One Gloucestershire
Transforming Care, Transforming Communities

NHS

FIT FOR THE FUTURE

Output of Engagement

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1. Fit for the Future Engagement

The Fit for the Future (FFTF) public and staff engagement programme started in August 2019 to seek views on the future provision of urgent and specialist hospital care in Gloucestershire. All feedback received is collated into this comprehensive Engagement Report and online appendices and will be used to inform the development of potential solutions for future local NHS services.

The focus of the engagement over the past months has been on:

- ideas to support easier, faster and more convenient ways to get urgent same day advice and care wherever people live in Gloucestershire
- what's important to local people in getting urgent (not life threatening) same day advice and care across our communities in Gloucestershire, including illness and injury services
- ideas for a 'Centres of Excellence' approach to providing specialist services at the two large hospital sites in the county
- a range of ideas for the next few years, including Accident, Emergency and Assessment Services (including A&E), General Surgery and Image guided interventional surgery
- a new hospital for the Forest of Dean (FOD)

There have been a number of innovative ways the NHS has involved local people and staff over the past few months, from a survey and 'drop in' events to independently facilitated workshops to an engagement hearing.

The Fit for the Future Output of Engagement Report is intended to be used as a practical resource for **One Gloucestershire** partners to inform the development of priorities, programmes and potential solutions. It will be shared widely across the local health and care community and is available to all on the One Gloucestershire website www.onegloucestershire.net .

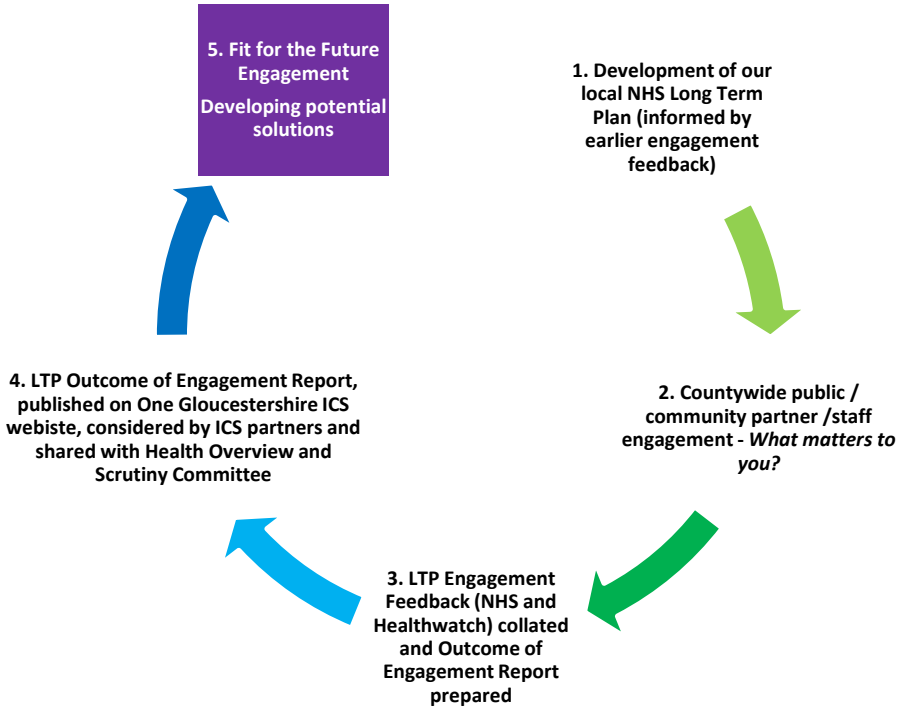
One Gloucestershire partners are invited to consider the feedback from engagement and indicate how it has influenced their thinking and future planning.

One Gloucestershire is a partnership between the county's NHS and care organisations to help keep people healthy, support active communities and ensure high quality, joined up care when needed.

The NHS partners of One Gloucestershire are:

- NHS Gloucestershire Clinical Commissioning Group (CCG)
- Primary care (GP) providers
- Gloucestershire Health and Care NHS Foundation Trust (formerly 2gether NHS Foundation Trust and Gloucestershire Care Services NHS Trust)
- Gloucestershire Hospitals NHS Foundation Trust
- South Western Ambulance Services NHS Foundation Trust

The FFTF engagement is the latest element of the cycle[1] to develop the Gloucestershire response to the NHS Long Term Plan.



We would like to thank everyone who has taken the time to share their views and ideas.

2. Making the best use the information provided in this Report

There are elements of feedback which will be relevant and of interest to all readers; these can be easily found in the main body of the report.

All feedback relating to the specific areas: 'improving urgent care services in local communities' and 'improving specialist hospital services and developing *'Centres of Excellence'* can be found in a series of online Appendices. These Appendices include all comments collected including copies of individual submissions received in addition to the FFTF survey responses. The Appendices also include independent reports of all workshops.

The theming of the qualitative feedback presented in this report has been undertaken by members of the One Gloucestershire Communications and Engagement Group.

All feedback received has been read and coded into themes such as: 'access', 'workforce' and 'quality'. We acknowledge that such an exercise includes a subjective element and we recognise that others may have chosen to place items of feedback under alternative headings. To provide assurance, all qualitative written feedback from both survey respondents, comments and individual correspondence received and collected by

[1] **Previous engagements** https://www.onegloucestershire.net/yoursay/

representatives of **One Gloucestershire** partners during the engagement period is included within this report and/or the online Appendices.

This report is produced in both print and on-line (searchable PDF) formats.

For details of how to obtain copies in other formats please turn to the back cover of this Report.

Appendices

All appendices are available at: www.onegloucestershire.net

Appendix 1: Inclusion Gloucestershire's Report for NHS One Gloucestershire Engagement Workshops 1st August – 17th October 2019

Appendix 2: Gloucestershire Hospitals NHS foundation Trust 'Centres of Excellence' Staff Engagement Report January – October 2019

Appendix 3: Independent reports of all workshops

Appendix 4: Engagement Hearing materials

Appendix 5: FFTF Survey responses (full, redacted for personally identifiable information e.g. names)

3. Equality Impact Analysis (EIA)

Equality, diversity, Human Rights and inclusion are at the heart of delivering personal, fair and diverse health and social care services. All commissioners and providers of health and social care services have legal obligations under equality legislation to ensure that people with one or more protected characteristics[2] are not barred from access to services and decision making processes

An Equality Impact Analysis (EIA) of the planned engagement activities associated with Fit for the Future: Developing urgent and hospital care in Gloucestershire and Fit for the Future: A new hospital for the Forest of Dean was undertaken prior to the commencement of engagement.

To support FFTF communications and engagement, the FFTF EIA took account of the following recommendations from the Outcome of Engagement associated with the engagement earlier this year: *Developing our local NHS Long Term Plan*.

Further consideration given to the collection of demographic information relating to participants at public engagement events.
Inclusion Gloucestershire (see below) and the Independent facilitation team have collected a wider range of demographic information about participants at engagement workshops.
In partnership with Inclusion Gloucestershire, Healthwatch Gloucestershire and ICS Partners we will endeavour to actively seek the views of people who are representative of the protected characteristics.
Extract from the FFTF EIA: Inclusion Gloucestershire (a local user-led organisation whose aim is to reduce health inequalities) has received a grant from NHS Gloucestershire Clinical Commissioning Group to assist the STP/ICS to break down barriers to engagement. This project will independently coordinate engagement opportunities across all protected characteristic groups and groups that are known to face health inequalities to ensure that those groups are involved in workshops shaping local health and care services. Inclusion Gloucestershire expects to deliver: Recruitment of individuals to attend approximately 10 engagement events over the course of the six months, coproduced between Inclusion Gloucestershire and commissioners to ensure that they are as inclusive and accessible as possible. Inclusion Gloucestershire would support and enable these events, which would be run by commissioners. We would ensure that people can take part in discussions by advising organisers on the format of engagement, materials and tools, and translating complex issues and information. These events would bring together people from protected characteristic groups to shape the design of health and social care services, take part in options appraisals and share their valuable lived experience. Each event will be attended by approximately 15 representatives from a mix of backgrounds and groups who experience health inequalities.

[2] It is against the law to discriminate against someone because of: age; disability; gender reassignment; marriage and civil partnership; pregnancy and maternity; race; religion or belief; sex, sexual orientation. These are called protected characteristics. https://www.equalityhumanrights.com/en/equality-act/protected-characteristics

We will continue to test our engagement materials with lay representatives to ensure that they are written in plain language which is easily accessible and understandable. Wherever possible we will ask open questions which will facilitate, but not lead, responses to engagement and consultation.
Healthwatch Gloucestershire Readers panel have been involved in the preparation of engagement materials
We will continually review our approach to engagement to ensure that it reflects good practice, working with The Consultation Institute to quality assure our processes.
The Consultation Institute has provided advice and guidance throughout the FFTF engagement process.

The *Fit for the Future* Engagement exercise was open to all and engagement activities were designed to facilitate feedback from as wide a cross-section of the local community as possible. The EIA can be found via the following links:
https://www.onegloucestershire.net/yoursay/fit-for-the-future/
https://www.onegloucestershire.net/wp-content/uploads/2019/08/FFTF-Equality-Impact-Analysis.pdf

4. Our approach to communications and engagement

4.1 Working with The Consultation Institute, independent workshop facilitators, Inclusion Gloucestershire, Healthwatch Gloucestershire

The FFTF Engagement has been supported by independent groups3. The Consultation Institute has provided advice and guidance in relation to all aspects of the engagement planning and activity. The series of speciality and locality workshops were independently facilitated and reported by ASV Research Ltd. Healthwatch Gloucestershire Lay Readers Panel supported the production of engagement materials. Inclusion Gloucestershire (a local user-led organisation whose aim is to reduce health inequalities) and Healthwatch Gloucestershire supported the recruitment of local lay people to participate in the independently facilitated workshops.

Inclusion Gloucestershire's Report for NHS One Gloucestershire Engagement Workshops 1st August – 17th October 2019 can be found at Appendix 1 Inclusion Gloucestershire's report sets out what they did to identify individuals from protected characteristic groups and invite them to attend the workshops, to enable people to have their voices heard, details of who attended (by protected characteristic groups: Age – including a young carer; Disability – physical disability, Autism and learning disabilities; Race – individuals from different BME communities; Religion or belief; Substance misuse; Sexual orientation and those who are socially isolated. The report sets out what worked well and learning for future engagement.

4.2 Developing understanding and supporting Fit for the Future engagement

A range of communications and engagement methodologies were used during the FFTF Engagement period. This section describes the wide ranging approach taken to promoting the *Fit for the Future* engagement and the range of involvement opportunities.

In summary:

4.2.1. Media releases and stakeholder briefings

This included:

- launch materials – media release and stakeholder briefing
- media statements reinforcing key messages and involvement opportunities
- a further open stakeholder letter to 615 community stakeholders including Patient Participation Groups, local authorities, voluntary and community organisations
- Healthwatch Gloucestershire included an awareness raising summary of the *Fit for the Future* launch in their public e-bulletin.

3

https://www.consultationinstitute.org/

https://www.asv-online.co.uk

https://www.inclusiongloucestershire.co.uk/

https://www.healthwatchgloucestershire.co.uk/

4.2.2. Hardcopy engagement booklets

7,000 booklets were widely distributed to a range of public places including community pharmacies, GP surgeries, hospitals and libraries. The booklets included the survey and information detailing the ways people could get involved.

4.2.3. 'Your Say' area on the One Gloucestershire and FOD Health websites

Fit for the Future: Developing urgent and hospital care in Gloucestershire: https://www.onegloucestershire.net/yoursay/

Fit for the Future: A new hospital for the Forest of Dean: https://www.fodhealth.nhs.uk/engagement/

The dedicated webpages included the engagement booklets, survey, events listing, information on all other involvement opportunities, a summary (introductory) film, case studies, fact sheets and a live FAQs summary updated throughout the engagement period. These materials were also used to support engagement events.

Latest news pages provided regular updates (also linked to social media posts – see below).

The website analytics show that during the engagement there were 18,872 views of the One Gloucestershire website, including 4,755 views of the Fit for the Future engagement page. In addition, there were 1,800 visits to the Forest of Dean website.

Awareness of the sites and resources was raised through media editorial, social media, booklets, media advertising and information bus/display stands.

The Engagement Hearing was live streamed from the One Gloucestershire website.

4.2.4. Social media

Social media was used extensively to support the engagement period and planned activity covered topics such as promotion of how people could get involved, the 'talking heads' film, drop in events, promotion of the booklet and survey, availability of FAQs, promotion of the locality workshops, engagement hearing (including the live stream) and juror recruitment to the independent Citizens' Jury.

4.2.5. Facebook

During the engagement there were 21 Facebook posts (non- paid for activity), with a total reach of 34,406. There were 464 'engagements' with these posts (i.e. actions such as comments, likes or shares) of which 159 were shares. There was also a 4-week paid for advert that linked to the engagement section on the One Gloucestershire website. This achieved a reach of 57,440 with 82 shares.

4.2.6. Twitter

During the engagement period there were 49 tweets, with a total of 42,625 impressions. There were 988 'engagements' with these tweets (i.e. actions such as link clicks, retweets, likes, or comments) of which 122 were retweets and 169 were clicks through to the One Gloucestershire website. Activity on Twitter covered the themes referred to in the Facebook section above.

4.2.7. Media advertising

As well as the methods described above, Public Drop-in engagement events were advertised in local media titles including Gloucester Citizen, Gloucestershire Echo, Forest of Dean and Wye Valley Review, Wilts & Glos Standard, Stroud News & Journal, Cotswold Journal and Gloucestershire Gazette.

4.3. Staff communication and engagement

All staff working across NHS and care organisations have been encouraged to participate in the FFTF Engagement. Significant involvement and communication activity has taken place. This included:

4.3.1. Gloucestershire Care Services NHS Trust and 2gether NHS Foundation Trust4

- August – hard copies of the FFTF booklets were distributed to all 2g and GCS sites
- August 20, FFTF launch covered on both 2g and GCS Trust intranets
- August 21, FFTF launch covered on both 2g and GCS Trust websites
- August 29, information about programme of engagement and ways to get involved shared at Senior Leadership Network and monthly senior leaders' gathering (joint event for 2g and GCS)
- September 9, information about engagement and methods for responding shared via Team Talk –a monthly management cascade briefing (joint for 2g and GCS)
- September 12, story on both Trust intranets updating on FFTF process and giving dates of community workshops and other engagement methods
- September 19, story on GCS and 2g intranets sharing letter from Medical Directors, encouraging response to FFTF engagement

4.3.2. Gloucestershire Health and Care NHS Foundation Trust (GHCNHSFT)

- October 9, story on GHC website regarding Citizens' Jury recruitment getting underway
- October 14, story about FFTF engagement closing 'today' published on GHC Trust intranet

4.3.3. Gloucestershire Hospitals NHS Foundation Trust (GHNHSFT)

In total 1624 staff from across GHFT and the wider Integrated Care System (ICS) have been asked for their views on the programme and to contribute their ideas to its development.

Staff involvement activities to develop the *'Centres of Excellence'* Clinical model to date have included:

- Semi-structured interviews
- New Models of Care Board (x 3 meetings)
- Model of Care workshop – April 2019
- Staff workshops
- Staff engagement roadshow
- Briefings

GHNHSFT has produced a comprehensive 'Centres of Excellence' Staff Engagement Report January – October 2019 which can be found at Appendix 2.

[4] *The organisations merged on 1 October 2019 (now Gloucestershire Health and Care NHS Foundation Trust)

4.3.4. Gloucestershire County Council (GCC)

Gloucestershire County Council Health Overview and Scrutiny Committee Members have received regular updates on the FFTF programme and engagement. Copies of the engagement booklet have been available to elected members and staff.

Members of GCC staff involved with the development of the Gloucestershire Health and Wellbeing Strategy have joined several of the FFTF engagement events to promote the Strategy and to participate in discussion groups.

4.3.5. NHS Gloucestershire CCG

The CCG held an engagement session as part of its Accountable Officer led Team Brief session, included articles and updates in its Team Brief e-bulletin, update features on the Intranet homepage featuring engagement opportunities. Articles were also placed in the weekly CCG 'What's New This Week' GP member practice e-bulletin. The CCG introduced FFTF discussions at a variety of county meetings such as Integrated Locality Partnerships and the New Models of Care Board.

4.4. Engaging stakeholders and the public

4.4.1. Surveys

Two surveys were developed to support the FFTF engagement. These were available as print, FREEPOST return copies in the engagement booklets and also on line at:

Fit for the Future: Developing urgent and hospital care in Gloucestershire:
https://www.smartsurvey.co.uk/s/fitforthefuture/

 Fit for the Future: A new hospital for the Forest of Dean:
https://www.smartsurvey.co.uk/s/FFTF-ANewHositalFoD/

A total of **2482** FFTF: *Developing urgent and hospital care in Gloucestershire* surveys have been received. This includes 1252 identical surveys submitted via the Cheltenham MP (see below).

 A total of **153**: *A new hospital for the Forest of Dean* surveys have been received.

4.4.2. Other surveys and petitions

At the time of preparing this report One Gloucestershire NHS Partners are aware of one alternative survey, a template response to the FFTF Engagement Survey and two petitions created during the FFTT Engagement period.

REACH: Restore Emergency at Cheltenham Hospital – Alternative Survey

The REACH campaign created a survey an alternative survey to the FFTF Engagement Survey. The responses to this survey have not been shared with NHS One Gloucestershire partners at the time of preparing this report.

Conservative MP for Cheltenham, Alex Chalk – template response to the FFTF Engagement Survey

During the period of FFTF Engagement Conservative MP for Cheltenham delivered or posted 1252 completed printed FFTF Engagement surveys to the offices of NHS Gloucestershire Clinical Commissioning Group. Referred to in this Report as the 'Cheltenham MP FFTF surveys', the surveys received via this route are all typed identical responses to the FFTF Engagement questions including some handwritten or typed demographic information (in

most cases a name and postcode) or an attached list of typed names and postcodes appended to a single completed survey.

The template responses to the Cheltenham MP FFTF surveys are included later in this Report at Sections 6.5 (Survey feedback). The responses to the Cheltenham MP FFTF surveys have been recorded as a group response in the qualitative analysis of the FFTF Engagement surveys below. The limited demographic information provided in the Cheltenham MP FFTF surveys has not been included in the overall total demographic information reported below. Postcode demographic from the Cheltenham MP surveys is reported separately. In addition to the completed surveys delivered by hand or posted by the Cheltenham MP, the template response created by the Cheltenham MP was posted on social media with instructions regarding how to complete the FFTF Engagement survey. A number of surveys received from individuals during the FFTF Engagement contained the identical responses to the Cheltenham MP FFTF surveys. These surveys, received from individual respondents, have been included as individual responses received in the analysis presented in this Report.

We are not aware of any other related surveys at the time of preparing this Report.

Liberal Democrat Prospective Parliamentary Candidate for Cheltenham

In November 2019, during the FFTF Engagement period, Max Wilkinson, Liberal Democrat Prospective Parliamentary Candidate for Cheltenham, presented a petition at the Gloucestershire County Council Health Overview and Scrutiny Committee. This petition at that stage had 2,055 signatures and included the following narrative:

> *We the undersigned wholeheartedly oppose the closure of Cheltenham's Accident and Emergency Department*
>
> *We the undersigned reject the view that an Urgent Treatment Centre is sufficient for a town of nearly 120,000 people*
>
> *We call on Gloucestershire's NHS Hospitals Foundation Trust to abandon this short-sighted policy and to guarantee the future of Cheltenham's Accident and Emergency Department.*

Rushworth Residents' Association

21 residents of Rushworth House, Cheltenham, signed and sent a petition to the FFTF engagement which said:

> *We, the undersigned, do not want Cheltenham Hospital's Accident and Emergency Department to be downgraded. We believe it should be a fully functioning Accident and Emergency Department, with specialist doctors and nurses.*
>
> *We do not want to see specialists who work with Cancer patients, removed from Cheltenham Hospital.*
>
> *We do not wish to see services moved from Cheltenham Hospital to Gloucester Royal as we believe this will affect the safety of patients.*
>
> *We believe that no account has been taken of the difficulty of accessing Gloucester Royal Hospital from Cheltenham and other areas of the County.*
>
> *We want to see those doctors, who look after patients with gastro intestinal problems, or those who might suddenly need emergency treatment while a patient at Cheltenham Hospital, retained at Cheltenham Hospital.*
>
> *We do not believe that the proposals set out by the Trust are in the best interests of patients.*

We are not aware of any other petitions at the time of preparing this Report.

5. Engagement events activity timeline

Information Bus Drop In: Outside Marks and Spencer on Cheltenham High Street

Information Bus Visits and Exhibition Stands Activity also includes focus on engagement for *A New Community Hospital for the Forest of Dean*			
Date	**Event and number of**	**Venue**	**Time of Event**
Thursday 22nd August	Information Bus	Gloucester, The Cross	10:00am – 3:00pm
Friday 23rd August	Information Bus	Clock Tower roundabout, Coleford	10:00am – 3:00pm
Monday 26th August	Winchcombe country Show – Information bus	Winchcombe School	12:00pm – 5:30pm
Tuesday 27th August	Information Bus	Cheltenham town Centre, Outside Marks & Spencer	10:00am – 3:00pm
Thursday 29th August	Information Bus	Stroud, Tesco	10:00am – 3:00pm
Saturday 31st August	Information Bus	Cinderford, Co-Op	10:00am – 3:00pm
Monday 2nd September	Information Bus	Gloucester, The Cross	10:00am – 3:00pm
Wednesday 4th September	Information Bus	Newent, Market Place	10:00am – 3:00pm
Wednesday 4th September	Stand (Military Fresher's Fayre)	Imjin Barracks	10:00am – 2:00pm
Friday 6th September	Information Bus	Lydney, Newerne St carpark	10:00am – 3:00pm
Saturday 7th September	Information Bus	Cheltenham, outside Marks & Spencer	10:00am – 3:00pm
Sunday 8th September	Information Bus	Frampton Country Show	9:00am – 6:00pm
Monday 9th September	Information Bus	Tewkesbury, Morrisons	10:00am – 3:00pm
Wednesday 11th September	Information Bus	Cirencester, Market Place	10:00am – 3:00pm
Thursday 12th September	Information Bus	Moreton-in-Marsh, Town centre	10:00am – 3:00pm
Thursday 12th September	Stand (GHT AMM)	Cheltenham, Sandford Education Centre	4:30pm – 7:30pm
Thursday 12th September	Stand	Sedbury	4:30pm – 7:30pm

Information Bus Visits and Exhibition Stands Activity also includes focus on engagement for *A New Community Hospital for the Forest of Dean*			
Date	**Event and number of**	**Venue**	**Time of Event**
Friday 13th September	Stand	Coleford, The Main Place,	4:00pm – 7:00pm
Saturday 14th September	Information Bus (Pride in the park)	Gloucester Park	11:00am – 7:00pm
Saturday 14th September	Stand (Tetbury Hospital Open Day)	Tetbury Hospital	10:00am – 4:00pm
Monday 16th September	Information Bus	Dursley, Town centre	10:00am – 3:00pm
Wednesday 18th September	Stand	Cinderford, Co-Op	10:00am – 2:00pm
Friday 20th September	Information Bus	Stow-on-the-Wold, Market Square	10:00am – 3:00pm
Saturday 21st September	Information Bus	Cheltenham, outside M&S	10:00am – 3:00pm
Saturday 21st September	Stand	Lydney, Tesco	10:00am – 2:00pm
Friday 27th September	Information Bus (with Dementia Alliance)	Coleford, Berry Hill Rugby Club	10:00am – 3:00pm
Friday 27th September	Stand	Newent, Library	4:00pm – 7:00pm
Thursday 3rd October	Stand/Drop In	Sedbury	16.00 – 19.00

Independently Facilitated Workshops / Activities Activity also includes focus on engagement for *A New Community Hospital for the Forest of Dean*			
Date	**Event**	**Venue**	**Time of Event**
Thursday 1st August	Community Urgent Care	University of Gloucestershire	12.30 – 17.30
Wednesday 21st August	General Surgery	University of Gloucestershire	15.00 – 19.00
Wednesday 2nd October	Image Guided Interventional Surgery	University of Gloucestershire	9.00 – 13.00
Friday 4th October	Acute and Emergency Medicine	University of Gloucestershire	14.00 – 18.00

Tuesday 8th October	Gloucester, Community Urgent Care	Churchdown Community Centre	10-12.30
Tuesday 8th October	Cheltenham, Community Urgent Care	Churchdown Community Centre	14.00 – 17.00
Friday 11th October	Patient Participation Group Network, Community Urgent Care	Churchdown Community Centre	10-12.30
Tuesday 15th October	North Cotswolds, Community Urgent Care	Cirencester Football Club	9.00 – 12.00
Tuesday 15th October	South Cotswolds, Community Urgent Care	Cirencester Football Club	14.00 – 17.00
Wednesday 16th October	Forest of Dean, Community Urgent Care	Coleford, Forest Hill Golf Club	9.00 – 14.00
Wednesday 16th October	Tewkesbury, Community Urgent Care	Highnam, Community Centre	14.30 – 17.30
Thursday 17th October	Stroud and Berkley Vale, Community Urgent Care	Nailsworth, Town Hall	9.00 – 12.00
Thursday 24th October	Engagement Hearing	Brockworth, The Chase Hotel	11.30 start

Pride in the Park, Gloucester – 14 September 2019

Winchcombe Show: 26 August 2019

Other Events **Activity also includes focus on engagement for *A New Community Hospital for the Forest of Dean***			
Date	**Event**	**Venue**	**Time of Event**
Tuesday 3rd September	Forest Health Forum	Bream Community Centre	19.00 start
Monday 9th September	Cheltenham Borough Council Scrutiny Committee	Cheltenham Borough Council	18.00 start
Tuesday 10th September	Health Overview and Scrutiny Committee	Gloucester, Shire Hall	10.00 start
Tuesday 10th September	Research 4 Gloucestershire, Research Matters Conference	University of Gloucestershire	16.00 start
Thursday 12th September	GHNHSFT Annual Members' meeting	Cheltenham, Sandford Education Centre	18.00 start
Thursday 19th September	Forest of Dean Locality Reference Group	Coleford, Great Oaks Hospital	14.00 – 17.00

Date	Event	Venue	Time of Event
Thursday 3rd October	Clinical Commissioning Annual Event – general surgery, community urgent care and emergency and acute medicine GP workshops	Cheltenham Racecourse	14.00 start
Tuesday 8th October	Cinderford Town Council	Cinderford	19.30 start
Tuesday 15th October	Coleford Town Council meeting	Coleford	19.30 start
Monday 21st October	District Members' Seminar, Tewkesbury Borough Council	Tewkesbury	18.00 start
Tuesday 22nd October	Stroud District Council, Members Seminar	Stroud	19.00 start
Wednesday 23rd October	Cotswolds District Council, Members Seminar	Cirencester	12.45 start
Monday 28th October	Gloucester City and Gloucestershire County Council, Joint Members Seminar	Gloucester	16.00 start

More than 3,300 face-to-face contacts have been made during the FFTF Engagement period.

5.1. Themes from feedback collected at Information Bus Visits and Exhibition Stands

Date and type of Event	Number of visitors[5]	Venue	Key feedback
Thursday 22nd August Information Bus	45	Gloucester, The Cross	Concerns regarding siting of FoD Hospital in Cinderford. Don't downgrade A&E in Cheltenham, GRH won't be able to cope with extra patients. Individual PALS enquiries.
Friday 23rd August Information Bus 	65	Clock Tower roundabout, Coleford	Keeping two hospitals in FoD. Don't reduce the number of beds in FoD – 24 not enough. Access poor to Cinderford, especially public transport. Don't privatise the NHS.
Monday 26th August Winchcombe country Show – Information bus	70	Winchcombe School	Don't close Cheltenham A&E.
Tuesday 27th August Information Bus	95	Cheltenham Town Centre, Outside Marks & Spencer	Don't close Cheltenham A&E.
Thursday 29th August Information Bus	60	Stroud, Tesco	Don't close Cheltenham A&E. Stop NHS Cuts. Individual PALS Enquiries.
Saturday 31st August Information Bus 	45	Cinderford, Co-Op	New hospital - positive about being able to access outpatients, diagnostics, urgent care and inpatient beds in FoD. Long waiting times at GRH/transport and access concerns. Keep two hospitals in FoD/keep the NHS Public
Monday 2nd September Information Bus	65	Gloucester, The Cross	CGH A&E closure/some concerns re: insufficient capacity at GRH/individual patient concerns. Some individual PALS enquiries.

[5] Due to the nature of public drop in engagement events, attendees' numbers have been rounded down to the nearest 0 or 5 to reflect that some attendees may not have participated in the FFTF engagement. For example some visitors to the NHS Information Bus may have visited to access non FFTF related information or advice.

Date and type of Event	Number of visitors[5]	Venue	Key feedback
Wednesday 4th September Information Bus 	50	Newent, Market Place	Majority positive about new hospital in FoD. Some concerns re: transport to Cinderford /long waits for urgent care, confusion re: opening times at CGH and GRH/ long waits for GP appointments.
Wednesday 4th September Stand (Military Fresher's Fayre)		Imjin Barracks	(Event shared with Maternity Voices). Lengthy discussions re: maternity services/ promotion of FFTF engagement
Friday 6th September Information Bus 	45	Lydney, Newerne St carpark	Services needed in Lydney area, unhappy about Cinderford as location for new hospital.
Saturday 7th September Information Bus	205	Cheltenham, outside Marks & Spencer	Don't close A&E in Cheltenham/confusion over whether it is going to close or not – impact on GRH (demand) Important to keep urgent care 24/7 walk in service in Cheltenham (and Gloucester) Happy to travel further for specialist care/want to see the most experienced staff even if further away/support for direction of travel Awareness of service availability important e.g. Cheltenham at night Praise for NHS – ED staff, consultants, ambulance service, pharmacists Limited negative feedback on services - NHS 111 is not at all helpful/nursing staff on some of the wards – not caring Don't privatise the NHS Access and transport – e.g. important to keep 24/7 urgent care access for people who don't drive and can't afford a taxi. Transport back from ED/visiting patients – 99 bus not going from the racecourse anymore is a problem Significant number of PALS referrals More information would be good on why separate planned/emergency care People need to take responsibility for their own health.

Date and type of Event	Number of visitors[5]	Venue	Key feedback
Sunday 8th September Information Bus	55	Frampton Country Show	Mostly low awareness of FFTF. Many out of county visitors due to location and nature of the event.
Monday 9th September Information Bus	90	Tewkesbury, Morrisons	Positive feedback about the NHS generally e.g. GP services in Tewkesbury. Levels of staff engagement/information available e.g. staff at GRH. Perception of continuing 'service downgrades' at Tewkesbury Hospital e.g. beds/x-ray.
Wednesday 11th September Information Bus	80	Cirencester, Market Place	Ambulance Service – concern over reliability/ speed. Some positive comments about idea/potential for GP led walk in services.
Thursday 12th September Information Bus	25	Moreton-in-Marsh, Town centre	Some concern over future of radiology service/ access (x-ray) Low awareness level of FFTF
Thursday 12th September Stand (GHT AGM)	90	Cheltenham, Sandford Education Centre	What potential changes might mean in relation to A&E in Cheltenham.
Thursday 12th September Stand 	5	Sedbury	Don't close Lydney hospital. We need more hospital beds - 24 is not enough. No public transport to Cinderford from Sedbury.
Friday 13th September Stand 	5	Coleford, The Main Place,	Concerns re number of beds in new community hospital in FoD. Poor community transport in FoD.
Saturday 14th September Information Bus (Pride in the park)	10	Gloucester Park	FFTF Awareness Raising.
Saturday 14th September Stand (Tetbury Hospital Open Day)	20	Tetbury Hospital	Tetbury MIU service greatly valued. Interest in future urgent care provision e.g. UTC

Date and type of Event	Number of visitors[5]	Venue	Key feedback
Monday 16th September Information Bus	35	Dursley, Town centre	Concern re: 'Loss' of beds to stroke unit. Support for MIIU provision. Concern over x-ray provision/long waits. Some concern over access to GP appointments
Wednesday 18th September Stand	85	Cinderford, Co-Op	Mixed views re: new hospital. Call for maternity provision. Future of the Dilke site. Pressure on SWAST/waiting times for ambulances in the Forest of Dean. *Quality of discharge from GRH (multiple venues)
Friday 20th September Information Bus	20	Stow-on-the-Wold, Market Square	Don't close A&E in Cheltenham. GRH has too much pressure already. Put services in to community hospitals to all MIU's to do more and stop people going to A&E. Relieve paramedics more quickly when they have delivered someone to A&E. Better public transport links to the hospitals from the villages. Waiting time for hip replacement. Waits to see GP is too long even if you don't mind which GP you see. Put NHS dentists into community hospitals or GP practices. Hospitals should establish a volunteer driver scheme. Consider a mobile primary care centre similar to the mobile chemotherapy lorry.
Saturday 21st September Information Bus	120	Cheltenham, outside M&S	Don't close A&E in Cheltenham, GRH has too much pressure already. Resource community hospitals to allow MIIU's to do more and stop people going to A&E. Relieve paramedics more quickly when they have delivered someone to A&E. Call for better public transport links to the hospitals from the villages. Wait to see GP is too long, even if you don't mind which GP you see.

