

Gloucestershire Health Overview & Scrutiny Committee

Written report from Cllr Martin Horwood to CBC overview & scrutiny committee 3 June 2019

The Gloucestershire Health Overview & Scrutiny Committee (HOSC) met on **21 May 2019**. This is a modified committee, some responsibilities of the previous Health & Care Overview & Scrutiny Committee relating to adult social care and public health having been hived off to a separate county scrutiny committee. This split was criticised by members as against the run of national policy towards holistic treatment of health and social care, and carried out without consultation with districts.

A more welcome change is that future HOSC meetings, from July, will feature public questions.

A complete video with all presentation slides is available at https://gloucestershire.public-tv/core/portal/webcast_interactive/423381.

The main agenda items were:

- Minutes of special HCOSC meeting on **general surgery**, 20 February 2019

Under these minutes, I requested an update on the proposed “pilot” general surgery changes (also known as Option 2) which were to have moved both emergency and complex elective general surgery to Gloucestershire Royal Hospital (GRH). Since the special HCOSC meeting, the Trust had agreed to set aside their decision to implement their decision to implement the “pilot” and explore all options under threat of judicial review (on the grounds that it wasn’t really a pilot but in reality a major service change requiring full public consultation).

Gloucestershire Hospitals NHS Foundation Trust replied that Option 4 - centralising emergency general surgery in Gloucester and elective general surgery in Cheltenham - had ‘merits’ but couldn’t be implemented in the immediate future so Option 2 remained the Trust’s preference. They are now planning engagement with stakeholders this summer, looking at all options, followed by full public consultation on the option or options which they considered feasible. The Trust said different options might be looked at on different timescales (presumably Option 4 as a long-term goal but Option 2 as the immediate plan).

A HCOSC task & finish group on this issue was suspended when a judicial review was threatened so I asked if this would now be reinstated. The chair said she would take advice on this but did want the process to be completed with a report and questions answered.

- **Stroke rehabilitation update**

A new 14 bed community stroke rehabilitation unit opened in February at the Vale Hospital, Dursley. This is now operating alongside the acute unit at GRH and there have been 39 admissions so far. The new unit offers intensive specialist therapy available 7 days a week, single en suite accommodation and more specialist time with patients, including new speech & language therapists. Patient and clinical feedback is very positive so far.

Questions were asked about waiting times and admission criteria. There is a very short waiting list. Acute cases obviously go to the acute unit at GRH initially and the least ill go straight to discharge but with few exceptions (such as patients receiving tube feeding or dialysis), all appropriate cases do go to the Vale even if other medical conditions are present. Travel to the Vale was raised. There was free, accessible parking - in contrast to the acute hospitals - and few complaints so far but members were concerned about distance and difficulty for relatives.

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- **Gastroenterology evaluation and pilot proposals**

A pilot centralising inpatient gastroenterology (stomach, pancreas, bowel and liver problems) at Cheltenham General Hospital (CGH) went live in November 2018. Two highly acute beds remain in GRH but most activity has moved to CGH, easing overall pressure on beds in Gloucester. A much less laborious admission and ward round system is in place along with quicker endoscopy. Waiting times to see a specialist are significantly down and patient and clinical feedback are very positive.

A major side benefit has been that hospital gastroenterologists now have time to offer more advice & guidance to GPs as recommended by the Department of Health (DH) and Gloucestershire now ranks third nationally for GP use of all advice & guidance (not just gastroenterology): there are about 100 GP requests a month, of which 96% are responded to within two days in February, a good example of cross-sector working.

- **Trauma and orthopaedic pilot**

This pilot, centralising trauma and orthopaedics at GRH, went live in November 2017. The Trust painted an extremely rosy picture including quicker pain relief and fewer on-the-day cancellations of surgery (although there was some question about whether these were all like-for-like data). Many of the triage and patient pathway improvements were clearly welcome in any setting.

A concern was that waiting times from referral to upper limb trauma surgery had actually gone up (by 11%) and I used evidence I had obtained of waits so long that injuries needing remanipulation or even corrective surgery because bones had already set badly. The Trust itself acknowledged that independent health data analysts drfoster.com had also raised concerns. I promised to submit more detailed questions about more detailed stats for a future meeting.

- **Radiology service update**

Temporary changes to radiology services - mainly cuts to x-ray services in outlying community hospitals - were approved by HCOSC in November 2018 due to staff shortages. The Trust now sees 'opportunities' as well as challenges in diagnostics and wants to take a strategic approach. This will look at new technologies such as point of care testing and genomics and new national recommendations for diagnostics including ultrasound, CT scanning, pathology and endoscopy as well as radiology. The fear amongst HOSC colleagues was obviously that this could be yet another temporary change which may be about to become permanent, raising wider issues.

In relation to the staff shortages, the Trust reported that they had been able to restore 44 hours per week of community radiography since November 2018 mainly through the use of agency staff but have lost 11 permanent staff against 9.5 WTE recruited.

Average waiting times for GP referred patients are significantly up since the changes. In Cheltenham, these have only increased from 8 days to 9 but in the North Cotswolds waits have gone up from 8 days to 12, and in Tewkesbury from 9 to 16.

- **Clinical Commissioning Group report**

The proportion of patients being seen within 4 hours in **A&E** continues to decline, now to 87%. We were not given disaggregated data between Cheltenham and Gloucester at this meeting - it has been promised again in future - but we can guess that GRH Emergency Department continues to fall far short of the target. The CCG said that demand continues to rise despite attempts to reduce it. The Hospitals Trust reported that Gloucestershire is nevertheless in the upper quartile nationally which is actually quite worrying (and certainly does not apply to GRH).

The 62 day wait for **cancer patients** from referral to first definitive treatment also continues to be missed and is also getting worse. The CCG aimed for the target to be met by September 2019. They reported that some sub-specialisms (lung & skin cancer) have seen dramatic improvements, new patient pathways are being tried (eg skipping outpatient appointments and going straight to testing) and new recruitment is taking place.

- **Integrated Care System**

The ICS report was taken as read but I raised the issue of an 'ICS Executive' being mentioned and whether this was some **new countywide NHS structure** emerging and was told this was the chief execs of the various county NHS bodies meeting together and there was also an 'ICS Board' where all chief execs and chairs met. Yet again, the issue of why the potentially important cross-NHS **Cheltenham locality partnership** remained invisible to the public and to district councillors. I received a long but unclear answer promising more presentations.

The CCG accountable officer report was taken as read.

Martin Horwood
31 May 2019