Your Health, Your Care
Maintaining high quality, specialist services

Extraordinary HCCOSC Meeting
8 Feb 2013
Summary

• Background & current service distribution
• Context and constraints
• Provisional proposals:
  – Emergency & urgent medical care including trauma
  – Medical specialties
  – Paediatric day cases
• Public engagement process
Proposals in context:
Your Health Your Care - 2012

- Further development of community teams
- Development of ‘co-ordinator’ role for people with long term conditions
- Reduce the reliance on hospital based services
- Maintain high quality specialist health services in the county
Background

History of successful site/service reconfiguration:

• Neutropenia Service to CGH (1994)
• Interventional Cardiology Service to CGH (1996)
• ENT to GRH (2000)
• Ophthalmology to CGH (2000)
• Paediatric inpatients to GRH (2006)
• Obstetrics, neonatology & benign gynaecology to GRH (2011)
• Inpatient urology to CGH (2011)
• Paediatric emergency assessments to GRH (2011)
• Major Trauma to Bristol & GRH (2012)
• Stroke & Transient Ischemic Attack (TIA) to GRH (2012)
• General & Old Age Medicine (GOAM) balanced (2012)

Remaining commitment:

• Inpatient vascular surgery to CGH (2013)
What type of care do we want to provide?

• Consistent and ‘right first time’
• Patient centred
• Consultant led
• Locally accessible
System constraints

• Two-site hospital
  – two points of entry for acute admissions
  – if services can be provided locally then they should be, particularly for pathways with multiple visits

• Theatre capacity

• Financial envelope
Why can’t we stay as we are..?

“With **fewer staff** and **increasing standards**, we need to concentrate services in **fewer locations**.”

- Inability to recruit
- National shortages & competition
- European Working Time Directive
- Sub-specialisation

- Junior doctor supervision
- 24-7 consistent care
- National quality standards
- Sub-specialisation
Benefits of concentrating services..

• Improved outcomes
• Consistent care
• Efficient use of resources

Drawbacks..

• Not all services available locally
• Additional distance in ambulance for urgent cases
• Rare occasions when urgent transfer required
• Additional travel for relatives, carers & visitors
Proposals - 2013

- Emergency & urgent medical care including trauma
- Medical specialties
- Paediatric day cases
Emergency & urgent medical care including trauma
Urgent and Emergency care Whole System

Emergency care services at CGH and GRH are part of a whole health community urgent and emergency care system, including community hospitals (Minor Injury Units) and the ambulance service.
Emergency & urgent medical care including trauma

**Example pathways:**

<table>
<thead>
<tr>
<th>Common examples of three main streams:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Walk-in ‘minors’</strong></td>
<td><strong>GP-reviewed admissions</strong></td>
</tr>
<tr>
<td>Cuts</td>
<td>Chest infection</td>
</tr>
<tr>
<td>Sprains</td>
<td>Urinary infection</td>
</tr>
<tr>
<td>Broken arm</td>
<td>Shortness of breath</td>
</tr>
<tr>
<td>Bruises</td>
<td>Palpitations</td>
</tr>
</tbody>
</table>
Why can’t we stay as we are..?
1. Patient safety and clinical standards

“Patients admitted as an emergency at weekends are significantly more likely to die.” Dr Foster Research Ltd.

- It is no longer acceptable for junior doctors to treat patients routinely without supervision.
- It is no longer acceptable for standards of care to be different at night and weekends from during the day.
- If we don’t achieve national clinical standards, we risk losing services altogether in the county.
- National review to be led by Sir Bruce Keogh – launched January 2013, emerging principles to be published in spring:

  “Treatments for many common conditions such as heart attacks and strokes have evolved considerably over the last decade and are now best treated in specialist centres. Yet we know people want their A&E nearby.”
2. Availability of staff

“There is a crisis in recruitment into emergency medicine and general medicine at both training and consultant levels.”

Royal College of Physicians September 2012

- Continued failure to recruit close to the number of recommended doctors in Emergency Medicine so we still don’t have enough senior doctors in our EDs. This applies to consultants and middle grades.

