One Gloucestershire
Transforming Care, Transforming Communities

NHS

# Engagement Hearing: 24 October, 2019

# Abbey & Avon Rooms, 1st floor

## Programme

*(NB: Presenters will be greeted in the foyer outside the lifts on First Floor)*

| | |
|---|---|
| 11:30 | Introduction and written submission from Suicide Crisis |
| 11:45 | Cllr Richard Stanley, Tewkesbury Borough Council |
| 12: 30 | Break |
| 13:15 | Cllr Flo Clucas, Cheltenham Borough Council |
| 14:00 | Professor Robert Arnott, Cheltenham Labour Party |
| 14:45 | Tony Foster, Cheltenham resident |
| 15:30 | REACH |
| 16:15 | John Thurston, Friends of Lydney Hospital |

One Gloucestershire
Transforming Care, Transforming Communities

NHS

## Engagement Hearing: 24 October, 2019, The Chase Hotel, Shurdington Road, Brockworth, Glos, GL3 4PB

**Live stream available at: https://www.onegloucestershire.net/category/news/**

**Independent Chair: Nicholas Duffin, Fellow, The Consultation Institute**

| Core Panel Members | GPs | Glos Hospitals NHS Foundation Trust | Glos Health and Care NHS Foundation Trust | Glos Clinical Commissioning Group |
|---|---|---|---|---|
| | • Jeremy Welch (pm only), GP Lead Urgent Care<br>• Will Miles (a.m. ONLY) GP Clinical Commissioning Lead, CCG<br>• Caroline Bennett, Caroline (a.m. only), GP Clinical Commissioning Lead, CCG | • Steve Hams, Director of Quality and Chief Nurse<br>• Mark Pietroni, Medical Director<br>• Simon Lanceley, Director of Strategy and Transformation<br>• Rob Stacey – Consultant in Emergency Medicine<br>• Eve Olivant – Specialty Director, Cardiology | • Amjad Uppal, Medical Directory<br>• Kathy Cambell, Service Director for Urgent Care | • Andrew Seymour, (pm only) Clinical Chair<br>• Julie Clatworthy, Registered Nurse, Governing Body<br>• Ellen Rule, Director of Transformation and Service Redesign<br>• Maria Metherall, Senior Nurse, Urgent & Emergency Care |

| Observers | ICS | Glos Hospitals NHS Foundation Trust | Glos Health and Care NHS Foundation Trust | Glos Clinical Commissioning Group |
|---|---|---|---|---|
| | • Mary Hutton, Accountable Officer, CCG and ICS Lead<br>• Micky Griffith, Programme Director | • Deborah Lee, Chief Executive,<br>• Jo Underwood, Transformation Programme Director | • Paul Roberts, Chief Executive<br>• Angela Potter, Director of Strategy & Partnerships,<br>• John Campbell, Chief Operating Officer | • Mark Walkingshaw, Deputy Accountable Officer and Director of Commissioning |

| | |
|---|---|
| **Attendees** | ***Members of the Public:***<br><br>***NHS Representatives***<br>*Emily Beardshall, Deputy ICS Programme Director*<br>*Hazel Braund, Programme Director, Glos Health and Care NHSFT*<br>*Anthony Dallimore, Associate Director, Communications, Glos CCG*<br>*Tom Hewish, Programme Manager, Glos Hospitals NHSFT*<br>*Peter Lachecki, Chair, Glos Hospitals NHSFT*<br>*Roger McDermott, Senior Programme Manager, Glos CCG*<br>*Becky Parish, Associate Director, Engagement and Experience, Glos CCG*<br>*Anna Rarity, Patient and Public Involvement Manager, Glos Hospitals NHSFT*<br>*Caroline Smith, Senior Manager, Engagement & Inclusion, Glos CCG*<br>*Clare Stephenson, Programme Manager, Glos Hospitals NHSFT* |

# Written submission

# (on behalf of Suicide Crisis)

**Email feedback Sent: 22 September 2019 11:16.**

***Included in full within this report with permission of the author.***

**Developing urgent and hospital care in Gloucestershire - engagement**

I write in response to your request to involve us in the engagement process ("developing urgent and hospital care in Gloucestershire").

I am writing on behalf of the charity Suicide Crisis -a charity which provides two Suicide Crisis Centres in Cheltenham, and a Trauma Centre. We have been providing these services since 2013. We provide a county-wide service, as we also go out to people in crisis, either in their homes or in other appropriate venues.

