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Centres of Excellence Workshop Report 5th April 2019

One Gloucestershire
Transforming Care, Transforming Communities

Contents

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Introduction

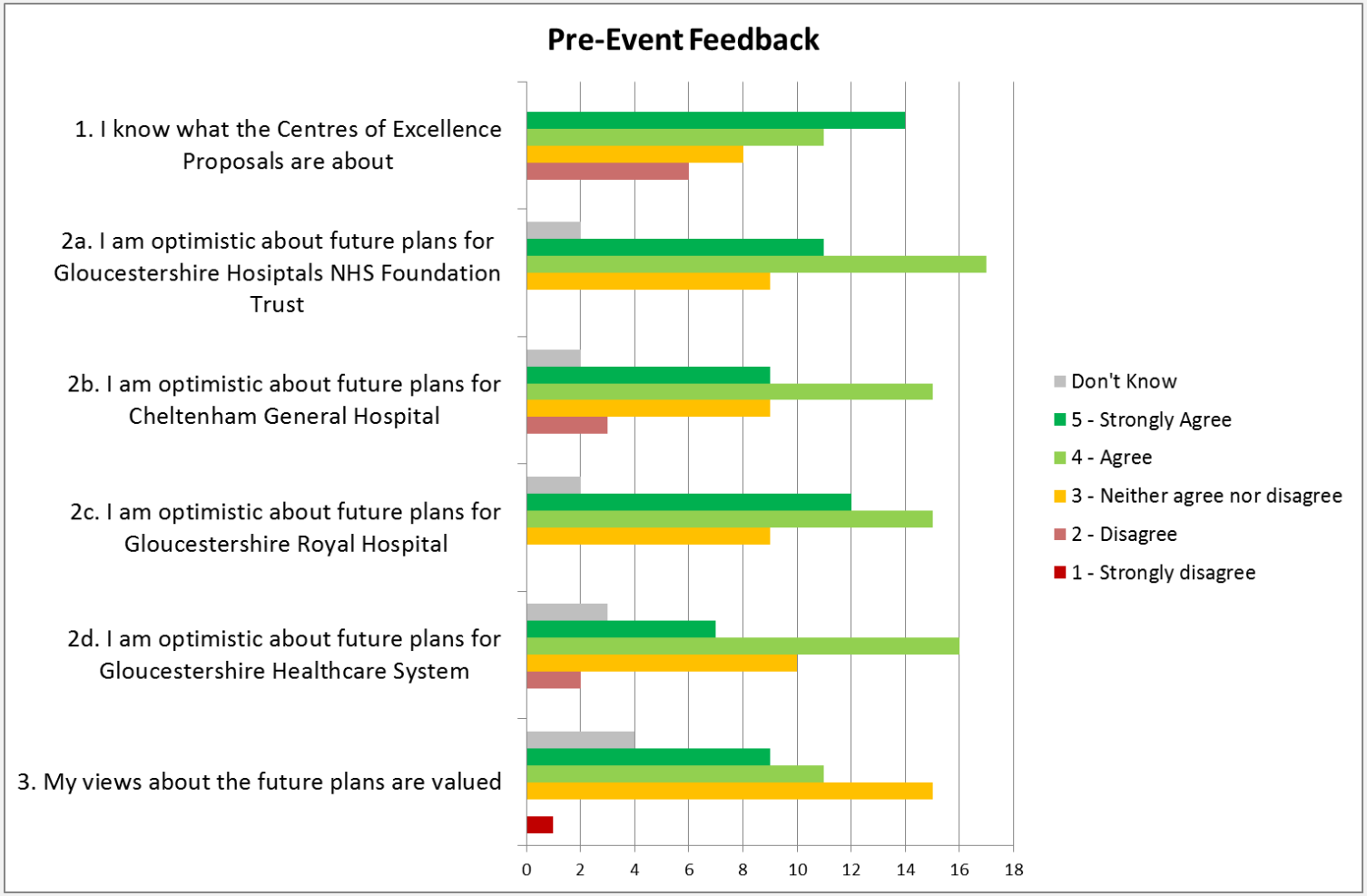
- Gloucestershire Hospitals NHS Foundation Trust, working in partnership with health and social care partners as ‘One Gloucestershire’, wishes to involve staff and the public in a conversation about how best to configure acute services in the future.
- We currently offer a range of services at our two main sites – Cheltenham General Hospital and Gloucestershire Royal Hospital, as well as outreach to a number of community sites. The ten-year goal is to *optimise* this provision to improve patient and staff experience, and ultimately health outcomes.
- The working title for this programme is ‘Centres of Excellence’.
- On 5th April 2019, 80 stakeholders attended a Centres of Excellence workshop at Cheltenham Racecourse to take part in a conversation about acute services configuration.
- Participants included patients and public representatives, Healthwatch Gloucestershire, hospital staff – both clinical and non-clinical, staff-side, Governors and Non-Executives, GPs and colleagues from partner organisations.

This information is confidential. Proposals detailed within this document are subject to consultation/involvement

Objectives

- ‘Conversation not conclusion’ – the workshop was deliberately designed to enable conversation and capture a range of views, rather than seek decision or consensus.
- Through an interactive format we wanted to:
  - Get participants’ input into the Centres of Excellence Case for Change and suggestions so far
  - Raise awareness of the Centres of Excellence vision
  - Gather feedback and content to be used for further involvement and engagement activities as well as material for potential business cases and public consultation

Pre-Event Feedback



Opening Remarks

Deborah Lee, Chief Executive of Gloucestershire Hospitals NHS Foundation Trust, opened proceedings by observing that two major hospital sites has been considered by some as a barrier to offering high quality care to the people of Gloucestershire and beyond.

She reflected that continuing to offer services as we currently do runs the risk of being merely adequate, when we have such potential to deliver excellence. The founding principle of our future planning is therefore that there will be **two major acute hospitals** in Gloucestershire.

The challenge for us is to agree the key distinctions between these sites which will enable each to offer excellent specialist care, only duplicating services in both sites where it is sensible to do so.

We have great potential to offer more local services to local people, as well as to allow neighbours in other counties to access world-class provision in Gloucestershire. Please make sure we hear your voice in today's conversation.

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Centres of Excellence Overview

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Overview

Simon Lanceley, Director of Strategy & Transformation for Gloucestershire Hospitals NHS Foundation Trust, provided a brief overview of the Centres of Excellence programme:

- Our Centres of Excellence approach is likely to include a greater separation between emergency care and planned care;
- Rather than looking at configuration service by service, we want to set out our longer term (2028) aspiration – to put phased changes in context
- The driving principle is improvement of patient experience and outcomes through optimised use of resources
- The primary focus is **admitted specialty care for adults** – there is work underway on outpatients and other areas which is not the focus of today

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Trust Clinical Strategy

Our Centres of Excellence approach is likely to include a greater separation between emergency care and planned care:

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Taking a longer term approach…

Engage & consult the public on this

10 year clinical strategy defined (2019-29)

Today

Phase 1: 2022/23
50% of strategy implemented

Phase 2:
75% implemented

Phase 3:
90% implemented

Phase n:
100% implemented

Timescale enabled by:

- Workforce
- Estate/ capital
- Technology
- Integration
- Productivity

Principles

- To improve:
  - Quality: patient safety, patient experience and clinical effectiveness
  - staff training, development and experience
  - performance (e.g. waiting times)
  - how we use our resources – beds, theatres
- Two thriving but distinct specialist sites
- Don’t limit our ambition by current workforce, capacity and estate constraints
- Learn from previous reconfigurations and current pilots, both locally and nationally
- Maximise the opportunities of an Integrated Care System.

Scope of the day

- ✓ Configuration of hospital services (where specialist wards and operating theatres are located)
- ✓ Adult services
- ✓ Emergency, planned & cancer hospital care

Wider Programme Scope includes:

- Maternity and children's services
- Outpatient clinics
- Transformation of clinical pathways

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Workshop Format

For the remainder of the workshop, participants worked in groups of 8-10. They spent the day with the same group, moving through the activities described in this report together.

Each group comprised at least one patient/public representative, clinical staff from the hospital trust, operational management, senior management and a partner organisation representative (e.g. CCG, GP).

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Poster Gallery

Key elements of the case for change

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Poster Gallery Introduction

- A ‘Gallery’ of six posters was displayed for participants to review – these are illustrated in the following pages
- The posters contained quite a lot of content that might be included in a ‘Case for Change’
- In pairs, participants reviewed the posters and filled in a feedback sheet asking the following questions for each poster:
  - What is the key message you took from this poster?
  - Is there more/different information you would like to have seen?
  - Any other comments
- In preparation for a later session, participants were also asked to post their personal experience of visiting/working in the two hospital sites
- The groups reconvened to discuss and capture collective thoughts

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Key messages: Support for the need to change. Concerns about rising population, demographics and workforce. More facts wanted to demonstrate benefits.

We can't continue as we are, not changing is not an option

Stronger argument about inability to invest on both sites, e.g. robotic surgery

Impact of technology is missing. Activity information

Need to advance in terms of expectation and more diverse technologies, rising demand and not enough staff

Service focussed – patient need is very different across the county and even within the two cities.

Risk of loss of specialist services

Patient expectations are reported as actual experience

Change is needed; priority and urgency of change not communicated

More info needed on <u>why</u> we are not meeting our patient's needs.

Data is all about activity and nothing about outcomes

Would like to see:
More personal messages – pressure on workforce: stress, recruitment, retention. Highlight the strategy risk of NO change

Would like to see:
Recognition increased specialisation we may fail to achieve in current set up. Safety of current arrangement

Would like to see:
Predicting what will happen if we don't change

Would like to see:
Whole system approach – wrapping around patient – mental health focus

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Key messages: Not enough / contradictory info. Data is old. Patients want to see specialist – use patient stories

Friends and Family test shows high satisfaction

Examples of poor patient experience. Patients less bothered about travelling for specialist care. Place for some emergency dep service at CGH

Reflects a system that is bursting at the seams. Patients will travel for a better experience

Consequences as well as excellence - real world. Data a little old. Opportunity for specialist services. Data needs to as transparent as possible.

