Fit For The Future - What matters to you?

Responses from health and care professionals

Please tell us what you think about our preferred option to develop: A 'centre of excellence' for Acute Medicine (Acute Medical Take) at Gloucestershire Royal Hospital.

		Response Percent	Response Total
1	Strongly support	33.57%	48
2	Support	38.46%	55
3	Oppose	6.99%	10
4	Strongly oppose	13.99%	20
5	No opinion	6.99%	10
		answered	143
		skipped	1

Please tell us why you think this, e.g. the information you would like us to consider (62)

1	But needs much bigger a+e at GRH
2	It would make sense to send sick medical patients to a single site where a full team can look after them rather than patients going to two different sites where they experience long wait times on AMU because the clinical rotas have lots of gaps.
3	All acute work should be on one site.
4	need to put all the expertise in one place 24/7
5	How would you support acute medical at CGH and that side of the county? Increasing travel time for a seriously unwell patient
6	Centre of excellence as opposed to two try hards
7	It will be easier to manage 24/7 and we will be able to afford the best equipment if only one piece is needed instead of several.
8	AMU should be spread across both sites to prevent a bottle neck where we are changing wards such as gynaecology into a amu. It is not appropriate for women going through tough times and having to have miscarriages in bays with patients from other specialties. It violates privacy and dignity and is heartless, but no other choice due to hospital management.
9	There needs to be acute medical services at CGH also.
10	From a staffing perspective, the difference to the acute medical staffing is much better having it centralised. However, I do think that there needs to be some kind of pathway for cardiology admissions; they currently have to go from AEC to ED GRH when they have been post taked by a consultant, just to come back to Cheltenham the next day.
11	This already works well with the acute medical take at GRH and all patients can be seen within the 14 hours that has to be a great improvement. Patients not being seen means their stay may be longer and their recovery poorer. It is frightening as a patient or relative if you are waiting sometimes days to be seen or reviewed and this would prevent that so a definite yes from me.
12	Especially with COVID it is sensible to centralise this service.
13	I think at the present time (ie in the middle of a pandemic) it is sensible to concentrate all acute services on one site and ALL elective services on the other.

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14	Both hospitals need to be able to assess and treat from both A +E departments. Currently Cotswold patients are having to be admitted to GRH meaning extra journey time for them and their families. Transferring Stroke and elderly patients back to CGH is not ideal and would be better being able to being able to provide holistic care for patients on both sites as we have done well for some time.		
15	To centralise services in one place. To have the specialist equipment and staff on one site.		
16	Bed demand at GRH already very high in comparison to CGH; consolidating all of medical take to GRH would sustain or even increase this demand. It is hard to see how the current situation, even pre-winter demands and Covid resurgence, can be maintained without regular black escalation statuses and ""clearing the decks"" of patients to CGH. Patients seen at CGH ED would need to be transferred to GRH if they needed an AMU bed.		
17	There's no point, the trust is focusing too much on the 'front door' and acute medical unit! What about the rest of the hospital, not good for pt. flow is the other services aren't looked at properly! Also not everyone lives in Gloucester, this is not their nearest hospital!		
18	It’s not clear what services will be ‘removed’ from GRH in order to accommodate a CoE. Also by locating a major single service at one of the two hospitals doesn’t address the increased time to travel for patients from the East of the County, the parking inconvenience (every part as bad at GRH as CGH, or cost of travelling further. Equally it does seemingly support (perceptibly at least) the downgrading of CGH A&E more permanently which is already and will continue to be an appalling decision.		
19	As a clinician having worked in the acute sector predominantly at CGH I can not support the aim to centralise acute services at GRH strongly enough- doing so will enable a much higher level/ standard of care to be provide to all patients requiring acute care and will also improve the experience of our trainees working in this environment. The latter will then hopefully increase the attractiveness of working in the trust and/ or the acute sector of the trust to future junior and senior doctors.		
20	It is not clear what this actually means. Does it mean A&E will not be available in CGH?		
21	this is completely unsafe and ludicrous		
22	this move is completely unsafe and a silly move the organisation. Cheltenham needs an amu too.		
23	unsafe for patients		
24	Cheltenham needs an acute care ward. how can you have a functioning a and e, which the trust keeps on insisting it will have at Cheltenham with no where for the patient to go after initial treatment? putting sick people in ambulances to grh is ridiculous. making the public believe they will have an a and e when they will have a sub par service is deceitful		
25	stupid idea how can a county this size have no medical take in cheltenham		
26	Makes sense as A&E located there		
27	Cheltenham is a large town that deserves an ED and Acute medical intake. Previous to this change Gloucester would on a regular daily basis divert either their GP and acute admissions to CGH ACUC as GRH could not cope with the high demand of patients. I feel the care is unsafe and compromised as a result of the change. Cheltenham ED and ACUC would receive patients from the Cotswolds which is an ageing population who relied on CGH service.		
28	Coming from Cheltenham and having spent over 30 years working in CGH before moving to GRH, I am quite saddened that CGH seems to be the 'poor relation' and while I understand that for many reasons, services need to be streamlined and centralised, it's hard not to feel upset at certain changes.		
29	A centre of excellence is a title conferred on a centre by other institutions and is not something you can simply decide to be. Aspiration to excellence is essential but not if this is considered zero sum - i.e. we can aspire to be a centre of excellence in A and therefore B will not be excellent. Also there are currently services which are already considered excellent : does the Trust know what these are and do the various plans consider that aspiring to excellence in one domain might strip and already considered excellent service of its status?		
30	Focusses resources in one place and should be located where ED is located		

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31	Please consider the effect this will have on the large number of elderly, frail patients admitted,(and readmitted) who are often MSFD early on but have multiple moves within GRH and CGH before eventually transferring out of hospital.(recent example: 89 yr old with advancing Parkinsons Disease and increasing frailty admitted for 5 days and had 5 moves: ED/AMU/7A/Snowshill/Bibury. Family were contacted when in AMU and happy to have him home from AMU). This is not uncommon.These moves have a deteriorating effect on cognition, general physical functioning and continence. How can we make this better for this cohort of patients? Consider direct to FAS/AMU then transfer to specialist Elderly Care Ward. Also please consider use of beds at CGH: Ryeworth is the only specialist COTE ward,far too many outlying COTE pts across Bibury/Cardiac2/Knightsbridge. Consider reinstating a second COTE wards at CGH. Our 'back door' is as important as out 'front door'.		
32	localised care rather than having to transfer out/ redirect ambulances at great cost and challenge to the patient		
33	Enables acute medical team to focus their resource on one site rather than being split and struggling to cover both hospitals.		
34	it makes sense to have a collection of acute medicine departments in a single place. But these do need to be fit for purpose and fit for the 21st century, neither site currently is fit for purpose		
35	there is nothing in the questionnaire relating to cardiology. But the booklet clearly states amalgamating cardiology and cath labs with other radiology procedures. these are NOT the same, they are specialised and individual. This would break up any cardiology teams who foster good relations with other disciplines and work very well together. A general recovery area for these patients would be detrimental to their care and knowledge the staff hold diluted to basic and not the high standard of care we give at the moment. - its a bonkers idea. Why is cardiology constantly treated like the poor relation and not one of the jewels in the crown. why not try to create a cardiac centre of excellence?? its an increasing issue with increasingly younger patients. we do not service the population of Gloucester well without a Cardiac Centre of excellence. please don't shoehorn cardiology within radiology - isn't good and generalist staff haven't worked elsewhere. It has been tried and didn't succeed. staff will leave and will reduce staff and patient wellbeing alike.		
36	More expertise on one site and better care		
37	Cheltenham should remain an acute general hospital		
38	this move has made it very unsafe for patients as grh staff just cant cope with the high volume of patients they are getting. The worst move they have decided to do.		
39	I cannot see any reason to make a case against it		
40	We need to concentrate our resources for acute medicine on one site.		
41	To help flow.		
42	Concentrate this and the required support services for this on one site		
43	Would like Pathology to be taken into account with these decisions - especially Blood Transfusion as we are having to do an increasing amount of work overnight yet have no funding for extra staff! 1 person that covers the whole hospital at GRH is dangerous.		
44	Acute medicine consultant workfroce better concentrated to provide sustainable rota on single site rather than split across two hospitals. Better use of resources at singel site with economies of scale need to caution about overnight medical cover being adequate across remaining patients at CGH and patient frlows for walk-ins would need acute medical offer		
45	There just isn't a big enough ED at Gloucester, not enough Resus vays and just too cramped		
46	Evidence is that specialist stroke unit and cardiac units provide better patient outcomes		

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47	I support the proposals to change and think the information provided presents a strong case. However, throughout the consultation document I see little or no reference to: a) How staff are to be retained, trained, recruited and afforded. b) No refernce to any improvements to process or service instigated as part of the response to Covid -19 which will be retained as Best Practice moving forward. c) Limited reference to the way that services will be re-modelled in line with international Best Practice. There is limited information given for example on the use of telemedicine, telephone consultation and foillow up, health education in primary care, transfer of services into coimmunity settings, converstions to higher day case rates, better streaming through outpatients (and ED). The proposals appear to deal with the issue of duplication of services across two sites and consequent rationalisation and whilst this is to be welcomed, of itself, it does little to illustrate how the models of care can or will change. Similarly there is no financial analysis (that I can see) with the documentation provided. In an increasingly stretched NHS, this must be a consideration for services to be long term sustainable.		
48	Better to have all emergency services on one site		
49	I wish to ensure that the best treatment is available as timely as possible and is not compromised by duplication of service across sites.		
50	there is ample evidence that diffusing resources results in worse outcomes for patients. The term centre of excellence is best avoided - it sounds good but means nothing - why would anyone not want excellence? How do yo define a centre of excellence?		
51	Had an acute kidney stone admission few years ago just after Xmas - live next door to CGH - last thing would have wanted would have been to have been taken to GRH!		
52	No clinicians I have spoken to think that this is a good idea - and I am dubious as to whether this is about patient care or whether it's to save money. Sadly I suspect the latter.		
53	There are still likely to be acute medical beds in CGH, so many patients will be being transferred. Currently, even prior to COVID there was too much disorganised movement of patients to aid flow that was/is detrimental to their care. CGH has now become an overflow hospital for GRH not a centre of excellence.		
54	The area of Gloucestershire requires services at both Cheltenham and Gloucester		
55	Clear clinical advantages in not duplicating staff, so long as sufficient / additional staff numbers are working shifts to deal with increased numbers (you couldn't just shift the take and keep the same number of staff with increased number of patients).		
56	GRH should receive all unselected acute admissions. This will enable us to screen patients for infectious conditions such as COVID-19 and keep them there until it is safe to transfer to the ""green"" CGH site. this way we minimise the risk of disruption of elective specialist treatment such as surgical and non-surgical cancer care.		
57	This sounds like it would lead to the loss of Acute Medicine at CGH. I have really noticed during the COVID changes that this often leads to multiple patient transfers across areas and hospitals which can be difficult and dangerous. Several patients on RYE had been to 4 ward areas prior to arriving on RYE.		
58	Lack of community beds and placements means that this is needed across both sites in Gloucestershire especially GRH as cheltenham is more surgical and recent changes have only shown the failures of trying to downsize it and move specialities		
59	The idea of creating centres of excellence at both of the two excellent large hospitals in Gloucestershire makes sense. It is worth remembering that the other specialist inpatient services, which have already centralised at either CGH or GRH e.g. cancer services at CGH and childrens' services at GRH, are working really well for patients.		
60	Too far to GRH for large areas of the county. I live in Cirencester, it can take an hour in peak times to get to GRH.		
61	All acute services including the ED and both takes should be on a single site (GRH) to allow for CGH to be developed into a major elective cancer surgery hub.		

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62	Need to consider how beds will be managed without disrupting more urgent changes. Eg transferring to emergency acut admissions to specialist teams on CGH site.		

