Fit for the Future 2: Developing specialist services in Gloucestershire

Staff responses

1. Please tell us what you think about our ideas for Benign Gynaecology.

	Answer Choices		Response Percent	Response Total
1	Strong support		20.45%	9
2	Support		43.18%	19
3	Oppose		2.27%	1
4	Strongly oppose		0.00%	0
5	No opinion		34.09%	15
			answered	44
			skipped	4

Please tell us why you think this e.g., the information you would like us to consider. (15)

1	Seems sensible if the procedure is minor and doesn't involve complications. Although consideration needs to be given to more complex patients with additional needs who may require inpatient care. You can have a rule/principle but also need to establish exceptions and how these will be managed - a one-size-fits-all service may meet the majority of patients but we need to ensure that outlier patients with unusual case histories are considered uniquely, and the service/intervention is designed around them.
2	All women have the right to timely medical involvement
3	reductions in cancellations are a necessity
4	minor surgery suitable for CGH
5	The loss of the gynae ward has been detrimental to patients this specialty needs nurses who have this knowledge do not put inpatients on general mixed specialty wards. The Cheltenham option works
6	Get operations done when no beds
7	Developing and delivering day cases in a less acute hospital with less impact from emergency admission is sensible and appropriate.
8	I think it is exciting to be having treatment in the new Day unit being built in CGH rather than the very tired unit in GRH
9	Wish it was in CGH. No one takes any notice of the staff when they are stressed due to not enough staff and not enough pay. This is across the whole hospital CGH and GRH in every department
10	For day case procedures not expecting overnight stays, I feel this appropriate
11	Sounds like a robust plan to consolidate services on a single site and reduce the impact of bed availability on cancellations
12	In general, everything sounds good, however, it would be beneficial if services could be offered in smaller hospitals such as Stroud, Berkeley and Cirencester.
13	centralising this service so that this particular group are together and for one day only, would likely work well.
14	If this is going to be day case at Cheltenham general more car parking for our patients is needed. This is not acceptable for the patients to be stressed before even coming into hospital for surgery. This has such a negative impact on patients. As I said irk at Cheltenham General Hospital and straight away the conversation in the morning will be about parking.

1. Please tell us what you think about our ideas for Benign Gynaecology.

15	I don't really have a strong opinion and it doesn't really impact me, but there were a lot of pros in the email.

2. Please tell us what you think about our ideas for Diabetes and Endocrinology.

Answer Choices			Response Percent	Response Total
1	Strong support		28.89%	13
2	Support		40.00%	18
3	Oppose		0.00%	0
4	Strongly oppose		0.00%	0
5	No opinion		31.11%	14
			answered	45
			skipped	3

Please tell us why you think this e.g., the information you would like us to consider. (14)

1	Diabetes managed properly need not cause problems, but it needs to be caught early and managed
2	Having experts on site
3	Most of the time, patients with diabetes end up really poorly in hospital or have a long recovery after an acute illness. We are seeing more and more patients for the past year. Patient education is really important especially in the community or primary care, encouraging people for lifestyle change as this will impact hospital admissions and help them be on the right track/ control their diabetes.
4	Huge growing demand more investment in diabetes specialist nurses required
5	Managing a cohort of patients who are admittedly unpredictably with linked specialties (vascular Renal) is appropriate. The ability to provide advice and support across the county for all diabetic patients is important however.
6	The Diabetes team is extremely small and therefore centralising services to GRH site makes sense
7	I think it is important to integrate care for people with diabetes. Currently the information held by primary care and by secondary care is often separate, leading to loss of time, repeated tests and possibly poorer outcomes. Appointments in the community would be helpful, but one IT system with information for all outpatients with diabetes (I think the renal service has something similar) would save everyone a lot of time. If there was a better career progression pathway for secondary care DSNs, maybe they would stay longer, and the team would struggle less to provide a generally wonderful service. They are not supported by the hospital management to do this currently. I have lost count of the number of highly training DSNs who have left.
8	Reducing hospital admissions is key and having diabetes specialists/teams in the community to offer the same specialist care that one receives in hospital helps to reduce the admissions and length of stay in hospital
9	Centralizing service will improve outcomes and patient care and experience. Opportunities to develop the workforce will also be greater with more local support from the wider MDT
10	Could work - although with reservations. With 20% of the hospital population having the diabetes, I almost think of it as 'normal', although having patients who need more extensive input, it is good to have them together under one team.
11	I personally use these services and find them easier to access in Gloucester as parking is freely available close by and the hospital in Gloucester feels more modern when not in the tower block and also cleaner and easier to navigate.

2. Please tell us what you think about our ideas for Diabetes and Endocrinology.

12	Again, Parking needs to be improved massively.
13	I don't really have a strong opinion and it doesn't really impact me, but there were a lot of pros in the email.
14	I am concerned that reconfiguration discussions which are 'site centric' overlook the overwhelming need to move diabetes services into the community to point of near exclusivity. This is need is already pressing and will become more acute with each month that passes. The model of care should increasingly focus on how people with diabetes (especially younger Type 1 diabetics) contact their supporting team. We can no longer rely on 6 monthly trips to outpatient clinics and expect outcomes to improve. Have these plans been discussed with Dr Partha Kar (National Specialty Advisor at NHSE England) as he has a decade long track record of reforming community diabetes care?

3. What do you think are the most important things to be considered in improving Frailty services?

	Answer Choices	Response Percent	Response Total
1	Open-Ended Question	100.00%	45

1	Adequate provision of community care improving community therapy staffing to reduce wait times for urgent rehab needs to ensure patients can stay in their own home falls awareness training for all staff adequate equipment system to avoid lengthy delays and improve communication with inpatient ward teams
2	Being near emergency care and medical admissions
3	Provision of specialist social care so that patients can be discharged more rapidly when medically fit for discharge, their ongoing care and recovery can be maintained safely once they leave the acute hospital environment
4	Timely advice for family and carers. A help and support line would be very useful
5	Essential to look at things differently. Keeping patients in hospital in the misguided view that they are safer cannot continue with the aging population. Virtual ward is a great plan, but there is a need to bolster staff to respond to emergencies, as we have to stop hospital admission as being the only option has to cease
6	complex surgical specialities such as vascular need to follow the lead of ortho/trauma and have geriatricians imbedded in the teams.
7	Timely assessment and discharge.
8	Support at home; easier access to medical services when needed to prevent deterioration at home--which can prevent hospital admission
9	Dignity choice and information to all involved
10	More outreach into community and enhanced work with the ambulance service and care homes to improve patient care pre hospital and avoid hospital admissions
11	Inpatient ward fit for purpose clear pathway to community hospitals which should very much be part of this review
12	Keeping patients out of hospital
13	Frailty impacts upon all specialties and services and must be recognised in an aging population. I would think greater interaction with other specialties to help manage frail elderly patients should be a priority. Frailty is not always the reason for admission but affects management, prognosis, length of stay and discharge planning. A focused team assessing all patients in this category across all specialties will have the greatest impact.
14	Removing patients from GRH where beds are critically limited