What matters to patients. Safety, timely, pleasant environment. Highlight these more. Need to tell the story to the public

Patients want expert care delivery of a service as promised e.g. no cancellations and uncertainty, in a hospital that has pride in itself

- 69% agreed that should change
- 59% expertise of consultant
- 8% distance surprise

? Survey participants age span, location

Context of patient stories not clear

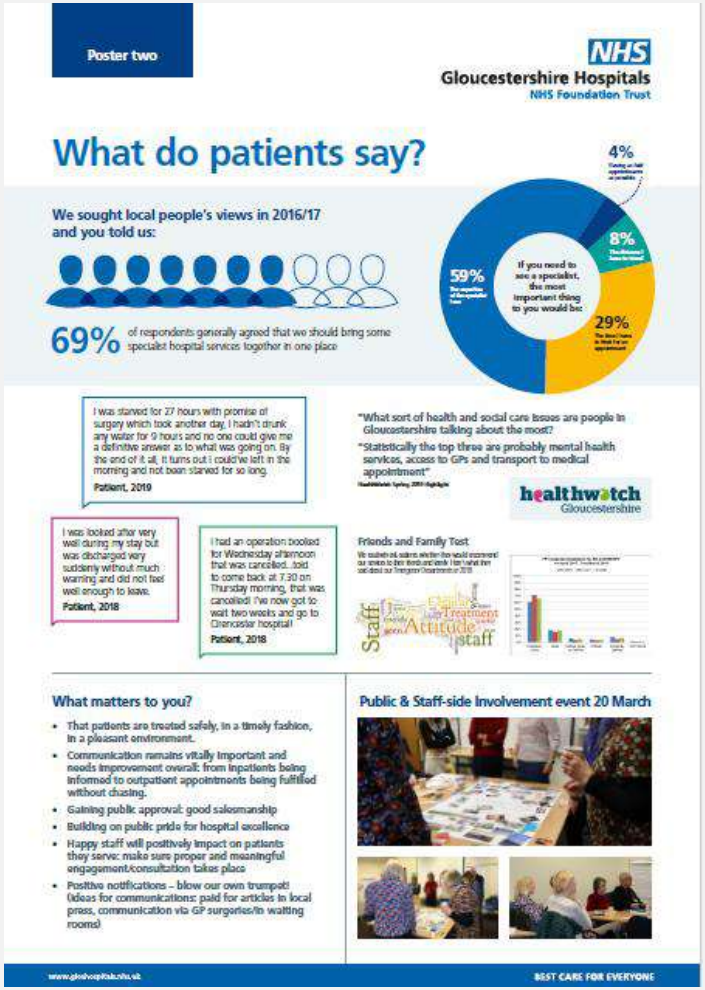
How do we involve people more in the evidence base?

Healthwatch can help here to canvas opinion

Discussed the potential role of a citizens jury

Expertise of specialist is more important than distance travelled

Impact of cancellations on the same day and poorly planned and communicated patient discharges



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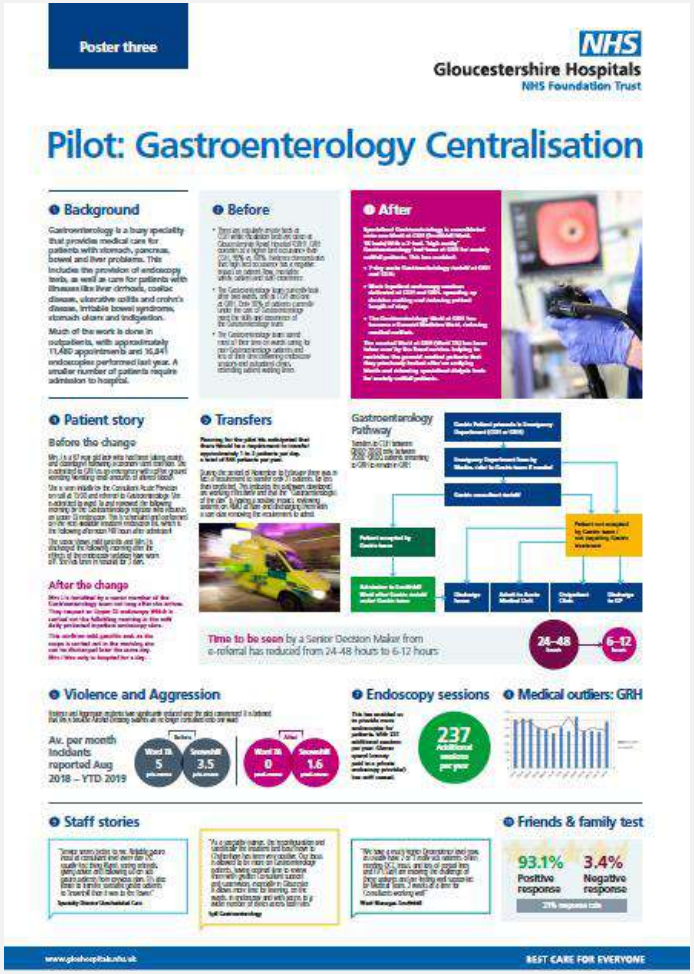
Key message: Appreciation for staff and patient stories – raises questions about follow-up and building on good impressions

- Positive patient story
- Patient story should be forefront.
- Better for patients less time as in-patient. Bed availability & better service
- Bit more on violence & aggression and detox
- Medical outliers??? What does this bar chart mean. Does this tell us anything
- Need better clarification of sites for Gastro pathway e.g. Snowshill is at CGH
- Centralisation of services working and patient experience and pathways improved
- Make more of increase in Endoscopies leading to less private contract use
- Would like to see impact on length of stay. Impact on other teams covering Gen Med inpatients at GRH
- Clear pathway now in place. Reduced wait times for senior decisions. Less patient transfers than expected.
- Concern regarding end point of journey e.g. start at GRH and end at CGH
- Friends and family test shows high satisfaction
- Were there any negatives that came out of this?
- Fewer transfers than expected, very successful
- Prove to patients that they are safe at night on the 'cold' campus
- Would like to see: % bed occupancy after changes were made
- Good poster balanced evidence



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Key messages: Need for more patient / staff stories – be more targeted with the information, be prepared to talk about positives and negatives

Would like to see: clearer idea of where service is based.

Challenge from GIRFT enabled change whole service engagement. Evidence - multiple sources to support need for change

Would like to see: transparency of the challenges and how these were overcome

Waiting times may be challenged - from time of injury to op. No staff comments.

How, why and what meant lives saved. What does the numbers mean?

Public opinion is missing. People have gone to MP was not mentioned

Proven good results from programme key improvements

Didn't realise they'd already started pilots but think it's an excellent idea to get things in one place

What about staff?

Hip fracture works better. Mortality rates dropped on average

Patient experience is missing in this poster - particularly after 8pm, junior doctor experience too. Re-enforce the national exemplar part.

Success of the approach. Opportunity for National Excellence

Fewer cancellations, less time to review. Lots of planning

Next steps, future further improvements

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Key message: useful to refer to past experience but if we do, be clear about the point we are making (e.g. centralisation improves training, or is just the start of an improvement journey), beware of jargon

We are a UK leader in ophthalmology and centralising over 10 years ago. Benefits of involving community in stroke

Staff feel more optimistic. Better outcomes for patients

Useful to have historic perspective

Technical posters so difficult for non experts to draw conclusions especially stroke

Need to highlight the positives much more.

Diabetic eye disease care is excellent. Stroke care improvement seems minimal. What does D&E scores mean

Benefit of centralising to increase scale, centralisation only part of solution

Stroke complicated, needs a good metric

Reconfiguration provides opportunity + quality - good top half of poster

Stroke - reconfiguring alone is not the answer, improved process is key. Ophthalmology works well.

More data should be presented

Bigger section of community involvement

Why are we configuring is it for patients or staff?

Good for training and attracting specialists

Acronyms need to go, explain it better

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Key messages: lots of evidence - some found to much and confusing, more local info needed

No clear model to follow - up to us, separating emergency and elective a good idea

Could highlight absence of evidence of harm. Importance of local solutions for local problems

More local data what do we want to get better at

Could we create part of the national evidence base? Needs to be 'unique' to Gloucestershire

No optimal design Process is important Patient experience needs to balance clinical effectiveness

Very high level reconfiguration requires good staff engagement

The evidence is incomplete - should be more positive

Nothing about staffing views / satisfaction.

Inputs from interviews and public could have been clearer

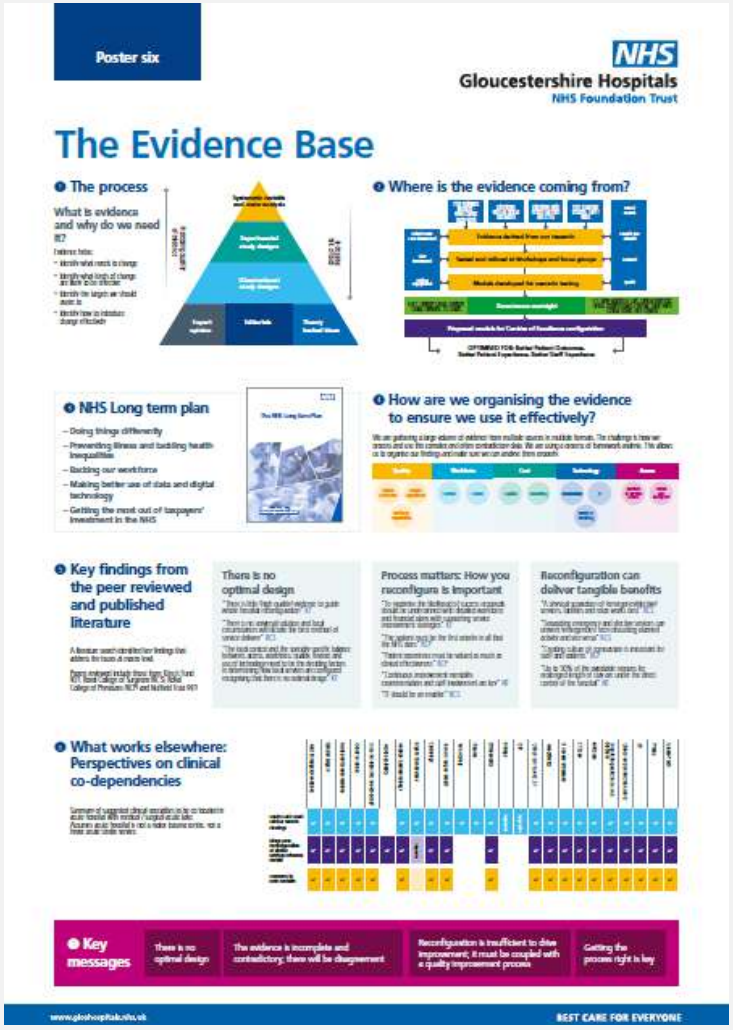
Knowing the figures for what happens to patients who need 'urgent' care on the CGH campus at night