Date and type of Event	Number of visitors[5]	Venue	Key feedback
Saturday 21st September Stand 	315	Lydney, Tesco	Don't close Lydney hospital. We need more hospital beds - 24 is not enough. No public transport to Cinderford from Lydney and south of the Forest of Dean. What will happen to Lydney hospital? Some people were positive about the new hospital and recognised that their current facilities were not up-to-date.
Friday 27th September Information Bus (with Dementia Alliance) 	15	Coleford, Berry Hill Rugby Club	24 inpatient beds will not be enough given the growing population. We need End of Life Care in our Community Hospital - support to die at home is good, but this is not an option for everyone. We need to consider patients already in hospital too, who deteriorate and cannot be moved.
Friday 27th September Stand 	5	Newent, Library	Positive about the new hospital. Some interest in being involved in the future.
Thursday 3rd October Stand/Drop In 	20	Sedbury	Don't close Lydney hospital. We need more hospital beds - 24 is not enough. No public transport to Cinderford from Sedbury. Dial a ride does not cover that area. Public transport to Gloucester also not good. Distance to travel to Cinderford, in particular concern over access to urgent care. Access to community services on both sides of the border.

6. Targeted engagement August-October 2019

6.1. Clinical Commissioning Annual Event – general surgery, community urgent care and emergency and acute medicine GP workshops

The Annual GP Commissioning Event provided an opportunity for GPs from the across Gloucestershire to come together to participate in the FFTF Engagement.

Key themes and questions from the feedback from GPs from this event are as follows:

6.1.1. Community Urgent Care

This workshop brought together GPs from several districts, both rural and urban, across Gloucestershire. Participants were invited to think about issues and opportunities in relation to current community urgent care services.

Stroud

- Problem not looked at in the round.
- Community hospitals provide a good service
- Receptionist covers Minor Illness and Injury Unit (MIIU) and Outpatient Department
- Stroud MIIU manages ok 1 nurse
- 70% increase in GP appointments over a 12 month period. Not sure about the GP resilience if asked to take on minor injury cover.
- GP's are a free service – until it changes we will continue to experience problems.

Gloucester

- Potential impact of direct bookings from 111 – call back would be helpful.
- Better marketing of NHS 111 – GP in hours, 111 out of hours
- Very strong view to redirect away from Acute.
- What else is on offer for high risk patients? We see the Friday phenomenon for high risk patients.
- Support for high intensity patients.

Cheltenham

- GP practices already provide some provision for MII.
- The average GP in Cheltenham sees minor urgent illness as GP responsibility.
- 111 and paramedics with a lower threshold but GP's have no spare capacity to take patient referrals from them.
- Seen an increase in GP day to day workload in urgent care.
- Spare capacity – a proportion of patients who are triaged and seen are not urgent but you don't know until you see. Pharmacists are not always managing referrals to primary care appropriately.
- System needs to clarify what services are provided within the county as we don't know at any given time (MIIU provision)
- There needs to be more collaboration and better use of services/ resources in the system.

Cotswolds

- Managing patients with frailty is challenging.
- We would struggle without an MIIU resource in the North Cotswolds.
- Look to combine improved access to GP services with MIIU.
- Move some demand to practice based (MIIU).

- Some patients wouldn't travel far to access urgent care services.
- Suggest 70/30 split between practice and MIIU for minor illness and injury

6.1.2. Emergency and Acute Medicine

The Emergency and Acute Medicine and General Surgery workshops used a Question and Answer and comments format.

The following questions were asked and answers and comments recorded:

In relation to PCI's where do patients currently go if they live in Worcester, Hereford or Swindon?	*They go to Bristol or Birmingham*
How old is the equipment in the Cath lab at Cheltenham General Hospital?	*It is very old and is on the risk register*
Worried about having a site without critical care or general surgery	*CGH a more acute site/ Vascular at CGH so would maintain critical care*
SWAST ambulance cover is not enough for Gloucestershire – significant waits for an ambulance - are they included in these discussions?	
It appears the specialists are spread too thinly. Need to make the two sites distinctive. Why is there this problem?	*Combination of National Standards* *4 hour target* *Aging population* *Expectations of patients* *Victims of own success due to bringing in work from Worcestershire, Herefordshire and Swindon.*

6.1.3. General Surgery

In terms of the increase in numbers, what is driving this?	*There is no single driver for the increase in numbers coming through. The increase could, for the most part, be attributed to the volume of patients coming through from A&E; the way that A&E is staffed; and the time-pressures on A&E. All of which has resulted in a large number of patients coming through to General Surgery with undiagnosed pain. General Surgery has been providing a greater level of support to A&E. In general the number and quality of GP referrals has not been an issue. The population changes over the years has had an impact too, including an aging population and an increase in obesity rates, which coincides with an increase in Gall Bladder issues.*
With regards to the Surgical Assessment Unit (SAU), are they only coming through from ED (A&E) or are there clinics which can be directly referred to in addition to this?	*There are currently no General Surgery 'Hot Clinics' running, as these cannot be staffed in the current service configuration. [If Emergency General Surgery was centralised to one site, this would enable running a daily emergency surgical clinic].*

Going back to the scenario presented around having a gall bladder removed, how would that be different with the proposal [to centralise emergencies]?	*There are currently two on call teams: one based at Cheltenham General Hospital and the other in Gloucestershire Royal Hospital. If these could be combined onto one site, it would enable a sub-speciality rota. This means that there would always be an Upper GI and a Lower GI (Colorectal) consultant on call. The on-call consultants are freed up from their elective commitments to deal with the emergencies and have access to the operating theatre 24/7 for that week.*
Is there a reason why a patient would be transferred across [between sites]?	*If an emergency patient presented to the site where the on call team were not physically located (i.e. they self-presented to the ED, not via 999 ambulance), and they were stable enough to travel, they would be transferred to the other site.*
What had been highlighted within the presentation were the nuances of what was important, and what the benefits were of having a two consultant rota. It might be easier for medical colleagues to understand the staffing challenges	*This presentation has been delivered to the general public and they understood the staffing challenges. They were asked if they would prefer 'high quality, safe care' or 'care closer to home' and a quarter of the room still answered 'care closer to home'.*
It could be argued that all GI surgeons would provide high quality and safe care. It is assumed that a patient would want to come under the sub-specialist who is the expert of the particular condition. This is a challenging concept to portray to the public	*There are workforce challenges and the presentation shows this. What is not yet understood is 'where is the alternative workforce' other than the trainees, i.e. physicians assistants, overseas doctors etc. The 'alternative' workforce options have been considered, initially by looking into recruitment of Advanced Nurse Practitioners, however, although you can train ANPs or Physician Associates to diagnose deteriorating patients, they cannot operate….only surgeons can. There have been a number of advertisements for surgeons (approximately five) over the last two years and these have not been successful. The streamlining of the training pathway has meant that there is a reduced number of trainees choosing to specialise in surgery.*
What happens in CGH without an SAU?	*The same process as what used to happen in GRH. The patient would be admitted to a surgical ward. The big difference is that a ward admission would mean the patient is admitted for at least 24 hours, however the SAU is more ambulatory based and patients would be seen, assessed and a plan would be made. If the patient is well enough to go home they can be discharged home, with a plan. This supports flow through the hospital.*
Are you counting the 'ones' that, with the change in pathway, would've gone through A&E? What	*Answer unknown*

percentage of the increase is the change of the ones that would've gone through Utopia?	
'Three out of ten' [of emergency presentations] are for suspected gallstones. What about the other seven out of ten? Are there other examples?	*Most common presentations are for acute abdominal pain, which includes biliary disease and appendicitis.*
It was highlighted by a member of the audience that a number of people/general public and other healthcare professionals may not understand that the operations require different surgeons [lack of understanding of the variances between upper/lower GI surgeon].	
It was queried about what the difference would be/mean between moving between Cheltenham and Gloucester?	*Note that they are not far apart.* *It depends what goes where and elective services are part of the solution discussions, not just emergency general surgery [and they are connected].* *The Upper GI surgeons are keen for their major resectional work to be located on the same site as the emergencies. Other views are that a separate elective service not located with emergencies would provide a better environment and fewer cancellations; this option however involves additional staffing challenges.*

6.2. Independently facilitated workshops

Round table discussions about 'what matters to you' at one of the engagement workshops

A series of independently facilitated workshops were held between August and October 2019. Each workshop focussed on a specific topic.

The first group of four workshops considered countywide issues and collected countywide perspectives: Community Urgent Care, General Surgery, Image Guided Interventional Surgery, Acute and Emergency Medicine.

The second group of eight workshops focussed on Community Urgent Care but from a locality perspective.

The Locality Workshop held in the Forest of Dean also considered the development of the new hospital for the Forest of Dean.

An objective of the workshops was to achieve discussions in a *balanced room* in which the opinions of neither professionals nor lay participants were allowed to dominate.

To achieve this balance, Inclusion Gloucestershire (a local user-led organisation whose aim is to reduce health inequalities) acted as the independent agency recruiting members of the public as experts in their own lives to provide the required balance of opinion in discussions with NHS clinicians and professionals.

Inclusion Gloucestershire prepared Report for NHS One Gloucestershire Engagement Workshops - 1st August – 17th October 2019. This can be found in full at Appendix 1.

Through promoting the workshops, Inclusion Gloucestershire recruited 45 individuals to attend the workshops, some of whom attended more than one workshop depending on their experience relating to the topics. Characteristic groups relating to those who attended the workshops were as follows:

- Age – including a young carer
- Disability – physical disability, Autism and learning disabilities
- Race – individuals from different BME communities
- Religion or belief
- Substance misuse
- Sexual orientation
- Those who are socially isolated

All 12 workshops considered the question ‘what is important to you’ to assist with the development of **evaluation criteria** for potential solutions. A facilitated group exercise at each workshop explored the areas of relative and most importance providing an important step in developing selection criteria for use in any further decision-making processes following this initial engagement phase. A set of ‘draft’ evaluation criteria was shared with workshop participant to promote these discussions. As part of a dynamic and responsive engagement process, following feedback received at the first workshop, the ‘draft’ criteria were adapted for subsequent workshops discussions.

Below is a summary of the outcomes of the independently facilitated workshops. Full independent reports of all workshops can be found at Appendix 3.

Feeding back at one of the workshops

Round table discussions at the Stroud and Berkley Vale workshop in Nailsworth

6.2.1. General Surgery

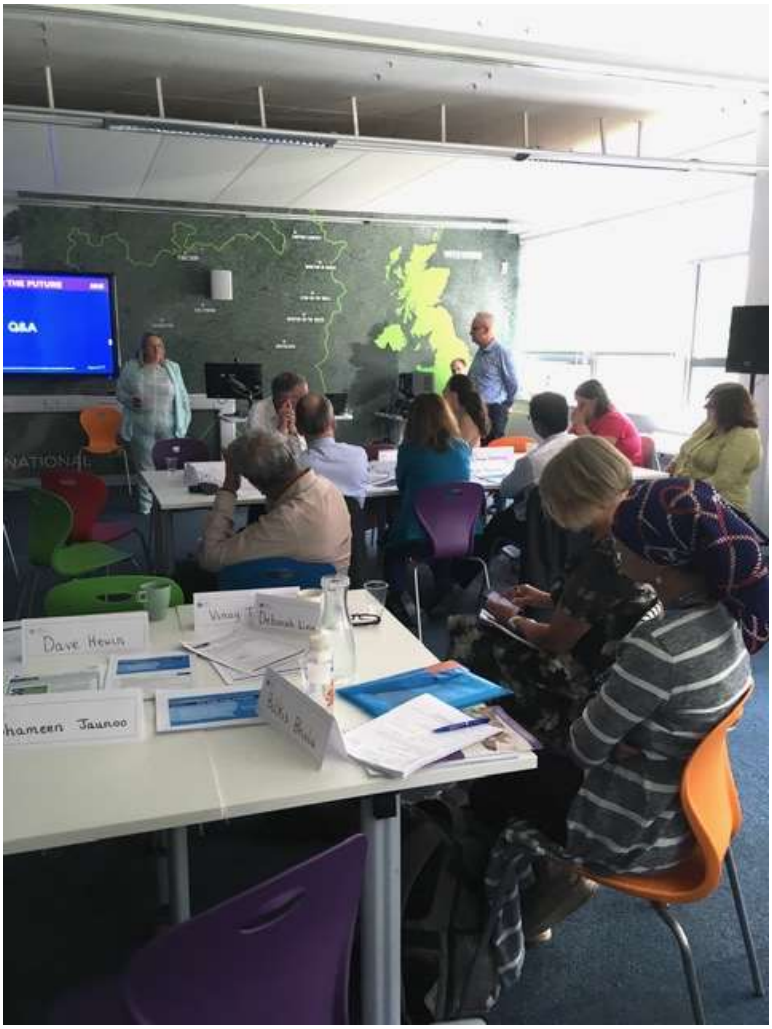
Extracts from Independent Report:

What are your first impressions of the issues?

- Concern over the length of time patients wait for planned surgery
- More could be done about making jobs in Gloucestershire more attractive for sub-specialists within General Surgery
- Improvement should be balanced between elective and emergency surgery.
- If children's services are all at Gloucester, how does this impact other areas in the county?
- Will the proposed changes improve the services and the experiences of the patients?
- A lot of logistics to overcome
- The lack of buses and transport is not clearly addressed
- Not enough experienced staff in the system
- Are two sites a positive or a negative for the delivery of general surgery in Gloucestershire?

Is there anything that is missing or hasn't been considered?

- There are three different services: planned, day case (no inpatient (overnight) beds required) and emergency; are the support services available for each of these, such as radiology?
- Are IT/technology issues being considered?
- The choice between quality and convenience. It remained a discussion without resolution, but there was a strong leaning towards a preference for quality services even if that involved travelling.
- Consideration of the ways in which any future changes can help people on low income in terms of transport and access, including carers
- To make informed decisions on any proposed changes the inclusion of clinical details are important to understand the issues
- The role of different staff, aside from consultants, to help with the issues identified
- No information on demand. Is it going up? Will there be a growth in demand through, for instance, an ageing population?
- Discharge information to help reduce re-admissions/re-referral.



General Surgery Workshop: 21 August 2019

Was there anything in the presentation that prevented your understanding of the issues?

- Complicated questions that in themselves are difficult to understand
- …we don't know what we don't know.
- Lack of public understanding of job roles, for instance the stages in a doctors training
- Lack of explanation of which services are located at each hospital and the future plans for the use of the space available
- Lack of information on the opportunities for expansion of the sites, e.g. parking/what is at each site.
- …we do not know the demand of the services in the years to come.
- To aid understanding, examples of good practice or different approaches from other areas (hospitals) would be useful.

Summary of Views on Relative Importance – appraisal criteria

First impression of the draft criteria

- To be seen rapidly by an appropriate decision maker
- Access to the right team and surgeon, how they are accessed and being able to access them for both planned and emergency operations is also very important. Including consideration of access for patients who do not have their own car.
- Being kept informed
- Personalised care with a responsible care coordinator.

What else should be considered?

- Success: Need to be able to plan for success through agreed changes and ensure the system is right.
- Good will of staff: At the moment the system is surviving on good will, which is not sustainable.
- Best use of resources
- National Policy: The national policy that there might be fewer general surgeons as a result of focusing on encouraging GP trainees
- The 'Granny Principle': The need to educate people about prevention and management of their own health care
- Quality or convenience? The balance between quality and convenience can tip, dependent on the urgency of the situation
- Options for quality of life beyond medical
- Expertise and a correct diagnosis.
- Subsidy for transport
- The choice a person may wish to make – listening up as opposed to speaking up.
- Short waiting list
- Communication that works. Not everyone has the internet and leaflets are not always the best way to access information.
- Open culture where staff feel supported if mistakes are made
- Welcome and support patients who are anxious – Don't want to be a nuisance. (prevention)
- That the best surgeon and care is available for both elective and emergency surgery. Equipment availability is also important, again at the right time in the right place.
- That planned care, both inpatient and day case, should be reliable and predictable.
- That the right team and surgeon is in place to be able to deal effectively with both elective and emergency surgery.
- Staff – happy/not tired/not overstretched/fewer locums.
- Beds availability – How to ensure enough in one place.
- That discharge is improved.
- Right service, right time.

Which of these is most important?

- Quality of care of care for the patient has to be first and most important factor over time and cost.
- Choices.
- An environment that provides support for staff and patients families and particularly vulnerable groups.
- Access to expertise/quality.
- Share your knowledge.
- In an emergency it is important that patients get all the services and support as those receiving planned care.
- Important that people are seen ASAP.

6.2.2. Image Guided Interventional Surgery

Extracts from Independent Report

In response to the guide question …*what are your first impressions of the issues*? the groups identified the following themes:

- Surprise and shock at the explanation of the current situation (patients having to go out of county for treatment.
- Real and perceived service disparities.
- Why aren't we doing this already?
- Workforce frustration

In response to the guide question …*is there anything that is missing or hasn't been considered?* the groups identified the following themes:

- Relevant data and information (e.g. what happens in other areas, patient stories)
- Transport/Logistics
- Workforce issues
- Political and stakeholder consensus
- Finance and sustainability (investment required)
- Reorganisation/service change in IGIS is not a standalone event
- The benefits of IGIS to patients

What else would work well?

- Don't take too long to implement changes
- One centre, in one hospital, for all of Gloucestershire

Preventing understanding of the issues?

- Message / presentation may need adaptation to aid understanding


Summary of Views on Relative Importance – appraisal criteria.

First impression of the draft criteria

- Too broad, abstract, wordy and use too much jargon
- Too many criteria?
- Weighting the criteria is important, which has the most value to decision making?
- Quality and accessibility are key drivers, but they are not the same thing

What is important?

- Workforce issues are fully considered in any potential solution
- Solutions should place the needs and interests of the patients at the fore
- Solutions must be efficient
- Solutions must be safe and sustainable
- Solutions should ensure timely and quality treatment
- Solutions should consider integration with other services, providers and partners
- Solutions should include communications and awareness mechanisms that are simple and easily understood

6.2.3. Emergency and Acute Medicine

Extracts from Independent Report:

In response to the guide question …*what are your first impressions of the issues?* the groups identified the following themes:

Confusion

- This is an extremely complex issue. It is easy to become overwhelmed with the information presented. Simple messages are hard to formulate for a complex issue.
- There was a large amount of information presented – possibly too much attempted to be communicated. The language used is important if this is to be understood by a wider audience
- The current situation is confusing for patients
- The issue of patients going out of county wasn't commonly understood.
- The language used is confusing, even departmental titles are not clear and interchangeable in some cases.

Sustainability

- It is clear that the system can't throw money at it; there are limits to the finances available to the NHS to address this issues.
- Not sustainable as it is, and the system is going to have to change.
- No more money: no possibility of finding new staff to fill roles: need to make the best of what we have bearing in mind the increase in volume of patients

Workforce Issues

- What can we do with the staff we have? The service is good already but there is lots of pressure, can innovative solutions be found?
- There is more to it than workforce: it's how good the system can be. Meeting system

targets 90% of the time, but how could we achieve 95%?
- It is important to maintain a critical mass of type/volume of patients. Failure to do so impacts on the skill mix.

Access

- Access to information; access to services; equality and equity
- Local access is important to patients

In response to the guide question …*is there anything that is missing or hasn't been considered?* the groups identified the following themes:

Data required to support detailed understanding

- Data is needed around the impact on ambulance service versus patient outcomes.
- Data showing the volume of patients Cheltenham General Hospital currently see. We get the message Cheltenham General Hospital is not closed overnight, but it would be useful to see what the Emergency Nurse Practitioners do between 8pm-8am.
- An understanding of the impact on the discharge service, for instance when patients come in by ambulance and are subsequently discharged forty miles away from their home.
- Understanding of the number/impact of inter hospital transfers
- Transparency about finance to establish the aim of providing the best resource in one central location. not trying to disadvantage one half of the county.
- The interlink with Minor Illness and Injury Units. The performance of these is supporting achievement of the system target and would be helpful to see the breakdown by site.
- Legal requirement for reasonable adjustment.
- A clear description of pathways and protocols.
- Consideration of the impact of travel / transport.
- System challenges, such as no GP appointments.

Ensuring mental health is considered and built into the system

- Improving mental health responses
- Locating mental health provision on both sites.

A focus on what works now, not just the challenges

- Consideration/recognition of the skills and commitment of the existing team;
- There needs to be more of a celebration of what is provided
- Same site gives good triage;

More work needed to set out the issues

- A clear presentation
- Too many acronyms.

Creating/Sending the Right Message

- Promotion of the self-care message.
- How well is the message getting across with regard to the difference between urgent and emergency care?
- Consistency of message re Minor Illness and Injury Units;

Potential Solutions

- Consideration of co-located services: one option could provision of a one door approach to access ED/AMIA/GP;
- Minor Illness and Injury Units in Cheltenham General Hospital and Emergency Department in Gloucester Royal Hospital, has this been considered?

Designing new solutions

- Emphasis should be on getting the care provided properly
- Get it right first time in the right place
- How much should the public be involved?
- Physical facilities are limiting to best patient flow.

Supporting the Ambulance Service

Non-local ambulances e.g. from Bristol are not necessarily aware of where to go.

Concern of the accuracy/ability to use the Manchester Triage system particularly around mental health emergencies. In Gloucester Royal Hospital and Cheltenham General Hospital there is a modified triage system for mental health patients, but this is not used by South West Ambulance Service Trust.

In response to the guide question …*in your opinion, what else do you think will work well?* the groups identified the following themes:

Transport

- More patient transport, emergency ambulances.
- Concern for visiting relatives, have transport links been considered?

Mental health and social services linkages

- Streamlining mental health services
- Is social care and mental health factored in, and will they be improved?
- Links with mental health teams: how can these patients be managed better (Core 24)

Workforce issues

- Protecting staff (retention)
- Site rotations for staff (busy vs less busy department)

A fresh start

- Ideally, we would build a brand-new hospital: however, this would not facilitate the separation of Emergency and Acute from elective services
- Supporting the Ambulance Service
- Will there be an effect on the ambulance service if emergency services focused on one site?

In response to the guide question …*was there anything in the presentation that prevented your understanding of the issues?* the groups identified the following themes:

Language and presentation

- The use of abbreviations and medical language:
- Definitions of the differences between AEC/AMIA (different functions) and

ACUC/AMU (same function, different names.)

- The slides in the presentation were very densely populated which made it hard to follow/understand.

Making it real

- The lack of case studies to make the presentation and descriptions related to real life experience.
- Heart attack example: Gloucester Royal Hospital was cited but not mentioned that patients can go to Cheltenham General Hospital as well.
- Transport
- Need to know about the availability of public transport between Gloucester Royal Hospital and Cheltenham General Hospital
- Details of any travel impact assessments

In response to the guide question …*what is important to you?* the groups identified the following themes in determining the criteria important to them:

Solutions must include actions to ensure the public is aware of any changes made and how it will affect them:

- Criteria for helping in raising awareness, easy to read and understand and accessible to all. Need to identify the key messages to the public

Solutions must provide a safe and appropriate environment:

- Service has to be safe.
- An environment appropriate to the level of care.
- Safe service – patient safety and personal safety.
- Quality of service
- Providing an excellent service where patients don't mind travel times.
- Patient safety:
- Right care, but this needs to be defined;
- Best quality, again needs defining;
- Access; and
- Easily manageable.

Solutions should be designed to signpost people to the appropriate service:

- Signposting to service: can be confusing so needs to be the same on both sites
- Clear communication when you get there, i.e. where to go
- Connections to other services

Workforce issues are fully considered in any potential solution:

- Needs to help attract and retain staff.
- Staff are well trained and do their jobs well.
- Experts are needed.
- Staff feedback.
- Retention / job satisfaction

Solutions are accessible to all:

- Good quality and accessible treatment.
- Seen by right specialist at the right time.

- The time taken to be seen.
- Equity - ensuring all in Gloucestershire have equal:
    - Health outcomes; and
    - Access

Travel and transport issues must be fully considered in any solution:

- Travel and transport links for patients and carers
- Transport issues are considered. Choices are limited for the most vulnerable and those who live rurally.

Criteria for decision making and service delivery must be measurable:

- Measurability of success – indicators established and new

Financial sustainability is addressed in any solution:

- Feasibility / affordability in terms of:
    - Workforce
    - Sustainability
    - Acceptability / retention, recruitment
    - Work/life balance
- Financial implications and affordability
- Sustainability

The solution has given adequate consideration to the future demands:

- Innovation / future proofing / quality
- Is / has the problem been identified.

Solutions consider all the associated risks in any solution:

- Consideration is given to the risks of doing nothing
    - Expensive?
    - Care may not be best care; way delivered, who delivers?
    - Ability to recruit will not change.
    - Does not address rising demand?
    - Compromise to patient safety?

Consideration of the risk level in any possible solution:

- Is it equal to the existing service (better or worse?)
- How do we measure this?
- How have acceptable levels of risk been set?
- Impact on others – engagement with other providers e.g. transport.
- Firefighting now – stops the ability to look to the future and innovative ideas.
- Resilience – if one site only is offered.

In response to the guide question …*what is your first impression of the draft criteria?* the groups identified the following themes:

The draft criteria are too complex:

- Overall the language used is poor.
- Simplicity is important, the criteria need to be easy to understand and navigate. For instance, in Criteria 4 how will protected characteristics / equalities be taken into account?

Merging criteria:

- Criteria 2 Supports sustainable ways of working and Criteria 7 should be merged together.
- In our opinion criteria 5 and 6 should be merged as there is a strategic fit between them.

Criteria 2:

- Criteria 2: what does 'sustainable' mean? Is it referring to a financial, environmental or some other definition?
- In terms of sustainability activity is only going to increase
- Criteria 2 should focus on workforce issues.

Criteria 3:

- Criteria 3: Isn't acceptability across the whole of engagement. So it shouldn't be part of the criteria it's so subjective and political. We recommend taking out this criteria from consideration.

Criteria 6:

- Criteria 6: do we need it at all?

Criteria 7:

- For Criteria 7, our key question is how will this be measured?

Criteria 8:

- Criteria 8: setting a realistic timescale is important.
- Criteria 8: there needs to be consideration of timing/timescales and what's reasonable.

Acceptable draft criteria:

- In our opinion criteria 1, 3, 4, and 8 are 'ticked' as being fit for purpose.

Views on the relative importance of the draft criteria:

- Of the draft criteria the group felt 1 and 4 are two of the most important:
- Quality of outcomes; and
- Accessibility

Conclusions - Emergency and Acute Medicine

Consistent themes for consideration with other workshops in the Fit for the Future engagement were:

The importance of considering transport in any future solutions:

- Transport issues, including the potential to further isolate vulnerable and rural residents, should not be overlooked in any future proposals including consideration of:
    - 999 ambulances;
    - Transfer between hospitals;
    - Patients attending and returning home from a service;
    - Relatives, loved ones, and friends attending and returning home.

Communications:

- Clear and consistent communications between patients and staff and between departments is crucial in any solution.

Providing sufficient information:

- There is a need for further data and information to be available to inform decision making in developing future solutions in any further engagement.

Navigating the range of services needs to be clear and simple:

- What a service can provide needs to be clear; and
- Navigating the range of services needs to be simple.
- This calls for liaison, close relationships, and 'ownership' of patient needs between departments.

Workforce issues need to recognised:

- Solutions need to make best use of current staff; and
- Recognise that there are limited resources available.

Mental health care:

- Mental health provision needs to be given appropriate priority

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6.2.4. Community Urgent Care, Countywide

Patient Participation Group Countywide Network: 11 October 2019

Extracts from Independent Report:

In response to the question: …*what are your first impressions of the issues?*

- The current community urgent care is very confusing for patients and staff to navigate
- Patients only want to explain their condition once, but they have to repeat it again and again, every time someone new comes into the room.
- The presentation and documentation is a good start in explaining community urgent care, but more work is needed to make it accessible and understandable to all.
- The role of self-care and prevention do not appear to be considered effectively in the presentation or documentation.
- People are not clear on the difference between urgent and emergency care
- The issues are widespread and complex
- There are inequalities in the current community urgent care system in terms of geography and demographics across Gloucestershire
- There is a very real concern over the future of the Emergency Department in Cheltenham
- Failure to address language and cultural issue is increasing inequity of access to community urgent care for groups in Gloucestershire
- Lack of confidence in the 111 service based on previous poor experiences limiting the effectiveness of the services as the first point of call for community urgent care
- The system is under unsustainable pressure and change is needed in community urgent care:
- The system puts too much emphasis on the patient to know where to go. There appears to be 'patient blaming' for system failings:
- Mental health, particularly crisis, doesn't seem to be included in the thinking on community urgent care.

- To some extent the NHS and the Emergency Department is the victim of its own success
- There is a need for a clear and concise communication/education approach to support people in making the right choices for community urgent care
- Inconsistency in the times of service delivery, in some areas it's 24/7 in others not
- Workforce issues are complicated and impact on national staffing levels not just in Gloucestershire
- Transport issues are not considered, which have a major impact on the ability of many people in Gloucestershire to access community urgent care services
- There are issues with the availability and location of equipment to support the delivery of community urgent care
- Do GP practices have the capacity to play the major role that is required of them in the future community urgent care system?
- There seems to be little consideration of the impact of the changes in community urgent care in Gloucestershire on surrounding areas and vice versa
- There seems to be little consideration of integration with other services, particularly social services, to ensure community urgent care is more effective.
- There is no discussion of the financial implications of the current situation, any future proposals and the budget available to address community urgent care for the future
- There are specific issues related to the Forest of Dean and the provision of MIIUs

Cotswolds: 15 October 2019

In response to the question: *…is there anything that is missing or hasn't been considered?*

- Providing mechanisms to support patients and staff to deal with the complexity of the community urgent care system allowing easy navigation of the system. Simplifying the message around access to and use of community urgent care:
- Transport is a big issue in a county the size of Gloucestershire, particularly for people on low incomes, without a car, who do not necessarily speak English as their first language or are vulnerable. No consideration is given to this or the provision of

robust alternatives to public transport.

- The majority opinion of the groups is that urgent mental health care is not considered in the presentation or documentation. It may be an implied commitment to service, but this is too an important issue not to have explicit discussion.
- There is no consideration of the support required or to be provided for people with additional needs
- Measures to explore, understand and support the issues of frequent attendance by a small number of patients
- There is a lack of specific data in the presentation and documentation, and when it is provided it is unclear or incomplete.
- Using 'people' friendly language to support the triage process, including technology solutions such as Apps or virtual/augmented reality:
- A clear description of the 'patient journey' through the community urgent care system from the viewpoint of the wider community, including protected characteristic groups
- Workforce issues are not explored, including recognition of the national staff shortages and the issues faced by frontline staff (training and safety)
- There are clearly missing groups from the community urgent care engagement conversation, including working people and those with school age children, there is a need to ensure they are fully involved to hear their opinions.
- The consideration of the involvement of private providers, and the voluntary and community sectors in the discussions. Currently the feedback from the groups is that not enough have been involved in the engagement conversation on community urgent care.
- Discussions of the mechanisms to ensure robust data service, not just within the NHS, but across all partners services to ensure all patient data is available and they only have to tell their story once:
- There is no discussion of the balance/compromise that may be required to allow timely triage and providing triage by a clinician every time.
- A clear discussion of the variations in service patients receive in the current community urgent care system
- Prevention of illness and crisis is not considered
- No clear discussion of the impact on the community urgent care system from known changes such as the developing Primary Care Networks:
- Funding and finances are not clearly discussed, including the current budget limitations in the system. There is also a lack of recognition that the changes will take time to realise any benefits and the changes themselves will cause additional work.
- The role of community pharmacies and any challenges they may face in supporting delivery of urgent care is not clearly discussed in the current documentation/presentation
- No consideration of the integration with social services and the importance this has for community urgent care, especially for the vulnerable, frail and elderly
- Measures to address the lack of faith the public have in the 111 service conducting and 'receptionists' conducting effective triage or recognising appropriate advocacy on behalf of vulnerable patients
- A clear description of what a centre of excellence for community urgent care, and a failure to address the issue of a lack of such facilities in Cheltenham and Gloucester.
- It is not clear from the presentation/documentation how equity of access to

community urgent care will be ensure across the entire county and for people of all abilities

- The impact of the rising number of dementia patients and the need for complex care at home is not considered in the presentation or documentation
- Consideration of the different treatment needs of children and young people under 18.
- Explanation of the ways in which community urgent care will ensure patients see the right person, at the right time, every time to ensure they receive the best treatment for their condition
- No specific recognition that in a county the size of Gloucestershire there will be different needs in different areas, including the issue of communities on the Welsh border.
- The risks of adopting a 'one size fits all' approach does not consider patients with out of the ordinary conditions, this does not appear to be considered in the presentation/documentation.
- Consideration of the impact of lifestyle choices on the relative frailty and need of patients, irrespective of age

Cheltenham: 8 October 2019

In response to the question: *…in your view, what are the most important things to consider in developing services to ensure that everyone can access consistent urgent advice, assessment and treatment?*

- Person centred care
- Easily navigable and consistent system to receive urgent care:
- Education and communication to ensure patients can navigate the system appropriately
- The right workforce is in place and supported appropriately
- There is a focus on prevention and self-care
- There is no 'one size fits all' the urgent care system needs to be flexible
- Community pharmacies are recognised as an important part of urgent care by the public and professional alike
- Access to the right healthcare professional at the right time
- Improved 111 service to restore trust in the service
- Mental health is explicitly addressed in the community urgent care system
- Community urgent care is provided in a way that provides equity of access to everyone irrespective of where they live in the county
- Transport issues prevent equitable access across the county
- Distance/travelling time can be offset by access to high quality urgent care
- The new solution provides best value for money for all of Gloucestershire
- The right equipment and services are available at the right time in the right place
- The new operational model for community urgent care is fully integrated
- Simplified communication and admin for and between healthcare professionals
- Being clear on the definition and delivery of urgent care to inform both patients and professionals
- If the changes are introduced will the community urgent care system be able to cope? If everyone went to the right place – would that be new? Would the system work?