3. What do you think are the most important things to be considered in improving Frailty services?

	Patients have the ability for early intervention before coming into hospital out in the community with a linked service within the acute. Patients can get access to social services early on during assessment to try and avoid admissions
15	There is so many specialist community doctors, nurses, physiotherapists, occupational therapists, speech and language therapists, dietitians, social workers, pharmacists and psychologists - before Gloucestershire Hospitals specialists in caring for older people who may be frail. please don't forget other specialist preventions - good bladder & bowel management (countywide nurse specialists), falls and pressure sores (TVN)
16	There must be better collaboration between health & care in order to provide speedy support in a crisis so that a patient can be treated at home or if they need acute hospital care they can return home the day they are fit. The current waits for D2A beds are a disgrace, people are dying while they are waiting. It would be cost effective and clinically effective to provide the speedy support quickly which would allow most people to keep their independence and require minimal or no care. The current system means that a patient who has been stranded for weeks/months finally leaves hospital in such a poor state that they are likely to need permanent, costly, care. We need equity across the county, not the current patchwork of services. There are a number of areas that have no frailty services. I think you need to be careful not to put too much hope into direct admissions to the FAU, they will not result in a radical change and there is a risk that patients who have fallen do not get the correct treatment/ injuries missed etc. ED are v gd at dealing with injuries. You talk about stays of 23 hrs or 3-5 days; this will only happen if you sort out the discharge pathways. The current FAU doesn't work because the site managers move inappropriate patients off other wards there.
17	Definitely need this in CGH. My Mum was in GRH horrendous Care. Pay the nurses more so good people apply for jobs
18	Health budgets and availability of care packages of Choice
19	Improved health & wellbeing for moderately & less frail patients to reduce increasing frailty. This could include referring to a Social Prescriber to address/support/identify any socially related issues which could be impacting on the health & wellbeing of the patient. By considering the patients social situation improvements can be made in quality of life and feelings of value and purpose by connection to local communities, initiatives and resources e.g., groups/activities/classes.
20	Admission prevention. Working with community teams to recognise those who are high risk for admission to hospital. Encouraging community DNAR reviews and plans that reflect the patient's wishes with regards to hospitals admissions. Pathways for referrals to community hospitals for support / nursing homes / other care settings as appropriate
21	Improving LOS and avoiding admission if possible. There is some overlap with vascular services as some vascular patients are frail and would benefit from the same approach - i.e., avoiding long waits in ED, a designated space for seeing the patient to assess them and avoid admission as far as possible. I would be interested to know if patients from other specialties who fit into the frail category can be seen in FAS?
22	I don't believe the best place for people living with frailty to receive an assessment is in the hospital, surely it should be in their own home, whenever possible? There are highly skilled and qualified community frailty practitioners working in services providing person centred assessment, treatment and care, preventing people living with frailty being admitted in the first place, which are not represented in the Fit for the future document, this is really short-sighted. Closer working with FAU, HAT and existing community services would stop people having to go to the hospital in the first place. More investment in community services and integration between FAU and HAT would provide a more seamless service for our population and would perhaps improve recruitment and retention in the trusts, with more career opportunities and peer support for staff working in this area. Easier access to consultant geriatricians and GPs with a special interest in frailty would also benefit the population with dedicated time to assess patients in their own home. Everything does not have to revolve around hospitals, community is the future, whilst recognising the valuable part that the acute trust has to play, in acute situations requiring admission for something that cannot be safely managed in the community.
23	Complex care at home team (Frailty service) is a fairly new team (4 years) that offers expert individualised care for up to 12 weeks for individuals that are frail and at high risk of further hospital admissions. This team appears to be largely unrecognised and requires recognition for its valuable care and treatment to

3. What do you think are the most important things to be considered in improving Frailty services?	
	individuals at risk of further hospital admissions. Recognising pre-hospital admissions and having a team of specialists working with individuals to prevent any hospital admissions by providing virtual wards to anyone at risk of a hospital admission which would improve patient recovery, reduce deconditioning, reduce depression diagnosis. reduce falls and improve mobility Strong emphasis on hospital admission prevention alternative numbers/teams to contact instead of attending A&E to be directed to appropriate team/pathway
24	Needs to be recognised that frail elderly patients need to be cared for in the community in their own homes and not by what is described as a Virtual ward model - the term is very unfortunate as it does not describe what this population need! In my opinion and having cared for many such patients this is a gross oversimplification. I don't disagree they need close monitoring but not in a way that will be intrusive or anxiety provoking. We already know the frail elderly don't do well in the unfamiliar, hi tech environment of an acute medical unit so why would we seek to turn their homes & their place of safety into one. There are far better ways. The Complex Care at Home team can provide an holistic assessment and ongoing review to stabilise chronic, long term conditions. The Matrons that lead this service (who work closely with GP networks and hospitals) are medically skilled & are all experienced Non-Medical Prescribers. We even have Dementia Matrons and access to Consultant Geriatricians across both acute sites who tandem visit this population (at home) as and when needed. We see many instances where the frail population are admitted to hospital due to safeguarding concerns due to lack of support with daily care due to escalating costs, they are unable to afford. What I would like (& what I believe my Community NHS colleagues would agree with) is to see increased funding for Reablement/ Home first, NHS Community care to back up services aiming to keep patient's living independently and well in their own homes. Yes, being realistic we need some beds but locate them around the county closer to where people and their families/ support networks live i.e., Community Hospitals.
25	More focus on existing services such as complex care at home who are already delivering outcomes
26	I work as a Community Matron in GHC -I work with the Complex care at Home Team -I was disappointed not to see any reference to the work our team engage with. We work as Case managers supporting people to remain out of hospital (if medically indicated is best option) We support those who are identified as frail -at whatever age to build resilience and help them engage in treatments and options to maximise their potential -as identified by them. we work alongside multi agency partners and are able to provide very intense, focussed input. Our team consists of General Nurses, therapists, Dietician, Mental Health and well-being coordinators who provide much support. We work alongside Social Care colleagues to assist the individual and family to navigate our systems. Some reference to the many individuals we have successfully supported would be valued.
27	Access to specialist teams and services, increased investment in the right resource for example more consideration of the Therapy workforce and provision to support initial assessments, prevention of de-conditioning, early assessment and intervention and continuation of rehabilitation across the patient pathway from an acute stay to home first. would benefit from increased joint working across an integrated care service, breaking down barriers to ongoing care and support.
28	Support for people in their homes just isn't in place right now, and government funded care homes are closing, which I believe will lead to increased risk of falls and deaths. I really hope that you manage to integrate with adult social care, otherwise this will be disastrous.
29	I'm extremely concerned that my team, The Complex Care at Home (CC@H) team, haven't been mentioned anywhere in this document. The document describes the remit of the team and all that we already do without mentioning us by name! However, to address the question: the need for more nurses, therapists (physios, occupational therapists, dieticians), as well as Health and Well-Being coordinators and social care workers (social care navigators and assessors) working specifically with the frail elderly in the community is essential. Another missing essential is that more carers are required to call on at short notice. A recent example of working to keep a patient in their own home follows. Yesterday evening I stayed until nearly 8pm to prevent a patient being admitted (I should have finished at 6pm) and working with a friend of the patient (who is a carer) we managed to prevent them being

