Other Correspondence

Written Response from Cheltenham Borough Council

Unanimously approved at full Council, and subsequently endorsed by Cheltenham Labour Party

Cheltenham Borough Council

Council – 7 December 2020

One Gloucestershire Consultation: Fit for the Future -Developing urgent and hospital care in Gloucestershire

Accountable member	Councillor Flo Clucas, Cabinet Member for Cabinet Member Healthy Lifestyles
Accountable officer	Darren Knight, Executive Director – People & Change
Ward(s) affected	All
Key/Significant Decision	Yes
Executive summary	Comprehensive NHS provision in Cheltenham is critical for not just the people of Cheltenham but also those service users who receive treatment from Cheltenham General Hospital throughout Gloucestershire and surrounding areas. Changes proposed to provision at Cheltenham General Hospital through the One Gloucestershire Consultation – Fit for the Future 2020, therefore need careful consideration, evaluation and response. It is therefore critical that the Council agrees its formal response to the consultation and makes its position clear as not only a key stakeholder but also as critical friend. Following a Council motion on the 16th November, the purpose of this report is to formally confirm the Council's recommendations as part of the consultation response on the future of Cheltenham General Hospital and NHS provision in Gloucestershire.
Recommendations	1. **The issues highlighted in section 6 of this report to form the basis of the Council's response to the Fit for the Future consultation to be submitted before the 17 December.** 2. **The Council report should also be forwarded to Gloucestershire County Council's Health & Overview Scrutiny Committee (HOSC) for their consideration.**

Financial implications	There are no financial implications as a result of this report **Contact officer: Martin Yates** **martin.yates@publicagroup.uk**
Legal implications	There are no legal implications as a result of this report **Contact officer: One Legal** **legal.services@tewkesbury.gov.uk, 01684 272012**
HR implications (including learning and organisational development)	There are no HR implications as a result of this report **Contact officer: Julie McCarthy** **julie.mccarthy@publicagroup.uk, 01242 264355**
Key risks	Risk assessment attached
Corporate and community plan Implications	The Cheltenham place vision sets out the collective ambition for Cheltenham to be a place that champions physical and mental wellbeing. As a council it is therefore important that we place a high priority on ensuring that our residents have access to comprehensive health and wellbeing services that support people with their physical and mental wellbeing.
Environmental and climate change implications	The way in which services are organised in the future will have an impact on carbon emissions, which will be affected (positively or negatively) by the ways in which people are able to access services, the distance people need to travel to obtain treatment and also the frequency of transfer between hospitals.
Property/Asset Implications	There are no property implications as a result of this report **Contact officer: Dominic.Stead@cheltenham.gov.uk**

1. Background:

1.1 2020 has shown more than ever before how important comprehensive NHS provision is. Therefore, any proposed changes to local provision needs to be carefully considered, evaluated and responded to in order to ensure that service users now and in the future continue to receive the best possible provision.

1.2 The Council has a key role in this consultation process, not only as a stakeholder whose elected members represent the people of Cheltenham but also as a critical friend who want the best for service users and NHS employees.

1.3 Following a motion debated at full Council on the 16 November, it was agreed that the Council would prepare and agree a consultation submission reflecting the observations and direction for in motion and where Council can formally agree such submission prior to submission.

1.4 The purpose of this report is to formally confirm the Council's position and recommendations as part of the consultation on the future of Cheltenham General Hospital and NHS provision in Gloucestershire.

2. What is Fit for the Future:

2.1 Fit for the Future is part of the One Gloucestershire vision focussing on the medium and long-term future of specialist hospital services at Cheltenham General Hospital (CGH) and Gloucestershire Royal Hospital (GRH).

2.2 More information about the proposed changes and consultation can be found from https://www.onegloucestershire.net/yoursay/fit-for-the-future/ and from appendix 1 Fit-for-the-Future-Engagement-Booklet.

3. Council Motion:

3.1 On the 16 November there was a motion raised at full Council, which was unanimously supported by members, which raised a number of concerns regarding the proposed changes, which included:

- Council is concerned that A&E at Gloucestershire Royal Hospital does not have the capacity to cope with all A&E patients from the whole County. It is also less accessible from large parts of the county and does not have the Emergency Ambulance capacity. Council is also concerned the additional six-month extension at Cheltenham General Hospital could become a long term or permanent change.
- Council urges the Trust not to downgrade our Type 1 A&E at all (i.e. to an Urgent Treatment Centre) and to present local councils with a long-term plan for the full restoration of a 24 hour Type 1 A&E at Cheltenham.
- Council remains opposed to permanent closure or downgrading of Accident and Emergency (A&E) facilities at Cheltenham General Hospital
- Council is requested to prepare a consultation submission reflecting the observations and direction in this motion. Council can formally agree such submission prior to submission.

4. Alternative options considered:

4.1 Not taking this report to Council was dismissed due to the important nature of the issue and possible impact on local health provision. It is important that the Council makes its recommendations clear as a united body.

5. Council engagement with Gloucestershire NHS Trust:

5.1 On Wednesday the 18 November 2020, representatives from the Gloucestershire NHS Trust presented a summary of the proposed changes and took part in a question and answer session with members. A copy of the presentation is attached in appendix 2.

5.2 On Monday the 9 September 2019, representatives from the Gloucestershire NHS Trust attended the Council's Overview & Scrutiny Committee with a presentation followed by a question and answer session with committee members - https://democracy.cheltenham.gov.uk/documents/g2989/Public%20reports%20pack%2021st-Oct-2019%2018.00%20Overview%20Scrutiny%20Committee.pdf?T=10

5.3 We would like to put on record our sincere thanks to Gloucestershire NHS Trust for their efforts in engaging with Council representatives as part of their stakeholder engagement process.

6. Consultation response:

6.1 It is recommended that the Council's response to the consultation is based on the following points:

- Centralisation of the acute medical service onto a single site at Gloucestershire Royal Hospital (GRH) will place very significant pressure on bed availability, even with the planned expansion of the acute admissions unit at GRH
- For any acute medical centralisation to be successful, the Trust must make every effort to transfer elective activity to Cheltenham General Hospital (CGH)
- Any proposals under Fit for the Future regarding acute medicine must ensure adequate twenty four hour provision of emergency medical care to support the inpatient population at Cheltenham as well as the ED on the east side of the county
- Support the option of centralising gastroenterology inpatient services at CGH. Co-locating inpatient gastroenterology with a centre for major elective colorectal surgery in Cheltenham will provide an integrated service for patients with bowel disease
- CGH should be developed to become a Centre of Excellence for Cancer at Cheltenham. CGH is a highly regarded Cancer Centre with facilities to deliver modern radiotherapy and systemic treatments
- The creation of an elective Centre of Excellence for Cancer with co-located surgery and oncology would also afforded a degree of protection for cancer services in the face of any future pandemic threat
- Centralisation of emergency general surgery and the acute medical onto a single site at GRH may increase bed pressures in that unit. If centralisation proceeds for emergency general surgery at GRH, it is vital that all elective surgical activity is centralised at CGH, so that elective patients can be treated without disruption from emergency bed pressures or indeed future pandemics
- Elective major colorectal surgery should be centralised onto a single site at CGH. This centralisation will help to create a large elective Cancer Hospital, with reference to major pelvic surgery
- As the vast majority of arterial vascular surgery is elective, it would seem entirely reasonable that this should be located at the elective Centre of Excellence at the CGH

- The main interventional radiology hub should be located at CGH, where the majority of non-vascular interventional radiology cases are currently performed
- Not to downgrade CGH as a Type 1 A&E at all (i.e. to an Urgent Treatment Centre) and to present local councils with a long-term plan for the full restoration of a 24 hour Type 1 A&E at Cheltenham
- The Council is opposed to permanent closure or downgrading of Accident and Emergency (A&E) facilities at CGH

Report author:	**Contact officer:** Darren Knight **Tel:** 01242 264387 **Email:** Darren.knight@cheltenham.gov.uk
Appendices:	**Appendix 1:** One-Gloucestershire-Fit-for-the-Future-Engagement-Booklet-Aug 2019 **Appendix 2:** Fit for the Future Consultation Presentation
Background information:	https://www.onegloucestershire.net/yoursay/fit-for-the-future/ Overview & Scrutiny Committee Minutes from September 2019 - https://democracy.cheltenham.gov.uk/documents/g2989/Public%20reports%20pack%2021st-Oct-2019%2018.00%20Overview%20Scrutiny%20Committee.pdf?T=10

Risk Assessment

Appendix 1

The risk				Original risk score (impact x likelihood)			Managing risk				
Risk ref.	Risk description	Risk Owner	Date raised	Impact 1-5	Likeli-hood 1-6	Score	Control	Action	Deadline	Responsible officer	Transferred to risk register
1	Council not agreeing a united response to the Fit for the Future Consultation	Darren Knight	16/11/2020	4	1	4	Motion agreed in the 16/11/2020 to take a report back to Council before the consultation period ends	Council report prepared for full Council consideration	25/11/2020	Darren Knight	N/A

Explanatory notes

Impact – an assessment of the impact if the risk occurs on a scale of 1-5 (1 being least impact and 5 being major or critical)

Likelihood – how likely is it that the risk will occur on a scale of 1-6

(1 being almost impossible, 2 is very low, 3 is low, 4 significant, 5 high and 6 a very high probability)

Control - Either: Reduce / Accept / Transfer to 3rd party / Close

Written Response from Cllr Martin Horwood

Cllr Martin Horwood
Liberal Democrat Cheltenham Borough Councillor for Leckhampton ward, Leckhampton with Warden Hill Parish Councillor and Member of the countywide Health Overview & Scrutiny Committee

Liberal Democrats
Cheltenham

Response to the **Fit for the Future** consultation on specialist hospital services in Gloucestershire by *One Gloucestershire*, December 2020

The timing and nature of this consultation

Along with all local representatives, I am deeply grateful to NHS frontline and support staff and management at this difficult time and recognise the heroic efforts made to provide care while simultaneously coping with higher than normal levels of illness and absence themselves.

It is partly for this reason that, as I argued strongly at the county Health Overview& Scrutiny Committee (HOSC) last month, the timing of these proposed changes and this consultation during the second peak of a pandemic which is so severely testing local hospital services and which should surely be the sole focus of NHS management at this time.

The pandemic has caused huge short-term disruption and reconfiguration of the services under discussion, raising serious capacity and resilience issues from which valuable lessons may be drawn once the pandemic has subsided - but not by this week.

We do not yet know what 'the new normal' will look like. It is striking that the consultation document makes no reference to preparedness for or resilience to future pandemics.

The national lockdown and local Tier 2 restrictions during the consultation period have all but ruled out face to face questions and consultation (and challenge) leaving residents with only an online survey largely composed of leading questions inviting people to support or oppose 'centres of excellence' (who would want to oppose a centre of excellence'?) and the print versions of which confusingly appear to consult Cheltenham residents on the future of services in the Forest of Dean. Some statements in the consultation booklet seem almost deliberately misleading (on p45 it says that 'there is state of the art CT scanning machine at GRH (only 5 of these new CT scanners in the country)' without mentioning that one of the others is next door to Cheltenham General at the highly advanced Cobalt imaging centre.

A sub-standard consultation will inevitably undermine confidence in the outcome of the consultation.

I would urge NHS management, even at this late stage, to reconsider the wisdom and timing of consulting on and proceeding with such major configuration at this time.

Cheltenham context

Cheltenham had a population of 115,000 recorded in the 2011 census[1] but is likely to have grown to well over 120,000 by 2021. Along with another 150-2000,000 people in the east of the county, it has been served by local services at a district general hospital since 1839. I can find no other British town or city of comparable size without a fully fledged district general hospital but these proposals would represent the most significant downgrade in services at Cheltenham ever made. The rationale for them must therefore be beyond doubt.

[1] All data in this section from Gloucestershire County Council District Profile at https://inform.gloucestershire.gov.uk/media/1521158/cheltenham-1.pdf

Although Cheltenham has an affluent reputation and enjoys higher than average levels of education, health and wellbeing, the borough nevertheless contains a range of incomes, ages and levels of need:

- According to the overall Index of Multiple Deprivation, **8 of Cheltenham's lower super-output areas (LSOAs) are amongst the most deprived 20% in England.**
- **11 of Cheltenham's LSOAs are amongst the most deprived 20% in England in terms of Income Deprivation Affecting Children.**
- **5 of Cheltenham's LSOAs are amongst the most deprived 20% in England in terms of Income Deprivation Affecting Older People**
- **There were 17,506 people in Cheltenham with a long term health problem or disability that limited their day to day activities, this equates to 15.2% of the total population.**

Distance to local hospital services

It has been a well-established aim of NHS strategies over many years to deliver services closer to home. So with more older residents, more carers and significant minorities living in poverty and/or without access to cars, distances to local hospital services matter to Cheltenham. The tables below show the increased travel distances by car and increased travel times by public transport to each hospital from specific locations in Cheltenham, one with one of the highest deprivation scores and the other with one of the largest proportions of older people[2].

Predictably the differences are very significant. **Travel distances by car to provide lifts as a carer, attend outpatient clinics or visit relatives multiply by nearly eight times** if a service has moved from Cheltenham to Gloucester. This increases costs but more significantly reduces the practicality of visiting and attending as brief round trips turn into major expeditions, especially at peak hours when the A46 and A417 routes to Gloucester become extremely congested, often doubling travel times from less than 20 minutes to as much as 40 minutes making round trips well in excess of an hour - enough to disrupt other plans and commitments such as work and childcare.

The percentage increases by public transport are less - although still two to four times longer - but **for those without cars the absolute times become very significant. 14 minutes to CGH and 14 minutes back to Charlton Kings with a 20 minute visit or appointment can be achieved in a lunch hour. A comparable trip to Gloucestershire Royal and back by public transport takes well over two hours, which is likely to cause much disruption to work, child care or other arrangements.**

Travel distances	Cheltenham General Hospital by car (miles)	Glos Royal Hospital by car (miles)	% diff	CGH by public transport (minutes)	GRH by public transport (minutes)	% diff
Grevil House, Charlton Kings	1.5m	11.9m	**793%**	14 mins	53 mins	**378%**
Clyde Crescent, Whaddon	1.6m	12.2m	**762%**	27 mins	67 mins	**248%**

[2] Sources: Google maps and traveline.info. Public transport times exclude routes involving more than 15 minutes walking time. Sampled at roughly 1500 on a weekday.

So the permanent shifting of any service to Gloucester from Cheltenham will systematically disadvantage Cheltenham residents and particularly those who are elderly, on low incomes who are the most frequent users of hospital services[3].

This does not, of course, mean that no service should ever be centralised or reconfigured to achieve better outcomes but it does place a responsibility on NHS management to make a very strong clinical case for such changes and conduct a proper impact assessment in such cases, in particular assessing whether or not the changes increase health inequalities. No evidence is presented in the consultation document that this has been done and **so I would submit that no changes should proceed until a full impact assessment, including health inequalities, has been done.**

Specific consultation questions

1. **Acute medicine**

The key rationale in the consultation document for the closure of the acute medical beds at Cheltenham General appears to be that 'we struggle to recruit enough medical and nursing staff which makes it difficult to fully staff both hospitals' (p27). Alarming as this is, it only supports the further conclusion that 'patients are more likely to receive timely assessment, diagnosis and treatment when they arrive at hospital' if there is sufficient capacity at Gloucester.

I am mindful of the expert opinion of the REACH campaign[4] that

> 'acute medical patients comprise the large majority of all emergency admissions to UK hospitals. Moreover, many of these acute medical patients end up having lengthy hospital stays due to the increasing complex comorbidity seen in older patients. In addition, acute medical patients account for the largest proportion of seriously ill patients requiring treatment in Intensive Care Units (ICU). There can be significant large peaks in demand, which are not confined solely to the winter.
>
> Hence, the centralisation of the acute medical take onto a single site at Gloucestershire Royal Hospital (GRH) will place very significant pressure on bed availability, even with the planned expansion of the acute admissions unit at GRH. Large peak influxes of acute medical patients will lead to a lack of bed capacity and blocks the Emergency Department (ED), which can no longer transfer sick patients into a hospital bed and thus create capacity for new patients to be seen in the ED.'

These fears seem well-founded given the evidence provided to HOSC of capacity pressures at GRH revealed in the chart on the next page of already poor and now deteriorating A&E waiting times at Gloucester (red dots)[5], which reflect admission capacity issues within GRH as much as demand for ED services or staffing pressures at Gloucester (the trend line continues downwards even after the closure of CGH A&E in June and during the lightest phase of the pandemic in July and August.

It is laudable to aim to create a centre of excellence for acute medicine in Gloucester but no evidence is presented beyond the simplistic chart on p 31 that Cheltenham is failing in acute medicine or that the trust could not aspire to a centre of excellence on each district general hospital site.

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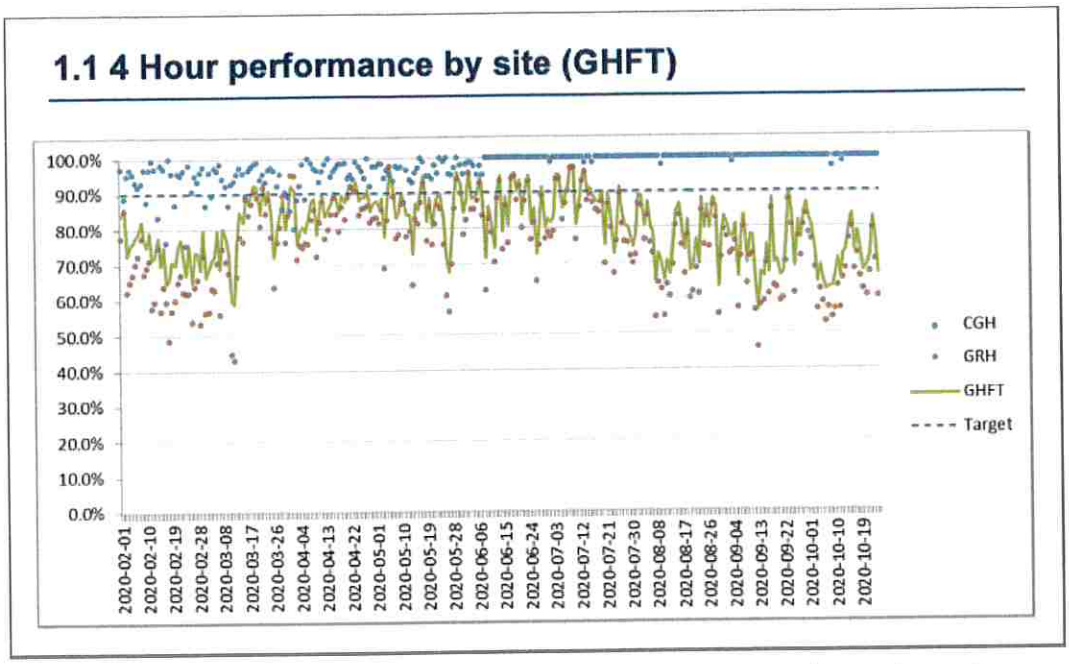
4 Response by REACH to the One Gloucestershire consultation Fit for the Future [REACH, November 2020]

5 Gloucestershire CCG Performance report November 2020, Health Overview & Scrutiny Committee 17 November 2020



The concerns from the feedback exercise outlined on p28 include capacity and equal access as highlighted above but these are not answered in the consultation document.

