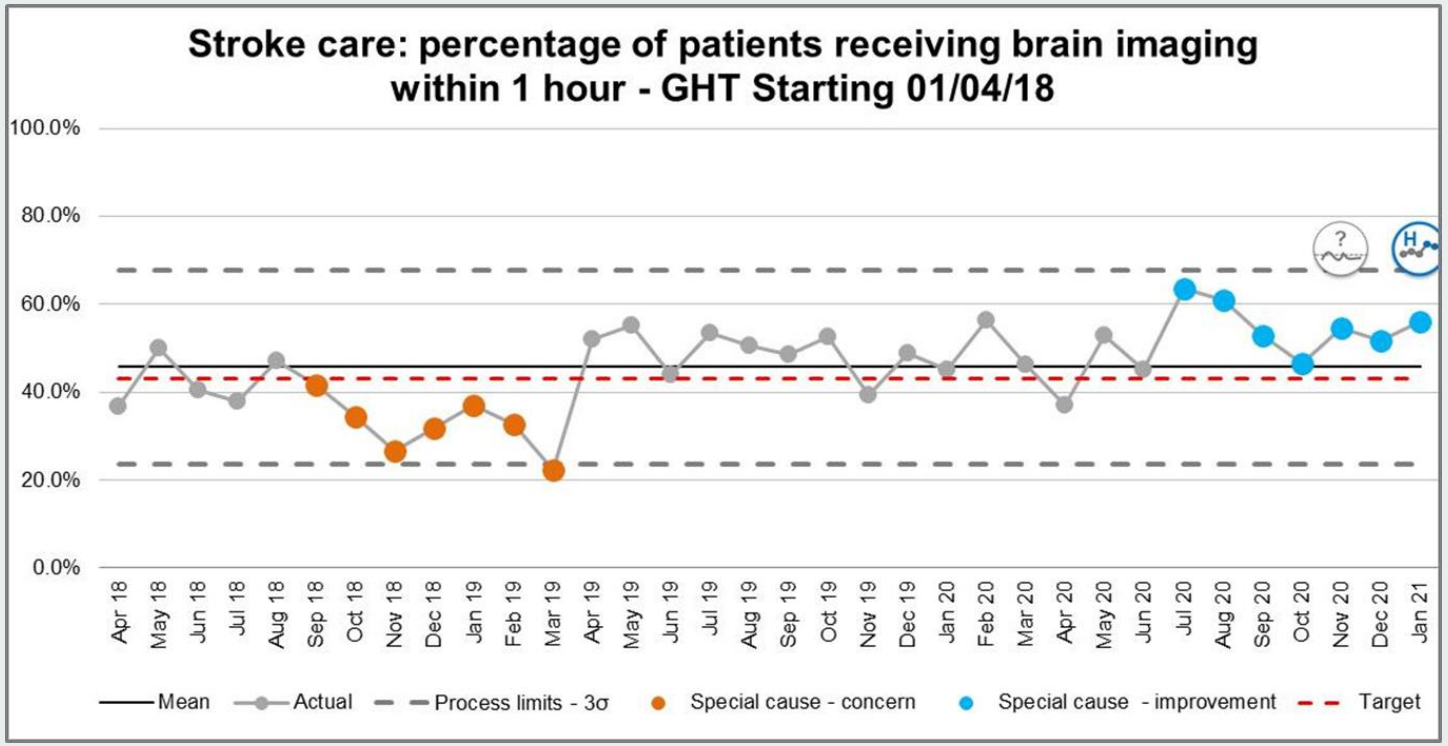
- Deputy Chief Operating Officer

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 5 data points which are above the line. There are 8 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points below the mean.
Run	When there is a run of 7 increasing or decreasing sequential points this may indicate a significant change in the process. This process is not in control. In this data set there is a run of rising points
2 of 3	When 2 out of 3 points lie near the LPL and UPL this is a warning that the process may be changing

Access:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

Improvement of 4.4% on December performance (51.70%). 36 patients breached the target in the month of January. Of these 36:
- 5 patients were delayed due to an unclear diagnosis leading to a delay in scan request.
- 7 patients were admitted out of hours for the Stroke team
- 2 patients were already an inpatient
- 11 patients experienced a delay in stroke team being notified which impacted scan request time.
- 3 patients were delayed as the Stroke team were assessing other patients in ED
- 7 patients were delayed due to an unknown reason
- 1 patient was delayed due to sicknesses in the SSN team leading to reduced capacity to review patients.

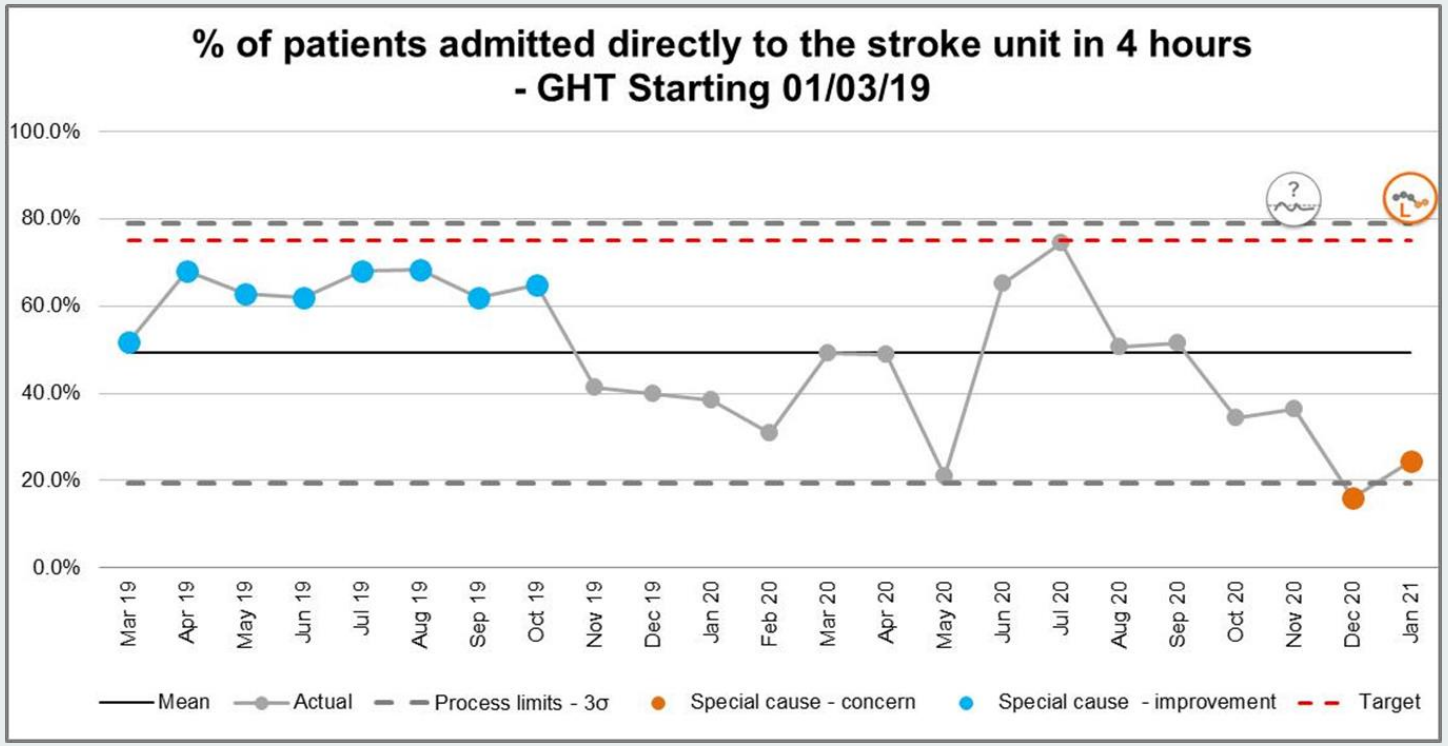
- Director of Unscheduled Care and Deputy Chief Operating Officer

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There is 1 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above and below the mean.
2 of 3	When 2 out of 3 points lie near the UPL this is a warning that the process may be changing

Access:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

Deterioration of 2.6% on December performance (70.60%). 26 patients breached the target in the month of January. Of those 26:
18 patients were delayed in receiving a bed on the Stroke Unit and therefore had a delayed swallow screening.
4 patients were delayed due to an unclear diagnosis which led to them initially being admitted to AMU for further tests.
4 patients were too unwell to receive a swallow screen within the four hour target.

- Director of Unscheduled Care and Deputy Chief Operating Officer

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There is 1 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above the mean.
2 of 3	When 2 out of 3 points lie near the LPL this is a warning that the process may be changing

Quality Dashboard

Gloucestershire Hospitals NHS Foundation Trust

This dashboard shows the most recent performance of metrics in the Quality category. Where SPC analysis is not possible the metric is RAG rated against national standards. Exception reports are shown on the following pages.

Key

Assurance

- Consistently hit target
- Hit and miss target subject to random
- Consistently fail target

Variation

- Special Cause Concerning variation
- Common Cause
- Special Cause Improving variation

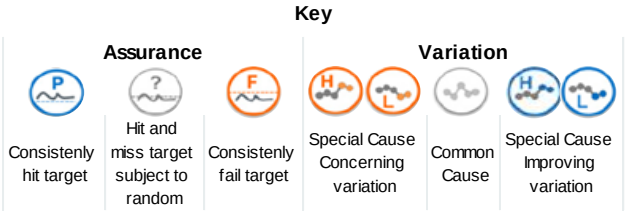
MetricTopic	MetricNameAlias	Target & Assurance	Latest Performance & Variance	
Dementia Screening	% of patients who have been screened for dementia (within 72 hours)	>=90%	Jan-21	65%
Dementia Screening	% of patients who have scored positively on dementia screening tool that then received a dementia diagnostic	>=90%	Mar-20	0%
Dementia Screening	% of patients who have received a dementia diagnostic assessment with positive or inconclusive results that were	>=90%	Dec-19	0%
Friends & Family Test	Inpatients % positive	>=96%	Jan-21	89.7%
Friends & Family Test	ED % positive	>=84%	Jan-21	87.2%
Friends & Family Test	Maternity % positive	>=97%	Jan-21	98.6%
Friends & Family Test	Outpatients % positive	>=94%	Jan-21	94.7%
Friends & Family Test	Total % positive	>=93%	Jan-21	93.2%
PALS	Number of PALS concerns logged	No Target	Jan-21	137
PALS	% of PALS concerns closed in 5 days	>=95%	Jan-21	86%
Infection Control	Number of trust apportioned MRSA bacteraemia	Zero	Jan-21	0
Infection Control	MRSA bacteraemia – infection rate per 100,000 bed days	Zero	Jan-21	0
Infection Control	Number of trust apportioned Clostridium difficile cases per month	2019/20: 114	Jan-21	4
Infection Control	Number of community-onset healthcare-associated Clostridioides difficile cases per month	<=5	Jan-21	2
Infection Control	Number of hospital-onset healthcare-associated Clostridioides difficile cases per month	<=5	Jan-21	2
Infection Control	Clostridium difficile – infection rate per 100,000 bed days	<30.2	Jan-21	19.2
Infection Control	Number of MSSA bacteraemia cases	<=8	Jan-21	1
Infection Control	MSSA – infection rate per 100,000 bed days	<=12.7	Jan-21	3.8
Infection Control	Number of ecoli cases	No target	Jan-21	2
Infection Control	Number of pseudomona cases	No target	Jan-21	0
Infection Control	Number of klebsiella cases	No target	Jan-21	3
Infection Control	Number of bed days lost due to infection control outbreaks	<10	Oct-20	5