3. What do you think are the most important things to be considered in improving Frailty services?	
	admitted. I received a call from the physio and Health & Well Being Coordinator as they had concerns that the patient might have an infection and wasn't engaging with the physio at his visit. The patient was 'stuck' in their chair, and needed help that required working over 2 hours to ensure that they understood what we needed to do to help them keep safely at home, eventually agreeing with the plan to support a transfer to the profiling bed. This length of time isn't available to regular carers, who are given about ½ hour to carry out personal care. Indeed, private carers had left just before I arrived as they were unable to support the patient with their standing problem. With patience, support, engagement (and allowing for the patient's need to talk, share their particular sense of humour and many anecdotes) which has come from a long period of relationship building and trust, we managed to support them to bed, attended to their personal care, made them comfortable and supported to leave safely overnight with a lifeline until the next care visit. By anticipating that a crisis in their care was about to occur we were able to ensure that all services, equipment and anticipatory care planning was in place. Once in bed I was able to carry out a clinical assessment and prescribe antibiotics to treat an infection, and update the GP, SW and other teams. This situation isn't unusual. Many people found in these situations will be admitted to hospital and remain there with all the adherent risks of being an inpatient. However, even with the best of care from our team, this patient is likely to self-neglect and unfortunately on occasions will find themselves in the acute trust to manage an exacerbation or infection if the ambulance service are called. This is not a happy experience and each time the patient is desperate to come home again. With more therapists, carers and nurses over longer hours (possibly a 7 day a week working rota over a 12-hour day, I feel that many more admissions could be avoided. Often there are family/spouses, or neighbours who are trying to attend to their loved ones on their own. Sometimes it is the support for the carers to continue in their role that is our focus. Having access to respite care, financial support/advice with benefits or just helping to understand how to safely mange medicines, manual handling, diet and the patient's health problems is important. Indeed, asking the patient what matters to them is very revealing to understand their values. We also ask our patients what they think is wrong, or what their main concerns/problems are. Having insight into what they feel is important in order to understand what they want is often not the focus of their management in hospital (I have worked in the hospital!!). 'MFFD' is the mantra – the 'medical' bit often being the important decider when saying whether someone can be discharged. Personally, I would like that this expression is abandoned. My experience is that patients will say whatever they need to say to get home. On discharge, they don't often reflect the assessment made at discharge from the hospital. I strongly advocate that there is strengthened community services for the frail elderly, that they are, as much as possible, assessed in their own homes (believe me, their homes do not resemble a ward environment if you truly want an objective assessment!), that there is better support for the teams such as mine to do this (ideally an expansion of my team county wide), and that we are the point of contact to discuss patients that are frail. There still is poor contact with the hospital wards and community teams - we work hard to overcome this, but it still isn't sufficient to support a safe discharge. The Frailty/HAT teams are very knowledgeable and understand our roles. In the community, we have a different approach to the acute trust – we are looking for a shift, a change in what the patient or family are experiencing as a stressor or block to living well in older age with frailty. At this point we consider discharge and leave access open to contact us if there are any problems, they want signposting with, or a discussion about something troubling them. I still get occasional updates about some of my patients that I have long since discharged. It's important that people feel confident with moving forward. There is a fear from some professionals that this will be abused or other concerns. I haven't experienced any such problem. The work requires personnel with tenacity, ability to work in a multi-disciplinary team sharing care, understands advocacy, respects the individual, compassion, a high level of interpersonal and interprofessional skills, academic knowledge and patience. The work is proactive and preventative. If one is looking for a 'quick fix' with the frail patient, you are probably in the wrong job!
30	Staffing in the therapy service as the team do not have the capacity to prevent patients becoming deconditioned and the responsibility is often seen as solely as therapies rather than the wider MDT, patients who are admitted quickly become dependent or lose their ability to walk and require packages of care that weren't needed when they were admitted. I find it terribly sad that as a service we are disabling a vast number of patients which puts further pressure on community services that are already overwhelmed which in turn blocks beds in our hospitals.
31	More rapid access to care packages/ support out of hospital. Virtual wards to offer advice and outreach to patients' homes to prevent avoidable/ social admissions that often mean patients staying in hospital longer than is needed increasing the risk of picking up hospital acquired infections. Social workers in hospital to assist with discharges to enable therapists to rehabilitate patients and not spend majority of time discharge planning and advising relatives on onward care options.

3. What do you think are the most important things to be considered in improving Frailty services?

32	Lengthy stays in hospital due to poor community flow- no community beds available to improve hospital flows, contributing to deconditioning and poor health outcomes for elderly people who stay in hospital when they do not need to. Admissions of elderly/frail people who can be managed within the community, often with social and cognitive issues therefore end up in hospital waiting for months, likely for a Discharge to Assess bed, as cannot return to their previous residence. Vicious cycle.
33	Better staffing and funding
34	Offering as much support for frail patients within their own home. Occupational therapist support, Dietician support, Physiotherapy support, Nurse overview, Well-being coordinator social support, Housing support, social care support through Care Navigators. Imagine having all of this within one service, we do. Complex care at Home is this. The aim is to support frail patients with access to all of the above including a complex health review and medication management. A Case Management approach to enable patients to remain in their own homes. This service works well at any stage but best when linked with proactive prevention where service users are supported during initial stages of decline, educating and motivating service users to take responsibility for their own healthcare, thus resulting in reduced hospital admissions and reduced NHS expenditure.
35	- Preventing unnecessary admissions to hospital. - Returning home quickly and efficiently. -
36	Quality of diagnosis
37	access to support services to reduce risk of attendance at Ed or admission Improve quality of life for patients and carers
38	Getting out of the ambulance and not queuing would be a start! Keep the Oshawa homes open use them as intermediary care and rehab where they can stop bed blocking, be FULLY assessed doing daily living tasks and then decide can they stand alone at home, do they need Dom care or do they need residential support!!! You have capacity issues as people can't go home but are well enough to be discharged, intermediary care can upskill or reskill, and capacity should improve in Dom care it's common sense. Having realistic goals makes them have a purpose, makes them feel respected and valued and that they have hope as opposed to being a piece on a shuffle board with no say in their or even asked for their opinion. They need confidence building more often than not. We need to be person centred properly
39	Family Carers involvement in supporting their family member during inpatient stays, at discharge and at home in the community.
40	skilled staff and well being
41	Keeping elderly/frail people out of acute hospital as much as possible. GPs having discussions with patients and family members to identify ppl not coping at home early and put in place care, community assessments or moves to more appropriate housing. Also, to encourage health/financial PoAs be put in place before it is too late. Once ppl are admitted early assessment by doctors and other needed professionals - better OT and physio staffing and assistant. Better capacity of services like home first, packages of care, and discharge to assess beds. Better communication with patients and their families about plans to go home. Nurse training to ensure they are encouraging independence in patients rather than doing too much for them (preventing learned helplessness). Increased understanding from the public regarding realistic expectations that their family members cannot stay in hospital indefinitely when they do not have medical/therapy needs.
42	Wellness and mental health. Address loneliness and independence.
43	Ensure on-going support is in place on discharge , access to home-support which is easy to navigate . To ensure that due to any change to location of the Ward , patients are not isolated as their loved ones are able to visit them, for example if a patient is from Cheltenham , are key family members also from Cheltenham, would these family members be able to visit , due to perhaps mobility issues or other LTC/illnesses , otherwise if the length of stay in longer than anticipated the patient may feel lonely and isolated from family , Having friends/Family to visit the elderly & frail is very important , helps aid recovery .
44	loneliness to be considered and looking at how we can help people remain safely in their homes