- Furthermore the evaluation criteria presented in the consultation document include:
- patient choice
- making access simple
- impact on travel for patients, carers & families and
- improving or maintaining service hours and locations

We are not told how these have been taken into account in the case of the closure of 24 acute beds at Cheltenham - which ostensibly fails on all these criteria.

Given the close links set out in the consultation document itself between the Emergency Departments and the acute medical beds, and if Cheltenham A&E is indeed to re-open, there seems an obvious risk of this proposal also failing the test of the criteria of transfer of patients between sites and travel times and risk which will inevitably be higher if an acutely ill patient has to be transferred from Cheltenham ED to an acute medical bed in Gloucester to be admitted.

There are some rationales given for the change but some of these are obviously self-fulfilling, such as 'many patients will need to be seen by different specialists when attending the hospital. It is becoming increasingly difficult to meet these needs across the two hospitals'. This is of course increasingly bound to be true if more and more services are centralised on one site or the other.

On the evidence presented therefore, I support option A1 and strongly oppose the closure of the acute medical beds at Cheltenham and their centralisation of the acute medical take at Gloucester.

2. **General Surgery**

I am once again mindful of the expert opinions of REACH that there is a trend towards the separation of elective and emergency general surgery on different sites and that

> 'if the GHNHSFT decides to proceed with the centralisation of emergency general surgery at GRH, it is vital that all elective surgical activity is centralised at CGH, so that elective patients can be treated without disruption from emergency bed pressures or indeed future pandemics.
>
> REACH strongly believes that elective major colorectal surgery should be centralised onto a single site at CGH. This centralisation will help to create a large elective Cancer Hospital, with reference to major pelvic surgery. Patients with gynaecological, urological and large bowel cancer may develop cancers which involves different neighbouring organs and

require expert joint surgical procedures between gynaecologists, urologists, and colorectal surgeons. The co-location of such a pelvic cancer [centre] with the Oncology Centre would facilitate high quality multidisciplinary care of complex cancer patients. Also, patients with complex inflammatory bowel disease can be managed in co-ordination with on-site gastroenterologists.'

I personally met with many clinicians about the loss of all general surgery at Cheltenham the last time this was suggested[6], and they strongly highlighted the inter-relationships and real-time on-site collaboration between general surgery and urologists, oncologists, anaesthetists and other specialists. Although the Hospitals Trust maintains there is now wide clinical support for this change, this was asserted the last time and when tested through such private meetings with clinicians, there was found to be very significant clinical opposition. Testing the Trust's assertion in this way is impossible under the current circumstances, not least because it would detract from vital medical work at present in any case.

It seems to me that option C3 - centralising *emergency* general surgery in Gloucester - can accord with good practice but if and only if it is combined with Option C5 and C11 to centralise planned lower GI surgery and day case general surgery at Cheltenham. I support that combination of options and would further commend REACH's recommendation of centralising all elective general surgery at Cheltenham.

3. Other services

The consultation also asks for views on the further extension of the 'centre of excellence' model to image guided interventional surgery (GIS), vascular surgery, trauma and orthopaedics.

On each of these categories, I'm again mindful of the expert opinions of REACH:

- In the case of **vascular surgery**, the case is put that vascular surgery is now recommended for co-location with trauma services and acute medical take but of course if acute medical take is still located in Cheltenham, this case is weakened. REACH makes a particularly powerful case for the retention of vascular surgery in purpose-built facilities at Cheltenham and indeed for its centralisation at Cheltenham if the 'centre of excellence' strategy is to be pursued:

  > 'REACH would recommend that arterial vascular surgery services remain at CGH, where a £2.5 million bespoke large footprint hybrid vascular theatre was commissioned just over five years ago...we understand that the vast majority of consultant vascular surgeons in the county would prefer to continue the arterial vascular service at the CGH, where the correct infrastructure with the hybrid vascular theatre is available. This would also be consistent with any future resilience planning to separate elective and emergency care. As the vast majority of arterial vascular surgery is elective, it would seem entirely reasonable that this should be located at the elective Centre of Excellence at the CGH.'

- The consultation document suggests there is strong evidence for more efficient centralisation of **Image Guided Interventional Surgery (IGIS)** on one site but offers no particular rationale for this being at Gloucester rather than Cheltenham. Indeed the engagement feedback it reports (on p46) accepts the feedback supported one site but not *which one*.

  REACH on the other hand makes a strong case for the location of the IGIS 'hub' to be at Cheltenham, co-located with the oncology centre, and the 'spoke' at Gloucester:

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[6] https://www.gloucestershirelive.co.uk/news/cheltenham-news/hospital-pilot-plans-centralise-general-2826113

'Although interventional radiology services should be available in every district general hospital site, the majority of non-vascular interventional radiology procedures (both in hours and out of hours) are performed on urology and oncology patients. Both of these patient cohorts are located in CGH.

Hence, REACH would recommend that the main interventional radiology hub should be located at CGH, where the majority of non-vascular interventional radiology cases are performed. An interventional radiology spoke should also be available at Gloucester, as some patients, albeit fewer in number, may also require interventional radiology input during their hospital stay. '

There is a further rationale for locating imaging-led services at Cheltenham which is the presence there of the Cobalt charity's unique Imaging Centre which houses a high definition 3.0 Tesla MRI scanner and a state-of-the-art PET/CT scanner and is the base for Cobalt's fleet of six mobile MRI scanners, including two of Europe's first and only 3.0 Tesla MRI scanners and new 1.5 Tesla wide bore MRI systems, which, they say, 'have increased patient comfort, shorter scanning times and deliver superior image quality.'

A Centre of Excellence in vascular surgery and IGIS in Cheltenham seems perfectly achievable and rational and I believe this should be consulted upon alongside the options offered. I therefore reject both options B1 and B2.

The further questions on Trauma and Orthopaedics depend on the proper evaluation of the pilot already being conducted. There seems to be real dispute from REACH on the validity of the data and conclusions from this pilot and so I would like to reserve judgement on these questions.

I'm very grateful for the opportunity to comment on this consultation, the reservations expressed above about its timing and wisdom notwithstanding.

Martin Horwood
December 2020

Written Response from Leckhampton with Warden Hill Parish Council

Leckhampton with Warden Hill Parish Council

Response to the **Fit for the Future** consultation on specialist hospital services in Gloucestershire by *One Gloucestershire*, December 2020

The timing and nature of this consultation

The council would like to place on record its gratitude to NHS frontline and support staff and management at this difficult time and recognises the heroic efforts made to provide care while simultaneously coping with higher than normal levels of illness and absence themselves.

It is partly for this reason that the council regrets the timing of these proposed changes and this consultation during the second peak of a pandemic which is so severely testing local hospital services and which should surely be the sole focus of NHS management at this time.

The pandemic has caused huge short-term disruption and reconfiguration of the services under discussion, raising serious capacity and resilience issues from which valuable lessons may be drawn once the pandemic has subsided - but not by this week.

The national lockdown and local Tier 2 restrictions during the consultation period have all but ruled out face to face questions and consultation (and challenge) leaving residents with only an online survey largely composed of leading questions inviting people to support or oppose 'centres of excellence' (who would want to oppose a centre of excellence'?) and the print versions of which confusingly appear to consult Leckhampton and Warden Hill residents on the future of services in the Forest of Dean. Some statements in the consultation booklet seem almost deliberately misleading (on p45 it says that 'there is state of the art CT scanning machine at GRH (only 5 of these new CT scanners in the country)' without mentioning that one of the others is next door to Cheltenham General at the highly advanced Cobalt imaging centre.

A sub-standard consultation will inevitably undermine confidence in the outcome of the consultation.

We invite NHS management, even at this stage, to reconsider the wisdom and timing of consulting on and proceeding with such major configuration at this time.

About Leckhampton and Warden Hill

Leckhampton with Warden Hill is a largely urban parish to the south of Cheltenham Borough. It is almost exactly equivalent to the county council division of the same name which has a population of 10,950[1]. Although Leckhampton in particular contains some of the most affluent neighbourhoods in the county and enjoys higher than average levels of education, health and wellbeing, the two wards of the parish nevertheless contain a range of incomes, ages and levels of need:

- **24% of our population is over 65** (2,620 people) and 27.5% of our households are pensioner households (1,305), both significantly higher than the England average. The percentage claiming attendance allowance (13.6%, 355) is only fractionally below the England average.
- **14% of our households have no car**, 9% of local children live in poverty and 5.2% of local people claim working age DWP benefits. 1,133 local households fall into the 30% most deprived in England by Multiple Indices of Deprivation. These are all lower percentages than the

[1] All data in this section from Gloucestershire County Council Local Insight Profile 2017 https://www.gloucestershire.gov.uk/media/1521194/leckhampton-and-warden-hill-2017.pdf

national or county averages but nevertheless represent **thousands of local people living in relative deprivation.**

- Combining some of this data, 554 pensioner households in Leckhampton & Warden Hill (38% of the total number) have no car.
- **10.8% of local people (1,159) are providing unpaid care, higher than the England average.**
- 0.8% of local people (90) live in care settings, higher than the England average.

Although Leckhampton & Warden Hill residents enjoy generally better than average health, we have higher than average rates of breast cancer (120, national average = 100) and prostate cancer (120) and **higher rates of emergency admission for coronary heart disease (83) and myocardial infarction (98) than the county average.**

Distance to local hospital services

It has been a well-established aim of NHS strategies over many years to deliver services closer to home. So with more older residents, more carers and significant minorities living in poverty and/or without access to cars, distances to local hospital services matter to Leckhampton & Warden Hill. The tables below show the increased travel distances by car and increased travel times by public transport to each hospital from each ward of the parish[2].

Predictably the differences are very significant. **Travel distances by car to provide lifts as a carer, attend outpatient clinics or visit relatives multiply by four or five times** if a service has moved from Cheltenham to Gloucester. This increases costs but more significantly reduces the practicality of visiting and attending as brief round trips turn into major expeditions, especially at peak hours when the A46 and A417 routes to Gloucester become extremely congested, often doubling travel times from less than 20 minutes to as much as 40 minutes making round trips well in excess of an hour - enough to disrupt other plans and commitments such as work and childcare.

The percentage increases by public transport are less - two to four times longer - but **for those without cars the absolute times become very significant. 20 minutes to CGH and 20 minutes back to Leckhampton with a 20 minute visit or appointment can be achieved in a lunch hour. A comparable trip to Gloucestershire Royal by public transport takes nearly three hours, massively disrupting work, child care or other arrangements.**

Travel distances	Cheltenham General Hospital by car (miles)	Glos Royal Hospital by car (miles)	% diff	CGH by public transport (minutes)	GRH by public transport (minutes)	% diff
Warden Hill shops, Salisbury Avenue	1.6m	8.2m	**512%**	20 mins	43 mins	**215%**
Leckhampton Primary School, Hall Road	1.8m	8.2m	**456%**	20 mins	74 mins	**370%**

[2] Sources: Google maps and traveline.info. Public transport times exclude routes involving more than 15 minutes walking time. Sampled at roughly 1500 on a weekday.

So the permanent shifting of any service to Gloucester from Cheltenham will systematically disadvantage Leckhampton with Warden Hill residents and particularly those who are elderly, on low incomes who are the most frequent users of hospital services[3].

This does not, of course, mean that no service should ever be centralised or reconfigured to achieve better outcomes but it does place a responsibility on NHS management to make a very strong clinical case for such changes and conduct a proper impact assessment in such cases, in particular assessing whether or not the changes increase health inequalities. No evidence is presented in the consultation document that this has been done and **the council believes no changes should proceed until a full impact assessment, including health inequalities, has been done.**

Specific consultation questions

1. **Acute medicine**

The key rationale in the consultation document for the closure of the acute medical beds at Cheltenham General appears to be that 'we struggle to recruit enough medical and nursing staff which makes it difficult to fully staff both hospitals' (p27). Alarming as this is, it only supports the further conclusion that 'patients are more likely to receive timely assessment, diagnosis and treatment when they arrive at hospital' if there is sufficient capacity at Gloucester.

The council is mindful of the expert opinion of the REACH campaign[4] that

> 'acute medical patients comprise the large majority of all emergency admissions to UK hospitals. Moreover, many of these acute medical patients end up having lengthy hospital stays due to the increasing complex comorbidity seen in older patients. In addition, acute medical patients account for the largest proportion of seriously ill patients requiring treatment in Intensive Care Units (ICU). There can be significant large peaks in demand, which are not confined solely to the winter.
>
> Hence, the centralisation of the acute medical take onto a single site at Gloucestershire Royal Hospital (GRH) will place very significant pressure on bed availability, even with the planned expansion of the acute admissions unit at GRH. Large peak influxes of acute medical patients will lead to a lack of bed capacity and blocks the Emergency Department (ED), which can no longer transfer sick patients into a hospital bed and thus create capacity for new patients to be seen in the ED.'

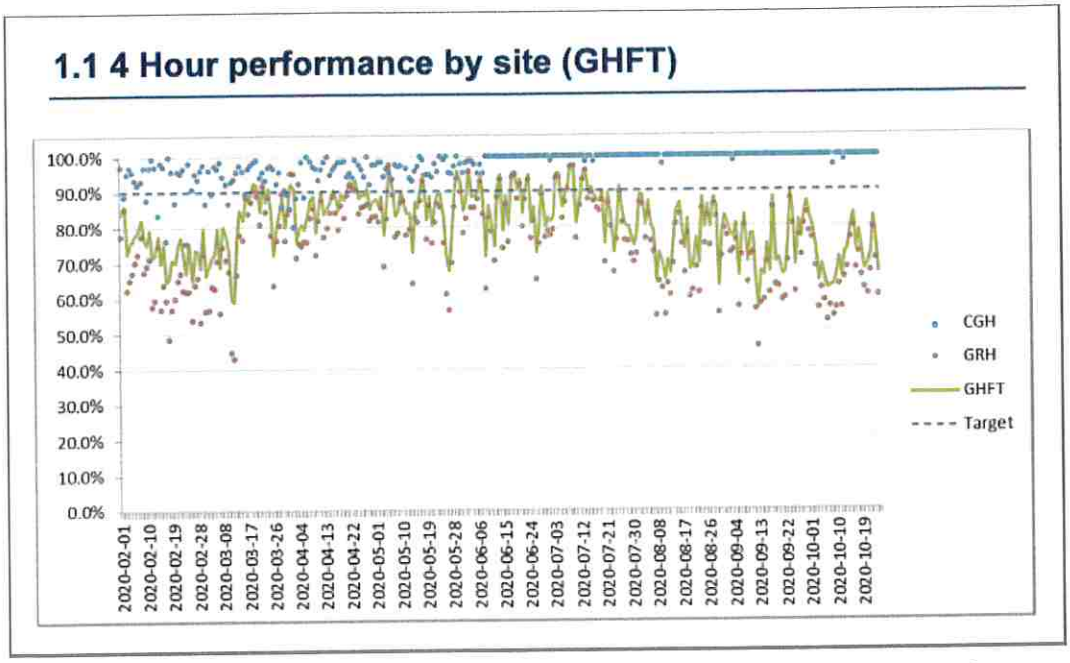
These fears seem well-founded given the evidence provided to the county HOSC committee of capacity pressures at GRH revealed in the chart on the next page of already poor and now deteriorating A&E waiting times at Gloucester (red dots)[5], which reflect admission capacity issues within GRH as much as demand for ED services or staffing pressures at Gloucester (the trend line continues downwards even after the closure of CGH A&E in June and during the lightest phase of the pandemic in July and August.

It is laudable to aim to create a centre of excellence for acute medicine in Gloucester but no evidence is presented beyond the simplistic chart on p 31 that Cheltenham is failing in acute medicine or that the trust could not aspire to a centre of excellence on each district general hospital site.

3

4 Response by REACH to the One Gloucestershire consultation Fit for the Future [REACH, November 2020]

5 Gloucestershire CCG Performance report November 2020, Health Overview & Scrutiny Committee 17 November 2020



The concerns from the feedback exercise outlined on p28 include capacity and equal access as highlighted above but these are not answered in the consultation document.

- Furthermore the evaluation criteria presented in the consultation document include:
- patient choice
- making access simple
- impact on travel for patients, carers & families and
- improving or maintaining service hours and locations

We are not told how these have been taken into account in the case of the closure of 24 acute beds at Cheltenham - which ostensibly fails on all these criteria.

Given the close links set out in the consultation document itself between the Emergency Departments and the acute medical beds, and if Cheltenham A&E is indeed to re-open, there seems an obvious risk of this proposal also failing the test of the criteria of transfer of patients between sites and travel times and risk which will inevitably be higher if an acutely ill patient has to be transferred from Cheltenham ED to an acute medical bed in Gloucester to be admitted.

There are some rationales given for the change but some of these are obviously self-fulfilling, such as 'many patients will need to be seen by different specialists when attending the hospital. It is becoming increasingly difficult to meet these needs across the two hospitals'. This is of course increasingly bound to be true if more and more services are centralised on one site or the other.

On the evidence presented therefore, this council supports option A1 and strongly opposes the closure of the acute medical beds at Cheltenham and their centralisation of the acute medical take at Gloucester.

2. **General Surgery**

The council is again mindful of the expert opinions of REACH that there is a trend towards the separation of elective and emergency general surgery on different sites and that

> 'if the GHNHSFT decides to proceed with the centralisation of emergency general surgery at GRH, it is vital that all elective surgical activity is centralised at CGH, so that elective patients can be treated without disruption from emergency bed pressures or indeed future pandemics.
>
> REACH strongly believes that elective major colorectal surgery should be centralised onto a single site at CGH. This centralisation will help to create a large elective Cancer Hospital, with reference to major pelvic surgery. Patients with gynaecological, urological and large bowel cancer may develop cancers which involves different neighbouring organs and

require expert joint surgical procedures between gynaecologists, urologists, and colorectal surgeons. The co-location of such a pelvic cancer [centre] with the Oncology Centre would facilitate high quality multidisciplinary care of complex cancer patients. Also, patients with complex inflammatory bowel disease can be managed in co-ordination with on-site gastroenterologists.'

There were well-publicised concerns expressed by many clinicians about the loss of all general surgery at Cheltenham the last time this was suggested[6], which highlighted the inter-relationships and real-time on-site collaboration between general surgery and urologists, oncologists, anaesthetists and other specialists. Although the Hospitals Trust maintains there is now wide clinical support for this change, this was asserted the last time and when tested through private meetings with clinicians, there was found to be very significant clinical opposition. Testing the Trust's assertion in this way is impossible under the current circumstances, not least because it would detract from vital medical work at present in any case.