Long term plan / direction of hospital

Linking the design and the process is crucial

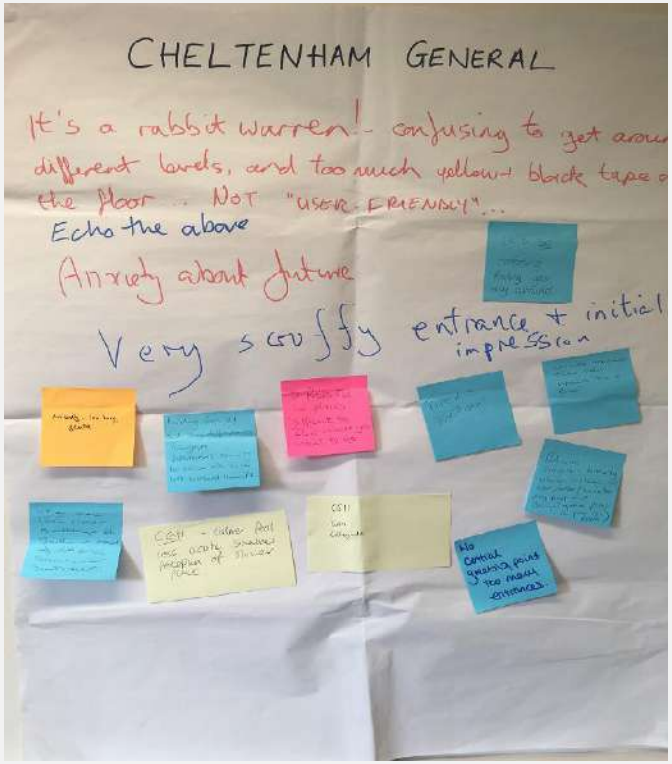
There is a lot of information and studies to comprehend. Difficulty in identifying relevance to our situation

That there is incomplete evidence, no obvious answer - we need to design our own answer



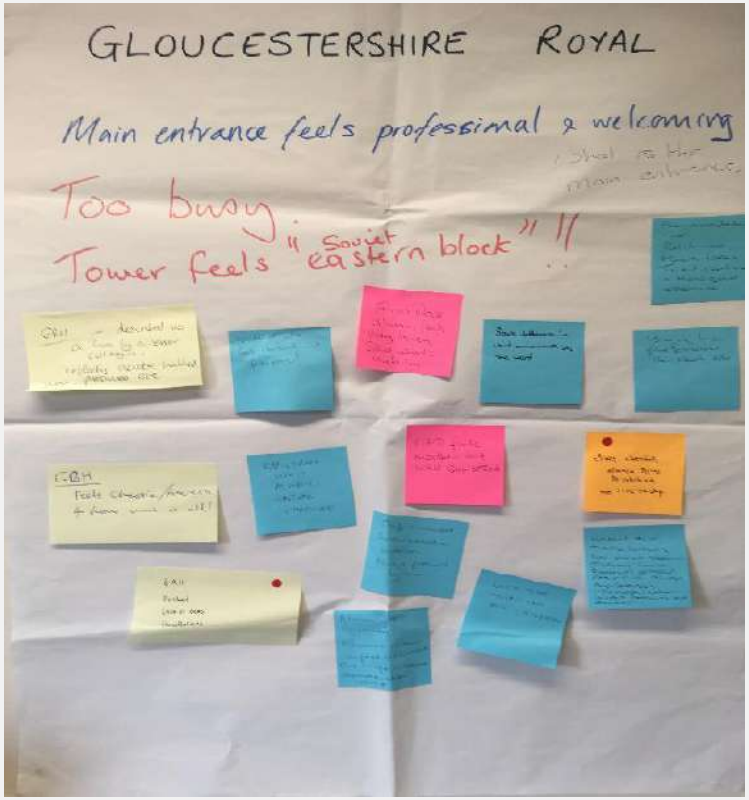
Current Experience - CGH

We asked participants to tell us their current experience of Cheltenham General…



Current Experience - GRH

… and their current experience of Gloucestershire Royal…



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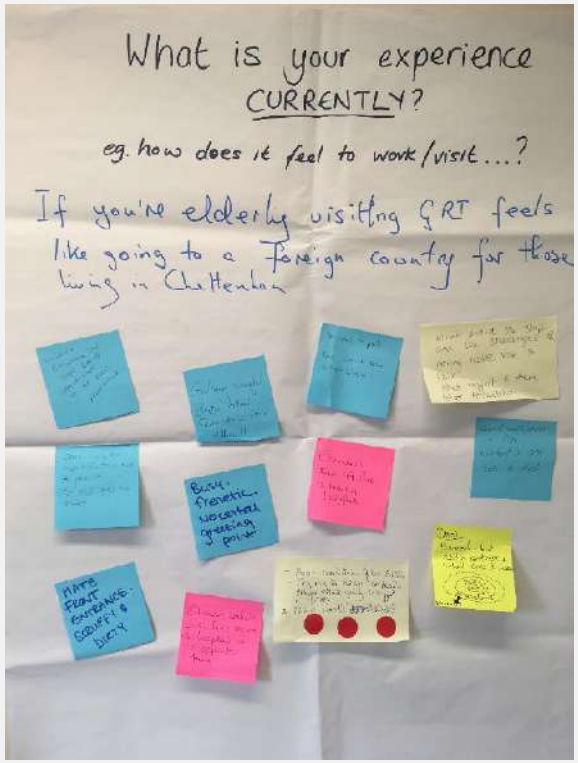
Current Experience – non site specific

… and any experience that wasn't specific to either site.



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World Café

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World Café Introduction

- Participants worked in their groups to visit seven different tables focusing on elements of the Centres of Excellence programme
- Each table had relevant information available to brief participants on the topic and thinking so far to enable discussion
- A facilitator and, where relevant, clinical leads, ran each table as a short (20-25 minute) discussion group
- Feedback was captured according to two main questions:
  - What concerns do you think patients/staff will have?
  - What might appeal to patients/staff?
- All participants visited all seven discussion groups during the remainder of the workshop
- The World Café table topics are set out overleaf

World Café Tables

Table	Theme
1	Emergency Pathway
2	Centre of Excellence for Emergency Care
3	Centre of Excellence for Planned Care & Cancer
4	Deteriorating patient
5	Imaging Hub
6	Measuring the benefits
7	Hospital site ‘mood boards’

1. Urgent & Emergency pathway

This workshop described the wider One Place programme of work to deliver consistent access to Urgent Treatment Centres to the whole population in line with National commitments.

A suggestion is that existing departments in Cheltenham and Gloucestershire could be developed to provide the local population with access to 24/7 Urgent Treatment Centres.

Alongside this, the Centres of Excellence proposals talk about developing one site as the specialist centre for emergencies.

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1. Urgent & Emergency pathway

What concerns do you think patients/staff will have?

- How do people decide where to go? i.e.the grey area between when someone is clearly an emergency and when they are deemed 'urgent' (going to the 'wrong' place)
- How will healthcare professionals know where to go?
- Concern about an extra 15 minutes' travel time for life-threatening conditions
- Will I need to be transferred? Will an ambulance be fast enough?
- People don't understand the current offer in Cheltenham
- How long will it take to get there? For me? For visitors?
- Will I transfer back to my more local hospital once I am no longer an emergency?
- Different needs depending on where you live in the county – rural areas expect to travel but may be more impacted
- Need to listen to seldom-heard groups
- Will my notes be available?

What might appeal to patients/staff?

- Describe the enhanced overnight offer to patients attending Cheltenham
- "If I am really ill I don't care where I am taken"
- Information about how 111 has improved
- Communicate main message about access to experts early on in the pathway – from where we are now to excellent emergency care
- Split the message: UTC in Chelt and Glos, specialist ED on one site
- Speed of access
- Real-life examples to 'myth bust' concerns about timely access to life saving care

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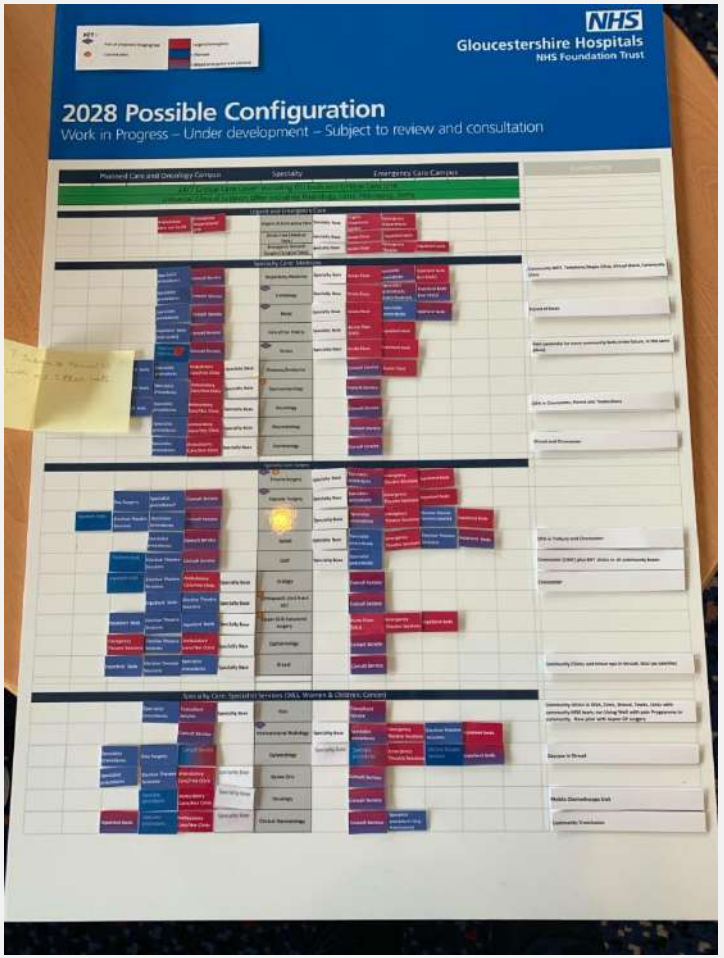
2. Centre of Excellence for Emergency Care

Discussion for Table 2 and 3 focused on the Interactive Configuration Board pictured here.

