QUESTIONS &ANSWERS

1. *How can you call it a centre of excellence with so many people genuinely opposed to closure and reorganisation?*

This was an engagement exercise where we did not seek to set out proposed solutions ('closure and reorganisation'). Taking a 'centres of excellence' approach has a sound basis in clinical evidence and is recommended by the Department of Health and clinical Royal Colleges. The term 'excellence' is used because these configurations can improve patient experience, improve outcomes, reduce harm and improves availability of high quality clinical services.

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?*

Summary of the evidence:

There are a variety of possible **benefits** of *centres of excellence* including:

1. Earlier investigation
2. Better continuity of care
3. Reducing hospital acquired infections.
4. Reducing length of stay
5. More predictable workflow / load / hours
6. Increased senior supervision
7. Less cancellations
8. Improved efficiencies
9. Enhanced patient outcomes
10. Reduced waiting lists
11. More efficient use of theatres
12. Reduced complications
13. More timely care
14. Improved training
15. Enhanced patient safety
16. Increased quality of care

Risks could include

- duplication of work
- cost
- idle theatres.

Separation must be well planned and resourced and have a high volume of patients to ensure efficiencies. Separate unit on the same site is preferable to a completely separate location.

There is no one solution and local circumstances will need to be considered.

Sources:

- **The reconfiguration of clinical services: what is the evidence. Kings Fund (2014)** https://www.kingsfund.org.uk/sites/default/files/field/field_publication_summary/Reconfiguration-of-clinical-services-kings-fund-nov-2014.pdf
- **Improving length of stay what can hospitals do? Nuffield Trust (2015)** https://www.nuffieldtrust.org.uk/files/2017-01/improving-length-of-stay-hospitals-web-final.pdf
- **Separating emergency and elective surgical care: recommendations for practice. The Royal College of Surgeons (2007)**

- **Strategy 10: Improving elective care through separating acute and elective surgery (2012)**

The following resources were searched:

- Medline, Embase, Cinahl, BNI, HMIC, HBE
- Evidence Search
- Google
- A range of appropriate websites including The Kings Fund, Nuffield Trust, various NHS websites

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.

What cover for emergencies would be put in place in the planned facility?

Our Deteriorating Patient Model would provide care for patients whose condition may deteriorate in the planned care facility. The model consists of:

- 24/7 ITU – no reductions planned
- Resident ITU Consultant overnight
- Middle grade ITU doctor 24/7
- Band 8a Acute Care Practitioner 24/7
- Band 7 Acute Care Assistant Practitioner 24/7

This model would be in place whatever the recommended configuration of sub-specialties on the planned facility. Once the configuration is identified (through this process), it will determine the specialty and general resident medical cover required in addition to this model.

Is there not some theory/research about the best way to plan services, particularly a cold / hot split?

Yes there is (see the answer to Q2), and there are several different versions of 'recommended' configurations. The main finding from our research of the evidence was that there is not a 'gold standard' one-size-fits-all model. Local context is key – how the Trusts are managed, how far apart they are, what current configurations and ways of working are. All of these mean that Gloucestershire's preferred model may differ for reasons that are valid and acceptable to the public and clinical teams.

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?*

Great idea, thank you. We do have information about how this and other centralised configurations (maternity, paediatrics, stroke, ophthalmology) have improved the care and welfare of patients and staff. We will use more of these examples as we start to develop possible options.

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 (ie 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?*

Why are you limiting changes to the 4 noted in the question?

Thank you for your suggestions which we have taken into account in our potential options. We are not limiting ourselves to 3 services, but we have started with these 3 because preferences on where they are located will help us define whether further consideration is needed of the wider range of adult specialties.

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?
The engagement phase was not setting out any proposals. We are not reluctant to change doctors' working patterns, and we do not know whether the two hospitals have sufficient capacity until we have agreed proposals that we can test. We fully intend to publish plans honestly so they can be considered – this is part of the solutions development and consultation phase.
Why shouldn't Bristol and Swindon acute units be considered as part of the answer? They currently are and will be considered in the description of proposed solutions.

