Gloucestershire Hospitals
NHS Foundation Trust

PUBLIC BOARD AGENDA

Meeting: **Trust Board meeting**

Date/Time: Thursday 14 January 2021 at 12:30

Location: Microsoft Teams

	Agenda Item	Lead	Purpose	Time	Paper
	Welcome and apologies	Chair		12:30	
1.	Declarations of interest	Chair			
2.	Minutes of the previous meeting	Chair	Approval		YES
3.	Matters arising	Chair	Approval		YES
4.	Chief Executive Officer's report	Deborah Lee	Information	12:35	YES
5.	Trust risk register	Emma Wood	Approval	12:50	YES
6.	Fit for the Future - Receive the Outcome of Consultation report	Simon Lanceley	Approval	12:55	YES
	PEOPLE AND ORGANISATIONAL DEVELOPMENT				
7.	People and OD development report	Emma Wood	Assurance	13:15	YES
8.	Assurance report of the Chair of the People & OD Committee	Balvinder Heran	Assurance	13:25	YES
	FINANCE AND DIGITAL				
9.	Finance report	Karen Johnson	Assurance	13:30	YES
10.	Digital report	Mark Hutchinson	Assurance	13:35	YES
11.	Assurance report of the Chair of the Finance & Digital Committee	Rob Graves	Assurance	13:40	YES
	BREAK			13:45	
	QUALITY AND PERFORMANCE				
12.	Quality and Performance report	Steve Hams / Rachael de Caux / Mark Pietroni	Assurance	13:55	YES
13.	Ockenden Report	Steve Hams	Assurance	14:05	YES

14.	Journey To Outstanding (J2O) visits quarterly report	Steve Hams	Assurance	14:10	YES
15.	Assurance report of the Chair of the Quality and Performance Committee	Alison Moon	Assurance	14:15	YES
	STANDING ITEMS				
16.	Minutes of the Meeting of the Council of Governors held 21 October 2020	Chair	Information	14:20	YES
17.	Governor questions and comments	Chair			
18.	New risks identified	Chair			
19.	Any other business	Chair			
CLOSE				14:30	

Date of the next meeting: Thursday 11 February 2021 at 12:30 via MS Teams

Public Bodies (Admissions to Meetings) Act 1960 "That under the provisions of Section 1 (2) of the Public Bodies (Admissions to Meetings) Act 1960, the public be excluded from the remainder of the meeting on the grounds that publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted."

Due to the restrictions on gatherings during the COVID-19 pandemic, there will be no physical attendees at the meeting. However members of the public who wish to observe virtually are very welcome and can request to do so by emailing ghn-tr.corporategovernance@nhs.net at least 48 hours before the meeting. There will be no questions at the meeting however these can be submitted in the usual way via email to ghn-tr.corporategovernance@nhs.net and a response will be provided separately.

Board Members	
Peter Lachecki, Chair	
Non-Executive Directors	**Executive Directors**
Claire Feehily Rob Graves Marie-Annick Gournet Balvinder Heran Alison Moon Mike Napier Elaine Warwicker	Deborah Lee, Chief Executive Officer Emma Wood, Director of People and Deputy Chief Executive Rachael de Caux, Chief Operating Officer Steve Hams, Director of Quality and Chief Nurse Mark Hutchinson, Chief Digital and Information Officer Karen Johnson, Director of Finance Simon Lanceley, Director of Strategy & Transformation Mark Pietroni, Director of Safety and Medical Director

Gloucestershire Hospitals
NHS Foundation Trust

DRAFT MINUTES OF THE TRUST BOARD MEETING HELD VIA MS TEAMS ON THURSDAY 10 DECEMBER 2020 AT 12:30

THESE MINUTES MAY BE MADE AVAILABLE TO THE PUBLIC AND PERSONS OUTSIDE THE TRUST AS PART OF THE TRUST'S COMPLIANCE WITH THE FREEDOM OF INFORMATION ACT 2000

PRESENT:		
Peter Lachecki	PL	Chair
Deborah Lee	DL	Chief Executive Officer
Rachael de Caux	RdC	Chief Operating Officer
Claire Feehily	CF	Non-Executive Director (NED)
Marie-Annick Gournet	MAG	Non-Executive Director
Rob Graves	RG	Non-Executive Director and Deputy Chair
Steve Hams	SH	Director of Quality and Chief Nurse
Balvinder Heran	BH	Non-Executive Director
Mark Hutchinson	MH	Chief Digital and Information Officer
Karen Johnson	KJ	Director of Finance
Simon Lanceley	SL	Director of Strategy and Transformation
Alison Moon	AM	Non-Executive Director
Mike Napier	MN	Non-Executive Director
Elaine Warwicker	EWa	Non-Executive Director
Emma Wood	EW	Director of People and Organisational Development & Deputy Chief Executive Officer
IN ATTENDANCE:		
James Brown	JB	Director of Engagement
Alex d'Agapayeff	AdA	Deputy Medical Director
Sim Foreman	SF	Trust Secretary
Katie Parker-Roberts	KPR	Head of Quality and Freedom to Speak Up Guardian (for Patient Story)
Lucy Mathieson	LM	Patient Story
APOLOGIES		
Mark Pietroni	MP	Director of Safety and Medical Director
MEMBERS OF THE PUBLIC/PRESS/STAFF/GOVERNORS:		
There were six governors, four staff and two members of the public present.		

The Chair welcomed MAG to her first Board meeting since her appointment as a Non-Executive Director (NED) on 1 December 2020. Welcomes were also extended to governors, staff, members of the public and Matthew Hill, Health Reporter from the BBC.

ACTION

208/20 PATIENT STORY

KPR introduced LM, who was known to many as a member of staff but was here to share the story of her husband Alan, which was to form part of the Trust's new induction programme to ensure focus on patient experience and the compassionate culture from day one.

LM conducted an exercise to ask board members to share what mattered to them in terms of care for themselves and their family and used this to demonstrate that the same things matter to staff and patients.

The Board were played an audio file of Alan's story which described his experiences of being admitted following a heart attack during the first wave of COVID-19 and other admissions that followed. Alan's story demonstrated the difficulties patients have in hearing what is said to them, especially when they have hearing difficulties, and how this can be compounded by the use of Personal Protective Equipment (PPE), different accents and also the fear from not knowing what is happening to them or how they are provided with information. LM advised that neither she nor Alan wanted to complain as they were grateful for the care but had been left feeling disappointment at times.

Board members thanked LM for sharing a very powerful story and were pleased this would be used as part of the induction. It was recognised how confusing and difficult it must have been for both them.

SH commented that whilst there was a demonstrable effect from COVID-19 which explains and excuses some of the issues, he could not excuse the way in which Alan and LM had been spoken to when the bed was moved and apologised.

Other comments from board members recognised that the feeling of safety should be taken for granted by both staff and patients, but most of the time patients don't want to be in hospital which is an alien environment for them and staff, who work here every day, should remember that. There should be recognition that people feel "othered" and that through "walking in their shoes" and providing a kind word and a smile staff can make a dramatic difference to how patients feel cared for.

The Chair advised that as well the regular patient story follow-up report to Board on what has happened or changed, it would also be good to receive assurance via the People and OD Committee (PODC) on the new induction process.

RESOLVED: The Board NOTED the patient story and thanked LM for her sharing Alan's story.

LM and KPR left the meeting.

209/20 DECLARATIONS OF INTEREST

There were NO declarations of interest.

210/20 MINUTES OF THE PREVIOUS MEETING

RESOLVED: The Board APPROVED the minutes of the meetings held on Thursday 12 November 2020 as a true and accurate record for signature by the Chair.

211/20 MATTERS ARISING

RESOLVED: The Board NOTED the report and APPROVED the closed matters.

ACTION

212/20 UPDATE FROM THE CHAIR

The Chair updated on the proposal to maintain virtual meetings until the end of March 2021 with a commitment to monitor the situation so that physical or hybrid meetings could occur sooner if practicable. The Chair also thanked the Corporate Governance team for their work to support the meetings.

RESOLVED: The Board APPROVED that Board, Committee and Governor meetings continue to be held virtually until 31 March 2021.

213/20 CHIEF EXECUTIVE OFFICER'S REPORT

DL presented the report and acknowledged that despite some hard challenges at present, there were a lot of positive things happening.

In relation to COVID-19 the Trust was still in the midst of a second wave with more inpatients than during the first wave (160+ patients which was c20% higher than in the first wave). Critical care was also busy with 12 patients although this proportionately lower than during the first wave and a testament to earlier identification of cases and access to treatment.

Community transmission rates had fallen in the county demonstrating a positive effect from the lockdown although, as mentioned in the Facebook Live sessions there was anxiety towards the change of approach over the festive period and DL encouraged all to be proportionate and adhere to the rules.

The launch of the vaccination programme earlier in the week had been tremendous. Over 220 people had been vaccinated in the first two days including a number of care home staff. The rollout will continue to focus on NHS and care staff and the priority groups in the community as determined by the Joint Committee on Vaccination and Immunisation (JCVI). The community programme would be delivered by primary care through ten centres and was expected to start next week.

DL acknowledged the work and leadership of SH and Craig Bradley, Associate Chief Nurse and Deputy Director of Infection Prevention & Control, for the Trust achieving the highest flu vaccination rate in the South West (87%) through the peer vaccinator programme. It was hoped there would be a further increase.

Lateral Flow Testing (LTF) for COVID-19 has been made available to 95% of patient facing staff to enable them to undertake voluntary twice weekly testing. The same technology has been rolled out to care homes.

The Board heard that the One Gloucestershire approach was still making progress across the system on tackling health inequalities and disadvantaged communities. DL reported that the outcomes for BAME patients had been better in Gloucestershire during both waves of the pandemic than other areas and the local approach to care for people with learning disabilities (LD) was showing outcomes were better than

the South West and national outcomes. Although the latter focused on a small sample size, DL was heartened that the eight patients who had received care from the Trust were known by name to the Lead for Vulnerable Adults.

DL acknowledged the publication of "The next steps to building strong and effective integrated care systems across England" by NHS England and advised that the document also describes options for giving ICSs a firmer footing in legislation likely to take effect from April 2022 (subject to parliamentary decision). Consultation is open until 8 January 2021 and the Board heard discussions were underway on the local impact of this and what it might mean for the system; which could include smaller systems becoming part of a new system covering a wider geographical area.

DL highlighted a number of the key things to be celebrated which included the partnership work with University of Gloucestershire as they now offered six healthcare degrees. The Chair echoed the comments on the strength of the partnership with the University of Gloucestershire.

The Board also heard that widening participation work was continuing and there had been a well-attended Facebook Live event facilitated by DWC, the external consultants supporting the work.

DL updated by sharing reflections from a great day to celebrate Ward Clerks and to congratulate the "Yellow Lanyard team" for wining a Nursing Times awards (in the thirtieth year of the awards and the Year of the Nurse) for their work during the first wave of COVID-19 to support colleagues in providing respiratory care.

CF referenced public understanding of the vaccination programme and asked how far local messaging could be adapted for Gloucestershire from the national messaging. DL confirmed plans were in place for this and it would be possible to do this when they time was right but whilst confirmation of supplies was awaited, there was a need to remain guarded in the meantime.

AM asked that the Board receive a copy of the ICS response to the NHS England consultation and whether more discussion time needed to be scheduled to consider arrangements post April 2022. DL confirmed this would be shared and explained there was a huge degree of consensus amongst system partners. If it was felt that Gloucestershire was too small then DL flagged that significant discussions would be needed and assured partners were also aligned on alternative plans too. **DL**

RG reinforced DL's opening point on the scope of work that was happening at present and thanked all staff for immense success responding to the pandemic whilst running initiatives in parallel. This was seconded by MN.

MN noted the initial numbers in the first few days of the vaccination programme that that targets would run into thousands and asked what the maximum number was for the Trust and the system. SH advised that primary care would be vaccinating around 10,000 people per week over

an 18-19 week period to achieve 80% uptake of the eligible population. There was also potential to establish "pop-up mop-up" centres using Gloucestershire Fire and Rescue service sites if additional capacity was required.

RESOLVED: The Board NOTED the Chief Executive Officer's report.

214/20 TRUST RISK REGISTER

EW presented the paper and updated there were no new risks, no closed risks and no risks downgraded. There had been one revision to a risk score related to the ability to maintain services and patient care/safety where the likelihood scores for Safety and Quality had increased to 4 and 5 respectively. EW assured the Board the risks were reviewed weekly by the Executive and Trust Risk Manager.

EW also highlighted the work by the Board to review and update risk appetite and tolerance statement. This was presented for formal approval. It was explained the domains and risk appetite definitions had been updated following the Board strategy session, to provide greater clarity for the Board and colleagues reporting and managing risks. The risk appetite for the Environmental domain has shifted from "Open/Risk taking" to "Cautious" to reflect the Trust's declaration of a climate emergency in December 2019. If approved, the risk team will work with Divisions to refresh their registers and this would be reflected in the revised Trust Risk Register next month.

RESOLVED: The Board NOTED the changes to the Trust Risk Register and APPROVED the changes to risk appetite and tolerance.

215/20 BOARD ASSURANCE FRAMEWORK

SF presented the Board Assurance Framework (BAF) as at the end of Quarter 2. There are currently 26 principal risks to the Strategic Objectives with no new or closed risks. The Board received the details of those risks rated RED and were assured that each assurance committee reviewed all risks for which it held oversight with the Audit and Assurance Committee (AAC) receiving the whole BAF. SF added the next iteration of the BAF would reflect the changes to risk appetite and tolerance.

RG commended the evolution of the BAF, the processes that underpinned it and the links to the Trust Risk Register. CF linked to the AAC Chair's report and updated that the methodologies were considered in detail at the Committee and good assurance had been attained from this and also feedback from the external auditors on their wider views on best practice in the sector.

MN also felt the document was coming together and that principal risks to strategic objectives were being reviewed. MN queried whether, given some committees were bi-monthly, whether the Board should review the BAF twice a year rather than quarterly. The Chair added that a review of the strategic objectives was planned for January 2021 which may result in some changes. SF and EW felt the current quarterly reporting should

continue for 2020/21 but a six month review from April 2021 would be scheduled.

RESOLVED: The Board REVIEWED the controls and assurances for those principal risks reported to the Board to be assured they were adequate. The Board APPROVED the BAF and NOTED the updates and agreed assurance ratings for Q2 2020/21.

216/20 EMERGENCY PREPAREDNESS, RESILIENCE AND RESPONSE (EPRR) ASSURANCE REPORT 2020-21

RdC presented the report which had also been considered in detail at the AAC and demonstrates an audit of compliance via a tracked action plan by the new Head of EPRR. The Trust had previously reported partial compliance against 11 areas of assurance but, as shown in the paper, excellent progress had been made to move to demonstrating substantial assurance in 58/64 domains with clear progress being made on the others.

AM, CF and MN all commended the document, the work carried out in a short period of time and the huge assurance provided. RdC added for further assurance that the changes were sustainable and had taken place alongside the work to tackle COVID-19.

RG noted a comment on page 18 that "recall to duty" was not working well and asked how quickly this would be addressed. RdC explained this related to staffing a rota to respond to Chemical, Biological, Radiological and Nuclear (CBRN) events and whilst the Trust had the appropriate staff in place and had also tested the plans, a formal 24/7 rota (with associated costs) was not yet in place but would be reviewed in the next three months.

The Chair asked whether there was any detriment to having a few smaller fire evacuation exercises instead of a larger one. RdC advised a large exercise had planned for October 2020 but stood down due to the risk of COVID-19, infection control and operational pressures to avoid unnecessary movement of patients. It was safer to conduct smaller exercises such as the one in Critical Care and to hold ward level table top exercises to maintain staff familiarity with plans and processes in their areas.

RESOLVED: The Board NOTED the contents of the report for assurance compliance.

217/20 ASSURANCE REPORT OF THE CHAIR OF THE AUDIT AND ASSURANCE COMMITTEE

CF presented the report and highlighted the EPRR report had been one of the most significant agenda items and the Trust's new external auditors (Deloitte) had attended their first meeting following a tender exercise involving governors.

The Internal Auditors (BDO) had presented a detailed report on backlog maintenance which had shown limited assurance; however the

Committee were assured by the clear intention and plans from management to address this with detailed oversight to be provided by the Estates and Facilities Committee (EFC).

The AAC also reviewed the BAF, losses and compensation, single tender waivers in relation to assurance of internal control and management oversight.

RESOLVED: The Board RECEIVED the report as assurance of the scrutiny and challenge undertaken by the Audit and Assurance Committee.

218/20 ASSURANCE REPORT OF THE CHAIR OF THE ESTATES AND FACILITIES COMMITTEE

MN presented the report and highlighted the Committee had requested further assurance on the number of claims made to GMS for slips, trips and falls on the Trust's estates being contrary to an external review of surfaces by a surveyor.

The report from the Contract Management Group (CMG) had provided assurance that the quality of cleaning was up to standard, in line with contract and under control. Nosocomial infection rates were also discussed and these are also considered by the Quality and Performance Committee (QPC) via Infection Prevention and Control reports.

Suggested performance metrics for GMS had been presented which were tighter than previous metrics and raised performance. The Board heard there would be shadow reporting until April 2021 when the metrics would be live. Metrics for waste management and estates backlog maintenance were still being developed.

The GMS business plan was presented along with an update on the current year which showed things were generally on track with some slippage related to COVID-19, including a reduction in retail income as result of the reduction in the number of visitors.

The Committee had received the Full Business Case (FBC) for the £39.5m Strategic Site Development (SSD) programme and fully supported the scoping and elements for which it had oversight. MN also confirmed planning approval from the local councils in Cheltenham and Gloucester had been granted. Phase 2 of the programme included all other plans to improve the physical estate in line with the strategic objectives.

Assurance on the management of Trust retained contracts by GMS had been received which included the Private Finance Initiative (PFI) and parking contracts.

The Committee oversee the development of the sustainability plan in response to the climate emergency declaration and MN advised there was a national aim to achieve net zero carbon for the NHS by 2040 (rather than 2050). MN stated that EFC was not the only interested party

for this work and requested all assurance committees include it within their agendas and work programmes.

The Chair thanked MN for a comprehensive report and added he had received positive feedback about GMS staff working alongside Trust colleagues in response to the pandemic.

RESOLVED: The Board RECEIVED the report as assurance of the scrutiny and challenge undertaken by the Estates and Facilities Committee.

219/20 FINANCE REPORT

KJ presented the finance report as at the end of Month 7 (M7) and confirmed the Trust was receiving a fixed funding allocation for the final six months of the year. The Trust forecast was for a £15.5m deficit at the year end with an overall Gloucestershire system deficit of £28.4m.

There had been a £1m improvement in M7 which accounted for 2% of the 13% planned for. This reflected a consistent pattern through the year of 1% increase in activity resulting in £90k additional costs. The £1m had been applied to the financial bottom line for year but as it derived from reduced activity and performance, it was not so good for patients. KJ added that the report did not assume any financial penalties from national incentive schemes for elective activity, but did include some additional income such as high cost drugs.

KJ advised that COVID-19 costs incurred were claimed via the “true-up” process and that a high degree of scrutiny had been applied to claims. The Trust’s M6 claim had been approved apart from the £4.2m VAT for HMRC which would continue to show as a pressure.

The Board heard that capital spending was £1m behind plan due to one scheme awaiting confirmation of a Memorandum of Understanding and also £600k of purchase orders related to pathology temperature control to be processed. KJ advised these were in train and there would be catch up. The Chair queried the confidence in the ability to spend all capital monies before the end of March. KJ advised that early indications for M8 were still behind plan and a review was underway to identify areas of slippage so alternative schemes could be considered i.e. IT infrastructure. KJ assured all teams were pushing as hard as possible to deliver the £40m plan and she was confident it would all be spent.

MN noted that the deficit plan had not been signed off by the regional team and asked if this would happen. KJ advised the regional team had announced there would be follow up questions for some systems, but Gloucestershire was not one of these. The Board noted that no formal acceptance of the deficit plan would be received and in the absence of this, the goal was to move forward and deliver it.

RESOLVED: The Board RECEIVED the contents of the report as a source of assurance that the financial position is understood and under control.

ACTION

220/20 DIGITAL REPORT

MH presented the report highlighting 110k tests had been requested since the launch of Order Comms at the end of August 2020 and he had received positive feedback from acute physicians on the ability to track patients being tested for COVID-19. Phase 3 will see rollout in outpatients, theatres and Women's and Children's Services.

The team were also building drug catalogues ahead of launching electronic prescribing in 12 months and had completed an update to the radiology system the previous evening.

A number of projects had been closed such as removing fax machines from the Trust and upgrading all PCs to Windows 10 two months earlier than planned. MH advised the Service Desk was seeing an increase in demand from staff working from home and accessing remote technology.

The project to launch the Electronic Patient Record (EPR) in Cheltenham General Hospital ED (then Gloucestershire Royal Hospital ED) was probably going to be the most complicated the team had undertaken due to the national reporting requirements. In response to a question from the Chair, MH confirmed the uncertainty on national ED reporting would not hold things up as the work would ensure the Trust's compliance with current and future requirements.

EWa asked if the COVID-19 vaccination programme had impacted on the team and MH confirmed this had required an adaptation of the flu booking system and there were some challenges arising from an ever growing number of local enhancement and national changes needed at short notice. MH advised the team would need to work additional hours to deliver their routine work which was possible but only sustainable in the short term.

AM stated she was keen to explore the benefits section of the report highlighting the need to be explicit on the benefits from the digital programme in way that can be clearly understood by both staff and patients. MH responded that there were benefits in respect of efficiency, quality and safety but that the questioning and challenge at FDC was based on the remit of the Committee, MH hoped to use clinicians to tell the story of how things had improved for them and patients in order to provide greater assurance. AM agreed the need to demonstrate a return on investment and suggested QPC should seek assurance on the improvements.

The Chair flagged that MH's suggestion of using clinicians to highlight the benefits of digital could be a staff story for a future meeting. **MH/SF**

RESOLVED: The Board NOTED the contents of the report as a source of assurance and information.

221/20 ASSURANCE REPORT OF THE CHAIR OF THE FINANCE AND DIGITAL COMMITTEE

RG updated that the Committee had been satisfied on the M7 financials as reported by KJ earlier. A more detailed review of capital had taken place and satisfied the Committee that the programme was under control and there was flexibility built in.

The Cost Improvement Programme (CIP) was looked at in a different way focusing on the detail for next year. There had also been an update on the budget setting process.

With regard to digital, RG advised that the Committee had received assurance on the individual programmes as described by MH and maintained a concern about capacity within the team and if it as resilient as it can be.

RG closed his report to update that for both finance and digital projects, the Committee had identified the need for post-implementation reviews that could be shared with other assurance committees and the Board.

RESOLVED: The Board RECEIVED the report as assurance of the scrutiny and challenge undertaken by the Finance and Digital Committee.

222/20 QUALITY AND PERFORMANCE REPORT

SH, RdC and AdA presented the report highlighting points relevant to their area.

SH was disappointed to report an increase in the number of Clostridium Difficile (C.Diff) cases in the previous month. These had all been reviewed and it was believed was a consequence of increased anti-microbial prescribing within primary care due to a reduction in face to face appointments.

SH assured that operational and infection control colleagues were working together to keep a strong focus on tackling nosocomial transmission of COVID-19 and early signs were that the high levels reported in November's Committee were starting to fall.

RdC highlighted the continued strong performance in cancer care across Two Week wait, 14 day and 62 day standards and a new queue fit protocol. RdC added that some patients were awaiting specialist care in centres in Bristol and Birmingham.

The steady recovery of planned care activity had been impacted by the second wave of COVID-19 but to date no cancer or urgent patients had been cancelled and mutual aid arrangements were in place.

AdA referred to the Hospital Standardised Mortality Ratio (HSMR) and explained the rise that had been seen over the COVID-19 period was coming down over time. Emergency readmissions also have a higher incidence over the same period.

MN had asked a question a few months ago about ambulance handover times and the reply was that they delay were due to the temporary service changes in August 2020, but data suggested this had continued. RdC confirmed ambulance handover was intense area of focus across the South West and a revised protocol had been approved by NHS England and Improvement (NHSE/I). The Trust had also received an urgent support visit and handovers only stop with Gold level executive approval. Despite these measures and best efforts, RdC advised the Board that separate flows needed to handle COVID-19 patients could not be ignored and there were delays, compounded by winter pressures.

The Chair noted the report showed the lowest vacancy rate for Registered Nurses and asked if this could be attributed to anything particular. EW confirmed the reasons were multi-factorial but an overall result of sustained efforts through a number of initiatives over the past two years to improve retention and stability to match and better those of university hospital peers.

RESOLVED: The Board RECEIVED the contents of the report as assurance that the Executive team and Divisions fully understood the levels of non-delivery against performance standards and have action plans to improve the position.

223/20 ANNUAL COMPLAINTS REPORT

SH presented the report and updated that it had been considered in details at QPC in October 2020. SH recorded his thanks to Jo Mason-Higgins, Head of Claims, Complaints and Patient Safety Investigations and her team for their work to improve performance and responsiveness to complaints. The report showed focused work had delivered improvements in a number of areas but continued focus was required in relation to the responsiveness and timeliness of admissions and discharges.

The Chair asked how best to capture those instances of disappointment that did not materialise into a formal complaint. SH confirmed this was actioned through real-time surveying and although it had to be paused due to COVID-19 remained the key for the future SH recognised that people were often grateful and didn't want to complain as shown in Alan's patient story earlier.

MN welcomed the updated on real-time feedback and queried whether it was possible to show the severity of complaints received and the quality of the resolution. PALS feedback was suggested as possible source.

CF queried the level of confidence that the Trust would have sufficient resource to deal with the increase in complaints in the coming months that related to COVID-19. SH confirmed his confidence in the resources and that there was sufficient resource in the Complaints team and added additional staff had been provided for the PALS team (some in part to cover sickness experienced).

RESOLVED: The Board APPROVED the Annual Complaints Report and NOTED as a source of assurance.

224/20 ASSURANCE REPORT OF THE CHAIR OF THE QUALITY AND PERFORMANCE REPORT

AM presented the report and highlighted in relation to the previous item, that the Committee positivity shown by the number of people/patients going to PALS before making a formal complaint and this helped support an open, honest environment in assurance terms.

AM explained the QPC had previously specifically requested details on how the Quality Delivery Group (QDG), which reports into QPC, sought greater assurance in its challenge and review. The Committee had received good evidence in support of this.

There had been a number of successes to note and AM highlighted cancer performance, Referral To Treatment (RTT), recovery of services and the Getting It Right First Time (GIRFT) programme.

AM stated that real-time feedback would greatly assist work on patient experience but that there had previously been mixed level of assurance on the Friends and Family Test (FFT) and the Committee was due to receive an update on a deep dive in this area. The increased PALS activity had also been noted and the QPC was assured the themes were similar to previous but with a greater volume relating to delays in care due to the impact of the pandemic on waiting times.

Discussion on urgent care had recognised the challenging environment and that staff were doing their best in the circumstances. The Committee had received a presentation on those areas the Care Quality Commission would focus on in their inspections.

The Committee also discussed improvements in stroke services and GP communications on discharge noting that MP had initiated work in respect of these.

Linked to the EFC update, AM reported the QPC were due to receive the Infection Control assurance framework at the next meeting.

RESOLVED: The Board RECEIVED the report as assurance of the scrutiny and challenge undertaken by the Quality and Performance Committee.

225/20 GOVERNOR QUESTIONS AND COMMENTS

Alan Thomas (AT), Public Governor for Cheltenham and Lead Governor was invited to speak on behalf of governors. AT commended staff for their hard work and efforts, noting that patients often didn't want to complain or speak up because they were getting care. He stated that little things often mean a lot to people and this was recognised by all governors. AT felt the patient story was very powerful and was pleased to see that this would be part of the induction programme.

AT referenced MN's comment on the Annual Complaint Report and if it was possible to rate or grade severity as he felt that the determination of someone to make a complaint showed it was serious to them and there should be caution on the language used.

AT requested that governors be able to attend the Big Conversation events. DL thought this had happened but asked EW to double check. **EW**

AT had read the ICS consultation documents on the proposed changes and also seen the comments from the Chief Executive of NHS Providers and in reference to DL's point about the risk of Gloucestershire going into a larger system and being subsumed without a voice; he felt this was how governors felt about the ICS. AT felt that changes to the ICS were a strategic issue and views from governors should be taken into account. DL acknowledged this as a legitimate request and confirmed that there would be a process to hear and consider views to take them into account if the Gloucestershire ICS did not continue as at present. It was acknowledged that the NED/Lay network meeting had not happened and the Chair would discuss this with the ICS Chair. **PL**

226/20 NEW RISKS IDENTIFIED

There were none.

227/20 ANY OTHER BUSINESS

There were no items of any other business.

The Chair thanked the Executives and all staff for their work in what had been truly difficult and challenging year.

[Meeting closed at 15:01]

Date of the next meeting: Thursday 14 January 2020 at 12:30 via Microsoft Teams.

Signed as a true and accurate record:

Chair
14 January 2020

Gloucestershire Hospitals
NHS Foundation Trust

Public Trust Board – Matters arising – January 2021

Minute	Action	Owner	Target Date	Update	Status
10 DECEMBER 2020					
213/20	**CHIEF EXECUTIVE OFFICER'S REPORT**				
	Board to receive a copy of the ICS response to the NHS England consultation.	DL	January 2021	To be provided ahead of board meeting.	**CLOSED**
220/20	**DIGITAL REPORT**				
	Using clinicians to highlight the benefits of digital could be a staff story for a future meeting.	MH/SF	January 2021	Scheduled for May 2021 staff story and added to work planner.	**CLOSED**
225/20	**GOVERNOR QUESTIONS AND COMMENTS**				
	Follow up on involvement and inclusion of governors in "Big Conversation" events.	EW	January 2021	DWC (consultants) convening specific session for governors on 29 January 2021 and invites issued.	**CLOSED**
	Discuss progression of the NED/Lay network and governor involvement with ICS Chair.	PL	January 2021	Network meeting scheduled for 27 January 2021, partly with focus on future ICS options.	**CLOSED**

Gloucestershire Hospitals
NHS Foundation Trust

PUBLIC BOARD – JANUARY 2021

CHIEF EXECUTIVE OFFICER'S REPORT

1 Operational Context

1.1 The operational context for the Trust is currently very challenging as a result of further increases in the number of COVID positive patients and the large numbers of patients whose discharge from hospital is unavoidably delayed, which is affecting the availability of beds. The number of COVID positive patients in our hospitals peaked at 236 in the week ending Friday 8 January 2021, an increase from the peak of 166 reported last month and 60% higher than the peak of 148 in April 2020. The numbers of patients in critical care as a proportion of total COVID positive patients remain considerably lower than the first wave. When adjusted for the introduction of Respiratory High Care in Wave Two, currently c13% of those in our hospitals have required critical care compared to 30% during Wave One; this improved position has enabled the Trust to offer mutual aid, for a small number of patients, from other Regions.

1.2 In respect of community transmission, the picture is a worsened and worrying one with rates of transmission in the county at their peak, with Gloucester City experiencing the highest rates but growth rates in areas such as Cheltenham and Tewkesbury as well as significant numbers of care home outbreaks. On the latter, primary care colleagues are very well advanced in the COVID-19 vaccination programme and we can confidently expect these outbreaks to have been largely mitigated by the middle of February. Regrettably, there is emerging evidence that the household mixing of c14 days has contributed to the most recent rises. Gloucestershire County Council (GCC) is delivering a large number of nuanced and targeted interventions to influence behaviour and support compliance with the requirements of the national lockdown and the Trust has been at the forefront of local communication this week, sharing insights from inside our hospitals, imploring the public to follow the guidance.

1.3 Positively, following decisive action to remove beds from our bed base (despite the operational impact) I am very pleased to note a significant reduction in the transmission of COVID within our hospitals. This, coupled with our continued efforts to screen asymptomatic front line colleagues, places the Trust in the lower range for this important measure of infection prevention and control (IPC).

1.4 This week the Trust was advised that it was one of twenty Trusts who had been selected for a targeted inspection, by the Care Quality Commission (CQC), in relation to our IPC practice. The review will comprise of a desk top review and interviews with a small number of Trust staff followed (when safe and appropriate) by a short notice on-site inspection. The Trust is incredibly proud of its IPC strategy, team and practice and look forward to welcoming the CQC later this month.

1.5 Unfortunately, due to the impact of an increase in COVID and those patients whose discharge is delayed, the Trust has seen a reduction in the amount of routine operating that it has been able to carry out, with operating activity largely reflecting those awaiting cancer surgery and the minority of other patients for whom an operation is considered necessary without delay. To date, the Trust has not had to cancel any surgery that could not be rescheduled in a clinically acceptable timeframe and these instances were very seldom. Our ability to continue with all other services remains under constant review in keeping with such a dynamic set of circumstances.

1.6 Regrettably, a minority of individuals, locally and nationally, have sought to portray our hospitals as largely empty, going as far to declare the pandemic as a hoax. The posting of such material on social media has been incredibly distressing for colleagues, given the reality is so far from this version of events. The Trust issued its own rebuttal immediately following the posts and the Police were swift in responding and taking action commensurate with any scenario where an individual knowingly breaks the law. As described above, this issue has not been contained to Gloucestershire and Sir Simon Stevens, Chief Executive of the NHS, appeared alongside the Prime Minister, unequivocally condemning the actions of these individuals and drawing attention to the risks to life, posed by such reckless and unlawful behaviour. However, like many events during this pandemic it has also triggered a powerful 'silver lining' in the guise of an outpouring of public support for NHS staff, which was a huge boost to colleagues who are all too aware that the public displays of support, which characterised Wave one of the pandemic, have waned more recently. For many staff the return to Thursday's visible expression of support through the *Clap For Heroes,* came at a very poignant moment although social media does reflect a degree of mixed emotions about the clapping!

1.7 Throughout the pandemic, we have maintained all of the usual oversight of the quality of our services both through close monitoring of our usual quality measures including careful review of complaints, Friends and Family Test and the themes that our Patient Advice and Liaison Service (PALS) have been receiving. Positively, the balance of compliments and concerns remains very much biased to positive feedback about the care we deliver and have maintained during the pandemic. Despite considerable operational pressures at our Gloucestershire Royal Hospital (GRH) front door and all of our wards, feedback from staff and their families has been incredibly positive with many patients recognising the difficult times we are all facing and sharing these positive experiences widely through social media.

2 Key Highlights

2.1 Under the leadership of Professor Steve Hams, our vaccination programme goes from strength to strength with hugely positive feedback from both staff and patients. We have now vaccinated over a third of eligible health and care staff and are over a quarter of a way through the priority groups which Government have pledged will be vaccinated by mid-February. Subject to continued good vaccine supply, we are on target to achieve all of these milestones which is a hugely positive step towards dramatically reducing the number of patients who die – 88% of whom are in these four priority groups – and the number of patients who are admitted to hospital which make up around 55% of all those admitted.

2.2 *Cancer Waiting Times 2020*

As we say goodbye to 2020 and all of its challenges, it feels fitting to reflect on one of the stand out achievements for our patients, where we have emerged as the regional and national best performer in respect of national cancer waiting times.

- We are currently on target to meet the Two Week Wait (2ww) standard for the year 20/21 which has not been achieved for seven years.
- We are currently on target to meet the 31 day new standard for 20/21 for the first time in three years.
- We met the 62 day GP standard in two consecutive months and >80% for annual performance which has not been achieved for seven years.

- Our cancer screening services continue a long legacy of delivering well above national average including recovering from first wave quicker than the national picture.
- Our >62 day and >104 day backlogs have never been lower since data started in 2016.
- Meeting all measures required in the Pandemic Phase 3 Response.

		Oct-20		
CWT standard	**Target**	**GHFT**	**National**	**Variation**
2ww standard	*93%*	95.9%	87.9%	8%
2ww standard (breast symptomatic)	*93%*	97.1%	77.0%	20.1%
31 day new treatment	*96%*	100%	95.7%	4.3%
62 day GP referral treatments	*85%*	85.1%	74.5%	10.6%
62 day screening	*90%*	100%	85.0%	15%
31 day subs – surgery	*94%*	100%	89.9%	10.1%
31 day subs - chemotherapy	*98%*	100%	99.5%	0.5%
31 day subs - Radiotherapy	*94%*	100%	97.1%	2.9%
No. of standards met target				**8/8**
No. of standards above national average				**8/8**

2.3 Whilst the stroke service remains under pressure due to the ongoing impact of longstanding gaps in both medical and specialist stroke nursing, the service has recently achieved a “B” rating in the Sentinel Stroke National Audit Programme (SNAPP) SSNAP score (A being the best and E the lowest), for the period April 2020 – June 2020. This is the best performance since 2016 and will hopefully position the Trust to appoint in to our current vacancies.

2.4 Hospital food has long been the butt of many a national joke but also the subject of very serious concerns from patients and families. I am delighted therefore that our own catering team has been singled out to be a case study exemplar by the Hospital Caterers Association. From celebrating Black History Month with a Caribbean feast to the recent and very popular “Christmas Lunch In A Box” initiative. My postbag since I arrived in Gloucestershire has stood out for the number of positive comments about our food and the very few complaints. I would like extend huge thanks to colleagues in Gloucestershire Managed Services (GMS) and their catering team including Shelly Alder, Mark Lane and Brigitte Hooper.

2.5 Never has support to colleagues been more important and we continue to place considerable focus on this. One such support tool is the roll out of an approach known as TRiM – Trauma Risk Management – which is an intervention delivered by TRiM trained practitioners to support staff who have been exposed to potentially traumatic events, such as those experienced by many staff during COVID and to work with

individuals to enable them to “process” what they have experienced with the aim of reducing the long term consequences of these events. Training of TRiM managers will commence next month with the aim of going on to train 40 TRiM practitioners during March. This is a hugely positive step which will sit alongside the wide range of support offers available through the 2020 Hub.

2.6 This month we received confirmation that planning permission has been granted for our two storey build at GRH in the courtyard area adjacent to the Tower. This was funded through the additional £4.4m of national funding secured in Autumn 2020 to expand urgent and emergency care capacity and through the same funding route, we have also taken receipt of a modular build which will sit alongside the GRH Emergency Department and provide much needed additional space to ensure our services remain *COVID Secure* and that we can manage demand, even at its peaks.

2.7 It has been a hugely busy period since my last report but one through which it has remained an absolute privilege to work alongside and lead the 8,500+ staff in the Gloucestershire Hospitals family.

Deborah Lee
Chief Executive Officer
January 2021

Gloucestershire Hospitals
NHS Foundation Trust

TRUST BOARD – 14 JANUARY 2021

Report Title
TRUST RISK REGISTER (TRR)
Sponsor and Author(s)
Author: Lee Troake, Corporate Risk, Health & Safety Sponsor: Emma Wood, Deputy CEO and Director of People and OD
Executive Summary

Purpose

The Trust Risk Register enables the Board to have oversight, and be assured of, the active management of the key risks within the organisation.

Key issues to note

The following risks have been agreed for entry on to the Trust Risk Register by Risk Management Group (RMG):

- **M2353Diab -** The risk to patient safety for inpatients with Diabetes whom will not receive the specialist nursing input to support and optimise diabetic management and overall sub-optimal care provision.

  Score: Safety C3 x L4= 12, Quality C2 x L4 = 8, Workforce C2 x L4 = 8, Statutory C2 x L3 = 6, Business C3x L3 = 9, Finance C3x L3 = 9

- **C3223COVID -** The risk to safety in relation to transmission of COVID between staff and patients
  Score: Safety C5 x L5 = 25, Quality C5 x L5 = 25, Workforce C4 x L5 = 20, Statutory C3 x L3 = 9

The scores on the following risk on the TRR were increased:

- **C3169COVID -** Risk of the Trust being unable to deliver or maintain its usual range of comprehensive, high quality services with consequent impact on patient safety, experience and staff wellbeing due to the second wave of COVID-19 Pandemic and winter pressures.

  Score: Safety C4 x L4 = 16, Quality C4 x L5 = 20, Workforce C4 x L4 = 16, Statutory C3 xL3 = 9, Business C4 x L4 =16, Finance C4 xL3 = 12

There were no proposed downgrades or closure on the Trust Risk Register.

Recommendations
To note this report.
Impact Upon Risk – known or new
The RMG / TRR identifies the risks which may impact on the achievement of the strategic objectives
Equality & Patient Impact
Potential impact on patient care, as described under individual risks on the register.

Resource Implications			
Finance		Information Management & Technology	
Human Resources		Buildings	

Action/Decision Required							
For Decision		For Assurance	**X**	For Approval		For Information	

Date the paper was presented to previous Committees		
Divisional Board	**Trust Leadership Team Sub-group**	**Other (Specify)**
	December 2020	Risk Management Group 4 November, 3 December 2020
Outcome of discussion when presented to previous Committees To accept changes recommended		
Risks agreed for TRR.		

Ref	Inherent Risk	Controls in place	Action / Mitigation	Division	Highest Scoring Domain	Consequence	Likelihood	Score	Current	Date Risk to be reviewed by	Operational Lead for Risk	Approval status
M2353Diab	The risk to patient safety for inpatients with Diabetes whom will not receive the specialist nursing input to support and optimise diabetic management and overall sub-optimal care provision.	1)E referral system in place which is triaged daily Monday to Friday. 2)Unfunded limited inpatients diabetes service available Monday - Friday although this is dependent on outpatient workload including ad hoc urgent new patients.	Business case draft 2 to be submitted Business case to be submitted Demand and Capacity model for diabetes Liaise with Steve Hams to raise this diabetes risk onto TRR	Medical	Safety	Moderate (3)	Likely - Weekly (4)	12	8 -12 High risk	29/01/2021	Sandra Attwood	Trust Risk Register
C3089COOEFD	Risk of failure to achieve the Trust's performance standard for domestic cleaning services due to performance standards not being met by service partner.	1. Domestic Cleaning Services are currently provided by the Service Partner with defined performance standards/KPIs for functional areas in the clinical & non-clinical environment. (NB. Performance Standards/KPIs are agreed Trust standards that marginally deviate from guideline document 'The National Specifications for Cleanliness in the NHS – April 2007'); 2. Cleaning Services are periodically measured via self-audit process and performance is reported against the agreed Performance Standards/KPIs to the Contract Management Group (bi-monthly, every two months); 3. Scope of Cleaning Service currently agreed with the Service Partner includes – Scheduled & Reactive Cleaning, Planned Cleaning, Barrier Cleaning, Deep Cleaning and other Domestic Duties; 4. Provision of an Ad-hoc cleaning service is provided by the Service Partner with defined rectification times for the functional areas; 5. Cleaning activities and schedules are noted as being agreed at local levels (e.g. departmental/ward level) between Trust and Service Partner representatives.	Review, Assess and enact agreed future actions/controls	Corporate, Diagnostics and Specialties, Gloucestershire Managed Services, Medical, Surgical, Women's and Children's	Quality	Major (4)	Likely - Weekly (4)	16	15 - 25 Extreme risk	05/04/2021	Akin Makinde	Trust Risk Register
C2817COO	Tower block ward ducts / vents have built up dust and debris over recent years.	Funding for cleaning now secured; Schedule for cleaning drawn up to be undertaken in the summer months where wards can be decanted to day surgery areas, allowing cleaning to take place at weekends.	Duct cleaning only possible when ward is fully decanted. Implement ward closure programe to provide access to undertake the works. Ward 3B being assessed for ability to undertake works this Summer	Corporate, Gloucestershire Managed Services	Safety	Catastrophic (5)	Rare - Less than annually (1)	5	4 - 6 Moderate risk	30/10/2020	Steve Rowe	Trust Risk Register
C2970COOEFD	Risk of harm or injury to staff and public due to dilapidation and/or structural failure of external elevations of Centre Block and Hazelton Ward Ceiling – resulting in loose, blown or spalled render/masonry to external & internal areas.	1) Snapshot' visual survey undertaken from ground level to establish the scope of the loose, blown or spalled render and masonry to the external elevations of the building & any loose material removed (frequency TBC); 2) Heras fencing has been put up to isolate persons from the areas of immediate concern; 3) Areas of concern being monitored (frequency TBC). (All Controls to be reviewed and confirmed as active & appropriate).	Refurbish the roof outside and make safe To undertake a comprehensive structural survey of the external elevations of Centre Block to identify all areas requiring repair or replacement and to undertake those works Planning permission for investigatory works	Corporate, Diagnostics and Specialties, Gloucestershire Managed Services, Medical, Surgical	Safety	Catastrophic (5)	Rare - Less than annually (1)	5	4 - 6 Moderate risk	05/04/2021	Akin Makinde	Trust Risk Register
C2669N	The risk of harm to patients as a result of falls	1. Patient Falls Policy 2. Falls Care Plan 3. Post falls protocol 4. Equipment to support falls prevention and post falls management 5. Acute Specialist Falls Nurse in post 6.Falls link persons on wards 7. Falls monitored and reported at the Health and Safety Committee and the Quality and Performance Committee 8. Falls management training package	Discussion with Matrons on 2 ward to trial process Develop and implement falls training package for registered nurses develop and implement training package for HCAs #Litle things matter campaign Discussion with matrons on 2 wards to trial process Review 12 hr standard for completion of risk assessment Alter falls policy to reflect use of hoverjack for retrieval from floor	Diagnostics and Specialties, Medical, Surgical, Women's and Children's	Safety	Major (4)	Possible - Monthly (3)	12	8 -12 High risk	30/10/2020	Craig Bradley	Trust Risk Register

C3169MDCOVID	Risk of the Trust being unable to deliver or maintain its usual range of comprehensive, high quality services with consequent impact on patient safety, experience and staff wellbeing due to the second wave of COVID-19 Pandemic and winter pressures.	• Winter pressure plan in place • RED ED flip / RED surge Plan • Empty two green bays on 8a to create red capacity • Paediatrics red area • Following National Guidance across all domains / reviewing guidance and applying according to local circumstances• Fit testing programme • PPE training provision, training, information and PPE Safety Officers / social distancing guardians• Action cards published for staff• Pathways for trauma for COVID and non COVID for all specialties• COVID testing on admission, testing on day 5• Outbreak MDT meetings - clinical staff, ICP and Safety • COVID Secure programme & working group • Provision of social distancing materials / guidance and PPE • All staff to wear masks if within 2m of others • Patients to be required to wear mask if away from bed space (and can tolerate it)• Paediatrics and Obstetrics – both have clear pathway for COVID or non COVID problem patients • Gynaecology – early pregnancy and miscarriage is being managed through OP where possible • Limited public access to hospital • Telephone triage support to ED to reduce wait times e.g. OMF • Prescriptions (FP10s) e-mailed direct to community Pharmacies• Patient belongings and letters drop-off service • Family and friends helpline • Continued provision of critical / mandatory training • Rapid refresher training sessions for nurses • Revised training programme • Virtual meetings to support governance framework / statutory requirements• Workforce Hub and specialist staff support network• New psychological support services and link workers • Revision of medical rotas to ensure staffing supports activity, recruitment of volunteer workforce, redeployment to areas of greatest need, retired staff returning • All rotas can be revised to a 12 hour rota for juniors if needed • Clinical and non-clinical home working – with access to EPR, scans, results, email, datix, VPN etc. • Daily staff updates with key messages and links to key resources • Extended childcare offer• Subsidised food and drink • Emergency accommodation offer • Going the Extra Mile (GEM) postcards to say thank you, quickly • Cross-site parking permits• Staff / family member pillar 1 testing for those self-insolation commenced to support return to work • Specialist Platinum COVID19 on-call rota composed of CEO and Exec Tri • Senior Nurse cover until 8pm and 24/7 Nurse Director on call • Outpatient appointments moved from face to face to video conference where possible • Initial telephone triage of 2 week wait referrals to identify patients that can go 'straight to test' without a face to face appointment • Microbiologist resource – are providing a 1 in 5 rota and the out of hours service. Lab results available hourly• Cancellation of non-urgent elective work to reduce demand on anaesthetics team if required• Digital solutions to allow continuation of routine OP work where workforce permits • Stress testing of key infrastructure as part of contingency planning e.g. max Oxygen capacity at both sites • Community hospital eligibility criteria expanded resulting in reduced DTOC and >21d LOS • Pharmacy service continuity plans• Multiple diagnostics arranged for the same day to support one-stop outpatient appointments • Use of Private Provider facilities in extremis• Usage of Private Provider Bed Stock to gain additional capacity • Working closely with Community and Social care partners• Use of Microsoft teams for all staff to connect • specialty transition and recovery planning• Ophthalmology has changed its triage service to 7 days a week from 8am-8pm• Additional resources in the form of bank, student nurse volunteers • Exploration of use of national charity funds for long term health issues• Deployment hub• Weekly psychological briefing for execcv Weekly hub analysis for trends • Proactive communication to vulnerable groups – BAME and shielded	Establish IMT to manage response	Corporate, Diagnostics and Specialties, Gloucestershire Managed Services, Medical, Surgical, Women's and Children's	Quality	Major (4)	Likely - Weekly (4)	16	15 - 25 Extreme risk	30/11/2020	Felicity Taylor-Drewe	Trust Risk Register
F2895	There is a risk the Trust is unable to generate and borrow sufficient capital for its routine annual plans (estimated backlog value £60m), resulting in patients and staff being exposed to poor quality care or service interruptions as a result of failure to make required progress on estate maintenance, repair and refurbishment of core equipment and/or buildings.	1. Board approved, risk assessed capital plan including backlog maintenance items; 2. Prioritisation and allocation of cyclical capital (and contingency capital) via MEF and Capital Control Group; 3. Capital funding issue and maintenance backlog escalated to NHSI; 4. All opportunities to apply for capital made; 5. Finance and Digital Committee provide oversight for risk management/works prioritisation; 6. Trust Board provide oversight for risk management/works prioritisation; 7. GMS Committee provide oversight for risk management/works prioritisation; 8. Prioritisation of Capital managed through intolerable risk process 2019-20 – Complete 30/4/19 and revisited periodically through Capital contingency funds; 9. On-going escalation to NHSI for Capital Investment requirements – Trust recently awarded Capital Investment for replacement of diagnostic imaging equipment (MR, CT and mammography) in October 2019, SOC for £39.5 million Strategic Site Development on GRH and CGH sites approved September 2019, Trust recently rewarded emergency Capital of £5million for 19/20 from NHSI.	1. Prioritisation of capital managed through the intolerable risks process for 2019/20 Ongoing escalation to NHSI and system	Corporate, Gloucestershire Managed Services	Environmental	Major (4)	Likely - Weekly (4)	16	15 - 25 Extreme risk	29/01/2021	Akin Makinde	Trust Risk Register
C3253PODCOVID	Risk to the health of staff working in the healthcare setting who are extremely clinically vulnerable, clinically vulnerable or BAME and are at increased risk a more serious outcome or fatality as a result of contracting COVID-19 infection.	1. Risk assessment templates provided to managers to support a personal risk assessment for each member of staff within these groups 2. Managers will be asked to confirm with the hub that the assessment has been completed 3. Assessments will be kept on personal files 4. Extremely clinically vulnerable staff to work from home 5. Clinically vulnerable staff to work from home or a suitable low risk environment 6 IT resources provided to enable remote working 7. DSE equipment available to work from home 8. Home working policy 9 Social distancing guidelines and toolkit developed 10. Risk assessment templates provided to support social distancing risk assessment 11. Social Distancing guardians 12. PPE available to all staff 13. Hand gel and masks on all public entrances 14. Inpatients now wear masks where possible 15. IPC working with outbreak areas / daily outbreak meetings 16. Continual comms on social distancing	To set up SD guardians Risk Assessment Audit for NHSE/I	Corporate, Diagnostics and Specialties, Gloucestershire Managed Services, Medical, Surgical, Women's and Children's	Safety	Catastrophic (5)	Unlikely - Annually (2)	10	8 -12 High risk	31/12/2020	Alison Koeltgen	Trust Risk Register
C3224COOCOVID	Risks to safety and quality of care for patients with increased waiting in relation to the services that were suspended or which remain reduced	• RAG rating of patients in clinical priorisation & Clinical Harm Reviews • Movement of the acute take from CGH to GRH (see issues outlined in gaps below) ED dept at CGH will operate as a minor injuries unit, all emergency patients are managed through GRH. This will enable CGH to manage planned patients who have tested negative to COVID. • All emergency surgery will move to GRH. Vascular emergency patients will move from CGH to GRH. 50% of benign Gynaecology elective day cases will transfer from GRH to CGH. Some Upper GI urgent activity may also move to CGH (Hot laparoscopic Cholecystectomy), if additional theatre capacity is required. • Use of BI models to underpin next phases in medicine – impact on AMU / ACUC • 9a will come in to Medicine and there will be clear pathways to move Elderly Care and Stroke to CGH • Respiratory bed base will be at GRH with a HOT Respiratory Consultant at CGH • Cardiology has an allocation of 17 beds at GRH due to acute specialty and all elective activity to go to CGH. • Hot PCI's will go directly to CGH and managed in side rooms pending swabs, supported by a Respiratory nurse to give full review of patients at CGH • Have assessed impact of move to GRH based on patient numbers and acuity in MIU at CGH overnight • Overnight staffing of MIU to be moved to GRH to increase GRH ED resilience • AEC presence 8am-8pm at CGH / triage via Cinapsis • Red Oncology – after patients are triaged on the helpline they will go to GRH if suspect red. If confirmed COVID they will not have chemo and will stay under medical beds at GRH. If Haematology is the primary issue they will move to Knightsbridge. • limit emergency admissions through to CGH as predominantly NON COVID Site • Green ITU established at CGH • Optimise elective activity whilst maintaining COVID beds and ready to take another surge • Optimise urgent and less urgent diagnostic and therapeutic activities across specialties whilst maintaining COVID beds and ready to take another surge • Pre-op testing and 7 days patient isolation for surgical pathways in place • Cancer & urgent work is put out to the Nuffield & Winfield • Wider discussions with ICS Board and regional colleagues • Communication Strategy in place with affected staff • HR Business Partner point of contact to link with PMO • Impact assessment for completed in relation to surgical staff • Financial planning and COVID-19 cost recovery activities under development (e.g. consideration of 6/7 day working *Harm review Policy updated to reflect Covid-19 approach	Incremental step up of elective activities, including through the independent sector Continued review of clinical waiting lists	Corporate, Diagnostics and Specialties, Gloucestershire Managed Services, Medical, Surgical, Women's and Children's	Safety	Major (4)	Possible - Monthly (3)	12	8 -12 High risk	31/12/2020	Felicity Taylor-Drewe	Trust Risk Register
	The risk to patient safety as a result of lab failure due to ageing imaging equipment within the Cardiac Laboratories, the service is	Platinum level service agreement on Room 3 - with 24 hour call out. Tube replacement has taken place in Room 3 which has corrected dosing issues however image quality remains poor.	This has been worked up at part of STP replace bid. Submission of cardiac cath lab case									

M2613Card	Imaging equipment within the Cardiac Laboratories, the service is at risk due to potential increased downtime and failure to secure replacement equipment.	Cost analysis carried out and procurement of mobile lab to take place should either lab fail permanently prior to a build solution. Regular Dosimeter checking and radiation reporting. Service Line fully compliant with IRMER regulations as per CQC review Jan 20.	Procure Mobile cath lab	Medical	Safety	Major (4)	Possible - Monthly (3)	12	8 -12 High risk	26/02/2021	Joseph Mills	Trust Risk Register
D&S2517Path	The risk of non-compliance with statutory requirements to the control the ambient air temperature in the Pathology Laboratories. Failure to comply could lead to equipment and sample failure, the suspension of pathology laboratory services at GHT and the loss of UKAS accreditation.	Air conditioning installed in some laboratory (although not adequate) Desktop and floor-standing fans used in some areas Quality control procedures for lab analysis Temperature monitoring systems Temperature alarm for body store Contingency plan is to transfer work to another laboratory in the event of total loss of service, such as to North Bristol	Review performance and advise on improvement Review service schedule A full risk assessment should be completed in terms of the future potential risk to the service if the temperature control within the laboratories is not addressed A business case should be put forward with the risk assessment and should be put forward as a key priority for the service and division as part of the planning rounds for 2019/20.	Diagnostics and Specialties	Statutory	Major (4)	Likely - Weekly (4)	16	15 - 25 Extreme risk	31/12/2020	Jonathan Lewis	Trust Risk Register
C18S0NSafe	The risk of safety to patients, staff and visitors in the event of any adolescent 12-18yrs presenting with significant mental illness, behavioural, emotional and social difficulties, with potentially self harming and violent behaviour whilst on the ward. Patient's stay at GHT is prolonged whilst waiting assessment and a place of safety with an Adolescent Mental Health (Tier 4) facility or foster care placement.	1. The paediatric environment has been risk assessed and adjusted to make the area safer for self harming patients with agreed protocols. 2. Relevant extra staff including RMN's are employed via and agency during admission periods to support the care and supervision of these patients. 3. CQC\commissioners have been made formally aware of the risk issues. 4. Individual cases are escalated to relevant services for support . 5. Welfare support for staff available - decompression sessions can be given to support staff after difficult incidents 6. Designated social work allocated by CCG	Develop Intensive Intervention programme Escalation of risk to Mental Health County Partnership Escaled to CCG	Medical, Surgical, Women's and Children's	Safety	Moderate (3)	Likely - Weekly (4)	12	8 -12 High risk	31/12/2020	Vivien Mortimore	Trust Risk Register
C2719COO	The risk of inefficient evacuation of the tower block in the event of fire, where training and equipment is not in place.	All divisions now taking accountability to ensure fire training and evacuation being undertaken and evidence; Records kept at local level as per fire safety standards to includes: fire warden training, e-learning, fire drills and location of fire safety equipment: Fire safety committee now established; Training needs and equipment are identified; Training programs launched to include drills using an apprenticeship model: see one, do one, teach, one for matrons (to be distributed out to staffing); Education standardisation documentation established for all areas; Localised walkabouts arranged with fire officer (Site team prioritised); Consistent messaging cascaded at the site meeting for training and compliance.	Monitoring and ensure all areas received the approrpaite training and drills to evaucate patients safely	Corporate, Diagnostics and Specialties, Medical, Surgical, Women's and Children's	Safety	Catastrophic (5)	Rare - Less than annually (1)	5	4 - 6 Moderate risk	28/08/2020	Alison McGirr	Trust Risk Register
C1798COO	The risk of delayed follow up care due outpatient capacity constraints all specialities. (Rheumatology & Ophthalmology) Risk to both quality of care through patient experience impact(15)and safety risk associated with delays to treatment(4).	1. Speciality specific review administratively of patients (i.e. clearance of duplicates) (administrative validation) 2. Speciality specific clinical review of patients (clinical validation) 3. Utilisation of existing capacity to support long waiting follow up patients 4.Weekly review at Check and Challenge meeting with each service line, with specific focus on the three specialties 5.Do Not Breach DNB (or DNC)functionality within the report for clinical colleagues to use with 'urgent' patients. 6. Use of telephone follow up for patients - where clinically appropriate 7. Additional capacity (non recurrent) for Ophthalmology to be reviewed post C-19 8. Adoption of virtual approaches to mitigate risk in patient volumes in key specialities 9. Review of % over breach report with validated administratively and clinically the values 10. Each speciality to formulate plan and to self-determine trajectory. 11. Services supporting review where possible if clinical teams are working whilst self-isolating.	1. Revise systems for reviewing patients waiting over time 2. Assurance from specialities through the delivery and assurance structures to complete the follow-up plan 3. Additional provision for capacity in key specialities to support f/u clearance of backlog	Medical, Surgical	Quality	Moderate (3)	Almost certain - Daily (5)	15	15 - 25 Extreme risk	31/01/2021	Felicity Taylor-Drewe	Trust Risk Register
C2819N	The risk of serious harm to the deteriorating patient as a consequence of inconsistent use of NEWS2 which may result in the risk of failure to recognise, plan and deliver appropriate urgent care needs	Ongoing education on NEWS2 to nursing, medical staff, AHPs etc o E-learning package o Mandatory training o Induction training o Targeted training to specific staff groups, Band 2, Preceptorship and Resuscitation Study Days o Ward Based Simulation o Acute Care Response Team Feedback to Ward teams	Monthly Audits of NEWS2. Assessing completeness, accuracy and evidence of escalation. Feeding back to ward teams Development of an Improvement Programme	Diagnostics and Specialties, Medical, Surgical, Women's and Children's	Safety	Major (4)	Possible - Monthly (3)	12	8 -12 High risk	30/10/2020	Ben King	Trust Risk Register
C3084P&OD	The risk of inadequate quality and safety management as GHFT relies on the daily use of outdated electronic systems for compliance, reporting, analysis and assurance. Outdated systems include those used for Policy, Safety, Incidents, Risks, Alerts, Audits, Inspections, Claims, Complaints, Radiation, Compliance etc. across the Trust at all levels.	Risk Managers monitoring the system daily Risk Managers manually following up overdue risks, partially completed risks, uncontrolled risks and overdue actions Risk Assessments, inspections and audits held by local departments Risk Management Framework in place Risk management policy in place SharePoint used to manage policies and other documents	Prepare a business case for upgrade / replacement of DATIX Arrange demonstration of DATIX and Ulysis	Corporate, Diagnostics and Specialties, Gloucestershire Managed Services, Medical, Surgical, Women's and Children's	Quality	Moderate (3)	Almost certain - Daily (5)	15	15 - 25 Extreme risk	30/01/2021	Lee Troake	Trust Risk Register
C2628COO	The risk of regulatory intervention (including fines) and poor patient experience resulting from the non-delivery of appointments within 18 weeks within the NHS Constitutional standards.	The RTT standard is not being met and re-reporting took place in March 2019 (February data). RTT trajectory and Waiting list size (NHS I agreed) is being met by the Trust. The long waiting patients (52s)are on a continued downward trajectory and this is the area of main concern Controls in place from an operational perspective are: 1.The daily review of existing patient tracking list 2. Additional resource to support central and divisional validation of the patient tracking list. 3.Review of all patients at 45 weeks for action e.g. removal from list (DNA / Duplicates) or 1st OPA, investigations or TCI. 4. A delivery plan for the delivery to standard across specialities is in place 5. Additional non-recurrent funding (between cancer/ diagnostics and follow ups) to support the reduction in long waiting 6. Picking practice report developed by BI and theatres operations, reviewed with 2 specialities (Jan 2020) and issued to all service lines (Jan 2020) to implement. Reporting through Theatre Collaborative and PCDG. 7. PTL will be reviewed to ensure the management of our patients alongside the clinical review RAG rating	1.RTT and TrakCare plans monitored through the delivery and assurance structures	Diagnostics and Specialties, Medical, Surgical, Women's and Children's	Statutory	Major (4)	Likely - Weekly (4)	16	15 - 25 Extreme risk	31/01/2021	Felicity Taylor-Drewe	Trust Risk Register
S2917CC	The risk of patient and staff harm and loss of life as a result of an inability to horizontally evacuate patients from critical care	Presence of fire escape staircase Hover-jack to aid evacuation of level 3 patient Fire extinguisher training for staff	Fire extinguisher training Simulation training to evaluate hoverjack and slide sheets Discuss estates option for creating adequate fire escape facilities Purchase of twenty sliding sheets order oxygen cylinder holders Evacuation practice	Gloucestershire Managed Services, Surgical	Safety	Catastrophic (5)	Rare - Less than annually (1)	5	4 - 6 Moderate risk	13/01/2021	Rebecca Offord	Trust Risk Register

M2268Emer	The risk of patient deterioration (Safety) due to lack of capacity leading to ED overcrowding with patients in the corridor	RN identified for ambulance assessment corridor 24/7 Identified band 3 24 hours a day for third radiology corridor with identified accountable RN on every shift Additional band 3 staffing in ambulance assessment corridor 24 hours a day - improvement in NEWS compliance and safety checklist Where possible room 24 to be kept available to rotate patients 9(or identified alternative where 24 occupied) (GRH) 8am - 12mn consultant cover 7/7 (GRH) reviewed by fire officers safety checklist; Escalation to silver/gold on call for extra help should the department require to overflow into the third (radiology) corridor. Silver QI project undertaken to attempt to improve quality of care delivered in corridor inc. fleeced single use blankets and introduction of patient leaflet to allow for patients to access PALS. 90% recovery plan May 2019. adherence. Pitstop process late shifts Mon - Fri to rapidly assess all patient arriving by ambulance - early recognition of increased acuity to prioritise into the department. Establishment of GPAU to stream GP referrals direct into alternative assessment area reducing demand in corridor.	Complete CQC action plan Compliance with 90% recovery plan Monies identified to increase staffing in escalation areas in E, increase numbers in Transfer Teams, increase throughput in AMIA. Upgrage risk to reflect ED corridor being used for frequently + liaise with Steve Hams so get risk back on TRR	Medical	Safety	Moderate (3)	Likely - Weekly (4)	12	8 -12 High risk	31/12/2020	Tiffany Cairns	Trust Risk Register
C3034N	The risk of patient deterioration, poor patient experience, poor compliance with standard operating procedures (high reliability)and reduce patient flow as a result of registered nurse vacancies within adult inpatient areas at Gloucestershire Royal Hospital and Cheltenham General Hospital.	1. Temporary Staffing Service on site 7 days per week. 2. Twice daily staffing calls to identify shortfalls at 9am and 3pm between Divisional Matron and Temporary Staffing team. 3. Out of hours senior nurse covers Director of Nursing on call for support to all wards and departments and approval of agency staffing shifts. 4. Band 7 cover across both sites on Saturday and Sunday to manage staffing and escalate concerns. 5. Safe care live completed across wards 3 times daily shift by shift of ward acuity and dependency, reviewed shift by shift by divisional senior nurses. 6. Master Vendor Agreement for Agency Nurses with agreed KPI's relating to quality standards. 7. Facilitated approach to identifying poor performance of Bank and Agency workers as detailed in Temporary Staffing Procedure. 8. Long lines of agency approved for areas with known long term vacancies to provide consistency, continuity in workers supplied. 9. Robust approach to induction of temporary staffing with all Bank and Agency nurses required to complete a Trust local Induction within first 2 shifts worked. 10. Regular Monitoring of Nursing Metrics to identify any areas of concern. 11, Acute Care Response Team in place to support deteriorating patients. 12, Implementation of eObs to provide better visibility of deteriorating patients. 13, Agency induction programmes to ensure agency nurses are familiar with policy, systems and processes. 14, Increasing fill rate of bank staff who have greater familiarity with policy, systems and processes.	To review and update relevant retention policies Set up career guidance clinics for nursing staff Review and update GHT job opportunities website Support staff wellbing and staff engagment Assist with implementing RePAIR priorities for GHFT and the wider ICS Devise an action plan for NHSi Retention programme - cohort 5 Trustwide support and Implementation of BAME agenda Devise a strategy for international recruitment	Medical, Surgical	Safety	Moderate (3)	Almost certain - Daily (5)	15	15 - 25 Extreme risk	26/02/2021	Carole Webster	Trust Risk Register
C29B9COOEFD	The risk of patient, staff, public safety due to fragility of single glazed windows. Risk of person falling from window and sustaining serious injury or life threatening injuries. Serious injury from contact with broken glass / shattered windows. Glass shards may be used as a weapon against staff, other patients or visitors. Risk of distress to other patients / visitors and staff if person falls	1. All faults are logged on Backtraq via the Estates Helpdesk either on-line or via the 6800 number and reports are available as necessary; 2. Many windows have a protective film to prevent shards of glass fragmenting and causing harm; 3. Patient Risk Assessments are in place by the Trust for vulnerable patients to ensure that controls are in place locally to minimise and/or mitigating patient contact with windows/glass; 4. Window Restrictors are fitted to all windows which require them and are maintained on an annual PPM schedule by Gloucestershire Managed Services; 5. Window Restrictor Policy in place which is reviewed and updated on a three yearly basis or as required; 6. If a window is broken or damaged it is replaced with a window which has toughened glass and complies with all current legislative requirements (e.g. 6.4mm laminate safety glass tested to provide class 2 level of protection to BS EN 12600, manufactured to BS EN 14449 and/or BS EN ISO 12543-2); 7. Money is made available in the Capital budget for replacement of windows (Note for AM: Accuracy of control/mitigation action to be confirmed).	Replacement, or upgrade of windows. 100 windows need replacing throughout the Tower Block. Decision to be made as to whether each window needs to be replaced, or whether each window is replaced on a ward first at a cost of £30, 000 per ward Review, assess and enact agreed future actions/controls	Corporate, Diagnostics and Specialties, Gloucestershire Managed Services, Medical, Surgical, Women's and Children's	Environmental	Minor (2)	Almost certain - Daily (5)	10	8 -12 High risk	05/04/2021	Akin Makinde	Trust Risk Register
C3295COO	The risk of patients experiencing harm through extended wait times for both diagnosis and treatment	Booking systems/processes: Two systems were implemented in response to the covid 19 pandemic. (1) The first being that a CAS system was implemented for all New Referrals. The motivation for moving to this model being to avoid a directly bookable system and the risk of patients being able to book into a face to face appointment. This triage system would allow an informed decision as to whether it should be face to face, telephone or video. To assist, specific covid-19 vetting outcomes were established to facilitate the intended use of the CAS and guidance sent out previously, with the expectation being that every referral be categorised as telephone, video or face to face. (2) The second system was to develop a RAG rating process for all patients that were on a waiting list, including for instance those cancelled during the pandemic, those booked in future clinics, and those unbooked. Guidance processes circulated advising Red = must be seen F2F; Amber = Telephone or Video and Green = can be deferred or discharged (with instructions required). Both systems were operational from end March. Activity: Recognising significant loss of elective activity during the pandemic services are required to undertake the above processes and closely review their PTLs. The review process creating both the opportunity of managing patients remotely; identifying the more urgent patients; and deferring or discharging those patients that can be managed in primary care. RTT delivery plans are also being sought to identify the actions available to provide adequate capacity to recover this position. The Clinical Harm Policy has also been reviewed and Divisions undertaking harm reviews as required. Harm reviews suspended aside from Cancer. The RAG process described above has moved into a P category status = all patients are now being validated under this prioritisation on the INPWL - a report has also been provided at speciality level to detail the volume completed	No Further actions	Corporate	Safety	Major (4)	Likely - Weekly (4)	16	15 - 25 Extreme risk	30/01/2021	Felicity Taylor-Drewe	Trust Risk Register

M2473Emer	The risk of poor quality patient experience during periods of overcrowding in the Emergency Department	Identified corridor nurse at GRH for all shifts; ED escalation policy in place to ensure timely escalation internally; Cubicle kept empty to allow patients to have ECG / investigations (GRH); Pre-emptive transfer policy Patient safety checklist up to 14 hours Monitoring Privacy & Dignity by Senior nurses Appointment of band 3 HCA's to maintain quality of care for patients in escalation areas. Review of safety checklist to incorporate comfort measures and oxygen checks. Introduction of pitstop trial to identify urgent patient needs including analgesia and comfort measures.	CQC action plan for ED Development of and compliance with 90% recovery plan Winter summit business case Liase with Tiff Cairns to discuss with Steve Hams to get ED corridor risks back up to TRR	Medical	Quality	Moderate (3)	Almost certain - Daily (5)	15	15 - 25 Extreme risk	31/12/2020	Anna Blake	Trust Risk Register
S2045T&O	The risk to patient safety of poorer than average outcomes for patients presenting with a fractured neck of femur at Gloucestershire Royal	Prioritisation of patients in ED Early pain relief Admission proforma Volumetric pump fluid administration Anaesthetic standardisation Post op care bundle – Haemocus in recovery and consideration for DCC Return to ward care bundle Supplemental Patient nutrition with nutrition assistant medical cover at weekends OG consultant review at weekends therapy services at weekends Theatre coordinator Golden patients on theatre list Discharge planning and onward referrals at point of admission	Deliver the agreed action fractured neck of femur action plan Develop quality improvement plan with GSIA Review of reasons behind increase in patients with delirium Development of parallel pathway for patients who fracture NOF in hospital	Surgical	Safety	Major (4)	Possible - Monthly (3)	12	8 -12 High risk	31/12/2020	Diana Thomas	Trust Risk Register
C2667NIC	The risk to patient safety and quality of care and/or outcomes as a result of hospital acquired C .difficile infection.	1. Annual programme of infection control in place 2. Annual programme of antimicrobial stewardship in place 3. Action plan to improve cleaning together with GMS	1. Delivery of the detailed action plan, developed and reviewed by the Infection Control Committee. The plan focusses on reducing potential contamination, improving management of patients with C.Diff, staff education and awareness, buildings and the envi	Diagnostics and Specialties, Medical, Surgical, Women's and Children's	Safety	Major (4)	Possible - Monthly (3)	12	8 -12 High risk	30/10/2020	Craig Bradley	Trust Risk Register
D&S3103Path	The risk of total shutdown of the Chem Path laboratory service on the GRH site due to ambient temperatures exceeding the operating temperature window of the instrumentation.	Air conditioning installed in some laboratory areas but not adequate. Cooler units installed to mitigate the increase in temperature during the summer period (now removed). *UPDATE* Cooler units now reinstalled as we return to summer months. Quality control procedures for lab analysis Temperature monitoring systems Contingency would be to transfer work to another laboratory in the event of total loss of service (however, ventilation and cooling in both labs in GHT is compromised, so there is a risk that if the ambient temperature in one lab is high enough to result in loss of service, the other lab would almost certainly be affected). Thus work may need to be transferred to N Bristol (compromising their capacity and compromising turnaround times).	Develop draft business case for additional cooling Submit business case for additional cooling based on survey conducted by Capita Rent portable A/C units for laboratory	Diagnostics and Specialties	Quality	Major (4)	Likely - Weekly (4)	16	15 - 25 Extreme risk	17/12/2020	Linford Rees	Trust Risk Register
C1945NTVN	The risk of moderate to severe harm due to insufficient pressure ulcer prevention controls	1. Evidence based working practices including, but not limited to; Nursing pathway, documentation and training including assessment of MUST score, Waterlow (risk) score, Anderson score (in ED), SSKIN bundle (assessment of at risk patients and prevention management), care rounding and first hour priorities. 2. Tissue Viability Nurse team cover both sites in Mon-Fri providing advice and training. 3. Nutritional assistants on several wards where patients are at higher risk (COTE and T&O) and dietician review available for all at risk of poor nutrition. 4. Pressure relieving equipment in place Trust wide throughout the patients journey - from ED to DWA once assessment suggests patient's skin may be at risk. 5. Trustwide rapid learning from the most serious pressure ulcers, RCAs completed within 72 hours and reviewed at the weekly Preventing Harm Improvement Hub.	1. To create a rolling action plan to reduce pressure ulcers 2. Amend RCSA for presure ulcers to obtain learning and facilitate sharing across divisions 3. Sharing of learning from incidents via matrons meetings, governance and quality meetings, Trust wide pressure ulcer group, ward dashboards and metric reporting. 4. NHS collabborative work in 2018 to support evidence based care provision and idea sharing Discuss DoC letter with Head of patient investigations Advise purchase of mirrors within Division to aid visibility of pressure ulcers update TVN link nurse list and clarify roles and responsibilities implement rolling programme of lunchtime teaching sessions on core topics TVN team to audit and validate waterlow scores on Prescott ward purchase of dynamic cushions share microteaches and workbooks to support react 2 red cascade learning around cheers for ears campaign	Diagnostics and Specialties, Medical, Surgical, Women's and Children's	Safety	Moderate (3)	Possible - Monthly (3)	9	8 -12 High risk	30/10/2020	Craig Bradley	Trust Risk Register

			Education and supprt to staff on 5b for pressure ulcer dressings Review pressure ulcer care for patients attending dilysis on ward 7a									

Gloucestershire Hospitals NHS
NHS Foundation Trust

TRUST BOARD PUBLIC SESSION – JANUARY 2021

Report Title
Fit For The Future: Output of Consultation
Sponsor and Author(s)
Author: Simon Lanceley, Director of Strategy and Transformation Sponsor: Deborah Lee, Chief Executive
Executive Summary

Purpose

To update Board on the output from the Fit For The Future (FFTF) public consultation.

Key issues to note

- Following the HOSC meeting on 22 October, the FFTF programme proceeded to public consultation which ran until 17 December 2020.
- FFTF consultation proposals focussed on five specialist services: Acute Medicine (Acute Medical Take), General Surgery, Image Guided Interventional Surgery (IGIS), Vascular Surgery, Gastroenterology and Trauma and Orthopaedics.
- A 'socially distant' public consultation programme was designed that including the use of on- line interactive events, webpages, on-line surveys and social media alongside traditional leaflet drops, IPC compliant community bus visits, written booklets and radio interviews.
- An independent Integrated Impact Assessment (IIA) identified who in the Gloucestershire population could be most affected by the proposals and the consultation was designed to ensure we heard from these groups.
- The consultation programme and output report has been subject to the Consultation Institute's 6-stage Quality Assurance process.
- The Output of Consultation report will form part of the evidence considered by a second independently facilitated Citizens' Jury to be held in January 2021.
- The Decision Making Business Case that will come to Board in March will describe how the output of the public consultation and Citizens Jury has informed the FFtF recommendations.

FFTF programme gateways:

Gateway #1: Trust Board – 13/8, approval to submit PCBC to NHSE - COMPLETED

Gateway #2: South West Clinical Senate Panel – 20/8, confirmation all shortlisted options are clinically viable - COMPLETED

Gateway #3: NHSE/I Stage 2 Assurance – 1/10, 5 of 5 statutory tests passed - COMPLETED

Gateway #4: Trust Board – 8/10, approval to proceed to public consultation - COMPLETED

Gateway #5: HOSC – 22/10, approval to proceed to public consultation – COMPLETED

Gateway #6: Trust Board – 11/3, Final Decision Making Business Case (DMBC) incorporating outcome of public consultation.

Recommendations

Board is asked to:

1. **NOTE** the output of consultation report and identify any areas for further work by the FFtF programme team that need to be addressed in the Decision Making Business Case.

Impact Upon Strategic Objectives

Delivers the 'Centres of Excellence' objective and supports delivery of 'Outstanding Care'

Impact Upon Corporate Risks

C2784 – Risk of formal legal challenge to the process we have used to develop and consult on our service reconfiguration proposals. Throughout the FFTF programme expert advice has been sought and followed As far as it is possible to do so (and as supported by the recent commissioned legal review of our PCBC and consultation materials), we believe we have done all we can to mitigate the risk of a successful challenge.
The programme has at each stage acted in line with our statutory duties and our assessment of best practice, supported by regular advice from the Independent Reconfiguration Panel (IRP), commissioned legal advice and best practice shared by the Consultation Institute (TCI). It should be noted that this position is based on the assessment of risk against known precedents and that this risk cannot ever be completely mitigated to zero.

Regulatory and/or Legal Implications

As a clinical reconfiguration programme Fit for the Future carries a risk of legal challenge. This is well understood and the processes set out in the business case are designed deliberately to ensure transparency of decision making and clarity that discussions and suggestions are subject to evaluation of impact, and public engagement and consultation where required. Our approach throughout the programme has been grounded in expert advice as set out above.

Equality & Patient Impact

A comprehensive Baseline Impact Assessment report was prepared for the solutions development phase. The PCBC contained preliminary findings on the impact of preferred solutions.
An independent Integrated Impact Assessment (IIA) identified who in the Gloucestershire population could be most affected by the proposals and the consultation was designed to ensure we heard from these groups.

Resource Implications

Finance	X	Information Management & Technology	X
Human Resources	X	Buildings	

Action/Decision Required

For Decision		For Assurance		For Approval		For Information	X

Date the paper was presented to previous Committees

Quality & Performance Committee	Finance & Digital Committee	Audit & Assurance Committee	People and OD Committee	Remuneration Committee	Trust Leadership Team	Other (specify)
					07/01/21	

Outcome of discussion when presented to previous Committees

Progress noted.

Fit for the Future

Developing specialist hospital services in Gloucestershire

Output of Consultation: Summary

Trust Board

14th January 2021

Key Facts…

Fit for the Future
Developing specialist hospital services in Gloucestershire

- **297,000 door-to-door leaflets** distributed, generating 1700+ requests for information
- **4,885 consultation booklets** distributed
- **75+ consultation events**
- **1000+ socially distanced face-to-face contacts** with members of the public + 350+ staff
- **140,000 reach on Facebook** driven by 20+ posts, leading to 1,500+ engagements & 1,000+ clicks on the link
- **30,000 Twitter impressions** and 800 engagements driven by 35+ Tweets.

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Consultation approach & responses…

Fit for the Future
Developing specialist hospital services in Gloucestershire

Two key consultation routes:

1. **Promoting formal consultation routes & encouraging participation** – on-line & face to face events, social media, media, County & Borough Councils, PCNs, Governors etc.
2. **Proactive consultation with targeted groups as informed by Integrated Impact Analysis (IIA)** – BAME community, LGBQT+, gypsy/traveller community, mental health and learning disability groups, frail elderly, long term condition groups, low income areas, people living with a disability, adult & young carers, young people homeless

Responses:

- **700+ survey responses** (full & *easy read* versions)
- **30% staff** (*health or social care professional*)
- **19 separate e-mail/written responses**

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Level of support for proposals…

Fit for the Future
Developing specialist hospital services in Gloucestershire

Proposal	Strong support/ support	Strongly oppose/ oppose	No opinion
Acute Medicine to GRH	**68%** (73%)[1]	25% (19%)	7% (8%)
EGS to GRH	**68%** (67%)	23% (23%)	9% (10%)
Centralise EL Colorectal [2]	**79%** (73%)	8% (12%)	13% (15%)
DC general surgery to CGH	**73%** (67%)	9% (13%)	18% (20%)
IGIS hub at GRH, spoke at CGH	**67%** (77%)	15% (10%)	18% (13%)
Vascular to GRH	**60%** (68%)	20% (15%)	20% (17%)
Gastro to CGH	**72%** (68%)	7% (10%)	21% (22%)
T&O split	**76%** (70%)	11% (13%)	13% (17%)

[1] %s in brackets are *easy read* responses

[2] View on location of centralised elective colorectal surgery service:

Group	CGH	GRH	No opinion
All survey responses	51% (28%)	20% (28%)	30% (45%)
Staff only	57%	13%	30%

Representation*…

Fit for the Future
Developing specialist hospital services in Gloucestershire

- Proportionally **more people from Cheltenham** competed the survey
- **More women than men** completed the survey (55% / 39%)
- **Good age range** of respondents from Under 18 - Over 75 years
- **A third of responses came from staff**
- **Over 20%** of responses came from people who considered themselves to have a **disability**
- **Over a quarter** of respondents were **'unpaid' carers**
- **15%** of respondents were **not white British**

*We only know about respondents who completed the 'About You' questions in the survey

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Main themes from free-text responses…

Fit for the Future
Developing specialist hospital services in Gloucestershire

The qualitative feedback from completed surveys and correspondence has been grouped into themes:

- Access
- Capacity
- Diversity
- Efficiency
- Environment
- Facilities
- Integration (with primary and community services)
- Interdependency
- Patient & Staff Experience
- Pilot
- Quality
- Resources
- Transport
- Workforce

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Limiting negative impact…

Fit for the Future
Developing specialist hospital services in Gloucestershire

Survey respondents shared the **following mitigations to limit any potential negative impacts** of centralisation of specialist hospital services:

- **Improve Patient Communications**
- **Improve integration** between hospitals, community services and GP practices
- **Reduce the number of patient transfers** between Acute hospitals
- Improve **public transport**
- **Access:** retain services on both sites
- **Build a new Acute Hospital** on a Single Site
- Speed up payment of **eligible Travel Claims**
- **Encourage more staff to work in Gloucestershire.**

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Public responses received from other organisations…

Fit for the Future
Developing specialist hospital services in Gloucestershire

9 written responses were received during the consultation:

- Cheltenham Borough Council
- Cllr Martin Horwood, Liberal Democrat, Cheltenham Borough Council Leckhampton with Warden Hill Parish Council
- REACH: Restore Emergency At Cheltenham General Hospital campaign, including REACH survey interim report (REACH undertook an alternative survey)
- Tewkesbury Borough Council
- 4 x members of the public

10 email responses were received from members of the public

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Next steps…

Fit for the Future
Developing specialist hospital services in Gloucestershire

Completing the communication, engagement and consultation for the Fit for the Future programme

- **Citizens' Jury #**2 - "*What are the most important findings of the public consultation that decision makers should take into account*?" - Jan 21 (x8 2hr sessions run by Citizens Juries CIC)
- **Recommended solution for General Surgery** – TLT on 4th Feb
- **Consultation review period/ implementation planning –** Jan/ Feb
- **Decision Making Business Case** – Jan/ Feb
- **Decision making** - March
- **Implementation** - April onwards

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Fit for the Future

Developing specialist hospital services in Gloucestershire

Interim Output of Consultation Report

Contents

Fit for the Future *Interim* Output of Consultation Report
Executive Summary

Fit for the Future: Developing specialist hospital services in Gloucestershire

Consultation Key Facts

- Consultation proposals focussed on five specialist services: Acute Medicine (Acute Medical Take), General Surgery: Upper and Lower Gastrointestinal (including Emergency General Surgery), Image Guided Interventional Surgery (including Vascular Surgery), Gastroenterology inpatient services and Trauma and Orthopaedic inpatient services.
- Approximately 5000 Consultation booklets distributed across the county.
- 297,000 door-to-door leaflets distributed, generating 1700+ requests for information
- 75+ consultation events.
- More than 1000 socially distanced face-to-face contacts with members of the public/over 350 staff.
- 20+ Facebook posts with a reach of over 140,000 with over 1,500 'engagements' which included over 1,000 clicks on the link in the post.
- 35+ tweets generated over 30,000 impressions and almost 800 engagements.
- 700+ Fit for the Future surveys completed [110+ paper copies received, 1 telephone survey completed; the remainder being online].

Fit for the Future Survey responses

Acute Medicine (Acute Medical Take)

Preferred option to develop: A 'centre of excellence' for Acute Medicine (Acute Medical Take) at Gloucestershire Royal Hospital.

- 67.61% (Easy read: 72.09%) strongly supported or supported the proposal
- 24.83% (Easy read: 18.6%) strongly opposed or opposed the proposal

Emergency General Surgery

Preferred option to develop: to develop: A 'centre of excellence' for Emergency General Surgery at Gloucestershire Royal Hospital.

- 68.31% Fit for the Future survey respondents strongly supported or supported the proposal. Easy read survey respondents: 66.67% strongly supported or supported the proposal
- 23.44% Fit for the Future survey respondents strongly opposed or opposed the proposal. Easy read survey respondents: 22.99% strongly supported or supported the proposal

Planned Lower GI (colorectal) surgery

Preferred option to develop: to develop: A 'centre of excellence' for Planned Lower GI (colorectal) general surgery at Cheltenham General Hospital (CGH) or Gloucestershire Royal Hospital (GRH).

- 79.1% Fit for the Future survey respondents strongly supported or supported the proposal. Easy read survey respondents: 72.84%) strongly supported or supported the proposal.
- 7.83% Fit for the Future survey respondents strongly opposed or opposed the proposal. Easy Read survey respondents: 14.81% strongly opposed or opposed the proposal.

Where do you think we should do planned Lower GI (Colorectal) General Surgery?

- 50.76% Fit for the Future survey respondents chose Cheltenham General Hospital. 27.50% Easy Read respondents chose Cheltenham General Hospital.
- 20.27% Fit for the Future survey respondents chose Gloucestershire Royal Hospital. 27.50% Easy Read respondents chose Gloucestershire Royal Hospital.
- 30.30% Fit for the Future survey respondents had no opinion. 45% Easy Read respondents had no opinion.

Planned day case, Upper and Lower GI

Preferred option to develop: to develop: A 'centre of excellence' for planned day case Upper and Lower GI (colorectal) surgery at Cheltenham General Hospital (CGH).

- 73.49% Fit for the Future survey respondents strongly supported or supported the proposal. (Easy read respondents: 67.47% strongly supported or supported the proposal.
- 8.52% Fit for the Future survey respondents strongly opposed or opposed the proposal. Easy read respondents: 13.25% strongly opposed or opposed the proposal.

Image Guided Interventional Surgery (IGIS) including Vascular Surgery

Preferred option to develop: to develop: A 24/7 Image Guided Interventional Surgery (IGIS) 'Hub' at Gloucestershire Royal Hospital and a 'Spoke' at Cheltenham General Hospital.

- 66.54% Fit for the Future survey respondents strongly supported or supported the proposal. Easy read respondents: 76.54%) strongly supported or supported the proposal.
- 15.39% Fit for the Future survey respondents (Easy read: 9.88%) strongly opposed or opposed the proposal. Easy read respondents: 9.88% strongly opposed or opposed the proposal.

Vascular Surgery

Preferred option to develop: to develop: A 'centre of excellence' for Vascular Surgery at Gloucestershire Royal Hospital.

- 60.27% Fit for the Future survey respondents strongly supported or supported the proposal. Easy read respondents: 68.35% strongly supported or supported the proposal.
- 19.97% Fit for the Future survey respondents strongly opposed or opposed the proposal. Easy read respondents: 15.19% strongly opposed or opposed the proposal.

Gastroenterology inpatient services

Preferred option to develop: A 'centre of excellence' for Gastroenterology inpatient services at Cheltenham General Hospital.

- 71.96% Fit for the Future survey respondents strongly supported or supported the proposal. Easy read respondents: 68.35% strongly supported or supported the proposal.
- 6.67% Fit for the Future survey respondents strongly opposed or opposed the proposal. Easy read respondents: 10.13% strongly opposed or opposed the proposal.

Trauma and Orthopaedics (T&O) inpatient services

Preferred option to develop: to develop: Two permanent 'centres of excellence' for Trauma at Gloucestershire Royal Hospital and Orthopaedics at Cheltenham General Hospital.

- 76.02% Fit for the Future survey respondents strongly supported or supported the proposal
- 10.53% Fit for the Future survey respondents strongly opposed or opposed the proposal

The Easy read survey was divided into two questions:

Trauma:	Support: 70.51%	Oppose: 12.82%	Not sure: 16.67%
Orthopaedics:	Support: 73.08%	Oppose: 14.10&	Not sure: 12.82%

Themes

Responses to the consultation focussed on the following themes: **Access; Capacity; Diversity; Efficiency; Environment; Facilities; Interdependency; Integration (with primary and community services); Patient Experience / Staff Experience; Pilot; Quality; Resources; Transport; and Workforce.**

Who got involved?

In terms of the reach of the consultation, demographic information is known about those survey respondents who chose to provide 'About You' information in their survey responses. There is a broad representation of groups in responses to the survey. There is extended reach through the targeted activities, which ensured voices from all groups identified in the Independent Integrated Impact Assessment had an opportunity to be heard e.g. carers, homeless people, Black, Asian and Minority Ethnic communities.

During the consultation, participants took the opportunity to access information, ask questions and comment on the national and local response to the coronavirus pandemic. Many people expressed their gratitude to NHS and care staff and recognised Gloucestershire's diverse communities' collective acts of support for colleagues, friends, families and neighbours.

A detailed summary of feedback received can be found in Part 2. All feedback received can be found in the online Appendices to this Report.

INTRODUCTION

Fit for the Future Consultation

Purpose of this Report

The Fit for the Future Interim Output of Consultation Report is intended to be used as a practical resource for **One Gloucestershire** partners; to provide them with information about how the public, community partners and staff feel about the Fit for the Future proposals for change in order to inform their decision making in 2021. One Gloucestershire is a partnership between the county's NHS and care organisations to help keep people healthy, support active communities and ensure high quality, joined up care when needed.

The NHS partners of One Gloucestershire are:

- NHS Gloucestershire Clinical Commissioning Group (CCG)
- Primary care (GP) providers
- Gloucestershire Health and Care NHS Foundation Trust (GHC)
- Gloucestershire Hospitals NHS Foundation Trust (GHT)
- South Western Ambulance Services NHS Foundation Trust (SWAST)

This Report will form part of the evidence considered by a second independently facilitated Citizens' Jury, to be held in January 2021. This Report will be shared widely across the local health and care community and is available to all on the One Gloucestershire website www.onegloucestershire.net and on the online participation platform Get Involved in Gloucestershire https://getinvolved.glos.nhs.net

This interim report will be updated before decisions are made to include: the output of the Citizens Jury#2; the outcome of the Elective Lower Gastrointestinal (GI) (colorectal) surgery location discussions; the output of the updated independent Integrated Impact Assessment and other relevant information received. The updated report will be published on the One Gloucestershire website (link above) and shared with decision makers in order for them to give conscientious consideration to all relevant information prior to making decisions about the proposals.

One Gloucestershire partners are invited to consider the feedback from consultation and indicate how it has influenced their decision making. Full details of the next steps for the Fit for the Future Programme can be found in Section 1.4.

This Report has been prepared by the One Gloucestershire Communications and Engagement Group. This report is produced in both print and on-line (searchable PDF) formats. For details of how to obtain copies in other formats please turn to the back cover of this Report.

We would like to thank everyone who has taken the time to share their views and ideas.

Making the best use the information provided in this Report

This report is divided into two parts: Part 1 provides background information about the Fit for the Future Programme, the co-development of the consultation proposals and the consultation planning and activities. Part 2 provides a summary of the feedback received during the consultation. The final section of this report is an evaluation of the consultation activity. This report is supported by a series of online Appendices.

There are elements of feedback which will be relevant and of interest to all readers; these can be easily found in the main body of the report.

All feedback received can be found in a series of online Appendices. These Appendices include all comments collated during the consultation, including copies of individual submissions received, in addition to the FIT FOR THE FUTURE survey responses.

The theming of the qualitative feedback received through the Fit for the Future survey presented in this report has been undertaken by members of the **One Gloucestershire** Communications and Engagement Group using SmartSurvey.

Some respondents may have answered the formal consultation survey as well as giving feedback in other ways, such as sending a letter or participating in a discussion event. All feedback received has been read and coded into themes such as: 'access', 'workforce' and 'quality'. Please note that individual's comments may cover more than one theme.
All qualitative feedback received by representatives of **One Gloucestershire** partners during the consultation period is available in the online Appendices. The information provided in this report and Appendices will be used by decision makers to 'conscientiously consider'[1] all feedback received.

Appendices

All appendices are available at: www.onegloucestershire.net

Appendix 1: Survey responses by specific groups:

i) Full survey
ii) Easy Read
iii) Feedback from targeted groups (identified through independent Integrated Impact Assessment) from Full survey[2]
   a. BAME
   b. Over 66 living with a disability
   c. BAME living with a long term condition
   d. People living with a disability
   e. People with mental health problems and/or learning difficulties

[1] One of the Gunning Principles that have formed a strong legal foundation from which the legitimacy of public consultations is often assessed.
[2] Due to the smaller number of responses to the Easy Read survey, further analysis by demographic has not been completed in order to avoid potentially identifying individuals.

f. Unpaid Carer
g. People who identify as LGBTQ+
h. People who live in 12 most deprived wards in Gloucestershire (Indices of Deprivation 2019)
i. Staff
j. Public and Community Partners
k. Postcodes from East of county
l. Postcodes from West of county

Appendix 2: Other Correspondence

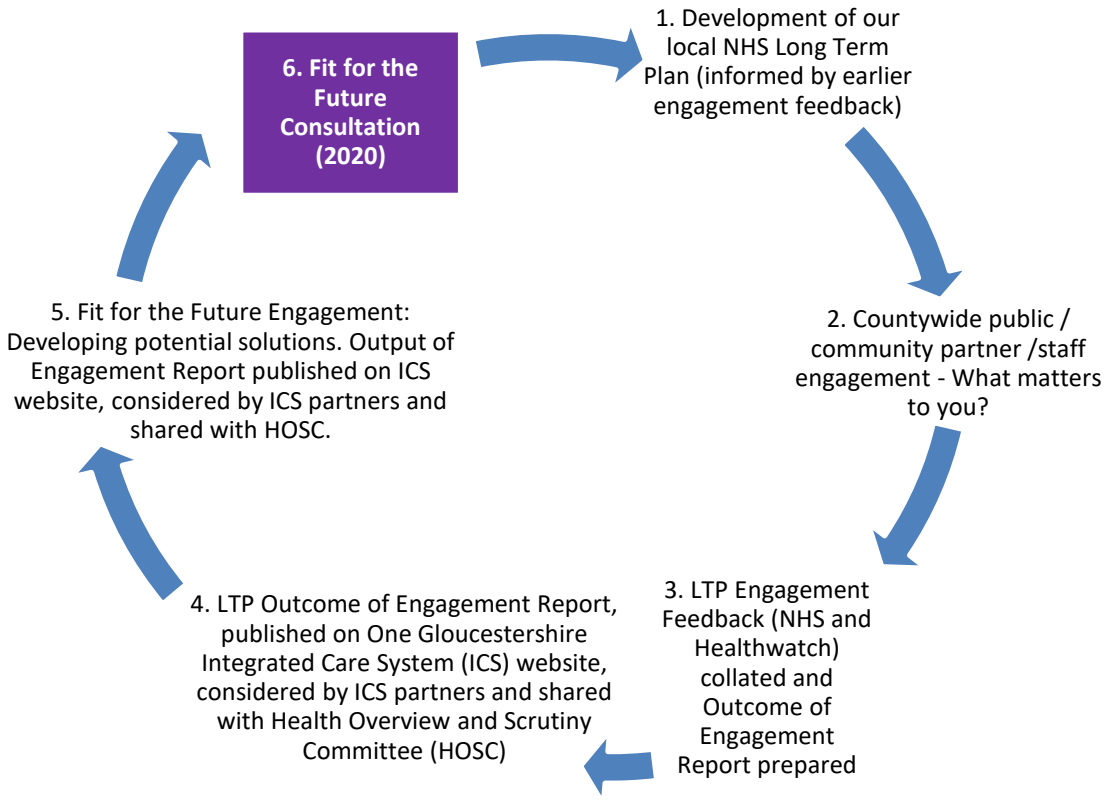
Appendix 3: Glossary

PART 1

1. Background

Over the last few years the NHS in Gloucestershire Fit for the Future programme has been involving local people and staff in looking at potential ways to develop specialist hospital services in Gloucestershire. Through this process the 'centres of excellence'[3] approach has been designed.

Through the earlier Fit for the Future Engagement in 2019 and during earlier conversations about the NHS Long Term Plan in 2018, the NHS in Gloucestershire has been involving staff, patients, local people and the public in looking at a number of services and developing potential 'solutions'. The Fit for the Future Consultation is the latest element of the engagement cycle[4] to develop the Gloucestershire response to the NHS Long Term Plan, which began in 2018.



[3] Centres of excellence: bringing staff, equipment and facilities together in one place to provide leading edge care and create links with other related services and staff.

[4] Previous engagement activities can be found at: www.onegloucestershire.net/yoursay/

The aims of the Fit for the Future programme are to:

- Improve health outcomes
- Reduce waiting times and ensure fewer cancelled operations
- Ensure patients receive the right care at the right time in the right place
- Ensure there are always safe staffing levels, including senior doctors available 24/7
- Support joint working between services to reduce the number of visits you have to make to hospital
- Attract and keep the best staff in Gloucestershire.

To achieve these things and to make the most of developing staff skills, precious resources and advances in medicine and technology, the Fit for the Future programme looks at how some specialist hospital services at Gloucestershire Royal and Cheltenham General could be configured to make best use of both hospital sites. This move towards creating 'centres of excellence' at the two hospitals is not new and this approach reflects the way a number of other services are already provided e.g. Cancer Services in Cheltenham and Children's services in Gloucester.

1.1 What the Fit for the Future consultation is about

The purpose of the consultation was to seek views on the future provision of five specialist hospital services in Gloucestershire:

- Acute Medicine (Acute Medical Take). This is the coordination of initial medical care for patients referred to the Acute Medical Team by a GP or the Emergency Departments and where decisions are made as to whether patients need a hospital stay.

- Gastroenterology inpatient services; medical care for stomach, pancreas, bowel or liver problems.

- General Surgery conditions relating to the gut. Specifically, emergency general surgery, planned Lower Gastrointestinal (GI) (colorectal) surgery and day case Upper and Lower GI surgery.

- Image Guided Interventional Surgery (IGIS) including vascular surgery. IGIS is where the surgeon uses instruments with live images to guide the surgery.

- Trauma and Orthopaedic inpatient services (T&O) diagnosis and treatment of conditions relating to the bones and joints.

1.2 What the Fit for the Future consultation is not about

Cheltenham General Hospital Accident & Emergency (A&E) Department

A public commitment has been made to the future of the Accident and Emergency (A&E) Department in Cheltenham. The service will remain consultant led and there will be no change to the opening hours. The proposals for change described in the Fit for the Future consultation do not include the A&E Department at Cheltenham General Hospital, post pandemic, the department will revert to being a 7-day consultant led A&E unit between 8am and 8pm and a nurse led unit between 8pm and 8am. This is the A&E service model that has been in place at Cheltenham since 2013.

COVID-19 Temporary Changes

Fit for the Future is not about the COVID-19 temporary changes made in 2020. However, some of the medium to long term changes proposed relate to some of the same clinical services where temporary changes have had to be made recently in order to keep our hospitals safe.

Outpatients, Community and Primary Care Services

The focus of this consultation is five specialist inpatient services provided at Cheltenham General and Gloucestershire Royal Hospitals. No changes to outpatient, community or primary care services are included within this consultation.

1.3 Consultation process

The Fit for the Future public and staff consultation started on 22 October 2020 and ran until 17 December 2020.

There have been a number of innovative ways the NHS has involved local people and staff during the consultation, from online events, to a 'socially distanced' Information Bus Tour and a door-to-door mail-drop of an information leaflet delivered by Royal Mail to all households in Gloucestershire. Full details of the consultation process can be found in Section 2.

1.4 Next Steps: Completing the communication, engagement and consultation for the Fit for the Future programme

Citizens' Jury

A second Jury, independently facilitated by Citizens Juries CIC, will be held in January 2021 to consider the feedback from this consultation. 18 independently recruited jurors (not the same jurors who participated in Jury #1), representative of local communities from a broad range of demographics, will receive evidence from a range of witnesses, record their observations and make their recommendations to decision makers of the NHS organisations involved. This will include key feedback from the consultation process, which will be taken into account when making a final decision on the future configuration of the five specialty

acute hospital services. The Citizens' Jury will be hosted online; audio recordings of the plenary sessions will be available on request from Citizens Juries CIC, witness presentation recordings and slides will be available on the One Gloucestershire website https://www.onegloucestershire.net/yoursay/fit-for-the-future-developing-specialist-hospital-services-in-gloucestershire/ . Details will be publicised nearer the time.

Elective Lower Gastrointestinal (GI) (colorectal) surgery – no preferred option proposed in the consultation

The Fit for the Future consultation did not propose a preferred option for Elective Lower Gastrointestinal (GI) surgery; two options were described. The next step is to select one of the two options for this service; to co-locate at either CGH or GRH to take forward for a decision.

This will be carried out at the beginning of February 2021 and will be a two stage process. Firstly an appraisal by the Trust Leadership Team of Gloucestershire Hospitals NHS Foundation Trust using the feedback from consultation to obtain a recommendation, with the option chosen by the Trust Board and then a final decision made by the NHS Gloucestershire Clinical Commissioning Group Governing Body in March 2021 (see **Decision** below). The following information will be reviewed:

- Feedback from the Public Consultation
- Citizen's Jury #2 output
- Presentations on the two options
- Pre-Consultation Business Case and attachments
- Financial Information
- Beds and resource requirements
- Workforce plans including rotas

Consultation review period

There will then be a consultation review period, where Gloucestershire Hospitals NHS Foundation Trust and NHS Gloucestershire Clinical Commissioning Group will carefully consider all of the feedback.

Decision

A final decision will be made about the Fit for the Future proposals at the CCG Governing Body meeting on 11 March 2021. This will be live streamed on the internet.

Process of implementation

If the proposals set out in this consultation are supported by the Governing Body of the Clinical Commissioning Group; then the Emergency General Surgery, Gastroenterology and Trauma & Orthopaedics inpatient services changes will be made permanent. The timescale for other changes will be determined by a number of factors such as estates, staff recruitment and training. The F Programme structure will remain in place with programme and project managers working with clinical staff within the specialties to develop and then

deliver detailed implementation plans. Plans to involve local people in the implementation and evaluation process are being developed.

1.5 Providing feedback to you on the consultation and decisions

The feedback from the consultation, the recommendations and observations of the Citizens' Jury and the final decision made by the CCG Governing Body will be published at: www.onegloucestershire.net/yoursay and shared on the online participation platform Get Involved in Gloucestershire https://getinvolved.glos.nhs.uk

2. Our approach to communications and consultation

2.1 Working with others

The planning and delivery of the Fit for the Future consultation has been supported by many external groups:

- The Consultation Institute: The consultation process, including this Interim Output of Consultation Report, has been Quality Assured by The Consultation Institute[5]. A Consultation Institute Advisor worked with the Fit for the Future programme, acting as a critical friend; each stage of the consultation planning and activity was formally signed-off by a Consultation Institute Assessor, ensuring a totally independent element in the consultation process. The six stages, or gateways, of the Quality Assurance process are:
    - Scope and Governance
    - The Project Plan
    - Consultation Document Review
    - Mid-Point Review
    - Closing Review
    - Final Report (at the time of publication, The Consultation Institute is reviewing this interim report).
- Inclusion Gloucestershire: Assisted with the development of Easy Read materials.
- Gloucestershire County Council's Digital Innovation Fund Forum: Informed early planning for online activities and assisted with awareness-raising of the consultation to potentially digitally excluded groups.
- Friends from the Friendship Café in Gloucester City: Supported awareness raising and survey completion within diverse communities.
- Healthwatch Gloucestershire (HWG): HWG Readers Panel reviewed an early draft of the full consultation booklet and made suggestions for changes, which were incorporated into the final version. A HWG representative will be a member of the independent Oversight Panel for the second Fit for the Future Citizens' Jury.
- Aneurin Bevan Health Board (ABHB): ABHB facilitated the translation of the summary consultation booklet into Welsh, and facilitated an Information Bus visit to Chepstow Hospital in Monmouthshire to enable residents living close to the Wales England Border, who might access services in Gloucestershire the opportunity to find out more about the consultation.

5 https://www.consultationinstitute.org/services/quality-assurance/ https://www.consultationinstitute.org/wp-content/uploads/2019/12/Quality-Assurance.pdf

- Know Your Patch (KYP) Coordinators: KYPs allowed us space on agendas to share information at online meetings during October and November 2020 to promote the consultation.
- District/Borough Councils and Retail partners: Supported the 'socially distanced' visits of the Information Bus (outside of Lockdown 2) to locations with maximum footfall across the county. District and Borough Councils also hosted members' seminars to discuss the Fit for the Future consultation.
- Local media: Gloucestershire Live, BBC Radio Gloucestershire and GFM Radio
- Others: Many other groups and individuals have helped to raise awareness of the consultation such as Trust Governors, staff-side representatives, hospital volunteers and community and voluntary sector organisations such as homelessness support charities.

Thank you to everyone who has supported this consultation.

2.2 Equality and Engagement Impact Analysis (EEIA)

Equality, diversity, Human Rights and inclusion are at the heart of delivering personal, fair and diverse health and social care services. All commissioners and providers of health and social care services have legal obligations under equality legislation to ensure that people with one or more protected characteristics[6] are not barred from access to services and decision making processes.

The consultation has been informed by the experience of managing earlier extensive engagement activities. The approach and detailed plan for communications and consultation was informed by feedback from those engagement activities, including feedback from NHSE/I Assurance process.

Extract from NHSE/I Assurance Process feedback in relation to communications and engagement:

- The engagement output report shows that the team have really given people every opportunity to take part in the engagement programme and the resulting output report is very extensive. Full credit for openness and transparency
- Would benefit from an accompanying glossary to explain all the inevitable acronyms and terminology sprinkled throughout people's quotes
- The engagement for Fit for the Future described in the PCBC and engagement output report was proportionate, targeted and had due regard for protected groups. From feedback received, the system is in a good place to know what the county as a whole think and the locations where the most negatively impacted populations live
- Further engagement to address the homogeneity of participants in Phase 1.
- In response to COVID-19 restrictions the Strategy and Plan has been designed to support a 'socially distanced' consultation. It includes an Appendix/Briefing which summarises recent advice and guidance regarding online consultation, sets out assumptions and considerations and makes the following observations and conclusions, which will be taken into account during the consultation:
- Consideration to be paid to online deliberation and engagement are those you should pay attention to regardless of whether engagement is face to face or online. Things such as feeling safe, ensuring transparency and that participants have the facts to be able to make an informed decision would apply regardless of how you engage.
- Online consultations prove to be most successful when used in conjunction with offline methods such as telephone structured interviews/market research techniques/managed exhibitions.
- Two-way direct communication is crucial in creating meaningful dialogue – video conferencing software (Zoom, Microsoft Teams etc.) can facilitate this.

[6] It is against the law to discriminate against someone because of: age; disability; gender reassignment; marriage and civil partnership; pregnancy and maternity; race; religion or belief; sex, sexual orientation. These are called protected characteristics. https://www.equalityhumanrights.com/en/equality-act/protected-characteristics

- Online forums should be moderated to keep discussion topics organised and to keep participants safe.
- Think about varying the times of online events – avoid excluding working age participants.
- Online events should be no longer than 2 hours and comfort breaks should be scheduled.
- Use creative and interactive dialogue methods for online and offline activities.
- Paper surveys should be replicated as online surveys.
- Some individuals or groups feel more comfortable sharing their thoughts on their own platforms, rather than official channels designed explicitly for themed discussions.
- Different marketing messages required to encourage online participation for 'always' (compete with other opportunities), 'seldom' (relevance, links to pandemic interests) and 'never' online (other opportunities or assistance required).

The FIT FOR THE FUTURE proposals for change have not been implemented as they are subject to this consultation. Two of the services in scope for the consultation are currently piloting the proposed changes and have been evaluated.

The impact of potential changes

We have worked with independent analysts from Mid and South Essex University Hospitals to complete an Integrated Impact Assessment (which covers Health Inequalities and Equality) of the proposed development of 'centres of excellence' for the specialist services described in the Fit for the Future consultation. This can be found at www.onegloucestershire.net/yoursay

The analysis considered a wide range of information, including feedback from the Engagement, to describe how different groups of people who are likely to access and experience health services, could be impacted by the proposed changes for each of the combinations of specialist services. Impact analysis, as part of the evaluation of the two pilot changes (Gastroenterology and Trauma & Orthopaedic inpatient services) has been undertaken locally with the support of the Local Authority Public Health Department. A Lay Reference Group made up of patient, public and VCS representatives was established to support the Impact Analysis and Solutions Appraisal activities.

In addition to the independent Integrated Impact Assessment (IIA) of the proposals, an Equality and Engagement Impact Analysis (EEIA) of the planned consultation activities has also been undertaken.

2.2.1 Groups potentially impacted, issues identified and actions taken

Our aim with this consultation was to reach a good representation of the local population, whilst making sure we hear from those groups who might be most affected by the proposed changes. We sought out the views of people from the groups, set out below, during the consultation to gain a better understanding of the potential impact on them and to identify ways to lessen any potential negative impacts:

- Black, Asian and Minority Ethnic (BAME) communities, in particular people aged over 65
- People with mental health conditions
- Over 65s who are more likely to have long term conditions such as cardiovascular disease, obesity or diabetes
- Frail older people who are more likely to experience falls
- People from BAME communities who are living with a long term condition
- People living with a disability (includes physical impairments; learning disability; sensory impairment; mental health conditions; long-term medical conditions).
- Adult Carers and Young Carers
- Homeless people
- Gypsy/Traveller communities
- LGBTQ+ people
- People living in low income areas.

2.2.2 Issues identified pre-consultation in the EEIA and action taken ahead of consultation

Less information, less jargon and easy read

The Consultation booklet was reviewed by the Healthwatch Gloucestershire Lay Readers Panel. An Easy Read version of the consultation booklet and survey was produced by Inclusion Gloucestershire. A summary version of the consultation booklet was produced.

Accompanying glossary recommended

There is an accompanying glossary in the full consultation document (which is available in print and online).

Further engagement to address the homogeneity of participants

Targeted opportunities for consultation with protected characteristic groups identified through the Impact Analysis e.g. via the Homeless Healthcare Team, Carers Forum etc. Alternative formats of all consultation materials available on request. Contract in place with telephone (and face to face) interpreters, incl. BSL and for written translation.

Paper surveys should be replicated as online surveys

Surveys were available on line in regular and easy read formats. People were also offered assistance to complete surveys over the telephone.

Different marketing messages required to encourage online participation for 'always' (compete with other opportunities), 'seldom' (relevance, links to pandemic interests) and 'never' online (other opportunities or assistance required).

All forms of media, print, broadcast, and social media platforms were used. An awareness raising leaflet was delivered to all households by Royal Mail in Gloucestershire telling them about the consultation and how they could get involved.

Liaise with community leaders to hold specific workshops within the BAME communities with community support for interpreters

We contacted local groups, including BAME communities to arrange culturally appropriate opportunities for participation in the consultation e.g. Information Bus visit to Gloucester Mosque at their invitation [Unfortunately we were unable to attend the Mosque visit due to Covid-19 Lockdown 2 restrictions. However, we liaised with local community leaders about alternative ways to promote the consultation, including WhatsApp and interview on local Community Radio[7]]

Use creative and interactive dialogue methods

We used a range of methods: Online, face-to-face (socially distanced), telephone, written.

Online consultations prove to be most successful when used in conjunction with offline methods such as telephone structured interviews/market research techniques/managed exhibitions.

We hosted online activities, chat forums and Live discussions recorded on YouTube [In response to feedback after the first Live discussion, broadcast was moved to FaceBook Live for better reach]. We invited people to call us to leave a message to book telephone interviews. We toured our Information Bus to all localities in the county and to the Mosque in Gloucester [see note above].

Online forums should be moderated

The Forum function of the Get Involved in Gloucestershire online participation platform is independently moderated. The Gloucestershire Live Face Book Events were hosted by an independent chair and questions were moderated.

Varying the times of online events

Events were held at different times of day and different days of the week

Events, e.g. workshops, no longer than 2 hours

[7] https://gloucesterfm.com/ 7 December 2020, Community Link Show – repeated 8 December 2020

All scheduled events were no longer than 90 minutes, with online events mostly lasting 30-45 minutes. Most events were online and we make it clear that participants could get up, have a comfort/refreshment break

Some individuals or groups feel more comfortable sharing their thoughts on their own platforms, rather than official channels designed explicitly for themed discussions.

We offered to use the platforms, which worked best for the individual or group: Zoom, Face Time, Microsoft Teams, Webex – We completed DPIA (Data Protection Impact Assessments) for any new platforms requested. We also offered more traditional methods such as telephone calls.

Target groups identified through the IIA

Representatives from the groups identified in the IIA were contacted to discuss methods to facilitate participation in the consultation. Example: Advice from the Homeless Healthcare Team, Age UK, Carers Hub

The Fit for the Future consultation was open to all with activities designed to facilitate feedback from as wide a cross-section of the local community as possible. The full EEIA can be found via the following link:
https://www.onegloucestershire.net/wp-content/uploads/2020/10/Equality-and-Engagement-Impact-Assessment-FINAL-1.pdf

The Pre Consultation Business Case independent Integrated Impact Assessment can be found via the following link: https://www.onegloucestershire.net/wp-content/uploads/2020/12/Appendix-14a_Annex_IIA.pdf

The independent Integrated Impact Assessment will be updated to take into account the response to consultation. The updated assessment will be included in the Decision Making Business Case, which will be available on the One Gloucestershire website.2.3

2.3 Covid 19: A socially distanced consultation

A traditional consultation process would include many of the methods described below, such as producing information, hosting discussion events and developing surveys.
One factor to be taken into account with this consultation was the reduced opportunity to engage with people face-to-face due to pandemic public health restrictions. Therefore a largely 'socially distanced' consultation was planned. In order to maximise opportunities to raise awareness of the consultation and opportunities to get involved the following methods were used.

2.4 Communications: Developing understanding and supporting Fit for the Future consultation

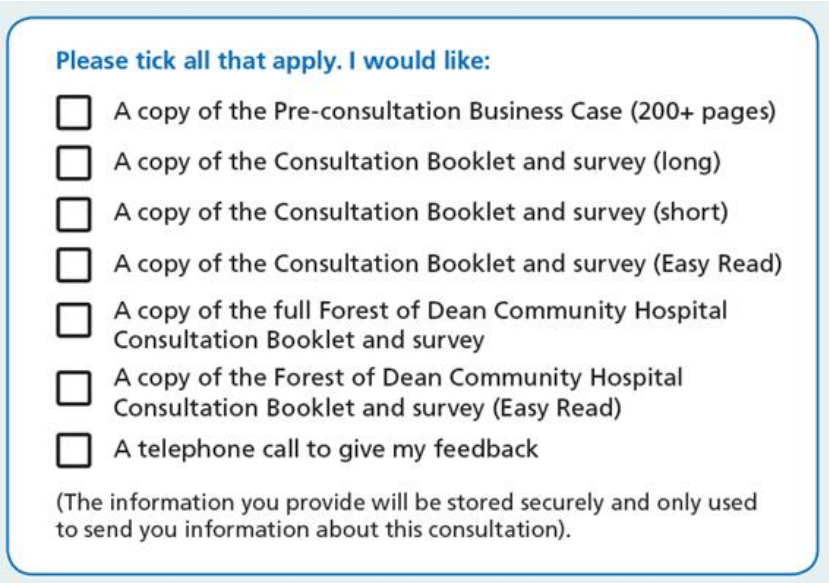
A range of communications and consultation methodologies were used during the Fit for the Future consultation. This section describes the wide ranging approach taken to promoting the *Fit for the Future* consultation and the range of involvement opportunities.

In summary:

Door to Door awareness raising leaflet

The NHS commissioned the Royal Mail to deliver a leaflet to all households in Gloucestershire. One Gloucestershire commissioned Royal Mail to deliver297,000 Fit for the Future leaflet to all Gloucestershire postcodes. Where residents have chosen Royal Mail Door to Door opt out, they will not have received this information[8]

This was a key method for ensuring that people not able to access materials on-line were able to engage with the consultation. The leaflet included brief information about the Fit for the Future consultation and also the Forest of Dean Community Hospital consultation; which has been running concurrently[9]. The mailer included a freepost reply slip to request information or a telephone call.



Please tick all that apply. I would like:

- ☐ A copy of the Pre-consultation Business Case (200+ pages)
- ☐ A copy of the Consultation Booklet and survey (long)
- ☐ A copy of the Consultation Booklet and survey (short)
- ☐ A copy of the Consultation Booklet and survey (Easy Read)
- ☐ A copy of the full Forest of Dean Community Hospital Consultation Booklet and survey
- ☐ A copy of the Forest of Dean Community Hospital Consultation Booklet and survey (Easy Read)
- ☐ A telephone call to give my feedback

(The information you provide will be stored securely and only used to send you information about this consultation).

- 1,743 requests for information were received (1,286 items posted, all other items were sent by email). Many people requested more than one item or documents relating to both live consultations.
    - Fit For the Future (1,248)
        - Long 226 (162 sent by post)
        - Short 587 (415 sent by post)

[8] https://www.royalmail.com/sites/default/files/D2D-Opt-Out-Application-Form-2015.pdf

[9] Details of the Forest of Dean Community Hospital Consultation can be found at: https://www.fodhealth.nhs.uk/consultation/

        - Easy Read 256 (193 sent by post)
        - Pre Consultation Business Case 180 (132 sent by post)
    - Forest of Dean Community Hospital (495)
        - Long 308 (239 sent by post)
        - Easy Read 187 (145 sent by post)
- 116 requests for telephone call backs
    - Fit for the Future (83)
    - Forest of Dean Community Hospital (33)

Media releases and stakeholder briefings

This included:

- launch materials – media release and stakeholder briefing
- media statements reinforcing key messages and involvement opportunities
- a further open stakeholder letter sent to community stakeholders by email including Patient Participation Groups, local authorities, voluntary and community organisations
- Foundation Trust Membership communications promoting the consultation

Hardcopy engagement booklets

Approximately 5,000 booklets were widely distributed to a range of public places including Cheltenham General and Gloucestershire Royal Hospitals, community pharmacies, GP surgeries and libraries. The booklets included the survey and information detailing the ways people could get involved.

'Your Say' area on the One Gloucestershire Health website and Get Involved in Gloucestershire online participation platform

All consultation materials can be found at: Fit for the Future: Developing urgent and hospital care in Gloucestershire: https://www.onegloucestershire.net/yoursay/ Get Involved in Gloucestershire is an online participation space where anyone can share views, experiences and ideas about local health and care services. Information about the consultation including activities can be found at https://getinvolved.glos.nhs.uk/fit-for-the-future

Further engagement to address the homogeneity of participants

Targeted opportunities for consultation with protected characteristic groups were identified through the Equality and Engagement Impact Analysis e.g. via the Homeless Healthcare Team, Carers Forum etc. Alternative formats of all consultation materials available on request. Contract in place with telephone (and face to face) interpreters, incl. BSL and for written translation. An introduction to the Consultation, with information about support to enable people to participate, was sent to Talking Newspapers

Social media

Social media was used extensively to support the consultation and planned activity covered topics such as promotion of how people could get involved, films, Information Bus Tour and

Cuppa and Chat events, promotion of the booklet and survey, and promotion of the online clinical discussions.

Facebook

During the engagement there were a total of 22 Facebook posts from the One Gloucestershire account, with a total reach of 91, 141[10]. There were 5,555 'engagements' with these posts (i.e. actions such as comments, likes or shares) of which 444 clicked the links in the post. There were also three sponsored boosts across the period of the consultation, including a post to launch the consultation, our intro to Fit for the Future video, and to promote the Q&A sessions. Each of these posts also linked to the One Gloucestershire website. This achieved a total reach of 142,512* with 1,793 'engagements' which included 1,016 clicks on the link in the post.

Twitter

During the engagement period there were 38 tweets and retweets from the One Gloucestershire account, with a total of 30,088 impressions. There were 791 'engagements' with these tweets (i.e. actions such as link clicks, retweets, likes, or comments) of which 97 were retweets and 107 were clicks through to the One Gloucestershire website. Activity on Twitter covered the themes referred to in the Facebook section above.

Media Advertising

As well as the methods described above, the initial Information Bus events were advertised in local media titles including Gloucester Citizen, Gloucestershire Echo, The Forester, Wilts & Glos Standard, Stroud News & Journal, Cotswold Journal and Gloucestershire Gazette. We also took out sponsored digital adverts with the titles listed above, which went out via their websites and social media channels. These pushed people to the main Fit for the Future consultation page where people could find our documents, videos and details for how to get involved online or offline.

[10] It is important to note that the total reach across all posts will include many people who saw more than one of our posts. However, on each post, reach only includes each individual once, even if they saw a post multiple times.

2.5 Staff communication and engagement

Gloucestershire Hospitals NHS Foundation Trust staff

Four main programmes of internal communication and engagement were rolled out to support staff.

1) Corporate communications:

Video communication to all staff: Executives regularly updated staff on the programme of work as part of the fortnightly Vlog shared with all staff and hosted on the Trust intranet. To enable greater uptake the intranet has also been made mobile friendly so staff can keep up to date via their own personal device at a time of their choosing.

Key statistics:

- Total page views: 3,242
- unique views: 2,786
- Average time on Vlog: 09m:16s

Global emails: As well as video format, programme leads regularly updated staff on developments in written format via global emails which go out to all staff 3 times a week. This messaging regularly linked back to the intranet page where staff could find out more and were actively encouraged to complete the online survey. Unfortunately due to

restrictions with Outlook software there's no tracking device that enables tracking of email updates. However, intranet tracking is available and is covered in the next section.

Intranet: The intranet was used a platform to share all the latest information including opportunities for staff to get involved, learn more about the programme and how to complete the online survey.

Key statistics:

- Total page views: 795
- Unique page views: 647
- Average time on page: 04:39

Website: In addition to the main website platform (onegloucestershire.net), the Hospitals Trust also uploaded an information update (media release) to its website (www.gloshospitals.nhs.uk).

Key statistics:

- Total page views: 394
- unique views: 339
- average time on page: 02:32

2) Staff online discussion forum

Throughout the consultation staff were offered 3 dedicated online sessions to learn more about the programme. Typically each session would include an introduction, overview of the programme, the case for change and the opportunity each afforded. The sessions were clinically supported and executive lead. Staff were invited to participate and ask live questions which were shared and answered.

Monday, 2nd November: x 4 participants
Tuesday, 8th December: x 6 participants
Monday, 14th December: No participants

3) Staff drop in sessions

Information points were established at busy thoroughfares across the hospitals. These were staffed on 10 separate occasions for three hours throughout the period of the consultation. This qualitative approach was designed to understand in more detail the views of staff. Consultation booklets were also distributed widely in staff areas across both Cheltenham General and Gloucestershire Royal Hospital. Total number of contacts made with staff: 351

Themes that emerged:

- Awareness levels varied: some staff were well informed and knowledgeable while others less so
- Anecdotally awareness levels appeared to increase throughout the consultation
- There was some confusion in relation to COVID temporary/emergency changes and long-term strategic proposals for changes as part of Fit for the Future

From those staff, who were engaged, the following themes emerged:

- Broadly there was support for the centres of excellence vision
- Staff understood the benefits of a greater separation between emergency and elective services across both sites
- Staff could point to inefficiencies and duplication which didn't optimise opportunities for better patient care and staff working
- There was a level of anxiety in relation to bed modelling and access to theatres, equipment and wards
- Staff had preferences over which site they preferred to work
- Staff wanted to continue to work within the same team

4) Staff ambassadors

Clinical and managerial leaders supported the programme within their divisions and teams and were encouraged to take the message to them as part of the consultation programme. Clinical and managerial leaders were reminded of the importance of this responsibility during regular corporate and clinical leadership meetings such as the Trust's Leadership Team meeting. By having ambassadors widely dispersed across the hospitals they acted as touch points and support pillars for clinical colleagues, administrative and managerial staff.

Primary care (GP practices) and NHS Gloucestershire Clinical Commissioning Group (CCG)

The Fit for the Future consultation has been regularly promoted to all staff working at NHS Gloucestershire Clinical Commissioning Group and in GP practices, Primary Care Networks and the Local Medical Committee via the Primary Care Bulletin. The consultation was promoted at a meeting of the countywide Primary Care Clinical Network Clinical Directors.

2.6 Other stakeholder communication and engagement

Elected Representatives

Members of Parliament

Regular MP briefings have taken place prior to and during the Fit for the Future consultation period.

Gloucestershire County Council (GCC)

Gloucestershire County Council Health Overview and Scrutiny Committee Members have received regular updates on the FIT FOR THE FUTURE programme and consultation. Consultation materials have been available to elected members and staff.

District and Borough Councils

A series of Fit for the Future Members Seminars have taken place across the county. Following presentations, members had the opportunity to participate in Question and Answer sessions.

REACH Campaign

A series of constructive meetings were held throughout the consultation with representatives of REACH[11]. These meetings provided an opportunity to share information and to respond to questions. During the consultation period REACH produced an alternative survey to the NHS Fit for the Future survey. Details of the REACH survey and responses to it have been shared with the Fit for the Future consultation team and can be found in Part 2.

[11] https://www.reachnow.org.uk/ extract from website:

The REACH (Restore Emergency At Cheltenham General Hospital) campaign was launched by Cheltenham Chamber of Commerce, which is now working with local businesses, local residents and other campaign groups to achieve the following objective: "To have a fully functioning, fully staffed A&E Department operating 24/7 re-instated at Cheltenham General Hospital, which serves a population of at least 200,000 in Cheltenham, Tewkesbury Borough and the North Cotswolds, at the earliest possible opportunity."

2.7 Public Consultation Activities

Gloucestershire Media: Live social media partnership (@GlosLiveOnline)

Underpinning the 'socially distanced' approach to consultation was a new and ground breaking partnership with local media stakeholder Gloucestershire Media. In terms of the format six half hour productions were broadcast live via Glos Media's Facebook channel (as well as Glos Hospitals Facebook channel) during peak period. Chaired by an independent figure well-known in the local community and presented as a Q&A public session with hospital clinicians, the sessions were broadcast at 12.30pm each Wednesday (from 4th November – 9th December).

Each session focussed on each of the individual service proposals under the Fit for the Future public consultation programme e.g. acute medicine, gastroenterology inpatient services, trauma & orthopaedics, general surgery and image guided interventional surgery. The exception to that was the first broadcast which went out as a COVID special on 4th November. The strength of the broadcasts was the level of clinical representation and participation. Under the partnership arrangement other local media outlets including the BBC were given access to the content produced as well as access to the hospitals and clinicians.

Gloucestershire Media: Live social media partnership (@GlosLiveOnline) Analytics:

Table 1 (analytics of the broadcast)

Platform	Date	Subject	Reach	Comments	Likes	Shares	Views
Facebook	11/11/2020	Gastroenterology Inpatient Services	Glos Live: 49,500 Glos Hos: 14,366	74 23	54 29	7 17	10,000
	18/11/2020	Acute Medicine	Glos Live: 58,000 Glos Hos: 3,187	69 16	54 31	7 5	11,000
	25/11/20	T&O	Glos Live: 20,000 Glos Hos: 3,789	36 25	23 27	3 6	6,000
	02/12/2020	General Surgery	Glos Live: 16,000 Glos Hos: N/A	17 N/A	27 N/A	2 N/A	6,500
	09/12/2020	IGIS	Glos Live: 33,234 Glos Hos: 3,900	29 0	54 28	1 5	8,800

Table 2 (analytics of the promotional material)

Platform	Date	Subject	Reach	Comments	Likes	Shares
Facebook	10/11/2020	Gastroenterology	28,800	60	16	6
	11/11/2020	Gastroenterology	20,300	19	34	4
	17/11/2020	Acute Medicine	27,700	44	15	2
	24/11/2020	T&O	14,400	41	7	1
	01/12/2020	General Surgery	11,000	0	3	2
	04/12/2020	T&O	30	1	9	2
	08/12/2020	IGIS	8,000	0	7	2

Gloucestershire Hospitals: Facebook live (@GlosHospitals)

Running parallel to the Gloucestershire Media partnership described above was the Hospitals Trust's own Facebook live production. Clinically led and executive supported, all 7 sessions were broadcast live via the Trust's Facebook channel. In a similar way to the Gloucestershire Media productions, each session was dedicated to an individual service proposal and led by those specialist clinicians. Typically each session would include an introduction, overview of the service, the case for change and the opportunity each afforded. The public were invited to participate and ask live questions which were shared and answered.

Gloucestershire Hospitals: Facebook live (@GlosHospitals): Analytics:

Platform	Date	Subject	Reach	Comments	Likes	Shares	Views
Facebook	02/12/2020	Acute Medicine	18,277	5	24	2	2.5k
	03/12/2020	Gastroenterology Inpatient Services	3,099	0	11	4	1.4k
	03/12/20	General Surgery	2113	1	5	1	970
	04/12/2020	IGIS	3,072	9	8	14	1.4k
	04/12/2020	T&O	30	1	9	2	1.4k
YouTube*	02/11/2020	Acute Medicine	N/A	1	3	N/A	146

* The Hospitals Trust switched from YouTube to Facebook in response to increased audiences and greater accessibility. The Trust ran an additional broadcast on Acute Medicine to ensure the full sequence of service proposals had been broadcast.

Gloucestershire Patient Participation Group Network

https://getinvolved.glos.nhs.uk/ppg-network

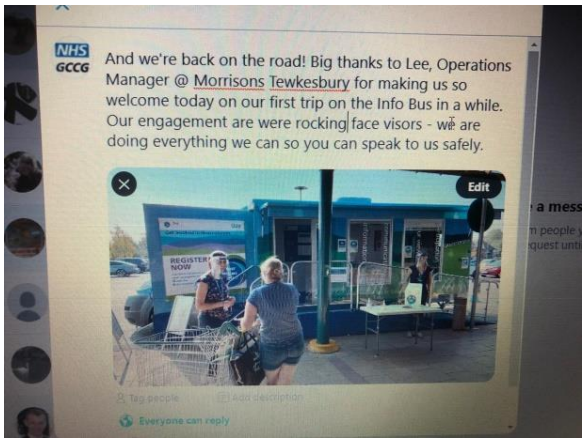
All GP practices in England are required to have a patient participation group. The Gloucestershire PPG Network is organised by Gloucestershire Clinical Commissioning Group (CCG). It is designed to provide a space for PPG members from across the county to share their experiences with one another in order for each PPG to learn and continue to provide an effective role in their practice.

NHS Gloucestershire CCG involves PPG members in engagement and consultation work, provides support to PPG's on an individual basis and also provides opportunities for PPG's to learn and develop. In addition, NHS Gloucestershire CCG hosts a quarterly network meeting. However, during the current pandemic this has moved to holding meetings virtually using MS Teams. An Extraordinary PPG Network meeting to focus solely on the Fit for the Future and Forest of Dean new community hospital consultations attended by 25 PPG members was held in November 2020.

NHS Information Bus Tour

The Information Bus aims to facilitate partnership working, offering information and activities which support self-care, health and wellbeing and self-management across the communities of Gloucestershire. The Bus is also used a consultation resource to support engagement with the public to inform service planning and design.

Prior to the launch of the consultation, the Bus was used during September 2020 to promote the new Get Involved in Gloucestershire online participation platform.



An Information Bus Tour to raise awareness of the consultation, to gather views and answer questions commenced on 2 November 2020. Unfortunately due to new Covid-19 restrictions introduced from 5 November 2020, planned Information Bus Dates originally planned for November 2020 were cancelled. However all these dates were re-provided in December once lockdown in England ended and Gloucestershire moved into Tier 2. Three events had been held prior to lockdown. The Bus was used as a venue for Covid-19 staff testing while it was off the road.

The Bus recommenced its Tour on 1 December 2020 in Chepstow, Monmouthshire (where lockdown was not in place) and in Cheltenham on 3 December 2020.

Chepstow Hospital

Tesco, Tewkesbury Road Cheltenham

Gloucester Quays

During the consultation 433 people visited the Information Bus. See Section 2.10 for details of all Information Bus Tour dates.

Cuppa and Chats

When the Information Bus Tour was paused in November 2020, locality and countywide online 'Cuppa and Chats' were set up to replace the socially distanced face-to-face visits planned. These took the form of a short presentation (including showing of an information film) followed by a shared discussion.

The sessions were initially organised as Microsoft Teams meetings, in response to feedback from public participants, the sessions were moved to an alternative platform, Zoom, more frequently used by community partners.

8 'Cuppa and Chats' were hosted reaching 44 participants.

Targeted activities

In addition to the main consultation activities, the consultation sought feedback from groups identified in the independent Integrated Impact Assessment. Details of how we have engaged these groups in the consultation can be found below in section 2.8.

Fit for the Future Surveys

Two surveys (standard and Easy Read) were developed by the NHS to support the FIT FOR THE FUTURE engagement. These were available as print, FREEPOST return copies in the engagement booklets and also on line at:
https://www.onegloucestershire.net/yoursay/fit-for-the-future-developing-specialist-hospital-services-in-gloucestershire/
and
https://getinvolved.glos.nhs.uk/fit-for-the-future

A total of 713 Fit for the Future surveys have been received. This included 110+ Freepost paper surveys, 1 telephone survey with the remainder online.

Other surveys and petitions

REACH created an alternative survey to gather views to inform their response to the Fit for the Future consultation proposals.
[Extract from REACH website) https://www.reachnow.org.uk/

REACH launch their Fit for the Future Survey **(19 November 2020)**

REACH are concerned that the One Gloucestershire Fit for the Future survey that forms part of the consultation has been constructed in such a manner that the results can be used to justify a decision that the respondents would not have supported. Because of this REACH have chosen to launch their own survey, to gather the real preferences of those local people in Gloucestershire and surrounding areas, who will be affected by these proposals.

"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 have chosen to produce our own Fit for the Future survey.

"We would encourage as many people as possible to take part in our survey and allow their views to be heard. We will be making the results of this survey public and will be sharing them with One Gloucestershire. To help the general public understand some of the fairly complex issues involved we have also produced a non- medical persons' guide to some of the key points"

The results from the REACH survey have been shared with the One Gloucestershire Communications and Engagement Team and are included in the detailed summary of consultation feedback in Part 2 of this report. REACH has also provided a formal response to the consultation which can be found in the online appendices.

Petitions

At the time of writing no petitions relating to Fit for the Future have been received by NHS partners of One Gloucestershire.

2.8 Consulting people with protected characteristics and others identified in the Independent Integrated Impact Analysis

The consultation took two main routes to reach, gather and record views from people with protected characteristics and others identified in the independent Integrated Impact Analysis:

- promoting the formal consultation routes and encouraging participation. The consultation survey asks for respondents to provide demographic information (see Part 2)
- proactive consultation with targeted groups. The consultation team contacted groups across Gloucestershire using existing well established networks and Your Circle https://www.yourcircle.org.uk/, which is a local online directory to help you find your way around care and support and connect with people, places and activities in Gloucestershire. The following describes activities undertaken to encourage participation from these groups and themes from their responses to the consultation where possible without identifying individual's responses.

Black, Asian and Minority Ethnic (BAME) communities, in particular people aged over 65

There are a number of responses to the survey from people from BAME communities (39 people identified as: White Other, Asian or Asian British, Black or Black British, Chinese, Mixed who complete the 'About you' survey questions). A small number of respondents from BAME communities also indicated they were aged over 66. Members of the consultation team worked with Friends from the Friendship Café in Gloucester City to supported awareness raising and survey completion within diverse communities. Information about the consultation was shared with the members of the Impact of COVID-19 on BAME Community/Groups Gloucestershire Task and Finish Group. Consultation materials were shared with the Gloucestershire VCS Alliance BAME/Diverse Communities Forum. An interview on the Community Link Programme on Gloucester FM Radio promoted the consultation to listeners. Gloucester FM community radio station, has an emphasis on local issues, information, advice and music reflecting Gloucestershire's multi-cultural community https://gloucesterfm.com/

People with mental health conditions [and learning disabilities]

There is a good response to the survey from people who indicated they have a disability (including mental health problem or learning disability). During the consultation, members of the consultation team attended all Know Your Patch meetings across the county to promote Fit for the Future and the Get Involved in Gloucestershire online participation platform. Know Your Patch builds networks for those working with individuals and groups to help people stay independent for longer and to lead full and happier lives. Know Your Patch has a network of organisations in each district in Gloucestershire. These networks meet quarterly for networking and discussion and communicate through email bulletins and updates. These networks help connect VSCE and statutory organisations together for effective partnership working https://knowyourpatch.co.uk/networks/ Information about

the consultation was also shared with the Mental Health and Learning Disability Partnership Boards.

The online appendices includes reports of the responses from all survey respondents, who completed the 'About You' questions in the survey, who stated they had a mental health problem or a learning disability.

Over 65s who are more likely to have long term conditions such as cardiovascular disease, obesity or diabetes

There is a good response to the survey from people aged 66 and over, and also from people who indicated they have a disability. Staff from Gloucestershire Health and Care NHS Foundation Trust, working in Cardiac Rehabilitation, have been provided with consultation materials. The Gloucestershire Heart Support Group, HeartSmart (Cirencester), Heart to Heart Exercise Group and Where the Heart Is Group, were provided with information about the consultation to share with members of their groups. Visits were made to the Cardiac Ward and Coronary Care Unit at Cheltenham General Hospital and Gloucestershire Royal Hospital to provide awareness raising flyers, summary booklets and full booklets for clinical staff to share with patients who were well enough to read of them. Information about the consultation was also shared via email with 20 members of the Gloucester Diabetes Support Group and at a Gloucestershire Stroke Zoom Café attended by 5 members.

Frail older people who are more likely to experience falls

The activities described above for Over 65s with long terms conditions apply to this group as well. Contact was also made with the local branch of Age UK to promote the consultation.

The online appendices provide a report of the responses from all survey respondents, who completed the 'About You' questions in the survey, who are over 66 and who stated they had a disability.

People from BAME communities who are living with a long term condition

There is a proportional response to the survey from people from BAME communities. A small number of respondents from BAME communities also indicated they had a disability.

As referenced above, members of the consultation team worked with Friends from the Friendship Café in Gloucester City to supported awareness raising and survey completion within diverse communities.

Information about the consultation was shared with the members of the Impact of COVID-19 on BAME Community/Groups Gloucestershire Task and Finish Group. An interview on the Community Link Programme on Gloucester FM Radio promoted the consultation to listeners. Gloucester FM community radio station, has an emphasis on local issues, information, advice and music reflecting Gloucestershire's multi-cultural community https://gloucesterfm.com/

The online appendices provide a report of the responses from all survey respondents, who completed the 'About You' questions in the survey, who are from BAME communities and who stated they had a disability.

People living with a disability (includes physical impairments; learning disability; sensory impairment; mental health conditions; long-term medical conditions)

There is a good response to the survey from people who indicated they have a disability. As above, during the consultation, members of the consultation team attended all Know Your Patch meetings across the county to promote Fit for the Future and the Get Involved in Gloucestershire online participation platform.

Know Your Patch builds networks for those working with individuals and groups to help people stay independent for longer and to lead full and happier lives. Know Your Patch has a network of organisations in each district in Gloucestershire. These networks meet quarterly for networking and discussion and communicate through email bulletins and updates. These networks help connect VSCE and statutory organisations together for effective partnership working https://knowyourpatch.co.uk/networks/

Information about the consultation was also shared with the Learning Disability Partnership Board and Physical Disability and Sensory Impairment Partnership Board who have a total of 179 members between them. Information about the consultation was directly targeted by the Integrated Disabilities Commissioning Hub to 31 members involved of the Building Better Transport Links (BBTL) group, who are looking at better transport arrangements for people with disabilities. The consultation also targeted people with visually impairment through representatives from the Sight Loss Council, the Macular Society and Royal National Institute for the Blind; following their advice information was sent to Gloucestershire's

network of talking newspapers and Fit for the Future VLOGs, as well as written updates, were added to social media channels.

The online appendices provide a report of the responses from all survey respondents, who completed the 'About You' questions in the survey, who stated they had a disability.

Young people

The Gloucestershire Hospitals NHS Foundation Trust Youth Group held a discussion group about the Fit for the Future consultation proposals. Members were encouraged to visit the Get Involved in Gloucestershire online participation platform. 2 Youth Ambassadors created short films, which were shared on social media, to encourage young people to get involved. One member of the Youth Group sent a formal written response to the consultation.

Adult Carers and Young Carers

There is a good response to the survey from people who indicated that (unpaid) they look after, or give any help or support to family members friends, neighbours or others because of either a physical or mental health need or problems related to old age. During the consultation members of the consultation team attended carers group meetings to talk about the Fit for the Future consultation including Gloucestershire Hospitals NHS Foundation Trust Carers Hospitals Reflections and Experience Group and YACTION – Young Adult Carers Group. The groups both emphasised the importance of good clear communications around any proposed changes and the need to work closely and in partnership with carers.

YACTION in action, we talked about Fit for the Future, while together we crafted Christmas decorations.

The online appendices provide a report of the responses from all survey respondents, who completed the 'About You' questions in the survey, who stated they were unpaid carers.

Homeless people (and rough sleepers)

Homelessness is not a characteristic the survey collects. Therefore, in order to ensure the feedback from homeless people can be identified, enhanced targeted activity has taken

place to raise awareness of Fit for the Future and Get Involved in Gloucestershire; and to collect feedback specific to the consultation proposals and any other issues of importance to homeless people. Members of the consultation team have attended several meetings of groups who support homeless people in Gloucestershire: Gloucester Homeless Forum, Cheltenham Housing & Care Forum, Cheltenham Open Door, Cheltenham Housing Aid Centre and also engaged with the Homeless Specialist Nurse.

> Summary of feedback: - *Requests were made for more outreach services, in particular in Cheltenham and for the local NHS to ensure that, whichever hospital vulnerable people were admitted to, they are treated well and with dignity.*

Gypsy/Traveller communities

Members of the consultation team met with the Travellers' Welfare Officer to discuss the Fit for the Future consultation proposals. General comments about the experience of travelling families of Gloucestershire NHS service related to the attitude of NHS staff to travelling families, in particular from ward staff when visiting family members in hospital. Respect for travelling families and understanding of what is important to them, such as space, was highlighted. Constructive suggestions were recorded regarding improvement to communications and information sharing. These will be taken forward in 2021.

LGBTQ+ people

There is a good response to the survey regarding sexual orientation, with a small number of respondents describing themselves as LGB. No respondents to the survey, who completed the 'About You' questions stated that they did not identify with the gender they were registered with at birth. 1 respondent to the survey, who completed the 'About You' questions stated they were transgender. Information about the consultation was shared with the members of the Gloucestershire LGBT+ partnership and there was an opportunity to raise awareness of the consultation when the NHS Information Bus supported the LGBTQ+ partnership as a mobile venue during Hate Crime week in September 2020.

The online appendices provide a report of the responses from all survey respondents, who completed the 'About You' questions in the survey, who identified as LGBTQ+ [The combined number is greater than 10]

People living in low income areas

Low income is not a characteristic the survey collects. However, there is information within local data which records indices of deprivation and shows which areas of the county are most likely to be low income areas. Extract from Inform website: https://inform.gloucestershire.gov.uk/deprivation/overview/

> *The Indices of Deprivation 2019 are national measures based on 39 indicators, which highlight characteristics of deprivation such as unemployment, low income, crime and poor access to education and health services. The 2019 indices offer an in-depth approach to pinpointing small pockets of deprivation. Each indicator was based on*

data from the most recent time point available. Using the latest data available means there is not a single consistent time point for all 39 indicators. https://inform.gloucestershire.gov.uk/media/2094524/gloucestershire_deprivation_2019_v13.pdf

….There are 12 areas of Gloucestershire in the most deprived 10% nationally for the overall IMD. [9 of the 12 are in Gloucester District Council: GL1, GL2 and GL4 postcode areas, 2 in Cheltenham GL50 and GL51 and 1 in the Forest of Dean GL14.

1. *Podsmead 1 Gloucester 621 (n=national rank out of 32,844 small areas or neighbourhoods called Lower-layer Super Output Areas in England[12])*
2. *Matson and Robinswood 1 Gloucester 735*
3. *Westgate 1 Gloucester 1,183*
4. *Kingsholm and Wotton 3 Gloucester 1,456*
5. *Westgate 5 Gloucester 1,579*
6. *St Mark's 1 Cheltenham 2,178*
7. *Moreland 4 Gloucester 2,221*
8. *St Paul's 2 Cheltenham 2,368*
9. *Cinderford West 1 Forest of Dean 2,729*
10. *Tuffley 4 Gloucester 2,801*
11. *Matson and Robinswood 5 Gloucester 2,948*
12. *Barton and Tredworth 4 Gloucester 3,126*

Employment status is one of the indices of deprivation. Information available on the Inform website the latest available unemployment data for October and November 2020 indicates that Barton and Tredworth ward in the GL1 postcode of Gloucester has the highest claimant rate (Job Seekers Allowance and Universal Credit) in Gloucestershire. https://inform.gloucestershire.gov.uk/media/2102589/unemployment-bulletin-147-oct-20.pdf and https://inform.gloucestershire.gov.uk/media/2103578/unemployment-bulletin-148-nov-20.pdf

The Fit for the Future consultation survey collects top level postcode information (first part of the postcode e.g. GL16 or GL3) to avoid potential for identifying individual survey respondents.

The online appendices provide a report of the responses from all survey respondents, who completed the 'About You' questions in the survey, who stated they lived in the GL1 postcode area and who lived in GL1, GL2, GL4, GL50, GL51 and GL14.

12 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/835115/IoD2019_Statistical_Release.pdf

2.9 District/Borough Council Member Seminars

Representatives from One Gloucestershire NHS partners attended a series of District/Borough Council Member Seminars. Discussions were on the following themes:

Centres of Excellence approach

- Impact of centralisation of services on patient access and choice
- Impact of proposals on planned operations being cancelled in future
- Centres of Excellence – positive separation of planned and urgent care, potential to reduce reliance on private sector for planned procedures
- Centralisation: NHS benefits (efficiency) balanced against impact on the public (social costs)
- Ambulances need to know which hospital to bring patients to
- Hospitals are only one part of the patient journey, they need to work in partnership with community and primary care and the voluntary sector
- One Gloucestershire borders many counties and Wales, consider cross-border flow of patients

Cheltenham General Hospital A&E Department

- Confirmation requested regarding A&E arrangements a Cheltenham General Hospital reverting to pre-Covid service and clarification of what the pre-Covid arrangements were.
- Covid temporary changes – challenges with Ambulance delayed at Gloucestershire Royal Hospital (GRH) and capacity at GRH.

Communications

- Patients understanding of which services are provided at each hospital now and in the future
- Communications and Public Relations more innovation needed to meet diverse communities' requirements
- The public need to know which services are available, where and at what times of the day and night
- Level of Clinical support for the proposals

Sustainability/Estates

- How hospitals keep up to date with new developments/treatments
- The plans for increasing 7 day working
- Consideration should be given to building one new Acute General Hospital for Gloucestershire – more efficient

Transport/Access/Rurality

- Centralising services results in longer travel times for patients and visitors
- Rural transport infrastructure poor in county
- Ambulance response times in rural areas of the county

2.10 Consultation events activity timeline

Week	Activity	Number engaged with	Protected Characteristic (where applicable)
22 –28 October	Health Overview and Scrutiny Committee (HOSC)	15	
	Stroke Zoom Café	5	Disability
	Get Involved in Gloucestershire (GIG) with Gloucestershire Hospitals NHS Foundation Trust (GHT) Governors	6	
29 October – 4 November	Tewkesbury Know Your Patch (KYP)	13	Multi Voluntary Community Sector (VCS)
	Information bus – Cheltenham, High Street	55	
	Information bus – Cinderford, Co-Op (Forest of Dean)	22	
	Information bus – Gloucester, Quays	37	
	Stroud and Berkeley Vale Patient Participation Group (PPG)	16	
	Acute Medicine Clinical Q&A YouTube Live	15	
	GIG with GHT Governors	6	
	GHT Carers focus group	15	Carers
	Gloucester Homeless Forum (professionals/VCS)	30	Homeless
	GHT Youth Group	18	Age, young adults
	Primary Care Network (PCN) Clinical Directors	16	
	Cotswolds KYP	27	Multi VCS
	Friendship Café	4	BAME
	GHT Staff drop ins and ward visits	134	Health Professionals
	GHT staff online discussion forum	4	Health Professionals
5 – 11 November	KYP Gloucester	38	Multi VCS
	PPG Network	25	

	Stroud and Berkeley Vale PPG	16	
	GHT staff online discussion forum	6	Health Professionals
	GHT Governors	15	
	Gloucestershire Live Gastroenterology Inpatient service (Facebook Live)	10,000 views Combined reach - 63,866	
12 – 18 November	Cuppa and Chat - Stroud (using Microsoft Teams)	2	
	Forest of Dean Locality Reference Group	13	
	Cuppa and Chat – Cotswolds (using Microsoft Teams)	3	
	HOSC	15	
	Forest of Dean Community Connectors/KYP	17	VCS organisations; housing associations
	BAME/Diverse communities Forum (VCS Alliance)	Online link sent	BAME
	KYP Stroud	49	Multi VCS
	Cheltenham Borough Council Members Seminar	21	
	Gloucestershire Live Acute Medicine (Facebook Live)	11,000 views Combined reach – 61,187	
	RNIB (SW Facebook group)	up to 2500 followers	Disability
	Macular society Gloucestershire meeting	9	Disability
	Gloucester diabetes support group	20	Disability
	Cancer Patient Reference Group	13	Disability
	Cuppa and Chat – Tewkesbury (using Zoom)	6	
19 – 25 November	Cuppa and Chat - Forest of Dean (using Zoom)	10	
	GHT reflections and experience group	15	
	Housing and Support Forum	24	Health Inequalities
	Gloucester City Council Members Seminar	14	

	Cuppa and Chat – Cheltenham (using Zoom)	7	
	Gloucestershire Live Trauma & Orthopaedics (Facebook Live)	6,000 views Combined reach – 23,789	
26 November – 2 December	Information bus - Chepstow	17	
	Alney Practice PPG	12	
	Cuppa and Chat – Gloucester (using Zoom)	7	
	BAME C19 Task and Finish Group	12 and information sent to full membership	BAME
	Forest of Dean District Council briefing	14	
	Acute Medicine Clinical Q&A Facebook Live	2,500 views Reach – 18,277	
	Gloucestershire Live General Surgery (Facebook Live)	6,500 views Combined reach – 16,000 (not on GHT Facebook page)	
3– 9 December	Tewkesbury Borough Council briefing	10	
	Information bus –Cheltenham, High Street	31	
	Information bus – Cheltenham, Tesco	12	
	Cuppa and Chat – Fit for the Future (using Zoom)	7	
	Information bus – Lydney, Newerne Street car park (Forest of Dean)	32	
	Gastroenterology Clinical Q&A Facebook Live	1,400 views Reach 3,099	
	Cuppa and Chat - Forest of Dean	2	
	Information bus – Gloucester, Quays	17	
	Information bus – Gloucester, Tesco St Oswald's Road	24	
	General Surgery Clinical Q&A Facebook Live	970 views Reach – 2,113	
	Information bus – Stroud, Tesco	25	
	Image Guided Interventional Surgery (IGIS) Clinical Q&A Facebook Live	1,400 views Reach – 3,072	
	Trauma & Orthopaedics Clinical Q&A Facebook Live	1,400 views Reach – 3,000	

	Information bus – Cirencester Market Place (Cotswolds)	37	
	Forest of Dean PCN	19	
	Information bus – Stow Market Place (Cotswolds)	58	
10 -17 December	Information bus – Tewkesbury, Spring Gardens car park	28	
	Cotswold District Council	11	
	Information bus - Coleford Clock Tower (Forest of Dean)	38	

PART 2

3. Responses to the consultation

Feedback to the consultation was received in two main ways:

- Fit for the Future survey (Main and Easy Read) responses 713 Surveys received (Paper copies: 81 Fit for the Future Survey and 32 Fit For the Future Easy Read)
- Other correspondence/written responses

The qualitative feedback from completed surveys and correspondence has been grouped into a series of themes under the following headings (A to Z):

- Access
- Capacity
- Diversity
- Efficiency
- Environment
- Facilities
- Interdependency
- Integration (with primary and community services)
- Patient Experience / Staff Experience
- Pilot
- Quality
- Resources
- Transport
- Workforce

All written feedback received (redacted for personally identifiable information e.g. names) can be found in the online appendices.

3.1 Demographic information

Respondents to the Fit for the Future surveys (Main and Easy Read)

Demographic information about respondents was collected by the Fit for the Future surveys. Monitoring of equality data requires a two-stage process: data collection and analysis. Gathering good equality data supports legislative requirements in that it aids prevention of discrimination. This is why it is really important to provide an explanation that the process is worthwhile and necessary.

The Fit for the Future survey included the following statement:

> *About You: Completing the "About You" section [of the survey] is optional, but the information you give helps to show that people with a wide range of experiences and circumstances have been involved. Your support with this is really appreciated.*

The Fit for the Future Easy Read survey included the following statement:

> *About You: You don't have to fill in this information, but it will help us know that we have asked a lot of different people what they think about our ideas.*

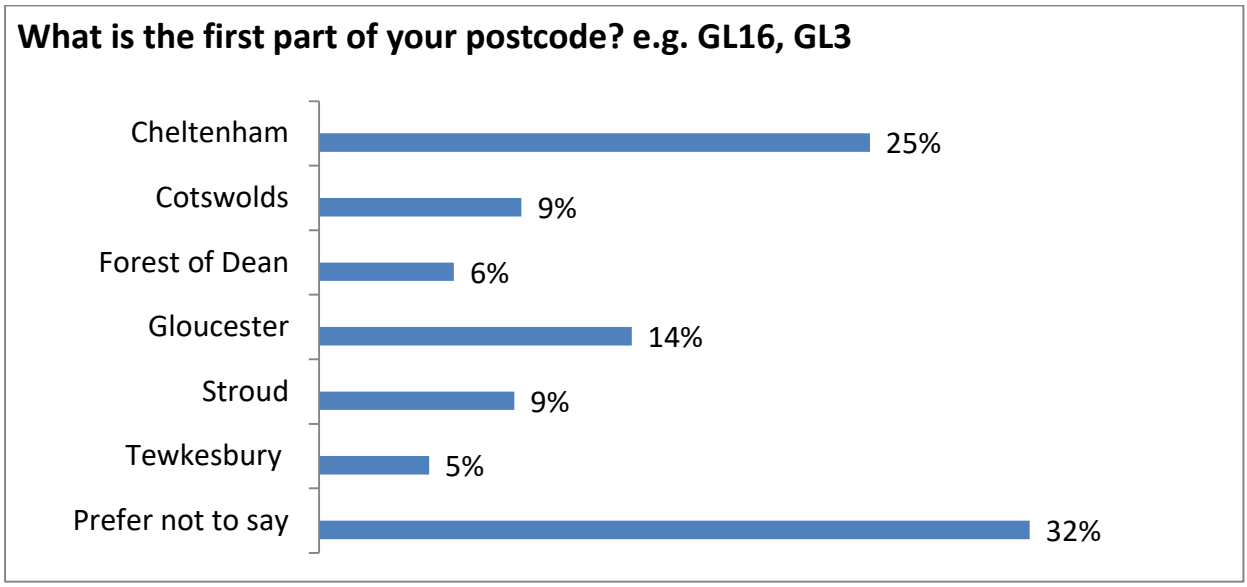
Not everyone who responded to the survey completed any/all of the demographic questions. However, the data presented below indicates that a diverse range of respondents from all protected characteristic groups, and those identified in the Independent Integrated Impact Assessment have provided feedback to the consultation.

Targeted activities aimed to extend the reach of the Consultation and collect data on all protected groups, as recommended in earlier Equality Impact Assessments. Analysis of the survey responses shows there is a broad representation of most groups. Initial analysis of responses by various demographics, e.g. age, gender, health and care professionals, does not show any significant variation compared with the overall themes. The independent Integrated Impact Assessment will be updated to take into account the response to consultation. The updated assessment will be included in the Decision Making Business Case, which will be available on the One Gloucestershire website.

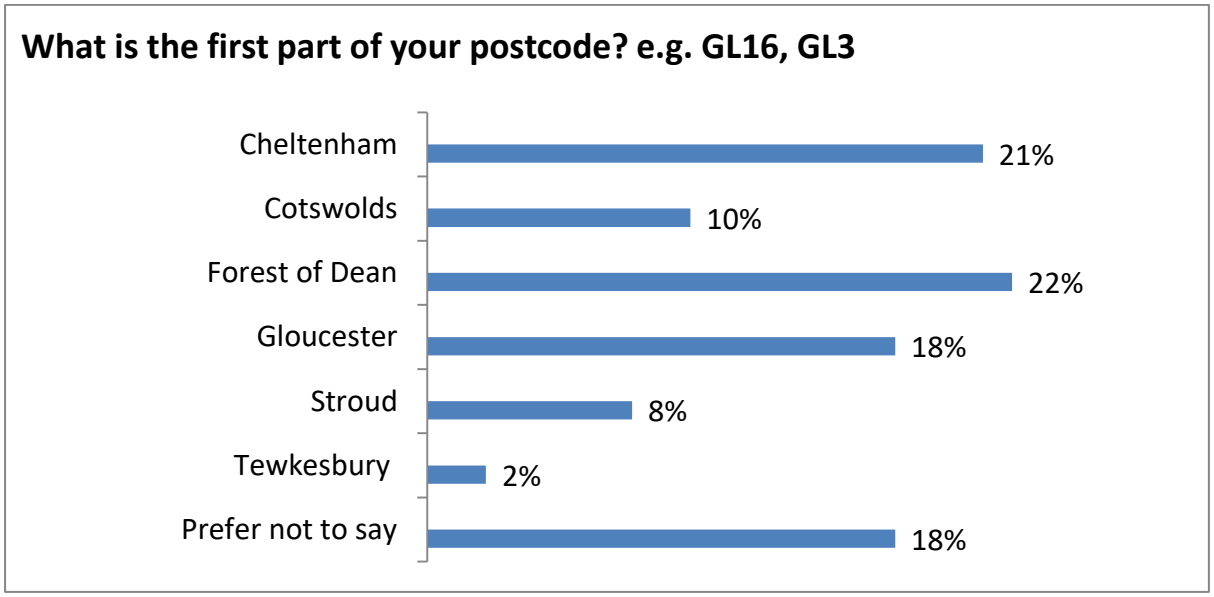
The level of support for each proposal from staff and public is included in the summary information below. Further information about targeted engagement with some of these groups can be found in Section 2.8.

Demographic Information about Fit for the Future surveys (Main and Easy Read) respondents

Fit for Future Survey



Fit for Future Survey Easy Read



Fit for the Future Survey

Which age group are you:			
		Response Percent	Response Total
1	Under 18	1.65%	8
2	18-25	2.06%	10
3	26-35	10.91%	53
4	36-45	12.35%	60
5	46-55	18.72%	91
6	56-65	22.22%	108
7	66-75	18.93%	92
8	Over 75	11.32%	55
9	Prefer not to say	1.85%	9
		answered	486
		skipped	138

Fit for the Future Survey Easy Read

Which age group are you:			
		Response Percent	Response Total
1	0 - 18	1.27%	1
2	18-25	1.27%	1
3	26-35	1.27%	1
4	36-45	3.80%	3
5	46-55	8.86%	7
6	56-65	20.25%	16
7	66-75	43.04%	34
8	75+	20.25%	16
9	Not saying	0.00%	0
		answered	79
		skipped	10

Fit for the Future Survey

Are you:				
			Response Percent	Response Total
1	A health or social care professional		29.57%	144
2	A community partner		1.64%	8
3	A member of the public		62.63%	305
4	Prefer not to say		6.16%	30
			answered	487
			skipped	137

Fit for the Future Survey Easy Read

Are you:				
			Response Percent	Response Total
1	Someone who works in health or social care		7.50%	6
2	A member of the public		88.75%	71
3	Not saying		3.75%	3
			answered	80
			skipped	9

Fit for the Future Survey

Do you consider yourself to have a disability? (Tick all that apply)			
		Response Percent	Response Total
1	No	72.16%	350
2	Mental health problem	4.54%	22
3	Visual Impairment	2.89%	14
4	Learning difficulties	0.41%	2
5	Hearing impairment	5.36%	26
6	Long term condition	17.32%	84
7	Physical disability	4.74%	23
8	Prefer not to say	3.09%	15
		answered	485
		skipped	139

Fit for the Future Survey Easy Read

Do you have a disability - tick the ones that describe you.			
		Response Percent	Response Total
1	No	50.00%	37
2	Mental health problem	9.46%	7
3	Problems with your sight	9.46%	7
4	Learning difficulties	4.05%	3
5	Problems with your hearing	14.86%	11
6	A health problem you have had for a long time like asthma, diabetes, or something else	36.49%	27
7	Physical disability	8.11%	6
8	Not saying	1.35%	1
		answered	74
		skipped	15

Fit for the Future Survey

Do you look after, or give any help or support to family members, friends, neighbours or others because of either a long term physical or mental ill health need or problems related to old age? Please do not count anything you do as part of your paid employment.

		Response Percent	Response Total
1	Yes	28.30%	135
2	No	67.51%	322
3	Prefer not to say	4.19%	20
		answered	477
		skipped	147

Fit for the Future Survey Easy Read

Do you look after, or give any help and support that you don't get paid for, to other people because they are ill or older?

		Response Percent	Response Total
1	No, I don't	75.68%	56
2	Yes, I do	22.97%	17
3	Not saying	1.35%	1
		answered	74
		skipped	15

Fit for the Future Survey

Which best describes your ethnicity?			
		Response Percent	Response Total
1	White British	84.71%	410
2	White Other	3.72%	18
3	Asian or Asian British	2.48%	12
4	Black or Black British	0.62%	3
5	Chinese	0.00%	0
6	Mixed	0.62%	3
7	Prefer not to say	7.23%	35
8	Other (please specify):	0.62%	3
		answered	484
		skipped	140

Other (please specify): (3)

1	Why is this relevant to the survey
2	European
3	White English

Fit for the Future Survey Easy Read

Please can you tell us which of the groups in our list best describes you? This is called ethnicity.			
		Response Percent	Response Total
1	White British	93.59%	73
2	White Other	1.28%	1
3	Asian or Asian British	1.28%	1
4	Black or Black British	0.00%	0
5	Chinese	0.00%	0
6	Mixed	1.28%	1
7	Not saying	2.56%	2
		answered	78
		skipped	11

Fit for the Future Survey

Which, if any, of the following best describes your religion or belief?			
		Response Percent	Response Total
1	No religion	39.38%	191
2	Buddhist	0.41%	2
3	Christian (including Church of England, Catholic, Methodist and other denominations)	48.04%	233
4	Hindu	0.41%	2
5	Jewish	0.41%	2
6	Muslim	1.65%	8
7	Sikh	0.00%	0
8	Other	1.44%	7
9	Prefer not to say	8.25%	40
		answered	485
		skipped	139

Fit for the Future Survey Easy Read

Please tick if you have any of these religions or beliefs			
		Response Percent	Response Total
1	None	19.74%	15
2	Buddhist	0.00%	0
3	Christian	71.05%	54
4	Hindu	0.00%	0
5	Jewish	0.00%	0
6	Muslim	0.00%	0
7	Sikh	0.00%	0
8	Other	1.32%	1
9	Not saying	7.89%	6
		answered	76
		skipped	13

Fit for the Future Survey

Are you:				
			Response Percent	Response Total
1	Male		38.76%	188
2	Female		54.64%	265
3	Transgender		0.21%	1
4	Prefer not to say		6.39%	31
			answered	485
			skipped	139

Fit for the Future Survey Easy Read

Can you say about your gender? Tick the one that describes you.				
			Response Percent	Response Total
1	Male		49.37%	39
2	Female		48.10%	38
3	Transgender		0.00%	0
4	Non-binary		1.27%	1
5	Not saying		1.27%	1
			answered	79
			skipped	10

Fit for the Future Survey

Do you identify with your gender as registered at birth?			
		Response Percent	Response Total
1	Yes	93.81%	455
2	No	0.00%	0
3	Prefer not to say	6.19%	30
		answered	485
		skipped	139

Fit for the Future Survey Easy Read

Are you the same gender you were born with?			
		Response Percent	Response Total
1	Yes	94.74%	72
2	No	2.63%	2
3	Not saying	2.63%	2
		answered	76
		skipped	13

Fit for the Future Survey

Which of the following best describes how you think of yourself?			
		Response Percent	Response Total
1	Heterosexual or straight	86.21%	419
2	Gay or lesbian	1.85%	9
3	Bisexual	1.65%	8
4	Other	0.21%	1
5	Prefer not to say	10.08%	49
		answered	486
		skipped	138

Fit for the Future Survey Easy Read

Can you say how you think of yourself?			
		Response Percent	Response Total
1	Heterosexual or straight	90.79%	69
2	Gay or lesbian	1.32%	1
3	Bisexual	1.32%	1
4	Other	0.00%	0
5	Not saying	6.58%	5
		answered	76
		skipped	13

Fit for the Future Survey

Are you currently pregnant or have given birth in the last year?			
		Response Percent	Response Total
1	Yes	1.46%	7
2	No	68.75%	330
3	Not applicable	24.17%	116
4	Prefer not to say	5.63%	27
		answered	480
		skipped	144

Fit for the Future Survey Easy Read

Are you pregnant or had a baby in the last year?			
		Response Percent	Response Total
1	Yes	0.00%	0
2	No	52.56%	41
3	Not saying	1.28%	1
4	This question doesn't apply to me	46.15%	36
		answered	78
		skipped	11

4. Survey Feedback

This section sets out the survey feedback received about each of the specialist services (Acute Medicine, Gastroenterology inpatient services, General Surgery (emergency general surgery, planned Lower Gastrointestinal [GI] / colorectal surgery and day case Upper and Lower GI surgery), Image Guided Interventional Surgery (IGIS) including Vascular Surgery, and Trauma and Orthopaedics (T&O) inpatient services).

The Fit for the Future survey included two types of questions:

- **Quantitative** questions, which offer a choice for the respondent e.g.

  Acute Medicine (Acute Medical Take)
  Please tell us what you think about our preferred option to develop: A 'centre of excellence' for Acute Medicine (Acute Medical Take) at Gloucestershire Royal Hospital.
  - *Strongly support*
  - *Support*
  - *Oppose*
  - *Strongly oppose*
  - *No opinion*
- and **Qualitative** questions which invite the respondent to write a comment

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

As mentioned previously, the qualitative feedback from completed surveys and correspondence has been grouped into themes under the following headings (A to Z):

- Access
- Capacity
- Diversity
- Efficiency
- Environment
- Facilities
- Integration (with primary and community services)
- Interdependency
- Patient Experience / Staff Experience
- Pilot
- Quality
- Resources
- Transport
- Workforce

In this report, illustrative quotations have been selected from the free-text responses from the survey for each of the proposals and other correspondence received. All free text

responses and other correspondence can be found in the online appendices at: https://www.onegloucestershire.net/yoursay/fit-for-the-future-developing-specialist-hospital-services-in-gloucestershire/

4.1 Acute Medicine (Acute Medical Take)

Preferred option to develop: A 'centre of excellence' for Acute Medicine (Acute Medical Take) at Gloucestershire Royal Hospital.

- 67.61% (Easy read: 72.09%) of all survey respondents either **strongly supported** or **supported** the proposal
- 24.83% (Easy read: 18.6%) of survey respondents either **strongly opposed** or **opposed** the proposal
- 7.55% (Easy Read: 9.3%) of survey respondents had **no opinion**

- 72.03% of staff respondents either **strongly supported** or **supported** the proposal
- 66.23% of respondents excluding staff either **strongly supported** or **supported** the proposal

Fit for the Future Survey

Please tell us what you think about our preferred option to develop: A 'centre of excellence' for Acute Medicine (Acute Medical Take) at Gloucestershire Royal Hospital.			Response Percent	Response Total
1	Strongly support		36.07%	215
2	Support		31.54%	188
3	Oppose		11.24%	67
4	Strongly oppose		13.59%	81
5	No opinion		7.55%	45
			answered	596
			skipped	28

Fit for the Future Survey Easy Read

What do you think about having the service for Acute Medicine (Acute Medical Take) at Gloucestershire Royal Hospital? Acute medicine is treatment and assessment for things like very bad headaches, chest pain, pneumonia or asthma			Response Percent	Response Total
1	Good idea		72.09%	62
2	Bad idea		18.60%	16
3	Not sure		9.30%	8
			answered	86
			skipped	3

Qualitative Themes: Acute Medicine (Acute Medical Take)

The following quotes are from survey responses either supporting or opposing the preferred option.
The quotes included below are illustrative of key themes in the feedback received regarding Acute Medicine:

Themes in the responses to the proposal relating to Acute Medicine are (A-Z):
Access; Capacity; Efficiency; Interdependency; Patient Experience; Quality; Resources; Transport; and Workforce.

Acute Medicine (Acute Medical Take)

Preferred option to develop: A 'centre of excellence' for Acute Medicine (Acute Medical Take) at Gloucestershire Royal Hospital.

- 67.61% (Easy read: 72.09%) of survey respondents either **strongly supported** or **supported** the proposal
- 24.83% (Easy read: 18.6%) of survey respondents either **strongly opposed** or **opposed** the proposal
- 7.55% (Easy Read: 9.3%) of survey respondents had **no opinion**

Supporting the proposal	Opposing the proposal
It's a rational use of limited resources. Concentration of specialist people, and specialist kit, absolutely makes sense, and research shows that it produces better outcomes. [Quality, Resources, Workforce]	*I do not think that Gloucester Royal Hospital will cope with all the acute services that you wish to base there. They cannot cope with the influx of patients at the moment particularly at night. These plans do not improve patient experience they merely allow the trust to attempt to save money* [Capacity, Resources, Patient Experience]
Creating CoEs across the county will inevitably create a good deal more traversing of the county for patients. I can empathise with the desire to make best use of resources. [Access,	*Damaging effect on the local community, as it disproportionately affects vulnerable individuals with protected characteristics. Concerns about bed space at GRH. Concerns about a bottleneck effect at GRH - if you double the amount of traffic, you need to double the width of the road, ALL roads,*

Resources]	*leading in and out. Leading on to concerns about the lack of funding for SWAS [Ambulance Service] as per their financial outlook to provide the additional ambulance service coverage. Flawed notion of attracting high quality staff from a business/management perspective. Gloucestershire's market has competitors in Bristol, Birmingham (to an extent), Oxford, and of course London. Centralised services will not enable GHNHSFT to outcompete these, leaving us with 'the best of the rest'. This would have been the case whether centralisation occurred or not, thus centralisation itself is a moot point. Flawed concept of 'extra time' to care. This will inevitably lead to cost savings (perhaps instructed by ministers, and not immediately) by reducing staff numbers to provide current levels of care, only now at one site. [Capacity, Transport / Access, Staff/Resources]*
Having a centre of excellence for acute medicine at GRH makes a lot of sense, but it is important to reflect on what centre of excellence might be appropriate for CGH, perhaps chronic or ongoing care? I think it is very important to ensure that CGH is not appear to be downgraded and is valued as a site for quality care provision.[Quality]	*Cheltenham and surrounding villages and other small towns in Gloucestershire deserve to have their own "Acute Medical Take" at CGH. Travelling is difficult enough in Gloucestershire and Gloucester Royal Hospital has very inadequate and expensive parking. This is a very busy tourist town with many festivals bringing thousands of people to the town and it is a very poor decision to only have a centre of excellence in Gloucester. We need our own A & E and also our own Acute Medical Take I am not opposed to Gloucester having its own centre but both places should be treated the same. Gloucester is a very large county stretching from the borders of Wales to the edge of Oxfordshire and Worcestershire.* [Transport / Access]
Makes absolute sense to have a Centre of excellence. Paramedics and GP's will know where to take and send	*I believe CGH should offer equal services to GRH and not all resources*

associated patients rather than pot luck between two options. [Efficiency, Quality]	*diverted to Gloucester.* [Access]
I agree with this ONLY if the A&E at Cheltenham is maintained at the same level they were pre-COVID. [Access]	*The preferred option would mean that people living in the east of Gloucestershire would have to travel further for urgent medical care.* [Transport / Access]
All acute services including the ED and both takes should be on a single site (GRH) to allow for CGH to be developed into a major elective cancer surgery hub. [Quality]	*I think it should be split between the 2 hospitals so that you can go to the nearest hospital to where you live. I see no reason that both hospitals cannot have enough or share staff so that this can happen* [Transport / Access, Staff/Resources]
The idea of creating centres of excellence at both of the two excellent large hospitals in Gloucestershire makes sense. It is worth remembering that the other specialist inpatient services, which have already centralised at either CGH or GRH e.g. cancer services at CGH and children's services at GRH, are working really well for patients. [Interdependency]	*The provision for Emergency, consultant led 24/7 care on the East of the County is essential for best outcomes for the aging population given how overcrowded Glos A&E is. Therefore anything which doesn't re-provide the highest tier of A&E at CGH puts patients at more immediate risk of poor outcomes IMO.* [Quality and Capacity]
Centralisation of this speciality will ensure that the clinicians with the right skills are always available. It will reduce risks to the public and reduce the need for potential transfer either to another facility or out of county. [Quality]	*It worries me hugely that the town the size of Cheltenham already hasn't got 24/7 Consultant Led A&E services. This seems another plan to reduce this even further. I worry about increased time to get emergency help for my children and elderly parents by having to travel to another town.* [Quality, Transport / Access]

Having centres of excellence is ideal providing it does reduce waiting time, and ensures operations are not cancelled. All expertise in one place so if second opinion is needed there is someone to consult immediately without the necessity of a follow up visit somewhere else. [Quality]	
After having experienced 'in patient ' services at both CGH and GRH on two separate occasions resulting from pneumonia. I would fully support the objective of developing a 'centre of excellence' at GRH. The disadvantage of extra travelling for Cheltenham residents is outweighed by the improved facilities, better use of and more focused staff. [Quality]	
Presume staffing a single acute centre is easier than two, making the care it can provide more consistent and 'guaranteed'. Only reason my response is 'Support' and not 'Strongly Support' is the extra 10 miles I would need to travel. [Quality, Transport/Access]	
I believe that there must be economies of scale in forming specialist centres. One whole is more beneficial than two halves in this case. This should mean savings in the cost of staff, equipment, spares and consumables, after an initial cost to physically create the unit. Some may get emotional about losing a service in 'their' area, but as a relative newcomer to the area, the hospitals are physically so close together, with good transport links between the two, I would consider the benefits to	

outweigh this. [Staff/Resources]	
With stretched specialised NHS resources concentrating particular but different Specialists at each hospital makes sense. I am also reassured that A&E will remain at Cheltenham hospital as we live in Bourton-on-the-Water so need to be confident that the closeness of A&E in Cheltenham in an emergency provides a much better chance of survival rather than going all the way to far side of Gloucester from here. [Transport/Access]	

Neutral and other correspondence examples

Neutral

A centre of excellence is a title conferred on a centre by other institutions and is not something you can simply decide to be. Aspiration to excellence is essential but not if this is considered zero sum - i.e. we can aspire to be a centre of excellence in A and therefore B will not be excellent. Also there are currently services which are already considered excellent: does the Trust know what these are and do the various plans consider that aspiring to excellence in one domain might strip and already considered excellent service of its status?

REACH survey

"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!"

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."

Other correspondence

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 CGH.

Given the close links set out in the consultation document between the Emergency Departments and the acute medical beds, and if Cheltenham A&E is indeed to reopen, there seems an obvious risk of this proposal … 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 between Cheltenham ED to an acute medical bed in Gloucester to be admitted.

…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 in Cheltenham as well as the ED on the east side of the county… …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.

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 of resources including staff as well as equipment.

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.

4.2 General Surgery (emergency general surgery, planned Lower Gastrointestinal [GI] / colorectal surgery and day case Upper and Lower GI surgery)

4.2.1 Emergency General Surgery

Preferred option to develop: to develop: A 'centre of excellence' for Emergency General Surgery at Gloucestershire Royal Hospital.

- 68.31% (Easy read: 66.67%) of all survey respondents either **strongly supported** or **supported** the proposal
- 23.44% (Easy read: 22.99%) of survey respondents either **strongly opposed** or **opposed** the proposal
- 8.24% (Easy Read: 10.34%) of survey respondents had **no opinion**

- 77.62% of staff respondents either **strongly supported** or **supported** the proposal
- 65.01% of respondents excluding staff either **strongly supported** or **supported** the proposal

Emergency General Surgery

Fit for the Future Survey

Please tell us what you think about our preferred option to develop: A 'centre of excellence' for Emergency General Surgery at Gloucestershire Royal Hospital.			Response Percent	Response Total
1	Strongly support		35.71%	195
2	Support		32.60%	178
3	Oppose		10.62%	58
4	Strongly oppose		12.82%	70
5	No opinion		8.24%	45
			answered	546
			skipped	78

Fit for the Future Survey Easy Read

What do you think about having the service for Emergency General Surgery at Gloucestershire Royal Hospital? These are emergency operations on the gut which is where you digest food			Response Percent	Response Total
1	Good idea		66.67%	58
2	Bad idea		22.99%	20
3	Not sure		10.34%	9
			answered	87
			skipped	2

Qualitative Themes: Emergency General Surgery

The following quotes are from survey responses either supporting or opposing the proposal. The quotes included below are illustrative of key themes in the feedback received regarding Emergency General Surgery services. Themes in the responses to the proposal relating to Emergency General are (A-Z): Access; Capacity; Efficiency; Interdependency; Patient Experience; Quality; Resources; Transport; Workforce

Emergency General Surgery

Preferred option to develop: Preferred option to develop: to develop: A 'centre of excellence' for Emergency General Surgery at Gloucestershire Royal Hospital.

- 68.31% (Easy read: 66.67%) of survey respondents either **strongly supported** or **supported** the proposal
- 23.44% (Easy read: 22.99%) of survey respondents either **strongly opposed** or **opposed** the proposal
- 8.24% (Easy Read: 10.34%) of survey respondents had **no opinion**

Supporting the proposal	Opposing the proposal
It [Gloucestershire Royal Hospital] *is bigger hospital and easy for access (not confusing as opposed to CGH which is a maze and patients are constantly lost).* [Access, Patient Experience]	*This would further reduce/support the case for reducing the provision of the highest tier of A&E at CGH (East) so should not be considered*. [Access]
If acute care services are to be centred at GRH it makes sense for the emergency general surgery to also be at GRH to avoid transfers of very sick patients. [Interdependency]	*There needs to be more than one centre as GRH may be unavailable through a disaster, infection or overloading. Currently GRH A&E is too busy.* [Capacity]
This is important BUT is not and should not be seen as mutually exclusive to a centre of excellence in pelvic resection. [Interdependency]	*There should be surgery facilities at both sites, and both should be "excellent". Transferring emergency patients to GRH wastes precious time and could risk lives.* [Quality]

Skilled teams can provide care needed People may have to travel, but for a good outcome it is worth it. [Access/Travel, Quality]	*According to the Royal College of Surgeons "Patients requiring emergency surgical assessment or treatment are among the most unwell patients in the NHS. Often elderly, frail and with significant other health problems, the risk of death or serious complication is unacceptably high." This means the increasing unacceptable the risk to patients of making them travel from east of Cheltenham travel through the town and a further 10 miles to GRH.* [Quality, Access]
More efficient use of staff. The more surgeries completed the better the surgeons become and so patient outcomes should improve. [Efficiency, Quality]	*Cheltenham is a General hospital and should have surgical beds, including emergency surgery. What sort of hospital would Cheltenham become if medical patients and surgical emergencies were transferred to GRH. This is exercise is about downgrading Cheltenham, which currently has the facilities to offer high quality care. This will have an impact on the A&E department, essentially turning it into a minor injuries unit.* [Quality]
It is a good idea, except… that as we are on the edge of the county Gloucestershire is further away. [Access]	*Many people from Cheltenham and North Gloucestershire would die on the way to Gloucester Royal. The traffic at many times of the day is appalling in Gloucester. You seem to be considering Cheltenham as a small village when in fact it has a population of 112,700. When you include the Cotswolds it rises to 196,300. With the regular increases of population throughout the year this should surely make a difference to your decision.* [Quality, Access/Transport]
Better to have emergency care in one place with a full team of experts. Planned surgery can then take place at Cheltenham. [Quality]	*Having all your 'specialist' staff in one area may be better and more cost effective for you but as always it's the patients who suffer. Traveling to and from Gloucester is not easy for those without their own transport. Even if the patient is transported to Gloucester by ambulance, once discharged they*

	have still got to find their own way home, probably still feeling very unwell. They may not have friends with a car or have sufficient funds to cover the cost of a taxi, which leaves the bus, if it is running and if it is not full - not very good for infection control following surgery. There is also historically a poor reputation for infection control at GRH. I would not feel confident going there for anything serious. [Access/Transport, Quality]
To centralise services, staff, expertise and equipment at one site. If this ensures that planned surgery is protected and not impacted by emergencies, then I would strongly support this option. [Efficiency, Quality]	*The key word is Emergency. All emergencies should be treated as close as possible to the point at which the emergency was recognised. Unnecessary travel is best avoided and may introduce stress to the detriment of the patient.* [Access/Transport, Quality]
Improve patient outcomes, centralised care with specialists available to review patients as all based at Gloucester. Staff morale and retention. Improve care of patients including access to SAU and patient flow. Reduce cancellation of specific surgical procedures. Improve quality of care provided. [Quality, Workforce]	*The current system, with surgery at both hospitals, is better for anyone who: has money issues lacks transport has complex needs of any type I understand the desire to group services together for the NHS' logistical sake, but for anyone who struggles, in any way, being themselves in another town or having their loved ones in another town creates complications and unhappiness as mentioned in my previous answer. By doing this, you prioritise those with money, time and head space to cope with these extra complications, and disadvantage anyone who struggles in any way.* [Access/Transport, Resources]
If emergency treatment is performed at one hospital, GRH, it leaves planned surgery at the other, CGH, not liable to interruption for emergency surgery. [Quality]	*As with all your proposals to centralise services the problem is that of access for patients and their families. Whilst many have access to private transport a very large minority do not and they are frequently the elderly and less*

	financially secure. For these people centralisation poses a major difficulty in accessing your services unless you propose to offer free transport between the sites. Even for those with private transport difficulties in accessing parking at either site pose difficulties and high costs. [Access/Transport]
A centre of excellence is essential and you shouldn't spread your resources. The hospitals are close enough that no areas should be disadvantaged. [Access/Transport, Resources, Quality]	
Specialisation usually leads to higher quality service and the attraction of most able doctors. [Quality, Workforce]	

Neutral and other correspondence examples

REACH SURVEY

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.

Other correspondence

Centralisation of emergency general surgery and the acute medical onto a single site at GRH may increase bed pressure in that unit. If centralisation proceeds for emergency general surgery at GRH it is vital that all elective activity is centralised at CGH, so that elective patients can be treated without disruption from emergency bed pressures or indeed future pandemics.

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 planner lower GI surgery and day case general surgery at Cheltenham.

I feel that we should establish a General Surgery Centre of Excellence at GRH with centralised Emergency General Surgery alongside centralised planned Upper GI service and newly centralised planned Lower GI Service. Planned day case for both upper and lower GI surgery to be centralised at CGH.

4.2.2 (i) Planned Lower GI (colorectal) surgery

Preferred option to develop: to develop: A 'centre of excellence' for Planned Lower GI (colorectal) general surgery at Cheltenham General Hospital (CGH) or Gloucestershire Royal Hospital (GRH).

- 79.1% (Easy read: 72.84%) of all survey respondents either **strongly supported** or **supported** the proposal
- 7.83% (Easy read: 20.27%) of survey respondents either **strongly opposed** or **opposed** the proposal
- 13.06% (Easy Read: 12.35%) of survey respondents had **no opinion**

- 85.31% of staff respondents either **strongly supported** or **supported** the proposal
- 76.84% respondents excluding staff either **strongly supported** or **supported** the proposal

Planned Lower GI (colorectal) surgery

Fit for the Future Survey

Please tell us what you think about our preferred option to develop: A 'centre of excellence' for Planned Lower GI (colorectal) general surgery at Cheltenham General Hospital (CGH) or Gloucestershire Royal Hospital (GRH).			Response Percent	Response Total
1	Strongly support		44.59%	239
2	Support		34.51%	185
3	Oppose		4.66%	25
4	Strongly oppose		3.17%	17
5	No opinion		13.06%	70
			answered	536
			skipped	88

Fit for the Future Survey Easy Read

What do you think about having the planned Lower GI (Colorectal) General Surgery in one hospital? These are planned, not emergency, operations on the lower part of the gut.			Response Percent	Response Total
1	Good idea		72.84%	59
2	Bad idea		14.81%	12
3	Not sure		12.35%	10
			answered	81
			skipped	8

4.2.2 (ii) Planned Lower GI: Location

Fit for the Future Survey

In supporting our preferred option to create a single site 'centre of excellence', where do you think a 'centre of excellence' for Planned Lower GI (colorectal) general surgery should be developed?			Response Percent	Response Total
1	Cheltenham General Hospital (CGH)		50.76%	268
2	Gloucestershire Royal Hospital (GRH)		20.27%	107
3	No opinion		30.30%	160
			answered	528
			skipped	96

Fit for the Future Survey Easy Read

Where do you think we should do planned Lower GI (Colorectal) General Surgery? These are planned, not emergency, operations on the lower part of the gut.			Response Percent	Response Total
1	Cheltenham General Hospital		27.50%	22
2	Gloucestershire Royal Hospital		27.50%	22
3	Don't mind		45.00%	36
			answered	80
			skipped	9

Qualitative Themes: Planned Lower GI (colorectal) Surgery

The following quotes are from survey responses either supporting or opposing the proposal. The quotes included below are illustrative of key themes in the feedback received regarding Planned Lower GI (colorectal) Surgery. Themes in the responses to the proposal relating to Planned Lower GI (colorectal) Surgery are (A-Z): Access; Capacity; Efficiency; Facilities; Interdependency; Patient Experience; Quality; Resources; Transport and Workforce.

Planned Lower GI (colorectal) Surgery

Preferred option to develop: A 'centre of excellence' for Planned Lower GI (colorectal) general surgery at Cheltenham General Hospital (CGH) or Gloucestershire Royal Hospital (GRH).

- 79.1% (Easy read: 72.84%) of survey respondents either **strongly supported** or **supported** the proposal
- 7.83% (Easy read: 20.27%) of survey respondents either **strongly opposed** or **opposed** the proposal
- 13.06% (Easy Read: 30.30%) of survey respondents had **no opinion**

Supporting the proposal	Opposing the proposal
Based on my support for emergency care at Gloucester, presumably it would make room at Cheltenham for this area of non-urgent operations. [Capacity, Facilities]	*You should be able to go to nearest hospital for treatment, staff should be split between the 2 hospitals if necessary so this can be done.* [Access]
Good to have a centre of excellence. Attracts staff and makes good effective use of both equipment and staff. [Workforce, Efficiency]	*Lower GI surgical provision impacts on other surgical specialties including gynae oncology. Gynaecology is linked to Obstetrics, an acute specialty based in Gloucester. Acute gynaecology, including acute gynae oncology admissions, is based in Gloucester hospital. It is not possible to move this acute provision as the registrars cross cover Gynaecology and Obstetrics when on shifts. Moving gynae oncology with Lower GI to Gloucester would provide better training and ward safety for patients*.[Interdependency]

Please bear in mind any treatments taken prior to appointments which may make a long journey very difficult. [Patient Experience]	*It is easier for elderly, disabled, and very sick people to travel to their nearest hospital. Some of the people in this category will not be able to either drive themselves or travel on public transport. An unfamiliar environment may be distressing for them, and it may be more difficult for their families to visit if they are further away. Therefore, all procedures should be available in all hospitals, not in one centre.* [Access/Transport]
I have had fantastic service and a colorectal resection at GRH. This started with the Bowel Cancer Screening at Stroud Hospital, and two operations at GRH, with follow up care. The care and dedication of all the staff at GRH has been exemplary, and I am so grateful to them! Of course if CGH was chosen, as long as the staff moved also, then the service would be just as excellent. A slight fear I have that when I think merge and provide an ever better service', the accountants hear 'merge, provide the same service, and cut costs'. The latter really would be a betrayal of trust. [Quality, Patient Experience, Resources]	*Unless there is a shortage of staff with the correct expertise I do not see why a single centre of excellence in Gloucester is a fair option for Cheltonians. It's a long journey and a real challenge for elderly patients - visiting and collection of discharged patients becomes far more challenging especially for those restricted to public transport.* [Access/Transport, Staff, Resources]
Need to locate the planned specialties into CGH if emergency medicine and surgery are going to GRH. [Interdependency]	
Separating emergency from planned services should prevent cancellations and create the right number of beds for the planned procedures. Co-locating with other pelvic services makes sense as I suspect they often need to work together. [Patient Experience, Capacity, Interdependency]	
GRH surgical bedspace already limited; conversely beds	

available at CGH for increased surgical work. Transfer to all planned colorectal work to GRH would increase already high pressure on surgical bed availability. Centralising lower GI at CGH would make use of existing surgical cover and surgical nursing staff with less bed pressures than at GRH. Benefits to be had from concentrating all colorectal lists at a single site - CGH the obvious option as currently has less bed pressure than GRH but still has required surgical and nursing expertise. Gastroenterology already at CGH which would benefit those patients who need input from gastro medics whilst under care of Lower GI surgeons. [Capacity, Quality, Patient Experience)	
Gloucestershire Royal is the most modern of the two hospitals and parts of the Cheltenham Hospital are 200 years old and unsuitable for 21st century health care provision. The most recent blocks in College Road Cheltenham could be used to complement the services provided at the Gloucester base. [Facilities]	
Having experienced this service, I know that the present set-up works well. CGH is already a centre of excellence for cancer, colorectal surgery is integral to that service, it makes common sense to fully embed this at CGH. Further, I am aware that moving this service to GRH is not popular with staff and could result in the loss of crucial expertise. Staff retention is a critical issue at all times - conserve what you have. [Patient Experience,	

Workforce, Resources]	
Specialist staff in one place should mean collaboration in terms of quickly dealing with patient problems. Quick treatment/ diagnosis of Crohn's can reduce the need for surgery, less time off work and a better quality of life! [Workforce, Quality]	
Neutral and other correspondence examples	
Neutral *It has been mooted for some time, so that GRH would become the 'hot' hospital, while CGH would take 'cold surgery'. This seems to have been an accepted version of things to come, so it is no surprise, and for me, there is no good reason to oppose* *All planed surgery should be subject of a centre of excellence, at both hospitals, not just Lower GI* **REACH survey** *It would be sensible to have this service at CGH with gynaecological 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.* *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.* **Other correspondence** *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 pelvic surgery.*	

Where do you think we should do planned Lower GI (Colorectal) General Surgery?

- 50.76% (27.50% Easy Read) survey respondents chose Cheltenham General Hospital
- 20.27% (27.50% East Read) of survey respondents chose Gloucestershire Royal Hospital
- 30.30% (45% Easy Read) had no opinion
- Staff:
    - Cheltenham General Hospital (CGH) 56.64%
    - Gloucestershire Royal Hospital (GRH) 13.29%
    - No opinion 30.07%
- Public and Community Partners:
    - Cheltenham General Hospital (CGH) 48.14%
    - Gloucestershire Royal Hospital (GRH) 22.37%
    - No opinion 30.85%

Cheltenham General Hospital	Neutral	Gloucestershire Royal Hospital
As I have mentioned, public views will revolve how location, for example, will affect the individual. CGH is closer to me than GRH so this is obviously my choice. That is naive and there are many many far more important factors that should determine the location. I really don't understand how public consultation on this matter assists the process.	Remain with both sites as both large populations. Travelling to either site difficult if not in either town/ city. Keep both therefore quicker and more local access. Helps reduce carbon and, safety) health risks involved in traveling	GRH is a larger site, has better facilities and is more accessible for visitors. I have had surgery in CGH in the past and felt the facilities were poor and the care was lacking. It is also very difficult for visitors to find somewhere to park.
Having benefited from this excellent service, and still under their care, I would really like the service in Cheltenham to be bolstered. I live at the extreme Northern tip of the county, and Gloucester Hospital would have been a nightmare for family visits, and for me getting home from the multiple operations I have had. Given the fantastic care I had at Cheltenham, I would be keen for it not to be moved	I believe that you are wrong in trying to decide one place against the other hospital. Gloucester Royal is full to capacity and often difficult to reach because of its situation. The best solution would be to build a new hospital at Staverton and put any "centres of excellence" there. This idea, whilst not likely to ever be considered, would be a perfect solution. There is plenty of space at Staverton and the surrounding land. Sites at Gloucester and Cheltenham could be then be sold at a huge profit	I live in Stroud and find it easier to get to GRH and easier to park the car.
1. co-located with other pelvic cancer services (urology, gynae-oncology) 2. co-located with	Whichever site has best capacity of operating theatres and staffing for this proposal	I think it makes more sense to have surgical units for upper and lower GI surgery in one

oncology 3. co-located with gastroenterology inpatient care 4. Protected bedbase from emergency admissions (if going with the emergency hub in GRH) and allows screened admissions only in the covid era 5. Ease of access to HDU / ITU for all planned major resections 6. Separated (geographically) elective v emergency care as recommended by a) GIRFT, b) Current President of the RCS Eng (Prof Neil Mortensen) c) external senate review		location
To co-locate with urology and gynae-oncology. By taking elective lower GI from GRH space would be freed up for other needs.	Again, it doesn't matter which site, so long as the service is there and available and ensure capacity and effective care for Gloucestershire residents. In my mind it would make sense to have a particular specialist treatment at both sites i.e. GRH is centre of excellence for XX and CGH is centre of excellence for YY. So that one or other site does not become defunct.	Greater diversity in Gloucester
A strong case has been made for both. On balance I think CGH.	Care needs to be taken in assessing the user demographic to make a suitable choice. Ideally it would be in the centre of the most common user base.	I think a centre of excellence, a single one would benefit the local and wider community by being situated in Gloucester.

If the 24hr A&E is at GRH, then the planned surgery to be at CGH.	Very important to have separate sites for emergency and elective surgery for better patient experience and outcome	I understand that there can some crossover between Upper and Lower GI* and this suggests to me that collocating them would be wise provided that there is sufficient space and facilities at GRH. *Last year I had emergency Lower GI surgery carried out at CGH by an Upper GI consultant (excellent outcome!)
CGH should be the site for all planned activity	Both hospitals should have their own colorectal services.	I know the GRH team are fantastic, but have had no dealings with CGH.
I believe it would be sensible to try and ensure that CGH takes on planned / elective surgery with lower risks involved, and that GRH is responsible for caring for emergency surgery. However, I also appreciate that this could result in specialist surgical cover required across both sites rather than just covering one and could be confusing for the public if there is general surgery offered at both sites.	Keep both hospitals operating as hospitals for all services. This centre of Excellence "concept" is in my opinion RUBBISH. Stop pretending that you are offering a better service when you are diluting what is already available	If you think upper GI surgery needs to be on the same site as emergency general surgery, surely the same should apply to colorectal surgery. If you are struggling to run the general surgery service on two sites at the moment why would you want to set a service that continues to run general surgery on two sites?
I think that the 'reputation' of Cheltenham Hospital needs to be preserved if emergencies go to Gloucester, even if in a new way, so putting excellent planned	Crucial item for me is that there is an equal balance between what is in Cheltenham and what is in Gloucester....with equal numbers of essential services in each. It must not be	All major General surgery located with acute services makes common sense.

operations in Cheltenham would be good.	Gloucester is the centre with bits in Cheltenham	
Due to other specialities already doing pelvic surgery in this hospital. Surely a 'centre of excellence' would allow surgeons to assist and advise each other when required.	As it is planned surgery the patient can arrange transport beforehand so I don't see any issues	It makes sense for all GI (lower and upper) services to be in one hospital
Would seemingly make best sense to locate this at CGH to create a centre of excellence for pelvic resection; and to keep this surgery service entirely separated from the pressures of the Emergency General Surgery at GRH (as suggested in the consultation booklet)'	we live in Stroud - now my son has transitioned into adult IBD services we have had infusions in GRH, consultant appointment in GRH and MRI in Chelt - the travel relatively easy for us so wherever means staff travelling less.	I would like Gloucester to be a better option for care, this should be improved so that it is more viable than having to travel to Cheltenham to visit people.
Calmer atmosphere. Better patient experience.	Although my own experience has been of having colorectal surgery at GRH, I think location for this is less important than concentrating the expertise at one centre.	[GRH] Better parking for staff and visitor options more mid-way for Forest patient and visitors. Near to train links.
It would appear logical to have all cancer services on one site and given Cheltenham's preeminent role in cancer treatment then all related services should be located there,	I've put no opinion because transport is about the same for both, and planning a service is a complex task that looks at a wide range of information. I trust One Gloucestershire to make a good choice.	Just because it is the nearest hospital to where I live, I should imagine anyone living near to Cheltenham would choose the Cheltenham one as their option
most of the issues are probably cancer related so it makes sense to put this in	At the moment, both CGH and GRH seem to have a Planned Lower GI general surgery	It seems likely that management of complications would be best on the site with

Cheltenham with the existing unit - although the buildings at Cheltenham are in dire need of refurbishment and modernising	facility. I think the decision on which location to invest more excellency should mostly be focused on statistic and medical opinion, such as estimated time of arrival from one location to the hospital; percentage of local and not local patients who come to the hospital; accessibility to the yard; transportation accessibility etc. While Cheltenham could be more easily accessible, in my opinion, GRH offers facilities on Upper GI general surgery, which could contribute to the treatment of exceptional patients who may need assistance with both.	the most robust emergency cover
If the plan is to have the Day Case focussed at CGH it would seem to be sensible to have the rest of the GI provision on the same site	a cold, elective hospital allows access to beds, ITU, and allows all the relevant surgical specialities to work closely together to deliver excellent care. The removal of colorectal surgery from CGH would mean that urology and gynae-oncology may not be able to stay, which would put more pressure on GRH	As above, the premises at Gloucester are superior and those at Cheltenham have fallen way behind. In my view Cheltenham should have constructed a new hospital to replace Cheltenham General in the hospital building boom of the 1990s and early 2000s when a large number of towns and cities constructed new hospitals, such as Worcester, Swindon, Birmingham, Stratford -on-Avon, Hereford, Taunton, etc. etc. Cheltenham missed out then and a new replacement for Cheltenham General is unlikely now

Consultants and staff are fed up. Colorectal worked at Cheltenham before stop fixing things that aren't broken. Wasting good theatres, what's the point in not using something we already have. And you have amazing nurses and HCAs with colorectal experience in Cheltenham that will not go to Gloucester.	On your facebook live session the consultant said that 12 out of 15 consultants supported this model, shouldn't you be listening to what the experts think as they provide the service and should know how it works.	Elective days-case/short stay surgery in a dedicated unit in CGH. Resectional lower GI surgery co-located with emergency general surgery in GRH.
This builds on already established reputation and allows other interdependent excellent services to continue to flourish because they have ongoing on site, immediate lower GI surgical support. Removing lower GI surgical support from CGH would diminish urological, gynaecological oncology, gastroenterology and oncology services. Specifically gynaecological oncology simply could not operate in the same way and all ovarian cancer surgery would need to move to GRH to facilitate appropriately supported radical surgery within any governance framework	Either. But a Centre of excellence makes sense.	Needs to be co-located with the emergency general surgery service.

4.2.3 Planned day case, Upper and Lower GI

Preferred option to develop: to develop: A 'centre of excellence' for planned day case Upper and Lower GI (colorectal) surgery at Cheltenham General Hospital (CGH).

- 73.49% (Easy read: 67.47%) of all survey respondents either **strongly supported** or **supported** the proposal
- 8.52% (Easy read: 13.25%) of survey respondents either **strongly opposed** or **opposed** the proposal
- 17.99% (Easy Read: 19.28%) of survey respondents had **no opinion**

- 79.58% of staff respondents either **strongly supported** or **supported** the proposal
- 71.24% of respondents excluding staff either **strongly supported** or **supported** the proposal

Fit for the Future Survey

Please tell us what you think about our preferred option to develop: A 'centre of excellence' for planned day case Upper and Lower GI (colorectal) surgery at Cheltenham General Hospital (CGH).				
			Response Percent	Response Total
1	Strongly support		38.07%	201
2	Support		35.42%	187
3	Oppose		5.11%	27
4	Strongly oppose		3.41%	18
5	No opinion		17.99%	95
			answered	528
			skipped	96

Fit for the Future Survey Easy Read

What do you think about having the service for General Surgery Day Cases (Upper and Lower GI) at Cheltenham General Hospital? These are operations on the gut which is where you digest your food. People have their operation and go home the same day.				
			Response Percent	Response Total
1	Good idea		67.47%	56
2	Bad idea		13.25%	11
3	Not sure		19.28%	16
			answered	83
			skipped	6

Qualitative Themes: Planned day case Upper and Lower GI (colorectal) surgery

The following quotes are from survey responses either supporting or opposing the proposal. The quotes included below are illustrative of key themes in the feedback received regarding Planned day case Upper and Lower GI (colorectal) surgery. Themes in the responses to the proposal relating to Planned day case Upper and Lower GI (colorectal) surgery are (A-Z): Access; Capacity; Efficiency; Facilities; Interdependency; Quality; Resources and Workforce.

Planned day case Upper and Lower GI (colorectal) surgery

Preferred option to develop: A 'centre of excellence' for planned day case Upper and Lower GI (colorectal) surgery at Cheltenham General Hospital (CGH).

- 73.49% (Easy read: 67.47%) of survey respondents either **strongly supported** or **supported** the proposal
- 8.52% (Easy read: 13.25%) of survey respondents either **strongly opposed** or **opposed** the proposal
- 17.99% (Easy Read: 19.28%) of survey respondents had **no opinion**

Supporting the proposal	Opposing the proposal
There aren't enough staff to go around, so we need to make best use of those we have. [Resource/Workforce]	*Don't like the single site option, would like both hospitals to offer as many treatments as possible* [Access].
Cheltenham already has this function so it would be sensible to maintain this service. [Efficiency]	*Why not at both, this involves improving Cheltenham at the expense of Gloucester.* [Access]
This type of surgery is at most risk of cancellation when emergency pressures are high. We should have access to protected facilities so these operations are not cancelled. This will be good for CGH as more planned surgery will be performed there than in GRH. [Patient Experience, Capacity]	*This is a bad decision and the people of the forest of dean and Monmouth deserve better.* [Access]

One of your consultants proposed a model for low risk patients which included patients staying in hospital for one or two nights having their operation in Cheltenham to reduce the risk of cancellation. This sounds like a good idea as long as there is capacity. [Patient Experience, Capacity]	*This proposal is another way of saying that CGH becomes a hospital for day case surgery only, chiefly benign conditions, i.e. not a proper hospital in the sense that is understood by most people. Since there is not room for all inpatient GI surgery on the site, to embrace this option is a sure fire way of ensuring that the malignant bowel surgery would have to be moved elsewhere (GRH), which is probably why it has been packaged up this way. Is CGH envisaged as a proper cancer hospital or not? If it is, then the malignant bowel surgery should take place there and not benign day case procedures instead.* [Capacity]
Would require better facilities at Cheltenham general in my opinion hospital dated and tired in appearance. [Facilities]	*I don't support having only one centre for anything, given the size and demographic of Glos.* [Access]
I have experience of this and know that the process is well embedded in CGH, with highly skilled specialists. Further, this type of surgery is usually directly associated with colorectal surgery e.g. stoma loop reversal, it makes sense for the surgeon who created the loop to reverse it thus maintaining continuity. [Interdependency]	*As with all your proposals to centralise services the problem is that of access for patients and their families. Whilst many have access to private transport a very large minority do not and they are frequently the elderly and less financially secure. For these people centralisation poses a major difficulty in accessing your services unless you propose to offer free transport between the sites. Even for those with private transport difficulties in accessing parking at either site pose difficulties and high costs.* [Access/Transport]
On the focus of Cheltenham General Hospital as an elective centre this fits well. The pelvic centre of excellence with the arthroplasty, gyno and urinary would all work well together although it may reduce the General Surgery pool slightly at GRH.	*It needs to be Gloucester more central for Gloucestershire.* [Access]

[Interdependency]	
Having an excellent readily available service that treats me even if I have to travel is preferred to waiting and perhaps getting a second class service because of a dilution of resources/service simply to accommodate operating on both sites. It is 7 miles not travelling to the moon. [Patient Experience, Quality, Access]	
If planned centre of excellence for lower GI general surgery will be in Cheltenham it is only sensible for day cases upper and lower surgery to be there also. [Interdependency]	
Neutral and other correspondence examples	
Neutral *Concentration in one centre is the most important issue.* *Day case can be done anywhere* **REACH survey** *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.* *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.*	

4.3 Image Guided Interventional Surgery (IGIS) including Vascular Surgery

Preferred option to develop: to develop: A 24/7 Image Guided Interventional Surgery (IGIS) 'Hub' at Gloucestershire Royal Hospital and a 'Spoke' at Cheltenham General Hospital.

- 66.54% (Easy read: 76.54%) of all survey respondents either **strongly supported** or **supported** the proposal
- 15.39% (Easy read: 9.88%) of survey respondents either **strongly opposed** or **opposed** the proposal
- 18.08% (Easy Read: 13.58%) of survey respondents had **no opinion**

- 63.12% of staff respondents either **strongly supported** or **supported** the proposal
- 67.81% of respondents excluding staff either **strongly supported** or **supported** the proposal

4.3.1 IGIS Hub and Spoke

Fit for the Future Survey

A 24/7 Image Guided Interventional Surgery (IGIS) 'Hub' at Gloucestershire Royal Hospital and a 'Spoke' at Cheltenham General Hospital.				
			Response Percent	Response Total
1	Strongly support		32.69%	170
2	Support		33.85%	176
3	Oppose		8.85%	46
4	Strongly oppose		6.54%	34
5	No opinion		18.08%	94
			answered	520
			skipped	104

Fit for the Future Survey Easy Read

What do you think about having a 24 hour 7 days a week IGIS Hub at Gloucestershire Royal Hospital and an IGIS Spoke at Cheltenham General Hospital? A Hub is the main place something happens, and a Spoke is linked to the Hub. IGIS is Image-guided Interventional Surgery. This is where cameras are used inside the body so the surgeon can see what is going on.				
			Response Percent	Response Total
1	Good idea		76.54%	62
2	Bad idea		9.88%	8
3	Not sure		13.58%	11
			answered	81
			skipped	8

4.3.2 Vascular Surgery

Preferred option to develop: to develop: A 'centre of excellence' for Vascular Surgery at Gloucestershire Royal Hospital.

- 60.27% (Easy read: 68.35%) of all survey respondents either **strongly supported** or **supported** the proposal
- 19.97% (Easy read: 15.19%) of survey respondents either **strongly opposed** or **opposed** the proposal
- 19.77% (Easy Read: 17.72%) of survey respondents had **no opinion**

- 58.86% of staff respondents either **strongly supported** or **supported** the proposal
- 60.8% of respondents excluding staff either **strongly supported** or **supported** the proposal

Fit for the Future Survey

A 'centre of excellence' for Vascular Surgery at Gloucestershire Royal Hospital.				
			Response Percent	Response Total
1	Strongly support		29.26%	151
2	Support		31.01%	160
3	Oppose		9.50%	49
4	Strongly oppose		10.47%	54
5	No opinion		19.77%	102
			answered	516
			skipped	108

Vascular Surgery

Fit for the Future Survey Easy Read

What do you think about having the Vascular Surgery at Gloucestershire Royal Hospital? Vascular is about blood vessels				
			Response Percent	Response Total
1	Good idea		68.35%	54
2	Bad idea		15.19%	12
3	Not sure		17.72%	14
			answered	79
			skipped	10

Qualitative Themes: Image Guided Interventional Surgery (IGIS).

The following quotes are from survey responses either supporting or opposing the proposal. The quotes included below are illustrative of key themes in the feedback received regarding Image Guided Interventional Surgery (IGIS). Themes in the responses to the proposal relating to Image Guided Interventional Surgery (IGIS) (A-Z): Access; Efficiency; Facilities; Interdependency; Quality; Resources and Workforce.

Image Guided Interventional Surgery (IGIS)

Preferred option to develop: A 24/7 Image Guided Interventional Surgery (IGIS) 'Hub' at Gloucestershire Royal Hospital and a 'Spoke' at Cheltenham General Hospital.

- 66.54% (Easy read: 76.54%) of survey respondents either **strongly supported** or **supported** the proposal
- 15.39% (Easy read: 9.88%) of survey respondents either **strongly opposed** or **opposed** the proposal
- 18.08% (Easy Read: 13.58%) of survey respondents had **no opinion**

Supporting the proposal	Opposing the proposal
I believe it is good to have different hospitals with different specialisms. This will also promote inter hospital information exchange. I presume Cheltenham would be a spoke and therefore provide back up. [Efficiency]	*Heart attack patients need treatment at closest hospital this would be better than using Bristol but should be available on both sites.* [Access]
The major IGIS is acute related often so should be with the trauma and stroke unit. However, Cheltenham General Hospital as a spoke would allow elective investigations and pelvic and oncology to occur. [Interdependency]	*I would not support anything being moved from Cheltenham to Gloucester.* [Access]
Important to rationalise and make optimum use of very	*Most cases are already performed in Cheltenham and it should be the main Hub because it already has a new purpose built facility costing several*

expensive and latest equipment. [Efficiency, Resources]	*millions. It would be hugely wasteful to remove this service from Cheltenham.* [Facilities, Resources]
Such a move would avoid duplication of expensive equipment. The proposal refers to a 24/7 hub, my support is conditional on this meaning availability 24 hours a day 7 days a week. [Efficiency, Access]	*Vascular services currently at CGH with IGIS, alongside urology, cardiology and cancer services. GRH is run down with tower block wards which are not suitable for all these services.* [Interdependency, Facilities]
If EGS and Acute Medical Take are located at GRH, then it makes good sense to make GRH the hub for IGIS. It would also seem sensible for there to be a 'spoke' at CGH to work alongside oncology, urology and other specialisations there. [Interdependency]	*Extreme nature of emergency IGIS means the time delay going from Cheltenham to Gloucester would be far too risky re. Loss of life to a patient who may, for example's sake, live just across the road from CGH.* [Access, Quality]
Have had heart surgery and this would have helped me at the time and taken away the need to attend Oxford. Great for bringing the specialists to Gloucestershire to work. Open up the service to more charitable funds. [Patient Experience, Access, Resources]	*I do not understand why, following the presumed logic elsewhere in this consultation why the IGIS service needs a 'hub and spoke model'. There is no convincing argument made for this on any rationalisation, financial, staffing or any other basis. Just create a centre of excellence based on sensible criteria and get on with it.* [Efficiency, Resources]
Key point of focus at GRH. It is unclear to me why you would want a spoke at CGH. Resources staff and equipment would be split. Imaging equipment requires ongoing maintenance programme better focused at one location. [Efficiency, Resources]	
Centralised approach is good. The equipment needed to undertake these investigations are often expensive, particularly	

the imaging equipment. Staffing levels are often difficult to maintain and are often difficult to recruit. State of the art equipment will help to attract highly trained staff. [Resources, Workforce]	
I support this on the basis that fewer people would need to travel outside of the county for treatment. We need to start thinking 'Gloucestershire' when considering these matters. If people are having to travel further beyond county boundaries then it makes sense to centralise some services here. That said good to see there would be an IGIS spoke at CGH to support specialties there. [Access]	
Appears to be specialist treatment needing expensive specialist equipment operated by experts. Given this seems better to centralise as one service - some people may travel a little further but far fewer would need to travel out of county at evenings/weekends. Going to hospital unexpectedly (or even planned) is not a good experience so removing a longer journey with some of the complications this can lead to seems a beneficial step. [Access, Patient Experience]	
Neutral and other correspondence examples	
Strongly support the concept but if this is elective work wouldn't it be sensible to base it at cgh and have a spoke at grh? *This set up should be in the best site for the overall plan. IGIS is an increasingly import part of urgent clinical care so it makes sense to create a hub and spoke approach.*	

There is a …rationale for locating imaging-led services at Cheltenham which is the presence there of the Cobalt charity's unique Imaging Centre…which they say 'have increased patient comfort, shorter scanning times and deliver superior image quality'.

Qualitative Themes: Vascular Surgery

The following quotes are from survey responses either supporting or opposing the proposal. The quotes included below are illustrative of key themes in the feedback received regarding Vascular Surgery. Themes in the responses to the proposal relating to Vascular Surgery (A-Z): Access; Capacity; Diversity; Facilities; Interdependency; Patient Experience; Quality; Resources and Workforce.

Vascular Surgery

Preferred option to develop: A 'centre of excellence' for Vascular Surgery at Gloucestershire Royal Hospital.

- 60.27% (Easy read: 68.35%) of survey respondents either **strongly supported** or **supported** the proposal
- 19.97% (Easy read: 15.19%) of survey respondents either **strongly opposed** or **opposed** the proposal
- 19.77% (Easy Read: 17.72%) of survey respondents had **no opinion**

Supporting the proposal	Opposing the proposal
Better facilities and car-parking at GRH. [Facilities, Access]	*I think Vascular should remain at CGH. Only a relatively short time ago much investment was made to establish a centralised service at CGH. Going forward with future phases of Fit for the Future there will be a need to have established services at CGH and this is one that could fit and not compromise safety.* [Resources, Quality]
Having Vascular surgery at GRH will mean that vascular surgery will be able to support the emergency services better.	*Provide services at both hospitals, provides for the two large population sites and better for outlying areas. Provides back up for either place. Better*

[Interdependency]	*for patients requiring emergency support.* [Access, Quality]
Why not? The importance is that the unit exists and is available 24/7 as and when. [Access, Patient Experience]	*I feel emergency and elective vascular surgery should be split so that emergency work is aligned with the surgical take whilst elective work continues at CGH. This will ensure there is critical care capacity available to support the elective work otherwise there is likely to be an ever increasing pressure on ICU beds at GRH.* [Interdependency, Capacity]
BME communities have higher rates as diversity to Cheltenham and Gloucester - GRH is perfectly placed. [Access, Diversity]	*This should be in CGH where the available beds are, and where there is the state of the art interventional theatre.* [Capacity, Facilities]
Vascular is predominantly a service where patients can be suffering from a life threatening event (AAA) that requires immediate intervention in a theatre designed for this type of surgery. I think splitting Vascular across two sites will provide a sparse clinical cover across two sites rather than strong cover on one site. I can see the intrinsic link between IGIS and Vascular and therefore wherever the IGIS hub is, Vascular should be centralised to and vice versa. [Interdependency, Workforce]	*The wards at GRH are not fit for practice. They are overcrowded, beds too close together increasing the infection risk. The tower block appears generally dirty. Your report reads that if you live in a deprived area (25% of Gloucester population) you will get preferential treatment on your door step and blow the rest of the county. Given that most vascular issues occur in the over 65 age group and these people are spread out across the county if you live at Morton/Bourton area East Gloucestershire, you won't stand much chance of survival.* [Facilities, Access, Diversity]
This should be concentrated at Gloucestershire Royal and it is not asking too much for patients needing such procedures to have them carried out at Gloucester. [Access]	*Vascular surgery carries a burden of heavy emergency list use, often at unpredictable times. This has impacted the emergency theatre provision at GRH such that, even with an extra emergency theatre and consultant anaesthetist on site, access to emergency surgery in a timely fashion has deteriorated for all specialties. CGH would be well placed in terms of facilities and aftercare provision to re-accommodate vascular surgery after the recent experimental transfer to GRH. The fully equipped and recently*

	provisioned IR theatre at CGH is currently lying fallow much of the time and is superior to anything available in GRH. [Capacity, Facilities]
I believe that some thought should be given to maintaining some 'low risk' non urgent vascular capability for some elective vascular surgery at Cheltenham General Hospital. [Access]	*I appreciate that these skills cannot be shared between too sites but for emergencies people living in many of the remote parts of Gloucestershire they need quicker access to a hospital and Gloucester is far from us.* [Access]
Hard to have IGIS at GRH and vascular at CGH so makes sense. [Interdependency]	
You need the technology to do this and therefore would be good to be in Gloucestershire. Need to have the wards set up for this close to the theatres. Will pull in staff and money by having a centre of excellence. Increase the number of specialist nurses. [Resources, Workforce]	

Neutral and other correspondence examples

This service was previously being managed well at CGH but if it not possible to split elective e.g. IGIS and emergency vascular surgery then I believe it would be preferable to keep it on the GRH emergency site and then consider the "spoke" option at CGH for the elective surgery. Splitting this service will have an impact on the intensity / quality of Therapy those patients will receive unless additional funding is provided to support splitting this service across sites.

It depends where other surgical specialties are cited.

REACH survey

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

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.

Other correspondence

The 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.

4.4 Gastroenterology inpatient services

Preferred option to develop: A 'centre of excellence' for Gastroenterology inpatient services at Cheltenham General Hospital.

- 71.96% (Easy read: 68.35%) of all survey respondents either **strongly supported** or **supported** the proposal
- 6.67% (Easy read: 10.13%) of survey respondents either **strongly opposed** or **opposed** the proposal
- 21.37% (Easy Read: 21.52%) of survey respondents had **no opinion**

- 68.08% of staff respondents either **strongly supported** or **supported** the proposal
- 73.44% of respondents excluding staff either **strongly supported** or **supported** the proposal

Fit for the Future Survey

A permanent 'centre of excellence' for Gastroenterology inpatient services at Cheltenham General Hospital.				
			Response Percent	Response Total
1	Strongly support		39.41%	201
2	Support		32.55%	166
3	Oppose		3.92%	20
4	Strongly oppose		2.75%	14
5	No opinion		21.37%	109
			answered	510
			skipped	114

Fit for the Future Survey Easy Read

What do you think about us carrying on doing Gastroenterology at Cheltenham General Hospital after the pilot? Gastroenterology is where tests or treatment are needed for the stomach, bowel, liver and pancreas for things like Crohn's Disease and stomach ulcers				
			Response Percent	Response Total
1	Good idea		68.35%	54
2	Bad idea		10.13%	8
3	Not sure		21.52%	17
			answered	79
			skipped	10

Qualitative Themes: Gastroenterology Inpatient Services

The following quotes are from survey responses either supporting or opposing the proposal. The quotes included below are illustrative of key themes in the feedback received regarding Gastroenterology inpatient services. Themes in the responses to the proposal relating to Gastroenterology inpatient services are (A-Z): Access; Capacity; Interdependency; Quality; Resources; Staff experience; Transport and Workforce.

Gastroenterology Inpatient Services

Preferred option to develop: A 'centre of excellence' for Gastroenterology inpatient services at Cheltenham General Hospital.

- 71.96% (Easy read: 68.35%) of survey respondents either **strongly supported** or **supported** the proposal
- 6.67% (Easy read: 10.13%) of survey respondents either **strongly opposed** or **opposed** the proposal
- 21.37% (Easy Read: 21.52%) of survey respondents had **no opinion**

Supporting the proposal	Opposing the proposal
This has been piloted successfully and seems a sensible balance between the two hospitals. [Access, Quality]	*As with all your proposals to centralise services the problem is that of access for patients and their families. Whilst many have access to private transport a very large minority do not and they are frequently the elderly and less financially secure. For these people centralisation poses a major difficulty in accessing your services unless you propose to offer free transport between the sites. Even for those with private transport difficulties in accessing parking at either site pose difficulties and high costs.* [Access / Transport]
Efficient use of resources, access to specialist staff at all times, no waiting for them to travel from GRH to CGH and vice-versa. The total patient capacity must still remain the same (and hopefully higher!), not reduce as a result. [Access, Capacity,	*Both hospitals need a centre of excellence due to the size of the population and the location of the services.* [Access]

Workforce, Resources]	
I am in support of this if it means that all the specialists are in one place. I do have concerns about the lack of parking facilities at CGH - especially if patients are being asked to travel from further afield to attend this site. [Access, Facilities]	*Despite gastro inpatients being at CGH currently, gastro inpatients are still seen on GRH wards and do not get the care they need from the gastro team. Patients either need to be moved promptly so the care of the patient is not impacted, or have a service at both sites.* [Quality]
Only if lower GI surgery is co-located - rapid senior surgical review with alacrity ensures that decisions for surgery are correctly timed and that non-surgical interventions are not pursued too long; if all one has is a hammer then everything looks like a nail. [Interdependency]	
Got to move something to CGH to balance the shift to GRH. Aligns well to elective services generally centralising to CGH. [Interdependency]	
Links with upper /lower GI as well as colorectal and cancer based surgeries, this is a no brainer as it would all fit together and enable this centre of excellence aim. [Interdependency]	
Gastroenterology experience has been demonstrably improved by the recent pilot. Less violence and aggression on the ward, less non-gastro (general medicine) patients using specialised beds and better staff satisfaction from cohorting our clinical capacity onto a single site. [Quality, Staff experience]	
A centre of excellence would benefit both staff, services delivered and patient care. [Quality, Staff/Resources]	
Neutral and other correspondence examples	
I support the proposals to change and think the information provided presents a strong case. However, throughout the consultation document I	

see little or no reference to: a) How staff are to be retained, trained, recruited and afforded. b) No reference to any improvements to process or service instigated as part of the response to Covid -19 which will be retained as Best Practice moving forward. c) Limited reference to the way that services will be re-modelled in line with international Best Practice. There is limited information given for example on the use of telemedicine, telephone consultation and follow up, health education in primary care, transfer of services into community settings, conversations to higher day case rates, better streaming through outpatients (and ED). The proposals appear to deal with the issue of duplication of services across two sites and consequent rationalisation and whilst this is to be welcomed, of itself, it does little to illustrate how the models of care can or will change. Similarly there is no financial analysis (that I can see) with the documentation provided. In an increasingly stretched NHS, this must be a consideration for services to be long term sustainable.

I feel this service could be led from either hospital and the service continue I the hospital why change for change sake . Save money and develop leadership on either site and share good practice online

REACH survey

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

Other correspondence

Retain Gastroenterology Services at CGH as this fits with the Centre of Excellence model

4.5 Trauma and Orthopaedics (T&O) inpatient services

Preferred option to develop: to develop: Two permanent 'centres of excellence' for Trauma at Gloucestershire Royal Hospital and Orthopaedics at Cheltenham General Hospital.

- 76.02% of all survey respondents either **strongly supported** or **supported** the proposal
- 10.53% of survey respondents either **strongly opposed** or **opposed** the proposal
- 13.45% of survey respondents had **no opinion**
- Easy read had two questions:
    - Trauma: 70.51% support / 12.82% oppose / 16.67% no opinion
    - Orthopaedics: 73.08% support / 14.10 oppose / 12.82% no opinion

- 75.35% of staff respondents either **strongly supported** or **supported** the proposal
- 76.28% of respondents excluding staff either **strongly supported** or **supported** the proposal

Fit for the Future Survey

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

			Response Percent	Response Total
1	Strongly support		44.44%	228
2	Support		31.58%	162
3	Oppose		7.41%	38
4	Strongly oppose		3.12%	16
5	No opinion		13.45%	69
			answered	513
			skipped	111

Trauma and Orthopaedics (T&O) inpatient services

The Easy Read Survey separated out the Trauma and Orthopaedic proposal into two questions:

Fit for the Future Survey Easy Read - Trauma

What do you think about us carrying on doing Trauma Surgery at Gloucestershire Royal Hospital after the pilot? Trauma Surgery is where people need operations after they have been injured in an accident.

		Response Percent	Response Total
1	Good idea	70.51%	55
2	Bad idea	12.82%	10
3	Not sure	16.67%	13
		answered	78
		skipped	11

Fit for the Future Survey Easy Read – Planned Orthopaedics

What do you think about us carrying on doing Planned Orthopaedics at Cheltenham General Hospital after the pilot? Planned Orthopaedics are operations for things like hip replacements and knee surgery.

		Response Percent	Response Total
1	Good idea	73.08%	57
2	Bad idea	14.10%	11
3	Not sure	12.82%	10
		answered	78
		skipped	11

Qualitative Themes: Trauma and Orthopaedics (T&O) inpatient services

The following quotes from survey responses are from survey responses either supporting or opposing the proposal. The quotes included below are illustrative of key themes in the feedback received regarding Trauma and Orthopaedics (T&O) inpatient services. Themes in the responses to the proposal relating to Trauma and Orthopaedics (T&O) inpatient services (A-Z): Access; Capacity; Efficiency; Facilities; Interdependency; Patient Experience; Pilot; Quality; Resources; Transport; Workforce

Trauma and Orthopaedics (T&O) inpatient services

Preferred option to develop: Two permanent 'centres of excellence' for Trauma at Gloucestershire Royal Hospital and Orthopaedics at Cheltenham General Hospital.

- 76.02% of survey respondents either **strongly supported** or **supported** the proposal
- 10.53% of survey respondents either **strongly opposed** or **opposed** the proposal
- 13.45% of survey respondents had **no opinion**
- Easy read had two questions:
    - Trauma: 70.51% support / 12.82% oppose / 16.67% no opinion
    - Orthopaedics: 73.08% support / 14.10 oppose / 12.82% no opinion

Supporting the proposal	Opposing the proposal
Separating trauma and planned surgery proven model, elsewhere, in terms of bed base, theatre capacity and managing infection rates. [Efficiency, Quality]	*Trauma needs unambiguous and fast treatment. I've no idea where/when I can go to CGH so I'd call an ambulance rather than go by car. What a stupid waste of resources.* [Patient Experience]
This is something that I believe is already pretty much established with GRH being the trauma site and CGH being the elective site. [Efficiency]	*I am concerned that having these two sited at different hospitals will result in increased patient transfers due to the overlap of specialities.* [Access/Transport]
This principle is sound - to concentrate emergencies on one site	*Both hospitals have the population to support a centre of excellence- this is*

and orthopaedics on the other and it will help the ambulance service to direct patients to the appropriate site. [Efficiency]	*just stealing Cheltenham hospital services away which has been happening by stealth over recent years!* [Access]
This scenario has been in place for some time and seems to work well. Keeping elective patients away from acute admissions is vital to minimise the risk of prosthetic joint infections.[Efficiency, Quality]	*The pilot study at GRH regarding Trauma has not been publicly scrutinised. I gather it has not been successful due to pressure on beds and operating time, consequently causing delays to surgery. It would not be sensible or responsible to continue this service at GRH. Orthopaedics at CGH on the other-hand has performed better.* [Pilot, Capacity, Patient Experience]
Ok, need to give county spread. But Cheltenham not so easily accessible and very difficult for family and visitors without a car.... Cheltenham has a very limited evening bus service e.g. from Stroud. [Access, Transport]	*From things I have heard about Trauma & Orthopaedics I am not convinced the T&O Pilot study has gone as well as the Hospital Trust has claimed. I should like to see the full report of the Trial, before forming a judgement on this. I am not opposed to most elective orthopaedic surgery being done on one site and most trauma orthopaedics being done on the other, to minimise disruption to elective orthopaedic procedures, but Trauma Orthopaedics is fundamental to a fully functioning A&E Department, not least because it is not always obvious until x-rayed whether an injury is a broken bone or a soft-tissue injury. At least some trauma orthopaedic capacity should be retained on both sites.* [Pilot, Quality]
If elective T&O operations are low risk then basing them on a site away from emergencies makes sense as there will be a reduced chance of cancellation. Trauma is best location near the main A&E. [Capacity, Patient Experience]	*Trauma and orthopaedics should stay together at GRH.* [Interdependency]
As someone who is on the waiting list for a knee replacement and living in Cheltenham being able to keep a permanent 'centre	*No there should be one centre to concentrate all resources in one place, unless one is for emergencies and one for electives. Two sites would dilute*

of excellence' at Cheltenham General would be good. [Patient Experience, Access]	*this.* [Efficiency]
Separating out emergency trauma and elective orthopaedics makes sense as it again puts the planned care in CGH which will be a calmer hospital and more suitable for that type of services, and the emergency services can have their centre of excellence at GRH. Again, having the centres of excellence is a sensible way forward, and the pilot seems to have worked well. [Facilities, Quality]	*Trauma and orthopaedic need to go together. It would be VERY confusing to split them. You've GOT to start treating this as one hospital over 2 sites; not 2 different hospitals. EVRRYTHING trauma and orthopaedic at Gloucester.* [Efficiency]
Much like with previous service responses I believe that by keeping Trauma linked with Orthopaedics will inevitably lead to Orthopaedics losing out because acute patients (trauma) has to take priority for beds, theatre space and staffing requirements. This allows the massive Orthopaedics service to properly deliver aside from the constraints put on them through sharing bed and staff capacity with Trauma. [Quality, Capacity]	*If it is a trauma case, it is quite possibly an ambulance admission and GRH cannot cope now. All ambulances go to GRH and then orthopaedics would have to be transferred to CGH, increased cost, risk, time and staff.* [Capacity, Resources/Workforce]

Neutral and other correspondence examples

Don't know why we need two centres. Probably better to have everyone on one site rather than spreading resources more thinly across two sites.

Because the two are so closely linked, why not have one Centre of Excellence in one place?

REACH survey

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?

Other correspondence

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.

4.6 Impact of our proposals on you and your family

The following quotes from survey responses illustrate the impacts (positive and negative) identified by respondents to the survey: Access; Environmental; Facilities/Car Parking, Outpatients, Patient Experience; Quality; and Safety.

The predominant impact identified from respondents from all areas of the county is **Access** to centralised services; whether at Cheltenham General Hospital or Gloucestershire Royal Hospital. Therefore, a significant number of examples of this impact have been selected below. Frequently respondents have linked Access with either expected improvement in quality of services or deterioration in quality of services. Several respondents highlight **Environmental** aspects of increased travel.

I do not believe they would impact negatively, the distance between the two centres is not very far, if it was an emergency the patient would be blue lighted anyway. I would rather get the best possible care than decisions being made on geography. If as a plus this means that patients may not need to be sent out of county this is huge benefit. [Access, Quality]

My wife and I are both in our 80s and moved from a rural location in 2019 as we anticipate a point at which we will not own a car. We deliberately bought a property within walking distance of CGH. We have already found it necessary to travel to Gloucester for X-ray and my wife was admitted for emergency treatment late on a Saturday evening. I had to return home to collect her essential medication and was able to do so in the car. This would have been particularly difficult without our own transport. [Access]

Any proposal that fails to deliver the full restoration of 24/7 type-1 consultant-led A&E services at CGH, will make it considerably more difficult to access emergency health care for me and my family. [Access]

Removal of services from Cheltenham would make it very difficult for people of North Cotswolds who depend very strongly on Cheltenham. [Access]

Minimal impact currently - may involve slightly longer travel dependent on outcome. Applies to services that would move to GRH. [Access]

As someone of working age with access to independent transport, I think this is a positive move for me. However, I am concerned about the social practical impacts for people who are dependent on public transport, elderly, need support to travel, more financially disadvantaged. [Access]

I live in the Forest of dean so any move to Cheltenham will put 30 minutes extra on my journey. Maybe longer when you consider how difficult it is to park in Cheltenham. [Access]

Difficulty in getting to Cheltenham general hospital, public transport links poor or non-existent. [Access]

We live on the border in Herefordshire but our nearest GP surgery is in Gloucestershire where we access services. Having to travel to Cheltenham is too far. [Access]

I live in Moreton-in-Marsh and I am not able to drive. Gloucester is a foreign country! Oxford or Worcester is easier to reach. Any suggestion of concentrating services at GRH is therefore bad news. Only super specialist services should be located here. [Access]

Any medical treatment should be available at a local hospital. It is wrong to expect patients who are obviously ill to travel to long distances for treatment. Ecologically it is also better for a few medical staff to move between hospitals than for large numbers of patients to travel. [Access, Environmental]

If the services are not at both units this would mean further travel and time. It also means for Carers there days would be more disrupted getting patients to appointments in larger units. [Access]

I have multiple disabilities and cannot drive or travel on public transport. If I ever need any of the services covered in this proposal, I want them to be as close as possible to my home. It is easier for elderly, disabled, and very sick people to travel to their nearest hospital. An unfamiliar environment may be distressing for them, and it may be more difficult for their families to visit if they are further away. I will not be the only person in this category who is not able to either drive themselves or travel on public transport. Therefore, all procedures should be available in all hospitals, not in one centre. This feedback relates to all the services. [Access]

My view is that centres of excellence would be a positive proposal. Negative could be transport/parking etc. issues in either getting to hospital, or for visitors. A free green shuttle between the sites would help with this. But really transport issues are far down the line when compared to top class treatment. [Access, Transport, Environment]

Both hospitals pretty much equidistant for us and are over thirty mins away, so no change for us. [Access]

Obviously because I live in the forest of Dean it would be better for my family to have all resources staff and centres of excellence at Gloucester but Cheltenham needs to have its own centres of excellence. [Access]

As a Gloucester based family it is always easier for us to go to GRH. However, I would prefer to travel a bit further to a centre of excellence. [Access, Quality]

There could be more travel for patients depending on the proposals, but clearly the aim is for people to have world class care and I personally would be prepared to travel a bit more and not be so territorial. It's your health that matters at the end of the day. Also, some of the proposals like IGIS should mean fewer people having to travel out of county which is a good thing. [Access, Quality]

As a resident of Cheltenham I am happy to travel if it means better care. I just want the right people in the right place to look after my family if they are unwell. [Access, Quality]

Car parking is an issue at CGH, assurances need to be made that relatives are able to park, to be able to transport and visit their relatives.
The estate has to be able to support the changes to the centres of excellence along with staffing and support services. [Facilities/Car Parking]

I imagine most opposition to the proposals will come from those who live significantly closer to one hospital or the other. We are fortunate in living more or less halfway between the two. Despite it being easier, therefore, for me to agree to the proposals, I do feel strongly that rationalisation of provision is important. [Access, Efficiency]

As long as the clinic appointments are in the same place I think it will have very little impact on my family. [Outpatients]

I am concerned that scarce resource (pathology, radiology, social work etc.) is diverted to GRH leaving a second rate services that would not be able to safely support any centre of excellence (including oncology) based in CGH. [Quality/Safety]

A possible positive impact would be an increased likelihood of a successful outcome of any treatment in the future. [Quality]

Because we live in the very south of the county to a certain extent these changes will have very little impact on us as we are pretty much as far away from one hospital as the other. The time taken to get to either of them is about the same, and as there is no public transport to either hospital, it doesn't really matter for any of the services at either hospital. However, I know that having centres of excellence can generally improve patient outcomes, which is

why I support the developments of the centres of excellence. At the moment some trauma and emergencies from our area are dealt with at Southmead, so if GRH and CGH can become superior centres of excellence, then perhaps we would be more likely to be treated in county. I would rather battle the traffic into Cheltenham or Gloucester than Bristol. [Access]

Creating a major elective hub at CGH is likely to be beneficial to my family. This would allow good access to intensive care if needed and reduce the risk of hospital acquired infection. [Quality]

My family and I could be affected positively by services being centralised because we would get the treatment we need in time by highly motivated trained staff. [Quality]

All proposals would have a positive impact on me and my family. I don't care where I or my loved ones are treated. If any one of us had an extremely unusual condition requiring us to travel to London for treatment, we would do it. It therefore makes no difference to me whether I have to travel to Cheltenham or to Gloucester for treatment, as long as the service is good, well-staffed with enough of the right staff and capacity available is all I care about. [Quality, Access]

4.7 Limiting negative impact

The following quotes from survey responses illustrate suggestions for limiting negative impacts identified by respondents to the survey [Access; Communications, Integration; Reduce patient transfers; Single Site, Transport, Travel Claims; and Workforce.]

Survey respondents shared the following mitigations to limit potential negative impacts of centralisation of specialist hospital services.

- Retain services on both sites
- Improve Patient Communications
- Improve integration between hospitals, community services and GP practices
- Reduce the number of patient transfers between Acute hospitals
- Build a new Acute Hospital on a Single Site
- Improve public transport
- Speed up payment of eligible Travel Claims
- Encourage more staff to work in Gloucestershire

As far as possible try to maintain urgent/emergency/acute facilities at both sites while splitting care not in those categories into centres of excellence across the two sites. [Access]

I cannot understand why it seems the Trust struggles with employing adequate staff for both hospitals. Gloucestershire is a beautiful county, more and more people are leaving cities and moving into the countryside, like the Cotswolds and Cheltenham is the home of the 'festivals' after all! So providing more staffing and investing in equipment etc should be a priority for both hospitals. Why do staff have to cover both sites? The two hospitals are separate sites and should continue to provide equal facilities because Gloucestershire is such a large growing county. [Workforce]

Work with the transport services. [Access, Transport]

It is important that free public transport is available for patients between the two hospitals, so that (for example) people living in Cheltenham are not financially disadvantaged by having to travel to GRH, if they do not have a car. [Access, Transport]

Make all services available in all hospitals. If this is not possible, then there should be excellent hospital or volunteer transport which is suitable for individual patients with a variety of disabilities including severe allergies (I cannot travel in standard hospital transport or on public transport because of allergies to perfumed products from laundry detergent to standard toiletries.) [Access]

24 transport links (99 bus useful but only mon-fri) between CGH and GRH. Cheaper parking if patient needs transfer from/to CGH/GRH. [Access, Transport]

Easier travel; more car parking spaces and lower charges for parking. Move to a paperless system so there is no need to transfer paper notes and images between sites - practical experience at both hospitals show lost notes are very common. [Access, Transport, Car Parking]

You really need to have a "Southmead" in the Golden Valley area. And you need to consider better bus services to both sites for general public to reduce car parking requirements and problems. [Single site, Transport]

Finding ways to minimise the need to transfer patients between sites is important. Communication about any changes that are made and why they are necessary always helps. [Reduce patient transfers, Communications]

Greater visibility and support given to people needing to claim travel expenses for hospital visits. Citizens Advice Stroud ran a campaign about this 3-4 years ago, surveying the hospitals and surgeries to see how visible the information was and how easy to claim. The

procedure for making a claim and receiving payment was poor. Stressed relatives need immediate assistance. They should not have to wait a month to be reimbursed. [Travel Claims]

Get it Right First Time. Direct to FAS/ COTE bed. Another specialist COTE ward at CGH (although difficult to recruit to this area) Discussion with community partners: keep Community Hospital and Bed Based Rehab beds for patients needing these services to speed transfers out of acute hospital. Blocking beds in the community blocks up our ' back door' and our beds perpetuating the problem of flow. [Integration]

Better 'advertising' of which conditions and situations are for which hospital so we can make decisions without convoluted calls to 111. [Communications]

Try leadership and staff support for both units from one hospital. Sharing good practice teams can meet online. [Workforce]

4.8 Anything else you want to tell us

The following quotes from survey responses illustrate other comments made by respondents to the survey:

Bring back Cheltenham A&E full-time and with full services as soon as Covid restrictions are lifted.

My hope would be that by making these changes the local service will be made better and the cancelling of planned procedures is significantly reduced.

Just think more about travel access, parking facilities and best of all getting appointments and blood tests done promptly. The Cotswolds is treated as a backwater by Glos NHS

More free car parking at GRH and CGH.

If would help if other bodies such as Glos Highways and bus companies could be persuaded to consider better road access and enhanced public transport facilities to reduce difficulties in trying to access two sites.

I would be interested to know what consideration One Gloucestershire have given to inclusion in terms of practical access to the hospital sites e.g. public transport providers, charities with volunteer drivers, support groups in disadvantaged areas.

Given the health inequalities which have been demonstrated through the Covid-19 situation, it is vital to me that these considerations are given a platform in any changes, else we risk worsening inequalities already present. As well as the patient, this can impact visitors, whose support can positively bolster outcomes for a patient.
Also, there is no mention of the impact on ambulance services, but presumably there will be an impact in terms of transfers needed (not just when ambulance first called to patient, but also transfers between GRH and CGH). I am wondering how this has been assessed?
Thank you for appreciating the importance of having an A & E service in Cheltenham to local people, I am really pleased this is reflected in the plan.

Build a new County Hospital between Gloucester and Cheltenham, or focus development on the Gloucester site. Improve access (sheltered pedestrian links) to Gloucester rail and bus stations.

The shuttle bus between CGH and GRH is a great asset in relation to access to services. A commitment to its future would be good to hear. It would also be good to hear that discussions are being held to see whether the bus route could include a stop at Park and Ride at Cheltenham Racecourse. Decision makers should consider evaluation of services changes if implemented and the involvement of patients, carers and VCS in the evaluation.

Keep up the good work. Will be interested in the result of survey. Any plans for head injuries, chest surgery - including cardiac or neurosurgery, so these still go to Bristol of John Radcliffe, Oxford. Guess if you live west of the M5 you want all in GRH, east of the M5 CGH. There are of course major incidents to remember where anything and everything can turn up.

I understand and agree with your reasons for wanting to change things in these two big hospitals, but I would urge you to also consider our more rural hospitals (Cirencester, Stroud etc.) when it comes to where funds go. I would hate these to be underfunded at the expense of these changes.

The public's primary concern about the reconfiguration of specialist services within the hospital relate to the convenience and accessibility of services and the long term sustainability of a Type 1 A&E Department in Cheltenham. Of some of these proposals are implemented it is difficult to see how a full Type 1 A&E Department would be sustainable in the long term. This is despite the reassurances the Hospital Trust has repeatedly been given. It is these proposals which have undermined staff and public confidence in the Hospital Trust's sincerity over the re-opening of Cheltenham A&E and its long term future.

If you centralise more long queue and parks, waste cancelled appointments staff on sick holidays etc. As more money was used in covid 19. We have to think weekly and keep NHS

going for years to come. Electric chargers at hospital while wait for o/patient and visitors. Cars in come for hospital?

Refreshing to see such an in depth review and consultation. How about integration of Social Services and the NHS next?

Whatever decision is made, the correct and additional staff numbers must be allocated. You cannot simply move the patient workload (currently split over two sites with two teams) to one site with only that sites pre-existing team numbers. This will be a recipe for failure / disquiet. Working in a small speciality which centralised 10 or so years ago the benefits are huge for us.

Improving continuity of care, reducing outliers and improving communication with families might be improved if a balance in activity across the hospitals is achieved.

These are excellent consultation proposals but miss one very important heading - THE CUSTOMER CARE EXPERIENCE. Visits to both major hospitals are still very poor experiences. Everyone does their best with awful facilities and it's time we moved from a 1958 experience to 2020.

I would like to see a very positive statement, and concrete proposals for the better care of patients presenting with mental health problems in ED. This has been a long ongoing concern, how will Fit for the Future ensure that mental health is given proper consideration?

I worry about the link and relationship between these proposals and GP services. GP services need to be as much a part of this as the hospitals and the hospitals cannot do this in isolation of community services. I can see part of the proposal is to enable more joined up working but this has to work in practice with collaboration and cooperation across the services. While I have experienced fantastic GP services in Gloucestershire (up to about 10 years ago). Unfortunately I have also experienced some poor GP service provision in Gloucestershire, which has deteriorated over the last 8 to 10 years. My biggest concern is that if the GP services are not joined up with these proposals, this will not be able to succeed.

I have been watching this play out for years and too much time and negative energy has been spent which has hampered the development of all specialties in both hospitals. I am utterly fed up with it.

Inappropriate and dangerous hospital discharges happen regularly, particularly at GRH. I hope these changes will help reduce these. Mental health support is very poor, particularly in GRH, I hope the cost and staff savings can be used to provide better mental health support for patients with mental ill health.

I used to work for the department of health. The fashion for building new hospitals would alternate between big is beautiful and small is beautiful on a 10 year cycle. The result was that all current buildings was out of step with prevailing thinking. Health trusts need to resolve this conundrum and ensure a successful balance between specialist and locally delivered hospital based options.

Just ensure that the investment needed to provide these changes properly and not half hearted is there for all services involved including those that are sometimes overlooked. There is no point picking a service up and moving it to one side of the county or other if you don't use this opportunity to actually improve it.

A future proof plan for reduced waiting times, reduced hospital stay, access to cutting edge skills and equipment along with optimal training of junior staff and attracting the best must be a positive move.

Invest in your nursing staff as you do with every other professional group. Pay them more and develop their skills. This is the only way you will be seriously considered as addressing the recruitment and retention crisis.

I find taking part in the survey stimulating and support the developments.

Do not ignore the publics opinion we have a right to choose where we have our care.

5. Other correspondence/written responses

9 written responses were received during the consultation (A-Z).

- Cheltenham Borough Council [Access, Capacity, Interdependency + commitment to Cheltenham General Hospital A&E]
- Cllr Martin Horwood, Liberal Democrat, Cheltenham Borough Council [Capacity, Access, Pilot + timing of consultation]
- Leckhampton with Warden Hill Parish Council [Capacity, Access, Pilot + timing of consultation]
- REACH: Restore Emergency At Cheltenham General Hospital campaign (including REACH survey interim report) [Capacity, Access, Interdependency, Facilities, Quality, Pilot + commitment to Cheltenham General Hospital A&E] – Summary of REACH Survey responses below.
- Tewkesbury Borough Council [Access + commitment to Cheltenham General Hospital A&E]
- 4 x members of the public [#1: Quality, Resources, Workforce, Facilities, Staff Experience, Pilot. #2: Workforce. #3: Quality, Patient Experience. #4: Efficiency, Resources, Capacity, Workforce]

10 email responses were received from members of the during the consultation from members of the public

[#1. Efficiency, Resources. #2: Access, Resources. #3: Patient Experience, Access, Resources, Facilities, Integration (use North Cotswolds Community Hospital). #4: Integration (use North Cotswolds Community Hospital), Access. #5: Access, Integration (use North Cotswolds Community Hospital). #6: Access. #7: Access + commitment to Cheltenham General Hospital A&E Department. #8: Access, Patient Experience. #9: Interest in Stroke services. #10: Copy of Member of the Public Letter 4: Efficiency, Resources, Capacity, Workforce]

5.1 REACH Survey – summary interim results

The REACH Report on Interim Results (17 December) has been shared with the Fit for the Future consultation team and can be found in full in the online appendices.

The REACH survey asked different questions to those in the Fit for the Future Survey and Fit for the Future Easy Read Survey.

The REACH survey number of responses or demographics of respondents have not been shared with the Fit for the Future consultation team at the time of writing.

Summary results (EXTRACTS from the REACH Interim Report] regarding each specialist services are proposals are as follows:

Acute Medical Take: NHS Preferred option to develop: A 'centre of excellence' for Acute Medicine (Acute Medical Take) at Gloucestershire Royal Hospital.
REACH survey question: Do you agree with the Trust's preferred option of centralising acute emergency medical patients on to the GRH site?
EXTRACT: The public response has been overwhelming, indicating that the people do not support centralisation of the acute medical take or emergency admissions at GRH.

Emergency General Surgery: NHS Preferred option to develop: A 'centre of excellence' for Emergency General Surgery at Gloucestershire Royal Hospital**.**
REACH survey question: Do you agree with the Trust's preferred option of centralising acute emergency general surgical patients on to the GRH site?
EXTRACT: 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.

Planned Lower GI (colorectal) general surgery: NHS Preferred option to develop: A 'centre of excellence' for Planned Lower GI (colorectal) general surgery at Cheltenham General Hospital (CGH) or Gloucestershire Royal Hospital (GRH).
REACH survey question: Do you agree with the Trust's preferred option of centralising planned lower gastrointestinal/colorectal patients onto a single hospital site?
EXTRACT: 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.

Location of Planned Lower GI (colorectal) general surgery: NHS No preferred option.

REACH survey question: 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?

EXTRACT: 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.

Planned day case Upper and Lower GI (colorectal) surgery: NHS preferred option to develop: A 'centre of excellence' for planned day case Upper and Lower GI (colorectal) surgery at Cheltenham General Hospital.

REACH survey question: 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?

EXTRACT: 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.

Image Guided Interventional Surgery (IGIS): NHS preferred option to develop: A 24/7 Image Guided Interventional Surgery (IGIS) 'Hub' at Gloucestershire Royal Hospital and a 'Spoke' at Cheltenham General Hospital.

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

EXTRACT: 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.

Vascular Surgery: NHS preferred option to develop a 'centre of excellence' for Vascular Surgery at Gloucestershire Royal Hospital.

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

EXTRACT: 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.

INTERVENTIONAL CARDIOLOGY [question not included in the Fit for the Future Survey and Fit for the Future Easy Read Survey]

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

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

INPATIENT VASCULAR SURGERY [question not included in the Fit for the Future Survey and Fit for the Future Easy Read Survey]

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

EXTRACT: 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.

Gastroenterology inpatient services: NHS preferred option to maintain a permanent 'centre of excellence' for Gastroenterology inpatient services at Cheltenham General Hospital.

REACH survey question: Where do you believe that the gastroenterology inpatient service should be located in?

EXTRACT: The vast majority of respondents indicated that the single site gastroenterology inpatient site should be 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.

Trauma and Orthopaedic inpatient services: NHS preferred option to maintain two permanent 'centres of excellence' for Trauma at Gloucestershire Royal Hospital and Orthopaedics at Cheltenham General Hospital.

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

EXTRACT: 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.

REACH survey question: 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?

EXTRACT: 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.

5.2 Other comments received during the consultation

(Not directly related to the Fit for the Future consultation proposals)

During the consultation, members of the consultation team spoke to participants about matters unrelated to the Fit for the Future proposals. Other subjects included the national and local response to the Coronavirus pandemic, including practical questions about Covid-19 testing and vaccination; the timing of the consultation taking place during a pandemic; feedback about services such as primary care (GP) services and mental health services.

The final subject to report was the significant number of messages of thanks to health and care staff and other frontline workers for their efforts to maintain services during the pandemic.

6. Addressing themes from the Consultation

This Interim Output of Consultation Report is one of a number of key documents that decision makers utilise (and which are made available to the public), when assessing service change proposals. To support 'conscientious consideration'[13] decision makers should be able to provide evidence that they have taken consultation responses into account. As part of this process, the Decision Making Business Case (another of the key documents utilised by decision makers), will include significant content from the consultation. In addition to summarising the consultation process it will also include:

- A summary of consultation findings
- Analysis of consultation responses including any alternative suggestions to the proposals
- New evidence from the consultation and the impact of this on the proposals
- An updated Integrated Impact Assessment that includes feedback from the consultation

This information is a crucial part of determining the final proposals that are included in the Decision Making Business Case (DMBC) for consideration by decision makers. Further work will be completed to ensure decision makers are able to take a proportional view based on the quantitative and qualitative responses.

Sections 3 and 4.7 have already identified key themes and mitigations to limit potential negative impacts that will be need to be addressed by the DMBC. The table below lists some of the specific topics, identified from all sources of consultation responses that will need to be considered and responded to as part of the post-consultation, pre-decision making process. As with all consultations there are a range of issues identified commensurate with the differing views of those responding to the consultation.

Theme	Topic
Access	• Establish Centres of Excellence on both sites (GRH & CGH) • Improve communication regarding location of services • Ambulance response times and capacity • Car parking • Public transport including Park & Ride and Inter-site" 99" bus service • Travel expenses claim process • Practical travel support to access services for those disadvantaged groups and impact on health inequalities • Additional services provided in-county to avoid out-of-county travel

[13] One of the Gunning Principles that have formed a strong legal foundation from which the legitimacy of public consultations is often assessed.

Capacity	• GRH capacity including beds and Emergency Department • Making the most of the CGH site • Impact of population growth on proposals • Impact of COVID-19 on separation of emergency and elective surgical services • Use of virtual technologies to support services
Facilities	• New hospital • Use of the hybrid theatre at CGH • Use of community hospitals to support services
Integration	• Increased co-operation with other regional hospitals • Partnership with community and primary care and the voluntary sector • Integration of Social Services and the NHS • Care of patients presenting with mental health problems in Emergency Department
Interdependencies	• Access to theatres • Colorectal surgery and emergency general surgery co-located • Separation of elective and emergency vascular surgery • Co-location of colorectal surgery with gynaecology and urology at CGH • Interventional radiology hub at CGH and spoke at GRH • Centralise all IGIS at GRH, no requirement for a spoke at CGH.
Pilot	• Publication of Trauma and Orthopaedic pilot evaluation information
Quality	• Training hospital • More information on infection control • Plans to improve services once re-located • Medical cover at CGH

7. Questions and Answers

Throughout the consultation a range of questions have been received from a variety of sources e.g. online discussion groups, Information Bus Tour, survey free text responses. The following questions (and responses) are representative of frequently asked questions.

Question	Response
Acute Medicine (Acute Medical Take)	
How are you going to ensure GRH will be able to cope with the increase in patients?	FIT FOR THE FUTURE is a long term strategic plan, which would take a number of years to implement. We are also investing in new facilities at both hospitals which will increase the number of patients we can look after. As part of the programme we are reviewing bed numbers across both sites to ensure that they align with the proposed change in services. If approved additional acute medicine beds would be provided at GRH.
If you move Acute Medicine, surely you will end up closing the A&E department?	We have made a public commitment to maintain the A&E department at CGH. The department will continue to provide Consultant Led A&E services 8 a.m. to 8 p.m. and a Nurse Led service from 8 p.m. to 8 a.m. This model of care has been in place at Cheltenham A&E since 2013. Under the FIT FOR THE FUTURE proposals, the same day emergency care service at CGH (which is provided by acute medicine and is consultant led) would extend from 8am to 6pm, Mon to Fri to 8am to 8pm Mon to Fri.
Are you closing the Acute Care Unit (ACU) in Cheltenham?	Under the FIT FOR THE FUTURE proposals this service would move from CGH and form part of an expanded Acute Medical Unit at GRH.
Presume staffing a single acute centre is easier than two making the care it can provide more consistent and 'guaranteed'. Is this the case?	Yes this is correct and a key driver for the change. Moving the acute medical take to one site would mean we have greater flexibility to cover staff rotas and provide a sustainable service.
Aspiration to excellence is essential but not	Our proposals are focused on creating

if this is considered zero sum - i.e. we can aspire to be a centre of excellence in A and therefore B will not be excellent. How are you proposing to ensure this does not happen?	Centres of Excellence at both hospital sites; for planned care and cancer at CGH and for emergency care, paediatrics and obstetrics at GRH. Through the centralisation of specialist services we would be able to utilise our resources (staff, buildings and equipment) in a more effective, efficient and sustainable way.
There are currently services which are already considered excellent: does the Trust know what these are and do the various plans consider that aspiring to excellence in one domain might strip an already considered excellent service of its status?	The FIT FOR THE FUTURE proposals aim to build on our services which are already considered excellent, for example cancer care at CGH and paediatrics and obstetrics at GRH, by using the same approach of centralisation of highly specialist services which allows us to utilise our resources (staff, buildings and equipment) in a more effective, efficient and sustainable way. There are no plans to change those services but rather learn from their experience to ensure that we have excellent services for the population we serve.
We know that to give patients a good experience at the 'front door' we have to have an efficient 'back door'. How are you going to support the hospitals 'back door' as this is as important as the 'front door'?	FIT FOR THE FUTURE focuses specifically on specialist services provided by the GHFT which includes the admission and discharge of affected patients. However, the Trust continues to work in collaboration with our local integrated care system to improve end to end care pathways across a wide range of services; this work is ongoing and complementary to the FIT FOR THE FUTURE programme.
We know that moving older patients and particularly patients with dementia multiple times is not good for their recovery. How can we make this better for this cohort of patients?	We are fully aware of this risk and do our utmost to minimise any unnecessary ward moves in patients with delirium and dementia unless the clinical situation or operational pressures make this imperative Our Staff are trained in supporting the care of patients living with dementia and aim to work in partnership with carers and relatives. We use a butterfly symbol to make all members of the team aware that a

	patient needs extra support. The butterfly symbol may be on the patient's medical notes and/or on their hospital identity wristband. We also support 'John's campaign.
What plans do you have to ensure patients are not moved multiple times between sites, or indeed, wards at each site?	As part of FIT FOR THE FUTURE programme we are identifying the number of beds required on both sites in order to support the proposed changes. We are also developing protocols to ensure that the best care is provided on both sites and that patients are not moved unnecessarily. In addition our Cinapsis system is helping GPs to have conversations with Consultants to determine if a patient needs to be seen in A&E, or admitted and if so which hospital to refer to.
Currently, the acute medicine facilities are woeful. What investment are you putting in to improve the acute medicine facilities?	Separate to FIT FOR THE FUTURE the Trust has a capital development plan to improve the space and layout of the Same Day Emergency Care and Acute Medical Unit facilities at GRH.
What are you offering Cheltenham to ensure it doesn't suffer as a town because you have made Gloucester your focus?	Our proposals are focused on creating Centres of Excellence at both hospital sites; for planned care and cancer at CGH and for emergency care, paediatrics and obstetrics at GRH. Through the centralisation of specialist services we would be able to utilise our resources (staff, buildings and equipment) in a more effective, efficient and sustainable way. Separate to FIT FOR THE FUTURE the Trust has a capital development plan to provide two new theatres and a day surgery suite at CGH. FIT FOR THE FUTURE proposes no change to the availability of outpatient services at CGH and we have made a public commitment to maintain the A&E department at CGH. The

	department will continue to provide Consultant Led services 8 a.m. to 8 p.m. and a Nurse Led service from 8 p.m. to 8 a.m. This model of care has been in place at Cheltenham A&E since 2013. Under the FIT FOR THE FUTURE proposals, the same day emergency care service at CGH (which is provided by acute medicine and is consultant led) would extend from 8am to 6pm, Mon to Fri to 8am to 8pm Mon to Fri. It is anticipated that FIT FOR THE FUTURE proposed changes would impact approx. 20-30 people a day i.e. these patients would need to travel to or be taken to GRH for their acute care.
Will the centralisation of the Acute Medicine take improve access to mental health services?	Similar to centralising acute medicine onto one site, the mental health team supporting acute medical patients would be able to concentrate their team that supports these patients onto one site giving them greater flexibility to deliver these services.
Are you going to increase the bed capacity at Gloucester so that it can cope?	FIT FOR THE FUTURE is a long term strategic plan, which will take a number of years to implement as it will require changes to estate (including ward and theatre capacity), workforce and equipment. As part of the programme we are reviewing bed numbers across both sites to ensure that they align with the proposed change in services.
How are you involving support services e.g. Pathology and Pharmacy in the planning?	Support services requirements have been factored into the design of our proposals and were included in the process of developing and appraising the FIT FOR THE FUTURE solutions.
Dropping off close to entrances is difficult, particularly A&E and finding a parking space is difficult at GRH. What are your plans, if	As part of the capital development programme at GRH, access to the A&E department will be improved. Whilst there

any, to improve and increase the access and parking facilities at GRH?	are currently no plans to increase parking spaces we regularly review the provision of public transport to help improve access to our hospitals.
Why has Cardiology not been considered in any of these plans?	Interventional Cardiology is included in this consultation (as part of the Image Guided Interventional Surgery (IGIS) service. Non interventional cardiology could be included in any future phase of FIT FOR THE FUTURE.
There are far too many elderly patients as outliers across the hospital; another care of the elderly ward would be beneficial. Are you considering the use of beds at CGH?	As part of FIT FOR THE FUTURE programme we are modelling the number of beds required on both sites to support the proposed changes. This modelling focuses on activity by specialty rather than existing bed numbers. The aim will be to avoid patients having to be admitted as 'outliers' to the wards of other specialties.
Gastroenterology inpatient services	
Has the recent pilot trialling this been successful?	Yes very. The service has been able to provide a better patient experience as patients are treated by the right specialists at the right time. Clinicians have been able to concentrate on sub-specialty work and have increased the number of endoscopy sessions and clinics. The pilot has worked well for junior doctor who have been able to undertake the specialist training required and improves staff retention and recruitment.
What are the results / outcomes of the recent pilot trailing this?	As above
Despite gastro inpatients being at CGH currently, gastro inpatients are still seen on GRH wards and do not get the care they need from the gastro team. Will you move patients to CGH to get the specialist care they need and care is not impacted?	Although the Gastro ward is based at CGH, there is an on call consultant and registrar at GRH to give timely opinion to patients coming into ED at GRH and also patients who require assessment and short term treatment can be seen at GRH. However if a longer stay for a more complex condition is required the patent will be transferred to the specialist ward at CGH.
Will there be some gastroenterology	As above

presence at GRH also?	
Would it not be better suited at GRH where other acute medical care is taking place?	As explained above there are clinicians at both sites, the transfer to CGH is only for those who need specific and complex gastrointestinal specialty care.
Do both hospitals not need a centre of excellence due to the size of the population and the location of the services? Will CGH be able to cope with demand for this service?	Gloucestershire Hospitals is a very large Trust but the number of patients who require treatment as an in-patient in gastroenterology is relatively small and co-locating the In-patient team on one site enables the provision of the best service.
Will colorectal surgery is also be located at CGH? Without this it will leave Gastroenterology exposed.	There are two options for colorectal surgery, one at CGH and one at GRH. In either option there would be a daily senior gastroenterology clinical team at both sites and so liaison with the colorectal team would continue whichever site colorectal is based.
Will you consider having continuing support for Gastroenterology services at Cirencester hospital?	Endoscopy and outpatient clinics, where most treatment is carried out will remain unchanged and continue to be provided at community hospitals.
Will Emergency Gastroenterology patients be admitted to ED at CGH once it's reopened? Otherwise you don't have a 'centre of excellence. You will have patients on both sites.	The ED at CGH is closed temporarily as a result of the COVID epidemic and the plan is to restore the previous service. The plan is for patients to be able to access the service at both sites.
Will Pathology be taken into account with these decisions? - especially Blood Transfusion	It is essential when services are re-organised that all support services are included as no service can run without input from colleagues. Before making the changes task and finish groups are implemented to involve all services that will be affected so that we have the assurance that they are able to provide the support. The pilot has run for 2 years and the service is running well.
Will this be a Proper centre of excellence? If you want to have a centre of excellence EVERYTHING to do with that area of medicine needs to be there, no half	The Specialist ward at CGH will be a centre of excellence for patients with complex conditions and the team will be co-located to provide this. However it is important that

measures.	those who require out-patient or short stay assessment and treatment have access to treatment nearer to home at CGH, GRH and Community Hospitals.
Describe centre of excellence as this term is being overused in the survey?	When specialist care is needed our aim is to increasingly deliver this through 'Centres of Excellence', centralised services where we can consolidate skills and equipment to provide the very best care. Sometimes these centres may be outside Gloucestershire, but where possible as an Integrated Care System we think it would benefit patients to develop our specialist services so we can provide specialist care in our county.
Will this service be easily accessible?	Yes patients would be assessed at both CGH and GRH EDs and out-patient clinics and endoscopy clinics would be maintained at all sites including community hospitals.
Is this not already in place?	The pilot was started 2 years ago but consultation is being sought to make this move permanent.
General Surgery (emergency general surgery, planned Lower Gastrointestinal [GI] / colorectal surgery and day case Upper and Lower GI surgery)	
How would you support those that need emergency surgery at CGH?	The proposal is for all emergency surgery to be located at GRH. If an ambulance is called the paramedics would review and would take the patient directly to GRH. If patients 'walk in' to CGH ED and need to be reviewed or referred to the surgical team there are existing Standard Operating Processes in place depending on how poorly the patient is.
Are patients that require emergency general surgery fit to travel between sites?	As above.
Why can there not be this service offered at CGH too?	There are a number of very high risks involved with continuing to provide emergency general surgical services at both sites, they are: • There are not enough junior (trainee) doctors to cover rotas on both sites

	and there is negative feedback from trainees about their workload. • In a 7 month period in 2019 15% of shifts (390) for emergency surgery were not covered. Gaps in rotas have increased by 46% in three years. • At times senior doctors are in theatre an unavailable to review you if you are waiting for specialist assessment in the ED or surgical assessment unit. This leads to delays. All these issues would be resolved by moving to one site.
Will the bed capacity at GRH be able to cope with this? How will you ensure surgical patients are not outliers on other wards?	Bed capacity is being modelled; services would not be moved permanently before bed capacity is established.
Will GRH A&E be able to cope with the increase in emergencies?	The service has moved as part of the COVID changes and already we have seen the ED process improve with higher percentage of patients seen quickly. This is because there is a dedicated senior team of clinicians that are not rostered to be in theatre and can give a specialist opinion. There is also a surgical assessment unit to provide timely assessment and treatment, which means patients often don't need to be admitted to a bed.
Will there still be surgical cover at CGH even after centralisation?	There will still be surgery carried out at CGH, urology, gynae-oncology, elective orthopaedics, breast surgery and day surgery. Elective colorectal surgery is being discussed as part of the programme with options for centralisation at either CGH or GRH. There will still be an out of hours theatre team on call at CGH, to provide care for patients who need to return to theatre with complications. There are Standard Operating Processes in place to ensure a patient is reviewed by or referred to the surgical team depending on

	how poorly the patient is.
By making this change will you be able to protect planned surgery and reduce the number of cancellations especially those cancelled on the day?	Yes, particularly for those who are planned to have day case surgery as in times of very high demand sometimes it is necessary to use beds in the day surgery ward at GRH for in-patients. By moving this work to CGH where a new designated day surgery ward and two new theatres are to be built, this should reduce cancellations and improve patient experience.
How many will this change affect per year – i.e. how much emergency general surgery is performed each year?	In the year Feb 2019 to Jan 2020, 5,782 people underwent emergency general surgery. Of these 1,753 were carried out at CGH. An impact assessment has been undertaken to assess the travel impact, it shows: • For 74 patients who had emergency surgery at CGH the transfer to GRH would be positive • For 1,342 patients who had emergency surgery at CGH the transfer to GRH would be neutral • For 337 patients who had emergency surgery at CGH the transfer to GRH would be negative
How are you going to increase the bed availability at GRH to manage this?	FIT FOR THE FUTURE is a long term strategic plan, which would take a number of years to implement. We are also investing in new facilities at both hospitals which will increase the number of patients we can look after. As part of the programme we are reviewing bed numbers across both sites to ensure that they align with the proposed change in services.
How are you going to ensure CGH theatre staff maintain their skills in emergency surgery?	Many staff work on both sites already and often this is done to gain experience in different fields. When the final decisions are made all affected staff would be involved in discussion to assess the best area for them to work with regard to their personal situation and training and experience.