It lists clinical specialties in grey down the middle with possible Cheltenham-based services on the left and Gloucester on the right. There is also space for community hospital provision.

Movable 'building blocks' were provided, e.g. elective operating sessions in blue and emergency ward beds in red to aid discussion about possible configuration ideas.

An initial future configuration was provided based on around 35 semi-structured interviews already completed with specialty clinical leads. Further interviews were still underway at the time of writing.



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2. Centre of Excellence for Emergency Care

What concerns do you think patients/staff will have?

- Parking and travel time
- More off-site rehab (elderly care)
- Where services / resources have been split across sites, is there a risk that the 'in-reach' site could be offering sub-optimal care?
- This is mostly about what staff want...patients just need to know they're getting best care.
- Are there enough beds?
- Reassurance that where specialty base is at other site vs. those specialist procedures that this is not sub-optimal set up.
- Patients may fear services being taken away from their local hospital – is it worth describing it as the specialist portion of their care or just where the inpatient part will be? I.e. choice still exists for outpatients.
- All elective General Surgery to Cheltenham General.
- Who's going to be looking after the 'General Medicine' patients?
- Critical Care Capacity
- Dementia care (minimum moves between locations please!)

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2. Centre of Excellence for Emergency Care

What might appeal to patients/staff?

- Opportunity to collocate urgent services.
- Potential for dermatology to be off the acute site
- Patient voice: Will it be safer?
- Patient voice: Will quality improve?
- Development of early supported discharge for stroke.
- Emphasise the fact that you are bringing services to patient on acute floor, rather than moving them to service. Early diagnosis input of specialist.
- End of life care on planned side of the county….less frenetic environment.
- Potential for ENT & Max Fax at CGH – wouldn't have to maintain lab in GRH for frozen sections
- Agreed the way the proposal was presented was a useful representation for staff & patients.
- Really helpful way of presenting the two sites, but please make clear no change to outpatients
- Use patient scenarios on the model too
- More powerful than any of the posters….shows we've thought about it!
- Use a variant of the 2028 possible configuration chart to 'sell' the future plans to the public. It shows the plans much more clearly than the posters.

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2. Centre of Excellence for Emergency Care

General Comments and Actions

- What is the split of diagnostic equipment and staff between planned and emergency care? Involve Lead Physiologist – in diagnostics programme
- Patients need to have enough information to understand that they are in the right place for the specialist support they need.
- In Gloucester, it's really important to have a good information department to monitor throughput and outcome.
- Infectious Diseases not currently on the list and should run the OPAT(?) service with hub on the GRH site.
- Need to represent requirement of ring-fenced beds on the plan for urgent care.
- Face value it looks quite balanced between the sites and this could help us with our messaging and moving away from "hot / cold" terminology.
- Maybe don't focus on what is moving (people / public may not even be aware of what's where now?!)
- Could have done with longer to look at the chart and absorb (this was noted at the shorter 15 minute table session, versus the standard 20).
- More community functions to be populated…..we have received offers to help with this.

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3. Centre of Excellence for Planned Care & Cancer

What concerns do you think patients/staff will have?

- The biggest concern was that, in reality, this vision will not be deliverable, e.g.
  - emergency site cannot accommodate demand and things still spill over.
  - emergency site sucks in all the resources and the planned care site is under-resourced as a result.
  - current infrastructure: facilities and inter-site transport being insufficient to support the vision.
  - service delivery when specialties are divided: how will services be optimally delivered across the two sites?
- Concerns around how complex or deteriorating patients would be managed on the planned care site were raised. (Mainly in early sessions where participants had not yet been through deteriorating patient table)
- A number of people raised specific concerns around whether the consult and review model would work away from the specialty base site.
  - One model may not fit all specialties (gastro/T&O have different approaches)
  - Concerns about equity of patient experience between 2 sites was raised and ability to deliver holistic, patient centred care particularly in complex patients with multi morbidities.
- Some felt the importance of HDU beds did not come through in the model and this is a critical need to support complex planned work.
- Participants were concerned that links to other services were insufficiently articulated eg links to mental health support, alcohol misuse services, clinical psychology, genetics and the wider community health teams
- A number of workforce concerns were raised.
  - Many felt the future vision assumed a change in workforce and were concerned that, given national shortages, this could not be realised
  - Participants also raised that if staff were asked to rotate between the two sites it would disproportionately negatively impact some (particularly those with families or on lower salary scales)

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3. Centre of Excellence for Planned Care & Cancer

What might appeal to patients/staff?

- Participants responded very positively to the aim of ensuring emergency care did not disrupt planned care. This benefit was articulated frequently and in multiple ways e.g. fewer cancellations to operations, less stress to patients from not having operations cancelled, reduced waiting times and less stress on staff having to tell patients operations were cancelled.
- Participants generally responded well to the visual of one hospital trust operating from two campuses.
  - They liked being able to see the range of services for all specialties across both sites.
  - It was felt this visual representation helped illustrate that all specialties were still represented on both sites and that it demonstrated that neither site was being downgraded.
- Participants expressed that the planned care site might help realise benefits associated with having a calmer environment
  - Staff would be freer to focus fully on enhanced patient experience and not crisis management.
  - One group raised that early intervention/prevention benefits were more likely to be achieved with an undisrupted planed care site.
- Participants identified the “one trust with two linked but distinct campuses model” as having potential workforce benefits.
  - Could potentially reduce burnout by rotating staff through both sites (and the community)
  - Increased professional development/education opportunities by being exposed to patients at different levels of acuteness.
- Participants expressed that this presented on opportunity to build on the positive reputation the oncology centre

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3. Centre of Excellence for Planned Care & Cancer

Key Messages

- The whole vision hinges critically on the point that planned care will be more efficient under this model. If anything jeopardises this then participants felt the vision does not really work.
- How you communicate this is key:
  - Illustrating continuum of care can be helpful particularly in illustrating that no one site is being downgraded
  - Finding the right language and illustrations is important – eg “planned care” does not necessarily communicate that these cases can still be very complex and specialist and that an emergency might be urgent but relatively straightforward.
  - Complexity is an issue – some want more information, others less
- Delivery will be difficult and the more cross division/cross-organisation working the better. Need to focus on commonalities not differences.
- Finally, what the sites are called is important (and highly contentious!). Some felt new nomenclature that focussed on the pan-Gloucestershire brand was a must, while others felt that any name change would be very alienating and that the “Royal” must be kept at all costs.

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2/3. Future Configuration format suggestions

Comments on the formatting/content of (interactive) future configuration boards

- Should 'sub-acute' be in a different colour, as neither emergency or planned?
- Provide current configuration for side by side comparison with the 'Design our hospital' board (and bed numbers would be useful)
- Think it is important to describe as a whole …..including diagnostics and outpatients, not just inpatients.
- General medicine needed on the chart.
- Pain is a surgical specialty, needs to move on the diagram please.
- How much is 'no change' to current configuration (+ / - symbols would be useful).
- Concerns around how to illustrate this in a way that has sufficient detail but was still understandable to non-experts, e.g. some felt the complexity was not sufficiently illustrated, others that it was already too complex and we might struggle to communicate it clearly to the public

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2/3. Future Configuration clinical comments

Comments on the clinical configuration

- Defining Emergency & Planned: Emergency is 'Acute Take', urgent intervention required. At one point, does our Emergency patient become planned? E.g. Trauma patient needing to be bought back for joint surgery (could therefore go to Cheltenham after initial intervention?)
- Stroke 'sub-acute' beds at CGH….shouldn't this be a community service?
- ENT – why in GRH?
- Diabetes – should be GRH?
- Requirement for a Trauma 'consult service' in CGH (linking to Care of the Elderly)
- Vascular in GRH potentially allows haematology / transfusion to be centralised at GRH…..avoids lone working and potentially money saving too.
- Consult service: is this someone based at planned CoEx or called as required?.....dependent on the specialty?
- Would we repatriate specialist services locally….again, specialty dependent.
- OMF / Spinal / Max Fax – could be on planned side, which is different from the current proposal
- Renal provision – need something on the east side of the county….patient travel.
- GI not agreed, happy to consider
- Why have elective lower GI on unscheduled care GRH site?