3. What do you think are the most important things to be considered in improving Frailty services?

45	Further improving communications between hospital specialties and community frailty teams.

answered	45
skipped	3

4. Please tell us what you think about our ideas for Non-interventional Cardiology.

Answer Choices			Response Percent	Response Total
1	Strong support		32.56%	14
2	Support		34.88%	15
3	Oppose		2.33%	1
4	Strongly oppose		0.00%	0
5	No opinion		30.23%	13
		answered		43
		skipped		5

Please tell us why you think this e.g., the information you would like us to consider. (13)

1	prevention is better than cure
2	urgent transfers cross county take days. this needs to be considered.
3	This service has suffered since changes from its purpose built ward at GRH with move to ground floor the environment does not cardiology needs. Emergency cardiology should be at GRH due to ED department. Better pathway to interventional investigations this is too slow.
4	Inpatient management for specialties should be collocated as the benefits of clinical linkages will be present for all patients. I support a model where all complex cases both acute and planned (both behave unpredictably) should be looked after in one hospital. Resources (HCP) will not permit effective management of these cases on multiple sites.
5	Cardiology should be based on the site with greatest cover from Vascular and Interventional Radiology
6	Pay the staff more so more good people will apply
7	Agree cardiology inpatient provisions should be based at GRH
8	centralising services on the GRH site will be of great benefit to ongoing cardiac care/services hopefully reduce waiting times for interventions, improving patient outcomes and LOS in the long term and decreasing the need for transfers out of county
9	As with all the proposed interventions, the travel may cause a difficulty for some people, however. the benefits appear to outweigh the negatives.
10	Parking needs to be sorted massively as well as improving other things at Cheltenham general.
11	-Cardiology should be on the same site as Vascular Services.
12	It seems to make sense to consolidate cardiology beds in one site (GRH). Would be great for additional funding for MRI, CT, services as well as services related to heart failure and genetic heart conditions.
13	I am concerned that this good work in centralising specialist services will be overly reliant on Ambulance Service performance when a huge proportion of their capacity is routinely misdirected by NHS 111, which is the elephant in the room that we never appear to be able to change.

5. Please tell us what you think about our ideas for Respiratory care.

Answer Choices			Response Percent	Response Total
1	Strong support		33.33%	15
2	Support		35.56%	16
3	Oppose		0.00%	0
4	Strongly oppose		0.00%	0
5	No opinion		31.11%	14
			answered	45
			skipped	3

Please tell us why you think this e.g., the information you would like us to consider. (13)

1	Respiratory high care service is a needed service to be able to meet the requirements of acutely unwell respiratory patients. This needs to be MDT led with adequate staffing for a level 2 area, inclusive of therapy with a culture of continual education. Ward environment needs to be suitable with monitoring equipment at all bed spaces, clear documentation charts similar to those use in intensive care.
2	Curious as to why some respiratory services couldn't be offered at community level.
3	I suffer myself and anything that helps is a bonus
4	Evidence from Covid suggests a higher level of reap care needed. This service is well led but needs an environment fit for purpose. Better pathways for COPD to avoid admissions. Specialist roles work well
5	Complex inpatient care should be co-horted in the same hospital near to ED where they can be managed from admission in a timely fashion promoting early effect treatment and patient flow.
6	Respiratory is a service that has worked well being centralised to GRH site
7	Anyone with a diagnosis of acute respiratory illness having access to relevant teams' numbers to avoid A&E attendance, perhaps contact through the direct admission pathway to avoid the emergency department
8	the proposal is exciting, there needs to be consideration of the workforce resource required outside of medics and nursing. Therapy resource will be an important consideration in supporting the best care and outcomes of acutely ill patients in a respiratory high care setting, supporting joint up working across specialties and critical care, whilst also enabling early rehabilitation intervention and continuing care. There is further work to be done with improving integration of services across the ICS with further investment for managing respiratory conditions and access to services such as pulmonary rehabilitation and care/support in the community. there is likely to be better uptake with increased joined up care across the organisations. there are opportunities to further improve and enhance joined up working across the respiratory service for the benefit of patients.
9	As before, but I think the benefits may outweigh the negatives
10	I support your idea with regards to patient critical urgency and what hospital they go to. But again, these patient will still need visitors in hospital and the parking is atrocious at Cheltenham general.
11	It seems to make sense to consolidate beds in one site esp. with more consultant emergency cover should ppl become acutely unwell
12	Over the new year I was in GRH and treated for pneumonia, the care was excellent, The Respiratory Team were really great during my 10 day stay. the Consultant visited me on the ward with his team daily, I really appreciated the time he & members of his team took to explain things to me relating to my on-going care. The Specialist Respiratory Nurses were also really great as were the support staff, I felt I was able to speak to any member of staff on the Ward and they were always happy to answer my questions, the personalised care due to my faith was also excellent and much appreciated. . When I was discharged, I was discharged with the Respiratory Nurse/Team, keeping in touch daily to monitor my oxygen/temperature levels, this gave me the opportunity to talk to the team if I had any

5. Please tell us what you think about our ideas for Respiratory care.

	concerns about my recovery or any symptoms. This was excellent, as I was able to recover at home, but knew if I had any concerns I could speak to the team on a daily basis for reassurance, where necessary I was sent for further x-rays as an out-patient, further I was also able to see my Consultant for a follow-up very soon after my discharge, which I was pleased about. Thank you to the Respiratory Team at GRH for excellent acute care and follow-up care upon my discharge.
13	The Respiratory service at the Trust is exceptionally well lead and proactive in its outlook and approach, which is more important than site. I would support any proposal that has the enthusiastic support of my respiratory physician colleagues, particularly where it helps them to deliver an even better service.

6. Please tell us what you think about our ideas for Stroke care.

	Answer Choices		Response Percent	Response Total
1	Strong support		28.57%	12
2	Support		28.57%	12
3	Oppose		0.00%	0
4	Strongly oppose		21.43%	9
5	No opinion		21.43%	9
			answered	42
			skipped	6

Please tell us why you think this e.g., the information you would like us to consider. (20)