Please tell us what you think about our preferred option to develop:A ‘centre of excellence’ for Emergency General Surgery at Gloucestershire Royal Hospital.			Response Percent	Response Total
1	Strongly support		36.36%	52
2	Support		41.26%	59
3	Oppose		8.39%	12
4	Strongly oppose		8.39%	12
5	No opinion		5.59%	8
			answered	143
			skipped	1

Please tell us why you think this, e.g. the information you would like us to consider (54)	
1	I think split site working for all departments should end. Single site for each speciality should be a priority
2	If General Surgery cannot sustain a rota across two sites then for safety reasons we should divert patients to a single site so they can receive treatment in a timely manner.
3	need to centralise expertise 24/7 ideally alongside other emergency services
4	How would you support those that need emergency surgery at CGH - are patients fit to travel between sites if they need emergency surgery?
5	The same as previous it is easier to manage and better cost savings for the trust, tax payer.
6	Needs to reopen Cheltenham.
7	There needs to be capacity for this at CGH also.
8	All emergency cases come to GRH and I feel that Emergency General Surgery should be at GRH because of this.
9	I have, however, concerns regarding the bed base in GRH and resident surgical cover will still be required in CGH even with centralisation.
10	I think the separation of acute and elective work in the middle of a pandemic is sensible.
11	We do not have the bed capacity at GRH to provide the care that patients need. . Lack of beds mean that all surgical patients are often outliers on various wards making it difficult getting the surgical teams to review patients when needed.
12	To centralise services, staff, expertise and equipment at one site. If this ensures that planned surgery is protected and not impacted by emergencies, then I would strongly support this option.
13	Again, for same reasons as Acute care - GRH doesn’t have capacity
14	as previous- we do not have resources to spread this service across two sites and still provide the exemplary level of care to which we all aspire

Please tell us what you think about our preferred option to develop:A ‘centre of excellence’ for Emergency General Surgery at Gloucestershire Royal Hospital.		Response Percent	Response Total
15	There should be surgery facilities at both sites, and both should be ""excellent"". Transferring emergency patients to GRH wastes precious time and could risk lives.		
16	county too big for this to work		
17	makes sense as A&E located there		
18	Over working the system, more operating out of hours due to long busy list which is dangerous, battling different specialties on emergency lists resulting in longer waits for patients who might need an urgent operation, waste of Cheltenham general theatre teams skills, experience and facilities.		
19	As before		
20	This is important BUT is not and should not be seen as mutually exclusive to a centre of excellence in pelvic resection		
21	we still receive urology emergencies into the theatre department with no provision for paediatrics overnight and no anaesthetic cover from 2200hrs apart from the DCC Doctors If emergencies are to remain in GRH then it needs to be all emergencies or proper provision for patients that remain in PACU after 2200hrs		
22	Avoids duplication and reduced likelihood of routine/elective surgery being cancelled due to emergencies.		
23	this is a big DGH with high numbers of patients and population often requiring more than the basic care on offer outside of tertiary centres. transporting or redirecting patients involves time, money and stress for all concerned so more localised specialist care will better meet all stakeholders		
24	It seems sensible for emergency surgery to take place in the same hospital where there is a 24/7 consultant led emergency department		
25	It is bigger hospital and easy for access (not confusing as opposed to CGH which is a maze and patients are constantly lost)		
26	as the main ED is currently at GRH this would make sense, however I would be anxious to avoid all eggs in one basket. this also involves the elderly and infirm travelling distances to a site that isn't easy to get to by public transport especially if you are unwell		
27	More expertise on one site leading to better care		
28	Cheltenham should remain an acute general hospital		
29	cgh also needs general surgery so thr ED should be re opened to		
30	I can see no reason against this proposal		
31	I don't think any of the 4 options are enough - I would like to know what happens to people who are admitted to CGH before 8pm in an emergency situation where a delay to GRH could be critical and could be criticised by the Coroner should something happen? The time delays - picking up a patient from, say, the other side of the Cotswolds - surely they need to get to the correct help as quickly as possible and GRH may be quite a lot further away than CGH.		
32	Again, we need to concentrate our resources on a single site to make best use of staffing and e.g. radiology		
33	Cheltenham needs surgery. As some people can not travel to Gloucester		
34	Would like Pathology to be taken into account with these decisions - especially Blood Transfusion as we are having to do an increasing amount of work overnight yet have no funding for extra staff! 1 person that covers the whole hospital at GRH is dangerous.		
35	To keep emergency and elective surgery seperate.		
36	Because the majority of emergency admissions go to Gloucester so it is logical for them to have all emergency surgery. However, I think Cheltenham needs to have a 24 hr ED with a specialism in oncology, urology and colorectal.		
37	Trauma units have better expertise		
38	centralised is better		

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39	I support the proposals to change and think the information provided presents a strong case. However, throughout the consultation document I see little or no reference to: a) How staff are to be retained, trained, recruited and afforded. b) No refernce to any improvements to process or service instigated as part of the response to Covid -19 which will be retained as Best Practice moving forward. c) Limited reference to the way that services will be re-modelled in line with international Best Practice. There is limited information given for example on the use of telemedicine, telephone consultation and foillow up, health education in primary care, transfer of services into coimmunity settings, converstions to higher day case rates, better streaming through outpatients (and ED). The proposals appear to deal with the issue of duplication of services across two sites and consequent rationalisation and whilst this is to be welcomed, of itself, it does little to illustrate how the models of care can or will change. Similarly there is no financial analysis (that I can see) with the documentation provided. In an increasingly stretched NHS, this must be a consideration for services to be long term sustainable.		
40	As before all emergency services should be centralised		
41	Makes absolutely sense to centralise and link in with the 24/;7 emergency care concept. It is simply not feasible to deliver across two sites and making GRH the site fits with the 24/7 emergency pathways.		
42	Concentration of emergency team in one place means		
43	in line with evidence, a well equipped unit with expert doctors, nurses, pharmacists, physio and other AHP is associated with better outcomes; travelling further is a hard but worthwhile price to pay		
44	Again would like CGH to be able to continue to provide this to local residents and not all centralised at GRH.		
45	Full AE needs to be at both sites to cope with capacity		
46	Again reduce duplication of doctors. Allow prompt senior review by team. Again sufficient senior staff must be on shift. One team operating and one reviewing pts. Busy team (CGH & GRH worth of pts at GRH) with only one team available will mean operating or reviewing not both. NEED BOTH. Also if this is to happen more GRH emergency theatre space will be needed so that other surgical specialities can do their cases promptly too!		
47	Better care for the community		
48	It is best to concentrate acute unselected surgical admission to one site which will also house acute medicine as well as ED and Critical care.		
49	Recent months have shown that the shutting of A&E in cheltenham and the removal of emergency surgery/planned surgery from Cheltenham has negatively impacted on patients and their experiences when previously having it on both sites worked due to the available DCC beds and the larger capacity. Raises questions of who is to blame for deaths when emergency surgery is not available on one site and someone dies on route, that is negligence where those that have made these decisions do not bare the blame, no family or patient deserved to go through this. Plus as gloucestershire is continually expanding with a rising population having one center for emergency surgery is simple foolery as it will not be able to cope with the ride in demands on already under funded and under staffed wards that receive no reprieve or help of any kind regardless of what is passed around internally or via media outlets		
50	The idea of creating centres of excellence at both of the two excellent large hospitals in Gloucestershire makes sense. It is worth remembering that the other specialist inpatient services, which have already centralised at either CGH or GRH e.g. cancer services at CGH and childrens' services at GRH, are working really well for patients.		
51	Improved dr cover including a review by the correct sub specialty		
52	As with previous question, centralising acute services on the GRH site will allow CGH to be a major elective surgical centre with patients following, on the whole, a relatively fixed pathway allowing for optimal flow and best use of the existing critical care unit at CGH which otherwise risks being mothballed.		

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53	Ensure the facilities are set up with adequate space to assess patients in a timely manner. The current temporary changes are working well with more patients seen in a shorter time frame. However, limited space and beds in assessment rooms impacts on the the ability to deliver a truly first class service.		
54	you are sucking the life out of CHG all hospitals should have these specialties.		

Please tell us what you think about our preferred option to develop:A ‘centre of excellence’ for Planned Lower GI (colorectal) general surgery at Cheltenham General Hospital (CGH) or Gloucestershire Royal Hospital (GRH).			Response Percent	Response Total
1	Strongly support		46.15%	66
2	Support		39.16%	56
3	Oppose		2.80%	4
4	Strongly oppose		0.00%	0
5	No opinion		11.89%	17
			answered	143
			skipped	1

Please tell us why you think this, e.g. the information you would like us to consider (43)	
1	Cohorting patients and clinical expertise leads to better patient care from a highly specialised team. We have seen the benefits of this through Vascular and Trauma networks.
2	Less bed issues for elective cases if away from emergency pathways. Fully staffed DCC at CGH barely used currently.
3	for planned work we need to avoid the emergency site so the work continues despite emergencies - needs to be based at the non-emergency hospital cgh
4	It makes sense to consolidate planned care at either site, but does an emergency service need to remain at the other site?
5	The same as previous it is easier to manage and better cost savings for the trust, tax payer.
6	Elective services would benefit from single site 'centre of excellence' but with the capacity to transfer from Acute medicine/surgery at both sites.
7	I think that all planned colorectal general surgery should take place at Cheltenham General Hospital. If I was a patient I would know my operation is less likely to be cancelled, that the ward would be clean and CGH is currently the 'green' site. I would not want to chance being put in a bed next to an emergency surgery patient who has not had a covid swab results prior to admission.
8	As stated previously it is sensible to separate the acute and elective work in the current pandemic. There are not enough beds in GRH to have all the acute work + elective GI surgery.
9	care of all patients in the trust has deteriorated in the last few years due to lack of access to specialist services that used to be on both sites. Patient discharge is often delayed by days awaiting review by specialities based on different sites. This is frustrating for Staff, patients and their relatives
10	Centralising planned aspects of care could take pressure off these being cancelled due to emergency procedures taking precedent.

Please tell us what you think about our preferred option to develop:A ‘centre of excellence’ for Planned Lower GI (colorectal) general surgery at Cheltenham General Hospital (CGH) or Gloucestershire Royal Hospital (GRH).		Response Percent	Response Total
11	GRH surgical bedspace already limited; conversely beds available at CGH for increased surgical work. Transfer to all planned colorectal work to GRH would increase already high pressure on surgical bed availability. Centralising lower GI at CGH would make use of existing surgical cover and surgical nursing staff with less bed pressures than at GRH. Benefits to be had from concentrating all colorectal lists at a single site - CGH the obvious option as currently has less bed pressure than GRH but still has required surgical and nursing expertise. Gastroenterology already at CGH which would benefit those patients who need input from gastro medics whilst under care of Lower GI surgeons.		
12	as previous		
13	I think planned surgery could be better placed within CGH so that GRH can focus on the emergency general surgery.		
14	Making Cheltenham a centre for elective surgery makes sense if you are wishing to centralise emergency at GRH, especially with covid. However patient choice does not seem to factor in your decisions.		
15	It has been mooted for some time, so that GRH would become the 'hot' hospital, while CGH would take 'cold surgery'. This seems to have been an accepted version of things to come, so it is no surprise, and for me, there is no good reason to oppose		
16	Lower GI at CGH is already considered excellent within the surgical community and so this could be built on		
17	as above		
18	It should be CGH, because you want everything to be easy and understandable not only for the patients, but also for the workforce. I mean try to close the cycle within one medical field. Get Endoscopy, Theatres at one place.		
19	planned surgery in a centre of excellence is nothing but good, but the site needs to be fit for this and to be able to accommodate patients staff and services alike		
20	Better care due to expertise and less chance of cancelling operations		
21	Planned at CGH Emergency at GRH.. It would be a neat way of organising activities		
22	Makes sense if centralising other GI services.		
23	Would like Pathology to be taken into account with these decisions - especially Blood Transfusion as we are having to do an increasing amount of work overnight yet have no funding for extra staff! 1 person that covers the whole hospital at GRH is dangerous.		
24	Cheltenham needs to become a centre of excellence for colorectal surgery, urology and oncology, both planned and emergency		
25	What is the evidence for specialist bowel surgery ?		
26	I think it would be beneficial to have lower G.I. consultants operating or based at Cheltenham. Often other specialities such as Gynae-oncology and urology doing pelvic surgery require assistance or advice from lower G.I. surgeons.		

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27	I support the proposals to change and think the information provided presents a strong case. However, throughout the consultation document I see little or no reference to: a) How staff are to be retained, trained, recruited and afforded. b) No refernce to any improvements to process or service instigated as part of the response to Covid -19 which will be retained as Best Practice moving forward. c) Limited reference to the way that services will be re-modelled in line with international Best Practice. There is limited information given for example on the use of telemedicine, telephone consultation and foillow up, health education in primary care, transfer of services into coimmunity settings, converstions to higher day case rates, better streaming through outpatients (and ED). The proposals appear to deal with the issue of duplication of services across two sites and consequent rationalisation and whilst this is to be welcomed, of itself, it does little to illustrate how the models of care can or will change. Similarly there is no financial analysis (that I can see) with the documentation provided. In an increasingly stretched NHS, this must be a consideration for services to be long term sustainable.		
28	Support the concept of having centralised services. From clinical delivery stance, staffing and financial.		
29	Team work is vital to good patient experience and outcomes - fragmented teams cannot provide this and do not attract the best to come and work in them.		
30	but only in one centre		
31	Please try and keep all acute specialities on one site.		
32	Support options where there is access to both sites so this is good		
33	I strongly prefer this to be at the CGH site as this will ensure elective care for surgical patients will not be affected by the emergency admissions and operations, as is the case now. Also, the ITU at the Cheltenham site can be used solely for elective surgical patients.		
34	Elective care should be split from emergency where clinically appropriate / demand exists - which it does in GS		
35	centre at cheltenham		
36	It can only be a good thing for the people of Gloucestershire		
37	I I support this service to be placed at Cheltenham General Hospital. Having worked there I know they have a good record of care in this specialty.		
38	This should be on the same site as non-surgical oncology as the two have to work very closely together.		
39	At Cheltenham General without a doubt, this has been in place for years and has worked without failure to a high standard. I, my family and friends have received care on this ward to a fantastic degree and then have unfortunately been subjected to GRH due to current events this year, to say that we were disgusted by this change would be a vast understatement. Why change what isn't broken, why ruin a system that has supported so many for years with such a dedicated team that is being picked apart and why support such an idiotic decision to shift CGH to a more medically acute when GRH does not have space for all this surgery and that has also been proven and found this year		
40	Lower GI surgical provision impacts on other surgical specialties including gynae oncology. Gynaecology is linked to Obstetrics, an acute specialty based in Gloucester. Acute gynaecology, including acute gynae oncology admissions, is based in Gloucester hospital. It is not possible to move this acute provision as the registrars cross cover Gynaecology and Obstetrics when on shifts. Moving gynae oncology with Lower GI to Gloucester would provide better training and ward safety for patients.		
41	The idea of creating centres of excellence at both of the two excellent large hospitals in Gloucestershire makes sense. It is worth remembering that the other specialist inpatient services, which have already centralised at either CGH or GRH e.g. cancer services at CGH and childrens' services at GRH, are working really well for patients.		
42	This should be at GRH for EGS to support. Everyone together in the same place		

Please tell us what you think about our preferred option to develop:A ‘centre of excellence’ for Planned Lower GI (colorectal) general surgery at Cheltenham General Hospital (CGH) or Gloucestershire Royal Hospital (GRH).		Response Percent	Response Total
43	Combining expertise will enhance surgical training and allow us to offer tracing in sub specialist areas of colorectal surgery. There will be greater standardisation of care. Also enhanced nursing care.		