My comments below relate to our concerns about the potential loss of Cheltenham General Hospital's A&E department. I hope to demonstrate that this may lead to a risk of loss of lives.

Although we provide essential crisis support to people who are in suicidal crisis, there are times when it is clear that the person is not just in suicidal crisis, but may be very mentally unwell, too. At such times, we have a responsibility to ensure that they are assessed by a psychiatric clinician. We have an advising psychiatrist working within our charity, but he only works in an advisory capacity, to our team. He does not work directly with our clients.

If we contact the 2gether NHSFT mental health crisis team in relation to a client, they may refuse to take the referral. The crisis team has often said to us that, unless the person consents to being contacted by the crisis team, they will not contact the person. The crisis team will often require specific consent from the person. And, in any case, the fastest route to a mental health assessment is via A&E. The psychiatric liaison team is accessible 24 hours at the hospitals.

It is widely (and quite rightly) stated that a person at imminent risk of suicide should go to an A&E department.

I myself walked into Cheltenham A&E when I had a strong intent to end my life, a few years ago. That led to an assessment by one of the mental health liaison team nurses, who recommended that I was immediately admitted to psychiatric hospital. If Cheltenham A&E had not existed, I might not be alive today. I was able to walk to Cheltenham A&E. That simply required putting one foot in front of another – it was a twenty minute walk and I knew the route to Cheltenham A&E well. I had been a volunteer at the hospital in the past.

However, I would not have been able to navigate the more complex journey to Gloucester A&E. That would have required a degree of forward planning about buses, travel, and how to get there. I don't drive. The thought of a longer, complex journey and having to be around people on buses while so mentally unwell – I simply wouldn't have been able to do it.

Recently I stayed on the phone to a client as she walked to Cheltenham A&E during the daytime. When she called us that day, it was clear that she was at an outdoor location where she was unsafe. Her presentation was very different from usual – I was concerned that she needed a mental health assessment with a psychiatrist. I encouraged her to go to A&E, keeping me on the phone all the time, and because she had built a strong trust with our organisation, she did as I asked. I could not have done the same to get her to Gloucester, requiring her to take more than one bus journey. It was the simplicity of the journey – just one foot in front of the other – which made it possible for her, just as it did for me in the past.

Having a Minor Injuries Unit makes a difference to patients who are in mental health crisis or in suicidal crisis. We have heard of people being turned away from the Cheltenham Minor Injuries Unit at night, if they are feeling suicidal. Some clients coming to us have reported that happening. They have been told "This is not an appropriate place for you. You need to go to Gloucester A&E department."

As my previous paragraphs have explained, for many patients the effort and complexity of the journey over to Gloucester is not possible at that point. They simply walk out of Cheltenham A&E at a point where they are at risk of suicide. I have not heard of these patients being transported to Gloucester A&E by ambulance. They are left to make their own arrangements – and are unlikely to be able to do so.

I believe that the closure of Cheltenham A&E will create a risk to life for some people who are in suicidal crisis. I hope that matters as much to Gloucestershire Hospital bosses as it matters to us.

We also have to look at the capacity of Gloucester Royal Hospital to be able to cope with the additional numbers of patients which Cheltenham A&E sees during the daytime. I accompanied a Gloucester-based client to Gloucester A&E department last month. We were taken by ambulance because he was presenting as though he was having a seizure. At Gloucester A&E, he was lined up in the corridor with other patients, all of them on trolleys. Gloucester A&E was clearly struggling to cope with the numbers in the daytime. I asked one of the paramedics if it was usual for patients to be lined up on trolleys in the corridor in the daytime – and he said it was. I was shocked to hear this.

We strongly urge hospital bosses not to close Cheltenham A&E. I believe that there is a real and continuing risk that they will, because they have only made a commitment to having urgent care in Cheltenham hospital, and urgent care can mean a Minor Injuries Unit, not an Accident and Emergency department.