It seems to this council that option C3 - centralising *emergency* general surgery in Gloucester - can accord with good practice but if and only if it is combined with Option C5 and C11 to centralise planned lower GI surgery and day case general surgery at Cheltenham. This council supports that combination of options and would further commend REACH's recommendation of centralising <u>all</u> elective general surgery at Cheltenham.

3. Other services

The consultation also asks for views on the further extension of the 'centre of excellence' model to image guided interventional surgery (GIS), vascular surgery, trauma and orthopaedics.

On each of these categories, the council is again mindful of the expert opinions of REACH:

- In the case of **vascular surgery**, the case is put that vascular surgery is now recommended for co-location with trauma services and acute medical take but of course if acute medical take is still located in Cheltenham, this case is weakened. REACH makes a particularly powerful case for the retention of vascular surgery in purpose-built facilities at Cheltenham and indeed for its centralisation at Cheltenham if the 'centre of excellence' strategy is to be pursued:

  > 'REACH would recommend that arterial vascular surgery services remain at CGH, where a £2.5 million bespoke large footprint hybrid vascular theatre was commissioned just over five years ago…we understand that the vast majority of consultant vascular surgeons in the county would prefer to continue the arterial vascular service at the CGH, where the correct infrastructure with the hybrid vascular theatre is available. This would also be consistent with any future resilience planning to separate elective and emergency care. As the vast majority of arterial vascular surgery is elective, it would seem entirely reasonable that this should be located at the elective Centre of Excellence at the CGH.'

- The consultation document suggests there is strong evidence for more efficient centralisation of **Image Guided Interventional Surgery (IGIS)** on one site but offers no particular rationale for this being at Gloucester rather than Cheltenham. Indeed the engagement feedback it reports (on p46) accepts the feedback supported one site but not *which one*.

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[6] https://www.gloucestershirelive.co.uk/news/cheltenham-news/hospital-pilot-plans-centralise-general-2826113

REACH on the other hand makes a strong case for the location of the IGIS 'hub' to be at Cheltenham, co-located with the oncology centre, and the 'spoke' at Gloucester:

> 'Although interventional radiology services should be available in every district general hospital site, the majority of non-vascular interventional radiology procedures (both in hours and out of hours) are performed on urology and oncology patients. Both of these patient cohorts are located in CGH.
>
> Hence, REACH would recommend that the main interventional radiology hub should be located at CGH, where the majority of non-vascular interventional radiology cases are performed. An interventional radiology spoke should also be available at Gloucester, as some patients, albeit fewer in number, may also require interventional radiology input during their hospital stay. '

There is a further rationale for locating imaging-led services at Cheltenham which is the presence there of the Cobalt charity's unique Imaging Centre which houses a high definition 3.0 Tesla MRI scanner and a state-of-the-art PET/CT scanner and is the base for Cobalt's fleet of six mobile MRI scanners, including two of Europe's first and only 3.0 Tesla MRI scanners and new 1.5 Tesla wide bore MRI systems, which, they say, 'have increased patient comfort, shorter scanning times and deliver superior image quality.'

A Centre of Excellence in vascular surgery and IGIS in Cheltenham seems perfectly achievable and rational and the council believes this should be consulted upon alongside the options offered. We thus reject both options B1 and B2.

The further questions on Trauma and Orthopaedics depend on the proper evaluation of the pilot already being conducted. There seems to be real dispute from REACH on the validity of the data and conclusions from this pilot and so the council reserves its judgement on these questions.

We are grateful for the opportunity to comment on this consultation, the reservations expressed above about its timing and wisdom notwithstanding.

Leckhampton with Warden Hill Parish Council
December 2020

Written response from REACH and:

- **REACH "Non-Medical" persons' explanation of some of the Fit for the Future key points**
- **REACH Report on interim REACH survey results, 17 December 2020**

REACH

RESPONSE BY REACH TO THE ONE GLOUCESTERSHIRE CONSULTATION *FIT FOR THE FUTURE* [2020]

1. Acute Medicine (Acute Medical Take) (Section A)

1.1 Acute medical patients comprise the large majority of all emergency admissions to UK hospitals. Moreover, many of these acute medical patients end up have lengthy hospital stays due to the increasing complex comorbidity seen in older patients. In addition, acute medical patients account for the largest proportion of seriously ill patients requiring treatment in Intensive Care Units (ICU). There can be significant large peaks in demand, which are not confined solely to the winter.

1.2 Hence, the centralisation of the acute medical take onto a single site at Gloucestershire Royal Hospital (GRH) will place very significant pressure on bed availability, even with the planned expansion of the acute admissions unit at GRH. Large peak influxes of acute medical patients will lead to a lack of bed capacity and blocks the Emergency Department (ED), which can no longer transfer sick patients into a hospital bed and thus create capacity for new patients to be seen in the ED.

1.3 Furthermore, but bed shortages created by peaks in acute medical emergency demand also create significant problems for the ICU at GRH. If hospital beds in normal wards are full, recovering patients in the ICU cannot be discharged to a normal ward due to a lack of beds. Thus, the centralisation of the acute medical take to a single site at GRH will also place significant pressure on the capacity of the ICU.

1.4 In order for any such acute medical take centralisation to be successful, the Trust must make every effort to transfer elective activity to Cheltenham General Hospital (CGH), in order to create sufficient bed capacity to absorb large peaks in emergency acute medical demand.

1.5 If the acute medical take is centralised to GRH, the Gloucestershire Hospitals NHS Foundation Trust (GHNHSFT) will have to make provision for robust emergency medical cover at CGH. As that hospital has over four hundred inpatients, some of these patients will develop acute medical emergencies during their stay and require urgent expert assistance.

1.6 In addition, the GHNHSFT has made a firm commitment to reopening the Type I ED at CGH once the COVID-19 pandemic has settled. If the ED at CGH is to remain viable, on-site availability of emergency physicians will be required to ensure that patients attending the Cheltenham ED can be managed appropriately.

1.7 Therefore, any proposal under *Fit for the Future* regarding acute medicine must ensure adequate twenty four hour provision of emergency medical care to support the inpatient population at Cheltenham as well as the ED on the east side of the county.

1.8 Whilst REACH would prefer to see the option of a continuing acute medical take at Cheltenham, REACH recognises the need for future resilience planning to allow local healthcare to continue in case of any future pandemic or health emergency.

2. Gastroenterology Inpatient Services (Section B)

2.1 REACH fully supports the option of centralising gastroenterology inpatient services at CGH. It is important to view the management of gastrointestinal conditions in a multidisciplinary fashion with input from both physicians (gastroenterologists) and colorectal surgeons. Co-locating inpatient gastroenterology with a centre for major elective colorectal surgery in Cheltenham will provide an integrated service for patients with bowel disease.

3. General Surgery (Section C)

3.1 The GHNHSFT has contrasted the options of developing a Centre of Excellence for Pelvic Surgery in Cheltenham with the other option of creating a Centre of Excellence for General Surgery in Gloucester. The concept of a Centre of Excellence for General Surgery is an oxymoron, as every acute hospital has General Surgery facilities.

3.2 REACH strongly believes that the GHNHSFT should develop a Centre of Excellence for Cancer at Cheltenham. CGH is a highly regarded Cancer Centre with facilities to deliver modern radiotherapy and systemic treatments. As the modern care of cancer patients involves careful coordination between surgeons and oncologists, REACH believes that the GHNHSFT should create a multidisciplinary Cancer Hospital in Cheltenham, which might over time bear comparison with the world-famous Royal Marsden Hospital in London and Christie Hospital in Manchester.

3.3 The creation of an elective Centre of Excellence for Cancer with co-located surgery and oncology would also afforded a degree of protection for cancer services in the face of any future pandemic threat.

4. Emergency General Surgery (Section Ci)

4.1 REACH recognises the national trend to separate emergency and elective surgical services. The COVID-19 pandemic has highlighted this need. Numerous national bodies including NHS England, GiRFT and the Royal College of Surgeons of England have all recommended the separation of emergency and elective surgical services, preferably on different hospital sites.

4.2 When this current pandemic has settled, REACH recognises the need to ensure future resilience in the health care provision for patients in the county. Hence, although REACH believes that emergency general surgical patients have being equally well treated on both acute hospital sites, REACH understands the potential benefits of centralising emergency general surgery.

4.3 However, the centralisation of emergency general surgery and the acute medical take onto a single site at GRH will only amplify the significant bed pressures in that unit. Hence, if the GHNHSFT decides to proceed with the centralisation of emergency general surgery at GRH, it is vital that all elective surgical activity is centralised at CGH, so that elective patients can be treated without disruption from emergency bed pressures or indeed future pandemics.

5. Elective Major Colorectal Surgery (Section Cii)

5.1 REACH strongly believes that elective major colorectal surgery should be centralised onto a single site at CGH. This centralisation will help to create a large elective Cancer Hospital, with reference to major pelvic surgery. Patients with gynaecological, urological and large bowel cancer may develop cancers which involves different neighbouring organs and require expert joint surgical procedures between

gynaecsologists, urologists, and colorectal surgeons. The co-location of such a pelvic cancer with the Oncology Centre would facilitate high quality multidisciplinary care of complex cancer patients. Also, patients with complex inflammatory bowel disease can be managed in coordination with on-site gastroenterologists.

5.2 The separation of planned major surgery on to an elective site will mean that patients requiring bowel cancer surgery are not subject to disruption or delays due to insufficient beds. In addition, such as separation of emergency and elective work will provide further resilience in case of future pandemics or healthcare emergencies.

5.3 In fact, REACH believes that this principle of separation of emergency and elective work should extend beyond the limited field of colorectal surgery. The COVID-19 pandemic has highlighted the need for long-term resilience planning with separation of emergency and elective patient cohorts on different sites. We hope that the GHNHSFT will share REACH's vision for the creation of a world-class cancer hospital in Cheltenham with the centralisation of planned cancer surgery and oncology on a single site.

6. Image Guided Interventional Surgery (Section D)

6.1 This heading incorporates several categories of patient groups, all of which require separate review and planning.

7. Vascular surgery, specifically arterial vascular surgery (Section Di)

7.1 Patients with aortic and peripheral vascular disease are managed by vascular surgeons in conjunction with interventional radiologists. Indeed, some vascular surgeons are now skilled in interventional vascular radiological procedures, and there is significant crossover in roles between vascular surgeons and interventional radiologists.

7.2 What some patients with peripheral or aortic vascular disease can be managed with interventional radiology e.g. angioplasty, stent insertion, or EVAR, there is a significant proportion of patients with arterial vascular disease, who still require open surgery such as aneurysm repair or vascular bypass. In fact, the vast majority of patients with vascular disease have their treatment either as planned elective surgery or as urgent, but not emergency cases.

7.3 Whilst previous commissioning documents have recommended the co-location of emergency and elected vascular services on a single site, the COVID-19 pandemic has changed national advice. The Vascular GiRFT document recommended in early June 2020 that emergency and elective vascular services should be separated, preferably on separate physical hospital sites.

7.4 REACH understands the desire for the GHNHSFT to centralise emergency services onto the GRH site. The number of true vascular emergency cases has fallen and continues to fall in light of aortic aneurysm screening and reductions in cigarette smoking in the local population. REACH understands that the number of true vascular emergencies, such as ruptured aortic aneurysms, numbers significantly less than 20 cases per year across Gloucestershire and Wiltshire.

7.5 As almost all arterial vascular cases are undertaken either as true elective or as urgent elective cases, REACH would recommend that arterial vascular surgery services remain at CGH, where a £2.5 million bespoke large footprint hybrid vascular theatre was commissioned just over five years ago. The GHNHSFT has always trumpeted the fact that decisions are led by its clinicians. We understand that the vast majority of consultant vascular surgeons in the county would prefer to continue the arterial vascular

service at the CGH, where the correct infrastructure with the hybrid vascular theatre is available. This would also be consistent with any future resilience planning to separate elective and emergency care. As the vast majority of arterial vascular surgery is elective, it would seem entirely reasonable that this should be located at the elective Centre of Excellence at the CGH.

8. Non-vascular interventional radiology (Section Dii)

8.1 The majority of non-vascular interventional radiology cases involve stenting of the urological tract in cases of ureteric obstruction. This situation can occur in patients with abdominal or pelvic malignancy, as well as in patients with benign kidney stone disease. A smaller proportion of patients with biliary obstruction may also require stenting, but many of these patients can be successfully treated by endoscopic guided stunting (ERCP) rather than interventional radiology.

8.2 Emergency interventional radiology procedures most commonly involve emergency stenting of blocked ureters for urosepsis, although occasionally emergency interventional drainage for biliary sepsis may be required.

8.3 Although interventional radiology services should be available in every district general hospital site, the majority of non-vascular interventional radiology procedures (both in hours and out of hours) are performed on urology and oncology patients. Both of these patient cohorts are located in CGH.

8.4 Hence, REACH would recommend that the main interventional radiology hub should be located iat CGH, where the majority of non-vascular interventional radiology cases are performed. An interventional radiology spoke should also be available at Gloucester, as some patients, albeit fewer in number, may also require interventional radiology input during their hospital stay.

9. Interventional cardiology (Section Diii)

9.1 Over the last three decades, there has been an increased use of interventional cardiology procedures, such as angioplasty and stent insertion. Much of this occurs as planned elective procedures for patients with ischaemic heart disease. However, emergency angioplasty all percutaneous coronary intervention (PCI) is now the preferred treatment for patients presenting with acute myocardial infarction or heart attack.

9.2 More recently, further interventional radiology procedures had been developed for patients with cardiac arrhythmia, in order to allow minimally invasive ablation of aberrant conduction pathways. The majority of interventional cardiac interventions are performed on either an elective or urgent elective basis.

9.3 For patients requiring emergency intervention for a myocardial infarction or heart attack, the most important aspect is the "door to balloon time". It is vital for patients suffering a heart attack that the interventional cardiac procedure is performed as soon as possible after arrival in hospital, in order to minimise the damage to the cardiac muscle and the long-term sequelae of the cardiac injury.

9.4 The 2013 NHS England Commissioning Document for PCI (A09/S/d) emphasised the need to minimise the "door to balloon time". It also indicates that the best outcomes occur in units, where patients with suspected heart attack are delivered directly to the cardiac intervention unit or so-called "catheter lab" without passing through an ED, where delays will adversely affect the outcome for the patient. There are protocols in

place for paramedic crews to contact the on-call cardiology team directly on attendance at the scene with the casualty, so that patients can be directed properly to the cardiology department.

9.5 Therefore, REACH believes that the interventional cardiology service could be equally placed at either the CGH or the GGH and that the public consultation should take into account both options.

10. Trauma and orthopaedic inpatient services (T&O) (Section E)

10.1 Approximately three years ago, the GHNHSFT Introduced a T&O Pilot Scheme, which centralised emergency orthopaedic trauma cases in GRH, whilst transferring all elective planned orthopaedic procedures to CGH.

10.2 Over the last three years, this T&O Pilot Scheme has led to an improvement in the timeliness of planned elective orthopaedic procedures at CGH.

10.3 However, the centralisation of orthopaedic trauma at GRH, has not been a startling success. One of the key performance indicators for an orthopaedic trauma department is the outcome for patients presenting with a hip fracture (fractured neck of femur or FNF). One of the key guiding principles is to ensure that patients with a FNF have appropriate surgery either on the day of the injury or on the following day i.e. within twenty four hours (see *NICE 2011 Guidance on Management of Hip Fracture*). Timely surgery leads to rapid recovery and low thirty day post-operative mortality. However, delays in surgery lead to prolonged hospital stays and an increased 30-day mortality.

10.4 Prior to the institution of the T&O Pilot Scheme, the time to surgery and thirty day post-operative mortality for FNF patients operated on at CGH was good, with this unit comparable to its peers nationally. However, the Trauma unit at GRH was one of the worst performers in the South-West prior to the changes.

10.5 REACH understands that there are still major concerns regarding the management of patients with FNF in Gloucestershire, following the centralisation of trauma orthopaedic surgery at the GRH. Whilst the centralisation has led to some improvements, such as joint care with care of the elderly physicians, problems with bed and theatre capacity have led to continuing delays in timely surgery for some patients.

10.5 In addition, internal audits performed in the T&O Department at the GHNHSFT have also shown that the management of upper limb trauma patients (fractured wrists) deteriorated markedly following the institution of the T&O Pilot Scheme. Indeed, a significant proportion of patients required a change in management due to the delays in managing the fractures. The institution of virtual fracture clinics has not completely solved this problem.

10.6 Another internal audit on the management of lower limb and ankle fractures has also shown significant concerns. The audit has shown again that a number of patients face unacceptable delays in time to surgery, such that the management of ankle fractures in these cases is changed significantly.

10.6 REACH is aware that the GHNHSFT Trust has publicised the success of the T&O Pilot Scheme. We are also aware that statutory consultees, such as HOSC, have repeatedly requested patient outcome data regarding the trauma service, but these results have not been made public.

10.7 We would hope that the GHNHSFT will publish comparative outcome data regarding the management of fractured neck of femur, lower limb and ankle fractures, and upper limb fractures for further scrutiny. Data for these key performance groups of trauma patients should be made available for both hospitals prior to the institution of the T&O Pilot Scheme, as well as outcome data during the pilot period. The success or otherwise of this Pilot Scheme should be judged on objective outcome data.

10.8 REACH believes that the proposal to convert the T&O Pilot Scheme into a permanent service change requires detailed and careful consideration, as REACH believes that the Pilot Scheme has not been a total success. The Pilot Scheme has led to improvements in elective planned orthopaedic surgery, but REACH believes that significant concern remains in respect of the management of orthopaedic trauma patients in th
e county.

11. Cheltenham General Hospital's Emergency Department (Section F)

11.1 REACH is pleased that the GHNHSFT is committed to the restoration of the ED at CGH to its pre-COVID-19 configuration i.e. as a Type I Department between 08.00 hours and 20.00 hours and as an overnight nurse led unit between 20.00 hours and 08.00 hours.

11.1 As indicated above, REACH would like reassurances from the GHNHSFT that the CGH ED will continue to receive adequate support from acute medicine and emergency surgery, in order for it to remain viable in the long term. Indeed, in due course REACH would like the GHNHSFT to consider reopening the CGH ED to its pre-2013 twenty four hour status.

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REACH

"Non Medical" persons' explanation of some of the Fit for the Future key points

What is the purpose of the Consultation?

Gloucestershire Hospitals and Clinical Commissioning Group would like to reorganise hospital services between Gloucestershire Royal Hospital (GRH) and Cheltenham General Hospital (CGH).

They have created the concept of "Centres of Excellence". This concept is essentially centralisation of a particular specialty or service on either the GRH or CGH site, meaning that that service would no longer be available in the other hospital. Whilst the hospital has suggested that this would provide "excellent" care, there is little to suggest that the quality of care in the current configuration is anything other than good or excellent.

Whilst the centralisation of any particular specialty might improve the quality of care slightly, such a reorganisation would also inevitably mean that half of the County would need to travel further for this specialist care in each circumstance.

