



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

gynaecologists, 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 stenting (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 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.

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 and 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 the 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.

REACH (Restore Emergency at Cheltenham General Hospital)
c/o Cheltenham Chamber of Commerce
2 Trafalgar Street
Cheltenham
GL50 1UH
Email: info@reachnow.org.uk
Website: <https://www.reachnow.org.uk/contact/>