



Phase 2
Decision-making
Business Case

Version 1.1

March 2023

*Work in Progress – subject to
decision-making*

Fit for the
Future²
Developing specialist health
services in Gloucestershire



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¹ See section 2.6 for document iterations.

1 Executive Summary

1.1 Strategic Statement

We, the health and social care organisations in Gloucestershire have committed to working together as an Integrated Care System (ICS) to improve the health of local people through supporting them to take more control of their own health, with a greater focus on prevention and self-care (people looking after themselves when they can), and ensuring we deliver the right care, in the right place at the right time. Fit for the Future is a key enabler to our right care, right place, right time objective.

Prioritising Self Care and Prevention means that we are using our data to understand the health needs of local people and working to improve long term health and wellbeing. Health and wellbeing are influenced by more than just health services, so as an ICS we work as an active partner in the public sector to improve health through better housing, better education, better employment, better transport and keeping people safe.

Evidence and experience tell us that people can find it harder to improve their own health or to access our services when they have other challenges in their lives. These include living with deprivation, disability, or a mental health condition. Our commitment is that we will ensure our services are easier to access for people with health inequalities, both ensuring our services recognise and deliver parity of esteem for mental health and provide additional support when people need it.

Delivering the right care in the right place at the right time means that when care can be delivered at home or close to home, it will be. When people need to come to a centre to get care, our aim is to minimise the distance needed to travel to get there, as it can be hard to get around our county particularly with a long-term health condition.

Sometimes however, we will need to prioritise achieving a better health outcome over trying to minimise travel for people. Health care for some conditions is increasingly high tech and needs highly trained staff and expensive equipment to keep pace with the best in the world. When specialist care is needed our aim is to increasingly deliver this through *Centres of Excellence*, that separate emergency and planned care and centralise services where we can consolidate skills and equipment to provide the very best care.

The NHS is going through the most challenging period of its 75-year history to date. Gloucestershire's health and care system, like other parts of the country, is in the process of recovering from the pressures that the COVID pandemic placed on our services, staff and local communities. There are also the added challenges of recent industrial action and a rise in seasonal illness.

Living within our means to make the best use of every Gloucestershire pound means a commitment to work together to put the patient first in everything we do, developing our workforce, and streamlining our services and organisations where possible to ensure everything we deliver is as efficient as it can possibly be.

We know we still have a long way to go, but we believe that the proposals in this second phase of Fit for the Future (FFTF2) will help us to keep moving in the right direction. We are confident that our plans for service development, including some that are temporary service changes made in response to the pandemic, will deliver benefits in the long-term.

1.2 Why we think that change is needed

Our strategic statement set out above is a summary of our ICS strategic response to the triple challenges facing health and care services delivery as described in the NHS Five Year Forward view, the health and wellbeing gap, the care and quality gap and the finance and efficiency gap.

The Fit for the Future (FFTF) Programme and *Centres of Excellence* approach described in this document are specifically looking to address issues and risks arising from the historic configuration of hospital services across Cheltenham General Hospital (CGH) and Gloucestershire Royal hospital (GRH), part of Gloucestershire Hospitals NHS Foundation Trust and located eight miles apart.

Since merging to form a single Trust in 2002, a number of services have now been centralised including those in the first phase of FFTF², paediatrics ophthalmology, oncology and urology. For a number of other specialties, the FFTF programme is seeking to address issues and risks arising from continuing to deliver services across both sites. These include pressures on workforce, quality and safety as resources become ever more stretched to cope with increasing demand. At times, this means services can be compromised in terms of their potential to develop the same standard of specialist care across both sites. We believe reconfiguring some of our services more efficiently across the two sites to improve clinical linkages between services will deliver improvements against the care and quality gap.

We aim to address the health and wellbeing gap by increasing the quality and health outcomes that our hospital services deliver, increasing the specialist services offer in our county and supporting the identified health needs of our population.

1.3 Proposals

It is the Programme's recommendation to the Board of Gloucestershire Hospitals NHS Foundation Trust (GHNHSFT) and the NHS Gloucestershire Integrated Care Board (GICB) that the following resolutions should be considered for agreement and approval, considering all the evidence that has been made available, on the basis that they represent the most appropriate option to address the case for change.

- **Resolution #1:** To locate the majority of Benign Gynaecology Day Cases at Cheltenham General Hospital.
- **Resolution #2:** To centralise the dedicated Diabetes and Endocrinology Inpatient beds at Gloucestershire Royal Hospital and provide a Diabetes and Endocrinology Consult service at Cheltenham General Hospital.
- **Resolution #3:** To centralise Non-Interventional Cardiology inpatient beds³ at Gloucestershire Royal Hospital and provide a Cardiology Consult service at Cheltenham General Hospital.
- **Resolution #4a:** To centralise Respiratory Inpatient beds at Gloucestershire Royal Hospital and provide a Respiratory Consult service at Cheltenham General Hospital.
- **Resolution #4b:** To establish a Respiratory High Care unit at Gloucestershire Royal Hospital.

² Details in section 3.5

³ Centralisation of Interventional Cardiology Inpatient Beds at GRH was approved as part of FFTF1.

- **Resolution #5:** To locate the Hyper Acute Stroke Unit (HASU) and Acute Stroke Unit (ASU) at Cheltenham General Hospital.

This Decision-Making Business Case (DMBC) sets out the rationale for proceeding with these resolutions in the context of the extensive work that has been undertaken through the Fit for the Future Programme. This includes consideration of the outcome, findings and feedback

- The public, patient and staff involvement process (May- July 2022);
- The South West Clinical Review Panel (Aug 2022);
- Gloucestershire Health Overview and Scrutiny Committee (October 2022), and;
- NHS England South West Regional Team (October 2022).

This DMBC has been drafted on the basis of decisions taken by the Board of Gloucestershire Hospitals NHS Foundation Trust (November 2022) and the NHS Gloucestershire Integrated Care Board (November 2022).

Details of the patient, staff, efficiency, and effectiveness benefits of each resolution can be found in the individual service sections, which directly or indirectly support our ICS objectives set out in our response to the NHS Long-Term Plan including:

- Ensuring people with specialist health conditions can access outstanding hospital care
- Delivering high quality, joined up services with the right care, staff skills and equipment in the right place
- Delivering care that is fit for the future through the development of outstanding specialist hospital care in the future across the CGH and GRH sites
- Developing and supporting our workforce and meeting the challenge of recruiting and keeping enough staff with the right skills and expertise.

1.4 Decision-making business case structure

Fit for the Future (FFTF) Phase 2 builds on the learning from Phase 1, and this document is designed to meet the requirements set out in the NHS England (NHSE) *Planning, assuring and delivering service change for patients (March 2018)* and *Addendum (May 2022)*, and in accordance with the South West Clinical Senate review process.

- **Section 2** sets out the purpose and scope of this Decision-making Business Case (DMBC) and the process we are undertaking.
- **Section 3** introduces our system, our challenges and our Integrated Delivery Plan priorities including FFTF.
- **Section 4** describes our FFTF2 public, patient and staff engagement activities and includes feedback from our engagement survey.
- **Section 5** provides information affecting all of the service change proposals including the options appraisal process, overall bed impact, and requirements relating to inter-hospital site ambulance transfers.
- **Sections 6 to 10** present detailed information on the five FFTF2 service proposals including the current service model, the case for change, preferred option evaluation, clinical evidence, benefits; workforce, “blue light” impact, responses to Clinical Senate review, engagement themes and responses.

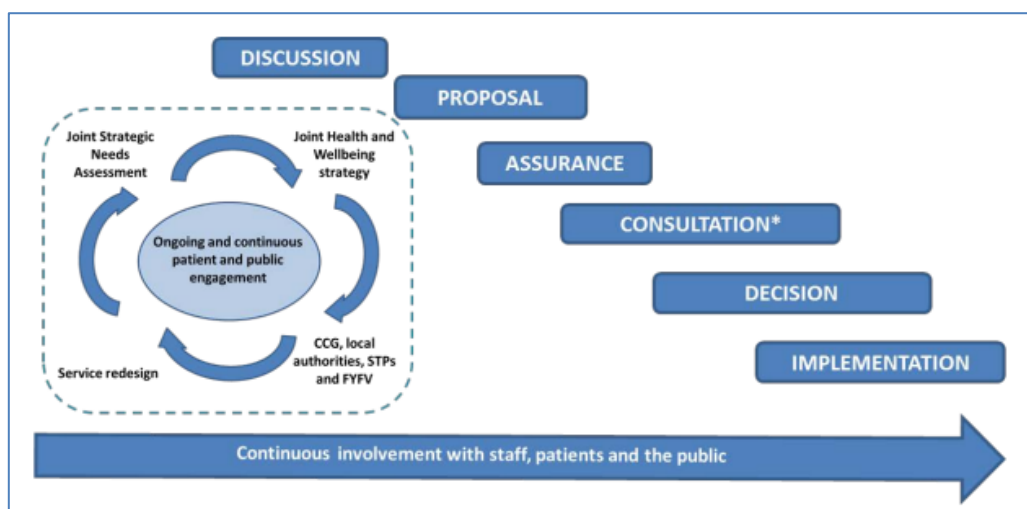
- **Section 11** describes our approach to integrated impact assessment and a summary of Equality Impact, Health Inequalities Impact and Health Impact assessments.
- **Section 12** provides the economic and financial analysis.
- **Section 13** provides details of our internal and external governance and decision-making processes.
- **Section 14** sets out the resolutions to be approved.
- **Section 15** provides our implementation structure and high-level schedule.

2 Purpose of the document

2.1 The process we are undertaking

As with all service reconfiguration programmes, we have worked closely with NHS England (NHSE) through the regional office and are guided by the *Planning, assuring, and delivering service change for patients (March 2018)* and *Addendum (May 2022)*⁴. This guidance is designed to be used by those considering, and involved in, substantial service change to navigate a clear path from inception to implementation. It supports commissioners and providers to consider how to take forward their proposals, including effective public involvement, enabling them to reach robust decisions on change in the best interests of their patients.

Service change has several phases from setting the strategic context to implementation. A summary of these (from the guidance), is set out below:



2.2 Single-step business case

As noted in the guidance³, public consultation may not be required in every case and the decision about whether public consultation is required should be made considering the views of the local authority.

The ICB is therefore able to depart from the NHSE Guidance provided it has good reason to do so. When deciding if consultation would be required for FFTF2, the ICB considered the following factors:

- The extensive amount of engagement that had already been carried out and the positive response to the proposals.
- The ICB had produced an Output of Engagement report of the kind that would normally be produced following public consultation
- The Output of Engagement Report was considered by the Health Overview and Scrutiny Committee (HOSC) in October 2022; The committee discussed next steps and considered whether further public involvement would provide additional information, such as alternatives or impacts, that could influence decision making. The committee did not raise any concerns with the engagement undertaken to date and the approach suggested by the ICB, and requested that updates be brought to

⁴ [NHS England » Planning, assuring and delivering service change for patients](#)

future meetings of the committee regarding the implementation of Fit for the Future 2 service changes

- Discussions had taken place with the SW Regional NHSE team, and NHSE were content that no further public involvement (including consultation) was expected. This would also mean that NHSE Stage 2 assurance process was not required.
- Of the five FFTF services that are the subject of FFTF Phase 2, four of the proposed changes are already in place as part of Temporary Service Changes and have been well publicised.
- It was also relevant that ICBs must be mindful of the cost of undertaking public consultation, when resources are stretched, and it is incumbent on public bodies to manage resources efficiently and effectively.

The subject of further FFTF2 public involvement, including consultation, was discussed at the ICB public meeting on 30/11/22 (having previously been considered by the GHNHSFT Board on 10/11/22). Details of the papers and minutes of the meeting can be found at [Board Meetings : NHS Gloucestershire ICB \(nhsglos.nhs.uk\)](https://www.nhsglos.nhs.uk/Board-Meetings).

On the basis of the particular facts and circumstances stated above, and in full understanding of its duties, the ICB Board took a formal view that there should be no further public involvement in Phase 2 of the FFTF programme. The Board agreed that next steps should be taken to bring a decision-making Business Case (DMBC) to the March 2023 Board meeting.

In the light of this decision there is not a requirement for a Pre-Consultation Business Case (PCBC) to be approved by the ICB and therefore as we now have a single-step business case process, for the benefit of decision-makers and for completeness, some information usually included within a PCBC is contained within this DMBC.

2.3 Purpose and scope of DMBC

This Decision Making business case (DMBC) is concerned with the configuration of hospital services across Gloucestershire Hospitals NHS Foundation Trust (GHNHSFT), specifically between Gloucestershire Royal Hospital (GRH) and Cheltenham General Hospital (CGH). This DMBC is based on the evidence compiled in the business case submitted to the South West Clinical Senate (and copied to NHSE), feedback from FFTF2 public, patient and staff engagement and includes the outputs from the engagement report⁵ and seeks to ensure that progress to decision-making and implementation is fully informed by detailed analysis of outcomes.

The DMBC will present and summarise the extensive work completed to date, with the following purposes in mind:

- To present our response to the FFTF2 engagement and involvement;
- To demonstrate that options, benefits, and impact on service users have been considered, and;
- To confirm the recommendations for service change in order to enable decision-makers to determine if these proposals should be implemented

⁵ The full FFTF2 Output of Engagement Report can be found in Appendix 1

2.4 Intended audiences and their decision-making roles

This DMBC is written by the Gloucestershire Fit for the Future Programme for the following audiences:

- The NHS Gloucestershire Integrated Care Board (GICB) which will decide whether the proposed service changes should be implemented based on the evidence presented. The ICB is the legally accountable Authority so has final responsibility for approving next steps.
- The Board of Gloucestershire Hospitals NHS Foundation Trust (GHNHSFT) who will confirm organisational level support for the proposed changes to clinical services including formal approval of the case in terms of finance, workforce, and implementation plans.
- NHS England and Improvement (NHSE&I) who have undertaken a Stage 1 review of FFTF2, received the pre-consultation business case submitted to the South West Clinical Senate and confirmed that a Stage 2 assurance process was not required⁶.
- The Gloucestershire Health Overview and Scrutiny committee (HOSC) who will continue to scrutinise the proposals in line with their responsibilities.

For the purposes of transparency, the final version of this DMBC will be made available publicly, but the document is not written with a public audience in mind.

2.5 Document Status

This document has been written at a point in time, reflecting information (including sources and references accessed) as of the date of publication. The document, including its related analysis and conclusions, may change based on new or additional information which is made available to the programme.

Until published as part of publicly available Board papers, this is a confidential document for discussion purposes and any application for disclosure under the Freedom of Information Act 2000 should be considered against the potential exemptions contained in s.22 (Information intended for future publication), s.36 (Prejudice to effective conduct of public affairs) and s.43 (Commercial interests). Prior to any envisaged disclosure under the Freedom of Information Act, the parties should discuss the potential impact of releasing such information as is requested.

The involved NHS bodies understand and will comply with their statutory obligations when seeking to make decisions that will have an impact on the provision of care services.

⁶ See section 2.2

2.6 Document Iteration

This document has been developed through an iterative process designed to meet the needs of the various stages of internal and external assurance. The table below presents both the document types and the approval/ review forum to date; culminating in a DMBC:

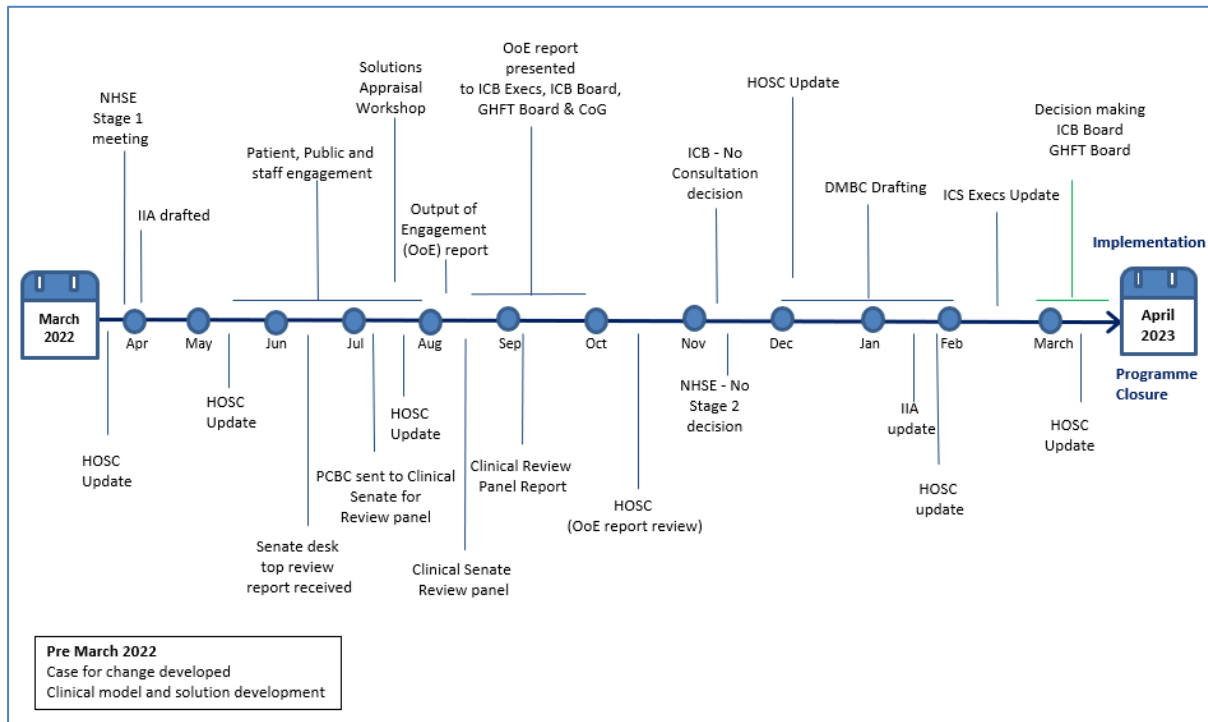
Forum/Audience	Date	Document name and version
NHSE	31/03/22	Glos. ICS Stage 1 Information (v1.2)
GHNHSFT Council of Governors	23/03/22	Glos. ICS Stage 1 Information (v1.2)
ICS Lay & NED Network	12/04/22	Glos. ICS Stage 1 Information (v1.2)
GHNHSFT Board	14/04/22	Glos. ICS Stage 1 Information (v1.2)
GCCG Governing Body	21/04/22	Glos. ICS Stage 1 Information (v1.2)
ICS Executives	05/05/22	Glos. ICS Stage 1 Information (v1.2)
HOSC	17/05/22	FFTF2 Information (v1.3)
South West Clinical Senate (Desk-Top Review)	19/05/22	FFTF2 Information (v1.4)
South West Clinical Senate (Clinical Review Panel)	28/07/22	FFTF2 Pre-Consultation Business Case ⁷ (v1.6)
GHNHSFT Board	09/03/23	FFTF2 DMBC (v1.1)
Gloucestershire ICB	29/03/23	FFTF2 DMBC (v 1.1)

In addition to the above, the FFTF2 Output of Engagement Report (Appendix 1) was reviewed and discussed at the following meetings and published on the ICS Get Involved in Gloucestershire website:

Forum/Audience	Date	v#
Integrated Care System Strategic Directors	18/08/22	1.2
GHNHSFT Board	08/09/22	1.2
GHNHSFT Council of Governors	22/09/22	1.2
NHS Gloucestershire Integrated Care Board	28/09/22	1.2
HOSC	18/10/22	1.3

⁷ The decision not to consult was taken after the Clinical Review Panel (see section 2.1)

2.7 FFTF2 Programme Timeline



Key Points

- Our proposals are guided and informed by the NHSE *Planning, assuring and delivering service change for patients (March 2018)* and *Addendum (May 2022)*
- Following discussion with NHSE and HOSC, the decision was taken to undertake a single-step business case process and move to decision-making (DMBC) following extensive public, patient and staff involvement.
- Due to the single-step business case process this DMBC includes information that would usually be included in a Pre-Consultation Business Case.
- This DMBC includes information previously submitted to the South West Clinical Senate for review and contains Senate feedback.

3 Introduction to the System

3.1 One Gloucestershire Integrated Care System

Our One Gloucestershire Integrated Care System (ICS) is a partnership that brings together NHS, social care, public health and other public, voluntary and community sector organisations, which became a legal entity on 01/07/22.

Our vision for health and care in Gloucestershire

Our vision for health and care in Gloucestershire:

To improve the health and wellbeing of our population, we believe that by all working better together - in a more joined up way, and using the strengths of individuals, carers and local communities - we will transform the quality of support and care we provide to all local people.

*will be replaced with new vision when agreed

We will do this by focusing on three areas:

1

Health and care services today

2

Transforming what we do now

3

Making Gloucestershire a better place for the future

Our priorities



Health and care services today:

- Supporting improvements in urgent and emergency care
- Reducing waiting times for appointments, treatment and operations as we recover from the pandemic
- Expand and improve mental health services for people of all ages including support for people with learning disabilities and autism.