Some of the centralisations would require very large numbers of inpatient or overnight hospital beds (e.g. the highest number being acute medicine, followed by emergency surgery and trauma orthopaedics), whereas some of the proposals, such as day surgery, would require no inpatient beds, as the definition of day surgery is that patients go home on the same day. Understanding the implications for hospital bed requirements with each proposal is important, as it is essential that the hospital beds on both sites are used effectively for the benefit of all the local population.

Please note that the Consultation does not include the Cheltenham A & E Department, as the Hospital Trust is committed to re-opening Cheltenham General A & E after the pandemic.

1. ACUTE MEDICINE (ACUTE MEDICAL TAKE)

The Trust would like to centralise the admission of all emergency medical patients to GRH. Until the recent temporary COVID changes, emergency medical patients (such as those presenting with heart problems, pneumonia, stroke, sepsis, confusion etc) were admitted to both GRH and CGH. This change would mean that medical emergency patients from the Eastern half of the County would have to travel further for care.

Please note that the number of acute medical patients constitutes by far the largest number of emergency admissions in any hospital. In previous years, daily medical admissions of between 30 to 60 patients at both Cheltenham and Gloucester would not have been unusual, particularly during the winter period. Hence, centralising emergency medical admissions to GRH will require a large number of hospital beds at that site. This needs to be borne in mind when considering other proposals, which might centralise inpatient services further at GRH.

2. CENTRALISATION OF EMERGENCY GENERAL SURGERY AT GLOUCESTERSHIRE ROYAL HOSPITAL

General surgery is a specialty in its own right, and includes the care of patients with upper gastrointestinal (gullet, stomach, liver, and gallbladder), lower gastrointestinal/colorectal (small and large intestine), breast surgery, and vascular surgery (dealing with patients with blocked or diseased arteries and veins).

Up until the recent temporary COVID changes, patients requiring emergency general surgical care were treated at both GRH and CGH. Emergency surgical problems include appendicitis, peritonitis, inflamed gallbladders, bowel blockage, and internal bleeding. National audits showed that emergency patients at both sites received good or excellent care.

The Trust would like to centralise the admission and treatment of all emergency surgical patients at Gloucester and would like to close the emergency surgical service at Cheltenham. Centralising emergency general surgery at GRH would require a reasonable number of extra inpatient/overnight beds at Gloucester, and would free up the equivalent number of inpatient/overnight beds at Cheltenham, which could potentially be used for a number of major inpatient service. This would particularly affect patients on the eastern side of Gloucestershire, who would normally access the emergency general surgery service at Cheltenham.

3. CENTRALISATION OF PLANNED LOWER GASTROINTESTINAL (COLORECTAL) SURGERY ON ONE SITE

A large proportion of patients having planned lower gastrointestinal (colorectal) surgery are patients with large bowel (colon or rectal) cancer. These specialist surgeons also operate on patients with inflammatory bowel disease (ulcerative colitis or Crohn's disease), as well as repairing large abdominal hernias (which are not suitable for day case surgery). Patients with other problems, such as ovarian, womb or bladder cancer may also require the specialist input of colorectal surgeons, as these particular tumours can grow around the large intestine.

Currently, this group of patients are treated on both GRH and CGH sites. Patients with ovarian, womb, bladder, prostate and kidney cancer have their cancer operations performed in Cheltenham, and there are no plans to alter this service. Centralising this service on a single site would require a moderate number of inpatient/ overnight hospital beds. Please note that the Cancer Centre for Gloucestershire, Herefordshire and Worcestershire (Three Counties Cancer Centre) Is located at Cheltenham.

5. CENTRALISATION OF PLANNED DAY CASE OPERATIONS FOR UPPER AND LOWER GI SURGERY AT CHELTENHAM GENERAL HOSPITAL

This centralisation involves the care of patients having day case procedures such as routine hernia repair, gallbladder removal, haemorrhoid surgery, and endoscopy (gastroscopy and colonoscopy). Currently, these procedures are performed at Gloucestershire Royal Hospital, Cheltenham General Hospital, as well as in the community hospitals, such as Cirencester, Tetbury, Tewkesbury and Stroud General. Day case procedures are usually low risk operations, and can be delivered safely in both community and district general hospitals.

As these patients are day cases, there will be no requirement for overnight beds, as it is anticipated the patients will be discharged on the day of surgery. Therefore, centralisation of day case operations at Cheltenham General Hospital is unlikely to create significant numbers of free inpatient/overnight beds at Gloucestershire Royal Hospital.

6. IMAGE GUIDED INTERVENTIONAL SURGERY (IGIS)

Image guided interventional surgery covers a number of specialties, which involve both planned and emergency care. The IGIS grouping, as described by the Trust, is not a grouping of specialties, which is widely recognised in its own right. The services, which the Trust would like to centralise, are described below.

Interventional radiology

Over the last 30 to 40 years, X-ray specialists or radiologists have performed procedures under local anaesthetic, which involve the insertion of tubes or drains. These procedures are known as interventional radiology. The most common type of procedure is to drain an infected blocked kidney either by inserting a tube from the bladder up to the kidney (ureteric stent) or by inserting a tube directly through the skin into the blocked kidney (nephrostomy). Less commonly, radiologists may need to insert tubes to drain a blocked gallbladder or liver and sometimes a drain may be needed to treat a patient with a large abscess inside the torso.

The Trust describes a "hub and spoke" model. The "hub" is the main central unit, which performs most of the procedures. The "spoke" is the secondary unit at the other hospital, which provides a facility for occasional emergency or urgent procedures.

The most common interventional radiology procedure involves draining a blocked kidney. Emergency patients with infected blocked kidneys most commonly present via the urology or oncology services, which are located in Cheltenham. A smaller number of emergency procedures are performed in Gloucester.

7. INTERVENTIONAL MINIMALLY INVASIVE VASCULAR RADIOLOGY/SURGERY

Traditionally patients with blocked or diseased arteries were treated with an open operation to bypass or repair the affected artery. Over the last 20 years or so, radiologists and vascular surgeons have together developed new techniques to unblock diseased arteries from inside the artery itself. This is performed by inserting a tube or catheter into a good part of the artery away from the disease, guiding this catheter under x-ray control until it is in the diseased artery, and then opening up or repairing the artery from within.

Patients with vascular disease are usually treated either in a planned way or as an urgent procedure within a day or two of admission. Emergency treatment at night time is rarely required. About 6 years ago, the Trust built and commissioned a new state-of-the-art £2.5 million hybrid vascular interventional operating theatre at Cheltenham General. This purpose-built, large footprint operating theatre is regarded by many as being one of the very best in the South West of England.

8. INTERVENTIONAL CARDIOLOGY

For 30 to 40 years, heart specialists or cardiologists have been performing specialist interventional procedures to diagnose and treat heart problems. Initially, these procedures involved inserting a catheter or tube via an artery in the groin or elbow, so that special dye can be injected into the coronary arteries feeding the heart, thus diagnosing blockages or narrowing in the coronary arteries.

More recently, new techniques have allowed the cardiologists not only to diagnose blockages in the coronary arteries, but also to stretch the blockages back open (angioplasty) and to insert a self opening liner (stent) to keep the blockage open. These procedures are known as Percutaneous Coronary Intervention (PCI). PCI is usually performed as a planned a day case procedure for patients with known heart disease, but sometimes these techniques are required in the middle of the night as an emergency for patients, who are suffering a heart attack. Emergency heart-attack patients are usually diagnosed with a heart tracing performed by the paramedic ambulance crews, and this heart tracing can be forwarded electronically to the heart specialists as the ambulance leaves the scene.

Currently, the majority of the planned PCI procedures in Gloucestershire are performed at Cheltenham in the Hartpury Suite. Some of the emergency procedures for heart attack patients are also performed there. Until recently, some of the out of hours heart-attack patients were treated in Bristol, but the Trust would like to develop a robust 24/7 service for the County. Importantly, the national guidance suggests that heart attack patients do better, if they are not delayed in a busy Accident and Emergency department.

9. INPATIENT VASCULAR SURGERY

Vascular surgeons treat patients with blocked or narrowed arteries, as well as conditions such as varicose veins. The vast majority of vascular surgical inpatients comprise patients with badly narrowed arteries in the leg or disease in the main artery (aorta). The majority of arterial vascular operations are performed in a planned manner or at worst in an urgent scenario within 24 to 48 hours of admission. The numbers of emergency vascular operations in the middle of the night are now vanishingly small.

Although interventional vascular radiology/surgery procedures are performed in a number of patients with blocked or narrowed arteries, there is still a need for patients to have an open operation under general anaesthetic. Until the temporary COVID changes came in earlier this year, planned inpatient vascular surgery was performed at both hospitals, although the majority of interventional vascular radiology/surgical cases were performed in the £2.5 million state-of-the-art hybrid interventional radiology/vascular theatre at Cheltenham however the Trust is seeking to centralise this service on one site. The number of vascular inpatient beds required for this service is moderate.

10. GASTROENTEROLOGY PLANNED INPATIENT SERVICES

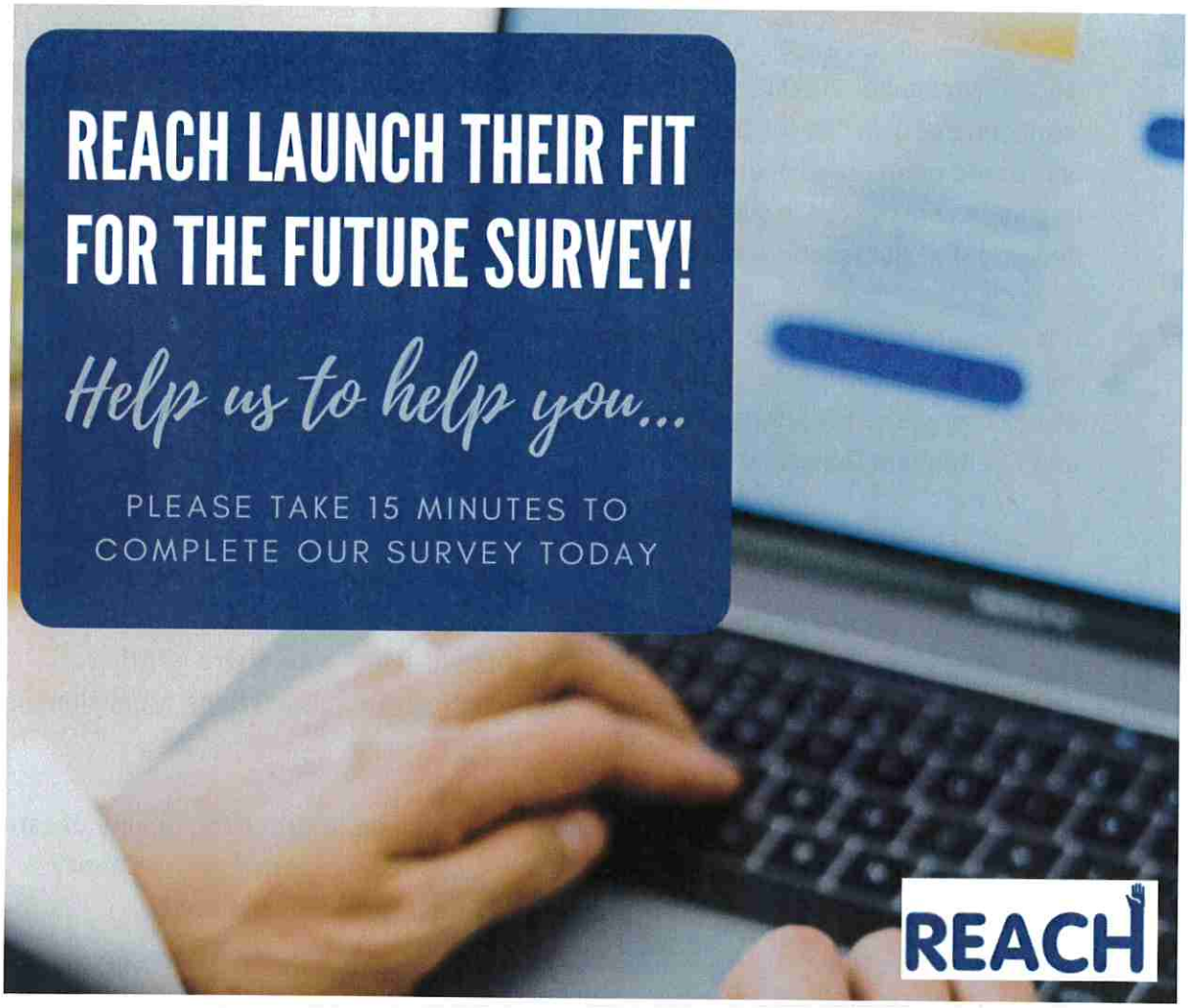
The Trust is planning to centralise planned admissions for patients with gastroenterology (gut/ liver medical) conditions. The number of patients, who are admitted as inpatients/overnight for planned investigations for gut problems is very small. On the contrary, more patients are admitted with emergency gastroenterology problems, such as vomiting blood, jaundice etc. The management of these emergency gastroenterology problems is not the subject of this consultation.

There are advantages in co-locating the gastroenterology service with the major inpatient lower gastrointestinal/colorectal surgery service, as some patients may require attention from both the medical and surgical gut specialists. REACH believes that colorectal and bowel cancer surgery would be best centralised at Cheltenham alongside the Cancer Centre.

11. TRAUMA AND ORTHOPAEDICS (T & O) INPATIENT SERVICES

Three years ago, the Trust Instituted a "Pilot Study", which centralised orthopaedic trauma (fractured bones) patients at Gloucester, whilst concentrating planned orthopaedic surgery at Cheltenham (except for major spinal surgery, which remained in Gloucester). Although the Trust labelled this as a "Pilot Study", the Trust has not presented any objective results of this "Pilot" for public scrutiny.

Whilst patients having planned orthopaedic operations in Cheltenham have generally had this performed efficiently, the results of the Trauma service in Gloucester have apparently not been as successful. Pressure on beds and operating time has led to continuing delays in performing surgery on trauma patients at Gloucester in a prompt fashion; delays in surgery can lead to worse outcomes. In spite of this uncertainty about whether the "Pilot Study" has been successful, the Trust would like to make this arrangement for Trauma services in Gloucester and planned orthopaedic care in Cheltenham permanent.



REPORT ON INTERIM RESULTS

17 December 2020

1. Foreword by Michael Ratcliffe MBE – Chairman of REACH

On 19th November 2020 Restore Emergency at Cheltenham General Surgery (REACH) launched our own "Fit for the Future" survey. The rationale for producing the survey was based upon our concern that the One Gloucestershire Fit for the Future survey, had been constructed in such a manner that the results could be used to justify a decision that the respondents would not have supported.

It is worth reflecting at this point what the purpose of the "Fit for the Future" consultation is. Gloucestershire Hospitals and Clinical Commissioning Group would like to reorganise hospital services between Gloucestershire Royal Hospital (GRH) and Cheltenham General Hospital (CGH).

They have created the concept of "Centres of Excellence". This concept is essentially centralisation of a particular specialty or service on either the GRH or CGH site, meaning that service would no longer be available in the other hospital. Whilst the hospital has suggested that this would provide "excellent" care, there is little to suggest that the quality of care in the current configuration is anything other than good or excellent.

Whilst the centralisation of any particular specialty might improve the quality of care slightly, such a reorganisation would also inevitably mean that half of the County would need to travel further for this specialist care in each circumstance.

Some of the centralisations would require very large numbers of inpatient or overnight hospital beds (e.g. the highest number being acute medicine, followed by emergency surgery and trauma orthopaedics), whereas some of the proposals, such as day surgery, would require no inpatient beds, as the definition of day surgery is that patients go home on the same day. Understanding the implications for hospital bed requirements with each proposal is important, as it is essential that the hospital beds on both sites are used effectively for the benefit of all the local population.

One point that we cannot nor should we overlook is the fact that the Consultation does not include the Cheltenham A & E Department, as the Hospital Trust has committed itself to re-opening Cheltenham General A & E after the pandemic.

We launched our own survey, to gather the real preferences of those local people in Gloucestershire and surrounding areas, who will be affected by these proposals. We would like to thank everybody who has taken the time and trouble respond to our survey. The issues addressed in the survey are complex and as a consequence required quite a bit of explanation, hence the length of our survey.

We believe it is vital that the public can actively engage in this consultation. We are not convinced that the One Gloucestershire survey enables the public to express clear responses to some of the key points, which is why we chose to produce our own Fit for the Future survey.

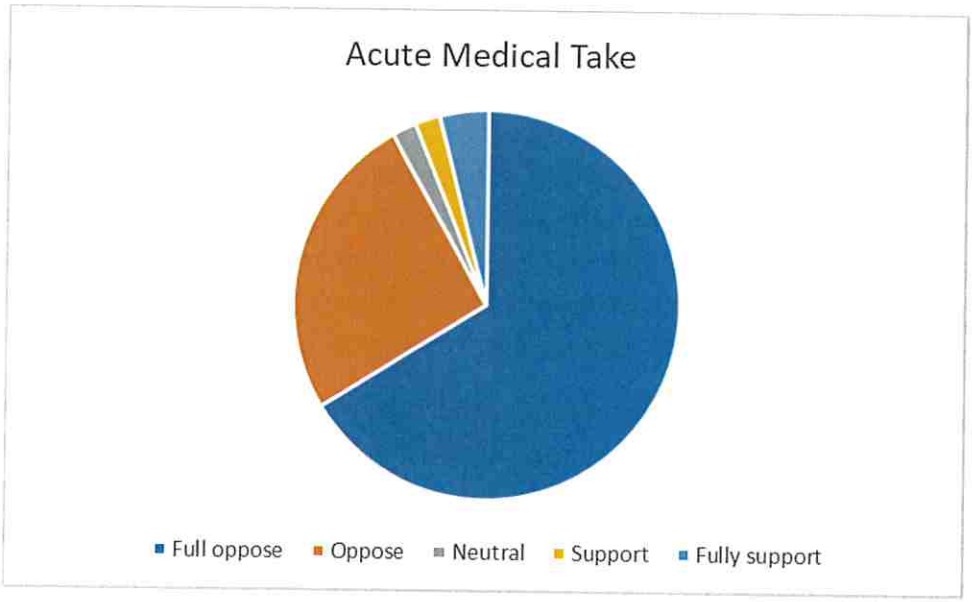
Interim Results

Question 1 ACUTE MEDICINE (ACUTE MEDICAL TAKE)

The Trust would like to centralise the admission of all emergency medical patients to GRH. Until the recent temporary COVID changes, emergency medical patients (such as those presenting with heart problems, pneumonia, stroke, sepsis, confusion etc) were admitted to both GRH and CGH. This change would mean that medical emergency patients from the Eastern half of the County would have to travel further for care.

Please note that the number of acute medical patients constitutes by far the largest number of emergency admissions in any hospital. In previous years, daily medical admissions of between 30 to 60 patients at both Cheltenham and Gloucester would not have been unusual, particularly during the winter period. Hence, centralising emergency medical admissions to GRH will require a large number of hospital beds at that site. This needs to be borne in mind when considering other proposals, which might centralise inpatient services further at GRH.

Do you agree with the Trust's preferred option of centralising acute emergency medical patients on to the GRH site?