MetricTopic	MetricNameAlias	Target & Assurance	Latest Performance & Variance	
Infection Control	COVID-19 community-onset – First positive specimen <=2 days after admission	TBC	Jan-21	444
Infection Control	COVID-19 hospital-onset indeterminate healthcare-associated – First positive specimen 3-7 days after admission	TBC	Jan-21	42
Infection Control	COVID-19 hospital-onset probably healthcare-associated – First positive specimen 8-14 days after admission	TBC	Jan-21	41
Infection Control	COVID-19 hospital-onset definite healthcare-associated – First positive specimen >=15 days after admission	TBC	Jan-21	30
Inpatient Questions	How much information about your condition or treatment or care has been given to you?	>=90%	Mar-20	78%
Inpatient Questions	Are you involved as much as you want to be in decisions about your care and treatment?	>=90%	Mar-20	92%
Inpatient Questions	Do you feel that you are treated with respect and dignity?	>=90%	Mar-20	100%
Inpatient Questions	Do you feel well looked after by staff treating or caring for you?	>=90%	Mar-20	99%
Inpatient Questions	Do you get enough help from staff to eat your meals?	>=90%	Mar-20	67%
Inpatient Questions	In your opinion, how clean is your room or the area that you receive treatment in?	>=90%	Mar-20	100%
Inpatient Questions	Do you get enough help from staff to wash or keep yourself clean?	>=90%	Mar-20	86%
Maternity	% C-section rate (planned and emergency)	<=27%	Jan-21	28.12%
Maternity	% emergency C-section rate	No target	Jan-21	15.7%
Maternity	% of women smoking at delivery	<=14.5%	Jan-21	8.80%
Maternity	% of women that have an induced labour	<=30%	Jan-21	33.9%
Maternity	% stillbirths as percentage of all pregnancies > 24 weeks	<0.52%	Jan-21	0.25%
Maternity	% of women on a Continuity of Carer pathway	No target	Jan-21	0.0%
Mortality	Summary hospital mortality indicator (SHMI) – national data	NHS Digital	Sep-20	1.1
Mortality	Hospital standardised mortality ratio (HSMR)	Dr Foster	Oct-20	103.9
Mortality	Hospital standardised mortality ratio (HSMR) – weekend	Dr Foster	Oct-20	105.5
Mortality	Number of inpatient deaths	No target	Jan-21	278

Quality Dashboard

Gloucestershire Hospitals NHS Foundation Trust

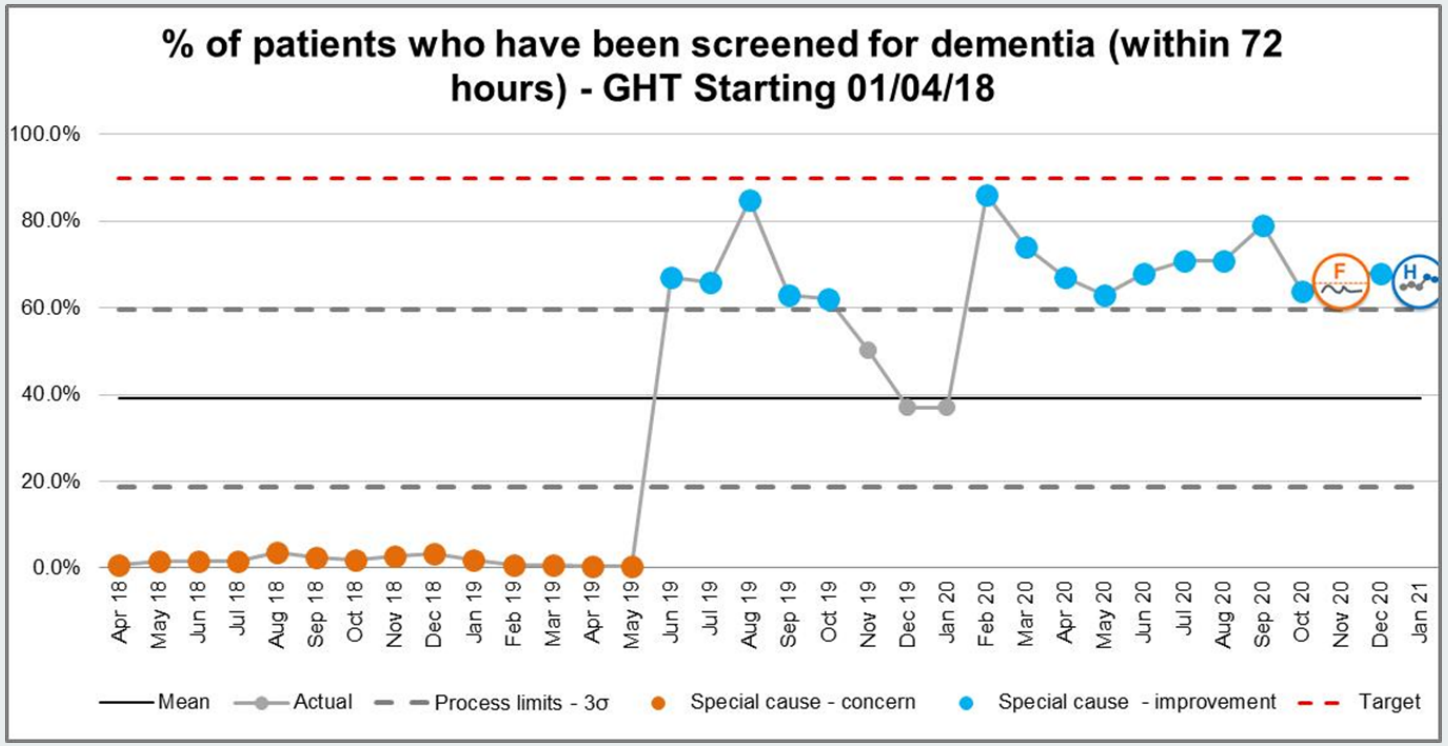
This dashboard shows the most recent performance of metrics in the Quality category. Where SPC analysis is not possible the metric is RAG rated against national standards. Exception reports are shown on the following pages.



MetricTopic	MetricNameAlias	Target & Assurance	Latest Performance & Variance		
Mortality	Number of deaths of patients with a learning disability	No target	Jan-21	2	
MSA	Number of breaches of mixed sex accommodation	<=10	Jan-21	2	
Patient Safety Incidents	Number of patient safety alerts outstanding	Zero	Jan-21	0	
Patient Safety Incidents	Number of falls per 1,000 bed days	<=6	Jan-21	8.6	
Patient Safety Incidents	Number of falls resulting in harm (moderate/severe)	<=3	Jan-21	4	
Patient Safety Incidents	Number of patient safety incidents – severe harm (major/death)	No target	Jan-21	4	
Patient Safety Incidents	Medication error resulting in severe harm	No target	Jan-21	0	
Patient Safety Incidents	Medication error resulting in moderate harm	No target	Jan-21	6	
Patient Safety Incidents	Medication error resulting in low harm	No target	Jan-21	14	
Patient Safety Incidents	Number of category 2 pressure ulcers acquired as in-patient	<=30	Jan-21	27	
Patient Safety Incidents	Number of category 3 pressure ulcers acquired as in-patient	<=5	Jan-21	0	
Patient Safety Incidents	Number of category 4 pressure ulcers acquired as in-patient	Zero	Jan-21	0	
Patient Safety Incidents	Number of unstagable pressure ulcers acquired as in-patient	<=3	Jan-21	2	
Patient Safety Incidents	Number of deep tissue injury pressure ulcers acquired as in-patient	<=5	Jan-21	6	
Sepsis Identification	Proportion of emergency patients with severe sepsis who were given IV antibiotics within 1 hour of diagnosis	>=90%	Sep-20	74%	
RIDDOR	Number of RIDDOR	SPC	Jan-21	3	
Safety Thermometer	Safety thermometer – % of new harms	>96%	Mar-20	97.8%	
Serious Incidents	Number of never events reported	Zero	Jan-21	0	
Serious Incidents	Number of serious incidents reported	No target	Jan-21	2	
Serious Incidents	Serious incidents – 72 hour report completed within contract timescale	>90%	Jan-21	100.0%	
Serious Incidents	Percentage of serious incident investigations completed within contract timescale	>80%	Jan-21	100%	
VTE Prevention	% of adult inpatients who have received a VTE risk assessment	>95%	Jan-21	90.4%	

Quality:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

The manual audit for this indicator shows a consistent performance in screening the 30 case notes sampled, but is still below compliance, and as the Dementia Improvement Plan (DIP) has developed its performance dashboard, it should be noted that the sample size is approximately 10% of monthly dementia admissions.

The dementia and delirium pathway process is currently being assessed for approval and discussions taking place to develop the EPR process to support the screening and assessment of delirium and dementia. A review of the Trust's dementia training is taking place to support the clinical pathway. In addition a recent Task & Finish Group as part of the ICS Dementia Steering Group has been established to achieve a one system approach to delirium.

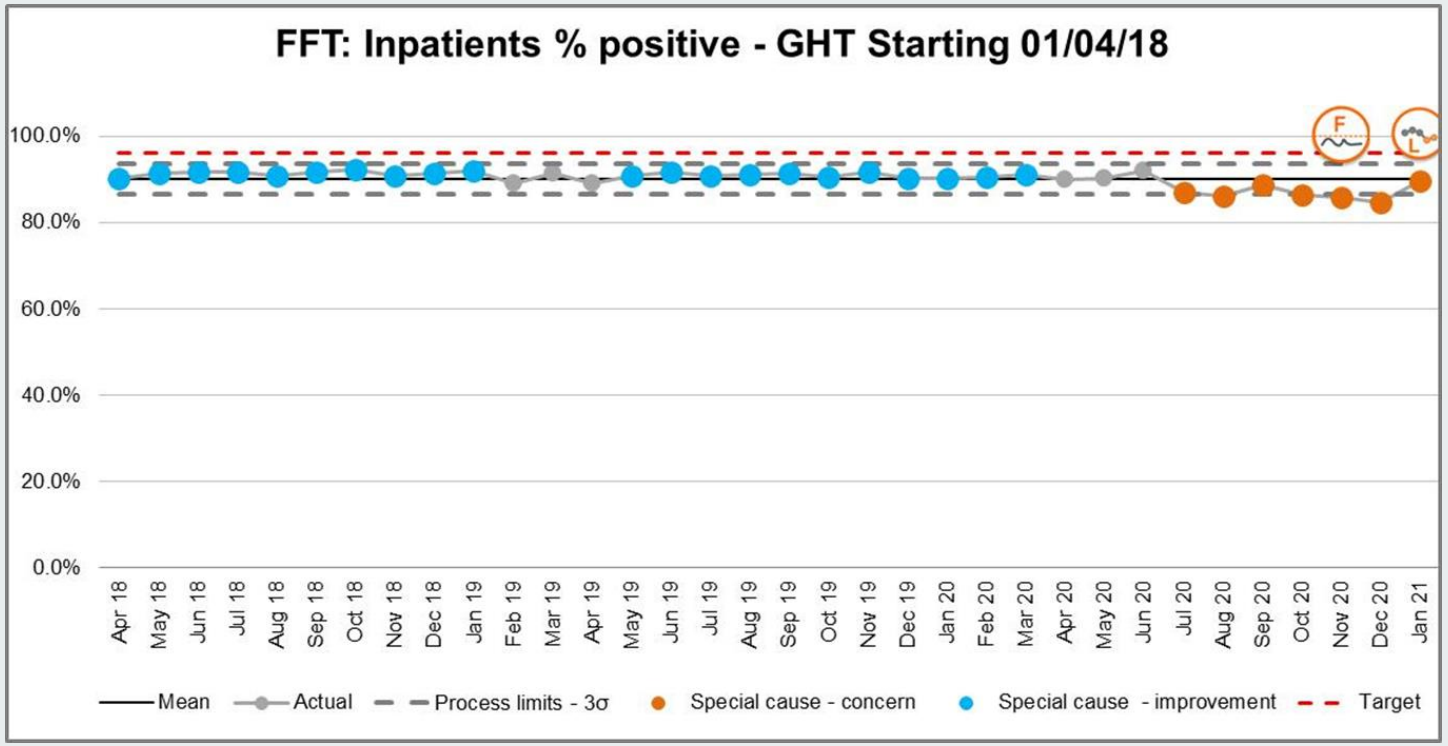
- Deputy Chief Nurse

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 17 data points which are above the line. There are 14 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above and below the mean.
2 of 3	When 2 out of 3 points lie near the LPL and UPL this is a warning that the process may be changing

Quality:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

The inpatient FFT score for January has seen a 4% increase to 89.7% positive score, and has seen an increase in the number of responses received, providing more validity to this improvement. There are still areas where we are receiving a lower number of responses each month, which does risk results being skewed either positively or negatively. The Patient Experience team are working with divisions to identify how the FFT scores and other survey feedback is being utilised to inform local improvement plans, and to offer additional routes for gaining patient experience feedback that can challenge or validate some of these scores in areas with lower numbers. This includes running bespoke local surveys to increase insight on areas potentially highlighted in the FFT feedback, as is currently happening in AMU, or to increase numbers or responses to provide a more representative experience. This is ongoing and will be monitored monthly through QDG.