Regards

Joy Hibbins
Founder and CEO
Suicide Crisis
Tel. 07889 420 200
**Website: www.suicidecrisis.co.uk**
**Suicide Crisis is a registered charity which runs a Suicide Crisis Centre and a Trauma Centre. We have been providing services for six years and have never had a suicide of a client under our care.**
Suicide Crisis is a registered charity (charity no. 1170444).
Registered as a charity in England and Wales.
**Facebook**: http://www.facebook.com/SuicideCrisisCentre
**Twitter:** @Suicide Crisis

suicidecrisis
supporting people with a suicide or trauma crisis

Presenter: Cllr Richard Stanley,
Tewkesbury Borough Council

No presentation submitted, three images shared (3 x maps)


# Community Development Area Map

# Drive Time Access to Hospitals
# Accessibility Matrix 2019

MAIDEN

GCC

## Key

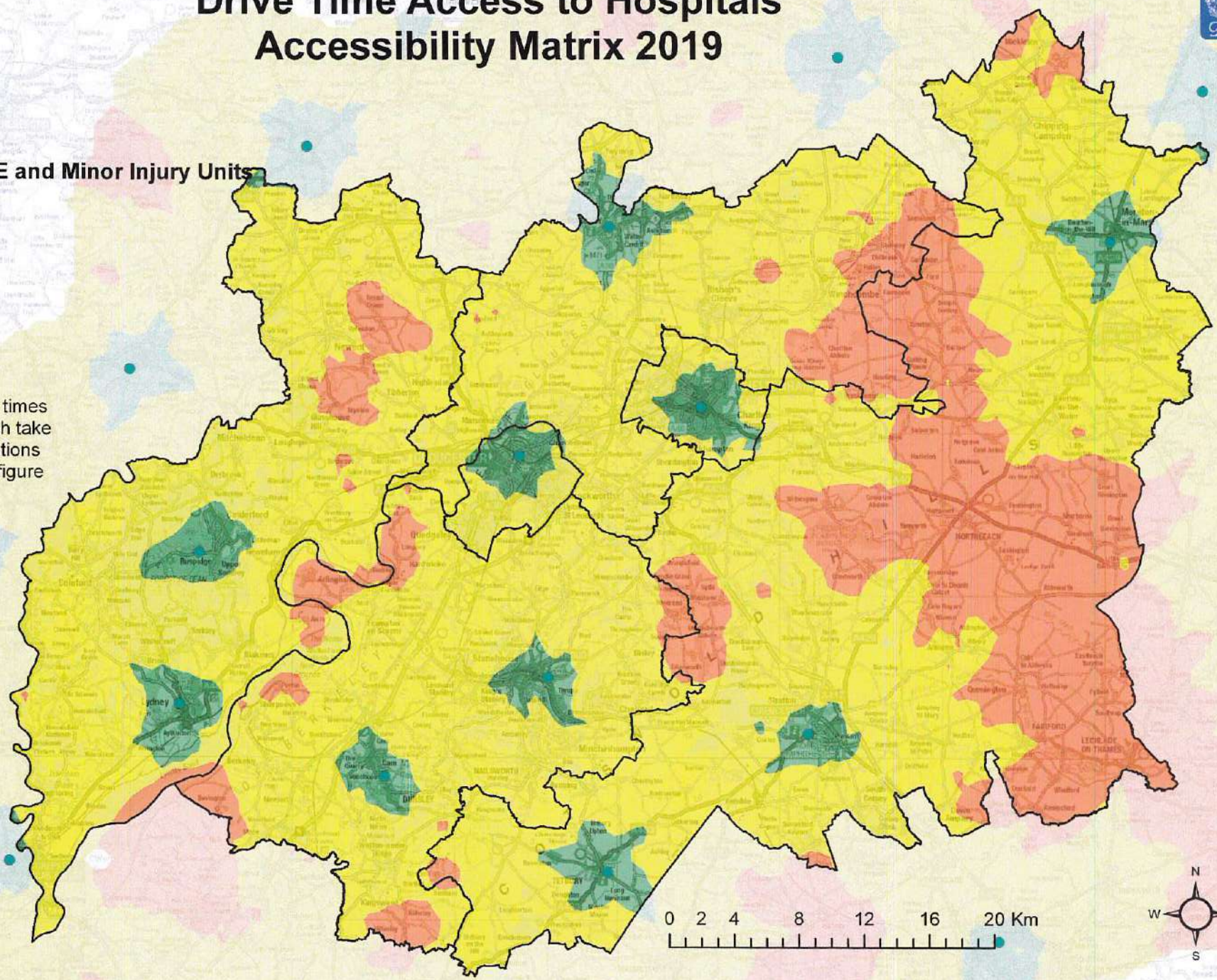
- Hospital Locations
- District Boundaries

**Drive time access to A&E and Minor Injury Units**

**Time in minutes**

- Up to 5
- 5-15
- 15+

These are theoretical minimum times (i.e. no traffic or red lights) which take no account of actual road conditions but which provide a consistent figure for comparisons.