The public response has been overwhelming, indicating that the people do not support centralisation of the acute medical take or emergency admissions at GRH.

Whilst a few respondents supporting the centralisation have pointed to potentially higher standards of specialist care, the majority of respondents have concerns about lack of bed capacity at GRH, travelling and access to care. One respondent succinctly said that *"It is hard to imagine a General Hospital without acute medical beds. Cheltenham is a General Hospital, it needs to supply beds for both surgical and medical patients. Removing medical beds from Cheltenham is essentially downgrading this hospital and masking it less important, like asset stripping!"*

The response to REACH's public survey indicates that the majority of the public would like to see acute emergency medical patient admissions retained at CGH. One Gloucestershire's argument that centralising emergency medical specialists onto one site to improve care has not been persuasive enough to sway public opinion.

REACH recognises that there may be other factors influencing One Gloucestershire's preferred option, such as staffing and other resources. The Government has pledged to increase nursing and doctor numbers. This has already led to a larger number of medical graduates as well as a large expansion in medical school places and universities offering medical training. Hence any current staffing pressures are likely to be ameliorated in future.

"If this accounts for largest number of admissions surely danger of GRH being overwhelmed?

I absolutely disagree with A&E services being centralised at GRH, you only have to look at what has been going on recently over there to see the mayhem it would cause. It puts unnecessary pressure on the staff at GRH.

I had to go into hospital as an emergency. No ambulance available to take me to GRH. The paramedic took me in his car. GRH full to capacity; lay on a trolley in a corridor for 3 hours before being seen. I could have died and no one would have known.

Ridiculous idea. Preposterous to even think this could work without an increase in bed space. Will this also not increase the workload of the staff at GRH? Are there plans to adequately staff GRH? Nursing staff are leaving and are filled with expensive agency staff. I suspect there is a similar issue with the staffing levels of the doctors. Or are they expected just to get on with it whilst compromising care of constituents.

It is admirable to want to keep all your experts on one site. However, I fear the sheer numbers of people needing to be seen at any one venue are not practicable. Better, surely to see people at two sites, meaning they can be treated in half the time. If in a critical condition, then surely any extra waiting time endangers the patient. That includes transit time.

International evidence shows centres of excellence provide better care for patients. It also helps to recruit the best people to work there. If you have a serious heart attack

in Gloucestershire at present you may be diverted to Bristol as this is where the best treatment is available. What is wrong with wanting that here in Gloucester."

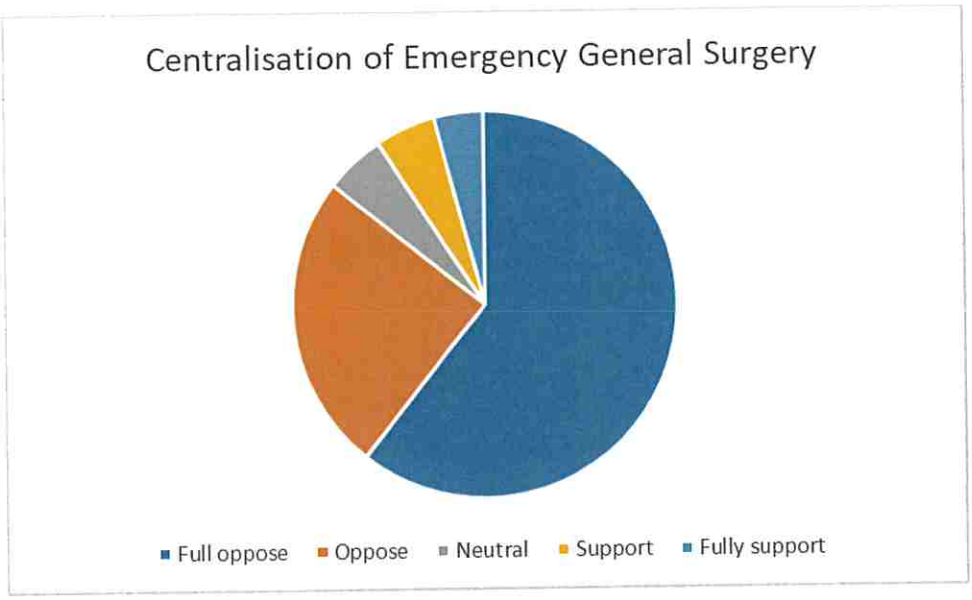
Question 2 CENTRALISATION OF EMERGENCY GENERAL SURGERY AT GLOUCESTERSHIRE ROYAL HOSPITAL

General surgery is a specialty in its own right, and includes the care of patients with upper gastrointestinal (gullet, stomach, liver, and gallbladder), lower gastrointestinal/colorectal (small and large intestine), breast surgery, and vascular surgery (dealing with patients with blocked or diseased arteries and veins).

Up until the recent temporary COVID changes, patients requiring emergency general surgical care were treated at both GRH and CGH. Emergency surgical problems include appendicitis, peritonitis, inflamed gallbladders, bowel blockage, and internal bleeding. National audits showed that emergency patients at both sites received good or excellent care.

The Trust would like to centralise the admission and treatment of all emergency surgical patients at Gloucester and would like to close the emergency surgical service at Cheltenham. Centralising emergency general surgery at GRH would require a reasonable number of extra inpatient/overnight beds at Gloucester, and would free up the equivalent number of inpatient/overnight beds at Cheltenham, which could potentially be used for a number of major inpatient service. This would particularly affect patients on the eastern side of Gloucestershire, who would normally access the emergency general surgery service at Cheltenham.

Do you agree with the Trust's preferred option of centralising acute emergency general surgical patients on to the GRH site?



Public opinion is again not in favour of centralising emergency general surgery onto the GRH site. Only a small minority support One Gloucestershire's preferred option.

The public response has cited concerns over lack of bed capacity at GRH, travelling & access times, the fact that emergency services were excellent previously, and a potential waste of nursing skills at Cheltenham for those nurse whose social circumstances prevent them from working at Gloucester. The increased pressure on Critical Care bed capacity at Gloucester was also highlighted as a concern, whilst the state of the art intensive care at Cheltenham would be under-utilised.

Supporters of the proposal indicate that cooperation and pooling of manpower between GRH and CGH surgeons at one site might lead to improved quality of care with quicker opinions for emergency admissions.

"Where are they going to get all the extra beds from, having been an inpatient last year when there were no beds available, I cannot see how this would work to patients' advantage, in fact I can see people having to wait for 'emergency' surgery with all the risks to their lives that that would bring.

Both sites are capable of providing excellent services; dividing work between the two increases flexibility.

So, essentially work that was performed at 2 sites is now all going to be at GRH alone. Does that mean staffing is still the same as if catering for the needs of 2 hospitals but just at GRH or more likely the poor sods at GRH will be doing double the work they originally would have done. Whilst houses continue to be built and the population continue to expand. This is cost cutting surely whilst stretching I presume an already stretched workforce.

Centralising may be easier for people delivering the service, but means patients nearly always have to travel greater distances. This can mean extreme discomfort for some, me included, but a lot more stress for patients...

This will allow a fully staffed surgical team to manage these patients. They should not have to wait to be seen until a doctor can leave the operating theatre.

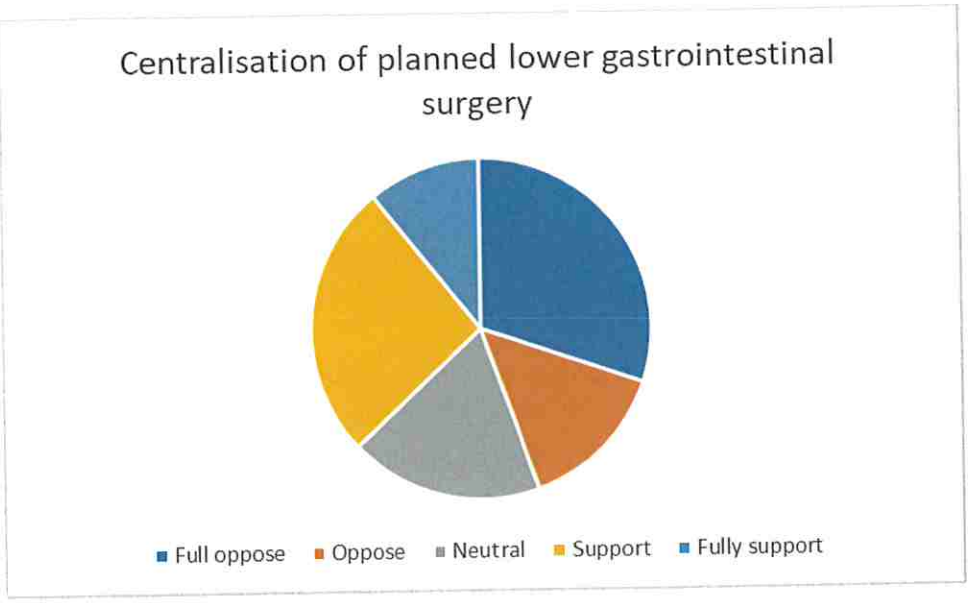
Surgeons presently working at CGH would join colleagues at GRH and be able to share experience and expertise. Cooperation of this sort is important. There is an unfortunate tendency for staff at different hospital sites to feel that they are in competition with each other. Cooperation is always preferable. Moreover, freeing CGH for elective procedures would avoid the all too frequent and distressing cancellation of routine surgery because of an influx of surgical emergencies."

Question 3 CENTRALISATION OF PLANNED LOWER GASTROINTESTINAL (COLORECTAL) SURGERY ON ONE SITE

A large proportion of patients having planned lower gastrointestinal (colorectal) surgery are patients with large bowel (colon or rectal) cancer. These specialist surgeons also operate on patients with inflammatory bowel disease (ulcerative colitis or Crohn's disease), as well as repairing large abdominal hernias (which are not suitable for day case surgery). Patients with other problems, such as ovarian, womb or bladder cancer may also require the specialist input of colorectal surgeons, as these particular tumours can grow around the large intestine.

Currently, this group of patients are treated on both GRH and CGH sites. Patients with ovarian, womb, bladder, prostate and kidney cancer have their cancer operations performed in Cheltenham, and there are no plans to alter this service. Centralising this service on a single site would require a moderate number of inpatient/ overnight hospital beds. Please note that the Cancer Centre for Gloucestershire, Herefordshire and Worcestershire (Three Counties Cancer Centre) Is located at Cheltenham.

Do you agree with the Trust's preferred option of centralising planned lower gastrointestinal/colorectal patients onto a single hospital site?



Public opinion on this issue was split. Notably a significant minority of people were neutral on this topic, as they believed that this should be available at both sites, or that answering this depended on the outcome of the emergency surgery debate. It would appear that the public would ideally prefer to have services as close as possible to home, whether this might be for emergency or elective care.

Supporters of this proposal, however, indicated that this should be centralised in Cheltenham as part of the Cancer Centre.

"*Should all cancer work not be done at Cheltenham where the outstanding cancer service is situated or am I being simplistic?*

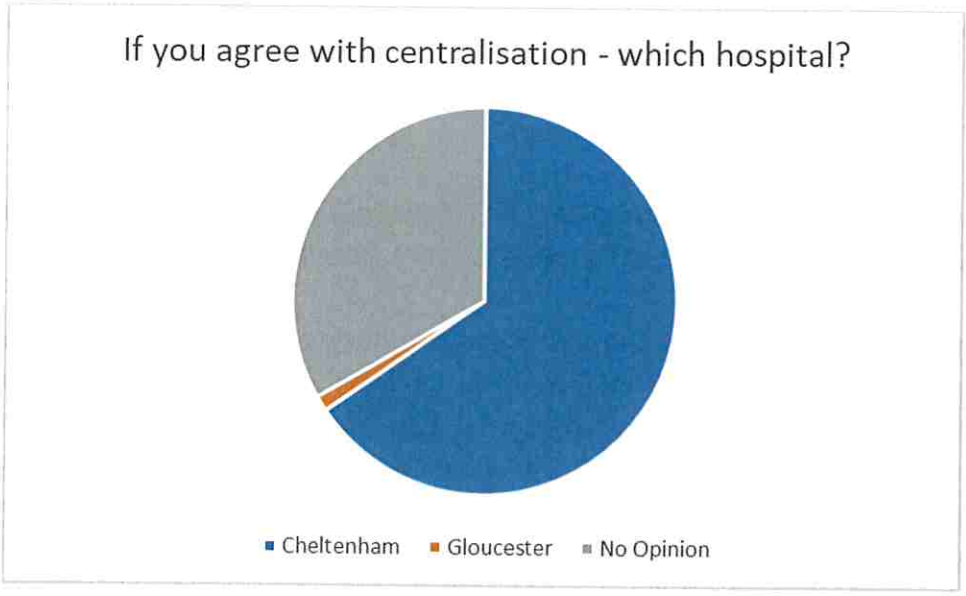
It would be sensible to have this service at CGH with gynecological oncology.

Whilst there may be a case for centralising at Cheltenham - certainly not at GRH - this could only be considered in the light of decisions made on other issues. There seems to me the danger of progressively demoting Cheltenham as a centre of excellence, but there has also to be regard to the needs of patients in the west of the county.

We should have a choice, of hospital.

After opposing centralisation for the first 2 at Gloucester and Cheltenham is my local hospital I can't agree for the people of Gloucester having the same problem of getting to Cheltenham."

Question 4 If you do agree that it would be sensible to centralise planned lower gastrointestinal/colorectal patients onto a single hospital site, which hospital would best deliver this service?



Supporters of centralising colorectal planned patients onto one site overwhelmingly indicated that Cheltenham should be the preferred site for such a proposal. Many respondents cited the importance of co-locating colorectal surgery with the Cancer Centre and patients with other cancer requiring colorectal expertise e.g .gynaecological and urological cancer patients. Some patients were neutral on this question, but this may reflect the respondents to the previous related question, who were not persuaded about centralisation.

"It is important to have experienced surgeons in cancer care who have done many operations. Keeping them on one site would mean that MDT meetings and on call would always have experienced staff. In fact I thought cancer care had to be in one site for an area now.

How will the gynae and urology consultants dealing with cancer be able to enlist the help of general surgeons if there are none on site?

Planned GI surgery should be concentrated on the site where there is already a Centre of Excellence for cancer treatment.

Whilst there may be a case for centralising at Cheltenham - certainly not at GRH - this could only be considered in the light of decisions made on other issues. There seems to me the danger of progressively demoting Cheltenham as a centre of excellence, but there has also to be regard to the needs of patients in the west of the county.

Elective patients currently have a poor service at GRH because if the chaos from the sheer number of emergency patients. They are not in a centre of excellence if the threat of being exposed to Covid is real. CGH colorectal combined with gynae/onc and urology define what a pelvic resection centre should look like. It is then in same

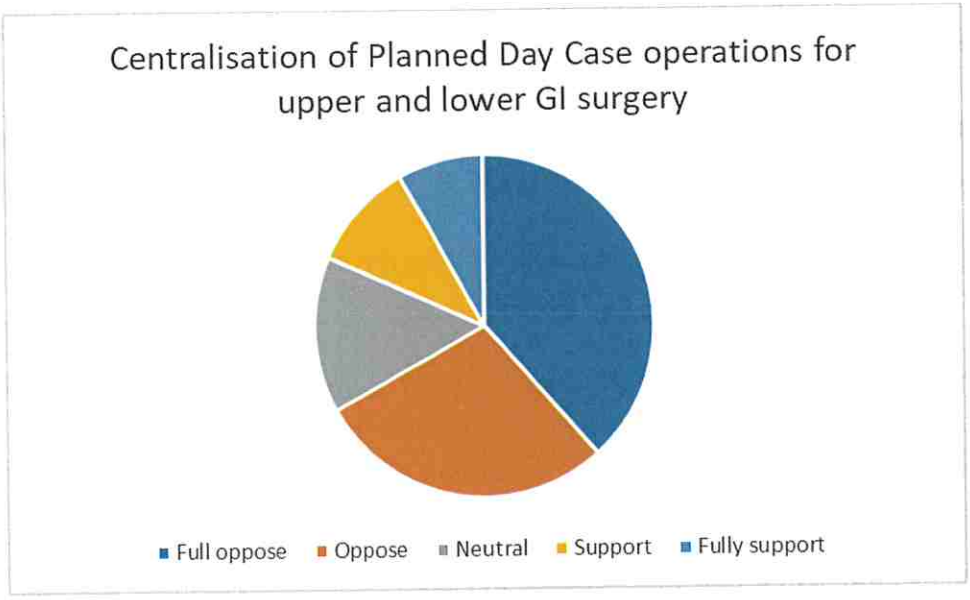
site as oncology. Elective surgery is less likely to be cancelled and CGH can establish itself as a green site pelvic centre of excellence."

Question 5 CENTRALISATION OF PLANNED DAY CASE OPERATIONS FOR UPPER AND LOWER GI SURGERY AT CHELTENHAM GENERAL HOSPITAL

This centralisation involves the care of patients having day case procedures such as routine hernia repair, gallbladder removal, haemorrhoid surgery, and endoscopy (gastroscopy and colonoscopy). Currently, these procedures are performed at Gloucestershire Royal Hospital, Cheltenham General Hospital, as well as in the community hospitals, such as Cirencester, Tetbury, Tewkesbury and Stroud General. Day case procedures are usually low risk operations, and can be delivered safely in both community and district general hospitals.

As these patients are day cases, there will be no requirement for overnight beds, as it is anticipated the patients will be discharged on the day of surgery. Therefore, centralisation of day case operations at Cheltenham General Hospital is unlikely to create significant numbers of free inpatient/overnight beds at Gloucestershire Royal Hospital.

Do you agree with the Trust's preferred option of centralising planned day case upper and lower gastrointestinal patients onto the CGH site, as opposed to continuing day surgery in community hospitals and the two main hospitals?



Public opinion clearly opposes the centralisation of daycase surgery at CGH. The public wants to have daycase surgery performed as close to home as possible, with the community hospitals. This would seem perfectly reasonable, as the delivery of

daycase surgery in community as well as acute hospitals is entirely appropriate patients.

"*With this service being offered at GRH and CGH as well as community hospitals it enables patients to have treatment nearer to their home*

Spreading the workload of minor procedures over many local sites seems sensible and popular with the public who prefer to travel to their nearest site.

Again it seems to me that the system works well at present, and I know that things have to change with progress, but would this progress, if you have lots more patients waiting for day case operations in one place surely this lists will get longer. And it's almost like the Trust is trying to downgrade CGH in the process, giving it less emergency work etc etc.

These day procedures should remain dispersed throughout all the hospitals to reduce demand on a centralised location, freeing up resources for more critical procedures. Dispersal of the service will serve local communities much better and help to ensure the viability of the community hospitals. It seems unnecessary to centralise this service and, (forgive me), appears a bit of a sop to CGH after proposed removal of so many of their services."

Question 6 IMAGE GUIDED INTERVENTIONAL SURGERY (IGIS)

Image guided interventional surgery covers a number of specialties, which involve both planned and emergency care. The IGIS grouping, as described by the Trust, is not a grouping of specialties, which is widely recognised in its own right. The services, which the Trust would like to centralise, are described below.