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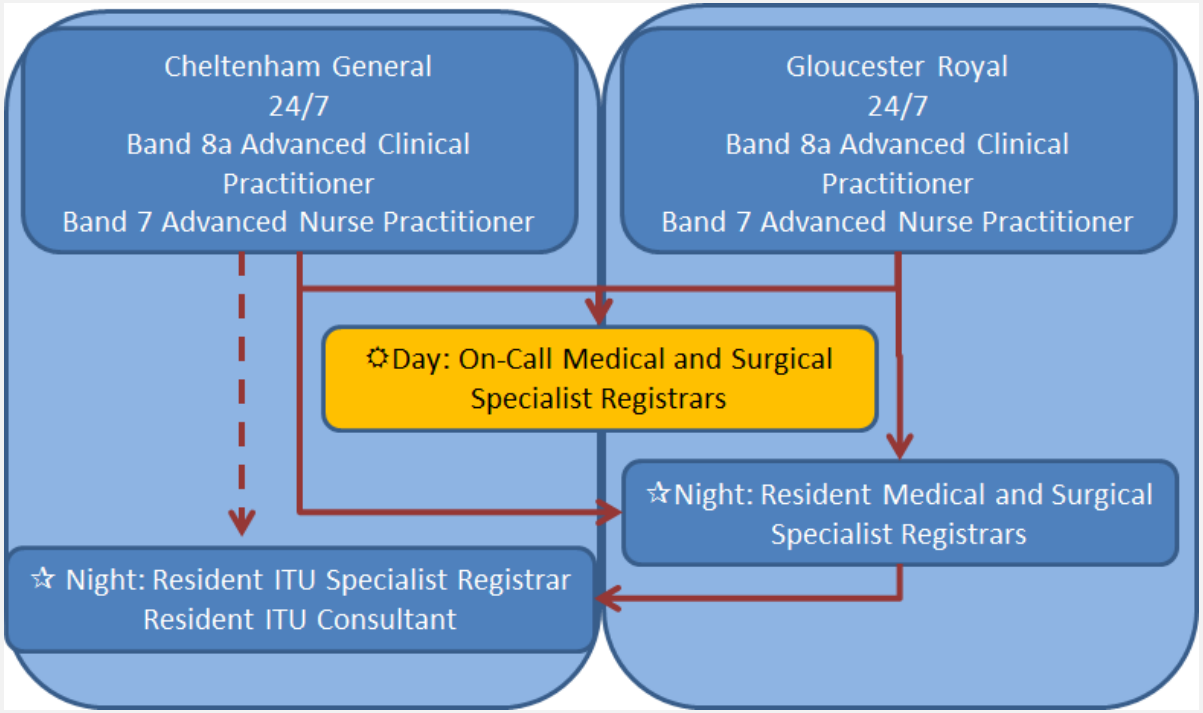
4. Caring for the Deteriorating Patient

Rationale: proposed differences in the two sites means we need to ensure patients whose condition deteriorates in either location are managed safely and effectively.

The Proposition: A new 'Deteriorating Patients Team' – specialist in deteriorating patients regardless of specialty or site. Supported overnight by Resident Specialty Registrars in Gloucestershire and Intensive Care Consultant in Cheltenham ****this is subject to clinical agreement**



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4. Caring for the Deteriorating Patient

What concerns do you think patients/staff will have?

- Staff: are there enough and are the ITU Consultants in agreement?
- Equity – scenario of the acute abdominal obstruction for a patient on elective or emergency site: responded to differently depending on whether they are seen by the Surgical Registrar or the Senior Practitioner/ITU Consultant who then needs to access the Surgical Reg for advice
- Concerns about some of the language talking about what is 'left in Cheltenham' rather than focusing on what we're building up there
- Safety – need the answers and reassurance that patients will be safe on either site
- Will there be access to imaging/diagnostics on the Cheltenham site overnight (yes – 24/7 urgent/emergency care still in place)
- Who is transported – patient or clinician (it will depend but we should develop case studies)
- Pilot experience: need access to Trauma 'consult' service in Cheltenham for falls
- This isn't a commonly-asked question by the public so need to think about how/whether to explain it

What might appeal to patients/staff?

- The plan looks good if it can be delivered
- Reassuring that we are/have been thinking about safety and solutions
- What is proposed is more/better than now in terms of seniority and experience – an "amazing service" vital to get the message 'out there'
- Moving people less – the care you need available on the site you're on
- There is 24/7 Critical Care on both sites – this wasn't clear/was assumed not to be there from media coverage
- Offers training opportunities for staff – ward nurses to extend their practice, other health professionals to develop as Deteriorating Patient practitioners, junior doctors could rotate into the team as part of their core training
- A specialist planned care site is more appealing for staff
- Vision builds on the benefits of having a very experienced deteriorating patient team – stable, permanent, well-trained

5. Imaging Hub

Image-Guided Interventional Surgery (IGIS) is keyhole surgery supported by the use of radiographic imaging. Many procedures historically conducted through open surgery can now be undertaken using IGIS. IGIS primarily consists of interventional cardiology, interventional radiology and vascular surgery. The benefits compared with traditional surgical procedures include reduced length of stay in elective patients and can avoid cost, risk, morbidity and mortality in emergency patients. Demand for Interventional Radiology services is far exceeding demographic growth predictions as newer techniques are introduced and indications expand.

The proposal discussed was to establish a hub for IGIS, collocating Interventional Cardiology, Vascular Surgery and Interventional Radiology to a single location.

Interventional Cardiology, Vascular Surgery and Interventional Radiology use similar equipment, similarly trained support staff, and similar recovery processes post-operatively. By co-locating these services to create a new unit we will be able to maximise the use of the support staff and absorb redundancy across the two services. The current split-site provision often results in patients requiring urgent treatment being transferred between sites. Establishment of an IGIS hub will allow us to rationalise expensive equipment and also consumables that are currently required to be provided at two sites.

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5. Imaging Hub

What concerns do you think patients/staff will have?

- Very few concerns raised in general
- What if the delivery is delayed?
- Oncology remains in CGH (a growth area for IR) but proposal is to centralise IR to GRH
- Finances are informing the decision rather than clinical need
- Proposal to centralise IR to GRH goes against the elective/emergency split

What might appeal to patients/staff?

- There was a lot of support and excitement about the proposal from the participants
- In general participants felt this table was an outsider as all the other tables had potentially controversial proposals whereas IR was received as a good news story – "Just get on and do it" was the most common phrase.
- There was also some feedback that we had cut through the medical jargon and made the proposal understandable to a lay-person.

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6. Measuring the Benefits

What concerns do you think patients/staff will have? (DISBENEFITS/RISKS)

- Things deteriorate during the interim phases and in the future state
- Patients refuse to go to a new location that is further away and hence reduce their health. This could impact more on people from deprived areas – increased inequity of access to services
- Patients will go out-of-county if they have to travel further in-county
- Clinical risk - access to emergency surgeon at CGH
- Patient and staff 'winners and losers' from the changes
- Staff will leave because: travel to a new site, new teams, move to 24/7 shifts, near retirement and do not wish to retrain, expectation that stresses will increase as we move through the implementation
- Staff burnout and sickness rates increase due to increased pressures of implementing the changes and managing rising patient numbers
- Staff development – may see their career as stalled, e.g. if they now only do planned work
- Increased tribal working and separation across the 2 sites
- Risk of poor design of interim phases and future state due to political influence, staff conflicts of interest influencing design process, compromises, not enough understanding of co-dependencies, no bed modelling, community hospitals not considered
- National political changes derailing the programme
- Local pressure groups inform the public that CGH being "downgraded" and we lose public support
- Staff and public do not understand the vision
- CoEx programme is perceived as a cost cutting scheme
- One or other site is perceived as a favourite
- Public questions how the programme budget could have been better spent on equipment, staff and services
- High public and staff expectations not met and corresponding increase in public and political pressures

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6. Measuring the Benefits

What concerns do you think patients/staff will have? (DISBENEFITS/RISKS continued)

- Risk that during the interim phases over the next 10 years that services get worse
- At present we provide the same service at 2 different sites and we rely on the other site being operational if one site falls down. If we only offer a service from a single site we lose resilience. The mitigation is that we need to invest in the estate to ensure each service at a single site is resilient
- Risk that we don't invest in services alongside the reconfiguration (moving from A to B gives limited benefit)
- Risk that not enough parking at a particular site
- Risk that services not affected by this programme do not receive investment to improve
- Risk that private providers enter the market over the next 10 years
- Increase in travel increases air pollution and CO2 emissions
- High risk that costs go North and timeline goes to the right. Need to ensure high percentage contingency budget based on evidence of increase at other Trusts running similar programmes
- Costs of new equipment, labs, facilities and moving existing equipment
- High cost of interim phases where equipment and staff may be duplicated and patients not seen
- Time and costs associated with retraining staff in new skills
- Increased staff travel costs for which GHT is liable
- Risk of increased public travel costs
- Programme and team costs
- Risk that we discover the programme is unaffordable
- It is common that benefits promised are not delivered. Risk that future model is not viable. Need to be conservative on the financial benefits of the CoEx programme
- Risk that we don't have the IT and finance management software to manage the finance across the 2 sites

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6. Measuring the Benefits

What might appeal to patients/staff? (BENEFITS/OPPORTUNITIES)

- Improve on speciality specific clinical indicators
- Reduce waiting times and improve cancellation rates
- Improve referral to treatment times
- Reduce length of stay
- Improve equality measures
- Lower Mortality and morbidity rates
- Improve lifespan in deprived areas
- Improve GIRFT quality measures
- Improve patient and public satisfaction and reduce number of complaints
- Benchmark against other hospital trusts
- Improved care pathways and better ways of working should enable earlier diagnosis and prevention and reduced duplication of tests and questions asked of patients
- Enable patients to be empowered and have a say in their treatment
- CoEx should create new, exciting roles and attract quality staff creating a better buzz and desire to work here
- Improve staff retention rates, reduce staff sickness and vacancies
- Reduction in clinical variation as bring teams together and improve pathways
- Reduce operational costs as gain efficiencies through centralisation and economies of scale and through fewer cancellations
- Use operational and support service KPIs to measure improvements

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7. Hospital Mood Boards

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7. Hospital Mood Boards

What concerns do you think patients/staff will have?

- Staff on 'quieter' site might become stale or lose skills
- Staff on emergency side might experience burnout
- It is essential for patients to be able to get to both sites but transport must be improved
- Some staff felt that the two hospitals should remain the same and thus equal
- Cheltenham must look the part as well as feel the part and some work to the estate would be needed
- If Cheltenham was promoted for its calm environment, patients in GRH might feel overwhelmed or like they were getting less care and attention
- The hospitals and the NHS in the county must communicate better about the services
- Transport & parking, both for ambulances and for patients and visitors would have to be SIGNIFICANTLY improved

What might appeal to patients/staff?