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D Carr - Jan 2019

MAIDEN

# Public Transport Access to A&E and MIUs
# Accessibility Matrix 2019

**Travelling on Tuesday between 10am and midday**

GCC

## Key

- Hospital Locations
- District Boundaries

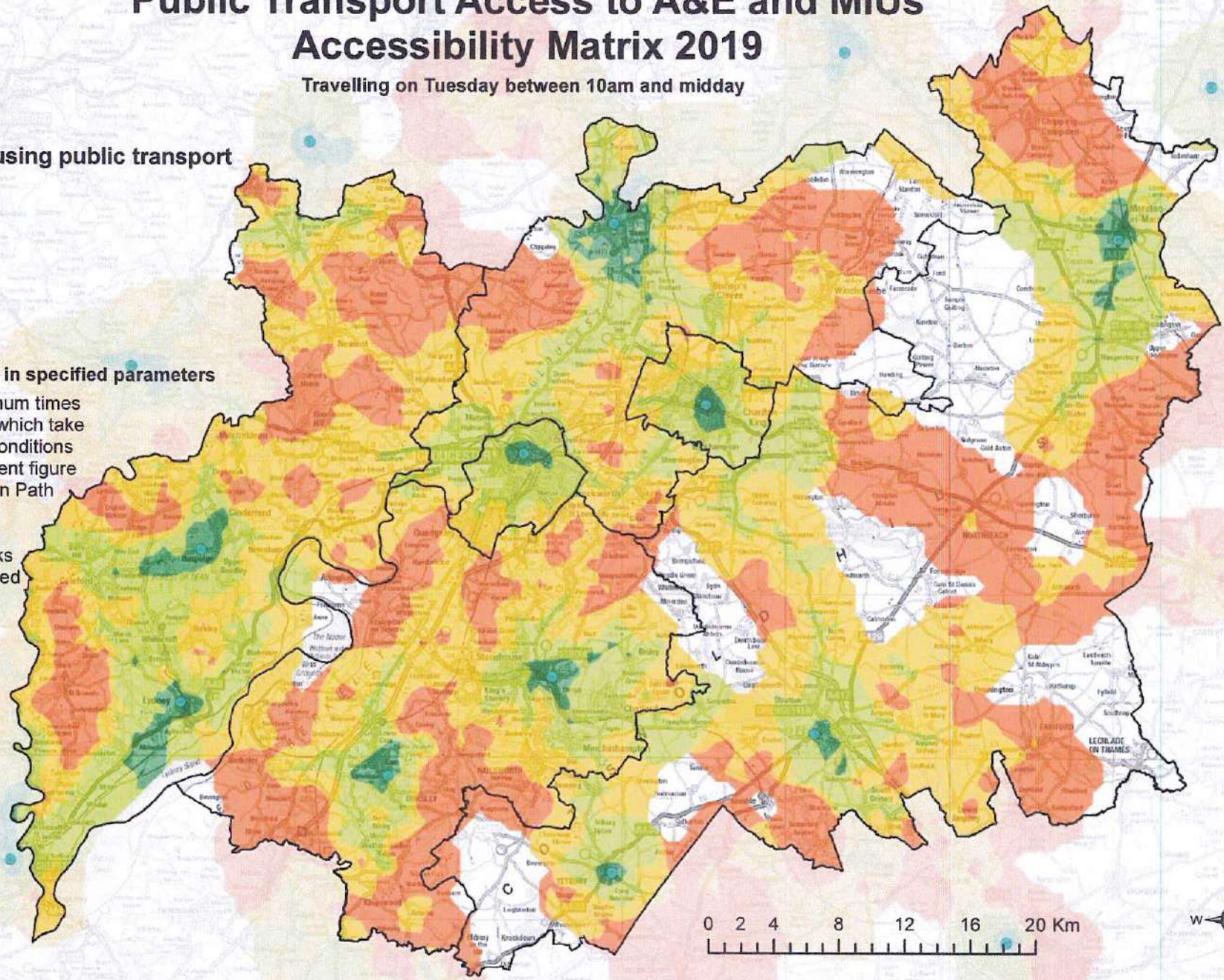
**Access to Hospitals using public transport**

**Time in minutes**

- Up to 15
- Up to 30
- Up to 45
- Over 45

**Blank areas = impossible in specified parameters**

These are theoretical minimum times (i.e. no traffic or red lights) which take no account of actual road conditions but which provide a consistent figure for comparisons. The Urban Path network is used for walking journeys to the nearest bus stop. Footpath networks in rural areas are not included e.g. Public Rights of Way.