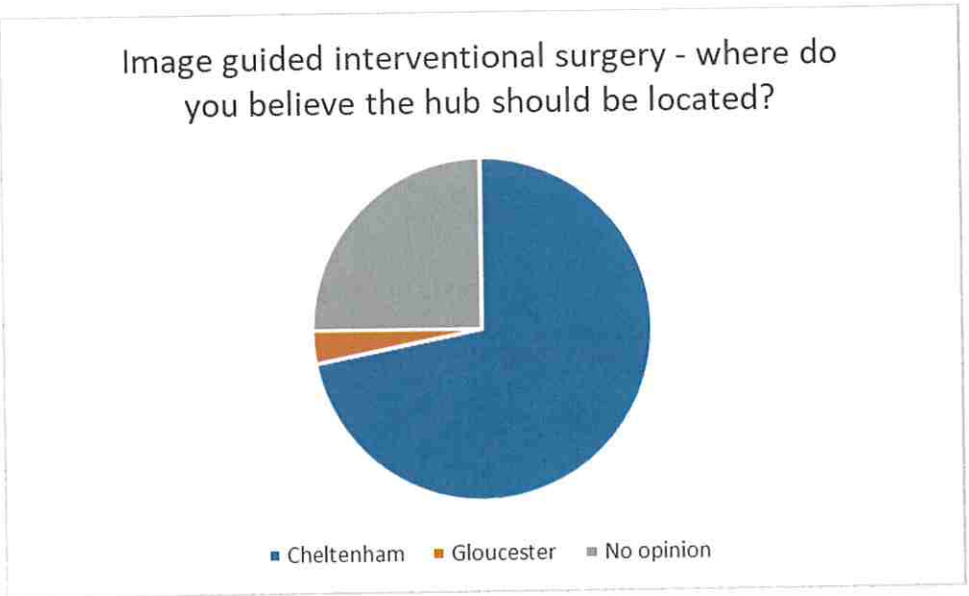
Interventional radiology

Over the last 30 to 40 years, X-ray specialists or radiologists have performed procedures under local anaesthetic, which involve the insertion of tubes or drains. These procedures are known as interventional radiology. The most common type of procedure is to drain an infected blocked kidney either by inserting a tube from the bladder up to the kidney (ureteric stent) or by inserting a tube directly through the skin into the blocked kidney (nephrostomy). Less commonly, radiologists may need to insert tubes to drain a blocked gallbladder or liver and sometimes a drain may be needed to treat a patient with a large abscess inside the torso.

The Trust describes a "hub and spoke" model. The "hub" is the main central unit, which performs most of the procedures. The "spoke" is the secondary unit at the other hospital, which provides a facility for occasional emergency or urgent procedures.

The most common interventional radiology procedure involves draining a blocked kidney. Emergency patients with infected blocked kidneys most commonly present via the urology or oncology services, which are located in Cheltenham. A smaller number of emergency procedures are performed in Gloucester.

Where do you believe that the main interventional radiology centre or "hub" should be located in?



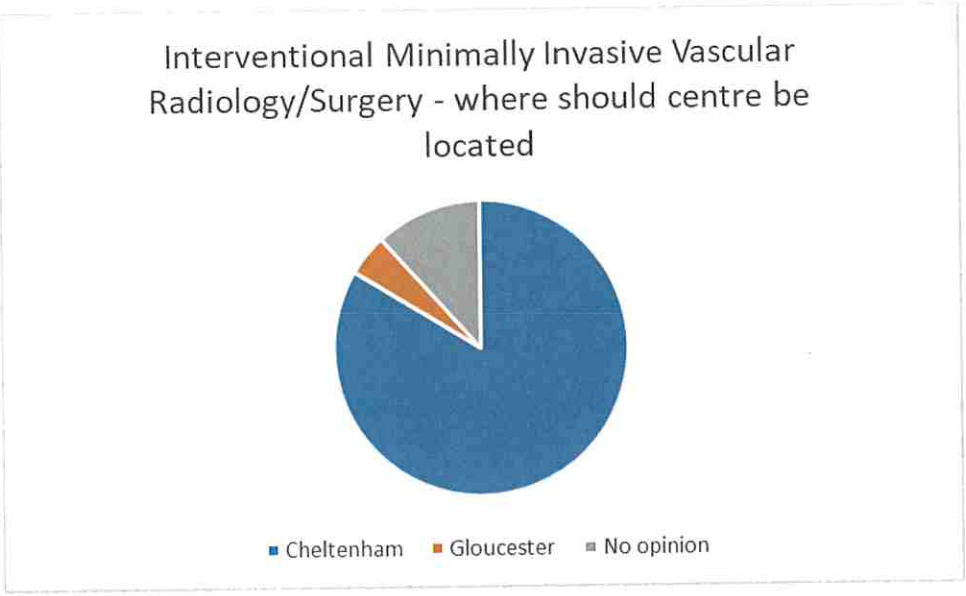
A clear majority of the public replies indicate that the main centre or hub for interventional radiology should be at Cheltenham. The respondents indicating "no opinion" generally said that this service should be provided at both hospitals. The Proposal from One Gloucestershire is for a "hub and spoke" model. Public opinion indicates that the main centre or "hub" should be at Cheltenham with a smaller service or "spoke" at Gloucester.

Question 7 INTERVENTIONAL MINIMALLY INVASIVE VASCULAR RADIOLOGY/SURGERY

Traditionally patients with blocked or diseased arteries were treated with an open operation to bypass or repair the affected artery. Over the last 20 years or so, radiologists and vascular surgeons have together developed new techniques to unblock diseased arteries from inside the artery itself. This is performed by inserting a tube or catheter into a good part of the artery away from the disease, guiding this catheter under x-ray control until it is in the diseased artery, and then opening up or repairing the artery from within.

Patients with vascular disease are usually treated either in a planned way or as an urgent procedure within a day or two of admission. Emergency treatment at night time is rarely required. About 6 years ago, the Trust built and commissioned a new state-of-the-art £2.5 million hybrid vascular interventional operating theatre at Cheltenham General. This purpose-built, large footprint operating theatre is regarded by many as being one of the very best in the South West of England.

Where do you believe that the main vascular interventional radiology/surgery centre should be located in?



The overwhelming public response is that the interventional vascular centre should remain at Cheltenham, maximising the use of the state of the art hybrid interventional operating theatre at CGH.

"*Given the installation of a £2.5 million facility at CGH six years ago it would be hard to justify moving the centre now*

As the Trust built a new state-of-the-art £2.5 million hybrid vascular interventional operating theatre at Cheltenham General, it makes sense for this emergency treatment to remain in Cheltenham General. It would be a waste of taxpayers money to move this state of the art facility.

Millions of pounds have already been spent on this facility in Cheltenham already. It would be a scandalous waste of money to undo this. I understand that the majority of vascular surgeons also support it staying in Cheltenham."

Question 8 INTERVENTIONAL CARDIOLOGY

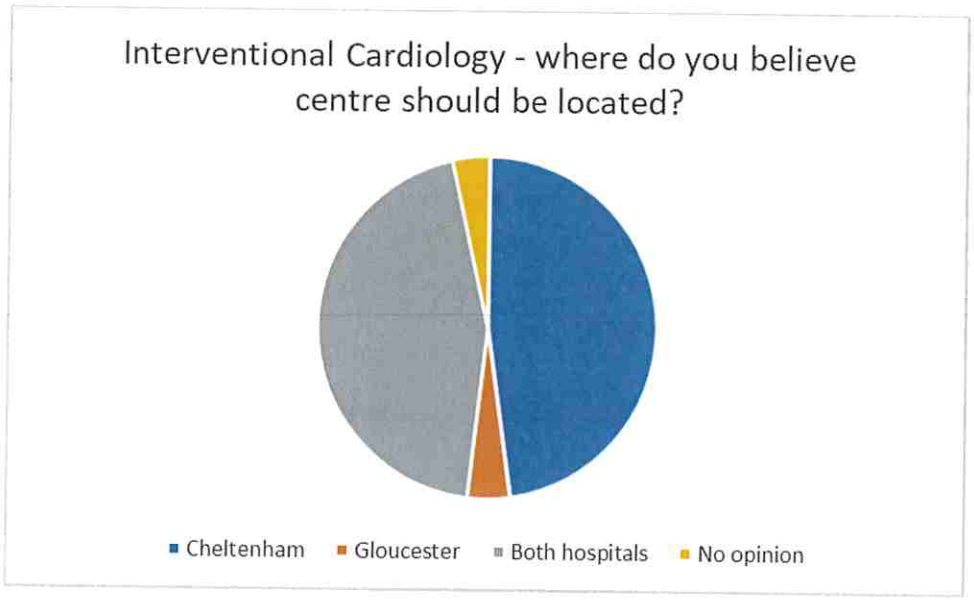
For 30 to 40 years, heart specialists or cardiologists have been performing specialist interventional procedures to diagnose and treat heart problems. Initially, these procedures involved inserting a catheter or tube via an artery in the groin or elbow, so that special dye can be injected into the coronary arteries feeding the heart, thus diagnosing blockages or narrowing in the coronary arteries.

More recently, new techniques have allowed the cardiologists not only to diagnose blockages in the coronary arteries, but also to stretch the blockages back open (angioplasty) and to insert a self opening liner (stent) to keep the blockage open. These procedures are known as Percutaneous Coronary Intervention (PCI). PCI is

usually performed as a planned day case procedure for patients with known heart disease, but sometimes these techniques are required in the middle of the night as an emergency for patients, who are suffering a heart attack. Emergency heart attack patients are usually diagnosed with a heart tracing performed by the paramedic ambulance crews, and this heart tracing can be forwarded electronically to the heart specialists as the ambulance leaves the scene.

Currently, the majority of the planned PCI procedures in Gloucestershire are performed at Cheltenham in the Hartpury Suite. Some of the emergency procedures for heart attack patients are also performed there. Until recently, some of the out of hours heart attack patients were treated in Bristol, but the Trust would like to develop a robust 24/7 service for the County. Importantly, the national guidance suggests that heart attack patients do better, if they are not delayed in a busy Accident and Emergency department.

Where do you believe that the main cardiac interventional radiology/surgery centre should be located in?



The public response was evenly split between between having interventional cardiology at both sites or at Cheltenham alone.

"I think it's vital to have services like this available in both sites. Staff can work across sites as they currently do plus it's in their contracts to. We shouldn't bottle neck this service.

Having been treated in both hospitals for a heart condition, I have to say that I received excellent treatment in both. To me it would make perfect sense to have this facility on both rather than having to transport patients for treatment.

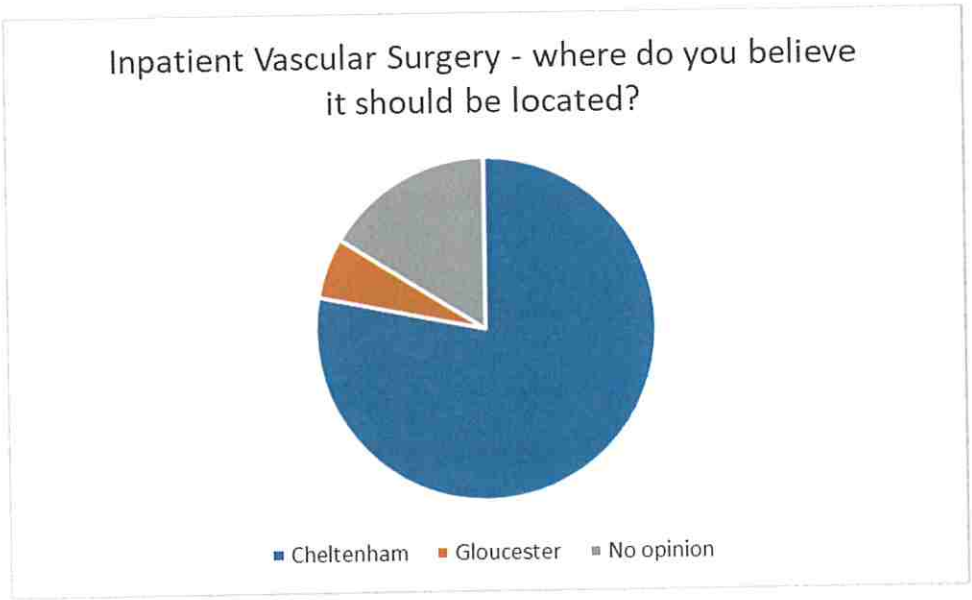
Cheltenham is already the Centre of Excellence for planned Cardiovascular surgery. My next door neighbour had a heart attack and had to be taken to Bristol. He died four days later. Who knows if he could have been saved if he had not had to be taken all the way to Bristol. Cheltenham should be developed as the Cardiovascular centre to reduce the number of heart attack patients who currently have to be taken to Bristol."

Question 9 INPATIENT VASCULAR SURGERY

Vascular surgeons treat patients with blocked or narrowed arteries, as well as conditions such as varicose veins. The vast majority of vascular surgical inpatients comprise patients with badly narrowed arteries in the leg or disease in the main artery (aorta). The majority of arterial vascular operations are performed in a planned manner or at worst in an urgent scenario within 24 to 48 hours of admission. The numbers of emergency vascular operations in the middle of the night are now vanishingly small.

Although interventional vascular radiology/surgery procedures are performed in a number of patients with blocked or narrowed arteries, there is still a need for patients to have an open operation under general anaesthetic. Until the temporary COVID changes came in earlier this year, planned inpatient vascular surgery was performed at both hospitals, although the majority of interventional vascular radiology/surgical cases were performed in the £2.5 million state-of-the-art hybrid interventional radiology/vascular theatre at Cheltenham however the Trust is seeking to centralise this service on one site. The number of vascular inpatient beds required for this service is moderate.

Where do you believe that the main vascular inpatient surgery centre should be located in?



The overwhelming public response is that inpatient vascular surgery should remain at Cheltenham, so that the state of the art hybrid vascular theatre can be used properly. The public do not believe that spending more money to replicate this facility at Gloucester represents value for taxpayers' money.

"As the Trust has a state-of-the-art £2.5 million hybrid vascular interventional operating theatre at Cheltenham General, it makes sense financially for it to remain there. It would be a waste of taxpayers money to move this.

I understand that vascular surgery was recently transferred from CGH to GRH as an 'emergency COVID measure'; staff and accommodation were drastically reduced. I can see no reason why this service should not be reinstated at CGH as soon as possible, It is a nonsense to waste the valuable and well regarded vascular operating theatre.

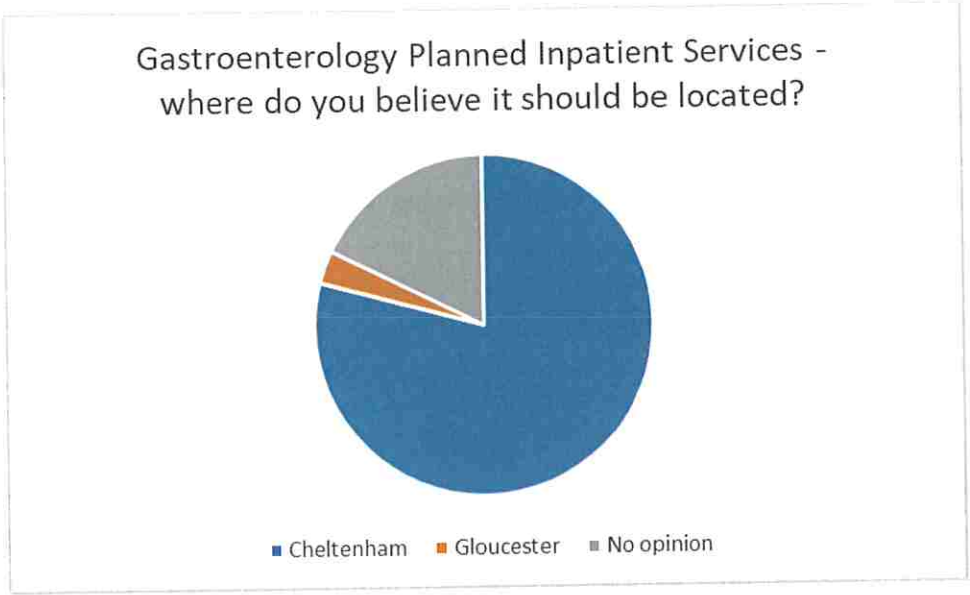
If there is already a state of the art centre for dealing with this at CGH surely there is absolutely no need to change it."

Question 10 GASTROENTEROLOGY PLANNED INPATIENT SERVICES

The Trust is planning to centralise planned admissions for patients with gastroenterology (gut/ liver medical) conditions. The number of patients, who are admitted as inpatients/overnight for planned investigations for gut problems is very small. On the contrary, more patients are admitted with emergency gastroenterology problems, such as vomiting blood, jaundice etc. The management of these emergency gastroenterology problems is not the subject of this consultation.

There are advantages in co-locating the gastroenterology service with the major inpatient lower gastrointestinal/colorectal surgery service, as some patients may require attention from both the medical and surgical gut specialists. REACH believes that colorectal and bowel cancer surgery would be best centralised at Cheltenham alongside the Cancer Centre.

Where do you believe that the gastroenterology inpatient service should be located in?



The vast majority of respondents indicated that the single site gastroenterology inpatient site should located in Cheltenham. Many cited that this is sensible, as it would be sited alongside the cancer centre in Cheltenham. Those who expressed no opinion indicated their preference for this service to continue on both sites.

"*Patients always benefit from a joined up approach to care and specialists on the same site makes for a less stressful experience*

Makes sense to me if it is centralised alongside the Cancer Centre at Cheltenham.

It has already moved to CGH, there is Gastro cover every day in GRH to see any referrals."