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.*

This question gets to the heart of whether you value easy access over safe, effective care. Our engagement activities have told us there is no universal 'right' answer.
Although healthcare providers might assume people would always prioritise better outcomes, many people have told us explicitly that they would prioritise ease of access even if the extra travel would offer a better chance of a successful outcome.
We will try to balance the two points of view by considering them in:

a. design of solutions that would entail less change to existing availability of planned care services, compared with more, and;
b. evaluation of the travel impact of these proposals, and testing any assumptions with those likely to be most affected

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?*

We have committed to continuing to offer an Emergency Department as currently configured to residents of Cheltenham.

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?*

We have committed to continuing to offer an Emergency Department as currently configured to residents of Cheltenham.

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?*

We have committed to continuing to offer an Emergency Department as currently configured to residents of Cheltenham.
Relative impact on populations, population outcomes, inequality, and vulnerable groups will be considered for any proposed options. We have a statutory duty not to worsen any existing health inequalities with any proposed changes.

10. *Has there been any sort of patient outcome study done since the restricted opening times of A&E at CGH?*

Two review workshops took place following implementation of the change – after 6 and 12 months respectively. A report was prepared for Health Overview and Scrutiny in 2014.
The purpose of the report was to *'provide a final review of the Cheltenham and Gloucester Emergency Department (ED) reconfiguration one year since its launch in July 2013. It is based upon performance indicators and the outcome of a workshop held with clinical, managerial and lay representatives from GHFT, GCCG, Healthwatch Gloucestershire and SWAST'.*

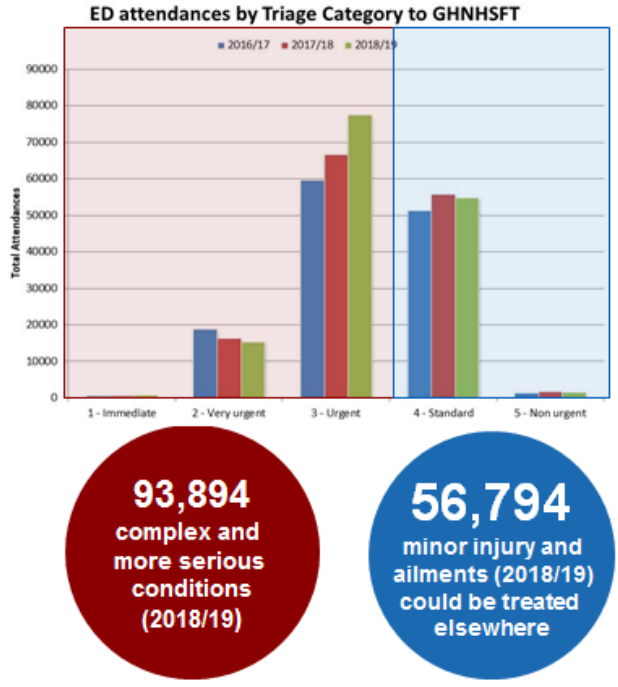
The report reviewed 7 key questions to assess the reconfiguration against its original intentions. The findings were as follows:

- *Supervision of doctors has significantly improved as a result of the reconfiguration and the Trust is no longer at risk of losing its trainee doctors.* However, the report does note that vacancies still exist at the middle grade level, with only 7 wte in post against a requirement for 10.
- *The predictions of the number of patients the change would affect were broadly correct.*
- *Waiting times in departments have generally improved and are better than the England average. CGH performance consistently exceeds the national target. Performance at GRH has improved but does not consistently meet the target.*
- *Mortality appears to have reduced and there have been no adverse incidents as a result of the change.*
- *Patient experience has improved with less complaints and more compliments.*
- *There has been some increase in the number of transfers and diverts of patients between sites, which remains a concern and is the subject of focussed efforts to minimise unnecessary disruption. With a two site model and increased specialisation, transfer between sites will be inevitable. The priority is to minimise transfers and ensure, when required, the process is safe and efficient. '*

The report concludes: 'The final report reviewing the reconfiguration has found it achieved the majority of its objectives and importantly has ensured good doctor training and supervision and improved care. Key lessons from this change and the review are being taken forward by the health community. There remains a firm commitment by GHFT and GCCG that there will be a strong and vibrant future for both CGH and GRH'.