In supporting our preferred option to create a single site 'centre of excellence', where do you think a ‘centre of excellence’ for Planned Lower GI (colorectal) general surgery should be developed?			Response Percent	Response Total
1	Cheltenham General Hospital (CGH)		56.64%	81
2	Gloucestershire Royal Hospital (GRH)		13.29%	19
3	No opinion		30.07%	43
			answered	143
			skipped	1

Please tell us why you think this, e.g. the information you would like us to consider: (51)

1	this would support gynaeoncology surgery
2	Because I think that elective or planned procedures should run from the site with a lease amount of emergency bed pressures. I believe that this will lead to fewer patient cancellations and overall a better experience post operatively where wards are full of elective patients all receiving appropriate post operative care rather than mixing with other non-surgical patients who are placed there because there is no other room.
3	As above.
4	because it's not the emergency site and patient flow can be better managed
5	I don't know enough about existing surgical set up, but you would think the site that is currently best set up to house surgery would be the most sensible choice.
6	Wherever you feel it is easier and safer to provide this from. Where other support services are on hand.
7	I think it is best placed where the post op care is- I am not sure if they routinely require ITU admission. If they do, I would suggest keep at CGH to free ITU beds for unscheduled admissions.
8	I think this fits in with gynae and urology planned surgery and often these patients may need two consultants operating at a time. It will also mean that planned surgery is centralised. This will make it more appealing for staff working at CGH knowing they work on a site that is considered a centre of excellence.
9	It is a ""no brainier"" interns of bed base, pandemic planning, and protection of our elective cancer patients from cancellations peak periods to have this service in CGH.
10	There are not enough beds in GRH to have all the acute inpatients plus the elective work. During the pandemic the elective patients should be protected and kept separate. There needs to be adequate surgical resident cover in CGH to deal with any postoperative complications and also provide surgical support to the oncology service.
11	I
12	If the 24hr A&E is at GRH, then the planned surgery to be at CGH.

In supporting our preferred option to create a single site 'centre of excellence', where do you think a 'centre of excellence' for Planned Lower GI (colorectal) general surgery should be developed?		Response Percent	Response Total
13	Bed space available at CGH for increase in existing colorectal work; patients requiring transfer or input from gastroenterology would benefit from existing presence of gastro services on site in Snowshill at CGH. Available bedspace for colorectal patients (alongside gynae oncology) currently being used as medical overflow with associated reduced and unsafe medical cover, loss of experienced surgical nursing staff and reduced quality of patient care.		
14	To remove it from the impact on bed capacity of the seasonal variation in medical emergencies.		
15	I believe it would be sensible to try and ensure that CGH takes on planned / elective surgery with lower risks involved, and that GRH is responsible for caring for emergency surgery. However, I also appreciate that this could result in specialist surgical cover required across both sites rather than just covering one and could be confusing for the public if there is general surgery offered at both sites.		
16	a cold, elective hospital allows access to beds, ITU, and allows all the relevant surgical specialities to work closely together to deliver excellent care. The removal of colorectal surgery from CGH would mean that urology and gynaeoncology may not be able to stay, which would put more pressure on GRH		
17	Oncology centre		
18	Which ever site has best capacity of operating theatres and staffing for this proposal		
19	What will there be about CGH to attract anybody to work there, if surgery is removed from Cheltenham altogether?		
20	This builds on already established reputation and allows other interdependent excellent services to continue to flourish because they have ongoing on site, immediate lower GI surgical support. Removing lower GI surgical support from CGH would diminish urological, gynaecological oncology, gastroeneterology and oncology services. Specifically gynaecological oncology simply could not operate in the same way and all ovarian cancer surgery would need to move to GRH to facilitate appropriately supported radical surgery within any governance framework		
21	It makes sense to have as much major surgery as possible in CGH for the pandemic, and also for usual winter pressures in GRH. This also applies to elective vascular and upper GI surgery.		
22	1. co-located with other pelvic cancer services (urology, gynae-oncology) 2. co-located with oncology 3. co-located with gastroenterology inpatient care 4. Protected bedbase from emergency admissions (if going with the emergency hub in GRH) and allows screened admissons only in the covid era 5. Ease of access to HDU / ITU for all planned major resections 6. Separated (geographically) elective v emergency care as recommended by a) GIRFT, b) Current President of the RCS Eng (Prof Neil Mortensen) c) external senate review		
23	wherever the facilities allow best at minimal cost and upheaval		
24	I can see benefits to both hospital, GRH because of workforce but for patients which may also involve other organs in the pelvis, CGH seems more appropriate		
25	It is easy to get all GI surgeries in one place closer to Endoscopy.		
26	CGH would make sense as there is the oncology dept is also there. The dots are joined up in that respect		
27	Consultants and staff are fed up. Colorectal worked at Cheltenham before stop fixing things that aren't broken. Wasting good theatres, what's the point in not using something we already have. And you have amazing nurses and HCA's with colorectal experience in Cheltenham that will not go to Gloucester.		
28	As it is planned surgery the patient can arrange transport beforehand so I don't see any issues		
29	Makes sense to continue the planned trend at CGH.		
30	Would like Pathology to be taken into account with these decisions - especially Blood Transfusion as we are having to do an increasing amount of work overnight yet have no funding for extra staff! 1 person that covers the whole hospital at GRH is dangerous.		

In supporting our preferred option to create a single site 'centre of excellence', where do you think a 'centre of excellence' for Planned Lower GI (colorectal) general surgery should be developed?		Response Percent	Response Total
31	As already said emergency and elective surgery needs to be kept separate as they require differnet sorts of treatment. Keep CGH clean and where there ae more beds to keeps elective particually cancer surgery running no matter what the emergency take is		
32	Cheltenham already deals with urology and it would make sense for ALL lower GI surgery, planned and emergency		
33	Due to other specialities already doing pelvic surgery in this hospital. Surely a 'centre of excellence' would allow surgeons to assist and advise each other when required.		
34	I support the proposals to change and think the information provided presents a strong case. However, throughout the consultation document I see little or no reference to: a) How staff are to be retained, trained, recruited and afforded. b) No refernce to any improvements to process or service instigated as part of the response to Covid -19 which will be retained as Best Practice moving forward. c) Limited reference to the way that services will be re-modelled in line with international Best Practice. There is limited information given for example on the use of telemedicine, telephone consultation and foillow up, health education in primary care, transfer of services into coimmunity settings, converstions to higher day case rates, better streaming through outpatients (and ED). The proposals appear to deal with the issue of duplication of services across two sites and consequent rationalisation and whilst this is to be welcomed, of itself, it does little to illustrate how the models of care can or will change. Similarly there is no financial analysis (that I can see) with the documentation provided. In an increasingly stretched NHS, this must be a consideration for services to be long term sustainable. I cannot determine which site I would prefer this service to be provided on without the information referred to above as this becomes merely a geographical preference rather than an option considered as to what is right.		
35	Less chance of cancellation as less pressure on beds Gynae oncology and urology based at CGH - makes sense to have a cancer centre of excellence at CGH where oncological services are based.		
36	There are pros and cons for both sites.		
37	This is major surgery and should be carried out in fully staffed hospital having access to all facilities 24/7		
38	the centre should be close to GI medicine, specialist inpatient care (as in ITU) and imaging		
39	It seems likely that management of complications would be best on the site with the most robust emergency cover		
40	This should be based at the site with emergency theatres.		
41	Whichever site the clinicians feel is most appropriate		
42	I have already stated why above,		
43	Cancer surgery and non-surgical treatment (radiotherapy an systemic therapy) need to be one one site in order to ensure seamless cooperation for patients who develope acute conditions requuiring surgical intervention. I have worked in London centres of excellence for non-surgical oncology where there was no surgical cover on-site for emergencies. This did not work well and treatment was sub-optimal.		
44	To colocate it with Gynae and Urology for a pelvic oncology surgery centre of excellence		

In supporting our preferred option to create a single site 'centre of excellence', where do you think a 'centre of excellence' for Planned Lower GI (colorectal) general surgery should be developed?		Response Percent	Response Total
45	At Cheltenham General without a doubt, this has been in place for years and has worked without failure to a high standard. I, my family and friends have received care on this ward to a fantastic degree and then have unfortunately been subjected to GRH due to current events this year, to say that we were disgusted by this change would be a vast understatement. Why change what isn't broken, why ruin a system that has supported so many for years with such a dedicated team that is being picked apart and why support such an idiotic decision to shift CGH to a more medically acute when GRH does not have space for all this surgery and that has also been proven and found this year Please consider the fact that whichever higher up or suited monkey has been trying to shut cheltenham A&E for years due to funding and the arrangement of doctors across sites. This is bad in practice and paper, especially when the current state of affairs in CGH due to some of these measures already being in place has slowed down patient care because their is no one on site available to offer the urgent care that is needed or they are being rushed off to see to someone in a supposable MIU that continually blue lights patients to gloucester only for them to come back again as their is no capacity or available beds		
46	Proposals for either option appear to be well thought through.		
47	GRH is too busy, to stitched and too stressed with the increased volume of emergency surgery it has absorbed recently. Conversely, CGH is well placed to deliver such a role, with teams in place, surgeons and anaesthetists, HDU/ITU cover and dedicated elective wards.		
48	As above		
49	Happy with move towards CGH as an elective site predominantly and more emergency focus at GRH, as oncology centre at CGH indicates more elective treatment. But not to strip all emergency services away		
50	As above, allows for best patient flow and maintenance of elective work with the backup of a fully functioning intensive care unit.		
51	Ask why 12 of 15 consultants support this model. The consultants work in the system and know the details. This is the only option that will deliver sub specialist care seven days a week for emergency patients, complex UGI patients and complex colorectal patients. Why would you want to treat one of these groups differently and provide care that does not match up to other aspects of our service? The consultants know that the linkages to oncology, gastroenterology, urology and gynae are tenuous. A greater linkage is between upper GI and colorectal: the same junior staff, development of the service eg robotic surgery, same theatre staff, shared patient groups eg hernias.. This option is also the only one that allows us to develop the whole of our service. The model is actually about more than just colorectal and by moving complex colorectal to GRH it will create the theatre capacity to allow us to develop short stay surgery (not just day case) at CGH for both upper GI and colorectal. Why as an organisation have we not described the model that the majority of GI consultants have put forward?		