Transforming what we do now:

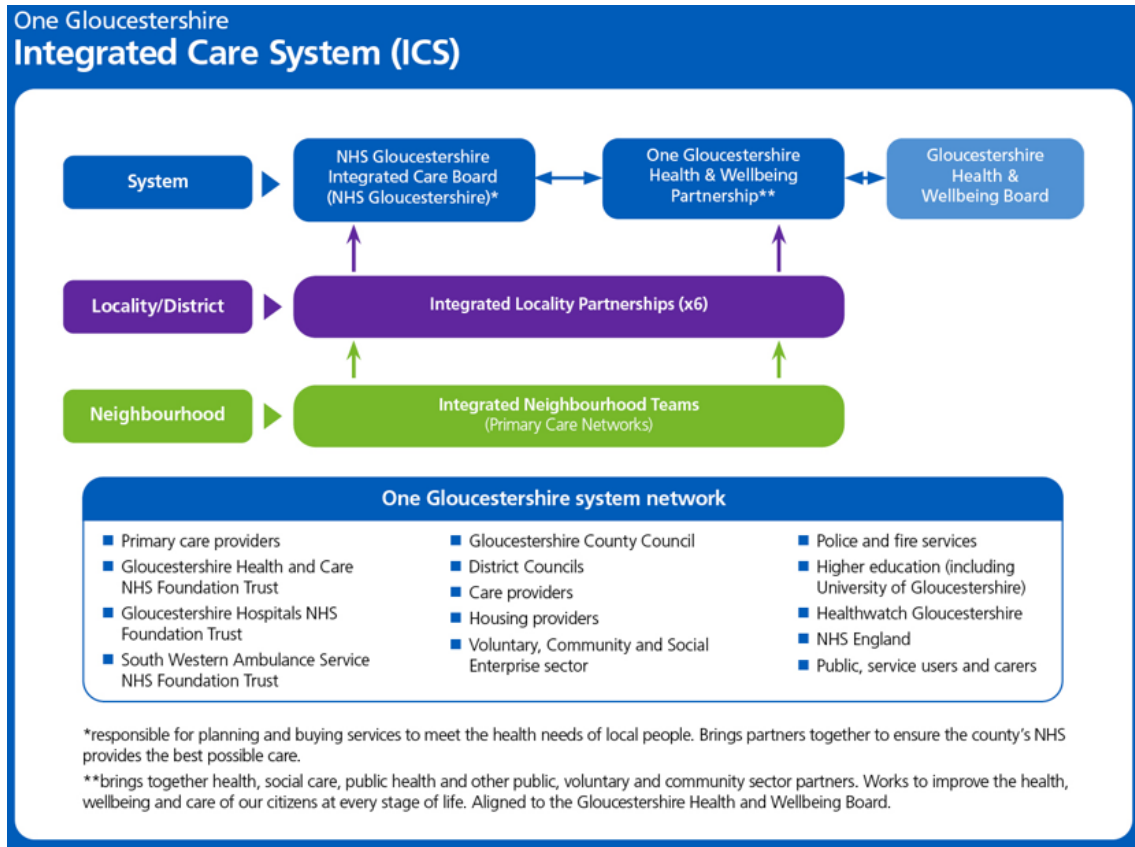
- Developing and supporting our existing workforce whilst attracting new people to come and work in Gloucestershire
- Making the most of data and technology to support your care
- Making best use of the 'Gloucestershire pound' and delivering services efficiently.



Making Gloucestershire a better place for the future:

- Improving care across Gloucestershire, closer to home where possible
- Improving the health and wellbeing of our citizens across their lifetime
- Reducing health inequalities
- Supporting broader social and economic development.

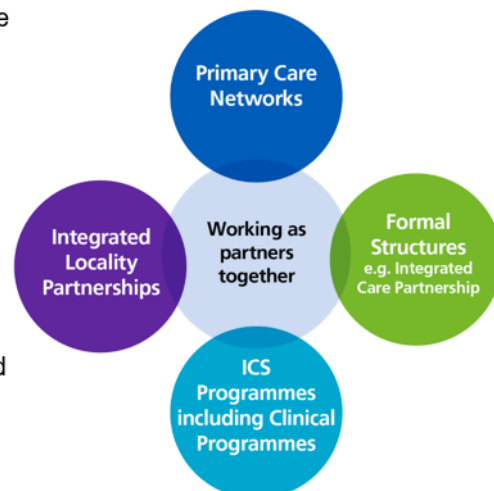
Our NHS Gloucestershire Integrated Care Board (NHS Gloucestershire) is responsible for planning and buying services to meet the health needs of local people. It also brings partners together to ensure the county’s NHS provides the best possible care. It works alongside our One Gloucestershire Health and Wellbeing Partnership - ensuring a joined-up approach across the NHS, public health, social care and the wider public, voluntary and community sector.



Working as partners

We are committed to working together with partners to deliver our collective ambitions for health and care in Gloucestershire. Partners will continue to be involved in:

- Supporting the delivery of care closer to home through **Primary Care Networks (soon to be known as Integrated Neighbourhood Teams)**
- Improving population health through district level **Integrated Locality Partnerships** in Gloucestershire
- Redesigning the way health and care is provided through **ICS transformation programmes**
- Where appropriate **engaging through formal board structures** such as the Integrated Care Partnership.



We know that by working together we can build a healthier Gloucestershire; supporting people to live well and providing high-quality joined-up care when people need it. We are ambitious for our county. We want to work with our communities, to improve health and wellbeing.

3.1.1 One Gloucestershire Integrated Delivery Plan

Our Integrated Delivery Plan sets out our priority programmes and the activities that we will be seeking to deliver as partners across the health and social care system in Gloucestershire. The plan has been formed from delivery plans that have been developed for each of our Integrated Care System transformation programmes, setting out objectives for the future⁸. These plans have been worked up with partner organisations and reflect a shared commitment to delivery for the years ahead.



⁸ Further details can be found at [Our priorities in Gloucestershire : NHS Gloucestershire ICB \(nhsglos.nhs.uk\)](https://www.nhs.uk/our-priorities-in-gloucestershire/)

3.1.2 ICS Clinical Programme Groups

The ICS Clinical Programme Groups (CPGs) are well established in a number of disease areas, working with system partners and lay representatives to ensure optimal clinical pathways for the people of Gloucestershire.

The aim of the programme is to deliver whole pathway transformation across key clinical programme areas, utilising a structured 'Clinical Programmes Approach' based on the principles of improvement science. A fundamental priority is to deliver the best value healthcare for our population.

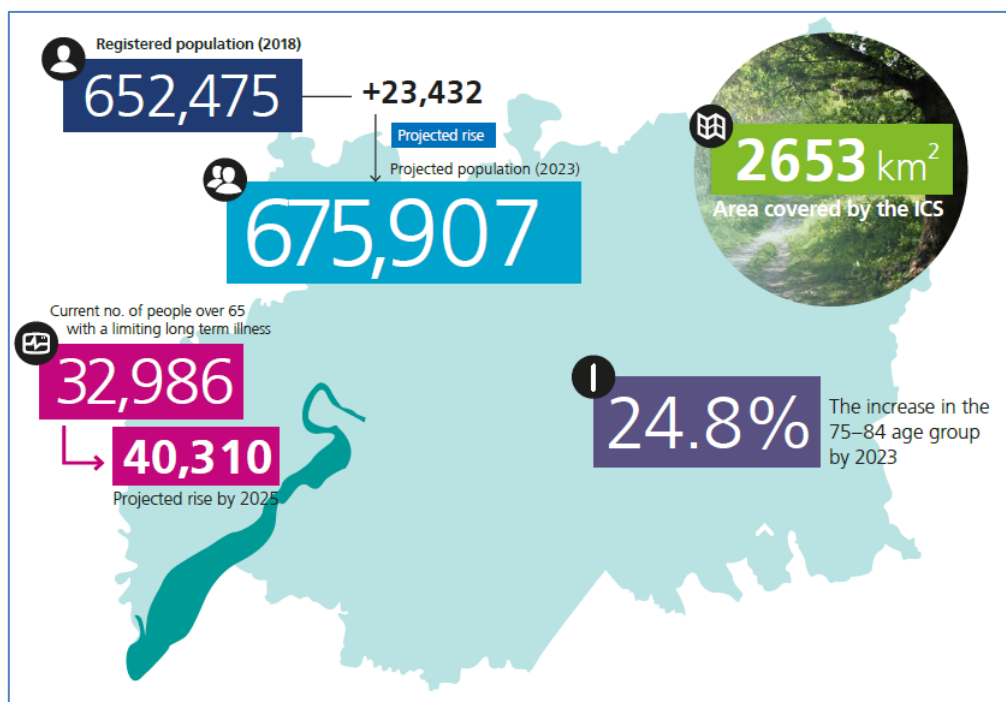
The programme takes a pro-active approach to preventing disease, diagnosing and treating and managing the condition from its early stages. We build on the strong foundations of the clinical programme approach to deliver truly integrated care- both within physical and mental health; challenging system partners to remove barriers to care delivery and reduce the health inequality gap.

We work with all partners to ensure that the clinical programme approach is contributing to eradicating health inequalities, through analysis of data and proactive engagement with service users and the communities we serve through prevention, early diagnosis and timely access to support throughout their lives and be supported at their most vulnerable times to access personalised care, including end of life.

As part of a collaboration between our priority programmes, CPGs and FFTF came together to set up and support service Task and Finish groups in 2021, covering stroke and frailty.

3.2 Local Health Context

The FFTF programme undertakes an integrated impact assessment (see section 11), for the individual services in scope, however, a summary of countywide demographic information is provided below.



The health of people in Gloucestershire is generally better than the England average. Gloucestershire is one of the 20% least deprived counties/unitary authorities in England, however about 12.6% (13,320) children live in low income families. Life expectancy for both

men and women is higher than the England average although it is 8.4 years lower for men and 5.4 years lower for women in the most deprived areas of Gloucestershire than in the least deprived areas.

Gloucestershire has a lower proportion of 0-19-year olds and 20-64-year olds when compared to the national figure, whilst the proportion of people aged 65+ exceeds the national figure. As is the case in many parts of the UK, the number of older people in the county has steadily increased over the last 10 years. Projections suggest this trend will continue, with the number of people aged 65+ projected to increase by 77,000 or 59.4% between 2016 and 2041.

According to the 2011 Census ⁹16.7% of Gloucestershire residents reported having a long-term limiting health problem; this was below the national figure. As age increases the proportion of respondents reporting a limiting long-term health problem increases. Given the ageing population, the number of people with a limiting long-term health problem is likely to increase in the future.

The three leading causes of death for our population are cancer (27.9%), cardiovascular disease (26.8%) and respiratory disease (14.2%). Age is the leading risk; however, the burden of disease in these categories is associated with four additional key risk factors: poor diet, physical inactivity, smoking and excess alcohol consumption.

Poor mental and emotional wellbeing also have a key part to play. Gloucestershire is broadly in line with national and regional benchmarks for alcohol related admissions to hospital, levels of physical activity and adult excess weight, although some districts have worse rates than the county as a whole, notably in the west of the county in the Forest of Dean, Gloucester and Tewkesbury. Smoking rates in Gloucestershire are steadily declining and are lower than comparators.

Our ageing population, changing patterns of disease (more people living with multiple long-term conditions) and rising public and patient expectations mean that fundamental changes are required to the way in which care is delivered in our county. We will more fully involve individuals in their own health and care by making shared decision-making a reality by intensively training our clinicians to give people the support and information they need for effective self-management and involving their families and carers to support them in making the changes needed to keep healthy. There is clear evidence that most people want to be more involved in their own health and that, when they are, decisions are better, health outcomes improve, and resources are allocated more efficiently.

3.2.1 Population and Demand Growth

Our assessment of the impact of population growth uses 2018 subnational population projections from the Office of National Statistics (ONS). We have reviewed the age-group, gender, and locality profiles of patients for each of the proposals in scope and applied the appropriate growth rates to our baseline activity to assess the impact of cumulative growth for the period 2022 to 2031.

The management of growth demand is a consistent and ongoing objective within the ICS to ensure that hospital appointments and admissions are appropriate as well as the year-on-year efficiencies within GHNHSFT to deliver productivity improvements.

Whilst the ONS projections are recognised as the usual source for growth assumptions, it should be noted that they were published in 2018 and pre-date the Coronavirus (COVID)

⁹ See section 11 for rationale regarding use of 2021 census

pandemic. As with all systems, the past 36 months (since March 2020), has seen a significant change in the demand distribution and commensurate use of resources; for example, when comparing 2019 with 2021 we have seen a >25% reduction in average surgical bed numbers used (and a reduction as a proportion of total) and a 50% increase in number of beds occupied by Medically Fit for Discharge/ Not Meeting the Criteria to Reside (MFFD/NMCTR). Given the multi-factorial nature of current resource demands, including COVID, elective recovery, continuing Urgent & Emergency Care demand, and uncertainty as to their impacts, this DMBC has not attempted to inflate resource demand (including bed demand and capacity, see section 5.7), based on an unmitigated position. Our modelling takes account of the last three years, our pre-COVID demand and our plans for the future.

If these proposals are approved and the programme shifts to implementation over the coming years, decisions will take account of the position at the time, and the developing recovery paradigm.

Our proposals are to deliver our case for change over the medium to long-term and we have therefore, in agreement with NHSE, excluded these impacts from our baseline data, staffing models, resource requirements and finances.

3.2.2 Joint Strategic Needs Assessment & Joint Health and Wellbeing Strategy

The Gloucestershire Joint Health and Wellbeing Strategy 2019-2030¹⁰ (JHWS) sets out the plans to address our seven Health and Wellbeing Board priorities:

- Physical activity
- Adverse childhood experiences (ACEs)
- Mental wellbeing
- Social isolation and loneliness
- Healthy lifestyles
- Early years and best start in life
- Housing

As an ICS we recognise that our JHWS is intrinsically linked to our response to the NHS Long-Term Plan (LTP) and the services included within this document should not be seen in isolation from all the other developments that support the delivery of our JHWS and address the issues and challenges identified in our Joint Strategic Needs Assessment 2017 (JSNA)¹¹. Our JSNA does highlight that Gloucestershire has an ageing population, with a higher and growing number and proportion of older people and this is developed as part of our Case for Change

3.3 Local Providers Context

The One Gloucestershire ICS structure is presented in section 3.1 and includes the following organisations, NHS Gloucestershire Integrated Care Board, Gloucestershire Hospitals NHS Foundation Trust, Gloucestershire County Council, South Western Ambulance Service Foundation Trust and Gloucestershire Health and Care Services NHS Foundation Trust.

¹⁰ Gloucestershire Joint Health and Wellbeing Strategy 2019-2030 can be found in Appendix 2

¹¹ Gloucestershire Joint Strategic Needs Assessment (2017) can be found in Appendix 3

3.4 Introduction to the Fit for the Future Programme

As part of our response to the NHS Long Term Plan and commitment to the public in Gloucestershire, when patients require specialist care, we believe they should receive treatment in centres with the right specialist staff, skills and equipment by delivering care that is fit for the future.

Our FFTF Programme includes looking at how we can develop outstanding specialist hospital care in the future across the Cheltenham General (CGH) and Gloucestershire Royal (GRH) hospital sites. Our *Centres of Excellence* vision for the future configuration of specialist hospital services with GRH focussing more (but not exclusively) on emergency care, paediatrics, and obstetrics and CGH focussing more (but not exclusively) on planned care and oncology. Across the UK and the world, it is recognised that an element of separation between planned and emergency care services can improve care for everyone.

Clinical Strategy...

A single, ground-breaking specialist hospital for Gloucestershire operating out of two campuses, one in Cheltenham and one in Gloucester.

All the specialist care and expertise you need will be right on hand whether you are coming to us for planned surgery, or in an emergency.

What we mean by *centres of excellence*...

Not all clinical specialties will be centres of excellence in their own right.

Co-locating services that work together to rapidly stabilise, triage, diagnose and treat patients will form the basis of our centre of excellence for emergency care at GRH...

Wherever possible, **planned care and oncology will be provided on a separate site** to ensure our teams and patients have reliable access to diagnostic facilities, inpatient beds, daycase trollies, operating theatres and critical care will form the basis of our centre for excellence for planned care at CGH.

Not a purest strategy, not all emergency care will be provided from GRH and not all planned care will be provided at CGH.

Centres of excellence are not limited to our acute sites. Some services will deliver better outcomes and experience from being co-located off-site with community or primary care services.

3.4.1 National drivers/context

This section sets out the national context in which this FFTF2 business case has been developed.

The *Centres of Excellence* programme envisions that some specialties will have a greater separation of urgent care and planned care to improve availability of beds, access to appropriate senior staff, ensure fewer cancelled operations and improve waiting times. The benefits of separating planned and unplanned activity are cited by a number of sources.

The Royal College of Surgeons of England (RCS) recommends separating planned surgical admissions from emergency admissions (ideally on a single site), suggesting that this can result in earlier investigation, definitive treatment and better continuity of care, as well as reducing hospital-acquired infections and length of stay (particularly medical emergencies) wherever possible.¹² The King's Fund also states that professional guidance, as well as the available research evidence, support the separation of planned from emergency surgery (either geographically or through the provision of dedicated facilities and staff).

The NHS Long Term Plan¹³ states that separating urgent from planned services can make it easier for NHS hospitals to run efficient surgical services. Planned services are provided from a 'cold' site where capacity can be protected to reduce the risk of operations being postponed at the last minute if more urgent cases come in. Managing emergency care on a separate 'hot' site allows trusts to provide improved trauma assessment and better access to specialist care, so that patients have better access to the right expertise at the right time. NHS England has confirmed that it will continue to support hospitals that wish to pursue this model.

The NHS England Transforming Urgent and Emergency Care Services in England guide for local health and social care communities (2015) states that:

- Getting patients to definitive, specialist hospital care can be more important to outcomes than getting them to the nearest hospital for certain conditions, such as stroke, major trauma and heart attacks.
- In an emergency, patients should be seen by a senior clinical decision maker as soon as possible. This improves outcomes and reduces length of stay, hospitalisation rates and cost.
- Acute assessment units (which co-ordinate tests and input from the different hospital specialist teams) enhance patient safety, improve outcomes and reduce length of stay.

3.5 Fit for the Future: Phase 1

FFTF Phase 1 completed its Stage 2 review in September 2020 and the Decision-Making Business Case (DMBC) was approved in March 2021. The reconfigurations agreed in Phase 1 are presented overleaf, including their implementation status which is linked to GHNHSFTs Strategic Site Development (SSD) programme. This has allowed us to phase the implementation of the proposals contained within FFTF, ensuring that the necessary facilities and infrastructure are in place to support the reconfiguration of services.

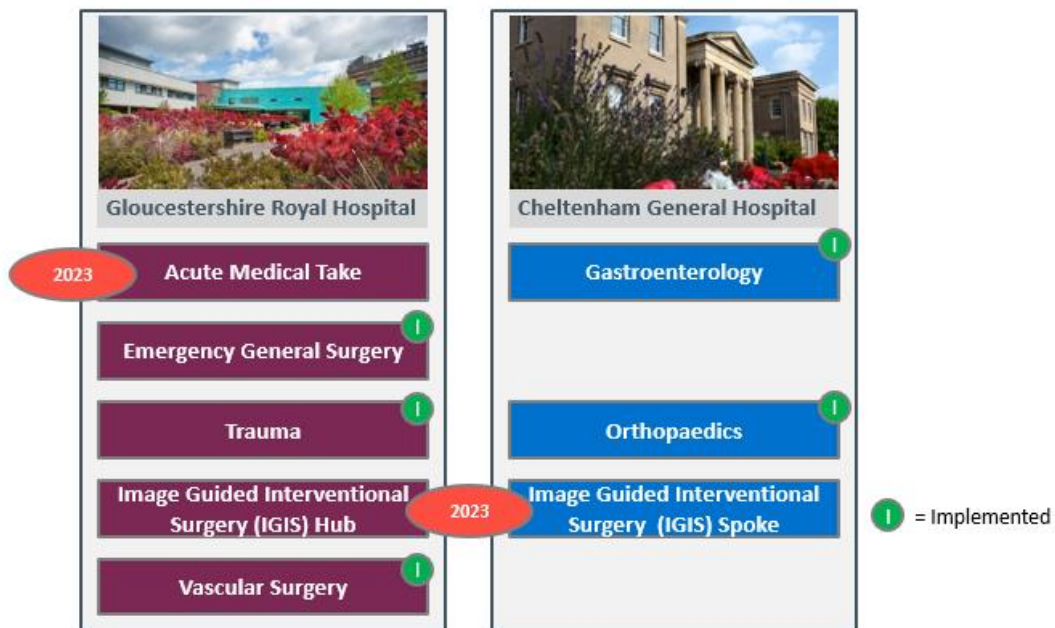
¹² RCS referenced in King's Fund (2014) <https://www.kingsfund.org.uk/publications/reconfiguration-clinical-services/elective-surgical>

¹³ NHS (2019) <https://www.longtermplan.nhs.uk/wp-content/uploads/2019/01/nhs-long-term-plan.pdf>

The SSD programme includes two additional theatres and a Day Surgery Unit at CGH; the new facilities will improve patient experience, reduce waiting lists and result in fewer operations being cancelled. GRH will benefit from an improved Emergency Department and acute medical care facilities designed to speed up diagnosis, assessment and treatment. There will be a redesigned outpatients and fracture clinic accommodation for orthopaedic outpatients, additional x-ray capacity and a programme of ward refurbishment. The current timescales (subject to change) for completion of key GSSD developments are:

- GRH Gallery wing – creation of additional inpatient ward facilities – Completed
- CGH Day case unit - April 2023
- GRH Catheter Labs - September 23
- CGH Theatres - October 2023
- GRH Expanded Emergency Department (ED)
 - Phase 2A (New Minors/Fractures) and 2B (Majors) – Completed
 - Phase 5b (Existing ED refurbishment) –June 2023.
- GRH Acute Medical Unit
 - AMU 2 (single side room with ensuite) –February 2023
 - AMU 1 (x15 bed spaces) –May 2023.