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).*

This is the 2018/19 Emergency Department activity split by triage category. There are 5 categories:



Category 1 and 2 conditions are the most serious requiring the expert care of ED staff.
Category 3 patients can have complex and serious conditions, not all of which require the expert care of ED staff. For summary purposes categories 1, 2 and 3 are grouped together as having 'complex and more serious conditions'. This is 2/3rds of the total activity or approx. 250 patients a day.

Categories 4 and 5 represent 'minor injury and ailments' that could be treated elsewhere. This is 1/3 of patients or approx. 150 a day. For people who are triaged to the 4/5

categories, a visit to a Minor Injury/Illness Unit, a discussion with their GP, pharmacist or 111 may have avoided the ED attendance.
The '100' figure we quoted as needing ED services is, as you rightly point out, less than the 2/3rds of patients triaged to the 'complex and more serious' category. Here's why:

We know that around 44 patients a day are triaged to Category 1 or 2 and certainly need to be in an ED.
The issue is in 'Category 3', within which some people definitely require the expertise of an ED team, while others may be complex and serious but cared for just as well or better by expert care practitioners in other types of setting (e.g. GPs, Advanced Nurse Practitioners community rapid response teams).
There are no universally applicable rules about how many category 3 patients specifically require an ED. Clinicians in Gloucestershire carried out an audit of patients triaged to 'category 3'. They concluded patients who were referred by their GP needed to be in the ED. However, 70% of patients who had **not** been referred by their GP would have benefited more from services other than ED. For example, a frail elderly patient who has fallen and is confused might benefit more from referral to a complex care at home team who are better placed to co-ordinate out of hospital review and support. An ED in this instance is not always the best place for that individual to end up.
If you add 70% of non-GP referred category 3 patients to the 44 category 1-2 patients this gives you approximately 100 patients a day **who are best cared for in an ED** rather than alternative services

12. *Where should I R be? Makes sense for pci 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?*

In all solutions being considered IGIS will be available at both hospital sites. Options being considered include establishing an IGIS hub onto one hospital site. Whichever site this is on we would retain one IR lab on the opposing site to allow flexibility for teams to support each other with both emergency and planned patients requiring interventional radiology expertise.
The GI surgeons would continue to support other specialties requiring GI input.

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?*

We have developed potential solutions which include establishing an IGIS hub onto either the planned or the emergency site. Whichever site this is on, we would retain one IR lab on the opposing site to allow flexibility for teams to support each other with both emergency and planned patients requiring interventional radiology expertise.
These facilities, if configured with the correct specification, can be utilised to perform many cardiology procedures and investigations, as well as interventional radiology. The extent to which cardiology procedures and investigations are conducted on each site will be informed by the configuration of both IGIS services and Emergency and Acute Care.