- The calmer environment of the elective site would be excellent for developing skills and learning
- It is appealing to patients to know exactly what is at each site and this MUST be promoted and celebrated
- It makes sense for the hospitals to be celebrated for their difference
- It makes sense to make the best use of limited resources and to spend public money wisely
- Cheltenham would feel less neglected and have a hospital to be proud of that's not about trying to catch up with Gloucester
- Statistics and case studies tell the story
- The different environments and 'mood' of the hospitals would tell a useful story for recruitment
- Fewer cancellations would be very positive

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Next steps

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Month	Activity
April 2019	Workshop feedback report to all participants
	Continue to refine and develop proposals
May 2019	Draft of clinical configuration model
	Staff engagement (continues through next phases)
June 2019	Business Case for clinical configuration
	Prepare for public engagement
July – September 2019	Public engagement
October 2019	Review plans based on feedback
November – January 2020	Public consultation
February 2020 up to 2028	Phased implementation of changes if agreed

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Key Messages from the Event

Participants valued the opportunity to get a more rounded view on the Centres of Excellence ideas. They were particularly positive about the mix of clinical and patient representatives on the day, which led to a more rounded discussion.

Some key messages from the day which are informing the next phase of developing our proposals:

- **Patient experience is paramount – describe now/future in the context of what happens to patients**
- **Aim to engage patients, the public and staff as much as possible to shape the proposals and the way we talk about them**
- **Be honest – present both the positives and negatives of our reconfiguration experience so far**
- **In general the ideas were positively received with feedback that future plans are not getting out to the public – all they are hearing is negative news**
- **We have a great opportunity to shape an excellent specialist hospital system, and in so doing we can inform the national picture and evidence base**

We also added to our growing list of questions we still need to answer and people we still need to talk to so thank you so much to everyone for your suggestions.

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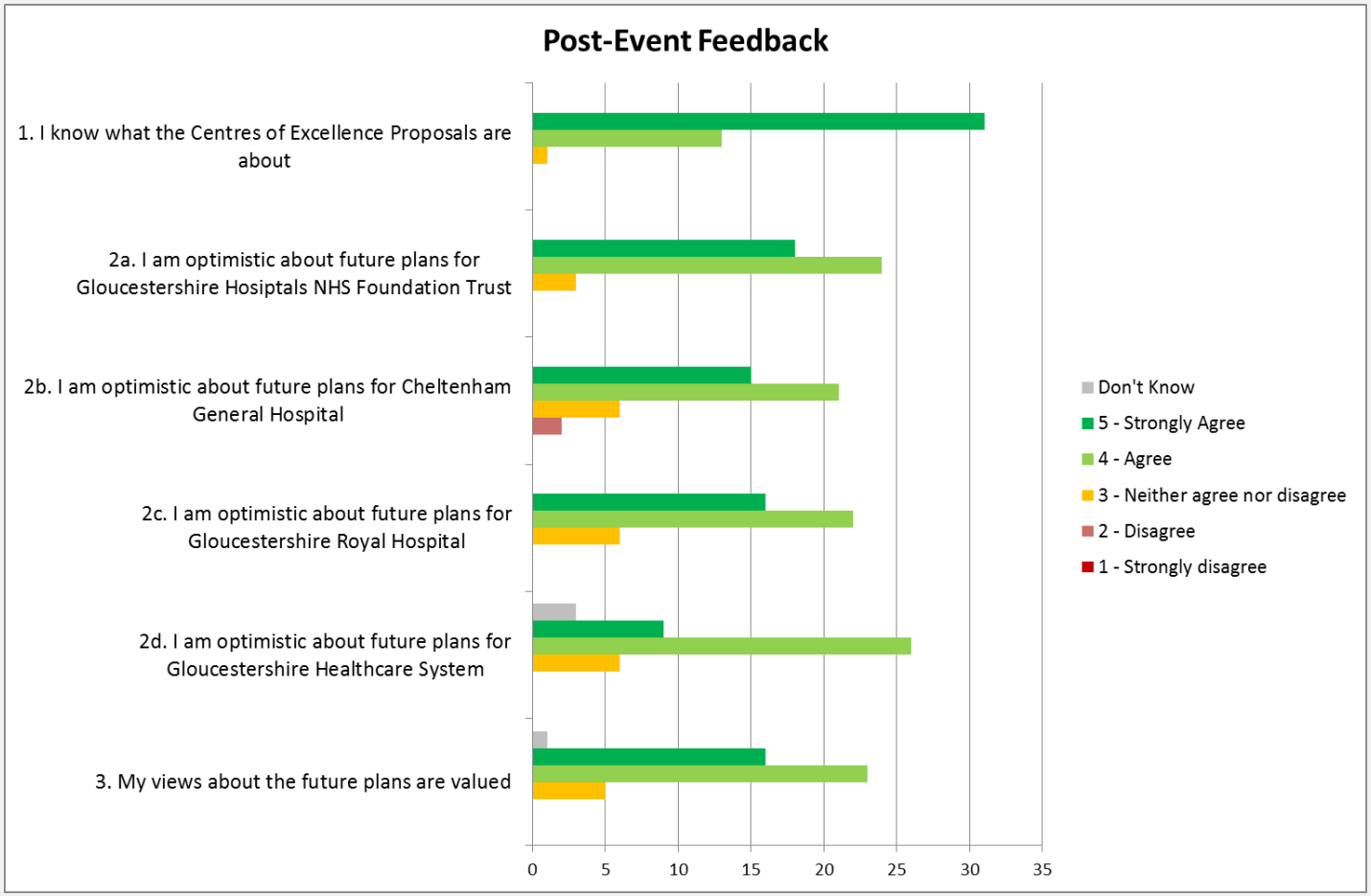
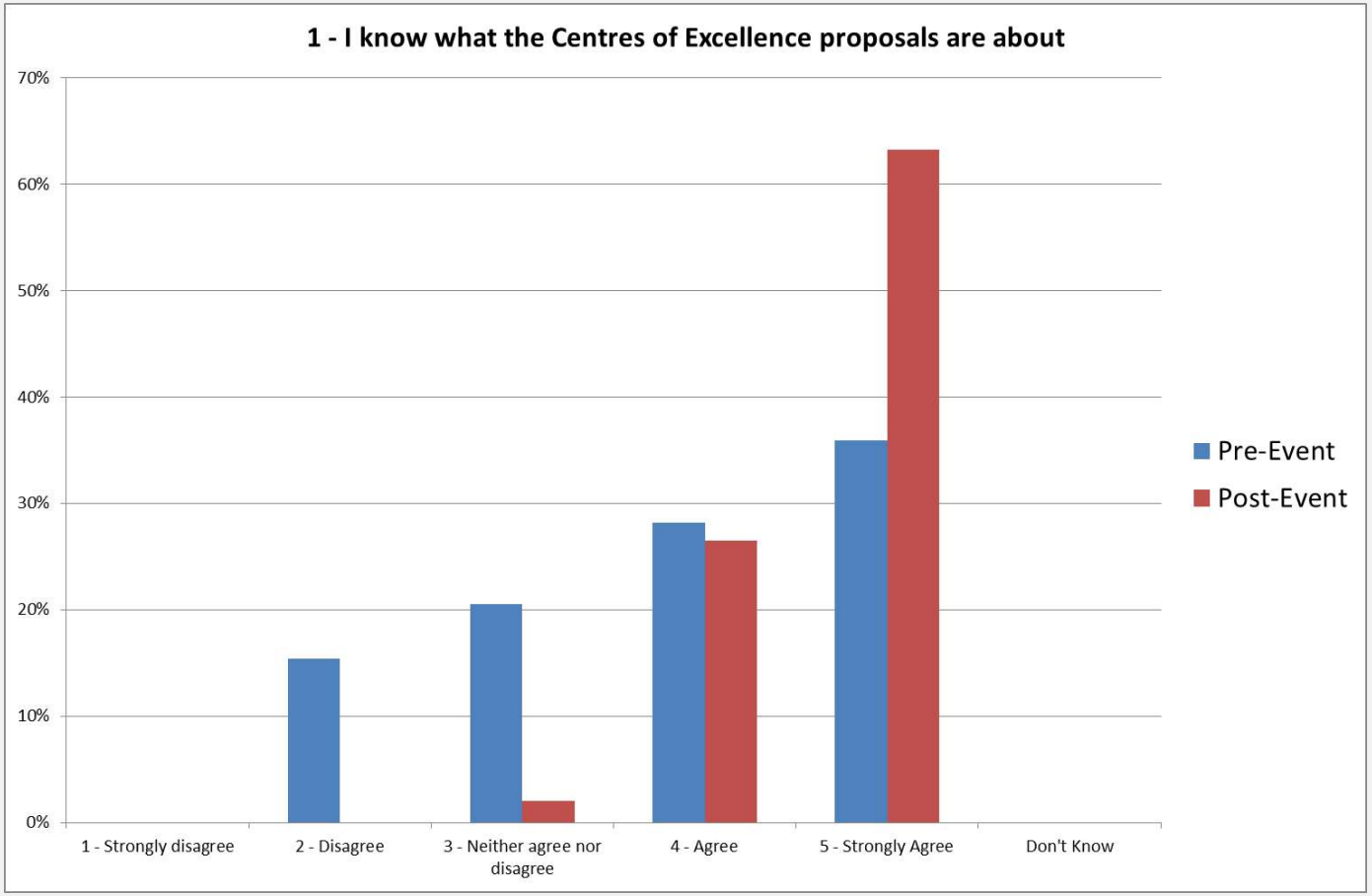
Post-Event Feedback



This information is confidential. Proposals detailed within this document are subject to consultation/involvement