FTTF Phase 1 Service re-configurations



The benefits to services included in Phase 1 were designed to:

- Improve health outcomes for patients
- Make sure patients are always assessed by the right hospital specialist (e.g., doctor) with timely decisions about their treatment and care
- Ensure there are always safe staffing levels, including senior doctors available 24/7 and teams have the best equipment and facilities
- Reduce waiting times and limit the number of operations that are cancelled
- Support joint working between services to reduce the number of hospital visits people have to make

- Create flagship centres for research, training and learning - attracting and keeping the best staff in Gloucestershire
- Deliver more specialist services in Gloucestershire to enable people to receive care locally rather than travelling to Bristol, Birmingham and Oxford as they do now.

For the services implemented we are delivering many of the benefits described in our FFTF1 DMBC; details can be found in Appendix 4b. We continue to work on the realisation of the FFTF1 benefits and these will be added to as we implement the remaining FFTF1 service reconfigurations in 2023.

All our Phase 1 documents (including the DMBC) can be found at [Fit for the Future: Developing specialist hospital services in Gloucestershire – OneGloucestershire.net](#)

With these Phase 1 changes agreed and the principle of a greater separation of emergency and planned care established, the programme developed Phase 2 reconfigurations that fit with this model, which are subject of this decision-making business case.

3.5.1 Planned General Surgery

The only FFTF Phase 1 service not covered above is Planned General Surgery. Prior to the DMBC approval process, GHNHSFT Trust Leadership Team (TLT) explored in detail the configuration options for Lower GI (colorectal) surgery, and it was evident as a result of the debate, which considered feedback received during FFTF1 public engagement and consultation, that there was an alternative, potentially even better option, that includes the best elements from the two options presented during consultation and notably the opportunity to deliver even more planned elective surgery from the Cheltenham Hospital site.

The recommendation was that further work should begin with the General Surgery team to define this new, emerging option. Since then, significant work has been undertaken and further proposals presented, and decisions made, by TLT (November 2022). The latest position is that the division are developing a decision-making business case to cover the following:

1. The creation of dedicated Gastrointestinal day surgery lists at CGH.
2. The creation of specialised centres at CGH for Bariatric, Biliary, Pelvic Floor and Early Rectal Cancer.
3. Co-location of all resectional Upper Gastrointestinal Surgery at GRH
4. Co-location of all Colorectal resectional surgery at GRH.

The benefits of this proposal include greater numbers of patients within the Centres of Excellence model making use of the new Day Surgery unit in Cheltenham, reduction of cancellation for bed pressures- especially when the new theatres are completed in 2023 and the creation of highly specialised units to maximise efficient theatre lists and reduce cancellation.

It should be noted that there are no dependencies between this last remaining FFTF Phase 1 service change and our proposals in FFTF Phase 2.

3.6 Fit for the Future: Phase 2

'Fit for the Future - 2' is not only about the continued development of the 'Centres of Excellence' approach and how we organise specialist hospital care at CGH and GRH, in some cases it's also about how we can improve the wider journey of care (pathway) for the person who needs services or support.

The services we focus on in FTF2 are:

- Benign Gynaecology *¹⁴
- Diabetes and Endocrinology *
- Non-interventional Cardiology
- Respiratory *
- Stroke *

Each of the services will be covered in detail in their individual sections. In developing our FTF2 programme we sought to look at the whole pathway for some services rather than a focus only GHNHSFT services, as was the case in FTF1.

When we are looking at how, when and where we support, or provide healthcare to someone, there are a number of things we need to think about:

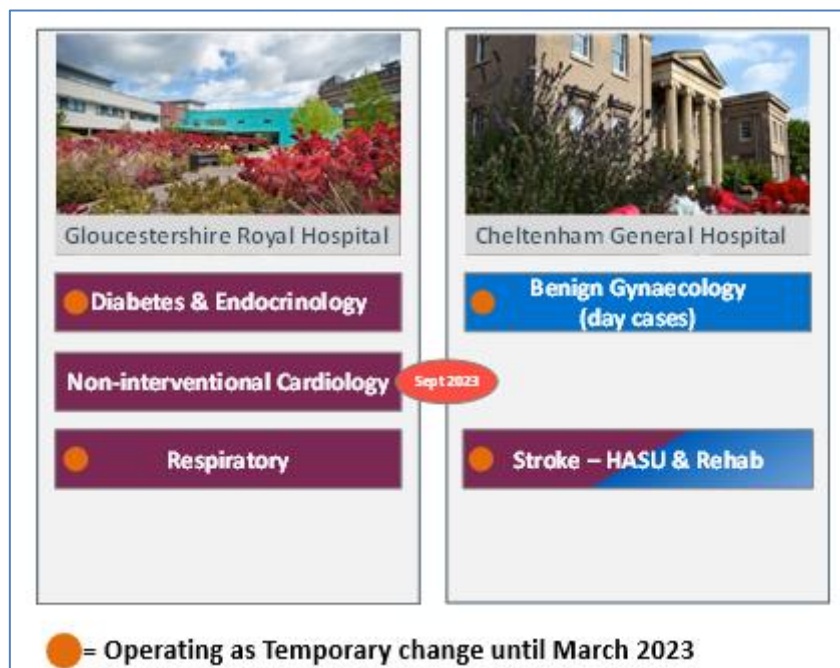
How we can provide the very best care for people at each stage of their illness or injury

i.e., very specialist care for people when they are very unwell, rehabilitation support for people to help them recover and regain their independence, e.g., from an operation or other treatment and - in many cases - follow up care and support over the longer term

Opportunities to join up care (integration) - improve communication and make care simpler and smoother across services and communities. This could be:

- between related services in a hospital
- between GP surgeries and community or hospital services
- between health and social care services and;
- between the NHS, social care and other key community partners, e.g., local councils, voluntary and community groups and others.

How we tackle health inequalities, i.e., ensure that we improve health outcomes for everyone - regardless of where they live in the county and their social, environmental or economic circumstances.



¹⁴ *Currently subject to Temporary Service Change (for details see individual service sections)

One of the services included in our FTF2 engagement (see section 4), was Frailty/Care of The Elderly as we wanted to take the opportunity to hear from the public, patients and staff about their experiences of current services. However, the potential developments and improvements to the frailty pathway would not be subject to the statutory duty requirements co-ordinated by the FTF Programme. For this reason, Frailty/Care of The Elderly is not included in this DMBC.

The only other temporary service change not covered in FTF2 is the re-location of the Medical Day Unit at CGH. It was not part of our FTF2 engagement and is being managed as a separate process.

It is also important to state what Fit for the Future 2 (FTF2) is not about. It is not about:

- Saving money. The priority is quality of care and health outcomes
- FTF1 - the public consultation in 2020, past decisions and the service changes that are now being implemented
- The Accident and Emergency Department in Cheltenham, which remains a 24-hour A&E (nurse led service overnight 8pm to 8am).

Key Points

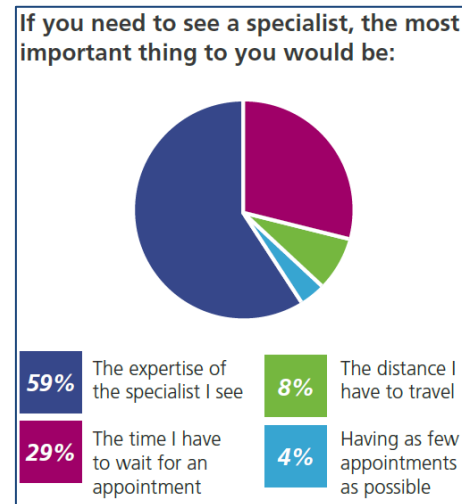
- **Fit for the Future (FTF) is a key element of our ICS Integrated Delivery Plan**
- **FTF links with our ICS Clinical Programme Groups to deliver whole pathway transformation.**
- **FTF is part of our response to the NHS Long Term Plan delivering our Centres of Excellence vision for the future configuration of specialist hospital services at GRH and CGH.**
- **The FTF Programme has two phases (FTF 1 & 2), working closely with the GHNHSFT Strategic Site Development, to deliver benefits to our population.**

4 Public, Patient and Staff Engagement

In this section we seek to demonstrate that the Fit for the Future2 (FFTF2) programme has built on the extensive engagement and consultation activities for FFTF Phase 1, which clearly identified that there is high recognition of *Centres of Excellence* amongst those responding to our surveys. In addition, many respondents to our FFTF1 Consultation felt that the centralising of services would optimise care quality, increase staff retention and learning for staff which would result in reduced waiting times and cancellations.

Furthermore, as part of developing our local plans for Gloucestershire over the last few years, we have been asking staff, patients, carers, public and community partners, what matters to them about local health and care services

- 69% of respondents agreed we should bring some specialist hospital services together in one place
- A significant proportion felt the expertise of the specialist was more important than distance to travel (see opposite).



It is our contention that FFTF2 has engaged inclusively¹⁵, innovatively and constructively with our internal and external stakeholders, most importantly with the residents of Gloucestershire and users of our services. In doing so we believe we have met the requirements of NHSE Guidance:

- Robust public involvement;
- To be proactive to local populations;
- To be accessible and convenient;
- To consider different information and communication needs, and;
- To involve clinicians.

Our learning from the Phase 1 consultation highlighted the benefits of new channels of communication with the public (as a result of COVID restrictions), and our engagement for Phase 2 included blended approach of face to face and virtual.

The FFTF2 public and staff engagement programme started in May 2022 (until 31/07/22), to seek views on the future provision of specialist hospital care in Gloucestershire. The full Output of Engagement report can be found in Appendix 1, and details all the engagement activities, full demographic analysis of survey respondents and all quantitative data. As stated in section 2 the report has been widely shared and formally reviewed by NHS Gloucestershire ICB, Gloucestershire Hospitals NHS Foundation Trust (GHNHSFT), NHSE and Gloucestershire Health Overview and Scrutiny Committee (HOSC).

A brief summary is presented in this section.

¹⁵ See Appendix 1 OoE - section 5.5 Engaging people with protected characteristics and others identified in the Integrated Impact Analysis and individual service IIAs (Appendix 13)

4.1 Engagement Materials

The engagement programme produced and utilised the following:

Engagement Booklet (Long)	Engagement Booklet (Short)
Engagement Booklet (Easy Read)	Display materials
An Engagement questionnaire/survey (online and hard copy)	Range of videos (with local clinicians explaining each of the service proposals)
Frequently asked questions	

4.2 Engagement activities

A range of communications channels have been used including:

Gloucestershire Hospitals: Facebook Live (@GlosHospitals)	Targeted engagement to address the homogeneity of participants
'Your Say' area on the One Gloucestershire Health website and Get Involved in Gloucestershire online participation platform	GHNHSFT staff FTF2 events plus presentations and awareness raising at team, divisional and Trust-wide meetings
NHS Information Bus Tour	Public events
A phased communication campaign for GHNHSFT staff using existing channels (CEO briefing etc.), weekly FTF2 service focus emails, posters across both hospital sites, booklet drops to teams and Q&A sessions.	Presentations to Integrated Locality Partnerships; ILPs are operational and strategic partnership of senior leaders of providers and local government, supporting integration at PCN level
Healthwatch Gloucestershire	Presentations to local councillors
Presentations to PCN clinical leads	Media releases and stakeholder briefings
Media (print and social) advertising	

4.2.1 Staff Communication and Engagement

Details of staff engagement activities referred to above are provided in Appendix 1 and feedback themes from staff are included in both this section and in the individual service sections.

It is important to note that, following feedback from staff during FTF1 we adapted our survey categorisation nomenclature and also enhanced and improved our staff engagement campaign for FTF2. We had a very good response from staff to our survey, at 43% respondents (i.e., excluding those not completing or "preferring not to say").

Informal feedback from staff has been that FTF2 staff engagement was better than FTF1.

4.3 Quantitative Analysis

Full details are in the individual service sections (6-10) and indicate a strong level of support for all service ideas, summarised in the table below:

Service	Support	Oppose
Benign Gynaecology	92%	8%
Diabetes and Endocrinology	98%	2%
Non-interventional Cardiology	99%	1%
Respiratory	97%	3%
Stroke	84%	16%

4.4 Qualitative Analysis - Engagement feedback themes

Details of the responses and themes is provided for each of the services in sections, however, a number of themes were consistent across all services; these included:

4.4.1.1 Public and Patients themes

- Support for Centres of Excellence approach
- Travel and Transport
- Car parking
- Ward environment

4.4.1.2 Staff themes

- Benefits of the Centres of Excellence approach
- Travel and Transport
- Car parking for patients
- Health inequalities
- Interdependencies with other clinical services
- Improved integration with primary and community services

4.5 Other Stakeholders

4.5.1 Neighbouring ICBs and Health Boards

The FFTF Programme team have been in contact with neighbouring ICBs at the start of our engagement to encourage them and their residents to participate. We have shared information on the programme scope, exchanging of activity information and agreements to build relationships and share information as the preferred option(s) are finalised.

The overall activity numbers for FFTF2 are considerably lower than FFTF1 and the impact on patients registered outside Glos. is similarly reduced. We also look at patients per practice and have contacted the practices direct (those >4). This is summarised in the table below.

ICB and Health Boards	Activity	Practices >4
Aneurin Bevan University Health Board	65	3
NHS Bath and North East Somerset, Swindon and Wiltshire Integrated Care Board	16	13
NHS Coventry and Warwickshire Integrated Care Board	2	1
NHS Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board	6	2
NHS Bristol, North Somerset and South Gloucestershire Integrated Care Board	29	24
NHS Herefordshire and Worcestershire Integrated Care Board	200	41

4.5.2 **Health Overview and Scrutiny Committee**

Throughout both the Fit for the Future Programmes regular updates on the FFTF programme and engagement have been provided to the Gloucestershire Health Overview and Scrutiny Committee (HOSC), with the Output of Engagement report will be presented and discussed with members in October 2022.

4.5.3 **MPs**

The ICS Executives are in regular communication with local MPs, and this has included proposals within scope of the Fit for the Future Programme.

Key Points

- **Fit for the Future 2 (FFTF2) built on the extensive engagement and consultation activities for FFTF Phase 1**
- **FFTF2 has engaged inclusively, innovatively and constructively with our internal and external stakeholders, most importantly with the residents of Gloucestershire and users of our services.**
- **Engagement responses indicate strong support for our proposals.**

5 Information for all FFTF2 Service Proposals

As described in Section 3.6 there are five services in scope for Fit for the Future (FFTF) Phase 2 and, whilst all are aligned to our strategy, the drivers for change vary across each service.

This section provides information on aspects common to all proposals whilst the following sections provide information for each individual service change proposal, covering:

- The “current state” service model
- Clinical engagement
- Case for change, the problem we are seeking to address
- Clinical evidence
- Our preferred option for “future state” and the work done to assess
- Benefits
- Interdependencies
- Workforce
- Learning from temporary service change period (where applicable)
- South West Clinical Senate review
- Engagement feedback
- Addressing themes from engagement.

5.1 South West Clinical Senate Review

The FFTF programme has worked closely with the South West Clinical Senate through Phases 1 and 2 and greatly values the Senate’s input to provide an independent clinical review of large-scale service changes, to ensure there is a clear clinical basis underpinning any proposals for reconfiguration. The senate also check whether proposals for large scale service change meet the Department of Health’s tests for service change, particularly the clinical model and the evidence base (and the bed test where relevant).

Details of the Senate Clinical Review Panel (including the full report) would usually be contained with a PCBC but, as detailed in section 2.2, we are using a single-step business case and therefore have included both the report and a summary in the DMBC.

5.1.1 Senate Review Process

The review is undertaken in two stages:

1. **Stage 1 Sense-Check /Desktop Review by Senate:** completed via desktop by a small (4-6) ‘virtual’ panel of Senate Clinicians. The Desktop Review Report (received 28/06/22) raised a number of questions and details of these and our responses are presented in the relevant service sections).
2. **Clinical Review Panel (10/08/22):** This brings together a panel of out of area clinicians relevant to the service areas and our clinical leads for the proposed models to present the model of care, followed by questions and discussion with the panel. The Clinical Review Report (received 15/09/22), is in Appendix 5, a brief summary is provided in the section below, and our comments are presented in the relevant service sections.

5.1.2 Clinical Review Panel summary

Full details can be found in the report and those specific to each service are contained in the relevant sections, however there were a number of general findings:

- The Panel observed that the proposals would deliver some clear benefits for patients, had good clinical leadership, that they had been well thought through and appraised, and that there were clear plans for implementation.

- The Panel did not have any concerns about the proposals from an access, equality, or diversity perspective.
- Some of the proposed service changes were introduced as temporary measures as part of the response to the COVID pandemic and the Trust has had the opportunity to learn from this.
- Some of the proposed service changes have impacts outside the services included in the scope and these have been considered alongside the specific proposals.
- The panel was reassured that the Trust has ensured that all specialities providing specialty medical consultation services at CGH have included this work in consultant job planning. The panel believes that it is essential that this continues in the future.

The panel report also included specific points that would need to be factored into the implementation plans, for both Phase 1 and Phase 2 of the FFTF Programme. Details can be found in the report (Appendix 5) but can be summarised as:

- The management and monitoring of inter-site ambulance transfers (see section 5.6)
- Preparations for the centralisation of the acute medical take to GRH including medical cover at CGH, SWASFT protocols and acuity of Emergency Department walk-in patients (see section 15)
- Workforce (see section 5.4)
- Bed modelling (see section 5.7)
- Stroke (see section 10), and
- Communication (see section 15.4)

5.2 Options Evaluation Process

5.2.1 *A structured process was used to identify options*

The Fit for the Future Programme has, from the outset, had a clear process in place to develop its clinical models through a combination of innovative ways to involve local people and staff (from a survey and 'drop in' events, independently facilitated workshops, an engagement hearing, and culminating in an inclusive and transparent solutions appraisal process), a clear governance structure and agreed and delivered outputs.

The process was initially developed as part of Phase 1; details are available in the Phase 1 Pre-Consultation Business Case ([Fit for the Future | Get Involved In Gloucestershire \(glos.nhs.uk\)](#)) and has been adapted for Phase 2. This is a two-stage process using hurdle/essential criteria to a long-list and then desirable criteria to the medium/short-list to identify the preferred option. In a summary our process involves:

- **Building a clear Case for Change** - This involved describing the local population's health and care needs now and into the future, setting out how services are currently provided and highlighting the challenges faced by current health and care services now and in the future as they seek to meet the needs of our local population.
- **Defining evaluation criteria**, against which different *Centres of Excellence* models for the future have been assessed. These were heavily shaped by feedback from the pre-consultation engagement phase.
- **Developing best practice care pathways and models of care**. This first involved drawing on local, national and international exemplars.

- The **shortlisted options** have been evaluated against the agreed criteria; detailed in individual service sections.
- The **preferred options** have been tested for safety, feasibility and viability both internally (by the ICS and organisational governance) and review by the South West Clinical Senate and NHSE.

5.2.2 *Hurdle Criteria*

Hurdle criteria are applied by the individual services (with support from the FFTF programme team) at a dedicated service meetings and confirmed by the relevant Divisional meeting. The criteria were developed in Phase 1 following engagement feedback and are:

- Address the issues identified in the Case for Change
- Supports the delivery of high-quality care across Gloucestershire, ensuring provision of a clinically safe service.
- Achievable and able to be delivered in a timely and sustainable way.
- Affordable and offers best value for money, making the most of the Gloucestershire pound
- Supports sustainable ways of working and facilitates both recruitment and retention of our workforce.

5.2.3 *Desirable Criteria*

There are a number of domains (each with a sub-set of questions), including:

Quality of care (10 questions)

This section included questions to evaluate clinical effectiveness, patient outcomes, patient and carer experience, continuity of care, the quality of the care environment, self-care, patient transfers, travel time impact and the management of risk.

Access to care (10 questions)

This section included questions to evaluate the impact on patient choice, simplifying the offer to patients, travel burden for patients, carers and families, waiting times, supporting the use of new technology to improve access, improving or maintaining service operating hours and locations, impact on equality and health inequalities and accounting for future changes in population size and demographics.

Deliverability (8 questions)

This section included questions to evaluate the expected time to deliver, meeting the relevant national, regional or local delivery timescales, access to the required staffing capacity and capability, support services, premises/estates and technology to be successfully implemented.

Workforce (12 questions)

This section included questions to evaluate the impact on workforce capacity / resilience, optimising the efficient and effective use of clinical staff, cross-organisational working across the patient pathway, flexible deployment of staff and the development of innovative staffing models, staff health and wellbeing, recruitment and retention, maintaining or improving the availability of trainers, enabling staff to maintain or enhance their capabilities/ competencies, the travel burden for staff and clinical supervision.

Strategic fit (2 questions)

This section included questions to evaluate compatibility with the One Gloucestershire vision and the NHS Long Term Plan

Acceptability (1 question)

This question seeks to evaluate if the model has satisfactorily considered the FFTF engagement feedback.

5.2.4 Assessment Process

The process used by the FFTF programme is to arrange workshops, both in person and virtual (as requested by our FFTF Lay Reference Group), consisting of clinical and operational staff from each service, members of the public, stakeholders, GPs and organisational and system leadership.