1	Frankly bonkers. Allied specialities who are integral to this service (IGUS, vascular, Diabetes/Endocrine) are all based in GRH. This is astonishing in its lack of cohesive thinking.
2	Stroke services must be located at an acute GRH site, being situated at CGH causing unnecessary and avoidable delays in diagnostic and treatment.
3	Not enough after care is given to stroke victims.
4	This service keeps moving the purpose built ward at CGH is suitable. Direct access to interventional care essential at site. Pathway issues with ED at GRH and stroke. Ed's at CGH. Vale hospital gives great care need to extend pathway with funding more beds at Vale including MDT
5	Clinical services have been re-aligned in Gloucestershire to provide almost all acute care in GRH, and predominantly elective care in CGH. Considering acute vascular emergencies (heart attacks, major bleeds, legs at risk of amputation), both cardiology and vascular surgery have been moved / will shortly move to GRH. large capital spend underway (IGIS hub) to facilitate the delivery of excellent care for these high risk patients, for whom timely intervention by specialist teams is an absolute requirement. Also, staffing models have been redesigned to enable 24/7 care of acutely unwell patients at GRH, with a lighter staffing model planned at CGH. The decision to move acute stroke to CGH is wrong. I doubt it would command support at external peer review. Patients presenting with an acute stroke are much less likely to get timely investigation and treatment (particularly when they present out of hours). What happens when an acute stroke patient has a heart attack or other cardiological emergency? Up to 20% of acute stroke patients suffer a heart attack, heart failure or cardiac death shortly after a stroke! Deliberately separating acute stroke from acute cardiology is wrong, and patients will die as a direct consequence. On a similar vein, 15-20% of strokes are due to carotid artery disease, and these patients need an urgent carotid ultrasound scan (which can be delivered in either CGH or GRH, and then an urgent review by a vascular surgeon and an urgent operation if there is a tight carotid narrowing. Again, to deliberately separate Acute Stroke from Vascular Surgery, a service which relocated to GRH, in part to be co-located with Acute Stroke, Acute Cardiology

6. Please tell us what you think about our ideas for Stroke care.

	and Renal, is wrong, will lead to delayed surgery and result in patients having recurrent disabling strokes. The argument for locating Stroke in CGH is weak. I am surprised that this proposal is the preferred one, and the document does not give a detailed description of the risks associated with this decision.
6	This flies in the face of (almost) every other decision of FFTF. It is basically a fudge to fix a temporary challenge in bed resource and staffing. In other words, patient care will be compromised (for patient presenting with acute stroke needing urgent assessment and intervention) by removing the service from the main ED and delaying crucial intervention such as thrombolysis. It is precisely for this reason Cardiology has moved in the other direction. This undermines the Trusts vision and plan where patient care and pathways are compromised to fit estates and clinician preferences. Estates and clinician choices should prioritise effective patient care and adapt accordingly (More beds and more staff). It will also delay review for patients requiring urgent Vascular Surgical review (based at GRH) and treatment. There is evidence for this from the last time the Trust separated the 2 specialties. This puts patients at unnecessary risk. Complicated pathways and algorithms fail to patient cost.
7	Stroke service performance has deteriorated and patients are scattered across CGH. The Thrombectomy pathway is compromised, and the service has moved away from Vascular which is a disaster. The Vale hospital will remove the extra beds dedicated to Stroke during COVID and this will likely topple the service over. Overall, a terrible move into not enough beds.
8	Having stroke care at CGH will result in delays for patients requiring vascular intervention for their stroke as the vascular team is based at GRH, this would delay patient being reviewed and getting their much needed intervention which could result in further catastrophic stroke. This move may mean there is a need for an acutely unwell patient to be transferred from CGH to GRH for assessment, or the need for the on call vascular consultant to leave GRH (where the acutely unwell vascular patients are based) to go to CGH to review patients, then if deemed appropriate, to have them transferred to GRH anyway.
9	In your recap of stroke services, no mention has been made of the patients who are found to have had an embolic stroke or TIA and may need to have a carotid endarterectomy. If stroke and vascular services are separated, then this will add to the number of patients requiring transfer from CGH to GRH for surgery. Joined up care is more difficult in 2 locations. There has already been some delays in seeing patients who have been referred from the stroke service to the vascular team.
10	further consideration of access to rehabilitation services and resource available to enhance access to the right care at the right time by the right person/profession. Increased resource to support care closer to home if not at home when required
11	I share the concern about receiving the correct treatment, diagnosis and transfers to Cheltenham.
12	I feel this is difficult - as identified, stroke mimics may cause problems with being able to be assured the patient is in the right place. If not, there is a likelihood of needing to be transferred to another hospital and this can cause disruption and dissatisfaction.
13	I feel that the new model for HASU works well having limited beds and a focus on patients being moved on quickly, I feel however that Cheltenham hospital itself has many issues as a hospital which then impacts the service stroke patients receive. HASU is currently in a ward shared with ACUC and these 2 teams work well together however the current ward is not fit for purpose, often seeing stroke patients who are often unwell and die as a consequence of their stroke in an undignified cramped space because side rooms are unavailable and bed spaces have very limited space with the patient next door being within arm's reach which also causes issues for the space needed for necessary equipment for patients' rehab. Cheltenham hospital is an old hospital with damp issues and split levels and lots of segregated areas which make it confusing to navigate not only for staff but also visitors. The "modern" Woodmancote ward has views from its windows of a bare concrete courtyard and windows that do not open, and so no fresh air is provided and an air conditioning system which it is accepted that doesn't provide a cool or comfortable environment in either winter or summer. I find this cruel when we have patients that require rehab often spanning months and I do not know how we can refer to this ward as modern when even the Victorians understood the importance of fresh air and greenery for mental health and physical recovery after a trauma, and there is now masses of research to support this. Some patients of course have the luxury of being able to be taken off the ward by visitors if they are capable of sitting into a wheelchair only then to be wheeled around the car park because of the lack of space with Cheltenham's location.
14	It has hugely helped with staffing and team moral being on the same site. I feel that another move would disrupt the team and service again causing more anxiety and distress. Woodmancote is more modern and lighter, and purpose built for Stroke rehabilitation. If to be set up at CGH permanently, Stroke HASU would need an adequately equipped ward with hoists that work, enough space to move chairs and manual handling equipment, private spaces for assessments that need concentration, large bathrooms for

6. Please tell us what you think about our ideas for Stroke care.

	assessment. The only issues I foresee, is what happens to overnight Strokes when ACUC moves to GRH, and the medical cover goes with it? More training needed in ED to enable better identification and a better in reach system as we had at GRH. Parking would have to be looked at as majority of complaints from staff members who come here is the lack of parking meaning they have to park in side streets and walk in (with many cars being vandalised)
15	More Community hospital beds for stroke specific therapy are needed.
16	Larger clinical area for HASU - more room for beginning rehabilitation of patients. Better training for newly qualified staff and staff new to stroke, especially with NGT and safe manual handling technique for patients with one-sided weakness. Better management of tone and spasticity.
17	Stroke services should be on the same site as Vascular surgery - this would ensure a multidisciplinary approach to the stroke patients needing urgent referral/ vascular surgery.
18	Stroke services should be at biggest acute hospital in the city where socioeconomic circumstances make stroke most common, and where there is immediate access to necessary supporting specialties i.e., cardiology, neurology. To separate it from these specialties is to go back 20 years.
19	I agree that Stroke services are best located on one site (Cheltenham) for the reasons mentioned. I point out that especially for understaffed therapy teams, HASU and ASU being on the same site saves huge amounts of resources as the therapists can help out on each ward depending on staffing and patient demands. Woodmancote is well suited to the therapy needs of patients considering the track hoists and large therapy room and Cheltenham hospital is a good environment for these patients with nice outdoor areas that can be accessed. I would also say that the service should have more funding for therapists and assistants and would benefit from an activities coordinator, social work support, complex discharge coordinator, and nurses who are specifically interested in stroke. The service would also benefit from increased beds at the Vale to free up ASU beds for patients requiring stroke-specific services.
20	Again, my support is tempered by concerns about Ambulance service capacity in the face of ongoing disaster that is NHS 111.