How will you minimise the number of times patients are moved between each hospital or between wards at each hospital?	For people undergoing elective (planned) surgery, the site would be specified. For those who are emergency admissions; if they arrive by ambulance they would be taken to GRH directly. The patients that may need to travel are those who 'walk in' to ED at CGH and after assessment are found to require hospital admission. These patients will be transferred to GRH.
Will there be enough parking at GRH for the increase in people going there?	There is more car parking available on the GRH site as the Trust gained permission to build a multi storey car park. On the GRH site there are a total of 11 car parks providing 1,854 car parking spaces, of which 532 are public, 1208 staff and 87 spaces available for blue badge holders (DDA). On the CGH site there are a total of 11 car parks providing 741 car parking spaces, of which 192 public, 437 staff and 40 Oncology patient car parking spaces with 56 spaces for blue badge holders.
What are the financial implications of this move?	There are no changes anticipated to income or workforce and so the financial impact is neutral
How are you going to measure if this change has been successful in improving patient and staff experiences and outcomes?	There are a wide range of quality, outcome, patient and staff performance measures that are monitored to assess the impact of any changes. In addition there are currently 5 items on the GHFT Risk Register with regard to emergency general surgery which would be monitored; they are: • A risk of unsafe surgical staffing caused by a combination of insufficient trainees and excessive work patterns. • A risk of patient safety caused by insufficient senior surgical cover resulting in delayed senior assessment and treatment. • A risk to safe service provision caused by an inability to provide an

	appropriate training environment leading to poor trainee feedback which could result in a reduction in trainees and therefore adversely impacting on the workforce. • A risk of sub-optimal care for patients with gall-bladder disease and other sub-specialty conditions caused by a lack of ability to create a sub-specialty rota which could result in inequitable care and different clinical outcomes. • A risk of sub-optimal care caused by the limited day time access to emergency theatres resulting in an increased length of stay and poor patient experience.
Why can't you build a new hospital in the middle?	Over a billion pounds would be required and although Gloucestershire County Council does have this as a goal for the future, it would take 12-15 years to deliver. It in meantime we need to provide the best care with the resources that we currently have.
Will you consider the support services when you make this change for example Pathology?	This is a really important point, no service can move without the support of other services. During the months before the start of the pilot weekly task and finish meetings were held with all associated services, pathology, pharmacy, therapy, theatre, nursing, radiology and the emergency department to ensure that SOPs were in place and rotas etc. had been amended to reflect the changes.
How will you ensure resilience when you have an outbreak of Norovirus or Covid and have to shut wards?	This would not change, sadly these outbreaks can and do occur at either site. There is a dedicated infection control team who advise on a daily basis with the optimal way to segregate and treat patients who have or are exposed to these infections.
Have you been working with the ambulance service when looking at these changes?	Yes, we have been working closely with the ambulance trust to ensure that all options

	are deliverable.
What will there be about CGH to attract anybody to work there, if surgery is removed from Cheltenham altogether?	There are no proposals to remove surgery from CGH altogether. Surgery for urology, gynae-oncology, elective orthopaedics, breast surgery and day surgery will be based at CGH. Elective colorectal surgery is being discussed as part of the programme with options for centralisation at either CGH or GRH.
Which hospital is safer, Gloucester or Cheltenham?	Both are safe, all service moves are carefully considered and safety is of paramount importance. If the executive team and external agencies are not reassured that a proposal is safe, it would not be considered.
Haven't you already made the decision about where you are going to locate services?	There is a preferred option for emergency surgery which is at GRH and for day surgery at CGH. These recommendations come after significant work to assess the best options by assessing the patient benefits of co-locating services. As there was not a preferred option for elective colorectal surgery, either CGH or GRH, both were included in the consultation; the feedback of which is carefully considered before decisions are made on any permanent changes.
Image Guided Interventional Surgery (IGIS) including Vascular Surgery	
Are you going to invest in the theatres at GRH to provide an environment at least comparable to that already in Cheltenham?	Yes. We would convert theatre capacity at GRH to a 'hybrid theatre' facility to allow complex endovascular procedures to be undertaken. The existing hybrid facility at CGH would be converted to a standard theatre.
How are you going to ensure there are enough beds at GRH to manage the extra demand?	FIT FOR THE FUTURE is a long term strategic plan, which would take a number of years to implement. We are investing in new facilities at both hospitals which will increase the number of patients we can look after; for example 41 additional beds at GRH as well as improved day case theatre facilities at CGH.
Are you planning to invest in the ward space	Absolutely. It would be important to ensure

for this patient group if this change goes ahead?	services are allocated a sufficient number of beds to manage their patient throughput, and that these beds are within an appropriate environment which supports the delivery of excellent care.
Why did you invest in a hybrid theatre in Cheltenham to then decide to move the service?	In 2007 the decision was taken to centralise Vascular Surgery. At that time an options appraisal was undertaken to consider the benefits of centralisation at either CGH or GRH. CGH was selected as the preferred location. The proposal we are now consulting on to relocate the Vascular arterial centre (regional hub) to GRH is in consideration of the current and proposed configuration of services. Critical to this is the relationship with general surgery, the benefits of centralising emergency general surgery at GRH, and the requirement for general surgery staff to form part of the on-call surgical rotas for Vascular Surgery. The Hybrid facility in CGH was installed in 2013, and the technical equipment within it is now reaching its planned end of life.
Will the proposed change mean that planned vascular surgery is less likely to be cancelled?	The proposals are to relocate the vascular arterial centre and inpatient bed base to GRH. This would mean that complex endovascular surgery and vascular surgery patients requiring an overnight stay in hospital would take place in the safest environment, with other emergency services available to assist at the same location 24/7 should complications arise. Approximately one third of surgical interventions undertaken in vascular surgery are conducted as day cases. Elective day case procedures would be undertaken at CGH in the new Day Surgery unit, allowing these vascular patients to benefit from the Centre of Excellence for Elective Care.
Do these proposals cover all of vascular or are you going to split emergency and	These proposals would move all emergency vascular work to GRH. Any vascular

planned between the two hospitals?	procedure requiring an overnight stay would also be undertaken at GRH, as well as complex surgery and endovascular surgery requiring the hybrid theatre facility. Approximately one third of our vascular procedures are undertaken as day cases and these would be conducted at the new Day Surgery unit at CGH.
Why are you centralising vascular at GRH and leaving cardiology at CGH?	Interventional cardiology is part of the FIT FOR THE FUTURE Phase 1 scope and it is proposed this is located at GRH with vascular surgery. The wider cardiology service is expected to form part of the FIT FOR THE FUTURE Phase 2. All configuration scenarios will be considered during this process and appraised in order to determine the preferred configuration.
Trauma and Orthopaedics (T&O) inpatient services	
1. Trauma and orthopaedic need to go together. It would be VERY confusing to split them. You've GOT to start treating this as one hospital over 2 sites; not 2 different hospitals. EVERYTHING trauma and orthopaedic at Gloucester. How will this work across 2 sites with transferring patients and ambulance admissions? And 2. Because the two are so closely linked, why not have one Centre of Excellence in one place? 3. Why are these separated at two sites? Are they not related, so should be together on one site?	The orthopaedic service has always been divided into two categories, trauma and elective (planned) surgery. Although there are some similarities the two work quite differently and have completely separate wards (even on the same site). The reason for this is that for many orthopaedic operations, for example joint replacements need ultra clean environments to prevent infection, so the elective wards are ring-fenced for this group alone and patients have stringent tests for MRSA, MSSA and COVID 19 before admission. Separating facilities for emergency care (from planned care) would ensure that, if you have a life or limb threatening emergency, the right facilities and staff would always be available to give you the best possible chance of survival and recovery. Conversely separating the elective (planned) surgery would mean a smaller chance of cancellation at short notice. It would also be impossible to have the

	whole service on one site as the infrastructure does not allow this. 8 laminar flow theatres would be required on one site.
I think it makes sense to have trauma on one site but there needs to be adequate orthopaedic cover for the other site. Will this happen?	This is a very important point. The pilot was started at the end of 2017. The majority of the out of hours team will be working with the unscheduled or Trauma site. However it is essential that the elective site is also fully covered. There is a separate doctor rota at the elective site together with a team of dedicated nurses, therapists, pharmacists, radiographers and extended scope practitioners. In the early days of the pilot we also started a daily ward round for elective patients as we felt there was a gap in service provision.
Will sites be able to cope with capacity?	Yes, the service is very large and was previously spread across the site so was able to refine the service within the existing footprint.
Are both sites fit for purpose?	Yes, but centralising the service onto separate sites is really just the beginning; it provides the foundation to build for the future. For example the service has continued to evolve with Enhanced Recovery after Surgery work and rationalisation of surgical equipment in elective surgery and the implementation of a Trauma Assessment & Treatment Unit within Trauma services
Has the recent pilot trialling this been successful?	Yes, many things have improved for example: Trauma: • Now there is a review of every trauma patient 24/7. • There is always a senior orthopaedic surgeon available to respond to patients in ED. • The feedback from junior doctors regarding training is much improved Elective: • There are significantly fewer

	cancellations • There are increased volumes of hip and knee surgery (until theatre refurb in 2019 and COVID in 2020) • Changes have facilitated improvements in ERAS. However the service continues to evolve and improve with the provision of Trauma Assessment & Treatment Unit and responding to the needs of the patients and staff.
Will Pathology to be taken into account with these decisions - especially Blood Transfusion?	This is a really important point, no service can move without the support of other services. During the months before the start of the pilot weekly task and finish meetings were held with all associated services, pathology, pharmacy, therapy, theatre, nursing, radiology and the emergency department to ensure that SOPs were in place and rotas etc. had been amended to reflect the changes.
Only makes sense if full A&E restored at Cheltenham?	There is a national trauma network in place. For Gloucestershire the Trauma Centre is in Bristol but Gloucestershire Royal Hospital (GRH) is designated a Trauma unit. Therefore the only patients attending Cheltenham General Hospital (CGH) for a trauma injury will be those who 'walk in' or those that the ambulance teams have assessed can be managed at CGH. There are well established operational policies in place to manage any patients that need to be transferred from CGH to GRH for admission.

8. Evaluation

8.1 Considerations and learning points for future engagement and communication activities

Our approach to evaluating the effectiveness of our consultation activities locally is to apply a well-known quality improvement methodology, using an iterative process: Plan, Do, Study, Act (PDSA cycle) https://improvement.nhs.uk/documents/2142/plan-do-study-act.pdf

We have applied the following evaluation framework.

Engagement (and Consultation), Experience and Inclusion Evaluation Framework developed by The Science and Technologies Facilities Council has developed a useful engagement evaluation framework, https://stfc.ukri.org/files/corporate-publications/public-engagement-evaluation-framework/ We have adapted this to support the STUDY element in our Engagement, Experience and Inclusion PDSA Cycle		
Dimension	Definition	Response
Inputs	Engagement (and Consultation), experience and inclusion inputs include the time, skills and money that are invested into delivering engagement activities.	A comprehensive Fit for the Future communications and consultation plan was developed to support the consultation activity. This plan, assured by NHS England/Improvement and independently by The Consultation Institute, set out the approach to communications and consultation. In response to pandemic restrictions, the plan was developed to support a 'socially distanced' consultation. This included the development of more online methods such as the new Get Involved in Gloucestershire online participation platform; independently chaired Gloucestershire Media @GlosLiveOnline discussions and Gloucestershire Hospitals NHS Foundation Trust Facebook Live produced clinical discussions. The plan was evaluated using an Engagement and Equality Impact Assessment https://www.onegloucestershire.net/wp-content/uploads/2020/10/Equality-and-Engagement-Impact-Assessment-FINAL-1.pdf
Outputs	Engagement (and consultation), experience and inclusion outputs are the activities we	Over 75 engagement events were held. The majority of events were held on line. The Information Bus Tour were socially distanced face to face events. Approximately 5000 information booklets were produced and distributed in local communities.

	undertake and the resources that we create.	A door to door drop of 297,000 delivered information to households in Gloucestershire. This resulted in over 1,700 requests for information. This was a key method for ensuring that people not able to access materials on-line were able to engage with the consultation. Feedback received did include comments on the Fit for the Future communications and consultation process itself. Feedback received was a mixture of positive and negative comments. An example of learning from feedback of this kind from the earlier Fit for the Future engagement was the suggestion to use of QR codes on future publications to allow people to link quickly to website materials. A QR code was added to the Fit for the Future consultation materials.
Reach	Reach has two main elements: The number of people engaged, this includes attendance at events, completion of surveys, social media interaction etc. The types or diversity of people engaged.	Total face-to-face contacts was more than 1000 (public) and more than 350 staff. More than 700 Fit for the Future surveys completed. There were 22 Facebook posts with a reach of over 90,000. 38 tweets generated over 30,000 impressions and over 750 engagements. We do not routinely collect demographic information about individuals participating in events/drop-ins etc. Demographic information was collected through our survey, but these questions were optional and consequently were not always completed. However, the demography of the county is considered during consultation planning and events/meetings targeted to reach a wide range of communities of interest and those groups identified though the independent Integrated Impact Assessment.
Outcomes	Outcomes are the way that audiences respond to the engagement, experience and inclusion activity – completed event evaluation forms,	The consultation has been independently Quality Assured by The Consultation Institute. A Consultation Institute Advisor worked with the Fit for the Future programme, acting as a critical friend; each stage of the consultation planning and activity was formally signed-off by a Consultation Institute Assessor, ensuring a totally independent element in the consultation process. The six stages, or gateways, of the Quality Assurance process are: • Scope and Governance • The Project Plan • Consultation Document Review • Mid-Point Review*

	independent observation reports	• Closing Review • Final Report *The Mid-Point Review considered the efficacy of the consultation activities to date and those planned for the second half of the consultation period to identify any potential gaps in opportunities for participation. Prior to the Mid-Point review Covid-19 Lockdown#2 necessitated the postponement of some Information Bus Tour Dates, alternative locality online 'Cuppa and Chats' were arranged to provide opportunities for geographically based participants to discuss the consultation proposals. The Information Bus Tour recommenced after the end of Lockdown#2
Processes	Processes are the way we work to plan, develop and deliver our engagement, experience and inclusion activities. They include our approaches to quality assurance and following good practice.	See above The Consultation Institute Quality Assurance process. Inclusion Gloucestershire: Assisted with the development of Easy Read materials. Gloucestershire County Council's Digital Innovation Fund Forum: Informed early planning for online activities and assisted with awareness-raising of the consultation to potentially digitally excluded groups. Friends from the Friendship Café in Gloucester City: Supported awareness raising and survey completion within diverse communities. Healthwatch Gloucestershire (HWG): HWG Readers Panel reviewed an early draft of the full consultation booklet and made suggestions for changes, which were incorporated into the final version. A HWG representative will be a member of the independent Oversight Panel for the second Fit for the Future Citizens' Jury. Aneurin Bevan Health Board (ABHB): ABHB facilitated the translation of the summary consultation booklet into Welsh, and facilitated an Information Bus visit to Chepstow Hospital in Monmouthshire to enable residents living close to the Wales England Border, who might access services in Gloucestershire the opportunity to find out more about the consultation.

		Know Your Patch (KYP) Coordinators: KYPs allowed us space on agendas to share information at online meetings during October and November 2020 to promote the consultation. District/Borough Councils and Retail partners: Supported the 'socially distanced' visits of the Information Bus (outside of Lockdown 2) to locations with maximum footfall across the county. District and Borough Councils also hosted members' seminars to discuss the Fit for the Future consultation. Local media: Gloucestershire Live, BBC Radio Gloucestershire and GFM Radio Others: Many other groups and individuals have helped to raise awareness of the consultation such as Trust Governors, staff-side representatives, hospital volunteers and community and voluntary sector organisations such as homelessness support charities.

8.2 ACT (following Fit for the Future engagement)

The following actions were undertaken following feedback received during the FIT FOR THE FUTURE engagement to support future communications and engagement associated with FIT FOR THE FUTURE Programme:

Inclusion Gloucestershire participants identified the following areas for us to consider to improve engagement further (extract from Inclusion Gloucestershire Engagement Report):

- Less information, less jargon and easy read copies of all information.
- From our experience, people who represent the seldom heard groups tend to need more time and preparation to support them to engage. It would have been helpful to have had at least two weeks research time prior to each area workshops.
- Workshops to be held later in the morning to enable people who use public transport to use their bus passes.
- Workshops to be held in the actual areas and at times that people can attend. For example: Tewkesbury was held in Highnam for 09.00am, Stroud and Berkley Vale held in Nailsworth for 09.00am and North Cotswolds was held in Cirencester for 09.00am.
- Some people from the BME communities were not able to engage in the workshops due to a language barrier. Going forward it might be more beneficial to liaise with community leaders to hold specific workshops within the BME communities with community support for interpreters. We know that there are many barriers for people from the BME communities accessing health care. For many, they don't know how to ask for the health care that they need or struggle to understand treatment options.

- For One Gloucestershire to go out to community groups such as the Inclusion Hubs for those who need to go at a slower pace and for a wider group of people to be included in the process.

8.3 ACT (following Fit for the Future consultation)

The following actions will be undertaken following feedback received during the Fit for the Future consultation to support future communications and engagement:

- The consultation targeted the **visually impaired** people through representatives from the Sight Loss Council, the Macular Society and RNIB. The following suggestions were shared with the consultation team in order for them to reach more people with Visual Impairment:
    - Place adverts in Talking newspapers
    - Use BBC local radio
    - Focus on promotion of telephone line and ability to order large print copies of the booklet
    - Focus on voice based/telephone based contact as most of people with visual impairment don't use desktops/laptops and rely on mobile phones.

- The consultation targeted the **homeless people;** the consultation team now has established good links with homelessness charities in Gloucestershire, these networks should be maintained and development further through links with the Gloucestershire Hospitals NHS Foundation Trust Homeless Specialist Nurse.

- The consultation targeted **travelling communities;** the consultation team now has established good links with the County Council Traveller Welfare Officer. Plans to improve communications for travelling communities about local NHS services are planned for 2021.

- The consultation used more **online participation methods** than ever before. These proved to be very popular with groups who may not have engaged with consultations before and facilitated easier access to more people who may not have previously been willing or able to attend face to face events. The One Gloucestershire Communications and Engagement Sub Group will review the current online methods available and consider opportunities for maximising their use for future engagement and consultation activities; in particular use of a range of online platforms will be explored to maximise choice and access.

9. Copies of this report

This report is available on the One Gloucestershire website at:
https://www.onegloucestershire.net/yoursay/
and on the online participation platform Get Involved in Gloucestershire
https://getinvolved.glos.nhs.uk

Print copies of the report can be obtained from the NHS Gloucestershire Clinical Commissioning Group Engagement and Experience Team by calling:
Freephone 0800 0151 548
or email: GLCCG.participation@nhs.net

To discuss receiving this information in large print or Braille please ring **0800 0151 548.**

To discuss receiving this information in other formats please contact:

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FREEPOST RRYY-KSGT-AGBR,
PALS, NHS Gloucestershire Clinical Commissioning Group, Sanger House, 5220 Valiant Court, Gloucester Business Park Gloucester GL3 4FE

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FREEPOST RRYY-KSGT-AGBR
Fit for the Future, Sanger House, 5220 Valiant Court,
Gloucester Business Park, Gloucester GL3 4FE

Print date: January 2021

Fit For The Future - What matters to you?

Full report – quantitative and qualitative data

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

		Response Percent	Response Total
1	Strongly support	36.07%	215
2	Support	31.54%	188
3	Oppose	11.24%	67
4	Strongly oppose	13.59%	81
5	No opinion	7.55%	45
		answered	596
		skipped	28

Please tell us why you think this, e.g. the information you would like us to consider (299)

1	If its means reliable and consistent access to specialists regardless of the the day or night then it deserves full support.
2	Gloucester hospital is renowned for putting the fear of God into people when they have to go there for care, removing options for Cheltenham - especially during a pandemic seems insensitive to say the very least. We live in Stroud but have previously chosen to drive to A&E in Cheltenham to avoid GRH. I think there should be a lot more work going into trust in our services and more specifically the paper pushers at CCG before trying to garner support for another master plan that will inevitably cost trillions, be done without consent and have frustrating outcomes for patience and staff.
3	Gloucester itself is simply not big enough to accommodate current demand yet alone the additional 5,000 plus hour being built in Cheltenham in the next few years!
4	But needs much bigger a+e at GRH
5	Many patients do not have transport and will be unable to travel to the 'alternative' hospital.
6	There should be one at Cheltenham General also
7	It would make sense to send sick medical patients to a single site where a full team can look after them rather than patients going to two different sites where they experience long wait times on AMU because the clinical rotas have lots of gaps.
8	All acute work should be on one site.
9	Very misleading question. I would doubt anyone will not want a centre of excellence, but more importantly how will this impact the other services
10	need to put all the expertise in one place 24/7
11	How would you support acute medical at CGH and that side of the county? Increasing travel time for a seriously unwell patient
12	Centre of excellence as opposed to two try hards
13	It will be easier to manage 24/7 and we will be able to afford the best equipment if only one piece is needed instead of several.
14	AMU should be spread across both sites to prevent a bottle neck where we are changing wards such as gynaecology into a amu. It is not appropriate for women going through tough times and having to have miscarriages in bays with patients from other specialties. It violates privacy and dignity and is heartless, but no other choice due to hospital management.

Please tell us what you think about our preferred option to develop: A 'centre of excellence' for Acute Medicine (Acute Medical Take) at Gloucestershire Royal Hospital.		Response Percent	Response Total
15	In a county this size , with the shortage of doctor and nurses we need to ensure that we have the safest care available and to do this efficiently as possible we need to have services centred on one site , in acute medicine GRH is the preferred site. This will not be popular with Cheltenham people but they have to accept that they will never ever have a fully functioning hospital on their site .		
16	There needs to be acute medical services at CGH also.		
17	From a staffing perspective, the difference to the acute medical staffing is much better having it centralised. However, I do think that there needs to be some kind of pathway for cardiology admissions; they currently have to go from AEC to ED GRH when they have been post taked by a consultant, just to come back to Cheltenham the next day.		
18	As things are, without increased levels of staffing on medical wards, numbers of staff on each shift will just continue to be inadequate/bordering on unsafe. It will be inpossible to provide holistic care.		
19	This already works well with the acute medical take at GRH and all patients can be seen within the 14 hours that has to be a great improvement. Patients not being seen means their stay may be longer and their recovery poorer. It is frightening as a patient or relative if you are waiting sometimes days to be seen or reviewed and this would prevent that so a definite yes from me.		
20	Especially with COVID it is sensible to centralise this service.		
21	I think at the present time (ie in the middle of a pandemic) it is sensible to concentrate all acute services on one site and ALL elective services on the other.		
22	Both hospitals need to be able to assess and treat from both A +E departments. Currently Cotswold patients are having to be admitted to GRH meaning extra journey time for them and their families. Transferring Stroke and elderly patients back to CGH is not ideal and would be better being able to being able to provide holistic care for patients on both sites as we have done well for some time.		
23	I think it should be split between the 2 hospitals so that you can go to the nearest hospital to where you live. I see no reason that both hospitals can not have enough or share staff so that this can happen		
24	To centralise services in one place. To have the specialist equipment and staff on one site.		
25	Damaging effect on the local community, as it disproportionately affects vulnerable individuals with protected characteristics. Concerns about bed space at GRH. Concerns about a bottleneck effect at GRH - if you double the amount of traffic, you need to double the width of the road, ALL roads, leading in and out. Leading on to concerns about the lack of funding for SWAS as per their financial outlook to provide the additional ambulance service coverage. Flawed notion of attracting high quality staff from a business/management perspective. Gloucestershire's market has competitors in Bristol, Birmingham (to an extent), Oxford, and of course London. Centralised services will not enable GHNHSFT to outcompete these, leaving us with 'the best of the rest'. This would have been the case whether centralisation occurred or not, thus centralisation itself is a moot point. Flawed concept of 'extra time' to care. This will inevitably lead to cost savings (perhaps instructed by ministers, and not immediately) by reducing staff numbers to provide current levels of care, only now at one site.		
26	I think the gastrointestinal ward should be bk in Cheltenham as I have a stoma and Gloucester hospital is far from me		
27	Bed demand at GRH already very high in comparison to CGH; consolidating all of medical take to GRH would sustain or even increase this demand. It is hard to see how the current situation, even pre-winter demands and Covid resurgence, can be maintained without regular black escalation statuses and ""clearing the decks"" of patients to CGH. Patients seen at CGH ED would need to be transferred to GRH if they needed an AMU bed.		
28	There's no point, the trust is focusing too much on the 'front door' and acute medical unit! What about the rest of the hospital, not good for pt. flow is the other services aren't looked at properly! Also not everyone lives in Gloucester, this is not their nearest hospital!		
29	GRH will be overwhelmed. Unable to provide ""excellent"" acute care at present even since acute take moved there under ""temporary"" Covid changes.		

Please tell us what you think about our preferred option to develop: A 'centre of excellence' for Acute Medicine (Acute Medical Take) at Gloucestershire Royal Hospital.		Response Percent	Response Total
30	Gloucester Hospital cannot cope with Cheltenham patients - while I was in Gloucester with my Dad the relative of someone fainted as they had nowhere to sit and were enduring a long wait with their relative in the corridor. People were sitting on the floor - very shabby we need both Cheltenham and Gloucester hospitals working a full range of services as they have always managed in the past:		
31	There aren't enough staff to go around, so we need to make best use of those we have.		
32	It's not clear what services will be 'removed' from GRH in order to accommodate a CoE. Also by locating a major single service at one of the two hospitals doesn't address the increased time to travel for patients from the East of the County, the parking inconvenience (every part as bad at GRH as CGH, or cost of travelling further. Equally it does seemingly support (perceptibly at least) the downgrading of CGH A&E more permanently which is already and will continue to be an appalling decision.		
33	As a clinician having worked in the acute sector predominantly at CGH I can not support the aim to centralise acute services at GRH strongly enough- doing so will enable a much higher level/ standard of care to be provide to all patients requiring acute care and will also improve the experience of our trainees working in this environment. The latter will then hopefully increase the attractiveness of working in the trust and/ or the acute sector of the trust to future junior and senior doctors.		
34	GRH cannot cope with current level of acute medical admissions and we have not yet reached the Winter. Regarding retaining staff, both medical and nursing, the Trust appears to be steam rolling ahead with implementing it's changes to services regardless of how staff feel. At least 3 acute medical consultants at CGH have been lost to other Trusts due to the Trust's disregard for them: of course there is a shortage of Consultants because the Trust doesn't care about them and won't admit that it has made mistakes. the Trust board ultimately has it's own interests in mind i.e. to implement it's changes. Nursing staff have been subject to managers that have been extremely economical with the truth. Established, skilled teams have been pulled apart, often at short notice, under the guise of ""temporary"" measures, timescales which have been increased. It is quite obvious the Trust has no intention of reinstating acute medicine. The Trust needs to be honest with staff and tell them that this is probably the case rather than being evasive and sly.		
35	I would prefer to go to a site where the specialists are, rather than a hospital that is nearer but there are less staff available		
36	It is not clear what this actually means. Does it mean A&E will not be available in CGH?		
37	this is completely unsafe and ludicrous		
38	We need an A+E and an acute care unit at Cheltenham general hospital.		
39	this move is completely unsafe and a silly move the organisation. Cheltenham needs an amu too.		
40	unsafe for patients		
41	Cheltenham needs an acute care ward. how can you have a functioning a and e, which the trust keeps on insisting it will have at Cheltenham with no where for the patient to go after initial treatment? putting sick people in ambulances to grh is ridiculous. making the public believe they will have an a and e when they will have a sub par service is deceitful		
42	stupid idea how can a county this size have no medical take in cheltenham		
43	Makes sense as A&E located there		
44	Cheltenham is a large town that deserves an ED and Acute medical intake. Previous to this change Gloucester would on a regular daily basis divert either their GP and acute admissions to CGH ACUC as GRH could not cope with the high demand of patients. I feel the care is unsafe and compromised as a result of the change. Cheltenham ED and ACUC would receive patients from the Cotswolds which is an ageing population who relied on CGH service.		
45	Presume staffing a single acute centre is easier than two, making the care it can provide more consistent and 'guaranteed'. Only reason my response is 'Support' and not 'Strongly Support' is the extra 10 miles I would need to travel.		
46	The provision for Emergency, consultant led 24/7 care on the East of the County is essential for best outcomes for the aging population given how overcrowded Glos A&E is. Therefore anything which doesn't re-provide the highest tier of A&E at CGH puts patients at more immediate risk of poor outcomes IMO.		

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47	Coming from Cheltenham and having spent over 30 years working in CGH before moving to GRH, I am quite saddened that CGH seems to be the 'poor relation' and while I understand that for many reasons, services need to be streamlined and centralised, it's hard not to feel upset at certain changes.		
48	A centre of excellence is a title conferred on a centre by other institutions and is not something you can simply decide to be. Aspiration to excellence is essential but not if this is considered zero sum - i.e. we can aspire to be a centre of excellence in A and therefore B will not be excellent. Also there are currently services which are already considered excellent : does the Trust know what these are and do the various plans consider that aspiring to excellence in one domain might strip and already considered excellent service of its status?		
49	Focusses resources in one place and should be located where ED is located		
50	Please consider the effect this will have on the large number of elderly, frail patients admitted,(and readmitted) who are often MSFD early on but have multiple moves within GRH and CGH before eventually transferring out of hospital.(recent example: 89 yr old with advancing Parkinsons Disease and increasing frailty admitted for 5 days and had 5 moves: ED/AMU/7A/Snowshill/Bibury. Family were contacted when in AMU and happy to have him home from AMU). This is not uncommon.These moves have a deteriorating effect on cognition, general physical functioning and continence. How can we make this better for this cohort of patients? Consider direct to FAS/AMU then transfer to specialist Elderly Care Ward. Also please consider use of beds at CGH: Ryeworth is the only specialist COTE ward,far too many outlying COTE pts across Bibury/Cardiac2/Knightsbridge. Consider reinstating a second COTE wards at CGH. Our 'back door' is as important as out 'front door'.		
51	localised care rather than having to transfer out/ redirect ambulances at great cost and challenge to the patient		
52	Far too far away from Fairford to be a good option for patients from that town/area		
53	Enables acute medical team to focus their resource on one site rather than being split and struggling to cover both hospitals.		
54	it makes sense to have a collection of acute medicine departments in a single place. But these do need to be fit for purpose and fit for the 21st century, neither site currently is fit for purpose		
55	there is nothing in the questionnaire relating to cardiology. But the booklet clearly states amalgamating cardiology and cath labs with other radiology procedures. these are NOT the same, they are specialised and individual. This would break up any cardiology teams who foster good relations with other disciplines and work very well together. A general recovery area for these patients would be detrimental to their care and knowledge the staff hold diluted to basic and not the high standard of care we give at the moment. - its a bonkers idea. Why is cardiology constantly treated like the poor relation and not one of the jewels in the crown. why not try to create a cardiac centre of excellence?? its an increasing issue with increasingly younger patients. we do not service the population of Gloucester well without a Cardiac Centre of excellence. please don't shoehorn cardiology within radiology - isn't good and generalist staff haven't worked elsewhere. It has been tried and didn't succeed. staff will leave and will reduce staff and patient wellbeing alike.		
56	Too Gloucester central, what about those of us who live to the East of the County?		
57	More expertise on one site and better care		
58	Cheltenham should remain an acute general hospital		
59	Services provided at Gloucestershire Royal Hospital and Cheltenham General Hospital should not be duplicated. Either one or the other facility should provide a specific medical speciality.In that way the specialist teams will be concentrated on one site		
60	It would be problematic for rural locations, travel, job continuity and economic health in and around CGH		
61	this move has made it very unsafe for patients as grh staff just cant cope with the high volume of patients they are getting. The worst move they have decided to do.		
62	good to have all services in one place.		

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63	Its a great idea in paper apparently due to severe lack of medical bed capacity in the current situation its impossible to be a centre of excellence. Also without medical admission in cheltenham general hospital the ideology of ED is impossible as most of the cases presenting to ED is medical who may or may not need admission. Elderly people are most affected.		
64	Having a more centralised provision will be more beneficial to patients.		
65	I cannot see any reason to make a case against it		
66	I strongly believe in centres of excellence and to me it is clear that the GRH is the only site for such a service. One significant factor is the possibiliyy of more timely access to Mental health services		
67	At present all medical take is at GRH and therefore at CGH we get all the medical patients that are difficult to manage and that GRH do not want. By having medical take at both sites the types of medical patients are more evenly spread.		
68	If it is a place where future care via a plan is determined it must be good.		
69	We need to concentrate our resources for acute medicine on one site.		
70	Members of the public having to travel over to GRH. Not everyone has access to a car, can afford a taxi or easily access the bus service.		
71	Gloucester hospital is at full capacity as it is and is barely able to cope. As it stands, Cheltenham and the surrounding areas are already clamoring for a fully working hospital of their own.		
72	Services provided by Gloucestershire Royal Hospital and Cheltenham General Hospital should not be duplicated. Either one or the other should provide specific services. This is the best way forward so that specialist teams can be based on one site		
73	Would require adequate staffing and physical space which maybe easier to achieve located on one site		
74	lbecause you seem to be reducing services at Cheltenham General Hospital in favour of Gloucestershire Royal. This hospital is already stretched to the limit. It is in a most difficult place in Gloucester with very limited parking and for people north of Cheltenham it is a long journey		
75	In theory it sounds good but I worry that the bed capacity in grh is not enough to get patients through safely		
76	GRH would get overloaded as is the case with ED		
77	Would better serve our large catchment area and reduce requirement for travel to alternative sites (Bristol, Oxford, Worcester)		
78	I believe we need a dedicated Accident and Emergency facility of sufficient size and with sufficient resources to meet the needs of the whole county. This should be in partnership with enhanced minor injury units.		
79	Makes sense to focus these resources in one place rather than dividing them across two sites.		
80	The majority of specialties are based at Gloucester, so it makes sense to admit primarily to Gloucester. This speeds up the patient journey and prevents there being wasted time waiting for particular consultant ward rounds or transfer to opposite sites.		
81	this was the worst decision the organisation has made. massively unsafe for patients		
82	I would only support this if a significant piece of work is done to make sure that frail older patients, particularly those with dementia are not moved around from ward to ward, site to site with little care or thought of their needs and the harm that is being done to them.		
83	Gloucester Royal is not easy to get to from many pay of the county		
84	Having a centre of excellence for acute medicine at GRH makes a lot of sense, but it is important to reflect on what centre of excellence might be appropriate for CGH, perhaps chronic or ongoing care? I think it is very important to ensure that CGH is not appear to be downgraded and is valued as a site for quality care provision.		

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85	If A&E at CGH is truly to be returned to 24/7 Consultant led, it stands to reason that Acute Medicine must also be on site to provides beds and support for A&E. Therefore it makes common sense that both GRH and CGH should both have centres of excellence. One hospital cannot be a tertiary of the other. Further, recent history shows that GRH cannot cope with any reasonable pressure on A&E and Acute Medicine without falling over. Having both site working provides a relief valve for the other in dire emergencies.		
86	I do not think that Gloucester Royal Hospital will cope with all the acute services that you wish to base there. They cannot cope with the influx of patients at the moment particularly at night. These plans do not improve patient experience they merely allow the trust to attempt to save money		
87	Cheltenham General can offer the same service if you let them		
88	To help flow.		
89	I think it will promote continuing excellence in the services provided and will attract good quality staff to the area.		
90	having access to wide range of specialists as quickly as possible seems key		
91	I support because of all the diseases occuring around the world and the development of vaccines will be at the forefront of medicine technology.		
92	Because AMC waiting times will be extended and staff have excessive work loads to negociate		
93	It should be spread across two sites for geographic reasons, to reduce waiting times and reduce staff stress		
94	I want my care as I get older close to home so that family can visit. I would have no intention of being in a hospital away from my home town. This has high priority for me. Acute medicine has worked well at CGH for us up until now with ACUC managing the Acute Admissions well. From my observations of the medical wards at GRH they are not fit for practice. They are old, overcrowded, dirty, poorly staffed I would never wish to be a patient on these wards from my parents experience of being a patient on them. This would not be a centre of excellence - just an overcrowded cattle market.		
95	Concentrate this and the required support services for this on one site		
96	Would like Pathology to be taken into account with these decisions - especially Blood Transfusion as we are having to do an increasing amount of work overnight yet have no funding for extra staff! 1 person that covers the whole hospital at GRH is dangerous.		
97	I believe CGH should offer equal services to GRH and not all resources diverted to Gloucester		
98	I am in favour of the centre for excellence approach to medical treatment. We have two main hospitals which need to be operating coherently.		
99	Cheltenham and surrounding villages and other small towns in Gloucestershire deserve to have their own ""Acute Medical Take"" at CGH. Travelling is difficult enough in Gloucestershire and Gloucester Royal Hospital has very inadequate and expensive parking. This is a very busy tourist town with many festivals bringing thousands of people to the town and it is a very poor decision to only have a centre of excellence in Gloucester. We need our own A & E and also our own Acute Medical Take I am not opposed to Gloucester having its own centre but both places should be treated the same. Gloucester is a very large county stretching from the borders of Wales to the edge of Oxfordshire and Worcestershire.		
100	I live in the Gloucester area to have only 1 acute medical intake would be disastrous, and I cant help but feel you are more than willing to put peoples life at risk for the sake of money		
101	This will reduce ease of access for Cheltenham and Cotswold patients. The site at GRI is difficult to access and navigate and crucially parking facilities are woeful. Traffic congestion around GRI is often very bad - this will add to the problems in people from Cheltenham and Cotswolds getting to the hospital easily for treatment,		

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102	Acute medicine consultant workfroce better concentrated to provide sustainable rota on single site rather than split across two hospitals. Better use of resources at singel site with economies of scale need to caution about overnight medical cover being adequate across remaining patients at CGH and patient frlows for walk-ins would need acute medical offer		
103	increased travel time from the Cotswolds for A and E services More pressure on one hospital		
104	I think it is important to aim for providing the best possible conditions in the service provided		
105	Both centres need to provide all sorts of emergency medicine .		
106	It makes a lot of sense in so many ways. Specialist staff where they are needed and economy of one place but the assurance of cross information when necessary. A huge plus is that scheduled day surgery will be able to go ahead as planned. As a patient I have experienced surgery required after attending ED with a cut tendon, having to be surgery ready each morning only to be told it would not happen and finally being extremely ill after being giving antibiotics because of the increased risk of infection. I also think that the guided imagery will offer huge benefits e.g. to stroke patients attending ED, removing the clot quickly could mean a reduction in brain damage.		
107	There just isn't a big enough ED at Gloucester, not enough Resus vays and just too cramped		
108	This will mean Cheltenham residents will have to get there and Cheltenham hospital will not be needed, we need a centre of excellence in every hospital		
109	Need a 24/7 type-1, consultant-led A&E at Cheltenham General Hospital.		
110	Evidence is that specialist stroke unit and cardiac units provide better patient outcomes		
111	There will need to be adequate space to accommodate the increased workload		
112	It's a rational use of limited resources. Concentration of specialist people, and specialist kit, absolutely makes sense, and research shows that it produces better outcomes.		
113	I'm disabled and have no transport to get to and from the hospital in Gloucester would very especially as wheelchair accessible transport is no longer provided to bring me home on the day of discharge		
114	Centralisation of this speciality will ensure that the clinicians with the right skills are always available. It will reduce risks to the public and reduce the need for potential transfer either to another facility or out of county		
115	Best location in the county for this service		
116	It is sensible to make best use of resources and nor split them between two sites		
117	Gloucestershire hospital is terrible as an in patient. The care and communication with family members is practically non existent. I personally would not want to be treated at Gloucestershire Royal hospital for anything.		
118	Gloucestershire Royal is a difficult journey from North Cotswolds with poor bus services. Difficult for older people to visit relatives.		
119	It is the right approach for the future.		
120	Because without a facility for acute medical take at Cheltenham it would Be much more likely that the A& E dept at CGH would be rendered unviable. Travel times from the East of the county would be increased. If this option were to be adopted the facilities at GRH to accept the increased number of acute medical patients would have to be considerably improved.		
121	Better treatment for all		
122	A centre of excellence in one location enables experience and expertise to be shared, high standards to be set and maintained, as long as its management is supportive and creates an environment where the organisation and the individual members can learn and develop, not compete.		

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123	It makes sense to me have the expertise in one centre.		
124	Acute Medicine seems to be an area of health where time is its greatest obstacle for a steady recovery. The availability of a correct specialist could likely contribute to the realisation of the actual problem rather than concerning around the symptoms that initially brought the patient to the hospital. Hopefully a 'centre of excellence' would increase the value of medical investigation of a patient's condition so that prevention can be enforced in the treatment. Although Gloucestershire Royal Hospital is central, the medical team may also require consideration of how patients from other towns may be able to access the yard without delay or complications.		
125	The options outlined appear to make medical and operational sense		
126	Broadly support this measure although concerned about travelling distance for patient and/or family and friends if having to travel from e.g. the east/north of the county. Using a bus (could be 2+), particularly later in the day/evening, or having to fork out a for a taxi/persuade a friend/family member to drive further is far from ideal. Some concerns over whether there would be sufficient bed space for services to be centralised - other hospitals who have merged services from two sites relatively near to each other onto one site have experienced issues with capacity e.g. a county to the north of Gloucestershire Can see the benefits of seeing the right person sooner which is very beneficial for all concerned		
127	A single centre in Gloucester will inevitably: Increase congestion in the department Increase nurse triage time Incease doctor wait to be seen time Significantly increase ambulance job cycle times for SWASFT Increase the amount of inter-site ambulance transfers between GRH & CGH undertaken by 3rd party providers Delay commencement of treatment for residents in Cotswolds & Cheltenham by having to travel to GRH		
128	This will give best outcomes for patients. Highly skilled teams will be able to care for patients & be able to support each other.		
129	More efficient use of specialised staff		
130	If this is thought to be a good idea, it probably is!		
131	Both Cheltenham and GRH should have full facilities. This will give flexibility in terms of capacity and also provide options should one facility be unusable through disaster or infection. Currently I have experienced GRH A&E is working beyond capacity with beds in corridors'		
132	The proposed solution in the Consultation Document appears sound.		
133	Gloucester is in the centre of the county so it would be logical to have the acute medical take here.		
134	We live in the east of the county, and Gloucester is a long way to travel. This problem is exacerbated as we get older, and private transport becomes more difficult. Public transport is simply not an option.		
135	I believe Gloucestershire needs more than one center of excellence. This will give options should GRH be overloaded or temporarily unavailable (infections, disaster of some type).		
136	Transport from the Cotswolds to GRH is not easy. Buses only run six days a week and require changing at Cheltenham. Parking at GRH is well nigh impossible and very exodnsive		
137	With stretched specialised NHS resources concentrating particular but different Specialists at each hospital makes sense. I am also reassured that A&E will remain at Cheltenham hospital as we live in Bourton-on-the-Water so need to be confident that the closeness of A&E in Cheltenham in an emergency provides a much better chance of survival rather than going all the way to far side of Gloucester from here.		
138	Having centres of excellence is ideal providing it does reduce waiting time, and ensures operations are not cancelled. All expertise in one place so if second opinion is needed there is someone to consult immediately without the necessity of a follow up visit somewhere else.		

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139	Services need to be nearer the population rather than centralised.		
140	quick and accurate diagnosis are very important.		
141	Creating CoEs across the county will inevitably create a good deal more traversing of the county for patients. I can empathise with the desire to make best use of resources.		
142	I think the proposal is fine for the short/medium term but with major population growth planned for both Tewkedbury and Cheltenham, planning should commence for sharing between both hospitals in 5/10 years		
143	24/7 access to multidiciplanary teams. Specialist equipment. RIght disciplines to provide services and ability to train more staff		
144	Acute medical take is urgent care and represents one third of all hospital admissions (Royal Coll Physicians - 'Supporting the Acute Medical Take Dec 2015). While I support the principle of single centre of excellence approach for the Glos NHS Trust, surely for urgent care which represents such a high proportion of cases we need to serve both ends of the county properly. This would surely also mean a massive shift of patient numbers from Chelt to Glos and a resulting decline in budget for Chelt leading to further reduction of services there		
145	I think it is important that the best acute care is needed where there is a concentration of expertise. Diluting staff expertise in two centres is not the best way to achieve this. Having acute medicine (acute medical take in Gloucester makes absolute sense, and I do appreciate that for some cases, subsequent transfer to the regional centre in Bristol (e.g. BRI/Southmead) may still be required for the most serious cases.		
146	I feel that this sort of service should be available at Both Cheltenham and Gloucester		
147	More effective/efficient to have one centre for this		
148	The need to employ qualified medical and surgical staff Increasing demand for complex treatment		
149	Local		
150	GCH is so far away from the majority of the county		
151	I support the proposals to change and think the information provided presents a strong case. However, throughout the consultation document I see little or no reference to: a) How staff are to be retained, trained, recruited and afforded. b) No refernce to any improvements to process or service instigated as part of the response to Covid -19 which will be retained as Best Practice moving forward. c) Limited reference to the way that services will be re-modelled in line with international Best Practice. There is limited information given for example on the use of telemedicine, telephone consultation and foillow up, health education in primary care, transfer of services into coimmunity settings, converstions to higher day case rates, better streaming through outpatients (and ED). The proposals appear to deal with the issue of duplication of services across two sites and consequent rationalisation and whilst this is to be welcomed, of itself, it does little to illustrate how the models of care can or will change. Similarly there is no financial analysis (that I can see) with the documentation provided. In an increasingly stretched NHS, this must be a consideration for services to be long term sustainable.		
152	Whilst GRH is further travel time for me, I recognise the need for focussing practice		
153	As long as capacity is adequate and doesnt impact upon other services		
154	Worried about what you promise but probably won't do at Cheltenham.		
155	It worries me hugely that the town the size of Cheltenham already hasn't got 24/7 Consultant Led A&E services. This seems another plan to reduce this even further. I worry about increased time to get emergency help for my children and elderly parents by having to travel to another town.		

Please tell us what you think about our preferred option to develop: A 'centre of excellence' for Acute Medicine (Acute Medical Take) at Gloucestershire Royal Hospital.		Response Percent	Response Total
156	Having all your 'specialist' staff in one area may be better and more cost effective for you but as always it's the patients who suffer. Traveling to and from Gloucester is not easy for those without their own transport. Even if the patient is transported to Gloucester by ambulance, once discharged they have still got to find their own way home, probably still feeling very unwell. They may not have friends with a car or have sufficient funds to cover the cost of a taxi, which leaves the bus, if it is running and if it is not full. There is also historically a poor reputation for infection control at GRH. I would not feel confident going there for anything serious.		
157	The concentration of key resources in one place to reduce duplication and wastage.		
158	It sounds like a good idea, but as we are on the edge of gloucestershire it would be further for visitors to travel for us		
159	Ambulatory Care is the way forward and many more people are likely to be treated this way in the future. It makes more sense to have two hospitals offering this service in such a large county area. Cheltenham is much easier to get to for many than Gloucester.		
160	Better to have all emergency services on one site		
161	Whilst GRH is further travel time for me, I recognise the need for focussing practice		
162	I feel it shame that departments at Cheltenham Hospital are bit by bit being transferred to Gloucester. Eventually Cheltenham hospital will become a minor community hospital. Cheltenham is large enough to warrant its own fully functional hospital. It seems the main problem is lack of staff resources. Rather than transferring and closing departments which is not in the interest of Cheltenham residents the only real long term solution is to recruit and train staff. The people of Cheltenham deserve better. Regarding this survey I find the information provided complex not concise. It is really time consuming for general public to work out what is being decided and make their comment. There is also a feeling that whatever the public opinion is the NHS management will just do what they want.		
163	I understand the need to concentrate resources.		
164	acute medicine is required both sites. CGH has ICU beds nad medical meds to help ease the patient load		
165	I wish to ensure that the best treatment is available as timely as possible and is not compromised by duplication of service across sites.		
166	The Report and its recommendations have been prepared by hugely professional, experienced and competent personnel. Ninety nine per cent of feedback from the public is likely to be simply based on how it affects their personal situation regarding treatment required and location, and not necessarily related to what is best for the community at large and indeed the NHS.		
167	all experts in one place considering the staff shortage the NHS is currently under		
168	It's closer for most people. Ie the forest and cotswolds		
169	It makes sense to have one 'centre of excellence' rather than reduced facilities over 2 sites 12 miles apart		
170	I will appreciate one world-class centre for the county; without spreading the expertise by having a second service in Cheltenham. The current A&E provision at CGH (i.e. its Minor Injuries and Illnesses Unit) looks appropriate to me.		
171	It does make some sense to centre areas of expertise. However certain things also need to be taken into consideration. Access for people getting to the locations. Danger of additional time for emergency cases having to go to GRH. What is the impact on the other hospitals such as Cirencester, Tewksbury, Stroud etc.		
172	It enables Gloucester Royal to be a centre of excellence for treating trauma patients which will improve patient outcomes. Takes pressure off cold case planned beds.		
173	This is a hospital stay (even if 1 night) for which the patient and their family/carers have not planned. Hard enough to cope if it is local but very stressful if it is not. This is a case where both hospitals must be centres of excellence.		

Please tell us what you think about our preferred option to develop: A 'centre of excellence' for Acute Medicine (Acute Medical Take) at Gloucestershire Royal Hospital.		Response Percent	Response Total
174	I believe in current medicine, centres of excellence are a 'good thing'. GRH has the space and I trust facilities for this so I am happy to proceed.		
175	there is ample evidence that diffusing resources results in worse outcomes for patients. The term centre of excellence is best avoided - it sounds good but means nothing - why would anyone not want excellence? How do yo define a centre of excellence?		
176	Depends on future direction of Cheltenham General Hospital		
177	Opportunity to improve recruitment and retention of staff a strong argument for single site, linked to 24 hr consultant A&E		
178	Had an acute kidney stone admission few years ago just after Xmas - live next door to CGH - last thing would have wanted would have been to have been taken to GRH!		
179	If this means moving acute patients from Cheltenham to Gloucester then I oppose. These are normally time critical cases and travel is clinically detrimental. There are large and growing populations in both towns and future demand will require acute services at both sites.		
180	In the modern NHS it makes sense to create centres of excellence for various specialities		
181	Separate emergency services from elective services completely		
182	Centers of excellence has to be the way forward to benefit the use of technology and Consultant/specialist skills.		
183	I can understand the reasoning and rationale for this option but I worry about capacity, if everyone suddenly has to attend GRH with no option to attend at CGH will waiting times be longer, will standards of care to the community be affected, will it mean that other treatments and services suffer at GRH. I am not against the proposal but these are some thoughts and questions I am having as a (potential) service user and a resident of Gloucestershire. I worry that this is also a step to wind down care and service provision at CGH too.		
184	Why have a hospital in your own town that your not able to use for all services		
185	Its a long way from the outer borders of the county - and not much use if it takes over an hour to get there - starting from 999		
186	It is better to complete the assessment of a patient where they are and transfer once if needs be to the correct place.		
187	No clinicians I have spoken to think that this is a good idea - and I am dubious as to whether this is about patient care or whether it's to save money. Sadly I suspect the latter.		
188	You're proposing to close Acute Medical Take at Cheltenham. This looks a lot like yet another attempt to downgrade the emergency care at Cheltenham. Both hospitals need full A&E and Acute Medical Take.		
189	There are still likely to be acute medical beds in CGH, so many patients will be being transferred. Currently, even prior to COVID there was too much disorganised movement of patients to aid flow that was/is detrimental to their care. CGH has now become an overflow hospital for GRH not a centre of excellence.		
190	The area of Gloucestershire requires services at both Cheltenham and Gloucester		
191	Clear clinical advantages in not duplicating staff, so long as sufficient / additional staff numbers are working shifts to deal with increased numbers (you couldn't just shift the take and keep the same number of staff with increased number of patients).		
192	Up to date medical science and future developments		
193	It makes sense to centralise this area		
194	Centralisation seems fine from a management point of view but the impact on the recipients can be major in terms of travel and access to the services.		
195	Particular medical conditions can be prevented from getting worse if treated / diagnosed earlier		
196	The rationale seems clear		

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197	make the best use of the expertise for each discipline. Not point in having too many duplicated services.		
198	As I live in the Forest of Dean it would be far more convenient for my family as possible patients to be treated in Gloucester		
199	I think everyone would prefer to be treated where specialist care is available and immediately accessible. This comment applies to all sections		
200	Our guests (we're from Cheltenham Open Door) have complex needs and issues (addiction, mental health issues, etc). If we don't have local emergency care (or suspect, if they have to be admitted, it will be in Gloucester) they are unlikely to seek help when they need it and may wait until the situation is critical and they have to call an ambulance. This will make for worse outcomes for them and the need for (presumably) more expensive and complex intervention for the NHS. Not all our guests have hugely complex needs but most would struggle if everything acute was at Gloucester. Very few would be able to have people bring stuff to them or visit if they're in Gloucester (bus fare, logistics, etc). Many rely solely on their groups of friends for support, being estranged from their families, and simply wouldn't present until the last minute if they thought they'd be taken to Gloucester. You mention ""The importance of mental health support as part of all services"" BUT not all mental health support is provided by the NHS. Sometimes, perhaps, it is as or more important to have the people who regularly provide your stability and support able to easily access and reassure you. On a personal note, I and my colleague have elderly parents who have been in A&E/ambulance situations. It's a nightmare when they are taken to Gloucester. If it's rush hour, following the ambulance takes an hour and a half and you can't pop in and out to take them things they need. You feel you have to abandon them, and they feel abandoned, when you are trying to support them from a different town. It creates anxiety, logistical issues and upset. It isn't what anyone wants.		
201	My Husband had excellent care at Cheltenham General. A serious op for Bladder Cancer in 2015		
202	Quicker access to specialist doctors Shorter waiting times Costs of transfer for GRH to CGH for some patients and ambulance service pressure is a concern		
203	Anything that reduces risk, Travelling time, being passed from pillar to post offers a quality service, with quality staff can only be excellent		
204	Travel to Gloucester from my home by public transport would not be easy and unnecessary when there is a Hospital nearer in Cheltenham. Type 1 diabetes is not easy to live with and at an advanced age can be traumatic when having to travel.		
205	Recruitment and retention in the NHS is a severe, long lasting, problem. A two site model makes it much harder to recruit staff and to retain them. A single site model makes it easier to recruit staff. A two site model will struggle to maintain safety. A single site model will be safer. Most people will get quicker, better, care in a single site model. A single site model unleashes allows staff and systems to work better. Importantly: a centre of excellence at GRH will benefit people with mental ill health who attend for physical health reasons.		
206	travel time concerns, availability of parking if centralised on once site		
207	The facilities exist to enable this.		
208	This will disadvantage people who are close to Cheltenham. Both sites should be the centre of excellence for acute medicine. It will also cause the Trust money if someone gets unwell in cheltenham to be moved to Gloucester.		

Please tell us what you think about our preferred option to develop: A 'centre of excellence' for Acute Medicine (Acute Medical Take) at Gloucestershire Royal Hospital.		Response Percent	Response Total
209	A single focus in a large county is not practical. Travelling to and from one hospital site is difficult and unpractical for many people that get especially with no transport and poor transport links. In emergency the further away from the centre the longer travel on times, problems getting through traffic, fund a means of transport to get to hospital. With large populations in different locations no sense to have resource in one Gloucester city alone that is also difficult to get to fit many outside Gloucester....travel times and ease of access can be critical		
210	Do things well in one place. Concentrate skills and workload.		
211	I It will ensure that specialist care is available at all times although it means I will have to travel from my home within walking distance of CGH.		
212	Having this can allow resources (provision and expertise) to be used effectively and not watered down.		
213	As with all your proposals to centralise services the problem is that of access for patients and their families. Whilst many have access to private transport a very large minority do not and they are frequently the elderly and less financially secure. For these people centralisation poses a major difficulty in accessing your services unless you propose to offer free transport between the sites. Even for those with private transport difficulties in accessing parking at iether site pose difficulties and high costs.		
214	Overall better patient outcomes and improved workforce environment.		
215	GRH should receive all unselected acute admissions. This will enable us to screen patients for infectious conditions such as COVID-19 and keep them there until it is safe to transfer to the ""green"" CGH site. this way we minimise the risk of disruption of elective specialist treatment such as surgical and non-surgical cancer care.		
216	Makes absolute sense to have a Centre of excellence. Paramedics and GP's will know where to take and send associated patients rather than pot luck between two options.		
217	Glos Royal needs to improve		
218	Reduced waiting times Specialised staff in one place, so prompt decisions, better staffing		
219	As I don't drive its most useful		
220	Localised specialist care hub should improve quality of care and outcome providing any delay in transit CGH to GRH is avoided.		
221	Save on staffing and equipment by focussing on one location. Provide a better service.		
222	A good central location with good transport links. Ensure more bus services from out laying locations		
223	This sounds like it would lead to the loss of Acute Medicine at CGH. I have really noticed during the COVID changes that this often leads to multiple patient transfers across areas and hospitals which can be difficult and dangerous. Several patients on RYE had been to 4 ward areas prior to arriving on RYE.		
224	Experienced qualified staff centralised More opportunities for shared learning and research Intensive care facilities on one site High tech imaging facilities...		
225	I respect the reasons set out in the consultation document		
226	The creation of a COE will benefit staff and Patients However a more ""joinup"" public transport option needs to be considered - the holder of Gloucester main Bus provider Stagecoach should be able to used their daily/weekly/monthly bus pass in the 99 that links the two hospitals.		
227	Timelyt assessment and diagnosis and improved staff cover		
228	Gloucestershire Royal already has good facilities and these could be improved if it was made a centre of excellence.		

Please tell us what you think about our preferred option to develop: A 'centre of excellence' for Acute Medicine (Acute Medical Take) at Gloucestershire Royal Hospital.		Response Percent	Response Total
229	Lack of community beds and placements means that this is needed across both sites in Gloucestershire especially GRH as cheltenham is more surgical and recent changes have only shown the failures of trying to downsize it and move specialities		
230	Makes sense to be centrailised although I worry about patients who turn up to A&E at CGH and then require admission. The current communication about transfers with families is often poor.		
231	Having one centre of excellence in Gloucestershire should allow for more throughput, giving staff more experience, leading to better outcomes for patients.		
232	More convenient/centralized.		
233	Increased chances of seeing the right specialist more quickly. Will provide more focussed training/learning opportunities for junior doctors and medical staff, with continuous supervision by senior doctors. This will contribute to attracting staff and improved retention rates.		
234	After having experienced ' in patient ' services at both CGH and GRH on two separate occasions resulting from pneumonia. I would fully support the objective of developing a 'centre of excellence ' at GRH. The disadvantage of extra travelling for Cheltenham residents is outweighed by the improved facilities, better use of and more focused staff.		
235	Gloucestershire Royal Hospital is not large enough to accommodate such a move		
236	I agree with this ONLY if the A&E at Cheltenham is maintained at the same level they were pre-COVID		
237	The Acute Medical unit should stay in Cheltenham (as well as Gloucester). It is after all a General hospital. You say your preferred option would affect 20-30 patients a day. That is 140 - 210 patients a week and 7,000 - 11,000 a year. I cannot see how this is going to improve care for Gloucestershire residents, particularly those in and around Cheltenham and the north east of the county. The more likely effect will be patients needlessly suffering and dying due to pressures at GRH and longer transport times.		
238	The term 'Centre of Excellence' is meaningless. Why should this suddenly become an aspiration for the service that exists already, except as a piece of window-dressing.		
239	Prefer Cheltenham - see page 37 My wife and I are in our 90th year. She is not allowed to drive. I prefer daylight and not Mon or Friday. We live in Tetbury and wish treatment there. So: We prefer Cheltenham and do not like Gloucester, the former being easier for us to reach by car and more convenient in terms of other activities on the day.		
240	Because I live in Gloucester.		
241	Good to centralise it but please consider things like parking etc. Slapping a biblically expensive P + D doesn't cut it.		
242	The idea of creating centres of excellence at both of the two excellent large hospitals in Gloucestershire makes sense. It is worth remembering that the other specialist inpatient services, which have already centralised at either CGH or GRH e.g. cancer services at CGH and childrens' services at GRH, are working really well for patients.		
243	The facilities can be enhanced at less cost at this hospital		
244	Distance to travel from North Cotswolds to Gloucester is to far.		
245	It would make sense to have a particular specialism in one location to avoid possible delays to be seen by a specific consultant and relieve unnecessary travel between sites.		
246	will you have enough beds? Some of the other changes seem more pressing		

Please tell us what you think about our preferred option to develop: A 'centre of excellence' for Acute Medicine (Acute Medical Take) at Gloucestershire Royal Hospital.		Response Percent	Response Total
247	Your literature does not cover a large proportion of elderly people who are taken to a&e after falls. Would they stay in the same hospital? My mother has arrived after waiting over 6 hours for an ambulance after a fall, not fit to go home but no broken bones. Where does she she up? Also, it is all very well to say this, but where are the beds? Again my mother waited overnight in a&e for a bed (with no offer of food or drink). Surely it makes sense to use a bed where there is one? What about the wait for an ambulance to take the patient from Cheltenham to Gloucester? Would that patient be back in the queue at Gloucester a&e (in my experience no doctors read patients notes and the hospitals do not share anything online)?		
248	The idea of creating 'centres of excellence' at either CGH or GRH makes sense and has worked well for other specialty inpatient services e.g. cancer services at CGH and childrens' services at GRH It is important to remember that both CGH and GRH are 'centres of excellence' for distinctive specialist services.		
249	With ever more complex equipment and specialist staff required it makes sense to centalise the service providing the infrastructure, beds and staff are provided. Such a move must not be seen as part of a cost cutting exercise.		
250	Don't see why this needs to be only available in Gloucester and services removed from Cheltenham		
251	Central to county for us in FOD		
252	I want to know acute medical expertise is available locally to me		
253	Mainly happy - but difficult to travel to GRH from Cheltenham area if unwell		
254	We need to focus specialities and skills on a single site to maximise the use of specialist personnel and resources		
255	We have to be realistic about the challenges and do what's needed to try and mitigate them.		
256	What if the specialist team is based at CGH, thus will be some back and forth between sites. It is not clear how when a patient presents themselves to CGH and need further investigation at GRH, how move between sites. If this question JUST refers to ACU beds, then I have no opinion		
257	Although there will still be an A&E at CGH, I strongly believe that having specialists at one hospital GRH, would be beneficial to patients. My concern is the statement, " being seen by a consultant within 14 hours", is far too long a period of time. The realistic time should be a maximum of 7 hours.		
258	I don't want to go to Gloucester Royal it has a bad reputation and I would not be happy there.		
259	Cheltenham has a GENERAL hospital and as such should have the capacity for medical beds as it does now. This will seriously impact the A&E dept by downgrading it to a MIU because most emergencies will go to GRH. Your preferred option would affect, you say, in a negative way, 20-30 patients a day. That is 140-210 patients a week, 500-900 a month and 7000-11,000 a year! Are you really prepared to risk this many lives because of longer transport times for people living in Cheltenham and the North East of the county. I think this will be detrimental, causing increased suffering and death, when you stress you want to improve health outcomes for people!		
260	I like the ""centre of excellence"" approach		
261	In line with the A&E focus		
262	As things stand, I don't believe that GRH has the space, or facilities which would be needed to do this. I am also concerned about the management of that hospital.		
263	Emergency medical patients should continue to be admitted to both GRH and CGH. This change would mean that medical emergency patients from the North and East of the County would have to travel further for care.		

Please tell us what you think about our preferred option to develop: A 'centre of excellence' for Acute Medicine (Acute Medical Take) at Gloucestershire Royal Hospital.		Response Percent	Response Total
264	I have a concern that the information presented that Gloucester Royal Hospital has 49 beds is misrepresented by including frailty beds. However I generally support this.		
265	The preferred option would mean that people living in the east of Gloucestershire would have to travel further for urgent medical care.		
266	Both hospitals more encourage to train and keeping staff.		
267	I think it is vitally important to be able to have access to the right specialists (senior doctors) in a time of need, also address safety issues		
268	Although I support this option I have the following concerns:- Glos is a large county to have one A&E consultant led overnight. This will have an impact because in emergency care timing is vital and many patients will have to travel further to get the treatment they require.		
269	Lack of space at GRH and waiting times. Poor access for North Cotswold communities		
270	Too far to GRH for large areas of the county. I live in Cirencester, it can take an hour in peak times to get to GRH.		
271	Strongly support the idea of having 'specialties' at one of the two hospitals only.		
272	Possible, good concentration of staff		
273	Because of the increased local population both sites should be used.		
274	I don't think GRH has the capacity, now or planned.		
275	A specialist unit such as this makes sense.		
276	All consultants, doctors, specialist nurses and ancillary staff under the same roof. Encourage medical staff and other i.e. nurses - rehabilitation staff to come and work/train. Will give encouragement to patients knowing they are in a highly specialised unit.		
277	To concentrate the necessary skills in the centre of the catchment area		
278	Less need to transfer between hospitals which takes ambulance time away from emergency calls.		
279	I can understand the rationale for this proposal but Gloucester Royal is very difficult to reach from the south-east corner of the county (Fairford). I appreciate your comments in the long version about the need to help older patients who may not be familiar with one of the centralised centres. In our case, I would struggle to find GRH. I am concerned about the reduction in services in Cheltenham. One is a selfish reason: I am familiar with Cheltenham and can get there easily. My husband has been seriously ill a number of times and I know how stressful it is to find an unfamiliar hospital at night when you are panicking. My second objective reason is that it will be very difficult for ambulances (and patients in private vehicles) to get to GRH from the Cirencester area until the bottleneck of the Air Balloon on the A417 has been resolved.		
280	All acute services including the ED and both takes should be on a single site (GRH) to allow for CGH to be developed into a major elective cancer surgery hub.		
281	Need to consider how beds will be managed without disrupting more urgent changes. Eg transferring to emergency acut admissions to specialist teams on CGH site.		
282	Too far for people from east Gloucestershire to go and it is always busy.		
283	My thoughts on this question, and answer to it, will be the same for many of the survey questions. I believe that there must be economies of scale in forming specialist centres. One whole is more beneficial than two halves in this case. This should mean savings in the cost of staff, equipment, spares and consumables, after an initial cost to physically create the unit. Some may get emotional about losing a service in 'their' area, but as a relative newcomer to the area, the hospitals are physically so close together, with good transport links between the two, I would consider the benefits to outweigh this.		
284	I do not wish the emergency services available at CGH to be downgraded, and think that access would be reduced if services were centralised to a single site.		

Please tell us what you think about our preferred option to develop: A 'centre of excellence' for Acute Medicine (Acute Medical Take) at Gloucestershire Royal Hospital.		Response Percent	Response Total
285	locating all resources at centre will remove from other part of zone hence increase travel time for a type of care that is time critical, better to have at least some support closer to all users hence alble to treat in 'golden time'		
286	I am concerned that too much emphasis is being placed on GRH. This concerns me because I do not believe that GRH has the facilities or space to cope with extra work. I would not support the concentration of services on one hospital site if that led to, for example, a reduction in consultants at CGH.		
287	If the Acute Medical intake is concentrated on one site, it will make a Type 1 A&E Department less viable on the other site. It also reduces flexibility between the two hospitals, especially in times of any future pandemics.		
288	Medical patients constitute the largest number of emergency admissions, so taking away beds from CGH will leave patients at risk of lengthier travel times to GRH with the prospect of increased suffering and death. Cheltenham is a General hospital which has already the ability to offer medical inpatient and medical emergency services. It will have an impact on CGH A&E, essentially downgrading the use of this facility. It is more than possible that between 10,000-20,000 Gloucestershire patients a year will be affected if the acute medical take transfers to Gloucester. GRH will need a high number of extra beds to cope with the amount of people who will require care and support.		
289	A state of the art hospital should be built in the forest of dean. Five Acres would be excellent, with maternity facilities. The travel to Gloucester and Cheltenham to and from the forest is horrendous and expensive.		
290	As my marking shows I am very much opposed to ""Acute Medical Take"" being centred in GRH. Cheltenham and the North Cotswolds have for very many years (in my case over 75) relied on CGH to provide care, quickly and without unnecessary and dificult travel to GRH, which can be critical to survival. Prior to the downgrading of CGH A+E two members (now deceased) of my family were well served by CGH at their time of need as I have. CGH provide the very best chance of survival. Many people in Cheltenham have regarded the hospital as a ""Centre of Excellence"" prior to it's downgrading. I understand the provision of a full A+E presents challenges to the trust however challenges do need to be overcome in order to match a clear need.		
291	Cheltenham would be more convenient for me, but Gloucester is potentially bigger and within easy reach		
292	Keeping track of all medicine and where they are used.		
293	GRH is inaccessible for residents of the north cotswolds		
294	More specialist nurses required in Acute Medicine. Real lull in activity when you get up to Acute Medicine.		
295	It is probably best to divide the centre of excellence status for best use of available expertise		
296	Crucial that there is sufficient capacity to easily meet demands		
297	Quicker response to a service when needed - waiting times - if all under one roof - higher demand?		
298	If there is only one centre and something goes wrong will there be no back up service		
299	If one centre will numbers be too high who need to be seen		

Please tell us what you think about our preferred option to develop:A ‘centre of excellence’ for Emergency General Surgery at Gloucestershire Royal Hospital.				
			Response Percent	Response Total
1	Strongly support		35.71%	195
2	Support		32.60%	178
3	Oppose		10.62%	58
4	Strongly oppose		12.82%	70
5	No opinion		8.24%	45
			answered	546
			skipped	78

Please tell us why you think this, e.g. the information you would like us to consider (249)

1	The rationale in the consultation booklet is compelling and makes the case very strongly. We need to put patient care first before all other considerations.
2	There is too little trust in the care provided by GRH, from poor food, lack of staff, nasty conditions and poor staff morale to convince me that a bunch of desk workers in brockworth have the support of the grass root level staff. There needs to be far more public trust in CCG and GRH before big moves are planned.
3	I think split site working for all departments should end. Single site for each speciality should be a priority
4	Should also have one at Cheltenham General
5	If General Surgery cannot sustain a rota across two sites then for safety reasons we should divert patients to a single site so they can receive treatment in a timely manner.
6	need to centralise expertise 24/7 ideally alongside other emergency services
7	How would you support those that need emergency surgery at CGH - are patients fit to travel between sites if they need emergency surgery?
8	The same as previous it is easier to manage and better cost savings for the trust, tax payer.
9	Needs to reopen Cheltenham.
10	See previous answer. Best outcomes for patients is having centralised specialist units where training can also continue and also attract the best and Bridgestone staff .
11	There needs to be capacity for this at CGH also.
12	All emergency cases come to GRH and I feel that Emergency General Surgery should be at GRH because of this.
13	I have, however, concerns regarding the bed base in GRH and resident surgical cover will still be required in CGH even with centralisation.
14	I think the separation of acute and elective work in the middle of a pandemic is sensible.
15	We do not have the bed capacity at GRH to provide the care that patients need. . Lack of beds mean that all surgical patients are often outliers on various wards making it difficult getting the surgical teams to review patients when needed.
16	It should be able to be at both hospitals, hopefully this will mean less people at each of the hospitals and also the nearer the hospital the better chance you have of helping someone especially if it is life or death
17	To centralise services, staff, expertise and equipment at one site. If this ensures that planned surgery is protected and not impacted by emergencies, then I would strongly support this option.

Please tell us what you think about our preferred option to develop:A ‘centre of excellence’ for Emergency General Surgery at Gloucestershire Royal Hospital.		Response Percent	Response Total
18	Support the notion of highly specialised surgical teams at one site. Only concerns are managing the increased throughput. Emergency surgery is rarer than acute medicine so the negative effects there should not occur here.		
19	Total chaos at glos royal. I have complex health and since cheltenham a and e closed to gp referrals I have gone to gloucester royal minimum 5 admissions. I am from cheltenham so it is much further to go, having to explain everything about your history to another medic who doesn't know you even though they have read your notes. More importantly waiting hours in a assesment unit I mean 8 plus hours when in pain is not on then to be told you are being admitted then waiting hours to be allocated a bed. I have bowel problems and I for one wouldn't want to be operated on at glos royal!		
20	You need centres of excellence in both Cheltenham and Gloucester and I believe with proper budget management this is possible I don’t feel the trust have any interest in keeping the Cheltenham service.		
21	There aren't enough staff to go around, so we need to make best use of those we have.		
22	Again, for same reasons as Acute care - GRH doesn’t have capacity		
23	as previous- we do not have resources to spread this service across two sites and still provide the exemplary level of care to which we all aspire		
24	Same reason as before, I know there aren't enough specialists, it makes sense to me to have them in one location. If I was in need of emergency surgery I'm not sure I would care where I was as long as someone with the required skill and knowledge was in the same place.		
25	There should be surgery facilities at both sites, and both should be ""excellent"". Transferring emergency patients to GRH wastes precious time and could risk lives.		
26	county too big for this to work		
27	makes sense as A&E located there		
28	Over working the system, more operating out of hours due to long busy list which is dangerous, battling different specialties on emergency lists resulting in longer waits for patients who might need an urgent operation, waste of Cheltenham general theatre teams skills, experience and facilities.		
29	Long emergency waiting list. Long eating times in a and e. No beds. Rushed surgery. Waste of Cheltenham General facilities and staff.		
30	Lack of beds, long a&e waiting times, longer wait for operations		
31	If the specialists and kit are all in one place, surely this makes patient care better regardless of an extra few miles for those who live on the east side of the M5.		
32	This would further reduce/support the case for reducing the provision of the highest tier of A&E at CGH (East) so should not be considered.		
33	As before		
34	This is important BUT is not and should not be seen as mutually exclusive to a centre of excellence in pelvic resection		
35	we still receive urology emergencies into the theatre department with no provision for paediatrics overnight and no anaesthetic cover from 2200hrs apart from the DCC Doctors If emergencies are to remain in GRH then it needs to be all emergencies or proper provision for patients that remain in PACU after 2200hrs		
36	Avoids duplication and reduced likelihood of routine/elective surgery being cancelled due to emergencies.		
37	this is a big DGH with high numbers of patients and population often requiring more than the basic care on offer outside of tertiary centres. transporting or redirecting patients involves time, money and stress for all concerned so more localised specialist care will better meet all stakeholders		
38	Emergency surgery on one site means patients will be treated by appropriate surgical specialist		
39	It seems sensible for emergency surgery to take place in the same hospital where there is a 24/7 consultant led emergency department		

Please tell us what you think about our preferred option to develop:A ‘centre of excellence’ for Emergency General Surgery at Gloucestershire Royal Hospital.		Response Percent	Response Total
40	It is bigger hospital and easy for access (not confusing as opposed to CGH which is a maze and patients are constantly lost)		
41	Far too far away from Fairford to be a good option for patients from that town/area		
42	as the main ED is currently at GRH this would make sense, however I would be anxious to avoid all eggs in one basket. this also involves the elderly and infirm travelling distances to a site that isn't easy to get to by public transport especially if you are unwell		
43	GRH should concentrate on emergency work.		
44	Too Gloucester central, what about those of us in the East of the Counry?		
45	Cheltenham should also be a centre of excellence for surgery.		
46	More expertise on one site leading to better care		
47	Cheltenham should remain an acute general hospital		
48	I strongly support this. With Accident and Emergency to be located in Gloucester this makes sense		
49	We have hospitals in the county i.e Cheltenhem and Cirencester which could be used which would be better for those who live locally to them		
50	Same reason for my previous choice. Internal operation and streamlining should not come at the cost of local community well-being.		
51	cgh also needs general surgery so thr ED should be re opened to		
52	The patient to travel with illness from remote towns near cheltenham not ideal as it may be a risk too as can't depend on ambulances at all times.		
53	I can see no reason against this proposal		
54	I don't think any of the 4 options are enough - I would like to know what happens to people who are admitted to CGH before 8pm in an emergency situation where a delay to GRH could be critical and could be criticised by the Coroner should something happen? The time delays - picking up a patient from, say, the other side of the Cotswolds - surely they need to get to the correct help as quickly as possible and GRH may be quite a lot further away than CGH.		
55	As before I strongly support ""centres of excellence"". It seems appropriate that this shoul be colocated with Acute medecine		
56	Any centre of excellence must be good.		
57	Again, we need to concentrate our resources on a single site to make best use of staffing and e.g. radiology		
58	Same as my previous answer.		
59	As said on previous answer, people are clamoring for Cheltenham Gen Hospital to come back. We have already had some relatives not happy about patients being moved to and fro or why they need to go all the way to GRH (or CGH). I believe Cheltenham needs its own hospital.		
60	If tgere are surgeons available for ""Elective Surgery"" where I am aware the Trust is paid to do this by the government, then wht can't theses same surgeons be available for Emergency Surgery??		
61	Would like in with plans to the acute site plans		
62	Why do you keep forgetting Cheltenham General Hospital		
63	Patient choice		
64	This is too narrowly focused to meet the needs of the whole county.		
65	If IGIS is in GRH, that's where EGS should be too		

Please tell us what you think about our preferred option to develop:A 'centre of excellence' for Emergency General Surgery at Gloucestershire Royal Hospital.		Response Percent	Response Total
66	Improve patient outcomes, centralised care with specialists available to review patients as all based at Gloucester. Staff morale and retention. Improve care of patients including access to SAU and patient flow. Reduce cancellation of specific surgical procedures. Improve quality of care provided.		
67	As in previous answer not easy to get to from some parts of County and parking very difficult		
68	If acute care services are to be centred at GRH it makes sense for the emergency general surgery to also be at GRH to avoid transfers of very sick patients.		
69	Again as with the previous question, it stands to reason that Emergency General Surgery needs to be on both sites as this is the next step further into the hospital system after A&E and Acute Medicine.		
70	CGH can offer the same service, like they used to		
71	Cheltenham needs surgery. As some people can not travel to Gloucester		
72	I think it will benefit local people to have this provision and will promote continued quality improvement and performance in this area.		
73	I want to see best staff possible in an emergency - I don't mind where it is but Gloucester makes more sense		
74	I support this because a centre of excellence breeds faith in the healthcare provided.		
75	The main cardiac ward is at GRH		
76	No Way. Build a new hospital and I might consider it. The tower block is not fit for practice. Its old and outdated with few siderooms.		
77	Would like Pathology to be taken into account with these decisions - especially Blood Transfusion as we are having to do an increasing amount of work overnight yet have no funding for extra staff! 1 person that covers the whole hospital at GRH is dangerous.		
78	Services at CG H should be of equivalent quality.		
79	A sensible approach.		
80	Many people from Cheltenham and North Gloucestershire would die on the way to Gloucester Royal. The traffic at many times of the day is apalling in Gloucester. You seem to be considering Cheltenham as a small village when in fact it has a population of 112,700. When you include the Cotswolds it rises to 196,300. With the regular increases of population throughout the year this should surely make a difference to your decision.		
81	To keep emergency and elective surgery seperate.		
82	Similar concerns to those outlined in first answer. Access problems, insufficient parking, traffic congestion and in addition the removal of general surgery is a highly significant reduction in the capability of the Cheltenham Hospital which will in due course be used as the rationale for full closure. Having services available on two sites also provides capacity and resilience in terms of space and equipment etc if one site has to be closed due to an outbreak of norovirus or covid for example. Please don't say this won't happen as you know this is the tried and tested route taken in other hospital reorganisations that have taken place across the country.		
83	Important to patients and staff.		
84	Both centres need to provide excellent emergency surgery.		
85	Please see earlier comments,		
86	Because the majority of emergency admissions go to Gloucester so it is logical for them to have all emergency surgery. However, I think Cheltenham needs to have a 24 hr ED with a specialism in oncology, urology and colorectal.		

Please tell us what you think about our preferred option to develop:A ‘centre of excellence’ for Emergency General Surgery at Gloucestershire Royal Hospital.		Response Percent	Response Total
87	This should be done in Cheltenham too		
88	Need these services at Cheltenham General Hospital too.		
89	Trauma units have better expertise		
90	Too far to travel for people living East of Cheltenham		
91	The establishment of a single site for emergency general surgery will lead to better access to subspecialist care. There needs to be adequate provision of beds and assessment areas. Junior doctors will be better supported. If the same staff provide emergency, elective and day case surgery surely making changes to one component will impact on the others. Why are the changes to generals not being considered as a whole?		
92	It's a rational use of limited resources. Concentration of specialist people, and specialist kit, absolutely makes sense, and research shows that it produces better outcomes.		
93	Best location and facilities in the county		
94	see above		
95	I have to travel to both hospitals, so it makes no difference to me.		
96	How would the rotas become more robust if the hospital is lacking enough trainees and junior doctors?		
97	Again one location makes sense		
98	centralised is better		
99	There should be good emergency general surgery at both GRH and CGH together wit 24 hour consultant led A&E departments at both locations.		
100	Please note I don't fully follow the options here - the short booklet seemed to refer to the longer booklet. the long booklet was too confusing as to what you really meant. A picture /diagram of the before vs after might help add the clarity required Would support measures to be seen by the right person sooner but some concerns about travelling distance for patient and/or family and friends if having to travel from e.g. the east/north of the county. Using a bus (could be 2+), particularly later in the day/evening, or having to fork out a for a taxi/persuade a friend/family member to drive further is far from ideal. Some concerns over whether there would be sufficient bed space for services to be centralised - other hospitals who have merged services from two sites relatively near to each other onto one site have experienced issues with capacity e.g. a county to the north of Gloucestershire		
101	If, as stated, you have no plans to close CGH ED, I'm concerned that transfers from CGH to GRH for emergency surgery would need to occur. What is the mitigation for this - do you commission additional resources from SWASFT or purchase additional 3rd party ambulance resource to undertake the additional transfers that will inevitably occur should this proceed.		
102	Skilled teams can provide care needed People may have to travel, but for a good outcome it is worth it		
103	More efficient use of staff. The more surgeries completed the better the surgeons become and so patient outcomes should improve.		
104	If emergency treatment is performed at one hospital, GRH, it leaves planned surgery at the other, CGH, not liable to interruption for emergency surgery.		
105	NOt a good option. The county needs flexibility for disasters and infections. Using Cheltenham fully will also mean patients are treated faster ensuring minimal complications, quicker recovery and better availability of Ambulances.		
106	The proposed solution in the Consultation Document appears sound.		
107	Service already good		

Please tell us what you think about our preferred option to develop:A ‘centre of excellence’ for Emergency General Surgery at Gloucestershire Royal Hospital.		Response Percent	Response Total
108	I believe it is essential to have emergency general surgery at two locations in the county ie Cheltenham and Gloucester.		
109	See my previous answer		
110	There needs to be more than one center as GRH may be unavailable through a disaster, infection or overloading. Currently GRH A&E is too busy.		
111	Transport to GRH from the Cotswolds is both difficult and expensive		
112	As mentioned on previous page		
113	As before		
114	Emergency treatment should be available at both hospitals. General surgery could be centred in GRH but both hospitals should be able to save lives.		
115	Again there needs to be more access to services nearer the population rather than centralised.		
116	Emergency general surgery should also be in Cheltenham		
117	Much more favoured is spreading surgical procedures across the county's various community hospitals. It would also provide more centres of learning for the clinical staff.		
118	because of location personally I would prefer Cheltenham to have a unit too but accept the managements experience. However have they experienced as a patient/patients family having to travel from Northern parts of our county?		
119	As for Acute medicine, access to multidisciplanry team and equipment		
120	Makes sense to specialise		
121	According to the Royal College of Surgeons ""Patients requiring emergency surgical assessment or treatment are among the most unwell patients in the NHS. Often elderly, frail and with significant other health problems, the risk of death or serious complication is unacceptably high."". This means the increasing unacceptable the risk to patients of making them travel from east of Cheltenham travel through the town and a further 10 miles to GRH		
122	It makes sense to concentrate expertise at one hospital, and GRH has already road tested this approach.		
123	As mentioned this sort of service MUST be available at both hospitals. Frankly I do not understand why it should ben centred at one hospital. It appears to be a cost cutting ploy		
124	will it mean no surgery at other hospitals and will they then be less of a centre of excellence. Assume not so need care with wording and implications		
125	Need to provide theatres with the most up to date equipment, drugs and staff		
126	Forerunner to removing emergency from Cheltenham		

Please tell us what you think about our preferred option to develop:A ‘centre of excellence’ for Emergency General Surgery at Gloucestershire Royal Hospital.		Response Percent	Response Total
	127	I support the proposals to change and think the information provided presents a strong case. However, throughout the consultation document I see little or no reference to: a) How staff are to be retained, trained, recruited and afforded. b) No refernce to any improvements to process or service instigated as part of the response to Covid -19 which will be retained as Best Practice moving forward. c) Limited reference to the way that services will be re-modelled in line with international Best Practice. There is limited information given for example on the use of telemedicine, telephone consultation and foillow up, health education in primary care, transfer of services into coimmunity settings, converstions to higher day case rates, better streaming through outpatients (and ED). The proposals appear to deal with the issue of duplication of services across two sites and consequent rationalisation and whilst this is to be welcomed, of itself, it does little to illustrate how the models of care can or will change. Similarly there is no financial analysis (that I can see) with the documentation provided. In an increasingly stretched NHS, this must be a consideration for services to be long term sustainable.		
	128	For my reasons under Acute Medical		
	129	See my previous answer. All Emergency services should be excellent. The fact that many who come aren't emergency is another matter and requires more education and awareness raising to also not put those off that really should seek emergency help.		
	130	There should be 2 full A&E services. Cheltenham should be full A&E not just sprained wrists.		
	131	Having all your 'specialist' staff in one area may be better and more cost effective for you but as always it's the patients who suffer. Traveling to and from Gloucester is not easy for those without their own transport. Even if the patient is transported to Gloucester by ambulance, once discharged they have still got to find their own way home, probably still feeling very unwell. They may not have friends with a car or have sufficient funds to cover the cost of a taxi, which leaves the bus, if it is running and if it is not full - not very good for infection control following surgery. There is also historically a poor reputation for infection control at GRH. I would not feel confident going there for anything serious.		
	132	Concentration of key resources in one place to reduce duplication and wastage.		
	133	It is a good idea, except again that as we are on the edge of the county Gloucestershire is further away		
	134	As before all emergency services should be centralised		
	135	As above		
	136	GRH simply does not have the capacity with all of the counties A/E cases medical & surgical. the ICU is only rated good & has poor patient flow due to lack of beds in the service. CHG has the beds, the staff, the theatre space & an outstanding CQC rated ICU. emergency surgery has been carried out at CGH with excellent outcomes & no compromise to patient care. keeping everything at GRH simply isn't the safest or the best outcome for the patient. east side of the county considerably at a disadvantage		
	137	Makes absolutely sense to centralise and link in with the 24/;7 emergency care concept. It is simply not feasible to deliver across two sites and making GRH the site fits with the 24/7 emergency pathways.		
	138	Smaller A and .e with nurse practitioners would lessen the load on the big hospitals		
	139	Concentration of emergency team in one place means		
	140	Again, it makes sense to have one very well equipped and staffed hospital rather than 2 close but less well resourced units		
	141	Right to co-locate this with the A&E centre of excellence.		
	142	Yes but the risks of additional transfer time for patients. Waiting times are already considerably higher. Can this be mitigated by keeping 'much less urgent cases away'? Strain on Ambulance Service. How does this all impact the other Gloucestershire Hospitals?		
	143	Benefits patients outcomes to have a centralised service, that will strive to become the centre of excellence		

Please tell us what you think about our preferred option to develop:A ‘centre of excellence’ for Emergency General Surgery at Gloucestershire Royal Hospital.		Response Percent	Response Total
144	The key word is Emergency. All emergencies should be treated as close as possible to the point at which the emergency was recognised. Unnecessary travel is best avoided and may introduce stress to the detriment of the patient.		
145	in line with evidence, a well equipped unit with expert doctors, nurses, pharmacists, physio and other AHP is associated with better outcomes; travelling further is a hard but worthwhile price to pay		
146	Travel visiting and carers		
147	As I live in the northern tip of Gloucestershire, the extra distance to Gloucester for many of these services worries me		
148	Mocking all emergency services to GRH site logical I terms of collocation and impact on ambulance services		
149	Again would like CGH to be able to continue to provide this to local residents and not all centralised at GRH.		
150	It is important to have have the acute services on one site so people can receive the emrgency care they need quickly and easily		
151	Separate emergency services from elective services completely		
152	As long as theatre space would increase in line with the need		
153	Please see my comments on the previous section regarding capacity and my support of the proposal IF the level of service is maintained to ensure that full and effective delivery, commensurate with the population of the area, can still be provided (or this proposal makes the service delivery more efficient).		
154	Better to have emergency care in one place with a full team of experts . Planned surgery can then take place at Cheltenham		
155	Why should we have a hospital in our town but only offering limited services		
156	Same as previous question - it's creating an even greater imbalance in the emergency care at the two hospitals.		
157	Full AE needs to be at both sites to cope with capacity		
158	Again reduce duplication of doctors. Allow prompt senior review by team. Again sufficient senior staff must be on shift. One team operating and one reviewing pts. Busy team (CGH & GRH worth of pts at GRH) with only one team available will mean operating or reviewing not both. NEED BOTH. Also if this is to happen more GRH emergency theatre space will be needed so that other surgical specialities can do their cases promptly too!		
159	Better care for the community		
160	Essential for the county		
161	This leaves too much dependancy on the Ambulance Service to deliver services in a timely manner. It seems ludicrous to have ambulances criss crossing the county with all the attendant traffic delays that seem to be on Gloucestershire's roads. Are there any Service Level Agreements iwth the Ambulance Serviced to ensure timely tarhgets are met. What happens if (as seems to happen often) there is no availability of ambulances.		
162	One would hope a centre of excellence would deal with patients quickly - I am aware of patients who feel the waiting time is too long and go aboard / different county for treatment and often end up worse		
163	Gloucester closer to M% for post accident care and emergency admissions		
164	Agree with any proposal to avoid unnecessary duplication		
165	Emergency general surgery should be available at both hospitals		
166	It seems sensible and more cost effective to centralise services		

Please tell us what you think about our preferred option to develop:A ‘centre of excellence’ for Emergency General Surgery at Gloucestershire Royal Hospital.		Response Percent	Response Total
167	The current system, with surgery at both hospitals, is better for anyone who: has money issues lacks transport has complex needs of any type I understand the desire to group services together for the NHS' logistical sake, but for anyone who struggles, in any way, being themselves in another town or having their loved ones in another town creates complications and unhappiness as mentioned in my previous answer. By doing this, you prioritise those with money, time and head space to cope with these extra complications, and disadvantage anyone who struggles in any way.		
168	A centre of excellence at Gloucester Royal would detract from the service at Cheltenham General		
169	Anything that improves capacity, reduces cancellations must be good. I prefer option 2		
170	Reducing waiting time, planned surgeries that are preformed on time contributes significantly to the health and wellbeing of patients and their families reducing stress and unnecessary waiting times		
171	Ditto for reasons of building great teams, having all the equipment you need on site, better patient experience.		
172	Too one centre focused for large county. Means relatives and patients taken a long way from their home area and support network. Foreign strange environment therefore better if more local based		
173	Lessen impact on planned surgery		
174	Again, although this would be less convenient in respect of a present home the benefits would seem to outweigh the convenience		
175	This presumably will ensure connection with acute medical care		
176	As with all your proposals to centralise services the problem is that of access for patients and their families. Whilst many have access to private transport a very large minority do not and they are frequently the elderly and less financially secure. For these people centralisation poses a major difficulty in accessing your services unless you propose to offer free transport between the sites. Even for those with private transport difficulties in accessing parking at iether site pose difficulties and high costs.		
177	It is best to concentrate acute unselected surgical admission to one site which will also house acute medicine as well as ED and Critical care.		
178	As previous question.		
179	Glos Royal needs to improve.		
180	Pressure eased on gaps in surgery and better for consultants and trainees. Shorter waiting and being messed about.		
181	As previous		
182	Specialist staff and equipment in one location. Saves on time and money.		
183	As stated before about transport links.		
184	Same as Acute Medicine comments Experienced qualified staff centralised More opportunities for shared learning and research Intensive care facilities on one site High tech imaging facilities...		
185	Because it makes best use of all resources		
186	The other options are more suitable		
187	Being seen by the right specialist, not going through several appointments and being re-directed		
188	Gloucestershire royal already has good facilities and several operating theatres with experienced staff		

Please tell us what you think about our preferred option to develop:A ‘centre of excellence’ for Emergency General Surgery at Gloucestershire Royal Hospital.		Response Percent	Response Total
189	Recent months have shown that the shutting of A&E in cheltenham and the removal of emergency surgery/planned surgery from Cheltenham has negatively impacted on patients and their experiences when previously having it on both sites worked due to the available DCC beds and the larger capacity. Raises questions of who is to blame for deaths when emergency surgery is not available on one site and someone dies on route, that is negligence where those that have made these decisions do not bare the blame, no family or patient deserved to go through this. Plus as gloucestershire is continually expanding with a rising population having one center for emergency surgery is simple foolery as it will not be able to cope with the ride in demands on already under funded and under staffed wards that receive no reprieve or help of any kind regardless of what is passed around internally or via media outlets		
190	Larger teams with a range of skills should give better outcomes.		
191	Good communications hub.		
192	If its an emergency, the worry is that you would arrive at CGH and time would be wasted going to GRH because its 5:55pm.		
193	Quicker, more direct access for patients to the right specialist. A 'centre of excellence' will be an attractor for young doctors. Concentration of the right staff cover. Concentrated and improved learning opportunities for junior staff. However, resources, including beds, nursing staff and theatres, will need to be increased at GRH accordingly.		
194	I would fully support the concept of Centre's of excellence for all the reasons documented in your summary document ' Fit for the future'		
195	I do not think that Gloucestershire Royal is a large enough site and believe that patients should have the option to choose which hospital they are treated at and I believe the system works as it was before the shake up of services due to the Covid pandemic. It is blatantly clear that GRH cannot cope with being the only 24hr A&E unit as evidenced by the numerous complaints and concerns that have been raised about this.		
196	Again only if you will continue to have services available at Cheltenham Hospital		
197	Cheltenham is a General hospital and should have surgical beds, including emergency surgery. What sort of hospital would Cheltenham become if medical patients and surgical emergencies were transferred to GRH. This is exercise is about downgrading Cheltenham, which currently has the facilities to offer high quality care. This will have an impact on the A&E department, essentially turning it into a minor injuries unit.		
198	The term ‘Centre of Excellence for General Surgery’ is meaningless and is a smokescreen; what on earth have the services that currently exist been aspiring to if not ‘excellence’? There has been no evidence disclosed to illustrate this contention and it is quite plain that the ‘detailed’ consideration performed internally has been deliberately configured to yield a predetermined outcome. The only area where there has been any relative underperformance on the CGH site has been the surgical management of acute biliary disease. This has been brought up repeatedly by the Gloucestershire Royal surgeons over the last six or seven years whilst the general surgical service at CGH has been deliberately and unnecessarily run down. If this deficit was so significant an issue, why wasn’t something done about it years ago? Simple solutions were readily available but were ignored by the Trust because they rather inconveniently did not fit with the centralising narrative. If this was genuinely a significant deficit, harming patients, then there is real culpability on the part of management not to have addressed it a very long time ago.		
199	We prefer Cheltenham - see page 37 My wife and I are in our 90th year. She is not allowed to drive. I prefer daylight and not Mon or Friday. We live in Tetbury and wish treatment there. So: We prefer Cheltenham and do not like Gloucester, the former being easier for us to reach by car and more convenient in terms of other activities on the day.		
200	As above Because I live in Gloucester		

Please tell us what you think about our preferred option to develop:A ‘centre of excellence’ for Emergency General Surgery at Gloucestershire Royal Hospital.		Response Percent	Response Total
201	The idea of creating centres of excellence at both of the two excellent large hospitals in Gloucestershire makes sense. It is worth remembering that the other specialist inpatient services, which have already centralised at either CGH or GRH e.g. cancer services at CGH and childrens' services at GRH, are working really well for patients.		
202	The facilities can be enhanced at less cost at this hospital		
203	Distance from North Cotswolds		
204	This would be a more efficient use of resources.		
205	It seems that this is working well in the temporary changes that you have made		
206	Surely access to care should be of primary concern to a hospital? Any solution should not have a negative impact? I query your statistics? The positive benefit for this change is for the homeless and people fro deprived areas (why what is the number of these that have general surgery) You quote 25% of Gloucester are from deprived areas but how many of these have emergency surgery? What is the proportion from the deprived and homeless areas around cheltenham? The negative benefit is for 40% of patients! So you already know that 40% of your most vulnerable are over 65 and these are the people most affected? So you are negatively affecting almost half your patients?		
207	I can see the advantages of the proposal but I am concerned GRH's capacity to provide the capacity and service levels proposed.		
208	Again, involves removing important services from Cheltenham. Calling something a ""centre of excellence"" doesn't actually mask the fact that it's an excuse to cut services elsewhere.		
209	Central to county for all		
210	Unsafe, inadequate beds, chaotic, not essential to be on one site, worked very well on both sites. Poor bed flow inadequate ICU. Poor service for east side of county.		
211	Focus of resources on one site		
212	It makes sense to co-locate emergency medicine and surgery at GRH		
213	The creation of a General Surgery Centre of Excellence, would provide the best fit with Emergency Surgery. Therefore the first option.		
214	I would prefer to go to Cheltenham Hospital.		
215	Improved dr cover including a review by the correct sub specialty		
216	Again Cheltenham should not be downgraded by taking away, not only medical beds but also the capacity to perform emergency general surgery. This will have adverse effects on the A&E, because patients will be directed to GRH, essentially downgrading Cheltenham A&E to a MIU. If I was pushed to decide on the two option - because I would not want Cheltenham to lose surgical services then I would choose the second proposal of making CGH a centre for pelvic resection etc.		
217	I like the idea of concentrating the expertise in a single location		
218	In line with acute medicine and A&E focus		
219	The risks mean that this should be with the Acute provision.		
220	The preferred option would mean that people living in the east of Gloucestershire would have to travel further for treatment in an emergency. This may mean people will die en route to Gloucester.		
221	Mental health at Cheltenham Good centre		
222	Yes I would like this to stay in Gloucester I am bias I live just outside Gloucester I like the benefits to staff members and staff retention.		
223	There is a need for general surgery services at CGH otherwise patients would need to be moved in an emergency situation.		

Please tell us what you think about our preferred option to develop:A ‘centre of excellence’ for Emergency General Surgery at Gloucestershire Royal Hospital.		Response Percent	Response Total
224	As above Strongly support the idea of having 'specialties' at one of the two hospitals only.		
225	Better building and access		
226	Because of the increased local population both sites should be used.		
227	I don't think GRH has capacity now or planned		
228	A specialist unit such as this makes sense.		
229	These cases can develop for the Acute Medical Take, so continuity in treatment, assessment and rehab will flow more easily. Confidence for patient.		
230	For the same reasons as above To concentrate the necessary skills in the centre of the catchment area		
231	No General Surgery beds at 1 hospital could impact badly on some patients.		
232	As mentioned on the previous page, I am concerned about the perceived downgrading of Cheltenham. Gloucester is difficult to reach from the Fairford end of the county and parking is difficult. Also (as mentioned previously) it takes longer to get to GRH than it does to Cheltenham hospital and the travel time varies depending on the traffic on the A417 (particularly at the Air Balloon).		
233	As with previous question, centralising acute services on the GRH site will allow CGH to be a major elective surgical centre with patients following, on the whole, a relatively fixed pathway allowing for optimal flow and best use of the existing critical care unit at CGH which otherwise risks being mothballed.		
234	Ensure the facilities are set up with adequate space to assess patients in a timely manner. The current temporary changes are working well with more patients seen in a shorter time frame. However, limited space and beds in assessment rooms impacts on the the ability to deliver a truly first class service.		
235	Nothing in the proposals that says emergency general surgery is better here than anywhere else.		
236	Same as the comment on the first page. If I were requiring this service, the hospital location wouldn't matter, but the level of service would. If merging meant a world class service, then be difficult to argue against it.		
237	as per commentary in last page; fear over increase travel times		
238	I have no objection to the siting of specialist services on one hospital site. If this allows the particular hospital to improve its services in that field so much the better. I am, however, concerned that too much emphasis is being placed on GRH. This concerns me because I do not believe that GRH has the facilities or space to cope with extra work.		
239	If ALL emergencies are taken to Gloucestershire Royal Hospital it means the A&E Department at Cheltenham would no longer be a Type 1 A&E Department.		
240	Taking away this service from Cheltenham GENERAL hospital, where patients receive as the National Audit shows, good or excellent care, is a very short-sighted and poor decision. More patients will suffer and die needlessly because of lengthier travel to GRH. GRH will require to increase it's capacity of beds to cope with the extra demands. This will impact Cheltenham A&E department as surgical emergencies will be redirected to GRH. What sort of unit will CGH have then?		
241	Please note my previous comments the journey from FoD especially for older people is worrying and expensive. Hospital transport has failed badly and causing long delays in returning home. I am 90 years of age		
242	Look at the appointment systems and make the phone system shorter.		
243	see previous comment		
244	A centre of excellence is essential and you shouldn't spread your resources. The hospitals are close enough that no areas should be disadvantaged.		
245	you are sucking the life out of CHG all hospitals should have these specialties.		

Please tell us what you think about our preferred option to develop:A ‘centre of excellence’ for Emergency General Surgery at Gloucestershire Royal Hospital.		Response Percent	Response Total
246	It is probably best to divide the centre of excellence status for best use of available expertise		
247	Your second option		
248	Specialisation usually leads to higher quality service and the attraction of most able doctors		
249	always needed - Will specialist staff really be available or too busy elsewhere? How practical will this be or is sit just a hope		

Please tell us what you think about our preferred option to develop: A ‘centre of excellence’ for Planned Lower GI (colorectal) general surgery at Cheltenham General Hospital (CGH) or Gloucestershire Royal Hospital (GRH).			Response Percent	Response Total
1	Strongly support		44.59%	239
2	Support		34.51%	185
3	Oppose		4.66%	25
4	Strongly oppose		3.17%	17
5	No opinion		13.06%	70
			answered	536
			skipped	88

Please tell us why you think this, e.g. the information you would like us to consider (216)	
1	If it means fewer cancelled operations and less disruption in the busy winter months then it has to be a good thing.
2	I would like Gloucester to be a better option for care, this should be improved so that its more viable than having to travel to cheltenham to visit people.
3	Or???? Which is it?
4	Cohorting patients and clinical expertise leads to better patient care from a highly specialised team. We have seen the benefits of this through Vascular and Trauma networks.
5	Less bed issues for elective cases if away from emergency pathways. Fully staffed DCC at CGH barely used currently.
6	for planned work we need to avoid the emergency site so the work continues despite emergencies - needs to be based at the non-emergency hospital cgh
7	It makes sense to consolidate planned care at either site, but does an emergency service need to remain at the other site?
8	The same as previous it is easier to manage and better cost savings for the trust, tax payer.
9	Again it would make sense to have all GI surger on one site as patients don’t always fit nicely into one speciality . So, GRH.
10	Elective services would benefit from single site 'centre of excellence' but with the capacity to transfer from Acute medicine/surgery at both sites.
11	If the ward is staffed properly, it could work.

Please tell us what you think about our preferred option to develop: A ‘centre of excellence’ for Planned Lower GI (colorectal) general surgery at Cheltenham General Hospital (CGH) or Gloucestershire Royal Hospital (GRH).		Response Percent	Response Total
12	I think that all planned colorectal general surgery should take place at Cheltenham General Hospital. If I was a patient I would know my operation is less likely to be cancelled, that the ward would be clean and CGH is currently the 'green' site. I would not want to chance being put in a bed next to an emergency surgery patient who has not had a covid swab results prior to admission.		
13	As stated previously it is sensible to separate the acute and elective work in the current pandemic. There are not enough beds in GRH to have all the acute work + elective GI surgery.		
14	care of all patients in the trust has deteriorated in the last few years due to lack of access to specialist services that used to be on both sites. Patient discharge is often delayed by days awaiting review by specialities based on different sites. This is frustrating for Staff, patients and their relatives		
15	You should be able to go to nearest hospital for treatment, staff should be split between the 2 hospitals if necessary so this can be done		
16	Centralising planned aspects of care could take pressure off these being cancelled due to emergency procedures taking precedent.		
17	If it's planned, why not just go to Oxford and build a bigger unit there?		
18	Absolutely no way, Gloucestershire is way to big gloucester hospital can't cope with what services it so so provides, so sending colorectal patients to gloucester shouldn't happen. Cheltenham should keep all of the surgery especially colorectal.		
19	I think it should be bk in Cheltenham		
20	GRH surgical bedspace already limited; conversely beds available at CGH for increased surgical work. Transfer to all planned colorectal work to GRH would increase already high pressure on surgical bed availability. Centralising lower GI at CGH would make use of existing surgical cover and surgical nursing staff with less bed pressures than at GRH. Benefits to be had from concentrating all colorectal lists at a single site - CGH the obvious option as currently has less bed pressure than GRH but still has required surgical and nursing expertise. Gastroenterology already at CGH which would benefit those patients who need input from gastro medics whilst under care of Lower GI surgeons.		
21	Unless there is a shortage of staff with the correct expertise I do not see why a single centre of excellence in Gloucester is a fair option for Cheltonians. It’s a long journey and a real challenge for elderly patients - visiting and collection of discharged patients becomes far more challenging especially for those restricted to public transport.		
22	There aren't enough staff to go around, so we need to make best use of those we have.		
23	as previous		
24	Planned care still requires experts and equipment, its unreasonable to expect the NHS to be able to fund this on two sites that are so close to each other		
25	I think planned surgery could be better placed within CGH so that GRH can focus on the emergency general surgery.		
26	The service needs to be split across the county with two centres of excellence. A dedicated stand alone day case unit in CGH will enable the vast majority of Goucestershires' patients to have their elective surgery in a protected cold unit. Resectional surgery needs to be co-located with emergency general surgery for safety and staffing reasons.		
27	Making Cheltenham a centre for elective surgery makes sense if you are wishing to centralise emergency at GRH, especially with covid. However patient choice does not seem to factor in your decisions.		
28	Based on my support for emergency care at Gloucester, presumably it would make room at Cheltenham for this area of non-urgent operations.		
29	Silo'd services appear much simpler to locate on a single site.		
30	It has been mooted for some time, so that GRH would become the 'hot' hospital, while CGH would take 'cold surgery'. This seems to have been an accepted version of things to come, so it is no surprise, and for me, there is no good reason to oppose		

Please tell us what you think about our preferred option to develop: A 'centre of excellence' for Planned Lower GI (colorectal) general surgery at Cheltenham General Hospital (CGH) or Gloucestershire Royal Hospital (GRH).		Response Percent	Response Total
31	Lower GI at CGH is already considered excellent within the surgical community and so this could be built on		
32	as above		
33	Major colorectal surgery should be on one site		
34	It should be CGH, because you want everything to be easy and understandable not only for the patients, but also for the workforce. I mean try to close the cycle within one medical field. Get Endoscopy, Theatres at one place.		
35	Far too far away from Fairford to be a good option for patients from that town/area		
36	planned surgery in a centre of excellence is nothing but good, but the site needs to be fit for this and to be able to accommodate patients staff and services alike		
37	Better than at Gloucester but improve parking		
38	GRH cannot cope with the surgical requirements, especially if they take all the elective surgery too.		
39	Better care due to expertise and less chance of cancelling operations		
40	Gloucestershire Royal is the most modern of the two hospitals and parts of the Cheltenham Hospital are 200 years old and unsuitable for 21st century health care provision. The most recent blocks in College Road Cheltenham could be used to complement the services provided at the Gloucester base		
41	As above		
42	Planned surgery can be dealt either in cheltenham/Gloucester. But ideal would be in 2 different hospitals. so more cases can be conducted.		
43	Planned at CGH Emergency at GRH.. It would be a neat way of organising activities		
44	Main reason as before		
45	A unit at CGH would be the best option as if at GRH then the patients would be at risk of being mixed with emergency surgery and all the problems that can cause.		
46	If some cases would follow on from an a & e visit it makes sense to have it where the larger a & e capacity is		
47	It's limiting public access to one site.		
48	I support this but I don't have much opinion about it.		
49	Planned care may be beneficial to site at CGH		
50	There is an increasing population in Cheltenham and we are in danger of being forgotten.		
51	Patient choice		
52	Too narrowly focused to meet the needs of the whole county. Vulnerable to cuts in staffing and funding		
53	means that elective patients are less likely to be cancelled for emergencies.		
54	Improve patient outcomes, enhance quality of care, improve patient flow, improve staff retention and accessibility of the service.		
55	Cheltenham General should remain a major hospital together with great in the area		
56	As I mentioned before; it is important to reflect the importance and value of CGH in any plans going forward - seeing the two sites as a split site, rather than prioritising GRH. Something like planned surgery would be a good fit for CGH		

Please tell us what you think about our preferred option to develop: A 'centre of excellence' for Planned Lower GI (colorectal) general surgery at Cheltenham General Hospital (CGH) or Gloucestershire Royal Hospital (GRH).		Response Percent	Response Total
57	Having experienced this service, I know that the present set-up works well. CGH is already a centre of excellence for cancer, colorectal surgery is integral to that service, it makes common sense to fully embed this at CGH. Further, I am aware that moving this service to GRH is not popular with staff and could result in the loss of crucial expertise. Staff retention is a critical issue at all times - conserve what you have.		
58	CGH can do this just like they used to		
59	This is an 'either or' question without giving an opportunity to vote for either. It is nonsense.		
60	Makes sense if centralising other GI services.		
61	It will benefit local people needing this type of surgery		
62	essential to attract good specialists and perhaps in time take on childrens so we dont have to travel to Bristol		
63	This is also at the forefront of healthcare and we should try to learn all we can about this deadly problem.Centres of excellence are important because we give patients the best care possible.		
64	It would be good for the hospital to specialise in this field, however the colorectal ward is at GRH		
65	I would support this if CGH was the 'centre of excellence' for lower GI. But again not GRH. There are not enough beds at GRH for emergency surgery and planned surgery. If it was at GRH alot of planned surgery would be cancelled because the beds would get used up by Emergency surgery and medical patients. As alot of this is cancer surgery it needs to be in a hospital that is clean and where the Oncology service/support services are.		
66	Would like Pathology to be taken into account with these decisions - especially Blood Transfusion as we are having to do an increasing amount of work overnight yet have no funding for extra staff! 1 person that covers the whole hospital at GRH is dangerous.		
67	Both hospitals should offer an equivalent standard of care		
68	Specialist staff in one place should mean collaboration in terms of quickly dealing with patient problems. Quick treatment/ diagnosis of Crohn's can reduce the need for surgery, less time off work and a better quality of life!		
69	A sensible rational approach		
70	Yes it soulnds fine but surely Gloucester Royal will want their own as well!		
71	As a sufferer in this speciality I consider it to be of great importance to provide the best possible service.		
72	I would support this to be at CGH.		
73	Cheltenham needs to become a centre of excellence for colorectal surgery, urology and oncology, both planned and emergency		
74	Both Cheltenham and Gloucester need to do general surgery, I was released from hospital in gloucester at 11.30pm and as I was taken there by ambulance I didn't have my car, thankfully I have a son that drives but many people would be stranded, I could of walked home if I had been taken to Cheltenham		
75	What is the evidence for specialist bowel surgery ?		
76	Combining the service will provide greater scope for subspecialist practice within colorectal surgery. Training will be enhanced and a concentration of resources including medical and nursing will make the service run more smoothly		
77	Diagnostics are ok at Cheltenham, but specialist surgery needs to be where specialist surgery is based...		
78	But Cheltenham would be easier because of my disability and needing wheechair accessible transport which cost more if I am required to go to Gloucester Royal		
79	CGH		
80	Higher standards and expertise can be employed centrally		
81	I would prefer it to,be at Cheltenham generL as it is a better hospital than Gloucestershire royal		

Please tell us what you think about our preferred option to develop: A 'centre of excellence' for Planned Lower GI (colorectal) general surgery at Cheltenham General Hospital (CGH) or Gloucestershire Royal Hospital (GRH).		Response Percent	Response Total
82	Prefer Cheltenham for reason quoted earlier		
83	experienced good service/care at CGH		
84	But on both sites		
85	I support a centre for excellence.		
86	Again slightly confused as to the proposal here - a before/after diagram might have helped. Would support measures to cut risk of operations being cancelled at the last minute / being able to be seen/treated by the right person sooner. Again this needs balancing with the risks of insufficient bed spaces if centralised on one sight (e.g. county to the north of Gloucestershire. In addition there are the same travel concerns - if one is not well, coming by car may be the most practical method of transport, however unpalatable it may be. Hence adequate parking facilities are a must e.g. a dedicated carpark with more short term spaces say of up to 45 minutes		
87	Being able to have all services on one site is cost effective with equipment best outcome for patients if staff are experts		
88	I agree with the center of excellence approach in principle. I think it will improve patient outcomes.		
89	I think it would be beneficial to have lower G.I. consultants operating or based at Cheltenham. Often other specialities such as Gynae-oncology and urology doing pelvic surgery require assistance or advice from lower G.I. surgeons.		
90	I presume GRH would be a spoke and therefore provide back up.		
91	The relevant proposals in the Consultation Document appear sound.		
92	Need specialist services		
93	It is probably more efficient to concentrate resources at one dedicated hospital.		
94	Cheltenham is quite far enough for us to travel		
95	This would be with the proviso that other hospitals are secondary but still have abilities.		
96	see previous comment re transport		
97	With elective surgery the distances to either hospital are manageable and can be planned. It the A&E that needs to remain available at both sites.		
98	As before		
99	GI is already at CGH why change it, rather expand on it		
100	Again single centres are taking care away from local areas		
101	all planed surgery should be subject of a centre of excellence, at both hospitals, not just Lower GI		
102	As above		
103	Personal preference Cheltenham but would support either or shared		
104	seperating emergency from planned services should prevent cancellations and create the right number of beds for the planned procedures. Co-locating with other pelvic services makes sense as I suspect they often need to work together		
105	I accept it is no longer practical/affordable to have all specialisms at both sites		
106	Again, this is about providing the best patient service by locating staff at one centre.		
107	Again have services available at both Cheltenham and Gloucester		
108	dont know enough about this problem but previous comments would apply		

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109	Having undergone colorectal surgery for cancer of the lower bowel in March 2020 I was confident that any complications would be dealt with		
110	I support the proposals to change and think the information provided presents a strong case. However, throughout the consultation document I see little or no reference to: a) How staff are to be retained, trained, recruited and afforded. b) No refernce to any improvements to process or service instigated as part of the response to Covid -19 which will be retained as Best Practice moving forward. c) Limited reference to the way that services will be re-modelled in line with international Best Practice. There is limited information given for example on the use of telemedicine, telephone consultation and foillow up, health education in primary care, transfer of services into coimmunity settings, converstions to higher day case rates, better streaming through outpatients (and ED). The proposals appear to deal with the issue of duplication of services across two sites and consequent rationalisation and whilst this is to be welcomed, of itself, it does little to illustrate how the models of care can or will change. Similarly there is no financial analysis (that I can see) with the documentation provided. In an increasingly stretched NHS, this must be a consideration for services to be long term sustainable.		
111	We need to establish strong bases in Cheltenham. Naive perhaps to suggest centres of excellence should be visible fairly equally in both hospitals, but there could be a tendency otherwise for one of the two (probably CGH) to have lesser standing, lesser research/funding potential		
112	Don't understand. Talking jargon.		
113	If it is planned surgery the patient will have had time to plan how they will get to and from the hospital, and anyone who wishes to visit can factor the distance into their preparations. There is still the question of the exorbitant parking fees on the GRH site. Although CGH also charges stupidly high parking fees, Cheltenham based patients being treated in Cheltenham and their visitors might not need to use their cars and could avoid these phenomenally high charges. There is also historically a poor reputation for infection control at GRH. I would not feel confident going there for anything serious.		
114	Concentration of key resources in one place to reduce duplication and wastage.		
115	It is a good idea, except again that as we are on the edge of the county Gloucestershire is further away		
116	this will allow the trust to develop a service which will be second to none. it will link in with gynae / urology & a centre of excellence for oncology too. the bed flow / capacity is there. CGH has an outstanding ICU and staff who are specialised in pelvic surgery to provide excellent care. patient flow & discharge will improve. patients will get an improved service so not mixed with emergency care & can maintain a green site especially if future pandemics as per recommendations		
117	Support the concept of having centralised services. From clinical delivery stance, staffing and financial.		
118	Team work is vital to good patient experience and outcomes - fragmented teams cannot provide this and do not attract the best to come and work in them.		
119	Again, it makes sense to have one very well equipped and staffed hospital rather than 2 close but less well resourced units		
120	One world-class centre looks ideal to me.		
121	As per previous comments		
122	Good to have a centre of excellence. Attracts staff and makes good effective use of both equipment and staff.		
123	but only in one centre		
124	Personal experience of my life being saved this last May when admitted through A&E at CGH with Fournier's disease for immediate operation to deal with gangrene and sepsis from infected scrotum.		
125	Please try and keep all acute specialities on one site.		

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126	Same reasons do not oppose a centre of excellence for Gloucestershire but do oppose strongly the lack of operations at either hospital		
127	Support options where there is access to both sites so this is good		
128	Again the principle of centres of excellence is a good one - I would site it at the most appropriate site - if other planned surgery is at CGH then this should be there too		
129	I strongly prefer this to be at the CGH site as this will ensure elective care for surgical patients will not be affected by the emergency admissions and operations, as is the case now. Also, the ITU at the Cheltenham site can be used solely for elective surgical patients.		
130	It doesn't matter which site, so long as the service is there and available.		
131	Obviously to split up centre of excellence means less pushing people from one A&E to somewhere everything is not to hand		
132	I can't support that being at Cheltenham since you're proposing it in exchange for an inferior emergency service.		
133	Elective care should be split from emergency where clinically appropriate / demand exists - which it does in GS		
134	centre at cheltenham		
135	It can only be a good thing for the people of Gloucestershire		
136	ensure up to date medical procedures are available		
137	Planned surgery at least gives patients time to make suitable travelkarrangements		
138	Pros and cons here but overall would support		
139	Agree with any proposal to avoid unnecessary duplication		
140	CGH would be the better location		
141	Again it seems sensible to centralise resources and staff		
142	Please bear in mind any treatments taken prior to appointments which may make a long journey very difficult		
143	I can't find any notes on the current vs planned systems for this, but if you mean ""all services being in EITHER CGH or GRH"" then my previous comments apply!		
144	We would prefer this service to be available at Cheltenham where my husband had excellence care		
145	As above		
146	Ditto.		
147	Again with population sizes, distances to travel, time of travel, means and ease of travel/access, away from home area and family support better if services are nearer the target audience than a large single centre. Or vide services for both Cheltenham and Gloucester as well as surrounding regions.....Mickleton is a long way to Gloucester		
148	Centre of Excellence required at both hospitals		
149	The proposal would seem to make more effective use of staff and facilities		
150	Planning the priority for hospitals makes sense		
151	As with all your proposals to centralise services the problem is that of access for patients and their families. Whilst many have access to private transport a very large minority do not and they are frequently the elderly and less financially secure. For these people centralisation poses a major difficulty in accessing your services unless you propose to offer free transport between the sites. Even for those with private transport difficulties in accessing parking at iether site pose difficulties and high costs.		

Please tell us what you think about our preferred option to develop: A 'centre of excellence' for Planned Lower GI (colorectal) general surgery at Cheltenham General Hospital (CGH) or Gloucestershire Royal Hospital (GRH).		Response Percent	Response Total
152	I I support this service to be placed at Cheltenham General Hospital. Having worked there I know they have a good record of care in this specialty.		
153	Likely to dilute service and so negatively impact patient outcomes.		
154	This should be on the same site as non-surgical oncology as the two have to work very closely together.		
155	Confused!		
156	Not sure about this as people from the Cotswolds need the nearest place yet Gloucester is better for people from that area.		
157	Single centre would be preferred.		
158	Focussing a specialism in one location makes the most sense providing value for money.		
159	A good way ahead.		
160	Same comments Experienced qualified staff centralised More opportunities for shared learning and research Intensive care facilities on one site High tech imaging facilities...		
161	A single centre makes best use of sataff and resources		
162	COE will benefit Patients and Staff, and make effective use of existing resources		
163	Often have to go to Cheltenham for appointments so makes sense to do it at Cheltenham		
164	At Cheltenham General without a doubt, this has been in place for years and has worked without failure to a high standard. I, my family and friends have received care on this ward to a fantastic degree and then have unfortunately been subjected to GRH due to current events this year, to say that we were disgusted by this change would be a vast understatement. Why change what isn't broken, why ruin a system that has supported so many for years with such a dedicated team that is being picked apart and why support such an idiotic decision to shift CGH to a more medically acute when GRH does not have space for all this surgery and that has also been proven and found this year		
165	Lower GI surgical provision impacts on other surgical specialties including gynae oncology. Gynaecology is linked to Obstetrics, an acute specialty based in Gloucester. Acute gynaecology, including acute gynae oncology admissions, is based in Gloucester hospital. It is not possible to move this acute provision as the registrars cross cover Gynaecology and Obstetrics when on shifts. Moving gynae oncology with Lower GI to Gloucester would provide better training and ward safety for patients.		
166	Not qualified to judge.		
167	If its excellent, who cares where it is?		
168	Concentration of a specialised team and the necessary resources.		
169	Would prefer this option to be at Cheltenham General Hospital		
170	I really dislike the term 'centre of excellence' as it implies that one or the other hospital is somehow failing to provide good quality care. Gloucestershire is a big county with a growing population and a large number of homes being built. Even the new Cybercentre is coming to Cheltenham so it would be very short sighted of the Trust to make permanent changes at a time when Covid is changing the way people want to live and work, particularly bringing more people to live in rural areas. Planned surgery should be located at both hospitals.		
171	CGH already has oncology expertise on site and most colorectal surgery is concerned with malignant disease.		
172	Near both		
173	If it is at GRH		

Please tell us what you think about our preferred option to develop: A ‘centre of excellence’ for Planned Lower GI (colorectal) general surgery at Cheltenham General Hospital (CGH) or Gloucestershire Royal Hospital (GRH).		Response Percent	Response Total
174	The idea of creating centres of excellence at both of the two excellent large hospitals in Gloucestershire makes sense. It is worth remembering that the other specialist inpatient services, which have already centralised at either CGH or GRH e.g. cancer services at CGH and childrens' services at GRH, are working really well for patients.		
175	This hospital specialises in this area		
176	Again, it must be best to have all the specialists in one location.		
177	Concentrating the service presumably means that I will be able to see a subspecialist all the time.		
178	Centralising upper GI seems to have been beneficial, presumably the same will happen with colorectal.		
179	I believe that CGH is the optimum site for such a centre of excellence - to maintain quality and patient experience CGH would serve the purpose better than an overstretched GRH, which is already struggling currently with a very high volume of emergency cases.		
180	In this case, though I'm based in Cheltenham, this would again seem to be downgrading services to be only available at one location instead of at 2.		
181	Not central to county. Parking nightmare, travel time - hours away		
182	Available beds, less likely to be cancelled calmer safe green site. Excellent ICU linked to essential other services to make centre of excellence. Oncology onsite national recommendations.		
183	Focus of resources on one site		
184	Need to locate the planned specialties into CGH if emergency medicine and surgery are going to GRH		
185	I am a strong believer and advocate of specialised services at one hospital, my choice is Cheltenham General Hospital.		
186	At Cheltenham		
187	This should be at GRH for EGS to support. Everyone together in the same place		
188	Both are GENERAL hospitals, and as such should have the capacity to offer these services at both sites. But if I was to choose, based on my previous answer, it would make sense to have planned lower GI general surgery at Cheltenham to match with the idea of making it a centre for abdominal and pelvic surgery.		
189	Again, I like the scntre of excellence approach and likelihood of fewer cancellations		
190	Public perception and access focused at one hospital for one type of heath issue		
191	A centre of excellence would be good for everyone!		
192	It is easier for elderly, disabled, and very sick people to travel to their nearest hospital. Some of the people in this category will not be able to either drive themselves or travel on public transport. An unfamiliar environment may be distressing for them, and it may be more difficult for their families to visit if they are further away. Therefore, all procedures should be available in all hospitals, not in one centre.		
193	For Chelt		
194	I think there would be lots of advantages to keeping all the planned lower colorectal general surgery in Gloucester. Everything and every member of staff present.		
195	As above Strongly support the idea of having 'specialties' at one of the two hospitals only.		
196	As above Better building and access		
197	It needs to be Gloucester for access from the forest of dean		
198	In all cases time must be allowed to talk between medical staff and patients. Sufficient staff levels should be attained 24/7 of 'centres of excellence' comes into being.		

Please tell us what you think about our preferred option to develop: A 'centre of excellence' for Planned Lower GI (colorectal) general surgery at Cheltenham General Hospital (CGH) or Gloucestershire Royal Hospital (GRH).		Response Percent	Response Total
	199	To help spread skills to other major assets	
	200	It would help provide rotas for the appropriate surgeons.	
	201	Again, I understand the logic but I hope Cheltenham will not be downgraded. However, I do understand the issues raised in the booklets about staffing.	
	202	Strongly support PROVIDED that site is Cheltenham	
	203	Combining expertise will enhance surgical training and allow us to offer tracing in sub specialist areas of colorectal surgery. There will be greater standardisation of care. Also enhanced nursing care.	
	204	Makes more sense to be at Cheltenham.	
	205	It makes sense to have this at CGH where the gynaecological oncology is carried out. (Pelvic surgery)	
	206	As previous questions. But I have had fantastic service and a colorectal resection at GRH. This started with the Bowel Cancer Screening at Stroud Hospital, and two operations at GRH, with follow up care. The care and dedication of all the staff at GRH has been exemplary, and I am so grateful to them! Of course if CGH was chosen, as long as the staff moved also, then the service would be just as excellent. A slight fear I have that when I think merge and provide an ever better service', the accountants hear 'merge, provide the same service, and cut costs'. The latter really would be a betrayal of trust.	
	207	lose of this type of surgery would result in doctors/other specialists relocating hence would be unable to support A&E dept	
	208	I would not support the concentration of services on one hospital site if that led to, for example, a reduction in consultants at CGH which would eventually put the future of services at that site in question	
	209	General Surgery is not really a 'surgical specialism', as it relates to many different conditions. In order to justify centralising General Surgery the Hospital Trust appears to be attempting to redefine it as a specialism relating only to colorectal surgery.	
	210	Cheltenham already has the Cancer Centre so it would make sense for it to have the above service.	
	211	See my previous answers on GRH but more so to travel to CGH. My wife is desabled hospital transport is a joke. I wrote to MP Mark Harper about this. I pay for transport and it is expensive	
	212	CGH has always been a centre for excellence for this surgery - let it stay so!! Don't change	
	213	The plan seems to be to downgrade Cheltenham GH despite the wide catchment area and substantially increased population in the rural parts of North Gloucestershire	
	214	Parking and the use of public transport enabling the general public to use buses from Waterwells through to GRH	
	215	CGH is the preferred option	
	216	To build expertise at CGH for this speciality	

In supporting our preferred option to create a single site 'centre of excellence', where do you think a 'centre of excellence' for Planned Lower GI (colorectal) general surgery should be developed?

		Response Percent	Response Total
1	Cheltenham General Hospital (CGH)	50.76%	268
2	Gloucestershire Royal Hospital (GRH)	20.27%	107
3	No opinion	30.30%	160
		answered	528
		skipped	96

Please tell us why you think this, e.g. the information you would like us to consider: (238)

1	A strong case has been made for both. On balance I think CGH.
2	I would like Gloucester to be a better option for care, this should be improved so that its more viable than having to travel to cheltenham to visit people.
3	Crucial item for me is that there is an equal balance between what is in Cheltenham and what is in Gloucester....with equal numbers of essential services in each. It must not be Gloucester is the centre with bits in Cheltenham
4	I believe that no one site can cope with providing the service for people who usually attend two sites. The waiting times increase, the staff are stretched and patients feel that they are suffering as a result. Gloucestershire is too big to have one site for a speciality.
5	this would support gynaeoncology surgery
6	Because I think that elective or planned procedures should run from the site with a lease amount of emergency bed pressures. I believe that this will lead to fewer patient cancellations and overall a better experience post operatively where wards are full of elective patients all receiving appropriate post operative care rather than mixing with other non-surgical patients who are placed there because there is no other room.
7	As above.
8	Insufficient bed base of acute medicine, let alone medicine plus surgery. Certainly no possibility of a centre of excellence for planned care in a hospital with insufficient bed capacity for acute services.
9	because it's not the emergency site and patient flow can be better managed
10	I don't know enough about existing surgical set up, but you would think the site that is currently best set up to house surgery would be the most sensible choice.
11	Wherever you feel it is easier and safer to provide this from. Where other support services are on hand.
12	As above so the specialists are on one site , can cross cover be available.
13	I think it is best placed where the post op care is- I am not sure if they routinely require ITU admission. If they do, I would suggest keep at CGH to free ITU beds for unscheduled admissions.
14	Lower GI is currently at CGH, and in general works well with a v.dedicated multidisciplinary team.
15	I think this fits in with gynae and urology planned surgery and often these patients may need two consultants operating at a time. It will also mean that planned surgery is centralised. This will make it more appealing for staff working at CGH knowing they work on a site that is considered a centre of excellence.
16	It is a ""no brainier"" interns of bed base, pandemic planning, and protection of our elective cancer patients from cancellations peak periods to have this service in CGH.
17	There are not enough beds in GRH to have all the acute inpatients plus the elective work. During the pandemic the elective patients should be protected and kept separate. There needs to be adequate surgical resident cover in CGH to deal with any postoperative complications and also provide surgical support to the oncology service.

In supporting our preferred option to create a single site 'centre of excellence', where do you think a ‘centre of excellence’ for Planned Lower GI (colorectal) general surgery should be developed?		Response Percent	Response Total
18	I		
19	Just because it is the nearest hospital to where I live, I should imagine anyone living near to Cheltenham would choose the Cheltenham one as their option		
20	If the 24hr A&E is at GRH, then the planned surgery to be at CGH.		
21	Why should people from Cheltenham go to Gloucester when they can go to Oxford? If it's planned...		
22	Both hospitals should have their own colorectal services.		
23	Bed space available at CGH for increase in existing colorectal work; patients requiring transfer or input from gastroenterology would benefit from existing presence of gastro services on site in Snowshill at CGH. Available bedspace for colorectal patients (alongside gynae oncology) currently being used as medical overflow with associated reduced and unsafe medical cover, loss of experienced surgical nursing staff and reduced quality of patient care.		
24	To remove it from the impact on bed capacity of the seasonal variation in medical emergencies.		
25	Both should offer excellence I don’t agree with either/or as the geographical region is huge and large populations will be disadvantaged. Surely these services should already be offering excellence or is this an acknowledgment that you are currently offering sub standard services?		
26	Elective and CGH and emergency at GRH		
27	CGH should be the site for all planned activity		
28	I believe it would be sensible to try and ensure that CGH takes on planned / elective surgery with lower risks involved, and that GRH is responsible for caring for emergency surgery. However, I also appreciate that this could result in specialist surgical cover required across both sites rather than just covering one and could be confusing for the public if there is general surgery offered at both sites.		
29	Elective days-case/short stay surgery in a dedicated unit in CGH. Resectional lower GI surgery co-located with emergency general surgery in GRH.		
30	a cold, elective hospital allows access to beds, ITU, and allows all the relevant surgical specialities to work closely together to deliver excellent care. The removal of colorectal surgery from CGH would mean that urology and gynaeoncology may not be able to stay, which would put more pressure on GRH		
31	Oncology centre		
32	Oncology centre.		
33	Oncology		
34	I think that the 'reputation' of Cheltenham Hospital needs to be preserved if emergencies go to Gloucester, even if in a new way, so putting excellent planned operations in Cheltenham would be good.		
35	Which ever site has best capacity of operating theatres and staffing for this proposal		
36	What will there be about CGH to attract anybody to work there, if surgery is removed from Cheltenham altogether?		
37	This builds on already established reputation and allows other interdependent excellent services to continue to flourish because they have ongoing on site, immediate lower GI surgical support. Removing lower GI surgical support from CGH would diminish urological, gynaecological oncology, gastroeneterology and oncology services. Specifically gynaecological oncology simply could not operate in the same way and all ovarian cancer surgery would need to move to GRH to facilitate appropriately supported radical surgery within any governance framework		
38	It makes sense to have as much major surgery as possible in CGH for the pandemic, and also for usual winter pressures in GRH. This also applies to elective vascular and upper GI surgery.		

In supporting our preferred option to create a single site 'centre of excellence', where do you think a 'centre of excellence' for Planned Lower GI (colorectal) general surgery should be developed?		Response Percent	Response Total
39	1. co-located with other pelvic cancer services (urology, gynae-oncology) 2. co-located with oncology 3. co-located with gastroenterology inpatient care 4. Protected bedbase from emergency admissions (if going with the emergency hub in GRH) and allows screened admissons only in the covid era 5. Ease of access to HDU / ITU for all planned major resections 6. Separated (geographically) elective v emergency care as recommended by a) GIRFT, b) Current President of the RCS Eng (Prof Neil Mortensen) c) external senate review		
40	wherever the facilities allow best at minimal cost and upheaval		
41	Needs to be co-located with the emergency general surgery service.		
42	I can see benefits to both hospital, GRH because of workforce but for patients which may also involve other organs in the pelvis, CGH seems more appropriate		
43	It is easy to get all GI surgeries in one place closer to Endoscopy.		
44	I don't support your preferred option at all		
45	CGH would make sense as there is the oncology dept is also there. The dots are joined up in that respect		
46	Calmer atmosphere. Better patient experience.		
47	Is Great Western Hospital Swindon a better option for those living on The Cotswolds, perhaps a joint venture with Glos NHS		
48	Consultants and staff are fed up. Colorectal worked at Cheltenham before stop fixing things that aren't broken. Wasting good theatres, what's the point in not using something we already have. And you have amazing nurses and HCA's with colorectal experience in Cheltenham that will not go to Gloucester.		
49	As above, the premises at Gloucester are superior and those at Cheltenham have fallen way behind. In my view Cheltenham should have constructed a new hospital to replace Cheltenham General in the hospital building boom of the 1990s and early 2000s when a large number of towns and cities constructed new hospitals, such as Worcester, Swindon, Birmingham, Stratford -on-Avon, Hereford, Taunton, etc, etc. Cheltenham missed out then and a new replacement for Cheltenham General is unlikely now		
50	both sites.		
51	As this is intimately linked to gastroenterology (which is being focussed at CGH), it makes sense for this to be at CGH too.		
52	As it is planned surgery the patient can arrange transport beforehand so I don't see any issues		
53	BOTH HOSPITALS. STOP PUTTING PRESSURE ALL ONTO ONE SITE		
54	I have no views about which hospital should be the site - this is clearly a matter for the best use of resources - both physical and staff - and I am in no position to take a view on the information provided		
55	Planned surgery at CGH would reduce likelihood of patients operations being cancelled. Staff would be trained to manage all types of pelvic surgery and therefore give better service and earlier discharge.		
56	It should be available on both sites.		
57	Its slightly less crowded in Cheltenham.		
58	See above		
59	More opportunities to expand the service inclusive of A&E, surgical assessment unit and expand and develop wards.		
60	Don't like the single site option		
61	As above; CGH needs to be valued and acknowledged as a centre of excellence (alongside GRH)		
62	Please see the previous answer.		

In supporting our preferred option to create a single site 'centre of excellence', where do you think a 'centre of excellence' for Planned Lower GI (colorectal) general surgery should be developed?		Response Percent	Response Total
63	What CGH can do GRH can do the same		
64	Makes sense to continue the planned trend at CGH.		
65	I don't think it matters where the provision is. I cant see that one site has more benefit that the other.		
66	we live in Stroud - now my son has transitioned into adult IBD services we have had infusions in GRH, consultant appointment in GRH and MRI in Chelt - the travel relatively easy for us so wherever means staff travelling less.		
67	I am the governor of the forest of dean and it's even further for people to travel when it's at Cheltenham.Its also newer and more easily accessible than Cheltenham.		
68	The colorectal ward is at GRH		
69	As above		
70	Would like Pathology to be taken into account with these decisions - especially Blood Transfusion as we are having to do an increasing amount of work overnight yet have no funding for extra staff! 1 person that covers the whole hospital at GRH is dangerous.		
71	Neither site should take priority.		
72	We have two major hospital sites in Gloucestershire. It makes better sense to have single site consolidated approaches to medical units		
73	I believe that you are wrong in trying to decide one place against the other hospital. Gloucester Royal is full to capacity and often difficult to reach because of its situation. The best solution would be to build a new hospital at Staverton and put any ""centres of excellence"" there. This idea, whilst not likely to ever be considered, would be a perfect solution. There is plenty of space at Staverton and the surrounding land. Sites at Gloucester and Cheltenham could be then be sold at a huge profit		
74	As already said emergency and elective surgery needs to be kept separate as they require differnet sorts of treatment. Keep CGH clean and where there ae more beds to keeps elective particually cancer surgery running no matter what the emergency take is		
75	Cheltenham must be the planned care centre if the Emergency centre is going to work		
76	It would appear logical to have all cancer services on one site and given Cheltenham's preeminent role in cancer treatment then all related services should be located there,		
77	At present I am not familiar with either Hospital.		
78	My personal experience ,choice.		
79	Cheltenham already deals with urology and it would make sense for ALL lower GI surgery, planned and emergency		
80	Both need this		
81	Don't care as long as 24/7 type-1 consultant-led A&E services are restored at CGH.		
82	If the benefit of the emergency changes is to provide immediate subspecialist care why would you consider something different for elective patients? You propose to locate elective upper GI surgery on the same site as emergency surgery, it seems incongruous to propose that another group of general surgery patients should be treated differently. If the two sites could be staffed equally there would not be a need to change. You need to ensure that the level of cover out of hours for patients undergoing major colorectal operations is the same irrespective of their mode of presentation (emergency vs elective). Specialist nursing input eg stoma nurses, cancer nurses will be facilitated by being on the same site as emergency surgery. Will a unit on a separate site have sufficient patients to be a specialist ward or will it be overrun by other specialties? Would such an arrangement really enable specialist nursing care? How do the other components of the general surgery changes impact on colorectal surgery?		
83	See previous question		

In supporting our preferred option to create a single site 'centre of excellence', where do you think a 'centre of excellence' for Planned Lower GI (colorectal) general surgery should be developed?		Response Percent	Response Total
84	For reason given previously		
85	It is a better hospital than cheltenham, providing better care. Although, it too has rude staff !		
86	As previous		
87	Surgical team availability. Easier to set up cell salvage, if needed during the oerations.		
88	To co-locate with urology and gynae-oncology. By taking elective lower GI from GRH space would be freed up for other needs.		
89	Only those involved with actually doing it and the rersource implications can make this decision. Whatever is done must take into account the time and travel implications for the whole County and the environmental impact.		
90	At the moment, both CGH and GRH seem to have a Planned Lower GI general surgery facility. I think the decision on which location to invest more excellency should mostly be focused on statistic and medical opinion, such as estimated time of arrival from one location to the hospital; percentage of local and not local patients who come to the hospital; accessibility to the yard; transportation accessibility etc. While Cheltenham could be more easily accessible, in my opinion, GRH offers facilities on Upper GI general surgery, which could contribute to the treatment of exceptional patients who may need assistance with both.		
91	Ensure services are split more equally between sites & prevent all the eggs being put into one basket. If at Gloucester, could lead to capacity problems and there is only a finite amount of space to build on, if indeed funds can be found to pay for construction/re-figurement. By locating in Cheltenham, seems to sit/align with other services to allow a more wholistic treatment service		
92	Where the best service can be provided. Ensuring correct equipment, staff & space.		
93	I think it makes more sense to have surgical units for upper and lower GI surgery in one location		
94	Cheltenham is a significantly better run and more pleasant place to be than Gloucester. However, smaller hospitals such as Cirencester would be a welcome addition.		
95	Due to other specialities already doing pelvic surgery in this hospital. Surely a 'centre of excellence' would allow surgeons to assist and advise each other when required.		
96	Important that each hospital has the ability to raise its reputation by having a centre of excellence. It must be ensured that Cheltenham is not regarded as a second choice.		
97	GRH is currently too busy. I presume GRH would be a spoke and therefore provide back up.		
98	I have no relevant technical knowledge to offer an informed view		
99	Either would do.		
100	See above		
101	Wherever the space is available and where the necessary ancillary departments are. Which will have the capability to ensure bottlenecks do not occur - scanning, X-ray, theatres, outpatient capacity.		
102	Both		
103	Both hospitals should be aiming for all surgeries,		
104	As above		
105	personal preference only based on my location. Accept entirely that management team must consider a much wider criteria		
106	as previous question		
107	Hard to have an opinion unless you are a user		

In supporting our preferred option to create a single site 'centre of excellence', where do you think a 'centre of excellence' for Planned Lower GI (colorectal) general surgery should be developed?		Response Percent	Response Total
108	Although my own experience has been of having colocrectal surgery at GRH, I think location for this is less important than concentrating the expertise at one centre.		
109	Keep both hospitals operating as hospitals for all services. This centre of Excellence "" concept"" is in my opinion RUBBISH. Stop pretending that you are offering a better service when you are diluting what is already available		
110	not qualified to judge which would be best. Access, free parking other facilities to fit around this would need to be thought through		
111	Happy with the Cheltenham hospital cancer care teams		
112	I support the proposals to change and think the information provided presents a strong case. However, throughout the consultation document I see little or no reference to: a) How staff are to be retained, trained, recruited and afforded. b) No refernce to any improvements to process or service instigated as part of the response to Covid -19 which will be retained as Best Practice moving forward. c) Limited reference to the way that services will be re-modelled in line with international Best Practice. There is limited information given for example on the use of telemedicine, telephone consultation and foillow up, health education in primary care, transfer of services into coimmunity settings, converstions to higher day case rates, better streaming through outpatients (and ED). The proposals appear to deal with the issue of duplication of services across two sites and consequent rationalisation and whilst this is to be welcomed, of itself, it does little to illustrate how the models of care can or will change. Similarly there is no financial analysis (that I can see) with the documentation provided. In an increasingly stretched NHS, this must be a consideration for services to be long term sustainable. I cannot determine which site I would prefer this service to be provided on without the information referred to above as this becomes merely a geographical preference rather than an option considered as to what is right.		
113	I understand that there can some crossover between Upper and Lower GI* and this suggests to me that collocating them would be wise provided that the is sufficient space and facilities at GRH. *Last year I had emergency Lower GI surgery carried out at CGH by an Upper GI consultant (excellent outcome!)		
114	As both centres do this now, just in terms of equalising the two hospitals as mentioned above		
115	GRH is a larger site, has better facilities and is more accessible for visitors. I have had surgery in CGH in the past and felt the facilities were poor and the care was lacking. It is also very difficult for visitors to find somewhere to park.		
116	If it is planned surgery the patient will have had time to plan how they will get to and from the hospital, and anyone who wishes to visit can factor the distance into their preparations. There is still the question of the exorbitant parking fees on the GRH site. Although CGH also charges stupidly high parking fees, Cheltenham based patients being treated in Cheltenham and their visitors might not need to use their cars and could avoid these phenomenally high charges. There is also historically a poor reputation for infection control at GRH. I would not feel confident going there for anything serious.		
117	I live in Stroud and find it easier to get to GRH and easier to park the car.		
118	From our point of view it is nearer		
119	Less chance of cancellation as less pressure on beds Gynae oncology and urology based at CGH - makes sense to have a cancer centre of excellence at CGH where oncological services are based.		

In supporting our preferred option to create a single site 'centre of excellence', where do you think a 'centre of excellence' for Planned Lower GI (colorectal) general surgery should be developed?		Response Percent	Response Total
120	this will allow the trust to develop a service which will be second to none. it will link in with gynae / urology & a centre of excellence for oncology too. the bed flow / capacity is there. CGH has an outstanding ICU and staff who are specialised in pelvic surgery to provide excellent care. patient flow & discharge will improve. patients will get an improved service so not mixed with emergency care & can maintain a green site especially if future pandemics as per recommendations		
121	There are pros and cons for both sites.		
122	As I have mentioned, public views will revolve how location, for example, will affect the individual. CGH is closer to me than GRH so this is obviously my choice. That is naive and there are many many far more important factors that should determine the location. I really don't understand how public consultation on this matter assists the process.		
123	Most of the surgery might involve a cancer and Cheltenham is the cancer centre		
124	This is major surgery and should be carried out in fully staffed hospital having access to all facilities 24/7		
125	most of the issues are probably cancer related so it makes sense to put this in Cheltenham with the existing unit - although the buildings at Cheltenham are in dire need of refurbishment and modernising		
126	the main center for this type of surgery is already in Cheltenham - so why would you wan t to move it ?		
127	Don't really mind but feels appropriate to co-locate with the cancer (oncology) centre in Cheltenham. Nb. I have a family history of bowel cancer so take particular interest in this area.		
128	To make a decision about this, there must be many other holistic factors about the sites, capacity, etc which I am not aware of.		
129	Either site so long it is centralised at one or other site. It would be advantageous to have both upper and lower GI planned surgery at one site. Staffing and equipment availability should be considered.		
130	I am not fullt aware of the different skills between GRH and CGH but roughly would like to see a 50/50 spread of centres of excellence over the county's two leading hospitals.		
131	the centre should be close to GI medicine, specialist inpatient care (as in ITU) and imaging		
132	The emergency detailed above meant I had minutes to live, my kidneys had already failed . My family were called to the hospital soon after the operation as I was given about two hours to live. Living in Hewlett Road, Cheltenham meant a speedy access to A&E which ironically closed about a week or so later. If the timing of my illness had occurred two weeks later I would not be filling in this form.		
133	It seems likely that management of complications would be best on the site with the most robust emergency cover		
134	As above		
135	Having benefited from this excellent service, and still under their care, I would really like the service in Cheltenham to be bolstered. I live at the extreme Northern tip of the county, and Gloucester Hospital would have been a nightmare for family visits, and for me getting home from the multiple operations I have had. Given the fantastic care I had at Cheltenham, I would be keen for it not to be moved		
136	Ability to protect beds and theatre capacity		
137	Separate emergency services from elective services completely - Cheltenham must be the centre of planned excellence		
138	As long as the support services match the need.		
139	Again, it doesn't matter which site, so long as the service is there and available and ensure capacity and effective care for Gloucestershire residents. In my mind it would make sense to have a particular specialist treatment at both sites i.e. GRH is centre of excellence for XX and CGH is centre of excellence for YY. So that one or other site does not become defunct.		
140	This should be based at the site with emergency theatres.		

In supporting our preferred option to create a single site 'centre of excellence', where do you think a 'centre of excellence' for Planned Lower GI (colorectal) general surgery should be developed?		Response Percent	Response Total
141	Because should I or my neighbours need it, it is within easy reach for local transport. GRH in rush hour can take at least 1.5 hours		
142	Whichever site the clinicians feel is most appropriate		
143	This closet to me and the family		
144	It makes sense for all GI (lower and upper) services to be in one hospital		
145	Care needs to be taken in assessing the user demographic to make a suitable choice. Ideally it would be in the centre of the most common user base.		
146	Greater diversity in Gloucester		
147	Gloucester seems the preferable site to develop. Far better access by public transport.... crucial for many people and their families		
148	Cheltenham and Gloucester hospitals should be equally recognised for their own specialisms and resources. Gloucester Hospital cannot have it all		
149	Obviously Gloucester is the closest to me, for same reason stated above. Cotswold residents would almost certainly disagree		
150	Obviously, given what I've said, I'd choose Cheltenham. Gloucester residents would presumably prefer it there!		
151	Which option is most cost effective		
152	Greater Diversity in Gloucester - some longer term health conditions higher with minority ethics Ease of access and family support as communities live close together		
153	Cost, population refevance (obviously). Less obvious: parking availability for patients and staff, bus routes from different areas and related departments.		
154	More central to the area, better parking facilities and better transport links		
155	I've put no opinion because transport is about the same for both, and planning a service is a complex task that looks at a wide range of information. I trust One Gloucestershire to make a good choice.		
156	Remain with both sites as both large populations. Travelling to either site difficult if not in either town/ city. Keep both therefore quicker and more local access. Helps reduce carbon and, safety) health risks involved in traveling		
157	There is an air of calm efficiency and care at Cheltenham General Hospital which leads to a more rapid recovery time whereas at Gloucester Royal Hospital I feel that the wards seem to be under more pressure.		
158	A good match with other services. Also seems too much at GRH which could lead to conflicts of staff time		
159	Both		
160	Ideal in respect of our place of residence		
161	As before; it is better not to centralise unless and until provision is made for transport between the sites. This is vital for the elderly and less financially secure. (Frequently these are the same.)		
162	I have already stated why above,		
163	Best for outcomes and workforce with limited negative impact on travel/access for those living east of Cheltenham.		
164	Cancer surgery and non-surgical treatment (radiotherapy an systemic therapy) need to be one one site in order to ensure seamless cooperation for patients who develope acute conditions requuiring surgical intervention. I have worked in London centres of excellence for non-surgical oncology where there was no surgical cover on-site for emergencies. This did not work well and treatment was sub-optimal.		

In supporting our preferred option to create a single site 'centre of excellence', where do you think a 'centre of excellence' for Planned Lower GI (colorectal) general surgery should be developed?		Response Percent	Response Total
165	Either. But a Centre of excellence makes sense.		
166	Would keep at both		
167	If the majority of this department is located in GRH, it makes sense for all of it to be located at GRH.		
168	Better parking for staff and visitor options more mid way for Forest patient and visitors. Near to train links.		
169	A very confused layout that could be fixed easily.		
170	Quality of patient experience much improved if planned surgery is separated from emergency activity.		
171	Make effective use of existing resources		
172	To colocate it with Gynae and Urology for a pelvic oncology surgery centre of excellence		
173	Cheltenham should be the centre of excellence for all impatient planned care		
174	Very important to have separate sites for emergency and elective surgery for better patient experience and outcome		
175	Important to keep services separate for patient experience and outcome		
176	Better on-site facilities and car-parking at Gloucester. Not sure where there is adequate space in Cheltenham		
177	As above		
178	At Cheltenham General without a doubt, this has been in place for years and has worked without failure to a high standard. I, my family and friends have received care on this ward to a fantastic degree and then have unfortunately been subjected to GRH due to current events this year, to say that we were disgusted by this change would be a vast understatement. Why change what isn't broken, why ruin a system that has supported so many for years with such a dedicated team that is being picked apart and why support such an idiotic decision to shift CGH to a more medically acute when GRH does not have space for all this surgery and that has also been proven and found this year Please consider the fact that whichever higher up or suited monkey has been trying to shut cheltenham A&E for years due to funding and the arrangement of doctors across sites. This is bad in practice and paper, especially when the current state of affairs in CGH due to some of these measures already being in place has slowed down patient care because their is no one on site available to offer the urgent care that is needed or they are being rushed off to see to someone in a supposable MIU that continually blue lights patients to gloucester only for them to come back again as their is no capacity or available beds		
179	The department already exists together with the oncology unit at Cheltenham General.		
180	Not qualified to judge.		
181	If its excellent, who cares where it is?		
182	Would seemingly make best sense to locate this at CGH to create a centre of excellence for pelvic resection; and to keep this surgery service entirely separated from the pressures of the Emergency General Surgery at GRH (as suggested in the consultation booklet)'		
183	I would support the decision made by those individuals directly involved in the provision of this service at both hospitals. Is that information available ? I assume that is being considered in any final decision and it would have a significant impact on any final assessment.		
184	Very important to have emergency and elective surgery on separate sites to improve patient experience and outcome		
185	I do not support your option. The size of the population here in Gloucestershire with the growing numbers wanting to live in this beautiful country, warrants both hospitals having this facility.		

In supporting our preferred option to create a single site 'centre of excellence', where do you think a ‘centre of excellence’ for Planned Lower GI (colorectal) general surgery should be developed?		Response Percent	Response Total
	186	CGH already has oncology expertise on site and most colorectal surgery is concerned with malignant disease. It would be madness to make an exception for this major (in terms of numbers) malignancy by locating it anywhere else and makes a mockery of the notion that Gloucestershire has an ‘oncology centre’. Outsiders consider the notion of siting it elsewhere as bizarre. Add to this the dismantling of a very successful existing partnership between the gynaecological oncologists and the colorectal surgeons that already exist on the CGH site, to dismantle it by moving the colorectal team elsewhere would be criminally irresponsible. But when outsiders, even when invited by the Trust, suggest this, their contributions are dropped from further discussion.	
	187	Suits us better - see page 37 My wife and I are in our 90th year. She is not allowed to drive. I prefer daylight and not Mon or Friday. We live in Tetbury and wish treatment there. So: We prefer Cheltenham and do not like Gloucester, the former being easier for us to reach by car and more convenient in terms of other activities on the day.	
	188	Gloucester is MUCH easier to travel to	
	189	Proposals for either option appear to be well thought through.	
	190	This hospital specialises in this area	
	191	It is important not to concentrate every resource at one location, e.g. Glos, as this would increase the possibility of a single point failure.	
	192	On your facebook live session the consultant said that 12 out of 15 consultants supported this model, shouldn't you be listening to what the experts think as they provide the service and should know how it works.	
	193	If you think upper GI surgery needs to be on the same site as emergency general surgery, surely the same should apply to colorectal surgery. If you are struggling to run the general surgery service on two sites at the moment why would you want to set a a service that continues to run general surgery on two sites?	
	194	GRH is too busy, to stitched and too stressed with the increased volume of emergency surgery it has absorbed recently. Conversely, CGH is well placed to deliver such a role, with teams in place, surgeons and anaesthetists, HDU/ITU cover and dedicated elective wards.	
	195	All the requisite components - surgeons, anaesthetists, dedicated specialist wards and ITU/HDU are already in place. CGH is ideally positioned as the transfer of emergency services to GRH has left a residual capacity with teams in place to fulfil the functions of a CofE. GRH conversely is essentially too busy, too stretched and too stressed to meet the need.	
	196	I don't support it	
	197	Again central	
	198	As above	
	199	If the plan is to have the Day Case focussed at CGH it would seem to be sensible to have the rest of the GI provision on the same site	
	200	see previous response	
	201	It would be sensible to co-locate with other pelvic area specialists.	
	202	Having experienced prostate cancer surgery at CGH, I know it is well placed with excellent Consultants and support staff to provide a first class service service.	
	203	Cheltenham has a better reputation in area.	
	204	As above	

In supporting our preferred option to create a single site 'centre of excellence', where do you think a 'centre of excellence' for Planned Lower GI (colorectal) general surgery should be developed?		Response Percent	Response Total
205	I would like to know, that if you make GRH the centre for emergency general surgery, what would happen in the case of an emergency following a planned abdominal/pelvic operation at Cheltenham? Does that mean a patient would be transferred to GRH as it would be the hospital receiving surgical emergencies? Planned day cases may become more complicated and require emergency surgical intervention as all surgery comes with risks, that is why patients have to sign a consent form. Will surgeons operating on planned cases have the ability to care for patients who have a surgical emergency? Will they have the experience?		
206	I like the link with the gynae cancer treatment at Chetenham to form Pelvic Resection centre of excellence		
207	To align with the upper colorectal service at CGH		
208	All major General surgery located with acute services makes common sense.		
209	I do not support your preferred option. I think that procedures should be available in all hospitals. However, of the two I would marginally prefer Cheltenham as it is marginally nearer to those of us in the east of Gloucestershire.		
210	I think a centre of excellence, a single one would benefit the local and wider community by being situated in Gloucester.		
211	Happy with move towards CGH as an elective site predominantly and more emergency focus at GRH, as oncology centre at CGH indicates more elective treatment. But not to strip all emergency services away		
212	Strongly support the idea of single site excellence for all and any hospital procedures		
213	Ditto Better building and access		
214	Its more central for Gloucestershire		
215	Which ever hospital has the space and facilities for development. CGH has very little space but other specialties can move. I leave to planning team!		
216	It would make the centre of excellence and help maintain Chelts specialism to attract staff.		
217	This is my biased opinion, as Cheltenham is so much more convenient to reach from the Fairford area.		
218	As above, allows for best patient flow and maintenance of elective work with the backup of a fully functioning intensive care unit.		
219	Ask why 12 of 15 consultants support this model. The consultants work in the system and know the details. This is the only option that will deliver sub specialist care seven days a week for emergency patients, complex UGI patients and complex colorectal patients. Why would you want to treat one of these groups differently and provide care that does not match up to other aspects of our service? The consultants know that the linkages to oncology, gastroenterology, urology and gynae are tenuous. A greater linkage is between upper GI and colorectal: the same junior staff, development of the service eg robotic surgery, same theatre staff, shared patient groups eg hernias.. This option is also the only one that allows us to develop the whole of our service. The model is actually about more than just colorectal and by moving complex colorectal to GRH it will create the theatre capacity to allow us to develop short stay surgery (not just day case) at CGH for both upper GI and colorectal. Why as an organisation have we not described the model that the majority of GI consultants have put forward?		
220	Fits in with above.		
221	I know the GRH team are fantastic, but have had no dealings with CGH.		
222	north of zone seems to be where population will grow (housing plan) and south activity would likely be split between gch & new forest of dean hospital		
223	I am concerned that too much emphasis is being placed on GRH. This concerns me because I do not believe that GRH has the facilities or space to cope with extra work.		
224	If this is centralised on one site, it should be on the site where the existing Centre of Excellence for Cancer is based, because of the close relationship between Lower GI Colorectal Surgery and cancer.		

In supporting our preferred option to create a single site 'centre of excellence', where do you think a ‘centre of excellence’ for Planned Lower GI (colorectal) general surgery should be developed?		Response Percent	Response Total
225	See above.		
226	I am willing to provide a contribution towards the cost of a new hospital in FoD. Monmouthshire Council I am sure would also contribute instead of having people travelling to Cumbran		
227	It doesn't make sense to have a centre for excellence across 2 sites but transport needs to be available and affordable for those that need it		
228	Seems like a lot of specialist services are at GRH so good to have this one at CGH		
229	It has always fulfilled. This need - leave it as it is		
230	See above		
231	More information about ones operations		
232	To fit in with the other related specialities at Cheltenham		
233	access to GRH is almost impossible for day patients and for visitors to in-patients if they reside in the north cotswolds		
234	Family orientated at Cheltenham and more friendly, smaller pods.		
235	So that centre of excellence status is not all centred at GRH		
236	Appears that more facilities are already there		
237	Prefer something at both sites		
238	Once again if only one centre and there are issues is there a back up service?		

Please tell us what you think about our preferred option to develop:A ‘centre of excellence’ for planned day case Upper and Lower GI (colorectal) surgery at Cheltenham General Hospital (CGH).			Response Percent	Response Total
1	Strongly support		38.07%	201
2	Support		35.42%	187
3	Oppose		5.11%	27
4	Strongly oppose		3.41%	18
5	No opinion		17.99%	95
			answered	528
			skipped	96

Please tell us why you think this, e.g. the information you would like us to consider (188)	
1	Ring fenced facilities at CGH make sense to minimise disruption.
2	I would like Gloucester to be a better option for care, this should be improved so that its more viable than having to travel to cheltenham to visit people.

Please tell us what you think about our preferred option to develop:A ‘centre of excellence’ for planned day case Upper and Lower GI (colorectal) surgery at Cheltenham General Hospital (CGH).		Response Percent	Response Total
3	As per my previous response I think splitting the acute general surgery take out from the elective demand is sensible and will lead to improved clinical outcomes, better patient experience and increased clinical skill development.		
4	See previous answer		
5	planned = cheltenham		
6	Presuming it will be here as the service and supporting team are already in situ at CGH?		
7	The same as previous it is easier to manage and better cost savings for the trust, tax payer.		
8	If there are enough surgeons to cover this service , my concern is if an emergency service is also working how will the oncology patients be managed in an emergency situation		
9	As per previous		
10	I know that the Day Surgery Unit at CGH is expanding so this would be the ideal location for day case surgery for upper and lower GI cases.		
11	All elective work should be on the same site.		
12	I think it should be at both hospitals, leaving it easier for people to go to hospital nearest to where they live		
13	If the 24hr A&E is at GRH then to have this option at CGH would be good.		
14	Why go to Gloucester when you can go to Oxford?		
15	Cheltenham and Gloucester should have their own elected and day surgery cases.		
16	Existing surgical teams at CGH; centralising all day case GI work at CGH would reduce pressure on GRH to focus on emergency general surgery		
17	The co-location of daycases with emergencies makes more sense as day cases are much less likely to be impacted by the demands of peaks in emergency patients.		
18	As per your previous question the region and population mean this is not an either/ or answer BOTH hospitals with their significant budgets should offer centres of excellence.		
19	There aren't enough staff to go around, so we need to make best use of those we have.		
20	new day surgery unit planned for CGH that will be able to facilitate day case surgery and provide a centre of excellence		
21	If planned surgery is on the same site then you keep a cohort of skills in that location		
22	Once again, I believe that there would be less breaches in waiting times for elective surgery if they were on one site and therefore protected from issues such as lack of staffing the rotas and access to resources		
23	would be better to have day cases on your site where A&E is, which would allow your theatres to be used, and put your inpatients at CGH		
24	As per previous answers - if Gloucester starts taking more of the emergency stuff, Cheltenham's position/prestige needs to be maintained for non-emergency stuff.		
25	Make absolute sense to create an elective surgical oncology resection service at one site ; i.e. colocated with the oncology services and away from emergency services with their greater and unpredictable demands on beds which leads to the cancellation of cancer operations when the two are co-located		
26	I understand that the plans are in for two new day unit theatres to be built in CGH so hasn't this decision already been made		
27	Good idea. Protects the beds from emergencies so reducing need for last minute cancellations		
28	It is far more important to move major surgery urgently, before mass cancellations inevitably happen this winter		

Please tell us what you think about our preferred option to develop:A ‘centre of excellence’ for planned day case Upper and Lower GI (colorectal) surgery at Cheltenham General Hospital (CGH).		Response Percent	Response Total
29	Day case can be done anywhere		
30	as previous		
31	Separates short stay surgery from complex elective surgery and emergency surgery. Best use of beds, minimal cancellations.		
32	I have already said that in my previous answers. Try to concentrate in one place all cases related to GI interventions. It is better for the workforce too.		
33	I don't support having only one centre for anything, given the size and demographic of Glos.		
34	as previous question located in the best site alongside the supporting departments such as Oncology. the imaging services also need to be there too		
35	As before		
36	It is obvious that some services will have to remain in Cheltenham for the time being as Gloucester is not large enough to accommodate them all		
37	Why spend more money when there are already perfectly adequate hospitals		
38	Prefer a surgical unit in cheltenham as it can take pressure away and enhance smooth running by carrying out more cases through which more profit is available.		
39	In my view clearly better that this should be on one site.		
40	Keep low-risk surgery away from the acute site to improve (reduce) cancellations		
41	Should be available on both sites.		
42	located on one site, ensure specialism is located in one area - time effective for clinicians, day case parking for patients on site or near		
43	I feel that Cheltenham should be considered as Gloucestershire Royal Hospital is stretched to the limit		
44	Safeguarding elective procedures so that they are not cancelled for emergencies		
45	Don't like the single site option, would like both hospitals to offer as many treatments as possible		
46	As before		
47	Again, I have experience of this and know that the process is well embedded in CGH, with highly skilled specialists. Further, this type of surgery is usually directly associated with colorectal surgery e.g. stoma loop reversal, it makes sense for the surgeon who created the loop to reverse it thus maintaining continuity.		
48	Benefits local people.		
49	I agree with this and centres of excellence give people faith in the NHS		
50	Excellent idea, leave the longer cases at GRH where the ward is there to offer support for the patient after		
51	Would these beds be ringfenced for day surgery and not have patients put in them overnight? as is the usual case.		
52	Would like Pathology to be taken into account with these decisions - especially Blood Transfusion.		
53	Specialist equipment in one place, more efficient use of resources and specialist staff.		
54	Rational, straight forward, clarity for patients in terms of where their care will take place.		
55	Cheltenham is the obvious choice for the planned care centre		
56	moving to a planned care centre of excellence can protect access from being hindered by urgent care demand; Using Cheltenham for this is more practical that CGh given the site, the existing status of GRh as Major trauma unit and A&E status overnight at CGH		

Please tell us what you think about our preferred option to develop:A ‘centre of excellence’ for planned day case Upper and Lower GI (colorectal) surgery at Cheltenham General Hospital (CGH).		Response Percent	Response Total
57	Very important to develop high quality standards whatever the length of visit or stay in a hospital		
58	Really can’t imagine what day case GI surgery would entail .		
59	See first comment re planned surgery being able to go ahead without theatres being needed for emergencies.		
60	It needs to be clear that if you have a centre of excellence, it is in one place. GU/GI at Cheltenham - Totally! along with oncology. Everything else to GRH		
61	Both Cheltenham and Gloucestershire need this		
62	Don't care as long as 24/7 type-1 consultant-led A&E services are restored to CGH.		
63	Does this have potential to be expanded to include short stay patients? Many patients undergoing gallbladder surgery stay overnight. The same is true for patients undergoing colorectal surgery. Would a facility to accommodate these patients be better than pure day case? This might allow increased numbers of patients to have their surgery in CGH and help maintain a vibrant hospital. How do the other changes to general surgery affect the ability to deliver either day case or short stay services in CGH?		
64	Helps to manage an appropriate split between hot and cold sites		
65	Easy access and close to carers who need to visit me and don't drive		
66	Would require better facilities at Cheltenham general in my opinion hospital dated and tired in appearance		
67	I support the idea of one team on one site locally		
68	I think Cheltenham does deserve a comprehensive GI surgery facility as it is a reasonably large town which hosts national and international visitors every year. The capacity of the town to provide extensive health assistance, alongside Gloucestershire Royal Hospital would also likely relieve the stress sometimes found in waiting rooms. The availability could also assist patients who are needed to stay longer in the hospital under supervision, allowing the medical team to have sufficient equipment in the event of an incident or emergency. GI conditions can be debilitating at times and the circumstance of having to travel could risk worsening, especially if no preventative methods were ever applied in their case.		
69	Now very confused - how is this different to the previous two questions? Answers are as previous - support measures to cut last minute cancellations & being able to be seen & treated by the right person quicker. however this needs balancing with concerns over travel distance and reaching capacity at one site		
70	Planned day case surgery should have no impact on emergency care pathways and can be provided at any site.		
71	Proposals in the Consultation Document appear sound.		
72	As above		
73	As before		
74	see above.		
75	Spreading scarce resources around the county is a preferred method.		
76	have experienced it and was impressed		
77	as before		
78	Biased. Nearer me!		
79	As per my previous answer. Concentration in one centre is the most important issue.		
80	see earlier comments		
81	previous comments will apply to this		

Please tell us what you think about our preferred option to develop:A ‘centre of excellence’ for planned day case Upper and Lower GI (colorectal) surgery at Cheltenham General Hospital (CGH).		Response Percent	Response Total
82	Shorter theatre times with staff on the same site in addition to longer operations and emergency post operative complications after colorectal surgery		
83	I support the proposals to change and think the information provided presents a strong case. However, throughout the consultation document I see little or no reference to: a) How staff are to be retained, trained, recruited and afforded. b) No refernce to any improvements to process or service instigated as part of the response to Covid -19 which will be retained as Best Practice moving forward. c) Limited reference to the way that services will be re-modelled in line with international Best Practice. There is limited information given for example on the use of telemedicine, telephone consultation and foillow up, health education in primary care, transfer of services into coimmunity settings, converstions to higher day case rates, better streaming through outpatients (and ED). The proposals appear to deal with the issue of duplication of services across two sites and consequent rationalisation and whilst this is to be welcomed, of itself, it does little to illustrate how the models of care can or will change. Similarly there is no financial analysis (that I can see) with the documentation provided. In an increasingly stretched NHS, this must be a consideration for services to be long term sustainable.		
84	Have just received attention at Cheltenham and Gloucester.		
85	For planned day surgery it makes no difference to where I travel to within an hour. Parking seems much better at Gloucester.		
86	Although I support the idea of a 'centre of excellence', I do think that CGH needs some significant investment in order to become this and it's not the easiest place to travel to/park at due to the limited facilities. I like the idea of specialist care and if this is more readily available at CGH than GRH, then I am in support.		
87	As mentioned previously it is obviously better for those living in the Cheltenham area for as many services as possible to be fully delivered at CGH. There is also historically a poor reputation for infection control at GRH. I would not feel confident going there for anything serious.		
88	Concentration of key resources to reduce duplication and wastage.		
89	Less risk of cancellation due to less bed pressures		
90	day case can be done either site		
91	Having a excellent readily available service that treats me even if I have to travel is preferred to waiting and perhaps getting a second class service because of a dilution of resources/service simply to accommodate operating on both sites. It is 7 miles not travelling to the moon.		
92	As before		
93	This type of surgery is at most risk of cancellation when emergency pressures are high. We should have access to protected facilities so these operations are not cancelled. This will be good for CGH as more planned surgery will be performed there than in GRH		
94	as previous answer		
95	This is already in Cheltenham. I have had to use it and found it excellent.		
96	I like the emphasis of removing emergency from CGH so that all the planned can proceed without interruption by the obviously unpredicability of emergencies.		
97	Planned surgery in one location does make a lot of sense, as long as the wait times do not increase and also operations are not cancelled due to other factors.		
98	Good idea, for all the reasons previously given.		
99	But for day cases, there should be one at GRH as well.		

Please tell us what you think about our preferred option to develop:A ‘centre of excellence’ for planned day case Upper and Lower GI (colorectal) surgery at Cheltenham General Hospital (CGH).		Response Percent	Response Total
100	is there sufficient IT resource so paper records can be consigned to history and all relevant clinical information is available on both sites		
101	My personal experience detailed in previous page and previous personal observation of the Chichester Hospital whereas friend of ours son is a senior Consultant specialising in this area. He was able to advise my family on my predicament, which he only comes in contact with about once a year. I would like CGH to have this sort of level of skill set.		
102	Should’ve at both units if Gloucester hospital and Cheltenham hospital are Gloucestershire hospital service why not at both.		
103	Ability to manage beds and theatre capacity. Support to staff.		
104	Personally this suits me but appreciate that Glocs residents may not want to come all way over to Cheltenham		
105	Again you can develop excellence and proceess for suport services to create the ideal environment for this		
106	Separate emergency services from elective services completely - planned at Cheltenham		
107	It would make sense that both upper and lower should be on the same site as support services and staff would have similar skill sets		
108	So long as patients can access the location where their surgery is taking place.		
109	Facilitate throughput of these cases - ideally including a short stay model with low acuity 1-2 night stays.		
110	One hospital for emergencies and one for planned surgery. As long as the hospital for emergencies has enough OR.		
111	This is valuable facility essential for the area		
112	Seems sensible to keep upper and lower together - otherwise in the middle might slip through the space inbetween		
113	Staffing levels		
114	Agree with any proposal to avoid unnecessary duplication		
115	If planned centre of excellence for lower GI general surgery will be in Cheltenham it is only sensible for day cases upper and lower surgery to be there also		
116	See previous 2 comments		
117	See previous.		
118	The journey to Cheltenham from Winchcombe is far better than Gloucester Royal when you are unwell		
119	Too much dependence upon centralising services at GRH is, in my opinion a mistake. Gloucestershire needs to use its two mains sites fully		
120	See previous I believe Glos is a better location		
121	As before - economies of scale vasically		
122	More convenient from a personal point of view		
123	As long as we know what we can expect from the two hospitals I think the sharing of responsibility for medical disciplines will ensure scrutiny		
124	As with all your proposals to centralise services the problem is that of access for patients and their families. Whilst many have access to private transport a very large minority do not and they are frequently the elderly and less financially secure. For these people centralisation poses a major difficulty in accessing your services unless you propose to offer free transport between the sites. Even for those with private transport difficulties in accessing parking at iether site pose difficulties and high costs.		
125	Key to this is ""Planned"" which increases Trust's capacity without negative workforce impact.		

Please tell us what you think about our preferred option to develop:A ‘centre of excellence’ for planned day case Upper and Lower GI (colorectal) surgery at Cheltenham General Hospital (CGH).		Response Percent	Response Total
	126	As above. This will also benefit us interms of cooperation in research hwere both surgical and medical treatment are being evaluated e.g. in cancer studies.	
	127	Single centre of excellence preferred as above providing transfers are swift and well planned.	
	128	Transport to CGH needs improvement	
	129	Same comments as planned general surgery Experienced qualified staff centralised More opportunities for shared learning and research Intensive care facilities on one site High tech imaging facilities...	
	130	Separating Planned surgerty will reduce cancellation and improve patients waiting times	
	131	As stated	
	132	A smart decision as these teams are set up and in place already with exemplary experience as well as the chances to expand on these services as their is adequate space	
	133	Fewer last minute cancellations and better throughput.	
	134	Not qualified to judge.	
	135	Concentration of expertise and dedicated staff in one location will improve patient care and efficiency.	
	136	I support the basis of 'Centres of Excellence' and would assume that the decision to base a particular function at each hospital is based on building up the core competency that already exists at the chosen hospital	
	137	I think further investment in CGH is very desirable	
	138	General surgery even planned can go wrong. Abdominal surgery is major surgery and that's why everyone has to sign a Consent form. There should be facilities on both sites. What happens in an emergency, does that mean patients transfer to Gloucester where surgical emergencies will be located as your preferred option? It is utter madness to put patients at such risk. What will happen to the day surgery performed at local community hospitals, such as Cirencester and Tewkesbury. I presume the next step will be to close these hospitals in order to save money!	
	139	This proposal is another way of saying that CGH becomes a hospital for day case surgery only, chiefly benign conditions, i.e. not a proper hospital in the sense that is understood by most people. Since there is not room for all inpatient gi surgery on the site, to embrace this option is a sure fire way of ensuring that the malignant bowel surgery would have to be moved elsewhere (GRH), which is probably why it has been packaged up this way. Is CGH envisaged as a proper cancer hospital or not? If it is, then the malignant bowel surgery should take place there and not benign day case procedures instead.	
	140	N/A	
	141	The idea of creating centres of excellence at both of the two excellent large hospitals in Gloucestershire makes sense. It is worth remembering that the other specialist inpatient services, which have already centralised at either CGH or GRH e.g. cancer services at CGH and childrens' services at GRH, are working really well for patients.	
	142	This hospital specialises in this area	
	143	As there may be possible overlap between the two treatments it would be best if there were all located in the same site.	
	144	One of your consultants proposed a model for low risk patients which included patients staying in hospital for one or two nights having their operation in Cheltenham to reduce the risk of cancellation. This sound like a good idea as long as there is capacity.	
	145	If I need my gallbladder removed with an overnight stay would I be able to have this done in CGH?	

Please tell us what you think about our preferred option to develop:A ‘centre of excellence’ for planned day case Upper and Lower GI (colorectal) surgery at Cheltenham General Hospital (CGH).		Response Percent	Response Total
146	CGH is well-placed for this role, which would function more efficiently and with better patient experience in an environment away from emergency pressures.		
147	Why not at both, this involves improving Cheltenham at the expense of Gloucester		
148	Not central to county		
149	Not essential on single site		
150	See previous comments		
151	Need more emergency slots at GRH, ambulances queuing		
152	keeping planned activity in CGH if emergency services are going to GRH makes sense		
153	Reduces the potential for cancellations due to emergency surgery		
154	I think it is a good idea to separate out the emergency and planned cases, so having the day cases all at CGH makes sense along with other planned general surgery and the emergency cases in GR.		
155	If you have the best and most experienced medical staff at one hospital site, it follows they can provide the best medical outcome.		
156	Cheltenham has a better reputation.		
157	To avoid cancellations		
158	I cannot understand why all this has to be divided up, it is quite complicated.		
159	GPs' recommendations		
160	Alll skills and staff for GI health issues in one location. Single point of contact in Trust for GI		
161	On the focus of Cheltenham General Hospital as an elective centre this fits well. The pelvic centre of excellence with the arthroplasty, gyno and urinary would all work well together although it may reduce the General Surgery pool slightly at GRH.		
162	It is easier for elderly, disabled, and very sick people to travel to their nearest hospital. Some of the people in this category will not be able to either drive themselves or travel on public transport. An unfamiliar environment may be distressing for them, and it may be more difficult for their families to visit if they are further away. Therefore, all procedures should be available in all hospitals, not in one centre. However, Cheltenham is marginally better for us than Gloucester, so I have ticked no opinion.		
163	At Chelt		
164	This would work well because it is planned surgery instead of emergency surgery. Not so much of an issue around transport and time scales		
165	Links with earlier point		
166	As above Strongly support the idea of single site excellence for all and any hospital procedures		
167	Makes sense to spread workload		
168	Because of the increased local population both sites should be used.		
169	It needs to be Gloucester more central for Gloucestershire.		
170	Which ever hospital has the space and facilities for development. CGH has very little space but other specialties can move. I leave to planning team!		
171	To centralise the entire colorectal skills		
172	Help develop skills of junior surgeons and provide good support for them.		

Please tell us what you think about our preferred option to develop:A ‘centre of excellence’ for planned day case Upper and Lower GI (colorectal) surgery at Cheltenham General Hospital (CGH).		Response Percent	Response Total
	173	Cheltenham is easy to reach. Also, my husband has been treated in Cheltenham for bowel cancer and an emergency hernia and I was very grateful for the good treatment.	
	174	I would support routine day case surgery being done on the CGH site but this needs to be in a dedicated unit separate from the main building which cannot then be used to treat in-patients. This would also allow main theatres to be used for major elective surgery.	
	175	This is intimately linked to the other changes that are being proposed. Movement of complex colorectal out of CGH will help create the theatre capacity required to allow us to deliver this in the short term before other theatres are built. The model supported by the majority of surgeons proposes to expand this to short stay cases in both upper and lower GI surgery.. This needs to be taken in to consideration.	
	176	What does 'centre of excellence' mean? This is a ridiculous phrase. Who wouldn't want a centre of excellence. As opposed to trying to frame the question for your desired answer, you could try phrasing it the question in more balanced way. E.g. admitting that it means focussing resources and personnel in one or both of the sites, so those taking the time to engage with your questionnaire, do not feel manipulated.	
	177	Same as previous answers really. However, although the sites are close, transport links between them should be free, and green. A sort of very frequent campus type shuttle, perhaps with a couple of pick up points en-route.	
	178	if there does need to be service better where county housing plan will put most new housing/greater need.	
	179	I have no objection to the siting of specialist services on one hospital site. If this allows the particular hospital to improve its services in that field so much the better and consider that GRH is already overloaded.	
	180	It makes sense to focus planned surgery on one site, but this should not only be ""planned day case"", it should also include more complex elective surgery and not merely 'day case surgery'.	
	181	Cheltenham already has this function so it would be sensible to maintain this service.	
	182	See my previous comments. This is a bad decision and the people of the forest of dean and Monmouth deserve better.	
	183	It is very good as is	
	184	N/A	
	185	Keep Upper GI at Glos	
	186	CGH is convenient GRH is useless for day patients	
	187	Yes for centre of excellence and yes for Cheltenham.	
	188	Helpful to split areas of excellence	

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

			Response Percent	Response Total
1	Strongly support		32.69%	170
2	Support		33.85%	176
3	Oppose		8.85%	46
4	Strongly oppose		6.54%	34
5	No opinion		18.08%	94
			answered	520
			skipped	104

Please tell us why you think this, e.g. the information you would like us to consider (184)

1	I support this on the basis that fewer people would need to travel outside of the county for treatment. We need to start thinking 'Gloucestershire' when considering these matters. If people are having to travel further beyond county boundaries then it makes sense to centralise some services here. That said, good to see there would be an IGIS spoke at CGH to support specialties there.
2	I suspect more money has gone into coming up with the terms / logos for hub and spoke than into IGIS. Both places should be equal and more money should be invested and the CCG shrunk to release the funds.
3	Image guidance needs to have services in both locations
4	both hospitals should have it
5	IGIS should be concentrated on the site receiving the acute take for both medicine and surgery. It is as illogical to split the IGIS service over two sites to offer a compromised service as it is to split either acute take over two sites with poorly manned rotas.
6	strongly support the concept but if this is elective work wouldn't it be sensible to base it at cgh and have a spoke at grh?
7	The same as previous it is easier to manage and better cost savings for the trust, tax payer.
8	Makes sense as the oncology services are at Chet=ltenham so would need support
9	Provided there is emergency cardiac interventional capacity at CGH also. It would not matter if this was at CGH considering the trust's stated aim of reopening ED at CGH post pandemic and it already exists there.
10	There is a state of the art interventional theatre in CGH, and no similar facility in GRH - nor are there plans or budget for one.
11	There is a state of the art interventional theatre in CGH and no such facility in GRH and it therefore makes sense to have the hub in CGH and the spoke at GRH to cover any vascular emergencies.
12	I think it should be at both hospitals so people can go to hospital nearest to where they live
13	If this means that this service is available 24/7 at GRH then I would support this, especially if this stopped delays.
14	Extreme nature of emergency IGIS means the time delay going from Cheltenham to Gloucester would be far too risky re. loss of life to a patient who may, for example's sake, live just across the road from CGH.
15	There needs to be 24/7 cardiac intervention! This has been needed for years & should all be on one site!
16	Centres of excellence should be at both hospitals!
17	The spoke is a ‘gesture’ and perceptibly will be seen as something to sacrifice at a later date to move all services to GRH....
18	if this is the same type of procedure then use just one site (either) to reduce costs/communication
19	this will tie in with previously mentioned improvement in medical and surgical acute care by concentrating resources on one site and allowing patients to access this ground breaking/ cutting edge service

A 24/7 Image Guided Interventional Surgery (IGIS) 'Hub' at Gloucestershire Royal Hospital and a 'Spoke' at Cheltenham General Hospital.		Response Percent	Response Total
20	It is not clear what this actually means.		
21	Cheltenham with a functioning a and e needs 24/7 imaging		
22	Cheltenham needs a functioning A&E and will need a imaging		
23	I feel like this could fit the idea of GRH being for emergency care and CGH for elective care. I understand that there are already vascath labs at both sites so one could assume we already have the staff / resources to cover both sites if necessary.		
24	Imaging is essential to remain in CGH, Unsure as to why their is a need to transfer everything to GRH when there is a perfectly good working hospital with skilled staff members at CGH.		
25	Even if only elective at CGH, there can still be emergency interventions needed. Moving them across site whilst unstable is dangerous.		
26	Assuming this fits with the 'Gloucestershire emergency / Cheltenham planned' route, this makes sense, if this IGIS work is used a lot in emergency situations.		
27	Should be colocated with maternity and emergency services		
28	Emergency interventional procedures should absolutely be where the main ED is - primary PCI being one of them. It is completely unacceptable that patients, in the throes of having a heart attack are driven across the A40 or down the M5. This is a dangerous practice.		
29	Requirement exists at both sites. Urology is a high user and based in CGH. Vascular (elective) ought to be in CGH.		
30	Needs to be located with acute services.		
31	State of the art equipment in GRH		
32	It should be on one place. But I have not estimated the premises that we have available at CGH even if we have to build up a new building it is going to be far more better for the service than the service to be scattered.		
33	Grudging support since something will be offered at both sites		
34	making sure that the supporting staff are enough to provide this		
35	Cheltenham or Swindon		
36	This is a very important part of present and future health care and will greatly increase in the coming years		
37	re opening CGH ED as we have perfectly good imaging equipment and needs to be used.		
38	Any		
39	On balance on the information provided GRH seems the more appropriate site		
40	Again, we need to concentrate our resources on a single site to make best use of staffing and e.g. radiology		
41	this question is not really explained to the average person 'spoke'?		
42	Emergency Interventional Cardiology needs the resources to operate as a modern up to date facility, and should be where the acute medical take and full ED is located.		
43	A spoke will still split the vital staffing groups but in reverse.		
44	Reluctantly support, again would like both hospitals to offer as many treatments as possible		
45	This makes sense.		
46	Heart attack patients need treatment at closest hospital this would be better than using Bristol but should be available on both sites		
47	what ever GRH can do Why cant CGH do the same		

A 24/7 Image Guided Interventional Surgery (IGIS) 'Hub' at Gloucestershire Royal Hospital and a 'Spoke' at Cheltenham General Hospital.		Response Percent	Response Total
48	As long as this allows radiology to expand and develop. Be bold and invest here, this could be a real jewel in the crown for healthcare in Gloucestershire.		
49	Will provide a better health care service for local people.		
50	espensive kit and specialist staff - makes no sense to try and run 2 sites		
51	This is a good thing because it's a preemptive surgery to catch problems before they get worse.		
52	Good to have two sites will it be possible to staff them effectively?		
53	As vascular and cardiology are at CGH then this service needs to be based on this site.		
54	Would like Pathology to be taken into account with these decisions - especially Blood Transfusion as we are having to do an increasing amount of work overnight yet have no funding for extra staff! 1 person that covers the whole hospital at GRH is dangerous.		
55	Need this to be on two sites to ensure no delay in treatments		
56	aligns to centre of excellence for vascular at GRH, including IR move from CGh to GRH		
57	again more pressure on centralised service further travel for people from the Cotswolds and Forest		
58	In view of the distances patients are required to travel, I strongly support this proposal		
59	Image Guided intervention main hub should be alongside ED		
60	Both hospitals need this		
61	Don't care as long as 24/7 type-1 consultant-led A&E services are restored at CGH.		
62	Best located with the main emergency work		
63	It's a rational use of limited resources. Concentration of specialist people, and specialist kit, absolutely makes sense, and research shows that it produces better outcomes.		
64	This will reduce the need for patients travelling out of count out of hours and increase the ability to recruit high quality staff		
65	Reasons given previously		
66	I would not support anything being moved from cheltenham to gloucester		
67	Such specialised intervention should be centralised		
68	The way ahead if all the needed skill sets are in place.		
69	This would presumably mean that there could be more appointments available.		
70	I think investing in IGIS is a fantastic action. To my understanding and experience, IGIS provides an alternative to what could be a very invasive surgery and allows patients a safer and quicker recovery. It seems to me that it is something that should be evaluated to possibly be instigated in other areas of the country, if they so need it.		
71	Being a more modern hospital having the hub in Gloucester makes sense		
72	Appears to be specialist treatment needing expensive specialist equipment operated by experts. Given this seems better to centralise as one service - some people may travel a little further but far fewer would need to travel out of county at evenings/weekends. Going to hospital unexpectedly (or even planned) is not a good experience so removing a longer journey with some of the complications this can lead to seems a beneficial step		
73	How will you managed the inevitable transfers from GRH to the 'spoke' at Cheltenham without impacting on SWASFT's current operating model?		
74	Need more info on this reason, ie is it staff, facilities or something else?		

A 24/7 Image Guided Interventional Surgery (IGIS) 'Hub' at Gloucestershire Royal Hospital and a 'Spoke' at Cheltenham General Hospital.		Response Percent	Response Total
75	I believe it is good to have different hospitals with different specialisms. This will also promote inter hospital information exchange. I presume Cheltenham would be a spoke and therefore provide back up.		
76	Proposals in the consultation document appear sound.		
77	This would limit Cheltenham's A&E capacity and ability.		
78	Should have equal amounts at both hospitals		
79	In the AI age this can be shared between both hospitals		
80	what do you call Hub and Spoke? Cheltenham does not want to become a second class hospital		
81	seems sensible in view enormous cost of equipment		
82	updating equipment and locating in one site is more cost effective		
83	As long as the tech is good enough this is fine. But the tech has to be up to this task		
84	see earlier comments		
85	use of one set of very expensive equipment - no duplicated expense		
86	Imaging is already at Cheltenham, why move		
87	I do not understand why, following the presumed logic elsewhere in this consultation why the IGIS service needs a 'hub and spoke model'. There is no convincing argument made for this on any rationalisation, financial, staffing or any other basis. Just create a centre of excellence based on sensible criteria and get on with it		
88	This makes sense. I assume the Spoke would deal with geographically favoured patients who are non urgent		
89	I am not sure why it is that CGH always seems to get the second best option of anything being considered, but as I have not needed treatment of this type I am not in a position to make further comment.		
90	Concentration of key resources to reduce duplication and wastage.		
91	it would be good if people could go to the nearer one if possible		
92	with major pelvic surgery we need interventional surgery which will also tie in with oncology		
93	Having a service that operates in the main where the acute take is makes the most sense.		
94	More central for the county		
95	Would prefer all in one place to maximise use of resources but accept probably a need at Cheltenham for a smaller unit in support of other services based there		
96	Centralised approach is good. The equipment needed to undertake these investigations are often expensive, particularly the imaging equipment. Staffing levels are often difficult to maintain and are often difficult to recruit. State of the ark equipment will help to attract highly trained staff.		
97	It is unclear to me what the difference between a Hub and a Spoke in this context. The best of treatment should be available in both locations.		
98	Interesting to see the hub and spoke concept. Will this leave the hub as a centre of excellence? Can there be other spokes such as Forest of Dean or smaller hospitals such as Cirencester?		
99	more details are required to ensure both are adequately resourced (people and equipment) and overnight care available on site if needed; a waste of resource if personnel spend time travelling between centres		
100	It depends what you mean by Spoke.		
101	This would support the acute medicine and emergency general surgery services best		
102	Should be at both		

A 24/7 Image Guided Interventional Surgery (IGIS) 'Hub' at Gloucestershire Royal Hospital and a 'Spoke' at Cheltenham General Hospital.		Response Percent	Response Total
103	Help with recruiting and developing a centre of excellence good for population of Gloucestershire		
104	I prefer it to be offered at both		
105	This set up should be in the best site for the overall plan. IGIS is an increasingly import part of urgent clinical care so it makes sense to create a hub and spoke approach.		
106	As long as there is suitable staffing to support this arrangement, eg. Radiologists, nursing staff, radiology staff, physiology staff.		
107	I have put 'oppose' because I feel neutral about this proposal (so I do have an opinion but not either way at the moment). My reason is as follows: as long as patients attending both have the same access to the surgery/treatment they need e.g. so that those patients attending a non surgical centre are not disadvantaged by this model/proposal.		
108	Needs to be linked to Emergency Gen Surgery		
109	IGIS & vascular should be on same site		
110	essential facility important for the community		
111	Probably necessary due to availability of technology and equipment.		
112	Reducing risks and stays in hospital and manual intervention is always good. Anxiety of carers and family is minimised as patients return home quicker		
113	Important to rationalise and make optimum use of very expensive and latest equipment		
114	Staffing levels		
115	Agree with any proposal to avoid unnecessary duplication		
116	Provided the spoke at Cheltenham is accessible and operational		
117	See previous		
118	We have the excellent cobalt centre in Cheltenham		
119	Makes sense to have a provision at both sites and reduce need for out of county travel by patients		
120	Often with services / treatments there is a lot of confusion where to go Cheltenham or Gloucester? a centralised hub offering as much as possible at one place would provide a ""comfort zone"" for the patient without having to travel to different places. Doesn't have a feeling of disconnect		
121	Provide services at both hospitals, provides for the two large population sites and better for outlying areas. Provides back up for either place. Better for patients requiring emergency support		
122	This could have been a centre for excellence in cgh ?		
123	We've invested in Cheltenham already, make Cheltenham the Hub.		
124	Seems to make sense		
125	These services are at present sited at CGH and I believe should be supported there and aging equipment replaced.		
126	This is a very specialised service and heavy on equipment costs so centralisation makes sense.		
127	Bringing the hub into one location makes sense, as staff and equipment can be focussed on one place not split over two sites.		
128	Good choice based on current buildings		
129	It is more effective to provide a hub at GRI but a spoke allows more freedom for management		
130	This Provide the Best Option - and will mean patients can be seen locally.		

A 24/7 Image Guided Interventional Surgery (IGIS) 'Hub' at Gloucestershire Royal Hospital and a 'Spoke' at Cheltenham General Hospital.		Response Percent	Response Total
131	Less likelihood of being transferred to other hospital sites. Retention of staff is paramount		
132	Availability re transport and parking for patients and carers		
133	If this helps people and their is space on sites then definitely as delays in scans are detrimental to patient safety and outpatient urgent appointments		
134	There should be one main centre as this should lead to improved patient outcomes.		
135	Vascular services currently at cgh with IGIS,, alongside urology, cardiology and cancer services. GRH is run down with tower block wards which are not suitable for all these services		
136	Seems effective.		
137	The staff who maintain the LINACS (at CGH) would be best to carry out emergency repairs and maintenance, surely?		
138	If EGS and Acute Medical Take are located at GRH, then it makes good sense to make GRH the hub for IGIS. It would also seem sensible for there to be a 'spoke' at CGH to work alongside oncology, urology and other specialisations there.		
139	Much of the reason why patients have to go outside the County for image guided surgery is that Gloucester is not in the centre of the County and certainly for people like me living in Chipping Campden it is a long way away		
140	No the main hub should be Cheltenham after all it has more to offer with it's current services. Most of the procedures are done in Cheltenham so it would be a poor decision to downgrade this facility.		
141	N/A		
142	The idea of creating centres of excellence at both of the two excellent large hospitals in Gloucestershire makes sense. It is worth remembering that the other specialist inpatient services, which have already centralised at either CGH or GRH e.g. cancer services at CGH and childrens' services at GRH, are working really well for patients.		
143	Combine the two centres to get maximum benefit.		
144	It would seem that more patients could be treated in this way.		
145	Concentrating the service presumably mean better access to specialists in the field		
146	It looks as though this makes it more likely that i would be able to have my treatment in Gloucestershire		
147	Such a move would avoid duplication of expensive equipment. The proposal refers to a 24/7 hub, my support is conditional on this meaning availability 24 hours a day 7 days a week.		
148	see previous answers		
149	GRH should be main site		
150	Meets most eventualities		
151	This type of system is going to expand rapidly might need a target spike at Chelt.		
152	This depends where the activity is required - in emergency surgery or planned		
153	However, I do believe that more surgery will head in this direction and thus equipment at both sites to cover a range of specialities will be required.		
154	I think this will allow the best use of equipment by having the main hub at GRH but still maintaining some of the spoke services at CGH.		
155	IGIS is the technology and service that will become more important in the future. Cost will dictate that only one hospital can invest in this equipment and reluctantly I have to chose GRH, with a "spoke" at CGH.		
156	If we can choose where we go.		

A 24/7 Image Guided Interventional Surgery (IGIS) 'Hub' at Gloucestershire Royal Hospital and a 'Spoke' at Cheltenham General Hospital.		Response Percent	Response Total
157	There is a 2.5 million centre that has not long been built at Cheltenham. To move this hub to GRH is a waste of money when the service is already functioning well at Cheltenham.		
158	Gloucester Royal is best for me		
159	Key point of focus at GRH. It is unclear to me why you would want a spoke at CGH. Resources staff and equipment would be split. Imaging equipment requires on going maintenance programme better focused at one location		
160	The major IGIS is acute related often so should be with the trauma and stroke unit. However, Cheltenham General Hospital as a spoke would allow elective investigations and pelvic and oncology to occur.		
161	Support encourage people to come to hosp a more quicker turn around		
162	Yes I would like IGIS Hus at Gloucester and a spoke at Cheltenham General Hospital, I like the fact you do not have to travel between sites and outside of the county.		
163	There is a need to support the oncology unit at CGH		
164	As above - is the 'spoke' necessary? Strongly support the idea of single site excellence for all and any hospital procedures		
165	Because of the increased local population both sites should be used.		
166	This makes sense with use of 'on call' specialists. CGH 'cold' centre for elective procedures.		
167	Explain why this can't just be at Gloucester		
168	Sounds sensible. Emergency cases coming into either unit may need IGIS - so good back up for A&E.		
169	It is the logical place		
170	Having read the information in this booklet I think it would be better to have 1 place for IGIS at GRH.		
171	I understand the rationale so would have to accept the proposals. GRH is difficult to reach but, on balance, the centre of excellence is more important.		
172	Emergency interventional radiology should be on the acute site, supporting emergency vascular surgery in particular. The 'spoke' could then be used to support daytime work at CGH and this will make optimal use of the existing hybrid theatre.		
173	This will provide a better service for general surgery patients. A significant number of elective patients undergo interventional radiological procedures which is another reason for locating complex upper and lower GI patients on the GRH site.		
174	My quick thought is spoke detracts from the economies of scale argument.		
175	I would not support the concentration of services on one hospital site if that led to, for example, a reduction in consultants at CGH		
176	Image Guided Interventional Surgery appears to cross a variety of other specialisms, but seems most relevant to Cardiology and Vascular Surgery, which should be located in the first-class facility that was only created at Cheltenham three years ago.		
177	Most cases are already performed in Cheltenham and it should be the main Hub because it already has a new purpose built facility costing several millions. It would be hugely wasteful to remove this service from Cheltenham.		
178	See my previous comments. The people making the decisions have not had to journey from the FoD to Glos and Chelt 4 or 5 times a year as we have and paid for the privilege		
179	While I have no set of opinion on this I would nevertheless prefer such a service be provided at CGH. To the best of my very limited knowledge this is a not an exceptionally urgent procedure. A planned procedure???		
180	Good idea		
181	patients can be taken to/from GRH by ambulance, access problems are therefore left crucial.		

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

		Response Percent	Response Total
182	Have had heart surgery and this would have helped me at the time and taken away the need to attend Oxford. Great for bringing the specialists to Gloucestershire to work. Open up the service to more charitable funds.		
183	Single location		
184	Need to be able to meet the demand and provide the highest quality of service		

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

			Response Percent	Response Total
1	Strongly support		29.26%	151
2	Support		31.01%	160
3	Oppose		9.50%	49
4	Strongly oppose		10.47%	54
5	No opinion		19.77%	102
			answered	516
			skipped	108

Please tell us why you think this, e.g. the information you would like us to consider (174)

1	both hospitals should have it
2	Vascular is predominantly a service where patients can be suffering from a life threatening event (AAA) that requires immediate intervention in a theatre designed for this type of surgery. I think splitting Vascular across two sites will provide a sparse clinical cover across two sites rather than strong cover on one site. I can see the intrinsic link between IGIS and Vascular and therefore wherever the IGIS hub is, Vascular should be centralised to and vice versa.
3	Theatres less suitable compared to IR theatre at CGH. Major urology surgery has needed a vascular surgeon immediately at CGH in the past 10 days.
4	I would like Glos population served as a consquence of this. Currently patients from outside the county have skewed access to aligned services as a consequence - mainly radiology.
5	probably unless we split acute and elective
6	Renal services are at GRH. This would support renal service well.
7	The same as previous it is easier to manage and better cost savings for the trust, tax payer.
8	Vascular surgery should stay in Gloucester, however there is increasing amount of t&o outliers.
9	Cardiology and vascular services should be on the same site to service emergencies.
10	It depends where other surgical specialties are cited
11	The current location of this ward is totally unsuitable-i.e not enough space between beds, and only one bathroom that a wheelchair can fit into.
12	This should be in CGH where the available beds are, and where there is the state of the art interventional theatre

A ‘centre of excellence’ for Vascular Surgery at Gloucestershire Royal Hospital.		Response Percent	Response Total
13	The interventional theatre is in CGH and there are not enough beds in GRH to cope with all the acute medical patients, all of the acute surgical patients and trauma and vascular.		
14	I would support this if GRH were able to provide vascular surgery with a ward that was fit for purpose! Vascular patients are currently on a ward that does not have the space or capacity for the patients. Wheelchair patients have 1 accessible toilet and shower for 21 patients. This in not good for rehabilitation of patients post amputation and impossible for all patients to access shower facilities. This is adversely affecting patient care. Lack of space around beds make life hazardous for staff and patients as we are often transferring patients from bed to wheelchair with hoist and moving furniture around to make this possible.		
15	Again it should be at both hospitals so that people can go to hospital nearest to where they live		
16	Centralising of this service, improved staff availability, expertise and ensuring this prevents delays and wait time.		
17	Again, why not just go to Oxford if you live east of Cheltenham?		
18	Bedspace constraints at GRH reducing efficiency of vascular care; current ward for vascular patients at GRH unsuited to patient type and care required		
19	Hybrid theatre set up and a bigger, dedicated ward at CGH		
20	This seems like an enormous waste of previous investment in facilities such as the hybrid theatre.		
21	Centres of excellence are required at both hospitals- the region and population support it - you are reducing Cheltenham hospital to a first aid centre by stealth. Offering centres of excellence is merely a ploy to reduc3 services in Cheltenham which remain badly needed!		
22	This service was previously being managed well at CGH but if it not possible to split elective e.g. IGIS and emergency vascular surgery then I believe it would be preferable to keep it on the GRH emergency site and then consider the ""spoke"" option at CGH for the elective surgery. Splitting this service will have an impact on the intensity / quality of Therapy those patients will receive unless additional funding is provided to support splitting this service across sites.		
23	Multi million pound interventional radiography theatre built in Cheltenham, consultants still wishing to do hybrid cases in IR resulting in transferring patients post major surgery across site, emergency list overwhelmed in Gloucester Royal as battle for specialities to operate		
24	Too many operations at CGH have the potential to cause life threatening bleeding from major vessels (pelvic, aorta, IVC - renal, gynaeoncology) for it to be safe to have no available vascular surgeons immediately available at CGH.		
25	1. there is a redundant state of the art IR theatre in CGH 2. Winter pressures and COVID in GRH make it non sensical to keep elective vascular there		
26	Emergency vascular should be in GRH, elective should be in CGH - bespoke IR theatre already exists there and same arguments for bed base, HDU / ITU etc as for elective colorectal apply		
27	Vascular surgery can be a stand alone speciality		
28	Other services such as renal medicine, diabetes which have a strong link to vascular surgery are largely based in GRH		
29	Because is not GI surgery. Every surgery not related to GI can go in GRH.		
30	Far too far away from Fairford to be a good option for patients from that town/area		
31	its already there		
32	Speciality doesn't really have elective admissions. They have urgent emergency type patients		
33	Too Glos central		
34	Vascular has already moved to gloucester		
35	Urgent care site status will mean operations may be cancelled		

A 'centre of excellence' for Vascular Surgery at Gloucestershire Royal Hospital.		Response Percent	Response Total
36	This should be concentrated at Gloucestershire Royal and it is not asking too much for patients needing such procedures to have them carried out at Gloucester		
37	I prefer vascular surgery in one hospital either cheltenham or gloucester.		
38	vascular surgeons will mainly be based here for acute interventions		
39	as above		
40	Vascular surgery worked well for many years at CGH and the ward environment was much better than the present situation at GRH. Patients travelling from Swindon have much further to go for treatment so it is better situated in Cheltenham.		
41	Should have vascular surgery where acute services are and e.g. renal, stroke		
42	This is something that needs to be covered at both sites		
43	keep potential more acute care on one site		
44	Should be where the full ED is located for emergency patients		
45	See my previous answers, Great getting too busy with parking and accessibility problems		
46	This, too, makes sense.		
47	Heart attack patients need treatment at closest hospital this would be better than using Bristol but should be available on both sites		
48	What ever GRH can do , CGH should do the same		
49	Hard to have IGIS at GRH and vascular at CGH so makes sense.		
50	I think it is an interesting area of surgery and will provide excellent provision for local people.		
51	Agree		
52	Ties in with cardiolgy		
53	Again the wards at GRH are not fit for practice. They are overcrowded, beds too close together increasing the infection risk. The tower block appears generally dirty. Your report reads that if you live in a deprived area(25% of Gloucester population) you will get preferential treatment on your door step and blow the rest of the county. Given that most vascular issues occur in the over 65 age group and these people are spread out across the county if you live at Morton/Bourton area East Gloucestershire, you wont stand much chance of survival.		
54	Would like Pathology to be taken into account with these decisions - especially Blood Transfusion as we are having to do an increasing amount of work overnight yet have no funding for extra staff! 1 person that covers the whole hospital at GRH is dangerous.		
55	Once again rationalised approach to medical unit		
56	aligns well with emergency provision for vascular / stroke etc		
57	An important part of medicine that needs a Centre of excellence		
58	As above,		
59	Keep Cheltenham as centre of excellence for everything GU/GI and oncology and all other surgery at GRH		
60	Both hospitals should do this		
61	Don't care as long as 24/7 type-1 consultant-led A&E services are restored at CGH		

A 'centre of excellence' for Vascular Surgery at Gloucestershire Royal Hospital.			
		Response Percent	Response Total
	62	Supporting evidence required	
	63	Ideally it would be located with the IGIS hub. Needs adequate provision of beds and and appropriate theatre.	
	64	It's a rational use of limited resources. Concentration of specialist people, and specialist kit, absolutely makes sense, and research shows that it produces better outcomes.	
	65	Access to skilled medical staff in the right location	
	66	Ditto	
	67	I would not wish to be treated for any reason at Gloucestershire Royal hospital	
	68	see above	
	69	One team working closely together	
	70	Same as the above	
	71	Again confused - suggest you need to engage some communications experts to put the proposals AND link them to the survey in plain english/language understandable by non medical persons. Appears to be specialist treatment needing expensive specialist equipment operated by experts. Given this seems better to centralise as one service - some people may travel a little further but far fewer would need to travel out of county at evenings/weekends. Going to hospital unexpectedly (or even planned) is not a good experience so removing a longer journey with some of the complications this can lead to seems a beneficial step	
	72	Support if planned & elective care.	
	73	Whilst I support this, I believe there needs to be a vascular consultant available to cover CGH at all times due to the major surgery that CGH provides. In an emergency situation in theatre a vascular surgeon could be needed very quickly!	
	74	Would seem to complement IGIS	
	75	Proposals in the consultation document appear sound.	
	76	As before - transport is a serious worry for us	
	77	Transport difficulties for patients from the Cotswolds	
	78	Centres of excellent remove local services	
	79	See above, I do not believe in splitting services between the hospitals	
	80	Might use this	
	81	see earlier comments	
	82	Would fit with plans for all cardiac care	

A 'centre of excellence' for Vascular Surgery at Gloucestershire Royal Hospital.		Response Percent	Response Total
83	I support the proposals to change and think the information provided presents a strong case. However, throughout the consultation document I see little or no reference to: a) How staff are to be retained, trained, recruited and afforded. b) No reference to any improvements to process or service instigated as part of the response to Covid -19 which will be retained as Best Practice moving forward. c) Limited reference to the way that services will be re-modelled in line with international Best Practice. There is limited information given for example on the use of telemedicine, telephone consultation and follow up, health education in primary care, transfer of services into community settings, conversations to higher day case rates, better streaming through outpatients (and ED). The proposals appear to deal with the issue of duplication of services across two sites and consequent rationalisation and whilst this is to be welcomed, of itself, it does little to illustrate how the models of care can or will change. Similarly there is no financial analysis (that I can see) with the documentation provided. In an increasingly stretched NHS, this must be a consideration for services to be long term sustainable.		
84	I am not sure why it is that CGH always seems to get the second best option of anything being considered, but as I have not needed treatment of this type I am not in a position to make further comment.		
85	Concentration of key resources to reduce duplication and wastage.		
86	Theatres at GRH currently not suitable for vascular surgery - too small to accommodate equipment for EVAR procedures. Urology surgery (open nephrectomy) can potentially need help from vascular surgeons immediately- this is not possible if vascular based at GRH		
87	Again reducing Cheltenham		
88	I think Vascular should remain at CGH. Only a relatively short time ago much investment was made to establish a centralised service at CGH. Going forward with future phases of FFtF there will be a need to have established services at CGH and this is one that could fit and not compromise safety.		
89	Again more central for the county and transport links		
90	Again, the same point of view. Maximise the use of resources in one place rather than try to do everything everywhere		
91	As per previous observations		
92	Same reasons as above.		
93	This should be true of CGH too		
94	as with GI surgery		
95	As before services should be at both to ease travel for elderly who do not drive		
96	Should include mechanical thrombectomy for LAO strokes		
97	Meets best practice requirements		
98	I think it should be offered at both sites		
99	I support the whole concept of of centres of excellence		
100	Planned care should be at Cheltenham General - that's the Centres of Excellence model		
101	As long as there is suitable staffing to support this arrangement, eg. Radiologists, nursing staff, radiology staff, physiology staff.		
102	Please read my earlier comments regarding capacity, service delivery and my reservations that moving particular services to GRH alone must not lead to the closure of CGH (based on the assumption that GRH alone cannot service the whole catchment community).		

A 'centre of excellence' for Vascular Surgery at Gloucestershire Royal Hospital.			
		Response Percent	Response Total
103	Needs to be linked to IR		
104	If Gloucester is the best hospital then yes but don't overload it.		
105	Most vascular surgery is urgent, however the vast majority is planned so it seems daft to move too GRH. especially when a lot of resources and planning went into developing an excellent service at CGH.If it is moved to Gloucester Royal then it is essential for the accommodation to be fit for purpose. eg: large bed space, assessable showering/bath facilities to meet the needs of patient demographics. Vascular surgery inpatient and outpatients and vascular lab should be in close proximity		
106	IGIS & vascular should be on same site		
107	Essential facility important for the community		
108	It would be good not to have to go out of county for this		
109	Agree with any proposal to avoid unnecessary duplication		
110	See previous		
111	Seems to make sense		
112	Provide services at both hospitals, provides for the two large population sites and better for outlying areas. Provides back up for either place. Better for patients requiring emergency support		
113	As above		
114	Needs to be at both hospitals		
115	As with all your proposals to centralise services the problem is that of access for patients and their families. Whilst many have access to private transport a very large minority do not and they are frequently the elderly and less financially secure. For these people centralisation poses a major difficulty in accessing your services unless you propose to offer free transport between the sites. Even for those with private transport difficulties in accessing parking at either site pose difficulties and high costs.		
116	Why change sites when you have this service functioning at CGH.		
117	As above		
118	Very good choice		
119	One excellent speciality		
120	I Struggle to see the Justifcation for the move - other than to be Closer to Trauma unit.		
121	Planned care at Cheltenham		
122	Better facilities and car-parking at GRH		
123	Good parking, already has a good unit at GRH		
124	This team have been in place and excelled in gloucester as majority of admissions of this type are sourced from gloucester. Also the equipment and resources required for this are centered in Gloucester with years of practice		
125	As above, wards not suitable for vascular patients, due to limited mobility, cgh has cancer centre of excellence, these patients would have to travel to grh if igis not working. Theatre in cgh could be upgraded as service there already		
126	Not qualified to judge.		
127	As I said before, as long as it is excellent, who cares where it is?		
128	Patients and clinical teams will have continual access to other acute speciality services, and these can operate in a more efficient linked-up manner.		

A ‘centre of excellence’ for Vascular Surgery at Gloucestershire Royal Hospital.			
		Response Percent	Response Total
129	Vascular Surgery had a very good set up at Cheltenham General Hospital with the IR theatre being built and utilised. The theatre sessions at Gloucestershire Royal Hospital are inadequate and the ward is literally a joke, not fit for purpose and the ward is dirty and the bed capacity is severely lacking. The service works perfectly well at Cheltenham General Hospital and would be costly to move on a permanent basis and even the consultants in the department are strongly opposed to moving on the grounds of patient safety and capacity issues.		
130	I appreciate that these skills cannot be shared between too sites but for emergencies people living in many of the remote parts of Gloucestershire they need quicker access to a hospital and Gloucester is far from us		
131	There is a state of the art facility at Cheltenham being built only 6 years ago. To take away this service is wasteful and nonsensical. It is highly regarded.		
132	N/A My wife and I are in our 90th year. She is not allowed to drive. I prefer daylight and not Mon or Friday. We live in Tetbury and wish treatment there. So: We prefer Cheltenham and do not like Gloucester, the former being easier for us to reach by car and more convenient in terms of other activities on the day.		
133	The idea of creating centres of excellence at both of the two excellent large hospitals in Gloucestershire makes sense. It is worth remembering that the other specialist inpatient services, which have already centralised at either CGH or GRH e.g. cancer services at CGH and childrens' services at GRH, are working really well for patients.		
134	This site has more suitability for these operations		
135	They seem ton work closely with the radiologists so doesn't it make sense for them to be on the same site?		
136	It seems that this is closely linked to the IGIS hub		
137	Vascular surgery has brought a heavy and unpredictable emergency workload to GRH since its recent transfer from CGH. This has impaired access to emergency operating for all specialties, despite extra emergency theatre and consultant anaesthetist provision. CGH has a well equipped and recently provisioned IR theatre, which is currently lying fallow much of the time, and which is superior to any similar facility in GRH. CGH should welcome vascular surgery back.		
138	Vascular surgery carries a burden of heavy emergency list use, often at unpredictable times. This has impacted the emergency theatre provision at GRH such that, even with an extra emergency theatre and consultant anaesthetist on site, access to emergency surgery in a timely fashion has deteriorated for all specialties. CGH would be well placed in terms of facilities and aftercare provision to re-accommodate vascular surgery after the recent experimental transfer to GRH. The fully equipped and recently provisioned IR theatre at CGH is currently lying fallow much of the time and is superior to anything available in GRH.		
139	see previous answers		
140	Main site		
141	Focus of resources on one site		
142	Having Vascular surgery at GRH will mean that vascular surgery will be able to support the emergency services better.		
143	If the investment in IGIS is at GRH, it follows that "A Centre of Excellence for Vascular Surgery, should be at GRH.		
144	I would like to make sure that we get best care not sure which hospital is best.		
145	Again the facility is already at CGH and working well, make the hub at Cheltenham and the spoke at Gloucester, as it makes sense as this is the way it operates at present. Why put all that money and energy into building a purpose built facility at Cheltenham only for it to be downgraded.		
146	In line with decision to locate the IGIS primarily at GRH		

A 'centre of excellence' for Vascular Surgery at Gloucestershire Royal Hospital.			
		Response Percent	Response Total
147	I believe that some thought should be given to maintaining some 'low risk' non urgent vascular capability for some elective vascular surgery at Cheltenham General Hospital		
148	Keep it has it is ensure a good quality service		
149	I appreciate the fact less invasive surgery would be needed and reduced travel time for some procedures, so that would be a bonus.		
150	As above Strongly support the idea of single site excellence for all and any hospital procedures		
151	Because of the increased local population both sites should be used.		
152	As long as there is critical care support e.g. for aortic aneurysms		
153	It needs to be Gloucester central for Gloucestershire		
154	Why not? The importance is that the unit exists and is available 24/7 as and when.		
155	This and IGIS should be in the same location		
156	Single specialist centre would enable better and timely patient care.		
157	I understand the rationale so would have to accept the proposals. GRH is difficult to reach but, on balance, the centre of excellence is more important. Regarding concerns about going out of county, Gloucester is no more convenient than Bristol (although I accept there may be budgetary considerations).		
158	I feel emergency and elective vascular surgery should be split so that emergency work is aligned with the surgical take whilst elective work continues at CGH. This will ensure there is critical care capacity available to support the elective work otherwise there is likely to be an ever increasing pressure on ICU beds at GRH.		
159	Concentrating resources provides better care		
160	Is there not a new vascular theatre in Cheltenham?		
161	Hasn't millions of pounds recently been spent on a vascular theatre in Cheltenham!!		
162	As previous answers.		
163	as noted earlier CofE reduces resourcing supporting A&E from other hospitals		
164	I would not support the concentration of services on one hospital site if that led to, for example, a reduction in consultants at CGH.		
165	There is an excellent, nearly new Cardiovascular Unit at Cheltenham General Hospital, which the Hospital Trust spent £2.3m or more on. This is one of the best facilities of its kind in the South West, if not the whole country. It makes no sense to relocate this to the Gloucestershire Royal, especially since, according to six our of seven of the Consultants involved, the facilities there are not nearly as good.		
166	The Trust commissioned a new facility at Cheltenham which cost several million. It is regarded as the very best in the South West. It would be hugely wasteful to take it away. Most cardiology and inpatient vascular surgery is already performed at Cheltenham, it should stay.		
167	Se my previous comments and reverse you decision. My wife is disabled and I am 90 years of age and her carer. Traveling to Chel and Glos 4 or 5 times a year is traumatic.		
168	I support this option since I recognise that resources have to be used to the very best effect so if this is the Trusts preference I would support it.		
169	Another very good idea.		
170	CGH already does it		
171	You need the technology to do this and therefore would be good to be in Gloucestershire. Need to have the wards set up for this close to the theatres. Will pull in staff and money by having a centre of excellence. Increase the number of specialist nurses.		
172	The need to create the centre of excellence for specific specialisation over the 2 hospitals		

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

		Response Percent	Response Total
173	Single location		
174	BME communities have higher rates as diversity to Cheltenham and Gloucester - GRH is perfectly placed		

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

		Response Percent	Response Total
1	Strongly support	39.41%	201
2	Support	32.55%	166
3	Oppose	3.92%	20
4	Strongly oppose	2.75%	14
5	No opinion	21.37%	109
		answered	510
		skipped	114

Please tell us why you think this, e.g. the information you would like us to consider (148)

1	Good to see this could be made permanent. It appears that a lot of progress has been made since the pilot scheme was put in place. Good clear proposal.
2	Gastroenterology experience has been demonstrably improved by the recent pilot. Less violence and aggression on the ward, less non-gastro (general medicine) patients using specialised beds and better staff satisfaction from cohorting our clinical capacity onto a single site.
3	better to avoid the emergency site
4	Despite gastro inpts being at CGH currently, gastro inpts are still seen on GRH wards and do not get the care they need from the gastro team. Patients either need to be moved promptly so the care of the patient is not impacted, or have a service at both sites.
5	The same as previous it is easier to manage and better cost savings for the trust, tax payer.
6	Provided there is some gastroenterolgy presence at GRH also.
7	I feel that this ward is located on the wrong site and should move to GRH where the other acute medical care is taking place. Many patients need regular access to Endoscopy but there are not enough gastro patients at CGH to warrant an inpatient list each day or weekend access to services. By moving this ward to GRH patients would have improved access to endoscopy services 7 days of the week on dedicated inpatient lists. They would not have to be transported cross site either
8	It should be at both hospitals so people can go to hospital nearest to where they live
9	Everyone will know where it is and again centralising services and insuring expertise, experience and staffing is available.
10	Gastroenterology at cheltenham is the best. Keep it in cheltenham.
11	Both hospitals need a centre of excellence due to the size of the population and the location of the services .
12	This fits with separating surgical and medical divisions across each site.
13	as long as colorectal surgery is also located there - without this it will leave gastro very exposed

A permanent ‘centre of excellence’ for Gastroenterology inpatient services at Cheltenham General Hospital.		Response Percent	Response Total
14	Only if lower GI surgery is colocated - rapid senior surgical review with alacrity ensures that decisions for surgery are correctly timed and that non surgical interventions are not pursued too long ; if all one has is a hammer then everything looks like a nail		
15	It is closer to Endoscopy Unit. Patients can be easily transferred to it.		
16	I would also like to see continuing support for Gastroenterology services at Cirencester hospital. I have had excellent treatment there.		
17	Better for patients from Fairford, but not good for patients living at the west edges of Glos.		
18	If GI surgery is at CGh this needs to be too		
19	Consider Great Western Swindon for Cotswold residents		
20	Nothing wrong with snowshill, Again don’t fix what’s not broken just make it bigger		
21	Some services will need to be continued at Cheltenham as Gloucestershire Royal will not be able to accommodate them all		
22	Should be in Gloucester with the rest of medicine		
23	prefers a medical unit in cheltenham which helps all people		
24	Having one of the sites be the centre of excellence makes absolute sense. As the pilot has been at CGH - this should continue. However, having had personal experience of the CGH provision both in 2019 (in December) and in 2020 (May/June), some work is needed on this provision. My brother was in CGH for over 8 weeks in 2019 and for over 11 weeks in 2020 - and the care was poor. There was lack of continuity of care, and rarely saw a gastroenterology specialist on each day. While I appreciate that this might not be the 'norm' for most patients - I am aware of two other patients that have had this experience. At the moment, the continuity of care and plan for patients being discharged is poor and needs to be improved.		
25	This has been piloted successfully and seems a sensible balance between the two hospitals		
26	See all my previous answers		
27	Save me travelling to Gloucester and pay expensive park fees for long visits and bus fares		
28	As the pilot has been seemingly successful then makes sense.		
29	I think if gastroenterology is going to be based at Cheltenham then the surgery should be carried out there too so that all gastroenterology services are under one roof. I don't like departments being split between the different sites.		
30	Excellent idea provides a focal point and links in neatly with spoke and other services provided		
31	Emergency Gastroenterology patients should also be admitted to ED at CGH once its reopened other wise you dont have a 'centre of excellence. You will have patients on both sites.		
32	Would like Pathology to be taken into account with these decisions - especially Blood Transfusion.		
33	Efficient use of resources, access to specialist staff at all times, no waiting for them to travel from GRH to CGH and vice-versa. The total patient capacity must still remain the same (and hopefully higher!), not reduce as a result.		
34	It makes total sense to be clear which of the two sites is the centre for excellence and not to have activities on two sites		
35	This goes along with the idea of a centre of excellence in planned care		
36	I have concerns that the underlying message of specialisation does not take into account issues of resilience, access, critical mass or community. The approach being taken is "standard" nhs review practice to downgrade one site to the benefit of another. In effect closure by instalments: Why does the Senior Health Management in Gloucestershire look at closing both hospitals and locating a new one just off J11 or 11a of the M5?		

A permanent ‘centre of excellence’ for Gastroenterology inpatient services at Cheltenham General Hospital.		Response Percent	Response Total
37	got to move something to CGh to balance the shift to GRH. aligns well to elective services generally centralising to CGH		
38	Again, important to have these services readily available		
39	I fully support the Centre of Excellence principle and am happy to leave the ‘where’ to those more qualified than me to make that decision.		
40	If you want to have a centre of excellence EVERYTHING to do with that area of medicine needs to be there, no half measures and aahh but this bit goes to Gloucester. You need to keep things simple and easy for Joe Public to understand as well as your HCP partners.		
41	Both hospitals need this		
42	Don't care as long as 24/7 type-1 consultant-led A&E services are restored at CGH		
43	Describe centre of excellence as this term is being overused in the survey		
44	There needs to be an outreach service to GRH. Interaction with emergency general surgery is still possible - need to ensure this is not affected. Interaction with elective surgical patients is principally on an outpatient basis		
45	Easily accessible		
46	The data presented strongly supports not reverting back to the old model		
47	Reasons given previously re: buildings		
48	prefer location of all specialist resources at GRH, Gloucester City site		
49	experienced excellent care re gastro at CGH		
50	Already in place? One stop shop.		
51	Expertise and resources at one site.		
52	Seem to be wanting to move all other services away from Cheltenham - might be an exaggeration but that is what is coming across, whether intended or not. The shorter booklet was understandable until it referred you to the longer booklet - that just descended into more confusion Again support measures to have less last minute cancellations & being seen/treated by the right person sooner. Need to balance this against over centralising and leading to capacity constraints & greater travelling time for those in the west of the county, particularly at the start/end of the day & at weekends		
53	If no gastro inpatient services at GRH, how will you manage the inevitable additional transfers required without impacting on SWASFT's operating model? What are the considerations for additional travel time and public travel routes for those that will subsequently need to travel to CGH that do not have access to their own transport?		
54	if teams are on site to support patients		
55	Would compliment other specialisms		
56	Proposals in the consultation document appear sound.		
57	Need specialist services		
58	As above		
59	This would seem to be a similar specialism to upper and lower GI		
60	centres of excellence remove local services		
61	simply accept the judgement of the people making the recommendation		
62	co-locating with planned day cases with specialist staff and contact points for inpatient and long-term ongoing care		

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

		Response Percent	Response Total
63	Yes both hospitals should be capable of offering all services		
64	Would work well with a planned centre at CGH for colorectal surgery		
65	I support the proposals to change and think the information provided presents a strong case. However, throughout the consultation document I see little or no reference to: a) How staff are to be retained, trained, recruited and afforded. b) No reference to any improvements to process or service instigated as part of the response to Covid -19 which will be retained as Best Practice moving forward. c) Limited reference to the way that services will be re-modelled in line with international Best Practice. There is limited information given for example on the use of telemedicine, telephone consultation and follow up, health education in primary care, transfer of services into community settings, conversations to higher day case rates, better streaming through outpatients (and ED). The proposals appear to deal with the issue of duplication of services across two sites and consequent rationalisation and whilst this is to be welcomed, of itself, it does little to illustrate how the models of care can or will change. Similarly there is no financial analysis (that I can see) with the documentation provided. In an increasingly stretched NHS, this must be a consideration for services to be long term sustainable.		
66	Bias on my part. No real rationale to be honest		
67	Again, makes no difference to me as a patient where this is based		
68	I am in support of this if it means that all the specialists are in one place. I do have concerns about the lack of parking facilities at CGH - especially if patients are being asked to travel from further afield to attend this site.		
69	As mentioned previously it is obviously better for those living in the Cheltenham area for as many services as possible to be fully delivered at CGH. There is also historically a poor reputation for infection control at GRH. I would not feel confident going there for anything serious.		
70	Concentration of key resources to reduce duplication and wastage.		
71	will tie in with colorectal making patient experience & expertise seamless		
72	The evidence supports this remaining and expanding at CGH.		
73	I have a potential gastroenterology condition, so Cheltenham suits me. That should not be the criteria, when professionals have studied the situation extensively and come to a conclusion.		
74	One unit to maximise use of resources but tempered by the fact that Cheltenham hospital is in drastic need of refurbishment.		
75	But not only at CGH.		
76	Gastroenterology services should (at least in my view) be in close proximity to GI surgery. Optimal care of such patients often involves close collaboration between the two arms		
77	Keep all acute services under one roof. Cheltenham seems better suited for planned, elective services.		
78	I feel this service could be led from either hospital and the service continue I the hospital why change for change sake . Save money and develop leadership on either site and share good practice online		
79	As long a there are support services, equipment and staffing to support this		
80	As long as it meets patient need, is accessible and effective. My responses are based on the assumption that this proposal will deliver better efficiency and improved clinical outcomes than the current model/service provision in place.		
81	Balance of services between the hospitals.		
82	This will only work if medical beds are managed by the specialty teams, when pressure increases in GRH this is always lost.		

A permanent ‘centre of excellence’ for Gastroenterology inpatient services at Cheltenham General Hospital.			
		Response Percent	Response Total
	83	Whichever the clinicians think is best	
	84	Essential facility important for the community	
	85	GI and gastroenterology services should all be at the same hospital	
	86	These are common aliments and overall benefits outweigh the negatives	
	87	Can see reason to concentrate into a single centre of excellence but accessibility of Cheltenham a problem eg public transport	
	88	it depends on staffing levels	
	89	Agree with any proposal to avoid unnecessary duplication	
	90	This is a linked to ties in with a centre of excellence for planned lower colorectal and day case surgery at Cheltenham	
	91	See previous	
	92	I have received excellent care at Cheltenham	
	93	If the pilot showed improvements why revert back to former arrangement Proposal sounds more efficient from hospital and patient prospective	
	94	Urgent general need for many people. Reduced waiting times - quality focused attention and care for the patient is always a win win	
	95	Is there the parking facilities to support this - what are the people numbers?	
	96	Support concept	
	97	Ideal location from a personal point of view	
	98	As with all your proposals to centralise services the problem is that of access for patients and their families. Whilst many have access to private transport a very large minority do not and they are frequently the elderly and less financially secure. For these people centralisation poses a major difficulty in accessing your services unless you propose to offer free transport between the sites. Even for those with private transport difficulties in accessing parking at either site pose difficulties and high costs.	
	99	Proven already via Pilot.	
	100	Gastroeneterology support for cancer patients needs to be improved and this move would help that.	
	101	As above	
	102	Focus a centre of excellence on one site, don't try to split it across two geographical locations.	
	103	Layout issues at CGH	
	104	The Pilot seems to indicate that this is and will continue to work well	
	105	Treated more quickly by a specialist	
	106	Links with upper /lower GI as well as colorectal and cancer based surgeries, this is a no brainer as it would all fit together and enable this center of excellence aim	
	107	More specialist case throughput should lead to better outcomes.	
	108	Not qualified to judge.	
	109	Improved conditions for medical staff, and therefore beneficial for patients.	

A permanent ‘centre of excellence’ for Gastroenterology inpatient services at Cheltenham General Hospital.		Response Percent	Response Total
	110	Suits us - see page 37 My wife and I are in our 90th year. She is not allowed to drive. I prefer daylight and not Mon or Friday. We live in Tetbury and wish treatment there. So: We prefer Cheltenham and do not like Gloucester, the former being easier for us to reach by car and more convenient in terms of other activities on the day.	
	111	The idea of creating centres of excellence at both of the two excellent large hospitals in Gloucestershire makes sense. It is worth remembering that the other specialist inpatient services, which have already centralised at either CGH or GRH e.g. cancer services at CGH and childrens' services at GRH, are working really well for patients.	
	112	As mentioned before this is utilising this hospitals strengths.	
	113	Combining the service presumably means that there will be better access to specialist inpatient care. They need to make sure that they provide a service to Gloucester Hospital.	
	114	Your pilot appears to have worked well	
	115	As above, also strongly sceptical of your use of the word ""permanent"", given the constant change and deterioration that is going on in NHS services locally	
	116	Not central site. Too far away for lots of people and parking a nightmare and expensive	
	117	I support this if linked with colorectal surgery at Cheltenham	
	118	Makes sense with plan to have centre of excellence at CGH for Colorectal surgery.	
	119	If other GI services are to be at CGH then this should be too	
	120	linking this with the Cancer centre streamlines care	
	121	It appears that the pilot works.	
	122	It is clear that reverting to the set-up from the pre-pilot stage would be worse off for many aspects. It seems to be working well, and it is fulfilling the world-wide move to centres of excellence.	
	123	CGH has an enviable reputation in this field and with more investment can become the "Centre of Excellence".	
	124	As this appears to be working well from the pilot then it seems sensible to keep the service as it is now.	
	125	This is in line with the decision to locate the GI services at CGH but to be effective and efficient the CGH facilities, resources and staffing levels need to be expanded and improved at CGH if the CGH is to be the centre of excellence.	
	126	Cheltenham General Hospital concentrating of elective support in the area is sensible.	
	127	We think all procedures should be available at all hospitals, but Cheltenham is preferable to us over Gloucester as it is marginally closer.	
	128	All in one place	
	129	Yes, always keep anything that is excellent and working well!	
	130	As above Strongly support the idea of single site excellence for all and any hospital procedures	
	131	Because of the increased local population both sites should be used.	
	132	Will need surgical support	
	133	It needs to be Gloucester more central for Gloucestershire	
	134	This probably follows on from the other gut services, so yes.	
	135	Keep the gastro disciplines together	

A permanent ‘centre of excellence’ for Gastroenterology inpatient services at Cheltenham General Hospital.		Response Percent	Response Total
	136	A centre of excellence would benefit both staff, services delivered and patient care.	
	137	My husband received excellent care for bowel cancer and an emergency hernia. Cheltenham is so much more convenient for the Fairford end of the county.	
	138	The current setup seems to work well. All acute admission would still need to be via GRH but once stable transferring patients across to CGH optimises flow and also helps reduce pressure on GRH DCC for patients who then deteriorate on the ward and require intensive care.	
	139	Interaction with gastroenterology on a day to day basis for general surgery is either on an outpatient basis or as an emergency. The current system of having a gastroenterologist on site in GRH works well. Outpatients continues to work as before. Overall the changes do not affect the general surgery service.	
	140	As before really.	
	141	Cheltenham as an older demographic than other parts of the zone covered by trust however might be best not to have CofE so specialist doctors are available for A&E support at all the hospitals in the trusts zone	
	142	I have no objection to the siting of specialist services on one hospital site. If this allows the particular hospital to improve its services in that field so much the better.	
	143	this is a service which should, as far as possible, be located as close to the existing Cancer Centre in Cheltenham General Hospital.	
	144	This could work well alongside the Cancer Centre.	
	145	See my previous comments	
	146	Perfect - the ideal site and facilities for such a service.	
	147	CGH is best located for the whole of the county	
	148	Cheltenham would do well with the long term illnesses and having a centre of excellence for this specialty. Facilities are questionable to make this a great centre excellence - the physical building.	

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

		Response Percent	Response Total
1	Strongly support	44.44%	228
2	Support	31.58%	162
3	Oppose	7.41%	38
4	Strongly oppose	3.12%	16
5	No opinion	13.45%	69
		answered	513
		skipped	111

Please tell us why you think this, e.g. the information you would like us to consider (182)

1	Fully support and it appears to reflect the wider logic of the overall Centres of Excellence approach. Supporting staff to provide the very best specialist care.
2	absolutely - this should be a number 1 priority - better trauma and A&E care at both destinations - there is NO WAY that one centre will suffice and we know this undermines public trust in CCG (who honestly now must be loved about as much as covid 19 itself).
3	both should have trauma and ortho
4	If it is a trauma case, it is quite possibly an ambulance admission and GRH cannot cope now. All ambulances go to GRH and then orthopaedics would have to be transferred to CGH, increased cost, risk, time and staff
5	Much like with previous service responses I believe that by keeping Trauma linked with Orthopaedics will inevitably lead to Orthopaedics losing out because acute patients (trauma) has to take priority for beds, theatre space and staffing requirements. This allows the massive Orthopaedics service to properly deliver aside from the constraints put on them through sharing bed and staff capacity with Trauma.
6	makes complete sense
7	The same as previous it is easier to manage and better cost savings for the trust, tax payer.
8	There are a high number of T&O patients so both sites is good
9	Need to be on one site . Have CRH as cold , non emergency surgery and GRH as emergency. Which would protect beds at CRH
10	I agree that all trauma should come to GRH and planned orthopaedics to CGH.
11	Question is unclear, but I support Trauma remaining in GRH to protect elective surgery in CGH
12	I think it makes sense to have trauma on one site but there needs to be adequate orthopaedic cover for the other site. At the moment this is not happening.
13	This has to be fit for purpose and capacity needs to be concidered
14	Again both of these subjects should be at both hospitals so people can go to nearest hospital to where they live
15	If the 24hr A&E is at GRH I it makes sense for trauma to be centralised there. Orthopaedics at CGH again if this ensures this service is protected and trauma emergencies doesn’t interfere with this.
16	Both hospitals have the population to support a centre of excellence- this is just stealing Cheltenham hospital services away which has been happening by stealth over recent years!
17	if these are similar and use the same resources then use one site (either) to reduce costs/communication
18	This makes sense to enable the more acute work to be separated from the elective lists thus enabling the latter to proceed despite other pressures in the acute sector
19	Why are these separated at two sites? Are they not related, so should be together on one site?

Two permanent ‘centres of excellence’ for Trauma at Gloucestershire Royal Hospital and Orthopaedics at Cheltenham General Hospital.		Response Percent	Response Total
	20	This is something that I believe is already pretty much established with GRH being the trauma site and CGH being the elective site	
	21	trauma where A&E is, elective orthopaedics at cold site with no bed pressures	
	22	Southmead is the regional major trauma centre ; it is faintly ridiculous to imagine that GRH will every be a national centre of excellence for trauma in this context	
	23	this has worked well since 2017	
	24	Emergency T&O in GRH and elective T&O at CGH.	
	25	if this is tenable on two sites, why not? if resources do not allow this then one site will be better than none and centralises specialist care	
	26	Again acute trauma is better placed in GRH because of the 24/7 access to consultant led A&E	
	27	It should be everything in GRH. This is my refrain. It is logical and simple. The simpler is the better is. Perfection is in simplicity.	
	28	its needed across both sites. trying to travel from e.g moreton in marsh on crutches or with arthritis to GRH isn't acceptable. there is no realistic hospital transport for these folk	
	29	Trauma and orthopaedics should stay together at GRH	
	30	Prefers a unit in cheltenham for orthopaedics.	
	31	emergency site and planned site	
	32	Again this seems to have been piloted successfully and I support the proposed allocation of services	
	33	Appears to work well at the present. Not sure why spinal surgery is not at CGH too.	
	34	Keep low risk elective surgery away from acute site, concentrate acute resources	
	35	Both sites should be covering Trauma this would save lives!!	
	36	No there should be one centre to concentrate all resources in one place, unless one is for emergencies and one for electives. Two sites would dilute this.	
	37	Just what I would like, both hospitals offering service	
	38	It is important not to feel that CGH is not being downgraded, so I think this is really important	
	39	This is known to be good practice and the pilot has been working well. Why change it?	
	40	Don't know why we need two centres. Probably better to have everyone on one site rather than spreading resources more thinly across two sites.	
	41	I still think one trauma centre would be better but understand why Cheltenham seen as important	
	42	Good to differentiate . Gloucester is a bigger site	
	43	Each sit should cover both services due to the size of the county.	
	44	Would like Pathology to be taken into account with these decisions - especially Blood Transfusion as we are having to do an increasing amount of work overnight yet have no funding for extra staff!	
	45	Trauma at Gloucester and Orthopaedics at Cheltenham makes total sense	
	46	because this would be an excellent idea	
	47	In view of the large numbers of traffic accidents that seem to have been taking place recently it works appear that the service is essential	
	48	For similar reasons as already explained, orthopaedics more likely to be planned.	

Two permanent ‘centres of excellence’ for Trauma at Gloucestershire Royal Hospital and Orthopaedics at Cheltenham General Hospital.		Response Percent	Response Total
49	Trauma and orthopaedic need to go together. It would be VERY confusing to split them. You've GOT to start treating this as one hospital over 2 sites; not 2 different hospitals. EVRRYTHING trauma and orthopaedic at Gloucester. Coronary Care also needs to be centralised wherever PPCI is.		
50	Glad both are being considered		
51	Don't care as long as 24/7 type-1 consultant-led A&E services are restored at CGH		
52	Not sure about separate centres for orthpaedics.		
53	Only makes sense if full A&E restored at Cheltenham		
54	If elective T&O operations are low risk then basing them on a site away from emergencies makes sense as there will be a reduced chance of cancellation. Trauma is best location near the main A&E.		
55	It's a large specialty and it makes sense to share across both sites, assuming that complex and/or higher risk cases are at Gloucester.		
56	Separating out trauma surgery increasing the likelihood of planned activities going ahead		
57	Agree need in both locations		
58	both equally important and necessary		
59	Best idea for the specialist teams. Already happening. personal experience.		
60	Because the two are so closely linked, why not have one Centre of Excellence in one place?		
61	This would seem to imply that services could be maximised.		
62	There seems to be a lot of opportunities on time management, however not much information around patient care, consideration of harm, preventative measures or long-term future routine checks. The prevention of further complications could be also considered in the new plans.		
63	Given the nature of these services it makes sense to have in both locations		
64	Seems to be 'mainstream' treatments/services - in a county of Gloucestershire's size, two centres seem to balance travel times for patients etc vs having enough staff/wards/capacity for treatment. Also avoids needless over centralising and the risks of having insufficient capacity / something happening at one site meaning all treatment is affected		
65	If data shows that it is needed at both sites & provides best patient care		
66	I went to Gloucester A&E on 2 Jan this year with a comminuted, displaced fracture of my elbow. I was assessed by a nurse and sent home with a box of cocodamol, in shock and terrible pain, to await a phone call to arrange an operation. I was operated on 5 days later. I feel that my treatment that night, and subsequently was appalling.I have since been left with nerve damage affecting my right hand. A centre of excellence approach would hopefully mean that patients such as myself would have prompt, consultant led assessment and treatment, which would lead to better outcomes and less stress and suffering for patients.		
67	If this is practicable and possible.		
68	Excellent for response times and flexibility to cope with peaks in demand, disasters and infections.		
69	One centre would be better, but the Consultation Document identifies insufficient Theatre capacity on a single site.		
70	Always a need, for all age groups		
71	I have experiences emergency treatment for a broken wrist at Cheltenham last December. The treatment was outstanding. It was delivered, I leant (after the successful manipulation), by a wonderful Nurse Practitioner. My follow-up consultation at Gloucester was frankly disgraceful - the consultant's treatment was appalling and I complained about him. Excellence must be analysed, and all staff must be tutored to deliver excellent outcomes.		
72	Gives flexibility		

Two permanent ‘centres of excellence’ for Trauma at Gloucestershire Royal Hospital and Orthopaedics at Cheltenham General Hospital.		Response Percent	Response Total
73	Two centres are better than just one		
74	keep specialisms together for better access and equipment		
75	Everyone needs trauma services nearby		
76	Yes both hospitals should be capable of offering all services		
77	Increased demands for these services across a rural county need 2 sites		
78	I support the proposals to change and think the information provided presents a strong case. However, throughout the consultation document I see little or no reference to: a) How staff are to be retained, trained, recruited and afforded. b) No reference to any improvements to process or service instigated as part of the response to Covid -19 which will be retained as Best Practice moving forward. c) Limited reference to the way that services will be re-modelled in line with international Best Practice. There is limited information given for example on the use of telemedicine, telephone consultation and follow up, health education in primary care, transfer of services into community settings, conversations to higher day case rates, better streaming through outpatients (and ED). The proposals appear to deal with the issue of duplication of services across two sites and consequent rationalisation and whilst this is to be welcomed, of itself, it does little to illustrate how the models of care can or will change. Similarly there is no financial analysis (that I can see) with the documentation provided. In an increasingly stretched NHS, this must be a consideration for services to be long term sustainable.		
79	Can't answer. You're once again going down the route of 'Cheltenham or Gloucester '.		
80	As mentioned previously it is obviously better for those living in the Cheltenham area for as many services as possible to be fully delivered at CGH.		
81	Concentration of key resources to reduce duplication and wastage.		
82	Long waiting lists currently for NHS. GPs really just prescribe anti inflammatory drugs and until your condition deteriorates badly before referral process is even initiated.		
83	cant decide as pilot study not complete & compared nationally		
84	Support that the pilot be made permanent.		
85	To shore the load between hospitals		
86	Tie in with need to keep A& E open at both locations		
87	Transport for staff who currently work at one or other of the hospitals who have to travel by bike / walk / bus etc be supported having to then travel further?		
88	Reasons the same as previous answers		
89	This is needed in both locations		
90	orthopaedics and trauma should be in close proximity so personnel can collaborate and reduce need to duplicate equipment		
91	Most sensible response to needs of this large community although leadership could be in either hospital		
92	Separating trauma and planned surgery proven model,elsewhere, in terms of bed base, theatre capacity and managing infection rates.		
93	Again this principle is sound - to concentrate emergencies on one site and orthopaedics on the other and it will help the ambulance service to direct patients to the appropriate site		
94	This is another example of why planned - elective things should be at Cheltenham General and Emergencies at Gloucester Royal		

Two permanent ‘centres of excellence’ for Trauma at Gloucestershire Royal Hospital and Orthopaedics at Cheltenham General Hospital.		Response Percent	Response Total
95	As long as there are support services, and staffing to support this		
96	Please refer to my previous comments, I support this if it will service the community more effectively and if it will lead to improved clinical outcomes.		
97	Orthopaedics can usually hang around and be given pain killers for a certain amount of time.		
98	Again, despite some weasel words, you're clearly proposing to focus emergency/trauma care at Gloucester, with Cheltenham remaining second fiddle. Both hospitals need full emergency capability.		
99	As long as orthopaedics can provide adequate cover to the inpatient wards in CGH. The cover is very poor currently. If you fracture as an inpatient in CGH you are worse off then if you fracture in the community.		
100	Again splitting elective and trauma sensible if demand / need exists.		
101	This an essential facility important for the community for accidents		
102	I think this is necessary because of what people are constantly being told about the ""Golden Hour"" for successful outcomes. It seems useless in trauma cases if a large part of this period is used in travelling to the necessary hospital		
103	Urgent need for excellent, quality, immediate support when there is a need. Quality of services is literally a balance between life and death		
104	Ok, need to give county spread. But Cheltenham not so easily accessible and very difficult for family and visitors without a car.... Cheltenham has a very limited evening bus service eg from stroud		
105	Presume there is sufficient workload to justify 2 similar services. CGH is closer to us, so of course I'm having to have anything that may be needed urgently as close as possible		
106	Again sensible and more cost effective to locate particular areas of expertise and resources in specific places		
107	Why would you not make one orthopaedic department in one hospital. would that ensure specialist care available always		
108	See previous		
109	We have an ongoing population in Winchcombe and Cheltenham General is very much more convenient for everybody. This is very important when you are unwell. A&E, MRI and scans, Orthopaedics, Oncology all provide an excellent service for us and or course surgery as well		
110	Once again if the pilot arrangements provide improvements, use this model as the way forward		
111	Needs no words to say this is a critical service and needs to have all the positives. Better care and attention and help out at the outset reduces issues developing later		
112	As above		
113	Having had a very successful hip replacement at Cheltenham eighteen months ago, I can only say that every aspect of my treatment was excellent, the surgeon was informative, the nursing was brilliant, even the food was good, and the outcome has given me my life back. It is working really well there, so perhaps Cheltenham is a good place for it to be based.		
114	makes effective use of resources		
115	That makes sense		
116	Proven via Pilot already.		
117	Patients with pathological fractures or spinal cord compression should not require moving especially when delay might be induced due to lack of beds in the acute hospital (GRH).		
118	An excellent idea.		
119	Common injuries from all over the County will benefit from 2 sites.		
120	We need a 2 point disperstion for this		

Two permanent ‘centres of excellence’ for Trauma at Gloucestershire Royal Hospital and Orthopaedics at Cheltenham General Hospital.			
		Response Percent	Response Total
121	The divide between the two disciplines is required given the extra resources for orthopaedics		
122	The results of this pilot indicate that the proposal is and will continue to work well		
123	Trauma surgery has long wait times and increasing number of patients for hip, knee surgery can only be of benefit particularly the age demographic in Gloucestershire		
124	Parking and general access for patients		
125	Rising admissions of this kind every year and shortages of community rehab placements means that this is needed now more than ever especially as this is lengthening inpatient stays which slows down admissions rates especially when both hospitals are running with only one A&E		
126	Should lead to less last minute cancellations of planned surgery. Planned cases should be treated quicker.		
127	This is going against all your saying about centre of excellence by having two		
128	Not qualified to judge.		
129	Trauma needs unambiguous and fast treatment. I've no idea where/when I can go to CGH so I'd call an ambulance rather than go by car. What a stupid waste of resouces.		
130	It suggests a more efficient and effective division of labour, building upon the existing specialisations in both hospitals.		
131	These are widely required services and so it makes sense to share them between the two hospitals		
132	The pilot study in Trauma at GRH has not established whether this is the place to continue this service. To take away trauma from Cheltenham will have an impact on it's A&E department. This will mean all accidents including road traffic collisions will be directed to GRH, leaving Cheltenham operating as a minor injuries unit.		
133	See onwards to page 37 My wife and I are in our 90th year. She is not allowed to drive. I prefer daylight and not Mon or Friday. We live in Tetbury and wish treatment there. So: We prefer Cheltenham and do not like Gloucester, the former being easier for us to reach by car and more convenient in terms of other activities on the day.		
134	The idea of creating centres of excellence at both of the two excellent large hospitals in Gloucestershire makes sense. It is worth remembering that the other specialist inpatient services, which have already centralised at either CGH or GRH e.g. cancer services at CGH and childrens' services at GRH, are working really well for patients.		
135	Perfect for both hospitals strengths		
136	Best to have two centres as this creates redundancy to allow combined work in the event of failure at one site without affecting the other.		
137	This seems to be working in the temporary changes that you have made. If it is better than it was, why change it back?		
138	Your pilot seems to have worked well		
139	The separation of Trauma and elective orthopaedic surgery has been a success story and has enabled CGH to concentrate on high quality enhanced recovery pathways, which can develop more easily in an environment away from emergency pressures.		
140	Seems to be the first area that recognises the need for quality services at both sites		
141	One centre of excellence at GRH. Reduce travel time for medical staff etc.		
142	As someone who is on the waiting list for a knee replacement and living in Cheltenham being able to keep a permanent 'centre of excellence' at Cheltenham General would be good.		
143	Not seen enough evidence as pilot		

Two permanent ‘centres of excellence’ for Trauma at Gloucestershire Royal Hospital and Orthopaedics at Cheltenham General Hospital.		Response Percent	Response Total
144	Seems very complicate. What happens to a trauma case requiring orthopaedic in patient treatment?		
145	I don't see the need to split resources over two sites.		
146	Important to have pre op at the place of operation		
147	Separating out emergency trauma and elective orthopaedics makes sense as it again puts the planned care in CGH which will be a calmer hospital and more suitable for that type of services, and the emergency services can have their centre of excellence at GRH. Again, having the centres of excellence is a sensible way forward, and the pilot seems to have worked well.		
148	If in the opinion of all medical staff the present system is working to a high standard, then both hospitals should continue operate in tandem.		
149	Having Trauma at one site (GRH) reduces the function of Cheltenham A&E department. As with medical and emergency surgery, the proposal to send emergency trauma cases (road traffic accidents for example) to GRH will make CGH A&E department less viable and will it then become a MIU?		
150	Suggest the trust review the statistics to determine how much of the trauma cases are orthopaedic related before deciding on this. Moving orthopaedic patients from GRH to CGH for treatment post trauma triage at cause significant pain and discomfort.		
151	All major Trauma at a single location makes sense. Most orthopaedics are less urgent and straight forward or even elective so Cheltenham General is the logical choice co-located with the arthoplasty.		
152	It is a much better model to have expertise available at different hospitals, than to have it based only in one location. However, we would prefer all procedures to be available at other hospitals in Gloucestershire too.		
153	Yes keep as it the county is increasing with people living in areas FOD, severn vale, Tewkesbury, Cotswold etc		
154	Yes I agree with this, this can be needed at anytime, having two centres of excellent is very comforting. Reduces travel, retention of staff , waiting times		
155	CGH would be left with no trauma support go back to pre-pilot arrangement		
156	As above Strongly support the idea of single site excellence for all and any hospital procedures		
157	Because of the increased local population both sites should be used.		
158	I think insufficient capacity on the site		
159	It needs to be Gloucester more central for Gloucestershire		
160	Would like to see both under one roof. Trauma can often lead to cold orthopaedics. ie. RTA - to joint replacement. Rehab via physio and occupational therapy can be used by both.		
161	I have no support or opposition		
162	Trauma is a very immediate service and i helpful for patients.		
163	Seems sensible to have two options.		
164	This scenario has been in place for some time and seems to work well. Keeping elective patients away from acute admissions is vital to minimise the risk of prosthetic joint infections.		
165	Elective orthopaedic patients are at low risk of major complications post operatively and offering them surgery in an environment with a reduced risk of cancellation makes sense.		
166	What happened to the pilot of trauma surgery in Gloucester?		
167	This is an ambiguously phrased question. I thought the move of trauma to GRH a few years ago was a pilot and we have never seen the results of that pilot.		
168	I think one centre of excellence is the way forward.		

Two permanent ‘centres of excellence’ for Trauma at Gloucestershire Royal Hospital and Orthopaedics at Cheltenham General Hospital.		Response Percent	Response Total
169	Trauma will in many cases also require Orthopaedics support so it seems best to have both specialist available in both hospitals		
170	I am concerned that having these two sited at different hospitals will result n increased patient transfers due to the overlap of specialities.		
171	From things I have heard about Trauma & Orthopaedics I am not convinced the T&O Pilot study has gone as well as the Hospital Trust has claimed. I should like to see the full report of the Trial, before forming a judgement on this. I am not opposed to most elective orthopaedic surgery being done on one site and most trauma orthopaedics being done on the other, to minimise disruption to elective orthopaedic procedures, but Trauma Orthopaedics is fundamental to a fully functioning A&E Department, not least because it is not always obvious until x-rayed whether an injury is a broken bone or a soft-tissue injury. At least some trauma orthopaedic capacity should be retained on both sites.		
172	The pilot study at GRH regarding Trauma has not been publicly scrutinised. I gather it has not been successful due to pressure on beds and operating time, consequently causing delays to surgery. It would not be sensible or responsible to continue this service at GRH. Orthopaedics at CGH on the other-hand has performed better.		
173	as long as a streamlined service can be provided at both sites consultants, ultrasound etc need to be available. Registrations are fine but it duplicates appointments. If you could see a consultant sooner service would be slicker		
174	Fits both communities with respective ages of those communities		
175	I recently had a 2 week stay in Gloucester hospital after I had a trauma to my ankle (I completely shattered all the bones in my ankle and required 4 hours of surgery under general anaesthetic to mend it)		
176	Convenient for residents of both areas		
177	Yes very well needed		
178	The 2 centres provide good coverage but CGH has to provide the facilities for trauma patients.		
179	Yes, have the planned events at Cheltenham as this is the direction of travel and would work well.		
180	These will not be planned procedures - some instances and being able to receive treatment at the nearest hospital therefore an advantage		
181	Maintain present pilot scheme		
182	Anything that reduces waiting times and ensures quality of surgery would be good		

Please tell us about any impact, either positive or adverse, that you think any of our proposals could have on you and your family (please tell us which service your feedback relates to e.g. IGIS)?		Response Percent	Response Total
1	Open-Ended Question	100.00%	285
1	All proposals. There could be more travel for patients depending on the proposals, but clearly the aim is for people to have world class care and I personally would be prepared to travel a bit more and not be so territorial. It's your health that matters at the end of the day. Also, some of the proposals like IGIS should mean fewer people having to travel out of county which is a good thing.		
2	extra travel time, costs and difficulty if services are required.		

Please tell us about any impact, either positive or adverse, that you think any of our proposals could have on you and your family (please tell us which service your feedback relates to e.g. IGIS)?		Response Percent	Response Total
3	I think more efficient working by having majority of specialist services single site is in everyone's best interest.		
4	Although not explicitly mentioned, I worry that the A&E department at Cheltenham hospital will have a reduced service, particularly for children, as part of the proposal. Having to travel to Gloucester for emergency treatment would have an adverse impact, it is a long distance and we would struggle to get there, and in a severe emergency I worry that the extra time to get to the hospital could adversely affect the outcome. It is bad enough that children cannot be treated at Cheltenham A&E after 8pm.		
5	Both hospitals should have centres of excellence and provide all facilities - the catchment area for Cheltenham is very large and such services should not be transferred to Gloucester Royal		
6	If the only option for a certain appointment or procedure was in GH, I would not attend and know from discussions that my family would not either. We have had relatives in GRH and the experience has been unsatisfactory both fr them and for us whereas CGH experiences were much better.		
7	All proposals would have a positive impact on me and my family. I don't care where I or my loved ones are treated. If any one of us had an extremely unusual condition requiring us to travel to London for treatment, we would do it. It therefore makes no difference to me whether I have to travel to Cheltenham or to Gloucester for treatment, as long as the service is good, well staffed with enough of the right staff and capacity available is all I care about.		
8	I am concerned that any developments are a short term solution which does not address the fundamental issue of either site having a sufficient bed base to run an acute take for medicine and surgery (plus O&T, Gynae etc). We need a new hospital based an a different site to achieve. The suggestions are well intentioned but ultimately a waste of tax payer money.		
9	pretending we have 2 acute hospitals is the biggest potential detriment to services		
10	I live in Cheltenham. If acute medical and emergency surgical care moves to GRH, I am concerned myself or my family will have to travel further for emergency care when they are very unwell. I believe the public strongly hold this view also		
11	The proposals I think will mean better care overall for me and my family		
12	It will be safer for us to have everything in one place.		
13	AMU needs to be spread across both sites. Head and Neck ward with Gynaecology doesn’t make sense		
14	I want the best care for my family and whether we travel to Cheltenham or Gloucester is irrelevant and has no bearing.		
15	Failure to deliver emergency care in Cheltenham has already negatively impacted my family and our view of the trust's performance.		
16	These proposals would improve the care provided if myself or my family ever needed treatment at GRH or CGH.		
17	Cheltenham maybe too far to travel, public transport route to Cheltenham from the towns that are in the county are poor. Also car parking and cost is a concern		
18	The current burdening of services in GRH will have a major impact on ED care, ward care and intensive care. It is unsafe and must be addressed rapidly. I have concerns that my family will not receive adequate care in this Trust and I would take them to Bristol if possible in an emergency. I have significant concerns regarding the piecemeal junior led cover at nights for surgery in CGH at present.		
19	I am concerned that if the majority of the services continue to be relocated to GRH the hospital will become unsafe. It is not infrequently at the highest alert and we haven't hit winter yet. I am worried about the care my family will receive and if possible will travel to alternative hospitals.		

Please tell us about any impact, either positive or adverse, that you think any of our proposals could have on you and your family (please tell us which service your feedback relates to e.g. IGIS)?		Response Percent	Response Total
	20	The Trust's decision to move services post Covid peak had a negative impact on staff morale and mental health. Working through the difficult time of March and April was stressful for all and whilst all were happy to go where needed we were working in new teams in new ways with little support in this emergency situation. Moving back to our own wards and teams meant that we were starting to share the difficulties of the previous weeks and just as we were supporting each other we were told we were to move sites, splitting the ward staff and putting all through more stress and uncertainly. I do not think management realize how traumatic this was for those involved. The priority for staff is to provide good holistic nursing care for patients and support our colleagues. I feel that we have not been able to do that for a long time.		
	21	Cant answer that as no way of knowing if or what treatment me and my family are likely to need in the future		
	22	I feel the benefits of services being in one place where the expertise, experience and correct staffing levels are available are huge. If these changes ensures this happens and the reduction in procedures, surgeries and appointments being cancelled is the result I would feel this is hugely beneficial.		
	23	Concerns about impact on BAME communities. Concerns about bottleneck effect on Acute Medicine at GRH. Major concerns about IGIS - if a patient needed an emergency procedure in this field and had to be transported to Gloucester, when the lived right next to CGH, the difference in both outcome re. risk of loss of life is to great a difference. Concerns about funding increased Ambulance Service provisions. Flawed concept of attracting high quality staff - London, Oxford, Bristol will always leave us with the best of the rest which the proposals would have no bearing on. Political concerns that down the line (years), any improvements will result in savings related staff reductions.		
	24	I live in cheltenham and like I have explained I have complex bowel needs and going to gloucester when my family live in cheltenham puts a lot of stress and strain on my husband when they come to visit. Colorectal surgery and gastroenterology. Parking is a rip off. Parking should be taken back within the nhs and monies made put into equipment or services provided. For patients relatives who dont drive and have to use public transport it not fair on them as it takes around 45 mins on a bus from chelt to glos then same on a return trip, even harder for families who have small children going to see a relative in hospital and have to travel further to see them.		
	25	Gloucester hospital is very inconvenient to get to and previous experience of care there does not make me believe me and my family would not receive the same amount of care at GRH.		
	26	no 24hr access to A7E at Cheltenham - transfer time to GRH - longer waits then at GRH		
	27	GRH further to go. GRH already overwhelmed by acute medical take and unable to cope and provide quality care.. I have been witness to poor standards of medical care at GRH. I do not wish either my family or my self to be subjected to long waits for care.		
	28	The waiting lists will be even longer than they are now. Cheltenham people will have a glorified health centre not a hospital. The journey to Gloucester is long, discharge difficult to manage and visits reduced (non covid era) due to the cost and distance involved.		
	29	The travel between sites may become a problem for us.		
	30	Travelling and parking. Cheltenham nearer for all services.		
	31	Travel, parking, costs of parking, congestion all negative. With an ageing population with less mobility it's likely less visiting will take place the more you centralise services on a single site.		
	32	Further travel to obtain emergency services and for visitors if admitted		
	33	Cheltenham needs a amu and functioning a and e, plans to ship patients across country are absurd and detrimental to patient safety		
	34	the removal of a and e puts everyone in the county at risk. putting people in ambulances between sites is already damaging. stop letting this continue		
	35	changing our jobs yet again, nurses don't matter		
	36	Completely changing my job again		

Please tell us about any impact, either positive or adverse, that you think any of our proposals could have on you and your family (please tell us which service your feedback relates to e.g. IGIS)?		Response Percent	Response Total
37	negative all round.		
38	risking the health and safety of those further out in the county.		
39	cannot have one medical take, it cant cope already		
40	If this is established successfully I think it will have a positive impact on establishing better pathways with our primary services and accessing community follow up etc.. and hopefully work reciprocally with helping admission prevention / flow in the acute setting.		
41	I want myself and my family to have the best access to cancer care should we ever need it. I believe splitting the elective and emergency services allows both to be delivered in the safest possible way		
42	long waiting times and hugely packed waiting areas are not ideal when you are poorly		
43	Any emergency situations would mean a longer journey to Gloucester for us, but with two young children that's less of an issue as the emergency children's services are already there anyway.		
44	None		
45	Centres of excellence mean clinical expertise is concentrated in one area, rather than split across the county. This means better, more responsive specialist care for me and my family when we need it.		
46	I think that the advances in remote/telehealth should mean that some services currently occupying time and space within the two sites could be re-provisioned using better technology, thus freeing up resources (space and skills/people) to restore CGH to a full A&E consultant led 24/7. Anything less continues to reduce survivability of patients in the East.		
47	Removing lower GI surgical support from CGH would diminish the service which I work in and I would have to consider whether the Trust's ambitions for my service match my own in terms of where I work in the future and whether my family move. Conversely moving all GI cancer surgery to CGH would be a significant statement of the kind of cancer surgery we want to provide in the future - i.e. comprehensive, safe and cutting edge		
48	further for some patients to travel too if A and E in Glos		
49	IGIS - emergency interventional 24/7 cardiology is essential where the ED is located and would be hugely beneficial to patients. I do not think the Trust can justify having a split any longer. It is behind the times and incredibly poor clinical practice.		
50	Continuing to overload GRH with emergency services without balancing a shift of major services to CGH will cause a crisis for the community		
51	COTE. Acute take at GRH appears to have increased the number of ward moves and the number of pts MSFD being transferred to CGH awaiting discharge or for ongoing discharge planning. Both elderly in-laws recently subjected to this. A poor experience for both of them. This is not the level of service we aspire to yet sadly no longer uncommon for this demographic.		
52	both hospitals pretty much equidistant for us and are over thirty mins away, so no change for us		
53	Vital to co-locate elective major GI surgery and emergency surgery on one site. Necessary for optimum care of patients.		
54	none		
55	It is only positive		
56	In modern healthcare the only way to deliver efficient, research based and effective services is to centralise in a centre of excellence. Services cannot be diluted just because that's the way they've always been. We need to keep up with advances in health care so that the current and future population benefits		
57	One major impact on having services at both Cheltenham and Gloucester, How do elderly patients get to these hospitals. Public transport is not good and Taxies are very expensive. We need more localised services!		