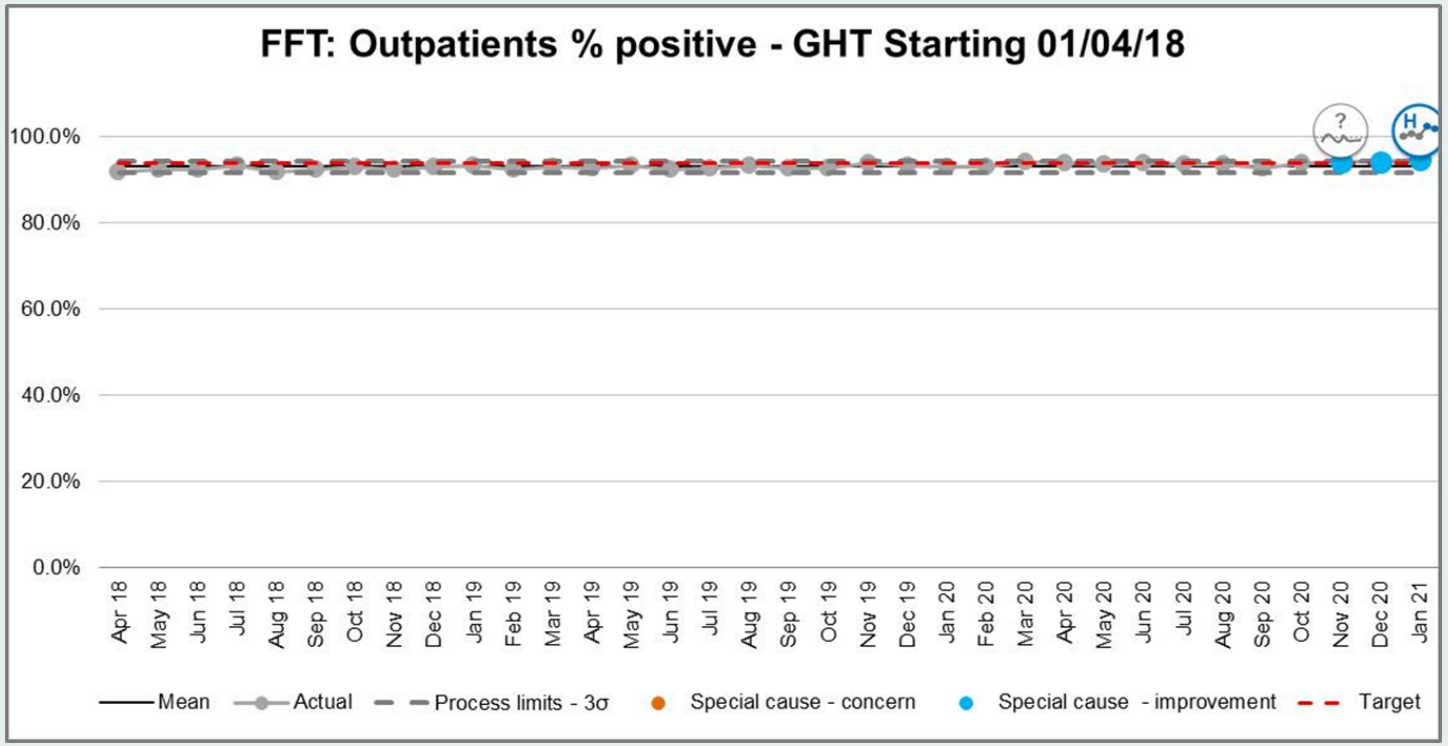
- Deputy Director of Quality

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 4 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above and below the mean.
2 of 3	When 2 out of 3 points lie near the LPL this is a warning that the process may be changing

Quality:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

The outpatient FFT score for January has seen a slight increase to 94.7% positive score; the outpatient FFT score has been the most stable throughout Covid, having remained at >94% positive score for the last few months. Feedback on outpatient services is also being gathered through the Attend Anywhere remote consultation platform, which is also showing patients are reporting a positive experience of this service. We will continue to monitor and triangulate this data

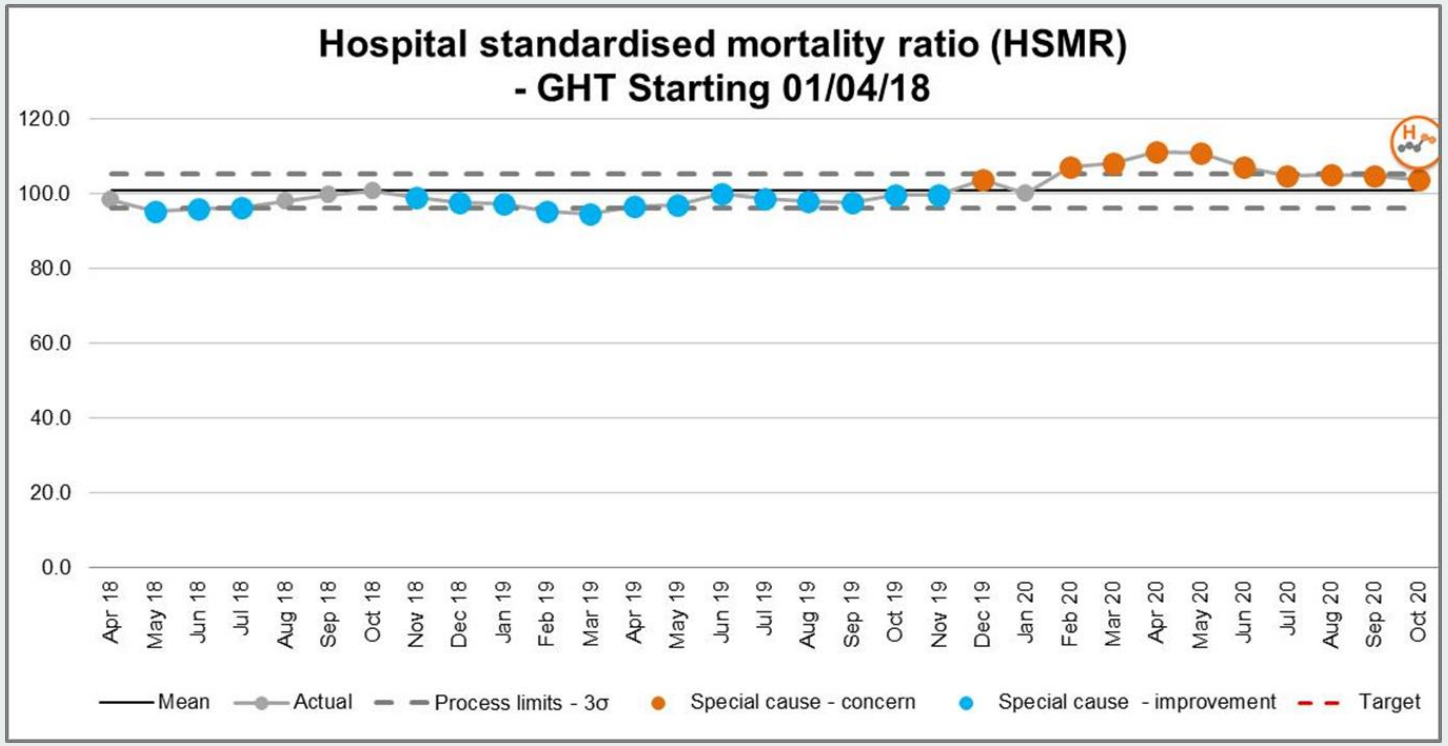
- Deputy Director of Quality

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There is 1 data point which is above the line.
2 of 3	When 2 out of 3 points lie near the UPL this is a warning that the process may be changing

Quality:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

These metrics were raised in keeping with expectations during Covid wave 1, due reduction in case load of low risk patients elective and emergency these are now green in keeping with the period between wave 1 and 2. It can be expected these will rise again but probably to lesser extent during wave 2.

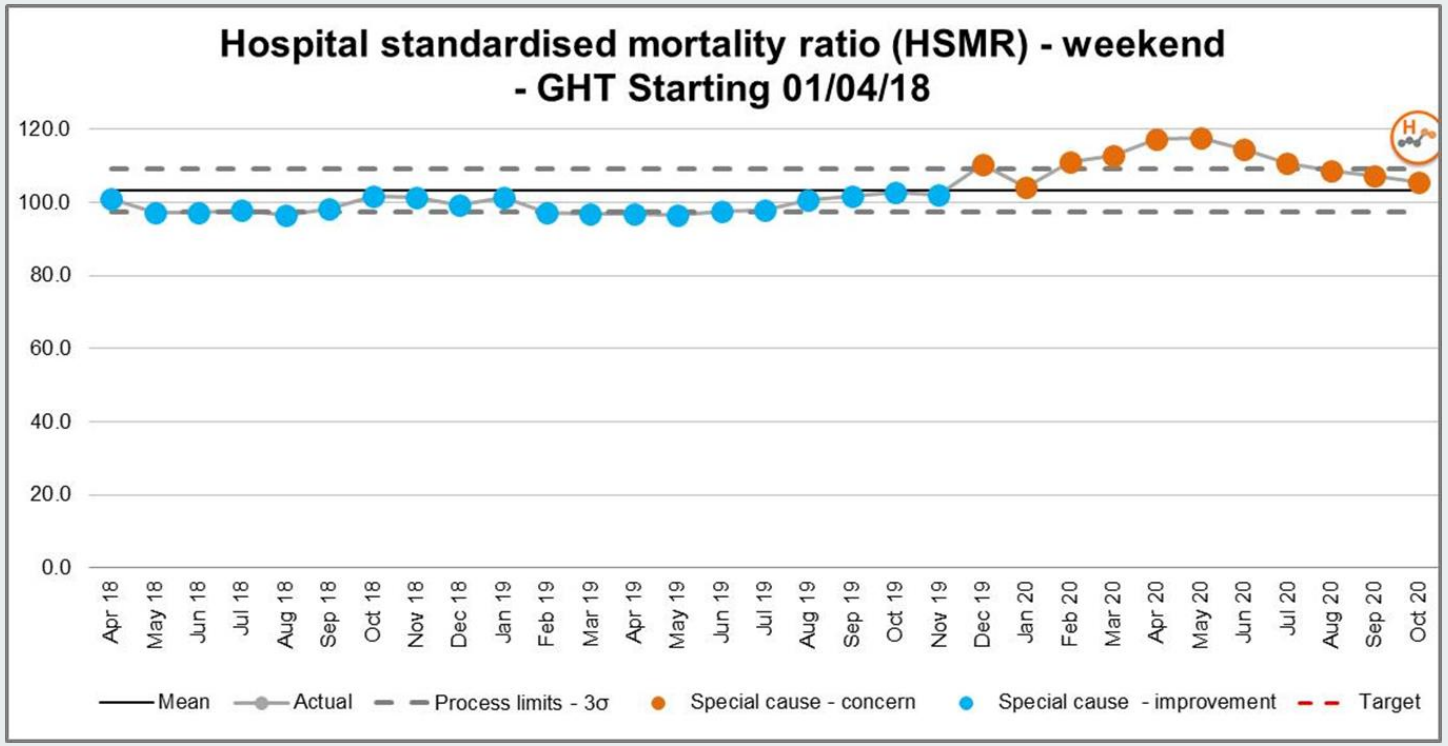
- Medical Division Audit and M&M Lead

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 5 data points which are above the line. There are 3 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above and below the mean.
2 of 3	When 2 out of 3 points lie near the LPL and UPL this is a warning that the process may be changing