<table>
<thead>
<tr>
<th></th>
<th>Required</th>
<th>Current</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultants</td>
<td>20</td>
<td>11</td>
</tr>
<tr>
<td></td>
<td>(10 per site)</td>
<td></td>
</tr>
<tr>
<td>Middle grades</td>
<td>16</td>
<td>7.5</td>
</tr>
<tr>
<td>(≥ ST4 or equivalent)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>(8 per site)</td>
<td></td>
</tr>
</tbody>
</table>
2. Availability of staff – national issue

“The specialty of Emergency Medicine is currently facing critical workforce shortages at ST4 and Consultant level in many areas in England.”

College of Emergency Medicine Taskforce - 2012

- Fewer trainees are opting for Emergency Medicine due to work intensity and conditions, unsociable hours and the sustainability of such a career to the age of 68
- For ST4 (first year of higher training) in 2012, there were 196 posts in England of which 86 (44%) were filled.
- The Centre for Workforce Intelligence (CfWI) predicts it will take until 2020 to secure sufficient numbers of consultants.
3. External scrutiny – The Severn Deanery

“.. Recruitment into medical posts will not provide a sustainable future solution.” Severn Deanery report Dec 2012

• “There must be a recognition that emergency medicine trainee numbers will not increase for the foreseeable future.”

• “The Severn Deanery would support the reconfiguration of emergency medicine provision and the move towards a greater emphasis on the Gloucester site.”

• “The Severn Deanery wish to see a timetable for the proposed reconfiguration of the emergency medicine services in the Gloucestershire hospitals.”
Emergency & urgent medical care including trauma

Proposals:

• Approach is to ensure safety for sickest patients while understanding and managing impact on capacity in ED, theatres and wards

• Proposed model from August 2013:

<table>
<thead>
<tr>
<th>Time</th>
<th>Cheltenham General Hospital</th>
<th>Gloucestershire Royal Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>8am-8pm</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>➕ (1)</td>
<td></td>
</tr>
<tr>
<td>8pm-8am</td>
<td>✓ (2)</td>
<td>➕</td>
</tr>
<tr>
<td></td>
<td>➕ (3)</td>
<td></td>
</tr>
</tbody>
</table>

1. Except trauma, stroke, paeds, maternity
2. Patients requiring admission directed/transferred to GRH
3. Except for patients with specific conditions agreed with the Ambulance Service
Emergency & urgent medical care including trauma

Patient Numbers – current average per 24 hours:

<table>
<thead>
<tr>
<th>Time</th>
<th>Cheltenham General Hospital</th>
<th>Gloucestershire Royal Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Walk-in ‘minors’</td>
<td>GP-reviewed admissions</td>
</tr>
<tr>
<td>8am-8pm</td>
<td>63</td>
<td>21</td>
</tr>
<tr>
<td>8pm-8am</td>
<td>17(^{(2)})</td>
<td>5</td>
</tr>
</tbody>
</table>

1. Of which, approximately 3 are orthopaedic trauma
2. Of which, on average, 3 are admitted
Emergency & urgent medical care including trauma

**Timescales:**

- Change is needed in August 2013 due to:
  - rotation of trainees – there is no guarantee we will even have the number of doctors we have currently
  - Requirements of Deanery to address current issues with training
- This change will need to be kept under review to assess whether it is sustainable, or whether further change is required.
Medical specialties

- Gastroenterology & hepatology
- Cardiology
- Respiratory (thoracic) medicine
Why can’t we stay as we are..?
Gastroenterology, Cardiology & Respiratory

Drivers for change

• Combining specialist skills
  – Improve quality and consistency of care

• Impact of changes to emergency & urgent medical services
  – Retain the balance of services across sites
  – Ensure patients are seen by the appropriate specialist when needed

• Improving patient experience
  – Reduce delays for cardiac investigations on Hartpury caused by physical capacity
  – Hartpury does not meet modern standards for single sex accommodation or infection control
Gastroenterology, Cardiology & Respiratory Proposals

- Retain medical cover to both sites but change the ‘functional distribution’ to address drivers and maintain capacity
- Gastroenterology: Centralise the majority of elective activity to CGH
- Cardiology: Increase the size of Hartpury suite to reduce delays and allow single sex and infection control issues to be addressed
- Respiratory: Concentrate services for patients with complex conditions more towards CGH
Paediatric day cases

• Day surgery
• Medical investigations which can’t take place in an outpatient clinic
  (e.g. MRI/CT sedations, endocrine tests, renal imaging, medication test doses, IV infusions and IV antibiotics)

*The proposals do not affect elective outpatient services which are available on both sites.*
Paediatric day cases Current service