Please tell us about any impact, either positive or adverse, that you think any of our proposals could have on you and your family (please tell us which service your feedback relates to e.g. IGIS)?		Response Percent	Response Total
58	Any move to create single centres of excellence in Glos OR Chelt is going to have an adverse impact on patients living furthest away from both hospitals.		
59	trying to access some services at CGH and some at GRH via public transport if you are unwell or infirm is frankly awful. .		
60	You need to consider access/travel time		
61	Please keep acute services at cgh		
62	I live in Cheltenham and fortunately at the moment I am not receiving any services from either hospital . I I recognize that there are issues with Cheltenham General in view of the fact that parts of the building are 200 years old and not in current use because they are not fit for 21st century health care. I favour a new facility in Cheltenham being constructed on the edge of town so that the present buildings can be vacated and the land redeveloped. In the meantime I realise that the bulk of the services will need to be provided at Gloucester or even out of the county		
63	You are making a big mistake most people want local facilities and the Cost!!!		
64	good service		
65	Will be able to get looked after by specialist people whether in Glos or Cheltenham		
66	Nothing		
67	For my family, the gastroenterology provision is the most important consideration. If I had faith that the centralised CGH provision will work - then I fully support this. But from personal experience of the centralised provision since the pilot started in 2018, it is not working as set out in the consultation document. What sort of assessment of the pilot has been done already and what is being put in place to ensure patients who are going through the treatment are being listened to and problems are addressed?		
68	-		
69	I don't drive so to get to CGH I would have to go on the bus, that's if I can afford it. Or not go at all.		
70	Only with delays getting to GRH if CGH is nearer to where it happens.		
71	For us CGH and GRH are equally accessible and the essential issue is the provision of the highest quality of services		
72	None in my case		
73	Positive - patients going across a corridor to cardiac labs from ED would be much much safer for our patients, rather than across the Golden Valley bypass or down the M5. It's dangerous to transfer them like this. I strongly support the IGIS plan		
74	IGIS information is actually not entirely accurate as from a non medical view and those lacking the insight into the interventional area its trying to broadly cohort based on superficial skills where they are entirely separate skill sets. The idea of grouping in a similar location is good but the idea that cross cover occurs easily between disciplines is completely inaccurate and actually won't create staffing efficiencies. It is in fact going to dilute a very specialised skill set within each of those specialities.		
75	Getting to GRH is very difficult for us so keeping both hospitals offering treatments best option		
76	I am happy with all of the proposals.		
77	I live in the forest of dean so any move to cheltenham will put 30 minutes extra on my journey. Maybe longer when you consider how difficult it is to park in Cheltenham.		
78	No direct on my family currently.		
79	CGH has served Cheltenham for over a 100 years Why change it		
80	Travelling to GRH		

Please tell us about any impact, either positive or adverse, that you think any of our proposals could have on you and your family (please tell us which service your feedback relates to e.g. IGIS)?		Response Percent	Response Total
81	I live in Gloucester and would prefer Gloucester hospital to be able to deliver all services to an excellent standard, Cheltenham hospital is difficult to get to, difficult to park at and it is extremely annoying to be sent there for treatment.		
82	I think in general the proposals are positive and will improve the services available in Gloucester.		
83	my son comes under gastroenterology and a strong specialist team is what is important not where they are based		
84	Patients having to be cared for away from their home and families. I have no desire to be sat in a ED Department for hours on end. The hospitals have worked well as two separate hospitals for years - why change. MONEY Trauma Services need to be provided across the county not just one site. - so if you live in a deprived area or your homeless you will benefit from a single site service!! what about the rest of the population.		
85	longer ravel times are a reality, not a possible consequence		
86	Focused centres of excellence to allow for planned care at CGH and more acute/emergency care at GRH but still maintaining access to ED across both sites		
87	Nil		
88	If all services are concentrated away from CGH then patients such as myself living to the North of Cheltenham will be negatively impacted both for emergency services and for planned surgeries because of the time and difficulty in travelling longer distances, particularly difficult for the frail and elderly such as ourselves.		
89	Gastroenterology. Patient myself, diagnosed with Crohn's at the age of 13, 27 now. Dr Shaw and the Gastro team are extremely skilled, and give good treatment to their patients. However during my latest severe flare up (2015/16) I struggled to get the medication and testing I needed, this delay of several months stopped me being able to work as a teacher for 9/10 months, eventually leading to surgery to remove scar tissue. I hope that if the proposed centre of excellence goes ahead patients would be able to access testing, medication and surgery much faster. Faster treatment would save the need for surgery in some cases, saving the NHS money if the disease can be controlled by medication as soon as a flare up occurs.		
90	As I live equidistant between the two hospitals this has no impact on me. However for those living in the outer reaches of Gloucestershire there will be more impact		
91	If you move most services to Gloucester Royal it would immediately present many problems for travelling or finding a place to park. Many older people would be distressed at being so far away from their families.		
92	getting rid of the medial intake or Cheltenham a and e is just gambling with peoples lives, Gloucester have already made so many mistake with peoples healths before all this covid happened they will only make more mistakes with the added pressure, Gloucester falsely diagnosed myself under pressure to discharge patients from ED and AMU which later cause for a big operation and then also the same with my child nearly causing her to die. this is nothing to the number of mistakes Gloucester currently make and it will only get worse, I myself would never trust the staff under the pressure to treat me or my family if it changes		
93	Please reinstore the full blood service at Cirencester Hospital - it gives an immediate, quick service. GP service will cause long delays and worries to patients, inconvenience and cost to travel to Glos.		
94	Centralising emergency surgery will make it harder to get to the hospital. Making Cheltenham general the planned centre for GI surgery will make to safer and better to have major surgery. We need more major surgery at Cheltenham		
95	The proposals to reduce services at Cheltenham will cause massive inconvenience and huge concern. A&E services are the vital bedrock of any "proper" hospital. This set of measures will reduce access, potentially harming those seriously ill due to delays in receiving expert help. The car parking problem will add to stress of both patients and families and there is real concern that this is yet another in a long line of service reductions at Cheltenham. The clear agenda being to cut the site back so far that it is unviable.		
96	none		

Please tell us about any impact, either positive or adverse, that you think any of our proposals could have on you and your family (please tell us which service your feedback relates to e.g. IGIS)?		Response Percent	Response Total
97	As a Volunteer Patient Representative working directly with the NHS, all aspects of medicine concern me and my family		
98	I do not believe they would impact negatively, the distance between the two centres is not very far, if it was an emergency the patient would be blue lighted anyway. I would rather get the best possible care than decisions being made on geography. If as a plus this means that patients may not need to be sent out of county this is huge benefit		
99	You just need to have one place to go to for one SUBJECT e.g. Oncology, CVS, and GU/GI at Cheltenham and everything else at GRH. You've got to make it simple. And you need to make ED at Cheltenham 24/7 with doctors. Or you've got to double the size of ED at GRH. You've lost 2 x resus bays by closing CGH to ambulances, yet not increased capacity at GRH at all. It's ridiculous at Gloucester ED- and don't blame COVID. ED at Gloucester is not fit for purpose, being the only ED in the COUNTY!! JUST KEEP IT SIMPLE, so that everyone can understand it. You've been got to stop thinking like a person in the NHS and start thinking how the public views the organisation of the services offered. I don't believe you'll re-open ED at Cheltenham, you've been wanting to get rid of it for ages, but GRH ED is NOT fit for purpose with current demand - and demand is not going to decrease. You also need a centre of excellence for the Older Person. By 2040 , 25% of Glos CCG patients will be over the age of 65.		
100	I live in Cheltenham and work in the community, the cost of coming back to Cheltenham is high if you get taken via ambulance to glos royal, if you stay in, family find it expensive to visit you therefore your mental health deteriorates and your physical health recovery is slower, if it wasn't for my son being able to pick me up at 11.30 at night I would of had to stay in overnight, this would of caused a bed to be taken by me when I was well enough to go home but had no money to get home, a bus Journey from chelt to go's is a long time when you are travelling in pain or in recovery fir follow up appointments, we need a centre of excellence in both hospitals		
101	Any proposal that fails to deliver the full restoration of 24/7 type-1 consultant-led A&E services at CGH, will make it considerably more difficult to access emergency health care for me and my family.		
102	Travel and access to both sites for those with out cars or relatives locally		
103	Neither site is well located for people living outside Gloucester or Cheltenham. Especially relevant for critical A&E cases where time is critical. Closure of Cheltenham A&E for people like us living East of Cheltenham means significant additional delays, on top of what are already poor response times. We would be better served going to Oxford or Worcester.		
104	Access to subspecialist care across the board		
105	Rationalised services produce better outcomes.		
106	we live near to CGH and already lost our A&E		
107	Think these changes will be positive overall - they will provide clarity over what each hospital provides, reduce duplication and ensure that staffing rotas can be more robustly filled which means we will recieve a more timely and quality experience		
108	I think you are ignoring a large percentage of residence east of Gloucester not to have a full equipped center of excellence at CGH covering every eventually from A&E to full trauma situations		
109	Positive impact		
110	Removal of services from Cheltenham would make it very difficult for people of North Cotswolds who depend very strongly on Cheltenham.		
111	Additional travel.		
112	In 2019 I had a IGIS abroad, in my country of origin. I could have returned to the UK, but instead I stayed overtime in the country to have an emergency surgery for removal of my gallbladder after going through a routine appointment where I had no symptoms. My experience with the NHS is that there is not much investigation on preventative measures. I had had an ultrasound before, to follow up on my IUS, and there was no interest in verifying the state of my internal organs at that appointment. I hope that by investing in a more thorough facility, incidents can be avoided.		

Please tell us about any impact, either positive or adverse, that you think any of our proposals could have on you and your family (please tell us which service your feedback relates to e.g. IGIS)?		Response Percent	Response Total
113	Keeping the temporary nurse led A&E for 50% of the time rather than having 100% consultant led services at CGH for 24 hours will have life threatening consequences for a large area of the north of the county.		
114	Support measures to cut last minute cancellations & ensure quicker treatment by the right person - if staff cannot be recruited / equipment not replaced due to budget constraints / equipment not being used as e.g. staff are on the other site, something needs to change to allow people to be treated and sent home more quickly either better or with appropriate measures in place.		
115	We may have to travel further to access services, but if they provide excellent care & outcomes its worth it. Good example of this is the breast care services. As a patient if all done in one visit on one site worth the travel		
116	We are equidistant from Cheltenham and Gloucester, so the planned changes will not have any real impact on us		
117	Cheltenham and Gloucester are not that far from each other and the rest of the area is poorly served. Driving to either on a very regular basis (such as for dialysis) is gruelling and time consuming.		
118	We are fortunate to have transport, so if we had to travel to Gloucester it would not be a big deal.		
119	A&E All of Cheltenham and North of Cheltenham would benefit from A&E as response times, time to treatment would be minimised.		
120	Proposals overall seem likely to lead to better patient care and improved medical training.		
121	Orthopaedic: every age group needs this support		
122	No current impact on us.		
123	It seems that Cheltenham will become to minor centre. I'm particularly worried about trauma treatment - an accident causing serious injury in the west of the county, where we are, could result in fatality if there were delay in reaching Gloucester hospital.		
124	All service development has the potential for increasing the health service possibly needed in the future by my immediate		
125	We might have to travel further to Gloucester hospital in the event Of a certain condition as we are in Bourton-on-the-Water so neither sites are especially close but the extra distance is a small price to pay for increased expertise/ excellence and reduced cancellations of operations		
126	I think that all of the proposals will have a positive impact on everyone, as the services in the long run will be better, if certain hospitals become centres of excellence for individual things.		
127	Impact if all works well and delays in appointments are reduced will be of benefit to my family and myself.		
128	I am so far healthy therefore none of these proposals would impact me but I would like you to consider patients travelling to either hospital.		
129	Positive impact on any proposal. We live in Hucclecote and have easy access to either hospital		
130	Centralisation of treatments and procedures becomes wasteful because they lead to long waiting lists, and inevitably centralise specialist staff to the detriment of other hospitals and staff skills loss.		
131	rarely require hospital intervention in the past with only one referral to NHS Gloucestershire in 20+ years but now in mid seventies I suspect that will change. The negative aspects for me living in a rural location with little or no public transport are therefore based around access both distance and time taken and cost		
132	Gastroenterology and General surgery both needed and would be better if it is clear what service is offered where, and so that continuity of care can be improved. THe proposed changes will achieve this for me		
133	I think all these plans are terrific. Thank you.		
134	As stated above I am concerned for myself and all others like me who live east of CGH that relocating acute medical intake and emergency general surgery solely to Cheltenham may put my life at risk in future		

Please tell us about any impact, either positive or adverse, that you think any of our proposals could have on you and your family (please tell us which service your feedback relates to e.g. IGIS)?		Response Percent	Response Total
135	Concentration of some services in Cheltenham may involve us travelling 8 miles further (I live in Gloucester) but I would be happy to do that as the expertise would be in one place.		
136	I can only see advantage in focussing particular specialisms on one site, as much as that is possible,		
137	Any medical treatment should be available at a local hospital. It is wrong to expect patients who are obviously ill to travel to long distances for treatment. Ecologically it is also better for a few medical staff to move between hospitals than for large numbers of patients to travel		
138	Planed lower GI - benefits patients such as myself with Cancer Diagnosis		
139	I haven't had to use hospital services so it is difficult to form a clear opinion. But access to Gloucester is easier. It's really about geography.		
140	Local and ease		
141	AS I and my family live closer to Cheltenham rather than Gloucester, everything that moves to Gloucester will have an impact on us. Realistically however the geography of acute secondary and tertiary services does not matter. I want an accessible service with low waiting lists, efficient administration, decent transport services into it/parking, fully staffed with competent doctors, nurses and support staff staff who are well looked after. I also only want to come to such a hospital when I need to and I would like to see the development of community based services (using the fine physical facility at Moreton in Marsh for example) and an integrated approach with primary care and Community services. I also want the NHS to start communicating with its customers on its strategy (not the politically motivated rubbish that is pumped out daily) get realistic about its major downfall of staff shortages(between c40 k and 84k shortfall of staff now and likely to get worse in the next 10 years with limited reality about training, limited prospect of sensible overseas recruitment and a pretty awful reputation for looking after its staff) and preparing the population for the reality of what actually is affordable. Very happy to share my thoughts on this also somewhere else if you wish.		
142	I imagine most opposition to the proposals will come from those who live significantly closer to one hospital or the other. We are fortunate in living more or less halfway between the two. Despite it being easier, therefore, for me to agree to the proposals, I do feel strongly that rationalisation of provision is important.		
143	I am over 65 and whilst in good health and newly permanent in Cheltenham the idea of access to a local hospital for potential issues related to age is attractive. This I am not referring to a particular service		
144	I am hugely concerned about the already much reduced emergency cover at Cheltenham. I feel the centre of excellence (!!) for acute medicine in Gloucester will further reduce care for Cheltenham (and surrounding areas) residents. This is not a small place but with 100000 inhabitants and an elderly population.		
145	The gastro services will have a direct impact on me. Theft that all specialists will be in the one place, and waiting lists will be lower is a hugely positive thing. My main concern is the lack of parking and facilities at CGH vs GRH.		
146	I anticipate that the most likely service that I or my family would need would be the Acute Medicine. Being dragged over to Gloucester in a crisis situation would significantly increase the levels of stress experienced by both the patient and their family.		
147	Living in Stroud, I find it harder to get to CGH and harder to park there, however I think it is still a Good idea to concentrate key resources in one place, wherever it is.		
148	Gloucestershire is a longer journey for us		
149	This would mean more journeys to Gloucester hospital which isn't easy to get to. Also bad for the environment and I wonder if there is room at Gloucester Royal over the long term.		
150	Positive impact across the board to have the expertise concentrated on 1 site for the various services allowing sensible on call rotas and adequate staffing for those services rather than splitting the expertise across 2 sites.		

Please tell us about any impact, either positive or adverse, that you think any of our proposals could have on you and your family (please tell us which service your feedback relates to e.g. IGIS)?		Response Percent	Response Total
151	My concern is for those living particularly in rural parts of Gloucestershire and the transport problems for reaching the two hospitals. There are implications for public transport, patient transport and for patients and carers attending hospital in their own cars, when having to travel further, or in challenging conditions. It would be reassuring to know, as in data] more about how the ambulance service has managed the extra distance to Gloucester Royal from the outlying areas of North Gloucestershire, for example.		
152	in 2020 the crucial factor should not be postcode but the delivery of excellent, safe and timely patient care. It is simply not possible nor is it safe to continue to try and provide duplicated services which in turn often compromise the quality of care. We also should not forget the enormous pressure this places on staff, in terms of staff shortages, cross site cover at short notice, pressure of always feeling there an added pressure.		
153	It is a significant journey from my part of Gloucestershire to both hospitals. So in journey terms the proposals wont impact negatively on me or my family. I believe it makes sense to coalesce the various specialties on one site to maximise expertise and capacity. I would therefore support the proposals.		
154	I believe the proposals will result in better services and improved use of capacity and resources. For those of us who live outside of Cheltenham and Gloucester we have a journey to either hospital so the proposals have no negative impact on that respect.		
155	The Report and its recommendations have been prepared by hugely professional, experienced and competent personnel. Ninety nine per cent of feedback from the public is likely to be simply based on how it affects their personal situation regarding treatment required and location, and not necessarily related to what is best for the community at large and indeed the NHS.		
156	To have the experts in one place is a positive		
157	None at the present time none at the present time q		
158	I want to have access to the best health services possible. These must be provided in the safest hospital possible - that means fully staffed and, with access to all facilities all the time. For more minor surgery, I would like to be treated in a dedicated unit away from the emergency hospital to reduce the worry of having my operation cancelled		
159	noone		
160	Have used Cheltenham when needed Colonoscopy using the 2 week wait system etc. Found the building itself confusing (easier to find from outside than inside). but the care received was excellent and easily accessable.		
161	Looks fine. We live in Shurdington so GRH and CGH and both readily accessible		
162	As someone of working age with access to independent transport, I think this is a positive move for me. However, I am concerned about the social practical impacts for people who are dependent on public transport, elderly, need support to to travel, more financially disadvantaged.		
163	These proposals I think would have a positive impact, for all services mentioned. I would like to be able to access any service that is a centre of excellence to allow my family and I to have the best outcomes.		
164	Treatment not available at CGH is less likely to be taken up - especially if it involves more than one visit. For family reasons we would prefer to look for treatment at Southmead where support is readily available.		
165	Until and unless we have the need for any of these services, I find it difficult to comment.		
166	It would mean travelling longer distances but this is a price well worth paying for better outcomes		
167	As a resident of Cheltenham I am happy to travel if it means better care. I just want the right people in the right place to look after my family if they are unwell.		
168	If the services are not at both units this would mean further travel and time. It also means for Carers there days would be more disrupted getting patients to appointments in larger units .		

Please tell us about any impact, either positive or adverse, that you think any of our proposals could have on you and your family (please tell us which service your feedback relates to e.g. IGIS)?		Response Percent	Response Total
169	I would like to suggest the establishment of a 24hour mechanical thrombectomy centre in Gloucestershire with the capability to deal with LAO strokes. There also needs to be a link with the ambulance service and emergency call handlers to ensure these strokes are quickly recognised so that patients are transported directly to the centre without delay. A related issue is the use of ongoing tests for every patient "MOT-style" to determine risk factors and identify problems early - this applies to other areas too, particularly cancer detection [apart from human suffering, this has the potential to save money by avoiding cases in the first place] A significant proportion of ischemic strokes are due to LAO's with their associated high morbidity and mortality. The effectiveness of recanalisation by mechanical thrombectomy (compared with alteplase which is largely ineffective due to the high clot burden) to deal with these devastating strokes has recently been established and has led to an Implementation Guide being produced for the UK: https://www.oxfordahsn.org/wp-content/uploads/2019/07/Mechanical-Thrombectomy-for-Ischaemic-Stroke-August-2019.pdf A potential further benefit, even for later presenters, is the avoidance of edema and need for craniectomy. Err on the side of going for it. Gloucestershire would fit well geographically with the current centres at Oxford and Bristol (not currently 24hrs). Bringing the UK up to european levels. Lack of treatment is an unnecessary cause of morbidity / mortality. Overall money saver, considering rehabilitation and ongoing care costs. I am personally living in total devastation following the death of my wife aged 63 in April 2019. She was taken to a local hospital where a severe stroke was quickly identified but unfortunately she deteriorated after a few days due to edema. She was just 3 years too old to be considered for decompressive hemicraniectomy. Her stroke came completely "out of the blue", she was always so fit and well with low risk factors. She was an extremely talented person and her untimely loss is so far reaching.		
170	Find travel to GRH difficult		
171	It's a long way from the edges of the county to these hospitals...		
172	Potential impact from travel requirements depending on hospital site services centred on. Parking already challenging at sites. For planned surgery options May choose to use sites outside Gloucestershire as nearer, or through choose and book use private provider option if that is closer.		
173	I prefer it when Cheltenham residents can get access at CGH for all these things where possible. E.g. my phototherapy treatment used to be at CGH a ten mins walk for me now I have an hour round trip to GRH which is bad for the environment and a complete time waste.		
174	I am able to travel to both sites and I would be happier with centres of excellence rather than splitting expertise across 2 sites		
175	Only by separating emergency and planned care will the proposal really work		
176	No impact.		
177	Negative impact for me, if GI services moved from the Cheltenham site.		
178	difficulty in getting to Cheltenham general hospital, public transport links poor or non exsistant		
179	Car parking is an issue at CGH, assurances need to be made that relatives are able to park, to be able to transport and visit their relatives. The estate has to be able to support the changes to the centres of excellence along with staffing and support services.- all		
180	For me an my family we can access either GRH or CGH but I know that this will not be the case for all residents requiring care.		
181	No should be ok.		

Please tell us about any impact, either positive or adverse, that you think any of our proposals could have on you and your family (please tell us which service your feedback relates to e.g. IGIS)?		Response Percent	Response Total
182	The move of cardiology and the creation of a centre of excellence to Glos Royal makes no sense....This already exists at Cheltenham Gen and will effect me personally .....I have an existing heart condition.		
183	I think that both hospitals should be running independently like they have as not everyone can get to Gloucester royal hospital and why should Cheltenham residents be penalised for extra charges gained from transport.		
184	I accept the principle tat it is impossible to finance all services at both hospitals. I was recently in GRH for ""draining"" excess water thus preventing heart failure and was treated very efficiently. However, it was disappointing five minutes in my journey to be passing CGH and making the significantly longer journey to Gloucester. Is this ""emergency"" treatment not available from Chelthenham General.		
185	I and my family have been served very well by the Health Services - but I have had to be referred to both Banbury and Oxford hospitals in my time and was very well looked after. My husband however visiting his mother and my in different hospitals (Banbury and Chelt) went to sleep at the wheel of the car and had a slight crash		
186	I think it would adversly affect my work		
187	I am concerned that scarce resource (pathology, radiology, social work etc) is diverted to GRH leaving a second rate services that would not be able to safely support any centre of excellence (including oncology) based in CGH.		
188	Minimal impact currently - may involve slightly longer travel dependent on outcome. Applies to services that would move to GRH		
189	na		
190	The importance to me and my family is the travel to and from Gloucestershire and Cheltenham hospitals. if we needed treatment		
191	I don't see any adverse effects		
192	We live in Stroud so both Cheltenham and Gloucester hospitals are easily accessible to us		
193	Better patient care, less waiting time, easier access, better holistic care & treatment. Less travel time - better all around outcomes		
194	I think any change to trauma or emergency services will impact my family where reduces easy access to services is involved. Also the assessments seems to only produce marginal gains from a staffing point of view.		
195	Strongly favour Gloucester as so well served by trains and buses. Cheltenham hopeless for the former and very difficult for the latter. We cant all afford taxis		
196	Transport??		
197	some services will be further away if located at GRH, but when traveling by car it doesn't make a great difference		
198	Please see my comments under anything else. I would not support any services restructuring which adversely effect CGH's viability. I cannot comment on the medical proposals but Gloucestershire needs two major hospitals particularly with new settlements.		
199	Obviously because I live in the forest of Dean it would be better for my family to have all resources staff and centres of excellence at Gloucester but Cheltenham needs to have its own centres of excellence		
200	If as set out, the proposals provide quicker, more efficient service, linked to reduced wastage. I am fully in agreement. If one was in the ideal world of developing a brand new single site solution then a site between Gloucester and Cheltenham would make a lot of sense to all concerned. But we aren't. We need to make best use of what we have and some centralisation of services make best sense		
201	I need, from time to time, the need for treatment for colorectal and/or gastroenterology problems. I always feel more comfortable in Cheltenham General Hospital		

Please tell us about any impact, either positive or adverse, that you think any of our proposals could have on you and your family (please tell us which service your feedback relates to e.g. IGIS)?		Response Percent	Response Total
202	As a family, I think it is better to know which hospital you will be treated at as it's not easy for everyone if loved ones get transferred back and forth. It's nice to know in advance of planned treatment where you will be.		
203	My wife and I are both in our 80s and moved from a rural location in 2019 as we anticipate a point at which we will not own a car. We deliberately bought a property within walking distance of CGH. We have already found it necessary to travel to Gloucester for Xray and my wife was admitted for emergency treatment late on a Saturday evening. I had to return home to collect her essential medication and was able to do so in the car. This would have been particularly difficult without our own transport.		
204	I suffer from Ulcerative Colitis and my wife has a liver condition. Whilst we have a car if I were to have to stop driving we would have real difficulty accessing Cheltenham hospital if necessary.		
205	I believe it is vital we maintain services at both hospitals. The area covered by both hospitals is vast often receiving patients out of County. Like many others living in the Cheltenham area I have seen the erosion of our A&E services as hugely detrimental as the numerous reports of long waits at Gloucester A&E, with patients being treated in Corridors testifies. I have had such an experience myself.		
206	Due to the ""Centre of excellence"" approach and optimising the logistics around 2 hospitals within 30 minutes of each other there will be an overall benefit to: 1. Patient outcomes. 2. Workforce environment and job satisfaction. 3. Improved staff retention and recruitment.		
207	Very important that Accident and Emergency teams are operational at Both hospitals as speed is essential when time is of the essence.		
208	Any proposals impact us if we have to go to Cheltenham as I don't drive. However all options have to be considered when cost is involved.		
209	Some increased travel time for some services but a specialised centre of excellence should offset this.		
210	Living close to GRH the proposals will not impact me greatly. It makes sense to use resources (staff and equipment) as wisely as possible given funding shortages, therefore the changes seem sensible.		
211	I live at the extreme edge of any area that will use these services, I need to see transport in and out for relatives.		
212	Concerns: Transport availability to both sites Can GRH accommodate more activity - car parks, visitors etc Cheltenham Hospital not become the 'poor relation' regarding investment in buildings, staff and education.		
213	I live in Cheltenham but have had both inpatient and outpatient treatment at both hospital I have no argument with proposals that lead to improvement in services and staffing		
214	I think overall there will be a positive benefits having local COE's with appropriate staffing		
215	Having a centre of excellence in planned care at Cheltenham will make it better for us to have treatment.		
216	Positive impact, we have all been treated under the NHS in the last 12-18 months and these proposals can only improve primary healthcare in Gloucestershire		
217	For either hospital it is access from the forest and other outlying areas such as Stroud. Good transport links might be essential		
218	Positive to moving all specialties to gloucester and none in cheltenham: None, on all accounts care provided is slowed down, bed spaces limited, more in patient moves and exposure risks of various infections and the disruption and unfairness that the staff are subjected to with these moves, how is this fair that their loyalty to their teams is rewarded with bitterness and unfair choices with their opinions not being heard Positive to specialties linked across both sites : better patient flow, increased admissions and faster patient care to get people home		
219	The convenience of travelling to GRH and CGH is very similar for me.		

Please tell us about any impact, either positive or adverse, that you think any of our proposals could have on you and your family (please tell us which service your feedback relates to e.g. IGIS)?		Response Percent	Response Total
220	Adverse as facilities would not be local, impact on non driver		
221	There needs tobe a fair balance of services available for people living in different areas of the Trust.		
222	Support the best option proposed by medics.		
223	None at present. Who knows the future?		
224	Concentrating expertise in one of two hospitals will be beneficial for staff and patients; improve the capacity of hospitals to be both centres of excellence and centres of medical training; reduce waiting times and improve chances for patients of being seen by the right specialists more quickly, with the necessary follow-up care.		
225	Additional impact would be increased travelling to GRH but this is outweighed by the benefits as described in your documentation.		
226	I started to work for Cheltenham Hospital 27 years ago when I lived in Gloucester and have since moved to Tewkesbury and then Evesham. The travel time now is almost an hour each way and moving the department I work in (and have worked in for nearly 8 years) to Gloucestershire Royal Hospital will add at least an extra 30 minutes each way to my journey. I will not be able to sustain this and will subsequently be forced to look for work elsewhere within Cheltenham Hospital, something I do not want to do as I thoroughly enjoy working in Vascular surgery. I work in Vascular Surgery.		
227	The temporary changes made to Emergency General Surgery at GRH have had a positive effect on patient care, patient experience and staff morale. Patients now see the correct speciality during admission within a timely manner.		
228	Emergency lower/upper GI surgery to stay at GRH.		
229	All - I think the most important consideration is how to provide the best services to the widest number of people including my family and residents of my Cotswold ward. Psychologically we all feel that Gloucester is a remote, far away place whilst Cheltenham is more familiar with better access - we have no public transport to Gloucester		
230	It seems that most services will be taken away from Cheltenham General hospital, particularly emergency cases. Cheltenham A&E will be essentially downgraded. That will have an adverse impact on residents. As with any emergency, whether it is medical, surgical or trauma, time is of the essence. The longer transfer time for patients to GRH will be life threatening. Gloucester A&E department has been overwhelmed during Covid with long ambulances waits for patients to be admitted and the consequences that has for patients needing an ambulance.		
231	The centralisation of general surgery at Gloucester Royal enables all patients, regardless of geographic location in the county, to receive the best possible outcomes as a result of the surgical team having both upper and lower GI specialists on call at the same site. The teams on the fifth floor are both well established and highly skilled to deal with both emergency and elective patients.		
232	Lack of choice		
233	I believe both hospitals have their strengths and as mentioned this is probably one of the better solutions to get the maximum use out of the top class facilities they would have.		
234	A possible positive impact would be an increased likelihood of a successful outcome of any treatment in the future.		
235	We may need to travel slightly further but this is a small price to pay for an improved service. Quality over convenience please.		
236	As long as the clinic appointments are in the same place I think it will have very little impact on my family		
237	By moving more acute medicine and a&e overnight to gloucester, I think it will cause problems with delays in treatment for anyone going to cheltenham.		

Please tell us about any impact, either positive or adverse, that you think any of our proposals could have on you and your family (please tell us which service your feedback relates to e.g. IGIS)?		Response Percent	Response Total
	238	Despite their proximity, travelling between Gloucester and Cheltenham is very difficult for many members of the loca population, and can lead to delays in treatment, great stress over travel arrangements, difficulty for family visitors, etc. I have personal experience of the problem in relatoion to removal of 24-hour A&E services from Cheltenham, which should be fully restored as soon as possible.	
	239	FOD is a deprived area, we need one hospital for people to travel to (20 miles) and when inpatients - family can visit one centre of excellence for county. Cheltenham too old, parking nightmare	
	240	At the moment I am not in need of other services than a knee operation so do not feel qualified to comment on them. The main thing I would like to know is that Cheltenham A & E services will not be discontinued. When I had a heart attack in 2011 if I had had to be taken to Gloucester, I would not be here. I was told that any delay would have meant I would not have survived. As it was I was seen straight away and given a stent immediately. Obviously being able to stay in Cheltenham for my knee operation would suit me as it would be far easier for follow up appointments as well. Therefore I think the present arrangement works well.	
	241	Major elective general surgery - I am concerned if located in GRH - COVID cancellation of operations, poor quality care, chaos not good environment for recovery	
	242	We have yet to have need of any of these services	
	243	As a Gloucester based family it is always easier for us to go to GRH. However, I would prefer to travel a bit further to a centre of excellence.	
	244	Because we live in the very south of the county to a certain extent these changes will have very little impact on us as we are pretty much as far away from one hospital as the other. The time taken to get to either of them is about the same, and as there is no public transport to either hospital, it doesn't really matter for any of the services at either hospital. However, I know that having centres of excellence can generally improve patient outcomes, which is why I support the developments of the centres of excellence. At the moment some trauma and emergencies from our area are dealt with at Southmead, so if GRH and CGH can become superior centres of excellence, then perhaps we would be more likely to be treated in county. i would rather battle the traffic into Cheltenham or Gloucester than Bristol.	
	245	I received knee surgery at Cheltenham General Hospital four years ago. My surgeon decided after opening up my right knee that I only required a half knee replacement. The operation has provided with pain free mobility. The follow up by my surgeon, Mr Aung is ongoing, this year it will be a telephone call. Friends who opted for private treatment, have not received this follow up service.	
	246	The parking fees are an outrage and would stop us being able to visit, I feel uncomfortable with being in Gloucester Royal due to bad reputation	
	247	We live on the border in Herefordshire but our nearest GP surgery is in Gloucestershire where we access services. Having to travel to Cheltenham is too far.	
	248	I just want the best care in the right place and don’t mind a few extra miles travel in order to achieve this	
	249	I think the impact this will have on all residents in Gloucestershire is a serious one. Gloucestershire is a big county that is growing. The number of homes being built and with the Cybercentre bringing new jobs to Cheltenham will mean that both hospitals will need to offer high quality services, that include, medical and surgical facilities and the ability to offer specialities, including viable A&E departments. The downsides are that both hospitals will not be able to offer basic services. There will be increased travel for many people. Surgeons will have to opt for being either trauma specialists or non-trauma specialists. Same for General Surgeons - upper or lower specialists.	
	250	General Surgery at Gloucester Royal	
	251	The formation of centres of excellence will provide clarity on where public can expect to be treated. CGH would require upgrading in some cases which may be disruptive. My family can access both CGH and GRH relatively easily	

Please tell us about any impact, either positive or adverse, that you think any of our proposals could have on you and your family (please tell us which service your feedback relates to e.g. IGIS)?		Response Percent	Response Total
252	I have multiple disabilities and cannot drive or travel on public transport. If I ever need any of the services covered in this proposal, I want them to be as close as possible to my home. It is easier for elderly, disabled, and very sick people to travel to their nearest hospital. An unfamiliar environment may be distressing for them, and it may be more difficult for their families to visit if they are further away. I will not be the only person in this category who is not able to either drive themselves or travel on public transport. Therefore, all procedures should be available in all hospitals, not in one centre. This feedback relates to all the services.		
253	I had excellence service with my eyes op chelt covid 19. Has been await a call to staff must be needed for the future of NHS.		
254	My family and I could be affected positively by services being centralised because we would get the treatment we need in time by highly motivated trained staff.		
255	It was traumatic for my husband to be transferred to CGH at 2am because of vascular problems. It would have been beneficial to have been beneficial to have had a vascular centre at GRH.		
256	The proposals are driving towards a focus on emergency care at one hospital and planned care at another. Considering the areas covered by the Trusts 2 main hospitals, there is a need for 2 viable A&E departments.		
257	Closure of CGH A&E could lead to delays in emergency treatment to those south of the county, with potential for negative outcomes for time critical conditions.		
258	None		
259	Gloucester Royal has a record of poor patient satisfaction! To loose Cheltenham General would only increase the workload on GRH. In the long term, because of local increase in population, a new DGH should be considered! The proposed changes are just sticking plaster.		
260	I have good mobility and transport but would affect other members of my family if they had to travel.		
261	How are we supposed to travel to Cheltenham from the Forest of Dean? Have any of you ever tried it? Especially to arrive at 9am.		
262	Having had various admissions and day case appointments in the last few years I have received excellent care at both hospitals for which I am more than thankful. The locality is immaterial - the efficient and professional care are what matters.		
263	Any movement away from Cheltenham would be more difficult for us to access. This applies to all disciplines.		
264	Creating a major elective hub at CGH is likely to be beneficial to my family. This would allow good access to intensive care if needed and reduce the risk of hospital acquired infection.		
265	We'd rather have to quality care and travel further than average care on our doorstep.		
266	Having to travel further for urgent trauma surgery from Cheltenham to Gloucester could affect anyone.		
267	Any member of my family could require urgent treatment at any time and having to go to Gloucester as opposed to Cheltenham could hardly be seen as an improvement and could be dangerous.		
268	My view is that centres of excellence would be a positive proposal. Negative could be transport/parking etc issues in either getting to hospital, or for visitors. As I mentioned before a free green shuttle between the sites would help with this. But really transport issues are far down the line when compared to top class treatment.		
269	Travel / visits - for any of these services - not so much for us - we live in Chalford, away from both anyway, but for less well off people who live closer.		
270	Hope fully our only need will be A&E based and in this area I fear the proposals are negative		
271	I have no objection to the siting of specialist services on one hospital site. If this allows the particular hospital to improve its services in that field so much the better. I am, however, concerned that too much emphasis is being placed on GRH. This concerns me because I do not believe that GRH has the facilities or space to cope with extra work. I have personally seen, and experienced, people left waiting on trolleys or chairs in reception areas for very many hours at GRH. I would not support the concentration of services on one hospital site if that led to, for example, a reduction in consultants at CGH which would eventually put the A&E at that site in question.		

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

		Response Percent	Response Total
272	I strongly believe health care needs to be delivered as close to where people live and work as possible. This is supposed to be a primary policy of the NHS, yet it seems there is a trend towards ever more centralisation and a move to more and more remote services. While some services can no doubt benefit from greater centralisation, especially where investment in very expensive equipment is concerned, administrative and clinical convenience should not be elevated above ease of access to healthcare.		
273	Taking away services from Cheltenham is not looking after Gloucestershire residents welfare. Any General hospital should have the ability and capacity to offer basic medical and surgical services. Moving emergency cases to GRH will mean lengthier travel times for residents living to the North and East of Gloucester. The consequences of this will mean more suffering and death. As the term implies Surgical or Medical emergencies require prompt action and this will certainly not happen if Cheltenham loses these vital services.		
274	As agree people this could - and likely to - have very dramatic effect on us		
275	I hope that under the new proposed services any future problems i have with my replaced ankle will be dealt with by highly trained specialists in a very well educated and informed manner kindly and efficiently. The service I received was great (the surgeon was excellent) and the consultant aftercare was brilliant		
276	Gloucester GH is twice the distance than Cheltenham GH is and there is no patient transport to Gloucester		
277	Cardiac and renal. I am 84, have had 2 heart attacks and been cared for at both hospitals. I have chronic kidney disease		
278	no opinions but good idea		
279	I live in Moreton-in-Marsh and I am not able to drive. Gloucester is a foreign country! Oxford or Worcester is easier to reach. any suggestion of concentrating services at GRH is therefore bad news. only super specialist services should be located here.		
280	Would have a centre of excellence as this would have helped me. Joined up access to medical records across the county. Would be good to have the images able to be shared with GP.		
281	Its too far to go to GRH		
282	The service I use most is eye care and there is no reference to Ophthalmology: any reduction in this service at Cheltenham would be greatly concerning for me.		
283	Should be good		
284	Close proximity to where I live Easy to travel to Gloucester hospital I like the idea of specialists in one area Centres of excellence should enable easy communications between staff		
285	Easy travel time Minimal waiting		
		answered	285
		skipped	339

If you think any of our proposals could have a negative impact on you and your family, how should we try to limit this (please tell us which service your feedback relates to e.g. IGIS)?			
		Response Percent	Response Total
1	Open-Ended Question	100.00%	198
	1	On balance I don't think they would - on health outcomes I mean.	
	2	this should not be undertaken this year, if a government integrated review has to be delayed I don't see how it can be ethical that Gloucestershire CCG even have the man power to consider this - let alone spend money on making it happen. Is this a project pushed to the forefront to benefit an individuals career?	
	3	To protect Cheltenham A&E	
	4	Both hospitals should have centres of excellence and provide all facilities - the catchment area for Cheltenham is very large and such services should not be transferred to Gloucester Royal - travelling time and distance	
	5	Keep both sites running and share the workload between them as they are. GRH is difficult to get too, the parking is unsatisfactory and the building totally unwelcoming and difficult to navigate - i had to run to theatres ? 7th or 8th floor via the stairs because both lifts were out of action for maintenance - I had to leave on the ground floor someone who was in a wheelchair. In CGH, there are other route options so this wouldn't happen.	
	6	No although this will remove some services from each site by centralising to the other I think overall the experience will be better and clinical outcomes likely to be improved.	
	7	GRH will be full all if not most of the time. Rapid discharge (prematurely) will inevitably happen to create bed capacity.	
	8	pretending we have 2 acute hospitals is the biggest potential detriment to services	
	9	As above	
	10	I would be worried if resources are spread thinly if there aren't centres of excellence.	
	11	NO	
	12	I consider the effect will be positive	
	13	Interventional Cardiology. This should remain at CGH where it performs very well despite the trusts problems.	
	14	I do not think there are any negative impacts to the proposed changes.	
	15	Move all elective major lower and upper GI, plus vascular, to Cheltenham and ensure adequate resident surgical support.	
	16	Move more services to CGH. If all elective major upper and GI surgery, vascular and interventional surgery were moved to CGH there would be less pressure on the beds in GRH. It would also protect the elective patients from cancellations and also separate the elective patients from the COVID patients. There needs to be adequate resident surgical cover overnight in CGH regardless of the solution.	
	17	Managers need to ensure that there is the bed capacity to provide centres of excellence. Movement of patients between wards and sites is not conducive to good care. Staff need to be consulted and views listened to.	
	18	Cant answer that as no way of knowing if or what treatment me and my family are likely to need in the future, if services changed to Cheltenham then we would need to get there and the parking in Cheltenham is awful and the hospital is not near the actual town centre	
	19	The centralising of services is important, but this also relies on the availability and access to the means to get people to hospital, in the sense of emergencies and the correct emergency services on hand when needed, whether this is an ambulance or paramedic car, with the correct expertise on site.	
	20	Delay the proposals by a year. Engage with a private business/ management consultancy firm to determine the true long term impact of these changes, and amend proposals. Social impacts may change too - changes to the way we work in response to Covid may change the landscape such that new options become available.	

If you think any of our proposals could have a negative impact on you and your family, how should we try to limit this (please tell us which service your feedback relates to e.g. IGIS)?		Response Percent	Response Total
21	Colorectal, general surgery and gastroenterology should stay in Cheltenham.		
22	Not do it.		
23	Reassess A&E times		
24	Both EDs open and Acute medical take shared across both sites.		
25	You should retain Cheltenham as a fully functioning hospital - no excuse for not offering excellence at both!		
26	Can patients utilise a shuttle bus?		
27	As above		
28	Free parking?		
29	make a fully functioning a and e in Cheltenham to protect their health.		
30	risks everyones lives. not having an acute service in Cheltenham is laughable.		
31	will completely change my job, again! lower staff morale and lose a much needed acute care service		
32	We are seven generations of Cheltonians we need to keep what we know		
33	a fully functioning A&E needs to be in Cheltenham and our ACU and AMU needs to come back. patients safety is massively compromised.		
34	risking family health by providing sub par a and e service at Cheltenham		
35	GRH cannot and does not cope. to say otherwise is incorrect. you only need to speak to staff and patients to see Cheltenham needs a medical take		
36	As long as there is data and outcome measures to reflect that this costly reconfiguration is truly having a positive impact on waiting times, avoiding cancelation of elective surgery etc.. then I cannot anticipate any negative issues.		
37	If elective colorectal went to GRH that would yet further increase the pressure on beds at GRH, meaning longer waits for patients in A&E		
38	Cheltenham needs a functioning ED with acute medical intake		
39	Better 'advertising' of which conditions and situations are for which hospital so we can make decisions without convoluted calls to 111.		
40	None		
41	See previous answer.		
42	As above		
43	Paediatrics definitely need looking at as if emergency cases for urology are still being operated on in CGH transferring them to GRH is a logistical nightmare. Its embarrassing to tell patients that we have to transfer patients , it takes ambulances away from emergencies calls, waiting times for ambulance, can sometimes be early hours of the morning, is it safe to transfer , staffing for paediatrics , its not giving the child a positive experience, could cause increased anxiety for future admissions		
44	The only negative impact is if the plans for IGIS do not go ahead.		
45	Move as much major elective surgery to CGH as possible, to free up GRH bedspace		
46	Get it Right First Time. Direct to FAS/ COTE bed. Another specialist COTE ward at CGH (although difficult to recruit to this area) Discussion with community partners: keep CH and Bed Based Rehab beds for pts needing these services to speed transfers out of acute hospital. Blocking beds in the community blocks up our ' back door' and our beds perpetuating the problem of flow.		

If you think any of our proposals could have a negative impact on you and your family, how should we try to limit this (please tell us which service your feedback relates to e.g. IGIS)?		Response Percent	Response Total
47	no		
48	I don`t see any negative effect. I live in Cheltenham and had to go to GRH as a patient. I just got on the bus and was there on time for my appointment. It was fine. In emergency I can get a taxi if an ambulance car is not available.		
49	Hospital transport is only for those very unwell, not for those who cant afford a taxi - we need to support all patients not just the wealthy		
50	Needs to be more Glos central or joint venture with Great Western Hospital Swindon		
51	Not being able to access surgery at the CGH site will impact all the other services being provided at GRH. The hospital cannot cope as it is with the move of the emergency department to GRH.		
52	Keep cgh an acute hospital		
53	The proposals will have no impact on me as I am not receiving any services at either hospital at present.		
54	As above		
55	no		
56	this has a massive impact on me and my family. I wouldn't want my family member going to GRH unwell knowing what state the hospital is. patient care isn't what it use to be like unfortunately.		
57	Long awaiting in emergency department can harm the life of people and also travelling with illness is a high risk.		
58	- parking at cgh is poor		
59	There should be all services on both sites. Other wise people just would not/could not travel for treatment and they would risk death as they could not access the treatment they need.		
60	None		
61	Not applicable		
62	N/A		
63	As described above. We are meant to be aspiring to be the best in what we do and sharing staffing groups isn't the answer. Ensuring we recruit and retain is and taking pride in the quality of our work.		
64	Difficult for us to get to and park at GRH so would like CGH to keep full service		
65	N/A		
66	I feel reading and answering your question - you want to close CGH and turn it into a cottage hospital		
67	Travelling to GRH		
68	None		
69	none		
70	Talk to and listen to the local population. People prefer to have a local hospital with local services rather than 'centre of excellence' We all know that this is just about bed reductions, lack of staff as there has been a failure by the Trust to invest in its staff. Applies to all services.		
71	work with the transport services		
72	N/A		
73	N/A		
74	Retain full facilities at both sites.		
75	Capacity must remain the same or increase in totality for Gloucestershire.		

If you think any of our proposals could have a negative impact on you and your family, how should we try to limit this (please tell us which service your feedback relates to e.g. IGIS)?		Response Percent	Response Total
76	See above		
77	I would like to know what suggestions you may have for the following. If my husband had strong pains in his chest in the middle of the rush hour what would be his chances of survival is he were to be taken to Gloucester Royal and there was a traffic jam due to an accident on the Golden Valley? Not great I think.		
78	keep it as it was prior to covid! theres no need to change for money peoples health and lifes come first		
79	Downgrading Cirencester Hospital blood testing service		
80	Accident and Emergency must stay open at Cheltenham even if emergency surgery and medicine is in Gloucester		
81	Do not alter or reduce A&E provisions at Cheltenham. Do not centralise general surgery at GRI		
82	none		
83	You really need to have a ""Southmead"" in the Golden Valley area. And you need to consider better bus services to both sites for general public yo reduce car parking requirements and problems.		
84	Any proposal that fails to deliver the full restoration of 24/7 type-1 consultant-led A&E services at CGH, will make it considerably more difficult to access emergency health care for me and my family.		
85	If A&E centre of excellence is going to be based at GRH, there needs to be more 24x7 ambulance provision for remote areas to compensate for additional journey time.		
86	Minor impact on travel but this is offset by the improvement in the quality of the service provided.		
87	None		
88	Mum died in GRH and my Daughter had such a traumatic time having her first baby she refused to return there to have her second baby. She was treated so badly she was traumatised		
89	None		
90	Personally at present not, but who knows as we get older!		
91	The only downside of creating centres of excellence could be that I may have two family members being treated at the same time on different sites which could cause problems with supporting them. However, this is hopefully unlikely.		
92	I think accessibility is the main key in these new proposals, such as transportation, informational and also medical - providing a knowledgeable doctor who takes the patients concern into account when making decisions on examination and treatment.		
93	See above.		
94	All proposals where treatment is being centralised - travel times/arrangements. Concern over extended travel times for patient/family/friends, particularly when someone is unwell. Relying on public transport particularly at the start of the day/evenings/weekends does not sound great. Even in the middle of the day it does not sound great when it could be 2 or 3 buses and all the hanging around that entails. Paying for a taxi is expensive & if relying on friends/family/a neighbour, it is more awkward to ask them to double/triple/quadruple the journey time		
95	Providing value for money parking on site.		
96	No negative impact, however I think that there needs to be clear communication about which services are provided by which hospital		
97	As above		
98	-		
99	N/A		

If you think any of our proposals could have a negative impact on you and your family, how should we try to limit this (please tell us which service your feedback relates to e.g. IGIS)?		Response Percent	Response Total
	100	See above	
	101	I can think of no negative effects of adding to or developing services unless such development diminishes the value already present.	
	102	Travelling by car more likely to be required to get to more distant Gloucester hospital so Additional parking provision would help.	
	103	No	
	104	The answer for me and my wife would be to make consultations for all but time critical issues, available at Cheltenham even if subsequently any surgery had to take place in Gloucester	
	105	Further to travel to Gloucester Royal for emergeny/trauma but if the care is better tht should be mitigated. Cheltenham is still available but not consultant led overnight, which is a concern for trauma admissions	
	106	As far as possible try to maintain urgent/emergency/acute facilities at both sites while splitting care not in those categories into centres of excellence across the two sites	
	107	It is important that free public transport is available for patients between the two hospitals, so that (for example) people living in Cheltenham are not financially disadvantaged by having to travel to GRH, if they do not have a car.	
	108	YES! All the proposals. you are trying to reduce the service offered.	
	109	Travel distances, free parking, access to other services	
	110	Travelling to Cheltenham from the south end of gloucestershire is difficult.	
	111	Biggest concern is travel for people like us with no car	
	112	It is crucial that these proposals are considered in the context of affordability and proper epidemological prediction modelling (none of which is illustrated in the documents circulated to date. The biggest negative effect on me and mine is if these p[proposals are implemented properly and because the basic work has not been done or done poorly, in 5 years time we have to change everything again,	
	113	Offer 2 centres of excellence for Acute Medicine	
	114	A&E should have two sites not one	
	115	Any service which compels patients to travel a significant distance gives a significant negative impact. It is not just the physical and financial inconvenience of organising travel to and from the hospital, there is also the significant negative psychological impact of the actual GRH site, which is noisy, confusing, over-crowded and uncomfortable. Every time I have visited the site, even as a visitor, I have left it feeling completely drained and unwell. I realise you are going to do the changes anyway as you have to cut costs and this consultation is a 'box ticking' exercise.	
	116	Better parking facilities at CGH.	
	117	No immediate impact but a potential long term negative impact.	
	118	None. It is important that the spoke IGIS service at CGH is a proper service to properly resource urology and not just an ""add on"".	
	119	we need a local type 1 A/E with elderly relatives it is an increased financial burden to travel across county. emergency general surgery as well as acute can be a matter of life & death & this added journey time has the potential to have a negative impact on survival. we have a right to LOCAL emergency treatment	
	120	None	
	121	No negative impact.	
	122	none	

If you think any of our proposals could have a negative impact on you and your family, how should we try to limit this (please tell us which service your feedback relates to e.g. IGIS)?		Response Percent	Response Total
123	Trying to find areas in Cheltenham hospital is not easy. Make sure you enter the building at the correct entrance, as finding your way inside the building is impossible.		
124	Not that I can see		
125	I can imagine transport for some patients families that need support might need to be considered. Parking access - is there sufficient to support these changes? Bus services?		
126	In all cases of treatment there is the question of transport but both hospitals have reasonable provision for access and parking (albeit at a fee which is a matter for separate discussion).		
127	Easier travel; more car parking spaces and lower charges for parking. Move to a paperless system so there is no need to transfer paper notes and images between sites - practical experience at both hospitals show lost notes are very common		
128	Try leadership and staff support for both units from one hospital. Sharing good practice teams can meet online.		
129	Parking a key issue Outpatient service provision at community hospital sites for pre and post care could off set some challenges. Or of course a virtual OP offering.		
130	I want access to as many things to continue at CGH as possible. this consultation seems to want to centralise as many things to GRH as possible and I'm against that e.g. moving the A&E away from CGH has not gone down well with local residents and our MP		
131	Longer way to travel for emergency services - could be too long		
132	We need to have centres of excellence I. Gloucestershire		
133	free travel on 99 bus between sites for patients with an appointment letter		
134	Logistics, ensuring that patients can access the site they need. Ensuring that care is not compromised by having specialisms at a particular site i.e. will there be enough Nurses, Doctors, Specialists to provide effective care under the models proposed or will it mean less capacity. Will the proposals be affected by inevitable budget cuts that will take place from now as a result of the economic decline for this country we are entering now. I am assuming the proposals were put together at a different point in time and wonder if the current economic climate and impact that this will have on costs (budget) and the health of the population means that the proposal has to be reviewed to ensure it is still fit for purpose.		
135	Any moves of existing heart, cancer treatment, colo-rectal and imaging facilities to a Gloucester Royal 'centre of excellence' is a retrograde step and a huge waste of funds already spent ..... There should be a full and proper published and publicly available for review Cost Benefit analysis which includes in the model a true and comprehensive explanation of the previous expenditure and costs both current and capital at Cheltenham General. This previous expenditure and the proposed 'write off/downgrade' must be part of the costs.		
136	Open Cheltenham general with all services		
137	So far at 90 no negative feedback, but I'm glad I did not have to go to GRH for babies. its a long way and can take a long time. Ambulances when I have needed them have not usually taken too long, but I think a car service, where possible, with blue light supplied might be useful.		
138	It would negatively impact on me and my family if elective work was not done in Cheltenham as they would be a lack of beds in GRH		
139	Closing Cheltenham's A&E is a terrible mistake. For patients in the Cotswolds, Tewkesbury and surrounding areas - the time wasted going to GRH could literally mean life and death. I also do not believe that Gloucestershire Royal can cope with the numbers they would need to deal with at present. One A&E for a whole county is madness and is so transparently being considered to save money rather than lives.		
140	2 hospitals with all the resource based in 1, and so any centre of excellence in CGH will not be able to thrive.		
141	Nil		
142	na		

If you think any of our proposals could have a negative impact on you and your family, how should we try to limit this (please tell us which service your feedback relates to e.g. IGIS)?		Response Percent	Response Total
143	Travel especially if you don't drive		
144	I don't see any negative effects		
145	The main problems we have for both hospitals and across all proposals are 1) parking 2) accessibility for older patients		
146	As long as you don’t try to close cgh a&e you will have my support.		
147	My wife has problems with her eyes and we both have hearing issues. We are able to access both services at Cheltenham within walking distance of our home. There are no references to the future location of either, presumably these will be covered in the next phase of planning?		
148	Relating to all centralisation proposals. I firmly believe that centralisation should only go ahead as and when a free transport service is available for patients and their families between the two sites. Only then will your objective of good accesability be achievable.		
149	None		
150	As above, it is distance to visit.		
151	I worry that as we rely on public transport we may not be able to travel easily between hospitals. We have already had to use taxi to do this - that proves expensive; and perhaps will lead to us not bothering		
152	As above		
153	Take a good look at gloucester and the way it is run. It has a reputation for a reason, myself being a patient it is a common subject that people do and will actively avoid Gloucester Royal hospital because it is a shambles with too many problems that never see the light of day		
154	IGIS, which affects not only local gloucestershire patients but also adding extra mileage for elderly wiltshire patients, with regards to vascular, although improving cardiac services to 24hours is an improvement		
155	Support the best option proposed by medics. Later question (Do you consider yourself to have ...) misses the ""Other"" options which I would have added ""Losing confidence in the NHS"" regrettably.		
156	None I can foresee		
157	I work in Vascular Surgery which has currently been moved to Gloucester Royal Hospital ""temporarily"" because of the Covid pandemic. I do not think this decision is likely to be reversed as I believe the Trust has been looking to move the service to Gloucestershire Royal and the pandemic has simply meant they could move the service earlier than planned and they have simply said it is ""temporary"" to stop any backlash. I do not think that the Trust will be able to limit this as the distance I travel to work if I am forced to move to Gloucester cannot be changed.		
158	None		
159	In emergencies the ambulance service often takes people from out locality to Warwick Hospital as it is quicker to reach		
160	Both Cheltenham and Gloucester are General hospitals, medical and surgical wards should be located within each hospital. Moving essential care like medicine and emergency surgery to GRH will obviously have a negative impact.		

If you think any of our proposals could have a negative impact on you and your family, how should we try to limit this (please tell us which service your feedback relates to e.g. IGIS)?		Response Percent	Response Total
161	See next box My wife and I are in our 90th year. She is not allowed to drive. I prefer daylight and not Mon or Friday. We live in Tetbury and wish treatment there. So: We prefer Cheltenham and do not like Gloucester, the former being easier for us to reach by car and more convenient in terms of other activities on the day.		
162	N/A		
163	Acute medicine and A&E needs to be fully supported in both hospitals. I have already detailed why.		
164	Don't specialist in only one place without considering and doing everything you can to alleviate the transport difficulties of patients and their family.I		
165	As above		
166	As above		
167	Finding ways to minimise the need to transfer patients between sites is important. Communication about any changes that are made and why they are necessary always helps		
168	Access if we are ill for any of the services is difficult if we can't drive because there is no public transport. It doesn't matter how good the services are, how good the consultants are or how nice the hospitals are, if you can't get to them. So it would be nice if there was a more consistent patient transport service. Not one that you constantly have to justify why you are using it. One where you aren't left sitting for hours wonder whether or not they are going to turn up.		
169	It is the high cost of IGIS that means it is necessary to concentrate this service in one hospital. If both hospitals could be equipped with similar IGIS then this would be perfect.		
170	None		
171	I cannot understand why it seems the Trust struggles with employing adequate staff for both hospitals. Gloucestershire is a beautiful county, more and more people are leaving cities and moving into the countryside, like the Cotswolds and Cheltenham is the home of the 'festivals' after all! So providing more staffing and investing in equipment etc should be a priority for both hospitals. Why do staff have to cover both sites? The two hospitals are separate sites and should continue to provide equal facilities because Gloucestershire is such a large growing county.		
172	No		
173	Please see answer to previous question, and if possible make all services available in all hospitals. If this is not possible, then there should be excellent hospital or volunteer transport which is suitable for individual patients with a variety of disabilities including severe allergies (I cannot travel in standard hospital transport or on public transport because of allergies to perfumed products from laundry detergent to standard toiletries.) This feedback relates to all the services.		
174	My family and I could be affected by long waiting lists, staff shortages, transport links, not being able to see a specialist consultant. This would be the negative impact.		
175	Time is of the essence in an emergency and lack of capacity with a growing population will lead to more queues of ambulances at GRH and patients on trolleys. Cheltenham has already lost the dedicated Battledown Children's Hospital, St Pauls Maternity and Delancey capacity. The changes in the Forest of Dean will also impact demand on GRH.		
176	All hospital services - whilst I am able to drive at present, for the future and for all patients a dependable public transport system becomes even more vital if these proposals are enacted.		
177	?24 transport links (99 bus useful but only mon-fri) between CGH and GRH. Cheaper parking if patient needs transfer from/to CGH/GRH.		
178	Its going to cause a lot of hardship and missed appointments		

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

		Response Percent	Response Total
179	Progress must go on. 24/7 is important to deal with an ever increasing population - also 7 days a week for all services particularly rehab and back up.		
180	I am not sure how it could be achieved, but you do acknowledge that older patients may find it difficult to access an unfamiliar centre of excellence.		
181	Keep the A&E dept running properly in Cheltenham General.		
182	You should restore a proper accident and emergency department at CGH and not keep fudging the issue.		
183	See above re transport.		
184	Greater visibility and support given to people needing to claim travel expenses for hospital visits. Citizens Advice Stroud ran a campaign about this 3-4 years ago, surveying the hospitals and surgeries to see how visible the information was and how easy to claim. The procedure for making a claim and receiving payment was poor. Stressed relatives need immediate assistance. They should not have to wait a month to be reimbursed.		
185	if we do set up CofE then we need to maintain 24/7 coverage elsewhere via a core of specialists (maybe a little more junior with access to more senior experts via telepresence)		
186	It is noted that A&E in not part of this review. However, I support the retention of A&E departments at CGH and GRH. I also support the return of a full A&E at CGH because I don't believe that GRH has the facilities to cope with providing the services which a reduced facility at CGH requires them to do.		
187	Senior management should listen much more to the views of ALL its frontline staff and not merely those of some of its most Senior Consultants. The Hospital cannot deliver excellent healthcare, regardless of how well equipped its 'Centres of Excellence' are without the goodwill and dedication of all of its staff. It is quite clear the failure to involve frontline staff sufficiently in developing services is undermining morale. There appears to be widespread distrust of senior management among staff and a sense of grudging resignation to having reorganisations imposed on them in a heavy-handed 'top-down' way.		
188	Possibly		
189	I am worried that the aim to be more efficient to reduce waiting times and free up beds will lead to hasty treatment and rushing patients out of the hospital without proper care or after-care treatment. I felt disappointed with a few aspects of the service I received		
190	Recruit more staff to enable you to operate both hospitals as has been the case for the past 30years.		
191	n/a		
192	no negative impact		
193	all services other than super-specialist ones need to be mirrored at CGH		
194	Improved communication and access to medical records. Improved access to staffing by having a centre of excellence. Make sure you have the necessary resources in place. Open up the options to make contact.		
195	We live only 12 min walk from CGH, therefore the centres of excellence in Gloucester will be less accessible. Not having access to 24 hour A&E is a downside for us.		
196	None that come to mind		
197	Parking issues		
198	If there is only one centre of excellence will parking be not adversely affected		
		answered	198
		skipped	426

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

		Response Percent	Response Total
1	Open-Ended Question	100.00%	113

1	yes centres of excellence in both hospitals
2	split the clinics between both sites at different times or weeks but keep the specialities at both. Re-open A&E as a FULL setting and not as a nurse led one which will reduce the impact on GRH.
3	No.
4	no
5	No. Those providing them will know what alternative proposals are best.
6	Gloucestershire would be better served by ambitious plans for a new hospital between Gloucester and Cheltenham along the M5 corridor. This would solve most of the trust's problems.
7	I think that all Upper GI surgery emergency and planned should take place at GRH and all lower GI surgery at CGH so they are kept separate.
8	Move all elective major lower and upper GI, plus vascular, to Cheltenham and ensure adequate resident surgical support.
9	I think all elective services where possible should be on a separate site to the acute patients to avoid cancellations and protect them during the pandemic. ALL upper and lower GI surgery and vascular and interventional surgery should be moved to CGH.
10	The trust used to provide fantastic care that I have seen deteriorate over time with the changes and ""streamlining"" of services. Patients often need a combination of services to meet their needs and not having them on both sites impacts on our capacity to provide good holistic care.
11	As mentioned previously I think the services should be in both hospitals, don't see why the staff cannot be shared between the hospitals or more staff if required - if I was running the hospitals I would make it far more efficient that it currently is, I think there is a lot of money wasted in services the hospitals have to pay for, I would be obtaining them cheaper and would not waste items that have to be thrown away from a packet that 1 item has been removed. It is ridiculous and wastes so much money, it can all be sterilised and then money saved on these things could help with the services
12	Keep emergency care/ acute medical on both sites. Share planned care with Bristol and Oxford. Rotate staff between hospitals/ secondments to generate the requisite culture of flexibility in planned care, with the savings and increased efficiency used to fund emergency care in both local sites.
13	Don't fix what isn't broken.
14	Open A&E fully to cover both Gloucester and Cheltenham
15	Both EDs open and Acute medical take shared across both sites.
16	My suggestion is you continue to support BOTH hospitals and ensure excellence in both - the population is simply too great for either hospital to be the sole service provider.
17	stop hiding behind lies and tell people the truth re closing a and in Cheltenham
18	reinstate the services previously supplied by Cheltenham. local opinion is not being considered at all. Cheltenham needs an acute care ward and a and e
19	reinstate a and e Cheltenham, don't fob us off as a downgraded service that then has to push emergencies to grh in ambulances.
20	we need to be told the truth and they need to stop hiding behind the lies they are telling us. its completely ruined staff morale and staff are not enjoying work.
21	Cheltenham needs an amu.

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

		Response Percent	Response Total
22	Nil.		
23	I heard an interview with the president of the Royal college of surgeons this morning clearly explaining how he feels the NHS should be re-structured to have emergency hospitals, and elective hospitals - meaning fewer cancellations of elective cases, and best care for all. We have this opportunity to deliver this		
24	It has been found that management have not been honest with informing staff about changes		
25	Can any of these services be done away from the two main hospitals, to make parking and other access easier, and use the two hospital spaces better for essential healthcare?		
26	yes, all emergencies to GRH urology and ophthalmology included (paediatrics)		
27	N/A		
28	no		
29	Nothing is mentioned about ERCP. This is part of GI service. It should be in CGH as a part of the entire circle. It is limited at the moment to two half days a week. It should be at least on a 5-day basis (every morning let`s say). There must be an ERCP centre. It could play a big role as a Centre of Excellence for training within the UK if the consultants think that they are able to develop it in this way. If not, then our patients will benefit at least from centre like this.		
30	We need to keep the blood monitoring service at Cirencester Hospital, even Cheltenham is too far away. If you need a frequent test it would be impossible to do this if you do not have your own transport.		
31	A new build fit for purpose and fit for the 21st century with bus/road and rail links between the two major sites		
32	Joint venture with Great Western Swindon for those living on The Cotswolds		
33	As before, the answer to all the questions is to provide a new hospital for Cheltenham designed to provide the location for all the latest developments in 21st century health care		
34	regarding appointments I really wants to appreciate the services		
35	CGH ED department needs to reopen so that the pressure is taken off GRH and CGH has their Acute Care wards open again. GRH cant cope with the whole county.		
36	To improve the health outcomes its better that there are all specialities like medical, surgical and orthopaedics, elderly care in both the hospitals as the hospitals are located in 2 towns surrounded by a growing population around them than few years ago.. This can improve the provision of care facilities to all the population equally and in an excellent way reducing the stress and pressure.		
37	No		
38	No		
39	see previous comments		
40	N/A		
41	Bring Cheltenhams A&E back		
42	The size and geographical location of Gloucestershire warrants two fully functioning hospitals.		
43	Build brand new hospital at J11 of M5 next to the Airport to serve the whole of Gloucestershire.		
44	Both CGH and GRH need 24/7 type-1 consultant-led A&E services to support their growing communities. Anything less is totally unacceptable. GRH clearly cannot cope.		
45	Close both existing sites and build new Gloucestershire central hospital at a more accessible location, e.g. by Staverton airport. More scope for providing CoE departments, whilst being accessible to more people - including out-of-area opportunities. Old sites could be sold for offsetting capital cost.		

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

		Response Percent	Response Total
46	There is insufficient reference here to supporting patients at home, rather than admitting them to hospital. There is insufficient reference to the interface with social care services, and therefore to supporting clearing the back door of the hospitals.		
47	Open A&E in CGH and pay the staff more so they don't leave. Maternity in CGH could have at least one consultant for safety		
48	No		
49	no		
50	Keep 24 hour consultant led A&E at CGH.		
51	I feel that the centre of excellence approach is the way to go. I don't have a strong opinion as to which services should be provided by which hospital - it depends on the current strengths of each team in the hospitals I think.		
52	No		
53	On occasion I have come across some silo issues where, for example, such provision as physiotherapy is not always referenced in relation to other clinics where a natural connection seems relatively low priority obvious. This could be achieved through the GP intermediary or by direct referral within a hospital.		
54	No your proposals are well thought through and you know the business needs better than I do. I feel confident you will have used best endeavours to get it right.		
55	whatever is decided should be very clearly communicated as it is rather confusing at the moment		
56	To be ""Fit for the future"" try to repair the damage that has been afflicted to the NHS over recent years. Stop putting operations out to private companies. Work on restoring services which have been cut, reduce waiting times. Put NHS money into the NHS and NOT into private companies		
57	no.		
58	My general comments previously in this document all refer - I do not have alternative suggestions as I do not have the necessary information to propose anything sensible at this time. This consultation is most encouraging (and one of the better engagements I have seen) but is still very short on decent fact and analysis which presumably has been done somewhere.		
59	Reducing costs and providing a good service to all patients do not go hand in hand. You have already done your 'cost / benefit' analysis and decided what you are going to do, so even if I had sufficient knowledge of hospital processes to offer suggestions it would be a waste of time.		
60	No.		
61	CGH has an oncology centre of excellence therefore it makes sense to collaborate this first class service with colorectal/gynae/urology on the same site to make this a world class service. put CGH on the map ! expertise can then be developed with training and services offered. patient care will improve		
62	Whilst I understand that this is politically sensitive I am really struggling with the provision of an ED at Cheltenham, this should be a minor injury unit 24/7 end of.		
63	Other than knock both GRH and Cheltenham down, sell the land and build a new Southmead like hospital somewhere between the two. Probably not practical financially though		
64	no		
65	Are there options for co-operating with neighbouring Trusts, Hospital groups etc? Depending on the level of cases there could be opportunities for cross-border (whatever those borders may be) co-operation.		
66	Keep all acute services in one hub. Elective services in another hub. It simplifies things		

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

		Response Percent	Response Total
67	Assessment should be done by an expert in hospital. The amount of staff appointed could be the answer. One person travelling is better that ten patients.		
68	Try to make centres of excellence at both sites where possible		
69	No, if the statistics show that this model will provide better clinical outcomes, less waiting times, joint working and attraction/retention of the right staff, then I do not have another model to suggest.		
70	""""developed in collaboration with local people during the Fit for the Future Engagement (see pages 17/19 of the full consultation booklet)."""" This just means that the one's who shout loudest are listened too the most.....It also assumes the the voices from the deemed 'stakeholders' [NHS chosen or invited!!] are the truly interested parties. Most of us are too busy in our everyday lives to give up time to be part of this stakeholder echo chamber.		
71	I think most of possible suggestions seem very sensible, but perhaps more use could be made of voluntary services (stopping blood flow from nasty cuts or wounds where the nearest A&E is not very near and it is closed). Dealing wit fits in children, concussion (small blows to the head). 999 is excellent but Gloucestershire is a big county and the borders far from the centre. Surely we should have a service that can take us to the nearest centre for help and rely on zoom for specialism?		
72	.		
73	The provision of temporary accommodation for vascular services, provided at GRH during phase 2 of COVID19 is severely lacking. It does not provide essential facilities for patients or staff. Moving from a ward at CGH which is ideal for this group of patients into an area which falls well below the normal standards, will have a devastating effect on patient outcomes and staff moral. If this experience is a sign of how it will be in the future, I would suggest that you will not be providing a centre of excellence for this group of patients. If however it is in ,the plans to create a ward environment which is similar in layout to Guiting ward at CGH which is close to Vascular laboratory, I would not be so concerned		
74	Both estates are too old and the sites are not of appropriate size to support an urgent and elective site - we should not be throwing more money away on them. A new combined hospital should have been built years ago. Neither is fit for purpose.		
75	na		
76	It would be good to have some services in either the forest or the Cotswolds as people travel long distances to get treatment		
77	I don't current suggestions		
78	Staff could be made more fully aware of resources at local hopsitals such as dilke, Lydney, Tewkesbury, Stroud, etc Many staff in Gloucester and Cheltenham do not know that x ray services are available at both Lydney and Dilke		
79	Could make cgh the vascular centre.		
80	No suggestions - the proposals seem to make sense		
81	Re-instate a fully functioning A&E service at CGH.		
82	Pages 12 to 69 - your thinking and planning and stats and experiences and practicalities and timescales and costs seem daunting, but are clearly essential and within your skills. However, I don't feel competent to judge the options except for showing an obvious personal preference for necessary services being available at Cheltenham or Bourton, rather than Gloucester or Moreton, to avoid extra travel and time and costs and stress.		

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

		Response Percent	Response Total
83	Fully supportive of the changes planned, as timing will be improved and better staffing.		
84	No		
85	Extra hospital in FOD used by visiting team		
86	None		
87	Use precious structure and perhaps have a rotational table for specialties on an axel bases to offer variety of care over standard time frames		
88	No		
89	Specialties need to stay in the same hospital. Orthopaedic need to all be in one hospital. Vascular needs to all be in one hospital where they can get treatments etc		
90	My wife and I are in our 90th year. She is not allowed to drive. I prefer daylight and not Mon or Friday. We live in Tetbury and wish treatment there. So: We prefer Cheltenham and do not like Gloucester, the former being easier for us to reach by car and more convenient in terms of other activities on the day.		
91	I am a civil servant so I recognise the phrases used here - which don't really mean anything. How can you have a new modern hospital in CGH? It's an old maybe listed building. It all sounds really good but basically it's a money saving scheme. Charge people who come into A&E when it isn't an emergency. You have to pay to call an ambulance to your home or your insurance pays when called to a road accident.		
92	You need to cover more about how the elderly are catered for in acute medicine and a&e. Also what happens when services/surgery/beds are not available. Also the impact on ambulance transfers and wait times for ambulances. How will the services/surgery/beds be allocated from cheltenham? You could move a patient to gloucester to find there was no capacity?		
93	New hospital that would be fit for the future with our expanding population. We deserve it!!		
94	If you wish to attract the best Clinicians, Consultants, Doctors and medical staff, it is necessary to provide the best environment, and the best equipment. There are many negative reasons for Consultants / Doctors and patients having to travel to use specialist equipment in say, Birmingham or Bristol. Time and money is wasted. We must provide all services in our two excellent hospitals.		
95	the trust may wish to consider the potential benefits of working with Hereford and Worcester to optimise service provision, availability and delivery (use all available resources and staff all of the time) and thereby minimise patient waiting times in the three counties area.		
96	It is vital to maintain access to care to patients across the whole county of Gloucestershire, so our alternative suggestion is that all services should be available in all hospitals.		
97	No		
98	No		
99	Gloucestershire Royal has major problems, very poor booking system, staff morale. Sorry to say but patient experience has over years been negative.		
100	Quality - travel times may influence this - delays in transfer can be critical Access - as above - patient choice used to be primary concern, but less so now. 24 hour access is important. Not everyone has a car or access to one. Deliverability - need clarity on proposals and times for implementation Workforce - joined up working essential. Staff stress must be minimised. Staff travel times should be minimal. Development for staff essential - colleges will be watching training.		
101	Centralise all at Gloucester Royal Hospital. The hospital for Gloucestershire		

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

		Response Percent	Response Total
102	Help! As a sometime retired physiotherapist in the NHS I have been out too long to justify comment. I think 24/7, 7 day a week is important, people have problems 7/7 not 5/7 - this possibly goes beyond your remit. I was very glad recently to see doctors from the max-fac department as some ungodly hour on a Sunday morning (CGH).		
103	This is an impossible question. No ordinary working person has the time to analyse endless pages and documents developed over several years.		
104	In general I would ask you to consider that when a patient is the subject of care between department, that a single point of contact be established between the departments. I think this would be even more important if the departments are on different sites.		
105	A covering team at each hospital with more senior staff visit each site to under take teaching etc but always being available for support/advice via telepresence or VR		
106	Recognising the need for change, the proposals for Gastro-intestinal Surgery contained in what was Option 4 should be fully worked up into a proposal, in preference to Option 2 which is what the Hospital Trust appears to have adopted in opposition to the majority of the Consultants involved and GiRFT advice.		
107	Build a state of the art hospital in the Forest of Dean at Five Acres which is for sale. Traveling to Glos and Chelt is traumatic, worrying and time consuming for older people who are suffering because of you decisions. We travel 4 or 5 times a year to Glos and Chelt so we know how terrible the journeys are at a time when we are ill and anxious.		
108	ensure each patient sees a consultant on their first occasion and gets ultrasound etc in the hospital closest to their home ie Gloucester people in GRH etc. Email appointment letters to people. Its faster and saves on postage. It also reduces the number of telephone calls coming in. If you offer email as a way to communicate ensure NHS staff have the ability to email the patient back		
109	no		
110	I live in Moreton, We have a fine new hospital building which is woefully underused, Yet I am invited to travel to Gloucester for a routine exam, The NHS needs to resolve service delivery issues of this kind, preferably before the new forest of dean hospital opens, for the same problems will arise there. The general impression given in this survey is that services will be organised for the convenience of patients who will usually be sick or indisposed.		
111	Training hospital again - start with one centre of excellence. Proposal is excellent to move into the modern world - make sure you have the technology to support this and the staff to support this. Efficiency of resources is a concern. Waiting times should improve with these proposals. Measure of improvement.		
112	My alternative suggestion rather than wasting money on expensive surveys like this is to have ONE hospital, between Cheltenham and Gloucester, which could then be available for both. The overall saving to the NHS would after the initial expense, be enormous. I believe the only reason this has not already happened is the ridiculous failure by the two relevant local authorities to agree on a site.		
113	None		
		answered	113
		skipped	511

Anything else you would like to say?

		Response Percent	Response Total
1	Open-Ended Question	100.00%	187

1	Good quality consultation materials and great glossary.
2	This is the wrong time, please spend the funds on dramatically improving A&E / Trauma and on building public trust in our local health services.
3	There are services eg haematology that are split site and struggling because of the inefficiency this causes. Would be good to see haem si flew sote at CGH
4	No.
5	I don't understand why we have to keep both EDs open. What matters is what happens once patients arrive and to deliver the service I would expect, would mean concentrating emergency staff expertise. I don't live in C or G so have no emotional attitude to either department but I do expect one fully staffed centre of ED expertise somewhere in the middle of the county.
6	It makes sense to look at the service provision in this way.
7	This should have been done years ago. Having doctors and staff working across two sites is inefficient and detrimental to patient care . Ideally we should have one hospital at Staverrton !!!!
8	Invest in your nursing staff as you do with every other professional group. Pay them more and develop their skills. This is the only way you will be seriously considered as addressing the recruitment and retention crisis.
9	Gastroenterology ward should be moved back to GRH.
10	We are approaching a winter crisis, and the move of all of ED, acute medicine, acute surgery and vascular to an already overstretched site in GRH in the height of a pandemic without a significant shift of major services back to CGH is posing a significant and immediate risk to patient safety.
11	Don't think so
12	My hope would be that by making these changes the local service will be made better and the cancelling of planned procedures is significantly reduced.
13	-
14	Management have no clue how the services are run and what is best for the Gloucestershire pts.
15	The major elective centre at CGH away from the pressures of the emergency takes seems like a no-brainer. I don't know why it is being approached so cautiously. Why not move major head and neck resections, upper GI resections etc. I think too much weight is put on the inertia of clinicians who do not want to change. The Trust needs to be stronger in terms of telling people where they will work in future. Short term unhappiness for long term gain.
16	I am very disappointed that you are offering a false premise ie. do you want excellence if so this must be at one hospital. We have already suffered greatly by the reduced services in Cheltenham. My husbands appts have been haphazard since services for Linc have been moved to Glos. I have been in A & E in Glos with 2 relatives recently we waited extensively for assistance and the hospital was clearly overwhelmed by the demand.
17	How any of this helps patient flow and integration with primary care is poorly explained.
18	I fully understand the publics desire to be able to access all services that they require as close to their home as possible, and therefore the negative public/ local MP perception of the trusts plans to separate services across the two site. However, as a clinician I feel that these parties should really be made aware of the limited resources (both personal and capital estates) that we have to fulfil this objective across two sites. If the public and politicians of Gloucestershire truly want to access an exemplary standard of clinical care and research within the county then they should fully support the trusts current proposals which will begin the process of enabling us to do this and are, in my view, long overdue.
19	Trying to maintain two hospitals with duplicate services so close together makes no sense in any regard. This is the best compromise that I have heard suggested for a very long time

Anything else you would like to say?

		Response Percent	Response Total
20	patient safety is being compromised daily already, let alone letting this carry on further. nursing morale is at rock bottom.		
21	stop trying to deceive everyone and be up front with the plans. this effects people livelihood and health. stop treating nurses as if we don't matter by moving us all pillar to post.		
22	the Gloucestershire nhs service needs to at least attempt to show some honesty and integrity when dealing with the public and its staff. do not treat us as though we are fools.		
23	we need to be told the truth and be kept in the loop more. the patients are also taking the brunt from staff because of these moves		
24	stop using covid as an excuse to flatline emergency services at Cheltenham. treat staff with more respect, our opinions and skills as professionals are repeatedly ignored by trust management. stop shipping patients who are unwell between two sites, this is unsafe and immoral. the only ones being shipped about are those with lower capacity, confusion and complex needs. disgraceful. I support reinstating amu at Cheltenham to stop this nonsense.		
25	Although it has been stated that staff have been consulted I wonder whether it has been at managerial level rather than at patient facing level? Often the feedback with consultation processes is staff feel like the right people have not been involved and therefore they have not truly had the opportunity to feedback their opinions on the process. Ultimately, the majority of staff working in the acute setting will always want to accept change if the end result is better patient care and staff experience.		
26	I believe that management have wanted to close Cheltenham ED for many years and have used Covid as an opportunity to do exactly that		
27	I live in Cheltenham and find it easier to travel to work to CGH but am not opposed to travelling to GRH but the 99 bus service could help if the times of the buses fit the shifts of staff.		
28	Bring cardiology together in GRH, with the space and resource for us to really enhance our services to the population of Gloucestershire, and then we could create a centre of excellence for cardiology. It is incredibly difficult to do this effectively being split not only across two sites, but also within those sites.		
29	I hope that you are going to see the picture in different levels, i.e. locally, nationally and internationally.		
30	Just get on with it.		
31	Get Cirencester and Tetbury hospitals better integrated into the services provided for patients		
32	With the reconfigurations proposed moving the surgical and medical takes to GRH there is then no safe way to run an ED in CGH. I strongly feel we would be lying to the public if we pretend that an ED can function in CGH without the supporting inpatient services behind it. It seems illogical to discuss these reconfigurations without factoring in the impact on the ED.		
33	don't put all of the eggs in one basket. PFI is very costly to taxpayers, but appreciate sometimes its the only way.		
34	Just think more about travel access, parking facilities and best of all getting appointments and blood tests done promptly. The Cotswolds is treated as a backwater by Glos NHS		
35	CGH has theatres and surgical wards that aren’t being used for that purpose. GRH is struggling to keep up with the demand. Why not make use of CGH and bring some of the surgical demand over?		
36	I have responded to a number of surveys such as this over the years and none of them appears to have resulted in any changes being made.Hopefully this one will result in some positive action		
37	I think that the change in how the trust operates (more acute beds at GRH)could have a detrimental effect on communities in the north and east of the county. I genuinely believe that resource should be spread to support all communities to access all resources at convenience. The time and effort should be spent instead of solving the issue of people attempting to access incorrect services. We all know that personal responsibility of people in the community accessing healthcare is the key area that would have the largest impact on operational streamlining for the trust. Don’t reinvent the wheel by moving departments for convenience.		
38	overall good		

Anything else you would like to say?

		Response Percent	Response Total
39	please ignore the people of cheltenham who are biased against Gloucester and who shout the loudest. this would be a good opportunity to also increase health equality in the county.		
40	The excellence is achieved only if the right treatment is available at the right time. due to long waiting this is badly lapsed currently. From the media coverage the Gloucester hospital ED is overwhelming and very poor in meeting the 'excellence'. If this is the scene in the front door all could imagine how pathetic the other areas could be.		
41	does a centre of excellence include evoked potential testing with some of the orthpaedic surgeries?		
42	I think most people would like to point out that even though it states CGH will re-open - it is easy to see that GRH just cannot cope with the amount of people in Gloucestershire. I know ED is not on this questionnaire but it needs to be taken into consideration with regards to where everything is to be situated.		
43	It seems a well thought out plan		
44	No		
45	I think we should bring cardiology together in one place rather than splitting across sites and within both sites. Continuity and effective teamwork is hampered by the current situation. OK for elective work in labs in CGH, but we should all really be together.		
46	Please consider the elderly and vulnerable who have to use public transport to make visits to a further hospital. Will public transport be improved? Will more hospital transport be accessible to those who need it?		
47	To save money on postage go back to the old system of pencil and a diary for appointments I am an ex NHS employee in Bath Royal united hospital and GRH and CGH and Standish. The old saying is with the NHS If it works - Change it		
48	Cheltenham need a A&E		
49	Why are there not adequate children's services in the area? My daughter was transferred to Bristol for endoscopy and gastric surgery despite Gloucester having the services necessary.		
50	Just ensure that the investment needed to provide these changes properly and not half hearted is there for all services involved including those that are sometimes overlooked. There is no point picking a service up and moving it to one side of the county or other if you don't use this opportunity to actually improve it.		
51	Would like Pathology to be taken into account with these decisions - especially Blood Transfusion as we are having to do an increasing amount of work overnight yet have no funding for extra staff! 1 person that covers the whole hospital at GRH in particular is dangerous.		
52	Thank you for putting Gastroenterology in the spotlight!		
53	This is a very ambivalent survey. I am sure not many people will bother to complete it fully I read the lengthy booklet and after looking at the various rather repetitive questions I imagine many people will give up. This I think is what you want. You have intentions and ideas to carry out and I don't believe as a member of this community our opinions matter at all.		
54	im disgusted as a member of the public for what hospitals will do for myself and children and ashamed I work in them now		
55	Downgrading the blood testing service at Cirencester impacts heavily on local residents		
56	Centres of Excellence is really good but only if they are really separated - emergencies in Gloucester and all planned in Cheltenham		
57	I would like to see a very positive statement, and concrete proposals for the better care of patients presenting with mental health problems in ED. This has been a long ongoing concern, how will Fit for the Future ensure that mental health is given proper consideration?		

Anything else you would like to say?

		Response Percent	Response Total
58	It is completely cynical to perform this type of public consultation during a ""once in a century"" global pandemic. By proceeding with this the NHS trust are showing utter contempt for the communities they serve. These proposals and this consultation should be put on hold until Covid-19 restrictions have been lifted by central government.		
59	I support the local people living in Cheltenham. It's a wonderful Hospital but does need some money spent on it to use the space it already has. Some wards are closed due to building collapsing.		
60	No		
61	Build a new County Hospital between Gloucester and Cheltenham, or focus development on the Gloucester site. Improve access (sheltered pedestrian links) to Gloucester rail and bus stations.		
62	Cary on with the plans.		
63	Whatever you do, do it well. Avoid letting politicians, who are only interested in the next election and showing that they can get things done on the cheap, get too involved. I realise that they hold the purse-strings, but don't let it just be about money. The USA really DO NOT have it right.		
64	no		
65	Can a hospital have a true A and E without the back up of eg general surgery vascular surgery Acute medicine etc		
66	Yes. Use some common sense, for goodness sake.		
67	It would be good to see more localised services. Smaller hospitals such as Cirencester and Tetbury should be used to enable patients receiving regular care to avoid having to make regular long journeys especially through the winter. Even one or two e.g. dialysis bays in a day hospital like Tetbury would reduce the exposure of vulnerable patients to the risks of travel and exposure to other diseases.		
68	I haven't the experience to comment on most of this questionnaire.		
69	I believe NHS purchasing has room to improve and gain expertise from elsewhere. I also believe that there is opportunity to improve efficiency. I have witnessed nurses spending more time walking around than actually providing care.		
70	Even your summary document is far too full and obfuscating! I'd like an honest and clear comparison between services as they were before COVID and as they would be under your preferred proposals, with an indication on the impact in time and accessibility for patients in the various parts of the county.		
71	Just a point about competition between services. Central Government, in particular the Minister for Health and Social Welfare, has repeatedly affirmed that the BHS has remained open for non-COVID health provision. This is nor strictly the case. For example, prior to the first phase of the pandemic I attended the BOTOX Clinic every 10 weeks. At the peak of the pandemic it was understandable that out-patient services should be a relatively low priority. However, eight months on my condition has worsened and when I receive the promised appointment I suspect that treatment will have to be re-assessed and possibly extended to achieve some parity with the positive outcomes achieved over many years of treatment . This must also be the case where there are other conflicts even during normal times. I am fully supportive of the need for centres of excellence but I would want to be reassured that other services are not reduced in terms of financial and staff resources in order to accommodate them.		
72	No		
73	No		
74	thank you for inviting comment. I do hope that patients views are taken into account if trends emerge and that this not just a ""going through the motions"" exercise		
75	I cannot thank the NHS enough in Gloucestershire for all your brilliant ideas and work.		

Anything else you would like to say?

		Response Percent	Response Total
76	The geographical disadvantage of one site over the other is usually overstated. We would all like things based as close to home as possible, but unless resident in Gloucester City or Cheltenham it actually makes very little difference to most people to site they need to travel. Using public transport is more complicated from rural areas, but the shuttle bus largely overcomes that issue for outpatients and visiting.		
77	The NHS was a great organisation. Over the years it has slowly been destroyed. One great problem is with the GP service. If effectively stops patients from accessing the main NHS services. It is almost impossible to get to see a GP. An example - In November 2019 I had a fall. I damaged my arm. A shard of metal punctured the arm to quite a depth. The arm from elbow to palm of hand went blue and remained blue for weeks. A huge swelling erupted at the puncture point. It was impossible to see my GP. By late December the arm was still swollen and bruised. I was concerned with Christmas upon me. I live alone. I phone 111 I was referred to see my GP the following day. When I entered the GP surgery the first words from GP were I don't usually see people who just walk in off the street. Obviously the GP service is NOT there for older people. The telephone 111 service is a farce. Please don't talk about centre of excellence and fit for the future. Just restore the NHS to a functioning system now The whole of your document has annoyed me. you say that you are attempting to provide centre of excellence while what you are doing is actually trying to whittle away even more of the flesh from the skeleton of the NHS which was a great organisation but which is now a shadow of what it once was. The hospital work is good still once one can get past the deliberate obstacle of the local GP. I have already mentioned the case of my GP who said "" I don't usually see people who walk in off the street"" when I had been referred by 111 service. The episode convinced me that the NHS is simply not there for older people. Please stop trying to fool me into thinking that you are trying to offer centre of excellence Long before that event I went to the GP reception as I have done in the past, to ask for an appointment. The receptionist who is obviously there to protect the doctors from seeing patients, told me that the system had changed. I had to go home and telephone for an appointment. I pointed out that I was there, talking face to face to her so why not organise an appointment. I simply wanted a routine appointment because I was concerned about a long term health issue I have. The receptionist then became aggressive and told me to go home and phone for an appointment. I returned home and phoned the surgery. The line was engaged. I tried to phone many times. The line was always engaged. Making an appointment is now virtually impossible. I presume that your aim is to force people who can afford to, to opt for private treatment. Pleased do not try to disguise your actions as creating centres of excellence The other possible method of getting medical attention is via the A&E. It is a last resort. When I badly damaged my arm I did not bother the A&E system. I would not abuse such a service. However other people who are desperate for treatment have used A&E. You have tried to counter that by removing the A&E from Cheltenham hospital. A lot of public pressure prevented that move completely but you ask about centres of excellence. It is in my opinion impudence on your part. I have health issues. I am elderly and live alone. If I get covid it will no doubt kill me, but I have determined that I will not even try to contact my GP. you so obviously intent on destroying the NHS as it stands. The government says it will be free at the point of delivery and so you are ensuring that there is no point of delivery. I do remember times before the NHS. What a disagree that we are returning to such times again. Centres of excellence RUBBISH		
78	Living in the Stroud area means that either Cheltenham or Gloucester are equally accessible (or not) for treatment or visiting. I feel it is important that specialisms are concentrated where they can best be delivered effectively and efficiently.		
79	whatever the experts in the NHS think I would be supportive of.		
80	See comments above.		
81	Please keep to your word about reversion to prev Covid A and E at Cheltenham.		
82	From recent experiences in the past two months and two days. Cheltenham A&E open 24hrs. Gloucester A&E was EXACTLY as shown on TV on Wednesday. Wait outside on an ambulance followed by wait inside in the corridor. We understand that you state there are no proposals to close Cheltenham A&E, yet you have! It is currently a minor injuries unit. Sorry, don't believe you.		
83	What consideration has been given to accessing these locations both by public transport and by car? Parking at both sites is difficult and iniquitously expensive.		

Anything else you would like to say?

		Response Percent	Response Total
84	These are excellent consultation proposals but miss one very important heading - THE CUSTOMER CARE EXPERIENCE. Visits to both major hospitals are still very poor experiences. Everyone does their best with awful facilities and it's time we moved from a 1958 experience to 2020		
85	I am extremely dissatisfied that there is not a department at CGH which specialises in treating children. When my grandson was 6 years old he fell at school and received a large gash to his forehead which needed stitching. I was told I would have to get him to GRH because it could not be dealt with at CGH. I had to drive him over the Golden Valley by-pass, in the rush-hour, in the pouring rain, trying to keep him from falling asleep on the journey because I was concerned about possible concussion. He was kept at GRH for 6 hours without being treated then sent home overnight and told to come back the next day for the stitches. An injured child should not have to undergo such a lengthy and hazardous journey or be left so long without proper treatment. Fortunately I had a car and sufficient petrol to get to Gloucester, but if I hadn't how would I have got him there, with his head cut open, by bus?		
86	No.		
87	It		
88	I am very concerned about the closing down of some services at Cirencester Hospital. The town is about to expand by about 30% with the Bathurst development at Chesterton. The hospital (which is excellent) should be expanding for the future, not declining. The climate change agenda requires us to have less reliance on car transport. For many the only realistic way to get to Gloucester or Cheltenham Hospitals is to drive. With a town population of around 20,000 (probably 27,000 with the new development) and with many surrounding villages, it seems to make more sense to develop local services better in Cirencester.		
89	Access to local facilities is important as I live in Tetbury. However, for specialist care i am prepared to travel further a field to Gloucester, Cheltenham and Oxford.		
90	Both Cheltenham and Gloucester hospitals are quite old and have grown in a piecemeal fashion with inefficient layouts. I can see the point of centralising specialist units. I think the only long term solution is to build a new hospital half way in between and then sell the existing sites which are close to city centres. The pressure should be put on the government and not to ask the public to accept dwindling local services.		
91	The proposals all seem excellent and recognise the realities of the problems fully staffing and offering all services at 2 DGHs which are only 10 miles apart.. It is not a problem to have to travel relatively short distances to access the best care. Tribal allegiances to GRH or CGH have gone on for far too long and obstructive practices by both clinicians, the general public and local politicians have delayed what has been obvious for far too long (at least to me in the 30 years I have lived and worked in the area).		
92	why oh why do this survey during a pandemic and why hasn't elective & emergency surgery been separated as per recommendations ?		
93	I understand and agree with your reasons for wanting to change things in these two big hospitals, but I would urge you to also consider our more rural hospitals (Cirencester, Stroud etc.) when it comes to where funds go. I would hate these to be underfunded at the expense of these changes.		
94	I support the changes as they will bring expertise and people together for the benefit of patients.		
95	Pure fluke heard about the consultation apparently running since late October. Leaflet only came with post on 2nd December. Good way of minimising responses		
96	no		

Anything else you would like to say?

		Response Percent	Response Total
97	I would be interested to know what consideration One Gloucestershire have given to inclusion in terms of practical access to the hospital sites e.g. public transport providers, charities with volunteer drivers, support groups in disadvantaged areas. Given the health inequalities which have been demonstrated through the Covid-19 situation, it is vital to me that these considerations are given a platform in any changes, else we risk worsening inequalities already present. As well as the patient, this can impact visitors, whose support can positively bolster outcomes for a patient. Also, there is no mention of the impact on ambulance services, but presumably there will be an impact in terms of transfers needed (not just when ambulance first called to patient, but also transfers between GRH and CGH) . Am wondering how this has been assessed? Thank you for appreciating the importance of having an A & E service in Cheltenham to local people, I am really pleased this is reflected in the plan.		
98	It is clear that the NHS cannot simply go on as before. How will these changes be monitored to see if they are successful? Who will monitor them and make any necessary adjustments if required, or indeed share best practice. In my lifetime I have seen many of the areas hospitals close or reduce their services, and I have not picked up on how all of this will impact the remaining hospitals in the area.		
99	For some people, the thought of travelling to GRH from Cheltenham (or, I imagine, CGH from Gloucester) would be a major consideration in the choice of whether to have treatment or not to have treatment. Travel to the ""wrong"" hospital is an extra journey for visitors by public transport and has led to my certain knowledge to some elderly patients having no visitors during their stay, with whatever psychological effect this has had on their recovery. The people likely to be reading this consultation and making decisions subsequently are likely to be those who think nothing of a few miles of distance on good, if busy, roads. Many, who are often less articulate or just more diffident find it a major obstacle.		
100	The priority is to optimise outcomes. IN my experience, working on two sites is ineffective and leads to worse outcomes for patients so there are two mediocre sites rather than one excellent one. The leadership needs to take the initiative to avoid local populations wanting to retain local services at the expense of quality - the NNHS has a poor record in this		
101	Good luck changing services is always a problem and change for this reason seems ridiculous		
102	Parking at both centres is problematic and public transport during Covid19 advised against		
103	My experience of being treated at CGH has been very positive. I am very supportive of its ongoing centrality to future plans		
104	The trust obviously has a plan for the medium/ longer term about how the 2 sites should be developed. Would be better to review theses current services within that wider context. I can only assume a hot cold site is the longer term plan. Overall will the trust be increasing its bed base with the significant housing development plans in place across Gloucestershire?		
105	Page 6 doesn't state what happens to ""Hyper Acute Stroke Unit and Acute Stroke"" under the preferred option. Page 23 does but is isn't clear if that include treating people with Acute Stroke cases.		
106	Thank you for the opportunity to participate		
107	I worry about the link and relationship between these proposals and GP services. GP services need to be as much a part of this as the hospitals and the hospitals cannot do this in isolation of community services. I can see part of the proposal is to enable more joined up working but this has to work in practice with collaboration and cooperation across the services. While I have experienced fantastic GP services in Gloucestershire (up to about 10 years ago). Unfortunately I have also experienced some poor GP service provision in Gloucestershire, which has deteriorated over the last 8 to 10 years. My biggest concern is that if the GP services are not joined up with these proposals, this will not be able to succeed.		
108	I live on my own so for me it is important that my nearest hospital covers all of my needs		
109	This appears to me to be yet another way to spend money to create 'something new' and the associated empire building both administratively and medically that goes with that. All proposals need to be matched to realistic assumptions of need and the first priority should be proper utilisation of existing resource. Acceptance of the waste of resource [both income and capital] appears to be a huge part of the default NHS model.		

Anything else you would like to say?

		Response Percent	Response Total
110	The provision of some tests possible available at Cheltenham but routinely carried out at GRH, does not seem to take into account the impact on elderly patients. For example my wife, aged 82 had her second cataract procedure at Cheltenham, where we live and she is pleased with the outcome. In preparation for the procedure, she was required to attend GRH for tests the day before. She assumed that these would be similar to those done previously and was prepared for a lengthy amount of time away from home. In fact the only test carried out was for Covid19 which surely could have been done at Cheltenham!		
111	I don't think 'Centres of Excellence' should be considered at present, and yet again my suspicion is that if it looks good from the outside - ie when the CCG walk round with the scent of paint in their nostrils - it doesn't matter that staff and patients are unhappy with the way things are.		
112	I support the need for patients that require surgery on the same day as admission to be done at one site. however not all urgent surgery is same day. I think the hospital at GRH would struggle to meet capacity/ demands if all Acute work was on GRH site.		
113	I have been watching this play out for years and too much time and negative energy has been spent which has hampered the development of all specialties in both hospitals. I am utterly fed up with it.		
114	Whatever decision is made, the correct and additional staff numbers must be allocated. You cannot simply move the patient workload (currently split over two sites with two teams) to one site with only that sites pre-existing team numbers. This will be a recipe for failure / disquiet. Working in a small speciality which centralised 10 or so years ago the benefits are huge for us		
115	no		
116	I find taking part in the survey stimulating and support the developments		
117	The assessments continually refer to the BAME and homeless community if Gloucester (some 32,000 quoted) as being a major criteria in deciding where the services will be located. There are over 600,000 people in Gloucestershire . Do you not think this is a case of ""the tail wagging the dog"" . I also believe that some of these changes are being brought in to cover up for poor management in the past. Surely better recruitment schemes and a decreased insistence on nurses being degree trained would improve day to day outcomes for most patients.		
118	Any improvements as to how patients are treated are welcome		
119	Have several times mentioned access by public transport. This is clearly not a clinical issue, but in the general context of availability of the best services for people reliant on public transport, it can make a huge difference. Facing cancer surgery and daily radiotherapy it was actually cheaper and easier for me to go to UCH in London than try to use buses and taxis from Stroud to Cheltenham. Yet Gloucester is easy and has been very good for other health needs		
120	Consider what minor injuries services etc could be made more easily available at GP surgeries. Even discounting the Covid effect, the GP is a bottleneck. Overall the treatment me and wife have received from CGH and GRH has been timely and very successful. Thanks to everyone.		
121	I am not a medic but my above preferences are based on the viability of CGH. Covid 19 has shown we need more hospitals without affecting ordinary services. GRH has better rail access but at times the hospital is overwhelmed. I do think that concentrating more services at GRH at the expense of CGH is a serious mistake. There must be equal allocation of services between GRH and CGH. CGH must be protected from closure. Cheltenham is a growing town and needs a viable hospital. so does Gloucestershire		
122	Any changes should be accompanied by improved information / communication to staff and public. Staff need to be aware of geography and travel difficulties for appointments to be as convenient as possible. Where as I believe a centre of excellence is essential - longer journeys for clients with children or frail adults will inevitably increase stress levels. With ambulances being tied up for longer transferring patients to the appropriate hospital. You speak of specialist doctors. Are experienced nurses willing to change work base from CGH to GRH		

Anything else you would like to say?

		Response Percent	Response Total
123	1) As someone whose wife died recently of cancer we found the oncology unit in Cheltenham an excellent facility. That is centralised not necessarily most conveniently to u living in Dursley area but very accessible. 2) Reduce waste by greater use of electronic mail and not sending out lots of letters. Sometimes 3 in same post. 3) We need to make greater use of excellent facilities in Dursley and Tetbury		
124	We are extremely fortunate to have two such good hospitals serving us.		
125	I find it really hard to comment sensibly since most the areas of medicine are not known to me or what is currently available. I don't feel competent.		
126	1. I was very concerned at the poor timing of this exercise. I received the 'Fit for the Future' flier in the post today (9/12/20) with consultation closing on 17/12/20. Although I was able to go online for some of the information there was insufficient time to get the 'Pre-consultation Business Case' and read it before the deadline.(Minimum 2 days for freepost card, 5 days including the weekend for a response, 3 days for parcel post and the deadline is past.) 2.		
127	Refreshing to see such an in depth review and consultation. How about integration of Social Services and the NHS next?		
128	As a moderately fit 90 yo, male living in the eastern part of the county, I have sadly needed a range of your services, and have been well served - but have often felt that health education and preventative measures and self help situations should be stronger, from cradle onwards, for the whole nation. Individually. How else can the nation and it Health Service survive the decades?		
129	Maybe it is my age? It took a long time to read and digest mentally the information in the Fit for the Future book. I would prefer excellence in all hospitals with adequate staff - well paid and well trained. It would seem that the changes are needed for inpatient care. However, small local hospitals like The Vale at Dursley are most needed for being specialists in maintaining health especially the elderly. Travelling 6 miles is much preferable than 26 miles especially if you cannot use a car!		
130	No. A future proof plan for reduced waiting times, reduced hospital stay, access to cutting edge skills and equipment along with optimal training of junior staff and attracting the best must be a positive move.		
131	Inappropriate and dangerous hospital discharges happen regularly, particularly at GRH. I hope these changes will help reduce these. Mental health support is very poor, particularly in GRH, I hope the cost and staff savings can be used to provide better mental health support for patients with mental ill health.		
132	No		
133	Having experienced such changes in Cornwall staff were concerned in the smaller hospital about their education, training and personal development Staff who were near retirement were sometimes sidelined out of the acute setting, consequently did not feel valued Recruitment difficulties occured Elderly population struggled with the changes on all site. Major review of signage was required and more volunteers needed to guide patients around the sites. Strong communication strategy required I am unaware of your IT strategy but would hope all hospital sites have equal access to current IT and future developments. Good luck		
134	Please look at improving the bus links ! The fact that you use a stagecoach bus for one part of your journey and a pullman for other part - is just not Cost effective for patients.		
135	Centres of excellence works if it is a proper complete split		
136	None		

Anything else you would like to say?

		Response Percent	Response Total
137	Many people have feared because of the changes and continue to do so. Many people see this as a move to shut or deminish CGH and don't want this because CGH is the hospital of their choice and is closer to home and family. GRH is a mess, one such example is the previous stroke specialist team... All resigned due to management the problems they had on the ward and the way it was run, when bullying is rampant on a ward and months of whistle blowing and datixing is met by scorn and inaction, nobody wants to see this happen in cheltenham as well		
138	It is essential that if a service is on one site then serious consideration is given to how patients are cared for on the 'other' site. Each specialty needs a plan that is put into action and monitored to ensure safety and quality. This is not something that I think the trust is very good at at the moment.		
139	From listening to the facebook consultation regarding IGIS limited capacity was mentioned, with the response space and wards would be facilitated for these moves, presently vascular services have moved temporarily to an area not ideal for patient needs, will this be properly addressed with this plan?		
140	Overall i agree with the proposals as specified in the consultation booklet 'Fit for the Future.'		
141	Key is to have confidence in our medics. My area of concern is- Communications. Followup (after discharge). Options/Expectations.		
142	Emergency lower/upper GI surgery need more space.		
143	I think you have spent too much on your glossy booklet - it could have been made simpler and cheaper - a poor use of resources		
144	The survey is difficult for non medics to comprehend. See points above.		
145	Why are there so many different names? It's only one NHS. Get Government to stop giving large wage rises to consultants but give better rises to nurses.		
146	More free car parking at GRH and CGH		
147	The shuttle bus between CGH and GRH is a great asset in relation to access to services. A commitment to its future would be good to hear. It would also be good to hear that discussions are being held to see whether the bus route could include a stop at Park and Ride at Cheltenham Racecourse. Decision makers should consider evaluation of services changes if implemented and the involvement of patients, carers and VCS in the evaluation.		
148	If would help if other bodies such as Glos Highways and bus companies could be persuaded to consider better road access and enhanced public transport facilities to reduce difficulties in trying to access two sites.		
149	It seems that the biggest effect on deliverability will be your staffing levels. Concentrating services to one site or other seems to make sense as you will not be spreading your staff too thinly		
150	I am sorry to say that I think more local people would be happier going to gloucester hospital if there were more staff to give better aftercare on the wards. Also staff need training on how to understand the needs of the elderly. Misunderstanding of being slightly deaf, confused in surroundings, stoma care being common problems I have seen.		
151	The consultation makes no reference to the impact on transport issues for staff and patient visitors. For instance establishing a specialist centre in Gloucester only is bound to necessitate greater staff movement from Cheltenham and vice versa. Is greater capacity on the bus service and/or for car parking required? The success of whatever strategy is adopted should not be only measured in clinical terms.		
152	Bring back Cheltenham A&E full-time and with full services as soon as Covid restrictions are lifted		
153	I have concerns about the length of waiting times for children's appointments as these are impacting on childhood development		

Anything else you would like to say?

		Response Percent	Response Total
154	We have had need to avail ourselves of Cardiac - pacemaker/heart valve and bypass Oncology - Thyroid cancers TIA Trauma - hips A&E Endoscopy Audio Other family members use the Cardiff/Newport hospitals where we assist them		
155	Improving continuity of care, reducing outliers and improving communication with families might be improved if a balance in activity across the hospitals is achieved		
156	The general concept must be welcomed. However P14 column and does not take account of the here and now. With regard to A&E going straight to a specialist ward doesn't happen due to bed shortages so this needs to be addressed. Also at a more strategic level these centres of excellence represent a staff gap. What is really needed is the construction of a brand new hospital like Southmead. Which would consolidate both Gloucester and Cheltenham. It would be all encompassing in location. Have new smaller wards if not private rooms and take account of the high demands from increases in population and ageing.		
157	1. On both sites the outpatients should be fully maned such that if an appointment is cancelled for what ever reason, the new appointment offered should be at the same site. 2. The A&E at CGH should be 24/7 with a doctor, such that if someone walks in late at night, then (assuming not needing a bed) they can be dealt with and avoiding them being referred to GRH without an examination. With the result that the person has to find their way to GRH whilst not knowing how bad their situation is. All ambulances 8pm - 8am still directed to GRH.		
158	I was treated for prostate cancer by open surgery in 2009 at CGH, my surgeon was Mr Sole, based in Hereford but twice a month he would operate at CGH. This was to ease the pressure on the Urology medical staff. Since my operation 11 years ago the department now has a robotic system. This type of equipment had been identified as an improvement for both the patients and the medical team, unfortunately, it could not be purchased immediately because of its high cost. If the two Gloucestershire hospitals are to be A Centre of Excellence then cost of equipment must not be a barrier to purchase. Only the best medical staff will be persuaded to work in CGH and GRH if we can provide the best equipment.		
159	Relatives need to be able to visit very ill patients at moment this will delay recovery.		
160	I am strongly opposed to downgrading one hospital over the other. They should have equal value and maintain safe staffing levels on both sites. It seems to me that there is a faction that wants to take away basic services from CGH, a hospital that has offered its services for over 200 years and highly valued to residents in and around it.		
161	Thank you for providing the public the opportunity to have our say on this important issue		
162	CGH A&E should be consultant led 24/7		
163	Issues with parking around Cheltenham General Hospital may cause issues for more rural communities and those not on regular bus schedules for Cheltenham's proposed day and elective role.		
164	This survey is part completed because we accidentally submitted the form when part way through the survey.		
165	If you centralise more long queue and parks, waste cancelled appointments staff on sick holidays etc. As more money was used in covid 19. We have to think weekly and keep NHS going for years to come. Electric chargers at hospital while wait for o/patient and visitors. Cars in come for hospital?		
166	No		
167	No		
168	I think consultation period is too shore and suggest extension for 3 month. Very few people are aware of the deadline on Dec 17 amid covid 'lockdowns' and tier 2 restrictions. I only happened on the documents by chance (and I've been a user of services this year and was health professional for approx 40 years).		
169	Do not ignore the publics opinion we have a right to choose where we have our care.		

Anything else you would like to say?

		Response Percent	Response Total
170	Keep up the good work. Will be interested in the result of survey. Any plans for head injuries, chest surgery - including cardiac or neurosurgery, so these still go to Bristol of John Radcliffe, Oxford. Guess if you live west of the M5 you want all in GRH, east of the M5 CGH. There are of course major incidents to remember where anything and everything can turn up.		
171	I know we all demand more from the NHS. However, sometimes the changes may seem rational but have a detrimental effect on local people in relation to access and other things. In a different area, when Fairford Hospital was closed, we were told it would lead to more efficient services. I am not sure that this is the case and I think it was a bad decision to remove care beds from the system, as it would have provided capacity to look after patients who needed care but not access to expensive equipment, freeing up beds in acute hospitals. I think it was a bad decision.		
172	It is, frankly, disgraceful that a consultation such as this one, which has had the resources of countless hours of input from selected sources within the organisations comprising 'One Gloucestershire' should be sent out for public 'consultation' in the middle of the greatest health crisis the country has seen for a century. The public have too much else on their minds at this time to be in a position to properly consider the issues that have been put before them. This is a massively cynical exercise designed to produce the answers that 'One Gloucestershire' have already decided on (ask any member of staff at Cheltenham General Hospital); sneaking the exercise in consultation at this time is almost certainly an abuse of process. And most egregious of all: the document purporting to be a 'plan' for the future of healthcare delivery in the county makes NO MENTION of pandemic planning. How can we be expected to take it seriously in the light of such a glaring omission?		
173	When making the final decision, ensure that you fully understand the models of care that have been proposed for general surgery because this consultation document does not accurately reflect what those working in the service have put forward. Trying to impose a service that 80% of the consultant body do not support will not augur well for its success.		
174	This feels like a token consultation. I do not know anyone outside of the medical sphere who has even heard of this.		
175	I don’t have any friends who have even heard of this exercise. Why hasn’t the questionnaire been sent to every household in the county?		
176	I recently had an operation in the QE2 hospital in Birmingham. Is it time Gloucestershire had a new state of the art campus hospital, part paid for by the valuable land (especially CGH) land the current hospitals stand on?		
177	Covid-19 as shown us that resourcing can come back to bite us		
178	I am also concerned about the management of GRH. I do not question the skills, competence or dedication of the staff at GRH. However, again from experience, I do not believe that the management of the hospital is as good as it should be. I support GRH and CGH being in one trust, but I do wonder if a different management structure is needed within that trust so that greater emphasis is placed on delivering the services which patients are entitled to expect. I feel that as part of the management structure there should be someone in place who is responsible for ensuring that liaison with patients and their families is far better than it currently is. I think there is a case across Gloucestershire to be made for one trust to cover all health services – primary care, community hospitals, acute trusts, social and after care etc – and believe that this should be explored. I think this would have the potential to reduce costs and improve co-ordination of services. We have seen during the Covid crisis the inability of the acute hospitals to move sufficient numbers of patients out into care homes, community hospitals and into their own homes with support packages in place, and I think one management of all the services, with the appropriate structures within that trust, should be considered. I realise that the above would challenge the CCG arrangements, but again I feel that being part of one service might help coordination. For example, I believe that many more patients could be treated at primary care level than is currently the case, thus relieving the pressure on hospitals. Much greater use should be made of pharmacies.		

Anything else you would like to say?

		Response Percent	Response Total
179	The publics primary concern about the reconfiguration of specialist services within the hospital relate to the convenience and accessibility of services and the long term sustainability of a Type 1 A&E Department in Cheltenham. Of some of these proposals are implemented it is difficult to see how a full Type 1 A&E Department would be sustainable in the long term. This is despite the reassurances the Hospital Trust has repeatedly been given. It is these proposals which have undermined staff and public confidence in the Hospital Trust's sincerity over the re-opening of Cheltenham A&E and its long term future.		
180	See above please re-think before its too late		
181	When I was in hospital following the trauma to my ankle I felt well looked after by some of the nurses on shift, especially the ""day"" nurses. I was shocked however by a ""night nurse on the night shift asked me if I could hop!!! to the toilet rather than waste her time with her getting me a walking aid - remember this was when my leg was still in a very heavy plaster cast and I'd only just had the operation on my ankle that day - I was weak and very much in pain and certainly wouldn't be able to HOP to the damn toilet!! I couldn't believe my ears when she asked me that and that she almost seemed put out that i was in need of her assistance as the night nurse on shift. I was in hospital for two weeks but it was hoped and suggested by some junior doctors and at least one consultant that I leave after my first week. I was no where near ready to leave hospital after one week. I was still in tremendous pain and still had a heavy plaster cast on which considering my living situation at home was not at all ideal for supporting me with this current disability. I was discharged after two weeks after my insistence that I stay for longer. I still feel I was discharged too early. My date to get my plaster cast removed was ill-scheduled and I was lumbered with dragging a heavy, itchy and uncomfortable cast around for about four weeks when it should have been two weeks after my operation that the temporary cast removed and a lighter more comfortable one put on. I requested transport to the hospital by ambulance which was denied so after getting a taxi half of the way still had to make my way through the grounds and the various corridors to get the appropriate place. I very much feel I was left unsupported during my out patient recovery, especially during the time I was discharged and waiting for my new and lighter cast. The stress and anxiety was very detrimental to my fragile mental health. I suffer with anxiety and depression and undiagnosed and untreated OCD and complex PTSD all of which compounds to instable moods and frequent mental breakdowns. I do manage my mental health with medication and receive mental health support. I just wish my treatment as outpatient in aftercare was better monitored by professionals and I was better assisted and supported. I feel the COVID19 situation is part to blame for the seemingly hurrying of me out of the hospital and the quick discharge out of my own private room at the hospital where I have to say, I would have recovered better and faster perhaps rather than being herded onto an open ward where I was constantly disturbed by other patients and nursing staff. If I hadn't come into hospital during the corona virus pandemic I do believe my stay would have been far more pleasant and i wouldn't have struggled as much as i did with anxiety that i was using up vital bed space. I feel i should have stayed recovering in hospital for longer than i ended up staying.		
182	Quick and easy access is essential when you are ill. There is a much larger older population in North Cotswolds. Moreton in Marsh hospital is not included in this survey. So is a modern hospital intended to serve the North of the county yet when ever I or friends have visited it is empty. Why is this expensive new building not being used?		
183	no		
184	I used to work for the department of health. The fashion for building new hospitals would alternate between big is beautiful and small is beautiful on a 10 year cycle. The result was that all current buildings was out of step with prevailing thinking. Health trusts need to resolve this conundrum and ensure a successful balance between specialist and locally delivered hospital based options.		
185	Addition of trainee nurses and other healthcare professions in specialities means you can retain them more easily and get more money!		
186	Great believer in logic		
187	seems like GRH has a more specialist focus under one roof - will this lead to overcrowding, parking issues, less quality face to face time with staff / professionals		
		answered	187
		skipped	437

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

		Response Percent	Response Total
1	Open-Ended Question	100.00%	426

1	GL54
2	gl2
3	Gl4
4	Gl3
5	GL52
6	gl53
7	GL4
8	GL51
9	GL52
10	gL50
11	GL1
12	GL1
13	GL3
14	GL53
15	GL50
16	GL4
17	GL52
18	GL6
19	WR14
20	GL52
21	gl1
22	Gl51
23	GL4
24	GL50
25	GL4
26	GL53
27	Gl5
28	GL5
29	GL14
30	GL52
31	GL51
32	Gl1
33	GL4
34	GL4

What is the first part of your postcode? eg. GL1, GL20			
		Response Percent	Response Total
35	GL4		
36	GL52		
37	GL53		
38	GL10		
39	Gl52		
40	Gl51		
41	GL13		
42	Gl15		
43	GL6		
44	GL2		
45	GL53		
46	GL52		
47	GL52		
48	GL53		
49	gl52		
50	GL4		
51	Gl2		
52	WR11		
53	gl51		
54	GL53		
55	GL2		
56	GL52		
57	gl51		
58	gl51		
59	gl2		
60	GL1		
61	wr12		
62	gl3		
63	gl53		
64	GL51		
65	gl20		
66	GL7		
67	GL16		
68	wR11		
69	GL52		

What is the first part of your postcode? eg. GL1, GL20			
		Response Percent	Response Total
	70	Gl2	
	71	GL2	
	72	Gl4	
	73	Gl52	
	74	GL52	
	75	GL2	
	76	GL2	
	77	GL52	
	78	GL6	
	79	gl14	
	80	GL2	
	81	GL3	
	82	GL54	
	83	GL20	
	84	GL7	
	85	Gl52	
	86	GL53	
	87	GL7	
	88	gl51	
	89	GL50	
	90	Gl16	
	91	GL7	
	92	GL7	
	93	GL13	
	94	gl51	
	95	GL54	
	96	GL 54	
	97	GL51	
	98	Gl50	
	99	Gl2	
	100	Gl20	
	101	GL5	
	102	Gl51	
	103	GL50	
	104	GL7	

What is the first part of your postcode? eg. GL1, GL20			
		Response Percent	Response Total
105	GL1		
106	gl1		
107	Gl50		
108	Gl50		
109	GL5		
110	GL5		
111	gl5		
112	gl1		
113	GL4		
114	GL53		
115	GL		
116	GL5		
117	GL2		
118	OX18		
119	GL51		
120	SN2		
121	GL7		
122	gl4		
123	GL3		
124	GL53		
125	GL51		
126	GL18		
127	GL53		
128	GL51		
129	GL2		
130	GL4		
131	GL2		
132	GL5		
133	GL3		
134	GL52		
135	Gl14		
136	GL2		
137	GL53		
138	GL52		
139	GL3		

What is the first part of your postcode? eg. GL1, GL20			
		Response Percent	Response Total
140	GL53		
141	gl52		
142	SN6		
143	GL19		
144	GL19		
145	GL19		
146	GL19		
147	GL51		
148	GL17		
149	OX18		
150	GL52		
151	GL53		
152	GL1		
153	Gl51		
154	GL51		
155	GL50		
156	GL2		
157	GL54		
158	GL53		
159	CV36		
160	GL52		
161	GL5		
162	GL7		
163	gl52		
164	GL3		
165	gl1		
166	GL54		
167	GL18		
168	GL16		
169	GL13		
170	GL52		
171	GL11		
172	GL12		
173	GL53		
174	GL2		

What is the first part of your postcode? eg. GL1, GL20			
		Response Percent	Response Total
	175	Gl53	
	176	GL52	
	177	GL52	
	178	GL52	
	179	GL6	
	180	GL20	
	181	GL8	
	182	GL16	
	183	GL52	
	184	GL53	
	185	GL52	
	186	GL6	
	187	GL6	
	188	Gl5	
	189	GL5	
	190	GL54	
	191	GL54	
	192	GL2	
	193	gl2	
	194	GL54	
	195	GL51	
	196	Gl14	
	197	GL19	
	198	Gl53	
	199	GL3	
	200	GL5	
	201	GL52	
	202	GL7	
	203	GL6	
	204	gl5	
	205	gl51	
	206	GL3	
	207	GL1	
	208	GL10	
	209	GL52	

What is the first part of your postcode? eg. GL1, GL20		Response Percent	Response Total
210	gl5		
211	GL6		
212	GL5		
213	Gl51		
214	GL53		
215	GL56		
216	GL3		
217	GL53		
218	GL20		
219	Gl52		
220	GL6		
221	GL52		
222	GL7		
223	Gl6		
224	GL51		
225	GL4		
226	GL5		
227	GL7		
228	GL7		
229	GL8		
230	GL53		
231	GL3		
232	GL54		
233	GL53		
234	GL7		
235	GL3		
236	GL18		
237	GL18		
238	Gl7		
239	GL54		
240	gl15		
241	GL19		
242	GL52		
243	GL2		
244	GL51		

What is the first part of your postcode? eg. GL1, GL20			
		Response Percent	Response Total
245	GL50		
246	GL52		
247	GL18		
248	gl53		
249	GL7		
250	GL54		
251	GL		
252	GL53		
253	GL18		
254	GL53		
255	GL7		
256	GL52		
257	GL56		
258	GL5		
259	gl50		
260	GL15		
261	GL50		
262	GL15		
263	GL19		
264	GL20		
265	GL19		
266	GL19		
267	GL19		
268	GL19		
269	GL5		
270	gl51		
271	GL52		
272	GL4		
273	GL4		
274	GL52		
275	GL18		
276	GL51		
277	Gl51		
278	GL53		
279	GL14		

What is the first part of your postcode? eg. GL1, GL20			
		Response Percent	Response Total
280	GL52		
281	GL52		
282	GL53		
283	GL53		
284	gl3		
285	GL53		
286	GL53		
287	GL50		
288	gl1		
289	gl15		
290	GL7		
291	GL6		
292	GL51		
293	GL1		
294	GL5		
295	GL15		
296	GL13		
297	GL52		
298	GL5		
299	GL54		
300	GL17		
301	GL17		
302	GL52		
303	GL54		
304	GL11		
305	GL1		
306	Gl51		
307	GL14		
308	Gl4		
309	GL53		
310	GL52		
311	gl3		
312	GL6		
313	GL11		
314	GL54		

What is the first part of your postcode? eg. GL1, GL20			
		Response Percent	Response Total
315	GL12		
316	GL56		
317	GL56		
318	GL2		
319	GL15		
320	NP16		
321	gl2		
322	GL52		
323	gl50		
324	Gl53		
325	GL1		
326	GL53		
327	GL53		
328	GL52		
329	GL14		
330	Gl3		
331	GL13		
332	Gl5		
333	GL53		
334	GL53		
335	GL16		
336	GL53		
337	GL15		
338	GL52		
339	GL53		
340	GL20		
341	WR11		
342	Gl2		
343	GL51		
344	GL7		
345	GL55		
346	GL53		
347	GL8		
348	GL3		
349	GL20		

What is the first part of your postcode? eg. GL1, GL20			
		Response Percent	Response Total
	350	GL16	
	351	GL3	
	352	GL20	
	353	GL5	
	354	GL54	
	355	GL3	
	356	GL6	
	357	GL53	
	358	GL50	
	359	Gl19	
	360	GL50	
	361	Gl51	
	362	GL12	
	363	GL53	
	364	gl51	
	365	Gl20	
	366	GL16	
	367	GL52	
	368	GL51	
	369	GL52	
	370	GL3	
	371	GL4	
	372	GL6	
	373	GL53	
	374	GL1	
	375	GL8	
	376	GL20	
	377	GL5	
	378	HR9	
	379	GL3	
	380	GL52	
	381	GL2	
	382	GL51	
	383	GL19	
	384	GL52	

What is the first part of your postcode? eg. GL1, GL20			
		Response Percent	Response Total
	385	GL7	
	386	GL14	
	387	GL4	
	388	GL2	
	389	GL7	
	390	GL11	
	391	GL3	
	392	GL6	
	393	GL53	
	394	GL15	
	395	GL20	
	396	GL11	
	397	GL53	
	398	GL7	
	399	GL54	
	400	GL7	
	401	Gl53	
	402	GL53	
	403	GL54	
	404	GL6	
	405	gl50	
	406	GL20	
	407	GL50	
	408	GL52	
	409	GL16	
	410	GL1	
	411	GL50	
	412	GL52	
	413	GL54	
	414	GL50	
	415	GL2	
	416	NP16	
	417	GL51	
	418	GL56	
	419	GL3	

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

		Response Percent	Response Total
420	GL50		
421	GL50		
422	GL5		
423	GL7		
424	GL1		
425	GL1		
426	GL4		
		answered	426
		skipped	198

Which age group are you:

			Response Percent	Response Total
1	Under 18		1.65%	8
2	18-25		2.06%	10
3	26-35		10.91%	53
4	36-45		12.35%	60
5	46-55		18.72%	91
6	56-65		22.22%	108
7	66-75		18.93%	92
8	Over 75		11.32%	55
9	Prefer not to say		1.85%	9
			answered	486
			skipped	138

Are you:				
			Response Percent	Response Total
1	A health or social care professional		29.57%	144
2	A community partner		1.64%	8
3	A member of the public		62.63%	305
4	Prefer not to say		6.16%	30
			answered	487
			skipped	137

Do you consider yourself to have a disability? (Tick all that apply)				
			Response Percent	Response Total
1	No		72.16%	350
2	Mental health problem		4.54%	22
3	Visual Impairment		2.89%	14
4	Learning difficulties		0.41%	2
5	Hearing impairment		5.36%	26
6	Long term condition		17.32%	84
7	Physical disability		4.74%	23
8	Prefer not to say		3.09%	15
			answered	485
			skipped	139

Do you look after, or give any help or support to family members, friends, neighbours or others because of either a long term physical or mental ill health need or problems related to old age? Please do not count anything you do as part of your paid employment.				
			Response Percent	Response Total
1	Yes		28.30%	135
2	No		67.51%	322
3	Prefer not to say		4.19%	20
			answered	477
			skipped	147

Which best describes your ethnicity?

		Response Percent	Response Total
1	White British	84.71%	410
2	White Other	3.72%	18
3	Asian or Asian British	2.48%	12
4	Black or Black British	0.62%	3
5	Chinese	0.00%	0
6	Mixed	0.62%	3
7	Prefer not to say	7.23%	35
8	Other (please specify):	0.62%	3
		answered	484
		skipped	140

Other (please specify): (3)

1	Why is this relevant to the survey
2	European
3	White English

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

		Response Percent	Response Total
1	No religion	39.38%	191
2	Buddhist	0.41%	2
3	Christian (including Church of England, Catholic, Methodist and other denominations)	47.84%	232
4	Hindu	0.41%	2
5	Jewish	0.62%	3
6	Muslim	1.65%	8
7	Sikh	0.00%	0
8	Other	1.44%	7
9	Prefer not to say	8.25%	40
		answered	485
		skipped	139

Are you:

		Response Percent	Response Total
1	Male	38.76%	188
2	Female	54.64%	265
3	Transgender	0.21%	1
4	Prefer not to say	6.39%	31
		answered	485
		skipped	139

Do you identify with your gender as registered at birth?

		Response Percent	Response Total
1	Yes	93.81%	455
2	No	0.00%	0
3	Prefer not to say	6.19%	30
		answered	485
		skipped	139

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

		Response Percent	Response Total
1	Heterosexual or straight	86.21%	419
2	Gay or lesbian	1.85%	9
3	Bisexual	1.65%	8
4	Other	0.21%	1
5	Prefer not to say	10.08%	49
		answered	486
		skipped	138

Are you currently pregnant or have given birth in the last year?				
			Response Percent	Response Total
1	Yes		1.46%	7
2	No		68.75%	330
3	Not applicable		24.17%	116
4	Prefer not to say		5.63%	27
			answered	480
			skipped	144

Fit for the Future Survey (Easy Read)

What do you think about having the service for Acute Medicine (Acute Medical Take) at Gloucestershire Royal Hospital? Acute medicine is treatment and assessment for things like very bad headaches, chest pain, pneumonia or asthma

			Response Percent	Response Total
1	Good idea		72.09%	62
2	Bad idea		18.60%	16
3	Not sure		9.30%	8
			answered	86
			skipped	3

What do you think about having the service for Emergency General Surgery at Gloucestershire Royal Hospital? These are emergency operations on the gut which is where you digest food

			Response Percent	Response Total
1	Good idea		66.67%	58
2	Bad idea		22.99%	20
3	Not sure		10.34%	9
			answered	87
			skipped	2

Do you want to tell us anything else about these ideas?

		Response Percent	Response Total
1	Open-Ended Question	100.00%	36

1	As long as the waiting lists are addressed quickly, and moving it to one area doesn't pro- long the waiting lists.
2	a center of excellence
3	A large proportion of patients show up in A&E with late stage conditions that have not been picked up by the local GP or because GPs have been reluctant to refer for asymptomatic claims because of the patient's lack of understanding about their own symptoms. Assessing and progressing faster on better planned procedures will improve the success rate of these operations
4	Improve staff recruitment & retention
5	I could not answer the questions because I do not know if these are additional services i.e. we do not have them now, or if they are being moved from somewhere else i.e.Cheltenham General. This information is needed to enable an informed decision.
6	Emergency general surgery should be at the nearest point if need and therefore the service should LAO be available at Cheltenham General .
7	The population is increasing at a fast rate with more homes to be built. The Forests covers a large rural area. We need these facilities locally

Do you want to tell us anything else about these ideas?

		Response Percent	Response Total
8	Making patient travel further than their local hospitals in general not a great idea for emergency care		
9	If something is acute or emergency -surely time is a critical factor; so by having this centralised how do you plan to ensure a patient living further away form the centralised gets to hospital quickly. have you found a critical time frame linked to outcomes? Does one location ensure all patients can be treated within this timeframe		
10	It makes sense on balance, because centralising services for safer care, and more cost-effective provision, is essential. Worried about the difficulty getting to Gloucester site from North Cotswolds. It is not helpful to say it is only 8 miles from Cheltenham to Gloucester. There is a bus infrequently from parts of the North Cotswolds to Cheltenham, however there is no easy connection to Gloucester. Have to walk between bus stops for example. Have to get to Moreton or Bourton in first place, then find parking if driving to catch the bus. All difficult to do. Trying to visit a family member in an emergency situation is really difficult. This is a legitimate concern. A frequent free minibus between the 2 sites could help both staff and hospital users, and overcome these concerns largely. Please do take this suggestion seriously and not dismiss as too expensive.		
11	If you are removing these services from Cheltenham this is a bad idea		
12	I understand & support the principle of centres of excellence and, although preferring that Cheltenham could provide these capabilities for all patients in this part of the county, assume that Gloucester Royal is better set up for this COE.		
13	Good idea but feel you should still have treatment for the more minor elements of this and Gloucester to focus on the more serious cases.		
14	There needs to be suggestions of where else you would put it. I think Gloucester is over run and maybe Victoria doc's could host. Are you planning on becoming a specialist hospital or continuing with general?		
15	I think that for emergency surgery there should be a facility at both Gloucester and Cheltenham		
16	I will always be guided by what the experts say. Obviously living where I do Gloucester and Cheltenham are equally accessible		
17	The royal hospital and Cheltenham gen to be funded independently. So keep the status quo		
18	Should be done at both hospitals to avoid unnecessary travel.		
19	To many services going to GRH. Will you be able to cope?		
20	For emergency general surgery in Cheltenham please, Because near my home. If I goes to Gloucestershire Royal Hospital. I will have to goes in taxi		
21	I may be biased as I live in Gloucester		
22	I can see the benefits of having these centralised units, but from a patients point of view getting to and from some hospital can be a problem and deterrent.		
23	As I don't drive GRH is best for me.		
24	In an emergency Gloucester is too far away.		
25	good to have specialists in one hospital so the best appropriate care can be given		
26	I was hovering over the 'not sure', but I suppose if a hospital can resource these services efficiently, then why not?		
27	2 hospital for to be maintain more people living.		
28	no		
29	As we have two hospitals why not use both. Older people without own transport will have to use public transport and not knowing how many years covid 19 will last mixing as little as possible on buses is essential.		

Do you want to tell us anything else about these ideas?

		Response Percent	Response Total
30	Keep all General Surgery for the gut in the same place must help with staffing and skills being utilized efficiently.		
31	It is always preferable to have a focus or Centre of Excellence for any major activity and Healthcare is a prime candidate for this. A centre of excellence should have the same equipment and staff as split facilities - this means that the same number of cases can be dealt with. A centre of excellence should not just be about cost saving - it should deliver the same results as split facilities.		
32	Both hospitals have patients that have to travel distances, not everyone lives in the town or city. By concentrating services in one hospital it will make travel a lot worse for some patients and their relatives.		
33	Specialist Drs and nurses in one hospital, it has to be the best care to receive, best care, in one place.		
34	Cheltenham is easier to get to		
35	GRH is too far away from this side of the county		
36	It is to be hoped that if good recoveries are made that patients could be transferred back to a hospital / care facility near to home and family		
		answered	36
		skipped	53

What do you think about having the planned Lower GI (Colorectal) General Surgery in one hospital? These are planned, not emergency, operations on the lower part of the gut.

		Response Percent	Response Total
1	Good idea	72.84%	59
2	Bad idea	14.81%	12
3	Not sure	12.35%	10
		answered	81
		skipped	8

Where do you think we should do planned Lower GI (Colorectal) General Surgery? These are planned, not emergency, operations on the lower part of the gut.

		Response Percent	Response Total
1	Cheltenham General Hospital	27.50%	22
2	Gloucestershire Royal Hospital	27.50%	22
3	Don't mind	45.00%	36
		answered	80
		skipped	9

Can you say why this is your choice?

		Response Percent	Response Total
1	Open-Ended Question	100.00%	49

1	As long as the waiting lists are addressed quickly, and moving it to one area doesn't pro- long the waiting lists.
2	GRH is much better suited for colorectal surgery
3	More modern hospital, better infrastructure and access to general public as well as better geographically positioned. GRH is also cruelly lacking surgery infrastructure and theaters and it could be a good investment to de cluster CRH
4	I think making Cheltenham a specialist unit for elective surgery will improve patient care. Having a specialist Nursing team dedicated to elective enhanced care will improve the patient experience with no disturbances by emergency admission in a calm environment. This will improve length of stays. The intensive care will have dedicated to elective care and not be taken up by emergency admissions.
5	Because it will be collocated with Gynae oncology and Urology.
6	All experts together
7	Centralising services should make them better albeit more difficult for some patients/visitors to get to.
8	Cheltenham General Hospital should be a specialist centre, not closed or become a cold hospital
9	Depends on how common is the need for this surgery per population. if its relatively more common and routine then it should be available at both places. If not then it should be at the same hospital as the Upper GI.
10	This questions is fixed in that you have to opt for one of the limited choice to gain access to the box and I want that noted please. Why cannot minor surgery be done locally and other cases go to the closest hospital i.e. Gloucester.Those living on the far side of the Forest have a huge trek to get to Cheltenham
11	Good idea to have planned surgery in one location if this brings greater expertise, reduces waiting times by better planning and saves costs; however I am sure many people's response will be based on proximity to their own location
12	Because the general idea is to have emergency procedures at Gloucester site and the planned procedures largely at Cheltenham. If there is some benefit from having Upper GI and Lower GI amalgamated on one site, then perhaps my answer should be different. But I haven't been told that is the case. Perhaps there is more benefits in having lower GI surgery where diagnostics, chronic care eg dietetics, outpatient facilities, oncology and other associated consultations may take place is helpful to the patient as they become familiar with a single site.
13	if its a planned operation I dont mind where it is as long as its leading care
14	Needs to be at both hospitals could be controlled and led by the same team
15	Cheltenham is well established for this requirement and I have been very happy with my experiences as a past colorectal & hernia patient
16	I say GRH because I am from Gloucester but my main concern with all these proposals to centralise care for certain areas on one hospital is the travel arrangements to get there and availability of parking. To be honest I would like to see Gloucestershire get a brand new state of the art hospital somewhere like the Staverton Airport site (with that being moved to kemble) a pipe dream I know, but that would give room for expansion of the hospital, plenty of room for parking provision. Be central to the county with good road access, and remove the risk to GCHQ being in the flight path of an airport.
17	Keep more major items at Gloucester but still have minor facilities at Cheltenham and perhaps other local hospitals
18	Given where I live, it is an easier hospital to access.
19	I think lower GI and upper GI planned operations should be done at the same hospital. either Cheltenham or Gloucester
20	I think it would be better to have all GI surgery in one place
21	I don't see an advantage in having this in one hospital over the other

Can you say why this is your choice?

		Response Percent	Response Total
22	Gloucester nearer for FOD residents		
23	Both. Gloucestershire is a huge county so by sharing the ops it will reduce pressure on both of them		
24	I will always be guided by what the experts say. Obviously living where I do Gloucester and Cheltenham are equally accessible		
25	I live in the Cheltenham catchment		
26	I believe (it is my assumption!) that GRH is better equipped and has more modern facilities for such operations.		
27	They already have the skills in place. I am an ex patient!		
28	Easy to get to by bus		
29	Because nearly my home		
30	There is a regular bus service from GRH to Cheltenham hospital		
31	Local		
32	As this is planned surgery the distance is not as much of an issue		
33	keep all GI surgery on one site		
34	Wherever you have the resource and professionalism to cover these operations		
35	Not knowing abut the numbers involved leaves me non committal		
36	Central to county re travel miles/parking		
37	If there could be benefits from having both this service being on the same site as Planned Upper GI and Emergency General Surgery it seems sensible to go for this option		
38	Nearer		
39	BOTH. Public transport to Glos and Chelt have planned pick up points at both hospitals so why not use both hospitals.		
40	All skills and staff associated with GI would be better in one place to assist efficiency.		
41	This should be delivered where there is sufficient space and infrastructure.		
42	By splitting this over two sites, there is more possibility that there will be extra room when needed		
43	I'd like to see available in more than one hospital		
44	I think make th current pilot permanent. Drs and nurses can focus on their special areas.		
45	I believe your planned suggestions are sound		
46	Nearer		
47	not so far away from this area and not so difficult to navigate and easier for duty visits.		
48	I have a car as does my partner. I can get to either hospital		
49	Because its nearer to where I live. The Forest of Dean Coleford		
		answered	49
		skipped	40

What do you think about having the service for General Surgery Day Cases (Upper and Lower GI) at Cheltenham General Hospital? These are operations on the gut which is where you digest your food. People have their operation and go home the same day.				
			Response Percent	Response Total
1	Good idea		67.47%	56
2	Bad idea		13.25%	11
3	Not sure		19.28%	16
			answered	83
			skipped	6

What do you think about having a 24 hour 7 days a week IGIS Hub at Gloucestershire Royal Hospital and an IGIS Spoke at Cheltenham General Hospital? A Hub is the main place something happens, and a Spoke is linked to the Hub. IGIS is Image-guided Interventional Surgery. This is where cameras are used inside the body so the surgeon can see what is going on.				
			Response Percent	Response Total
1	Good idea		76.54%	62
2	Bad idea		9.88%	8
3	Not sure		13.58%	11
			answered	81
			skipped	8

What do you think about having the Vascular Surgery at Gloucestershire Royal Hospital? Vascular is about blood vessels				
			Response Percent	Response Total
1	Good idea		68.35%	54
2	Bad idea		15.19%	12
3	Not sure		17.72%	14
			answered	79
			skipped	10

Do you want to tell us anything else about these ideas?

		Response Percent	Response Total
1	Open-Ended Question	103.23%	32

1	As long as the waiting lists are addressed quickly, and moving it to one area doesn't pro- long the waiting lists.
2	Cheltenham hospital is much better suited for vascular surgery. It has bespoke theatres. Etc. Grh is already flooded with other emergency specialties I think Cheltenham should be the hub for vascular
3	GRH, although a major hub for specialist consultations is completely under equipped for cardiology procedure which have to be carried out in emergency and therefore leaving loads of neighbouring patients to be either directed to Bristol, Oxford or the completely saturated WRH. Is so doing we would help conditions like stroke, ischaemia and other related cardiovascular emergency to prevent from worsening during transfers
4	Do we have it anywhere at present? If so where and if not at GRH why are we moving it there? Again, not enough information is given to enable an informed decision.
5	Depends on ow common/frequent is the need for Vascular Surgery in the population. if it is relatively more common then having this expert service at one hospital may choke the service due to other factors, eg demography, and lead to longer waiting times.
6	Why not have minor surgery locally and anything else at the next closest hospital
7	Vascular surgery has important links to other specialties and other comorbidities. Is there scope for connection with interventional radiology and computer assisted remote surgery and with specialist diagnostic tech? What developments are on the longer term horizon eg 10 years and are these plans future proofing adequately?
8	As before you can put the control and lead where you like but the operations should take place at both units
9	I am assuming that Gloucester is better set up as a COE
10	I am assuming that Gloucester is better set up as a COE
11	As previous comment really. I worry about how to get to Cheltenham general Hospital and whether there is anywhere nearby to park safely.
12	Good idea but still have minor surgery at smaller local hospitals.
13	It seems sensible to have the specialist care in one place for any given surgical/medical need.
14	Good idea to have expertise at both hospitals
15	What helps the service be the best
16	Why Don, t we have. Statistics to back up the idea.
17	Should be done at Cheltenham too.
18	You need a balance. Share the workload between both sites.
19	I don't mind either as I can drive to either or get the bus
20	have speciality on one site - one combined hospital site at for instance at Elbridge Court would serve the county and have better road links for the whole county.
21	No
22	GRH is central to county for FOD
23	Covid 19 is going around for some time so hospital must be maintain at this moment, Glos, Chelt, Dilke, Lydney until the situation changes for a while.
24	No
25	As I live in Gloucester and thought this a good idea I would consider myself very selfish
26	Unless urgent cases could be dealt with at Chelt.
27	Centre of excellence again - focus should be on one world class facility which is fully equipped and staffed.

Do you want to tell us anything else about these ideas?

		Response Percent	Response Total
28	Difficulty in travel to the hospital for visiting so bad for patients morale if they cannot have visitors. Not everyone has a car or wants to drive in Gloucester		
29	It would be good to have a 24/7 IGIS one hub in Gloucestershire, as well as an IGIS spoke at CGH. Specialist treatment and a centre of excellence.		
30	Cheltenham is closer I trust the consultants there. Problems always occur with records not being transferrable.		
31	In this part of Gloucestershire, Gloucester Royal has a bad reputation!		
32	I had an artery in my right thigh cut and Gloster hospital repaired it amicably for me.		
		answered	31
		skipped	58

What do you think about us carrying on doing Gastroenterology at Cheltenham General Hospital after the pilot? Gastroenterology is where tests or treatment are needed for the stomach, bowel, liver and pancreas for things like Crohns Disease and stomach ulcers

		Response Percent	Response Total
1	Good idea	68.35%	54
2	Bad idea	10.13%	8
3	Not sure	21.52%	17
		answered	79
		skipped	10

What do you think about us carrying on doing Trauma Surgery at Gloucestershire Royal Hospital after the pilot? Trauma Surgery is where people need operations after they have been injured in an accident.

		Response Percent	Response Total
1	Good idea	70.51%	55
2	Bad idea	12.82%	10
3	Not sure	16.67%	13
		answered	78
		skipped	11

What do you think about us carrying on doing Planned Orthopaedics at Cheltenham General Hospital after the pilot? Planned Orthopaedics are operations for things like hip replacements and knee surgery.

		Response Percent	Response Total
1	Good idea	73.08%	57
2	Bad idea	14.10%	11
3	Not sure	12.82%	10
		answered	78
		skipped	11

Do you want to tell us anything else about these ideas?

		Response Percent	Response Total
1	Open-Ended Question	100.00%	36

1	As long as the waiting lists are addressed quickly, and moving it to one area doesn't pro- long the waiting lists.
2	I feel that the elective orthopaedic waiting lists appear to be very large when you are the pt awaiting the surgery, I think that elective surgeries should be done on both sites to reduce the waiting time
3	Too many patients are on waiting lists for orthopaedic surgery and that would help the process
4	Because they will become 'centres of excellence' which are, by definition a good thing.
5	all experts together
6	Not enough information is given about the current location of these services is given to enable me to make a decision I am comfortable with!
7	if Trauma Surgery is deemed to be unplanned emergency service then this should be available at both hospitals
8	Cheltenham is too far away from the Forest. Why , with a new hospital, cannot these cases be handled locally
9	I am slightly confused about planned treatment being in one space and emergency type treatment in another, surely to increase experience and specialism all similar services should be in one place. What impact odes this have on follow up appointments do people have treatment after an accident in one hospital and then follow up in another with another team - This does not work well from a patient perspective as no continuity of care
10	Is there a disconnect for people following trauma eg attend A&E but then have follow up trauma clinic presumably at cheltenham? Again my point about the essential need for a minibus link between the two hospital campuses.
11	the key thing for me is having a facility nearby glos is over a hour from my home in forest of dean and cheltenham even further its very difficult to get there in rush hour if a family member had trauma its a long way to go the key thing for me is excellent treatment as near as possible to my home
12	It appears to me that you want to shut the services at one hospital and not the other. Bigger is not better. It is more complicated than that and for the people who are the patients more travel would be involved and you could argue it is not reducing your carbon footprint.

Do you want to tell us anything else about these ideas?

		Response Percent	Response Total
13	I have answered bad idea for Trauma surgery at Gloucester purely because I feel very strongly that we must maintain a full 24 x 7 A&E at Cheltenham to cover people in this town and towns / villages closer to Cheltenham than Gloucester. I would be less concerned if the subsequent 20 minute journey to Gloucester for follow up ""emergency"" treatment did not adversely affect patients requiring such treatment.		
14	For me personally I would have trouble getting there. It is expensive by taxi and out of the question by bus		
15	Routine operations and treatment to stay at local hospitals - but a dedicated center for more serious or complex treatment is a good idea.		
16	As long as the right staff and facilities are in place for each specialism, and there is accessible parking, then it is good to have concentrations in either hub or spoke hospitals.		
17	Sorry it is just that I don't like or trust Cheltenham Hospital personnel		
18	If the trial has worked well then I believe this should continue		
19	Living in the FOD Cheltenham is quite difficult to get unless you have transport		
20	Sensible approach		
21	I have my treatment in Cheltenham. Crohns. Very satisfied		
22	Gloucester is the city and needs to have Trauma surgery at GRH		
23	You know where you've got the resource and expertise and must have access to stats on frequency, so wherever safe and staffed to do so is ok with me.		
24	Seems like a good idea to have specific place for specific problems		
25	Again central to county		
26	A long way to go for A&E FOD Cotswold. 2 A&E Dept Glos and Chelt		
27	No		
28	Carry on with this service [Trauma Surgery] as now at Gloucester but open Chelt Hospital for same service.		
29	Difficulty in travel must always be a consideration for patients and relatives and by concentrating a one hospital makes this worse for someone. Also space in one hospital only may be limited		
30	I understand why you want the experts in one place but i feel that it downgrades Cheltenham hospital in the years to come especially casualty department.		
31	should be available as widely as possible		
32	Keep trauma at GRH, majority planned orthopaedics at CGH, make the current pilot permanent		
33	Keep all treatments local to help the aging		
34	If it works and there are positive outcomes, go for it		
35	Trauma should be in both hospitals		
36	I had a RTC in 1982 where my injuries were multiple fractures to right femur, head trauma where I was in a coma for months		
		answered	36
		skipped	53

Can you say if you think any of these ideas will be better for you and your family, or worse?			
		Response Percent	Response Total
1	Open-Ended Question	100.00%	48
	1 I think they will be better for my family as we will get better care		
	2 I think it is better because if I need specialist care I won't need to travel to other places.		
	3 We live in Cheltenham and consider Cheltenham General the best hospital in the area.		
	4 I believe we are fortunate to have 2 large hospitals in Gloucestershire. As long as waiting list start to be properly addressed and routine operations can be addressed as well as oncology issues progress should be made.		
	5 Would much prefer vascular to stay at Cheltenham		
	6 I think for it's better for the family especially as the parking is better at Gloucester		
	7 my elderly parent has had both hip replaced and a spinal surgery all of which she had to wait too long for so reducing the wait will no longer benefit he but it would have done		
	8 it's better for specialist communities to be together. now adays a lot of technical equipment is used		
	9 Access to local hospitals is very important for future sustainability of the NHS.		
	10 Better for everyone and their family to prevent commuting to speciality hospital often far away from their counties		
	11 To improve the patient experience for my family it is important to streamline ED to delay waiting times		
	12 nil change		
	13 Not enough information is given about the current location / state of these services to enable me to make a decision about this.		
	14 Undecided but what concerns me most is that emergency services become inefficient and inconvenient by centralising at one hospital.		
	15 It can only be worse. The planned number of beds will be lower at the outset than we have now and the hospital is already overstretched. We don't want to be carted off like cattle to Gloucester and certainly not Cheltenham		
	16 Knowing what is carried out where can be reassuring however the wards at Cheltenham always feel calmer. The wards always feel brighter due to there situation.		
	17 Probably worse as Cheltenham is many miles from our location		
	18 There is only me. If my health needs or treatment needs leaves me unable to drive, I am left helpless if having to attend Gloucester. It makes clinical sense to specialise on sites as you plan to, however patient access needs require mitigation measures which must be costed and ringfenced. Not easy pickings for future cost improvements a few years on. I confess I have told you someone is driving me home, then got home alone, or I have caught a bus when advised I must not, due to lack of support or money for a taxi or even for the Cotswold Friends transport volunteers at 50p/mile		
	19 Worse . Travel time , visiting , care and for care home patients longer journeys and more time to support their clients.		
	20 As we are located nearer to Cheltenham we can see that COE's at the General will benefit us - and those wishing to visit us during recovery.		
	21 My main concern is too have as much treatment including A&E at Cheltenham this is best for me as a patient and family as well. I feel real concern for people living in the Cotswolds to go straight past Cheltenham to be taken to Gloucester, and because of increased demand have to wait in an Ambulance.		

Can you say if you think any of these ideas will be better for you and your family, or worse?		Response Percent	Response Total
22	My main worry would be having to go to Cheltenham for treatment with regards transport, and or parking. Parking is sometimes difficult at Gloucester but at least getting a taxi there does not cost an arm and a leg. So for myself (I have no family) I would worry about needing treatments at Cheltenham a lot more than at GRH which is local to me.		
23	I think everyone would prefer to be treated at local hospitals both for convenience and a local more personal feel.		
24	Thus far, I have fortunate enough not to call upon hospital services very much. I therefore am not sure whether these ideas would be better or worse for myself or my partner. As long as it is clear where, and why, there are different treatments/operations and accessibility is good as well as the right staff for the job, then I would hope to see these ideas working effectively.		
25	For me and my family it makes little difference Cheltenham is further away but not enough to be a problem		
26	I think it will a bad idea to have all the surgeon s under the same roof.		
27	Better. My son is a Crohns sufferer		
28	I live in Churchdown. Midway.		
29	I am on my own so Glous is better to get on		
30	People with disabled like me like to be nearly hospital. I am on my own and my mother lives Wiltshire. I think more disabled people in Cheltenham need be nearly hospital.		
31	It may be inconvenient but we all have cars. My sister had her hip replacement in Cheltenham		
32	Wife has been waiting for a knee replacement since Jan 2020 then covid intervenes		
33	I would like as much as possible available in Cheltenham but clearly some things might be better at Gloucester		
34	as we live between both sites distance is not affected, we would prefer to go to a specialist centre to receive the most up to date treatment		
35	As we are quite fit and mobile, it shouldn't be an issue. If we were living alone with no support or access to transport, then there would be an issue.		
36	Moving some services to CGH is ok but what about people who have limited mobility or no support? How are they going to get there? Maybe a dial a ride would help rather than individual hospital transport? Parking at CGH is also on issue and needs to be addressed		
37	Living south of Gloucestershire - would like any treatment to be closer to home but realise that this is not logistically feasable. (basically age related)		
38	Too far to travel parking, costly/limited too old building and refurbishment poor		
39	I think they could improve services to all in the whole area		
40	BETTER		
41	Anything that improves communication within a hospital should benefit.		
42	Better		
43	Living in Gloucester and having to travel to Cheltenham for treatment means a two hour journey on public transport the idea seems ludicrous. We don't all drive cars.		
44	There will be some impact on travel for many people. There will also be some impact on emergency treatments where longer transport in ambulances is required to get a patient to a Centre of Excellence. Parking charges should be reviewed but not completely removed.		
45	I am sure these ideas will be better for us in the long run if we needed them, Specialist treatment at a centre of excellence has to be better for us for the future.		
46	it is all about convenience and travelling time.		
47	Generally my family and I would prefer Cheltenham. It's nearer and we prefer it.		

Can you say if you think any of these ideas will be better for you and your family, or worse?

		Response Percent	Response Total
48	Cheltenham hospital is a bit too far away for me and my family to get to so I would rather go to Gloucester hospital		
		answered	48
		skipped	41

If you think any of these ideas would be worse for you or your family, can you say what we could do to make things better?

		Response Percent	Response Total
1	Open-Ended Question	100.00%	34
1	You can make sure it is easy for people to know where they need to go when they have an emergency		
2	Clean Gloucester Royal properly; decorate where necessary. Ask the staff to work a bit faster.		
3	Visiting would be adversely affected.		
4	All these ideas are so remote for us in the Forest of Dean. The problems of travelling to Gloucester and Cheltenham. Now you want to close the two hospitals we have and replace it with a smaller hospital when these areas are growing by population does not make sense.		
5	no change		
6	Not enough information is given about the current location / state of these services to enable me to make a decision about this.		
7	Depending on the frequency and need for emergency services which require hospitalisation, the best outcome would be have services at both hospitals, to allow some diversity and redundancy. so as to avoid undue delays due to unforeseen factors.		
8	Good local facilities can only be reassuring for local people, less travel, more chance of survival if dealt with quickly		
9	Link minibus between sites. Increase use of community hospitals whenever possible. Use of technology for remote consultations. During Covid lockdown, I have had virtual ""zoom"" style consults for my hernia, with a doctor able to video my directed manipulations for him to decide whether to send me for emergency consult at A&E overnight. So perhaps I could travel to my local community hospital for a remote consult to the specialist sitting at Gloucester Royal?		
10	ability to get to the hospitals quicker they are a long way from Forest of dean a bridge over the severn further up would help - in traffic its so far to go. parking is very difficult and very expensive last time I went the machine wasn't working it was very stressful thinking I would get a ticket when my son was taken in		
11	Have the leads in one hospital and continue to operate or give care in both. Expertise can be shared online . COVID has shown we do not need to be in the same room.		
12	Any move to withdraw full 24x7 A&E from Cheltenham General - and the ability to perform associated emergency treatment on site - would be worse so please ensure that this does not happen		
13	Please consider to open A&E Cheltenham fully to alleviate the demand on Gloucester.		
14	Personally, that would be reliable hospital transport, or the reassurance that there is adequate parking close by so there was no anxiety about spending ages trying to find somewhere to park in an unfamiliar area.		

If you think any of these ideas would be worse for you or your family, can you say what we could do to make things better?

		Response Percent	Response Total
15	See above. Only more serious/complex issues to the central hospital.		
16	It would be more difficult for my sister who has no transport but the family can assist		
17	How about more signs to direct people		
18	None		
19	Keep both hospitals fully functioning as far as possible.		
20	My sister felt a bit ""left out"" as the family had to make a ""specific trip"" to Cheltenham. Plus parking problems.		
21	Improve parking and the cost especially at Cheltenham		
22	Again I don't drive and wife on waiting list for knee replacement		
23	Living in Winchcombe makes distance an issue		
24	adequate free parking for out-patient and in-patient care for patients and visitors - perhaps have appointment letter scanned for access		
25	Support with transport if needed		
26	I don't think any of these ideas would adversely affect my family as long as we can get there.		
27	One main hospital in Gloucester - fit for all		
28	Has an appointment for a skin complaint in Gloucester. Follow up appointment in Cheltenham six months later met same doctor. Has the Dermatology Dept moved to Cheltenham now?		
29	facilities should be available as widely as possible		
30	easy and short transport route to the hospital		
31	Gloucester is further away - transport is the issue.		
32	Generally my family and I would prefer Cheltenham. It's nearer and we prefer it.		
33	We are a very rural county so all this looks good on paper; but travelling long distances for acute problems taking into account road conditions especially at this time of year - public transport constraints to some rural areas, relatives could find it more problematic visit patients.		
34	Keep Gloucester hospital open		
		answered	34
		skipped	55

Please tell us if you have any ideas about the things we have asked about of if there is anything else you want to say.

		Response Percent	Response Total
1	Open-Ended Question	100.00%	27
1	Ideally even if there is another large outbreak of COVID keeping one Hospital as Green within Gloucestershire so procedures and operations can still be addressed so life can keep moving would give patients hope. stopping all routine operations has had a huge effect on patients wellbeing and lifestyle		
2	We need more upstream assessing units, more theatres and more surgeons to decongest the waiting lists that are making the patients suffer and aggravate their conditions unnecessarily		

Please tell us if you have any ideas about the things we have asked about of if there is anything else you want to say.		Response Percent	Response Total
3	Please re design this questionnaire so that it gives adequate information to enable informed decisions to be made.		
4	i believe Planned services could be centralised but unplanned emergency services should be at the nearest point to the patient		
5	More beds. Also this survey pushes you towards certain answers as though the idea has already been decided. - we want local services		
6	Please remember: 1. Patients viewpoint, as well as safe medicine, as well as cost-effective centralisation. Perhaps I would comply better with aftercare, driving, physio advice, nutrition etc, if I didn't have to travel so far. So the efficacy may have a net better outcome if I can stay local, even if on paper centralisation improves my outcome 2. Transport poverty and rural isolation. Not everyone can get to other places, with little notice 3. Costs of accessing health care are very high. An elderly couple no longer able to drive paid £80 roundtrip for one hospital appointment recently. They told me privately that this affected the budget they had for food that month. Really sad, please never forget this.		
7	I just dont think the forest of dean is well served its a bit like we are second class citizens		
8	Both GRH and CGH appear to me to be bursting at the seams in their current sites. Just looking at the sheer number of high density housing estates that have been built and are in the pipeline I really do fear that the current buildings just will not cope with the population pressures as time goes by. Would be good to see money being spent now to prevent this becoming a real problem. Gloucestershire needs a new state of the art central hospital, built on a site with room for future expansion and with ample space for parking provision and good transport links.		
9	Large hospitals such as Southmead near Bristol look good but are inefficient and unwelcoming. The only real advantage they have for patents is that they have a number of specialist sections in the hospital. As people get older they normally have a number of other heath issues. If individual hospitals are allowed to become only specialist in one field then there is a risk they will miss other symptoms or have to transfer people to different hospitals for their ongoing treatments when they are already ill.		
10	Clear communication for patients/potential patients and families is key.		
11	A&E needs to be as quick and accessible as possible		
12	I'm concerned that you want to make Gloucester the main hospital and reduce Cheltenham to more of a cottage type hospital. A lot of money has been spent on Cheltenham hospital and it's ridiculous to move everything to Gloucester.		
13	I think we need to help both hospitals. Gloucestershire is a large county and people die on route to hospital. I think some people should be charged for using A&E when they could have gone to the Doctor.		
14	Having moved to Gloucester 11 years ago from Bristol where we saw the redevelopment of Southmead Hospital I would like to see GRH and CGH merged into 1 large hospital (midway between the 2 cities)		
15	Ongoing support from Cardiac unit in Cheltenham has been excellent		
16	one central county site		
17	Nothing further to add		
18	I picked up the summary consultation booklet in GRH and was very impressed with the whole document. I appreciate that it is a good idea to have public consultation but my view on these issues is that the specialists know best and I have complete faith in the NHS team to make the right decisions. I am sorry that I could not make more dynamic comments but I feel is rather like asking me to comment on the way the armed forces should be organised where I dont think my view would be terribly significant!		
19	No		
20	A&E in Cheltenham should open same hours as in Gloucester		

Please tell us if you have any ideas about the things we have asked about of if there is anything else you want to say.

		Response Percent	Response Total
21	I believe very strongly in Centres of Excellence. This is a way of providing first class services but should not be seen purely as a cost cutting exercise. A single large facility should have the same amount of equipment and staff as two smaller units - that way the same number of cases can be treated.		
22	Give people a choice of where they would like treatment because some people won't mind at all but others it will be very important. This can only be achieved if both hospitals do both		
23	specialist hospitals are great, but I wish to say that you should be aware of the ever growing aging community, visiting families over long distances from home, we are over 1 hour from GRH and it would cause us problems. Some form of accommodation should be made available for emergency overnight stays for the families to be near in case of a critical situation.		
24	open up small local hospitals		
25	Solve the transport and the parking and you have a good solution to your service offering. Get your IT sorted. A&E to talk to general wards records		
26	The issue between Gloucester Royal and Cheltenham is a big consideration in our area. We all prefer Cheltenham.		
27	Keep Gloucester hospital open. Gloucester hospital saved my life. All be it not as good as it was prior to my RTC		
		answered	27
		skipped	62

Can you tell us the first part of your postcode? eg. GL16, GL3

		Response Percent	Response Total
1	Open-Ended Question	100.00%	73
1	GL15		
2	Gl15		
3	GL51		
4	GL52		
5	GL51		
6	GL15		
7	GL3		
8	gl3		
9	gl15		
10	GL52		
11	GL18		
12	gl53		
13	Gl3		
14	GL11		
15	Gl20		

Can you tell us the first part of your postcode? eg. GL16, GL3		Response Percent	Response Total
16	GL15		
17	GL54		
18	gl15		
19	GL51		
20	GL51		
21	GL8		
22	GL51		
23	GL11		
24	GL17		
25	GL10		
26	GL15		
27	GL54		
28	gl52		
29	GL14		
30	GL51		
31	GL52		
32	GL4		
33	gl14		
34	GL11		
35	GL6		
36	GL6		
37	GL16		
38	GL17		
39	GL2		
40	Gl51		
41	GL2		
42	GL52		
43	GL3		
44	GL11		
45	GL52		
46	GL3		
47	GL16		
48	GL2		
49	GL54		
50	GL3		

Can you tell us the first part of your postcode? eg. GL16, GL3			
		Response Percent	Response Total
51	GL51		
52	GL3		
53	GL1		
54	GL2		
55	GL16		
56	GL7		
57	GL14		
58	GL16		
59	GL51		
60	GL20		
61	GL4		
62	GL2		
63	GL1		
64	GL53		
65	GL53		
66	GL17		
67	gl56		
68	GL16		
69	GL7		
70	GL8		
71	GL54		
72	GL51		
73	GL16		
		answered	73
		skipped	16

Which age group are you:

		Response Percent	Response Total
1	0 - 18	1.27%	1
2	18-25	1.27%	1
3	26-35	1.27%	1
4	36-45	3.80%	3
5	46-55	8.86%	7
6	56-65	20.25%	16
7	66-75	43.04%	34
8	75+	20.25%	16
9	Not saying	0.00%	0
		answered	79
		skipped	10

Are you:

		Response Percent	Response Total
1	Someone who works in health or social care	7.50%	6
2	A member of the public	88.75%	71
3	Not saying	3.75%	3
		answered	80
		skipped	9

Do you have a disability - tick the ones that describe you.

		Response Percent	Response Total
1	No	50.00%	37
2	Mental health problem	9.46%	7
3	Problems with your sight	9.46%	7
4	Learning difficulties	4.05%	3
5	Problems with your hearing	14.86%	11
6	A health problem you have had for a long time like asthma, diabetes, or something else	36.49%	27
7	Physical disability	8.11%	6
8	Not saying	1.35%	1
		answered	74
		skipped	15

Do you look after, or give any help and support that you don't get paid for, to other people because they are ill or older?

		Response Percent	Response Total
1	No, I don't	75.68%	56
2	Yes, I do	22.97%	17
3	Not saying	1.35%	1
		answered	74
		skipped	15

Please can you tell us which o the groups in our list best describes you? This is called ethnicity.				
			Response Percent	Response Total
1	White British		93.59%	73
2	White Other		1.28%	1
3	Asian or Asian British		1.28%	1
4	Black or Black British		0.00%	0
5	Chinese		0.00%	0
6	Mixed		1.28%	1
7	Not saying		2.56%	2
			answered	78
			skipped	11

Please tick if you have any of these religions or beliefs				
			Response Percent	Response Total
1	None		19.74%	15
2	Buddhist		0.00%	0
3	Christian		71.05%	54
4	Hindu		0.00%	0
5	Jewish		0.00%	0
6	Muslim		0.00%	0
7	Sikh		0.00%	0
8	Other		1.32%	1
9	Not saying		7.89%	6
			answered	76
			skipped	13

Can you say about your gender? Tick the one that describes you.

		Response Percent	Response Total
1	Male	49.37%	39
2	Female	48.10%	38
3	Transgender	0.00%	0
4	Non-binary	1.27%	1
5	Not saying	1.27%	1
		answered	79
		skipped	10

Are you the same gender you were born with?

		Response Percent	Response Total
1	Yes	94.74%	72
2	No	2.63%	2
3	Not saying	2.63%	2
		answered	76
		skipped	13

Can you say how you think of yourself?

		Response Percent	Response Total
1	Heterosexual or straight	90.79%	69
2	Gay or lesbian	1.32%	1
3	Bisexual	1.32%	1
4	Other	0.00%	0
5	Not saying	6.58%	5
		answered	76
		skipped	13

Are you pregnant or had a baby in the last year?				
			Response Percent	Response Total
1	Yes		0.00%	0
2	No		52.56%	41
3	Not saying		1.28%	1
4	This question doesn't apply to me		46.15%	36
			answered	78
			skipped	11

Fit For The Future - What matters to you?

Responses from BAME

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

		Response Percent	Response Total
1	Strongly support	51.28%	20
2	Support	30.77%	12
3	Oppose	5.13%	2
4	Strongly oppose	7.69%	3
5	No opinion	5.13%	2
		answered	39
		skipped	0

Please tell us why you think this, e.g. the information you would like us to consider (19)

1	need to put all the expertise in one place 24/7
2	Damaging effect on the local community, as it disproportionately affects vulnerable individuals with protected characteristics. Concerns about bed space at GRH. Concerns about a bottleneck effect at GRH - if you double the amount of traffic, you need to double the width of the road, ALL roads, leading in and out. Leading on to concerns about the lack of funding for SWAS as per their financial outlook to provide the additional ambulance service coverage. Flawed notion of attracting high quality staff from a business/management perspective. Gloucestershire's market has competitors in Bristol, Birmingham (to an extent), Oxford, and of course London. Centralised services will not enable GHNHSFT to outcompete these, leaving us with 'the best of the rest'. This would have been the case whether centralisation occurred or not, thus centralisation itself is a moot point. Flawed concept of 'extra time' to care. This will inevitably lead to cost savings (perhaps instructed by ministers, and not immediately) by reducing staff numbers to provide current levels of care, only now at one site.
3	Cheltenham needs an acute care ward. how can you have a functioning a and e, which the trust keeps on insisting it will have at Cheltenham with no where for the patient to go after initial treatment? putting sick people in ambulances to grh is ridiculous. making the public believe they will have an a and e when they will have a sub par service is deceitful
4	It's a rational use of limited resources. Concentration of specialist people, and specialist kit, absolutely makes sense, and research shows that it produces better outcomes.
5	Better treatment for all
6	Acute Medicine seems to be an area of health where time is its greatest obstacle for a steady recovery. The availability of a correct specialist could likely contribute to the realisation of the actual problem rather than concerning around the symptoms that initially brought the patient to the hospital. Hopefully a 'centre of excellence' would increase the value of medical investigation of a patient's condition so that prevention can be enforced in the treatment. Although Gloucestershire Royal Hospital is central, the medical team may also require consideration of how patients from other towns may be able to access the yard without delay or complications.
7	A single centre in Gloucester will inevitably: Increase congestion in the department Increase nurse triage time Incease doctor wait to be seen time Significantly increase ambulance job cycle times for SWASFT Increase the amount of inter-site ambulance transfers between GRH & CGH undertaken by 3rd party providers Delay commencement of treatment for residents in Cotswolds & Cheltenham by having to travel to GRH
8	Gloucester is in the centre of the county so it would be logical to have the acute medical take here.

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

		Response Percent	Response Total
9	Having centres of excellence is ideal providing it does reduce waiting time, and ensures operations are not cancelled. All expertise in one place so if second opinion is needed there is someone to consult immediately without the necessity of a follow up visit somewhere else.		
10	24/7 access to multidiciplanary teams. Specialist equipment. RIght disciplines to provide services and ability to train more staff		
11	Local		
12	It worries me hugely that the town the size of Cheltenham already hasn't got 24/7 Consultant Led A&E services. This seems another plan to reduce this even further. I worry about increased time to get emergency help for my children and elderly parents by having to travel to another town.		
13	I believe in current medicine, centres of excellence are a 'good thing'. GRH has the space and I trust facilities for this so I am happy to proceed.		
14	Particular medical conditions can be prevented from getting worse if treated / diagnosed earlier		
15	Anything that reduces risk, Travelling time, being passed from pillar to post offers a quality service, with quality staff can only be excellent		
16	GRH should receive all unselected acute admissions. This will enable us to screen patients for infectious conditions such as COVID-19 and keep them there until it is safe to transfer to the ""green"" CGH site. this way we minimise the risk of disruption of elective specialist treatment such as surgical and non-surgical cancer care.		
17	Quicker response to a service when needed - waiting times - if all under one roof - higher demand?		
18	If there is only one centre and something goes wrong will there be no back up service		
19	If one centre will numbers be too high who need to be seen		

Please tell us what you think about our preferred option to develop:A ‘centre of excellence’ for Emergency General Surgery at Gloucestershire Royal Hospital.

		Response Percent	Response Total
1	Strongly support	53.85%	21
2	Support	30.77%	12
3	Oppose	5.13%	2
4	Strongly oppose	5.13%	2
5	No opinion	5.13%	2
		answered	39
		skipped	0

Please tell us why you think this, e.g. the information you would like us to consider (16)

1	need to centralise expertise 24/7 ideally alongside other emergency services
2	Support the notion of highly specialised surgical teams at one site. Only concerns are managing the increased throughput. Emergency surgery is rarer than acute medicine so the negative effects there should not occur here.
3	It is bigger hospital and easy for access (not confusing as opposed to CGH which is a maze and patients are constantly lost)

Please tell us what you think about our preferred option to develop:A ‘centre of excellence’ for Emergency General Surgery at Gloucestershire Royal Hospital.		Response Percent	Response Total
4	If tgere are surgeons available for ""Elective Surgery"" where I am aware the Trust is paid to do this by the government, then wht can't theses same surgeons be available for Emergency Surgery??		
5	It's a rational use of limited resources. Concentration of specialist people, and specialist kit, absolutely makes sense, and research shows that it produces better outcomes.		
6	How would the rotas become more robust if the hospital is lacking enough trainees and junior doctors?		
7	If, as stated, you have no plans to close CGH ED, I'm concerned that transfers from CGH to GRH for emergency surgery would need to occur. What is the mitigation for this - do you commission additional resources from SWASFT or purchase additional 3rd party ambulance resource to undertake the additional transfers that will inevitably occur should this proceed.		
8	I believe it is essential to have emergency general surgery at two locations in the county ie Cheltenham and Gloucester.		
9	As before		
10	As for Acute medicine, access to multidisciplanry team and equipment		
11	See my previous answer. All Emergency services should be excellent. The fact that many who come aren't emergency is another matter and requires more education and awareness raising to also not put those off that really should seek emergency help.		
12	Travel visiting and carers		
13	One would hope a centre of excellence would deal with patients quickly - I am aware of patients who feel the waiting time is too long and go aboard / different county for treatment and often end up worse		
14	Reducing waiting time, planned surgeries that are preformed on time contributes significantly to the health and wellbeing of patients and their families reducing stress and unnecessary waiting times		
15	It is best to concentrate acute unselected surgical admission to one site which will also house acute medicine as well as ED and Critical care.		
16	always needed - Will specialist staff really be available or too busy elsewhere? How practical will this be or is sit just a hope		

Please tell us what you think about our preferred option to develop:A ‘centre of excellence’ for Planned Lower GI (colorectal) general surgery at Cheltenham General Hospital (CGH) or Gloucestershire Royal Hospital (GRH).			Response Percent	Response Total
1	Strongly support		44.44%	16
2	Support		41.67%	15
3	Oppose		2.78%	1
4	Strongly oppose		0.00%	0
5	No opinion		11.11%	4
			answered	36
			skipped	3

Please tell us why you think this, e.g. the information you would like us to consider (11)

Please tell us what you think about our preferred option to develop:A ‘centre of excellence’ for Planned Lower GI (colorectal) general surgery at Cheltenham General Hospital (CGH) or Gloucestershire Royal Hospital (GRH).

		Response Percent	Response Total
1	for planned work we need to avoid the emergency site so the work continues despite emergencies - needs to be based at the non-emergency hospital cgh		
2	If it's planned, why not just go to Oxford and build a bigger unit there?		
3	It should be CGH, because you want everything to be easy and understandable not only for the patients, but also for the workforce. I mean try to close the cycle within one medical field. Get Endoscopy, Theatres at one place.		
4	Diagnostics are ok at Cheltenham, but specialist surgery needs to be where specialist surgery is based...		
5	But on both sites		
6	It is probably more efficient to concentrate resources at one dedicated hospital.		
7	As before		
8	seperating emergency from planned services should prevent cancellations and create the right number of beds for the planned procedures. Co-locating with other pelvic services makes sense as I suspect they often need to work together		
9	Same reasons do not oppose a centre of excellence for Gloucestershire but do oppose strongly the lack of operations at either hospital		
10	As above		
11	This should be on the same site as non-surgical oncology as the two have to work very closely together.		

In supporting our preferred option to create a single site 'centre of excellence', where do you think a ‘centre of excellence’ for Planned Lower GI (colorectal) general surgery should be developed?

			Response Percent	Response Total
1	Cheltenham General Hospital (CGH)		43.24%	16
2	Gloucestershire Royal Hospital (GRH)		24.32%	9
3	No opinion		32.43%	12
			answered	37
			skipped	2

Please tell us why you think this, e.g. the information you would like us to consider: (14)

1	because it's not the emergency site and patient flow can be better managed
2	Why should people from Cheltenham go to Gloucester when they can go to Oxford? If it's planned...
3	It is easy to get all GI surgeries in one place closer to Endoscopy.
4	At the moment, both CGH and GRH seem to have a Planned Lower GI general surgery facility. I think the decision on which location to invest more excellency should mostly be focused on statistic and medical opinion, such as estimated time of arrival from one location to the hospital; percentage of local and not local patients who come to the hospital; accessibility to the yard; transportation accessibility etc. While Cheltenham could be more easily accessible, in my opinion, GRH offers facilities on Upper GI general surgery, which could contribute to the treatment of exceptional patients who may need assistance with both.
5	Either would do.

In supporting our preferred option to create a single site 'centre of excellence', where do you think a ‘centre of excellence’ for Planned Lower GI (colorectal) general surgery should be developed?

		Response Percent	Response Total
6	Wherever the space is available and where the necessary ancillary departments are. Which will have the capability to ensure bottlenecks do not occur - scanning, X-ray, theatres, outpatient capacity.		
7	as previous question		
8	I am not fullt aware of the different skills between GRH and CGH but roughly would like to see a 50/50 spread of centres of excellence over the county's two leading hospitals.		
9	As above		
10	Greater diversity in Gloucester		
11	Greater Diversity in Gloucester - some longer term health conditions higher with minority ethics Ease of access and family support as communities live close together		
12	Cancer surgery and non-surgical treatment (radiotherapy an systemic therapy) need to be one one site in order to ensure seamless cooperation for patients who develope acute conditions requuiring surgical intervention. I have worked in London centres of excellence for non-surgical oncology where there was no surgical cover on-site for emergencies. This did not work well and treatment was sub-optimal.		
13	Prefer something at both sites		
14	Once again if only one centre and there are issues is there a back up service?		

Please tell us what you think about our preferred option to develop:A ‘centre of excellence’ for planned day case Upper and Lower GI (colorectal) surgery at Cheltenham General Hospital (CGH).

		Response Percent	Response Total
1	Strongly support	43.24%	16
2	Support	35.14%	13
3	Oppose	0.00%	0
4	Strongly oppose	0.00%	0
5	No opinion	21.62%	8
		answered	37
		skipped	2

Please tell us why you think this, e.g. the information you would like us to consider (11)

1	planned = cheltenham
2	Why go to Gloucester when you can go to Oxford?
3	I have already said that in my previous answers. Try to concentrate in one place all cases related to GI interventions. It is better for the workforce too.
4	Helps to manage an appropriate split between hot and cold sites
5	I think Cheltenham does deserve a comprehensive GI surgery facility as it is a reasonably large town which hosts national and international visitors every year. The capacity of the town to provide extensive health assistance, alongside Gloucestershire Royal Hospital would also likely relieve the stress sometimes found in waiting rooms. The availability could also assist patients who are needed to stay longer in the hospital under supervision, allowing the medical team to have sufficient equipment in the event of an incident or emergency. GI conditions can be debilitating at times and the circumstance of having to travel could risk worsening, especially if no preventative methods were ever applied in their case.

Please tell us what you think about our preferred option to develop:A ‘centre of excellence’ for planned day case Upper and Lower GI (colorectal) surgery at Cheltenham General Hospital (CGH).

		Response Percent	Response Total
6	Planned day case surgery should have no impact on emergency care pathways and can be provided at any site.		
7	As before		
8	as before		
9	For planned day surgery it makes no difference to where I travel to within an hour. Parking seems much better at Gloucester.		
10	Should’ve at both units if Gloucester hospital and Cheltenham hospital are Gloucestershire hospital service why not at both.		
11	As above. This will also benefit us interms of cooperation in research hwere both surgical and medical treatment are being evaluated e.g. in cancer studies.		

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

			Response Percent	Response Total
1	Strongly support		36.84%	14
2	Support		36.84%	14
3	Oppose		7.89%	3
4	Strongly oppose		5.26%	2
5	No opinion		13.16%	5
			answered	38
			skipped	1

Please tell us why you think this, e.g. the information you would like us to consider (12)

1	strongly support the concept but if this is elective work wouldn't it be sensible to base it at cgh and have a spoke at grh?
2	Extreme nature of emergency IGIS means the time delay going from Cheltenham to Gloucester would be far too risky re. loss of life to a patient who may, for example's sake, live just across the road from CGH.
3	It should be on one place. But I have not estimated the premises that we have available at CGH even if we have to build up a new building it is going to be far more better for the service than the service to be scattered.
4	A spoke will still split the vital staffing groups but in reverse.
5	It's a rational use of limited resources. Concentration of specialist people, and specialist kit, absolutely makes sense, and research shows that it produces better outcomes.
6	I think investing in IGIS is a fantastic action. To my understanding and experience, IGIS provides an alternative to what could be a very invasive surgery and allows patients a safer and quicker recovery. It seems to me that it is something that should be evaluated to possibly be instigated in other areas of the country, if they so need it.
7	How will you managed the inevitable transfers from GRH to the 'spoke' at Cheltenham without impacting on SWASFT's current operating model?
8	updating equiment and locating in one site is more cost effective

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

		Response Percent	Response Total
9	Interesting to see the hub and spoke concept. Will this leave the hub as a centre of excellence? Can there be other spokes such as Forest of Dean or smaller hospitals such as Cirencester?		
10	Should be at both		
11	Reducing risks and stays in hospital and manual intervention is always good. Anxiety of carers and family is minimised as patients return home quicker		
12	Often with services / treatments there is a lot of confusion where to go Cheltenham or Gloucester? a centralised hub offering as much as possible at one place would provide a ""comfort zone"" for the patient without having to travel to different places. Doesn't have a feeling of disconnect		

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

		Response Percent	Response Total
1	Strongly support	27.78%	10
2	Support	47.22%	17
3	Oppose	5.56%	2
4	Strongly oppose	2.78%	1
5	No opinion	16.67%	6
		answered	36
		skipped	3

Please tell us why you think this, e.g. the information you would like us to consider (8)

1	probably unless we split acute and elective
2	Again, why not just go to Oxford if you live east of Cheltenham?
3	Because is not GI surgery. Every surgery not related to GI can go in GRH.
4	Tbis is something that needs to be covered at bith sites
5	It's a rational use of limited resources. Concentration of specialist people, and specialist kit, absolutely makes sense, and research shows that it produces better outcomes.
6	Support if planned & elective care.
7	As before services should be at both to ease travel for elderly who do not drive
8	BME communities have higher rates as diversity to Cheltenham and Gloucester - GRH is perfectly placed

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

		Response Percent	Response Total
1	Strongly support	44.44%	16
2	Support	33.33%	12
3	Oppose	5.56%	2
4	Strongly oppose	0.00%	0
5	No opinion	16.67%	6
		answered	36
		skipped	3

Please tell us why you think this, e.g. the information you would like us to consider (9)

1	better to avoid the emergency site
2	It is closer to Endoscopy Unit. Patients can be easily transferred to it.
3	If no gastro inpatient services at GRH, how will you manage the inevitable additional transfers required without impacting on SWASFT's operating model? What are the considerations for additional travel time and public travel routes for those that will subsequently need to travel to CGH that do not have access to their own transport?
4	co-locating with planned day cases with specialist staff and contact points for inpatient and long-term ongoing care
5	Again, makes no difference to me as a patient where this is based
6	I feel this service could be led from either hospital and the service continue I the hospital why change for change sake . Save money and develop leadership on either site and share good practice online
7	These are common aliments and overall benefits outweigh the negatives
8	Urgent general need for many people. Reduced waiting times - quality focused attention and care for the patient is always a win win
9	Gastroeneterology dsupport for cancer patients needs to be improved and this move would help that.

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

		Response Percent	Response Total
1	Strongly support	56.41%	22
2	Support	25.64%	10
3	Oppose	5.13%	2
4	Strongly oppose	5.13%	2
5	No opinion	7.69%	3
		answered	39
		skipped	0

Please tell us why you think this, e.g. the information you would like us to consider (10)

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

		Response Percent	Response Total
1	makes complete sense		
2	It should be everything in GRH. This is my refrain. It is logical and simple. The simpler is the better is. Perfection is in simplicity.		
3	Both sites should be covering Trauma this would save lives!!		
4	It's a large specialty and it makes sense to share across both sites, assuming that complex and/or higher risk cases are at Gloucester.		
5	There seems to be a lot of opportunities on time management, however not much information around patient care, consideration of harm, preventative measures or long-term future routine checks. The prevention of further complications could be also considered in the new plans.		
6	keep specialisms together for better access and equipment		
7	Most sensible response to needs of this large community although leadership could be in either hospital		
8	Urgent need for excellent, quality, immediate support when there is a need. Quality of services is literally a balance between life and death		
9	Needs no words to say this is a critical service and needs to have all the positives. Better care and attention and help out at the outset reduces issues developing later		
10	Patients with pathological fractures or spinal cord compression should not require moving especially when delay might be induced due to lack of beds in the scute hospital (GRH).		

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

		Response Percent	Response Total
1	Open-Ended Question	100.00%	20
1	pretending we have 2 acute hospitals is the biggest potential detriment to services		
2	Concerns about impact on BAME communities. Concerns about bottleneck effect on Acute Medicine at GRH. Major concerns about IGIS - if a patient needed an emergency procedure in this field and had to be transported to Gloucester, when the lived right next to CGH, the difference in both outcome re. risk of loss of life is to great a difference. Concerns about funding increased Ambulance Service provisions. Flawed concept of attracting high quality staff - London, Oxford, Bristol will always leave us with the best of the rest which the proposals would have no bearing on. Political concerns that down the line (years), any improvements will result in savings related staff reductions.		
3	risking the health and safety of those further out in the county.		
4	It is only positive		
5	good service		
6	IGIS information is actually not entirely accurate as from a non medical view and those lacking the insight into the interventional area its trying to broadly cohort based on superficial skills where they are entirely separate skill sets. The idea of grouping in a similar location is good but the idea that cross cover occurs easily between disciplines is completely inaccurate and actually won't create staffing efficiencies. It is in fact going to dilute a very specialised skill set within each of those specialities.		
7	Rationalised services produce better outcomes.		

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

		Response Percent	Response Total
8	In 2019 I had a IGIS abroad, in my country of origin. I could have returned to the UK, but instead I stayed overtime in the country to have an emergency surgery for removal of my gallbladder after going through a routine appointment where I had no symptoms. My experience with the NHS is that there is not much investigation on preventative measures. I had had an ultrasound before, to follow up on my IUS, and there was no interest in verifying the state of my internal organs at that appointment. I hope that by investing in a more thorough facility, incidents can be avoided.		
9	No current impact on us.		
10	Impact if all works well and delays in appointments are reduced will be of benefit to my family and myself.		
11	Gastroenterology and General surgery both needed and would be better if it is clear what service is offered where, and so that continuity of care can be improved. THe proposed changes will achiee this for me		
12	I think all these plans are terrific. Thank you.		
13	I can only see advantage in focussing particular specialisms on one site, as much as that is possible,		
14	Local and ease		
15	I am hugely concerned about the already much reduced emergency cover at Cheltenham. I feel the centre of excellence (!!) for acute medicine in Gloucester will further reduce care for Cheltenham (and surrounding areas) residents. This is not a small place but with 100000 inhabitants and an elderly population.		
16	Until and unless we have the need for any of these services, I find it difficult to comment.		
17	If the services are not at both units this would mean further travel and time. It also means for Carers there days would be more disrupted getting patients to appointments in larger units .		
18	Better patient care, less waiting time, easier access, better holistic care & treatment. Less travel time - better all around outcomes		
19	Close proximity to where I live Easy to travel to Gloucester hospital I like the idea of specialists in one area Centres of excellence should enable easy communications between staff		
20	Easy travel time Minimal waiting		
		answered	20
		skipped	19

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

		Response Percent	Response Total
1	Open-Ended Question	100.00%	17
1	pretending we have 2 acute hospitals is the biggest potential detriment to services		
2	Delay the proposals by a year. Engage with a private business/ management consultancy firm to determine the true long term impact of these changes, and amend proposals. Social impacts may change too - changes to the way we work in response to Covid may change the landscape such that new options become available.		
3	risking family health by providing sub par a and e service at Cheltenham		

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

		Response Percent	Response Total
4	I don`t see any negative effect. I live in Cheltenham and had to go to GRH as a patient. I just got on the bus and was there on time for my appointment. It was fine. In emergency I can get a taxi if an ambulance car is not available.		
5	no		
6	As described above. We are meant to be aspiring to be the best in what we do and sharing staffing groups isn't the answer. Ensuring we recruit and retain is and taking pride in the quality of our work.		
7	None		
8	I think accessibility is the main key in these new proposals, such as transportation, informational and also medical - providing a knowledgeable doctor who takes the patients concern into account when making decisions on examination and treatment.		
9	N/A		
10	No		
11	Further to travel to Gloucester Royal for emergeny/trauma but if the care is better tht should be mitigated. Cheltenham is still available but not consultant led overnight, which is a concern for trauma admissions		
12	Offer 2 centres of excellence for Acute Medicine		
13	In all cases of treatment there is the question of transport but both hospitals have reasonable provision for access and parking (albeit at a fee which is a matter for separate discussion).		
14	Try leadership and staff support for both units from one hospital. Sharing good practice teams can meet online.		
15	We need to have centres of excellence I. Gloucestershire		
16	Parking issues		
17	If there is only one centre of excellence will parking be not adversely affected		
		answered	17
		skipped	22

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

		Response Percent	Response Total
1	Open-Ended Question	100.00%	9
1	no		
2	Keep emergency care/ acute medical on both sites. Share planned care with Bristol and Oxford. Rotate staff between hospitals/ secondments to generate the requisite culture of flexibility in planned care, with the savings and increased efficiency used to fund emergency care in both local sites.		
3	Cheltenham needs an amu.		

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

		Response Percent	Response Total
4	Nothing is mentioned about ERCP. This is part of GI service. It should be in CGH as a part of the entire circle. It is limited at the moment to two half days a week. It should be at least on a 5-day basis (every morning let`s say). There must be an ERCP centre. It could play a big role as a Centre of Excellence for training within the UK if the consultants think that they are able to develop it in this way. If not, then our patients will benefit at least from centre like this.		
5	regarding appointments I really wants to appreciate the services		
6	There is insufficient reference here to supporting patients at home, rather than admitting them to hospital. There is insufficient reference to the interface with social care services, and therefore to supporting clearing the back door of the hospitals.		
7	whatever is decided should be very clearly communicated as it is rather confusing at the moment		
8	Are there options for co-operating with neighbouring Trusts, Hospital groups etc? Depending on the level of cases there could be opportunities for cross-border (whatever those borders may be) co-operation.		
9	Assessment should be done by an expert in hospital. The amount of staff appointed could be the answer. One person travelling is better that ten patients.		
		answered	9
		skipped	30

Anything else you would like to say?

		Response Percent	Response Total
1	Open-Ended Question	100.00%	10
1	I don't understand why we have to keep both EDs open. What matters is what happens once patients arrive and to deliver the service I would expect, would mean concentrating emergency staff expertise. I don't live in C or G so have no emotional attitude to either department but I do expect one fully staffed centre of ED expertise somewhere in the middle of the county.		
2	-		
3	stop using covid as an excuse to flatline emergency services at Cheltenham. treat staff with more respect, our opinions and skills as professionals are repeatedly ignored by trust management. stop shipping patients who are unwell between two sites, this is unsafe and immoral. the only ones being shipped about are those with lower capacity, confusion and complex needs. disgraceful. I support reinstating amu at Cheltenham to stop this nonsense.		
4	I hope that you are going to see the picture in different levels, i.e. locally, nationally and internationally.		
5	overall good		
6	I cannot thank the NHS enough in Gloucestershire for all your brilliant ideas and work.		
7	The geographical disadvantage of one site over the other is usually overstated. We would all like things based as close to home as possible, but unless resident in Gloucester City or Cheltenham it actually makes very little difference to most people to site they need to travel. Using public transport is more complicated from rural areas, but the shuttle bus largely overcomes that issue for outpatients and visiting.		
8	Good luck changing services is always a problem and change for this reason seems ridiculous		
9	Any improvements as to how patients are treated are welcome		

Anything else you would like to say?

		Response Percent	Response Total
	10	seems like GRH has a more specialist focus under one roof - will this lead to overcrowding, parking issues, less quality face to face time with staff / professionals	
		answered	10
		skipped	29

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

		Response Percent	Response Total
1	Open-Ended Question	100.00%	29
	1	GL4	
	2	GL53	
	3	gl51	
	4	gl3	
	5	gl14	
	6	Gl52	
	7	GL50	
	8	GL51	
	9	GL1	
	10	SN2	
	11	CV36	
	12	GL52	
	13	GL53	
	14	Gl5	
	15	GL19	
	16	GL7	
	17	gl5	
	18	GL10	
	19	Gl51	
	20	Gl52	
	21	GL7	
	22	gl50	
	23	GL5	
	24	GL1	
	25	GL1	
	26	gl50	

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

		Response Percent	Response Total
27	GL1		
28	GL1		
29	GL4		
		answered	29
		skipped	10

Which age group are you:

			Response Percent	Response Total
1	Under 18		2.63%	1
2	18-25		2.63%	1
3	26-35		10.53%	4
4	36-45		15.79%	6
5	46-55		23.68%	9
6	56-65		31.58%	12
7	66-75		10.53%	4
8	Over 75		2.63%	1
9	Prefer not to say		0.00%	0
			answered	38
			skipped	1

Are you:

			Response Percent	Response Total
1	A health or social care professional		34.21%	13
2	A community partner		0.00%	0
3	A member of the public		63.16%	24
4	Prefer not to say		2.63%	1
			answered	38
			skipped	1

Do you consider yourself to have a disability? (Tick all that apply)				
			Response Percent	Response Total
1	No		84.21%	32
2	Mental health problem		2.63%	1
3	Visual Impairment		0.00%	0
4	Learning difficulties		0.00%	0
5	Hearing impairment		0.00%	0
6	Long term condition		7.89%	3
7	Physical disability		2.63%	1
8	Prefer not to say		5.26%	2
			answered	38
			skipped	1

Do you look after, or give any help or support to family members, friends, neighbours or others because of either a long term physical or mental ill health need or problems related to old age? Please do not count anything you do as part of your paid employment.				
			Response Percent	Response Total
1	Yes		40.54%	15
2	No		56.76%	21
3	Prefer not to say		2.70%	1
			answered	37
			skipped	2

Which best describes your ethnicity?

		Response Percent	Response Total
1	White British	0.00%	0
2	White Other	46.15%	18
3	Asian or Asian British	30.77%	12
4	Black or Black British	7.69%	3
5	Chinese	0.00%	0
6	Mixed	7.69%	3
7	Prefer not to say	0.00%	0
8	Other (please specify):	7.69%	3
		answered	39
		skipped	0

Other (please specify): (3)

1	Why is this relevant to the survey
2	European
3	White English

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

		Response Percent	Response Total
1	No religion	36.84%	14
2	Buddhist	2.63%	1
3	Christian (including Church of England, Catholic, Methodist and other denominations)	34.21%	13
4	Hindu	5.26%	2
5	Jewish	0.00%	0
6	Muslim	18.42%	7
7	Sikh	0.00%	0
8	Other	0.00%	0
9	Prefer not to say	2.63%	1
		answered	38
		skipped	1

Are you:

		Response Percent	Response Total
1	Male	42.11%	16
2	Female	57.89%	22
3	Transgender	0.00%	0
4	Prefer not to say	0.00%	0
		answered	38
		skipped	1

Do you identify with your gender as registered at birth?

		Response Percent	Response Total
1	Yes	97.30%	36
2	No	0.00%	0
3	Prefer not to say	2.70%	1
		answered	37
		skipped	2

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

		Response Percent	Response Total
1	Heterosexual or straight	89.47%	34
2	Gay or lesbian	5.26%	2
3	Bisexual	2.63%	1
4	Other	0.00%	0
5	Prefer not to say	2.63%	1
		answered	38
		skipped	1

Are you currently pregnant or have given birth in the last year?				
			Response Percent	Response Total
1	Yes		0.00%	0
2	No		77.78%	28
3	Not applicable		19.44%	7
4	Prefer not to say		2.78%	1
			answered	36
			skipped	3

Fit For The Future - What matters to you?

Responses from those over age 66, with a disability

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

		Response Percent	Response Total
1	Strongly support	39.66%	23
2	Support	29.31%	17
3	Oppose	17.24%	10
4	Strongly oppose	10.34%	6
5	No opinion	3.45%	2
		answered	58
		skipped	2

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

1	Far too far away from Fairford to be a good option for patients from that town/area
2	Too Gloucester central, what about those of us who live to the East of the County?
3	Gloucester Royal is not easy to get to from many pay of the county
4	Cheltenham and surrounding villages and other small towns in Gloucestershire deserve to have their own ""Acute Medical Take"" at CGH. Travelling is difficult enough in Gloucestershire and Gloucester Royal Hospital has very inadequate and expensive parking. This is a very busy tourist town with many festivals bringing thousands of people to the town and it is a very poor decision to only have a centre of excellence in Gloucester. We need our own A & E and also our own Acute Medical Take I am not opposed to Gloucester having its own centre but both places should be treated the same. Gloucester is a very large county stretching from the borders of Wales to the edge of Oxfordshire and Worcestershire.
5	I think it is important to aim for providing the best possible conditions in the service provided
6	Both centres need to provide all sorts of emergency medicine .
7	It makes a lot of sense in so many ways. Specialist staff where they are needed and economy of one place but the assurance of cross information when necessary. A huge plus is that scheduled day surgery will be able to go ahead as planned. As a patient I have experienced surgery required after attending ED with a cut tendon, having to be surgery ready each morning only to be told it would not happen and finally being extremely ill after being giving antibiotics because of the increased risk of infection. I also think that the guided imagery will offer huge benefits e.g. to stroke patients attending ED, removing the clot quickly could mean a reduction in brain damage.
8	Best location in the county for this service
9	Gloucestershire Royal is a difficult journey from North Cotswolds with poor bus services. Difficult for older people to visit relatives.
10	It is the right approach for the future.
11	If this is thought to be a good idea, it probably is!
12	We live in the east of the county, and Gloucester is a long way to travel. This problem is exacerbated as we get older, and private transport becomes more difficult. Public transport is simply not an option.
13	Creating CoEs across the county will inevitably create a good deal more traversing of the county for patients. I can empathise with the desire to make best use of resources.

Please tell us what you think about our preferred option to develop: A 'centre of excellence' for Acute Medicine (Acute Medical Take) at Gloucestershire Royal Hospital.		Response Percent	Response Total
14	I think it is important that the best acute care is needed where there is a concentration of expertise. Diluting staff expertise in two centres is not the best way to achieve this. Having acute medicine (acute medical take in Gloucester makes absolute sense, and I do appreciate that for some cases, subsequent transfer to the regional centre in Bristol (e.g. BRI/Southmead) may still be required for the most serious cases.		
15	I feel that this sort of service should be available at Both Cheltenham and Gloucester		
16	Depends on future direction of Cheltenham General Hospital		
17	Centers of excellence has to be the way forward to benefit the use of technology and Consultant/specialist skills.		
18	Its a long way from the outer borders of the county - and not much use if it takes over an hour to get there - starting from 999		
19	It makes sense to centralise this area		
20	make the best use of the expertise for each discipline. Not point in having too many duplicated services.		
21	I think everyone would prefer to be treated where specialist care is available and immediately accessible. This comment applies to all sections		
22	My Husband had excellent care at Cheltenham General. A serious op for Bladder Cancer in 2015		
23	I It will ensure that specialist care is available at all times although it means I will have to travel from my home within walking distance of CGH.		
24	Makes absolute sense to have a Centre of excellence. Paramedics and GP's will know where to take and send associated patients rather than pot luck between two options.		
25	Glos Royal needs to improve		
26	Reduced waiting times Specialised staff in one place, so prompt decisions, better staffing		
27	As I don't drive its most useful		
28	I respect the reasons set out in the consultation document		
29	The creation of a COE will benefit staff and Patients However a more ""joinup"" public transport option needs to be considered - the holder of Gloucester main Bus provider Stagecoach should be able to used their daily/weekly/monthly bus pass in the 99 that links the two hospitals.		
30	Prefer Cheltenham - see page 37 My wife and I are in our 90th year. She is not allowed to drive. I prefer daylight and not Mon or Friday. We live in Tetbury and wish treatment there. So: We prefer Cheltenham and do not like Gloucester, the former being easier for us to reach by car and more convenient in terms of other activities on the day.		
31	I like the ""centre of excellence"" approach		
32	Strongly support the idea of having 'specialties' at one of the two hospitals only.		
33	Possible, good concentration of staff		
34	To concentrate the necessary skills in the centre of the catchment area		
35	If the Acute Medical intake is concentrated on one site, it will make a Type 1 A&E Department less viable on the other site. It also reduces flexibility between the two hospitals, especially in times of any future pandemics.		
36	A state of the art hospital should be built in the forest of dean. Five Acres would be excellent, with maternity facilities. The travel to Gloucester and Cheltenham to and from the forest is horrendous and expensive.		
37	Cheltenham would be more convenient for me, but Gloucester is potentially bigger and within easy reach		

Please tell us what you think about our preferred option to develop: A ‘centre of excellence’ for Acute Medicine (Acute Medical Take) at Gloucestershire Royal Hospital.		Response Percent	Response Total
38	Keeping track of all medicine and where they are used.		
39	GRH is inaccessible for residents of the north cotswolds		
40	It is probably best to divide the centre of excellence status for best use of available expertise		
41	Crucial that there is sufficient capacity to easily meet demands		

Please tell us what you think about our preferred option to develop:A ‘centre of excellence’ for Emergency General Surgery at Gloucestershire Royal Hospital.			Response Percent	Response Total
1	Strongly support		32.76%	19
2	Support		27.59%	16
3	Oppose		12.07%	7
4	Strongly oppose		20.69%	12
5	No opinion		6.90%	4
			answered	58
			skipped	2

Please tell us why you think this, e.g. the information you would like us to consider (36)	
1	Far too far away from Fairford to be a good option for patients from that town/area
2	Too Gloucester central, what about those of us in the East of the Counry?
3	As in previous answer not easy to get to from some parts of County and parking very difficult
4	Many people from Cheltenham and North Gloucestershire would die on the way to Gloucester Royal. The traffic at many times of the day is apalling in Gloucester. You seem to be considering Cheltenham as a small village when in fact it has a population of 112,700. When you include the Cotswolds it rises to 196,300. With the regular increases of population throughout the year this should surely make a difference to your decision.
5	Important to patients and staff.
6	Both centres need to provide excellent emergency surgery.
7	Please see earlier comments,
8	Best location and facilities in the county
9	see above
10	If emergency treatment is performed at one hospital, GRH, it leaves planned surgery at the other, CGH, not liable to interruption for emergency surgery.
11	See my previous answer
12	Emergency treatment should be available at both hospitals. General surgery could be centred in GRH but both hospitals should be able to save lives.
13	Much more favoured is spreading surgical procedures across the county's various community hospitals. It would also provide more centres of learning for the clinical staff.

Please tell us what you think about our preferred option to develop:A ‘centre of excellence’ for Emergency General Surgery at Gloucestershire Royal Hospital.		Response Percent	Response Total
14	It makes sense to concentrate expertise at one hospital, and GRH has already road tested this approach.		
15	As mentioned this sort of service MUST be available at both hospitals. Frankly I do not understand why it should ben centred at one hospital. It appears to be a cost cutting ploy		
16	Agree with any proposal to avoid unnecessary duplication		
17	A centre of excellence at Gloucester Royal would detract from the service at Cheltenham General		
18	Again, although this would be less convenient in respect of a present home the benefits would seem to outweigh the convenience		
19	As previous question.		
20	Glos Royal needs to improve.		
21	Pressure eased on gaps in surgery and better for consultants and trainees. Shorter waiting and being messed about.		
22	Because it makes best use of all resources		
23	The other options are more suitable		
24	If its an emergency, the worry is that you would arrive at CGH and time would be wasted going to GRH because its 5:55pm.		
25	We prefer Cheltenham - see page 37 My wife and I are in our 90th year. She is not allowed to drive. I prefer daylight and not Mon or Friday. We live in Tetbury and wish treatment there. So: We prefer Cheltenham and do not like Gloucester, the former being easier for us to reach by car and more convenient in terms of other activities on the day.		
26	I like the idea of concentrating the expertise in a single location		
27	As above Strongly support the idea of having 'specialties' at one of the two hospitals only.		
28	Better building and access		
29	For the same reasons as above To concentrate the necessary skills in the centre of the catchment area		
30	If ALL emergencies are taken to Gloucestershire Royal Hospital it means the A&E Department at Cheltenham would no longer be a Type 1 A&E Department.		
31	Please note my previous comments the journey from FoD especially for older people is worrying and expensive. Hospital transport has failed badly and causing long delays in returning home. I am 90 years of age		
32	Look at the appointment systems and make the phone system shorter.		
33	see previous comment		
34	It is probably best to divide the centre of excellence status for best use of available expertise		
35	Your second option		
36	Specialisation usually leads to higher quality service and the attraction of most able doctors		

Please tell us what you think about our preferred option to develop:A 'centre of excellence' for Planned Lower GI (colorectal) general surgery at Cheltenham General Hospital (CGH) or Gloucestershire Royal Hospital (GRH).

		Response Percent	Response Total
1	Strongly support	41.38%	24
2	Support	41.38%	24
3	Oppose	1.72%	1
4	Strongly oppose	10.34%	6
5	No opinion	5.17%	3
		answered	58
		skipped	2

Please tell us why you think this, e.g. the information you would like us to consider (34)

1	Far too far away from Fairford to be a good option for patients from that town/area
2	Better than at Gloucester but improve parking
3	Cheltenham General should remain a major hospital together with great in the area
4	Yes it soulnds fine but surely Gloucester Royal will want their own as well!
5	As a sufferer in this speciality I consider it to be of great importance to provide the best possible service.
6	I would support this to be at CGH.
7	Higher standards and expertise can be employed centrally
8	Prefer Cheltenham for reason quoted earlier
9	Cheltenham is quite far enough for us to travel
10	GI is already at CGH why change it, rather expand on it
11	As above
12	Again, this is about providing the best patient service by locating staff at one centre.
13	Again have services available at both Cheltenham and Gloucester
14	Personal experience of my life being saved this last May when admitted through A&E at CGH with Fournier's disease for immediate operation to deal with gangrene and sepsis from infected scrotum.
15	Obviously to split up centre of excellence means less pushing people from one A&E to somewhere everything is not to hand
16	Agree with any proposal to avoid unnecessary duplication
17	Please bear in mind any treatments taken prior to appointments which may make a long journey very difficult
18	We would prefer this service to be available at Cheltenham where my husband had excellence care
19	The proposal would seem to make more effective use of staff and facilities
20	Confused!
21	Not sure about this as people from the Cotswolds need the nearest place yet Gloucester is better for people from that area.
22	A single centre makes best use of sataff and resources
23	COE will benefit Patients and Staff, and make effective use of existing resources
24	If its excellent, who cares where it is?
25	Near both

Please tell us what you think about our preferred option to develop:A ‘centre of excellence’ for Planned Lower GI (colorectal) general surgery at Cheltenham General Hospital (CGH) or Gloucestershire Royal Hospital (GRH).		Response Percent	Response Total
26	Again, I like the scntre of excellence approach and likelihood of fewer cancellations		
27	As above Strongly support the idea of having 'specialties' at one of the two hospitals only.		
28	As above Better building and access		
29	To help spread skills to other major assets		
30	General Surgery is not really a 'surgical specialism', as it relates to many different conditions. In order to justify centralising General Surgery the Hospital Trust appears to be attempting to redefine it as a specialism relating only to colorectal surgery.		
31	See my previous answers on GRH but more so to travel to CGH. My wife is desabled hospital transport is a joke. I wrote to MP Mark Harper about this. I pay for transport and it is expensive		
32	Parking and the use of public transport enabling the general public to use buses from Waterwells through to GRH		
33	CGH is the preferred option		
34	To build expertise at CGH for this speciality		

In supporting our preferred option to create a single site 'centre of excellence', where do you think a ‘centre of excellence’ for Planned Lower GI (colorectal) general surgery should be developed?			Response Percent	Response Total
1	Cheltenham General Hospital (CGH)		51.79%	29
2	Gloucestershire Royal Hospital (GRH)		21.43%	12
3	No opinion		28.57%	16
			answered	56
			skipped	4

Please tell us why you think this, e.g. the information you would like us to consider: (33)	
1	Crucial item for me is that there is an equal balance between what is in Cheltenham and what is in Gloucester....with equal numbers of essential services in each. It must not be Gloucester is the centre with bits in Cheltenham
2	I don't support your preferred option at all
3	Is Great Western Hospital Swindon a better option for those living on The Cotswolds, perhaps a joint venture with Glos NHS
4	Don't like the single site option
5	I believe that you are wrong in trying to decide one place against the other hospital. Gloucester Royal is full to capacity and often difficult to reach because of its situation. The best solution would be to build a new hospital at Staverton and put any ""centres of excellence"" there. This idea, whilst not likely to ever be considered, would be a perfect solution. There is plenty of space at Staverton and the surrounding land. Sites at Gloucester and Cheltenham could be then be sold at a huge profit
6	At present I am not familiar with either Hospital.
7	My personal experience ,choice.

In supporting our preferred option to create a single site 'centre of excellence', where do you think a 'centre of excellence' for Planned Lower GI (colorectal) general surgery should be developed?		Response Percent	Response Total
8	For reason given previously		
9	Surgical team availability. Easier to set up cell salvage, if needed during the oerations.		
10	See above		
11	As above		
12	Although my own experience has been of having colocrectal surgery at GRH, I think location for this is less important than concentrating the expertise at one centre.		
13	Keep both hospitals operating as hospitals for all services. This centre of Excellence "" concept"" is in my opinion RUBBISH. Stop pretending that you are offering a better service when you are diluting what is already available		
14	The emergency detailed above meant I had minutes to live, my kidneys had already failed . My family were called to the hospital soon after the operation as I was given about two hours to live. Living in Hewlett Road, Cheltenham meant a speedy access to A&E which ironically closed about a week or so later. If the timing of my illness had occurred two weeks later I would not be filling in this form.		
15	Because should I or my neighbours need it, it is within easy reach for local transport. GRH in rush hour can take at least 1.5 hours		
16	It makes sense for all GI (lower and upper) services to be in one hospital		
17	Obviously Gloucester is the closest to me, for same reason stated above. Cotswold residents would almost certainly disagree		
18	There is an air of calm efficiency and care at Cheltenham General Hospital which leads to a more rapid recovery time whereas at Gloucester Royal Hospital I feel that the wards seem to be under more pressure.		
19	Ideal in respect of our place of residence		
20	Either. But a Centre of excellence makes sense.		
21	Would keep at both		
22	Make effective use of existing resources		
23	If its excellent, who cares where it is?		
24	Suits us better - see page 37 My wife and I are in our 90th year. She is not allowed to drive. I prefer daylight and not Mon or Friday. We live in Tetbury and wish treatment there. So: We prefer Cheltenham and do not like Gloucester, the former being easier for us to reach by car and more convenient in terms of other activities on the day.		
25	I like the link with the gynae cancer treatment at Chetenham to form Pelvic Resection centre of excellence		
26	Strongly support the idea of single site excellence for all and any hospital procedures		
27	Ditto Better building and access		
28	If this is centralised on one site, it should be on the site where the existing Centre of Excellence for Cancer is based, because of the close relationship between Lower GI Colorectal Surgery and cancer.		
29	I am willing to provide a contribution towards the cost of a new hospital in FoD. Monmouthshire Council I am sure would also contribute instead of having people travelling to Cumbran		
30	More information about ones operations		
31	access to GRH is almost impossible for day patients and for visitors to in-patients if they reside in the north cotswolds		
32	So that centre of excellence status is not all centred at GRH		
33	Appears that more facilities are already there		

Please tell us what you think about our preferred option to develop:A ‘centre of excellence’ for planned day case Upper and Lower GI (colorectal) surgery at Cheltenham General Hospital (CGH).				
			Response Percent	Response Total
1	Strongly support		39.29%	22
2	Support		32.14%	18
3	Oppose		7.14%	4
4	Strongly oppose		7.14%	4
5	No opinion		14.29%	8
			answered	56
			skipped	4

Please tell us why you think this, e.g. the information you would like us to consider (27)	
1	I don't support having only one centre for anything, given the size and demographic of Glos.
2	As before
3	Don't like the single site option, would like both hospitals to offer as many treatments as possible
4	Very important to develop high quality standards whatever the length of visit or stay in a hospital
5	Really can’t imagine what day case GI surgery would entail .
6	See first comment re planned surgery being able to go ahead without theatres being needed for emergencies.
7	Would require better facilities at Cheltenham general in my opinion hospital dated and tired in appearance
8	As above
9	Spreading scarce resources around the county is a preferred method.
10	As per my previous answer. Concentration in one centre is the most important issue.
11	see earlier comments
12	My personal experience detailed in previous page and previous personal observation of the Chichester Hospital whereas friend of ours son is a senior Consultant specialising in this area. He was able to advise my family on my predicament, which he only comes in contact with about once a year. I would like CGH to have this sort of level of skill set.
13	Agree with any proposal to avoid unnecessary duplication
14	See previous 2 comments
15	The journey to Cheltenham from Winchcombe is far better than Gloucester Royal when you are unwell
16	More convenient from a personal point of view
17	Separating Planned surgerty will reduce cancellation and improve patients waiting times
18	N/A
19	GPs' recommendations
20	As above Strongly support the idea of single site excellence for all and any hospital procedures
21	Makes sense to spread workload
22	To centralise the entire colorectal skills
23	It makes sense to focus planned surgery on one site, but this should not only be ""planned day case"", it should also include more complex elective surgery and not merely 'day case surgery'.

Please tell us what you think about our preferred option to develop:A ‘centre of excellence’ for planned day case Upper and Lower GI (colorectal) surgery at Cheltenham General Hospital (CGH).

		Response Percent	Response Total
24	See my previous comments. This is a bad decision and the people of the forest of dean and Monmouth deserve better.		
25	N/A		
26	CGH is convenient GRH is useless for day patients		
27	Helpful to split areas of excellence		

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

			Response Percent	Response Total
1	Strongly support		40.68%	24
2	Support		33.90%	20
3	Oppose		8.47%	5
4	Strongly oppose		5.08%	3
5	No opinion		11.86%	7
			answered	59
			skipped	1

Please tell us why you think this, e.g. the information you would like us to consider (28)

1	Image guidance needs to have services in both locations
2	Grudging support since something will be offered at both sites
3	Cheltenham or Swindon
4	Reluctantly support, again would like both hospitals to offer as many treatments as possible
5	In view of the distances patients are required to travel, I strongly support this proposal
6	Image Guided intervention main hub should be alongside ED
7	Reasons given previously
8	Such specialised intervention should be centralised
9	The way ahead if all the needed skill sets are in place.
10	In the AI age this can be shared between both hospitals
11	see earlier comments
12	It depends what you mean by Spoke.
13	Agree with any proposal to avoid unnecessary duplication
14	We have the excellent cobalt centre in Cheltenham
15	Seems to make sense
16	It is more effective to provide a hub at GRI but a spoke allows more freedom for management
17	This Provide the Best Option - and will mean patients can be seen locally.

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

		Response Percent	Response Total
18	The staff who maintain the LINACS (at CGH) would be best to carry out emergency repairs and maintenance, surely?		
19	N/A		
20	Gloucester Royal is best for me		
21	As above - is the 'spoke' necessary? Strongly support the idea of single site excellence for all and any hospital procedures		
22	It is the logical place		
23	Image Guided Interventional Surgery appears to cross a variety of other specialisms, but seems most relevant to Cardiology and Vascular Surgery, which should be located in the first-class facility that was only created at Cheltenham three years ago.		
24	See my previous comments. The people making the decisions have not had to journey from the FoD to Glos and Chelt 4 or 5 times a year as we have and paid for the privilege		
25	Good idea		
26	patients can be taken to/from GRH by ambulance, access problems are therefore left crucial.		
27	Single location		
28	Need to be able to meet the demand and provide the highest quality of service		

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

			Response Percent	Response Total
1	Strongly support		35.09%	20
2	Support		22.81%	13
3	Oppose		14.04%	8
4	Strongly oppose		7.02%	4
5	No opinion		21.05%	12
			answered	57
			skipped	3

Please tell us why you think this, e.g. the information you would like us to consider (23)

1	Far too far away from Fairford to be a good option for patients from that town/area
2	Too Glos central
3	See my previous answers, Great getting too busy with parking and accessibility problems
4	An important part of medicine that needs a Centre ofvexcellence
5	As above,
6	Ditto

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

		Response Percent	Response Total
7	see above		
8	As before - transport is a serious worry for us		
9	see earlier comments		
10	Agree with any proposal to avoid unnecessary duplication		
11	One excellent speciality		
12	I Struggle to see the Justifcation for the move - other than to be Closer to Trauma unit.		
13	As I said before, as long as it is excellent, who cares where it is?		
14	N/A My wife and I are in our 90th year. She is not allowed to drive. I prefer daylight and not Mon or Friday. We live in Tetbury and wish treatment there. So: We prefer Cheltenham and do not like Gloucester, the former being easier for us to reach by car and more convenient in terms of other activities on the day.		
15	As above Strongly support the idea of single site excellence for all and any hospital procedures		
16	This and IGIS should be in the same location		
17	There is an excellent, nearly new Cardiovascular Unit at Cheltenham General Hospital, which the Hospital Trust spent £2.3m or more on. This is one of the best facilities of its kind in the South West, if not the whole country. It makes no sense to relocate this to the Gloucestershire Royal, especially since, according to six our of seven of the Consultants involved, the facilities there are not nearly as good.		
18	Se my previous comments and reverse you decision. My wife is disabled and I am 90 years of age and her carer. Traveling to Chel and Glos 4 or 5 times a year is traumatic.		
19	Another very good idea.		
20	CGH already does it		
21	The need to create the centre of excellence for specific specialisation over the 2 hospitals		
22	Single location		
23	BME communities have higher rates as diversity to Cheltenham and Gloucester - GRH is perfectly placed		

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

			Response Percent	Response Total
1	Strongly support		40.74%	22
2	Support		40.74%	22
3	Oppose		5.56%	3
4	Strongly oppose		1.85%	1
5	No opinion		11.11%	6
			answered	54
			skipped	6

A permanent ‘centre of excellence’ for Gastroenterology inpatient services at Cheltenham General Hospital.			
		Response Percent	Response Total
Please tell us why you think this, e.g. the information you would like us to consider (21)			
	1	I would also like to see continuing support for Gastroenterology services at Cirencester hospital. I have had excellent treatment there.	
	2	Better for patients from Fairford, but not good for patients living at the west edges of Glos.	
	3	Consider Great Western Swindon for Cotswold residents	
	4	See all my previous answers	
	5	Again, important to have these services readily available	
	6	I fully support the Centre of Excellence principle and am happy to leave the ‘where’ to those more qualified than me to make that decision.	
	7	Reasons given previously re: buildings	
	8	Already in place? One stop shop.	
	9	As above	
	10	Yes both hospitals should be capable of offering all services	
	11	GI and gastroenterology services should all be at the same hospital	
	12	Agree with any proposal to avoid unnecessary duplication	
	13	I have received excellent care at Cheltenham	
	14	Ideal location from a personal point of view	
	15	The Pilot seems to indicate that this is and will continue to work well	
	16	Suits us - see page 37 My wife and I are in our 90th year. She is not allowed to drive. I prefer daylight and not Mon or Friday. We live in Tetbury and wish treatment there. So: We prefer Cheltenham and do not like Gloucester, the former being easier for us to reach by car and more convenient in terms of other activities on the day.	
	17	As above Strongly support the idea of single site excellence for all and any hospital procedures	
	18	Keep the gastro disciplines together	
	19	this is a service which should, as far as possible, be located as close to the existing Cancer Centre in Cheltenham General Hospital.	
	20	See my previous comments	
	21	CGH is best located for the whole of the county	

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

		Response Percent	Response Total
1	Strongly support	57.14%	32
2	Support	26.79%	15
3	Oppose	8.93%	5
4	Strongly oppose	0.00%	0
5	No opinion	7.14%	4
		answered	56
		skipped	4

Please tell us why you think this, e.g. the information you would like us to consider (27)

1	Just what I would like, both hospitals offering service
2	because this would be an excellent idea
3	In view of the large numbers of traffic accidents that seem to have been taking place recently it works appear that the service is essential
4	For similar reasons as already explained, orthopaedics more likely to be planned.
5	Agree need in both locations
6	Best idea for the specialist teams. Already happening. personal experience.
7	I have experiences emergency treatment for a broken wrist at Cheltenham last December. The treatment was outstanding. It was delivered, I leant (after the successful manipulation), by a wonderful Nurse Practitioner. My follow-up consultation at Gloucester was frankly disgraceful - the consultant's treatment was appalling and I complained about him. Excellence must be analysed, and all staff must be tutored to deliver excellent outcomes.
8	Yes both hospitals should be capable of offering all services
9	Orthopaedics can usually hang around and be given pain killers for a certain amount of time.
10	Presume there is sufficient workload to justify 2 similar services. CGH is closer to us, so of course I'm having to have anything that may be needed urgently as close as possible
11	Why would you not make one orthopaedic department in one hospital. would that ensure specialist care available always
12	We have an ongoing population in Winchcombe and Cheltenham General is very much more convenient for everybody. This is very important when you are unwell. A&E, MRI and scans, Orthopaedics, Oncology all provide an excellent service for us and or course surgery as well
13	makes effective use of resources
14	An excellent idea.
15	The divide between the two disciplines is required given the extra resources for orthopaedics
16	The results of this pilot indicate that the proposal is and will continue to work wll
17	Trauma needs unambiguous and fast treatment. I've no idea where/when I can go to CGH so I'd call an ambulance rather than go by car. What a stupid waste of resouces.
18	See onwards to page 37 My wife and I are in our 90th year. She is not allowed to drive. I prefer daylight and not Mon or Friday. We live in Tetbury and wish treatment there. So: We prefer Cheltenham and do not like Gloucester, the former being easier for us to reach by car and more convenient in terms of other activities on the day.

Two permanent ‘centres of excellence’ for Trauma at Gloucestershire Royal Hospital and Orthopaedics at Cheltenham General Hospital.		Response Percent	Response Total
19	As above Strongly support the idea of single site excellence for all and any hospital procedures		
20	I have no support or opposition		
21	From things I have heard about Trauma & Orthopaedics I am not convinced the T&O Pilot study has gone as well as the Hospital Trust has claimed. I should like to see the full report of the Trial, before forming a judgement on this. I am not opposed to most elective orthopaedic surgery being done on one site and most trauma orthopaedics being done on the other, to minimise disruption to elective orthopaedic procedures, but Trauma Orthopaedics is fundamental to a fully functioning A&E Department, not least because it is not always obvious until x-rayed whether an injury is a broken bone or a soft-tissue injury. At least some trauma orthopaedic capacity should be retained on both sites.		
22	Convenient for residents of both areas		
23	Yes very well needed		
24	The 2 centres provide good coverage but CGH has to provide the facilities for trauma patients.		
25	These will not be planned procedures - some instances and being able to receive treatment at the nearest hospital therefore an advantage		
26	Maintain present pilot scheme		
27	Anything that reduces waiting times and ensures quality of surgery would be good		

Please tell us about any impact, either positive or adverse, that you think any of our proposals could have on you and your family (please tell us which service your feedback relates to e.g. IGIS)?		Response Percent	Response Total
1	Open-Ended Question	100.00%	41
1	One major impact on having services at both Cheltenham and Gloucester, How do elderly patients get to these hospitals. Public transport is not good and Taxies are very expensive. We need more localised services!		
2	Any move to create single centres of excellence in Glos OR Chelt is going to have an adverse impact on patients living furthest away from both hospitals.		
3	You need to consider access/travel time		
4	Getting to GRH is very difficult for us so keeping both hospitals offering treatments best option		
5	If you move most services to Gloucester Royal it would immediately present many problems for travelling or finding a place to park. Many older people would be distressed at being so far away from their families.		
6	Please reinstore the full blood service at Cirencester Hospital - it gives an immediate, quick service. GP service will cause long delays and worries to patients, inconvenience and cost to travel to Glos.		
7	As a Volunteer Patienr Representative working directly with the NHS, all aspects of medicine concern me and my family		
8	I do not believe they would impact negatively, the distance between the two centres is not very far, if it was an emergency the patient would be blue lighted anyway. I would rather get the best possible care than decisions being made on geography. If as a plus this means that patients may not need to be sent out of county this is huge benefit		
9	I think you are ignoring a large percentage of residence east of Gloucester not to have a full equipped center of excellence at CGH covering every eventually from A&E to full trauma situations		
10	Positive impact		

Please tell us about any impact, either positive or adverse, that you think any of our proposals could have on you and your family (please tell us which service your feedback relates to e.g. IGIS)?		Response Percent	Response Total
11	Removal of services from Cheltenham would make it very difficult for people of North Cotswolds who depend very strongly on Cheltenham.		
12	Additional travel.		
13	It seems that Cheltenham will become to minor centre. I'm particularly worried about trauma treatment - an accident causing serious injury in the west of the county, where we are, could result in fatality if there were delay in reaching Gloucester hospital.		
14	I am so far healthy therefore none of these proposals would impact me but I would like you to consider patients travelling to either hospital.		
15	Centralisation of treatmentsand procedures becomes wasteful because they lead to long waiting lists, and inevitably centralise specialist staff to the detriment of other hospitals and staff skills loss.		
16	Concentration of some services in Cheltenham may involve us travelling 8 miles further (I live in Gloucester) but I would be happy to do that as the expertise would be in one place.		
17	Any medical treatment should be available at a local hospital. It is wrong to expect patients who are obviously ill to travel to long distances for treatment. Ecologically it is also better for a few medical staff to move between hospitals than for large numbers of patients to travel		
18	Find travel to GRH difficult		
19	No impact.		
20	The move of cardiology and the creation of a centre of excellence to Glos Royal makes no sense....This already exists at Cheltenham Gen and will effect me personally .....I have an existing heart condition.		
21	I and my family have been served very well by the Health Services - but I have had to be referred to both Banbury and Oxford hospitals in my time and was very well looked after. My husband however visiting his mother and my in different hospitals (Banbury and Chelt) went to sleep at the wheel of the car and had a slight crash		
22	We live in Stroud so both Cheltenham and Gloucester hospitals are easily accessible to us		
23	some services will be further away if located at GRH, but when traveling by car it doesn't make a great difference		
24	I need, from time to time, the need for treatment for colorectal and/or gastroenterology problems. I always feel more comfortable in Cheltenham General Hospital		
25	My wife and I are both in our 80s and moved from a rural location in 2019 as we anticipate a point at which we will not own a car. We deliberately bought a property within walking distance of CGH. We have already found it necessary to travel to Gloucester for Xray and my wife was admitted for emergency treatment late on a Saturday evening. I had to return home to collect her essential medication and was able to do so in the car. This would have been particularly difficult without our own transport.		
26	Very important that Accident and Emergency teams are operational at Both hospitals as speed is essential when time is of the essence.		
27	Any proposals impact us if we have to go to Cheltenham as I don't drive. However all options have to be considered when cost is involved.		
28	I live in Cheltenham but have had both inpatient and outpatient treatment at both hospital I have no argument with proposals that lead to improvement in services and staffing		
29	I think overall there will be a positive benefits having local COE's with appropriate staffing		
30	None at present. Who knows the future?		
31	Lack of choice		
32	We live on the border in Herefordshire but our nearest GP surgery is in Gloucestershire where we access services. Having to travel to Cheltenham is too far.		
33	General Surgery at Gloucester Royal		
34	None		

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

		Response Percent	Response Total
35	Travel / visits - for any of these services - not so much for us - we live in Chalford, away from both anyway, but for less well off people who live closer.		
36	I strongly believe health care needs to be delivered as close to where people live and work as possible. This is supposed to be a primary policy of the NHS, yet it seems there is a trend towards ever more centralisation and a move to more and more remote services. While some services can no doubt benefit from greater centralisation, especially where investment in very expensive equipment is concerned, administrative and clinical convenience should not be elevated above ease of access to healthcare.		
37	Cardiac and renal. I am 84, have had 2 heart attacks and been cared for at both hospitals. I have chronic kidney disease		
38	no opinions but good idea		
39	I live in Moreton-in-Marsh and I am not able to drive. Gloucester is a foreign country! Oxford or Worcester is easier to reach. any suggestion of concentrating services at GRH is therefore bad news. only super specialist services should be located here.		
40	The service I use most is eye care and there is no reference to Ophthalmology: any reduction in this service at Cheltenham would be greatly concerning for me.		
41	Should be good		
		answered	41
		skipped	19

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

		Response Percent	Response Total
1	Open-Ended Question	100.00%	23
1	Needs to be more Glos central or joint venture with Great Western Hospital Swindon		
2	Difficult for us to get to and park at GRH so would like CGH to keep full service		
3	I would like to know what suggestions you may have for the following. If my husband had strong pains in his chest in the middle of the rush hour what would be his chances of survival is he were to be taken to Gloucester Royal and there was a traffic jam due to an accident on the Golden Valley? Not great I think.		
4	Downgrading Cirencester Hospital blood tersting service		
5	None		
6	Personally at present not, but who knows as we get older!		
7	See above		
8	It is important that free public transport is available for patients between the two hospitals, so that (for example) people living in Cheltenham are not financially disadvantaged by having to travel to GRH, if they do not have a car.		
9	YES! All the proposals. you are trying to reduce the service offered.		

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

		Response Percent	Response Total
10	Any moves of existing heart, cancer treatment, colo-rectal and imaging facilities to a Gloucester Royal 'centre of excellence' is a retrograde step and a huge waste of funds already spent ..... There should be a full and proper published and publicly available for review Cost Benefit analysis which includes in the model a true and comprehensive explanation of the previous expenditure and costs both current and capital at Cheltenham General. This previous expenditure and the proposed 'write off/downgrade' must be part of the costs.		
11	So far at 90 no negative feedback, but I'm glad I did not have to go to GRH for babies. its a long way and can take a long time. Ambulances when I have needed them have not usually taken too long, but I think a car service, where possible, with blue light supplied might be useful.		
12	My wife has problems with her eyes and we both have hearing issues. We are able to access both services at Cheltenham within walking distance of our home. There are no references to the future location of either, presumably these will be covered in the next phase of planning?		
13	I worry that as we rely on public transport we may not be able to travel easily between hospitals. We have already had to use taxi to do this - that proves expensive; and perhaps will lead to us not bothering		
14	None I can foresee		
15	See next box My wife and I are in our 90th year. She is not allowed to drive. I prefer daylight and not Mon or Friday. We live in Tetbury and wish treatment there. So: We prefer Cheltenham and do not like Gloucester, the former being easier for us to reach by car and more convenient in terms of other activities on the day.		
16	All hospital services - whilst I am able to drive at present, for the future and for all patients a dependable public transport system becomes even more vital if these proposals are enacted.		
17	Greater visibility and support given to people needing to claim travel expenses for hospital visits. Citizens Advice Stroud ran a campaign about this 3-4 years ago, surveying the hospitals and surgeries to see how visible the information was and how easy to claim. The procedure for making a claim and receiving payment was poor. Stressed relatives need immediate assistance. They should not have to wait a month to be reimbursed.		
18	Senior management should listen much more to the views of ALL its frontline staff and not merely those of some of its most Senior Consultants. The Hospital cannot deliver excellent healthcare, regardless of how well equipped its 'Centres of Excellence' are without the goodwill and dedication of all of its staff. It is quite clear the failure to involve frontline staff sufficiently in developing services is undermining morale. There appears to be widespread distrust of senior management among staff and a sense of grudging resignation to having reorganisations imposed on them in a heavy-handed 'top-down' way.		
19	n/a		
20	no negative impact		
21	all services other than super-specialist ones need to be mirrored at CGH		
22	We live only 12 min walk from CGH, therefore the centres of excellence in Gloucester will be less accessible. Not having access to 24 hour A&E is a downside for us.		
23	None that come to mind		
		answered	23
		skipped	37

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

		Response Percent	Response Total
1	Open-Ended Question	100.00%	16

1	We need to keep the blood monitoring service at Cirencester Hospital, even Cheltenham is too far away. If you need a frequent test it would be impossible to do this if you do not have your own transport.
2	Jpoint venture with Great Western Swindon for those living on The Cotswolds
3	No
4	To be ""Fit for the future"" try to repair the damage that has been afflicted to the NHS over recent years. Stop putting operations out to private companies. Work on restoring services which have been cut, reduce waiting times. Put NHS money into the NHS and NOT into private companies
5	""""""developed in collaboration with local people during the Fit for the Future Engagement (see pages 17/19 of the full consultation booklet)."""""" This just means that the one's who shout loudest are listened too the most.....It also assumes the the voices from the deemed 'stakeholders' [NHS chosen or invited!!] are the truly interested parties. Most of us are too busy in our everyday lives to give up time to be part of this stakeholder echo chamber.
6	I think most of possible suggestions seem very sensible, but perhaps more use could be made of voluntary services (stopping blood flow from nasty cuts or wounds where the nearest A&E is not very near and it is closed). Dealing wit fits in children, concussion (small blows to the head). 999 is excellent but Gloucestershire is a big county and the borders far from the centre. Surely we should have a service that can take us to the nearest centre for help and rely on zoom for specialism?
7	No suggestions - the proposals seem to make sense
8	Fully supportive of the changes planned, as timing will be improved and better staffing.
9	My wife and I are in our 90th year. She is not allowed to drive. I prefer daylight and not Mon or Friday. We live in Tetbury and wish treatment there. So: We prefer Cheltenham and do not like Gloucester, the former being easier for us to reach by car and more convenient in terms of other activities on the day.
10	No
11	Recognising the need for change, the proposals for Gastro-intestinal Surgery contained in what was Option 4 should be fully worked up into a proposal, in preference to Option 2 which is what the Hospital Trust appears to have adopted in opposition to the majority of the Consultants involved and GiRFT advice.
12	Build a state of the art hospital in the Forest of Dean at Five Acres which is for sale. Traveling to Glos and Chelt is traumatic, worrying and time consuming for older people who are suffering because of you decisions. We travel 4 or 5 times a year to Glos and Chelt so we know how terrible the journeys are at a time when we are ill and anxious.
13	no
14	I live in Moreton, We have a fine new hospital building which is woefully underused, Yet I am invited to travel to Gloucester for a routine exam, The NHS needs to resolve service delivery issues of this kind, preferably before the new forest of dean hospital opens, for the same problems will arise there. The general impression given in this survey is that services will be organised for the convenience of patients who will usually be sick or indisposed.
15	My alternative suggestion rather than wasting money on expensive surveys like this is to have ONE hospital, between Cheltenham and Gloucester, which could then be available for both. The overall saving to the NHS would after the initial expense, be enormous. I believe the only reason this has not already happened is the ridiculous failure by the two relevant local authorities to agree on a site.
16	None

answered	16
skipped	44

Anything else you would like to say?

		Response Percent	Response Total
1	Open-Ended Question	100.00%	23

	1	Get Cirencester and Tetbury hospitals better integrated into the services provided for patients
	2	Just think more about travel access, parking facilities and best of all getting appointments and blood tests done promptly. The Cotswolds is treated as a backwater by Glos NHS
	3	This is a very ambivalent survey. I am sure not many people will bother to complete it fully I read the lengthy booklet and after looking at the various rather repetitive questions I imagine many people will give up. This I think is what you want. You have intentions and ideas to carry out and I don't believe as a member of this community our opinions matter at all.
	4	Downgrading the blood testing service at Cirencester impacts heavily on local residents
	5	I would like to see a very positive statement, and concrete proposals for the better care of patients presenting with mental health problems in ED. This has been a long ongoing concern, how will Fit for the Future ensure that mental health is given proper consideration?
	6	No
	7	Cary on with the plans.
	8	I haven't the experience to comment on most of this questionnaire.
	9	Even your summary document is far too full and obfuscating! I'd like an honest and clear comparison between services as they were before COVID and as they would be under your preferred proposals, with an indication on the impact in time and accessibility for patients in the various parts of the county.

Anything else you would like to say?

		Response Percent	Response Total
10	The NHS was a great organisation. Over the years it has slowly been destroyed. One great problem is with the GP service. If effectively stops patients from accessing the main NHS services. It is almost impossible to get to see a GP. An example - In November 2019 I had a fall. I damaged my arm. A shard of metal punctured the arm to quite a depth. The arm from elbow to palm of hand went blue and remained blue for weeks. A huge swelling erupted at the puncture point. It was impossible to see my GP. By late December the arm was still swollen and bruised. I was concerned with Christmas upon me. I live alone. I phone 111 I was referred to see my GP the following day. When I entered the GP surgery the first words from GP were I don't usually see people who just walk in off the street. Obviously the GP service is NOT there for older people. The telephone 111 service is a farce. Please don't talk about centre of excellence and fit for the future. Just restore the NHS to a functioning system now The whole of your document has annoyed me. you say that you are attempting to provide centre of excellence while what you are doing is actually trying to whittle away even more of the flesh from the skeleton of the NHS which was a great organisation but which is now a shadow of what it once was. The hospital work is good still once one can get past the deliberate obstacle of the local GP. I have already mentioned the case of my GP who said "" I don't usually see people who walk in off the street"" when I had been referred by 111 service. The episode convinced me that the NHS is simply not there for older people. Please stop trying to fool me into thinking that you are trying to offer centre of excellence Long before that event I went to the GP reception as I have done in the past, to ask for an appointment. The receptionist who is obviously there to protect the doctors from seeing patients, told me that the system had changed. I had to go home and telephone for an appointment. I pointed out that I was there, talking face to face to her so why not organise an appointment. I simply wanted a routine appointment because I was concerned about a long term health issue I have. The receptionist then became aggressive and told me to go home and phone for an appointment. I returned home and phoned the surgery. The line was engaged. I tried to phone many times. The line was always engaged. Making an appointment is now virtually impossible. I presume that your aim is to force people who can afford to, to opt for private treatment. Pleased do not try to disguise your actions as creating centres of excellence The other possible method of getting medical attention is via the A&E. It is a last resort. When I badly damaged my arm I did not bother the A&E system. I would not abuse such a service. However other people who are desperate for treatment have used A&E. You have tried to counter that by removing the A&E from Cheltenham hospital. A lot of public pressure prevented that move completely but you ask about centres of excellence. It is in my opinion impudence on your part. I have health issues. I am elderly and live alone. If I get covid it will no doubt kill me, but I have determined that I will not even try to contact my GP. you so obviously intent on destroying the NHS as it stands. The government says it will be free at the point of delivery and so you are ensuring that there is no point of delivery. I do remember times before the NHS. What a disagree that we are returning to such times again. Centres of excellence RUBBISH		
11	Parking at both centres is problematic and public transport during Covid19 advised against		
12	This appears to me to be yet another way to spend money to create 'something new' and the associated empire building both administratively and medically tghat goes with that. All proposals need to be matched to realistic assumptions of need and the first priority should be proper utilisation of existing resource. Acceptance of the waste of resource [both income and capital] appears to be a huge part of the default NHS model.		
13	Consider what minor injuries services etc could be made more easily available at GP surgeries. Even discounting the Covid effect, the GP is a bottleneck. Overall the treatment me and wife have received from CGH and GRH has been timely and very successful. Thanks to everyone.		
14	Any changes should be accompanied by improved information / communication to staff and public. Staff need to be aware of geography and travel difficulties for appointments to be as convenient as possible. Where as I believe a centre of excellence is essential - longer journeys for clients with children or frail adults will inevitably increase stress levels. With ambulances being tied up for longer transferring patients to the appropriate hospital. You speak of specialist doctors. Are experienced nurses willing to change work base from CGH to GRH		
15	Maybe it is my age? It took a long time to read and digest mentally the information in the Fit for the Future book. I would prefer excellence in all hospitals with adequate staff - well paid and well trained. It would seem that the changes are needed for inpatient care. However, small local hospitals like The Vale at Dursley are most needed for being specialists in maintaining health especially the elderly. Travelling 6 miles is much preferable than 26 miles especially if you cannot use a car!		

Anything else you would like to say?

		Response Percent	Response Total
16	Please look at improving the bus links ! The fact that you use a stagecoach bus for one part of your journey and a pullman for other part - is just not Cost effective for patients.		
17	The survey is difficult for non medics to comprehend. See points above.		
18	No		
19	The publics primary concern about the reconfiguration of specialist services within the hospital relate to the convenience and accessibility of services and the long term sustainability of a Type 1 A&E Department in Cheltenham. Of some of these proposals are implemented it is difficult to see how a full Type 1 A&E Department would be sustainable in the long term. This is despite the reassurances the Hospital Trust has repeatedly been given. It is these proposals which have undermined staff and public confidence in the Hospital Trust's sincerity over the re-opening of Cheltenham A&E and its long term future.		
20	See above please re-think before its too late		
21	no		
22	I used to work for the department of health. The fashion for building new hospitals would alternate between big is beautiful and small is beautiful on a 10 year cycle. The result was that all current buildings was out of step with prevailing thinking. Health trusts need to resolve this conundrum and ensure a successful balance between specialist and locally delivered hospital based options.		
23	Great believer in logic		
		answered	23
		skipped	37

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

		Response Percent	Response Total
1	Open-Ended Question	100.00%	54
1	GL51		
2	GL7		
3	GL7		
4	GL7		
5	GL53		
6	SN6		
7	OX18		
8	GL52		
9	GL53		
10	gl52		
11	GL3		
12	GL54		
13	GL16		
14	GL16		
15	GL54		

What is the first part of your postcode? eg. GL1, GL20		Response Percent	Response Total
16	GL54		
17	Gl53		
18	GL5		
19	GL3		
20	GL52		
21	GL		
22	GL52		
23	GL20		
24	GL51		
25	GL14		
26	GL52		
27	GL6		
28	GL52		
29	GL17		
30	GL54		
31	GL52		
32	GL11		
33	GL12		
34	GL56		
35	Gl53		
36	GL1		
37	GL53		
38	GL8		
39	GL50		
40	HR9		
41	GL51		
42	GL11		
43	GL3		
44	GL11		
45	GL6		
46	GL50		
47	GL16		
48	GL50		
49	GL2		
50	GL56		
51	GL50		
52	GL50		

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

		Response Percent	Response Total
53	GL5		
54	GL7		
		answered	54
		skipped	6

Which age group are you:

			Response Percent	Response Total
1	Under 18		0.00%	0
2	18-25		0.00%	0
3	26-35		0.00%	0
4	36-45		0.00%	0
5	46-55		0.00%	0
6	56-65		0.00%	0
7	66-75		45.00%	27
8	Over 75		55.00%	33
9	Prefer not to say		0.00%	0
			answered	60
			skipped	0

Are you:

			Response Percent	Response Total
1	A health or social care professional		0.00%	0
2	A community partner		3.33%	2
3	A member of the public		96.67%	58
4	Prefer not to say		0.00%	0
			answered	60
			skipped	0

Do you consider yourself to have a disability? (Tick all that apply)				
			Response Percent	Response Total
1	No		5.00%	3
2	Mental health problem		8.33%	5
3	Visual Impairment		11.67%	7
4	Learning difficulties		0.00%	0
5	Hearing impairment		28.33%	17
6	Long term condition		65.00%	39
7	Physical disability		20.00%	12
8	Prefer not to say		0.00%	0
			answered	60
			skipped	0

Do you look after, or give any help or support to family members, friends, neighbours or others because of either a long term physical or mental ill health need or problems related to old age? Please do not count anything you do as part of your paid employment.				
			Response Percent	Response Total
1	Yes		29.31%	17
2	No		67.24%	39
3	Prefer not to say		3.45%	2
			answered	58
			skipped	2

Which best describes your ethnicity?

		Response Percent	Response Total
1	White British	98.33%	59
2	White Other	0.00%	0
3	Asian or Asian British	1.67%	1
4	Black or Black British	0.00%	0
5	Chinese	0.00%	0
6	Mixed	0.00%	0
7	Prefer not to say	0.00%	0
8	Other (please specify):	0.00%	0
		answered	60
		skipped	0

Other (please specify): (0)

No answers found.

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

		Response Percent	Response Total
1	No religion	25.00%	15
2	Buddhist	0.00%	0
3	Christian (including Church of England, Catholic, Methodist and other denominations)	70.00%	42
4	Hindu	0.00%	0
5	Jewish	0.00%	0
6	Muslim	1.67%	1
7	Sikh	0.00%	0
8	Other	1.67%	1
9	Prefer not to say	1.67%	1
		answered	60
		skipped	0

Are you:

		Response Percent	Response Total
1	Male	60.00%	36
2	Female	40.00%	24
3	Transgender	0.00%	0
4	Prefer not to say	0.00%	0
		answered	60
		skipped	0

Do you identify with your gender as registered at birth?

		Response Percent	Response Total
1	Yes	100.00%	60
2	No	0.00%	0
3	Prefer not to say	0.00%	0
		answered	60
		skipped	0

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

		Response Percent	Response Total
1	Heterosexual or straight	94.92%	56
2	Gay or lesbian	0.00%	0
3	Bisexual	0.00%	0
4	Other	0.00%	0
5	Prefer not to say	5.08%	3
		answered	59
		skipped	1

Are you currently pregnant or have given birth in the last year?				
			Response Percent	Response Total
1	Yes		0.00%	0
2	No		50.00%	30
3	Not applicable		50.00%	30
4	Prefer not to say		0.00%	0
			answered	60
			skipped	0

Fit For The Future - What matters to you?

BAME, living with a disability

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

		Response Percent	Response Total
1	Strongly support	60.00%	3
2	Support	20.00%	1
3	Oppose	20.00%	1
4	Strongly oppose	0.00%	0
5	No opinion	0.00%	0
		answered	5
		skipped	0

Please tell us why you think this, e.g. the information you would like us to consider (2)

1	Damaging effect on the local community, as it disproportionately affects vulnerable individuals with protected characteristics. Concerns about bed space at GRH. Concerns about a bottleneck effect at GRH - if you double the amount of traffic, you need to double the width of the road, ALL roads, leading in and out. Leading on to concerns about the lack of funding for SWAS as per their financial outlook to provide the additional ambulance service coverage. Flawed notion of attracting high quality staff from a business/management perspective. Gloucestershire's market has competitors in Bristol, Birmingham (to an extent), Oxford, and of course London. Centralised services will not enable GHNHSFT to outcompete these, leaving us with 'the best of the rest'. This would have been the case whether centralisation occurred or not, thus centralisation itself is a moot point. Flawed concept of 'extra time' to care. This will inevitably lead to cost savings (perhaps instructed by ministers, and not immediately) by reducing staff numbers to provide current levels of care, only now at one site.
2	24/7 access to multidiciplanary teams. Specialist equipment. RIght disciplines to provide services and ability to train more staff

Please tell us what you think about our preferred option to develop: A 'centre of excellence' for Emergency General Surgery at Gloucestershire Royal Hospital.

		Response Percent	Response Total
1	Strongly support	80.00%	4
2	Support	20.00%	1
3	Oppose	0.00%	0
4	Strongly oppose	0.00%	0
5	No opinion	0.00%	0
		answered	5
		skipped	0

Please tell us why you think this, e.g. the information you would like us to consider (2)

Please tell us what you think about our preferred option to develop: A ‘centre of excellence’ for Emergency General Surgery at Gloucestershire Royal Hospital.

		Response Percent	Response Total
1	Support the notion of highly specialised surgical teams at one site. Only concerns are managing the increased throughput. Emergency surgery is rarer than acute medicine so the negative effects there should not occur here.		
2	As for Acute medicine, access to multidisciplanry team and equipment		

Please tell us what you think about our preferred option to develop: A ‘centre of excellence’ for Planned Lower GI (colorectal) general surgery at Cheltenham General Hospital (CGH) or Gloucestershire Royal Hospital (GRH).

		Response Percent	Response Total
1	Strongly support	40.00%	2
2	Support	40.00%	2
3	Oppose	0.00%	0
4	Strongly oppose	0.00%	0
5	No opinion	20.00%	1
		answered	5
		skipped	0

Please tell us why you think this, e.g. the information you would like us to consider (2)

1	If it's planned, why not just go to Oxford and build a bigger unit there?
2	seperating emergency from planned services should prevent cancellations and create the right number of beds for the planned procedures. Co-locating with other pelvic services makes sense as I suspect they often need to work together

In supporting our preferred option to create a single site 'centre of excellence', where do you think a ‘centre of excellence’ for Planned Lower GI (colorectal) general surgery should be developed?

		Response Percent	Response Total
1	Cheltenham General Hospital (CGH)	60.00%	3
2	Gloucestershire Royal Hospital (GRH)	20.00%	1
3	No opinion	20.00%	1
		answered	5
		skipped	0

Please tell us why you think this, e.g. the information you would like us to consider: (2)

1	Why should people from Cheltenham go to Gloucester when they can go to Oxford? If it's planned...
2	as previous question

Please tell us what you think about our preferred option to develop: A ‘centre of excellence’ for planned day case Upper and Lower GI (colorectal) surgery at Cheltenham General Hospital (CGH).				
			Response Percent	Response Total
1	Strongly support		75.00%	3
2	Support		0.00%	0
3	Oppose		0.00%	0
4	Strongly oppose		0.00%	0
5	No opinion		25.00%	1
			answered	4
			skipped	1

Please tell us why you think this, e.g. the information you would like us to consider (2)	
1	Why go to Gloucester when you can go to Oxford?
2	as before

A 24/7 Image Guided Interventional Surgery (IGIS) ‘Hub’ at Gloucestershire Royal Hospital and a ‘Spoke' at Cheltenham General Hospital.				
			Response Percent	Response Total
1	Strongly support		40.00%	2
2	Support		40.00%	2
3	Oppose		0.00%	0
4	Strongly oppose		20.00%	1
5	No opinion		0.00%	0
			answered	5
			skipped	0

Please tell us why you think this, e.g. the information you would like us to consider (2)	
1	Extreme nature of emergency IGIS means the time delay going from Cheltenham to Gloucester would be far too risky re. loss of life to a patient who may, for example's sake, live just across the road from CGH.
2	updating equiment and locating in one site is more cost effective

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

		Response Percent	Response Total
1	Strongly support	25.00%	1
2	Support	25.00%	1
3	Oppose	0.00%	0
4	Strongly oppose	0.00%	0
5	No opinion	50.00%	2
		answered	4
		skipped	1

Please tell us why you think this, e.g. the information you would like us to consider (2)

1	Again, why not just go to Oxford if you live east of Cheltenham?
2	BME communities have higher rates as diversity to Cheltenham and Gloucester - GRH is perfectly placed

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

		Response Percent	Response Total
1	Strongly support	50.00%	2
2	Support	25.00%	1
3	Oppose	0.00%	0
4	Strongly oppose	0.00%	0
5	No opinion	25.00%	1
		answered	4
		skipped	1

Please tell us why you think this, e.g. the information you would like us to consider (1)

1	co-locating with planned day cases with specialist staff and contact points for inpatient and long-term ongoing care

Two permanent ‘centres of excellence’ for Trauma at Gloucestershire Royal Hospital and Orthopaedics at Cheltenham General Hospital.				
			Response Percent	Response Total
1	Strongly support		40.00%	2
2	Support		40.00%	2
3	Oppose		0.00%	0
4	Strongly oppose		0.00%	0
5	No opinion		20.00%	1
			answered	5
			skipped	0

Please tell us why you think this, e.g. the information you would like us to consider (1)	
1	keep specialisms together for better access and equipment

Please tell us about any impact, either positive or adverse, that you think any of our proposals could have on you and your family (please tell us which service your feedback relates to e.g. IGIS)?			
		Response Percent	Response Total
1	Open-Ended Question	100.00%	3
1	Concerns about impact on BAME communities. Concerns about bottleneck effect on Acute Medicine at GRH. Major concerns about IGIS - if a patient needed an emergency procedure in this field and had to be transported to Gloucester, when the lived right next to CGH, the difference in both outcome re. risk of loss of life is to great a difference. Concerns about funding increased Ambulance Service provisions. Flawed concept of attracting high quality staff - London, Oxford, Bristol will always leave us with the best of the rest which the proposals would have no bearing on. Political concerns that down the line (years), any improvements will result in savings related staff reductions.		
2	Gastroenterology and General surgery both needed and would be better if it is clear what service is offered where, and so that continuity of care can be improved. THe proposed changes will achiee this for me		
3	Close proximity to where I live Easy to travel to Gloucester hospital I like the idea of specialists in one area Centres of excellence should enable easy communications between staff		
		answered	3
		skipped	2

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

		Response Percent	Response Total
1	Open-Ended Question	100.00%	3
	1 Delay the proposals by a year. Engage with a private business/ management consultancy firm to determine the true long term impact of these changes, and amend proposals. Social impacts may change too - changes to the way we work in response to Covid may change the landscape such that new options become available.		
	2 Further to travel to Gloucester Royal for emergeny/trauma but if the care is better tht should be mitigated. Cheltenham is still available but not consultant led overnight, which is a concern for trauma admissions		
	3 Parking issues		
		answered	3
		skipped	2

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

		Response Percent	Response Total
1	Open-Ended Question	100.00%	2
	1 Keep emergency care/ acute medical on both sites. Share planned care with Bristol and Oxford. Rotate staff between hospitals/ secondments to generate the requisite culture of flexibility in planned care, with the savings and increased efficiency used to fund emergency care in both local sites.		
	2 whatever is decided should be very clearly communicated as it is rather confusing at the moment		
		answered	2
		skipped	3

Anything else you would like to say?

		Response Percent	Response Total
1	Open-Ended Question	100.00%	1
	1 -		
		answered	1
		skipped	4

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

		Response Percent	Response Total
1	Open-Ended Question	100.00%	4
	1 GL53		
	2 gl51		
	3 GL7		
	4 GL1		
		answered	4
		skipped	1

Which age group are you:

			Response Percent	Response Total
1	Under 18		0.00%	0
2	18-25		0.00%	0
3	26-35		20.00%	1
4	36-45		20.00%	1
5	46-55		0.00%	0
6	56-65		40.00%	2
7	66-75		0.00%	0
8	Over 75		20.00%	1
9	Prefer not to say		0.00%	0
			answered	5
			skipped	0

Are you:

			Response Percent	Response Total
1	A health or social care professional		20.00%	1
2	A community partner		0.00%	0
3	A member of the public		80.00%	4
4	Prefer not to say		0.00%	0
			answered	5
			skipped	0

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

		Response Percent	Response Total
1	No	0.00%	0
2	Mental health problem	20.00%	1
3	Visual Impairment	0.00%	0
4	Learning difficulties	0.00%	0
5	Hearing impairment	0.00%	0
6	Long term condition	60.00%	3
7	Physical disability	20.00%	1
8	Prefer not to say	20.00%	1
		answered	5
		skipped	0

Do you look after, or give any help or support to family members, friends, neighbours or others because of either a long term physical or mental ill health need or problems related to old age? Please do not count anything you do as part of your paid employment.

		Response Percent	Response Total
1	Yes	40.00%	2
2	No	60.00%	3
3	Prefer not to say	0.00%	0
		answered	5
		skipped	0

Which best describes your ethnicity?

		Response Percent	Response Total
1	White British	0.00%	0
2	White Other	40.00%	2
3	Asian or Asian British	40.00%	2
4	Black or Black British	20.00%	1
5	Chinese	0.00%	0
6	Mixed	0.00%	0
7	Prefer not to say	0.00%	0
8	Other (please specify):	0.00%	0
		answered	5
		skipped	0

Other (please specify): (0)

No answers found.

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

		Response Percent	Response Total
1	No religion	20.00%	1
2	Buddhist	0.00%	0
3	Christian (including Church of England, Catholic, Methodist and other denominations)	60.00%	3
4	Hindu	0.00%	0
5	Jewish	0.00%	0
6	Muslim	20.00%	1
7	Sikh	0.00%	0
8	Other	0.00%	0
9	Prefer not to say	0.00%	0
		answered	5
		skipped	0

Are you:				
			Response Percent	Response Total
1	Male		40.00%	2
2	Female		60.00%	3
3	Transgender		0.00%	0
4	Prefer not to say		0.00%	0
			answered	5
			skipped	0

Do you identify with your gender as registered at birth?				
			Response Percent	Response Total
1	Yes		100.00%	5
2	No		0.00%	0
3	Prefer not to say		0.00%	0
			answered	5
			skipped	0

Which of the following best describes how you think of yourself?				
			Response Percent	Response Total
1	Heterosexual or straight		80.00%	4
2	Gay or lesbian		20.00%	1
3	Bisexual		0.00%	0
4	Other		0.00%	0
5	Prefer not to say		0.00%	0
			answered	5
			skipped	0

Are you currently pregnant or have given birth in the last year?				
			Response Percent	Response Total
1	Yes		0.00%	0
2	No		80.00%	4
3	Not applicable		20.00%	1
4	Prefer not to say		0.00%	0
			answered	5
			skipped	0

Fit For The Future - What matters to you?

Responses from people with a disability

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

		Response Percent	Response Total
1	Strongly support	44.35%	55
2	Support	26.61%	33
3	Oppose	12.10%	15
4	Strongly oppose	11.29%	14
5	No opinion	5.65%	7
		answered	124
		skipped	4

Please tell us why you think this, e.g. the information you would like us to consider (73)

1	Many patients do not have transport and will be unable to travel to the'alternative' hospital.
2	It will be easier to manage 24/7 and we will be able to afford the best equipment if only one piece is needed instead of several.
3	In a county this size , with the shortage of doctor and nurses we need to ensure that we have the safest care available and to do this efficiently as possible we need to have services centred on one site , in acute medicine GRH is the preferred site. This will not be popular with Cheltenham people but they have to accept that they will never ever have a fully functioning hospital on their site .
4	As things are, without increased levels of staffing on medical wards, numbers of staff on each shift will just continue to be inadequate/bordering on unsafe. It will be inpossible to provide holistic care.
5	Damaging effect on the local community, as it disproportionately affects vulnerable individuals with protected characteristics. Concerns about bed space at GRH. Concerns about a bottleneck effect at GRH - if you double the amount of traffic, you need to double the width of the road, ALL roads, leading in and out. Leading on to concerns about the lack of funding for SWAS as per their financial outlook to provide the additional ambulance service coverage. Flawed notion of attracting high quality staff from a business/management perspective. Gloucestershire's market has competitors in Bristol, Birmingham (to an extent), Oxford, and of course London. Centralised services will not enable GHNHSFT to outcompete these, leaving us with 'the best of the rest'. This would have been the case whether centralisation occurred or not, thus centralisation itself is a moot point. Flawed concept of 'extra time' to care. This will inevitably lead to cost savings (perhaps instructed by ministers, and not immediately) by reducing staff numbers to provide current levels of care, only now at one site.
6	I think the gastrointestinal ward should be bk in Cheltenham as I have a stoma and Gloucester hospital is far from me
7	I would prefer to go to a site where the specialists are, rather than a hospital that is nearer but there are less staff available
8	Cheltenham is a large town that deserves an ED and Acute medical intake. Previous to this change Gloucester would on a regular daily basis divert either their GP and acute admissions to CGH ACUC as GRH could not cope with the high demand of patients. I feel the care is unsafe and compromised as a result of the change. Cheltenham ED and ACUC would receive patients from the Cotswolds which is an ageing population who relied on CGH service.
9	Coming from Cheltenham and having spent over 30 years working in CGH before moving to GRH, I am quite saddened that CGH seems to be the 'poor relation' and while I understand that for many reasons, services need to be streamlined and centralised, it's hard not to feel upset at certain changes.
10	Far too far away from Fairford to be a good option for patients from that town/area

Please tell us what you think about our preferred option to develop:A ‘centre of excellence’ for Acute Medicine (Acute Medical Take) at Gloucestershire Royal Hospital.		Response Percent	Response Total
11	Too Gloucester central, what about those of us who live to the East of the County?		
12	If it is a place where future care via a plan is determined it must be good.		
13	Gloucester Royal is not easy to get to from many pay of the county		
14	I think it will promote continuing excellence in the services provided and will attract good quality staff to the area.		
15	having access to wide range of specialists as quickly as possible seems key		
16	Cheltenham and surrounding villages and other small towns in Gloucestershire deserve to have their own ""Acute Medical Take"" at CGH. Travelling is difficult enough in Gloucestershire and Gloucester Royal Hospital has very inadequate and expensive parking. This is a very busy tourist town with many festivals bringing thousands of people to the town and it is a very poor decision to only have a centre of excellence in Gloucester. We need our own A & E and also our own Acute Medical Take I am not opposed to Gloucester having its own centre but both places should be treated the same. Gloucester is a very large county stretching from the borders of Wales to the edge of Oxfordshire and Worcestershire.		
17	I think it is important to aim for providing the best possible conditions in the service provided		
18	Both centres need to provide all sorts of emergency medicine .		
19	It makes a lot of sense in so many ways. Specialist staff where they are needed and economy of one place but the assurance of cross information when necessary. A huge plus is that scheduled day surgery will be able to go ahead as planned. As a patient I have experienced surgery required after attending ED with a cut tendon, having to be surgery ready each morning only to be told it would not happen and finally being extremely ill after being giving antibiotics because of the increased risk of infection. I also think that the guided imagery will offer huge benefits e.g. to stroke patients attending ED, removing the clot quickly could mean a reduction in brain damage.		
20	I'm disabled and have no transport to get to and from the hospital in Gloucester would very especially as wheelchair accessible transport is no longer provided to bring me home on the day of discharge		
21	Best location in the county for this service		
22	Gloucestershire Royal is a difficult journey from North Cotswolds with poor bus services. Difficult for older people to visit relatives.		
23	It is the right approach for the future.		
24	It makes sense to me have the expertise in one centre.		
25	Broadly support this measure although concerned about travelling distance for patient and/or family and friends if having to travel from e.g. the east/north of the county. Using a bus (could be 2+), particularly later in the day/evening, or having to fork out a for a taxi/persuade a friend/family member to drive further is far from ideal. Some concerns over whether there would be sufficient bed space for services to be centralised - other hospitals who have merged services from two sites relatively near to each other onto one site have experienced issues with capacity e.g. a county to the north of Gloucestershire Can see the benefits of seeing the right person sooner which is very beneficial for all concerned		
26	More efficient use of specialised staff		
27	If this is thought to be a good idea, it probably is!		
28	We live in the east of the county, and Gloucester is a long way to travel. This problem is exacerbated as we get older, and private transport becomes more difficult. Public transport is simply not an option.		
29	With stretched specialised NHS resources concentrating particular but different Specialists at each hospital makes sense. I am also reassured that A&E will remain at Cheltenham hospital as we live in Bourton-on-the-Water so need to be confident that the closeness of A&E in Cheltenham in an emergency provides a much better chance of survival rather than going all the way to far side of Gloucester from here.		

Please tell us what you think about our preferred option to develop:A ‘centre of excellence’ for Acute Medicine (Acute Medical Take) at Gloucestershire Royal Hospital.		Response Percent	Response Total
30	Creating CoEs across the county will inevitably create a good deal more traversing of the county for patients. I can empathise with the desire to make best use of resources.		
31	24/7 access to multidiciplanary teams. Specialist equipment. RIght disciplines to provide services and ability to train more staff		
32	I think it is important that the best acute care is needed where there is a concentration of expertise. Diluting staff expertise in two centres is not the best way to achieve this. Having acute medicine (acute medical take in Gloucester makes absolute sense, and I do appreciate that for some cases, subsequent transfer to the regional centre in Bristol (e.g. BRI/Southmead) may still be required for the most serious cases.		
33	I feel that this sort of service should be available at Both Cheltenham and Gloucester		
34	all experts in one place considering the staff shortage the NHS is currently under		
35	It makes sense to have one 'centre of excellence' rather than reduced facilities over 2 sites 12 miles apart		
36	It does make some sense to centre areas of expertise. However certain things also need to be taken into consideration. Access for people getting to the locations. Danger of additional time for emergency cases having to go to GRH. What is the impact on the other hospitals such as Cirencester, Tewksbury, Stroud etc.		
37	Depends on future direction of Cheltenham General Hospital		
38	Had an acute kidney stone admission few years ago just after Xmas - live next door to CGH - last thing would have wanted would have been to have been taken to GRH!		
39	Centers of excellence has to be the way forward to benefit the use of technology and Consultant/specialist skills.		
40	I can understand the reasoning and rationale for this option but I worry about capacity, if everyone suddenly has to attend GRH with no option to attend at CGH will waiting times be longer, will standards of care to the community be affected, will it mean that other treatments and services suffer at GRH. I am not against the proposal but these are some thoughts and questions I am having as a (potential) service user and a resident of Gloucestershire. I worry that this is also a step to wind down care and service provision at CGH too.		
41	Its a long way from the outer borders of the county - and not much use if it takes over an hour to get there - starting from 999		
42	No clinicians I have spoken to think that this is a good idea - and I am dubious as to whether this is about patient care or whether it's to save money. Sadly I suspect the latter.		
43	It makes sense to centralise this area		
44	make the best use of the expertise for each discipline. Not point in having too many duplicated services.		
45	I think everyone would prefer to be treated where specialist care is available and immediately accessible. This comment applies to all sections		
46	My Husband had excellent care at Cheltenham General. A serious op for Bladder Cancer in 2015		
47	I It will ensure that specialist care is available at all times although it means I will have to travel from my home within walking distance of CGH.		
48	Makes absolute sense to have a Centre of excellence. Paramedics and GP's will know where to take and send associated patients rather than pot luck between two options.		
49	Glos Royal needs to improve		
50	Reduced waiting times Specialised staff in one place, so prompt decisions, better staffing		
51	As I don't drive its most useful		
52	I respect the reasons set out in the consultation document		

Please tell us what you think about our preferred option to develop:A ‘centre of excellence’ for Acute Medicine (Acute Medical Take) at Gloucestershire Royal Hospital.		Response Percent	Response Total
53	The creation of a COE will benefit staff and Patients However a more ""joinup"" public transport option needs to be considered - the holder of Gloucester main Bus provider Stagecoach should be able to used their daily/weekly/monthly bus pass in the 99 that links the two hospitals.		
54	Timelyt assessment and diagnosis and improved staff cover		
55	Increased chances of seeing the right specialist more quickly. Will provide more focussed training/learning opportunities for junior doctors and medical staff, with continuous supervision by senior doctors. This will contribute to attracting staff and improved retention rates.		
56	Gloucestershire Royal Hospital is not large enough to accommodate such a move		
57	Prefer Cheltenham - see page 37 My wife and I are in our 90th year. She is not allowed to drive. I prefer daylight and not Mon or Friday. We live in Tetbury and wish treatment there. So: We prefer Cheltenham and do not like Gloucester, the former being easier for us to reach by car and more convenient in terms of other activities on the day.		
58	It would make sense to have a particular specialism in one location to avoid possible delays to be seen by a specific consultant and relieve unnecessary travel between sites.		
59	I don't want to go to Gloucester Royal it has a bad reputation and I would not be happy there.		
60	I like the ""centre of excellence"" approach		
61	I think it is vitally important to be able to have access to the right specialists (senior doctors) in a time of need, also address safety issues		
62	Strongly support the idea of having 'specialties' at one of the two hospitals only.		
63	Possible, good concentration of staff		
64	To concentrate the necessary skills in the centre of the catchment area		
65	locating all resources at centre will remove from other part of zone hence increase travel time for a type of care that is time critical, better to have at least some support closer to all users hence alble to treat in 'golden time'		
66	If the Acute Medical intake is concentrated on one site, it will make a Type 1 A&E Department less viable on the other site. It also reduces flexibility between the two hospitals, especially in times of any future pandemics.		
67	A state of the art hospital should be built in the forest of dean. Five Acres would be excellent, with maternity facilities. The travel to Gloucester and Cheltenham to and from the forest is horrendous and expensive.		
68	Cheltenham would be more convenient for me, but Gloucester is potentially bigger and within easy reach		
69	Keeping track of all medicine and where they are used.		
70	GRH is inaccessible for residents of the north cotswolds		
71	More specialist nurses required in Acute Medicine. Real lull in activity when you get up to Acute Medicine.		
72	It is probably best to divide the centre of excellence status for best use of available expertise		
73	Crucial that there is sufficient capacity to easily meet demands		

Please tell us what you think about our preferred option to develop: A 'centre of excellence' for Emergency General Surgery at Gloucestershire Royal Hospital.			Response Percent	Response Total
1	Strongly support		37.40%	46
2	Support		29.27%	36
3	Oppose		8.94%	11
4	Strongly oppose		13.82%	17
5	No opinion		10.57%	13
			answered	123
			skipped	5

Please tell us why you think this, e.g. the information you would like us to consider (66)

1	The same as previous it is easier to manage and better cost savings for the trust, tax payer.
2	See previous answer. Best outcomes for patients is having centralised specialist units where training can also continue and also attract the best and Bridgestone staff .
3	Support the notion of highly specialised surgical teams at one site. Only concerns are managing the increased throughput. Emergency surgery is rarer than acute medicine so the negative effects there should not occur here.
4	Same reason as before, I know there aren't enough specialists, it makes sense to me to have them in one location. If I was in need of emergency surgery I'm not sure I would care where I was as long as someone with the required skill and knowledge was in the same place.
5	Lack of beds, long a&e waiting times, longer wait for operations
6	As before
7	Far too far away from Fairford to be a good option for patients from that town/area
8	Too Gloucester central, what about those of us in the East of the Counry?
9	I don't think any of the 4 options are enough - I would like to know what happens to people who are admitted to CGH before 8pm in an emergency situation where a delay to GRH could be critical and could be criticised by the Coroner should something happen? The time delays - picking up a patient from, say, the other side of the Cotswolds - surely they need to get to the correct help as quickly as possible and GRH may be quite a lot further away than CGH.
10	Any centre of excellence must be good.
11	As in previous answer not easy to get to from some parts of County and parking very difficult
12	I think it will benefit local people to have this provision and will promote continued quality improvement and performance in this area.
13	I want to see best staff possible in an emergency - I don't mind where it is but Gloucester makes more sense
14	Many people from Cheltenham and North Gloucestershire would die on the way to Gloucester Royal. The traffic at many times of the day is apalling in Gloucester. You seem to be considering Cheltenham as a small village when in fact it has a population of 112,700. When you include the Cotswolds it rises to 196,300. With the regular increases of population throughout the year this should surely make a difference to your decision.
15	Important to patients and staff.
16	Both centres need to provide excellent emergency surgery.
17	Please see earlier comments,
18	Too far to travel for people living East of Cheltenham
19	Best location and facilities in the county

Please tell us what you think about our preferred option to develop: A 'centre of excellence' for Emergency General Surgery at Gloucestershire Royal Hospital.		Response Percent	Response Total
20	see above		
21	I have to travel to both hospitals, so it makes no difference to me.		
22	Please note I don't fully follow the options here - the short booklet seemed to refer to the longer booklet. the long booklet was too confusing as to what you really meant. A picture /diagram of the before vs after might help add the clarity required Would support measures to be seen by the right person sooner but some concerns about travelling distance for patient and/or family and friends if having to travel from e.g. the east/north of the county. Using a bus (could be 2+), particularly later in the day/evening, or having to fork out a for a taxi/persuade a friend/family member to drive further is far from ideal. Some concerns over whether there would be sufficient bed space for services to be centralised - other hospitals who have merged services from two sites relatively near to each other onto one site have experienced issues with capacity e.g. a county to the north of Gloucestershire		
23	More efficient use of staff. The more surgeries completed the better the surgeons become and so patient outcomes should improve.		
24	If emergency treatment is performed at one hospital, GRH, it leaves planned surgery at the other, CGH, not liable to interruption for emergency surgery.		
25	See my previous answer		
26	As mentioned on previous page		
27	Emergency treatment should be available at both hospitals. General surgery could be centred in GRH but both hospitals should be able to save lives.		
28	Much more favoured is spreading surgical procedures across the county's various community hospitals. It would also provide more centres of learning for the clinical staff.		
29	As for Acute medicine, access to multidisciplanry team and equipment		
30	It makes sense to concentrate expertise at one hospital, and GRH has already road tested this approach.		
31	As mentioned this sort of service MUST be available at both hospitals. Frankly I do not understand why it should ben centred at one hospital. It appears to be a cost cutting ploy		
32	Again, it makes sense to have one very well equipped and staffed hospital rather than 2 close but less well resourced units		
33	Yes but the risks of additional transfer time for patients. Waiting times are already considerably higher. Can this be mitigated by keeping 'much less urgent cases away'? Strain on Ambulance Service. How does this all impact the other Gloucestershire Hospitals?		
34	Again would like CGH to be able to continue to provide this to local residents and not all centralised at GRH.		
35	Please see my comments on the previous section regarding capacity and my support of the proposal IF the level of service is maintained to ensure that full and effective delivery, commensurate with the population of the area, can still be provided (or this proposal makes the service delivery more efficient).		
36	Better care for the community		
37	Agree with any proposal to avoid unnecessary duplication		
38	Emergency general surgery should be available at both hospitals		
39	A centre of excellence at Gloucester Royal would detract from the service at Cheltenham General		
40	Again, although this would be less convenient in respect of a present home the benefits would seem to outweigh the convenience		
41	As previous question.		
42	Glos Royal needs to improve.		