Quality:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



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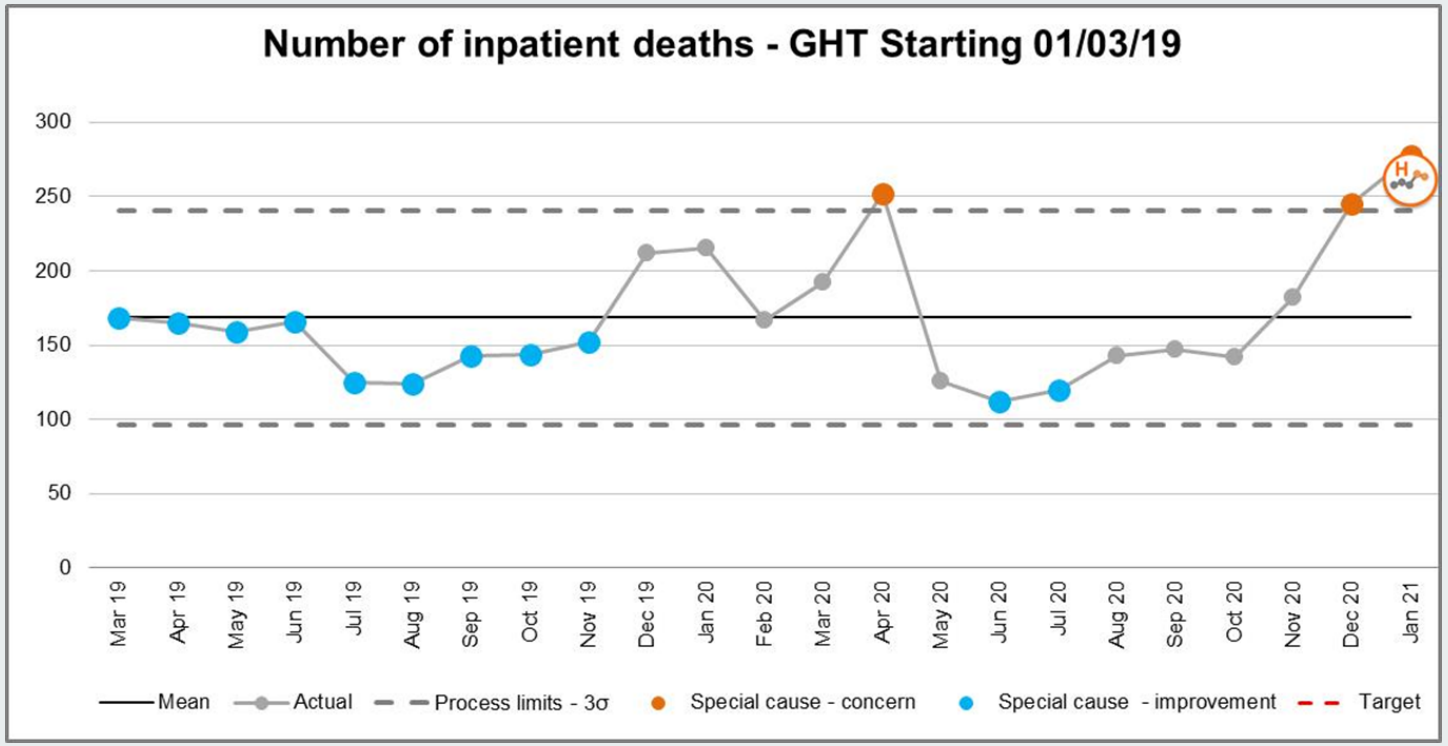
- Medical Division Audit and M&M Lead

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 7 data points which are above the line. There are 7 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above and below the mean.
2 of 3	When 2 out of 3 points lie near the LPL and UPL this is a warning that the process may be changing

Quality:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

The number of inpatient deaths is high for January, similar to the number in April 2020. This is the result of the second wave of the COVID pandemic.

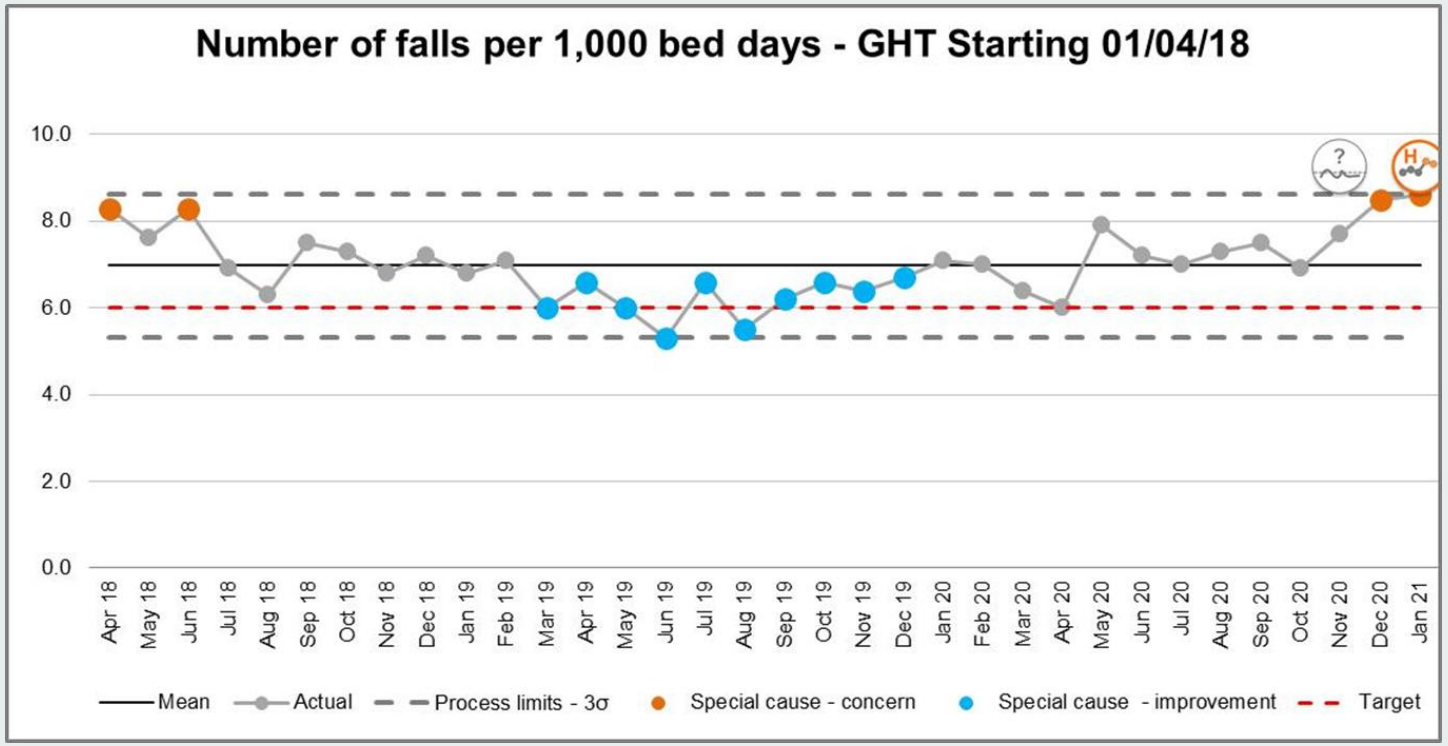
- Medical Director

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 3 data points which are above the line.
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points below the mean.
2 of 3	When 2 out of 3 points lie near the LPL this is a warning that the process may be changing

Quality:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

Falls have increased due to a number of factors; increased deconditioning, reduced visiting which decreases supervision, inability to fill enhanced care requests, multiple bed moves and transfers including late night. The falls reduction programme is active and all cases with moderate harm or above are rapidly reviewed in Preventing Harm Hub.

- Director of Safety

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There is 1 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points below the mean.
2 of 3	When 2 out of 3 points lie near the LPL and UPL this is a warning that the process may be changing

Financial Dashboard

Gloucestershire Hospitals NHS Foundation Trust

This dashboard shows the most recent performance of metrics in the Financial category. Where SPC analysis is not possible the metric is RAG rated against national standards. Exception reports are shown on the following pages.

Key

Assurance

- Consistently hit target
- Hit and miss target subject to random
- Consistenly fail target

Variation

- Special Cause Concerning variation
- Common Cause
- Special Cause Improving variation

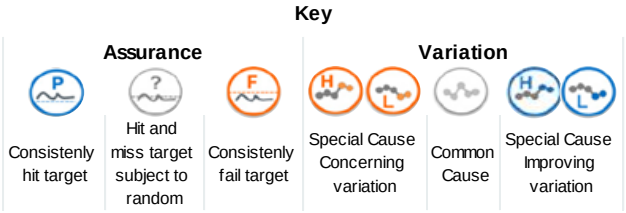
MetricTopic	MetricNameAlias	Target & Assurance	Latest Performance & Variance	
Finance	Total PayBill Spend		Sep-20	34.7
Finance	YTD Performance against Financial Recovery Plan		Sep-20	0
Finance	Cost Improvement Year to Date Variance		Sep-20	N/A
Finance	NHSI Financial Risk Rating		Sep-20	N/A
Finance	Capital service		Sep-20	N/A
Finance	Liquidity		Sep-20	N/A
Finance	Agency – Performance Against NHSI Set Agency Ceiling		Sep-20	N/A