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D Carr - Jan 2019

Presenter: Cllr Flo Clucas,

Cheltenham Borough Council

No presentation submitted

Presenter: Professor Robert Arnott

Cheltenham Labour Party

**Statement by Professor Robert Arnott on behalf of Cheltenham Labour Party given to the One Gloucestershire Engagement Hearing on *Fit for The Future: developing urgent and hospital care in Gloucestershire,* held on 24 October 2019**

I shall start with introducing myself. I am Professor Robert Arnott of Cheltenham, a Fellow of Green Templeton College in the University of Oxford, where I teach and undertake research on UK and global health policy. On this occasion, however, I speak exclusively on behalf of Cheltenham Labour Party.

I am grateful for the opportunity to make this statement as part of the public engagement exercise on the future of hospital services in Cheltenham and Gloucestershire outlined in *Fit for the Future: developing urgent and hospital care in Gloucestershire*, by One Gloucestershire. I shall principally address my remarks around the issue of A&E services in Cheltenham and the rationalisation of general surgery; a matter in which I have a particular interest, but also some general comments concerning the future of the NHS locally.

Before I start with A&E services, I want to say one or two things about the engagement exercise itself. I strongly believe that openness and transparency should be at the very heart of every NHS organisation and service. For this engagement exercise to work, I must be able to go away from today assured that nothing is yet agreed and that those who participate in today's exercise or members of the public who respond to the engagement document are doing so in the knowledge that they can influence decisions.

## Accident and Emergency Services

Yesterday afternoon, I was informed that in a reply to an intervention in the House of Commons by Alex Chalk MP, the Secretary of State for Health and Social Care, announced that "....the A&E will remain open and that no proposals to close the A&E at Cheltenham will be part of the forthcoming consultation."

What does this actually mean? Whilst this news is very welcome, it creates a whole host of questions:

(a) Is it a full reprieve?

(b) Is the plan to downgrade Cheltenham to an Urgent Treatment Centre now completely abandoned or is it on the back burner?

(c) Is there any chance that Cheltenham could return to a full twenty-four-hour A&E service?

(d) Was the A&E rationalisation part of any plan to provide a contribution to the Department of Health and Social Care's requirement to produce efficiency savings. If so, will any other service need to be cut to meet this requirement?

a one hundred- and thirty-nine-minute wait and sixty-nine people in the queue waiting to be seen. This is, of course, the waiting time to initial assessment, not the total time for treatment. The target for initial triage is fifteen minutes and the target for completion of treatment is four hours. From what I know and from personal experience, this is often the situation, with Cheltenham apparently coping and Gloucester at higher risk of missing the targets. The centralisation of A&E services in Gloucester would only have added to their problems. What we now need is for One Gloucestershire to tell us how they propose to resolve this issue.

The proposals for reconfiguration of services at the two hospitals must be seen in the context of the proposal to move services from Cheltenham General Hospital to Gloucestershire Royal Hospital since the merger of the two Hospital Trusts, with only a few key moves in the other direction. We are reminded of the succession of changes in service provision in Cheltenham, weakening and undermining of services available locally. I shall refer again to this under my comments on the proposed centralisation of general surgery on Gloucester, which also forms part of this consultation process.

Another area of concern is that with less surgical staff and facilities available in Urgent Treatment Centres throughout the County (but not in Cheltenham and Gloucester), it will become a standalone operation. This could easily open it up for the possibility of being put out for tender and becoming operated by a private for-profit company in the future. We express our total opposition to any proposal to privatise any of the current or future services and state publicly that it would be strenuously opposed.

Of course, I am the first to recognise that A&E problems in Gloucestershire are greatly exacerbated by the difficulty in members of the public by being able to secure a timely GP appointment. I know of a four week waiting list at some surgeries and the Gloucestershire CCG needs to urgently address this issue and its impact on A&E services throughout the county.

Finally, on the A&E issue, a personal comment. Three weeks ago, I had the urgent need to attend Cheltenham A&E Department as a patient, presenting with a severe urological condition. I want to put on public record my admiration for the highly professional and caring manner in which I was treated. Some of my colleagues have said to me, however, that this was taking my preparation for today's hearing just a little too far!