Please tell us what you think about our preferred option to develop: A ‘centre of excellence’ for Emergency General Surgery at Gloucestershire Royal Hospital.		Response Percent	Response Total
43	Pressure eased on gaps in surgery and better for consultants and trainees. Shorter waiting and being messed about.		
44	Because it makes best use of all resources		
45	The other options are more suitable		
46	Being seen by the right specialist, not going through several appointments and being re-directed		
47	If its an emergency, the worry is that you would arrive at CGH and time would be wasted going to GRH because its 5:55pm.		
48	Quicker, more direct access for patients to the right specialist. A 'centre of excellence' will be an attractor for young doctors. Concentration of the right staff cover. Concentrated and improved learning opportunities for junior staff. However, resources, including beds, nursing staff and theatres, will need to be increased at GRH accordingly.		
49	I do not think that Gloucestershire Royal is a large enough site and believe that patients should have the option to choose which hospital they are treated at and I believe the system works as it was before the shake up of services due to the Covid pandemic. It is blatantly clear that GRH cannot cope with being the only 24hr A&E unit as evidenced by the numerous complaints and concerns that have been raised about this.		
50	We prefer Cheltenham - see page 37 My wife and I are in our 90th year. She is not allowed to drive. I prefer daylight and not Mon or Friday. We live in Tetbury and wish treatment there. So: We prefer Cheltenham and do not like Gloucester, the former being easier for us to reach by car and more convenient in terms of other activities on the day.		
51	This would be a more efficient use of resources.		
52	I would prefer to go to Cheltenham Hospital.		
53	I like the idea of concentrating the expertise in a single location		
54	Yes I would like this to stay in Gloucester I am bias I live just outside Gloucester I like the benefits to staff members and staff retention.		
55	As above Strongly support the idea of having 'specialties' at one of the two hospitals only.		
56	Better building and access		
57	For the same reasons as above To concentrate the necessary skills in the centre of the catchment area		
58	as per commentary in last page; fear over increase travel times		
59	If ALL emergencies are taken to Gloucestershire Royal Hospital it means the A&E Department at Cheltenham would no longer be a Type 1 A&E Department.		
60	Please note my previous comments the journey from FoD especially for older people is worrying and expensive. Hospital transport has failed badly and causing long delays in returning home. I am 90 years of age		
61	Look at the appointment systems and make the phone system shorter.		
62	see previous comment		
63	A centre of excellence is essential and you shouldn't spread your resources. The hospitals are close enough that no areas should be disadvantaged.		
64	It is probably best to divide the centre of excellence status for best use of available expertise		
65	Your second option		
66	Specialisation usually leads to higher quality service and the attraction of most able doctors		

Please tell us what you think about our preferred option to develop:A ‘centre of excellence’ for Planned Lower GI (colorectal) general surgery at Cheltenham General Hospital (CGH) or Gloucestershire Royal Hospital (GRH).				
			Response Percent	Response Total
1	Strongly support		48.36%	59
2	Support		31.15%	38
3	Oppose		2.46%	3
4	Strongly oppose		5.74%	7
5	No opinion		12.30%	15
			answered	122
			skipped	6

Please tell us why you think this, e.g. the information you would like us to consider (66)	
1	The same as previous it is easier to manage and better cost savings for the trust, tax payer.
2	Again it would make sense to have all GI surger on one site as patients don’t always fit nicely into one speciality . So, GRH.
3	If the ward is staffed properly, it could work.
4	If it's planned, why not just go to Oxford and build a bigger unit there?
5	I think it should be bk in Cheltenham
6	Planned care still requires experts and equipment, its unreasonable to expect the NHS to be able to fund this on two sites that are so close to each other
7	It has been mooted for some time, so that GRH would become the 'hot' hospital, while CGH would take 'cold surgery'. This seems to have been an accepted version of things to come, so it is no surprise, and for me, there is no good reason to oppose
8	Far too far away from Fairford to be a good option for patients from that town/area
9	Better than at Gloucester but improve parking
10	If some cases would follow on from an a & e visit it makes sense to have it where the larger a & e capacity is
11	Cheltenham General should remain a major hospital together with great in the area
12	It will benefit local people needing this type of surgery
13	essential to attract good specialists and perhaps in time take on childrens so we dont have to travel to Bristol
14	Specialist staff in one place should mean collaboration in terms of quickly dealing with patient problems. Quick treatment/ diagnosis of Crohn’s can reduce the need for surgery, less time off work and a better quality of life!
15	Yes it soulnds fine but surely Gloucester Royal will want their own as well!
16	As a sufferer in this speciality I consider it to be of great importance to provide the best possible service.
17	I would support this to be at CGH.
18	But Cheltenham would be easier because of my disability and needing wheechair accessible transport which cost more if I am required to go to Gloucester Royal
19	CGH
20	Higher standards and expertise can be employed centrally
21	Prefer Cheltenham for reason quoted earlier
22	experienced good service/care at CGH

Please tell us what you think about our preferred option to develop:A ‘centre of excellence’ for Planned Lower GI (colorectal) general surgery at Cheltenham General Hospital (CGH) or Gloucestershire Royal Hospital (GRH).		Response Percent	Response Total
23	I support a centre for excellence.		
24	Again slightly confused as to the proposal here - a before/after diagram might have helped. Would support measures to cut risk of operations being cancelled at the last minute / being able to be seen/treated by the right person sooner. Again this needs balancing with the risks of insufficient bed spaces if centralised on one sight (e.g. county to the north of Gloucestershire. In addition there are the same travel concerns - if one is not well, coming by car may be the most practical method of transport, however unpalatable it may be. Hence adequate parking facilities are a must e.g. a dedicated carpark with more short term spaces say of up to 45 minutes		
25	I agree with the center of excellence approach in principle. I think it will improve patient outcomes.		
26	I think it would be beneficial to have lower G.I. consultants operating or based at Cheltenham. Often other specialities such as Gynae-oncology and urology doing pelvic surgery require assistance or advice from lower G.I. surgeons.		
27	Cheltenham is quite far enough for us to travel		
28	With elective surgery the distances to either hospital are manageable and can be planned. It the A&E that needs to remain available at both sites.		
29	GI is already at CGH why change it, rather expand on it		
30	As above		
31	seperating emergency from planned services should prevent cancellations and create the right number of beds for the planned procedures. Co-locating with other pelvic services makes sense as I suspect they often need to work together		
32	Again, this is about providing the best patient service by locating staff at one centre.		
33	Again have services available at both Cheltenham and Gloucester		
34	Again, it makes sense to have one very well equipped and staffed hospital rather than 2 close but less well resourced units		
35	As per previous comments		
36	Personal experience of my life being saved this last May when admitted through A&E at CGH with Fournier’s disease for immediate operation to deal with gangrene and sepsis from infected scrotum.		
37	Support options where there is access to both sites so this is good		
38	It doesn't matter which site, so long as the service is there and available.		
39	Obviously to split up centre of excellence means less pushing people from one A&E to somewhere everything is not to hand		
40	It can only be a good thing for the people of Gloucestershire		
41	Agree with any proposal to avoid unnecessary duplication		
42	CGH would be the better location		
43	Please bear in mind any treatments taken prior to appointments which may make a long journey very difficult		
44	We would prefer this service to be available at Cheltenham where my husband had excellence care		
45	The proposal would seem to make more effective use of staff and facilities		
46	Confused!		
47	Not sure about this as people from the Cotswolds need the nearest place yet Gloucester is better for people from that area.		
48	A single centre makes best use of sataff and resources		

Please tell us what you think about our preferred option to develop:A ‘centre of excellence’ for Planned Lower GI (colorectal) general surgery at Cheltenham General Hospital (CGH) or Gloucestershire Royal Hospital (GRH).		Response Percent	Response Total
49	COE will benefit Patients and Staff, and make effective use of existing resources		
50	If its excellent, who cares where it is?		
51	Concentration of a specialised team and the necessary resources.		
52	Near both		
53	If it is at GRH		
54	Again, it must be best to have all the specialists in one location.		
55	At Cheltenham		
56	Again, I like the scntre of excellence approach and likelihood of fewer cancellations		
57	I think there would be lots of advantages to keeping all the planned lower colorectal general surgery in Gloucester. Everything and every member of staff present.		
58	As above Strongly support the idea of having 'specialties' at one of the two hospitals only.		
59	As above Better building and access		
60	To help spread skills to other major assets		
61	lose of this type of surgery would result in doctors/other specialists relocating hence would be unable to support A&E dept		
62	General Surgery is not really a 'surgical specialism', as it relates to many different conditions. In order to justify centralising General Surgery the Hospital Trust appears to be attempting to redefine it as a specialism relating only to colorectal surgery.		
63	See my previous answers on GRH but more so to travel to CGH. My wife is desabled hospital transport is a joke. I wrote to MP Mark Harper about this. I pay for transport and it is expensive		
64	Parking and the use of public transport enabling the general public to use buses from Waterwells through to GRH		
65	CGH is the preferred option		
66	To build expertise at CGH for this speciality		

In supporting our preferred option to create a single site 'centre of excellence', where do you think a ‘centre of excellence’ for Planned Lower GI (colorectal) general surgery should be developed?			Response Percent	Response Total
1	Cheltenham General Hospital (CGH)		47.11%	57
2	Gloucestershire Royal Hospital (GRH)		21.49%	26
3	No opinion		33.06%	40
			answered	121
			skipped	7

Please tell us why you think this, e.g. the information you would like us to consider: (61)

In supporting our preferred option to create a single site 'centre of excellence', where do you think a ‘centre of excellence’ for Planned Lower GI (colorectal) general surgery should be developed?		Response Percent	Response Total
1	Crucial item for me is that there is an equal balance between what is in Cheltenham and what is in Gloucester....with equal numbers of essential services in each. It must not be Gloucester is the centre with bits in Cheltenham		
2	Wherever you feel it is easier and safer to provide this from. Where other support services are on hand.		
3	As above so the specialists are on one site , can cross cover be available.		
4	Lower GI is currently at CGH, and in general works well with a v.dedicated multidisciplinary team.		
5	Why should people from Cheltenham go to Gloucester when they can go to Oxford? If it's planned...		
6	CGH should be the site for all planned activity		
7	Oncology		
8	What will there be about CGH to attract anybody to work there, if surgery is removed from Cheltenham altogether?		
9	I don't support your preferred option at all		
10	Is Great Western Hospital Swindon a better option for those living on The Cotswolds, perhaps a joint venture with Glos NHS		
11	As it is planned surgery the patient can arrange transport beforehand so I don't see any issues		
12	BOTH HOSPITALS. STOP PUTTING PRESSURE ALL ONTO ONE SITE		
13	Don't like the single site option		
14	I don't think it matters where the provision is. I cant see that one site has more benefit that the other.		
15	we live in Stroud - now my son has transitioned into adult IBD services we have had infusions in GRH, consultant appointment in GRH and MRI in Chelt - the travel relatively easy for us so wherever means staff travelling less.		
16	I believe that you are wrong in trying to decide one place against the other hospital. Gloucester Royal is full to capacity and often difficult to reach because of its situation. The best solution would be to build a new hospital at Staverton and put any ""centres of excellence"" there. This idea, whilst not likely to ever be considered, would be a perfect solution. There is plenty of space at Staverton and the surrounding land. Sites at Gloucester and Cheltenham could be then be sold at a huge profit		
17	At present I am not familiar with either Hospital.		
18	My personal experience ,choice.		
19	See previous question		
20	For reason given previously		
21	As previous		
22	Surgical team availability. Easier to set up cell salvage, if needed during the oerations.		
23	Ensure services are split more equally between sites & prevent all the eggs being put into one basket. If at Gloucester, could lead to capacity problems and there is only a finite amount of space to build on, if indeed funds can be found to pay for construction/re-figurement. By locating in Cheltenham, seems to sit/align with other services to allow a more wholistic treatment service		
24	I think it makes more sense to have surgical units for upper and lower GI surgery in one location		
25	Due to other specialities already doing pelvic surgery in this hospital. Surely a 'centre of excellence' would allow surgeons to assist and advise each other when required.		
26	See above		
27	As above		

In supporting our preferred option to create a single site 'centre of excellence', where do you think a 'centre of excellence' for Planned Lower GI (colorectal) general surgery should be developed?		Response Percent	Response Total
28	as previous question		
29	Although my own experience has been of having colocrectal surgery at GRH, I think location for this is less important than concentrating the expertise at one centre.		
30	Keep both hospitals operating as hospitals for all services. This centre of Excellence "" concept"" is in my opinion RUBBISH. Stop pretending that you are offering a better service when you are diluting what is already available		
31	GRH is a larger site, has better facilities and is more accessible for visitors. I have had surgery in CGH in the past and felt the facilities were poor and the care was lacking. It is also very difficult for visitors to find somewhere to park.		
32	most of the issues are probably cancer related so it makes sense to put this in Cheltenham with the existing unit - although the buildings at Cheltenham are in dire need of refurbishment and modernising		
33	the main center for this type of surgery is already in Cheltenham - so why would you wan t to move it ?		
34	The emergency detailed above meant I had minutes to live, my kidneys had already failed . My family were called to the hospital soon after the operation as I was given about two hours to live. Living in Hewlett Road, Cheltenham meant a speedy access to A&E which ironically closed about a week or so later. If the timing of my illness had occurred two weeks later I would not be filling in this form.		
35	Again, it doesn't matter which site, so long as the service is there and available and ensure capacity and effective care for Gloucestershire residents. In my mind it would make sense to have a particular specialist treatment at both sites i.e. GRH is centre of excellence for XX and CGH is centre of excellence for YY. So that one or other site does not become defunct.		
36	Because should I or my neighbours need it, it is within easy reach for local transport. GRH in rush hour can take at least 1.5 hours		
37	It makes sense for all GI (lower and upper) services to be in one hospital		
38	Obviously Gloucester is the closest to me, for same reason stated above. Cotswold residents would almost certainly disagree		
39	There is an air of calm efficiency and care at Cheltenham General Hospital which leads to a more rapid recovery time whereas at Gloucester Royal Hospital I feel that the wards seem to be under more pressure.		
40	Ideal in respect of our place of residence		
41	Either. But a Centre of excellence makes sense.		
42	Would keep at both		
43	Make effective use of existing resources		
44	Better on-site facilities and car-parking at Gloucester. Not sure where there is adequate space in Cheltenham		
45	If its excellent, who cares where it is?		
46	Would seemingly make best sense to locate this at CGH to create a centre of excellence for pelvic resection; and to keep this surgery service entirely separated from the pressures of the Emergency General Surgery at GRH (as suggested in the consultation booklet)'		
47	Suits us better - see page 37 My wife and I are in our 90th year. She is not allowed to drive. I prefer daylight and not Mon or Friday. We live in Tetbury and wish treatment there. So: We prefer Cheltenham and do not like Gloucester, the former being easier for us to reach by car and more convenient in terms of other activities on the day.		
48	It is important not to concentrate every resource at one location, e.g. Glos, as this would increase the possibility of a single point failure.		
49	Cheltenham has a better reputation in area.		

In supporting our preferred option to create a single site 'centre of excellence', where do you think a ‘centre of excellence’ for Planned Lower GI (colorectal) general surgery should be developed?		Response Percent	Response Total
50	I like the link with the gynae cancer treatment at Chetenham to form Pelvic Resection centre of excellence		
51	I think a centre of excellence, a single one would benefit the local and wider community by being situated in Gloucester.		
52	Strongly support the idea of single site excellence for all and any hospital procedures		
53	Ditto Better building and access		
54	north of zone seems to be where population will grow (housing plan) and south activity would likely be split between gch & new forest of dean hospital		
55	If this is centralised on one site, it should be on the site where the existing Centre of Excellence for Cancer is based, because of the close relationship between Lower GI Colorectal Surgery and cancer.		
56	I am willing to provide a contribution towards the cost of a new hospital in FoD. Monmouthshire Council I am sure would also contribute instead of having people travelling to Cumbran		
57	More information about ones operations		
58	access to GRH is almost impossible for day patients and for visitors to in-patients if they reside in the north cotswolds		
59	Family orientated at Cheltenham and more friendly, smaller pods.		
60	So that centre of excellence status is not all centred at GRH		
61	Appears that more facilities are already there		

Please tell us what you think about our preferred option to develop:A ‘centre of excellence’ for planned day case Upper and Lower GI (colorectal) surgery at Cheltenham General Hospital (CGH).			Response Percent	Response Total
1	Strongly support		42.15%	51
2	Support		29.75%	36
3	Oppose		4.13%	5
4	Strongly oppose		4.96%	6
5	No opinion		19.01%	23
			answered	121
			skipped	7

Please tell us why you think this, e.g. the information you would like us to consider (50)	
1	The same as previous it is easier to manage and better cost savings for the trust, tax payer.
2	If there are enough surgeons to cover this service , my concern is if an emergency service is also working how will the oncology patients be managed in an emergency situation
3	Why go to Gloucester when you can go to Oxford?
4	If planned surgery is on the same site then you keep a cohort of skills in that location
5	I don't support having only one centre for anything, given the size and demographic of Glos.

Please tell us what you think about our preferred option to develop:A ‘centre of excellence’ for planned day case Upper and Lower GI (colorectal) surgery at Cheltenham General Hospital (CGH).		Response Percent	Response Total
6	As before		
7	Don't like the single site option, would like both hospitals to offer as many treatments as possible		
8	Benefits local people.		
9	Specialist equipment in one place, more efficient use of resources and specialist staff.		
10	Very important to develop high quality standards whatever the length of visit or stay in a hospital		
11	Really can’t imagine what day case GI surgery would entail .		
12	See first comment re planned surgery being able to go ahead without theatres being needed for emergencies.		
13	Easy access and close to carers who need to visit me and don't drive		
14	Would require better facilities at Cheltenham general in my opinion hospital dated and tired in appearance		
15	I support the idea of one team on one site locally		
16	Now very confused - how is this different to the previous two questions? Answers are as previous - support measures to cut last minute cancellations & being able to be seen & treated by the right person quicker. however this needs balancing with concerns over travel distance and reaching capacity at one site		
17	As above		
18	Spreading scarce resources around the county is a preferred method.		
19	as before		
20	As per my previous answer. Concentration in one centre is the most important issue.		
21	see earlier comments		
22	Although I support the idea of a 'centre of excellence', I do think that CGH needs some significant investment in order to become this and it's not the easiest place to travel to/park at due to the limited facilities. I like the idea of specialist care and if this is more readily available at CGH than GRH, then I am in support.		
23	as previous answer		
24	This is already in Cheltenham. I have had to use it and found it excellent.		
25	Planned surgery in one location does make a lot of sense, as long as the wait times do not increase and also operations are not cancelled due to other factors.		
26	My personal experience detailed in previous page and previous personal observation of the Chichester Hospital whereas friend of ours son is a senior Consultant specialising in this area. He was able to advise my family on my predicament, which he only comes in contact with about once a year. I would like CGH to have this sort of level of skill set.		
27	Personally this suits me but appreciate that Glocs residents may not want to come all way over to Cheltenham		
28	So long as patients can access the location where their surgery is taking place.		
29	Agree with any proposal to avoid unnecessary duplication		
30	See previous 2 comments		
31	The journey to Cheltenham from Winchcombe is far better than Gloucester Royal when you are unwell		
32	More convenient from a personal point of view		
33	Separating Planned surgerty will reduce cancellation and improve patients waiting times		
34	Concentration of expertise and dedicated staff in one location will improve patient care and efficiency.		

Please tell us what you think about our preferred option to develop:A ‘centre of excellence’ for planned day case Upper and Lower GI (colorectal) surgery at Cheltenham General Hospital (CGH).		Response Percent	Response Total
35	N/A		
36	As there may be possible overlap between the two treatments it would be best if there were all located in the same site.		
37	I think it is a good idea to separate out the emergency and planned cases, so having the day cases all at CGH makes sense along with other planned general surgery and the emergency cases in GR.		
38	Cheltenham has a better reputation.		
39	GPs' recommendations		
40	This would work well because it is planned surgery instead of emergency surgery. Not so much of an issue around transport and time scales		
41	As above Strongly support the idea of single site excellence for all and any hospital procedures		
42	Makes sense to spread workload		
43	To centralise the entire colorectal skills		
44	if there does need to be service better where county housing plan will put most new housing/greater need.		
45	It makes sense to focus planned surgery on one site, but this should not only be ""planned day case"", it should also include more complex elective surgery and not merely 'day case surgery'.		
46	See my previous comments. This is a bad decision and the people of the forest of dean and Monmouth deserve better.		
47	N/A		
48	CGH is convenient GRH is useless for day patients		
49	Yes for centre of excellence and yes for Cheltenham.		
50	Helpful to split areas of excellence		

A 24/7 Image Guided Interventional Surgery (IGIS) ‘Hub’ at Gloucestershire Royal Hospital and a ‘Spoke' at Cheltenham General Hospital.			Response Percent	Response Total
1	Strongly support		37.90%	47
2	Support		33.06%	41
3	Oppose		7.26%	9
4	Strongly oppose		5.65%	7
5	No opinion		16.13%	20
			answered	124
			skipped	4

Please tell us why you think this, e.g. the information you would like us to consider (47)	
1	Image guidance needs to have services in both locations
2	The same as previous it is easier to manage and better cost savings for the trust, tax payer.

A 24/7 Image Guided Interventional Surgery (IGIS) ‘Hub’ at Gloucestershire Royal Hospital and a ‘Spoke' at Cheltenham General Hospital.		Response Percent	Response Total
3	Makes sense as the oncology services are at Chet=ltenham so would need support		
4	Extreme nature of emergency IGIS means the time delay going from Cheltenham to Gloucester would be far too risky re. loss of life to a patient who may, for example's sake, live just across the road from CGH.		
5	Imaging is essential to remain in CGH, Unsure as to why their is a need to transfer everything to GRH when there is a perfectly good working hospital with skilled staff members at CGH.		
6	Grudging support since something will be offered at both sites		
7	Cheltenham or Swindon		
8	Reluctantly support, again would like both hospitals to offer as many treatments as possible		
9	Will provide a better health care service for local people.		
10	espensive kit and specialist staff - makes no sense to try and run 2 sites		
11	In view of the distances patients are required to travel, I strongly support this proposal		
12	Image Guided intervention main hub should be alongside ED		
13	Reasons given previously		
14	Such specialised intervention should be centralised		
15	The way ahead if all the needed skill sets are in place.		
16	This would presumably mean that there could be more appointments available.		
17	Appears to be specialist treatment needing expensive specialist equipment operated by experts. Given this seems better to centralise as one service - some people may travel a little further but far fewer would need to travel out of county at evenings/weekends. Going to hospital unexpectedly (or even planned) is not a good experience so removing a longer journey with some of the complications this can lead to seems a beneficial step		
18	In the AI age this can be shared between both hospitals		
19	updating equiment and locating in one site is more cost effective		
20	see earlier comments		
21	Would prefer all in one place to maximise use of resources but accept probably a need at Cheltenham for a smaller unit in support of other services based there		
22	It depends what you mean by Spoke.		
23	I prefer it to be offred at both		
24	I have put 'oppose' because I feel neutral about this proposal (so I do have an opinion but not either way at the moment). My reason is as follows: as long as patients attending both have the same access to the surgery/treatment they need e.g. so that those patients attending a non surgical centre are not disadvantaged by this model/proposal.		
25	Agree with any proposal to avoid unnecessary duplication		
26	We have the excellent cobalt centre in Cheltenham		
27	Seems to make sense		
28	It is more effective to provide a hub at GRI but a spoke allows more freedom for management		
29	This Provide the Best Option - and will mean patients can be seen locally.		
30	Less likelihood of being transferred to other hospital sites. Retention of staff is pararmount		
31	The staff who maintain the LINACS (at CGH) would be best to carry out emergency repairs and maintenance, surely?		

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

		Response Percent	Response Total
32	If EGS and Acute Medical Take are located at GRH, then it makes good sense to make GRH the hub for IGIS. It would also seem sensible for there to be a 'spoke' at CGH to work alongside oncology, urology and other specialisations there.		
33	N/A		
34	It would seem that more patients could be treated in this way.		
35	I think this will allow the best use of equipment by having the main hub at GRH but still maintaining some of the spoke services at CGH.		
36	If we can choose where we go.		
37	Gloucester Royal is best for me		
38	Yes I would like IGIS Hus at Gloucester and a spoke at Cheltenham General Hospital, I like the fact you do not have to travel between sites and outside of the county.		
39	As above - is the 'spoke' necessary? Strongly support the idea of single site excellence for all and any hospital procedures		
40	It is the logical place		
41	Image Guided Interventional Surgery appears to cross a variety of other specialisms, but seems most relevant to Cardiology and Vascular Surgery, which should be located in the first-class facility that was only created at Cheltenham three years ago.		
42	See my previous comments. The people making the decisions have not had to journey from the FoD to Glos and Chelt 4 or 5 times a year as we have and paid for the privilege		
43	Good idea		
44	patients can be taken to/from GRH by ambulance, access problems are therefore left crucial.		
45	Have had heart surgery and this would have helped me at the time and taken away the need to attend Oxford. Great for bringing the specialists to Gloucestershire to work. Open up the service to more charitable funds.		
46	Single location		
47	Need to be able to meet the demand and provide the highest quality of service		

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

			Response Percent	Response Total
1	Strongly support		32.20%	38
2	Support		25.42%	30
3	Oppose		11.02%	13
4	Strongly oppose		7.63%	9
5	No opinion		23.73%	28
			answered	118
			skipped	10

Please tell us why you think this, e.g. the information you would like us to consider (42)

A 'centre of excellence' for Vascular Surgery at Gloucestershire Royal Hospital.			
		Response Percent	Response Total
1	The same as previous it is easier to manage and better cost savings for the trust, tax payer.		
2	The current location of this ward is totally unsuitable-i.e not enough space between beds, and only one bathroom that a wheelchair can fit into.		
3	Again, why not just go to Oxford if you live east of Cheltenham?		
4	Far too far away from Fairford to be a good option for patients from that town/area		
5	Too Glos central		
6	See my previous answers, Great getting too busy with parking and accessibility problems		
7	I think it is an interesting area of surgery and will provide excellent provision for local people.		
8	An important part of medicine that needs a Centre ofvexcellence		
9	As above,		
10	Ditto		
11	see above		
12	One team working closely together		
13	Again confused - suggest you need to engage some communications experts to put the proposals AND link them to the survey in plain english/language understandable by non medical persons. Appears to be specialist treatment needing expensive specialist equipment operated by experts. Given this seems better to centralise as one service - some people may travel a little further but far fewer would need to travel out of county at evenings/weekends. Going to hospital unexpectedly (or even planned) is not a good experience so removing a longer journey with some of the complications this can lead to seems a beneficial step		
14	Whilst I support this, I believe there needs to be a vascular consultant available to cover CGH at all times due to the major surgery that CGH provides. In an emergency situation in theatre a vascular surgeon could be needed very quickly!		
15	As before - transport is a serious worry for us		
16	see earlier comments		
17	Again, the same point of view. Maximise the use of resources in one place rather than try to do everything everywhere		
18	As per previous observations		
19	I think it should be offered at both sites		
20	Please read my earlier comments regarding capacity, service delivery and my reservations that moving particular services to GRH alone must not lead to the closure of CGH (based on the assumption that GRH alone cannot service the whole catchment community).		
21	Agree with any proposal to avoid unnecessary duplication		
22	One excellent speciality		
23	I Struggle to see the Justifcation for the move - other than to be Closer to Trauma unit.		
24	Better facilities and car-parking at GRH		

A 'centre of excellence' for Vascular Surgery at Gloucestershire Royal Hospital.			
		Response Percent	Response Total
	25	As I said before, as long as it is excellent, who cares where it is?	
	26	Patients and clinical teams will have continual access to other acute speciality services, and these can operate in a more efficient linked-up manner.	
	27	Vascular Surgery had a very good set up at Cheltenham General Hospital with the IR theatre being built and utilised. The theatre sessions at Gloucestershire Royal Hospital are inadequate and the ward is literally a joke, not fit for purpose and the ward is dirty and the bed capacity is severely lacking. The service works perfectly well at Cheltenham General Hospital and would be costly to move on a permanent basis and even the consultants in the department are strongly opposed to moving on the grounds of patient safety and capacity issues.	
	28	N/A My wife and I are in our 90th year. She is not allowed to drive. I prefer daylight and not Mon or Friday. We live in Tetbury and wish treatment there. So: We prefer Cheltenham and do not like Gloucester, the former being easier for us to reach by car and more convenient in terms of other activities on the day.	
	29	Having Vascular surgery at GRH will mean that vascular surgery will be able to support the emergency services better.	
	30	I would like to make sure that we get best care not sure which hospital is best.	
	31	I appreciate the fact less invasive surgery would be needed and reduced travel time for some procedures, so that would be a bonus.	
	32	As above Strongly support the idea of single site excellence for all and any hospital procedures	
	33	This and IGIS should be in the same location	
	34	as noted earlier CofE reduces resourcing supporting A&E from other hospitals	
	35	There is an excellent, nearly new Cardiovascular Unit at Cheltenham General Hospital, which the Hospital Trust spent £2.3m or more on. This is one of the best facilities of its kind in the South West, if not the whole country. It makes no sense to relocate this to the Gloucestershire Royal, especially since, according to six our of seven of the Consultants involved, the facilities there are not nearly as good.	
	36	Se my previous comments and reverse you decision. My wife is disabled and I am 90 years of age and her carer. Traveling to Chel and Glos 4 or 5 times a year is traumatic.	
	37	Another very good idea.	
	38	CGH already does it	
	39	You need the technology to do this and therefore would be good to be in Gloucestershire. Need to have the wards set up for this close to the theatres. Will pull in staff and money by having a centre of excellence. Increase the number of specialist nurses.	
	40	The need to create the centre of excellence for specific specialisation over the 2 hospitals	
	41	Single location	
	42	BME communities have higher rates as diversity to Cheltenham and Gloucester - GRH is perfectly placed	

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

		Response Percent	Response Total
1	Strongly support	44.92%	53
2	Support	31.36%	37
3	Oppose	3.39%	4
4	Strongly oppose	1.69%	2
5	No opinion	18.64%	22
		answered	118
		skipped	10

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

1	The same as previous it is easier to manage and better cost savings for the trust, tax payer.
2	I would also like to see continuing support for Gastroenterology services at Cirencester hospital. I have had excellent treatment there.
3	Better for patients from Fairford, but not good for patients living at the west edges of Glos.
4	Consider Great Western Swindon for Cotswold residents
5	See all my previous answers
6	I think if gastroenterology is going to be based at Cheltenham then the surgery should be carried out there too so that all gastroenterology services are under one roof. I don't like departments being split between the different sites.
7	Efficient use of resources, access to specialist staff at all times, no waiting for them to travel from GRH to CGH and vice-versa. The total patient capacity must still remain the same (and hopefully higher!), not reduce as a result.
8	Again, important to have these services readily available
9	I fully support the Centre of Excellence principle and am happy to leave the ‘where’ to those more qualified than me to make that decision.
10	Easily accessable
11	Reasons given previously re: buildings
12	experienced excellent care re gastro at CGH
13	Already in place? One stop shop.
14	Expertise and resources at one site.
15	Seem to be wanting to move all other services away from Cheltenham - might be an exaggeration but that is what is coming across, whether intended or not. The shorter booklet was understandable until it referred you to the longer booklet - that just descended into more confusion Again support measures to have less last minute cancellations & being seen/treated by the right person sooner. Need to balance this against over centralising and leading to capacity constraints & greater travelling time for those in the west of the county, particularly at the start/end of the day & at weekends
16	As above
17	co-locating with planned day cases with specialist staff and contact points for inpatient and long-term ongoing care
18	Yes both hospitals should be capable of offering all services
19	I am in support of this if it means that all the specialists are in one place. I do have concerns about the lack of parking facilities at CGH - especially if patients are being asked to travel from further afield to attend this site.

A permanent ‘centre of excellence’ for Gastroenterology inpatient services at Cheltenham General Hospital.		Response Percent	Response Total
	20	One unit to maximise use of resources but tempered by the fact that Cheltenham hospital is in drastic need of refurbishment.	
	21	As long as it meets patient need, is accessible and effective. My responses are based on the assumption that this proposal will deliver better efficiency and improved clinical outcomes than the current model/service provision in place.	
	22	GI and gastroenterology services should all be at the same hospital	
	23	Agree with any proposal to avoid unnecessary duplication	
	24	I have received excellent care at Cheltenham	
	25	Ideal location from a personal point of view	
	26	The Pilot seems to indicate that this is and will continue to work well	
	27	Treated more quickly by a specialist	
	28	Improved conditions for medical staff, and therefore beneficial for patients.	
	29	Suits us - see page 37 My wife and I are in our 90th year. She is not allowed to drive. I prefer daylight and not Mon or Friday. We live in Tetbury and wish treatment there. So: We prefer Cheltenham and do not like Gloucester, the former being easier for us to reach by car and more convenient in terms of other activities on the day.	
	30	It is clear that reverting to the set-up from the pre-pilot stage would be worse off for many aspects. It seems to be working well, and it is fulfilling the world-wide move to centres of excellence.	
	31	We think all procedures should be available at all hospitals, but Cheltenham is preferable to us over Gloucester as it is marginally closer.	
	32	Yes, always keep anything that is excellent and working well!	
	33	As above Strongly support the idea of single site excellence for all and any hospital procedures	
	34	Keep the gastro disciplines together	
	35	Cheltenham as an older demographic than other parts of the zone covered by trust however might be best not to have CofE so specialist doctors are available for A&E support at all the hospitals in the trusts zone	
	36	this is a service which should, as far as possible, be located as close to the existing Cancer Centre in Cheltenham General Hospital.	
	37	See my previous comments	
	38	CGH is best located for the whole of the county	
	39	Cheltenham would do well with the long term illnesses and having a centre of excellence for this specialty. Facilities are questionable to make this a great centre excellence - the physical building.	

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

		Response Percent	Response Total
1	Strongly support	48.76%	59
2	Support	29.75%	36
3	Oppose	5.79%	7
4	Strongly oppose	1.65%	2
5	No opinion	14.05%	17
		answered	121
		skipped	7

Please tell us why you think this, e.g. the information you would like us to consider (49)

1	The same as previous it is easier to manage and better cost savings for the trust, tax payer.
2	Need to be on one site . Have CRH as cold , non emergency surgery and GRH as emergency. Which would protect beds at CRH
3	Just what I would like, both hospitals offering service
4	Don't know why we need two centres. Probably better to have everyone on one site rather than spreading resources more thinly across two sites.
5	I still think one trauma centre would be better but understand why Cheltenham seen as important
6	because this would be an excellent idea
7	In view of the large numbers of traffic accidents that seem to have been taking place recently it works appear that the service is essential
8	For similar reasons as already explained, orthopaedics more likely to be planned.
9	Only makes sense if full A&E restored at Cheltenham
10	Agree need in both locations
11	both equally important and necessary
12	Best idea for the specialist teams. Already happening. personal experience.
13	This would seem to imply that services could be maximised.
14	Seems to be 'mainstream' treatments/services - in a county of Gloucestershire's size, two centres seem to balance travel times for patients etc vs having enough staff/wards/capacity for treatment. Also avoids needless over centralising and the risks of having insufficient capacity / something happening at one site meaning all treatment is affected
15	I have experiences emergency treatment for a broken wrist at Cheltenham last December. The treatment was outstanding. It was delivered, I leant (after the successful manipulation), by a wonderful Nurse Practitioner. My follow-up consultation at Gloucester was frankly disgraceful - the consultant's treatment was appalling and I complained about him. Excellence must be analysed, and all staff must be tutored to deliver excellent outcomes.
16	keep specialisms together for better access and equipment
17	Yes both hospitals should be capable of offering all services
18	Long waiting lists currently for NHS. GPs really just prescribe anti inflammatory drugs and until your condition deteriorates badly before referral process is even initiated.
19	Tie in with need to keep A& E open at both locations
20	Transport for staff who currently work at one or other of the hospitals who have to travel by bike / walk / bus etc be supported having to then travel further?

Two permanent ‘centres of excellence’ for Trauma at Gloucestershire Royal Hospital and Orthopaedics at Cheltenham General Hospital.		Response Percent	Response Total
21	Please refer to my previous comments, I support this if it will service the community more effectively and if it will lead to improved clinical outcomes.		
22	Orthopaedics can usually hang around and be given pain killers for a certain amount of time.		
23	Presume there is sufficient workload to justify 2 similar services. CGH is closer to us, so of course I'm having to have anything that may be needed urgently as close as possible		
24	Why would you not make one orthopaedic department in one hospital. would that ensure specialist care available always		
25	We have an ongoing population in Winchcombe and Cheltenham General is very much more convenient for everybody. This is very important when you are unwell. A&E, MRI and scans, Orthopaedics, Oncology all provide an excellent service for us and or course surgery as well		
26	makes effective use of resources		
27	An excellent idea.		
28	The divide between the two disciplines is required given the extra resources for orthopaedics		
29	The results of this pilot indicate that the proposal is and will continue to work wll		
30	Trauma surgery has long wait times and increasing number of patients for hip, knee surgery can only be of benefit particularly the age demographic in Gloucestershire		
31	Trauma needs unambiguous and fast treatment. I've no idea where/when I can go to CGH so I'd call an ambulance rather than go by car. What a stupid waste of resouces.		
32	It suggests a more efficient and effective division of labour, building upon the existing specialisations in both hospitals.		
33	See onwards to page 37 My wife and I are in our 90th year. She is not allowed to drive. I prefer daylight and not Mon or Friday. We live in Tetbury and wish treatment there. So: We prefer Cheltenham and do not like Gloucester, the former being easier for us to reach by car and more convenient in terms of other activities on the day.		
34	Best to have two centres as this creates redundancy to allow combined work in the event of failure at one site without affecting the other.		
35	Separating out emergency trauma and elective orthopaedics makes sense as it again puts the planned care in CGH which will be a calmer hospital and more suitable for that type of services, and the emergency services can have their centre of excellence at GRH. Again, having the centres of excellence is a sensible way forward, and the pilot seems to have worked well.		
36	It is a much better model to have expertise available at different hospitals, than to have it based only in one location. However, we would prefer all procedures to be available at other hospitals in Gloucestershire too.		
37	Yes I agree with this, this can be needed at anytime, having two centres of excellent is very comforting. Reduces travel, retention of staff , waiting times		
38	As above Strongly support the idea of single site excellence for all and any hospital procedures		
39	I have no support or opposition		
40	Trauma will in many cases also require Orthopaedics support so it seems best to have both specialist available in both hospitals		

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

		Response Percent	Response Total
41	From things I have heard about Trauma & Orthopaedics I am not convinced the T&O Pilot study has gone as well as the Hospital Trust has claimed. I should like to see the full report of the Trial, before forming a judgement on this. I am not opposed to most elective orthopaedic surgery being done on one site and most trauma orthopaedics being done on the other, to minimise disruption to elective orthopaedic procedures, but Trauma Orthopaedics is fundamental to a fully functioning A&E Department, not least because it is not always obvious until x-rayed whether an injury is a broken bone or a soft-tissue injury. At least some trauma orthopaedic capacity should be retained on both sites.		
42	I recently had a 2 week stay in Gloucester hospital after I had a trauma to my ankle (I completely shattered all the bones in my ankle and required 4 hours of surgery under general anaesthetic to mend it)		
43	Convenient for residents of both areas		
44	Yes very well needed		
45	The 2 centres provide good coverage but CGH has to provide the facilities for trauma patients.		
46	Yes, have the planned events at Cheltenham as this is the direction of travel and would work well.		
47	These will not be planned procedures - some instances and being able to receive treatment at the nearest hospital therefore an advantage		
48	Maintain present pilot scheme		
49	Anything that reduces waiting times and ensures quality of surgery would be good		

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

		Response Percent	Response Total
1	Open-Ended Question	100.00%	79
1	It will be safer for us to have everything in one place.		
2	I want the best care for my family and whether we travel to Cheltenham or Gloucester is irrelevant and has no bearing.		
3	Concerns about impact on BAME communities. Concerns about bottleneck effect on Acute Medicine at GRH. Major concerns about IGIS - if a patient needed an emergency procedure in this field and had to be transported to Gloucester, when the lived right next to CGH, the difference in both outcome re. risk of loss of life is to great a difference. Concerns about funding increased Ambulance Service provisions. Flawed concept of attracting high quality staff - London, Oxford, Bristol will always leave us with the best of the rest which the proposals would have no bearing on. Political concerns that down the line (years), any improvements will result in savings related staff reductions.		
4	long waiting times and hugely packed waiting areas are not ideal when you are poorly		
5	One major impact on having services at both Cheltenham and Gloucester, How do elderly patients get to these hospitals. Public transport is not good and Taxies are very expensive. We need more localised services!		
6	Any move to create single centres of excellence in Glos OR Chelt is going to have an adverse impact on patients living furthest away from both hospitals.		
7	You need to consider access/travel time		
8	I don't drive so to get to CGH I would have to go on the bus, that's if I can afford it. Or not go at all.		

Please tell us about any impact, either positive or adverse, that you think any of our proposals could have on you and your family (please tell us which service your feedback relates to e.g. IGIS)?		Response Percent	Response Total
9	Only with delays getting to GRH if CGH is nearer to where it happens.		
10	Getting to GRH is very difficult for us so keeping both hospitals offering treatments best option		
11	I think in general the proposals are positive and will improve the services available in Gloucester.		
12	my son comes under gastroenterology and a strong specialist team is what is important not where they are based		
13	longer ravel times are a reality, not a possible consequence		
14	Gastroenterology. Patient myself, diagnosed with Crohn's at the age of 13, 27 now. Dr Shaw and the Gastro team are extremely skilled, and give good treatment to their patients. However during my latest severe flare up (2015/16) I struggled to get the medication and testing I needed, this delay of several months stopped me being able to work as a teacher for 9/10 months, eventually leading to surgery to remove scar tissue. I hope that if the proposed centre of excellence goes ahead patients would be able to access testing, medication and surgery much faster. Faster treatment would save the need for surgery in some cases, saving the NHS money if the disease can be controlled by medication as soon as a flare up occurs.		
15	If you move most services to Gloucester Royal it would immediately present many problems for travelling or finding a place to park. Many older people would be distressed at being so far away from their families.		
16	Please reinstore the full blood service at Cirencester Hospital - it gives an immediate, quick service. GP service will cause long delays and worries to patients, inconvenience and cost to travel to Glos.		
17	As a Volunteer Patienr Representative working directly with the NHS, all aspects of medicine concern me and my family		
18	I do not believe they would impact negatively, the distance between the two centres is not very far, if it was an emergency the patient would be blue lighted anyway. I would rather get the best possible care than decisions being made on geography. If as a plus this means that patients may not need to be sent out of county this is huge benefit		
19	Neither site is well located for people living outside Gloucester or Cheltenham. Especially relevant for critical A&E cases where time is critical. Closure of Cheltenham A&E for people like us living East of Cheltenham means significant additional delays, on top of what are already poor response times. We would be better served going to Oxford or Worcester.		
20	we live near to CGH and already lost our A&E		
21	I think you are ignoring a large percentage of residence east of Gloucester not to have a full equipped center of excellence at CGH covering every eventually from A&E to full trauma situations		
22	Positive impact		
23	Removal of services from Cheltenham would make it very difficult for people of North Cotswolds who depend very strongly on Cheltenham.		
24	Additional travel.		
25	Support measures to cut last minute cancellations & ensure quicker treatment by the right person - if staff cannot be recruited / equipment not replaced due to budget constraints / equipment not being used as e.g. staff are on the other site, something needs to change to allow people to be treated and sent home more quickly either better or with appropriate measures in place.		
26	We are equidistant from Cheltenham and Gloucester, so the planned changes will not have any real impact on us		
27	It seems that Cheltenham will become to minor centre. I'm particularly worried about trauma treatment - an accident causing serious injury in the west of the county, where we are, could result in fatality if there were delay in reaching Gloucester hospital.		

Please tell us about any impact, either positive or adverse, that you think any of our proposals could have on you and your family (please tell us which service your feedback relates to e.g. IGIS)?		Response Percent	Response Total
28	We might have to travel further to Gloucester hospital in the event Of a certain condition as we are in Bourton-on-the-Water so neither sites are especially close but the extra distance is a small price to pay for increased expertise/ excellence and reduced cancellations of operations		
29	I am so far healthy therefore none of these proposals would impact me but I would like you to consider patients travelling to either hospital.		
30	Centralisation of treatmentsand procedures becomes wasteful because they lead to long waiting lists, and inevitably centralise specialist staff to the detriment of other hospitals and staff skills loss.		
31	Gastroenterology and General surgery both needed and would be better if it is clear what service is offered where, and so that continuity of care can be improved. THe proposed changes will achiee this for me		
32	Concentration of some services in Cheltenham may involve us travelling 8 miles further (I live in Gloucester) but I would be happy to do that as the expertise would be in one place.		
33	Any medical treatment should be available at a local hospital. It is wrong to expect patients who are obviously ill to travel to long distances for treatment. Ecologically it is also better for a few medical staff to move between hospitals than for large numbers of patients to travel		
34	I haven't had to use hospital services so it is difficult to form a clear opinion. But access to Gloucester is easier. It's really about geography.		
35	The gastro services will have a direct impact on me. Theft that all specialists will be in the one place, and waiting lists will be lower is a hugely positive thing. My main concern is the lack of parking and facilities at CGH vs GRH.		
36	To have the experts in one place is a positive		
37	noone		
38	Have used Cheltenham when needed Colonoscopy using the 2 week wait system etc. Found the building itself confusing (easier to find from outside than inside). but the care received was excellent and easily accessable.		
39	Find travel to GRH difficult		
40	I prefer it when Cheltenham residents can get access at CGH for all these things where possible. E.g. my phototherapy treatment used to be at CGH a ten mins walk for me now I have an hour round trip to GRH which is bad for the environment and a complete time waste.		
41	No impact.		
42	For me an my family we can access either GRH or CGH but I know that this will not be the case for all residents requiring care.		
43	The move of cardiology and the creation of a centre of excellence to Glos Royal makes no sense....This already exists at Cheltenham Gen and will effect me personally .....I have an existing heart condition.		
44	I and my family have been served very well by the Health Services - but I have had to be referred to both Banbury and Oxford hospitals in my time and was very well looked after. My husband however visiting his mother and my in different hospitals (Banbury and Chelt) went to sleep at the wheel of the car and had a slight crash		
45	I think it would adversly affect my work		
46	The importance to me and my family is the travel to and from Gloucestershire and Cheltenham hospitals. if we needed treatment		
47	We live in Stroud so both Cheltenham and Gloucester hospitals are easily accessible to us		
48	some services will be further away if located at GRH, but when traveling by car it doesn't make a great difference		
49	Please see my comments under anything else. I would not support any services restructuring which adversely effect CGH's viability. I cannot comment on the medical proposals but Gloucestershire needs two major hospitals particularly with new settlements.		

Please tell us about any impact, either positive or adverse, that you think any of our proposals could have on you and your family (please tell us which service your feedback relates to e.g. IGIS)?		Response Percent	Response Total
50	I need, from time to time, the need for treatment for colorectal and/or gastroenterology problems. I always feel more comfortable in Cheltenham General Hospital		
51	My wife and I are both in our 80s and moved from a rural location in 2019 as we anticipate a point at which we will not own a car. We deliberately bought a property within walking distance of CGH. We have already found it necessary to travel to Gloucester for Xray and my wife was admitted for emergency treatment late on a Saturday evening. I had to return home to collect her essential medication and was able to do so in the car. This would have been particularly difficult without our own transport.		
52	Very important that Accident and Emergency teams are operational at Both hospitals as speed is essential when time is of the essence.		
53	Any proposals impact us if we have to go to Cheltenham as I don't drive. However all options have to be considered when cost is involved.		
54	I live in Cheltenham but have had both inpatient and outpatient treatment at both hospital I have no argument with proposals that lead to improvement in services and staffing		
55	I think overall there will be a positive benefits having local COE's with appropriate staffing		
56	Positive impact, we have all been treated under the NHS in the last 12-18 months and these proposals can only improve primary healthcare in Gloucestershire		
57	None at present. Who knows the future?		
58	Concentrating expertise in one of two hospitals will be beneficial for staff and patients; improve the capacity of hospitals to be both centres of excellence and centres of medical training; reduce waiting times and improve chances for patients of being seen by the right specialists more quickly, with the necessary follow-up care.		
59	I started to work for Cheltenham Hospital 27 years ago when I lived in Gloucester and have since moved to Tewkesbury and then Evesham. The travel time now is almost an hour each way and moving the department I work in (and have worked in for nearly 8 years) to Gloucestershire Royal Hospital will add at least an extra 30 minutes each way to my journey. I will not be able to sustain this and will subsequently be forced to look for work elsewhere within Cheltenham Hospital, something I do not want to do as I thoroughly enjoy working in Vascular surgery. I work in Vascular Surgery.		
60	Lack of choice		
61	A possible positive impact would be an increased likelihood of a successful outcome of any treatment in the future.		
62	Because we live in the very south of the county to a certain extent these changes will have very little impact on us as we are pretty much as far away from one hospital as the other. The time taken to get to either of them is about the same, and as there is no public transport to either hospital, it doesn't really matter for any of the services at either hospital. However, I know that having centres of excellence can generally improve patient outcomes, which is why I support the developments of the centres of excellence. At the moment some trauma and emergencies from our area are dealt with at Southmead, so if GRH and CGH can become superior centres of excellence, then perhaps we would be more likely to be treated in county. i would rather battle the traffic into Cheltenham or Gloucester than Bristol.		
63	The parking fees are an outrage and would stop us being able to visit, I feel uncomfortable with being in Gloucester Royal due to bad reputation		
64	We live on the border in Herefordshire but our nearest GP surgery is in Gloucestershire where we access services. Having to travel to Cheltenham is too far.		
65	General Surgery at Gloucester Royal		

Please tell us about any impact, either positive or adverse, that you think any of our proposals could have on you and your family (please tell us which service your feedback relates to e.g. IGIS)?		Response Percent	Response Total
66	I have multiple disabilities and cannot drive or travel on public transport. If I ever need any of the services covered in this proposal, I want them to be as close as possible to my home. It is easier for elderly, disabled, and very sick people to travel to their nearest hospital. An unfamiliar environment may be distressing for them, and it may be more difficult for their families to visit if they are further away. I will not be the only person in this category who is not able to either drive themselves or travel on public transport. Therefore, all procedures should be available in all hospitals, not in one centre. This feedback relates to all the services.		
67	My family and I could be affected positively by services being centralised because we would get the treatment we need in time by highly motivated trained staff.		
68	None		
69	Travel / visits - for any of these services - not so much for us - we live in Chalford, away from both anyway, but for less well off people who live closer.		
70	Hope fully our only need will be A&E based and in this area I fear the proposals are negative		
71	I strongly believe health care needs to be delivered as close to where people live and work as possible. This is supposed to be a primary policy of the NHS, yet it seems there is a trend towards ever more centralisation and a move to more and more remote services. While some services can no doubt benefit from greater centralisation, especially where investment in very expensive equipment is concerned, administrative and clinical convenience should not be elevated above ease of access to healthcare.		
72	I hope that under the new proposed services any future problems i have with my replaced ankle will be dealt with by highly trained specialists in a very well educated and informed manner kindly and efficiently. The service I received was great (the surgeon was excellent) and the consultant aftercare was brilliant		
73	Cardiac and renal. I am 84, have had 2 heart attacks and been cared for at both hospitals. I have chronic kidney disease		
74	no opinions but good idea		
75	I live in Moreton-in-Marsh and I am not able to drive. Gloucester is a foreign country! Oxford or Worcester is easier to reach. any suggestion of concentrating services at GRH is therefore bad news. only super specialist services should be located here.		
76	Would have a centre of excellence as this would have helped me. Joined up access to medical records across the county. Would be good to have the images able to be shared with GP.		
77	The service I use most is eye care and there is no reference to Ophthalmology: any reduction in this service at Cheltenham would be greatly concerning for me.		
78	Should be good		
79	Close proximity to where I live Easy to travel to Gloucester hospital I like the idea of specialists in one area Centres of excellence should enable easy communications between staff		
		answered	79
		skipped	49

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

		Response Percent	Response Total
1	Open-Ended Question	100.00%	57

1	NO
2	I consider the effect will be positive
3	Delay the proposals by a year. Engage with a private business/ management consultancy firm to determine the true long term impact of these changes, and amend proposals. Social impacts may change too - changes to the way we work in response to Covid may change the landscape such that new options become available.
4	Cheltenham needs a functioning ED with acute medical intake
5	Needs to be more Glos central or joint venture with Great Western Hospital Swindon
6	There should be all services on both sites. Other wise people just would not/could not travel for treatment and they would risk death as they could not access the treatment they need.
7	Difficult for us to get to and park at GRH so would like CGH to keep full service
8	None
9	none
10	work with the transport services
11	Capacity must remain the same or increase in totality for Gloucestershire.
12	I would like to know what suggestions you may have for the following. If my husband had strong pains in his chest in the middle of the rush hour what would be his chances of survival is he were to be taken to Gloucester Royal and there was a traffic jam due to an accident on the Golden Valley? Not great I think.
13	Downgrading Cirencester Hospital blood tersting service
14	If A&E centre of excellence is going to be based at GRH, there needs to be more 24x7 ambulance provision for remote areas to compensate for additional journey time.
15	Mum died in GRH and my Daughter had such a traumatic time having her first baby she refused to return there to have her second baby. She was treated so badly she was traumatised
16	None
17	Personally at present not, but who knows as we get older!
18	The only downside of creating centres of excellence could be that I may have two family members being treated at the same time on different sites which could cause problems with supporting them. However, this is hopefully unlikely.
19	All proposals where treatment is being centralised - travel times/arrangements. Concern over extended travel times for patient/family/friends, particularly when someone is unwell. Relying on public transport particularly at the start of the day/evenings/weekends does not sound great. Even in the middle of the day it does not sound great when it could be 2 or 3 buses and all the hanging around that entails. Paying for a taxi is expensive & if relying on friends/family/a neighbour, it is more awkward to ask them to double/triple/quadruple the journey time
20	No negative impact, however I think that there needs to be clear communication about which services are provided by which hospital
21	See above
22	Travelling by car more likely to be required to get to more distant Gloucester hospital so Additional parking provision would help.
23	Further to travel to Gloucester Royal for emergeny/trauma but if the care is better tht should be mitigated. Cheltenham is still available but not consultant led overnight, which is a concern for trauma admissions

If you think any of our proposals could have a negative impact on you and your family, how should we try to limit this (please tell us which service your feedback relates to e.g. IGIS)?		Response Percent	Response Total
24	It is important that free public transport is available for patients between the two hospitals, so that (for example) people living in Cheltenham are not financially disadvantaged by having to travel to GRH, if they do not have a car.		
25	YES! All the proposals. you are trying to reduce the service offered.		
26	Travelling to Cheltenham from the south end of gloucestershire is difficult.		
27	none		
28	Trying to find areas in Cheltenham hospital is not easy. Make sure you enter the building at the correct entrance, as finding your way inside the building is impossible.		
29	I can imagine transport for some patients families that need support might need to be considered. Parking access - is there sufficient to support these changes? Bus services?		
30	I want access to as many things to continue at CGH as possible. this consultation seeems to want to centralise as amny things to GRH as possible and I'm against that e.g. moving the A&E away from CGH has not gone down well with local residents and our MP		
31	Logistics, ensuring that patients can access the site they need. Ensuring that care is not compromised by having specialisms at a particular site i.e. will there be enough Nurses, Doctors, Specialists to provide effective care under the models proposed or will it mean less capacity. Will the proposals be affected by inevitable budget cuts that will take place from now as a result of the economic decline for this country we are entering now. I am assuming the proposals were put together at a different point in time and wonder if the current economic climate and impact that this will have on costs (budget) and the health of the population means that the proposal has to be reviewed to ensure it is still fit for purpose.		
32	Any moves of existing heart, cancer treatment, colo-rectal and imaging facilities to a Gloucester Royal 'centre of excellence' is a retrograde step and a huge waste of funds already spent ..... There should be a full and proper published and publicly available for review Cost Benefit analysis which includes in the model a true and comprehensive explanation of the previous expenditure and costs both current and capital at Cheltenham General. This previous expenditure and the proposed 'write off/downgrade' must be part of the costs.		
33	So far at 90 no negative feedback, but I'm glad I did not have to go to GRH for babies. its a long way and can take a long time. Ambulances when I have needed them have not usually taken too long, but I think a car service, where possible, with blue light supplied might be useful.		
34	It would negatively impact on me and my family if elective work was not done in Cheltenham as they would be a lack of beds in GRH		
35	Closing Cheltenham's A&E is a terrible mistake. For patients in the Cotswolds, Tewkesbury and surrounding areas - the time wasted going to GRH could literally mean life and death. I also do not believe that Gloucestershire Royal can cope with the numbers they would need to deal with at present. One A&E for a whole county is madness and is so transparently being considered to save money rather than lives.		
36	Travel especially if you don't drive		
37	My wife has problems with her eyes and we both have hearing issues. We are able to access both services at Cheltenham within walking distance of our home. There are no references to the future location of either, presumably these will be covered in the next phase of planning?		
38	I worry that as we rely on public transport we may not be able to travel easily between hospitals. We have already had to use taxi to do this - that proves expensive; and perhaps will lead to us not bothering		
39	None I can foresee		
40	I work in Vascular Surgery which has currently been moved to Gloucester Royal Hospital ""temporarily"" because of the Covid pandemic. I do not think this decision is likely to be reversed as I believe the Trust has been looking to move the service to Gloucestershire Royal and the pandemic has simply meant they could move the service earlier than planned and they have simply said it is ""temporary"" to stop any backlash. I do not think that the Trust will be able to limit this as the distance I travel to work if I am forced to move to Gloucester cannot be changed.		

If you think any of our proposals could have a negative impact on you and your family, how should we try to limit this (please tell us which service your feedback relates to e.g. IGIS)?		Response Percent	Response Total
41	See next box My wife and I are in our 90th year. She is not allowed to drive. I prefer daylight and not Mon or Friday. We live in Tetbury and wish treatment there. So: We prefer Cheltenham and do not like Gloucester, the former being easier for us to reach by car and more convenient in terms of other activities on the day.		
42	N/A		
43	Access if we are ill for any of the services is difficult if we can't drive because there is no public transport. It doesn't matter how good the services are, how good the consultants are or how nice the hospitals are, if you can't get to them. So it would be nice if there was a more consistent patient transport service. Not one that you constantly have to justify why you are using it. One where you aren't left sitting for hours wonder whether or not they are going to turn up.		
44	Please see answer to previous question, and if possible make all services available in all hospitals. If this is not possible, then there should be excellent hospital or volunteer transport which is suitable for individual patients with a variety of disabilities including severe allergies (I cannot travel in standard hospital transport or on public transport because of allergies to perfumed products from laundry detergent to standard toiletries.) This feedback relates to all the services.		
45	My family and I could be affected by long waiting lists, staff shortages, transport links, not being able to see a specialist consultant. This would be the negative impact.		
46	All hospital services - whilst I am able to drive at present, for the future and for all patients a dependable public transport system becomes even more vital if these proposals are enacted.		
47	Greater visibility and support given to people needing to claim travel expenses for hospital visits. Citizens Advice Stroud ran a campaign about this 3-4 years ago, surveying the hospitals and surgeries to see how visible the information was and how easy to claim. The procedure for making a claim and receiving payment was poor. Stressed relatives need immediate assistance. They should not have to wait a month to be reimbursed.		
48	if we do set up CofE then we need to maintain 24/7 coverage elsewhere via a core of specialists (maybe a little more junior with access to more senior experts via telepresence)		
49	Senior management should listen much more to the views of ALL its frontline staff and not merely those of some of its most Senior Consultants. The Hospital cannot deliver excellent healthcare, regardless of how well equipped its 'Centres of Excellence' are without the goodwill and dedication of all of its staff. It is quite clear the failure to involve frontline staff sufficiently in developing services is undermining morale. There appears to be widespread distrust of senior management among staff and a sense of grudging resignation to having reorganisations imposed on them in a heavy-handed 'top-down' way.		
50	I am worried that the aim to be more efficient to reduce waiting times and free up beds will lead to hasty treatment and rushing patients out of the hospital without proper care or after-care treatment. I felt disappointed with a few aspects of the service I received		
51	n/a		
52	no negative impact		
53	all services other than super-specialist ones need to be mirrored at CGH		
54	Improved communication and access to medical records. Improved access to staffing by having a centre of excellence. Make sure you have the necessary resources in place. Open up the options to make contact.		
55	We live only 12 min walk from CGH, therefore the centres of excellence in Gloucester will be less accessible. Not having access to 24 hour A&E is a downside for us.		
56	None that come to mind		

If you think any of our proposals could have a negative impact on you and your family, how should we try to limit this (please tell us which service your feedback relates to e.g. IGIS)?		Response Percent	Response Total
	57 Parking issues		
		answered	57
		skipped	71

Do you have any alternative suggestions for how any of the services covered in the consultation could be organised (please tell us which service your feedback relates to e.g. IGIS)? When describing your suggestions where possible please refer to the assessment criteria, developed in collaboration with local people during the Fit for the Future Engagement (see pages 17/19 of the full consultation booklet).		Response Percent	Response Total
1	Open-Ended Question	100.00%	35
	1 No. Those providing them will know what alternative proposals are best.		
	2 Keep emergency care/ acute medical on both sites. Share planned care with Bristol and Oxford. Rotate staff between hospitals/ secondments to generate the requisite culture of flexibility in planned care, with the savings and increased efficiency used to fund emergency care in both local sites.		
	3 It has been found that management have not been honest with informing staff about changes		
	4 We need to keep the blood monitoring service at Cirencester Hospital, even Cheltenham is too far away. If you need a frequent test it would be impossible to do this if you do not have your own transport.		
	5 Jpoint venture with Great Western Swindon for those living on The Cotswolds		
	6 Close both existing sites and build new Gloucestershire central hospital at a more accessible location, e.g. by Staverton airport. More scope for providing CoE departments, whilst being accessible to more people - including out-of-area opportunities. Old sites could be sold for offsetting capital cost.		
	7 Open A&E in CGH and pay the staff more so they don't leave. Maternity in CGH could have at least one consultant for safety		
	8 No		
	9 no		
	10 I feel that the centre of excellence approach is the way to go. I don't have a strong opinion as to which services should be provided by which hospital - it depends on the current strengths of each team in the hospitals I think.		
	11 No your proposals are well thought through and you know the business needs better than I do. I feel confident you will have used best endeavours to get it right.		
	12 whatever is decided should be very clearly communicated as it is rather confusing at the moment		
	13 To be ""Fit for the future"" try to repair the damage that has been afflicted to the NHS over recent years. Stop putting operations out to private companies. Work on restoring services which have been cut, reduce waiting times. Put NHS money into the NHS and NOT into private companies		
	14 no.		
	15 Other than knock both GRH and Cheltenham down, sell the land and build a new Southmead like hospital somewhere between the two. Probably not practical financially though		
	16 Try to make centres of excellence at both sites where possible		
	17 No, if the statistics show that this model will provide better clinical outcomes, less waiting times, joint working and attraction/retention of the right staff, then I do not have another model to suggest.		

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

		Response Percent	Response Total
18	""""developed in collaboration with local people during the Fit for the Future Engagement (see pages 17/19 of the full consultation booklet)."""" This just means that the one's who shout loudest are listened too the most.....It also assumes the the voices from the deemed 'stakeholders' [NHS chosen or invited!!] are the truly interested parties. Most of us are too busy in our everyday lives to give up time to be part of this stakeholder echo chamber.		
19	I think most of possible suggestions seem very sensible, but perhaps more use could be made of voluntary services (stopping blood flow from nasty cuts or wounds where the nearest A&E is not very near and it is closed). Dealing wit fits in children, concussion (small blows to the head). 999 is excellent but Gloucestershire is a big county and the borders far from the centre. Surely we should have a service that can take us to the nearest centre for help and rely on zoom for specialism?		
20	.		
21	It would be good to have some services in either the forest or the Cotswolds as people travel long distances to get treatment		
22	No suggestions - the proposals seem to make sense		
23	Fully supportive of the changes planned, as timing will be improved and better staffing.		
24	My wife and I are in our 90th year. She is not allowed to drive. I prefer daylight and not Mon or Friday. We live in Tetbury and wish treatment there. So: We prefer Cheltenham and do not like Gloucester, the former being easier for us to reach by car and more convenient in terms of other activities on the day.		
25	It is vital to maintain access to care to patients across the whole county of Gloucestershire, so our alternative suggestion is that all services should be available in all hospitals.		
26	No		
27	No		
28	A covering team at each hospital with more senior staff visit each site to under take teaching etc but always being available for support/advice via telepresence or VR		
29	Recognising the need for change, the proposals for Gastro-intestinal Surgery contained in what was Option 4 should be fully worked up into a proposal, in preference to Option 2 which is what the Hospital Trust appears to have adopted in opposition to the majority of the Consultants involved and GiRFT advice.		
30	Build a state of the art hospital in the Forest of Dean at Five Acres which is for sale. Traveling to Glos and Chelt is traumatic, worrying and time consuming for older people who are suffering because of you decisions. We travel 4 or 5 times a year to Glos and Chelt so we know how terrible the journeys are at a time when we are ill and anxious.		
31	no		
32	I live in Moreton, We have a fine new hospital building which is woefully underused, Yet I am invited to travel to Gloucester for a routine exam, The NHS needs to resolve service delivery issues of this kind, preferably before the new forest of dean hospital opens, for the same problems will arise there. The general impression given in this survey is that services will be organised for the convenience of patients who will usually be sick or indisposed.		
33	Training hospital again - start with one centre of excellence. Proposal is excellent to move into the modern world - make sure you have the technology to support this and the staff to support this. Efficiency of resources is a concern. Waiting times should improve with these proposals. Measure of improvement.		

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

		Response Percent	Response Total
34	My alternative suggestion rather than wasting money on expensive surveys like this is to have ONE hospital, between Cheltenham and Gloucester, which could then be available for both. The overall saving to the NHS would after the initial expense, be enormous. I believe the only reason this has not already happened is the ridiculous failure by the two relevant local authorities to agree on a site.		
35	None		
		answered	35
		skipped	93

Anything else you would like to say?

		Response Percent	Response Total
1	Open-Ended Question	100.00%	50
1	It makes sense to look at the service provision in this way.		
2	This should have been done years ago. Having doctors and staff working across two sites is inefficient and detrimental to patient care . Ideally we should have one hospital at Staverrton !!!!		
3	-		
4	Trying to maintain two hospitals with duplicate services so close together makes no sense in any regard. This is the best compromise that I have heard suggested for a very long time		
5	I believe that management have wanted to close Cheltenham ED for many years and have used Covid as an opportunity to do exactly that		
6	I live in Cheltenham and find it easier to travel to work to CGH but am not opposed to travelling to GRH but the 99 bus service could help if the times of the buses fit the shifts of staff.		
7	Get Cirencester and Tetbury hospitals better integrated into the services provided for patients		
8	Just think more about travel access, parking facilities and best of all getting appointments and blood tests done promptly. The Cotswolds is treated as a backwater by Glos NHS		
9	I think most people would like to point out that even though it states CGH will re-open - it is easy to see that GRH just cannot cope with the amount of people in Gloucestershire. I know ED is not on this questionnaire but it needs to be taken into consideration with regards to where everything is to be situated.		
10	Thank you for putting Gastroenterology in the spotlight!		
11	This is a very ambivalent survey. I am sure not many people will bother to complete it fully I read the lengthy booklet and after looking at the various rather repetitive questions I imagine many people will give up. This I think is what you want. You have intentions and ideas to carry out and I don't believe as a member of this community our opinions matter at all.		
12	Downgrading the blood testing service at Cirencester impacts heavily on local residents		
13	I would like to see a very positive statement, and concrete proposals for the better care of patients presenting with mental health problems in ED. This has been a long ongoing concern, how will Fit for the Future ensure that mental health is given proper consideration?		
14	I support the local people living in Cheltenham. It's a wonderful Hospital but does need some money spent on it to use the space it already has. Some wards are closed due to building collapsing.		

Anything else you would like to say?

		Response Percent	Response Total
15	No		
16	Cary on with the plans.		
17	no		
18	I haven't the experience to comment on most of this questionnaire.		
19	Even your summary document is far too full and obfuscating! I'd like an honest and clear comparison between services as they were before COVID and as they would be under your preferred proposals, with an indication on the impact in time and accessibility for patients in the various parts of the county.		
20	No		
21	The NHS was a great organisation. Over the years it has slowly been destroyed. One great problem is with the GP service. If effectively stops patients from accessing the main NHS services. It is almost impossible to get to see a GP. An example - In November 2019 I had a fall. I damaged my arm. A shard of metal punctured the arm to quite a depth. The arm from elbow to palm of hand went blue and remained blue for weeks. A huge swelling erupted at the puncture point. It was impossible to see my GP. By late December the arm was still swollen and bruised. I was concerned with Christmas upon me. I live alone. I phone 111 I was referred to see my GP the following day. When I entered the GP surgery the first words from GP were I don't usually see people who just walk in off the street. Obviously the GP service is NOT there for older people. The telephone 111 service is a farce. Please don't talk about centre of excellence and fit for the future. Just restore the NHS to a functioning system now The whole of your document has annoyed me. you say that you are attempting to provide centre of excellence while what you are doing is actually trying to whittle away even more of the flesh from the skeleton of the NHS which was a great organisation but which is now a shadow of what it once was. The hospital work is good still once one can get past the deliberate obstacle of the local GP. I have already mentioned the case of my GP who said "" I don't usually see people who walk in off the street"" when I had been referred by 111 service. The episode convinced me that the NHS is simply not there for older people. Please stop trying to fool me into thinking that you are trying to offer centre of excellence Long before that event I went to the GP reception as I have done in the past, to ask for an appointment. The receptionist who is obviously there to protect the doctors from seeing patients, told me that the system had changed. I had to go home and telephone for an appointment. I pointed out that I was there, talking face to face to her so why not organise an appointment. I simply wanted a routine appointment because I was concerned about a long term health issue I have. The receptionist then became aggressive and told me to go home and phone for an appointment. I returned home and phoned the surgery. The line was engaged. I tried to phone many times. The line was always engaged. Making an appointment is now virtually impossible. I presume that your aim is to force people who can afford to, to opt for private treatment. Pleased do not try to disguise your actions as creating centres of excellence The other possible method of getting medical attention is via the A&E. It is a last resort. When I badly damaged my arm I did not bother the A&E system. I would not abuse such a service. However other people who are desperate for treatment have used A&E. You have tried to counter that by removing the A&E from Cheltenham hospital. A lot of public pressure prevented that move completely but you ask about centres of excellence. It is in my opinion impudence on your part. I have health issues. I am elderly and live alone. If I get covid it will no doubt kill me, but I have determined that I will not even try to contact my GP. you so obviously intent on destroying the NHS as it stands. The government says it will be free at the point of delivery and so you are ensuring that there is no point of delivery. I do remember times before the NHS. What a disagree that we are returning to such times again. Centres of excellence RUBBISH		
22	whatever the experts in the NHS think I would be supportive of.		
23	Access to local facilities is important as I live in Tetbury. However, for specialist care i am prepared to travel further a field to Gloucester, Cheltenham and Oxford.		
24	I understand and agree with your reasons for wanting to change things in these two big hospitals, but I would urge you to also consider our more rural hospitals (Cirencester, Stroud etc.) when it comes to where funds go. I would hate these to be underfunded at the expense of these changes.		
25	Pure fluke heard about the consultation apparently running since late October. Leaflet only came with post on 2nd December. Good way of minimising responses		

Anything else you would like to say?

		Response Percent	Response Total
26	It is clear that the NHS cannot simply go on as before. How will these changes be monitored to see if they are successful? Who will monitor them and make any necessary adjustments if required, or indeed share best practice. In my lifetime I have seen many of the areas hospitals close or reduce their services, and I have not picked up on how all of this will impact the remaining hospitals in the area.		
27	Parking at both centres is problematic and public transport during Covid19 advised against		
28	I worry about the link and relationship between these proposals and GP services. GP services need to be as much a part of this as the hospitals and the hospitals cannot do this in isolation of community services. I can see part of the proposal is to enable more joined up working but this has to work in practice with collaboration and cooperation across the services. While I have experienced fantastic GP services in Gloucestershire (up to about 10 years ago). Unfortunately I have also experienced some poor GP service provision in Gloucestershire, which has deteriorated over the last 8 to 10 years. My biggest concern is that if the GP services are not joined up with these proposals, this will not be able to succeed.		
29	This appears to me to be yet another way to spend money to create 'something new' and the associated empire building both administratively and medically tghat goes with that. All proposals need to be matched to realistic assumptions of need and the first priority should be proper utilisation of existing resource. Acceptance of the waste of resource [both income and capital] appears to be a huge part of the default NHS model.		
30	I don't think 'Centres of Excellence' should be considered at present, and yet again my suspicion is that if it looks good from the outside - ie when the CCG walk round with the scent of paint in their nostrils - it doesn't matter that staff and patients are unhappy with the way things are.		
31	Consider what minor injuries services etc could be made more easily available at GP surgeries. Even discounting the Covid effect, the GP is a bottleneck. Overall the treatment me and wife have received from CGH and GRH has been timely and very successful. Thanks to everyone.		
32	I am not a medic but my above preferences are based on the viability of CGH. Covid 19 has shown we need more hospitals without affecting ordinary services. GRH has better rail access but at times the hospital is overwhelmed. I do think that concentrating more services at GRH at the expense of CGH is a serious mistake. There must be equal allocation of services between GRH and CGH. CGH must be protected from closure. Cheltenham is a growing town and needs a viable hospital. so does Gloucestershire		
33	Any changes should be accompanied by improved information / communication to staff and public. Staff need to be aware of geography and travel difficulties for appointments to be as convenient as possible. Where as I believe a centre of excellence is essential - longer journeys for clients with children or frail adults will inevitably increase stress levels. With ambulances being tied up for longer transferring patients to the appropriate hospital. You speak of specialist doctors. Are experienced nurses willing to change work base from CGH to GRH		
34	Maybe it is my age? It took a long time to read and digest mentally the information in the Fit for the Future book. I would prefer excellence in all hospitals with adequate staff - well paid and well trained. It would seem that the changes are needed for inpatient care. However, small local hospitals like The Vale at Dursley are most needed for being specialists in maintaining health especially the elderly. Travelling 6 miles is much preferable than 26 miles especially if you cannot use a car!		
35	Please look at improving the bus links ! The fact that you use a stagecoach bus for one part of your journey and a pullman for other part - is just not Cost effective for patients.		
36	The survey is difficult for non medics to comprehend. See points above.		
37	More free car parking at GRH and CGH		
38	If would help if other bodies such as Glos Highways and bus companies could be persuaded to consider better road access and enhanced public transport facilities to reduce difficulties in trying to access two sites.		
39	Relatives need to be able to visit very ill patients at moment this will delay recovery.		
40	This survey is part completed because we accidentally submitted the form when part way through the survey.		
41	No		

Anything else you would like to say?

		Response Percent	Response Total
42	No		
43	Covid-19 as shown us that resourcing can come back to bite us		
44	The publics primary concern about the reconfiguration of specialist services within the hospital relate to the convenience and accessibility of services and the long term sustainability of a Type 1 A&E Department in Cheltenham. Of some of these proposals are implemented it is difficult to see how a full Type 1 A&E Department would be sustainable in the long term. This is despite the reassurances the Hospital Trust has repeatedly been given. It is these proposals which have undermined staff and public confidence in the Hospital Trust's sincerity over the re-opening of Cheltenham A&E and its long term future.		
45	See above please re-think before its too late		
46	When I was in hospital following the trauma to my ankle I felt well looked after by some of the nurses on shift, especially the ""day"" nurses. I was shocked however by a ""night nurse on the night shift asked me if I could hop!!! to the toilet rather than waste her time with her getting me a walking aid - remember this was when my leg was still in a very heavy plaster cast and I'd only just had the operation on my ankle that day - I was weak and very much in pain and certainly wouldn't be able to HOP to the damn toilet!! I couldn't believe my ears when she asked me that and that she almost seemed put out that i was in need of her assistance as the night nurse on shift. I was in hospital for two weeks but it was hoped and suggested by some junior doctors and at least one consultant that I leave after my first week. I was no where near ready to leave hospital after one week. I was still in tremendous pain and still had a heavy plaster cast on which considering my living situation at home was not at all ideal for supporting me with this current disability. I was discharged after two weeks after my insistence that I stay for lnger. I still feel I was discharged too early. My date to get my plaster cast removed was ill-scheduled and I was lumbered with dragging a heavy, itchy and uncomfortable cast around for about four weeks when it should have been two weeks after my operation that the temporary cast removed and a lighter more comfortable one put on. I requested transport to the hospital by ambulance which was denied so after getting a taxi half of the way still had to make my way through the grounds and the various corridors to get the appropriate place. I very much feel I was left unsupported durring my out patient recovery, especially during the time I was discharged and waiting for my new and lighter cast. The stress and anxiety was very detrimental to my fragile mental health. I suffer with anxiety and depression and undiagnosed and untreated OCD and complex PTSD all of which compounds to instable moods and frequent mental breakdowns. I do manage my mental health with medication and receive mental health support. I just wish my treatment as outpatient in aftercare was better monitored by professionals and I was better assisted and supported. I feel the COVID19 situation is part to blame for the seemingly hurrying of me out of the hospital and the quick discharge out of my own private room at the hospital where I have to say, I would have recovered better and faster perhaps rather than being herded onto an open ward where I was constantly disturbed by other patients and nursing staff. If I hadn't come into hospital during the corona virus pandemic I do believe my stay would have been far more pleasant and i wouldn't have struggled as much as i did with anxiety that i was using up vital bed space. I feel i should have stayed recovering in hospital for longer than i ended up staying.		
47	no		
48	I used to work for the department of health. The fashion for building new hospitals would alternate between big is beautiful and small is beautiful on a 10 year cycle. The result was that all current buildings was out of step with prevailing thinking. Health trusts need to resolve this conundrum and ensure a successful balance between specialist and locally delivered hospital based options.		
49	Addition of trainee nurses and other healthcare professions in specialities means you can retain them more easily and get more money!		
50	Great believer in logic		
		answered	50
		skipped	78

What is the first part of your postcode? eg. GL1, GL20			
		Response Percent	Response Total
1	Open-Ended Question	100.00%	116
	1 GL4		
	2 GL51		
	3 GL52		
	4 GL4		
	5 GL53		
	6 Gl5		
	7 Gl1		
	8 GL53		
	9 Gl51		
	10 GL53		
	11 gl51		
	12 GL2		
	13 wR11		
	14 GL52		
	15 Gl4		
	16 GL52		
	17 GL7		
	18 GL7		
	19 GL53		
	20 GL		
	21 GL51		
	22 GL7		
	23 GL2		
	24 GL5		
	25 Gl14		
	26 GL3		
	27 GL53		
	28 SN6		
	29 OX18		
	30 GL52		
	31 GL53		
	32 GL2		
	33 GL54		
	34 GL52		

What is the first part of your postcode? eg. GL1, GL20			
		Response Percent	Response Total
	35	GL5	
	36	gl52	
	37	GL3	
	38	GL54	
	39	GL18	
	40	GL16	
	41	GL12	
	42	GL52	
	43	GL20	
	44	GL16	
	45	GL52	
	46	GL54	
	47	GL54	
	48	GL54	
	49	Gl53	
	50	GL5	
	51	GL7	
	52	GL3	
	53	GL1	
	54	GL52	
	55	GL5	
	56	GL52	
	57	Gl8	
	58	GL7	
	59	gl15	
	60	GL2	
	61	GL52	
	62	GL	
	63	GL52	
	64	GL50	
	65	GL20	
	66	GL4	
	67	GL51	
	68	GL14	
	69	GL52	

What is the first part of your postcode? eg. GL1, GL20			
		Response Percent	Response Total
	70	GL52	
	71	GL53	
	72	gl15	
	73	GL6	
	74	GL13	
	75	GL52	
	76	GL5	
	77	GL17	
	78	GL54	
	79	GL52	
	80	GL11	
	81	GL12	
	82	GL56	
	83	Gl53	
	84	GL1	
	85	GL52	
	86	GL53	
	87	GL15	
	88	WR11	
	89	GL8	
	90	GL16	
	91	GL6	
	92	GL50	
	93	Gl51	
	94	GL8	
	95	GL5	
	96	HR9	
	97	GL51	
	98	GL7	
	99	GL4	
	100	GL11	
	101	GL3	
	102	GL11	
	103	GL6	
	104	gl50	

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

		Response Percent	Response Total
105	GL50		
106	GL16		
107	GL52		
108	GL50		
109	GL2		
110	GL56		
111	GL3		
112	GL50		
113	GL50		
114	GL5		
115	GL7		
116	GL1		
		answered	116
		skipped	12

Which age group are you:

			Response Percent	Response Total
1	Under 18		0.78%	1
2	18-25		0.78%	1
3	26-35		7.03%	9
4	36-45		7.81%	10
5	46-55		14.06%	18
6	56-65		22.66%	29
7	66-75		21.09%	27
8	Over 75		25.78%	33
9	Prefer not to say		0.00%	0
			answered	128
			skipped	0

Are you:				
			Response Percent	Response Total
1	A health or social care professional		10.94%	14
2	A community partner		1.56%	2
3	A member of the public		82.81%	106
4	Prefer not to say		4.69%	6
			answered	128
			skipped	0

Do you consider yourself to have a disability? (Tick all that apply)				
			Response Percent	Response Total
1	No		5.47%	7
2	Mental health problem		17.19%	22
3	Visual Impairment		10.94%	14
4	Learning difficulties		1.56%	2
5	Hearing impairment		20.31%	26
6	Long term condition		65.63%	84
7	Physical disability		17.97%	23
8	Prefer not to say		0.78%	1
			answered	128
			skipped	0

Do you look after, or give any help or support to family members, friends, neighbours or others because of either a long term physical or mental ill health need or problems related to old age? Please do not count anything you do as part of your paid employment.				
			Response Percent	Response Total
1	Yes		35.20%	44
2	No		62.40%	78
3	Prefer not to say		2.40%	3
			answered	125
			skipped	3

Which best describes your ethnicity?

		Response Percent	Response Total
1	White British	93.75%	120
2	White Other	1.56%	2
3	Asian or Asian British	1.56%	2
4	Black or Black British	0.78%	1
5	Chinese	0.00%	0
6	Mixed	0.00%	0
7	Prefer not to say	2.34%	3
8	Other (please specify):	0.00%	0
		answered	128
		skipped	0

Other (please specify): (0)

No answers found.

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

		Response Percent	Response Total
1	No religion	36.22%	46
2	Buddhist	0.00%	0
3	Christian (including Church of England, Catholic, Methodist and other denominations)	57.48%	73
4	Hindu	0.00%	0
5	Jewish	0.00%	0
6	Muslim	1.57%	2
7	Sikh	0.00%	0
8	Other	1.57%	2
9	Prefer not to say	3.15%	4
		answered	127
		skipped	1

Are you:

		Response Percent	Response Total
1	Male	44.53%	57
2	Female	53.13%	68
3	Transgender	0.00%	0
4	Prefer not to say	2.34%	3
		answered	128
		skipped	0

Do you identify with your gender as registered at birth?

		Response Percent	Response Total
1	Yes	98.44%	126
2	No	0.00%	0
3	Prefer not to say	1.56%	2
		answered	128
		skipped	0

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

		Response Percent	Response Total
1	Heterosexual or straight	86.51%	109
2	Gay or lesbian	3.17%	4
3	Bisexual	3.97%	5
4	Other	0.00%	0
5	Prefer not to say	6.35%	8
		answered	126
		skipped	2

Are you currently pregnant or have given birth in the last year?				
			Response Percent	Response Total
1	Yes		0.78%	1
2	No		62.50%	80
3	Not applicable		35.16%	45
4	Prefer not to say		1.56%	2
			answered	128
			skipped	0

Fit For The Future - What matters to you?

People with mental health problems and/or learning difficulties

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

			Response Percent	Response Total
1	Strongly support		36.36%	8
2	Support		27.27%	6
3	Oppose		4.55%	1
4	Strongly oppose		22.73%	5
5	No opinion		9.09%	2
			answered	22
			skipped	1

Please tell us why you think this, e.g. the information you would like us to consider (9)

1	I think the gastrointestinal ward should be bk in Cheltenham as I have a stoma and Gloucester hospital is far from me
2	I think it will promote continuing excellence in the services provided and will attract good quality staff to the area.
3	I'm disabled and have no transport to get to and from the hospital in Gloucester would very especially as wheelchair accessible transport is no longer provided to bring me home on the day of discharge
4	If this is thought to be a good idea, it probably is!
5	I feel that this sort of service should be available at Both Cheltenham and Gloucester
6	I can understand the reasoning and rationale for this option but I worry about capacity, if everyone suddenly has to attend GRH with no option to attend at CGH will waiting times be longer, will standards of care to the community be affected, will it mean that other treatments and services suffer at GRH. I am not against the proposal but these are some thoughts and questions I am having as a (potential) service user and a resident of Gloucestershire. I worry that this is also a step to wind down care and service provision at CGH too.
7	No clinicians I have spoken to think that this is a good idea - and I am dubious as to whether this is about patient care or whether it's to save money. Sadly I suspect the latter.
8	Timely assessment and diagnosis and improved staff cover
9	Cheltenham would be more convenient for me, but Gloucester is potentially bigger and within easy reach

Please tell us what you think about our preferred option to develop: A 'centre of excellence' for Emergency General Surgery at Gloucestershire Royal Hospital.

		Response Percent	Response Total
1	Strongly support	27.27%	6
2	Support	36.36%	8
3	Oppose	4.55%	1
4	Strongly oppose	13.64%	3
5	No opinion	18.18%	4
		answered	22
		skipped	1

Please tell us why you think this, e.g. the information you would like us to consider (5)

1	I think it will benefit local people to have this provision and will promote continued quality improvement and performance in this area.
2	If emergency treatment is performed at one hospital, GRH, it leaves planned surgery at the other, CGH, not liable to interruption for emergency surgery.
3	As mentioned this sort of service MUST be available at both hospitals. Frankly I do not understand why it should ben centred at one hospital. It appears to be a cost cutting ploy
4	Please see my comments on the previous section regarding capacity and my support of the proposal IF the level of service is maintained to ensure that full and effective delivery, commensurate with the population of the area, can still be provided (or this proposal makes the service delivery more efficient).
5	Being seen by the right specialist, not going through several appointments and being re-directed

Please tell us what you think about our preferred option to develop: A 'centre of excellence' for Planned Lower GI (colorectal) general surgery at Cheltenham General Hospital (CGH) or Gloucestershire Royal Hospital (GRH).

		Response Percent	Response Total
1	Strongly support	42.86%	9
2	Support	14.29%	3
3	Oppose	0.00%	0
4	Strongly oppose	14.29%	3
5	No opinion	28.57%	6
		answered	21
		skipped	2

Please tell us why you think this, e.g. the information you would like us to consider (5)

1	I think it should be bk in Cheltenham
2	It will benefit local people needing this type of surgery
3	But Cheltenham would be easier because of my disability and needing wheechair accessible transport which cost more if I am required to go to Gloucester Royal
4	Again have services available at both Cheltenham and Gloucester

Please tell us what you think about our preferred option to develop: A ‘centre of excellence’ for Planned Lower GI (colorectal) general surgery at Cheltenham General Hospital (CGH) or Gloucestershire Royal Hospital (GRH).

		Response Percent	Response Total
5	It doesn't matter which site, so long as the service is there and available.		

In supporting our preferred option to create a single site 'centre of excellence', where do you think a ‘centre of excellence’ for Planned Lower GI (colorectal) general surgery should be developed?

			Response Percent	Response Total
1	Cheltenham General Hospital (CGH)		47.62%	10
2	Gloucestershire Royal Hospital (GRH)		28.57%	6
3	No opinion		33.33%	7
			answered	21
			skipped	2

Please tell us why you think this, e.g. the information you would like us to consider: (6)

1	BOTH HOSPITALS. STOP PUTTING PRESSURE ALL ONTO ONE SITE
2	I don't think it matters where the provision is. I cant see that one site has more benefit that the other.
3	See previous question
4	Keep both hospitals operating as hospitals for all services. This centre of Excellence "" concept"" is in my opinion RUBBISH. Stop pretending that you are offering a better service when you are diluting what is already available
5	Again, it doesn't matter which site, so long as the service is there and available and ensure capacity and effective care for Gloucestershire residents. In my mind it would make sense to have a particular specialist treatment at both sites i.e. GRH is centre of excellence for XX and CGH is centre of excellence for YY. So that one or other site does not become defunct.
6	Better on-site facilities and car-parking at Gloucester. Not sure where there is adequate space in Cheltenham

Please tell us what you think about our preferred option to develop: A ‘centre of excellence’ for planned day case Upper and Lower GI (colorectal) surgery at Cheltenham General Hospital (CGH).

			Response Percent	Response Total
1	Strongly support		33.33%	7
2	Support		23.81%	5
3	Oppose		0.00%	0
4	Strongly oppose		14.29%	3
5	No opinion		28.57%	6
			answered	21
			skipped	2

Please tell us what you think about our preferred option to develop: A ‘centre of excellence’ for planned day case Upper and Lower GI (colorectal) surgery at Cheltenham General Hospital (CGH).

		Response Percent	Response Total
Please tell us why you think this, e.g. the information you would like us to consider (4)			
1	Benefits local people.		
2	Easy access and close to carers who need to visit me and don't drive		
3	see earlier comments		
4	So long as patients can access the location where their surgery is taking place.		

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

			Response Percent	Response Total
1	Strongly support		28.57%	6
2	Support		33.33%	7
3	Oppose		9.52%	2
4	Strongly oppose		9.52%	2
5	No opinion		19.05%	4
			answered	21
			skipped	2

Please tell us why you think this, e.g. the information you would like us to consider (4)		
1	Will provide a better health care service for local people.	
2	see earlier comments	
3	I have put 'oppose' because I feel neutral about this proposal (so I do have an opinion but not either way at the moment). My reason is as follows: as long as patients attending both have the same access to the surgery/treatment they need e.g. so that those patients attending a non surgical centre are not disadvantaged by this model/proposal.	
4	Less likelihood of being transferred to other hospital sites. Retention of staff is pararmount	

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

		Response Percent	Response Total
1	Strongly support	15.00%	3
2	Support	45.00%	9
3	Oppose	10.00%	2
4	Strongly oppose	10.00%	2
5	No opinion	20.00%	4
		answered	20
		skipped	3

Please tell us why you think this, e.g. the information you would like us to consider (4)

1	I think it is an interesting area of surgery and will provide excellent provision for local people.
2	see earlier comments
3	Please read my earlier comments regarding capacity, service delivery and my reservations that moving particular services to GRH alone must not lead to the closure of CGH (based on the assumption that GRH alone cannot service the whole catchment community).
4	Better facilities and car-parking at GRH

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

		Response Percent	Response Total
1	Strongly support	40.00%	8
2	Support	25.00%	5
3	Oppose	5.00%	1
4	Strongly oppose	5.00%	1
5	No opinion	25.00%	5
		answered	20
		skipped	3

Please tell us why you think this, e.g. the information you would like us to consider (5)

1	I think if gastroenterology is going to be based at Cheltenham then the surgery should be carried out there too so that all gastroenterology services are under one roof. I don't like departments being split between the different sites.
2	Easily accessable
3	Yes both hospitals should be capable of offering all services
4	As long as it meets patient need, is accessible and effective. My responses are based on the assumption that this proposal will deliver better efficiency and improved clinical outcomes than the current model/service provision in place.
5	Treated more quickly by a specialist

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

			Response Percent	Response Total
1	Strongly support		36.36%	8
2	Support		27.27%	6
3	Oppose		9.09%	2
4	Strongly oppose		0.00%	0
5	No opinion		27.27%	6
			answered	22
			skipped	1

Please tell us why you think this, e.g. the information you would like us to consider (6)

1	Don't know why we need two centres. Probably better to have everyone on one site rather than spreading resources more thinly across two sites.
2	Yes both hospitals should be capable of offering all services
3	Please refer to my previous comments, I support this if it will service the community more effectively and if it will lead to improved clinical outcomes.
4	Trauma surgery has long wait times and increasing number of patients for hip, knee surgery can only be of benefit particularly the age demographic in Gloucestershire
5	I recently had a 2 week stay in Gloucester hospital after I had a trauma to my ankle (I completely shattered all the bones in my ankle and required 4 hours of surgery under general anaesthetic to mend it)
6	Convenient for residents of both areas

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

		Response Percent	Response Total
1	Open-Ended Question	100.00%	10

1	I don't drive so to get to CGH I would have to go on the bus, that's if I can afford it. Or not go at all.
2	I think in general the proposals are positive and will improve the services available in Gloucester.
3	Any medical treatment should be available at a local hospital. It is wrong to expect patients who are obviously ill to travel to long distances for treatment. Ecologically it is also better for a few medical staff to move between hospitals than for large numbers of patients to travel
4	Find travel to GRH difficult
5	For me an my family we can access either GRH or CGH but I know that this will not be the case for all residents requiring care.
6	I think it would adversly affect my work
7	Positive impact, we have all been treated under the NHS in the last 12-18 months and these proposals can only improve primary healthcare in Gloucestershire
8	We live on the border in Herefordshire but our nearest GP surgery is in Gloucestershire where we access services. Having to travel to Cheltenham is too far.

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

		Response Percent	Response Total
9	I hope that under the new proposed services any future problems i have with my replaced ankle will be dealt with by highly trained specialists in a very well educated and informed manner kindly and efficiently. The service I received was great (the surgeon was excellent) and the consultant aftercare was brilliant		
10	Cardiac and renal. I am 84, have had 2 heart attacks and been cared for at both hospitals. I have chronic kidney disease		
		answered	10
		skipped	13

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

		Response Percent	Response Total
1	Open-Ended Question	100.00%	8
1	There should be all services on both sites. Other wise people just would not/could not travel for treatment and they would risk death as they could not access the treatment they need.		
2	None		
3	YES! All the proposals. you are trying to reduce the service offered.		
4	Logistics, ensuring that patients can access the site they need. Ensuring that care is not compromised by having specialisms at a particular site i.e. will there be enough Nurses, Doctors, Specialists to provide effective care under the models proposed or will it mean less capacity. Will the proposals be affected by inevitable budget cuts that will take place from now as a result of the economic decline for this country we are entering now. I am assuming the proposals were put together at a different point in time and wonder if the current economic climate and impact that this will have on costs (budget) and the health of the population means that the proposal has to be reviewed to ensure it is still fit for purpose.		
5	It would negatively impact on me and my family if elective work was not done in Cheltenham as they would be a lack of beds in GRH		
6	Closing Cheltenham's A&E is a terrible mistake. For patients in the Cotswolds, Tewkesbury and surrounding areas - the time wasted going to GRH could literally mean life and death. I also do not believe that Gloucestershire Royal can cope with the numbers they would need to deal with at present. One A&E for a whole county is madness and is so transparently being considered to save money rather than lives.		
7	I am worried that the aim to be more efficient to reduce waiting times and free up beds will lead to hasty treatment and rushing patients out of the hospital without proper care or after-care treatment. I felt disappointed with a few aspects of the service I received		
8	n/a		
		answered	8
		skipped	15

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

		Response Percent	Response Total
1	Open-Ended Question	100.00%	3
	1 To be ""Fit for the future"" try to repair the damage that has been afflicted to the NHS over recent years. Stop putting operations out to private companies. Work on restoring services which have been cut, reduce waiting times. Put NHS money into the NHS and NOT into private companies		
	2 No, if the statistics show that this model will provide better clinical outcomes, less waiting times, joint working and attraction/retention of the right staff, then I do not have another model to suggest.		
	3 .		
		answered	3
		skipped	20

Anything else you would like to say?

		Response Percent	Response Total
1	Open-Ended Question	100.00%	8
	1 I live in Cheltenham and find it easier to travel to work to CGH but am not opposed to travelling to GRH but the 99 bus service could help if the times of the buses fit the shifts of staff.		
	2 I haven't the experience to comment on most of this questionnaire.		

Anything else you would like to say?

		Response Percent	Response Total
3	The NHS was a great organisation. Over the years it has slowly been destroyed. One great problem is with the GP service. If effectively stops patients from accessing the main NHS services. It is almost impossible to get to see a GP. An example - In November 2019 I had a fall. I damaged my arm. A shard of metal punctured the arm to quite a depth. The arm from elbow to palm of hand went blue and remained blue for weeks. A huge swelling erupted at the puncture point. It was impossible to see my GP. By late December the arm was still swollen and bruised. I was concerned with Christmas upon me. I live alone. I phone 111 I was referred to see my GP the following day. When I entered the GP surgery the first words from GP were I don't usually see people who just walk in off the street. Obviously the GP service is NOT there for older people. The telephone 111 service is a farce. Please don't talk about centre of excellence and fit for the future. Just restore the NHS to a functioning system now The whole of your document has annoyed me. you say that you are attempting to provide centre of excellence while what you are doing is actually trying to whittle away even more of the flesh from the skeleton of the NHS which was a great organisation but which is now a shadow of what it once was. The hospital work is good still once one can get past the deliberate obstacle of the local GP. I have already mentioned the case of my GP who said "" I don't usually see people who walk in off the street"" when I had been referred by 111 service. The episode convinced me that the NHS is simply not there for older people. Please stop trying to fool me into thinking that you are trying to offer centre of excellence Long before that event I went to the GP reception as I have done in the past, to ask for an appointment. The receptionist who is obviously there to protect the doctors from seeing patients, told me that the system had changed. I had to go home and telephone for an appointment. I pointed out that I was there, talking face to face to her so why not organise an appointment. I simply wanted a routine appointment because I was concerned about a long term health issue I have. The receptionist then became aggressive and told me to go home and phone for an appointment. I returned home and phoned the surgery. The line was engaged. I tried to phone many times. The line was always engaged. Making an appointment is now virtually impossible. I presume that your aim is to force people who can afford to, to opt for private treatment. Pleased do not try to disguise your actions as creating centres of excellence The other possible method of getting medical attention is via the A&E. It is a last resort. When I badly damaged my arm I did not bother the A&E system. I would not abuse such a service. However other people who are desperate for treatment have used A&E. You have tried to counter that by removing the A&E from Cheltenham hospital. A lot of public pressure prevented that move completely but you ask about centres of excellence. It is in my opinion impudence on your part. I have health issues. I am elderly and live alone. If I get covid it will no doubt kill me, but I have determined that I will not even try to contact my GP. you so obviously intent on destroying the NHS as it stands. The government says it will be free at the point of delivery and so you are ensuring that there is no point of delivery. I do remember times before the NHS. What a disagree that we are returning to such times again. Centres of excellence RUBBISH		
4	I understand and agree with your reasons for wanting to change things in these two big hospitals, but I would urge you to also consider our more rural hospitals (Cirencester, Stroud etc.) when it comes to where funds go. I would hate these to be underfunded at the expense of these changes.		
5	Parking at both centres is problematic and public transport during Covid19 advised against		
6	I worry about the link and relationship between these proposals and GP services. GP services need to be as much a part of this as the hospitals and the hospitals cannot do this in isolation of community services. I can see part of the proposal is to enable more joined up working but this has to work in practice with collaboration and cooperation across the services. While I have experienced fantastic GP services in Gloucestershire (up to about 10 years ago). Unfortunately I have also experienced some poor GP service provision in Gloucestershire, which has deteriorated over the last 8 to 10 years. My biggest concern is that if the GP services are not joined up with these proposals, this will not be able to succeed.		
7	I don't think 'Centres of Excellence' should be considered at present, and yet again my suspicion is that if it looks good from the outside - ie when the CCG walk round with the scent of paint in their nostrils - it doesn't matter that staff and patients are unhappy with the way things are.		

Anything else you would like to say?

		Response Percent	Response Total
8	When I was in hospital following the trauma to my ankle I felt well looked after by some of the nurses on shift, especially the ""day"" nurses. I was shocked however by a ""night nurse on the night shift asked me if I could hop!!! to the toilet rather than waste her time with her getting me a walking aid - remember this was when my leg was still in a very heavy plaster cast and I'd only just had the operation on my ankle that day - I was weak and very much in pain and certainly wouldn't be able to HOP to the damn toilet!! I couldn't believe my ears when she asked me that and that she almost seemed put out that i was in need of her assistance as the night nurse on shift. I was in hospital for two weeks but it was hoped and suggested by some junior doctors and at least one consultant that I leave after my first week. I was no where near ready to leave hospital after one week. I was still in tremendous pain and still had a heavy plaster cast on which considering my living situation at home was not at all ideal for supporting me with this current disability. I was discharged after two weeks after my insistence that I stay for lnger. I still feel I was discharged too early. My date to get my plaster cast removed was ill-scheduled and I was lumbered with dragging a heavy, itchy and uncomfortable cast around for about four weeks when it should have been two weeks after my operation that the temporary cast removed and a lighter more comfortable one put on. I requested transport to the hospital by ambulance which was denied so after getting a taxi half of the way still had to make my way through the grounds and the various corridors to get the appropriate place. I very much feel I was left unsupported durring my out patient recovery, especially during the time I was discharged and waiting for my new and lighter cast. The stress and anxiety was very detrimental to my fragile mental health. I suffer with anxiety and depression and undiagnosed and untreated OCD and complex PTSD all of which compounds to instable moods and frequent mental breakdowns. I do manage my mental health with medication and receive mental health support. I just wish my treatment as outpatient in aftercare was better monitored by professionals and I was better assisted and supported. I feel the COVID19 situation is part to blame for the seemingly hurrying of me out of the hospital and the quick discharge out of my own private room at the hospital where I have to say, I would have recovered better and faster perhaps rather than being herded onto an open ward where I was constantly disturbed by other patients and nursing staff. If I hadn't come into hospital during the corona virus pandemic I do believe my stay would have been far more pleasant and i wouldn't have struggled as much as i did with anxiety that i was using up vital bed space. I feel i should have stayed recovering in hospital for longer than i ended up staying.		
		answered	8
		skipped	15

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

		Response Percent	Response Total
1	Open-Ended Question	100.00%	21
1	GL53		
2	Gl51		
3	gl51		
4	GL52		
5	GL		
6	GL2		
7	GL2		
8	GL52		
9	GL16		
10	GL1		
11	GL52		

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

		Response Percent	Response Total
12	GL7		
13	GL52		
14	GL4		
15	GL52		
16	GL53		
17	GL13		
18	GL52		
19	HR9		
20	GL52		
21	GL50		
		answered	21
		skipped	2

Which age group are you:

			Response Percent	Response Total
1	Under 18		4.35%	1
2	18-25		0.00%	0
3	26-35		30.43%	7
4	36-45		17.39%	4
5	46-55		13.04%	3
6	56-65		13.04%	3
7	66-75		13.04%	3
8	Over 75		8.70%	2
9	Prefer not to say		0.00%	0
			answered	23
			skipped	0

Are you:

		Response Percent	Response Total
1	A health or social care professional	26.09%	6
2	A community partner	0.00%	0
3	A member of the public	60.87%	14
4	Prefer not to say	13.04%	3
		answered	23
		skipped	0

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

		Response Percent	Response Total
1	No	0.00%	0
2	Mental health problem	95.65%	22
3	Visual Impairment	4.35%	1
4	Learning difficulties	8.70%	2
5	Hearing impairment	4.35%	1
6	Long term condition	39.13%	9
7	Physical disability	17.39%	4
8	Prefer not to say	0.00%	0
		answered	23
		skipped	0

Do you look after, or give any help or support to family members, friends, neighbours or others because of either a long term physical or mental ill health need or problems related to old age? Please do not count anything you do as part of your paid employment.

		Response Percent	Response Total
1	Yes	34.78%	8
2	No	60.87%	14
3	Prefer not to say	4.35%	1
		answered	23
		skipped	0

Which best describes your ethnicity?

		Response Percent	Response Total
1	White British	86.96%	20
2	White Other	4.35%	1
3	Asian or Asian British	0.00%	0
4	Black or Black British	0.00%	0
5	Chinese	0.00%	0
6	Mixed	0.00%	0
7	Prefer not to say	8.70%	2
8	Other (please specify):	0.00%	0
		answered	23
		skipped	0

Other (please specify): (0)

No answers found.

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

		Response Percent	Response Total
1	No religion	68.18%	15
2	Buddhist	0.00%	0
3	Christian (including Church of England, Catholic, Methodist and other denominations)	22.73%	5
4	Hindu	0.00%	0
5	Jewish	0.00%	0
6	Muslim	0.00%	0
7	Sikh	0.00%	0
8	Other	0.00%	0
9	Prefer not to say	9.09%	2
		answered	22
		skipped	1

Are you:

		Response Percent	Response Total
1	Male	30.43%	7
2	Female	60.87%	14
3	Transgender	0.00%	0
4	Prefer not to say	8.70%	2
		answered	23
		skipped	0

Do you identify with your gender as registered at birth?

		Response Percent	Response Total
1	Yes	95.65%	22
2	No	0.00%	0
3	Prefer not to say	4.35%	1
		answered	23
		skipped	0

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

		Response Percent	Response Total
1	Heterosexual or straight	63.64%	14
2	Gay or lesbian	9.09%	2
3	Bisexual	13.64%	3
4	Other	0.00%	0
5	Prefer not to say	13.64%	3
		answered	22
		skipped	1

Are you currently pregnant or have given birth in the last year?				
			Response Percent	Response Total
1	Yes		0.00%	0
2	No		73.91%	17
3	Not applicable		17.39%	4
4	Prefer not to say		8.70%	2
			answered	23
			skipped	0

Fit For The Future - What matters to you?

Responses from Carers

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

		Response Percent	Response Total
1	Strongly support	44.70%	59
2	Support	23.48%	31
3	Oppose	11.36%	15
4	Strongly oppose	17.42%	23
5	No opinion	3.03%	4
		answered	132
		skipped	3

Please tell us why you think this, e.g. the information you would like us to consider (88)

1	Gloucester hospital is renowned for putting the fear of God into people when they have to go there for care, removing options for Cheltenham - especially during a pandemic seems insensitive to say the very least. We live in Stroud but have previously chosen to drive to A&E in Cheltenham to avoid GRH. I think there should be a lot more work going into trust in our services and more specifically the paper pushers at CCG before trying to garner support for another master plan that will inevitably cost trillions, be done without consent and have frustrating outcomes for patience and staff.
2	But needs much bigger a+e at GRH
3	There should be one at Cheltenham General also
4	Centre of excellence as opposed to two try hards
5	It will be easier to manage 24/7 and we will be able to afford the best equipment if only one piece is needed instead of several.
6	In a county this size , with the shortage of doctor and nurses we need to ensure that we have the safest care available and to do this efficiently as possible we need to have services centred on one site , in acute medicine GRH is the preferred site. This will not be popular with Cheltenham people but they have to accept that they will never ever have a fully functioning hospital on their site .
7	There needs to be acute medical services at CGH also.
8	As things are, without increased levels of staffing on medical wards, numbers of staff on each shift will just continue to be inadequate/bordering on unsafe. It will be inpossible to provide holistic care.
9	Damaging effect on the local community, as it disproportionately affects vulnerable individuals with protected characteristics. Concerns about bed space at GRH. Concerns about a bottleneck effect at GRH - if you double the amount of traffic, you need to double the width of the road, ALL roads, leading in and out. Leading on to concerns about the lack of funding for SWAS as per their financial outlook to provide the additional ambulance service coverage. Flawed notion of attracting high quality staff from a business/management perspective. Gloucestershire's market has competitors in Bristol, Birmingham (to an extent), Oxford, and of course London. Centralised services will not enable GHNHSFT to outcompete these, leaving us with 'the best of the rest'. This would have been the case whether centralisation occurred or not, thus centralisation itself is a moot point. Flawed concept of 'extra time' to care. This will inevitably lead to cost savings (perhaps instructed by ministers, and not immediately) by reducing staff numbers to provide current levels of care, only now at one site.
10	GRH will be overwhelmed. Unable to provide ""excellent"" acute care at present even since acute take moved there under ""temporary"" Covid changes.

Please tell us what you think about our preferred option to develop: A 'centre of excellence' for Acute Medicine (Acute Medical Take) at Gloucestershire Royal Hospital.		Response Percent	Response Total
11	Gloucester Hospital cannot cope with Cheltenham patients - while I was in Gloucester with my Dad the relative of someone fainted as they had nowhere to sit and were enduring a long wait with their relative in the corridor. People were sitting on the floor - very shabby we need both Cheltenham and Gloucester hospitals working a full range of services as they have always managed in the past:		
12	It's not clear what services will be 'removed' from GRH in order to accommodate a CoE. Also by locating a major single service at one of the two hospitals doesn't address the increased time to travel for patients from the East of the County, the parking inconvenience (every part as bad at GRH as CGH, or cost of travelling further. Equally it does seemingly support (perceptibly at least) the downgrading of CGH A&E more permanently which is already and will continue to be an appalling decision.		
13	The provision for Emergency, consultant led 24/7 care on the East of the County is essential for best outcomes for the aging population given how overcrowded Glos A&E is. Therefore anything which doesn't re-provide the highest tier of A&E at CGH puts patients at more immediate risk of poor outcomes IMO.		
14	Please consider the effect this will have on the large number of elderly, frail patients admitted,(and readmitted) who are often MSFD early on but have multiple moves within GRH and CGH before eventually transferring out of hospital.(recent example: 89 yr old with advancing Parkinsons Disease and increasing frailty admitted for 5 days and had 5 moves: ED/AMU/7A/Snowshill/Bibury. Family were contacted when in AMU and happy to have him home from AMU). This is not uncommon.These moves have a deteriorating effect on cognition, general physical functioning and continence. How can we make this better for this cohort of patients? Consider direct to FAS/AMU then transfer to specialist Elderly Care Ward. Also please consider use of beds at CGH: Ryeworth is the only specialist COTE ward,far too many outlying COTE pts across Bibury/Cardiac2/Knightsbridge. Consider reinstating a second COTE wards at CGH. Our 'back door' is as important as out 'front door'.		
15	it makes sense to have a collection of acute medicine departments in a single place. But these do need to be fit for purpose and fit for the 21st century, neither site currently is fit for purpose		
16	Cheltenham should remain an acute general hospital		
17	It would be problematic for rural locations, travel, job continuity and economic health in and around CGH		
18	good to have all services in one place.		
19	Its a great idea in paper apparently due to severe lack of medical bed capacity in the current situation its impossible to be a centre of excellence. Also without medical admission in cheltenham general hospital the ideology of ED is impossible as most of the cases presenting to ED is medical who may or may not need admission. Elderly people are most affected.		
20	Having a more centralised provision will be more beneficial to patients.		
21	We need to concentrate our resources for acute medicine on one site.		
22	To help flow.		
23	I think it will promote continuing excellence in the services provided and will attract good quality staff to the area.		
24	having access to wide range of specialists as quickly as possible seems key		
25	I want my care as I get older close to home so that family can visit. I would have no intention of being in a hospital away from my home town. This has high priority for me. Acute medicine has worked well at CGH for us up until now with ACUC managing the Acute Admissions well. From my observations of the medical wards at GRH they are not fit for practice. They are old, overcrowded, dirty, poorly staffed I would never wish to be a patient on these wards from my parents experience of being a patient on them. This would not be a centre of excellence - just an overcrowded cattle market.		
26	Concentrate this and the required support services for this on one site		
27	I believe CGH should offer equal services to GRH and not all resources diverted to Gloucester		

Please tell us what you think about our preferred option to develop: A 'centre of excellence' for Acute Medicine (Acute Medical Take) at Gloucestershire Royal Hospital.		Response Percent	Response Total
28	Cheltenham and surrounding villages and other small towns in Gloucestershire deserve to have their own ""Acute Medical Take"" at CGH. Travelling is difficult enough in Gloucestershire and Gloucester Royal Hospital has very inadequate and expensive parking. This is a very busy tourist town with many festivals bringing thousands of people to the town and it is a very poor decision to only have a centre of excellence in Gloucester. We need our own A & E and also our own Acute Medical Take I am not opposed to Gloucester having its own centre but both places should be treated the same. Gloucester is a very large county stretching from the borders of Wales to the edge of Oxfordshire and Worcestershire.		
29	There just isn't a big enough ED at Gloucester, not enough Resus vays and just too cramped		
30	This will mean Cheltenham residents will have to get there and Cheltenham hospital will not be needed, we need a centre of excellence in every hospital		
31	It's a rational use of limited resources. Concentration of specialist people, and specialist kit, absolutely makes sense, and research shows that it produces better outcomes.		
32	Best location in the county for this service		
33	Better treatment for all		
34	It makes sense to me have the expertise in one centre.		
35	The options outlined appear to make medical and operational sense		
36	Broadly support this measure although concerned about travelling distance for patient and/or family and friends if having to travel from e.g. the east/north of the county. Using a bus (could be 2+), particularly later in the day/evening, or having to fork out a for a taxi/persuade a friend/family member to drive further is far from ideal. Some concerns over whether there would be sufficient bed space for services to be centralised - other hospitals who have merged services from two sites relatively near to each other onto one site have experienced issues with capacity e.g. a county to the north of Gloucestershire Can see the benefits of seeing the right person sooner which is very beneficial for all concerned		
37	Both Cheltenham and GRH should have full facilities. This will give flexibility in terms of capacity and also provide options should one facility be unusable through disaster or infection. Currently I have experienced GRH A&E is working beyond capacity with beds in corridors'		
38	We live in the east of the county, and Gloucester is a long way to travel. This problem is exacerbated as we get older, and private transport becomes more difficult. Public transport is simply not an option.		
39	Having centres of excellence is ideal providing it does reduce waiting time, and ensures operations are not cancelled. All expertise in one place so if second opinion is needed there is someone to consult immediately without the necessity of a follow up visit somewhere else.		
40	The concentration of key resources in one place to reduce duplication and wastage.		
41	acute medicine is required both sites. CGH has ICU beds nad medical meds to help ease the patient load		
42	all experts in one place considering the staff shortage the NHS is currently under		
43	It's closer for most people. Ie the forest and cotswolds		
44	It makes sense to have one 'centre of excellence' rather than reduced facilities over 2 sites 12 miles apart		
45	It does make some sense to centre areas of expertise. However certain things also need to be taken into consideration. Access for people getting to the locations. Danger of additional time for emergency cases having to go to GRH. What is the impact on the other hospitals such as Cirencester, Tewksbury, Stroud etc.		
46	This is a hospital stay (even if 1 night) for which the patient and their family/carers have not planned. Hard enough to cope if it is local but very stressful if it is not. This is a case where both hospitals must be centres of excellence.		

Please tell us what you think about our preferred option to develop: A 'centre of excellence' for Acute Medicine (Acute Medical Take) at Gloucestershire Royal Hospital.		Response Percent	Response Total
47	there is ample evidence that diffusing resources results in worse outcomes for patients. The term centre of excellence is best avoided - it sounds good but means nothing - why would anyone not want excellence? How do yo define a centre of excellence?		
48	Opportunity to improve recruitment and retention of staff a strong argument for single site, linked to 24 hr consultant A&E		
49	Particular medical conditions can be prevented from getting worse if treated / diagnosed earlier		
50	As I live in the Forest of Dean it would be far more convenient for my family as possible patients to be treated in Gloucester		
51	I think everyone would prefer to be treated where specialist care is available and immediately accessible. This comment applies to all sections		
52	Our guests (we're from Cheltenham Open Door) have complex needs and issues (addiction, mental health issues, etc). If we don't have local emergency care (or suspect, if they have to be admitted, it will be in Gloucester) they are unlikely to seek help when they need it and may wait until the situation is critical and they have to call an ambulance. This will make for worse outcomes for them and the need for (presumably) more expensive and complex intervention for the NHS. Not all our guests have hugely complex needs but most would struggle if everything acute was at Gloucester. Very few would be able to have people bring stuff to them or visit if they're in Gloucester (bus fare, logistics, etc). Many rely solely on their groups of friends for support, being estranged from their families, and simply wouldn't present until the last minute if they thought they'd be taken to Gloucester. You mention ""The importance of mental health support as part of all services"" BUT not all mental health support is provided by the NHS. Sometimes, perhaps, it is as or more important to have the people who regularly provide your stability and support able to easily access and reassure you. On a personal note, I and my colleague have elderly parents who have been in A&E/ambulance situations. It's a nightmare when they are taken to Gloucester. If it's rush hour, following the ambulance takes an hour and a half and you can't pop in and out to take them things they need. You feel you have to abandon them, and they feel abandoned, when you are trying to support them from a different town. It creates anxiety, logistical issues and upset. It isn't what anyone wants.		
53	Anything that reduces risk, Travelling time, being passed from pillar to post offers a quality service, with quality staff can only be excellent		
54	Do things well in one place. Concentrate skills and workload.		
55	I It will ensure that specialist care is available at all times although it means I will have to travel from my home within walking distance of CGH.		
56	Glos Royal needs to improve		
57	Reduced waiting times Specialised staff in one place, so prompt decisions, better staffing		
58	Save on staffing and equipment by focussing on one location. Provide a better service.		
59	The creation of a COE will benefit staff and Patients However a more ""joinup"" public transport option needs to be considered - the holder of Gloucester main Bus provider Stagecoach should be able to used their daily/weekly/monthly bus pass in the 99 that links the two hospitals.		
60	Gloucestershire Royal already has good facilities and these could be improved if it was made a centre of excellence.		
61	Lack of community beds and placements means that this is needed across both sites in Gloucestershire especially GRH as cheltenham is more surgical and recent changes have only shown the failures of trying to downsize it and move specialities		
62	More convenient/centralized.		

Please tell us what you think about our preferred option to develop: A 'centre of excellence' for Acute Medicine (Acute Medical Take) at Gloucestershire Royal Hospital.		Response Percent	Response Total
63	After having experienced ' in patient ' services at both CGH and GRH on two separate occasions resulting from pneumonia. I would fully support the objective of developing a 'centre of excellence ' at GRH. The disadvantage of extra travelling for Cheltenham residents is outweighed by the improved facilities, better use of and more focused staff.		
64	Prefer Cheltenham - see page 37 My wife and I are in our 90th year. She is not allowed to drive. I prefer daylight and not Mon or Friday. We live in Tetbury and wish treatment there. So: We prefer Cheltenham and do not like Gloucester, the former being easier for us to reach by car and more convenient in terms of other activities on the day.		
65	The idea of creating centres of excellence at both of the two excellent large hospitals in Gloucestershire makes sense. It is worth remembering that the other specialist inpatient services, which have already centralised at either CGH or GRH e.g. cancer services at CGH and childrens' services at GRH, are working really well for patients.		
66	Your literature does not cover a large proportion of elderly people who are taken to a&e after falls. Would they stay in the same hospital? My mother has arrived after waiting over 6 hours for an ambulance after a fall, not fit to go home but no broken bones. Where does she she up? Also, it is all very well to say this, but where are the beds? Again my mother waited overnight in a&e for a bed (with no offer of food or drink). Surely it makes sense to use a bed where there is one? What about the wait for an ambulance to take the patient from Cheltenham to Gloucester? Would that patient be back in the queue at Gloucester a&e (in my experience no doctors read patients notes and the hospitals do not share anything online)?		
67	Don't see why this needs to be only available in Gloucester and services removed from Cheltenham		
68	Central to county for us in FOD		
69	We have to be realistic about the challenges and do what's needed to try and mitigate them.		
70	In line with the A&E focus		
71	I have a concern that the information presented that Gloucester Royal Hospital has 49 beds is misrepresented by including frailty beds. However I generally support this.		
72	I think it is vitally important to be able to have access to the right specialists (senior doctors) in a time of need, also address safety issues		
73	A specialist unit such as this makes sense.		
74	To concentrate the necessary skills in the centre of the catchment area		
75	Less need to transfer between hospitals which takes ambulance time away from emergency calls.		
76	I can understand the rationale for this proposal but Gloucester Royal is very difficult to reach from the south-east corner of the county (Fairford). I appreciate your comments in the long version about the need to help older patients who may not be familiar with one of the centralised centres. In our case, I would struggle to find GRH. I am concerned about the reduction in services in Cheltenham. One is a selfish reason: I am familiar with Cheltenham and can get there easily. My husband has been seriously ill a number of times and I know how stressful it is to find an unfamiliar hospital at night when you are panicking. My second objective reason is that it will be very difficult for ambulances (and patients in private vehicles) to get to GRH from the Cirencester area until the bottleneck of the Air Balloon on the A417 has been resolved.		
77	Too far for people from east Gloucestershire to go and it is always busy.		
78	My thoughts on this question, and answer to it, will be the same for many of the survey questions. I believe that there must be economies of scale in forming specialist centres. One whole is more beneficial than two halves in this case. This should mean savings in the cost of staff, equipment, spares and consumables, after an initial cost to physically create the unit. Some may get emotional about losing a service in 'their' area, but as a relative newcomer to the area, the hospitals are physically so close together, with good transport links between the two, I would consider the benefits to outweigh this.		

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

		Response Percent	Response Total
79	I do not wish the emergency services available at CGH to be downgraded, and think that access would be reduced if services were centralised to a single site.		
80	I am concerned that too much emphasis is being placed on GRH. This concerns me because I do not believe that GRH has the facilities or space to cope with extra work. I would not support the concentration of services on one hospital site if that led to, for example, a reduction in consultants at CGH.		
81	If the Acute Medical intake is concentrated on one site, it will make a Type 1 A&E Department less viable on the other site. It also reduces flexibility between the two hospitals, especially in times of any future pandemics.		
82	A state of the art hospital should be built in the forest of dean. Five Acres would be excellent, with maternity facilities. The travel to Gloucester and Cheltenham to and from the forest is horrendous and expensive.		
83	As my marking shows I am very much opposed to ""Acute Medical Take"" being centred in GRH. Cheltenham and the North Cotswolds have for very many years (in my case over 75) relied on CGH to provide care, quickly and without unnecessary and dificult travel to GRH, which can be critical to survival. Prior to the downgrading of CGH A+E two members (now deceased) of my family were well served by CGH at their time of need as I have. CGH provide the very best chance of survival. Many people in Cheltenham have regarded the hospital as a ""Centre of Excellence"" prior to it's downgrading. I understand the provision of a full A+E presents challenges to the trust however challenges do need to be overcome in order to match a clear need.		
84	Cheltenham would be more convenient for me, but Gloucester is potentially bigger and within easy reach		
85	More specialist nurses required in Acute Medicine. Real lull in activity when you get up to Acute Medicine.		
86	Quicker response to a service when needed - waiting times - if all under one roof - higher demand?		
87	If there is only one centre and something goes wrong will there be no back up service		
88	If one centre will numbers be too high who need to be seen		

Please tell us what you think about our preferred option to develop:A ‘centre of excellence’ for Emergency General Surgery at Gloucestershire Royal Hospital.

			Response Percent	Response Total
1	Strongly support		42.31%	55
2	Support		20.77%	27
3	Oppose		10.77%	14
4	Strongly oppose		18.46%	24
5	No opinion		7.69%	10
			answered	130
			skipped	5

Please tell us why you think this, e.g. the information you would like us to consider (81)

1	There is too little trust in the care provided by GRH, from poor food, lack of staff, nasty conditions and poor staff morale to convince me that a bunch of desk workers in brockworth have the support of the grass root level staff. There needs to be far more public trust in CCG and GRH before big moves are planned.
2	I think split site working for all departments should end. Single site for each speciality should be a priority
3	Should also have one at Cheltenham General

Please tell us what you think about our preferred option to develop:A ‘centre of excellence’ for Emergency General Surgery at Gloucestershire Royal Hospital.		Response Percent	Response Total
4	The same as previous it is easier to manage and better cost savings for the trust, tax payer.		
5	See previous answer. Best outcomes for patients is having centralised specialist units where training can also continue and also attract the best and Bridgestone staff .		
6	There needs to be capacity for this at CGH also.		
7	Support the notion of highly specialised surgical teams at one site. Only concerns are managing the increased throughput. Emergency surgery is rarer than acute medicine so the negative effects there should not occur here.		
8	You need centres of excellence in both Cheltenham and Gloucester and I believe with proper budget management this is possible I don’t feel the trust have any interest in keeping the Cheltenham service.		
9	Again, for same reasons as Acute care - GRH doesn’t have capacity		
10	This would further reduce/support the case for reducing the provision of the highest tier of A&E at CGH (East) so should not be considered.		
11	as the main ED is currently at GRH this would make sense, however I would be anxious to avoid all eggs in one basket. this also involves the elderly and infirm travelling distances to a site that isn't easy to get to by public transport especially if you are unwell		
12	Cheltenham should remain an acute general hospital		
13	Same reason for my previous choice. Internal operation and streamlining should not come at the cost of local community well-being.		
14	The patient to travel with illness from remote towns near cheltenham not ideal as it may be a risk too as can't depend on ambulances at all times.		
15	Again, we need to concentrate our resources on a single site to make best use of staffing and e.g. radiology		
16	Cheltenham needs surgery. As some people can not travel to Gloucester		
17	I think it will benefit local people to have this provision and will promote continued quality improvement and performance in this area.		
18	I want to see best staff possible in an emergency - I don't mind where it is but Gloucester makes more sense		
19	No Way. Build a new hospital and I might consider it. The tower block is not fit for practice. Its old and outdated with few siderooms.		
20	Services at CG H should be of equivalent quality.		
21	Many people from Cheltenham and North Gloucestershire would die on the way to Gloucester Royal. The traffic at many times of the day is apalling in Gloucester. You seem to be considering Cheltenham as a small village when in fact it has a population of 112,700. When you include the Cotswolds it rises to 196,300. With the regular increases of population throughout the year this should surely make a difference to your decision.		
22	Because the majority of emergency admissions go to Gloucester so it is logical for them to have all emergency surgery. However, I think Cheltenham needs to have a 24 hr ED with a specialism in oncology, urology and colorectal.		
23	This should be done in Cheltenham too		
24	It's a rational use of limited resources. Concentration of specialist people, and specialist kit, absolutely makes sense, and research shows that it produces better outcomes.		
25	Best location and facilities in the county		
26	I have to travel to both hospitals, so it makes no difference to me.		

Please tell us what you think about our preferred option to develop:A ‘centre of excellence’ for Emergency General Surgery at Gloucestershire Royal Hospital.		Response Percent	Response Total
27	Again one location makes sense		
28	There should be good emergency general surgery at both GRH and CGH together wit 24 hour consultant led A&E departments at both locations.		
29	Please note I don't fully follow the options here - the short booklet seemed to refer to the longer booklet. the long booklet was too confusing as to what you really meant. A picture /diagram of the before vs after might help add the clarity required Would support measures to be seen by the right person sooner but some concerns about travelling distance for patient and/or family and friends if having to travel from e.g. the east/north of the county. Using a bus (could be 2+), particularly later in the day/evening, or having to fork out a for a taxi/persuade a friend/family member to drive further is far from ideal. Some concerns over whether there would be sufficient bed space for services to be centralised - other hospitals who have merged services from two sites relatively near to each other onto one site have experienced issues with capacity e.g. a county to the north of Gloucestershire		
30	NOt a good option. The county needs flexibility for disasters and infections. Using Cheltenham fully will also mean patients are treated faster ensuring minimal complications, quicker recovery and better availability of Ambulances.		
31	Service already good		
32	See my previous answer		
33	As before		
34	Makes sense to specialise		
35	Concentration of key resources in one place to reduce duplication and wastage.		
36	GRH simply does not have the capacity with all of the counties A/E cases medical & surgical. the ICU is only rated good & has poor patient flow due to lack of beds in the service. CHG has the beds, the staff, the theatre space & an outstanding CQC rated ICU. emergency surgery has been carried out at CGH with excellent outcomes & no compromise to patient care. keeping everything at GRH simply isn't the safest or the best outcome for the patient. east side of the county considerably at a disadvantage		
37	Smaller A and .e with nurse practitioners would lessen the load on the big hospitals		
38	Again, it makes sense to have one very well equipped and staffed hospital rather than 2 close but less well resourced units		
39	Yes but the risks of additional transfer time for patients. Waiting times are already considerably higher. Can this be mitigated by keeping 'much less urgent cases away'? Strain on Ambulance Service. How does this all impact the other Gloucestershire Hospitals?		
40	The key word is Emergency. All emergencies should be treated as close as possible to the point at which the emergency was recognised. Unnecessary travel is best avoided and may introduce stress to the detriment of the patient.		
41	in line with evidence, a well equipped unit with expert doctors, nurses, pharmacists, physio and other AHP is associated with better outcomes; travelling further is a hard but worthwhile price to pay		
42	Travel visiting and carers		
43	Mocking all emergency services to GRH site logical I terms of collocation and impact on ambulance services		
44	As long as theatre space would increase in line with the need		
45	Better care for the community		
46	One would hope a centre of excellence would deal with patients quickly - I am aware of patients who feel the waiting time is too long and go aboard / different county for treatment and often end up worse		
47	Emergency general surgery should be available at both hospitals		

Please tell us what you think about our preferred option to develop:A ‘centre of excellence’ for Emergency General Surgery at Gloucestershire Royal Hospital.		Response Percent	Response Total
48	It seems sensible and more cost effective to centralise services		
49	The current system, with surgery at both hospitals, is better for anyone who: has money issues lacks transport has complex needs of any type I understand the desire to group services together for the NHS' logistical sake, but for anyone who struggles, in any way, being themselves in another town or having their loved ones in another town creates complications and unhappiness as mentioned in my previous answer. By doing this, you prioritise those with money, time and head space to cope with these extra complications, and disadvantage anyone who struggles in any way.		
50	Reducing waiting time, planned surgeries that are preformed on time contributes significantly to the health and wellbeing of patients and their families reducing stress and unnecessary waiting times		
51	Lessen impact on planned surgery		
52	Again, although this would be less convenient in respect of a present home the benefits would seem to outweigh the convenience		
53	Glos Royal needs to improve.		
54	Pressure eased on gaps in surgery and better for consultants and trainees. Shorter waiting and being messed about.		
55	Specialist staff and equipment in one location. Saves on time and money.		
56	The other options are more suitable		
57	Gloucestershire royal already has good facilities and several operating theatres with experienced staff		
58	Recent months have shown that the shutting of A&E in cheltenham and the removal of emergency surgery/planned surgery from Cheltenham has negatively impacted on patients and their experiences when previously having it on both sites worked due to the available DCC beds and the larger capacity. Raises questions of who is to blame for deaths when emergency surgery is not available on one site and someone dies on route, that is negligence where those that have made these decisions do not bare the blame, no family or patient deserved to go through this. Plus as gloucestershire is continually expanding with a rising population having one center for emergency surgery is simple foolery as it will not be able to cope with the ride in demands on already under funded and under staffed wards that receive no reprieve or help of any kind regardless of what is passed around internally or via media outlets		
59	Good communications hub.		
60	If its an emergency, the worry is that you would arrive at CGH and time would be wasted going to GRH because its 5:55pm.		
61	I would fully support the concept of Centre's of excellence for all the reasons documented in your summary document ' Fit for the future'		
62	We prefer Cheltenham - see page 37 My wife and I are in our 90th year. She is not allowed to drive. I prefer daylight and not Mon or Friday. We live in Tetbury and wish treatment there. So: We prefer Cheltenham and do not like Gloucester, the former being easier for us to reach by car and more convenient in terms of other activities on the day.		
63	The idea of creating centres of excellence at both of the two excellent large hospitals in Gloucestershire makes sense. It is worth remembering that the other specialist inpatient services, which have already centralised at either CGH or GRH e.g. cancer services at CGH and childrens' services at GRH, are working really well for patients.		

Please tell us what you think about our preferred option to develop:A ‘centre of excellence’ for Emergency General Surgery at Gloucestershire Royal Hospital.		Response Percent	Response Total
64	Surely access to care should be of primary concern to a hospital? Any solution should not have a negative impact? I query your statistics? The positive benefit for this change is for the homeless and people fro deprived areas (why what is the number of these that have general surgery) You quote 25% of Gloucester are from deprived areas but how many of these have emergency surgery? What is the proportion from the deprived and homeless areas around cheltenham? The negative benefit is for 40% of patients! So you already know that 40% of your most vulnerable are over 65 and these are the people most affected? So you are negatively affecting almost half your patients?		
65	Again, involves removing important services from Cheltenham. Calling something a ""centre of excellence"" doesn't actually mask the fact that it's an excuse to cut services elsewhere.		
66	Central to county for all		
67	It makes sense to co-locate emergency medicine and surgery at GRH		
68	In line with acute medicine and A&E focus		
69	The risks mean that this should be with the Acute provision.		
70	Yes I would like this to stay in Gloucester I am bias I live just outside Gloucester I like the benefits to staff members and staff retention.		
71	A specialist unit such as this makes sense.		
72	For the same reasons as above To concentrate the necessary skills in the centre of the catchment area		
73	No General Surgery beds at 1 hospital could impact badly on some patients.		
74	As mentioned on the previous page, I am concerned about the perceived downgrading of Cheltenham. Gloucester is difficult to reach from the Fairford end of the county and parking is difficult. Also (as mentioned previously) it takes longer to get to GRH than it does to Cheltenham hospital and the travel time varies depending on the traffic on the A417 (particularly at the Air Balloon).		
75	Nothing in the proposals that says emergency general surgery is better here than anywhere else.		
76	Same as the comment on the first page. If I were requiring this service, the hospital location wouldn't matter, but the level of service would. If merging meant a world class service, then be difficult to argue against it.		
77	I have no objection to the siting of specialist services on one hospital site. If this allows the particular hospital to improve its services in that field so much the better. I am, however, concerned that too much emphasis is being placed on GRH. This concerns me because I do not believe that GRH has the facilities or space to cope with extra work.		
78	If ALL emergencies are taken to Gloucestershire Royal Hospital it means the A&E Department at Cheltenham would no longer be a Type 1 A&E Department.		
79	Please note my previous comments the journey from FoD especially for older people is worrying and expensive. Hospital transport has failed badly and causing long delays in returning home. I am 90 years of age		
80	A centre of excellence is essential and you shouldn't spread your resources. The hospitals are close enough that no areas should be disadvantaged.		
81	always needed - Will specialist staff really be available or too busy elsewhere? How practical will this be or is sit just a hope		

Please tell us what you think about our preferred option to develop:A 'centre of excellence' for Planned Lower GI (colorectal) general surgery at Cheltenham General Hospital (CGH) or Gloucestershire Royal Hospital (GRH).

		Response Percent	Response Total
1	Strongly support	46.40%	58
2	Support	31.20%	39
3	Oppose	2.40%	3
4	Strongly oppose	5.60%	7
5	No opinion	14.40%	18
		answered	125
		skipped	10

Please tell us why you think this, e.g. the information you would like us to consider (69)

1	I would like Gloucester to be a better option for care, this should be improved so that its more viable than having to travel to cheltenham to visit people.
2	The same as previous it is easier to manage and better cost savings for the trust, tax payer.
3	Again it would make sense to have all GI surger on one site as patients don't always fit nicely into one speciality . So, GRH.
4	Elective services would benefit from single site 'centre of excellence' but with the capacity to transfer from Acute medicine/surgery at both sites.
5	If the ward is staffed properly, it could work.
6	If it's planned, why not just go to Oxford and build a bigger unit there?
7	Unless there is a shortage of staff with the correct expertise I do not see why a single centre of excellence in Gloucester is a fair option for Cheltonians. It's a long journey and a real challenge for elderly patients - visiting and collection of discharged patients becomes far more challenging especially for those restricted to public transport.
8	Silo'd services appear much simpler to locate on a single site.
9	planned surgery in a centre of excellence is nothing but good, but the site needs to be fit for this and to be able to accommodate patients staff and services alike
10	Planned surgery can be dealt either in cheltenham/Gloucester. But ideal would be in 2 different hospitals. so more cases can be conducted.
11	This is an 'either or' question without giving an opportunity to vote for either. It is nonsense.
12	Makes sense if centralising other GI services.
13	It will benefit local people needing this type of surgery
14	essential to attract good specialists and perhaps in time take on childrens so we dont have to travel to Bristol
15	I would support this if CGH was the 'centre of excellence' for lower GI. But again not GRH. There are not enough beds at GRH for emergency surgery and planned surgery. If it was at GRH alot of planned surgery would be cancelled because the beds would get used up by Emergency surgery and medical patients. As alot of this is cancer surgery it needs to be in a hospital that is clean and where the Oncology service/support services are.
16	Both hospitals should offer an equivalent standard of care
17	Yes it soulnds fine but surely Gloucester Royal will want their own as well!
18	Cheltenham needs to become a centre of excellence for colorectal surgery, urology and oncology, both planned and emergency

Please tell us what you think about our preferred option to develop:A ‘centre of excellence’ for Planned Lower GI (colorectal) general surgery at Cheltenham General Hospital (CGH) or Gloucestershire Royal Hospital (GRH).		Response Percent	Response Total
19	Both Cheltenham and Gloucester need to do general surgery, I was released from hospital in gloucester at 11.30pm and as I was taken there by ambulance I didn’t have my car, thankfully I have a son that drives but many people would be stranded, I could of walked home if I had been taken to Cheltenham		
20	Diagnostics are ok at Cheltenham, but specialist surgery needs to be where specialist surgery is based...		
21	Higher standards and expertise can be employed centrally		
22	But on both sites		
23	I support a centre for excellence.		
24	Again slightly confused as to the proposal here - a before/after diagram might have helped. Would support measures to cut risk of operations being cancelled at the last minute / being able to be seen/treated by the right person sooner. Again this needs balancing with the risks of insufficient bed spaces if centralised on one sight (e.g. county to the north of Gloucestershire. In addition there are the same travel concerns - if one is not well, coming by car may be the most practical method of transport, however unpalatable it may be. Hence adequate parking facilities are a must e.g. a dedicated carpark with more short term spaces say of up to 45 minutes		
25	I presume GRH would be a spoke and therefore provide back up.		
26	Need specialist services		
27	Cheltenham is quite far enough for us to travel		
28	As before		
29	Concentration of key resources in one place to reduce duplication and wastage.		
30	this will allow the trust to develop a service which will be second to none. it will link in with gynae / urology & a centre of excellence for oncology too. the bed flow / capacity is there. CGH has an outstanding ICU and staff who are specialised in pelvic surgery to provide excellent care. patient flow & discharge will improve. patients will get an improved service so not mixed with emergency care & can maintain a green site especially if future pandemics as per recommendations		
31	Again, it makes sense to have one very well equipped and staffed hospital rather than 2 close but less well resourced units		
32	As per previous comments		
33	but only in one centre		
34	Same reasons do not oppose a centre of excellence for Gloucestershire but do oppose strongly the lack of operations at either hospital		
35	It can only be a good thing for the people of Gloucestershire		
36	CGH would be the better location		
37	Again it seems sensible to centralise resources and staff		
38	Please bear in mind any treatments taken prior to appointments which may make a long journey very difficult		
39	I can't find any notes on the current vs planned systems for this, but if you mean ""all services being in EITHER CGH or GRH"" then my previous comments apply!		
40	As above		
41	The proposal would seem to make more effective use of staff and facilities		
42	Confused!		
43	Not sure about this as people from the Cotswolds need the nearest place yet Gloucester is better for people from that area.		

Please tell us what you think about our preferred option to develop:A ‘centre of excellence’ for Planned Lower GI (colorectal) general surgery at Cheltenham General Hospital (CGH) or Gloucestershire Royal Hospital (GRH).		Response Percent	Response Total
44	Focussing a specialism in one location makes the most sense providing value for money.		
45	COE will benefit Patients and Staff, and make effective use of existing resources		
46	Often have to go to Cheltenham for appointments so makes sense to do it at Cheltenham		
47	At Cheltenham General without a doubt, this has been in place for years and has worked without failure to a high standard. I, my family and friends have received care on this ward to a fantastic degree and then have unfortunately been subjected to GRH due to current events this year, to say that we were disgusted by this change would be a vast understatement. Why change what isn't broken, why ruin a system that has supported so many for years with such a dedicated team that is being picked apart and why support such an idiotic decision to shift CGH to a more medically acute when GRH does not have space for all this surgery and that has also been proven and found this year		
48	Not qualified to judge.		
49	If its excellent, who cares where it is?		
50	Near both		
51	If it is at GRH		
52	The idea of creating centres of excellence at both of the two excellent large hospitals in Gloucestershire makes sense. It is worth remembering that the other specialist inpatient services, which have already centralised at either CGH or GRH e.g. cancer services at CGH and childrens' services at GRH, are working really well for patients.		
53	In this case, though I'm based in Cheltenham, this would again seem to be downgrading services to be only available at one location instead of at 2.		
54	Not central to county. Parking nightmare, travel time - hours away		
55	Need to locate the planned specialties into CGH if emergency medicine and surgery are going to GRH		
56	Public perception and access focused at one hospital for one type of heath issue		
57	A centre of excellence would be good for everyone!		
58	I think there would be lots of advantages to keeping all the planned lower colorectal general surgery in Gloucester. Everything and every member of staff present.		
59	It needs to be Gloucester for access from the forest of dean		
60	To help spread skills to other major assets		
61	It would help provide rotas for the appropriate surgeons.		
62	Again, I understand the logic but I hope Cheltenham will not be downgraded. However, I do understand the issues raised in the booklets about staffing.		
63	Strongly support PROVIDED that site is Cheltenham		
64	It makes sense to have this at CGH where the gynaecological oncology is carried out. (Pelvic surgery)		
65	As previous questions. But I have had fantastic service and a colorectal resection at GRH. This started with the Bowel Cancer Screening at Stroud Hospital, and two operations at GRH, with follow up care. The care and dedication of all the staff at GRH has been exemplary, and I am so grateful to them! Of course if CGH was chosen, as long as the staff moved also, then the service would be just as excellent. A slight fear I have that when I think merge and provide an ever better service', the accountants hear 'merge, provide the same service, and cut costs'. The latter really would be a betrayal of trust.		
66	I would not support the concentration of services on one hospital site if that led to, for example, a reduction in consultants at CGH which would eventually put the future of services at that site in question		

Please tell us what you think about our preferred option to develop:A ‘centre of excellence’ for Planned Lower GI (colorectal) general surgery at Cheltenham General Hospital (CGH) or Gloucestershire Royal Hospital (GRH).

		Response Percent	Response Total
67	General Surgery is not really a 'surgical specialism', as it relates to many different conditions. In order to justify centralising General Surgery the Hospital Trust appears to be attempting to redefine it as a specialism relating only to colorectal surgery.		
68	See my previous answers on GRH but more so to travel to CGH. My wife is desabled hospital transport is a joke. I wrote to MP Mark Harper about this. I pay for transport and it is expensive		
69	CGH has always been a centre for excellence for this surgery - let it stay so!! Don't change		

In supporting our preferred option to create a single site 'centre of excellence', where do you think a ‘centre of excellence’ for Planned Lower GI (colorectal) general surgery should be developed?

		Response Percent	Response Total
1	Cheltenham General Hospital (CGH)	44.44%	56
2	Gloucestershire Royal Hospital (GRH)	21.43%	27
3	No opinion	35.71%	45
		answered	126
		skipped	9

Please tell us why you think this, e.g. the information you would like us to consider: (71)

1	I would like Gloucester to be a better option for care, this should be improved so that its more viable than having to travel to cheltenham to visit people.
2	Crucial item for me is that there is an equal balance between what is in Cheltenham and what is in Gloucester....with equal numbers of essential services in each. It must not be Gloucester is the centre with bits in Cheltenham
3	I believe that no one site can cope with providing the service for people who usually attend two sites. The waiting times increase, the staff are stretched and patients feel that they are suffering as a result. Gloucestershire is too big to have one site for a speciality.
4	this would support gynaeoncology surgery
5	Wherever you feel it is easier and safer to provide this from. Where other support services are on hand.
6	As above so the specialists are on one site , can cross cover be available.
7	Lower GI is currently at CGH, and in general works well with a v.dedicated multidisciplinary team.
8	Why should people from Cheltenham go to Gloucester when they can go to Oxford? If it's planned...
9	Both should offer excellence I don’t agree with either/or as the geographical region is huge and large populations will be disadvantaged. Surely these services should already be offering excellence or is this an acknowledgment that you are currently offering sub standard services?
10	CGH would make sense as there is the oncology dept is also there. The dots are joined up in that respect
11	both sites.
12	As this is intimately linked to gastroenterology (which is being focussed at CGH), it makes sense for this to be at CGH too.
13	Makes sense to continue the planned trend at CGH.

In supporting our preferred option to create a single site 'centre of excellence', where do you think a 'centre of excellence' for Planned Lower GI (colorectal) general surgery should be developed?		Response Percent	Response Total
14	I don't think it matters where the provision is. I cant see that one site has more benefit that the other.		
15	we live in Stroud - now my son has transitioned into adult IBD services we have had infusions in GRH, consultant appointment in GRH and MRI in Chelt - the travel relatively easy for us so wherever means staff travelling less.		
16	As above		
17	Neither site should take priority.		
18	I believe that you are wrong in trying to decide one place against the other hospital. Gloucester Royal is full to capacity and often difficult to reach because of its situation. The best solution would be to build a new hospital at Staverton and put any ""centres of excellence"" there. This idea, whilst not likely to ever be considered, would be a perfect solution. There is plenty of space at Staverton and the surrounding land. Sites at Gloucester and Cheltenham could be then be sold at a huge profit		
19	Cheltenham already deals with urology and it would make sense for ALL lower GI surgery, planned and emergency		
20	Both need this		
21	For reason given previously		
22	Ensure services are split more equally between sites & prevent all the eggs being put into one basket. If at Gloucester, could lead to capacity problems and there is only a finite amount of space to build on, if indeed funds can be found to pay for construction/re-figurement. By locating in Cheltenham, seems to sit/align with other services to allow a more wholistic treatment service		
23	Cheltenham is a significantly better run and more pleasant place to be than Gloucester. However, smaller hospitals such as Cirencester would be a welcome addition.		
24	GRH is currently too busy. I presume GRH would be a spoke and therefore provide back up.		
25	See above		
26	Wherever the space is available and where the necessary ancillary departments are. Which will have the capability to ensure bottlenecks do not occur - scanning, X-ray, theatres, outpatient capacity.		
27	Hard to have an opinion unless you are a user		
28	I live in Stroud and find it easier to get to GRH and easier to park the car.		
29	this will allow the trust to develop a service which will be second to none. it will link in with gynae / urology & a centre of excellence for oncology too. the bed flow / capacity is there. CGH has an outstanding ICU and staff who are specialised in pelvic surgery to provide excellent care. patient flow & discharge will improve. patients will get an improved service so not mixed with emergency care & can maintain a green site especially if future pandemics as per recommendations		
30	Most of the surgery might involve a cancer and Cheltenham is the cancer centre		
31	most of the issues are probably cancer related so it makes sense to put this in Cheltenham with the existing unit - although the buildings at Cheltenham are in dire need of refurbishment and modernising		
32	the main center for this type of surgery is already in Cheltenham - so why would you wan t to move it ?		
33	the centre should be close to GI medicine, specialist inpatient care (as in ITU) and imaging		
34	As above		
35	Ability to protect beds and theatre capacity		
36	As long as the support services match the need.		
37	Greater diversity in Gloucester		

In supporting our preferred option to create a single site 'centre of excellence', where do you think a 'centre of excellence' for Planned Lower GI (colorectal) general surgery should be developed?		Response Percent	Response Total
38	Cheltenham and Gloucester hospitals should be equally recognised for their own specialisms and resources. Gloucester Hospital cannot have it all		
39	Obviously Gloucester is the closest to me, for same reason stated above. Cotswold residents would almost certainly disagree		
40	Obviously, given what I've said, I'd choose Cheltenham. Gloucester residents would presumably prefer it there!		
41	Greater Diversity in Gloucester - some longer term health conditions higher with minority ethics Ease of access and family support as communities live close together		
42	A good match with other services. Also seems too much at GRH which could lead to conflicts of staff time		
43	Ideal in respect of our place of residence		
44	Would keep at both		
45	If the majority of this department is located in GRH, it makes sense for all of it to be located at GRH.		
46	Make effective use of existing resources		
47	As above		
48	At Cheltenham General without a doubt, this has been in place for years and has worked without failure to a high standard. I, my family and friends have received care on this ward to a fantastic degree and then have unfortunately been subjected to GRH due to current events this year, to say that we were disgusted by this change would be a vast understatement. Why change what isn't broken, why ruin a system that has supported so many for years with such a dedicated team that is being picked apart and why support such an idiotic decision to shift CGH to a more medically acute when GRH does not have space for all this surgery and that has also been proven and found this year Please consider the fact that whichever higher up or suited monkey has been trying to shut cheltenham A&E for years due to funding and the arrangement of doctors across sites. This is bad in practice and paper, especially when the current state of affairs in CGH due to some of these measures already being in place has slowed down patient care because their is no one on site available to offer the urgent care that is needed or they are being rushed off to see to someone in a supposable MIU that continually blue lights patients to gloucester only for them to come back again as their is no capacity or available beds		
49	Not qualified to judge.		
50	If its excellent, who cares where it is?		
51	I would support the decision made by those individuals directly involved in the provision of this service at both hospitals. Is that information available ? I assume that is being considered in any final decision and it would have a significant impact on any final assessment.		
52	Suits us better - see page 37 My wife and I are in our 90th year. She is not allowed to drive. I prefer daylight and not Mon or Friday. We live in Tetbury and wish treatment there. So: We prefer Cheltenham and do not like Gloucester, the former being easier for us to reach by car and more convenient in terms of other activities on the day.		
53	Proposals for either option appear to be well thought through.		
54	I don't support it		
55	Again central		
56	see previous response		
57	To align with the upper colorectal service at CGH		

In supporting our preferred option to create a single site 'centre of excellence', where do you think a ‘centre of excellence’ for Planned Lower GI (colorectal) general surgery should be developed?		Response Percent	Response Total
58	All major General surgery located with acute services makes common sense.		
59	I think a centre of excellence, a single one would benefit the local and wider community by being situated in Gloucester.		
60	Its more central for Gloucestershire		
61	It would make the centre of excellence and help maintain Chelts specialism to attract staff.		
62	This is my biased opinion, as Cheltenham is so much more convenient to reach from the Fairford area.		
63	Fits in with above.		
64	I know the GRH team are fantastic, but have had no dealings with CGH.		
65	I am concerned that too much emphasis is being placed on GRH. This concerns me because I do not believe that GRH has the facilities or space to cope with extra work.		
66	If this is centralised on one site, it should be on the site where the existing Centre of Excellence for Cancer is based, because of the close relationship between Lower GI Colorectal Surgery and cancer.		
67	I am willing to provide a contribution towards the cost of a new hospital in FoD. Monmouthshire Council I am sure would also contribute instead of having people travelling to Cumbran		
68	It has always fulfilled. This need - leave it as it is		
69	Family orientated at Cheltenham and more friendly, smaller pods.		
70	Prefer something at both sites		
71	Once again if only one centre and there are issues is there a back up service?		

Please tell us what you think about our preferred option to develop:A ‘centre of excellence’ for planned day case Upper and Lower GI (colorectal) surgery at Cheltenham General Hospital (CGH).			Response Percent	Response Total
1	Strongly support		39.53%	51
2	Support		33.33%	43
3	Oppose		3.10%	4
4	Strongly oppose		5.43%	7
5	No opinion		18.60%	24
			answered	129
			skipped	6

Please tell us why you think this, e.g. the information you would like us to consider (57)

1	I would like Gloucester to be a better option for care, this should be improved so that its more viable than having to travel to cheltenham to visit people.
2	The same as previous it is easier to manage and better cost savings for the trust, tax payer.
3	If there are enough surgeons to cover this service , my concern is if an emergency service is also working how will the oncology patients be managed in an emergency situation

Please tell us what you think about our preferred option to develop:A ‘centre of excellence’ for planned day case Upper and Lower GI (colorectal) surgery at Cheltenham General Hospital (CGH).		Response Percent	Response Total
4	Why go to Gloucester when you can go to Oxford?		
5	As per your previous question the region and population mean this is not an either/ or answer BOTH hospitals with their significant budgets should offer centres of excellence.		
6	as previous question located in the best site alongside the supporting departments such as Oncology. the imaging services also need to be there too		
7	Prefer a surgical unit in cheltenham as it can take pressure away and enhance smooth running by carrying out more cases through which more profit is available.		
8	Keep low-risk surgery away from the acute site to improve (reduce) cancellations		
9	Benefits local people.		
10	Would these beds be ringfenced for day surgery and not have patients put in them overnight? as is the usual case.		
11	It needs to be clear that if you have a centre of excellence, it is in one place. GU/GI at Cheltenham - Totally! along with oncology. Everything else to GRH		
12	Both Cheltenham and Gloucestershire need this		
13	Helps to manage an appropriate split between hot and cold sites		
14	Would require better facilities at Cheltenham general in my opinion hospital dated and tired in appearance		
15	I support the idea of one team on one site locally		
16	Now very confused - how is this different to the previous two questions? Answers are as previous - support measures to cut last minute cancellations & being able to be seen & treated by the right person quicker. however this needs balancing with concerns over travel distance and reaching capacity at one site		
17	As above		
18	As before		
19	Concentration of key resources to reduce duplication and wastage.		
20	day case can be done either site		
21	As before		
22	as previous answer		
23	This is already in Cheltenham. I have had to use it and found it excellent.		
24	Planned surgery in one location does make a lot of sense, as long as the wait times do not increase and also operations are not cancelled due to other factors.		
25	But for day cases, there should be one at GRH as well.		
26	is there sufficient IT resource so paper records can be consigned to history and all relevant clinical information is available on both sites		
27	Should’ve at both units if Gloucester hospital and Cheltenham hospital are Gloucestershire hospital service why not at both.		
28	Ability to manage beds and theatre capacity. Support to staff.		
29	It would make sense that both upper and lower should be on the same site as support services and staff would have similar skill sets		
30	If planned centre of excellence for lower GI general surgery will be in Cheltenham it is only sensible for day cases upper and lower surgery to be there also		

Please tell us what you think about our preferred option to develop:A ‘centre of excellence’ for planned day case Upper and Lower GI (colorectal) surgery at Cheltenham General Hospital (CGH).		Response Percent	Response Total
31	See previous 2 comments		
32	See previous.		
33	As before - economies of scale vasically		
34	More convenient from a personal point of view		
35	Separating Planned surgerty will reduce cancellation and improve patients waiting times		
36	A smart decision as these teams are set up and in place already with exemplary experience as well as the chances to expand on these services as their is adequate space		
37	Not qualified to judge.		
38	I support the basis of 'Centres of Excellence' and would assume that the decision to base a particular function at each hospital is based on building up the core competency that already exists at the chosen hospital		
39	N/A		
40	The idea of creating centres of excellence at both of the two excellent large hospitals in Gloucestershire makes sense. It is worth remembering that the other specialist inpatient services, which have already centralised at either CGH or GRH e.g. cancer services at CGH and childrens' services at GRH, are working really well for patients.		
41	Why not at both, this involves improving Cheltenham at the expense of Gloucester		
42	Not central to county		
43	keeping planned activity in CGH if emergency services are going to GRH makes sense		
44	I think it is a good idea to separate out the emergency and planned cases, so having the day cases all at CGH makes sense along with other planned general surgery and the emergency cases in GR.		
45	Alll skills and staff for GI health issues in one location. Single point of contact in Trust for GI		
46	On the focus of Cheltenham General Hospital as an elective centre this fits well. The pelvic centre of excellence with the arthroplasty, gyno and urinary would all work well together although it may reduce the General Surgery pool slightly at GRH.		
47	This would work well because it is planned surgery instead of emergency surgery. Not so much of an issue around transport and time scales		
48	It needs to be Gloucester more central for Gloucestershire.		
49	To centralise the entire colorectal skills		
50	Help develop skills of junior surgeons and provide good support for them.		
51	Cheltenham is easy to reach. Also, my husband has been treated in Cheltenham for bowel cancer and an emergency hernia and I was very grateful for the good treatment.		
52	Same as previous answers really. However, although the sites are close, transport links between them should be free, and green. A sort of very frequent campus type shuttle, perhaps with a couple of pick up points en-route.		
53	I have no objection to the siting of specialist services on one hospital site. If this allows the particular hospital to improve its services in that field so much the better and consider that GRH is already overloaded.		
54	It makes sense to focus planned surgery on one site, but this should not only be ""planned day case"", it should also include more complex elective surgery and not merely 'day case surgery'.		
55	See my previous comments. This is a bad decision and the people of the forest of dean and Monmouth deserve better.		
56	It is very good as is		
57	Yes for centre of excellence and yes for Cheltenham.		

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

		Response Percent	Response Total
1	Strongly support	32.82%	43
2	Support	32.82%	43
3	Oppose	9.16%	12
4	Strongly oppose	6.11%	8
5	No opinion	19.08%	25
		answered	131
		skipped	4

Please tell us why you think this, e.g. the information you would like us to consider (64)

1	I suspect more money has gone into coming up with the terms / logos for hub and spoke than into IGIS. Both places should be equal and more money should be invested and the CCG shrunk to release the funds.
2	Image guidance needs to have services in both locations
3	both hospitals should have it
4	The same as previous it is easier to manage and better cost savings for the trust, tax payer.
5	Makes sense as the oncology services are at Chet=ltenham so would need support
6	Provided there is emergency cardiac interventional capacity at CGH also. It would not matter if this was at CGH considering the trust's stated aim of reopening ED at CGH post pandemic and it already exists there.
7	Extreme nature of emergency IGIS means the time delay going from Cheltenham to Gloucester would be far too risky re. loss of life to a patient who may, for example's sake, live just across the road from CGH.
8	Centres of excellence should be at both hospitals!
9	The spoke is a ‘gesture’ and perceptibly will be seen as something to sacrifice at a later date to move all services to GRH....
10	making sure that the supporting staff are enough to provide this
11	Any
12	Again, we need to concentrate our resources on a single site to make best use of staffing and e.g. radiology
13	As long as this allows radiology to expand and develop. Be bold and invest here, this could be a real jewel in the crown for healthcare in Gloucestershire.
14	Will provide a better health care service for local people.
15	espensive kit and specialist staff - makes no sense to try and run 2 sites
16	As vascular and cardiology are at CGH then this service needs to be based on this site.
17	Both hospitals need this
18	It's a rational use of limited resources. Concentration of specialist people, and specialist kit, absolutely makes sense, and research shows that it produces better outcomes.
19	Reasons given previously
20	This would presumably mean that there could be more appointments available.
21	Being a more modern hospital having the hub in Gloucester makes sense

A 24/7 Image Guided Interventional Surgery (IGIS) ‘Hub’ at Gloucestershire Royal Hospital and a ‘Spoke' at Cheltenham General Hospital.		Response Percent	Response Total
22	Appears to be specialist treatment needing expensive specialist equipment operated by experts. Given this seems better to centralise as one service - some people may travel a little further but far fewer would need to travel out of county at evenings/weekends. Going to hospital unexpectedly (or even planned) is not a good experience so removing a longer journey with some of the complications this can lead to seems a beneficial step		
23	I believe it is good to have different hospitals with different specialisms. This will also promote inter hospital information exchange. I presume Cheltenham would be a spoke and therefore provide back up.		
24	As long as the tech is good enough this is fine. But the tech has to be up to this task		
25	Concentration of key resources to reduce duplication and wastage.		
26	with major pelvic surgery we need interventional surgery which will also tie in with oncology		
27	More central for the county		
28	Would prefer all in one place to maximise use of resources but accept probably a need at Cheltenham for a smaller unit in support of other services based there		
29	It is unclear to me what the difference between a Hub and a Spoke in this context. The best of treatment should be available in both locations.		
30	more details are required to ensure both are adequately resourced (people and equipment) and overnight care available on site if needed; a waste of resource if personnel spend time travelling between centres		
31	Should be at both		
32	Help with recruiting and developing a centre of excellence good for population of Gloucestershire		
33	As long as there is suitable staffing to support this arrangement, eg. Radiologists, nursing staff, radiology staff, physiology staff.		
34	Reducing risks and stays in hospital and manual intervention is always good. Anxiety of carers and family is minimised as patients return home quicker		
35	Provided the spoke at Cheltenham is accessible and operational		
36	See previous		
37	Often with services / treatments there is a lot of confusion where to go Cheltenham or Gloucester? a centralised hub offering as much as possible at one place would provide a ""comfort zone"" for the patient without having to travel to different places. Doesn't have a feeling of disconnect		
38	This could have been a centre for excellence in cgh ?		
39	Seems to make sense		
40	Bringing the hub into one location makes sense, as staff and equipment can be focussed on one place not split over two sites.		
41	This Provide the Best Option - and will mean patients can be seen locally.		
42	Availability re transport and parking for patients and carers		
43	If this helps people and their is space on sites then definitely as delays in scans are detrimental to patient safety and outpatient urgent appointments		
44	Seems effective.		
45	The staff who maintain the LINACS (at CGH) would be best to carry out emergency repairs and maintenance, surely?		
46	N/A		

A 24/7 Image Guided Interventional Surgery (IGIS) ‘Hub’ at Gloucestershire Royal Hospital and a ‘Spoke' at Cheltenham General Hospital.		Response Percent	Response Total
47	The idea of creating centres of excellence at both of the two excellent large hospitals in Gloucestershire makes sense. It is worth remembering that the other specialist inpatient services, which have already centralised at either CGH or GRH e.g. cancer services at CGH and childrens' services at GRH, are working really well for patients.		
48	see previous answers		
49	GRH should be main site		
50	This depends where the activity is required - in emergency surgery or planned		
51	I think this will allow the best use of equipment by having the main hub at GRH but still maintaining some of the spoke services at CGH.		
52	Key point of focus at GRH. It is unclear to me why you would want a spoke at CGH. Resources staff and equipment would be split. Imaging equipment requires on going maintenance programme better focused at one location		
53	The major IGIS is acute related often so should be with the trauma and stroke unit. However, Cheltenham General Hospital as a spoke would allow elective investigations and pelvic and oncology to occur.		
54	Yes I would like IGIS Hus at Gloucester and a spoke at Cheltenham General Hospital, I like the fact you do not have to travel between sites and outside of the county.		
55	Explain why this can't just be at Gloucester		
56	It is the logical place		
57	Having read the information in this booklet I think it would be better to have 1 place for IGIS at GRH.		
58	I understand the rationale so would have to accept the proposals. GRH is difficult to reach but, on balance, the centre of excellence is more important.		
59	My quick thought is spoke detracts from the economies of scale argument.		
60	I would not support the concentration of services on one hospital site if that led to, for example, a reduction in consultants at CGH		
61	Image Guided Interventional Surgery appears to cross a variety of other specialisms, but seems most relevant to Cardiology and Vascular Surgery, which should be located in the first-class facility that was only created at Cheltenham three years ago.		
62	See my previous comments. The people making the decisions have not had to journey from the FoD to Glos and Chelt 4 or 5 times a year as we have and paid for the privilege		
63	While I have no set of opinion on this I would nevertheless prefer such a service be provided at CGH. To the best of my very limited knowledge this is a not an exceptionally urgent procedure. A planned procedure???		
64	Have had heart surgery and this would have helped me at the time and taken away the need to attend Oxford. Great for bringing the specialists to Gloucestershire to work. Open up the service to more charitable funds.		

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

			Response Percent	Response Total
1	Strongly support		36.51%	46
2	Support		30.16%	38
3	Oppose		7.94%	10
4	Strongly oppose		8.73%	11
5	No opinion		16.67%	21
			answered	126
			skipped	9

Please tell us why you think this, e.g. the information you would like us to consider (58)

1	both hospitals should have it
2	The same as previous it is easier to manage and better cost savings for the trust, tax payer.
3	Cardiology and vascular services should be on the same site to service emergencies.
4	The current location of this ward is totally unsuitable-i.e not enough space between beds, and only one bathroom that a wheelchair can fit into.
5	Again, why not just go to Oxford if you live east of Cheltenham?
6	Centres of excellence are required at both hospitals- the region and population support it - you are reducing Cheltenham hospital to a first aid centre by stealth. Offering centres of excellence is merely a ploy to reduc3 services in Cheltenham which remain badly needed!
7	its already there
8	I prefer vascular surgery in one hospital either cheltenham or gloucester.
9	Should have vascular surgery where acute services are and e.g. renal, stroke
10	Hard to have IGIS at GRH and vascular at CGH so makes sense.
11	I think it is an interesting area of surgery and will provide excellent provision for local people.
12	Again the wards at GRH are not fit for practice. They are overcrowded, beds too close together increasing the infection risk. The tower block appears generally dirty. Your report reads that if you live in a deprived area(25% of Gloucester population) you will get preferential treatment on your door step and blow the rest of the county. Given that most vascular issues occur in the over 65 age group and these people are spread out across the county if you live at Morton/Bourton area East Gloucestershire, you wont stand much chance of survival.
13	Keep Cheltenham as centre of excellence for everything GU/GI and oncology and all other surgery at GRH
14	Both hospitals should do this
15	It's a rational use of limited resources. Concentration of specialist people, and specialist kit, absolutely makes sense, and research shows that it produces better outcomes.
16	Ditto
17	One team working closely together
18	Same as the above

A 'centre of excellence' for Vascular Surgery at Gloucestershire Royal Hospital.			
		Response Percent	Response Total
	19	Again confused - suggest you need to engage some communications experts to put the proposals AND link them to the survey in plain english/language understandable by non medical persons. Appears to be specialist treatment needing expensive specialist equipment operated by experts. Given this seems better to centralise as one service - some people may travel a little further but far fewer would need to travel out of county at evenings/weekends. Going to hospital unexpectedly (or even planned) is not a good experience so removing a longer journey with some of the complications this can lead to seems a beneficial step	
	20	Would seem to complement IGIS	
	21	As before - transport is a serious worry for us	
	22	Might use this	
	23	Concentration of key resources to reduce duplication and wastage.	
	24	Again more central for the county and transport links	
	25	Again, the same point of view. Maximise the use of resources in one place rather than try to do everything everywhere	
	26	As per previous observations	
	27	This should be true of CGH too	
	28	as with GI surgery	
	29	As before services should be at both to ease travel for elderly who do not drive	
	30	Meets best practice requirements	
	31	As long as there is suitable staffing to support this arrangement, eg. Radiologists, nursing staff, radiology staff, physiology staff.	
	32	Most vascular surgery is urgent, however the vast majority is planned so it seems daft to move too GRH. especially when a lot of resources and planning went into developing an excellent service at CGH.If it is moved to Gloucester Royal then it is essential for the accommodation to be fit for purpose. eg: large bed space, assessable showering/bath facilities to meet the needs of patient demographics. Vascular surgery inpatient and outpatients and vascular lab should be in close proximity	
	33	See previous	
	34	As above	
	35	I Struggle to see the Justifcation for the move - other than to be Closer to Trauma unit.	
	36	Good parking, already has a good unit at GRH	
	37	This team have been in place and excelled in gloucester as majority of admissions of this type are sourced from gloucester. Also the equipment and resources required for this are centered in Gloucester with years of practice	
	38	Not qualified to judge.	
	39	As I said before, as long as it is excellent, who cares where it is?	
	40	N/A My wife and I are in our 90th year. She is not allowed to drive. I prefer daylight and not Mon or Friday. We live in Tetbury and wish treatment there. So: We prefer Cheltenham and do not like Gloucester, the former being easier for us to reach by car and more convenient in terms of other activities on the day.	

A ‘centre of excellence’ for Vascular Surgery at Gloucestershire Royal Hospital.			
		Response Percent	Response Total
	41	The idea of creating centres of excellence at both of the two excellent large hospitals in Gloucestershire makes sense. It is worth remembering that the other specialist inpatient services, which have already centralised at either CGH or GRH e.g. cancer services at CGH and childrens' services at GRH, are working really well for patients.	
	42	see previous answers	
	43	Main site	
	44	Having Vascular surgery at GRH will mean that vascular surgery will be able to support the emergency services better.	
	45	In line with decision to locate the IGIS primarily at GRH	
	46	I believe that some thought should be given to maintaining some 'low risk' non urgent vascular capability for some elective vascular surgery at Cheltenham General Hospital	
	47	I appreciate the fact less invasive surgery would be needed and reduced travel time for some procedures, so that would be a bonus.	
	48	It needs to be Gloucester central for Gloucestershire	
	49	This and IGIS should be in the same location	
	50	Single specialist centre would enable better and timely patient care.	
	51	I understand the rationale so would have to accept the proposals. GRH is difficult to reach but, on balance, the centre of excellence is more important. Regarding concerns about going out of county, Gloucester is no more convenient than Bristol (although I accept there may be budgetary considerations).	
	52	Hasn’t millions of pounds recently been spent on a vascular theatre in Cheltenham!!	
	53	As previous answers.	
	54	I would not support the concentration of services on one hospital site if that led to, for example, a reduction in consultants at CGH.	
	55	There is an excellent, nearly new Cardiovascular Unit at Cheltenham General Hospital, which the Hospital Trust spent £2.3m or more on. This is one of the best facilities of its kind in the South West, if not the whole country. It makes no sense to relocate this to the Gloucestershire Royal, especially since, according to six our of seven of the Consultants involved, the facilities there are not nearly as good.	
	56	Se my previous comments and reverse you decision. My wife is disabled and I am 90 years of age and her carer. Traveling to Chel and Glos 4 or 5 times a year is traumatic.	
	57	I support this option since I recognise that resources have to be used to the very best effect so if this is the Trusts preference I would support it.	
	58	You need the technology to do this and therefore would be good to be in Gloucestershire. Need to have the wards set up for this close to the theatres. Will pull in staff and money by having a centre of excellence. Increase the number of specialist nurses.	

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

		Response Percent	Response Total
1	Strongly support	41.41%	53
2	Support	28.91%	37
3	Oppose	2.34%	3
4	Strongly oppose	6.25%	8
5	No opinion	21.09%	27
		answered	128
		skipped	7

Please tell us why you think this, e.g. the information you would like us to consider (55)

1	The same as previous it is easier to manage and better cost savings for the trust, tax payer.
2	Provided there is some gastroenterolgy presence at GRH also.
3	Both hospitals need a centre of excellence due to the size of the population and the location of the services .
4	If GI suregery is at CGh this needs to be too
5	Should be in Gloucester with the rest of medicine
6	prefers a medical unit in cheltenham which helps all people
7	Having one of the sites be the centre of excellence makes absolute sense. As the pilot has been at CGH - this should continue. However, having had personal experience of the CGH provision both in 2019 (in December) and in 2020 (May/June), some work is needed on this provision. My brother was in CGH for over 8 weeks in 2019 and for over 11 weeks in 2020 - and the care was poor. There was lack of continuity of care, and rarely saw a gastroenterology specialist on each day. While I appreciate that this might not be the 'norm' for most patients - I am aware of two other patients that have had this experience. At the moment, the continuity of care and plan for patients being discharged is poor and needs to be improved.
8	As the pilot has been seemingly successful then makes sense.
9	I think if gastroenterology is going to be based at Cheltenham then the surgery should be carried out there too so that all gastroenterology services are under one roof. I don't like departments being split between the different sites.
10	Emergency Gastroenterology patients should also be admitted to ED at CGH once its reopened other wise you dont have a 'centre of excellence. You will have patients on both sites.
11	If you want to have a centre of excellence EVERYTHING to do with that area of medicine needs to be there, no half measures and aahh but this bit goes to Gloucester. You need to keep things simple and easy for Joe Public yo understand as well as your HCP partners.
12	Both hospitals need this
13	Reasons given previously re: buildings
14	Expertise and resources at one site.
15	Seem to be wanting to move all other services away from Cheltenham - might be an exaggeration but that is what is coming across, whether intended or not. The shorter booklet was understandable until it referred you to the longer booklet - that just descended into more confusion Again support measures to have less last minute cancellations & being seen/treated by the right person sooner. Need to balance this against over centralising and leading to capacity constraints & greater travelling time for those in the west of the county, particularly at the start/end of the day & at weekends
16	Would compliment other specialisms
17	Need specialist services

A permanent ‘centre of excellence’ for Gastroenterology inpatient services at Cheltenham General Hospital.			
		Response Percent	Response Total
18	As above		
19	Concentration of key resources to reduce duplication and wastage.		
20	will tie in with colorectal making patient experience & expertise seamless		
21	One unit to maximise use of resources but tempered by the fact that Cheltenham hospital is in drastic need of refurbishment.		
22	But not only at CGH.		
23	Gastroenterology services should (at least in my view) be in close proximity to GI surgery. Optimal care of such patients often involves close collaboration between the two arms		
24	I feel this service could be led from either hospital and the service continue I the hospital why change for change sake . Save money and develop leadership on either site and share good practice online		
25	As long a there are support services, equipment and staffing to support this		
26	These are common aliments and overall benefits outweigh the negatives		
27	This is a linked to ties in with a centre of excellence for planned lower colorectal and day case surgery at Cheltenham		
28	See previous		
29	Urgent general need for many people. Reduced waiting times - quality focused attention and care for the patient is always a win win		
30	Support concept		
31	Ideal location from a personal point of view		
32	Focus a centre of excellence on one site, don't try to split it across two geographical locations.		
33	The Pilot seems to indicate that this is and will continue to work well		
34	Links with upper /lower GI as well as colorevtal and cancer based surgeries, this is a no brainer as it would all fit together and enable this center of excellence aim		
35	Not qualified to judge.		
36	Suits us - see page 37 My wife and I are in our 90th year. She is not allowed to drive. I prefer daylight and not Mon or Friday. We live in Tetbury and wish treatment there. So: We prefer Cheltenham and do not like Gloucester, the former being easier for us to reach by car and more convenient in terms of other activities on the day.		
37	The idea of creating centres of excellence at both of the two excellent large hospitals in Gloucestershire makes sense. It is worth remembering that the other specialist inpatient services, which have already centralised at either CGH or GRH e.g. cancer services at CGH and childrens' services at GRH, are working really well for patients.		
38	As above, also strongly sceptical of your use of the word ""permanent"", given the constant change and deterioration that is going on in NHS services locally		
39	Not central site. Too far away for lots of people and parking a nightmare and expensive		
40	linking this with the Cancer centre streamlines care		
41	It is clear that reverting to the set-up from the pre-pilot stage would be worse off for many aspects. It seems to be working well, and it is fulfilling the world-wide move to centres of excellence.		
42	This is in line with the decision to locate the GI services at CGH but to be effective and efficiet the CGH facilities, resources and staffing levels need to be expanded and improved at CGH if the CGH is to be the centre of excellence.		

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

		Response Percent	Response Total
43	Cheltenham General Hospital concentrating ofn elective support in the area is sensible.		
44	We think all procedures should be available at all hospitals, but Cheltenham is preferable to us over Gloucester as it is marginally closer.		
45	Yes, always keep anything that is excellent and working well!		
46	It needs to be Gloucester more central for Gloucestershire		
47	Keep the gastro disciplines together		
48	A centre of excellence would benefit both staff, services delivered and patient care.		
49	My husband received excellent care for bowel cancer and an emergency hernia. Cheltenham is so much more convenient for the Fairford end of the county.		
50	As before really.		
51	I have no objection to the siting of specialist services on one hospital site. If this allows the particular hospital to improve its services in that field so much the better.		
52	this is a service which should, as far as possible, be located as close to the existing Cancer Centre in Cheltenham General Hospital.		
53	See my previous comments		
54	Perfect - the ideal site and facilities for such a service.		
55	Cheltenham would do well with the long term illnesses and having a centre of excellence for this specialty. Facilities are questionable to make this a great centre excellence - the physical building.		

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

		Response Percent	Response Total
1	Strongly support	46.51%	60
2	Support	23.26%	30
3	Oppose	6.98%	9
4	Strongly oppose	6.98%	9
5	No opinion	16.28%	21
		answered	129
		skipped	6

Please tell us why you think this, e.g. the information you would like us to consider (69)

1	absolutely - this should be a number 1 priority - better trauma and A&E care at both destinations - there is NO WAY that one centre will suffice and we know this undermines public trust in CCG (who honestly now must be loved about as much as covid 19 itself).
2	both should have trauma and ortho
3	If it is a trauma case, it is quite possibly an ambulance admission and GRH cannot cope now. All ambulances go to GRH and then orthopaedics would have to be transferred to CGH, increased cost, risk, time and staff
4	The same as previous it is easier to manage and better cost savings for the trust, tax payer.

Two permanent ‘centres of excellence’ for Trauma at Gloucestershire Royal Hospital and Orthopaedics at Cheltenham General Hospital.		Response Percent	Response Total
5	Need to be on one site . Have CRH as cold , non emergency surgery and GRH as emergency. Which would protect beds at CRH		
6	Both hospitals have the population to support a centre of excellence- this is just stealing Cheltenham hospital services away which has been happening by stealth over recent years!		
7	its needed across both sites. trying to travel from e.g moreton in marsh on crutches or with arthritis to GRH isn't acceptable. there is no realistic hospital transport for these folk		
8	Prefers a unit in cheltenham for orthopaedics.		
9	Keep low risk elective surgery away from acute site, concentrate acute resources		
10	This is known to be good practice and the pilot has been working well. Why change it?		
11	Don't know why we need two centres. Probably better to have everyone on one site rather than spreading resources more thinly across two sites.		
12	I still think one trauma centre would be better but understand why Cheltenham seen as important		
13	Each sit should cover both services due to the size of the county.		
14	because this would be an excellent idea		
15	Trauma and orthopaedic need to go together. It would be VERY confusing to split them. You've GOT to start treating this as one hospital over 2 sites; not 2 different hospitsls. EVRRYTHING trauma and orthopaedic at Gloucester. Coronary Care also needs to be centralised wherever PPCI is.		
16	Glad both are being considered		
17	It's a large specialty and it makes sense to share across both sites, assuming that complex and/or higher risk cases are at Gloucester.		
18	Agree need in both locations		
19	This would seem to imply that services could be maximised.		
20	Given the nature of these services it makes sense to have in both locations		
21	Seems to be 'mainstream' treatments/services - in a county of Gloucestershire's size, two centres seem to balance travel times for patients etc vs having enough staff/wards/capacity for treatment. Also avoids needless over centralising and the risks of having insufficient capacity / something happening at one site meaning all treatment is affected		
22	Excellent for response times and flexibility to cope with peaks in demand, disasters and infections.		
23	Always a need, for all age groups		
24	I have experiences emergency treatment for a broken wrist at Cheltenham last December. The treatment was outstanding. It was delivered, I leant (after the successful manipulation), by a wonderful Nurse Practitioner. My follow-up consultation at Gloucester was frankly disgraceful - the consultant's treatment was appalling and I complained about him. Excellence must be analysed, and all staff must be tutored to deliver excellent outcomes.		
25	Everyone needs trauma services nearby		
26	Concentration of key resources to reduce duplication and wastage.		
27	cant decide as pilot study not complete & compared nationally		
28	To shore the load between hospitals		
29	Tie in with need to keep A& E open at both locations		
30	Transport for staff who currently work at one or other of the hospitals who have to travel by bike / walk / bus etc be supported having to then travel further?		

Two permanent ‘centres of excellence’ for Trauma at Gloucestershire Royal Hospital and Orthopaedics at Cheltenham General Hospital.			
		Response Percent	Response Total
31	This is neede in both locations		
32	orthopaedics and trauma should be in close proximity so personnel can collaborate and reduce need to duplicate equipment		
33	Most sensible response to needs of this large community although leadership could be in either hospital		
34	Separating trauma and planned surgery proven model,elsewhere, in terms of bed base, theatre capacity and managing infection rates.		
35	As long as there are support services, and staffing to support this		
36	Urgent need for excellent, quality, immediate support when there is a need. Quality of services is literally a balance between life and death		
37	Again sensible and more cost effective to locate particular areas of expertise and resources in specific places		
38	Why would you not make one orthopaedic department in one hospital. would that ensure specialist care available always		
39	See previous		
40	Needs no words to say this is a critical service and needs to have all the positives. Better care and attention and help out at the outset reduces issues developing later		
41	As above		
42	makes effective use of resources		
43	An excellent idea.		
44	The results of this pilot indicate that the proposal is and will continue to work wll		
45	Parking and general access for patients		
46	Rising admissions of this kind every year and shortages of community rehab placements means that this is needed now more than ever especially as this is lengthening inpatient stays which slows down admissions rates especially when both hospitals are running with only one A&E		
47	Not qualified to judge.		
48	Trauma needs unambiguous and fast treatment. I've no idea where/when I can go to CGH so I'd call an ambulance rather than go by car. What a stupid waste of resouces.		
49	See onwards to page 37 My wife and I are in our 90th year. She is not allowed to drive. I prefer daylight and not Mon or Friday. We live in Tetbury and wish treatment there. So: We prefer Cheltenham and do not like Gloucester, the former being easier for us to reach by car and more convenient in terms of other activities on the day.		
50	The idea of creating centres of excellence at both of the two excellent large hospitals in Gloucestershire makes sense. It is worth remembering that the other specialist inpatient services, which have already centralised at either CGH or GRH e.g. cancer services at CGH and childrens' services at GRH, are working really well for patients.		
51	Seems to be the first area that recognises the need for quality services at both sites		
52	One centre of excellence at GRH. Reduce travel time for medical staff etc.		
53	As someone who is on the waiting list for a knee replacement and living in Cheltenham being able to keep a permanent 'centre of excellence' at Cheltenham General would be good.		
54	Separating out emergency trauma and elective orthopaedics makes sense as it again puts the planned care in CGH which will be a calmer hospital and more suitable for that type of services, and the emergency services can have their centre of excellence at GRH. Again, having the centres of excellence is a sensible way forward, and the pilot seems to have worked well.		

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

		Response Percent	Response Total
	55	Suggest the trust review the statistics to determine how much of the trauma cases are orthopaedic related before deciding on this. Moving orthopaedic patients from GRH to CGH for treatment post trauma triage at cause significant pain and discomfort.	
	56	All major Trauma at a single location makes sense. Most orthopaedics are less urgent and straight forward or even elective so Cheltenham General is the logical choice co-located with the arthoplasty.	
	57	It is a much better model to have expertise available at different hospitals, than to have it based only in one location. However, we would prefer all procedures to be available at other hospitals in Gloucestershire too.	
	58	Yes I agree with this, this can be needed at anytime, having two centres of excellent is very comforting. Reduces travel, retention of staff , waiting times	
	59	It needs to be Gloucester more central for Gloucestershire	
	60	I have no support or opposition	
	61	Trauma is a very immediate service and i helpful for patients.	
	62	Seems sensible to have two options.	
	63	This is an ambiguously phrased question. I thought the move of trauma to GRH a few years ago was a pilot and we have never seen the results of that pilot.	
	64	I think one centre of excellence is the way forward.	
	65	I am concerned that having these two sited at different hospitals will result n increased patient transfers due to the overlap of specialities.	
	66	From things I have heard about Trauma & Orthopaedics I am not convinced the T&O Pilot study has gone as well as the Hospital Trust has claimed. I should like to see the full report of the Trial, before forming a judgement on this. I am not opposed to most elective orthopaedic surgery being done on one site and most trauma orthopaedics being done on the other, to minimise disruption to elective orthopaedic procedures, but Trauma Orthopaedics is fundamental to a fully functioning A&E Department, not least because it is not always obvious until x-rayed whether an injury is a broken bone or a soft-tissue injury. At least some trauma orthopaedic capacity should be retained on both sites.	
	67	Fits both communities with respective ages of those communities	
	68	Convenient for residents of both areas	
	69	Yes, have the planned events at Cheltenham as this is the direction of travel and would work well.	

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

		Response Percent	Response Total
1	Open-Ended Question	100.00%	91
	1	extra travel time, costs and difficulty if services are required.	
	2	I think more efficient working by having majority of specialist services single site is in everyone's best interest.	
	3	Both hospitals should have centres of excellence and provide all facilities - the catchment area for Cheltenham is very large and such services should not be transferred to Gloucester Royal	
	4	If the only option for a certain appointment or procedure was in GH, I would not attend and know from discussions that my family would not either. We have had relatives in GRH and the experience has been unsatisfactory both fr them and for us whereas CGH experiences were much better.	

Please tell us about any impact, either positive or adverse, that you think any of our proposals could have on you and your family (please tell us which service your feedback relates to e.g. IGIS)?		Response Percent	Response Total
5	The proposals I think will mean better care overall for me and my family		
6	It will be safer for us to have everything in one place.		
7	I want the best care for my family and whether we travel to Cheltenham or Gloucester is irrelevant and has no bearing.		
8	Failure to deliver emergency care in Cheltenham has already negatively impacted my family and our view of the trust's performance.		
9	Cheltenham maybe too far to travel, public transport route to Cheltenham from the towns that are in the county are poor. Also car parking and cost is a concern		
10	Concerns about impact on BAME communities. Concerns about bottleneck effect on Acute Medicine at GRH. Major concerns about IGIS - if a patient needed an emergency procedure in this field and had to be transported to Gloucester, when the lived right next to CGH, the difference in both outcome re. risk of loss of life is to great a difference. Concerns about funding increased Ambulance Service provisions. Flawed concept of attracting high quality staff - London, Oxford, Bristol will always leave us with the best of the rest which the proposals would have no bearing on. Political concerns that down the line (years), any improvements will result in savings related staff reductions.		
11	GRH further to go. GRH already overwhelmed by acute medical take and unable to cope and provide quality care.. I have been witness to poor standards of medical care at GRH. I do not wish either my family or my self to be subjected to long waits for care.		
12	The waiting lists will be even longer than they are now. Cheltenham people will have a glorified health centre not a hospital. The journey to Gloucester is long, discharge difficult to manage and visits reduced (non covid era) due to the cost and distance involved.		
13	Travel, parking, costs of parking, congestion all negative. With an ageing population with less mobility it's likely less visiting will take place the more you centralise services on a single site.		
14	I think that the advances in remote/telehealth should mean that some services currently occupying time and space within the two sites could be re-provisioned using better technology, thus freeing up resources (space and skills/people) to restore CGH to a full A&E consultant led 24/7. Anything less continues to reduce survivability of patients in the East.		
15	COTE. Acute take at GRH appears to have increased the number of ward moves and the number of pts MSFD being transferred to CGH awaiting discharge or for ongoing discharge planning. Both elderly in-laws recently subjected to this. A poor experience for both of them. This is not the level of service we aspire to yet sadly no longer uncommon for this demographic.		
16	trying to access some services at CGH and some at GRH via public transport if you are unwell or infirm is frankly awful. .		
17	Please keep acute services at cgh		
18	good service		
19	Nothing		
20	For my family, the gastroenterology provision is the most important consideration. If I had faith that the centralised CGH provision will work - then I fully support this. But from personal experience of the centralised provision since the pilot started in 2018, it is not working as set out in the consultation document. What sort of assessment of the pilot has been done already and what is being put in place to ensure patients who are going through the treatment are being listened to and problems are addressed?		
21	I don't drive so to get to CGH I would have to go on the bus, that's if I can afford it. Or not go at all.		
22	None in my case		
23	Travelling to GRH		

Please tell us about any impact, either positive or adverse, that you think any of our proposals could have on you and your family (please tell us which service your feedback relates to e.g. IGIS)?		Response Percent	Response Total
24	I live in Gloucester and would prefer Gloucester hospital to be able to deliver all services to an excellent standard, Cheltenham hospital is difficult to get to, difficult to park at and it is extremely annoying to be sent there for treatment.		
25	I think in general the proposals are positive and will improve the services available in Gloucester.		
26	my son comes under gastroenterology and a strong specialist team is what is important not where they are based		
27	Patients having to be cared for away from their home and families. I have no desire to be sat in a ED Department for hours on end. The hospitals have worked well as two separate hospitals for years - why change. MONEY Trauma Services need to be provided across the county not just one site. - so if you live in a deprived area or your homeless you will benefit from a single site service!! what about the rest of the population.		
28	Focused centres of excellence to allow for planned care at CGH and more acute/emergency care at GRH but still maintaining access to ED across both sites		
29	If all services are concentrated away from CGH then patients such as myself living to the North of Cheltenham will be negatively impacted both for emergency services and for planned surgeries because of the time and difficulty in travelling longer distances, particularly difficult for the frail and elderly such as ourselves.		
30	If you move most services to Gloucester Royal it would immediately present many problems for travelling or finding a place to park. Many older people would be distressed at being so far away from their families.		
31	You just need to have one place to go to for one SUBJECT e.g. Oncology, CVS, and GU/GI at Cheltenham and everything else at GRH. You've got to make it simple. And you need to make ED at Cheltenham 24/7 with doctors. Or you've got to double the size of ED at GRH. You've lost 2 x resus bays by closing CGH to ambulances, yet not increased capacity at GRH at all. It's ridiculous at Gloucester ED- and don't blame COVID. ED at Gloucester is not fit for purpose, being the only ED in the COUNTY!! JUST KEEP IT SIMPLE, so that everyone can understand it. You've been got to stop thinking like a person in the NHS and start thinking how the public views the organisation of the services offered. I don't believe you'll re-open ED at Cheltenham, you've been wanting to get rid of it for ages, but GRH ED is NOT fit for purpose with current demand - and demand is not going to decrease. You also need a centre of excellence for the Older Person. By 2040 , 25% of Glis CCG patients will be over the age of 65.		
32	I live in Cheltenham and work in the community, the cost of coming back to Cheltenham is high if you get taken via ambulance to glos royal, if you stay in, family find it expensive to visit you therefore your mental health deteriorates and your physical health recovery is slower, if it wasn't for my son being able to pick me up at 11.30 at night I would of had to stay in overnight, this would of caused a bed to be taken by me when I was well enough to go home but had no money to get home, a bus Journey from chelt to go's is a long time when you are travelling in pain or in recovery fir follow up appointments, we need a centre of excellence in both hospitals		
33	Rationalised services produce better outcomes.		
34	Positive impact		
35	Keeping the temporary nurse led A&E for 50% of the time rather than having 100% consultant led services at CGH for 24 hours will have life threatening consequences for a large area of the north of the county.		
36	Support measures to cut last minute cancellations & ensure quicker treatment by the right person - if staff cannot be recruited / equipment not replaced due to budget constraints / equipment not being used as e.g. staff are on the other site, something needs to change to allow people to be treated and sent home more quickly either better or with appropriate measures in place.		
37	Cheltenham and Gloucester are not that far from each other and the rest of the area is poorly served. Driving to either on a very regular basis (such as for dialysis) is gruelling and time consuming.		
38	A&E All of Cheltenham and North of Cheltenham would benefit from A&E as response times, time to treatment would be minimised.		

Please tell us about any impact, either positive or adverse, that you think any of our proposals could have on you and your family (please tell us which service your feedback relates to e.g. IGIS)?		Response Percent	Response Total
39	Orthopaedic: every age group needs this support		
40	It seems that Cheltenham will become to minor centre. I'm particularly worried about trauma treatment - an accident causing serious injury in the west of the county, where we are, could result in fatality if there were delay in reaching Gloucester hospital.		
41	All service development has the potential for increasing the health service possibly needed in the future by my immediate		
42	Impact if all works well and delays in appointments are reduced will be of benefit to my family and myself.		
43	I can only see advantage in focussing particular specialisms on one site, as much as that is possible,		
44	I haven't had to use hospital services so it is difficult to form a clear opinion. But access to Gloucester is easier. It's really about geography.		
45	Living in Stroud, I find it harder to get to CGH and harder to park there, however I think it is still a Good idea to concentrate key resources in one place, wherever it is.		
46	To have the experts in one place is a positive		
47	None at the present time none at the present time q		
48	noone		
49	Have used Cheltenham when needed Colonoscopy using the 2 week wait system etc. Found the building itself confusing (easier to find from outside than inside). but the care received was excellent and easily accessable.		
50	Treatment not available at CGH is less likely to be taken up - especially if it involves more than one visit. For family reasons we would prefer to look for treatment at Southmead where support is readily available.		
51	It would mean travelling longer distances but this is a price well worth paying for better outcomes		
52	If the services are not at both units this would mean further travel and time. It also means for Carers there days would be more disrupted getting patients to appointments in larger units .		
53	Find travel to GRH difficult		
54	Potential,impact from travel requirements depending on hospital site services centred on. Parking already challenging at sites. For planned surgery optionsMay choose to use sites outside Gloucestershire as nearer, or through choose and book use private provider option if that is closer.		
55	Car parking is an issue at CGH, assurances need to be made that relatives are able to park, to be able to transport and visit their relatives. The estate has to be able to support the changes to the centres of excellence along with staffing and support services.- all		
56	The importance to me and my family is the travel to and from Gloucestershire and Cheltenham hospitals. if we needed treatment		
57	Better patient care, less waiting time, easier access, better holistic care & treatment. Less travel time - better all around outcomes		
58	Please see my comments under anything else. I would not support any services restructuring which adversely effect CGH's viability. I cannot comment on the medical proposals but Gloucestershire needs two major hospitals particularly with new settlements.		
59	Obviously because I live in the forest of Dean it would be better for my family to have all resources staff and centres of excellence at Gloucester but Cheltenham needs to have its own centres of excellence		
60	As a family, I think it is better to know which hospital you will be treated at as it's not easy for everyone if loved ones get transferred back and forth. It's nice to know in advance of planned treatment where you will be.		

Please tell us about any impact, either positive or adverse, that you think any of our proposals could have on you and your family (please tell us which service your feedback relates to e.g. IGIS)?		Response Percent	Response Total
61	My wife and I are both in our 80s and moved from a rural location in 2019 as we anticipate a point at which we will not own a car. We deliberately bought a property within walking distance of CGH. We have already found it necessary to travel to Gloucester for Xray and my wife was admitted for emergency treatment late on a Saturday evening. I had to return home to collect her essential medication and was able to do so in the car. This would have been particularly difficult without our own transport.		
62	Very important that Accident and Emergency teams are operational at Both hospitals as speed is essential when time is of the essence.		
63	Living close to GRH the proposals will not impact me greatly. It makes sense to use resources (staff and equipment) as wisely as possible given funding shortages, therefore the changes seem sensible.		
64	I think overall there will be a positive benefits having local COE's with appropriate staffing		
65	For either hospital it is access from the forest and other outlying areas such as Stroud. Good transport links might be essential		
66	Positive to moving all specialties to gloucester and none in cheltenham: None, on all accounts care provided is slowed down, bed spaces limited, more in patient moves and exposure risks of various infections and the disruption and unfairness that the staff are subjected to with these moves, how is this fair that their loyalty to their teams is rewarded with bitterness and unfair choices with their opinions not being heard Positive to specialties linked across both sites : better patient flow, increased admissions and faster patient care to get people home		
67	Support the best option proposed by medics.		
68	None at present. Who knows the future?		
69	Additional impact would be increased travelling to GRH but this is outweighed by the benefits as described in your documentation.		
70	Lack of choice		
71	By moving more acute medicine and a&e overnight to gloucester, I think it will cause problems with delays in treatment for anyone going to cheltenham.		
72	Despite their proximity, travelling between Gloucester and Cheltenham is very difficult for many members of the loca population, and can lead to delays in treatment, great stress over travel arrangements, difficulty for family visitors, etc. I have personal experience of the problem in relatoion to removal of 24-hour A&E services from Cheltenham, which should be fully restored as soon as possible.		
73	FOD is a deprived area, we need one hospital for people to travel to (20 miles) and when inpatients - family can visit one centre of excellence for county. Cheltenham too old, parking nightmare		
74	At the moment I am not in need of other services than a knee operation so do not feel qualified to comment on them. The main thing I would like to know is that Cheltenham A & E services will not be discontinued. When I had a heart attack in 2011 if I had had to be taken to Gloucester, I would not be here. I was told that any delay would have meant I would not have survived. As it was I was seen straight away and given a stent immediately. Obviously being able to stay in Cheltenham for my knee operation would suit me as it would be far easier for follow up appointments as well. Therefore I think the present arrangement works well.		
75	As a Gloucester based family it is always easier for us to go to GRH. However, I would prefer to travel a bit further to a centre of excellence.		

Please tell us about any impact, either positive or adverse, that you think any of our proposals could have on you and your family (please tell us which service your feedback relates to e.g. IGIS)?		Response Percent	Response Total
76	Because we live in the very south of the county to a certain extent these changes will have very little impact on us as we are pretty much as far away from one hospital as the other. The time taken to get to either of them is about the same, and as there is no public transport to either hospital, it doesn't really matter for any of the services at either hospital. However, I know that having centres of excellence can generally improve patient outcomes, which is why I support the developments of the centres of excellence. At the moment some trauma and emergencies from our area are dealt with at Southmead, so if GRH and CGH can become superior centres of excellence, then perhaps we would be more likely to be treated in county. i would rather battle the traffic into Cheltenham or Gloucester than Bristol.		
77	The formation of centres of excellence will provide clarity on where public can expect to be treated. CGH would require upgrading in some cases which may be disruptive. My family can access both CGH and GRH relatively easily		
78	I have multiple disabilities and cannot drive or travel on public transport. If I ever need any of the services covered in this proposal, I want them to be as close as possible to my home. It is easier for elderly, disabled, and very sick people to travel to their nearest hospital. An unfamiliar environment may be distressing for them, and it may be more difficult for their families to visit if they are further away. I will not be the only person in this category who is not able to either drive themselves or travel on public transport. Therefore, all procedures should be available in all hospitals, not in one centre. This feedback relates to all the services.		
79	My family and I could be affected positively by services being centralised because we would get the treatment we need in time by highly motivated trained staff.		
80	How are we supposed to travel to Cheltenham from the Forest of Dean? Have any of you ever tried it? Especially to arrive at 9am.		
81	Any movement away from Cheltenham would be more difficult for us to access. This applies to all disciplines.		
82	Any member of my family could require urgent treatment at any time and having to go to Gloucester as opposed to Cheltenham could hardly be seen as an improvement and could be dangerous.		
83	My view is that centres of excellence would be a positive proposal. Negative could be transport/parking etc issues in either getting to hospital, or for visitors. As I mentioned before a free green shuttle between the sites would help with this. But really transport issues are far down the line when compared to top class treatment.		
84	Travel / visits - for any of these services - not so much for us - we live in Chalford, away from both anyway, but for less well off people who live closer.		
85	I have no objection to the siting of specialist services on one hospital site. If this allows the particular hospital to improve its services in that field so much the better. I am, however, concerned that too much emphasis is being placed on GRH. This concerns me because I do not believe that GRH has the facilities or space to cope with extra work. I have personally seen, and experienced, people left waiting on trolleys or chairs in reception areas for very many hours at GRH. I would not support the concentration of services on one hospital site if that led to, for example, a reduction in consultants at CGH which would eventually put the A&E at that site in question.		
86	I strongly believe health care needs to be delivered as close to where people live and work as possible. This is supposed to be a primary policy of the NHS, yet it seems there is a trend towards ever more centralisation and a move to more and more remote services. While some services can no doubt benefit from greater centralisation, especially where investment in very expensive equipment is concerned, administrative and clinical convenience should not be elevated above ease of access to healthcare.		
87	As agree people this could - and likely to - have very dramatic effect on us		
88	Cardiac and renal. I am 84, have had 2 heart attacks and been cared for at both hospitals. I have chronic kidney disease		
89	Would have a centre of excellence as this would have helped me. Joined up access to medical records across the county. Would be good to have the images able to be shared with GP.		

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

		Response Percent	Response Total
90	Close proximity to where I live Easy to travel to Gloucester hospital I like the idea of specialists in one area Centres of excellence should enable easy communications between staff		
91	Easy travel time Minimal waiting		
		answered	91
		skipped	44

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

		Response Percent	Response Total
1	Open-Ended Question	100.00%	76
1	this should not be undertaken this year, if a government integrated review has to be delayed I don't see how it can be ethical that Gloucestershire CCG even have the man power to consider this - let alone spend money on making it happen. Is this a project pushed to the forefront to benefit an individuals career?		
2	Both hospitals should have centres of excellence and provide all facilities - the catchment area for Cheltenham is very large and such services should not be transferred to Gloucester Royal - travelling time and distance		
3	Keep both sites running and share the workload between them as they are. GRH is difficult to get too, the parking is unsatisfactory and the building totally unwelcoming and difficult to navigate - i had to run to theatres ? 7th or 8th floor via the stairs because both lifts were out of action for maintenance - I had to leave on the ground floor someone who was in a wheelchair. In CGH, there are other route options so this wouldn't happen.		
4	I would be worried if resources are spread thinly if there aren't centres of excellence.		
5	NO		
6	I consider the effect will be positive		
7	Interventional Cardiology. This should remain at CGH where it performs very well despite the trusts problems.		
8	Delay the proposals by a year. Engage with a private business/ management consultancy firm to determine the true long term impact of these changes, and amend proposals. Social impacts may change too - changes to the way we work in response to Covid may change the landscape such that new options become available.		
9	Both EDs open and Acute medical take shared across both sites.		
10	You should retain Cheltenham as a fully functioning hospital - no excuse for not offering excellence at both!		
11	As above		
12	See previous answer.		
13	Get it Right First Time. Direct to FAS/ COTE bed. Another specialist COTE ward at CGH (although difficult to recruit to this area) Discussion with community partners: keep CH and Bed Based Rehab beds for pts needing these services to speed transfers out of acute hospital. Blocking beds in the community blocks up our ' back door' and our beds perpetuating the problem of flow.		
14	Hospital transport is only for those very unwell, not for those who cant afford a taxi - we need to support all patients not just the wealthy		

If you think any of our proposals could have a negative impact on you and your family, how should we try to limit this (please tell us which service your feedback relates to e.g. IGIS)?		Response Percent	Response Total
15	Keep cgh an acute hospital		
16	no		
17	Long awaiting in emergency department can harm the life of people and also travelling with illness is a high risk.		
18	There should be all services on both sites. Other wise people just would not/could not travel for treatment and they would risk death as they could not access the treatment they need.		
19	Not applicable		
20	Travelling to GRH		
21	None		
22	none		
23	Talk to and listen to the local population. People prefer to have a local hospital with local services rather than 'centre of excellence' We all know that this is just about bed reductions, lack of staff as there has been a failure by the Trust to invest in its staff. Applies to all services.		
24	N/A		
25	Retain full facilities at both sites.		
26	I would like to know what suggestions you may have for the following. If my husband had strong pains in his chest in the middle of the rush hour what would be his chances of survival is he were to be taken to Gloucester Royal and there was a traffic jam due to an accident on the Golden Valley? Not great I think.		
27	You really need to have a ""Southmead"" in the Golden Valley area. And you need to consider better bus services to both sites for general public yo reduce car parking requirements and problems.		
28	None		
29	None		
30	The only downside of creating centres of excellence could be that I may have two family members being treated at the same time on different sites which could cause problems with supporting them. However, this is hopefully unlikely.		
31	See above.		
32	All proposals where treatment is being centralised - travel times/arrangements. Concern over extended travel times for patient/family/friends, particularly when someone is unwell. Relying on public transport particularly at the start of the day/evenings/weekends does not sound great. Even in the middle of the day it does not sound great when it could be 2 or 3 buses and all the hanging around that entails. Paying for a taxi is expensive & if relying on friends/family/a neighbour, it is more awkward to ask them to double/triple/quadruple the journey time		
33	As above		
34	-		
35	See above		
36	I can think of no negative effects of adding to or developing services unless such development diminishes the value already present.		
37	No		
38	Travelling to Cheltenham from the south end of gloucestershire is difficult.		
39	Better parking facilities at CGH.		

If you think any of our proposals could have a negative impact on you and your family, how should we try to limit this (please tell us which service your feedback relates to e.g. IGIS)?		Response Percent	Response Total
40	we need a local type 1 A/E with elderly relatives it is an increased financial burden to travel across county. emergency general surgery as well as acute can be a matter of life & death & this added journey time has the potential to have a negative impact on survival. we have a right to LOCAL emergency treatment		
41	none		
42	Trying to find areas in Cheltenham hospital is not easy. Make sure you enter the building at the correct entrance, as finding your way inside the building is impossible.		
43	I can imagine transport for some patients families that need support might need to be considered. Parking access - is there sufficient to support these changes? Bus services?		
44	Easier travel; more car parking spaces and lower charges for parking. Move to a paperless system so there is no need to transfer paper notes and images between sites - practical experience at both hospitals show lost notes are very common		
45	Try leadership and staff support for both units from one hospital. Sharing good practice teams can meet online.		
46	Parking a key issue Outpatient service provision at community hospital sites for pre and post care could off set some challenges. Or of course a virtual OP offering.		
47	Travel especially if you don't drive		
48	The main problems we have for both hospitals and across all proposals are 1) parking 2) accessibility for older patients		
49	As long as you don’t try to close cgh a&e you will have my support.		
50	My wife has problems with her eyes and we both have hearing issues. We are able to access both services at Cheltenham within walking distance of our home. There are no references to the future location of either, presumably these will be covered in the next phase of planning?		
51	I worry that as we rely on public transport we may not be able to travel easily between hospitals. We have already had to use taxi to do this - that proves expensive; and perhaps will lead to us not bothering		
52	As above		
53	Take a good look at gloucteser and the way it is run. It has a reputation for a reason, myself being a patient it is a common subject that people do and will actively avoid Gloucester Royal hospital because it is a shambles with too many problems that never see the light of day		
54	Support the best option proposed by medics. Later question (Do you consider yourself to have ...) misses the ""Other"" options which I would have added ""Losing confidence in the NHS"" regrettably.		
55	None I can foresee		
56	See next box My wife and I are in our 90th year. She is not allowed to drive. I prefer daylight and not Mon or Friday. We live in Tetbury and wish treatment there. So: We prefer Cheltenham and do not like Gloucester, the former being easier for us to reach by car and more convenient in terms of other activities on the day.		
57	Acute medicine and A&E needs to be fully supported in both hospitals. I have already detailed why.		
58	Don't specialist in only one place without considering and doing everything you can to alleviate the transport difficulties of patients and their family.l		
59	As above		

If you think any of our proposals could have a negative impact on you and your family, how should we try to limit this (please tell us which service your feedback relates to e.g. IGIS)?		Response Percent	Response Total
60	Finding ways to minimise the need to transfer patients between sites is important. Communication about any changes that are made and why they are necessary always helps		
61	Access if we are ill for any of the services is difficult if we can't drive because there is no public transport. It doesn't matter how good the services are, how good the consultants are or how nice the hospitals are, if you can't get to them. So it would be nice if there was a more consistent patient transport service. Not one that you constantly have to justify why you are using it. One where you aren't left sitting for hours wonder whether or not they are going to turn up.		
62	No		
63	Please see answer to previous question, and if possible make all services available in all hospitals. If this is not possible, then there should be excellent hospital or volunteer transport which is suitable for individual patients with a variety of disabilities including severe allergies (I cannot travel in standard hospital transport or on public transport because of allergies to perfumed products from laundry detergent to standard toiletries.) This feedback relates to all the services.		
64	My family and I could be affected by long waiting lists, staff shortages, transport links, not being able to see a specialist consultant. This would be the negative impact.		
65	Its going to cause a lot of hardship and missed appointments		
66	I am not sure how it could be achieved, but you do acknowledge that older patients may find it difficult to access an unfamiliar centre of excellence.		
67	You should restore a proper accident and emergency department at CGH and not keep fudging the issue.		
68	See above re transport.		
69	Greater visibility and support given to people needing to claim travel expenses for hospital visits. Citizens Advice Stroud ran a campaign about this 3-4 years ago, surveying the hospitals and surgeries to see how visible the information was and how easy to claim. The procedure for making a claim and receiving payment was poor. Stressed relatives need immediate assistance. They should not have to wait a month to be reimbursed.		
70	It is noted that A&E in not part of this review. However, I support the retention of A&E departments at CGH and GRH. I also support the return of a full A&E at CGH because I don't believe that GRH has the facilities to cope with providing the services which a reduced facility at CGH requires them to do.		
71	Senior management should listen much more to the views of ALL its frontline staff and not merely those of some of its most Senior Consultants. The Hospital cannot deliver excellent healthcare, regardless of how well equipped its 'Centres of Excellence' are without the goodwill and dedication of all of its staff. It is quite clear the failure to involve frontline staff sufficiently in developing services is undermining morale. There appears to be widespread distrust of senior management among staff and a sense of grudging resignation to having reorganisations imposed on them in a heavy-handed 'top-down' way.		
72	Possibly		
73	n/a		
74	Improved communication and access to medical records. Improved access to staffing by having a centre of excellence. Make sure you have the necessary resources in place. Open up the options to make contact.		
75	Parking issues		
76	If there is only one centre of excellence will parking be not adversely affected		
		answered	76
		skipped	59

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

		Response Percent	Response Total
1	Open-Ended Question	100.00%	45

1	yes centres of excellence in both hospitals
2	split the clinics between both sites at different times or weeks but keep the specialities at both. Re-open A&E as a FULL setting and not as a nurse led one which will reduce the impact on GRH.
3	No. Those providing them will know what alternative proposals are best.
4	Gloucestershire would be better served by ambitious plans for a new hospital between Gloucester and Cheltenham along the M5 corridor. This would solve most of the trust's problems.
5	Keep emergency care/ acute medical on both sites. Share planned care with Bristol and Oxford. Rotate staff between hospitals/ secondments to generate the requisite culture of flexibility in planned care, with the savings and increased efficiency used to fund emergency care in both local sites.
6	Both EDs open and Acute medical take shared across both sites.
7	My suggestion is you continue to support BOTH hospitals and ensure excellence in both - the population is simply too great for either hospital to be the sole service provider.
8	A new build fit for purpose and fit for the 21st century with bus/road and rail links between the two major sites
9	regarding appointments I really wants to appreciate the services
10	To improve the health outcomes its better that there are all specialities like medical, surgical and orthopaedics, elderly care in both the hospitals as the hospitals are located in 2 towns surrounded by a growing population around them than few years ago.. This can improve the provision of care facilities to all the population equally and in an excellent way reducing the stress and pressure.
11	No
12	Bring Cheltenhams A&E back
13	The size and geographical location of Gloucestershire warrants two fully functioning hospitals.
14	There is insufficient reference here to supporting patients at home, rather than admitting them to hospital. There is insufficient reference to the interface with social care services, and therefore to supporting clearing the back door of the hospitals.
15	No
16	no
17	Keep 24 hour consultant led A&E at CGH.
18	On occasion I have come across some silo issues where, for example, such provision as physiotherapy is not always referenced in relation to other clinics where a natural connection seema relatively low prioritys obvious. This could be achieved through the GP intermediary or by direct referral within a hospital.
19	no.
20	No.
21	CGH has an oncology centre of excellence therefore it makes sense to collaborate this first class service with colorectal/gynae/urology on the same site to make this a world class service. put CGH on the map ! expertise can then be developed with training and services offered. patient care will improve
22	Other than knock both GRH and Cheltenham down, sell the land and build a new Southmead like hospital somewhere between the two. Probably not practical financially though
23	Assessment should be done by an expert in hospital. The amount of staff appointed could be the answer. One person travelling is better that ten patients.

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

		Response Percent	Response Total
24	The provision of temporary accommodation for vascular services, provided at GRH during phase 2 of COVID19 is severely lacking. It does not provide essential facilities for patients or staff. Moving from a ward at CGH which is ideal for this group of patients into an area which falls well below the normal standards, will have a devastating effect on patient outcomes and staff moral. If this experience is a sign of how it will be in the future, I would suggest that you will not be providing a centre of excellence for this group of patients. If however it is in ,the plans to create a ward environment which is similar in layout to Guiting ward at CGH which is close to Vascular laboratory, I would not be so concerned		
25	It would be good to have some services in either the forest or the Cotswolds as people travel long distances to get treatment		
26	Staff could be made more fully aware of resources at local hopsitals such as dilke, Lydney, Tewkesbury, Stroud, etc Many staff in Gloucester and Cheltenham do not know that x ray services are available at both Lydney and Dilke		
27	Could make cgh the vascular centre.		
28	No suggestions - the proposals seem to make sense		
29	Pages 12 to 69 - your thinking and planning and stats and experiences and practicalities and timescales and costs seem daunting, but are clearly essential and within your skills. However, I don't feel competent to judge the options except for showing an obvious personal preference for necessary services being available at Cheltenham or Bourton, rather than Gloucester or Moreton, to avoid extra travel and time and costs and stress.		
30	Fully supportive of the changes planned, as timing will be improved and better staffing.		
31	None		
32	Use precious structure and perhaps have a rotational table for specialties on an axel bases to offer variety of care over standard time frames		
33	No		
34	My wife and I are in our 90th year. She is not allowed to drive. I prefer daylight and not Mon or Friday. We live in Tetbury and wish treatment there. So: We prefer Cheltenham and do not like Gloucester, the former being easier for us to reach by car and more convenient in terms of other activities on the day.		
35	You need to cover more about how the elderly are catered for in acute medicine and a&e. Also what happens when services/surgery/beds are not available. Also the impact on ambulance transfers and wait times for ambulances. How will the services/surgery/beds be allocated from cheltenham? You could move a patient to gloucester to find there was no capacity?		
36	New hospital that would be fit for the future with our expanding population. We deserve it!!		
37	the trust may wish to consider the potential benefits of working with Hereford and Worcester to optimise service provision, availability and delivery (use all available resources and staff all of the time) and thereby minimise patient waiting times in the three counties area.		
38	It is vital to maintain access to care to patients across the whole county of Gloucestershire, so our alternative suggestion is that all services should be available in all hospitals.		
39	No		
40	Centralise all at Gloucester Royal Hospital. The hospital for Gloucestershire		

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

		Response Percent	Response Total
41	This is an impossible question. No ordinary working person has the time to analyse endless pages and documents developed over several years.		
42	In general I would ask you to consider that when a patient is the subject of care between department, that a single point of contact be established between the departments. I think this would be even more important if the departments are on different sites.		
43	Recognising the need for change, the proposals for Gastro-intestinal Surgery contained in what was Option 4 should be fully worked up into a proposal, in preference to Option 2 which is what the Hospital Trust appears to have adopted in opposition to the majority of the Consultants involved and GiRFT advice.		
44	Build a state of the art hospital in the Forest of Dean at Five Acres which is for sale. Traveling to Glos and Chelt is traumatic, worrying and time consuming for older people who are suffering because of you decisions. We travel 4 or 5 times a year to Glos and Chelt so we know how terrible the journeys are at a time when we are ill and anxious.		
45	Training hospital again - start with one centre of excellence. Proposal is excellent to move into the modern world - make sure you have the technology to support this and the staff to support this. Efficiency of resources is a concern. Waiting times should improve with these proposals. Measure of improvement.		
		answered	45
		skipped	90

Anything else you would like to say?

		Response Percent	Response Total
1	Open-Ended Question	100.00%	69
1	This is the wrong time, please spend the funds on dramatically improving A&E / Trauma and on building public trust in our local health services.		
2	There are services eg haematology that are split site and struggling because of the inefficiency this causes. Would be good to see haem si flew sote at CGH		
3	It makes sense to look at the service provision in this way.		
4	This should have been done years ago. Having doctors and staff working across two sites is inefficient and detrimental to patient care . Ideally we should have one hospital at Staverrton !!!!		
5	Invest in your nursing staff as you do with every other professional group. Pay them more and develop their skills. This is the only way you will be seriously considered as addressing the recruitment and retention crisis.		
6	-		
7	I am very disappointed that you are offering a false premise ie. do you want excellence if so this must be at one hospital. We have already suffered greatly by the reduced services in Cheltenham. My husbands appts have been haphazard since services for Linc have been moved to Glos. I have been in A & E in Glos with 2 relatives recently we waited extensively for assistance and the hospital was clearly overwhelmed by the demand.		
8	How any of this helps patient flow and integration with primary care is poorly explained.		
9	I live in Cheltenham and find it easier to travel to work to CGH but am not opposed to travelling to GRH but the 99 bus service could help if the times of the buses fit the shifts of staff.		

Anything else you would like to say?

		Response Percent	Response Total
10	don't put all of the eggs in one basket. PFI is very costly to taxpayers, but appreciate sometimes its the only way.		
11	I think that the change in how the trust operates (more acute beds at GRH)could have a detrimental effect on communities in the north and east of the county. I genuinely believe that resource should be spread to support all communities to access all resources at convenience. The time and effort should be spent instead of solving the issue of people attempting to access incorrect services. We all know that personal responsibility of people in the community accessing healthcare is the key area that would have the largest impact on operational streamlining for the trust. Don't reinvent the wheel by moving departments for convenience.		
12	overall good		
13	please ignore the people of cheltenham who are biased against Gloucester and who shout the loudest. this would be a good opportunity to also increase health equality in the county.		
14	The excellence is achieved only if the right treatment is available at the right time. due to long waiting this is badly lapsed currently. From the media coverage the Gloucester hospital ED is overwhelming and very poor in meeting the 'excellence'. If this is the scene in the front door all could imagine how pathetic the other areas could be.		
15	No		
16	Cheltenham need a A&E		
17	Why are there not adequate children's services in the area? My daughter was transferred to Bristol for endoscopy and gastric surgery despite Gloucester having the services necessary.		
18	Just ensure that the investment needed to provide these changes properly and not half hearted is there for all services involved including those that are sometimes overlooked. There is no point picking a service up and moving it to one side of the county or other if you don't use this opportunity to actually improve it.		
19	This is a very ambivalent survey. I am sure not many people will bother to complete it fully I read the lengthy booklet and after looking at the various rather repetitive questions I imagine many people will give up. This I think is what you want. You have intentions and ideas to carry out and I don't believe as a member of this community our opinions matter at all.		
20	No		
21	no		
22	Yes. Use some common sense, for goodness sake.		
23	It would be good to see more localised services. Smaller hospitals such as Cirencester and Tetbury should be used to enable patients receiving regular care to avoid having to make regular long journeys especially through the winter. Even one or two e.g. dialysis bays in a day hospital like Tetbury would reduce the exposure of vulnerable patients to the risks of travel and exposure to other diseases.		
24	I believe NHS purchasing has room to improve and gain expertise from elsewhere. I also believe that there is opportunity to improve efficiency. I have witnessed nurses spending more time walking around than actually providing care.		
25	Even your summary document is far too full and obfuscating! I'd like an honest and clear comparison between services as they were before COVID and as they would be under your preferred proposals, with an indication on the impact in time and accessibility for patients in the various parts of the county.		
26	Just a point about competition between services. Central Government, in particular the Minister for Health and Social Welfare, has repeatedly affirmed that the BHS has remained open for non-COVID health provision. This is nor strictly the case. For example, prior to the first phase of the pandemic I attended the BOTOX Clinic every 10 weeks. At the peak of the pandemic it was understandable that out-patient services should be a relatively low priority. However, eight months on my condition has worsened and when I receive the promised appointment I suspect that treatment will have to be re-assessed and possibly extended to achieve some parity with the positive outcomes achieved over many years of treatment . This must also be the case where there are other conflicts even during normal times. I am fully supportive of the need for centres of excellence but I would want to be reassured that other services are not reduced in terms of financial and staff resources in order to accommodate them.		

Anything else you would like to say?

		Response Percent	Response Total
27	The geographical disadvantage of one site over the other is usually overstated. We would all like things based as close to home as possible, but unless resident in Gloucester City or Cheltenham it actually makes very little difference to most people to site they need to travel. Using public transport is more complicated from rural areas, but the shuttle bus largely overcomes that issue for outpatients and visiting.		
28	whatever the experts in the NHS think I would be supportive of.		
29	No.		
30	why oh why do this survey during a pandemic and why hasn't elective & emergency surgery been separated as per recommendations ?		
31	Pure fluke heard about the consultation apparently running since late October. Leaflet only came with post on 2nd December. Good way of minimising responses		
32	It is clear that the NHS cannot simply go on as before. How will these changes be monitored to see if they are successful? Who will monitor them and make any necessary adjustments if required, or indeed share best practice. In my lifetime I have seen many of the areas hospitals close or reduce their services, and I have not picked up on how all of this will impact the remaining hospitals in the area.		
33	For some people, the thought of travelling to GRH from Cheltenham (or, I imagine, CGH from Gloucester) would be a major consideration in the choice of whether to have treatment or not to have treatment. Travel to the ""wrong"" hospital is an extra journey for visitors by public transport and has led to my certain knowledge to some elderly patients having no visitors during their stay, with whatever psychological effect this has had on their recovery. The people likely to be reading this consultation and making decisions subsequently are likely to be those who think nothing of a few miles of distance on good, if busy, roads. Many, who are often less articulate or just more diffident find it a major obstacle.		
34	The priority is to optimise outcomes. IN my experience, working on two sites is ineffective and leads to worse outcomes for patients so there are two mediocre sites rather than one excellent one. The leadership needs to take the initiative to avoid local populations wanting to retain local services at the expense of quality - the NNHS has a poor record in this		
35	Good luck changing services is always a problem and change for this reason seems ridiculous		
36	Parking at both centres is problematic and public transport during Covid19 advised against		
37	The trust obviously has a plan for the medium/ longer term about how the 2 sites should be developed. Would be better to review theses current services within that wider context. I can only assume a hot cold site is the longer term plan. Overall will the trust be increasing its bed base with the significant housing development plans in place across Gloucestershire?		
38	I support the need for patients that require surgery on the same day as admission to be done at one site. however not all urgent surgery is same day. I think the hospital at GRH would struggle to meet capacity/ demands if all Acute work was on GRH site.		
39	Any improvements as to how patients are treated are welcome		
40	I am not a medic but my above preferences are based on the viability of CGH. Covid 19 has shown we need more hospitals without affecting ordinary services. GRH has better rail access but at times the hospital is overwhelmed. I do think that concentrating more services at GRH at the expense of CGH is a serious mistake. There must be equal allocation of services between GRH and CGH. CGH must be protected from closure. Cheltenham is a growing town and needs a viable hospital. so does Gloucestershire		
41	Any changes should be accompanied by improved information / communication to staff and public. Staff need to be aware of geography and travel difficulties for appointments to be as convenient as possible. Where as I believe a centre of excellence is essential - longer journeys for clients with children or frail adults will inevitably increase stress levels. With ambulances being tied up for longer transferring patients to the appropriate hospital. You speak of specialist doctors. Are experienced nurses willing to change work base from CGH to GRH		
42	As a moderately fit 90 yo, male living in the eastern part of the county, I have sadly needed a range of your services, and have been well served - but have often felt that health education and preventative measures and self help situations should be stronger, from cradle onwards, for the whole nation. Individually. How else can the nation and it Health Service survive the decades?		

Anything else you would like to say?

		Response Percent	Response Total
43	Maybe it is my age? It took a long time to read and digest mentally the information in the Fit for the Future book. I would prefer excellence in all hospitals with adequate staff - well paid and well trained. It would seem that the changes are needed for inpatient care. However, small local hospitals like The Vale at Dursley are most needed for being specialists in maintaining health especially the elderly. Travelling 6 miles is much preferable than 26 miles especially if you cannot use a car!		
44	Inappropriate and dangerous hospital discharges happen regularly, particularly at GRH. I hope these changes will help reduce these. Mental health support is very poor, particularly in GRH, I hope the cost and staff savings can be used to provide better mental health support for patients with mental ill health.		
45	Please look at improving the bus links ! The fact that you use a stagecoach bus for one part of your journey and a pullman for other part - is just not Cost effective for patients.		
46	None		
47	Many people have feared because of the changes and continue to do so. Many people see this as a move to shut or deminish CGH and don't want this because CGH is the hospital of their choice and is closer to home and family. GRH is a mess, one such example is the previous stroke specialist team... All resigned due to management the problems they had on the ward and the way it was run, when bullying is rampant on a ward and months of whistle blowing and datixing is met by scorn and inaction, nobkdy wants to see this happen in cheltenham as well		
48	Key is to have confidence in our medics. My area of concern is- Communications. Followup (after discharge). Options/Expectations.		
49	The survey is difficult for non medics to comprehend. See points above.		
50	More free car parking at GRH and CGH		
51	The shuttle bus between CGH and GRH is a great asset in relation to access to services. A commitment to its future would be good to hear. It would also be good to hear that discussions are being held to see whether the bus route could include a stop at Park and Ride at Cheltenham Racecourse. Decision makers should consider evaluation of services changes if implemented and the involvement of patients, carers and VCS in the evaluation.		
52	I am sorry to say that I think more local people would be happier going to gloucester hospital if there were more staff to give better aftercare on the wards. Also staff need training on how to understand the needs of the elderly. Misunderstanding of being slightly deaf, confused in surroundings, stoma care being common problems I have seen.		
53	Bring back Cheltenahm A&E full-time and with full services as soon as Covid restrictions are lifted		
54	Improving continuity of care, reducing outliers and improving communication with families might be improved if a balance in activity across the hospitals is achieved		
55	The general concept must be welcomed. However P14 column and does not take account of the here and now. With regard to A&E going straight to a specialist ward doesn't happen due to bed shortages so this needs to be addressed. Also at a more strategic level these centres of excellence represent a staff gap. What is really needed is the construction of a brand new hospital like Southmead. Which would consolidate both Gloucester and Cheltenham. It would be all encompassing in location. Have new smaller wards if not private rooms and take account of the high demands from increases in population and ageing.		
56	Thank you for providing the public the opportunity to have our say on this important issue		
57	Issues with parking around Cheltenham General Hospital may cause issues for more rural communities and those not on regular bus schedules for Cheltenham's proposed day and elective role.		
58	This survey is part completed because we accidentally submitted the form when part way through the survey.		

Anything else you would like to say?

		Response Percent	Response Total
59	No		
60	Do not ignore the publics opinion we have a right to choose where we have our care.		
61	I know we all demand more from the NHS. However, sometimes the changes may seem rational but have a detrimental effect on local people in relation to access and other things. In a different area, when Fairford Hospital was closed, we were told it would lead to more efficient services. I am not sure that this is the case and I think it was a bad decision to remove care beds from the system, as it would have provided capacity to look after patients who needed care but not access to expensive equipment, freeing up beds in acute hospitals. I think it was a bad decision.		
62	It is, frankly, disgraceful that a consultation such as this one, which has had the resources of countless hours of input from selected sources within the organisations comprising 'One Gloucestershire' should be sent out for public 'consultation' in the middle of the greatest health crisis the country has seen for a century. The public have too much else on their minds at this time to be in a position to properly consider the issues that have been put before them. This is a massively cynical exercise designed to produce the answers that 'One Gloucestershire' have already decided on (ask any member of staff at Cheltenham General Hospital); sneaking the exercise in consultation at this time is almost certainly an abuse of process. And most egregious of all: the document purporting to be a 'plan' for the future of healthcare delivery in the county makes NO MENTION of pandemic planning. How can we be expected to take it seriously in the light of such a glaring omission?		
63	I don't have any friends who have even heard of this exercise. Why hasn't the questionnaire been sent to every household in the county?		
64	I recently had an operation in the QE2 hospital in Birmingham. Is it time Gloucestershire had a new state of the art campus hospital, part paid for by the valuable land (especially CGH) land the current hospitals stand on?		
65	I am also concerned about the management of GRH. I do not question the skills, competence or dedication of the staff at GRH. However, again from experience, I do not believe that the management of the hospital is as good as it should be. I support GRH and CGH being in one trust, but I do wonder if a different management structure is needed within that trust so that greater emphasis is placed on delivering the services which patients are entitled to expect. I feel that as part of the management structure there should be someone in place who is responsible for ensuring that liaison with patients and their families is far better than it currently is. I think there is a case across Gloucestershire to be made for one trust to cover all health services – primary care, community hospitals, acute trusts, social and after care etc – and believe that this should be explored. I think this would have the potential to reduce costs and improve co-ordination of services. We have seen during the Covid crisis the inability of the acute hospitals to move sufficient numbers of patients out into care homes, community hospitals and into their own homes with support packages in place, and I think one management of all the services, with the appropriate structures within that trust, should be considered. I realise that the above would challenge the CCG arrangements, but again I feel that being part of one service might help coordination. For example, I believe that many more patients could be treated at primary care level than is currently the case, thus relieving the pressure on hospitals. Much greater use should be made of pharmacies.		
66	The publics primary concern about the reconfiguration of specialist services within the hospital relate to the convenience and accessibility of services and the long term sustainability of a Type 1 A&E Department in Cheltenham. Of some of these proposals are implemented it is difficult to see how a full Type 1 A&E Department would be sustainable in the long term. This is despite the reassurances the Hospital Trust has repeatedly been given. It is these proposals which have undermined staff and public confidence in the Hospital Trust's sincerity over the re-opening of Cheltenham A&E and its long term future.		
67	See above please re-think before its too late		
68	Addition of trainee nurses and other healthcare professions in specialities means you can retain them more easily and get more money!		
69	seems like GRH has a more specialist focus under one roof - will this lead to overcrowding, parking issues, less quality face to face time with staff / professionals		

Anything else you would like to say?

	Response Percent	Response Total
	answered	69
	skipped	66

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

		Response Percent	Response Total
1	Open-Ended Question	100.00%	118
	1 gl2		
	2 Gl3		
	3 GL51		
	4 GL52		
	5 gL50		
	6 GL1		
	7 WR14		
	8 GL52		
	9 GL4		
	10 GL50		
	11 GL53		
	12 GL5		
	13 GL53		
	14 GL52		
	15 GL4		
	16 GL52		
	17 GL54		
	18 gl51		
	19 GL54		
	20 Gl51		
	21 GL1		
	22 Gl50		
	23 GL5		
	24 OX18		
	25 GL51		
	26 GL2		
	27 GL4		

What is the first part of your postcode? eg. GL1, GL20			
		Response Percent	Response Total
	28	GL2	
	29	GL5	
	30	GL52	
	31	GL2	
	32	GL52	
	33	GL53	
	34	GL1	
	35	Gl51	
	36	CV36	
	37	GL3	
	38	GL52	
	39	GL12	
	40	GL2	
	41	GL52	
	42	GL52	
	43	GL52	
	44	GL8	
	45	GL52	
	46	GL6	
	47	GL54	
	48	GL2	
	49	GL19	
	50	GL6	
	51	GL10	
	52	GL5	
	53	GL5	
	54	GL53	
	55	gl15	
	56	GL19	
	57	GL2	
	58	GL52	
	59	gl53	
	60	GL54	
	61	GL52	
	62	GL5	

What is the first part of your postcode? eg. GL1, GL20			
		Response Percent	Response Total
63	GL15		
64	GL4		
65	gl3		
66	gl15		
67	GL13		
68	GL5		
69	GL17		
70	GL17		
71	GL52		
72	GL1		
73	Gl51		
74	Gl4		
75	GL52		
76	GL54		
77	GL12		
78	GL56		
79	GL2		
80	GL1		
81	GL14		
82	Gl3		
83	GL16		
84	GL53		
85	GL52		
86	GL20		
87	GL8		
88	GL16		
89	GL20		
90	GL3		
91	Gl19		
92	Gl51		
93	GL53		
94	GL16		
95	GL52		
96	GL4		
97	GL6		

What is the first part of your postcode? eg. GL1, GL20		Response Percent	Response Total
98	GL1		
99	GL8		
100	GL19		
101	GL52		
102	GL7		
103	GL4		
104	GL15		
105	GL11		
106	GL53		
107	GL7		
108	GL7		
109	GL54		
110	GL6		
111	GL20		
112	GL50		
113	GL16		
114	GL50		
115	GL3		
116	GL1		
117	GL1		
118	GL4		
		answered	118
		skipped	17

Which age group are you:				
			Response Percent	Response Total
1	Under 18		0.00%	0
2	18-25		0.00%	0
3	26-35		6.06%	8
4	36-45		12.12%	16
5	46-55		19.70%	26
6	56-65		32.58%	43
7	66-75		18.18%	24
8	Over 75		9.85%	13
9	Prefer not to say		1.52%	2
			answered	132
			skipped	3

Are you:				
			Response Percent	Response Total
1	A health or social care professional		20.15%	27
2	A community partner		3.73%	5
3	A member of the public		71.64%	96
4	Prefer not to say		4.48%	6
			answered	134
			skipped	1

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

		Response Percent	Response Total
1	No	67.91%	91
2	Mental health problem	5.97%	8
3	Visual Impairment	4.48%	6
4	Learning difficulties	0.75%	1
5	Hearing impairment	5.97%	8
6	Long term condition	26.87%	36
7	Physical disability	6.72%	9
8	Prefer not to say	2.24%	3
		answered	134
		skipped	1

Do you look after, or give any help or support to family members, friends, neighbours or others because of either a long term physical or mental ill health need or problems related to old age? Please do not count anything you do as part of your paid employment.

		Response Percent	Response Total
1	Yes	100.00%	135
2	No	0.00%	0
3	Prefer not to say	0.00%	0
		answered	135
		skipped	0

Which best describes your ethnicity?

		Response Percent	Response Total
1	White British	81.95%	109
2	White Other	1.50%	2
3	Asian or Asian British	6.02%	8
4	Black or Black British	2.26%	3
5	Chinese	0.00%	0
6	Mixed	0.75%	1
7	Prefer not to say	6.77%	9
8	Other (please specify):	0.75%	1
		answered	133
		skipped	2

Other (please specify): (1)

1	European

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

		Response Percent	Response Total
1	No religion	31.11%	42
2	Buddhist	0.00%	0
3	Christian (including Church of England, Catholic, Methodist and other denominations)	52.59%	71
4	Hindu	0.74%	1
5	Jewish	0.00%	0
6	Muslim	4.44%	6
7	Sikh	0.00%	0
8	Other	3.70%	5
9	Prefer not to say	7.41%	10
		answered	135
		skipped	0

Are you:

		Response Percent	Response Total
1	Male	38.06%	51
2	Female	55.97%	75
3	Transgender	0.75%	1
4	Prefer not to say	5.22%	7
		answered	134
		skipped	1

Do you identify with your gender as registered at birth?

		Response Percent	Response Total
1	Yes	94.03%	126
2	No	0.00%	0
3	Prefer not to say	5.97%	8
		answered	134
		skipped	1

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

		Response Percent	Response Total
1	Heterosexual or straight	85.93%	116
2	Gay or lesbian	1.48%	2
3	Bisexual	0.74%	1
4	Other	0.74%	1
5	Prefer not to say	11.11%	15
		answered	135
		skipped	0

Are you currently pregnant or have given birth in the last year?				
			Response Percent	Response Total
1	Yes		0.00%	0
2	No		67.18%	88
3	Not applicable		28.24%	37
4	Prefer not to say		4.58%	6
			answered	131
			skipped	4

Fit For The Future - What matters to you?

Responses from those who identify as LGBT+

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

		Response Percent	Response Total
1	Strongly support	15.79%	3
2	Support	42.11%	8
3	Oppose	15.79%	3
4	Strongly oppose	21.05%	4
5	No opinion	5.26%	1
		answered	19
		skipped	0

Please tell us why you think this, e.g. the information you would like us to consider (9)

1	Gloucester hospital is renowned for putting the fear of God into people when they have to go there for care, removing options for Cheltenham - especially during a pandemic seems insensitive to say the very least. We live in Stroud but have previously chosen to drive to A&E in Cheltenham to avoid GRH. I think there should be a lot more work going into trust in our services and more specifically the paper pushers at CCG before trying to garner support for another master plan that will inevitably cost trillions, be done without consent and have frustrating outcomes for patience and staff.
2	Cheltenham needs an acute care ward. how can you have a functioning a and e, which the trust keeps on insisting it will have at Cheltenham with no where for the patient to go after initial treatment? putting sick people in ambulances to grh is ridiculous. making the public believe they will have an a and e when they will have a sub par service is deceitful
3	Cheltenham should remain an acute general hospital
4	There just isn't a big enough ED at Gloucester, not enough Resus vays and just too cramped
5	As long as capacity is adequate and doesnt impact upon other services
6	It does make some sense to centre areas of expertise. However certain things also need to be taken into consideration. Access for people getting to the locations. Danger of additional time for emergency cases having to go to GRH. What is the impact on the other hospitals such as Cirencester, Tewksbury, Stroud etc.
7	No clinicians I have spoken to think that this is a good idea - and I am dubious as to whether this is about patient care or whether it's to save money. Sadly I suspect the latter.
8	Increased chances of seeing the right specialist more quickly. Will provide more focussed training/learning opportunities for junior doctors and medical staff, with continuous supervision by senior doctors. This will contribute to attracting staff and improved retention rates.
9	Too far to GRH for large areas of the county. I live in Cirencester, it can take an hour in peak times to get to GRH.

Please tell us what you think about our preferred option to develop:A ‘centre of excellence’ for Emergency General Surgery at Gloucestershire Royal Hospital.

		Response Percent	Response Total
1	Strongly support	26.32%	5
2	Support	47.37%	9
3	Oppose	15.79%	3
4	Strongly oppose	5.26%	1
5	No opinion	5.26%	1
		answered	19
		skipped	0

Please tell us why you think this, e.g. the information you would like us to consider (5)

1	There is too little trust in the care provided by GRH, from poor food, lack of staff, nasty conditions and poor staff morale to convince me that a bunch of desk workers in brockworth have the support of the grass root level staff. There needs to be far more public trust in CCG and GRH before big moves are planned.
2	Cheltenham should remain an acute general hospital
3	Because the majority of emergency admissions go to Gloucester so it is logical for them to have all emergency surgery. However, I think Cheltenham needs to have a 24 hr ED with a specialism in oncology, urology and colorectal.
4	Yes but the risks of additional transfer time for patients. Waiting times are already considerably higher. Can this be mitigated by keeping 'much less urgent cases away'? Strain on Ambulance Service. How does this all impact the other Gloucestershire Hospitals?
5	Quicker, more direct access for patients to the right specialist. A 'centre of excellence' will be an attractor for young doctors. Concentration of the right staff cover. Concentrated and improved learning opportunities for junior staff. However, resources, including beds, nursing staff and theatres, will need to be increased at GRH accordingly.

Please tell us what you think about our preferred option to develop:A ‘centre of excellence’ for Planned Lower GI (colorectal) general surgery at Cheltenham General Hospital (CGH) or Gloucestershire Royal Hospital (GRH).

		Response Percent	Response Total
1	Strongly support	52.63%	10
2	Support	31.58%	6
3	Oppose	0.00%	0
4	Strongly oppose	0.00%	0
5	No opinion	15.79%	3
		answered	19
		skipped	0

Please tell us why you think this, e.g. the information you would like us to consider (5)

Please tell us what you think about our preferred option to develop:A ‘centre of excellence’ for Planned Lower GI (colorectal) general surgery at Cheltenham General Hospital (CGH) or Gloucestershire Royal Hospital (GRH).

			Response Percent	Response Total
1	22/10/2020 16:03 PM	I would like Gloucester to be a better option for care, this should be improved so that its more viable than having to travel to cheltenham to visit people.		
2	17/11/2020 20:54 PM	Cheltenham needs to become a centre of excellence for colorectal surgery, urology and oncology, both planned and emergency		
3	03/12/2020 11:16 AM	As per previous comments		
4	13/12/2020 17:20 PM	Concentration of a specialised team and the necessary resources.		
5	18/12/2020 11:56 AM	The plan seems to be to downgrade Cheltenham GH despite the wide catchment area and substantially increased population in the rural parts of North Gloucestershire		

In supporting our preferred option to create a single site 'centre of excellence', where do you think a ‘centre of excellence’ for Planned Lower GI (colorectal) general surgery should be developed?

			Response Percent	Response Total
1	Cheltenham General Hospital (CGH)		57.89%	11
2	Gloucestershire Royal Hospital (GRH)		15.79%	3
3	No opinion		26.32%	5
			answered	19
			skipped	0

Please tell us why you think this, e.g. the information you would like us to consider: (5)

1	I would like Gloucester to be a better option for care, this should be improved so that its more viable than having to travel to cheltenham to visit people.
2	Cheltenham already deals with urology and it would make sense for ALL lower GI surgery, planned and emergency
3	Would seemingly make best sense to locate this at CGH to create a centre of excellence for pelvic resection; and to keep this surgery service entirely separated from the pressures of the Emergency General Surgery at GRH (as suggested in the consultation booklet)'
4	Happy with move towards CGH as an elective site predominantly and more emergency focus at GRH, as oncology centre at CGH indicates more elective treatment. But not to strip all emergency services away
5	See above

Please tell us what you think about our preferred option to develop:A ‘centre of excellence’ for planned day case Upper and Lower GI (colorectal) surgery at Cheltenham General Hospital (CGH).

		Response Percent	Response Total
1	Strongly support	44.44%	8
2	Support	33.33%	6
3	Oppose	0.00%	0
4	Strongly oppose	0.00%	0
5	No opinion	22.22%	4
		answered	18
		skipped	1

Please tell us why you think this, e.g. the information you would like us to consider (5)

1	I would like Gloucester to be a better option for care, this should be improved so that its more viable than having to travel to cheltenham to visit people.
2	It needs to be clear that if you have a centre of excellence, it is in one place. GU/GI at Cheltenham - Totally! along with oncology. Everything else to GRH
3	Planned surgery in one location does make a lot of sense, as long as the wait times do not increase and also operations are not cancelled due to other factors.
4	Concentration of expertise and dedicated staff in one location will improve patient care and efficiency.
5	Links with earlier point

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

		Response Percent	Response Total
1	Strongly support	16.67%	3
2	Support	38.89%	7
3	Oppose	5.56%	1
4	Strongly oppose	0.00%	0
5	No opinion	38.89%	7
		answered	18
		skipped	1

Please tell us why you think this, e.g. the information you would like us to consider (2)

1	I suspect more money has gone into coming up with the terms / logos for hub and spoke than into IGIS. Both places should be equal and more money should be invested and the CCG shrunk to release the funds.
2	If EGS and Acute Medical Take are located at GRH, then it makes good sense to make GRH the hub for IGIS. It would also seem sensible for there to be a 'spoke' at CGH to work alongside oncology, urology and other specialisations there.

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

		Response Percent	Response Total
1	Strongly support	22.22%	4
2	Support	55.56%	10
3	Oppose	0.00%	0
4	Strongly oppose	0.00%	0
5	No opinion	22.22%	4
		answered	18
		skipped	1

Please tell us why you think this, e.g. the information you would like us to consider (3)

1	Keep Cheltenham as centre of excellence for everything GU/GI and oncology and all other surgery at GRH
2	As per previous observations
3	Patients and clinical teams will have continual access to other acute speciality services, and these can operate in a more efficient linked-up manner.

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

		Response Percent	Response Total
1	Strongly support	61.11%	11
2	Support	11.11%	2
3	Oppose	5.56%	1
4	Strongly oppose	0.00%	0
5	No opinion	22.22%	4
		answered	18
		skipped	1

Please tell us why you think this, e.g. the information you would like us to consider (2)

1	If you want to have a centre of excellence EVERYTHING to do with that area of medicine needs to be there, no half measures and aahh but this bit goes to Gloucester. You need to keep things simple and easy for Joe Public you understand as well as your HCP partners.
2	Improved conditions for medical staff, and therefore beneficial for patients.

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

		Response Percent	Response Total
1	Strongly support	36.84%	7
2	Support	31.58%	6
3	Oppose	5.26%	1
4	Strongly oppose	5.26%	1
5	No opinion	21.05%	4
		answered	19
		skipped	0

Please tell us why you think this, e.g. the information you would like us to consider (4)

1	absolutely - this should be a number 1 priority - better trauma and A&E care at both destinations - there is NO WAY that one centre will suffice and we know this undermines public trust in CCG (who honestly now must be loved about as much as covid 19 itself).
2	Trauma and orthopaedic need to go together. It would be VERY confusing to split them. You've GOT to start treating this as one hospital over 2 sites; not 2 different hospitals. EVRRYTHING trauma and orthopaedic at Gloucester. Coronary Care also needs to be centralised wherever PPCI is.
3	Transport for staff who currently work at one or other of the hospitals who have to travel by bike / walk / bus etc be supported having to then travel further?
4	It suggests a more efficient and effective division of labour, building upon the existing specialisations in both hospitals.

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

		Response Percent	Response Total
1	Open-Ended Question	100.00%	8

1	extra travel time, costs and difficulty if services are required.
2	risking the health and safety of those further out in the county.
3	Please keep acute services at cgh
4	You just need to have one place to go to for one SUBJECT e.g. Oncology, CVS, and GU/GI at Cheltenham and everything else at GRH. You've got to make it simple. And you need to make ED at Cheltenham 24/7 with doctors. Or you've got to double the size of ED at GRH. You've lost 2 x resus bays by closing CGH to ambulances, yet not increased capacity at GRH at all. It's ridiculous at Gloucester ED- and don't blame COVID. ED at Gloucester is not fit for purpose, being the only ED in the COUNTY!! JUST KEEP IT SIMPLE, so that everyone can understand it. You've been got to stop thinking like a person in the NHS and start thinking how the public views the organisation of the services offered. I don't believe you'll re-open ED at Cheltenham, you've been wanting to get rid of it for ages, but GRH ED is NOT fit for purpose with current demand - and demand is not going to decrease. You also need a centre of excellence for the Older Person. By 2040 , 25% of Glis CCG patients will be over the age of 65.

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

		Response Percent	Response Total
5	I think it would adversly affect my work		
6	Concentrating expertise in one of two hospitals will be beneficial for staff and patients; improve the capacity of hospitals to be both centres of excellence and centres of medical training; reduce waiting times and improve chances for patients of being seen by the right specialists more quickly, with the necessary follow-up care.		
7	Closure of CGH A&E could lead to delays in emergency treatment to those south of the county, with potential for negative outcomes for time critical conditions.		
8	Gloucester GH is twice the distance than Cheltenham GH is and there is no patient transport to Gloucester		
		answered	8
		skipped	11

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

		Response Percent	Response Total
1	Open-Ended Question	100.00%	8
1	this should not be undertaken this year, if a government integrated review has to be delayed I don't see how it can be ethical that Gloucestershire CCG even have the man power to consider this - let alone spend money on making it happen. Is this a project pushed to the forefront to benefit an individuals career?		
2	risking family health by providing sub par a and e service at Cheltenham		
3	Keep cgh an acute hospital		
4	You really need to have a ""Southmead"" in the Golden Valley area. And you need to consider better bus services to both sites for general public yo reduce car parking requirements and problems.		
5	I can imagine transport for some patients families that need support might need to be considered. Parking access - is there sufficient to support these changes? Bus services?		
6	It would negatively impact on me and my family if elective work was not done in Cheltenham as they would be a lack of beds in GRH		
7	Closing Cheltenham's A&E is a terrible mistake. For patients in the Cotswolds, Tewkesbury and surrounding areas - the time wasted going to GRH could literally mean life and death. I also do not believe that Gloucestershire Royal can cope with the numbers they would need to deal with at present. One A&E for a whole county is madness and is so transparently being considered to save money rather than lives.		
8	Recruit more staff to enable you to operate both hospitals as has been the case for the past 30years.		
		answered	8
		skipped	11

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

		Response Percent	Response Total
1	Open-Ended Question	100.00%	2
	1 Cheltenham needs an amu.		
	2 .		
		answered	2
		skipped	17

Anything else you would like to say?

		Response Percent	Response Total
1	Open-Ended Question	100.00%	6
	1 This is the wrong time, please spend the funds on dramatically improving A&E / Trauma and on building public trust in our local health services.		
	2 stop using covid as an excuse to flatline emergency services at Cheltenham. treat staff with more respect, our opinions and skills as professionals are repeatedly ignored by trust management. stop shipping patients who are unwell between two sites, this is unsafe and immoral. the only ones being shipped about are those with lower capacity, confusion and complex needs. disgraceful. I support reinstating amu at Cheltenham to stop this nonsense.		
	3 I live in Cheltenham and find it easier to travel to work to CGH but am not opposed to travelling to GRH but the 99 bus service could help if the times of the buses fit the shifts of staff.		
	4 It is clear that the NHS cannot simply go on as before. How will these changes be monitored to see if they are successful? Who will monitor them and make any necessary adjustments if required, or indeed share best practice. In my lifetime I have seen many of the areas hospitals close or reduce their services, and I have not picked up on how all of this will impact the remaining hospitals in the area.		
	5 I don't think 'Centres of Excellence' should be considered at present, and yet again my suspicion is that if it looks good from the outside - ie when the CCG walk round with the scent of paint in their nostrils - it doesn't matter that staff and patients are unhappy with the way things are.		
	6 Quick and easy access is essential when you are ill. There is a much larger older population in North Cotswolds. Moreton in Marsh hospital is not included in this survey. So is a modern hospital intended to serve the North of the county yet whenever I or friends have visited it is empty. Why is this expensive new building not being used?		
		answered	6
		skipped	13

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

		Response Percent	Response Total
1	Open-Ended Question	100.00%	16

1	gl2
2	Gl5
3	gl51
4	gl3
5	GL52
6	Gl51
7	GL1
8	GL2
9	GL52
10	GL52
11	GL53
12	gl50
13	GL15
14	gl51
15	GL7
16	GL54

	answered	16
	skipped	3

Which age group are you:

			Response Percent	Response Total
1	Under 18		5.56%	1
2	18-25		0.00%	0
3	26-35		50.00%	9
4	36-45		0.00%	0
5	46-55		27.78%	5
6	56-65		11.11%	2
7	66-75		0.00%	0
8	Over 75		5.56%	1
9	Prefer not to say		0.00%	0
		answered	18	
		skipped	1	

Are you:

		Response Percent	Response Total
1	A health or social care professional	57.89%	11
2	A community partner	5.26%	1
3	A member of the public	36.84%	7
4	Prefer not to say	0.00%	0
		answered	19
		skipped	0

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

		Response Percent	Response Total
1	No	47.37%	9
2	Mental health problem	26.32%	5
3	Visual Impairment	0.00%	0
4	Learning difficulties	0.00%	0
5	Hearing impairment	5.26%	1
6	Long term condition	21.05%	4
7	Physical disability	5.26%	1
8	Prefer not to say	5.26%	1
		answered	19
		skipped	0

Do you look after, or give any help or support to family members, friends, neighbours or others because of either a long term physical or mental ill health need or problems related to old age? Please do not count anything you do as part of your paid employment.

		Response Percent	Response Total
1	Yes	26.32%	5
2	No	73.68%	14
3	Prefer not to say	0.00%	0
		answered	19
		skipped	0

Which best describes your ethnicity?

		Response Percent	Response Total
1	White British	73.68%	14
2	White Other	15.79%	3
3	Asian or Asian British	0.00%	0
4	Black or Black British	0.00%	0
5	Chinese	0.00%	0
6	Mixed	0.00%	0
7	Prefer not to say	10.53%	2
8	Other (please specify):	0.00%	0
		answered	19
		skipped	0

Other (please specify): (0)

No answers found.

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

		Response Percent	Response Total
1	No religion	57.89%	11
2	Buddhist	0.00%	0
3	Christian (including Church of England, Catholic, Methodist and other denominations)	21.05%	4
4	Hindu	0.00%	0
5	Jewish	0.00%	0
6	Muslim	0.00%	0
7	Sikh	0.00%	0
8	Other	5.26%	1
9	Prefer not to say	15.79%	3
		answered	19
		skipped	0

Are you:

		Response Percent	Response Total
1	Male	42.11%	8
2	Female	52.63%	10
3	Transgender	5.26%	1
4	Prefer not to say	0.00%	0
		answered	19
		skipped	0

Do you identify with your gender as registered at birth?

		Response Percent	Response Total
1	Yes	94.74%	18
2	No	0.00%	0
3	Prefer not to say	5.26%	1
		answered	19
		skipped	0

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

		Response Percent	Response Total
1	Heterosexual or straight	5.26%	1
2	Gay or lesbian	47.37%	9
3	Bisexual	42.11%	8
4	Other	5.26%	1
5	Prefer not to say	0.00%	0
		answered	19
		skipped	0

Are you currently pregnant or have given birth in the last year?				
			Response Percent	Response Total
1	Yes		0.00%	0
2	No		78.95%	15
3	Not applicable		21.05%	4
4	Prefer not to say		0.00%	0
			answered	19
			skipped	0

Fit For The Future - What matters to you?

Responses from most deprived wards

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

		Response Percent	Response Total
1	Strongly support	37.01%	47
2	Support	26.77%	34
3	Oppose	9.45%	12
4	Strongly oppose	17.32%	22
5	No opinion	9.45%	12
		answered	127
		skipped	1

Please tell us why you think this, e.g. the information you would like us to consider (60)

1	Gloucester hospital is renowned for putting the fear of God into people when they have to go there for care, removing options for Cheltenham - especially during a pandemic seems insensitive to say the very least. We live in Stroud but have previously chosen to drive to A&E in Cheltenham to avoid GRH. I think there should be a lot more work going into trust in our services and more specifically the paper pushers at CCG before trying to garner support for another master plan that will inevitably cost trillions, be done without consent and have frustrating outcomes for patience and staff.
2	Gloucester itself is simply not big enough to accommodate current demand yet alone the additional 5,000 plus hour being built in Cheltenham in the next few years!
3	Many patients do not have transport and will be unable to travel to the'alternative' hospital.
4	Very misleading question. I would doubt anyone will not want a centre of excellence, but more importantly how will this impact the other services
5	need to put all the expertise in one place 24/7
6	AMU should be spread across both sites to prevent a bottle neck where we are changing wards such as gynaecology into a amu. It is not appropriate for women going through tough times and having to have miscarriages in bays with patients from other specialties. It violates privacy and dignity and is heartless, but no other choice due to hospital management.
7	In a county this size , with the shortage of doctor and nurses we need to ensure that we have the safest care available and to do this efficiently as possible we need to have services centred on one site , in acute medicine GRH is the preferred site. This will not be popular with Cheltenham people but they have to accept that they will never ever have a fully functioning hospital on their site .
8	There needs to be acute medical services at CGH also.
9	This already works well with the acute medical take at GRH and all patients can be seen within the 14 hours that has to be a great improvement. Patients not being seen means their stay may be longer and their recovery poorer. It is frightening as a patient or relative if you are waiting sometimes days to be seen or reviewed and this would prevent that so a definite yes from me.
10	Both hospitals need to be able to assess and treat from both A +E departments. Currently Cotswold patients are having to be admitted to GRH meaning extra journey time for them and their families. Transferring Stroke and elderly patients back to CGH is not ideal and would be better being able to being able to provide holistic care for patients on both sites as we have done well for some time.
11	I think it should be split between the 2 hospitals so that you can go to the nearest hospital to where you live. I see no reason that both hospitals can not have enough or share staff so that this can happen

Please tell us what you think about our preferred option to develop: A 'centre of excellence' for Acute Medicine (Acute Medical Take) at Gloucestershire Royal Hospital.		Response Percent	Response Total
12	I think the gastrointestinal ward should be bk in Cheltenham as I have a stoma and Gloucester hospital is far from me		
13	There's no point, the trust is focusing too much on the 'front door' and acute medical unit! What about the rest of the hospital, not good for pt. flow is the other services aren't looked at properly! Also not everyone lives in Gloucester, this is not their nearest hospital!		
14	It's not clear what services will be 'removed' from GRH in order to accommodate a CoE. Also by locating a major single service at one of the two hospitals doesn't address the increased time to travel for patients from the East of the County, the parking inconvenience (every part as bad at GRH as CGH, or cost of travelling further. Equally it does seemingly support (perceptibly at least) the downgrading of CGH A&E more permanently which is already and will continue to be an appalling decision.		
15	I would prefer to go to a site where the specialists are, rather than a hospital that is nearer but there are less staff available		
16	this is completely unsafe and ludicrous		
17	this move is completely unsafe and a silly move the organisation. Cheltenham needs an amu too.		
18	Cheltenham should remain an acute general hospital		
19	Services provided at Gloucestershire Royal Hospital and Cheltenham General Hospital should not be duplicated. Either one or the other facility should provide a specific medical speciality.In that way the specialist teams will be concentrated on one site		
20	this move has made it very unsafe for patients as grh staff just cant cope with the high volume of patients they are getting. The worst move they have decided to do.		
21	good to have all services in one place.		
22	At present all medical take is at GRH and therefore at CGH we get all the medical patients that are difficult to manage and that GRH do not want. By having medical take at both sites the types of medical patients are more evenly spread.		
23	To help flow.		
24	I think it will promote continuing excellence in the services provided and will attract good quality staff to the area.		
25	Concentrate this and the required support services for this on one site		
26	This will reduce ease of access for Cheltenham and Cotswold patients. The site at GRI is difficult to access and navigate and crucially parking facilities are woeful. Traffic congestion around GRI is often very bad - this will add to the problems in people from Cheltenham and Cotswolds getting to the hospital easily for treatment,		
27	There just isn't a big enough ED at Gloucester, not enough Resus vays and just too cramped		
28	This will mean Cheltenham residents will have to get there and Cheltenham hospital will not be needed, we need a centre of excellence in every hospital		
29	Need a 24/7 type-1, consultant-led A&E at Cheltenham General Hospital.		
30	Evidence is that specialist stroke unit and cardiac units provide better patient outcomes		
31	The options outlined appear to make medical and operational sense		
32	Acute medical take is urgent care and represents one third of all hospital admissions (Royal Coll Physicians - 'Supporting the Acute Medical Take Dec 2015). While I support the principle of single centre of excellence approach for the Glos NHS Trust, surely for urgent care which represents such a high proportion of cases we need to serve both ends of the county properly. This would surely also mean a massive shift of patient numbers from Chelt to Glos and a resulting decline in budget for Chelt leading to further reduction of services there		
33	Local		

Please tell us what you think about our preferred option to develop: A ‘centre of excellence’ for Acute Medicine (Acute Medical Take) at Gloucestershire Royal Hospital.		Response Percent	Response Total
34	Having all your 'specialist' staff in one area may be better and more cost effective for you but as always it's the patients who suffer. Traveling to and from Gloucester is not easy for those without their own transport. Even if the patient is transported to Gloucester by ambulance, once discharged they have still got to find their own way home, probably still feeling very unwell. They may not have friends with a car or have sufficient funds to cover the cost of a taxi, which leaves the bus, if it is running and if it is not full. There is also historically a poor reputation for infection control at GRH. I would not feel confident going there for anything serious.		
35	I will appreciate one world-class centre for the county; without spreading the expertise by having a second service in Cheltenham. The current A&E provision at CGH (i.e. its Minor Injuries and Illnesses Unit) looks appropriate to me.		
36	Had an acute kidney stone admission few years ago just after Xmas - live next door to CGH - last thing would have wanted would have been to have been taken to GRH!		
37	I can understand the reasoning and rationale for this option but I worry about capacity, if everyone suddenly has to attend GRH with no option to attend at CGH will waiting times be longer, will standards of care to the community be affected, will it mean that other treatments and services suffer at GRH. I am not against the proposal but these are some thoughts and questions I am having as a (potential) service user and a resident of Gloucestershire. I worry that this is also a step to wind down care and service provision at CGH too.		
38	Why have a hospital in your own town that your not able to use for all services		
39	Its a long way from the outer borders of the county - and not much use if it takes over an hour to get there - starting from 999		
40	Clear clinical advantages in not duplicating staff, so long as sufficient / additional staff numbers are working shifts to deal with increased numbers (you couldn't just shift the take and keep the same number of staff with increased number of patients).		
41	Centralisation seems fine from a management point of view but the impact on the recipients can be major in terms of travel and access to the services.		
42	Anything that reduces risk, Travelling time, being passed from pillar to post offers a quality service, with quality staff can only be excellent		
43	Do things well in one place. Concentrate skills and workload.		
44	Save on staffing and equipment by focussing on one location. Provide a better service.		
45	This sounds like it would lead to the loss of Acute Medicine at CGH. I have really noticed during the COVID changes that this often leads to multiple patient transfers across areas and hospitals which can be difficult and dangerous. Several patients on RYE had been to 4 ward areas prior to arriving on RYE.		
46	The creation of a COE will benefit staff and Patients However a more ""joinup"" public transport option needs to be considered - the holder of Gloucester main Bus provider Stagecoach should be able to used their daily/weekly/monthly bus pass in the 99 that links the two hospitals.		
47	Gloucestershire Royal already has good facilities and these could be improved if it was made a centre of excellence.		
48	I want to know acute medical expertise is available locally to me		
49	We have to be realistic about the challenges and do what's needed to try and mitigate them.		
50	I like the ""centre of excellence"" approach		
51	Both hospitals more encourage to train and keeping staff.		
52	I think it is vitally important to be able to have access to the right specialists (senior doctors) in a time of need, also address safety issues		

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

		Response Percent	Response Total
53	Although I support this option I have the following concerns:- Glos is a large county to have one A&E consultant led overnight. This will have an impact because in emergency care timing is vital and many patients will have to travel further to get the treatment they require.		
54	locating all resources at centre will remove from other part of zone hence increase travel time for a type of care that is time critical, better to have at least some support closer to all users hence alble to treat in 'golden time'		
55	If the Acute Medical intake is concentrated on one site, it will make a Type 1 A&E Department less viable on the other site. It also reduces flexibility between the two hospitals, especially in times of any future pandemics.		
56	Cheltenham would be more convenient for me, but Gloucester is potentially bigger and within easy reach		
57	Keeping track of all medicine and where they are used.		
58	It is probably best to divide the centre of excellence status for best use of available expertise		
59	Quicker response to a service when needed - waiting times - if all under one roof - higher demand?		
60	If one centre will numbers be too high who need to be seen		

Please tell us what you think about our preferred option to develop:A ‘centre of excellence’ for Emergency General Surgery at Gloucestershire Royal Hospital.

		Response Percent	Response Total
1	Strongly support	37.60%	47
2	Support	30.40%	38
3	Oppose	10.40%	13
4	Strongly oppose	15.20%	19
5	No opinion	6.40%	8
		answered	125
		skipped	3

Please tell us why you think this, e.g. the information you would like us to consider (52)

1	There is too little trust in the care provided by GRH, from poor food, lack of staff, nasty conditions and poor staff morale to convince me that a bunch of desk workers in brockworth have the support of the grass root level staff. There needs to be far more public trust in CCG and GRH before big moves are planned.
2	need to centralise expertise 24/7 ideally alongside other emergency services
3	Needs to reopen Cheltenham.
4	See previous answer. Best outcomes for patients is having centralised specialist units where training can also continue and also attract the best and Bridgestone staff .
5	There needs to be capacity for this at CGH also.
6	All emergency cases come to GRH and I feel that Emergency General Surgery should be at GRH because of this.
7	We do not have the bed capacity at GRH to provide the care that patients need. . Lack of beds mean that all surgical patients are often outliers on various wards making it difficult getting the surgical teams to review patients when needed.

Please tell us what you think about our preferred option to develop:A ‘centre of excellence’ for Emergency General Surgery at Gloucestershire Royal Hospital.		Response Percent	Response Total
8	It should be able to be at both hospitals, hopefully this will mean less people at each of the hospitals and also the nearer the hospital the better chance you have of helping someone especially if it is life or death		
9	Again, for same reasons as Acute care - GRH doesn’t have capacity		
10	Same reason as before, I know there aren't enough specialists, it makes sense to me to have them in one location. If I was in need of emergency surgery I'm not sure I would care where I was as long as someone with the required skill and knowledge was in the same place.		
11	county too big for this to work		
12	Over working the system, more operating out of hours due to long busy list which is dangerous, battling different specialties on emergency lists resulting in longer waits for patients who might need an urgent operation, waste of Cheltenham general theatre teams skills, experience and facilities.		
13	Long emergency waiting list. Long eating times in a and e. No beds. Rushed surgery. Waste of Cheltenham General facilities and staff.		
14	Lack of beds, long a&e waiting times, longer wait for operations		
15	we still receive urology emergencies into the theatre department with no provision for paediatrics overnight and no anaesthetic cover from 2200hrs apart from the DCC Doctors If emergencies are to remain in GRH then it needs to be all emergencies or proper provision for patients that remain in PACU after 2200hrs		
16	It is bigger hospital and easy for access (not confusing as opposed to CGH which is a maze and patients are constantly lost)		
17	GRH should concentrate on emergency work.		
18	Cheltenham should remain an acute general hospital		
19	I strongly support this. With Accident and Emergency to be located in Gloucester this makes sense		
20	cgh also needs general surgery so thr ED should be re opened to		
21	Cheltenham needs surgery. As some people can not travel to Gloucester		
22	I think it will benefit local people to have this provision and will promote continued quality improvement and performance in this area.		
23	Similar concerns to those outlined in first answer. Access problems, insufficient parking, traffic congestion and in addition the removal of general surgery is a highly significant reduction in the capability of the Cheltenham Hospital which will in due course be used as the rationale for full closure. Having services available on two sites also provides capacity and resilience in terms of space and equipment etc if one site has to be closed due to an outbreak of norovirus or covid for example. Please don’t say this won’t happen as you know this is the tried and tested route taken in other hospital reorganisations that have taken place across the country.		
24	Because the majority of emergency admissions go to Gloucester so it is logical for them to have all emergency surgery. However, I think Cheltenham needs to have a 24 hr ED with a specialism in oncology, urology and colorectal.		
25	This should be done in Cheltenham too		
26	Need these services at Cheltenham General Hospital too.		
27	Trauma units have better expertise		
28	Again one location makes sense		
29	According to the Royal College of Surgeons ""Patients requiring emergency surgical assessment or treatment are among the most unwell patients in the NHS. Often elderly, frail and with significant other health problems, the risk of death or serious complication is unacceptably high."". This means the increasing unacceptable the risk to patients of making them travel from east of Cheltenham travel through the town and a further 10 miles to GRH		

Please tell us what you think about our preferred option to develop:A ‘centre of excellence’ for Emergency General Surgery at Gloucestershire Royal Hospital.		Response Percent	Response Total
30	Having all your 'specialist' staff in one area may be better and more cost effective for you but as always it's the patients who suffer. Traveling to and from Gloucester is not easy for those without their own transport. Even if the patient is transported to Gloucester by ambulance, once discharged they have still got to find their own way home, probably still feeling very unwell. They may not have friends with a car or have sufficient funds to cover the cost of a taxi, which leaves the bus, if it is running and if it is not full - not very good for infection control following surgery. There is also historically a poor reputation for infection control at GRH. I would not feel confident going there for anything serious.		
31	Right to co-locate this with the A&E centre of excellence.		
32	Again would like CGH to be able to continue to provide this to local residents and not all centralised at GRH.		
33	As long as theatre space would increase in line with the need		
34	Please see my comments on the previous section regarding capacity and my support of the proposal IF the level of service is maintained to ensure that full and effective delivery, commensurate with the population of the area, can still be provided (or this proposal makes the service delivery more efficient).		
35	Why should we have a hospital in our town but only offering limited services		
36	Again reduce duplication of doctors. Allow prompt senior review by team. Again sufficient senior staff must be on shift. One team operating and one reviewing pts. Busy team (CGH & GRH worth of pts at GRH) with only one team available will mean operating or reviewing not both. NEED BOTH. Also if this is to happen more GRH emergency theatre space will be needed so that other surgical specialities can do their cases promptly too!		
37	This leaves too much dependancy on the Ambulance Service to deliver services in a timely manner. It seems ludicrous to have ambulances criss crossing the county with all the attendant traffic delays that seem to be on Gloucestershire's roads. Are there any Service Level Agreements iwth the Ambulance Serviced to ensure timely tarhgets are met. What happens if (as seems to happen often) there is no availability of ambulances.		
38	Reducing waiting time, planned surgeries that are preformed on time contributes significantly to the health and wellbeing of patients and their families reducing stress and unnecessary waiting times		
39	Lessen impact on planned surgery		
40	Specialist staff and equipment in one location. Saves on time and money.		
41	The other options are more suitable		
42	Gloucestershire royal already has good facilities and several operating theatres with experienced staff		
43	Unsafe, inadequate beds, chaotic, not essential to be on one site, worked very well on both sites. Poor bed flow inadequate ICU. Poor service for east side of county.		
44	It makes sense to co-locate emergency medicine and surgery at GRH		
45	I like the idea of concentrating the expertise in a single location		
46	Mental health at Cheltenham Good centre		
47	Yes I would like this to stay in Gloucester I am bias I live just outside Gloucester I like the benefits to staff members and staff retention.		
48	as per commentary in last page; fear over increase travel times		
49	If ALL emergencies are taken to Gloucestershire Royal Hospital it means the A&E Department at Cheltenham would no longer be a Type 1 A&E Department.		
50	Look at the appointment systems and make the phone system shorter.		
51	It is probably best to divide the centre of excellence status for best use of available expertise		
52	always needed - Will specialist staff really be available or too busy elsewhere? How practical will this be or is sit just a hope		

Please tell us what you think about our preferred option to develop:A 'centre of excellence' for Planned Lower GI (colorectal) general surgery at Cheltenham General Hospital (CGH) or Gloucestershire Royal Hospital (GRH).