Please note that the finance metrics have no data available due to COVID-19

People & OD Dashboard

Gloucestershire Hospitals NHS Foundation Trust

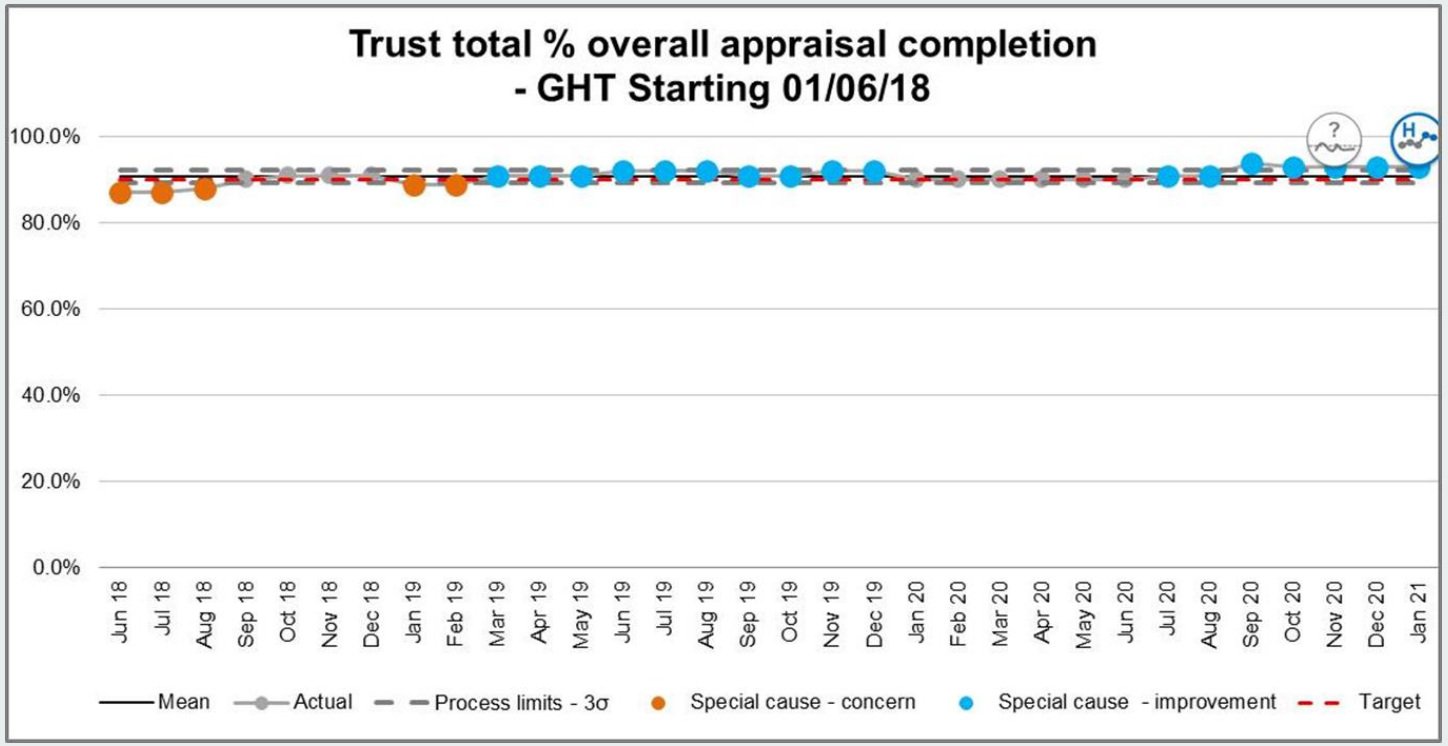
This dashboard shows the most recent performance of metrics in the People & Organisational Development category. Where SPC analysis is not possible the metric is RAG rated against national standards. Exception reports are shown on the following pages.



MetricTopic	MetricNameAlias	Target & Assurance		Latest Performance & Variance		
Appraisal and Mandatory	Trust total % overall appraisal completion	>=90%		Jan-21	82.0%	
Appraisal and Mandatory	Trust total % mandatory training compliance	>=90%		Jan-21	93%	
Safe Nurse Staffing	Overall % of nursing shifts filled with substantive staff	>=75%		Jan-21	90.9%	
Safe Nurse Staffing	% registered nurse day	>=90%		Jan-21	93.8%	
Safe Nurse Staffing	% unregistered care staff day	>=90%		Jan-21	99.2%	
Safe Nurse Staffing	% registered nurse night	>=90%		Jan-21	94.8%	
Safe Nurse Staffing	% unregistered care staff night	>=90%		Jan-21	99.2%	
Safe Nurse Staffing	Care hours per patient day RN	>=5		Jan-21	6.1	
Safe Nurse Staffing	Care hours per patient day HCA	>=3		Jan-21	3.9	
Safe nurse staffing	Care hours per patient day total	>=8		Jan-21	10.1	
Vacancy and WTE	Staff in post FTE	No target		Jan-21	6560.89	
Vacancy and WTE	Vacancy FTE	No target		Jan-21	409.32	
Vacancy and WTE	Starters FTE	No target		Jan-21	50.64	
Vacancy and WTE	Leavers FTE	No target		Jan-21	50.03	
Vacancy and WTE	% total vacancy rate	<=11.5%		Jan-21	5.57%	
Vacancy and WTE	% vacancy rate for doctors	<=5%		Jan-21	1.77%	
Vacancy and WTE	% vacancy rate for registered nurses	<=5%		Jan-21	8.80%	
Workforce Expenditure	% turnover	<=12.6%		Jan-21	9.5%	
Workforce Expenditure	% turnover rate for nursing	<=12.6%		Jan-21	9.8%	
Workforce Expenditure	% sickness rate	<=4.05%		Jan-21	3.7%	

People & OD:
SPC – Special Cause Variation

Gloucestershire Hospitals
NHS Foundation Trust



Commentary

Trust compliance overall remains high at 93%, supported by the increased digitalization of programmes using more videos and eLearning. All divisions have achieved the target of 90%, ranging from medicine at 91% to 95% by both Corporate and D&S.

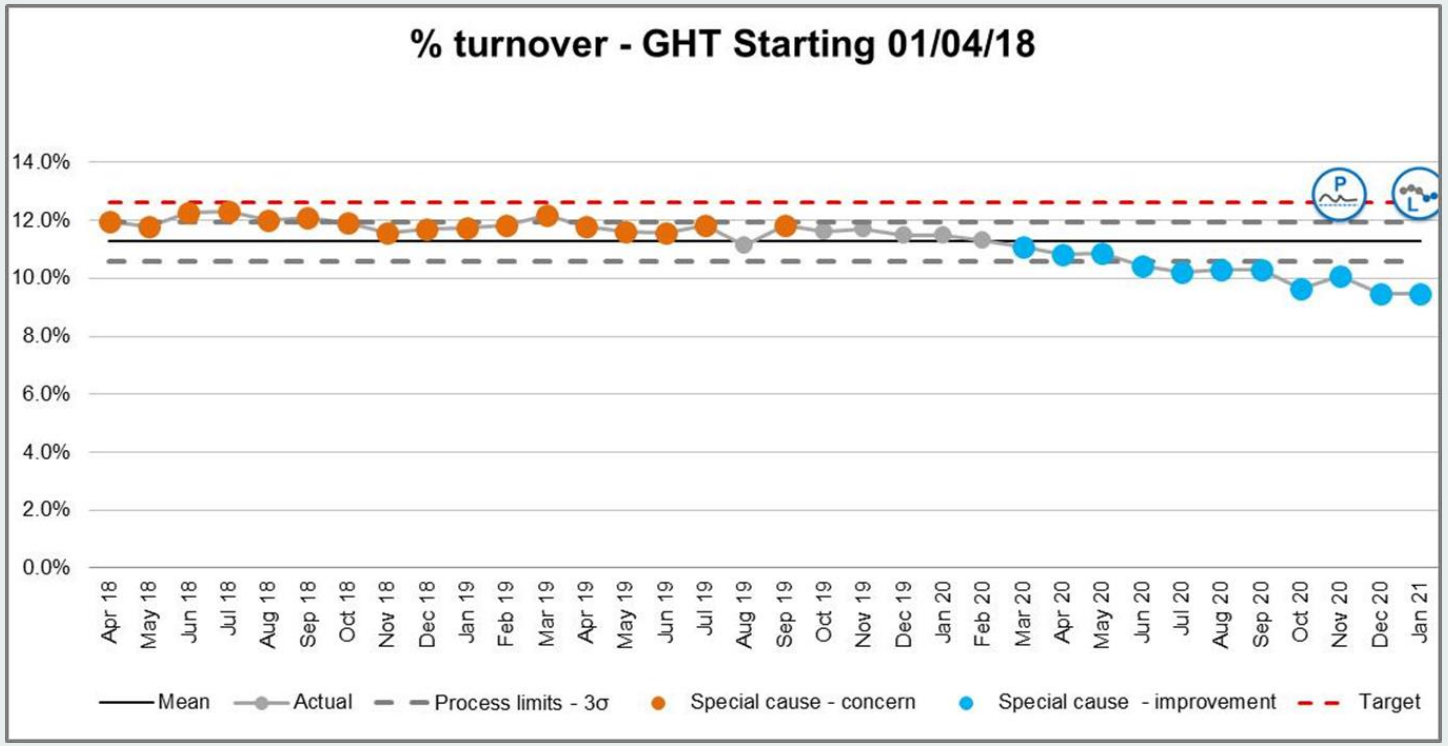
- **Director of Human Resources and Operational Development**

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 5 data points which are above the line. There are 5 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above the mean.
2 of 3	When 2 out of 3 points lie near the LPL and UPL this is a warning that the process may be changing

People & OD:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

The rolling annual turnover rate shows a consistent gradual decrease since 2019 and is reported at 9.45%, placing the Trust in the top quartile for retention when benchmarked to the Model Hospital Peer Group. Registered Nurse Retention figures remain consistently higher than Model Hospital Peers and show a gradual improvement during 2020.

- **Director of Human Resources and Operational Development**

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 6 data points which are above the line. There are 8 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above and below the mean.
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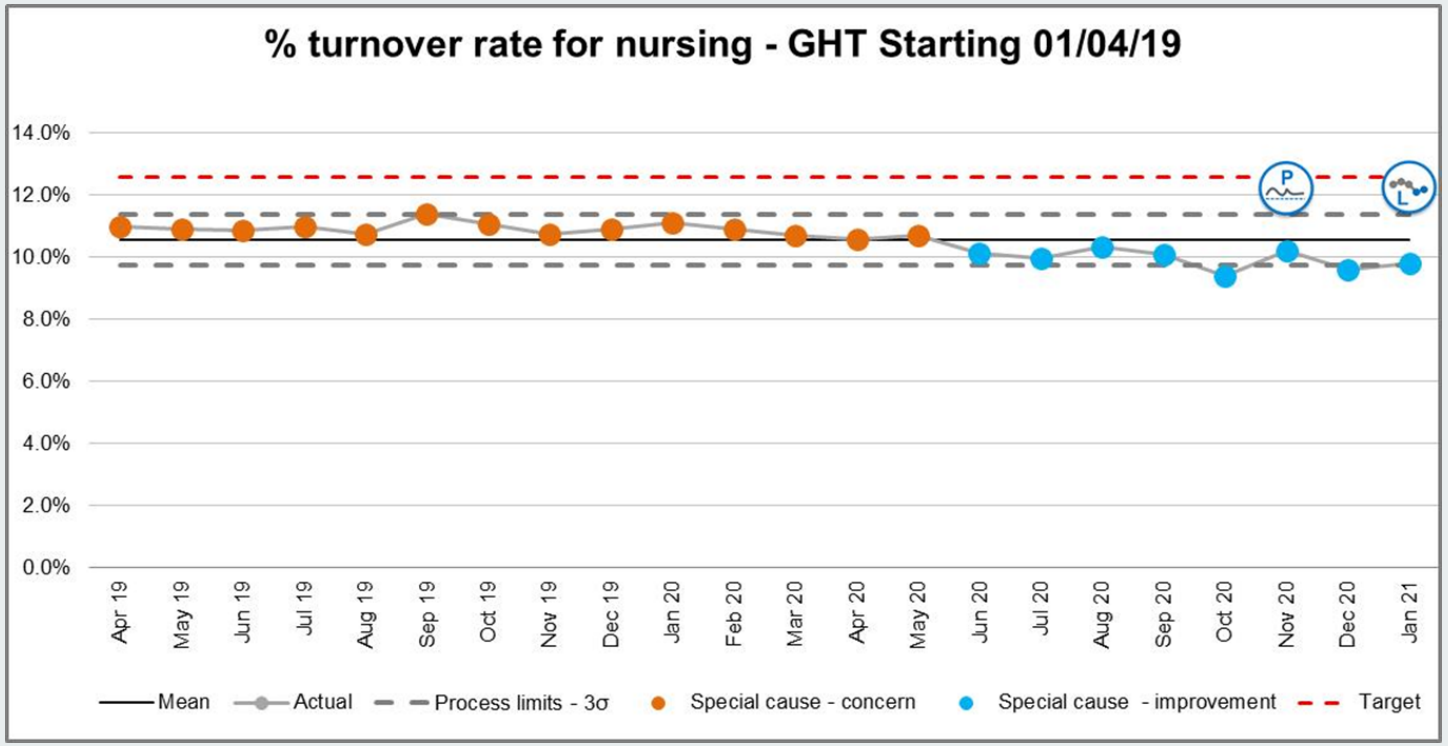
People & OD:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



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- **Director of Human Resources and Operational Development**