Please tell us what you think about our preferred option to develop:A 'centre of excellence' for planned day case Upper and Lower GI (colorectal) surgery at Cheltenham General Hospital (CGH).			Response Percent	Response Total
1	Strongly support		44.37%	63
2	Support		35.21%	50
3	Oppose		3.52%	5
4	Strongly oppose		0.70%	1
5	No opinion		16.20%	23
			answered	142
			skipped	2

Please tell us what you think about our preferred option to develop:A ‘centre of excellence’ for planned day case Upper and Lower GI (colorectal) surgery at Cheltenham General Hospital (CGH).			
		Response Percent	Response Total
Please tell us why you think this, e.g. the information you would like us to consider (40)			
	1	As per my previous response I think splitting the acute general surgery take out from the elective demand is sensible and will lead to improved clinical outcomes, better patient experience and increased clinical skill development.	
	2	planned = cheltenham	
	3	Presuming it will be here as the service and supporting team are already in situ at CGH?	
	4	The same as previous it is easier to manage and better cost savings for the trust, tax payer.	
	5	As per previous	
	6	I know that the Day Surgery Unit at CGH is expanding so this would be the ideal location for day case surgery for upper and lower GI cases.	
	7	All elective work should be on the same site.	
	8	If the 24hr A&E is at GRH then to have this option at CGH would be good.	
	9	Existing surgical teams at CGH; centralising all day case GI work at CGH would reduce pressure on GRH to focus on emergency general surgery	
	10	The co-location of daycases with emergencies makes more sense as day cases are much less likely to be impacted by the demands of peaks in emergency patients.	
	11	new day surgery unit planned for CGH that will be able to facilitate day case surgery and provide a centre of excellence	
	12	Once again, I believe that there would be less breaches in waiting times for elective surgery if they were on one site and therefore protected from issues such as lack of staffing the rotas and access to resources	
	13	would be better to have day cases on your site where A&E is, which would allow your theatres to be used, and put your inpatients at CGH	
	14	Make absolute sense to create an elective surgical oncology resection service at one site ; i.e. colocated with the oncology services and away from emergency services with their greater and unpredictable demands on beds which leads to the cancellation of cancer operations when the two are co-located	
	15	I understand that the plans are in for two new day unit theatres to be built in CGH so hasn't this decision already been made	
	16	Good idea. Protects the beds from emergencies so reducing need for last minute cancellations	
	17	It is far more important to move major surgery urgently, before mass cancellations inevitably happen this winter	
	18	Day case can be done anywhere	
	19	as previous	
	20	I have already said that in my previous answers. Try to concentrate in one place all cases related to GI interventions. It is better for the workforce too.	
	21	as previous question located in the best site alongside the supporting departments such as Oncology. the imaging services also need to be there too	
	22	Keep low-risk surgery away from the acute site to improve (reduce) cancellations	
	23	Would like Pathology to be taken into account with these decisions - especially Blood Transfusion.	
	24	moving to a planned care centre of excellence can protect access from being hindered by urgent care demand; Using Cheltenham for this is more practical that CGh given the site, the existing status of GRh as Major trauma unit and A&E status overnight at CGH	

Please tell us what you think about our preferred option to develop:A ‘centre of excellence’ for planned day case Upper and Lower GI (colorectal) surgery at Cheltenham General Hospital (CGH).		Response Percent	Response Total
25	It needs to be clear that if you have a centre of excellence, it is in one place. GU/GI at Cheltenham - Totally! along with oncology. Everything else to GRH		
26	I support the proposals to change and think the information provided presents a strong case. However, throughout the consultation document I see little or no reference to: a) How staff are to be retained, trained, recruited and afforded. b) No refernce to any improvements to process or service instigated as part of the response to Covid -19 which will be retained as Best Practice moving forward. c) Limited reference to the way that services will be re-modelled in line with international Best Practice. There is limited information given for example on the use of telemedicine, telephone consultation and foillow up, health education in primary care, transfer of services into coimmunity settings, converstions to higher day case rates, better streaming through outpatients (and ED). The proposals appear to deal with the issue of duplication of services across two sites and consequent rationalisation and whilst this is to be welcomed, of itself, it does little to illustrate how the models of care can or will change. Similarly there is no financial analysis (that I can see) with the documentation provided. In an increasingly stretched NHS, this must be a consideration for services to be long term sustainable.		
27	Less risk of cancellation due to less bed pressures		
28	Having a excellent readily available service that treats me even if I have to travel is preferred to waiting and perhaps getting a second class service because of a dilution of resources/service simply to accommodate operating on both sites. It is 7 miles not travelling to the moon.		
29	This type of surgery is at most risk of cancellation when emergency pressures are high. We should have access to protected facilities so these operations are not cancelled. This will be good for CGH as more planned surgery will be performed there than in GRH		
30	is there sufficient IT resource so paper records can be consigned to history and all relevant clinical information is available on both sites		
31	Personally this suits me but appreciate that Glocs residents may not want to come all way over to Cheltenham		
32	Facilitate throughput of these cases - ideally including a short stay model with low acuity 1-2 night stays.		
33	As above. This will also benefit us interms of cooperation in research hwere both surgical and medical treatment are being evaluated e.g. in cancer studies.		
34	A smart decision as these teams are set up and in place already with exemplary experience as well as the chances to expand on these services as their is adequate space		
35	The idea of creating centres of excellence at both of the two excellent large hospitals in Gloucestershire makes sense. It is worth remembering that the other specialist inpatient services, which have already centralised at either CGH or GRH e.g. cancer services at CGH and childrens' services at GRH, are working really well for patients.		
36	CGH is well-placed for this role, which would function more efficiently and with better patient experience in an environment away from emergency pressures.		
37	To avoid cancellations		
38	Links with earlier point		
39	I would support routine day case surgery being done on the CGH site but this needs to be in a dedicated unit separate from the main building which cannot then be used to treat in-patients. This would also allow main theatres to be used for major elective surgery.		
40	This is intimately linked to the other changes that are being proposed. Movement of complex colorectal out of CGH will help create the theatre capacity required to allow us to deliver this in the short term before other theatres are built. The model supported by the majority of surgeons proposes to expand this to short stay cases in both upper and lower GI surgery.. This needs to be taken in to consideration.		

A 24/7 Image Guided Interventional Surgery (IGIS) ‘Hub’ at Gloucestershire Royal Hospital and a ‘Spoke' at Cheltenham General Hospital.

			Response Percent	Response Total
1	Strongly support		26.95%	38
2	Support		36.17%	51
3	Oppose		10.64%	15
4	Strongly oppose		6.38%	9
5	No opinion		19.86%	28
			answered	141
			skipped	3

Please tell us why you think this, e.g. the information you would like us to consider (41)

1	IGIS should be concentrated on the site receiving the acute take for both medicine and surgery. It is as illogical to split the IGIS service over two sites to offer a compromised service as it is to split either acute take over two sites with poorly manned rotas.
2	strongly support the concept but if this is elective work wouldn't it be sensible to base it at cgh and have a spoke at grh?
3	The same as previous it is easier to manage and better cost savings for the trust, tax payer.
4	Provided there is emergency cardiac interventional capacity at CGH also. It would not matter if this was at CGH considering the trust's stated aim of reopening ED at CGH post pandemic and it already exists there.
5	There is a state of the art interventional theatre in CGH, and no similar facility in GRH - nor are there plans or budget for one.
6	There is a state of the art interventional theatre in CGH and no such facility in GRH and it therefore makes sense to have the hub in CGH and the spoke at GRH to cover any vascular emergencies.
7	If this means that this service is available 24/7 at GRH then I would support this, especially if this stopped delays.
8	There needs to be 24/7 cardiac intervention! This has been needed for years & should all be on one site!
9	The spoke is a ‘gesture’ and perceptibly will be seen as something to sacrifice at a later date to move all services to GRH....
10	if this is the same type of procedure then use just one site (either) to reduce costs/communication
11	this will tie in with previously mentioned improvement in medical and surgical acute care by concentrating resources on one site and allowing patients to access this ground breaking/ cutting edge service
12	It is not clear what this actually means.
13	Cheltenham with a functioning a and e needs 24/7 imaging
14	Cheltenham needs a functioning A&E and will need a imaging
15	I feel like this could fit the idea of GRH being for emergency care and CGH for elective care. I understand that there are already vascath labs at both sites so one could assume we already have the staff / resources to cover both sites if necessary.
16	Imaging is essential to remain in CGH, Unsure as to why their is a need to transfer everything to GRH when there is a perfectly good working hospital with skilled staff members at CGH.
17	. Even if only elective at CGH, there can still be emergency interventions needed. Moving them across site whilst unstable is dangerous.
18	Should be colocated with maternity and emergency services

A 24/7 Image Guided Interventional Surgery (IGIS) ‘Hub’ at Gloucestershire Royal Hospital and a ‘Spoke' at Cheltenham General Hospital.		Response Percent	Response Total
19	Emergency interventional procedures should absolutely be where the main ED is - primary PCI being one of them. It is completely unacceptable that patients, in the throes of having a heart attack are driven across the A40 or down the M5. This is a dangerous practice.		
20	Requirement exists at both sites. Urology is a high user and based in CGH. Vascular (elective) ought to be in CGH.		
21	State of the art equipment in GRH		
22	It should be on one place. But I have not estimated the premises that we have available at CGH even if we have to build up a new building it is going to be far more better for the service than the service to be scattered.		
23	making sure that the supporting staff are enough to provide this		
24	re opening CGH ED as we have perfectly good imaging equipment and needs to be used.		
25	Again, we need to concentrate our resources on a single site to make best use of staffing and e.g. radiology		
26	A spoke will still split the vital staffing groups but in reverse.		
27	As long as this allows radiology to expand and develop. Be bold and invest here, this could be a real jewel in the crown for healthcare in Gloucestershire.		
28	Would like Pathology to be taken into account with these decisions - especially Blood Transfusion as we are having to do an increasing amount of work overnight yet have no funding for extra staff! 1 person that covers the whole hospital at GRH is dangerous.		
29	aligns to centre of excellence for vascular at GRH, including IR move from CGh to GRH		
30	I do not understand why, following the presumed logic elsewhere in this consultation why the IGIS seervice needs a 'hub and spoke model'. There is no convincing argument made for this on any rationalisation, financial, staffing or any other basis. Just create a centre of excellence badsed on sensible criteria and get on with it		
31	Having a service that operates in the main where the acute take is makes the most sense.		
32	more details are required to ensure both are adequately resourced (people and equipment) and overnight care available on site if needed; a waste of resource if personnel spend time travelling between centres		
33	This would support the acute medicine and emergency general surgery services best		
34	I prefer it to be offred at both		
35	Needs to be linked to Emergency Gen Surgery		
36	IGIS & vascular should be on same site		
37	These services are at present sited at CGH and I believe shoulld be supported there and aging equipment replaced.		
38	If this helps people and their is space on sites then definitely as delays in scans are detrimental to patient safety and outpatient urgent appointments		
39	The idea of creating centres of excellence at both of the two excellent large hospitals in Gloucestershire makes sense. It is worth remembering that the other specialist inpatient services, which have already centralised at either CGH or GRH e.g. cancer services at CGH and childrens' services at GRH, are working really well for patients.		
40	Emergency interventional radiology should be on the acute site, supporting emergency vascular surgery in particular. The 'spoke' could then be used to support daytime work at CGH and this will make optimal use of the existing hybrid theatre.		
41	This will provide a better service for general surgery patients. A significant number of elective patients undergo interventional radiological procedures which is another reason for locating complex upper and lower GI patients on the GRH site.		

A ‘centre of excellence’ for Vascular Surgery at Gloucestershire Royal Hospital.

			Response Percent	Response Total
1	Strongly support		24.82%	35
2	Support		34.04%	48
3	Oppose		11.35%	16
4	Strongly oppose		8.51%	12
5	No opinion		21.28%	30
			answered	141
			skipped	3

Please tell us why you think this, e.g. the information you would like us to consider (46)

1	Vascular is predominantly a service where patients can be suffering from a life threatening event (AAA) that requires immediate intervention in a theatre designed for this type of surgery. I think splitting Vascular across two sites will provide a sparse clinical cover across two sites rather than strong cover on one site. I can see the intrinsic link between IGIS and Vascular and therefore wherever the IGIS hub is, Vascular should be centralised to and vice versa.
2	Theatres less suitable compared to IR theatre at CGH. Major urology surgery has needed a vascular surgeon immediately at CGH in the past 10 days.
3	probably unless we split acute and elective
4	Renal services are at GRH. This would support renal service well.
5	The same as previous it is easier to manage and better cost savings for the trust, tax payer.
6	Vascular surgery should stay in Gloucester, however there is increasing amount of t&o outliers.
7	Cardiology and vascular services should be on the same site to service emergencies.
8	It depends where other surgical specialties are cited
9	This should be in CGH where the available beds are, and where there is the state of the art interventional theatre
10	The interventional theatre is in CGH and there are not enough beds in GRH to cope with all the acute medical patients, all of the acute surgical patients and trauma and vascular.
11	I would support this if GRH were able to provide vascular surgery with a ward that was fit for purpose! Vascular patients are currently on a ward that does not have the space or capacity for the patients. Wheelchair patients have 1 accessible toilet and shower for 21 patients. This in not good for rehabilitation of patients post amputation and impossible for all patients to access shower facilities. This is adversely affecting patient care. Lack of space around beds make life hazardous for staff and patients as we are often transferring patients from bed to wheelchair with hoist and moving furniture around to make this possible.
12	Centralising of this service, improved staff availability, expertise and ensuring this prevents delays and wait time.
13	Bedspace constraints at GRH reducing efficiency of vascular care; current ward for vascular patients at GRH unsuited to patient type and care required
14	This seems like an enormous waste of previous investment in facilities such as the hybrid theatre.
15	This service was previously being managed well at CGH but if it not possible to split elective e.g. IGIS and emergency vascular surgery then I believe it would be preferable to keep it on the GRH emergency site and then consider the ""spoke"" option at CGH for the elective surgery. Splitting this service will have an impact on the intensity / quality of Therapy those patients will receive unless additional funding is provided to support splitting this service across sites.

A ‘centre of excellence’ for Vascular Surgery at Gloucestershire Royal Hospital.