Forest of Dean: 16 October 2019

In response to the question: *…in your opinion, what else do you think will work well?*

- Celebrating what works well in the system currently
- Ensuring all the current services delivering and supporting community urgent care are mapped and their contribution recognised
- The complexity of the solution needs to match the complexity of the problem, recognising one size doesn't fit all and the patient should experience a seamless service
- Ensuring local knowledge is at hand at all times, particularly for 111 to ensure patients go to the right service that requires the least travelling time
- Provision of a local volunteer transport service for community urgent care
- Developing a marketing and communications offer to support patients in their choices for community urgent care
- Employing effective commissioning and contract management
- Providing a dedicated ambulance and paramedics for community urgent care centres:
- Consider the most equitable location of MIIUs to ensure equitable cover in the county and assess the extent to which they refer to the Emergency Department
- Making use of volunteers in the community such as first responders
- Integrating community urgent care with other services, particularly social care
- Consider developing optimum workforce coverage to ensure most efficient use of resources
- Using all the available data to understand not only the urgent care demand but issues related to illness prevention and mental health
- A single point of access to community urgent care services that is clinician led
- Valuing pharmacists, nurses and other healthcare professionals for their ability to deliver significant elements of community urgent care
- More services in the community to support the effective deliver of urgent care:
- Provide an urgent treatment centre in Cheltenham; what an urgent treatment centre could look like for Cheltenham?
    - Short waiting times.
    - Open 24 hours 7 days/week.
    - Access to urgent blood teste/imaging (x rays/MRI/CT/Ultrasound.
    - Will it cater for PO/PI? Only p2-p4?
    - Easily accessible – bus routes-central-parking(sufficient)
    - As well as or instead of Cheltenham ED?
    - Onsite of CGH? -people will know where it is/going to the same place.
    - Shared patient information – community/GP/Hospital systems.
    - Holistic view/ completing treatment to prevent presenting again
    - Collaboration with GP/ other healthcare providers.
    - Fully staff – experience/expertise.
    - 24/7

Gloucester: 8 October 2019

In response to the question: *…was there anything in the presentation that prevented your understanding of the issues?*

- For many already familiar with the situation the presentation / documentation was clear and understandable
- The use of NHS language and jargon in the presentation and documentation
- The sheer complexity of the current community urgent care system makes it difficult to explain in an understandable manner, with people saying either too much or too little information was provided
- The presentation/documentation was not differentiated for the needs of people with additional needs, for example by providing easy read versions of the booklet, which hindered participation and understanding
- Consideration of urgent care in isolation from discussions around the Emergency Department/acute services caused difficulty in understanding for some participants
- The lack of storytelling in the documentation and an over reliance on data. People tend to recognise other people's experience rather than the numbers

Tewkesbury: 16 October 2019

In response to the question: …*what criteria do you think potential solutions should be tested against?*

- Solutions must be safe, effective and sustainable
- Solutions must be accessible and equitable
- Workforce issues are fully considered in any potential solution:
- Patient information is shared securely throughout the system
- Solutions must deliver care in in a timely manner
- The solution must provide best financial value for the people of Gloucestershire (efficient, effective and economical)
- Solutions must include clear care planning:
- Any potential urgent care solution must explicitly address mental health
- Solutions must include communications and awareness mechanisms that are simple and easily understood helping people navigate the system more easily
- Solutions must contain specific measurable achievable realistic and time-bound targets
- Solutions must be developed in an inclusive manner; everybody needs to have had an input; how have hard to reach people been approached? It needs to be an open and transparent decision. Staff need to be included.
- Solutions must be fully integrated across all providers and partners

- Solutions must ensure the right equipment is in place, staffed and available on a consistent, regular, schedule
- Solutions must ensure care is delivered by the right persons, at the right time or ensure effective signposting/transfer to the appropriate service.
- Any potential solution should consider effective prevention activity and the opportunity to support self-care
- The culture of any potential solution must support appropriate risk, move from a blame culture and learn from risks
- Any potential solution must adequately consider travel and transport issues
- All healthcare professionals are recognised as asset and providing an equal and valuable contribution to any potential solution
- The potential solution sets out a realistic explanation of what patients and staff can expect from any changes
- Whole system approach: The potential solution is clear in addressing the 'knock on' implications any changes may have to the wider NHS and partner systems
- The potential solution addresses the specific needs of protected characteristic groups and those most likely to be affected are met to ensure equity of access
- Solutions should always seek to reduce the number of times a patient has to tell their story
- The potential solution provides sufficient flexibility to meet patient choice

In response to the question: …what is your first impression of the draft criteria?

- The draft criteria are too complicated and contain too much jargon
- The draft criteria are too vague and allow too much room for interpretation
- The draft criteria do not include any clear measures that would allow their useful application
- The draft criteria don't take into account patient/staff perspectives, priorities, needs
- The draft criteria do not encourage or take account of innovation in any potential solutions
- The draft criteria are not flexible enough to change to changing circumstances
- There is no prioritisation in the draft criteria which could lead to a solution that does not achieve the overall ambitions of the programme becoming a 'preferred' possibility for further consideration.
- The draft criteria do not take into the issue of transport which was consistently flagged up a being important by the workshop discussions
- The draft criteria do not take into account the need to build in sufficient expertise to ensure even the rarest condition is diagnosed accurately in the community urgent care system and treats all patients equally.
- The draft criteria do not, but absolutely must, take into account the extent to which community urgent care is integrated with social care

- Comments on specific draft criteria:
    - Criteria 1: Quality of Outcomes, how is quality defined?
    - Criteria 2:'Supports sustainable ways of working' doesn't address capacity and resilience in workforce and patient/government expectations.
    - Criteria 4: Accessibility, it needs to move beyond 'takes into account, health and equalities', and be more explicit, to state 'will address health and inequalities.'
    - Criteria 5: Aligns and complements with other Fit for the Future solutions /enablers, is not easy to understand.

In response to the question: …*which of the additional criteria you have generated as a group is most important to you?*

- Safe and sustainable
- Person centred
- Timely and effective care
- Right place, right place
- Measurable and achievable
- Accessible for all
- Transport issues are considered

6.3. Engagement Hearing

An independently chaired Engagement Hearing, which was live-streamed to the internet, was held in public on Thursday 24 October 2019. The Hearing offered people an opportunity to share their ideas and views on developing urgent and specialist hospital care in Gloucestershire in the future. The Hearing was also an opportunity for individuals and groups to share their thoughts on what they think should be taken into account, or what they think is essential, in arriving at the best solutions for services.

A panel of experienced doctors and other healthcare professionals (see Appendix 4) formed the panel which listened to people's views and ideas and considered, explored and discussed them together.

The panel listened to people's ideas and views on developing community urgent care and also on how specialist hospital care could be provided across the Cheltenham General and Gloucestershire Royal hospital sites in the future.

The following individuals/groups presented information at the Hearing:

- Suicide Crisis (submission read on behalf of the group) - Urgent and emergency care services with a particular focus on access to services in Cheltenham.
- Cllr Richard Stanley, Tewkesbury Borough Council - Urgent and emergency care services
- Cllr Flo Clucas, Cheltenham Borough Council - Urgent and emergency care services with a particular focus on access to services in Cheltenham

- Professor Robert Arnott, Cheltenham Labour Party - Urgent and emergency care services and 'Centres of Excellence' with a particular focus on access to services in Cheltenham
- Tony Foster, Cheltenham resident - Urgent and emergency care services
- REACH - Urgent and emergency care services and 'Centres of Excellence' with a particular focus on access to services in Cheltenham
- John Thurston and Mary Thurston, Friends of Lydney Hospital - Urgent and emergency care services in the Forest of Dean with a particular focus on access to services in the south Forest of Dean area.

Engagement Hearing materials can be found at Appendix 4.

6.4. FFTF Survey

All written feedback received via the FFTF survey (redacted for personally identifiable information e.g. names) can be found in Appendix 5.

Demographic information was collected through responses to the FFTF Engagement survey.

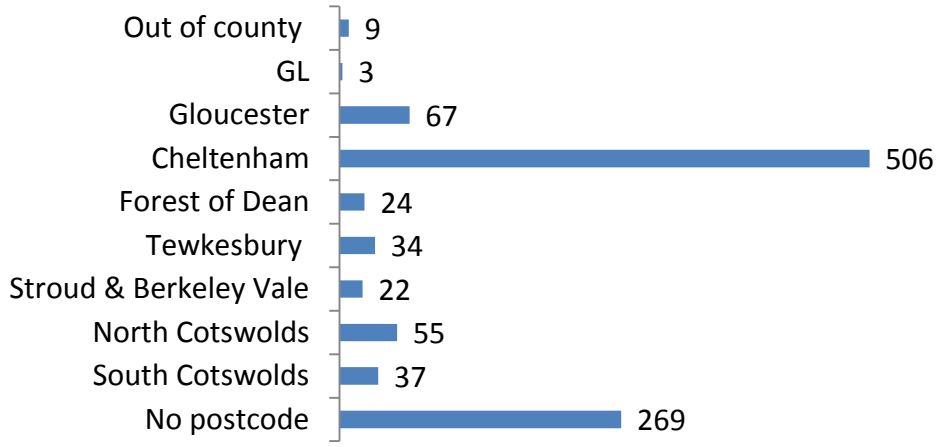
6.4.1. Demographic information

(NB: not everyone completed all of the demographic questions)

Which age group are you:				
			Response Percent	Response Total
1	Under 18		0.00%	0
2	18-25		1.44%	12
3	26-35		3.95%	33
4	36-45		10.17%	85
5	46-55		18.18%	152
6	56-65		26.20%	219
7	66-75		25.84%	216
8	Over 75		12.44%	104
9	Prefer not to say		1.79%	15
			answered	836
			skipped	190

Are you:				
			Response Percent	Response Total
1	A health or social care professional		14.87%	117
2	A community partner/member of the public		76.62%	603
3	Prefer not to say		8.51%	67
			answered	787
			skipped	239

What is the first part of your postcode? eg. GL1, GL20



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

		Response Percent	Response Total
1	No	69.93%	579
2	Mental health problem	4.23%	35
3	Visual Impairment	3.26%	27
4	Learning difficulties	0.48%	4
5	Hearing impairment	5.19%	43
6	Long term condition	18.00%	149
7	Physical disability	7.00%	58
8	Prefer not to say	5.56%	46
		answered	828
		skipped	198

Do you look after, or give any help or support to family members, friends, neighbours or others because of either a long term physical or mental ill health need or problems related to old age? Please do not count anything you do as part of your paid employment.

		Response Percent	Response Total
1	Yes	39.46%	322
2	No	54.53%	445
3	Prefer not to say	6.00%	49
		answered	816
		skipped	210

Which best describes your ethnicity?				
			Response Percent	Response Total
1	White British		87.09%	722
2	White Other		2.53%	21
3	Asian or Asian British		0.60%	5
4	Black or Black British		0.24%	2
5	Chinese		0.12%	1
6	Mixed		0.12%	1
7	Prefer not to say		9.29%	77
			answered	829
			skipped	197

Which, if any, of the following best describes your religion or belief?				
			Response Percent	Response Total
1	No religion		35.10%	291
2	Buddhist		0.60%	5
3	Christian (including Church of England, Catholic, Methodist and other denominations)		49.94%	414
4	Hindu		0.00%	0
5	Jewish		0.36%	3
6	Muslim		0.00%	0
7	Sikh		0.00%	0
8	Other		1.81%	15
9	Prefer not to say		12.18%	101
			answered	829
			skipped	197

Are you:				
			Response Percent	Response Total
1	Male		40.05%	332
2	Female		54.04%	448
3	Transgender		0.00%	0
4	Prefer not to say		5.91%	49
			answered	829
			skipped	197

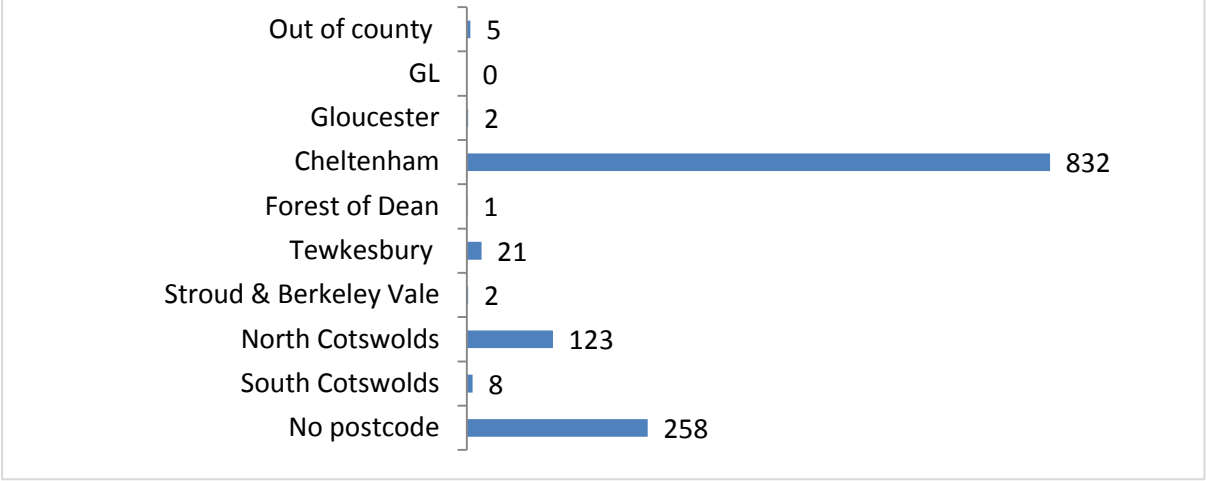
Do you identify with your gender as registered at birth?				
			Response Percent	Response Total
1	Yes		94.03%	772
2	No		0.24%	2
3	Prefer not to say		5.72%	47
			answered	821
			skipped	205

Which of the following best describes how you think of yourself?				
			Response Percent	Response Total
1	Heterosexual or straight		85.68%	706
2	Gay or lesbian		0.85%	7
3	Bisexual		0.61%	5
4	Other		0.36%	3
5	Prefer not to say		12.50%	103
			answered	824
			skipped	202

Are you currently pregnant or have given birth in the last year?				
			Response Percent	Response Total
1	Yes		0.72%	6
2	No		65.58%	543
3	Not applicable		28.50%	236
4	Prefer not to say		5.19%	43
			answered	828
			skipped	198

Demographic information included in Cheltenham MP FFTF surveys:

What is the first part of your postcode? eg. GL1, GL20



6.4.2. Workshops

The demographic information recorded at the FFTF Workshops is included in the full reports, which can be found in Appendix 3.

6.5. Survey Feedback

The qualitative feedback from completed surveys, comment cards and correspondence has been grouped into a series of themes under two main headings: **Improving urgent care services in local communities and Improving specialist hospital services and developing *'Centres of Excellence'.***

6.5.1 Summary of feedback received - Improving urgent care services in local communities

In your view, what are the most important things to be considered in developing services to ensure everyone can access consistent urgent advice, assessment and treatment?
1. **£/Funding**: Additional investment is needed in the NHS. Need to ensure value for money/best use of resources. *Value for money - meaning cost effective deployment of resources* *Agree with most of the suggestions for improvement to services BUT we must invest more money in providing all these services, that means more Nurses, Doctors and specialists*
2. **111**: Need an improved 111 that people have confidence in and that directs you to the most appropriate service. • *The 111 service could take a stronger line in enforcing more appropriate routes to care. I have been sent to A&E with my son on more than one occasion by the 111 service when a priority appointment with my GP (or urgent care service) the next day would have been a far better option.*
3. **Accessible and timely**: Access in terms of opening hours, travel times/location is essential. Services need to be provided in a timely manner. Need to consider the needs of population/ demographic, now and into the future. • *The most important things are accessibility in location and hours of opening bearing in mind that there is an increasing older demographic who may not have transport or family support.* • *Access, availability and location. Distance travelled in any emergency or life threatening position is paramount.* • *Transport arrangements have been significantly under prioritised in the plans so far. A 30 minute drive is no good for someone who cannot drive (for a variety of reasons including the illness or injury concerned).* • *The key issue is availability of advice, assessment and treatment, which encompasses location and resources.* • *Although it is essential to consider having the appropriate levels of expertise on a particular site, the time it takes to get to a site from home is still the most important factor for a number of conditions where time is of an essence and every minute counts e.g. stroke, heart attack. In the case of more minor injuries, it is vital that the facilities are in place in centres elsewhere, thus avoiding attendance at A&E units. These facilities need to be available 24/7, minor injuries do not just happen in the day!* • *Would be happy to just have urgent care centres located next to A&E so that if urgent can go directly to A&E - happy to drive further to get well manned and 24-7 centre.*

- *The population has grown massively and is still rising with no thought of where or how these people will be treated in times of ill health and emergencies that will not doubt arise.*
- *Timely and appropriate treatment. It's all very well having 'Centres of Excellence' but we know that the success of many treatments is very time dependent.*
- *Time elapsed to a genuine consultation with an appropriate clinician is essential to success.*
- *Access to expert treatment/assessment in a timely manner. Reduced cancellation of procedures/surgeries.*

4. **Improved pathway and communication**: Ensure that people know where and when to seek support. Establish simple, accessible pathways.
   - *Improving how you advise and communicate with people which would be the best service to deal with their problem, so that A&E departments in both hospitals get less inundated with minor injuries.*
   - *Making it very easy for people to work out - via phone, online, in NHS locations - which is the best and quickest way to get treatment for their particular problem.*
   - *Easily available general health advice is something I consider to be very important, whether by a booklet or internet.... Illustrating the advice with case studies is a powerful way of getting the message across to those reluctant to change their habits.*
   - *The most important piece in all this is the quality of communications and the NHS is absolute abysmal in its communications at every level*

5. **Quality and Equity**: Ensuring provision is resilient; of a high quality; and that it is fair and equitable across the county.
   - *The healthcare offer should be simple to understand and there should not be variation in the offer between different localities.*
   - *Quality of outcome - get me to the right person, service, advice first time.*
   - *There need to enough resources and capacity to ensure development and improvement of services so that patients currently experiencing excellent care are not disadvantaged by changing site of services.*
   - *Making the most of our resources (staff / equipment / estate) to ensure that whoever you are and wherever you live, you are able to access the right care, in the right place, at the right time.*

6. **Access to GP services**: Improved access to GP appointments, both urgent and routine and out of hours. Better use of a range of healthcare professionals at GP practices.
   - *GP's need to be more accessible - it continues to be crazy hard to see any GP - never mind one who you've seen consistently.*
   - *Better/more primary care service to ensure patients are able to access timely appropriate care.*
   - *Need to consider out of hours provision and surge times. Often very hard to get through to a GP on a Monday morning.*
   - *'Drop in' centres for minor ailments staffed by nurse practitioners, reducing unnecessary visits to A&E, these could be attached to GP medical centres.*

7. **Integration & workforce**: A more joined up way of providing care, which makes the most of the diversity of the workforce. Ensuring sufficient numbers of staff, with appropriate mix of skills to deliver range of services required. Staff recruitment and

retention.

- *Joining things up so that health professionals get a consistent and up to date record of the patient's needs and medication.*
- *Improved staffing levels, better infrastructure and more GP surgeries available out of hours to reduce the strain on hospitals.*
- *A coherent and comprehensive integrated vision with a corresponding clear plan for implementation that includes all health service provision in the county. Emergency care should involve specialists not generalists so that appropriate intervention happens round the clock.*
- *Skills and expertise of staff - good outcomes from treatment.*
- *Adequate staffing and resource to deliver urgent care and high standards of care.*
- *Having staff who are able to cope holistically with people rather than viewing them as a particular presentation to the exclusion of other health and social care support needs.*

8. **Minor Illness and Injury Units (MIIU)**: Ensure MIIUs provide local, equitable access, are well-resourced (staff and equipment) with access to a range of diagnostics. Introduce MIIUs for Gloucester and Cheltenham.
   - *The hospitals that have minor injuries units are not fit for purpose, X-ray is not available 24 hours, healthcare Professionals are not available 24 hours a day, if you want these hospitals used for urgent care they must be upgraded.*
   - *Diagnostic services most appropriate to the types of injury most frequently presenting at Minor Injuries*
   - *Both Gloucester and Cheltenham need to have a minor injury and minor illness centres, this would relieve the pressure on A&E.*

9. **Cheltenham General Hospital**: Extensive feedback relating to the need to keep A&E open in Cheltenham. Requests to restore overnight services at Cheltenham General Hospital (CGH). Main reasons given for these requests are:
   - Gloucestershire Royal Hospital (GRH) unable to cope with additional patients.
   - Distance to travel to GRH from Cheltenham and villages on the east of the county.
   - Population of Cheltenham is growing and a town of this size warrants a full A&E service.

   - *Definitely need A&E departments in Cheltenham and Gloucester re travel time in emergencies especially for the elderly and young families and those living in the Cotswolds.*
   - *Consideration must be given to quick access to the right expertise in an emergency. Having an urgent GP led centre in Cheltenham will not provide us with the right level of care required.*
   - *Reopen Cheltenham A&E at night time. Cheltenham and its outlying areas is expanding - you don't have to travel very far to see another building site. More and more people are moving to our area, and the night time services are invaluable.*
   - *Cheltenham is an expanding town which has a diverse demographic, and so it remains essential that Cheltenham General Hospital operates with a fully functioning A&E Department that is available to the Community 24 hours a day & 7 days a week*
   - *Reducing any service at CGH with a growing and aging population seems to be the opposite of what is required*
   - *The number of people living in Cheltenham is great enough to warrant an A&E. The*

one at Gloucester is a long way to travel by car and often crowded.

- *It is crucial that critically ill patients can get to A&E and be triaged as fast as possible. This time will be affected by the distance to be travelled from the point of trauma and how fast the treatment centre can respond when the patient arrives. Any suggestion that suggests a reduction in the opening hours for Cheltenham A&E must impact on this critical period for most patients living or travelling in North Glos and particularly for those in parts of South Worcs.*
- *I don't believe it is possible to fully separate emergency and urgent care in the manner outlined and I believe it is essential that hospital services for both emergency and urgent cases remain closely integrated and that both are available at both Gloucester and Cheltenham.*
- *Given the appalling public transport provision (lack thereof) - especially for those of us using wheelchairs/trolley-walkers and don't drive - getting to Gloucester Hospital [is difficult].*

What do you think about our ideas for urgent advice, assessment and treatment services ASAP?

A range of ideas, comments and suggestions have been made in this section. There is some confusion about whether there are proposals to close or downgrade services at Cheltenham General Hospital, as evidenced by the spectrum of comments summarised below.

An overview of comments, both supportive and ante the ideas set out in the engagement materials follow. In addition, there are comments that relate to specific parts of the existing urgent care system, such as 111, GP appointments and Minor Illness and Injury Units. Comments were received regarding communication relating to urgent care services now and in the future. A number of ideas and suggestions for future services are also noted.

1. There is **support** for the ideas, with some explanation given as to why people like the concept. Some people have given some caveats to their support and raised concerns about the resilience of wider healthcare systems, for example GP services, to cope with initial changes in demand that may arise. There is also recognition that services need to be accessible and equitable across the county:

    - *The personal care aspect is definitely an excellent idea due to the nature of many patients needing consistent, specialised care.*
    - *Very clear and local population based, makes it much easier with more options than having to attend the main emergency departments when living in Gloucester.*
    - *A good idea if it can be made to work subject to a clear understanding by all involved -patients and professionals alike as to how the service should be accessed and used (as outlined above) to maximise the most efficient and effective way of matching the appropriate use of the resources staff, equipment and finances available.*
    - *I fully agree that A & E Services should be centred in one unit at Gloucester. There is no point in duplicating this service when the two units are so close together. The Hospital at Cheltenham is very old and not really suitable for 21st century health care. It is surprising that it is still being used and compares very badly with the new hospitals situated in Worcester, Swindon, Hereford and Birmingham.*
    - *The ideas are good but that depends on them being properly funded and staffed by experienced qualified people.*
    - *Makes sense if the WHOLE system works, if one part fails it all goes back to A&E as it*

does at present.

- *I think that key way to reduce unnecessary A&E attendance (particularly out of hours) is to have minor illness/injuries units located right next to A&E at Glos and Chelt.*
- *I feel strongly that something like a minor injuries unit, with access to x-ray facilities, is needed at Glos and Chelt. Patients can first go there with less serious issues (I am thinking about out of hours). If they need to be re-directed to A&E or admitted in to the hospital, they can be, without staring the process of assessment from the beginning.*
- *A logical process, but a challenge to persuade patients to deal remotely (telephone, App, web) with NHS staff.*
- *I like the concept you are describing but I think you need to ensure you provide an inclusive option for rural communities and non-drivers and drive customer behaviours through consistent messaging in all service providers. This may need to include some tougher messaging for people who do not make appropriate use of the A&E services. I have some concerns about the strain this will place on GPs who are as entitled to a work life balance as the rest of us.*
- *The 111 service is a good model and I support expanding that. Calling 111 is much easier than visiting the GP. The problem with GP service is that everything has to start with a visit to a doctor and that creates the bottleneck which sends people to A&E.*

2. Conversely, some people **do not agree** with the concept of ASAP and have given reasons why it is not acceptable. Some typical responses are shown below:

   - *It sounds like you are trying to streamline your resources instead of putting the patient first and then spending more money on a 24 ambulance shuttle service instead. There is no sensible logic to this.*
   - *How it actually works is not clear to me from reading the booklet. I am not confident that levels 1 and 2 (A & S) meet the need and any uncertainty or hold up can push the issue up the chain.*
   - *I am not convinced that allowing the wrong patients to walk in A&E with non-life-threatening conditions has been fully tackled by the NHS locally. I think that merging A&E departments into one unit at Gloucester will not solve this.*
   - *Not specific enough, just vague ideas which sound great but are not new and no real information on exactly what or how anything is to be achieved.*
   - *It's too complicated:*
     - different times of day and days of week you need to call different numbers
     - you need to understand if you have an injury or an illness
     - I only care about how I start the journey.
   - *It puts too much onus on the patient to give a clear and detailed account of their symptoms (111 service) or to determine the urgency of their condition (NHS online).*
   - *I think they are to the disadvantage of genuine emergency treatment, i.e. life or limb threatening.. It is recognised that about a third of visits to A+E departments could be treated elsewhere which clearly leaves a 2/3 majority which could not.*
   - *I think they are unrealistic. In my experience urgent care doesn't follow a one size fits all mnemonic. There is a degree of fear, ignorance (of what is wrong) and panic that means that you can't access a rigid system effectively.*
   - *Centralising such care at one hospital for such a large area does not meet the criteria*

above. Centralising A&E at Gloucester would lead to overcrowding and long waits for follow up care.

- *Not convinced, I think that the current minor injuries or A&E services currently available are probably the best way to feed into Central 'Centres of Excellence'.*
- *It's also not always possible to determine whether a condition is life threatening or just urgent, without an assessment from a medical professional. This may also require prompt access to a range of other services, such as X-Ray, etc.*

3. **Cheltenham General Hospital**: There is significant opposition to any suggestion of downgrading or closing the A&E at Cheltenham General Hospital. The main reasons for this are the perception that such a move would not support the ethos of ASAP and that any changes to services at Cheltenham would create accessibility problems for the town's residents and those living in the east of the county. There are also calls to reinstate the Consultant led service overnight at Cheltenham General Hospital (from 8pm to 8am).

   - *They are fundamentally flawed. Cheltenham A&E must be retained and returned to 24/7.*
   - *I am concerned that 'your' ideas include the removal of Cheltenham A&E, replaced by services at Gloucester. A town the size of Cheltenham requires its own such services accessible to all within the locale.*
   - *Much of it is theoretical, and it seems as if those proposing them have no practical experience of how it actually is. We need both Cheltenham and Gloucester hospitals to be fully functioning for emergency care at all times.*
   - *The ' ASAP ' model proposed in the booklet aspires for A&E to be there for you if patients have had a life and limb threatening medical emergency . The best way to ensure that aspiration is met is to keep the A&E at Cheltenham General Hospital open, ensuring local access and avoiding increased journey times and extra costs involved.*
   - *How can people with urgent medical needs receive the service / treatment that you aspire to give if they don't have access to services in Cheltenham. It just doesn't tally up. Ideas and reality need to match!*
   - *Great idea - as long as it involves keeping Cheltenham A&E open and restoring 24/7 service.*
   - *Having two hospitals open means that patients can be seen quicker and then diverted if required.*
   - *The Fit for the Future model talks about an ASAP model. Travelling an additional 20-30 mins for emergency or life-threatening treatment for people located in the north and east of the county cannot possibly meet this goal. CGH A&E must remain to address this need.*
   - *If either of the A&E departments were to be closed , then the aspirations of the ASAP model are simply nothing more than a cynical exercise in spin.*
   - *I feel frustrated that the issue of clinician availability and availability of expertise is being used to remove local urgent medical services.*
   - *The principles sound ok but in practice for two towns as large as Cheltenham and Gloucester and the far wider area and size of population they cover both centres need to be fully equipped to give the urgent care required on a 24 hour basis. It should not be a question of one or another.*

- *Looking very much to the future and considering the great number of housing developments being established in Gloucestershire, I feel that it is imperative that there should be two A and E centres with 24 hour provision.*

4. **Communication**: There is recognition that providing people with information about how to access services, and which services meet there needs, is really important. People have also commented on how people access information, the range of methods that need to be considered in the future and the challenges of telephone and online advice verses face-to-face communication.

    - *To me it all hinges on getting the correct information to direct the patient appropriately.*
    - *The emergency pathways are multiple and complicated A +E departments are only one cog in the wheel so we need to talk more about the emergency service as a whole.*
    - *Despite repeated efforts to keep patients away from ED and direct them to other services the demand on the ED continues to increase. It is very confusing for patients when there are multiple different options about where to go with an illness or injury (with different opening hours and different capabilities). Patients recognise the A&E brand so will often opt for the service they know and trust.*
    - *Maybe your adverts to launch this sort of service should show a comparison of cost, time and outcome against the different services*
    - *You need to tabulate the differences between 'as is now' and 'to be in the future'. Without this, it's hard to get a clear picture of the changes you are proposing. The content on your web pages has a rambling, narrative style that is frankly hard to take in when trying to understand *changes*.*
    - *The key is how you build community knowledge of how to access services. It is also very important to remember that not everybody is able to access the internet or will even be able to read.*
    - *However [there] is a need for information to be circulated and shared. There is an assumption that pharmacists do prescriptions not everyone is aware they can offer medical help and advice.*
    - *Make sure all services are fully accessible to all disabilities, age groups and ethnic groups. Advice via text message may be useful for some, all websites and apps need to be screen reader compatible, have high contrast and size options, need to be simple and easy to use for the non-technical minded*
    - *Why do you think people go to A&E?? It's to see a real person who physically examines and treats their injury, not someone who says go and see your GP (and good luck with that!).*
    - *Given that many users of the NHS tend to be older people I'm not sure that an online system would take much of the burden.*

5. **Accessibility & timeliness**: Many of the comments regarding the ideas for urgent care and assessment recognise the difficulties people experience in accessing services, particularly from the rural areas of the county. The need for services to be as local as possible is a key theme.