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There is 1 data point which is above the line. There are 2 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above and below the mean.
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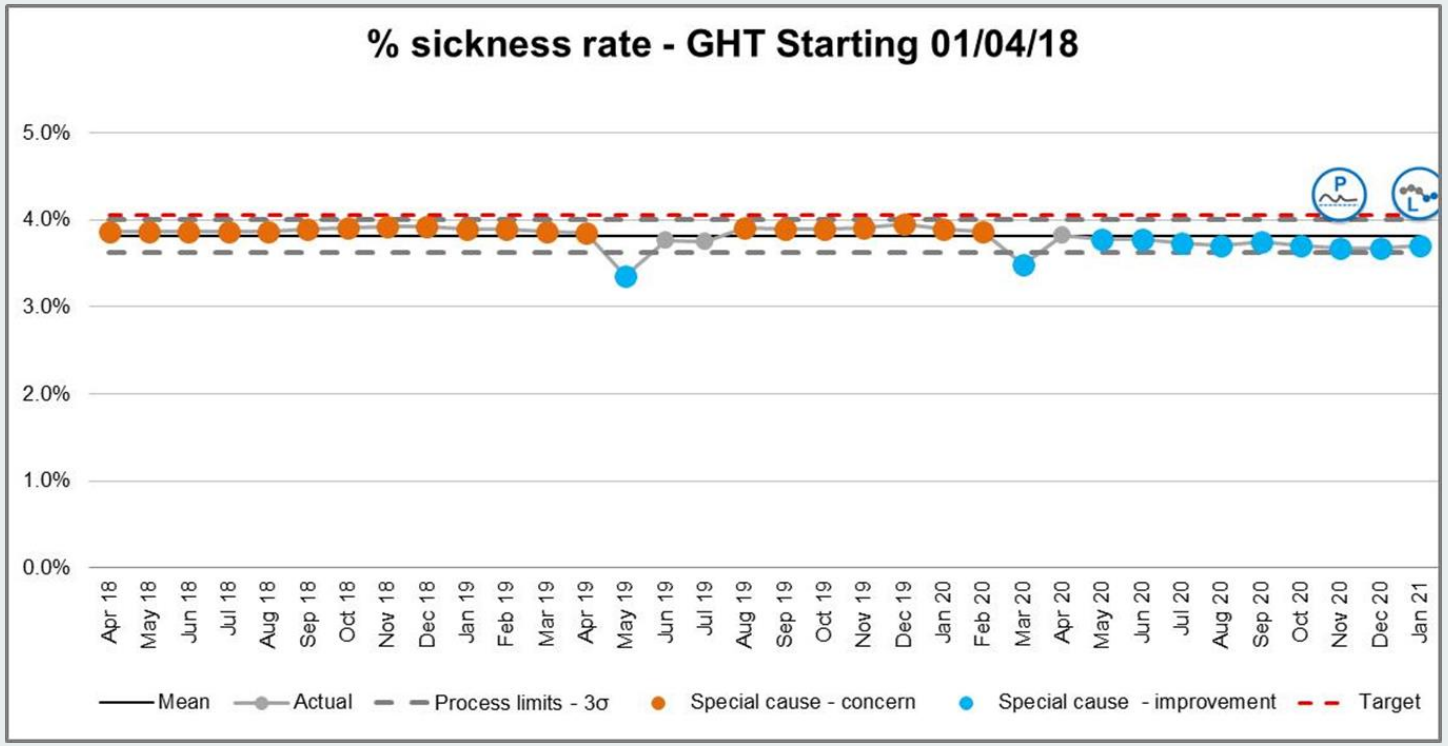
People & OD:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

Non-Covid absence remains low and below 2019 figures (3.69%). However, with Covid-19 sickness absence out absence rate has increased to 5.41%. We continue to recognise the risk that as we progress into 2021 we are likely to experience an increase in colleagues with mental health concerns, exhaustion and those experiencing the effects of 'burnout'. With this in mind we are placing significant focus and energy into building a more resilient staff support and psychology link worker support service, to work with our existing Staff Advice and Support Hub and Employee Assistance Programme. This is being enhanced with the support of phase 3 charities money and the realignment of staff support services into the People and OD Department.

- **Director of Human Resources and Operational Development**

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 2 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above and below the mean.

Gloucestershire Hospitals NHS
NHS Foundation Trust

TRUST PUBLIC BOARD – MARCH 2021

Report Title
COVID-19 Temporary Service Change - Extension
Sponsor and Author(s)
Author: Simon Lanceley, Director of Strategy and Transformation Sponsor: Deborah Lee, Chief Executive

Executive Summary

Purpose

To secure Trust Board approval to extend the temporary service changes, implemented in response to the COVID-19 Pandemic, to the end of June 2021. The exception is the Aveta Birthing Centre at Cheltenham General Hospital (CGH) that will be reinstated in March 2021.

Background

As part of the Trust and Integrated Care System (ICS) response to the COVID-19 Global Pandemic a number of temporary service changes were implemented in three phases:

Phase 1: Implemented 1st April 2020

- Emergency General Surgery was centralised to Gloucestershire Royal Hospital (GRH)

Phase 2: Implemented 9th June 2020

- Emergency Department (ED) at CGH changed to a Minor Injury & Illness Unit (MIIU), 7-days a week 8am to 8pm
- All 999 and undifferentiated (non-diagnosed) GP referrals centralised to GRH. This included the centralisation of the Acute Medical Take including Respiratory
- Acute Stroke Unit (ASU) moved to CGH, Hyper Acute Stroke Unit (HASU) remained at GRH
- Emergency and elective Vascular surgery moved to GRH
- Emergency Urology pathway moved to GRH, planned pathways remained at CGH

Phase 3: Implemented in Dec 2020 & Jan 2021

- Medical Day Unit moved from GRH to CGH
- Neurology inpatient service moved from GRH to CGH
- Aveta Birthing Centre (Midwife led unit) moved from CGH to GRH (expectant mothers were also offered a home birth or delivery at Stroud Maternity Unit, subject to appropriate risk assessment).

The objectives of the service changes are:

- To limit the risk of transmission of the virus to patients and staff
- To enable planned care and cancer diagnosis and treatment to continue, especially to those patients who are most vulnerable
- To give confidence to our local population that both our hospitals are safe places to visit
- To ensure NHS colleagues are supported to continue providing care throughout this pandemic and to minimise the impact of Covid-19 related staff absence on service delivery.

Performance against these objectives is reported monthly to Quality & Performance Committee.

Key points to note:

- We are hopefully now managing the tail of this global pandemic but there is still uncertainty on

the impact the vaccination programme will have on community transmission and infection rates once the artificial suppression of lockdown has been removed.

- Infection Prevention and Control monitoring during the pandemic has shown the greatest risk to nosocomial (in hospital) transmission is the mixing of Covid and non-Covid pathways. Point of Care testing in Emergency Departments can help to reduce this but it does not eliminate it.
- The temporary changes have enabled us to minimise the mixing of these pathways and we need to see evidence that community infection rates will continue to reduce and be maintained at a low level before we can have confidence that reversing the temporary changes would not expose patients and staff to intolerable risk – i.e. increased nosocomial transmission leading to increased patient infection and reduced staff availability impacting on service delivery.
- Significant operational planning is required to plan and implement the phased reversal of the temporary changes and we are mindful of the urgent need to give NHS and Social Care colleagues time to rest & recover from the first 2 phases of the pandemic.
- All temporary service changes have been implemented with support and agreement from Gloucestershire Health Overview & Scrutiny Committee (HOSC), using the previously agreement Memorandum of Understanding (MOU).
    - At a meeting of HOSC on 14th July, Phase 1 changes were extended to October 2020.
    - At a meeting of HOSC on 22nd October, Phase 1 and Phase 2 changes were extended to March 2021
    - At a meeting of HOSC on 2nd March 2021, support was secured to extend Phase 1, 2 and 3 changes to 30th June 2021.
- The Covid-19 temporary service changes will come to an end on 30th June 2021.

Recommendations

Trust Board is asked to **Approve** the extension of the COVID-19 temporary service changes to the end of June 2021.

Impact Upon Strategic Objectives

N/A – these are operational changes in response to a Global Pandemic and are not linked to longer term strategic objectives.

Impact Upon Corporate Risks

A number of corporate risks relating to the impact of COVID-19 on service delivery, workforce, nosocomial infection and safety were entered onto the Trust Risk Register due to the pandemic and have subsequently been reduced as a result of these temporary changes and other measures taken.

Regulatory and/or Legal Implications

The changes have been implemented with support and approval of Gloucestershire HOSC as *Emergency (Temporary) Service Changes* as defined in the agreed MOU.

Equality & Patient Impact

Information about the temporary service changes were shared with the Trust's Voluntary & Community Sector Involvement Network, asking that this information be cascaded through their networks. Network members were encouraged to contact us if there were any questions about the temporary measures or if there was any feedback, positive or negative from patients, carers or families regarding the impact.
A Quality Impact Assessment (QIA) has been completed and is available if required.

Resource Implications			
Finance	X	Information Management & Technology	
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 & Digital Committee	Audit & Assurance Committee	People and OD Committee	Remuneration Committee	Trust Leadership Team	Other (specify)
24/02/21						HOSC – 02/03/21
Outcome of discussion when presented to previous Committees						
• Proposal to extend to June 2021 supported						

GHFT COVID-19 Temporary Service Changes

Gloucestershire Hospitals
NHS Foundation Trust

Cheltenham General Hospital

Gloucestershire Royal Hospital

Key:
3 phases:
[1] Implemented 1st April 2020 in response to pandemic
[2] Implemented 9th June 2020 as part of wave 1 response
[3] Implemented in Dec 2020 & Jan 2021 as part of wave 2 response

	Cheltenham General Hospital		Gloucestershire Royal Hospital
[1]	Emergency General Surgery	→	Emergency General Surgery
[2]	Acute Medical Take (including respiratory)	→	Acute Medical Take (including respiratory)
[2]	Vascular Surgery	→	Vascular Surgery
[2]	Emergency Department (CGH changed to MIIU 8am to 8pm)	→	Emergency Department
[2]	Urology emergency pathway	→	Urology emergency pathway
[2]	Acute Stroke	←	Acute Stroke
[3]	Medical Day Unit	←	Medical Day Unit
[3]	Neurology	←	Neurology
[3]	Aveta Birthing Centre (Midwife Led Unit)	→	Midwifery Led Unit*

To be extended for a further 3-months to end June 2021

To be reinstated March 2021

* Or home birth or Stroud Maternity Unit

Gloucestershire Hospitals
NHS Foundation Trust

Temporary service changes to be extended due to criteria #4…

The table below shows the criteria agreed with HOSC that would need to be met to trigger the restoration of Cheltenham A&E to its pre COVID-19 state of:

A: Cheltenham A&E – Consultant led, 8am to 8pm

B: Cheltenham A&E - Nurse led, 8pm to 8am

#	**Restoration Criteria** (same opening hours as pre-Covid temporary changes)	**A: CGH A&E Consultant led (8am- 8pm)**	**B:CGH A&E Nurse led (8pm-8am)**
1	**Availability of Point of Care Testing** (POCT) to: • enable emergency patients attending CGH to be treated safely in one of three pathways: confirmed COVID-19, possible COVID-19, non- COVID-19, • maintain current very low levels nosocomial (in hospital) transmission.	X	
2	Evidence that reversing the temporary service change **would not reduce the scope or level of activity currently being delivered in elective and cancer care** (diagnostics and operations).	X	X
3	**Workforce availability:** it is possible to continue to fill greater than 85% of GRH and CGH A&E rotas with substantive staff.	X	X
4	Any factor where reversing the temporary change would expose patients and/ or staff to **an intolerable safety risk**.	X	X

Gloucestershire Hospitals
NHS Foundation Trust

REPORT TO TRUST BOARD – March 2021

From The Quality and Performance Committee – Alison Moon, Non-Executive Director

This report describes the business conducted at the Quality and Performance Committee held on the 24 February 2021, indicating the NED challenges made and the assurances received and residual concerns and/or gaps in assurance.