		Response Percent	Response Total
1	Strongly support	46.72%	57
2	Support	33.61%	41
3	Oppose	4.10%	5
4	Strongly oppose	1.64%	2
5	No opinion	13.93%	17
		answered	122
		skipped	6

Please tell us why you think this, e.g. the information you would like us to consider (43)

1	I would like Gloucester to be a better option for care, this should be improved so that its more viable than having to travel to cheltenham to visit people.
2	Or???? Which is it?
3	for planned work we need to avoid the emergency site so the work continues despite emergencies - needs to be based at the non-emergency hospital cgh
4	Again it would make sense to have all GI surger on one site as patients don't always fit nicely into one speciality . So, GRH.
5	Elective services would benefit from single site 'centre of excellence' but with the capacity to transfer from Acute medicine/surgery at both sites.
6	I think that all planned colorectal general surgery should take place at Cheltenham General Hospital. If I was a patient I would know my operation is less likely to be cancelled, that the ward would be clean and CGH is currently the 'green' site. I would not want to chance being put in a bed next to an emergency surgery patient who has not had a covid swab results prior to admission.
7	care of all patients in the trust has deteriorated in the last few years due to lack of access to specialist services that used to be on both sites. Patient discharge is often delayed by days awaiting review by specialities based on different sites. This is frustrating for Staff, patients and their relatives
8	You should be able to go to nearest hospital for treatment, staff should be split between the 2 hospitals if necessary so this can be done
9	I think it should be bk in Cheltenham
10	Planned care still requires experts and equipment, its unreasonable to expect the NHS to be able to fund this on two sites that are so close to each other
11	I think planned surgery could be better placed within CGH so that GRH can focus on the emergency general surgery.
12	It should be CGH, because you want everything to be easy and understandable not only for the patients, but also for the workforce. I mean try to close the cycle within one medical field. Get Endoscopy, Theatres at one place.
13	Gloucestershire Royal is the most modern of the two hospitals and parts of the Cheltenham Hospital are 200 years old and unsuitable for 21st century health care provision. The most recent blocks in College Road Cheltenham could be used to complement the services provided at the Gloucester base
14	A unit at CGH would be the best option as if at GRH then the patients would be at risk of being mixed with emergency surgery and all the problems that can cause.
15	This is an 'either or' question without giving an opportunity to vote for either. It is nonsense.
16	Makes sense if centralising other GI services.
17	It will benefit local people needing this type of surgery

Please tell us what you think about our preferred option to develop:A ‘centre of excellence’ for Planned Lower GI (colorectal) general surgery at Cheltenham General Hospital (CGH) or Gloucestershire Royal Hospital (GRH).		Response Percent	Response Total
18	Cheltenham needs to become a centre of excellence for colorectal surgery, urology and oncology, both planned and emergency		
19	Both Cheltenham and Gloucester need to do general surgery, I was released from hospital in gloucester at 11.30pm and as I was taken there by ambulance I didn’t have my car, thankfully I have a son that drives but many people would be stranded, I could of walked home if I had been taken to Cheltenham		
20	What is the evidence for specialist bowel surgery ?		
21	I accept it is no longer practical/affordable to have all specialisms at both sites		
22	If it is planned surgery the patient will have had time to plan how they will get to and from the hospital, and anyone who wishes to visit can factor the distance into their preparations. There is still the question of the exorbitant parking fees on the GRH site. Although CGH also charges stupidly high parking fees, Cheltenham based patients being treated in Cheltenham and their visitors might not need to use their cars and could avoid these phenomenally high charges. There is also historically a poor reputation for infection control at GRH. I would not feel confident going there for anything serious.		
23	One world-class centre looks ideal to me.		
24	Support options where there is access to both sites so this is good		
25	It doesn't matter which site, so long as the service is there and available.		
26	Obviously to split up centre of excellence means less pushing people from one A&E to somewhere everything is not to hand		
27	Elective care should be split from emergency where clinically appropriate / demand exists - which it does in GS		
28	centre at cheltenham		
29	Planned surgery at least gives patients time to make suitable travelkarrangements		
30	As above		
31	Focussing a specialism in one location makes the most sense providing value for money.		
32	COE will benefit Patients and Staff, and make effective use of existing resources		
33	Often have to go to Cheltenham for appointments so makes sense to do it at Cheltenham		
34	Centralising upper GI seems to have been beneficial, presumably the same will happen with colorectal.		
35	Available beds, less likely to be cancelled calmer safe green site. Excellent ICU linked to essential other services to make centre of excellence. Oncology onsite national recommendations.		
36	Need to locate the planned specialties into CGH if emergency medicine and surgery are going to GRH		
37	Again, I like the scntre of excellence approach and likelihood of fewer cancellations		
38	For Chelt		
39	I think there would be lots of advantages to keeping all the planned lower colorectal general surgery in Gloucester. Everything and every member of staff present.		
40	lose of this type of surgery would result in doctors/other specialists relocating hence would be unable to support A&E dept		
41	General Surgery is not really a 'surgical specialism', as it relates to many different conditions. In order to justify centralising General Surgery the Hospital Trust appears to be attempting to redefine it as a specialism relating only to colorectal surgery.		
42	Parking and the use of public transport enabling the general public to use buses from Waterwells through to GRH		
43	To build expertise at CGH for this speciality		

In supporting our preferred option to create a single site 'centre of excellence', where do you think a 'centre of excellence' for Planned Lower GI (colorectal) general surgery should be developed?			Response Percent	Response Total
1	Cheltenham General Hospital (CGH)		54.84%	68
2	Gloucestershire Royal Hospital (GRH)		24.19%	30
3	No opinion		22.58%	28
			answered	124
			skipped	4

Please tell us why you think this, e.g. the information you would like us to consider: (53)

1	I would like Gloucester to be a better option for care, this should be improved so that its more viable than having to travel to cheltenham to visit people.
2	Crucial item for me is that there is an equal balance between what is in Cheltenham and what is in Gloucester....with equal numbers of essential services in each. It must not be Gloucester is the centre with bits in Cheltenham
3	I believe that no one site can cope with providing the service for people who usually attend two sites. The waiting times increase, the staff are stretched and patients feel that they are suffering as a result. Gloucestershire is too big to have one site for a speciality.
4	this would support gynaeoncology surgery
5	Insufficient bed base of acute medicine, let alone medicine plus surgery. Certainly no possibility of a centre of excellence for planned care in a hospital with insufficient bed capacity for acute services.
6	because it's not the emergency site and patient flow can be better managed
7	As above so the specialists are on one site , can cross cover be available.
8	I think this fits in with gynae and urology planned surgery and often these patients may need two consultants operating at a time. It will also mean that planned surgery is centralised. This will make it more appealing for staff working at CGH knowing they work on a site that is considered a centre of excellence.
9	I
10	Just because it is the nearest hospital to where I live, I should imagine anyone living near to Cheltenham would choose the Cheltenham one as their option
11	CGH should be the site for all planned activity
12	I believe it would be sensible to try and ensure that CGH takes on planned / elective surgery with lower risks involved, and that GRH is responsible for caring for emergency surgery. However, I also appreciate that this could result in specialist surgical cover required across both sites rather than just covering one and could be confusing for the public if there is general surgery offered at both sites.
13	Oncology centre
14	Oncology centre.
15	Oncology
16	Which ever site has best capacity of operating theatres and staffing for this proposal
17	It is easy to get all GI surgeries in one place closer to Endoscopy.
18	Calmer atmosphere. Better patient experience.
19	Consultants and staff are fed up. Colorectal worked at Cheltenham before stop fixing things that aren't broken. Wasting good theatres, what's the point in not using something we already have. And you have amazing nurses and HCA's with colorectal experience in Cheltenham that will not go to Gloucester.

In supporting our preferred option to create a single site 'centre of excellence', where do you think a 'centre of excellence' for Planned Lower GI (colorectal) general surgery should be developed?		Response Percent	Response Total
20	As above, the premises at Gloucester are superior and those at Cheltenham have fallen way behind. In my view Cheltenham should have constructed a new hospital to replace Cheltenham General in the hospital building boom of the 1990s and early 2000s when a large number of towns and cities constructed new hospitals, such as Worcester, Swindon, Birmingham, Stratford -on-Avon, Hereford, Taunton, etc, etc. Cheltenham missed out then and a new replacement for Cheltenham General is unlikely now		
21	Planned surgery at CGH would reduce likelihood of patients operations being cancelled. Staff would be trained to manage all types of pelvic surgery and therefore give better service and earlier discharge.		
22	Makes sense to continue the planned trend at CGH.		
23	I don't think it matters where the provision is. I cant see that one site has more benefit that the other.		
24	It would appear logical to have all cancer services on one site and given Cheltenham's preeminent role in cancer treatment then all related services should be located there,		
25	Cheltenham already deals with urology and it would make sense for ALL lower GI surgery, planned and emergency		
26	Both need this		
27	Don't care as long as 24/7 type-1 consultant-led A&E services are restored at CGH.		
28	If it is planned surgery the patient will have had time to plan how they will get to and from the hospital, and anyone who wishes to visit can factor the distance into their preparations. There is still the question of the exorbitant parking fees on the GRH site. Although CGH also charges stupidly high parking fees, Cheltenham based patients being treated in Cheltenham and their visitors might not need to use their cars and could avoid these phenomenally high charges. There is also historically a poor reputation for infection control at GRH. I would not feel confident going there for anything serious.		
29	the main center for this type of surgery is already in Cheltenham - so why would you wan t to move it ?		
30	Don't really mind but feels appropriate to co-locate with the cancer (oncology) centre in Cheltenham. Nb. I have a family history of bowel cancer so take particular interest in this area.		
31	To make a decision about this, there must be many other holistic factors about the sites, capacity, etc which I am not aware of.		
32	As long as the support services match the need.		
33	Again, it doesn't matter which site, so long as the service is there and available and ensure capacity and effective care for Gloucestershire residents. In my mind it would make sense to have a particular specialist treatment at both sites i.e. GRH is centre of excellence for XX and CGH is centre of excellence for YY. So that one or other site does not become defunct.		
34	Because should I or my neighbours need it, it is within easy reach for local transport. GRH in rush hour can take at least 1.5 hours		
35	Whichever site the clinicians feel is most appropriate		
36	Care needs to be taken in assessing the user demographic to make a suitable choice. Ideally it would be in the centre of the most common user base.		
37	Greater Diversity in Gloucester - some longer term health conditions higher with minority ethics Ease of access and family support as communities live close together		
38	A good match with other services. Also seems too much at GRH which could lead to conflicts of staff time		
39	If the majority of this department is located in GRH, it makes sense for all of it to be located at GRH.		
40	Make effective use of existing resources		
41	As above		
42	If you think upper GI surgery needs to be on the same site as emergency general surgery, surely the same should apply to colorectal surgery. If you are struggling to run the general surgery service on two sites at the moment why would you want to set a a service that continues to run general surgery on two sites?		

In supporting our preferred option to create a single site 'centre of excellence', where do you think a ‘centre of excellence’ for Planned Lower GI (colorectal) general surgery should be developed?		Response Percent	Response Total
43	As above		
44	see previous response		
45	I like the link with the gynae cancer treatment at Chetenham to form Pelvic Resection centre of excellence		
46	I think a centre of excellence, a single one would benefit the local and wider community by being situated in Gloucester.		
47	north of zone seems to be where population will grow (housing plan) and south activity would likely be split between gch & new forest of dean hospital		
48	If this is centralised on one site, it should be on the site where the existing Centre of Excellence for Cancer is based, because of the close relationship between Lower GI Colorectal Surgery and cancer.		
49	It doesn't make sense to have a centre for excellence across 2 sites but transport needs to be available and affordable for those that need it		
50	Seems like a lot of specialist services are at GRH so good to have this one at CGH		
51	More information about ones operations		
52	So that centre of excellence status is not all centred at GRH		
53	Prefer something at both sites		

Please tell us what you think about our preferred option to develop:A ‘centre of excellence’ for planned day case Upper and Lower GI (colorectal) surgery at Cheltenham General Hospital (CGH).			Response Percent	Response Total
1	Strongly support		39.20%	49
2	Support		38.40%	48
3	Oppose		4.80%	6
4	Strongly oppose		2.40%	3
5	No opinion		15.20%	19
			answered	125
			skipped	3

Please tell us why you think this, e.g. the information you would like us to consider (32)	
1	I would like Gloucester to be a better option for care, this should be improved so that its more viable than having to travel to cheltenham to visit people.
2	See previous answer
3	planned = cheltenham
4	If there are enough surgeons to cover this service , my concern is if an emergency service is also working how will the oncology patients be managed in an emergency situation
5	I know that the Day Surgery Unit at CGH is expanding so this would be the ideal location for day case surgery for upper and lower GI cases.
6	I think it should be at both hospitals, leaving it easier for people to go to hospital nearest to where they live

Please tell us what you think about our preferred option to develop:A ‘centre of excellence’ for planned day case Upper and Lower GI (colorectal) surgery at Cheltenham General Hospital (CGH).		Response Percent	Response Total
7	If planned surgery is on the same site then you keep a cohort of skills in that location		
8	Once again, I believe that there would be less breaches in waiting times for elective surgery if they were on one site and therefore protected from issues such as lack of staffing the rotas and access to resources		
9	I understand that the plans are in for two new day unit theatres to be built in CGH so hasn't this decision already been made		
10	I have already said that in my previous answers. Try to concentrate in one place all cases related to GI interventions. It is better for the workforce too.		
11	It is obvious that some services will have to remain in Cheltenham for the time being as Gloucester is not large enough to accommodate them all		
12	Benefits local people.		
13	It needs to be clear that if you have a centre of excellence, it is in one place. GU/GI at Cheltenham - Totally! along with oncology. Everything else to GRH		
14	Both Cheltenham and Gloucestershire need this		
15	Don't care as long as 24/7 type-1 consultant-led A&E services are restored to CGH.		
16	Biased. Nearer me!		
17	As mentioned previously it is obviously better for those living in the Cheltenham area for as many services as possible to be fully delivered at CGH. There is also historically a poor reputation for infection control at GRH. I would not feel confident going there for anything serious.		
18	This is already in Cheltenham. I have had to use it and found it excellent.		
19	I like the emphasis of removing emergency from CGH so that all the planned can proceed without interruption by the obviously unpredicability of emergencies.		
20	Personally this suits me but appreciate that Glocs residents may not want to come all way over to Cheltenham		
21	It would make sense that both upper and lower should be on the same site as support services and staff would have similar skill sets		
22	So long as patients can access the location where their surgery is taking place.		
23	As before - economies of scale basically		
24	Separating Planned surgerty will reduce cancellation and improve patients waiting times		
25	If I need my gallbladder removed with an overnight stay would I be able to have this done in CGH?		
26	Not essential on single site		
27	keeping planned activity in CGH if emergency services are going to GRH makes sense		
28	At Chelt		
29	This would work well because it is planned surgery instead of emergency surgery. Not so much of an issue around transport and time scales		
30	if there does need to be service better where county housing plan will put most new housing/greater need.		
31	It makes sense to focus planned surgery on one site, but this should not only be ""planned day case"", it should also include more complex elective surgery and not merely 'day case surgery'.		
32	N/A		

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

		Response Percent	Response Total
1	Strongly support	32.00%	40
2	Support	31.20%	39
3	Oppose	9.60%	12
4	Strongly oppose	8.00%	10
5	No opinion	19.20%	24
		answered	125
		skipped	3

Please tell us why you think this, e.g. the information you would like us to consider (38)

1	I suspect more money has gone into coming up with the terms / logos for hub and spoke than into IGIS. Both places should be equal and more money should be invested and the CCG shrunk to release the funds.
2	Image guidance needs to have services in both locations
3	strongly support the concept but if this is elective work wouldn't it be sensible to base it at cgh and have a spoke at grh?
4	Makes sense as the oncology services are at Chet=ltenham so would need support
5	Provided there is emergency cardiac interventional capacity at CGH also. It would not matter if this was at CGH considering the trust's stated aim of reopening ED at CGH post pandemic and it already exists there.
6	I think it should be at both hospitals so people can go to hospital nearest to where they live
7	There needs to be 24/7 cardiac intervention! This has been needed for years & should all be on one site!
8	The spoke is a ‘gesture’ and perceptibly will be seen as something to sacrifice at a later date to move all services to GRH....
9	Cheltenham with a functioning a and e needs 24/7 imaging
10	Cheltenham needs a functioning A&E and will need a imaging
11	I feel like this could fit the idea of GRH being for emergency care and CGH for elective care. I understand that there are already vascath labs at both sites so one could assume we already have the staff / resources to cover both sites if necessary.
12	It should be on one place. But I have not estimated the premises that we have available at CGH even if we have to build up a new building it is going to be far more better for the service than the service to be scattered.
13	This is a very important part of present and future health care and will greatly increase in the coming years
14	re opening CGH ED as we have perfectly good imaging equipment and needs to be used.
15	Heart attack patients need treatment at closest hospital this would be better than using Bristol but should be available on both sites
16	As long as this allows radiology to expand and develop. Be bold and invest here, this could be a real jewel in the crown for healthcare in Gloucestershire.
17	Will provide a better health care service for local people.
18	Both hospitals need this
19	Don't care as long as 24/7 type-1 consultant-led A&E services are restored at CGH.
20	Being a more modern hospital having the hub in Gloucester makes sense
21	Should have equal amounts at both hospitals

A 24/7 Image Guided Interventional Surgery (IGIS) ‘Hub’ at Gloucestershire Royal Hospital and a ‘Spoke' at Cheltenham General Hospital.		Response Percent	Response Total
22	I am not sure why it is that CGH always seems to get the second best option of anything being considered, but as I have not needed treatment of this type I am not in a position to make further comment.		
23	I prefer it to be offred at both		
24	As long as there is suitable staffing to support this arrangement, eg. Radiologists, nursing staff, radiology staff, physiology staff.		
25	I have put 'oppose' because I feel neutral about this proposal (so I do have an opinion but not either way at the moment). My reason is as follows: as long as patients attending both have the same access to the surgery/treatment they need e.g. so that those patients attending a non surgical centre are not disadvantaged by this model/proposal.		
26	IGIS & vascular should be on same site		
27	Probably necessary due to availability of technology and equipment.		
28	Often with services / treatments there is a lot of confusion where to go Cheltenham or Gloucester? a centralised hub offering as much as possible at one place would provide a ""comfort zone"" for the patient without having to travel to different places. Doesn't have a feeling of disconnect		
29	This could have been a centre for excellence in cgh ?		
30	Bringing the hub into one location makes sense, as staff and equipment can be focussed on one place not split over two sites.		
31	This Provide the Best Option - and will mean patients can be seen locally.		
32	Availability re transport and parking for patients and carers		
33	It looks as though this makes it more likely that i would be able to have my treatment in Gloucestershire		
34	This depends where the activity is required - in emergency surgery or planned		
35	Support encourage people to come to hosp a more quicker turn around		
36	Yes I would like IGIS Hus at Gloucester and a spoke at Cheltenham General Hospital, I like the fact you do not have to travel between sites and outside of the county.		
37	Image Guided Interventional Surgery appears to cross a variety of other specialisms, but seems most relevant to Cardiology and Vascular Surgery, which should be located in the first-class facility that was only created at Cheltenham three years ago.		
38	Good idea		

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

			Response Percent	Response Total
1	Strongly support		26.83%	33
2	Support		32.52%	40
3	Oppose		6.50%	8
4	Strongly oppose		11.38%	14
5	No opinion		22.76%	28
			answered	123
			skipped	5

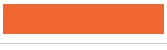
Please tell us why you think this, e.g. the information you would like us to consider (36)

1	I would like Glos population served as a consquence of this. Currently patients from outside the county have skewed access to aligned services as a consequence - mainly radiology.
2	probably unless we split acute and elective
3	Vascular surgery should stay in Gloucester, however there is increasing amount of t&o outliers.
4	Cardiology and vascular services should be on the same site to service emergencies.
5	I would support this if GRH were able to provide vascular surgery with a ward that was fit for purpose! Vascular patients are currently on a ward that does not have the space or capacity for the patients. Wheelchair patients have 1 accessible toilet and shower for 21 patients. This in not good for rehabilitation of patients post amputation and impossible for all patients to access shower facilities. This is adversely affecting patient care. Lack of space around beds make life hazardous for staff and patients as we are often transferring patients from bed to wheelchair with hoist and moving furniture around to make this possible.
6	Again it should be at both hospitals so that people can go to hospital nearest to where they live
7	This service was previously being managed well at CGH but if it not possible to split elective e.g. IGIS and emergency vascular surgery then I believe it would be preferable to keep it on the GRH emergency site and then consider the ""spoke"" option at CGH for the elective surgery. Splitting this service will have an impact on the intensity / quality of Therapy those patients will receive unless additional funding is provided to support splitting this service across sites.
8	Multi million pound interventional radiography theatre built in Cheltenham, consultants still wishing to do hybrid cases in IR resulting in transferring patients post major surgery across site, emergency list overwhelmed in Gloucester Royal as battle for specialities to operate
9	Because is not GI surgery. Every surgery not related to GI can go in GRH.
10	Speciality doesn't really have elective admissions. They have urgent emergency type patients
11	Vascular has already moved to gloucester
12	This should be concentrated at Gloucestershire Royal and it is not asking too much for patients needing such procedures to have them carried out at Gloucester
13	Vascular surgery worked well for many years at CGH and the ward environment was much better than the present situation at GRH. Patients travelling from Swindon have much further to go for treatment so it is better situated in Cheltenham.
14	Heart attack patients need treatment at closest hospital this would be better than using Bristol but should be available on both sites
15	Hard to have IGIS at GRH and vascular at CGH so makes sense.
16	I think it is an interesting area of surgery and will provide excellent provision for local people.
17	Keep Cheltenham as centre of excellence for everything GU/GI and oncology and all other surgery at GRH
18	Both hospitals should do this

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

		Response Percent	Response Total
19	Don't care as long as 24/7 type-1 consultant-led A&E services are restored at CGH		
20	Supporting evidence required		
21	Same as the above		
22	I am not sure why it is that CGH always seems to get the second best option of anything being considered, but as I have not needed treatment of this type I am not in a position to make further comment.		
23	I think it should be offered at both sites		
24	As long as there is suitable staffing to support this arrangement, eg. Radiologists, nursing staff, radiology staff, physiology staff.		
25	Please read my earlier comments regarding capacity, service delivery and my reservations that moving particular services to GRH alone must not lead to the closure of CGH (based on the assumption that GRH alone cannot service the whole catchment community).		
26	IGIS & vascular should be on same site		
27	As above		
28	I Struggle to see the Justifcation for the move - other than to be Closer to Trauma unit.		
29	Good parking, already has a good unit at GRH		
30	It seems that this is closely linked to the IGIS hub		
31	Keep it has it is ensure a good quality service		
32	I appreciate the fact less invasive surgery would be needed and reduced travel time for some procedures, so that would be a bonus.		
33	as noted earlier CofE reduces resourcing supporting A&E from other hospitals		
34	There is an excellent, nearly new Cardiovascular Unit at Cheltenham General Hospital, which the Hospital Trust spent £2.3m or more on. This is one of the best facilities of its kind in the South West, if not the whole country. It makes no sense to relocate this to the Gloucestershire Royal, especially since, according to six our of seven of the Consultants involved, the facilities there are not nearly as good.		
35	Another very good idea.		
36	The need to create the centre of excellence for specific specialisation over the 2 hospitals		

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

			Response Percent	Response Total
1	Strongly support		33.88%	41
2	Support		34.71%	42
3	Oppose		4.96%	6
4	Strongly oppose		3.31%	4
5	No opinion		23.14%	28
			answered	121
			skipped	7

A permanent ‘centre of excellence’ for Gastroenterology inpatient services at Cheltenham General Hospital.		
	Response Percent	Response Total
Please tell us why you think this, e.g. the information you would like us to consider (32)		
1	better to avoid the emergency site	
2	Provided there is some gastroenterolgy presence at GRH also.	
3	I feel that this ward is located on the wrong site and should move to GRH where the other acute medical care is taking place. Many patients need regular access to Endoscopy but there are not enough gastro patients at CGH to warrant an inpatient list each day or weekend access to services. By moving this ward to GRH patients would have improved access to endoscopy services 7 days of the week on dedicated inpatient lists. They would not have to be transported cross site either	
4	It should be at both hospitals so people can go to hospital nearest to where they live	
5	This fits with separating surgical and medical divisions across each site.	
6	It is closer to Endoscopy Unit. Patients can be easily transferred to it.	
7	Nothing wrong with snowshill, Again don’t fix what’s not broken just make it bigger	
8	Some services will need to be continued at Cheltenham as Gloucestershire Royal will not be able to accommodate them all	
9	Should be in Gloucester with the rest of medicine	
10	As the pilot has been seemingly successful then makes sense.	
11	I think if gastroenterology is going to be based at Cheltenham then the surgery should be carried out there too so that all gastroenterology services are under one roof. I don't like departments being split between the different sites.	
12	I have concerns that the underlying message of specialisation does not take into account issues of resilience, access, critical mass or community. The approach being taken is "standard" nhs review practice to downgrade one site to the benefit of another. In effect closure by instalments: Why does the Senior Health Management in Gloucestershire look at closing both hospitals and locating a new one just off J11 or 11a of the M5?	
13	If you want to have a centre of excellence EVERYTHING to do with that area of medicine needs to be there, no half measures and aahh but this bit goes to Gloucester. You need to keep things simple and easy for Joe Public yo understand as well as your HCP partners.	
14	Both hospitals need this	
15	Don't care as long as 24/7 type-1 consultant-led A&E services are restored at CGH	
16	Describe centre of excellence as this term is being overused in the survey	
17	prefer location of all specialist resources at GRH, Gloucester City site	
18	As mentioned previously it is obviously better for those living in the Cheltenham area for as many services as possible to be fully delivered at CGH. There is also historically a poor reputation for infection control at GRH. I would not feel confident going there for anything serious.	
19	As long a there are support services, equipment and staffing to support this	
20	As long as it meets patient need, is accessible and effective. My responses are based on the assumption that this proposal will deliver better efficiency and improved clinical outcomes than the current model/service provision in place.	
21	Whichever the clinicians think is best	
22	Urgent general need for many people. Reduced waiting times - quality focused attention and care for the patient is always a win win	
23	Support concept	

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

		Response Percent	Response Total
24	Focus a centre of excellence on one site, don't try to split it across two geographical locations.		
25	The Pilot seems to indicate that this is and will continue to work well		
26	Your pilot appears to have worked well		
27	I support this if linked with colorectal surgery at Cheltenham		
28	linking this with the Cancer centre streamlines care		
29	All in one place		
30	Yes, always keep anything that is excellent and working well!		
31	Cheltenham as an older demographic than other parts of the zone covered by trust however might be best not to have CofE so specialist doctors are available for A&E support at all the hospitals in the trusts zone		
32	this is a service which should, as far as possible, be located as close to the existing Cancer Centre in Cheltenham General Hospital.		

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

		Response Percent	Response Total
1	Strongly support	48.00%	60
2	Support	31.20%	39
3	Oppose	8.00%	10
4	Strongly oppose	3.20%	4
5	No opinion	9.60%	12
		answered	125
		skipped	3

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

1	absolutely - this should be a number 1 priority - better trauma and A&E care at both destinations - there is NO WAY that one centre will suffice and we know this undermines public trust in CCG (who honestly now must be loved about as much as covid 19 itself).
2	If it is a trauma case, it is quite possibly an ambulance admission and GRH cannot cope now. All ambulances go to GRH and then orthopaedics would have to be transferred to CGH, increased cost, risk, time and staff
3	makes complete sense
4	There are a high number of T&O patients so both sites is good
5	Need to be on one site . Have CRH as cold , non emergency surgery and GRH as emergency. Which would protect beds at CRH
6	I agree that all trauma should come to GRH and planned orthopaedics to CGH.
7	This has to be fit for purpose and capacity needs to be concidered
8	Again both of these subjects should be at both hospitals so people can go to nearest hospital to where they live

Two permanent ‘centres of excellence’ for Trauma at Gloucestershire Royal Hospital and Orthopaedics at Cheltenham General Hospital.			
		Response Percent	Response Total
9	This is something that I believe is already pretty much established with GRH being the trauma site and CGH being the elective site		
10	this has worked well since 2017		
11	It should be everything in GRH. This is my refrain. It is logical and simple. The simpler is the better is. Perfection is in simplicity.		
12	Trauma and orthopaedics should stay together at GRH		
13	Appears to work well at the present. Not sure why spinal surgery is not at CGH too.		
14	This is known to be good practice and the pilot has been working well. Why change it?		
15	Don't know why we need two centres. Probably better to have everyone on one site rather than spreading resources more thinly across two sites.		
16	Trauma and orthopaedic need to go together. It would be VERY confusing to split them. You've GOT to start treating this as one hospital over 2 sites; not 2 different hospitsls. EVRRYTHING trauma and orthopaedic at Gloucester. Coronary Care also needs to be centralised wherever PPCI is.		
17	Glad both are being considered		
18	Don't care as long as 24/7 type-1 consultant-led A&E services are restored at CGH		
19	Not sure aboutb separate centres for orthpaedics.		
20	Given the nature of these services it makes sense to have in both locations		
21	As mentioned previously it is obviously better for those living in the Cheltenham area for as many services as possible to be fully delivered at CGH.		
22	As long as there are support services, and staffing to support this		
23	Please refer to my previous comments, I support this if it will service the community more effectively and if it will lead to improved clinical outcomes.		
24	Orthopaedics can usually hang around and be given pain killers for a certain amount of time.		
25	Again splitting elective and trauma sensible if demand / need exists.		
26	I think this is necessary because of what people are constantly being told about the ""Golden Hour"" for successful outcomes. It seems useless in trauma cases if a large part of this period is used in travelling to the necessary hospital		
27	Needs no words to say this is a critical service and needs to have all the positives. Better care and attention and help out at the outset reduces issues developing later		
28	As above		
29	Having had a very successful hip replacement at Cheltenham eighteen months ago, I can only say that every aspect of my treatment was excellent, the surgeon was informative, the nursing was brilliant, even the food was good, and the outcome has given me my life back. It is working really well there, so perhaps Cheltenham is a good place for it to be based.		
30	The results of this pilot indicate that the proposal is and will continue to work wll		
31	Parking and general access for patients		
32	Your pilot wsems to have worked well		
33	Not seen enough evidence as pilot		
34	Yes keep as it the county is increasing with people living in areas FOD, severn vale, Tewkesbury, Cotswold etc		

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

		Response Percent	Response Total
35	Yes I agree with this, this can be needed at anytime, having two centres of excellent is very comforting. Reduces travel, retention of staff , waiting times		
36	Trauma will in many cases also require Orthopaedics support so it seems best to have both specialist available in both hospitals		
37	From things I have heard about Trauma & Orthopaedics I am not convinced the T&O Pilot study has gone as well as the Hospital Trust has claimed. I should like to see the full report of the Trial, before forming a judgement on this. I am not opposed to most elective orthopaedic surgery being done on one site and most trauma orthopaedics being done on the other, to minimise disruption to elective orthopaedic procedures, but Trauma Orthopaedics is fundamental to a fully functioning A&E Department, not least because it is not always obvious until x-rayed whether an injury is a broken bone or a soft-tissue injury. At least some trauma orthopaedic capacity should be retained on both sites.		
38	as long as a streamlined service can be provided at both sites consultants, ultrasound etc need to be available. Registrations are fine but it duplicates appointments. If you could see a consultant sooner service would be slicker		
39	Convenient for residents of both areas		
40	Yes very well needed		
41	These will not be planned procedures - some instances and being able to receive treatment at the nearest hospital therefore an advantage		

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

		Response Percent	Response Total
1	Open-Ended Question	100.00%	68
1	extra travel time, costs and difficulty if services are required.		
2	If the only option for a certain appointment or procedure was in GH, I would not attend and know from discussions that my family would not either. We have had relatives in GRH and the experience has been unsatisfactory both fr them and for us whereas CGH experiences were much better.		
3	I am concerned that any developments are a short term solution which does not address the fundamental issue of either site having a sufficient bed base to run an acute take for medicine and surgery (plus O&T, Gynae etc). We need a new hospital based an a different site to achieve. The suggestions are well intentioned but ultimately a wast of tax payer money.		
4	pretending we have 2 acute hospitals is the biggest potential detriment to services		
5	AMU needs to be spread across both sites. Head and Neck ward with Gynaecology doesn’t make sense		
6	I want the best care for my family and whether we travel to Cheltenham or Gloucester is irrelevant and has no bearing.		
7	Failure to deliver emergency care in Cheltenham has already negatively impacted my family and our view of the trust's performance.		
8	These proposals would improve the care provided if myself or my family ever needed treatment at GRH or CGH.		
9	Cheltenham maybe too far to travel, public transport route to Cheltenham from the towns that are in the county are poor. Also car parking and cost is a concern		

Please tell us about any impact, either positive or adverse, that you think any of our proposals could have on you and your family (please tell us which service your feedback relates to e.g. IGIS)?		Response Percent	Response Total
10	The Trust's decision to move services post Covid peak had a negative impact on staff morale and mental health. Working through the difficult time of March and April was stressful for all and whilst all were happy to go where needed we were working in new teams in new ways with little support in this emergency situation. Moving back to our own wards and teams meant that we were starting to share the difficulties of the previous weeks and just as we were supporting each other we were told we were to move sites, splitting the ward staff and putting all through more stress and uncertainly. I do not think management realize how traumatic this was for those involved. The priority for staff is to provide good holistic nursing care for patients and support our colleagues. I feel that we have not been able to do that for a long time.		
11	Cant answer that as no way of knowing if or what treatment me and my family are likely to need in the future		
12	Travel, parking, costs of parking, congestion all negative. With an ageing population with less mobility it's likely less visiting will take place the more you centralise services on a single site.		
13	Cheltenham needs a amu and functioning a and e, plans to ship patients across country are absurd and detrimental to patient safety		
14	the removal of a and e puts everyone in the county at risk. putting people in ambulances between sites is already damaging. stop letting this continue		
15	changing our jobs yet again, nurses don't matter		
16	negative all round.		
17	If this is established successfully I think it will have a positive impact on establishing better pathways with our primary services and accessing community follow up etc.. and hopefully work reciprocally with helping admission prevention / flow in the acute setting.		
18	None		
19	Centres of excellence mean clinical expertise is concentrated in one area, rather than split across the county. This means better, more responsive specialist care for me and my family when we need it.		
20	further for some patients to travel too if A and E in Glos		
21	It is only positive		
22	Please keep acute services at cgh		
23	I live in Cheltenham and fortunately at the moment I am not receiving any services from either hospital . I I recognize that there are issues with Cheltenham General in view of the fact that parts of the building are 200 years old and not in current use because they are not fit for 21st century health care. I favour a new facility in Cheltenham being constructed on the edge of town so that the present buildings can be vacated and the land redeveloped. In the meantime I realise that the bulk of the services will need to be provided at Gloucester or even out of the county		
24	Will be able to get looked after by specialist people wether in Glos or Cheltenham		
25	Travelling to GRH		
26	I live in Gloucester and would prefer Gloucester hospital to be able to deliver all services to an excellent standard, Cheltenham hospital is difficult to get to, difficult to park at and it is extremely annoying to be sent there for treatment.		
27	I think in general the proposals are positive and will improve the services available in Gloucester.		
28	longer ravel times are a reality, not a possible consequence		
29	Focused centres of excellence to allow for planned care at CGH and more acute/emergency care at GRH but still maintaining access to ED across both sites		
30	The proposals to reduce services at Cheltenham will cause massive inconvenience and huge concern. A&E services are the vital bedrock of any "proper" hospital. This set of measures will reduce access, potentially harming those seriously ill due to delays in receiving expert help. The car parking problem will add to stress of both patients and families and there is real concern that this is yet another in a long line of service reductions at Cheltenham. The clear agenda being to cut the site back so far that it is unviable.		

Please tell us about any impact, either positive or adverse, that you think any of our proposals could have on you and your family (please tell us which service your feedback relates to e.g. IGIS)?		Response Percent	Response Total
31	You just need to have one place to go to for one SUBJECT e.g. Oncology, CVS, and GU/GI at Cheltenham and everything else at GRH. You've got to make it simple. And you need to make ED at Cheltenham 24/7 with doctors. Or you've got to double the size of ED at GRH. You've lost 2 x resus bays by closing CGH to ambulances, yet not increased capacity at GRH at all. It's ridiculous at Gloucester ED- and don't blame COVID. ED at Gloucester is not fit for purpose, being the only ED in the COUNTY!! JUST KEEP IT SIMPLE, so that everyone can understand it. You've been got to stop thinking like a person in the NHS and start thinking how the public views the organisation of the services offered. I don't believe you'll re-open ED at Cheltenham, you've been wanting to get rid of it for ages, but GRH ED is NOT fit for purpose with current demand - and demand is not going to decrease. You also need a centre of excellence for the Older Person. By 2040 , 25% of Glis CCG patients will be over the age of 65.		
32	I live in Cheltenham and work in the community, the cost of coming back to Cheltenham is high if you get taken via ambulance to glos royal, if you stay in, family find it expensive to visit you therefore your mental health deteriorates and your physical health recovery is slower, if it wasn't for my son being able to pick me up at 11.30 at night I would of had to stay in overnight, this would of caused a bed to be taken by me when I was well enough to go home but had no money to get home, a bus Journey from chelt to go's is a long time when you are travelling in pain or in recovery fir follow up appointments, we need a centre of excellence in both hospitals		
33	Any proposal that fails to deliver the full restoration of 24/7 type-1 consultant-led A&E services at CGH, will make it considerably more difficult to access emergency health care for me and my family.		
34	Travel and access to both sites for those with out cars or relatives locally		
35	All service development has the potential for increasing the health service possibly needed in the future by my immediate		
36	I think that all of the proposals will have a positive impact on everyone, as the services in the long run will be better, if certain hospitals become centres of excellence for individual things.		
37	As stated above I am concerned for myself and all others like me who live east of CGH that relocating acute medical intake and emergency general surgery solely to Cheltenham may put my life at risk in future		
38	Local and ease		
39	I anticipate that the most likely service that I or my family would need would be the Acute Medicine. Being dragged over to Gloucester in a crisis situation would significantly increase the levels of stress experienced by both the patient and their family.		
40	Have used Cheltenham when needed Colonoscopy using the 2 week wait system etc. Found the building itself confusing (easier to find from outside than inside). but the care received was excellent and easily accessable.		
41	Looks fine. We live in Shurdington so GRH and CGH and both readily accessible		
42	As someone of working age with access to independent transport, I think this is a positive move for me. However, I am concerned about the social practical impacts for people who are dependent on public transport, elderly, need support to to travel, more financially disadvantaged.		
43	I prefer it when Cheltenham residents can get access at CGH for all these things where possible. E.g. my phototherapy treatment used to be at CGH a ten mins walk for me now I have an hour round trip to GRH which is bad for the environment and a complete time waste.		
44	Car parking is an issue at CGH, assurances need to be made that relatives are able to park, to be able to transport and visit their relatives. The estate has to be able to support the changes to the centres of excellence along with staffing and support services.- all		
45	For me an my family we can access either GRH or CGH but I know that this will not be the case for all residents requiring care.		
46	The move of cardiology and the creation of a centre of excellence to Glos Royal makes no sense....This already exists at Cheltenham Gen and will effect me personally .....I have an existing heart condition.		

Please tell us about any impact, either positive or adverse, that you think any of our proposals could have on you and your family (please tell us which service your feedback relates to e.g. IGIS)?		Response Percent	Response Total
47	I think that both hospitals should be running independently like they have as not everyone can get to Gloucester royal hospital and why should Cheltenham residents be penalised for extra charges gained from transport.		
48	I and my family have been served very well by the Health Services - but I have had to be referred to both Banbury and Oxford hospitals in my time and was very well looked after. My husband however visiting his mother and my in different hospitals (Banbury and Chelt) went to sleep at the wheel of the car and had a slight crash		
49	Minimal impact currently - may involve slightly longer travel dependent on outcome. Applies to services that would move to GRH		
50	na		
51	I think any change to trauma or emergency services will impact my family where reduces easy access to services is involved. Also the assessments seems to only produce marginal gains from a staffing point of view.		
52	As a family, I think it is better to know which hospital you will be treated at as it's not easy for everyone if loved ones get transferred back and forth. It's nice to know in advance of planned treatment where you will be.		
53	Living close to GRH the proposals will not impact me greatly. It makes sense to use resources (staff and equipment) as wisely as possible given funding shortages, therefore the changes seem sensible.		
54	I think overall there will be a positive benefits having local COE's with appropriate staffing		
55	For either hospital it is access from the forest and other outlying areas such as Stroud. Good transport links might be essential		
56	The temporary changes made to Emergency General Surgery at GRH have had a positive effect on patient care, patient experience and staff morale. Patients now see the correct speciality during admission within a timely manner.		
57	As long as the clinic appointments are in the same place I think ti will have very little impact on my family		
58	Major elective general surgery - I am concerned if located in GRH - COVID cancellation of operations, poor quality care, chaos not good environment for recovery		
59	As a Gloucester based family it is always easier for us to go to GRH. However, I would prefer to travel a bit further to a centre of excellence.		
60	I had excellence service with my eyes op chelt covid 19. Has been await a call to staff must be needed for the future of NHS.		
61	My family and I could be affected positively by services being centralised because we would get the treatment we need in time by highly motivated trained staff.		
62	It was traumatic for my husband to be transferred to CGH at 2am because of vascular problems. It would have been beneficial to have been beneficial to have had a vascular centre at GRH.		
63	Hope fully our only need will be A&E based and in this area I fear the proposals are negative		
64	I strongly believe health care needs to be delivered as close to where people live and work as possible. This is supposed to be a primary policy of the NHS, yet it seems there is a trend towards ever more centralisation and a move to more and more remote services. While some services can no doubt benefit from greater centralisation, especially where investment in very expensive equipment is concerned, administrative and clinical convenience should not be elevated above ease of access to healthcare.		
65	Cardiac and renal. I am 84, have had 2 heart attacks and been cared for at both hospitals. I have chronic kidney disease		
66	no opinions but good idea		
67	The service I use most is eye care and there is no reference to Ophthalmology: any reduction in this service at Cheltenham would be greatly concerning for me.		

Please tell us about any impact, either positive or adverse, that you think any of our proposals could have on you and your family (please tell us which service your feedback relates to e.g. IGIS)?		Response Percent	Response Total
68	Close proximity to where I live Easy to travel to Gloucester hospital I like the idea of specialists in one area Centres of excellence should enable easy communications between staff		
		answered	68
		skipped	60

If you think any of our proposals could have a negative impact on you and your family, how should we try to limit this (please tell us which service your feedback relates to e.g. IGIS)?		Response Percent	Response Total
1	Open-Ended Question	100.00%	53
1	this should not be undertaken this year, if a government integrated review has to be delayed I don't see how it can be ethical that Gloucestershire CCG even have the man power to consider this - let alone spend money on making it happen. Is this a project pushed to the forefront to benefit an individuals career?		
2	Keep both sites running and share the workload between them as they are. GRH is difficult to get too, the parking is unsatisfactory and the building totally unwelcoming and difficult to navigate - i had to run to theatres ? 7th or 8th floor via the stairs because both lifts were out of action for maintenance - I had to leave on the ground floor someone who was in a wheelchair. In CGH, there are other route options so this wouldn't happen.		
3	GRH will be full all if not most of the time. Rapid discharge (prematurely) will inevitably happen to create bed capacity.		
4	pretending we have 2 acute hospitals is the biggest potential detriment to services		
5	I consider the effect will be positive		
6	Interventional Cardiology. This should remain at CGH where it performs very well despite the trusts problems.		
7	I do not think there are any negative impacts to the proposed changes.		
8	Managers need to ensure that there is the bed capacity to provide centres of excellence. Movement of patients between wards and sites is not conducive to good care. Staff need to be consulted and views listened to.		
9	Cant answer that as no way of knowing if or what treatment me and my family are likely to need in the future, if services changed to Cheltenham then we would need to get there and the parking in Cheltenham is awful and the hospital is not near the actual town centre		
10	As above		
11	make a fully functioning a and e in Cheltenham to protect their health.		
12	risks everyones lives. not having an acute service in Cheltenham is laughable.		
13	will completely change my job, again! lower staff morale and lose a much needed acute care service		
14	a fully functioning A&E needs to be in Cheltenham and our ACU and AMU needs to come back. patients safety is massively compromised.		
15	As long as there is data and outcome measures to reflect that this costly reconfiguration is truly having a positive impact on waiting times, avoiding cancelation of elective surgery etc.. then I cannot anticipate any negative issues.		
16	None		

If you think any of our proposals could have a negative impact on you and your family, how should we try to limit this (please tell us which service your feedback relates to e.g. IGIS)?		Response Percent	Response Total
17	Paediatrics definitely need looking at as if emergency cases for urology are still being operated on in CGH transferring them to GRH is a logistical nightmare. Its embarrassing to tell patients that we have to transfer patients , it takes ambulances away from emergencies calls, waiting times for ambulance, can sometimes be early hours of the morning, is it safe to transfer , staffing for paediatrics , its not giving the child a positive experience, could cause increased anxiety for future admissions		
18	I don`t see any negative effect. I live in Cheltenham and had to go to GRH as a patient. I just got on the bus and was there on time for my appointment. It was fine. In emergency I can get a taxi if an ambulance car is not available.		
19	Keep cgh an acute hospital		
20	The proposals will have no impact on me as I am not receiving any services at either hospital at present.		
21	this has a massive impact on me and my family. I wouldn't want my family member going to GRH unwell knowing what state the hospital is. patient care isn't what it use to be like unfortunately.		
22	Travelling to GRH		
23	None		
24	work with the transport services		
25	N/A		
26	Do not alter or reduce A&E provisions at Cheltenham. Do not centralise general surgery at GRI		
27	You really need to have a ""Southmead"" in the Golden Valley area. And you need to consider better bus services to both sites for general public yo reduce car parking requirements and problems.		
28	Any proposal that fails to deliver the full restoration of 24/7 type-1 consultant-led A&E services at CGH, will make it considerably more difficult to access emergency health care for me and my family.		
29	I can think of no negative effects of adding to or developing services unless such development diminishes the value already present.		
30	As far as possible try to maintain urgent/emergency/acute facilities at both sites while splitting care not in those categories into centres of excellence across the two sites		
31	Any service which compels patients to travel a significant distance gives a significant negative impact. It is not just the physical and financial inconvenience of organising travel to and from the hospital, there is also the significant negative psychological impact of the actual GRH site, which is noisy, confusing, over-crowded and uncomfortable. Every time I have visited the site, even as a visitor, I have left it feeling completely drained and unwell. I realise you are going to do the changes anyway as you have to cut costs and this consultation is a 'box ticking' exercise.		
32	Trying to find areas in Cheltenham hospital is not easy. Make sure you enter the building at the correct entrance, as finding your way inside the building is impossible.		
33	Not that I can see		
34	I want access to as many things to continue at CGH as possible. this consultation seeems to want to centralise as amny things to GRH as possible and I'm against that e.g. moving the A&E away from CGH has not gone down well with local residents and our MP		
35	Logistics, ensuring that patients can access the site they need. Ensuring that care is not compromised by having specialisms at a particular site i.e. will there be enough Nurses, Doctors, Specialists to provide effective care under the models proposed or will it mean less capacity. Will the proposals be affected by inevitable budget cuts that will take place from now as a result of the economic decline for this country we are entering now. I am assuming the proposals were put together at a different point in time and wonder if the current economic climate and impact that this will have on costs (budget) and the health of the population means that the proposal has to be reviewed to ensure it is still fit for purpose.		

If you think any of our proposals could have a negative impact on you and your family, how should we try to limit this (please tell us which service your feedback relates to e.g. IGIS)?		Response Percent	Response Total
36	Any moves of existing heart, cancer treatment, colo-rectal and imaging facilities to a Gloucester Royal 'centre of excellence' is a retrograde step and a huge waste of funds already spent ..... There should be a full and proper published and publicly available for review Cost Benefit analysis which includes in the model a true and comprehensive explanation of the previous expenditure and costs both current and capital at Cheltenham General. This previous expenditure and the proposed 'write off/downgrade' must be part of the costs.		
37	Open Cheltenham general with all services		
38	So far at 90 no negative feedback, but I'm glad I did not have to go to GRH for babies. its a long way and can take a long time. Ambulances when I have needed them have not usually taken too long, but I think a car service, where possible, with blue light supplied might be useful.		
39	Nil		
40	na		
41	As long as you don't try to close cgh a&e you will have my support.		
42	I worry that as we rely on public transport we may not be able to travel easily between hospitals. We have already had to use taxi to do this - that proves expensive; and perhaps will lead to us not bothering		
43	As above		
44	None		
45	As above		
46	Finding ways to minimise the need to transfer patients between sites is important. Communication about any changes that are made and why they are necessary always helps		
47	My family and I could be affected by long waiting lists, staff shortages, transport links, not being able to see a specialist consultant. This would be the negative impact.		
48	if we do set up CofE then we need to maintain 24/7 coverage elsewhere via a core of specialists (maybe a little more junior with access to more senior experts via telepresence)		
49	Senior management should listen much more to the views of ALL its frontline staff and not merely those of some of its most Senior Consultants. The Hospital cannot deliver excellent healthcare, regardless of how well equipped its 'Centres of Excellence' are without the goodwill and dedication of all of its staff. It is quite clear the failure to involve frontline staff sufficiently in developing services is undermining morale. There appears to be widespread distrust of senior management among staff and a sense of grudging resignation to having reorganisations imposed on them in a heavy-handed 'top-down' way.		
50	n/a		
51	no negative impact		
52	We live only 12 min walk from CGH, therefore the centres of excellence in Gloucester will be less accessible. Not having access to 24 hour A&E is a downside for us.		
53	Parking issues		
		answered	53
		skipped	75

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

		Response Percent	Response Total
1	Open-Ended Question	100.00%	34

1	split the clinics between both sites at different times or weeks but keep the specialities at both. Re-open A&E as a FULL setting and not as a nurse led one which will reduce the impact on GRH.
2	no
3	Gloucestershire would be better served by ambitious plans for a new hospital between Gloucester and Cheltenham along the M5 corridor. This would solve most of the trust's problems.
4	I think that all Upper GI surgery emergency and planned should take place at GRH and all lower GI surgery at CGH so they are kept separate.
5	The trust used to provide fantastic care that I have seen deteriorate over time with the changes and ""streamlining"" of services. Patients often need a combination of services to meet their needs and not having them on both sites impacts on our capacity to provide good holistic care.
6	As mentioned previously I think the services should be in both hospitals, don't see why the staff cannot be shared between the hospitals or more staff if required - if I was running the hospitals I would make it far more efficient that it currently is, I think there is a lot of money wasted in services the hospitals have to pay for, I would be obtaining them cheaper and would not waste items that have to be thrown away from a packet that 1 item has been removed. It is ridiculous and wastes so much money, it can all be sterilised and then money saved on these things could help with the services
7	stop hiding behind lies and tell people the truth re closing a and in Cheltenham
8	reinstate the services previously supplied by Cheltenham. local opinion is not being considered at all. Cheltenham needs an acute care ward and a and e
9	reinstate a and e Cheltenham, don't fob us off as a downgraded service that then has to push emergencies to grh in ambulances.
10	we need to be told the truth and they need to stop hiding behind the lies they are telling us. its completely ruined staff morale and staff are not enjoying work.
11	Nil.
12	yes, all emergencies to GRH urology and ophthalmology included (paediatrics)
13	Nothing is mentioned about ERCP. This is part of GI service. It should be in CGH as a part of the entire circle. It is limited at the moment to two half days a week. It should be at least on a 5-day basis (every morning let`s say). There must be an ERCP centre. It could play a big role as a Centre of Excellence for training within the UK if the consultants think that they are able to develop it in this way. If not, then our patients will benefit at least from centre like this.
14	As before, the answer to all the questions is to provide a new hospital for Cheltenham designed to provide the location for all the latest developments in 21st century health care
15	CGH ED department needs to reopen so that the pressure is taken off GRH and CGH has their Aute Care wards open again. GRH cant cope with the whole county.
16	Bring Cheltenhams A&E back
17	Build brand new hospital at J11 of M5 next to the Airport to serve the whole of Gloucestershire.
18	Both CGH and GRH need 24/7 type-1 consultant-led A&E services to support their growing communities. Anything less is totally unacceptable. GRH clearly cannot cope.
19	On occasion I have come across some silo issues where, for example, such provision as physiotherapy is not always referenced in relation to other clinics where a natural connection seema relatively low prioritys obvious. This could be achieved through the GP intermediary or by direct referral within a hospital.

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

		Response Percent	Response Total
20	Reducing costs and providing a good service to all patients do not go hand in hand. You have already done your 'cost / benefit' analysis and decided what you are going to do, so even if I had sufficient knowledge of hospital processes to offer suggestions it would be a waste of time.		
21	no		
22	Try to make centres of excellence at both sites where possible		
23	No, if the statistics show that this model will provide better clinical outcomes, less waiting times, joint working and attraction/retention of the right staff, then I do not have another model to suggest.		
24	""""developed in collaboration with local people during the Fit for the Future Engagement (see pages 17/19 of the full consultation booklet)."""" This just means that the one's who shout loudest are listened too the most.....It also assumes the the voices from the deemed 'stakeholders' [NHS chosen or invited!!] are the truly interested parties. Most of us are too busy in our everyday lives to give up time to be part of this stakeholder echo chamber.		
25	I think most of possible suggestions seem very sensible, but perhaps more use could be made of voluntary services (stopping blood flow from nasty cuts or wounds where the nearest A&E is not very near and it is closed). Dealing wit fits in children, concussion (small blows to the head). 999 is excellent but Gloucestershire is a big county and the borders far from the centre. Surely we should have a service that can take us to the nearest centre for help and rely on zoom for specialism?		
26	na		
27	Could make cgh the vascular centre.		
28	None		
29	No		
30	A covering team at each hospital with more senior staff visit each site to under take teaching etc but always being available for support/advice via telepresence or VR		
31	Recognising the need for change, the proposals for Gastro-intestinal Surgery contained in what was Option 4 should be fully worked up into a proposal, in preference to Option 2 which is what the Hospital Trust appears to have adopted in opposition to the majority of the Consultants involved and GiRFT advice.		
32	ensure each patient sees a consultant on their first occasion and gets ultrasound etc in the hospital closest to their home ie Gloucester people in GRH etc. Email appointment letters to people. Its faster and saves on postage. It also reduces the number of telephone calls coming in. If you offer email as a way to communicate ensure NHS staff have the ability to email the patient back		
33	no		
34	My alternative suggestion rather than wasting money on expensive surveys like this is to have ONE hospital, between Cheltenham and Gloucester, which could then be available for both. The overall saving to the NHS would after the initial expense, be enormous. I believe the only reason this has not already happened is the ridiculous failure by the two relevant local authorities to agree on a site.		
		answered	34
		skipped	94

Anything else you would like to say?

		Response Percent	Response Total
1	Open-Ended Question	100.00%	42

1	This is the wrong time, please spend the funds on dramatically improving A&E / Trauma and on building public trust in our local health services.
2	I don't understand why we have to keep both EDs open. What matters is what happens once patients arrive and to deliver the service I would expect, would mean concentrating emergency staff expertise. I don't live in C or G so have no emotional attitude to either department but I do expect one fully staffed centre of ED expertise somewhere in the middle of the county.
3	This should have been done years ago. Having doctors and staff working across two sites is inefficient and detrimental to patient care . Ideally we should have one hospital at Staverrton !!!!
4	Invest in your nursing staff as you do with every other professional group. Pay them more and develop their skills. This is the only way you will be seriously considered as addressing the recruitment and retention crisis.
5	Gastroenterology ward should be moved back to GRH.
6	Don't think so
7	Management have no clue how the services are run and what is best for the Gloucestershire pts.
8	How any of this helps patient flow and integration with primary care is poorly explained.
9	Trying to maintain two hospitals with duplicate services so close together makes no sense in any regard. This is the best compromise that I have heard suggested for a very long time
10	patient safety is being compromised daily already, let alone letting this carry on further. nursing morale is at rock bottom.
11	stop trying to deceive everyone and be up front with the plans. this effects people livelihood and health. stop treating nurses as if we don't matter by moving us all pillar to post.
12	the Gloucestershire nhs service needs to at least attempt to show some honesty and integrity when dealing with the public and its staff. do not treat us as though we are fools.
13	we need to be told the truth and be kept in the loop more. the patients are also taking the brunt from staff because of these moves
14	Although it has been stated that staff have been consulted I wonder whether it has been at managerial level rather than at patient facing level? Often the feedback with consultation processes is staff feel like the right people have not been involved and therefore they have not truly had the opportunity to feedback their opinions on the process. Ultimately, the majority of staff working in the acute setting will always want to accept change if the end result is better patient care and staff experience.
15	I hope that you are going to see the picture in different levels, i.e. locally, nationally and internationally.
16	I have responded to a number of surveys such as this over the years and none of them appears to have resulted in any changes being made.Hopefully this one will result in some positive action
17	please ignore the people of cheltenham who are biased against Gloucester and who shout the loudest. this would be a good opportunity to also increase health equality in the county.
18	Cheltenham need a A&E
19	Why are there not adequate children’s services in the area? My daughter was transferred to Bristol for endoscopy and gastric surgery despite Gloucester having the services necessary.
20	Just ensure that the investment needed to provide these changes properly and not half hearted is there for all services involved including those that are sometimes overlooked. There is no point picking a service up and moving it to one side of the county or other if you don't use this opportunity to actually improve it.
21	It is completely cynical to perform this type of public consultation during a ""once in a century"" global pandemic. By proceeding with this the NHS trust are showing utter contempt for the communities they serve. These proposals and this consultation should be put on hold until Covid-19 restrictions have been lifted by central government.

Anything else you would like to say?

		Response Percent	Response Total
22	Build a new County Hospital between Gloucester and Cheltenham, or focus development on the Gloucester site. Improve access (sheltered pedestrian links) to Gloucester rail and bus stations.		
23	Just a point about competition between services. Central Government, in particular the Minister for Health and Social Welfare, has repeatedly affirmed that the BHS has remained open for non-COVID health provision. This is nor strictly the case. For example, prior to the first phase of the pandemic I attended the BOTOX Clinic every 10 weeks. At the peak of the pandemic it was understandable that out-patient services should be a relatively low priority. However, eight months on my condition has worsened and when I receive the promised appointment I suspect that treatment will have to be re-assessed and possibly extended to achieve some parity with the positive outcomes achieved over many years of treatment . This must also be the case where there are other conflicts even during normal times. I am fully supportive of the need for centres of excellence but I would want to be reassured that other services are not reduced in terms of financial and staff resources in order to accommodate them.		
24	I am extremely dissatisfied that there is not a department at CGH which specialiases in treating children. When my grandson was 6 years old he fell at school and received a large gash to his forehead which needed stitching. I was told I would have to get him to GRH because it could not be dealt with at CGH. I had to drive him over the Golden Valley by-pass, in the rush-hour, in the pouring rain, trying to keep him from falling asleep on the journey because I was concerned about possible concussion. He was kept at GRH for 6 hours without being treated then sent home overnight and told to come back the next day for the stitches. An injured child should not have to undergo such a lengthy and hazardous journey or be left so long without proper treatment. Fortunately I had a car and sufficient petrol to get to Gloucester, but if I hadn't how would I have got him there, with his head cut open, by bus?		
25	no		
26	I would be interested to know what consideration One Gloucestershire have given to inclusion in terms of practical access to the hospital sites e.g. public transport providers, charities with volunteer drivers, support groups in disadvantaged areas. Given the health inequalities which have been demonstrated through the Covid-19 situation, it is vital to me that these considerations are given a platform in any changes, else we risk worsening inequalities already present. As well as the patient, this can impact visitors, whose support can positively bolster outcomes for a patient. Also, there is no mention of the impact on ambulance services, but presumably there will be an impact in terms of transfers needed (not just when ambulance first called to patient, but also transfers between GRH and CGH) . Am wondering how this has been assessed? Thank you for appreciating the importance of having an A & E service in Cheltenham to local people, I am really pleased this is reflected in the plan.		
27	I worry about the link and relationship between these proposals and GP services. GP services need to be as much a part of this as the hospitals and the hospitals cannot do this in isolation of community services. I can see part of the proposal is to enable more joined up working but this has to work in practice with collaboration and cooperation across the services. While I have experienced fantastic GP services in Gloucestershire (up to about 10 years ago). Unfortunately I have also experienced some poor GP service provision in Gloucestershire, which has deteriorated over the last 8 to 10 years. My biggest concern is that if the GP services are not joined up with these proposals, this will not be able to succeed.		
28	This appears to me to be yet another way to spend money to create 'something new' and the associated empire building both administratively and medically tghat goes with that. All proposals need to be matched to realistic assumptions of need and the first priority should be proper utilisation of existing resource. Acceptance of the waste of resource [both income and capital] appears to be a huge part of the default NHS model.		
29	Whatever decision is made, the correct and additional staff numbers must be allocated. You cannot simply move the patient workload (currently split over two sites with two teams) to one site with only that sites pre-existing team numbers. This will be a recipe for failure / disquiet. Working in a small speciality which centralised 10 or so years ago the benefits are huge for us		
30	no		

Anything else you would like to say?

		Response Percent	Response Total
31	The assessments continually refer to the BAME and homeless community if Gloucester (some 32,000 quoted) as being a major criteria in deciding where the services will be located. There are over 600,000 people in Gloucestershire . Do you not think this is a case of ""the tail wagging the dog"" . I also believe that some of these changes are being brought in to cover up for poor management in the past. Surely better recruitment schemes and a decreased insistence on nurses being degree trained would improve day to day outcomes for most patients.		
32	We are extremely fortunate to have two such good hospitals serving us.		
33	Inappropriate and dangerous hospital discharges happen regularly, particularly at GRH. I hope these changes will help reduce these. Mental health support is very poor, particularly in GRH, I hope the cost and staff savings can be used to provide better mental health support for patients with mental ill health.		
34	Please look at improving the bus links ! The fact that you use a stagecoach bus for one part of your journey and a pullman for other part - is just not Cost effective for patients.		
35	None		
36	Improving continuity of care, reducing outliers and improving communication with families might be improved if a balance in activity across the hospitals is achieved		
37	If you centralise more long queue and parks, waste cancelled appointments staff on sick holidays etc. As more money was used in covid 19. We have to think weekly and keep NHS going for years to come. Electric chargers at hospital while wait for o/patient and visitors. Cars in come for hospital?		
38	No		
39	Covid-19 as shown us that resourcing can come back to bite us		
40	The publics primary concern about the reconfiguration of specialist services within the hospital relate to the convenience and accessibility of services and the long term sustainability of a Type 1 A&E Department in Cheltenham. Of some of these proposals are implemented it is difficult to see how a full Type 1 A&E Department would be sustainable in the long term. This is despite the reassurances the Hospital Trust has repeatedly been given. It is these proposals which have undermined staff and public confidence in the Hospital Trust's sincerity over the re-opening of Cheltenham A&E and its long term future.		
41	no		
42	seems like GRH has a more specialist focus under one roof - will this lead to overcrowding, parking issues, less quality face to face time with staff / professionals		
		answered	42
		skipped	86

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

		Response Percent	Response Total
1	Open-Ended Question	100.00%	128
1	gl2		
2	Gl4		
3	GL4		
4	GL51		

What is the first part of your postcode? eg. GL1, GL20			
		Response Percent	Response Total
5	gL50		
6	GL1		
7	GL1		
8	GL50		
9	GL4		
10	gl1		
11	Gl51		
12	GL4		
13	GL50		
14	GL4		
15	GL5		
16	GL14		
17	GL51		
18	Gl1		
19	GL4		
20	GL4		
21	GL4		
22	Gl51		
23	GL2		
24	GL4		
25	Gl2		
26	gl51		
27	GL2		
28	gl51		
29	gl51		
30	gl2		
31	GL1		
32	GL51		
33	Gl2		
34	GL2		
35	Gl4		
36	GL2		
37	GL2		
38	gl14		
39	GL2		

What is the first part of your postcode? eg. GL1, GL20			
		Response Percent	Response Total
	40	gl51	
	41	GL50	
	42	gl51	
	43	GL51	
	44	Gl50	
	45	Gl2	
	46	Gl51	
	47	GL50	
	48	gl1	
	49	Gl50	
	50	Gl50	
	51	gl1	
	52	GL4	
	53	GL2	
	54	GL51	
	55	gl4	
	56	GL51	
	57	GL51	
	58	GL2	
	59	GL4	
	60	GL2	
	61	Gl14	
	62	GL2	
	63	GL51	
	64	GL1	
	65	Gl51	
	66	GL51	
	67	GL50	
	68	GL2	
	69	gl1	
	70	GL2	
	71	GL2	
	72	gl2	
	73	GL51	
	74	Gl14	

What is the first part of your postcode? eg. GL1, GL20			
		Response Percent	Response Total
75	gl51		
76	GL1		
77	Gl51		
78	GL51		
79	GL4		
80	GL2		
81	GL51		
82	GL50		
83	gl50		
84	GL50		
85	gl51		
86	GL4		
87	GL4		
88	GL51		
89	Gl51		
90	GL14		
91	GL50		
92	gl1		
93	GL51		
94	GL1		
95	GL1		
96	Gl51		
97	GL14		
98	Gl4		
99	GL2		
100	gl2		
101	gl50		
102	GL1		
103	GL14		
104	Gl2		
105	GL51		
106	GL50		
107	GL50		
108	Gl51		
109	gl51		

What is the first part of your postcode? eg. GL1, GL20		Response Percent	Response Total
110	GL51		
111	GL4		
112	GL2		
113	GL51		
114	GL14		
115	GL4		
116	GL2		
117	gl50		
118	GL50		
119	GL1		
120	GL50		
121	GL50		
122	GL2		
123	GL51		
124	GL50		
125	GL50		
126	GL1		
127	GL1		
128	GL4		
		answered	128
		skipped	0

Which age group are you:				
			Response Percent	Response Total
1	Under 18		0.79%	1
2	18-25		5.51%	7
3	26-35		17.32%	22
4	36-45		15.75%	20
5	46-55		18.90%	24
6	56-65		22.05%	28
7	66-75		11.81%	15
8	Over 75		6.30%	8
9	Prefer not to say		1.57%	2
			answered	127
			skipped	1

Are you:				
			Response Percent	Response Total
1	A health or social care professional		36.22%	46
2	A community partner		0.00%	0
3	A member of the public		58.27%	74
4	Prefer not to say		5.51%	7
			answered	127
			skipped	1

Do you consider yourself to have a disability? (Tick all that apply)				
			Response Percent	Response Total
1	No		71.88%	92
2	Mental health problem		4.69%	6
3	Visual Impairment		3.13%	4
4	Learning difficulties		0.78%	1
5	Hearing impairment		3.91%	5
6	Long term condition		16.41%	21
7	Physical disability		3.13%	4
8	Prefer not to say		6.25%	8
			answered	128
			skipped	0

Do you look after, or give any help or support to family members, friends, neighbours or others because of either a long term physical or mental ill health need or problems related to old age? Please do not count anything you do as part of your paid employment.				
			Response Percent	Response Total
1	Yes		29.03%	36
2	No		66.13%	82
3	Prefer not to say		4.84%	6
			answered	124
			skipped	4

Which best describes your ethnicity?

		Response Percent	Response Total
1	White British	84.92%	107
2	White Other	4.76%	6
3	Asian or Asian British	3.17%	4
4	Black or Black British	1.59%	2
5	Chinese	0.00%	0
6	Mixed	0.00%	0
7	Prefer not to say	4.76%	6
8	Other (please specify):	0.79%	1
		answered	126
		skipped	2

Other (please specify): (1)

1	White English

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

		Response Percent	Response Total
1	No religion	44.09%	56
2	Buddhist	0.79%	1
3	Christian (including Church of England, Catholic, Methodist and other denominations)	44.09%	56
4	Hindu	0.79%	1
5	Jewish	0.00%	0
6	Muslim	1.57%	2
7	Sikh	0.00%	0
8	Other	3.15%	4
9	Prefer not to say	5.51%	7
		answered	127
		skipped	1

Are you:

		Response Percent	Response Total
1	Male	32.03%	41
2	Female	61.72%	79
3	Transgender	0.78%	1
4	Prefer not to say	5.47%	7
		answered	128
		skipped	0

Do you identify with your gender as registered at birth?

		Response Percent	Response Total
1	Yes	93.65%	118
2	No	0.00%	0
3	Prefer not to say	6.35%	8
		answered	126
		skipped	2

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

		Response Percent	Response Total
1	Heterosexual or straight	85.04%	108
2	Gay or lesbian	3.15%	4
3	Bisexual	0.79%	1
4	Other	0.79%	1
5	Prefer not to say	10.24%	13
		answered	127
		skipped	1

Are you currently pregnant or have given birth in the last year?				
			Response Percent	Response Total
1	Yes		2.36%	3
2	No		74.80%	95
3	Not applicable		17.32%	22
4	Prefer not to say		5.51%	7
			answered	127
			skipped	1

Fit For The Future - What matters to you?

Responses from health and care professionals

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

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

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

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

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

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

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

Please tell us what you think about our preferred option to develop: A ‘centre of excellence’ for Acute Medicine (Acute Medical Take) at Gloucestershire Royal Hospital.		Response Percent	Response Total
62	Need to consider how beds will be managed without disrupting more urgent changes. Eg transferring to emergency acut admissions to specialist teams on CGH site.		

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

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

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

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

Please tell us what you think about our preferred option to develop:A ‘centre of excellence’ for Emergency General Surgery at Gloucestershire Royal Hospital.		Response Percent	Response Total
53	Ensure the facilities are set up with adequate space to assess patients in a timely manner. The current temporary changes are working well with more patients seen in a shorter time frame. However, limited space and beds in assessment rooms impacts on the the ability to deliver a truly first class service.		
54	you are sucking the life out of CHG all hospitals should have these specialties.		

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

Please tell us why you think this, e.g. the information you would like us to consider (43)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Anything else you would like to say?

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

Anything else you would like to say?

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

Anything else you would like to say?

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

Anything else you would like to say?

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

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

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

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

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

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

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

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

Which age group are you:

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

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

Do you consider yourself to have a disability? (Tick all that apply)				
			Response Percent	Response Total
1	No		88.89%	128
2	Mental health problem		4.17%	6
3	Visual Impairment		0.69%	1
4	Learning difficulties		0.00%	0
5	Hearing impairment		2.78%	4
6	Long term condition		4.17%	6
7	Physical disability		0.69%	1
8	Prefer not to say		1.39%	2
			answered	144
			skipped	0

Do you look after, or give any help or support to family members, friends, neighbours or others because of either a long term physical or mental ill health need or problems related to old age? Please do not count anything you do as part of your paid employment.				
			Response Percent	Response Total
1	Yes		19.15%	27
2	No		77.30%	109
3	Prefer not to say		3.55%	5
			answered	141
			skipped	3

Which best describes your ethnicity?

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

Other (please specify): (1)

1	European

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

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

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

Do you identify with your gender as registered at birth?			Response Percent	Response Total
1	Yes		95.74%	135
2	No		0.00%	0
3	Prefer not to say		4.26%	6
			answered	141
			skipped	3

Which of the following best describes how you think of yourself?			Response Percent	Response Total
1	Heterosexual or straight		86.81%	125
2	Gay or lesbian		2.78%	4
3	Bisexual		4.17%	6
4	Other		0.69%	1
5	Prefer not to say		5.56%	8
			answered	144
			skipped	0

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

Fit For The Future - What matters to you?

Response from public & community partners

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

		Response Percent	Response Total
1	Strongly support	42.11%	128
2	Support	28.62%	87
3	Oppose	11.84%	36
4	Strongly oppose	12.50%	38
5	No opinion	4.93%	15
		answered	304
		skipped	9

Please tell us why you think this, e.g. the information you would like us to consider (183)

1	If its means reliable and consistent access to specialists regardless of the the day or night then it deserves full support.
2	Gloucester hospital is renowned for putting the fear of God into people when they have to go there for care, removing options for Cheltenham - especially during a pandemic seems insensitive to say the very least. We live in Stroud but have previously chosen to drive to A&E in Cheltenham to avoid GRH. I think there should be a lot more work going into trust in our services and more specifically the paper pushers at CCG before trying to garner support for another master plan that will inevitably cost trillions, be done without consent and have frustrating outcomes for patience and staff.
3	Gloucester itself is simply not big enough to accommodate current demand yet alone the additional 5,000 plus hour being built in Cheltenham in the next few years!
4	Many patients do not have transport and will be unable to travel to the'alternative' hospital.
5	There should be one at Cheltenham General also
6	In a county this size , with the shortage of doctor and nurses we need to ensure that we have the safest care available and to do this efficiently as possible we need to have services centred on one site , in acute medicine GRH is the preferred site. This will not be popular with Cheltenham people but they have to accept that they will never ever have a fully functioning hospital on their site .
7	I think it should be split between the 2 hospitals so that you can go to the nearest hospital to where you live. I see no reason that both hospitals can not have enough or share staff so that this can happen
8	Damaging effect on the local community, as it disproportionately affects vulnerable individuals with protected characteristics. Concerns about bed space at GRH. Concerns about a bottleneck effect at GRH - if you double the amount of traffic, you need to double the width of the road, ALL roads, leading in and out. Leading on to concerns about the lack of funding for SWAS as per their financial outlook to provide the additional ambulance service coverage. Flawed notion of attracting high quality staff from a business/management perspective. Gloucestershire's market has competitors in Bristol, Birmingham (to an extent), Oxford, and of course London. Centralised services will not enable GHNHSFT to outcompete these, leaving us with 'the best of the rest'. This would have been the case whether centralisation occurred or not, thus centralisation itself is a moot point. Flawed concept of 'extra time' to care. This will inevitably lead to cost savings (perhaps instructed by ministers, and not immediately) by reducing staff numbers to provide current levels of care, only now at one site.
9	I think the gastrointestinal ward should be bk in Cheltenham as I have a stoma and Gloucester hospital is far from me

Please tell us what you think about our preferred option to develop: A 'centre of excellence' for Acute Medicine (Acute Medical Take) at Gloucestershire Royal Hospital.		Response Percent	Response Total
10	Gloucester Hospital cannot cope with Cheltenham patients - while I was in Gloucester with my Dad the relative of someone fainted as they had nowhere to sit and were enduring a long wait with their relative in the corridor. People were sitting on the floor - very shabby we need both Cheltenham and Gloucester hospitals working a full range of services as they have always managed in the past:		
11	There aren't enough staff to go around, so we need to make best use of those we have.		
12	I would prefer to go to a site where the specialists are, rather than a hospital that is nearer but there are less staff available		
13	Presume staffing a single acute centre is easier than two, making the care it can provide more consistent and 'guaranteed'. Only reason my response is 'Support' and not 'Strongly Support' is the extra 10 miles I would need to travel.		
14	The provision for Emergency, consultant led 24/7 care on the East of the County is essential for best outcomes for the aging population given how overcrowded Glos A&E is. Therefore anything which doesn't re-provide the highest tier of A&E at CGH puts patients at more immediate risk of poor outcomes IMO.		
15	Far too far away from Fairford to be a good option for patients from that town/area		
16	Too Gloucester central, what about those of us who live to the East of the County?		
17	Services provided at Gloucestershire Royal Hospital and Cheltenham General Hospital should not be duplicated. Either one or the other facility should provide a specific medical speciality.In that way the specialist teams will be concentrated on one site		
18	It would be problematic for rural locations, travel, job continuity and economic health in and around CGH		
19	good to have all services in one place.		
20	Its a great idea in paper apparently due to severe lack of medical bed capacity in the current situation its impossible to be a centre of excellence. Also without medical admission in cheltenham general hospital the ideology of ED is impossible as most of the cases presenting to ED is medical who may or may not need admission. Elderly people are most affected.		
21	Having a more centralised provision will be more beneficial to patients.		
22	I strongly believe in centres of excellence and to me it is clear that the GRH is the only site for such a service. One significant factor is the possibiliyy of more timely access to Mental health services		
23	If it is a place where future care via a plan is determined it must be good.		
24	Gloucester Royal is not easy to get to from many pay of the county		
25	Cheltenham General can offer the same service if you let them		
26	having access to wide range of specialists as quickly as possible seems key		
27	I want my care as I get older close to home so that family can visit. I would have no intention of being in a hospital away from my home town. This has high priority for me. Acute medicine has worked well at CGH for us up until now with ACUC managing the Acute Admissions well. From my observations of the medical wards at GRH they are not fit for practice. They are old, overcrowded, dirty, poorly staffed I would never wish to be a patient on these wards from my parents experience of being a patient on them. This would not be a centre of excellence - just an overcrowded cattle market.		
28	I believe CGH should offer equal services to GRH and not all resources diverted to Gloucester		
29	I am in favour of the centre for excellence approach to medical treatment. We have two main hospitals which need to be operating coherently.		

Please tell us what you think about our preferred option to develop: A 'centre of excellence' for Acute Medicine (Acute Medical Take) at Gloucestershire Royal Hospital.		Response Percent	Response Total
	30	Cheltenham and surrounding villages and other small towns in Gloucestershire deserve to have their own ""Acute Medical Take"" at CGH. Travelling is difficult enough in Gloucestershire and Gloucester Royal Hospital has very inadequate and expensive parking. This is a very busy tourist town with many festivals bringing thousands of people to the town and it is a very poor decision to only have a centre of excellence in Gloucester. We need our own A & E and also our own Acute Medical Take I am not opposed to Gloucester having its own centre but both places should be treated the same. Gloucester is a very large county stretching from the borders of Wales to the edge of Oxfordshire and Worcestershire.		
	31	I think it is important to aim for providing the best possible conditions in the service provided		
	32	Both centres need to provide all sorts of emergency medicine .		
	33	It makes a lot of sense in so many ways. Specialist staff where they are needed and economy of one place but the assurance of cross information when necessary. A huge plus is that scheduled day surgery will be able to go ahead as planned. As a patient I have experienced surgery required after attending ED with a cut tendon, having to be surgery ready each morning only to be told it would not happen and finally being extremely ill after being giving antibiotics because of the increased risk of infection. I also think that the guided imagery will offer huge benefits e.g. to stroke patients attending ED, removing the clot quickly could mean a reduction in brain damage.		
	34	This will mean Cheltenham residents will have to get there and Cheltenham hospital will not be needed, we need a centre of excellence in every hospital		
	35	Need a 24/7 type-1, consultant-led A&E at Cheltenham General Hospital.		
	36	There will need to be adequate space to accommodate the increased workload		
	37	It's a rational use of limited resources. Concentration of specialist people, and specialist kit, absolutely makes sense, and research shows that it produces better outcomes.		
	38	I'm disabled and have no transport to get to and from the hospital in Gloucester would very especially as wheelchair accessible transport is no longer provided to bring me home on the day of discharge		
	39	Centralisation of this speciality will ensure that the clinicians with the right skills are always available. It will reduce risks to the public and reduce the need for potential transfer either to another facility or out of county		
	40	Best location in the county for this service		
	41	Gloucestershire Royal is a difficult journey from North Cotswolds with poor bus services. Difficult for older people to visit relatives.		
	42	It is the right approach for the future.		
	43	Because without a facility for acute medical take at Cheltenham it would Be much more likely that the A& E dept at CGH would be rendered unviable. Travel times from the East of the county would be increased. If this option were to be adopted the facilities at GRH to accept the increased number of acute medical patients would have to be considerably improved.		
	44	Better treatment for all		
	45	A centre of excellence in one location enables experience and expertise to be shared, high standards to be set and maintained, as long as its management is supportive and creates an environment where the organisation and the individual members can learn and develop, not compete.		
	46	It makes sense to me have the expertise in one centre.		
	47	Acute Medicine seems to be an area of health where time is its greatest obstacle for a steady recovery. The availability of a correct specialist could likely contribute to the realisation of the actual problem rather than concerning around the symptoms that initially brought the patient to the hospital. Hopefully a 'centre of excellence' would increase the value of medical investigation of a patient's condition so that prevention can be enforced in the treatment. Although Gloucestershire Royal Hospital is central, the medical team may also require consideration of how patients from other towns may be able to access the yard without delay or complications.		

Please tell us what you think about our preferred option to develop: A 'centre of excellence' for Acute Medicine (Acute Medical Take) at Gloucestershire Royal Hospital.		Response Percent	Response Total
48	The options outlined appear to make medical and operational sense		
49	Broadly support this measure although concerned about travelling distance for patient and/or family and friends if having to travel from e.g. the east/north of the county. Using a bus (could be 2+), particularly later in the day/evening, or having to fork out a for a taxi/persuade a friend/family member to drive further is far from ideal. Some concerns over whether there would be sufficient bed space for services to be centralised - other hospitals who have merged services from two sites relatively near to each other onto one site have experienced issues with capacity e.g. a county to the north of Gloucestershire Can see the benefits of seeing the right person sooner which is very beneficial for all concerned		
50	This will give best outcomes for patients. Highly skilled teams will be able to care for patients & be able to support each other.		
51	More efficient use of specialised staff		
52	If this is thought to be a good idea, it probably is!		
53	Both Cheltenham and GRH should have full facilities. This will give flexibility in terms of capacity and also provide options should one facility be unusable through disaster or infection. Currently I have experienced GRH A&E is working beyond capacity with beds in corridors'		
54	The proposed solution in the Consultation Document appears sound.		
55	Gloucester is in the centre of the county so it would be logical to have the acute medical take here.		
56	We live in the east of the county, and Gloucester is a long way to travel. This problem is exacerbated as we get older, and private transport becomes more difficult. Public transport is simply not an option.		
57	With stretched specialised NHS resources concentrating particular but different Specialists at each hospital makes sense. I am also reassured that A&E will remain at Cheltenham hospital as we live in Bourton-on-the-Water so need to be confident that the closeness of A&E in Cheltenham in an emergency provides a much better chance of survival rather than going all the way to far side of Gloucester from here.		
58	Having centres of excellence is ideal providing it does reduce waiting time, and ensures operations are not cancelled. All expertise in one place so if second opinion is needed there is someone to consult immediately without the necessity of a follow up visit somewhere else.		
59	Creating CoEs across the county will inevitably create a good deal more traversing of the county for patients. I can empathise with the desire to make best use of resources.		
60	I think the proposal is fine for the short/medium term but with major population growth planned for both Tewkedbury and Cheltenham, planning should commence for sharing between both hospitals in 5/10 years		
61	24/7 access to multidiciplanary teams. Specialist equipment. RIght disciplines to provide services and ability to train more staff		
62	Acute medical take is urgent care and represents one third of all hospital admissions (Royal Coll Physicians - 'Supporting the Acute Medical Take Dec 2015). While I support the principle of single centre of excellence approach for the Glos NHS Trust, surely for urgent care which represents such a high proportion of cases we need to serve both ends of the county properly. This would surely also mean a massive shift of patient numbers from Chelt to Glos and a resulting decline in budget for Chelt leading to further reduction of services there		
63	I think it is important that the best acute care is needed where there is a concentration of expertise. Diluting staff expertise in two centres is not the best way to achieve this. Having acute medicine (acute medical take in Gloucester makes absolute sense, and I do appreciate that for some cases, subsequent transfer to the regional centre in Bristol (e.g. BRI/Southmead) may still be required for the most serious cases.		
64	I feel that this sort of service should be available at Both Cheltenham and Gloucester		
65	More effective/efficient to have one centre for this		
66	Local		

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67	GCH is so far away from the majority of the county		
68	Whilst GRH is further travel time for me, I recognise the need for focussing practice		
69	As long as capacity is adequate and doesnt impact upon other services		
70	Worried about what you promise but probably won't do at Cheltenham.		
71	It worries me hugely that the town the size of Cheltenham already hasn't got 24/7 Consultant Led A&E services. This seems another plan to reduce this even further. I worry about increased time to get emergency help for my children and elderly parents by having to travel to another town.		
72	Having all your 'specialist' staff in one area may be better and more cost effective for you but as always it's the patients who suffer. Traveling to and from Gloucester is not easy for those without their own transport. Even if the patient is transported to Gloucester by ambulance, once discharged they have still got to find their own way home, probably still feeling very unwell. They may not have friends with a car or have sufficient funds to cover the cost of a taxi, which leaves the bus, if it is running and if it is not full. There is also historically a poor reputation for infection control at GRH. I would not feel confident going there for anything serious.		
73	The concentration of key resources in one place to reduce duplication and wastage.		
74	It sounds like a good idea, but as we are on the edge of gloucestershire it would be further for visitors to travel for us		
75	Ambulatory Care is the way forward and many more people are likely to be treated this way in the future. It makes more sense to have two hospitals offering this service in such a large county area. Cheltenham is much easier to get to for many than Gloucester.		
76	I feel it shame that departments at Cheltenham Hospital are bit by bit being transferred to Gloucester. Eventually Cheltenham hospital will become a minor community hospital. Cheltenham is large enough to warrant its own fully functional hospital. It seems the main problem is lack of staff resources. Rather than transferring and closing departments which is not in the interest of Cheltenham residents the only real long term solution is to recruit and train staff. The people of Cheltenham deserve better. Regarding this survey I find the information provided complex not concise. It is really time consuming for general public to work out what is being decided and make their comment. There is also a feeling that whatever the public opinion is the NHS management will just do what they want.		
77	I understand the need to concentrate resources.		
78	acute medicine is required both sites. CGH has ICU beds nad medical meds to help ease the patient load		
79	The Report and its recommendations have been prepared by hugely professional, experienced and competent personnel. Ninety nine per cent of feedback from the public is likely to be simply based on how it affects their personal situation regarding treatment required and location, and not necessarily related to what is best for the community at large and indeed the NHS.		
80	all experts in one place considering the staff shortage the NHS is currently under		
81	It's closer for most people. Ie the forest and cotswolds		
82	It makes sense to have one 'centre of excellence' rather than reduced facilities over 2 sites 12 miles apart		
83	I will appreciate one world-class centre for the county; without spreading the expertise by having a second service in Cheltenham. The current A&E provision at CGH (i.e. its Minor Injuries and Illnesses Unit) looks appropriate to me.		
84	It does make some sense to centre areas of expertise. However certain things also need to be taken into consideration. Access for people getting to the locations. Danger of additional time for emergency cases having to go to GRH. What is the impact on the other hospitals such as Cirencester, Tewksbury, Stroud etc.		
85	It enables Gloucester Royal to be a centre of excellence for treating trauma patients which will improve patient outcomes. Takes pressure off cold case planned beds.		

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86	This is a hospital stay (even if 1 night) for which the patient and their family/carers have not planned. Hard enough to cope if it is local but very stressful if it is not. This is a case where both hospitals must be centres of excellence.		
87	I believe in current medicine, centres of excellence are a 'good thing'. GRH has the space and I trust facilities for this so I am happy to proceed.		
88	Depends on future direction of Cheltenham General Hospital		
89	Opportunity to improve recruitment and retention of staff a strong argument for single site, linked to 24 hr consultant A&E		
90	If this means moving acute patients from Cheltenham to Gloucester then I oppose. These are normally time critical cases and travel is clinically detrimental. There are large and growing populations in both towns and future demand will require acute services at both sites.		
91	In the modern NHS it makes sense to create centres of excellence for various specialities		
92	Separate emergency services from elective services completely		
93	Centers of excellence has to be the way forward to benefit the use of technology and Consultant/specialist skills.		
94	I can understand the reasoning and rationale for this option but I worry about capacity, if everyone suddenly has to attend GRH with no option to attend at CGH will waiting times be longer, will standards of care to the community be affected, will it mean that other treatments and services suffer at GRH. I am not against the proposal but these are some thoughts and questions I am having as a (potential) service user and a resident of Gloucestershire. I worry that this is also a step to wind down care and service provision at CGH too.		
95	Why have a hospital in your own town that your not able to use for all services		
96	Its a long way from the outer borders of the county - and not much use if it takes over an hour to get there - starting from 999		
97	It is better to complete the assessment of a patient where they are and transfer once if needs be to the correct place.		
98	You're proposing to close Acute Medical Take at Cheltenham. This looks a lot like yet another attempt to downgrade the emergency care at Cheltenham. Both hospitals need full A&E and Acute Medical Take.		
99	Up to date medical science and future developments		
100	It makes sense to centralise this area		
101	Centralisation seems fine from a management point of view but the impact on the recipients can be major in terms of travel and access to the services.		
102	Particular medical conditions can be prevented from getting worse if treated / diagnosed earlier		
103	The rationale seems clear		
104	make the best use of the expertise for each discipline. Not point in having too many duplicated services.		
105	As I live in the Forest of Dean it would be far more convenient for my family as possible patients to be treated in Gloucester		
106	I think everyone would prefer to be treated where specialist care is available and immediately accessible. This comment applies to all sections		

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107	Our guests (we're from Cheltenham Open Door) have complex needs and issues (addiction, mental health issues, etc). If we don't have local emergency care (or suspect, if they have to be admitted, it will be in Gloucester) they are unlikely to seek help when they need it and may wait until the situation is critical and they have to call an ambulance. This will make for worse outcomes for them and the need for (presumably) more expensive and complex intervention for the NHS. Not all our guests have hugely complex needs but most would struggle if everything acute was at Gloucester. Very few would be able to have people bring stuff to them or visit if they're in Gloucester (bus fare, logistics, etc). Many rely solely on their groups of friends for support, being estranged from their families, and simply wouldn't present until the last minute if they thought they'd be taken to Gloucester. You mention ""The importance of mental health support as part of all services"" BUT not all mental health support is provided by the NHS. Sometimes, perhaps, it is as or more important to have the people who regularly provide your stability and support able to easily access and reassure you. On a personal note, I and my colleague have elderly parents who have been in A&E/ambulance situations. It's a nightmare when they are taken to Gloucester. If it's rush hour, following the ambulance takes an hour and a half and you can't pop in and out to take them things they need. You feel you have to abandon them, and they feel abandoned, when you are trying to support them from a different town. It creates anxiety, logistical issues and upset. It isn't what anyone wants.		
108	My Husband had excellent care at Cheltenham General. A serious op for Bladder Cancer in 2015		
109	Quicker access to specialist doctors Shorter waiting times Costs of transfer for GRH to CGH for some patients and ambulance service pressure is a concern		
110	Anything that reduces risk, Travelling time, being passed from pillar to post offers a quality service, with quality staff can only be excellent		
111	Do things well in one place. Concentrate skills and workload.		
112	I It will ensure that specialist care is available at all times although it means I will have to travel from my home within walking distance of CGH.		
113	Having this can allow resources (provision and expertise) to be used effectively and not watered down.		
114	As with all your proposals to centralise services the problem is that of access for patients and their families. Whilst many have access to private transport a very large minority do not and they are frequently the elderly and less financially secure. For these people centralisation poses a major difficulty in accessing your services unless you propose to offer free transport between the sites. Even for those with private transport difficulties in accessing parking at iether site pose difficulties and high costs.		
115	Overall better patient outcomes and improved workforce environment.		
116	Makes absolute sense to have a Centre of excellence. Paramedics and GP's will know where to take and send associated patients rather than pot luck between two options.		
117	Glos Royal needs to improve		
118	Reduced waiting times Specialised staff in one place, so prompt decisions, better staffing		
119	As I don't drive its most useful		
120	Localised specialist care hub should improve quality of care and outcome providing any delay in transit CGH to GRH is avoided.		
121	Save on staffing and equipment by focussing on one location. Provide a better service.		
122	A good central location with good transport links. Ensure more bus services from out laying locations		
123	Experienced qualified staff centralised More opportunities for shared learning and research Intensive care facilities on one site High tech imaging facilities...		
124	I respect the reasons set out in the consultation document		

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125	The creation of a COE will benefit staff and Patients However a more ""joinup"" public transport option needs to be considered - the holder of Gloucester main Bus provider Stagecoach should be able to used their daily/weekly/monthly bus pass in the 99 that links the two hospitals.		
126	Timelyt assessment and diagnosis and improved staff cover		
127	Gloucestershire Royal already has good facilities and these could be improved if it was made a centre of excellence.		
128	Makes sense to be centrailised although I worry about patients who turn up to A&E at CGH and then require admission. The current communication about transfers with families is often poor.		
129	Having one centre of excellence in Gloucestershire should allow for more throughput, giving staff more experience, leading to better outcomes for patients.		
130	More convenient/centralized.		
131	Increased chances of seeing the right specialist more quickly. Will provide more focussed training/learning opportunities for junior doctors and medical staff, with continuous supervision by senior doctors. This will contribute to attracting staff and improved retention rates.		
132	After having experienced ' in patient ' services at both CGH and GRH on two separate occasions resulting from pneumonia. I would fully support the objective of developing a 'centre of excellence ' at GRH. The disadvantage of extra travelling for Cheltenham residents is outweighed by the improved facilities, better use of and more focused staff.		
133	Gloucestershire Royal Hospital is not large enough to accommodate such a move		
134	I agree with this ONLY if the A&E at Cheltenham is maintained at the same level they were pre-COVID		
135	Prefer Cheltenham - see page 37 My wife and I are in our 90th year. She is not allowed to drive. I prefer daylight and not Mon or Friday. We live in Tetbury and wish treatment there. So: We prefer Cheltenham and do not like Gloucester, the former being easier for us to reach by car and more convenient in terms of other activities on the day.		
136	Because I live in Gloucester.		
137	Good to centralise it but please consider things like parking etc. Slapping a biblically expensive P + D doesn't cut it.		
138	The facilities can be enhanced at less cost at this hospital		
139	Distance to travel from North Cotswolds to Gloucester is to far.		
140	It would make sense to have a particular specialism in one location to avoid possible delays to be seen by a specific consultant and relieve unnecessary travel between sites.		
141	Your literature does not cover a large proportion of elderly people who are taken to a&e after falls. Would they stay in the same hospital? My mother has arrived after waiting over 6 hours for an ambulance after a fall, not fit to go home but no broken bones. Where does she she up? Also, it is all very well to say this, but where are the beds? Again my mother waited overnight in a&e for a bed (with no offer of food or drink). Surely it makes sense to use a bed where there is one? What about the wait for an ambulance to take the patient from Cheltenham to Gloucester? Would that patient be back in the queue at Gloucester a&e (in my experience no doctors read patients notes and the hospitals do not share anything online)?		

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142	With ever more complex equipment and specialist staff required it makes sense to centalise the service providing the infrastructure, beds and staff are provided. Such a move must not be seen as part of a cost cutting exercise.		
143	Don't see why this needs to be only available in Gloucester and services removed from Cheltenham		
144	Central to county for us in FOD		
145	I want to know acute medical expertise is available locally to me		
146	Mainly happy - but difficult to travel to GRH from Cheltenham area if unwell		
147	We need to focus specialities and skills on a single site to maximise the use of specialist personnel and resources		
148	We have to be realistic about the challenges and do what's needed to try and mitigate them.		
149	What if the specialist team is based at CGH, thus will be some back and forth between sites. It is not clear how when a patient presents themselves to CGH and need further investigation at GRH, how move between sites. If this question JUST refers to ACU beds, then I have no opinion		
150	Although there will still be an A&E at CGH, I strongly believe that having specialists at one hospital GRH, would be beneficial to patients. My concern is the statement, " being seen by a consultant within 14 hours", is far too long a period of time. The realistic time should be a maximum of 7 hours.		
151	I don't want to go to Gloucester Royal it has a bad reputation and I would not be happy there.		
152	Cheltenham has a GENERAL hospital and as such should have the capacity for medical beds as it does now. This will seriously impact the A&E dept by downgrading it to a MIU because most emergencies will go to GRH. Your preferred option would affect, you say, in a negative way, 20-30 patients a day. That is 140-210 patients a week, 500-900 a month and 7000-11,000 a year! Are you really prepared to risk this many lives because of longer transport times for people living in Cheltenham and the North East of the county. I think this will be detrimental, causing increased suffering and death, when you stress you want to improve health outcomes for people!		
153	I like the ""centre of excellence"" approach		
154	In line with the A&E focus		
155	I have a concern that the information presented that Gloucester Royal Hospital has 49 beds is misrepresented by including frailty beds. However I generally support this.		
156	I think it is vitally important to be able to have access to the right specialists (senior doctors) in a time of need, also address safety issues		
157	Although I support this option I have the following concerns:- Glos is a large county to have one A&E consultant led overnight. This will have an impact because in emergency care timing is vital and many patients will have to travel further to get the treatment they require.		
158	Strongly support the idea of having 'specialties' at one of the two hospitals only.		
159	Possible, good concentration of staff		
160	Because of the increased local population both sites should be used.		
161	I don't think GRH has the capacity, now or planned.		
162	A specialist unit such as this makes sense.		
163	All consultants, doctors, specialist nurses and ancillary staff under the same roof. Encourage medical staff and other i.e. nurses - rehabilitation staff to come and work/train. Will give encouragement to patients knowing they are in a highly specialised unit.		
164	To concentrate the necessary skills in the centre of the catchment area		

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165	Less need to transfer between hospitals which takes ambulance time away from emergency calls.		
166	I can understand the rationale for this proposal but Gloucester Royal is very difficult to reach from the south-east corner of the county (Fairford). I appreciate your comments in the long version about the need to help older patients who may not be familiar with one of the centralised centres. In our case, I would struggle to find GRH. I am concerned about the reduction in services in Cheltenham. One is a selfish reason: I am familiar with Cheltenham and can get there easily. My husband has been seriously ill a number of times and I know how stressful it is to find an unfamiliar hospital at night when you are panicking. My second objective reason is that it will be very difficult for ambulances (and patients in private vehicles) to get to GRH from the Cirencester area until the bottleneck of the Air Balloon on the A417 has been resolved.		
167	My thoughts on this question, and answer to it, will be the same for many of the survey questions. I believe that there must be economies of scale in forming specialist centres. One whole is more beneficial than two halves in this case. This should mean savings in the cost of staff, equipment, spares and consumables, after an initial cost to physically create the unit. Some may get emotional about losing a service in 'their' area, but as a relative newcomer to the area, the hospitals are physically so close together, with good transport links between the two, I would consider the benefits to outweigh this.		
168	I do not wish the emergency services available at CGH to be downgraded, and think that access would be reduced if services were centralised to a single site.		
169	locating all resources at centre will remove from other part of zone hence increase travel time for a type of care that is time critical, better to have at least some support closer to all users hence alble to treat in 'golden time'		
170	I am concerned that too much emphasis is being placed on GRH. This concerns me because I do not believe that GRH has the facilities or space to cope with extra work. I would not support the concentration of services on one hospital site if that led to, for example, a reduction in consultants at CGH.		
171	If the Acute Medical intake is concentrated on one site, it will make a Type 1 A&E Department less viable on the other site. It also reduces flexibility between the two hospitals, especially in times of any future pandemics.		
172	Medical patients constitute the largest number of emergency admissions, so taking away beds from CGH will leave patients at risk of lengthier travel times to GRH with the prospect of increased suffering and death. Cheltenham is a General hospital which has already the ability to offer medical inpatient and medical emergency services. It will have an impact on CGH A&E, essentially downgrading the use of this facility. It is more than possible that between 10,000-20,000 Gloucestershire patients a year will be affected if the acute medical take transfers to Gloucester. GRH will need a high number of extra beds to cope with the amount of people who will require care and support.		
173	A state of the art hospital should be built in the forest of dean. Five Acres would be excellent, with maternity facilities. The travel to Gloucester and Cheltenham to and from the forest is horrendous and expensive.		
174	As my marking shows I am very much opposed to ""Acute Medical Take"" being centred in GRH. Cheltenham and the North Cotswolds have for very many years (in my case over 75) relied on CGH to provide care, quickly and without unnecessary and dificult travel to GRH, which can be critical to survival. Prior to the downgrading of CGH A+E two members (now deceased) of my family were well served by CGH at their time of need as I have. CGH provide the very best chance of survival. Many people in Cheltenham have regarded the hospital as a ""Centre of Excellence"" prior to it's downgrading. I understand the provision of a full A+E presents challenges to the trust however challenges do need to be overcome in order to match a clear need.		
175	Cheltenham would be more convenient for me, but Gloucester is potentially bigger and within easy reach		
176	Keeping track of all medicine and where they are used.		
177	GRH is inaccessible for residents of the north cotswolds		
178	More specialist nurses required in Acute Medicine. Real lull in activity when you get up to Acute Medicine.		
179	It is probably best to divide the centre of excellence status for best use of available expertise		
180	Crucial that there is sufficient capacity to easily meet demands		

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

		Response Percent	Response Total
181	Quicker response to a service when needed - waiting times - if all under one roof - higher demand?		
182	If there is only one centre and something goes wrong will there be no back up service		
183	If one centre will numbers be too high who need to be seen		

Please tell us what you think about our preferred option to develop:A ‘centre of excellence’ for Emergency General Surgery at Gloucestershire Royal Hospital.

			Response Percent	Response Total
1	Strongly support		38.08%	115
2	Support		29.80%	90
3	Oppose		11.59%	35
4	Strongly oppose		14.24%	43
5	No opinion		6.29%	19
			answered	302
			skipped	11

Please tell us why you think this, e.g. the information you would like us to consider (162)

1	The rationale in the consultation booklet is compelling and makes the case very strongly. We need to put patient care first before all other considerations.
2	There is too little trust in the care provided by GRH, from poor food, lack of staff, nasty conditions and poor staff morale to convince me that a bunch of desk workers in brockworth have the support of the grass root level staff. There needs to be far more public trust in CCG and GRH before big moves are planned.
3	Should also have one at Cheltenham General
4	See previous answer. Best outcomes for patients is having centralised specialist units where training can also continue and also attract the best and Bridgestone staff .
5	It should be able to be at both hospitals, hopefully this will mean less people at each of the hospitals and also the nearer the hospital the better chance you have of helping someone especially if it is life or death
6	Support the notion of highly specialised surgical teams at one site. Only concerns are managing the increased throughput. Emergency surgery is rarer than acute medicine so the negative effects there should not occur here.
7	Total chaos at glos royal. I have complex health and since cheltenham a and e closed to gp referrals I have gone to gloucester royal minimum 5 admissions. I am from cheltenham so it is much further to go, having to explain everything about your history to another medic who doesn't know you even though they have read your notes. More importantly waiting hours in a assesment unit I mean 8 plus hours when in pain is not on then to be told you are being admitted then waiting hours to be allocated a bed. I have bowel problems and I for one wouldn't want to be operated on at glos royal!
8	You need centres of excellence in both Cheltenham and Gloucester and I believe with proper budget management this is possible I don’t feel the trust have any interest in keeping the Cheltenham service.
9	There aren't enough staff to go around, so we need to make best use of those we have.
10	Same reason as before, I know there aren't enough specialists, it makes sense to me to have them in one location. If I was in need of emergency surgery I'm not sure I would care where I was as long as someone with the required skill and knowledge was in the same place.

Please tell us what you think about our preferred option to develop:A ‘centre of excellence’ for Emergency General Surgery at Gloucestershire Royal Hospital.		Response Percent	Response Total
11	Long emergency waiting list. Long eating times in a and e. No beds. Rushed surgery. Waste of Cheltenham General facilities and staff.		
12	Lack of beds, long a&e waiting times, longer wait for operations		
13	If the specialists and kit are all in one place, surely this makes patient care better regardless of an extra few miles for those who live on the east side of the M5.		
14	This would further reduce/support the case for reducing the provision of the highest tier of A&E at CGH (East) so should not be considered.		
15	Far too far away from Fairford to be a good option for patients from that town/area		
16	GRH should concentrate on emergency work.		
17	Too Gloucester central, what about those of us in the East of the Counry?		
18	I strongly support this. With Accident and Emergency to be located in Gloucester this makes sense		
19	We have hospitals in the county i.e Cheltenhem and Cirencester which could be used which would be better for those who live locally to them		
20	Same reason for my previous choice. Internal operation and streamlining should not come at the cost of local community well-being.		
21	The patient to travel with illness from remote towns near cheltenham not ideal as it may be a risk too as can't depend on ambulances at all times.		
22	As before I strongly support ""centres of excellence"". It seems appropriate that this shoul be colocated with Acute medecine		
23	Any centre of excellence must be good.		
24	As in previous answer not easy to get to from some parts of County and parking very difficult		
25	CGH can offer the same service, like they used to		
26	I want to see best staff possible in an emergency - I don't mind where it is but Gloucester makes more sense		
27	No Way. Build a new hospital and I might consider it. The tower block is not fit for practice. Its old and outdated with few siderooms.		
28	Services at CG H should be of equivalent quality.		
29	A sensible approach.		
30	Many people from Cheltenham and North Gloucestershire would die on the way to Gloucester Royal. The traffic at many times of the day is apalling in Gloucester. You seem to be considering Cheltenham as a small village when in fact it has a population of 112,700. When you include the Cotswolds it rises to 196,300. With the regular increases of population throughout the year this should surely make a difference to your decision.		
31	Important to patients and staff.		
32	Both centres need to provide excellent emergency surgery.		
33	Please see earlier comments,		
34	This should be done in Cheltenham too		
35	Need these services at Cheltenham General Hospital too.		
36	Too far to travel for people living East of Cheltenham		

Please tell us what you think about our preferred option to develop:A ‘centre of excellence’ for Emergency General Surgery at Gloucestershire Royal Hospital.		Response Percent	Response Total
37	The establishment of a single site for emergency general surgery will lead to better access to subspecialist care. There needs to be adequate provision of beds and assessment areas. Junior doctors will be better supported. If the same staff provide emergency, elective and day case surgery surely making changes to one component will impact on the others. Why are the changes to generals not being considered as a whole?		
38	It's a rational use of limited resources. Concentration of specialist people, and specialist kit, absolutely makes sense, and research shows that it produces better outcomes.		
39	Best location and facilities in the county		
40	see above		
41	I have to travel to both hospitals, so it makes no difference to me.		
42	How would the rotas become more robust if the hospital is lacking enough trainees and junior doctors?		
43	Again one location makes sense		
44	There should be good emergency general surgery at both GRH and CGH together wit 24 hour consultant led A&E departments at both locations.		
45	Please note I don't fully follow the options here - the short booklet seemed to refer to the longer booklet. the long booklet was too confusing as to what you really meant. A picture /diagram of the before vs after might help add the clarity required Would support measures to be seen by the right person sooner but some concerns about travelling distance for patient and/or family and friends if having to travel from e.g. the east/north of the county. Using a bus (could be 2+), particularly later in the day/evening, or having to fork out a for a taxi/persuade a friend/family member to drive further is far from ideal. Some concerns over whether there would be sufficient bed space for services to be centralised - other hospitals who have merged services from two sites relatively near to each other onto one site have experienced issues with capacity e.g. a county to the north of Gloucestershire		
46	Skilled teams can provide care needed People may have to travel, but for a good outcome it is worth it		
47	More efficient use of staff. The more surgeries completed the better the surgeons become and so patient outcomes should improve.		
48	If emergency treatment is performed at one hospital, GRH, it leaves planned surgery at the other, CGH, not liable to interruption for emergency surgery.		
49	NOt a good option. The county needs flexibility for disasters and infections. Using Cheltenham fully will also mean patients are treated faster ensuring minimal complications, quicker recovery and better availability of Ambulances.		
50	The proposed solution in the Consultation Document appears sound.		
51	Service already good		
52	I believe it is essential to have emergency general surgery at two locations in the county ie Cheltenham and Gloucester.		
53	See my previous answer		
54	As mentioned on previous page		
55	As before		
56	Emergency treatment should be available at both hospitals. General surgery could be centred in GRH but both hospitals should be able to save lives.		
57	Much more favoured is spreading surgical procedures across the county's various community hospitals. It would also provide more centres of learning for the clinical staff.		

Please tell us what you think about our preferred option to develop:A ‘centre of excellence’ for Emergency General Surgery at Gloucestershire Royal Hospital.		Response Percent	Response Total
58	because of location personally I would prefer Cheltenham to have a unit too but accept the managements experience. However have they experienced as a patient/patients family having to travel from Northern parts of our county?		
59	As for Acute medicine, access to multidisciplanry team and equipment		
60	Makes sense to specialise		
61	According to the Royal College of Surgeons ""Patients requiring emergency surgical assessment or treatment are among the most unwell patients in the NHS. Often elderly, frail and with significant other health problems, the risk of death or serious complication is unacceptably high."". This means the increasing unacceptable the risk to patients of making them travel from east of Cheltenham travel through the town and a further 10 miles to GRH		
62	It makes sense to concentrate expertise at one hospital, and GRH has already road tested this approach.		
63	As mentioned this sort of service MUST be available at both hospitals. Frankly I do not understand why it should ben centred at one hospital. It appears to be a cost cutting ploy		
64	will it mean no surgery at other hospitals and will they then be less of a centre of excellence. Assume not so need care with wording and implications		
65	Forerunner to removing emergency from Cheltenham		
66	For my reasons under Acute Medical		
67	See my previous answer. All Emergency services should be excellent. The fact that many who come aren't emergency is another matter and requires more education and awareness raising to also not put those off that really should seek emergency help.		
68	There should be 2 full A&E services. Cheltenham should be full A&E not just sprained wrists.		
69	Having all your 'specialist' staff in one area may be better and more cost effective for you but as always it's the patients who suffer. Traveling to and from Gloucester is not easy for those without their own transport. Even if the patient is transported to Gloucester by ambulance, once discharged they have still got to find their own way home, probably still feeling very unwell. They may not have friends with a car or have sufficient funds to cover the cost of a taxi, which leaves the bus, if it is running and if it is not full - not very good for infection control following surgery. There is also historically a poor reputation for infection control at GRH. I would not feel confident going there for anything serious.		
70	Concentration of key resources in one place to reduce duplication and wastage.		
71	It is a good idea, except again that as we are on the edge of the county Gloucestershire is further away		
72	As above		
73	GRH simply does not have the capacity with all of the counties A/E cases medical & surgical. the ICU is only rated good & has poor patient flow due to lack of beds in the service. CHG has the beds, the staff, the theatre space & an outstanding CQC rated ICU. emergency surgery has been carried out at CGH with excellent outcomes & no compromise to patient care. keeping everything at GRH simply isn't the safest or the best outcome for the patient. east side of the county considerably at a disadvantage		
74	Smaller A and .e with nurse practitioners would lessen the load on the big hospitals		
75	Again, it makes sense to have one very well equipped and staffed hospital rather than 2 close but less well resourced units		
76	Right to co-locate this with the A&E centre of excellence.		
77	Yes but the risks of additional transfer time for patients. Waiting times are already considerably higher. Can this be mitigated by keeping 'much less urgent cases away'? Strain on Ambulance Service. How does this all impact the other Gloucestershire Hospitals?		
78	Benefits patients outcomes to have a centralised service, that will strive to become the centre of excellence		

Please tell us what you think about our preferred option to develop:A 'centre of excellence' for Emergency General Surgery at Gloucestershire Royal Hospital.		Response Percent	Response Total
79	The key word is Emergency. All emergencies should be treated as close as possible to the point at which the emergency was recognised. Unnecessary travel is best avoided and may introduce stress to the detriment of the patient.		
80	Travel visiting and carers		
81	As I live in the northern tip of Gloucestershire, the extra distance to Gloucester for many of these services worries me		
82	Mocking all emergency services to GRH site logical I terms of collocation and impact on ambulance services		
83	It is important to have have the acute services on one site so people can receive the emrgency care they need quickly and easily		
84	Separate emergency services from elective services completely		
85	Please see my comments on the previous section regarding capacity and my support of the proposal IF the level of service is maintained to ensure that full and effective delivery, commensurate with the population of the area, can still be provided (or this proposal makes the service delivery more efficient).		
86	Better to have emergency care in one place with a full team of experts . Planned surgery can then take place at Cheltenham		
87	Why should we have a hospital in our town but only offering limited services		
88	Same as previous question - it's creating an even greater imbalance in the emergency care at the two hospitals.		
89	Essential for the county		
90	This leaves too much dependancy on the Ambulance Service to deliver services in a timely manner. It seems ludicrous to have ambulances criss crossing the county with all the attendant traffic delays that seem to be on Gloucestershire's roads. Are there any Service Level Agreements iwth the Ambulance Serviced to ensure timely tarhgets are met. What happens if (as seems to happen often) there is no availability of ambulances.		
91	One would hope a centre of excellence would deal with patients quickly - I am aware of patients who feel the waiting time is too long and go aboard / different county for treatment and often end up worse		
92	Gloucester closer to M% for post accident care and emergency admissions		
93	Agree with any proposal to avoid unnecessary duplication		
94	Emergency general surgery should be available at both hospitals		
95	It seems sensible and more cost effective to centralise services		
96	The current system, with surgery at both hospitals, is better for anyone who: has money issues lacks transport has complex needs of any type I understand the desire to group services together for the NHS' logistical sake, but for anyone who struggles, in any way, being themselves in another town or having their loved ones in another town creates complications and unhappiness as mentioned in my previous answer. By doing this, you prioritise those with money, time and head space to cope with these extra complications, and disadvantage anyone who struggles in any way.		
97	A centre of excellence at Gloucester Royal would detract from the service at Cheltenham General		
98	Anything that improves capacity, reduces cancellations must be good. I prefer option 2		
99	Reducing waiting time, planned surgeries that are preformed on time contributes significantly to the health and wellbeing of patients and their families reducing stress and unnecessary waiting times		
100	Lessen impact on planned surgery		
101	Again, although this would be less convenient in respect of a present home the benefits would seem to outweigh the convenience		

Please tell us what you think about our preferred option to develop:A ‘centre of excellence’ for Emergency General Surgery at Gloucestershire Royal Hospital.		Response Percent	Response Total
102	This presumably will ensure connection with acute medical care		
103	As with all your proposals to centralise services the problem is that of access for patients and their families. Whilst many have access to private transport a very large minority do not and they are frequently the elderly and less financially secure. For these people centralisation poses a major difficulty in accessing your services unless you propose to offer free transport between the sites. Even for those with private transport difficulties in accessing parking at iether site pose difficulties and high costs.		
104	As previous question.		
105	Glos Royal needs to improve.		
106	Pressure eased on gaps in surgery and better for consultants and trainees. Shorter waiting and being messed about.		
107	As previous		
108	Specialist staff and equipment in one location. Saves on time and money.		
109	As stated before about transport links.		
110	Same as Acute Medicine comments Experienced qualified staff centralised More opportunities for shared learning and research Intensive care facilities on one site High tech imaging facilities...		
111	Because it makes best use of all resources		
112	The other options are more suitable		
113	Being seen by the right specialist, not going through several appointments and being re-directed		
114	Gloucestershire royal already has good facilities and several operating theatres with experienced staff		
115	Larger teams with a range of skills should give better outcomes.		
116	Good communications hub.		
117	If its an emergency, the worry is that you would arrive at CGH and time would be wasted going to GRH because its 5:55pm.		
118	Quicker, more direct access for patients to the right specialist. A 'centre of excellence' will be an attractor for young doctors. Concentration of the right staff cover. Concentrated and improved learning opportunities for junior staff. However, resources, including beds, nursing staff and theatres, will need to be increased at GRH accordingly.		
119	I would fully support the concept of Centre's of excellence for all the reasons documented in your summary document ' Fit for the future'		
120	I do not think that Gloucestershire Royal is a large enough site and believe that patients should have the option to choose which hospital they are treated at and I believe the system works as it was before the shake up of services due to the Covid pandemic. It is blatantly clear that GRH cannot cope with being the only 24hr A&E unit as evidenced by the numerous complaints and concerns that have been raised about this.		
121	Again only if you will continue to have services available at Cheltenham Hospital		
122	We prefer Cheltenham - see page 37 My wife and I are in our 90th year. She is not allowed to drive. I prefer daylight and not Mon or Friday. We live in Tetbury and wish treatment there. So: We prefer Cheltenham and do not like Gloucester, the former being easier for us to reach by car and more convenient in terms of other activities on the day.		

Please tell us what you think about our preferred option to develop:A ‘centre of excellence’ for Emergency General Surgery at Gloucestershire Royal Hospital.		Response Percent	Response Total
123	As above Because I live in Gloucester		
124	The facilities can be enhanced at less cost at this hospital		
125	Distance from North Cotswolds		
126	This would be a more efficient use of resources.		
127	Surely access to care should be of primary concern to a hospital? Any solution should not have a negative impact? I query your statistics? The positive benefit for this change is for the homeless and people fro deprived areas (why what is the number of these that have general surgery) You quote 25% of Gloucester are from deprived areas but how many of these have emergency surgery? What is the proportion from the deprived and homeless areas around cheltenham? The negative benefit is for 40% of patients! So you already know that 40% of your most vulnerable are over 65 and these are the people most affected? So you are negatively affecting almost half your patients?		
128	I can see the advantages of the proposal but I am concerned GRH's capacity to provide the capacity and service levels proposed.		
129	Again, involves removing important services from Cheltenham. Calling something a ""centre of excellence"" doesn't actually mask the fact that it's an excuse to cut services elsewhere.		
130	Central to county for all		
131	Unsafe, inadequate beds, chaotic, not essential to be on one site, worked very well on both sites. Poor bed flow inadequate ICU. Poor service for east side of county.		
132	Focus of resources on one site		
133	It makes sense to co-locate emergency medicine and surgery at GRH		
134	The creation of a General Surgery Centre of Excellence, would provide the best fit with Emergency Surgery. Therefore the first option.		
135	I would prefer to go to Cheltenham Hospital.		
136	Again Cheltenham should not be downgraded by taking away, not only medical beds but also the capacity to perform emergency general surgery. This will have adverse effects on the A&E, because patients will be directed to GRH, essentially downgrading Cheltenham A&E to a MIU. If I was pushed to decide on the two option - because I would not want Cheltenham to lose surgical services then I would choose the second proposal of making CGH a centre for pelvic resection etc.		
137	I like the idea of concentrating the expertise in a single location		
138	In line with acute medicine and A&E focus		
139	The risks mean that this should be with the Acute provision.		
140	Yes I would like this to stay in Gloucester I am bias I live just outside Gloucester I like the benefits to staff members and staff retention.		
141	As above Strongly support the idea of having 'specialties' at one of the two hospitals only.		
142	Better building and access		
143	Because of the increased local population both sites should be used.		
144	I don't think GRH has capacity now or planned		
145	A specialist unit such as this makes sense.		
146	These cases can develop for the Acute Medical Take, so continuity in treatment, assessment and rehab will flow more easily. Confidence for patient.		

Please tell us what you think about our preferred option to develop:A ‘centre of excellence’ for Emergency General Surgery at Gloucestershire Royal Hospital.		Response Percent	Response Total
147	For the same reasons as above To concentrate the necessary skills in the centre of the catchment area		
148	No General Surgery beds at 1 hospital could impact badly on some patients.		
149	As mentioned on the previous page, I am concerned about the perceived downgrading of Cheltenham. Gloucester is difficult to reach from the Fairford end of the county and parking is difficult. Also (as mentioned previously) it takes longer to get to GRH than it does to Cheltenham hospital and the travel time varies depending on the traffic on the A417 (particularly at the Air Balloon).		
150	Same as the comment on the first page. If I were requiring this service, the hospital location wouldn't matter, but the level of service would. If merging meant a world class service, then be difficult to argue against it.		
151	as per commentary in last page; fear over increase travel times		
152	I have no objection to the siting of specialist services on one hospital site. If this allows the particular hospital to improve its services in that field so much the better. I am, however, concerned that too much emphasis is being placed on GRH. This concerns me because I do not believe that GRH has the facilities or space to cope with extra work.		
153	If ALL emergencies are taken to Gloucestershire Royal Hospital it means the A&E Department at Cheltenham would no longer be a Type 1 A&E Department.		
154	Taking away this service from Cheltenham GENERAL hospital, where patients receive as the National Audit shows, good or excellent care, is a very short-sighted and poor decision. More patients will suffer and die needlessly because of lengthier travel to GRH. GRH will require to increase it's capacity of beds to cope with the extra demands. This will impact Cheltenham A&E department as surgical emergencies will be redirected to GRH. What sort of unit will CGH have then?		
155	Please note my previous comments the journey from FoD especially for older people is worrying and expensive. Hospital transport has failed badly and causing long delays in returning home. I am 90 years of age		
156	Look at the appointment systems and make the phone system shorter.		
157	see previous comment		
158	A centre of excellence is essential and you shouldn't spread your resources. The hospitals are close enough that no areas should be disadvantaged.		
159	It is probably best to divide the centre of excellence status for best use of available expertise		
160	Your second option		
161	Specialisation usually leads to higher quality service and the attraction of most able doctors		
162	always needed - Will specialist staff really be available or too busy elsewhere? How practical will this be or is sit just a hope		

Please tell us what you think about our preferred option to develop: A 'centre of excellence' for Planned Lower GI (colorectal) general surgery at Cheltenham General Hospital (CGH) or Gloucestershire Royal Hospital (GRH).				
			Response Percent	Response Total
1	Strongly support		46.44%	137
2	Support		33.90%	100
3	Oppose		4.07%	12
4	Strongly oppose		4.07%	12
5	No opinion		11.53%	34
			answered	295
			skipped	18

Please tell us why you think this, e.g. the information you would like us to consider (139)

1	If it means fewer cancelled operations and less disruption in the busy winter months then it has to be a good thing.
2	I would like Gloucester to be a better option for care, this should be improved so that its more viable than having to travel to cheltenham to visit people.
3	Or???? Which is it?
4	Again it would make sense to have all GI surger on one site as patients don't always fit nicely into one speciality . So, GRH.
5	You should be able to go to nearest hospital for treatment, staff should be split between the 2 hospitals if necessary so this can be done
6	If it's planned, why not just go to Oxford and build a bigger unit there?
7	Absolutely no way, Gloucestershire is way to big gloucester hospital can't cope with what services it so so provides, so sending colorectal patients to gloucester shouldn't happen. Cheltenham should keep all of the surgery especially colorectal.
8	I think it should be bk in Cheltenham
9	Unless there is a shortage of staff with the correct expertise I do not see why a single centre of excellence in Gloucester is a fair option for Cheltonians. It's a long journey and a real challenge for elderly patients - visiting and collection of discharged patients becomes far more challenging especially for those restricted to public transport.
10	There aren't enough staff to go around, so we need to make best use of those we have.
11	Planned care still requires experts and equipment, its unreasonable to expect the NHS to be able to fund this on two sites that are so close to each other
12	Based on my support for emergency care at Gloucester, presumably it would make room at Cheltenham for this area of non-urgent operations.
13	Silo'd services appear much simpler to locate on a single site.
14	Far too far away from Fairford to be a good option for patients from that town/area
15	Better than at Gloucester but improve parking
16	Gloucestershire Royal is the most modern of the two hospitals and parts of the Cheltenham Hospital are 200 years old and unsuitable for 21st century health care provision. The most recent blocks in College Road Cheltenham could be used to complement the services provided at the Gloucester base
17	As above
18	Planned surgery can be dealt either in cheltenham/Gloucester. But ideal would be in 2 different hospitals. so more cases can be conducted.

Please tell us what you think about our preferred option to develop: A 'centre of excellence' for Planned Lower GI (colorectal) general surgery at Cheltenham General Hospital (CGH) or Gloucestershire Royal Hospital (GRH).		Response Percent	Response Total
19	Main reason as before		
20	If some cases would follow on from an a & e visit it makes sense to have it where the larger a & e capacity is		
21	Cheltenham General should remain a major hospital together with great in the area		
22	CGH can do this just like they used to		
23	This is an 'either or' question without giving an opportunity to vote for either. It is nonsense.		
24	essential to attract good specialists and perhaps in time take on childrens so we dont have to travel to Bristol		
25	I would support this if CGH was the 'centre of excellence' for lower GI. But again not GRH. There are not enough beds at GRH for emergency surgery and planned surgery. If it was at GRH alot of planned surgery would be cancelled because the beds would get used up by Emergency surgery and medical patients. As alot of this is cancer surgery it needs to be in a hospital that is clean and where the Oncology service/support services are.		
26	Both hospitals should offer an equivalent standard of care		
27	Specialist staff in one place should mean collaboration in terms of quickly dealing with patient problems. Quick treatment/ diagnosis of Crohn's can reduce the need for surgery, less time off work and a better quality of life!		
28	A sensible rational approach		
29	Yes it soulnds fine but surely Gloucester Royal will want their own as well!		
30	As a sufferer in this speciality I consider it to be of great importance to provide the best possible service.		
31	I would support this to be at CGH.		
32	Both Cheltenham and Gloucester need to do general surgery, I was released from hospital in gloucester at 11.30pm and as I was taken there by ambulance I didn't have my car, thankfully I have a son that drives but many people would be stranded, I could of walked home if I had been taken to Cheltenham		
33	Combining the service will provide greater scope for subspecialist practice within colorectal surgery. Training will be enhanced and a concentration of resources including medical and nursing will make the service run more smoothly		
34	Diagnostics are ok at Cheltenham, but specialist surgery needs to be where specialist surgery is based...		
35	But Cheltenham would be easier because of my disability and needing wheechair accessible transport which cost more if I am required to go to Gloucester Royal		
36	Higher standards and expertise can be employed centrally		
37	Prefer Cheltenham for reason quoted earlier		
38	experienced good service/care at CGH		
39	But on both sites		
40	I support a centre for excellence.		
41	Again slightly confused as to the proposal here - a before/after diagram might have helped. Would support measures to cut risk of operations being cancelled at the last minute / being able to be seen/treated by the right person sooner. Again this needs balancing with the risks of insufficient bed spaces if centralised on one sight (e.g. county to the north of Gloucestershire. In addition there are the same travel concerns - if one is not well, coming by car may be the most practical method of transport, however unpalatable it may be. Hence adequate parking facilities are a must e.g. a dedicated carpark with more short term spaces say of up to 45 minutes		
42	Being able to have all services on one site is cost effective with equipment best outcome for patients if staff are experts		

Please tell us what you think about our preferred option to develop: A 'centre of excellence' for Planned Lower GI (colorectal) general surgery at Cheltenham General Hospital (CGH) or Gloucestershire Royal Hospital (GRH).		Response Percent	Response Total
43	I agree with the center of excellence approach in principle. I think it will improve patient outcomes.		
44	I presume GRH would be a spoke and therefore provide back up.		
45	The relevant proposals in the Consultation Document appear sound.		
46	Need specialist services		
47	It is probably more efficient to concentrate resources at one dedicated hospital.		
48	Cheltenham is quite far enough for us to travel		
49	With elective surgery the distances to either hospital are manageable and can be planned. It the A&E that needs to remain available at both sites.		
50	As before		
51	GI is already at CGH why change it, rather expand on it		
52	As above		
53	Personal preference Cheltenham but would support either or shared		
54	seperating emergency from planned services should prevent cancellations and create the right number of beds for the planned procedures. Co-locating with other pelvic services makes sense as I suspect they often need to work together		
55	I accept it is no longer practical/affordable to have all specialisms at both sites		
56	Again, this is about providing the best patient service by locating staff at one centre.		
57	Again have services available at both Cheltenham and Gloucester		
58	dont know enough about this problem but previous comments would apply		
59	We need to establish strong bases in Cheltenham. Naive perhaps to suggest centres of excellence should be visible fairly equally in both hospitals, but there could be a tendency otherwise for one of the two (probably CGH) to have lesser standing, lesser research/funding potential		
60	Don't understand. Talking jargon.		
61	If it is planned surgery the patient will have had time to plan how they will get to and from the hospital, and anyone who wishes to visit can factor the distance into their preparations. There is still the question of the exorbitant parking fees on the GRH site. Although CGH also charges stupidly high parking fees, Cheltenham based patients being treated in Cheltenham and their visitors might not need to use their cars and could avoid these phenomenally high charges. There is also historically a poor reputation for infection control at GRH. I would not feel confident going there for anything serious.		
62	Concentration of key resources in one place to reduce duplication and wastage.		
63	It is a good idea, except again that as we are on the edge of the county Gloucestershire is further away		
64	this will allow the trust to develop a service which will be second to none. it will link in with gynae / urology & a centre of excellence for oncology too. the bed flow / capacity is there. CGH has an outstanding ICU and staff who are specialised in pelvic surgery to provide excellent care. patient flow & discharge will improve. patients will get an improved service so not mixed with emergency care & can maintain a green site especially if future pandemics as per recommendations		
65	Again, it makes sense to have one very well equipped and staffed hospital rather than 2 close but less well resourced units		
66	One world-class centre looks ideal to me.		
67	As per previous comments		
68	Good to have a centre of excellence. Attracts staff and makes good effective use of both equipment and staff.		

Please tell us what you think about our preferred option to develop: A 'centre of excellence' for Planned Lower GI (colorectal) general surgery at Cheltenham General Hospital (CGH) or Gloucestershire Royal Hospital (GRH).		Response Percent	Response Total
69	Personal experience of my life being saved this last May when admitted through A&E at CGH with Fournier's disease for immediate operation to deal with gangrene and sepsis from infected scrotum.		
70	Same reasons do not oppose a centre of excellence for Gloucestershire but do oppose strongly the lack of operations at either hospital		
71	Again the principle of centres of excellence is a good one - I would site it at the most appropriate site - if other planned surgery is at CGH then this should be there too		
72	It doesn't matter which site, so long as the service is there and available.		
73	Obviously to split up centre of excellence means less pushing people from one A&E to somewhere everything is not to hand		
74	I can't support that being at Cheltenham since you're proposing it in exchange for an inferior emergency service.		
75	ensure up to date medical procedures are available		
76	Planned surgery at least gives patients time to make suitable travelkarrangements		
77	Pros and cons here but overall would support		
78	Agree with any proposal to avoid unnecessary duplication		
79	CGH would be the better location		
80	Again it seems sensible to centralise resources and staff		
81	Please bear in mind any treatments taken prior to appointments which may make a long journey very difficult		
82	I can't find any notes on the current vs planned systems for this, but if you mean ""all services being in EITHER CGH or GRH"" then my previous comments apply!		
83	We would prefer this service to be available at Cheltenham where my husband had excellence care		
84	As above		
85	Centre of Excellence required at both hospitals		
86	The proposal would seem to make more effective use of staff and facilities		
87	Planning the priority for hospitals makes sense		
88	As with all your proposals to centralise services the problem is that of access for patients and their families. Whilst many have access to private transport a very large minority do not and they are frequently the elderly and less financially secure. For these people centralisation poses a major difficulty in accessing your services unless you propose to offer free transport between the sites. Even for those with private transport difficulties in accessing parking at iether site pose difficulties and high costs.		
89	Likely to dilute service and so negatively impact patient outcomes.		
90	Confused!		
91	Not sure about this as people from the Cotswolds need the nearest place yet Gloucester is better for people from that area.		
92	Single centre would be preferred.		
93	Focussing a specialism in one location makes the most sense providing value for money.		
94	A good way ahead.		
95	Same comments Experienced qualified staff centralised More opportunities for shared learning and research Intensive care facilities on one site High tech imaging facilities...		

Please tell us what you think about our preferred option to develop: A 'centre of excellence' for Planned Lower GI (colorectal) general surgery at Cheltenham General Hospital (CGH) or Gloucestershire Royal Hospital (GRH).		Response Percent	Response Total
96	A single centre makes best use of sataff and resources		
97	COE will benefit Patients and Staff, and make effective use of existing resources		
98	Often have to go to Cheltenham for appointments so makes sense to do it at Cheltenham		
99	Not qualified to judge.		
100	If its excellent, who cares where it is?		
101	Concentration of a specialised team and the necessary resources.		
102	Would prefer this option to be at Cheltenham General Hospital		
103	Near both		
104	If it is at GRH		
105	This hospital specialises in this area		
106	Again, it must be best to have all the specialists in one location.		
107	Centralising upper GI seems to have been beneficial, presumably the same will happen with colorectal.		
108	In this case, though I'm based in Cheltenham, this would again seem to be downgrading services to be only available at one location instead of at 2.		
109	Not central to county. Parking nightmare, travel time - hours away		
110	Available beds, less likely to be cancelled calmer safe green site. Excellent ICU linked to essential other services to make centre of excellence. Oncology onsite national recommendations.		
111	Focus of resources on one site		
112	Need to locate the planned specialties into CGH if emergency medicine and surgery are going to GRH		
113	I am a strong believer and advocate of specialised services at one hospital, my choice is Cheltenham General Hospital.		
114	At Cheltenham		
115	Both are GENERAL hospitals, and as such should have the capacity to offer these services at both sites. But if I was to choose, based on my previous answer, it would make sense to have planned lower GI general surgery at Cheltenham to match with the idea of making it a centre for abdominal and pelvic surgery.		
116	Again, I like the scntre of excellence approach and likelihood of fewer cancellations		
117	Public perception and access focused at one hospital for one type of heath issue		
118	A centre of excellence would be good for everyone!		
119	I think there would be lots of advantages to keeping all the planned lower colorectal general surgery in Gloucester. Everything and every member of staff present.		
120	As above Strongly support the idea of having 'specialties' at one of the two hospitals only.		
121	As above Better building and access		
122	It needs to be Gloucester for access from the forest of dean		
123	In all cases time must be allowed to talk between medical staff and patients. Sufficient staff levels should be attained 24/7 of 'centres of excellence' comes into being.		
124	To help spread skills to other major assets		
125	It would help provide rotas for the appropriate surgeons.		

Please tell us what you think about our preferred option to develop: A 'centre of excellence' for Planned Lower GI (colorectal) general surgery at Cheltenham General Hospital (CGH) or Gloucestershire Royal Hospital (GRH).		Response Percent	Response Total
126	Again, I understand the logic but I hope Cheltenham will not be downgraded. However, I do understand the issues raised in the booklets about staffing.		
127	Strongly support PROVIDED that site is Cheltenham		
128	Makes more sense to be at Cheltenham.		
129	As previous questions. But I have had fantastic service and a colorectal resection at GRH. This started with the Bowel Cancer Screening at Stroud Hospital, and two operations at GRH, with follow up care. The care and dedication of all the staff at GRH has been exemplary, and I am so grateful to them! Of course if CGH was chosen, as long as the staff moved also, then the service would be just as excellent. A slight fear I have that when I think merge and provide an ever better service', the accountants hear 'merge, provide the same service, and cut costs'. The latter really would be a betrayal of trust.		
130	lose of this type of surgery would result in doctors/other specialists relocating hence would be unable to support A&E dept		
131	I would not support the concentration of services on one hospital site if that led to, for example, a reduction in consultants at CGH which would eventually put the future of services at that site in question		
132	General Surgery is not really a 'surgical specialism', as it relates to many different conditions. In order to justify centralising General Surgery the Hospital Trust appears to be attempting to redefine it as a specialism relating only to colorectal surgery.		
133	Cheltenham already has the Cancer Centre so it would make sense for it to have the above service.		
134	See my previous answers on GRH but more so to travel to CGH. My wife is desabled hospital transport is a joke. I wrote to MP Mark Harper about this. I pay for transport and it is expensive		
135	CGH has always been a centre for excellence for this surgery - let it stay so!! Don't change		
136	The plan seems to be to downgrade Cheltenham GH despite the wide catchment area and substantially increased population in the rural parts of North Gloucestershire		
137	Parking and the use of public transport enabling the general public to use buses from Waterwells through to GRH		
138	CGH is the preferred option		
139	To build expertise at CGH for this speciality		

In supporting our preferred option to create a single site 'centre of excellence', where do you think a 'centre of excellence' for Planned Lower GI (colorectal) general surgery should be developed?

		Response Percent	Response Total
1	Cheltenham General Hospital (CGH)	48.14%	142
2	Gloucestershire Royal Hospital (GRH)	22.37%	66
3	No opinion	30.85%	91
		answered	295
		skipped	18

Please tell us why you think this, e.g. the information you would like us to consider: (155)

1	A strong case has been made for both. On balance I think CGH.
2	I would like Gloucester to be a better option for care, this should be improved so that its more viable than having to travel to cheltenham to visit people.
3	Crucial item for me is that there is an equal balance between what is in Cheltenham and what is in Gloucester....with equal numbers of essential services in each. It must not be Gloucester is the centre with bits in Cheltenham
4	I believe that no one site can cope with providing the service for people who usually attend two sites. The waiting times increase, the staff are stretched and patients feel that they are suffering as a result. Gloucestershire is too big to have one site for a speciality.
5	As above so the specialists are on one site , can cross cover be available.
6	Just because it is the nearest hospital to where I live, I should imagine anyone living near to Cheltenham would choose the Cheltenham one as their option
7	Why should people from Cheltenham go to Gloucester when they can go to Oxford? If it's planned...
8	Both hospitals should have their own colorectal services.
9	Both should offer excellence I don't agree with either/or as the geographical region is huge and large populations will be disadvantaged. Surely these services should already be offering excellence or is this an acknowledgment that you are currently offering sub standard services?
10	Elective and CGH and emergency at GRH
11	CGH should be the site for all planned activity
12	Oncology centre.
13	Oncology
14	I think that the 'reputation' of Cheltenham Hospital needs to be preserved if emergencies go to Gloucester, even if in a new way, so putting excellent planned operations in Cheltenham would be good.
15	I don't support your preferred option at all
16	Calmer atmosphere. Better patient experience.
17	Is Great Western Hospital Swindon a better option for those living on The Cotswolds, perhaps a joint venture with Glos NHS
18	As above, the premises at Gloucester are superior and those at Cheltenham have fallen way behind. In my view Cheltenham should have constructed a new hospital to replace Cheltenham General in the hospital building boom of the 1990s and early 2000s when a large number of towns and cities constructed new hospitals, such as Worcester, Swindon, Birmingham, Stratford -on-Avon, Hereford, Taunton, etc, etc. Cheltenham missed out then and a new replacement for Cheltenham General is unlikely now
19	both sites.

In supporting our preferred option to create a single site 'centre of excellence', where do you think a 'centre of excellence' for Planned Lower GI (colorectal) general surgery should be developed?		Response Percent	Response Total
20	As this is intimately linked to gastroenterology (which is being focussed at CGH), it makes sense for this to be at CGH too.		
21	I have no views about which hospital should be the site - this is clearly a matter for the best use of resources - both physical and staff - and I am in no position to take a view on the information provided		
22	Don't like the single site option		
23	What CGH can do GRH can do the same		
24	we live in Stroud - now my son has transitioned into adult IBD services we have had infusions in GRH, consultant appointment in GRH and MRI in Chelt - the travel relatively easy for us so wherever means staff travelling less.		
25	As above		
26	Neither site should take priority.		
27	We have two major hospital sites in Gloucestershire. It makes better sense to have single site consolidated approaches to medical units		
28	I believe that you are wrong in trying to decide one place against the other hospital. Gloucester Royal is full to capacity and often difficult to reach because of its situation. The best solution would be to build a new hospital at Staverton and put any ""centres of excellence"" there. This idea, whilst not likely to ever be considered, would be a perfect solution. There is plenty of space at Staverton and the surrounding land. Sites at Gloucester and Cheltenham could be then be sold at a huge profit		
29	Cheltenham must be the planned care centre if the Emergency centre is going to work		
30	At present I am not familiar with either Hospital.		
31	My personal experience ,choice.		
32	Both need this		
33	Don't care as long as 24/7 type-1 consultant-led A&E services are restored at CGH.		
34	If the benefit of the emergency changes is to provide immediate subspecialist care why would you consider something different for elective patients? You propose to locate elective upper GI surgery on the same site as emergency surgery, it seems incongruous to propose that another group of general surgery patients should be treated differently. If the two sites could be staffed equally there would not be a need to change. You need to ensure that the level of cover out of hours for patients undergoing major colorectal operations is the same irrespective of their mode of presentation (emergency vs elective). Specialist nursing input eg stoma nurses, cancer nurses will be facilitated by being on the same site as emergency surgery. Will a unit on a separate site have sufficient patients to be a specialist ward or will it be overrun by other specialties? Would such an arrangement really enable specialist nursing care? How do the other components of the general surgery changes impact on colorectal surgery?		
35	See previous question		
36	For reason given previously		
37	As previous		
38	Surgical team availability. Easier to set up cell salvage, if needed during the oerations.		
39	To co-locate with urology and gynae-oncology. By taking elective lower GI from GRH space would be freed up for other needs.		
40	Only those involved with actually doing it and the rersource implications can make this decision. Whatever is done must take into account the time and travel implications for the whole County and the environmental impact.		

In supporting our preferred option to create a single site 'centre of excellence', where do you think a 'centre of excellence' for Planned Lower GI (colorectal) general surgery should be developed?		Response Percent	Response Total
41	At the moment, both CGH and GRH seem to have a Planned Lower GI general surgery facility. I think the decision on which location to invest more excellency should mostly be focused on statistic and medical opinion, such as estimated time of arrival from one location to the hospital; percentage of local and not local patients who come to the hospital; accessibility to the yard; transportation accessibility etc. While Cheltenham could be more easily accessible, in my opinion, GRH offers facilities on Upper GI general surgery, which could contribute to the treatment of exceptional patients who may need assistance with both.		
42	Ensure services are split more equally between sites & prevent all the eggs being put into one basket. If at Gloucester, could lead to capacity problems and there is only a finite amount of space to build on, if indeed funds can be found to pay for construction/re-figurement. By locating in Cheltenham, seems to sit/align with other services to allow a more wholistic treatment service		
43	Where the best service can be provided. Ensuring correct equipment, staff & space.		
44	I think it makes more sense to have surgical units for upper and lower GI surgery in one location		
45	Cheltenham is a significantly better run and more pleasant place to be than Gloucester. However, smaller hospitals such as Cirencester would be a welcome addition.		
46	Important that each hospital has the ability to raise its reputation by having a centre of excellence. It must be ensured that Cheltenham is not regarded as a second choice.		
47	GRH is currently too busy. I presume GRH would be a spoke and therefore provide back up.		
48	I have no relevant technical knowledge to offer an informed view		
49	Either would do.		
50	See above		
51	Wherever the space is available and where the necessary ancillary departments are. Which will have the capability to ensure bottlenecks do not occur - scanning, X-ray, theatres, outpatient capacity.		
52	As above		
53	personal preference only based on my location. Accept entirely that management team must consider a much wider criteria		
54	as previous question		
55	Hard to have an opinion unless you are a user		
56	Although my own experience has been of having colocrectal surgery at GRH, I think location for this is less important than concentrating the expertise at one centre.		
57	Keep both hospitals operating as hospitals for all services. This centre of Excellence "" concept"" is in my opinion RUBBISH. Stop pretending that you are offering a better service when you are diluting what is already available		
58	not qualified to judge which would be best. Access, free parking other facilities to fit around this would need to be thought through		
59	I understand that there can some crossover between Upper and Lower GI* and this suggests to me that collocating them would be wise provided that the is sufficient space and facilities at GRH. *Last year I had emergency Lower GI surgery carried out at CGH by an Upper GI consultant (excellent outcome!)		
60	As both centres do this now, just in terms of equalising the two hospitals as mentioned above		
61	GRH is a larger site, has better facilities and is more accessible for visitors. I have had surgery in CGH in the past and felt the facilities were poor and the care was lacking. It is also very difficult for visitors to find somewhere to park.		

In supporting our preferred option to create a single site 'centre of excellence', where do you think a 'centre of excellence' for Planned Lower GI (colorectal) general surgery should be developed?		Response Percent	Response Total
62	If it is planned surgery the patient will have had time to plan how they will get to and from the hospital, and anyone who wishes to visit can factor the distance into their preparations. There is still the question of the exorbitant parking fees on the GRH site. Although CGH also charges stupidly high parking fees, Cheltenham based patients being treated in Cheltenham and their visitors might not need to use their cars and could avoid these phenomenally high charges. There is also historically a poor reputation for infection control at GRH. I would not feel confident going there for anything serious.		
63	I live in Stroud and find it easier to get to GRH and easier to park the car.		
64	From our point of view it is nearer		
65	this will allow the trust to develop a service which will be second to none. it will link in with gynae / urology & a centre of excellence for oncology too. the bed flow / capacity is there. CGH has an outstanding ICU and staff who are specialised in pelvic surgery to provide excellent care. patient flow & discharge will improve. patients will get an improved service so not mixed with emergency care & can maintain a green site especially if future pandemics as per recommendations		
66	As I have mentioned, public views will revolve how location, for example, will affect the individual. CGH is closer to me than GRH so this is obviously my choice. That is naive and there are many many far more important factors that should determine the location. I really don't understand how public consultation on this matter assists the process.		
67	Most of the surgery might involve a cancer and Cheltenham is the cancer centre		
68	most of the issues are probably cancer related so it makes sense to put this in Cheltenham with the existing unit - although the buildings at Cheltenham are in dire need of refurbishment and modernising		
69	the main center for this type of surgery is already in Cheltenham - so why would you wan t to move it ?		
70	Don't really mind but feels appropriate to co-locate with the cancer (oncology) centre in Cheltenham. Nb. I have a family history of bowel cancer so take particular interest in this area.		
71	To make a decision about this, there must be many other holistic factors about the sites, capacity, etc which I am not aware of.		
72	Either site so long it is centralised at one or other site. It would be advantageous to have both upper and lower GI planned surgery at one site. Staffing and equipment availability should be considered.		
73	I am not fullt aware of the different skills between GRH and CGH but roughly would like to see a 50/50 spread of centres of excellence over the county's two leading hospitals.		
74	The emergency detailed above meant I had minutes to live, my kidneys had already failed . My family were called to the hospital soon after the operation as I was given about two hours to live. Living in Hewlett Road, Cheltenham meant a speedy access to A&E which ironically closed about a week or so later. If the timing of my illness had occurred two weeks later I would not be filling in this form.		
75	As above		
76	Having benefited from this excellent service, and still under their care, I would really like the service in Cheltenham to be bolstered. I live at the extreme Northern tip of the county, and Gloucester Hospital would have been a nightmare for family visits, and for me getting home from the multiple operations I have had. Given the fantastic care I had at Cheltenham, I would be keen for it not to be moved		
77	Ability to protect beds and theatre capacity		
78	Separate emergency services from elective services completely - Cheltenham must be the centre of planned excellence		
79	Again, it doesn't matter which site, so long as the service is there and available and ensure capacity and effective care for Gloucestershire residents. In my mind it would make sense to have a particular specialist treatment at both sites i.e. GRH is centre of excellence for XX and CGH is centre of excellence for YY. So that one or other site does not become defunct.		
80	Because should I or my neighbours need it, it is within easy reach for local transport. GRH in rush hour can take at least 1.5 hours		

In supporting our preferred option to create a single site 'centre of excellence', where do you think a 'centre of excellence' for Planned Lower GI (colorectal) general surgery should be developed?		Response Percent	Response Total
81	This closet to me and the family		
82	It makes sense for all GI (lower and upper) services to be in one hospital		
83	Care needs to be taken in assessing the user demographic to make a suitable choice. Ideally it would be in the centre of the most common user base.		
84	Greater diversity in Gloucester		
85	Gloucester seems the preferable site to develop. Far better access by public transport.... crucial for many people and their families		
86	Cheltenham and Gloucester hospitals should be equally recognised for their own specialisms and resources. Gloucester Hospital cannot have it all		
87	Obviously Gloucester is the closest to me, for same reason stated above. Cotswold residents would almost certainly disagree		
88	Obviously, given what I've said, I'd choose Cheltenham. Gloucester residents would presumably prefer it there!		
89	Which option is most cost effective		
90	Greater Diversity in Gloucester - some longer term health conditions higher with minority ethics Ease of access and family support as communities live close together		
91	There is an air of calm efficiency and care at Cheltenham General Hospital which leads to a more rapid recovery time whereas at Gloucester Royal Hospital I feel that the wards seem to be under more pressure.		
92	A good match with other services. Also seems too much at GRH which could lead to conflicts of staff time		
93	Both		
94	Ideal in respect of our place of residence		
95	As before; it is better not to centralise unless and until provision is made for transport between the sites. This is vital for the elderly and less financially secure. (Frequently these are the same.)		
96	Best for outcomes and workforce with limited negative impact on travel/access for those living east of Cheltenham.		
97	Either. But a Centre of excellence makes sense.		
98	Would keep at both		
99	If the majority of this department is located in GRH, it makes sense for all of it to be located at GRH.		
100	Better parking for staff and visitor options more mid way for Forest patient and visitors. Near to train links.		
101	A very confused layout that could be fixed easily.		
102	Quality of patient experience much improved if planned surgery is separated from emergency activity.		
103	Make effective use of existing resources		
104	Cheltenham should be the centre of excellence for all impatient planned care		
105	Very important to have separate sites for emergency and elective surgery for better patient experience and outcome		
106	Important to keep services separate for patient experience and outcome		
107	Better on-site facilities and car-parking at Gloucester. Not sure where there is adequate space in Cheltenham		
108	As above		
109	The department already exists together with the oncology unit at Cheltenham General.		

In supporting our preferred option to create a single site 'centre of excellence', where do you think a 'centre of excellence' for Planned Lower GI (colorectal) general surgery should be developed?		Response Percent	Response Total
110	Not qualified to judge.		
111	If its excellent, who cares where it is?		
112	Would seemingly make best sense to locate this at CGH to create a centre of excellence for pelvic resection; and to keep this surgery service entirely separated from the pressures of the Emergency General Surgery at GRH (as suggested in the consultation booklet)'		
113	I would support the decision made by those individuals directly involved in the provision of this service at both hospitals. Is that information available ? I assume that is being considered in any final decision and it would have a significant impact on any final assessment.		
114	Suits us better - see page 37 My wife and I are in our 90th year. She is not allowed to drive. I prefer daylight and not Mon or Friday. We live in Tetbury and wish treatment there. So: We prefer Cheltenham and do not like Gloucester, the former being easier for us to reach by car and more convenient in terms of other activities on the day.		
115	Gloucester is MUCH easier to travel to		
116	This hospital specialises in this area		
117	It is important not to concentrate every resource at one location, e.g. Glos, as this would increase the possibility of a single point failure.		
118	If you think upper GI surgery needs to be on the same site as emergency general surgery, surely the same should apply to colorectal surgery. If you are struggling to run the general surgery service on two sites at the moment why would you want to set a a service that continues to run general surgery on two sites?		
119	I don't support it		
120	Again central		
121	As above		
122	If the plan is to have the Day Case focussed at CGH it would seem to be sensible to have the rest of the GI provision on the same site		
123	see previous response		
124	It would be sensible to co-locate with other pelvic area specialists.		
125	Having experienced prostate cancer surgery at CGH, I know it is well placed with excellent Consultants and support staff to provide a first class service service.		
126	Cheltenham has a better reputation in area.		
127	I would like to know, that if you make GRH the centre for emergency general surgery, what would happen in the case of an emergency following a planned abdominal/pelvic operation at Cheltenham? Does that mean a patient would be transferred to GRH as it would be the hospital receiving surgical emergencies? Planned day cases may become more complicated and require emergency surgical intervention as all surgery comes with risks, that is why patients have to sign a consent form. Will surgeons operating on planned cases have the ability to care for patients who have a surgical emergency? Will they have the experience?		
128	I like the link with the gynae cancer treatment at Chetenham to form Pelvic Resection centre of excellence		
129	To align with the upper colorectal service at CGH		
130	All major General surgery located with acute services makes common sense.		
131	I think a centre of excellence, a single one would benefit the local and wider community by being situated in Gloucester.		

In supporting our preferred option to create a single site 'centre of excellence', where do you think a 'centre of excellence' for Planned Lower GI (colorectal) general surgery should be developed?		Response Percent	Response Total
132	Strongly support the idea of single site excellence for all and any hospital procedures		
133	Ditto Better building and access		
134	Its more central for Gloucestershire		
135	Which ever hospital has the space and facilities for development. CGH has very little space but other specialties can move. I leave to planning team!		
136	It would make the centre of excellence and help maintain Chelts specialism to attract staff.		
137	This is my biased opinion, as Cheltenham is so much more convenient to reach from the Fairford area.		
138	I know the GRH team are fantastic, but have had no dealings with CGH.		
139	north of zone seems to be where population will grow (housing plan) and south activity would likely be split between gch & new forest of dean hospital		
140	I am concerned that too much emphasis is being placed on GRH. This concerns me because I do not believe that GRH has the facilities or space to cope with extra work.		
141	If this is centralised on one site, it should be on the site where the existing Centre of Excellence for Cancer is based, because of the close relationship between Lower GI Colorectal Surgery and cancer.		
142	See above.		
143	I am willing to provide a contribution towards the cost of a new hospital in FoD. Monmouthshire Council I am sure would also contribute instead of having people travelling to Cumbran		
144	It doesn't make sense to have a centre for excellence across 2 sites but transport needs to be available and affordable for those that need it		
145	Seems like a lot of specialist services are at GRH so good to have this one at CGH		
146	It has always fulfilled. This need - leave it as it is		
147	See above		
148	More information about ones operations		
149	To fit in with the other related specialities at Cheltenham		
150	access to GRH is almost impossible for day patients and for visitors to in-patients if they reside in the north cotswolds		
151	Family orientated at Cheltenham and more friendly, smaller pods.		
152	So that centre of excellence status is not all centred at GRH		
153	Appears that more facilities are already there		
154	Prefer something at both sites		
155	Once again if only one centre and there are issues is there a back up service?		

Please tell us what you think about our preferred option to develop:A ‘centre of excellence’ for planned day case Upper and Lower GI (colorectal) surgery at Cheltenham General Hospital (CGH).				
			Response Percent	Response Total
1	Strongly support		37.29%	110
2	Support		36.95%	109
3	Oppose		5.08%	15
4	Strongly oppose		4.07%	12
5	No opinion		16.61%	49
			answered	295
			skipped	18

Please tell us why you think this, e.g. the information you would like us to consider (127)

1	Ring fenced facilities at CGH make sense to minimise disruption.
2	I would like Gloucester to be a better option for care, this should be improved so that its more viable than having to travel to cheltenham to visit people.
3	If there are enough surgeons to cover this service , my concern is if an emergency service is also working how will the oncology patients be managed in an emergency situation
4	I think it should be at both hospitals, leaving it easier for people to go to hospital nearest to where they live
5	Why go to Gloucester when you can go to Oxford?
6	Cheltenham and Gloucester should have their own elected and day surgery cases.
7	As per your previous question the region and population mean this is not an either/ or answer BOTH hospitals with their significant budgets should offer centres of excellence.
8	There aren't enough staff to go around, so we need to make best use of those we have.
9	If planned surgery is on the same site then you keep a cohort of skills in that location
10	As per previous answers - if Gloucester starts taking more of the emergency stuff, Cheltenham's position/prestige needs to be maintained for non-emergency stuff.
11	I don't support having only one centre for anything, given the size and demographic of Glos.
12	As before
13	It is obvious that some services will have to remain in Cheltenham for the time being as Gloucester is not large enough to accommodate them all
14	Why spend more money when there are already perfectly adequate hospitals
15	Prefer a surgical unit in cheltenham as it can take pressure away and enhance smooth running by carrying out more cases through which more profit is available.
16	In my view clearly better that this should be on one site.
17	Don't like the single site option, would like both hospitals to offer as many treatments as possible
18	Would these beds be ringfenced for day surgery and not have patients put in them overnight? as is the usual case.
19	Specialist equipment in one place, more efficient use of resources and specialist staff.
20	Rational, straight forward, clarity for patients in terms of where their care will take place.
21	Cheltenham is the obvious choice for the planned care centre
22	Very important to develop high quality standards whatever the length of visit or stay in a hospital

Please tell us what you think about our preferred option to develop:A ‘centre of excellence’ for planned day case Upper and Lower GI (colorectal) surgery at Cheltenham General Hospital (CGH).		Response Percent	Response Total
23	Really can’t imagine what day case GI surgery would entail .		
24	See first comment re planned surgery being able to go ahead without theatres being needed for emergencies.		
25	Both Cheltenham and Gloucestershire need this		
26	Don't care as long as 24/7 type-1 consultant-led A&E services are restored to CGH.		
27	Does this have potential to be expanded to include short stay patients? Many patients undergoing gallbladder surgery stay overnight. The same is true for patients undergoing colorectal surgery. Would a facility to accommodate these patients be better than pure day case? This might allow increased numbers of patients to have their surgery in CGH and help maintain a vibrant hospital. How do the other changes to general surgery affect the ability to deliver either day case or short stay services in CGH?		
28	Helps to manage an appropriate split between hot and cold sites		
29	Easy access and close to carers who need to visit me and don't drive		
30	Would require better facilities at Cheltenham general in my opinion hospital dated and tired in appearance		
31	I support the idea of one team on one site locally		
32	I think Cheltenham does deserve a comprehensive GI surgery facility as it is a reasonably large town which hosts national and international visitors every year. The capacity of the town to provide extensive health assistance, alongside Gloucestershire Royal Hospital would also likely relieve the stress sometimes found in waiting rooms. The availability could also assist patients who are needed to stay longer in the hospital under supervision, allowing the medical team to have sufficient equipment in the event of an incident or emergency. GI conditions can be debilitating at times and the circumstance of having to travel could risk worsening, especially if no preventative methods were ever applied in their case.		
33	Now very confused - how is this different to the previous two questions? Answers are as previous - support measures to cut last minute cancellations & being able to be seen & treated by the right person quicker. however this needs balancing with concerns over travel distance and reaching capacity at one site		
34	Proposals in the Consultation Document appear sound.		
35	As above		
36	As before		
37	Spreading scarce resources around the county is a preferred method.		
38	have experienced it and was impressed		
39	as before		
40	Biased. Nearer me!		
41	As per my previous answer. Concentration in one centre is the most important issue.		
42	see earlier comments		
43	previous comments will apply to this		
44	Have just received attention at Cheltenham and Gloucester.		
45	For planned day surgery it makes no difference to where I travel to within an hour. Parking seems much better at Gloucester.		
46	Although I support the idea of a 'centre of excellence', I do think that CGH needs some significant investment in order to become this and it's not the easiest place to travel to/park at due to the limited facilities. I like the idea of specialist care and if this is more readily available at CGH than GRH, then I am in support.		

Please tell us what you think about our preferred option to develop:A ‘centre of excellence’ for planned day case Upper and Lower GI (colorectal) surgery at Cheltenham General Hospital (CGH).		Response Percent	Response Total
47	As mentioned previously it is obviously better for those living in the Cheltenham area for as many services as possible to be fully delivered at CGH. There is also historically a poor reputation for infection control at GRH. I would not feel confident going there for anything serious.		
48	Concentration of key resources to reduce duplication and wastage.		
49	day case can be done either site		
50	As before		
51	as previous answer		
52	This is already in Cheltenham. I have had to use it and found it excellent.		
53	I like the emphasis of removing emergency from CGH so that all the planned can proceed without interruption by the obviously unpredicability of emergencies.		
54	Planned surgery in one location does make a lot of sense, as long as the wait times do not increase and also operations are not cancelled due to other factors.		
55	Good idea, for all the reasons previously given.		
56	But for day cases, there should be one at GRH as well.		
57	My personal experience detailed in previous page and previous personal observation of the Chichester Hospital whereas friend of ours son is a senior Consultant specialising in this area. He was able to advise my family on my predicament, which he only comes in contact with about once a year. I would like CGH to have this sort of level of skill set.		
58	Should’ve at both units if Gloucester hospital and Cheltenham hospital are Gloucestershire hospital service why not at both.		
59	Ability to manage beds and theatre capacity. Support to staff.		
60	Again you can develop excellence and proceess for suport services to create the ideal environment for this		
61	Separate emergency services from elective services completely - planned at Cheltenham		
62	So long as patients can access the location where their surgery is taking place.		
63	One hospital for emergencies and one for planned surgery. As long as the hospital for emergencies has enough OR.		
64	This is valuable facility essential for the area		
65	Seems sensible to keep upper and lower together - otherwise in the middle might slip through the space inbetween		
66	Staffing levels		
67	Agree with any proposal to avoid unnecessary duplication		
68	If planned centre of excellence for lower GI general surgery will be in Cheltenham it is only sensible for day cases upper and lower surgery to be there also		
69	See previous 2 comments		
70	See previous.		
71	The journey to Cheltenham from Winchcombe is far better than Gloucester Royal when you are unwell		
72	Too much dependence upon centralising services at GRH is, in my opinion a mistake. Gloucestershire needs to use its two mains sites fully		
73	As before - economies of scale vasically		
74	More convenient from a personal point of view		

Please tell us what you think about our preferred option to develop:A ‘centre of excellence’ for planned day case Upper and Lower GI (colorectal) surgery at Cheltenham General Hospital (CGH).		Response Percent	Response Total
75	As long as we know what we can expect from the two hospitals I think the sharing of responsibility for medical disciplines will ensure scrutiny		
76	As with all your proposals to centralise services the problem is that of access for patients and their families. Whilst many have access to private transport a very large minority do not and they are frequently the elderly and less financially secure. For these people centralisation poses a major difficulty in accessing your services unless you propose to offer free transport between the sites. Even for those with private transport difficulties in accessing parking at iether site pose difficulties and high costs.		
77	Key to this is ""Planned"" which increases Trust's capacity without negative workforce impact.		
78	Single centre of excellence preferred as above providing transfers are swift and well planned.		
79	Transport to CGH needs improvement		
80	Same comments as planned general surgery Experienced qualified staff centralised More opportunities for shared learning and research Intensive care facilities on one site High tech imaging facilities...		
81	Separating Planned surgerty will reduce cancellation and improve patients waiting times		
82	As stated		
83	Fewer last minute cancellations and better throughput.		
84	Not qualified to judge.		
85	Concentration of expertise and dedicated staff in one location will improve patient care and efficiency.		
86	I support the basis of 'Centres of Excellence' and would assume that the decision to base a particular function at each hospital is based on building up the core competency that already exists at the chosen hospital		
87	I think further investment in CGH is very desirable		
88	N/A		
89	This hospital specialises in this area		
90	As there may be possible overlap between the two treatments it would be best if there were all located in the same site.		
91	If I need my gallbladder removed with an overnight stay would I be able to have this done in CGH?		
92	Why not at both, this involves improving Cheltenham at the expense of Gloucester		
93	Not central to county		
94	Not essential on single site		
95	See previous comments		
96	Need more emergency slots at GRH, ambulances queuing		
97	keeping planned activity in CGH if emergency services are going to GRH makes sense		
98	Reduces the potential for cancellations due to emergency surgery		
99	I think it is a good idea to separate out the emergency and planned cases, so having the day cases all at CGH makes sense along with other planned general surgery and the emergency cases in GR.		
100	If you have the best and most experienced medical staff at one hospital site, it follows they can provide the best medical outcome.		
101	Cheltenham has a better reputation.		

Please tell us what you think about our preferred option to develop:A ‘centre of excellence’ for planned day case Upper and Lower GI (colorectal) surgery at Cheltenham General Hospital (CGH).		Response Percent	Response Total
102	I cannot understand why all this has to be divided up, it is quite complicated.		
103	GPs' recommendations		
104	Alll skills and staff for GI health issues in one location. Single point of contact in Trust for GI		
105	On the focus of Cheltenham General Hospital as an elective centre this fits well. The pelvic centre of excellence with the arthroplasty, gyno and urinary would all work well together although it may reduce the General Surgery pool slightly at GRH.		
106	This would work well because it is planned surgery instead of emergency surgery. Not so much of an issue around transport and time scales		
107	As above Strongly support the idea of single site excellence for all and any hospital procedures		
108	Makes sense to spread workload		
109	Because of the increased local population both sites should be used.		
110	It needs to be Gloucester more central for Gloucestershire.		
111	Which ever hospital has the space and facilities for development. CGH has very little space but other specialties can move. I leave to planning team!		
112	To centralise the entire colorectal skills		
113	Help develop skills of junior surgeons and provide good support for them.		
114	Cheltenham is easy to reach. Also, my husband has been treated in Cheltenham for bowel cancer and an emergency hernia and I was very grateful for the good treatment.		
115	What does 'centre of excellence' mean? This is a ridiculous phrase. Who wouldn't want a centre of excellence. As opposed to trying to frame the question for your desired answer, you could try phrasing it the question in more balanced way. E.g. admitting that it means focussing resources and personnel in one or both of the sites, so those taking the time to engage with your questionnaire, do not feel manipulated.		
116	Same as previous answers really. However, although the sites are close, transport links between them should be free, and green. A sort of very frequent campus type shuttle, perhaps with a couple of pick up points en-route.		
117	if there does need to be service better where county housing plan will put most new housing/greater need.		
118	I have no objection to the siting of specialist services on one hospital site. If this allows the particular hospital to improve its services in that field so much the better and consider that GRH is already overloaded.		
119	It makes sense to focus planned surgery on one site, but this should not only be ""planned day case"", it should also include more complex elective surgery and not merely 'day case surgery'.		
120	Cheltenham already has this function so it would be sensible to maintain this service.		
121	See my previous comments. This is a bad decision and the people of the forest of dean and Monmouth deserve better.		
122	It is very good as is		
123	N/A		
124	Keep Upper GI at Glos		
125	CGH is convenient GRH is useless for day patients		
126	Yes for centre of excellence and yes for Cheltenham.		
127	Helpful to split areas of excellence		

A 24/7 Image Guided Interventional Surgery (IGIS) ‘Hub’ at Gloucestershire Royal Hospital and a ‘Spoke' at Cheltenham General Hospital.				
			Response Percent	Response Total
1	Strongly support		35.43%	107
2	Support		34.77%	105
3	Oppose		7.62%	23
4	Strongly oppose		5.63%	17
5	No opinion		16.56%	50
			answered	302
			skipped	11

Please tell us why you think this, e.g. the information you would like us to consider (123)

1	I support this on the basis that fewer people would need to travel outside of the county for treatment. We need to start thinking 'Gloucestershire' when considering these matters. If people are having to travel further beyond county boundaries then it makes sense to centralise some services here. That said, good to see there would be an IGIS spoke at CGH to support specialties there.
2	I suspect more money has gone into coming up with the terms / logos for hub and spoke than into IGIS. Both places should be equal and more money should be invested and the CCG shrunk to release the funds.
3	Image guidance needs to have services in both locations
4	both hospitals should have it
5	Makes sense as the oncology services are at Chet=ltenham so would need support
6	I think it should be at both hospitals so people can go to hospital nearest to where they live
7	Extreme nature of emergency IGIS means the time delay going from Cheltenham to Gloucester would be far too risky re. loss of life to a patient who may, for example's sake, live just across the road from CGH.
8	Centres of excellence should be at both hospitals!
9	Assuming this fits with the 'Gloucestershire emergency / Cheltenham planned' route, this makes sense, if this IGIS work is used a lot in emergency situations.
10	Grudging support since something will be offered at both sites
11	Cheltenham or Swindon
12	This is a very important part of present and future health care and will greatly increase in the coming years
13	Any
14	On balance on the information provided GRH seems the more appropriate site
15	Reluctantly support, again would like both hospitals to offer as many treatments as possible
16	Heart attack patients need treatment at closest hospital this would be better than using Bristol but should be available on both sites
17	what ever GRH can do Why cant CGH do the same
18	espensive kit and specialist staff - makes no sense to try and run 2 sites
19	As vascular and cardiology are at CGH then this service needs to be based on this site.
20	Need this to be on two sites to ensure no delay in treatments
21	In view of the distances patients are required to travel, I strongly support this proposal
22	Image Guided intervention main hub should be alongside ED

A 24/7 Image Guided Interventional Surgery (IGIS) ‘Hub’ at Gloucestershire Royal Hospital and a ‘Spoke' at Cheltenham General Hospital.		Response Percent	Response Total
23	Both hospitals need this		
24	Don't care as long as 24/7 type-1 consultant-led A&E services are restored at CGH.		
25	Best located with the main emergency work		
26	It's a rational use of limited resources. Concentration of specialist people, and specialist kit, absolutely makes sense, and research shows that it produces better outcomes.		
27	This will reduce the need for patients travelling out of count out of hours and increase the ability to recruit high quality staff		
28	Reasons given previously		
29	Such specialised intervention should be centralised		
30	The way ahead if all the needed skill sets are in place.		
31	This would presumably mean that there could be more appointments available.		
32	I think investing in IGIS is a fantastic action. To my understanding and experience, IGIS provides an alternative to what could be a very invasive surgery and allows patients a safer and quicker recovery. It seems to me that it is something that should be evaluated to possibly be instigated in other areas of the country, if they so need it.		
33	Being a more modern hospital having the hub in Gloucester makes sense		
34	Appears to be specialist treatment needing expensive specialist equipment operated by experts. Given this seems better to centralise as one service - some people may travel a little further but far fewer would need to travel out of county at evenings/weekends. Going to hospital unexpectedly (or even planned) is not a good experience so removing a longer journey with some of the complications this can lead to seems a beneficial step		
35	Need more info on this reason, ie is it staff, facilities or something else?		
36	I believe it is good to have different hospitals with different specialisms. This will also promote inter hospital information exchange. I presume Cheltenham would be a spoke and therefore provide back up.		
37	Prposals in the consultation document appear sound.		
38	Should have equal amounts at both hospitals		
39	In the AI age this can be shared between both hospitals		
40	seems sensible in view enormous cost of equipment		
41	updating equiment and locating in one site is more cost effective		
42	As long as the tech is good enough this is fine. But the tech has to be up to this task		
43	see earlier comments		
44	Imaging is already at Cheltenham, why move		
45	This makes sense. I assume the Spoke would deal with geographically favoured patients who are nion urgent		
46	I am not sure why it is that CGH always seems to get the second best option of anything being considered, but as I have not needed treatment of this type I am not in a position to make further comment.		
47	Concentration of key resources to reduce duplication and wastage.		
48	it would be good if people could go to the nearer one if possible		
49	with major pelvic surgery we need interventional surgery which will also tie in with oncology		
50	More central for the county		

A 24/7 Image Guided Interventional Surgery (IGIS) ‘Hub’ at Gloucestershire Royal Hospital and a ‘Spoke' at Cheltenham General Hospital.		Response Percent	Response Total
51	Would prefer all in one place to maximise use of resources but accept probably a need at Cheltenham for a smaller unit in support of other services based there		
52	Centralised approach is good. The equipment needed to undertake these investigations are often expensive, particularly the imaging equipment. Staffing levels are often difficult to maintain and are often difficult to recruit. State of the ark equipment will help to attract highly trained staff.		
53	It is unclear to me what the difference between a Hub and a Spoke in this context. The best of treatment should be available in both locations.		
54	Interesting to see the hub and spoke concept. Will this leave the hub as a centre of excellence? Can there be other spokes such as Forest of Dean or smaller hospitals such as Cirencester?		
55	It depends what you mean by Spoke.		
56	Should be at both		
57	Help with recruiting and developing a centre of excellence good for population of Gloucestershire		
58	This set up should be in the best site for the overall plan. IGIS is an increasingly import part of urgent clinical care so it makes sense to create a hub and spoke approach.		
59	I have put 'oppose' because I feel neutral about this proposal (so I do have an opinion but not either way at the moment). My reason is as follows: as long as patients attending both have the same access to the surgery/treatment they need e.g. so that those patients attending a non surgical centre are not disadvantaged by this model/proposal.		
60	essential facility important for the community		
61	Probably necessary due to availability of technology and equipment.		
62	Reducing risks and stays in hospital and manual intervention is always good. Anxiety of carers and family is minimised as patients return home quicker		
63	Important to rationalise and make optimum use of very expensive and latest equipment		
64	Staffing levels		
65	Agree with any proposal to avoid unnecessary duplication		
66	Provided the spoke at Cheltenham is accessible and operational		
67	See previous		
68	We have the excellent cobalt centre in Cheltenham		
69	Makes sense to have a provision at both sites and reduce need for out of county travel by patients		
70	Often with services / treatments there is a lot of confusion where to go Cheltenham or Gloucester? a centralised hub offering as much as possible at one place would provide a ""comfort zone"" for the patient without having to travel to different places. Doesn't have a feeling of disconnect		
71	This could have been a centre for excellence in cgh ?		
72	We've invested in Cheltenham already, make Cheltenham the Hub.		
73	Seems to make sense		
74	This is a very specialised service and heavy on equipment costs so centralisation makes sense.		
75	Bringing the hub into one location makes sense, as staff and equipment can be focussed on one place not split over two sites.		
76	Good choice based on current buildings		
77	It is more effective to provide a hub at GRI but a spoke allows more freedom for management		

A 24/7 Image Guided Interventional Surgery (IGIS) ‘Hub’ at Gloucestershire Royal Hospital and a ‘Spoke' at Cheltenham General Hospital.		Response Percent	Response Total
78	This Provide the Best Option - and will mean patients can be seen locally.		
79	Less likelihood of being transferred to other hospital sites. Retention of staff is pararmount		
80	Availability re transport and parking for patients and carers		
81	There should be one main centre as this should lead to improved patient outcomes.		
82	Seems effective.		
83	The staff who maintain the LINACS (at CGH) would be best to carry out emergency repairs and maintenance, surely?		
84	If EGS and Acute Medical Take are located at GRH, then it makes good sense to make GRH the hub for IGIS. It would also seem sensible for there to be a 'spoke' at CGH to work alongside oncology, urology and other specialisations there.		
85	Much of the reason why patients have to go outside the County for image guided surgery is that Gloucester is not in the centre of the County and certainly for people like me living in Chipping Campden it is a long way away		
86	N/A		
87	Combine the two centres to get maximum benefit.		
88	It would seem that more patients could be treated in this way.		
89	It looks as though this makes it more likely that i would be able to have my treatment in Gloucestershire		
90	Such a move would avoid duplication of expensive equipment. The proposal refers to a 24/7 hub, my support is conditional on this meaning availability 24 hours a day 7 days a week.		
91	see previous answers		
92	GRH should be main site		
93	Meets most eventualities		
94	This type of system is going to expand rapidly might need a target spike at Chelt.		
95	This depends where the activity is required - in emergency surgery or planned		
96	However, I do believe that more surgery will head in this direction and thus equipment at both sites to cover a range of specialities will be required.		
97	I think this will allow the best use of equipment by having the main hub at GRH but still maintaining some of the spoke services at CGH.		
98	IGIS is the technology and service that will become more important in the future. Cost will dictate that only one hospital can invest in this equipment and reluctantly I have to chose GRH, with a "spoke" at CGH.		
99	If we can choose where we go.		
100	There is a 2.5 million centre that has not long been built at Cheltenham. To move this hub to GRH is a waste of money when the service is already functioning well at Cheltenham.		
101	Gloucester Royal is best for me		
102	Key point of focus at GRH. It is unclear to me why you would want a spoke at CGH. Resources staff and equipment would be split. Imaging equipment requires on going maintenance programme better focused at one location		
103	The major IGIS is acute related often so should be with the trauma and stroke unit. However, Cheltenham General Hospital as a spoke would allow elective investigations and pelvic and oncology to occur.		
104	Yes I would like IGIS Hus at Gloucester and a spoke at Cheltenham General Hospital, I like the fact you do not have to travel between sites and outside of the county.		

A 24/7 Image Guided Interventional Surgery (IGIS) ‘Hub’ at Gloucestershire Royal Hospital and a ‘Spoke' at Cheltenham General Hospital.		Response Percent	Response Total
105	As above - is the 'spoke' necessary? Strongly support the idea of single site excellence for all and any hospital procedures		
106	Because of the increased local population both sites should be used.		
107	This makes sense with use of 'on call' specialists. CGH 'cold' centre for elective procedures.		
108	Explain why this can't just be at Gloucester		
109	Sounds sensible. Emergency cases coming into either unit may need IGIS - so good back up for A&E.		
110	It is the logical place		
111	Having read the information in this booklet I think it would be better to have 1 place for IGIS at GRH.		
112	I understand the rationale so would have to accept the proposals. GRH is difficult to reach but, on balance, the centre of excellence is more important.		
113	My quick thought is spoke detracts from the economies of scale argument.		
114	I would not support the concentration of services on one hospital site if that led to, for example, a reduction in consultants at CGH		
115	Image Guided Interventional Surgery appears to cross a variety of other specialisms, but seems most relevant to Cardiology and Vascular Surgery, which should be located in the first-class facility that was only created at Cheltenham three years ago.		
116	Most cases are already performed in Cheltenham and it should be the main Hub because it already has a new purpose built facility costing several millions. It would be hugely wasteful to remove this service from Cheltenham.		
117	See my previous comments. The people making the decisions have not had to journey from the FoD to Glos and Chelt 4 or 5 times a year as we have and paid for the privilege		
118	While I have no set of opinion on this I would nevertheless prefer such a service be provided at CGH. To the best of my very limited knowledge this is a not an exceptionally urgent procedure. A planned procedure???		
119	Good idea		
120	patients can be taken to/from GRH by ambulance, access problems are therefore left crucial.		
121	Have had heart surgery and this would have helped me at the time and taken away the need to attend Oxford. Great for bringing the specialists to Gloucestershire to work. Open up the service to more charitable funds.		
122	Single location		
123	Need to be able to meet the demand and provide the highest quality of service		

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

		Response Percent	Response Total
1	Strongly support	32.54%	96
2	Support	30.51%	90
3	Oppose	6.78%	20
4	Strongly oppose	10.51%	31
5	No opinion	19.66%	58
		answered	295
		skipped	18

Please tell us why you think this, e.g. the information you would like us to consider (102)

1	both hospitals should have it
2	Again it should be at both hospitals so that people can go to hospital nearest to where they live
3	Again, why not just go to Oxford if you live east of Cheltenham?
4	Centres of excellence are required at both hospitals- the region and population support it - you are reducing Cheltenham hospital to a first aid centre by stealth. Offering centres of excellence is merely a ploy to reduc3 services in Cheltenham which remain badly needed!
5	Far too far away from Fairford to be a good option for patients from that town/area
6	Speciality doesn't really have elective admissions. They have urgent emergency type patients
7	Too Glos central
8	This should be concentrated at Gloucestershire Royal and it is not asking too much for patients needing such procedures to have them carried out at Gloucester
9	I prefer vascular surgery in one hospital either cheltenham or gloucester.
10	as above
11	See my previous answers, Great getting too busy with parking and accessibility problems
12	Heart attack patients need treatment at closest hospital this would be better than using Bristol but should be available on both sites
13	What ever GRH can do , CGH should do the same
14	Again the wards at GRH are not fit for practice. They are overcrowded, beds too close together increasing the infection risk. The tower block appears generally dirty. Your report reads that if you live in a deprived area(25% of Gloucester population) you will get preferential treatment on your door step and blow the rest of the county. Given that most vascular issues occur in the over 65 age group and these people are spread out across the county if you live at Morton/Bourton area East Gloucestershire, you wont stand much chance of survival.
15	Once again rationalised approach to medical unit
16	An important part of medicine that needs a Centre ofvexcellence
17	As above,
18	Both hospitals should do this
19	Don't care as long as 24/7 type-1 consultant-led A&E services are restored at CGH

A 'centre of excellence' for Vascular Surgery at Gloucestershire Royal Hospital.			
		Response Percent	Response Total
	20	Ideally it would be located with the IGIS hub. Needs adequate provision of beds and and appropriate theatre.	
	21	It's a rational use of limited resources. Concentration of specialist people, and specialist kit, absolutely makes sense, and research shows that it produces better outcomes.	
	22	Access to skilled medical staff in the right location	
	23	Ditto	
	24	see above	
	25	One team working closely together	
	26	Same as the above	
	27	Again confused - suggest you need to engage some communications experts to put the proposals AND link them to the survey in plain english/language understandable by non medical persons. Appears to be specialist treatment needing expensive specialist equipment operated by experts. Given this seems better to centralise as one service - some people may travel a little further but far fewer would need to travel out of county at evenings/weekends. Going to hospital unexpectedly (or even planned) is not a good experience so removing a longer journey with some of the complications this can lead to seems a beneficial step	
	28	Would seem to complement IGIS	
	29	Proposals in the consultation document appear sound.	
	30	As before - transport is a serious worry for us	
	31	Might use this	
	32	see earlier comments	
	33	I am not sure why it is that CGH always seems to get the second best option of anything being considered, but as I have not needed treatment of this type I am not in a position to make further comment.	
	34	Concentration of key resources to reduce duplication and wastage.	
	35	Again reducing Cheltenham	
	36	Again more central for the county and transport links	
	37	Again, the same point of view. Maximise the use of resources in one place rather than try to do everything everywhere	
	38	As per previous observations	
	39	Same reasons as above.	
	40	This should be true of CGH too	
	41	As before services should be at both to ease travel for elderly who do not drive	
	42	Should include mechanical thrombectomy for LAO strokes	
	43	Meets best practice requirements	
	44	I support the whole concept of of centres of excellence	
	45	Planned care should be at Cheltenham General - that's the Centres of Excellence model	
	46	Please read my earlier comments regarding capacity, service delivery and my reservations that moving particular services to GRH alone must not lead to the closure of CGH (based on the assumption that GRH alone cannot service the whole catchment community).	
	47	If Gloucester is the best hospital then yes but don't overload it.	

A 'centre of excellence' for Vascular Surgery at Gloucestershire Royal Hospital.			
		Response Percent	Response Total
	48	Essential facility important for the community	
	49	It would be good not to have to go out of county for this	
	50	Agree with any proposal to avoid unnecessary duplication	
	51	See previous	
	52	Seems to make sense	
	53	As above	
	54	Needs to be at both hospitals	
	55	As with all your proposals to centralise services the problem is that of access for patients and their families. Whilst many have access to private transport a very large minority do not and they are frequently the elderly and less financially secure. For these people centralisation poses a major difficulty in accessing your services unless you propose to offer free transport between the sites. Even for those with private transport difficulties in accessing parking at iether site pose difficulties and high costs.	
	56	As above	
	57	Very good choice	
	58	One excellent speciality	
	59	I Struggle to see the Justifcation for the move - other than to be Closer to Trauma unit.	
	60	Planned care at Cheltenham	
	61	Better facilities and car-parking at GRH	
	62	Good parking, already has a good unit at GRH	
	63	Not qualified to judge.	
	64	As I said before, as long as it is excellent, who cares where it is?	
	65	Patients and clinical teams will have continual access to other acute speciality services, and these can operate in a more efficient linked-up manner.	
	66	Vascular Surgery had a very good set up at Cheltenham General Hospital with the IR theatre being built and utilised. The theatre sessions at Gloucestershire Royal Hospital are inadequate and the ward is literally a joke, not fit for purpose and the ward is dirty and the bed capacity is severely lacking. The service works perfectly well at Cheltenham General Hospital and would be costly to move on a permanent basis and even the consultants in the department are strongly opposed to moving on the grounds of patient safety and capacity issues.	
	67	I appreciate that these skills cannot be shared between too sites but for emergencies people living in many of the remote parts of Gloucestershire they need quicker access to a hospital and Gloucester is far from us	
	68	N/A My wife and I are in our 90th year. She is not allowed to drive. I prefer daylight and not Mon or Friday. We live in Tetbury and wish treatment there. So: We prefer Cheltenham and do not like Gloucester, the former being easier for us to reach by car and more convenient in terms of other activities on the day.	
	69	This site has more suitability for these operations	
	70	It seems that this is closely linked to the IGIS hub	
	71	see previous answers	
	72	Main site	

A 'centre of excellence' for Vascular Surgery at Gloucestershire Royal Hospital.			
		Response Percent	Response Total
73	Focus of resources on one site		
74	Having Vascular surgery at GRH will mean that vascular surgery will be able to support the emergency services better.		
75	If the investment in IGIS is at GRH, it follows that "A Centre of Excellence for Vascular Surgery, should be at GRH.		
76	I would like to make sure that we get best care not sure which hospital is best.		
77	Again the facility is already at CGH and working well, make the hub at Cheltenham and the spoke at Gloucester, as it makes sense as this is the way it operates at present. Why put all that money and energy into building a purpose built facility at Cheltenham only for it to be downgraded.		
78	In line with decision to locate the IGIS primarily at GRH		
79	I believe that some thought should be given to maintaining some 'low risk' non urgent vascular capability for some elective vascular surgery at Cheltenham General Hospital		
80	I appreciate the fact less invasive surgery would be needed and reduced travel time for some procedures, so that would be a bonus.		
81	As above Strongly support the idea of single site excellence for all and any hospital procedures		
82	Because of the increased local population both sites should be used.		
83	As long as there is critical care support e.g. for aortic aneurysms		
84	It needs to be Gloucester central for Gloucestershire		
85	Why not? The importance is that the unit exists and is available 24/7 as and when.		
86	This and IGIS should be in the same location		
87	Single specialist centre would enable better and timely patient care.		
88	I understand the rationale so would have to accept the proposals. GRH is difficult to reach but, on balance, the centre of excellence is more important. Regarding concerns about going out of county, Gloucester is no more convenient than Bristol (although I accept there may be budgetary considerations).		
89	Is there not a new vascular theatre in Cheltenham?		
90	As previous answers.		
91	as noted earlier CofE reduces resourcing supporting A&E from other hospitals		
92	I would not support the concentration of services on one hospital site if that led to, for example, a reduction in consultants at CGH.		
93	There is an excellent, nearly new Cardiovascular Unit at Cheltenham General Hospital, which the Hospital Trust spent £2.3m or more on. This is one of the best facilities of its kind in the South West, if not the whole country. It makes no sense to relocate this to the Gloucestershire Royal, especially since, according to six our of seven of the Consultants involved, the facilities there are not nearly as good.		
94	The Trust commissioned a new facility at Cheltenham which cost several million. It is regarded as the very best in the South West. It would be hugely wasteful to take it away. Most cardiology and inpatient vascular surgery is already performed at Cheltenham, it should stay.		
95	Se my previous comments and reverse you decision. My wife is disabled and I am 90 years of age and her carer. Traveling to Chel and Glos 4 or 5 times a year is traumatic.		
96	I support this option since I recognise that resources have to be used to the very best effect so if this is the Trusts preference I would support it.		
97	Another very good idea.		
98	CGH already does it		

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

		Response Percent	Response Total
99	You need the technology to do this and therefore would be good to be in Gloucestershire. Need to have the wards set up for this close to the theatres. Will pull in staff and money by having a centre of excellence. Increase the number of specialist nurses.		
100	The need to create the centre of excellence for specific specialisation over the 2 hospitals		
101	Single location		
102	BME communities have higher rates as diversity to Cheltenham and Gloucester - GRH is perfectly placed		

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

			Response Percent	Response Total
1	Strongly support		44.90%	132
2	Support		32.99%	97
3	Oppose		3.06%	9
4	Strongly oppose		2.04%	6
5	No opinion		17.01%	50
			answered	294
			skipped	19

Please tell us why you think this, e.g. the information you would like us to consider (108)

1	Good to see this could be made permanent. It appears that a lot of progress has been made since the pilot scheme was put in place. Good clear proposal.
2	It should be at both hospitals so people can go to hospital nearest to where they live
3	Gastroenterology at cheltenham is the best. Keep it in cheltenham.
4	Both hospitals need a centre of excellence due to the size of the population and the location of the services .
5	I would also like to see continuing support for Gastroenterology services at Cirencester hospital. I have had excellent treatment there.
6	Better for patients from Fairford, but not good for patients living at the west edges of Glos.
7	Consider Great Western Swindon for Cotswold residents
8	Some services will need to be continued at Cheltenham as Gloucestershire Royal will not be able to accommodate them all
9	Should be in Gloucester with the rest of medicine
10	prefers a medical unit in cheltenham which helps all people
11	Having one of the sites be the centre of excellence makes absolute sense. As the pilot has been at CGH - this should continue. However, having had personal experience of the CGH provision both in 2019 (in December) and in 2020 (May/June), some work is needed on this provision. My brother was in CGH for over 8 weeks in 2019 and for over 11 weeks in 2020 - and the care was poor. There was lack of continuity of care, and rarely saw a gastroenterology specialist on each day. While I appreciate that this might not be the 'norm' for most patients - I am aware of two other patients that have had this experience. At the moment, the continuity of care and plan for patients being discharged is poor and needs to be improved.

A permanent ‘centre of excellence’ for Gastroenterology inpatient services at Cheltenham General Hospital.			
		Response Percent	Response Total
12	This has been piloted successfully and seems a sensible balance between the two hospitals		
13	See all my previous answers		
14	Save me travelling to Gloucester and pay expensive park fees for long visits and bus fares		
15	Emergency Gastroenterology patients should also be admitted to ED at CGH once its reopened other wise you dont have a 'centre of excellence. You will have patients on both sites.		
16	Efficient use of resources, access to specialist staff at all times, no waiting for them to travel from GRH to CGH and vice-versa. The total patient capacity must still remain the same (and hopefully higher!), not reduce as a result.		
17	It makes total sense to be clear which of the two sites is the centre for excellence and notmto have activities on two sites		
18	This goes along with the idea of a centre of excellence in planned care		
19	Again, important to have these services readily available		
20	I fully support the Centre of Excellence principle and am happy to leave the ‘where’ to those more qualified than me to make that decision.		
21	Both hospitals need this		
22	Don't care as long as 24/7 type-1 consultant-led A&E services are restored at CGH		
23	There needs to be an outreach service to GRH. Interaction with emergency general surgery is still possible - need to ensure this is not affected. Interaction with elective surgical patients is principally on an outpatient basis		
24	Easily accessable		
25	The data presented strongly supports not reverting back to the old model		
26	Reasons given previously re: buildings		
27	prefer location of all specialist resources at GRH, Gloucester City site		
28	experienced excellent care re gastro at CGH		
29	Already in place? One stop shop.		
30	Expertise and resources at one site.		
31	Seem to be wanting to move all other services away from Cheltenham - might be an exaggeration but that is what is coming across, whether intended or not. The shorter booklet was understandable until it referred you to the longer booklet - that just descended into more confusion Again support measures to have less last minute cancellations & being seen/treated by the right person sooner. Need to balance this against over centralising and leading to capacity constraints & greater travelling time for those in the west of the county, particularly at the start/end of the day & at weekends		
32	if teams are on site to support patients		
33	Would compliment other specialisms		
34	Proposals in the consultation document appear sound.		
35	Need specialist services		
36	As above		
37	simply accept the judgement of the people making the recommendation		
38	co-locating with planned day cases with specialist staff and contact points for inpatient and long-term ongoing care		
39	Yes both hospitals should be capable of offering all services		

A permanent ‘centre of excellence’ for Gastroenterology inpatient services at Cheltenham General Hospital.			
		Response Percent	Response Total
	40	Bias on my part. No real rationale to be honest	
	41	Again, makes no difference to me as a patient where this is based	
	42	I am in support of this if it means that all the specialists are in one place. I do have concerns about the lack of parking facilities at CGH - especially if patients are being asked to travel from further afield to attend this site.	
	43	As mentioned previously it is obviously better for those living in the Cheltenham area for as many services as possible to be fully delivered at CGH. There is also historically a poor reputation for infection control at GRH. I would not feel confident going there for anything serious.	
	44	Concentration of key resources to reduce duplication and wastage.	
	45	will tie in with colorectal making patient experience & expertise seamless	
	46	I have a potential gastroenterology condition, so Cheltenham suits me. That should not be the criteria, when professionals have studied the situation extensively and come to a conclusion.	
	47	One unit to maximise use of resources but tempered by the fact that Cheltenham hospital is in drastic need of refurbishment.	
	48	But not only at CGH.	
	49	I feel this service could be led from either hospital and the service continue I the hospital why change for change sake . Save money and develop leadership on either site and share good practice online	
	50	As long as it meets patient need, is accessible and effective. My responses are based on the assumption that this proposal will deliver better efficiency and improved clinical outcomes than the current model/service provision in place.	
	51	Balance of serviices between the hospitals.	
	52	Essential facility important for the community	
	53	GI and gastroenterology services should all be at the same hospital	
	54	These are common aliments and overall benefits outweigh the negatives	
	55	Can see reason to concentrate into a single centre of excellence but accessibility of Cheltenham a problem eg public transport	
	56	it depends on staffing levels	
	57	Agree with any proposal to avoid unnecessary duplication	
	58	This is a linked to ties in with a centre of excellence for planned lower colorectal and day case surgery at Cheltenham	
	59	See previous	
	60	I have received excellent care at Cheltenham	
	61	If the pilot showed improvements why revert back to former arrangement Proposal sounds more efficient from hospital and patient prospective	
	62	Urgent general need for many people. Reduced waiting times - quality focused attention and care for the patient is always a win win	
	63	Support concept	
	64	Ideal location from a personal point of view	
	65	As with all your proposals to centralise services the problem is that of access for patients and their families. Whilst many have access to private transport a very large minority do not and they are frequently the elderly and less financially secure. For these people centralisation poses a major difficulty in accessing your services unless you propose to offer free transport between the sites. Even for those with private transport difficulties in accessing parking at iether site pose difficulties and high costs.	

A permanent ‘centre of excellence’ for Gastroenterology inpatient services at Cheltenham General Hospital.			
		Response Percent	Response Total
66	Proven already via Pilot.		
67	As above		
68	Focus a centre of excellence on one site, don't try to split it across two geographical locations.		
69	Layout issues at CGH		
70	The Pilot seems to indicate that this is and will continue to work well		
71	Treated more quickly by a specialist		
72	More specialist case throughput should lead to better outcomes.		
73	Not qualified to judge.		
74	Improved conditions for medical staff, and therefore beneficial for patients.		
75	Suits us - see page 37 My wife and I are in our 90th year. She is not allowed to drive. I prefer daylight and not Mon or Friday. We live in Tetbury and wish treatment there. So: We prefer Cheltenham and do not like Gloucester, the former being easier for us to reach by car and more convenient in terms of other activities on the day.		
76	As mentioned before this is utilising this hospitals strengths.		
77	Your pilot appears to have worked well		
78	As above, also strongly sceptical of your use of the word ""permanent"", given the constant change and deterioration that is going on in NHS services locally		
79	Not central site. Too far away for lots of people and parking a nightmare and expensive		
80	I support this if linked with colorectal surgery at Cheltenham		
81	Makes sense with plan to have centre of excellence at CGH for Colorectal surgery.		
82	If other GI services are to be at CGH then this should be too		
83	linking this with the Cancer centre streamlines care		
84	It appears that the pilot works.		
85	It is clear that reverting to the set-up from the pre-pilot stage would be worse off for many aspects. It seems to be working well, and it is fulfilling the world-wide move to centres of excellence.		
86	CGH has an enviable reputation in this field and with more investment can become the "Centre of Excellence".		
87	As this appears to be working well from the pilot then it seems sensible to keep the service as it is now.		
88	This is in line with the decision to locate the GI services at CGH but to be effective and efficiet the CGH facilities, resources and staffing levels need to be expanded and improved at CGH if the CGH is to be the centre of excellence.		
89	Cheltenham General Hospital concentrating ofn elective support in the area is sensible.		
90	We think all procedures should be available at all hospitals, but Cheltenham is preferable to us over Gloucester as it is marginally closer.		
91	Yes, always keep anything that is excellent and working well!		
92	As above Strongly support the idea of single site excellence for all and any hospital procedures		
93	Because of the increased local population both sites should be used.		

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

		Response Percent	Response Total
94	Will need surgical support		
95	It needs to be Gloucester more central for Gloucestershire		
96	This probably follows on from the other gut services, so yes.		
97	Keep the gastro disciplines together		
98	A centre of excellence would benefit both staff, services delivered and patient care.		
99	My husband received excellent care for bowel cancer and an emergency hernia. Cheltenham is so much more convenient for the Fairford end of the county.		
100	As before really.		
101	Cheltenham as an older demographic than other parts of the zone covered by trust however might be best not to have CofE so specialist doctors are available for A&E support at all the hospitals in the trusts zone		
102	I have no objection to the siting of specialist services on one hospital site. If this allows the particular hospital to improve its services in that field so much the better.		
103	this is a service which should, as far as possible, be located as close to the existing Cancer Centre in Cheltenham General Hospital.		
104	This could work well alongside the Cancer Centre.		
105	See my previous comments		
106	Perfect - the ideal site and facilities for such a service.		
107	CGH is best located for the whole of the county		
108	Cheltenham would do well with the long term illnesses and having a centre of excellence for this specialty. Facilities are questionable to make this a great centre excellence - the physical building.		

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

		Response Percent	Response Total
1	Strongly support	49.83%	148
2	Support	29.63%	88
3	Oppose	6.73%	20
4	Strongly oppose	2.36%	7
5	No opinion	11.45%	34
		answered	297
		skipped	16

Please tell us why you think this, e.g. the information you would like us to consider (127)

1	Fully support and it appears to reflect the wider logic of the overall Centres of Excellence approach. Supporting staff to provide the very best specialist care.
2	absolutely - this should be a number 1 priority - better trauma and A&E care at both destinations - there is NO WAY that one centre will suffice and we know this undermines public trust in CCG (who honestly now must be loved about as much as covid 19 itself).

Two permanent ‘centres of excellence’ for Trauma at Gloucestershire Royal Hospital and Orthopaedics at Cheltenham General Hospital.			
		Response Percent	Response Total
3	both should have trauma and ortho		
4	If it is a trauma case, it is quite possibly an ambulance admission and GRH cannot cope now. All ambulances go to GRH and then orthopaedics would have to be transferred to CGH, increased cost, risk, time and staff		
5	Need to be on one site . Have CRH as cold , non emergency surgery and GRH as emergency. Which would protect beds at CRH		
6	Again both of these subjects should be at both hospitals so people can go to nearest hospital to where they live		
7	Both hospitals have the population to support a centre of excellence- this is just stealing Cheltenham hospital services away which has been happening by stealth over recent years!		
8	Prefers a unit in cheltenham for orthopaedics.		
9	Again this seems to have been piloted successfully and I support the proposed allocation of services		
10	Just what I would like, both hospitals offering service		
11	I still think one trauma centre would be better but understand why Cheltenham seen as important		
12	Each sit should cover both services due to the size of the county.		
13	Trauma at Gloucester and Orthopaedics at Cheltenham makes total sense		
14	because this would be an excellent idea		
15	In view of the large numbers of traffic accidents that seem to have been taking place recently it works appear that the service is essential		
16	For similar reasons as already explained, orthopaedics more likely to be planned.		
17	Glad both are being considered		
18	Don't care as long as 24/7 type-1 consultant-led A&E services are restored at CGH		
19	Only makes sense if full A&E restored at Cheltenham		
20	If elective T&O operations are low risk then basing them on a site away from emergencies makes sense as there will be a reduced chance of cancellation. Trauma is best location near the main A&E.		
21	It's a large specialty and it makes sense to share across both sites, assuming that complex and/or higher risk cases are at Gloucester.		
22	Separating out trauma surgery increasing the likelihood of planned activities going ahead		
23	Agree need in both locations		
24	both equally important and necessary		
25	Best idea for the specialist teams. Already happening. personal experience.		
26	Because the two are so closely linked, why not have one Centre of Excellence in one place?		
27	This would seem to imply that services could be maximised.		
28	There seems to be a lot of opportunities on time management, however not much information around patient care, consideration of harm, preventative measures or long-term future routine checks. The prevention of further complications could be also considered in the new plans.		
29	Given the nature of these services it makes sense to have in both locations		
30	Seems to be 'mainstream' treatments/services - in a county of Gloucestershire's size, two centres seem to balance travel times for patients etc vs having enough staff/wards/capacity for treatment. Also avoids needless over centralising and the risks of having insufficient capacity / something happening at one site meaning all treatment is affected		
31	If data shows that it is needed at both sites & provides best patient care		

Two permanent ‘centres of excellence’ for Trauma at Gloucestershire Royal Hospital and Orthopaedics at Cheltenham General Hospital.		Response Percent	Response Total
	32	I went to Gloucester A&E on 2 Jan this year with a comminuted, displaced fracture of my elbow. I was assessed by a nurse and sent home with a box of cocodamol, in shock and terrible pain, to await a phone call to arrange an operation. I was operated on 5 days later. I feel that my treatment that night, and subsequently was appalling.I have since been left with nerve damage affecting my right hand. A centre of excellence approach would hopefully mean that patients such as myself would have prompt, consultant led assessment and treatment, which would lead to better outcomes and less stress and suffering for patients.	
	33	If this is practicable and possible.	
	34	Excellent for response times and flexibility to cope with peaks in demand, disasters and infections.	
	35	One centre would be better, but the Consultation Document identifies insufficient Theatre capacity on a single site.	
	36	Always a need, for all age groups	
	37	I have experiences emergency treatment for a broken wrist at Cheltenham last December. The treatment was outstanding. It was delivered, I leant (after the successful manipulation), by a wonderful Nurse Practitioner. My follow-up consultation at Gloucester was frankly disgraceful - the consultant's treatment was appalling and I complained about him. Excellence must be analysed, and all staff must be tutored to deliver excellent outcomes.	
	38	keep specialisms together for better access and equipment	
	39	Everyone needs trauma services nearby	
	40	Yes both hospitals should be capable of offering all services	
	41	Can't answer. You're once again going down the route of 'Cheltenham or Gloucester '.	
	42	As mentioned previously it is obviously better for those living in the Cheltenham area for as many services as possible to be fully delivered at CGH.	
	43	Concentration of key resources to reduce duplication and wastage.	
	44	Long waiting lists currently for NHS. GPs really just prescribe anti inflammatory drugs and until your condition deteriorates badly before referral process is even initiated.	
	45	cant decide as pilot study not complete & compared nationally	
	46	To shore the load between hospitals	
	47	Tie in with need to keep A& E open at both locations	
	48	Transport for staff who currently work at one or other of the hospitals who have to travel by bike / walk / bus etc be supported having to then travel further?	
	49	Reasons the same as previous answers	
	50	This is neede in both locations	
	51	Most sensible response to needs of this large community although leadership could be in either hospital	
	52	Separating trauma and planned surgery proven model,elsewhere, in terms of bed base, theatre capacity and managing infection rates.	
	53	Again this principle is sound - to concentrate emergencies on one site and orthopaedics on the other and it will help the ambulance service to direct patients to the appropriate site	
	54	This is another example of why planned - elective things should be at Cheltenham General and Emergencies at Gloucester Royal	
	55	Please refer to my previous comments, I support this if it will service the community more effectively and if it will lead to improved clinical outcomes.	
	56	Orthopaedics can usually hang around and be given pain killers for a certain amount of time.	

Two permanent ‘centres of excellence’ for Trauma at Gloucestershire Royal Hospital and Orthopaedics at Cheltenham General Hospital.		Response Percent	Response Total
57	Again, despite some weasel words, you're clearly proposing to focus emergency/trauma care at Gloucester, with Cheltenham remaining second fiddle. Both hospitals need full emergency capability.		
58	This an essential facility important for the community for accidents		
59	I think this is necessary because of what people are constantly being told about the ""Golden Hour"" for successful outcomes. It seems useless in trauma cases if a large part of this period is used in travelling to the necessary hospital		
60	Urgent need for excellent, quality, immediate support when there is a need. Quality of services is literally a balance between life and death		
61	Ok, need to give county spread. But Cheltenham not so easily accessible and very difficult for family and visitors without a car.... Cheltenham has a very limited evening bus service eg from stroud		
62	Presume there is sufficient workload to justify 2 similar services. CGH is closer to us, so of course I'm having to have anything that may be needed urgently as close as possible		
63	Again sensible and more cost effective to locate particular areas of expertise and resources in specific places		
64	Why would you not make one orthopaedic department in one hospital. would that ensure specialist care available always		
65	See previous		
66	We have an ongoing population in Winchcombe and Cheltenham General is very much more convenient for everybody. This is very important when you are unwell. A&E, MRI and scans, Orthopaedics, Oncology all provide an excellent service for us and or course surgery as well		
67	Once again if the pilot arrangements provide improvements, use this model as the way forward		
68	Needs no words to say this is a critical service and needs to have all the positives. Better care and attention and help out at the outset reduces issues developing later		
69	As above		
70	Having had a very successful hip replacement at Cheltenham eighteen months ago, I can only say that every aspect of my treatment was excellent, the surgeon was informative, the nursing was brilliant, even the food was good, and the outcome has given me my life back. It is working really well there, so perhaps Cheltenham is a good place for it to be based.		
71	makes effective use of resources		
72	That makes sense		
73	Proven via Pilot already.		
74	An excellent idea.		
75	Common injuries from all over the County will benefit from 2 sites.		
76	We need a 2 point disperstion for this		
77	The divide between the two disciplines is required given the extra resources for orthopaedics		
78	The results of this pilot indicate that the proposal is and will continue to work wll		
79	Trauma surgery has long wait times and increasing number of patients for hip, knee surgery can only be of benefit particularly the age demographic in Gloucestershire		
80	Parking and general access for patients		
81	Should lead to less last minute cancellations of planned surgery. Planned cases should be treated quicker.		
82	Not qualified to judge.		
83	Trauma needs unambiguous and fast treatment. I've no idea where/when I can go to CGH so I'd call an ambulance rather than go by car. What a stupid waste of resouces.		

Two permanent ‘centres of excellence’ for Trauma at Gloucestershire Royal Hospital and Orthopaedics at Cheltenham General Hospital.			
		Response Percent	Response Total
	84	It suggests a more efficient and effective division of labour, building upon the existing specialisations in both hospitals.	
	85	These are widely required services and so it makes sense to share them between the two hospitals	
	86	See onwards to page 37 My wife and I are in our 90th year. She is not allowed to drive. I prefer daylight and not Mon or Friday. We live in Tetbury and wish treatment there. So: We prefer Cheltenham and do not like Gloucester, the former being easier for us to reach by car and more convenient in terms of other activities on the day.	
	87	Perfect for both hospitals strengths	
	88	Best to have two centres as this creates redundancy to allow combined work in the event of failure at one site without affecting the other.	
	89	Your pilot wsems to have worked well	
	90	Seems to be the first area that recognises the need for quality services at both sites	
	91	One centre of excellence at GRH. Reduce travel time for medical staff etc.	
	92	As someone who is on the waiting list for a knee replacement and living in Cheltenham being able to keep a permanent 'centre of excellence' at Cheltenham General would be good.	
	93	Not seen enough evidence as pilot	
	94	Seems very complicate. What happens to a trauma case requiring orthopaedic in patient treatment?	
	95	I don't see the need to split resources over two sites.	
	96	Important to have pre op at the place of operation	
	97	Separating out emergency trauma and elective orthopaedics makes sense as it again puts the planned care in CGH which will be a calmer hospital and more suitable for that type of services, and the emergency services can have their centre of excellence at GRH. Again, having the centres of excellence is a sensible way forward, and the pilot seems to have worked well.	
	98	If in the opinion of all medical staff the present system is working to a high standard, then both hospitals should continue operate in tandem.	
	99	Having Trauma at one site (GRH) reduces the function of Cheltenham A&E department. As with medical and emergency surgery, the proposal to send emergency trauma cases (road traffic accidents for example) to GRH will make CGH A&E department less viable and will it then become a MIU?	
	100	Suggest the trust review the statistics to determine how much of the trauma cases are orthopaedic related before deciding on this. Moving orthopaedic patients from GRH to CGH for treatment post trauma triage at cause significant pain and discomfort.	
	101	All major Trauma at a single location makes sense. Most orthopaedics are less urgent and straight forward or even elective so Cheltenham General is the logical choice co-located with the arthoplasty.	
	102	It is a much better model to have expertise available at different hospitals, than to have it based only in one location. However, we would prefer all procedures to be available at other hospitals in Gloucestershire too.	
	103	Yes I agree with this, this can be needed at anytime, having two centres of excellent is very comforting. Reduces travel, retention of staff , waiting times	
	104	As above Strongly support the idea of single site excellence for all and any hospital procedures	
	105	Because of the increased local population both sites should be used.	
	106	I think insufficient capacity on the site	

Two permanent ‘centres of excellence’ for Trauma at Gloucestershire Royal Hospital and Orthopaedics at Cheltenham General Hospital.		Response Percent	Response Total
	107	It needs to be Gloucester more central for Gloucestershire	
	108	Would like to see both under one roof. Trauma can often lead to cold orthopaedics. ie. RTA - to joint replacement. Rehab via physio and occupational therapy can be used by both.	
	109	I have no support or opposition	
	110	Trauma is a very immediate service and i helpful for patients.	
	111	Seems sensible to have two options.	
	112	What happened to the pilot of trauma surgery in Gloucester?	
	113	I think one centre of excellence is the way forward.	
	114	Trauma will in many cases also require Orthopaedics support so it seems best to have both specialist available in both hospitals	
	115	I am concerned that having these two sited at different hospitals will result n increased patient transfers due to the overlap of specialities.	
	116	From things I have heard about Trauma & Orthopaedics I am not convinced the T&O Pilot study has gone as well as the Hospital Trust has claimed. I should like to see the full report of the Trial, before forming a judgement on this. I am not opposed to most elective orthopaedic surgery being done on one site and most trauma orthopaedics being done on the other, to minimise disruption to elective orthopaedic procedures, but Trauma Orthopaedics is fundamental to a fully functioning A&E Department, not least because it is not always obvious until x-rayed whether an injury is a broken bone or a soft-tissue injury. At least some trauma orthopaedic capacity should be retained on both sites.	
	117	The pilot study at GRH regarding Trauma has not been publicly scrutinised. I gather it has not been successful due to pressure on beds and operating time, consequently causing delays to surgery. It would not be sensible or responsible to continue this service at GRH. Orthopaedics at CGH on the other-hand has performed better.	
	118	as long as a streamlined service can be provided at both sites consultants, ultrasound etc need to be available. Registrations are fine but it duplicates appointments. If you could see a consultant sooner service would be slicker	
	119	Fits both communities with respective ages of those communities	
	120	I recently had a 2 week stay in Gloucester hospital after I had a trauma to my ankle (I completely shattered all the bones in my ankle and required 4 hours of surgery under general anaesthetic to mend it)	
	121	Convenient for residents of both areas	
	122	Yes very well needed	
	123	The 2 centres provide good coverage but CGH has to provide the facilities for trauma patients.	
	124	Yes, have the planned events at Cheltenham as this is the direction of travel and would work well.	
	125	These will not be planned procedures - some instances and being able to receive treatment at the nearest hospital therefore an advantage	
	126	Maintain present pilot scheme	
	127	Anything that reduces waiting times and ensures quality of surgery would be good	

Please tell us about any impact, either positive or adverse, that you think any of our proposals could have on you and your family (please tell us which service your feedback relates to e.g. IGIS)?		Response Percent	Response Total
1	Open-Ended Question	100.00%	189
1	All proposals. There could be more travel for patients depending on the proposals, but clearly the aim is for people to have world class care and I personally would be prepared to travel a bit more and not be so territorial. It's your health that matters at the end of the day. Also, some of the proposals like IGIS should mean fewer people having to travel out of county which is a good thing.		
2	extra travel time, costs and difficulty if services are required.		
3	Although not explicitly mentioned, I worry that the A&E department at Cheltenham hospital will have a reduced service, particularly for children, as part of the proposal. Having to travel to Gloucester for emergency treatment would have an adverse impact, it is a long distance and we would struggle to get there, and in a severe emergency I worry that the extra time to get to the hospital could adversely affect the outcome. It is bad enough that children cannot be treated at Cheltenham A&E after 8pm.		
4	Both hospitals should have centres of excellence and provide all facilities - the catchment area for Cheltenham is very large and such services should not be transferred to Gloucester Royal		
5	If the only option for a certain appointment or procedure was in GH, I would not attend and know from discussions that my family would not either. We have had relatives in GRH and the experience has been unsatisfactory both fr them and for us whereas CGH experiences were much better.		
6	I want the best care for my family and whether we travel to Cheltenham or Gloucester is irrelevant and has no bearing.		
7	Cheltenham maybe too far to travel, public transport route to Cheltenham from the towns that are in the county are poor. Also car parking and cost is a concern		
8	Cant answer that as no way of knowing if or what treatment me and my family are likely to need in the future		
9	Concerns about impact on BAME communities. Concerns about bottleneck effect on Acute Medicine at GRH. Major concerns about IGIS - if a patient needed an emergency procedure in this field and had to be transported to Gloucester, when the lived right next to CGH, the difference in both outcome re. risk of loss of life is to great a difference. Concerns about funding increased Ambulance Service provisions. Flawed concept of attracting high quality staff - London, Oxford, Bristol will always leave us with the best of the rest which the proposals would have no bearing on. Political concerns that down the line (years), any improvements will result in savings related staff reductions.		
10	I live in cheltenham and like I have explained I have complex bowel needs and going to gloucester when my family live in cheltenham puts a lot of stress and strain on my husband when they come to visit. Colorectal surgery and gastroenterology. Parking is a rip off. Parking should be taken back within the nhs and monies made put into equipment or services provided. For patients relatives who dont drive and have to use public transport it not fair on them as it takes around 45 mins on a bus from chelt to glos then same on a return trip, even harder for families who have small children going to see a relative in hospital and have to travel further to see them.		
11	no 24hr access to A7E at Cheltenham - transfer time to GRH - longer waits then at GRH		
12	The waiting lists will be even longer than they are now. Cheltenham people will have a glorified health centre not a hospital. The journey to Gloucester is long, discharge difficult to manage and visits reduced (non covid era) due to the cost and distance involved.		
13	The travel between sites may become a problem for us.		
14	Travelling and parking. Cheltenham nearer for all services.		
15	Any emergency situations would mean a longer journey to Gloucester for us, but with two young children that's less of an issue as the emergency children's services are already there anyway.		
16	I think that the advances in remote/telehealth should mean that some services currently occupying time and space within the two sites could be re-provisioned using better technology, thus freeing up resources (space and skills/people) to restore CGH to a full A&E consultant led 24/7. Anything less continues to reduce survivability of patients in the East.		

Please tell us about any impact, either positive or adverse, that you think any of our proposals could have on you and your family (please tell us which service your feedback relates to e.g. IGIS)?		Response Percent	Response Total
17	In modern healthcare the only way to deliver efficient, research based and effective services is to centralise in a centre of excellence. Services cannot be diluted just because that's the way they've always been. We need to keep up with advances in health care so that the current and future population benefits		
18	One major impact on having services at both Cheltenham and Gloucester, How do elderly patients get to these hospitals. Public transport is not good and Taxies are very expensive. We need more localised services!		
19	Any move to create single centres of excellence in Glos OR Chelt is going to have an adverse impact on patients living furthest away from both hospitals.		
20	You need to consider access/travel time		
21	I live in Cheltenham and fortunately at the moment I am not receiving any services from either hospital . I recognize that there are issues with Cheltenham General in view of the fact that parts of the building are 200 years old and not in current use because they are not fit for 21st century health care. I favour a new facility in Cheltenham being constructed on the edge of town so that the present buildings can be vacated and the land redeveloped. In the meantime I realise that the bulk of the services will need to be provided at Gloucester or even out of the county		
22	You are making a big mistake most people want local facilities and the Cost!!!		
23	Will be able to get looked after by specialist people whether in Glos or Cheltenham		
24	Nothing		
25	For my family, the gastroenterology provision is the most important consideration. If I had faith that the centralised CGH provision will work - then I fully support this. But from personal experience of the centralised provision since the pilot started in 2018, it is not working as set out in the consultation document. What sort of assessment of the pilot has been done already and what is being put in place to ensure patients who are going through the treatment are being listened to and problems are addressed?		
26	For us CGH and GRH are equally accessible and the essential issue is the provision of the highest quality of services		
27	Getting to GRH is very difficult for us so keeping both hospitals offering treatments best option		
28	CGH has served Cheltenham for over a 100 years Why change it		
29	I live in Gloucester and would prefer Gloucester hospital to be able to deliver all services to an excellent standard, Cheltenham hospital is difficult to get to, difficult to park at and it is extremely annoying to be sent there for treatment.		
30	my son comes under gastroenterology and a strong specialist team is what is important not where they are based		
31	Patients having to be cared for away from their home and families. I have no desire to be sat in a ED Department for hours on end. The hospitals have worked well as two separate hospitals for years - why change. MONEY Trauma Services need to be provided across the county not just one site. - so if you live in a deprived area or your homeless you will benefit from a single site service!! what about the rest of the population.		
32	longer ravel times are a reality, not a possible consequence		
33	If all services are concentrated away from CGH then patients such as myself living to the North of Cheltenham will be negatively impacted both for emergency services and for planned surgeries because of the time and difficulty in travelling longer distances, particularly difficult for the frail and elderly such as ourselves.		

Please tell us about any impact, either positive or adverse, that you think any of our proposals could have on you and your family (please tell us which service your feedback relates to e.g. IGIS)?		Response Percent	Response Total
34	Gastroenterology. Patient myself, diagnosed with Crohn's at the age of 13, 27 now. Dr Shaw and the Gastro team are extremely skilled, and give good treatment to their patients. However during my latest severe flare up (2015/16) I struggled to get the medication and testing I needed, this delay of several months stopped me being able to work as a teacher for 9/10 months, eventually leading to surgery to remove scar tissue. I hope that if the proposed centre of excellence goes ahead patients would be able to access testing, medication and surgery much faster. Faster treatment would save the need for surgery in some cases, saving the NHS money if the disease can be controlled by medication as soon as a flare up occurs.		
35	As I live equidistant between the two hospitals this has no impact on me. However for those living in the outer reaches of Gloucestershire there will be more impact		
36	If you move most services to Gloucester Royal it would immediately present many problems for travelling or finding a place to park. Many older people would be distressed at being so far away from their families.		
37	Please reinstore the full blood service at Cirencester Hospital - it gives an immediate, quick service. GP service will cause long delays and worries to patients, inconvenience and cost to travel to Glos.		
38	Centralising emergency surgery will make it harder to get to the hospital. Making Cheltenham general the planned centre for GI surgery will make to safer and better to have major surgery. We need more major surgery at Cheltenham		
39	As a Volunteer Patient Representative working directly with the NHS, all aspects of medicine concern me and my family		
40	I do not believe they would impact negatively, the distance between the two centres is not very far, if it was an emergency the patient would be blue lighted anyway. I would rather get the best possible care than decisions being made on geography. If as a plus this means that patients may not need to be sent out of county this is huge benefit		
41	I live in Cheltenham and work in the community, the cost of coming back to Cheltenham is high if you get taken via ambulance to glos royal, if you stay in, family find it expensive to visit you therefore your mental health deteriorates and your physical health recovery is slower, if it wasn't for my son being able to pick me up at 11.30 at night I would of had to stay in overnight, this would of caused a bed to be taken by me when I was well enough to go home but had no money to get home, a bus Journey from chelt to go's is a long time when you are travelling in pain or in recovery fir follow up appointments, we need a centre of excellence in both hospitals		
42	Any proposal that fails to deliver the full restoration of 24/7 type-1 consultant-led A&E services at CGH, will make it considerably more difficult to access emergency health care for me and my family.		
43	Neither site is well located for people living outside Gloucester or Cheltenham. Especially relevant for critical A&E cases where time is critical. Closure of Cheltenham A&E for people like us living East of Cheltenham means significant additional delays, on top of what are already poor response times. We would be better served going to Oxford or Worcester.		
44	Access to subspecialist care across the board		
45	Rationalised services produce better outcomes.		
46	Think these changes will be positive overall - they will provide clarity over what each hospital provides, reduce duplication and ensure that staffing rotas can be more robustly filled which means we will receive a more timely and quality experience		
47	I think you are ignoring a large percentage of residence east of Gloucester not to have a full equipped center of excellence at CGH covering every eventually from A&E to full trauma situations		
48	Positive impact		
49	Removal of services from Cheltenham would make it very difficult for people of North Cotswolds who depend very strongly on Cheltenham.		
50	Additional travel.		

Please tell us about any impact, either positive or adverse, that you think any of our proposals could have on you and your family (please tell us which service your feedback relates to e.g. IGIS)?		Response Percent	Response Total
51	In 2019 I had a IGIS abroad, in my country of origin. I could have returned to the UK, but instead I stayed overtime in the country to have an emergency surgery for removal of my gallbladder after going through a routine appointment where I had no symptoms. My experience with the NHS is that there is not much investigation on preventative measures. I had had an ultrasound before, to follow up on my IUS, and there was no interest in verifying the state of my internal organs at that appointment. I hope that by investing in a more thorough facility, incidents can be avoided.		
52	Keeping the temporary nurse led A&E for 50% of the time rather than having 100% consultant led services at CGH for 24 hours will have life threatening consequences for a large area of the north of the county.		
53	Support measures to cut last minute cancellations & ensure quicker treatment by the right person - if staff cannot be recruited / equipment not replaced due to budget constraints / equipment not being used as e.g. staff are on the other site, something needs to change to allow people to be treated and sent home more quickly either better or with appropriate measures in place.		
54	We may have to travel further to access services, but if they provide excellent care & outcomes its worth it. Good example of this is the breast care services. As a patient if all done in one visit on one site worth the travel		
55	We are equidistant from Cheltenham and Gloucester, so the planned changes will not have any real impact on us		
56	Cheltenham and Gloucester are not that far from each other and the rest of the area is poorly served. Driving to either on a very regular basis (such as for dialysis) is gruelling and time consuming.		
57	We are fortunate to have transport, so if we had to travel to Gloucester it would not be a big deal.		
58	A&E All of Cheltenham and North of Cheltenham would benefit from A&E as response times, time to treatment would be minimised.		
59	Proposals overall seem likely to lead to better patient care and improved medical training.		
60	Orthopaedic: every age group needs this support		
61	No current impact on us.		
62	It seems that Cheltenham will become to minor centre. I'm particularly worried about trauma treatment - an accident causing serious injury in the west of the county, where we are, could result in fatality if there were delay in reaching Gloucester hospital.		
63	All service development has the potential for increasing the health service possibly needed in the future by my immediate		
64	We might have to travel further to Gloucester hospital in the event Of a certain condition as we are in Bourton-on-the-Water so neither sites are especially close but the extra distance is a small price to pay for increased expertise/ excellence and reduced cancellations of operations		
65	Impact if all works well and delays in appointments are reduced will be of benefit to my family and myself.		
66	I am so far healthy therefore none of these proposals would impact me but I would like you to consider patients travelling to either hospital.		
67	Positive impact on any proposal. We live in Hucclecote and have easy access to either hospital		
68	Centralisation of treatmentsand procedures becomes wasteful because they lead to long waiting lists, and inevitably centralise specialist staff to the detriment of other hospitals and staff skills loss.		
69	rarely require hospital intervention in the past with only one referral to NHS Gloucestershire in 20+ years but now in mid seventies I suspect that will change. The negative aspects for me living in a rural location with little or no public transport are therefore based around access both distance and time taken and cost		
70	Gastroenterology and General surgery both needed and would be better if it is clear what service is offered where, and so that continuity of care can be improved. THe proposed changes will achiee this for me		
71	I think all these plans are terrific. Thank you.		

Please tell us about any impact, either positive or adverse, that you think any of our proposals could have on you and your family (please tell us which service your feedback relates to e.g. IGIS)?		Response Percent	Response Total
72	As stated above I am concerned for myself and all others like me who live east of CGH that relocating acute medical intake and emergency general surgery solely to Cheltenham may put my life at risk in future		
73	Concentration of some services in Cheltenham may involve us travelling 8 miles further (I live in Gloucester) but I would be happy to do that as the expertise would be in one place.		
74	Any medical treatment should be available at a local hospital. It is wrong to expect patients who are obviously ill to travel to long distances for treatment. Ecologically it is also better for a few medical staff to move between hospitals than for large numbers of patients to travel		
75	I haven't had to use hospital services so it is difficult to form a clear opinion. But access to Gloucester is easier. It's really about geography.		
76	Local and ease		
77	I imagine most opposition to the proposals will come from those who live significantly closer to one hospital or the other. We are fortunate in living more or less halfway between the two. Despite it being easier, therefore, for me to agree to the proposals, I do feel strongly that rationalisation of provision is important.		
78	I am over 65 and whilst in good health and newly permanent in Cheltrnham the idea of access to a local hospital for potential issues related to age is attractive. This I am not referring to a particular service		
79	I am hugely concerned about the already much reduced emergency cover at Cheltenham. I feel the centre of excellence (!!) for acute medicine in Gloucester will further reduce care for Cheltenham (and surrounding areas) residents. This is not a small place but with 100000 inhabitants and an elderly population.		
80	The gastro services will have a direct impact on me. Theft that all specialists will be in the one place, and waiting lists will be lower is a hugely positive thing. My main concern is the lack of parking and facilities at CGH vs GRH.		
81	I anticipate that the most likely service that I or my family would need would be the Acute Medicine. Being dragged over to Gloucester in a crisis situation would significantly increase the levels of stress experienced by both the patient and their family.		
82	Living in Stroud, I find it harder to get to CGH and harder to park there, however I think it is still a Good idea to concentrate key resources in one place, wherever it is.		
83	Gloucestershire is a longer journey for us		
84	This would mean more journeys to Gloucester hospital which isn't easy to get to. Also bad for the environment and I wonder if there is room at Gloucester Royal over the long term.		
85	My concern is for those living particularly in rural parts of Gloucestershire and the transport problems for reaching the two hospitals. There are implications for public transport, patient transport and for patients and carers attending hospital in their own cars, when having to travel further, or in challenging conditions. It would be reassuring to know, as in data] more about how the ambulance service has managed the extra distance to Gloucester Royal from the outlying areas of North Gloucestershire, for example.		
86	It is a significant journey from my part of Gloucestershire to both hospitals. So in journey terms the proposals wont impact negatively on me or my family. I believe it makes sense to coalesce the various specialties on one site to maximise expertise and capacity. I would therefore support the proposals.		
87	The Report and its recommendations have been prepared by hugely professional, experienced and competent personnel. Ninety nine per cent of feedback from the public is likely to be simply based on how it affects their personal situation regarding treatment required and location, and not necessarily related to what is best for the community at large and indeed the NHS.		
88	To have the experts in one place is a positive		
89	None at the present time none at the present time q		
90	noone		

Please tell us about any impact, either positive or adverse, that you think any of our proposals could have on you and your family (please tell us which service your feedback relates to e.g. IGIS)?		Response Percent	Response Total
91	Have used Cheltenham when needed Colonoscopy using the 2 week wait system etc. Found the building itself confusing (easier to find from outside than inside). but the care received was excellent and easily accessable.		
92	Looks fine. We live in Shurdington so GRH and CGH and both readily accessible		
93	As someone of working age with access to independent transport, I think this is a positive move for me. However, I am concerned about the social practical impacts for people who are dependent on public transport, elderly, need support to to travel, more financially disadvantaged.		
94	These proposals I think would have a positive impact, for all services mentioned. I would like to beable to access any service that is a centre of excellence to allow my family and I to have the best outcomes.		
95	Treatment not available at CGH is less likely to be taken up - especially if it involves more than one visit. For family reasons we would prefer to look for treatment at Southmead where support is readily available.		
96	Until and unless we have the need for any of these services, I find it difficult to comment.		
97	If the services are not at both units this would mean further travel and time. It also means for Carers there days would be more disrupted getting patients to appointments in larger units .		
98	I would like to suggest the establishment of a 24hour mechanical thrombectomy centre in Gloucestershire with the capability to deal with LAO strokes. There also needs to be a link with the ambulance service and emergency call handlers to ensure these strokes are quickly recognised so that patients are transported directly to the centre without delay. A related issue is the use of ongoing tests for every patient "MOT-style" to determine risk factors and identify problems early - this applies to other areas too, particularly cancer detection [apart from human suffering, this has the potential to save money by avoiding cases in the first place] A significant proportion of ischemic strokes are due to LAO's with their associated high morbidity and mortality. The effectiveness of recanalisation by mechanical thrombectomy (compared with alteplase which is largely ineffective due to the high clot burden) to deal with these devastating strokes has recently been established and has led to an Implementation Guide being produced for the UK: https://www.oxfordahsn.org/wp-content/uploads/2019/07/Mechanical-Thrombectomy-for-Ischaemic-Stroke-August-2019.pdf A potential further benefit, even for later presenters, is the avoidance of edema and need for craniectomy. Err on the side of going for it. Gloucestershire would fit well geographically with the current centres at Oxford and Bristol (not currently 24hrs). Bringing the UK up to european levels. Lack of treatment is an unnecessary cause of morbidity / mortality. Overall money saver, considering rehabilitation and ongoing care costs. I am personally living in total devastation following the death of my wife aged 63 in April 2019. She was taken to a local hospital where a severe stroke was quickly identified but unfortunately she deteriorated after a few days due to edema. She was just 3 years too old to be considered for decompressive hemicraniectomy. Her stroke came completely "out of the blue", she was always so fit and well with low risk factors. She was an extremely talented person and her untimely loss is so far reaching.		
99	Find travel to GRH difficult		
100	It's a long way from the edges of the county to these hospitals...		
101	Potential,impact from travel requirements depending on hospital site services centred on. Parking already challenging at sites. For planned surgery optionsMay choose to use sites outside Gloucestershire as nearer, or through choose and book use private provider option if that is closer.		
102	I am able to travel to both sites and I would be happier with centres of excellence rather than splitting expertise across 2 sites		

Please tell us about any impact, either positive or adverse, that you think any of our proposals could have on you and your family (please tell us which service your feedback relates to e.g. IGIS)?		Response Percent	Response Total
103	Only by separating emergency and planned care will the proposal really work		
104	No impact.		
105	For me an my family we can access either GRH or CGH but I know that this will not be the case for all residents requiring care.		
106	No should be ok.		
107	The move of cardiology and the creation of a centre of excellence to Glos Royal makes no sense....This already exists at Cheltenham Gen and will effect me personally .....I have an existing heart condition.		
108	I think that both hospitals should be running independently like they have as not everyone can get to Gloucester royal hospital and why should Cheltenham residents be penalised for extra charges gained from transport.		
109	I accept the principle tat it is impossible to finance all services at both hospitals. I was recently in GRH for ""draining"" excess water thus preventing heart failure and was treated very efficiently. However, it was disappointing five minutes in my journey to be passing CGH and making the significantly longer journey to Gloucester. Is this ""emergency"" treatment not available from Chelthenham General.		
110	I and my family have been served very well by the Health Services - but I have had to be referred to both Banbury and Oxford hospitals in my time and was very well looked after. My husband however visiting his mother and my in different hospitals (Banbury and Chelt) went to sleep at the wheel of the car and had a slight crash		
111	I don't see any adverse effects		
112	We live in Stroud so both Cheltenham and Gloucester hospitals are easily accessible to us		
113	Better patient care, less waiting time, easier access, better holistic care & treatment. Less travel time - better all around outcomes		
114	I think any change to trauma or emergency services will impact my family where reduces easy access to services is involved. Also the assessments seems to only produce marginal gains from a staffing point of view.		
115	Strongly favour Gloucester as so well served by trains and buses. Cheltenham hopeless for the former and very difficult for the latter. We cant all afford taxis		
116	Transport??		
117	some services will be further away if located at GRH, but when traveling by car it doesn't make a great difference		
118	Please see my comments under anything else. I would not support any services restructuring which adversely effect CGH's viability. I cannot comment on the medical proposals but Gloucestershire needs two major hospitals particularly with new settlements.		
119	Obviously because I live in the forest of Dean it would be better for my family to have all resources staff and centres of excellence at Gloucester but Cheltenham needs to have its own centres of excellence		
120	If as set out, the proposals provide quicker, more efficient service, linked to reduced wastage. I am fully in agreement. If one was in the ideal world of developing a brand new single site solution then a site between Gloucester and Cheltenham would make a lot of sense to all concerned. But we aren't. We need to make best use of what we have and some centralisation of services make best sense		
121	I need, from time to time, the need for treatment for colorectal and/or gastroenterology problems. I always feel more comfortable in Cheltenham General Hospital		
122	As a family, I think it is better to know which hospital you will be treated at as it’s not easy for everyone if loved ones get transferred back and forth. It’s nice to know in advance of planned treatment where you will be.		

Please tell us about any impact, either positive or adverse, that you think any of our proposals could have on you and your family (please tell us which service your feedback relates to e.g. IGIS)?		Response Percent	Response Total
123	My wife and I are both in our 80s and moved from a rural location in 2019 as we anticipate a point at which we will not own a car. We deliberately bought a property within walking distance of CGH. We have already found it necessary to travel to Gloucester for Xray and my wife was admitted for emergency treatment late on a Saturday evening. I had to return home to collect her essential medication and was able to do so in the car. This would have been particularly difficult without our own transport.		
124	I suffer from Ulcerative Colitis and my wife has a liver condition. Whilst we have a car if I were to have to stop driving we would have real difficuty accessing Cheltenham hospital if necessary.		
125	Due to the ""Centre of excellence"" approach and optimising the logistics around 2 hospitals within 30 minutes of each other there will be an overall benefit to: 1. Patient outcomes. 2. Workforce environment and job satisfaction. 3. Improved staff retention and recruitment.		
126	Very important that Accident and Emergency teams are operational at Both hospitals as speed is essential when time is of the essence.		
127	Any proposals impact us if we have to go to Cheltenham as I don't drive. However all options have to be considered when cost is involved.		
128	Some increased travel time for some services but a specialised centre of excellence should offset this.		
129	Living close to GRH the proposals will not impact me greatly. It makes sense to use resources (staff and equipment) as wisely as possible given funding shortages, therefore the changes seem sensible.		
130	I live at the extreme edge of any area that will use these services, I need to see transport in and out for relatives.		
131	Concerns: Transport availability to both sites Can GRH accommodate more activity - car parks, visitors etc Cheltenham Hospital not become the 'poor relation' regarding investment in buildings, staff and education.		
132	I live in Cheltenham but have had both inpatient and outpatient treatment at both hospital I have no argument with proposals that lead to improvement in services and staffing		
133	I think overall there will be a positive benefits having local COE's with appropriate staffing		
134	Having a centre of excellence in planned care at Cheltenham will make it better for us to have treatment.		
135	Positive impact, we have all been treated under the NHS in the last 12-18 months and these proposals can only improve primary healthcare in Gloucestershire		
136	For either hospital it is access from the forest and other outlying areas such as Stroud. Good transport links might be essential		
137	The convenience of travelling to GRH and CGH is very similar for me.		
138	There needs tobe a fair balance of services available for people living in different areas of the Trust.		
139	Support the best option proposed by medics.		
140	None at present. Who knows the future?		
141	Concentrating expertise in one of two hospitals will be beneficial for staff and patients; improve the capacity of hospitals to be both centres of excellence and centres of medical training; reduce waiting times and improve chances for patients of being seen by the right specialists more quickly, with the necessary follow-up care.		
142	Additional impact would be increased travelling to GRH but this is outweighed by the benefits as described in your documentation.		

Please tell us about any impact, either positive or adverse, that you think any of our proposals could have on you and your family (please tell us which service your feedback relates to e.g. IGIS)?		Response Percent	Response Total
143	I started to work for Cheltenham Hospital 27 years ago when I lived in Gloucester and have since moved to Tewkesbury and then Evesham. The travel time now is almost an hour each way and moving the department I work in (and have worked in for nearly 8 years) to Gloucestershire Royal Hospital will add at least an extra 30 minutes each way to my journey. I will not be able to sustain this and will subsequently be forced to look for work elsewhere within Cheltenham Hospital, something I do not want to do as I thoroughly enjoy working in Vascular surgery. I work in Vascular Surgery.		
144	All - I think the most important consideration is how to provide the best services to the widest number of people including my family and residents of my Cotswold ward. Psychologically we all feel that Gloucester is a remote, far away place whilst Cheltenham is more familiar with better access - we have no public transport to Gloucester		
145	Lack of choice		
146	I believe both hospitals have their strengths and as mentioned this is probably one of the better solutions to get the maximum use out of the top class facilities they would have.		
147	A possible positive impact would be an increased likelihood of a successful outcome of any treatment in the future.		
148	As long as the clinic appointments are in the same place I think ti will have very little impact on my family		
149	By moving more acute medicine and a&e overnight to gloucester, I think it will cause problems with delays in treatment for anyone going to cheltenham.		
150	Despite their proximity, travelling between Gloucester and Cheltenham is very difficult for many members of the loca population, and can lead to delays in treatment, great stress over travel arrangements, difficulty for family visitors, etc. I have personal experience of the problem in relatoion to removal of 24-hour A&E services from Cheltenham, which should be fully restored as soon as possible.		
151	FOD is a deprived area, we need one hospital for people to travel to (20 miles) and when inpatients - family can visit one centre of excellence for county. Cheltenham too old, parking nightmare		
152	At the moment I am not in need of other services than a knee operation so do not feel qualified to comment on them. The main thing I would like to know is that Cheltenham A & E services will not be discontinued. When I had a heart attack in 2011 if I had had to be taken to Gloucester, I would not be here. I was told that any delay would have meant I would not have survived. As it was I was seen straight away and given a stent immediately. Obviously being able to stay in Cheltenham for my knee operation would suit me as it would be far easier for follow up appointments as well. Therefore I think the present arrangement works well.		
153	Major elective general surgery - I am concerned if located in GRH - COVID cancellation of operations, poor quality care, chaos not good environment for recovery		
154	We have yet to have need of any of these services		
155	As a Gloucester based family it is always easier for us to go to GRH. However, I would prefer to travel a bit further to a centre of excellence.		
156	Because we live in the very south of the county to a certain extent these changes will have very little impact on us as we are pretty much as far away from one hospital as the other. The time taken to get to either of them is about the same, and as there is no public transport to either hospital, it doesn't really matter for any of the services at either hospital. However, I know that having centres of excellence can generally improve patient outcomes, which is why I support the developments of the centres of excellence. At the moment some trauma and emergencies from our area are dealt with at Southmead, so if GRH and CGH can become superior centres of excellence, then perhaps we would be more likely to be treated in county. i would rather battle the traffic into Cheltenham or Gloucester than Bristol.		

Please tell us about any impact, either positive or adverse, that you think any of our proposals could have on you and your family (please tell us which service your feedback relates to e.g. IGIS)?		Response Percent	Response Total
157	I received knee surgery at Cheltenham General Hospital four years ago. My surgeon decided after opening up my right knee that I only required a half knee replacement. The operation has provided with pain free mobility. The follow up by my surgeon, Mr Aung is ongoing, this year it will be a telephone call. Friends who opted for private treatment, have not received this follow up service.		
158	The parking fees are an outrage and would stop us being able to visit, I feel uncomfortable with being in Gloucester Royal due to bad reputation		
159	We live on the border in Herefordshire but our nearest GP surgery is in Gloucestershire where we access services. Having to travel to Cheltenham is too far.		
160	I think the impact this will have on all residents in Gloucestershire is a serious one. Gloucestershire is a big county that is growing. The number of homes being built and with the Cybercentre bringing new jobs to Cheltenham will mean that both hospitals will need to offer high quality services, that include, medical and surgical facilities and the ability to offer specialities, including viable A&E departments. The downsides are that both hospitals will not be able to offer basic services. There will be increased travel for many people. Surgeons will have to opt for being either trauma specialists or non-trauma specialists. Same for General Surgeons - upper or lower specialists.		
161	General Surgery at Gloucester Royal		
162	The formation of centres of excellence will provide clarity on where public can expect to be treated. CGH would require upgrading in some cases which may be disruptive. My family can access both CGH and GRH relatively easily		
163	I have multiple disabilities and cannot drive or travel on public transport. If I ever need any of the services covered in this proposal, I want them to be as close as possible to my home. It is easier for elderly, disabled, and very sick people to travel to their nearest hospital. An unfamiliar environment may be distressing for them, and it may be more difficult for their families to visit if they are further away. I will not be the only person in this category who is not able to either drive themselves or travel on public transport. Therefore, all procedures should be available in all hospitals, not in one centre. This feedback relates to all the services.		
164	My family and I could be affected positively by services being centralised because we would get the treatment we need in time by highly motivated trained staff.		
165	It was traumatic for my husband to be transferred to CGH at 2am because of vascular problems. It would have been beneficial to have been beneficial to have had a vascular centre at GRH.		
166	None		
167	Gloucester Royal has a record of poor patient satisfaction! To loose Cheltenham General would only increase the workload on GRH. In the long term, because of local increase in population, a new DGH should be considered! The proposed changes are just sticking plaster.		
168	I have good mobility and transport but would affect other members of my family if they had to travel.		
169	How are we supposed to travel to Cheltenham from the Forest of Dean? Have any of you ever tried it? Especially to arrive at 9am.		
170	Having had various admissions and day case appointments in the last few years I have received excellent care at both hospitals for which I am more than thankful. The locality is immaterial - the efficient and professional care are what matters.		
171	Any movement away from Cheltenham would be more difficult for us to access. This applies to all disciplines.		
172	Having to travel further for urgent trauma surgery from Cheltenham to Gloucester could affect anyone.		
173	My view is that centres of excellence would be a positive proposal. Negative could be transport/parking etc issues in either getting to hospital, or for visitors. As I mentioned before a free green shuttle between the sites would help with this. But really transport issues are far down the line when compared to top class treatment.		
174	Travel / visits - for any of these services - not so much for us - we live in Chalford, away from both anyway, but for less well off people who live closer.		
175	Hope fully our only need will be A&E based and in this area I fear the proposals are negative		

Please tell us about any impact, either positive or adverse, that you think any of our proposals could have on you and your family (please tell us which service your feedback relates to e.g. IGIS)?		Response Percent	Response Total
176	I have no objection to the siting of specialist services on one hospital site. If this allows the particular hospital to improve its services in that field so much the better. I am, however, concerned that too much emphasis is being placed on GRH. This concerns me because I do not believe that GRH has the facilities or space to cope with extra work. I have personally seen, and experienced, people left waiting on trolleys or chairs in reception areas for very many hours at GRH. I would not support the concentration of services on one hospital site if that led to, for example, a reduction in consultants at CGH which would eventually put the A&E at that site in question.		
177	I strongly believe health care needs to be delivered as close to where people live and work as possible. This is supposed to be a primary policy of the NHS, yet it seems there is a trend towards ever more centralisation and a move to more and more remote services. While some services can no doubt benefit from greater centralisation, especially where investment in very expensive equipment is concerned, administrative and clinical convenience should not be elevated above ease of access to healthcare.		
178	Taking away services from Cheltenham is not looking after Gloucestershire residents welfare. Any General hospital should have the ability and capacity to offer basic medical and surgical services. Moving emergency cases to GRH will mean lengthier travel times for residents living to the North and East of Gloucester. The consequences of this will mean more suffering and death. As the term implies Surgical or Medical emergencies require prompt action and this will certainly not happen if Cheltenham loses these vital services.		
179	As agree people this could - and likely to - have very dramatic effect on us		
180	I hope that under the new proposed services any future problems i have with my replaced ankle will be dealt with by highly trained specialists in a very well educated and informed manner kindly and efficiently. The service I received was great (the surgeon was excellent) and the consultant aftercare was brilliant		
181	Gloucester GH is twice the distance than Cheltenham GH is and there is no patient transport to Gloucester		
182	Cardiac and renal. I am 84, have had 2 heart attacks and been cared for at both hospitals. I have chronic kidney disease		
183	no opinions but good idea		
184	I live in Moreton-in-Marsh and I am not able to drive. Gloucester is a foreign country! Oxford or Worcester is easier to reach. any suggestion of concentrating services at GRH is therefore bad news. only super specialist services should be located here.		
185	Would have a centre of excellence as this would have helped me. Joined up access to medical records across the county. Would be good to have the images able to be shared with GP.		
186	The service I use most is eye care and there is no reference to Ophthalmology: any reduction in this service at Cheltenham would be greatly concerning for me.		
187	Should be good		
188	Close proximity to where I live Easy to travel to Gloucester hospital I like the idea of specialists in one area Centres of excellence should enable easy communications between staff		
189	Easy travel time Minimal waiting		
		answered	189
		skipped	124

If you think any of our proposals could have a negative impact on you and your family, how should we try to limit this (please tell us which service your feedback relates to e.g. IGIS)?		Response Percent	Response Total
1	Open-Ended Question	100.00%	124
	1	On balance I don't think they would - on health outcomes I mean.	
	2	this should not be undertaken this year, if a government integrated review has to be delayed I don't see how it can be ethical that Gloucestershire CCG even have the man power to consider this - let alone spend money on making it happen. Is this a project pushed to the forefront to benefit an individuals career?	
	3	To protect Cheltenham A&E	
	4	Both hospitals should have centres of excellence and provide all facilities - the catchment area for Cheltenham is very large and such services should not be transferred to Gloucester Royal - travelling time and distance	
	5	Keep both sites running and share the workload between them as they are. GRH is difficult to get too, the parking is unsatisfactory and the building totally unwelcoming and difficult to navigate - i had to run to theatres ? 7th or 8th floor via the stairs because both lifts were out of action for maintenance - I had to leave on the ground floor someone who was in a wheelchair. In CGH, there are other route options so this wouldn't happen.	
	6	I consider the effect will be positive	
	7	Cant answer that as no way of knowing if or what treatment me and my family are likely to need in the future, if services changed to Cheltenham then we would need to get there and the parking in Cheltenham is awful and the hospital is not near the actual town centre	
	8	Delay the proposals by a year. Engage with a private business/ management consultancy firm to determine the true long term impact of these changes, and amend proposals. Social impacts may change too - changes to the way we work in response to Covid may change the landscape such that new options become available.	
	9	Colorectal, general surgery and gastroenterology should stay in Cheltenham.	
	10	Reassess A&E times	
	11	You should retain Cheltenham as a fully functioning hospital - no excuse for not offering excellence at both!	
	12	Can patients utilise a shuttle bus?	
	13	Better 'advertising' of which conditions and situations are for which hospital so we can make decisions without convoluted calls to 111.	
	14	See previous answer.	
	15	Needs to be more Glos central or joint venture with Great Western Hospital Swindon	
	16	The proposals will have no impact on me as I am not receiving any services at either hospital at present.	
	17	As above	
	18	Long awaiting in emergency department can harm the life of people and also travelling with illness is a high risk.	
	19	None	
	20	Difficult for us to get to and park at GRH so would like CGH to keep full service	
	21	I feel reading and answering your question - you want to close CGH and turn it into a cottage hospital	
	22	none	
	23	Talk to and listen to the local population. People prefer to have a local hospital with local services rather than 'centre of excellence' We all know that this is just about bed reductions, lack of staff as there has been a failure by the Trust to invest in its staff. Applies to all services.	
	24	work with the transport services	

If you think any of our proposals could have a negative impact on you and your family, how should we try to limit this (please tell us which service your feedback relates to e.g. IGIS)?		Response Percent	Response Total
25	Retain full facilities at both sites.		
26	Capacity must remain the same or increase in totality for Gloucestershire.		
27	See above		
28	I would like to know what suggestions you may have for the following. If my husband had strong pains in his chest in the middle of the rush hour what would be his chances of survival is he were to be taken to Gloucester Royal and there was a traffic jam due to an accident on the Golden Valley? Not great I think.		
29	Downgrading Cirencester Hospital blood tersting service		
30	Accident and Emergency must stay open at Cheltenham even if emergency surgery and medicine is in Gloucester		
31	Any proposal that fails to deliver the full restoration of 24/7 type-1 consultant-led A&E services at CGH, will make it considerably more difficult to access emergency health care for me and my family.		
32	If A&E centre of excellence is going to be based at GRH, there needs to be more 24x7 ambulance provision for remote areas to compensate for additional journey time.		
33	Minor impact on travel but this is offset by the improvement in the quality of the service provided.		
34	None		
35	None		
36	Personally at present not, but who knows as we get older!		
37	The only downside of creating centres of excellence could be that I may have two family members being treated at the same time on different sites which could cause problems with supporting them. However, this is hopefully unlikely.		
38	I think accessibility is the main key in these new proposals, such as transportation, informational and also medical - providing a knowledgeable doctor who takes the patients concern into account when making decisions on examination and treatment.		
39	See above.		
40	All proposals where treatment is being centralised - travel times/arrangements. Concern over extended travel times for patient/family/friends, particularly when someone is unwell. Relying on public transport particularly at the start of the day/evenings/weekends does not sound great. Even in the middle of the day it does not sound great when it could be 2 or 3 buses and all the hanging around that entails. Paying for a taxi is expensive & if relying on friends/family/a neighbour, it is more awkward to ask them to double/triple/quadruple the journey time		
41	Providing value for money parking on site.		
42	No negative impact, however I think that there needs to be clear communication about which services are provided by which hospital		
43	As above		
44	-		
45	N/A		
46	See above		
47	I can think of no negative effects of adding to or developing services unless such development diminishes the value already present.		
48	Travelling by car more likely to be required to get to more distant Gloucester hospital so Additional parking provision would help.		
49	No		

If you think any of our proposals could have a negative impact on you and your family, how should we try to limit this (please tell us which service your feedback relates to e.g. IGIS)?		Response Percent	Response Total
50	The answer for me and my wife would be to make consultations for all but time critical issues, available at Cheltenham even if subsequently any surgery had to take place in Gloucester		
51	Further to travel to Gloucester Royal for emergeny/trauma but if the care is better tht should be mitigated. Cheltenham is still available but not consultant led overnight, which is a concern for trauma admissions		
52	As far as possible try to maintain urgent/emergency/acute facilities at both sites while splitting care not in those categories into centres of excellence across the two sites		
53	It is important that free public transport is available for patients between the two hospitals, so that (for example) people living in Cheltenham are not financially disadvantaged by having to travel to GRH, if they do not have a car.		
54	YES! All the proposals. you are trying to reduce the service offered.		
55	Travel distances, free parking, access to other services		
56	Travelling to Cheltenham from the south end of gloucestershire is difficult.		
57	Biggest concern is travel for people like us with no car		
58	Offer 2 centres of excellence for Acute Medicine		
59	A&E should have two sites not one		
60	Any service which compels patients to travel a significant distance gives a significant negative impact. It is not just the physical and financial inconvenience of organising travel to and from the hospital, there is also the significant negative psychological impact of the actual GRH site, which is noisy, confusing, over-crowded and uncomfortable. Every time I have visited the site, even as a visitor, I have left it feeling completely drained and unwell. I realise you are going to do the changes anyway as you have to cut costs and this consultation is a 'box ticking' exercise.		
61	Better parking facilities at CGH.		
62	No immediate impact but a potential long term negative impact.		
63	we need a local type 1 A/E with elderly relatives it is an increased financial burden to travel across county. emergency general surgery as well as acute can be a matter of life & death & this added journey time has the potential to have a negative impact on survival. we have a right to LOCAL emergency treatment		
64	none		
65	Trying to find areas in Cheltenham hospital is not easy. Make sure you enter the building at the correct entrance, as finding your way inside the building is impossible.		
66	Not that I can see		
67	I can imagine transport for some patients families that need support might need to be considered. Parking access - is there sufficient to support these changes? Bus services?		
68	In all cases of treatment there is the question of transport but both hospitals have reasonable provision for access and parking (albeit at a fee which is a matter for separate discussion).		
69	Try leadership and staff support for both units from one hospital. Sharing good practice teams can meet online.		
70	Parking a key issue Outpatient service provision at community hospital sites for pre and post care could off set some challenges. Or of course a virtual OP offering.		
71	Longer way to travel for emergency services - could be too long		
72	We need to have centres of excellence I. Gloucestershire		

If you think any of our proposals could have a negative impact on you and your family, how should we try to limit this (please tell us which service your feedback relates to e.g. IGIS)?		Response Percent	Response Total
73	Logistics, ensuring that patients can access the site they need. Ensuring that care is not compromised by having specialisms at a particular site i.e. will there be enough Nurses, Doctors, Specialists to provide effective care under the models proposed or will it mean less capacity. Will the proposals be affected by inevitable budget cuts that will take place from now as a result of the economic decline for this country we are entering now. I am assuming the proposals were put together at a different point in time and wonder if the current economic climate and impact that this will have on costs (budget) and the health of the population means that the proposal has to be reviewed to ensure it is still fit for purpose.		
74	Any moves of existing heart, cancer treatment, colo-rectal and imaging facilities to a Gloucester Royal 'centre of excellence' is a retrograde step and a huge waste of funds already spent ..... There should be a full and proper published and publicly available for review Cost Benefit analysis which includes in the model a true and comprehensive explanation of the previous expenditure and costs both current and capital at Cheltenham General. This previous expenditure and the proposed 'write off/downgrade' must be part of the costs.		
75	Open Cheltenham general with all services		
76	So far at 90 no negative feedback, but I'm glad I did not have to go to GRH for babies. its a long way and can take a long time. Ambulances when I have needed them have not usually taken too long, but I think a car service, where possible, with blue light supplied might be useful.		
77	I don't see any negative effects		
78	The main problems we have for both hospitals and across all proposals are 1) parking 2) accessibility for older patients		
79	As long as you don’t try to close cgh a&e you will have my support.		
80	My wife has problems with her eyes and we both have hearing issues. We are able to access both services at Cheltenham within walking distance of our home. There are no references to the future location of either, presumably these will be covered in the next phase of planning?		
81	Relating to all centralisation proposals. I firmly believe that centralisation should only go ahead as and when a free transport service is available for patients and their families between the two sites. Only then will your objective of good accesability be achievable.		
82	None		
83	As above, it is distance to visit.		
84	I worry that as we rely on public transport we may not be able to travel easily between hospitals. We have already had to use taxi to do this - that proves expensive; and perhaps will lead to us not bothering		
85	As above		
86	Support the best option proposed by medics. Later question (Do you consider yourself to have ...) misses the ""Other"" options which I would have added ""Losing confidence in the NHS"" regrettably.		
87	None I can foresee		
88	I work in Vascular Surgery which has currently been moved to Gloucester Royal Hospital ""temporarily"" because of the Covid pandemic. I do not think this decision is likely to be reversed as I believe the Trust has been looking to move the service to Gloucestershire Royal and the pandemic has simply meant they could move the service earlier than planned and they have simply said it is ""temporary"" to stop any backlash. I do not think that the Trust will be able to limit this as the distance I travel to work if I am forced to move to Gloucester cannot be changed.		
89	In emergencies the ambulance service often takes people from out locality to Warwick Hospital as it is quicker to reach		

If you think any of our proposals could have a negative impact on you and your family, how should we try to limit this (please tell us which service your feedback relates to e.g. IGIS)?		Response Percent	Response Total
90	See next box My wife and I are in our 90th year. She is not allowed to drive. I prefer daylight and not Mon or Friday. We live in Tetbury and wish treatment there. So: We prefer Cheltenham and do not like Gloucester, the former being easier for us to reach by car and more convenient in terms of other activities on the day.		
91	N/A		
92	Acute medicine and A&E needs to be fully supported in both hospitals. I have already detailed why.		
93	Don't specialist in only one place without considering and doing everything you can to alleviate the transport difficulties of patients and their family.I		
94	As above		
95	As above		
96	Finding ways to minimise the need to transfer patients between sites is important. Communication about any changes that are made and why they are necessary always helps		
97	Access if we are ill for any of the services is difficult if we can't drive because there is no public transport. It doesn't matter how good the services are, how good the consultants are or how nice the hospitals are, if you can't get to them. So it would be nice if there was a more consistent patient transport service. Not one that you constantly have to justify why you are using it. One where you aren't left sitting for hours wonder whether or not they are going to turn up.		
98	It is the high cost of IGIS that means it is necessary to concentrate this service in one hospital. If both hospitals could be equipped with similar IGIS then this would be perfect.		
99	I cannot understand why it seems the Trust struggles with employing adequate staff for both hospitals. Gloucestershire is a beautiful county, more and more people are leaving cities and moving into the countryside, like the Cotswolds and Cheltenham is the home of the 'festivals' after all! So providing more staffing and investing in equipment etc should be a priority for both hospitals. Why do staff have to cover both sites? The two hospitals are separate sites and should continue to provide equal facilities because Gloucestershsire is such a large growing county.		
100	No		
101	Please see answer to previous question, and if possible make all services available in all hospitals. If this is not possible, then there should be excellent hospital or volunteer transport which is suitable for individual patients with a variety of disabilities including severe allergies (I cannot travel in standard hospital transport or on public transport because of allergies to perfumed products from laundry detergent to standard toiletries.) This feedback relates to all the services.		
102	My family and I could be affected by long waiting lists, staff shortages, transport links, not being able to see a specialist consultant. This would be the negative impact.		
103	All hospital services - whilst I am able to drive at present, for the future and for all patients a dependable public transport system becomes even more vital if these proposals are enacted.		
104	?24 transport links (99 bus useful but only mon-fri) between CGH and GRH. Cheaper parking if patient needs transfer from/to CGH/GRH.		
105	Its going to cause a lot of hardship and missed appointments		
106	Progress must go on. 24/7 is important to deal with an ever increasing population - also 7 days a week for all services particularly rehab and back up.		
107	I am not sure how it could be achieved, but you do acknowledge that older patients may find it difficult to access an unfamiliar centre of excellence.		
108	Keep the A&E dept running properly in Cheltenham General.		

If you think any of our proposals could have a negative impact on you and your family, how should we try to limit this (please tell us which service your feedback relates to e.g. IGIS)?		Response Percent	Response Total
109	See above re transport.		
110	Greater visibility and support given to people needing to claim travel expenses for hospital visits. Citizens Advice Stroud ran a campaign about this 3-4 years ago, surveying the hospitals and surgeries to see how visible the information was and how easy to claim. The procedure for making a claim and receiving payment was poor. Stressed relatives need immediate assistance. They should not have to wait a month to be reimbursed.		
111	if we do set up CofE then we need to maintain 24/7 coverage elsewhere via a core of specialists (maybe a little more junior with access to more senior experts via telepresence)		
112	It is noted that A&E in not part of this review. However, I support the retention of A&E departments at CGH and GRH. I also support the return of a full A&E at CGH because I don't believe that GRH has the facilities to cope with providing the services which a reduced facility at CGH requires them to do.		
113	Senior management should listen much more to the views of ALL its frontline staff and not merely those of some of its most Senior Consultants. The Hospital cannot deliver excellent healthcare, regardless of how well equipped its 'Centres of Excellence' are without the goodwill and dedication of all of its staff. It is quite clear the failure to involve frontline staff sufficiently in developing services is undermining morale. There appears to be widespread distrust of senior management among staff and a sense of grudging resignation to having reorganisations imposed on them in a heavy-handed 'top-down' way.		
114	Possibly		
115	I am worried that the aim to be more efficient to reduce waiting times and free up beds will lead to hasty treatment and rushing patients out of the hospital without proper care or after-care treatment. I felt disappointed with a few aspects of the service I received		
116	Recruit more staff to enable you to operate both hospitals as has been the case for the past 30years.		
117	n/a		
118	no negative impact		
119	all services other than super-specialist ones need to be mirrored at CGH		
120	Improved communication and access to medical records. Improved access to staffing by having a centre of excellence. Make sure you have the necessary resources in place. Open up the options to make contact.		
121	We live only 12 min walk from CGH, therefore the centres of excellence in Gloucester will be less accessible. Not having access to 24 hour A&E is a downside for us.		
122	None that come to mind		
123	Parking issues		
124	If there is only one centre of excellence will parking be not adversely affected		
		answered	124
		skipped	189

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

		Response Percent	Response Total
1	Open-Ended Question	100.00%	69
1	yes centres of excellence in both hospitals		
2	split the clinics between both sites at different times or weeks but keep the specialities at both. Re-open A&E as a FULL setting and not as a nurse led one which will reduce the impact on GRH.		
3	As mentioned previously I think the services should be in both hospitals, don't see why the staff cannot be shared between the hospitals or more staff if required - if I was running the hospitals I would make it far more efficient that it currently is, I think there is a lot of money wasted in services the hospitals have to pay for, I would be obtaining them cheaper and would not waste items that have to be thrown away from a packet that 1 item has been removed. It is ridiculous and wastes so much money, it can all be sterilised and then money saved on these things could help with the services		
4	Keep emergency care/ acute medical on both sites. Share planned care with Bristol and Oxford. Rotate staff between hospitals/ secondments to generate the requisite culture of flexibility in planned care, with the savings and increased efficiency used to fund emergency care in both local sites.		
5	Open A7E fukky to cover both Gloucester and Chektenhsm		
6	My suggestion is you continue to support BOTH hospitals and ensure excellence in both - the population is simply too great for either hospital to be the sole service provider.		
7	Can any of these services be done away from the two main hospitals, to make parking and other access easier, and use the two hospital spaces better for essential healthcare?		
8	We need to keep the blood monitoring service at Cirencester Hospital, even Cheltenham is too far away. If you need a frequent test it would be impossible to do this if you do not have your own transport.		
9	Jpoint venture with Great Western Swindon for those living on The Cotswolds		
10	As before, the answer to all the questions is to provide a new hospital for Cheltenham designed to provide the location for all the latest developments in 21st century health care		
11	To improve the health outcomes its better that there are all specialities like medical, surgical and orthopaedics, elderly care in both the hospitals as the hospitals are located in 2 towns surrounded by a growing population around them than few years ago.. This can improve the provision of care facilities to all the population equally and in an excellent way reducing the stress and pressure.		
12	No		
13	The size and geographical location of Gloucestershire warrants two fully functioning hospitals.		
14	Both CGH and GRH need 24/7 type-1 consultant-led A&E services to support their growing communities. Anything less is totally unacceptable. GRH clearly cannot cope.		
15	Close both existing sites and build new Gloucestershire central hospital at a more accessible location, e.g. by Staverton airport. More scope for providing CoE departments, whilst being accessible to more people - including out-of-area opportunities. Old sites could be sold for offsetting capital cost.		
16	There is insufficient reference here to supporting patients at home, rather than admitting them to hospital. There is insufficient reference to the interface with social care services, and therefore to supporting clearing the back door of the hospitals.		
17	No		
18	no		
19	Keep 24 hour consultant led A&E at CGH.		
20	I feel that the centre of excellence approach is the way to go. I don't have a strong opinion as to which services should be provided by which hospital - it depends on the current strengths of each team in the hospitals I think.		

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

		Response Percent	Response Total
21	No		
22	On occasion I have come across some silo issues where, for example, such provision as physiotherapy is not always referenced in relation to other clinics where a natural connection seema relatively low prioritys obvious. This could be achieved through the GP intermediary or by direct referral within a hospital.		
23	No your proposals are well thought through and you know the business needs better than I do. I feel confident you will have used best endeavours to get it right.		
24	whatever is decided should be very clearly communicated as it is rather confusing at the moment		
25	To be ""Fit for the future"" try to repair the damage that has been afflicted to the NHS over recent years. Stop putting operations out to private companies. Work on restoring services which have been cut, reduce waiting times. Put NHS money into the NHS and NOT into private companies		
26	no.		
27	Reducing costs and providing a good service to all patients do not go hand in hand. You have already done your 'cost / benefit' analysis and decided what you are going to do, so even if I had sufficient knowledge of hospital processes to offer suggestions it would be a waste of time.		
28	No.		
29	CGH has an oncology centre of excellence therefore it makes sense to collaborate this first class service with colorectal/gynae/urology on the same site to make this a world class service. put CGH on the map ! expertise can then be developed with training and services offered. patient care will improve		
30	Other than knock both GRH and Cheltenham down, sell the land and build a new Southmead like hospital somewhere between the two. Probably not practical financially though		
31	no		
32	Are there options for co-operating with neighbouring Trusts, Hospital groups etc? Depending on the level of cases there could be opportunities for cross-border (whatever those borders may be) co-operation.		
33	Assessment should be done by an expert in hospital. The amount of staff appointed could be the answer. One person travelling is better that ten patients.		
34	No, if the statistics show that this model will provide better clinical outcomes, less waiting times, joint working and attraction/retention of the right staff, then I do not have another model to suggest.		
35	""""""developed in collaboration with local people during the Fit for the Future Engagement (see pages 17/19 of the full consultation booklet)."""""" This just means that the one's who shout loudest are listened too the most.....It also assumes the the voices from the deemed 'stakeholders' [NHS chosen or invited!!] are the truly interested parties. Most of us are too busy in our everyday lives to give up time to be part of this stakeholder echo chamber.		
36	I think most of possible suggestions seem very sensible, but perhaps more use could be made of voluntary services (stopping blood flow from nasty cuts or wounds where the nearest A&E is not very near and it is closed). Dealing wit fits in children, concussion (small blows to the head). 999 is excellent but Gloucestershire is a big county and the borders far from the centre. Surely we should have a service that can take us to the nearest centre for help and rely on zoom for specialism?		
37	I don't current suggestions		
38	Staff could be made more fully aware of resources at local hopsitals such as dilke, Lydney, Tewkesbury, Stroud, etc Many staff in Gloucester and Cheltenham do not know that x ray services are available at both Lydney and Dilke		
39	Could make cgh the vascular centre.		
40	No suggestions - the proposals seem to make sense		

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

		Response Percent	Response Total
41	Pages 12 to 69 - your thinking and planning and stats and experiences and practicalities and timescales and costs seem daunting, but are clearly essential and within your skills. However, I don't feel competent to judge the options except for showing an obvious personal preference for necessary services being available at Cheltenham or Bourton, rather than Gloucester or Moreton, to avoid extra travel and time and costs and stress.		
42	Fully supportive of the changes planned, as timing will be improved and better staffing.		
43	No		
44	Extra hospital in FOD used by visiting team		
45	None		
46	No		
47	My wife and I are in our 90th year. She is not allowed to drive. I prefer daylight and not Mon or Friday. We live in Tetbury and wish treatment there. So: We prefer Cheltenham and do not like Gloucester, the former being easier for us to reach by car and more convenient in terms of other activities on the day.		
48	I am a civil servant so I recognise the phrases used here - which don't really mean anything. How can you have a new modern hospital in CGH? It's an old maybe listed building. It all sounds really good but basically it's a money saving scheme. Charge people who come into A&E when it isn't an emergency. You have to pay to call an ambulance to your home or your insurance pays when called to a road accident.		
49	You need to cover more about how the elderly are catered for in acute medicine and a&e. Also what happens when services/surgery/beds are not available. Also the impact on ambulance transfers and wait times for ambulances. How will the services/surgery/beds be allocated from cheltenham? You could move a patient to gloucester to find there was no capacity?		
50	New hospital that would be fit for the future with our expanding population. We deserve it!!		
51	If you wish to attract the best Clinicians, Consultants, Doctors and medical staff, it is necessary to provide the best environment, and the best equipment. There are many negative reasons for Consultants / Doctors and patients having to travel to use specialist equipment in say, Birmingham or Bristol. Time and money is wasted. We must provide all services in our two excellent hospitals.		
52	the trust may wish to consider the potential benefits of working with Hereford and Worcester to optimise service provision, availability and delivery (use all available resources and staff all of the time) and thereby minimise patient waiting times in the three counties area.		
53	It is vital to maintain access to care to patients across the whole county of Gloucestershire, so our alternative suggestion is that all services should be available in all hospitals.		
54	No		
55	No		
56	Gloucestershire Royal has major problems, very poor booking system, staff morale. Sorry to say but patient experience has over years been negative.		
57	Quality - travel times may influence this - delays in transfer can be critical Access - as above - patient choice used to be primary concern, but less so now. 24 hour access is important. Not everyone has a car or access to one. Deliverability - need clarity on proposals and times for implementation Workforce - joined up working essential. Staff stress must be minimised. Staff travel times should be minimal. Development for staff essential - colleges will be watching training.		
58	Centralise all at Gloucester Royal Hospital. The hospital for Gloucestershire		

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

		Response Percent	Response Total
59	Help! As a sometime retired physiotherapist in the NHS I have been out too long to justify comment. I think 24/7, 7 day a week is important, people have problems 7/7 not 5/7 - this possibly goes beyond your remit. I was very glad recently to see doctors from the max-fac department as some ungodly hour on a Sunday morning (CGH).		
60	In general I would ask you to consider that when a patient is the subject of care between department, that a single point of contact be established between the departments. I think this would be even more important if the departments are on different sites.		
61	A covering team at each hospital with more senior staff visit each site to under take teaching etc but always being available for support/advice via telepresence or VR		
62	Recognising the need for change, the proposals for Gastro-intestinal Surgery contained in what was Option 4 should be fully worked up into a proposal, in preference to Option 2 which is what the Hospital Trust appears to have adopted in opposition to the majority of the Consultants involved and GiRFT advice.		
63	Build a state of the art hospital in the Forest of Dean at Five Acres which is for sale. Traveling to Glos and Chelt is traumatic, worrying and time consuming for older people who are suffering because of you decisions. We travel 4 or 5 times a year to Glos and Chelt so we know how terrible the journeys are at a time when we are ill and anxious.		
64	ensure each patient sees a consultant on their first occasion and gets ultrasound etc in the hospital closest to their home ie Gloucester people in GRH etc. Email appointment letters to people. Its faster and saves on postage. It also reduces the number of telephone calls coming in. If you offer email as a way to communicate ensure NHS staff have the ability to email the patient back		
65	no		
66	I live in Moreton, We have a fine new hospital building which is woefully underused, Yet I am invited to travel to Gloucester for a routine exam, The NHS needs to resolve service delivery issues of this kind, preferably before the new forest of dean hospital opens, for the same problems will arise there. The general impression given in this survey is that services will be organised for the convenience of patients who will usually be sick or indisposed.		
67	Training hospital again - start with one centre of excellence. Proposal is excellent to move into the modern world - make sure you have the technology to support this and the staff to support this. Efficiency of resources is a concern. Waiting times should improve with these proposals. Measure of improvement.		
68	My alternative suggestion rather than wasting money on expensive surveys like this is to have ONE hospital, between Cheltenham and Gloucester, which could then be available for both. The overall saving to the NHS would after the initial expense, be enormous. I believe the only reason this has not already happened is the ridiculous failure by the two relevant local authorities to agree on a site.		
69	None		
		answered	69
		skipped	244

Anything else you would like to say?