    - *Whilst a very good idea in theory, I would like to see outlined how it work in practice. You have to realise that not all people who need ASAP services live in Gloucester or*

Cheltenham. There are many other parts of Gloucestershire to consider - what provision of services will be available via ASAP at local Hospitals - e.g. Cirencester or Tetbury?

- *Not everyone can get to the assessment and other treatment services. No bus service in their area. Do not have a car. Pensioners living on a state pension can't afford a taxi as there is a cost and their money does or doesn't go that far.*
- *How is a patient to know if an urgent care centre is suitable?*
- *Emergency services need to be local, concentrate on providing that.*
- *We need to have 'local' services not centralised services that are inaccessible to many. Efficiency does not always equate to effectiveness.*
- *Agree it would help relieve the burden on A&E if people felt sure they could get help more locally promptly, so making sure all those other services (MIU, GP, pharmacies, etc.) can easily be accessed, and encouraging people to do that, is very much a first step.*
- *I worry about the '30 minutes drive from a centre for the majority of people' [p 13]. Particularly because of the large number of people living in rural Gloucestershire.*
- *Concentrating an emergency department at Gloucester gives many people to the east further to go on roads that are increasingly busy. This is not such a challenge for routine appointments or scheduled procedures, but when the need is urgent then the extra time could be the difference between life and death at the extreme.*
- *If ASAP is to work facilities must be available close to place of residence. Basing everything in Gloucester fails this essential requirement.*

6. **Resilience of future services**: In considering future services, there are lots of comments regarding the interdependencies of services and the ability of different parts of the pathway to work together and cope with demand. Comments reflect workforce and resourcing challenges.

    - *The ideas are good but that depends on them being properly funded and staffed by experienced qualified people.*
    - *In theory this could work but it really relies on join-up between the various triaged services. For example, ring 111 and inevitably you are told to go to A&E. You go to A&E where they ask why you are there as it was not necessary. So the overloading that you outline in the leaflet doesn't address this type of issue.*
    - *In principle it all sounds ideal but as a health care professional myself I know that sometimes the wrong advice is given to patients about how soon they need to be seen and by whom.*
    - *I do not see that saying that other providers can handle the less serious and less urgent cases tackles the problem at all. Who is providing the budget for extra paramedics to do on the spot treatment? Otherwise the poor response times and overburdened service just moves from A&E to ambulances or pharmacies. Just shifting the problem onto some else is not adequate and is certainly not good preparation for the future.*
    - *It MUST involve having sufficient staff to manage the volume of 111 calls especially during periods of high demand. Ongoing education about when to use pharmacies or look at NHS on line advice. Possibly combining the Minor Injuries service with GP services would make sense.*

There are comments that draw on experience of using specific services e.g. 111, Minor Injury and Illness Services, access to timely GP appointments and also suggest how these services could be improved in the future.

7. **Comments specific to the 111 service**:
    - *Too much emphasis on none medical advice (try phoning 111!) for medical problems and too much emphasis on distance advice.*
    - *Telephone access should be maintained. Not everyone has access to the internet or is happy to use it.*
    - *The service needs to be a one stop service. The assessment needs to be robust enough to ensure that someone who calls 111 gets referred appropriately 1st time and that all information is passed on and ready for other health professionals for further diagnosis without going through the same questions again and again. It is important that all records are available and used appropriately by professionals.*
    - *111 need to stop sending patients inappropriately to ED. Otherwise a good way of addressing the different levels of need/urgency.*
    - *There is a bit of a stigma that if you dial 111 you will end up in an ambulance or sent to hospital anyway. Hopefully with an updated service 111 will be more widely staffed for better advice and information rather than continuing to make A&E a busy place.*
    - *The new service for 111 is great, it gives people a chance to find out what service they should use and help with accessing it. However it relies on having the right services in place to access/having enough appointments so in theory it sounds great but I worry that the provision isn't there. People attend A&E because they can't get appointments with GPs etc.*
    - *I am concerned about the idea that local same day services will require booking rather than being walk-in. Booking an appointment through 111 sometimes happens now and it doesn't work well.*
    - *I think 111 needs to be reformatted with more training and consistent advice. Longer GP hours for urgent appointments would help. More publication regarding minor injuries units would be helpful - as not many people are even aware of them.*
    - *Without doubt, many people do attend A&E when it is not necessary. However this is often as a result of not knowing where else to go. 111 service, if this is to work properly it needs to be managed by properly trained persons with medical supervision on a 24 hour basis not simply manned by someone reading off a list of questions from a computer screen.*

8. **Comments about GP appointments:**
    - *If you need a GP then access to your local surgery on a same day, urgent basis should always be available. Or a LOCAL out of hours service.*
    - *Dealing with so-called 'urgent' cases by referring them to make a GP appointment is all very well but have you tried to get an on-the-day appointment with a GP recently?*
    - *At present advice from GP surgeries is not readily available, to be able to have a same day telephone slot to talk to a doctor at a GP practice could work very well and help reduce the pressures on A&E with so many non-urgent people attending.*
    - *There needs to be much better access to GP services and appointments - people go to A&E departments because they are worried and can't access their GPs*
    - *Better GP availability and better education can stop A&E being clogged up with non-emergencies*

- *Availability of seeing your GP is very rare, with GP surgeries being over-subscribed due to new house building with no integrated plans to include new GP surgeries on the large developments i.e. Longford, Innsworth and Twigworth. We now have to wait 6 weeks to see our own GP due to the Longford Development.*
- *The consultation does not address the simple fact that GPs do not have capacity. Booking an appointment is a Bull run at 8am and several times, I have got through in as little as 10 minutes to find out that there are no more appointments available. Unless you can work this out with GPs, the system is broken.*
- *We see many people in MIIU who really need a same day doctor appointment and are unable to obtain one - so easier access and extended service will be great.*
- *It would help if waiting times and rules for booking appointments in GP surgeries were less onerous and consistent between surgeries.*
- *I think it works in principle but will fail if routine appointments are not available within local GP practises. If people are told to wait 2-3 weeks for a GP appointment they will still present to ED regardless of the advice or alternative offer available.*
- *We need urgent care hubs in the community without taking GPs away from current jobs. This means recruiting and training more GPs or specialist urgent care practitioners at the same level-very difficult to do quickly.*
- *Local communities will always go to their GP and or Pharmacy first, I think it's here in the primary sector more investment is needed. ASAP is just a detour.*

9. Comments re Minor Injury and Illness Units (MIIU):

- *The MIIUs should be merged with general practice which has been more or less abandoned by the government with out of hours care provided on the same site.*
- *You say most people attending local minor injuries facilities do not need an X-ray. Many of them will not know whether they need one until someone qualified can assess this. You also say there is access at evenings and weekends but this is not my experience.*
- *Better urgent care services outside of GRH and CGH are desperately needed, current MIIU provision is poor.*
- *The public need to show responsibility in choosing the appropriate care. A single point of access which they have faith in, e.g. their GP surgery, through which they could be directed to the correct service (with appointments to MIIUs) could be utilised.*
- *Need to publicise/raise awareness of the MIUs as many individuals aren't aware of these units. This may be why the A&E departments continue to have such large walk in rates. Many would be put off by the fact that the x-ray departments are closed. These may not then return to use a MIU again. If we begin staffing these better, I feel the attendance rate to MIUs would be better.*
- *You should have MIU in Gloucester and Cheltenham, this would take pressure off the emergency depts.*

What other ideas do you have to help us? Do you have a solution to the challenge of developing services to ensure everyone can access consistent urgent advice, assessment and treatment services - if so what is it?

People responded to this question in different ways. Some people made generic comments and suggestions, whilst others gave more specific feedback and particular suggestions around improving urgent advice, assessment and treatment services. The comments

grouped below focus on urgent care, with a full breakdown included in Appendix 5.

1. **Accessible**: Feedback related to accessibility of services in terms of opening hours, travel times, location and equity. There were numerous comments about access to GP services and their role within the wider range of urgent care services.

    - *Looking at the map of Gloucestershire, I feel that there are gaps which could be filled by offering a local urgent care assessment, with the possibility of going to either of the 2 A&E departments as required. I do feel that people do not want to have to travel miles to get help in an emergency.*
    - *Joining up transportation links to ensure improved community coverage will help allay fears of further marginalisation and punishment for those of us who don't inhabit the cities. There has always been rhetoric on joining up transportation links, but it remains just that, rhetoric.*
    - *At a strategic level there needs to be a flexible approach to the geographic provision of services to reflect population shifts in the county. At a lower level, when possible, it would be good if the first contact was relatively local as that might enable some continuity and patient relationship to be developed.*
    - *Perhaps there could be drop in centres placed more strategically with consideration of population centres, proximity to bus routes for those who are not driving and some parking for those who can drive. I see that Post Offices have been established in some supermarkets and I am aware that pharmacies in supermarkets have rooms for private consultations. So there is already a precedent for mixed services within a shopping area. Even basic advice in directing patients to the appropriate provision would be helpful.*
    - *Some of the larger villages and towns are near county boundaries, if you work with neighbouring counties you may be able to improve services to people at the boundaries of the County. 30 minute journey across Gloucestershire could be a 15 minute drive across county lines.*
    - *I think it is important to retain services in districts as far as possible e.g. MIIUs but concede that safety and robustness of service is also impossible e.g. access to good staff levels, reliable service, opening hours you can count on and 7 day a week access to X-ray. A difficult balancing act - local access vs reliable/brilliant service every time.*
    - *GP surgeries and community hospitals need to expand services offered, it's a postcode lottery currently as to whether you can access a physio or dietitian in your surgery.*
    - *There should be clear standards and services that are equitable around the country not by county or town by town basis depending on what the PCT decide to commission - it is just a post code lottery and that is so unfair.*

    1.1. Access to GP services:

    - *People go to A and E partly due to the difficulty of getting GP appointments. This needs to be considered as part of the picture. If people are going to A and E with minor issues you need to establish why and deal with the reasons. This is no excuse for cutting an essential accessible emergency service for when this is really needed.*
    - *More walk-in centres would help to deal with problems of GP access. The one in Gloucester I have found very useful at times*
    - *If GP surgeries were open 7 days a week and people could walk in and wait their turn rather than have to have an appointment then more people would go to their GP and*

not to A&E.

- *There has long been the idea of having minor injury services in G.P Surgeries. Whereby a patient can receive treatment for cuts that require stitching, dressings for larger wounds etc. with an ongoing appointment for evaluation of the injury. I propose funding for such a service.*
- *As well as keeping Cheltenham General Hospital A&E for emergency care, it would be good if you bring a Health Access Centre to Cheltenham for urgent care. This would be an urgent care GP surgery, like Gloucester Health Access Centre. There was one in Cheltenham but it was removed. If you put it in the town centre, it would have been better.*
- *Put GPs back in control of OOH care, with a co-operative that worked wonderfully well before it was abandoned.*
- *GP practices attached to Gloucester Royal and Cheltenham General A&E/urgency centres with triage directing non urgent patients to their care to reduce the burden on hospital services.*
- *There needs to be increased options and accessibility of services other than A&E e.g. GP drop in clinics, increased facilities and opening hours of minor injury units and GP triage at the entrance to A&E to prevent patients actually being admitted to A&E who don't need to be.*

2. **Communication:** The importance of providing information about the range of services which enable people to make decisions about how and where to access care was highlighted:

    - *Better circulation and advertising of what services do what in local paper/leaflet taken home in schools/local supermarkets/pharmacies this would lead to less frustration of services users and managing their expectation of service delivery.*
    - *Clear vision of where and how to utilise very urgent responses and to ensure good practice all through e.g. better ambulance/specialist responses to scene plus pre-arrival preparation on admission.*
    - *Currently all people know instinctively of two routes - 999 or their surgery. An information campaign should drill into people the need to avoid A+E unless it is life or limb threatening. Ideally most cases seen there should be brought by an ambulance. Everything else should be to the MIIUs (suitably named something else) or the GPs (who can divert patients direct to the MIIUs).*
    - *Communication of existing provision is poor and the proposed changes are not well communicated. An advice Booklet to every household needs to be provided. Maybe as a direct communication from the registered GP Practice. Make it personal.*
    - *Give patients the opportunity to make the right choice, provide more education about self- help. Visual TV's with information on. Provide links to outside agencies i.e. Physio, OT services there are numerous providers out there.*

3. **£/Funding:** Additional investment is needed in urgent care services, ensuring value for money and the best use of the available resources:

    - *I think that the Rapid Response and Complex care at home teams are making a significant difference for the patients they support by helping to ensure patients remain at home and not sent to the acute trust. However, these services need to be increased and receive additional funding.*
    - *Spend money on patient care, on doctors and nurses, not on bureaucracy and grand*

ideas.

- *The money available needs to be spent sensibly - not wasted on surveys, access discussions etc. Use the available funds wisely to treat residents in the area served by CHELTENHAM Hospital.*

4. **Configuration of service**s: Suggestions were made regarding specific services that form part of the current urgent care offer. This included feedback about the A&E services at Cheltenham General Hospital.

4.1. **111**: An improved 111 service is needed, which people have confidence in and that directs you to the most appropriate care.

- *111 could improve so it's not largely a checklist experience. More medically qualified staff should be available.*
- *I propose a thorough nationwide advertisement campaign with the aim of making 111 the first point of call for all but critically ill patients. From there 111 can direct patients to the appropriate services. This should reduce A&E attendance and increase attendance at pharmacy, and minor injury units. In conjunction with the advertising campaign there should be a review of the 111 service to ensure patients are directed to the appropriate services and improve the spread of patients between services.*
- *I would have suggested that anyone considering visiting A&E should, wherever possible, be asked to telephone first, to confirm that their visit was necessary, and secondly to alert the staff as to what to expect. But my experience with hanging on the telephone listening to recorded messages telling me I am umpteenth in the queue does not make me enthusiastic for such a solution.*
- *To ease the burden of relatively trivial ailments presenting at A & E, improve the training given to operators of the NHS helpline. A number of people I've spoken to have rung for advice and been surprised to be told to go to A & E as they hadn't regarded their symptoms as being sufficiently serious to warrant emergency treatment.*
- *111 service is great idea but remote, impersonal and inconsistent. Could a more local personalised service be offered within Gloucestershire?*
- *Create a 111 service that is fit for purpose and adequately and competently staffed. It is not clear at the moment where one should start the process of looking for urgent advice or treatment. Local surgeries are often closed and, if open, always busy.*

4.2. **Minor Illness and Injury Units (MIIU):** Ensure MIIUs provide local, equitable access with access to a range of diagnostics. Introduce MIIUs in Gloucester and Cheltenham.

- *To have minor illness/injuries units located right next to A&E at Glos and Chelt. Patients can normally go to the minor injuries unit first. If necessary, they can be sent through to A&E (but not have to start the process from scratch)*
- *Maybe extend A&E service in Tewkesbury hospital? At present it closes at 8pm.*
- *Important to keep minor injuries unit at Moreton, potentially also out of hours and weekends. This would reduce dependence on Cheltenham or Gloucester 'Centres of Excellence'.*
- *Provide data on waiting times/waits online so patients can identify best unit to attend.*
- *Make sure minor injury and illness services are reliable - would rather have fewer units than struggle to get an x-ray or unit is temp. closed because there aren't*

enough nurses and other staff.

- *Practice nurses at doctors surgery need to run dressing clinics on weekends and not use minor injuries resources as we are not equipped nor trained in chronic wound management. They should be managing their own work load and not using us because we are open. Minor injuries staff should be trained in telephone triage to direct patients to appropriate service.*
- *Roll out additional community services, including more GP's and increase hours at MIIU's. Reinstate radiology services at MIIU's.....20% of attendees DO require an x-ray. GP services attached to hospitals where non urgent patients can be directed for care.*

4.3. **Cheltenham General Hospital:** Extensive feedback related to the need to keep A&E open in Cheltenham and restore overnight services at Cheltenham General Hospital (CGH). The main reasons given for this included:

- Gloucestershire Royal Hospital (GRH) is unable to cope with additional patients.
- Increased travel to GRH from Cheltenham and villages on the east of the county.
- Population of Cheltenham is growing and a town of this size warrants a full A&E service.

- *Invest in those services in the location in which there is the demand. I repeat, a town the size of Cheltenham requires those services on its doorstep, not 8 miles down the road, let alone those coming in from further afield, to whom Gloucester is just a step too far. You are in danger of placing your services out of reach of those who require access to them.*
- *Keep the Cheltenham A&E open, restore 24 hour cover for ambulances. Do not reduce capacity. Gloucester cannot deliver the capacity or the level of service. The idea that centralising services in one place in the middle of a busy town centre is fundamentally flawed.*
- *For the reasons I've given, one funnel only provides bottlenecks. Keep Cheltenham A&E open which will provide the access to the consistent advice, assessment and treatment you want/should offer.*
- *The Cheltenham A and E must remain to cope with the proposed residential growth of the town and the surrounding area. The closure of this facility on financial grounds and against the wishes of the majority of the populace shows that there is little care for the local community.*
- *Very important to keep two Emergency Departments open. GRH is often so busy there are patients queuing on stretchers in the corridor. Throughput is impacted when there are not enough inpatient beds there for admissions and sick patients have to wait for transportation to Cheltenham. This can be stressful for patients and their families and delay appropriate treatment.*
- *The best way to develop services is to keep the A&E at Cheltenham General Hospital open and strengthen its provision of services, this ensures local access and avoids increased journey times.*
- *The journey to Gloucester can often be adversely affected by traffic / accidents / road works that delay that treatment. Any delay to an emergency can be life threatening.*

5. **Integration, resilience & workforce:** Suggestions for improved integration across the urgent care pathway were made, relating to both services/infrastructure and workforce. This included comments relating to staff recruitment, retention and the range of

professionals who should be involved in delivering and supporting urgent care.

5.1. **Services and infrastructure:** Combining GP Improved Access clinics and Minor Injury Unit (MIU) services. We have too many different organisations providing the same services: GP Extended Hours, Improved Access clinics and MIU.

- *The future is a combination of drop in emergency centres and web based consultations with a health professional.*
- *I think we need a separate walk in centre in Cheltenham alongside A &E and the trust needs to recruit more doctors. Also within the community I feel there needs to be a team of rapid response nurses who work in the community who can treat people in their own homes rather than having to go into hospital.*
- *Instead an investment in technology to streamline systems for the docs and nurses on the ground could rapidly transform the offerings and meet the challenge faced.*
- *My solution is to maintain and expand existing A&E and urgent care facilities to have increased numbers of beds and health care professionals to match Gloucestershire's population growth rate (also considering the increasing number of elderly residents.) Re-organising the hospitals into 'Centres of Excellence' seems to me to be shuffling problems around without trying to achieve the right capacity.*
- *Some form of triage for all cases. Depending on the issue, a means of diverting people from the A&E Department. An example could be to direct as appropriate to a local pharmacy Department. Some larger hospitals across the country have a branch of Boots Chemists on site to assist with this. Also, being able to speak to and if necessary visit an out of hours GP service for issues needing a prescription.*
- *The ideas are fantastic but are unrealistic. Why not recruit and improve the services at BOTH hospitals, then the increasing population and the increase of housebuilding will have the infrastructure in place to accommodate everyone without choices of WHICH SITE is most suitable for what.*
- *In my observation, continue to focus correctly on human resources first and foremost. Then configure and improve, the building constructions, as indeed 'Centres of Excellence', based upon the identified needs of patients, and their consultant led treatment and care.*
- *I think we could do more with technology - Skype consultations into a hub staffed on long days might be an alternative especially to those in more remote locations. Seeing someone's face tends to give a degree more confidence that you've been understood and are taken seriously.*
- *We need a community hospital close to Chelt and Gloucester like Delancy to absorb rehab beds to free up the acute trust beds. Forest of Dean (Dilke, Lydney) and Ciren are too far away.*
- *Solutions such as NHS 111 need to be using the same information and advice as local centres - e.g. I have previously followed advice from 111 to attend an MIIU to be told by the MIIU that in accordance with NICE guidelines I had to go to A&E as they could not treat in those circumstances, to be told at A&E that they had a different guidance from A&E.*
- *Walk-in urgent care should have an on-site pharmacy which patients have to consult on their way in. If the pharmacy cannot help then the patient progresses to e.g. a prescribing ANP. If the ANP cannot help then the patient may be seen by a doctor. This should filter out patients who do not actually need to.*
- *Employ more people, improve working practices to make staff interchangeable*

between centres, make greater use of technology to monitor need, - essentially think more about the convenience of your customers (patients) than yourselves. Always have at least one GP practice per centre open 24 hours for minor emergencies, located at or near the hospital so that they can refer across to A&E if necessary; enable easy referral between that practice and a patient's own practice for emergencies and urgent cases.

- *Concept of streaming patients at the front door so that Trauma etc. goes to A&E and minor injuries etc. get seen appropriately in either Minor Injury Unit (MIU) or Urgent Treatment Centre (UTC). Or turning more people away and having a process where they get seen on the day by the GP.*
- *To avoid 'unsuitable' ED attendances, it may be best to have actual staff at the ED departments, turning people away, and telling them where they should be going with directions.*

5.2. Workforce development:

- *I like the idea of developing pharmacies so they can offer more specialist advice - models in France seem to work well. I also think community health and social care including mental health teams have an important role to play - need more funding, a better coordination / integration in health service. I really like one to local hospital (Cirencester) for minor injuries etc.*
- *Encouragement to Domiciliary care agencies to have a complete factual sheet about the person they look afters medical history, medication, family involvement which is clear and concise, thus relieving the paramedics of trying to find out information through looking through various parts of care file.*
- *One consideration is on recruitment, retention and training, and thinking about your strategy on this - Do you have one? Create a recruitment campaign to attract medical staff into the area.*
- *Expand duties of community practitioners to include urgent advice, and make the referral line staffed all night. We know people who can wait hours during the night for at home care, only to be told to go to A&E when they are trying to help by avoiding A&E in busy periods.*
- *Nurse led rapid response units which would attend to residents in own homes, assessing the need for transfer to A&E, Dr's advice, or be able to treat the patient themselves.*

6. **'Centres of Excellence'**: Comments were made regarding 'Centres of Excellence' and centralisation of services. This included a number of suggestions to amalgamate services on a single site replacing the existing hospitals.

- *I think creating 'Centres of Excellence' is a great idea in the context of planned treatment services. I do think there is scope for Cheltenham and Gloucester to develop their own areas of expertise so that planned appointments may be scheduled at one or the other. When not in an emergency situation, it is of course much easier to organise yourself for travel to a hospital further away.*
- *I think having services centralised and fully staffed with the best equipment is far more appropriate than spreading the service thinly.*
- *I would support the development of specialist care units within our 2 hospitals making them specific to certain areas of illness would help use resources in the best possible way and would allow patients to be located the right area without delay.*

- *I agree that it makes sense to have centres for specialities but some of your proposals seem to be about centralising general care. Closing A and E in Cheltenham for example overlooks the importance of time in getting patients seen.*
- *Stop centralising everything. It doesn't work, people don't like it, they don't want it and do not feel it provides good outcomes. Not everyone finds it easy to travel, and for someone who, say, lives in Winchcombe, going to Gloucester or having a relative admitted there can make a stressful situation worse.*
- *Concentration may seem more efficient in terms of your budget, but imposes significant cost on the most rural and poorest members of our community.*
- *Perhaps consider an ideal solution which is a single site purpose built facility, which should be included in this appraisal of possibilities so there would be the ability to expand in future in a sustainable way.*
- *Centralising services will save money but will lead to a much poorer level of care and service. I would look to keep at least two fully capable A&Es open and then focus on how we reduce the number of patients attending A&E. Ideas include:*
    - *Better out of hours GP services - can be centralised or offered by surgeries.*
    - *Due to the proximity of the Cheltenham and Gloucester hospitals, it makes sense to reduce duplication but from a users' perspective this makes more sense to happen for services offered after A&E. So get people seen and assessed ASAP and then if they have to move to a different hospital for the relevant service then so be it.*

If the way you receive services changes, what are the most important things to be considered to reduce any negative impact on you or people you know?

A range of ideas, comments and suggestions have been made in this section. There is some confusion about whether there are proposals to close or downgrade services at Cheltenham General Hospital, as evidenced by the spectrum of comments summarised below.

An overview of comments, both against and in favour of the ideas set out in the engagement materials follow. In addition, there are comments that relate to specific parts of the existing emergency and urgent care systems, such as Emergency Departments, 111, GP appointments and Minor Illness and Injury Units. Comments were received regarding communication relating to urgent care services now and in the future and ensuring that if any changes are made that these are communicated to the public well to ensure people use the right services. A number of ideas and suggestions for future services are also noted.

1. **Accessible and timely**: Access in terms of opening hours, travel times/location is essential. Services need to be provided in a timely manner. Need to consider the needs of population/demographic, now and into the future. The majority of comments focussed on being able to easily access emergency or urgent care services. This included the distance people needed to travel, the time people have to wait, the transport services available to patients and their families. There was an emphasis on ensuring services are available locally.

    - *To be seen or given advice as soon as possible with very little wait time.*
    - *Your emphasis on timeliness is good because that is what is most important, but it does require that resources are available to keep on top of peaks. We like to feel we are 'in the process' but don't like to feel that the process has got stuck!*
    - *Transport accessibility and expense…I want to be able to see a GP without a massive*

long wait of days/weeks. I want to have easy access to urgent non-life threatening care that is local to me in Cheltenham so I know where to go for something like a gashed hand that needs stitches at 9pm on a Sunday. If I need emergency care then I want an ambulance to get me and take me to an A&E quickly so I don't die

- *Services must be locally available as far as possible. Obviously, as we get older, we will need services more frequently but, with age, we are less able to travel significant distances and, in the case of state pensioners, probably unable to afford significant travel.*
- *Services still need to be available locally. If they are too far away it will cause unnecessary stress and worry.*
- *Access , treatment through an early response to needs . Local medical expertise to offer treatment without the need to ambulance patients to far away facilities .*
- *Clarity on where to go and service provision at different times of day*

2. **Quality and Equity:** Ensuring provision is resilient; of a high quality; and that it is fair and equitable across the county. There is an emphasis that any service that is provided should be high in quality for all those using the services including staff. That services are provided by highly trained professionals, that they are safe and that patients receive an efficient service.

- *Quality of service - fully trained medical professionals available around the clock. Efficient, quick and effective diagnosis and treatment. Easy access to services.*
- *Knowing that patients with complex care needs have a variety of specialities within the hospital to support them. Waiting for review by teams not on site can impact on the length of stay for patients.*
- *That the changes are first and foremost demonstrable an improvement on the existing system.*
- *A single, neutral site so there is no perceived inequity for staff or patients*
- *Stop impacting the villages in favour of the towns*

3. **Improved pathway and communication:** Ensure that people know where and when to seek support. Establish simple, accessible pathways. The majority of comments here were around ensuring that any changes made are simple to understand and follow, including what service is available where and when. Included in this is that any changes are communicated and publicised thoroughly across the whole county. There was also a feeling that the communication between the various NHS services is improved.

- *That we are aware of what services are available and at what times and for what conditions. And when attending the correct location waiting time is well managed*
- *Keep the pathways really simple. Too many options is confusing. Communication. Tell us what (once decided) you plan to put in place as a direct result of public feedback.*
- *Accessing what you need when you need it. Joined up communication between all the services providing care.*

4. **Workforce and resilient services:** Ensure consideration is given to the number, the skill mix and wellbeing of staff to deliver a high quality, caring service to patients. In addition to a strong workforce, consideration should be given to the infrastructure of services.

- *Looking after all the important people that treat and look after all our needs.*
- *Staff that really care, attitudes should be professional but enjoy the job they do.*

- *Need adequate staff levels at all levels and enough beds to cope*
- *I support the need for robust and resilient services. Great environments with good staffing levels.*

5. **Access to GP services:** Improved access to GP services, including availability of urgent, routine and out of hours appointments. Consideration given to the range of services offered at GP practices.

- *To me it doesn't matter which GP or other primary care person is available the key is to be accessible by whatever method as required in a timely manner to have to wait for ages on the telephone to get through to a GP surgery only to be told all appointments are gone can you book in two weeks time or ring in again first thing in the morning knowing the phone line will be engaged for an hour is not effective use of my time as well as waiting in GP surgeries or outpatients beyond a reasonable waiting time.*
- *Consistency. Seeing the same person who already knows your history. Reducing waiting times and the ability for GPs to refer to you a number of specialists at the same time rather than waiting to see one then waiting for tests, then waiting for results, then being referred back to GP then being referred to another specialist*
- *Having out of hours GPs at Cheltenham would be a mitigation*
- *Not having to wait for three weeks to get an appointment.*

6. **Cheltenham General Hospital:** Extensive feedback relating to the need to keep A&E open in Cheltenham. Requests to restore overnight services at Cheltenham General Hospital (CGH). Main reasons given for these requests are:
    - Distance to travel to Gloucestershire Royal Hospital from Cheltenham and the villages to the east of the county (both for patients and their visiting relatives)
    - GRH unable to cope with an increase in patients, both in relation to staffing but also building size
    - Population of Cheltenham is growing and a town of this size warrants a full A&E service

- *If Cheltenham lost its A&E, then the longer journey, greater wait times at Gloucester and higher stress on staff at Gloucester.*
- *There is no way I can see to reduce a very negative impact on my family, my elderly mother and all people that I know if Cheltenham were to lose this emergency facility.*
- *I live in Cheltenham. For urgent medical attention, time is essential. Therefore, having full and competent services including A & E 24/7 is essential. The longer the journey, the greater the risk of permanent damage (e.g. stroke treatment is more effective the sooner it can be instigated) or worse, death. For treatment services and so on, many are stressful, and an extended journey just adds to that.*
- *I don't think there is any way to reduce the concerns people in Cheltenham have about centralising A and E in GRH. GRH is already too busy and full, parking and access are dreadful and there is limited public transport outside daytime hours. Already roads in west Chelt are gridlocked at peak times and getting to Gloucester could take far too long. Our daughter could have lost her arm if she had had to get there instead if Cheltenham. Both sites need to be properly resourced in staffing, equipment, facilities and 24/7 access and this should not even be questioned.*
- *Do not close Cheltenham A&E - it covers far too wide a geographical rural/urban area & a growing & large population - to do so would be negligent & dangerous.*

- *I don't disagree with forming specialist 'Centres of Excellence' within the two hospitals in Cheltenham and Gloucester, but I do believe that a town the size of Cheltenham and surrounding catchment area deserves its own A&E and specialist services required for A&E should be maintained at both sites*
- *Gloucester barely copes at present. We have two main centres of population, can be isolated in extreme weather. Transit times getting worse as populations grow. Don't confuse A&E with referred treatment which already may use specialist centres. Cheltenham A&E already stretched at times, adding to Gloucester would not help.*

7. **Engagement**: Several comments have been made about the importance of the engagement process.

   - *We need to have the conversation early and we need to work harder on co-producing the topics people and communities want to discuss and take forward*
   - *that the reasons for change are fully understood by all groups & communicated to correctly to avoid misunderstanding*
   - *Clear, accessible guidance on those changes, plus ensuring those who have to implement those changes understand what and why, and are equipped with the knowledge and resources to be able to make them work. Invest in change management!*

8. **Minor Injury and Illness Units (MIIU):** Ensure MIIUs provide local, equitable access, are well-resourced (staff and equipment) with access to a range of diagnostics. There was a particular focus on ensuring services remained in Tetbury.

   - *Do not close the local MIIUs as this will have a great impact. Once they are lost they are unlikely to be replaced. Enhance these services to relieve pressure on A+E and on GP practices. Keep services as local as possible.*
   - *Firstly, continue to invest in and develop the capabilities of the Winchcombe Medical Centre along the lines of my answer to the first question. Secondly, continue to invest in and develop the extended-hours facilities at the Minor Injuries Unit of Tewkesbury Hospital.*

9. **£/ Funding:** Additional investment needed in the NHS. Need to ensure value for money/best use of resources

   - *As one of the richest nations in the world, we should expect to measure our success against the best health service standards in the world. That will mean spending more money and spending it appropriately. We cannot get away from improved funding even at the expense of tax increases*
   - *Better more sensible use of limited resources*

10. **Other**: A small number of comments were made that do not fit into the themes noted above, these include the use of technology, support for people suffering with mental ill health, the use of NHS 111 and the concept of 'Centres of Excellence'

    - *Better use of technology to overcome poor public transport systems and distance affecting ability to access services which may be further away.*
    - *The use of NHS 111, a call centre, would become even more confusing for patients. Who would patients refer to ring for advice and assessment? Someone they know*

who also knows them and that they trust, or a stranger working from an algorithm. Many surgeries around the country are now handling their own acute same day enquiries using askmyGP. This is not a technology platform alone, it is a whole system change.