7. Please tell us about any impact, either positive or negative, that you think any of these ideas for services could have on you and your family (please tell us which service your feedback relates to e.g., Stroke care)?

Answer Choices		Response Percent	Response Total
1	Open-Ended Question	100.00%	28

1	Nil
2	As myself (an NHS employee), and my family are now getting increasingly older, I am more aware of having the best services when we need them
3	I think easier access for medical services in the community plays a strong role in lessening the pressures of hospital admissions. If we have an efficient system (less delays, less waiting time), especially in GP surgeries, or outpatient departments, there is a higher chance that we could prevent conditions whether acute or chronic from worsening.
4	Stroke, cardiology and frailty are the most important
5	We want the services to be the best they can this will not happen without investment in staffing fibroid is inadequate and safer staffing is key. We don't want to wait in ED stop sending all admissions via this pathway the care is poor due to no staff. The issue with ED at CGH confuses the public they still don't know where to go. Poor environment for MIIU at GRH no receptionist poor staffing leaves the staff very vulnerable to practice and compromised. This pathway needs a review and made as important as ED pathway. Community hospitals offer excellent onward progression but need the right type of patients not just complex discharged patients still want care close to home
6	Stroke patients are more likely to die or be disabled if this proposal goes through.

7. Please tell us about any impact, either positive or negative, that you think any of these ideas for services could have on you and your family (please tell us which service your feedback relates to e.g., Stroke care)?	
7	I believe patients will be confused by having a hyper-acute unit on a planned site. I believe this will delay care.
8	If a relative of mine has a stroke I am likely to try and drive to another organisation as I would have no assurance that my loved one would end up on the Hyper Acute Stroke Unit if needed due to lack of beds.
9	negative
10	Frailty care: Keeping frail people out of ED is positive.
11	Frailty - centrally locating services will always have a negative impact in terms of support family and friends are able to provide for the person in need. You cannot underestimate the impact this support has on the person's ability to recover particularly in the frail elderly when they are placed in unfamiliar surroundings. A patient recently recalled to me that they spent 3 days stuck in bed unable to get out, on day 4 was given oral antibiotics and on day 5 discharged home by which time the legs had become very weak.
12	Not enough focus on existing community services such as complex care
13	would hope a positive impact with care provided in centres of excellence with adequate resources, travel is not an issue if the care is right for my family's needs.
14	My mother in law was transferred from GRH to CGH and we weren't informed of her transfer. This was during covid, but there was no excuse for not telling us, particularly as she was suffering from delirium and we hadn't been able to see her for 2 months before her transfer to a care home where a few days later she died. We felt that she was probably not treated well - the care she received was hard to evaluate, but there was rare efforts for the staff to support her with her mobile phone to talk with us as everyone was too busy. She must have felt neglected and abandoned by us. I, as her power of attorney, was only given information the day before her transfer to the home.
15	A friend of mine has experienced the stroke service, after being advised to attend GRH ED by the emergency services because ambulances were unavailable a relative drove them there before being told they needed Cheltenham hospital but there were no ambulances available so my relative drove them to CGH where they struggled to locate where they needed to be needing to ask several people for directions before locating where they needed to be, they then were quickly discharged after having some assessments from therapy but never being assessed or referred to speech and language therapy when their main symptom was dysarthria (slurred speech), they then didn't understand how to arrange the cardiac follow up they needed themselves partly because they are elderly and have been struggling with things they previously managed well but had no follow up from therapy. I have little confidence in the service I work for (stroke) and dread the thought of anyone I care about needing care within Cheltenham Hospital.
16	Stroke: I live in Cheltenham and so this enables me to walk to work and have a better work life balance than when services were at GRH.
17	Positive impact on all services if community flow improves.
18	Stroke care - would improve my confidence in the trust if a family member were to go into hospital with a stroke as I would feel more encouraged by levels of care being offered. It would help with my own job satisfaction as I am an OT on stroke and would reduce stress levels if there were more opportunities for rehab and better stroke care.
19	Frailty I support the concept of reduced waiting times for frail patients. Less time in Accident and Emergency, reduced risk of pressure damage from sitting on hard chairs of trolleys. My concerns are however the increased risk of delirium for elderly frail patients who are admitted for symptoms of a UTI or chest infection that could and can be managed at home. Should they develop delirium they risk an increased hospital stay resulting in the risk of deconditioning, hospital acquired infections and loss of confidence when returning home.
20	Very little
21	positive - better to centralise centres for excellence
22	All services: Impact is often measured in terms of subjective convenience. I think it would be inconvenient not to have one or any of these services available in this county. It is not necessary to duplicate.

7. Please tell us about any impact, either positive or negative, that you think any of these ideas for services could have on you and your family (please tell us which service your feedback relates to e.g., Stroke care)?

23	stroke
24	I work for the Stroke service in Cheltenham, I walk to work, and my son's nursery is in Cheltenham - It would be very challenging to commute to GRH and I would have to change my son's childcare arrangements. This would be very difficult and stressful.
25	I believe that funding should be addressed as the current 14week response time from receiving an answer from PIP/DLA is too long and this waiting period can have knock-on effects on mental health and well-being. Therefore, affecting their abilities to get the help needed to get better.
26	In the last 10 years, I have had 2 close family members and a number of close friends, who have been on the cancer pathway, the Oncology care was excellent and especially the support offered by the Focus team at CGH. I would say the Oncology Care and support was really personalised for each patient. which was reassuring. I believe mostly the patients would get tired with the travelling to CGH for treatment sessions, but overall, the family were able to manage this. Further we did as a family appreciate that when an elderly member of the family diagnosed with end-stage cancer, related appointments were at the GRH which really helped the patient and the family during a very challenging time.
27	little impact
28	Diabetes- as a GP with an interest in this clinical area I cannot overstate the importance and urgency of improving community delivered services and making them responsive to patients and clinical colleagues from other parts of the system.

answered	28
skipped	20

8. If you think any of the ideas for services could have a negative impact on you and your family, how should we try to limit this (please tell us which service your feedback relates to e.g., Stroke care)?

Answer Choices		Response Percent	Response Total
1	Open-Ended Question	100.00%	21

1	Nil
2	Naturally, we all want care closest to us.....but if we need specialist care we have to balance that. None of us would question having to go to a tertiary centre for cardiac surgery etc
3	Stop moving from site to site ensure the diagnostics meet the needs does vascular speciality need to work more closely with stroke
4	See above
5	If stroke services needed to be united it should be done on the unplanned site and beds should be found as well as staffing.
6	As per above.
7	Not moving stroke to CGH
8	Stroke care; quality of care could be affected for those patients needing carotid surgery.
9	Frailty - Over emphasis on hospital care, Frailty assessment Unit, Homeward assessment team and the Care of the elderly wards. Very little mention of the Complex care at home team who also undertake complex geriatrician assessment in patients own home where they live day to day and where the problems that bring them into the acute often originate. Hospital staff are very often unaware of these problems which can lead to a very different assessment and one that ultimately fails to prevent the readmission.
10	Too much emphasis on hospital based interventions

8. If you think any of the ideas for services could have a negative impact on you and your family, how should we try to limit this (please tell us which service your feedback relates to e.g., Stroke care)?

