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