		Response Percent	Response Total
16	Multi million pound interventional radiography theatre built in Cheltenham, consultants still wishing to do hybrid cases in IR resulting in transferring patients post major surgery across site, emergency list overwhelmed in Gloucester Royal as battle for specialities to operate		
17	Too many operations at CGH have the potential to cause life threatening bleeding from major vessels (pelvic, aorta, IVC - renal, gynaeoncology) for it to be safe to have no available vascular surgeons immediately available at CGH.		
18	1. there is a redundant state of the art IR theatre in CGH 2. Winter pressures and COVID in GRH make it non sensical to keep elective vascular there		
19	Emergency vascular should be in GRH, elective should be in CGH - bespoke IR theatre already exists there and same arguments for bed base, HDU / ITU etc as for elective colorectal apply		
20	Other services such as renal medicine, diabetes which have a strong link to vascular surgery are largely based in GRH		
21	Because is not GI surgery. Every surgery not related to GI can go in GRH.		
22	its already there		
23	Vascular has already moved to gloucester		
24	Urgent care site status will mean operations may be cancelled		
25	vascular surgeons will mainly be based here for acute interventions		
26	Should have vascular surgery where acute services are and e.g. renal, stroke		
27	Hard to have IGIS at GRH and vascular at CGH so makes sense.		
28	Would like Pathology to be taken into account with these decisions - especially Blood Transfusion as we are having to do an increasing amount of work overnight yet have no funding for extra staff! 1 person that covers the whole hospital at GRH is dangerous.		
29	aligns well with emergency provision for vascular / stroke etc		
30	Keep Cheltenham as centre of excellence for everything GU/GI and oncology and all other surgery at GRH		
31	Supporting evidence required		
32	Whilst I support this, I believe there needs to be a vascular consultant available to cover CGH at all times due to the major surgery that CGH provides. In an emergency situation in theatre a vascular surgeon could be needed very quickly!		
33	I support the proposals to change and think the information provided presents a strong case. However, throughout the consultation document I see little or no reference to: a) How staff are to be retained, trained, recruited and afforded. b) No refernce to any improvements to process or service instigated as part of the response to Covid -19 which will be retained as Best Practice moving forward. c) Limited reference to the way that services will be re-modelled in line with international Best Practice. There is limited information given for example on the use of telemedicine, telephone consultation and foillow up, health education in primary care, transfer of services into coimmunity settings, converstions to higher day case rates, better streaming through outpatients (and ED). The proposals appear to deal with the issue of duplication of services across two sites and consequent rationalisation and whilst this is to be welcomed, of itself, it does little to illustrate how the models of care can or will change. Similarly there is no financial analysis (that I can see) with the documentation provided. In an increasingly stretched NHS, this must be a consideration for services to be long term sustainable.		

A ‘centre of excellence’ for Vascular Surgery at Gloucestershire Royal Hospital.			
		Response Percent	Response Total
	34	Theatres at GRH currently not suitable for vascular surgery - too small to accommodate equipment for EVAR procedures. Urology surgery (open nephrectomy) can potentially need help from vascular surgeons immediately- this is not possible if vascular based at GRH	
	35	I think Vascular should remain at CGH. Only a relatively short time ago much investment was made to establish a centralised service at CGH. Gong forward with future phases of FFtF there will be a need to have established services at CGH and this is one that could fit and not compromise safety.	
	36	as with GI surgery	
	37	I think it should be offered at both sites	
	38	Needs to be linked to IR	
	39	Most vascular surgery is urgent, however the vast majority is planned so it seems daft to move too GRH. especially when a lot of resources and planning went into developing an excellent service at CGH.If it is moved to Gloucester Royal then it is essential for the accommodation to be fit for purpose. eg: large bed space, assessable showering/bath facilities to meet the needs of patient demographics. Vascular surgery inpatient and outpatients and vascular lab should be in close proximity	
	40	IGIS & vascular should be on same site	
	41	Why change sites when you have this service functioning at CGH.	
	42	This team have been in place and excelled in gloucester as majority of admissions of this type are sourced from gloucester. Also the equipment and resources required for this are centered in Gloucester with years of practice	
	43	The idea of creating centres of excellence at both of the two excellent large hospitals in Gloucestershire makes sense. It is worth remembering that the other specialist inpatient services, which have already centralised at either CGH or GRH e.g. cancer services at CGH and childrens' services at GRH, are working really well for patients.	
	44	Vascular surgery has brought a heavy and unpredictable emergency workload to GRH since its recent transfer from CGH. This has impaired access to emergency operating for all specialties, despite extra emergency theatre and consultant anaesthetist provision. CGH has a well equipped and recently provisioned IR theatre, which is currently lying fallow much of the time, and which is superior to any similar facility in GRH. CGH should welcome vascular surgery back.	
	45	I feel emergency and elective vascular surgery should be split so that emergency work is aligned with the surgical take whilst elective work continues at CGH. This will ensure there is critical care capacity available to support the elective work otherwise there is likely to be an ever increasing pressure on ICU beds at GRH.	
	46	Concentrating resources provides better care	

A permanent ‘centre of excellence’ for Gastroenterology inpatient services at Cheltenham General Hospital.

		Response Percent	Response Total
1	Strongly support	31.91%	45
2	Support	36.17%	51
3	Oppose	4.26%	6
4	Strongly oppose	1.42%	2
5	No opinion	26.24%	37
		answered	141
		skipped	3

Please tell us why you think this, e.g. the information you would like us to consider (29)

1	Gastroenterology experience has been demonstrably improved by the recent pilot. Less violence and aggression on the ward, less non-gastro (general medicine) patients using specialised beds and better staff satisfaction from cohorting our clinical capacity onto a single site.
2	better to avoid the emergency site
3	Despite gastro inpts being at CGH currently, gastro inpts are still seen on GRH wards and do not get the care they need from the gastro team. Patients either need to be moved promptly so the care of the patient is not impacted, or have a service at both sites.
4	The same as previous it is easier to manage and better cost savings for the trust, tax payer.
5	Provided there is some gastroenterolgy presence at GRH also.
6	I feel that this ward is located on the wrong site and should move to GRH where the other acute medical care is taking place. Many patients need regular access to Endoscopy but there are not enough gastro patients at CGH to warrant an inpatient list each day or weekend access to services. By moving this ward to GRH patients would have improved access to endoscopy services 7 days of the week on dedicated inpatient lists. They would not have to be transported cross site either
7	Everyone will know where it is and again centralising services and insuring expertise, experience and staffing is available.
8	This fits with separating surgical and medical divisions across each site.
9	as long as colorectal surgery is also located there - without this it will leave gastro very exposed
10	Only if lower GI surgery is colocated - rapid senior surgical review with alacrity ensures that decisions for surgery are correctly timed and that non surgical interventions are not pursued too long ; if all one has is a hammer then everything looks like a nail
11	It is closer to Endoscopy Unit. Patients can be easily transferred to it.
12	If GI suregery is at CGh this needs to be too
13	Nothing wrong with snowshill, Again don’t fix what’s not broken just make it bigger
14	As the pilot has been seemingly successful then makes sense.
15	Would like Pathology to be taken into account with these decisions - especially Blood Transfusion.
16	got to move something to CGh to balance the shift to GRH.aligns well to elective services generally centralising to CGH
17	If you want to have a centre of excellence EVERYTHING to do with that area of medicine needs to be there, no half measures and aahh but this bit goes to Gloucester. You need to keep things simple and easy for Joe Public yo understand as well as your HCP partners.
18	Describe centre of excellence as this term is being overused in the survey

A permanent ‘centre of excellence’ for Gastroenterology inpatient services at Cheltenham General Hospital.		Response Percent	Response Total
	19	I support the proposals to change and think the information provided presents a strong case. However, throughout the consultation document I see little or no reference to: a) How staff are to be retained, trained, recruited and afforded. b) No refernce to any improvements to process or service instigated as part of the response to Covid -19 which will be retained as Best Practice moving forward. c) Limited reference to the way that services will be re-modelled in line with international Best Practice. There is limited information given for example on the use of telemedicine, telephone consultation and foillow up, health education in primary care, transfer of services into coimmunity settings, converstions to higher day case rates, better streaming through outpatients (and ED). The proposals appear to deal with the issue of duplication of services across two sites and consequent rationalisation and whilst this is to be welcomed, of itself, it does little to illustrate how the models of care can or will change. Similarly there is no financial analysis (that I can see) with the documentation provided. In an increasingly stretched NHS, this must be a consideration for services to be long term sustainable.		
	20	The evidence supports this remaining and expanding at CGH.		
	21	Gastroenterology services should (at least in my view) be in close proximity to GI surgery. Optimal care of such patients often involves close collaboration between the two arms		
	22	Keep all acute services under one roof. Cheltenham seems better suited for planned, elective services.		
	23	This will only work if medical beds are managed by the specialty teams, when pressure increases in GRH this is always lost.		
	24	Whichever the clinicians think is best		
	25	Gastroeneterology dsupport for cancer patients needs to be improved and this move would help that.		
	26	Links with upper /lower GI as well as colorevtal and cancer based surgeries, this is a no brainer as it would all fit together and enable this center of excellence aim		
	27	The idea of creating centres of excellence at both of the two excellent large hospitals in Gloucestershire makes sense. It is worth remembering that the other specialist inpatient services, which have already centralised at either CGH or GRH e.g. cancer services at CGH and childrens' services at GRH, are working really well for patients.		
	28	The current setup seems to work well. All acute admission would still need to be via GRH but once stable transferring patients across to CGH optimises flow and also helps reduce pressure on GRH DCC for patients who then deteriorate on the ward and require intensive care.		
	29	Interaction with gastroenterology on a day to day basis for general surgery is either on an outpatient basis or as an emergency. The current system of having a gastroenterologist on site in GRH works well. Outpatients continues to work as before. Overall the changes do not affect the general surgery service.		

Two permanent ‘centres of excellence’ for Trauma at Gloucestershire Royal Hospital and Orthopaedics at Cheltenham General Hospital.

		Response Percent	Response Total
1	Strongly support	38.73%	55
2	Support	36.62%	52
3	Oppose	7.75%	11
4	Strongly oppose	1.41%	2
5	No opinion	15.49%	22
		answered	142
		skipped	2

Please tell us why you think this, e.g. the information you would like us to consider (39)

1	Much like with previous service responses I believe that by keeping Trauma linked with Orthopaedics will inevitably lead to Orthopaedics losing out because acute patients (trauma) has to take priority for beds, theatre space and staffing requirements. This allows the massive Orthopaedics service to properly deliver aside from the constraints put on them through sharing bed and staff capacity with Trauma.
2	makes complete sense
3	The same as previous it is easier to manage and better cost savings for the trust, tax payer.
4	There are a high number of T&O patients so both sites is good
5	I agree that all trauma should come to GRH and planned orthopaedics to CGH.
6	Question is unclear, but I support Trauma remaining in GRH to protect elective surgery in CGH
7	I think it makes sense to have trauma on one site but there needs to be adequate orthopaedic cover for the other site. At the moment this is not happening.
8	This has to be fit for purpose and capacity needs to be concidered
9	If the 24hr A&E is at GRH I it makes sense for trauma to be centralised there. Orthopaedics at CGH again if this ensures this service is protected and trauma emergencies doesn’t interfere with this.
10	if these are similar and use the same resources then use one site (either) to reduce costs/communication
11	This makes sense to enable the more acute work to be separated from the elective lists thus enabling the latter to proceed despite other pressures in the acute sector
12	Why are these separated at two sites? Are they not related, so should be together on one site?
13	This is something that I believe is already pretty much established with GRH being the trauma site and CGH being the elective site
14	trauma where A&E is, elective orthopaedics at cold site with no bed pressures
15	Southmead is the regional major trauma centre ; it is faintly ridiculous to imagine that GRH will every be a national centre of excellence for trauma in this context
16	this has worked well since 2017
17	Emergency T&O in GRH and elective T&O at CGH.
18	if this is tenable on two sites, why not? if resources do not allow this then one site will be better than none and centralises specialist care
19	Again acute trauma is better placed in GRH because of the 24/7 access to consultant led A&E
20	It should be everything in GRH. This is my refrain. It is logical and simple. The simpler is the better is. Perfection is in simplicity.

Two permanent ‘centres of excellence’ for Trauma at Gloucestershire Royal Hospital and Orthopaedics at Cheltenham General Hospital.		Response Percent	Response Total
21	its needed across both sites. trying to travel from e.g moreton in marsh on crutches or with arthritis to GRH isn't acceptable. there is no realistic hospital transport for these folk		
22	Trauma and orthopaedics should stay together at GRH		
23	emergency site and planned site		
24	Keep low risk elective surgery away from acute site, concentrate acute resources		
25	This is known to be good practice and the pilot has been working well. Why change it?		
26	Would like Pathology to be taken into account with these decisions - especially Blood Transfusion as we are having to do an increasing amount of work overnight yet have no funding for extra staff!		
27	Trauma and orthopaedic need to go together. It would be VERY confusing to split them. You've GOT to start treating this as one hospital over 2 sites; not 2 different hospitsls. EVRRYTHING trauma and orthopaedic at Gloucester. Coronary Care also needs to be centralised wherever PPCI is.		
28	Not sure aboutb separate centres for orthpaedics.		
29	I support the proposals to change and think the information provided presents a strong case. However, throughout the consultation document I see little or no reference to: a) How staff are to be retained, trained, recruited and afforded. b) No refernce to any improvements to process or service instigated as part of the response to Covid -19 which will be retained as Best Practice moving forward. c) Limited reference to the way that services will be re-modelled in line with international Best Practice. There is limited information given for example on the use of telemedicine, telephone consultation and foillow up, health education in primary care, transfer of services into coimmunity settings, converstions to higher day case rates, better streaming through outpatients (and ED). The proposals appear to deal with the issue of duplication of services across two sites and consequent rationalisation and whilst this is to be welcomed, of itself, it does little to illustrate how the models of care can or will change. Similarly there is no financial analysis (that I can see) with the documentation provided. In an increasingly stretched NHS, this must be a consideration for services to be long term sustainable.		
30	Support that the pilot be made permanent.		
31	orthopaedics and trauma should be in close proximity so personnel can collaborate and reduce need to duplicate equipment		
32	As long as orthopaedics can provide adequate cover to the inpatient wards in CGH. The cover is very poor currently. If you fracture as an inpatient in CGH you are worse off then if you fracture in the community.		
33	Again splitting elective and trauma sensible if demand / need exists.		
34	Patients with pathological fractures or spinal cord compression should not require moving especially when delay might be induced due to lack of beds in the scute hospital (GRH).		
35	Rising admissions of this kind every year and shortages of community rehab placements means that this is needed now more than ever especially as this is lengthening inpatient stays which slows down admissions rates especially when both hospitals are running with only one A&E		
36	The idea of creating centres of excellence at both of the two excellent large hospitals in Gloucestershire makes sense. It is worth remembering that the other specialist inpatient services, which have already centralised at either CGH or GRH e.g. cancer services at CGH and childrens' services at GRH, are working really well for patients.		
37	The separation of Trauma and elective orthopaedic surgery has been a success story and has enabled CGH to concentrate on high quality enhanced recovery pathways, which can develop more easily in an environment away from emergency pressures.		