## General Surgery

I shall now turn to the question of the future of general surgery. I should first of all declare an interest in that I have suffered with Crohn's Disease all my adult life and have had innumerable colorectal operations and I am now heavily involved in representing patients in this field. I am Chairman of the Patient Liaison Group of the Association of Coloproctology of Great

medical gastroenterology unit, which was centralised in Cheltenham only two years ago. Medical gastroenterology inpatients can deteriorate rapidly and require urgent surgical review and sometimes life-saving surgery by colorectal surgeons. The survival of Cheltenham's, A&E service, as announced yesterday, much f this may need to be reconfigured.

## Conclusion and General Remarks

In 1948, the Labour Party created the NHS and vigorously defends it. We are aware of what we believe lies behind many of the proposals we are discussing today. In 2013, NHS England reported that it faced a funding gap of £30 billion by the end of the decade, assuming government funding kept pace with inflation. The government has provided for an £8 billion funding increase, but with the expectation that £22 billion in "efficiency savings" would be made by the NHS. "Efficiency savings" is, in our view, a convenient expression for cuts to services, just the sort of service loss the so-called rationalisation we are discussing here.

The current government has promised additional funds for the NHS, but as the Nuffield Trust has highlighted, over half of this promised £1.8 billion was already in the hands of NHS Trusts, with the Department of Health and Social Care ordering it not to be spent. The Labour Party believes that the future lies in an investment of £30 billion over the course of the next Parliament, over and above what the 2013 NHS England review requires and a halt to the implementation of the Sustainability and Transformation Plans.

Professor Robert Arnott
Health Spokesman
Cheltenham Labour Party
robert.arnott@gtc.ox.ac.uk

Presenter: Tony Foster

Cheltenham Resident

**Gloucestershire Hospitals Engagement hearing 24 October 2019**

**Urgent and emergency care services**

## Introduction

Good afternoon. My name is Tony Foster, a Cheltenham resident for 20 years. I and my family have been occasional users of A&E at both Cheltenham and Gloucester – nothing life threatening and only one overnight stay.

I was for 6 years a non-executive director of the Hospital Trust, finishing my appointment last year. During that time I became familiar with all aspects of both hospitals operations and at various times was chair of finance and charitable funds committees and a member of quality and audit committees.

I was familiar with the discussion and conclusion a few years ago to change Cheltenham A&E to a consultant led centre for only daytime and evening and in the last year we had started discussing the pressures on A&E and other possible options for emergency and urgent care at both Gloucester and Cheltenham but not coming near to any conclusion. Since leaving the board I have had no contact with directors but have attended members meetings, most recently in September and also attended a workshop on urgent care at Churchdown on 8 October.

This afternoon I would like to explore some options for urgent care at Cheltenham, the important things to get right and the criteria for judging success when evaluating these and eventually implementing the preferred solution. I am not medically trained and the views are entirely my own. If I make any wrong assumptions I would be grateful to anyone who can correct me.

## The importance of the issue

Why is this issue so important and needs evaluation and possible change? A few years ago we had great difficulty recruiting enough consultants in emergency medicine to fully staff two A&E centres 24 hrs a day, 7 days a week. At one time we were down to only 12 full time consultants. The consultants view, and most importantly the view of senior deanery staff at Bristol, was that two 24 hr centres was not safe or sustainable. The deanery view was crucial because without their approval they would not supply the junior doctors for training, which are a crucial part of the staffing of an A&E department. That led to the change at Cheltenham, about which there are strong views. Since making that change the hospital has been able to recruit more consultants and I believe the

number is now 20. One of my roles was to chair consultant appointment committees and I recall a number of applicants for emergency medicine saying that they felt keen to apply to Gloucestershire Hospitals because we had made that change and established more stable staffing levels.

**What has changed recently?**

Nothing stands still and I understand there have been fresh challenges facing A&E in the county:-

- The number of people presenting themselves at both hospitals has increased every year and so has the number needing to be admitted for a stay in the hospital.
- There has been great difficulty in meeting the national requirement to treat 95% of attendees within 4 hrs. In fact the hospital has twice been placed in special measures by NHS Improvement because of the poor performance.
- Great advances continue to be made in the options and effectiveness of treating patients – not just the skills of doctors and nurses, but the use of analytical and diagnostic machines, which are very expensive and need specialist staff to operate them.

That is why there is talk of, but I believe no decision, to concentrate the expertise of emergency/life threatening treatment at one centre, probably Gloucester, which would be a centre of excellence comparable to anywhere in the country. I am not going to state the case for or against such a change. What I am interested in is what would be provided in Cheltenham if that change were thought to be the best option.