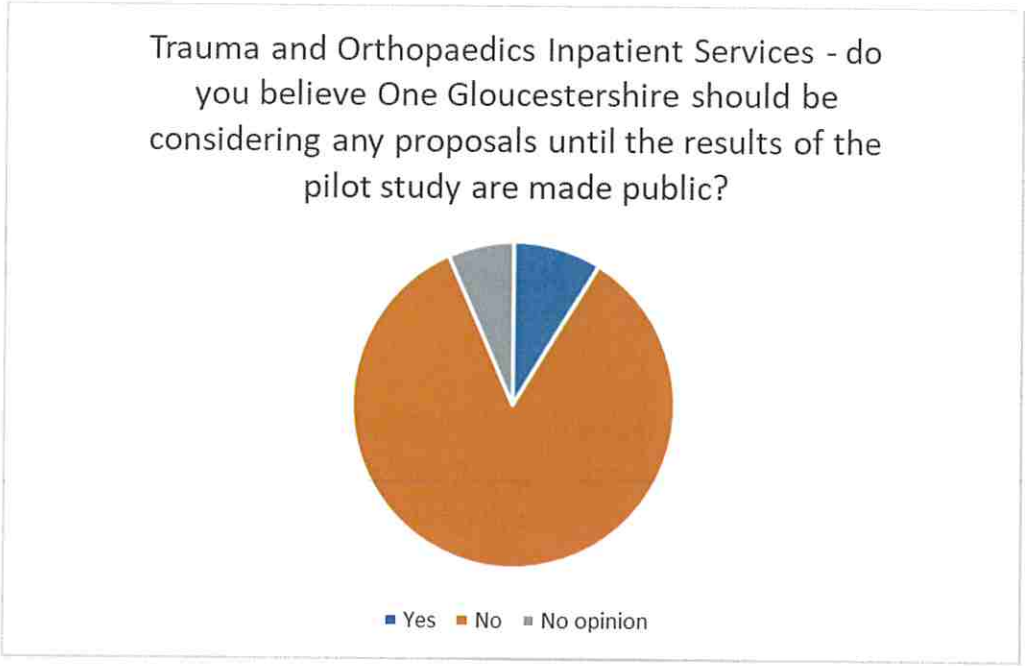
Question 11 TRAUMA AND ORTHOPAEDICS (T & O) INPATIENT SERVICES

Three years ago, the Trust Instituted a "Pilot Study", which centralised orthopaedic trauma (fractured bones) patients at Gloucester, whilst concentrating planned orthopaedic surgery at Cheltenham (except for major spinal surgery, which remained in Gloucester). Although the Trust labelled this as a "Pilot Study", the Trust has not presented any objective results of this "Pilot" for public scrutiny.

Whilst patients having planned orthopaedic operations in Cheltenham have generally had this performed efficiently, the results of the Trauma service in Gloucester have apparently not been as successful. Pressure on beds and operating time has led to continuing delays in performing surgery on trauma patients at Gloucester in a prompt fashion; delays in surgery can lead to worse outcomes. In

spite of this uncertainty about whether the "Pilot Study" has been successful, the Trust would like to make this arrangement for Trauma services in Gloucester and planned orthopaedic care in Cheltenham permanent.

Do you believe that One Gloucestershire should be considering any proposals until the results of the "Pilot Study" are made public for proper scrutiny?



There was overwhelming public opinion that the results of the "Pilot Study" on Trauma and Orthopaedics should be presented for scrutiny prior to considering any proposals for a permanent reorganisation. The public believe that One Gloucestershire should be transparent and share the data about trauma surgery outcomes for proper scrutiny.

"*To do anything other than publishing the results of a properly designed and unbiased evaluation would be a deceit of the highest order.*

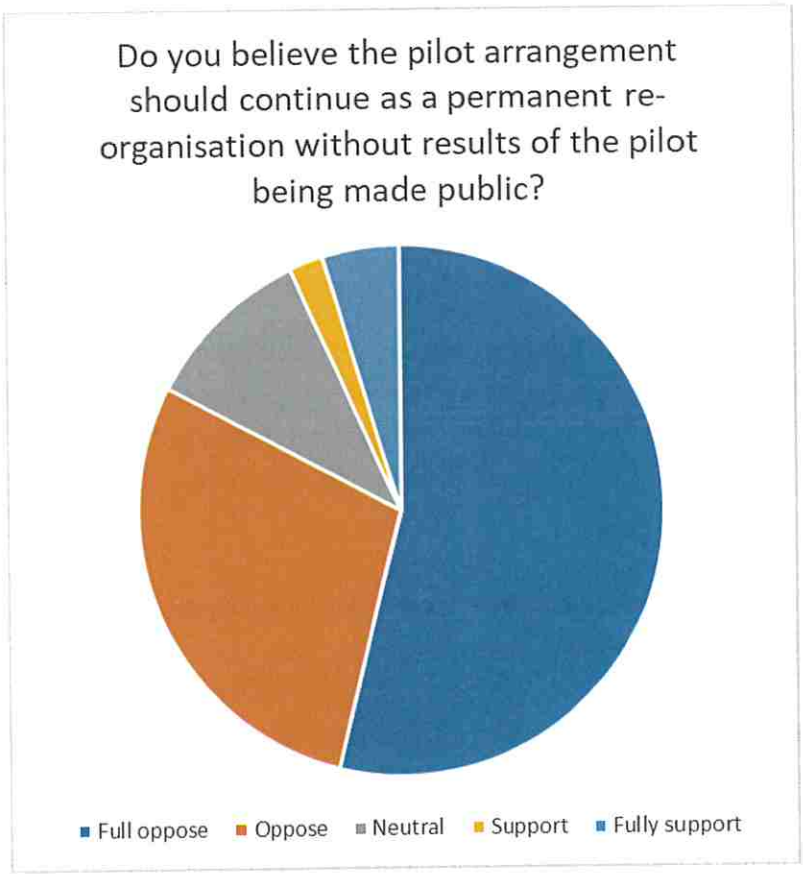
The Trust must see the results of the Pilot Study first, before making any further decisions on this. It would be reckless to proceed before any further facts, information and recommendations have been gleaned and shared with the public. Patient care and health could be compromised and it would be negligent for the Trust

to allow GRH to continue when it is currently not coping with demand. Quality of care over quantity of patients seen is of paramount importance.

No if the pilot study has shown delays and pressure on beds then I think it would be very unwise to make Gloucester the place for Trauma services. If they do, then all orthopaedic trauma will end up there, (road traffic accidents for example). This means Cheltenham A&E will no longer be used for this purpose, essentially downgrading the A&E department at Cheltenham and making it a minor injuries unit. Again what sort of A&E will Cheltenham have?

I got ""bumped"" three times before getting needed surgery on this service, once when admitted and prepped. Not good."

Question 12 Last but not least do you agree that the "Pilot Study" arrangement with Trauma based in Gloucester and planned orthopaedic surgery based in Cheltenham should continue as a permanent reorganisation, without the formal results of the "Pilot Study" being revealed?



The public believe that the proposal to make a permanent reconfiguration along the lines of the "Pilot Study" should not be enacted until the results of the "Pilot" have been fully evaluated. Fewer than 5% of the respondents believe that it would be appropriate to proceed on such a basis.

"*They have a duty to reveal the results of the Pilot Study. Without it, one can only assume, it doesn't say what the Trust want it to.*

We have to see the results of the pilot. If the pressure has proven too much for one hospital. I think the question is answered.

Having had major spinal trauma surgery in Gloucester there are serious issues - would need to see pilot first !

For the obvious reason that provisional management changes should be evaluated before being made permanent.

As a general addendum my experience at both hospitals is that whilst Cheltenham is certainly busy GRH is already under excessive pressure which potentially threatens patient care.

Evidence MUST be presented before any decision is made. I am very worried by this, (in some cases), non-evidential push by the Trust to 'beef up' the responsibilities of the GRH, whilst diluting those at CGH. I cannot see how their ambitions for GRH can be satisfactorily achieved without major investment and expansion of both buildings, equipment and staff. I am also concerned with the well-being of staff at Gloucester having to try and absorb the additional demand that would result from the Trust's proposals."

Summary

REACH has recognised that the proposals in Fit for the Future are complex and will have a wide ranging permanent impact on healthcare provision in our County.

The implications of centralising emergency care have not, we believe, been explained fully to the public by One Gloucestershire. The concept of excellent care is indeed laudable, and REACH recognises the challenges of staffing as well as the impact of advances in patient care.

Nevertheless, the public have overwhelmingly stated that they would prefer, in general, care closer to home. The public understand that there are significant bed pressures at GRH, which would be amplified further by centralising of acute medicine and emergency surgery at GRH. The public know that One Gloucestershire cannot squeeze the proverbial "quart into a pint pot."

The large number of extra inpatient beds required at GRH from the centralisation of emergency medicine and surgery are very substantial and are unlikely to be offset by proposals such as centralising day surgery at Cheltenham. The public are concerned that these proposals may downgrade Cheltenham and that proposals to centralise day surgery at Cheltenham might be regarded as a "sop" to public opinion. REACH believes that the excellent facilities and dedicated staff at both hospitals should be used efficiently and that happy and fully engaged staff can then provide the best care and service to the people of our County.

If One Gloucestershire wishes to proceed with its proposals to centralise emergency care at Gloucester in spite of public opinion, REACH believes that as much elective major activity should occur at Cheltenham, in order to utilise the beds, nursing expertise and importantly the excellent intensive care unit at Cheltenham. This public survey has shown that if there is a to be a centralisation of colorectal surgery and the vascular service, both these services should be located in Cheltenham.

REACH was concerned about the portrayal of Image Guided Interventional Surgery as a single specialty, when in fact this concept covers many disciplines. After explaining this to the public in non-medical language, the public have indicated that this should be located at Cheltenham. The exception to this is cardiac intervention, where the public indicated that this should either be a both sites or at Cheltenham.

The launch of Fit for the Future during the worst pandemic in living memory has caused concern among the public and REACH. The Government and healthcare community are concerned that we are likely to experience further future pandemics, or that the COVID virus may mutate significantly.

This COVID pandemic has wrought havoc to our healthcare system and caused the delay and cancellation of non COVID related healthcare for millions of people. REACH believes that any proposal for the future must include resilience planning for future pandemics. One Gloucestershire's Fit for the Future proposals include no proposals to render our local healthcare system more robust and we would exhort our healthcare leaders to re-examine the proposals in light of the catastrophic events of the last 9 months.

Written response from Tewkesbury Borough Council

649 ER. MH

Democratic Services

Tewkesbury Borough Council

NHS Gloucestershire Clinical Commissioning Group
5220 Valiant Court
Gloucester Business Park
Brockworth
GL3 4FE

16 November 2020

Dear Sir/Madam

MOTION: ACCIDENT AND EMERGENCY SERVICES AT CHELTENHAM GENERAL HOSPITAL

I write to set out Tewkesbury Borough Council's position on the future of the Accident and Emergency Services at Cheltenham General Hospital as agreed by the Council at its meeting on 29 September 2020. In line with the Motion, set out below, I would appreciate it if you could liaise with our Democratic Services Team - via democraticservices@tewkesbury.gov.uk – to agree a suitable date and time for the Clinical Commissioning Group to provide Councillors with an update on its proposals for Cheltenham Accident and Emergency Services.

"This Council remains opposed to permanent closure or downgrading of Accident & Emergency (A&E) facilities at Cheltenham General Hospital, in accordance with the motion by Councillors Gore and Hollaway approved on 1 October 2019, and we fully support the effective work by local MPs Laurence Robertson and Alex Chalk in this regard.

We thank the NHS Trust for its hard work and commitment during this COVID-19 emergency, and note that the recent three month closure of A&E was understood to help keep Cheltenham General 'COVID Free' during the height of the COVID transmission, in order that elective surgery could be resumed.

However, at the Gloucestershire Health Overview Scrutiny Committee (HOSC) meeting on 15 September 2020, the Gloucestershire Hospital NHS Foundation Trust proposed to extend the three-month closure of Cheltenham's Type 1 A&E Department for a further six months.

We are concerned about the proposed six month extension both in terms of the A&E at Gloucestershire Royal Hospital having the capacity to cope with all A&E patients from the whole County together with the capacity of Emergency Ambulance services and that the additional six month extension could become a long term or permanent change.

We are grateful to the Clinical Commissioning Group (CCG) for responding to our previous motion in such a positive way and taking the time to present their plans to us on 18 October 2019. In view of the latest developments we would welcome further representations from the CCG on its long-term intentions, but recognise that this needs to be when critical emergency COVID-19 work allows, so we extend an invitation to the CCG to provide us with an update on their proposals at the earliest appropriate time".

I look forward to hearing from you in response to this motion.

Yours sincerely

Head of Democratic Services

Written Responses from Members of the Public

Redacted for Personally Identifiable Data (names and addresses)

Fit for the Future Consultation

Feedback from [redacted]

Thank you for providing me with the opportunity to give feedback on the Fit for the Future proposal; part of One Gloucestershire's vision. Having studied and reflected on the proposals, I have noted the current challenges detailed in the consultation document:

- The inability to provide staff and particularly specialist staff for two hospital sites which are not in close proximity
- The importance for patients to have access to the appropriate specialists in a timely manner to optimise health outcomes
- The need to minimise the number of cancelled operations and achieve more effective use of resources
- The need to develop and improve greater multi-disciplinary and multi professional working as well as alignment to services and equipment
- The need to make best use of specialist high tech resources and minimise duplication to ensure better use of resources

This information has shaped my opinion and I feel that we should continue to promote, 'Centres of excellence' as I have seen with the Children's Centre and Oncology Services. I feel that we should:

- Establish a single Acute Medicine Take at Gloucestershire Royal Hospital
- Establish a General Surgery Centre of Excellence at GRH with centralised Emergency General Surgery Service alongside centralised planned Upper GI service and a newly centralised planned Lower GI Service. Planned day case for both upper and lower GI surgery to be centralised at CGH
- Establish a 24/7 hub for image guided interventional surgery – interventional radiology, interventional cardiology and vascular surgery at GRH
- Retain Gastroenterology Services at CGH as this fits with the Centre of Excellence model
- Retain planned orthopaedic surgery at CGH (as above) and keep trauma at GRH

So in summary, I feel that emergency care should be predominantly at GRH and planned day cases should mainly take place at CGH. This would, in my opinion, make the best use resources including staff as well as equipment. As I want to pursue a career in Medicine, I was interested to learn about the positive experience the pilots have made on the working lives of junior doctors.

To: NHS GLOUCESTERSHIRE.

From: [redacted] CAREER - JOURNALISM / MARKETING & PR. / CARER 10 YEARS.

PLEASE:

i) DOUBLE Training expenditure/places for NURSES & CARERS.

ii) SPEND on marketing the new opportunities to young boys & girls from School Age.

iii) PERSUADE Politicians NOW, of the urgent need to invest in medical TRAINING & EDUCATION, NOT NEW GLOSSY BUILDINGS.

PRIORITIZE INTELLIGENTLY. NOW. FOR PEOPLE IN FUTURE.

[redacted]

Fit for the Future
Sanger House
5220 Valiant Court
Gloucester Business Park
Gloucester
GL3 4FE

27th November 2020

Dear Sir/Madam

I am writing in response to a leaflet I have received regarding the 'Fit for the Future' public consultation. It is so reassuring and such a relief to understand that actions are being considered to improve the NHS service. Having experienced the traumatic death of my mother last year due to delayed surgery and the failure to diagnose gallbladder cancer, I would like to contribute from an individuals perspective on my experience, in the hope that actions can be taken to save lives and prevent suffering to other families.

In summary, [redacted] was diagnosed with acute cholecystitis due to a large gallbladder stone in [redacted]. Prior to this, she was a fit active lady, attending weekly fitness classes, regular walks with friends and a keen gardener. Regrettable surgery was delayed for 33 weeks despite ongoing symptoms, delays attributed to a 'wait and see' approach and the fact the surgeon broke his arm whilst on holiday. This waiting time far exceeded the publicised 18 weeks as stated on the NHS website for this hospital. It in incomprehensible that a large gallbladder stone would resolve without surgical intervention and no provisional operation date was made at the time of the wait and see approach, to prepare if the condition had not change or worsened. Complications arose in surgery including empyema and previous perforation of the gallbladdder, both of which I would question could have been prevented if surgery had not been delayed. Histopathology results reported cholecystitis and cholelithiasis only. Despite initial surgical complications, my mum healed very well and was signed off during her post op consultation 2.5 months later. Two weeks after this consultation she then developed swelling and tenderness at the original surgical sites, which she was told was likely to be a haematoma, seroma or an infection, but no one questioned the very unusual delayed appearance post op, particularly when they had noted 2 weeks prior to this that she had healed remarkably well. Twelve appointments and four months later she was eventually diagnoses with extensive disseminated peritoneal carcinomatosis.. She was admitted to hospital immediately following the consultation, as she had been struggling so long and could no longer cope at home with the pain and nausea. (Please note that in order to obtain this appointment, it took a total of 21 calls and three messages to the hospital to eventually arrange this appointment. Mum also attended A & E 2 months prior to this and was told she would continue to be treated as an outpatient as her symptoms were not acute enough to warrant immediate investigation). Following two weeks of hospitalisation she was eventually informed that on review of the original histopathology results 7 months ago, cancer cells had been missed. My mum died 11 days later.

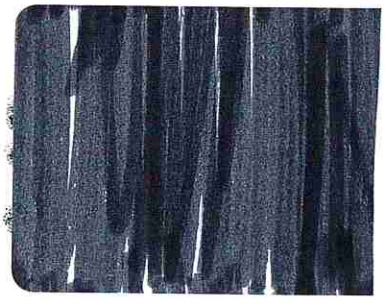
My mum was a casualty of a failing NHS system. All along I kept saying 'no one is listening'. With no continuity of care, we were passed from pillar to post and no one had the time to invest in addressing the issues we raised and question why a post op swelling would strangely appear several months after the operation.

Following my Mum's death, I spent several painful months collating all her medical notes and compiling a letter of complaint with suggestions on how to improve the system, in the hope that I could highlight the failings and ensure actions could be taken to prevent this happening again. What is so upsetting is that the misdiagnoses of gallbladder cancer was attributed to the fact there was only a few cancer cells and things may have been so different if the surgery had not been delayed. A consultant tried to reassure me that it would have made no difference to the outcome, however I disagree entirely. Arguable as early stage gallbladder cancer is so difficult to diagnose, it may well have been a case that it was discovered as an incidental finding post op and if found and removed early enough would have prevented the spread. The fact my Mum was denied this chance is too painful to consider. Even if the worst case scenario did occur, she would have been offered cancer treatments and the support and care she so deserved. Instead she struggled at home to cope with the pain and nausea and felt as if no one believed how poorly she was. Although I did receive a response, my complaint regarding the waiting list, increased risk factors of gallbladder cancer in older female patients, inability to contact the surgeon direct or indirectly and no provision for continuity of care has not been addressed. Apparently as gallbladder cancer is very rare, no actions will be taken to increase survival rates.

All I want is someone to acknowledge these failing and take action to help save lives and spare families from going through such a painful and distressing experience. I appreciate greatly that there are many lovely people working for the NHS, but the system is in crisis and delays not only risk lives but cost the NHS much more in the long term. My Mum was a wonderful supportive and very caring lady, always there to help others and we miss her greatly. I feel I am just starting to come to terms with her death, but fear I may never get over the fact she was denied the treatment, care and support she so deserved. Please do something to help others.

Should you require any further information please do not hesitate to contact me, I would be happy to help in anyway.

Yours sincerely



Dear Sir/Madam

I recently received a copy of Fit for the Future. I have lived in Gloucester since June 2017 and have had of necessity to use the facilities at GRH, Cirencester and Stroud both as a patient and as a visitor.

Firstly I wish to pay tribute to all the staff at GRH, Cheltenham and the other local hospitals who have worked hard during this tough time.

Having said that there are in my opinion things that should change. My comments are as below.

1. World Class

This is a really worthwhile aspiration. However having worked for 2 world class companies the amount of work involved is huge. In one company it was a turnaround situation and the time scale was over a year. It involved a complete workforce change around, clearing out unnecessary management and pushing responsibilities onto the workforce making them responsible and accountable for their actions. For example the person who is the expert in being a nurse – is a nurse, not a Doctor or a Manager.