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?*

Yes, solutions that have been identified which include establishing an IGIS hub onto one hospital site would also retain one IR lab on the opposing site.
15. *I do wonder where you are going to get all the interventional radiologists from?*
Whilst there is a national shortage of interventional radiologists GHFT is already in a strong position when compared with many other providers, and we believe the further development of these services will further improve our ability to both attract and retain specialist staff.
16. Is there going to be acute and elective general surgery on separate sites or all on one site?
We do not know yet. Our only viable 'medium list' proposal for emergency general surgery centralises it to a single site. We have developed a number of solutions to test different configurations of elective general surgery over the two sites. Preferred options will be developed and tested through consultation with the public.
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?*
Vascular services are primarily based in CGH – utilising this site as the arterial centre for the vascular network (GRH and Great Western Hospital, Swindon also being part of this network). Whilst vascular services are primarily centralised to a single site already, this is not the case for other services. Most interventional cardiology is based in CGH, with some pacing work conducted at GRH; the cardiology inpatient bed base is located across both sites. Interventional radiology is currently provided across both sites. This multi-location provision creates many challenges for staffing these facilities and forms part of the IGIS case for change.
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.*
This will be part of our solutions development and appraisal process. Not all possible solutions have an impact on the GRH site, but some might. As this is a long term (~10 year) strategy we expect to define what we believe to be a manageable implementation plan for any preferred option(s) put forward for decision. Any changes that increase demand to the GRH site would require enabling measures to be taken before the full change could be implemented.
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?*
This respondents' wife's case is at the heart of the Centres of Excellence vision, thank you for sharing. We are seeking options which improve our ability to provide: - Sufficient capacity for planned general surgery including HDU/ITU capacity - Specialty wards with dedicated expert teams, and an increased chance that the right patients will be on the right wards to benefit from their expertise - Complimentary services relevant to specialty care, e.g. stoma nurses - Enhanced ability for clinical teams to work together, e.g. oncology, gynaecology, colorectal, gastroenterology

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?*
In all of our models we would seek to have a better planned presence of all specialties in both hospitals, every day. Regardless of which site a specialty might have as a primary base, they would have a scheduled presence on the alternate site to review all patients requiring their input. This factor is particularly important in the consideration of a centre of excellence for emergency care though, where input from all specialties is time critical. A good example of this is a new Gastroenterology arrangement we have been testing. The Gastroenterology ward is currently on the Cheltenham General site, but there is a 'Gastroenterologist of the day' scheduled to be on the Gloucester site to review all emergency patients. This is proving to be a better arrangement than having a Gastro ward on the GRH site, as previously patients were admitted to this ward for the Gastroenterologist opinion.
21. Where are the specialists based and do they have 24 hour consultant cover?
There is 24 hour consultant cover for all services but not always on-site. Current specialist bases are: - Upper Gastrointestinal surgery – GRH - Lower Gastrointestinal (colorectal) surgery – both sites - Emergency general surgery – both sites - Emergency and acute medicine – both sites - Cardiology – both sites - Vascular – CGH - Interventional radiology – both sites
22. *Are there any plans to become a teaching hospital for the training of nurses?*
We are already a teaching hospital for the training of nurses.
23. *What impact does this have on staff travel?*
This was an engagement exercise where we did not seek to set out proposed solutions. Once we have proposed solutions we will assess the impact on staff, patient and carer travel.
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?
Private patient services were not in scope for this engagement.
25. *Has the increased cost of hospital transport been factored in?*
This was an engagement exercise where we did not seek to set out proposed solutions. Once we have proposed solutions we will assess the impact on hospital transport.
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.*
Private patient services were not in scope for this engagement.
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.*
The centres of excellence vision was informed by a range of clinical evidence, including

reports published by the Kings Fund, Royal College of Surgeons, Royal College of Physicians, Nuffield Trust, Clinical Senates and the NHS Long Term Plan which states [on page 74]:
"…separating urgent from planned services can make it easier for NHS hospitals to run efficient surgical services. Planned services are provided from a 'cold' site where capacity can be protected to reduce the risk of operations being postponed at the last minute if more urgent cases come in. Managing complex, urgent care on a separate 'hot' site allows trusts to provide improved trauma assessment and better access to specialist care, so that patients have better access to the right expertise at the right time. So we will continue to back hospitals that wish to pursue this model separation of emergency and planned care".
In the Queen's speech on December 19th 2019 the government committed to enshrine in law the funding of the NHS Long Term Plan by increasing funding by £33.9billion in cash terms, £20billion in real terms, to take total NHS spending to £148.5 billion by 2023/24. This investment is required to treat an ageing population with an increasing number of long term conditions and to support the objectives described in the Long Term Plan that require patients, families and communities, to have improved access to prevention and self-care services (healthy living), diagnostic equipment, drugs, clinical interventions and community rehabilitation support.
These monies will not be spent on topping up pension plans and pay rises.