- *Improve 111 services - they create too many acute problems*
- *Mental health: there needs to be more urgent care staff in the community all across the 24 hour period you cannot continue to leave the nights as they are.*
- *the people have Gloucestershire have to accept that they cannot have 2 singing all dancing hospitals and that with the shortage of doctors, nurses and AHP's the specialities have to be sited on one site and not split. As a Gloucestershire resident for ENT /Ophthalmology / oncology I have to travel to Cheltenham ...and crikey compared to other countries i.e.; Australia/Sweden that is a very short distance and we should be prepared to travel for the best care! Most Gloucester residents do not complain.*
- *to lessen use of Antibiotics for people who demand them for a sniffle - then antibiotics would work for really serious problems*

Anything else you would like us to hear in relation to making sure everyone can access consistent urgent advice, assessment and treatment services?

1. **Accessibility:** Many additional comments focussed on access to services, highlighting physical barriers to access and recognising the need to ensure we consider the diversity of our local communities. People also commented on the need to access services in timely manner and noted the importance of equity of provision across the county:

    - *Where trauma/stroke and MI are concerned I want to go to the best facilities with the best doctors/nurses where I will get the best outcomes. We all need to accept this and not be so parochial.*
    - *People without internet access should not be at a disadvantage.*
    - *The key word in the question above is 'everyone'. Gloucestershire's population is widely spread. Access and availability can best be delivered through local and hyper-local outlets and NOT a semi centralised location. You should be considering expanding the services offered not reducing them.*
    - *Rural areas need support with access, with local experts, especially at peak times e.g. winter virus often for quick low level response to save on higher level response needed later.*
    - *For the North of Gloucestershire not only is it accessing urgent care but also get home again as Gloucester is a significant distant and expensive to get home.*
    - *I believe long term and palliative care are important to have available locally. As we age, it is more important that our friends and family members can visit us in hospital.*

2. **Timely services:**

    - *Urgent care means it is needed quickly. It should also be the best i.e. from a specialist with expertise but it is less important how expert the centre is if it takes too long to get there.*
    - *Ensure that attempts to contact the services do not end up with the waiting times frequently encountered with many so-called help lines.*

- *They may indeed get excellent service when they arrive but it is surely inevitable that their outcomes will be affected by the distance the ambulance has to go in the first place to get to them which is then compounded by the extra time it takes to reach Gloucester.*

3. Equity of provision

- *Access should be available in all areas of Gloucestershire, not in one location, which involves travelling many miles for assessment.*
- *It is important to consider all the people in Gloucestershire re design of services, not only the wants for vociferous Cheltenham residents. Localising emergency services to Gloucester would be of large benefit to the whole county and only a minor inconvenience re travel for those living close to CGH*

4. **Resilience & Integration:** There were comments regarding better integration of care and suggestions about how we can ensure capacity and reliability of the services provided. This included comments relating to adequate funding of services:

- *As I keep saying just make the triage system at Cheltenham A&E stricter and support the staff in being able to carry this out. You're not going to stop the time wasters, they're already thinking they need emergency care, so will just bypass the self-diagnosis and call for a taxi ambulance. This urgent advice option is a nice concept but will not work because you're clearly not taking into account the human psychological factor.*
- *Continue joining up services & reducing inefficiency & bureaucracy.*
- *Processes to reduce readmission rates. Nurse practitioners to be made available to discharged patients who have had major, complex surgeries. Often these patients just need some advice and reassurance.*
- *Reliability and quality of service is everything at the end of the day.*
- *If you want a good service you have to be prepared to fund it. What's wrong with taxes dedicated at raising money purely for the health service??*
- *Fund it adequately and reject cuts. Remember it is a service we pay for so ensure our needs are met in relation to this service and don't cut corners.*

5. **Workforce**: Ensuring we have sufficient well-trained staff was raised as a concern:

- *Resources, staffing, training, access and understanding the issue are all concerns.*
- *Valuing staff is the best way to ensure a good patient experience. Care of NHS staff of high quality, training for them, listening to them and encouraging rather than imposing change on them will improve services for patients - and prevent staff shortages. I don't mind waiting if I am seen by someone who cares.*

6. **Communication**: Comments covered a range of issues broadly related to communication. This included how we communicate with patients; how we should communicate any changes to services; and comments relating to the Fit for the Future engagement process.

- *It is vital that people understand where they get the appropriate advise, then that they are understand that the assessment advise they are being given is consistent with the given problem, then what and why the particular treatment procedure is*

being given.

- *Much more practical description of changes that the ordinary person can relate to. Give real examples of how some conditions will be treated differently but better.*
- *Telephone appointments aren't a good substitute for a doctor being able to see you, listen to your breathing, take your blood pressure etc.*
- *Better communication , using emails texts and get rid of the paper that seems to get lost when it's passed from one department to another.*
- *Over 65s will need their own leaflet explaining access in a simplified way. If they are unwell and stressed and live alone they need to have this information to hand.*
- *This questionnaire is badly written and confusing and suspect it's designed to put people off from completing.*
- *This consultation has not been good enough and the v worst information documented that goes with this is too complicated. You should address how to achieve widest dissemination to Gloucestershire public and ensure proper engagement. The majority of people I have spoken to are NOT aware of this.*

7. **'Centres of Excellence'**: A small number of comments were included relating to the concept of 'Centres of Excellence'.

- *24/7 PCI [Percutaneous coronary intervention] service - ideally at CGH where all the experience currently is. It's still closer to GRH than Bristol and the ambulance usually makes the decision.*
- *'Centres of Excellence' I think we can all get behind, it's a great idea and we can all access Cheltenham/Gloucester with time to arrange lifts. Urgent Care appointments in Gloucester if you don't drive and feel very unwell - how do you expect us to get there? Get a bus? Pay £40 for a taxi? It's a serious issue for many people.*

8. **Other services:** Many comments focussed on the range of services currently provided, identifying issues and/or making suggestions for improvement.

8.1. **111 service**: Comments relating to the 111 service, including suggestions for improvement:

- *Suggest you try to use 111 to see what the problems are. The default is usually to dispatch an ambulance which means blockage of A&E.*
- *111 is a good way of accessing advice - but with limitations. It is annoying to have to go through a whole load of irrelevant questions when you know exactly what you need to ask.*
- *Again, it starts with 111. Investment in 111 will lighten the load on other services. Promote 111. Make it the first point of call for everyone. e.g. Train GP reception staff to ask patients if they've tried 111 before booking emergency GP appointments.*
- *More tie in with 111 and A&E, when I phone for advice and been told to wait for doctor call back, then told to go to A&E, the several hours I waited for the call back would be better spent at A&E getting seen sooner.*

8.2. GP services

- *Make online appointments available to see a doctor in a reasonable time frame available. Sometimes you ring and are offered appointments in 3 or 4 weeks' time.*
- *24hr GP service especially in rural areas.*
- *GP doctors used to be on call at night and at weekends, by a rota system obviously – a return to that system would be a help – if only because GPs know about their patients and so can assess the seriousness or not, of their needs.*

- *There are still a shortage of GP's in practices and waiting times to see a GP for routine appointments are still too long.*
- *Make it easier to see a GP. At present there is a hostile attitude towards patients which deters people. I now put up with medical problems until they become a real saga simply because I can't navigate the GP appointment booking system.*
- *I think the GP emergency weekend service behind A and E is a good idea. I also like the GP extended hours program.*

8.3. Minor Illness and Injury Units (MIIUs):

- *The reason people don't use minor injuries is that they either don't know about them or what they offer, free parking is also key. These could be brilliantly used if better communicated.*

8.4. **Pharmacy**

- *Pharmacists are a key resource but until health records are joined up, they a powerless to actually help in most cases. Give them access to records, prescribing powers, and the ability to fast stream patients to ongoing services - e.g. make an urgent GP appointment.*
- *Pharmacy staff are not always as readily available or helpful as the publicity suggests. Higher levels of well-trained staff are the only solution.*

8.5. Cheltenham General Hospital

- *As with earlier questions in the survey, many people provided additional feedback relating to the need to keep A&E services in Cheltenham.*
- *It is essential that 24h A&E services are provided at Cheltenham General Hospital.*
- *I would like you to listen to the many elderly people in Cheltenham and the villages and towns north and east of Cheltenham who will find it very difficult if you remove A & E services from our hospital and place them in Gloucester Royal.*
- *Cheltenham General Hospital cover a wide area (into the Cotswolds) and getting to Gloucester is too hard, takes too long, the route may not be known and the critical one hour window could be lost. Plus visiting - which is vital to recovery of a patient cold be reduced for the same reasons.*

The Cheltenham MP FFTF surveys template responses regarding:

Improving urgent care services in local communities

In your view, what are the most important things to be considered in developing services to ensure everyone can access consistent urgent advice, assessment and treatment?

To ensure high quality services in Gloucestershire it is essential that Cheltenham General Hospital keeps it's A&E. CGH serves over 115,000 people in Cheltenham (a figure that is only going to rise given the number of houses planned for the town) and it's A&E is relied upon by thousands more across the county – from Bishops Cleeve in the north to Bourton-on-the-Water in the east. GRH cannot replicate that provision – either in proximity or capacity.

What do you think about our ideas for urgent advice, assessment and treatment services ASAP?

The 'ASAP' model proposed in the booklet aspires for A&E to be there for you if patients have a life and limb threatening emergency. The best way to ensure that aspiration is met is to keep the A&E at Cheltenham General Hospital open, ensuring local access and avoiding increased journey times.

What other ideas do you have to help us? Do you have a solution to the challenge of developing services to ensure everyone can access consistent urgent advice, assessment and treatment services – if so what is it?

See above.

If the way you receive services changes, what are the most important things to be considered to reduce any negative impact on you or people you know?

If Cheltenham General were to lose its A&E, there are no credible measures that could mitigate the loss of such a vital provision.

Anything else you would like us to hear in relation to making sure everyone can access consistent urgent advice, assessment and treatment services?

No.

6.5.2. Suggestions and Questions - Improving urgent care services in local communities

Throughout the sections noted above, there were a number of suggestions regarding specific services, location of services or the approach needed in delivering care; some examples of these are given below. In addition, some people asked specific questions; some examples of these are given below. Responses to the questions below will be prepared as part of the response to this Report.

Suggestions

How care is delivered:

- *Focus on self-care and care for minor ailments nearer home. The ability to send away patients from ED that are not very ill.*
- *Better signposting or catching of inappropriate emergency department use. A pharmacy or triage professional at the entrance?*
- *I think there should be a consultant triaging in ED. I think this would hugely improve the service that is offered and speed up the processing and prioritise the sick in a more efficient manner. Would it be possible to then stream the not sick and not requiring investigations/ X-rays to a separate physical area or give them an appointment to be seen later at another facility or even have a bus going to the separate facility?*
- *Fast tracking of these patients who have been sent to A&E by another health professional.*
- *How about a skype service that might help*
- *Visiting service for frailty elderly to include nurses and paramedics would be good.*
- *Is there any scope for more, smaller, facilities for frequent types of emergencies where patients could be stabilised and transferred later for specialist attention, or await a specialist to reach them while the paramedic is freed more quickly to respond to further emergencies.*
- *Communities take responsibility of community run hospitals.*
- *NHS should privatise elements of care. You should have rapid response work covered by NHS and long term planned operations should go to the private sector to drive cost efficiencies.*
- *Better use could be made of the other ancillary hospitals especially Tewkesbury which we like very much.*
- *Run a minor injuries and non-urgent problems service alongside A&E, and anyone who has a GP level problem to be rerouted to a GP service with appointments made for them online as part of the attendance. Or run an out of hours GP service all the time.*
- *Advising desks at GP premises rather than always talk about appointments, not available 10 to 14 days for GPs!*
- *Mobile units? Taking a leaf out of Hope for Tomorrow's book*
- *Maybe more mobile paramedics who could visit homes to access or fast access to an out of hours GP.*
- *Local area having a weekly drop in service just for regular tests. E.g. blood pressure etc. where a nurse could sign post to DR or hospital if needed.*
- *Can you give the patient responsibility for holding their medical records (e.g. X ray on*

CD rom) so they take them with them whenever they go

Where care is delivered:

- *Leave things basically as they are and build new hospital combining all new elements to serve not only Cheltenham and Gloucester but also the outlying areas the best place to do this should be alongside M5 at Golden Valley interchange this would serve the whole of this glorious county we live in for the future.*
- *Local centres run by ENP's.*
- *Surely we need a new hospital for Glos. & Chelt. Somewhere near the golden valley would be ideal. Then both areas could share services and work as one.*
- *Possibly combining the Minor Injuries service with GP services would make sense.*
- *Medical care unit in Churchdown between Cheltenham and Gloucester - even off the A40 Golden Valley bypass.*

Transport

- *Transport is a major problem and the apparent expectancy that everyone has a car or has a relative, neighbour etc. who can get them there. Then there is the issue of parking, so I would request a transport system. There is a system of volunteer drivers based at Bream I think, perhaps more volunteer drivers who would drive people to appointments etc.? And transport patients to a care facility at short notice if they need urgent care but not really bad enough for ambulance. E.g. badly cut finger, nail in foot that type of thing.*
- *If A&E absolutely HAS to close, how about improved public transport options, such as a direct and fast shuttle bus between the sites, to avoid people overloading the ambulance service.*

Communication

- *'Talk before you walk' is used in some places and gives a clear message.*
- *Vulnerable people especially may find it hard to adjust to any change. If there are going to be changes made, I hope health professionals will be well informed, patients will be well informed in advance. Maybe some open sessions where patients can attend to learn about services changes and voice concerns.*

Questions: Improving urgent care services in local communities

QUESTIONS	ANSWERS
Definitions	
1. *Just what constitutes a serious condition which warrants a visit to A&E department?*	
Capacity / Demand	
2. *Why can't the A&E services at the main hospitals just be made bigger?*	
3. *Can Gloucestershire Royal capacity really cope with taking on a wider area?*	
4. Laudable ideas but do we have the infrastructure to deliver it?	
5. It's interesting to know the numbers of walk-ins and ambulances at both Cheltenham General and GRH but I think the important point is how do the hospitals manage the levels of patients, whether it's 10 or 100? The service and treatment both hospitals are able to provide and the impact it has is what should be measured.	
6. If Cheltenham A&E remains as a partial provision, can GRH continue to carry the extra burden of more patients when Cheltenham is closed? How will they manage patient numbers if Cheltenham A&E is permanently closed?	
7. What is the peak level of demand that is experienced by A&E at present? What is the breakdown of the types of complaints presented by the patients? How long does it take to tackle them? How successful is A&E in dealing with them? What proportion of cases have to be referred to another department because A&E cannot resolve them. Let's have average and peak demand data and indicate the frequency with which different levels of overload occur.	
Integrated services	
8. *Couldn't you have injury services in GP surgeries/medical centres to benefit a local population?*	

9. *I know a lot of the town [Tetbury] do not go to Romney House GP surgery, they go to Tolsey or Malmesbury, they are Gloucestershire residents but they fall into Wiltshire for Health services as their GP is located in Wiltshire. Have they been consulted as I know they would use Gloucestershire A&E and MIU services as they're closer?*	
10. What about urgent mental health care?	
Self-care/ Education	
11. *What about self-care and treatment? Maybe developing a simple course for the general public providing more first aid courses so people can treat themselves? Or 'simple first aid and minor illness awareness.*	
Data and evaluation	
12. *Will there be independent objective audit of changes so that failures are identified quickly and replaced?*	
13. *What is the mean fast time for a patient receiving care from the phone call to the service itself?*	
14. Where is the data that proves that people access services inappropriately?	
15. *Is A&E a 'legacy' service that (all) hospitals always provided - because no-one really thought about it?*	
16. For those in a truly life-threatening condition, is there evidence that the much longer ambulance ride to Gloucester does not adversely affect outcomes?	
17. There must be a lot of data involving the movement of blue lights away from CGH overnight for what 3 years now? Are you analysing that data? Why are you not discussing it publicly? And demonstrably basing plans on that data?	
18. Nowhere do you explain the criteria which will determine where various functions should be sited and neither do you declare the criteria against these changes will be measured as successful?	

'Centres of excellence' Approach	
19. *They talk about stakeholders, engagement & consultation but what are the drivers behind the review of provision from Cheltenham General?*	
20. *Ideas look good, delivery is vague. Not sure how often some of the services will run, i.e. will the planned services be comparable in equity to those in Gloucester and Cheltenham?*	

6.5.3. Summary of feedback received - Improving specialist hospital services and developing 'Centres of Excellence'

Most respondents to the survey provided either general comments about the 'Centres of Excellence' approach' or focussed only on Accident, Emergency and Assessment Services. Fewer responses were received regarding General Surgery or Image Guided Surgery.

What are the most important things to be considered in improving specialist hospital services (Accident, Emergency and Assessment Services, General Surgery and Image Guided Interventional Surgery) and developing 'Centres of Excellence'?

A range of ideas, comments and suggestions have been made in this section. An overview of comments, both against and in favour of the ideas set out in the engagement materials follow. These comments have been grouped together under a series of themes. Some comments cover more than one theme.

1. Positive, neutral and negative responses to the 'Centres of Excellence' approach

Examples of positive or neutral comments about the 'Centres of Excellence' approach:

- *Offering specialist services in both hospitals does not work – the current ethos is fundamentally different across the two sites and precious time is wasted in transferring staff and patients between hospitals for procedures, leading to increased length of stay and poorer treatment. Bite the bullet and centralise services, the hours not spent in transit between hospitals would provide hundreds of extra clinic appointments.*
- *'Centres of Excellence' are great, the notion is not new and has been around for ions. Locate CoE ('Centres of Excellence') across the region, not just in the biggest most expensive hospitals. Biggest is not best, small, agile and focused is, perhaps using the notion of mobile services? We have the technology, creativity is key, biggest isn't.*
- *Concentration of specialist services – especially tertiary or highly interventional services at regional level where the use of staff and resources can be maximised in the most efficient way plus associated district general and community hospitals ,walk in centres to deal with more routine medical issues. This is really an updated model of the 'hub and spoke' system previously advocated but stymied by broken spokes and missing hubs and lack of proper long term strategic planning.*
- *Makes perfect sense to have surgery 'Centres of Excellence'. Draw specialist doctors and equipment together. Attract specialist nursing staff.*

- *'Centres of Excellence' are important but the planning has to be first class. Services have moved backwards and forwards from Cheltenham to Gloucester but the infrastructure has not been able to support these moves. It comes down to bed occupancy, unless you can sort out your discharges especially for those with complex needs your plan will come to nothing. You already treat patients on a day-care basis as much as you can, but then you fill up the day units with inpatients so operations are cancelled. This is a classic example of the inadequacy of your infrastructure.*
- *Agree with 'Centres of Excellence' as it is hard to argue with the logic. Need to hear everyone's views and get best ideas in the plan.*
- *Getting to see the right doctor, having access to the best equipment etc. I support the centre of excellence for emergency care idea and it made a lot of sense for me. I see most people would continue to get most urgent care near where they live, so it was just critical life-saving care at a single unit, I think it should happen. Also I has two operations cancelled two years ago and I think that could have been avoided if planned and emergency was better separated.*
- *Services need to be designed to be sustainable and ensuring that pathways of care are appropriate. Services need to be designed around the most appropriate clinical pathways. Both CGH and GRH are easily accessible and there should not be a requirement to inefficiently duplicate services on both sites simply because of location.*
- *The development of specialised centres sounds promising but the basics of care cannot be forgotten. The correct infrastructure for travelling and access must be in place before things are moved from one hospital to another.*
- *Better to run one centre giving excellent care and more efficiently than struggling to maintain two sites. A fair split of specialist services between Gloucester and Cheltenham seems rational.*
- *'Centres of Excellence' can be built only if we concentrate fully on each of the two major types of services- emergency and elective. The best centres both nationally and internationally have dedicated emergency and elective services separated out and concentrated on.*
- *The ED needs to be large enough to accommodate the throughput and the bed base behind it needs to be able to accommodate the admissions. The advantage of having one site more focused on elective work is that hopefully it will reduce the number of patients who have procedures cancelled at short notice.*
- *Putting specialist centres for the different medical areas together in either Cheltenham or Gloucester for planned surgery is a great option. A&E assessment needs to be localised and once life stabilised move the patient to the area of specialism required. But this will not solve the under capacity of the NHS against the over demand of the public. We have an over demand for treatment that will only be serviced by more capacity in the hospitals. Specialised centres should be more efficient so it's a step forward but it won't solve the over demand we have.*
- *If I had a serious car accident or stroke or whatever, and high-quality emergency treatment was centred at Gloucester, then (although I would personally prefer it otherwise) I would have to accept that that was the optimal approach from the point of view of the professionals concerned.*
- *That the services provided are kept within Gloucestershire, so that we don't lose expertise to neighbouring counties. That the services provided are equitable for patients and staff. That the services are safe and sustainable. That co-dependent*

services are co-located on one site.

- *Changes should result in a true improvement in the quality of care delivered. Improving the quality of the service is more important than the location. I understand that patients having major planned abdominal surgery have potential for complication after operations and can become unwell. I would want to be looked after by a team of doctors with rapid access to emergency care in this setting.*
- *For planned admissions and routine ongoing care, developing 'Centres of Excellence' is a good idea and will improve efficiency of resource within the Trust. However, emergency care cannot be included in this, as for emergency care, a centre of excellence is no good if it is too far away.*
- *GETTING TO SEE THE RIGHT STAFF AND REDUCED WAITING TIMES. THIS IS SET OUT IN THE BOOKLET CLEARLY AND THE EMERGENCY/PLANNED SPLIT (CENTRE OF EXCELLENCE WAY OF DOING THINGS) IS HAPPENING IN OTHER AREAS LIKE IN TYNESIDE WHERE I USED TO LIVE. HARD FOR PEOPLE TO ACCEPT WHEN CHANGE IS AFOOT, BUT CARE GETS BETTER.*
- *Splitting planned care I think is more palatable since the travel etc. can be planned in. None of the mothers that I know objected to going to Gloucester for Consultant-led childbirth. The one thing I have found that was weird was having to see a specialist in GRH to be referred for a procedure in CGH and then get a follow-up to GRH only to be told by the GI clinic that they would take over the follow-up at Cheltenham! I think it would make more sense to centralise these.*
- *There is a difference between a centre of excellence where the treatment is planned (such as attending a specialist heart unit for a planned operation) and genuine emergency care. For the latter, this draws heavily on dependents, partners etc. and is usually a very highly stressed scenario. Having an A&E in the immediate location is better than having to travel further afield.*

Examples of negative comments about the 'Centres of Excellence' approach:

- *I'm fed up with the term 'centre of excellence'. Usually this just means a 'cost-cutting' exercise and the reduction of services with people having to travel far further for care. Everywhere should be a centre of excellence at what it does anyway, not some sub-standard service run into the ground by spiralling costs caused to a large extent by people not looking after/taking responsibility for their own health-well-being. For example, fertility treatment is not a basic right, but emergency care to stay alive after a heart-attack etc. is! Some services are absolutely essential, some are 'nice-to-haves'.*
- *Specialisms should not be pursued to the extent that CGH loses its A&E. Cheltenham General Hospital is exactly that- a general hospital- and no reconfiguration that might undermine that status should be considered.*
- *Forget 'Centres of Excellence'. Just provide good medical treatment as has always been offered in the past.*
- *There is a gross assumption that developing 'Centres of Excellence' will improve specialist hospital services. From the point of view of the patient, where there is some cross-over between various specialisms, where will they be treated or are some aspects of their problems just not dealt with adequately? The implication is that 'Centres of Excellence' will remove some excellence from other centres. This reveals that the focus of any potential changes is on the staff rather than on the patients. Cheltenham General Hospital A&E, for example, needs to continue to be sited where*

it is most needed and any move to close it cannot be seen as an improvement.

- *If you put all on one site the centres will not cope therefore will not be excellent.*
- *Existing service - whether considered specialist or not - should be retained. All services should be attaining the highest standards possible. There is little to be gained from attempting to pursue so-called 'Centres of Excellence'. This is usually no more than an exercise in self-aggrandisement and self-publicity. It is far better to have a good general range of services required by the local population. No one really cares if their life is saved by a centre of excellence or a regular department.*
- *Stop trying to be a centre of excellence and just be county hospitals. We live in a prime area where we have access to Birmingham and Bristol who both have various 'Centres of Excellence'. By trying to become a centre of excellence you are removing money/resources from another part. We don't have a university attached to it so there is no specialist teaching needed. Just try to be the best general hospital there is.*
- *For unplanned, urgent or emergency assessments and treatments distance of travel could be crucial especially at times when traffic conditions are busy. The idea that the population of Cheltenham and the wider catchment of Cheltenham A & E being channelled to Gloucester Royal with its poor road access and already stretched facilities and services is truly frightening.*

2. **Other specialty comments (General Surgery and Image Guided Interventional Surgery):** Some respondents to this question in the survey commented on specific specialties in the context of the *'Centres of Excellence'* approach. Examples are shown below:

General Surgery

- *Keeping general surgery in Cheltenham is also important. I had 4 stays in Cheltenham General in the last 3 years, including 3 operations. The standard of care was excellent, I could attend clinics on the bus, my family could visit on the bus and in reasonable time and I felt that it was within reach. When I had to attend a clinic in Gloucester it was hard to get to, parking was tricky, the hospital was unfamiliar and it took me a great deal longer to get there. It was a relief to have to go the Cheltenham after that.*
- *General Surgery - essential to continue at CGH 24 hours a day, particularly oncology unit. Radiology / intervention - Best centralised. Essential cardiology intervention is 7 days per week*
- *To take away General Surgery from Cheltenham and make that only available at Gloucester would relegate Cheltenham to a Cottage hospital not being to provide an A&E at all. Not only would Gloucester struggle to find enough beds it would cause considerable problems for patients and families having to travel such long distances.*
- *I support the 'Centres of Excellence' proposals, particularly regarding emergency & elective surgery and the image guided interventional surgery proposals. Being able to have multiple scans using different technologies within minutes will greatly reduce the time to diagnosis of the more complex emergency cases.*

Image guided interventional surgery

- *Leave it at both sites, oncology patients are at Cheltenham and often require this service.*
- *I genuinely believe the Imaging Hub is wrong - why centralise cardiac interventional*

work on the hot site at GRH when over 60% is done at present on the CGH site. Again this is simply removing work from CGH and cannot be disguised as anything different. CGH is ideal site for doing much of the imaging work and should be utilised to support the GRH site which is overworked and failing few to overload on limited systems

- *I believe that Image Guided Interventional Surgery may have to be located at one site due to cost constraints.*

3. Retain A&E at Cheltenham General Hospital (Gloucestershire Royal Hospital would be unable to cope with demand, Gloucestershire Royal is too far to travel from the east of the county)

- *Maintaining emergency care at CGH; GRH is too distant from a large tract of the county, and is it practical to provide adequate resources there?*
- *I think there should be a proper A&E in Cheltenham as well as Gloucester. I don't think it needs to be as big because if you can reduce self-referral of minor injuries, you would only have a relatively small number of cases, perhaps requiring 2 doctors and a handful of other staff.*

4. Develop Cheltenham General Hospital further as a centre of excellence

- *Specialism MIGHT dictate a centre of excellence but this must not be allowed to destroy or even diminish CGH's status as a GENERAL hospital.*
- *Specialisms do matter, but most of the time, specialisms are services which can be accessed in slower time over several days. The need to handle emergencies very fast, before the patient dies, and to handle general medical conditions which do not need specialist care, are exactly the things that general hospitals do really well. We should be supporting and growing Cheltenham General to serve this need.*

5. A&E is not a specialist service

- *You continue to include A& E with other specialist service as though the nature of the illnesses presented to the former was equivalent to the latter. It is not. A scheduled gall-bladder removal can be geographically footloose. 10 minutes in an ambulance [if that is the mode of transport chosen] is unlikely to affect the outcome. Not so for emergence admissions to A& E.*
- *I do not agree that A&E should be considered as a specialist hospital service. It is an essential service for local communities and should not be centralised in just a reduced number of facilities. Already, many A&E departments have closed or had their operating hours reduced. Further centralisation of local A&E services would be very bad news for our communities and should not be considered.*
- *A&E is not specialist until judged so by triage or maybe others qualified to do so, symptoms will not be judged as needing this unless assessed. If access is restricted in Cheltenham 24/7 serious developments in condition may occur. This has been the experience in my family several times - viz infant meningitis, head impacts, unrecognised bone fractures, infection spreading as blood poisoning turning to sepsis, heart fibrillation able to be treated urgently without ambulance. Don't confuse centres or locations of referred services with A&E in this context, where specialist centres already occur.*
- *Specialism should not be pursued to the level that is detrimental to a general A&E service. Again use some common sense a better service at Gloucester A&E does not*

help you if you die in traffic before you can use it.

- *It is not clear to me whether emergency medicine is a separate discipline or whether it involves people from a range of disciplines who might well be mainly in other 'Centres of Excellence' on a different site.*

6. Communications, better understanding of the 'Centres of Excellence' concept, improved awareness of services and role the public can play in self-care and taking responsibility for health and wellbeing:

- *To defend 'Centres of Excellence' you have to be more upfront about inadequacies of two site working. That takes courage and is open to the repost just get more money and people. Major task to establish confidence in non-A&E facility. Has to be open 24 hrs, very seldom transport anywhere else, if do help with return journey, good consistent info on what can be treated there. Maybe better time commitment e.g. treated within 2hrs not 4 hrs.*
- *Get clinicians totally onside for any change. You don't want competing views from clinicians and management.*
- *Make sure everyone knows their role in healthcare (including the populace), improve bottom up knowledge, only then will 'Centres of Excellence' not be swamped by day to day issues.*

7. £ - increase funding for Emergency Services, increase funding for workforce, quality buildings and specialist equipment. Use resources more efficiently. Anti-privatisation.

- *Investment in the services to ensure quality of care in suitable premises.*
- *Don't parcel up services into Cs of E so they can be privatised and then brought by US private equity*

8. Access

Speed of access to specialist services

- *Easy quick access. I have a problem. First appointment with my doctor is 3 weeks hence.*
- *Location, location, location… travelling an extra 40 minutes to get specialist provision of a service is fine if the condition hasn't arisen without notice and needs urgent attention. A&E is a specialist service but it's ridiculous to consider that in its case location and accessibility are not as important as the staff and equipment available. What's the good to have a wonderful department if you are dead or permanently damaged before you access those services.*
- *Firstly, lumping A&E with any non-emergency service is wrong. A&E is about non-planned events which need to be responded to ASAP. General surgery is not, neither is imaging or lab tests. Any attempt to treat A&E the same as other specialities shows a misunderstanding as to the purpose of A&E. There is nothing wrong with developing speciality centres for specialities where the patients are scheduled into the service. It remains that access to the service means as much as the quality of the service even in these cases since the service can only provide quality to those who gain access. If the best orthopaedic service is 200 miles away but an okay one is 10, I submit I'd be more likely to attend the local one.*
- *Local access to A&E. All other services reviewed and developed into 'Centres of Excellence' located where most appropriate. Keep all existing MIIU's and, if possible*

create more.

- *There is no point of having an eminent heart surgeon in Gloucester, if I have a heart attack on the outskirts of Cheltenham, but the CGH does not have the facilities to stabilise me before sending me over to Gloucester. Dead on Arrival in Gloucester does not enhance his or her career prospects and certainly won't help mine!*
- *The most important thing is waiting times. No one wants to wait hours to be seen.*
- *Keep A&E Cheltenham open. No point in providing a wonderful service (at Gloucester) if patients can't get there.*
- *Accessibility, Accessibility, Accessibility, Accessibility*
- *The most important is to retain A&E at Cheltenham. Our 94 year old relative has falls in the night but will not call for an ambulance because she knows it will take her to Gloucester, consequently she suffers.*

Access to GP appointments, respondents reporting choosing a specialist A&E service as unable to access GP services.