The proposals are assessed using the desirable criteria and the assessment method we use is to compare proposals to the status quo and record if:

++ Significantly better than status quo	+ Slightly better than status quo	● Similar to status quo	- Slightly worse than status quo	-- Significantly worse than status quo
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Scorers were provided in advance with a range of information for each of the services being evaluated including:

- Service description
- Service Change Proposal
- Case for Change
- Impact summary
- Evidence to support scoring – description of “what would be better” and “what would be worse” for every question
- Clinical Senate Desk-top Review feedback
- Integrated Impact Assessment including travel impact analysis

The scoring is normally a two stage process:

1. **Online questionnaire:** all the information is sent in advance and scorers complete individual assessments (including comments), of the solutions/models they had been allocated, prior to the workshop.
2. **Workshop consensus:** in-person workshops are held with each table reviewing a number of service proposals where:
 - scorers were given copies of their assessments
 - facilitators share the online results for each question
 - A discussion takes place referencing the workshop information and comments
 - A consensus score and any comments are agreed and recorded

Unfortunately, due to the ongoing system pressures, rising COVID and the heatwave in mid-July (when events had been booked 10 weeks in advance for clinical colleagues), GHNHSFT declared a Business Continuity Incident (BCI) on one of the workshop dates. Given the notice requirements for clinical staff and the deadline for clinical senate submission, in

agreement with NHSE, for two of the service change proposals we reverted to using the on-line responses from scorers and these have been reviewed and summarised by the FFTF Programme Director for inclusion in the relevant service sections.

The overall status is presented below:

Stroke	Evaluated in virtual workshop and consensus scores agreed
Respiratory	Evaluated in virtual workshop and consensus scores agreed
Diabetes and Endocrinology	Evaluated in virtual workshop and consensus scores agreed
Non-interventional Cardiology	Evaluated individually online and reviewed/ summarised by Programme Director
Benign Gynaecology	Evaluated individually online and reviewed/ summarised by Programme Director

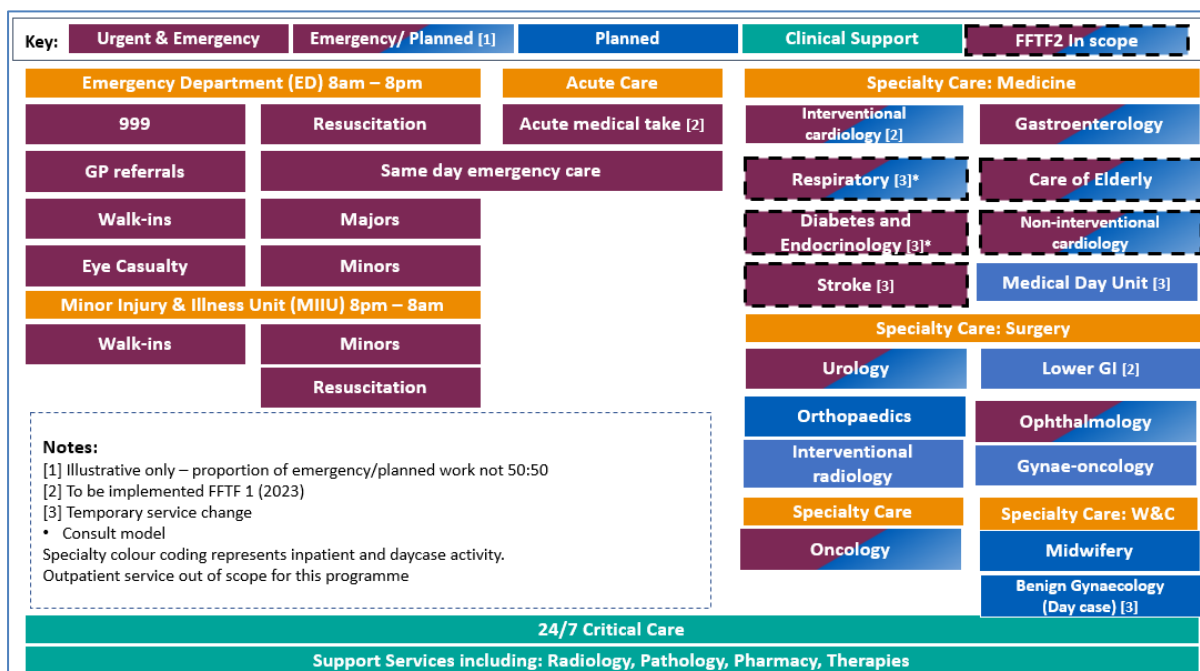
5.3 GHNHSFT Service locations

For context and completeness, we have included a summary of the “current state” and “future state” services at each site. This is, however, made complex as we need to take account of:

- FFTF1 services that are to be implemented in 2023
- FFTF2 services that are operating as temporary service changes.

The schematics below represent the “current state” location of services as of February 2023 and the “future state” when FFTF1 and FFTF 2 services are implemented.

5.3.1 Cheltenham General Hospital (CGH)- current state



5.3.2 Cheltenham General Hospital (CGH)- future state

Key:		Urgent & Emergency	Emergency/ Planned [1]	Planned	Clinical Support		
Emergency Department (ED) 8am – 8pm		Acute Care			Specialty Care: Medicine		
999	Resuscitation				Cardiology*	Gastroenterology	
GP referrals	Same day emergency care					Respiratory*	Care of Elderly
Walk-ins	Majors				Diabetes and Endocrinology*		
Eye Casualty	Minors				Stroke	Medical Day Unit	
Minor Injury & Illness Unit (MIIU) 8pm – 8am					Specialty Care: Surgery		
Walk-ins	Minors				Urology	Lower GI [2]	
	Resuscitation				Upper GI [2]	Ophthalmology	
					Orthopaedics	Gynae-oncology	
					Specialty Care: W&C	IGIS [3]	
					Midwifery	Specialty Care	
					Benign Gynaecology (Day case)	Oncology	
Notes: [1] Illustrative only – proportion of emergency/planned work not 50:50 [2] Day case & short-stay (final configuration tbc) [3] Image Guided Interventional Surgery (Spoke) * Consult model Specialty colour coding represents inpatient and daycase activity. Outpatient service provision continues as normal – out of scope for this programme							
24/7 Critical Care							
Support Services including: Radiology, Pathology, Pharmacy, Therapies							

5.3.3 Gloucestershire Royal Hospital (GRH)- current state

Key:		Urgent & Emergency	Emergency/ Planned [1]	Planned	Clinical Support	FTF2 In scope
Emergency Department (ED) 24 hours		Acute Care			Specialty Care: Medicine	
999	Resuscitation	Acute medical take			Non-Interventional Cardiology	Neurology
GP referrals	Majors	Assessment Units (AMU, FAS, SAU, PAU, GAU, Medicine Same Day Emergency Care)			Respiratory [2]	Care of The Elderly
Walk-ins	Minors	Emergency General Surgery			Diabetes & Endocrinology [2]	Renal
Eye Casualty					Specialty Care: Surgery	
					OMF	ENT
					Breast	Upper & Lower GI
					Trauma	Spinal
					Interventional radiology	Vascular
					Specialty Care: Haematology	
					Clinical Haematology	
					Specialty Care: Women & Children	
					Obstetrics and Gynaecology [3]	Paediatrics
Notes: [1] Illustrative only – proportion of emergency/planned work not 50:50 [2] Temporary service change [3] FTF2 - Gynaecology Day case only Specialty colour coding represents inpatient and daycase activity. Outpatient service provision continues as normal – out of scope for this programme						
24/7 Critical Care						
Support Services including: Radiology, Pathology, Pharmacy, Therapies						

5.3.4 Gloucestershire Royal Hospital (GRH)- future state

Key: Urgent & Emergency		Emergency/ Planned [1]	Planned	Clinical Support			
Emergency Department (ED) 24 hours		Acute Care		Specialty Care: Medicine			
999	Resuscitation	Acute medical take	Cardiology	Neurology			
GP referrals	Majors	Assessment Units (AMU, FAS, SAU, PAU, GAU, Medicine Same Day Emergency Care)	Respiratory	Care of The Elderly			
Walk-ins	Minors		Diabetes & Endocrinology	Renal			
Eye Casualty		Emergency General Surgery	Specialty Care: Surgery				
Notes: [1] Illustrative only – proportion of emergency/planned work not 50:50 [2] Image Guided Interventional Surgery (Hub) Specialty colour coding represents inpatient and daycase activity. Outpatient service provision continues as normal – out of scope for this programme			OMF	ENT			
			Breast	Upper & Lower GI			
			Trauma	Spinal			
			Interventional radiology /IGIS [2]	Vascular			
						Specialty Care: Haematology	
						Clinical Haematology	
						Specialty Care: Women & Children	
			Obstetrics and Gynaecology	Paediatrics			
24/7 Critical Care							
Support Services including: Radiology, Pathology, Pharmacy, Therapies							

5.4 Workforce

The ICS partners, as sponsors of this DMBC, are fully cognisant of the indispensable role that our staff have in the delivery of the proposed changes. GHNHSFTs People and Organisational Development Strategy sets out the trusts’ direction of travel to 2024 in terms of its staff and is centred around the ethos of “Caring for those who Care”. The NHS Long Term Plan sets out how we will transform models of care over a 5 year period with the People Plan 2020/2021¹⁶ setting out the workforce transformation needed to deliver 21st century care including an initiative to “release time to care”, all linked to the NHS Long Term Plan. Great emphasis is also placed on staff development, health and wellbeing and work life balance including a far more flexible approach to working patterns etc.

We are committed to supporting and developing our staff and fully endorse the NHS Long Term Plan ethos of ensuring we have “...enough people with the right skills and experience so that staff have the time they need to care for patients well” (NHS long Term Plan). All of this has underpinned our approach in respect of the workforce plans for Centres of Excellence.

We recognise that changes to location and ways of working can have a positive and negative impact on job satisfaction, morale, retention and travel time and cost. Staff affected will include those working directly in the services in scope and there may be some changes for staff working in support services.

Defining the long term configuration, co-location with other clinical services and supporting estate and equipment investment will help to improve recruitment and retention in services in scope. A change in site will also have a differential impact on staff with some colleagues seeing an increase in travel time and costs and some seeing a reduction.

¹⁶ NHS people has been further prioritised in the national planning guidance for 2021/22 and 2022/23, and work continues to develop for the longer term

5.4.1 Staff Engagement if a decision is made to implement proposed models

As indicated in the section above, of the five services that are the subject of FFTF Phase 2, four of the proposed changes are already in place as part of Temporary Service Changes (some since June 2020 and others from Feb 2022). Staff working arrangements have been agreed and put in place. If a decision is made to approve the proposals in this DMBC, in addition to the staff engagement detailed in section 4, further staff engagement will be undertaken for all services, either confirming the current locations and working arrangements (four services) or the proposed service change (1 service); the methodology is described below.

Managers will use team and one to one meetings to understand individual and team preferences on location or specialty. Staff wishing to remain within their current Division, e.g., Surgery, Medicine etc., will be accommodated and, wherever possible, within their current specific speciality. The objective will be to accommodate preferences wherever possible, i.e., stay on the same ward or site, stay together as a team or stay with the specialty (so move with the service) and this will be achieved through vacancy management which will form part of any implementation plan.

As staff are required to work across sites, relocation is not anticipated to be a contractual issue, but we recognise that there may be individual needs or concerns which will need to be accommodated and these will be raised with the HR Advisory and HR Business Partner (HRBP) team to resolve, e.g., travel issues and child care.

A staff briefing document will be provided to Managers to support these conversations and ensure consistency of message and will be sent to Staff Side for review. Feedback on the proposals will be captured on a standard form. A Frequently asked questions (FAQs) will also be provided.

Our approach is to encourage staff to talk to their line manager throughout the process to discuss individual issues or circumstances and if further support is required staff can seek advice from the HR Advisory Service, staff side representative or for staff wellbeing and psychological support through the GHNHSFT 2020 Hub.

To support the process, we will ensure regular communication between each affected HRBP with oversight by the Director of People and OD. This will ensure that we have early sight of any issues including if the messaging has been adequate and consistent and if there are any issues to implementation. Any inconsistencies or areas of concern will be escalated to the Divisional Tri and relevant HRBP and the team will be proactive in meeting colleagues and staff groups where necessary.

5.4.2 Workforce Planning Approach

The FFTF Programme, working with HR, clinical and operational colleagues, uses a workforce planning approach to model the workforce requirements of service change proposals. This was followed for FFTF1, where there were significant workforce changes and has been used proportionately for FFTF2, in recognition of the significantly smaller scale of workforce changes.

Critical to workforce planning is identifying demand and capacity and this has been central to the work underpinning this DMBC. Workforce planning is an essential element of any Business Planning Cycle and as such a crucial building block in the Operational planning for FFTF and establishing Centres of Excellence. In line with NHS directorate and Trust guidance the overall test is that we comply with the Safer Staffing requirements as detailed in National Quality Board (NQB) guidelines.

Ratio of staff to patients

When considering ratio of staff to patients a number of the NHS related recognised measuring tools were applied dependent upon speciality/professional staff group/expertise etc. GHNHSFT has an established process in terms of review of nursing (both registered and unregistered) that is undertaken annually with a bi annual review. In addition, an essential component of workforce planning is the “do ability” factor including:

- Application of uplift to ensure adequate cover for absence such as annual leave and training
- Legal compliance such as working time directive
- Rotas particularly in relation to sustainability of a rota

5.4.3 Recruitment and Retention

A key theme for the public, and core to our Case for Change, is the impact of proposed changes on clinical staff numbers, recruitment and retention and examples of our workforce challenges are detailed in the individual service sections, noting the scale of recruitment for Phase 2 is only 3.5 FTE, linked to Respiratory High Care (section 9).

The development and appraisal of our proposals have included the requirement to support sustainable ways of working and facilitate both recruitment and retention of our workforce.

If proposals are approved a planned phased approach to recruitment will be applied; with identified sources of pipeline and any marketing/advertising identified and planned. In terms of *best for patient and best for staff* having substantive staff in place is best all-round and therefore any required recruitment will be structured in such a way to minimise the use of locum/agency/bank.

In the FFTF2 service specific sections we detail how each proposed new clinical option will positively impact our workforce challenges including centralisation of services to avoid splitting resources across two hospital sites which we believe contributes to quality, workforce, financial and performance issues which affect patient outcomes and staff recruitment and retention and efficient use of resources.

5.4.4 Training – including new roles/ways of working’ realignment of skills and upskilling

We are committed to providing training, development and support to our staff. Any change in job role/area or working conditions such as equipment etc. would be identified and individual and personalised skills analysis work undertaken to identify skills and any gaps/upskilling required.

Where specialities are centralised on a particular site this will enhance the training and support offered to staff. It will also form closer working relationship and peer support which is a positive. For mentors this will prove invaluable in terms of easier access to those they are mentoring and vice versa.

5.4.4.1 Developing Advanced Clinical Practitioner roles

At GHNHSFT there has, for many years been opportunities for advanced level working with Consultant Nurses in Vascular, Trauma and Orthopaedics, Oncology, and Neurology and a Consultant Physiotherapist in MSK and a new appointment Consultant Paramedic in Emergency Department. There have previously been many Nursing, Therapy and Pharmacy Staff undertaking a variety of roles extending their scope of practice with variation in titles and educational pathways. However, since development of a GHNHSFT shared decision-

making council in December 2020 to discuss and debate further there resulted in successful completion of a Trust Policy in Advanced Practice first version September 2021. The Policy aligned to Health Education England definitions and education and supervision guidance has allowed scoping. A new One Gloucestershire Advanced Practice Lead Role from April 2022 drives a current workplan to formalise and develop the Advanced Clinical Practitioners (ACP) role within a safely governed framework.

Health Education England published the first Multi-Professional Framework for Advanced Practice in 2017. Advanced clinical practitioners come from a range of professional backgrounds such as nursing, pharmacy, paramedics and occupational therapy. They are healthcare professionals educated to Master's level and have developed the skills and knowledge to allow them to take on expanded roles and scope of practice caring for patients.

The benefits of this structure are that there is a defined level of practice within clinical professions such as nursing, pharmacy, paramedics and occupational therapy. This level of practice is designed to transform and modernise pathways of care, enabling the safe and effective sharing of skills across traditional professional boundaries.

Advanced clinical practitioners (ACPs) are healthcare professionals, educated to Master's level or equivalent, with the skills and knowledge to allow them to expand their scope of practice to better meet the needs of the people they care for. ACPs are deployed across all healthcare settings and work at a level of advanced clinical practice that pulls together the four ACP pillars of clinical practice, leadership and management, education and research.

A definition of ACP, its underpinning standards and governance, can be found in the Multi-professional framework for advanced clinical practice in England. The framework ensures there is national consistency in the level of practice across multi-professional roles that is clearly understood by the public, advanced clinical practitioners, their colleagues, education providers and employers.

The roles undertaken by advanced clinical practitioners are determined by the needs of the employer aligned to strategic workforce plans. Currently at GHNHSFT there are small number of established ACP roles aligning to HEE definition but there are developing teams of ACPs, Acute Response Team, also teams are currently being developed in ED, Critical Care, Same Day Emergency Care (SDEC), General Surgery, Respiratory and Neonatal Medicine

The NHS Long-Term Plan highlights how advanced clinical practice is central to helping transform service delivery and better meet local health needs by providing enhanced capacity, capability, productivity and efficiency within multi-professional teams. We have a dedicated One Gloucestershire Advanced Practice Lead Role since April 2021 reporting to system workforce leads. The role supported by SW Faculty Health Education England supports a drive in development and implementation of safely governed trainee and established roles. A unified framework for role development, progression, education pathways and supervision aligned to HEE guidance is being developed GHNHSFT to inform multi professional clinical, operational and education leads.

5.4.5 Staff Support through change

As indicated, of the five services that are the subject of FFTF Phase 2, four of the proposed changes are already in place as part of Temporary Service Changes (some since June 2020 and others from Feb 2022).

However, if the proposals are supported, confirmation that four of the changes are to become permanent and the one remaining service change will still have an impact on

individuals and groups of staff. A significant element of Managing Change is to support those individuals who are both directly and indirectly affected, one of the main being communication and underlining the need for staff involvement. This is an inclusive process not exclusive.

To support the process, we will ensure regular communication between each affected service line team, Chief Nurse and HRBP with overall oversight by the Director for People and OD. This will ensure that we have early sight of any issues including if the messaging has been adequate and consistent and if there are any issues to implementation. Any inconsistencies or areas of concern will be escalated to the Divisional Tri and relevant HRBP and the team will be proactive in meeting colleagues and staff groups where necessary. Any such change would be undertaken in line with the relevant HR policies.

How change affects individuals can differ greatly and that is why in line with our trust ethos of *Caring for those Care* individual personal needs will be considered. Whilst our underling needs must be to ensure we are able to meet the needs of the service in terms of patient safety and patients we will also balance this with the needs of our staff.

Through staff engagement we will identify individual wants and needs, managing this in line with our trust policies and procedures which are aimed to resolve matters wherever possible by consent.

Staff will be afforded support, and this will be made available and tapered to individual needs. This will also include confidential support links such as 2020 Staff Advise and Support Hub; Working Well (colloquially referred to as Occupational Health) and Staff Support.

5.4.6 Staff Travel

Remodelling of services across our two main hospital sites will ultimately have an impact on staff travel to and from work. Staff will experience

- No change as a result of reconfiguration.
- Positive change resulting in shorter travel times.
- Negative change resulting in increased travel time to get to and from their work place.

As described above, as most staff are required to work across sites within their service line relocation is not anticipated to be a contractual issue, but we recognise that there may be individual needs or concerns and our programme of staff engagement will provide opportunities for these to be addressed.

5.5 Impact of Changes on Junior Doctor Rotas and Training

5.5.1 Engagement with the Deanery

Historically, the main concern from trainees was a significant imbalance between CGH and GRH in workload and opportunity. This meant less than ideal training experience for trainees on either side – too much emergency work in GRH to get to clinics and too little experience in CGH for the number of trainees placed there. Part of the aim of reconfiguration is to better manage the emergency workload and even-out the opportunities for specialist trainee experience. The Medical Clinical Tutor and Deanery Representative have been in contact with the training Programme Director for Medicine to discuss how we are responding to the concerns raised. Further work is ongoing with the Director of Medical Education, Training programme directors and Clinical Tutors to review the training opportunities that the future configuration of services and will provide. This will

then be shared and discussed with the Programme Directors and Heads of School for Medicine.

The main upcoming change in postgraduate medical education is expansion of foundation trainee numbers over the next 3 years. Currently programmes are being designed to considering where trainees will be placed.

5.5.2 General advice from the Deanery:

It is important to maintain foundation trainee post numbers across the trust and all the work schedules for posts affected will be reviewed to ensure suitable learning opportunities are still open to them. The learning objectives for foundation doctors are set through a national curriculum, overseen by the UK foundation programme office and the GMC, and include:

- Foundation year 1 doctors require immediately available support from people with the skills to manage problems they might face (so that could be the Acute Care Response Team or DCC team).
- There is no precise specification for particular hours of the day or night, but posts should provide opportunities for experience to achieve the learning outcomes.
- Foundation year 1 doctors require immediately available support from people with the skills to manage patient care. F2s take on more responsibility for leading and managing patient care but still need to be able to access support for problems they might face (so that could be the Acute Care Response Team or Dept. of Critical Care team).
- There is no rule that requires training to be provided on one site. Many trainees will need to work at several sites to achieve their learning outcomes. Moving between sites should be justified on training grounds rather than service grounds and doctors in training must have induction to all areas and appropriate clinical supervision at all times. If doctors need to move sites during a shift, we need to think about how they will do that safely (and return back afterwards) and without interrupting continuity of patient care.
- Training posts must allow trainees to achieve the learning outcomes set in their curriculum. Colleges may set expectations for proportions of elective/emergency work, but this isn't universal across programmes and will be a guide.
- The risk of prioritising service over training is the withdrawal of training posts and loss of trainees.