**Common views about A&E**

Let me first suggest some common views that lots of people have about A&E centres:-

- I want a hospital as near as possible to me
- Once in a hospital I will be safe in the hands of the best possible care
- I know that I have a good chance of being seen within 4 hrs compared to the time it may take me to get a GP appointment
- I am worried and upset about the thought of travelling for even 15 minutes in an ambulance when I could have been having treatment
- I may understand the concept of world class emergency treatment in one place, but that won't happen to me. It's ordinary accidents I am concerned about

- I understand and have faith in something called A&E but I have no idea and no faith in anything less than that

Now facts and reasons for challenging these views can be produced but that is not my task today. A&E departments have developed into very different entities from their origins. Now we immediately identify attendees as major and minor cases. Understandably, prioritising major life threatening cases, and availability of hospital beds, can have a significant effect on waiting times and the general experience of non-emergency cases.

**The idea of an Urgent Treatment Centre**

As part of the concentration of emergency treatment in one centre of excellence, the idea has been floated of an Urgent Treatment Centre in Cheltenham. That name and type of centre is used in parts of the UK already but what we might have doesn't have to be identical to others. I believe some are staffed by GPs but it doesn't have to be like that. We might decide to use experienced A&E staff including one or two consultants.

It would be a place to go if you needed urgent medical attention, but it is not a life threatening situation – things like sprains and strains, minor head injuries, minor scalds and burns, suspected broken bones, ear and throat infections, skin infections and rashes, eye problems, fevers, abdominal pains, vomiting and diarrhoea. The list is not set in stone and can be developed in consultation between the community and doctors.

What would be the features that people might like to see in such a centre?

- Clear guidance provided on line, via GP surgeries, via the 111 service and perhaps via pharmacies, and of course ambulance crews would know exactly where to go
- Fully staffed 24 hrs a day, 7 days a week as stated in the booklet Fit for the Future. Accidents or symptoms can occur at any time
- The service is better than the current 4 hr standard
- It is not inferior to a centre for emergency care but excellent in its own right for what it does
- Patients would for the most part not be given any priority. They would be treated in turn
- It should be readily accessible in the centre of Cheltenham – preferably on the current hospital site with access to the necessary diagnostic and analytical machines and their staff
- If I have to be sent to Gloucester instead, I want it made much easier to return

- It has sufficient experience in some staff that if I should need to go to Gloucester, that decision will be recognised and arranged very quickly

What might the criteria be for measuring the success of such a centre?

- It should have the united support of emergency clinicians
- It should gain a majority support of Cheltenham citizens
- It should offer a better accident service than is currently managed
- It should be able to minimise the number of patients needing to be transferred to Gloucester. The vast majority of emergency cases would be recognised straight away and be sent direct to Gloucester
- Less people should die in emergency care than happens at the moment
- It should be highly rated when compared with similar UTCs elsewhere in the country

My final suggestion? If such a centre can be devised for Cheltenham with all these advantages, then shouldn't Gloucester have just the same as well? There would then be two, at least, excellent Urgent Treatment Centres and one excellent emergency centre for the county. Such a solution may give a better service for the vast majority of patients who do not have life threatening conditions and may also persuade people in Cheltenham that they are not being treated less well than those in Gloucester.

**Next steps**

We have to get beyond the simple trading of competing slogans:-

- Save Cheltenham A&E or
- Have one centre of excellence in Gloucester

The subject is much too important and complicated and needs better articulation of the possible reasons for change, the options, their characteristics, the criteria for choosing and the active participation of the community in voicing their views. Ultimately though this is not like a referendum. The statutory bodies, the CCG and Hospital Trust, have to decide. Events such as these can play a part, but in my view there is currently rather too much opinion and grandstanding and not enough objective information on which to take an informed view.

There is a dilemma in engagement and then consultation in not stating a preferred solution too early, or even describing options, and being accused of

already having made the decision. But in my view if more information could be made available it would help for a more informed debate. Things like:-

- What conditions are appropriate for UTCs and what are not
- What type and number of staff would be needed to run a UTC
- What standards of excellent performance might such a centre meet compared to today's A&E
- How many patients would be treated in each of the UTCs and how many in the emergency centre
- Would there be an identical UTC in Gloucester and perhaps elsewhere in the county
- Are there any cost implications for such a change, either greater or less and in both capital and revenue

To sum up, there is a danger that the current engagement process is taking place in too much of a vacuum. You cannot expect ordinary citizens to know all the facts and complexity. That doesn't mean that their views are not important. But more information has to be provided from our NHS bodies before we citizens can give our best informed and reasoned views.