		Response Percent	Response Total
1	Open-Ended Question	100.00%	131

1	Good quality consultation materials and great glossary.
2	This is the wrong time, please spend the funds on dramatically improving A&E / Trauma and on building public trust in our local health services.
3	This should have been done years ago. Having doctors and staff working across two sites is inefficient and detrimental to patient care . Ideally we should have one hospital at Staverrton !!!!
4	Don't think so
5	-
6	I am very disappointed that you are offering a false premise ie. do you want excellence if so this must be at one hospital. We have already suffered greatly by the reduced services in Cheltenham. My husbands appts have been haphazard since services for Linc have been moved to Glos. I have been in A & E in Glos with 2 relatives recently we waited extensively for assistance and the hospital was clearly overwhelmed by the demand.
7	Trying to maintain two hospitals with duplicate services so close together makes no sense in any regard. This is the best compromise that I have heard suggested for a very long time
8	Just get on with it.
9	Get Cirencester and Tetbury hospitals better integrated into the services provided for patients
10	Just think more about travel access, parking facilities and best of all getting appointments and blood tests done promptly. The Cotswolds is treated as a backwater by Glos NHS
11	I have responded to a number of surveys such as this over the years and none of them appears to have resulted in any changes being made.Hopefully this one will result in some positive action
12	I think that the change in how the trust operates (more acute beds at GRH)could have a detrimental effect on communities in the north and east of the county. I genuinely believe that resource should be spread to support all communities to access all resources at convenience. The time and effort should be spent instead of solving the issue of people attempting to access incorrect services. We all know that personal responsibility of people in the community accessing healthcare is the key area that would have the largest impact on operational streamlining for the trust. Don’t reinvent the wheel by moving departments for convenience.
13	please ignore the people of cheltenham who are biased against Gloucester and who shout the loudest. this would be a good opportunity to also increase health equality in the county.
14	The excellence is achieved only if the right treatment is available at the right time. due to long waiting this is badly lapsed currently. From the media coverage the Gloucester hospital ED is overwhelming and very poor in meeting the 'excellence'. If this is the scene in the front door all could imagine how pathetic the other areas could be.
15	It seems a well thought out plan
16	To save money on postage go back to the old system of pencil and a diary for appointments I am an ex NHS employee in Bath Royal united hospital and GRH and CGH and Standish. The old saying is with the NHS If it works - Change it
17	Why are there not adequate children’s services in the area? My daughter was transferred to Bristol for endoscopy and gastric surgery despite Gloucester having the services necessary.
18	Thank you for putting Gastroenterology in the spotlight!
19	This is a very ambivalent survey. I am sure not many people will bother to complete it fully I read the lengthy booklet and after looking at the various rather repetitive questions I imagine many people will give up. This I think is what you want. You have intentions and ideas to carry out and I don't believe as a member of this community our opinions matter at all.
20	Downgrading the blood testing service at Cirencester impacts heavily on local residents

Anything else you would like to say?

		Response Percent	Response Total
21	Centres of Excellence is really good but only if they are really separated - emergencies in Gloucester and all planned in Cheltenham		
22	I would like to see a very positive statement, and concrete proposals for the better care of patients presenting with mental health problems in ED. This has been a long ongoing concern, how will Fit for the Future ensure that mental health is given proper consideration?		
23	It is completely cynical to perform this type of public consultation during a ""once in a century"" global pandemic. By proceeding with this the NHS trust are showing utter contempt for the communities they serve. These proposals and this consultation should be put on hold until Covid-19 restrictions have been lifted by central government.		
24	No		
25	Build a new County Hospital between Gloucester and Cheltenham, or focus development on the Gloucester site. Improve access (sheltered pedestrian links) to Gloucester rail and bus stations.		
26	Cary on with the plans.		
27	Whatever you do, do it well. Avoid letting polititians, who are only interested in the next election and showing that they can get things done on the cheap, get too involved. I realise that they hold the purse-strings, but don't let it just be about money. The USA really DO NOT have it right.		
28	no		
29	Yes. Use some common sense, for goodness sake.		
30	It would be good to see more localised services. Smaller hospitals such as Cirencester and Tetbury should be used to enable patients receiving regular care to avoid having to make regular long journeys especially through the winter. Even one or two e.g. dialysis bays in a day hospital like Tetbury would reduce the exposure of vulnerable patients to the risks of travel and exposure to other diseases.		
31	I haven't the experience to comment on most of this questionnaire.		
32	I believe NHS purchasing has room to improve and gain expertise from elsewhere. I also believe that there is opportunity to improve efficiency. I have witnessed nurses spending more time walking around than actually providing care.		
33	Even your summary document is far too full and obfuscating! I'd like an honest and clear comparison between services as they were before COVID and as they would be under your preferred proposals, with an indication on the impact in time and accessibility for patients in the various parts of the county.		
34	Just a point about competition between services. Central Government, in particular the Minister for Health and Social Welfare, has repeatedly affirmed that the BHS has remained open for non-COVID health provision. This is nor strictly the case. For example, prior to the first phase of the pandemic I attended the BOTOX Clinic every 10 weeks. At the peak of the pandemic it was understandable that out-patient services should be a relatively low priority. However, eight months on my condition has worsened and when I receive the promised appointment I suspect that treatment will have to be re-assessed and possibly extended to achieve some parity with the positive outcomes achieved over many years of treatment . This must also be the case where there are other conflicts even during normal times. I am fully supportive of the need for centres of excellence but I would want to be reassured that other services are not reduced in terms of financial and staff resources in order to accommodate them.		
35	No		
36	No		
37	thank you for inviting comment. I do hope that patients views are taken into account if trends emerge and that this not just a ""going through the motions"" exercise		
38	I cannot thank the NHS enough in Gloucestershire for all your brilliant ideas and work.		

Anything else you would like to say?

		Response Percent	Response Total
39	The NHS was a great organisation. Over the years it has slowly been destroyed. One great problem is with the GP service. If effectively stops patients from accessing the main NHS services. It is almost impossible to get to see a GP. An example - In November 2019 I had a fall. I damaged my arm. A shard of metal punctured the arm to quite a depth. The arm from elbow to palm of hand went blue and remained blue for weeks. A huge swelling erupted at the puncture point. It was impossible to see my GP. By late December the arm was still swollen and bruised. I was concerned with Christmas upon me. I live alone. I phone 111 I was referred to see my GP the following day. When I entered the GP surgery the first words from GP were I don't usually see people who just walk in off the street. Obviously the GP service is NOT there for older people. The telephone 111 service is a farce. Please don't talk about centre of excellence and fit for the future. Just restore the NHS to a functioning system now The whole of your document has annoyed me. you say that you are attempting to provide centre of excellence while what you are doing is actually trying to whittle away even more of the flesh from the skeleton of the NHS which was a great organisation but which is now a shadow of what it once was. The hospital work is good still once one can get past the deliberate obstacle of the local GP. I have already mentioned the case of my GP who said "" I don't usually see people who walk in off the street"" when I had been referred by 111 service. The episode convinced me that the NHS is simply not there for older people. Please stop trying to fool me into thinking that you are trying to offer centre of excellence Long before that event I went to the GP reception as I have done in the past, to ask for an appointment. The receptionist who is obviously there to protect the doctors from seeing patients, told me that the system had changed. I had to go home and telephone for an appointment. I pointed out that I was there, talking face to face to her so why not organise an appointment. I simply wanted a routine appointment because I was concerned about a long term health issue I have. The receptionist then became aggressive and told me to go home and phone for an appointment. I returned home and phoned the surgery. The line was engaged. I tried to phone many times. The line was always engaged. Making an appointment is now virtually impossible. I presume that your aim is to force people who can afford to, to opt for private treatment. Pleased do not try to disguise your actions as creating centres of excellence The other possible method of getting medical attention is via the A&E. It is a last resort. When I badly damaged my arm I did not bother the A&E system. I would not abuse such a service. However other people who are desperate for treatment have used A&E. You have tried to counter that by removing the A&E from Cheltenham hospital. A lot of public pressure prevented that move completely but you ask about centres of excellence. It is in my opinion impudence on your part. I have health issues. I am elderly and live alone. If I get covid it will no doubt kill me, but I have determined that I will not even try to contact my GP. you so obviously intent on destroying the NHS as it stands. The government says it will be free at the point of delivery and so you are ensuring that there is no point of delivery. I do remember times before the NHS. What a disagree that we are returning to such times again. Centres of excellence RUBBISH		
40	Living in the Stroud area means that either Cheltenham or Gloucester are equally accessible (or not) for treatment or visiting. I feel it is important that specialisms are concentrated where they can best be delivered effectively and efficiently.		
41	whatever the experts in the NHS think I would be supportive of.		
42	Please keep to your word about reversion to prev Covid A and E at Cheltenham.		
43	From recent experiences in the past two months and two days. Cheltenham A&E open 24hrs. Gloucester A&E was EXACTLY as shown on TV on Wednesday. Wait outside on an ambulance followed by wait inside in the corridor. We understand that you state there are no proposals to close Cheltenham A&E, yet you have! It is currently a minor injuries unit. Sorry, don't believe you.		
44	What consideration has been given to accessing these locations both by public transport and by car? Parking at both sites is difficult and iniquitously expensive.		
45	These are excellent consultation proposals but miss one very important heading - THE CUSTOMER CARE EXPERIENCE. Visits to both major hospitals are still very poor experiences. Everyone does their best with awful facilities and it's time we moved from a 1958 experience to 2020		

Anything else you would like to say?

		Response Percent	Response Total
46	I am extremely dissatisfied that there is not a department at CGH which specialiases in treating children. When my grandson was 6 years old he fell at school and received a large gash to his forehead which needed stitching. I was told I would have to get him to GRH because it could not be dealt with at CGH. I had to drive him over the Golden Valley by-pass, in the rush-hour, in the pouring rain, trying to keep him from falling asleep on the journey because I was concerned about possible concussion. He was kept at GRH for 6 hours without being treated then sent home overnight and told to come back the next day for the stitches. An injured child should not have to undergo such a lengthy and hazardous journey or be left so long without proper treatment. Fortunately I had a car and sufficient petrol to get to Gloucester, but if I hadn't how would I have got him there, with his head cut open, by bus?		
47	No.		
48	It		
49	I am very concerned about the closing down of some services at Cirencester Hospital. The town is about to expand by about 30% with the Bathurst development at Chesterton. The hospital (which is excellent) should be expanding for the future, not declining. The climate change agenda requires us to have less reliance on car transport. For many the only realistic way to get to Gloucester or Cheltenham Hospitals is to drive. With a town population of around 20,000 (probably 27,000 with the new development) and with many surrounding villages, it seems to make more sense to develop local services better in Cirencester.		
50	Access to local facilities is important as I live in Tetbury. However, for specialist care i am prepared to travel further a field to Gloucester, Cheltenham and Oxford.		
51	Both Cheltenham and Gloucester hospitals are quite old and have grown in a piecemeal fashion with inefficient layouts. I can see the point of centralising specialist units. I think the only long term solution is to build a new hospital half way in between and then sell the existing sites which are close to city centres. The pressure should be put on the government and not to ask the public to accept dwindling local services.		
52	why oh why do this survey during a pandemic and why hasn't elective & emergency surgery been separated as per recommendations ?		
53	I understand and agree with your reasons for wanting to change things in these two big hospitals, but I would urge you to also consider our more rural hospitals (Cirencester, Stroud etc.) when it comes to where funds go. I would hate these to be underfunded at the expense of these changes.		
54	Pure fluke heard about the consultation apparently running since late October. Leaflet only came with post on 2nd December. Good way of minimising responses		
55	no		
56	I would be interested to know what consideration One Gloucestershire have given to inclusion in terms of practical access to the hospital sites e.g. public transport providers, charities with volunteer drivers, support groups in disadvantaged areas. Given the health inequalities which have been demonstrated through the Covid-19 situation, it is vital to me that these considerations are given a platform in any changes, else we risk worsening inequalities already present. As well as the patient, this can impact visitors, whose support can positively bolster outcomes for a patient. Also, there is no mention of the impact on ambulance services, but presumably there will be an impact in terms of transfers needed (not just when ambulance first called to patient, but also transfers between GRH and CGH) . Am wondering how this has been assessed? Thank you for appreciating the importance of having an A & E service in Cheltenham to local people, I am really pleased this is reflected in the plan.		
57	It is clear that the NHS cannot simply go on as before. How will these changes be monitored to see if they are successful? Who will monitor them and make any necessary adjustments if required, or indeed share best practice. In my lifetime I have seen many of the areas hospitals close or reduce their services, and I have not picked up on how all of this will impact the remaining hospitals in the area.		

Anything else you would like to say?

		Response Percent	Response Total
58	For some people, the thought of travelling to GRH from Cheltenham (or, I imagine, CGH from Gloucester) would be a major consideration in the choice of whether to have treatment or not to have treatment. Travel to the ""wrong"" hospital is an extra journey for visitors by public transport and has led to my certain knowledge to some elderly patients having no visitors during their stay, with whatever psychological effect this has had on their recovery. The people likely to be reading this consultation and making decisions subsequently are likely to be those who think nothing of a few miles of distance on good, if busy, roads. Many, who are often less articulate or just more diffident find it a major obstacle.		
59	Good luck changing services is always a problem and change for this reason seems ridiculous		
60	Parking at both centres is problematic and public transport during Covid19 advised against		
61	My experience of being treated at CGH has been very positive. I am very supportive of its ongoing centrality to future plans		
62	The trust obviously has a plan for the medium/ longer term about how the 2 sites should be developed. Would be better to review theses current services within that wider context. I can only assume a hot cold site is the longer term plan. Overall will the trust be increasing its bed base with the significant housing development plans in place across Gloucestershire?		
63	Page 6 doesn't state what happens to ""Hyper Acute Stroke Unit and Acute Stroke"" under the preferred option. Page 23 does but is isn't clear if that include treating people with Acute Stroke cases.		
64	Thank you for the opportunity to participate		
65	I worry about the link and relationship between these proposals and GP services. GP services need to be as much a part of this as the hospitals and the hospitals cannot do this in isolation of community services. I can see part of the proposal is to enable more joined up working but this has to work in practice with collaboration and cooperation across the services. While I have experienced fantastic GP services in Gloucestershire (up to about 10 years ago). Unfortunately I have also experienced some poor GP service provision in Gloucestershire, which has deteriorated over the last 8 to 10 years. My biggest concern is that if the GP services are not joined up with these proposals, this will not be able to succeed.		
66	I live on my own so for me it is important that my nearest hospital covers all of my needs		
67	This appears to me to be yet another way to spend money to create 'something new' and the associated empire building both administratively and medically tghat goes with that. All proposals need to be matched to realistic assumptions of need and the first priority should be proper utilisation of existing resource. Acceptance of the waste of resource [both income and capital] appears to be a huge part of the default NHS model.		
68	The provision of some tests possible available at Cheltenham but routinely carried out at GRH, does not seem to take into account the impact on elderly patients. For example my wife, aged 82 had her second cataract procedure at Cheltenham, where we live and she is pleased with the outcome. In preparation for the procedure, she was required to attend GRH for tests the day before. She assumed that these would be similar to those done previously and was prepared for a lengthy amount of time away from home. In fact the only test carried out was for Covid19 which surely could have been done at Cheltenham!		
69	I find taking part in the survey stimulating and support the developments		
70	The assessments continually refer to the BAME and homeless community if Gloucester (some 32,000 quoted) as being a major criteria in deciding where the services will be located. There are over 600,000 people in Gloucestershire . Do you not think this is a case of ""the tail wagging the dog"" . I also believe that some of these changes are being brought in to cover up for poor management in the past. Surely better recruitment schemes and a decreased insistence on nurses being degree trained would improve day to day outcomes for most patients.		
71	Any improvements as to how patients are treated are welcome		
72	Have several times mentioned access by public transport. This is clearly not a clinical issue, but in the general context of availability of the best services for people reliant on public transport, it can make a huge difference. Facing cancer surgery and daily radiotherapy it was actually cheaper and easier for me to go to UCH in London than try to use buses and taxis from Stroud to Cheltenham. Yet Gloucester is easy and has been very good for other health needs		

Anything else you would like to say?

		Response Percent	Response Total
73	Consider what minor injuries services etc could be made more easily available at GP surgeries. Even discounting the Covid effect, the GP is a bottleneck. Overall the treatment me and wife have received from CGH and GRH has been timely and very successful. Thanks to everyone.		
74	I am not a medic but my above preferences are based on the viability of CGH. Covid 19 has shown we need more hospitals without affecting ordinary services. GRH has better rail access but at times the hospital is overwhelmed. I do think that concentrating more services at GRH at the expense of CGH is a serious mistake. There must be equal allocation of services between GRH and CGH. CGH must be protected from closure. Cheltenham is a growing town and needs a viable hospital. so does Gloucestershire		
75	Any changes should be accompanied by improved information / communication to staff and public. Staff need to be aware of geography and travel difficulties for appointments to be as convenient as possible. Where as I believe a centre of excellence is essential - longer journeys for clients with children or frail adults will inevitably increase stress levels. With ambulances being tied up for longer transferring patients to the appropriate hospital. You speak of specialist doctors. Are experienced nurses willing to change work base from CGH to GRH		
76	1) As someone whose wife died recently of cancer we found the oncology unit in Cheltenham an excellent facility. That is centralised not necessarily most conveniently to u living in Dursley area but very accessible. 2) Reduce waste by greater use of electronic mail and not sending out lots of letters. Sometimes 3 in same post. 3) We need to make greater use of excellent facilities in Dursley and Tetbury		
77	We are extremely fortunate to have two such good hospitals serving us.		
78	I find it really hard to comment sensibly since most the areas of medicine are not known to me or what is currently available. I don’t feel competent.		
79	1. I was very concerned at the poor timing of this exercise. I received the 'Fit for the Future' flier in the post today (9/12/20) with consultation closing on 17/12/20. Although I was able to go online for some of the information there was insufficient time to get the 'Pre-consultation Business Case' and read it before the deadline.(Minimum 2 days for freepost card, 5 days including the weekend for a response, 3 days for parcel post and the deadline is past.) 2.		
80	Refreshing to see such an in depth review and consultation. How about integration of Social Services and the NHS next?		
81	As a moderately fit 90 yo, male living in the eastern part of the county, I have sadly needed a range of your services, and have been well served - but have often felt that health education and preventative measures and self help situations should be stronger, from cradle onwards, for the whole nation. Individually. How else can the nation and it Health Service survive the decades?		
82	Maybe it is my age? It took a long time to read and digest mentally the information in the Fit for the Future book. I would prefer excellence in all hospitals with adequate staff - well paid and well trained. It would seem that the changes are needed for inpatient care. However, small local hospitals like The Vale at Dursley are most needed for being specialists in maintaining health especially the elderly. Travelling 6 miles is much preferable than 26 miles especially if you cannot use a car!		
83	No. A future proof plan for reduced waiting times, reduced hospital stay, access to cutting edge skills and equipment along with optimal training of junior staff and attracting the best must be a positive move.		
84	Inappropriate and dangerous hospital discharges happen regularly, particularly at GRH. I hope these changes will help reduce these. Mental health support is very poor, particularly in GRH, I hope the cost and staff savings can be used to provide better mental health support for patients with mental ill health.		
85	No		

Anything else you would like to say?

		Response Percent	Response Total
86	Having experienced such changes in Cornwall staff were concerned in the smaller hospital about their education, training and personal development Staff who were near retirement were sometimes sidelined out of the acute setting, consequently did not feel valued Recruitment difficulties occured Elderly population struggled with the changes on all site. Major review of signage was required and more volunteers needed to guide patients around the sites. Strong communication strategy required I am unaware of your IT strategy but would hope all hospital sites have equal access to current IT and future developments. Good luck		
87	Please look at improving the bus links ! The fact that you use a stagecoach bus for one part of your journey and a pullman for other part - is just not Cost effective for patients.		
88	Centres of excellence works if it is a proper complete split		
89	None		
90	It is essential that if a service is on one site then serious consideration is given to how patients are cared for on the 'other' site. Each specialty needs a plan that is put into action and monitored to ensure safety and quality. This is not something that I think the trust is very good at at the moment.		
91	Overall i agree with the proposals as specified in the consultation booklet 'Fit for the Future.'		
92	Key is to have confidence in our medics. My area of concern is- Communications. Followup (after discharge). Options/Expectations.		
93	I think you have spent too much on your glossy booklet - it could have been made simpler and cheaper - a poor use of resources		
94	The survey is difficult for non medics to comprehend. See points above.		
95	Why are there so many different names? It's only one NHS. Get Government to stop giving large wage rises to consultants but give better rises to nurses.		
96	More free car parking at GRH and CGH		
97	If would help if other bodies such as Glos Highways and bus companies could be persuaded to consider better road access and enhanced public transport facilities to reduce difficulties in trying to access two sites.		
98	I am sorry to say that I think more local people would be happier going to gloucester hospital if there were more staff to give better aftercare on the wards. Also staff need training on how to understand the needs of the elderly. Misunderstanding of being slightly deaf, confused in surroundings, stoma care being common problems I have seen.		
99	The consultation makes no reference to the impact on transport issues for staff and patient visitors. For instance establishing a specialist centre in Gloucester only is bound to necessitate greater staff movement from Cheltenham and vise versa. Is greater capacity on the bus service and/or for car parking required? The success of whatever strategy is adopted should not be only measured in clinical terms.		
100	Bring back Cheltenahm A&E full-time and with full services as soon as Covid restrictions are lifted		
101	I have concerns about the length of waiting times for children's appointments as these are impacting on childhood developmenmt		
102	We have had need to avail ourselves of Cardiac - pacemaker/heart valve and bypass Oncology - Thyroid cancers TIA Trauma - hips A&E Endoscopy Audio Other family members use the Cardiff/Newport hospitals where we assist them		

Anything else you would like to say?

		Response Percent	Response Total
103	Improving continuity of care, reducing outliers and improving communication with families might be improved if a balance in activity across the hospitals is achieved		
104	The general concept must be welcomed. However P14 column and does not take account of the here and now. With regard to A&E going straight to a specialist ward doesn't happen due to bed shortages so this needs to be addressed. Also at a more strategic level these centres of excellence represent a staff gap. What is really needed is the construction of a brand new hospital like Southmead. Which would consolidate both Gloucester and Cheltenham. It would be all encompassing in location. Have new smaller wards if not private rooms and take account of the high demands from increases in population and ageing.		
105	1. On both sites the outpatients should be fully maned such that if an appointment is cancelled for what ever reason, the new appointment offered should be at the same site. 2. The A&E at CGH should be 24/7 with a doctor, such that if someone walks in late at night, then (assuming not needing a bed) they can be dealt with and avoiding them being referred to GRH without an examination. With the result that the person has to find their way to GRH whilst not knowing how bad their situation is. All ambulances 8pm - 8am still directed to GRH.		
106	I was treated for prostate cancer by open surgery in 2009 at CGH, my surgeon was Mr Sole, based in Hereford but twice a month he would operate at CGH. This was to ease the pressure on the Urology medical staff. Since my operation 11 years ago the department now has a robotic system. This type of equipment had been identified as an improvement for both the patients and the medical team, unfortunately, it could not be purchased immediately because of its high cost. If the two Gloucestershire hospitals are to be A Centre of Excellence then cost of equipment must not be a barrier to purchase. Only the best medical staff will be persuaded to work in CGH and GRH if we can provide the best equipment.		
107	Relatives need to be able to visit very ill patients at moment this will delay recovery.		
108	I am strongly opposed to downgrading one hospital over the other. They should have equal value and maintain safe staffing levels on both sites. It seems to me that there is a faction that wants to take away basic services from CGH, a hospital that has offered its services for over 200 years and highly valued to residents in and around it.		
109	Thank you for providing the public the opportunity to have our say on this important issue		
110	Issues with parking around Cheltenham General Hospital may cause issues for more rural communities and those not on regular bus schedules for Cheltenham's proposed day and elective role.		
111	This survey is part completed because we accidentally submitted the form when part way through the survey.		
112	No		
113	No		
114	I think consultation period is too shore and suggest extension for 3 month. Very few people are aware of the deadline on Dec 17 amid covid 'lockdowns' and tier 2 restrictions. I only happened on the documents by chance (and I've been a user of services this year and was health professional for approx 40 years).		
115	Do not ignore the publics opinion we have a right to choose where we have our care.		
116	Keep up the good work. Will be interested in the result of survey. Any plans for head injuries, chest surgery - including cardiac or neurosurgery, so these still go to Bristol of John Radcliffe, Oxford. Guess if you live west of the M5 you want all in GRH, east of the M5 CGH. There are of course major incidents to remember where anything and everything can turn up.		
117	I know we all demand more from the NHS. However, sometimes the changes may seem rational but have a detrimental effect on local people in relation to access and other things. In a different area, when Fairford Hospital was closed, we were told it would lead to more efficient services. I am not sure that this is the case and I think it was a bad decision to remove care beds from the system, as it would have provided capacity to look after patients who needed care but not access to expensive equipment, freeing up beds in acute hospitals. I think it was a bad decision.		

Anything else you would like to say?

		Response Percent	Response Total
118	It is, frankly, disgraceful that a consultation such as this one, which has had the resources of countless hours of input from selected sources within the organisations comprising 'One Gloucestershire' should be sent out for public 'consultation' in the middle of the greatest health crisis the country has seen for a century. The public have too much else on their minds at this time to be in a position to properly consider the issues that have been put before them. This is a massively cynical exercise designed to produce the answers that 'One Gloucestershire' have already decided on (ask any member of staff at Cheltenham General Hospital); sneaking the exercise in consultation at this time is almost certainly an abuse of process. And most egregious of all: the document purporting to be a 'plan' for the future of healthcare delivery in the county makes NO MENTION of pandemic planning. How can we be expected to take it seriously in the light of such a glaring omission?		
119	This feels like a token consultation. I do not know anyone outside of the medical sphere who has even heard of this.		
120	I recently had an operation in the QE2 hospital in Birmingham. Is it time Gloucestershire had a new state of the art campus hospital, part paid for by the valuable land (especially CGH) land the current hospitals stand on?		
121	Covid-19 as shown us that resourcing can come back to bite us		
122	I am also concerned about the management of GRH. I do not question the skills, competence or dedication of the staff at GRH. However, again from experience, I do not believe that the management of the hospital is as good as it should be. I support GRH and CGH being in one trust, but I do wonder if a different management structure is needed within that trust so that greater emphasis is placed on delivering the services which patients are entitled to expect. I feel that as part of the management structure there should be someone in place who is responsible for ensuring that liaison with patients and their families is far better than it currently is. I think there is a case across Gloucestershire to be made for one trust to cover all health services – primary care, community hospitals, acute trusts, social and after care etc – and believe that this should be explored. I think this would have the potential to reduce costs and improve co-ordination of services. We have seen during the Covid crisis the inability of the acute hospitals to move sufficient numbers of patients out into care homes, community hospitals and into their own homes with support packages in place, and I think one management of all the services, with the appropriate structures within that trust, should be considered. I realise that the above would challenge the CCG arrangements, but again I feel that being part of one service might help coordination. For example, I believe that many more patients could be treated at primary care level than is currently the case, thus relieving the pressure on hospitals. Much greater use should be made of pharmacies.		
123	The publics primary concern about the reconfiguration of specialist services within the hospital relate to the convenience and accessibility of services and the long term sustainability of a Type 1 A&E Department in Cheltenham. Of some of these proposals are implemented it is difficult to see how a full Type 1 A&E Department would be sustainable in the long term. This is despite the reassurances the Hospital Trust has repeatedly been given. It is these proposals which have undermined staff and public confidence in the Hospital Trust's sincerity over the re-opening of Cheltenham A&E and its long term future.		
124	See above please re-think before its too late		

Anything else you would like to say?

		Response Percent	Response Total
125	When I was in hospital following the trauma to my ankle I felt well looked after by some of the nurses on shift, especially the ""day"" nurses. I was shocked however by a ""night nurse on the night shift asked me if I could hop!!! to the toilet rather than waste her time with her getting me a walking aid - remember this was when my leg was still in a very heavy plaster cast and I'd only just had the operation on my ankle that day - I was weak and very much in pain and certainly wouldn't be able to HOP to the damn toilet!! I couldn't believe my ears when she asked me that and that she almost seemed put out that i was in need of her assistance as the night nurse on shift. I was in hospital for two weeks but it was hoped and suggested by some junior doctors and at least one consultant that I leave after my first week. I was no where near ready to leave hospital after one week. I was still in tremendous pain and still had a heavy plaster cast on which considering my living situation at home was not at all ideal for supporting me with this current disability. I was discharged after two weeks after my insistence that I stay for lnger. I still feel I was discharged too early. My date to get my plaster cast removed was ill-scheduled and I was lumbered with dragging a heavy, itchy and uncomfortable cast around for about four weeks when it should have been two weeks after my operation that the temporary cast removed and a lighter more comfortable one put on. I requested transport to the hospital by ambulance which was denied so after getting a taxi half of the way still had to make my way through the grounds and the various corridors to get the appropriate place. I very much feel I was left unsupported durring my out patient recovery, especially during the time I was discharged and waiting for my new and lighter cast. The stress and anxiety was very detrimental to my fragile mental health. I suffer with anxiety and depression and undiagnosed and untreated OCD and complex PTSD all of which compounds to instable moods and frequent mental breakdowns. I do manage my mental health with medication and receive mental health support. I just wish my treatment as outpatient in aftercare was better monitored by professionals and I was better assisted and supported. I feel the COVID19 situation is part to blame for the seemingly hurrying of me out of the hospital and the quick discharge out of my own private room at the hospital where I have to say, I would have recovered better and faster perhaps rather than being herded onto an open ward where I was constantly disturbed by other patients and nursing staff. If I hadn't come into hospital during the corona virus pandemic I do believe my stay would have been far more pleasant and i wouldn't have struggled as much as i did with anxiety that i was using up vital bed space. I feel i should have stayed recovering in hospital for longer than i ended up staying.		
126	Quick and easy access is essential when you are ill. There is a much larger older population in North Cotswolds. Moreton in Marsh hospital is not included in this survey. So is a modern hospital intended to serve the North of the county yet when ever I or friends have visited it is empty. Why is this expensive new building not being used?		
127	no		
128	I used to work for the department of health. The fashion for building new hospitals would alternate between big is beautiful and small is beautiful on a 10 year cycle. The result was that all current buildings was out of step with prevailing thinking. Health trusts need to resolve this conundrum and ensure a successful balance between specialist and locally delivered hospital based options.		
129	Addition of trainee nurses and other healthcare professions in specialities means you can retain them more easily and get more money!		
130	Great believer in logic		
131	seems like GRH has a more specialist focus under one roof - will this lead to overcrowding, parking issues, less quality face to face time with staff / professionals		
		answered	131
		skipped	182

What is the first part of your postcode? eg. GL1, GL20			
		Response Percent	Response Total
1	Open-Ended Question	100.00%	276
	1 GL54		
	2 gl2		
	3 Gl4		
	4 GL52		
	5 gl53		
	6 GL4		
	7 GL51		
	8 GL52		
	9 gL50		
	10 GL4		
	11 GL5		
	12 GL4		
	13 GL4		
	14 GL53		
	15 Gl52		
	16 Gl51		
	17 GL6		
	18 GL52		
	19 GL52		
	20 GL53		
	21 GL2		
	22 GL2		
	23 Gl4		
	24 GL52		
	25 gl51		
	26 Gl16		
	27 GL7		
	28 GL7		
	29 Gl50		
	30 GL50		
	31 GL7		
	32 Gl50		
	33 Gl50		
	34 GL5		

What is the first part of your postcode? eg. GL1, GL20			
		Response Percent	Response Total
	35	GL5	
	36	GL5	
	37	GL51	
	38	GL7	
	39	GL51	
	40	GL18	
	41	GL53	
	42	GL2	
	43	GL5	
	44	GL52	
	45	Gl14	
	46	GL52	
	47	GL3	
	48	GL53	
	49	SN6	
	50	GL19	
	51	GL19	
	52	GL19	
	53	GL19	
	54	OX18	
	55	GL52	
	56	GL53	
	57	Gl51	
	58	GL51	
	59	GL2	
	60	GL54	
	61	GL53	
	62	CV36	
	63	GL52	
	64	GL7	
	65	gl52	
	66	GL3	
	67	gl1	
	68	GL54	
	69	GL18	

What is the first part of your postcode? eg. GL1, GL20			
		Response Percent	Response Total
	70	GL16	
	71	GL13	
	72	GL52	
	73	GL11	
	74	GL12	
	75	GL53	
	76	GL2	
	77	GL52	
	78	GL52	
	79	GL52	
	80	GL6	
	81	GL20	
	82	GL8	
	83	GL16	
	84	GL53	
	85	GL52	
	86	GL6	
	87	GL6	
	88	Gl5	
	89	GL5	
	90	GL54	
	91	GL54	
	92	GL2	
	93	gl2	
	94	GL54	
	95	GL51	
	96	GL19	
	97	Gl53	
	98	GL3	
	99	GL5	
	100	GL52	
	101	GL7	
	102	GL6	
	103	gl5	
	104	gl51	

What is the first part of your postcode? eg. GL1, GL20			
		Response Percent	Response Total
	105	GL3	
	106	GL1	
	107	GL52	
	108	gl5	
	109	GL6	
	110	GL5	
	111	Gl51	
	112	GL53	
	113	GL3	
	114	GL53	
	115	GL20	
	116	Gl52	
	117	GL6	
	118	GL52	
	119	GL7	
	120	GL51	
	121	GL4	
	122	GL5	
	123	GL7	
	124	GL7	
	125	GL8	
	126	GL53	
	127	GL54	
	128	GL53	
	129	GL7	
	130	GL18	
	131	Gl7	
	132	GL54	
	133	gl15	
	134	GL19	
	135	GL2	
	136	GL51	
	137	GL50	
	138	GL52	
	139	GL18	

What is the first part of your postcode? eg. GL1, GL20			
		Response Percent	Response Total
	140	gl53	
	141	GL7	
	142	GL	
	143	GL7	
	144	GL52	
	145	GL56	
	146	GL15	
	147	GL15	
	148	GL19	
	149	GL20	
	150	GL19	
	151	GL19	
	152	GL19	
	153	GL19	
	154	GL5	
	155	gl51	
	156	GL4	
	157	GL18	
	158	GL51	
	159	Gl51	
	160	GL53	
	161	GL14	
	162	GL52	
	163	GL53	
	164	GL7	
	165	GL6	
	166	GL51	
	167	GL1	
	168	GL5	
	169	GL15	
	170	GL13	
	171	GL52	
	172	GL5	
	173	GL17	
	174	GL17	

What is the first part of your postcode? eg. GL1, GL20			
		Response Percent	Response Total
	175	GL52	
	176	GL54	
	177	GL11	
	178	GL1	
	179	Gl51	
	180	GL14	
	181	Gl4	
	182	GL53	
	183	GL52	
	184	gl3	
	185	GL6	
	186	GL11	
	187	GL54	
	188	GL12	
	189	GL56	
	190	GL56	
	191	GL2	
	192	GL15	
	193	NP16	
	194	GL52	
	195	Gl53	
	196	GL1	
	197	GL53	
	198	GL52	
	199	GL14	
	200	GL13	
	201	GL53	
	202	GL16	
	203	GL53	
	204	GL15	
	205	GL52	
	206	WR11	
	207	GL55	
	208	GL8	
	209	GL3	

What is the first part of your postcode? eg. GL1, GL20			
		Response Percent	Response Total
	210	GL20	
	211	GL16	
	212	GL5	
	213	GL54	
	214	GL3	
	215	GL6	
	216	GL50	
	217	Gl19	
	218	GL50	
	219	Gl51	
	220	GL12	
	221	GL53	
	222	gl51	
	223	GL16	
	224	GL52	
	225	GL51	
	226	GL52	
	227	GL3	
	228	GL4	
	229	GL6	
	230	GL53	
	231	GL8	
	232	GL20	
	233	GL5	
	234	HR9	
	235	GL52	
	236	GL2	
	237	GL51	
	238	GL19	
	239	GL52	
	240	GL7	
	241	GL4	
	242	GL2	
	243	GL11	
	244	GL3	

What is the first part of your postcode? eg. GL1, GL20		Response Percent	Response Total
245	GL6		
246	GL53		
247	GL15		
248	GL20		
249	GL11		
250	GL53		
251	GL7		
252	GL7		
253	GL53		
254	GL6		
255	gl50		
256	GL20		
257	GL50		
258	GL52		
259	GL16		
260	GL1		
261	GL50		
262	GL52		
263	GL54		
264	GL50		
265	GL2		
266	NP16		
267	GL51		
268	GL56		
269	GL3		
270	GL50		
271	GL50		
272	GL5		
273	GL7		
274	GL1		
275	GL1		
276	GL4		
		answered	276
		skipped	37

Which age group are you:				
			Response Percent	Response Total
1	Under 18		2.56%	8
2	18-25		0.96%	3
3	26-35		4.81%	15
4	36-45		7.37%	23
5	46-55		15.71%	49
6	56-65		23.40%	73
7	66-75		27.56%	86
8	Over 75		17.31%	54
9	Prefer not to say		0.32%	1
			answered	312
			skipped	1

Are you:				
			Response Percent	Response Total
1	A health or social care professional		0.00%	0
2	A community partner		2.56%	8
3	A member of the public		97.44%	305
4	Prefer not to say		0.00%	0
			answered	313
			skipped	0

Do you consider yourself to have a disability? (Tick all that apply)				
			Response Percent	Response Total
1	No		64.95%	202
2	Mental health problem		4.18%	13
3	Visual Impairment		4.18%	13
4	Learning difficulties		0.32%	1
5	Hearing impairment		7.07%	22
6	Long term condition		23.79%	74
7	Physical disability		6.75%	21
8	Prefer not to say		2.57%	8
			answered	311
			skipped	2

Do you look after, or give any help or support to family members, friends, neighbours or others because of either a long term physical or mental ill health need or problems related to old age? Please do not count anything you do as part of your paid employment.				
			Response Percent	Response Total
1	Yes		33.11%	101
2	No		64.92%	198
3	Prefer not to say		1.97%	6
			answered	305
			skipped	8

Which best describes your ethnicity?

		Response Percent	Response Total
1	White British	87.10%	270
2	White Other	2.26%	7
3	Asian or Asian British	3.23%	10
4	Black or Black British	0.97%	3
5	Chinese	0.00%	0
6	Mixed	0.97%	3
7	Prefer not to say	5.16%	16
8	Other (please specify):	0.32%	1
		answered	310
		skipped	3

Other (please specify): (1)

1	White English

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

		Response Percent	Response Total
1	No religion	34.42%	106
2	Buddhist	0.32%	1
3	Christian (including Church of England, Catholic, Methodist and other denominations)	53.90%	166
4	Hindu	0.65%	2
5	Jewish	0.65%	2
6	Muslim	2.27%	7
7	Sikh	0.00%	0
8	Other	1.62%	5
9	Prefer not to say	6.17%	19
		answered	308
		skipped	5

Are you:

		Response Percent	Response Total
1	Male	46.77%	145
2	Female	49.35%	153
3	Transgender	0.32%	1
4	Prefer not to say	3.55%	11
		answered	310
		skipped	3

Do you identify with your gender as registered at birth?

		Response Percent	Response Total
1	Yes	96.46%	300
2	No	0.00%	0
3	Prefer not to say	3.54%	11
		answered	311
		skipped	2

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

		Response Percent	Response Total
1	Heterosexual or straight	89.61%	276
2	Gay or lesbian	1.62%	5
3	Bisexual	0.65%	2
4	Other	0.00%	0
5	Prefer not to say	8.12%	25
		answered	308
		skipped	5

Are you currently pregnant or have given birth in the last year?				
			Response Percent	Response Total
1	Yes		0.98%	3
2	No		64.26%	196
3	Not applicable		31.80%	97
4	Prefer not to say		2.95%	9
			answered	305
			skipped	8

Fit For The Future - What matters to you?

Postcodes from East of county

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

		Response Percent	Response Total
1	Strongly support	30.47%	71
2	Support	30.47%	71
3	Oppose	13.73%	32
4	Strongly oppose	19.31%	45
5	No opinion	6.01%	14
		answered	233
		skipped	7

Please tell us why you think this, e.g. the information you would like us to consider (132)

1	If its means reliable and consistent access to specialists regardless of the the day or night then it deserves full support.
2	There should be one at Cheltenham General also
3	All acute work should be on one site.
4	Very misleading question. I would doubt anyone will not want a centre of excellence, but more importantly how will this impact the other services
5	How would you support acute medical at CGH and that side of the county? Increasing travel time for a seriously unwell patient
6	Centre of excellence as opposed to two try hards
7	It will be easier to manage 24/7 and we will be able to afford the best equipment if only one piece is needed instead of several.
8	AMU should be spread across both sites to prevent a bottle neck where we are changing wards such as gynaecology into a amu. It is not appropriate for women going through tough times and having to have miscarriages in bays with patients from other specialties. It violates privacy and dignity and is heartless, but no other choice due to hospital management.
9	There needs to be acute medical services at CGH also.
10	Both hospitals need to be able to assess and treat from both A +E departments. Currently Cotswold patients are having to be admitted to GRH meaning extra journey time for them and their families. Transferring Stroke and elderly patients back to CGH is not ideal and would be better being able to being able to provide holistic care for patients on both sites as we have done well for some time.
11	To centralise services in one place. To have the specialist equipment and staff on one site.

Please tell us what you think about our preferred option to develop:A ‘centre of excellence’ for Acute Medicine (Acute Medical Take) at Gloucestershire Royal Hospital.		Response Percent	Response Total
	12	Damaging effect on the local community, as it disproportionately affects vulnerable individuals with protected characteristics. Concerns about bed space at GRH. Concerns about a bottleneck effect at GRH - if you double the amount of traffic, you need to double the width of the road, ALL roads, leading in and out. Leading on to concerns about the lack of funding for SWAS as per their financial outlook to provide the additional ambulance service coverage. Flawed notion of attracting high quality staff from a business/management perspective. Gloucestershire's market has competitors in Bristol, Birmingham (to an extent), Oxford, and of course London. Centralised services will not enable GHNHSFT to outcompete these, leaving us with 'the best of the rest'. This would have been the case whether centralisation occurred or not, thus centralisation itself is a moot point. Flawed concept of 'extra time' to care. This will inevitably lead to cost savings (perhaps instructed by ministers, and not immediately) by reducing staff numbers to provide current levels of care, only now at one site.		
	13	I think the gastrointestinal ward should be bk in Cheltenham as I have a stoma and Gloucester hospital is far from me		
	14	Gloucester Hospital cannot cope with Cheltenham patients - while I was in Gloucester with my Dad the relative of someone fainted as they had nowhere to sit and were enduring a long wait with their relative in the corridor. People were sitting on the floor - very shabby we need both Cheltenham and Gloucester hospitals working a full range of services as they have always managed in the past:		
	15	There aren't enough staff to go around, so we need to make best use of those we have.		
	16	It is not clear what this actually means. Does it mean A&E will not be available in CGH?		
	17	this is completely unsafe and ludicrous		
	18	unsafe for patients		
	19	stupid idea how can a county this size have no medical take in cheltenham		
	20	Makes sense as A&E located there		
	21	Cheltenham is a large town that deserves an ED and Acute medical intake. Previous to this change Gloucester would on a regular daily basis divert either their GP and acute admissions to CGH ACUC as GRH could not cope with the high demand of patients. I feel the care is unsafe and compromised as a result of the change. Cheltenham ED and ACUC would receive patients from the Cotswolds which is an ageing population who relied on CGH service.		
	22	Presume staffing a single acute centre is easier than two, making the care it can provide more consistent and 'guaranteed'. Only reason my response is 'Support' and not 'Strongly Support' is the extra 10 miles I would need to travel.		
	23	Coming from Cheltenham and having spent over 30 years working in CGH before moving to GRH, I am quite saddened that CGH seems to be the 'poor relation' and while I understand that for many reasons, services need to be streamlined and centralised, it's hard not to feel upset at certain changes.		
	24	Please consider the effect this will have on the large number of elderly, frail patients admitted,(and readmitted) who are often MSFD early on but have multiple moves within GRH and CGH before eventually transferring out of hospital.(recent example: 89 yr old with advancing Parkinsons Disease and increasing frailty admitted for 5 days and had 5 moves: ED/AMU/7A/Snowshill/Bibury. Family were contacted when in AMU and happy to have him home from AMU). This is not uncommon.These moves have a deteriorating effect on cognition, general physical functioning and continence. How can we make this better for this cohort of patients? Consider direct to FAS/AMU then transfer to specialist Elderly Care Ward. Also please consider use of beds at CGH: Ryeworth is the only specialist COTE ward,far too many outlying COTE pts across Bibury/Cardiac2/Knightsbridge. Consider reinstating a second COTE wards at CGH. Our 'back door' is as important as out 'front door'.		
	25	localised care rather than having to transfer out/ redirect ambulances at great cost and challenge to the patient		
	26	Far too far away from Fairford to be a good option for patients from that town/area		
	27	it makes sense to have a collection of acute medicine departments in a single place. But these do need to be fit for purpose and fit for the 21st century, neither site currently is fit for purpose		

Please tell us what you think about our preferred option to develop:A ‘centre of excellence’ for Acute Medicine (Acute Medical Take) at Gloucestershire Royal Hospital.		Response Percent	Response Total
28	there is nothing in the questionnaire relating to cardiology. But the booklet clearly states amalgamating cardiology and cath labs with other radiology procedures. these are NOT the same, they are specialised and individual. This would break up any cardiology teams who foster good relations with other disciplines and work very well together. A general recovery area for these patients would be detrimental to their care and knowledge the staff hold diluted to basic and not the high standard of care we give at the moment. - its a bonkers idea. Why is cardiology constantly treated like the poor relation and not one of the jewels in the crown. why not try to create a cardiac centre of excellence?? its an increasing issue with increasingly younger patients. we do not service the population of Gloucester well without a Cardiac Centre of excellence. please don't shoehorn cardiology within radiology - isn't good and generalist staff haven't worked elsewhere. It has been tried and didn't succeed. staff will leave and will reduce staff and patient wellbeing alike.		
29	Cheltenham should remain an acute general hospital		
30	Services provided at Gloucestershire Royal Hospital and Cheltenham General Hospital should not be duplicated. Either one or the other facility should provide a specific medical speciality.In that way the specialist teams will be concentrated on one site		
31	good to have all services in one place.		
32	Gloucester Royal is not easy to get to from many pay of the county		
33	Cheltenham General can offer the same service if you let them		
34	I want my care as I get older close to home so that family can visit. I would have no intention of being in a hospital away from my home town. This has high priority for me. Acute medicine has worked well at CGH for us up until now with ACUC managing the Acute Admissions well. From my observations of the medical wards at GRH they are not fit for practice. They are old, overcrowded, dirty, poorly staffed I would never wish to be a patient on these wards from my parents experience of being a patient on them. This would not be a centre of excellence - just an overcrowded cattle market.		
35	I believe CGH should offer equal services to GRH and not all resources diverted to Gloucester		
36	Cheltenham and surrounding villages and other small towns in Gloucestershire deserve to have their own ""Acute Medical Take"" at CGH. Travelling is difficult enough in Gloucestershire and Gloucester Royal Hospital has very inadequate and expensive parking. This is a very busy tourist town with many festivals bringing thousands of people to the town and it is a very poor decision to only have a centre of excellence in Gloucester. We need our own A & E and also our own Acute Medical Take I am not opposed to Gloucester having its own centre but both places should be treated the same. Gloucester is a very large county stretching from the borders of Wales to the edge of Oxfordshire and Worcestershire.		
37	This will reduce ease of access for Cheltenham and Cotswold patients. The site at GRI is difficult to access and navigate and crucially parking facilities are woeful. Traffic congestion around GRI is often very bad - this will add to the problems in people from Cheltenham and Cotswolds getting to the hospital easily for treatment,		
38	Both centres need to provide all sorts of emergency medicine .		
39	It makes a lot of sense in so many ways. Specialist staff where they are needed and economy of one place but the assurance of cross information when necessary. A huge plus is that scheduled day surgery will be able to go ahead as planned. As a patient I have experienced surgery required after attending ED with a cut tendon, having to be surgery ready each morning only to be told it would not happen and finally being extremely ill after being giving antibiotics because of the increased risk of infection. I also think that the guided imagery will offer huge benefits e.g. to stroke patients attending ED, removing the clot quickly could mean a reduction in brain damage.		
40	This will mean Cheltenham residents will have to get there and Cheltenham hospital will not be needed, we need a centre of excellence in every hospital		
41	Need a 24/7 type-1, consultant-led A&E at Cheltenham General Hospital.		
42	Evidence is that specialist stroke unit and cardiac units provide better patient outcomes		
43	There will need to be adequate space to accommodate the increased workload		

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44	I'm disabled and have no transport to get to and from the hospital in Gloucester would very especially as wheelchair accessible transport is no longer provided to bring me home on the day of discharge		
45	Centralisation of this speciality will ensure that the clinicians with the right skills are always available. It will reduce risks to the public and reduce the need for potential transfer either to another facility or out of county		
46	Gloucestershire Royal is a difficult journey from North Cotswolds with poor bus services. Difficult for older people to visit relatives.		
47	Better treatment for all		
48	Acute Medicine seems to be an area of health where time is its greatest obstacle for a steady recovery. The availability of a correct specialist could likely contribute to the realisation of the actual problem rather than concerning around the symptoms that initially brought the patient to the hospital. Hopefully a 'centre of excellence' would increase the value of medical investigation of a patient's condition so that prevention can be enforced in the treatment. Although Gloucestershire Royal Hospital is central, the medical team may also require consideration of how patients from other towns may be able to access the yard without delay or complications.		
49	Broadly support this measure although concerned about travelling distance for patient and/or family and friends if having to travel from e.g. the east/north of the county. Using a bus (could be 2+), particularly later in the day/evening, or having to fork out a for a taxi/persuade a friend/family member to drive further is far from ideal. Some concerns over whether there would be sufficient bed space for services to be centralised - other hospitals who have merged services from two sites relatively near to each other onto one site have experienced issues with capacity e.g. a county to the north of Gloucestershire Can see the benefits of seeing the right person sooner which is very beneficial for all concerned		
50	More efficient use of specialised staff		
51	Both Cheltenham and GRH should have full facilities. This will give flexibility in terms of capacity and also provide options should one facility be unusable through disaster or infection. Currently I have experienced GRH A&E is working beyond capacity with beds in corridors'		
52	We live in the east of the county, and Gloucester is a long way to travel. This problem is exacerbated as we get older, and private transport becomes more difficult. Public transport is simply not an option.		
53	With stretched specialised NHS resources concentrating particular but different Specialists at each hospital makes sense. I am also reassured that A&E will remain at Cheltenham hospital as we live in Bourton-on-the-Water so need to be confident that the closeness of A&E in Cheltenham in an emergency provides a much better chance of survival rather than going all the way to far side of Gloucester from here.		
54	Having centres of excellence is ideal providing it does reduce waiting time, and ensures operations are not cancelled. All expertise in one place so if second opinion is needed there is someone to consult immediately without the necessity of a follow up visit somewhere else.		
55	I think the proposal is fine for the short/medium term but with major population growth planned for both Tewkedbury and Cheltenham, planning should commence for sharing between both hospitals in 5/10 years		
56	24/7 access to multidiciplanary teams. Specialist equipment. RIght disciplines to provide services and ability to train more staff		
57	Acute medical take is urgent care and represents one third of all hospital admissions (Royal Coll Physicians - 'Supporting the Acute Medical Take Dec 2015). While I support the principle of single centre of excellence approach for the Glos NHS Trust, surely for urgent care which represents such a high proportion of cases we need to serve both ends of the county properly. This would surely also mean a massive shift of patient numbers from Chelt to Glos and a resulting decline in budget for Chelt leading to further reduction of services there		
58	I feel that this sort of service should be available at Both Cheltenham and Gloucester		
59	Local		
60	GCH is so far away from the majority of the county		

Please tell us what you think about our preferred option to develop:A ‘centre of excellence’ for Acute Medicine (Acute Medical Take) at Gloucestershire Royal Hospital.		Response Percent	Response Total
61	I support the proposals to change and think the information provided presents a strong case. However, throughout the consultation document I see little or no reference to: a) How staff are to be retained, trained, recruited and afforded. b) No refernce to any improvements to process or service instigated as part of the response to Covid -19 which will be retained as Best Practice moving forward. c) Limited reference to the way that services will be re-modelled in line with international Best Practice. There is limited information given for example on the use of telemedicine, telephone consultation and foillow up, health education in primary care, transfer of services into coimmunity settings, converstions to higher day case rates, better streaming through outpatients (and ED). The proposals appear to deal with the issue of duplication of services across two sites and consequent rationalisation and whilst this is to be welcomed, of itself, it does little to illustrate how the models of care can or will change. Similarly there is no financial analysis (that I can see) with the documentation provided. In an increasingly stretched NHS, this must be a consideration for services to be long term sustainable.		
62	Whilst GRH is further travel time for me, I recognise the need for focussing practice		
63	Worried about what you promise but probably won't do at Cheltenham.		
64	It worries me hugely that the town the size of Cheltenham already hasn't got 24/7 Consultant Led A&E services. This seems another plan to reduce this even further. I worry about increased time to get emergency help for my children and elderly parents by having to travel to another town.		
65	Having all your 'specialist' staff in one area may be better and more cost effective for you but as always it's the patients who suffer. Traveling to and from Gloucester is not easy for those without their own transport. Even if the patient is transported to Gloucester by ambulance, once discharged they have still got to find their own way home, probably still feeling very unwell. They may not have friends with a car or have sufficient funds to cover the cost of a taxi, which leaves the bus, if it is running and if it is not full. There is also historically a poor reputation for infection control at GRH. I would not feel confident going there for anything serious.		
66	It sounds like a good idea, but as we are on the edge of gloucestershire it would be further for visitors to travel for us		
67	Ambulatory Care is the way forward and many more people are likely to be treated this way in the future. It makes more sense to have two hospitals offering this service in such a large county area. Cheltenham is much easier to get to for many than Gloucester.		
68	I feel it shame that departments at Cheltenham Hospital are bit by bit being transferred to Gloucester. Eventually Cheltenham hospital will become a minor community hospital. Cheltenham is large enough to warrant its own fully functional hospital. It seems the main problem is lack of staff resources. Rather than transferring and closing departments which is not in the interest of Cheltenham residents the only real long term solution is to recruit and train staff. The people of Cheltenham deserve better. Regarding this survey I find the information provided complex not concise. It is really time consuming for general public to work out what is being decided and make their comment. There is also a feeling that whatever the public opinion is the NHS management will just do what they want.		
69	I understand the need to concentrate resources.		
70	acute medicine is required both sites. CGH has ICU beds nad medical meds to help ease the patient load		
71	The Report and its recommendations have been prepared by hugely professional, experienced and competent personnel. Ninety nine per cent of feedback from the public is likely to be simply based on how it affects their personal situation regarding treatment required and location, and not necessarily related to what is best for the community at large and indeed the NHS.		
72	It’s closer for most people. Ie the forest and cotswolds		
73	I will appreciate one world-class centre for the county; without spreading the expertise by having a second service in Cheltenham. The current A&E provision at CGH (i.e. its Minor Injuries and Illnesses Unit) looks appropriate to me.		

Please tell us what you think about our preferred option to develop:A ‘centre of excellence’ for Acute Medicine (Acute Medical Take) at Gloucestershire Royal Hospital.		Response Percent	Response Total
74	It does make some sense to centre areas of expertise. However certain things also need to be taken into consideration. Access for people getting to the locations. Danger of additional time for emergency cases having to go to GRH. What is the impact on the other hospitals such as Cirencester, Tewksbury, Stroud etc.		
75	This is a hospital stay (even if 1 night) for which the patient and their family/carers have not planned. Hard enough to cope if it is local but very stressful if it is not. This is a case where both hospitals must be centres of excellence.		
76	I believe in current medicine, centres of excellence are a 'good thing'. GRH has the space and I trust facilities for this so I am happy to proceed.		
77	there is ample evidence that diffusing resources results in worse outcomes for patients. The term centre of excellence is best avoided - it sounds good but means nothing - why would anyone not want excellence? How do yo define a centre of excellence?		
78	Had an acute kidney stone admission few years ago just after Xmas - live next door to CGH - last thing would have wanted would have been to have been taken to GRH!		
79	Separate emergency services from elective services completely		
80	Centers of excellence has to be the way forward to benefit the use of technology and Consultant/specialist skills.		
81	Why have a hospital in your own town that your not able to use for all services		
82	It is better to complete the assessment of a patient where they are and transfer once if needs be to the correct place.		
83	No clinicians I have spoken to think that this is a good idea - and I am dubious as to whether this is about patient care or whether it's to save money. Sadly I suspect the latter.		
84	There are still likely to be acute medical beds in CGH, so many patients will be being transferred. Currently, even prior to COVID there was too much disorganised movement of patients to aid flow that was/is detrimental to their care. CGH has now become an overflow hospital for GRH not a centre of excellence.		
85	The area of Gloucestershire requires services at both Cheltenham and Gloucester		
86	Clear clinical advantages in not duplicating staff, so long as sufficient / additional staff numbers are working shifts to deal with increased numbers (you couldn't just shift the take and keep the same number of staff with increased number of patients).		
87	Up to date medical science and future developments		
88	Centralisation seems fine from a management point of view but the impact on the recipients can be major in terms of travel and access to the services.		
89	make the best use of the expertise for each discipline. Not point in having too many duplicated services.		
90	Our guests (we're from Cheltenham Open Door) have complex needs and issues (addiction, mental health issues, etc). If we don't have local emergency care (or suspect, if they have to be admitted, it will be in Gloucester) they are unlikely to seek help when they need it and may wait until the situation is critical and they have to call an ambulance. This will make for worse outcomes for them and the need for (presumably) more expensive and complex intervention for the NHS. Not all our guests have hugely complex needs but most would struggle if everything acute was at Gloucester. Very few would be able to have people bring stuff to them or visit if they're in Gloucester (bus fare, logistics, etc). Many rely solely on their groups of friends for support, being estranged from their families, and simply wouldn't present until the last minute if they thought they'd be taken to Gloucester. You mention ""The importance of mental health support as part of all services"" BUT not all mental health support is provided by the NHS. Sometimes, perhaps, it is as or more important to have the people who regularly provide your stability and support able to easily access and reassure you. On a personal note, I and my colleague have elderly parents who have been in A&E/ambulance situations. It's a nightmare when they are taken to Gloucester. If it's rush hour, following the ambulance takes an hour and a half and you can't pop in and out to take them things they need. You feel you have to abandon them, and they feel abandoned, when you are trying to support them from a different town. It creates anxiety, logistical issues and upset. It isn't what anyone wants.		

Please tell us what you think about our preferred option to develop:A ‘centre of excellence’ for Acute Medicine (Acute Medical Take) at Gloucestershire Royal Hospital.		Response Percent	Response Total
91	My Husband had excellent care at Cheltenham General. A serious op for Bladder Cancer in 2015		
92	Do things well in one place. Concentrate skills and workload.		
93	I It will ensure that specialist care is available at all times although it means I will have to travel from my home within walking distance of CGH.		
94	Reduced waiting times Specialised staff in one place, so prompt decisions, better staffing		
95	Localised specialist care hub should improve quality of care and outcome providing any delay in transit CGH to GRH is avoided.		
96	Experienced qualified staff centralised More opportunities for shared learning and research Intensive care facilities on one site High tech imaging facilities...		
97	I respect the reasons set out in the consultation document		
98	Timelyt assessment and diagnosis and improved staff cover		
99	After having experienced ' in patient ' services at both CGH and GRH on two separate occasions resulting from pneumonia. I would fully support the objective of developing a 'centre of excellence ' at GRH. The disadvantage of extra travelling for Cheltenham residents is outweighed by the improved facilities, better use of and more focused staff.		
100	Gloucestershire Royal Hospital is not large enough to accommodate such a move		
101	I agree with this ONLY if the A&E at Cheltenham is maintained at the same level they were pre-COVID		
102	Prefer Cheltenham - see page 37 My wife and I are in our 90th year. She is not allowed to drive. I prefer daylight and not Mon or Friday. We live in Tetbury and wish treatment there. So: We prefer Cheltenham and do not like Gloucester, the former being easier for us to reach by car and more convenient in terms of other activities on the day.		
103	Good to centralise it but please consider things like parking etc. Slapping a biblically expensive P + D doesn't cut it.		
104	The idea of creating centres of excellence at both of the two excellent large hospitals in Gloucestershire makes sense. It is worth remembering that the other specialist inpatient services, which have already centralised at either CGH or GRH e.g. cancer services at CGH and childrens' services at GRH, are working really well for patients.		
105	Distance to travel from North Cotswolds to Gloucester is to far.		
106	will you have enough beds? Some of the other changes seem more pressing		
107	Your literature does not cover a large proportion of elderly people who are taken to a&e after falls. Would they stay in the same hospital? My mother has arrived after waiting over 6 hours for an ambulance after a fall, not fit to go home but no broken bones. Where does she she up? Also, it is all very well to say this, but where are the beds? Again my mother waited overnight in a&e for a bed (with no offer of food or drink). Surely it makes sense to use a bed where there is one? What about the wait for an ambulance to take the patient from Cheltenham to Gloucester? Would that patient be back in the queue at Gloucester a&e (in my experience no doctors read patients notes and the hospitals do not share anything online)?		
108	Don't see why this needs to be only available in Gloucester and services removed from Cheltenham		
109	I want to know acute medical expertise is available locally to me		
110	Mainly happy - but difficult to travel to GRH from Cheltenham area if unwell		

Please tell us what you think about our preferred option to develop:A ‘centre of excellence’ for Acute Medicine (Acute Medical Take) at Gloucestershire Royal Hospital.		Response Percent	Response Total
111	What if the specialist team is based at CGH, thus will be some back and forth between sites. It is not clear how when a patient presents themselves to CGH and need further investigation at GRH, how move between sites. If this question JUST refers to ACU beds, then I have no opinion		
112	Although there will still be an A&E at CGH, I strongly believe that having specialists at one hospital GRH, would be beneficial to patients. My concern is the statement, " being seen by a consultant within 14 hours", is far too long a period of time. The realistic time should be a maximum of 7 hours.		
113	Cheltenham has a GENERAL hospital and as such should have the capacity for medical beds as it does now. This will seriously impact the A&E dept by downgrading it to a MIU because most emergencies will go to GRH. Your preferred option would affect, you say, in a negative way, 20-30 patients a day. That is 140-210 patients a week, 500-900 a month and 7000-11,000 a year! Are you really prepared to risk this many lives because of longer transport times for people living in Cheltenham and the North East of the county. I think this will be detrimental, causing increased suffering and death, when you stress you want to improve health outcomes for people!		
114	I like the ""centre of excellence"" approach		
115	In line with the A&E focus		
116	I have a concern that the information presented that Gloucester Royal Hospital has 49 beds is misrepresented by including frailty beds. However I generally support this.		
117	Too far to GRH for large areas of the county. I live in Cirencester, it can take an hour in peak times to get to GRH.		
118	I don't think GRH has the capacity, now or planned.		
119	All consultants, doctors, specialist nurses and ancillary staff under the same roof. Encourage medical staff and other i.e. nurses - rehabilitation staff to come and work/train. Will give encouragement to patients knowing they are in a highly specialised unit.		
120	Less need to transfer between hospitals which takes ambulance time away from emergency calls.		
121	I can understand the rationale for this proposal but Gloucester Royal is very difficult to reach from the south-east corner of the county (Fairford). I appreciate your comments in the long version about the need to help older patients who may not be familiar with one of the centralised centres. In our case, I would struggle to find GRH. I am concerned about the reduction in services in Cheltenham. One is a selfish reason: I am familiar with Cheltenham and can get there easily. My husband has been seriously ill a number of times and I know how stressful it is to find an unfamiliar hospital at night when you are panicking. My second objective reason is that it will be very difficult for ambulances (and patients in private vehicles) to get to GRH from the Cirencester area until the bottleneck of the Air Balloon on the A417 has been resolved.		
122	All acute services including the ED and both takes should be on a single site (GRH) to allow for CGH to be developed into a major elective cancer surgery hub.		
123	Need to consider how beds will be managed without disrupting more urgent changes. Eg transferring to emergency acut admissions to specialist teams on CGH site.		
124	Too far for people from east Gloucestershire to go and it is always busy.		
125	locating all resources at centre will remove from other part of zone hence increase travel time for a type of care that is time critical, better to have at least some support closer to all users hence alble to treat in 'golden time'		
126	I am concerned that too much emphasis is being placed on GRH. This concerns me because I do not believe that GRH has the facilities or space to cope with extra work. I would not support the concentration of services on one hospital site if that led to, for example, a reduction in consultants at CGH.		

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

		Response Percent	Response Total
127	If the Acute Medical intake is concentrated on one site, it will make a Type 1 A&E Department less viable on the other site. It also reduces flexibility between the two hospitals, especially in times of any future pandemics.		
128	Medical patients constitute the largest number of emergency admissions, so taking away beds from CGH will leave patients at risk of lengthier travel times to GRH with the prospect of increased suffering and death. Cheltenham is a General hospital which has already the ability to offer medical inpatient and medical emergency services. It will have an impact on CGH A&E, essentially downgrading the use of this facility. It is more than possible that between 10,000-20,000 Gloucestershire patients a year will be affected if the acute medical take transfers to Gloucester. GRH will need a high number of extra beds to cope with the amount of people who will require care and support.		
129	Cheltenham would be more convenient for me, but Gloucester is potentially bigger and within easy reach		
130	GRH is inaccessible for residents of the north cotswolds		
131	It is probably best to divide the centre of excellence status for best use of available expertise		
132	Crucial that there is sufficient capacity to easily meet demands		

Please tell us what you think about our preferred option to develop:A 'centre of excellence' for Emergency General Surgery at Gloucestershire Royal Hospital.

		Response Percent	Response Total
1	Strongly support	28.57%	66
2	Support	31.17%	72
3	Oppose	14.29%	33
4	Strongly oppose	17.32%	40
5	No opinion	8.66%	20
		answered	231
		skipped	9

Please tell us why you think this, e.g. the information you would like us to consider (121)

1	The rationale in the consultation booklet is compelling and makes the case very strongly. We need to put patient care first before all other considerations.
2	Should also have one at Cheltenham General
3	How would you support those that need emergency surgery at CGH - are patients fit to travel between sites if they need emergency surgery?
4	The same as previous it is easier to manage and better cost savings for the trust, tax payer.
5	Needs to reopen Cheltenham.
6	There needs to be capacity for this at CGH also.
7	We do not have the bed capacity at GRH to provide the care that patients need. . Lack of beds mean that all surgical patients are often outliers on various wards making it difficult getting the surgical teams to review patients when needed.
8	To centralise services, staff, expertise and equipment at one site. If this ensures that planned surgery is protected and not impacted by emergencies, then I would strongly support this option.

Please tell us what you think about our preferred option to develop:A ‘centre of excellence’ for Emergency General Surgery at Gloucestershire Royal Hospital.		Response Percent	Response Total
9	Support the notion of highly specialised surgical teams at one site. Only concerns are managing the increased throughput. Emergency surgery is rarer than acute medicine so the negative effects there should not occur here.		
10	Total chaos at glos royal. I have complex health and since cheltenham a and e closed to gp referrals I have gone to gloucester royal minimum 5 admissions. I am from cheltenham so it is much further to go, having to explain everything about your history to another medic who doesn't know you even though they have read your notes. More importantly waiting hours in a assesment unit I mean 8 plus hours when in pain is not on then to be told you are being admitted then waiting hours to be allocated a bed. I have bowel problems and I for one wouldn't want to be operated on at glos royal!		
11	You need centres of excellence in both Cheltenham and Gloucester and I believe with proper budget management this is possible I don’t feel the trust have any interest in keeping the Cheltenham service.		
12	There aren't enough staff to go around, so we need to make best use of those we have.		
13	There should be surgery facilities at both sites, and both should be ""excellent"". Transferring emergency patients to GRH wastes precious time and could risk lives.		
14	county too big for this to work		
15	makes sense as A&E located there		
16	If the specialists and kit are all in one place, surely this makes patient care better regardless of an extra few miles for those who live on the east side of the M5.		
17	As before		
18	this is a big DGH with high numbers of patients and population often requiring more than the basic care on offer outside of tertiary centres. transporting or redirecting patients involves time, money and stress for all concerned so more localised specialist care will better meet all stakeholders		
19	Emergency surgery on one site means patients will be treated by appropriate surgical specialist		
20	It seems sensible for emergency surgery to take place in the same hospital where there is a 24/7 consultant led emergency department		
21	It is bigger hospital and easy for access (not confusing as opposed to CGH which is a maze and patients are constantly lost)		
22	Far too far away from Fairford to be a good option for patients from that town/area		
23	as the main ED is currently at GRH this would make sense, however I would be anxious to avoid all eggs in one basket. this also involves the elderly and infirm travelling distances to a site that isn't easy to get to by public transport especially if you are unwell		
24	GRH should concentrate on emergency work.		
25	Cheltenham should also be a centre of excellence for surgery.		
26	Cheltenham should remain an acute general hospital		
27	I strongly support this. With Accident and Emergency to be located in Gloucester this makes sense		
28	We have hospitals in the county i.e Cheltenhem and Cirencester which could be used which would be better for those who live locally to them		
29	I don't think any of the 4 options are enough - I would like to know what happens to people who are admitted to CGH before 8pm in an emergency situation where a delay to GRH could be critical and could be criticised by the Coroner should something happen? The time delays - picking up a patient from, say, the other side of the Cotswolds - surely they need to get to the correct help as quickly as possible and GRH may be quite a lot further away than CGH.		
30	As in previous answer not easy to get to from some parts of County and parking very difficult		
31	CGH can offer the same service, like they used to		
32	Cheltenham needs surgery. As some people can not travel to Gloucester		

Please tell us what you think about our preferred option to develop:A 'centre of excellence' for Emergency General Surgery at Gloucestershire Royal Hospital.		Response Percent	Response Total
33	No Way. Build a new hospital and I might consider it. The tower block is not fit for practice. Its old and outdated with few siderooms.		
34	Services at CG H should be of equivalent quality.		
35	Many people from Cheltenham and North Gloucestershire would die on the way to Gloucester Royal. The traffic at many times of the day is apalling in Gloucester. You seem to be considering Cheltenham as a small village when in fact it has a population of 112,700. When you include the Cotswolds it rises to 196,300. With the regular increases of population throughout the year this should surely make a difference to your decision.		
36	To keep emergency and elective surgery seperate.		
37	Similar concerns to those outlined in first answer. Access problems, insufficient parking, traffic congestion and in addition the removal of general surgery is a highly significant reduction in the capability of the Cheltenham Hospital which will in due course be used as the rationale for full closure. Having services available on two sites also provides capacity and resilience in terms of space and equipment etc if one site has to be closed due to an outbreak of norovirus or covid for example. Please don't say this won't happen as you know this is the tried and tested route taken in other hospital reorganisations that have taken place across the country.		
38	Both centres need to provide excellent emergency surgery.		
39	Please see earlier comments,		
40	This should be done in Cheltenham too		
41	Need these services at Cheltenham General Hospital too.		
42	Trauma units have better expertise		
43	Too far to travel for people living East of Cheltenham		
44	The establishment of a single site for emergency general surgery will lead to better access to subspecialist care. There needs to be adequate provision of beds and assessment areas. Junior doctors will be better supported. If the same staff provide emergency, elective and day case surgery surely making changes to one component will impact on the others. Why are the changes to generals not being considered as a whole?		
45	How would the rotas become more robust if the hospital is lacking enough trainees and junior doctors?		
46	centralised is better		
47	There should be good emergency general surgery at both GRH and CGH together wit 24 hour consultant led A&E departments at both locations.		
48	Please note I don't fully follow the options here - the short booklet seemed to refer to the longer booklet. the long booklet was too confusing as to what you really meant. A picture /diagram of the before vs after might help add the clarity required Would support measures to be seen by the right person sooner but some concerns about travelling distance for patient and/or family and friends if having to travel from e.g. the east/north of the county. Using a bus (could be 2+), particularly later in the day/evening, or having to fork out a for a taxi/persuade a friend/family member to drive further is far from ideal. Some concerns over whether there would be sufficient bed space for services to be centralised - other hospitals who have merged services from two sites relatively near to each other onto one site have experienced issues with capacity e.g. a county to the north of Gloucestershire		
49	More efficient use of staff. The more surgeries completed the better the surgeons become and so patient outcomes should improve.		

Please tell us what you think about our preferred option to develop:A ‘centre of excellence’ for Emergency General Surgery at Gloucestershire Royal Hospital.		Response Percent	Response Total
50	NOt a good option. The county needs flexibility for disasters and infections. Using Cheltenham fully will also mean patients are treated faster ensuring minimal complications, quicker recovery and better availability of Ambulances.		
51	See my previous answer		
52	As mentioned on previous page		
53	As before		
54	Emergency treatment should be available at both hospitals. General surgery could be centred in GRH but both hospitals should be able to save lives.		
55	because of location personally I would prefer Cheltenham to have a unit too but accept the managements experience. However have they experienced as a patient/patients family having to travel from Northern parts of our county?		
56	As for Acute medicine, access to multidisciplanry team and equipment		
57	According to the Royal College of Surgeons ""Patients requiring emergency surgical assessment or treatment are among the most unwell patients in the NHS. Often elderly, frail and with significant other health problems, the risk of death or serious complication is unacceptably high."". This means the increasing unacceptable the risk to patients of making them travel from east of Cheltenham travel through the town and a further 10 miles to GRH		
58	As mentioned this sort of service MUST be available at both hospitals. Frankly I do not understand why it should ben centred at one hospital. It appears to be a cost cutting ploy		
59	Forerunner to removing emergency from Cheltenham		
60	I support the proposals to change and think the information provided presents a strong case. However, throughout the consultation document I see little or no reference to: a) How staff are to be retained, trained, recruited and afforded. b) No refernce to any improvements to process or service instigated as part of the response to Covid -19 which will be retained as Best Practice moving forward. c) Limited reference to the way that services will be re-modelled in line with international Best Practice. There is limited information given for example on the use of telemedicine, telephone consultation and foillow up, health education in primary care, transfer of services into coimmunity settings, converstions to higher day case rates, better streaming through outpatients (and ED). The proposals appear to deal with the issue of duplication of services across two sites and consequent rationalisation and whilst this is to be welcomed, of itself, it does little to illustrate how the models of care can or will change. Similarly there is no financial analysis (that I can see) with the documentation provided. In an increasingly stretched NHS, this must be a consideration for services to be long term sustainable.		
61	For my reasons under Acute Medical		
62	See my previous answer. All Emergency services should be excellent. The fact that many who come aren't emergency is another matter and requires more education and awareness raising to also not put those off that really should seek emergency help.		
63	There should be 2 full A&E services. Cheltenham should be full A&E not just sprained wrists.		
64	Having all your 'specialist' staff in one area may be better and more cost effective for you but as always it's the patients who suffer. Traveling to and from Gloucester is not easy for those without their own transport. Even if the patient is transported to Gloucester by ambulance, once discharged they have still got to find their own way home, probably still feeling very unwell. They may not have friends with a car or have sufficient funds to cover the cost of a taxi, which leaves the bus, if it is running and if it is not full - not very good for infection control following surgery. There is also historically a poor reputation for infection control at GRH. I would not feel confident going there for anything serious.		
65	It is a good idea, except again that as we are on the edge of the county Gloucestershire is further away		

Please tell us what you think about our preferred option to develop:A ‘centre of excellence’ for Emergency General Surgery at Gloucestershire Royal Hospital.		Response Percent	Response Total
66	As above		
67	GRH simply does not have the capacity with all of the counties A/E cases medical & surgical. the ICU is only rated good & has poor patient flow due to lack of beds in the service. CHG has the beds, the staff, the theatre space & an outstanding CQC rated ICU. emergency surgery has been carried out at CGH with excellent outcomes & no compromise to patient care. keeping everything at GRH simply isn't the safest or the best outcome for the patient. east side of the county considerably at a disadvantage		
68	Smaller A and .e with nurse practitioners would lessen the load on the big hospitals		
69	Concentration of emergency team in one place means		
70	Right to co-locate this with the A&E centre of excellence.		
71	Yes but the risks of additional transfer time for patients. Waiting times are already considerably higher. Can this be mitigated by keeping 'much less urgent cases away'? Strain on Ambulance Service. How does this all impact the other Gloucestershire Hospitals?		
72	The key word is Emergency. All emergencies should be treated as close as possible to the point at which the emergency was recognised. Unnecessary travel is best avoided and may introduce stress to the detriment of the patient.		
73	in line with evidence, a well equipped unit with expert doctors, nurses, pharmacists, physio and other AHP is associated with better outcomes; travelling further is a hard but worthwhile price to pay		
74	As I live in the northern tip of Gloucestershire, the extra distance to Gloucester for many of these services worries me		
75	Again would like CGH to be able to continue to provide this to local residents and not all centralised at GRH.		
76	Separate emergency services from elective services completely		
77	Why should we have a hospital in our town but only offering limited services		
78	Full AE needs to be at both sites to cope with capacity		
79	Again reduce duplication of doctors. Allow prompt senior review by team. Again sufficient senior staff must be on shift. One team operating and one reviewing pts. Busy team (CGH & GRH worth of pts at GRH) with only one team available will mean operating or reviewing not both. NEED BOTH. Also if this is to happen more GRH emergency theatre space will be needed so that other surgical specialities can do their cases promptly too!		
80	Essential for the county		
81	This leaves too much dependancy on the Ambulance Service to deliver services in a timely manner. It seems ludicrous to have ambulances criss crossing the county with all the attendant traffic delays that seem to be on Gloucestershire's roads. Are there any Service Level Agreements iwth the Ambulance Serviced to ensure timely tarhgets are met. What happens if (as seems to happen often) there is no availability of ambulances.		
82	Agree with any proposal to avoid unnecessary duplication		
83	The current system, with surgery at both hospitals, is better for anyone who: has money issues lacks transport has complex needs of any type I understand the desire to group services together for the NHS' logistical sake, but for anyone who struggles, in any way, being themselves in another town or having their loved ones in another town creates complications and unhappiness as mentioned in my previous answer. By doing this, you prioritise those with money, time and head space to cope with these extra complications, and disadvantage anyone who struggles in any way.		
84	A centre of excellence at Gloucester Royal would detract from the service at Cheltenham General		
85	Lessen impact on planned surgery		
86	Again, although this would be less convenient in respect of a present home the benefits would seem to outweigh the convenience		

Please tell us what you think about our preferred option to develop:A ‘centre of excellence’ for Emergency General Surgery at Gloucestershire Royal Hospital.		Response Percent	Response Total
87	Pressure eased on gaps in surgery and better for consultants and trainees. Shorter waiting and being messed about.		
88	As previous		
89	Same as Acute Medicine comments Experienced qualified staff centralised More opportunities for shared learning and research Intensive care facilities on one site High tech imaging facilities...		
90	Because it makes best use of all resources		
91	Being seen by the right specialist, not going through several appointments and being re-directed		
92	If its an emergency, the worry is that you would arrive at CGH and time would be wasted going to GRH because its 5:55pm.		
93	I would fully support the concept of Centre's of excellence for all the reasons documented in your summary document ' Fit for the future'		
94	I do not think that Gloucestershire Royal is a large enough site and believe that patients should have the option to choose which hospital they are treated at and I believe the system works as it was before the shake up of services due to the Covid pandemic. It is blatantly clear that GRH cannot cope with being the only 24hr A&E unit as evidenced by the numerous complaints and concerns that have been raised about this.		
95	Again only if you will continue to have services available at Cheltenham Hospital		
96	We prefer Cheltenham - see page 37 My wife and I are in our 90th year. She is not allowed to drive. I prefer daylight and not Mon or Friday. We live in Tetbury and wish treatment there. So: We prefer Cheltenham and do not like Gloucester, the former being easier for us to reach by car and more convenient in terms of other activities on the day.		
97	The idea of creating centres of excellence at both of the two excellent large hospitals in Gloucestershire makes sense. It is worth remembering that the other specialist inpatient services, which have already centralised at either CGH or GRH e.g. cancer services at CGH and childrens' services at GRH, are working really well for patients.		
98	Distance from North Cotswolds		
99	It seems that this is working well in the temporary changes that you have made		
100	Surely access to care should be of primary concern to a hospital? Any solution should not have a negative impact? I query your statistics? The positive benefit for this change is for the homeless and people fro deprived areas (why what is the number of these that have general surgery) You quote 25% of Gloucester are from deprived areas but how many of these have emergency surgery? What is the proportion from the deprived and homeless areas around cheltenham? The negative benefit is for 40% of patients! So you already know that 40% of your most vulnerable are over 65 and these are the people most affected? So you are negatively affecting almost half your patients?		
101	Again, involves removing important services from Cheltenham. Calling something a ""centre of excellence"" doesn't actually mask the fact that it's an excuse to cut services elsewhere.		
102	Unsafe, inadequate beds, chaotic, not essential to be on one site, worked very well on both sites. Poor bed flow inadequate ICU. Poor service for east side of county.		
103	The creation of a General Surgery Centre of Excellence, would provide the best fit with Emergency Surgery. Therefore the first option.		

Please tell us what you think about our preferred option to develop:A 'centre of excellence' for Emergency General Surgery at Gloucestershire Royal Hospital.		Response Percent	Response Total
	104	Again Cheltenham should not be downgraded by taking away, not only medical beds but also the capacity to perform emergency general surgery. This will have adverse effects on the A&E, because patients will be directed to GRH, essentially downgrading Cheltenham A&E to a MIU. If I was pushed to decide on the two option - because I would not want Cheltenham to lose surgical services then I would choose the second proposal of making CGH a centre for pelvic resection etc.	
	105	I like the idea of concentrating the expertise in a single location	
	106	In line with acute medicine and A&E focus	
	107	The risks mean that this should be with the Acute provision.	
	108	I don't think GRH has capacity now or planned	
	109	These cases can develop for the Acute Medical Take, so continuity in treatment, assessment and rehab will flow more easily. Confidence for patient.	
	110	No General Surgery beds at 1 hospital could impact badly on some patients.	
	111	As mentioned on the previous page, I am concerned about the perceived downgrading of Cheltenham. Gloucester is difficult to reach from the Fairford end of the county and parking is difficult. Also (as mentioned previously) it takes longer to get to GRH than it does to Cheltenham hospital and the travel time varies depending on the traffic on the A417 (particularly at the Air Balloon).	
	112	As with previous question, centralising acute services on the GRH site will allow CGH to be a major elective surgical centre with patients following, on the whole, a relatively fixed pathway allowing for optimal flow and best use of the existing critical care unit at CGH which otherwise risks being mothballed.	
	113	Ensure the facilities are set up with adequate space to assess patients in a timely manner. The current temporary changes are working well with more patients seen in a shorter time frame. However, limited space and beds in assessment rooms impacts on the the ability to deliver a truly first class service.	
	114	Nothing in the proposals that says emergency general surgery is better here than anywhere else.	
	115	as per commentary in last page; fear over increase travel times	
	116	I have no objection to the siting of specialist services on one hospital site. If this allows the particular hospital to improve its services in that field so much the better. I am, however, concerned that too much emphasis is being placed on GRH. This concerns me because I do not believe that GRH has the facilities or space to cope with extra work.	
	117	If ALL emergencies are taken to Gloucestershire Royal Hospital it means the A&E Department at Cheltenham would no longer be a Type 1 A&E Department.	
	118	Taking away this service from Cheltenham GENERAL hospital, where patients receive as the National Audit shows, good or excellent care, is a very short-sighted and poor decision. More patients will suffer and die needlessly because of lengthier travel to GRH. GRH will require to increase it's capacity of beds to cope with the extra demands. This will impact Cheltenham A&E department as surgical emergencies will be redirected to GRH. What sort of unit will CGH have then?	
	119	see previous comment	
	120	It is probably best to divide the centre of excellence status for best use of available expertise	
	121	Specialisation usually leads to higher quality service and the attraction of most able doctors	

Please tell us what you think about our preferred option to develop:A ‘centre of excellence’ for Planned Lower GI (colorectal) general surgery at Cheltenham General Hospital (CGH) or Gloucestershire Royal Hospital (GRH).				
			Response Percent	Response Total
1	Strongly support		45.81%	104
2	Support		35.24%	80
3	Oppose		4.41%	10
4	Strongly oppose		3.08%	7
5	No opinion		11.45%	26
			answered	227
			skipped	13

Please tell us why you think this, e.g. the information you would like us to consider (101)	
1	If it means fewer cancelled operations and less disruption in the busy winter months then it has to be a good thing.
2	Less bed issues for elective cases if away from emergency pathways. Fully staffed DCC at CGH barely used currently.
3	It makes sense to consolidate planned care at either site, but does an emergency service need to remain at the other site?
4	The same as previous it is easier to manage and better cost savings for the trust, tax payer.
5	Elective services would benefit from single site 'centre of excellence' but with the capacity to transfer from Acute medicine/surgery at both sites.
6	care of all patients in the trust has deteriorated in the last few years due to lack of access to specialist services that used to be on both sites. Patient discharge is often delayed by days awaiting review by specialities based on different sites. This is frustrating for Staff, patients and their relatives
7	Centralising planned aspects of care could take pressure off these being cancelled due to emergency procedures taking precedent.
8	If it's planned, why not just go to Oxford and build a bigger unit there?
9	Absolutely no way, Gloucestershire is way to big gloucester hospital can't cope with what services it so so provides, so sending colorectal patients to gloucester shouldn't happen. Cheltenham should keep all of the surgery especially colorectal.
10	I think it should be bk in Cheltenham
11	Unless there is a shortage of staff with the correct expertise I do not see why a single centre of excellence in Gloucester is a fair option for Cheltonians. It’s a long journey and a real challenge for elderly patients - visiting and collection of discharged patients becomes far more challenging especially for those restricted to public transport.
12	There aren't enough staff to go around, so we need to make best use of those we have.
13	I think planned surgery could be better placed within CGH so that GRH can focus on the emergency general surgery.
14	The service needs to be split across the county with two centres of excellence. A dedicated stand alone day case unit in CGH will enable the vast majority of Goucestershires' patients to have their elective surgery in a protected cold unit. Resectional surgery needs to be co-located with emergency general surgery for safety and staffing reasons.
15	Making Cheltenham a centre for elective surgery makes sense if you are wishing to centralise emergency at GRH, especially with covid. However patient choice does not seem to factor in your decisions.
16	Based on my support for emergency care at Gloucester, presumably it would make room at Cheltenham for this area of non-urgent operations.

Please tell us what you think about our preferred option to develop:A ‘centre of excellence’ for Planned Lower GI (colorectal) general surgery at Cheltenham General Hospital (CGH) or Gloucestershire Royal Hospital (GRH).		Response Percent	Response Total
17	It has been mooted for some time, so that GRH would become the 'hot' hospital, while CGH would take 'cold surgery'. This seems to have been an accepted version of things to come, so it is no surprise, and for me, there is no good reason to oppose		
18	as above		
19	Major colorectal surgery should be on one site		
20	It should be CGH, because you want everything to be easy and understandable not only for the patients, but also for the workforce. I mean try to close the cycle within one medical field. Get Endoscopy, Theatres at one place.		
21	Far too far away from Fairford to be a good option for patients from that town/area		
22	planned surgery in a centre of excellence is nothing but good, but the site needs to be fit for this and to be able to accommodate patients staff and services alike		
23	GRH cannot cope with the surgical requirements, especially if they take all the elective surgery too.		
24	Gloucestershire Royal is the most modern of the two hospitals and parts of the Cheltenham Hospital are 200 years old and unsuitable for 21st century health care provision. The most recent blocks in College Road Cheltenham could be used to complement the services provided at the Gloucester base		
25	As above		
26	Cheltenham General should remain a major hospital together with great in the area		
27	CGH can do this just like they used to		
28	I would support this if CGH was the 'centre of excellence' for lower GI. But again not GRH. There are not enough beds at GRH for emergency surgery and planned surgery. If it was at GRH alot of planned surgery would be cancelled because the beds would get used up by Emergency surgery and medical patients. As alot of this is cancer surgery it needs to be in a hospital that is clean and where the Oncology service/support services are.		
29	Both hospitals should offer an equivalent standard of care		
30	Yes it soulnds fine but surely Gloucester Royal will want their own as well!		
31	I would support this to be at CGH.		
32	Both Cheltenham and Gloucester need to do general surgery, I was released from hospital in gloucester at 11.30pm and as I was taken there by ambulance I didn’t have my car, thankfully I have a son that drives but many people would be stranded, I could of walked home if I had been taken to Cheltenham		
33	What is the evidence for specialist bowel surgery ?		
34	Combining the service will provide greater scope for subspecialist practice within colorectal surgery. Training will be enhanced and a concentration of resources including medical and nursing will make the service run more smoothly		
35	But Cheltenham would be easier because of my disability and needing wheechair accessible transport which cost more if I am required to go to Gloucester Royal		
36	Prefer Cheltenham for reason quoted earlier		
37	But on both sites		
38	Again slightly confused as to the proposal here - a before/after diagram might have helped. Would support measures to cut risk of operations being cancelled at the last minute / being able to be seen/treated by the right person sooner. Again this needs balancing with the risks of insufficient bed spaces if centralised on one sight (e.g. county to the north of Gloucestershire. In addition there are the same travel concerns - if one is not well, coming by car may be the most practical method of transport, however unpalatable it may be. Hence adequate parking facilities are a must e.g. a dedicated carpark with more short term spaces say of up to 45 minutes		

Please tell us what you think about our preferred option to develop:A ‘centre of excellence’ for Planned Lower GI (colorectal) general surgery at Cheltenham General Hospital (CGH) or Gloucestershire Royal Hospital (GRH).		Response Percent	Response Total
39	I agree with the center of excellence approach in principle. I think it will improve patient outcomes.		
40	I think it would be beneficial to have lower G.I. consultants operating or based at Cheltenham. Often other specialities such as Gynae-oncology and urology doing pelvic surgery require assistance or advice from lower G.I. surgeons.		
41	I presume GRH would be a spoke and therefore provide back up.		
42	Cheltenham is quite far enough for us to travel		
43	With elective surgery the distances to either hospital are manageable and can be planned. It the A&E that needs to remain available at both sites.		
44	As before		
45	GI is already at CGH why change it, rather expand on it		
46	Personal preference Cheltenham but would support either or shared		
47	seperating emergency from planned services should prevent cancellations and create the right number of beds for the planned procedures. Co-locating with other pelvic services makes sense as I suspect they often need to work together		
48	I accept it is no longer practical/affordable to have all specialisms at both sites		
49	Again have services available at both Cheltenham and Gloucester		
50	I support the proposals to change and think the information provided presents a strong case. However, throughout the consultation document I see little or no reference to: a) How staff are to be retained, trained, recruited and afforded. b) No refernce to any improvements to process or service instigated as part of the response to Covid -19 which will be retained as Best Practice moving forward. c) Limited reference to the way that services will be re-modelled in line with international Best Practice. There is limited information given for example on the use of telemedicine, telephone consultation and foillow up, health education in primary care, transfer of services into coimmunity settings, converstions to higher day case rates, better streaming through outpatients (and ED). The proposals appear to deal with the issue of duplication of services across two sites and consequent rationalisation and whilst this is to be welcomed, of itself, it does little to illustrate how the models of care can or will change. Similarly there is no financial analysis (that I can see) with the documentation provided. In an increasingly stretched NHS, this must be a consideration for services to be long term sustainable.		
51	We need to establish strong bases in Cheltenham. Naive perhaps to suggest centres of excellence should be visible fairly equally in both hospitals, but there could be a tendency otherwise for one of the two (probably CGH) to have lesser standing, lesser research/funding potential		
52	Don't understand. Talking jargon.		
53	If it is planned surgery the patient will have had time to plan how they will get to and from the hospital, and anyone who wishes to visit can factor the distance into their preparations. There is still the question of the exorbitant parking fees on the GRH site. Although CGH also charges stupidly high parking fees, Cheltenham based patients being treated in Cheltenham and their visitors might not need to use their cars and could avoid these phenomenally high charges. There is also historically a poor reputation for infection control at GRH. I would not feel confident going there for anything serious.		
54	It is a good idea, except again that as we are on the edge of the county Gloucestershire is further away		
55	this will allow the trust to develop a service which will be second to none. it will link in with gynae / urology & a centre of excellence for oncology too. the bed flow / capacity is there. CGH has an outstanding ICU and staff who are specialised in pelvic surgery to provide excellent care. patient flow & discharge will improve. patients will get an improved service so not mixed with emergency care & can maintain a green site especially if future pandemics as per recommendations		

Please tell us what you think about our preferred option to develop:A ‘centre of excellence’ for Planned Lower GI (colorectal) general surgery at Cheltenham General Hospital (CGH) or Gloucestershire Royal Hospital (GRH).		Response Percent	Response Total
56	Team work is vital to good patient experience and outcomes - fragmented teams cannot provide this and do not attract the best to come and work in them.		
57	One world-class centre looks ideal to me.		
58	As per previous comments		
59	but only in one centre		
60	Support options where there is access to both sites so this is good		
61	I strongly prefer this to be at the CGH site as this will ensure elective care for surgical patients will not be affected by the emergency admissions and operations, as is the case now. Also, the ITU at the Cheltenham site can be used solely for elective surgical patients.		
62	Elective care should be split from emergency where clinically appropriate / demand exists - which it does in GS		
63	ensure up to date medical procedures are available		
64	Planned surgery at least gives patients time to make suitable travelkarrangements		
65	Agree with any proposal to avoid unnecessary duplication		
66	I can't find any notes on the current vs planned systems for this, but if you mean ""all services being in EITHER CGH or GRH"" then my previous comments apply!		
67	We would prefer this service to be available at Cheltenham where my husband had excellence care		
68	Centre of Excellence required at both hospitals		
69	The proposal would seem to make more effective use of staff and facilities		
70	Not sure about this as people from the Cotswolds need the nearest place yet Gloucester is better for people from that area.		
71	Single centre would be preferred.		
72	Same comments Experienced qualified staff centralised More opportunities for shared learning and research Intensive care facilities on one site High tech imaging facilities...		
73	A single centre makes best use of sataff and resources		
74	Lower GI surgical provision impacts on other surgical specialties including gynae oncology. Gynaecology is linked to Obstetrics, an acute specialty based in Gloucester. Acute gynaecology, including acute gynae oncology admissions, is based in Gloucester hospital. It is not possible to move this acute provision as the registrars cross cover Gynaecology and Obstetrics when on shifts. Moving gynae oncology with Lower GI to Gloucester would provide better training and ward safety for patients.		
75	If its excellent, who cares where it is?		
76	Would prefer this option to be at Cheltenham General Hospital		
77	Near both		
78	The idea of creating centres of excellence at both of the two excellent large hospitals in Gloucestershire makes sense. It is worth remembering that the other specialist inpatient services, which have already centralised at either CGH or GRH e.g. cancer services at CGH and childrens' services at GRH, are working really well for patients.		
79	Concentrating the service presumably means that I will be able to see a subspecialist all the time.		
80	Centralising upper GI seems to have been beneficial, presumably the same will happen with colorectal.		

Please tell us what you think about our preferred option to develop:A ‘centre of excellence’ for Planned Lower GI (colorectal) general surgery at Cheltenham General Hospital (CGH) or Gloucestershire Royal Hospital (GRH).		Response Percent	Response Total
81	In this case, though I'm based in Cheltenham, this would again seem to be downgrading services to be only available at one location instead of at 2.		
82	Available beds, less likely to be cancelled calmer safe green site. Excellent ICU linked to essential other services to make centre of excellence. Oncology onsite national recommendations.		
83	I am a strong believer and advocate of specialised services at one hospital, my choice is Cheltenham General Hospital.		
84	Both are GENERAL hospitals, and as such should have the capacity to offer these services at both sites. But if I was to choose, based on my previous answer, it would make sense to have planned lower GI general surgery at Cheltenham to match with the idea of making it a centre for abdominal and pelvic surgery.		
85	Again, I like the scntre of excellence approach and likelihood of fewer cancellations		
86	Public perception and access focused at one hospital for one type of heath issue		
87	A centre of excellence would be good for everyone!		
88	In all cases time must be allowed to talk between medical staff and patients. Sufficient staff levels should be attained 24/7 of 'centres of excellence' comes into being.		
89	It would help provide rotas for the appropriate surgeons.		
90	Again, I understand the logic but I hope Cheltenham will not be downgraded. However, I do understand the issues raised in the booklets about staffing.		
91	Strongly support PROVIDED that site is Cheltenham		
92	Combining expertise will enhance surgical training and allow us to offer tracing in sub specialist areas of colorectal surgery. There will be greater standardisation of care. Also enhanced nursing care.		
93	Makes more sense to be at Cheltenham.		
94	It makes sense to have this at CGH where the gynaecological oncology is carried out. (Pelvic surgery)		
95	lose of this type of surgery would result in doctors/other specialists relocating hence would be unable to support A&E dept		
96	I would not support the concentration of services on one hospital site if that led to, for example, a reduction in consultants at CGH which would eventually put the future of services at that site in question		
97	General Surgery is not really a 'surgical specialism', as it relates to many different conditions. In order to justify centralising General Surgery the Hospital Trust appears to be attempting to redefine it as a specialism relating only to colorectal surgery.		
98	Cheltenham already has the Cancer Centre so it would make sense for it to have the above service.		
99	The plan seems to be to downgrade Cheltenham GH despite the wide catchment area and substantially increased population in the rural parts of North Gloucestershire		
100	CGH is the preferred option		
101	To build expertise at CGH for this speciality		

In supporting our preferred option to create a single site 'centre of excellence', where do you think a 'centre of excellence' for Planned Lower GI (colorectal) general surgery should be developed?				
			Response Percent	Response Total
1	Cheltenham General Hospital (CGH)		60.53%	138
2	Gloucestershire Royal Hospital (GRH)		14.47%	33
3	No opinion		27.19%	62
			answered	228
			skipped	12

Please tell us why you think this, e.g. the information you would like us to consider: (115)

1	A strong case has been made for both. On balance I think CGH.
2	Crucial item for me is that there is an equal balance between what is in Cheltenham and what is in Gloucester....with equal numbers of essential services in each. It must not be Gloucester is the centre with bits in Cheltenham
3	I believe that no one site can cope with providing the service for people who usually attend two sites. The waiting times increase, the staff are stretched and patients feel that they are suffering as a result. Gloucestershire is too big to have one site for a speciality.
4	As above.
5	Insufficient bed base of acute medicine, let alone medicine plus surgery. Certainly no possibility of a centre of excellence for planned care in a hospital with insufficient bed capacity for acute services.
6	I don't know enough about existing surgical set up, but you would think the site that is currently best set up to house surgery would be the most sensible choice.
7	Wherever you feel it is easier and safer to provide this from. Where other support services are on hand.
8	I
9	If the 24hr A&E is at GRH, then the planned surgery to be at CGH.
10	Why should people from Cheltenham go to Gloucester when they can go to Oxford? If it's planned...
11	Both hospitals should have their own colorectal services.
12	To remove it from the impact on bed capacity of the seasonal variation in medical emergencies.
13	Both should offer excellence I don't agree with either/or as the geographical region is huge and large populations will be disadvantaged. Surely these services should already be offering excellence or is this an acknowledgment that you are currently offering sub standard services?
14	Elective and CGH and emergency at GRH
15	I believe it would be sensible to try and ensure that CGH takes on planned / elective surgery with lower risks involved, and that GRH is responsible for caring for emergency surgery. However, I also appreciate that this could result in specialist surgical cover required across both sites rather than just covering one and could be confusing for the public if there is general surgery offered at both sites.
16	Elective days-case/short stay surgery in a dedicated unit in CGH. Resectional lower GI surgery co-located with emergency general surgery in GRH.
17	a cold, elective hospital allows access to beds, ITU, and allows all the relevant surgical specialities to work closely together to deliver excellent care. The removal of colorectal surgery from CGH would mean that urology and gynaeoncology may not be able to stay, which would put more pressure on GRH
18	I think that the 'reputation' of Cheltenham Hospital needs to be preserved if emergencies go to Gloucester, even if in a new way, so putting excellent planned operations in Cheltenham would be good.

In supporting our preferred option to create a single site 'centre of excellence', where do you think a 'centre of excellence' for Planned Lower GI (colorectal) general surgery should be developed?		Response Percent	Response Total
19	What will there be about CGH to attract anybody to work there, if surgery is removed from Cheltenham altogether?		
20	1. co-located with other pelvic cancer services (urology, gynae-oncology) 2. co-located with oncology 3. co-located with gastroenterology inpatient care 4. Protected bedbase from emergency admissions (if going with the emergency hub in GRH) and allows screened admissons only in the covid era 5. Ease of access to HDU / ITU for all planned major resections 6. Separated (geographically) elective v emergency care as recommended by a) GIRFT, b) Current President of the RCS Eng (Prof Neil Mortensen) c) external senate review		
21	wherever the facilities allow best at minimal cost and upheaval		
22	Needs to be co-located with the emergency general surgery service.		
23	I can see benefits to both hospital, GRH because of workforce but for patients which may also involve other organs in the pelvis, CGH seems more appropriate		
24	It is easy to get all GI surgeries in one place closer to Endoscopy.		
25	I don't support your preferred option at all		
26	CGH would make sense as there is the oncology dept is also there. The dots are joined up in that respect		
27	Calmer atmosphere. Better patient experience.		
28	As above, the premises at Gloucester are superior and those at Cheltenham have fallen way behind. In my view Cheltenham should have constructed a new hospital to replace Cheltenham General in the hospital building boom of the 1990s and early 2000s when a large number of towns and cities constructed new hospitals, such as Worcester, Swindon, Birmingham, Stratford -on-Avon, Hereford, Taunton, etc, etc. Cheltenham missed out then and a new replacement for Cheltenham General is unlikely now		
29	As it is planned surgery the patient can arrange transport beforehand so I don't see any issues		
30	Don't like the single site option		
31	What CGH can do GRH can do the same		
32	As above		
33	Neither site should take priority.		
34	I believe that you are wrong in trying to decide one place against the other hospital. Gloucester Royal is full to capacity and often difficult to reach because of its situation. The best solution would be to build a new hospital at Staverton and put any ""centres of excellence"" there. This idea, whilst not likely to ever be considered, would be a perfect solution. There is plenty of space at Staverton and the surrounding land. Sites at Gloucester and Cheltenham could be then be sold at a huge profit		
35	As already said emergency and elective surgery needs to be kept separate as they require differnet sorts of treatment. Keep CGH clean and where there ae more beds to keeps elective particually cancer surgery running no matter what the emergency take is		
36	Cheltenham must be the planned care centre if the Emergency centre is going to work		
37	It would appear logical to have all cancer services on one site and given Cheltenham's preeminent role in cancer treatment then all related services should be located there,		
38	My personal experience ,choice.		
39	Both need this		
40	Don't care as long as 24/7 type-1 consultant-led A&E services are restored at CGH.		

In supporting our preferred option to create a single site 'centre of excellence', where do you think a 'centre of excellence' for Planned Lower GI (colorectal) general surgery should be developed?		Response Percent	Response Total
41	If the benefit of the emergency changes is to provide immediate subspecialist care why would you consider something different for elective patients? You propose to locate elective upper GI surgery on the same site as emergency surgery, it seems incongruous to propose that another group of general surgery patients should be treated differently. If the two sites could be staffed equally there would not be a need to change. You need to ensure that the level of cover out of hours for patients undergoing major colorectal operations is the same irrespective of their mode of presentation (emergency vs elective). Specialist nursing input eg stoma nurses, cancer nurses will be facilitated by being on the same site as emergency surgery. Will a unit on a separate site have sufficient patients to be a specialist ward or will it be overrun by other specialties? Would such an arrangement really enable specialist nursing care? How do the other components of the general surgery changes impact on colorectal surgery?		
42	See previous question		
43	At the moment, both CGH and GRH seem to have a Planned Lower GI general surgery facility. I think the decision on which location to invest more excellency should mostly be focused on statistic and medical opinion, such as estimated time of arrival from one location to the hospital; percentage of local and not local patients who come to the hospital; accessibility to the yard; transportation accessibility etc. While Cheltenham could be more easily accessible, in my opinion, GRH offers facilities on Upper GI general surgery, which could contribute to the treatment of exceptional patients who may need assistance with both.		
44	Ensure services are split more equally between sites & prevent all the eggs being put into one basket. If at Gloucester, could lead to capacity problems and there is only a finite amount of space to build on, if indeed funds can be found to pay for construction/re-figurement. By locating in Cheltenham, seems to sit/align with other services to allow a more wholistic treatment service		
45	I think it makes more sense to have surgical units for upper and lower GI surgery in one location		
46	Cheltenham is a significantly better run and more pleasant place to be than Gloucester. However, smaller hospitals such as Cirencester would be a welcome addition.		
47	Due to other specialities already doing pelvic surgery in this hospital. Surely a 'centre of excellence' would allow surgeons to assist and advise each other when required.		
48	Important that each hospital has the ability to raise its reputation by having a centre of excellence. It must be ensured that Cheltenham is not regarded as a second choice.		
49	GRH is currently too busy. I presume GRH would be a spoke and therefore provide back up.		
50	See above		
51	Wherever the space is available and where the necessary ancillary departments are. Which will have the capability to ensure bottlenecks do not occur - scanning, X-ray, theatres, outpatient capacity.		
52	personal preference only based on my location. Accept entirely that management team must consider a much wider criteria		
53	as previous question		
54	Keep both hospitals operating as hospitals for all services. This centre of Excellence "" concept"" is in my opinion RUBBISH. Stop pretending that you are offering a better service when you are diluting what is already available		

In supporting our preferred option to create a single site 'centre of excellence', where do you think a 'centre of excellence' for Planned Lower GI (colorectal) general surgery should be developed?		Response Percent	Response Total
55	I support the proposals to change and think the information provided presents a strong case. However, throughout the consultation document I see little or no reference to: a) How staff are to be retained, trained, recruited and afforded. b) No refernce to any improvements to process or service instigated as part of the response to Covid -19 which will be retained as Best Practice moving forward. c) Limited reference to the way that services will be re-modelled in line with international Best Practice. There is limited information given for example on the use of telemedicine, telephone consultation and foillow up, health education in primary care, transfer of services into coimmunity settings, converstions to higher day case rates, better streaming through outpatients (and ED). The proposals appear to deal with the issue of duplication of services across two sites and consequent rationalisation and whilst this is to be welcomed, of itself, it does little to illustrate how the models of care can or will change. Similarly there is no financial analysis (that I can see) with the documentation provided. In an increasingly stretched NHS, this must be a consideration for services to be long term sustainable. I cannot determine which site I would prefer this service to be provided on without the information referred to above as this becomes merely a geographical preference rather than an option considered as to what is right.		
56	As both centres do this now, just in terms of equalising the two hospitals as mentioned above		
57	GRH is a larger site, has better facilities and is more accessible for visitors. I have had surgery in CGH in the past and felt the facilities were poor and the care was lacking. It is also very difficult for visitors to find somewhere to park.		
58	If it is planned surgery the patient will have had time to plan how they will get to and from the hospital, and anyone who wishes to visit can factor the distance into their preparations. There is still the question of the exorbitant parking fees on the GRH site. Although CGH also charges stupidly high parking fees, Cheltenham based patients being treated in Cheltenham and their visitors might not need to use their cars and could avoid these phenomenally high charges. There is also historically a poor reputation for infection control at GRH. I would not feel confident going there for anything serious.		
59	From our point of view it is nearer		
60	this will allow the trust to develop a service which will be second to none. it will link in with gynae / urology & a centre of excellence for oncology too. the bed flow / capacity is there. CGH has an outstanding ICU and staff who are specialised in pelvic surgery to provide excellent care. patient flow & discharge will improve. patients will get an improved service so not mixed with emergency care & can maintain a green site especially if future pandemics as per recommendations		
61	As I have mentioned, public views will revolve how location, for example, will affect the individual. CGH is closer to me than GRH so this is obviously my choice. That is naive and there are many many far more important factors that should determine the location. I really don't understand how public consultation on this matter assists the process.		
62	Most of the surgery might involve a cancer and Cheltenham is the cancer centre		
63	This is major surgery and should be carried out in fully staffed hospital having access to all facilities 24/7		
64	Don't really mind but feels appropriate to co-locate with the cancer (oncology) centre in Cheltenham. Nb. I have a family history of bowel cancer so take particular interest in this area.		
65	To make a decision about this, there must be many other holistic factors about the sites, capacity, etc which I am not aware of.		
66	I am not fullt aware of the different skills between GRH and CGH but roughly would like to see a 50/50 spread of centres of excellence over the county's two leading hospitals.		
67	the centre should be close to GI medicine, specialist inpatient care (as in ITU) and imaging		
68	It seems likely that management of complications would be best on the site with the most robust emergency cover		

In supporting our preferred option to create a single site 'centre of excellence', where do you think a 'centre of excellence' for Planned Lower GI (colorectal) general surgery should be developed?		Response Percent	Response Total
69	Having benefited from this excellent service, and still under their care, I would really like the service in Cheltenham to be bolstered. I live at the extreme Northern tip of the county, and Gloucester Hospital would have been a nightmare for family visits, and for me getting home from the multiple operations I have had. Given the fantastic care I had at Cheltenham, I would be keen for it not to be moved		
70	Separate emergency services from elective services completely - Cheltenham must be the centre of planned excellence		
71	This should be based at the site with emergency theatres.		
72	Whichever site the clinicians feel is most appropriate		
73	This closet to me and the family		
74	Care needs to be taken in assessing the user demographic to make a suitable choice. Ideally it would be in the centre of the most common user base.		
75	Obviously, given what I've said, I'd choose Cheltenham. Gloucester residents would presumably prefer it there!		
76	A good match with other services. Also seems too much at GRH which could lead to conflicts of staff time		
77	Both		
78	Ideal in respect of our place of residence		
79	Would keep at both		
80	Quality of patient experience much improved if planned surgery is separated from emergency activity.		
81	To colocate it with Gynae and Urology for a pelvic oncology surgery centre of excellence		
82	Cheltenham should be the centre of excellence for all impatient planned care		
83	Better on-site facilities and car-parking at Gloucester. Not sure where there is adequate space in Cheltenham		
84	The department already exists together with the oncology unit at Cheltenham General.		
85	If its excellent, who cares where it is?		
86	I would support the decision made by those individuals directly involved in the provision of this service at both hospitals. Is that information available ? I assume that is being considered in any final decision and it would have a significant impact on any final assessment.		
87	Suits us better - see page 37 My wife and I are in our 90th year. She is not allowed to drive. I prefer daylight and not Mon or Friday. We live in Tetbury and wish treatment there. So: We prefer Cheltenham and do not like Gloucester, the former being easier for us to reach by car and more convenient in terms of other activities on the day.		
88	Gloucester is MUCH easier to travel to		
89	Proposals for either option appear to be well thought through.		
90	On your facebook live session the consultant said that 12 out of 15 consultants supported this model, shouldn't you be listening to what the experts think as they provide the service and should know how it works.		
91	If you think upper GI surgery needs to be on the same site as emergency general surgery, surely the same should apply to colorectal surgery. If you are struggling to run the general surgery service on two sites at the moment why would you want to set a a service that continues to run general surgery on two sites?		
92	I don't support it		
93	As above		

In supporting our preferred option to create a single site 'centre of excellence', where do you think a 'centre of excellence' for Planned Lower GI (colorectal) general surgery should be developed?		Response Percent	Response Total
94	It would be sensible to co-locate with other pelvic area specialists.		
95	Having experienced prostate cancer surgery at CGH, I know it is well placed with excellent Consultants and support staff to provide a first class service service.		
96	I would like to know, that if you make GRH the centre for emergency general surgery, what would happen in the case of an emergency following a planned abdominal/pelvic operation at Cheltenham? Does that mean a patient would be transferred to GRH as it would be the hospital receiving surgical emergencies? Planned day cases may become more complicated and require emergency surgical intervention as all surgery comes with risks, that is why patients have to sign a consent form. Will surgeons operating on planned cases have the ability to care for patients who have a surgical emergency? Will they have the experience?		
97	I like the link with the gynae cancer treatment at Chetenham to form Pelvic Resection centre of excellence		
98	To align with the upper colorectal service at CGH		
99	All major General surgery located with acute services makes common sense.		
100	Happy with move towards CGH as an elective site predominantly and more emergency focus at GRH, as oncology centre at CGH indicates more elective treatment. But not to strip all emergency services away		
101	Which ever hospital has the space and facilities for development. CGH has very little space but other specialties can move. I leave to planning team!		
102	It would make the centre of excellence and help maintain Chelts specialism to attract staff.		
103	This is my biased opinion, as Cheltenham is so much more convenient to reach from the Fairford area.		
104	As above, allows for best patient flow and maintenance of elective work with the backup of a fully functioning intensive care unit.		
105	Ask why 12 of 15 consultants support this model. The consultants work in the system and know the details. This is the only option that will deliver sub specialist care seven days a week for emergency patients, complex UGI patients and complex colorectal patients. Why would you want to treat one of these groups differently and provide care that does not match up to other aspects of our service? The consultants know that the linkages to oncology, gastroenterology, urology and gynae are tenuous. A greater linkage is between upper GI and colorectal: the same junior staff, development of the service eg robotic surgery, same theatre staff, shared patient groups eg hernias.. This option is also the only one that allows us to develop the whole of our service. The model is actually about more than just colorectal and by moving complex colorectal to GRH it will create the theatre capacity to allow us to develop short stay surgery (not just day case) at CGH for both upper GI and colorectal. Why as an organisation have we not described the model that the majority of GI consultants have put forward?		
106	Fits in with above.		
107	north of zone seems to be where population will grow (housing plan) and south activity would likely be split between gch & new forest of dean hospital		
108	I am concerned that too much emphasis is being placed on GRH. This concerns me because I do not believe that GRH has the facilities or space to cope with extra work.		
109	If this is centralised on one site, it should be on the site where the existing Centre of Excellence for Cancer is based, because of the close relationship between Lower GI Colorectal Surgery and cancer.		
110	See above.		
111	Seems like a lot of specialist services are at GRH so good to have this one at CGH		
112	See above		
113	access to GRH is almost impossible for day patients and for visitors to in-patients if they reside in the north cotswolds		
114	So that centre of excellence status is not all centred at GRH		
115	Appears that more facilities are already there		

Please tell us what you think about our preferred option to develop:A ‘centre of excellence’ for planned day case Upper and Lower GI (colorectal) surgery at Cheltenham General Hospital (CGH).				
			Response Percent	Response Total
1	Strongly support		40.18%	90
2	Support		35.71%	80
3	Oppose		4.91%	11
4	Strongly oppose		2.23%	5
5	No opinion		16.96%	38
			answered	224
			skipped	16

Please tell us why you think this, e.g. the information you would like us to consider (89)

1	Ring fenced facilities at CGH make sense to minimise disruption.
2	See previous answer
3	Presuming it will be here as the service and supporting team are already in situ at CGH?
4	The same as previous it is easier to manage and better cost savings for the trust, tax payer.
5	If the 24hr A&E is at GRH then to have this option at CGH would be good.
6	Why go to Gloucester when you can go to Oxford?
7	Cheltenham and Gloucester should have their own elected and day surgery cases.
8	The co-location of daycases with emergencies makes more sense as day cases are much less likely to be impacted by the demands of peaks in emergency patients.
9	As per your previous question the region and population mean this is not an either/ or answer BOTH hospitals with their significant budgets should offer centres of excellence.
10	There aren't enough staff to go around, so we need to make best use of those we have.
11	new day surgery unit planned for CGH that will be able to facilitate day case surgery and provide a centre of excellence
12	Once again, I believe that there would be less breaches in waiting times for elective surgery if they were on one site and therefore protected from issues such as lack of staffing the rotas and access to resources
13	would be better to have day cases on your site where A&E is, which would allow your theatres to be used, and put your inpatients at CGH
14	As per previous answers - if Gloucester starts taking more of the emergency stuff, Cheltenham's position/prestige needs to be maintained for non-emergency stuff.
15	Day case can be done anywhere
16	as previous
17	Separates short stay surgery from complex elective surgery and emergency surgery. Best use of beds, minimal cancellations.
18	I have already said that in my previous answers. Try to concentrate in one place all cases related to GI interventions. It is better for the workforce too.
19	I don't support having only one centre for anything, given the size and demographic of Glos.
20	as previous question located in the best site alongside the supporting departments such as Oncology. the imaging services also need to be there too

Please tell us what you think about our preferred option to develop:A ‘centre of excellence’ for planned day case Upper and Lower GI (colorectal) surgery at Cheltenham General Hospital (CGH).		Response Percent	Response Total
21	It is obvious that some services will have to remain in Cheltenham for the time being as Gloucester is not large enough to accommodate them all		
22	Why spend more money when there are already perfectly adequate hospitals		
23	Don't like the single site option, would like both hospitals to offer as many treatments as possible		
24	Would these beds be ringfenced for day surgery and not have patients put in them overnight? as is the usual case.		
25	Cheltenham is the obvious choice for the planned care centre		
26	Really can’t imagine what day case GI surgery would entail .		
27	See first comment re planned surgery being able to go ahead without theatres being needed for emergencies.		
28	Both Cheltenham and Gloucestershire need this		
29	Don't care as long as 24/7 type-1 consultant-led A&E services are restored to CGH.		
30	Does this have potential to be expanded to include short stay patients? Many patients undergoing gallbladder surgery stay overnight. The same is true for patients undergoing colorectal surgery. Would a facility to accommodate these patients be better than pure day case? This might allow increased numbers of patients to have their surgery in CGH and help maintain a vibrant hospital. How do the other changes to general surgery affect the ability to deliver either day case or short stay services in CGH?		
31	Easy access and close to carers who need to visit me and don't drive		
32	I think Cheltenham does deserve a comprehensive GI surgery facility as it is a reasonably large town which hosts national and international visitors every year. The capacity of the town to provide extensive health assistance, alongside Gloucestershire Royal Hospital would also likely relieve the stress sometimes found in waiting rooms. The availability could also assist patients who are needed to stay longer in the hospital under supervision, allowing the medical team to have sufficient equipment in the event of an incident or emergency. GI conditions can be debilitating at times and the circumstance of having to travel could risk worsening, especially if no preventative methods were ever applied in their case.		
33	Now very confused - how is this different to the previous two questions? Answers are as previous - support measures to cut last minute cancellations & being able to be seen & treated by the right person quicker. however this needs balancing with concerns over travel distance and reaching capacity at one site		
34	As above		
35	As before		
36	have experienced it and was impressed		
37	as before		
38	Biased. Nearer me!		
39	see earlier comments		

Please tell us what you think about our preferred option to develop:A ‘centre of excellence’ for planned day case Upper and Lower GI (colorectal) surgery at Cheltenham General Hospital (CGH).		Response Percent	Response Total
40	I support the proposals to change and think the information provided presents a strong case. However, throughout the consultation document I see little or no reference to: a) How staff are to be retained, trained, recruited and afforded. b) No refernce to any improvements to process or service instigated as part of the response to Covid -19 which will be retained as Best Practice moving forward. c) Limited reference to the way that services will be re-modelled in line with international Best Practice. There is limited information given for example on the use of telemedicine, telephone consultation and foillow up, health education in primary care, transfer of services into coimmunity settings, converstions to higher day case rates, better streaming through outpatients (and ED). The proposals appear to deal with the issue of duplication of services across two sites and consequent rationalisation and whilst this is to be welcomed, of itself, it does little to illustrate how the models of care can or will change. Similarly there is no financial analysis (that I can see) with the documentation provided. In an increasingly stretched NHS, this must be a consideration for services to be long term sustainable.		
41	Have just received attention at Cheltenham and Gloucester.		
42	For planned day surgery it makes no difference to where I travel to within an hour. Parking seems much better at Gloucester.		
43	Although I support the idea of a 'centre of excellence', I do think that CGH needs some significant investment in order to become this and it's not the easiest place to travel to/park at due to the limited facilities. I like the idea of specialist care and if this is more readily available at CGH than GRH, then I am in support.		
44	As mentioned previously it is obviously better for those living in the Cheltenham area for as many services as possible to be fully delivered at CGH. There is also historically a poor reputation for infection control at GRH. I would not feel confident going there for anything serious.		
45	day case can be done either site		
46	As before		
47	This type of surgery is at most risk of cancellation when emergency pressures are high. We should have access to protected facilities so these operations are not cancelled. This will be good for CGH as more planned surgery will be performed there than in GRH		
48	I like the emphasis of removing emergency from CGH so that all the planned can proceed without interruption by the obviously unpredicability of emergencies.		
49	Planned surgery in one location does make a lot of sense, as long as the wait times do not increase and also operations are not cancelled due to other factors.		
50	But for day cases, there should be one at GRH as well.		
51	is there sufficient IT resource so paper records can be consigned to history and all relevant clinical information is available on both sites		
52	Personally this suits me but appreciate that Glocs residents may not want to come all way over to Cheltenham		
53	Separate emergency services from elective services completely - planned at Cheltenham		
54	Facilitate throughput of these cases - ideally including a short stay model with low acuity 1-2 night stays.		
55	This is valuable facility essential for the area		
56	Agree with any proposal to avoid unnecessary duplication		
57	See previous.		
58	The journey to Cheltenham from Winchcombe is far better than Gloucester Royal when you are unwell		
59	As before - economies of scale vasically		

Please tell us what you think about our preferred option to develop:A ‘centre of excellence’ for planned day case Upper and Lower GI (colorectal) surgery at Cheltenham General Hospital (CGH).		Response Percent	Response Total
60	More convenient from a personal point of view		
61	Single centre of excellence preferred as above providing transfers are swift and well planned.		
62	Same comments as planned general surgery Experienced qualified staff centralised More opportunities for shared learning and research Intensive care facilities on one site High tech imaging facilities...		
63	I support the basis of 'Centres of Excellence' and would assume that the decision to base a particular function at each hospital is based on building up the core competency that already exists at the chosen hospital		
64	I think further investment in CGH is very desirable		
65	N/A		
66	The idea of creating centres of excellence at both of the two excellent large hospitals in Gloucestershire makes sense. It is worth remembering that the other specialist inpatient services, which have already centralised at either CGH or GRH e.g. cancer services at CGH and childrens' services at GRH, are working really well for patients.		
67	One of your consultants proposed a model for low risk patients which included patients staying in hospital for one or two nights having their operation in Cheltenham to reduce the risk of cancellation. This sound like a good idea as long as there is capacity.		
68	If I need my gallbladder removed with an overnight stay would I be able to have this done in CGH?		
69	Why not at both, this involves improving Cheltenham at the expense of Gloucester		
70	Not essential on single site		
71	Reduces the potential for cancellations due to emergency surgery		
72	I think it is a good idea to separate out the emergency and planned cases, so having the day cases all at CGH makes sense along with other planned general surgery and the emergency cases in GR.		
73	If you have the best and most experienced medical staff at one hospital site, it follows they can provide the best medical outcome.		
74	I cannot understand why all this has to be divided up, it is quite complicated.		
75	Alll skills and staff for GI health issues in one location. Single point of contact in Trust for GI		
76	On the focus of Cheltenham General Hospital as an elective centre this fits well. The pelvic centre of excellence with the arthroplasty, gyno and urinary would all work well together although it may reduce the General Surgery pool slightly at GRH.		
77	Links with earlier point		
78	Which ever hospital has the space and facilities for development. CGH has very little space but other specialties can move. I leave to planning team!		
79	Help develop skills of junior surgeons and provide good support for them.		
80	Cheltenham is easy to reach. Also, my husband has been treated in Cheltenham for bowel cancer and an emergency hernia and I was very grateful for the good treatment.		
81	I would support routine day case surgery being done on the CGH site but this needs to be in a dedicated unit separate from the main building which cannot then be used to treat in-patients. This would also allow main theatres to be used for major elective surgery.		
82	This is intimately linked to the other changes that are being proposed. Movement of complex colorectal out of CGH will help create the theatre capacity required to allow us to deliver this in the short term before other theatres are built. The model supported by the majority of surgeons proposes to expand this to short stay cases in both upper and lower GI surgery.. This needs to be taken in to consideration.		

Please tell us what you think about our preferred option to develop:A ‘centre of excellence’ for planned day case Upper and Lower GI (colorectal) surgery at Cheltenham General Hospital (CGH).

		Response Percent	Response Total
83	What does 'centre of excellence' mean? This is a ridiculous phrase. Who wouldn't want a centre of excellence. As opposed to trying to frame the question for your desired answer, you could try phrasing it the question in more balanced way. E.g. admitting that it means focussing resources and personnel in one or both of the sites, so those taking the time to engage with your questionnaire, do not feel manipulated.		
84	if there does need to be service better where county housing plan will put most new housing/greater need.		
85	I have no objection to the siting of specialist services on one hospital site. If this allows the particular hospital to improve its services in that field so much the better and consider that GRH is already overloaded.		
86	It makes sense to focus planned surgery on one site, but this should not only be ""planned day case"", it should also include more complex elective surgery and not merely 'day case surgery'.		
87	Cheltenham already has this function so it would be sensible to maintain this service.		
88	CGH is convenient GRH is useless for day patients		
89	Helpful to split areas of excellence		

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

		Response Percent	Response Total
1	Strongly support	28.26%	65
2	Support	33.48%	77
3	Oppose	12.61%	29
4	Strongly oppose	7.83%	18
5	No opinion	17.83%	41
		answered	230
		skipped	10

Please tell us why you think this, e.g. the information you would like us to consider (92)

1	I support this on the basis that fewer people would need to travel outside of the county for treatment. We need to start thinking 'Gloucestershire' when considering these matters. If people are having to travel further beyond county boundaries then it makes sense to centralise some services here. That said, good to see there would be an IGIS spoke at CGH to support specialties there.
2	Image guidance needs to have services in both locations
3	both hospitals should have it
4	The same as previous it is easier to manage and better cost savings for the trust, tax payer.
5	Provided there is emergency cardiac interventional capacity at CGH also. It would not matter if this was at CGH considering the trust's stated aim of reopening ED at CGH post pandemic and it already exists there.
6	If this means that this service is available 24/7 at GRH then I would support this, especially if this stopped delays.
7	Extreme nature of emergency IGIS means the time delay going from Cheltenham to Gloucester would be far too risky re. loss of life to a patient who may, for example's sake, live just across the road from CGH.
8	Centres of excellence should be at both hospitals!

A 24/7 Image Guided Interventional Surgery (IGIS) ‘Hub’ at Gloucestershire Royal Hospital and a ‘Spoke' at Cheltenham General Hospital.		Response Percent	Response Total
9	if this is the same type of procedure then use just one site (either) to reduce costs/communication		
10	It is not clear what this actually means.		
11	Cheltenham with a functioning a and e needs 24/7 imaging		
12	I feel like this could fit the idea of GRH being for emergency care and CGH for elective care. I understand that there are already vascath labs at both sites so one could assume we already have the staff / resources to cover both sites if necessary.		
13	Imaging is essential to remain in CGH, Unsure as to why their is a need to transfer everything to GRH when there is a perfectly good working hospital with skilled staff members at CGH.		
14	. Even if only elective at CGH, there can still be emergency interventions needed. Moving them across site whilst unstable is dangerous.		
15	Assuming this fits with the 'Gloucestershire emergency / Cheltenham planned' route, this makes sense, if this IGIS work is used a lot in emergency situations.		
16	Requirement exists at both sites. Urology is a high user and based in CGH. Vascular (elective) ought to be in CGH.		
17	Needs to be located with acute services.		
18	State of the art equipment in GRH		
19	It should be on one place. But I have not estimated the premises that we have available at CGH even if we have to build up a new building it is going to be far more better for the service than the service to be scattered.		
20	Grudging support since something will be offered at both sites		
21	making sure that the supporting staff are enough to provide this		
22	This is a very important part of present and future health care and will greatly increase in the coming years		
23	A spoke will still split the vital staffing groups but in reverse.		
24	Reluctantly support, again would like both hospitals to offer as many treatments as possible		
25	Heart attack patients need treatment at closest hospital this would be better than using Bristol but should be available on both sites		
26	what ever GRH can do Why cant CGH do the same		
27	As vascular and cardiology are at CGH then this service needs to be based on this site.		
28	Image Guided intervention main hub should be alongside ED		
29	Both hospitals need this		
30	Don't care as long as 24/7 type-1 consultant-led A&E services are restored at CGH.		
31	Best located with the main emergency work		
32	This will reduce the need for patients travelling out of count out of hours and increase the ability to recruit high quality staff		
33	Such specialised intervention should be centralised		
34	I think investing in IGIS is a fantastic action. To my understanding and experience, IGIS provides an alternative to what could be a very invasive surgery and allows patients a safer and quicker recovery. It seems to me that it is something that should be evaluated to possibly be instigated in other areas of the country, if they so need it.		

A 24/7 Image Guided Interventional Surgery (IGIS) ‘Hub’ at Gloucestershire Royal Hospital and a ‘Spoke' at Cheltenham General Hospital.		Response Percent	Response Total
35	Appears to be specialist treatment needing expensive specialist equipment operated by experts. Given this seems better to centralise as one service - some people may travel a little further but far fewer would need to travel out of county at evenings/weekends. Going to hospital unexpectedly (or even planned) is not a good experience so removing a longer journey with some of the complications this can lead to seems a beneficial step		
36	Need more info on this reason, ie is it staff, facilities or something else?		
37	I believe it is good to have different hospitals with different specialisms. This will also promote inter hospital information exchange. I presume Cheltenham would be a spoke and therefore provide back up.		
38	Should have equal amounts at both hospitals		
39	In the AI age this can be shared between both hospitals		
40	seems sensible in view enormous cost of equipment		
41	updating equiment and locating in one site is more cost effective		
42	see earlier comments		
43	Imaging is already at Cheltenham, why move		
44	I do not understand why, following the presumed logic elsewhere in this consultation why the IGIS seervice needs a 'hub and spoke model'. There is no convincing argument made for this on any rationalisation, financial, staffing or any other basis. Just create a centre of excellence badsed on sensible criteria and get on with it		
45	This makes sense. I assume the Spoke would deal with geographically favoured patients who are nion urgent		
46	I am not sure why it is that CGH always seems to get the second best option of anything being considered, but as I have not needed treatment of this type I am not in a position to make further comment.		
47	it would be good if people could go to the nearer one if possible		
48	with major pelvic surgery we need interventional surgery which will also tie in with oncology		
49	More central for the county		
50	It is unclear to me what the difference between a Hub and a Spoke in this context. The best of treatment should be available in both locations.		
51	Interesting to see the hub and spoke concept. Will this leave the hub as a centre of excellence? Can there be other spokes such as Forest of Dean or smaller hospitals such as Cirencester?		
52	more details are required to ensure both are adequately resourced (people and equipment) and overnight care available on site if needed; a waste of resource if personnel spend time travelling between centres		
53	This would support the acute medicine and emergency general surgery services best		
54	I prefer it to be offred at both		
55	Needs to be linked to Emergency Gen Surgery		
56	IGIS & vascular should be on same site		
57	essential facility important for the community		
58	Probably necessary due to availability of technology and equipment.		
59	Agree with any proposal to avoid unnecessary duplication		
60	See previous		
61	We have the excellent cobalt centre in Cheltenham		
62	This could have been a centre for excellence in cgh ?		

A 24/7 Image Guided Interventional Surgery (IGIS) ‘Hub’ at Gloucestershire Royal Hospital and a ‘Spoke' at Cheltenham General Hospital.		Response Percent	Response Total
63	We've invested in Cheltenham already, make Cheltenham the Hub.		
64	Seems to make sense		
65	This is a very specialised service and heavy on equipment costs so centralisation makes sense.		
66	It is more effective to provide a hub at GRI but a spoke allows more freedom for management		
67	Less likelihood of being transferred to other hospital sites. Retention of staff is pararmount		
68	The staff who maintain the LINACS (at CGH) would be best to carry out emergency repairs and maintenance, surely?		
69	Much of the reason why patients have to go outside the County for image guided surgery is that Gloucester is not in the centre of the County and certainly for people like me living in Chipping Campden it is a long way away		
70	N/A		
71	The idea of creating centres of excellence at both of the two excellent large hospitals in Gloucestershire makes sense. It is worth remembering that the other specialist inpatient services, which have already centralised at either CGH or GRH e.g. cancer services at CGH and childrens' services at GRH, are working really well for patients.		
72	Concentrating the service presumably mean better access to specialists in the field		
73	It looks as though this makes it more likely that i would be able to have my treatment in Gloucestershire		
74	see previous answers		
75	Meets most eventualities		
76	However, I do believe that more surgery will head in this direction and thus equipment at both sites to cover a range of specialities will be required.		
77	I think this will allow the best use of equipment by having the main hub at GRH but still maintaining some of the spoke services at CGH.		
78	IGIS is the technology and service that will become more important in the future. Cost will dictate that only one hospital can invest in this equipment and reluctantly I have to chose GRH, with a "spoke" at CGH.		
79	There is a 2.5 million centre that has not long been built at Cheltenham. To move this hub to GRH is a waste of money when the service is already functioning well at Cheltenham.		
80	Key point of focus at GRH. It is unclear to me why you would want a spoke at CGH. Resources staff and equipment would be split. Imaging equipment requires on going maintenance programme better focused at one location		
81	The major IGIS is acute related often so should be with the trauma and stroke unit. However, Cheltenham General Hospital as a spoke would allow elective investigations and pelvic and oncology to occur.		
82	This makes sense with use of 'on call' specialists. CGH 'cold' centre for elective procedures.		
83	Sounds sensible. Emergency cases coming into either unit may need IGIS - so good back up for A&E.		
84	Having read the information in this booklet I think it would be better to have 1 place for IGIS at GRH.		
85	I understand the rationale so would have to accept the proposals. GRH is difficult to reach but, on balance, the centre of excellence is more important.		
86	Emergency interventional radiology should be on the acute site, supporting emergency vascular surgery in particular. The 'spoke' could then be used to support daytime work at CGH and this will make optimal use of the existing hybrid theatre.		
87	This will provide a better service for general surgery patients. A significant number of elective patients undergo interventional radiological procedures which is another reason for locating complex upper and lower GI patients on the GRH site.		

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

		Response Percent	Response Total
88	I would not support the concentration of services on one hospital site if that led to, for example, a reduction in consultants at CGH		
89	Image Guided Interventional Surgery appears to cross a variety of other specialisms, but seems most relevant to Cardiology and Vascular Surgery, which should be located in the first-class facility that was only created at Cheltenham three years ago.		
90	Most cases are already performed in Cheltenham and it should be the main Hub because it already has a new purpose built facility costing several millions. It would be hugely wasteful to remove this service from Cheltenham.		
91	patients can be taken to/from GRH by ambulance, access problems are therefore left crucial.		
92	Need to be able to meet the demand and provide the highest quality of service		

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

			Response Percent	Response Total
1	Strongly support		25.44%	58
2	Support		27.19%	62
3	Oppose		9.21%	21
4	Strongly oppose		15.35%	35
5	No opinion		22.81%	52
			answered	228
			skipped	12

Please tell us why you think this, e.g. the information you would like us to consider (84)

1	both hospitals should have it
2	Theatres less suitable compared to IR theatre at CGH. Major urology surgery has needed a vascular surgeon immediately at CGH in the past 10 days.
3	I would like Glos population served as a consquence of this. Currently patients from outside the county have skewed access to aligned services as a consequence - mainly radiology.
4	Renal services are at GRH. This would support renal service well.
5	The same as previous it is easier to manage and better cost savings for the trust, tax payer.
6	Vascular surgery should stay in Gloucester, however there is increasing amount of t&o outliers.
7	Cardiology and vascular services should be on the same site to service emergencies.
8	I would support this if GRH were able to provide vascular surgery with a ward that was fit for purpose! Vascular patients are currently on a ward that does not have the space or capacity for the patients. Wheelchair patients have 1 accessible toilet and shower for 21 patients. This in not good for rehabilitation of patients post amputation and impossible for all patients to access shower facilities. This is adversely affecting patient care. Lack of space around beds make life hazardous for staff and patients as we are often transferring patients from bed to wheelchair with hoist and moving furniture around to make this possible.
9	Centralising of this service, improved staff availability, expertise and ensuring this prevents delays and wait time.

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

		Response Percent	Response Total
10	Again, why not just go to Oxford if you live east of Cheltenham?		
11	This seems like an enormous waste of previous investment in facilities such as the hybrid theatre.		
12	Centres of excellence are required at both hospitals- the region and population support it - you are reducing Cheltenham hospital to a first aid centre by stealth. Offering centres of excellence is merely a ploy to reduc3 services in Cheltenham which remain badly needed!		
13	This service was previously being managed well at CGH but if it not possible to split elective e.g. IGIS and emergency vascular surgery then I believe it would be preferable to keep it on the GRH emergency site and then consider the ""spoke"" option at CGH for the elective surgery. Splitting this service will have an impact on the intensity / quality of Therapy those patients will receive unless additional funding is provided to support splitting this service across sites.		
14	Emergency vascular should be in GRH, elective should be in CGH - bespoke IR theatre already exists there and same arguments for bed base, HDU / ITU etc as for elective colorectal apply		
15	Vascular surgery can be a stand alone speciality		
16	Other services such as renal medicine, diabetes which have a strong link to vascular surgery are largely based in GRH		
17	Because is not GI surgery. Every surgery not related to GI can go in GRH.		
18	Far too far away from Fairford to be a good option for patients from that town/area		
19	its already there		
20	Speciality doesn't really have elective admissions. They have urgent emergency type patients		
21	This should be concentrated at Gloucestershire Royal and it is not asking too much for patients needing such procedures to have them carried out at Gloucester		
22	See my previous answers, Great getting too busy with parking and accessibility problems		
23	Heart attack patients need treatment at closest hospital this would be better than using Bristol but should be available on both sites		
24	What ever GRH can do , CGH should do the same		
25	Again the wards at GRH are not fit for practice. They are overcrowded, beds too close together increasing the infection risk. The tower block appears generally dirty. Your report reads that if you live in a deprived area(25% of Gloucester population) you will get preferential treatment on your door step and blow the rest of the county. Given that most vascular issues occur in the over 65 age group and these people are spread out across the county if you live at Morton/Bourton area East Gloucestershire, you wont stand much chance of survival.		
26	As above,		
27	Both hospitals should do this		
28	Don't care as long as 24/7 type-1 consultant-led A&E services are restored at CGH		
29	Supporting evidence required		
30	Ideally it would be located with the IGIS hub. Needs adequate provision of beds and and appropriate theatre.		
31	Access to skilled medical staff in the right location		

A 'centre of excellence' for Vascular Surgery at Gloucestershire Royal Hospital.		Response Percent	Response Total
	32	Again confused - suggest you need to engage some communications experts to put the proposals AND link them to the survey in plain english/language understandable by non medical persons. Appears to be specialist treatment needing expensive specialist equipment operated by experts. Given this seems better to centralise as one service - some people may travel a little further but far fewer would need to travel out of county at evenings/weekends. Going to hospital unexpectedly (or even planned) is not a good experience so removing a longer journey with some of the complications this can lead to seems a beneficial step	
	33	Whilst I support this, I believe there needs to be a vascular consultant available to cover CGH at all times due to the major surgery that CGH provides. In an emergency situation in theatre a vascular surgeon could be needed very quickly!	
	34	Would seem to complement IGIS	
	35	As before - transport is a serious worry for us	
	36	see earlier comments	
	37	I support the proposals to change and think the information provided presents a strong case. However, throughout the consultation document I see little or no reference to: a) How staff are to be retained, trained, recruited and afforded. b) No refernce to any improvements to process or service instigated as part of the response to Covid -19 which will be retained as Best Practice moving forward. c) Limited reference to the way that services will be re-modelled in line with international Best Practice. There is limited information given for example on the use of telemedicine, telephone consultation and foillow up, health education in primary care, transfer of services into coimmunity settings, converstions to higher day case rates, better streaming through outpatients (and ED). The proposals appear to deal with the issue of duplication of services across two sites and consequent rationalisation and whilst this is to be welcomed, of itself, it does little to illustrate how the models of care can or will change. Similarly there is no financial analysis (that I can see) with the documentation provided. In an increasingly stretched NHS, this must be a consideration for services to be long term sustainable.	
	38	I am not sure why it is that CGH always seems to get the second best option of anything being considered, but as I have not needed treatment of this type I am not in a position to make further comment.	
	39	Again reducing Cheltenham	
	40	Again more central for the county and transport links	
	41	As per previous observations	
	42	This should be true of CGH too	
	43	as with GI surgery	
	44	Should include mechanical thrombectomy for LAO strokes	
	45	I think it should be offered at both sites	
	46	Planned care should be at Cheltenham General - that's the Centres of Excellence model	
	47	Needs to be linked to IR	
	48	IGIS & vascular should be on same site	
	49	Essential facility important for the community	
	50	Agree with any proposal to avoid unnecessary duplication	
	51	See previous	
	52	As above	

A ‘centre of excellence’ for Vascular Surgery at Gloucestershire Royal Hospital.			
		Response Percent	Response Total
53	Needs to be at both hospitals		
54	As above		
55	One excellent speciality		
56	Planned care at Cheltenham		
57	Better facilities and car-parking at GRH		
58	As I said before, as long as it is excellent, who cares where it is?		
59	Vascular Surgery had a very good set up at Cheltenham General Hospital with the IR theatre being built and utilised. The theatre sessions at Gloucestershire Royal Hospital are inadequate and the ward is literally a joke, not fit for purpose and the ward is dirty and the bed capacity is severely lacking. The service works perfectly well at Cheltenham General Hospital and would be costly to move on a permanent basis and even the consultants in the department are strongly opposed to moving on the grounds of patient safety and capacity issues.		
60	I appreciate that these skills cannot be shared between too sites but for emergencies people living in many of the remote parts of Gloucestershire they need quicker access to a hospital and Gloucester is far from us		
61	N/A My wife and I are in our 90th year. She is not allowed to drive. I prefer daylight and not Mon or Friday. We live in Tetbury and wish treatment there. So: We prefer Cheltenham and do not like Gloucester, the former being easier for us to reach by car and more convenient in terms of other activities on the day.		
62	The idea of creating centres of excellence at both of the two excellent large hospitals in Gloucestershire makes sense. It is worth remembering that the other specialist inpatient services, which have already centralised at either CGH or GRH e.g. cancer services at CGH and childrens' services at GRH, are working really well for patients.		
63	They seem ton work closely with the radiologists so doesn't it make sense for them to be on the same site?		
64	It seems that this is closely linked to the IGIS hub		
65	see previous answers		
66	Having Vascular surgery at GRH will mean that vascular surgery will be able to support the emergency services better.		
67	If the investment in IGIS is at GRH, it follows that "A Centre of Excellence for Vascular Surgery, should be at GRH.		
68	Again the facility is already at CGH and working well, make the hub at Cheltenham and the spoke at Gloucester, as it makes sense as this is the way it operates at present. Why put all that money and energy into building a purpose built facility at Cheltenham only for it to be downgraded.		
69	In line with decision to locate the IGIS primarily at GRH		
70	I believe that some thought should be given to maintaining some 'low risk' non urgent vascular capability for some elective vascular surgery at Cheltenham General Hospital		
71	As long as there is critical care support e.g. for aortic aneurysms		
72	Why not? The importance is that the unit exists and is available 24/7 as and when.		
73	Single specialist centre would enable better and timely patient care.		
74	I understand the rationale so would have to accept the proposals. GRH is difficult to reach but, on balance, the centre of excellence is more important. Regarding concerns about going out of county, Gloucester is no more convenient than Bristol (although I accept there may be budgetary considerations).		

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

		Response Percent	Response Total
75	I feel emergency and elective vascular surgery should be split so that emergency work is aligned with the surgical take whilst elective work continues at CGH. This will ensure there is critical care capacity available to support the elective work otherwise there is likely to be an ever increasing pressure on ICU beds at GRH.		
76	Concentrating resources provides better care		
77	Is there not a new vascular theatre in Cheltenham?		
78	Hasn’t millions of pounds recently been spent on a vascular theatre in Cheltenham!!		
79	as noted earlier CofE reduces resourcing supporting A&E from other hospitals		
80	I would not support the concentration of services on one hospital site if that led to, for example, a reduction in consultants at CGH.		
81	There is an excellent, nearly new Cardiovascular Unit at Cheltenham General Hospital, which the Hospital Trust spent £2.3m or more on. This is one of the best facilities of its kind in the South West, if not the whole country. It makes no sense to relocate this to the Gloucestershire Royal, especially since, according to six our of seven of the Consultants involved, the facilities there are not nearly as good.		
82	The Trust commissioned a new facility at Cheltenham which cost several million. It is regarded as the very best in the South West. It would be hugely wasteful to take it away. Most cardiology and inpatient vascular surgery is already performed at Cheltenham, it should stay.		
83	CGH already does it		
84	The need to create the centre of excellence for specific specialisation over the 2 hospitals		

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

			Response Percent	Response Total
1	Strongly support		44.00%	99
2	Support		31.11%	70
3	Oppose		3.56%	8
4	Strongly oppose		1.78%	4
5	No opinion		19.56%	44
			answered	225
			skipped	15

Please tell us why you think this, e.g. the information you would like us to consider (77)

1	Good to see this could be made permanent. It appears that a lot of progress has been made since the pilot scheme was put in place. Good clear proposal.
2	Despite gastro inpts being at CGH currently, gastro inpts are still seen on GRH wards and do not get the care they need from the gastro team. Patients either need to be moved promptly so the care of the patient is not impacted, or have a service at both sites.
3	The same as previous it is easier to manage and better cost savings for the trust, tax payer.
4	Provided there is some gastroenterolgy presence at GRH also.
5	Everyone will know where it is and again centralising services and insuring expertise, experience and staffing is available.

A permanent ‘centre of excellence’ for Gastroenterology inpatient services at Cheltenham General Hospital.		Response Percent	Response Total
6	Gastroenterology at cheltenham is the best. Keep it in cheltenham.		
7	Both hospitals need a centre of excellence due to the size of the population and the location of the services .		
8	This fits with separating surgical and medical divisions across each site.		
9	as long as colorectal surgery is also located there - without this it will leave gastro very exposed		
10	It is closer to Endoscopy Unit. Patients can be easily transferred to it.		
11	I would also like to see continuing support for Gastroenterology services at Cirencester hospital. I have had excellent treatment there.		
12	Better for patients from Fairford, but not good for patients living at the west edges of Glos.		
13	If GI suregery is at CGh this needs to be too		
14	Some services will need to be continued at Cheltenham as Gloucestershire Royal will not be able to accommodate them all		
15	Should be in Gloucester with the rest of medicine		
16	See all my previous answers		
17	Save me travelling to Gloucester and pay expensive park fees for long visits and bus fares		
18	Emergency Gastroenterology patients should also be admitted to ED at CGH once its reopened other wise you dont have a 'centre of excellence. You will have patients on both sites.		
19	This goes along with the idea of a centre of excellence in planned care		
20	I have concerns that the underlying message of specialisation does not take into account issues of resilience, access, critical mass or community. The approach being taken is "standard" nhs review practice to downgrade one site to the benefit of another. In effect closure by instalments: Why does the Senior Health Management in Gloucestershire look at closing both hospitals and locating a new one just off J11 or 11a of the M5?		
21	I fully support the Centre of Excellence principle and am happy to leave the ‘where’ to those more qualified than me to make that decision.		
22	Both hospitals need this		
23	Don't care as long as 24/7 type-1 consultant-led A&E services are restored at CGH		
24	Describe centre of excellence as this term is being overused in the survey		
25	There needs to be an outreach service to GRH. Interaction with emergency general surgery is still possible - need to ensure this is not affected. Interaction with elective surgical patients is principally on an outpatient basis		
26	Easily accessable		
27	The data presented strongly supports not reverting back to the old model		
28	Seem to be wanting to move all other services away from Cheltenham - might be an exaggeration but that is what is coming across, whether intended or not. The shorter booklet was understandable until it referred you to the longer booklet - that just descended into more confusion Again support measures to have less last minute cancellations & being seen/treated by the right person sooner. Need to balance this against over centralising and leading to capacity constraints & greater travelling time for those in the west of the county, particularly at the start/end of the day & at weekends		
29	Would compliment other specialisms		
30	As above		
31	simply accept the judgement of the people making the recommendation		

A permanent ‘centre of excellence’ for Gastroenterology inpatient services at Cheltenham General Hospital.		Response Percent	Response Total
	32	co-locating with planned day cases with specialist staff and contact points for inpatient and long-term ongoing care	
	33	Yes both hospitals should be capable of offering all services	
	34	I support the proposals to change and think the information provided presents a strong case. However, throughout the consultation document I see little or no reference to: a) How staff are to be retained, trained, recruited and afforded. b) No refernce to any improvements to process or service instigated as part of the response to Covid -19 which will be retained as Best Practice moving forward. c) Limited reference to the way that services will be re-modelled in line with international Best Practice. There is limited information given for example on the use of telemedicine, telephone consultation and foillow up, health education in primary care, transfer of services into coimmunity settings, converstions to higher day case rates, better streaming through outpatients (and ED). The proposals appear to deal with the issue of duplication of services across two sites and consequent rationalisation and whilst this is to be welcomed, of itself, it does little to illustrate how the models of care can or will change. Similarly there is no financial analysis (that I can see) with the documentation provided. In an increasingly stretched NHS, this must be a consideration for services to be long term sustainable.	
	35	Bias on my part. No real rationale to be honest	
	36	Again, makes no difference to me as a patient where this is based	
	37	I am in support of this if it means that all the specialists are in one place. I do have concerns about the lack of parking facilities at CGH - especially if patients are being asked to travel from further afield to attend this site.	
	38	As mentioned previously it is obviously better for those living in the Cheltenham area for as many services as possible to be fully delivered at CGH. There is also historically a poor reputation for infection control at GRH. I would not feel confident going there for anything serious.	
	39	will tie in with colorectal making patient experience & expertise seamless	
	40	I have a potential gastroenterology condition, so Cheltenham suits me. That should not be the criteria, when professionals have studied the situation extensively and come to a conclusion.	
	41	But not only at CGH.	
	42	Gastroenterology services should (at least in my view) be in close proximity to GI surgery. Optimal care of such patients often involves close collaboration between the two arms	
	43	This will only work if medical beds are managed by the specialty teams, when pressure increases in GRH this is always lost.	
	44	Whichever the clinicians think is best	
	45	Essential facility important for the community	
	46	Agree with any proposal to avoid unnecessary duplication	
	47	See previous	
	48	I have received excellent care at Cheltenham	
	49	Support concept	
	50	Ideal location from a personal point of view	
	51	As above	
	52	Treated more quickly by a specialist	

A permanent ‘centre of excellence’ for Gastroenterology inpatient services at Cheltenham General Hospital.		Response Percent	Response Total
53	Suits us - see page 37 My wife and I are in our 90th year. She is not allowed to drive. I prefer daylight and not Mon or Friday. We live in Tetbury and wish treatment there. So: We prefer Cheltenham and do not like Gloucester, the former being easier for us to reach by car and more convenient in terms of other activities on the day.		
54	The idea of creating centres of excellence at both of the two excellent large hospitals in Gloucestershire makes sense. It is worth remembering that the other specialist inpatient services, which have already centralised at either CGH or GRH e.g. cancer services at CGH and childrens' services at GRH, are working really well for patients.		
55	Combining the service presumably means that there will be better access to specialist inpatient care. They need to make sure that they provide a service to Gloucester Hospital.		
56	Your pilot appears to have worked well		
57	As above, also strongly sceptical of your use of the word ""permanent"", given the constant change and deterioration that is going on in NHS services locally		
58	I support this if linked with colorectal surgery at Cheltenham		
59	Makes sense with plan to have centre of excellence at CGH for Colorectal surgery.		
60	It appears that the pilot works.		
61	It is clear that reverting to the set-up from the pre-pilot stage would be worse off for many aspects. It seems to be working well, and it is fulfilling the world-wide move to centres of excellence.		
62	CGH has an enviable reputation in this field and with more investment can become the "Centre of Excellence".		
63	As this appears to be working well from the pilot then it seems sensible to keep the service as it is now.		
64	This is in line with the decision to locate the GI services at CGH but to be effective and efficiet the CGH facilities, resources and staffing levels need to be expanded and improved at CGH if the CGH is to be the centre of excellence.		
65	Cheltenham General Hospital concentrating ofn elective support in the area is sensible.		
66	We think all procedures should be available at all hospitals, but Cheltenham is preferable to us over Gloucester as it is marginally closer.		
67	Will need surgical support		
68	This probably follows on from the other gut services, so yes.		
69	A centre of excellence would benefit both staff, services delivered and patient care.		
70	My husband received excellent care for bowel cancer and an emergency hernia. Cheltenham is so much more convenient for the Fairford end of the county.		
71	The current setup seems to work well. All acute admission would still need to be via GRH but once stable transferring patients across to CGH optimises flow and also helps reduce pressure on GRH DCC for patients who then deteriorate on the ward and require intensive care.		
72	Interaction with gastroenterology on a day to day basis for general surgery is either on an outpatient basis or as an emergency. The current system of having a gastroenterologist on site in GRH works well. Outpatients continues to work as before. Overall the changes do not affect the general surgery service.		
73	Cheltenham as an older demographic than other parts of the zone covered by trust however might be best not to have CofE so specialist doctors are available for A&E support at all the hospitals in the trusts zone		
74	I have no objection to the siting of specialist services on one hospital site. If this allows the particular hospital to improve its services in that field so much the better.		

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

		Response Percent	Response Total
75	this is a service which should, as far as possible, be located as close to the existing Cancer Centre in Cheltenham General Hospital.		
76	This could work well alongside the Cancer Centre.		
77	CGH is best located for the whole of the county		

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

			Response Percent	Response Total
1	Strongly support		44.74%	102
2	Support		30.26%	69
3	Oppose		7.89%	18
4	Strongly oppose		3.07%	7
5	No opinion		14.04%	32
			answered	228
			skipped	12

Please tell us why you think this, e.g. the information you would like us to consider (89)

1	Fully support and it appears to reflect the wider logic of the overall Centres of Excellence approach. Supporting staff to provide the very best specialist care.
2	both should have trauma and ortho
3	If it is a trauma case, it is quite possibly an ambulance admission and GRH cannot cope now. All ambulances go to GRH and then orthopaedics would have to be transferred to CGH, increased cost, risk, time and staff
4	The same as previous it is easier to manage and better cost savings for the trust, tax payer.
5	There are a high number of T&O patients so both sites is good
6	This has to be fit for purpose and capacity needs to be concidered
7	If the 24hr A&E is at GRH I it makes sense for trauma to be centralised there. Orthopaedics at CGH again if this ensures this service is protected and trauma emergencies doesn’t interfere with this.
8	Both hospitals have the population to support a centre of excellence- this is just stealing Cheltenham hospital services away which has been happening by stealth over recent years!
9	if these are similar and use the same resources then use one site (either) to reduce costs/communication
10	Why are these separated at two sites? Are they not related, so should be together on one site?
11	This is something that I believe is already pretty much established with GRH being the trauma site and CGH being the elective site
12	trauma where A&E is, elective orthopaedics at cold site with no bed pressures
13	if this is tenable on two sites, why not? if resources do not allow this then one site will be better than none and centralises specialist care
14	Again acute trauma is better placed in GRH because of the 24/7 access to consultant led A&E

Two permanent ‘centres of excellence’ for Trauma at Gloucestershire Royal Hospital and Orthopaedics at Cheltenham General Hospital.			
		Response Percent	Response Total
15	It should be everything in GRH. This is my refrain. It is logical and simple. The simpler is the better is. Perfection is in simplicity.		
16	its needed across both sites. trying to travel from e.g moreton in marsh on crutches or with arthritis to GRH isn't acceptable. there is no realistic hospital transport for these folk		
17	Just what I would like, both hospitals offering service		
18	Each sit should cover both services due to the size of the county.		
19	because this would be an excellent idea		
20	For similar reasons as already explained, orthopaedics more likely to be planned.		
21	Glad both are being considered		
22	Don't care as long as 24/7 type-1 consultant-led A&E services are restored at CGH		
23	Not sure aboutb separate centres for orthpaedics.		
24	Only makes sense if full A&E restored at Cheltenham		
25	If elective T&O operations are low risk then basing them on a site away from emergencies makes sense as there will be a reduced chance of cancellation. Trauma is best location near the main A&E.		
26	Separating out trauma surgery increasing the likelihood of planned activities going ahead		
27	There seems to be a lot of opportunities on time management, however not much information around patient care, consideration of harm, preventative measures or long-term future routine checks. The prevention of further complications could be also considered in the new plans.		
28	Seems to be 'mainstream' treatments/services - in a county of Gloucestershire's size, two centres seem to balance travel times for patients etc vs having enough staff/wards/capacity for treatment. Also avoids needless over centralising and the risks of having insufficient capacity / something happening at one site meaning all treatment is affected		
29	If this is practicable and possible.		
30	Excellent for response times and flexibility to cope with peaks in demand, disasters and infections.		
31	I have experiences emergency treatment for a broken wrist at Cheltenham last December. The treatment was outstanding. It was delivered, I leant (after the successful manipulation), by a wonderful Nurse Practitioner. My follow-up consultation at Gloucester was frankly disgraceful - the consultant's treatment was appalling and I complained about him. Excellence must be analysed, and all staff must be tutored to deliver excellent outcomes.		
32	keep specialisms together for better access and equipment		
33	Yes both hospitals should be capable of offering all services		
34	I support the proposals to change and think the information provided presents a strong case. However, throughout the consultation document I see little or no reference to: a) How staff are to be retained, trained, recruited and afforded. b) No refernce to any improvements to process or service instigated as part of the response to Covid -19 which will be retained as Best Practice moving forward. c) Limited reference to the way that services will be re-modelled in line with international Best Practice. There is limited information given for example on the use of telemedicine, telephone consultation and foillow up, health education in primary care, transfer of services into coimmunity settings, converstions to higher day case rates, better streaming through outpatients (and ED). The proposals appear to deal with the issue of duplication of services across two sites and consequent rationalisation and whilst this is to be welcomed, of itself, it does little to illustrate how the models of care can or will change. Similarly there is no financial analysis (that I can see) with the documentation provided. In an increasingly stretched NHS, this must be a consideration for services to be long term sustainable.		

Two permanent ‘centres of excellence’ for Trauma at Gloucestershire Royal Hospital and Orthopaedics at Cheltenham General Hospital.		Response Percent	Response Total
35	Can't answer. You're once again going down the route of 'Cheltenham or Gloucester '.		
36	As mentioned previously it is obviously better for those living in the Cheltenham area for as many services as possible to be fully delivered at CGH.		
37	Long waiting lists currently for NHS. GPs really just prescribe anti inflammatory drugs and until your condition deteriorates badly before referral process is even initiated.		
38	cant decide as pilot study not complete & compared nationally		
39	To shore the load between hospitals		
40	Transport for staff who currently work at one or other of the hospitals who have to travel by bike / walk / bus etc be supported having to then travel further?		
41	This is neede in both locations		
42	orthopaedics and trauma should be in close proximity so personnel can collaborate and reduce need to duplicate equipment		
43	This is another example of why planned - elective things should be at Cheltenham General and Emergencies at Gloucester Royal		
44	As long as orthopaedics can provide adequate cover to the inpatient wards in CGH. The cover is very poor currently. If you fracture as an inpatient in CGH you are worse off then if you fracture in the community.		
45	Again splitting elective and trauma sensible if demand / need exists.		
46	This an essential facility important for the community for accidents		
47	I think this is necessary because of what people are constantly being told about the ""Golden Hour"" for successful outcomes. It seems useless in trauma cases if a large part of this period is used in travelling to the necessary hospital		
48	Presume there is sufficient workload to justify 2 similar services. CGH is closer to us, so of course I'm having to have anything that may be needed urgently as close as possible		
49	See previous		
50	We have an ongoing population in Winchcombe and Cheltenham General is very much more convenient for everybody. This is very important when you are unwell. A&E, MRI and scans, Orthopaedics, Oncology all provide an excellent service for us and or course surgery as well		
51	As above		
52	makes effective use of resources		
53	An excellent idea.		
54	Common injuries from all over the County will benefit from 2 sites.		
55	The divide between the two disciplines is required given the extra resources for orthopaedics		
56	Trauma surgery has long wait times and increasing number of patients for hip, knee surgery can only be of benefit particularly the age demographic in Gloucestershire		
57	Trauma needs unambiguous and fast treatment. I've no idea where/when I can go to CGH so I'd call an ambulance rather than go by car. What a stupid waste of resouces.		
58	These are widely required services and so it makes sense to share them between the two hospitals		
59	See onwards to page 37 My wife and I are in our 90th year. She is not allowed to drive. I prefer daylight and not Mon or Friday. We live in Tetbury and wish treatment there. So: We prefer Cheltenham and do not like Gloucester, the former being easier for us to reach by car and more convenient in terms of other activities on the day.		

Two permanent ‘centres of excellence’ for Trauma at Gloucestershire Royal Hospital and Orthopaedics at Cheltenham General Hospital.		Response Percent	Response Total
60	The idea of creating centres of excellence at both of the two excellent large hospitals in Gloucestershire makes sense. It is worth remembering that the other specialist inpatient services, which have already centralised at either CGH or GRH e.g. cancer services at CGH and childrens' services at GRH, are working really well for patients.		
61	This seems to be working in the temporary changes that you have made. If it is better than it was, why change it back?		
62	Your pilot wsems to have worked well		
63	Seems to be the first area that recognises the need for quality services at both sites		
64	As someone who is on the waiting list for a knee replacement and living in Cheltenham being able to keep a permanent 'centre of excellence' at Cheltenham General would be good.		
65	Not seen enough evidence as pilot		
66	Seems very complicate. What happens to a trauma case requiring orthopaedic in patient treatment?		
67	Separating out emergency trauma and elective orthopaedics makes sense as it again puts the planned care in CGH which will be a calmer hospital and more suitable for that type of services, and the emergency services can have their centre of excellence at GRH. Again, having the centres of excellence is a sensible way forward, and the pilot seems to have worked well.		
68	If in the opinion of all medical staff the present system is working to a high standard, then both hospitals should continue operate in tandem.		
69	Having Trauma at one site (GRH) reduces the function of Cheltenham A&E department. As with medical and emergency surgery, the proposal to send emergency trauma cases (road traffic accidents for example) to GRH will make CGH A&E department less viable and will it then become a MIU?		
70	Suggest the trust review the statistics to determine how much of the trauma cases are orthopaedic related before deciding on this. Moving orthopaedic patients from GRH to CGH for treatment post trauma triage at cause significant pain and discomfort.		
71	All major Trauma at a single location makes sense. Most orthopaedics are less urgent and straight forward or even elective so Cheltenham General is the logical choice co-located with the arthoplasty.		
72	It is a much better model to have expertise available at different hospitals, than to have it based only in one location. However, we would prefer all procedures to be available at other hospitals in Gloucestershire too.		
73	I think insufficient capacity on the site		
74	Would like to see both under one roof. Trauma can often lead to cold orthopaedics. ie. RTA - to joint replacement. Rehab via physio and occupational therapy can be used by both.		
75	Trauma is a very immediate service and i helpful for patients.		
76	Seems sensible to have two options.		
77	This scenario has been in place for some time and seems to work well. Keeping elective patients away from acute admissions is vital to minimise the risk of prosthetic joint infections.		
78	Elective orthopaedic patients are at low risk of major complications post operatively and offering them surgery in an environment with a reduced risk of cancellation makes sense.		
79	What happened to the pilot of trauma surgery in Gloucester?		
80	This is an ambiguously phrased question. I thought the move of trauma to GRH a few years ago was a pilot and we have never seen the results of that pilot.		
81	Trauma will in many cases also require Orthopaedics support so it seems best to have both specialist available in both hospitals		
82	I am concerned that having these two sited at different hospitals will result n increased patient transfers due to the overlap of specialities.		

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

		Response Percent	Response Total
83	From things I have heard about Trauma & Orthopaedics I am not convinced the T&O Pilot study has gone as well as the Hospital Trust has claimed. I should like to see the full report of the Trial, before forming a judgement on this. I am not opposed to most elective orthopaedic surgery being done on one site and most trauma orthopaedics being done on the other, to minimise disruption to elective orthopaedic procedures, but Trauma Orthopaedics is fundamental to a fully functioning A&E Department, not least because it is not always obvious until x-rayed whether an injury is a broken bone or a soft-tissue injury. At least some trauma orthopaedic capacity should be retained on both sites.		
84	The pilot study at GRH regarding Trauma has not been publicly scrutinised. I gather it has not been successful due to pressure on beds and operating time, consequently causing delays to surgery. It would not be sensible or responsible to continue this service at GRH. Orthopaedics at CGH on the other-hand has performed better.		
85	I recently had a 2 week stay in Gloucester hospital after I had a trauma to my ankle (I completely shattered all the bones in my ankle and required 4 hours of surgery under general anaesthetic to mend it)		
86	Convenient for residents of both areas		
87	The 2 centres provide good coverage but CGH has to provide the facilities for trauma patients.		
88	These will not be planned procedures - some instances and being able to receive treatment at the nearest hospital therefore an advantage		
89	Anything that reduces waiting times and ensures quality of surgery would be good		

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

		Response Percent	Response Total
1	Open-Ended Question	100.00%	152
1	All proposals. There could be more travel for patients depending on the proposals, but clearly the aim is for people to have world class care and I personally would be prepared to travel a bit more and not be so territorial. It's your health that matters at the end of the day. Also, some of the proposals like IGIS should mean fewer people having to travel out of county which is a good thing.		
2	Although not explicitly mentioned, I worry that the A&E department at Cheltenham hospital will have a reduced service, particularly for children, as part of the proposal. Having to travel to Gloucester for emergency treatment would have an adverse impact, it is a long distance and we would struggle to get there, and in a severe emergency I worry that the extra time to get to the hospital could adversely affect the outcome. It is bad enough that children cannot be treated at Cheltenham A&E after 8pm.		
3	Both hospitals should have centres of excellence and provide all facilities - the catchment area for Cheltenham is very large and such services should not be transferred to Gloucester Royal		
4	If the only option for a certain appointment or procedure was in GH, I would not attend and know from discussions that my family would not either. We have had relatives in GRH and the experience has been unsatisfactory both fr them and for us whereas CGH experiences were much better.		
5	I am concerned that any developments are a short term solution which does not address the fundamental issue of either site having a sufficient bed base to run an acute take for medicine and surgery (plus O&T, Gynae etc). We need a new hospital based an a different site to achieve. The suggestions are well intentioned but ultimately a wast of tax payer money.		
6	I live in Cheltenham. If acute medical and emergency surgical care moves to GRH, I am concerned myself or my family will have to travel further for emergency care when they are very unwell. I believe the public strongly hold this view also		
7	The proposals I think will mean better care overall for me and my family		

Please tell us about any impact, either positive or adverse, that you think any of our proposals could have on you and your family (please tell us which service your feedback relates to e.g. IGIS)?		Response Percent	Response Total
8	It will be safer for us to have everything in one place.		
9	AMU needs to be spread across both sites. Head and Neck ward with Gynaecology doesn't make sense		
10	Failure to deliver emergency care in Cheltenham has already negatively impacted my family and our view of the trust's performance.		
11	The Trust's decision to move services post Covid peak had a negative impact on staff morale and mental health. Working through the difficult time of March and April was stressful for all and whilst all were happy to go where needed we were working in new teams in new ways with little support in this emergency situation. Moving back to our own wards and teams meant that we were starting to share the difficulties of the previous weeks and just as we were supporting each other we were told we were to move sites, splitting the ward staff and putting all through more stress and uncertainly. I do not think management realize how traumatic this was for those involved. The priority for staff is to provide good holistic nursing care for patients and support our colleagues. I feel that we have not been able to do that for a long time.		
12	I feel the benefits of services being in one place where the expertise, experience and correct staffing levels are available are huge. If these changes ensures this happens and the reduction in procedures, surgeries and appointments being cancelled is the result I would feel this is hugely beneficial.		
13	Concerns about impact on BAME communities. Concerns about bottleneck effect on Acute Medicine at GRH. Major concerns about IGIS - if a patient needed an emergency procedure in this field and had to be transported to Gloucester, when the lived right next to CGH, the difference in both outcome re. risk of loss of life is to great a difference. Concerns about funding increased Ambulance Service provisions. Flawed concept of attracting high quality staff - London, Oxford, Bristol will always leave us with the best of the rest which the proposals would have no bearing on. Political concerns that down the line (years), any improvements will result in savings related staff reductions.		
14	I live in cheltenham and like I have explained I have complex bowel needs and going to gloucester when my family live in cheltenham puts a lot of stress and strain on my husband when they come to visit. Colorectal surgery and gastroenterology. Parking is a rip off. Parking should be taken back within the nhs and monies made put into equipment or services provided. For patients relatives who dont drive and have to use public transport it not fair on them as it takes around 45 mins on a bus from chelt to glos then same on a return trip, even harder for families who have small children going to see a relative in hospital and have to travel further to see them.		
15	The waiting lists will be even longer than they are now. Cheltenham people will have a glorified health centre not a hospital. The journey to Gloucester is long, discharge difficult to manage and visits reduced (non covid era) due to the cost and distance involved.		
16	The travel between sites may become a problem for us.		
17	Further travel to obtain emergency services and for visitors if admitted		
18	Cheltenham needs a amu and functioning a and e, plans to ship patients across country are absurd and detrimental to patient safety		
19	the removal of a and e puts everyone in the county at risk. putting people in ambulances between sites is already damaging. stop letting this continue		
20	cannot have one medical take, it cant cope already		
21	If this is established successfully I think it will have a positive impact on establishing better pathways with our primary services and accessing community follow up etc.. and hopefully work reciprocally with helping admission prevention / flow in the acute setting.		
22	I want myself and my family to have the best access to cancer care should we ever need it. I believe splitting the elective and emergency services allows both to be delivered in the safest possible way		
23	long waiting times and hugely packed waiting areas are not ideal when you are poorly		
24	Any emergency situations would mean a longer journey to Gloucester for us, but with two young children that's less of an issue as the emergency children's services are already there anyway.		

Please tell us about any impact, either positive or adverse, that you think any of our proposals could have on you and your family (please tell us which service your feedback relates to e.g. IGIS)?		Response Percent	Response Total
	25	COTE. Acute take at GRH appears to have increased the number of ward moves and the number of pts MSFD being transferred to CGH awaiting discharge or for ongoing discharge planning. Both elderly in-laws recently subjected to this. A poor experience for both of them. This is not the level of service we aspire to yet sadly no longer uncommon for this demographic.	
	26	both hospitals pretty much equidistant for us and are over thirty mins away, so no change for us	
	27	Vital to co-locateelective major GI surgery and emergency surgery on one site. Necessary for optimum care of patients.	
	28	none	
	29	It is only positive	
	30	One major impact on having services at both Cheltenham and Gloucester, How do elderly patients get to these hospitals. Public transport is not good and Taxies are very expensive. We need more localised services!	
	31	Any move to create single centres of excellence in Glos OR Chelt is going to have an adverse impact on patients living furthest away from both hospitals.	
	32	trying to access some services at CGH and some at GRH via public transport if you are unwell or infirm is frankly awful. .	
	33	Please keep acute services at cgh	
	34	I live in Cheltenham and fortunately at the moment I am not receiving any services from either hospital . I I recognize that there are issues with Cheltenham General in view of the fact that parts of the building are 200 years old and not in current use because they are not fit for 21st century health care. I favour a new facility in Cheltenham being constructed on the edge of town so that the present buildings can be vacated and the land redeveloped. In the meantime I realise that the bulk of the services will need to be provided at Gloucester or even out of the county	
	35	You are making a big mistake most people want local facilities and the Cost!!!	
	36	Will be able to get looked after by specialist people wether in Glos or Cheltenham	
	37	Only with delays getting to GRH if CGH is nearer to where it happens.	
	38	IGIS information is actually not entirely accurate as from a non medical view and those lacking the insight into the interventional area its trying to broadly cohort based on superficial skills where they are entirely separate skill sets. The idea of grouping in a similar location is good but the idea that cross cover occurs easily between disciplines is completely inaccurate and actually won't create staffing efficiencies. It is in fact going to dilute a very specialised skill set within each of those specialities.	
	39	Getting to GRH is very difficult for us so keeping both hospitals offering treatments best option	
	40	No direct on my family currently.	
	41	CGH has served Cheltenham for over a 100 years Why change it	
	42	Travelling to GRH	
	43	Patients having to be cared for away from their home and families. I have no desire to be sat in a ED Department for hours on end. The hospitals have worked well as two separate hospitals for years - why change. MONEY Trauma Services need to be provided across the county not just one site. - so if you live in a deprived area or your homeless you will benefit from a single site service!! what about the rest of the population.	
	44	Nil	

Please tell us about any impact, either positive or adverse, that you think any of our proposals could have on you and your family (please tell us which service your feedback relates to e.g. IGIS)?		Response Percent	Response Total
45	If all services are concentrated away from CGH then patients such as myself living to the North of Cheltenham will be negatively impacted both for emergency services and for planned surgeries because of the time and difficulty in travelling longer distances, particularly difficult for the frail and elderly such as ourselves.		
46	If you move most services to Gloucester Royal it would immediately present many problems for travelling or finding a place to park. Many older people would be distressed at being so far away from their families.		
47	Please reinstore the full blood service at Cirencester Hospital - it gives an immediate, quick service. GP service will cause long delays and worries to patients, inconvenience and cost to travel to Glos.		
48	Centralising emergency surgery will make it harder to get to the hospital. Making Cheltenham general the planned centre for GI surgery will make to safer and better to have major surgery. We need more major surgery at Cheltenham		
49	The proposals to reduce services at Cheltenham will cause massive inconvenience and huge concern. A&E services are the vital bedrock of any "proper" hospital. This set of measures will reduce access, potentially harming those seriously ill due to delays in receiving expert help. The car parking problem will add to stress of both patients and families and there is real concern that this is yet another in a long line of service reductions at Cheltenham. The clear agenda being to cut the site back so far that it is unviable.		
50	I do not believe they would impact negatively, the distance between the two centres is not very far, if it was an emergency the patient would be blue lighted anyway. I would rather get the best possible care than decisions being made on geography. If as a plus this means that patients may not need to be sent out of county this is huge benefit		
51	I live in Cheltenham and work in the community, the cost of coming back to Cheltenham is high if you get taken via ambulance to glos royal, if you stay in, family find it expensive to visit you therefore your mental health deteriorates and your physical health recovery is slower, if it wasn't for my son being able to pick me up at 11.30 at night I would of had to stay in overnight, this would of caused a bed to be taken by me when I was well enough to go home but had no money to get home, a bus Journey from chelt to go's is a long time when you are travelling in pain or in recovery fir follow up appointments, we need a centre of excellence in both hospitals		
52	Any proposal that fails to deliver the full restoration of 24/7 type-1 consultant-led A&E services at CGH, will make it considerably more difficult to access emergency health care for me and my family.		
53	Travel and access to both sites for those with out cars or relatives locally		
54	Neither site is well located for people living outside Gloucester or Cheltenham. Especially relevant for critical A&E cases where time is critical. Closure of Cheltenham A&E for people like us living East of Cheltenham means significant additional delays, on top of what are already poor response times. We would be better served going to Oxford or Worcester.		
55	Access to subspecialist care across the board		
56	Think these changes will be positive overall - they will provide clarity over what each hospital provides, reduce duplication and ensure that staffing rotas can be more robustly filled which means we will recieve a more timely and qualty experience		
57	I think you are ignoring a large percentage of residence east of Gloucester not to have a full equipped center of excellence at CGH covering every eventually from A&E to full trauma situations		
58	Removal of services from Cheltenham would make it very difficult for people of North Cotswolds who depend very strongly on Cheltenham.		
59	In 2019 I had a IGIS abroad, in my country of origin. I could have returned to the UK, but instead I stayed overtime in the country to have an emergency surgery for removal of my gallbladder after going through a routine appointment where I had no symptoms. My experience with the NHS is that there is not much investigation on preventative measures. I had had an ultrasound before, to follow up on my IUS, and there was no interest in verifying the state of my internal organs at that appointment. I hope that by investing in a more thorough facility, incidents can be avoided.		

Please tell us about any impact, either positive or adverse, that you think any of our proposals could have on you and your family (please tell us which service your feedback relates to e.g. IGIS)?		Response Percent	Response Total
60	Keeping the temporary nurse led A&E for 50% of the time rather than having 100% consultant led services at CGH for 24 hours will have life threatening consequences for a large area of the north of the county.		
61	Support measures to cut last minute cancellations & ensure quicker treatment by the right person - if staff cannot be recruited / equipment not replaced due to budget constraints / equipment not being used as e.g. staff are on the other site, something needs to change to allow people to be treated and sent home more quickly either better or with appropriate measures in place.		
62	We are equidistant from Cheltenham and Gloucester, so the planned changes will not have any real impact on us		
63	Cheltenham and Gloucester are not that far from each other and the rest of the area is poorly served. Driving to either on a very regular basis (such as for dialysis) is gruelling and time consuming.		
64	We are fortunate to have transport, so if we had to travel to Gloucester it would not be a big deal.		
65	A&E All of Cheltenham and North of Cheltenham would benefit from A&E as response times, time to treatment would be minimised.		
66	It seems that Cheltenham will become to minor centre. I'm particularly worried about trauma treatment - an accident causing serious injury in the west of the county, where we are, could result in fatality if there were delay in reaching Gloucester hospital.		
67	We might have to travel further to Gloucester hospital in the event Of a certain condition as we are in Bourton-on-the-Water so neither sites are especially close but the extra distance is a small price to pay for increased expertise/ excellence and reduced cancellations of operations		
68	Impact if all works well and delays in appointments are reduced will be of benefit to my family and myself.		
69	I am so far healthy therefore none of these proposals would impact me but I would like you to consider patients travelling to either hospital.		
70	rarely require hospital intervention in the past with only one referral to NHS Gloucestershire in 20+ years but now in mid seventies I suspect that will change. The negative aspects for me living in a rural location with little or no public transport are therefore based around access both distance and time taken and cost		
71	Gastroenterology and General surgery both needed and would be better if it is clear what service is offered where, and so that continuity of care can be improved. THe proposed changes will achiee this for me		
72	As stated above I am concerned for myself and all others like me who live east of CGH that relocating acute medical intake and emergency general surgery solely to Cheltenham may put my life at risk in future		
73	Any medical treatment should be available at a local hospital. It is wrong to expect patients who are obviously ill to travel to long distances for treatment. Ecologically it is also better for a few medical staff to move between hospitals than for large numbers of patients to travel		
74	Local and ease		
75	AS I and my family live closer to Cheltenham rather than Gloucester, everything that moves to Gloucester will have an impact on us. Relistically however the geography of acute secondary and tertiary services does not matter. I want an accessible service with low waiting lists, efficient adninistration, decent transport services into it/parking, fully taffed with competent doctors, nurses and support staff staff who are well looked after. I also only want to come to such a hospital when I need to and I would like to see the development of community based services (using the fine physical facility at Moreton in Marsh for example) and an integrated approach with primary care and Community services. I also want the NHS to start communicating with its customers on its strategy (not the politicxally motivated rubbish that is pumped out daily) get realistic about its major downfall of staff shortages(between c40 k and 84k shortfall of staff now and likely to get worse in the next 10 years with limited reality about training, limited prospoct of sensible overseas recruitment and a pretty awful reputation for looking after its staff) and preparing the population for the reality of what actually is affordable. Very happy to share my thoughts on this also somewhere else if you wish.		
76	I am over 65 and whilst in good health and newly permanent in Cheltrnham the idea of access to a local hospital for potential issues related to age is attractive. This I am not referring to a particular service		

Please tell us about any impact, either positive or adverse, that you think any of our proposals could have on you and your family (please tell us which service your feedback relates to e.g. IGIS)?		Response Percent	Response Total
77	I am hugely concerned about the already much reduced emergency cover at Cheltenham. I feel the centre of excellence (!!) for acute medicine in Gloucester will further reduce care for Cheltenham (and surrounding areas) residents. This is not a small place but with 100000 inhabitants and an elderly population.		
78	The gastro services will have a direct impact on me. Theft that all specialists will be in the one place, and waiting lists will be lower is a hugely positive thing. My main concern is the lack of parking and facilities at CGH vs GRH.		
79	I anticipate that the most likely service that I or my family would need would be the Acute Medicine. Being dragged over to Gloucester in a crisis situation would significantly increase the levels of stress experienced by both the patient and their family.		
80	Gloucestershire is a longer journey for us		
81	This would mean more journeys to Gloucester hospital which isn't easy to get to. Also bad for the environment and I wonder if there is room at Gloucester Royal over the long term.		
82	My concern is for those living particularly in rural parts of Gloucestershire and the transport problems for reaching the two hospitals. There are implications for public transport, patient transport and for patients and carers attending hospital in their own cars, when having to travel further, or in challenging conditions. It would be reassuring to know, as in data] more about how the ambulance service has managed the extra distance to Gloucester Royal from the outlying areas of North Gloucestershire, for example.		
83	The Report and its recommendations have been prepared by hugely professional, experienced and competent personnel. Ninety nine per cent of feedback from the public is likely to be simply based on how it affects their personal situation regarding treatment required and location, and not necessarily related to what is best for the community at large and indeed the NHS.		
84	None at the present time none at the present time q		
85	I want to have access to the best health services possible. These must be provided in the safest hospital possible - that means fully staffed and, with access to all facilities all the time. For more minor surgery, I would like to be treated in a dedicated unit away from the emergency hospital to reduce the worry of having my operation cancelled		
86	Looks fine. We live in Shurdington so GRH and CGH and both readily accessible		
87	As someone of working age with access to independent transport, I think this is a positive move for me. However, I am concerned about the social practical impacts for people who are dependent on public transport, elderly, need support to to travel, more financially disadvantaged.		
88	Treatment not available at CGH is less likely to be taken up - especially if it involves more than one visit. For family reasons we would prefer to look for treatment at Southmead where support is readily available.		
89	Until and unless we have the need for any of these services, I find it difficult to comment.		
90	It would mean travelling longer distances but this is a price well worth paying for better outcomes		
91	As a resident of Cheltenham I am happy to travel if it means better care. I just want the right people in the right place to look after my family if they are unwell.		

Please tell us about any impact, either positive or adverse, that you think any of our proposals could have on you and your family (please tell us which service your feedback relates to e.g. IGIS)?		Response Percent	Response Total
92	I would like to suggest the establishment of a 24hour mechanical thrombectomy centre in Gloucestershire with the capability to deal with LAO strokes. There also needs to be a link with the ambulance service and emergency call handlers to ensure these strokes are quickly recognised so that patients are transported directly to the centre without delay. A related issue is the use of ongoing tests for every patient "MOT-style" to determine risk factors and identify problems early - this applies to other areas too, particularly cancer detection [apart from human suffering, this has the potential to save money by avoiding cases in the first place] A significant proportion of ischemic strokes are due to LAO's with their associated high morbidity and mortality. The effectiveness of recanalisation by mechanical thrombectomy (compared with alteplase which is largely ineffective due to the high clot burden) to deal with these devastating strokes has recently been established and has led to an Implementation Guide being produced for the UK: https://www.oxfordahsn.org/wp-content/uploads/2019/07/Mechanical-Thrombectomy-for-Ischaemic-Stroke-August-2019.pdf A potential further benefit, even for later presenters, is the avoidance of edema and need for craniectomy. Err on the side of going for it. Gloucestershire would fit well geographically with the current centres at Oxford and Bristol (not currently 24hrs). Bringing the UK up to european levels. Lack of treatment is an unnecessary cause of morbidity / mortality. Overall money saver, considering rehabilitation and ongoing care costs. I am personally living in total devastation following the death of my wife aged 63 in April 2019. She was taken to a local hospital where a severe stroke was quickly identified but unfortunately she deteriorated after a few days due to edema. She was just 3 years too old to be considered for decompressive hemicraniectomy. Her stroke came completely "out of the blue", she was always so fit and well with low risk factors. She was an extremely talented person and her untimely loss is so far reaching.		
93	Find travel to GRH difficult		
94	It's a long way from the edges of the county to these hospitals...		
95	I prefer it when Cheltenham residents can get access at CGH for all these things where possible. E.g. my phototherapy treatment used to be at CGH a ten mins walk for me now I have an hour round trip to GRH which is bad for the environment and a complete time waste.		
96	Only by separating emergency and planned care will the proposal really work		
97	No impact.		
98	Negative impact for me, if GI services moved from the Cheltenham site.		
99	The move of cardiology and the creation of a centre of excellence to Glos Royal makes no sense....This already exists at Cheltenham Gen and will effect me personally .....I have an existing heart condition.		
100	I think that both hospitals should be running independently like they have as not everyone can get to Gloucester royal hospital and why should Cheltenham residents be penalised for extra charges gained from transport.		
101	I accept the principle tat it is impossible to finance all services at both hospitals. I was recently in GRH for ""draining"" excess water thus preventing heart failure and was treated very efficiently. However, it was disappointing five minutes in my journey to be passing CGH and making the significantly longer journey to Gloucester. Is this ""emergency"" treatment not available from Chelthenham General.		
102	I think it would adversly affect my work		
103	I am concerned that scarce resource (pathology, radiology, social work etc) is diverted to GRH leaving a second rate services that would not be able to safely support any centre of excellence (including oncology) based in CGH.		

Please tell us about any impact, either positive or adverse, that you think any of our proposals could have on you and your family (please tell us which service your feedback relates to e.g. IGIS)?		Response Percent	Response Total
104	Minimal impact currently - may involve slightly longer travel dependent on outcome. Applies to services that would move to GRH		
105	I don't see any adverse effects		
106	I think any change to trauma or emergency services will impact my family where reduces easy access to services is involved. Also the assessments seems to only produce marginal gains from a staffing point of view.		
107	some services will be further away if located at GRH, but when traveling by car it doesn't make a great difference		
108	As a family, I think it is better to know which hospital you will be treated at as it's not easy for everyone if loved ones get transferred back and forth. It's nice to know in advance of planned treatment where you will be.		
109	My wife and I are both in our 80s and moved from a rural location in 2019 as we anticipate a point at which we will not own a car. We deliberately bought a property within walking distance of CGH. We have already found it necessary to travel to Gloucester for Xray and my wife was admitted for emergency treatment late on a Saturday evening. I had to return home to collect her essential medication and was able to do so in the car. This would have been particularly difficult without our own transport.		
110	Very important that Accident and Emergency teams are operational at Both hospitals as speed is essential when time is of the essence.		
111	Some increased travel time for some services but a specialised centre of excellence should offset this.		
112	Concerns: Transport availability to both sites Can GRH accommodate more activity - car parks, visitors etc Cheltenham Hospital not become the 'poor relation' regarding investment in buildings, staff and education.		
113	I live in Cheltenham but have had both inpatient and outpatient treatment at both hospital I have no argument with proposals that lead to improvement in services and staffing		
114	Having a centre of excellence in planned care at Cheltenham will make it better for us to have treatment.		
115	Positive impact, we have all been treated under the NHS in the last 12-18 months and these proposals can only improve primary healthcare in Gloucestershire		
116	There needs tobe a fair balance of services available for people living in different areas of the Trust.		
117	None at present. Who knows the future?		
118	Additional impact would be increased travelling to GRH but this is outweighed by the benefits as described in your documentation.		
119	I started to work for Cheltenham Hospital 27 years ago when I lived in Gloucester and have since moved to Tewkesbury and then Evesham. The travel time now is almost an hour each way and moving the department I work in (and have worked in for nearly 8 years) to Gloucestershire Royal Hospital will add at least an extra 30 minutes each way to my journey. I will not be able to sustain this and will subsequently be forced to look for work elsewhere within Cheltenham Hospital, something I do not want to do as I thoroughly enjoy working in Vascular surgery. I work in Vascular Surgery.		
120	The temporary changes made to Emergency General Surgery at GRH have had a positive effect on patient care, patient experience and staff morale. Patients now see the correct speciality during admission within a timely manner.		
121	Emergency lower/upper GI surgery to stay at GRH.		
122	All - I think the most important consideration is how to provide the best services to the widest number of people including my family and residents of my Cotswold ward. Psychologically we all feel that Gloucester is a remote, far away place whilst Cheltenham is more familiar with better access - we have no public transport to Gloucester		

Please tell us about any impact, either positive or adverse, that you think any of our proposals could have on you and your family (please tell us which service your feedback relates to e.g. IGIS)?		Response Percent	Response Total
123	The centralisation of general surgery at Gloucester Royal enables all patients, regardless of geographic location in the county, to receive the best possible outcomes as a result of the surgical team having both upper and lower GI specialists on call at the same site. The teams on the fifth floor are both well established and highly skilled to deal with both emergency and elective patients.		
124	Lack of choice		
125	We may need to travel slightly further but this is a small price to pay for an improved service. Quality over convenience please.		
126	As long as the clinic appointments are in the same place I think ti will have very little impact on my family		
127	By moving more acute medicine and a&e overnight to gloucester, I think it will cause problems with delays in treatment for anyone going to cheltenham.		
128	Despite their proximity, travelling between Gloucester and Cheltenham is very difficult for many members of the loca population, and can lead to delays in treatment, great stress over travel arrangements, difficulty for family visitors, etc. I have personal experience of the problem in relatoion to removal of 24-hour A&E services from Cheltenham, which should be fully restored as soon as possible.		
129	At the moment I am not in need of other services than a knee operation so do not feel qualified to comment on them. The main thing I would like to know is that Cheltenham A & E services will not be discontinued. When I had a heart attack in 2011 if I had had to be taken to Gloucester, I would not be here. I was told that any delay would have meant I would not have survived. As it was I was seen straight away and given a stent immediately. Obviously being able to stay in Cheltenham for my knee operation would suit me as it would be far easier for follow up appointments as well. Therefore I think the present arrangement works well.		
130	Major elective general surgery - I am concerned if located in GRH - COVID cancellation of operations, poor quality care, chaos not good environment for recovery		
131	Because we live in the very south of the county to a certain extent these changes will have very little impact on us as we are pretty much as far away from one hospital as the other. The time taken to get to either of them is about the same, and as there is no public transport to either hospital, it doesn't really matter for any of the services at either hospital. However, I know that having centres of excellence can generally improve patient outcomes, which is why I support the developments of the centres of excellence. At the moment some trauma and emergencies from our area are dealt with at Southmead, so if GRH and CGH can become superior centres of excellence, then perhaps we would be more likely to be treated in county. i would rather battle the traffic into Cheltenham or Gloucester than Bristol.		
132	I received knee surgery at Cheltenham General Hospital four years ago. My surgeon decided after opening up my right knee that I only required a half knee replacement. The operation has provided with pain free mobility. The follow up by my surgeon, Mr Aung is ongoing, this year it will be a telephone call. Friends who opted for private treatment, have not received this follow up service.		
133	I think the impact this will have on all residents in Gloucestershire is a serious one. Gloucestershire is a big county that is growing. The number of homes being built and with the Cybercentre bringing new jobs to Cheltenham will mean that both hospitals will need to offer high quality services, that include, medical and surgical facilities and the ability to offer specialities, including viable A&E departments. The downsides are that both hospitals will not be able to offer basic services. There will be increased travel for many people. Surgeons will have to opt for being either trauma specialists or non-trauma specialists. Same for General Surgeons - upper or lower specialists.		
134	The formation of centres of excellence will provide clarity on where public can expect to be treated. CGH would require upgrading in some cases which may be disruptive. My family can access both CGH and GRH relatively easily		

Please tell us about any impact, either positive or adverse, that you think any of our proposals could have on you and your family (please tell us which service your feedback relates to e.g. IGIS)?		Response Percent	Response Total
135	I have multiple disabilities and cannot drive or travel on public transport. If I ever need any of the services covered in this proposal, I want them to be as close as possible to my home. It is easier for elderly, disabled, and very sick people to travel to their nearest hospital. An unfamiliar environment may be distressing for them, and it may be more difficult for their families to visit if they are further away. I will not be the only person in this category who is not able to either drive themselves or travel on public transport. Therefore, all procedures should be available in all hospitals, not in one centre. This feedback relates to all the services.		
136	Closure of CGH A&E could lead to delays in emergency treatment to those south of the county, with potential for negative outcomes for time critical conditions.		
137	I have good mobility and transport but would affect other members of my family if they had to travel.		
138	Having had various admissions and day case appointments in the last few years I have received excellent care at both hospitals for which I am more than thankful. The locality is immaterial - the efficient and professional care are what matters.		
139	Any movement away from Cheltenham would be more difficult for us to access. This applies to all disciplines.		
140	Creating a major elective hub at CGH is likely to be beneficial to my family. This would allow good access to intensive care if needed and reduce the risk of hospital acquired infection.		
141	We'd rather have to quality care and travel further than average care on our doorstep.		
142	Having to travel further for urgent trauma surgery from Cheltenham to Gloucester could affect anyone.		
143	Any member of my family could require urgent treatment at any time and having to go to Gloucester as opposed to Cheltenham could hardly be seen as an improvement and could be dangerous.		
144	Hope fully our only need will be A&E based and in this area I fear the proposals are negative		
145	I have no objection to the siting of specialist services on one hospital site. If this allows the particular hospital to improve its services in that field so much the better. I am, however, concerned that too much emphasis is being placed on GRH. This concerns me because I do not believe that GRH has the facilities or space to cope with extra work. I have personally seen, and experienced, people left waiting on trolleys or chairs in reception areas for very many hours at GRH. I would not support the concentration of services on one hospital site if that led to, for example, a reduction in consultants at CGH which would eventually put the A&E at that site in question.		
146	I strongly believe health care needs to be delivered as close to where people live and work as possible. This is supposed to be a primary policy of the NHS, yet it seems there is a trend towards ever more centralisation and a move to more and more remote services. While some services can no doubt benefit from greater centralisation, especially where investment in very expensive equipment is concerned, administrative and clinical convenience should not be elevated above ease of access to healthcare.		
147	Taking away services from Cheltenham is not looking after Gloucestershire residents welfare. Any General hospital should have the ability and capacity to offer basic medical and surgical services. Moving emergency cases to GRH will mean lengthier travel times for residents living to the North and East of Gloucester. The consequences of this will mean more suffering and death. As the term implies Surgical or Medical emergencies require prompt action and this will certainly not happen if Cheltenham loses these vital services.		
148	I hope that under the new proposed services any future problems i have with my replaced ankle will be dealt with by highly trained specialists in a very well educated and informed manner kindly and efficiently. The service I received was great (the surgeon was excellent) and the consultant aftercare was brilliant		
149	Gloucester GH is twice the distance than Cheltenham GH is and there is no patient transport to Gloucester		
150	Cardiac and renal. I am 84, have had 2 heart attacks and been cared for at both hospitals. I have chronic kidney disease		
151	I live in Moreton-in-Marsh and I am not able to drive. Gloucester is a foreign country! Oxford or Worcester is easier to reach. any suggestion of concentrating services at GRH is therefore bad news. only super specialist services should be located here.		

Please tell us about any impact, either positive or adverse, that you think any of our proposals could have on you and your family (please tell us which service your feedback relates to e.g. IGIS)?		Response Percent	Response Total
152	The service I use most is eye care and there is no reference to Ophthalmology: any reduction in this service at Cheltenham would be greatly concerning for me.		
		answered	152
		skipped	88

If you think any of our proposals could have a negative impact on you and your family, how should we try to limit this (please tell us which service your feedback relates to e.g. IGIS)?		Response Percent	Response Total
1	Open-Ended Question	100.00%	107
1	On balance I don't think they would - on health outcomes I mean.		
2	To protect Cheltenham A&E		
3	Both hospitals should have centres of excellence and provide all facilities - the catchment area for Cheltenham is very large and such services should not be transferred to Gloucester Royal - travelling time and distance		
4	Keep both sites running and share the workload between them as they are. GRH is difficult to get too, the parking is unsatisfactory and the building totally unwelcoming and difficult to navigate - i had to run to theatres ? 7th or 8th floor via the stairs because both lifts were out of action for maintenance - I had to leave on the ground floor someone who was in a wheelchair. In CGH, there are other route options so this wouldn't happen.		
5	GRH will be full all if not most of the time. Rapid discharge (prematurely) will inevitably happen to create bed capacity.		
6	As above		
7	I would be worried if resources are spread thinly if there aren't centres of excellence.		
8	NO		
9	Interventional Cardiology. This should remain at CGH where it performs very well despite the trusts problems.		
10	Managers need to ensure that there is the bed capacity to provide centres of excellence. Movement of patients between wards and sites is not conducive to good care. Staff need to be consulted and views listened to.		
11	The centralising of services is important, but this also relies on the availability and access to the means to get people to hospital, in the sense of emergencies and the correct emergency services on hand when needed, whether this is an ambulance or paramedic car, with the correct expertise on site.		
12	Delay the proposals by a year. Engage with a private business/ management consultancy firm to determine the true long term impact of these changes, and amend proposals. Social impacts may change too - changes to the way we work in response to Covid may change the landscape such that new options become available.		
13	Colorectal, general surgery and gastroenterology should stay in Cheltenham.		
14	You should retain Cheltenham as a fully functioning hospital - no excuse for not offering excellence at both!		
15	Can patients utilise a shuttle bus?		
16	Free parking?		

If you think any of our proposals could have a negative impact on you and your family, how should we try to limit this (please tell us which service your feedback relates to e.g. IGIS)?		Response Percent	Response Total
17	make a fully functioning a and e in Cheltenham to protect their health.		
18	risks everyones lives. not having an acute service in Cheltenham is laughable.		
19	GRH cannot and does not cope. to say otherwise is incorrect. you only need to speak to staff and patients to see Cheltenham needs a medical take		
20	As long as there is data and outcome measures to reflect that this costly reconfiguration is truly having a positive impact on waiting times, avoiding cancelation of elective surgery etc.. then I cannot anticipate any negative issues.		
21	If elective colorectal went to GRH that would yet further increase the pressure on beds at GRH, meaning longer waits for patients in A&E		
22	Cheltenham needs a functioning ED with acute medical intake		
23	Better 'advertising' of which conditions and situations are for which hospital so we can make decisions without convoluted calls to 111.		
24	Get it Right First Time. Direct to FAS/ COTE bed. Another specialist COTE ward at CGH (although difficult to recruit to this area) Discussion with community partners: keep CH and Bed Based Rehab beds for pts needing these services to speed transfers out of acute hospital. Blocking beds in the community blocks up our ' back door' and our beds perpetuating the problem of flow.		
25	no		
26	I don`t see any negative effect. I live in Cheltenham and had to go to GRH as a patient. I just got on the bus and was there on time for my appointment. It was fine. In emergency I can get a taxi if an ambulance car is not available.		
27	Hospital transport is only for those very unwell, not for those who cant afford a taxi - we need to support all patients not just the wealthy		
28	Not being able to access surgery at the CGH site will impact all the other services being provided at GRH. The hospital cannot cope as it is with the move of the emergency department to GRH.		
29	Keep cgh an acute hospital		
30	The proposals will have no impact on me as I am not receiving any services at either hospital at present.		
31	As above		
32	As described above. We are meant to be aspiring to be the best in what we do and sharing staffing groups isn't the answer. Ensuring we recruit and retain is and taking pride in the quality of our work.		
33	Difficult for us to get to and park at GRH so would like CGH to keep full service		
34	I feel reading and answering your question - you want to close CGH and turn it into a cottage hospital		
35	Travelling to GRH		
36	Talk to and listen to the local population. People prefer to have a local hospital with local services rather than 'centre of excellence' We all know that this is just about bed reductions, lack of staff as there has been a failure by the Trust to invest in its staff. Applies to all services.		
37	N/A		
38	Retain full facilities at both sites.		
39	I would like to know what suggestions you may have for the following. If my husband had strong pains in his chest in the middle of the rush hour what would be his chances of survival is he were to be taken to Gloucester Royal and there was a traffic jam due to an accident on the Golden Valley? Not great I think.		

If you think any of our proposals could have a negative impact on you and your family, how should we try to limit this (please tell us which service your feedback relates to e.g. IGIS)?		Response Percent	Response Total
40	Downgrading Cirencester Hospital blood tersting service		
41	Accident and Emergency must stay open at Cheltenham even if emergency surgery and medicine is in Gloucester		
42	Do not alter or reduce A&E provisions at Cheltenham. Do not centralise general surgery at GRI		
43	Any proposal that fails to deliver the full restoration of 24/7 type-1 consultant-led A&E services at CGH, will make it considerably more difficult to access emergency health care for me and my family.		
44	If A&E centre of excellence is going to be based at GRH, there needs to be more 24x7 ambulance provision for remote areas to compensate for additional journey time.		
45	Minor impact on travel but this is offset by the improvement in the quality of the service provided.		
46	Personally at present not, but who knows as we get older!		
47	I think accessibility is the main key in these new proposals, such as transportation, informational and also medical - providing a knowledgeable doctor who takes the patients concern into account when making decisions on examination and treatment.		
48	See above.		
49	All proposals where treatment is being centralised - travel times/arrangements. Concern over extended travel times for patient/family/friends, particularly when someone is unwell. Relying on public transport particularly at the start of the day/evenings/weekends does not sound great. Even in the middle of the day it does not sound great when it could be 2 or 3 buses and all the hanging around that entails. Paying for a taxi is expensive & if relying on friends/family/a neighbour, it is more awkward to ask them to double/triple/quadruple the journey time		
50	No negative impact, however I think that there needs to be clear communication about which services are provided by which hospital		
51	As above		
52	See above		
53	Travelling by car more likely to be required to get to more distant Gloucester hospital so Additional parking provision would help.		
54	No		
55	The answer for me and my wife would be to make consultations for all but time critical issues, available at Cheltenham even if subsequently any surgery had to take place in Gloucester		
56	Further to travel to Gloucester Royal for emergeny/trauma but if the care is better tht should be mitigated. Cheltenham is still available but not consultant led overnight, which is a concern for trauma admissions		
57	As far as possible try to maintain urgent/emergency/acute facilities at both sites while splitting care not in those categories into centres of excellence across the two sites		
58	YES! All the proposals. you are trying to reduce the service offered.		
59	Biggest concern is travel for people like us with no car		
60	It is crucial that these proposals are considered in the context of affordability and proper edidemological prediction modelling (none of which is illustrated in the documents circulated to date. The biggest negative effect on me and mine is if these p[roposals are implemented properly and because the basic work has not been done or done poorly, in 5 years time we have to change everything again,		
61	Offer 2 centres of excellence for Acute Medicine		
62	A&E should have two sites not one		

If you think any of our proposals could have a negative impact on you and your family, how should we try to limit this (please tell us which service your feedback relates to e.g. IGIS)?		Response Percent	Response Total
63	Any service which compels patients to travel a significant distance gives a significant negative impact. It is not just the physical and financial inconvenience of organising travel to and from the hospital, there is also the significant negative psychological impact of the actual GRH site, which is noisy, confusing, over-crowded and uncomfortable. Every time I have visited the site, even as a visitor, I have left it feeling completely drained and unwell. I realise you are going to do the changes anyway as you have to cut costs and this consultation is a 'box ticking' exercise.		
64	No immediate impact but a potential long term negative impact.		
65	we need a local type 1 A/E with elderly relatives it is an increased financial burden to travel across county. emergency general surgery as well as acute can be a matter of life & death & this added journey time has the potential to have a negative impact on survival. we have a right to LOCAL emergency treatment		
66	Not that I can see		
67	I can imagine transport for some patients families that need support might need to be considered. Parking access - is there sufficient to support these changes? Bus services?		
68	In all cases of treatment there is the question of transport but both hospitals have reasonable provision for access and parking (albeit at a fee which is a matter for separate discussion).		
69	Easier travel; more car parking spaces and lower charges for parking. Move to a paperless system so there is no need to transfer paper notes and images between sites - practical experience at both hospitals show lost notes are very common		
70	I want access to as many things to continue at CGH as possible. this consultation seeems to want to centralise as amny things to GRH as possible and I'm against that e.g. moving the A&E away from CGH has not gone down well with local residents and our MP		
71	Longer way to travel for emergency services - could be too long		
72	Any moves of existing heart, cancer treatment, colo-rectal and imaging facilities to a Gloucester Royal 'centre of excellence' is a retrograde step and a huge waste of funds already spent ..... There should be a full and proper published and publicly available for review Cost Benefit analysis which includes in the model a true and comprehensive explanation of the previous expenditure and costs both current and capital at Cheltenham General. This previous expenditure and the proposed 'write off/downgrade' must be part of the costs.		
73	Open Cheltenham general with all services		
74	It would negatively impact on me and my family if elective work was not done in Cheltenham as they would be a lack of beds in GRH		
75	Closing Cheltenham's A&E is a terrible mistake. For patients in the Cotswolds, Tewkesbury and surrounding areas - the time wasted going to GRH could literally mean life and death. I also do not believe that Gloucestershire Royal can cope with the numbers they would need to deal with at present. One A&E for a whole county is madness and is so transparently being considered to save money rather than lives.		
76	2 hospitals with all the resource based in 1, and so any centre of excellence in CGH will not be able to thrive.		
77	Nil		
78	I don't see any negative effects		
79	As long as you don’t try to close cgh a&e you will have my support.		
80	My wife has problems with her eyes and we both have hearing issues. We are able to access both services at Cheltenham within walking distance of our home. There are no references to the future location of either, presumably these will be covered in the next phase of planning?		
81	None		
82	None I can foresee		

If you think any of our proposals could have a negative impact on you and your family, how should we try to limit this (please tell us which service your feedback relates to e.g. IGIS)?		Response Percent	Response Total
83	I work in Vascular Surgery which has currently been moved to Gloucester Royal Hospital ""temporarily"" because of the Covid pandemic. I do not think this decision is likely to be reversed as I believe the Trust has been looking to move the service to Gloucestershire Royal and the pandemic has simply meant they could move the service earlier than planned and they have simply said it is ""temporary"" to stop any backlash. I do not think that the Trust will be able to limit this as the distance I travel to work if I am forced to move to Gloucester cannot be changed.		
84	None		
85	In emergencies the ambulance service often takes people from out locality to Warwick Hospital as it is quicker to reach		
86	See next box My wife and I are in our 90th year. She is not allowed to drive. I prefer daylight and not Mon or Friday. We live in Tetbury and wish treatment there. So: We prefer Cheltenham and do not like Gloucester, the former being easier for us to reach by car and more convenient in terms of other activities on the day.		
87	Acute medicine and A&E needs to be fully supported in both hospitals. I have already detailed why.		
88	Don't specialist in only one place without considering and doing everything you can to alleviate the transport difficulties of patients and their family.I		
89	As above		
90	Access if we are ill for any of the services is difficult if we can't drive because there is no public transport. It doesn't matter how good the services are, how good the consultants are or how nice the hospitals are, if you can't get to them. So it would be nice if there was a more consistent patient transport service. Not one that you constantly have to justify why you are using it. One where you aren't left sitting for hours wonder whether or not they are going to turn up.		
91	It is the high cost of IGIS that means it is necessary to concentrate this service in one hospital. If both hospitals could be equipped with similar IGIS then this would be perfect.		
92	I cannot understand why it seems the Trust struggles with employing adequate staff for both hospitals. Gloucestershire is a beautiful county, more and more people are leaving cities and moving into the countryside, like the Cotswolds and Cheltenham is the home of the 'festivals' after all! So providing more staffing and investing in equipment etc should be a priority for both hospitals. Why do staff have to cover both sites? The two hospitals are separate sites and should continue to provide equal facilities because Gloucestershsire is such a large growing county.		
93	No		
94	Please see answer to previous question, and if possible make all services available in all hospitals. If this is not possible, then there should be excellent hospital or volunteer transport which is suitable for individual patients with a variety of disabilities including severe allergies (I cannot travel in standard hospital transport or on public transport because of allergies to perfumed products from laundry detergent to standard toiletries.) This feedback relates to all the services.		
95	?24 transport links (99 bus useful but only mon-fri) between CGH and GRH. Cheaper parking if patient needs transfer from/to CGH/GRH.		
96	Progress must go on. 24/7 is important to deal with an ever increasing population - also 7 days a week for all services particularly rehab and back up.		
97	I am not sure how it could be achieved, but you do acknowledge that older patients may find it difficult to access an unfamiliar centre of excellence.		
98	Keep the A&E dept running properly in Cheltenham General.		
99	You should restore a proper accident and emergency department at CGH and not keep fudging the issue.		

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

		Response Percent	Response Total
100	if we do set up CofE then we need to maintain 24/7 coverage elsewhere via a core of specialists (maybe a little more junior with access to more senior experts via telepresence)		
101	It is noted that A&E in not part of this review. However, I support the retention of A&E departments at CGH and GRH. I also support the return of a full A&E at CGH because I don't believe that GRH has the facilities to cope with providing the services which a reduced facility at CGH requires them to do.		
102	Senior management should listen much more to the views of ALL its frontline staff and not merely those of some of its most Senior Consultants. The Hospital cannot deliver excellent healthcare, regardless of how well equipped its 'Centres of Excellence' are without the goodwill and dedication of all of its staff. It is quite clear the failure to involve frontline staff sufficiently in developing services is undermining morale. There appears to be widespread distrust of senior management among staff and a sense of grudging resignation to having reorganisations imposed on them in a heavy-handed 'top-down' way.		
103	I am worried that the aim to be more efficient to reduce waiting times and free up beds will lead to hasty treatment and rushing patients out of the hospital without proper care or after-care treatment. I felt disappointed with a few aspects of the service I received		
104	Recruit more staff to enable you to operate both hospitals as has been the case for the past 30years.		
105	n/a		
106	all services other than super-specialist ones need to be mirrored at CGH		
107	We live only 12 min walk from CGH, therefore the centres of excellence in Gloucester will be less accessible. Not having access to 24 hour A&E is a downside for us.		
		answered	107
		skipped	133

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

		Response Percent	Response Total
1	Open-Ended Question	100.00%	56
1	yes centres of excellence in both hospitals		
2	split the clinics between both sites at different times or weeks but keep the specialities at both. Re-open A&E as a FULL setting and not as a nurse led one which will reduce the impact on GRH.		
3	No. Those providing them will know what alternative proposals are best.		
4	Gloucestershire would be better served by ambitious plans for a new hospital between Gloucester and Cheltenham along the M5 corridor. This would solve most of the trust's problems.		
5	The trust used to provide fantastic care that I have seen deteriorate over time with the changes and ""streamlining"" of services. Patients often need a combination of services to meet their needs and not having them on both sites impacts on our capacity to provide good holistic care.		
6	Keep emergency care/ acute medical on both sites. Share planned care with Bristol and Oxford. Rotate staff between hospitals/ secondments to generate the requisite culture of flexibility in planned care, with the savings and increased efficiency used to fund emergency care in both local sites.		

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

		Response Percent	Response Total
7	My suggestion is you continue to support BOTH hospitals and ensure excellence in both - the population is simply too great for either hospital to be the sole service provider.		
8	stop hiding behind lies and tell people the truth re closing a and in Cheltenham		
9	reinstate the services previously supplied by Cheltenham. local opinion is not being considered at all. Cheltenham needs an acute care ward and a and e		
10	Nil.		
11	I heard an interview with the president of the Royal college of surgeons this morning clearly explaining how he feels the NHS should be re-structured to have emergency hospitals, and elective hospitals - meaning fewer cancellations of elective cases, and best care for all. We have this opportunity to deliver this		
12	It has been found that management have not been honest with informing staff about changes		
13	Can any of these services be done away from the two main hospitals, to make parking and other access easier, and use the two hospital spaces better for essential healthcare?		
14	no		
15	Nothing is mentioned about ERCP. This is part of GI service. It should be in CGH as a part of the entire circle. It is limited at the moment to two half days a week. It should be at least on a 5-day basis (every morning let`s say). There must be an ERCP centre. It could play a big role as a Centre of Excellence for training within the UK if the consultants think that they are able to develop it in this way. If not, then our patients will benefit at least from centre like this.		
16	We need to keep the blood monitoring service at Cirencester Hospital, even Cheltenham is too far away. If you need a frequent test it would be impossible to do this if you do not have your own transport.		
17	A new build fit for purpose and fit for the 21st century with bus/road and rail links between the two major sites		
18	As before, the answer to all the questions is to provide a new hospital for Cheltenham designed to provide the location for all the latest developments in 21st century health care		
19	Bring Cheltenhams A&E back		
20	The size and geographical location of Gloucestershire warrants two fully functioning hospitals.		
21	Build brand new hospital at J11 of M5 next to the Airport to serve the whole of Gloucestershire.		
22	Both CGH and GRH need 24/7 type-1 consultant-led A&E services to support their growing communities. Anything less is totally unacceptable. GRH clearly cannot cope.		
23	Close both existing sites and build new Gloucestershire central hospital at a more accessible location, e.g. by Staverton airport. More scope for providing CoE departments, whilst being accessible to more people - including out-of-area opportunities. Old sites could be sold for offsetting capital cost.		
24	Keep 24 hour consultant led A&E at CGH.		
25	I feel that the centre of excellence approach is the way to go. I don't have a strong opinion as to which services should be provided by which hospital - it depends on the current strengths of each team in the hospitals I think.		
26	No your proposals are well thought through and you know the business needs better than I do. I feel confident you will have used best endeavours to get it right.		
27	whatever is decided should be very clearly communicated as it is rather confusing at the moment		
28	To be ""Fit for the future"" try to repair the damage that has been afflicted to the NHS over recent years. Stop putting operations out to private companies. Work on restoring services which have been cut, reduce waiting times. Put NHS money into the NHS and NOT into private companies		

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

		Response Percent	Response Total
29	My general comments previously in this diocument all refer - I do not have alternative suggestions as I do not have the necessary information to propose anything sensible at this time. This consultation is most encouraging (and one of the better engagements I have seen) but is still very short on decent fact and analysis which presumably has been done somewhere.		
30	Reducing costs and providing a good service to all patients do not go hand in hand. You have already done your 'cost / benefit' analysis and decided what you are going to do, so even if I had sufficient knowledge of hospital processes to offer suggestions it would be a waste of time.		
31	CGH has an oncology centre of excellence therefore it makes sense to collaborate this first class service with colorectal/gynae/urology on the same site to make this a world class service. put CGH on the map ! expertise can then be developed with training and services offered. patient care will improve		
32	no		
33	Are there options for co-operating with neighbouring Trusts, Hospital groups etc? Depending on the level of cases there could be opportunities for cross-border (whatever those borders may be) co-operation.		
34	Try to make centres of excellence at both sites where possible		
35	""""developed in collaboration with local people during the Fit for the Future Engagement (see pages 17/19 of the full consultation booklet)."""" This just means that the one's who shout loudest are listened too the most.....It also assumes the the voices from the deemed 'stakeholders' [NHS chosen or invited!!] are the truly interested parties. Most of us are too busy in our everyday lives to give up time to be part of this stakeholder echo chamber.		
36	.		
37	Both estates are too old and the sites are not of appropriate size to support an urgent and elective site - we should not be throwing more money away on them. A new combined hospital should have been built years ago. Neither is fit for purpose.		
38	I don't current suggestions		
39	Could make cgh the vascular centre.		
40	No suggestions - the proposals seem to make sense		
41	Pages 12 to 69 - your thinking and planning and stats and experiences and practicalities and timescales and costs seem daunting, but are clearly essential and within your skills. However, I don't feel competent to judge the options except for showing an obvious personal preference for necessary services being available at Cheltenham or Bourton, rather than Gloucester or Moreton, to avoid extra travel and time and costs and stress.		
42	Fully supportive of the changes planned, as timing will be improved and better staffing.		
43	No		
44	Specialties need to stay in the same hospital. Orthopaedic need to all be in one hospital. Vascular needs to all be in one hospital where they can get treatments etc		
45	My wife and I are in our 90th year. She is not allowed to drive. I prefer daylight and not Mon or Friday. We live in Tetbury and wish treatment there. So: We prefer Cheltenham and do not like Gloucester, the former being easier for us to reach by car and more convenient in terms of other activities on the day.		
46	You need to cover more about how the elderly are catered for in acute medicine and a&e. Also what happens when services/surgery/beds are not available. Also the impact on ambulance transfers and wait times for ambulances. How will the services/surgery/beds be allocated from cheltenham? You could move a patient to gloucester to find there was no capacity?		

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

		Response Percent	Response Total
47	If you wish to attract the best Clinicians, Consultants, Doctors and medical staff, it is necessary to provide the best environment, and the best equipment. There are many negative reasons for Consultants / Doctors and patients having to travel to use specialist equipment in say, Birmingham or Bristol. Time and money is wasted. We must provide all services in our two excellent hospitals.		
48	the trust may wish to consider the potential benefits of working with Hereford and Worcester to optimise service provision, availability and delivery (use all available resources and staff all of the time) and thereby minimise patient waiting times in the three counties area.		
49	It is vital to maintain access to care to patients across the whole county of Gloucestershire, so our alternative suggestion is that all services should be available in all hospitals.		
50	Quality - travel times may influence this - delays in transfer can be critical Access - as above - patient choice used to be primary concern, but less so now. 24 hour access is important. Not everyone has a car or access to one. Deliverability - need clarity on proposals and times for implementation Workforce - joined up working essential. Staff stress must be minimised. Staff travel times should be minimal. Development for staff essential - colleges will be watching training.		
51	Help! As a sometime retired physiotherapist in the NHS I have been out too long to justify comment. I think 24/7, 7 day a week is important, people have problems 7/7 not 5/7 - this possibly goes beyond your remit. I was very glad recently to see doctors from the max-fac department as some ungodly hour on a Sunday morning (CGH).		
52	This is an impossible question. No ordinary working person has the time to analyse endless pages and documents developed over several years.		
53	A covering team at each hospital with more senior staff visit each site to under take teaching etc but always being available for support/advice via telepresence or VR		
54	Recognising the need for change, the proposals for Gastro-intestinal Surgery contained in what was Option 4 should be fully worked up into a proposal, in preference to Option 2 which is what the Hospital Trust appears to have adopted in opposition to the majority of the Consultants involved and GiRFT advice.		
55	I live in Moreton, We have a fine new hospital building which is woefully underused, Yet I am invited to travel to Gloucester for a routine exam, The NHS needs to resolve service delivery issues of this kind, preferably before the new forest of dean hospital opens, for the same problems will arise there. The general impression given in this survey is that services will be organised for the convenience of patients who will usually be sick or indisposed.		
56	My alternative suggestion rather than wasting money on expensive surveys like this is to have ONE hospital, between Cheltenham and Gloucester, which could then be available for both. The overall saving to the NHS would after the initial expense, be enormous. I believe the only reason this has not already happened is the ridiculous failure by the two relevant local authorities to agree on a site.		
		answered	56
		skipped	184

Anything else you would like to say?

		Response Percent	Response Total
1	Open-Ended Question	100.00%	92
1	Good quality consultation materials and great glossary.		

Anything else you would like to say?

		Response Percent	Response Total
2	It makes sense to look at the service provision in this way.		
3	Invest in your nursing staff as you do with every other professional group. Pay them more and develop their skills. This is the only way you will be seriously considered as addressing the recruitment and retention crisis.		
4	My hope would be that by making these changes the local service will be made better and the cancelling of planned procedures is significantly reduced.		
5	-		
6	The major elective centre at CGH away from the pressures of the emergency takes seems like a no-brainer. I don't know why it is being approached so cautiously. Why not move major head and neck resections, upper GI resections etc. I think too much weight is put on the inertia of clinicians who do not want to change. The Trust needs to be stronger in terms of telling people where they will work in future. Short term unhappiness for long term gain.		
7	I am very disappointed that you are offering a false premise ie. do you want excellence if so this must be at one hospital. We have already suffered greatly by the reduced services in Cheltenham. My husbands appts have been haphazard since services for Linc have been moved to Glos. I have been in A & E in Glos with 2 relatives recently we waited extensively for assistance and the hospital was clearly overwhelmed by the demand.		
8	patient safety is being compromised daily already, let alone letting this carry on further. nursing morale is at rock bottom.		
9	stop trying to deceive everyone and be up front with the plans. this effects people livelihood and health. stop treating nurses as if we don't matter by moving us all pillar to post.		
10	Although it has been stated that staff have been consulted I wonder whether it has been at managerial level rather than at patient facing level? Often the feedback with consultation processes is staff feel like the right people have not been involved and therefore they have not truly had the opportunity to feedback their opinions on the process. Ultimately, the majority of staff working in the acute setting will always want to accept change if the end result is better patient care and staff experience.		
11	I believe that management have wanted to close Cheltenham ED for many years and have used Covid as an opportunity to do exactly that		
12	I live in Cheltenham and find it easier to travel to work to CGH but am not opposed to travelling to GRH but the 99 bus service could help if the times of the buses fit the shifts of staff.		
13	I hope that you are going to see the picture in different levels, i.e. locally, nationally and internationally.		
14	Get Cirencester and Tetbury hospitals better integrated into the services provided for patients		
15	don't put all of the eggs in one basket. PFI is very costly to taxpayers, but appreciate sometimes its the only way.		
16	CGH has theatres and surgical wards that aren't being used for that purpose. GRH is struggling to keep up with the demand. Why not make use of CGH and bring some of the surgical demand over?		
17	I have responded to a number of surveys such as this over the years and none of them appears to have resulted in any changes being made.Hopefully this one will result in some positive action		
18	please ignore the people of cheltenham who are biased against Gloucester and who shout the loudest. this would be a good opportunity to also increase health equality in the county.		
19	I think most people would like to point out that even though it states CGH will re-open - it is easy to see that GRH just cannot cope with the amount of people in Gloucestershire. I know ED is not on this questionnaire but it needs to be taken into consideration with regards to where everything is to be situated.		
20	Please consider the elderly and vulnerable who have to use public transport to make visits to a further hospital. Will public transport be improved? Will more hospital transport be accessible to those who need it?		

Anything else you would like to say?

		Response Percent	Response Total
21	To save money on postage go back to the old system of pencil and a diary for appointments I am an ex NHS employee in Bath Royal united hospital and GRH and CGH and Standish. The old saying is with the NHS If it works - Change it		
22	Cheltenham need a A&E		
23	This is a very ambivalent survey. I am sure not many people will bother to complete it fully I read the lengthy booklet and after looking at the various rather repetitive questions I imagine many people will give up. This I think is what you want. You have intentions and ideas to carry out and I don't believe as a member of this community our opinions matter at all.		
24	Downgrading the blood testing service at Cirencester impacts heavily on local residents		
25	Centres of Excellence is really good but only if they are really separated - emergencies in Gloucester and all planned in Cheltenham		
26	I would like to see a very positive statement, and concrete proposals for the better care of patients presenting with mental health problems in ED. This has been a long ongoing concern, how will Fit for the Future ensure that mental health is given proper consideration?		
27	It is completely cynical to perform this type of public consultation during a ""once in a century"" global pandemic. By proceeding with this the NHS trust are showing utter contempt for the communities they serve. These proposals and this consultation should be put on hold until Covid-19 restrictions have been lifted by central government.		
28	Can a hospital have a true A and E without the back up of eg general surgery vascular surgery Acute medicine etc		
29	Yes. Use some common sense, for goodness sake.		
30	It would be good to see more localised services. Smaller hospitals such as Cirencester and Tetbury should be used to enable patients receiving regular care to avoid having to make regular long journeys especially through the winter. Even one or two e.g. dialysis bays in a day hospital like Tetbury would reduce the exposure of vulnerable patients to the risks of travel and exposure to other diseases.		
31	I believe NHS purchasing has room to improve and gain expertise from elsewhere. I also believe that there is opportunity to improve efficiency. I have witnessed nurses spending more time walking around than actually providing care.		
32	Even your summary document is far too full and obfuscating! I'd like an honest and clear comparison between services as they were before COVID and as they would be under your preferred proposals, with an indication on the impact in time and accessibility for patients in the various parts of the county.		
33	No		
34	thank you for inviting comment. I do hope that patients views are taken into account if trends emerge and that this not just a ""going through the motions"" exercise		

Anything else you would like to say?

		Response Percent	Response Total
35	The NHS was a great organisation. Over the years it has slowly been destroyed. One great problem is with the GP service. If effectively stops patients from accessing the main NHS services. It is almost impossible to get to see a GP. An example - In November 2019 I had a fall. I damaged my arm. A shard of metal punctured the arm to quite a depth. The arm from elbow to palm of hand went blue and remained blue for weeks. A huge swelling erupted at the puncture point. It was impossible to see my GP. By late December the arm was still swollen and bruised. I was concerned with Christmas upon me. I live alone. I phone 111 I was referred to see my GP the following day. When I entered the GP surgery the first words from GP were I don't usually see people who just walk in off the street. Obviously the GP service is NOT there for older people. The telephone 111 service is a farce. Please don't talk about centre of excellence and fit for the future. Just restore the NHS to a functioning system now The whole of your document has annoyed me. you say that you are attempting to provide centre of excellence while what you are doing is actually trying to whittle away even more of the flesh from the skeleton of the NHS which was a great organisation but which is now a shadow of what it once was. The hospital work is good still once one can get past the deliberate obstacle of the local GP. I have already mentioned the case of my GP who said "" I don't usually see people who walk in off the street"" when I had been referred by 111 service. The episode convinced me that the NHS is simply not there for older people. Please stop trying to fool me into thinking that you are trying to offer centre of excellence Long before that event I went to the GP reception as I have done in the past, to ask for an appointment. The receptionist who is obviously there to protect the doctors from seeing patients, told me that the system had changed. I had to go home and telephone for an appointment. I pointed out that I was there, talking face to face to her so why not organise an appointment. I simply wanted a routine appointment because I was concerned about a long term health issue I have. The receptionist then became aggressive and told me to go home and phone for an appointment. I returned home and phoned the surgery. The line was engaged. I tried to phone many times. The line was always engaged. Making an appointment is now virtually impossible. I presume that your aim is to force people who can afford to, to opt for private treatment. Pleased do not try to disguise your actions as creating centres of excellence The other possible method of getting medical attention is via the A&E. It is a last resort. When I badly damaged my arm I did not bother the A&E system. I would not abuse such a service. However other people who are desperate for treatment have used A&E. You have tried to counter that by removing the A&E from Cheltenham hospital. A lot of public pressure prevented that move completely but you ask about centres of excellence. It is in my opinion impudence on your part. I have health issues. I am elderly and live alone. If I get covid it will no doubt kill me, but I have determined that I will not even try to contact my GP. you so obviously intent on destroying the NHS as it stands. The government says it will be free at the point of delivery and so you are ensuring that there is no point of delivery. I do remember times before the NHS. What a disagree that we are returning to such times again. Centres of excellence RUBBISH		
36	See comments above.		
37	Please keep to your word about reversion to prev Covid A and E at Cheltenham.		
38	From recent experiences in the past two months and two days. Cheltenham A&E open 24hrs. Gloucester A&E was EXACTLY as shown on TV on Wednesday. Wait outside on an ambulance followed by wait inside in the corridor. We understand that you state there are no proposals to close Cheltenham A&E, yet you have! It is currently a minor injuries unit. Sorry, don't believe you.		
39	These are excellent consultation proposals but miss one very important heading - THE CUSTOMER CARE EXPERIENCE. Visits to both major hospitals are still very poor experiences. Everyone does their best with awful facilities and it's time we moved from a 1958 experience to 2020		
40	I am extremely dissatisfied that there is not a department at CGH which specialiases in treating children. When my grandson was 6 years old he fell at school and received a large gash to his forehead which needed stitching. I was told I would have to get him to GRH because it could not be dealt with at CGH. I had to drive him over the Golden Valley by-pass, in the rush-hour, in the pouring rain, trying to keep him from falling asleep on the journey because I was concerned about possible concussion. He was kept at GRH for 6 hours without being treated then sent home overnight and told to come back the next day for the stitches. An injured child should not have to undergo such a lengthy and hazardous journey or be left so long without proper treatment. Fortunately I had a car and sufficient petrol to get to Gloucester, but if I hadn't how would I have got him there, with his head cut open, by bus?		
41	It		

Anything else you would like to say?

		Response Percent	Response Total
42	I am very concerned about the closing down of some services at Cirencester Hospital. The town is about to expand by about 30% with the Bathurst development at Chesterton. The hospital (which is excellent) should be expanding for the future, not declining. The climate change agenda requires us to have less reliance on car transport. For many the only realistic way to get to Gloucester or Cheltenham Hospitals is to drive. With a town population of around 20,000 (probably 27,000 with the new development) and with many surrounding villages, it seems to make more sense to develop local services better in Cirencester.		
43	Access to local facilities is important as I live in Tetbury. However, for specialist care i am prepared to travel further a field to Gloucester, Cheltenham and Oxford.		
44	Both Cheltenham and Gloucester hospitals are quite old and have grown in a piecemeal fashion with inefficient layouts. I can see the point of centralising specialist units. I think the only long term solution is to build a new hospital half way in between and then sell the existing sites which are close to city centres. The pressure should be put on the government and not to ask the public to accept dwindling local services.		
45	why oh why do this survey during a pandemic and why hasn't elective & emergency surgery been separated as per recommendations ?		
46	I understand and agree with your reasons for wanting to change things in these two big hospitals, but I would urge you to also consider our more rural hospitals (Cirencester, Stroud etc.) when it comes to where funds go. I would hate these to be underfunded at the expense of these changes.		
47	no		
48	I would be interested to know what consideration One Gloucestershire have given to inclusion in terms of practical access to the hospital sites e.g. public transport providers, charities with volunteer drivers, support groups in disadvantaged areas. Given the health inequalities which have been demonstrated through the Covid-19 situation, it is vital to me that these considerations are given a platform in any changes, else we risk worsening inequalities already present. As well as the patient, this can impact visitors, whose support can positively bolster outcomes for a patient. Also, there is no mention of the impact on ambulance services, but presumably there will be an impact in terms of transfers needed (not just when ambulance first called to patient, but also transfers between GRH and CGH) . Am wondering how this has been assessed? Thank you for appreciating the importance of having an A & E service in Cheltenham to local people, I am really pleased this is reflected in the plan.		
49	It is clear that the NHS cannot simply go on as before. How will these changes be monitored to see if they are successful? Who will monitor them and make any necessary adjustments if required, or indeed share best practice. In my lifetime I have seen many of the areas hospitals close or reduce their services, and I have not picked up on how all of this will impact the remaining hospitals in the area.		
50	For some people, the thought of travelling to GRH from Cheltenham (or, I imagine, CGH from Gloucester) would be a major consideration in the choice of whether to have treatment or not to have treatment. Travel to the ""wrong"" hospital is an extra journey for visitors by public transport and has led to my certain knowledge to some elderly patients having no visitors during their stay, with whatever psychological effect this has had on their recovery. The people likely to be reading this consultation and making decisions subsequently are likely to be those who think nothing of a few miles of distance on good, if busy, roads. Many, who are often less articulate or just more diffident find it a major obstacle.		
51	The priority is to optimise outcomes. IN my experience, working on two sites is ineffective and leads to worse outcomes for patients so there are two mediocre sites rather than one excellent one. The leadership needs to take the initiative to avoid local populations wanting to retain local services at the expense of quality - the NNHS has a poor record in this		
52	Parking at both centres is problematic and public transport during Covid19 advised against		
53	My experience of being treated at CGH has been very positive. I am very supportive of its ongoing centrality to future plans		

Anything else you would like to say?

		Response Percent	Response Total
54	This appears to me to be yet another way to spend money to create 'something new' and the associated empire building both administratively and medically tghat goes with that. All proposals need to be matched to realistic assumptions of need and the first priority should be proper utilisation of existing resource. Acceptance of the waste of resource [both income and capital] appears to be a huge part of the default NHS model.		
55	The provision of some tests possible available at Cheltenham but routinely carried out at GRH, does not seem to take into account the impact on elderly patients. For example my wife, aged 82 had her second cataract procedure at Cheltenham, where we live and she is pleased with the outcome. In preparation for the procedure, she was required to attend GRH for tests the day before. She assumed that these would be similar to those done previously and was prepared for a lengthy amount of time away from home. In fact the only test carried out was for Covid19 which surely could have been done at Cheltenham!		
56	I don't think 'Centres of Excellence' should be considered at present, and yet again my suspicion is that if it looks good from the outside - ie when the CCG walk round with the scent of paint in their nostrils - it doesn't matter that staff and patients are unhappy with the way things are.		
57	I have been watching this play out for years and too much time and negative energy has been spent which has hampered the development of all specialties in both hospitals. I am utterly fed up with it.		
58	Whatever decision is made, the correct and additional staff numbers must be allocated. You cannot simply move the patient workload (currently split over two sites with two teams) to one site with only that sites pre-existing team numbers. This will be a recipe for failure / disquiet. Working in a small speciality which centralised 10 or so years ago the benefits are huge for us		
59	I find taking part in the survey stimulating and support the developments		
60	The assessments continually refer to the BAME and homeless community if Gloucester (some 32,000 quoted) as being a major criteria in deciding where the services will be located. There are over 600,000 people in Gloucestershire . Do you not think this is a case of ""the tail wagging the dog"" . I also believe that some of these changes are being brought in to cover up for poor management in the past. Surely better recruitment schemes and a decreased insistence on nurses being degree trained would improve day to day outcomes for most patients.		
61	Consider what minor injuries services etc could be made more easily available at GP surgeries. Even discounting the Covid effect, the GP is a bottleneck. Overall the treatment me and wife have received from CGH and GRH has been timely and very successful. Thanks to everyone.		
62	As a moderately fit 90 yo, male living in the eastern part of the county, I have sadly needed a range of your services, and have been well served - but have often felt that health education and preventative measures and self help situations should be stronger, from cradle onwards, for the whole nation. Individually. How else can the nation and it Health Service survive the decades?		
63	No. A future proof plan for reduced waiting times, reduced hospital stay, access to cutting edge skills and equipment along with optimal training of junior staff and attracting the best must be a positive move.		
64	Having experienced such changes in Cornwall staff were concerned in the smaller hospital about their education, training and personal development Staff who were near retirement were sometimes sidelined out of the acute setting, consequently did not feel valued Recruitment difficulties occured Elderly population struggled with the changes on all site. Major review of signage was required and more volunteers needed to guide patients around the sites. Strong communication strategy required I am unaware of your IT strategy but would hope all hospital sites have equal access to current IT and future developments. Good luck		
65	Centres of excellence works if it is a proper complete split		
66	Overall i agree with the proposals as specified in the consultation booklet 'Fit for the Future.'		
67	Emergency lower/upper GI surgery need more space.		

Anything else you would like to say?

		Response Percent	Response Total
68	I think you have spent too much on your glossy booklet - it could have been made simpler and cheaper - a poor use of resources		
69	The survey is difficult for non medics to comprehend. See points above.		
70	The shuttle bus between CGH and GRH is a great asset in relation to access to services. A commitment to its future would be good to hear. It would also be good to hear that discussions are being held to see whether the bus route could include a stop at Park and Ride at Cheltenham Racecourse. Decision makers should consider evaluation of services changes if implemented and the involvement of patients, carers and VCS in the evaluation.		
71	It seems that the biggest effect on deliverability will be your staffing levels. Concentrating services to one site or other seems to make sense as you will not be spreading your staff too thinly		
72	I am sorry to say that I think more local people would be happier going to gloucester hospital if there were more staff to give better aftercare on the wards. Also staff need training on how to understand the needs of the elderly. Misunderstanding of being slightly deaf, confused in surroundings, stoma care being common problems I have seen.		
73	Bring back Cheltenahm A&E full-time and with full services as soon as Covid restrictions are lifted		
74	1. On both sites the outpatients should be fully maned such that if an appointment is cancelled for what ever reason, the new appointment offered should be at the same site. 2. The A&E at CGH should be 24/7 with a doctor, such that if someone walks in late at night, then (assuming not needing a bed) they can be dealt with and avoiding them being referred to GRH without an examination. With the result that the person has to find their way to GRH whilst not knowing how bad their situation is. All ambulances 8pm - 8am still directed to GRH.		
75	I was treated for prostate cancer by open surgery in 2009 at CGH, my surgeon was Mr Sole, based in Hereford but twice a month he would operate at CGH. This was to ease the pressure on the Urology medical staff. Since my operation 11 years ago the department now has a robotic system. This type of equipment had been identified as an improvement for both the patients and the medical team, unfortunately, it could not be purchased immediately because of its high cost. If the two Gloucestershire hospitals are to be A Centre of Excellence then cost of equipment must not be a barrier to purchase. Only the best medical staff will be persuaded to work in CGH and GRH if we can provide the best equipment.		
76	I am strongly opposed to downgrading one hospital over the other. They should have equal value and maintain safe staffing levels on both sites. It seems to me that there is a faction that wants to take away basic services from CGH, a hospital that has offered its services for over 200 years and highly valued to residents in and around it.		
77	Thank you for providing the public the opportunity to have our say on this important issue		
78	Issues with parking around Cheltenham General Hospital may cause issues for more rural communities and those not on regular bus schedules for Cheltenham's proposed day and elective role.		
79	This survey is part completed because we accidentally submitted the form when part way through the survey.		
80	I think consultation period is too shore and suggest extension for 3 month. Very few people are aware of the deadline on Dec 17 amid covid 'lockdowns' and tier 2 restrictions. I only happened on the documents by chance (and I've been a user of services this year and was health professional for approx 40 years).		
81	Keep up the good work. Will be interested in the result of survey. Any plans for head injuries, chest surgery - including cardiac or neurosurgery, so these still go to Bristol of John Radcliffe, Oxford. Guess if you live west of the M5 you want all in GRH, east of the M5 CGH. There are of course major incidents to remember where anything and everything can turn up.		
82	I know we all demand more from the NHS. However, sometimes the changes may seem rational but have a detrimental effect on local people in relation to access and other things. In a different area, when Fairford Hospital was closed, we were told it would lead to more efficient services. I am not sure that this is the case and I think it was a bad decision to remove care beds from the system, as it would have provided capacity to look after patients who needed care but not access to expensive equipment, freeing up beds in acute hospitals. I think it was a bad decision.		

Anything else you would like to say?

		Response Percent	Response Total
83	It is, frankly, disgraceful that a consultation such as this one, which has had the resources of countless hours of input from selected sources within the organisations comprising 'One Gloucestershire' should be sent out for public 'consultation' in the middle of the greatest health crisis the country has seen for a century. The public have too much else on their minds at this time to be in a position to properly consider the issues that have been put before them. This is a massively cynical exercise designed to produce the answers that 'One Gloucestershire' have already decided on (ask any member of staff at Cheltenham General Hospital); sneaking the exercise in consultation at this time is almost certainly an abuse of process. And most egregious of all: the document purporting to be a 'plan' for the future of healthcare delivery in the county makes NO MENTION of pandemic planning. How can we be expected to take it seriously in the light of such a glaring omission?		
84	When making the final decision, ensure that you fully understand the models of care that have been proposed for general surgery because this consultation document does not accurately reflect what those working in the service have put forward. Trying to impose a service that 80% of the consultant body do not support will not augur well for its success.		
85	This feels like a token consultation. I do not know anyone outside of the medical sphere who has even heard of this.		
86	I don't have any friends who have even heard of this exercise. Why hasn't the questionnaire been sent to every household in the county?		
87	Covid-19 as shown us that resourcing can come back to bite us		
88	I am also concerned about the management of GRH. I do not question the skills, competence or dedication of the staff at GRH. However, again from experience, I do not believe that the management of the hospital is as good as it should be. I support GRH and CGH being in one trust, but I do wonder if a different management structure is needed within that trust so that greater emphasis is placed on delivering the services which patients are entitled to expect. I feel that as part of the management structure there should be someone in place who is responsible for ensuring that liaison with patients and their families is far better than it currently is. I think there is a case across Gloucestershire to be made for one trust to cover all health services – primary care, community hospitals, acute trusts, social and after care etc – and believe that this should be explored. I think this would have the potential to reduce costs and improve co-ordination of services. We have seen during the Covid crisis the inability of the acute hospitals to move sufficient numbers of patients out into care homes, community hospitals and into their own homes with support packages in place, and I think one management of all the services, with the appropriate structures within that trust, should be considered. I realise that the above would challenge the CCG arrangements, but again I feel that being part of one service might help coordination. For example, I believe that many more patients could be treated at primary care level than is currently the case, thus relieving the pressure on hospitals. Much greater use should be made of pharmacies.		
89	The publics primary concern about the reconfiguration of specialist services within the hospital relate to the convenience and accessibility of services and the long term sustainability of a Type 1 A&E Department in Cheltenham. Of some of these proposals are implemented it is difficult to see how a full Type 1 A&E Department would be sustainable in the long term. This is despite the reassurances the Hospital Trust has repeatedly been given. It is these proposals which have undermined staff and public confidence in the Hospital Trust's sincerity over the re-opening of Cheltenham A&E and its long term future.		

Anything else you would like to say?

		Response Percent	Response Total
90	When I was in hospital following the trauma to my ankle I felt well looked after by some of the nurses on shift, especially the ""day"" nurses. I was shocked however by a ""night nurse on the night shift asked me if I could hop!!! to the toilet rather than waste her time with her getting me a walking aid - remember this was when my leg was still in a very heavy plaster cast and I'd only just had the operation on my ankle that day - I was weak and very much in pain and certainly wouldn't be able to HOP to the damn toilet!! I couldn't believe my ears when she asked me that and that she almost seemed put out that i was in need of her assistance as the night nurse on shift. I was in hospital for two weeks but it was hoped and suggested by some junior doctors and at least one consultant that I leave after my first week. I was no where near ready to leave hospital after one week. I was still in tremendous pain and still had a heavy plaster cast on which considering my living situation at home was not at all ideal for supporting me with this current disability. I was discharged after two weeks after my insistence that I stay for lnger. I still feel I was discharged too early. My date to get my plaster cast removed was ill-scheduled and I was lumbered with dragging a heavy, itchy and uncomfortable cast around for about four weeks when it should have been two weeks after my operation that the temporary cast removed and a lighter more comfortable one put on. I requested transport to the hospital by ambulance which was denied so after getting a taxi half of the way still had to make my way through the grounds and the various corridors to get the appropriate place. I very much feel I was left unsupported durring my out patient recovery, especially during the time I was discharged and waiting for my new and lighter cast. The stress and anxiety was very detrimental to my fragile mental health. I suffer with anxiety and depression and undiagnosed and untreated OCD and complex PTSD all of which compounds to instable moods and frequent mental breakdowns. I do manage my mental health with medication and receive mental health support. I just wish my treatment as outpatient in aftercare was better monitored by professionals and I was better assisted and supported. I feel the COVID19 situation is part to blame for the seemingly hurrying of me out of the hospital and the quick discharge out of my own private room at the hospital where I have to say, I would have recovered better and faster perhaps rather than being herded onto an open ward where I was constantly disturbed by other patients and nursing staff. If I hadn't come into hospital during the corona virus pandemic I do believe my stay would have been far more pleasant and i wouldn't have struggled as much as i did with anxiety that i was using up vital bed space. I feel i should have stayed recovering in hospital for longer than i ended up staying.		
91	Quick and easy access is essential when you are ill. There is a much larger older population in North Cotswolds. Moreton in Marsh hospital is not included in this survey. So is a modern hospital intended to serve the North of the county yet when ever I or friends have visited it is empty. Why is this expensive new building not being used?		
92	I used to work for the department of health. The fashion for building new hospitals would alternate between big is beautiful and small is beautiful on a 10 year cycle. The result was that all current buildings was out of step with prevailing thinking. Health trusts need to resolve this conundrum and ensure a successful balance between specialist and locally delivered hospital based options.		
		answered	92
		skipped	148

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

		Response Percent	Response Total
1	Open-Ended Question	100.00%	240
1	GL54		
2	GL52		
3	gl53		
4	GL51		
5	GL52		
6	gL50		

What is the first part of your postcode? eg. GL1, GL20			
		Response Percent	Response Total
7	GL53		
8	GL50		
9	GL52		
10	WR14		
11	GL52		
12	Gl51		
13	GL50		
14	GL53		
15	GL52		
16	GL51		
17	GL52		
18	GL53		
19	Gl52		
20	Gl51		
21	GL53		
22	GL52		
23	GL52		
24	GL53		
25	gl52		
26	WR11		
27	gl51		
28	GL53		
29	GL52		
30	gl51		
31	gl51		
32	wr12		
33	gl53		
34	GL51		
35	gl20		
36	GL7		
37	wR11		
38	GL52		
39	Gl52		
40	GL52		
41	GL52		

What is the first part of your postcode? eg. GL1, GL20			
		Response Percent	Response Total
42	GL54		
43	GL20		
44	GL7		
45	Gl52		
46	GL53		
47	GL7		
48	gl51		
49	GL50		
50	GL7		
51	GL7		
52	gl51		
53	GL54		
54	GL54		
55	GL51		
56	Gl50		
57	Gl20		
58	Gl51		
59	GL50		
60	GL7		
61	Gl50		
62	Gl50		
63	GL53		
64	GL51		
65	SN2		
66	GL7		
67	GL53		
68	GL51		
69	GL53		
70	GL51		
71	GL52		
72	GL53		
73	GL52		
74	GL53		
75	gl52		
76	SN6		

What is the first part of your postcode? eg. GL1, GL20			
		Response Percent	Response Total
	77	GL19	
	78	GL19	
	79	GL19	
	80	GL19	
	81	GL51	
	82	GL52	
	83	GL53	
	84	Gl51	
	85	GL51	
	86	GL50	
	87	GL54	
	88	GL53	
	89	GL52	
	90	GL7	
	91	gl52	
	92	GL54	
	93	GL52	
	94	GL53	
	95	Gl53	
	96	GL52	
	97	GL52	
	98	GL52	
	99	GL20	
	100	GL8	
	101	GL52	
	102	GL53	
	103	GL52	
	104	GL54	
	105	GL54	
	106	GL54	
	107	GL51	
	108	GL19	
	109	Gl53	
	110	GL52	
	111	GL7	

What is the first part of your postcode? eg. GL1, GL20			
		Response Percent	Response Total
	112	gl51	
	113	GL52	
	114	Gl51	
	115	GL53	
	116	GL56	
	117	GL53	
	118	GL20	
	119	Gl52	
	120	GL52	
	121	GL7	
	122	GL51	
	123	GL7	
	124	GL7	
	125	GL8	
	126	GL53	
	127	GL54	
	128	GL53	
	129	GL7	
	130	Gl7	
	131	GL54	
	132	GL19	
	133	GL52	
	134	GL51	
	135	GL50	
	136	GL52	
	137	gl53	
	138	GL7	
	139	GL54	
	140	GL53	
	141	GL53	
	142	GL7	
	143	GL52	
	144	GL56	
	145	gl50	
	146	GL50	

What is the first part of your postcode? eg. GL1, GL20			
		Response Percent	Response Total
147	GL19		
148	GL20		
149	GL19		
150	GL19		
151	GL19		
152	GL19		
153	gl51		
154	GL52		
155	GL52		
156	GL51		
157	Gl51		
158	GL53		
159	GL52		
160	GL52		
161	GL53		
162	GL53		
163	GL53		
164	GL53		
165	GL50		
166	GL7		
167	GL51		
168	GL52		
169	GL54		
170	GL52		
171	GL54		
172	Gl51		
173	GL53		
174	GL52		
175	GL54		
176	GL56		
177	GL56		
178	GL52		
179	gl50		
180	Gl53		
181	GL53		

What is the first part of your postcode? eg. GL1, GL20			
		Response Percent	Response Total
	182	GL53	
	183	GL52	
	184	GL53	
	185	GL53	
	186	GL53	
	187	GL52	
	188	GL53	
	189	GL20	
	190	WR11	
	191	GL51	
	192	GL7	
	193	GL55	
	194	GL53	
	195	GL8	
	196	GL20	
	197	GL20	
	198	GL54	
	199	GL53	
	200	GL50	
	201	Gl19	
	202	GL50	
	203	Gl51	
	204	GL53	
	205	gl51	
	206	Gl20	
	207	GL52	
	208	GL51	
	209	GL52	
	210	GL53	
	211	GL8	
	212	GL20	
	213	GL52	
	214	GL51	
	215	GL19	
	216	GL52	

What is the first part of your postcode? eg. GL1, GL20			
		Response Percent	Response Total
	217	GL7	
	218	GL7	
	219	GL53	
	220	GL20	
	221	GL53	
	222	GL7	
	223	GL54	
	224	GL7	
	225	Gl53	
	226	GL53	
	227	GL54	
	228	gl50	
	229	GL20	
	230	GL50	
	231	GL52	
	232	GL50	
	233	GL52	
	234	GL54	
	235	GL50	
	236	GL51	
	237	GL56	
	238	GL50	
	239	GL50	
	240	GL7	
		answered	240
		skipped	0

Which age group are you:				
			Response Percent	Response Total
1	Under 18		2.51%	6
2	18-25		1.26%	3
3	26-35		11.72%	28
4	36-45		10.88%	26
5	46-55		19.67%	47
6	56-65		21.76%	52
7	66-75		19.25%	46
8	Over 75		11.30%	27
9	Prefer not to say		1.67%	4
			answered	239
			skipped	1

Are you:				
			Response Percent	Response Total
1	A health or social care professional		29.29%	70
2	A community partner		1.26%	3
3	A member of the public		65.27%	156
4	Prefer not to say		4.18%	10
			answered	239
			skipped	1

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

		Response Percent	Response Total
1	No	71.55%	171
2	Mental health problem	5.44%	13
3	Visual Impairment	3.35%	8
4	Learning difficulties	0.00%	0
5	Hearing impairment	5.86%	14
6	Long term condition	17.99%	43
7	Physical disability	4.60%	11
8	Prefer not to say	2.51%	6
		answered	239
		skipped	1

Do you look after, or give any help or support to family members, friends, neighbours or others because of either a long term physical or mental ill health need or problems related to old age? Please do not count anything you do as part of your paid employment.

		Response Percent	Response Total
1	Yes	25.54%	59
2	No	70.56%	163
3	Prefer not to say	3.90%	9
		answered	231
		skipped	9

Which best describes your ethnicity?

		Response Percent	Response Total
1	White British	86.50%	205
2	White Other	4.64%	11
3	Asian or Asian British	0.84%	2
4	Black or Black British	0.42%	1
5	Chinese	0.00%	0
6	Mixed	0.00%	0
7	Prefer not to say	7.17%	17
8	Other (please specify):	0.42%	1
		answered	237
		skipped	3

Other (please specify): (1)

1	White English

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

		Response Percent	Response Total
1	No religion	40.25%	95
2	Buddhist	0.00%	0
3	Christian (including Church of England, Catholic, Methodist and other denominations)	48.31%	114
4	Hindu	0.00%	0
5	Jewish	0.85%	2
6	Muslim	0.00%	0
7	Sikh	0.00%	0
8	Other	2.12%	5
9	Prefer not to say	8.47%	20
		answered	236
		skipped	4

Are you:

		Response Percent	Response Total
1	Male	42.62%	101
2	Female	52.32%	124
3	Transgender	0.00%	0
4	Prefer not to say	5.06%	12
		answered	237
		skipped	3

Do you identify with your gender as registered at birth?

		Response Percent	Response Total
1	Yes	95.34%	225
2	No	0.00%	0
3	Prefer not to say	4.66%	11
		answered	236
		skipped	4

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

		Response Percent	Response Total
1	Heterosexual or straight	85.23%	202
2	Gay or lesbian	2.11%	5
3	Bisexual	2.11%	5
4	Other	0.00%	0
5	Prefer not to say	10.55%	25
		answered	237
		skipped	3

Are you currently pregnant or have given birth in the last year?				
			Response Percent	Response Total
1	Yes		1.28%	3
2	No		69.36%	163
3	Not applicable		24.68%	58
4	Prefer not to say		4.68%	11
			answered	235
			skipped	5

Fit For The Future - What matters to you?

Postcodes from West of the county

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

		Response Percent	Response Total
1	Strongly support	50.28%	90
2	Support	31.84%	57
3	Oppose	6.70%	12
4	Strongly oppose	5.59%	10
5	No opinion	5.59%	10
		answered	179
		skipped	2

Please tell us why you think this, e.g. the information you would like us to consider (90)

1	Gloucester hospital is renowned for putting the fear of God into people when they have to go there for care, removing options for Cheltenham - especially during a pandemic seems insensitive to say the very least. We live in Stroud but have previously chosen to drive to A&E in Cheltenham to avoid GRH. I think there should be a lot more work going into trust in our services and more specifically the paper pushers at CCG before trying to garner support for another master plan that will inevitably cost trillions, be done without consent and have frustrating outcomes for patience and staff.
2	Gloucester itself is simply not big enough to accommodate current demand yet alone the additional 5,000 plus hour being built in Cheltenham in the next few years!
3	But needs much bigger a+e at GRH
4	Many patients do not have transport and will be unable to travel to the'alternative' hospital.
5	It would make sense to send sick medical patients to a single site where a full team can look after them rather than patients going to two different sites where they experience long wait times on AMU because the clinical rotas have lots of gaps.
6	need to put all the expertise in one place 24/7
7	In a county this size , with the shortage of doctor and nurses we need to ensure that we have the safest care available and to do this efficiently as possible we need to have services centred on one site , in acute medicine GRH is the preferred site. This will not be popular with Cheltenham people but they have to accept that they will never ever have a fully functioning hospital on their site .
8	This already works well with the acute medical take at GRH and all patients can be seen within the 14 hours that has to be a great improvement. Patients not being seen means their stay may be longer and their recovery poorer. It is frightening as a patient or relative if you are waiting sometimes days to be seen or reviewed and this would prevent that so a definite yes from me.
9	I think it should be split between the 2 hospitals so that you can go to the nearest hospital to where you live. I see no reason that both hospitals can not have enough or share staff so that this can happen
10	Bed demand at GRH already very high in comparison to CGH; consolidating all of medical take to GRH would sustain or even increase this demand. It is hard to see how the current situation, even pre-winter demands and Covid resurgence, can be maintained without regular black escalation statuses and ""clearing the decks"" of patients to CGH. Patients seen at CGH ED would need to be transferred to GRH if they needed an AMU bed.
11	There's no point, the trust is focusing too much on the 'front door' and acute medical unit! What about the rest of the hospital, not good for pt. flow is the other services aren't looked at properly! Also not everyone lives in Gloucester, this is not their nearest hospital!

Please tell us what you think about our preferred option to develop:A ‘centre of excellence’ for Acute Medicine (Acute Medical Take) at Gloucestershire Royal Hospital.		Response Percent	Response Total
12	It’s not clear what services will be ‘removed’ from GRH in order to accommodate a CoE. Also by locating a major single service at one of the two hospitals doesn’t address the increased time to travel for patients from the East of the County, the parking inconvenience (every part as bad at GRH as CGH, or cost of travelling further. Equally it does seemingly support (perceptibly at least) the downgrading of CGH A&E more permanently which is already and will continue to be an appalling decision.		
13	I would prefer to go to a site where the specialists are, rather than a hospital that is nearer but there are less staff available		
14	this move is completely unsafe and a silly move the organisation. Cheltenham needs an amu too.		
15	Cheltenham needs an acute care ward. how can you have a functioning a and e, which the trust keeps on insisting it will have at Cheltenham with no where for the patient to go after initial treatment? putting sick people in ambulances to grh is ridiculous. making the public believe they will have an a and e when they will have a sub par service is deceitful		
16	A centre of excellence is a title conferred on a centre by other institutions and is not something you can simply decide to be. Aspiration to excellence is essential but not if this is considered zero sum - i.e. we can aspire to be a centre of excellence in A and therefore B will not be excellent. Also there are currently services which are already considered excellent : does the Trust know what these are and do the various plans consider that aspiring to excellence in one domain might strip and already considered excellent service of its status?		
17	Focusses resources in one place and should be located where ED is located		
18	Enables acute medical team to focus their resource on one site rather than being split and struggling to cover both hospitals.		
19	More expertise on one site and better care		
20	this move has made it very unsafe for patients as grh staff just cant cope with the high volume of patients they are getting. The worst move they have decided to do.		
21	Having a more centralised provision will be more beneficial to patients.		
22	I cannot see any reason to make a case against it		
23	I strongly believe in centres of excellence and to me it is clear that the GRH is the only site for such a service. One significant factor is the possibiliyy of more timely access to Mental health services		
24	At present all medical take is at GRH and therefore at CGH we get all the medical patients that are difficult to manage and that GRH do not want. By having medical take at both sites the types of medical patients are more evenly spread.		
25	To help flow.		
26	I think it will promote continuing excellence in the services provided and will attract good quality staff to the area.		
27	having access to wide range of specialists as quickly as possible seems key		
28	Concentrate this and the required support services for this on one site		
29	Acute medicine consultant workfroce better concentrated to provide sustainable rota on single site rather than split across two hospitals. Better use of resources at singel site with economies of scale need to caution about overnight medical cover being adequate across remaining patients at CGH and patient frlows for walk-ins would need acute medical offer		
30	There just isn't a big enough ED at Gloucester, not enough Resus vays and just too cramped		
31	Best location in the county for this service		
32	It is the right approach for the future.		