Details of the trainee posts affected by FFTF Phase 2 changes are presented overleaf and the impact of FFTF2 planned and proposed service changes on Out of hours Doctor rotas in Appendix 6.

	FY1Trainees	SHO (FY2, CT1 & 2)	ST3 and above
Cardiology, Diabetes & Endocrinology. Respiratory & Stroke.	Rotas for foundation doctors are largely unchanged with foundation doctors working with their allocated teams during the day. Out of hours rotas were altered 2 years ago to enable cross site working which will continue which gives access to the advantages that each site offers. However, there will be greater numbers working in GRH.	With these services co-located the SHOs will have greater access to registrar support; this should improve learning opportunities and training. Rotas for out of hours shifts are worked at both sites which is unchanged, however more shifts will be at GRH.	With these services co-located the Registrars will have greater access to consultant support; this should improve learning opportunities and training. Out of hours rotas are unchanged.
Gynaecology Surgery (Day-Case only)	All foundation doctors will remain at GRH- training will be unchanged	All SHO doctors will remain at GRH- training will be unchanged	Registrars who are assisting surgical day case lists will travel from GRH to CGH. However, the inconvenience of the short journey will be offset by the reduction in cancelled lists; therefore, offering improved training opportunities.

5.6 Inter-site Ambulance Transfers

The Trust and the ICB have contracts in place with independent providers to deliver patient transfers by ambulance. The transfers include transporting patients from the GRH to Hartpury Suite (Cath Lab) at CGH, supporting patient discharge to their place of residence or to other providers and transferring patients between the two hospital sites.

As part of FFTF Phase 1, work was carried out to identify the inter hospital demand to support the centralisation of emergency general surgery and the acute medical take at GRH, and the transfer of vascular services and interventional cardiology services to GRH. This work has been updated to reflect the current experience during the temporary service changes and the proposed service changes within FFTF Phase 2, i.e., the centralisation of respiratory, cardiology, diabetes and endocrinology services at GRH and the centralisation of stroke services at CGH.

Examples of patient cohorts used in our activity modelling include the following:

Stroke	<ul style="list-style-type: none"> • Patient attending ED at GRH who were transferred to the stroke ward at CGH • Patients on a stroke ward at CGH transferred to another specialty ward at GRH • Patients transferred from an inpatient ward at GRH to a stroke ward at CGH
Respiratory	<ul style="list-style-type: none"> • Patient attending CGH ED and admitted to respiratory ward at GRH
Cardiology	<ul style="list-style-type: none"> • Patient attending ED who were admitted to a cardiology ward at CGH and GRH
Diabetes	<ul style="list-style-type: none"> • Patient attending ED at CGH who were transferred to GRH

It is estimated that the service changes set out in FFTF Phase 1 and 2 equate to approximately 10 patient transfers per day. This assessment has been based on activity data showing the number of patients attending the Emergency Departments at CGH and GRH who are then transferred to the other hospital site for admission and inpatient transfers between the two hospitals. We have also included an assessment of the number of walk-in patients attending the ED at CGH who are then admitted to a cardiology ward. For comparison we have also reviewed the patient transfer activity during COVID, when there were a substantial number of service moves across the two sites. This shows that at its peak there were on average 16 transfers a day.

The Trust is currently exploring, with advice from the ICB, how best to meet this future demand, recognising that some of the service moves have either already been formally completed or have temporarily moved in response to COVID (and are therefore in our current activity). It is anticipated that we will utilise the funding approved in the FFTF1 DMBC invest in provision of a further ambulance for inter hospital transfers only, that the crew will be trained to paramedic standard, the service will operate 7 days a week. In addition, it is proposed to provide a budget to cover ad-hoc transfers, which will be an expansion of the current ambulance transfer availability.

These proposals for inter-site ambulance transfers are planned on the basis of the current demands being placed on SWASFT and the impact of demand and hand-over delays on current response times. However, further work will be required to develop SOPs with SWASFT and GHNHSFT colleagues (where these are not currently in place), to confirm the precise response on the basis of each specific patient cohort and the clinical decision-making.

The South West Clinical Senate panel report included specific points regarding inter-site transfers that would need to be factored into the implementation plans, for both Phase 1 and Phase 2 of the FFTF Programme. These are listed below and will be picked up as part of the Cross Division Task and Finish Group (section 15.3.1):

- The Panel recommended that the Trust monitors the time taken and impact of transferring patients in both directions between sites when clinically necessary.
- The Panel recommended that the expected patient flows between the hospitals should be modelled and included in the proposals
- The Panel recommended that there should be a programme in place to review all inpatient transfers so that learning is captured, to help minimise the number of avoidable transfers.

- The Panel recommended that there should be central coordination of this service to ensure that journeys in both directions are used optimally and that empty return journeys are minimised.

5.7 Bed Demand and Capacity Modelling

5.7.1 Approach

As part of Phase 2 we undertook a full refresh of our bed demand and capacity modelling and this was combined with an extensive engagement process across GHNHSFT including clinical teams, operational Directors, Divisional Boards, our Clinical Advisory Group, a dedicated Cross-Divisional working group and senior Executives. A specific Decisions Summit was convened to discuss and agree bed numbers and ward allocations. This initially confirmed the vast majority of ward allocations, and these were presented to the South West Clinical Senate in August 2022. Subsequently, as part of the system operational planning cycle a further revalidation process has been undertaken by operational teams, as well as triangulation with BI reporting to assure alignment.

Appendix 7 presents full details by ward and service of the 2019/20 baseline, the proposed individual service and ward changes (both FTF and non-FTF) and the expected future state once all moves are completed.

A short summary of the key elements from the bed modelling are provided in the sub-sections below.

5.7.2 Bed Capacity/ Availability

Separate to the FTF programme there have been a number of developments at GHNHSFT (see Appendix 7), affecting the numbers of beds (i.e. capacity), these include the impact of:

- Strategic Site Development
- An increase in Assessment Units
- Other operational changes

5.7.2.1 GHNHSFT Strategic Site Development (SSD) Programme

As part of the Trust's strategic site development (SSD) programme changes at GRH include the extension of the Same Day Emergency Care (SDEC) area, which provides an improved same day emergency care provision, the extension of the Acute Medical Assessment Unit, which will increase the bed space by 16 beds and enable the centralisation of acute medicine at GRH along with improved Mental Health provision and the conversion of non-clinical space within Gallery Wing to create a new 24-bed ward.

5.7.2.2 Assessment Units

A significant factor affecting both bed demand and capacity is the increasing move towards provision of Assessment Units. These units all have a similar function, providing timely care for patients with a fast-track through to the specialist team and quicker treatment. They all reduce attendances to ED and will work more closely with GPs and paramedics using Cinapsis to bypass ED, where clinically appropriate.

Our plans are to extend and expand the use of Assessment Units and the details, including context, performance and proposals, for each are provided in Appendix 7 and include:

- **GRH:** Surgical Assessment Unit (SAU) and Vascular Assessment Unit (VAU)
- **GRH:** Frailty Assessment Service /Unit (FAS/FAU)
- **GRH:** Gynaecology Assessment Unit (GAU)

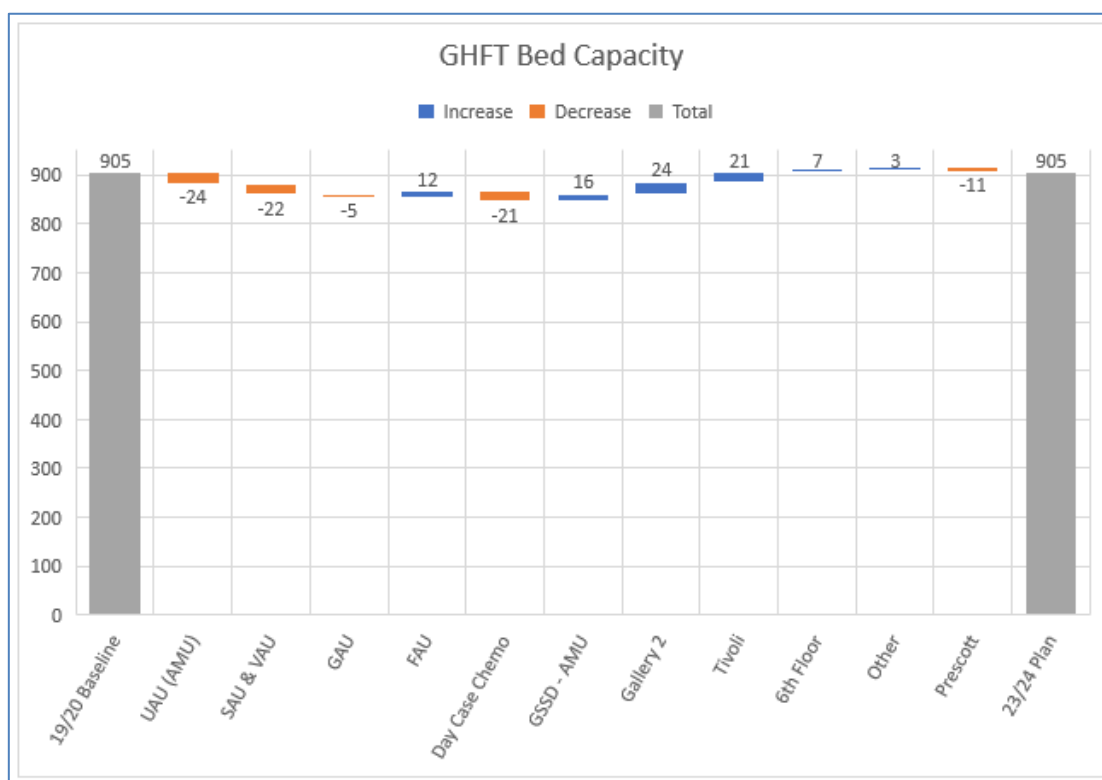
- **CGH:** Urology Assessment Unit (UAU)

5.7.2.3 Operational Changes

These include:

- **CGH:** Day Case Chemotherapy - provision of Systemic Anti-Cancer Therapy (SACT)
- **GRH:** 6th Floor Developments
- **CGH:** Hazelton/Tivoli Ward
- **CGH:** Prescott from 35 to 24 beds. The use of the ward is currently being reviewed (a process which is not part of FFTF).
- **GRH & CGH:** There are a small number of bed reductions due to either IPC, patient experience or previous unfunded escalation capacity that have been removed from the bed capacity stock modelled.

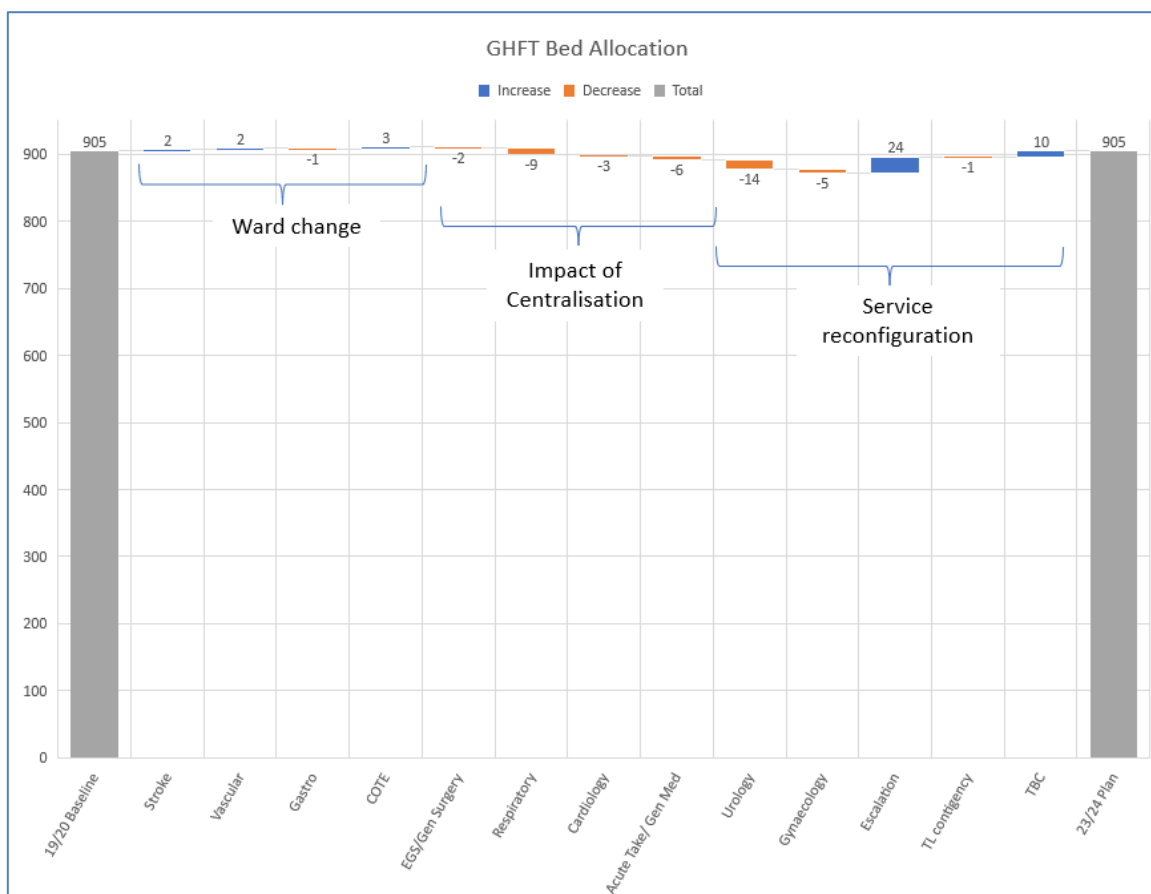
The overall impact of the above changes on bed capacity for the Trust as a whole is presented in the below.



5.7.3 Bed Demand Impacts and Capacity Allocations

Once the bed capacity has been determined, the bed modelling process then seeks to allocate the available capacity to the individual services/ specialities to ensure that the FFTF proposals can be accommodated on the two sites. This process takes account of the previous/ current demand and factors in any changes such as:

- FFTF1 & 2 Centralisation impacts – including efficiency improvements that result in a reduction in beds required e.g. reduced length of stay.
- Service reconfigurations – a change in the way services are operated.
- Ward changes - A small number of bed changes result from the allocation of different services to different wards.



It should be noted that Stroke and Vascular were already centralised prior to being relocated as part of FFTF.

5.7.4 Department of Critical Care (DCC)

5.7.4.1 Background

Implementing service change proposals in Phase 1 and Phase 2 of FFTF has an impact on the capacity requirements of the Trust’s two DCC units, particularly the timing of the centralisation of acute medical take to GRH, planned for September 2023 when the GSSD new build is completed. Overall, there will be a shift in DCC activity from CGH to GRH.

As with acute bed modelling (section 5.7.1), the past 36 months (since March 2020), has seen a significant change in the demand distribution and commensurate use of DCC beds on both GRH and CGH, due to both COVID patients and reductions in elective activity. This makes DCC modelling complex, so to take account of these exceptional circumstances we have used a range of information and data to inform our DCC demand and capacity modelling.

A full refresh of the DCC bed model has been undertaken for the years 2018-2021, split by specialty capturing the daily average (from the 4 hourly census), patient activity, new admissions and bed days per admission. This is used to calculate an average bed demand per specialty per month.

The detailed paper outlining the work the DCC, Divisional, Business Intelligence and FFTF Programme teams have undertaken to model the impact of all the proposed changes, identify the scale of the capacity challenge and describe and appraise a range of mitigations can be found in Appendix 8.

A brief summary of the mitigations and impact is presented overleaf.

5.7.4.2 GRH DCC Potential Mitigations

Transfer from DCC at GRH to DCC at CGH of patients who are likely to stay on DCC for two weeks or above.

This is undertaken for clinical reasons; the CGH DCC is less busy and able to offer a better patient experience and access to rehabilitation. The clinical team has established a consultant led retrieval service, which is able to provide a transfer service with very low risk of harm. This process is already in place but could be expanded. The number of additional patients who could be effectively transferred would be 3 a month (as assessed by clinical teams) these patients would stay an average of 10 days each. Giving a monthly mitigation of one bed GRH. This initiative has already been started and is reflected in some of recent modelling. However, there may be capacity to increase this if services are able to continue their review at the CGH site. There is an estimation that to extend this model might gain 0.5 of a bed at GRH.

Respiratory High Care

The creation of a dedicated High care Unit within the respiratory wards will decrease the number of patients into DCC. The BI team have produced a report showing GRH DCC Admissions 01/01/2017 to 31/01/2020 with Primary or Secondary Reason for Admission System = Respiratory showing:

- Advanced Respiratory Days = Number of days receiving advanced respiratory care i.e., mechanical ventilation; and
- Basic Respiratory Days = Number of days receiving basic respiratory care i.e., CPAP, Non-Invasive Ventilation (NIV), NHFO etc

From this report it has been calculated that 990 bed days on DCC for patients who received NIV alone in a 3-year period would be saved. An average of 330 bed days a year, one bed if spread out over the year. This could be higher as the calculations do not include the time on NIV for patients who were also ventilated but these numbers are smaller.

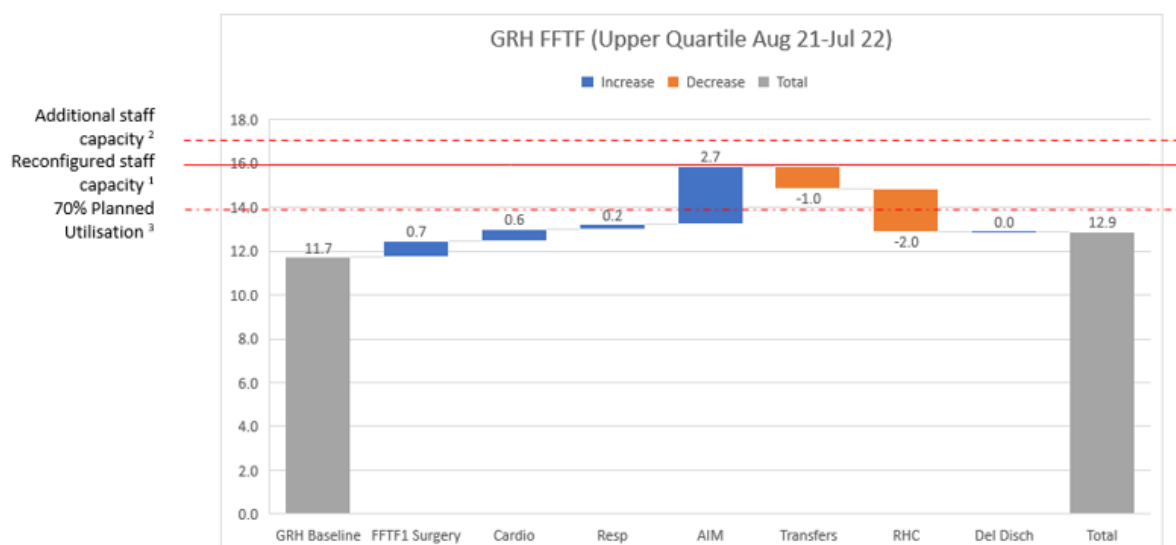
Respiratory patients are more likely to be unwell during the winter months. Although the numbers have been averaged over a year, the greatest impact on DCC at GRH will be in the winter; which is when the demand is highest and therefore this option would be highly effective; numbers range from 0-7 patients. A very effective temporary Respiratory High Care was set up for COVID patients. However, the patients for whom the new service is designed were not included in the trial and so would give greater DCC capacity.

Reduce delayed discharges

Analysis shows that on average roughly 2 beds are taken up by patients that shouldn't be in DCC. This increases to 3 beds during peak hours (10-5). However, it should be noted that this is a long-term issue resulting in the difficulty of discharging patients from hospital who although medically fit have further social and care needs, resulting in the inability to discharge patients from DCC to the ward. Work would be required across the integrated healthcare sector to reduce the number of patients without criteria to reside before any impact on DCC could be anticipated; **this has therefore not been included as a mitigation.** Other mitigations are included in Appendix 8.

An extract of the analysis presented in Appendix 8 representing the current best estimate of activity and mitigations is presented overleaf. A key set of performance metrics have been agreed and will be monitored by the Cross Division Task and Finish Group (see section 15.3.1).

Mitigated demand at GRH using upper quartile activity for all services (including baseline) combined (excluding delayed discharge mitigation)



#1: Reconfigured staff capacity excl. contingency staffing #2: Additional staff capacity excl. contingency staffing
 #3: DCC planning preference is for 70% planned bed utilisation. Note: activity presented includes both planned and unplanned

As stated in the FFTF1 DMBC this will be a key stop / go decision point for the implementation programme to confirm at the point that the Acute Take is scheduled to centralise.

Key Points

- The South West Clinical Senate panel observed that the proposals would deliver some clear benefits for patients, had good clinical leadership, that they had been well thought through and appraised, and that there were clear plans for implementation.
- The FFTF programme has developed an inclusive and transparent options appraisal process
- The crucial role of our staff is highlighted and our plans for staff engagement and support through change are presented along with the anticipated benefits of these proposals for recruitment and retention.
- The impact of our proposals on Inter-site ambulance transfers are understood and plans in place to manage and mitigate.
- A comprehensive bed demand and capacity modelling process has been undertaken to support these proposals.

