One Gloucestershire Public Engagement

General Surgery & Vascular/Cardiac Radiology Intervention

Citizens' Jury – January 2020

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Is there anything the jury might want to find out from the NHS, public etc. to inform jury recommendations?

Think about the 'balance' of inputs to the jury.

- $4\frac{1}{2}$ days of input controlled by the Trust, followed by round table discussions with selected reps

Vs

- A half day from the whole stakeholder community with no opportunity to explore or engage

Are you getting sufficient broad spectrum of information to allow you to come to an informed and balanced view?

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Trust & Confidence in the Process

- Low Trust
  - Information not shared
  - Promises not kept
  - Secretive and manipulative
  - Misrepresentation
- Low Confidence
  - Decide first –
  - Consult to achieve pre-determined position
  - Supported by selective use of evidence

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What Does REACH Support?

- Development of health services for the whole of Gloucestershire
- Serious consideration of the 'Centres of Excellence' model across the county e.g.
  - Cancer care
  - Cardiac care
- Plans to develop sustainable and full 'Blue Light' Emergency depts in both Cheltenham and Gloucester because of transport issues

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Emergency Surgery Vision

- Support Dr. Pietroni's view
- 'Right surgeon, first time' – the surgeon to the patient
- Supporting urgent care at Gloucester and Cheltenham

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The Elective/Planned Surgery Vision

- Dedicated Centre for specialists in planned care doing Planned General Surgery
- Beds, nurses, teams of doctors, facilities and theatres dedicated to planned in-patient care
- Smoothest pathway, the best experience; no holds ups, no cancellations
- Bringing together all the relevant teams in one place
- Building on existing regionally and nationally renowned expertise

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Relieving Pressures on Emergency Surgery

It is reasonable to explore:

- Centralising emergency general surgery at Gloucester
  - i.e. take suspected surgical emergency admissions to GRH
- Centralising planned major surgery at Cheltenham
  - i.e. move all GRH planned surgery to CGH
  - N.B. the capacity for urgent out of hours surgery needs to be maintained at CGH for patient safety

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REACH Position on Emergency Surgery

- Any proposal to centralise major emergency surgery at GRH requires:
  - A SYNCHRONOUS transfer of major in-patient planned general surgery to CGH
  - Doing this together creates bed and theatre capacity at GRH

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Separation of Emergency and Major Inpatient Elective General Surgery

- In keeping with National Strategy & GiRFT guidance
- Supported by John Abercrombie, National GiRFT Lead for General Surgery
- Minimises cancellations for patients, as confirmed by GHNHSFT Trauma & Orthopaedic Pilot
- Would create an Elective Centre of Excellence for Cancer and major planned general surgery

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Challenges - Resident On-Call Doctors

- Both GRH and CGH hospital need a resident anaesthetist – physician – surgeon 24/7 to keep every patient safe
- Resident middle grade surgeon at CGH to treat:
  - Patients who come to A&E in CGH
  - Patients coming to CGH with vascular and urology emergencies
  - Many Out Of Hours (OOH) General Surgical consultations at CGH are for patients in the hospital e.g. oncology, gastroenterology, ITU, orthopaedic etc.

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Any solution for emergency surgery, which removes resident middle grade surgeons from CGH, renders the care of 379 CGH in-patients less safe than that for in-patients at GRH!

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Any Questions?

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Pressures on Emergency Surgery

- Currently good clinical outcomes at CGH and GRH for emergency surgery
- Increasing attendances and admissions creating capacity issues at GRH (but NOT CGH)
- OPTIONS include:

1) Redistributing patients from GRH to CGH OR
2) Centralising emergency surgery on one site

N.B. poor access to care at GRH for N & SE Glos

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Challenges for GRH emergency centre

- Lack of beds - > 75% days on Red/Black Alert at GRH – (CGH <25%)
- Lack of GRH theatre capacity for extra emergency surgery cases
- GRH experiencing repeated “major internal incidents”, significant trolley waits, cancellations of elective surgery & long ambulance waits at A&E