If the hospital is really serious about becoming World Class what is the action plan. Which UK hospital will be the role model? There are sufficient hospitals in the UK that are World Class, they have already made the journey.

There are 2 major concepts KISS – keep it simple and don't re-invent the wheel.

Is the hospital going to be World Class in all departments or is it a case of spending money on a couple of new departments and then parading these couple of specialist departments as the World Class part of the hospital.

2. Existing hospital buildings in Gloucester and Cheltenham.

Cheltenham and Gloucester both have old and outdated buildings. The Tower block is an out of date facility with ergonomic and access issues for both staff and patients. The wards are over crowded. I did a 15 steps walk around which included an old ward and a refurbished ward. The old ward was not somewhere I would like to be following surgical intervention. Equipment was piled in a cupboard. World class it most certainly was not. What is the plan to bring these wards up to World Class standards?

What are the plans for the outdated facilities in Cheltenham.

3 . A and E and existing services

Which part of the hospital has the most usage, as an outsider I would imagine this is A and E? Is this not where the focus of improvements should begin?

Before planning new services, is it not reasonable to make sure existing services are to the highest standard possible, that is World Class?
The situation with GP's is that before Covid, access was difficult with waits of 4 weeks commonplace. Appointment times were limited to 10 minutes and some GP's made this a rule to be followed. If you have more than one condition, "make another appointment". In 10 minutes expecting a GP to cogently follow a complicated problem , make a diagnosis and write up the notes is fanciful. Who is the loser in this scenario?

The only other option a patient has is to go to A and E.

The GP situation is unlikely to change in the near future and in the current pandemic.

In addition the population in this area is expanding. Driving around the GRH catchment there are extensive developments in Stonehouse, Brockworth, Longford, Kingsway to mention a few. What plans are in place to cope with both the extra workload because of the GP access problems and the expanding population.

It is also well known that the country in general has an increasing number of elderly residents, who require more complicated attention and spend longer in hospital. This will be an additional burden on both ambulance staff and A and E.

What plans are in place?

Finally the ongoing muddle over the A and E departments at Cheltenham and Gloucester should be sorted out once and for all. It should be simple enough to make a case for definitive action based on the number of patients attending each facility? Do a Pareto analysis?

4. Staffing

This we are told is an issue throughout the NHS. The Fit for the Future business case mentions problems on hiring and keeping staff.
This is obviously a problem looking at the staff employed at GRH where one can see that staff have been drafted in from overseas to maintain numbers.
This is fine up to a point, but drafting in personnel who are not English Nationals is not without its challenges in understanding our culture and language. This particularly applies to nursing elderly patients, and those recovering from surgical procedures. These groups do not need the extra pressure of communication issues.
This is not racist but a practical problem and one I have experienced myself having lived abroad for 26 years in 3 separate countries, 2 of which were non English speaking.

Not all Hospitals have problems with attracting home grown talent but these are Hospitals who have started the journey to World Class status in all departments?

My late father had a triple heart bypass in South Tees (situated on Durham -Yorkshire border) hospital followed by weeks in intensive care. The nursing staff were predominantly local from Durham and Yorkshire (obvious by the accents). I am convinced that made a difference to his recovery even down to the use of local endearments.

The workplace is critical to attracting staff. How would one describe the working conditions at GRH especially in the Tower Block?

Conclusion

I strongly support the case for GRH and Cheltenham to become World Class facilities.

The move to World Class should begin with existing facilities that are the most intensively used.

What I want to see is a road map of how this is going to be achieved with timescales and costings. This should be done wherever possible by copy pasting what has been achieved in other hospitals.

I consider the most important actions are to get the existing facilities that are the most intensively used to World Class status before trying to add further facilities. This will be a big enough challenge.

[redacted] (NHS GLOUCESTERSHIRE CCG)

From: [redacted]
Sent: 17 November 2020 15:31
To: GIG (NHS GLOUCESTERSHIRE CCG)
Subject: Re: Fit for The Future

This message originated from outside of NHSmail. Please do not click links or open attachments unless you recognise the sender and know the content is safe.

I was unable to participate in the above but have read your summary booklet.
In my business career I was involved in procurement , logistics, and business consultancy. In all positions,I was dealing with people who were experts in their field and any changes that I recommended or implemented were based on their knowledge or suggestions. Whilst I would love to comment in detail on your proposed changes I do not feel that I am qualified to do so.
If however your proposals will bring about a more efficient and cost effective service I will most certainly support it and would be pleased to offer my services on a voluntary basis.
Regards

[redacted]

On Sat, 14 Nov 2020, 11:35 GIG (NHS GLOUCESTERSHIRE CCG), <glccg.gig@nhs.net> wrote:

[redacted]

Thank you for your interest in our virtual cuppa and chat sessions. Here is the link to the session you would like to join.

Locality	Date	Time	Link
Cotswolds	17 November	3:00pm	https://bit.ly/CuppaandChat-Cotswolds

We look forward to seeing you then. In the meantime, if you have any questions please email glccg.gig@nhs.net

You may also be interested in visiting our consultation webpages here where you can read more and complete the survey. If you are interested in Getting Involved in Gloucestershire then please visit our online participation space here.

[redacted]HS GLOUCESTERSHIRE CCG)

From: [redacted]
Sent: 24 November 2020 09:08
To: Participation (NHS GLOUCESTERSHIRE CCG)
Cc: Alex CHALK
Subject: consultation - specialist hospital services

Follow Up Flag: Follow up
Flag Status: Flagged

This message originated from outside of NHSmail. Please do not click links or open attachments unless you recognise the sender and know the content is safe.

Many thanks for inviting me to join the consultation on developing specialist hospital services in Gloucestershire.

I have looked at the questions on your website and frankly, despite many years of higher education and extensive professional experience (not in medicine), I feel totally inadequately equipped to answer the vast majority of your questions.

The only useful comments I can make relate to Cheltenham where we live. I therefore have of course a natural predilection to use a Cheltenham Hospital in preference to one in Gloucester for any purpose ...especially emergency treatment.

If I needed emergency treatment at any time of day or night ...including weekends.... I would expect to see a full service in Cheltenham.

I stress weekends because in the past, in cases concerning both myself and my mother, I have several times witnessed how NHS hospitals do not provide a full service at weekends. This is a nonsense. My professional experience was in the oil industry where billions of pounds of investment are put to work day and night. In my mind the NHS is no different. The amount of money invested in the NHS is immense. Short working at weekends is utterly unacceptable.

[redacted]

3.

[redacted]NHS GLOUCESTERSHIRE CCG)

From: [redacted]
Sent: 04 December 2020 21:16
To: Participation (NHS GLOUCESTERSHIRE CCG)
Subject: Fit for the Future

Follow Up Flag: Follow up
Flag Status: Flagged

Categories: FFTF booklet

Dear Sirs

I do not want – indeed, do not have the ability - to comment on the detailed proposals in the leaflet and on the website. What I should like to do is provide some general remarks, viz

It seems to me that there are three main criteria that should guide the decisions. In no particular order:-

1) Patient convenience. Some functions and specialities should be available at both CGH and GRH. Most obviously, these are A & E, outpatient clinics, and (probably) obstetrics & gynaecology and day surgery
2) Cost. Clearly those specialities that require particularly expensive equipment and other such resources should be centralised at one or other hospital
3) Centres of Excellence. In order to build exceptional teams, and thereby deliver five-star outcomes, many specialities should be focussed on one or other hospital. However, pre- and post-admission consultations (as distinct from treatments) could be delivered at both

It seems to me that the closure of community re-hab and cottage hospitals was a big mistake, and I should like to see a renewed focus on the re-establishment of such facilities. In the unlikely event of there being available funding, the ideal would be to build an entirely new hospital between Gloucester and Cheltenham, with GRH and CGH concentrating on the functions listed in 1) above – together with Moreton-in-Marsh, Cirencester, Stroud etc

I look forward to hearing of the outcomes to the future discussions

Regards

[redacted]

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4.

[redacted] (NHS GLOUCESTERSHIRE CCG)

From: [redacted]
Sent: 06 December 2020 13:38
To: Participation (NHS GLOUCESTERSHIRE CCG)
Subject: Fit for Future

Follow Up Flag: Follow up
Flag Status: Flagged

Categories: FFTF booklet

I am in receipt of your public consultation document, Fit for the Future.

The first thing that strikes me is that there is no reference to the North Cotswold Hospital in Moreton in Marsh. I appreciate that your documents main focus is on the hospitals in Cheltenham and Gloucester, and rightly so, but if community hospitals like North Cotswold were better utilised then this would help ease some pressure on the main locations and give the local population a much better service.

Time and again we see patients (especially the elderly) having to travel the 60 mile round trip taking up to one hour and thirty minutes each way, depending upon the time of day, for what in many cases are routine requirements such as dressings, hearing tests and monitoring. On several occasions, when these issues have been raised with the surgery or the specialist department involved, arrangements have been made to deal with these matters at North Cotswold. Thus easing the pressure on the main hospitals, reducing the need for unnecessary journeys and doing away with the stress of finding and paying for parking at the main sites.

It seems that sending patients to the two main sites is the default position making the North Cotswold underutilised which is not an efficient or patient friendly use of this important resource.

Kind Regards,

[redacted]

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5.

[redacted] NHS GLOUCESTERSHIRE CCG)

From: [redacted]
Sent: 08 December 2020 11:17
To: Participation (NHS GLOUCESTERSHIRE CCG)
Subject: Fit for the Future Consultation

Follow Up Flag: Follow up
Flag Status: Flagged

I would appreciate you keeping me informed on all the major issues concerning the public consultation on specialist hospital services across the Cheltenham General Hospital and Gloucestershire Royal Hospital sites.
My email address is: [redacted] I have recently seen on a GP surgery website that the 'Breast Screening' cabin that was periodically available at the North Cotswold Hospital has already been decommissioned. I believe this is a huge mistake as Moreton in Marsh has expanded rapidly during the 16+ years we have lived in the area and is due to expand even more in the near future, as plans have recently been passed for a further 250 homes to be built just south of the town. There will obviously be many young families with 'Mums' and even older people requiring check ups.
The North Cotswold Hospital needs MORE not less FACILITIES being made available to the local population living in the North Cotswold. The current travel time to Gloucester Royal Hospital is around ONE HOUR (outside of rush hour time) and the journey time to Cirencester is approx 35/40 minutes.
I know the NHS is having an extremely difficult time under the current crisis, however I am looking to the future and to what services will be available to residents living in the North Cotswolds who seem to be mostly forgotten when any plans for the re-structuring of the health services within the county are being considered.
I look forward to receiving all information available during this public consultation either by email attachment or by post.
With kind regards
[redacted]

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6.

[redacted] (NHS GLOUCESTERSHIRE CCG)

From: [redacted]
Sent: 12 December 2020 11:45
To: Participation (NHS GLOUCESTERSHIRE CCG)
Subject: Thoughts upon reading the consultation info

Follow Up Flag: Follow up
Flag Status: Flagged

Hello
Can you please clarify:
In future would there be any point in going to Cheltenham A & E as from what I have read if staff are unable to find the cause of a patient's problem they would have to go to Glos Royal Hospital anyway. Cheltenham Hospital is much closer to where I live and more straightforward and quicker to reach from Cirencester especially for those older people who don't drive so access is going to be an issue for many.
Kind regards
[redacted]

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7.

[redacted]NHS GLOUCESTERSHIRE CCG)

From: [redacted]
Sent: 15 December 2020 16:48
To: Participation (NHS GLOUCESTERSHIRE CCG)
Subject: fit for future

Proposal for Change
Acute Medicine-oppose
General Surgery-oppose
GI Surgery at either CGH or GRH-support
GI day surgery at CGH-support
IGIS-support
Vascular Surgery at GRH-support
Gastro inpatient at CGH-support
T&O inpatient at CGH & GRH-support
Comments-CGH A&E should be consultant lead 24/7

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8.

[redacted] (NHS GLOUCESTERSHIRE CCG)

From: [redacted]
Sent: 16 December 2020 08:21
To: Participation (NHS GLOUCESTERSHIRE CCG)
Subject: Consultation

Follow Up Flag: Follow up
Flag Status: Flagged

I apologise
I have not been able to complete your survey I found the report very interesting but find myself ill equipped to make an adequate response.
I think Centres of excellence a good idea I am concerned about access to the Flagship hospitals and very much support use of local hospitals for particular aspects of day surgery This means easy access, excellent individual care, calm atmosphere and of course planned attendance with confidence all round.
Thank you for your work

[redacted]

Sent from my iPad

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[redacted]NHS GLOUCESTERSHIRE CCG)

From: enquiries (NHS GLOUCESTERSHIRE CCG)
Sent: 02 December 2020 14:39
To: GIG (NHS GLOUCESTERSHIRE CCG); [redacted]SHIRE CCG)
Subject: FW: Strokes

Follow Up Flag: Follow up
Flag Status: Flagged

Kind regards

[redacted]

NHS Gloucestershire Clinical Commissioning Group

Contact: [redacted]

Follow us: @GlosCCG | @One_Glos | Facebook | Youtube

Website: gloucestershireccg.nhs.uk | onegloucestershire.net

Joined up care and communities

From: [redacted]
Sent: 02 December 2020 13:39
To: enquiries (NHS GLOUCESTERSHIRE CCG)
Subject: Strokes

Hi – I don't seem to be able to find anything on stroke units in the consultation documents on Gloucester and Cheltenham.

Are either classed as stroke units which offer specialist care, or is the nearest in North Bristol Trust?

And would suspected stroke patients in say Stroud, be able to be transported in reasonable time to a specialist unit?

Thank you.

[redacted]

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10.

[redacted] NHS GLOUCESTERSHIRE CCG)

From: [redacted]
Sent:
To: Participation (NHS GLOUCESTERSHIRE CCG)
Subject: Re: Fit for the future feedback
Attachments: fit for the future.odt

Please find the attachment included in this mail.

[redacted]

15th December 2020

Dear Sir/Madam

I recently received a copy of Fit for the Future. I have lived in Gloucester since June 2017 and have had of necessity to use the facilities at GRH, Cirencester and Stroud both as a patient and as a visitor.

Firstly I wish to pay tribute to all the staff at GRH, Cheltenham and the other local hospitals who have worked hard during this tough time.

Having said that there are in my opinion things that should change. My comments are as below.

1. World Class

This is a really worthwhile aspiration. However having worked for 2 world class companies the amount of work involved is huge. In one company it was a turnaround situation and the time scale was over a year. It involved a complete workforce change around, clearing out unnecessary management and pushing responsibilities onto the workforce making them responsible and accountable for their actions. For example the person who is the expert in being a nurse – is a nurse, not a Doctor or a Manager.

If the hospital is really serious about becoming World Class what is the action plan. Which UK hospital will be the role model? There are sufficient hospitals in the UK that are World Class, they have already made the journey.

There are 2 major concepts KISS – keep it simple and don't re-invent the wheel.

Is the hospital going to be World Class in all departments or is it a case of spending money on a couple of new departments and then parading these couple of specialist departments as the World Class part of the hospital.

2. Existing hospital buildings in Gloucester and Cheltenham.

Cheltenham and Gloucester both have old and outdated buildings. The Tower block is an out of date facility with ergonomic and access issues for both staff and patients. The wards are over crowded.

I did a 15 steps walk around which included an old ward and a refurbished ward. The old ward was not somewhere I would like to be following surgical intervention. Equipment was piled in a cupboard. World class it most certainly was not. What is the plan to bring these wards up to World Class standards?

What are the plans for the outdated facilities in Cheltenham.

3 . A and E and existing services

Which part of the hospital has the most usage, as an outsider I would imagine this is A and E? Is this not where the focus of improvements should begin?

Before planning new services, is it not reasonable to make sure existing services are to the highest standard possible, that is World Class?

The situation with GP's is that before Covid, access was difficult with waits of 4 weeks commonplace. Appointment times were limited to 10 minutes and some GP's made this a rule to be followed. If you have more than one condition, "make another appointment". In 10 minutes expecting a GP to cogently follow a complicated problem , make a diagnosis and write up the notes is fanciful. Who is the loser in this scenario?

The only other option a patient has is to go to A and E.

The GP situation is unlikely to change in the near future and in the current pandemic.

In addition the population in this area is expanding. Driving around the GRH catchment there are extensive developments in Stonehouse, Brockworth, Longford, Kingsway to mention a few. What plans are in place to cope with both the extra workload because of the GP access problems and the expanding population.

It is also well known that the country in general has an increasing number of elderly residents, who require more complicated attention and spend longer in hospital. This will be an additional burden on both ambulance staff and A and E.

What plans are in place?

Finally the ongoing muddle over the A and E departments at Cheltenham and Gloucester should be sorted out once and for all. It should be simple enough to make a case for definitive action based on the number of patients attending each facility? Do a Pareto analysis?

On Thu, Dec 31, 2020 at 12:17 PM Participation (NHS GLOUCESTERSHIRE CCG) <glccg.participation@nhs.net> wrote:

[redacted]

Thank you for contacting us regarding the Fit for the Future Consultation. Unfortunately I am unable to open the attachment that you sent to us and wondered if you would be able to resend it in another format? Perhaps a Word document, or alternatively copy the text into an email? We will be finalising our report next week and would like to ensure that we include your feedback.

Many thanks

[redacted]

Gloucestershire Clinical Commissioning Group

[redacted]

www.gloucestershireccg.nhs.uk

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From: [redacted].com]
Sent: 16 December 2020 19:37
To: Participation (NHS GLOUCESTERSHIRE CCG)
Subject: Re: Fit for the future feedback

[redacted]

4. Staffing

This we are told is an issue throughout the NHS. The Fit for the Future business case mentions problems on hiring and keeping staff.

This is obviously a problem looking at the staff employed at GRH where one can see that staff have been drafted in from overseas to maintain numbers.

This is fine up to a point, but drafting in personnel who are not English Nationals is not without its challenges in understanding our culture and language. This particularly applies to nursing elderly patients, and those recovering from surgical procedures. These groups do not need the extra pressure of communication issues.

This is not racist but a practical problem and one I have experienced myself having lived abroad for 26 years in 3 separate countries, 2 of which were non English speaking.

Not all Hospitals have problems with attracting home grown talent but these are Hospitals who have started the journey to World Class status in all departments?

My late father had a triple heart bypass in South Tees (situated on Durham - Yorkshire border) hospital followed by weeks in intensive care. The nursing staff were predominantly local from Durham and Yorkshire (obvious by the accents). I am convinced that made a difference to his recovery even down to the use of local endearments.

The workplace is critical to attracting staff. How would one describe the working conditions at GRH especially in the Tower Block?

Conclusion

I strongly support the case for GRH and Cheltenham to become World Class facilities.

The move to World Class should begin with existing facilities that are the most intensively used.

What I want to see is a road map of how this is going to be achieved with timescales and costings.

This should be done wherever possible by copy pasting what has been achieved in other hospitals.

I consider the most important actions are to get the existing facilities that are the most intensively used to World Class status before trying to add further facilities. This will be a big enough challenge.

[redacted]