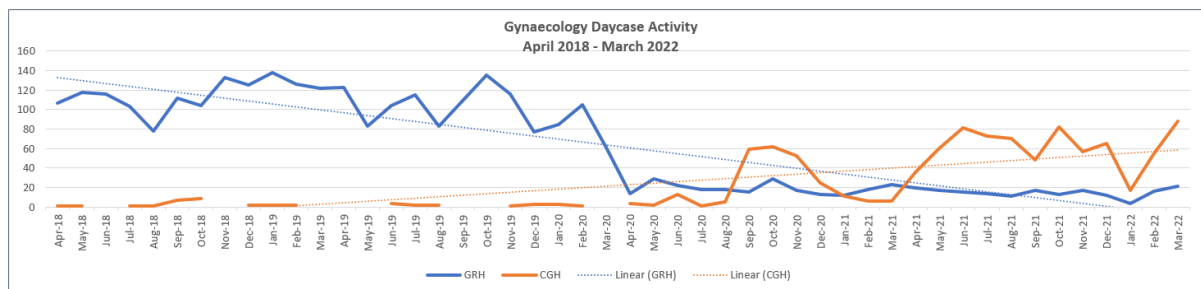
6 Benign Gynaecology

6.1 The 'current state' service model

It should be noted that the "current" service model is a result of temporary service changes and reflects proposals for the future configuration of services as opposed to the pre-COVID configuration which is the "no change".

Until the beginning of 2020, the majority of Gynaecology Day case operations were carried out at Gloucestershire Royal Hospital (GRH). However, during the COVID pandemic, the proportion of Gynaecology Day case surgeries carried out at Cheltenham General Hospital (CGH) significantly increased to facilitate our response to the pandemic.

The graph below evidences this shift¹⁷ and hence our decision to include the service in our FTF2 programme.



Outpatient appointments are provided at both acute hospital sites (Cheltenham and Gloucester), in the community and virtually when appropriate.

6.2 Activity

For the period Oct 2020 – Sept 2021 there were a total of 1143 Benign Gynaecology elective patients of which 512 were Day cases; of these 468 (90%) attended CGH and 44 (10%) at GRH.

6.3 Clinical Engagement

The clinical and operational teams were involved in the relocation of day cases to CGH during the pandemic and the discussions regarding the future proportions of activity to be undertaken at each site. The gynaecology team participated in the public, staff and patient engagement and the options appraisal process in July 2022.

6.4 Case for change: the problem we are seeking to address

When Benign Gynaecology Day case surgery was predominantly delivered at GRH there could be bed availability issues at times due to high numbers of emergency patients, resulting in patient cancellation because the day unit was required for emergency inpatients. As Benign Gynaecological day case surgery is not classed as urgent or related to cancer, the risk of cancellation is relatively high. Although the vast majority of this work may not be classed as clinically urgent; for many of the patients the symptoms experienced are unpleasant and affect the quality of their lives.

¹⁷ During 2020/21 129 day-cases were undertaken at either the Nuffield or Winfield Hospitals, this was a temporary arrangement to enable surgery to continue during the worst of the COVID 19 pandemic

Whilst a transfer of these cases to CGH does not guarantee that cancellation is avoided (there are still bed pressures when demand is extremely high) there is evidence of a significant lower level (a reduction of up to 50%) of cancellation.

This move would also align with the Centre of Excellence strategy for CGH to become the centre for Elective work. As part of Gloucestershire Strategic Site Development (GSSD) at CGH GHNHSFT are developing two new theatres and a new ring-fenced Chedworth Day Surgery Unit. The Day Surgery Unit is expected to be completed by April 2023 and the two new theatres by October 2023, subject to construction timelines.

In summary the new unit will provide:

- A waiting area and reception
- 27 individual pre-operative pods to prepare patients for surgery (they are designed so that the doors can accommodate a trolley if necessary but not a bed- thus ensuring that the unit cannot be affected by bed pressures)
- A treatment room used initially for pain procedures and Lithotripsy but with the ability to extend this.
- A fifteen bedded post operative area for day surgery patients
- A discharge lounge.

This cohort of Benign Gynaecology patients would greatly benefit from this environment which offers individual cubicles, providing privacy and dignity and, due to the design, are ring-fenced for elective surgery.







6.5 Clinical Evidence

This type of surgery can safely be undertaken at either site as both CGH and GRH have all the support services that are required. It is for operational capacity/ efficiency and patient experience benefits that the proposed change is being undertaken.

6.6 How was preferred option evaluated?

The Gynaecology Service developed a list of options with support from the FFTF Programme Team. Given the nature of the service and proposals, there were only two options, deliver the service at GRH only or the current proposal; to maintain the majority of Benign Gynaecology Day Cases at CGH. As described in section 5.2, the next step was the application of the FFTF desirable criteria. As previously described, due to the ongoing system pressures, rising COVID and the heatwave in mid-July (when events had been booked 10 weeks in advance for clinical colleagues), GHNHSFT declared a Business Continuity Incident (BCI) on the day of one of the workshops. Given the notice requirements for clinical staff and the deadline for clinical senate submission, in agreement with NHSE, we have reverted to using the on-line responses from scorers and these have been reviewed and summarised by the FFTF Programme Director for inclusion in this section.

The solutions appraisal exercise was designed to evaluate proposed changes compared with the status quo. Given that the changes outlined above are already in place, the proposed change evaluated in this case was **reverting back** to the original configurations, i.e., reversing the current temporary service change.

Revert Benign Gynaecology Day Cases from the majority at CGH back to all at GRH		
Quality	Scores	Similar to slightly worse than status quo 
	Comments	<ul style="list-style-type: none"> If care reverts back to GRH there is a higher chance that you will have a mix of patients on a ward due to urgent care pressures and this may impact on the quality of care for patients. New day surgery unit is completed and open, there will be a better patient experience in terms of the environment and the impact that has on privacy and dignity.
Access	Scores	Similar to slightly worse than status quo 
	Comments	<ul style="list-style-type: none"> 17% of patients are negatively affected but this is for a single day as day-case. Option for some patients in East to continue to be treated at GRH. If service moves back to GRH there is a higher likelihood of cancellation therefore increasing waiting times for the patients. Less cancellations = more capacity
Workforce	Scores	Similar to slightly worse than status quo 
	Comments	<ul style="list-style-type: none"> No difference as status quo but new DSU will improve working environment. A dedicated unit should aid recruitment and training. Potential for GRH urgent care pressures to impact on availability of trainers. Resources used are the same for the same activity Now that staff are settled in CGH moving back to GRH will be more disruptive.
Deliverability	Scores	Similar to significantly worse than status quo 
	Comments	<ul style="list-style-type: none"> Change has been made so resource would be required to re-schedule all activity back to GRH Better to stay at CGH and use the new day unit than to be shoehorned back into an already crowded GRH.
Strategic Fit	Scores	Similar to slightly worse than status quo 
	Comments	<ul style="list-style-type: none"> reverting elective activity to GRH is not aligned with CoEx strategy. New DSU will improve environment for patients. Public will soon accept the distinction between the 2 main hospitals CGH = Planned & GRH = Emergency
Acceptability	Scores	Slightly worse than status quo 
	Comments	<ul style="list-style-type: none"> 95% of respondents support the proposals. This includes staff

Based on the above assessment, the preferred option is to maintain the majority of Benign Gynaecology Day Cases at CGH.

There is minimal impact on pathways. Referral into the service would stay the same and the out-patient clinic appointments will continue at the same venues that they have always been.

The only change is the hospital site, with patients discharged the same day. If follow up clinics or therapy is required post operatively, this can be carried out at a site closest to the patient's home, this would not change because the site for surgery has changed. It is not the intention to bring all day-case gynaecology to CGH; a smaller number will remain at GRH to offer choice and to achieve maximum theatre list efficiency. A small number of day-cases are also undertaken at Stroud Hospital, there are no plans to change this.

There will be no change to outpatient clinic provision which will continue to be provided at both Acute Trust and Community Hospital sites.

6.7 How does this address the case for change?

Reason for change	How preferred option addresses this
Reduction in cancelations	Since moving the majority of Day Cases to CGH the cancelation rate has fallen by half (Oct 2020 to Sept 2021 @2.46% compared with Feb 2019 to Jan 2020 @4.75%)
Improved Patient experience	Chedworth Day Surgery Unit is expected to be completed by April 2023, providing individual pre-operative pods, which provide privacy and dignity for patients as they prepare for surgery, and a post operative bedded area.

6.8 Benefits including clinical outcomes

Potential Benefits

- Although initially a short-term COVID enabling move, the relocation to CGH has been beneficial as there are significant bed pressures on the GRH site. In addition, with fewer cancellations this proposal will provide better care for patients and enable quicker elective recovery post COVID.
- Fewer patient cancellations because the new day case unit at CGH would be dedicated to planned surgery and would not be used for emergency inpatients
- Access to the new Surgical Admissions and day case unit at CGH once complete in April 2023. The innovative unit will have individual rooms to prepare for surgery providing high levels of privacy and dignity for patients
- Individual rooms are beneficial to those with disabilities and special needs as well as carers who are so essential to the care of those with dementia and learning disabilities
- It would allow a higher number of operations to take place and would enable women/people with Gynaecological conditions, that may have gone undiagnosed to undergo surgery sooner, allowing for quicker post pandemic recovery for the service
- This change would fit with the strategic vision for Centres of Excellence with a greater focus on planned care (non-emergency services) at CGH
- Whilst a transfer of these cases to CGH does not guarantee that cancellation is avoided (there are still bed pressures when demand is extremely high) there is a significant lower level of cancellation (reduced by half).

Potential drawbacks

- 18% of patients would have longer to travel¹⁸ to CGH for day case surgery. Those affected would only need to make the extended journey on one occasion - on the day of surgery.
- This potential inconvenience for some patients should be considered alongside the potential reduction in rates of cancellation which could represent a greater stress and inconvenience to patients

6.9 Interdependencies

There are no specific interdependencies (over and above Business as Usual), related to the location of this service at CGH.

6.10 Workforce

There are no plans/ requirements to change the clinical or operational staffing as a result of these proposals.

6.11 “Blue light” ambulance travel impact

These proposals relate to Day cases and therefore there is no “Blue light” ambulance travel impact

6.12 Learning from Temporary Service Change Period

This Benign Gynaecology Day case proposal has been influenced as a result of temporary service changes made in response to the pandemic, and this provided the opportunity to test and trial service configurations before deciding formally to consider them as permanent change proposals.

6.13 South West Clinical Senate Review

The clinical panel made the following comments:

- The Panel supported the proposals for benign gynaecology services.
- The Panel noted that in many Trusts Advanced Nurse (Clinical) Practitioners (ANP/ACP) and Nurse Consultants now carry out much of the ambulatory care in gynaecology, including hysteroscopy, cystoscopy, and colposcopy and recommended that Gloucestershire explores these working practices to assist with capacity and workforce issues. Please see section 5.4.4.1 for details of the development of ACPs.

For completeness our responses to the Senate Desk-top review report are included in Appendix 17.

6.14 Engagement feedback

As described in section 4 we have undertaken an extensive public and staff engagement programme

6.14.1 Quantitative Survey responses

The proposal we engaged on was to continue to deliver the majority of Benign Gynaecology Day case surgery at Cheltenham General Hospital.

¹⁸ Details of the methodology can be found in section 11.5

- **92%** of *all* respondents either **strongly supported** or **supported** the idea
- **96%** of *staff* respondents either **strongly supported** or **supported** the idea

Respondent type and proportion (%)		Strong support	Support	Oppose	Total Support
Not stated	28%	45%	39%	16%	84%
A community partner	4%	50%	50%	0%	100%
A member of the public	37%	39%	56%	5%	95%
An employee working in health or social care	27%	33%	63%	4%	96%
Prefer not to say	5%	50%	33%	17%	83%
Grand Total	100%	40%	52%	8%	92%

Survey respondents were also asked to provide us with the rationale for their response and what information they would like us to consider. A summary of the key themes and some example comments (from staff and the public) are presented below, with our response in section 6.15.

6.14.2 Qualitative Responses - Public and Patient themes

Theme	Survey comment examples
Reduced cancellations	<ul style="list-style-type: none"> • It releases women from worry over a long period of time. • Fewer cancellations and shorter waiting
New Day Case unit at CGH	<ul style="list-style-type: none"> • The day case unit at CGH will be good for this, and having it at a site where there is less likely to be cancellations is good • Privacy and lack of fear of constant cancellation are far more important than the inconvenience of a longer journey • Individual rooms especially for those with disabilities etc.
Centres of Excellence	<ul style="list-style-type: none"> • If the intention is to make Cheltenham the main day-case site, then it would seem an appropriate to relocate this service to Cheltenham. • The case makes sense • Excellent plan benefits outweigh drawbacks
Travel	<ul style="list-style-type: none"> • Useful to centralise system but transport will always be a problem if you expect day cases to arrive by 7.30am • I find it incredibly difficult to get to Cheltenham general and I am fit and well with my own transport. GRH is far easier to get to it's all about not having the choice
Patient experience	<ul style="list-style-type: none"> • Women need to feel they are being seen speedily, by a professional who will listen and expedite treatment, in the near future. • Expertise in one place. Better services. Better access to services.

6.14.3 Qualitative Responses - Staff themes

Theme	Survey comment examples
Clinical considerations	<ul style="list-style-type: none"> Sensible if the procedure is minor and doesn't involve complications, consideration needs to be given to more complex patients with additional needs, who may require inpatient care. minor surgery suitable for CGH For day case procedures not expecting overnight stays, I feel this appropriate
New Day Case unit at CGH	<ul style="list-style-type: none"> Exciting to be having treatment in the new Day unit being built in CGH rather than the very tired unit in GRH
Reduced cancellations	<ul style="list-style-type: none"> Reductions in cancellations are a necessity Get operations done when no beds Sounds like a robust plan to consolidate services on a single site and reduce the impact of bed availability on cancellations
Car Parking	<ul style="list-style-type: none"> More car parking for our patients is needed

6.15 Addressing themes from engagement feedback

Feedback received and FTF2 response
New Day Case unit at CGH
It is welcomed that both staff and the public see the benefits from undertaking Benign Gynaecology Day cases at the new Chedworth Day Surgery Unit (opening April 2023)
Reduced cancellations
The negative impact of cancellations on this cohort of patients is recognised by both staff and the public and the positive impact that the reduction in cancellations will have if these proposals are confirmed.
Travel
The negative impact of increased travel, particularly for patients travelling from the Forest of Dean to CGH is clearly recognised. Analysis has indicated that ~ 18% of patients will be negatively impacted, with 82% neutral or positive. For this cohort the impact is only for one day and as it is not the intention to bring all day-case gynaecology to CGH, a smaller number will remain at GRH to offer choice based on circumstances. Finally, if follow up clinics or therapy is required post operatively, this can be carried out at a site closest to the patient's home.

Key Points

- This service change proposal delivers the case for change through reductions in cancellations and improved patient experience.**
- The new Chedworth Day Case unit has individual pre-operative pods, which provide privacy and dignity for patients as they prepare for surgery.**
- This service change proposal is supported by the Clinical Senate**
- This service change proposal is supported by respondents to our engagement**
- This proposal is currently implemented as a temporary service change**

7 Diabetes and Endocrinology

7.1 The 'current state' service model

It should be noted that the "current" service model is a result of temporary service changes and reflects proposals for the future configuration of services as opposed to the pre-COVID configuration which is the "no change".

The Diabetes and Endocrinology (D&E) Service provides outpatient and inpatient services for the population of Gloucestershire at both Gloucestershire Royal Hospital (GRH) and Cheltenham General Hospital (CGH). In addition, the service provides non-Covid related clinics for Diabetes patients at The Vale, North Cotswold and The Dilke community hospitals, with D&E clinics being held at Tewkesbury and Cirencester community hospitals.

There are a small number of diabetes and endocrinology patients admitted directly to the specialty beds, primarily for management following an acute diabetic or endocrine episode. Most of the inpatients cared for by the D&E Service are General Medicine patients. Whilst up to 20% (National Diabetes Inpatient data) of the Trusts inpatients are estimated to have diabetes, this is usually not the primary reason for patients to be admitted. These patients may not necessarily need to be on a specialist diabetes and endocrinology ward, but they may need clinical support from the D&E service.

The current service includes:

- Inpatient beds: 14 dedicated inpatient beds on Ward 9B at GRH for patients admitted via AMU.
- At CGH, the service is currently providing support to other hospital in-patients who happen to have diabetes.
- Outpatient services: General diabetes, insulin pumps, joint Renal clinics, general Endocrine, joint pituitary/neurosurgery, young adult diabetes, diabetes- podiatry clinics, antenatal clinics, lipid services

The service has 4.8 WTE consultants working across both sites. The service currently has 1.77 Band 6 WTE inpatient specialist nurses and 2.0 Band 5 WTE inpatient nurses.

The current inpatient pathway within the service for both sites is summarised below and can be found in Appendix 9:

- Patient presents at ED
- Patient admitted either direct to ward or for medical assessment (AMU or ACUC)
- Patient referred to D&E team for triage and admitted to ward (if not already) under care of D&E

Before the COVID pandemic, there were 26 beds across both GRH (14 beds) and CGH (12 beds). However, these beds were also used for General Medicine patients. It is estimated that the service requires 14 - 18 dedicated Diabetes and Endocrinology beds, with the remaining beds being used by General Medicine patients who are supported by the Diabetes and Endocrinology Team.

We have a traffic light system to prioritise admissions to the D&E ward. The highest priority would be a patient who is admitted with the diabetic or endocrine emergency; the next priority would be a patient who has a general medical problem but also has diabetes that might be slightly complex. Then a patient who has a general medical problem or straightforward diabetes condition and finally, a general medical patient who doesn't have diabetes or endocrine problems.

7.2 Activity

The total number of admissions for the service between February 2019 and January 2020 were 786 patients, with 45% of patients (357 patients) being admitted to CGH and 55% of patients (429 patients) being admitted to GRH.

7.3 Clinical Engagement

In order to develop the medium list of options for the service, a hurdle criteria workshop was held with clinical colleagues within the Diabetes and Endocrinology service and also clinical colleagues from services who work closely with Diabetes and Endocrinology. The workshop provided clinical staff members an opportunity to discuss the long list of options and decide on the medium list to take out to public and staff engagement. Furthermore, the medium list of options was shared at the Medicine Divisional Board for approval and sign off.

In addition to the hurdle criteria workshop, regular updates are provided to the Diabetes and Endocrinology Clinical Programme Group on the progress of the business case, including the options taken forward for public and staff engagement.

7.4 Case for change: the problem we are seeking to address

There is a small specialist team for diabetes and endocrine services, spread across multiple sites which has an impact on service delivery including:

- Disruption to services, caused by staff absence and sickness with staff spread too thinly across both sites.
- Increasing difficulties in providing:
 - Specialist diabetes and endocrinology inpatient service on both sites
 - A quick response to referrals from other departments within one (1) working day which delays patients transition into diabetes and endocrinology services; causing patients to stay in hospital for longer than they need to.
 - Regular daily visits to admission wards on both sites as well as Renal and Vascular wards who both receive a number of Diabetic and Endocrine patients.
 - Timely support to Emergency Departments

COVID has created additional pressure on Diabetes and Endocrinology services. It has aggravated pre-existing diabetes in some patients and has also triggered diabetes for some patients as a result of the virus or its treatment.

The Getting It Right First Time (GIRFT) report, which is a national programme designed to improve the treatment and care of patients through in-depth reviews of services, identified staffing levels as an issue for the D&E service in GHFT. This was particularly around providing In-patient diabetic nurses 7 days a week.

In order to address this, the service is in the process of establishing a dedicated Diabetic Inpatient Nurse Team for patients with a secondary diagnosis of Diabetes. This team will work across both sites and will provide additional support. The dedicated Diabetic Inpatient Nurse Team at GRH will assist the service in addressing the recommended action, as per the 2019 GIRFT report.

The main aim is to ensure that patients from across our county experience diabetic and endocrine services that are comparable to those areas at the leading edge of care, treatment, and outcomes.

7.5 Clinical Evidence

Studies suggest that type 1 and type 2 diabetes inpatients who are cared for by specialist diabetes nurses are likely to have a reduced length of stay, compared to patients who are cared for by general health care professionals (SIGN (2017) Management of diabetes: a national clinical guideline. SIGN 116.) Therefore, by consolidating the service at GRH, this would facilitate the service's ability to prioritise type 1 and type 2 diabetic patients who are cared for under other specialties but who will also require specialist diabetes nursing input. National evidence (Lancet, NHS England and Diabetes UK) has shown that COVID infection, in people with or without previously recognised diabetes, increases the risk of the emergency states of hyperglycaemia with ketones, Diabetic KetoAcidosis (DKA) and Hyperosmolar Hyperglycaemic State (HHS). Nationally, emergency admissions for DKA were 6% higher in the first wave of the pandemic compared to previous years and 7% higher in the second wave of the pandemic compared to previous years.

During COVID the Diabetes and Endocrinology service experienced an increase in ward referrals. In January 2021 there were 181 ward referrals for diabetic and endocrine patients, the majority of which were related to COVID and the use of Dexamethasone (a drug used for the treatment of severe cases of COVID and other serious infections).