Please tell us what you think about our preferred option to develop:A 'centre of excellence' for Acute Medicine (Acute Medical Take) at Gloucestershire Royal Hospital.		Response Percent	Response Total
33	Because without a facility for acute medical take at Cheltenham it would Be much more likely that the A& E dept at CGH would be rendered unviable. Travel times from the East of the county would be increased. If this option were to be adopted the facilities at GRH to accept the increased number of acute medical patients would have to be considerably improved.		
34	A centre of excellence in one location enables experience and expertise to be shared, high standards to be set and maintained, as long as its management is supportive and creates an environment where the organisation and the individual members can learn and develop, not compete.		
35	It makes sense to me have the expertise in one centre.		
36	The options outlined appear to make medical and operational sense		
37	This will give best outcomes for patients. Highly skilled teams will be able to care for patients & be able to support each other.		
38	If this is thought to be a good idea, it probably is!		
39	The proposed solution in the Consultation Document appears sound.		
40	Gloucester is in the centre of the county so it would be logical to have the acute medical take here.		
41	Creating CoEs across the county will inevitably create a good deal more traversing of the county for patients. I can empathise with the desire to make best use of resources.		
42	I think it is important that the best acute care is needed where there is a concentration of expertise. Diluting staff expertise in two centres is not the best way to achieve this. Having acute medicine (acute medical take in Gloucester makes absolute sense, and I do appreciate that for some cases, subsequent transfer to the regional centre in Bristol (e.g. BRI/Southmead) may still be required for the most serious cases.		
43	More effective/efficient to have one centre for this		
44	The concentration of key resources in one place to reduce duplication and wastage.		
45	I wish to ensure that the best treatment is available as timely as possible and is not compromised by duplication of service across sites.		
46	all experts in one place considering the staff shortage the NHS is currently under		
47	It enables Gloucester Royal to be a centre of excellence for treating trauma patients which will improve patient outcomes. Takes pressure off cold case planned beds.		
48	Opportunity to improve recruitment and retention of staff a strong argument for single site, linked to 24 hr consultant A&E		
49	If this means moving acute patients from Cheltenham to Gloucester then I oppose. These are normally time critical cases and travel is clinically detrimental. There are large and growing populations in both towns and future demand will require acute services at both sites.		
50	I can understand the reasoning and rationale for this option but I worry about capacity, if everyone suddenly has to attend GRH with no option to attend at CGH will waiting times be longer, will standards of care to the community be affected, will it mean that other treatments and services suffer at GRH. I am not against the proposal but these are some thoughts and questions I am having as a (potential) service user and a resident of Gloucestershire. I worry that this is also a step to wind down care and service provision at CGH too.		
51	Its a long way from the outer borders of the county - and not much use if it takes over an hour to get there - starting from 999		
52	It makes sense to centralise this area		
53	The rationale seems clear		
54	As I live in the Forest of Dean it would be far more convenient for my family as possible patients to be treated in Gloucester		

Please tell us what you think about our preferred option to develop:A ‘centre of excellence’ for Acute Medicine (Acute Medical Take) at Gloucestershire Royal Hospital.		Response Percent	Response Total
55	I think everyone would prefer to be treated where specialist care is available and immediately accessible. This comment applies to all sections		
56	Quicker access to specialist doctors Shorter waiting times Costs of transfer for GRH to CGH for some patients and ambulance service pressure is a concern		
57	Anything that reduces risk, Travelling time, being passed from pillar to post offers a quality service, with quality staff can only be excellent		
58	As with all your proposals to centralise services the problem is that of access for patients and their families. Whilst many have access to private transport a very large minority do not and they are frequently the elderly and less financially secure. For these people centralisation poses a major difficulty in accessing your services unless you propose to offer free transport between the sites. Even for those with private transport difficulties in accessing parking at iether site pose difficulties and high costs.		
59	Overall better patient outcomes and improved workforce environment.		
60	Makes absolute sense to have a Centre of excellence. Paramedics and GP's will know where to take and send associated patients rather than pot luck between two options.		
61	Glos Royal needs to improve		
62	Save on staffing and equipment by focussing on one location. Provide a better service.		
63	A good central location with good transport links. Ensure more bus services from out laying locations		
64	This sounds like it would lead to the loss of Acute Medicine at CGH. I have really noticed during the COVID changes that this often leads to multiple patient transfers across areas and hospitals which can be difficult and dangerous. Several patients on RYE had been to 4 ward areas prior to arriving on RYE.		
65	The creation of a COE will benefit staff and Patients However a more ""joinup"" public transport option needs to be considered - the holder of Gloucester main Bus provider Stagecoach should be able to used their daily/weekly/monthly bus pass in the 99 that links the two hospitals.		
66	Gloucestershire Royal already has good facilities and these could be improved if it was made a centre of excellence.		
67	Lack of community beds and placements means that this is needed across both sites in Gloucestershire especially GRH as cheltenham is more surgical and recent changes have only shown the failures of trying to downsize it and move specialities		
68	Having one centre of excellence in Gloucestershire should allow for more throughput, giving staff more experience, leading to better outcomes for patients.		
69	More convenient/centralized.		
70	Increased chances of seeing the right specialist more quickly. Will provide more focussed training/learning opportunities for junior doctors and medical staff, with continuous supervision by senior doctors. This will contribute to attracting staff and improved retention rates.		
71	Because I live in Gloucester.		
72	The facilities can be enhanced at less cost at this hospital		
73	It would make sense to have a particular specialism in one location to avoid possible delays to be seen by a specific consultant and relieve unnecessary travel between sites.		
74	With ever more complex equipment and specialist staff required it makes sense to centalise the service providing the infrastructure, beds and staff are provided. Such a move must not be seen as part of a cost cutting exercise.		
75	Central to county for us in FOD		

Please tell us what you think about our preferred option to develop:A ‘centre of excellence’ for Acute Medicine (Acute Medical Take) at Gloucestershire Royal Hospital.		Response Percent	Response Total
76	We have to be realistic about the challenges and do what's needed to try and mitigate them.		
77	I don't want to go to Gloucester Royal it has a bad reputation and I would not be happy there.		
78	Both hospitals more encourage to train and keeping staff.		
79	I think it is vitally important to be able to have access to the right specialists (senior doctors) in a time of need, also address safety issues		
80	Although I support this option I have the following concerns:- Glos is a large county to have one A&E consultant led overnight. This will have an impact because in emergency care timing is vital and many patients will have to travel further to get the treatment they require.		
81	Strongly support the idea of having 'specialties' at one of the two hospitals only.		
82	Possible, good concentration of staff		
83	Because of the increased local population both sites should be used.		
84	A specialist unit such as this makes sense.		
85	To concentrate the necessary skills in the centre of the catchment area		
86	A state of the art hospital should be built in the forest of dean. Five Acres would be excellent, with maternity facilities. The travel to Gloucester and Cheltenham to and from the forest is horrendous and expensive.		
87	Keeping track of all medicine and where they are used.		
88	More specialist nurses required in Acute Medicine. Real lull in activity when you get up to Acute Medicine.		
89	Quicker response to a service when needed - waiting times - if all under one roof - higher demand?		
90	If one centre will numbers be too high who need to be seen		

Please tell us what you think about our preferred option to develop:A ‘centre of excellence’ for Emergency General Surgery at Gloucestershire Royal Hospital.			Response Percent	Response Total
1	Strongly support		48.04%	86
2	Support		35.75%	64
3	Oppose		4.47%	8
4	Strongly oppose		6.70%	12
5	No opinion		5.03%	9
			answered	179
			skipped	2

Please tell us why you think this, e.g. the information you would like us to consider (79)	
1	There is too little trust in the care provided by GRH, from poor food, lack of staff, nasty conditions and poor staff morale to convince me that a bunch of desk workers in brockworth have the support of the grass root level staff. There needs to be far more public trust in CCG and GRH before big moves are planned.
2	I think split site working for all departments should end. Single site for each speciality should be a priority

Please tell us what you think about our preferred option to develop:A ‘centre of excellence’ for Emergency General Surgery at Gloucestershire Royal Hospital.		Response Percent	Response Total
3	If General Surgery cannot sustain a rota across two sites then for safety reasons we should divert patients to a single site so they can receive treatment in a timely manner.		
4	need to centralise expertise 24/7 ideally alongside other emergency services		
5	See previous answer. Best outcomes for patients is having centralised specialist units where training can also continue and also attract the best and Bridgestone staff .		
6	All emergency cases come to GRH and I feel that Emergency General Surgery should be at GRH because of this.		
7	It should be able to be at both hospitals, hopefully this will mean less people at each of the hospitals and also the nearer the hospital the better chance you have of helping someone especially if it is life or death		
8	Again, for same reasons as Acute care - GRH doesn’t have capacity		
9	Same reason as before, I know there aren't enough specialists, it makes sense to me to have them in one location. If I was in need of emergency surgery I'm not sure I would care where I was as long as someone with the required skill and knowledge was in the same place.		
10	Over working the system, more operating out of hours due to long busy list which is dangerous, battling different specialties on emergency lists resulting in longer waits for patients who might need an urgent operation, waste of Cheltenham general theatre teams skills, experience and facilities.		
11	Long emergency waiting list. Long eating times in a and e. No beds. Rushed surgery. Waste of Cheltenham General facilities and staff.		
12	Lack of beds, long a&e waiting times, longer wait for operations		
13	This is important BUT is not and should not be seen as mutually exclusive to a centre of excellence in pelvic resection		
14	we still receive urology emergencies into the theatre department with no provision for paediatrics overnight and no anaesthetic cover from 2200hrs apart from the DCC Doctors If emergencies are to remain in GRH then it needs to be all emergencies or proper provision for patients that remain in PACU after 2200hrs		
15	Avoids duplication and reduced likelihood of routine/elective surgery being cancelled due to emergencies.		
16	More expertise on one site leading to better care		
17	cgh also needs general surgery so thr ED should be re opened to		
18	I can see no reason against this proposal		
19	As before I strongly support ""centres of excellence"". It seems appropriate that this shoul be colocated with Acute medecine		
20	I think it will benefit local people to have this provision and will promote continued quality improvement and performance in this area.		
21	I want to see best staff possible in an emergency - I don't mind where it is but Gloucester makes more sense		
22	Because the majority of emergency admissions go to Gloucester so it is logical for them to have all emergency surgery. However, I think Cheltenham needs to have a 24 hr ED with a specialism in oncology, urology and colorectal.		
23	Best location and facilities in the county		
24	see above		
25	I have to travel to both hospitals, so it makes no difference to me.		
26	Again one location makes sense		
27	Skilled teams can provide care needed People may have to travel, but for a good outcome it is worth it		

Please tell us what you think about our preferred option to develop:A ‘centre of excellence’ for Emergency General Surgery at Gloucestershire Royal Hospital.		Response Percent	Response Total
28	If emergency treatment is performed at one hospital, GRH, it leaves planned surgery at the other, CGH, not liable to interruption for emergency surgery.		
29	The proposed solution in the Consultation Document appears sound.		
30	Service already good		
31	I believe it is essential to have emergency general surgery at two locations in the county ie Cheltenham and Gloucester.		
32	Much more favoured is spreading surgical procedures across the county's various community hospitals. It would also provide more centres of learning for the clinical staff.		
33	Makes sense to specialise		
34	It makes sense to concentrate expertise at one hospital, and GRH has already road tested this approach.		
35	will it mean no surgery at other hospitals and will they then be less of a centre of excellence. Assume not so need care with wording and implications		
36	Concentration of key resources in one place to reduce duplication and wastage.		
37	Makes absolutely sense to centralise and link in with the 24/;7 emergency care concept. It is simply not feasible to deliver across two sites and making GRH the site fits with the 24/7 emergency pathways.		
38	Benefits patients outcomes to have a centralised service, that will strive to become the centre of excellence		
39	Mocking all emergency services to GRH site logical I terms of collocation and impact on ambulance services		
40	As long as theatre space would increase in line with the need		
41	Please see my comments on the previous section regarding capacity and my support of the proposal IF the level of service is maintained to ensure that full and effective delivery, commensurate with the population of the area, can still be provided (or this proposal makes the service delivery more efficient).		
42	Better to have emergency care in one place with a full team of experts . Planned surgery can then take place at Cheltenham		
43	Better care for the community		
44	Gloucester closer to M% for post accident care and emergency admissions		
45	Emergency general surgery should be available at both hospitals		
46	It seems sensible and more cost effective to centralise services		
47	Anything that improves capacity, reduces cancellations must be good. I prefer option 2		
48	Reducing waiting time, planned surgeries that are preformed on time contributes significantly to the health and wellbeing of patients and their families reducing stress and unnecessary waiting times		
49	As with all your proposals to centralise services the problem is that of access for patients and their families. Whilst many have access to private transport a very large minority do not and they are frequently the elderly and less financially secure. For these people centralisation poses a major difficulty in accessing your services unless you propose to offer free transport between the sites. Even for those with private transport difficulties in accessing parking at iether site pose difficulties and high costs.		
50	As previous question.		
51	Glos Royal needs to improve.		
52	Specialist staff and equipment in one location. Saves on time and money.		
53	As stated before about transport links.		
54	The other options are more suitable		
55	Gloucestershire royal already has good facilities and several operating theatres with experienced staff		

Please tell us what you think about our preferred option to develop:A ‘centre of excellence’ for Emergency General Surgery at Gloucestershire Royal Hospital.		Response Percent	Response Total
56	Recent months have shown that the shutting of A&E in cheltenham and the removal of emergency surgery/planned surgery from Cheltenham has negatively impacted on patients and their experiences when previously having it on both sites worked due to the available DCC beds and the larger capacity. Raises questions of who is to blame for deaths when emergency surgery is not available on one site and someone dies on route, that is negligence where those that have made these decisions do not bare the blame, no family or patient deserved to go through this. Plus as gloucestershire is continually expanding with a rising population having one center for emergency surgery is simple foolery as it will not be able to cope with the ride in demands on already under funded and under staffed wards that receive no reprieve or help of any kind regardless of what is passed around internally or via media outlets		
57	Larger teams with a range of skills should give better outcomes.		
58	Good communications hub.		
59	Quicker, more direct access for patients to the right specialist. A 'centre of excellence' will be an attractor for young doctors. Concentration of the right staff cover. Concentrated and improved learning opportunities for junior staff. However, resources, including beds, nursing staff and theatres, will need to be increased at GRH accordingly.		
60	As above Because I live in Gloucester		
61	The facilities can be enhanced at less cost at this hospital		
62	This would be a more efficient use of resources.		
63	I can see the advantages of the proposal but I am concerned GRH's capacity to provide the capacity and service levels proposed.		
64	Central to county for all		
65	It makes sense to co-locate emergency medicine and surgery at GRH		
66	I would prefer to go to Cheltenham Hospital.		
67	Improved dr cover including a review by the correct sub specialty		
68	Mental health at Cheltenham Good centre		
69	Yes I would like this to stay in Gloucester I am bias I live just outside Gloucester I like the benefits to staff members and staff retention.		
70	As above Strongly support the idea of having 'specialties' at one of the two hospitals only.		
71	Better building and access		
72	Because of the increased local population both sites should be used.		
73	A specialist unit such as this makes sense.		
74	For the same reasons as above To concentrate the necessary skills in the centre of the catchment area		
75	Please note my previous comments the journey from FoD especially for older people is worrying and expensive. Hospital transport has failed badly and causing long delays in returning home. I am 90 years of age		
76	Look at the appointment systems and make the phone system shorter.		
77	A centre of excellence is essential and you shouldn't spread your resources. The hospitals are close enough that no areas should be disadvantaged.		
78	Your second option		
79	always needed - Will specialist staff really be available or too busy elsewhere? How practical will this be or is sit just a hope		

Please tell us what you think about our preferred option to develop:A 'centre of excellence' for Planned Lower GI (colorectal) general surgery at Cheltenham General Hospital (CGH) or Gloucestershire Royal Hospital (GRH).

		Response Percent	Response Total
1	Strongly support	47.73%	84
2	Support	34.66%	61
3	Oppose	2.84%	5
4	Strongly oppose	2.84%	5
5	No opinion	11.93%	21
		answered	176
		skipped	5

Please tell us why you think this, e.g. the information you would like us to consider (69)

1	I would like Gloucester to be a better option for care, this should be improved so that its more viable than having to travel to cheltenham to visit people.
2	Or???? Which is it?
3	Cohorting patients and clinical expertise leads to better patient care from a highly specialised team. We have seen the benefits of this through Vascular and Trauma networks.
4	for planned work we need to avoid the emergency site so the work continues despite emergencies - needs to be based at the non-emergency hospital cgh
5	Again it would make sense to have all GI surger on one site as patients don't always fit nicely into one speciality . So, GRH.
6	I think that all planned colorectal general surgery should take place at Cheltenham General Hospital. If I was a patient I would know my operation is less likely to be cancelled, that the ward would be clean and CGH is currently the 'green' site. I would not want to chance being put in a bed next to an emergency surgery patient who has not had a covid swab results prior to admission.
7	You should be able to go to nearest hospital for treatment, staff should be split between the 2 hospitals if necessary so this can be done
8	GRH surgical bedspace already limited; conversely beds available at CGH for increased surgical work. Transfer to all planned colorectal work to GRH would increase already high pressure on surgical bed availability. Centralising lower GI at CGH would make use of existing surgical cover and surgical nursing staff with less bed pressures than at GRH. Benefits to be had from concentrating all colorectal lists at a single site - CGH the obvious option as currently has less bed pressure than GRH but still has required surgical and nursing expertise. Gastroenterology already at CGH which would benefit those patients who need input from gastro medics whilst under care of Lower GI surgeons.
9	Planned care still requires experts and equipment, its unreasonable to expect the NHS to be able to fund this on two sites that are so close to each other
10	Lower GI at CGH is already considered excellent within the surgical community and so this could be built on
11	Better care due to expertise and less chance of cancelling operations
12	Planned at CGH Emergency at GRH.. It would be a neat way of organising activities
13	Main reason as before
14	A unit at CGH would be the best option as if at GRH then the patients would be at risk of being mixed with emergency surgery and all the problems that can cause.
15	This is an 'either or' question without giving an opportunity to vote for either. It is nonsense.

Please tell us what you think about our preferred option to develop:A ‘centre of excellence’ for Planned Lower GI (colorectal) general surgery at Cheltenham General Hospital (CGH) or Gloucestershire Royal Hospital (GRH).		Response Percent	Response Total
16	Makes sense if centralising other GI services.		
17	It will benefit local people needing this type of surgery		
18	essential to attract good specialists and perhaps in time take on childrens so we dont have to travel to Bristol		
19	Specialist staff in one place should mean collaboration in terms of quickly dealing with patient problems. Quick treatment/ diagnosis of Crohn’s can reduce the need for surgery, less time off work and a better quality of life!		
20	Cheltenham needs to become a centre of excellence for colorectal surgery, urology and oncology, both planned and emergency		
21	CGH		
22	Higher standards and expertise can be employed centrally		
23	experienced good service/care at CGH		
24	I support a centre for excellence.		
25	Being able to have all services on one site is cost effective with equipment best outcome for patients if staff are experts		
26	The relevant proposals in the Consultation Document appear sound.		
27	Need specialist services		
28	It is probably more efficient to concentrate resources at one dedicated hospital.		
29	As above		
30	Again, this is about providing the best patient service by locating staff at one centre.		
31	dont know enough about this problem but previous comments would apply		
32	Concentration of key resources in one place to reduce duplication and wastage.		
33	Support the concept of having centralised services. From clinical delivery stance, staffing and financial.		
34	Good to have a centre of excellence. Attracts staff and makes good effective use of both equipment and staff.		
35	Please try and keep all acute specialities on one site.		
36	It doesn't matter which site, so long as the service is there and available.		
37	Obviously to split up centre of excellence means less pushing people from one A&E to somewhere everything is not to hand		
38	centre at cheltenham		
39	It can only be a good thing for the people of Gloucestershire		
40	Pros and cons here but overall would support		
41	CGH would be the better location		
42	Again it seems sensible to centralise resources and staff		
43	Please bear in mind any treatments taken prior to appointments which may make a long journey very difficult		
44	As above		
45	As with all your proposals to centralise services the problem is that of access for patients and their families. Whilst many have access to private transport a very large minority do not and they are frequently the elderly and less financially secure. For these people centralisation poses a major difficulty in accessing your services unless you propose to offer free transport between the sites. Even for those with private transport difficulties in accessing parking at iether site pose difficulties and high costs.		
46	Likely to dilute service and so negatively impact patient outcomes.		

Please tell us what you think about our preferred option to develop:A ‘centre of excellence’ for Planned Lower GI (colorectal) general surgery at Cheltenham General Hospital (CGH) or Gloucestershire Royal Hospital (GRH).		Response Percent	Response Total
47	Confused!		
48	Focussing a specialism in one location makes the most sense providing value for money.		
49	A good way ahead.		
50	COE will benefit Patients and Staff, and make effective use of existing resources		
51	Often have to go to Cheltenham for appointments so makes sense to do it at Cheltenham		
52	At Cheltenham General without a doubt, this has been in place for years and has worked without failure to a high standard. I, my family and friends have received care on this ward to a fantastic degree and then have unfortunately been subjected to GRH due to current events this year, to say that we were disgusted by this change would be a vast understatement. Why change what isn't broken, why ruin a system that has supported so many for years with such a dedicated team that is being picked apart and why support such an idiotic decision to shift CGH to a more medically acute when GRH does not have space for all this surgery and that has also been proven and found this year		
53	Not qualified to judge.		
54	Concentration of a specialised team and the necessary resources.		
55	If it is at GRH		
56	This hospital specialises in this area		
57	Again, it must be best to have all the specialists in one location.		
58	Not central to county. Parking nightmare, travel time - hours away		
59	Need to locate the planned specialties into CGH if emergency medicine and surgery are going to GRH		
60	At Cheltenham		
61	This should be at GRH for EGS to support. Everyone together in the same place		
62	For Chelt		
63	I think there would be lots of advantages to keeping all the planned lower colorectal general surgery in Gloucester. Everything and every member of staff present.		
64	As above Strongly support the idea of having 'specialties' at one of the two hospitals only.		
65	As above Better building and access		
66	It needs to be Gloucester for access from the forest of dean		
67	To help spread skills to other major assets		
68	See my previous answers on GRH but more so to travel to CGH. My wife is desabled hospital transport is a joke. I wrote to MP Mark Harper about this. I pay for transport and it is expensive		
69	Parking and the use of public transport enabling the general public to use buses from Waterwells through to GRH		

In supporting our preferred option to create a single site 'centre of excellence', where do you think a 'centre of excellence' for Planned Lower GI (colorectal) general surgery should be developed?

		Response Percent	Response Total
1	Cheltenham General Hospital (CGH)	40.80%	71
2	Gloucestershire Royal Hospital (GRH)	28.74%	50
3	No opinion	30.46%	53
		answered	174
		skipped	7

Please tell us why you think this, e.g. the information you would like us to consider: (76)

1	I would like Gloucester to be a better option for care, this should be improved so that its more viable than having to travel to cheltenham to visit people.
2	this would support gynaeoncology surgery
3	Because I think that elective or planned procedures should run from the site with a lease amount of emergency bed pressures. I believe that this will lead to fewer patient cancellations and overall a better experience post operatively where wards are full of elective patients all receiving appropriate post operative care rather than mixing with other non-surgical patients who are placed there because there is no other room.
4	because it's not the emergency site and patient flow can be better managed
5	As above so the specialists are on one site , can cross cover be available.
6	I think this fits in with gynae and urology planned surgery and often these patients may need two consultants operating at a time. It will also mean that planned surgery is centralised. This will make it more appealing for staff working at CGH knowing they work on a site that is considered a centre of excellence.
7	Just because it is the nearest hospital to where I live, I should imagine anyone living near to Cheltenham would choose the Cheltenham one as their option
8	Bed space available at CGH for increase in existing colorectal work; patients requiring transfer or input from gastroenterology would benefit from existing presence of gastro services on site in Snowshill at CGH. Available bedspace for colorectal patients (alongside gynae oncology) currently being used as medical overflow with associated reduced and unsafe medical cover, loss of experienced surgical nursing staff and reduced quality of patient care.
9	CGH should be the site for all planned activity
10	Oncology centre
11	Oncology centre.
12	Oncology
13	Which ever site has best capacity of operating theatres and staffing for this proposal
14	This builds on already established reputation and allows other interdependent excellent services to continue to flourish because they have ongoing on site, immediate lower GI surgical support. Removing lower GI surgical support from CGH would diminish urological, gynaecological oncology, gastroeneterology and oncology services. Specifically gynaecological oncology simply could not operate in the same way and all ovarian cancer surgery would need to move to GRH to facilitate appropriately supported radical surgery within any governance framework
15	Consultants and staff are fed up. Colorectal worked at Cheltenham before stop fixing things that aren't broken. Wasting good theatres, what's the point in not using something we already have. And you have amazing nurses and HCA's with colorectal experience in Cheltenham that will not go to Gloucester.
16	As this is intimately linked to gastroenterology (which is being focussed at CGH), it makes sense for this to be at CGH too.
17	I have no views about which hospital should be the site - this is clearly a matter for the best use of resources - both physical and staff - and I am in no position to take a view on the information provided

In supporting our preferred option to create a single site 'centre of excellence', where do you think a 'centre of excellence' for Planned Lower GI (colorectal) general surgery should be developed?		Response Percent	Response Total
18	Planned surgery at CGH would reduce likelihood of patients operations being cancelled. Staff would be trained to manage all types of pelvic surgery and therefore give better service and earlier discharge.		
19	Makes sense to continue the planned trend at CGH.		
20	I don't think it matters where the provision is. I cant see that one site has more benefit that the other.		
21	we live in Stroud - now my son has transitioned into adult IBD services we have had infusions in GRH, consultant appointment in GRH and MRI in Chelt - the travel relatively easy for us so wherever means staff travelling less.		
22	Cheltenham already deals with urology and it would make sense for ALL lower GI surgery, planned and emergency		
23	For reason given previously		
24	As previous		
25	Surgical team availability. Easier to set up cell salvage, if needed during the oerations.		
26	To co-locate with urology and gynae-oncology. By taking elective lower GI from GRH space would be freed up for other needs.		
27	Only those involved with actually doing it and the rersource implications can make this decision. Whatever is done must take into account the time and travel implications for the whole County and the environmental impact.		
28	Where the best service can be provided. Ensuring correct equipment, staff & space.		
29	I have no relevant technical knowledge to offer an informed view		
30	Either would do.		
31	As above		
32	Hard to have an opinion unless you are a user		
33	Although my own experience has been of having colocrectal surgery at GRH, I think location for this is less important than concentrating the expertise at one centre.		
34	not qualified to judge which would be best. Access, free parking other facilities to fit around this would need to be thought through		
35	I understand that there can some crossover between Upper and Lower GI* and this suggests to me that collocating them would be wise provided that the is sufficient space and facilities at GRH. *Last year I had emergency Lower GI surgery carried out at CGH by an Upper GI consultant (excellent outcome!)		
36	I live in Stroud and find it easier to get to GRH and easier to park the car.		
37	There are pros and cons for both sites.		
38	the main center for this type of surgery is already in Cheltenham - so why would you wan t to move it ?		
39	Either site so long it is centralised at one or other site. It would be advantageous to have both upper and lower GI planned surgery at one site. Staffing and equipment availability should be considered.		
40	Ability to protect beds and theatre capacity		
41	As long as the support services match the need.		
42	Again, it doesn't matter which site, so long as the service is there and available and ensure capacity and effective care for Gloucestershire residents. In my mind it would make sense to have a particular specialist treatment at both sites i.e. GRH is centre of excellence for XX and CGH is centre of excellence for YY. So that one or other site does not become defunct.		

In supporting our preferred option to create a single site 'centre of excellence', where do you think a 'centre of excellence' for Planned Lower GI (colorectal) general surgery should be developed?		Response Percent	Response Total
43	Because should I or my neighbours need it, it is within easy reach for local transport. GRH in rush hour can take at least 1.5 hours		
44	It makes sense for all GI (lower and upper) services to be in one hospital		
45	Gloucester seems the preferable site to develop. Far better access by public transport.... crucial for many people and their families		
46	Cheltenham and Gloucester hospitals should be equally recognised for their own specialisms and resources. Gloucester Hospital cannot have it all		
47	Obviously Gloucester is the closest to me, for same reason stated above. Cotswold residents would almost certainly disagree		
48	Which option is most cost effective		
49	Greater Diversity in Gloucester - some longer term health conditions higher with minority ethics Ease of access and family support as communities live close together		
50	As before; it is better not to centralise unless and until provision is made for transport between the sites. This is vital for the elderly and less financially secure. (Frequently these are the same.)		
51	Best for outcomes and workforce with limited negative impact on travel/access for those living east of Cheltenham.		
52	Either. But a Centre of excellence makes sense.		
53	If the majority of this department is located in GRH, it makes sense for all of it to be located at GRH.		
54	Better parking for staff and visitor options more mid way for Forest patient and visitors. Near to train links.		
55	A very confused layout that could be fixed easily.		
56	Make effective use of existing resources		
57	As above		
58	At Cheltenham General without a doubt, this has been in place for years and has worked without failure to a high standard. I, my family and friends have received care on this ward to a fantastic degree and then have unfortunately been subjected to GRH due to current events this year, to say that we were disgusted by this change would be a vast understatement. Why change what isn't broken, why ruin a system that has supported so many for years with such a dedicated team that is being picked apart and why support such an idiotic decision to shift CGH to a more medically acute when GRH does not have space for all this surgery and that has also been proven and found this year Please consider the fact that whichever higher up or suited monkey has been trying to shut cheltenham A&E for years due to funding and the arrangement of doctors across sites. This is bad in practice and paper, especially when the current state of affairs in CGH due to some of these measures already being in place has slowed down patient care because their is no one on site available to offer the urgent care that is needed or they are being rushed off to see to someone in a supposable MIU that continually blue lights patients to gloucester only for them to come back again as their is no capacity or available beds		
59	Not qualified to judge.		
60	Would seemingly make best sense to locate this at CGH to create a centre of excellence for pelvic resection; and to keep this surgery service entirely separated from the pressures of the Emergency General Surgery at GRH (as suggested in the consultation booklet)'		
61	This hospital specialises in this area		
62	It is important not to concentrate every resource at one location, e.g. Glos, as this would increase the possibility of a single point failure.		
63	Again central		
64	see previous response		

In supporting our preferred option to create a single site 'centre of excellence', where do you think a ‘centre of excellence’ for Planned Lower GI (colorectal) general surgery should be developed?		Response Percent	Response Total
65	Cheltenham has a better reputation in area.		
66	As above		
67	I think a centre of excellence, a single one would benefit the local and wider community by being situated in Gloucester.		
68	Strongly support the idea of single site excellence for all and any hospital procedures		
69	Ditto Better building and access		
70	Its more central for Gloucestershire		
71	I am willing to provide a contribution towards the cost of a new hospital in FoD. Monmouthshire Council I am sure would also contribute instead of having people travelling to Cumbran		
72	It doesn't make sense to have a centre for excellence across 2 sites but transport needs to be available and affordable for those that need it		
73	More information about ones operations		
74	To fit in with the other related specialities at Cheltenham		
75	Family orientated at Cheltenham and more friendly, smaller pods.		
76	Prefer something at both sites		

Please tell us what you think about our preferred option to develop:A ‘centre of excellence’ for planned day case Upper and Lower GI (colorectal) surgery at Cheltenham General Hospital (CGH).			Response Percent	Response Total
1	Strongly support		38.76%	69
2	Support		35.96%	64
3	Oppose		5.62%	10
4	Strongly oppose		4.49%	8
5	No opinion		15.17%	27
			answered	178
			skipped	3

Please tell us why you think this, e.g. the information you would like us to consider (61)	
1	I would like Gloucester to be a better option for care, this should be improved so that its more viable than having to travel to cheltenham to visit people.
2	As per my previous response I think splitting the acute general surgery take out from the elective demand is sensible and will lead to improved clinical outcomes, better patient experience and increased clinical skill development.
3	planned = cheltenham
4	If there are enough surgeons to cover this service , my concern is if an emergency service is also working how will the oncology patients be managed in an emergency situation

Please tell us what you think about our preferred option to develop:A ‘centre of excellence’ for planned day case Upper and Lower GI (colorectal) surgery at Cheltenham General Hospital (CGH).		Response Percent	Response Total
5	I know that the Day Surgery Unit at CGH is expanding so this would be the ideal location for day case surgery for upper and lower GI cases.		
6	I think it should be at both hospitals, leaving it easier for people to go to hospital nearest to where they live		
7	Existing surgical teams at CGH; centralising all day case GI work at CGH would reduce pressure on GRH to focus on emergency general surgery		
8	If planned surgery is on the same site then you keep a cohort of skills in that location		
9	Make absolute sense to create an elective surgical oncology resection service at one site ; i.e. colocated with the oncology services and away from emergency services with their greater and unpredictable demands on beds which leads to the cancellation of cancer operations when the two are co-located		
10	I understand that the plans are in for two new day unit theatres to be built in CGH so hasn't this decision already been made		
11	Good idea. Protects the beds from emergencies so reducing need for last minute cancellations		
12	In my view clearly better that this should be on one site.		
13	Benefits local people.		
14	Specialist equipment in one place, more efficient use of resources and specialist staff.		
15	moving to a planned care centre of excellence can protect access from being hindered by urgent care demand; Using Cheltenham for this is more practical that CGh given the site, the existing status of GRh as Major trauma unit and A&E status overnight at CGH		
16	It needs to be clear that if you have a centre of excellence, it is in one place. GU/GI at Cheltenham - Totally! along with oncology. Everything else to GRH		
17	Would require better facilities at Cheltenham general in my opinion hospital dated and tired in appearance		
18	I support the idea of one team on one site locally		
19	Proposals in the Consultation Document appear sound.		
20	Spreading scarce resources around the county is a preferred method.		
21	As per my previous answer. Concentration in one centre is the most important issue.		
22	previous comments will apply to this		
23	Concentration of key resources to reduce duplication and wastage.		
24	Having a excellent readily available service that treats me even if I have to travel is preferred to waiting and perhaps getting a second class service because of a dilution of resources/service simply to accommodate operating on both sites. It is 7 miles not travelling to the moon.		
25	This is already in Cheltenham. I have had to use it and found it excellent.		
26	Good idea, for all the reasons previously given.		
27	Ability to manage beds and theatre capacity. Support to staff.		
28	It would make sense that both upper and lower should be on the same site as support services and staff would have similar skill sets		
29	So long as patients can access the location where their surgery is taking place.		
30	One hospital for emergencies and one for planned surgery. As long as the hospital for emergencies has enough OR.		
31	Seems sensible to keep upper and lower together - otherwise in the middle might slip through the space inbetween		

Please tell us what you think about our preferred option to develop:A ‘centre of excellence’ for planned day case Upper and Lower GI (colorectal) surgery at Cheltenham General Hospital (CGH).		Response Percent	Response Total
32	Staffing levels		
33	If planned centre of excellence for lower GI general surgery will be in Cheltenham it is only sensible for day cases upper and lower surgery to be there also		
34	See previous 2 comments		
35	Too much dependence upon centralising services at GRH is, in my opinion a mistake. Gloucestershire needs to use its two mains sites fully		
36	As with all your proposals to centralise services the problem is that of access for patients and their families. Whilst many have access to private transport a very large minority do not and they are frequently the elderly and less financially secure. For these people centralisation poses a major difficulty in accessing your services unless you propose to offer free transport between the sites. Even for those with private transport difficulties in accessing parking at iether site pose difficulties and high costs.		
37	Key to this is ""Planned"" which increases Trust's capacity without negative workforce impact.		
38	Transport to CGH needs improvement		
39	Separating Planned surgerty will reduce cancellation and improve patients waiting times		
40	A smart decision as these teams are set up and in place already with exemplary experience as well as the chances to expand on these services as their is adequate space		
41	Fewer last minute cancellations and better throughput.		
42	Not qualified to judge.		
43	Concentration of expertise and dedicated staff in one location will improve patient care and efficiency.		
44	This hospital specialises in this area		
45	As there may be possible overlap between the two treatments it would be best if there were all located in the same site.		
46	Not central to county		
47	Need more emergency slots at GRH, ambulances queuing		
48	keeping planned activity in CGH if emergency services are going to GRH makes sense		
49	Cheltenham has a better reputation.		
50	To avoid cancellations		
51	At Chelt		
52	This would work well because it is planned surgery instead of emergency surgery. Not so much of an issue around transport and time scales		
53	As above Strongly support the idea of single site excellence for all and any hospital procedures		
54	Makes sense to spread workload		
55	Because of the increased local population both sites should be used.		
56	It needs to be Gloucester more central for Gloucestershire.		
57	To centralise the entire colorectal skills		
58	See my previous comments. This is a bad decision and the people of the forest of dean and Monmouth deserve better.		
59	N/A		
60	Keep Upper GI at Glos		

Please tell us what you think about our preferred option to develop:A ‘centre of excellence’ for planned day case Upper and Lower GI (colorectal) surgery at Cheltenham General Hospital (CGH).		Response Percent	Response Total
61	Yes for centre of excellence and yes for Cheltenham.		

A 24/7 Image Guided Interventional Surgery (IGIS) ‘Hub’ at Gloucestershire Royal Hospital and a ‘Spoke' at Cheltenham General Hospital.			Response Percent	Response Total
1	Strongly support		42.46%	76
2	Support		36.87%	66
3	Oppose		3.35%	6
4	Strongly oppose		4.47%	8
5	No opinion		12.85%	23
			answered	179
			skipped	2

Please tell us why you think this, e.g. the information you would like us to consider (59)

1	I suspect more money has gone into coming up with the terms / logos for hub and spoke than into IGIS. Both places should be equal and more money should be invested and the CCG shrunk to release the funds.
2	IGIS should be concentrated on the site receiving the acute take for both medicine and surgery. It is as illogical to split the IGIS service over two sites to offer a compromised service as it is to split either acute take over two sites with poorly manned rotas.
3	strongly support the concept but if this is elective work wouldn't it be sensible to base it at cgh and have a spoke at grh?
4	Makes sense as the oncology services are at Chet=ltenham so would need support
5	I think it should be at both hospitals so people can go to hospital nearest to where they live
6	There needs to be 24/7 cardiac intervention! This has been needed for years & should all be on one site!
7	The spoke is a ‘gesture’ and perceptibly will be seen as something to sacrifice at a later date to move all services to GRH....
8	Cheltenham needs a functioning A&E and will need a imaging
9	Should be colocated with maternity and emergency services
10	Emergency interventional procedures should absolutely be where the main ED is - primary PCI being one of them. It is completely unacceptable that patients, in the throes of having a heart attack are driven across the A40 or down the M5. This is a dangerous practice.
11	re opening CGH ED as we have perfectly good imaging equipment and needs to be used.
12	On balance on the information provided GRH seems the more appropriate site
13	As long as this allows radiology to expand and develop. Be bold and invest here, this could be a real jewel in the crown for healthcare in Gloucestershire.
14	Will provide a better health care service for local people.
15	espensive kit and specialist staff - makes no sense to try and run 2 sites
16	aligns to centre of excellence for vascular at GRH, including IR move from CGh to GRH

A 24/7 Image Guided Interventional Surgery (IGIS) 'Hub' at Gloucestershire Royal Hospital and a 'Spoke' at Cheltenham General Hospital.		Response Percent	Response Total
17	Reasons given previously		
18	The way ahead if all the needed skill sets are in place.		
19	This would presumably mean that there could be more appointments available.		
20	Being a more modern hospital having the hub in Gloucester makes sense		
21	Prposals in the consultation document appear sound.		
22	As long as the tech is good enough this is fine. But the tech has to be up to this task		
23	Concentration of key resources to reduce duplication and wastage.		
24	Having a service that operates in the main where the acute take is makes the most sense.		
25	Centralised approach is good. The equipment needed to undertake these investigations are often expensive, particularly the imaging equipment. Staffing levels are often difficult to maintain and are often difficult to recruit. State of the ark equipment will help to attract highly trained staff.		
26	Help with recruiting and developing a centre of excellence good for population of Gloucestershire		
27	As long as there is suitable staffing to support this arrangement, eg. Radiologists, nursing staff, radiology staff, physiology staff.		
28	I have put 'oppose' because I feel neutral about this proposal (so I do have an opinion but not either way at the moment). My reason is as follows: as long as patients attending both have the same access to the surgery/treatment they need e.g. so that those patients attending a non surgical centre are not disadvantaged by this model/proposal.		
29	Important to rationalise and make optimum use of very expensive and latest equipment		
30	Staffing levels		
31	Provided the spoke at Cheltenham is accessible and operational		
32	Makes sense to have a provision at both sites and reduce need for out of county travel by patients		
33	Often with services / treatments there is a lot of confusion where to go Cheltenham or Gloucester? a centralised hub offering as much as possible at one place would provide a ""comfort zone"" for the patient without having to travel to different places. Doesn't have a feeling of disconnect		
34	Bringing the hub into one location makes sense, as staff and equipment can be focussed on one place not split over two sites.		
35	Good choice based on current buildings		
36	This Provide the Best Option - and will mean patients can be seen locally.		
37	Availability re transport and parking for patients and carers		
38	If this helps people and their is space on sites then definitely as delays in scans are detrimental to patient safety and outpatient urgent appointments		
39	There should be one main centre as this should lead to improved patient outcomes.		
40	Vascular services currently at cgh with IGIS,, alongside urology, cardiology and cancer services. GRH is run down with tower block wards which are not suitable for all these services		
41	Seems effective.		
42	If EGS and Acute Medical Take are located at GRH, then it makes good sense to make GRH the hub for IGIS. It would also seem sensible for there to be a 'spoke' at CGH to work alongside oncology, urology and other specialisations there.		
43	Combine the two centres to get maximum benefit.		

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

		Response Percent	Response Total
44	It would seem that more patients could be treated in this way.		
45	Such a move would avoid duplication of expensive equipment. The proposal refers to a 24/7 hub, my support is conditional on this meaning availability 24 hours a day 7 days a week.		
46	GRH should be main site		
47	This type of system is going to expand rapidly might need a target spike at Chelt.		
48	This depends where the activity is required - in emergency surgery or planned		
49	If we can choose where we go.		
50	Support encourage people to come to hosp a more quicker turn around		
51	Yes I would like IGIS Hus at Gloucester and a spoke at Cheltenham General Hospital, I like the fact you do not have to travel between sites and outside of the county.		
52	As above - is the 'spoke' necessary? Strongly support the idea of single site excellence for all and any hospital procedures		
53	Because of the increased local population both sites should be used.		
54	Explain why this can't just be at Gloucester		
55	It is the logical place		
56	See my previous comments. The people making the decisions have not had to journey from the FoD to Glos and Chelt 4 or 5 times a year as we have and paid for the privilege		
57	Good idea		
58	Have had heart surgery and this would have helped me at the time and taken away the need to attend Oxford. Great for bringing the specialists to Gloucestershire to work. Open up the service to more charitable funds.		
59	Single location		

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

			Response Percent	Response Total
1	Strongly support		37.57%	65
2	Support		35.26%	61
3	Oppose		7.51%	13
4	Strongly oppose		5.20%	9
5	No opinion		14.45%	25
			answered	173
			skipped	8

Please tell us why you think this, e.g. the information you would like us to consider (52)

A ‘centre of excellence’ for Vascular Surgery at Gloucestershire Royal Hospital.			
		Response Percent	Response Total
1	Vascular is predominantly a service where patients can be suffering from a life threatening event (AAA) that requires immediate intervention in a theatre designed for this type of surgery. I think splitting Vascular across two sites will provide a sparse clinical cover across two sites rather than strong cover on one site. I can see the intrinsic link between IGIS and Vascular and therefore wherever the IGIS hub is, Vascular should be centralised to and vice versa.		
2	probably unless we split acute and elective		
3	Again it should be at both hospitals so that people can go to hospital nearest to where they live		
4	Bedspace constraints at GRH reducing efficiency of vascular care; current ward for vascular patients at GRH unsuited to patient type and care required		
5	Multi million pound interventional radiography theatre built in Cheltenham, consultants still wishing to do hybrid cases in IR resulting in transferring patients post major surgery across site, emergency list overwhelmed in Gloucester Royal as battle for specialities to operate		
6	Too many operations at CGH have the potential to cause life threatening bleeding from major vessels (pelvic, aorta, IVC - renal, gynaeoncology) for it to be safe to have no available vascular surgeons immediately available at CGH.		
7	Vascular has already moved to gloucester		
8	Urgent care site status will mean operations may be cancelled		
9	vascular surgeons will mainly be based here for acute interventions		
10	as above		
11	Vascular surgery worked well for many years at CGH and the ward environment was much better than the present situation at GRH. Patients travelling from Swindon have much further to go for treatment so it is better situated in Cheltenham.		
12	Hard to have IGIS at GRH and vascular at CGH so makes sense.		
13	I think it is an interesting area of surgery and will provide excellent provision for local people.		
14	aligns well with emergency provision for vascular / stroke etc		
15	Keep Cheltenham as centre of excellence for everything GU/GI and oncology and all other surgery at GRH		
16	Ditto		
17	see above		
18	One team working closely together		
19	Same as the above		
20	Proposals in the consultation document appear sound.		
21	Might use this		
22	Concentration of key resources to reduce duplication and wastage.		
23	I think Vascular should remain at CGH. Only a relatively short time ago much investment was made to establish a centralised service at CGH. Gong forward with future phases of FFtF there will be a need to have established services at CGH and this is one that could fit and not compromise safety.		
24	Same reasons as above.		
25	Meets best practice requirements		
26	As long as there is suitable staffing to support this arrangement, eg. Radiologists, nursing staff, radiology staff, physiology staff.		

A 'centre of excellence' for Vascular Surgery at Gloucestershire Royal Hospital.			
		Response Percent	Response Total
27	Please read my earlier comments regarding capacity, service delivery and my reservations that moving particular services to GRH alone must not lead to the closure of CGH (based on the assumption that GRH alone cannot service the whole catchment community).		
28	If Gloucester is the best hospital then yes but don't overload it.		
29	Most vascular surgery is urgent, however the vast majority is planned so it seems daft to move too GRH. especially when a lot of resources and planning went into developing an excellent service at CGH.If it is moved to Gloucester Royal then it is essential for the accommodation to be fit for purpose. eg: large bed space, assessable showering/bath facilities to meet the needs of patient demographics. Vascular surgery inpatient and outpatients and vascular lab should be in close proximity		
30	It would be good not to have to go out of county for this		
31	Seems to make sense		
32	As with all your proposals to centralise services the problem is that of access for patients and their families. Whilst many have access to private transport a very large minority do not and they are frequently the elderly and less financially secure. For these people centralisation poses a major difficulty in accessing your services unless you propose to offer free transport between the sites. Even for those with private transport difficulties in accessing parking at iether site pose difficulties and high costs.		
33	Very good choice		
34	I Struggle to see the Justifcation for the move - other than to be Closer to Trauma unit.		
35	Good parking, already has a good unit at GRH		
36	This team have been in place and excelled in gloucester as majority of admissions of this type are sourced from gloucester. Also the equipment and resources required for this are centered in Gloucester with years of practice		
37	As above, wards not suitable for vascular patients, due to limited mobility, cgh has cancer centre of excellence, these patients would have to travel to grh if igis not working. Theatre in cgh could be upgraded as service there already		
38	Not qualified to judge.		
39	Patients and clinical teams will have continual access to other acute speciality services, and these can operate in a more efficient linked-up manner.		
40	This site has more suitability for these operations		
41	Main site		
42	I would like to make sure that we get best care not sure which hospital is best.		
43	Keep it has it is ensure a good quality service		
44	I appreciate the fact less invasive surgery would be needed and reduced travel time for some procedures, so that would be a bonus.		
45	As above Strongly support the idea of single site excellence for all and any hospital procedures		
46	Because of the increased local population both sites should be used.		
47	It needs to be Gloucester central for Gloucestershire		
48	This and IGIS should be in the same location		
49	Se my previous comments and reverse you decision. My wife is disabled and I am 90 years of age and her carer. Traveling to Chel and Glos 4 or 5 times a year is traumatic.		
50	Another very good idea.		

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

		Response Percent	Response Total
51	You need the technology to do this and therefore would be good to be in Gloucestershire. Need to have the wards set up for this close to the theatres. Will pull in staff and money by having a centre of excellence. Increase the number of specialist nurses.		
52	Single location		

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

		Response Percent	Response Total
1	Strongly support	41.62%	72
2	Support	31.79%	55
3	Oppose	3.47%	6
4	Strongly oppose	2.89%	5
5	No opinion	20.23%	35
		answered	173
		skipped	8

Please tell us why you think this, e.g. the information you would like us to consider (53)

1	Gastroenterology experience has been demonstrably improved by the recent pilot. Less violence and aggression on the ward, less non-gastro (general medicine) patients using specialised beds and better staff satisfaction from cohorting our clinical capacity onto a single site.
2	better to avoid the emergency site
3	I feel that this ward is located on the wrong site and should move to GRH where the other acute medical care is taking place. Many patients need regular access to Endoscopy but there are not enough gastro patients at CGH to warrant an inpatient list each day or weekend access to services. By moving this ward to GRH patients would have improved access to endoscopy services 7 days of the week on dedicated inpatient lists. They would not have to be transported cross site either
4	It should be at both hospitals so people can go to hospital nearest to where they live
5	Only if lower GI surgery is colocated - rapid senior surgical review with alacrity ensures that decisions for surgery are correctly timed and that non surgical interventions are not pursued too long ; if all one has is a hammer then everything looks like a nail
6	Nothing wrong with snowshill, Again don’t fix what’s not broken just make it bigger
7	Having one of the sites be the centre of excellence makes absolute sense. As the pilot has been at CGH - this should continue. However, having had personal experience of the CGH provision both in 2019 (in December) and in 2020 (May/June), some work is needed on this provision. My brother was in CGH for over 8 weeks in 2019 and for over 11 weeks in 2020 - and the care was poor. There was lack of continuity of care, and rarely saw a gastroenterology specialist on each day. While I appreciate that this might not be the 'norm' for most patients - I am aware of two other patients that have had this experience. At the moment, the continuity of care and plan for patients being discharged is poor and needs to be improved.
8	This has been piloted successfully and seems a sensible balance between the two hospitals
9	As the pilot has been seemingly successful then makes sense.

A permanent ‘centre of excellence’ for Gastroenterology inpatient services at Cheltenham General Hospital.		Response Percent	Response Total
10	I think if gastroenterology is going to be based at Cheltenham then the surgery should be carried out there too so that all gastroenterology services are under one roof. I don't like departments being split between the different sites.		
11	Efficient use of resources, access to specialist staff at all times, no waiting for them to travel from GRH to CGH and vice-versa. The total patient capacity must still remain the same (and hopefully higher!), not reduce as a result.		
12	got to move something to CGh to balance the shift to GRH.aligns well to elective services generally centralising to CGH		
13	If you want to have a centre of excellence EVERYTHING to do with that area of medicine needs to be there, no half measures and aahh but this bit goes to Gloucester. You need to keep things simple and easy for Joe Public yo understand as well as your HCP partners.		
14	Reasons given previously re: buildings		
15	prefer location of all specialist resources at GRH, Gloucester City site		
16	experienced excellent care re gastro at CGH		
17	Already in place? One stop shop.		
18	Expertise and resources at one site.		
19	if teams are on site to support patients		
20	Proposals in the consultation document appear sound.		
21	Need specialist services		
22	Concentration of key resources to reduce duplication and wastage.		
23	The evidence supports this remaining and expanding at CGH.		
24	Keep all acute services under one roof. Cheltenham seems better suited for planned, elective services.		
25	As long a there are support services, equipment and staffing to support this		
26	As long as it meets patient need, is accessible and effective. My responses are based on the assumption that this proposal will deliver better efficiency and improved clinical outcomes than the current model/service provision in place.		
27	Balance of serviices between the hospitals.		
28	GI and gastroenterology services should all be at the same hospital		
29	Can see reason to concentrate into a single centre of excellence but accessibility of Cheltenham a problem eg public transport		
30	it depends on staffing levels		
31	This is a linked to ties in with a centre of excellence for planned lower colorectal and day case surgery at Cheltenham		
32	If the pilot showed improvements why revert back to former arrangement Proposal sounds more efficient from hospital and patient prospective		
33	Urgent general need for many people. Reduced waiting times - quality focused attention and care for the patient is always a win win		
34	As with all your proposals to centralise services the problem is that of access for patients and their families. Whilst many have access to private transport a very large minority do not and they are frequently the elderly and less financially secure. For these people centralisation poses a major difficulty in accessing your services unless you propose to offer free transport between the sites. Even for those with private transport difficulties in accessing parking at iether site pose difficulties and high costs.		
35	Proven already via Pilot.		

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

		Response Percent	Response Total
36	Focus a centre of excellence on one site, don't try to split it across two geographical locations.		
37	Layout issues at CGH		
38	The Pilot seems to indicate that this is and will continue to work well		
39	Links with upper /lower GI as well as colorevtal and cancer based surgeries, this is a no brainer as it would all fit together and enable this center of excellence aim		
40	More specialist case throughput should lead to better outcomes.		
41	Not qualified to judge.		
42	Improved conditions for medical staff, and therefore beneficial for patients.		
43	As mentioned before this is utilising this hospitals strengths.		
44	Not central site. Too far away for lots of people and parking a nightmare and expensive		
45	linking this with the Cancer centre streamlines care		
46	All in one place		
47	Yes, always keep anything that is excellent and working well!		
48	As above Strongly support the idea of single site excellence for all and any hospital procedures		
49	Because of the increased local population both sites should be used.		
50	It needs to be Gloucester more central for Gloucestershire		
51	Keep the gastro disciplines together		
52	See my previous comments		
53	Cheltenham would do well with the long term illnesses and having a centre of excellence for this specialty. Facilities are questionable to make this a great centre excellence - the physical building.		

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

			Response Percent	Response Total
1	Strongly support		49.43%	87
2	Support		32.95%	58
3	Oppose		5.68%	10
4	Strongly oppose		1.70%	3
5	No opinion		10.23%	18
			answered	176
			skipped	5

Please tell us why you think this, e.g. the information you would like us to consider (63)

1	absolutely - this should be a number 1 priority - better trauma and A&E care at both destinations - there is NO WAY that one centre will suffice and we know this undermines public trust in CCG (who honestly now must be loved about as much as covid 19 itself).

Two permanent ‘centres of excellence’ for Trauma at Gloucestershire Royal Hospital and Orthopaedics at Cheltenham General Hospital.			
		Response Percent	Response Total
2	Much like with previous service responses I believe that by keeping Trauma linked with Orthopaedics will inevitably lead to Orthopaedics losing out because acute patients (trauma) has to take priority for beds, theatre space and staffing requirements. This allows the massive Orthopaedics service to properly deliver aside from the constraints put on them through sharing bed and staff capacity with Trauma.		
3	makes complete sense		
4	Need to be on one site . Have CRH as cold , non emergency surgery and GRH as emergency. Which would protect beds at CRH		
5	I agree that all trauma should come to GRH and planned orthopaedics to CGH.		
6	Again both of these subjects should be at both hospitals so people can go to nearest hospital to where they live		
7	Southmead is the regional major trauma centre ; it is faintly ridiculous to imagine that GRH will every be a national centre of excellence for trauma in this context		
8	this has worked well since 2017		
9	Emergency T&O in GRH and elective T&O at CGH.		
10	Trauma and orthopaedics should stay together at GRH		
11	emergency site and planned site		
12	Again this seems to have been piloted successfully and I support the proposed allocation of services		
13	Appears to work well at the present. Not sure why spinal surgery is not at CGH too.		
14	This is known to be good practice and the pilot has been working well. Why change it?		
15	Don't know why we need two centres. Probably better to have everyone on one site rather than spreading resources more thinly across two sites.		
16	I still think one trauma centre would be better but understand why Cheltenham seen as important		
17	Trauma and orthopaedic need to go together. It would be VERY confusing to split them. You've GOT to start treating this as one hospital over 2 sites; not 2 different hospitsls. EVRRYTHING trauma and orthopaedic at Gloucester. Coronary Care also needs to be centralised wherever PPCI is.		
18	Agree need in both locations		
19	both equally important and necessary		
20	Best idea for the specialist teams. Already happening. personal experience.		
21	Because the two are so closely linked, why not have one Centre of Excellence in one place?		
22	This would seem to imply that services could be maximised.		
23	Given the nature of these services it makes sense to have in both locations		
24	If data shows that it is needed at both sites & provides best patient care		
25	One centre would be better, but the Consultation Document identifies insufficient Theatre capacity on a single site.		
26	Always a need, for all age groups		
27	Everyone needs trauma services nearby		
28	Concentration of key resources to reduce duplication and wastage.		
29	Support that the pilot be made permanent.		
30	Reasons the same as previous answers		

Two permanent ‘centres of excellence’ for Trauma at Gloucestershire Royal Hospital and Orthopaedics at Cheltenham General Hospital.			
		Response Percent	Response Total
31	Separating trauma and planned surgery proven model,elsewhere, in terms of bed base, theatre capacity and managing infection rates.		
32	As long as there are support services, and staffing to support this		
33	Please refer to my previous comments, I support this if it will service the community more effectively and if it will lead to improved clinical outcomes.		
34	Orthopaedics can usually hang around and be given pain killers for a certain amount of time.		
35	Ok, need to give county spread. But Cheltenham not so easily accessible and very difficult for family and visitors without a car.... Cheltenham has a very limited evening bus service eg from stroud		
36	Again sensible and more cost effective to locate particular areas of expertise and resources in specific places		
37	Why would you not make one orthopaedic department in one hospital. would that ensure specialist care available always		
38	Once again if the pilot arrangements provide improvements, use this model as the way forward		
39	Needs no words to say this is a critical service and needs to have all the positives. Better care and attention and help out at the outset reduces issues developing later		
40	Having had a very successful hip replacement at Cheltenham eighteen months ago, I can only say that every aspect of my treatment was excellent, the surgeon was informative, the nursing was brilliant, even the food was good, and the outcome has given me my life back. It is working really well there, so perhaps Cheltenham is a good place for it to be based.		
41	Proven via Pilot already.		
42	We need a 2 point disperstion for this		
43	The results of this pilot indicate that the proposal is and will continue to work wll		
44	Parking and general access for patients		
45	Rising admissions of this kind every year and shortages of community rehab placements means that this is needed now more than ever especially as this is lengthening inpatient stays which slows down admissions rates especially when both hospitals are running with only one A&E		
46	Should lead to less last minute cancellations of planned surgery. Planned cases should be treated quicker.		
47	This is going against all your saying about centre of excellence by having two		
48	Not qualified to judge.		
49	It suggests a more efficient and effective division of labour, building upon the existing specialisations in both hospitals.		
50	Perfect for both hospitals strengths		
51	Best to have two centres as this creates redundancy to allow combined work in the event of failure at one site without affecting the other.		
52	One centre of excellence at GRH. Reduce travel time for medical staff etc.		
53	Important to have pre op at the place of operation		
54	Yes keep as it the county is increasing with people living in areas FOD, severn vale, Tewkesbury, Cotswold etc		
55	Yes I agree with this, this can be needed at anytime, having two centres of excellent is very comforting. Reduces travel, retention of staff , waiting times		
56	As above Strongly support the idea of single site excellence for all and any hospital procedures		
57	Because of the increased local population both sites should be used.		

Two permanent ‘centres of excellence’ for Trauma at Gloucestershire Royal Hospital and Orthopaedics at Cheltenham General Hospital.		Response Percent	Response Total
58	It needs to be Gloucester more central for Gloucestershire		
59	I have no support or opposition		
60	as long as a streamlined service can be provided at both sites consultants, ultrasound etc need to be available. Registrations are fine but it duplicates appointments. If you could see a consultant sooner service would be slicker		
61	Yes very well needed		
62	Yes, have the planned events at Cheltenham as this is the direction of travel and would work well.		
63	Maintain present pilot scheme		

Please tell us about any impact, either positive or adverse, that you think any of our proposals could have on you and your family (please tell us which service your feedback relates to e.g. IGIS)?		Response Percent	Response Total
1	Open-Ended Question	100.00%	97
1	extra travel time, costs and difficulty if services are required.		
2	I think more efficient working by having majority of specialist services single site is in everyone's best interest.		
3	All proposals would have a positive impact on me and my family. I don't care where I or my loved ones are treated. If any one of us had an extremely unusual condition requiring us to travel to London for treatment, we would do it. It therefore makes no difference to me whether I have to travel to Cheltenham or to Gloucester for treatment, as long as the service is good, well staffed with enough of the right staff and capacity available is all I care about.		
4	pretending we have 2 acute hospitals is the biggest potential detriment to services		
5	I want the best care for my family and whether we travel to Cheltenham or Gloucester is irrelevant and has no bearing.		
6	These proposals would improve the care provided if myself or my family ever needed treatment at GRH or CGH.		
7	Cheltenham maybe too far to travel, public transport route to Cheltenham from the towns that are in the county are poor. Also car parking and cost is a concern		
8	Cant answer that as no way of knowing if or what treatment me and my family are likely to need in the future		
9	no 24hr access to A7E at Cheltenham - transfer time to GRH - longer waits then at GRH		
10	Travel, parking, costs of parking, congestion all negative. With an ageing population with less mobility it’s likely less visiting will take place the more you centralise services on a single site.		
11	changing our jobs yet again, nurses don't matter		
12	negative all round.		
13	risking the health and safety of those further out in the county.		
14	None		
15	Centres of excellence mean clinical expertise is concentrated in one area, rather than split across the county. This means better, more responsive specialist care for me and my family when we need it.		

Please tell us about any impact, either positive or adverse, that you think any of our proposals could have on you and your family (please tell us which service your feedback relates to e.g. IGIS)?		Response Percent	Response Total
16	Removing lower GI surgical support from CGH would diminish the service which I work in and I would have to consider whether the Trust's ambitions for my service match my own in terms of where I work in the future and whether my family move. Conversely moving all GI cancer surgery to CGH would be a significant statement of the kind of cancer surgery we want to provide in the future - i.e. comprehensive, safe and cutting edge		
17	further for some patients to travel too if A and E in Glos		
18	IGIS - emergency interventional 24/7 cardiology is essential where the ED is located and would be hugely beneficial to patients. I do not think the Trust can justify having a split any longer. It is behind the times and incredibly poor clinical practice.		
19	In modern healthcare the only way to deliver efficient, research based and effective services is to centralise in a centre of excellence. Services cannot be diluted just because that's the way they've always been. We need to keep up with advances in health care so that the current and future population benefits		
20	good service		
21	For my family, the gastroenterology provision is the most important consideration. If I had faith that the centralised CGH provision will work - then I fully support this. But from personal experience of the centralised provision since the pilot started in 2018, it is not working as set out in the consultation document. What sort of assessment of the pilot has been done already and what is being put in place to ensure patients who are going through the treatment are being listened to and problems are addressed?		
22	-		
23	For us CGH and GRH are equally accessible and the essential issue is the provision of the highest quality of services		
24	I am happy with all of the proposals.		
25	I live in Gloucester and would prefer Gloucester hospital to be able to deliver all services to an excellent standard, Cheltenham hospital is difficult to get to, difficult to park at and it is extremely annoying to be sent there for treatment.		
26	I think in general the proposals are positive and will improve the services available in Gloucester.		
27	my son comes under gastroenterology and a strong specialist team is what is important not where they are based		
28	longer ravel times are a reality, not a possible consequence		
29	Focused centres of excellence to allow for planned care at CGH and more acute/emergency care at GRH but still maintaining access to ED across both sites		
30	Gastroenterology. Patient myself, diagnosed with Crohn's at the age of 13, 27 now. Dr Shaw and the Gastro team are extremely skilled, and give good treatment to their patients. However during my latest severe flare up (2015/16) I struggled to get the medication and testing I needed, this delay of several months stopped me being able to work as a teacher for 9/10 months, eventually leading to surgery to remove scar tissue. I hope that if the proposed centre of excellence goes ahead patients would be able to access testing, medication and surgery much faster. Faster treatment would save the need for surgery in some cases, saving the NHS money if the disease can be controlled by medication as soon as a flare up occurs.		
31	You just need to have one place to go to for one SUBJECT e.g. Oncology, CVS, and GU/GI at Cheltenham and everything else at GRH. You've got to make it simple. And you need to make ED at Cheltenham 24/7 with doctors. Or you've got to double the size of ED at GRH. You've lost 2 x resus bays by closing CGH to ambulances, yet not increased capacity at GRH at all. It's ridiculous at Gloucester ED- and don't blame COVID. ED at Gloucester is not fit for purpose, being the only ED in the COUNTY!! JUST KEEP IT SIMPLE, so that everyone can understand it. You've been got to stop thinking like a person in the NHS and start thinking how the public views the organisation of the services offered. I don't believe you'll re-open ED at Cheltenham, you've been wanting to get rid of it for ages, but GRH ED is NOT fit for purpose with current demand - and demand is not going to decrease. You also need a centre of excellence for the Older Person. By 2040 , 25% of Glis CCG patients will be over the age of 65.		

Please tell us about any impact, either positive or adverse, that you think any of our proposals could have on you and your family (please tell us which service your feedback relates to e.g. IGIS)?		Response Percent	Response Total
32	we live near to CGH and already lost our A&E		
33	Positive impact		
34	Additional travel.		
35	We may have to travel further to access services, but if they provide excellent care & outcomes its worth it. Good example of this is the breast care services. As a patient if all done in one visit on one site worth the travel		
36	Proposals overall seem likely to lead to better patient care and improved medical training.		
37	Orthopaedic: every age group needs this support		
38	No current impact on us.		
39	All service development has the potential for increasing the health service possibly needed in the future by my immediate		
40	I think that all of the proposals will have a positive impact on everyone, as the services in the long run will be better, if certain hospitals become centres of excellence for individual things.		
41	Positive impact on any proposal. We live in Hucclecote and have easy access to either hospital		
42	Centralisation of treatmentsand procedures becomes wasteful because they lead to long waiting lists, and inevitably centralise specialist staff to the detriment of other hospitals and staff skills loss.		
43	I think all these plans are terrific. Thank you.		
44	Concentration of some services in Cheltenham may involve us travelling 8 miles further (I live in Gloucester) but I would be happy to do that as the expertise would be in one place.		
45	I can only see advantage in focussing particular specialisms on one site, as much as that is possible,		
46	I haven't had to use hospital services so it is difficult to form a clear opinion. But access to Gloucester is easier. It's really about geography.		
47	I imagine most opposition to the proposals will come from those who live significantly closer to one hospital or the other. We are fortunate in living more or less halfway between the two. Despite it being easier, therefore, for me to agree to the proposals, I do feel strongly that rationalisation of provision is important.		
48	Living in Stroud, I find it harder to get to CGH and harder to park there, however I think it is still a Good idea to concentrate key resources in one place, wherever it is.		
49	Positive impact across the board to have the expertise concentrated on 1 site for the various services allowing sensible on call rotas and adequate staffing for those services rather than splitting the expertise across 2 sites.		
50	in 2020 the crucial factor should not be postcode but the delivery of excellent, safe and timely patient care. It is simply not possible nor is it safe to continue to try and provide duplicated services which in turn often compromise the quality of care. We also should not forget the enormous pressure this places on staff, in terms of staff shortages, cross site cover at short notice, pressure of always feeling there an added pressure.		
51	It is a significant journey from my part of Gloucestershire to both hospitals. So in journey terms the proposals wont impact negatively on me or my family. I believe it makes sense to coalesce the various specialties on one site to maximise expertise and capacity. I would therefore support the proposals.		
52	I believe the proposals will result in better services and improved use of capacity and resources. For those of us who live outside of Cheltenham and Gloucester we have a journey to either hospital so the proposals have no negative impact on that respect.		
53	To have the experts in one place is a positive		
54	Have used Cheltenham when needed Colonoscopy using the 2 week wait system etc. Found the building itself confusing (easier to find from outside than inside). but the care received was excellent and easily accessable.		

Please tell us about any impact, either positive or adverse, that you think any of our proposals could have on you and your family (please tell us which service your feedback relates to e.g. IGIS)?		Response Percent	Response Total
55	These proposals I think would have a positive impact, for all services mentioned. I would like to beable to access any service that is a centre of excellence to allow my family and I to have the best outcomes.		
56	Potential,impact from travel requirements depending on hospital site services centred on. Parking already challenging at sites. For planned surgery optionsMay choose to use sites outside Gloucestershire as nearer, or through choose and book use private provider option if that is closer.		
57	Car parking is an issue at CGH, assurances need to be made that relatives are able to park, to be able to transport and visit their relatives. The estate has to be able to support the changes to the centres of excellence along with staffing and support services.- all		
58	For me an my family we can access either GRH or CGH but I know that this will not be the case for all residents requiring care.		
59	No should be ok.		
60	I and my family have been served very well by the Health Services - but I have had to be referred to both Banbury and Oxford hospitals in my time and was very well looked after. My husband however visiting his mother and my in different hospitals (Banbury and Chelt) went to sleep at the wheel of the car and had a slight crash		
61	na		
62	The importance to me and my family is the travel to and from Gloucestershire and Cheltenham hospitals. if we needed treatment		
63	We live in Stroud so both Cheltenham and Gloucester hospitals are easily accessible to us		
64	Strongly favour Gloucester as so well served by trains and buses. Cheltenham hopeless for the former and very difficult for the latter. We cant all afford taxis		
65	Transport??		
66	Please see my comments under anything else. I would not support any services restructuring which adversely effect CGH's viability. I cannot comment on the medical proposals but Gloucestershire needs two major hospitals particularly with new settlements.		
67	Obviously because I live in the forest of Dean it would be better for my family to have all resources staff and centres of excellence at Gloucester but Cheltenham needs to have its own centres of excellence		
68	If as set out, the proposals provide quicker, more efficient service, linked to reduced wastage. I am fully in agreement. If one was in the ideal world of developing a brand new single site solution then a site between Gloucester and Cheltenham would make a lot of sense to all concerned. But we aren't. We need to make best use of what we have and some centralisation of services make best sense		
69	I suffer from Ulcerative Colitis and my wife has a liver condition. Whilst we have a car if I were to have to stop driving we would have real difficuty accessing Cheltenham hospital if necessary.		
70	Due to the ""Centre of excellence"" approach and optimising the logistics around 2 hospitals within 30 minutes of each other there will be an overall benefit to: 1. Patient outcomes. 2. Workforce environment and job satisfaction. 3. Improved staff retention and recruitment.		
71	Living close to GRH the proposals will not impact me greatly. It makes sense to use resources (staff and equipment) as wisely as possible given funding shortages, therefore the changes seem sensible.		
72	I live at the extreme edge of any area that will use these services, I need to see transport in and out for relatives.		
73	I think overall there will be a positive benefits having local COE's with appropriate staffing		
74	For either hospital it is access from the forest and other outlying areas such as Stroud. Good transport links might be essential		

Please tell us about any impact, either positive or adverse, that you think any of our proposals could have on you and your family (please tell us which service your feedback relates to e.g. IGIS)?		Response Percent	Response Total
75	Positive to moving all specialties to gloucester and none in cheltenham: None, on all accounts care provided is slowed down, bed spaces limited, more in patient moves and exposure risks of various infections and the disruption and unfairness that the staff are subjected to with these moves, how is this fair that their loyalty to their teams is rewarded with bitterness and unfair choices with their opinions not being heard Positive to specialties linked across both sites : better patient flow, increased admissions and faster patient care to get people home		
76	The convenience of travelling to GRH and CGH is very similar for me.		
77	Adverse as facilities would not be local, impact on non driver		
78	Support the best option proposed by medics.		
79	Concentrating expertise in one of two hospitals will be beneficial for staff and patients; improve the capacity of hospitals to be both centres of excellence and centres of medical training; reduce waiting times and improve chances for patients of being seen by the right specialists more quickly, with the necessary follow-up care.		
80	I believe both hospitals have their strengths and as mentioned this is probably one of the better solutions to get the maximum use out of the top class facilities they would have.		
81	A possible positive impact would be an increased likelihood of a successful outcome of any treatment in the future.		
82	FOD is a deprived area, we need one hospital for people to travel to (20 miles) and when inpatients - family can visit one centre of excellence for county. Cheltenham too old, parking nightmare		
83	As a Gloucester based family it is always easier for us to go to GRH. However, I would prefer to travel a bit further to a centre of excellence.		
84	The parking fees are an outrage and would stop us being able to visit, I feel uncomfortable with being in Gloucester Royal due to bad reputation		
85	We live on the border in Herefordshire but our nearest GP surgery is in Gloucestershire where we access services. Having to travel to Cheltenham is too far.		
86	I just want the best care in the right place and don’t mind a few extra miles travel in order to achieve this		
87	I had excellence service with my eyes op chelt covid 19. Has been await a call to staff must be needed for the future of NHS.		
88	My family and I could be affected positively by services being centralised because we would get the treatment we need in time by highly motivated trained staff.		
89	It was traumatic for my husband to be transferred to CGH at 2am because of vascular problems. It would have been beneficial to have been beneficial to have had a vascular centre at GRH.		
90	None		
91	Gloucester Royal has a record of poor patient satisfaction! To loose Cheltenham General would only increase the workload on GRH. In the long term, because of local increase in population, a new DGH should be considered! The proposed changes are just sticking plaster.		
92	How are we supposed to travel to Cheltenham from the Forest of Dean? Have any of you ever tried it? Especially to arrive at 9am.		
93	Travel / visits - for any of these services - not so much for us - we live in Chalford, away from both anyway, but for less well off people who live closer.		
94	no opinions but good idea		
95	Would have a centre of excellence as this would have helped me. Joined up access to medical records across the county. Would be good to have the images able to be shared with GP.		
96	Should be good		

Please tell us about any impact, either positive or adverse, that you think any of our proposals could have on you and your family (please tell us which service your feedback relates to e.g. IGIS)?		Response Percent	Response Total
97	Close proximity to where I live Easy to travel to Gloucester hospital I like the idea of specialists in one area Centres of excellence should enable easy communications between staff		
		answered	97
		skipped	84

If you think any of our proposals could have a negative impact on you and your family, how should we try to limit this (please tell us which service your feedback relates to e.g. IGIS)?		Response Percent	Response Total
1	Open-Ended Question	100.00%	67
1	this should not be undertaken this year, if a government integrated review has to be delayed I don't see how it can be ethical that Gloucestershire CCG even have the man power to consider this - let alone spend money on making it happen. Is this a project pushed to the forefront to benefit an individuals career?		
2	No although this will remove some services from each site by centralising to the other I think overall the experience will be better and clinical outcomes likely to be improved.		
3	pretending we have 2 acute hospitals is the biggest potential detriment to services		
4	I consider the effect will be positive		
5	I do not think there are any negative impacts to the proposed changes.		
6	Cant answer that as no way of knowing if or what treatment me and my family are likely to need in the future, if services changed to Cheltenham then we would need to get there and the parking in Cheltenham is awful and the hospital is not near the actual town centre		
7	Reassess A&E times		
8	As above		
9	will completely change my job, again! lower staff morale and lose a much needed acute care service		
10	a fully functioning A&E needs to be in Cheltenham and our ACU and AMU needs to come back. patients safety is massively compromised.		
11	risking family health by providing sub par a and e service at Cheltenham		
12	None		
13	As above		
14	Paediatrics definitely need looking at as if emergency cases for urology are still being operated on in CGH transferring them to GRH is a logistical nightmare. Its embarrassing to tell patients that we have to transfer patients , it takes ambulances away from emergencies calls, waiting times for ambulance, can sometimes be early hours of the morning, is it safe to transfer , staffing for paediatrics , its not giving the child a positive experience, could cause increased anxiety for future admissions		
15	The only negative impact is if the plans for IGIS do not go ahead.		
16	no		
17	this has a massive impact on me and my family. I wouldn't want my family member going to GRH unwell knowing what state the hospital is. patient care isn't what it use to be like unfortunately.		
18	- parking at cgh is poor		

If you think any of our proposals could have a negative impact on you and your family, how should we try to limit this (please tell us which service your feedback relates to e.g. IGIS)?		Response Percent	Response Total
19	None		
20	N/A		
21	None		
22	none		
23	work with the transport services		
24	N/A		
25	Capacity must remain the same or increase in totality for Gloucestershire.		
26	You really need to have a ""Southmead"" in the Golden Valley area. And you need to consider better bus services to both sites for general public yo reduce car parking requirements and problems.		
27	Mum died in GRH and my Daughter had such a traumatic time having her first baby she refused to return there to have her second baby. She was treated so badly she was traumatised		
28	None		
29	The only downside of creating centres of excellence could be that I may have two family members being treated at the same time on different sites which could cause problems with supporting them. However, this is hopefully unlikely.		
30	Providing value for money parking on site.		
31	-		
32	N/A		
33	I can think of no negative effects of adding to or developing services unless such development diminishes the value already present.		
34	It is important that free public transport is available for patients between the two hospitals, so that (for example) people living in Cheltenham are not financially disadvantaged by having to travel to GRH, if they do not have a car.		
35	Travel distances, free parking, access to other services		
36	Travelling to Cheltenham from the south end of gloucestershire is difficult.		
37	Better parking facilities at CGH.		
38	None. It is important that the spoke IGIS service at CGH is a proper service to properly resource urology and not just an ""add on"".		
39	None		
40	No negative impact.		
41	Trying to find areas in Cheltenham hospital is not easy. Make sure you enter the building at the correct entrance, as finding your way inside the building is impossible.		
42	Parking a key issue Outpatient service provision at community hospital sites for pre and post care could off set some challenges. Or of course a virtual OP offering.		
43	We need to have centres of excellence I. Gloucestershire		

If you think any of our proposals could have a negative impact on you and your family, how should we try to limit this (please tell us which service your feedback relates to e.g. IGIS)?		Response Percent	Response Total
44	Logistics, ensuring that patients can access the site they need. Ensuring that care is not compromised by having specialisms at a particular site i.e. will there be enough Nurses, Doctors, Specialists to provide effective care under the models proposed or will it mean less capacity. Will the proposals be affected by inevitable budget cuts that will take place from now as a result of the economic decline for this country we are entering now. I am assuming the proposals were put together at a different point in time and wonder if the current economic climate and impact that this will have on costs (budget) and the health of the population means that the proposal has to be reviewed to ensure it is still fit for purpose.		
45	So far at 90 no negative feedback, but I'm glad I did not have to go to GRH for babies. its a long way and can take a long time. Ambulances when I have needed them have not usually taken too long, but I think a car service, where possible, with blue light supplied might be useful.		
46	na		
47	Travel especially if you don't drive		
48	The main problems we have for both hospitals and across all proposals are 1) parking 2) accessibility for older patients		
49	Relating to all centralisation proposals. I firmly believe that centralisation should only go ahead as and when a free transport service is available for patients and their families between the two sites. Only then will your objective of good accesability be achievable.		
50	As above, it is distance to visit.		
51	I worry that as we rely on public transport we may not be able to travel easily between hospitals. We have already had to use taxi to do this - that proves expensive; and perhaps will lead to us not bothering		
52	As above		
53	Take a good look at gloucteser and the way it is run. It has a reputation for a reason, myself being a patient it is a common subject that people do and will actively avoid Gloucester Royal hospital because it is a shambles with too many problems that never see the light of day		
54	IGIS, which affects not only local gloucestershire patients but also adding extra mileage for elderly wiltshire patients, with regards to vascular, although improving cardiac services to 24hours is an improvement		
55	Support the best option proposed by medics. Later question (Do you consider yourself to have ...) misses the ""Other"" options which I would have added ""Losing confidence in the NHS"" regrettably.		
56	N/A		
57	As above		
58	Finding ways to minimise the need to transfer patients between sites is important. Communication about any changes that are made and why they are necessary always helps		
59	None		
60	My family and I could be affected by long waiting lists, staff shortages, transport links, not being able to see a specialist consultant. This would be the negative impact.		
61	All hospital services - whilst I am able to drive at present, for the future and for all patients a dependable public transport system becomes even more vital if these proposals are enacted.		
62	Its going to cause a lot of hardship and missed appointments		

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

		Response Percent	Response Total
63	Greater visibility and support given to people needing to claim travel expenses for hospital visits. Citizens Advice Stroud ran a campaign about this 3-4 years ago, surveying the hospitals and surgeries to see how visible the information was and how easy to claim. The procedure for making a claim and receiving payment was poor. Stressed relatives need immediate assistance. They should not have to wait a month to be reimbursed.		
64	no negative impact		
65	Improved communication and access to medical records. Improved access to staffing by having a centre of excellence. Make sure you have the necessary resources in place. Open up the options to make contact.		
66	None that come to mind		
67	Parking issues		
		answered	67
		skipped	114

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

		Response Percent	Response Total
1	Open-Ended Question	100.00%	44
1	No.		
2	no		
3	I think that all Upper GI surgery emergency and planned should take place at GRH and all lower GI surgery at CGH so they are kept separate.		
4	As mentioned previously I think the services should be in both hospitals, don't see why the staff cannot be shared between the hospitals or more staff if required - if I was running the hospitals I would make it far more efficient that it currently is, I think there is a lot of money wasted in services the hospitals have to pay for, I would be obtaining them cheaper and would not waste items that have to be thrown away from a packet that 1 item has been removed. It is ridiculous and wastes so much money, it can all be sterilised and then money saved on these things could help with the services		
5	Open A7E fukky to cover both Gloucester and Chektenhsm		
6	reinstate a and e Cheltenham, don't fob us off as a downgraded service that then has to push emergencies to grh in ambulances.		
7	we need to be told the truth and they need to stop hiding behind the lies they are telling us. its completely ruined staff morale and staff are not enjoying work.		
8	Cheltenham needs an amu.		
9	yes, all emergencies to GRH urology and ophthalmology included (paediatrics)		
10	N/A		
11	regarding appointments I really wants to appreciate the services		

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

		Response Percent	Response Total
12	CGH ED department needs to reopen so that the pressure is taken off GRH and CGH has their Aute Care wards open again. GRH cant cope with the whole county.		
13	No		
14	N/A		
15	Open A&E in CGH and pay the staff more so they don't leave. Maternity in CGH could have at least one consultant for safety		
16	No		
17	no		
18	No		
19	On occasion I have come across some silo issues where, for example, such provision as physiotherapy is not always referenced in relation to other clinics where a natural connection seema relatively low prioritys obvious. This could be achieved through the GP intermediary or by direct referral within a hospital.		
20	no.		
21	No.		
22	Whilst I understand that this is politically sensitive I am really struggling with the provision of an ED at Cheltenham, this should be a minor injury unit 24/7 end of.		
23	Keep all acute services in one hub. Elective services in another hub. It simplifies things		
24	No, if the statistics show that this model will provide better clinical outcomes, less waiting times, joint working and attraction/retention of the right staff, then I do not have another model to suggest.		
25	I think most of possible suggestions seem very sensible, but perhaps more use could be made of voluntary services (stopping blood flow from nasty cuts or wounds where the nearest A&E is not very near and it is closed). Dealing wit fits in children, concussion (small blows to the head). 999 is excellent but Gloucestershire is a big county and the borders far from the centre. Surely we should have a service that can take us to the nearest centre for help and rely on zoom for specialism?		
26	The provision of temporary accommodation for vascular services, provided at GRH during phase 2 of COVID19 is severely lacking. It does not provide essential facilities for patients or staff. Moving from a ward at CGH which is ideal for this group of patients into an area which falls well below the normal standards, will have a devastating effect on patient outcomes and staff moral. If this experience is a sign of how it will be in the future, I would suggest that you will not be providing a centre of excellence for this group of patients. If however it is in ,the plans to create a ward environment which is similar in layout to Guiting ward at CGH which is close to Vascular laboratory, I would not be so concerned		
27	na		
28	It would be good to have some services in either the forest or the Cotswolds as people travel long distances to get treatment		
29	Staff could be made more fully aware of resources at local hopsitals such as dilke, Lydney, Tewkesbury, Stroud, etc Many staff in Gloucester and Cheltenham do not know that x ray services are available at both Lydney and Dilke		
30	Extra hospital in FOD used by visiting team		

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

		Response Percent	Response Total
31	None		
32	Use precious structure and perhaps have a rotational table for specialties on an axel bases to offer variety of care over standard time frames		
33	No		
34	I am a civil servant so I recognise the phrases used here - which don't really mean anything. How can you have a new modern hospital in CGH? It's an old maybe listed building. It all sounds really good but basically it's a money saving scheme. Charge people who come into A&E when it isn't an emergency. You have to pay to call an ambulance to your home or your insurance pays when called to a road accident.		
35	New hospital that would be fit for the future with our expanding population. We deserve it!!		
36	No		
37	No		
38	Gloucestershire Royal has major problems, very poor booking system, staff morale. Sorry to say but patient experience has over years been negative.		
39	Centralise all at Gloucester Royal Hospital. The hospital for Gloucestershire		
40	Build a state of the art hospital in the Forest of Dean at Five Acres which is for sale. Traveling to Glos and Chelt is traumatic, worrying and time consuming for older people who are suffering because of you decisions. We travel 4 or 5 times a year to Glos and Chelt so we know how terrible the journeys are at a time when we are ill and anxious.		
41	ensure each patient sees a consultant on their first occasion and gets ultrasound etc in the hospital closest to their home ie Gloucester people in GRH etc. Email appointment letters to people. Its faster and saves on postage. It also reduces the number of telephone calls coming in. If you offer email as a way to communicate ensure NHS staff have the ability to email the patient back		
42	no		
43	Training hospital again - start with one centre of excellence. Proposal is excellent to move into the modern world - make sure you have the technology to support this and the staff to support this. Efficiency of resources is a concern. Waiting times should improve with these proposals. Measure of improvement.		
44	None		
		answered	44
		skipped	137

Anything else you would like to say?

		Response Percent	Response Total
1	Open-Ended Question	100.00%	77
1	This is the wrong time, please spend the funds on dramatically improving A&E / Trauma and on building public trust in our local health services.		

Anything else you would like to say?

		Response Percent	Response Total
2	There are services eg haematology that are split site and struggling because of the inefficiency this causes. Would be good to see haem si flew sote at CGH		
3	No.		
4	I don't understand why we have to keep both EDs open. What matters is what happens once patients arrive and to deliver the service I would expect, would mean concentrating emergency staff expertise. I don't live in C or G so have no emotional attitude to either department but I do expect one fully staffed centre of ED expertise somewhere in the middle of the county.		
5	This should have been done years ago. Having doctors and staff working across two sites is inefficient and detrimental to patient care . Ideally we should have one hospital at Staverrton !!!!		
6	Gastroenterology ward should be moved back to GRH.		
7	Don't think so		
8	Management have no clue how the services are run and what is best for the Gloucestershire pts.		
9	How any of this helps patient flow and integration with primary care is poorly explained.		
10	Trying to maintain two hospitals with duplicate services so close together makes no sense in any regard. This is the best compromise that I have heard suggested for a very long time		
11	the Gloucestershire nhs service needs to at least attempt to show some honesty and integrity when dealing with the public and its staff. do not treat us as though we are fools.		
12	we need to be told the truth and be kept in the loop more. the patients are also taking the brunt from staff because of these moves		
13	stop using covid as an excuse to flatline emergency services at Cheltenham. treat staff with more respect, our opinions and skills as professionals are repeatedly ignored by trust management. stop shipping patients who are unwell between two sites, this is unsafe and immoral. the only ones being shipped about are those with lower capacity, confusion and complex needs. disgraceful. I support reinstating amu at Cheltenham to stop this nonsense.		
14	Bring cardiology together in GRH, with the space and resource for us to really enhance our services to the population of Gloucestershire, and then we could create a centre of excellence for cardiology. It is incredibly difficult to do this effectively being split not only across two sites, but also within those sites.		
15	Just get on with it.		
16	With the reconfigurations proposed moving the surgical and medical takes to GRH there is then no safe way to run an ED in CGH. I strongly feel we would be lying to the public if we pretend that an ED can function in CGH without the supporting inpatient services behind it. It seems illogical to discuss these reconfigurations without factoring in the impact on the ED.		
17	overall good		
18	does a centre of excellence include evoked potential testing with some of the orthpaedic surgeries?		
19	It seems a well thought out plan		
20	Why are there not adequate children’s services in the area? My daughter was transferred to Bristol for endoscopy and gastric surgery despite Gloucester having the services necessary.		
21	Just ensure that the investment needed to provide these changes properly and not half hearted is there for all services involved including those that are sometimes overlooked. There is no point picking a service up and moving it to one side of the county or other if you don't use this opportunity to actually improve it.		
22	Thank you for putting Gastroenterology in the spotlight!		
23	I support the local people living in Cheltenham. It's a wonderful Hospital but does need some money spent on it to use the space it already has. Some wards are closed due to building collapsing.		
24	No		

Anything else you would like to say?

		Response Percent	Response Total
25	Build a new County Hospital between Gloucester and Cheltenham, or focus development on the Gloucester site. Improve access (sheltered pedestrian links) to Gloucester rail and bus stations.		
26	Cary on with the plans.		
27	Whatever you do, do it well. Avoid letting polititians, who are only interested in the next election and showing that they can get things done on the cheap, get too involved. I realise that they hold the purse-strings, but don't let it just be about money. The USA really DO NOT have it right.		
28	no		
29	I haven't the experience to comment on most of this questionnaire.		
30	Just a point about competition between services. Central Government, in particular the Minister for Health and Social Welfare, has repeatedly affirmed that the BHS has remained open for non-COVID health provision. This is nor strictly the case. For example, prior to the first phase of the pandemic I attended the BOTOX Clinic every 10 weeks. At the peak of the pandemic it was understandable that out-patient services should be a relatively low priority. However, eight months on my condition has worsened and when I receive the promised appointment I suspect that treatment will have to be re-assessed and possibly extended to achieve some parity with the positive outcomes achieved over many years of treatment . This must also be the case where there are other conflicts even during normal times. I am fully supportive of the need for centres of excellence but I would want to be reassured that other services are not reduced in terms of financial and staff resources in order to accommodate them.		
31	No		
32	I cannot thank the NHS enough in Gloucestershire for all your brilliant ideas and work.		
33	The geographical disadvantage of one site over the other is usually overstated. We would all like things based as close to home as possible, but unless resident in Gloucester City or Cheltenham it actually makes very little difference to most people to site they need to travel. Using public transport is more complicated from rural areas, but the shuttle bus largely overcomes that issue for outpatients and visiting.		
34	Living in the Stroud area means that either Cheltenham or Gloucester are equally accessible (or not) for treatment or visiting. I feel it is important that specialisms are concentrated where they can best be delivered effectively and efficiently.		
35	whatever the experts in the NHS think I would be supportive of.		
36	What consideration has been given to accessing these locations both by public transport and by car? Parking at both sites is difficult and iniquitously expensive.		
37	No.		
38	The proposals all seem excellent and recognise the realities of the problems fully staffing and offering all services at 2 DGHs which are only 10 miles apart.. It is not a problem to have to travel relatively short distances to access the best care. Tribal allegiances to GRH or CGH have gone on for far too long and obstructive practices by both clinicians, the general public and local politicians have delayed what has been obvious for far too long (at least to me in the 30 years I have lived and worked in the area).		
39	I support the changes as they will bring expertise and people together for the benefit of patients.		
40	The trust obviously has a plan for the medium/ longer term about how the 2 sites should be developed. Would be better to review theses current services within that wider context. I can only assume a hot cold site is the longer term plan. Overall will the trust be increasing its bed base with the significant housing development plans in place across Gloucestershire?		
41	Page 6 doesn't state what happens to ""Hyper Acute Stroke Unit and Acute Stroke"" under the preferred option. Page 23 does but is isn't clear if that include treating people with Acute Stroke cases.		

Anything else you would like to say?

		Response Percent	Response Total
42	I worry about the link and relationship between these proposals and GP services. GP services need to be as much a part of this as the hospitals and the hospitals cannot do this in isolation of community services. I can see part of the proposal is to enable more joined up working but this has to work in practice with collaboration and cooperation across the services. While I have experienced fantastic GP services in Gloucestershire (up to about 10 years ago). Unfortunately I have also experienced some poor GP service provision in Gloucestershire, which has deteriorated over the last 8 to 10 years. My biggest concern is that if the GP services are not joined up with these proposals, this will not be able to succeed.		
43	I live on my own so for me it is important that my nearest hospital covers all of my needs		
44	I support the need for patients that require surgery on the same day as admission to be done at one site. however not all urgent surgery is same day. I think the hospital at GRH would struggle to meet capacity/ demands if all Acute work was on GRH site.		
45	no		
46	Have several times mentioned access by public transport. This is clearly not a clinical issue, but in the general context of availability of the best services for people reliant on public transport, it can make a huge difference. Facing cancer surgery and daily radiotherapy it was actually cheaper and easier for me to go to UCH in London than try to use buses and taxis from Stroud to Cheltenham. Yet Gloucester is easy and has been very good for other health needs		
47	I am not a medic but my above preferences are based on the viability of CGH. Covid 19 has shown we need more hospitals without affecting ordinary services. GRH has better rail access but at times the hospital is overwhelmed. I do think that concentrating more services at GRH at the expense of CGH is a serious mistake. There must be equal allocation of services between GRH and CGH. CGH must be protected from closure. Cheltenham is a growing town and needs a viable hospital. so does Gloucestershire		
48	Any changes should be accompanied by improved information / communication to staff and public. Staff need to be aware of geography and travel difficulties for appointments to be as convenient as possible. Where as I believe a centre of excellence is essential - longer journeys for clients with children or frail adults will inevitably increase stress levels. With ambulances being tied up for longer transferring patients to the appropriate hospital. You speak of specialist doctors. Are experienced nurses willing to change work base from CGH to GRH		
49	1) As someone whose wife died recently of cancer we found the oncology unit in Cheltenham an excellent facility. That is centralised not necessarily most conveniently to u living in Dursley area but very accessible. 2) Reduce waste by greater use of electronic mail and not sending out lots of letters. Sometimes 3 in same post. 3) We need to make greater use of excellent facilities in Dursley and Tetbury		
50	We are extremely fortunate to have two such good hospitals serving us.		
51	1. I was very concerned at the poor timing of this exercise. I received the 'Fit for the Future' flier in the post today (9/12/20) with consultation closing on 17/12/20. Although I was able to go online for some of the information there was insufficient time to get the 'Pre-consultation Business Case' and read it before the deadline.(Minimum 2 days for freepost card, 5 days including the weekend for a response, 3 days for parcel post and the deadline is past.) 2.		
52	Refreshing to see such an in depth review and consultation. How about integration of Social Services and the NHS next?		
53	Maybe it is my age? It took a long time to read and digest mentally the information in the Fit for the Future book. I would prefer excellence in all hospitals with adequate staff - well paid and well trained. It would seem that the changes are needed for inpatient care. However, small local hospitals like The Vale at Dursley are most needed for being specialists in maintaining health especially the elderly. Travelling 6 miles is much preferable than 26 miles especially if you cannot use a car!		
54	Inappropriate and dangerous hospital discharges happen regularly, particularly at GRH. I hope these changes will help reduce these. Mental health support is very poor, particularly in GRH, I hope the cost and staff savings can be used to provide better mental health support for patients with mental ill health.		

Anything else you would like to say?

		Response Percent	Response Total
55	No		
56	Please look at improving the bus links ! The fact that you use a stagecoach bus for one part of your journey and a pullman for other part - is just not Cost effective for patients.		
57	None		
58	Many people have feared because of the changes and continue to do so. Many people see this as a move to shut or deminish CGH and don't want this because CGH is the hospital of their choice and is closer to home and family. GRH is a mess, one such example is the previous stroke specialist team... All resigned due to management the problems they had on the ward and the way it was run, when bullying is rampant on a ward and months of whistle blowing and datixing is met by scorn and inaction, nobkdy wants to see this happen in cheltenham as well		
59	From listening to the facebook consultation regarding IGIS limited capacity was mentioned, with the response space and wards would be facilitated for these moves, presently vascular services have moved temporarily to an area not ideal for patient needs, will this be properly addressed with this plan?		
60	Key is to have confidence in our medics. My area of concern is- Communications. Followup (after discharge). Options/Expectations.		
61	Why are there so many different names? It's only one NHS. Get Government to stop giving large wage rises to consultants but give better rises to nurses.		
62	More free car parking at GRH and CGH		
63	If would help if other bodies such as Glos Highways and bus companies could be persuaded to consider better road access and enhanced public transport facilities to reduce difficulties in trying to access two sites.		
64	The consultation makes no reference to the impact on transport issues for staff and patient visitors. For instance establishing a specialist centre in Gloucester only is bound to necessitate greater staff movement from Cheltenham and vise versa. Is greater capacity on the bus service and/or for car parking required? The success of whatever strategy is adopted should not be only measured in clinical terms.		
65	We have had need to avail ourselves of Cardiac - pacemaker/heart valve and bypass Oncology - Thyroid cancers TIA Trauma - hips A&E Endoscopy Audio Other family members use the Cardiff/Newport hospitals where we assist them		
66	Improving continuity of care, reducing outliers and improving communication with families might be improved if a balance in activity across the hospitals is achieved		
67	The general concept must be welcomed. However P14 column and does not take account of the here and now. With regard to A&E going straight to a specialist ward doesn't happen due to bed shortages so this needs to be addressed. Also at a more strategic level these centres of excellence represent a staff gap. What is really needed is the construction of a brand new hospital like Southmead. Which would consolidate both Gloucester and Cheltenham. It would be all encompassing in location. Have new smaller wards if not private rooms and take account of the high demands from increases in population and ageing.		
68	Relatives need to be able to visit very ill patients at moment this will delay recovery.		
69	If you centralise more long queue and parks, waste cancelled appointments staff on sick holidays etc. As more money was used in covid 19. We have to think weekly and keep NHS going for years to come. Electric chargers at hospital while wait for o/patient and visitors. Cars in come for hospital?		
70	No		

Anything else you would like to say?

		Response Percent	Response Total
71	No		
72	Do not ignore the publics opinion we have a right to choose where we have our care.		
73	See above please re-think before its too late		
74	no		
75	Addition of trainee nurses and other healthcare professions in specialities means you can retain them more easily and get more money!		
76	Great believer in logic		
77	seems like GRH has a more specialist focus under one roof - will this lead to overcrowding, parking issues, less quality face to face time with staff / professionals		
		answered	77
		skipped	104

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

		Response Percent	Response Total
1	Open-Ended Question	100.00%	181
1	gl2		
2	Gl4		
3	Gl3		
4	GL4		
5	GL1		
6	GL1		
7	GL3		
8	GL4		
9	GL6		
10	gl1		
11	GL4		
12	GL4		
13	Gl5		
14	GL5		
15	GL14		
16	Gl1		
17	GL4		
18	GL4		
19	GL4		

What is the first part of your postcode? eg. GL1, GL20			
		Response Percent	Response Total
	20	GL10	
	21	GL13	
	22	Gl15	
	23	GL6	
	24	GL2	
	25	GL4	
	26	Gl2	
	27	GL2	
	28	gl2	
	29	GL1	
	30	gl3	
	31	GL16	
	32	Gl2	
	33	GL2	
	34	Gl4	
	35	GL2	
	36	GL2	
	37	GL6	
	38	gl14	
	39	GL2	
	40	GL3	
	41	Gl16	
	42	GL13	
	43	Gl2	
	44	GL5	
	45	GL1	
	46	gl1	
	47	GL5	
	48	GL5	
	49	gl5	
	50	gl1	
	51	GL4	
	52	GL5	
	53	GL2	
	54	gl4	

What is the first part of your postcode? eg. GL1, GL20		Response Percent	Response Total
55	GL3		
56	GL18		
57	GL2		
58	GL4		
59	GL2		
60	GL5		
61	GL3		
62	Gl14		
63	GL2		
64	GL3		
65	GL17		
66	GL1		
67	GL2		
68	GL5		
69	GL3		
70	gl1		
71	GL18		
72	GL16		
73	GL13		
74	GL11		
75	GL12		
76	GL2		
77	GL6		
78	GL16		
79	GL6		
80	GL6		
81	Gl5		
82	GL5		
83	GL2		
84	gl2		
85	Gl14		
86	GL3		
87	GL5		
88	GL6		
89	gl5		

What is the first part of your postcode? eg. GL1, GL20			
		Response Percent	Response Total
	90	GL3	
	91	GL1	
	92	GL10	
	93	gl5	
	94	GL6	
	95	GL5	
	96	GL3	
	97	GL6	
	98	Gl6	
	99	GL4	
	100	GL5	
	101	GL3	
	102	GL3	
	103	GL18	
	104	GL18	
	105	gl15	
	106	GL2	
	107	GL18	
	108	GL18	
	109	GL5	
	110	GL15	
	111	GL15	
	112	GL5	
	113	GL4	
	114	GL4	
	115	GL18	
	116	GL14	
	117	gl3	
	118	gl1	
	119	gl15	
	120	GL6	
	121	GL1	
	122	GL5	
	123	GL15	
	124	GL13	

What is the first part of your postcode? eg. GL1, GL20			
		Response Percent	Response Total
	125	GL5	
	126	GL17	
	127	GL17	
	128	GL11	
	129	GL1	
	130	GL14	
	131	Gl4	
	132	gl3	
	133	GL6	
	134	GL11	
	135	GL12	
	136	GL2	
	137	GL15	
	138	NP16	
	139	gl2	
	140	GL1	
	141	GL14	
	142	Gl3	
	143	GL13	
	144	Gl5	
	145	GL16	
	146	GL15	
	147	Gl2	
	148	GL3	
	149	GL16	
	150	GL3	
	151	GL5	
	152	GL3	
	153	GL6	
	154	GL12	
	155	GL16	
	156	GL3	
	157	GL4	
	158	GL6	
	159	GL1	

What is the first part of your postcode? eg. GL1, GL20			
		Response Percent	Response Total
	160	GL5	
	161	HR9	
	162	GL3	
	163	GL2	
	164	GL14	
	165	GL4	
	166	GL2	
	167	GL11	
	168	GL3	
	169	GL6	
	170	GL15	
	171	GL11	
	172	GL6	
	173	GL16	
	174	GL1	
	175	GL2	
	176	NP16	
	177	GL3	
	178	GL5	
	179	GL1	
	180	GL1	
	181	GL4	
		answered	181
		skipped	0

Which age group are you:				
			Response Percent	Response Total
1	Under 18		0.56%	1
2	18-25		3.91%	7
3	26-35		11.17%	20
4	36-45		13.97%	25
5	46-55		17.32%	31
6	56-65		21.23%	38
7	66-75		21.79%	39
8	Over 75		10.06%	18
9	Prefer not to say		0.00%	0
			answered	179
			skipped	2

Are you:				
			Response Percent	Response Total
1	A health or social care professional		32.22%	58
2	A community partner		0.56%	1
3	A member of the public		62.78%	113
4	Prefer not to say		4.44%	8
			answered	180
			skipped	1

Do you consider yourself to have a disability? (Tick all that apply)				
			Response Percent	Response Total
1	No		72.63%	130
2	Mental health problem		3.35%	6
3	Visual Impairment		2.23%	4
4	Learning difficulties		0.56%	1
5	Hearing impairment		4.47%	8
6	Long term condition		17.88%	32
7	Physical disability		2.79%	5
8	Prefer not to say		3.35%	6
			answered	179
			skipped	2

Do you look after, or give any help or support to family members, friends, neighbours or others because of either a long term physical or mental ill health need or problems related to old age? Please do not count anything you do as part of your paid employment.				
			Response Percent	Response Total
1	Yes		31.84%	57
2	No		65.36%	117
3	Prefer not to say		2.79%	5
			answered	179
			skipped	2

Which best describes your ethnicity?

		Response Percent	Response Total
1	White British	88.14%	156
2	White Other	2.26%	4
3	Asian or Asian British	2.26%	4
4	Black or Black British	1.13%	2
5	Chinese	0.00%	0
6	Mixed	1.13%	2
7	Prefer not to say	4.52%	8
8	Other (please specify):	0.56%	1
		answered	177
		skipped	4

Other (please specify): (1)

1	European

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

		Response Percent	Response Total
1	No religion	41.67%	75
2	Buddhist	1.11%	2
3	Christian (including Church of England, Catholic, Methodist and other denominations)	49.44%	89
4	Hindu	0.56%	1
5	Jewish	0.56%	1
6	Muslim	1.11%	2
7	Sikh	0.00%	0
8	Other	1.11%	2
9	Prefer not to say	4.44%	8
		answered	180
		skipped	1

Are you:

		Response Percent	Response Total
1	Male	34.27%	61
2	Female	60.67%	108
3	Transgender	0.56%	1
4	Prefer not to say	4.49%	8
		answered	178
		skipped	3

Do you identify with your gender as registered at birth?

		Response Percent	Response Total
1	Yes	96.07%	171
2	No	0.00%	0
3	Prefer not to say	3.93%	7
		answered	178
		skipped	3

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

		Response Percent	Response Total
1	Heterosexual or straight	91.62%	164
2	Gay or lesbian	1.68%	3
3	Bisexual	0.56%	1
4	Other	0.56%	1
5	Prefer not to say	5.59%	10
		answered	179
		skipped	2

Are you currently pregnant or have given birth in the last year?				
			Response Percent	Response Total
1	Yes		2.26%	4
2	No		72.32%	128
3	Not applicable		22.60%	40
4	Prefer not to say		2.82%	5
			answered	177
			skipped	4

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.'

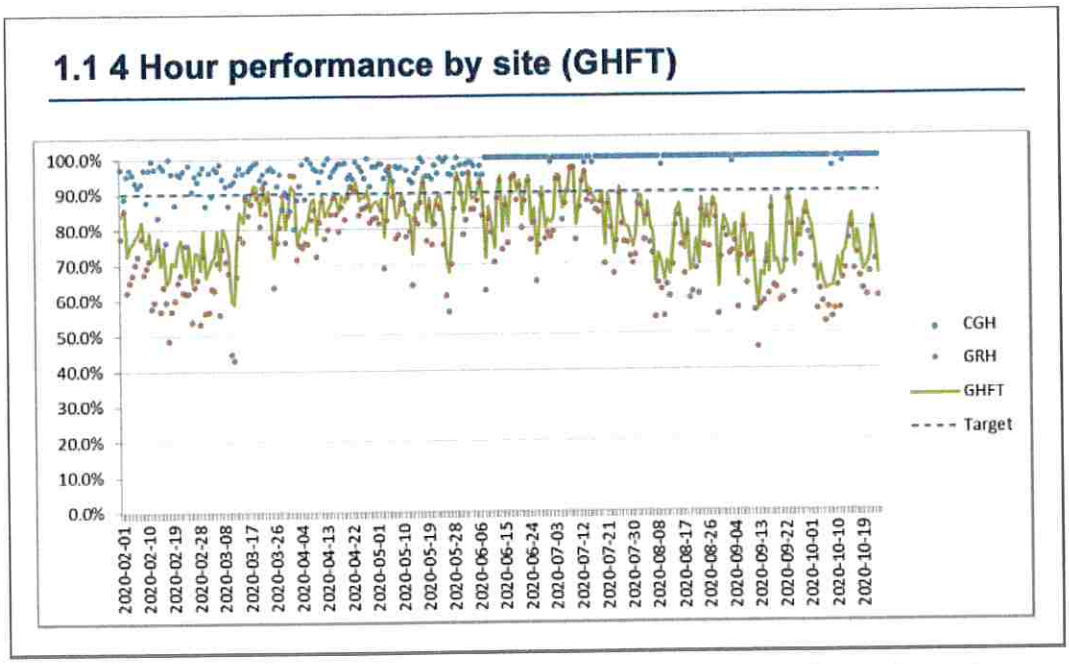
These fears seem well-founded given the evidence provided to HOSC of capacity pressures at GRH revealed in the chart on the next page of already poor and now deteriorating A&E waiting times at Gloucester (red dots)[5], which reflect admission capacity issues within GRH as much as demand for ED services 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.

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, 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.'

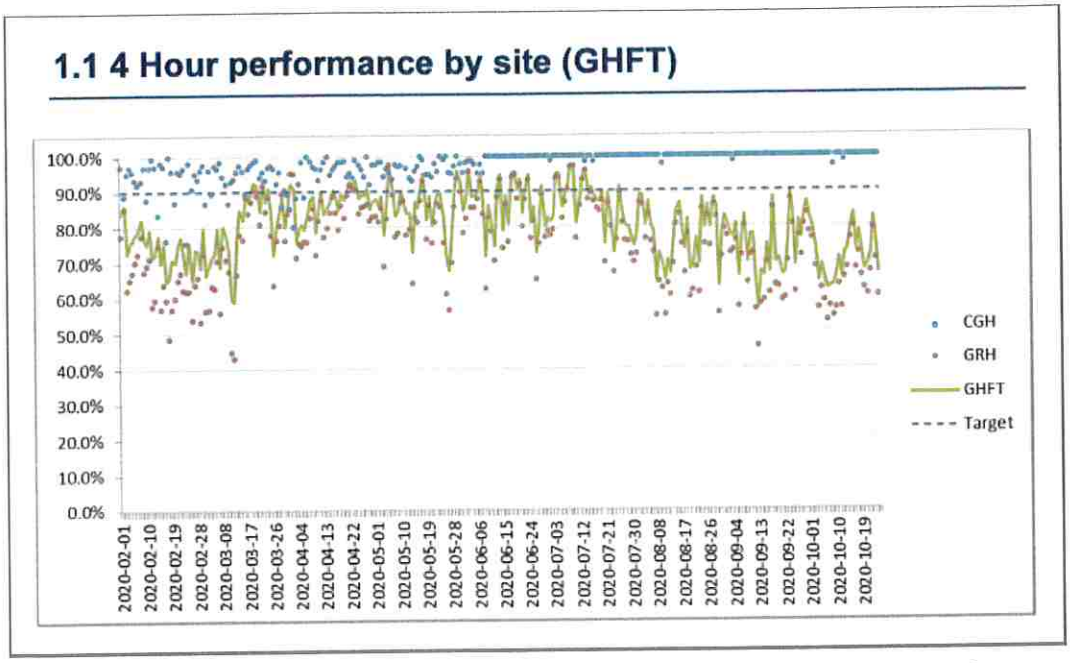
These fears seem well-founded given the evidence provided to the county HOSC committee of capacity pressures at GRH revealed in the chart on the next page of already poor and now deteriorating A&E waiting times at Gloucester (red dots)[5], which reflect admission capacity issues within GRH as much as 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.

REACH (Restore Emergency at Cheltenham General Hospital)
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GL50 1UH
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Website: https://www.reachnow.org.uk/contact/

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

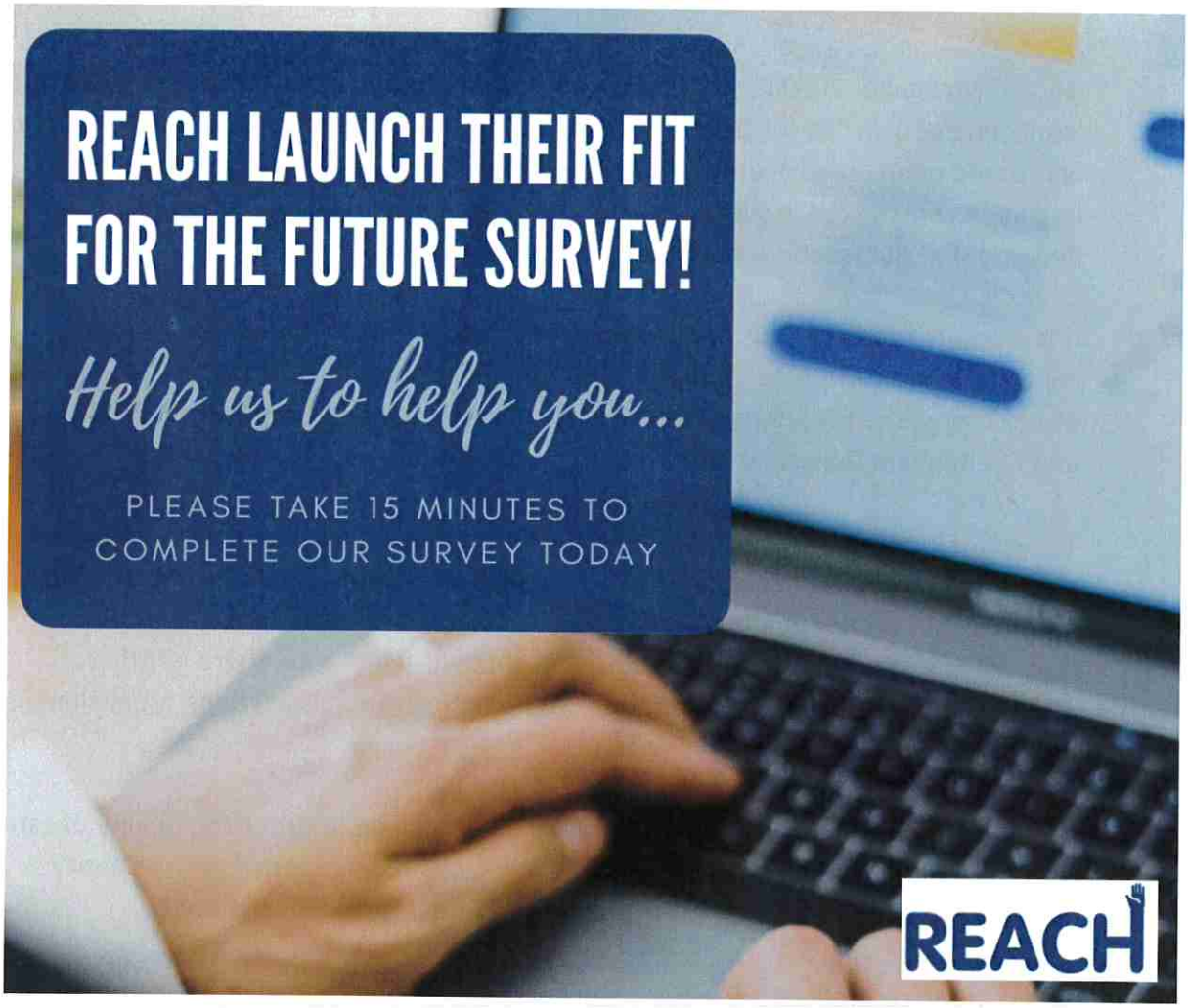
The Trust is planning to centralise planned admissions for patients with gastroenterology (gut/ liver medical) conditions. The number of patients, who are admitted as inpatients/overnight for planned investigations for gut problems is very small. On the contrary, more patients are admitted with emergency 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.

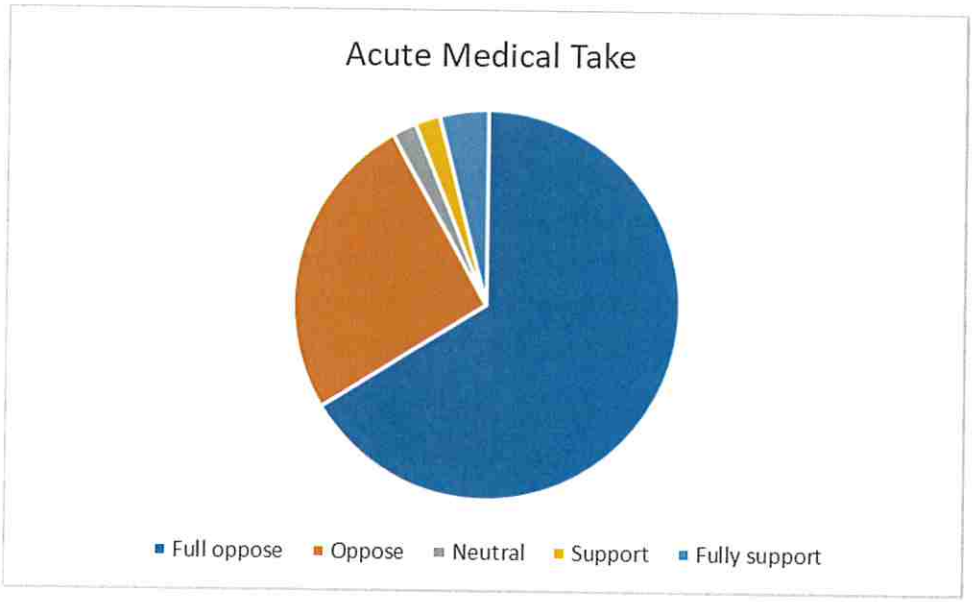
Interim Results

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."

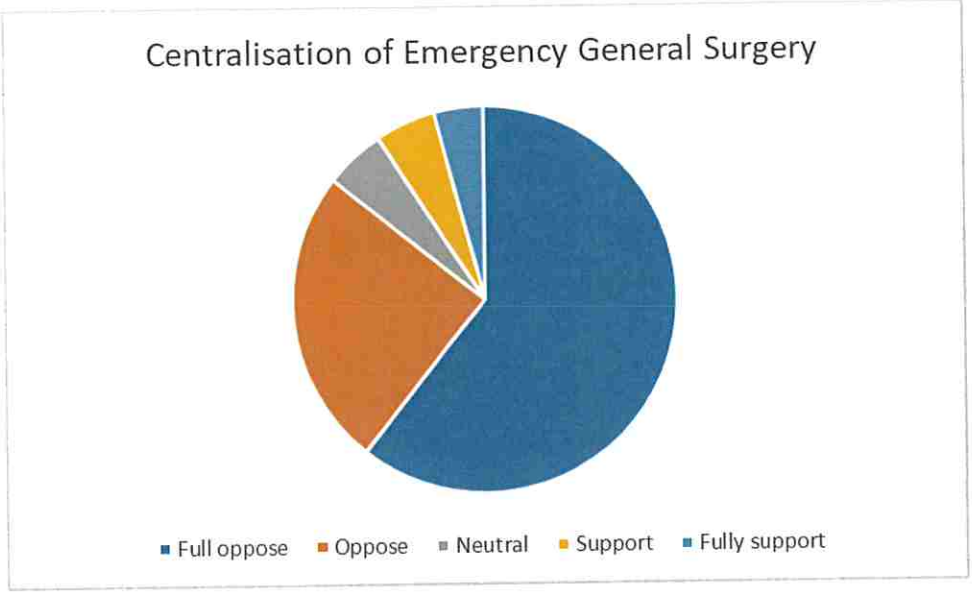
Question 2 CENTRALISATION OF EMERGENCY GENERAL SURGERY AT GLOUCESTERSHIRE ROYAL HOSPITAL

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.

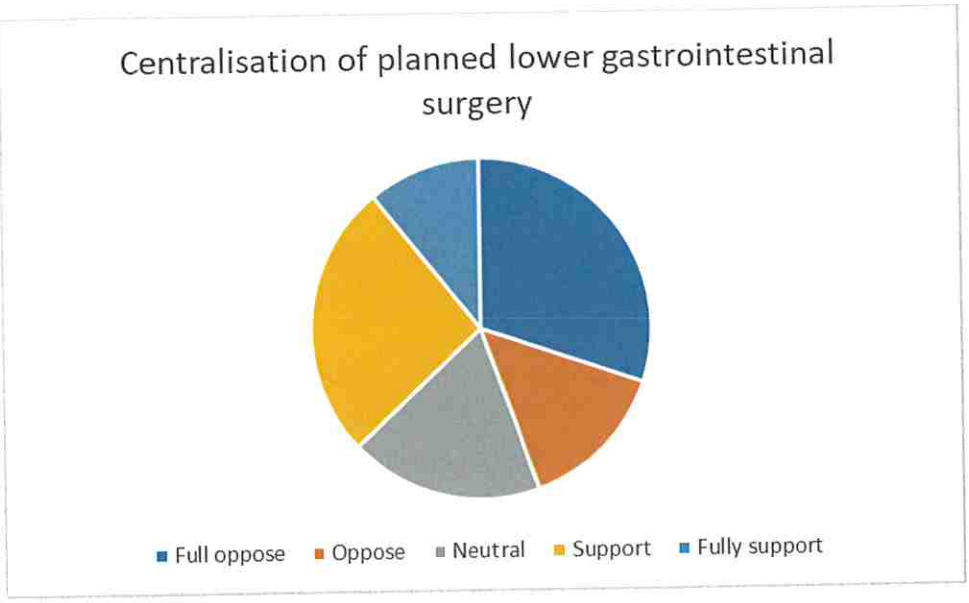
Surgeons presently working at CGH would join colleagues at GRH and be able to share experience and expertise. Cooperation of this sort is important. There is an unfortunate tendency for staff at different hospital sites to feel that they are in competition with each other. Cooperation is always preferable. 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?

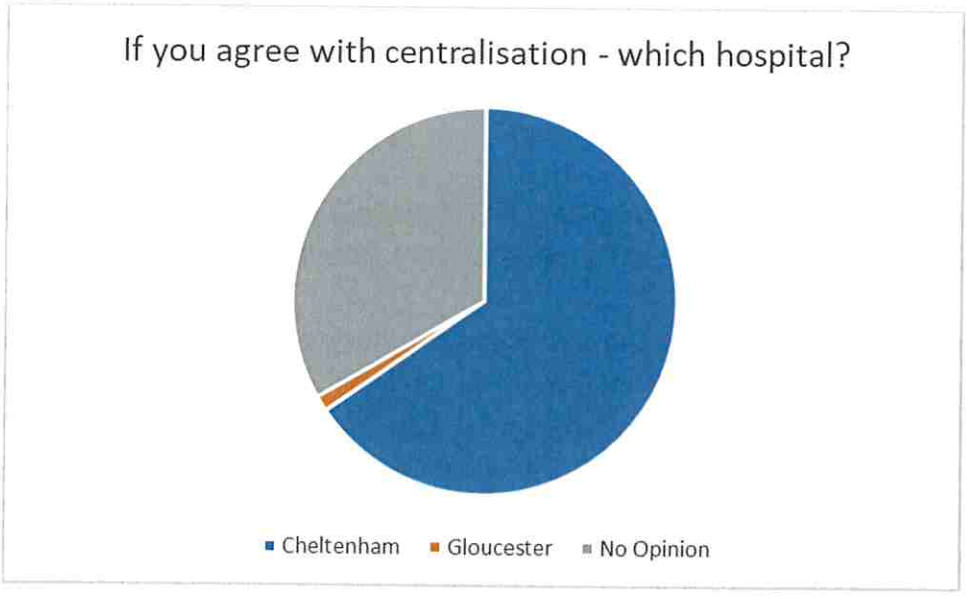
It would be sensible to have this service at CGH with gynecological oncology.

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

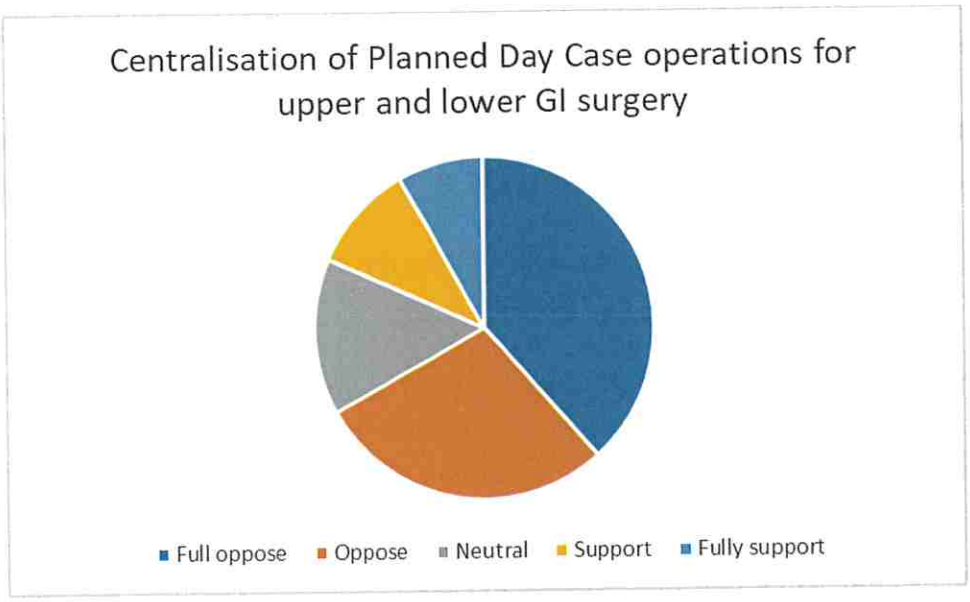
site as oncology. Elective surgery is less likely to be cancelled and CGH can establish itself as a green site pelvic centre of excellence."

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

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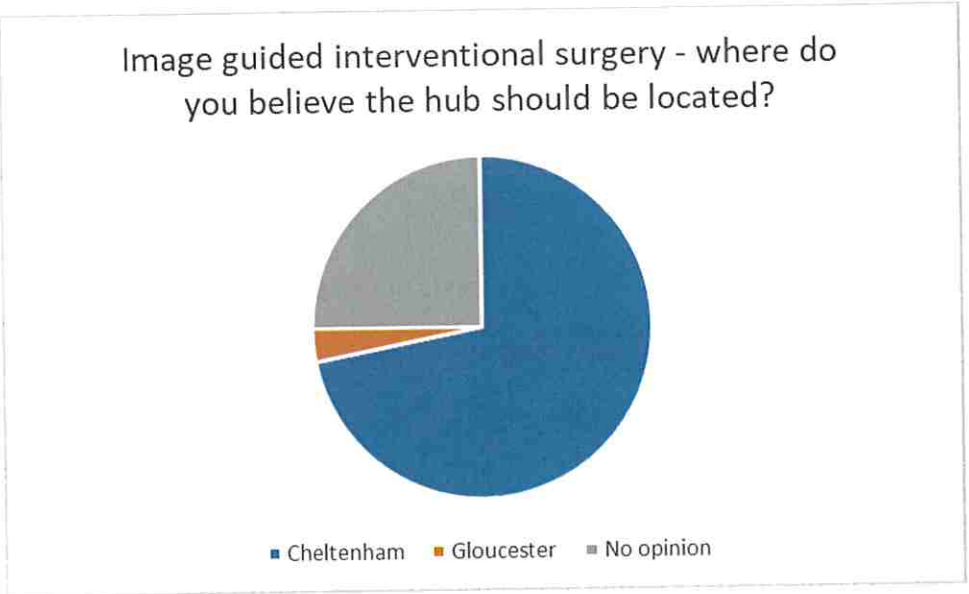
The Trust describes a "hub and spoke" model. The "hub" is the main central unit, which performs most of the procedures. The "spoke" is the secondary unit at the other hospital, which provides a facility for occasional emergency or urgent procedures.

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?



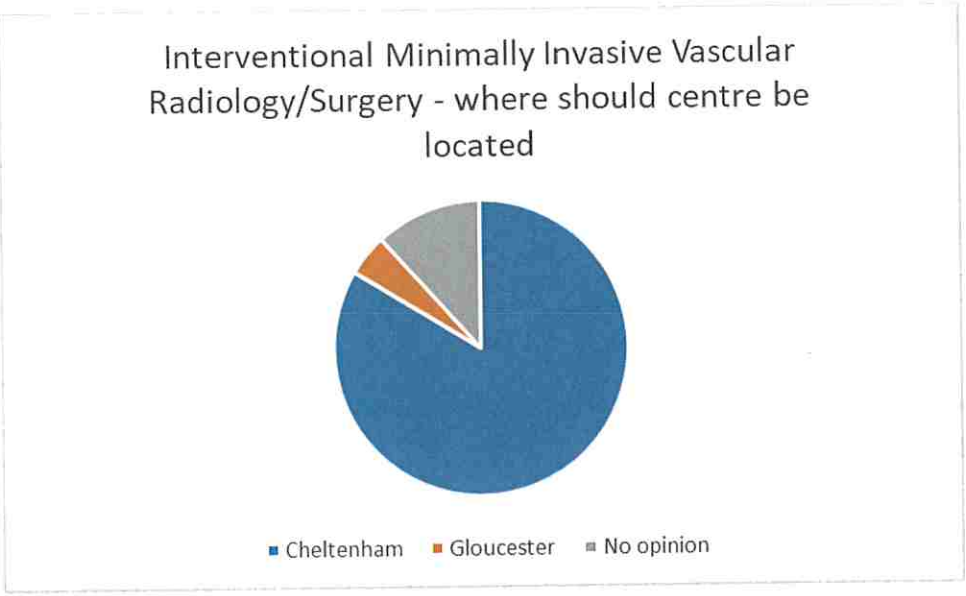
A clear majority of the public replies indicate that the main centre or hub for interventional radiology should be at Cheltenham. The respondents indicating "no opinion" generally said that this service should be provided at both hospitals. The Proposal from One Gloucestershire is for a "hub and spoke"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

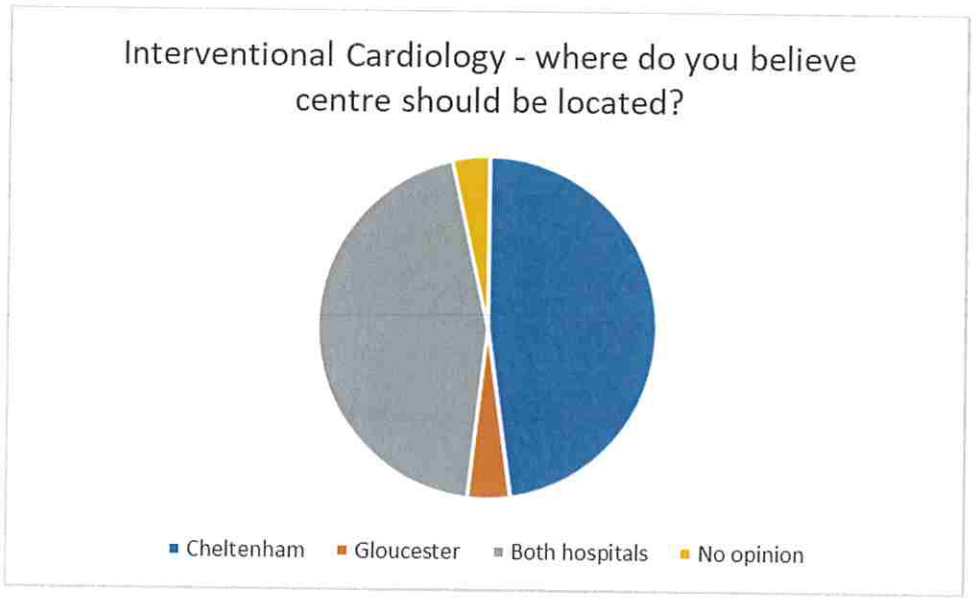
For 30 to 40 years, heart specialists or cardiologists have been performing specialist interventional procedures to diagnose and treat heart problems. Initially, these procedures involved inserting a catheter or tube via an artery in the groin or elbow, so that special dye can be injected into the coronary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

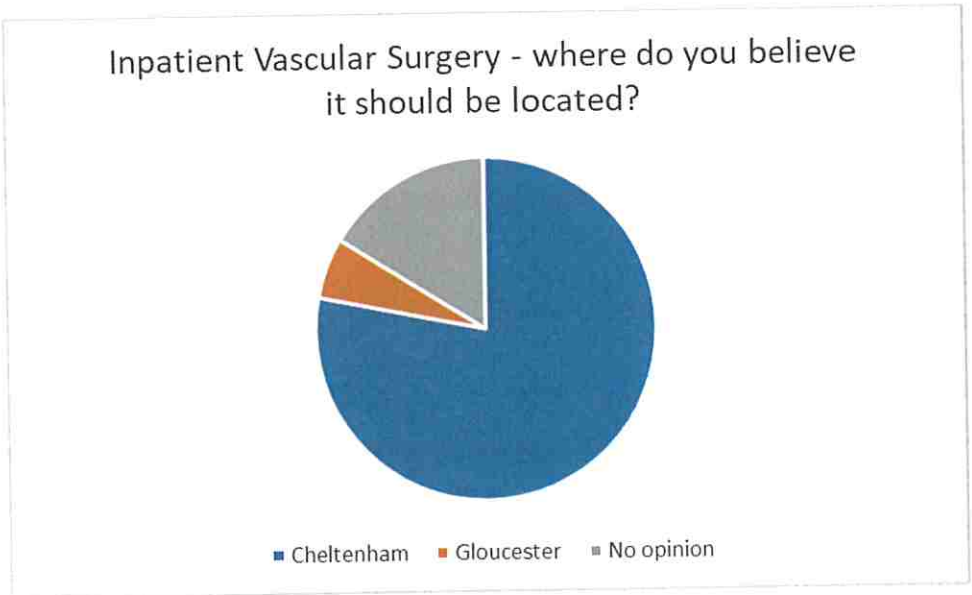
Cheltenham is already the Centre of Excellence for planned Cardiovascular surgery. My next door neighbour had a heart attack and had to be taken to Bristol. He died four days later. Who knows if he could have been saved if he had not had to be taken all the way to Bristol. Cheltenham should be developed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

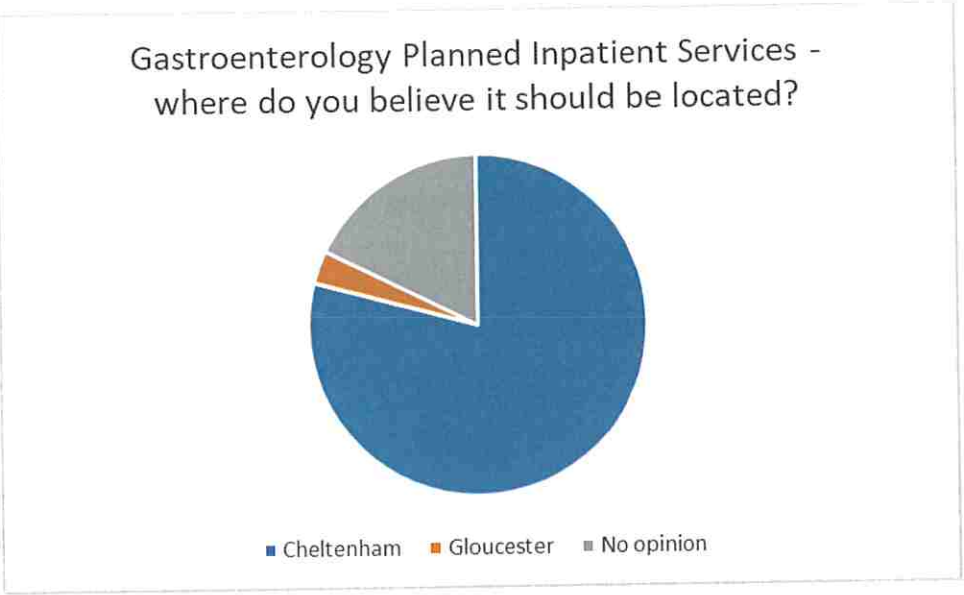
If there is already a state of the art centre for dealing with this at CGH surely there is absolutely no need to change it."

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."

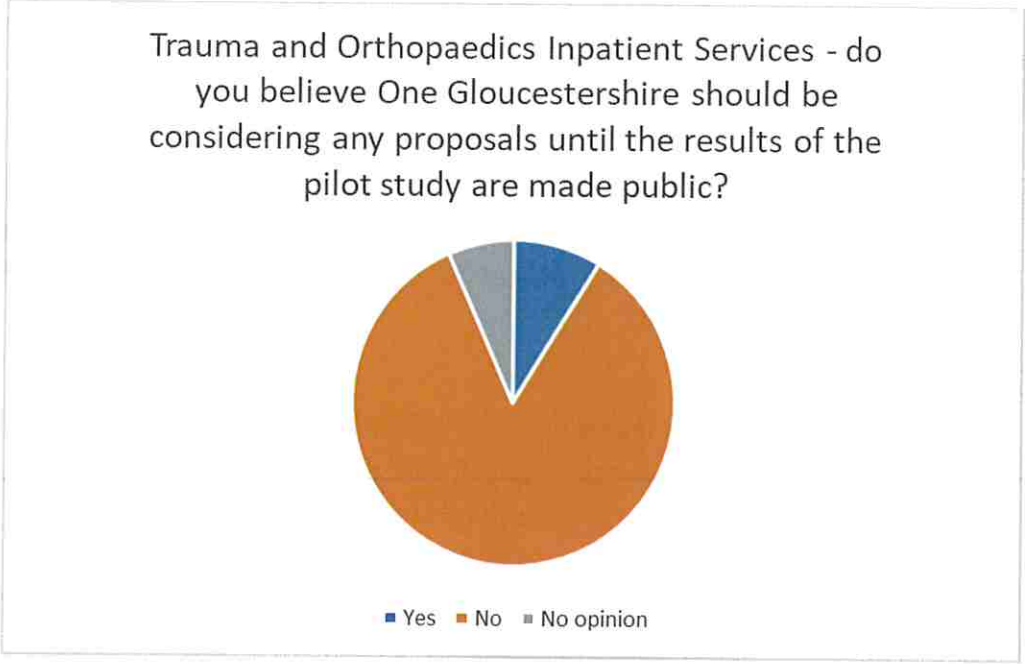
Question 11 TRAUMA AND ORTHOPAEDICS (T & O) INPATIENT SERVICES

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.

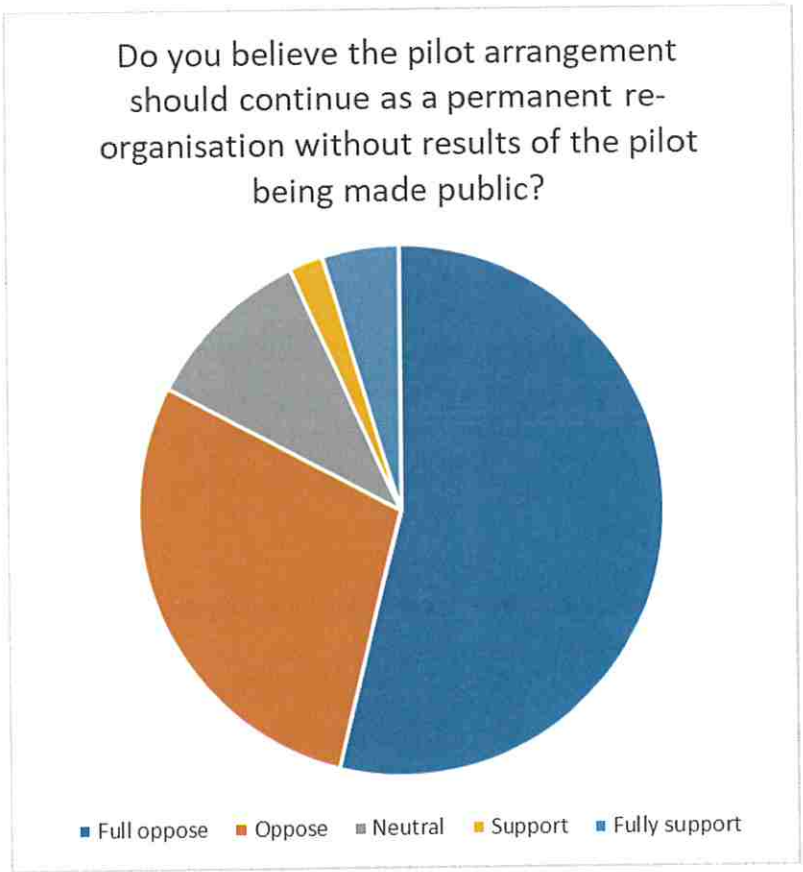
The Trust must see the results of the Pilot Study first, before making any further decisions on this. It would be reckless to proceed before any further facts, information and recommendations have been gleaned and shared with the public. Patient care and health could be compromised and it would be negligent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

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.

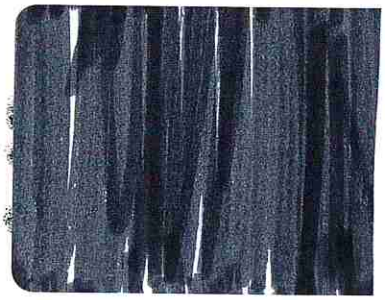
My mum was a casualty of a failing NHS system. All along I kept saying 'no one is listening'. With no continuity of care, we were passed from pillar to post and no one had the time to invest in addressing the issues we raised and question why a post op swelling would strangely appear several months after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

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

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]

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]

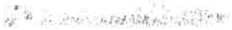
5.

[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]



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]

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

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

[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

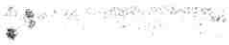
Hi – I don't seem to be able to find anything on stroke units in the consultation documents on Gloucester and Cheltenham.

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]



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

Please note: Whilst we make every effort to ensure the security of your personal information, messages sent by internet email can be intercepted and read by someone else. We strongly advise you not to email any information, which if disclosed to unrelated third parties would be likely to cause you distress. If you are sharing personal information in relation to your enquiry we will ask you to provide a postal address to allow us to communicate with you in a more secure way. If you prefer us to respond by email you must accept that there can be no guarantee of privacy.

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]

Glossary

Acute Medicine (Acute Medical Take): The Acute Medicine team coordinates initial medical care for patients referred to them by a GP or the Emergency Departments and decides on whether they need a hospital stay (also referred to as 'the acute medical take').

Admission (to hospital): a hospital stay.

Arthroplasty: a surgical procedure to restore the function of a joint.

Assessment (or Evaluation) Criteria: used to judge (assess) whether a way of organising services would work or not. Each criteria e.g. access to care - has a set of questions used to support the assessment. Used to compare different ways of organising services.

Centres of Excellence: bringing staff, equipment and facilities together in one place to provide leading edge care and create links with other related services and staff.

Citizens' jury: members of the public representing a cross section of the community are recruited and tackle a public policy question like 'how should we organise these health services?' The jury meets face to face or online and is provided with reliable, impartial information from expert witnesses. The jury members ask questions of the experts and work together to reach conclusions. The jury recommendations and observations are published and fed back to decision makers.

Clinical benefits: benefits of providing medical care in a certain way for patients, healthcare professionals or both.

Clinical outcomes: the impact of the medical advice, care or treatment patients receive on their health.

Clinically viable models: a way of providing services that works well to support high quality health care.

Coeliac disease: a condition where a person's immune system attacks their own tissues when they eat gluten. This damages the lining of the gut so the person is unable to absorb nutrients from food properly.

Comorbidity: is the state of having multiple health conditions at the same time. Morbidity is the state of being sick or having a disease.

Configuration: how services are organised.

Consultation: a consultation is designed to involve people in decision making. If there could be a significant change to the way NHS services are provided, we are required to carry out a consultation with the public and community partners. This helps us to understand how people may be affected by the proposed changes before we make decisions.

Crohn's disease: a lifelong condition where parts of the digestive system become inflamed.

Deliverability: looking at whether a potential service change can be successfully implemented or run.

Diagnosis: the identification of the nature of an illness or other problem by examining the symptoms. This can include carrying out tests.

Direct admission pathway: an agreed route for a patient to go straight to a hospital ward to get the care they need from doctors, nurses and other staff who specialise in that patient's illness or condition.

Discharge (from hospital): supporting a patient to leave hospital when they are fit to do so and receive onward care at home or in another health or care facility. Elective Care: care that can be planned in advance. Also known as planned care.

Endoscopy: a procedure where organs inside a person's body are looked at using an instrument called an endoscope. An endoscope is a long, thin, flexible tube that has a light and camera at one end. Images of the inside of the body are shown on a television screen. Endoscopy can be used to diagnose a condition.

Engagement: an open dialogue (conversation). An opportunity to discuss ideas and involve people in developing potential solutions to meet future health and care needs. Sharing information and exchanging views.

Gastroenterology: medical care (not surgery) for stomach, pancreas, bowel or liver problems.

General Surgery: relates to conditions of the abdomen, specifically the digestive system or gastrointestinal (GI) system (gut). There are specialists who look after either the 'upper' part of the gut or the 'lower' part of the gut: also known as Upper GI and Lower GI (colorectal).

Gynaecological oncology: a specialised area of cancer care focusing on the diagnosis and treatment of cancers affecting women's reproductive organs.

Health outcomes: the result of the advice, care or treatment a person receives on their health.

Hyper acute stroke unit: provides the initial investigation, treatment and care immediately following a stroke.

Image guided interventional surgery (IGIS): procedures where the surgeon uses instruments with live images to guide the surgery.

Integrated Impact Assessment (IIA): an assessment of potential changes to services that identifies groups who could be affected more than others by the changes.

Interventional cardiology: involves treating heart disease without using open surgery (large cuts or incisions to the body). The procedures are called 'minimally invasive', because they involve small cuts to gain access to the inside of the body and often use catheters (thin, hollow, flexible tubes).

Interventional radiology: means using real time images of the inside of the body, captured by X-ray, MRI, ultrasound scans and CT scans to diagnose or treat problems with blood vessels.

Interventionalist: physician specifically trained to perform interventional or minimally invasive procedures (see also Interventional cardiology for a definition of 'minimally invasive').

Invasive (and less invasive) surgery: invasive surgery involves a significant or large cut or entry into the body using medical instruments. Less invasive indicates the avoidance of a large cut or impact on the body e.g. performing surgery using instruments that only create a small 'key hole', which means people can heal and recover more quickly.

Length of stay: the amount of time someone has to stay in hospital for care, treatment and recovery.

Mitigation: measures/actions put in place to address negative impacts.

Multi-disciplinary Team: a group of professionals from one or more clinical disciplines who together make decisions regarding recommended treatment of individual patients.

Output of Consultation Report: a report that includes a description of the consultation activities and the themes of the feedback received.

Patient flow: the patient's care journey through a hospital to meet their care needs e.g. from initial assessment in a unit to surgery or care on a ward to leaving hospital. On occasions, it can involve transfer between hospital sites.

Pelvic resections: are complex surgeries in which a part of the pelvic ring is surgically removed, usually to treat a malignant tumour.

Potential solutions: an idea for improving the way services are organised and improving outcomes for patients (see health outcomes).

Pre assessment clinic: where health staff e.g. doctors and nurses can plan for a person's treatment or operation to ensure they get the best possible outcome (see health outcomes).

Pre Consultation Business Case: a detailed planning document the local NHS needs to produce when thinking about service changes.

Preferred option: a preferred way of organising a service or services that follows a process of engagement and appraisal (see engagement). There is not always a preferred option.

Prosthesis: an artificial body part, such as a joint or limb.

Rota (medical): a shared work schedule for a group of healthcare professionals in the same field of work or profession e.g. junior doctors covering a particular service or consultants (senior doctors) working in the same department.

Specialist care: care often carried out in hospitals for people with particular medical conditions provided by doctors, nurses and other staff with specific knowledge and skills.

Sub-specialty: a narrow (specific) field of specialist professional knowledge and skills within a broader specialty e.g. Lower Gastrointestinal (colorectal) surgery is a sub specialty of General Surgery (see General Surgery).

Sustainable service: a service that can be provided in a certain way for the long term. A service that will be able to meet the future needs of patients. A service that makes better use of resources e.g. medical equipment/facilities, people, money or environmental.

Trauma and orthopaedics (T&O): diagnosis and treatment of conditions relating to the bones and joints and their associated structures that enable movement - ligaments, tendons, muscles and nerves. Trauma surgery is urgent surgery e.g. if a person has been involved in an accident and orthopaedic surgery is planned surgery e.g. hip and knee replacements.

Ulcerative colitis: a long term condition where the colon (large intestine – bowel) and rectum become inflamed.

Urology: also known as genitourinary surgery, is the branch of medicine that focuses on surgical and medical diseases of the male and female urinary-tract system and the male reproductive organs.

Vascular surgery: area of specialist care dealing with the diagnosis and management of conditions affecting the circulation, including disease of the arteries, veins and lymphatic vessels.

Workforce: staff e.g. doctors, nurses, therapists.

Gloucestershire Hospitals
NHS Foundation Trust

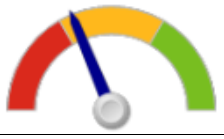
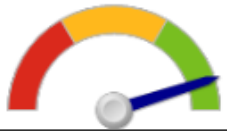
TRUST BOARD - 14 JANUARY 2021
Via MS Teams

Report Title
People and Organisational Development Performance Dashboard and Strategy Assurance
Sponsor and Author(s)
Author and Sponsoring Director: Emma Wood, Deputy CEO and Director of People and Organisational Development
Executive Summary

Purpose

This report provides an update on the performance dashboard aligned to the strategic and operational measures identified within the People and Organisational Development Strategy. It also provides an overview of delivery against the four strategic pillars of the People and OD Strategy.

Key measures detailed within the report are benchmarked (where appropriate) to Model Hospital Peer data and University Hospital/ Teaching Peers. These indicators include:

Retention, Turnover, Vacancy	
Appraisal	
Mandatory Training	
Sickness Absence	

SPC Charts and trend descriptors linked to all dashboard indicators are located in **annex 1**. The updated position on job planning was also reviewed **annex 2** and outliers discussed. The reasons for these were described as reflecting the current context of operational challenges faced by clinical staff and long term sickness.

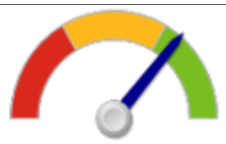
In addition to our usual Trust data which shows an ongoing improvement in performance the People and Organisational Development Committee also reviewed a data pack on the **retention of Nursing and Midwifery staff.** This pack generated by NHS England and Improvement as part of the national programme 'Looking After Our People' supported the Trust improvements in retention of nurses and midwives. Key points the committee noted were:

- The data confirmed the favourable position reported to the People and OD Committee regarding The Trusts position in the top quartile of model hospital peers.
- The Trust reported a higher level of retirements compared to peers and 2019 levels.
- The Trust reported a higher number of leavers due to 'work life balance' and flexibility

compared to peers and 2019 levels.

- The Trust continues to show an increase in capturing reasons for leaving a key objective the People and OD Committee sought improved compliance against.
- Proportionally, the Trust lose fewer Nurses and Midwives in their first year of employment compared to other South West Trusts.
- We show as having more vacancies that other south west trusts, whilst less than national figures.

The People and OD committee received a report on progress against the year 1-2 measures within the People and OD Strategy. Detailed reports mapped to the strategy are provided during the course of the year. A summary of progress against the four pillars within the strategy is provided every six months and the Board is asked to note the following achievements.

Transformation *Colleagues are organised around the patient, equipped and inspired to deliver the best care for everyone*	
Workforce Sustainability *A caring, compassionate and skilled workforce. A Trust able to attract, retain and develop the best people*	
Colleague Experience *Colleagues recognise the Trust as outstanding, they feel empowered and are confident that the Trust is driven by its values and ambition to excel in patient care*	
Equality Diversity, Inclusion and Human Rights *Colleagues will recognise we act with fairness, respect, equality, dignity and encourage autonomy. Colleagues will recognise that this is central to our values and behaviours*	

Next steps

The People and OD senior leadership team will continue to lead the delivery of the operational performance and the strategy. The team will focus on areas of performance which are not within the acceptable parameters and those items which are red and amber whilst maximising the opportunities which our response to COVID-19 afforded.

Specifically the team will:

- Continue to support divisions to improve HCA retention and recruitment. This will be aided by a new national programme of support to Trusts to reduce Health Care Support Workers vacancy rates to as close to zero as possible by March 2021;
- Oversee some refocused and multidisciplinary programmes of work to improve progress within the Colleague experience pillar specifically improving leadership for our health and well-being offers, embedding just learning outcomes and seeking new approaches to reducing violence and aggression and bullying and harassment

inclusive of improved governance under new working groups;
- Continue to progress the Equality, Diversity and Inclusion objectives set by the Board as part of our widening participation review and agenda;
- Continue to drive our Compassionate Culture and leadership agenda;
- Continue to develop career pathways and education offers;
- Collaborate with the ICS to deliver upon joint Equality and Diversity programmes.

Recommendations

The Board are asked to NOTE the report and take ASSURANCE from the progress made by the People and OD directorate

Impact Upon Strategic Objectives

Compassionate workforce – we have a compassionate, skilful and sustainable workforce, organised around the patient, that describes us as an Outstanding employer who attracts, develops and retains the very best people.
Quality improvement is at the heart of everything we do; our staff are empowered and equipped to do the very best for their patients and each other.

Impact Upon Corporate Risks

Delivery of the People and OD strategy mitigate against the principle risks which impact upon the delivery of the strategic objectives

1. Risk that we are unable to match recruitment needs (due to national and local shortages) with suitably qualified clinical colleagues
2. Risk that continued poor levels of staff engagement measured by national and local surveys may negatively impact upon retention, attraction and patient experience
3. Risk that we fail to attract, recruit and retain candidates from diverse communities resulting in the Trust workforce not being representative of the communities we serve

Regulatory and/or Legal Implications

The reports attached are designed in such a way to provide assurance that the Trust is operating in accordance with:
NHSI/E requirements
Best practice and employment legislation, including the Equality Act.
The aspirations of the People and OD strategy
The aspirations of the NHS People Plan.

Equality & Patient Impact

There is a known researched link between employee experience, stability, retention and patient experience and outcomes. The People and Organisational Development Strategy promotes a culture of 'caring for those who care', which in turn will enhance the experience of our patients.

Resource Implications

Finance	**X**	Information Management & Technology	
Human Resources	**X**	Buildings	

Action/Decision Required

For Decision		For Assurance	**X**	For Approval		For Information	

Date the paper was presented to previous Committees

Quality & Performance Committee	Finance Committee	Audit & Assurance Committee	People and OD Committee	Remuneration Committee	Trust Leadership Team	Other (specify)
			22 December 2020			

Outcome of discussion when presented to previous Committees

The People and OD committee noted the positive metrics within the dashboard and comparative data from NHSEI. The committee discussed how the People and OD directorate

could quantify the data improvements as real benefits for staff and how well these are analysed. In addition how the improvements and efforts impacted upon chronic workload, linking the compassionate leadership framing around empathy and understanding of staff pressures was discussed. The progress against the year 1 – 2 milestones within the People and OD strategy was explored and the red and amber metrics discussed. Assurance was given than many of the red targets were missed metrics such as time to hire to recruit of items not progressed due to new and different priorities, such as the High Potential Development Scheme within the ICS being replaced with three stepping up programmes.

Performance dashboard measures

WORKFORCE SUSTAINABILITY - Vacancy Factor and Supply Pipelines

Strategic Measure	Performance	Exception Report
Reduce Vacancy factor from 9% to 5% (long term plan) reduce by 0.75-1% per annum as a minimum. Improve attraction and pipeline of Nurses – establish a pipeline that looks to improve the supply of Nurses by 5-10% annually.	 For full performance trend see TAB 2, appendix 1	The November vacancy position shows an improvement from the last reported figures, **moving to a position of 5.14%** compared to 6.71% as previously reported. This means we remain on track to meet the long term objective. (See Tab 2 of annex 1 for detailed trend information). Using ESR establishment data, the November Staff Nurse/ODP vacancy rate is 12.24% showing an anticipated reduction to the August figure of 13.38%. Our finance establishment continues to require modification in order to reflect the true vacancy picture through the ESR reports however ongoing reconciliation helps us to understand the number of Staff Nurse vacancies actually sits at less than 60 wte. Medical staffing vacancy rate has decreased significantly to 0.37%. This vacancy rate translates to a shortfall of circa 3.4 fte. It should be noted that ongoing reconciliation activity between ESR and the finance ledger has reduced the vacancy numbers by 10 fte. The medical staffing and temporary staffing leads continue to work with Divisions to scrutinise long term locum use, against planned recruitment activity and hard to fill vacancy information; to identify whether there are any alternative workforce solutions or approaches that we are yet to consider. Vacancies/ locum placements under review include: Urology, T&O and Acute Medicine. **D&S Division** The current radiography vacancy rate is 14.96%: We expect this to reduce by February (reported in March 2021) as six new recruits are due to start between November and January; the current turnover rate for this group sits at only 7.65%. Three of these new starters have joined us from Nigeria and will complement the existing cohort of five Nigerian radiographers. Departmental support is in place to ensure these recruits have good induction and training and are welcomed into our community. In addition to this overseas recruitment in January 2021, the first cohort of Radiography trainees from Gloucestershire University join us – a key part of our longer term workforce plan for this speciality. **Medicine Division** Whilst the division is experiencing a high level of change in response to COVID-19, the vacancy and turnover data remains constant. The vacancy rate across the Division has reduced to 10.40%. The nursing and midwifery vacancy rate remains high at 16.62% however the additional clinical services rate has continued to

		reduce and now sits at 9.28%.
WORKFORCE SUSTAINABILITY - Turnover		
Reduce Turnover to meet top quartile in model hospital. Aim in year 1 to achieve national median and in year 2 next best peer. By year 5 match best in model hospital peers (moving year on year target) Reduce Health Care Assistant turnover from 15.5% to 10% **by 2024**, by reducing by 1% year on year. Reduce Admin and Clerical turnover from 13% to 10% **by 2024**, by reducing by 0.75% year on year.	 For full performance trend see TAB 1, appendix 1	The rolling annual turnover rate shows a consistent gradual decrease since 2019 and is now at 9.66%, placing the Trust in the top quartile of the Model Hospital Peer Group. **Additional Clinical Services as a Staff Group have the highest turnover to Aug 20 at 12.8%** - this is the group where non-registered nursing staff are located. All other Staff Groups are below the 12.6% threshold. **Medicine Division** The Medical Division remain an outlier in terms of high Turnover levels at 12.4%, however it should be noted that this is still lower than the 12.6% Peer Model Hospital level. **Non-Registered Nurse Turnover remains higher in Medicine** compared to our other clinical divisions. This turnover is reported at **17.4%**. This figure has reduced from the August figure of 20.27% (reported to the P&OD Committee in October 2020). To give this figure context, Women & Children TO rate is 12.6% & Surgery is 12.4%. Surgery employs a similar number of Non Reg nursing staff as Medicine. Within Medicine Division, Goam/Neurology/Stroke is the Service Line with the lowest turnover rate at 13.2% It is recognised that this rate of turnover has been a consistent exception within the Medical Division over a long period of time (3 years +) despite varying approaches to improving staff experience, including staff rotation, listening events and the HCA retention focus groups conducted in 2018. The Medical Division have committed to undertaking a more in-depth review of exit trends, utilising the exit interview methodology piloted by the Surgery division in the past year. The division are also conducting benchmarking with other Medical Divisions in acute Trusts (this has not been available through Model Hospital to date) to explore any trends associated with being a Health Care Assistant in a busy medical division. This work sits alongside the Divisional staff survey action plan and will be reported on through the Executive review process.

Operational Measure	Performance	Exception Report

Appraisal 90%	 For full performance trend see TAB 3, appendix 1	**Trust Appraisal rates for October 2020 returned to pre-covid levels.** **Corporate Division has fallen to the lowest rate at 77%. This Division has the highest number of staff working from home, therefore a message to service leads has been sent** **Diagnostic & Specialties** have a recovery plan in place and rates have begun to increase with a rise to 80% in September 2020. **Women and Children's** appraisal rates have recently reduced to 82%, the Division are in the process of scrutinising recovery plans to ensure improvement is made, **Surgery**, rates have improved to **87%** as a result of this year's recovery plan **Medicine Division** have reported a minor decrease to compliance with Appraisals from 87% in September to 86% in October.
Statutory/Mandatory Training 90%	 For full performance trend see TAB 3, appendix 1	The Trust remains above the 90% target, at 93% compliance**.** Some topics previously delivered in classrooms have been moved to eLearning by national approval as a result of the pandemic and the need for social distancing in classrooms (e.g. Safeguarding and Conflict Resolution). This has made it easier for staff to access and complete the training. Other topics are now being delivered virtually as supported by the Virtual Learning project. To demonstrate this, all divisions are over 90% with both Corporate and Diagnostics & Specialties achieving 95%: Per professional group, AHPs and Nursing and Midwifery are also over 90% in all subjects, in contrast with the highest number of red scores (under 70%) seen in the Medical staff training grades. Interestingly, this group has achieved 100% in two subjects – infection control and safeguarding adults so further investigation will take place in the New Year to determine what has made the difference in how the topics are covered for this staff group. At 99% Trust compliance (safeguarding children level 1 and infection control level 1), and 98% (Health and Safety and Equality & Diversity) these topics are at an all-time high compliance rate and are all delivered by interactive eLearning suggesting this is an accessible route for staff. Topics including Manual Handling Practical and Basic Life Support are performing less well as there is no option but to be delivered face to face at least in part, but are reduced to very small numbers for social distancing and a further reduction in available rooms as the education centres are redeployed to deliver the Hospital Hub vaccination programme.

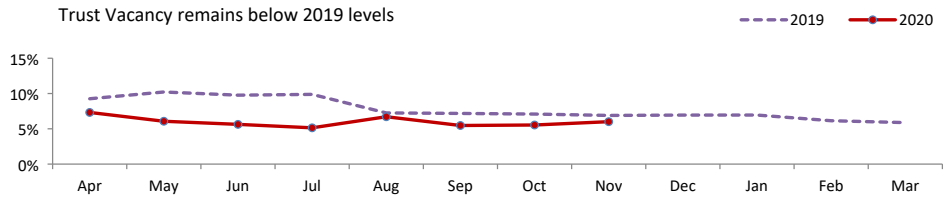
Strategic Measure	Performance	Exception Report
Absence rate to meet best peers from model hospital and aim to reduce by 1% per annum	 For full performance trend see TAB 1, appendix 1	**Non-Covid absence** remains low and below 2019 figures (3.69%). However, with Covid-19 sickness absence out absence rate has increased to 5.41% We continue to recognise the risk that as we progress into 2021 we are likely to experience an increase in colleagues with mental health concerns, exhaustion and those experiencing the effects of 'burnout'. With this in mind we are placing significant focus and energy into building a more resilient staff support and psychology link worker support service, to work with our existing Staff Advice and Support Hub and Employee Assistance Programme. This is being enhanced with the support of phase 3 charities money and the realignment of staff support services into the People and OD Department.

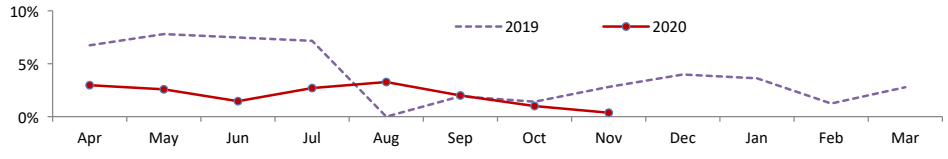
People and OD Strategy Pillar narrative

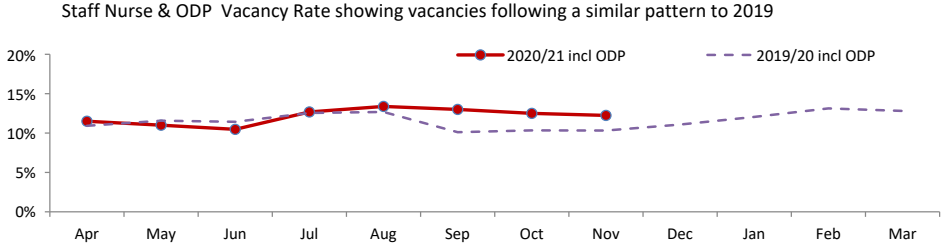
Transformation *Colleagues are organised around the patient, equipped and inspired to deliver the best care for everyone*		Within the transformation pillar most of the initiatives have met the year 1-2 metrics set these include; - Delivering the best professional education, learning and development; - Delivering new patient pathways within the Trust and ICS; - Delivering digital and technological efficiencies for people processes; - Delivering upon the University Hospital Status ambition.
Workforce Sustainability *A caring, compassionate and skilled workforce. A Trust able to attract, retain and develop the best people*		The workforce sustainability pillar is rated Green. Progress has included: - The design of a talent management system; - Improved retention of colleagues, best in class stability and turnover indexes; - Development of new roles and career paths; - Delivery of 5 year workforce plans to better understand future supply and demand needs; - Workforce and education collaboration within the ICS; - Improved student experience and placement capacity.

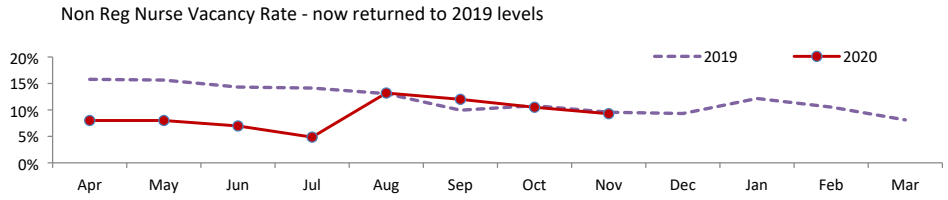
Colleague Experience *Colleagues recognise the Trust as outstanding, they feel empowered and are confident that the Trust is driven by its values and ambition to excel in patient care*		Within the Colleague experience pillar progress has commenced across many of the initiatives such as: - The development of a culture where our values are embedded in out practice and policy; - The development of the compassionate leadership framework; - Promotion of health and wellbeing services. There are a number of colleague experience initiatives which link to the final pillar, Equality, Diversity, Inclusion (EDI) and Human Rights. Progress has been made with the Board approved EDI action plan and the Widening Participation Review in particular, however there is an ongoing need to reduce colleagues experiences of discrimination, violence and aggression, bullying and harassment. Many of the colleague experience and EDI indicators link to the results of the staff survey and with the recent closure of the 2020 survey there will be a new opportunity to measure progress. Nationally participation declined due to operational pressures and challenges however our Trust achieved an overall response rate of 48%, only 1% less than 2019. Detailed results are anticipated in early 2021 however the People and OD committee will be given early sight of the raw data in February 2021 and divisions will receive their detailed analysis as these are released.
Equality Diversity, Inclusion and Human Rights *Colleagues will recognise we act with fairness, respect, equality, dignity and encourage autonomy. Colleagues will recognise that this is central to our values and behaviours*		See narrative above

Gloucestershire Hospitals NHS Foundation Trust

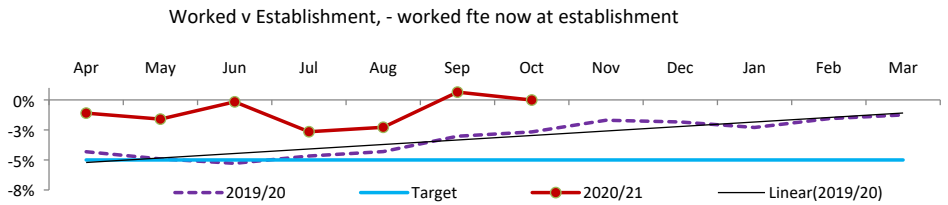
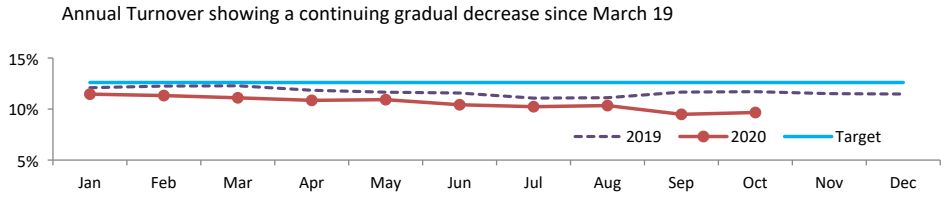
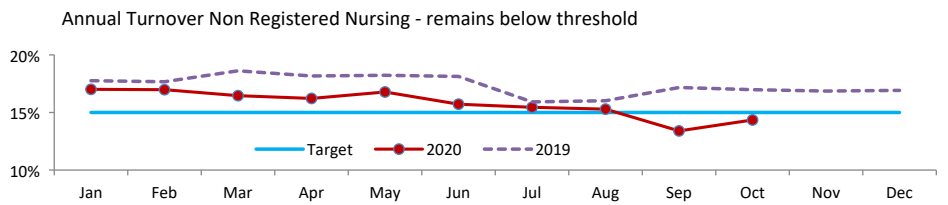
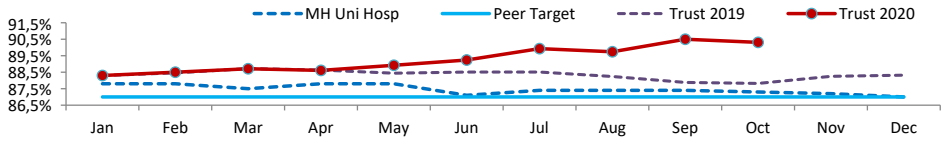
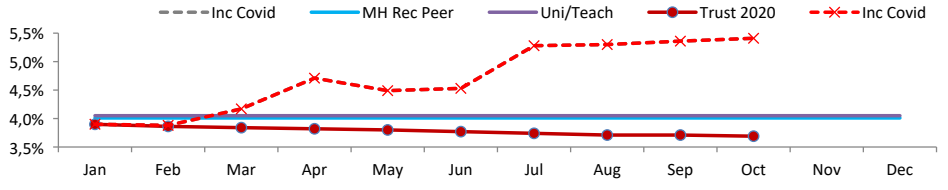
Measure	Description	mar-20	nov-20	Trend	Variation
Trust Vacancy Rate	The difference between the establishment and the staff in post as a percentage of establishment. From June 20, this is calculated using establishment on ESR.	5,88%	6,10%		November's vacancy rate of 5.14% has been calculated from establishment data loaded onto ESR. The % Rate represents 426 vacancies Trustwide, an increase of 38 from October. November figures are given since there were a large number of changes to establishment applied on 25th of November. These were monthly changes effective from September, but could only be applied together by ESR.

Measure	Description	mar-20	nov-20	Trend	Variation
Doctor Vacancy Rate	The difference between the establishment and the staff in post as a percentage of establishment. From June 20, this is calculated using establishment on ESR	2,78%	0,37%		The 0.37% vacancy rate translates to a shortfall of 3.4 fte. Estab has reduced by 10 over the last 3 months which explains the VR reduction. The true rate is less than this, the next step following on from the establishment /ESR project is to identify additional PAs funded and contracted. Calculating Addit PAs paid separately, gives an equivalent of 31.7 fte worked in August.

Measure	Description	mar-20	nov-20	Trend	Variation
Staff Nurse /ODP Vacancy Rate	The difference between the establishment and the staff in post as a percentage of establishment. From June 20, this is calculated using establishment on ESR.	12,81%	12,24%		The August Staff Nurse/ODP vacancy rate of 12.24% is represented as a reduction to the last report to POD.

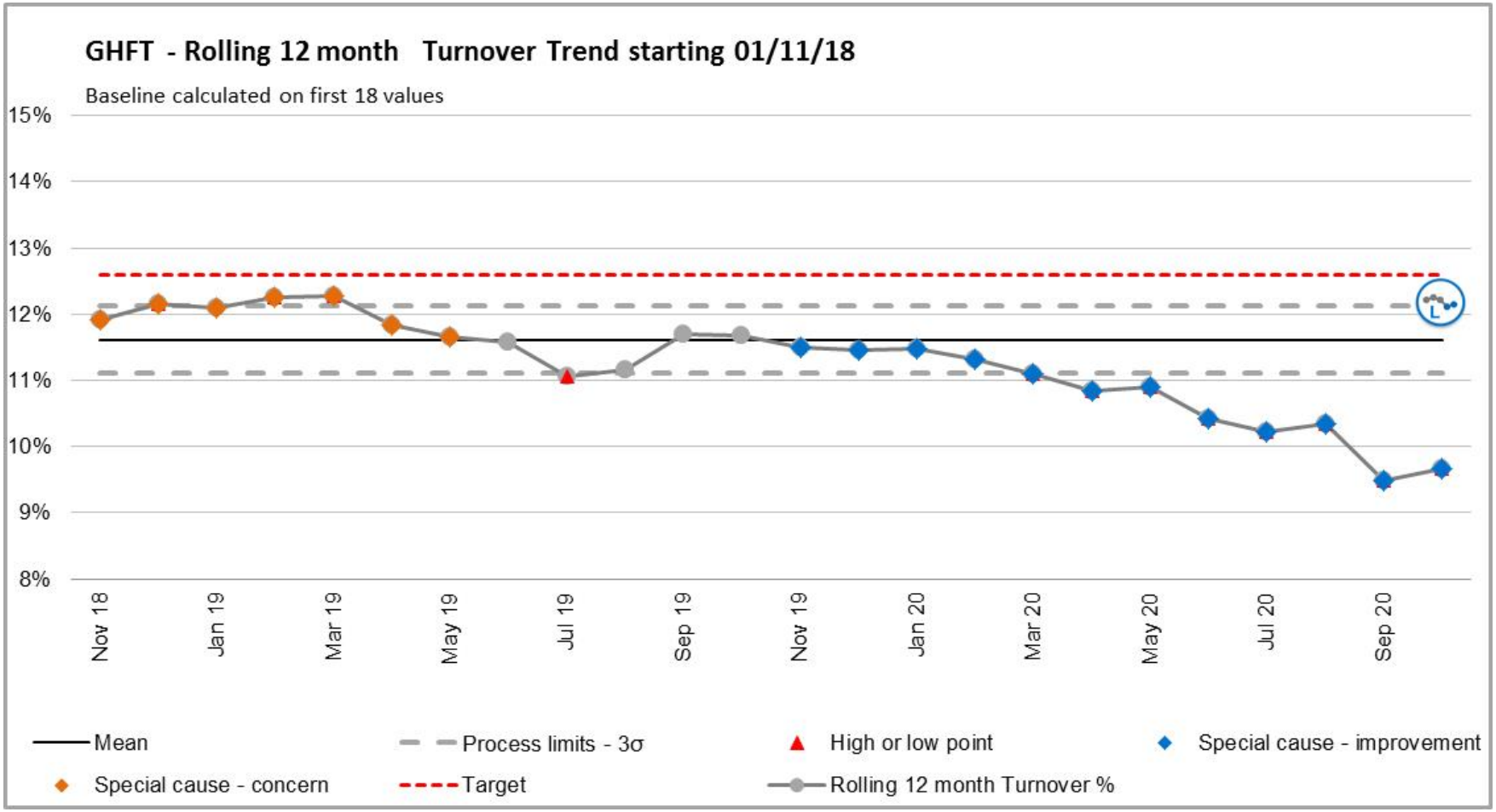
Measure	Description	mar-20	nov-20	Trend	Variation
Non Reg Nursing Vacancy Rate	The difference between the establishment and the staff in post as a percentage of establishment.	8,11%	9,28%		November's vacancy rate remains at 2019 levels. The influx of Year 2 nursing students to support staff during Covid (78 fte) temporarily reduced the vacancy rate. These students have now left and vacancies have therefore increased. Turnover also reduced during Covid but is now increasing again.

Gloucestershire Hospitals NHS Foundation Trust

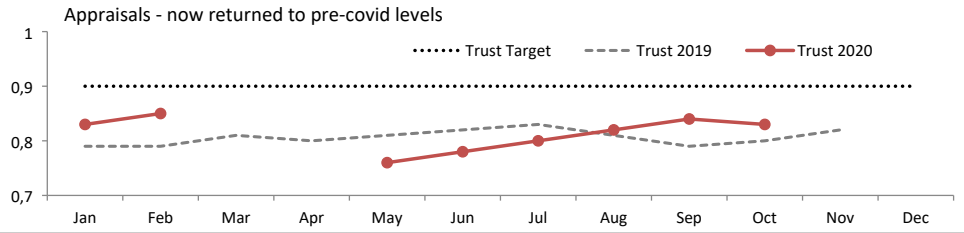
Measure	Description	mar-20	okt-20	Trend	Variation
Worked vs Establisment %	The difference between the establishment and worked fte as a percentage of establishment. Target in line with Monthly BI reporting. (0 to -5% is 'green'))	-1,25%	-0,01%		Worked fte increased steadily from June 2019 to November , picking up in February after a downturn in the winter months. April May and June have seen an increase in worked fte due to Covid. July & August have seen a reduction in worked numbers as the effect of Covid has eased.
12 Month Rolling Turnover Link to SPC chart	Turnover is the no of leavers (in fte) expressed as a % of the ave numbers (fte)over the period. It is based on permanent contracts only.Trust target 12.6% (Top quartile of Model Hospital Peer Group)	12,60%	9,66%		Additional Clinical Services as a Staff Group have the highest turnover to Oct 20 at 12.8% - this is the group where non-registered nursing staff are located. All other Staff Groups are below the 12.6% threshold. Medicine Division is now below the threshold, at 12.4%. The other three Clinical Divisions have a turnover rate below 10% Turnover since March 19 has been consistently lower than at the same period the previous year.
Non- Reg Nursing 12 Month Turnover	Non - registered nursing includes HCAs, Apprentice HCAs, Trainee Nursing Assistants. Threshold 15% This figure not avail from MH.	16,46%	14,35%		Of the clinical divisions, Medicine has the highest Turnover rate for non registered nursing staff at 17.4% (49.9 fte leavers). To give this figure context, Women & Children TO rate is 12.6% & Surgery is 12.4%. Surgery employs a similar number of Non Reg nursing staff as Medicine. Within Medicine Division, Goam/Neurology/Stroke is the Service Line with the lowest turnover rate at 13.2%
Nurse Retention Rate %	The percentage of nursing and health visitors that remained stable over 12 months period. Latest data from Model Hospital is Dec 18. University/Teaching Peer rate was 87%, MH recommended Peer rate 86.8% (NB excludes Midwifery)	88,71%	90,31%		Model Hospital data is calculated slightly differently to ESR, resulting in a figure approx 0.5% higher. The latest available from MH is December 18. Trust Nurse retention is showing a slight increase over the covid months. Turnover has reduced in this period, however there are signs that leavers/turnover is rising slightly.
Annual Sickness Absence % Link to SPC Chart	Sickness Absence is expressed as a percentage of fte lost /available fte. The Uni/Teaching Hospital Peer rate from MH is 4.05%. MH recommended peer rate is 4.01%	3,84%	3,69%		Without Covid , Trust annual sickness absence is reducing and remains below 2019 figures. From the beginning of March, absence due to self-isolation or actual Covid infection has a marked effect on the absence rate , rising from 3.81% to 5.41%. For Oct 20, 'normal' sickness was 3.69% and Covid absence was another 0.93%. Covid absence is down from a high of 6.75% in April. Additional Clinical Service & Nursing and Midwifery for October inc Covid were 6.94 % and 5.61% respectively. Women & Children Div Division had the highest covid inclusive rate for Oct 20 , at 6.23%.

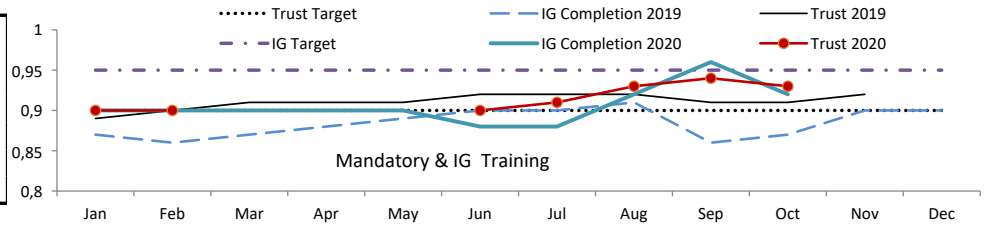
GHFT 12 month rolling turnover SPC chart

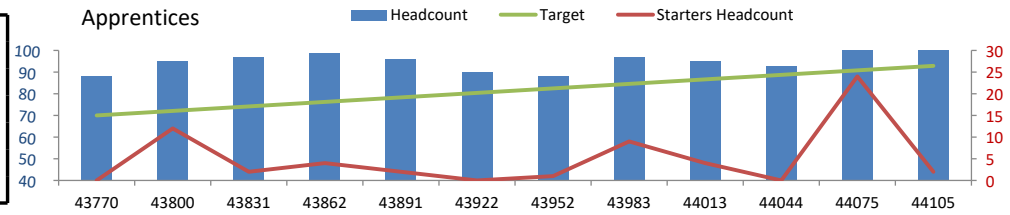
There has been a statistically significant reduction in Trust Turnover since April 2019 and a marked fall since May 2020, almost certainly down to Covid Lockdown etc.



Gloucestershire Hospitals NHS Foundation Trust

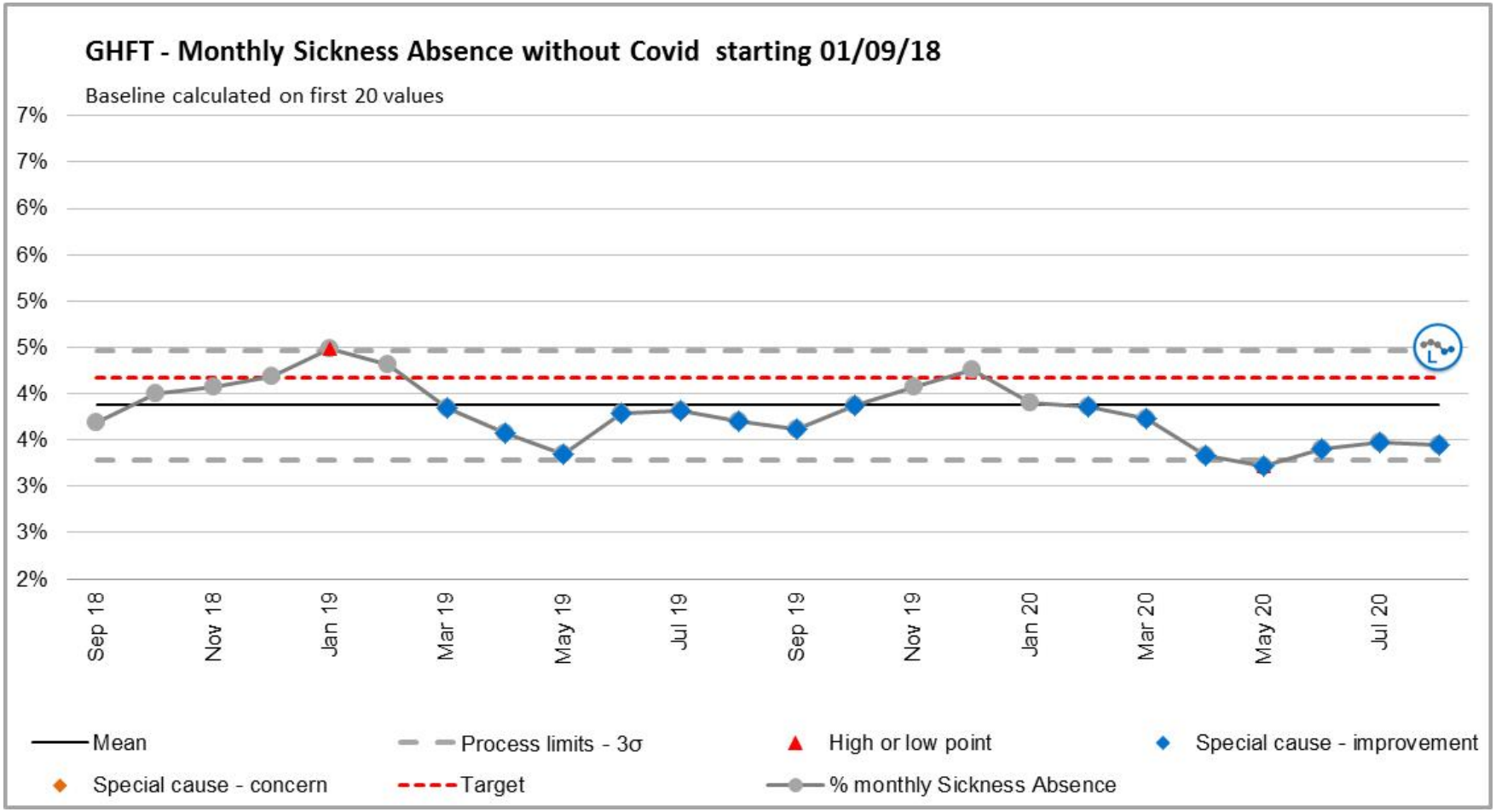
Measure	Description	okt-19	okt-20	Trend	Variation
Appraisals	% of Appraisals completed in previous 12 months. Excludes: Bank, staff joining Trust in the last 10 months (12 months for Medical staff) , staff on Maternity & adoption leave, suspended, external secondment, career break, Junior medcal staff.	80,00%	83,00%		Trust Appraisal rate has returned to 83%. Lowest Divisional Appraisal rate is Corporate with 77%. This is the Division which will have the highest proportion of staff working from home. No Division has reached target, Surgery is closest with 87% .

Measure	Description	jun-19	okt-20	Trend	Variation
Mandatory Training	Compliance rate is expressed as a percentage of number of completions meeting requirement /number of completions required. NHS Digital have set a national requirement to achieve a compliance target of 95% for Information Governance Training.	92,00%	93,00%		The Trust is above target (93% overall for Mandatory Training) .IG Training completion has fallen slightly to 92% from a 96% high in September 20. For IG, Corporate, Diagnostics , Medicine and W&C are close to target at 93%, Surgery are at 91%. For other Mandatory Training, Corporate & Diagnostics are above target at 95 % and the other Divisions are over the 90% target.

Measure	Description	okt-19	jun-20	Trend	Variation
Apprentice Recruitm'nt	The number of apprentices in post including starters per month. The target is an additional 10 apprentices in each Division by Y2.	90	118		The Apprentices in this report are those employed into an Apprentice post or a current employee who has transferred into one. Trainee Nursing Associates are also apprentices. Excluded are those who are undertaking training funded by the Apprenticeship levy in their current role .

GHFT monthly sickness Absence SPC chart

The SPC chart clearly demonstrates the seasonal variations in sickness absence rate. Although This could be illustrated equally well on a simple run chart, this report will continue with SPC charting to monitor high/low points.

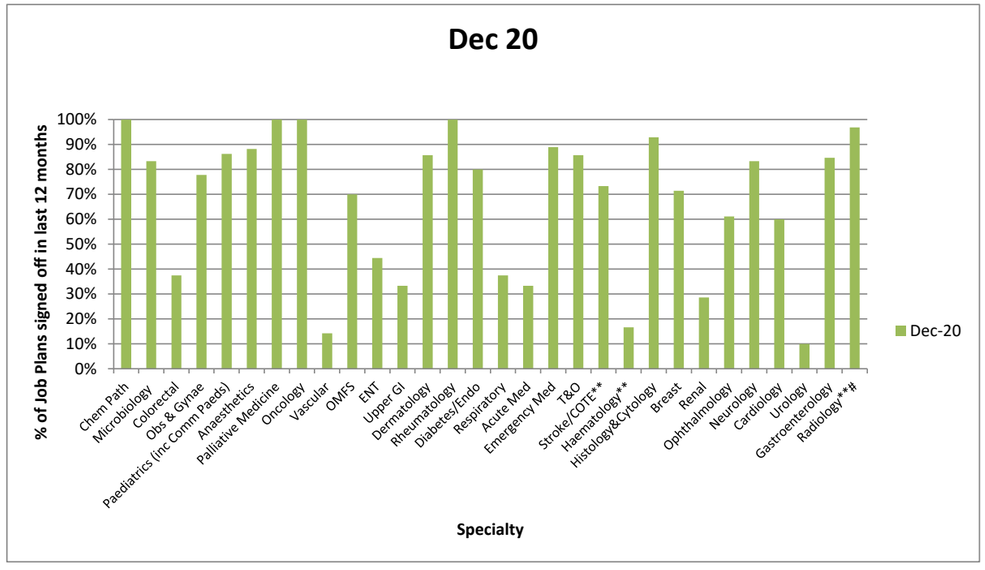


Specialty	Total No Consultants	No. JPs signed off in last 12 months as @ early Dec 20
Chem Path	2	2
Microbiology	6	5
Colorectal	8	3
Obs & Gynae#	18	14
Paediatrics (inc Comm Paeds)	29	25
Anaesthetics#	68	60
Palliative Medicine	4	4
Oncology	17	17
Vascular	7	1
OMFS	10	7
ENT	9	4
Upper GI	6	2
Dermatology	7	6
Rheumatology	6	6
Diabetes/Endo	5	4
Respiratory	8	3
Acute Med	9	3
Emergency Med	18	16
T&O	28	24
Stroke/COTE**	15	11
Haematology**	6	1
Histology&Cytology**	14	13
Breast	7	5
Renal	7	2
Ophthalmology	18	11
Neurology	6	5
Cardiology	10	6
Urology	10	1
Gastroenterology	13	11
Radiology**#	32	31
Total	403	303

Notes

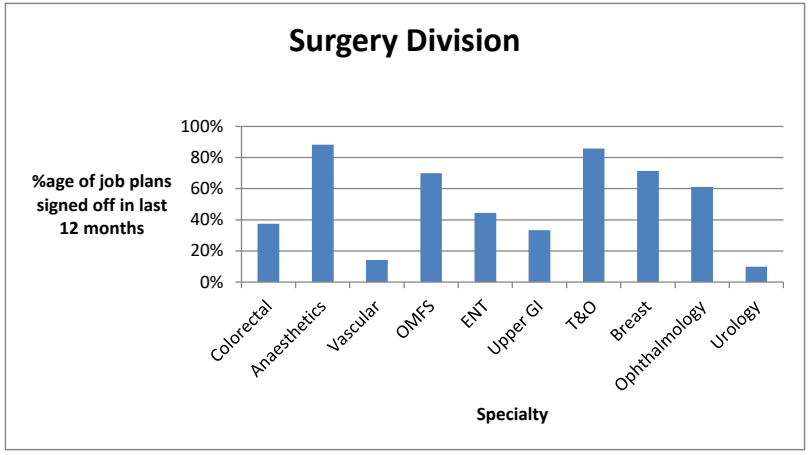
**One cons on long term sickness, number reduced
One cons on mat leave, number reduced

Specialty	Total No Consultants	% JPs signed off in last 12 months as @ early Dec 20
		Dec-20
Chem Path	2	100%
Microbiology	6	83%
Colorectal	8	38%
Obs & Gynae	18	78%
Paediatrics (inc Comm Paeds)	29	86%
Anaesthetics	68	88%
Palliative Medicine	4	100%
Oncology	17	100%
Vascular	7	14%
OMFS	10	70%
ENT	9	44%
Upper GI	6	33%
Dermatology	7	86%
Rheumatology	6	100%
Diabetes/Endo	5	80%
Respiratory	8	38%
Acute Med	9	33%
Emergency Med	18	89%
T&O	28	86%
Stroke/COTE**	15	73%
Haematology**	6	17%
Histology&Cytology	14	93%
Breast	7	71%
Renal	7	29%
Ophthalmology	18	61%
Neurology	6	83%
Cardiology	10	60%
Urology	10	10%
Gastroenterology	13	85%
Radiology**#	32	97%
TOTAL	403	75%



Specialty	Total No Consultants	No. JPs signed off in last 12 months as @ early Dec 20	Notes
Colorectal	8	3	
Anaesthetics#	68	60	
Vascular	7	1	
OMFS	10	7	
ENT	9	4	
Upper GI	6	2	
T&O	28	24	
Breast	7	5	
Ophthalmology	18	11	
Urology	10	1	
Total	171	118	

One cons on mat leave, number reduced

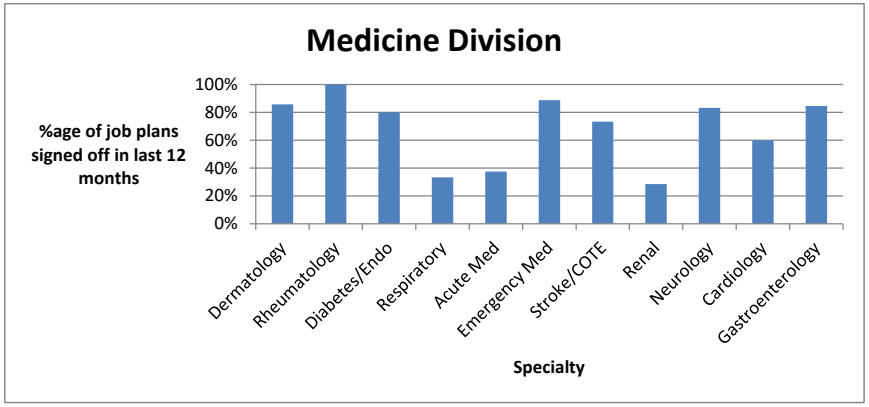


Specialty	Total No Consultants	% JPs signed off in last 12 months as @ early Dec 20
Colorectal	8	38%
Anaesthetics	68	88%
Vascular	7	14%
OMFS	10	70%
ENT	9	44%
Upper GI	6	33%
T&O	28	86%
Breast	7	71%
Ophthalmology	18	61%
Urology	10	10%
TOTAL	171	69%

Specialty	Total No Consultants	No. JPs signed off in last 12 months as @ early Dec 20	Notes
Dermatology	7	6	
Rheumatology	6	6	
Diabetes/Endo	5	4	
Respiratory	9	3	
Acute Med	8	3	
Emergency Med	18	16	
Stroke/COTE *	15	11	
Renal	7	2	
Neurology	6	5	
Cardiology	10	6	
Gastroenterology	13	11	
Total	104	73	

* Number reduced by 1 for long-term sickness

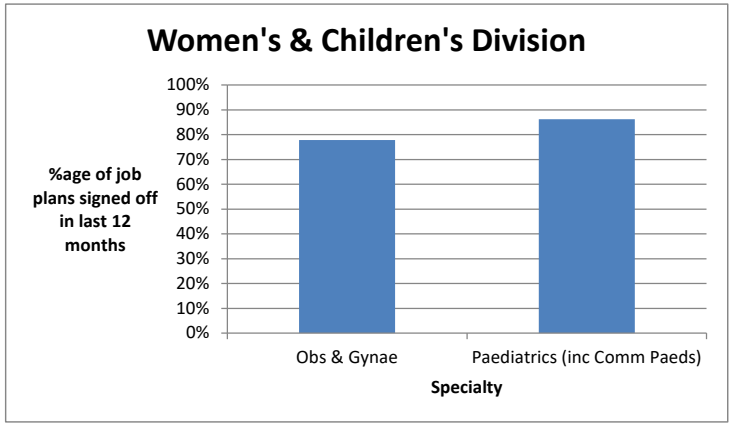
Specialty	Total No Consultants	% JPs signed off in last 12 months as @ early Dec 20
Dermatology	7	86%
Rheumatology	6	100%
Diabetes/Endo	5	80%
Respiratory	9	33%
Acute Med	8	38%
Emergency Med	18	89%
Stroke/COTE	15	73%
Renal	7	29%
Neurology	6	83%
Cardiology	10	60%
Gastroenterology	13	85%
TOTAL	104	70%



Specialty	Total No Consultants	No. JPs signed off in last 12 months as @ early Dec 20	Notes
Obs & Gynae#	18	14	
Paediatrics (inc Comm Paeds)	29	25	
Total	47	39	

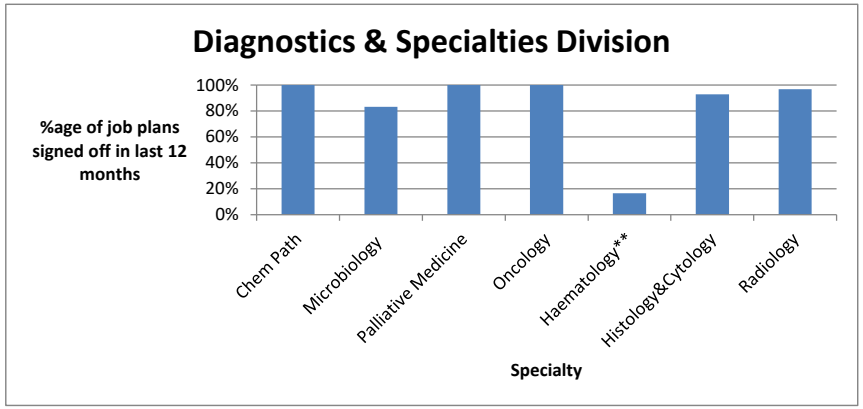
One cons on mat leave, number reduced

Specialty	Total No Consultants	% JPs signed off in last 12 months as @ early Dec 20
Obs & Gynae	18	78%
Paediatrics (inc Comm Paeds)	29	86%
TOTAL	47	83%



Specialty	Total No Consultants	No. JPs signed off in last 12 months as @ early Dec 20	Notes
Chem Path	2	2	
Microbiology	6	5	
Palliative Medicine	4	4	
Oncology	17	17	
Haematology**	6	1	
Histology&Cytology**	14	13	
Radiology**#	32	31	
Total	81	73	

**One cons on long term sickness, number reduced
One cons on mat leave, number reduced



Specialty	Total No Consultants	% JPs signed off in last 12 months as @ early Dec 20
Chem Path	2	100%
Microbiology	6	83%
Palliative Medicine	4	100%
Oncology	17	100%
Haematology**	6	17%
Histology&Cytology	14	93%
Radiology	32	97%
TOTAL	81	90%

Gloucestershire Hospitals
NHS Foundation Trust

REPORT TO TRUST BOARD – January 2021

From the People & Organisation Development Committee Chair – Balvinder Kaur Heran, Non-Executive Director

This report describes the business conducted at the People and Organisational Development Committee on 22 December 2020 indicating the NED challenges made and the assurances received and residual concerns and/or gaps in assurance.

	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
Performance Dashboard by exception	Metrics remain positive and in the upper quartile for peers and University Hospital Trusts. National recruitment and retention data shared and how the trust compares with South West Trusts which is favourable. People and OD teams are working with medicine on their retention programmes relating to Health Care Assistants. Appraisal compliance in the Corporate division is low.	How can we quantify improvements in data sets as real benefits to staff? How are we focusing on the chronic staff workload? What are we doing to ensure time is put aside for this key activity especially when so much is being asked of our staff? Having that one to one time is important to wellbeing and feeling valued.	Good assurance received across reduction in absence and turnover, improvements in stability reduction in agency spend, locum use, cost of recruitment, on boarding and training and reducing costs associated with absence and back fill. Efforts to recruit and fill gaps with permanent or temporary resources and build on career pathways assists with workload. Funding will come forward to improve nurse establishment as part of the 3-year investment agreed in 2019. Right sizing establishments is a priority for the Director of Nursing, notwithstanding national shortages will impact growth	Committee to be updated on medicine division staff retention and recruitment Committee to be kept updated on appraisal performance

	Statutory mandatory training continues to meet targets. Staff survey response rate was reported at 48% compared to 49% last year. An increase in response rates in medicine was noted.	Any view on the effectiveness of virtual training?	ambitions. The plan is to research the impact and effectiveness of training. Much training is virtual face to face training. National bodies are also researching value and effectiveness of this platform.	Present outcome of research to ensure the most effective training channels are being used.
Board Assurance Framework (BAF) quarterly review	Update on the principal risks was received. There were no changes to the risks and no closures of principle risks which remain at 7. RAG rated progress was green for Compassionate Workforce objective, green for Involved People and Amber for Research. Ratings were agreed. The committee noted the good progress on the Equality, Diversity and Inclusion priorities.	Are Divisions who need to deliver some of the people initiatives able to with operational pressures? How does the Trust decide what to pause? Is the Primary Care Network (PCN) risk of competing for resources satisfactorily captured or has this changed? Is the RAG rating correct? Is the rating about process or outcome	Divisions have paused some items. Priorities are discussed in the weekly Task and Finish group and at Executive review. New governance suggested to oversee role development within PCNs will reduce risks. The limited progress in PCNs to create new roles is a consequence of COVID so the risk of losing staff has lowered. Many PCN's haven't yet agreed their framework for recruiting to new roles. The Board Assurance Framework is about reducing risks to achieving the objectives over the 5-year period. The RAG rating is not necessarily about the outcome or achievement of the objective but the level of confidence to manage the	

			principle risks which ay destabilise. Other reports provide the detail of the work described in the BAF such as the Dashboard and the People and OD Strategy update which provides detail on process and outcome.	
Resourcing Update	A 6-month review of activity was provided, and progress noted specifically that: Resourcing support for COVID and mass vaccinations continues; Agency spend across all staff groups is adverse to target but progress has been made with £1.3 million reduced spend compared to last year; Agency fill continues to lower in favour of our internal bank. 65% of gaps are filled by the internal bank for nurses, 85% for Health Care Assistants Savings from direct engagement changes were noted; 600 temporary workers were recruited, inducted and deployed or COVID; International candidates continue	How can we understand the impact of mass vaccinations has on teams? Our hiring time is poorer than our peers. How can this be improved? Any observations on impact of COVID on supply?	The programme has had an impact on delivery of other priorities within resourcing such as amendments to the Recruitment and Selection Policy Pre October no mechanisms to establish time to hire. Assurance received that the new recruitment system, Trac recruitment allows measurement of processes and understand the blockages to resolve and/or change. There is an expectation to understand what we can change or improve with a few months. Seen fewer people moving between hospitals and locations. Seen more interest in non-clinical and Health Care assistants' roles, but unclear if this interest is about a new career or if employment has been lost.	Review impact on other priorities and their resourcing

	and additional funding from NHSE/I secured. The Trust Vacancy position has improved			
HEE CPD Funding	Assurance on how funding will be managed and spent by the end of the financial year. The funding enables development of practice education, coaching, research and improved training needs analysis. University links are being strengthened as courses are in development for registrants.	How are registrants involved in decision making on spending?	Assurance received that RCM/RCNs are part of the working group to ensure registrants understand what the CPD funding can be used for. Staff side have signed off plans and all training and development requests will link in with appraisals so registrants can consider what education they wish to access.	
Freedom to Speak Up update	In Q2 there were 19 cases. This is a decline from Q1. Fewer cases are now anonymous	Is the effect of line manager behaviour evident in the data? Why is analysis against protected characteristics still unreported?	There are reports around manager behaviour. Colleagues often come forward to Guardians instead of managers. This is not necessarily a reflection of their relationship with manager rather a preferred route to raising concerns. The DPIA (data protection impact assessment) team are not supportive of the Trust capturing the data and conversations continue.	Review outcome of discussions and impact of not capturing the data.
Staff health and wellbeing	A review of the Staff 2020 hub successes was provided and an	How can the psychological link worker help staff groups	Attention currently focussed on the COVID wards. Resource is 2	Review wider needs outside of

update	overview of trauma related training and proposals on improving support mechanisms for staff provided. Both reports were well received.	who won't or don't come forward? Is there anything that the team is frustrated about and wish could be done differently?	days a week but difficult to get staff released from their duties to speak to the psychologist. Looking at ways to working collaboratively with the matrons and utilise 'time to talk' initiatives being explored. There is a weekly meeting help to consider areas the Trust believe may need support. Keen to expedite the use of the national charities money to secure more full-time resources. The team have been constrained in terms of what they can offer due to resources. Wish to push forward the TRIM agenda with more pace but capacity issues within health and wellbeing space need to be resolved.	Covid wards and capacity required to widen this initiative.

Research and University Hospitals Update	COVD raised the profile of the research teams and we became the top recruiting Trust for Public Health research in the South West and 3rd in the country for SIREN testing Recruited 3985 patients vs 1800 in 2019 into various programmes University Hospital progress has involved the team looking at how to become a University Hospital System. Working with Research 4 Gloucester and holding progress discussions with universities. The ICS Board has been approached on creating a One Gloucestershire Research System and an application will be drafted.	Has funding been secured for University Hospital status?	Funding aimed to help the Trust to gain University Hospital Status not been achieved. Learning from other providers who have secured the status confirms the need to balance education and research. Emphasis on education agenda where good progress has been made will be highlighted on future applications.	
Progress against the People and OD Strategy and People Plan	The progress against the People and OD strategy was noted and assurance taken.	Are red ratings fair? Do they reflect delays? What are the main issues of concern?	Reds are either missed targets such as time to hire or an item that has not progressed such as the ICS high potential development scheme. Capacity within the senior team due to taking on additional tasks. A request for increased resources to be reviewed and impact on capacity to take on additional duties to be reviewed. Does not currently feature on any	Committee to receive progress updates on capacity to deliver on priorities

		How does this currently feature on the risk register or another forum?	risk registers as team did not want to highlight this publicly. The comments and concerns raised by the team need to be better understood. A clearer approach to understanding the challenges and pressures the team are under when new pressures and additional demands are required is critical especially given the comments around the pressures the team faced during the last few months. A review of capacity/current pressures to gain a better understanding and provide a forum to prioritise work against capacity available.	Committee to receive update on how capacity issues are reflected as part of Trust governance processes

Board note/matter for escalation
None

Balvinder Kaur Heran
Chair of People and OD Committee
22 December 2020

Gloucestershire Hospitals
NHS Foundation Trust

TRUST BOARD – 14TH JANUARY 2020
MS TEAMS commencing at 12:30

Report Title
Financial Performance Report **Month Ended 30th November 2020**
Sponsor and Author(s)
Author: Johanna Bogle, Associate Director of Financial Management Sponsor: Karen Johnson, Director of Finance
Executive Summary

Purpose

This purpose of this report is to present the Financial position of the Trust at Month 8 to the Board.

Key issues to note

Month 8 overview

At Month 8 we recorded a £0.9m surplus, compared to a planned deficit of £1.1m. This means that we were better than plan by £2.0m. This is as a result of incurring less cost than forecast, due to performing less activity than plan in month. There was also additional unexpected income from HEE where cost had already been incurred in prior months.

Our activity was 16% down compared to our planned level of activity, and down 3% compared to month 7. This was due to the second surge of Covid, and is expected to impact our month 9 activity and finances as well.

We have not assumed a financial penalty against missing elective incentive funding activity targets within our financial position.

Forecast Outturn

We submitted a M7-12 plan that costed the delivery of required activity levels, alongside Winter pressures, but excluding any Covid 2nd surge, at £336m. Due to the improvement against plan in months 7 and 8, and some additional block income from NHSE revisiting their earlier calculation, we have reduced our forecast outturn by £3.9m, which means that we are now forecasting a deficit of £11.6m. This includes an annual leave provision, as required nationally. The system forecast has not yet been updated to include the improvement to our Trust forecast.

Next Year

We are still working through what our exit run rate will look like, in order to inform discussions moving into 2021/22. Funding for next year is unknown, but it is likely that system allocations will again play a part and systems will be encouraged to share risk.

Capital

As at M8 the Trust have delivered £13.6m of the capital programme, with a Forecast spend of £40.8m for the year. The delivered spend represents an underspend of £3m against the year to date profile. A targeted action plan has been developed to gain assurance over the forecasts and capture the key risks around delivery. The initial focus will be on the schemes with the largest amount still to spend. This work is expected to conclude in December.

Conclusions

Note the Trust is reporting a year to date deficit of £3.5m, £3.1m better than the planned £6.6m deficit. The position does not include any financial penalties for under-achievement of activity against the elective incentive scheme.

Note that the system forecast deficit is £28.4m for the second half of the year, when there is no retrospective true-up. This does not yet include the improvement to our Trust forecast.

Note that the GHFT deficit forecast for the second half of the year is £11.6m, an improvement of £3.9m. This includes an annual leave provision, and the expectation that the Gen Med Vat provision is not supported by NHSE, despite us continuing to push for this to be funded.

Implications and Future Action Required

To continue the report the financial position monthly.

Recommendations
The Board is asked to receive the contents of the report as a source of assurance that the financial position is understood and under control.

Impact Upon Strategic Objectives
This report updates on our progress throughout the financial year of the Trust's strategic objective to achieve financial balance.

Impact Upon Corporate Risks
This report links to a number of Corporate risks around financial balance.

Regulatory and/or Legal Implications
No issues for regulatory of legal implications.

Equality & Patient Impact
None

Resource Implications			
Finance	**X**	Information Management & Technology	
Human Resources		Buildings	

Action/Decision Required							
For Decision		For Assurance	**X**	For Approval		For Information	

Date the paper was presented to previous Committees and/or Trust Leadership Team (TLT)							
Audit & Assurance Committee	**Finance & Digital Committee**	**Estates & Facilities Committee**	**People & OD Committee**	**Quality & Performance Committee**	**Remuneration Committee**	**Trust Leadership Team**	**Other (specify)**

Outcome of discussion when presented to previous Committees/TLT

NHS
Gloucestershire Hospitals
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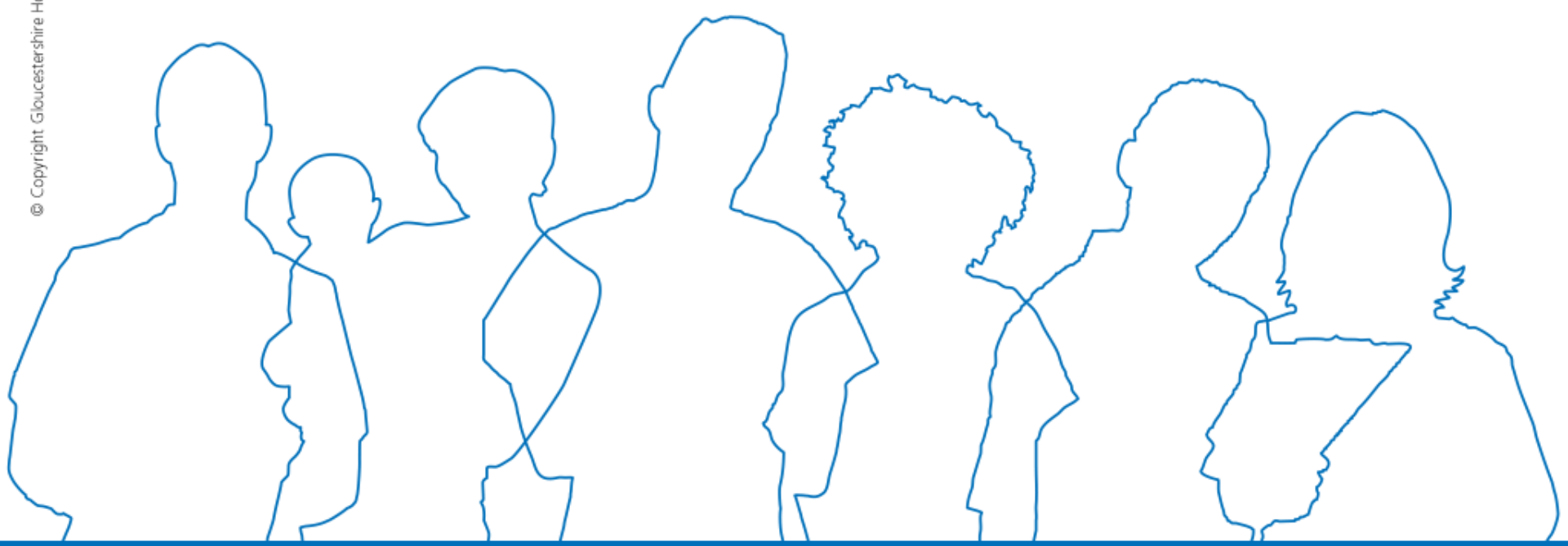
Report to the Trust Board

Financial Performance Report
Month Ended 30th November 2020



Director of Finance Summary

Gloucestershire Hospitals NHS Foundation Trust

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Month 8 headlines

Gloucestershire Hospitals NHS Foundation Trust

Headline	Compared to plan	Narrative	Change from last month
I&E Position YTD is £3.5m deficit.		Overall YTD financial performance is £3.5m deficit. This is £3.1m better than plan.	
Income is £425.0m YTD.		YTD £1.7m better than plan, due to income for private patient activity, injury cost recovery and pass-through drugs being higher than forecast, as well as some retrospective income from Higher Education England coming through in Month 8. There are currently no Elective Incentive Scheme provisions against our block income for missing national activity targets.	
Pay costs are lower than plan at £270.3m YTD.		YTD this is £1.5m lower than plan. This is due to lower activity than expected in October and November, with an associated reduction in temporary staff costs.	
Non-Pay expenditure is slightly worse than plan at £158.5m.		YTD this is £0.2m worse than plan. There are a number of small movements contributing to this position, including the additional pass-through drugs compared to plan, which are offset by income.	
CIP schemes on plan for 20/21.		As long as we are within our overall plan for 2020/21, CIP is delivered for this year. The budget setting process has now started, and will be aiming to identify CIP for 2021/22	
Capital expenditure is £13.7m YTD		Capital spending is £3.0m behind plan YTD but forecasting to spend the full £40.4m by year end.	
The cash balance is £90.3m		Cash is £15.9m more than plan. This is due to receipt of top-up cash from Gloucestershire CCG that was outstanding from previous months.	

Latest forecast position

Gloucestershire Hospitals NHS Foundation Trust

The Trust submitted a deficit planned position for the 20/21 year that amounted to £15.5m.

In Month 7, we improved our forecast by our in-month variance to plan of £1.0m. We were then informed of an increased national block adjustment relating to billing that was not part of the M8-10 calculation of £0.9m, and finally month 8 again saw a positive variance to plan that we are showing in our full year forecast.

	Current Forecast for 2020/21 - Updated at Month 8						
	Original H2 Forecast Outturn 20/21	M7 variance to plan improving Forecast Outturn	M8 Confirmation of additional Block Income	M8 variance to plan improving Forecast Outturn	Revised H2 Forecast Outturn	M1-6 Actuals 20/21	Full Year Forecast 20/21
Income	- 320,566		- 851	- 504	- 321,921	- 316,183	- **638,104**
Pay	212,937			- 1,549	211,388	202,419	**413,807**
Non Pay	123,145	- 1,020			122,125	113,764	**235,889**
Surplus / Deficit	**15,516**	**- 1,020**	**- 851**	**- 2,053**	**11,592**	**-**	**11,592**

YTD True-Up Funding agreed by NHSE

Gloucestershire Hospitals NHS Foundation Trust

For Months 1-6 the Trust was under a retrospective top-up arrangement. This meant that the Trust was expected to breakeven and, in order to do so, had to assume retrospective top-up income equivalent to any overspend. In total for the first half of the year, the Trust applied for £21.9m. This was made up of £15.2m of Covid-19 costs so far this year, plus the Gen Med VAT provision of £4.2m, plus other overspends of £2.5m compared to the nationally-calculated block funding.

NHSE have not yet transacted a true-up provision for Gen Mad VAT – we will continue to push this. The balance of the Month 6 true-up has been agreed and is expected to be paid to us on 15/12/2020.

To date we have received £19.3m. We continue to push the requirement for £4.2m in discussions with NHSE.

NHSE True-Up Income Position	Value (£'000)
True-Up M01 Paid	1,757
True-Up M02 Paid	1,769
True-Up M03 Paid	3,811
True-Up M04 Paid	3,627
True-Up M05 Initially Applied	6,505
True-Up M05 Rejected - Gen Med VAT	(4,200)
True-Up M05 Rejected - PDC (error in accts corrected)	(733)
True-Up M05 Revised Paid	1,572
True-Up M06 Unvalidated - Repeat of Gen Med	4,200
True-Up M06 Paid	5,145
Grand Total (Revised) True-Up YTD	**21,881**

Financial Position Compared to Plan

Gloucestershire Hospitals NHS Foundation Trust

We are reporting £2.05m better than plan in Month 8. This is predominantly around clinical underspend linked to reduced activity, but is also as a result of better income performance than expected, namely through HEE (costs already seen but income only recently confirmed) and private patients / overseas / road traffic / pass-through drugs income. It should be highlighted that the private patients and overseas income benefits are not expected to continue at this level moving forward.

For the year to date (YTD) we show a favourable variance to plan of £3.07m. Again, this is mainly as a result of reduced activity and higher-than expected income.

Feeding these favourable results through into our forecast, as well as the additional block income NHSE have now awarded us, we expect to improve against plan by £3.9m, reducing our £15.5m deficit to £11.6m deficit.

	In month Forecast	Actuals M08	In month variance	YTD Forecast	YTD Actuals	Variance to YTD Forecast	Original Full Year Forecast	Adjustments	Revised Full Year Forecast
Pay	34,328	33,546	782	263,235	262,146	1,089	412,056	(1,549)	410,507
Non Pay	18,682	18,720	- 38	143,067	143,354	- 287	224,391	(1,020)	223,371
Covid Costs	1,066	771	295	17,285	16,807	478	6,394	0	6,394
Non-operating Costs	803	767	36	6,598	6,509	89	9,869		9,869
Remove impact of Donated Asset Depreciation	(37)	(37)	0	(297)	(297)	0	(445)		(445)
Total Cost	54,842	53,767	1,075	429,888	428,519	1,369	652,265	(2,569)	649,696
Run Rate Funding / Billable Income	(53,710)	(54,688)	978	(401,436)	(403,141)	1,705	(636,749)	(1,355)	(638,104)
Total Deficit	**1,132**	**(921)**	**2,053**	**28,452**	**25,378**	**3,074**	**15,516**	**(3,924)**	**11,592**
True-up Funding (incl Unvalidated)	0	0	0	(21,883)	(21,883)	0	0		
Grand Total Deficit	**1,132**	**(921)**	**2,053**	**6,569**	**3,495**	**3,074**	**15,516**	**(3,924)**	**11,592**

Activity Position Compared to Plan

Gloucestershire Hospitals NHS Foundation Trust

For Month 8 we delivered 84% of planned delivery. We expected to decrease activity by 3% month-on-month. While we did decrease our activity month-on-month by 3%, we were already under-performing against planned month 7 activity (which delivered 84% of plan). This reduction is attributable to the impact of Covid surge 2 and the impact on our bed base and our elective activity capacity.

The most notable area of under-delivery was surgery, where we expected to increase activity 14% month-on-month, but actually reduced by 2%.

Our financial position reflects the associated reduced variable costs of lost activity and contributes towards our position financially being better than plan, although this is to the detriment of our patients and our waiting lists.

Summary Activity Increase Month on Month - BI figures day 5

	Month 7 Plan	Month 7 Actual	Month 7 Variance	Month 8 Plan	Month 8 Actual	Month 8 Variance	Month 8 % of Plan Delivered	MoM increase / (Decrease)	Planned MoM Increase / (decrease) %	Actual MoM increase / (decrease) %
W&C	9,680	8,711	(969)	10,352	8,075	(2,277)	78%	(636)	7%	(7%)
Surgery	31,703	30,485	(1,218)	36,079	29,920	(6,159)	83%	(565)	14%	(2%)
Medicine	33,677	28,496	(5,181)	35,584	27,222	(8,362)	77%	(1,274)	6%	(4%)
D&S	258,914	211,906	(47,008)	241,545	207,208	(34,337)	86%	(4,698)	(7%)	(2%)
Corp (Unid'd)	0	513	513	0	435	435	0%	(78)	0%	(15%)
Total	**333,974**	**280,111**	**(53,863)**	**323,560**	**272,860**	**(50,700)**	**84%**	**(7,251)**	**(3%)**	**(3%)**

Balance Sheet

Gloucestershire Hospitals NHS Foundation Trust

Trust Financial Position	Opening Balance 31st March 2020 £000	GROUP Balance as at M8 £000	B/S movements from 31st March 2020 £000
Non-Current Assests			
Intangible Assets	5,851	5,201	(650)
Property, Plant and Equipment	257,352	259,857	2,505
Trade and Other Receivables	5,889	5,804	(85)
Total Non-Current Assets	**269,092**	**270,862**	**1,770**
Current Assets			
Inventories	9,121	8,992	(129)
Trade and Other Receivables	31,268	23,904	(7,364)
Cash and Cash Equivalents	37,385	90,279	52,894
Total Current Assets	**77,774**	**123,175**	**45,401**
Current Liabilities			
Trade and Other Payables	(79,872)	(78,666)	1,206
Other Liabilities	(3,401)	(52,327)	(48,926)
Borrowings	(132,582)	(4,223)	128,359
Provisions	(170)	(170)	0
Total Current Liabilities	**(216,025)**	**(135,386)**	**80,639**
Net Current Assets	**(138,251)**	**(12,211)**	**126,040**
Non-Current Liabilities			
Other Liabilities	(6,484)	(6,233)	251
Borrowings	(40,609)	(37,990)	2,619
Provisions	(2,850)	(2,850)	0
Total Non-Current Liabilities	**(49,943)**	**(47,073)**	**2,870**
Total Assets Employed	**80,898**	**211,578**	**130,680**
Financed by Taxpayers Equity			
Public Dividend Capital	179,302	313,773	134,471
Reserves	29,891	29,891	0
Retained Earnings	(128,295)	(132,086)	(3,791)
Total Taxpayers' Equity	**80,898**	**211,578**	**130,680**

The table shows the M8 group balance sheet and movements from the 2019/20 closing balance sheet.

Current Assets

The movement in inventories relates to pharmacy stock.

Trade and other receivables balances have reduced. This mainly relates to accrued debt which is reflected in the cash position.

Cash has increased by £52.8m; the majority of this relates to the payment we received in April of an extra month of SLA income. Other large receipts in November to note were an extra £10m of cash from the GCCG due to the month 7 to 12 funding regime, HEE income in advance of £7.7m and £6.2m of PDC funding.

Current Liabilities

Trade and other payables have reduced by £2m. Other liabilities have increased by £48.9m this mainly relates to the advance month of SLA income and HEE mentioned above.

Cash Flow

Gloucestershire Hospitals
NHS Foundation Trust

Cashflow Analysis	Apr-20 £000s	May-20 £000s	Jun-20 £000s	Jul-20 £000s	Aug-20 £000s	Sep-20 £000s	Oct-20 £000s	Nov-20 £000s	Forecast Movement December 20 to March 21 £000s	Forecast Outturn £000s
Surplus (Deficit) from Operations	**818**	**954**	**1,035**	**908**	**967**	**92**	**(3,708)**	**2,602**	**1,795**	**5,463**
Adjust for non-cash items:									**0**	**0**
Depreciation	1,509	1,509	1,509	1,509	1,509	1,509	1,509	1,509	**5,916**	**17,988**
Other operating non-cash	0	0	0	0	0	0	0	0	**1,500**	**1,500**
Operating Cash flows before working capital	**2,327**	**2,463**	**2,544**	**2,417**	**2,476**	**1,601**	**(2,199)**	**4,111**	**9,211**	**24,951**
Working capital movements:										
(Inc.)/dec. in inventories	221	232	(57)	(152)	116	(429)	157	41	**(122)**	**7**
(Inc.)/dec. in trade and other receivables	(4,178)	10,065	(797)	(7,991)	1,749	(2,843)	(4,979)	16,338	**(17,079)**	**(9,715)**
Inc./(dec.) in current provisions	0	0	0	0	0	0	0	0	**0**	**0**
Inc./(dec.) in trade and other payables	35,152	(5,229)	(44,038)	7,110	2,503	3,027	3,933	(4,927)	**(4,666)**	**(7,135)**
Inc./(dec.) in other financial liabilities	7,099	(4,559)	41,320	(1,168)	2,140	1,665	(4,988)	7,417	**(48,776)**	**150**
Net cash in/(out) from working capital	**38,294**	**509**	**(3,572)**	**(2,201)**	**6,508**	**1,420**	**(5,877)**	**18,869**	**(70,643)**	**(16,693)**
Capital investment:										
Capital expenditure	(1,667)	(1,667)	(1,729)	(882)	(1,737)	(2,149)	(1,417)	(4,584)	**(18,903)**	**(34,735)**
Capital receipts	0	0	0	0	0	0	0	0	0	**0**
Net cash in/(out) from investment	**(1,667)**	**(1,667)**	**(1,729)**	**(882)**	**(1,737)**	**(2,149)**	**(1,417)**	**(4,584)**	**(18,903)**	**(34,735)**
Funding and debt:										
PDC Received	0	0	0	353	0	127,860	0	6,258	**5,459**	**139,930**
Interest Received	11	0	0	0	0	0	0	0	**0**	**11**
Interest Paid	0	0	0	0	(658)	(525)	0	0	**(658)**	**(1,841)**
DH loans - received	0	0	0	0			0	0	**0**	**0**
DH loans - repaid	0	0	0	0	0	(129,180)	0	0	**(865)**	**(130,045)**
Finance lease capital	(95)	(95)	(95)	(488)	(488)	(488)	(488)	(488)	**(1,952)**	**(4,677)**
Interest element of Finance Leases	(17)	(17)	(17)	(12)	(12)	(12)	(13)	(13)	**(52)**	**(165)**
PFI capital element	(43)	(43)	(43)	(68)	(68)	(68)	(68)	(68)	**(272)**	**(741)**
Interest element of PFI	(182)	(182)	(182)	(38)	(38)	(38)	(38)	(38)	**(152)**	**(888)**
PDC Dividend paid						0		(1,040)	**(4,204)**	**(5,244)**
Net cash in/(out) from financing	**(326)**	**(337)**	**(337)**	**(253)**	**(1,264)**	**(2,451)**	**(607)**	**4,611**	**(2,696)**	**(3,660)**
Net cash in/(out)	**38,628**	**968**	**(3,094)**	**(919)**	**5,983**	**(1,579)**	**(10,100)**	**23,007**	**(83,031)**	**(30,137)**
Cash at Bank - Opening	**37,385**	**76,013**	**76,981**	**73,887**	**72,968**	**78,951**	**77,372**	**67,272**	**90,279**	**37,385**
Closing	**76,013**	**76,981**	**73,887**	**72,968**	**78,951**	**77,372**	**67,272**	**90,279**	**7,248**	**7,248**

Recommendations

Gloucestershire Hospitals NHS Foundation Trust

The Board is asked to:

- Note the Trust is reporting a year to date deficit of £3.5m, £3.1m better than the planned £6.6m deficit. The position does not include any financial penalties for under-achievement of activity against the elective incentive scheme.
- Note that the system forecast deficit is £28.4m for the second half of the year, when there is no retrospective true-up. This does not yet include the improvement to our Trust forecast.
- Note that the GHFT deficit forecast for the second half of the year is £11.6m, an improvement of £3.9m. This includes an annual leave provision, and the expectation that the Gen Med Vat provision is not supported by NHSE, despite us continuing to push for this to be funded.

Authors: **Johanna Bogle, Associate Director of Financial Management**

Presenting Director: **Karen Johnson, Director of Finance**

Date: **December 2020**

Gloucestershire Hospitals
NHS Foundation Trust

TRUST PUBLIC BOARD – 14 January 2021
Microsoft Teams, Commencing at 12:30

Report Title
Digital Programme Report
Sponsor and Author(s)
Author: Anna Wibberley, Digital Programme Director. Nicola Davies, Digital Engagement & Change Lead Sponsor: Mark Hutchinson, Executive Chief Digital & Information Officer
Executive Summary
Purpose This paper provides updates and assurance on the delivery of digital workstreams and projects within GHFT, as well as business as usual functions. The progression of this agenda is in line with our ambition to become a digital leader. Key issues to note • As well as working towards major project go-lives; the EPR team is also supporting a programme of continuous improvement, detailed in the report. • A thorough review and prioritisation exercise has taken place to approve the next set of paper documents to be migrated over to Sunrise EPR. • TrakCare optimisations continue and an MR10 upgrade was successful. • Data quality improvements continue and as COVID-19 admissions increase, the business intelligence team will be supporting increased local, regional and national reporting. • Calls to the IT service desk continue to increase and be dominated by remote working kit requests and support for national NHSmail changes and MS Teams. Conclusions The importance of improving GHFTs digital maturity in line with our strategy has been significantly highlighted throughout the COVID-19 pandemic. Our ability to respond and care for our patients has been greatly enabled by our delivery so far, but needs to continue at pace. Implications and Future Action Required As services continue to move online and with an increase in remote working, demand for digital support is increasing.
Recommendations
The Committee is asked to note the report.
Impact Upon Strategic Objectives
The position presented identifies how the relevant strategic objectives will be achieved.
Impact Upon Corporate Risks
Progression of the digital agenda will allow us to significantly reduce a number of corporate risks.
Regulatory and/or Legal Implications
Progression of the digital agenda will allow the Trust to provide more robust and reliable data and information to provide assurance of our care and operational delivery.
Equality & Patient Impact
Progression of the digital agenda will improve the safety and reliability of care in the most efficient and effective manner.

Resource Implications			
Finance		Information Management & Technology	X
Human Resources		Buildings	

Action/Decision Required							
For Decision		For Assurance	X	For Approval		For Information	X

FINANCE AND DIGITAL COMMITTEE

DECEMBER 2020

DIGITAL PROGRAMME UPDATE

1. Purpose of report

This report provides updates and assurance on the delivery of digital projects within GHFT, as well as business as usual functions within the digital team. This includes the implementation of Sunrise EPR, TrakCare optimisation, digital programme office, data quality, information governance and IT. The progression of the digital agenda is in line with our ambition to become a digital leader.

2. Sunrise EPR programme update

This section provides an update on EPR improvements and optimisations carried out, as well as an overview of the main EPR delivery programme for 2021.

2.1 Sunrise EPR improvements

Since our first go live with nursing documentation in November 2019, we have been working hard to continuously improve Sunrise EPR, working closely with clinicians, operational teams, reporting teams and EPR build experts.

We have several routes-in for the improvement requests and suggestions we receive. These are:

- Issues picked up during the go live period by floorwalkers and users
- User feedback to our EPR mailbox and from digital super users
- Direct feedback from senior clinical and operational staff during the engagement process
- Changes to clinical process and practice
- Changes to reporting requirements

All of these requests are discussed and prioritised by the EPR configuration team in the first instance (which includes EPR specialist nurses), before being considered at the EPR programme delivery group (attended by the CCIO, CNIO and CDIO) and approved at the Clinical Documentation Group which meets monthly. The membership of this includes EPR technical staff as well as clinical leads from across the organisation.

COVID-19 has presented a number of new challenges and opportunities for the further development of our EPR and how the system can support changes being made on the ground.

All of our improvement work continues to run alongside the delivery of the EPR programme and every request is considered as part of our five year digital strategy. This section of the report provides an update on some of the improvements we've made this year.

E-Referral pilot

We were asked to develop an adult social care referral solution within Sunrise EPR, to support discharge of patients and improve patient flow. Working closely with social care colleagues, a pilot project has been rolled out to levels 3 and 4 in GRH which has been aiding discharge of patients over the last month. Early results are positive and we are planning a rollout to other ward areas and to CGH.

We are also reviewing all the other additional referrals currently in use across the Trust to prioritise the order of development once the pilot completes.

COVID alerting and clinical support

Since the first wave of the COVID-19 pandemic, we've been working closely with clinical teams to see how EPR can support the hospital's response, enable clinicians to see information in real time and reduce our reliance on paper.

- *Automatic flagging of COVID patients with infection alert*

This follows the Trust's standard logic for defining a patient as COVID positive. An infection alert appears on the tracking boards (visible to anyone accessing EPR and on every ward) and will be able to be tweaked and changed as this logic evolves.

- *Flagging to ward staff when COVID re-swabs are due*

Flags will be implemented on tracking boards which will appear when a green patient requires re-swabbing for COVID as per our Trust guidance. For example, flags will appear on day 3, 5 and 7 of inpatient stays and stay until a COVID swab is ordered in Sunrise EPR.

- *Patient list to show recent positive COVID results*

We are exploring options to allow real-time access to a patient list in Sunrise EPR which would contain a recent positive result returned from pathology labs, as well as other vital metrics such as number of patient deaths within certain timeframes.

Outpatient Documentation

We are currently developing a proof of concept for Community Palliative Care teams, allowing them to document outpatient care inside Sunrise EPR. We are also evaluating a suitable department to explore the next steps of this with and frontrunners so far include Respiratory, Oncology, Pain Management and Dermatology.

E-Observations

A new icon is being added to the tracking boards to alert ward staff to when the next set of observations are due for a patient. This will alert when there are 15 minutes to go until the next and then change colour once they are overdue. We are also adjusting the observations frequency in line with the approved changes to this Trust policy.

Sepsis documentation

Documentation has been developed and a process and pathway is under review by key stakeholders who are owning various parts of this new module and is being overseen by the Clinical Documentation workstream. We are currently reviewing the rollout plan of this new functionality, taking into account the current pressures on the Trust.

Onward Care Team documentation

New documentation within Sunrise EPR has been developed which the Onward Care Team will use to document discharge status and assist with the timely discharging of patients. Bringing this team into EPR and removing the need to document in Infoflex will share the wealth of information they gather with ward staff across the Trust and aid in discharging patients across both sites.

ADD / EDD rollout and site office monitoring

We have been supporting the hospital in its efforts to communicate and embed the timely completion of expected and actual dates of discharge; and ensuring it is completed using EPR. Once completed for patients these dates can be monitored by both site office and senior ward staff.

Lists of patients are now available to show when patients are due to leave the hospital (today or tomorrow) and we have added the ability to record 'levels of confidence' around discharge dates. This will soon be shared with site team to help with prioritising bed allocation.

Previously only nurses had permission to amend dates of discharge but since Doctors have started using EPR more fully (following the implementation of order comms) we have extended it to additional user groups.

MUST scoring optimisations

The completion of MUST scoring is one of the most talked about benefits of EPR, with completion rates improving significantly since moving from paper to computer. Evidence shows that completion of MUST scoring on admission can reduce length of stay, so we continue to work with nursing staff to make improvements where we can. We have implemented optimisations to the scoring and options when entering a MUST, to make the data more intelligent, and much easier to use for a wider range of patients, including in pregnancy and for younger patients.

Requests and results optimisations

We have made significant improvements to the layout and the logic for our requesting labels since going live in August 2020. Improvements now allow containers to combine where necessary and to display improved levels of information. The aim is to help streamline the process in the labs, supporting pathology staff with 'booking in' and reporting on all ranges of tests requested in Sunrise EPR.

We have also added additional guidance to tests; this ensures that when ordering a test which, for example, needs to be put on ice immediately, this information is available at the point of order and on the label that is printed to go to labs with the sample.

Further changes in development in EPR

The following additional improvements are underway or being scoped:

- **Care provider clean-up**

  A huge undertaking to review how care providers are used within both Trak and Sunrise EPR is vital to enable the next phases of deployment in outpatients. This will also allow a more real time assignment of patient/ consultant / provider on the tracking boards as well as on patient lists for inpatient ward areas.

- **Safeguarding changes to current adult admission documentation**

  We are currently exploring options for safeguarding changes in our admission documentation to support patients who are not strictly considered adults for safeguarding purposes. This would allow staff to make adjustments based on the age of patients and allow a better experience for patients who fall in the 16-18 age bracket.

- **Pre-Assessment clinic documentation and integration to inpatient spells**

  Pre-Assessment documentation is needed to allow the smooth transition from these areas into inpatient stays. This is being pursued now that a technical solution is available to allow these visit types to flow into admission stays in Sunrise EPR.

- **Women's & Children's Tracking Boards**

  We are currently exploring the option of rolling out tracking boards and location based Sunrise EPR services to Women's & Children's areas to help with patient flow and potentially allow staff to become accustomed to the look and feel of Sunrise EPR prior to the full rollout of requests and results (order comms) next year.

2.2 Prioritisation of next set of paper documents on EPR

A thorough review and prioritisation exercise has taken place to approve the next set of paper documents to be moved onto Sunrise EPR.

Clinical staff and documentation leads were initially asked to prioritise their documents against a series of key metrics which were weighted accordingly and are shown on the matrix below.

Measure of Consequences						
	Weighting	1	2	3	4	5
Impact on the safety of patients Docs with ineligible handwriting / continuity of documentation between systems / risk of missing documents etc.	5	Minimal impact on safety requiring no/minimal intervention or treatment.	Minor injury or illness, requiring minor intervention	Moderate injury requiring professional intervention	Major injury leading to long-term incapacity or disability	Potential incident leading to unexpected death. Serious sexual assault
Regulatory - Target / Standard Impact Reporting requirements relating to national submission etc.	3	Minimal requirement to report on document contents	Local risk of non-achievement of reporting standards. Single failure to meet internal standards	Divisional risk of non-achievement of reporting standards. Repeated failure to meet internal standards	Divisional risk of non-achievement of one or more Trust reporting standards – risk posed to overall Trust compliance	Current trust failure to meet national reporting standards
Alignment to Trust Strategic Objectives Strategic direction and Digital transformation	3	Rarely used document with no impact on achieving 5 year Strategic objectives	Occasionally used document with minor impact on achieving trust Strategic objectives	Occasionally used document with moderate impact on achieving trust Strategic objectives	Heavily used document with moderate impact on achieving trust Strategic objectives	Heavily used document with major impact on achieving trust Strategic objectives
Financial Impact / Utilisation Paper cost / order numbers *TBC with Colour Connect	2	Low cost / utilisation		Moderate cost / utilisation		Significant cost / utilisation
Patient Experience EPR vs paper and engagement with patient. Missing documentation impact. Speed of treatment etc.	4	Unsatisfactory patient experience which is able to be resolved locally	Unsatisfactory patient experience – minimal risk to patient safety in the short term	Mismanagement of patient care – short term effects. Impacting on a small number of patients. Could significantly impact on patient safety.	Mismanagement of patient care – long term effects, unsatisfactory patient outcome or experience	Totally unacceptable patient experience which impacts on a large number of patients
Staff / User Experience Ease of staying within single system for notes / single shared view of records etc.	4	Unsatisfactory staff experience which is does not impact on patient management	Unsatisfactory staff experience with potential risk to patient management	Difficultly in management of patient care due to multiple potential systems of record management	Mismanagement of patient care due to multiple care record systems with long term effects	Totally unacceptable staff experience which impacts on ability to treat patients.

Following this process, the Sunrise EPR team and specialist nurses reviewed and sanitised the scoring, before presenting the findings back to the EPR Clinical Documentation workstream. Here an agreement was made to prioritise the following for development:

1. Mental Capacity Assessment
2. Enhanced Care Bundle
3. Rockwood Scoring
4. Delirium Assessment
5. Food Chart
6. Stool Chart

Additional engagement is also being planned with consultants and junior doctors to roll-out some very basic documentation, to bring huge value to sharing continuation notes, working diagnosis and ward jobs for the day; as well as populating lists with this information. The adoption of this would naturally pave the way for the use of a fully structured assessment, such as the mental capacity document or delirium and Rockwood scoring.

We are also exploring a way to rationalise the hundreds of documents we use across the Trust and group certain types together for development in Sunrise EPR. For example, rather than having significant numbers of individual care plans for cannulas and other devices used with patients; we are exploring the creation of one document where all devices are stored and provide a streamlined user experience in accessing the type of assessments staff need.

This set of new documents is currently in development and a tentative date for a content drop has been proposed as the end of February 2021; however this is subject to further review by EPR programme delivery group.

2.3 Order Comms Project Summary

Following the successful implementation of requests and results in adult inpatient wards, we are focussing on the rollout to all other clinical areas. A summary of this work is outlined below.

Order comms phase 3 (W&C, outpatients, theatres) current and future state mapping exercises are complete and we are now proceeding to system build. End user devices roll out planning and execution is underway.

Order comms phases 4 and 5 (implementation of TCLE within the labs) build and integration is underway. A solution for histology and their advanced data capture needs is under development. The ICE ordering solution requires development by CliniSys, this is scheduled to be completed in December.

Emergency Department is progressing well, current state mapping is complete and the forum to sign these off is being agreed. Future state sessions have begun.

Electronic Prescribing and Medicines Administration (ePMA) is currently not progressing as all resources have been moved on to the EMIS project. This is to allow the EMIS drugs catalogue build to progress. Additional resources are being brought in to support the EMIS work, both internally and externally.

Paper-lite outpatients is kicking off with a proof of concept for the community palliative care team, however this proof of concept is delayed due to complexities of the pilot department. Following a successful trial, further detailed planning and testing of our outpatient list solution with additional (non-community) specialities will commence with a view to creating a baseline future state which can be used across multiple areas in outpatients to streamline our clinical pathways.

Activity planned for next period - we will begin translating phase 3 future state process maps into configuration requirements and commence the EPR build. With the final future state maps, end user devices can be rolled out. Orders for power and network installation are being placed. For phases 4 and 5, the CliniSys development will be a primary focus as well as finalising the TCLE/EPR build and integration.

Emergency Department must complete the future state process maps and start EPR build. Build for the Follow Me Desktop IT solution will be progressed. End user device roll out planning will be completed.

Pharmacy projects will have additional resources placed on them and the correction plan agreed/executed.

Current risks to the project timeline and success include:

- Increasing number of COVID-19 patients within the trust could prevent a lot of engagement with the EPR Programme. This has the potential to delay future state workshops, testing and training. It could reduce clinical input and buy in with the projects.

- CliniSys development has the potential to disrupt the TCLE project by delaying the project or by amending the trusts integration strategy. This could cause rework between SCM and TCLE.

- Pharmacy resource issues could cause further delay to the pharmacy projects. This risk could be exacerbated if pharmacy staff are diverted to COVID mass vaccination efforts.

2.4 Sunrise EPR Programme

Below is a RAG rated overview of the EPR delivery programme, against the agreed EPR roadmap for 2020/21.

Red	Significant issues with the workstream – scope, time or budget is beyond tolerance level
Amber	Issue/s having negative impact on the workstream performance, workstream is close to tolerance level
Green	On track

Workstream	Workstream update	RAG Status
Benefits	Additional measurements are being taken within pathology since phase 2 order comms went live to measure benefits.	**Green**
Order Comms	• Phase 3 current and future state have been signed off • Phase 3 build is underway. • Phase 4 and 5 build is underway. • CliniSys development is a risk to the TCLE project. • An order for kit has been placed but currently has a long lead time. Issues with Brexit and COVID have cited by suppliers. • There are concerns around funding for lab based kit for the TCLE implementation	**Amber**
EPMA (electronic prescribing)	• EPMA current state workflows have been signed off with future state ones to follow. • EPMA build activity is on hold due to lack of pharmacy resources to support.	**Current status Red but will move to Amber**
ED	• ED current state sessions are complete. Future state sessions are underway.	**Green**
EPR Optimisation	• COVID Alerting and E-Referrals pieces are progressing well. Sepsis/NEWS Integration and Clinical documentations have challenges due concerns around when they can be rolled out.	**Green**
Pharmacy Stock Control	• The drugs database build for EMIS needs even more resources to complete on time. Options have been identified and are being progressed.	**Current status Red but will move**

		to amber

3. EPR quality and benefits update

We are beginning to provide more detailed data on adoption of order comms (requests and results) across the trust. Requesting pathology and radiology tests went live on EPR at the end of August and we have been working closely with colleagues in pathology, in particular, to streamline the new process as much as possible.

More than 150,000 pathology requests have been made through EPR between go-live and 30 November 2020. Adoption on wards and by phlebotomy teams has been very good and we are now focussing on making improvements that will streamline the process in microbiology. Some of the issues we've addressed, and improvements we've made, in the last three months include:

- A new larger bag to contain more samples following requests from ward staff
- Regular communications about correct positioning of labels
- Reminders about how to place order forms and samples in bags, to make it quicker to process in the labs
- Improvements to the content on the labels – clearer information
- Improvements to the way labels are printed for samples, reducing spare
- Optimisations on EPR to make it quicker for clinicians to repeat regular orders, and create personal and favourite lists.

We have also created new reports on urgent requests, following a request from microbiology. As demand for urgent tests increases, microbiology teams need to be able to identify and separate out COVID tests. They are now able to run reports on urgent request by ward and consultant, providing a way to follow up with staff and provide advice on how and when the urgent status is used.

4. Digital Programme Office

This section provides updates on the delivery of projects from within the Digital Programme Management Office (PMO).

Key issues to note during November:

- The scope of the VNA PACS Imaging Archive Solution has been revised to separate the delivery of the VNA technical platform from the transition of services and usage which will be delivered as a separate, follow-on project.

- The PID and plan for Docman 10 – Transfers of Care has been redrafted to incorporate the phased delivery for outpatient letters, discharge summaries and the removal of paper letters from the process of communication.

- Since the last report four projects have been completed and closed and no projects have gone into closure.

5. TrakCare Optimisation Programme

This section provides an update from the TrakCare Optimisation Programme.

5.1 Programme overview

The priority for the programme during November has been the delivery of maintenance releases ten (MR10) for TrakCare. This release included fixes for some minor issues, required functionality for compliance with MSDS2 and some pre-cursor items for the roll-out of TCLE in the coming months.

MR10 was successfully implemented on 18 November. Extensive post-implementation support was provided both remotely and with on-site floor-walkers in all TRAK user locations.

The programme team continues to attract unplanned programme work. The expertise within the team is utilised to deliver programme discreet pieces of work but the team also acts as a highly specialised BAU team to quickly implement solutions to Trust priority issues. This work continues to be captured within the unplanned items workstream of the programme.

Transition to BAU is increasingly informing the work of the team with several changes in processes implemented in November to facilitate this. All future Tier 3 TRAK support will only be resolved in partnership with the substantive TRAK support team. The responsibility for TRAK issue escalation and attending and servicing monthly ISC service meetings has moved to the Deputy Head of BI for Data Management. The management of non-live TRAK environments has now been transferred to substantive staff. Future months will see more programme activities move to substantive teams.

The programme focus now turns to an assessment of remaining deliverables and the order in which these will be delivered. We will consult senior stakeholders and internal customers of these deliverables over the coming weeks to ensure the work of the programme remains aligned to organisational priorities.

5.2 RTT (Referral to treatment) and waiting lists

The resources allocated to the RTT/WL project have been utilised with:

- Testing that MR10 did not present any new issues within RTT reporting
- Specifying, testing, and implementing TRAKCARE functionality to enable the National Clinical Validation of IP waiting lists (NCVP) and developing the concomitant workflows.

The outgoing Inter-provider transfers (IPT) workstream has moved from an automated solution to supporting a manual process to ensure these referrals can proceed safely and effectively. In order to simplify the set-up work of adding the numerous providers available for onward referrals, the IPT process will first be trialled with potential transfers to two independent sector providers. This will be broadened to support transfers to other NHS providers once the functionality is proven. Data captured during the NCVP exercise around suitability of patients for independent sector care will help

identify the first cohort of patients utilising the new process. This deliverable has moved from Amber to Green.

Work around reducing RTT/WL DQ issues has been paused during the past month due to the diversion of project resources as detailed above but the status of this deliverable remains green with intended delivery of 10% reduction by programme closure.

5.3 Business as Usual (BAU) Transition

Three items have moved closer to BAU teams in the past month:

- Tier 3 support calls
- Management of ISC issues list
- Management of non-live environments

There are plans to move a further five items to BAU teams before the end of November 2020.

5.4 Programme Risks

Currently programme risks are:

- Remaining non-compliant with MSDS2 despite successful implementation of MR10
- Further unplanned items and concomitant resource requirements entering the programme due to shifting Trust priorities
- Lack of capacity within BAU teams to accept hand-over or undertake stabilised BAU functions as projects approach closure

6. Countywide IT Service (CITS) monthly report

During October 2020 we saw an improvement in calls answered within 90 seconds compared to September, but expect an increase in calls in November as the lockdown took effect in England. The majority of calls during October were related to user account access and NHSmail issues, as NHS national migration is still underway. The national migration is happening over 6 months and is due to finish by end of 2020.

Key highlights this month.

- Total calls received = 6028
- Calls answered within 90 seconds 55% - improvement on September.
- No P1 or P2 SLA breaches.
- Waiting list for video conferencing kit significantly reduced as stocks arrived.
- Increased demand towards end of October ahead of national lockdown, expect November figures to reflect that.

As more staff work remotely, calls to the service desk will remain at high levels and requests for additional video conferencing kit will increase. Planning is underway to support the large scale vaccination programme, adding additional pressure to the service desk to support the rollout.

7. Information Governance

This section of the report provides an update on information governance for GHT during October.

Information governance incidents are reviewed and investigated throughout the year and reported internally. Any incidents which meet the criteria set out in NHS Digital Guidance on notification, based on the legal requirements of the General Data Protection Regulation (GDPR) and guidance from the Information Commissioner's Office (ICO), are reported to the ICO through the DSP Toolkit where they may also be monitored by NHS England. Four incidents have been reported to the ICO during the 2020/21 reporting period to date. 29 confidentiality incidents were reported on the Trust internal Datix incident reporting system during October 2020.

7.1 Information Governance EU Exit Preparations

On leaving the EU the UK will become a third party state rather than a partner to GDPR legislation. Whilst the UK DPA is based on the GDPR once the UK is no longer a member state to continue transferring data additional arrangements are required to be in place.

This will be required for EU member states sending personal data from outside the UK (including from the EEA) into the UK. Transferring data outwards from the UK to the EEA will be permitted as the UK recognises the adequacy of the GDPR regime. However care will need to be taken to ensure that the return of the data is secured.

Personal data can be transferred from the EU to the EEA if it is covered by an adequacy decision, an appropriate safeguard or an exception.

The EU is currently assessing the UK for data adequacy, however, if there is no adequacy decision by the end of the transition period (31 December 2020), organisations will need to have put alternative transfer mechanisms in place to ensure the continued and legal flow of personal data from the EU/EEA to the UK and from the UK to the EU/EEA.

In anticipation that there will be no data adequacy decision made by 31 December the following actions are underway:

- Identifying where we have data flows from data controllers in the EU/EEA and ensuring an alternative transfer mechanisms such as Standard Contractual Clause is in place.
- Identifying where we store data with data processors based in the EU/EEA and asking them for written confirmation that data will continue to flow back to the UK after the end of the transition period and ensuring appropriate safeguards are in place.

Data flows

GHNHSFT Data flows identified are limited to ad hoc rather than regular large scale transfer and are typically;

- Patient data to support care may be transferred on request e.g. where a patient has moved or is on holiday within the EU/EEA.

- Patient data may be supplied to us on request for the support of treatment of individual patients - particularly those who may normally be resident in EU/EAA.

Similar arrangements are already in place for transfers outside of the EU. Each ad hoc request is assessed on an individual basis. Consent will typically be available but other grounds such as vital interests would be considered.

Data storage

GHNSFT Data storage identified within the EU/EAA; No processors provide storage of datasets as such, but several have been identified that will store data incidental to the provision of applications and services.

These have been risk assessed and the residual risk is low. Alternative arrangements can be made if necessary.

Each of the identified EU/EEA based data processors will be contacted before December 31 to provide assurance. It is not considered likely that any of these data flows will stop as processors are bound by Article 28 compliant contracts and failure to act in accordance with those contracts would be a breach of contract and their responsibilities as processors under GDPR to act at all times on the controller's instructions.

Currently this is considered to be an appropriate safeguard in the absence of any contrary indication from the Information Commissioner or the European Data Protection Board.

GHNHSFT are participating in regular NHSX IG policy webinars that are covering EU exit IG planning and have completed the required NHSX Data questionnaire.

8. Cyber Security

This section highlights cybersecurity activity for October 2020 and details the controls in place to protect Gloucestershire Healthcare Community's information assets. CITS Cyber function is working with GHC to agree cyber SLA requirements in order to support a standardised cyber approach across Gloucestershire ICS.

Key issues to note:

- GHC Cyber SLA is nearing agreement (due end Nov 2020)
- Two open audit findings, rated 'Moderate'
- GHC Netwrix & Nessus reporting will begin when the solutions are implemented (due Dec 2020).

- One High Severity CareCERT Advisory, noted below. Trend Micro IPS proof of concept nearing completion, affected domain controllers will soon be protected with Trend solution (first two weeks of Nov)

Authors:
Anna Wibberley, Digital Programme Director
Nicola Davies, Digital Engagement Lead

Presenter: Mark Hutchinson, Executive Chief Digital & Information Officer

Gloucestershire Hospitals
NHS Foundation Trust

REPORT TO TRUST BOARD – January 2021

From: The Finance and Digital Committee Chair – Rob Graves, Non-Executive Director

This report describes the business conducted at the Finance and Digital Committee held on 17 December 2020, indicating the NED challenges made and the assurances received and residual concerns and/or gaps in assurance.

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
Digital Programme Report	Status update provided on all major projects with supporting RAG rated summary of all active projects. Various system enhancements described (notably automated flagging of COVID patients). Order Comms module successfully implemented with high activity levels being achieved Pressures on County-wide IT Service driven by extensive adoption of Microsoft Teams and remote/ home working.	What is the capacity and how is the wellbeing of the team? Are there any issue with InterSystems service and response?	While 2020 has been a very difficult year the team has continued to respond well to deadlines. Recent operational pressures have required team members to assist with patient transfers. This has been for morale and allowed the team to see their work in operation. While significant challenges remain they are under control Some issues around service but these have been appropriately escalated. Prioritisation of the higher consequence issues is effective.	
Integrated Care System Update - Digital	Discussion covering current system wide initiatives and particularly support to GP systems and cross system	Is this effort the best use of the team's time?	While a current distraction strategically it is in the best interest of the organisation and system	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
	connectivity together with a need to have clarity of the investment and cost impact.			
Digital Risk Register	Review of latest risk register entries		Committee assured that the identification, recording and mitigations are functioning appropriately	
Financial Performance Report	Summary of the 8 month financial position - an in month surplus of £0.9 million. Result is currently ahead of the level projected for the 2nd half of the year. The result reflects the lower than planned activity levels with resulting reduction in variable costs. Cash balances remain adequate. Update provided on the VAT challenge from HMRC Trust component (£15.5 million deficit) of system wide full year financial outcome reviewed with the latest favourable variance yet to be incorporated.	Are reserve and provisioning policies being applied in the normal manner? With activity levels below plan due to COVID limitations are the expenditure reduction versus plan consistent with the change?	Yes Cost impact of a 1% activity change quantified and a strong correlation to overall activity and expenditure levels demonstrated	
Capital Programme Report	New style report presented covering overall planned and actual expenditure by project. Approach to ensuring projects remain on	Request for detailed variation between current and previously reported total year expenditure level.	Differences explained by project	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
	track described. Status of loan and funding applications summarised	Can a RAG rating be applied to project analysis to better illustrate the distribution of risk Will the in-year capital allocation be spent and any forfeiture be avoided?	Under close review with projects funded by Public Dividend Capital an area of concern - all project timing closely monitored	Report to be enhanced Review at next meeting
Integrated Care System Update - Financial	Update on the system wide working and co-operation across and between the finance teams which are progressing well. Weekly meetings taking place to ensure appropriate approach to the mass vaccination programme			
Finance Team Accomplishment	The Finance Director announced that the team had just been successful in their "Future Focused Finance (FFF) Level II Accreditation" – a very significant achievement		The Committee welcomed this news enthusiastically as it serves to further increase the strong assurance provided in the the suite of financial reports routinely received	

Rob Graves
Chair of Finance and Digital Committee
6 January 2021

Gloucestershire Hospitals
NHS Foundation Trust

TRUST PUBLIC BOARD – 14 January 2021
Microsoft Teams, Commencing at 12:30

Report Title
QUALITY AND PERFORMANCE REPORT
Sponsor and Author(s)
Author: Felicity Taylor-Drewe, Director Planned Care / Deputy COO Sponsor: Rachael De Caux, Chief Operating Officer
Executive Summary

Purpose

This report summarises the key highlights and exceptions in Trust performance for the November 2020 reporting period.

The Quality and Performance (Q&P) committee receives the Quality Performance Report (QPR) on a monthly basis. The supporting exception reports from Quality; Emergency Care; Cancer and Planned Care Delivery Groups support the areas of performance concerns.

We continue to report a number of nationally suspended indicators within this report with the QPR and QPR SPC, when national reporting regimes recommence we will include this within the respective indicators narrative. Any data that was un-validated at the time of the last report will be updated within the subsequent month. Un-validated data, broadly due to timing of reporting is identified within the QPR. Future QPRs will contain the delivery against the Phase 3 activity indicators.

Executive summary QPR

The information in the QPR is intended to help us make informed decisions about the quality of care provided. As is good practice we are reviewing all the quality indicators and we are:

- analysing existing indicators and establishing whether they present a comprehensive picture of quality
- identifying the main purposes for which indicators could be developed and considering whether current indicators would help to achieve these aims
- establishing how existing indicators could be used to understand the quality of care received by different population groups as we are working on our protected characteristics data collection
- considering whether the process for developing new indicators could be improved
- looking at the most effective way of developing future indicators within our quality account reported improvement programmes.

Quality Strategy Improvement Plan

The Covid-19 pandemic continues to impact on our quality indicators and below is an update on a selection of the improvement programmes.

Safety Domain - Safety Plan

Metric - never events

There has been three further Never Events since the last report. There are no obvious links with the 3 new never events, but the trend remains with wrong site surgery. QDG have just received an analysis

of the current wrong site surgery Never Events with recommendations being considered by the Divisions. The risk of regulatory action sits with the Medical Director below the level of Trust Risk Register (TRR) and will be reviewed.

- W141994 Retained foreign object (guide wire) this is a rare incident and has a safety (LOCCSIP) procedure in place which will be reviewed alongside the circumstances of the incident

- W142394 –- Wrong site surgery (wrong scar removal) this is a very similar incident to a recent Never Event (W130841) , extra support is being offered to establish the current mitigation plan

- W140308 – Administration of oral medication intravenously (wrong route medication) this is a rare incident and has controls in place (use of a purple syringe for oral liquid medication) to normally prevent occurrence

Person Centred Care – caring domain

Metric - Friends and Family Test

The combined inpatient and day case score has dropped very slightly; from 86.6% in October to 85.7%. in November. This is driven by a lower score for inpatients from 82.5% in October to 80.8% In November. There are plans to relaunch the patient experience improvement faculty in early 2021, which will have a focus on using our experience insight to drive improvement across our services. We will continue to monitor our inpatient scores with the DDQNs and matrons

Clinical Outcomes and Effectiveness Domain

Stroke Care Improvement Plan

The SSNAP data has recently been reported and we now have a “B” rating which is an improvement from a “C” last year. There are 10 domains and 44 key indicators and over all of them we are rated a B and we score an "A" rating for our audit compliance. There are 3 metrics on the QPR which continue to be a focus of the improvement work.

Metric %patients receiving a swallow screen

Improvement of 1.2% on October performance (63.50%). 31 patients breached the target in the month of November. Of those 31:

18 patients were delayed in receiving a bed on the Stroke Unit and therefore had a delayed swallow screening.

- 6 patients were delayed due to an unclear diagnosis which led to them initially being admitted to AMU for further tests.
- 7 patients were too unwell to receive a swallow screen within the four hour target.

Metric - % of patients admitted directly to the stroke unit in 4 hours

Improvement of 2% on October (34.50%). 47 patients breached the target in the month of November.

Of these 47:

- 10 patients experienced a delay in assessment as the Stroke team were not informed by ED. Led to breaches along the rest of the pathway elements
- 18 patients were delayed due to lack of beds - Lack of HASU beds (shared space with Cardiology)
- 11 patients were delayed due to an unclear diagnosis which led to them initially being admitted to AMU for further tests.
- 2 patients were too unwell to move from ED
- 2 patients

Metric - percentage of patients spending 90%+ time on stroke unit

We maintained position on October (71.4%). 10 patients breached the target in the month of November. Of those 10, 8 patients were admitted to a non-Stroke ward and experienced a delay in transferring to the Stroke Unit due to bed availability. Two patients were delayed in ED for over 10 hours due to high volumes of attendances and therefore experienced delays in being assessed and diagnostic tests to confirm Stroke.

Dementia Care Improvement Programme

Metric FAIR Test

The manual audit for this indicator shows a consistent performance in screening for dementia in the 30 case notes sampled, but is still below compliance, and as the Dementia Improvement Plan (DIP) has developed its performance dashboard, it should be noted that the sample size is approximately 10% of dementia admissions. The pace of the DIP's dementia & delirium QI project has been impacted by the current COVID priorities, but continues to look for ways to enable electronic record systems to prompt the assessment and recording of dementia and delirium, and this will also improve the ability to respond to DAR/FAIR indicator and the National Audit of Dementia. The DIP has identified delirium in patients with dementia as a key priority, as there is evidence from the Diagnose QI phase that multiple bed moves , Length of Stay and mortality rates are higher for this vulnerable group. A Dementia Council will be convened to support and monitor progress, and will be Chaired by the Trust's new Admiral Nurse and report to the Quality Delivery Group.

Better Births - Maternity Improvement Programme

The overarching action plan will be reviewed at January's QDG meeting.

Metric – antenatal booking by 12 weeks

As we have come out of lockdown with COVID and GP surgeries continuing to be open midwives are maintaining early contacts with women and early referrals from GPs allowing completion of bookings by 12 weeks.

Metric - maternity FFT

The overall maternity FFT score has increased by 5% on October's FFT positive response, with 69 responses for Maternity in November, with a positive score of 88.4%
There were 52 responses to the Birth survey, 92.3% positive and 17 responses to the Postnatal ward survey, 76.5% positive. The postnatal ward survey is where we had a decrease in this month's positive score, and the matron is leading a working group focused on understanding these experiences in more detail and identifying potential improvements.

Learning from Deaths Improvement Programme

Metric – HSMR

The HSMR increased during wave one of the pandemic, this is the seen to be improving and the latest figure is now green.

Performance

During November the Trust did not meet the national standards or Trust trajectories for; A&E 4 hour standard and 52 week waits. The Trust performance (type 1) for the 4 hour standard in November was 74.25% with system performance total 76.64%. The Trust did not meet the diagnostics standard for November at 14.6%, this is as yet un-validated performance at the time of the report. . We have, as with many services prioritised same day diagnostics and support for patients to be prioritised post clinical review & recovered the position for CT and MR diagnostics.

The Trust did meet the standard for 2 week wait cancer at 91.6% in November and for the 62day standard at 79.9% this is as yet un-validated performance at the time of the report.

For elective care, the RTT performance 70% in November, un-validated at the time of the report, and improved from the summer position. Our focus is to ensure that patients are risk stratified and we continue to step up to fully utilise our clinics and theatres during the next period as we continue to restore our services.

The key areas of focus remain the assurance of patient care and safety during this time. Teams

across the hospital continue to support each other to offer the best care for all our patients.
A review and recovery plan is being formulated with emphasis on how to continue to prioritise our patients clinically and enable secondary care intervention where needed for patient care and safety. This is being supported in line with Phase 3 guidance.
Directors Operational Group review the Unscheduled and Scheduled performance indicators with the Divisions and the wider Executive team.

Recommendations

The Trust Board is requested to receive the Report as assurance that the Executive team and Divisions fully understand the current levels of non-delivery against performance standards and have action plans to improve this position, alongside the plans to clinically prioritise those patients that need treatment planned or un-planned during the pandemic.

Impact Upon Strategic Objectives

Current performance jeopardises delivery of the Trust's strategic objective to improve the quality of care for our patients.

Impact Upon Corporate Risks

Continued poor performance in delivery of the two national waiting time standards ensures the Trust remains under scrutiny by local commissioners and regulators, subject to C-19.

Regulatory and/or Legal Implications

No fining regime determined for 2020 within C-19 at this time, activity recovery aligned with Phase 3 requirements.

Resource Implications

Finance		Information Management & Technology	
Human Resources		Buildings	

Action/Decision Required

For Decision		For Assurance	✓	For Approval		For Information	

Date the paper was presented to previous Committees

Quality & Performance Committee	Finance & Digital Committee	Audit & Assurance Committee	People & OD Committee	Remuneration Committee	Trust Leadership Team	Other (specify)
✓						

Outcome of discussion when presented to previous Committees

NHS
Gloucestershire Hospitals
NHS Foundation Trust

Quality and Performance Report Statistical Process Control Reporting

Reporting Period November 2020

Presented at December 2020 Q&P and January 2021 Trust Board

Contents

Gloucestershire Hospitals NHS Foundation Trust

Guidance

Gloucestershire Hospitals NHS Foundation Trust

Variation			Assurance		
					
Common cause – no significant change	Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values	Special cause of improving nature or lower pressure due to (H)igher or (L)ower values	Variation indicates inconsistently hitting passing and falling short of the target	Variation indicates consistently (P)assing the target	Variation indicates consistently (F)alling short of the target

How to interpret variation results:

- Variation results show the trends in performance over time
- Trends either show **special cause variation** or **common cause variation**
- **Special cause variation: Orange icons** indicate **concerning** special cause variation requiring action
- **Special cause variation: Blue icons** indicate where there appears to be **improvements**
- **Common cause variation: Grey icons** indicate **no significant change**

How to interpret assurance results:

- Assurance results show whether a target is likely to be achieved, and is based on trends in achieving the target over time
- **Blue icons** indicate that you would expect to **consistently achieve a target**
- **Orange icons** indicate that you would expect to **consistently miss a target**
- **Grey icons** indicate that **sometimes the target will be achieved and sometimes it will be missed**

Source: NHSI Making Data Count

Executive Summary

Gloucestershire Hospitals NHS Foundation Trust

The key areas of focus remain the assurance of patient care and safety during this time. Key reductions in non-urgent elective care took place in March to support organisational response to Covid-19 and continued into the summer. This has led to a number of changes and opportunities to deliver patient care in an enhanced way. The Trust through support of IM&T colleagues has embraced remote working with our patients & with Primary Care. For elective care (Cancer; Screening and RTT), all patients are being reviewed and clinically prioritised and national guidance enacted. We are ensuring that we are tracking all patients and that our waiting list size is consummate with those patients requiring secondary care opinion. During this time we also enacted a CAS to support primary care and remain open for referrals requiring a secondary care opinion. For unscheduled care the approach has equally been to support the safety and care of our patients to enable them to access specialist emergency care as they need to. Teams across the hospital have supported each other to offer the best care for all our patients.

A review and recovery plan is in place with emphasis on how to continue to prioritise our patients clinically and enable secondary care intervention where needed for patient care and safety.

During November the Trust did not meet the national standards for 52 week waits, diagnostics and the 4 hour standard.

The Trust performance (type 1) for the 4 hour standard in November was 68.40%, against the STP trajectory of 86.04%. The system did not meet the delivery of 90% for the system in November, at 79.64%. Note that the November performance targets / trajectories have not been formally agreed as the Operating Plan process was paused due to C-19, we have therefore taken the appropriate performance target from the national or previous local target where applicable.

The Trust did not meet the diagnostics standard for November at 14.67%. We have, as with many services prioritised same day diagnostics and support for patients to be prioritised post clinical review. The achievement of this standard has been majorly impacted by C-19, specifically endoscopy tests. MR and CT have recovered their waiting time position.

The Trust did not meet the standard for 2 week wait cancer at 91.6% in November or 62 day cancer waits at 79.7%, this is as yet un-validated performance at the time of the report.

For elective care, the RTT performance is 68.87% (un-validated) in November, work continues to ensure that the performance is stabilised. Significant work is underway to reduce our longest waiting patients of over 52 weeks, of which there were 1,428 in November. This is as yet un-validated performance at the time of the report.

Directors Operational Group will review the Unscheduled and Scheduled performance indicators with the Divisions and the wider Executive team.

The Quality Delivery Group (QDG) continues to monitor the performance of the quality metrics with the Divisions providing exception reports. The delivery of any action plans to deliver improvement are also reviewed within the meeting. There are improvement plans in place for any indicators that have consistently scored in the “red” target area.

Access Dashboard

Gloucestershire Hospitals NHS Foundation Trust

This dashboard shows the most recent performance of metrics in the Access category. Where SPC analysis is not possible the metric is RAG rated against national standards. Exception reports are shown on the following pages.

Key

Assurance

- Consistently hit target
- Hit and miss target subject to random
- Consistently fail target

Variation

- Special Cause Concerning variation
- Common Cause
- Special Cause Improving variation

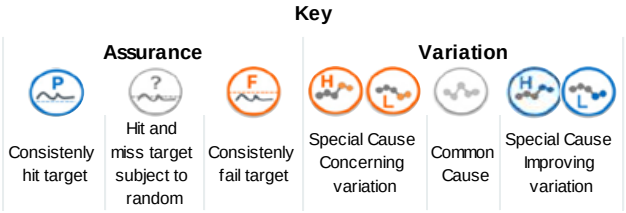
MetricTopic	MetricNameAlias	Target & Assurance		Latest Performance & Variance		
Cancer	Cancer – 28 day FDS two week wait	TBC		Nov-20	78.3%	
Cancer	Cancer – 28 day FDS breast symptom two week wait	TBC		Nov-20	95.4%	
Cancer	Cancer – 28 day FDS screening referral	TBC		Nov-20	61.8%	
Cancer	Cancer – urgent referrals seen in under 2 weeks from GP	>=93%	?	Nov-20	91.6%	
Cancer	2 week wait breast symptomatic referrals	>=93%	?	Nov-20	85.2%	L
Cancer	Cancer – 31 day diagnosis to treatment (first treatments)	>=96%	?	Nov-20	99.3%	H
Cancer	Cancer – 31 day diagnosis to treatment (subsequent – drug)	>=98%	?	Nov-20	100.0%	
Cancer	Cancer – 31 day diagnosis to treatment (subsequent – surgery)	>=94%	?	Nov-20	96.8%	
Cancer	Cancer – 31 day diagnosis to treatment (subsequent – radiotherapy)	>=94%	?	Nov-20	94.7%	
Cancer	Cancer 62 day referral to treatment (urgent GP referral)	>=85%	?	Nov-20	79.7%	
Cancer	Cancer 62 day referral to treatment (screenings)	>=90%	?	Nov-20	96.8%	
Cancer	Cancer 62 day referral to treatment (upgrades)	>=90%	?	Nov-20	70.8%	
Cancer	Number of patients waiting over 104 days with a TCI date	Zero	?	Nov-20	1	
Cancer	Number of patients waiting over 104 days without a TCI date	<=24	?	Nov-20	9	L
Diagnostics	% waiting for diagnostics 6 week wait and over (15 key tests)	<=1%	?	Nov-20	14.67%	H
Diagnostics	The number of planned / surveillance endoscopy patients waiting at month end	<=600	F	Nov-20	1,772	H
Discharge	Patient discharge summaries sent to GP within 24 hours	>=88%	F	Oct-20	60.7%	H
Emergency Department	ED: % total time in department – under 4 hours (type 1)	>=95%	F	Nov-20	69.40%	L
Emergency Department	ED: % total time in department – under 4 hours (types 1 & 3)	>=95%	F	Nov-20	79.64%	L
Emergency Department	ED: % total time in department – under 4 hours CGH	>=95%	?	Nov-20	99.94%	H
Emergency Department	ED: % total time in department – under 4 hours GRH	>=95%	F	Nov-20	69.40%	L

MetricTopic	MetricNameAlias	Target & Assurance		Latest Performance & Variance		
Emergency Department	ED: number of patients experiencing a 12 hour trolley wait (>12hours from decision to admit to admission)	Zero		Nov-20	14	
Emergency Department	ED: % of time to initial assessment – under 15 minutes	>=95%	F	Nov-20	66.5%	L
Emergency Department	ED: % of time to start of treatment – under 60 minutes	>=90%	F	Nov-20	41.8%	
Emergency Department	% of ambulance handovers that are over 30 minutes	<=2.96%	?	Nov-20	4.59%	
Emergency Department	% of ambulance handovers that are over 60 minutes	<=1%	P	Nov-20	2.63%	H
Maternity	% of women booked by 12 weeks gestation	>90%	?	Nov-20	95.4%	H
Operational Efficiency	Number of patients stable for discharge	<=70	?	Nov-20	84	
Operational Efficiency	Number of stranded patients with a length of stay of greater than 7 days	<=380	?	Nov-20	392	
Operational Efficiency	Average length of stay (spell)	<=5.06	?	Nov-20	4.79	L
Operational Efficiency	Length of stay for general and acute non-elective (occupied bed days) spells	<=5.65	?	Nov-20	5.43	L
Operational Efficiency	Length of stay for general and acute elective spells (occupied bed days)	<=3.4	P	Nov-20	2.15	L
Operational Efficiency	% day cases of all electives	>80%	?	Nov-20	83.34%	L
Operational Efficiency	Intra-session theatre utilisation rate	>85%	?	Nov-20	87.7%	
Operational Efficiency	Cancelled operations re-admitted within 28 days	>=95%	?	Nov-20	90.50%	H
Operational Efficiency	Urgent cancelled operations	No target		Nov-20	4	
Outpatient	Outpatient new to follow up ratio's	<=1.9	F	Nov-20	1.94	
Outpatient	Did not attend (DNA) rates	<=7.6%	?	Nov-20	6.30%	
Readmissions	Emergency re-admissions within 30 days following an elective or emergency spell	<8.25%	?	Oct-20	7.6%	H
Research	Research accruals	No target		Feb-20	98	

Access Dashboard

Gloucestershire Hospitals NHS Foundation Trust

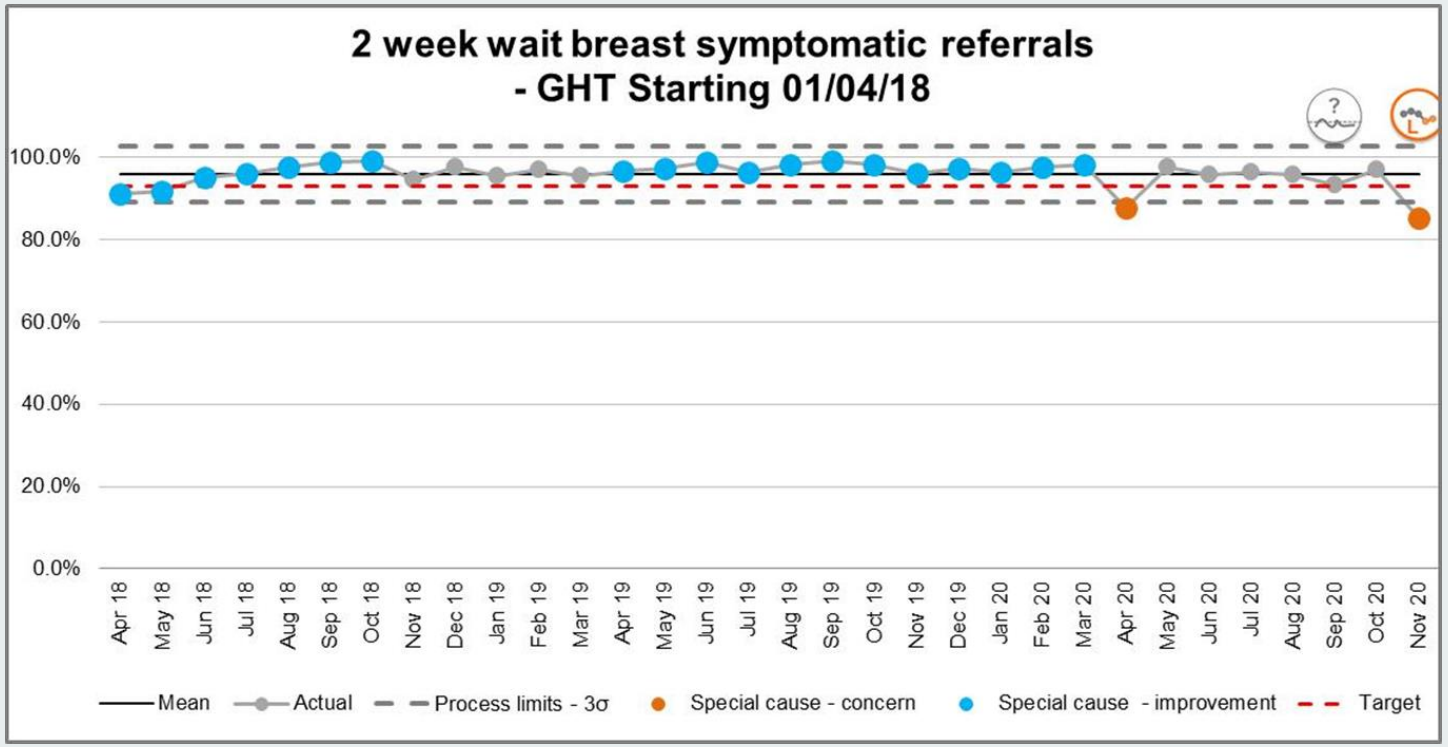
This dashboard shows the most recent performance of metrics in the Access category. Where SPC analysis is not possible the metric is RAG rated against national standards. Exception reports are shown on the following pages.