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
COVID Update, Quality and Performance Report briefing and exception reports form delivery groups	COVID activity stabilising although still pressurised, most escalation areas stood down. Noting surgical wards currently mostly caring for medical patients, so impact on elective activity. Continued reduced bed base of 169 beds (21% of bed base). Emerging national data, including Trust figures on impact of extended stays in the ED department. Update on Care Quality Commission targeted inspection of Infection, Prevention and Control, positive feedback of approach, highlighting sub optimal quality of environment of one of the escalation areas in	What is the trajectory of improvement for increasing the bed base and social distancing processes?	Assurance received of a four pronged plan which includes 1. Infection, Prevention and Control/Divisional review of the bed base 2. Restoration and recovery of services reviewing the minimum elective bed base required 3. Strategic review of medical bed base required. 4. Use of the virtual ward and other pathways which may benefit from this approach. In addition, system review of the use of the community assessment beds for people who are medically stable for discharge and how to	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
	experience terms. Nosocomial infections expected to remain high in next reporting period, although now decreasing. New Maternity metrics included within the report.	 Are we modelling increased admissions with schools returning? Is the escalation area noted by the CQC now closed?	improve its contribution. Modelling continues as from start of pandemic. An increase expected but not currently modelled to be a surge status. Currently closed but flexibility continues to be needed during the operational pressures still being seen.	
	Quality Delivery Group (QDG) highlighting key metrics, improved FFT results, increased PALS activity, strengthening links to improvement programmes, national surveys being reintroduced, focus on EPR benefits, continuing high levels of falls and pressure ulcers, activity trends in children's services and need for effective partnership working, focus on people with a learning difficulty.	As the report is so comprehensive, it is difficult to hold what the QDG really focusses on, can this be reviewed? Regarding EPR, where is operational effectiveness reviewed with the levels of compliance and any risks of non-compliance? With the experiences of people with learning difficulties during	Agreed to consider a summary approach for next report. Reviewed as part of QDG with Mark Hutchinson (Chief Information Officer) as Chair, through monthly executive review process and to Finance and Digital Committee. Compliance noted to be improving. Trust takes part in the LeDeR review process (learning from all deaths of	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
		COVID, what have we learnt for future patients? Data concerning presentations of children through this reporting period noted and concerns raised.	people with a learning disability) and reported through the quarterly report to committee. Detailed monitoring within services and feeding into the system wide safeguarding structures/partnerships as a concern.	
	Planned Care Delivery Group confirming extent of patients waiting for care/treatment and a developing service of an 'elective care hub,' Use of national model of Prioritisation categories for patients waiting. Emerging local approach to mass patient communications. Quest to find any regional or national exemplar sites noted.	How prepared are we for the amount of inbound patient communications and queries with the mass communications being sent out? Is there a system to ensure communications are connected with primary care colleagues?	Increased capacity in Central Booking Office now appointed. In addition new and innovative ways for communications will be shared with committee at future meeting. Assurance given that this is in place.	
	Cancer Care Delivery Group noting continued strong performance in seven of the eight national	Noting that the last two delivery groups have been cancelled, does this present governance	Assurance that cancer standards have continued to be reported at executive level with check and	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
	standards and increased use of the Information hub	issues/risks?	challenge approach.	
	Urgent Care Delivery Group highlighted very high numbers of patients admitted with COVID in January. Non achievement of 4 hour standard, an increased conversion rate from attendance to admissions, modular build in March. Positive impact of external processes, e.g. NHS 111, Rapid Response, Cinapsis not fully playing through yet. Ambulance handovers remain one of the biggest risks. Delay related harm of extended waits in the ED and links to increased mortality at 30 days post attendance highlighted, with emerging national dataset and local benchmarking.	With emerging data regarding extended stays in the ED, it is important for committee to see the distribution of waits over 4 hours. With the data on people with fractured necks of femurs, strokes, falls and pressure ulcers and a congested department and internal processes, is there a way to understand the whole pathway profile and is the serious incident reporting process sensitive enough? What is your confidence now in system partners owning the level of risks and leadership for improvement?	Agreed to include all delays by time series for future reports. Trust is undertaking a randomised review of 100 patients who waited over 8 hours, using a structured approach. ED key performance indicators being reviewed to ensure fit for purpose. Response that the system was sensitive enough to define groups of vulnerable patients. The risk of delay of 8 hours or more has now been added to the risk register. Partners engaged further discussions currently about the need for a demand and capacity system wide approach which includes social care	Committee to regularly receive time delay breakdown and outputs of the 100 patient notes review.

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
			and community services.	
Maternity Services Update on National Ockenden Review recommendations, Continuity of Carer and Internal Leadership and Governance of the Midwifery service.	Report on the Governance and Leadership Review of Midwifery Services resulting in 25 recommendations. Noted that the review members concluded a safe service is being delivered with committed and passionate staff. Leaders and colleagues engaged with the process, many examples of good practice. All recommendations have been fully accepted by the Divisional Leadership.	With so much going on in the services, how will this be made real and coherent? What were the review teams views of the experiences of women in the service? Recommendations include the need to protect capacity for the leaders to deliver, how will this be possible? Supporting the focus on delivery of the recommendations, there is a reflective piece of work needed to gain assurance on the	Recommendations include the development of one single overarching plan which brings various strands together and a focus on creating the vision of the service which will support the coherence. Evidence at committee of strong divisional leadership commitment to deliver improvements needed. Reviewers spent the day in department, informal conversations with patients, very positive feedback. More capacity secured within the Division and executive confidence that this will give the space needed for the local leaders.	Short term Maternity Delivery Group being set up to provide assurance directly into Quality and Performance Committee on progress against single consolidated plan of action involving Leadership Review, Ockenden recommendation and key performance indicators. Structured reflection paper will come to committee in three months (May).

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
		situation and what we have learnt from this and potentially for other services.		
	Update on progress of Continuity of Carer priority, noting successful business case, some current recruitment issues, delayed reporting to start in May rather than April.	Can the relevant briefing paper be made available to committee members?	Will be shared and focus on assurance of delivery of objectives. Key metric on Quality and Performance Report from May onwards.	
	Ockenden Maternity Services Assessment and assurance tool progress shared for information and RAG rated.			
Corporate Risk Register update	Review of relevant risks, noting two pieces of work related to risks.	Do the falls and stroke risks meet the criteria for an urgent review?	Confirmed, in progress.	
	1. Thematic review COVID related duty of candour- terms of reference being developed for a cross county/system.	Is the aim to do the right thing or is pressure of capacity to complete the main driver? The review has been outstanding for some time; a date is needed for return to committee.	Confirmed that the focus was on patients and resource would be found. A draft paper is with partners for review.	
	2. Deep dive of causes and contributory factors of incidents related to extended stays in ED.			Outputs will come to committee at future meetings.

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
Serious Incident report and Never Event Thematic Review	Report noting data and high level detail of three new serious incidents and detail of four action plans closed in month. Never Event Thematic review shared with proposed next steps implementing the recommendations.	How do we assess the adequacy of staffing levels through serious incident reporting?	Assurance received that as part of the investigation, discussions on staffing levels take place.	
		The external maternity review indicated the Trust used a different categorisation of serious incidents than others and benchmarked low in numbers, why is that?	Assurance given that the Trust uses the national framework for definition of Serious Incidents, although the framework does allow for some flexibility in interpretation.	
		Are the recommendations in the never event thematic review the right actions at the right level to give confidence in minimising the risks of never events occurring?	Wider national review on status of listed never events, the Trust has been asked to undertake pilot work.	

Alison Moon
Chair of Quality and Performance Committee
24 February 2021

Gloucestershire Hospitals
NHS Foundation Trust

MINUTES OF THE COUNCIL OF GOVERNORS HELD VIA MICROSOFT TEAMS ON WEDNESDAY 16 DECEMBER 2020 AT 14:30

THESE MINUTES MAY BE MADE AVAILABLE TO THE PUBLIC AND PERSONS OUTSIDE THE TRUST AS PART OF THE TRUST'S COMPLIANCE WITH THE FREEDOM OF INFORMATION ACT 2000

PRESENT:		
Alan Thomas	AT	Public Governor, Cheltenham (Lead)
Kate Atkinson	KA	Public Governor, Cotswold
Matt Babbage	MB	Appointed Governor, Gloucestershire County Council *(from 035/20)*
Hilary Bowen	HB	Public Governor, Forest of Dean
Tim Callaghan	TC	Public Governor, Cheltenham
Geoff Cave	GCa	Public Governor, Tewkesbury
Carolyne Claydon	CC	Staff Governor, Other and Non-Clinical
Graham Coughlin	GCo	Public Governor, Gloucester
Anne Davies	AD	Public Governor, Cotswold *(from 035/20)*
Colin Greaves	CG	Appointed Governor, Clinical Commissioning Group (CCG)
Pat Le Rolland	PLR	Appointed Governor, Age UK Gloucestershire
Fiona Marfleet	FM	Staff Governor, Allied Health Professional
Sarah Mather	SM	Staff Governor, Nursing and Midwifery
Russell Peek	RP	Staff Governor, Medical and Dental
Maggie Powell	MPo	Appointed Governor, Healthwatch
Julia Preston	JP	Staff Governor, Nursing and Midwifery
Nick Price	NP	Public Governor, Out of County
IN ATTENDANCE:		
Peter Lachecki	PL	Trust Chair
Deborah Lee	DL	Chief Executive Officer
Claire Feehily	CF	Non-Executive Director
Sim Foreman	SF	Trust Secretary
Rob Graves	RG	Non-Executive Director
Marie-Annick Gournet	MAG	Associate Non-Executive Director *(to 037/20)*
Balvinder Heran	BH	Non-Executive Director *(to 038/20)*
Mark Hutchinson	MH	Chief Digital and Information Officer
Natashia Judge	NJ	Corporate Governance Manager (Minutes)
Jo Mason-Higgins	JMH	Head of Complaints, Claims and Patient Safety
Alison Moon	AM	Non-Executive Director
Mike Napier	MN	Non-Executive Director
Katie Parker-Roberts	KPR	Head of Quality
Andrew Seaton	AS	Quality Improvement & Safety Director
Elaine Warwicker	EWa	Non-Executive Director
MEMBERS OF THE PUBLIC/PRESS/STAFF		
There were two members of the public present.		
APOLOGIES:		
Liz Berragan	LB	Public Governor, Gloucester
Debbie Cleaveley	DC	Public Governor, Stroud
Pat Eagle	PE	Public Governor, Stroud
Kedge Martin	KM	Public Governor, Tewkesbury

ACTION

030/20 DECLARATIONS OF INTEREST

ACTION

There were none.

031/20 MINUTES FROM THE PREVIOUS MEETING

JP reminded the Council that a question she asked at the last meeting had been excluded from the minutes. This related to whether the Trust investigated cases where staff moved department because they were unhappy. DL said she had responded at the time but was happy to confirm that turnover was monitored so that areas of high change could be investigated in order to establish any route causes, which included internal movements. A number of "deep dives" had taken place into wards or departments that had higher than expected turnover.

RESOLVED: Minutes APPROVED as an accurate record subject to a minor typographical amendment. **NJ**

032/20 MATTERS ARISING

Further update was provided on the following matters arising:

- **Matter Arising 016/20** DL reminded the Council that the patient experience survey had demonstrated that 15% of cancer patients were offered entry into trials and that she had committed to compare this to the Trust's data. DL explained that following investigation she had learnt that cancer registrations and subsequent entry into trials were recorded; however those who were ineligible or declined were not, therefore the Trust's figure was even lower than that stated in the patient experience survey. However, DL reassured that she was confident that the Trust was incredibly proactive in offering trials where they were available and that the cancer strategy and research strategy both signalled an intention to increase the number of cancer studies opened in the Trust. This matter arising was agreed closed.