Furthermore, recent research from a London NHS Trust suggested that 12% individuals (all who had type 2 diabetes and 4 of 5 who had COVID) died during their admission with DKA, compared with 2.3% pre-pandemic. Those who died had significant comorbidities or multiorgan failure at admission and were not deemed appropriate for intensive care or ventilatory support (American Diabetes Association). Thus, reflecting the importance of the Diabetes and Endocrinology service being able to support the management of patients admitted with COVID or who are recovering from COVID.

Therefore, by consolidating the service at GRH it will enable the service to support the management of patients admitted to GRH with COVID and patients recovering from COVID, through the centralisation of a dedicated diabetic and endocrine bed base at GRH, which is aligned to the Trusts policy of utilising GRH as the 'red site' for COVID patients.

In September 2019 the National Diabetes Inpatient Audit (NaDIA) was conducted in acute hospitals across England. NaDIA 2019 was a repeat of the 2010 to 2013 and 2015 to 2017 annual audits. There was no 2014 audit and NaDIA 2018 covered the hospital characteristics only.

In 2019 NADIA data reflected that GHNHSFT were in:

- The lowest quartile for average diabetes specialist nursing hours per patient.
- The second lowest quartile for average diabetes consultant hours per week per patient.
- The highest quartile for percentage of emergency admissions.
- The highest quartile for Medication, Prescription and Insulin errors.

The above NADIA data for GHNHSFT highlights areas for inpatient care which could be improved through the consolidation of the service's staff onto one site.

The Diabetes is Serious Report released in April 2022 suggests that:

- People in most deprived areas of Gloucestershire struggle the most with managing their condition (55% of patients in the most deprived areas and 37% of patients in the least deprived areas)

- Almost one third of inpatients across England with diabetes have a medication error during their hospital stay, due to lack of knowledge around diabetes from other non-specialist colleagues (NaDIA 2019).

The recommendation from the report is for ICSs to continue to invest in and support the development of specialist inpatient teams so that all hospitals can ensure minimum standards of care and people with diabetes are safe in hospital.

In respect of NICE guidance our proposals deliver the following:

- Service providers (hospitals) ensure that adults with type 1 diabetes in hospital receive advice from a multidisciplinary team with expertise in diabetes.
- Healthcare professionals (members of the multidisciplinary team) ensure that they provide advice to adults with type 1 diabetes who are in hospital and enable them to continue to administer their own insulin if they are willing and able and it is safe for them to do so.
- Adults with type 1 diabetes who go into hospital if they are ill or need an operation get advice from a team of specialists in diabetes, who will respect their expertise in managing their own diabetes. They are supported to carry on injecting their own insulin if they want to and can do so safely, although sometimes intravenous insulin will be needed instead (for example, if they cannot eat or are having an operation that affects blood glucose levels).

7.6 How was preferred option evaluated?


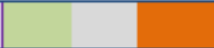




Hurdle criteria have been applied to the a long-list¹⁹ with representation from Diabetes and Endocrinology, Inpatient Therapy, Pharmacy, the wider Medical Division and Vascular to assess a long list of options for the service and to better understand clinical adjacencies.

This session provided a recommended medium list of options including Option 1a – Current Service Model Split Site D&E and Gen Med Cover, Option 2a – Consolidation of IP beds to GRH, D&E and Gen Med Cover and also Option 2b – Consolidation of IP beds to GRH with no Gen Med Cover. However, Option 2b was ruled out by the medical division as it would not be feasible to remove General Medical cover. Therefore, it was agreed that Option 1a and Option 2a would be worked up for public engagement.

As described in section 5.2, the next step was the application of the FFTF desirable criteria.

¹⁹ The long-list and hurdle assessment can be found in Appendix 9

The solutions appraisal exercise was designed to evaluate proposed changes compared with the status quo. Given that the changes outlined above are already in place, the proposed change evaluated in this case was **reverting back** to the original configurations, i.e., reversing the current temporary service change.

Revert the dedicated Diabetes and Endocrinology Inpatient Beds from a centralised model at GRH to a split site model at GRH and CGH		
Quality	Scores	Worse than status quo 
	Comments	<ul style="list-style-type: none"> • Co-location better for providing the service • Always a consultant at CGH to support inpatient referrals. • Single site improves continuity of care, plus teaching. • Diabetes work with a large number of teams. Broadly makes sense to have IP in the larger of the two hospitals. • Having more D&E on one site would support the emergency care pathway. • Single site supports better training opportunities and safer working environment with better staff cover.
Access	Scores	Broadly similar to status quo 
	Comments	<ul style="list-style-type: none"> • Looking at health inequalities - greater proportion of people with diabetes in Gloucester and the West of county. • Approx. 10% negative travel impact. • Making sure that barriers are removed for people impacted by travel - this is a system responsibility.
Workforce	Scores	Significantly worse than status quo 
	Comments	<ul style="list-style-type: none"> • Staff survey results - current model working well. • Better for staff recruitment, especially specialist staff. • Dedicated IP service is sustainable, means IP team better able to support other specialties. • Flexibility greater on one ward. • Supports further innovative models in areas of professional practice.
Deliverability	Scores	Significantly worse than status quo 
	Comments	<ul style="list-style-type: none"> • Changes already happened. • As renal and vascular ward at GRH this will be better for centralisation.
Strategic Fit	Scores	Slightly worse than status quo 
	Comments	<ul style="list-style-type: none"> • slightly worse as not supporting Centres of Excellence strategy
Acceptability	Scores	Slightly worse than status quo 
	Comments	<ul style="list-style-type: none"> • 98% of respondents support the proposals. • Important to have a very positive comms plan and also be willing to support those who may have negative consequences.

Based on the above assessment, the preferred option is to maintain the current consolidation of dedicated the Diabetes and Endocrinology Inpatient beds at GRH with a consult service at CGH.

There will continue to be a choice of outpatient appointments at both acute hospital sites, in the community and virtually when appropriate.

7.7 How does this address the case for change?

Reason for change	How preferred option addresses this
Disruption to services, caused by staff absence and sickness	Consolidating the Diabetic and Endocrinology Service’s inpatient bed base to Ward 9B at GRH will enable the service to provide a more resilient staffing model. Also support the retention and in-house development of specialist Nursing staff, better for specialist SPR training and also Nurse training, and facilitate better consultant job planning.
Provide a response to referrals from other departments within one (1) working day	Consolidating the Diabetic and Endocrinology Service’s inpatient bed base to Ward 9B at GRH will enable a consultant to cover inpatient work at GRH (currently 1-2 consultants at GRH + 1 consultant at CGH), which would allow the additional consultant to prioritise inpatient referrals from other wards. The consultant based at CGH would be able to prioritise inpatient referrals to support the 1 working day e-referral target, as opposed to waiting to see these patients post ward round and afternoon clinics. This would allow for a proactive service for patients, as opposed to the current reactive service.
Provide regular daily visits to admission wards on both sites as well as Renal and Vascular wards	Consolidating the Diabetic and Endocrinology Service’s inpatient bed base to Ward 9B at GRH will provide increased Consultant capacity
Timely support to Emergency Departments	Consolidating the Diabetic and Endocrinology Service’s inpatient bed base to Ward 9B at GRH will provide increased Consultant capacity. Potential for acute medicine SDEC in-reach service, would be better able to cover ED/SDEC, if centralised at GRH.

7.8 Benefits including clinical outcomes

<p>Potential Benefits</p> <ul style="list-style-type: none"> • Minimising the disruption to services caused by staff absence and sickness • Ensuring safe and consistent staffing levels, including senior doctors - 24 hours a day - leading to safer care and shorter hospital stays • More specialists in one place resulting in timely assessment and decision making from senior professionals when patients arrive at hospital - leading to prompt diagnosis, treatment and timely recovery • Diabetes and Endocrine consultants would be better able to coordinate inpatient work on the improved specialist ward

- Consultants would be better able to prioritise inpatient referrals from other wards and support a timely response to inpatients from other specialties (service areas) within one (1) working day. This in turn would help patients to leave hospital sooner after care
- Supporting joint working between care professionals; including links to related wards, facilities and equipment to avoid the need for multiple visits and hospital stays
- Creating better training and learning opportunities for nurses - the majority of consultants would be on one site to help develop their skills and knowledge in this area. Improving the service's ability to develop their own Diabetes and Endocrine nurses in-house could limit future shortages of specialist nurses. Studies suggest that type 1 and type 2 diabetes inpatients who are cared for by specialist diabetes nurses are likely to have a reduced length of stay in hospital, compared to patients who are cared for by general health care professionals.

Potential drawbacks

- The proposal would increase travel times for some patients and relatives/carers in the east of the county who previously would have travelled to CGH for inpatient care and now need to attend GRH.
- The overall impact is <10% of diabetes and endocrinology patients²⁰, families and carers are negatively affected by centralising at GRH

7.9 Interdependencies

Diabetic and Endocrinology Services has links with the Vascular Services, Complex Foot Clinics and Obstetrics – Gestational Diabetes.

It is not anticipated that the clinical links with Vascular, Renal, Neurosurgery or Complex Foot Clinics will be adversely impacted by these proposals vascular inpatients services are at GRH and Complex Foot Clinics are outpatient based, which will remain unchanged under this proposal.

For Obstetrics Gestational Diabetes, inpatients high risk clinics are already held at GRH where the Women's Centre is located. The Gestational Diabetes education groups at CGH will continue and remain unchanged.

It is not anticipated that either proposal will have a negative impact upon Imaging services as all services are provided on both sites. In addition, it is not anticipated that there will be significant impacts for Oncology or Therapy Services.

7.10 Workforce

There are no plans/ requirements to change the clinical or operational staffing as a result of these proposals.

The staff benefits of the preferred option are listed in section above and include better in-house training provision for specialist nurses, workload efficiencies would support consultants to prioritise inpatient referrals from other wards and help the service to make the best use of the staffing resource it currently has.

²⁰ Details of the methodology can be found in section 11.5

The services nursing staff have previously been required to work cross site, which will remain unchanged.

7.11 “Blue light” ambulance travel impact

As with FFTF1, the FFTF programme has worked closely with the South Western Ambulance Service NHS Foundation Trust (SWASFT) and Operational Research in Health (ORH) Limited to model the “blue light” ambulance travel impact.

In respect of diabetes and endocrinology patients the numbers are

- 239 ambulance admissions to GRH - < 5 patients per week (Feb 2019 and Jan 2020)
- 63 ambulance admissions to CGH - ~ 1 patient per week (Feb 2019 and Jan 2020)

There is also some cross-over of D&E patients captured in the “blue light” activity analysis for the Acute Medical take in FFTF1. Furthermore, the cost of separate analysis for D&E only was over £4,500 (£70 per patient record).

Based on the factors above, the decision was taken not to model separate D&E “blue light” activity in FFTF2.

In respect of any emergency inter-site transfers, please see section 5.6.

7.12 Standard Operating Procedures (SOPs)

A SOP is currently in development

7.13 Learning from Temporary Service Change Period

This diabetes and endocrinology proposal has been influenced as a result of temporary service changes made in response to the pandemic, and this provided the opportunity to test and trial service configurations before deciding formally to consider them as permanent change proposals.

In addition, COVID has created additional pressure on Diabetes and Endocrinology services. It has aggravated pre-existing diabetes in some people and has also triggered diabetes for some patients as a result of the virus or its treatment. This factor supports our proposals to improve the efficiency and effectiveness of the diabetes and endocrinology service by centralising the dedicated inpatient beds on the GRH site.

7.14 South West Clinical Senate Review

The clinical panel made the following comments:

- The Panel agreed that the move would strengthen links with vascular surgery, renal medicine and maternity services and that this would be advantageous for people with diabetes.
- The Panel was reassured that there will be sufficient specialist input available at CGH for the management of in-patients there with diabetes or other endocrine conditions.

For completeness our responses to the Senate Desk-top review report are included in Appendix 17.

7.15 Engagement feedback

As described in section 4 we have undertaken an extensive public and staff engagement programme.

7.15.1 Quantitative Survey responses

The proposal we engaged on was to continue to centralise the dedicated Diabetes and Endocrinology Inpatient beds at Gloucestershire Royal Hospital and provide a Diabetes and Endocrinology Consult service at Cheltenham General Hospital.

- **98%** of all respondents either **strongly supported** or **supported** the ideas
- **100%** of staff respondents either **strongly supported** or **supported** the ideas

Respondent type and proportion (%)		Strong support	Support	Oppose	Total Support
Not stated	26%	57%	36%	7%	93%
A community partner	4%	50%	50%	0%	100%
A member of the public	38%	44%	56%	0%	100%
An employee working in health or social care	28%	42%	58%	0%	100%
Prefer not to say	5%	40%	60%	0%	100%
Grand Total	100%	47%	51%	2%	98%

Survey respondents were also asked to provide us with the rationale for their response and what information they would like us to consider. A summary of the key themes and some example comments (from staff and the public) are presented below, with our response in section 7.16.

7.15.2 Qualitative Responses - Public and Patient themes

Theme	Survey comment examples
Innovation	<ul style="list-style-type: none"> • I think it's good to centralise a specialty in one place however I do think that you need make more use of technology, e.g., virtual monitoring • Self-help, education and support for new patients and healthy eating should be part of any new service approach • Train other NHS staff (Drs, nurses, AHPs & dietitians) to enable triage process. These trained staff can refer on &/or discuss directly (phone/email) with specialist diabetes personnel to determine care plan.
Clinical considerations	<ul style="list-style-type: none"> • A protocol for treating Addison's Crisis and patients being "red flagged" for urgent treatment • More support needed for long-term diabetics. • I think life style is very important and self-control of healthy eating is a better option than reliance on medication. Healthy exercise is also vital. • The staff need to be trained and competent, to deal with patients who have complex needs.

Theme	Survey comment examples
Centres of Excellence	<ul style="list-style-type: none"> • This seems to be the most efficient way to organise services, but continued support to patients with diabetes or endocrine conditions located on other wards is essential. • The case made is good • The Centres of Excellence approach should bring patient benefits
Travel	<ul style="list-style-type: none"> • Having the team under one roof is a good thing, but the transport problem is still there. • The benefits are partially outweighed by transport for some people • I believe there should be inpatient beds available at both Gloucester and Cheltenham sites.
Patient experience	<ul style="list-style-type: none"> • Would just like any services focusing on patient care.

7.15.3 Qualitative Responses - Staff themes

Theme	Survey comment examples
Clinical considerations	<ul style="list-style-type: none"> • It has several linkages to acute specialties that it should remain at GRH. • Centralising service will improve outcomes, patient care and experience.
Integration	<ul style="list-style-type: none"> • It is important to integrate care for people with diabetes • Diabetes specialists/teams in the community to offer specialist care. • Patient education is really important especially in the community or primary care • I am concerned that reconfiguration discussions which are 'site centric' overlook the overwhelming need to move diabetes services into the community to point of near exclusivity.
Workforce	<ul style="list-style-type: none"> • There are not enough Diabetic Community Nurses to cover the whole county. • The Diabetes team is extremely small and therefore centralising services to GRH site makes sense
Car Parking	<ul style="list-style-type: none"> • Parking needs to be improved massively.

7.16 Addressing themes from engagement feedback

Feedback received and FFTF2 response
<p>A protocol for treating Addison's Crisis</p> <p>There are protocols available on the Trust's intranet for treating Addisonian crisis. The previous Trakcare system has an icon available to all patients with specific healthcare needs, of which steroid dependency is one of them. Whenever a patient is started on replacement steroids the icon will be allocated to them on Trakcare. There have been some issues pulling this through onto the new EPR system, but this is being addressed currently.</p>

Feedback received and FFTF2 response**Diabetes specialists/teams in the community to offer specialist care**

Confirm that community D&E outpatient clinics will not be impacted.

Although this particular proposal focuses on inpatient care, The Hospital Trust does work in collaboration with Gloucestershire Health and Care to share information and projects being worked on in health care settings across Gloucestershire.

ICS Diabetes and Endocrinology Integration Model Project aims to develop a single point of access to manage patients in the community who may not need to go into Acute Trust. Type 2 diabetic patients would be included within the scope of this project, with the objective being that the vast majority of these patients would be seen in a community clinic by default. In order to facilitate this, the ICS have recruited a community Diabetic consultant.

CCG Virtual Ward Round Project - The virtual ward project is currently being scoped out by the ICS and focuses upon Diabetic and Endocrine patients who are discharged from the Hospital to reduce readmissions.

Patient education is really important especially in the community or primary care

The ICS run various patient education programs of people with newly diagnosed type 2 diabetes and for people who are starting on insulin. There are also a number of courses covering diet and lifestyle to assist in the prevention of the development of type 2 diabetes. In terms of type 1 diabetes, we do a lot of one-to-one work and also offer a number of options on learning to carbohydrate count, these are mainly online based.

Travel and Transport

The negative impact of increased travel is clearly recognised. Analysis has indicated that ~ 4% of patients will be negatively impacted, with 96% neutral or positive. Our Integrated Impact Assessment would indicate that the benefits (patient outcomes) outweigh the negative travel impact.

Train other NHS staff (Drs, nurses, AHPs, dietitians) to enable triage process.

The future plan is to have two Diabetes link nurses for each ward and ED areas. In addition, there will be updated training every 2 months for healthcare professionals. There is currently and diabetes e-learning available online for staff, which is currently being considered to become mandatory training for all medical staff members. Furthermore, the service already RAG rates patients to determine which inpatients do need to be seen by the specialist team.

Key Points

- **This service change proposal delivers the case for change through an improved staffing model.**
- **This service change proposal delivers a range of patient and staff benefits.**
- **This service change proposal is supported by the Clinical Senate**
- **This service change proposal is supported by respondents to our engagement**
- **This proposal is currently implemented as a temporary service change.**

8 Non-interventional Cardiology

8.1 The 'current state' service model

The cardiology services currently operate at both Gloucestershire Royal (GRH) and Cheltenham General Hospitals (CGH) with 21 inpatient beds at CGH and 25 at GRH. The service runs outpatient clinics at CGH, GRH and several other community hospitals in the county.

Diagnosis may include the use of X-ray, MRI, ultrasound scans and CT scans. For some patients the service also undertakes interventional cardiology within the cardiac catheter labs to perform surgery. Procedures are undertaken as day cases or inpatients.

The cardiology service is staffed by 6 HCA's (3.55 WTE), 26 registered nurses (RN) band 5-7 (26.48 WTE) and 14 consultants (12 WTE and 2 part time P/T).

Patient Pathway

Non-interventional cardiac admissions include pathways such as Heart Failure, endocarditis, and cardioversions. These pathways are replicated on both acute hospital sites. A typical patient pathway would be:

- Patient presents to ED (GRH / CGH)
- Initial emergency diagnostics undertaken
- Routed to Same-Day-Emergency-Care / diagnosed with primary cardiac condition
- Patient admitted to cardiac ward
- Further specialist cardiac diagnostics undertaken
- Patients are then likely to follow one or more of the following paths
 - Non-interventional treatment such as IV antibiotics given
 - Patients may then be discharged if stabilised, or
 - If intervention is not deemed urgent, patients may be discharged home to attend follow up as an outpatient or be admitted for a planned surgical intervention.

8.2 Activity

The total number of admissions for cardiology (both interventional and non-interventional) for the period Jan-Dec 2021 was 3,475.

8.3 Clinical Engagement

Clinical engagement has included regular discussions with clinical and operational leads in cardiology regarding development of options and case for change. The clinical and operational cardiac team developed a long list of options based on their developed Case for Change, then used the FFTF hurdle criteria to review this list and refine down to a medium list of options.

'Medical Triumvirate' senior leaders reviewed hurdle process whereby options are reduced from an initial long list to a medium list. Wider clinical engagement was achieved through monthly reporting to the Image Guided Interventional Surgery (IGIS) Programme Board, including clinical representation from Cardiology, Interventional Radiology and Vascular services.

The medium list was also shared for comment with clinical and operational representation for all services through presentation to the GHNHSFT Strategy & Transformation Delivery Group.

8.4 Case for change: the problem we are seeking to address

Before describing our ideas for FFTF2, it's helpful to summarise recent developments in cardiology services that were agreed as part of FFTF1.

These included the centralisation of interventional cardiology, the relocation of the two cardiac catheter labs to GRH and the creation of an Image Guided Interventional Surgery (IGIS) hub at GRH and a spoke service for planned care at CGH; due to be completed in 2023/24. As part of these changes 13 inpatient beds will move from CGH to GRH.

The centralisation of interventional cardiology and the relocation of the cardiac catheter labs to GRH does present an opportunity to explore how we could potentially reorganise the remaining eight cardiology inpatient beds at CGH.

The problems we are seeking to address include;

- The challenges with patient pathways and identifying those patients requiring intervention at the point of admission. Also, for patients whose care pathway changes during their inpatient stay.
- Better use of the staff groups with significant shortages, such as radiographers, physiologists and specialist nurses.
- The need to improve Out of Hours Care for cardiac patients.

The patients that could be affected by these proposals are those not requiring cardiac intervention who would currently be admitted or transferred to the eight cardiology beds at CGH.

8.5 Clinical Evidence

The Cardiology GIRFT Programme National Specialty Report (Feb 2021) highlighted the need to review the ways cardiac services are delivered and included the following:







- Prevention, diagnosis and management of cardiovascular disease forms a key part of the NHS England and NHS Improvement (NHSE/I) Long Term Plan.
- The falling CVD mortality rate has been the biggest contributor to increased life expectancy for men and women within the UK. However, demographic shifts within our society mean that CVD-related mortality is increasing.
- To address this, we need to review the ways cardiac services are delivered and who is delivering them, to ensure both that patients are getting the care they need and that services are fit for the future.
- The best way to deliver equity of access to appropriate services and expertise, match demand to capacity and make the most efficient use of resources.
- Cardiology beds should be co-located and in hospitals with a cath or pacing lab there should be ring-fenced beds, trolleys or chairs.
- Multidisciplinary meetings are an essential part of cardiology treatment pathways and a core function of the heart team.