Thank you for your patience.

Presenters: REACH

Presentation slides (printed) shared at the Engagement Hearing.

REACH representatives chose not to complete the presentation

# Response to One Gloucestershire Public Engagement

REACH

## REACH

- Led by Cheltenham Chamber of Commerce, supported by:
  - Local businesses
  - Local residents and
  - Other campaign groups
- Supported by the 4 main parties - Tories, Lib Dems, Labour & Greens
- Founded in 2014 when CGH had its hours reduced

REACH

## Support

- Over 25,000 have signed the 2 petitions run by political parties opposing the closure of A&E
- REACH Survey feedback to date – 95% oppose the closure of A&E
- Over 35,000 engagements on our social media feed supporting our stance
- Real evidence of real people opposing the Trust's plans

REACH

## What does REACH support?

- Development of Health services for the whole of Gloucestershire
- Proposals which would see Centres of Excellence across the county
- Plans to deliver first class emergency care for both county hospitals
- Plans to deliver a Centre of Excellence specializing in planned and cancer treatment
- Plans to develop sustainable full Type 1 Emergency depts in Cheltenham and Gloucester

REACH

## REACH aims

- 2 Sustainable Type 1 Emergency Depts in Cheltenham and Gloucester
- Create elective CoE providing complex major inpatient surgery
- Create CoE for emergency surgery with best care across both sites for all Glos patients

REACH

## The Emergency Surgery Vision

- Ensuring specialists available in both areas of General Surgery ('Upper' and 'Lower' bowel)
- Dedicated emergency admissions, wards and theatres
- 'Right surgeon, first time' – the surgeon to the patient
- Supporting urgent/emergency care at Gloucester and Cheltenham
- Relieving pressures on Gloucestershire Royal beds and critical care

REACH

## REACH position on emergency care

- Sustainable Type 1 Emergency depts in Cheltenham and Gloucester
- Able to assess fully emergency patients presenting with medical, surgical or orthopaedic problems on both sites
- Care delivered by specialist emergency, medical and surgical doctors
- Some patients may need to be transferred for best care either in or out of county (as happens now)

REACH

## URGENT ADVICE, ASSESSMENT & TREATMENT SERVICES

- Increased attendances at Type 1 A&E Depts in GRH & CGH
- Increase due to ageing population and cuts to community health and social care by Gloucestershire CCG and Social Services
- Reduced hours at MIUs
- Increasing difficulty of getting GP appointments
- A&E has become the 'default destination' and attendances at A&E for minor injuries and illnesses have increased
- The solution to this is NOT to make access to A&E more difficult, but to improve community health services.

REACH

## Developing Urgent Care in Gloucestershire

- 'Fit for the Future' refers to the MIUs, but no clarity about future Urgent Care services
- Difference between an MIU and a UTC? Changing the name confuses the public.
- Changes in number & location of MIU/UTCs
- Future relationship between the UTCs and GP O-o-H Service in the two acute hospitals?

REACH

## What Centres of Excellence?

- 2 hospital sites separated by a corridor
- Vision to provide outstanding care
- Best care for everyone; emergency and planned
- Separate Emergency care and planned (elective) surgery
  - Deliver both to the highest standards

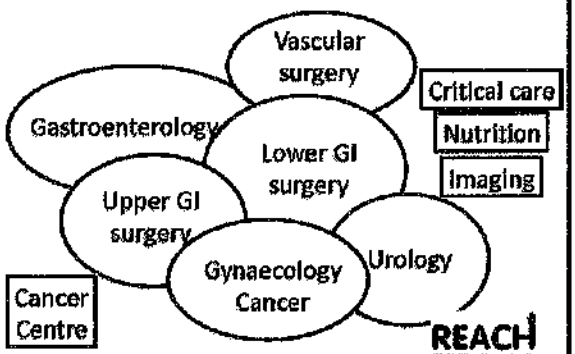
REACH

## REACH position on Elective/Planned care CoE in Cheltenham

- Beds, nurses, teams of doctors, facilities and theatres dedicated to planned in-patient care
- 'the smoothest pathway, the best experience; no holds ups, no cancellations'
- Bringing together all the teams that work together in one place
- Building on existing regionally and nationally renowned expertise – pelvic cancer treatment

REACH

## Planned In-patient Centre




REACH

Presenters: John and Mary Thurston

Friends of Lydney Hospital

Verbal presentation

(No presentation slides)