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 **“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.