Two permanent ‘centres of excellence’ for Trauma at Gloucestershire Royal Hospital and Orthopaedics at Cheltenham General Hospital.

		Response Percent	Response Total
38	This scenario has been in place for some time and seems to work well. Keeping elective patients away from acute admissions is vital to minimise the risk of prosthetic joint infections.		
39	Elective orthopaedic patients are at low risk of major complications post operatively and offering them surgery in an environment with a reduced risk of cancellation makes sense.		

Please tell us about any impact, either positive or adverse, that you think any of our proposals could have on you and your family (please tell us which service your feedback relates to e.g. IGIS)?

		Response Percent	Response Total
1	Open-Ended Question	100.00%	74
1	I think more efficient working by having majority of specialist services single site is in everyone's best interest.		
2	All proposals would have a positive impact on me and my family. I don't care where I or my loved ones are treated. If any one of us had an extremely unusual condition requiring us to travel to London for treatment, we would do it. It therefore makes no difference to me whether I have to travel to Cheltenham or to Gloucester for treatment, as long as the service is good, well staffed with enough of the right staff and capacity available is all I care about.		
3	pretending we have 2 acute hospitals is the biggest potential detriment to services		
4	I live in Cheltenham. If acute medical and emergency surgical care moves to GRH, I am concerned myself or my family will have to travel further for emergency care when they are very unwell. I believe the public strongly hold this view also		
5	The proposals I think will mean better care overall for me and my family		
6	It will be safer for us to have everything in one place.		
7	AMU needs to be spread across both sites. Head and Neck ward with Gynaecology doesn’t make sense		
8	Failure to deliver emergency care in Cheltenham has already negatively impacted my family and our view of the trust's performance.		
9	These proposals would improve the care provided if myself or my family ever needed treatment at GRH or CGH.		
10	The current burdening of services in GRH will have a major impact on ED care, ward care and intensive care. It is unsafe and must be addressed rapidly. I have concerns that my family will not receive adequate care in this Trust and I would take them to Bristol if possible in an emergency. I have significant concerns regarding the piecemeal junior led cover at nights for surgery in CGH at present.		
11	I am concerned that if the majority of the services continue to be relocated to GRH the hospital will become unsafe. It is not infrequently at the highest alert and we haven't hit winter yet. I am worried about the care my family will receive and if possible will travel to alternative hospitals.		
12	The Trust's decision to move services post Covid peak had a negative impact on staff morale and mental health. Working through the difficult time of March and April was stressful for all and whilst all were happy to go where needed we were working in new teams in new ways with little support in this emergency situation. Moving back to our own wards and teams meant that we were starting to share the difficulties of the previous weeks and just as we were supporting each other we were told we were to move sites, splitting the ward staff and putting all through more stress and uncertainly. I do not think management realize how traumatic this was for those involved. The priority for staff is to provide good holistic nursing care for patients and support our colleagues. I feel that we have not been able to do that for a long time.		
13	I feel the benefits of services being in one place where the expertise, experience and correct staffing levels are available are huge. If these changes ensures this happens and the reduction in procedures, surgeries and appointments being cancelled is the result I would feel this is hugely beneficial.		

Please tell us about any impact, either positive or adverse, that you think any of our proposals could have on you and your family (please tell us which service your feedback relates to e.g. IGIS)?		Response Percent	Response Total
14	Travel, parking, costs of parking, congestion all negative. With an ageing population with less mobility it's likely less visiting will take place the more you centralise services on a single site.		
15	Further travel to obtain emergency services and for visitors if admitted		
16	Cheltenham needs a amu and functioning a and e, plans to ship patients across country are absurd and detrimental to patient safety		
17	the removal of a and e puts everyone in the county at risk. putting people in ambulances between sites is already damaging. stop letting this continue		
18	changing our jobs yet again, nurses don't matter		
19	negative all round.		
20	risking the health and safety of those further out in the county.		
21	cannot have one medical take, it cant cope already		
22	If this is established successfully I think it will have a positive impact on establishing better pathways with our primary services and accessing community follow up etc.. and hopefully work reciprocally with helping admission prevention / flow in the acute setting.		
23	I want myself and my family to have the best access to cancer care should we ever need it. I believe splitting the elective and emergency services allows both to be delivered in the safest possible way		
24	long waiting times and hugely packed waiting areas are not ideal when you are poorly		
25	None		
26	Centres of excellence mean clinical expertise is concentrated in one area, rather than split across the county. This means better, more responsive specialist care for me and my family when we need it.		
27	Removing lower GI surgical support from CGH would diminish the service which I work in and I would have to consider whether the Trust's ambitions for my service match my own in terms of where I work in the future and whether my family move. Conversely moving all GI cancer surgery to CGH would be a significant statement of the kind of cancer surgery we want to provide in the future - i.e. comprehensive, safe and cutting edge		
28	further for some patients to travel too if A and E in Glos		
29	IGIS - emergency interventional 24/7 cardiology is essential where the ED is located and would be hugely beneficial to patients. I do not think the Trust can justify having a split any longer. It is behind the times and incredibly poor clinical practice.		
30	Continuing to overload GRH with emergency services without balancing a shift of major services to CGH will cause a crisis for the community		
31	COTE. Acute take at GRH appears to have increased the number of ward moves and the number of pts MSFD being transferred to CGH awaiting discharge or for ongoing discharge planning. Both elderly in-laws recently subjected to this. A poor experience for both of them. This is not the level of service we aspire to yet sadly no longer uncommon for this demographic.		
32	both hospitals pretty much equidistant for us and are over thirty mins away, so no change for us		
33	none		
34	It is only positive		
35	trying to access some services at CGH and some at GRH via public transport if you are unwell or infirm is frankly awful. .		
36	Please keep acute services at cgh		
37	good service		
38	-		

Please tell us about any impact, either positive or adverse, that you think any of our proposals could have on you and your family (please tell us which service your feedback relates to e.g. IGIS)?		Response Percent	Response Total
39	Only with delays getting to GRH if CGH is nearer to where it happens.		
40	None in my case		
41	IGIS information is actually not entirely accurate as from a non medical view and those lacking the insight into the interventional area its trying to broadly cohort based on superficial skills where they are entirely separate skill sets. The idea of grouping in a similar location is good but the idea that cross cover occurs easily between disciplines is completely inaccurate and actually won't create staffing efficiencies. It is in fact going to dilute a very specialised skill set within each of those specialities.		
42	I am happy with all of the proposals.		
43	No direct on my family currently.		
44	Travelling to GRH		
45	Focused centres of excellence to allow for planned care at CGH and more acute/emergency care at GRH but still maintaining access to ED across both sites		
46	Nil		
47	You just need to have one place to go to for one SUBJECT e.g. Oncology, CVS, and GU/GI at Cheltenham and everything else at GRH. You've got to make it simple. And you need to make ED at Cheltenham 24/7 with doctors. Or you've got to double the size of ED at GRH. You've lost 2 x resus bays by closing CGH to ambulances, yet not increased capacity at GRH at all. It's ridiculous at Gloucester ED- and don't blame COVID. ED at Gloucester is not fit for purpose, being the only ED in the COUNTY!! JUST KEEP IT SIMPLE, so that everyone can understand it. You've been got to stop thinking like a person in the NHS and start thinking how the public views the organisation of the services offered. I don't believe you'll re-open ED at Cheltenham, you've been wanting to get rid of it for ages, but GRH ED is NOT fit for purpose with current demand - and demand is not going to decrease. You also need a centre of excellence for the Older Person. By 2040 , 25% of Glis CCG patients will be over the age of 65.		
48	Travel and access to both sites for those with out cars or relatives locally		
49	I think that all of the proposals will have a positive impact on everyone, as the services in the long run will be better, if certain hospitals become centres of excellence for individual things.		
50	I can only see advantage in focussing particular specialisms on one site, as much as that is possible,		
51	AS I and my family live closer to Cheltenham rather than Gloucester, everything that moves to Gloucester will have an impact on us. Relistically however the geography of acute secondary and tertiary services does not matter. I want an accessible service with low waiting lists, efficient adninistration, decent transport services into it/parking, fully taffed with competent doctors, nurses and support staff staff who are well looked after. I also only want to come to such a hospital when I need to and I would like to see the development of community based services (using the fine physical facility at Moreton in Marsh for example) and an integrated approach with primary care and Community services. I also want the NHS to start communicating with its customers on its strategy (not the politicxally motivated rubbish that is pumped out daily) get realistic about its major downfall of staff shortages(between c40 k and 84k shortfall of staff now and likely to get worse in the next 10 years with limited reality about training, limited prospoct of sensible overseas recruitment and a pretty awful reputation for looking after its staff) and preparing the population for the reality of what actually is affordable. Very happy to share my thoughts on this also somewhere else if you wish.		
52	Positive impact across the board to have the expertise concentrated on 1 site for the various services allowing sensible on call rotas and adequate staffing for those services rather than splitting the expertise across 2 sites.		
53	in 2020 the crucial factor should not be postcode but the delivery of excellent, safe and timely patient care. It is simply not possible nor is it safe to continue to try and provide duplicated services which in turn often compromise the quality of care. We also should not forget the enormous pressure this places on staff, in terms of staff shortages, cross site cover at short notice, pressure of always feeling there an added pressure.		
54	I believe the proposals will result in better services and improved use of capacity and resources. For those of us who live outside of Cheltenham and Gloucester we have a journey to either hospital so the proposals have no negative impact on that respect.		

Please tell us about any impact, either positive or adverse, that you think any of our proposals could have on you and your family (please tell us which service your feedback relates to e.g. IGIS)?

		Response Percent	Response Total
55	I want to have access to the best health services possible. These must be provided in the safest hospital possible - that means fully staffed and, with access to all facilities all the time. For more minor surgery, I would like to be treated in a dedicated unit away from the emergency hospital to reduce the worry of having my operation cancelled		
56	It would mean travelling longer distances but this is a price well worth paying for better outcomes		
57	As a resident of Cheltenham I am happy to travel if it means better care. I just want the right people in the right place to look after my family if they are unwell.		
58	I prefer it when Cheltenham residents can get access at CGH for all these things where possible. E.g. my phototherapy treatment used to be at CGH a ten mins walk for me now I have an hour round trip to GRH which is bad for the environment and a complete time waste.		
59	Negative impact for me, if GI services moved from the Cheltenham site.		
60	difficulty in getting to Cheltenham general hospital, public transport links poor or non exsistant		
61	I think it would adversly affect my work		
62	I am concerned that scarce resource (pathology, radiology, social work etc) is diverted to GRH leaving a second rate services that would not be able to safely support any centre of excellence (including oncology) based in CGH.		
63	Minimal impact currently - may involve slightly longer travel dependent on outcome. Applies to services that would move to GRH		
64	na		
65	The importance to me and my family is the travel to and from Gloucestershire and Cheltenham hospitals. if we needed treatment		
66	I believe it is vital we maintain services at both hospitals. The area covered by both hospitals is vast often receiving patients out of County. Like many others living in the Cheltenham area I have seen the erosion of our A&E services as hugely detrimental as the numerous reports of long waits at Gloucester A&E, with patients being treated in Corridors testifies. I have had such an experience myse;lf.		
67	Positive to moving all specialties to gloucester and none in cheltenham: None, on all accounts care provided is slowed down, bed spaces limited, more in patient moves and exposure risks of various infections and the disruption and unfairness that the staff are subjected to with these moves, how is this fair that their loyalty to their teams is rewarded with bitterness and unfair choices with their opinions not being heard Positive to specialties linked across both sites : better patient flow, increased admissions and faster patient care to get people home		
68	The temporary changes made to Emergency General Surgery at GRH have had a positive effect on patient care, patient experience and staff morale. Patients now see the correct speciality during admission within a timely manner.		
69	Emergency lower/upper GI surgery to stay at GRH.		
70	I just want the best care in the right place and don't mind a few extra miles travel in order to achieve this		
71	Closure of CGH A&E could lead to delays in emergency treatment to those south of the county, with potential for negative outcomes for time critical conditions.		
72	Creating a major elective hub at CGH is likely to be beneficial to my family. This would allow good access to intensive care if needed and reduce the risk of hospital acquired infection.		
73	We'd rather have to quality care and travel further than average care on our doorstep.		
74	Its too far to go to GRH		
		answered	74
		skipped	70