At CGH:
• Paediatric day case facility for elective surgery, open 2 days a week
  – 307 patients in 2011-12
• Medical day case service open 2 days a week
  – 468 patients in 2011-12
• Paediatric nursing on Eyeford for dental procedures and eye surgery
  – 286 dental and 156 eye surgery patients in 2011-12

At GRH:
• Day case surgery: the main hospital Day Surgery Unit has a Paediatric bay within the adult unit open 5 days a week
  – 1159 patients in 2011-12
• Medical day case service in Outpatients and Paediatric Assessment Unit open 5 days a week
  – 324 patients in 2011-12
Why can’t we stay as we are..?
Paediatric day cases  Drivers for change

Specialists and their skills:
- Care Quality Commission Children’s Services Review raised concerns about the number of surgeons and anaesthetists carrying out low numbers of cases per year on children
- reduction in training grade doctors in paediatrics means that providing consistent care in multiple places is no longer sustainable

Child & family friendly environment:
- patients booked in the Day Surgery Unit at GRH, although in a separate bay, are in mixed or close proximity to adults which is not best practice
- theatre lists and areas for paediatric recovery are also commonly mixed with adults
### Paediatric day cases: Options considered

<table>
<thead>
<tr>
<th>Option</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>No change.</strong></td>
<td>This does not solve the issues</td>
</tr>
<tr>
<td><strong>Paediatric Day Unit no longer provided in the County</strong></td>
<td>Neighbouring units do not have the capacity to take this activity, there would be increased travel for patients, and a risk of day surgery becoming inpatient work.</td>
</tr>
<tr>
<td><strong>Paediatric Day Unit on both sites</strong></td>
<td>There is insufficient demand in the County to provide a robust paediatric day unit service on both sites, and it is increasingly difficult to provide the necessary medical cover.</td>
</tr>
<tr>
<td><strong>Paediatric Day Unit on a single site</strong></td>
<td>This is sustainable. It would concentrate the expertise of operating on children and enable the development of paediatric day case clinical pathways. As part of the options appraisal, evidence from the Royal Colleges was reviewed, which indicated that the preferred option should be to co-locate the unit on the same site as the Children’s Inpatient facility i.e. Gloucestershire Royal Hospital.</td>
</tr>
</tbody>
</table>
Paediatric day cases

Proposal

Centralise paediatric day cases, with the exception of ophthalmology, into a new dedicated unit in Children’s Centre at GRH

• This does not affect elective outpatient services which would continue as currently on both sites
• Investment in a new unit will address the current environmental issues
• As well as resolving the drivers for change within paediatrics and improving the environment for children, this has the added benefit of releasing Battledown ward area at CGH for other services
Engagement to date

June - October 2012:
• Specialty workstream meetings & workshops

October – November 2012:
• GHNHSFT Main Board
• Clinical Priorities Forum

December 2012:
• CCG & NHS Gloucestershire Executives
• Cheltenham GP locality group
• HCCOSC NHS Reference Group

January 2013:
• GHNHSFT Board & Governors
Public engagement process

- 9th Jan  SHA discussion – process assurance
- 24th Jan  Shadow CCG approval
- 31st Jan  NHS Gloucestershire Board approval
- 1st Feb  Start of 12 week engagement
- 8th Feb  HCCOSC extraordinary meeting
- 30 April – end of 12 week engagement – subject to monitoring during pre-election period (added 2 extra days for Easter Bank Holidays)
What are we going to tell the public?

- **Summary of current services**
- **Drivers for change – ‘why can’t we stay as we are’**
- **Proposed models**
- **Emphasis that the proposals are clinically led**
- **Emphasis that these changes are part of a continuum but the NHS in Gloucestershire is committed to retaining both hospitals**
What should we ask the public?

• How have you obtained information about the proposed changes?
• Do you have any suggestions about how else we could make this information available?
• Having read this booklet do you think you been provided with the right information to help you to understand and form a view about developments underway and the proposals for change?
• Do you agree with the views of clinicians and managers about the proposals for change?
• Please give us your views about the proposals for change.
• Respondent demographic information.
Methods of engagement and communication

- Engagement booklets including feedback form (print/on line)
- Countywide media advertising
- Community partner presentations
- Targetted group awareness raising
- Public drop-ins / Info Bus
- Displays
- Staff briefings
Questions..?