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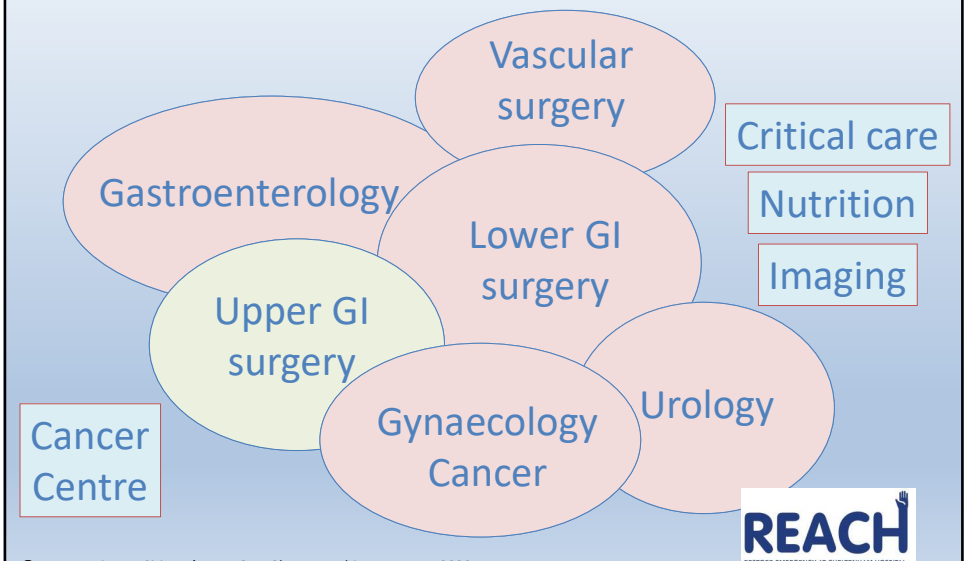
Planned In-Patient Centre



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REACH Position on Elective General Surgery

- Create a Centre of Excellence for elective/planned care providing complex major in-patient surgery at CGH
- Deliver better bed availability in both GRH & CGH - dedicated centres providing different types of care
- Ensure 24/7 resident surgeons at GRH & CGH to deliver safe care for all

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Vascular Cardiac and Interventional Radiology (IR) Services

- Interventional radiology used in the following scenarios:

  1) General radiology intervention - e.g. stent/nephrostomy for infected blocked kidney OR drain insertion for abscess

  2) Cardiac intervention – elective and emergency care of heart attack patients

  3) Vascular surgery – elective and emergency care of blocked or ruptured arteries

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General Radiological IR

- Should be available at every acute hospital
- Most common emergency non-vascular/cardiac IR interventions required in urology and oncology patients – but also ITU and general surgery
- Most common IR OOH intervention is emergency treatment of infected blocked kidney (causing life threatening sepsis)

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Cardiac Interventional Procedures

- Currently, both CGH and GRH have facilities for percutaneous coronary intervention (PCI)
- Currently, BRI (Bristol Royal Infirmary) provides out of hours acute cardiac intervention for Glos. patients – this is likely to end soon
- Acute Primary PCI (PPCI) for heart attack patients currently performed in daytime only at CGH & GRH - but will need to be performed in county 24/7 shortly

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Acute Cardiac Intervention

- NHS 2013 Commissioning Guidance (A09/S/d) states that:

"Patients who were admitted directly to the catheter laboratory bypassing accident and emergency had the lowest mortality"

- Therefore the 24/7 cardiac facility does not have to be co-located with the major A&E Dept at GRH. It could be located at CGH

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Centralisation of Cardiac Unit

- At GRH - would require major capital and infrastructure investment to provide an adequate facility, which would take time
- At CGH - would only require upgrading of obsolete equipment, as the building footprint is already available in the existing Hartpury Suite and 2 unused X-ray Rooms at CGH
- A cardiac centre at CGH would also have the backup use of the new (2014) hybrid vascular IR theatre, if needed (compliant with NHS 2013 Guidance)

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Vascular Interventional Radiology (IR) Centre

- A £2.5m state of the art hybrid interventional surgery/radiology operating theatre was commissioned at CGH only in 2014
- Vascular surgery was centralised to CGH in 2014
- Any transfer of vascular surgery to GRH would require a new capital build and lead to a waste of taxpayers' money with the CGH facility

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REACH Position on Cardiac, Vascular and IR Centre

- Both GRH and CGH require a general interventional radiology facility to provide 24/7 care for acute in-patients
- Centralising 24/7 cardiac PCI facilities to CGH would be quick and cheap, requiring only new equipment with no capital build cost
- It would be senseless to move vascular surgery/IR to GRH given the £2.5m capital investment at CGH in 2014

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