If you think any of our proposals could have a negative impact on you and your family, how should we try to limit this (please tell us which service your feedback relates to e.g. IGIS)?		Response Percent	Response Total
1	Open-Ended Question	100.00%	58
1	No although this will remove some services from each site by centralising to the other I think overall the experience will be better and clinical outcomes likely to be improved.		
2	pretending we have 2 acute hospitals is the biggest potential detriment to services		
3	As above		
4	I would be worried if resources are spread thinly if there aren't centres of excellence.		
5	NO		
6	Interventional Cardiology. This should remain at CGH where it performs very well despite the trusts problems.		
7	I do not think there are any negative impacts to the proposed changes.		
8	Move all elective major lower and upper GI, plus vascular, to Cheltenham and ensure adequate resident surgical support.		
9	Move more services to CGH. If all elective major upper and GI surgery, vascular and interventional surgery were moved to CGH there would be less pressure on the beds in GRH. It would also protect the elective patients from cancellations and also separate the elective patients from the COVID patients. There needs to be adequate resident surgical cover overnight in CGH regardless of the solution.		
10	Managers need to ensure that there is the bed capacity to provide centres of excellence. Movement of patients between wards and sites is not conducive to good care. Staff need to be consulted and views listened to.		
11	The centralising of services is important, but this also relies on the availability and access to the means to get people to hospital, in the sense of emergencies and the correct emergency services on hand when needed, whether this is an ambulance or paramedic car, with the correct expertise on site.		
12	As above		
13	Free parking?		
14	make a fully functioning a and e in Cheltenham to protect their health.		
15	risks everyones lives. not having an acute service in Cheltenham is laughable.		
16	will completely change my job, again! lower staff morale and lose a much needed acute care service		
17	a fully functioning A&E needs to be in Cheltenham and our ACU and AMU needs to come back. patients safety is massively compromised.		
18	risking family health by providing sub par a and e service at Cheltenham		
19	GRH cannot and does not cope. to say otherwise is incorrect. you only need to speak to staff and patients to see Cheltenham needs a medical take		
20	As long as there is data and outcome measures to reflect that this costly reconfiguration is truly having a positive impact on waiting times, avoiding cancelation of elective surgery etc.. then I cannot anticipate any negative issues.		
21	If elective colorectal went to GRH that would yet further increase the pressure on beds at GRH, meaning longer waits for patients in A&E		
22	Cheltenham needs a functioning ED with acute medical intake		
23	None		
24	As above		

If you think any of our proposals could have a negative impact on you and your family, how should we try to limit this (please tell us which service your feedback relates to e.g. IGIS)?		Response Percent	Response Total
25	Paediatrics definitely need looking at as if emergency cases for urology are still being operated on in CGH transferring them to GRH is a logistical nightmare. Its embarrassing to tell patients that we have to transfer patients , it takes ambulances away from emergencies calls, waiting times for ambulance, can sometimes be early hours of the morning, is it safe to transfer , staffing for paediatrics , its not giving the child a positive experience, could cause increased anxiety for future admissions		
26	The only negative impact is if the plans for IGIS do not go ahead.		
27	Move as much major elective surgery to CGH as possible, to free up GRH bedspace		
28	Get it Right First Time. Direct to FAS/ COTE bed. Another specialist COTE ward at CGH (although difficult to recruit to this area) Discussion with community partners: keep CH and Bed Based Rehab beds for pts needing these services to speed transfers out of acute hospital. Blocking beds in the community blocks up our ' back door' and our beds perpetuating the problem of flow.		
29	no		
30	I don`t see any negative effect. I live in Cheltenham and had to go to GRH as a patient. I just got on the bus and was there on time for my appointment. It was fine. In emergency I can get a taxi if an ambulance car is not available.		
31	Hospital transport is only for those very unwell, not for those who cant afford a taxi - we need to support all patients not just the wealthy		
32	Keep cgh an acute hospital		
33	no		
34	this has a massive impact on me and my family. I wouldn't want my family member going to GRH unwell knowing what state the hospital is. patient care isn't what it use to be like unfortunately.		
35	- parking at cgh is poor		
36	Not applicable		
37	As described above. We are meant to be aspiring to be the best in what we do and sharing staffing groups isn't the answer. Ensuring we recruit and retain is and taking pride in the quality of our work.		
38	N/A		
39	Travelling to GRH		
40	N/A		
41	N/A		
42	You really need to have a ""Southmead"" in the Golden Valley area. And you need to consider better bus services to both sites for general public yo reduce car parking requirements and problems.		
43	It is crucial that these proposals are considered in the context of affordability and proper edidemological prediction modelling (none of which is illustrated in the documents circulated to date. The biggest negative effect on me and mine is if these p[roposals are implemented properly and because the basic work has not been done or done poorly, in 5 years time we have to change everything again,		
44	None. It is important that the spoke IGIS service at CGH is a proper service to properly resource urology and not just an ""add on"".		
45	None		
46	No negative impact.		

If you think any of our proposals could have a negative impact on you and your family, how should we try to limit this (please tell us which service your feedback relates to e.g. IGIS)?

		Response Percent	Response Total
47	Easier travel; more car parking spaces and lower charges for parking. Move to a paperless system so there is no need to transfer paper notes and images between sites - practical experience at both hospitals show lost notes are very common		
48	I want access to as many things to continue at CGH as possible. this consultation seeems to want to centralise as amny things to GRH as possible and I'm against that e.g. moving the A&E away from CGH has not gone down well with local residents and our MP		
49	free travel on 99 bus between sites for patients with an appointment letter		
50	It would negatively impact on me and my family if elective work was not done in Cheltenham as they would be a lack of beds in GRH		
51	Closing Cheltenham's A&E is a terrible mistake. For patients in the Cotswolds, Tewkesbury and surrounding areas - the time wasted going to GRH could literally mean life and death. I also do not believe that Gloucestershire Royal can cope with the numbers they would need to deal with at present. One A&E for a whole county is madness and is so transparently being considered to save money rather than lives.		
52	2 hospitals with all the resource based in 1, and so any centre of excellence in CGH will not be able to thrive.		
53	Nil		
54	na		
55	Travel especially if you don't drive		
56	Take a good look at gloucteser and the way it is run. It has a reputation for a reason, myself being a patient it is a common subject that people do and will actively avoid Gloucester Royal hospital because it is a shambles with too many problems that never see the light of day		
57	None		
58	None		
		answered	58
		skipped	86

Do you have any alternative suggestions for how any of the services covered in the consultation could be organised (please tell us which service your feedback relates to e.g. IGIS)? When describing your suggestions where possible please refer to the assessment criteria, developed in collaboration with local people during the Fit for the Future Engagement (see pages 17/19 of the full consultation booklet).

		Response Percent	Response Total
1	Open-Ended Question	100.00%	38
1	No.		
2	no		
3	No. Those providing them will know what alternative proposals are best.		
4	Gloucestershire would be better served by ambitious plans for a new hospital between Gloucester and Cheltenham along the M5 corridor. This would solve most of the trust's problems.		
5	I think that all Upper GI surgery emergency and planned should take place at GRH and all lower GI surgery at CGH so they are kept separate.		

Do you have any alternative suggestions for how any of the services covered in the consultation could be organised (please tell us which service your feedback relates to e.g. IGIS)? When describing your suggestions where possible please refer to the assessment criteria, developed in collaboration with local people during the Fit for the Future Engagement (see pages 17/19 of the full consultation booklet).

		Response Percent	Response Total
6	Move all elective major lower and upper GI, plus vascular, to Cheltenham and ensure adequate resident surgical support.		
7	I think all elective services where possible should be on a separate site to the acute patients to avoid cancellations and protect them during the pandemic. ALL upper and lower GI surgery and vascular and interventional surgery should be moved to CGH.		
8	The trust used to provide fantastic care that I have seen deteriorate over time with the changes and ""streamlining"" of services. Patients often need a combination of services to meet their needs and not having them on both sites impacts on our capacity to provide good holistic care.		
9	stop hiding behind lies and tell people the truth re closing a and in Cheltenham		
10	reinstate the services previously supplied by Cheltenham. local opinion is not being considered at all. Cheltenham needs an acute care ward and a and e		
11	reinstate a and e Cheltenham, don't fob us off as a downgraded service that then has to push emergencies to grh in ambulances.		
12	we need to be told the truth and they need to stop hiding behind the lies they are telling us. its completely ruined staff morale and staff are not enjoying work.		
13	Cheltenham needs an amu.		
14	Nil.		
15	I heard an interview with the president of the Royal college of surgeons this morning clearly explaining how he feels the NHS should be re-structured to have emergency hospitals, and elective hospitals - meaning fewer cancellations of elective cases, and best care for all. We have this opportunity to deliver this		
16	It has been found that management have not been honest with informing staff about changes		
17	yes, all emergencies to GRH urology and ophthalmology included (paediatrics)		
18	N/A		
19	no		
20	Nothing is mentioned about ERCP. This is part of GI service. It should be in CGH as a part of the entire circle. It is limited at the moment to two half days a week. It should be at least on a 5-day basis (every morning let`s say). There must be an ERCP centre. It could play a big role as a Centre of Excellence for training within the UK if the consultants think that they are able to develop it in this way. If not, then our patients will benefit at least from centre like this.		
21	A new build fit for purpose and fit for the 21st century with bus/road and rail links between the two major sites		
22	regarding appointments I really wants to appreciate the services		
23	CGH ED department needs to reopen so that the pressure is taken off GRH and CGH has their Aute Care wards open again. GRH cant cope with the whole county.		
24	No		
25	N/A		
26	Bring Cheltenhams A&E back		
27	My general comments previously in this diocument all refer - I do not have alternative suggestions as I do not have the necessary information to propose anything sensible at this time. This consultation is most encouraging (and one of the better engagements I have seen) but is still very short on decent fact and analysis which presumably has been done somewhere.		

Do you have any alternative suggestions for how any of the services covered in the consultation could be organised (please tell us which service your feedback relates to e.g. IGIS)? When describing your suggestions where possible please refer to the assessment criteria, developed in collaboration with local people during the Fit for the Future Engagement (see pages 17/19 of the full consultation booklet).

		Response Percent	Response Total
28	Whilst I understand that this is politically sensitive I am really struggling with the provision of an ED at Cheltenham, this should be a minor injury unit 24/7 end of.		
29	Keep all acute services in one hub. Elective services in another hub. It simplifies things		
30	Try to make centres of excellence at both sites where possible		
31	.		
32	The provision of temporary accommodation for vascular services, provided at GRH during phase 2 of COVID19 is severely lacking. It does not provide essential facilities for patients or staff. Moving from a ward at CGH which is ideal for this group of patients into an area which falls well below the normal standards, will have a devastating effect on patient outcomes and staff moral. If this experience is a sign of how it will be in the future, I would suggest that you will not be providing a centre of excellence for this group of patients. If however it is in ,the plans to create a ward environment which is similar in layout to Guiting ward at CGH which is close to Vascular laboratory, I would not be so concerned		
33	Both estates are too old and the sites are not of appropriate size to support an urgent and elective site - we should not be throwing more money away on them. A new combined hospital should have been built years ago. Neither is fit for purpose.		
34	na		
35	It would be good to have some services in either the forest or the Cotswolds as people travel long distances to get treatment		
36	Re-instate a fully functioning A&E service at CGH.		
37	Use precious structure and perhaps have a rotational table for specialties on an axel bases to offer variety of care over standard time frames		
38	Specialties need to stay in the same hospital. Orthopaedic need to all be in one hospital. Vascular needs to all be in one hospital where they can get treatments etc		
		answered	38
		skipped	106

Anything else you would like to say?

		Response Percent	Response Total
1	Open-Ended Question	100.00%	47
1	There are services eg haematology that are split site and struggling because of the inefficiency this causes. Would be good to see haem si flew sote at CGH		
2	No.		
3	I don't understand why we have to keep both EDs open. What matters is what happens once patients arrive and to deliver the service I would expect, would mean concentrating emergency staff expertise. I don't live in C or G so have no emotional attitude to either department but I do expect one fully staffed centre of ED expertise somewhere in the middle of the county.		

Anything else you would like to say?