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.*

Individual patient-specific queries are dealt with separately

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?*

We consider services for older people to be a vital component of the specialist care we provide, wherever patients' care is being delivered.

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?*

'Direct admission' to specialties is one of the proposals we are looking at, thank you for raising this.
Other OOH services that patients may be directed to include: GP OOH service at both acute sites; Minor Injury and Illness units in the community or local pharmacies.

31. *What opportunities are there to share facilities with adjacent counties?*

Great question and yes, there are opportunities, some we have already progressed and some are in discussion. For example, our Oncology service already treats patients from Gloucestershire, Herefordshire and Worcestershire, including through a Gloucestershire Hospitals-run 'Satellite' Radiotherapy Unit at Wye Valley Hospital and our Vascular service treats patients from Gloucestershire and Swindon. Nationally, major trauma has been centralised to specialist centres and Bristol provides the major trauma service for our region.
We are currently exploring how through better use of digital technology some of our clinical support services could work more closely with adjacent counties, for example could we collectively better manage peaks and troughs in demand for reporting CT and MRI scans across the South West by linking up Consultant Radiologists?

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?*
Individual patient-specific queries are dealt with separately
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?
Not in the scope of this engagement. Individual patient-specific queries are dealt with separately
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?
It was not clear if this question is asking how much of our resources are used for out of area patients?
35. *Where is the published criteria for determining which services are located and the performance criteria against which such key discussions will be judged?*
This is the subject of the next phase of solutions development and appraisal. A Citizens' Jury in January will review the proposed criteria against which the proposals will be judged.
36. *This survey is NOT available online despite your claim it is. One more pretence at open communication.*
The survey was accessible
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?*
This would be part of our solutions development phase, once we have proposals we can evaluate. We have committed to continuing to offer an Emergency Department as currently configured. As well as providing continued access to residents of Cheltenham, this facility would continue to be available in the event of a major incident at a different site.
38. *What evidence do you have to show the waiting times and performance/response/outcomes will improve by closing Cheltenham A&E?*
We have committed to continuing to offer an Emergency Department as currently configured to residents of Cheltenham.
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?*
We have committed to continuing to offer an Emergency Department as currently configured to residents of Cheltenham.
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?*
Are these already transferring patients between hospitals? We will factor the volume of current inter-site transfers to our transport impact assessment **I wouldn't want my emergency treatment to be subject to the traffic on the roads between the two hospitals.** In an emergency the blue-light ambulance would make every effort to make reasonable progress through any normal traffic between the two sites. These two studies are of interest in evaluating the impact of travel time/distance on

emergencies:

Effects of driving distance and transport time on mortality among Level I and II traumas occurring in a metropolitan area (2018): A study in Chicago concluded: We find a modest effect of distance on mortality that is approximately linear over a range of 0 to 12 miles. Instrumental variables analysis indicated a corresponding increase in mortality with increasing transport time: https://journals.lww.com/jtrauma/Citation/2018/10000/Effects_of_driving_distance_and_transport_time_on.17.aspx

A matter of life and death: hospital distance and quality of care: evidence of emergency room closures and myocardial infarctions (2014) Health Econmetrics and Data Group University of York: In Sweden: "patients who experienced an increase in the distance to their home hospital of between 51 and 60 kilometres ran an estimated 15 percent lower risk of surviving the AMI [Acute Myocardial Infarction] than patients who lived within ten kilometres of their home hospital"

In the event that one of our receiving Emergency Departments is compromised, e.g. a Major Incident, the alternate site will be used, or the nearest/quickest alternative out of county site where relevant.