Comparing pre- and post-event



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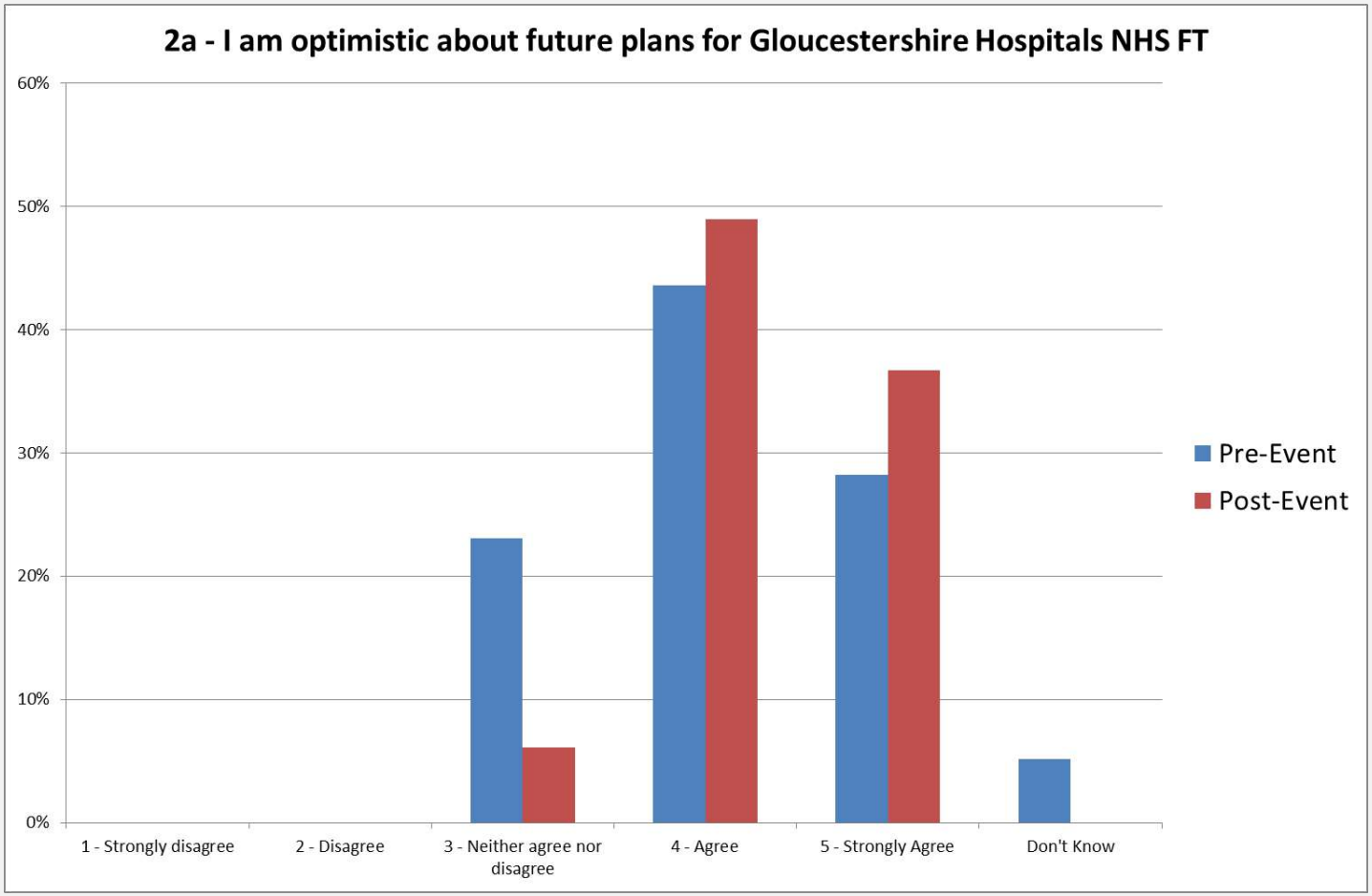
Comparing pre- and post-event (cont'd)



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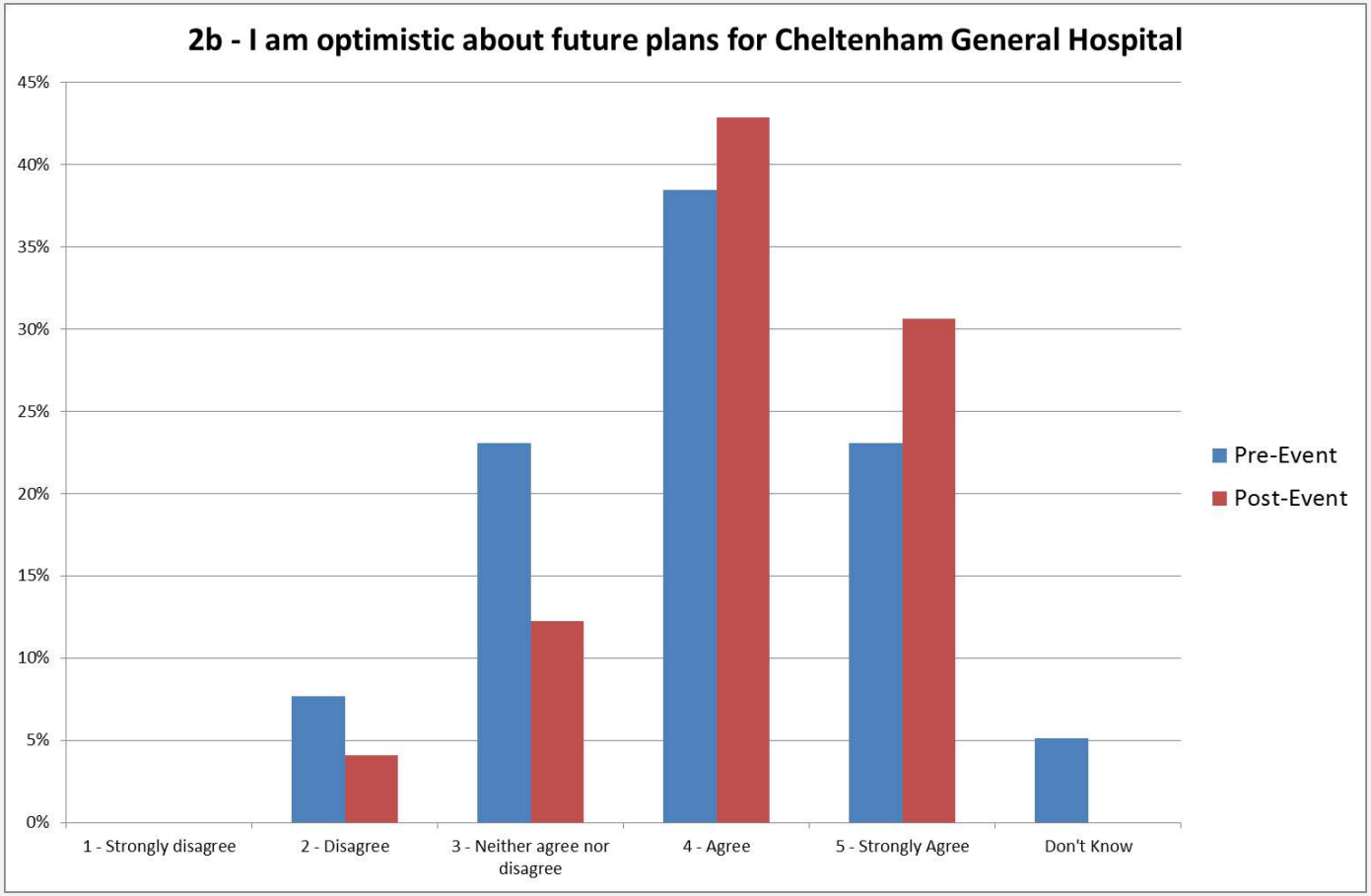

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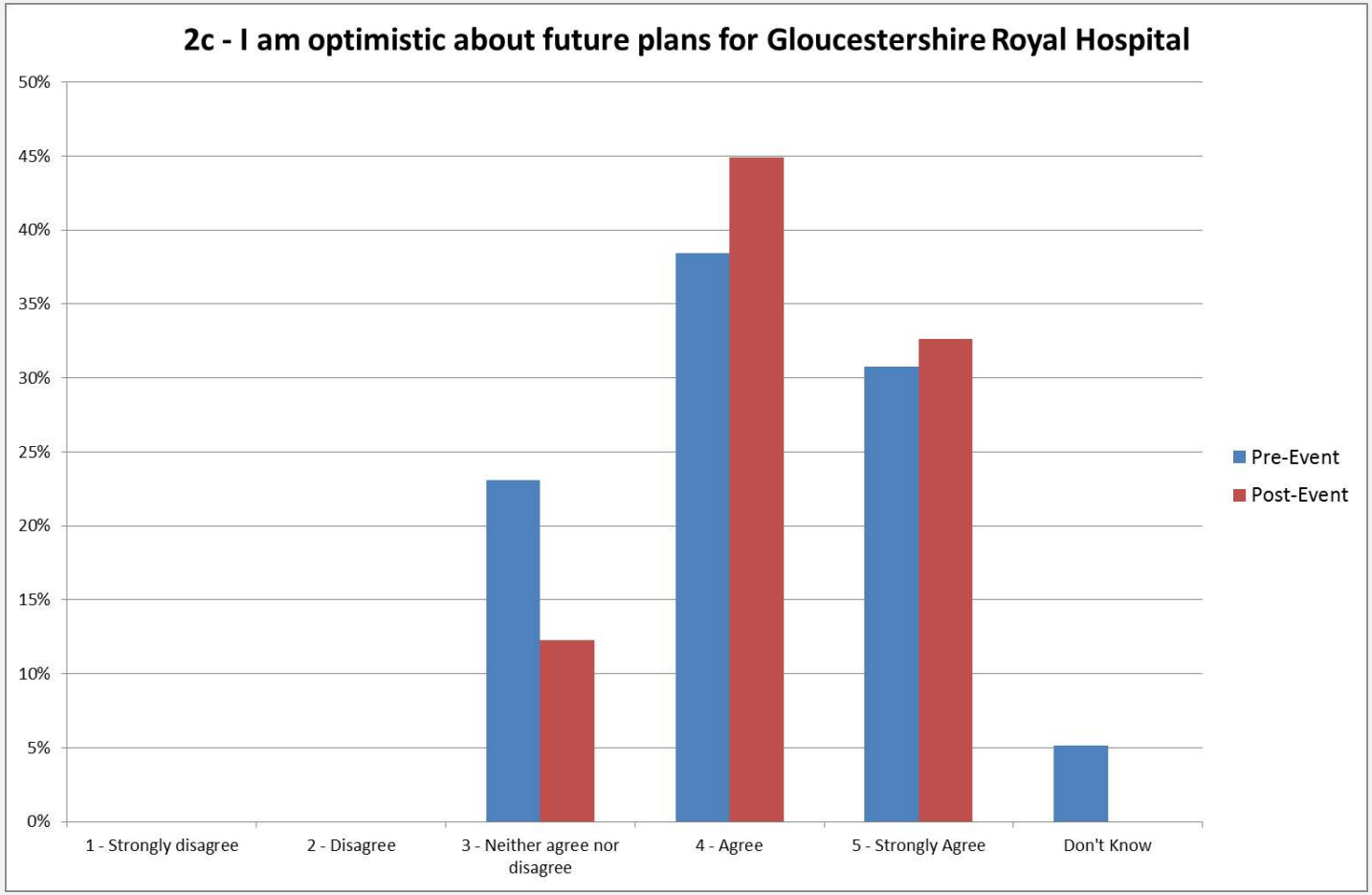