11	With shift of services from site and integration of staff teams, there needs to be promotions of integrated services and working as one, supporting each other and the wider teams ultimately for the benefit of those that need their help
12	As above. Also, as a relative or potential patient, I would not want to go into hospital. I do feel worried that I would receive poor care or not be listened to. I have had bad experiences before as a patient and when my husband was a patient. If I couldn't be sure where I would be after admission, I worry that my loved ones wouldn't be told where I was. This is what happened with my mother in law. We rang the ward to be told 'she's not here' - my husband thought at that point his mother had died. the person on the phone didn't know what had happened to her#. Because of my role, I knew to ring the operator to find out where she had gone. We were very stressed and angry.
13	I would like to see my family in a less prison/laboratory like environment if they required to stay as an inpatient for stroke rehab.
14	None
15	Frailty Embrace community services to offer support at home. More funds for care support even short term 48-72hrs following hospital admission. Utilise services such as Complex Care at Home to follow up and Case Manage patient discharges home, ensuring the appropriate equipment, care and support is in place. Utilise the team prior to admission, when signs of initial deterioration are present and proactive prevention can be used appropriately and effectively.
16	We live east of Cheltenham so would need to travel further to the services located in Gloucester. A single hospital in the middle makes more sense.
17	likely to affect some for traveling to appointments Does not affect me directly
18	GP Practices are below satisfactory
19	Increase the shuttle times between the sites. Have a pick up/drop off site in Leckhampton.
20	As above
21	No

answered	21
skipped	27

9. Do you have any alternative suggestions for how any of the services covered in the engagement could be organised (please tell us which service your feedback relates to e.g., Stroke care)? When describing your suggestions where possible please refer to the assessment criteria on page 9 of the engagement booklet.

Answer Choices		Response Percent	Response Total
1	Open-Ended Question	100.00%	17

1	County based enhanced or critical care services as we are the only county within the south west to have no enhanced or critical care services.
2	Offer on line focus groups and before decision is made use a citizens jury.
3	Centralise Stroke in GRH.
4	Stroke was centralised some years ago to GRH for specific reasons and this should be seriously reconsidered by the organisation if we are to stop our stroke service from completely failing. The move is detrimental to patient care and does not follow the logical pathway. We should be designing services around the optimal pathway and not compromising which creates bad quality and experience for patients.
5	As a patient or carer I want to see reduced access to GP or services simpler, reduced waiting times Gloucestershire appear to support the use of new technology to improve access to different services - this

9. Do you have any alternative suggestions for how any of the services covered in the engagement could be organised (please tell us which service your feedback relates to e.g., Stroke care)? When describing your suggestions where possible please refer to the assessment criteria on page 9 of the engagement booklet.	
	needs to continue Gloucestershire could improve or maintaining service hours and locations a little better i.e. increase the use of 7/7 day working and community hospitals facilities Please this is so important changes in population size and demographics - Gloucestershire known to have a particularly high elderly population and Learning disability yes please - access to the required best workforce - staffing: numbers and skills, support services, premises and technology to support successful implementation- Education , education , support, mentoring/ clinical supervision , encourage more secondments will help with staff development . Making best use of clinical staff (e.g., doctors, nurses and other staff) Joined up working across one health service - One Gloucestershire is a step nearer Staff health and wellbeing so important (where is our recreation, table tennis, fruit baskets (as video) or even yoga, may help to keep staff.
6	regular option of virtual appointments. Appointments closer to home for patients. Less waiting time - but to do this, appointments offered would need to be realistic in terms what can be achieved in 15 minutes. Single system of recording health information/ data/ letters/lab results/ meds etc
7	There needs to be a continued focus on joining up IT/electronic records - this would save thousands of staff hours and provide better patient care.
8	Stroke care: Keep HASU in GRH or improve the referral pathway
9	Frailty - Quality of care - greater investment in Community NHS as this is where the solution lies. Linking this back to joining up teams between Acute, Primary Care & Community - staff rotating through these areas to keep knowledge base up to date. Also, important that we are all able to understand each others challenges in providing care and treatment rather than complaining to service users about inadequacies on either side would make for more collaborative approach. It seems a small detail but consideration to adequate parking for carers at bed based sites at a reasonable cost is important to consider as it may just be a neighbour or a paid cleaner who visits the person.
10	Review of AHP services to support these changes and the impact. ensuring adequate resource is available to provide best care and outcomes as per NICE and other organisation guidance e.g., BTS, ICS, GPICS, and consideration of the ongoing rehabilitation needs beyond the acute phase. promoting integrated working across the ICS and reducing barriers that exist or lack of available services in the county (Stroke, Respiratory and Critical care)
11	Please refer to my thoughts under the frailty discussion. I feel that the frail patient needs more support to stay at home. this will be done by employing more care staff within the team who are able to not be time bounded with patients during a period of crisis. Sometimes a frail patient with multiple co-morbidities will take 15 minutes - more often when unwell, they might need 2 hours. To get someone through the crisis, however unpalatable, that is what is needed. To reflect the numbers of frail patients being admitted, I estimate and increase by a minimum of 20% staff in the CC@H teams with the knowledge, skills and attributes to do this work.
12	I agree that the HASU model works well and there are benefits to being on the same site as ASU, however I believe that it is common sense to have HASU based at the front door i.e. at the main admitting hospital, I also think regardless of where stroke rehab is provided it should be somewhere that offers patients some comfort as they are often very dependent/disabled by their strokes requiring a long period of time in hospital.
13	Stroke: HASU moving to a more appropriate ward than ACUC e.g., Cardiology when the service moves to GRH. This ward is already set up with telemetry and has a ward perfect for monitoring thrombolysed patients, there is more space to transfer patients and it would enable patients at the start of their rehab journey to stay before going to Woodmancote rather than overflowing into Guiting which is not a Stroke unit and is not staffed as one/ with qualified Stroke staff - this currently does not meet NICE/RCP guidelines.
14	Frailty All services highlighted within the engagement are excellent services. All are reactive services and will become involved only when an issue is raised, or an incident occurs. yet one service seems to be missing from the engagement. Consider a service that supports both a reactive response and a proactive response, lets reduce the need to be reactive, consider Complex care at Home Service.

9. Do you have any alternative suggestions for how any of the services covered in the engagement could be organised (please tell us which service your feedback relates to e.g., Stroke care)? When describing your suggestions where possible please refer to the assessment criteria on page 9 of the engagement booklet.