- *I'm not sure whether creating a centre of excellence that is world class is a good next step. In my view, you need to get basic care needs met first. I think that's what matters most. I also think that emergency care is not going to get better until access to GP appointments is improved and the consistency of quality of GP care is improved. At the moment if feels like a lottery as to whether you get help, it all depends on the doctor and if they really listen to you or not.*
- *A and E waiting times long often because some people who are not urgent cannot/ do not go to GP.*

Transport (including public transport), car parking, visiting, transport for discharge to home and environmental impact

- *Easy access to those services. Patient transport. Many people live alone and do not have others to rely on to get them across the county for appointments / treatment.*
- *Transport to from and between 'Centres of Excellence' is essential - at the moment this is non-existent. This includes when treatment is completed you cannot just kick out patients to find their own way home that is not on. This will need a big*
- *Reorganisation of your transportation contractor who is totally useless.*
- *You have set a time target of 30 minutes for people to drive to a treatment centre yet ambulance and patient transport systems currently take an average of many hours in the Forest of Dean, and public transport is extensively non-existent and where it exists, patchy and infrequent.*
- *Access to all both patient and family. The muted idea of general surgery being in Gloucester is in principle a good idea but patients and their families may be unable to attend if they live for example in the North Cotswolds where there are no bus or train services to Gloucester. These patients could I guess be referred to the John Radcliffe in Oxford which is more accessible than Gloucester for them.*
- *Consider the needs of diverse groups of people- people who may not be able to drive themselves or too ill to plan how to access facilities far from home. It is no good having 'Centres of Excellence' too far for family or friends to visit. We also now have to aware of the environment and try to make journeys as accessible as possible.*

9. Workforce and Technology

- *Fair pay and treatment of staff and zero tolerance to abusive patients*
- *Excellent staffing levels to deliver high quality care face to face. Strong & effective admin procedures to co-ordinate all care appointments and records. Nursing/medical staff able to spend more time with patients to carry out consultations and treatment.*
- *Staff.... Nothing will work when their aren't enough and therefore those that there are are demoralised and exhausted.*
- *Maintaining staff with clinical expertise. Having high quality services and outcomes, utilising technology where available to assist with this.*

10. Build a central hospital between Gloucester and Cheltenham

- *I am not convinced your 2 'Centres of Excellence' vision is sustainable. Why have you ruled out creating a new one centre of excellence midway between Gloucester and Cheltenham? Such as a new hospital near Staverton / Churchdown would have good transport links and much better serve the whole county.*

11. Quality of services (including Safety)

- *Concentrate on those things which improve quality of life of the majority.*
- *The most important considerations for me in terms of health care provision are: * The quality of care * Outcomes * Safety * Patient experience*
- *I don't think we should be prioritising centres of excellence we should prioritise care compassion and dignity.*
- *Safety of services and having appropriate levels of highly experienced/ qualified staff to provide those services. To do this with the increasing shortages of professionals , nurses , doctors etc. which is only going to get worse as they are all retiring early then services have to be on one site. Obviously, with oncology in Cheltenham there has to be urgent surgical services as it would be too dangerous to transfer someone critically ill.*

12. Resilience of services / population growth

- *The Cheltenham A& E must remain to cope with the proposed residential growth of the town and the surrounding area.*
- *Cheltenham is an expanding Town. There are numerous rural communities who also rely on the provision of NHS care, & so it is vital the Cheltenham Hospital has A&E facilities 24 hours a day, 7 days a week.*
- *A&E needs to be in Cheltenham as it is a growing town.*
- *Cheltenham is an expanding town which has a diverse demographic, and so it remains essential that Cheltenham General Hospital operates with a fully functioning A&E Department that is available to the Community 24 hours a day & 7 days a week.*

13. Equitable services, parity of services

- *We need more and better social care and access to this for all ages - children and elderly.*
- *We need better funding for mental health and physical health equity - all these services could be at the main hospitals with a drop in for advice and information for*

children's mental health crisis services too and with courses to cope with children and teenage difficulties and normalisation teenage difficulties and behaviours so we do not further disadvantage our young people and label then with mental health difficulties and build resilience and coping.

- *Access to 24hr mental health support for under18s.*

If the way you receive services changes, what are the most important things to be considered to reduce any negative impact on you or people you know?

A range of ideas, comments and suggestions have been made in this section. An overview of comments, both against and in favour of the ideas set out in the engagement materials follow. These comments have been grouped together under a series of themes. Some comments cover more than one theme.

1. NHS Management

- *To remove an essential service then ask how to solve the problems of its negative effects does not seem to be meeting the purpose, responsibilities and fitness of the trust to make such a drastic and irresponsible change without offering adequate replacement services. If you have to ask in a survey how to consider negative impacts perhaps the trust has a legal obligation to disclose its plans to reduce negative impacts.*
- *To avoid the transfer of services and specialisations out of the area, be it Cheltenham or Gloucester. If you want to save money, remove some of the management layers and transfer those released by this back to medicine.*

2. A single new acute hospital for Gloucestershire

- *Build a new single centre of excellence before closing Cheltenham and Gloucester hospitals.*

3. Engagement/ public and staff

- *Enhance current services, get the community more involved - fund raising events at the local hospital - put it to the community to see what they can do regularly to raise funds and celebrate this by having local heroes who come up with innovative ideas - ask local bit companies to donate time and money.*
- *Being actively listened to. Communication using my language. See me as a person, not a label, not an issue and not a number.*
- *A few well trained, knowledgeable people based in villages, towns, etc. would be so reassuring.*
- *Be prepared to amend your plans in response to feedback if your plans get a stronger than expected reaction.*
- *Staff need to be kept on board at every step and listened to in the consultation. Don't lose more staff in the reorganisation.*

4. Efficiency / Integration

- *Make each appointment a one stop shop to save patients from having to make several journeys for different appointments.*
- *Reduced outpatient waits. Better use of IT and telephone to reduce numbers of outpatient appts required. Speedy access to test results.*

- *A service that joins the dots. My elderly father has to make numerous visits to hospital resulting in many letters from many departments arriving at various times. He is confused with who he is seeing, when he is seeing them and often why. If there could be a joined up approach with one visit to see either one person who can do all the conversations and then feedback or one visit to see multiple clinics it would save NHS money and time and also my father, the patient.*
- *There are realistic alternatives to patient first local provision. The hospital must cease the practice of continually cancelling consultant determined follow up appointments. This adds cost to the NHS in clerical admin. Patient contact plus date critical blood test have to be re done, notwithstanding the patient anxiety caused.*
- *Avoid the need to travel to GRH for post operation assessments unless the local GP recommends it. So much time and expense is wasted telling patients they are fine.*

5. Equity / Equality

- *Keep emergency care local. Ensuring people with disabilities aren't marginalised, ensuing everywhere is fully wheelchair accessible.*
- *It will affect the elderly and disabled more if they can't drive to A&E and can't afford a taxi.*
- *To ensure that all ethnic groups and disabilities are consulted. Literature provided in their own communication method.*
- *An Equalities Impact Assessment MUST be completed at an early stage.*
- *Increased support in the community for those adults with mental health issues.*

6. Funding/Finance

- *Confidence that the changes aren't just for financial reasons and will deliver an improvement in services. Confidence in the people delivering the changes. Good communications from those making the changes - and some unity on the 'way ahead'.*

7. **Communications**

- *…time to sit and talk to patients in hospital to see how they are - human contact is so important as nurses and doctors are ran off their feet due to lack of resources and staff.*
- *Ensuring services such as NHS111 signpost to the most appropriate place to receive care - not just tell us to go to A&E, which has been my experience in the past.*
- *I believe that you need to promote the message better that it is a Gloucestershire wide initiative - at the moment people may think it looks like GRH vs CGH - they are defensive of their own local hospital. An analogy could be - take Gloucestershire University - they operate successfully across multi-site campus in Cheltenham and Gloucester. If you are a resident of Cheltenham and you want to study bricklaying you go to lectures at Gloucester. In many ways the heath care scenario is the same. Try to get over the 'us' and 'them' culture but recognise that people want good quality care at their local hospital. These proposals seem to suggest an over emphasis of delivery at GRH.*
- *We need to know what each hospital offers and how to access services. People need to understand the function of each one, the booklet gives a clear explanation of the intentions for each site.*
- *Ensuring that any changes are clearly communicated to current patients under care. Ensuring that letters re. appointments are accurate regarding names/location.*

- *Just being clear and honest and going out to people to speak about the changes.*
- *People need to have access to clear information, in particularly for planned care. Letters have to have clear maps and directions to the centres or hubs. There has to be contact information so that they can easily ask for clarification, or cancel their appointments if necessary.*
- *It would be helpful if there were a dedicated team of patient partners looking at things like letters and other communications surrounding these changes. Often what staff think a letter says is not how the patients see it, or understand it.*
- *Other hospitals have found that having a Patient Director is very helpful. Patients then have a dedicated place where they can go to find out more information or to explain when things don't work for them.*
- *Providing an information sheet outlining the process undergone to reach the proposed changes and the foreseen positive impact this should have (which should help outweigh and negative impact).*
- *Information, maps, what to expect, and a decent coffee!*
- *Communication of where to go to is key and it feels like we need something more in Gloucestershire like investment in a marketing company/advertising campaign so that patients and public know the right place to go. As current messages aren't being heard.*
- *That the changes are effectively communicated and the staff are fully prepared for the changes.*
- *Communicate the changes with a simple and clear explanation why this has had to happen.*

8. Access

Speed of access to local services

- *Local access is the most important thing. Immediate local facilities are most important, these can feed into the centres of care and excellence as required.*
- *Readily available advice, to be accessed quickly.*
- *I recently had a miscarriage and being able to speak to my GP on the phone the day of the miscarriage and for the Early Pregnancy Assessment Unit at Gloucester to be able to contact me later that day and then see me 48 hours later was good. My nephew (age 2) had a pulled elbow and was able to be seen at Cheltenham A&E very quickly and that was brilliant. I would be sad if these sort of services were unavailable. For the elderly and young I think having appointments nearby is very helpful, it relieves stress if they are able to go to somewhere nearby.*
- *I would hope that routine tests and investigations can be conducted near to home or work.*
- *Outpatient appointments should be available at both sites for all specialities as well as planned minor operations/ procedures.*
- *Don't run down radiography services in local hospitals.*
- *Being able to access appropriate local services quickly whether it be pharmaceutical, GP or A&E. Please note it currently feels a luxury to see my registered GP. When I do see him it saves a lot of time compared to the times I have to see another GP instead and explain everything to that GP from the start. My GP knows me far better than any other. Sadly his availability is poor as he is part time and getting an on-the-day appointment with him is quite frankly a lottery but based on how long the queue is outside the surgery when I join it before it opens and whether those in front of me*

want an appointment with him. I have been third in the queue and still missed out, in fact the last time I went to request one, being 30 secs later to join the queue than the person who got there before me resulted in being told to come back in 4 weeks when my GP next had on-the-day appointments. It is no wonder the hospitals particularly A&E are receiving more patients than they should with poor access to GP services.

- *Keep it local. There used to be a study that I believe referred to the 'golden hour' this indicated the chances of a good outcome following an incident being best if intervention is received in that first hour. Loosing this valuable time riding in an ambulance seems mad. Also patients that survive but have a poor outcome cost more.*
- *A&E at Cheltenham. I recently had to use 999 for a close family member, we delayed the call for 5 hours until 7am as we did not want to be taken to Gloucester. Had we been able we would have driven ourselves to CGH. The paramedics delayed taking them until 8am so they could go to Cheltenham. They died the following day and we 'thank god' that we did not end up at GRH where dealing with the situation for 18 hours would have added to an already distressing time. I know of other people who have also delayed a 999 call until after 8am to ensure they go to Cheltenham.*
- *Keeping the start of any form of investigation and treatment as local as possible.*

Travel / Transport / Parking / Directions

- *Easy access to transport. Public transport infrastructure. Car parking available and reasonably priced if not free.*
- *Accessibility, Accessibility, Accessibility - even if you don't have a car and can't afford the bus fare (assuming there is a bus service).*
- *Public transport to access the services this is normally the county council's responsibility but maybe hospitals can develop hospital shuttle bus services to ferry people between hospitals in the county.*
- *Bus services such as 99 between Cheltenham and Gloucester hospital to be 24 hours.*
- *Although it may seem an irrelevant point, it seems to me vital for a good specialist hospital to have good road access, good signage, good adequate parking, good phone switchboard, good catering services etc. etc. - i.e. not just good medical technology.*
- *Good travel arrangements for patients as it is stressful to go to hospital, even more stressful to go to a town that is not your own and totally stressful to then have to get lost on the way and end up paying lots of money for parking in the hospital car parks.*
- *Cheltenham General Hospital cover a wide area (into the Cotswolds) and getting to Gloucester is too hard, takes too long, the route may not be known and the critical one hour window could be lost. Plus visiting - which is vital to recovery of a patient cold be reduced for the same reasons.*
- *Travelling to different hospitals can increase the time to care. It can also put up the cost of NHS hospital transport for the elderly.*
- *The A&E is fundamental to Cheltenham. If this service changes or is lost completely, hundreds of thousands of people will be adversely affected. Journey times will soar, generating environmental damage and access difficulties, affecting older and younger generations alike. Reasonable efficiency savings, whether managerial or on the backroom side of the NHS, should be considered - but frontline serves need and deserve our protection.*
- *If the Cheltenham A&E is to close then it is even more important to improve the*

response times of ambulances. My home is 28 miles and 45 minutes from Gloucester. Recent waiting times for ambulances to our village have been over one hour meaning time to hospital from our village would be over 2 hours.

- *Transport is a major problem and the apparent expectancy that everyone has a car or has a relative, neighbour etc. who can get them there. Then there is the issue of parking, so I would request a transport system. There is a system of volunteer drivers based at Bream I think, perhaps more volunteer drivers who would drive people to appointments etc.?*
- *Travel - making sure the changes take into account bus routes and ensure that they are available to the most deprived and vulnerable communities - it's central. Taking into account the pressures that the ambulance service is under and how this in turn worries people that they won't get to the hospital in time. Taking into account the issues around NHS 111 service and ensuring that the current issues and concerns about how useful it is are addressed so that patients turn to more easily as a reliable way to get advice and be sent to the right NHS service provider.*
- *By far and away the most important is to maintain the A&E service at Cheltenham General Hospital. While the two-dimensional map of Gloucestershire would call into question the sense of having two A&E departments so close together and while it is plainly true that (in the words of One Gloucestershire) the majority of people in the county live within 30 minutes' travel of a putative single A&E in the Gloucester-Cheltenham conurbation, there is a significant minority who do not. The geography is different in three dimensions. My specific concern is of course those who live to the north-east of Cheltenham (I'm in GL54 5BT) who would be faced with having to drive through or round Cheltenham to reach an A&E department in Gloucester. In no way could this be reached in 30 minutes, even in the middle of the night – and people of my age have increasing difficulty driving at night anyway. Response to a 999 call from north-east of Winchcombe by an ambulance coming from Cheltenham and having to deliver the patient to GRH would mean the best part of an hour before the patient could be assessed. If the ambulance had to come from Gloucester in the first place, then it would be even more. It would be considerably longer still for those living in more outlying areas of this part of the County. We would almost be quicker driving to Worcester!*

9. Quality (Experience, Effectiveness, Safety)

- *Focus on safety.*
- *Reduce avoidable errors - get patients to the right advice or service first time.*
- *Quality is more important than location.*
- *Appoint a ward / floor manager for floor / ward in each hospital to monitor and address any patient issues and concerns. I know patients who have had operations in CGH and have not been given water or treatment in spite of several complaints to ward staff.*
- *Better hospital assistance, similar to Southmead's hospital helpers, would be a reassurance for many. A better consideration for dementia patients or those who struggle with access would be important. A positive reassurance from those using the service instead of people implementing the changes would be more relatable.*
- *If someone is having life threatening treatment having somewhere for the concerned relatives to park or to catch a bus, to have something to drink and eat is important as this would stop the patient from worrying about them as well the scary*

operation/treatment they are about to have.

10. Workforce

- *Respect the reason most nurses/doctors are in the profession - to care. Give them the time to do this and maintain the respect they deserve; and the trust the patients would like to have in them.*
- *I know many people who will leave if these proposals go ahead including myself. I want to see a trust who embraces staff ideas and visions. We have the staff, capacity, expertise, beds and passion to make the trust a pelvic centre of excellence. Keep elective surgery at CGH. People will suffer if everything moves. Waiting times, ambulance delays, transport and environmental costs will be negative on the communities.*

11. Other comments about potential impact of change

- *The most obvious answer is that, if changes are going to have a negative impact, don't make them!*
- *Good ideas don't need to mitigate negative impacts.*
- *I believe that as long as any decision you make is not influenced by political fear over the loss of votes than I am comfortable with the outcomes. Allowing political intervention based on loss of voters is cowardly and puts people's lives at risk.*
- *I think that if the changes are a big improvement on the service somebody already receives, there will probably be less complaints about them. The problem will be if the service is just as poor, or even worse. For example, with my eye clinic appointments, I often have to wait an hour. If the service moved, but the appointment was on time (more or less), it would be such an improvement, that I wouldn't really want to complain.*
- *The only way you can improve is to have a rolling programme of training doctors and clinicians on the wards to be provided with schedules of processes in the procedures and witnessing the procedures in those 'Centres of Excellence' to 'roll it out.*
- *Anything that speeds up the tardy service for day to day ailments would be appreciated.*
- *Clinical excellence and expertise is the key. Maintaining services in a sustainable thriving way is most important. This requires decision making to see big picture benefits rather than narrow short term financial (it won't pay off in the long run) or waiting time objectives as these could undermine existing services which might only require temporary support but have the basics of a nationally leading service.*
- *The changes must be seen to be sensible by the people on the ground and not just pushed through by a select group of surgeons pushing their own agenda e.g. the upper gastrointestinal surgeons seeking their own rota.*
- *I can't see how you can mitigate the impact of moving Cheltenham's A&E department and to suggest you can without impacting the safety of the local population is just fanciful.*

Do you have ideas about how to improve specialist hospital services (Accident, Emergency and Assessment Services, General Surgery and Image Guided Interventional Surgery) and developing 'Centres of Excellence' – if so what are they?

A range of ideas, comments and suggestions have been made in this section. An overview of comments, both against and in favour of the ideas set out in the engagement materials follow. These comments have been grouped together under a series of themes. Some comments cover more than one theme.

1. **'Centres of Excellence' approach / Specialist input**

- *Please consider how complex patients with multiple specialty inputs will be managed. For example what if an inpatient in Cheltenham needs an orthopaedic opinion. Do they have to get transferred to GRH every time? Actually, it works for neurology as they have their ward in GRH but they also do OP clinics in Cheltenham. So if there are inpatients in CGH who need a neurology opinion then the neurologist have been very amenable to attending the ward after a clinic. This needs to be thought about with orthopaedics as it is very difficult to gain an inpatient opinion if an inpatient has an orthopaedic opinion. And thereon for all the other specialties, in particular if acute general surgery moves to GRH.*
- *KEEP general surgery alongside other surgical services and oncology at Cheltenham. Build on the expertise already available and make Cheltenham a centre of excellence for the treatment of colorectal cancer.*
- *Move Orthopaedics to Cheltenham and moving Acute, Neuro, Renal etc. to Gloucester.*
- *Keep Oncology and elective General Surgery available at Cheltenham and develop a centre of excellence for the treatment and prevention of colorectal cancer at Cheltenham.*
- *'Centres of Excellence' are unique, highly specialised treatments only. They must not be used as an excuse to deny local provision for run of the mill treatments i.e. routine surgery, (e.g. Angiograms, stents, cataracts, hip / knee replacement etc. 'Centres of Excellence' show no concern for patients and their supporting relatives difficulty in travelling to these located in another town places. Tried parking in Bristol or oxford hospitals?*
- *I support the 'Centres of Excellence' model*
- *Concentrating specialist kit and expertise on one or other of the sites makes sense.*
- *Two A&E sites within 10 miles of each other seems like a luxury when funds are stretched. But if the Cheltenham A&E is closed down, an effective walk-in centre should be provided somewhere in Cheltenham.*
- *I think the centring of services is a brilliant idea in order to promote time and cost effectiveness for staff and to promote recruitment and retention of consultant staff.*
- *One hot and warm site to support staffing rotas / training / and senior decision making.*
- *Make a hot and cold site to protect elective care from unscheduled care.*
- *Consolidate staff in 1 place to aid efficiency, improving time to be seen and senior decision making for emergency care.*
- *Re-deploy specialist staff to provide more consistent on call cover i.e. surgeons not having to be on call and in theatre at the same time to ensure more timely review of patients referred to them.*
- *Grow the OPAL service, they are excellent.*

- *Cardiology services (not all of which fall under the category of Image Guided Interventional Surgery) should all be located on one site, ideally the same site as the emergency department.*
- *Create centres where specialist care is available so - Cheltenham mainly Cancer at the moment, make this one centre.*
- *Gloucester, create a fully staffed improved A&E centre with access to other hospitals.*
- *General surgery etc. needs to be available every day (including weekends) to make the best use of equipment.*
- *Concentrate emergency general surgery on one site with major abdominal surgery. From the document I understand that this will improve my chances of seeing the most appropriate specialist at an early stage and has potential to reduce waiting times. If I had to have major surgery I would feel reassured that there is a full complement of staff able to look after me out of hours.*
- *If I needed a smaller operation, having this done on a separate site away from the emergencies would help ensure that there is a bed available for my operation.*
- *Medicine is fast-moving and expensive in specialists and money, so the ideas of 'Centres of Excellence' can't really be argued with.*
- *Your question pre-supposes that there are substantial problems with the current arrangements - that has still to be demonstrated sufficiently for me to see the need for change in A&E. I have no issues with the plan to have areas of specialism in each hospital to avoid duplication that works and has the potential to be more efficient but not in urgent services where speed is of the essence.*
- *'Centres of Excellence' approach sounds extremely sensible and clinically the right thing to do. Lots of politics and showboating when it comes to Cheltenham and Gloucester, but need to take a view about what is best for the patient.*
- *Moving emergency general surgery to one site seems to be supported by all so people get to see the right doctor so good - go with it.*
- *An elective / emergency split has its own problems but would seem like the most sensible approach when there are insufficient medical staff to cover the demands of providing a service on 2 sites. If all emergency surgery is to be moved to GRH then elective surgery has to come to CGH otherwise the overcapacity crisis that is enveloping GRH will only be exacerbated. Elective lower GI and upper GI surgery needs to move to CGH. The surgical backup provided by the general surgeons for the other specialties in particular urology and gynaecologist oncology should not be underestimated. In terms of interventional radiology it makes sense to have this onsite with vascular and interventional cardiology. Currently this is all in CGH. Whether this would be better in CGH or GRH is difficult to know. Vascular surgery is required in the elective centre as backup for the other specialities so moving interventional vascular would split the vascular department which is not ideal. An ambulance could be allocated specifically for interventional cardiology / radiology so patients would experience minimal delay moving them from GRH ED to CGH.*
- *It would probably be sensible to move elective and emergency general surgery first and then decide if the interventional services need to be moved or whether it works well in CGH. Bearing in mind that a whole new interventional suite and cardiac cath labs would have to be built in GRH (not a small expense).*
- *Both hospitals to house outpatient portals offering A&E Assessment Services. General Surgery and IGIS could then be offered within more specialised inpatient and outpatient facilities, with areas of expertise specific to one hospital or the other.*

Transport would need to be available for outpatients needing to access the more distant hospital.

- *The 'Centres of Excellence' idea is basically good. I believe that an important part of recovery from accident or planned surgery is access for families and friends to visit the person receiving treatment, this helps that recovery and state of mind.*
- *Co-locating specialist teams is a good idea to pool resources and provide opportunities for sharing best practice. With the correct investment in staff development and training in these areas this could also lead to better recruitment and retention, which I would imagine is an ongoing issue currently.*
- *Streamline general planned surgery etc. and concentrate resource at one or other hospital.*
- *Increase the ambulatory care pathways for patients arriving at CGH if acute medicine moves to GRH.*
- *The surgeon running the take and the surgeon performing emergency operations should never be the same person. With fluid flow of patients from ED to other specialities there needs to be a hospital agreement about how radiology reports are acknowledged and actioned both in the trust and back into primary care. Flow coordinators working in the emergency department. Facilities for rapid electronic transfer of ECG's (without fax...) should be available from ambulances, MIUs and ED to any PCI centre. More Cardiology ANP's & seniors supporting the sharp end of the acute medical take over extended hours to minimise duplication. Similar to Respiratory and Renal model with direct ED access. A robust Emergency site escalation plan which is enacted whenever the pressures dictate.*

2. Equity/Equality

- *A specialised service in A&E for the care of the elderly, including specialist trained in dementia communication, do not be so quick to write off those with dementia many people still have a good quality of life, what you see in A&E is them at their worst not on a good day.*
- *Prioritise those services needed by the most vulnerable in society and keep those services locally and available at both locations.*

3. Quality (Experience, Effectiveness, Safety)

- *Refurbish Cheltenham A&E department.*
- *You will never convince patients to go to GRH when the wards, especially in the tower block, are so awful. Crowded, no privacy, noisy and generally looking tired and in need of complete overhaul. Parking expensive. Getting from multi story to main site impossible for some patients, they do not all have a disabled badge, how can you access porter to take you to site.*

4. Engagement (staff and public)

- *Volunteers with skill to help with admin and giving time emotionally to support people in A and E.*
- *Increased emphasis must be placed on detection and prevention. You can never have too much public awareness.*

5. £/Funding

- *Charge people that get drunk for their care at least £200.*
- *Penalties if people consistently miss appointments at surgeries or consultants offices. People need to be encouraged to not waste doctor's time.*
- *More regular assessment of repeat prescriptions. Many people stockpile things they do not need.*

6. Build a new hospital between Cheltenham and Gloucester

- *Abandon the existing hospital sites and build a new one outside the between Gloucester & Cheltenham.*
- *The obvious solution is to build a new hospital equidistant from each conurbation in the golden valley.*
- *Build an entirely new hospital better suited to the challenges of 21st health care. Both your existing hospitals have a huge infrastructure backlog and are frankly overwhelmed.*
- *Build new hospital with good public transport.*
- *Create one new centre of excellence midway between Cheltenham and Gloucester. Also try to incorporate health training college and a new medical school (maybe similar to Oxford or Birmingham named schools).*

7. Access

Speed of access to local services

- *Make initial point of contact as accessible as possible, reserve specialist centres to treatments requiring the most expensive technology, and have these available only on referral from a general centre with excellent diagnostic facilities.*
- *Cheltenham A&E should be open 24 hours a day. If you must have a centre of excellence then have doctors triage the most urgent cases in Cheltenham A&E and send them over to Gloucester by blue light ambulance. Broken limbs etc. could still be dealt with in Cheltenham.*
- *By having MIUs in Gloucester and Cheltenham, extending opening hrs at GPs would take the pressure off the emergency depts. People use A&E as they can't access a doctor.*
- *Many people going to A and E have simple but immediate needs, so is there a need for such provision within one of the surgeries in Cheltenham to meet this type of low level emergency, which may well not be life threatening, but more of a matter of knowledgeable first aid.*
- *With the growing threat of climate change/Extinction rebellion and a need to minimise pollution, serious consideration need to be devoted to distribution of all but the excessively specialist and expensive equipment around the county local hospitals.*
- *Cheltenham is a general hospital. Make Gloucester a specialist hospital by all means, but leave Cheltenham ED as part of a general hospital serving a geographical area that Gloucester cannot hope to cover.*

Travel / Transport / Parking / Directions

- *Transport needs to be looked at so that people do not need to use their cars so much for hospital visits, this would reduce some of the stress, if enough is offered it could*

even realize some ground for better use than car parking. It would take a lot of organizing so that vehicles are used to their most economical and viable way but this would help in so many ways, especially if used in connection with a 'park and ride' system so that if door to door can't be done (would be great but very unlikely). People could park their cars somewhere between Cheltenham and Glos - or close to one or another and catch a bus to the chosen hospital, esp. useful at visiting time as well as for patients already stressed at the thought of treatment etc.

- *One possible solution would be a dedicated hospital park and ride system, operating both between the two main hospitals, but also between the outlying patients and the hospitals. Preferably with free or reduced parking charges and frequent services. There is nothing more frustrating having to devote half a day for getting to the hospital, finding parking, and getting home again, all for a two minute appointment to have a monitor attached, or to be told everything is fine.*
- *You should consider transport issues and costs, for staff, patients and ambulances in all your deliberations. A solution which does not improve the lives of your staff, patients and families, is not a good solution. Healthcare should be about quality of life in the round.*

8. Communications

- *Improve communication make sure everyone understands why 'Centres of Excellence' have better outcomes. Many people understandably, have felt safe in being referred out of county i.e. Oxford or Bristol and feel they will get better care, much is historical in Gloucestershire.*
- *TV screens in A&E waiting rooms publicising alternative routes to receiving care if non-emergency or non-urgent.*
- *It is really confusing talking about specialist services and other services all in one go. The services are meeting very different needs and people use them differently. It would be better to talk about very specialist services entirely separately and really focus on patient stories to help people to understand better.*
- *For A and E, suggest contacting all people moving into area/around area through council tax/ mortgage brokers/ landlords to give address and contact numbers for surgeries in the vicinity with their hours. More should sign up before they need treatment and numbers known so extra GP capacity can be plumbed in.*
- *I repeat use improved audio/visual communications to make both centres operate as one. Highly technical operations are being trialled by experts based hundreds of miles away. Just giving all doctors smartphones and using readily available video chat would make one super expert available across the whole county, even into Cirencester, Tewksbury etc.*

9. Efficiency / Integration / Technology

- *Maximise work at CGH to offload GRH. That means for example:- doing as much imaging as possible in CGH in an elective pathway, general surgery elective and cancer work in CGH as elective - less likely to be cancelled for emergency work.*
- *Specialist surgeries should be grouped for what surgeon skills and equipment they can share. Fairly obvious not to dilute expertise. Scanners and diagnostic equipment should be efficiently and effectively used - not made redundant at weekends.*
- *KEEP both A&E departments open but use triage more effectively to redirect patients*

to community care.

- *Provide emergency surgical cover at both sites and keep both A&E departments open. Consider introducing a triage system by emergency nurse specialists so only those with genuine emergencies are directed to the treatment areas. Other patients could then be directed to other services within your network.*
- *Develop GP surgeries alongside the A&E departments so that nurses can direct patients at triage to their services. They would be run independently but attached/nearby to the hospital.*
- *Make the corridor queue a whole hospital agenda and spread the risk to wards to motivate their teams to consume their care responsibility and encourage early discharge planning.*
- *The ED needs to ensure it has sufficient capacity to accommodate the ever increasing attendances. An urgent treatment centre alongside the ED where patients can be streamed would be beneficial. It is clinically much safer to divert an undifferentiated patient to a co-located UTC than send them away from the Trust site. A co-located ED and UTC allows greater fluidity between primary and secondary care and allows easier escalation of treatment if required.*
- *More flexibility on appointment times. Specialist centre to have a call list of patients who is happy to be seen short notice, if there is a last minute cancellation.*
- *Reduce the number of visits required to see a diagnosis through. See a specialist, get the required tests or imaging, and then see the specialist at the end - all in one visit. That would save on everyone's time, and reduce the need for further appointments, at which everyone concerned has to reacquaint themselves with the problem.*
- *Some specialist services can be mobile and used as a mobile solution to ensure all communities have access.*
- *With an increasing elderly patients who often do not want complex interventions this is discussed fully beforehand with them and provision of community palliative care nursing, and adequate district nursing staff will help reduce unnecessary admissions.*
- *Greater use of hub and spoke delivery using the facilities in community hospitals, tele consultations, virtual clinics. More specialist nurse management, greater integration with community support services (including Social Care and yes you might need to move some of your funding to social care!)*
- *Better interface between the acute and urgent care and the follow up services - reduce gaps waits and availability inequalities between hospital care and community care.*
- *Improved capacity of Community hospitals and social care to support the main centres with throughput.*
- *I believe you should be able to see consultants as a multi-disciplinary approach. Sometimes when ruling out conditions you have to see various consultants and wait months between each appointment. I believe you should be allowed to see all the consultants and have all the tests done at the same time so save waiting times on treatment.*
- *Use Cat scanners etc. 7 days a week - it's a major waste not to schedule weekend appointments.*
- *Access on line to patient's surgery records-vital in an emergency.*
- *I don't know how much value there is in using video technology. Of course, you cannot always depend on it 100% but if someone needs a consult, could they not use skype to talk to a doctor at another hospital (not even necessarily just at the two*

main hospitals).