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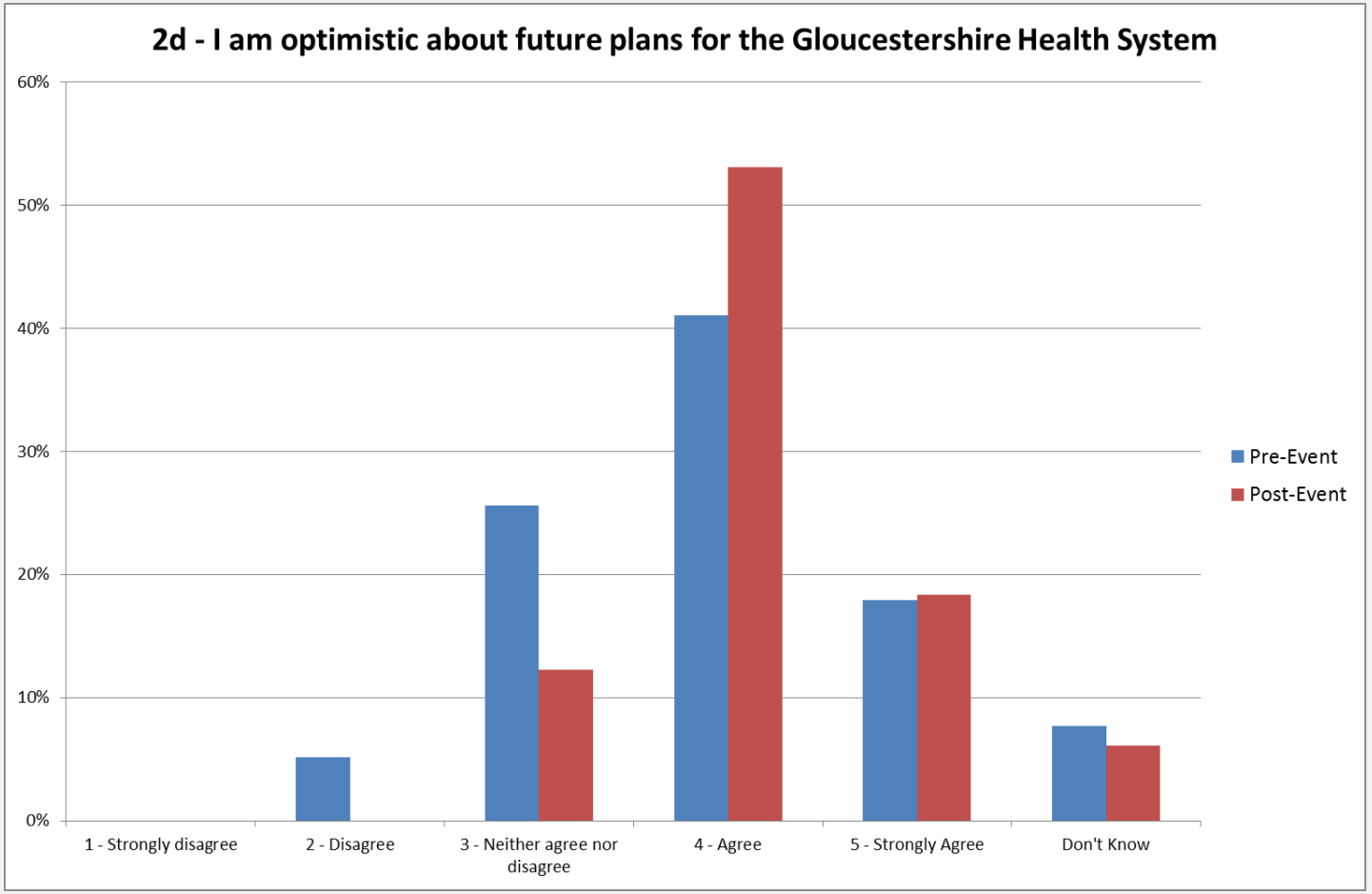

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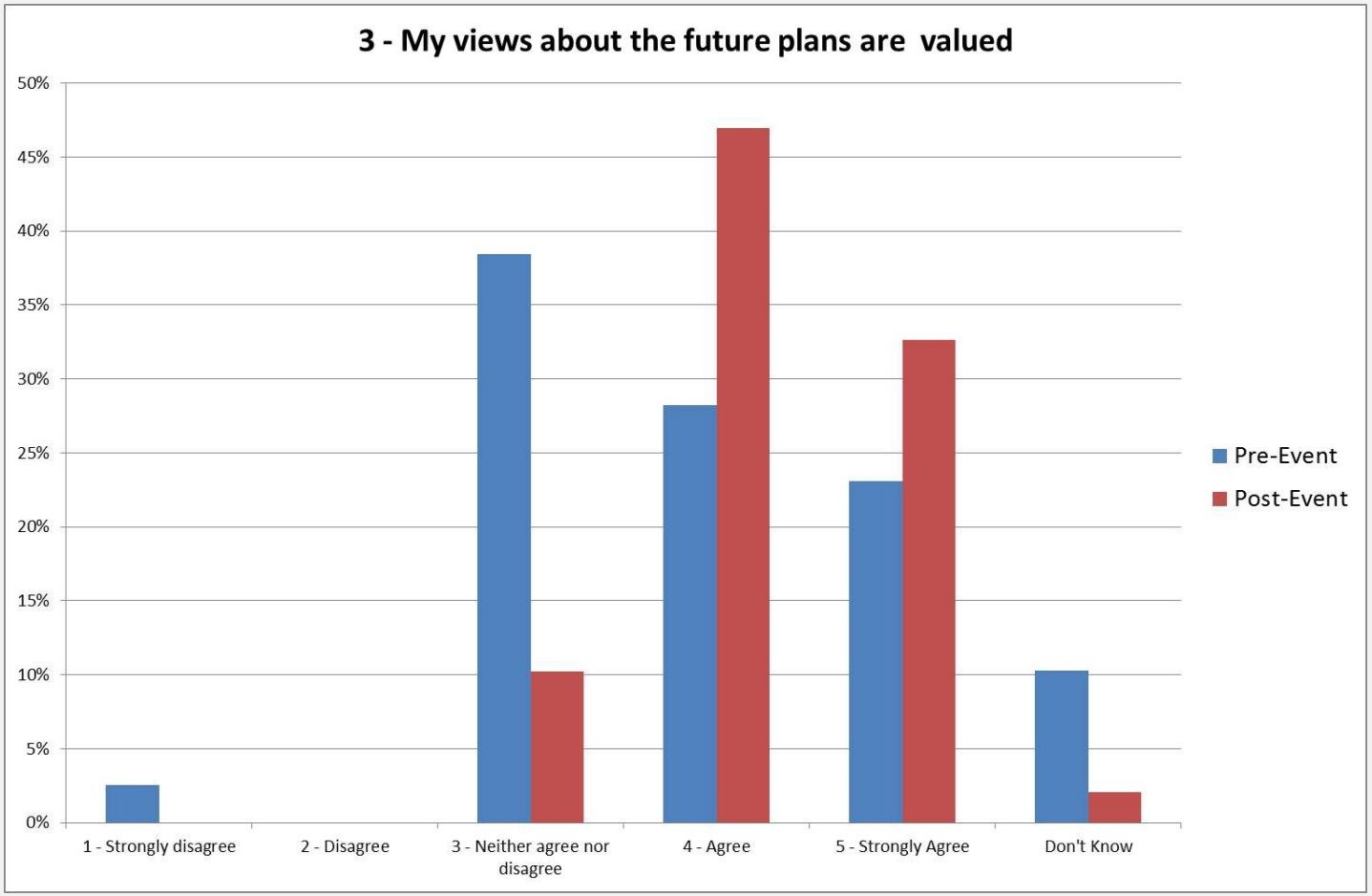

Feedback comments

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Great day and lots of vibrant discussion

Break out rooms next time – a bit noisy!

What worked well: Openness to ideas and challenges

Key learning point: all considerations for the proposals will be taken into account

Enjoyed poster exercise – found it interesting/thought provoking

A useful day . Stakeholder engagement and consultation to the wider audience will now be key.

Good mix of people on the tables. Good interactive sessions

The Trust has a plan and strategy which is refreshing. I'm not sure if it's achievable.

Need to be bold about selling the benefits

Suggested improvement: set tables specific questions/problems to solve

It was good to understand other people's views and opinions on proposed changes

Loved mood boards - would be a good exercise with staff affected

Too much information in the posters

Further workshopping with staff and patient reps who attended today to help with the messages – framing, emphasis

Good opportunity to talk to patient reps

Missing Ambulance, local authority, Glos Care Services, 2Gether

Exercises like the mood board didn't add much for me

More detailed cross-clinical specialty discussions

Brilliant work, well done team

Patient stories makes it real

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Thank you

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