MetricTopic	MetricNameAlias	Target & Assurance		Latest Performance & Variance		
RTT	Referral to treatment ongoing pathways under 18 weeks (%)	>=92%		Nov-20	69.87%	
RTT	Referral to treatment ongoing pathways 35+ Weeks (number)	No target		Nov-20	8,400	
RTT	Referral to treatment ongoing pathways 45+ Weeks (number)	No target		Nov-20	3,051	
RTT	Referral to treatment ongoing pathways over 52 weeks (number)	Zero		Nov-20	1,428	
RTT	Referral to treatment ongoing pathways 70+ Weeks (number)	No target		Nov-20	114	
Stroke Care	Stroke care: percentage of patients receiving brain imaging within 1 hour	>=50%		Nov-20	54.7%	
Stroke Care	Stroke care: percentage of patients spending 90%+ time on stroke unit	>=80%		Nov-20	71.4%	
Stroke Care	% of patients admitted directly to the stroke unit in 4 hours	>=80%		Nov-20	36.5%	
Stroke Care	% patients receiving a swallow screen within 4 hours of arrival	>=90%		Nov-20	64.7%	
SUS	Percentage of records submitted nationally with valid GP code	>=99%		Aug-20	100.00%	
SUS	Percentage of records submitted nationally with valid NHS number	>=99%		Aug-20	99.9%	
Trauma & Orthopaedics	% of fracture neck of femur patients treated within 36 hours	>=90%		Nov-20	85.10%	
Trauma & Orthopaedics	% fractured neck of femur patients meeting best practice criteria	>=65%		Nov-20	83.0%	

Access:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

2ww breast symptoms performance (unvalidated) = 85.2%
Target = 93.0%
National performance = 77.2%

122 Date first seens 18 breaches relating to operational issues in Breast Surgery expressed in 2ww standard

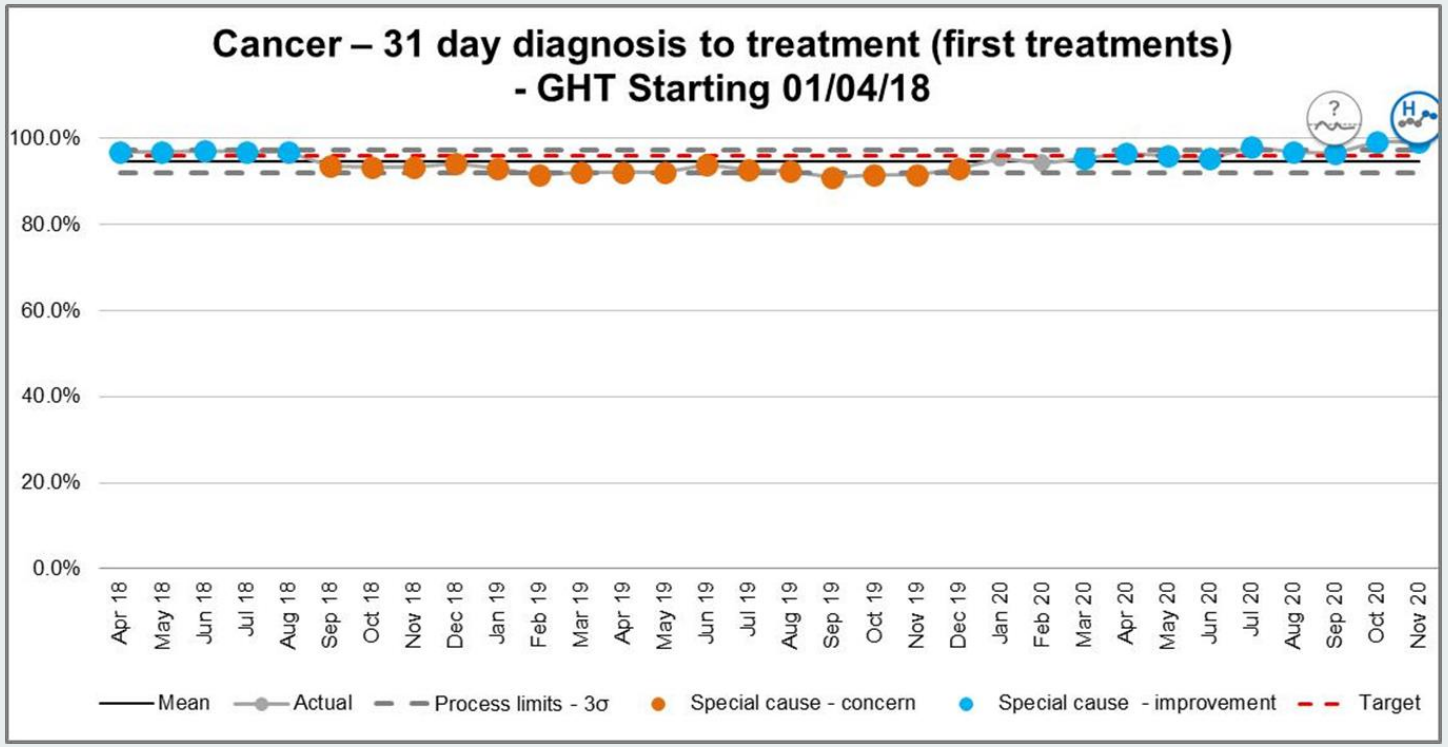
- Director of Planned Care and Deputy Chief Operating Officer

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 2 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above the mean.
Run	When there is a run of 7 increasing or decreasing sequential points this may indicate a significant change in the process. This process is not in control. In this data set there is a run of rising points

Access:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

31 day new performance (unvalidated) = 99.3%
Target = 96%
National performance = 94.5%

Currently 97.8% for annual performance 20/21. September will be the seventh month in a row of meeting the standard

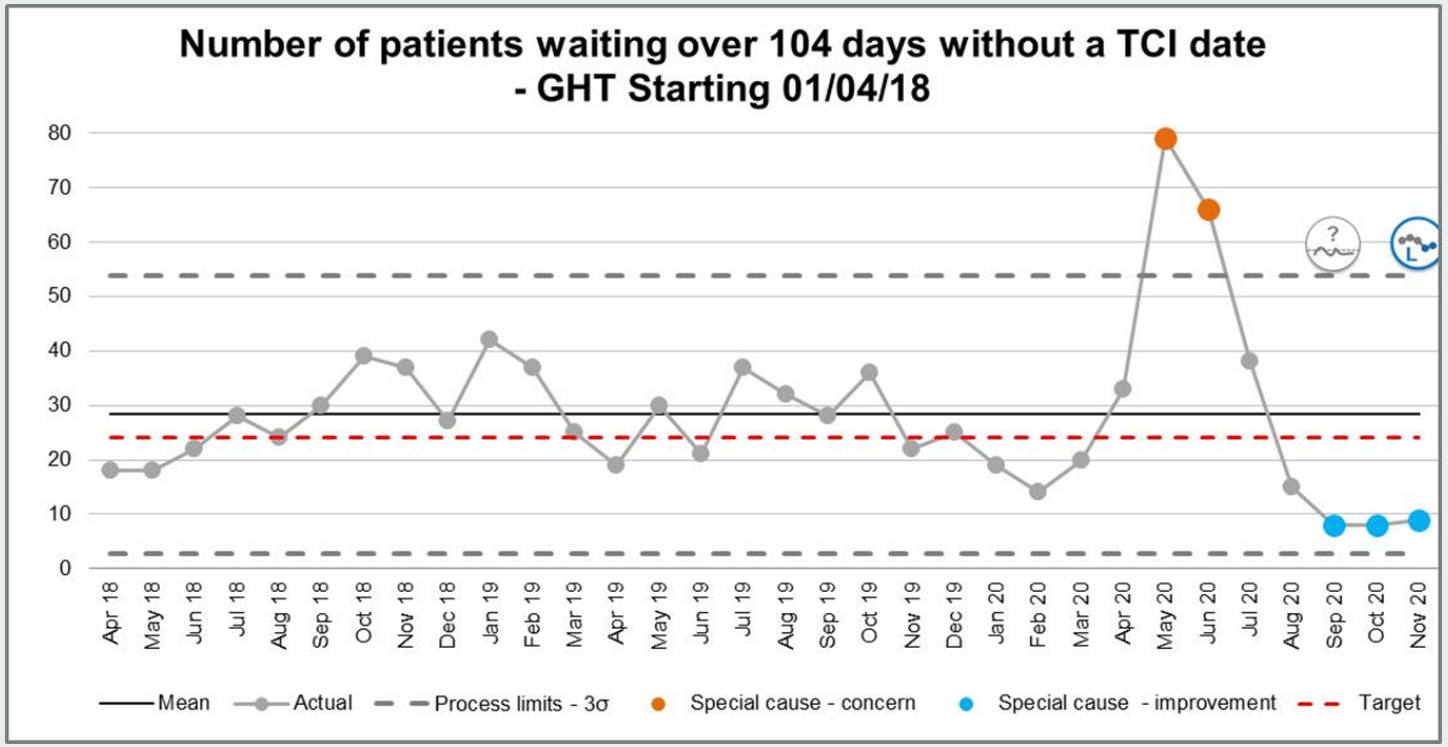
- Director of Planned Care and Deputy Chief Operating Officer

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 3 data points which are above the line. There are 5 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above and below the mean.
2 of 3	When 2 out of 3 points lie near the LPL and UPL this is a warning that the process may be changing

Access:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

Specialty No TCI
Lower GI 6
Upper GI 2
Head & neck 1
Grand Total 9
All 9 classed as unavoidable breaches with only two patients having a recorded primary diagnosis

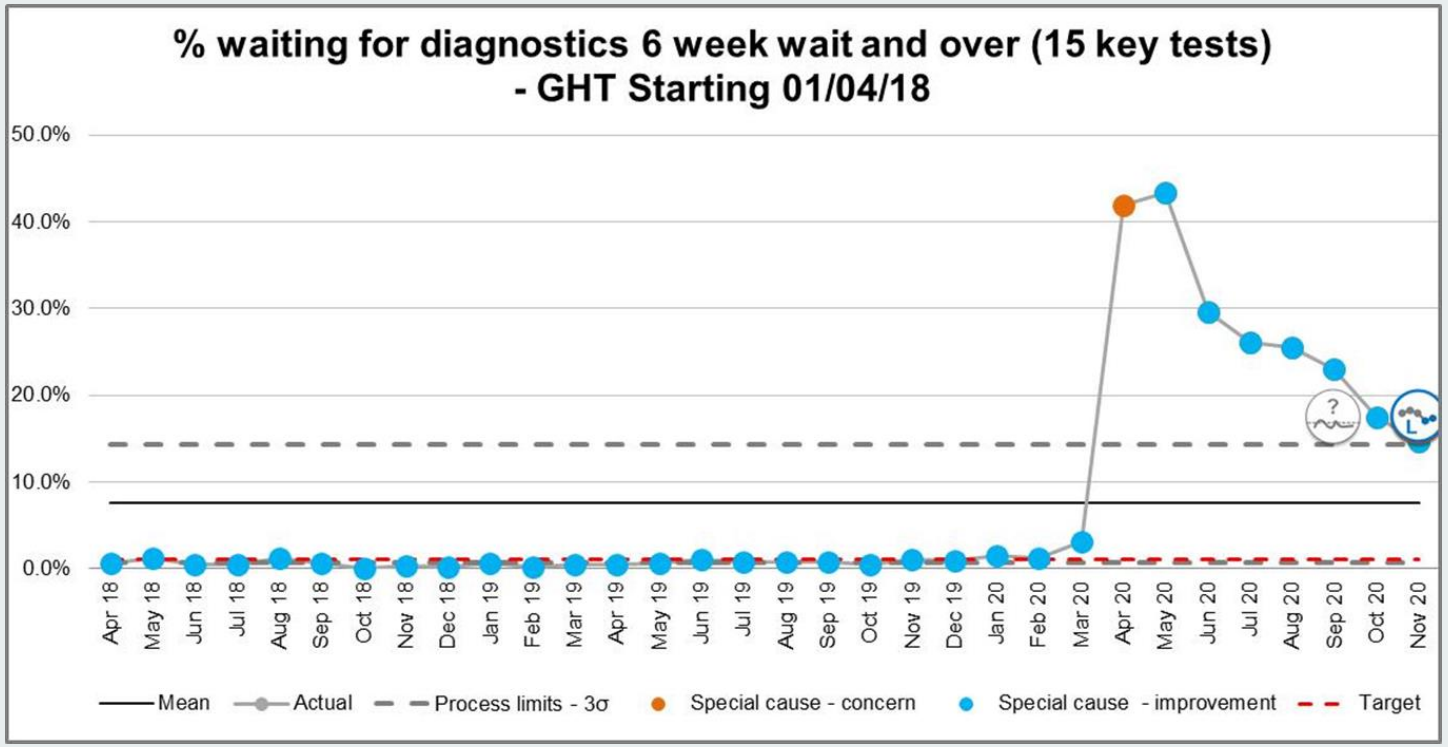
- Director of Planned Care and Deputy Chief Operating Officer

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 2 data points which are above the line.
2 of 3	When 2 out of 3 points lie near the LPL and UPL this is a warning that the process may be changing

Access:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

Diagnostics performance has improved, CT and MR are delivering within 6 weeks. Endoscopy and Cardiology are decreasing in breaches with their recovery plan in place.

- Director of Unscheduled Care and Deputy Chief Operating Officer

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 8 data points which are above the line. There are 16 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above and below the mean.
Run	When there is a run of 7 increasing or decreasing sequential points this may indicate a significant change in the process. This process is not in control. In this data set there is a run of falling points
2 of 3	When 2 out of 3 points lie near the LPL and UPL this is a warning that the process may be changing

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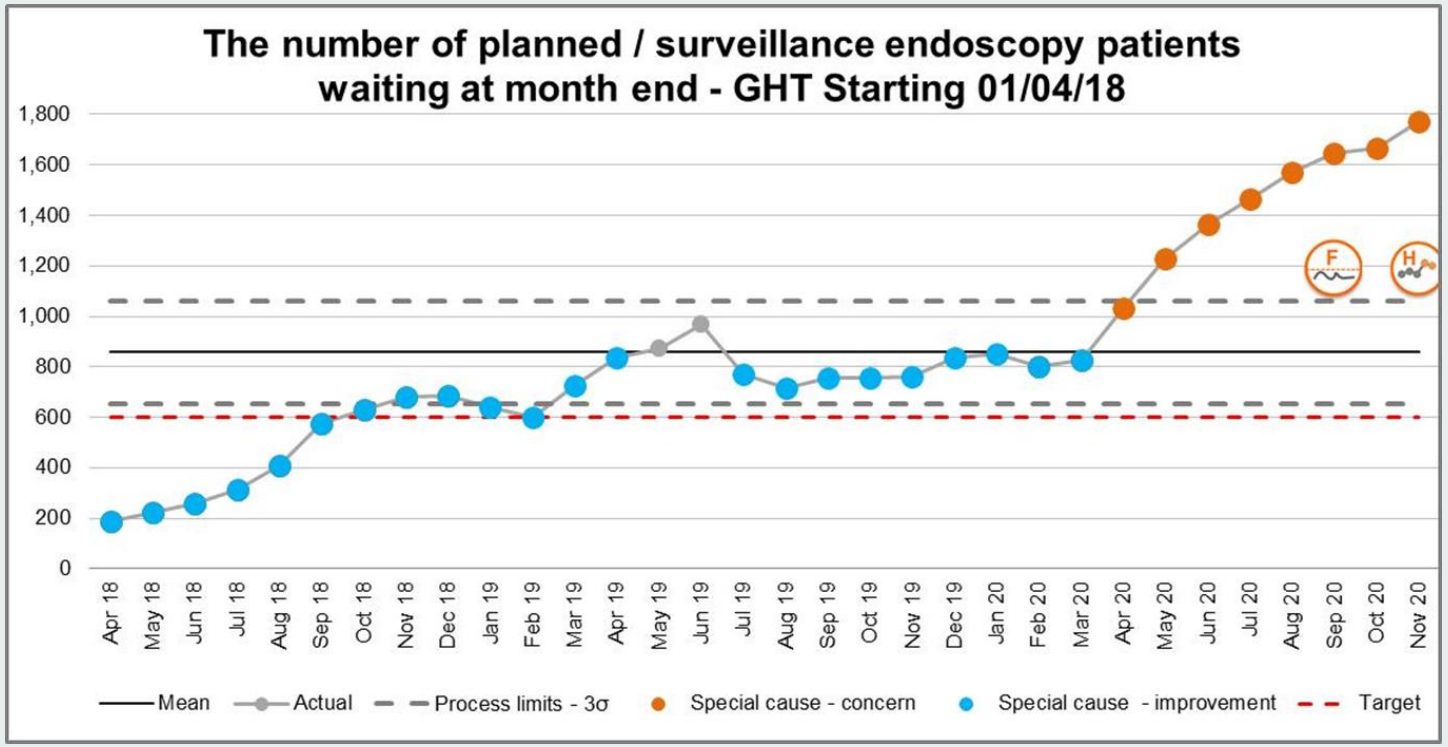

Commentary

There has been a deterioration of performance (107) in November following October's performance of 1665. The backlog position is due to COVID-19 pressures on a number of Endoscopy pathways, particularly cancer 2ww and 6ww diagnostic.

There is a systematic recovery plan for all Endoscopy pathways which will deliver a performance improvement for planned surveillance by March 2021.

- Director of Unscheduled Care and Deputy Chief Operating Officer

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 7 data points which are above the line. There are 9 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above and below the mean.
Run	When there is a run of 7 increasing or decreasing sequential points this may indicate a significant change in the process. This process is not in control. In this data set there is a run of rising points
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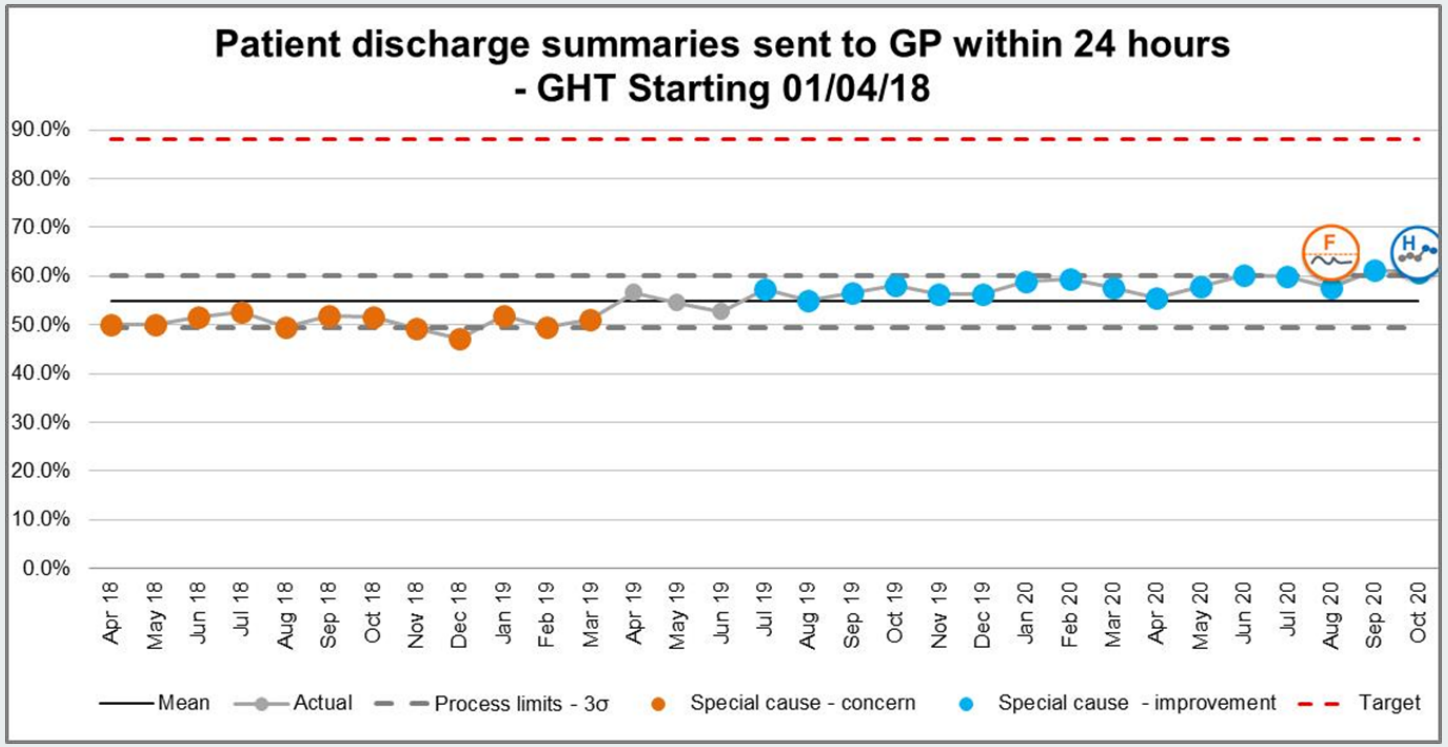

Commentary

Performance is improving marginally, continues to be monitored Executive reviews. Issue has been raised again with SDs.

- Medical Director

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 2 data points which are above the line. There are 2 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above and below the mean.
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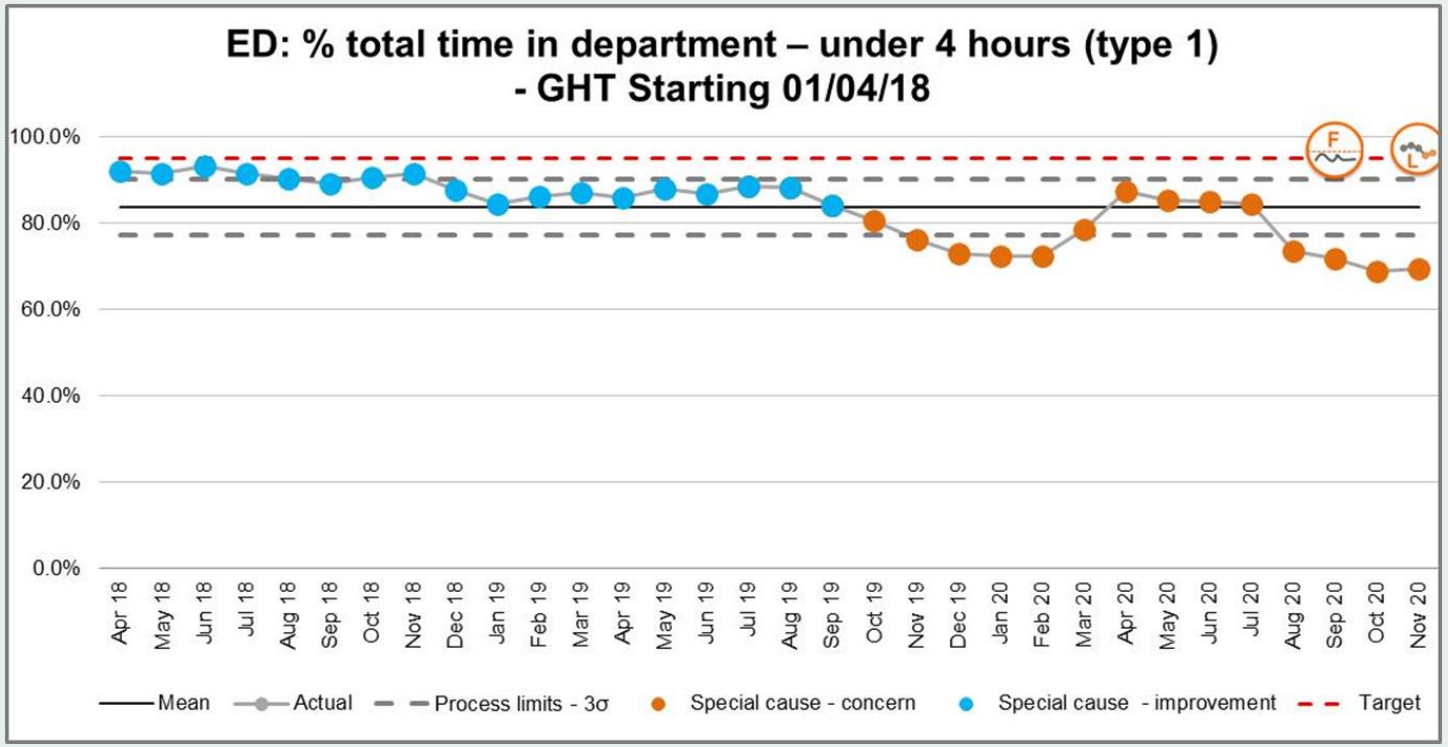

Commentary

Performance has increased by 0.44% compared to last month, this may be due to a reduction in attendances through the Emergency Department (ED) by 6.35% (-533 attendances). However the rate of admissions was still the same showing at patient acuity is still high

- Director of Unscheduled Care and Deputy Chief Operating Officer

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 7 data points which are above the line. There are 8 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above and below the mean.
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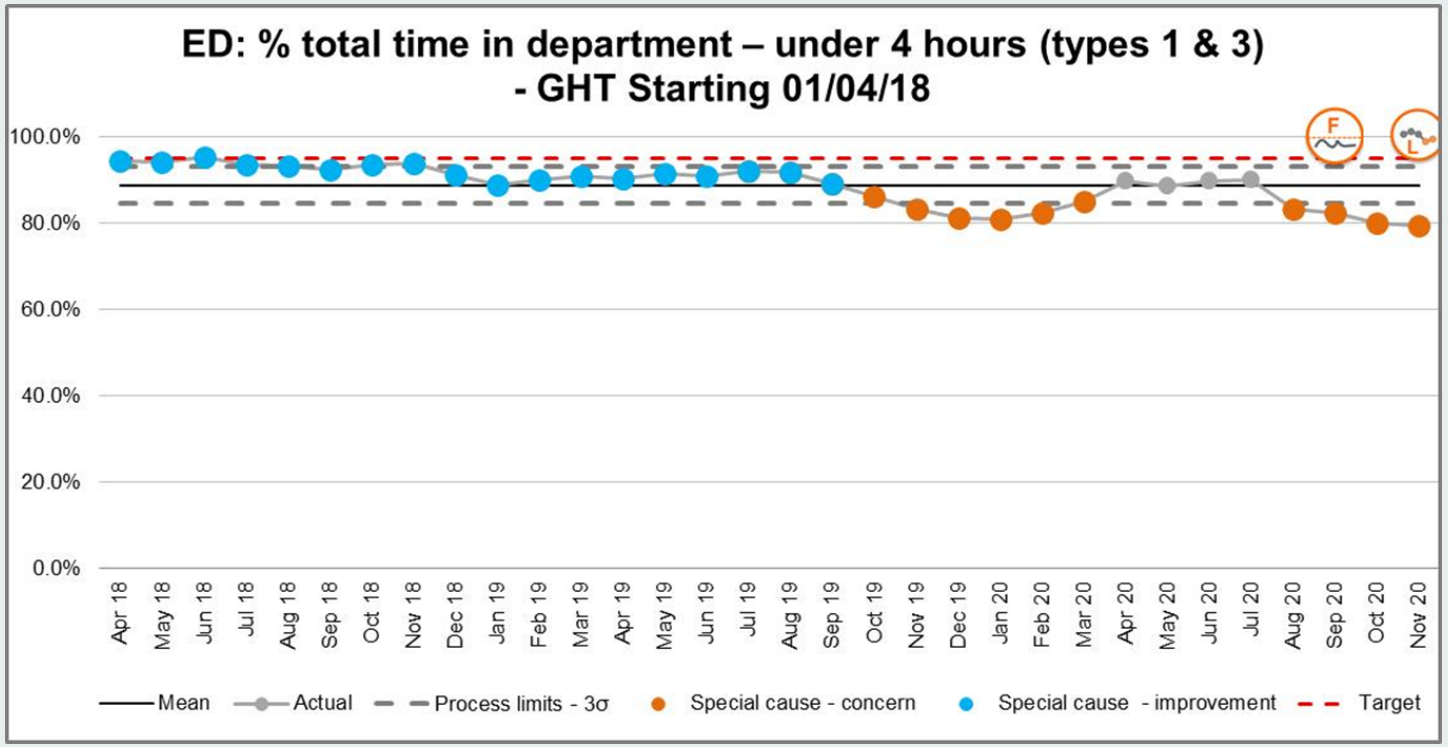

Commentary

November has shown a deterioration in performance of 0.57% which is due to higher acuity of patients through the Emergency Department (ED) and the inability to discharge patients once medically fir for discharge.

- Director of Unscheduled Care and Deputy Chief Operating Officer

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 7 data points which are above the line. There are 8 data point(s) below the line
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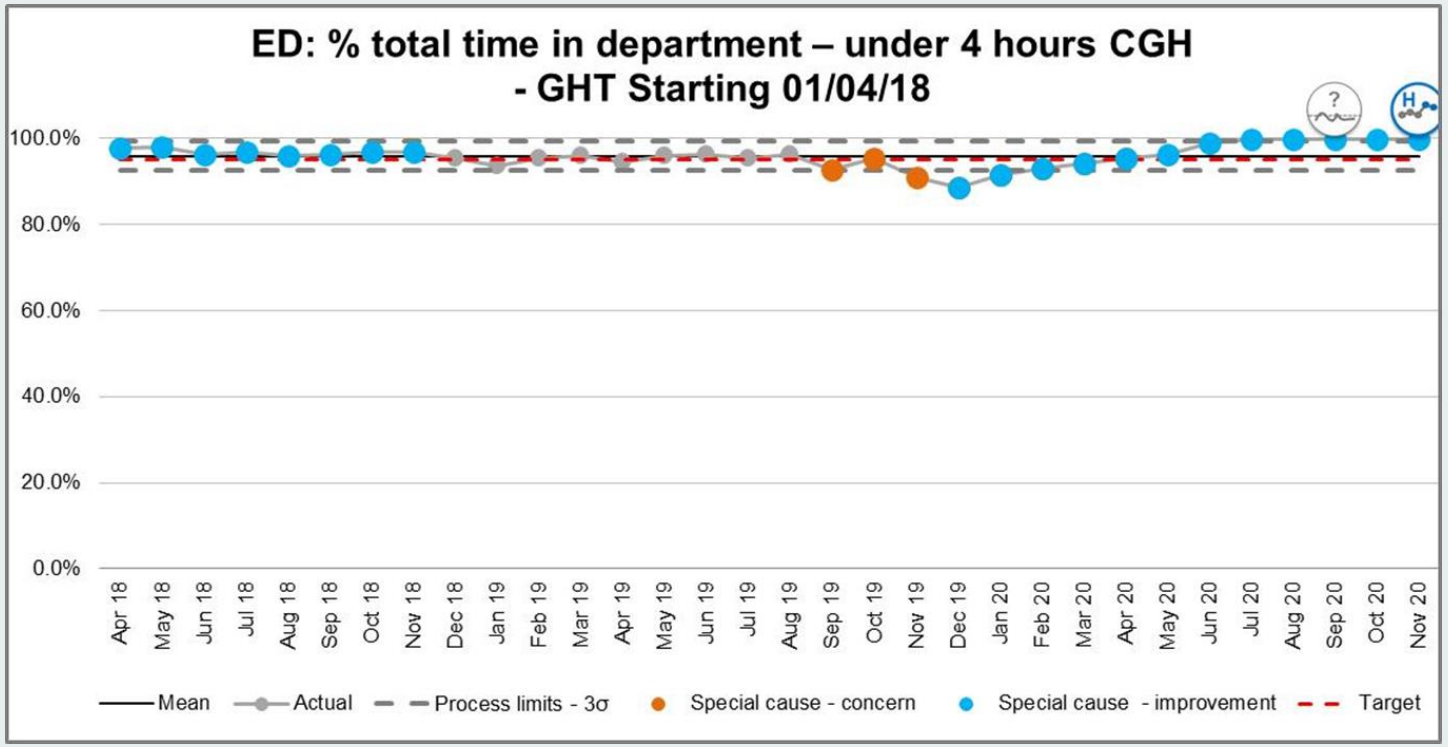

Commentary

Performance at CGH is still consistently above 95% and has been since the switch to a Minor Injuries and Illness Unit in June. This is because of the lower acuity of the patients it is seeing.

- Director of Unscheduled Care and Deputy Chief Operating Officer

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 5 data points which are above the line. There are 3 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above the mean.
Run	When there is a run of 7 increasing or decreasing sequential points this may indicate a significant change in the process. This process is not in control. In this data set there is a run of rising points
2 of 3	When 2 out of 3 points lie near the LPL and UPL this is a warning that the process may be changing

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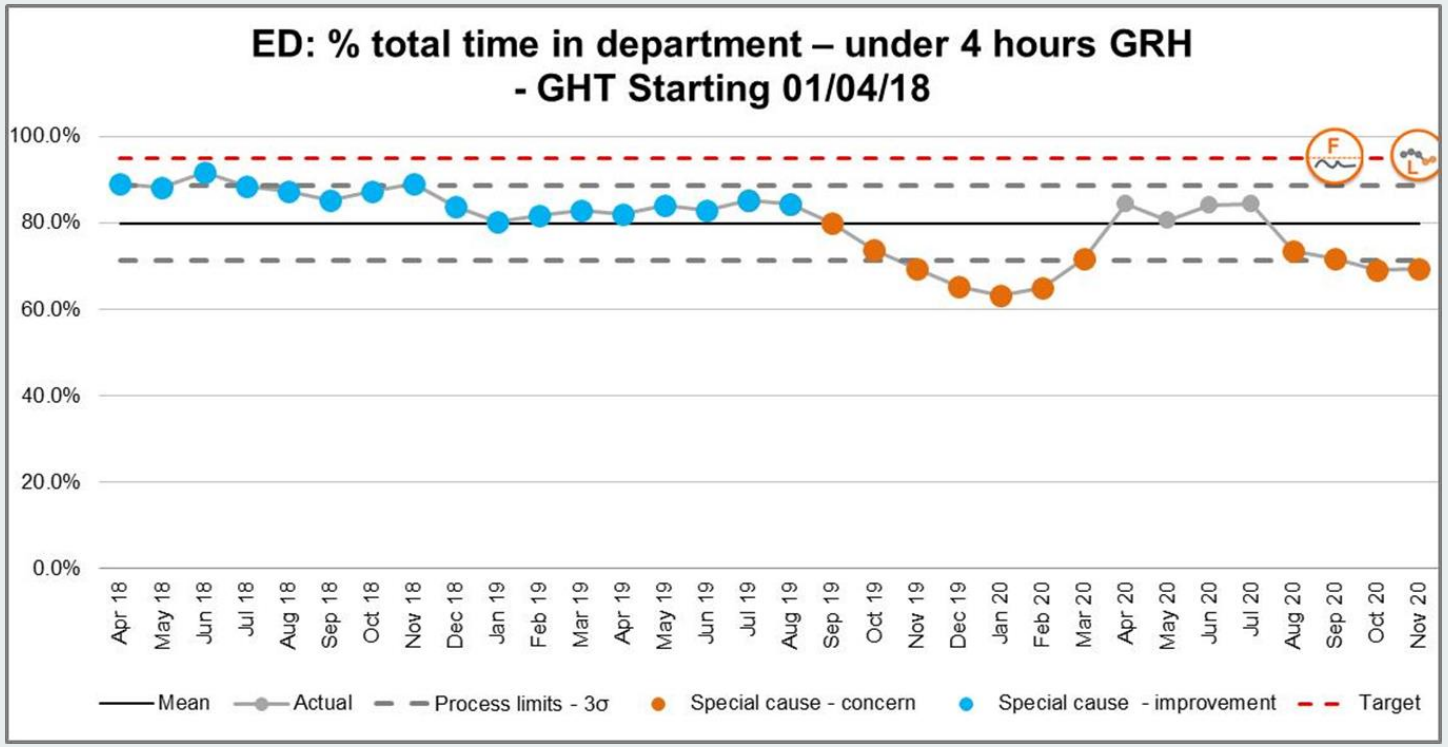

Commentary

Performance has increased by 0.44% compared to last month, this may be due to a reduction in attendances through the Emergency Department (ED) by 6.35% (-533 attendances). However the rate of admissions was still the same showing at patient acuity is still high

- Director of Unscheduled Care and Deputy Chief Operating Officer

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There is 3 data point which is above the line. There are 6 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above and below the mean.
Run	When there is a run of 7 increasing or decreasing sequential points this may indicate a significant change in the process. This process is not in control. In this data set there is a run of falling points
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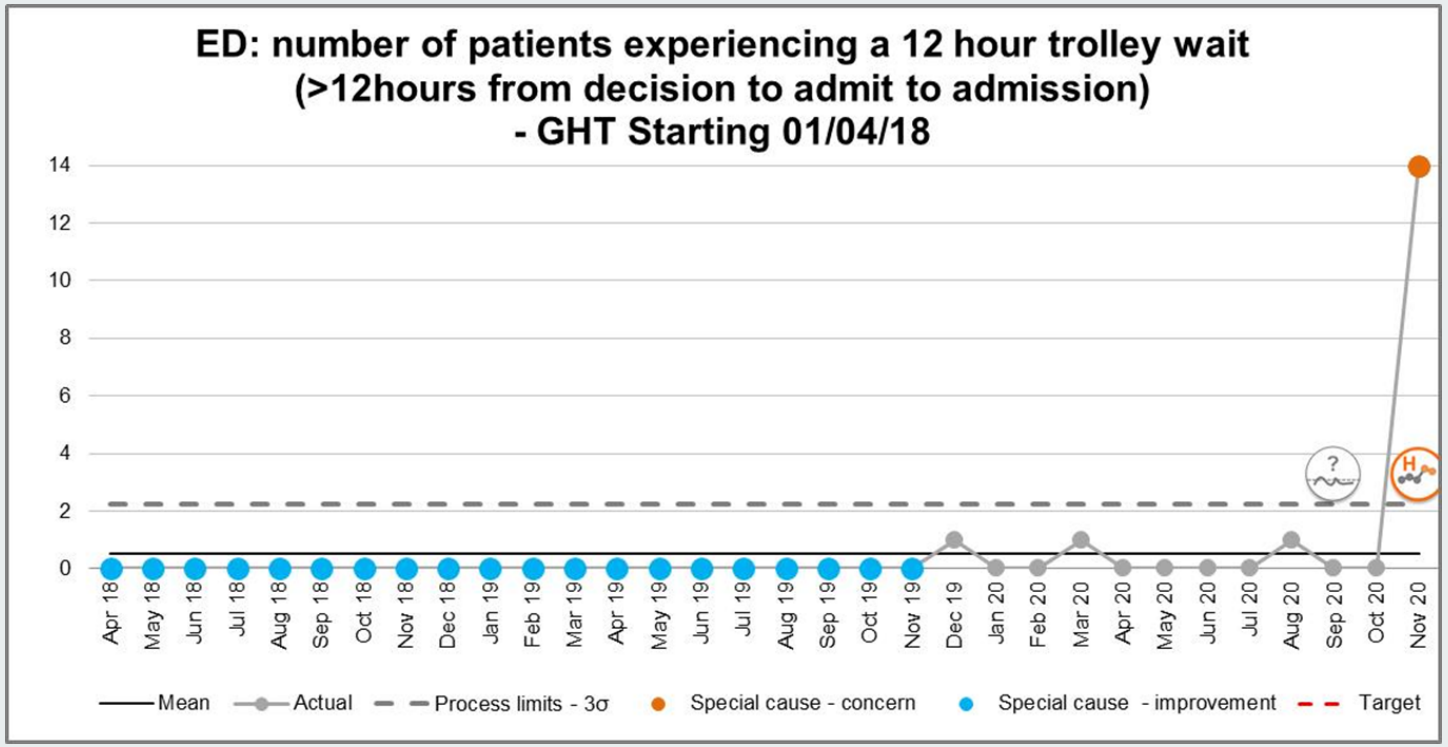

Commentary

There were fourteen 12 hour trolley breaches in November. This is because of a lack of flow in the hospital and a number of closed beds due to infection control.

- Director of Unscheduled Care and Deputy Chief Operating Officer

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There is 1 data point which is above the line.
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points below the mean.
Rule 4	When more than 15 consecutive points lie within the mean +/- 1σ this process is considered to be out of control.

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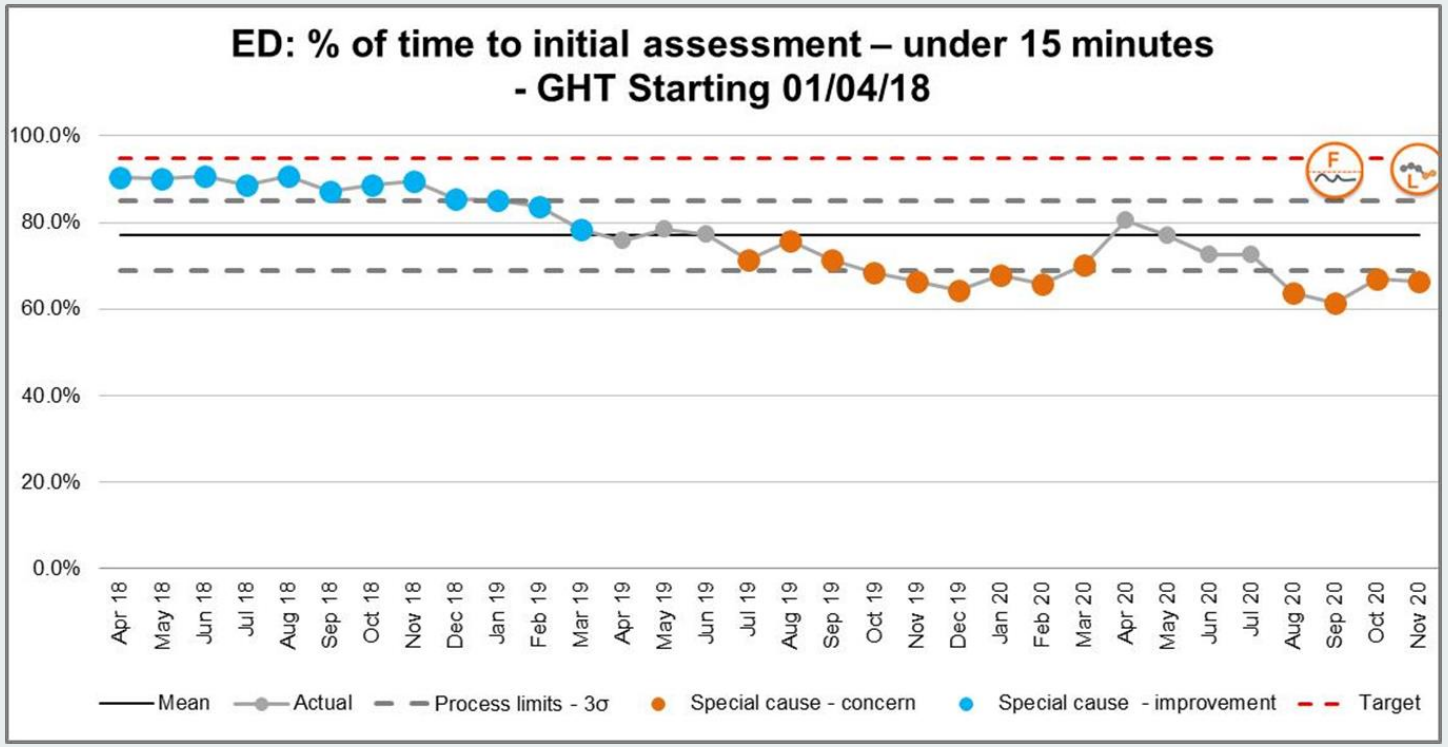

Commentary

Average triage has shown an improvement with waiting times lower in November than September. The trial of an additional triage nurse has improves performance for patients being triaged within 15 minutes of arrival, however still remains higher than the target of 15 minutes.

- Director of Unscheduled Care and Deputy Chief Operating Officer

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 10 data points which are above the line. There are 9 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above and below the mean.
2 of 3	When 2 out of 3 points lie near the LPL and UPL this is a warning that the process may be changing

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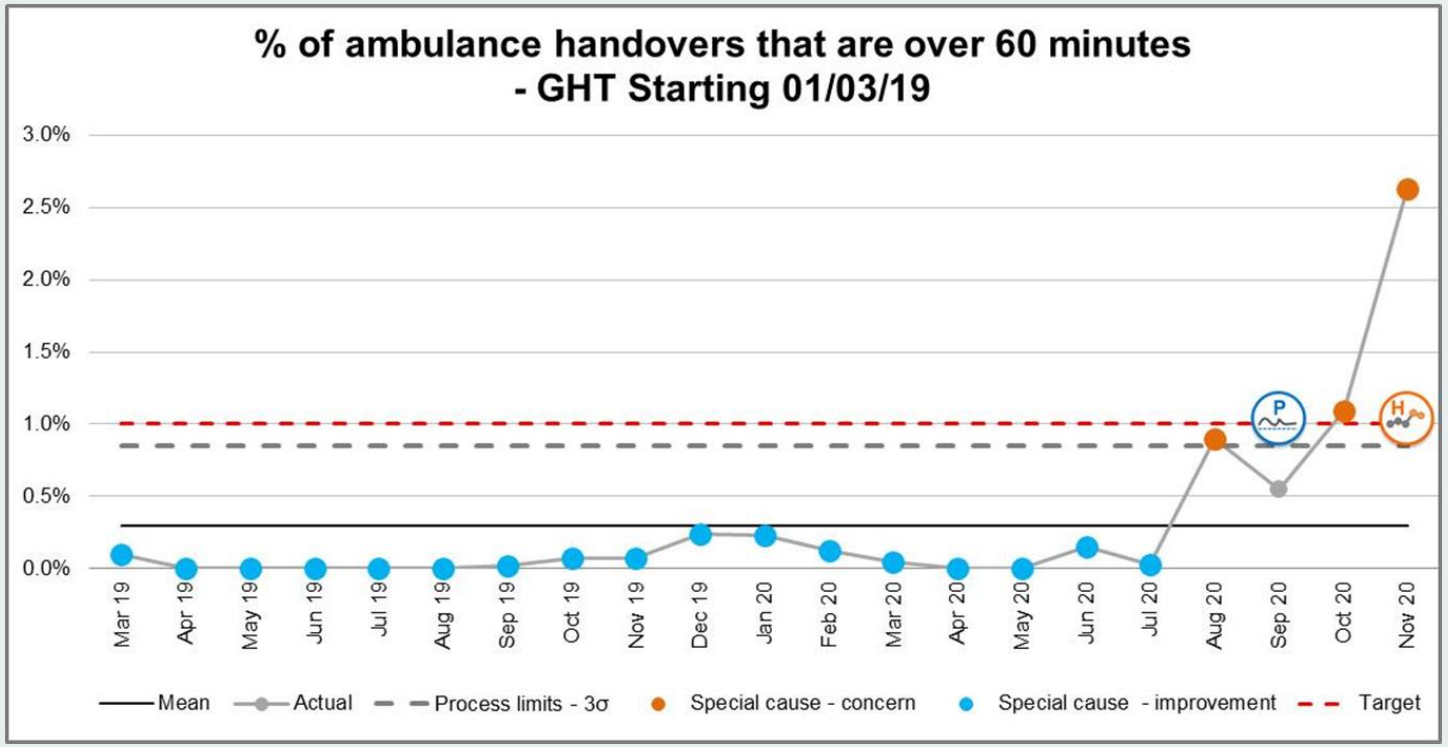

Commentary

Ambulance handover delays have increased in November due to a lack of flow in the Emergency Department (ED).

- Director of Unscheduled Care and Deputy Chief Operating Officer

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 3 data points which are above the line.
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points below the mean.
2 of 3	When 2 out of 3 points lie near the UPL this is a warning that the process may be changing

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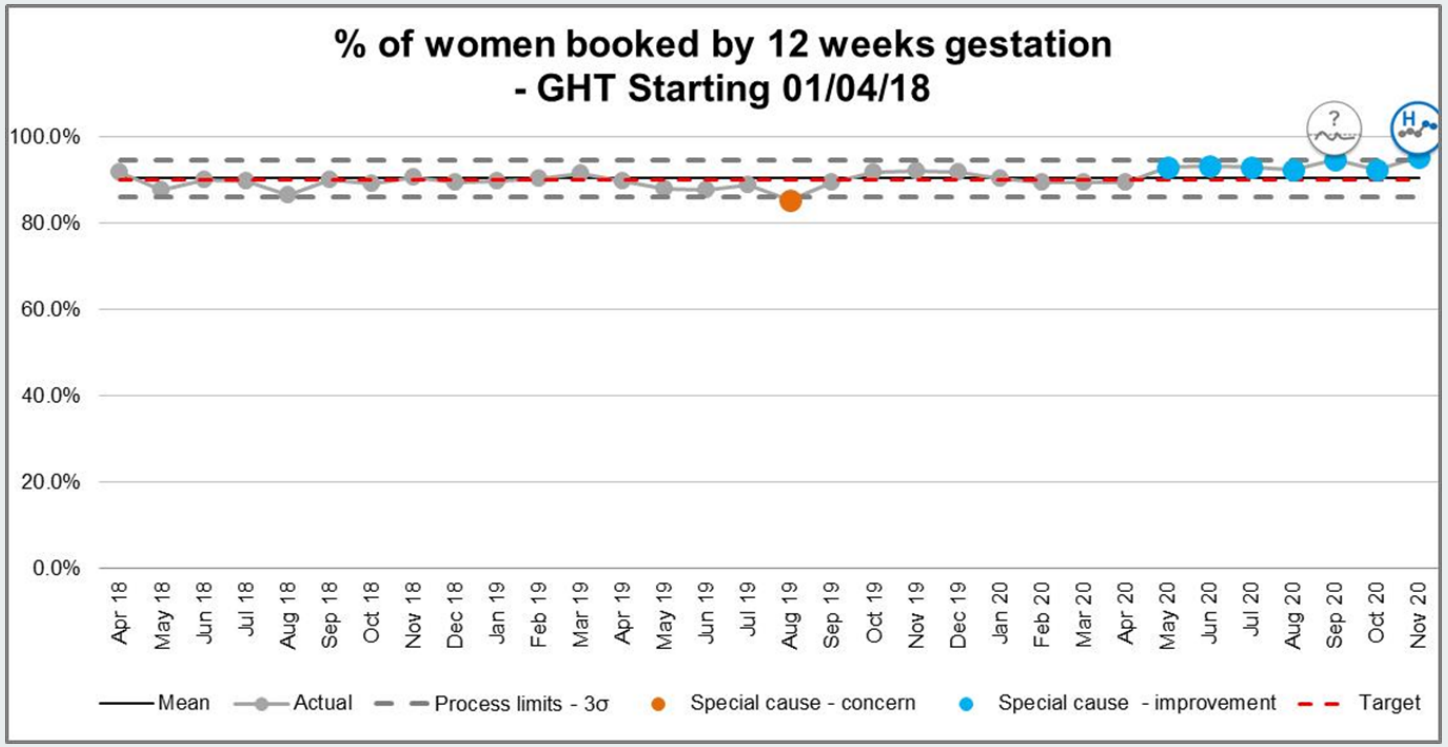

Commentary

As we have come out of lockdown with COVID and GP surgeries continuing to be open midwives are maintaining early contacts with women and early referrals from GPs allowing completion of bookings by 12 weeks.

- Director of Unscheduled Care and Deputy Chief Operating Officer

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 2 data points which are above the line. There is 1 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above the mean.
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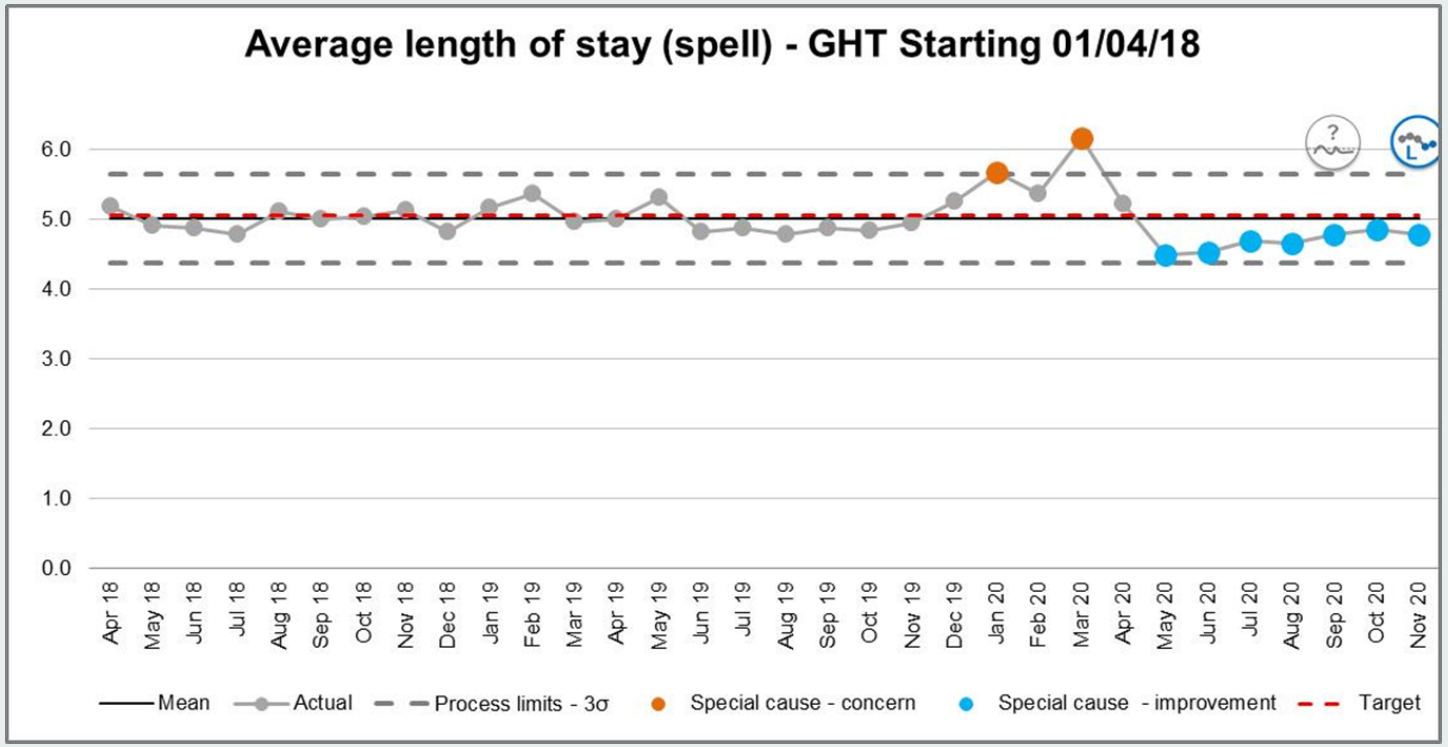

Commentary

Longest waiting patients under review. Medically stable for discharge supported by system partners.

- Director of Unscheduled Care and Deputy Chief Operating Officer

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 2 data points which are above the line.
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points below the mean.
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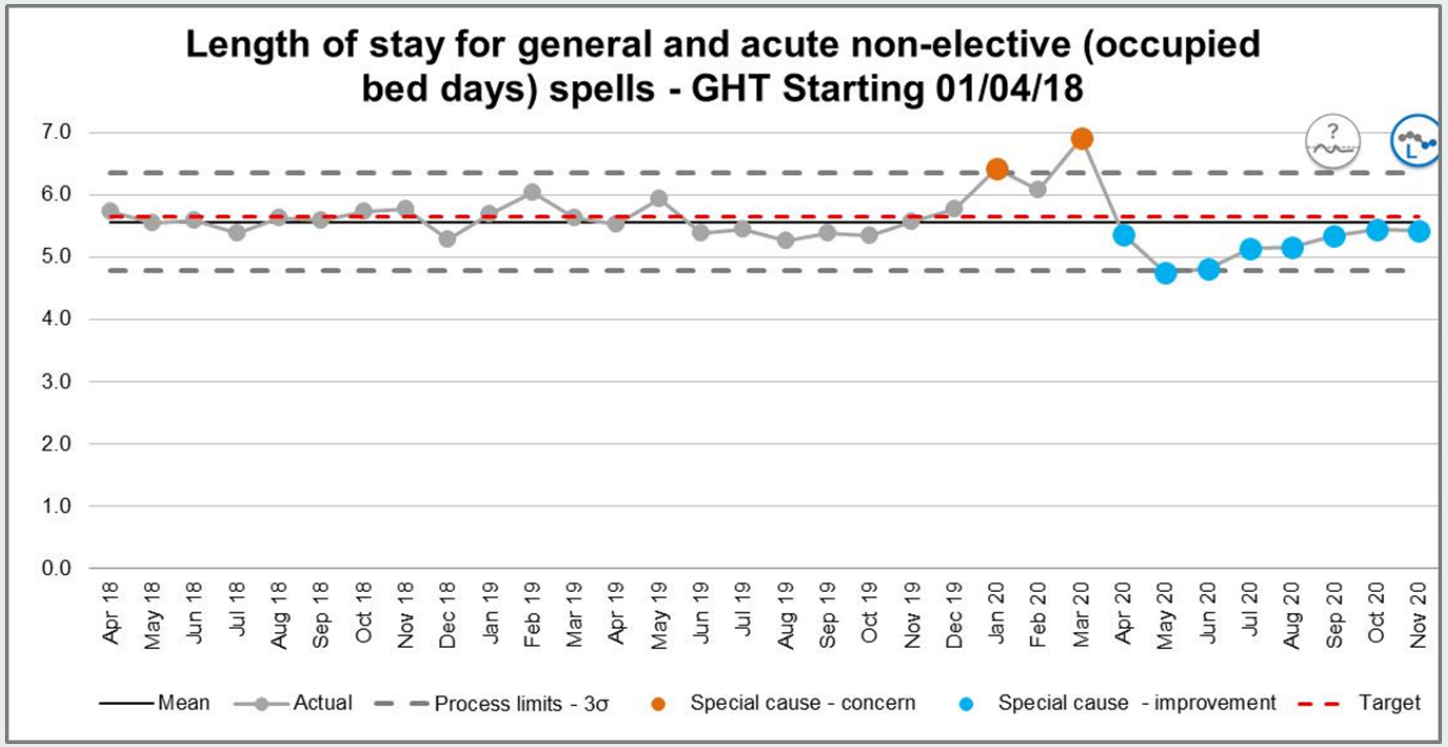

Commentary

Under review – noting work with system partners and surge 2 so ward base different.

- Deputy Chief Operating Officer

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 2 data points which are above the line. There is 1 data point(s) below the line
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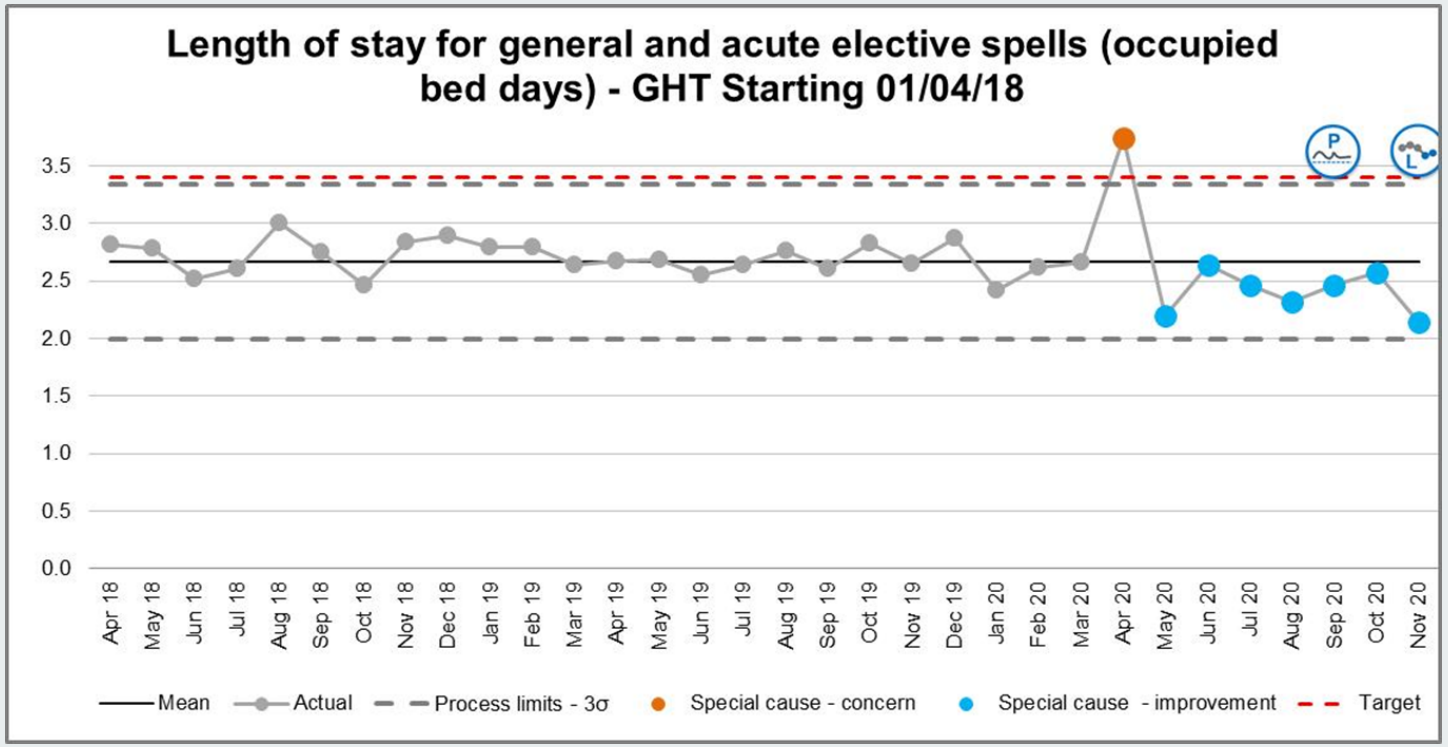

Commentary

Under review – noting work with system partners and surge 2 so ward base different.

- Deputy Chief Operating Officer

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There is 1 data point which is above the line.
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points below the mean.
Rule 4	When more than 15 consecutive points lie within the mean +/- 1σ this process is considered to be out of control.

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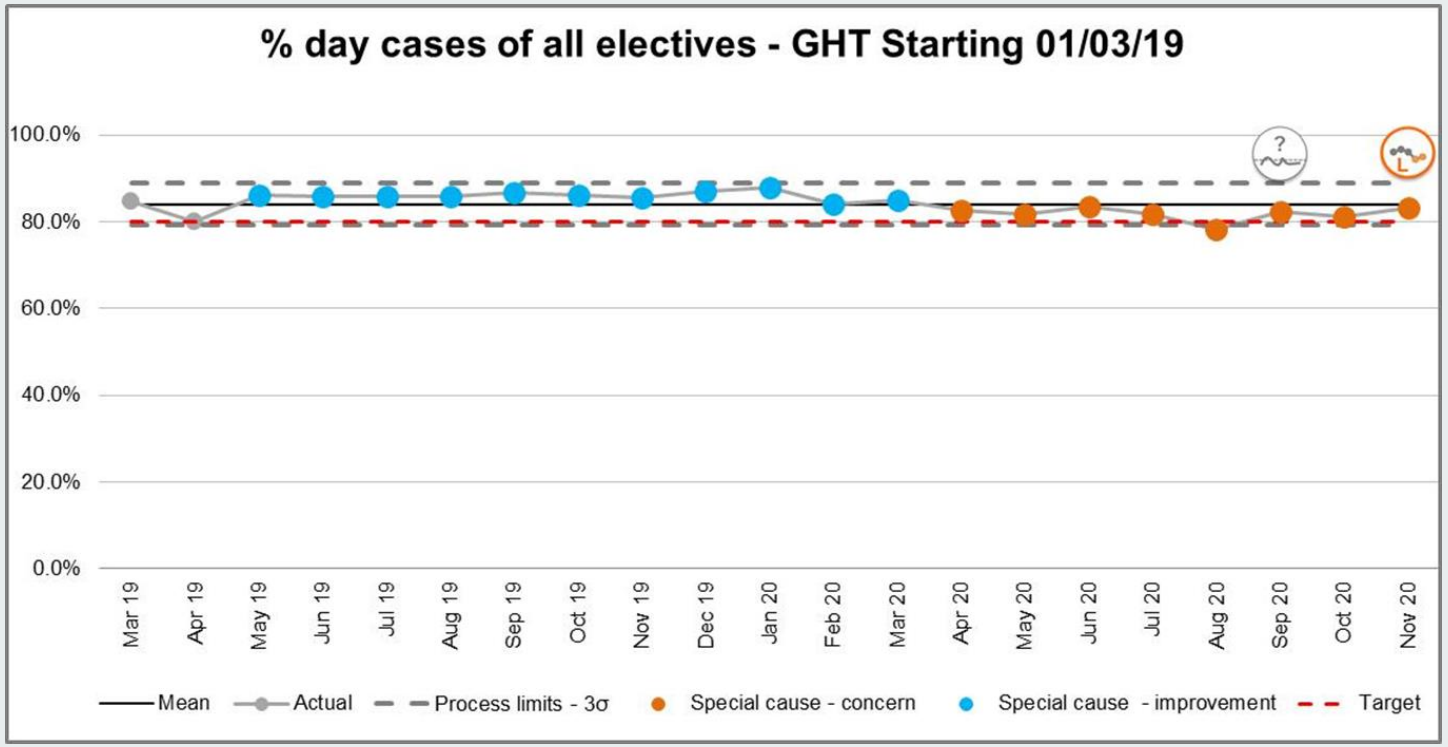

Commentary

Under review, recovery of performance priority balanced with flow.

- Deputy Chief Operating Officer

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control.There is 1 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above and below the mean.

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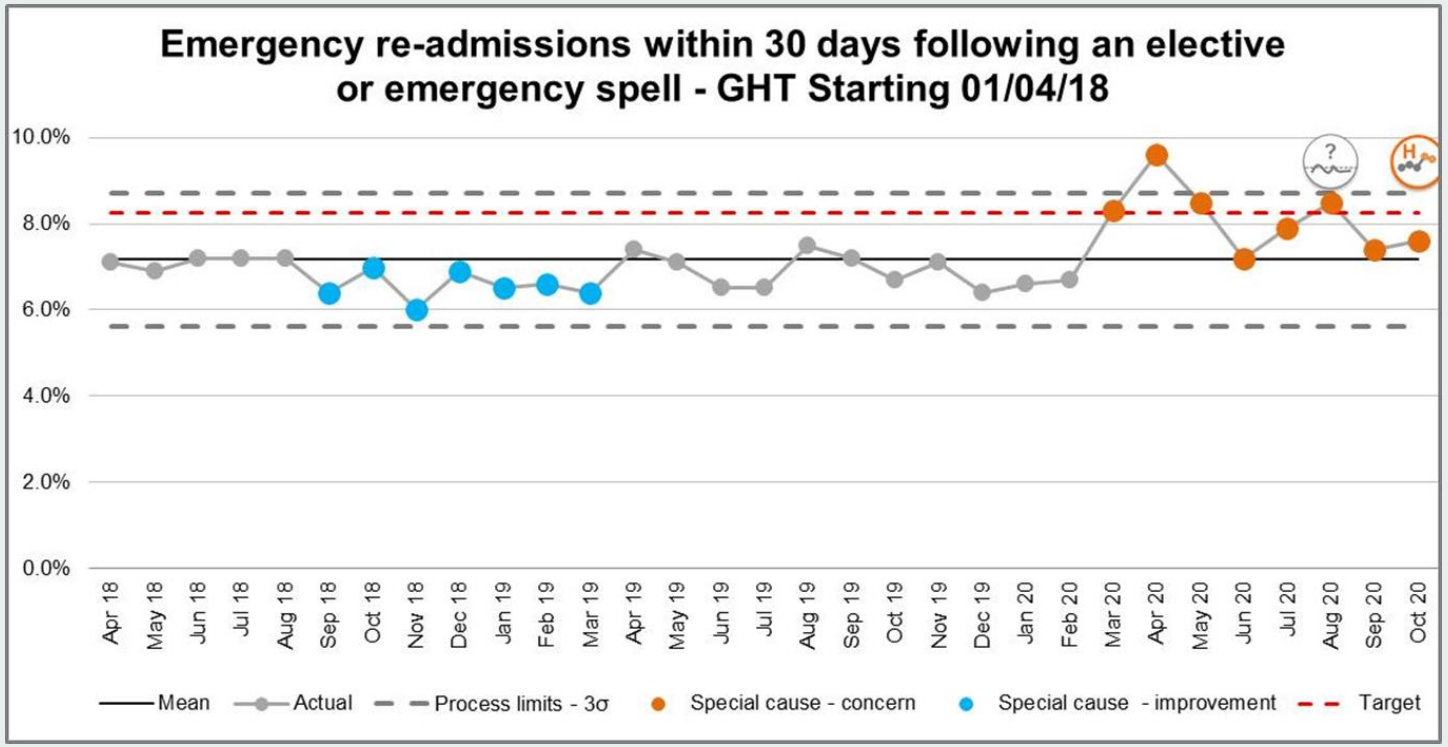

Commentary

This metric is now been green for the last 2 months, it was red at the height of wave one of the pandemic which is related to reduced elective activity and reduced attendances overall.

- Deputy Medical Director

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There is 1 data point which is above the line.
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above and below the mean.
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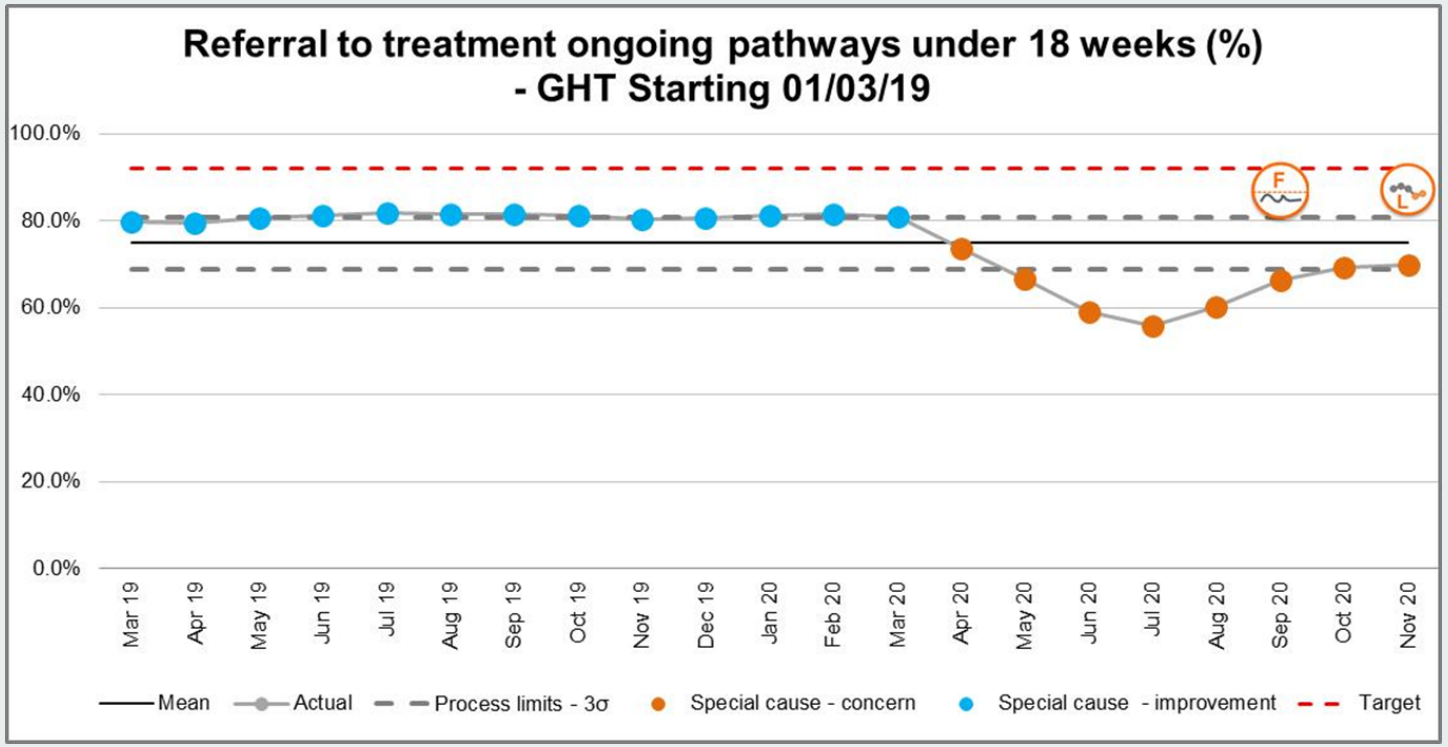

Commentary

See Planned Care Exception report for full details. The restoration and recovery phase continues (subject to surge 2) and since the low of 55.8% in July, performance continues to creep up. October was finalised as 69.36% and the part validated position is currently 69.9%, albeit 70% will be achieved prior to submission. As indicated in other metrics the long waiting cohort of patients has risen in recent months.

- Deputy Chief Operating Officer

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 8 data points which are above the line. There are 5 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above and below the mean.
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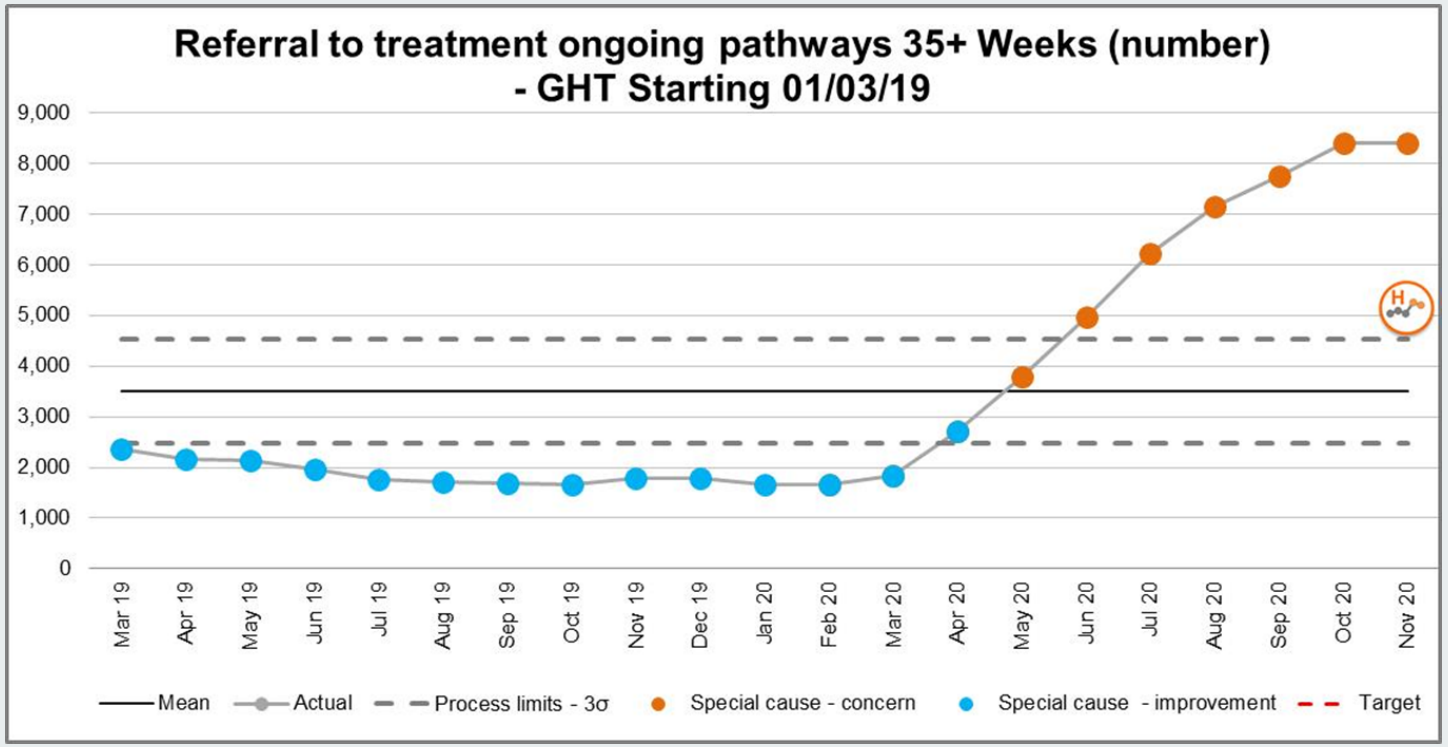

Commentary

Recovery and restoration continues (subject to surge 2) prioritising in accordance with clinical urgency followed by chronology. Consequently the cohort of long waiting patients has increased albeit November position comparable to October.

- Deputy Chief Operating Officer

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 6 data points which are above the line. There are 13 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above and below the mean.
Run	When there is a run of 7 increasing or decreasing sequential points this may indicate a significant change in the process. This process is not in control. In this data set there is a run of rising and falling points
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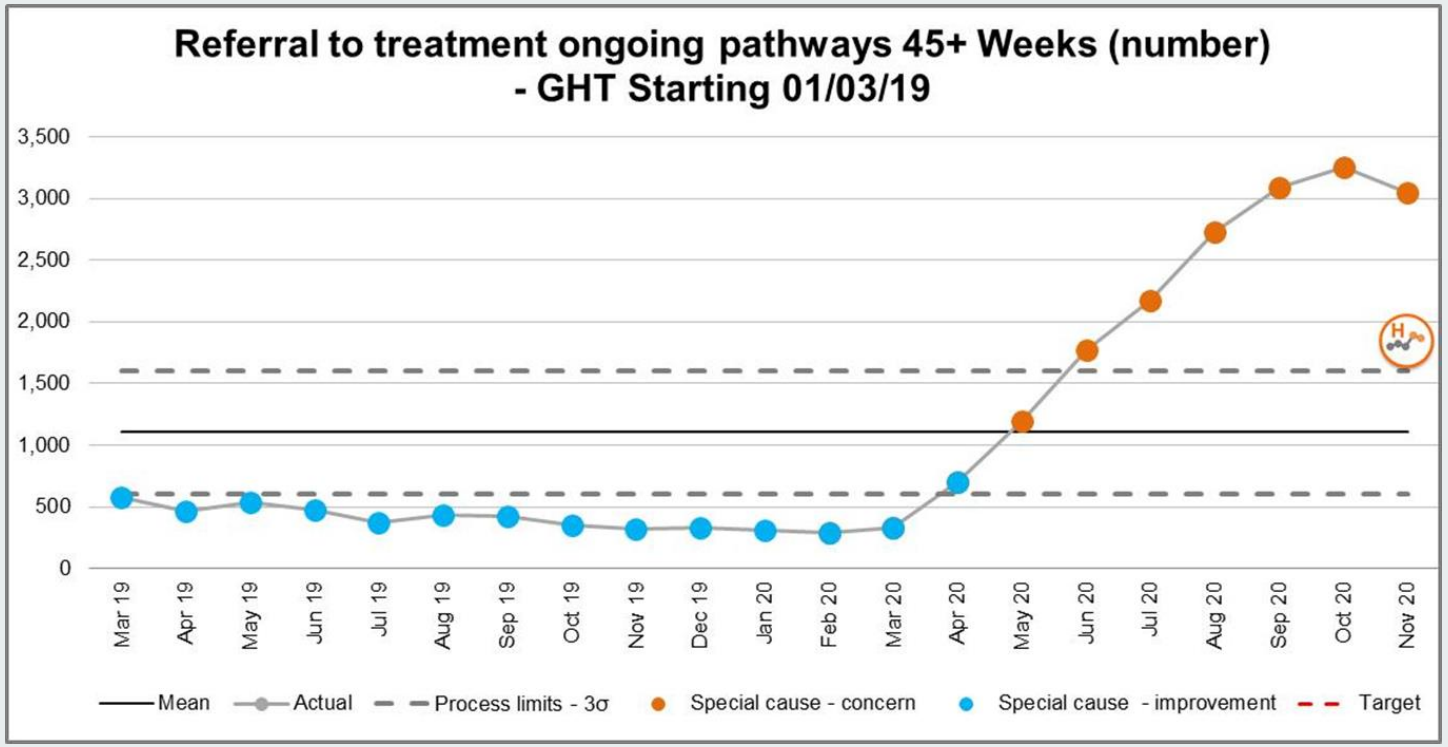

Commentary

Recovery and restoration continues (subject to surge 2) prioritising in accordance with clinical urgency followed by chronology. Consequently the cohort of long waiting patients has increased, albeit November has seen a reduction of approx 200 patients compared to October.

- Deputy Chief Operating Officer

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 5 data points which are above the line. There are 2 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points below the mean.
Run	When there is a run of 7 increasing or decreasing sequential points this may indicate a significant change in the process. This process is not in control. In this data set there is a run of rising points
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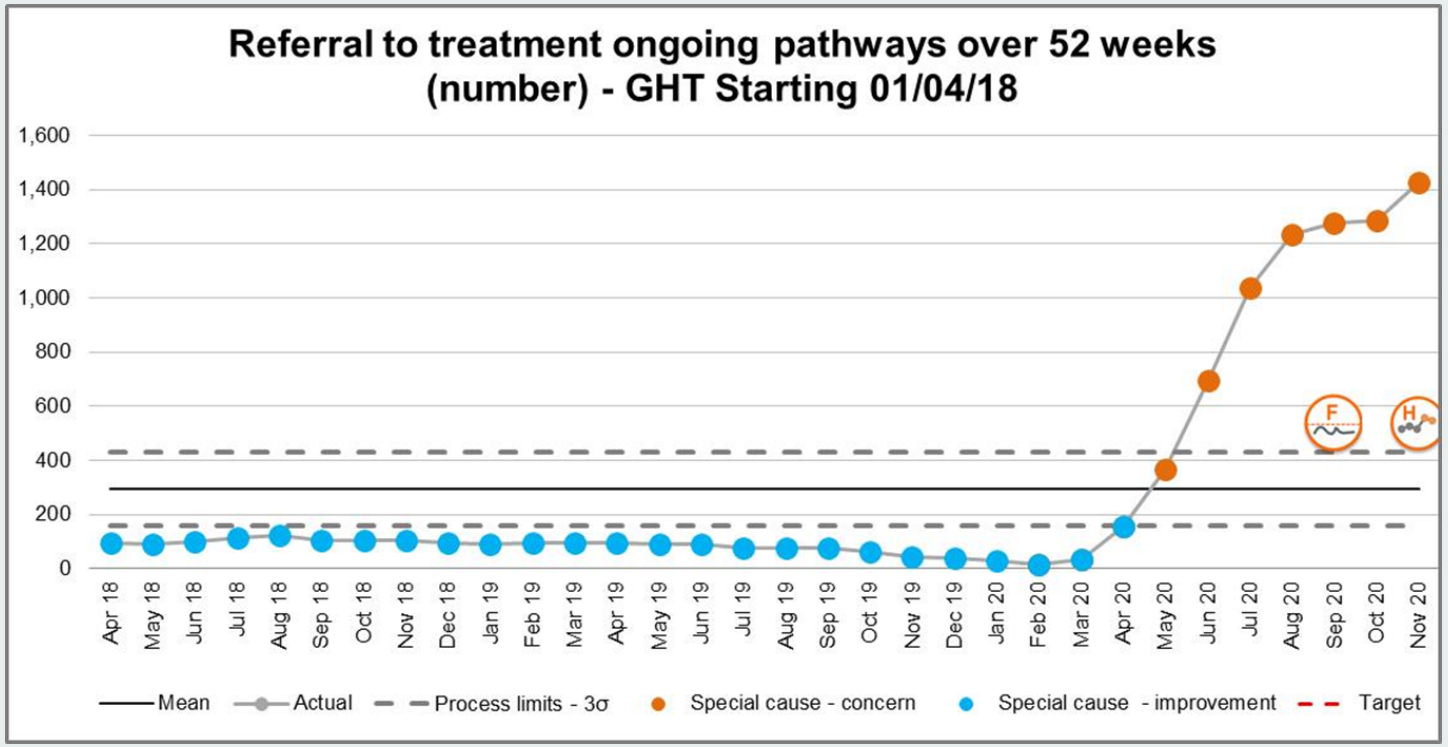

Commentary

See Planned Care Exception report for full details. The restoration and recovery phase continues, noting that our long waiting patients have increased over recent months. Although September and October had stabilised, the number of long waiters has increased in November primarily as a result of increased operational pressures with surge 2.

- Deputy Chief Operating Officer

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 6 data points which are above the line. There are 25 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above and below the mean.
Run	When there is a run of 7 increasing or decreasing sequential points this may indicate a significant change in the process. This process is not in control. In this data set there is a run of rising and falling points
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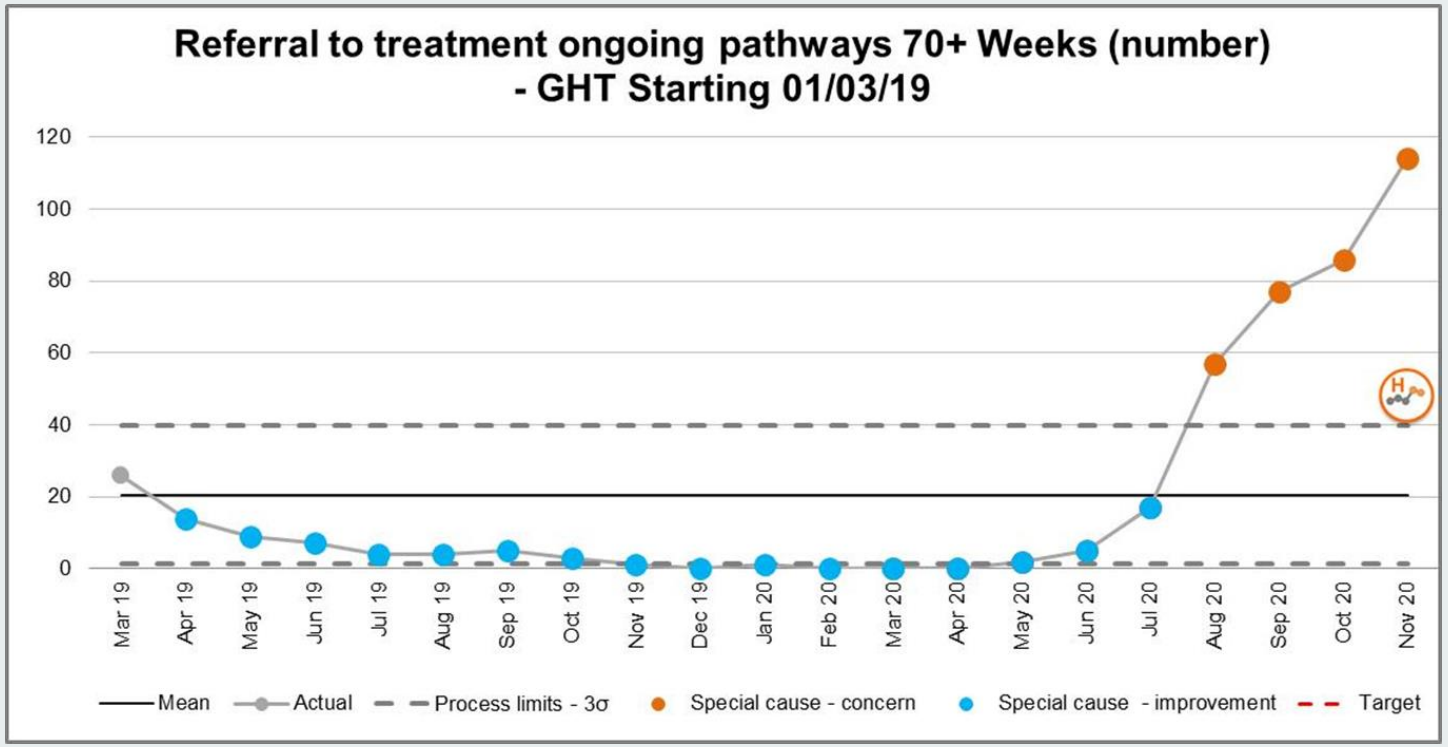


Commentary

Recovery and restoration continues (subject to surge 2) prioritising in accordance with clinical urgency followed by chronology. Consequently the cohort of long waiting patients has increased, albeit November has seen a reduction of approx 200 patients compared to October.

- Deputy Chief Operating Officer

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 4 data points which are above the line. There are 6 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points below the mean.
Run	When there is a run of 7 increasing or decreasing sequential points this may indicate a significant change in the process. This process is not in control. In this data set there is a run of rising points
2 of 3	When 2 out of 3 points lie near the LPL and UPL this is a warning that the process may be changing

Quality Dashboard

Gloucestershire Hospitals NHS Foundation Trust

This dashboard shows the most recent performance of metrics in the Quality category. Where SPC analysis is not possible the metric is RAG rated against national standards. Exception reports are shown on the following pages.

Key

Assurance

- Consistently hit target
- Hit and miss target subject to random
- Consistently fail target

Variation

- Special Cause Concerning variation
- Common Cause
- Special Cause Improving variation

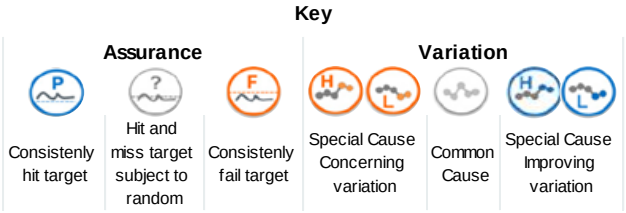
MetricTopic	MetricNameAlias	Target & Assurance	Latest Performance & Variance		
Dementia Screening	% of patients who have been screened for dementia (within 72 hours)	>=90%	Nov-20	68.0%	
Dementia Screening	% of patients who have scored positively on dementia screening tool that then received a dementia diagnostic	>=90%	Mar-20	0.0%	
Dementia Screening	% of patients who have received a dementia diagnostic assessment with positive or inconclusive results that were	>=90%	Dec-19	0.0%	
Friends & Family Test	Inpatients % positive	>=96%	Nov-20	85.7%	
Friends & Family Test	ED % positive	>=84%	Nov-20	83.7%	
Friends & Family Test	Maternity % positive	>=97%	Nov-20	88.4%	
Friends & Family Test	Outpatients % positive	>=94%	Nov-20	94.1%	
Friends & Family Test	Total % positive	>=93%	Nov-20	92.2%	
Infection Control	Number of trust apportioned MRSA bacteraemia	Zero	Nov-20	0	
Infection Control	MRSA bacteraemia – infection rate per 100,000 bed days	Zero	Nov-20	0	
Infection Control	Number of trust apportioned Clostridium difficile cases per month	2019/20: 114	Nov-20	4	
Infection Control	Number of community-onset healthcare-associated Clostridioides difficile cases per month	<=5	Nov-20	2	
Infection Control	Number of hospital-onset healthcare-associated Clostridioides difficile cases per month	<=5	Nov-20	2	
Infection Control	Clostridium difficile – infection rate per 100,000 bed days	<30.2	Oct-20	29.2	
Infection Control	Number of MSSA bacteraemia cases	<=8	Nov-20	1	
Infection Control	MSSA – infection rate per 100,000 bed days	<=12.7	Oct-20	3.6	
Infection Control	Number of ecoli cases	No target	Nov-20	3	
Infection Control	Number of pseudomona cases	No target	Nov-20	0	
Infection Control	Number of klebsiella cases	No target	Nov-20	1	
Infection Control	Number of bed days lost due to infection control outbreaks	<10	Oct-20	5	

MetricTopic	MetricNameAlias	Target & Assurance	Latest Performance & Variance		
Infection Control	COVID-19 community-onset – First positive specimen <=2 days after admission	TBC	Nov-20	224	
Infection Control	COVID-19 hospital-onset indeterminate healthcare-associated – First positive specimen 3-7 days after admission	TBC	Nov-20	57	
Infection Control	COVID-19 hospital-onset probably healthcare-associated – First positive specimen 8-14 days after admission	TBC	Nov-20	55	
Infection Control	COVID-19 hospital-onset definite healthcare-associated – First positive specimen >=15 days after admission	TBC	Nov-20	57	
Inpatient Questions	How much information about your condition or treatment or care has been given to you?	>=90%	Mar-20	78%	
Inpatient Questions	Are you involved as much as you want to be in decisions about your care and treatment?	>=90%	Mar-20	92%	
Inpatient Questions	Do you feel that you are treated with respect and dignity?	>=90%	Mar-20	100%	
Inpatient Questions	Do you feel well looked after by staff treating or caring for you?	>=90%	Mar-20	99%	
Inpatient Questions	Do you get enough help from staff to eat your meals?	>=90%	Mar-20	67%	
Inpatient Questions	In your opinion, how clean is your room or the area that you receive treatment in?	>=90%	Mar-20	100%	
Inpatient Questions	Do you get enough help from staff to wash or keep yourself clean?	>=90%	Mar-20	86%	
Maternity	% C-section rate (planned and emergency)	<=27%	Nov-20	28.09%	
Maternity	% emergency C-section rate	No target	Nov-20	15.7%	
Maternity	% of women smoking at delivery	<=14.5%	Nov-20	11.24%	
Maternity	% of women that have an induced labour	<=30%	Nov-20	32.6%	
Maternity	% stillbirths as percentage of all pregnancies > 24 weeks	<0.52%	Nov-20	0.68%	
Maternity	% of women on a Continuity of Carer pathway	No target	Nov-20	0.0%	
Mortality	Summary hospital mortality indicator (SHMI) – national data	NHS Digital	Jun-20	1.1	
Mortality	Hospital standardised mortality ratio (HSMR)	Dr Foster	Aug-20	105.1	
Mortality	Hospital standardised mortality ratio (HSMR) – weekend	Dr Foster	Aug-20	108.8	
Mortality	Number of inpatient deaths	No target	Nov-20	181	

Quality Dashboard

Gloucestershire Hospitals NHS Foundation Trust

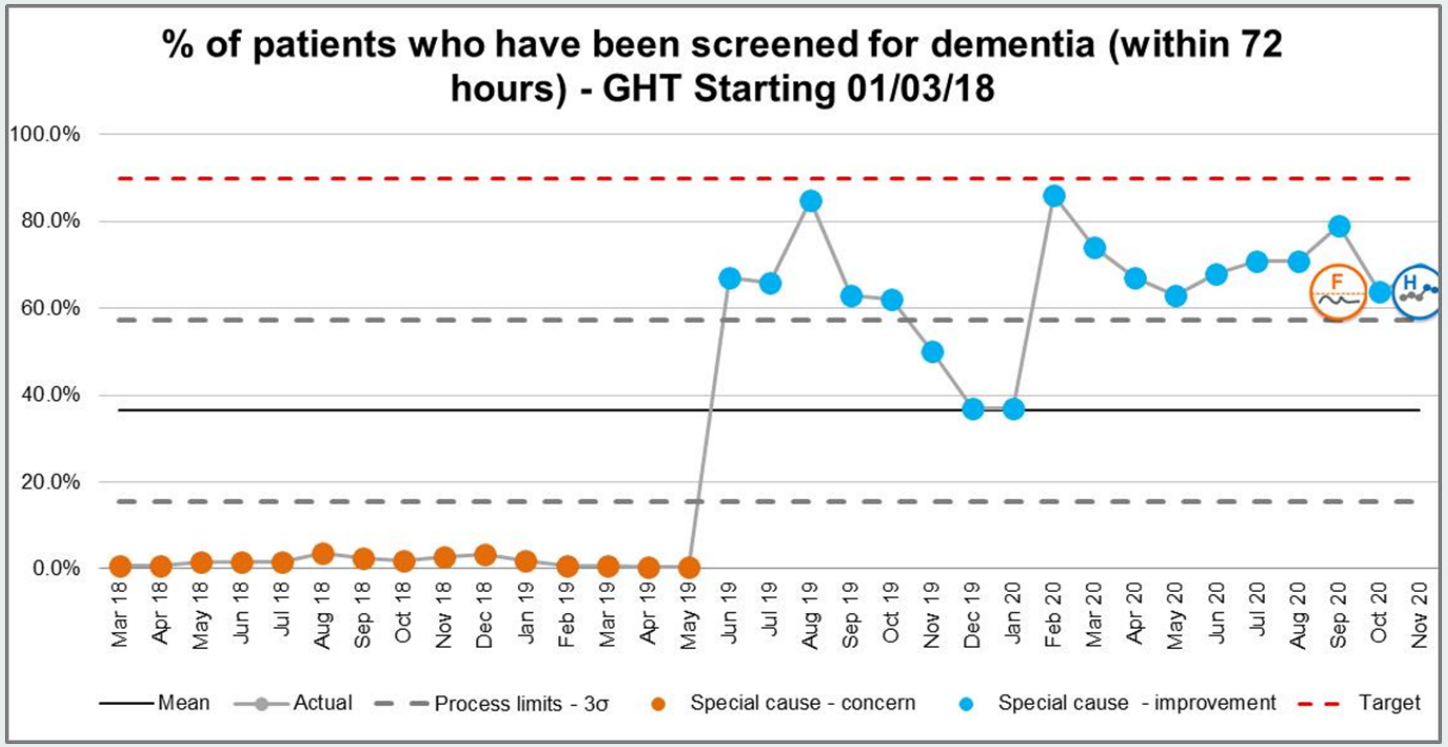
This dashboard shows the most recent performance of metrics in the Quality category. Where SPC analysis is not possible the metric is RAG rated against national standards. Exception reports are shown on the following pages.



MetricTopic	MetricNameAlias	Target & Assurance	Latest Performance & Variance		
Mortality	Number of deaths of patients with a learning disability	No target	Nov-20	1	
MSA	Number of breaches of mixed sex accommodation	<=10	Nov-20	0	
Patient Safety Incidents	Number of patient safety alerts outstanding	Zero	Nov-20	0	
Patient Safety Incidents	Number of falls per 1,000 bed days	<=6	Nov-20	7.7	
Patient Safety Incidents	Number of falls resulting in harm (moderate/severe)	<=3	Nov-20	6	
Patient Safety Incidents	Number of patient safety incidents – severe harm (major/death)	No target	Nov-20	6	
Patient Safety Incidents	Medication error resulting in severe harm	No target	Nov-20	0	
Patient Safety Incidents	Medication error resulting in moderate harm	No target	Nov-20	1	
Patient Safety Incidents	Medication error resulting in low harm	No target	Nov-20	15	
Patient Safety Incidents	Number of category 2 pressure ulcers acquired as in-patient	<=30	Nov-20	28	
Patient Safety Incidents	Number of category 3 pressure ulcers acquired as in-patient	<=5	Nov-20	3	
Patient Safety Incidents	Number of category 4 pressure ulcers acquired as in-patient	Zero	Nov-20	0	
Patient Safety Incidents	Number of unstagable pressure ulcers acquired as in-patient	<=3	Nov-20	6	
Patient Safety Incidents	Number of deep tissue injury pressure ulcers acquired as in-patient	<=5	Nov-20	5	
Sepsis Identification	Proportion of emergency patients with severe sepsis who were given IV antibiotics within 1 hour of diagnosis	>=90%	Sep-20	74%	
RIDDOR	Number of RIDDOR	SPC	Nov-20	3	
Safety Thermometer	Safety thermometer – % of new harms	>96%	Mar-20	97.8%	
Serious Incidents	Number of never events reported	Zero	Nov-20	3	
Serious Incidents	Number of serious incidents reported	No target	Nov-20	4	
Serious Incidents	Serious incidents – 72 hour report completed within contract timescale	>90%	Nov-20	100.0%	
Serious Incidents	Percentage of serious incident investigations completed within contract timescale	>80%	Nov-20	100%	
VTE Prevention	% of adult inpatients who have received a VTE risk assessment	>95%	Nov-20	94.6%	

Quality:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

The manual audit for this indicator shows a consistent performance in screening for dementia in the 30 case notes sampled, but is still below compliance, and as the Dementia Improvement Plan (DIP) has developed its performance dashboard, it should be noted that the sample size is approximately 10% of dementia admissions.

The pace of the DIP's dementia & delirium QI project has been impacted by the current COVID priorities, but continues to look for ways to enable electronic record systems to prompt the assessment and recording of dementia and delirium, and this will also improve the ability to respond to DAR/FAIR indicator and the National Audit of Dementia.

The DIP has identified delirium in patients with dementia as a key priority, as there is evidence from the Diagnose QI phase that multiple bed moves , Length of Stay and mortality rates are higher for this vulnerable group. A Dementia Council will be convened to support and monitor progress, and will be Chaired by the Trust's new Admiral Nurse and report to the Quality Delivery Group.

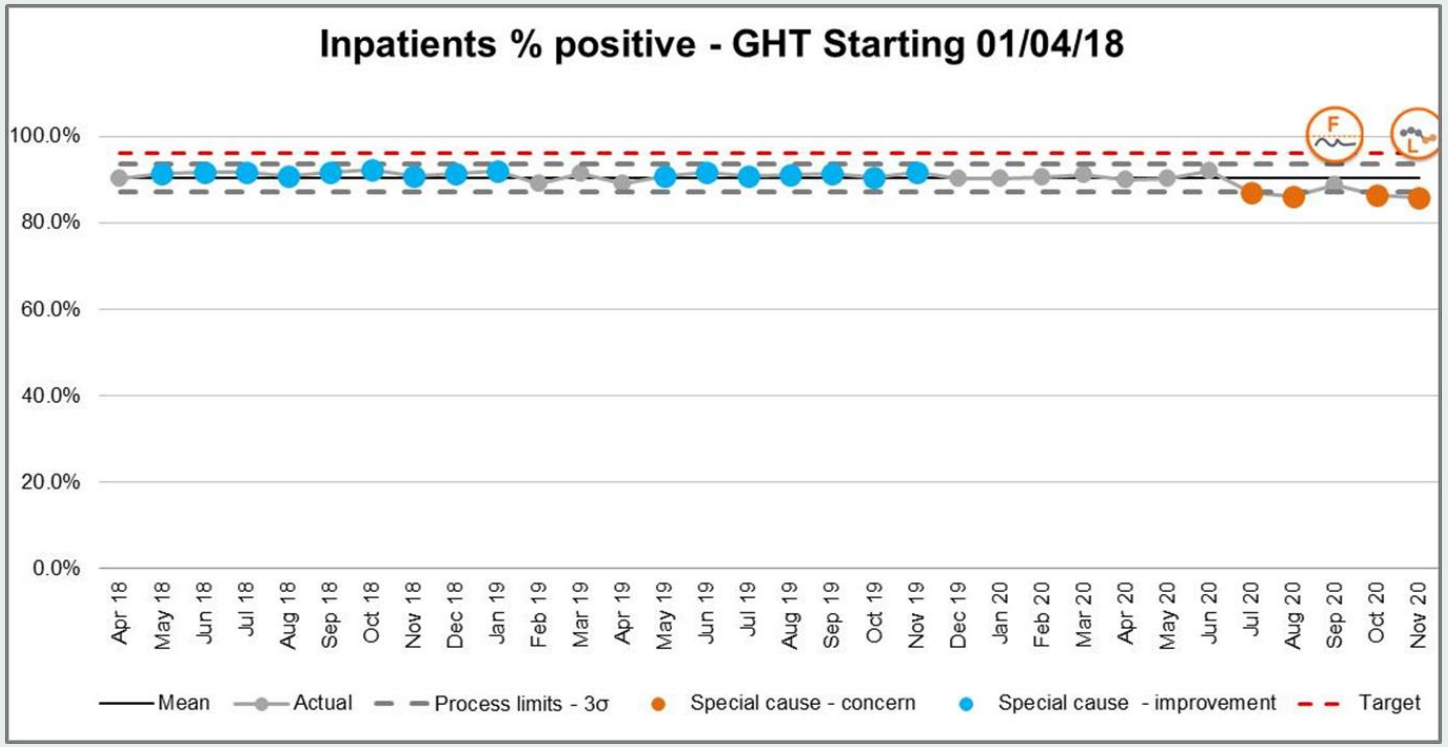
- Deputy Director of Quality

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 15 data points which are above the line. There are 15 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above and below the mean.
2 of 3	When 2 out of 3 points lie near the LPL and UPL this is a warning that the process may be changing

Quality:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

The combined inpatient and day case score has dropped very slightly; from 86.6% in October to 85.7%. in November This is driven by a lower score for inpatients from 82.5% in October to 80.8% In November. There are plans to relaunch the patient experience improvement faculty in early 2021, which will have a focus on using our experience insight to drive improvement across our services. We will continue to monitor our inpatient scores with the DDQNs and matrons.

- Deputy Director of Quality

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 4 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above the mean.
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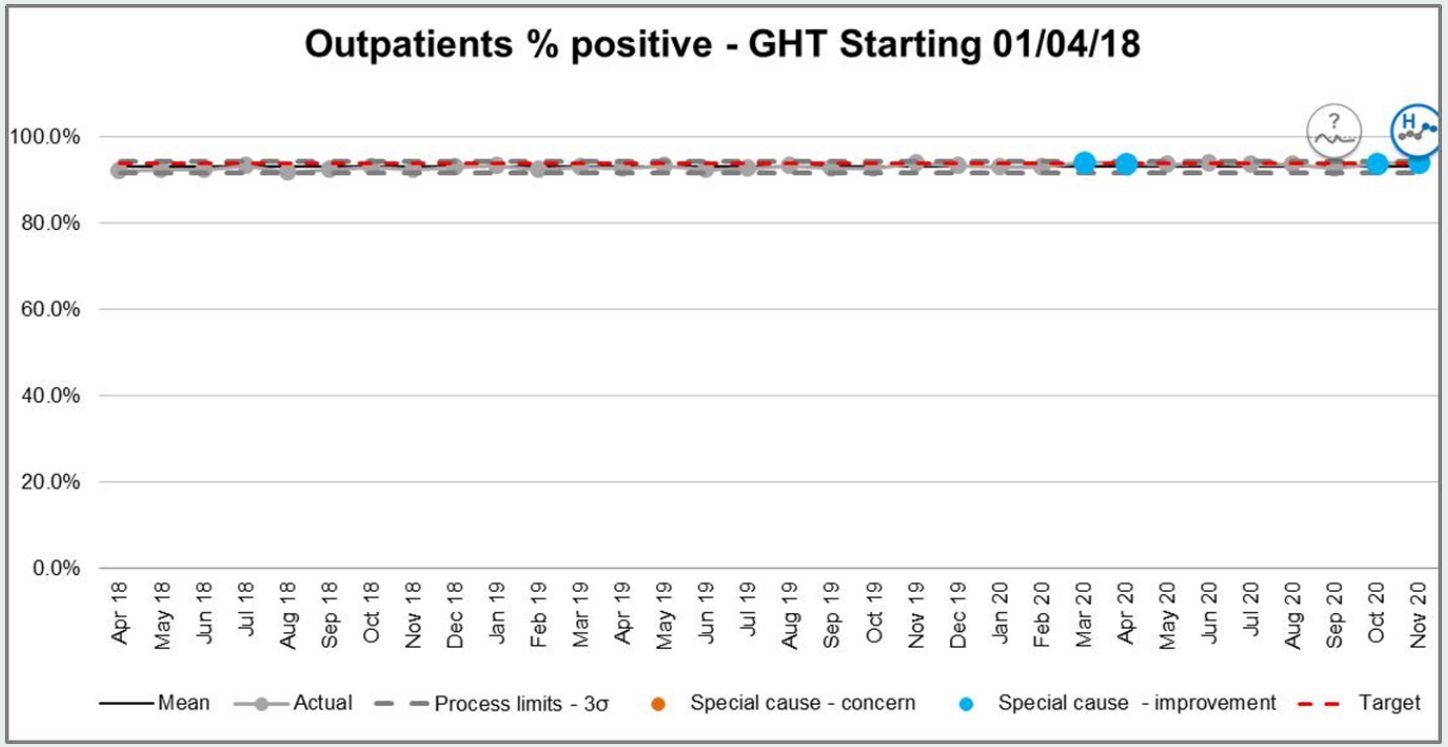
Quality:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

Under Review.

- Deputy Director of Quality

Data Observations

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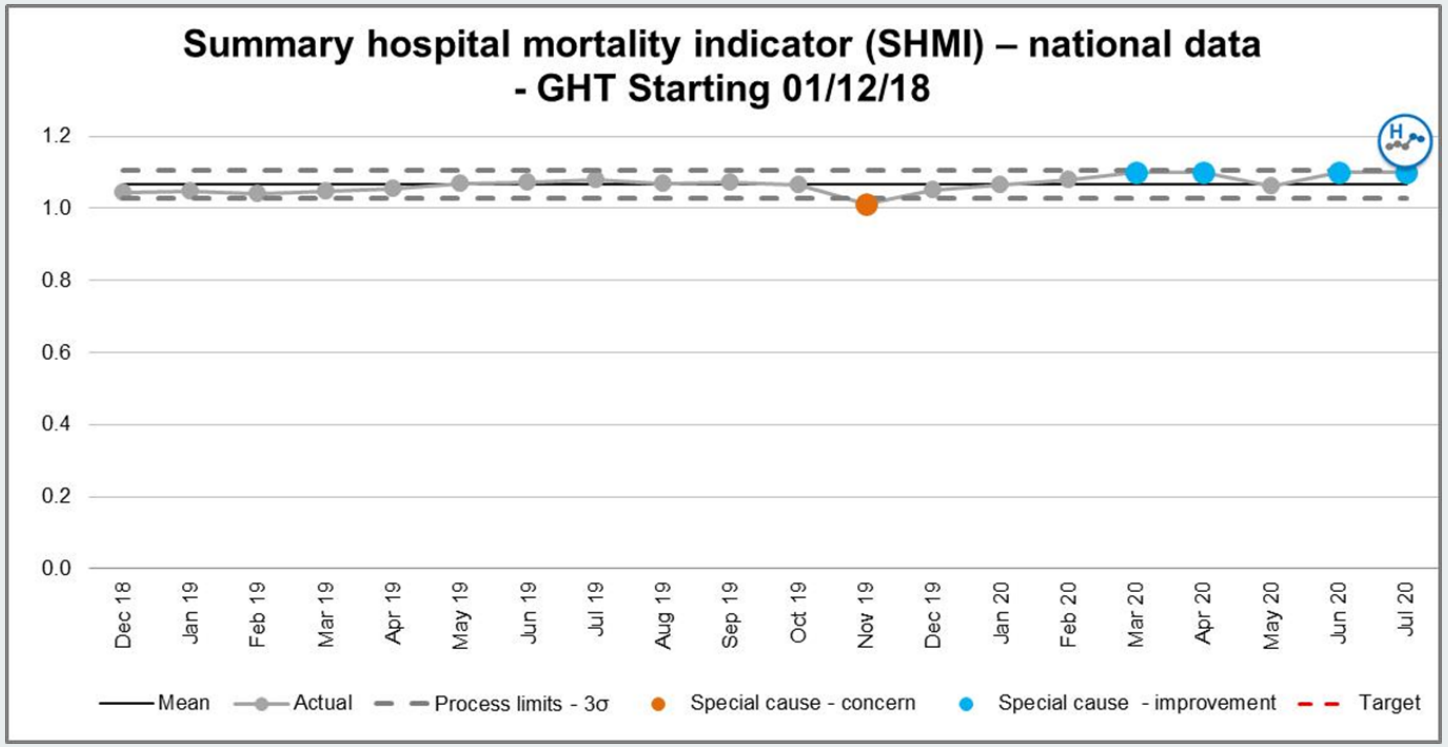
Quality:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

As per HSMR although these figures are produced less frequently so they take longer to come through. The latest figure covers the period up to July 2020 and is in the expected range a decrease from the previous published figure.

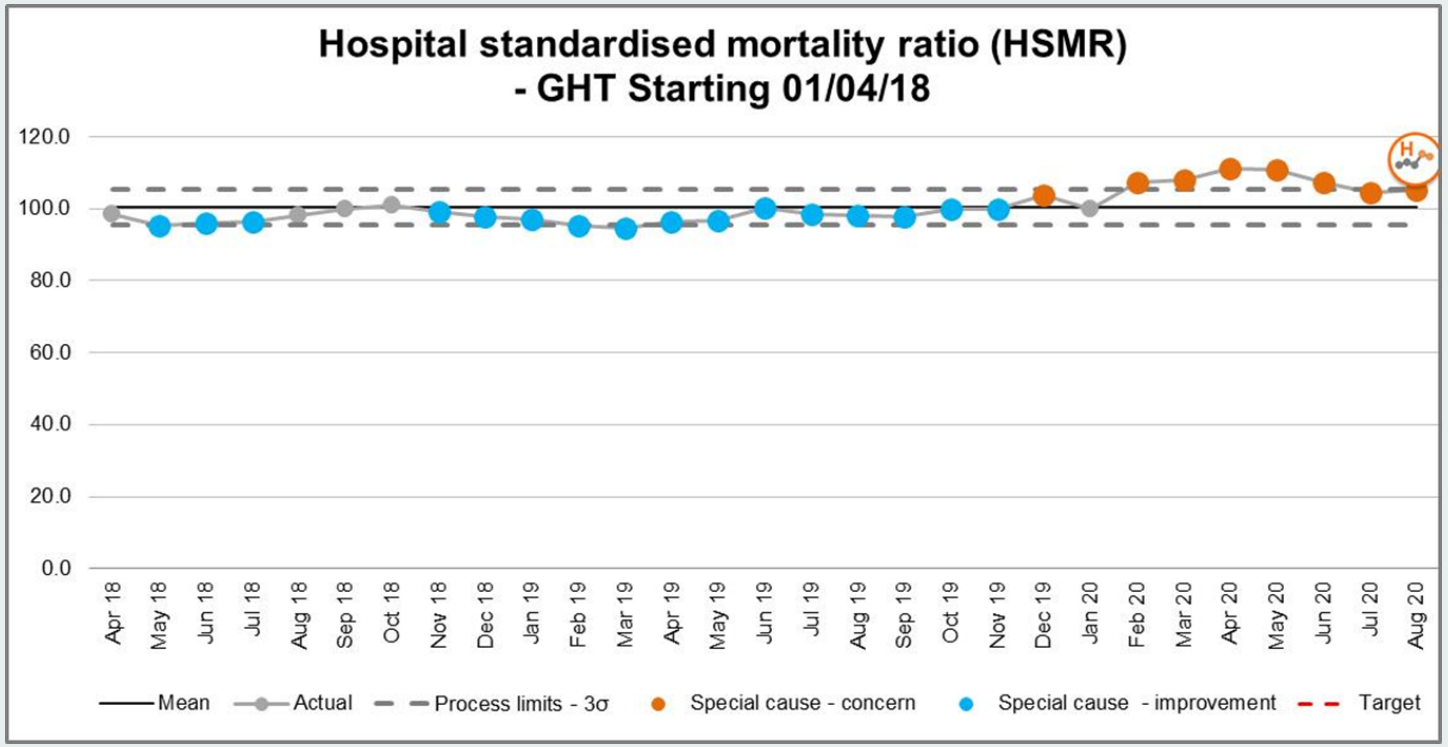
- Medical Division Audit and M&M Lead

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There is 1 data point(s) below the line
2 of 3	When 2 out of 3 points lie near the UPL this is a warning that the process may be changing

Quality:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

The HSMR increased during wave one of the pandemic, this is the seen to be improving and the latest figure is now green.

- Medical Division Audit and M&M Lead

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 5 data points which are above the line. There are 3 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above and below the mean.
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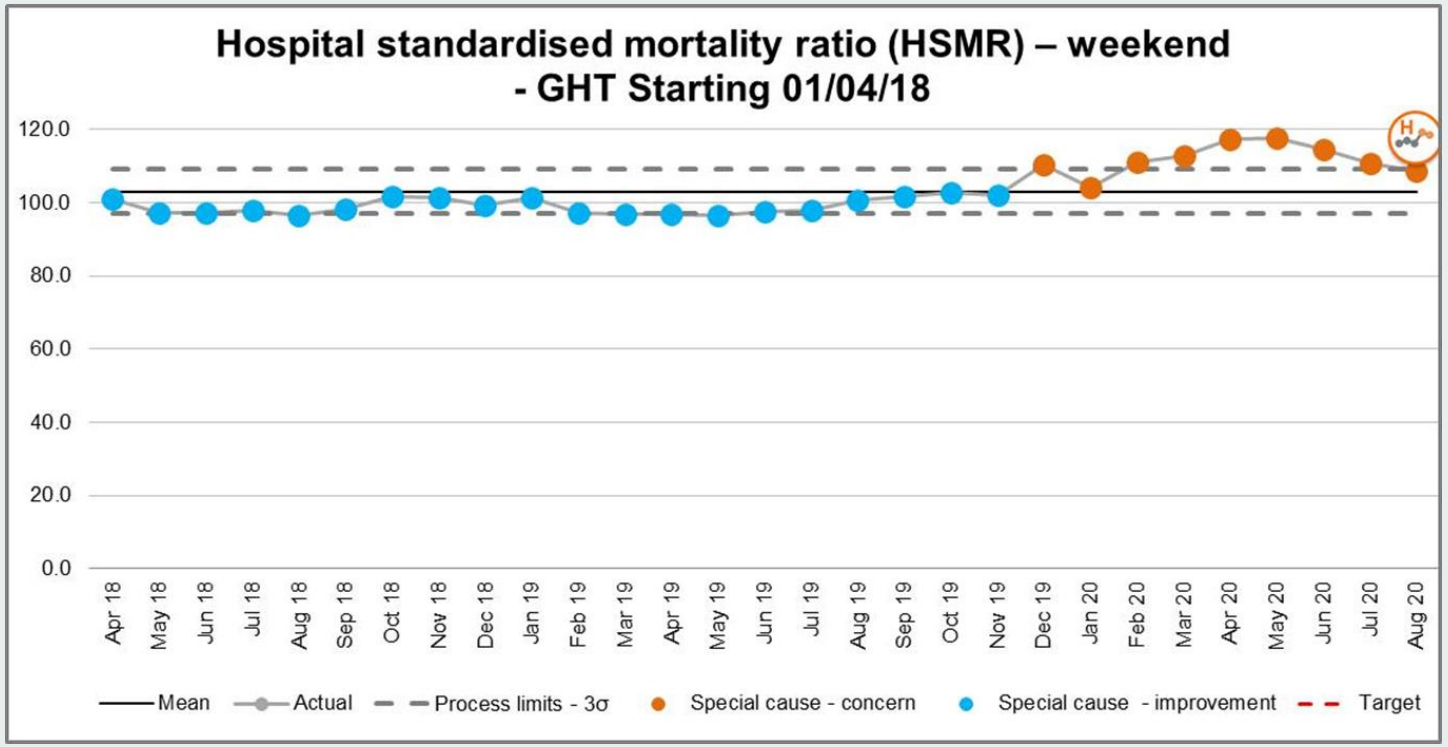
Quality:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



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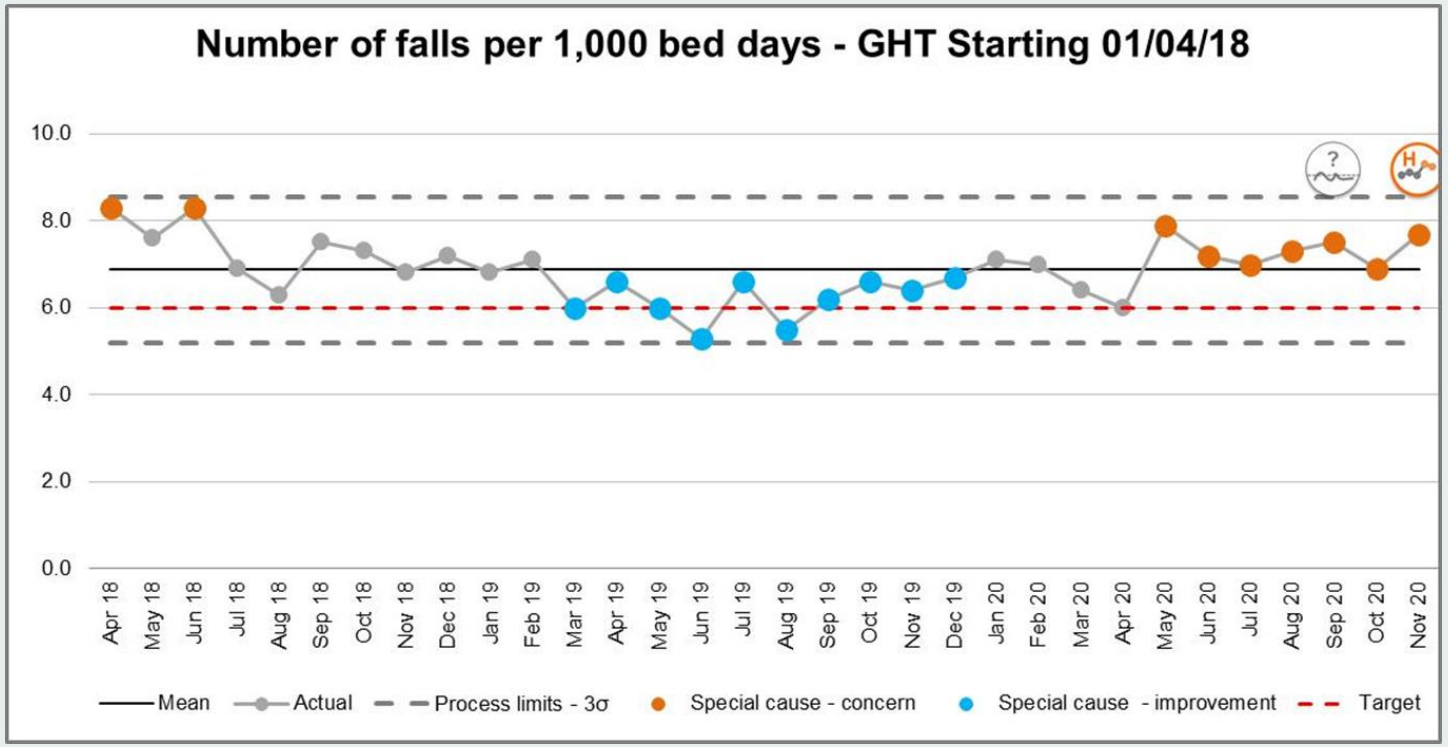
Gloucestershire Hospitals NHS Foundation Trust



Commentary

Under Review.

- Director of Safety

Data Observations

Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above and below the mean.
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Financial Dashboard

Gloucestershire Hospitals NHS Foundation Trust

This dashboard shows the most recent performance of metrics in the Financial category. Where SPC analysis is not possible the metric is RAG rated against national standards. Exception reports are shown on the following pages.

Key

Assurance

- Consistently hit target
- Hit and miss target subject to random
- Consistenly fail target

Variation

- Special Cause Concerning variation
- Common Cause
- Special Cause Improving variation

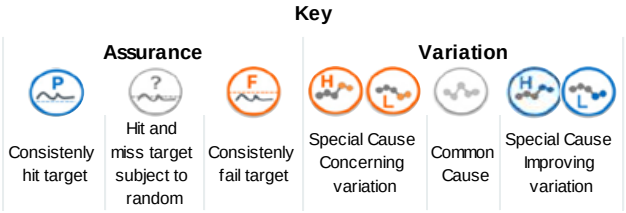
MetricTopic	MetricNameAlias	Target & Assurance	Latest Performance & Variance	
Finance	Total PayBill Spend		Sep-20	34.7
Finance	YTD Performance against Financial Recovery Plan		Sep-20	0
Finance	Cost Improvement Year to Date Variance		Sep-20	N/A
Finance	NHSI Financial Risk Rating		Sep-20	N/A
Finance	Capital service		Sep-20	N/A
Finance	Liquidity		Sep-20	N/A
Finance	Agency – Performance Against NHSI Set Agency Ceiling		Sep-20	N/A

Please note that the finance metrics have no data available due to COVID-19

People & OD Dashboard

Gloucestershire Hospitals NHS Foundation Trust

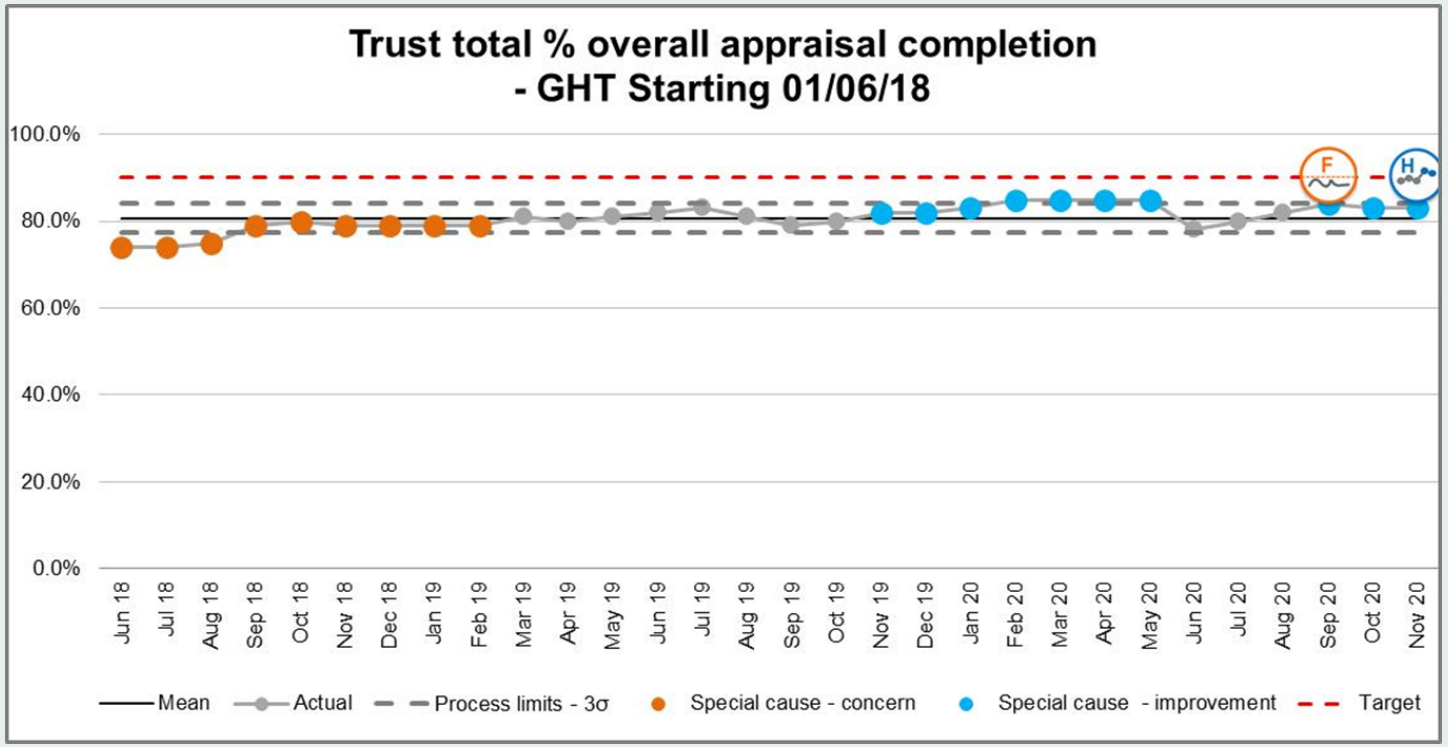
This dashboard shows the most recent performance of metrics in the People & Organisational Development category. Where SPC analysis is not possible the metric is RAG rated against national standards. Exception reports are shown on the following pages.



MetricTopic	MetricNameAlias	Target & Assurance		Latest Performance & Variance		
Appraisal and Mandatory	Trust total % overall appraisal completion	>=90%	F	Nov-20	83.0%	H
Appraisal and Mandatory	Trust total % mandatory training compliance	>=90%	?	Nov-20	93%	H
Safe Nurse Staffing	Overall % of nursing shifts filled with substantive staff	>=75%	P	Nov-20	94.9%	
Safe Nurse Staffing	% registered nurse day	>=90%	?	Nov-20	94.4%	
Safe Nurse Staffing	% unregistered care staff day	>=90%	P	Nov-20	102.4%	
Safe Nurse Staffing	% registered nurse night	>=90%	?	Nov-20	95.9%	
Safe Nurse Staffing	% unregistered care staff night	>=90%	P	Nov-20	112.0%	
Safe Nurse Staffing	Care hours per patient day RN	>=5		Nov-20	5.7	
Safe Nurse Staffing	Care hours per patient day HCA	>=3	?	Nov-20	3.7	
Safe nurse staffing	Care hours per patient day total	>=8		Nov-20	9.4	
Vacancy and WTE	Staff in post FTE	No target		Nov-20	6551.18	
Vacancy and WTE	Vacancy FTE	No target		Nov-20	420.14	L
Vacancy and WTE	Starters FTE	No target		Nov-20	46.87	
Vacancy and WTE	Leavers FTE	No target		Nov-20	68.76	
Vacancy and WTE	% total vacancy rate	<=11.5%	P	Nov-20	6.03%	L
Vacancy and WTE	% vacancy rate for doctors	<=5%	?	Nov-20	0.37%	
Vacancy and WTE	% vacancy rate for registered nurses	<=5%	F	Nov-20	9.06%	
Workforce Expenditure	% turnover	<=12.6%	P	Nov-20	10.1%	L
Workforce Expenditure	% turnover rate for nursing	<=12.6%	P	Nov-20	10.2%	
Workforce Expenditure	% sickness rate	<=4.05%	P	Nov-20	3.7%	L

People & OD:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

Under Review.

- **Director of Human Resources and Operational Development**

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 4 data points which are above the line. There are 3 data point(s) below the line
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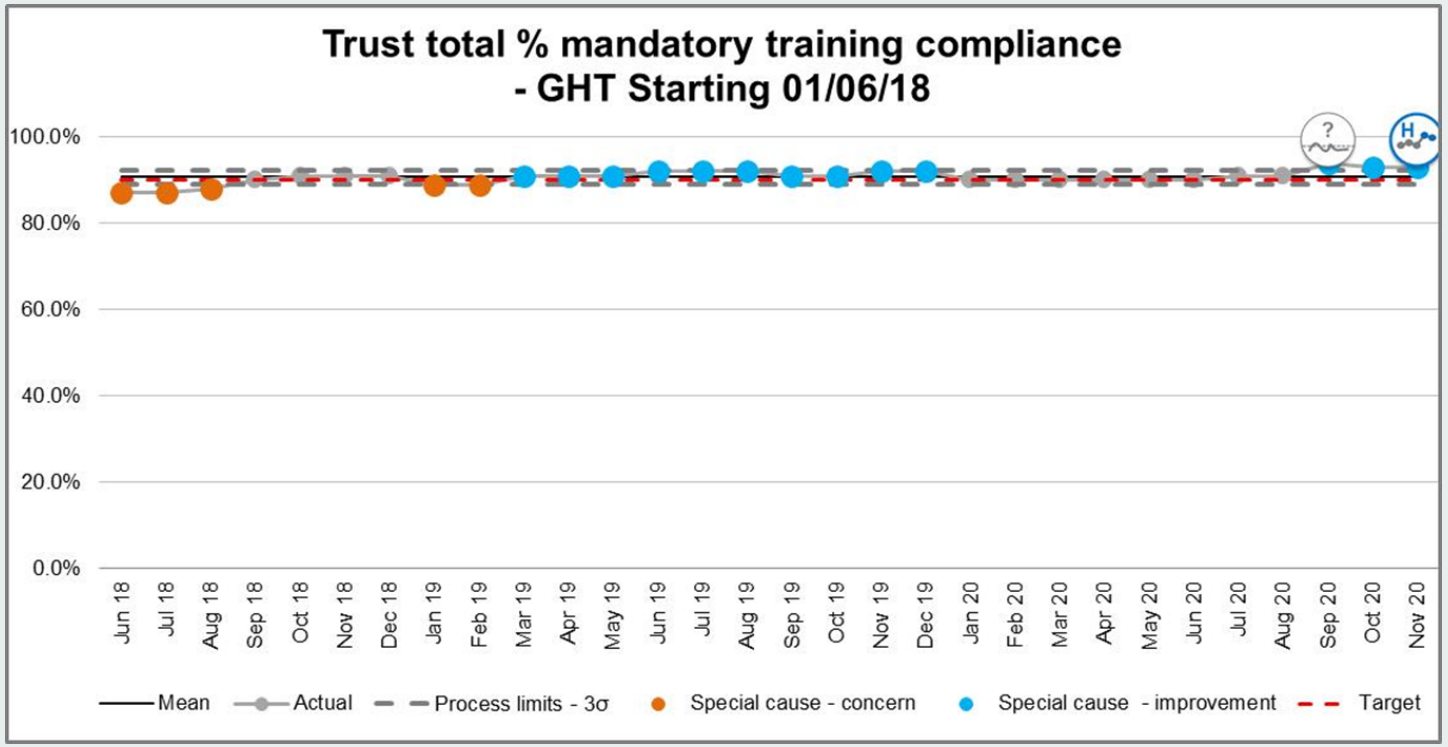
People & OD:
SPC – Special Cause Variation

Gloucestershire Hospitals
NHS Foundation Trust



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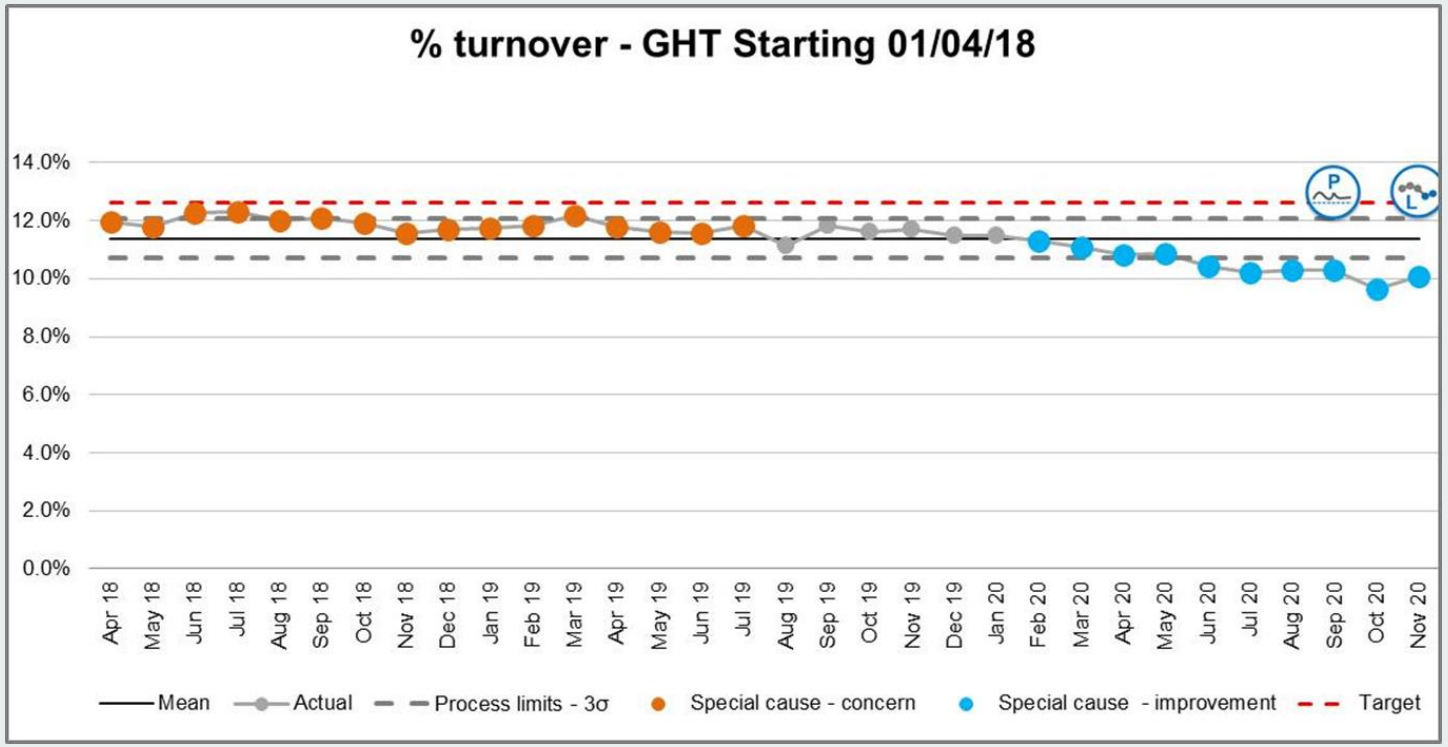
SPC – Special Cause Variation

Gloucestershire Hospitals
NHS Foundation Trust



Commentary

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- **Director of Human Resources and Operational Development**

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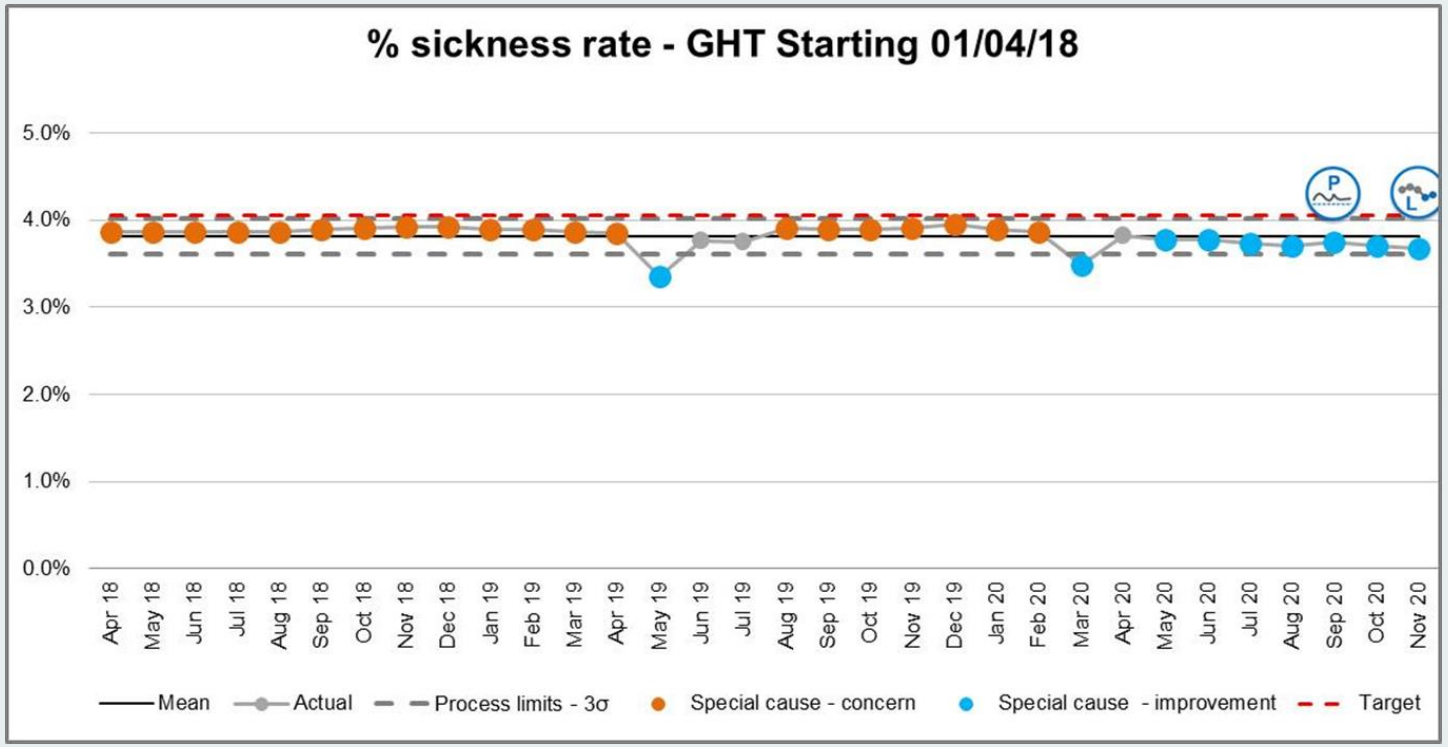

Commentary

Under Review.

- **Director of Human Resources and Operational Development**

Data Observations

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Gloucestershire Hospitals
NHS Foundation Trust

Quality and Performance Report

Reporting Period November 2020

Presented at December 2020 Q&P and January 2021 Trust Board

Contents

Gloucestershire Hospitals NHS Foundation Trust

Executive Summary

Gloucestershire Hospitals NHS Foundation Trust

The key areas of focus remain the assurance of patient care and safety during this time. Key reductions in non-urgent elective care took place in March to support organisational response to Covid-19 and continued into the summer. This has led to a number of changes and opportunities to deliver patient care in an enhanced way. The Trust through support of IM&T colleagues has embraced remote working with our patients & with Primary Care. For elective care (Cancer; Screening and RTT), all patients are being reviewed and clinically prioritised and national guidance enacted. We are ensuring that we are tracking all patients and that our waiting list size is consummate with those patients requiring secondary care opinion. During this time we also enacted a CAS to support primary care and remain open for referrals requiring a secondary care opinion. For unscheduled care the approach has equally been to support the safety and care of our patients to enable them to access specialist emergency care as they need to. Teams across the hospital have supported each other to offer the best care for all our patients.

A review and recovery plan is in place with emphasis on how to continue to prioritise our patients clinically and enable secondary care intervention where needed for patient care and safety.

During November the Trust did not meet the national standards for 52 week waits, diagnostics and the 4 hour standard.

The Trust performance (type 1) for the 4 hour standard in November was 68.40%, against the STP trajectory of 86.04%. The system did not meet the delivery of 90% for the system in November, at 79.64%. Note that the November performance targets / trajectories have not been formally agreed as the Operating Plan process was paused due to C-19, we have therefore taken the appropriate performance target from the national or previous local target where applicable.

The Trust did not meet the diagnostics standard for November at 14.67%. We have, as with many services prioritised same day diagnostics and support for patients to be prioritised post clinical review. The achievement of this standard has been majorly impacted by C-19, specifically endoscopy tests. MR and CT have recovered their waiting time position.

The Trust did not meet the standard for 2 week wait cancer at 91.6% in November or 62 day cancer waits at 79.7%, this is as yet un-validated performance at the time of the report.

For elective care, the RTT performance is 68.87% (un-validated) in November, work continues to ensure that the performance is stabilised. Significant work is underway to reduce our longest waiting patients of over 52 weeks, of which there were 1,428 in November. This is as yet un-validated performance at the time of the report.

Directors Operational Group will review the Unscheduled and Scheduled performance indicators with the Divisions and the wider Executive team.

The Quality Delivery Group (QDG) continues to monitor the performance of the quality metrics with the Divisions providing exception reports. The delivery of any action plans to deliver improvement are also reviewed within the meeting. There are improvement plans in place for any indicators that have consistently scored in the “red” target area.

Performance Against STP Trajectories

Gloucestershire Hospitals NHS Foundation Trust

The following table shows the monthly performance of the Trust's STP indicators for 2019/20. RAG Rating: The STP indicators are assessed against the monthly trajectories agreed with NHS Improvement.
Note that data is subject to change.

Indicator		Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20
Count of handover delays 30-60 minutes	Trajectory	40	40	40	40	40	40	40	40	40	40	40	40	40
	Actual	159	127	161	105	105	61	57	88	78	166	140	152	166
Count of handover delays 60+ minutes	Trajectory	0	0	0	0	0	0	0	0	0	0	0	0	0
	Actual	3	11	10	5	2	0	0	5	1	36	21	42	95
ED: % total time in department – under 4 hours (types 1 & 3)	Trajectory	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%
	Actual	83.41%	81.18%	81.02%	82.33%	85.08%	89.93%	88.72%	89.94%	90.05%	83.26%	82.34%	80.21%	79.64%
ED: % total time in department – under 4 hours (type 1)	Trajectory	86.04%	85.99%	86.19%	85.36%	85.79%	85.32%	85.37%	85.17%	85.90%	85.22%	85.61%	85.89%	86.04%
	Actual	76.24%	72.91%	72.45%	72.41%	78.56%	87.46%	85.41%	85.06%	84.46%	73.53%	71.74%	68.96%	69.40%
Referral to treatment ongoing pathways under 18 weeks (%)	Trajectory	79.60%	80.00%	80.30%	80.60%	81.00%	81.00%	81.00%	81.00%	81.00%	81.00%	81.00%	81.00%	81.00%
	Actual	80.29%	80.57%	81.06%	81.41%	81.01%	73.61%	66.53%	59.06%	55.83%	60.07%	66.27%	69.36%	69.87%
Referral to treatment ongoing pathways over 52 weeks (number)	Trajectory	67	60	40	20	0	0	0	0	0	0	0	0	0
	Actual	45	39	28	14	33	156	366	694	1037	1233	1279	1285	1428
% waiting for diagnostics 6 week wait and over (15 key tests)	Trajectory	0.99%	0.98%	0.98%	0.98%	0.98%	0.99%	0.99%	0.99%	0.99%	0.99%	0.99%	0.99%	0.99%
	Actual	1.06%	0.94%	1.50%	1.16%	3.16%	41.95%	43.43%	29.54%	26.07%	25.49%	23.00%	17.50%	14.67%
Cancer – urgent referrals seen in under 2 weeks from GP	Trajectory	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%
	Actual	94.60%	96.90%	95.10%	96.10%	95.10%	90.60%	99.10%	98.00%	96.50%	90.80%	95.20%	93.10%	91.60%
2 week wait breast symptomatic referrals	Trajectory	93.10%	93.20%	93.20%	93.20%	93.20%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%
	Actual	96.00%	97.40%	96.30%	97.80%	98.40%	87.90%	97.80%	95.70%	96.40%	95.90%	93.40%	97.10%	85.20%
Cancer – 31 day diagnosis to treatment (first treatments)	Trajectory	96.10%	96.20%	96.20%	96.20%	96.20%	96.00%	96.00%	96.00%	96.00%	96.00%	96.00%	96.00%	96.00%
	Actual	91.40%	93.00%	95.50%	94.30%	95.50%	96.60%	96.00%	95.30%	98.10%	96.70%	96.40%	99.30%	99.30%
Cancer – 31 day diagnosis to treatment (subsequent – drug)	Trajectory	98.00%	98.90%	98.00%	98.00%	98.00%	98.00%	98.00%	98.00%	98.00%	98.00%	98.00%	98.00%	98.00%
	Actual	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	94.00%	97.00%	100.00%	100.00%	100.00%	100.00%
Cancer – 31 day diagnosis to treatment (subsequent – radiotherapy)	Trajectory	95.10%	95.10%	95.10%	95.10%	95.10%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%
	Actual	94.80%	95.60%	96.70%	97.50%	100.00%	98.30%	96.70%	86.50%	83.00%	98.30%	97.30%	98.70%	94.70%
Cancer – 31 day diagnosis to treatment (subsequent – surgery)	Trajectory	95.40%	95.60%	94.80%	94.80%	94.80%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%
	Actual	98.00%	90.20%	98.30%	97.40%	94.10%	98.20%	92.60%	81.30%	78.90%	87.20%	96.20%	96.80%	96.80%
Cancer 62 day referral to treatment (screenings)	Trajectory	91.40%	92.30%	90.60%	90.60%	90.60%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%
	Actual	95.10%	91.10%	97.80%	96.70%	94.70%	90.90%	54.50%	60.00%	66.70%	77.80%	88.90%	100.00%	96.80%
Cancer 62 day referral to treatment (upgrades)	Trajectory	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
	Actual	83.30%	87.50%	69.20%	63.60%	76.50%	100.00%	88.90%	73.70%	91.70%	90.00%	91.70%	85.00%	70.80%
Cancer 62 day referral to treatment (urgent GP referral)	Trajectory	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%
	Actual	71.40%	74.20%	68.00%	76.50%	78.20%	78.00%	69.00%	78.00%	85.60%	87.60%	81.50%	84.60%	79.70%

Summary Scorecard

Gloucestershire Hospitals NHS Foundation Trust

The following table shows the Trust's current monthly performance against the chosen lead indicators within the Trust Scorecard.

RAG Rating: Overall RAG rating for a domain is an average performance of lead indicators against national standards. Where data is not available the lead indicator is treated as red.

Safe

- % of adult inpatients who have received a VTE risk assessment
- Number of never events reported
- Number of trust apportioned Clostridium difficile cases per month
- Number of trust apportioned MRSA bacteraemia
- Safety thermometer – % of new harms

Effective

- % C-section rate (planned and emergency)
- Emergency re-admissions within 30 days following an elective or emergency spell
- Hospital standardised mortality ratio (HSMR)
- Hospital standardised mortality ratio (HSMR) – weekend

Caring

- ED % positive
- Maternity % positive
- Number of breaches of mixed sex accommodation
- Outpatients % positive

Responsive

- % of ambulance handovers that are over 60 minutes
- % waiting for diagnostics 6 week wait and over (15 key tests)
- Cancer 62 day referral to treatment (screenings)
- Cancer 62 day referral to treatment (upgrades)
- Cancer 62 day referral to treatment (urgent GP referral)
- Did not attend (DNA) rates
- ED: % total time in department – under 4 hours (type 1)
- ED: % total time in department – under 4 hours (types 1 & 3)
- Referral to treatment ongoing pathways over 52 weeks (number)
- Referral to treatment ongoing pathways under 18 weeks (%)

Well Led

- % sickness rate
- % total vacancy rate
- % turnover
- Overall % of nursing shifts filled with substantive staff
- Trust total % mandatory training compliance
- Trust total % overall appraisal completion

Demand and Activity

Gloucestershire Hospitals NHS Foundation Trust

The table below shows monthly activity for key areas. The columns to the right show the percentage change in activity from:

1) The same month in the previous year
2) The same year to date (YTD) period in the previous year

Measure	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-19	Monthly (Nov)	YTD
GP Referrals	13,356	11,169	10,191	9,595	7,888	3,076	3,946	3,185	8,119	7,784	8,181	8,746	7,679	-42.5%	-90.7%
OP Attendances	13,379	10,823	13,634	12,167	10,637	26,018	30,419	40,646	44,330	39,151	49,790	51,948	51,957	288.3%	434.1%
New OP Attendances						7,002	8,812	12,052	13,870	12,542	16,179	17,326	16,882		
FUP OP Attendances						19,016	21,607	28,594	30,460	26,609	33,611	34,622	35,075		
Day cases	6,578	6,228	7,067	5,304	4,216	1,473	1,786	2,721	3,467	3,109	4,414	4,586	4,396	-33.2%	-101.5%
All electives	7,690	7,155	8,039	6,294	4,966	1,780	2,183	3,252	4,242	3,965	5,366	5,640	5,275	-31.4%	-96.3%
ED Attendances	13,066	13,287	12,624	11,695	9,721	6,861	8,913	9,819	10,957	11,636	10,903	10,279	9,475	-27.5%	-51.7%
Non Electives	4,837	5,052	4,664	4,353	3,874	3,110	3,728	4,205	4,421	4,320	4,495	4,584	4,233	-12.5%	-28.0%

Trust Scorecard - Safe (1)

OVERALL SCORE

Note that data in the Trust Scorecard section is subject to change.

	19/20	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	20/21 Q2	20/21	Standard	Threshold
Infection Control																		
COVID-19 community-onset – First positive specimen <=2 days after admission							250	64	9	5	4	18	48	224	27	617	TBC	
COVID-19 hospital-onset indeterminate healthcare-associated – First positive specimen 3-7 days after admission							68	7	1	1	0	1	3	57	2	138	TBC	
COVID-19 hospital-onset probably healthcare-associated – First positive specimen 8-14 days after admission							38	1	2	1	0	0	0	55	1	97	TBC	
COVID-19 hospital-onset definite healthcare-associated – First positive specimen >=15 days after admission							33	4	1	1	1	0	0	57	2	97	TBC	
Number of trust apportioned MRSA bacteraemia	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	Zero	
MRSA bacteraemia – infection rate per 100,000 bed days	.6	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	Zero	
Number of trust apportioned Clostridium difficile cases per month	97	12	7	8	6	5	4	7	2	7	0	4	8	4	23	48	2019/20: 114	
Number of hospital-onset healthcare-associated Clostridioides difficile cases per month	5	3	5	4	6	2	1	4	1	2	6	1	1	2	9	18	<=5	
Number of community-onset healthcare-associated Clostridioides difficile cases per month	45	9	2	4	0	3	3	3	1	5	6	3	7	2	14	30	<=5	
Clostridium difficile – infection rate per 100,000 bed days	28.8	42.4	24.4	29.7	21.5	17.6	25.6	38.6	9.9	30.3		15.7	29.2	15.8	14.9	19.9	<30.2	
Number of MSSA bacteraemia cases	18	1	2	1	1	2	1	0	3	1	1	0	1	1	1	8	<=8	
MSSA – infection rate per 100,000 bed days	5.3	3.5	7	3.3	3.6	7	6.4		14.9	4.3	4		3.6	3.9	2.7	4.4	<=12.7	
Number of ecoli cases	46	5	9	3	3	2	1	3	2	4	3	0	6	3	7	22	No target	
Number of pseudomona cases	9	0	0	3	0	1	0	2	0	0	0	0	0	0	0	2	No target	
Number of klebsiella cases	18	1	1	1	2	1	1	2	0	1	1	1	0	1	3	7	No target	
Number of bed days lost due to infection control outbreaks	1,264	240	276	100	13	0		0	0	4	0	0	5		4	9	<10	>30

Trust Scorecard - Safe (2)

OVERALL SCORE

	19/20	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	20/21 Q2	20/21	Standard	Threshold
Patient Safety Incidents																		
Number of patient safety alerts outstanding	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	Zero	
Number of falls per 1,000 bed days	6.4	6.4	6.7	7.1	7	6.4	6	7.9	7.2	7	7.3	7.5	6.9	7.7	7.3	7.2	<=6	
Number of falls resulting in harm (moderate/severe)	4	1	4	5	5	0	2	4	4	3	4	3	6	6	10	32	<=3	
Number of patient safety incidents – severe harm (major/death)	6	3	3	6	5	2	4	1	5	2	7	4	5	6	13	34	No target	
Medication error resulting in severe harm	0	0	0	0	1	1	0	0	0	0	0	0	0	0	0	0	No target	
Medication error resulting in moderate harm	2	1	1	5	2	1	2	3	2	6	1	2	1	1	9	18	No target	
Medication error resulting in low harm	12	23	7	10	8	11	9	15	7	8	14	14	9	15	36	91	No target	
Number of category 2 pressure ulcers acquired as in-patient	30	31	29	27	12	23	13	15	16	9	24	13	23	28	46	141	<=30	
Number of category 3 pressure ulcers acquired as in-patient	5	4	2	2	3	1	0	1	0	1	3	4	5	3	8	17	<=5	
Number of category 4 pressure ulcers acquired as in-patient	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	Zero	
Number of unstagable pressure ulcers acquired as in-patient		5	2	4	6	3	3	4	7	4	5	9	7	6	18	45	<=3	
Number of deep tissue injury pressure ulcers acquired as in-patient		8	3	5	3	4	4	6	1	2	6	4	12	5	12	40	<=5	
RIDDOR																		
Number of RIDDOR	35	1	2	4	2	2	2	1	5	3	0	2	1	3	5	14	SPC	
Safeguarding																		
Level 2 safeguarding adult training - e-learning package		95.00%															TBC	
Number of DoLs applied for		36	50			33			41	59	38						TBC	
Total attendances for infants aged < 6 months, all head injuries/long bone fractures							1			18							TBC	
Total attendances for infants aged < 6 months, other serious injury							17			30							TBC	
Total admissions aged 0-18 with DSH							6			31							TBC	
Total ED attendances aged 0-18 with DSH							26			55							TBC	
Total number of maternity social concerns forms completed		44	53			31			48								TBC	

Trust Scorecard - Safe (3)

OVERALL SCORE

	19/20	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	20/21 Q2	20/21	Standard	Threshold
Safety Thermometer																		
Safety thermometer – % of new harms	97.1%	95.8%	97.9%	96.5%	98.1%	97.8%											>96%	<93%
Sepsis Identification and Treatment																		
Proportion of emergency patients with severe sepsis who were given IV antibiotics within 1 hour of diagnosis	67.00%		71.00%			68.00%			68.00%			74.00%				71.00%	>=90%	<50%
Serious Incidents																		
Number of never events reported	6	0	1	1	1	0	0	0	2	0	0	1	0	3	1	6	Zero	
Number of serious incidents reported	3	3	1	2	3	2	0	0	2	2	5	4	3	4	11	20	No target	
Serious incidents – 72 hour report completed within contract timescale	100.0%	100.0%	99.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	>90%	
Percentage of serious incident investigations completed within contract timescale	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	>80%	
VTE Prevention																		
% of adult inpatients who have received a VTE risk assessment	93.2%	91.8%	92.6%	90.1%	94.2%	92.7%		90.1%	94.0%	93.8%	90.7%	87.0%	89.8%	94.6%	90.4%	91.4%	>95%	

Trust Scorecard - Effective (1)

OVERALL SCORE

	19/20	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	20/21 Q2	20/21	Standard	Threshold
Dementia Screening																		
% of patients who have been screened for dementia (within 72 hours)	0.8%	50.0%	37.0%	37.0%	86.0%	74.0%	67.0%	63.0%	68.0%	71.0%	71.0%	79.0%	64.0%	68.0%	73.0%	68.0%	>=90%	<70%
% of patients who have scored positively on dementia screening tool that then received a dementia diagnostic assessment (within 72 hours)	29.4%	0.0%	18.0%	0.0%	10.0%	0.0%											>=90%	<70%
% of patients who have received a dementia diagnostic assessment with positive or inconclusive results that were then referred for further diagnostic advice/FU (within 72 hours)	0.0%		0.0%														>=90%	<70%
Maternity																		
% of women on a Continuity of Carer pathway				4.30%	5.00%	4.40%	4.70%	3.00%	0.80%	0.00%	0.00%	0.40%	0.00%	0.00%	0.10%	1.00%	No target	
% C-section rate (planned and emergency)	28.39%	26.57%	31.30%	28.66%	30.23%	28.90%	27.73%	28.82%	25.94%	26.51%	27.80%	31.13%	32.91%	28.09%	28.45%	28.59%	<=27%	>=30%
% emergency C-section rate	15.74%	15.77%	13.48%	13.60%	16.36%	14.48%	12.73%	15.27%	12.08%	12.73%	16.20%	15.14%	19.50%	15.73%	14.71%	14.92%	No target	
% of women booked by 12 weeks gestation	88.9%	92.2%	91.9%	90.3%	89.5%	89.7%	89.6%	93.1%	93.3%	93.0%	92.4%	95.0%	92.3%	95.4%	93.8%	93.0%	>90%	
% of women that have an induced labour	28.65%	29.59%	30.00%	27.20%	28.42%	27.98%	27.50%	28.60%	29.70%	35.49%	31.20%	32.41%	28.72%	32.58%	33.03%	30.82%	<=30%	>33%
% of women smoking at delivery	10.95%	13.63%	11.52%	13.18%	8.64%	12.39%	9.55%	10.97%	11.29%	9.39%	13.80%	11.30%	12.58%	11.24%	11.52%	11.26%	<=14.5%	
% stillbirths as percentage of all pregnancies > 24 weeks	0.22%	0.43%	0.43%	0.21%	0.00%	0.23%	1.14%	0.00%	0.20%	0.42%	0.00%	0.21%	0.83%	0.68%	0.21%	0.42%	<0.52%	
Mortality																		
Summary hospital mortality indicator (SHMI) – national data	1.1	1	1.1	1.1	1.1	1.1	1.1	1.1	1.1	1.1						1.1	NHS Digital	
Hospital standardised mortality ratio (HSMR)	108	99.8	103.9	99.9	107.2	108	111.3	110.7	107.1	104.6	105.1				107.1	105.1	Dr Foster	
Hospital standardised mortality ratio (HSMR) – weekend	112.7	102.1	110.3	104.3	110.9	112.7	117.4	117.5	114.4	110.8	108.8				114.4	108.8	Dr Foster	
Number of inpatient deaths	1,964	152	212	215	167	192	252	126	112	120	143	147	141	181	410	1,222	No target	
Number of deaths of patients with a learning disability	15	0	1	4	0	0	4	2	0	1	3	4	1	1	8	16	No target	
Readmissions																		
Emergency re-admissions within 30 days following an elective or emergency spell	7.0%	7.1%	6.4%	6.6%	6.7%	8.3%	9.6%	8.5%	7.2%	7.9%	8.5%	7.4%	7.6%		7.9%	7.9%	<8.25%	>8.75%
Research																		
Research accruals		101	73	110	98												No target	

Trust Scorecard - Effective (2)

OVERALL SCORE

	19/20	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	20/21 Q2	20/21	Standard	Threshold
Stroke Care																		
Stroke care: percentage of patients receiving brain imaging within 1 hour	49.5%	39.4%	48.7%	45.2%	56.4%	46.2%	37.0%	53.0%	45.0%	63.5%	60.9%	52.9%	46.6%	54.7%	59.1%	51.7%	>=50%	<45%
Stroke care: percentage of patients spending 90%+ time on stroke unit	87.7%	81.1%	87.3%	88.5%	87.7%	90.4%	88.5%	78.0%	84.0%	95.1%	89.7%	94.3%	71.4%			83.5%	>=80%	<70%
% of patients admitted directly to the stroke unit in 4 hours	54.80%	41.40%	40.00%	38.40%	30.80%	49.30%	49.00%	21.00%	65.00%	74.50%	50.70%	51.60%	34.50%	36.50%	58.90%	45.00%	>=80%	<72%
% patients receiving a swallow screen within 4 hours of arrival	70.70%	71.20%	71.70%	69.20%	71.00%	65.20%	68.00%	76.00%	65.00%	78.60%	59.30%	62.70%	63.50%	64.70%	66.80%	67.20%	>=90%	<80%
Trauma & Orthopaedics																		
% of fracture neck of femur patients treated within 36 hours	55.7%	56.1%	58.3%	73.1%	58.6%	48.6%	75.0%	62.4%	72.7%	56.7%	71.9%	63.6%	60.7%	85.1%	62.1%	69.0%	>=90%	<80%
% fractured neck of femur patients meeting best practice criteria	54.90%	56.06%	58.30%	73.10%	55.20%	48.60%	53.10%	60.60%	70.91%	56.70%	70.20%	62.10%	58.80%	83.00%	60.60%	64.70%	>=65%	<55%

Trust Scorecard - Caring (1)

OVERALL SCORE

	19/20	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	20/21 Q2	20/21	Standard	Threshold
Friends & Family Test																		
Inpatients % positive	90.7%	91.8%	90.2%	90.2%	90.5%	91.1%	90.0%	90.2%	91.9%	87.0%	86.0%	88.7%	86.4%	85.7%	87.3%	89.0%	>=96%	<93%
ED % positive	82.1%	87.9%	78.9%	79.9%	79.2%	79.6%	90.2%	85.8%	86.8%	81.8%	77.2%	73.0%	75.4%	83.7%	77.3%	80.2%	>=84%	<81%
Maternity % positive	97.4%	0.0%	100.0%	100.0%	100.0%	100.0%	97.2%	100.0%	90.2%	100.0%	85.2%	93.9%	88.9%	88.4%	91.4%	91.1%	>=97%	<94%
Outpatients % positive	93.0%	93.8%	93.2%	93.1%	93.0%	94.3%	94.0%	93.6%	93.9%	93.7%	93.5%	92.8%	94.0%	94.1%	93.3%	93.4%	>=94%	<91%
Total % positive	91.2%	92.8%	91.3%	91.4%	91.1%	92.2%	92.9%	91.8%	92.4%	91.3%	90.0%	90.1%	91.7%	92.2%	90.4%	91.1%	>=93%	<90%
Inpatient Questions (Real time)																		
How much information about your condition or treatment or care has been given to you?	79.00%	83.00%	74.00%	81.00%	84.00%	78.00%											>=90%	
Are you involved as much as you want to be in decisions about your care and treatment?	92.00%	91.00%	88.00%	93.00%	95.00%	92.00%											>=90%	
Do you feel that you are treated with respect and dignity?	98.00%	100.00%	97.00%	99.00%	99.00%	100.00%											>=90%	
Do you feel well looked after by staff treating or caring for you?	99.00%	98.00%	98.00%	100.00%	100.00%	99.00%											>=90%	
Do you get enough help from staff to eat your meals?	89.00%	90.00%	63.00%	80.00%	96.00%	67.00%											>=90%	
In your opinion, how clean is your room or the area that you receive treatment in?	99.00%	98.00%	99.00%	98.00%	98.00%	100.00%											>=90%	
Do you get enough help from staff to wash or keep yourself clean?	96.00%	85.00%	96.00%	97.00%	93.00%	86.00%											>=90%	
MSA																		
Number of breaches of mixed sex accommodation	82	0	2	2	1	8	6	13	21	23	1	0	0	0	24	64	<=10	>=20

Trust Scorecard - Responsive (1)

OVERALL SCORE

	19/20	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	20/21 Q2	20/21	Standard	Threshold
Cancer																		
Cancer – 28 day FDS two week wait							53.9%	79.6%	77.9%	79.9%	79.4%	76.1%	77.1%	78.3%	76.5%	74.3%	TBC	
Cancer – 28 day FDS breast symptom two week wait							91.4%	95.7%	98.6%	99.1%	80.6%	98.3%	77.1%	95.4%	98.5%	97.8%	TBC	
Cancer – 28 day FDS screening referral							76.0%	50.0%	76.9%	100.0%	78.6%	65.4%	77.1%	61.8%	76.9%	73.2%	TBC	
Cancer – urgent referrals seen in under 2 weeks from GP	92.5%	94.6%	96.9%	95.1%	96.1%	95.1%	90.6%	99.1%	98.0%	96.5%	90.8%	95.2%	93.1%	91.6%	94.3%	95.2%	>=93%	<90%
2 week wait breast symptomatic referrals	97.5%	96.0%	97.4%	96.3%	97.8%	98.4%	87.9%	97.8%	95.7%	96.4%	95.9%	93.4%	97.1%	85.2%	95.5%	95.2%	>=93%	<90%
Cancer – 31 day diagnosis to treatment (first treatments)	93.4%	91.4%	93.0%	95.5%	94.3%	95.5%	96.6%	96.0%	95.3%	98.1%	96.7%	96.4%	99.3%	99.3%	96.9%	97.0%	>=96%	<94%
Cancer – 31 day diagnosis to treatment (subsequent – drug)	99.4%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	94.0%	97.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	>=98%	<96%
Cancer – 31 day diagnosis to treatment (subsequent – surgery)	93.6%	98.0%	90.2%	98.3%	97.4%	94.1%	98.2%	92.6%	81.3%	78.9%	87.2%	96.2%	96.8%	96.8%	91.5%	90.8%	>=94%	<92%
Cancer – 31 day diagnosis to treatment (subsequent – radiotherapy)	94.9%	94.8%	95.6%	96.7%	97.5%	100.0%	98.3%	96.7%	86.5%	83.0%	98.3%	97.3%	98.7%	94.7%	97.5%	95.9%	>=94%	<92%
Cancer 62 day referral to treatment (urgent GP referral)	73.1%	71.4%	74.2%	68.0%	76.5%	78.2%	78.0%	69.0%	78.0%	85.6%	87.6%	81.5%	84.6%	79.7%	85.4%	81.6%	>=85%	<80%
Cancer 62 day referral to treatment (screenings)	95.4%	95.1%	91.1%	97.8%	96.7%	94.7%	90.9%	54.5%	60.0%	66.7%	77.8%	88.9%	100.0%	96.8%	80.0%	80.0%	>=90%	<85%
Cancer 62 day referral to treatment (upgrades)	72.2%	83.3%	87.5%	69.2%	63.6%	76.5%	100.0%	88.9%	73.7%	91.7%	90.0%	91.7%	85.0%	70.8%	91.7%	89.3%	>=90%	<85%
Number of patients waiting over 104 days with a TCI date	170	12	6	5	4	3	4	8	8	21	2	3	3	1	16	40	Zero	
Number of patients waiting over 104 days without a TCI date	407	22	25	19	14	20	33	79	66	38	15	8	8	9	9	33	<=24	
Diagnostics																		
% waiting for diagnostics 6 week wait and over (15 key tests)	3.16%	1.06%	0.94%	1.50%	1.16%	3.16%	41.95%	43.43%	29.54%	26.07%	25.49%	23.00%	17.50%	14.67%	23.00%	14.67%	<=1%	>2%
The number of planned / surveillance endoscopy patients waiting at month end	825	763	835	853	803	825	1,035	1,230	1,367	1,465	1,569	1,648	1,665	1,772	1,648	1,665	<=600	
Discharge																		
Patient discharge summaries sent to GP within 24 hours	56.5%	56.4%	56.2%	58.9%	59.4%	57.7%	55.4%	57.8%	60.1%	60.0%	57.5%	61.2%	60.7%		59.6%	59.3%	>=88%	<75%

Trust Scorecard - Responsive (2)

OVERALL SCORE

	19/20	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	20/21 Q2	20/21	Standard	Threshold
Emergency Department																		
ED: % total time in department – under 4 hours (type 1)	81.58%	76.24%	72.91%	72.45%	72.41%	78.56%	87.46%	85.41%	85.06%	84.46%	73.53%	71.74%	68.96%	69.40%	76.53%	78.12%	>=95%	<90%
ED: % total time in department – under 4 hours (types 1 & 3)	87.40%	83.41%	81.18%	81.02%	82.33%	85.08%	89.93%	88.72%	89.94%	90.05%	83.26%	82.34%	80.21%	79.64%	85.16%	85.27%	>=95%	<90%
ED: % total time in department – under 4 hours CGH	93.70%	90.92%	88.74%	91.50%	93.02%	94.10%	95.42%	96.43%	98.93%	99.85%	99.91%	99.95%	99.84%	99.94%	99.91%	98.67%	>=95%	<90%
ED: % total time in department – under 4 hours GRH	81.59%	69.25%	65.20%	63.30%	64.91%	71.69%	84.28%	80.59%	84.01%	84.46%	73.53%	71.74%	68.96%	69.40%	76.53%	76.64%	>=95%	<90%
ED: number of patients experiencing a 12 hour trolley wait (>12hours from decision to admit to admission)	2	0	1	0	0	1	0	0	0	0	1	0	0	14	1	15	Zero	
ED: % of time to initial assessment – under 15 minutes	71.2%	66.5%	64.3%	68.0%	65.8%	70.1%	80.4%	77.0%	72.7%	72.5%	63.7%	61.3%	66.9%	66.5%	65.8%	69.4%	>=95%	<92%
ED: % of time to start of treatment – under 60 minutes	31.3%	26.6%	26.0%	31.9%	29.0%	40.9%	68.0%	57.5%	52.0%	44.5%	31.4%	30.9%	38.1%	41.8%	35.5%	44.0%	>=90%	<87%
% of ambulance handovers that are over 30 minutes	2.40%	3.71%	2.81%	3.76%	2.76%	2.87%	2.09%	1.74%	2.57%	2.04%	4.17%	3.67%	3.95%	4.59%	3.30%	3.16%	<=2.96%	
% of ambulance handovers that are over 60 minutes	0.07%	0.07%	0.24%	0.23%	0.13%	0.05%	0.00%	0.00%	0.15%	0.03%	0.90%	0.55%	1.09%	2.63%	0.50%	0.70%	<=1%	>2%
Operational Efficiency																		
Cancelled operations re-admitted within 28 days	74.03%	64.71%	80.00%	88.89%	74.07%	74.03%	-120.00%	100.00%	100.00%	94.00%	86.67%	94.74%	95.83%	90.50%	92.00%	75.42%	>=95%	
Urgent cancelled operations	8	0	1	1	1	0	0	0	0	11	2	10	7	4	23	34	No target	
Number of patients stable for discharge	86	87	81	112	101	70	14	33	45	66	68	72	99	84	206	420	<=70	
Number of stranded patients with a length of stay of greater than 7 days	423	406	403	431	427	358	204	213	248	288	332	325	379	392	315	298	<=380	
Average length of stay (spell)	5.14	4.95	5.25	5.68	5.36	6.16	5.22	4.49	4.54	4.69	4.66	4.78	4.86	4.79	4.71	4.75	<=5.06	
Length of stay for general and acute non-elective (occupied bed days) spells	5.73	5.56	5.77	6.43	6.07	6.9	5.37	4.75	4.81	5.13	5.15	5.34	5.44	5.43	5.21	5.19	<=5.65	
Length of stay for general and acute elective spells (occupied bed days)	2.67	2.65	2.87	2.42	2.62	2.66	3.74	2.2	2.64	2.47	2.32	2.47	2.58	2.15	2.42	2.48	<=3.4	>4.5
% day cases of all electives	85.59%	85.54%	87.04%	87.91%	84.27%	84.90%	82.75%	81.81%	83.67%	81.73%	78.41%	82.26%	81.28%	83.34%	80.97%	81.63%	>80%	<70%
Intra-session theatre utilisation rate	87.20%	88.00%	87.40%	86.40%	87.50%	85.60%	91.80%	87.60%	84.05%	87.30%	88.60%	86.70%	85.70%	87.70%	86.10%	86.50%	>85%	<70%

Trust Scorecard - Responsive (3)

OVERALL SCORE

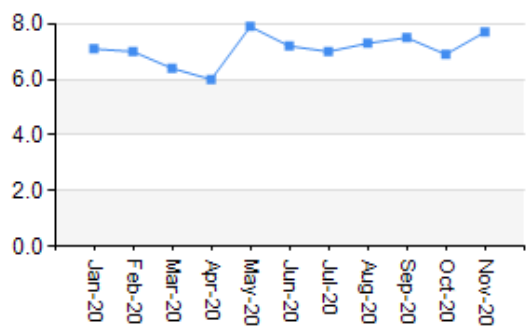
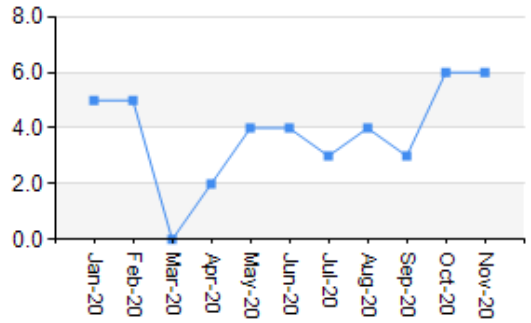
	19/20	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	20/21 Q2	20/21	Standard	Threshold
Outpatient																		
Outpatient new to follow up ratio's	1.88	1.81	1.89	1.86	1.93	2.04	2.49	2.32	2.28	2.04	2	1.94	1.88	1.94	1.99	2.05	<=1.9	
Did not attend (DNA) rates	6.90%	6.80%	6.90%	6.90%	6.40%	7.80%	4.20%	4.30%	4.70%	5.50%	6.10%	6.50%	6.30%	6.30%	6.00%	5.70%	<=7.6%	>10%
RTT																		
Referral to treatment ongoing pathways under 18 weeks (%)	81.01%	80.29%	80.57%	81.06%	81.41%	81.01%	73.61%	66.53%	59.06%	55.83%	60.07%	66.27%	69.36%	69.87%	60.78%	64.93%	>=92%	
Referral to treatment ongoing pathways 35+ Weeks (number)	1,833	1,792	1,790	1,658	1,653	1,833	2,719	3,794	4,967	6,226	7,155	7,748	8,404	8,400	7,043	6,198	No target	
Referral to treatment ongoing pathways 45+ Weeks (number)		325	330	309	286	334	707	1,197	1,768	2,172	2,724	3,084	3,253	3,051			No target	
Referral to treatment ongoing pathways over 52 weeks (number)	33	45	39	28	14	33	156	366	694	1,037	1,233	1,279	1,285	1,428	1,183	936	Zero	
Referral to treatment ongoing pathways 70+ Weeks (number)		1	0	1	0	0	0	2	5	17	57	77	86	114			No target	
SUS																		
Percentage of records submitted nationally with valid GP code	99.7%	99.8%	99.9%	99.9%	99.9%	99.9%	100.0%	100.0%	100.0%	100.0%	100.0%					100.0%	>=99%	
Percentage of records submitted nationally with valid NHS number	99.7%	99.9%	99.8%	99.8%	99.8%	99.8%	99.8%	99.8%		99.9%	99.9%					99.9%	>=99%	

Trust Scorecard - Well Led (1)

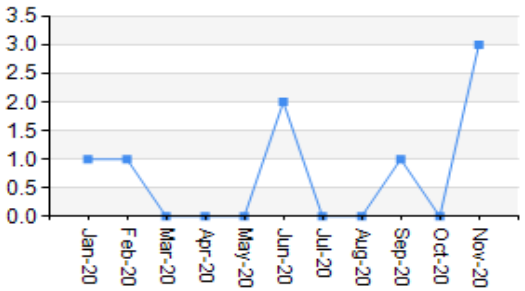
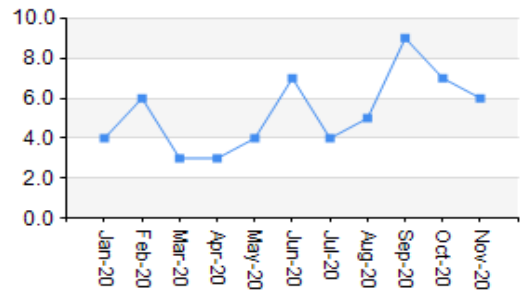
OVERALL SCORE

	19/20	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	20/21 Q2	20/21	Standard	Threshold
Appraisal and Mandatory Training																		
Trust total % overall appraisal completion	82.0%	82.0%	82.0%	83.0%	85.0%	85.0%	85.0%	85.0%	78.0%	80.0%	82.0%	84.0%	83.0%	83.0%			>=90%	<70%
Trust total % mandatory training compliance	92%	92%	92%	90%	90%	90%	90%	90%	90%	91%	91%	94%	93%	93%	94%		>=90%	<70%
Finance																		
Total PayBill Spend		31.3	31.4	30.1	31.6	30.2	32.5	33.8	34.3	33.2	33.9	34.7						
YTD Performance against Financial Recovery Plan		.6	.4	.3	.1	1.5	0	-.1	0	0	0	0						
Cost Improvement Year to Date Variance		1	-2	-2	-4	-8	0	0	0	0	0	0						
NHSI Financial Risk Rating		3	3	3	3	3	3	3	3	0	0	0						
Capital service		4	4	4	4	3	3	3	3	0	0	0						
Liquidity		4	4	4	4	4	4	4	4	0	0	0						
Agency – Performance Against NHSI Set Agency Ceiling		3	3	3	3	3	3	3	3	0	0	0						
Safe Nurse Staffing																		
Overall % of nursing shifts filled with substantive staff	97.40%	99.40%	98.30%	99.30%	98.30%				90.52%	100.77%	102.10%	93.82%	96.30%	94.90%	98.88%	96.40%	>=75%	<70%
% registered nurse day	98.20%	100.70%	98.70%	98.50%	98.10%				89.23%	100.82%	101.90%	93.04%	95.49%	94.40%	98.52%	95.70%	>=90%	<80%
% unregistered care staff day	100.20%	104.20%	98.60%	102.10%	100.20%				110.83%	120.86%	117.50%	106.50%	101.36%	102.40%	114.98%	109.80%	>=90%	<80%
% registered nurse night	95.70%	97.10%	97.50%	100.80%	98.60%				92.99%	100.69%	102.60%	95.27%	97.77%	95.90%	99.53%	97.50%	>=90%	<80%
% unregistered care staff night	106.20%	115.50%	105.40%	107.80%	109.70%				112.80%	131.01%	131.70%	114.61%	113.36%	112.00%	125.68%	119.00%	>=90%	<80%
Care hours per patient day RN	4.7	4.8	4.9	4.6	4.7				6.2	5.8	5.6	5.2	5.2	5.7	5.5	5.6	>=5	
Care hours per patient day HCA	3	3	3	2.9	3				4.5	4.2	3.9	3.5	3.4	3.7	3.9	3.8	>=3	
Care hours per patient day total	7.7	7.8	7.9	7.6	7.7				10.8	10.1	9.5	8.6	8.6	9.4	9.4	9.4	>=8	
Vacancy and WTE																		
% total vacancy rate		6.95%	7.00%	6.70%	6.15%	6.15%			5.97%	5.14%	7.10%	5.26%	5.74%	6.03%			<=11.5%	>13%
% vacancy rate for doctors		2.80%	2.80%	3.62%	1.24%				4.90%	2.70%	3.27%	1.54%	1.07%	0.37%			<=5%	>5.5%
% vacancy rate for registered nurses		8.30%	8.30%	9.92%	10.26%	10.26%			8.12%	8.44%	8.90%	10.01%	7.76%	9.06%			<=5%	>5.5%
Staff in post FTE		6354.32	6355	6351.41	6387.05	6422.86	6421.87	6549.97	6573.86	6485.99	6463.25	6548.39	6557.43	6551.18			No target	
Vacancy FTE		474.24	475	457.45	418.47	418.47			416.06	358	494.04	365.97	399.63	420.14			No target	
Starters FTE		51.61	69.42	55.75	63.74	44.17	32.81	30.05	57.65	49.45	62.46	151.56	73.19	46.87			No target	
Leavers FTE		47.02	49.37	52.49	36.99	58.37	43.37	46.93	38.57	96.43	106.66	66.41	76.11	68.76			No target	
Workforce Expenditure and Efficiency																		
% turnover		11.7%	11.5%	11.5%	11.3%	11.1%	10.8%	10.9%	10.4%	10.2%	10.3%	10.3%	9.6%	10.1%			<=12.6%	>15%
% turnover rate for nursing		10.75%	10.93%	11.12%	10.92%	10.73%	10.59%	10.72%	10.14%	9.98%	10.34%	10.10%	9.41%	10.23%			<=12.6%	>15%
% sickness rate		3.9%	4.0%	3.9%	3.9%	3.5%	3.8%	3.8%	3.8%	3.7%	3.7%	3.7%	3.7%	3.7%			<=4.05%	>4.5%

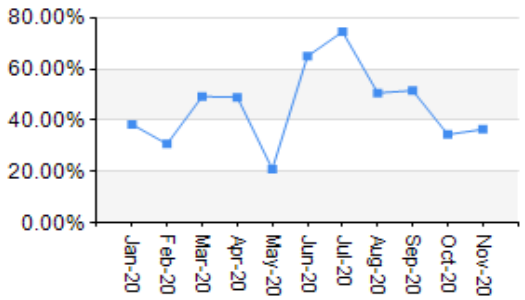
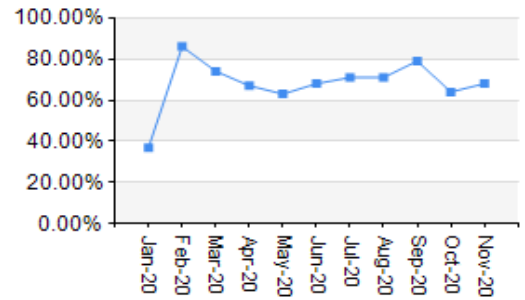
Exception Reports - Safe (1)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Number of falls per 1,000 bed days **Standard: <=6**		Under Review	**Director of Safety**
Number of falls resulting in harm (moderate/severe) **Standard: <=3**		Under Review	**Director of Safety**

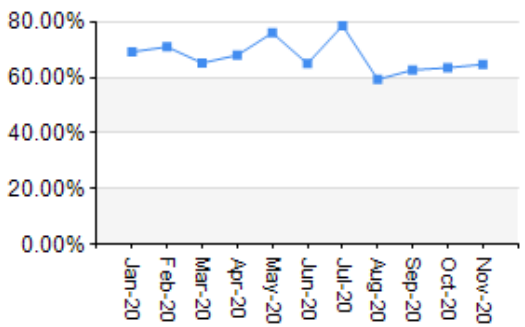
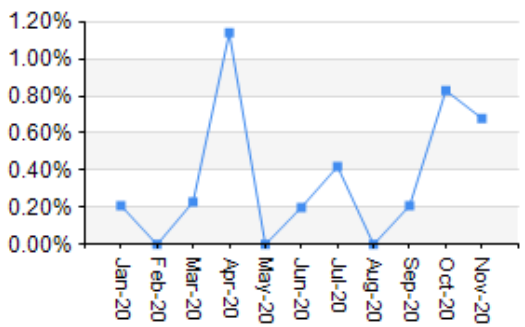
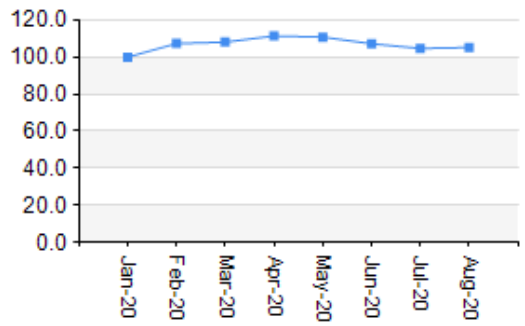
Exception Reports - Safe (2)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Number of never events reported **Standard: Zero**		There has been three further Never Events since the last report. W141994 - Retained guidewire - Retained foreign object This is a rare incident and has a safety (LOCCIP) procedure in place which will be reviewed alongside the circumstances of the incident W142394 – Wrong scar removal - Wrong site surgery This is a very similar incident to a recent Never Event (W130841) , extra support is being offered to establish the current mitigation plan W140308 – Administration of oral medication intravenously - Wrong route medication This is a rare incident and has controls in place (use of a purple syringe for oral liquid medication) to normally prevent occurrence There are no obvious links with the 3 new never events, but the trend remains with wrong site surgery. QDG have just received an analysis of the current wrong site surgery Never Events with recommendations being considered by the Divisions. The risk of regulatory action sits with the Medical Director below the level of TRR and will be reviewed.	**Director of Safety**
Number of unstagable pressure ulcers acquired as in-patient **Standard: <=3**		Under Review	**Deputy Nursing Director & Divisional Nursing Director - Surgery**

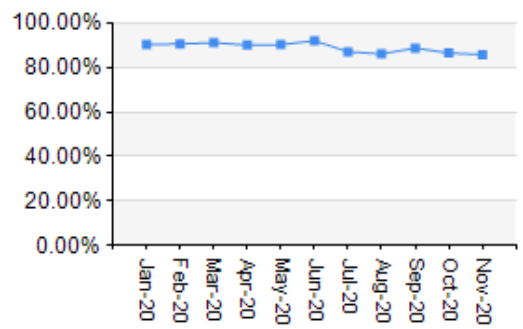
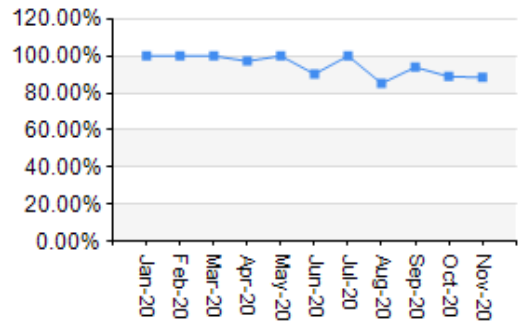
Exception Reports - Effective (1)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
% of patients admitted directly to the stroke unit in 4 hours **Standard: >=80%**		Improvement of 2% on October (34.50%). 47 patients breached the target in the month of November. Of these 47: 10 patients experienced a delay in assessment as the Stroke team were not informed by ED. Led to breaches along the rest of the pathway elements 18 patients were delayed due to lack of beds - Lack of HASU beds (shared space with Cardiology) 11 patients were delayed due to an unclear diagnosis which led to them initially being admitted to AMU for further tests. 2 patients were too unwell to move from ED 2 patients attended MIU in CGH and then had a delayed transfer over to GRH	**Director of Unscheduled Care and Deputy Chief Operating Officer**
% of patients who have been screened for dementia (within 72 hours) **Standard: >=90%**		The manual audit for this indicator shows a consistent performance in screening for dementia in the 30 case notes sampled, but is still below compliance, and as the Dementia Improvement Plan (DIP) has developed its performance dashboard, it should be noted that the sample size is approximately 10% of dementia admissions. The pace of the DIP's dementia & delirium QI project has been impacted by the current COVID priorities, but continues to look for ways to enable electronic record systems to prompt the assessment and recording of dementia and delirium, and this will also improve the ability to respond to DAR/FAIR indicator and the National Audit of Dementia. The DIP has identified delirium in patients with dementia as a key priority, as there is evidence from the Diagnose QI phase that multiple bed moves , Length of Stay and mortality rates are higher for this vulnerable group. A Dementia Council will be convened to support and monitor progress, and will be Chaired by the Trust's new Admiral Nurse and report to the Quality Delivery Group.	**Deputy Chief Nurse**

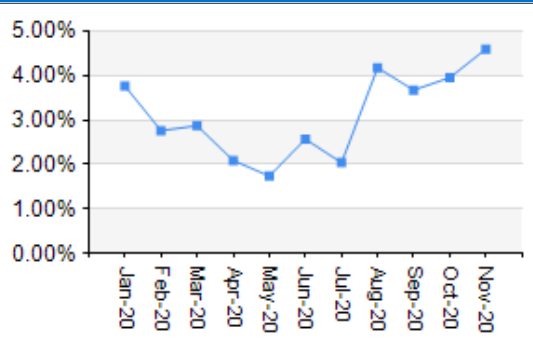
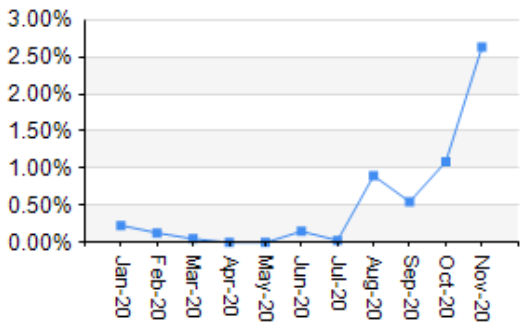
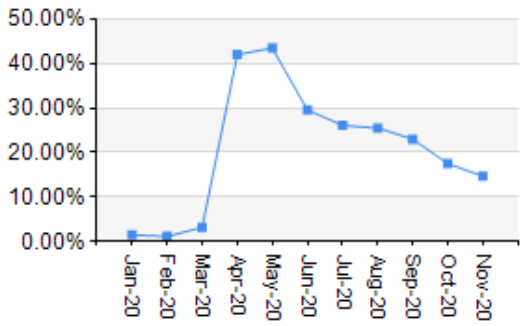
Exception Reports - Effective (2)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
% patients receiving a swallow screen within 4 hours of arrival **Standard: >=90%**		Improvement of 1.2% on October performance (63.50%). 31 patients breached the target in the month of November. Of those 31: 18 patients were delayed in receiving a bed on the Stroke Unit and therefore had a delayed swallow screening. 6 patients were delayed due to an unclear diagnosis which led to them initially being admitted to AMU for further tests. 7 patients were too unwell to receive a swallow screen within the four hour target.	**Director of Unscheduled Care and Deputy Chief Operating Officer**
% stillbirths as percentage of all pregnancies > 24 weeks **Standard: <0.52%**		Currently being reviewed by the service.	**Divisional Chief Nurse and Director of Midwifery**
Hospital standardised mortality ratio (HSMR) **Standard: Dr Foster**		The HSMR increased during wave one of the pandemic, this is the seen to be improving and the latest figure is now green.	**Medical Division Audit and M&M Lead**

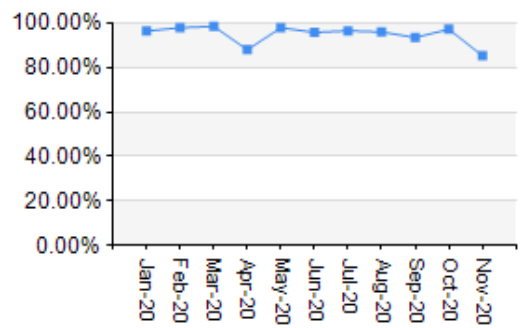
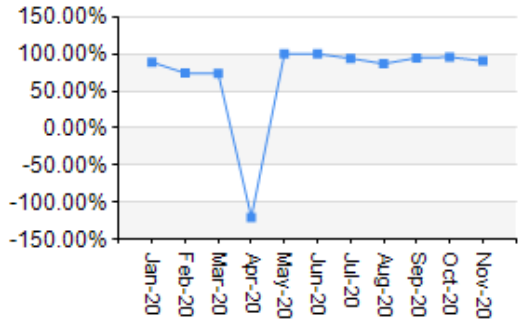
Exception Reports - Caring (1)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Inpatients % positive **Standard: >=96%**		The combined inpatient and day case score has dropped very slightly; from 86.6% in October to 85.7%. in November This is driven by a lower score for inpatients from 82.5% in October to 80.8% In November. There are plans to relaunch the patient experience improvement faculty in early 2021, which will have a focus on using our experience insight to drive improvement across our services. We will continue to monitor our inpatient scores with the DDQNs and matrons.	**Deputy Director of Quality**
Maternity % positive **Standard: >=97%**		The overall maternity FFT score has increased by 5% on October's FFT positive response, with 69 responses for Maternity in November, with a positive score of 88.4% o There were 52 responses to the Birth survey, 92.3% positive o 17 responses to the Postnatal ward survey, 76.5% positive The post natal ward survey is where we had a decrease in this month's positive score, and the matron is leading a working group focussed on understanding these experiences in more detail and identifying potential improvements	**Deputy Director of Quality**

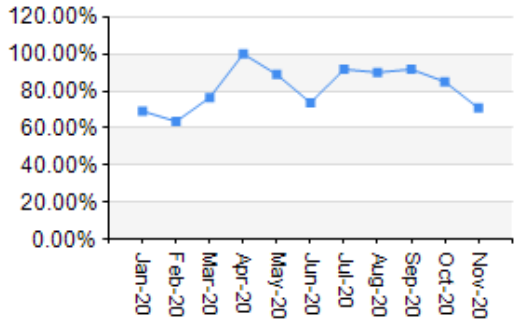
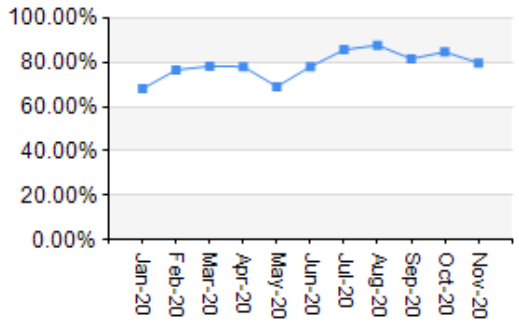
Exception Reports - Responsive (1)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
% of ambulance handovers that are over 30 minutes **Standard: <=2.96%**		Ambulance handover delays have increased in November due to a lack of flow in the Emergency Department (ED).	**Director of Unscheduled Care and Deputy Chief Operating Officer**
% of ambulance handovers that are over 60 minutes **Standard: <=1%**		Ambulance handover delays have increased in November due to a lack of flow in the Emergency Department (ED).	**Director of Unscheduled Care and Deputy Chief Operating Officer**
% waiting for diagnostics 6 week wait and over (15 key tests) **Standard: <=1%**		Diagnostics performance has improved, CT and MR are delivering within 6 weeks. Endoscopy and Cardiology are decreasing in breaches with their recovery plan in place.	**Deputy Chief Operating Officer**

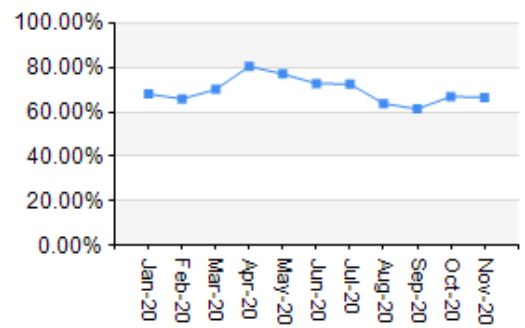
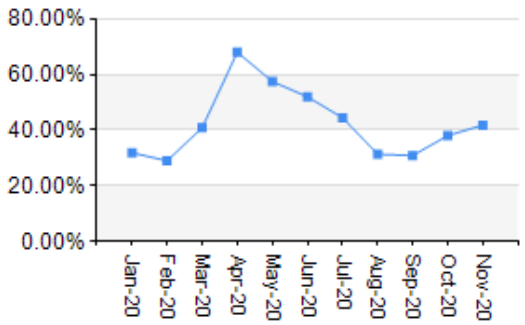
Exception Reports - Responsive (2)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
2 week wait breast symptomatic referrals **Standard: >=93%**		2ww breast symptoms performance (unvalidated) = 85.2% target = 93.0% National performance = 77.2% 122 Date first seens 18 breaches relating to operational issues in Breast Surgery expressed in 2ww standard	**Director of Planned Care and Deputy Chief Operating Officer**
Cancelled operations re-admitted within 28 days **Standard: >=95%**		Cancelled operations continue to be reviewed at specialty level and every effort made to reschedule within the 28 days. In November, 2 patients were cancelled on the day and could not be rescheduled within 28 days. This was an Ophthalmology patient cancelled due a leak in theatres which could not be rescheduled within 28 days due to other procedures the patient was having. The second, a Urology patient who was cancelled due to theatre running over and insufficient capacity to re-arrange within 28 days.	**Deputy Chief Operating Officer**

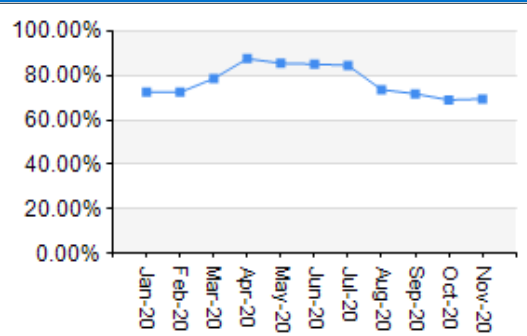
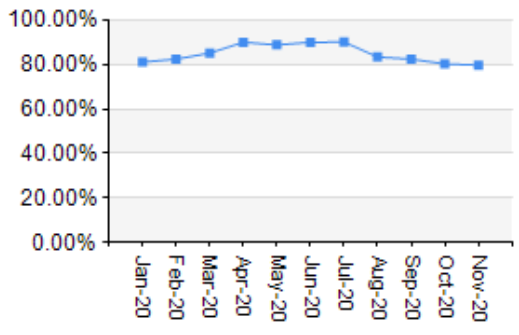
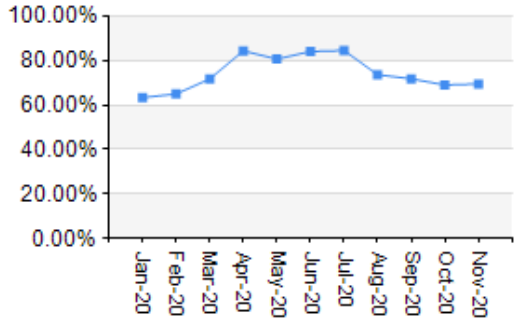
Exception Reports - Responsive (3)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Cancer 62 day referral to treatment (upgrades) **Standard: >=90%**		62 day upgrades performance (unvalidated)= 70.80% target = n/a National performance = 84.0%	**Director of Planned Care and Deputy Chief Operating Officer**
Cancer 62 day referral to treatment (urgent GP referral) **Standard: >=85%**		62 day GP performance (unvalidated) = 79.9% target = 85% National performance = 74.7% 154.5 treatments and 31 breaches Performance likely to improve given current low levels of skin treatments currently recorded Lower GI - 10, Haem 6, Gynae 3.5 Urology 3.5 5 breaches related to Covid restrictions. These mainly occuring on GI pathway where scoping activity has increased, in turn accuring more 62 day breaches. Annual performance currently 82.3% (compared to 73.8% in 19/20 and 77.8% in 18/19)	**Director of Planned Care and Deputy Chief Operating Officer**

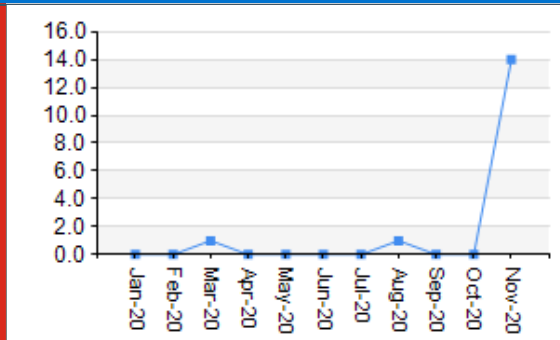
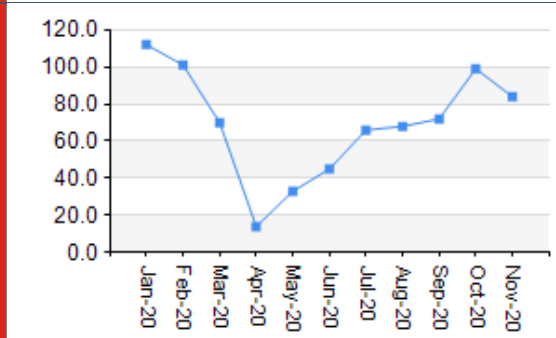
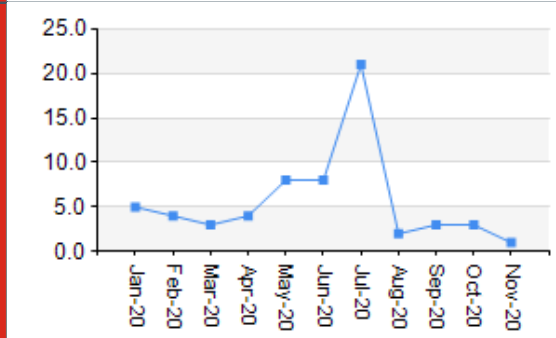
Exception Reports - Responsive (4)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
ED: % of time to initial assessment – under 15 minutes **Standard: >=95%**		Average triage has shown an improvement with waiting times lower in November than October. The trial of an additional triage nurse has improves performance for patients being triaged within 15 minutes of arrival, however still remains higher than the target of 15 minutes.	**Director of Unscheduled Care and Deputy Chief Operating Officer**
ED: % of time to start of treatment – under 60 minutes **Standard: >=90%**		The median wait to see a doctor has increase but still remains within target. A review of medical staffing is an area which Prof Cooke is reviewing which should help further improve this metric.	**Director of Unscheduled Care and Deputy Chief Operating Officer**

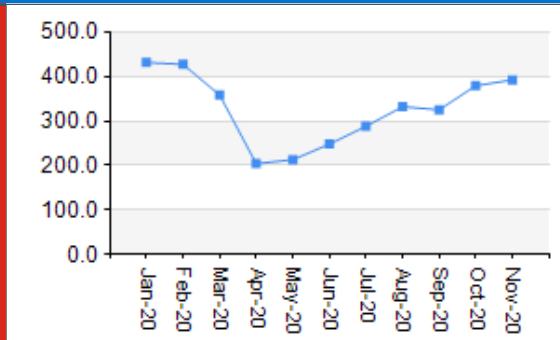
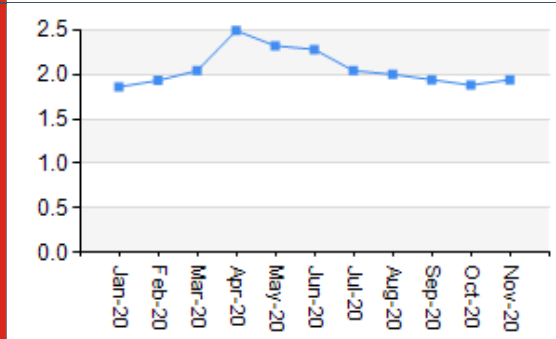
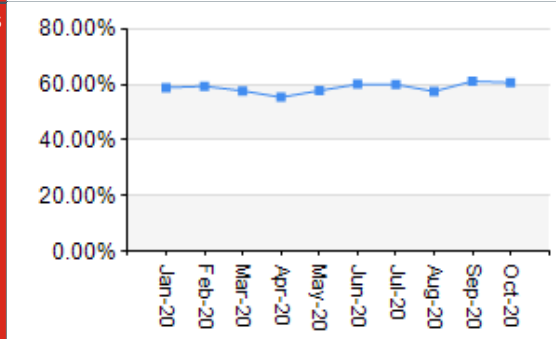
Exception Reports - Responsive (5)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
ED: % total time in department – under 4 hours (type 1) **Standard: >=95%**		Performance has increased by 0.44% compared to last month, this may be due to a reduction in attendances through the Emergency Department (ED) by 6.35% (-533 attendances). However the rate of admissions was still the same showing at patient acuity is still high.	**Director of Unscheduled Care and Deputy Chief Operating Officer**
ED: % total time in department – under 4 hours (types 1 & 3) **Standard: >=95%**		November has shown a deterioration in performance of 0.57% which is due to higher acuity of patients through the Emergency Department (ED) and the inability to discharge patients once medically fir for discharge.	**Director of Unscheduled Care and Deputy Chief Operating Officer**
ED: % total time in department – under 4 hours GRH **Standard: >=95%**		Performance has increased by 0.44% compared to last month, this may be due to a reduction in attendances through the Emergency Department (ED) by 6.35% (-533 attendances). However the rate of admissions was still the same showing at patient acuity is still high.	**Director of Unscheduled Care and Deputy Chief Operating Officer**

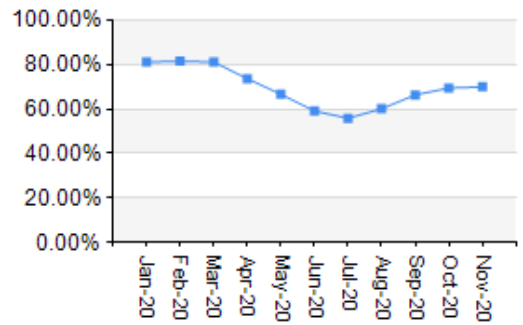
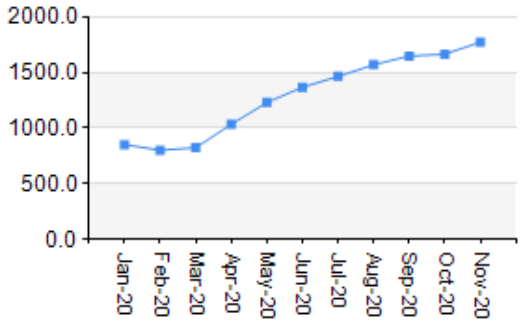
Exception Reports - Responsive (6)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
ED: number of patients experiencing a 12 hour trolley wait (>12hours from decision to admit to admission) **Standard: Zero**		There were fourteen 12 hour trolley breaches in November. This is because of a lack of flow in the hospital and a number of closed beds due to infection control.	**Director of Unscheduled Care and Deputy Chief Operating Officer**
Number of patients stable for discharge **Standard: <=70**		MSFD numbers remain up, with ongoing links to difficulties associated with COVID-19 and delays within realising social and home first pathways when patients remain COVID positive. Twice a day system flow calls continue with also twice weekly bronze calls to review the situation. Plans in place to clear 14+ days patients awaiting social input, plus NHSE/I work to commence to review the system against the new national hospital discharge guidelines.	**Head of Therapy & OCT**
Number of patients waiting over 104 days with a TCI date **Standard: Zero**		Specialty TCI recorded Lower GI 1 Gynaecological 1 Grand Total 2 >104 days still at low levels. >62 day numbers are still very low also. >104 day numbers are being impacted by a number of complex patients who are effectively medically deferred for a variety of reasons along with 4 patients who have been impacted by the scoping restrictions in endoscopy.	**Director of Planned Care and Deputy Chief Operating Officer**

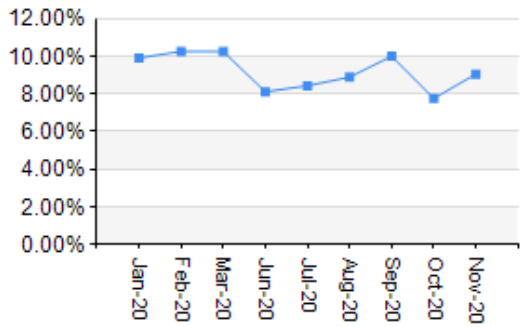
Exception Reports - Responsive (7)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Number of stranded patients with a length of stay of greater than 7 days **Standard: <=380**		Under review – noting work with system partners and surge 2 so ward base different.	**Deputy Chief Operating Officer**
Outpatient new to follow up ratio's **Standard: <=1.9**		Full recording of all virtual outpatients (especially to support f/u's) – supported by phase 3 recovery to drive up activity.	**Director of Unscheduled Care and Deputy Chief Operating Officer**
Patient discharge summaries sent to GP within 24 hours **Standard: >=88%**		Performance is improving marginally, continues to be monitored Executive reviews. Issue has been raised again with SDs.	**Medical Director**

Exception Reports - Responsive (8)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Referral to treatment ongoing pathways under 18 weeks (%) **Standard: >=92%**		See Planned Care Exception report for full details. The restoration and recovery phase continues (subject to surge 2) and since the low of 55.8% in July, performance continues to creep up. October was finalised as 69.36% and the part validated position is currently 69.9%, albeit 70% will be achieved prior to submission. As indicated in other metrics the long waiting cohort of patients has risen in recent months.	**Deputy Chief Operating Officer**
The number of planned / surveillance endoscopy patients waiting at month end **Standard: <=600**		There has been a deterioration of performance (107) in November following October's performance of 1665. The backlog position is due to COVID-19 pressures on a number of Endoscopy pathways, particularly cancer 2ww and 6ww diagnostic. There is a systematic recovery plan for all Endoscopy pathways which will deliver a performance improvement for planned surveillance by March 2021.	**Medical Director**

Exception Reports - Well Led (1)

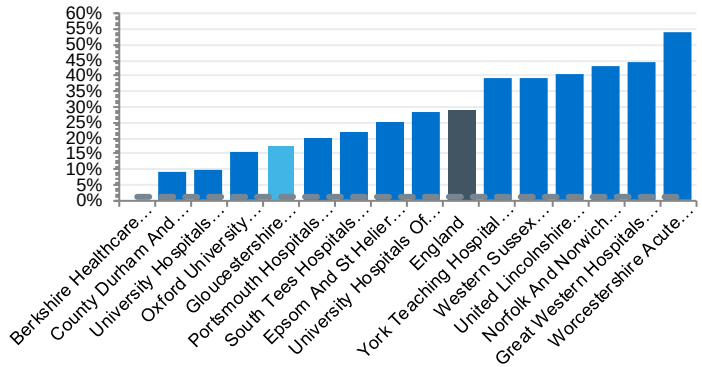
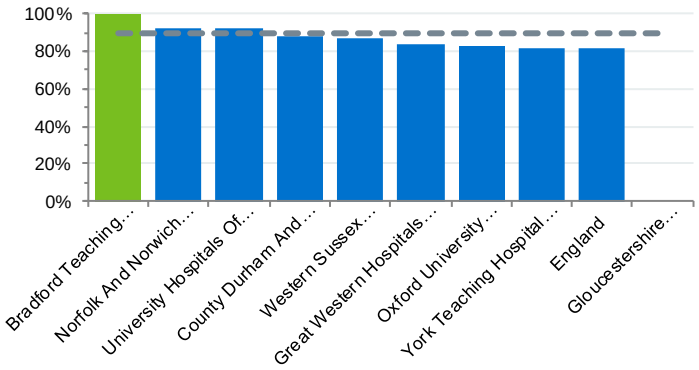
Metric Name & Standard	Trend Chart	Exception Notes	Owner
% vacancy rate for registered nurses **Standard: <=5%**		Under Review	**Director of Human Resources and Operational Development**

Benchmarking (1)

Gloucestershire Hospitals NHS Foundation Trust

Standard **England** **Other providers**
GHT **Best in class***

*Where there is more than one top performing provider, the first in alphabetical order is reported here

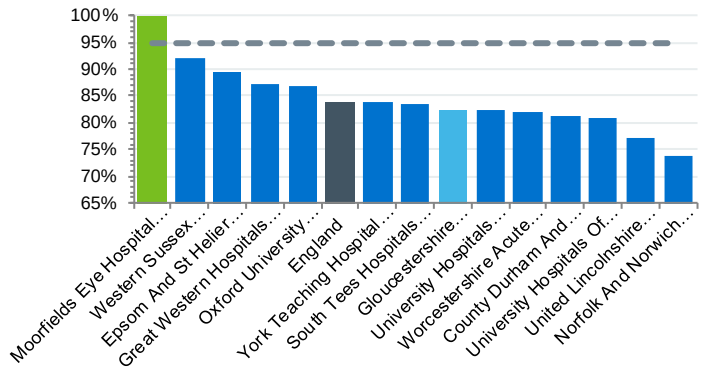
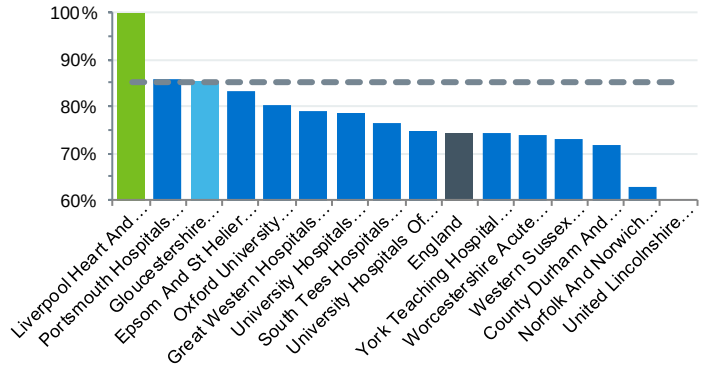
Metric	Period	Peer Group	Rank	Quartile
Diagnostics	October-20		50 / 160	2nd
Dementia	February-20		82 / 82	4th

Benchmarking (2)

Gloucestershire Hospitals NHS Foundation Trust

Standard **England** **Other providers**
GHT **Best in class***

*Where there is more than one top performing provider, the first in alphabetical order is reported here

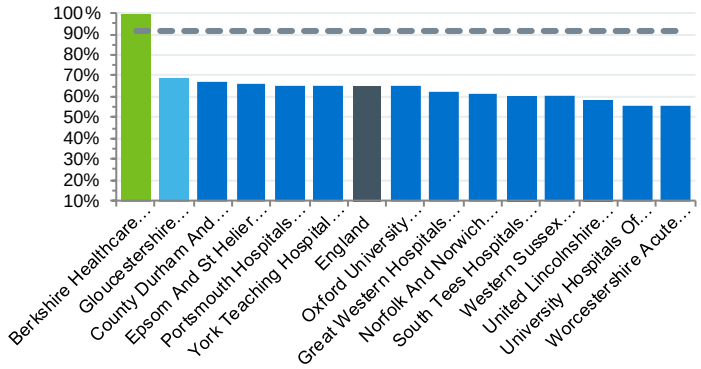
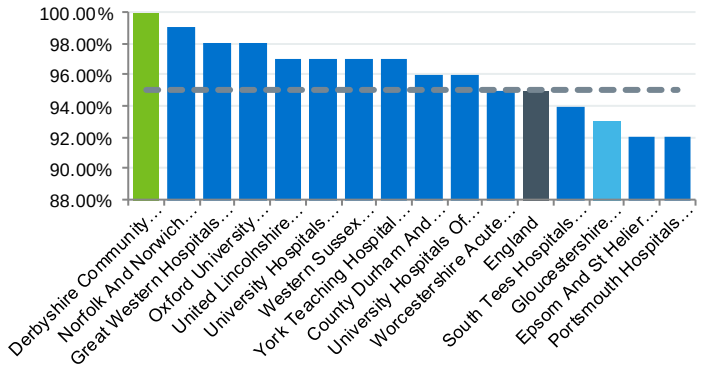
Metric	Period	Peer Group	Rank	Quartile
ED 4 Hour (Type 1 & Type 3)	November-20		67 / 114	3rd
Cancer 62 Days GP Referrals	October-20		22 / 137	1st

Benchmarking (3)

Gloucestershire Hospitals NHS Foundation Trust

Standard **England** **Other providers**
GHT **Best in class***

*Where there is more than one top performing provider, the first in alphabetical order is reported here

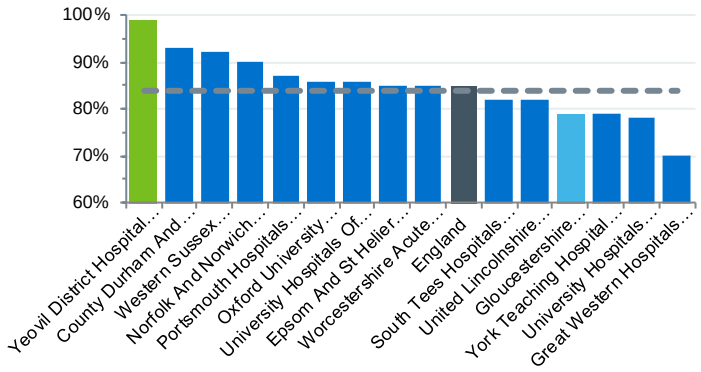
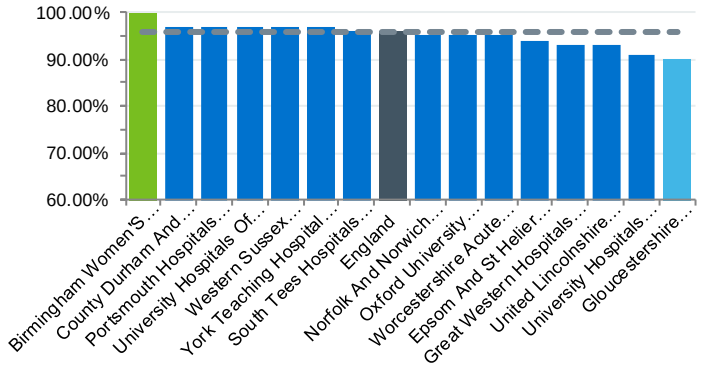
Metric	Period	Peer Group	Rank	Quartile
RTT	October-20		76 / 157	2nd
VTE (published quarterly)	December-19		116 / 149	4th

Benchmarking (4)

Gloucestershire Hospitals NHS Foundation Trust

Standard **England** **Other providers**
GHT **Best in class***

*Where there is more than one top performing provider, the first in alphabetical order is reported here

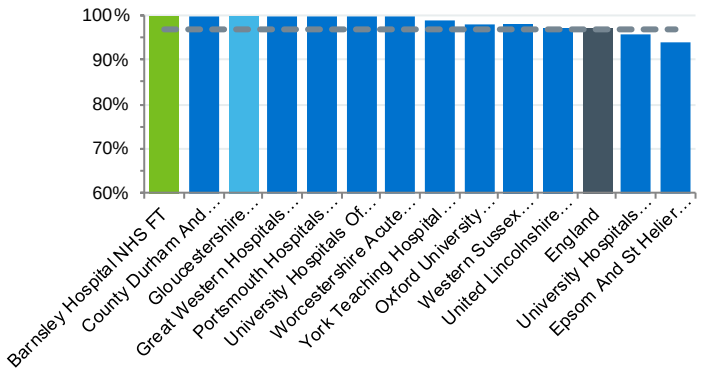
Metric	Period	Peer Group	Rank	Quartile
FFT - ED	February-20		109 / 131	4th
FFT - Inpatient	February-20		135 / 144	4th

Benchmarking (5)

Gloucestershire Hospitals NHS Foundation Trust

Standard **England** **Other providers**
GHT **Best in class***

*Where there is more than one top performing provider, the first in alphabetical order is reported here

Metric	Period	Peer Group	Rank	Quartile
FFT - Maternity	February-20		11 / 117	1st

Gloucestershire Hospitals
NHS Foundation Trust

TRUST BOARD – 14 JANUARY 2021
MS Teams at 12:30

Report Title
Ockenden Report - Immediate Essential Actions (IEAs) **NHSI 12 urgent clinical priorities**
Sponsor and Author(s)
Steve Hams and Carole Webster, Joint Directors of Quality and Chief Nurse
Executive Summary
Following the publication of Donna Ockenden's first report: Emerging Findings and Recommendations from the Independent Review of Maternity Services at the Shrewsbury and Telford Hospitals NHS Trust on 10 December 2020, NHS England and Improvement issued a letter to Chief Executives on 14 December 2020 setting out the immediate response required of all Trusts providing maternity services, and next steps to be taken nationally. The letter and the Trust's response are both provided for assurance following discussion and review at the Quality and Performance Committee in December 2020. In summary NHSI identified 12 urgent clinical priorities from the 7 IEAs and asked the Trust to confirm that we have implemented them by 21 December 2020. The action plan provided shows our benchmark position in which we have fully completed 6/12 priorities and have a plan in place to complete the priorities. Next steps will be to complete the full assurance assessment tool when it is published that will cover all 7 IEAs, NICE guidance relating to maternity, compliance against the CNST safety actions and a current workforce gap analysis.
Recommendations
The Board is asked to NOTE the Trust's plan for the 12 urgent clinical priorities and response to the actions required by the Ockenden review.
Impact Upon Strategic Objectives
This work links to Outstanding Care, Compassionate Workforce, Quality Improvement, Care Without Boundaries and Involved People.
Impact Upon Corporate Risks
There are no direct links corporate risks.
Regulatory and/or Legal Implications
Actions are required of trusts by NHS England and Improvement (the Regulator).
Equality & Patient Impact
The actions seek to ensure equality and improve care for women, babies and their families.

Resource Implications			
Finance		Information Management & Technology	
Human Resources	**X**	Buildings	

Action/Decision Required							
For Decision		For Assurance	**X**	For Approval		For Information	

Date the paper was presented to previous Committees and/or Trust Leadership Team

(TLT)							
Audit & Assurance Committee	**Finance & Digital Committee**	**Estates & Facilities Committee**	**People & OD Committee**	**Quality & Performance Committee**	**Remuneration Committee**	**Trust Leadership Team**	**Other (specify)**
				23 Dec 2020			
Outcome of discussion when presented to previous Committees/TLT							
Recommended for Board for assurance.							

Skipton House
80 London Road
London
SE1 6LH

To: NHS Trust and Foundation Trust Chief Executives

CC: Trust Chairs, STP and ICS Leaders, CCGs

14 December 2020

Dear colleague,

OCKENDEN REVIEW OF MATERNITY SERVICES – URGENT ACTION

Following the publication of Donna Ockenden's first report: Emerging Findings and Recommendations from the Independent Review of Maternity Services at the Shrewsbury and Telford Hospitals NHS Trust on 11th December 2020, this letter sets out the immediate response required of all Trusts providing maternity services, and next steps to be taken nationally.

You will have read the report and recognise the deep and lasting impact on those families who have lost loved ones, and those who continue to live with the injury and trauma caused.

Despite considerable progress having been made in improving maternity safety, there continues to be too much variation in experience and outcomes for women and their families. We must use this report and its 7 Immediate and Essential Actions (IEA) to redouble efforts to bring forward lasting improvements in our maternity services.

Immediate Actions

You should proceed to implement the full set of the Ockenden IEAs. However, we have identified 12 urgent clinical priorities from the IEAs which we are asking you to confirm you have implemented by **5pm on 21st December 2020**. The priorities are:

1) **Enhanced Safety**
   a) A plan to implement the Perinatal Clinical Quality Surveillance Model, further guidance will be published shortly
   b) All maternity SIs are shared with Trust boards at least monthly and the LMS, in addition to reporting as required to HSIB

2) **Listening to Women and their Families**
   a) Evidence that you have a robust mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services
   b) In addition to the identification of an Executive Director with specific responsibility for maternity services, confirmation of a named non-executive director who will support the Board maternity safety champion bringing a degree of independent challenge to the oversight of maternity and neonatal services and ensuring that the voices of service users and staff are heard. Further guidance will be shared shortly.

3) **Staff Training and working together**
   a) Implement consultant led labour ward rounds twice daily (over 24 hours) and 7 days per week.
   b) The report is clear that joint multi-disciplinary training is vital, and therefore we will be publishing further guidance shortly which must be implemented, In the meantime we are seeking assurance that a MDT training schedule is in place.
   c) Confirmation that funding allocated for maternity staff training is ringfenced and any CNST Maternity Incentive Scheme (MIS) refund is used exclusively for improving maternity safety

4) **Managing complex pregnancy**
   a) All women with complex pregnancy must have a named consultant lead, and mechanisms to regularly audit compliance must be in place
   b) Understand what further steps are required by your organisation to support the development of maternal medicine specialist centres

5) **Risk Assessment throughout pregnancy**
   a) A risk assessment must be completed and recorded at every contact. This must also include ongoing review and discussion of intended place of birth. This is a key element of the Personalised Care and Support Plan (PSCP). Regular audit mechanisms are in place to assess PCSP compliance

6) Monitoring Fetal Wellbeing
   a) Implement the saving babies lives bundle. Element 4 already states there needs to be one lead. We are now asking that a second lead is identified so that every unit has a lead midwife and a lead obstetrician in place to lead best practice, learning and support. This will include regular training sessions, review of cases and ensuring compliance with saving babies lives care bundle 2 and national guidelines.

7) Informed Consent
   a) Every trust should have the pathways of care clearly described, in written information in formats consistent with NHS policy and posted on the trust website. An example of good practice is available on the Chelsea and Westminster website.

Workforce - the report is clear that safe delivery of maternity services is dependent on a Multidisciplinary Team approach. The Maternity Transformation Programme has implemented a range of interventions to deliver increases in healthcare professionals and support workers including: the development of the maternity support worker role, the expansion of midwifery undergraduate numbers, additional maternity placements and active recruitment.

Alongside this, local maternity leaders should align assessments, safety, and workforce plans to the needs of local communities. We are therefore asking Trust Boards to confirm that they have a plan in place to the Birthrate Plus (BR+) standard by 31 January 2020 confirming timescales for implementation.

Please send confirmation of your compliance with these immediate actions signed off by you, as the CEO, along with confirmation of sign off from the Chair of your local LMS to your Regional Chief Midwife, by 21 December. They are available to support you with this request. Your individual responses will form part of the presentation and discussion at the NHSEI Public Board in January 2021 when the report, and immediate and longer-term actions will be considered.

We are also asking every trust providing maternity services to review the report at your next public board. The Board should reflect on whether the assurance mechanisms within your Trust are effective and, with your local maternity system (LMS), you are assured that poor care and avoidable deaths with no visibility or learning cannot happen in your own organisation. To support these discussions, we are asking Trusts to complete and take to your board the **assurance assessment tool,** which will be published shortly and draws together elements including:

1) All 7 IEAs of the Ockenden report,
2) NICE guidance relating to maternity,
3) compliance against the CNST safety actions, and
4) a current workforce gap analysis

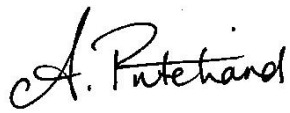
Your assurance assessment tool should also be reported through your LMS and shared with regional teams by the **15th January 2021**, in order to complete a gap and thematic analysis which will be reported to the regional and national Maternity Transformation Boards.

We undertake to work with regions, systems and Royal Colleges to implement the Ockenden 7 IEAs including: those for LMS; the independent senior advocate role in Trusts; and ensuring that networked maternal medicine is implemented across all regions. We will also review the MTP, now entering its final year, to ensure future plans are in line with the Ockenden 7 IEAs.

We are planning a webinar this week with Amanda Pritchard (Chief Operating Officer, NHS England and NHS Improvement and Chief Executive, NHS Improvement), Sarah-Jane Marsh (Chair, Maternity Transformation Programme, Chief Executive, Birmingham Women's and Children's NHS Foundation Trust) and Ruth May (Chief Nursing Officer, NHS England and NHS Improvement) to discuss and answer any questions you may have about this letter and the requests contained herein.

As you will no doubt agree our women and families deserve the best of NHS care and we must therefore act without delay to make further improvements. Thank you in advance in your collective support in responding to this.

Yours sincerely



Amanda Pritchard
Chief Operating Officer, NHS England and NHS Improvement
Chief Executive, NHS Improvement

Ruth May
Chief Nursing Officer, England

Professor Steve Powis

National Medical Director

NHS England and NHS Improvement

Gloucestershire Hospitals
NHS Foundation Trust

OCKENDEN REVIEW OF MATERNITY SERVICES
IMMEDIATE AND ESSENTIAL ACTIONS

DECEMBER 2020

Issue		Actions	Person responsible	Evidence of progress	Date for completion
1 Enhanced Safety	1A	A plan to implement the Perinatal Clinical Quality Surveillance Model, further guidance will be published shortly	Divisional Director of Quality and Nursing	• The revised Model has been noted and an action plan to address and shortfalls initiated. • Progress will l be monitored in Trust via Maternity Clinical Governance Meeting and reported directly to the Quality and Performance Committee and the Local Maternity System (LMS)	January 2021
	1B	All maternity SIs are shared with Trust Boards at least monthly and the LMS, in addition to reporting as required to HSIB.	Improvement and Safety Director Lead for Quality and Governance	• The Quality and Performance Committee and the Board of Directors receive serious incidents each month. • All cases that fit the criteria are reported to HSIB • Added to terms of Reference to ensure a quality report is submitted to the LMS on a monthly basis this will include serious incident and HSIB cases.	Complete January 2021
2 Listening to Women and their Families	2A	Evidence that you have a robust mechanism for gathering service user feedback and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services	Chair of the LMS	• Good engagement with the Gloucestershire Maternity Voices Partnership which is well established and works in partnership with the Maternity service. • MVP chair is a board member of the LMS • Quarterly and Annual report received by the LMS • LMS are now included in the Divisional Board minutes • Other mechanisms for user feedback are also in place i.e. FFT, Maternity Survey	Complete
	2B	In addition to the identification of an Executive Director with specific responsibility for maternity services, confirmation of a named non-executive director who will support the Board maternity safety champion bringing a degree of independent challenge to the oversight of maternity and neonatal services and ensuring that the voices of service users and staff are heard. Further guidance will be shared shortly	Joint Director of Quality and Chief Nurse	• The Joint Director of Quality and Chief Nurse is the executive Maternity Safety Champion • Alison Moon is non-executive director with oversight of maternity services	Complete
3 Staff training and working together	3A	Implement consultant led labour ward rounds twice daily (over 24hrs) and 7 days per week	Chief of Service	• Multidisciplinary team twice daily ward round already in place (0830/2030) every day	Complete
	3B	The report is clear that joint multi-disciplinary training is vital, and therefore further guidance will be published shortly which must be implemented. In the meantime, assurance is sought that a MDT training schedule is in place	Midwifery Practice development team	• Mandatory annual PROMPT training in place for many years, currently being undertaken as virtual training programme. Includes medical team/midwifery/anaesthetic and neonatal teams. • Scheduled training in place for year planned and executed by multidisciplinary practice development team	Complete

Issue		Actions	Person responsible	Evidence of progress	Date for completion
	3C	Confirmation that funding allocated for maternity staff training is ring-fenced and any CNST Maternity Incentive Scheme (MIS) refund is used exclusively for improving maternity safety	Director of Finance	• Divisional funding for training is always used to support professional development • CNST Maternity Incentive Scheme (MIS) refund is used in part to support maternity improvement. Further financial analysis is required to ensure the maternity improvement rebate is used for improvement.	Complete January 2021
4 Managing complex pregnancy	4A	All women with complex pregnancy must have a named consultant lead, and mechanisms to regularly audit compliance must be in place	Chief of Service	• All women who are not midwifery led care have named lead Consultant when complex pregnancy presents. • A mechanism for regular audit of records to ensure compliance will commence from January, with a manual review of a sample set of records each month.	Complete January 2021
	4B	Understand what further steps are required by your organisation to support the development of maternal medicine specialist centres	Specialty Director/Lead Obstetric Consultant Medical Disorders Clinic	• GHT already in discussion regarding maternal medicine network, paused for COVID but to be relaunched for South West. Maternity/Neonatal Network involved.	February 2021
5 Risk assessment throughout pregnancy	5A	A risk assessment must be completed and recorded at every contact. This must also include ongoing review and discussion of intended place of birth. This is a key element of the Personalised Care and Support Plan (PSCP. Regular audit mechanisms are in place to assess PCSP compliance.	Deputy Director of Midwifery/Specialty Director LMNS/Specialty Director/Deputy Director of Midwifery	• Whilst formalised RA not currently undertaken at every contact, discussion regarding care/ appropriate plan for ongoing pregnancy needs is undertaken. Formal risk assessment takes place at booking, 36 weeks and at the onset of labour. Compliance with the same is subject to prospective and retrospective audit. • Process for risk assessment is subject to review and will be developed to ensure documentation of a formal risk assessment at every contact by January 2021. • Personalised care and support plan has been coproduced with women, families and clinicians. We have piloted the approach and until we have a new EPR system will need to establish a way to collate numbers of plans. Digital transformation will be incorporated as a requirement into the procurement of a maternity information system, this is in progress. We have a lead clinician for personalised care and a number of staff have undertaken 'Better Conversations' training to understand and embed personalised care approaches into practice. Further training for staff will be included with implementation of Continuity of Carer.	 January 2021 February 2021

Issue		Actions	Person responsible	Evidence of progress	Date for completion
6 Monitoring fetal wellbeing	6A	Implement the savings babies lives bundle. Element 4 already states there needs to be one lead. We are now asking that a second lead is identified so that every unit has a lead midwife and a lead obstetrician in place to lead best practice, learning and support. This will include regular training sessions, review of cases and ensuring compliance with savings babies lives care bundle 2 and national guidelines	Specialty Director/Deputy Director of Midwifery	• 0.4wte CTG Midwife was appointed in 2018 as per recommendations of SBLv2 with MTP temporary funding. We are currently reappointing to this role with a view to establishing a substantive role. • Clinical Governance Lead Consultant is the lead for fetal monitoring • Regular training on fetal monitoring undertaken by MDT with competency assessments • Monitoring of SBLV2 and progress on implementation of these recommendations is undertaken by safer work stream and LMNS • Periprem programme in place • Monitoring of outcomes via maternity dashboard undertaken	Complete
7 Informed consent	7A	Every Trust should have the pathways of care clearly described, in written information in formats consistent with NHS policy and posted on the Trust website. An example of good practice is available on the Chelsea and Westminster website. www.chelwest.nhs.uk/services/maternity	Practice Development Midwives/ Comms team	• All maternity information leaflets on maternity website (women given QR code which takes them directly to Trust Website) • Link to maternity website also on MVP website • Maternity wallets (for notes) also has important pregnancy information and QR code	Complete

Gloucestershire Hospitals
NHS Foundation Trust

TRUST PUBLIC BOARD – 14 January 2021
Microsoft Teams, Commencing at 12:30

Report Title
J2O VISITS
Sponsor and Author(s)
Author – Andrew Seaton – Quality Improvement & Safety Director Sponsor – Steve Hams - Director of Quality and Chief Nurse
Executive Summary
Purpose To provide assurance of senior management engagement with wards and departments and Board visibility. Key issues to note There have been six visits with four completed notes attached (two missing due to sickness). Most of the more recent visits have been cancelled due to work pressures. Prior to each visit the areas are contacted to check the current position. Four virtual visits will be booked each month. Added content on themes will be added as the visits build up. Conclusions Although there is considerable workload pressure the visits will continue to be planned with a final check on the day to assess the department's workload. Implications and Future Action Required None
Recommendations
To RECEIVE the report as a source of assurance of leadership visibility and engagement with staff
Impact Upon Strategic Objectives
Outstanding Care **Quality Improvement** **Involved People**
Impact Upon Corporate Risks
Visits will support risk linked to engagement issues
Regulatory and/or Legal Implications
The visits will support the CQC Leadership domain

Equality & Patient Impact							
Currently visits have to be virtual so some staff may not be able to engage							
Resource Implications							
Finance		**X**	Information Management & Technology				
Human Resources		**X**	Buildings				
Action/Decision Required							
For Decision		For Assurance	**X**	For Approval		For Information	√

Date the paper was presented to previous Committees					
Quality & Performance Committee	**Finance Committee**	**Audit Committee**	**Remuneration & Nomination Committee**	**Trust Leadership Team**	**Other (specify)**
Outcome of discussion when presented to previous Committees/TLT					

Gloucestershire Hospitals
NHS Foundation Trust

MAIN BOARD – JANUARY 2021

REPORT ON J2O VISITS

1 Aim

To provide feedback on the J2O visits.

2 Background

During an increase in community transmission of COVID -19 virtual J2O visits were started in September 2020. The purpose of the visit is for Executive and Non-Executive Directors to engage directly with colleagues and discuss issues associated with our journey to outstanding.

The visit is designed to enables colleagues to share what is going well, what barriers there are to success and any key safety concerns affecting both staff and patients.

The visits also support the Boards desire to achieve ward/department to Board reporting and is a key part of the CQC Well Led domain.

In addition, the visits provide an opportunity for Board members to 'test' the delivery of strategy within the organisation and to actively receive feedback from colleagues.

The Trust executive team aims to complete 4 visits a month to encourage safety and experience improvement.

3 Actions from visits

Following the visit, notes from the visit will be shared with the visiting executive and/or Non-Executive and the team for accuracy checking. Once an approved set of notes have been agreed, these will be sent to the visiting team manager, the divisional risk/governance manager and the Divisional Director of Quality and Nursing. (Appendix 1)

Immediate actions relating to safety should be escalated to the Divisional Director of Quality and Nursing for resolution. The Quality Improvement and Safety Director will follow up with the visiting team manager three months following the visit to review actions.

4 Reports

Enclosed within the report are the action notes from each visit, the Director responsible for the visit will feedback the key issues, and through discussion identify any concerns.

5 Recommendation

To discuss the issues and ensure follow up of actions.

6 Next steps and communications

To provide feedback to Quality Delivery Group on a monthly basis.

Author: **Mary Barnes, Risk Co-ordinator/CAS Officer**
Presenting Director: **Andrew Seaton, Quality Improvement and Safety Director**
January 2021

Area September / October 2020	Site	Date	Report received from risk manager	Report approved by executive	Report sent to staff	Report sent to Quality Delivery Group	Executive/ Non-Executive
Critical Care	GRH	9/9/20	Cancelled rebooked as a virtual meeting 20/11/20				Steve Hams
Procurement	virtual	24/9/20	Y	Y	Y	Y	Emma Wood
Infection Control	virtual	29/9/20	Y	Y	Y	Y	Robert Graves
Pharmacy	virtual	29/9/20	N				Andrew Seaton
Area Planned for November							
Finance	virtual	9/11/20	Y	Y	Y	Y	Mark Hutchinson/ Elaine Warwicker
Health records	virtual	17/11/20	Cancelled rebooked as a virtual meeting 1/12/20				Simon Lanceley
Booking Office	virtual	18/11/20	Cancelled rebooked as a virtual meeting 21/12/20				Karen Johnson/ Alison Moon
Pathology	virtual	18/11/20	N				Deborah Lee/ Claire Feehily
Critical care	virtual	20/11/20	Y	Y	Y	Y	Steve Hams
Area planned for December							
Health records	virtual	1/12/20	Cancelled rebooked as a virtual meeting 28/1/21				Simon Lanceley
Theatres	virtual	10/12/20	Cancelled rebooked as a virtual meeting 21/12/20				Alex D'Agapeyeff
Physio and OT	virtual	16/12/20/2	Cancelled to be rebooked				Simon Lanceley
Booking Office	virtual	21/12/20	Cancelled to be rebooked				Karen Johnson
Theatres	virtual	21/12/20	Cancelled rebooked as a virtual meeting 6/1/21				Alex D'Agapeyeff
Area planned for January 2021							
Theatres	virtual	6/1/21					Alex

							D'Agapeyeff
Cirencester Theatres	virtual	20/1/21					Mark Hutchinson
IT	virtual	22/1/21					Andrew Seaton
West Block OPD	virtual	27/1/21					Emma Wood
Health records	virtual	28/1/21					Simon Lanceley
Radiotherapy	virtual	29/1/21					Deborah Lee

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

EXECUTIVE VISIT –Procurement

Date: 24/9/20

Director Emma Wood

Present: lee Robertson, Ed Taylor, Claire Selwyn, Rhiannon Wardle, Nicole Gannon, Kasia Drozd, Lurdes Magalluniues, Charley Bishop.

Discussion

- Emma Wood thanked the staff for their hard work during the COVID period, particularly with the PPE and supply issues.

Issues since March:

Homeworking:

- There have been issues with Microsoft Teams this week.
- Some staff working from home and some in office. Communication at the start of COVID was an issue but this was resolved by holding smaller team meetings morning and evening to discuss issues as they arose. Staff that wanted to buddied up to support and understand each other. This work is to be published within the Trust
- One of the biggest hurdles has been not foreseeing the situation lasting 6+ months.
- There have been issues with some of the systems not working well in VDI.

In the office:

- Within the office, there is space fro social distancing..
- Reasons for staff coming in are:
    - systems are not good enough at home ,
    - communication improves when in office as conversations often speed up issues.

Current issues:

- The team were asked to rate their resilience at the time of the meeting: these ranged from 2-8 but mainly 4 or 5. The team agreed that it depended on how much pressure they were under to deliver the service. They are currently trying to get the service up to pre COVID levels while planning for another possible wave,
- Everything is a priority at the moment

- Current Estates issues need to be completed by April due to funding.
- Currently 3million in Capital bids to be ordered in 3 months
- Staff feel they are all doing 2 peoples jobs
- Feel swamped by number of emails a day, all needing action.

Staff were asked how and when the work with COVID should be commemorated:

- Not now with 2nd peak expected
- The Trust has missed the boat should have been at end of first wave, about 2 months ago.
- Staff felt that the recognition should come with a personal letter (not just copy and paste) from senior management as they get regular appreciation from their line manager.

A design for a commemorative medal/ badge was shared. The staff In general liked the design with 2020 on and in gold.

Actions	
The team asked that staff were reminded that they are humans and they need time to make things happen and accept that they are not always able to achieve all demands	Emma Wood

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

EXECUTIVE VISIT –Infection Control Virtual meeting

Date: 29/9/20

Non-executive Director: Robert Graves

Present: Craig Bradley, Kerry Holden, Eve Spiers, Lyne Roberts, ~Jocelyn Wood, Sophie Turner, Geraldine

Discussion

- The team has had a very different year. Demand on the service has been immense,
- The safety culture in the Trust has improved.
- Team do not feel current level of workload is sustainable, everyone is generally fatigued.
- Feedback from other staff when challenged is not acceptable. Particularly staff using Fosters, they are rude to catering staff and other staff when challenged.
- Junior staff who have stepped up to being PPE leads from all wards and departments are getting challenged. The senior leadership team is looking into this.
- The fabric of the buildings means that cleaning is difficult due to age and condition. Joint audits carried out with GMS staff but feedback is slow.
- Infection control is every member of staff's business and other disciplines do not always recognise this. The level of specialisation the team provide optimises care. The team is more than a policing service . The team have a high level of credibility with other staff and are called on to help. During the pandemic the level and type of advice was very unpredictable.
- The Trust has a good reputation with other Trusts. COVID has put a different slant on how issues are dealt with but basically there is nothing new.
- The role of Safety officer is being taken on board by other Trusts.
- Our mortality figures are low compared with other Trusts.
- The team have good networking links with other Trusts.
- NHS England has reached out to our organisation for tips on our processes.
- The team always feel they can do better
- The team do not manage staff and it can be a struggle where local leadership within other teams is not strong.

- The team are very open to learning and change.
- There is still some way to go with most disciplines other than nursing staff. Being part of MS ward rounds is helping with this. Link workers has helped but again more input is needed from medical teams. The team feel this could be helped by them being more involved with QI projects with different teams.
- When asked if CQC came in now would we get Outstanding the team answered that nurses would readily give answers but other disciplines could struggle.
- Frustration with complicated GMS bureaucracy and poor quality of finish. There are forms to fill, slow processing and having to be exact in what is needed or there is another form to finish the job and another delay ,e.g. if ask for a board to be removed unless you specify you want the holes filled and the wall painted it will not be done. Also the process if there is a slight change in a process a review of SOP has to be done and the process re-costed.

1 Discuss with board/ communications ways to support staff when challenging social distancing	Robert Graves
2 Discuss ways for a structured review of estates for issues highlighted in audits	Robert Graves
3. Discuss with board ways that multidisciplinary working and understanding can be taken forward	Robert Graves
4. Discuss the GMS processes and frustrations	Robert Graves

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

EXECUTIVE VISIT –Finance

Date: 09/11/2020

Director Mark Hutchinson , Elaine Warwicker

Present: Jassy Few, Leanne Baker, Bogle Johanna, Janice Brett, Paul Bushell, Lisa Chapman, Paul Clapton, Carla Edwards, Paul Fantini, Paul Flavell, Alex Gent, Amruta Hiremath, Andrew Hoeller, Emma Jelfs, Julie Meecham, Antonette Mwamoamba, Robert Neale, Johanna Niehues, Caroline Parker, Josh Penston, Mandy Phelps, Ewelina Rosadowska-Labecka, Susan Simpson, Vikki Sleeman, Sarahj Smith, Suzanne Stephens, Gina Stevens, Hayley Summers, Sue Taylor, Rachel Walker-Morecroft,

Discussion

Elaine Warwicker gave praise to the team of their achievements, commitment and positive working especially through this time of COVID,

Things people are proud of?

- The team are heavily involved in Future Finance Level 2 which they hope to achieve by December 2020.
- They are currently continuing to undertake finance training across the trust via teams rather than face to face. They have so far managed to complete 5 sessions. They are starting to push to to other Trusts who have expressed an interest. Budget holders have been surveyed recently who have highlighted other training needs. The team are looking into providing this.
- Budget holders can now log-in to see their budget – which is proving beneficial.
- Setting up a Twitter account has allowed feedback to the team from clinical staff- most of which has been positive.
- Executive reporting packs have evolved and helped the team move forward on what is required. Board papers are now asking for more focused input which again is helping highlight requirements.

In the Office:

- There was lots of feedback of how well staff in both Procurement and Shared Services have adapted during COVID situation. Adapting to remote working, where communication between the teams have been challenging.
- Changing from paper-based systems to automation, the team took the opportunity to update the processes ensuring they are embedded to take forward in time.
- The Teams have shown such enthusiasm to succeed, using their multi talented experience and knowledge.
- The Finance Team has a multi-disciplinary team , including staff with analytical skills which has strengthened the team. Incoming finance has ten staff with nine having experience in project management.

Things people would improve if they could

- ICS working group in the county needs to be re-established to prevent working in silos to ensure collaboration working.
- Remote working and flexible working needs to be supported, IT Resources such as Virtual Desktop Infrastructure (VDI) access. The team have realised that processes need to be formalised and written down.
- Investing in an Integrated Finance system.
- Any investments that are made to the equipment and software for the continuation of remote working; it's essential there is a budget for staff support and training.
- Working together is important, everyone has priorities in their remit we need to integrate, working together and agreeing collectively on priorities. This has been difficult at times with COVID and new staff – regular virtual team and smaller meetings have helped with this.

None	

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST
EXECUTIVE VISIT – DCC
Date: 20/11/2020

Director: Steve Hams
Department Staff: Debbie Seal, Anne Whiteley, Abbeygale Clift, Abi Marie Mulhern

Discussion
Achievements: The team were commended on their massive and on going contribution to the Covid response. This response was alongside continuation of treatment of patients with cancer, which has been able to continue despite of the pandemic, due to their hard work and dedication. Covid Staff commented that the current second serge of increasing admissions of patients with Covid feels quite different from the first. Not as many patients are being intubated and are thus able to communicate with staff about how they are feeling. Patients seem to be improving more quickly. Staff reported that there were currently not many beds as elective admissions are continuing, whereas last time many services were cancelled to free up bed space in advance for Covid patients. However more patients are now able to be managed in respiratory on the 8th floor and DCC staff highlighted how it has been a good experience providing support to the team on the 8th floor. Staffing The team commented that staffing levels were good, as they were able to fill gaps with agency if required. They have also been able to recruit into 11 new posts. The team work across sites; therefore the staff are moved between CGH/GRH, based on need. The therapy team commented that they had not been given approval to recruit into 2 x therapy roles, potentially due to funding but were unsure of the finer details. Equipment The team felt that they had been provided with sufficient equipment. However more beds, space around beds and storage areas for equipment is needed. Clinical Psychology: The team expressed how important support from onsite clinical psychology was to staff, as well as de-brief sessions throughout this pandemic. Further access/support from psychology would be welcomed. A/L – Staff asked if there was any flexibility regarding the restriction of A/L to 3 days. SH said there was some flexibility as it is important staff have the opportunity to adequately rest, but leaders need to balance individual need for A/L with ward demands recognising the potential for increasing admissions over the coming weeks.

Actions required	Responsible person/date
Recruitment of additional therapy staff	Steve Hams

Gloucestershire Hospitals
NHS Foundation Trust

REPORT TO TRUST BOARD – January 2021

From Quality and Performance Committee – Alison Moon, Non-Executive Director

This report describes the business conducted at the Quality and Performance Committee held on 23 December 2020, indicating the NED challenges made and the assurances received and residual concerns and/or gaps in assurance.

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
Quality and Performance Report	Including an updated position regarding Covid, noting a fast changing situation. Consistently high numbers of inpatients and significant challenges in quality terms some of which are reflected in the report			
	Quality Delivery Group, Including a detailed report into FFT results. Continued pressure within the PALs function related to known themes of waiting, communications. ePR benefits realisation noted. CQC engagement meeting with Gynaecology noted to be positive. Focus on end of life work and plans to develop an end of life	FFT report contains ability for a different level of interpretation, Verbatim comments included generally positive, how do we ensure we take notice of the negative comments and learn from them? EPR and non-financial benefits raised at People and Organisational	Ability with new system to run multiple surveys, working at specialty level showing all feedback. Real time staff feedback important in this area and using cumulative insights, work in progress on this. Chief Nurse agreed to consider with executive colleagues.	Inclusion of feedback for next Committee to include both positive and negative comments.

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
	council, CQC engagement event taken place.	Development Committee and suggestion of bringing all benefits together and understanding a common narrative.		
	Cancer Delivery Group, reporting continued positive performance across several standards with focus on aim to maintain those services		Assurance received on achievement of standards to date, noting continual review, revisiting of patient lists and prioritisation with completed harm reviews.	
	Directors Operational and Assurance Group (Planned Care) noting further improvement in reporting month on RTT, internal audiology reporting, ongoing review of follow up waiting list with validation and speciality review. Prioritisation started against new nationally prescribed P indicators. Current position seeing significant pressures on delivery of elective care activity.	Was the quality summit as a result of staff raising concerns?	Position noted. Assurance of trust implementation of national P indicators for prioritisation and linked clearly to agenda item on clinical harm policy. See page 3.	
	Unscheduled Care report noting deterioration in 4 hour standard, multiple 12 hour	The summit created several actions, why does a summit get the	Work described as ongoing for some time, noting staff concerns and	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
	breaches and exponential rise in Covid related activity with no significant decrease in non Covid related emergency activity. Internal escalation within structured and well known governance processes to a Quality Summit (held day before committee) with verbal update which reported a positive and useful process and outlined several strands of work and focus for patients and staff. Noted concerns raised by staff.	areas which business as usual does not?	significant operational difficulty of previous week. Ability to spend more considered time on one area, enabling a methodical and inclusive approach, more focus on internal communications of active work streams to be considered through the trust structures. Importance of visible leadership and operational challenges within that acknowledged. Dialogue ongoing in ICS led by the Chief Executive on relative risks in the system and risk sharing. Huge effort and focus of executives and leaders noted in this area.	Outputs of the quality summit to be included in future reports to committee to gain assurance on progress.
Clinical Harm Policy update	Briefing on the review and implementation of the Policy which seeks to mitigate any risks for patients who are waiting for care. Speciality level focus in place. New national guidance on harm review process noted and Trust actions in progress and existing actions aligned with new	Noting size of this work, important to note the Trust risk based approach Is there a difference in	Assurance received that the policy is embedded across cancer services, not complete and remains a work in progress across other specialties. Confirmed this can play	Agreement to receive an update, including any audit results at February Committee.

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
	guidance.	what constitutes harm for a patient and professionals?	out in formal complaints. Importance of patient communications reiterated and noted to be a challenge in terms of content of comms, managerial and clinical focus on this.	
Infection Prevention and Control Board Assurance Framework	Report stating trust compliance with the Health and Social Care Act: Code of Practice, focus on COVID-19, noting sustained and significant situation. Reduced bed base noted to facilitate distancing aims.	Local success and impact noted of two PPE officers in particular, how can this be made consistent across the hospitals?	Interim arrangements in change of Director of Infection, Prevention and Control noted with direct reporting to Chief Executive. Significant work evidenced and assurance of strong and consistent leadership, noting also risks with length of time of pandemic and impact with patients and staff. Recruiting more PPE officers, using those in place as examples, focus on front line colleagues. Several actions including Matrons Assurance Framework launched that day to keep focus and standards as expected across the Trust.	Assurance Framework to return to Committee on regular basis with any exception reports if needed in between.
Serious Incident Report	Report outlining serious incidents and any never		Assurance received regarding the process in	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
	event which occur within reporting period. Good performance of timeliness of investigation and process noted.	With the current exceptional operational challenges in the hospitals, what outputs of those pressures would we see being triggered?	place to complete investigations. Three never events noted in month, a contributory factor review of never events was already on place and has been presented to the quality delivery group. Dashboards in use which give good insight but are at a point in time, agreement for Chief Executive and Director of Quality to explore further in terms of models of visible leadership and a sense of how 'it feels' on front line	Committee will seek assurance on the review and next steps at January Committee meeting.
Corporate Risk Register	Review of Register, noting movement/ addition of specific risks	If there are a cluster of risks which in themselves do not meet the criteria for the corporate risk register, but together could indicate a bigger themed issue, how would we know about these?	New and improved quality report in place at specialty level bringing together multiple points of data, raising through divisional review and to executive if needed. Would then come to Committee if appropriate.	
Quarterly executive Review briefing	Summary of the quarterly Chief Executive review meeting with four clinical divisions, underpinned by the Performance and Accountability Framework.		Good assurance received of comprehensive process with RAG ratings. Very helpful paper to understand breadth and depth of Divisional review.	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
	Focus on current performance, improvement trajectories, acknowledgement of successes and forward planning against objectives	By doing the review in this way, did it alert you to anything not covered through other routes? Is there a risk with ePR progress not being fast enough?	Suggestion to share with Council of Governors Nil confirmed as monthly executive review process is undertaken. Confirmed by Chief Nurse this has been an area of focus for divisions and improvements being implemented	
Ockenden Report and Trust response	National report published on maternity care in Shrewsbury and Telford area by Independent Chair, Donna Ockenden. Significant document outlining several major failings. Immediate and essential actions for wider NHS maternity services to be completed with short timescales. (December and January)	Are there any concerns in responding to the deadlines?	Assurance received that actions are either in place or being completed. January committee already had a substantive item on maternity services, of which the trust response to this report will be covered.	

Alison Moon
Chair of Quality and Performance Committee
24th December 2020

Gloucestershire Hospitals
NHS Foundation Trust

MINUTES OF THE COUNCIL OF GOVERNORS HELD VIA MICROSOFT TEAMS ON WEDNESDAY 21 OCTOBER 2020 AT 14:30

THESE MINUTES MAY BE MADE AVAILABLE TO THE PUBLIC AND PERSONS OUTSIDE THE TRUST AS PART OF THE TRUST'S COMPLIANCE WITH THE FREEDOM OF INFORMATION ACT 2000

PRESENT:		
Alan Thomas	AT	Public Governor, Cheltenham (Lead)
Matt Babbage	MB	Stakeholder Appointed Governor, Gloucestershire County Council (from 026/20)
Liz Berragan	LB	Public Governor, Gloucester
Hilary Bowen	HB	Public Governor, Forest of Dean
Tim Callaghan	TC	Public Governor, Cheltenham
Geoff Cave	GCa	Public Governor, Tewkesbury
Carolyne Claydon	CC	Staff Governor, Other and Non-Clinical
Debbie Cleaveley	DC	Public Governor, Stroud
Graham Coughlin	GCo	Public Governor, Gloucester
Anne Davies	AD	Public Governor, Cotswold
Pat Eagle	PE	Public Governor, Stroud
Colin Greaves	CG	Stakeholder Appointed Governor, Clinical Commissioning Group (CCG)
Pat Le Rolland	PLR	Stakeholder Appointed Governor, AgeUK Gloucestershire
Fiona Marfleet	FM	Staff Governor, Allied Health Professional
Sarah Mather	SM	Staff Governor, Nursing and Midwifery
Russell Peek	RP	Staff Governor, Medical and Dental
Maggie Powell	MPo	Stakeholder Appointed Governor, HealthWatch
Julia Preston	JP	Staff Governor, Nursing and Midwifery
Nick Price	NP	Public Governor, Out of County

IN ATTENDANCE:		
Peter Lachecki	PL	Trust Chair
Deborah Lee	DL	Chief Executive Officer
Claire Feehily	CF	Non-Executive Director (NED)
Sim Foreman	SF	Trust Secretary
Rob Graves	RG	Non-Executive Director
Micky Griffith	MG	Programme Director, Fit for the Future
Marie-Annick Gournet	MAG	Associate Non-Executive Director
Balvinder Heran	BH	Non-Executive Director
Natashia Judge	NJ	Corporate Governance Manager (Minutes)
Simon Lanceley	SL	Director of Strategy and Transformation
Alison Moon	AM	Non-Executive Director
Mike Napier	MN	Non-Executive Director
Elaine Warwicker	EWa	Non-Executive Director

APOLOGIES:		
Kate Atkinson	KA	Public Governor, Cotswold
Kedge Martin	KM	Public Governor, Tewkesbury
Emilio Palama	EP	Public Governor, Forest of Dean

ACTION

020/20 DECLARATIONS OF INTEREST

There were none.

ACTION

021/20 MINUTES FROM THE PREVIOUS MEETING

RESOLVED: Minutes APPROVED as an accurate record subject to some minor typographical amendments.

022/20 MATTERS ARISING

AT asked how the Council could be assured that matters arising to be addressed outside the meeting were progressed and completed. The Council discussed, with DL expressing that she felt it was important to evidence which area of the Trust's architecture would be responsible for actions once closed at CoG. CL suggested any resulting or outstanding action be captured as a new Matter Arising. SF and PL to agree how best to track actions arising from CoG meetings. **SF/PL**

It was agreed that **Matter Arising 018/20** regarding sharing the Governors' Log more widely would be followed up at Governors' Strategy and Engagement Meeting. NJ would add to the work plan. **NJ**

RESOLVED: The Committee APPROVED the open and closed items.

023/20 CHAIR'S UPDATE

The Chair thanked all former governors for their involvement and hard work over the last three years. He also welcomed new governors and felt that it was a challenging but interesting time to join the Council, with the opportunities to support and guide the Trust greater than ever before.

The Chair confirmed that virtual meetings would continue until at least the end of December, reflecting that this had not held the Trust back and that all participants had embraced the digital opportunities over the last few months. In particular, the Chair highlighted the success of the recently held virtual Annual Members' Meeting and thanked the teams involved for their co-ordination and support.

RESOLVED: The Council NOTED the update.

024/20 REPORT OF THE CHIEF EXECUTIVE OFFICER

DL presented her report to the Council and provided a contemporary update on:

- COVID-19: current inpatient levels and future surge plans
- Long COVID: current understanding and funding for service provision
- Restoration of paused services and current activity levels
- Communication with patients waiting
- Submission of the Trust's financial plan
- Diversity and inclusion and the Trust's Widening Participation Review

GCa asked how governors could be involved with Helen England's

(Organisational Development and Governance Consultant) engagement and involvement work. DL explained that the Trust's new Director of Engagement was now in post and would be working alongside governors to take the engagement and involvement strategy forward. In addition, GCa asked how governors could best represent the interests of BAME (Black, Asian, Minority and Ethnic) community members considering the lack of diversity within the Council. DL answered that while unfortunate that the increased efforts to establish a more diverse Council had been unsuccessful, the Council should still strive for diversity of thought and place importance on issues of equality and inclusivity. PL noted that upcoming recruitment for Non-Executive Director (NED) and Associate Non-Executive Director (ANED) roles would include a BAME observer to ensure the spirit of the Trust's equality, diversity and inclusion (EDI) commitments were at the forefront of governor minds. AT requested governors be involved in the Trust's Widening Participation Review. DL agreed and would request the Director of People and Organisational Development to discuss with the external partner how best to involve governors. **DL**

AT praised those involved in creating a great Annual Members' Meeting despite the challenges. PL shared that the success of the event had inspired the comms teams and that exciting developments in engagement would follow, encouraging governors to "watch this space!"

CG noted the submission of a deficit plan by the system. He added that while the Integrated Care System (ICS) had signed up to an agreed direction of travel, the responsibility lay with individual Boards. DL assured that the Trust Board had supported the deficit plan at an extraordinary Board Meeting prior to submission to the ICS.

RESOLVED: The Council NOTED the CEO's report.

025/20 FIT FOR THE FUTURE UPDATE

SL presented the Fit for the Future (FFtF) consultation booklet and supporting slides to the Council ahead of the launch of public consultation, following Health Overview Scrutiny Committee (HOSC) on Thursday 22 October 2020. Governors would also have an opportunity to provide formal feedback on the proposals at a session on 9 November 2020. This would be a structured review and summary videos would be made available to governors prior to the session.

SL clarified the options being taken to consultation, who would be consulted, how individuals could get involved and finally the programme timeline. SL reinforced that FFtF related to the Trust's longer term strategic approach and not temporary COVID-19 service changes**.**

GCa asked how governors could be identified with the process of consultation. SL answered that governors would be mentioned within the online presence and would be welcome to join online sessions. GCa asked how changes would impact cancer operations. SL explained that cancer treatment was planned care, and that as oncology was centralised at Cheltenham General Hospital there was a strong case to centralise planned care there also where it was safe to do so.

MN raised a concern regarding the Venn diagram within the materials and potential misinterpretation. SL said he would consider but to date no confusion had been raised with the audience who had seen it so far. **SL**

DC felt the consultation document was very comprehensive and wondered how the Trust would encourage inclusivity and whether an easy read version had been created. SL answered that the Trust had been collaborating with Inclusion Gloucestershire and Healthwatch Gloucestershire and an easy read version had been created. SL would share with governors. **SL**

AT reinforced the importance of being clear on the reinstatement of Cheltenham A&E services and that these would return to pre COVID-19 arrangements of 8am until 8pm. AT also asked whether any factual accuracies in the booklet could be amended. SL responded that they could be amended online immediately and updated in the second version of the booklet. DL agreed to raise ATs concerns with the CCG who were overseeing content. **DL**

RESOLVED: The Council NOTED the update.

026/20 CHAIRS' REPORTS

PL explained the governance process behind the Trust's Committees for new governors, and that the Chair's reports presented were intended to provide governors with a feel for the nature of the meeting and the way challenge and assurance had been sought.

Finance and Digital Committee

RG presented the Chair's report from the September 2020 meeting and explained, for the benefit of new governors, how the Committee operated. The digital portion of the Committee was noted to have focused on the deployment of a new electronic patient record (EPR) as well as the upgrade of legacy systems and project prioritisation. The finance portion of the meeting was noted to have focused on analysis of the Trust's current financial position and the impact of the COVID-19 funding. It was highlighted that the Trust was forecasting an operational deficit for the second half of the year.

Estates and Facilities Committee

MN presented the Chair's report from the September 2020 meeting and explained how the Committee operated as well as detailing which services were within the Committee's remit. Key issues for the Committee at present were noted to be Gloucestershire Managed Services (GMS) performance against key performance measures (KPIs), management of hard services, parking, Private Finance Initiative (PFI) contracts and progress of the Trust's strategic site development (SSD) programme. In addition, clarification was being sought on where final accountabilities lay between the Trust and GMS.

AT reflected that estates and facilities often felt quite removed, and that governor interest was on how management of these affected patient safety. AT felt it might be useful to have a longer briefing on estates

issues to bring governors up to speed. It was noted that this was scheduled to be arranged as part of governor induction over the next 18 months.

GCa asked what changes took place to cleaning standards/compliance as a result of COVID-19. MN answered honestly that he did not know this level of operational detail, only performance against cleaning standards. DL noted that additional cleaning had been commissioned but was not able to say how this was monitored but would ask for a response via the Governors Log so all could see the response. DL added that that the Trust had one of the lowest rates of nosocomial transmission in the South West with no transmissions since May 2020, suggesting no issues. **DL**

People and Organisational Development Committee

BH presented the Chair's report from August 2020 meeting and explained how the Committee operated, noting that the Committee focused on issues of workforce, retention, supply and planning as well as equality and equity. Key issues for the Committee at present were noted to be workforce related risks, staff experience and engagement with data analysed from the Freedom to Speak Up (FTSU) report and staff survey. Turnover and vacancy rates within Medicine were highlighted as a concern, with a deep dive underway in advance of the next meeting.

GCa noted the concerns around staff bullying and harassment and asked whether themes flagged via the employee assistance programme were analysed, and if so whether this was also visible within the contacts recorded. DL answered that data was collected from a variety of sources with strong triangulation with the employee assistance programme, though greater collection of demographics was needed to support granular analysis of how different groups were impacted. However, DL felt that as the problems were clear, addressing this was the priority as opposed to reaffirming them through different data sources.

MB queried the process behind exit interviews: whether these were undertaking externally or internally, by staff or HR, and whether staff moving internally were asked. DL answered that these were undertaken by HR, independently from managers, and were entirely voluntary. However, a focus on understanding why staff were leaving before the end of their notice period was being encouraged in case potential issues could be resolved and notices rescinded.

Quality and Performance Committee

AM presented the Chair's report from the September 2020 meeting and explained how the Committee operated. The Committee was noted to have a large agenda, covering safety, effectiveness, quality, performance and responsiveness with focus and priorities determined on a risk based approach. Key issues for the Committee at present were noted to be the deterioration in the Friends and Family Test, real time feedback from patients, red quality and performance metrics and the maternity assurance action plan in response to a letter from the Healthcare Safety Infection Branch (HSIB). AM also commended the

Trust on its cancer performance.

Audit and Assurance Committee
CF presented the Chair's report from the September 2020 meeting and explained how the Committee operated, focusing on review of systems and processes with statutory responsibilities such as review of annual report and accounts. Key issues for the Committee at present were noted to be management of risk, reports from internal audit on information technology and GMS.

RESOLVED: The Council NOTED the assurance reports from the Committee Chairs.

027/20 GOVERNOR ELECTION RESULTS

SF presented the report on the recent governor elections to the Council, noting the increased level of participation in this year's elections and Annual Members' Meeting. All new governors were noted to have begun their induction plan with the Trust, having received a copy of the Governor's Handbook, Quick Guides and an 18 month Induction and Education Programme with a development plan aligned to all assurance Committees.

AT noted some errors within the Governor Terms of Office document. NJ would update. **NJ**

RESOLVED: The Council NOTED the newly elected governors for INFORMATION.

028/20 GOVERNANCE AND NOMINATIONS COMMITTEE PROCESS

The Council of Governors was invited to agree the process for Governor nominations for the Governance and Nominations Committee. The Governance and Nominations Committee reviewed the process at its meeting on 13 October 2020 and agreed to recommend the process and timetable to the Council of Governors, outlined in the accompanying paper. PL expressed the importance of the Committee, and encouraged nominees to contact him or AT should they have any questions. Nominations would close on 8 October 2020.

RESOLVED: The Council APPROVED the process and timetable for appointing Governors to serve on the Governance and Nominations Committee and agree to proceed to nominations, and if required, elections.

029/20 GOVERNOR'S LOG

The Governors' Log and the process behind it were explained for the benefit of the new governors, with further guidance and standard operating procedure noted to be available within the Governor Handbook.

RESOLVED: The Council NOTED the Governor's Log.

		ACTION
009/20	**ANY OTHER BUSINESS**	

There were no items of any other business.

DATE AND TIME OF THE NEXT MEETING

The next meeting of the Council of Governors will take place at 14:30 on Wednesday 16 December 2020.

Signed as a true and accurate record:

Chair
16 December 2020