- *I think there is probably also scope for cost-saving with the bookings system. When I was trying to sort out some post-op bookings, it was all very postal-heavy (expensive) and also complicated, although the staff did manage to sort it out. It is another national-level issue but HMRC, for example, learned that by sharing a single notification system between all their departments, they not only saved lots of money but reduced the number of letters to each person (more than one letter in an envelope) but also, in many case, I would much rather get the docs on email so I can switch that on globally for all comms from the hospital.*
- *Stop duplicating work all of the time i.e. layers and layers of triage. I recently attended A&E with my partner , it was blindingly obvious as to what was happening but it took three nurses and 4 doctors to actually get going on what needed doing.*

10. Workforce

- *More specialist paediatric nursing skills at the front door.*
- *Investment in alternative qualified clinicians i.e. physicians associates, ANPs etc. to ease the staffing pressures.*
- *Recovery often requires Physio input. We need more in house Physio's in Hospitals whose intervention I am sure will help free up much need acute beds.*
- *Employ more staff. Instead of saying they are scarce put the effort in to finding them. They are out there and your efforts would be better placed finding them.*
- *Encourage loan transfers of skills between Trusts so that Gloucester & Cheltenham benefit from the working practices of consultants from other Geo-locations.*
- *Nurse in A and E waiting room. They could probably deal with half of it.*
- *I believe that the reason for closing Cheltenham's A&E overnight to all but walk-in patients was due to lack of available trained staff. This needs to be remedied. I have worked in environments where staff kept leaving and made the workload greater on those who remained - this is corrosive. I ended up leaving a job as trying to keep going and provide a good service to customers eventually had a negative impact on my life and health. I can't blame doctors if they are overworked but can jump posts to another role with better morale and reward. If there are issues with retention in any department in either hospital then this needs addressing before too many leave to sustain all the existing services.*
- *Retain the Cheltenham General Hospital A&E, restore 24/7 A&E cover to Cheltenham General Hospital, COMMIT to its future and by doing that attract the next generation of emergency dept. technicians / clinicians.*
- *The on-going uncertainty about the future of the Cheltenham hospital must have an impact on recruitment. It is essential that A&E is retained in Cheltenham for reasons outlined above and that the Trust commits to it for the long term.*
- *Keeping the A&E Dept. open for 24 hours a day would help. I'm sure by cutting down on unnecessary middle management you would be able to employ and train staff that are needed by the community. You must make a commitment to the people of Cheltenham!*

11. Other

- *I think you could learn a lot from Oxford Health NHSFT in terms of national 'Centres of Excellence'. I would suggest you approach them.*

- *People have to trust the hospital before they will trust the 'Centres of Excellence' contained therein. Generally, ordinary people are not aware of these (with notable exceptions such as Great Ormond Street for paediatrics, Frenchay - as was - for brain issues, etc.). In order to get people feeling that 'Centres of Excellence' is a. good move, they need convincing that the medical service they receive will be better, not that it will be cheaper or more efficient (not typically what a patient focusses on!)*
- *Unfortunately things needed to be put in place ages ago, and then by now we might already have 'Centres of Excellence', to allow this country to again lead the world in medicine and many other things too. We need politicians to be brave and increase taxes a little to allow this to happen.*
- *You are looking at incremental steps consolidating outdated hospital buildings in one place. If you do wish to improve, then radical investment in new facilities in a location which enhances rural coverage rather than reduces it should be on the cards.*
- *The deployment of a facility in the city to catch those who have over consumed would considerably improve the efficiency of GRH A&E at the weekend.*
- *Research Unit establish at the new hospital. Military/ Intelligence element? near GCHQ.*
- *I would seek out those Trusts that are grading excellent and look for transferable ideas.*
- *Look at Trusts that CQC have graded excellent & see how they do things. Identify best practice throughout the UK & abroad & apply those ideas that fit our county. Look at technology & how it is used today & make it work for you - go paper free. Apply Activity Analysis to back of house functions & streamline them. Ask why things happen & are they necessary. Don't reinvent the wheel!*
- *Remove 4 hour targets which get in way of treating patients.*
- *All the established hospitals of high repute appear to be training hospitals. Seek to make Cheltenham the destination of such practices.*

Anything else you would like us to hear from you in relation to improving specialist hospital services (Accident, Emergency and Assessment Services, General Surgery and image Guided Surgery) and developing 'Centres of Excellence'?

A range of ideas, comments and suggestions have been made in this section. An overview of comments, both against and in favour of the ideas set out in the engagement materials follow. These comments have been grouped together under a series of themes. Some comments cover more than one theme.

1. Engagement (staff and public)

- *The thing that never gets mentioned is how people using the services feel. Wellbeing is known to help people heal & this does not get a mention anywhere. All the top consultants and best equipment will not do as good a job if there is no feeling of wellbeing because it such a difficult journey to get somewhere for treatment or because relatives & friends find it so hard to visit. One of the recent comments I have heard from 2 different people who have been in hospital recently is that they were not treated as people. There was no eye contact or conversation at all, just looking at notes & equipment. This is a very important aspect of treatment seems to have been lost and needs adding back in.*

- *Involve public and staff in discussions and decision making.*
- *Sort out the management and administration side of the hospital. Too many inefficiencies, and staff that are not trained in managing customer experiences. Change the way you think - each patient is a customer. Drive the hospital like a business, create positive customer experiences and if staff are inefficient (trust me, from what I have seen, some are), manage them out of the organisation.*
- *A few well trained, knowledgeable people based in villages, towns, etc. would be so reassuring. Like the first responders who volunteer in villages and are called on to attend heart attacks until the paramedic can get there.*
- *The best thing for me has been face to face time with specialists who communicate well both with patients and their teams. Although phone calls and online advice are useful, nothing compares with personal contact at times of emergency / life changing situations.*
- *Please make this engagement exercise REAL - I know you say you have not yet taken any decisions about the future of emergency care BUT if this were truly the case your engagement events would be on the future of ALL levels and types of care, not predominantly about the provision of urgent care.*

2. Efficiency / Integration

- *Build one hospital between Cheltenham and Gloucester - in key position with great access to the rest of the county from M5/A40/and for emergency vehicles/Staverton. One hospital. One set of staff.*
- *Bite the bullet and plan for a single centre of excellence between Cheltenham and Gloucester. Such a vision I feel is much more sustainable and beneficial to the whole county.*
- *An IT system that can talk to all the units and EPR available to all so that patients going between units can be spotted and sent to the most appropriate facility.*
- *Acute mental health issues take up A&E / Emergency access services - Can these be dealt with outside of A&E.*
- *Smaller community led services, are cheaper to run, in comparison to the large specialist services.*
- *Direct access to specialist clinics without having to go through GP.*
- *I also think it's time to start to fine people for not attending appointments, money to go back into NHS or reduce hospital parking charges. Sufficient nurses to do this.*
- *Stop mythering over BREXIT and sort out a 21st C NHS! This may mean reducing the numbers of larger hospitals but this may be compensated for by more work in enhanced GP/local specialist settings to continue patient management post discharge.*
- *Social care is an area that needs better integration - I would be concerned with services being consolidated elsewhere and the effect on liaison with local councils. Furthermore, the onward capacity changes at Gloucester that would be required to cope with demand from cuts to services or 'rationalisation' I do not believe are feasible - we would end up with a worse service, over capacity, over stretched with the heart cut out of Cheltenham hospital in the meantime.*
- *Put more convalescence facilities in place with some medical care and good occupational therapists and physiotherapists. This would help to stop bed blocking in acute care.*
- *One health and social care route and the organisation barriers removed. Staffing*

makeup of services based across professions (better skill mix).

- *Update the medical records department, pharmacy departments who contribute to the slow discharge and moving of patients.*
- *Record metrics based on time from first call to 999 to arrival in ED. Not just processing time within the department.*
- *Do we need nurses and doctors spending hours sitting at computer, can you not invest in new technology where the staff have Dictaphone that can be plugged into computer and this info is downloaded. I am well aware record keeping is very important. I would like to add that current staff are incredible - no criticism of them at all.*
- *It would help if the Government had a joined up policy when it came to Social care and Medical needs. To allow a system where poor social care facilities block hospital beds with patients who cannot be released because of inadequate facilities is appalling and shows a deliberate paucity of thinking from the Government, Social care should be a part of the NHS.*

3. Communications

- *It goes without saying everyone who likes to be treated in their local hospital but again I think the elderly generation used to times of having my doctor find it hard to accept changes that have come in their lifetime and do not understand why they are expected to have a computer. Communication in as many ways as possible and reassurance.*
- *The NHS is changing, most of us see the bad news of hospitals closing, wards being left unused and lack of nurses and Doctors. Of course we get worried. Publicise good news relating to the NHS as there must be some. Please make it clear where we go and for what and what to expect.*
- *Sometimes families need help and advice on dealing with certain diagnosed conditions, leaflets and maybe contact numbers to be able to access would be helpful.*
- *A general point: Both hospitals have confusing signage.*
- *Why do they not use coloured the lines on the floor system to at least get to the right area (even in dept. names change). E.g. to the tower to East block.*
- *People will have different motivations, whether that be personal, emotional or political about any changes to either of the two sites.....but this needs to be 'background noise' and the focus should be on the hard facts around why these services do need to change. The case for change needs to be water-tight with clear evidence of why retaining the 'status quo' or to 'do nothing' is not an option.*
- *There is good academic research on signposting in hospitals and other public places:*

  https://hydeandrugg.wordpress.com/2014/11/20/signage-literacy-and-wayfinding-part-1/

  https://hydeandrugg.wordpress.com/2014/11/26/signage-literacy-and-wayfinding-part-2-indoor-signage-and-wayfinding/

- *Just try and remove the chaos and keep patients informed. Perhaps some administrators could be trained to support patients and guide them through the maze of A and E if there are ins People still need to be educated not to use A&E unless it's an emergency.*

4. Access / Travel/ Transport

- *Huge parking payments should be abolished - anyone with a parent/child/husband should have the right to park either for free or a minimal charged.*
- *The downgrading of the 99 bus which does not now serve Cheltenham racecourse car park causes significant difficulty for patients and staff is typical of lack of understanding by the NHS local management of the travel problems getting to our hospitals. The 99 bus should operate 7 days per week - yes people do visit hospitals on weekends. In any event car parking at both Gloucester and Cheltenham is never guaranteed so a reliable 7 day a week bus service is necessary.*

5. 'Centres of Excellence' approach / Specialist input

- *Emergency general surgery needs to stay on 2 sites GRH and CGH particularly oncology staying at CGH.*
- *The plan to develop an IMAGE GUIDED HUB seem poorly thought through. Most Interventional radiology work is referred from the UROLOGY and VASCULAR wards in Cheltenham (plus oncology, general surgery, gynae), so plans to concentrate services at GRH put capacity in the wrong place for many patients. CGH Interventional radiology relies on 4 sessions per week in the hybrid theatre (with vascular surgeons competing for sessions) and a 15 year old Interventional radiology room that has repeatedly failed to be replaced and is now so old that the manufacturers cannot guarantee repairs or support. It is one breakdown away from precipitating a crisis in covering this work. No-one in the management team seems to acknowledge this time bomb and there are no plans to replace a key facility. Are we to assume that we will just transfer acutely unwell patients to and from? The fact is that Interventional radiology is essential on both sites, not just one major site where there is over-enthusiasm to support a relatively small number of complex elective cases.*
- *Create 'Centres of Excellence' with Worcester and Birmingham.*
- *Good idea to centralised General surgery. I think people don't mind travelling for specialist clinics but want same day x rays / blood tests near them.*
- *The county requires two 'Centres of Excellence'.*
- *The 'Centres of Excellence' project needs to pause and rethink its strategy - potential to really improve healthcare in Gloucestershire but this isn't right. CGH needs to do much more work (not less) and that involves more imaging work (inc interventional work) and the general surgery elective work (not just day case cholecystectomies).*
- *Great to put Gloucestershire on the map as a centre of excellence.*
- *Any potential reconfiguration of services should be done in a very careful and considered way with full understanding of impacts. While the vision for 'Centres of Excellence' is compelling this should not be undermined by inadequate planning/management. I would also anticipate thorough staff and public engagement.*
- *The 'Centres of Excellence' idea is a good one and from a medical viewpoint it can't be argued with although politicians will.*
- *Having 'Centres of Excellence' is a good idea to keep all relevant resources in one hospital. A visit or an operation can be planned for.*
- *I was like many other people, keen for Cheltenham to maintain its ED just because of distances for access, but your excellent engagement booklet has persuaded me otherwise. I think it is the way forward - now!*

- *You have already sourced outside expertise in relation to general surgery you should take their recommendations.*

6. Quality

- *We all want everything to be local and feel that hospitals are getting too large and impersonal.*
- *I know computers are taking over the world but many people just cannot cope with them and the programmes. We still need the old fashioned personal touch.*

7. **Workforce**

- *Make sure there's staff trained and on board with the change. NHS staff are amazing, they are affected by change too. There needs to be efficient and effective management of the change.*
- *Make it compulsory for all new doctors and nurses, to work a year before specialising at the local hospital, normal hours for a fair wage...more doctors, less expense, like solicitors must do their articles.*
- *The paramedics are highly trained resource and should be enabled to provide extensive services and also would be a valuable resource to any changes as they have front line experience and knowledge more than doctors and medical staff.*
- *Invest in your personnel and their working environment. Equip them with the time and staffing support to provide their best service and (especially in the case of Cheltenham which is a very old building) and help them to it in a fit for purpose environment.*
- *Remind your team of clinicians that they do a fab job and their patients very much appreciate this.*
- *The services and skills offered by both hospitals are to be admired. The staffing levels need to be examined to ensure that they reflect the ongoing needs. This cannot be achieved by pouring more and more work on to an overstretched workforce.*

8. Other

- *Attract some companies that do research to come and work on site.*
- *In Tetbury we already have a centre of excellence it is imperative it is utilised as much as possible by NHS.*
- *I was unable to find A&E at Gloucester hospital, if it must be the only A&E in Gloucestershire, better signage needed.*
- *I would like to take this opportunity to strongly ask that the old Lydney and Dilke Hospitals be used for something for the community and if possible health related.*
- *Develop good voluntary services to help those attending each centre especially for those without local family and friends. Anybody can only have one centre of excellence. In health care that should be the patient not the pathway. Show a little more humility; allow others to describe you as excellent when, and only when, the patient experience is second to none.*

The Cheltenham MP FFTF surveys template responses regarding:

Improving specialist hospital services and developing 'Centres of Excellence'

In your view, what are the most important things to be considered in improving specialist hospital services (Accident, Emergency and Assessment Services, General Surgery and Image Guided Interventional Surgery) and developing 'Centres of Excellence'?

Specialisms should not be pursued to the extent that CGH loses its A&E. Cheltenham General Hospital is exactly that – a general hospital – and no reconfiguration that might undermine that status should be considered.

Do you have ideas about how to improve specialist hospital services (Accident, Emergency and Assessment Services, General Surgery and Image Guided Interventional Surgery) and developing 'Centres of Excellence' – if so what are they?

Retain Cheltenham's A&E, restore 24/7 cover, commit to its future, and in doing so attract the next generation of ED clinicians.

If the way you receive services changes, what are the most important things to be considered to reduce any negative impact on you or people you know?

No.

6.5.4. Suggestions and Questions - Improving specialist hospital services and developing 'Centres of Excellence'.

Throughout the sections noted above, there were a number of suggestions regarding either specific services, location of services or the approach needed in delivering care. Some examples of these are given below. In addition, some people asked specific questions. Responses to the questions below will be prepared as part of the response to this Report.

Suggestions

How care is delivered

- *To take the pressure off hospital patient services, why are not routine hospital procedures such as hip replacements, hernias, cataracts, not contracted out to private providers? This would free up beds for emergency cases.*
- *Availability of these services to NHS patients in NHS hospitals. Private hospitals and clinics to provide their clients with health care outside NHS facilities.*
- *Create another centre for MINOR A&E cases - Walk in centre, diverting patients from main A&E department.*
- *Those attending A&E should be monitored on reception and if possible advice given for home treatment and sent home.*
- *Have a filtering system in A&E to direct non-emergency cases to the correct area.*
- *Try to remove the chaos that exists in A and E. A nurse who would be responsible for guiding a patient through and not leaving patients for long periods not knowing what is happening or if they have been forgotten. There just aren't enough nurses and doctors available.*

- *Turn people away from ED who don't need it. Have an MIU terrapin outside.*
- *Having specialist teams to deal with musculoskeletal injuries as well as medical services.*
- *Ensuring that there is high quality of care wherever the patient presents. It is vital that each specialty has a clear policy in place to ensure that there is good care on both sites even if they are mainly working at one. Each specialty needs to be held to account to ensure this happens, it doesn't currently.*
- *More nursing assistants and nurses to help reduce staffing pressures and waiting times. More beds to help with back logs.*
- *Clearer options for pathways allowing for alternatives than admission to A&E. Better working relations and funding arrangements with social care.*
- *Major elective surgery needs to be as far away from the medical acute take and surgical if you want to access normal hospital beds, if you want to access critical care beds I would suggest only employing surgeons during the summer months unless a major expansion is delivered.*
- *Have everything in the same place from tests and preop clinics to surgery. Need urgent pathology tests done on site, since routine surgery can turn into emergency surgery quickly.*
- *The bed base in GRH has to increase dramatically. The influx to one hospital site and inability to curtail it by cancelling planned admissions means that a far greater redundancy must be built into the system. Although creating beds which may be empty seems inefficient, maintaining flow preserves efficiencies elsewhere in the organisation and I suspect improves staff moral and retention.*
- *The footprint of the A&E needs to change and increase, especially in the minors area. The surge already experienced at some points of the day will intensify with greater patient numbers. Specialities need 24/7 receiving areas for ambulant patients outside of ED. Separation of ED streams into minor injuries and minor illness.*
- *24/7 PCI is important. With this GRH should also be the primary Out of Hospital Cardiac Arrest Centre. This may impact on ITU (as will the other service changes).*
- *Extending Saturday & Sunday pharmacy opening needs to be considered on any Emergency site.*
- *Emergency patients generate a lot of paperwork and require a lot of admin input. The need for efficient joined up admin backup cannot be under stressed.*
- *In order to improve the specialist services you should consider rotating staff around locations to allow skill migration and improvements to be obtained in both sites.*
- *Drop in clinics for faster turnaround and diagnosis.*
- *Better communication between specialists.*
- *Get rid of the 111 Service it is just stopping people getting quick advice and has proved very negative.*

Where care is delivered

- *CGH has the capacity to have an excellent general surgery unit. There are other specialities on that site to make a superb pelvic unit, a proper centre of excellence. Oncology are on hand. There is no viable reason to move general surgery. If emergency care is moved how on this earth will anyone have specialised care in general surgery how very short sighted.*

- *Realistically we can't keep 2 emergency sites fully staffed and operational 24h within 12 miles of each other so we need to split the services provided at each and also expand what is available locally through GPs providing out of hours, walk in centres, community hospitals*
- *I believe the one team, two locations approach for emergency and urgent care hospital care is key. For other specialisms I believe it is reasonable to develop single-site excellence for certain types of surgery PROVIDED that hospital-based after-care can be provided at either location (with appropriate liaison and handover) so that patients can be in the part of the county most readily accessible to their relatives.*
- *If you are looking to minimise travelling between campuses for clinicians and nursing staff then outpatients may be better based with their centre of excellence? I see my neurologist in Gloucester because that is the easier travel option for me, but I know that my consultant and specialist-nurse have to travel to other outpatients clinics. This is probably not ideal, so maybe it would be possible to minimise the availability of outpatients clinics in other locations so that where possible people attend a primary clinic by default and perhaps have to 'opt' for a local one to ensure patients are excluded from treatment but the ones who really do need more local access are still able to get access to it.*
- *Create one new centre of excellence midway between Cheltenham and Gloucester. Also try to incorporate health training college and a new medical school (maybe similar to Oxford or Birmingham named schools).*
- *'Centres of Excellence' are good, but could the planned surgery centre also have regular clinics in the districts where they meet and brief future patients, to save those patients having to visit the centre? And the A&E centre: how do patients move from there back to their locality? More centralised resources are good for the NHS but more difficult for patients families*
- *When you take increase in population into account, how sustainable is the split site scenario? Keep pressure on funders and planners to release land at Staverton / Elmbridge for a single site, modern hospital serving both towns.*
- *Longer opening hours (shifts) in surgeries and pharmacies - we do not have Open All Hours policies in this country.*

Transport / Travel

- *Better parking especially for blue badge holders. Better directions on the website including where parking is available. The bus service is OK but the walk from the bus is too far therefore we need to use a car due to disability especially at Gloucester.*
- *Realistic strategy for the elderly and elderly spouse or carer to get to and from the service in winter time and summer.*
- *Consider staff and visitor parking at any 'emergency' site. Shift workers beginning in the afternoon already struggle and public transport not an option with a midnight finish.*
- *Transport of less unwell patients between sites and back home is already inefficient. Consider use of Uber etc.*
- *Doctors should certainly not have to travel between sites, that is inefficiency. Even if doctors have to work at both, they should be able to be scheduled for a full day at each site.*

Communication / Education

- *Educated people on making the right choice when accessing services, once you have done this then you may be able to amend the services on offer based on the demand from people who are educated to follow the right choice.*
- *My concern is that lots of people don't realise that children and those who have suffered a stroke now need to go to Gloucester and that Cheltenham is open overnight! Communication is key! Perhaps with these ideas it will be much clearer that if you have a serious injury Gloucester should be where you will be taken. But if you are walking wounded Cheltenham or a MIU can look after you. This will be clearer message to communicate, another positive to the idea.*
- *The public need to hear the value for money story.*
- *Better education to patients to tell them when not appropriate to attend A&E with MSK problems to cut load on service.*

Other

- *Charge people who don't turn up for appointments. Chase non-residents of UK who have treatment with no intention of paying. We are the only country in the world to allow this.*
- *Tea/coffee making facilities in day rooms would be good.*
- *Remember to consider the vulnerable first.*
- *Limit access to A&E by denying or delaying (To the back of the queue) selfish people who are drunk, drugged, aggressive etc.*
- *Establish better links with neighbouring Trusts so there is real excellence through volume of patients, rather than trying to do everything bit at lower quality.*
- *Please make careful quality measurements before planning a move and then publish before and after results.*
- *All centres need to be accessible, Gloucester for example has bike bars, this is stupid as navigating them in a wheelchair is near impossible. All rooms need to be large enough for wheelchair users, they currently aren't. There should be easy navigation for those with visual impairments, no random chairs, medical or cleaning equipment blocking parts of corridors or waiting rooms. Some patients with rare and complicated conditions will need their own carer with them at all times.*

Questions

QUESTIONS	*ANSWERS*
'Centres of excellence' Approach	
1. *How can you call it a centre of excellence with so many people genuinely opposed to closure and reorganisation?*	
2. *What evidence is available which justifies 'centres of excellence' in other trusts and which do not worsen patient care, confidence and reputation of the trusts?*	
3. *The idea of having one centre for emergency care and one for planned is a good one, however a planned procedure can go wrong, or recovery not as planned so what cover for emergencies would you put in place for the planned facility, for certain these situations will arise. Is there not some theory/research about the best way to plan services, particularly a cold / hot split? Why do you not use this to be you spur and plan services in the light of current best recommendation? At the moment Fit for the Future reads a lot like we've got a problem with 2 sites, this is what we're going to do about it, much better would be - this is best practice, this is how we can implement it in Gloucestershire.*	
4. *I presume you have evidence of how the Oncology Centre improves the care and welfare of cancer patients in Cheltenham. Can this be used as a model?*	
5. *It is clearly impractical to operate two hospitals with the same services at each. There are numerous ways to change this and benefit from economies of scale. You could divide by hot and cold surgery and split medicine by speciality around body part (i.e. link Cardiology with Cardiac Surgery. Or one could look as splits by day patient and in patient to ensure (particularly in day surgery) efficiencies around scheduling can be fully enhanced. (For example about 80% of urological procedures should under best practice now be undertaken on a day surgery basis. Why are you limiting changes to the 4 noted in the question? Why are you reluctant to change the work patterns of your doctors by telling them where they will work? Do you believe that one of the two*	

nominated hospitals has sufficient physical capacity to manage what is your preferred plan? If so why not publish your plans HONESTLY so that they can be considered? Why shouldn't Bristol and Swindon acute units be considered as part of the answer?	
6. *Why should a Patient attend GRH if he would prefer CGH? Surely it should be a Patients choice where he wants to have the surgery done.*	
7. *Can't you develop specialism AND still offer A and E for Cheltenham's share of the 100 people per day who really need it?*	
8. *Please maintain Cheltenham as a centre of excellence and keep the A&E. The area is growing, the population aging - please explain to me how reducing services is a sensible way forward in light of the above?*	
9. *I understand the rationale for focusing some countywide services in one or other hospital in the county, however it is interesting (and concerning) that Gloucester is being considered the best hospital for A&E 24 hr services not Cheltenham- this means that Gloucester has both the Access Centre and the local A&E services - it is starting to appear discriminatory! What about the rest of the county's populations access to urgent & emergency services?*	
10. *Has there been any sort of patient outcome study done since the restricted opening times of A&E at CGH?*	
11. *300 patients, not 100 patients a day need emergency care in Gloucestershire (on page 9 of your Fit for the Future publication you state that one third of patients attending A&E could be treated by a different NHS service. Hence, two thirds of patients attending A&E have done so appropriately. Given the NHS England statistics, this would in fact mean that over 300 patients a day would need to access an A&E Department, rather than the 100 stated on page 11 of your publication).*	
12. *Where should I R be? Makes sense for PCI* [Percutaneous Coronary Intervention] *to be on acute site. But what is then going to be on elective site? Is there enough flex for example to allow surgeons to help out cross specialty*	

e.g. urology and GI surgeons involved in gynae cases?	
13. *Image guided surgery is of great benefit but equally in emergency situations and for planned procedures. How does a demarcation of Cheltenham as the centre for planned procedures and Gloucester for emergencies fit in with this? Equally coronary angioplasty may be the best option for treating some heart attacks in emergency situations so having 24/7 service available in Gloucestershire would be excellent but equally many investigative / interventional procedures are undertaken in a planned fashion so would Cheltenham retain the capability for a wide range of cardiology related planned procedures / investigations?*	
14. *Image guided interventional surgery is both elective (elective AAA repair) and important in the most poorly emergency cases (embolisation pelvic vessels). As these emergency patients often can't be transferred I assume is there a cross site plan for this service?*	
15. *I do wonder where you are going to get all the interventional radiologists from?*	
16. *Is there going to be acute and elective general surgery on separate sites or all on one site?*	
17. *Accuracy of information with hard data would be useful. Cardiology, Interventional Radiology and Vascular surgery are already on one site and so there is already a 'centre of excellence' so why market this option as a possibility when it is already in existence?*	
18. *Can the GRH site deal with the increased emergency admissions? The current facilities are outdated and too small to accommodate increased emergency staff and admissions.*	
19. *Gloucester Royal lacks the capacity to handle additional elective general surgery, including provision of beds in the High Dependency unit. Implies general surgeons can work independent of other surgical and medical specialities currently located at Cheltenham Royal. My wife had bowel cancer, which potentially required the input of gynaecological surgeons should the cancer have spread further than eventuated. She was also cared for post-op on a ward where the staff had experience with both pelvic and bowel surgery enhancing her post-*	

operative care. Stoma nurses and biofeedback training are also located at Cheltenham, would you propose moving all complimentary services as well?	
20. I do believe it would help to have different areas of specialty in the hospitals although couldn't this mean problems for some patients who have more than one problem?	
Workforce	
21. Where are the specialists based and do they have 24 hour consultant cover?	
22. Are there any plans to become a teaching hospital for the training of nurses?	
23. What impact does this have on staff travel?	
£ / Funding	
24. Why is medication so highly priced when you are classed as a private patient and not having the work. How come private patients have to pay extra money for drugs when if you have the treatment on the NHS it is cheaper and you don't pay for the medication? Is not fair, it should be one price across the board as the medication comes from the same supplier? One on the NHS?	
25. Has the increased cost of hospital transport been factored in?	
26. More care needs to be taken in the oversight of private health providers of hospital services in the region. I have personal experience of clinicians deliberately driving patients towards their private practices through a variety of means. Though my experiences where this has happened are limited to working with one private health provider I am not reassured that it is not the same across providers.	
27. What assumptions are you basing your hair brained scheme on? I hear on the news that extra funding is being provided for essential care. Where is this being spent, I hope it's not being diverted to top up pension plans and pay rises for the highest earners.	
Integration of services	
28. Resources: do the resources actually exist in practice? I was discharged from hospital with a drain in situ and instructed to contact the GP practice nurses for help in managing it, changing dressings etc. The practice nurses	

said sorry but we have no appointments for over a week. The district nurses turned out to know nothing about drains. My wife coped as well as she could but it was scarcely ideal and, indeed, when problems developed with the drain that the district nurse did not recognize, I ended up back in hospital.	
29. I am keen to know how we will provide services for older people, if they have their surgery but are not ready/ able to return home how will they be managed will there still be older people's wards on each site?	
30. All patients OOH appear to be sent to A&E - why? They simply block the unit. Why not get the GP or whoever to send direct to the appropriate speciality?	
31. What opportunities are there to share facilities with adjacent counties?	
32. Better aftercare and follow up services. It is no use at all to have 'centres of excellence' with such little thought as to how people will manage when discharged. What has happened to the packages of aftercare?	
Other	
33. Why are immune suppressed patients still being seen at a packed Edward Jenner for Haematology, when they have been told not to mix with crowds this department is not fit for purpose?	
34. Please explain clearly what levels of service are provided to meet this area's needs, and what additional stuff you are doing on top of that provide services to outside areas?	
35. Where is the published criteria for determining which services are located and the performance criteria against which such key discussions will be judged?	
36. This survey is NOT available online despite your claim it is. One more pretence at open communication.	
37. Have you planned how the service would react to a Major Incident? If there is one near or in one of the hospitals, which services would be needed at the other to cope best with casualties? i.e. is having A&E in one place only, wise in this context?	

38. What evidence do you have to show the waiting times and performance/response/outcomes will improve by closing Cheltenham A&E?	
39. Population of Gloucestershire - 628,139 / Population of Gloucester - 129,083 / Population of Cheltenham - 117,128 (also outlying districts including Swindon). How can one department deal with these numbers?	
40. I have to comment that almost every journey I make on the A40 Golden Valley road I see at least one ambulance on an emergency call. It wasn't like this a few years ago. Are these already transferring patients between hospitals? I wouldn't want my emergency treatment to be subject to the traffic on the roads between the two hospitals. Also, what happens if the county has a single A&E and an event/situation occurs that closes it to new patients? How far do those patients then have to be taken?	

NHS
Gloucestershire
Clinical Commissioning Group

NHS
Gloucestershire
Care Services
NHS Trust

FIT FOR THE FUTURE: ENGAGEMENT

A NEW HOSPITAL FOR THE FOREST OF DEAN

OUTPUT OF ENGAGEMENT

WWW.FODHEALTH.NHS.UK

7. A new hospital for the Forest of Dean (FOD)

7.1. Previous engagement

Between September 2015 and July 2018, Forest of Dean residents have been asked their views about their health and care needs now and into the future. Healthcare professionals working in the Forest were also asked to share their thoughts and ideas for further improvement in delivering local services.

Following a period of Consultation in 2017, the Board of Gloucestershire Care Services NHS Trust and Governing Body of NHS Gloucestershire Clinical Commissioning Group approved the option to build a new community hospital in the Forest of Dean, which would replace The Dilke Memorial Hospital and Lydney and District Hospital.

A Citizens' Jury, made up of local people, met last summer and recommended that the new hospital for the Forest of Dean should be located in Cinderford.

7.2. Targeted engagement August-October 2019

As noted above, a survey was developed to support the FFTF engagement. These were available as print, FREEPOST return copies in the engagement booklets and also on line at:

Fit for the Future: A new hospital for the Forest of Dean:
https://www.smartsurvey.co.uk/s/FFTF-ANewHositalFoD/

A total of **153**: *A new hospital for the Forest of Dean* survey responses have been received.