- **Matter Arising 024/20** was noted to be closed however AT shared that governors had not yet been invited. NJ would pursue. **NJ**

RESOLVED: The Committee APPROVED the open and closed items.

033/20 CHAIR'S UPDATE

[This item was taken out of agenda order at the end of the meeting]

The Chair congratulated MAG on her appointment as a Non-Executive Director, and noted that Rebecca Pritchard and Roy Shubhabrata would be joining the Trust as Associated Non-Executive Directors in February 2021.

The Chair confirmed that virtual meetings would continue until at least the end of March, reflecting that this had not held the Trust back and that all participants had embraced the digital opportunities over the last few months with more participants than had been achieved when meetings had been face to face.

The Chair also reminded governors that they could suggest agenda items for the Council via him, the Lead Governor, or the Corporate Governance Team.

Post meeting note: Also to be noted that MPo has been appointed for a further three year term (until Annual Member Meeting 2023).

RESOLVED: The Council NOTED the update.

034/20 REPORT OF THE CHIEF EXECUTIVE OFFICER

DL presented her report to the Council and provided a contemporary update on:

- COVID-19: current inpatient levels and how the Trust was managing the increased number of positive patients alongside maintaining elective care and staff health and wellbeing.
- COVID-19 community cases and the rise in the previous few days, particularly in certain areas of the county such as the Forest of Dean.
- The ongoing planning for a potential third surge in mid to late January, following the relaxation of social distancing measures over the Christmas period.
- The successful implementation of the Trust's COVID-19 vaccination programme
- The upcoming Admin and Clerical Staff celebration day on 21 February 2020.

GC queried the transfer of COVID-19 infection within the Trust and the plans in place to combat. DL answered that the Trust had noted high levels of nosocomial transmission during the first wave which had dropped dramatically following a change in the configuration of ward beds to ensure social distancing between patients. Following the reduction in COVID cases and increased demand the Trust's bed base had almost returned to pre-COVID-19 levels, with screens placed between beds. However, this had proven to be less effective than distancing therefore the Trust would be reintroducing socially distanced beds. Improvements due to the introduction of lateral flow testing were also noted. Cases in November were reflective of the national picture but positively, were considerably lower in December so far.

MPo asked what the feeling was like within the Trust considering the large number of inpatients and lesser community support in comparison to the first wave. DL answered that it felt very challenging for staff within the Trust and that *'Wobble Rooms'* and the *'Ready to Leave Checklist'* had been reintroduced to support colleagues as these had been found to be the most effective measures in the first wave. In terms of infection prevention control, goody bags and food on wards had been found to be unhelpful to nosocomial transmission, however free drinks and 50% subsidy for all meals was still available to colleagues throughout the Trust.

SM reminded the Council that psychological support had been available to staff during the first wave through psychology link workers. DL answered that while psychological link workers were reduced, a number of TRIM (Trauma Risk Management) practitioners had been introduced to provide additional dedicated support for staff. DL would include a note on TRIM practitioners within the Trust's global communications re **DL**

remind everyone what was available.

RESOLVED: The Council NOTED the CEO's report.

035/20 PATIENT EXPERIENCE REPORT

KPR presented the Q2 (quarter 2) Patient Experience Report to the Council, highlighting in particular the difference in activity between Q1 and Q2, the increase in the responses to the Friends and Family test, and the increase in concerns raised via the PALS (Patient Advice and Liaison Service) team (returning to pre-COVID-19 levels) with themes around communication and delays to appointments.

MPo noted the implementation of psychological support for the PALS team due to the increase in distressing calls. She sought clarification as to whether this was due to distressing stories or verbally abusive patients. KP answered that the PALS team had upgraded their offer to provide a seven day support service and the emotional state of patients and their families had been more distressing. This was largely the reason for the additional psychological support, and while there had been an increase in abusive calls, the team were noted to be very adept and professional in handling.

GCa asked whether any clinical repetitive themes were emerging. KPR referenced appendix 2 of the report, and explained the overwhelming theme related to communication including families unable to get hold of wards for an update on their relative. The team were noted to be working closely with ward clerks in order to support communication channels. GCa asked further whether concerns regarding delays and misdiagnosis had arisen. KPR answered that there were rarely any regarding misdiagnosis however a substantial amount related to delays in appointments across all specialties, sadly inevitable due to the impact of COVID-19. DL confirmed that a potential misdiagnosis would be investigated under the Trust's incident policy and handled via the complaints process, rather than PALS.

AT noted that the Director of Quality and Chief Nurse had previously said that staffing issues within the PALS team had been rectified and asked whether there was now enough resource. KPR answered that additional resources had been provided but they had struggled to fill with temporary staff but were now working on longer term contracts which she hoped would resolve the issue. She confirmed that she was working closely with the Steve Hams, Director of Quality and Chief Nurse

The Chair thanked KPR for presenting the report, and reminded the Committee that this was received at the Quality and Performance Committee on a quarterly basis and circulated to Governors.

RESOLVED: The Council NOTED the report for INFORMATION.

036/20 ANNUAL COMPLAINTS REPORT

JMH and AS presented the Annual Complaints Report to the Council,

highlighting the successful changes to the patient investigation and learning team, the decrease in the number of complaints, and the teams approach to ensuring timely responses.

RP noted the small number of cases escalated to the Parliamentary and Health Service Ombudsman (PHSO) and asked whether there were any themes within these cases. JMH answered that there were a variety of reasons why cases were escalated to the PHSO, with no specific themes, and that sometimes cases were escalated simply because the views of the Trust and the patients differed. DL reminded the Council of the incredibly small number of PHSO cases, in comparison to the number of patients treated, and that the numbers of complaints upheld by them was very low. She also reflected on the impact of grief in many of the cases. Finally, DL praised the exceptional work of the team and of note the reduced burden on families associated with multiple independent investigations.

RESOLVED: The Council NOTED the report for INFORMATION.

037/20 CHAIRS' REPORTS

PL encouraged Committee observers to contribute to the Chair's reports should they wish, and reminded the Council that comprehensive reports on each area were available within the Trust's public Board papers.

Finance and Digital Committee
RG presented the Chair's report from the November 2020 meeting. The finance section of the meeting was noted to have focused on analysis of the Trust's current financial position, the Integrated Care System's (ICS) financial deficit (and the Trust's portion of this) the current cash position, the ability to spend capital allocations and 2021 Cost Improvement Schemes (CIP). The digital section of the Committee was noted to have focused on the deployment of a new electronic patient record (EPR), digital team resource and the progress of other projects via a Red Amber Green (RAG) status report.

Estates and Facilities Committee
MN presented the Chair's report from the November 2020 meeting. Key topics highlighted at the Committee included the implementation of actions highlighted in the Gleed Report, Gloucestershire Managed Services (GMS) performance against key performance measures (KPIs), changes to the Trust's security measures, updates on the GMS business plan, the progress of the Trust's strategic site development (SSD) programme, parking and Private Finance Initiative (PFI) contracts and finally an update on the Trust's sustainability ambitions.

People and Organisational Development Committee
BH presented the Chair's report from the October 2020 meeting. Key topics highlighted at the Committee included the importance of embedding the principles of partnership working, health and safety resources and the results of the Freedom to Speak Up (FTSU) report, Employee Relations Report and Equality Report.

Quality and Performance Committee

ACTION

AM presented the Chair's report from the November 2020 meeting. Key topics highlighted at the Committee included the current challenges within the organisation, concerns regarding some metrics in the Medial Division scorecard and red indicators on the Trust's Quality and Performance Report and issues within the Stroke service. It was noted that the COVID-19 Infection Prevention Control Board Assurance Framework (BAF) would be reviewed at the upcoming meeting with Maternity Services a substantive item at the January Meeting.

AT noted that governors heard relatively little regarding Stroud's Maternity Services. DL answered that beneath the aggregate data presented in the dashboard, Stroud was reviewed at a more granular level, with activity noted to be reducing as patients chose home births as opposed to midwifery led births. The team at Stroud were noted to rotate between either Cheltenham or Gloucester, to ensure that they were not only practicing at unit with low levels of birth. PL noted than much of Stroud's activity related to postnatal care.

Audit and Assurance Committee

CF presented the Chair's report from the November 2020. Key topics highlighted at the Committee included the review of emergency preparedness, the Trust's core financial controls, the introduction of the Trust's new external auditors, Deloitte, and the progress of the Internal Audit Plan, with a particularly challenging report on estates and backlog maintenance.

PLR praised the Committee meeting and raised the slippage of audit of the Mental Capacity Act to 2021/22 plan. CF explained that this had been due to higher priority audits taking precedence, and AM noted that she had raised at the Quality and Performance Committee and had received assurance from the Quality and Delivery Group that there had been an increase in compliance with the mental capacity act.

RESOLVED: The Council NOTED the assurance reports from the Committee Chairs.

038/20 SUNRISE EPR PRESENTATION

MH gave a presentation to governors on the progress of implementation of Sunrise EPR (electronic patient record) covering the:

- Trust's digital history and low digital maturity
- Reinvestment of money earmarked for Trakcare implementation into Sunrise EPR
- Implementation of change (in manageable portions)
- Removal of paper based systems
- Benefits to patients and the Trust following the change in nursing documentation, electronic observations and order communications
- Upcoming phases in project implementation

AT thanked MH for the presentation and commented that it was rare to see such direct linkage between project business cases and concrete benefits. He praised the impact on patients and noted how the EPR would combat medicine prescription errors.

RP said that he was excited for the EPR to be implemented in the Women's and Children's division but asked how the team would support areas with limited numbers of computers. MH answered that as part of implementation, teams would be provided with computers on wheels, laptops and tracking boards and that all was in hand.

GCa commented that it would be interesting to see whether implementation improved tracking of patients from the emergency department to wards, supporting enquiries from patient families. MH explained the previous transfer system and how this was time intensive and not always completed, noting that moving forward this would be done in a much more timely way.

FM asked how the EPR would interface with Allied Health Professional activities in outpatients. MH explained that the EPR would impact ordering of tests and review of results.

NP asked how MH would approach smaller specialties with independent patient management systems, for example Medisoft in Ophthalmology. MH explained that there were more than 200 legacy clinical systems across the organisation which would be not be possible (or necessary) to replace, therefore the focus was ensuring these other systems were integrated into the EPR so that results were available outside of those individual areas, for example.

The Chair asked what would enable the Trust to achieve a higher HIMMS (Healthcare Information and Management Systems Society) rating without having to go through all the evolved stages. MH answered that the Trust was taking advantage of the experiences and learning of other organisations. Governors sought to better understand the HIMMS digital maturity rating system. PL asked that the HIMMS digital maturity definitions chart be shared with governors. **MH**

GC asked whether there was potential for an integrated system between the Trust and primary care. MH explained the county's Joining Up Your Information (JUYI) initiative which provided a summary of patient care records from all organisations to each other. He also reflected the complexity of a system which integrated both primary and acute care, noting that there were exciting opportunities across the Integrated Care System to rationalise IT systems but he doubted the same system would be used across health and social care.

JP asked whether the EPR would be linked with point of care testing such as blood pressure machines. MH answered that the Trust was investigate integrating a whole range of medical devices in the future to reduce clinical time spent uploading results manually.

RESOLVED: The Council NOTED the report for INFORMATION.

039/20 GOVERNOR'S LOG

The Governors' Log and the process behind it were noted, with further guidance and standard operating procedure noted to be available within

the Governor Handbook.

RESOLVED: The Council NOTED the Governor's Log.

040/20 ANY OTHER BUSINESS

There were no items of any other business.

DATE AND TIME OF THE NEXT MEETING

The next meeting of the Council of Governors will take place at 14:30 on Wednesday 17 February 2021.

Signed as a true and accurate record:

Chair
17 February 2021