		Response Percent	Response Total
4	It makes sense to look at the service provision in this way.		
5	Invest in your nursing staff as you do with every other professional group. Pay them more and develop their skills. This is the only way you will be seriously considered as addressing the recruitment and retention crisis.		
6	Gastroenterology ward should be moved back to GRH.		
7	We are approaching a winter crisis, and the move of all of ED, acute medicine, acute surgery and vascular to an already overstretched site in GRH in the height of a pandemic without a significant shift of major services back to CGH is posing a significant and immediate risk to patient safety.		
8	My hope would be that by making these changes the local service will be made better and the cancelling of planned procedures is significantly reduced.		
9	Management have no clue how the services are run and what is best for the Gloucestershire pts.		
10	The major elective centre at CGH away from the pressures of the emergency takes seems like a no-brainer. I don't know why it is being approached so cautiously. Why not move major head and neck resections, upper GI resections etc. I think too much weight is put on the inertia of clinicians who do not want to change. The Trust needs to be stronger in terms of telling people where they will work in future. Short term unhappiness for long term gain.		
11	How any of this helps patient flow and integration with primary care is poorly explained.		
12	I fully understand the publics desire to be able to access all services that they require as close to their home as possible, and therefore the negative public/ local MP perception of the trusts plans to separate services across the two site. However, as a clinician I feel that these parties should really be made aware of the limited resources (both personal and capital estates) that we have to fulfil this objective across two sites. If the public and politicians of Gloucestershire truly want to access an exemplary standard of clinical care and research within the county then they should fully support the trusts current proposals which will begin the process of enabling us to do this and are, in my view, long overdue.		
13	patient safety is being compromised daily already, let alone letting this carry on further. nursing morale is at rock bottom.		
14	stop trying to deceive everyone and be up front with the plans. this effects people livelihood and health. stop treating nurses as if we don't matter by moving us all pillar to post.		
15	the Gloucestershire nhs service needs to at least attempt to show some honesty and integrity when dealing with the public and its staff. do not treat us as though we are fools.		
16	we need to be told the truth and be kept in the loop more. the patients are also taking the brunt from staff because of these moves		
17	stop using covid as an excuse to flatline emergency services at Cheltenham. treat staff with more respect, our opinions and skills as professionals are repeatedly ignored by trust management. stop shipping patients who are unwell between two sites, this is unsafe and immoral. the only ones being shipped about are those with lower capacity, confusion and complex needs. disgraceful. I support reinstating amu at Cheltenham to stop this nonsense.		
18	Although it has been stated that staff have been consulted I wonder whether it has been at managerial level rather than at patient facing level? Often the feedback with consultation processes is staff feel like the right people have not been involved and therefore they have not truly had the opportunity to feedback their opinions on the process. Ultimately, the majority of staff working in the acute setting will always want to accept change if the end result is better patient care and staff experience.		
19	I believe that management have wanted to close Cheltenham ED for many years and have used Covid as an opportunity to do exactly that		
20	I live in Cheltenham and find it easier to travel to work to CGH but am not opposed to travelling to GRH but the 99 bus service could help if the times of the buses fit the shifts of staff.		
21	Bring cardiology together in GRH, with the space and resource for us to really enhance our services to the population of Gloucestershire, and then we could create a centre of excellence for cardiology. It is incredibly difficult to do this effectively being split not only across two sites, but also within those sites.		

Anything else you would like to say?

		Response Percent	Response Total
22	I hope that you are going to see the picture in different levels, i.e. locally, nationally and internationally.		
23	With the reconfigurations proposed moving the surgical and medical takes to GRH there is then no safe way to run an ED in CGH. I strongly feel we would be lying to the public if we pretend that an ED can function in CGH without the supporting inpatient services behind it. It seems illogical to discuss these reconfigurations without factoring in the impact on the ED.		
24	don't put all of the eggs in one basket. PFI is very costly to taxpayers, but appreciate sometimes its the only way.		
25	overall good		
26	does a centre of excellence include evoked potential testing with some of the orthpaedic surgeries?		
27	I think most people would like to point out that even though it states CGH will re-open - it is easy to see that GRH just cannot cope with the amount of people in Gloucestershire. I know ED is not on this questionnaire but it needs to be taken into consideration with regards to where everything is to be situated.		
28	No		
29	Please consider the elderly and vulnerable who have to use public transport to make visits to a further hospital. Will public transport be improved? Will more hospital transport be accessible to those who need it?		
30	Cheltenham need a A&E		
31	Just ensure that the investment needed to provide these changes properly and not half hearted is there for all services involved including those that are sometimes overlooked. There is no point picking a service up and moving it to one side of the county or other if you don't use this opportunity to actually improve it.		
32	Would like Pathology to be taken into account with these decisions - especially Blood Transfusion as we are having to do an increasing amount of work overnight yet have no funding for extra staff! 1 person that covers the whole hospital at GRH in particular is dangerous.		
33	Can a hospital have a true A and E without the back up of eg general surgery vascular surgery Acute medicine etc		
34	The geographical disadvantage of one site over the other is usually overstated. We would all like things based as close to home as possible, but unless resident in Gloucester City or Cheltenham it actually makes very little difference to most people to site they need to travel. Using public transport is more complicated from rural areas, but the shuttle bus largely overcomes that issue for outpatients and visiting.		
35	See comments above.		
36	The proposals all seem excellent and recognise the realities of the problems fully staffing and offering all services at 2 DGHs which are only 10 miles apart.. It is not a problem to have to travel relatively short distances to access the best care. Tribal allegiances to GRH or CGH have gone on for far too long and obstructive practices by both clinicians, the general public and local politicians have delayed what has been obvious for far too long (at least to me in the 30 years I have lived and worked in the area).		
37	I support the changes as they will bring expertise and people together for the benefit of patients.		
38	The priority is to optimise outcomes. IN my experience, working on two sites is ineffective and leads to worse outcomes for patients so there are two mediocre sites rather than one excellent one. The leadership needs to take the initiative to avoid local populations wanting to retain local services at the expense of quality - the NNHS has a poor record in this		
39	I don't think 'Centres of Excellence' should be considered at present, and yet again my suspicion is that if it looks good from the outside - ie when the CCG walk round with the scent of paint in their nostrils - it doesn't matter that staff and patients are unhappy with the way things are.		
40	I support the need for patients that require surgery on the same day as admission to be done at one site. however not all urgent surgery is same day. I think the hospital at GRH would struggle to meet capacity/ demands if all Acute work was on GRH site.		
41	I have been watching this play out for years and too much time and negative energy has been spent which has hampered the development of all specialties in both hospitals. I am utterly fed up with it.		

Anything else you would like to say?

		Response Percent	Response Total
42	Whatever decision is made, the correct and additional staff numbers must be allocated. You cannot simply move the patient workload (currently split over two sites with two teams) to one site with only that sites pre-existing team numbers. This will be a recipe for failure / disquiet. Working in a small speciality which centralised 10 or so years ago the benefits are huge for us		
43	no		
44	Many people have feared because of the changes and continue to do so. Many people see this as a move to shut or deminish CGH and don't want this because CGH is the hospital of their choice and is closer to home and family. GRH is a mess, one such example is the previous stroke specialist team... All resigned due to management the problems they had on the ward and the way it was run, when bullying is rampant on a ward and months of whistle blowing and datixing is met by scorn and inaction, nobkdy wants to see this happen in cheltenham as well		
45	Emergency lower/upper GI surgery need more space.		
46	The shuttle bus between CGH and GRH is a great asset in relation to access to services. A commitment to its future would be good to hear. It would also be good to hear that discussions are being held to see whether the bus route could include a stop at Park and Ride at Cheltenham Racecourse. Decision makers should consider evaluation of services changes if implemented and the involvement of patients, carers and VCS in the evaluation.		
47	When making the final decision, ensure that you fully understand the models of care that have been proposed for general surgery because this consultation document does not accurately reflect what those working in the service have put forward. Trying to impose a service that 80% of the consultant body do not support will not augur well for its success.		
		answered	47
		skipped	97

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

		Response Percent	Response Total
1	Open-Ended Question	100.00%	129
1	Gl3		
2	GL1		
3	GL1		
4	GL3		
5	GL53		
6	GL4		
7	GL52		
8	GL6		
9	WR14		
10	GL52		
11	gl1		

What is the first part of your postcode? eg. GL1, GL20			
		Response Percent	Response Total
	12	Gl51	
	13	GL50	
	14	GL4	
	15	GL53	
	16	Gl5	
	17	GL52	
	18	GL51	
	19	GL4	
	20	GL52	
	21	GL10	
	22	GL13	
	23	Gl15	
	24	GL2	
	25	GL53	
	26	gl52	
	27	GL4	
	28	Gl2	
	29	WR11	
	30	gl51	
	31	GL53	
	32	GL52	
	33	gl51	
	34	gl51	
	35	gl2	
	36	GL1	
	37	wr12	
	38	gl3	
	39	gl53	
	40	GL51	
	41	GL7	
	42	GL16	
	43	wR11	
	44	GL52	
	45	Gl2	
	46	Gl52	

What is the first part of your postcode? eg. GL1, GL20			
		Response Percent	Response Total
	47	GL2	
	48	GL2	
	49	GL52	
	50	GL6	
	51	gl14	
	52	GL2	
	53	GL3	
	54	GL54	
	55	GL20	
	56	GL7	
	57	Gl52	
	58	GL7	
	59	GL50	
	60	GL13	
	61	gl51	
	62	GL54	
	63	GL 54	
	64	GL51	
	65	Gl2	
	66	GL5	
	67	Gl51	
	68	GL1,	
	69	gl1	
	70	gl5	
	71	gl1	
	72	GL4	
	73	GL53	
	74	OX18	
	75	SN2	
	76	gl4	
	77	GL3	
	78	GL53	
	79	GL51	
	80	GL4	
	81	GL3	

What is the first part of your postcode? eg. GL1, GL20			
		Response Percent	Response Total
	82	GL2	
	83	GL53	
	84	gl52	
	85	GL17	
	86	GL1	
	87	GL50	
	88	Gl53	
	89	GL52	
	90	Gl14	
	91	GL10	
	92	GL56	
	93	GL3	
	94	GL3	
	95	GL18	
	96	GL52	
	97	GL54	
	98	GL53	
	99	GL18	
	100	GL53	
	101	GL5	
	102	gl50	
	103	GL50	
	104	GL52	
	105	GL52	
	106	GL52	
	107	GL53	
	108	gl3	
	109	GL53	
	110	GL53	
	111	GL50	
	112	gl1	
	113	gl15	
	114	gl2	
	115	gl50	
	116	GL53	

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

		Response Percent	Response Total
117	Gl3		
118	Gl53		
119	GL20		
120	Gl2		
121	GL51		
122	GL7		
123	GL3		
124	GL20		
125	GL1		
126	GL3		
127	GL7		
128	GL54		
129	Gl53		
		answered	129
		skipped	15

Which age group are you:

			Response Percent	Response Total
1	Under 18		0.00%	0
2	18-25		4.93%	7
3	26-35		23.24%	33
4	36-45		23.24%	33
5	46-55		23.94%	34
6	56-65		19.01%	27
7	66-75		3.52%	5
8	Over 75		0.00%	0
9	Prefer not to say		2.11%	3
			answered	142
			skipped	2

Are you:

		Response Percent	Response Total
1	A health or social care professional	100.00%	144
2	A community partner	0.00%	0
3	A member of the public	0.00%	0
4	Prefer not to say	0.00%	0
		answered	144
		skipped	0

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

		Response Percent	Response Total
1	No	88.89%	128
2	Mental health problem	4.17%	6
3	Visual Impairment	0.69%	1
4	Learning difficulties	0.00%	0
5	Hearing impairment	2.78%	4
6	Long term condition	4.17%	6
7	Physical disability	0.69%	1
8	Prefer not to say	1.39%	2
		answered	144
		skipped	0

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	19.15%	27
2	No	77.30%	109
3	Prefer not to say	3.55%	5
		answered	141
		skipped	3

Which best describes your ethnicity?

		Response Percent	Response Total
1	White British	84.29%	118
2	White Other	7.14%	10
3	Asian or Asian British	1.43%	2
4	Black or Black British	0.00%	0
5	Chinese	0.00%	0
6	Mixed	0.00%	0
7	Prefer not to say	6.43%	9
8	Other (please specify):	0.71%	1
		answered	140
		skipped	4

Other (please specify): (1)

1	European

Which, if any, of the following best describes your religion or belief?

		Response Percent	Response Total
1	No religion	52.08%	75
2	Buddhist	0.69%	1
3	Christian (including Church of England, Catholic, Methodist and other denominations)	40.28%	58
4	Hindu	0.00%	0
5	Jewish	0.00%	0
6	Muslim	0.00%	0
7	Sikh	0.00%	0
8	Other	1.39%	2
9	Prefer not to say	5.56%	8
		answered	144
		skipped	0

Are you:

		Response Percent	Response Total
1	Male	26.95%	38
2	Female	68.09%	96
3	Transgender	0.00%	0
4	Prefer not to say	4.96%	7
		answered	141
		skipped	3

Do you identify with your gender as registered at birth?

		Response Percent	Response Total
1	Yes	95.74%	135
2	No	0.00%	0
3	Prefer not to say	4.26%	6
		answered	141
		skipped	3

Which of the following best describes how you think of yourself?

		Response Percent	Response Total
1	Heterosexual or straight	86.81%	125
2	Gay or lesbian	2.78%	4
3	Bisexual	4.17%	6
4	Other	0.69%	1
5	Prefer not to say	5.56%	8
		answered	144
		skipped	0

Are you currently pregnant or have given birth in the last year?				
			Response Percent	Response Total
1	Yes		2.82%	4
2	No		78.87%	112
3	Not applicable		13.38%	19
4	Prefer not to say		4.93%	7
			answered	142
			skipped	2