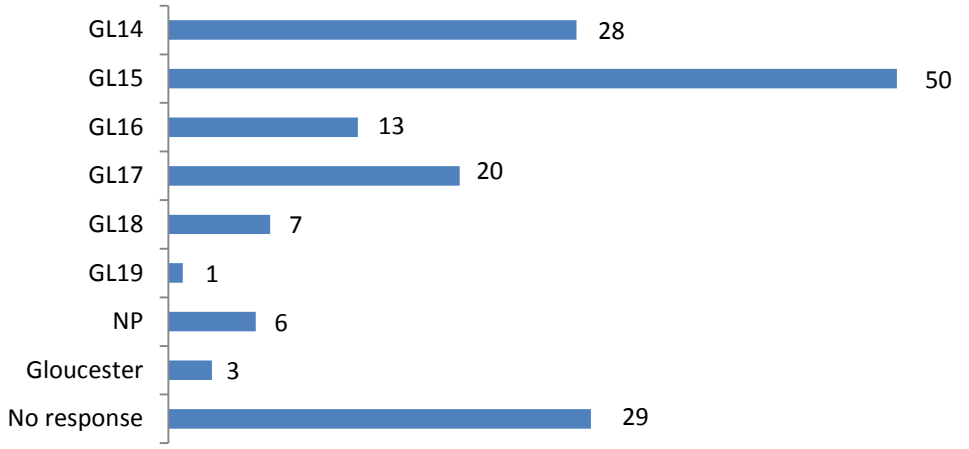
7.3. Feedback - Demographic information

Demographic information was collected through responses to the engagement survey *(NB: not everyone completed all of the demographic questions).*

Which age group are you?				
			Response Percent	Response Total
1	Under 18		0.00%	0
2	18-25		0.72%	1
3	26-35		5.80%	8
4	36-45		8.70%	12
5	46-55		10.14%	14
6	56-65		28.99%	40
7	66-75		28.99%	40
8	Over 75		14.49%	20
9	Prefer not to say		2.17%	3
			answered	138
			skipped	19

Are you:				
			Response Percent	Response Total
1	A health or social care professional		15.15%	20
2	A community partner/member of the public		76.52%	101
3	Prefer not to say		8.33%	11
			answered	132
			skipped	25

What is the first part of your postcode? eg. GL16



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

			Response Percent	Response Total
1	No		61.36%	81
2	Mental health problem		8.33%	11
3	Visual Impairment		4.55%	6
4	Learning difficulties		3.03%	4
5	Hearing impairment		9.09%	12
6	Long term condition		18.94%	25
7	Physical disability		12.12%	16
8	Prefer not to say		3.79%	5
			answered	132
			skipped	25

Do you look after, or give any help or support to family members, friends, neighbours or others because of either a long term physical or mental ill health need or problems related to old age? Please do not count anything you do as part of your paid employment.				
			Response Percent	Response Total
1	Yes		39.10%	52
2	No		57.14%	76
3	Prefer not to say		3.76%	5
			answered	133
			skipped	24

Which best describes your ethnicity?				
			Response Percent	Response Total
1	White British		93.38%	127
2	White Other		0.74%	1
3	Asian or Asian British		0.00%	0
4	Black or Black British		1.47%	2
5	Chinese		0.00%	0
6	Mixed		0.00%	0
7	Prefer not to say		4.41%	6
			answered	136
			skipped	21

Which, if any, of the following best describes your religion or belief?				
			Response Percent	Response Total
1	No religion		28.36%	38
2	Buddhist		0.00%	0
3	Christian (including Church of England, Catholic, Methodist and other denominations)		60.45%	81
4	Hindu		0.00%	0
5	Jewish		0.00%	0

Which, if any, of the following best describes your religion or belief?				
			Response Percent	Response Total
6	Muslim		0.00%	0
7	Sikh		0.00%	0
8	Other		4.48%	6
9	Prefer not to say		6.72%	9
			answered	134
			skipped	23

Are you:				
			Response Percent	Response Total
1	Male		27.41%	37
2	Female		68.89%	93
3	Transgender		0.00%	0
4	Prefer not to say		3.70%	5
			answered	135
			skipped	22

Do you identify with your gender as registered at birth?				
			Response Percent	Response Total
1	Yes		93.70%	119
2	No		0.79%	1
3	Prefer not to say		5.51%	7
			answered	127
			skipped	30

Which of the following best describes how you think of yourself?				
			Response Percent	Response Total
1	Heterosexual or straight		88.46%	115
2	Gay or lesbian		0.77%	1
3	Bisexual		0.77%	1
4	Other		0.00%	0
5	Prefer not to say		10.00%	13
			answered	130
			skipped	27

Are you currently pregnant or have given birth in the last year?				
			Response Percent	Response Total
1	Yes		0.77%	1
2	No		73.08%	95
3	Prefer not to say		3.08%	4
4	Not applicable		23.08%	30
			answered	130

7.4. Engagement Events

A schedule of events is included earlier in the report.

Engagement with Councils in the Forest of Dean

We met with the Forest of Dean District Council and Town Councils for Cinderford, Coleford, Lydney and Newent.

Feedback mirrored that captured through the survey and local drop-ins, with principal concerns relating to accessibility/transport in the Forest of Dean and the number of beds that will be provided in the new hospital. End of life care, urgent care and wider support for patients through enhanced primary care and community services were also discussed.

7.5. Quantitative and Qualitative feedback

7.5.1. Summary of feedback received

The qualitative feedback from completed surveys, either via the on-line version or paper copy/postal, has been grouped into a series of themes for each of the questions. Some people did not provide a response to every question. A letter was also received from a Forest of Dean resident.

All of the feedback collected through the FFTF survey is included in Appendix 5.

1. Inpatient services - Do you think that the things we have described on pages 6 & 7 of the booklet, to support our planning for how many inpatient beds are needed in the new Forest of Dean Hospital, are reasonable?

			Response Percent	Response Total
1	Yes		54.68%	76
2	No		45.32%	63

2. Inpatient services – what other things should we be taking into account in planning inpatient services in the new Forest of Dean Hospital?

Numbers of beds

Significant concerns were raised that the number of beds in the new hospital will be too small, given the rising population and increase in elderly demographic and there was insufficient detail provided regarding alternative provision for Gloucester and Cheltenham residents and people suggested it is not realistic to say that only Forest of Dean residents will use the beds in the new hospital. Consideration should also be given to the number of patients from the Forest of Dean in Gloucestershire Royal Hospital and Cheltenham General Hospital. Care in the home also needs to be improved if the number of beds is going to be reduced.

- *Population is growing considerably in the Forest and bed numbers needed now are not indicative of bed number that will be needed in as little as 10 years' time.*
- *Local facility in Gloucester city is crucial if the number of beds is going to be reduced. Have you taken a realistic look at the increasing population and in particular the increase in elderly population.*
- *How will you ensure that only Forest patients are admitted to Forest beds?*
- *It is unrealistic to assume that only Forest residents will occupy inpatient beds in the new hospital.*
- *There is a figure for patients from Gloucester city in this report, but no figure for how many patients from FOD area in Gloucester and Cheltenham hospital.*
- *It's not clear how many people from the Forest are in beds in other hospitals, who*

could be catered for in the Forest if the beds were available.

- *Until adequate and comprehensive Community support can be guaranteed in the population centres that are without a community hospital, it seems foolhardy to consider a significant reduction in inpatient beds which [means] they may not be available for local residents.*
- *As there are virtually no resources for care in the home – for elderly, dementia of stroke, it is pointless assuming this will be provided.*

End of Life Care

The number of beds does not seem to plan for people who chose to die in a community hospital. It is frequently suggested that there needs to be provision for End of Life Care in the planning for numbers of beds.

- *The services described do not refer to end of life care. There are many people who chose not to spend their last days at home, for many reasons, the community currently rely on the excellent end of life service offered in the Forest hospitals and this must be considered in the role of the Inpatient Unit in the new hospital.*
- *There is no mention of end of life beds. Not everyone wishes to die at home.*
- *Great Oaks is good as far as it goes but we need a proper hospice for those people*

Accessibility

People expressed concerns about being able to travel to the new hospital, in particular from the South Forest, Lydney and areas nearer the Welsh Border.

- *Access to the hospital for visitors/parking arrangements and public transport.*
- *With the recent bus changes, it is not fair to take the Lydney hospital away, as it would be easier to get to Gloucester than Cinderford, and this then has a massive impact on families.*
- *The most important thing that must be taken into account is the accessibility of the hospital transport, either [by] emergency services, local bus facilities or private vehicles. Many of the inpatients will be elderly and the main problem will be transportation to the hospital for follow up appointments as public transport is not directly accessible to the hospital from Lydney. In Winter Cinderford can be totally isolated due to bad weather.*

Other services

There are suggestions about other services that could be included in the hospital, such as maternity, children's services, support for mental health and a wide range of therapies.

- *I do think that some children's services would be nice to have in the FoD in addition to the adult care proposed.*
- *Maternity services.*
- *Adequate space between beds to allow for better therapy. Location of a therapy room, with kitchen space and rehab area including, practice steps, plinth and parallel bars.*
- *Areas where activities and groups can take place. Boredom is not supportive to mental wellbeing. Activities will allow engagement and ongoing functional assessment.*
- *I would like services that would help me with my learning disability and borderline personality disorder.*

Environment

There are some general comments relating to the environment of the new hospital – both internal e.g. dementia friendly and external, i.e. outdoor areas, parking.

- *A safe outdoor space would be extremely beneficial for outdoor mobility practise, with different surfaces, gradients, etc.*
- *Pleasant environment for visitors - café - community hospital shop.*
- *Better signage for departments, maybe coloured lines on the floors to show departments. No trees or plants in the grounds - in the winter months the leaves fall and blow into the hospital corridors, drainpipes, drains making it difficult to keep clean in areas to include outside - this becomes more hazardous in wet conditions!*
- *The environment itself, linking arts and the natural environment which we have on our doorstep. Both have been shown to improve wellbeing and potentially aid recovery - not just art on the walls (although this is important) but participation options where appropriate and easy access to outdoors. E.g. a garden project / community garden project.*
- *Building and services to be fit for purpose as well as medical services, catering, car parking, liaison with community services.*

Population

There are specific comments relating to the increasing population across the Forest of Dean and the increased number of elderly residents. Some of these comments relate to the numbers of beds for the new hospital, but others are more general.

- *The amount of new building that is forecast for the Forest of Dean and longevity of Forest people, many of whom will have children who are pensioners.*
- *I do not think the extent of the population increase, new housing and the Housing Allocations Policy have been sufficiently taken into account. The housing is currently increasing at a very fast rate, especially around Lydney/Berry Hill areas.*
- *The number of new houses being built, plus the withdrawal of the tolls on the Severn Bridge crossings, which are both contributing to an increase in the population of the Forest of Dean.*

3. Urgent Care Services - in your view what are the most important things to be considered in developing services to ensure that everyone can access consistent urgent advice, assessment and treatment?

Access

Transport/accessibility in the Forest of Dean is really difficult. Cinderford is particularly difficult to reach from the southern part of the Forest. Need to consider wider range of provision across the area.

- *High quality services throughout the Forest of Dean. These must be available locally, accessible and appropriate for local needs.*
- *Use of small centres as well as hospital because of size of Forest and poor public transport.*
- *Getting medicines on site when other chemists are closed also important.*
- *Advice should be available 24 hours a day from a team of professionals, not a service where you tick boxes.*
- *Convenience to access Cinderford is not a place people from Lydney can reach*

without their own transport.

- *Good geographical location centred for local use. 24 hour cover via telephone advice and staff on site to deal with relevant emergency car.*
- *The South Forest area is likely to be most affected part of the county when its hospital closes. Some form of improved health centre with a MIU facility is needed.*

Time

There needs to be 24/7 urgent care services available, including access to GPs, telephone support, urgent care centres/MIIUs. Consideration given to seasonal/daily variations.

- *Urgent Care services should be available at all times whether it's on the phone or in person and more treatment should be available to ensure people aren't always sent to GRH.*
- *Open longer hours in the summer when there are a high number of visitors to the area. Skill to cater for the types of injuries likely to be sustained in this area, such as from walkers and cyclists.*
- *Late Opening. GP access similar to the drop-in located in Barton Street.*
- *Illness and accidents happen at weekends as well as during the week.*
- *Local service with a wide range of opening times including access to diagnostics.*

Diagnostics

Provision of a good range of diagnostics which are integrated with and support the range of services across the hospital.

- *Maybe extend x-ray opening until 8.00pm or 10.00pm and weekends.*
- *MIIU and x-ray departments should work together and MIIU should be available on extended hours.*
- *Need to have staff with the right skills and expertise to deliver a good service locally and avoid people having to go to Gloucester A&E. They need to be able to do the right tests and have x-ray facilities so people can be treated fully and not have to make a return visit there or to another health care service.*
- *Diagnostic resources such as haematology, bio chemistry and x-ray.*

GP appointments

Improvements to accessibility of local GP appointments are required to support urgent/out-of-hours care.

- *GP surgeries open in evenings and weekends - would prevent minor injuries etc. turning up at local hospital.*
- *It is not uncommon for patients to wait as long as three weeks for a GP appointment. Patients need better assurance that they can access someone with urgent advice / treatment.*

Workforce

Need to ensure that sufficient numbers of staff, with the right skill mix, are available to support urgent care services and allow patients local access to services.

- *Adequate staffing levels and relevant specialist availability without having to travel to Gloucester unless this is medically essential at any time of the day or night.*
- *Enough trained staff on duty to run the services and keep up demand. Maybe a*

doctor on site over the weekend and 7 day week working x ray department.
- *The right teams with the right skills to offer the right treatment.*

Range of services

Consideration needs to be given to the range and scope of services available to support urgent care.

- *Sufficient resources and equipment and expertise to give the urgent care.*
- *Local urgent care; a mixture of planned and drop in appointments. Range of health care professionals to provide assessment, opening times.*
- *Out of hours GP & Prescription Services*
- *Need an A&E equipped to deal with most ailments, therefore saving the patient having to travel to GRH.*

Communication

High quality information should be available to enable people to make an informed choice about how and where they access services.

- *The public really need to be educated in what constitutes and emergency and what doesn't!*
- *Simple clear signposting in a range of formats to help people see where to go.*
- *Information on services to enable patients to be knowledgeable about options.*

Other

A range of other comments and suggestions were also included.

- *Getting medicines on site when other chemists are closed also important.*
- *Use of small centres as well as hospital because of size of Forest and poor public transport.*
- *Upgrade health infrastructure urgently to cope with major increase in population, and people getting older. Link with residential homes/ home caring/ hospice/surgeries/ clinics all need to be closer.*
- *Access to community teams - especially mental health.*
- *We need more clinics so there is not the need to travel to Gloucester or Cheltenham. Look at clinics which access needs of the elderly e.g. lung function, heart monitoring, leg ulcers etc.*
- *Leave things as they are. Majority of people are perfectly happy and content with the existing arrangements at the Dilke and Lydney.*

4. Outpatient services - What outpatient services do you think we should provide in the new hospital?

A sizable list of outpatient services are suggested including a range of therapies, follow-up appointments, diagnostics, children's services, screening clinics, ophthalmology and audiology/hearing aid services. There was general consent that the current range of services provided at the Dilke and Lydney hospitals should be provided in the new hospital in Cinderford. Some broader points were also made:

- *At least the same facilities with the same total capacity as the sum of the two current hospitals.*

- *Specialists available locally for follow up appointments at our new Hospital. Big savings in travelling costs to other Hospitals plus it gives us less pollution.*
- *Assessment and rehabilitation - providing patient centred holistic therapy for people with long term chronic conditions. Promoting prevention and self-management. Supporting reducing hospital admissions, active social prescribing / sign posting.*
- *As many as is possible. If a consultant agrees to do one day a week or month at the new hospital, this would help the forest people so much and ease the cost and anxiety of travelling.*
- *Space for providing group education sessions not just rooms for one to one appointments.*
- *It would be helpful to consider which appointments and services are provided at Gloucester and Cheltenham by those with a Forest postcode and offer the largest groups those services locally to have the biggest impact.*
- *I would suggest that the outpatient services which are most needed would be those that people in the forest have the most of and those that have the longest waiting list.*
- *Regular appointments for services, so that the hospital is a real choice for people.*
- *We need the same outpatient services retained as we currently have. This should be in-line with the Forest population, which is growing due to extensive growth of new housing within the Forest.*
- *As many as possible including the development of mobile screening services such as in cancer checks, eye screening and perhaps initial cardio checks.*
- *Lydney used to have 24 hour emergency cover and a minor surgery unit both used and appreciated by family members on many occasions. Cinderford is too far away from us for emergency cover. Again - why Cinderford? Clinics in Lydney are well used and essential to services.*

5. Diagnostic services - what diagnostic services do you think should be provided in the new hospital?

A wide range of diagnostic services are suggested. There is again a general point that the current range of services provided at the Dilke and Lydney hospitals should be provided in the new hospital in Cinderford. Some of the diagnostic services commonly mentioned include: blood tests, endoscopy and colonoscopy, screening, x-ray, and ultrasound.

- *At least the same capacity and services as the sum of the two currently available hospitals. With space for expansion as and when required in the future.*
- *The mobile unit for Cancer care is invaluable, but with the number of patients increasing how viable is it for the screening services to be incorporated in the new hospital.*
- *Any diagnostic services must be cost effective and not increase bureaucracy at the cost of patient care.*
- *Definitely diagnostic including endoscopy and colonoscopies. Of course breast examinations even if provided by a mobile service must be continued. I also believe wellness checks should be available for men.*
- *Diagnostic services need to be provided, particularly X-ray and Scans, but these are also needed for the large Lydney area population.*

6. Other services - what other services would you like to see in the new hospital for the Forest of Dean?

A range of additional services are suggested including mental health services, support relating to healthy lifestyles, sexual health, dental services, maternity, elderly care and group therapies.

- *One stop shop for older adults services - eyes / hearing / chiropody / memory clubs / activities to reduce isolation / educational groups for managing physical and mental health*
- *Community space and access to social prescribing.*
- *Well-being and aftercare hubs to get further information and meeting place. The joining up of mental health provision with physical health.*
- *Services to promote healthy lifestyle.*

Suggestions are also made relating to the hospital facilities, such as provision to accommodate partnership working with the third sector, enable community preventative and health related initiatives and an environment that supports mobile services.

- *A holistic approach to health and wellbeing through arts and nature and physical engagement activities for patients and the community i.e. preventative for example - dance for older people. Singing for those with lung conditions... Garden project, many, many more options based on well- being evidence.*
- *Hub for Emergency care in the community team - aim to prevent hospital admissions if possible.*
- *Ability for 3rd sectors to be part of the hospital holding information sessions to help patients manage their own health: Age UK, British Legion, Dementia support.*
- *A pharmacy department (to dispense medication as prescribed by a medical team for you to take home with you - from both outpatients and discharge from inpatient stay).*
- *Room for family therapy and group therapy.*
- *A large carpark to host mobile service vehicles for radiotherapy, chemotherapy, breast screening and dentistry.*
- *Dementia friendly day rooms (Reminiscence Rooms). Café. Larger relatives room - Difficult conversation room. Larger skills lab and resource room for staff in-house training.*

7. If the way you receive services changes, what are the most important things we should consider to limit any negative impact on you or people you know?

Accessibility

There are a number of comments relating to problems accessing the hospital in general and to some specific services. Difficulty with public transport and infrastructure is highlighted.

- *Access to the site and transport considerations the forest is often not easy to navigate for those who don't drive. Make it future proof to cope with increasing demands ahead.*
- *Ensuring the hospital is offered as a choice for outpatient appointments - this would improve local use and make more sustainable clinics. Good range of diagnostic*

services is crucial.

- *Prioritise the health needs of the Forest of Dean specifically. Prioritise transport issues that directly limit the ability of people in some areas to access any services. Don't duplicate other specialised services in GRH which could provide for Forest of Dean inhabitants if they could easily get there.*
- *Reliable public transport to the hospital from town and villages in its catchment area, plus adequate car parking.*
- *I'm sure that like most people a priority is speed of treatment, both from your GP and follow on services.*

Communication

Comments regarding communication about access to services and the new hospital are included in this section.

- *I think it will be important to sell the new hospital and clearly explain what services are available when it is finally ready to open. Concentrate on the positive aspects and don't apologise for what you can't provide. I think it might be worth targeting every forest household with a leaflet publicising the opening of a new 'Royal Forest Hospital'.*
- *A few 'Open Days' at the beginning so that people can familiarise themselves with the new setup and thus remove any fear of the unknown before they need any services.*

Other

There are additional comments included which relate to the impact the decision to replace the two existing hospitals will have, the number of beds that should be provided in the new hospital and need to ensure good healthcare provision in the Forest of Dean.

- *The current proposal to have only a single Hospital in Cinderford instead of two local hospitals, as at present takes no account of the rapidly increasing population and the poor transport links of the area. The current proposals will have a significant impact on my neighbours who will be unable to access facilities at Cinderford.*
- *Services continuing in existing hospitals until new hospital provision is up and running.*
- *All services currently provided by both Lydney and the Dilke hospitals should be continued with the additions previously mentioned.*
- *Ensure the number of inpatient beds meets our local population needs a minimum of 30 should be the option.*
- *I feel that the infrastructure being imposed on the Forest of Dean and surrounding areas warrants two hospitals which are both up-to-date and running with outpatient clinics, physiotherapy and diagnostic facilities rather than drag people off to Cinderford which is difficult to get to for most people.*

8. Anything else you would like to say?

Accessibility

Transport issues are raised again in this section. There are also some comments about the benefits of a local hospital.

- *Anything which can be done to minimise travel to Gloucester will be welcomed, as per my previous comments relating to public transport. Appointment times need to be offered which are supported by public transport to and from the new hospital.*
- *A drop off zone really is essential.*
- *If you wish to reduce numbers of patients going to Gloucester Royal Emergency department, you must provide good 24 hour care at the new hospital. A lot of visits to Gloucester Royal are because the facility at Forest of Dean is not good enough.*
- *The more services we have at the new hospital the less people will have to travel so eliminating the congestion on the two main routes into Gloucester / Cheltenham i.e. A40 / A48.*

Beds

Some people took the opportunity to raise the issue of number of hospital beds.

- *The hospital must be fit for purpose to meet the local needs this must include end of life beds as an option to allow patient choice please listen to those who know our local population*
- *Please reconsider the data for calculating the number of beds a minimum of 24 will not be enough.*

Communication

Comments include criticism of the questionnaire and previous consultation.

- *I think it's a good idea to ask the population what they would like and consult in this was as long as it is listened to and used.*
- *Questionnaire needs rewording. You can only really answer these questions if you have a full understanding of what the NHS offers. People are only going to answer these questions on what they have knowledge of.*
- *Firstly you conduct these surveys to get public opinion, when you don't get the answer you want, you ask again until you think you get the answer you want or proceed with what you want anyway.*

Environment

Some suggestions for the new hospital environment are included.

- *When building the hospital please be mindful of the benefits of the natural environment to rehabilitation and recovery.*
- *Some side rooms would be nice for end of life care and family rooms for bereaved family/visitors.*
- *Plans should allow for future expansion of wards and out-patient services. Should also include a café and a quiet room. Above all keep the friendliness that makes the Dilke and Lydney Hospitals so loved.*

Other

While there are additional comments relating to the previous decisions to replace the Dilke and Lydney Hospitals, there are some positive comments that welcome the building of a new hospital for the Forest of Dean.

- *The Dilke Hospital itself is a place held dear by generations of Foresters. Their families paid to build the Dilke via donations and fund raising, this hospital has and always will belong to the community. It should be returned to the community as a*

gesture of good will.

- *I don't think the decision making was as open and democratic as it could be. Moving everything to Cinderford makes no sense at all when it is closer to Gloucester than Lydney and much harder for those in Lydney and further up the A48 to reach.*
- *I would like to put these opinions, why are you doing all of this again as we have already stated we DID NOT WANT a new hospital, you did not listen to the public vote you carried on regardless, you are paying for all of this with our taxpayers money, to send all these people out and about the forest to discuss it all again.*
- *I am very much in favour of a new hospital based centrally in Cinderford. Let's get the best and most comprehensive service affordable built ASAP.*
- *The Forest of Dean deserves a flagship hospital which is able to serve everyone from anywhere and has space to expand. It will also require plenty of parking as many rural communities rely on private cars for transport.*
- *I was at the Citizen's Jury for one day and the enthusiasm of local residents was palpable. I think it's essential that this project presses on now to fulfil all the promise of that undertaking. There are still pockets of deprivation in the Forest where health needs remain unmet and the new hospital project needs to be ambitious in its ethos to meet those needs and reduce health inequalities.*

7.5.2. Workshop: Forest of Dean: consideration of inpatient beds

The locality workshop in the Forest of Dean locality (16 October) was extended by one hour to allow for the specific discussion of inpatient beds. During this session participants were asked to look at pages 6 and 7 of the engagement booklet (*A New Hospital for the Forest of Dean*) which set out a series of assumptions.

…are these the right things to consider?

- The considerations in the document appear to be based on professional/clinical judgement and not the needs of patients and their loved ones
- There are several other issues to be considered around social care and discharge into the community that do not appear to be covered by the assumptions in the document
- The assumptions around bed numbers and long stay need more detail before people can confirm they are the right things to consider
- It is unclear from the document that the assumptions enable provision of the right equipment at the right time in the new community hospital

What else should be taken into account?

- The assumptions are not explicit about the ways in which the real terms reductions in inpatient beds in the new community hospital will be addressed: Where Gloucester patients going? Reducing bed numbers from 47 to a minimum of 24, therefore other offers need to be resourced and robust
- The need for additional specialist services in the community to support enable people to avoid admittance to inpatient beds at the new community hospital does not appear to have been considered
- The need for twenty-four-hour, seven day a week support to enable people to avoid

admittance to inpatient beds at the new community hospital does not appear to have been considered
- Palliative and end of life care does not appear to have been considered
- Dementia care needs to be addressed explicitly
- Mental health needs to be addressed explicitly
- GPs are at the heart of the success of the plans for a new community hospital in the Forest of Dean, this is not reflected in the assumptions
- The assumptions in the document do not appear to recognise specific local issues, for both the Forest and other areas
- Has data sharing and all alternative methods of providing access to patient records been considered?
- Are the needs of all age groups considered in planning for the new community hospital e.g. working age adults, children?
- Have complementary therapies been considered in the new community hospital?
- Have transport needs in the Forest of Dean for patients and visitors been considered in the new community hospital?
- Will all the right equipment be in place for the community hospital?

End-of-life care in the Forest of Dean

During the workshop there was significant discussion of end-of-life care in the Forest of Dean. This was recognised as being both very important to the participants in the workshop and outside the scope of discussions, therefore, it was suggested that a separate session should be held to discuss this topic in the near future.

8. Evaluation and next steps

8.1. Considerations and learning points for future engagement and communication activities

One Gloucestershire has previously used a Sustainability and Transformation Partnership Checklist for governance and engagement. Although One Gloucestershire now operates as an Integrated Care System (ICS), this Checklist remains relevant. It sets out a series of questions which can be asked locally to support effective discussion and decision-making. The questions cover: governance, scrutiny and accountability; system-wide control totals; public engagement; and partnerships and collaborative working. The checklist for engagement asks the following:

- How does the communication strategy support meaningful engagement with patients, carers, the public and their representatives? Is the substance of our plan being communicated in a way that is understandable and meaningful to different populations?
- How has the engagement plan made the case for 'public value'? Do plans clearly communicate what changes mean for patient experience and outcomes and help explain how efficiency savings will be made and the impact on patients?
- How are plans being co-produced with patients and the public? What more can be done to involve patients in developing the plans and supporting the delivery of proposals?
- Does our engagement plan clearly link to existing plans and demonstrate how this plan is a continuation of plans already being delivered within our footprint? Or does the plan contain new ideas that go beyond existing plans?

Our practical approach to evaluating the effectiveness of our engagement activities locally is to apply a well-known quality improvement methodology, using an iterative process: Plan, Do, Study, Act (PDSA cycle) https://improvement.nhs.uk/documents/2142/plan-do-study-act.pdf

We have applied the following evaluation framework.

Engagement, Experience and Inclusion Evaluation Framework developed by The Science and Technologies Facilities Council has developed a useful engagement evaluation framework, https://stfc.ukri.org/files/corporate-publications/public-engagement-evaluation-framework/ We have adapted this to support the **STUDY** element in our Engagement, Experience and Inclusion PDSA Cycle

Dimension	Definition	Response
Inputs	Engagement, experience and inclusion inputs include the time, skills and money that are invested into delivering engagement activities.	Over 50 engagement events were held across the county. 7000 information booklets were produced and distributed in local communities.
Outputs	Engagement, experience and inclusion outputs are the activities we undertake and the resources that we create.	Feedback received did include comments on the FFTF communications and engagement process itself. Feedback received was a mixture of positive and negative comments. An

		example of learning from feedback of this kind from the earlier LTP engagement was the suggestion to use of QR codes on future publications to allow people to link quickly to website materials. A QR code was added to the FFTF Engagement materials.
Reach	Reach has two main elements: • The number of people engaged, this includes attendance at events, completion of surveys, social media interaction etc. • The types or diversity of people engaged.	• Total face-to-face contacts was more than 3000. More than 1000 FFTF surveys completed (plus more than 1000 Cheltenham MP FFTF surveys completed). There were 21 Facebook posts with a reach of over 30,000. 49 tweets generated over 40,000 impressions and almost 1000 engagements. • We do not routinely collect demographic information about individuals participating in events/drop-ins etc. Demographic information was collected through our survey and at the independently facilitated workshops, but these questions were optional and consequently were not always completed. However, the demography of the county is considered during engagement planning and events/meetings targeted to reach a wide range of communities of interest.
Outcomes	Outcomes are the way that audiences respond to the engagement, experience and inclusion activity – completed event evaluation forms, independent observation reports	Working with The Consultation Institute recommended independent workshop facilitators has provided a degree of independent scrutiny to our engagement processes. Workshop evaluation forms were completed at all workshops and feedback summarised in independently prepared workshop reports.
Processes	Processes are the way we work to plan, develop and deliver our engagement, experience and inclusion activities. They include our approaches to quality assurance and following good practice.	Working with ICS Partners, Independent workshop facilitators, Inclusion Gloucestershire and Healthwatch Gloucestershire we have been able to plan and deliver a range of engagement activities.

8.2. ACT (following LTP engagement)

The following actions were undertaken following feedback received during the LTP engagement to support communications and engagement associated with FFTF:

- Collection of more demographic information relating to participants at public engagement events.
- In partnership with Inclusion Gloucestershire, Healthwatch Gloucestershire and ICS Partners actively sought the views of people who are representative of the protected characteristics.
- Testing our engagement materials with Healthwatch Gloucestershire Readers Panel to ensure that they are written in plain language which is easily accessible and understandable.
- The FFTF survey asked open, qualitative questions to facilitate, but not lead, free text responses to engagement and consultation.

We will continually review our approach to engagement to ensure that it reflects good practice, working with The Consultation Institute to quality assure our processes.

8.3. ACT (following FFTF engagement)

The following actions will be undertaken following feedback received during the FFTF engagement to support future communications and engagement associated with FFTF Programme:

Inclusion Gloucestershire participants identified the following areas for us to consider to improve engagement further (extract from Inclusion Gloucestershire Engagement Report see Appendix 1):

- Less information, less jargon and easy read copies of all information.
- From our experience, people who represent the seldom heard groups tend to need more time and preparation to support them to engage. It would have been helpful to have had at least two weeks research time prior to each area workshops.
- Workshops to be held later in the morning to enable people who use public transport to use their bus passes.
- Workshops to be held in the actual areas and at times that people can attend. For example: Tewkesbury was held in Highnam for 09.00am, Stroud and Berkley Vale held in Nailsworth for 09.00am and North Cotswolds was held in Cirencester for 09.00am.
- Some people from the BME communities were not able to engage in the workshops due to a language barrier. Going forward it might be more beneficial to liaise with community leaders to hold specific workshops within the BME communities with community support for interpreters. We know that there are many barriers for people from the BME communities accessing health care. For many, they don't know how to ask for the health care that they need or struggle to understand treatment options.
- For One Gloucestershire to go out to community groups such as the Inclusion Hubs for those who need to go at a slower pace and for a wider group of people to be included in the process.

8.4. Next Steps: Future communications, engagement and consultation for the NHS Long Term Plan and Fit for the Future programme

The FFTF engagement is still underway, with a Citizens' Jury planned during 2020 to consider 'Centres of Excellence'.

A period of public consultation is anticipated over the summer 2020. Local people will be asked their views on a range of possible solutions, which have been influenced by this FFTF engagement focussing on **Improving urgent care services in local communities and Improving specialist hospital services and developing 'Centres of Excellence'.**

Any proposals for 'significant'[6] change will be brought back to the public for formal consultation. The public, patients and carers, staff, community partners and elected representatives will have the opportunity to scrutinise new proposals.

Ultimately it is the responsibility of One Gloucestershire ICS partners together to pay attention to the feedback received during the FFTF Engagement and to any subsequent public consultation. They will use this information to support decision-making about how to transform and sustain Gloucestershire's health and care system.

[6] There is no national definition of 'significant variation' set out in the legal duties relating to engagement and consultation. Gloucestershire ICS partners are working with the GCC Health Overview and Scrutiny Committee (HOSC) and Healthwatch Gloucestershire to agree a Memorandum of Understanding regarding the local definition of key terms.

9. Copies of this report

This report is available on the One Gloucestershire website at:
https://www.onegloucestershire.net/yoursay/

Print copies of the report can be obtained from the Engagement and Experience Team by calling Freephone 0800 0151 548 or email: GLCCG.participation@nhs.net

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FIT FOR THE FUTURE

Output of Engagement

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