15	Yes, stroke should be in the bigger and more acute hospital.
16	There should be an automated response from DLA/PIP that takes in consideration certain long-term conditions such as strokes, Fibromyalgia, arthritis, diabetes etc. Which would ultimately cut down the time waiting for an answer. Therefore, those with long term health condition would not suffer with added pressure to provide for their family or themselves and worry about what can happen rather than focusing on getting better.
17	All services which could be delivered closer to the community should be. Not only is it less expensive and more responsive, promising better outcomes, but modern technology is more than capable of facilitating this (as CINAPSIS has shown for acute care).

answered	17
skipped	31

10. What is the first part of your postcode? e.g., GL16, GL3

Answer Choices		Response Percent	Response Total
1	Open-Ended Question	100.00%	39

1	GL2
2	GL19
3	GL51
4	gl1
5	bs7
6	GL2
7	GL1
8	GL51
9	GL7
10	GL2
11	GL3
12	GL2
13	Gl53
14	Gl7
15	GL2
16	GL4
17	GL52
18	GL2 4LD
19	WR13
20	GL53 7QS
21	gl15 5eg

10. What is the first part of your postcode? e.g., GL16, GL3

22	GL3
23	GL51
24	GL5
25	GL4
26	GL51
27	GL3
28	BS16
29	GL51
30	GL51
31	gl18
32	Gl3
33	GL20
34	gl1
35	GL53
36	GL14 3NL
37	GL1
38	GL11
39	GL53

answered	39
skipped	9

11. Which age group are you:

	Answer Choices		Response Percent	Response Total
1	Under 18		0.00%	0
2	18-25		8.33%	4
3	26-35		18.75%	9
4	36-45		10.42%	5
5	46-55		39.58%	19
6	56-65		16.67%	8
7	66-75		4.17%	2
8	Over 75		0.00%	0
9	Prefer not to say		2.08%	1

answered	48
skipped	0

12. Are you:

	Answer Choices		Response Percent	Response Total
1	An employee working in health or social care		100.00%	48
2	A community partner		0.00%	0
3	A member of the public		0.00%	0
4	Prefer not to say		0.00%	0
			answered	48
			skipped	0

13. Have you accessed any of the following services or support in the last 12 months (please tick all that apply)?

	Answer Choices		Response Percent	Response Total
1	Primary Care (GP)		82.05%	32
2	NHS Community Service (e.g., Community Nursing)		5.13%	2
3	Outpatient Hospital Service		56.41%	22
4	Specialist Inpatient Hospital Service		23.08%	9
5	Voluntary or community support related to your health and wellbeing		10.26%	4
6	Urgent care (e.g., 111, Minor Injury and Illness Unit, A&E)		35.90%	14
			answered	39
			skipped	9

Please tell us which hospital, community or voluntary service(s) you have accessed (e.g., respiratory, community nursing, support group) (17)

1	Gloucestershire Hospitals. St. Georges Surgery
2	A and E, minor injuries and ongoing fracture support. I was unable to access any practice nurse support at all for wound
3	Aspen Medical Centre
4	Stroud hospital for X-rays Gloucester royal for ear appointment Gloucester for x-rays/ Teeth
5	GRH ENT CGH CT GRH miu this is my local service I don't want to travel to community hospitals if this is on my doorstep
6	Hospital - Paediatric Hospital - Dermatology Primary care - GP
7	allergy clinic, NHS wellbeing services

13. Have you accessed any of the following services or support in the last 12 months (please tick all that apply)?

8	GRH - A & E GRH - Ophthalmology
9	Orthopaedics CGH
10	Gloucester hospital for Endocrine as an inpatient and an outpatient, ED in Gloucester, minor injuries in Stroud and ADHD & Autism assessment clinic in Cheltenham.
11	111 service was so busy I couldn't have a call back from a on call GP. been off with a migraine for 12 days from work and by this stage was beside myself. They told me to go sit in A&E. When I had a migraine, I couldn't move from my bed or dark room feeling nauseated and that's how I got treated.
12	Gloucestershire Health and Care NHS Foundation Trust
13	GRH
14	Kings home surgery Gloucester
15	Live well to feel well CAMHS
16	A & E, Respiratory Team
17	used 111 to book emergency dental treatment

14. Do you consider yourself to have a disability? (Tick all that apply)

	Answer Choices	Response Percent	Response Total
1	No	89.36%	42
2	Mental health problem	4.26%	2
3	Visual Impairment	0.00%	0
4	Learning difficulties	0.00%	0
5	Hearing impairment	2.13%	1
6	Long term condition	10.64%	5
7	Physical disability	4.26%	2
8	Prefer not to say	0.00%	0
		answered	47
		skipped	1

15. 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.

	Answer Choices	Response Percent	Response Total
1	Yes	36.17%	17
2	No	61.70%	29

15. 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.

3	Prefer not to say	2.13%	1
		answered	47
		skipped	1

16. Which best describes your ethnicity?

Answer Choices		Response Percent	Response Total
1	White British	77.08%	37
2	White Other	4.17%	2
3	Asian or Asian British	6.25%	3
4	Black or Black British	0.00%	0
5	Chinese	0.00%	0
6	Mixed	6.25%	3
7	Prefer not to say	6.25%	3
8	Other (please specify):	0.00%	0
		answered	48
		skipped	0

Other (please specify): (0)

No answers found.

17. Which, if any, of the following best describes your religion or belief?

Answer Choices		Response Percent	Response Total
1	No religion	36.17%	17
2	Buddhist	2.13%	1
3	Christian (including Church of England, Catholic, Methodist and other denominations)	44.68%	21
4	Hindu	0.00%	0
5	Jewish	0.00%	0
6	Muslim	2.13%	1
7	Sikh	0.00%	0
8	Prefer not to say	8.51%	4

17. Which, if any, of the following best describes your religion or belief?

9	Other (please specify):	6.38%	3
		answered	47
		skipped	1

Other (please specify): (3)

1	mixed faith
2	Daoist
3	

18. Are you:

Answer Choices		Response Percent	Response Total
1	Male	21.28%	10
2	Female	70.21%	33
3	Transgender	0.00%	0
4	Non-binary	2.13%	1
5	Prefer to self-describe	0.00%	0
6	Prefer not to say	6.38%	3
		answered	47
		skipped	1

19. Which of the following best describes how you think of yourself?

Answer Choices		Response Percent	Response Total
1	Heterosexual or straight	91.49%	43
2	Gay or lesbian	2.13%	1
3	Bisexual	2.13%	1
4	Other	0.00%	0
5	Prefer not to say	4.26%	2
		answered	47
		skipped	1

20. Are you currently pregnant or have given birth in the last year?

	Answer Choices	Response Percent	Response Total
1	Yes	0.00%	0
2	No	85.11%	40
3	Not applicable	10.64%	5
4	Prefer not to say	4.26%	2
		answered	47
		skipped	1

21. If you are interested in participating in a discussion (face to face or virtual) about any of the FFTF2 services, please provide details below (to protect your anonymity, we will separate your contact information from the feedback you have provided in this survey).

	Answer Choices	Response Percent	Response Total
1	Name:	100.00%	16
	[Removed]		
2	Contact details (email, telephone):	100.00%	16
	1 [Removed]		
3	First part of your postcode (e.g., GL20):	100.00%	16
	1 [Removed]		
		answered	16
		skipped	32

22. Service/s you are interested in (please tick all that apply):

Answer Choices			Response Percent	Response Total
1	Benign Gynaecology		10.71%	3
2	Diabetes and Endocrinology		35.71%	10
3	Frailty/Care of the Elderly		60.71%	17
4	Non-interventional Cardiology		17.86%	5
5	Respiratory		32.14%	9
6	Stroke		60.71%	17
			answered	28
			skipped	20