8.6 How was preferred option evaluated?

The Cardiology Service developed a long-list of options with support from the FFTF Programme Team. Hurdle criteria have been applied to the long-list of options²¹. Where any option has failed any of the criteria, it was been removed from the longlist. As described

²¹ The long-list and hurdle assessment can be found in Appendix 10a

in section 5.2, the next step was the application of the FFTF desirable criteria.

Centralise Non-Interventional Cardiology inpatient beds at GRH. Consult service at CGH.		
Quality	Scores	Slightly to significantly better than status quo 
	Comments	<ul style="list-style-type: none"> Improved OOH care and ensures all cardiac patients are located on same site as interventional facilities. Impact on those walking into CGH ED. Inter-site transfers for cath labs cease Should improve continuity of care through services and clinicians being on one site reducing need for moves
Access	Scores	Broadly similar to status quo 
	Comments	<ul style="list-style-type: none"> Patients will still present to their nearest ED. Approx. 10% negative travel impact. Improved utilisation of cath labs Improved efficiency through centralisation could be used to create capacity.
Workforce	Scores	Significantly better than status quo 
	Comments	<ul style="list-style-type: none"> Single site allows improved staff cover and resilience. Only 1 x OOH consultant needed. Single site provision allows for more efficient deployment of nursing staff. Improved rota and cover arrangements. If rotas are more easily filled, then staff resilience will be improved. Middle grade doctors will benefit from more access to senior colleagues. Trainees will see a higher number of cases with standardised care.
Deliverability	Scores	Similar or slightly better than status quo 
	Comments	<ul style="list-style-type: none"> Implementation of non-interventional cardiology could be aligned with operationalising of interventional cardiology, part of IGIS FFTF Phase 1 proposals. Clinical staff within the service are well engaged and supportive of the preferred solution. Suitable location for the service identified at GRH.
Strategic Fit	Scores	Slightly to significantly better than status quo 
	Comments	<ul style="list-style-type: none"> Consolidating cardiology services are expected to achieve improved outcomes of care, reduced LoS and more timely and responsive intervention when required. Improvement for inpatients and carers accessing specialist support, information and guidance from a strengthened team on site
Acceptability	Scores	Significantly better than status quo 
	Comments	<ul style="list-style-type: none"> 98% of respondents support the proposals. Important to address the issues raised by the 2%. A change management programme of working with colleagues and professional partners along with a proactive communications campaign.

Based on the above assessment, the preferred option is to centralise Non-Interventional Cardiology inpatient beds at GRH and provide a consult service at CGH.

There will continue to be a choice of outpatient appointments at both acute hospital sites, in the community and virtually when appropriate.

8.7 How does this address the case for change?

Reason for change	How preferred option addresses this
The challenges with patient pathways and identifying those patients requiring intervention at the point of admission	Centralising all cardiology inpatient beds (interventional and non-interventional) at GRH would ensure patients were able to access the appropriate services once diagnosis was confirmed.
Improved out of hours care for patients	One consultant on call can attend to patients with greater efficiency when they are located on a single site.
Better use of the staff groups with significant shortages	Increased clinical presence for more ward rounds and consequently more efficient patient management. Length of stay reduction in transfer between sites, continuity of care with single consultant, increased efficiency of cath labs (delays caused from site transfers)

8.8 Benefits including clinical outcomes

Potential Benefits

- Looking ahead to the implementation of the FFTF1 IGIS model and the centralisation of interventional cardiology at GRH, the cardiology service believes it can provide a more efficient, more responsive and safer service by consolidating inpatient beds at GRH and providing a fully centralised cardiology inpatient service.
- Reduce length of stay for patients.
- Increased clinical presence for more ward rounds and consequently more efficient patient management. Length of stay reduction in transfer between sites, continuity of care with single consultant, increased efficiency of cath labs (delays caused from site transfers).
- Improved out of hours care for patients. One consultant on call can attend to patients with greater efficiency when they are located on a single site. Travelling cross sites can incur delays due to travel.
- Improved staff cover and improved staff resilience for sickness and absence
- Improved cross specialty working, i.e., how cardiology teams work with other acute specialties (service areas)
- Provide enhanced training for junior and middle grade doctors with regular access to the full clinical team
- Ensure that patients requiring regular Electrocardiogram (ECGs) receive this treatment in a timely way
- Ensure staff resilience for the future of the service through centralisation and by cross training a number of clinical members of staff; specifically nursing staff.
- Prevent the need for patient transfer which has cost implications. Transfer costs include both the ambulance cost but also for some patients the cost of a nurse

chaperone.) This is on the risk register. M2174CARD (score of 8) – risk to patient safety due to inability to treat patients whilst transferring between sites.

Potential drawbacks

- Friends or family travelling from the east of the county visiting a patient receiving non-interventional cardiology inpatient care at GRH would have to travel further.
- Approximately 10% of patients, families/carers²² are negatively affected by centralising services on GRH.

8.9 Interdependencies

These include:

FFTF1 Implementation - As detailed in section 8.4 there are clear interdependencies with the centralisation of interventional cardiology, the relocation of the two cardiac catheter labs to GRH and the creation of an IGIS hub at GRH and a spoke service for planned care at CGH; due to be completed in September 2023.

Acute medical take – Impact of the centralisation of the acute medical take in September 2023.

Dept. Critical Care at GRH – the centralisation of cardiology will increase DCC demand at GRH.

8.10 Workforce

The cardiology service is staffed by 6 HCA's (3.55 WTE), 26 registered nurses (RN) band 5-7 (26.48 WTE) and 14 consultants (12 WTE and 2 part time P/T).

There are no plans/ requirements to change the clinical or operational staffing as a result of these proposals.

The staff benefits of the preferred option are listed above and include better training, workload efficiencies and help the service to make the best use of the staffing resource it currently has.

8.11 “Blue light” ambulance travel impact

As with FFTF1, the FFTF programme has worked closely with the South Western Ambulance Service NHS Foundation Trust (SWASFT) and Operational Research in Health (ORH) Limited to model the “blue light” ambulance travel impact.

As part of FFTF1 we modelled the “blue light ambulance travel impact for interventional cardiology and we do not anticipate any requirement for non-interventional cardiology.

In respect of any emergency inter-site transfers, please see section 5.6.

8.12 Standard Operating Procedures (SOPs)

The current SOP is attached as Appendix 10b. This describes in more detail the pathway process outlined earlier. This SOP will be updated when the acute take centralises at GRH.

8.13 Learning from Temporary Service Change Period

Cardiology services (interventional and non-interventional) have not been subject to any temporary service changes made in response to the pandemic.

²² Details of the methodology can be found in section 11.5

8.14 South West Clinical Senate Review

The clinical panel made the following comments:

- The panel agreed that the move of non-interventional cardiology in-patient services to the same site as the interventional service (i.e. at GRH) was advantageous.
- The Panel noted that routine echocardiograms performed by physiologists are not available at weekends at either GRH or CGH. They were reassured that when clinically necessary, echocardiograms can be performed by an on-call consultant cardiologist; however, recognising that the provision of echocardiograms is essential to an acute cardiology service and to other service such as critical care and stroke, the Panel recommends that, if possible, steps are taken to address this issue.

In response the clinical teams have indicated that we rarely need access to immediate echo for stroke patients but have good access weekdays and link with the cardiologists at the weekend if required.

For completeness our responses to the Senate Desk-top review report are included in Appendix 17.

8.15 Engagement feedback

As described in section 4 we have undertaken an extensive public and staff engagement programme.

8.15.1 Quantitative Survey responses

The proposal we engaged on was to centralise Non-Interventional Cardiology inpatient beds at Gloucestershire Royal Hospital and provide a Cardiology Consult service at Cheltenham General Hospital.

- **99%** of all respondents excluding staff either **strongly supported** or **supported** the ideas
- **97%** of staff respondents either **strongly supported** or **supported** the ideas

Respondent type and proportion (%)		Strong support	Support	Oppose	Total Support
Not stated	14%	50%	50%	0%	100%
A community partner	4%	33%	67%	0%	100%
A member of the public	42%	49%	51%	0%	100%
An employee working in health or social care	37%	45%	52%	3%	97%
Prefer not to say	4%	33%	67%	0%	100%
Grand Total	100%	47%	52%	1%	99%

Survey respondents were also asked to provide us with the rationale for their response and what information they would like us to consider. A summary of the key themes and some example comments (from staff and the public) are presented overleaf, with our response in section 8.16.

8.15.2 Qualitative Responses - Public and Patient themes

Theme	Survey comment examples
Innovation	<ul style="list-style-type: none"> Use of technology to reduce referral times, e.g., patient/ GP/ specialist video calls and portable ultrasound and ECG equipment that can be used to provide diagnostic information to specialists
Clinical considerations	<ul style="list-style-type: none"> How will patients with other medical issues who also have a need for non-interventional cardiology be treated in CGH? It seems to make sense to consolidate cardiology beds in one site (GRH). Would be great for additional funding for MRI, CT, as well as services related to heart failure and genetic heart conditions. Reduce length of stays. All different specialists under one roof, better for care and training, more likely to get correct specialist.
Centres of Excellence	<ul style="list-style-type: none"> I can see the logic in moving the remaining non-interventional beds to be under the care of the centralised inpatient cardiology team. Concentrating expertise in one hospital is important. Objectively - absolutely right to optimise cardiac services in one place. Hard sell for past patients who have been treated successfully in Cheltenham, but this should be pushed forward.
Travel	<ul style="list-style-type: none"> Transport over the county is appalling Makes sense but it is the traveling that could be a problem for those without their own
Patient experience	<ul style="list-style-type: none"> My first symptoms were over 65 years ago, and I am truly grateful for the NHS support I had since! I still enjoy life.

8.15.3 Qualitative Responses - Staff themes

Theme	Survey comment examples
Clinical considerations	<ul style="list-style-type: none"> Best located where support services are Agree cardiology inpatient provisions should be based at GRH Centralising services on the GRH site will be of great benefit to ongoing cardiac care/services hopefully reduce waiting times for interventions, improving patient outcomes and LoS in the long term and decreasing the need for transfers out of county. Better pathway to interventional investigations
Interdependencies	<ul style="list-style-type: none"> Cardiology should be on the same site as Vascular Services Cardiology should be based on the site with greatest cover from Vascular and Interventional Radiology I am concerned that this good work in centralising specialist services will be overly reliant on Ambulance Service performance.
Travel	<ul style="list-style-type: none"> Travel may cause a difficulty for some people; however, the benefits appear to outweigh the negatives.

8.16 Addressing themes from engagement feedback

Feedback received and FFTF2 response
Co-location of all cardiology services (FFTF1 and FFTF2)
It is welcomed that both staff and the public see the benefits from centralising all cardiology inpatient services at GRH
Co-location of cardiology with vascular
It is welcomed that staff see the benefits from centralising all cardiology inpatient services at GRH which will be co-located with vascular services.
Travel and Transport
The negative impact of increased travel is clearly recognised. Analysis has indicated that ~ 10% of patients will be negatively impacted, with 90% neutral or positive. Our Integrated Impact Assessment would indicate that the benefits (patient outcomes) outweigh the negative travel impact.

Key Points

- **This service change proposal delivers the case for change.**
- **This service change proposal delivers a range of patient and staff benefits.**
- **This service change proposal is supported by the Clinical Senate**
- **This service change proposal is supported by respondents to our engagement**

9 Respiratory

9.1 The 'current state' service model

It should be noted that the "current" service model is a result of temporary service changes and reflects proposals for the future configuration of services as opposed to the pre-COVID configuration which is the "no change".

Our respiratory services provide a patient centred service for all ages of patients, presenting with respiratory related issues. The team consists of medical, nursing, therapy and support staff. The Consultant led Outpatient Clinics/Services are provided at both acute hospital sites plus seven locations in the community. These services are used for general respiratory conditions and also suspected cancer and sleep disorders. As part of the investigation patients may be referred for further screening. This could be arranged for the same day or as a separate appointment for another service for example an X-Ray, a CT scan, a blood test, lung function tests, a sleep study, an allergy skin prick test or a bronchoscopy, all of which will be undertaken as an Outpatients appointment.

Prior to the temporary COVID service changes (see below), specialist respiratory inpatient beds were provided on both hospital sites. At CGH they were located on Knightsbridge Ward (12 beds) and on Avening Ward (21 beds). At GRH they were located on Ward 8b (33 beds). A total of 66 beds. There were over 11,000 hospital admissions per year, with an average length of stay of 5.1 days; 77% of the admissions were to GRH and 23% to CGH (Feb 2019 to Jan 2020).

In June 2020, GHNHSFT implemented a number of temporary service changes as part of the Integrated Care System (ICS) response to the COVID Pandemic. The changes were implemented to reduce the number of emergency routes into hospital and to free-up additional capacity on the GRH site to create a 'red' emergency care COVID controlled site with patients managed through three emergency admission pathways: confirmed COVID, suspected COVID and confirmed non-COVID.

As part of these changes, GRH became the site for emergency admissions for patients in acute respiratory failure and a COVID Respiratory High Care (RHC) unit was created on one of the wards at GRH, where patients receive advanced respiratory support via non-invasive ventilation (NIV) or nasal high flow oxygen with full cardio-respiratory monitoring. This relieved the demand on the intensive care unit.

Under the temporary service changes, the improvements in efficiency and reduction in outliers ensure that the respiratory specialty inpatient beds, including High Care, can be located on Ward 8a and 8B (58 beds) at GRH. Currently, approximately 92% of patients are admitted to GRH and 8% admitted to CGH.

Current patient pathway

For patients attending ED a referral is made to the respiratory team for a respiratory assessment, either by an ED consultant or by the acute take physician. The patient is assessed and depending on the outcome, they are admitted to a respiratory bed, referred to another specialty or discharged.

The respiratory team provide a consultation service to other specialties (service areas) at CGH for patients who may require a specialist respiratory assessment or treatment.

Clinical protocols are in place to support the early recognition of and transfer of deteriorating patients at CGH and the management of patients in CGH needing advanced respiratory support.

9.2 Activity

From Feb 2019 to Jan 2020 there were 11,384 admissions, with an average length of stay of 5.1 days; 77% of the admissions were to GRH and 23% of these admissions were to CGH.

A comparison has been made of activity over a three-month period (July – Sept 2021) against the FFTF baseline year 2019/20, with the same time period in 2021. During this period there were 2210 admissions in 2019/20 compared to 2421 admissions in 2021, showing a 10% increase in admissions.

In 2021 approximately 92% of patients were admitted to GRH and 8% were admitted to CGH, which reflects the temporary centralisation of respiratory specialty beds at GRH. Also, during this period 146 patients were cared for within COVID respiratory high care beds.

9.3 Clinical Engagement

The clinical team developed a long list of options and used the FFTF hurdle criteria to review this list and develop a medium list of options. The medium list, together with the case for change was presented to the Medical Division Board, which was approved. The Trust has also presented the case for change and the medium list of options to the Respiratory Clinical Programme Group (CPG). The CPG has also supported the case for change and the medium list of options.

9.4 Case for change: the problem we are seeking to address

The proposals are concerned with centralisation of respiratory inpatient beds and the provision of the respiratory high care service taking into consideration a number of factors, including:

- Workforce challenges;
- Benefits of a Respiratory High Care Unit (RHC)²³;
- Improvements to multi-disciplinary team working, and;
- Interdependencies related to the centralisation of the acute medical take to GRH in Sept 2023 (FFTF1).

Workforce challenges

- Make more efficient and effective use of the specialist team
- Need to cover gaps in establishment, medical staff rotas and staff absences.
- Need to improve staff recruitment and retention
- Need to improve junior doctor training and improved training for nursing and therapy staff
- To provide resource support towards the development of a Respiratory High Care unit

²³ Also known as Respiratory Support Units (RSU)

Respiratory High Care (RHC)

- A Respiratory High Care Unit is a dedicated area of enhanced care that enables a higher level of monitoring and respiratory intervention than would be expected for a standard ward environment.
- Currently there isn't a dedicated area for patients requiring non-invasive ventilation (NIV) on the Respiratory wards and there are no central monitoring facilities. This makes it difficult to co-ordinate and safely manage the care for patients receiving NIV.
- The service does not have the necessary support from Advanced Care Practitioners and physiotherapists to be able to deliver high quality care. The lack of facilities and dedicated skilled resource means that the service is limited in its ability offer NIV to patients who would benefit from this service.
- Evidence has shown that patients requiring NIV can be managed within a Respiratory High Care facility, avoiding the need for admission to DCC²⁴
- RHC delivers Improved clinical outcomes, specifically improved mortality rates.

Improved multi-disciplinary team working

- Desire to improved multi-disciplinary team working
- Support the implementation of new ACP roles

Support the Centralised Acute Medical Take

- Acute respiratory patients represent a significant proportion of the acute medical take, including many of the sickest patients who often require immediate care on a specialist unit
- There is a need to ensure that the respiratory service has the on-site staff and bed capacity to support the acute medical take.

Compliance with National Recommendations

- Nationally the British Thoracic Society, the Intensive Care Society and the Getting It Right First Time (GIRFT) programme recommend the development and implementation of RHC/ RSU

9.5 Clinical Evidence

The new national report for respiratory medicine published in Sept 2021, by the Getting It Right First Time (GIRFT) programme, outlined how more patients' lives could be saved if all acute trusts could establish a dedicated NIV unit. The report highlighted a gap in provision of NIV. GIRFT recommends a series of actions to help all trusts work towards a dedicated NIV service to help improve outcomes for patients. These include measures to identify the right patients for treatment and starting more treatment at the right time. These units emerged as a key response to the pandemic, delivering improved outcomes for patients and allowing respiratory support for patients outside of intensive care, freeing critical care capacity for those patients who needed invasive ventilation. GIRFT aligns with the British Thoracic Society (BTS) in recommending RSUs in all NHS hospitals.

²⁴ The intensive care at GHNHSFT is known as Dept. of Critical Care (DCC)

The British Thoracic Society and Intensive Care Society²⁵ provides guidance on the development and implementation of Respiratory Support Units, setting out the following recommendations:

- Acute NIV should be offered to all patients who meet evidence-based criteria. Hospitals must ensure there is adequate capacity to provide NIV to all eligible patients.
- Acute NIV should only be carried out in specified clinical areas designated for the delivery of acute NIV.
- All staff who prescribe, initiate or make changes to acute NIV treatment should have evidence of training and maintenance of competencies appropriate for their role.

9.6 How was the preferred option evaluated?

Hurdle criteria have been applied across all options²⁶. Where any option has failed any of the criteria, it has been removed from the longlist. Whilst the medium-term trajectory of this, and potential future, pandemics is uncertain, the capability to establish a COVID controlled respiratory ward at short notice, is a key part of our response, particularly as we learn more about how the longer-term pattern of these diseases in our communities emerge. The lessons learned regarding the benefits of high care for other (non-COVID) respiratory patients in our hospitals is another factor in developing this important service. Due to the specialist staffing, equipment and infection control measures already installed at GRH, there is no realistic CGH location for high care in the short to medium term.

As described in section 5.2, the next step was the application of the FFTF desirable criteria.

The solutions appraisal exercise was designed to evaluate proposed changes compared with the status quo. Given that the changes outlined above are already in place, the proposed change evaluated in this case was **reverting back** to the original configurations, i.e., reversing the current temporary service change.

The scorecard from the solutions appraisal process is presented overleaf.







The Trust is currently collaborating with the West of England Academic Health Science Network (AHSN) on implementing an NIV care bundle with ongoing data monitoring, audit and evaluation. Data monitoring would include:

- Numbers of patients receiving RHC on the ward
- Mortality rates in comparison with other Trusts providing RHC
- Early discharges
- Length of stay
- Number of admissions to DCC compared to current position
- Avoidance of readmissions

The outputs will be reviewed as part of the monthly service line review process within the Medical Division.

²⁵ British Thoracic Society and Intensive Care Society. *Respiratory Support Units: Guidance on development and implementation - June 2021*, ISSN 2040-2023, British Thoracic Society Reports, Vol 12, Issue 3, June 2021

²⁶ The long-list and hurdle assessment can be found in Appendix 11a

Revert the Respiratory Inpatient Beds from a centralised model at GRH (with High Care) to a split site model at GRH and CGH (without High Care).		
Quality	Scores	Similar to significantly worse than status quo 
	Comments	<ul style="list-style-type: none"> • When Acute take at GRH more patients would require transfer if revert back. • Most patients will be directed to correct site pre arrival but some 'walk in patients' to CGH may require transfer. • Time to start NIV is important so a reduction in transfer will optimise start time. • Average of 7mins increase in "blue light" does not have clinical impact.
Access	Scores	Similar to status quo 
	Comments	<ul style="list-style-type: none"> • Little effect on patient travel- maybe more on family • Same staffing hours but centralisation gives slightly more clinical time. • Respiratory disease often associated with deprivation therefore proposal to collocate at GRH has a positive impact. • Distribution of beds better matched to caseload. • Increased resilience from centralisation to offer Resp. High care
Workforce	Scores	Slightly to significantly worse than status quo 
	Comments	<ul style="list-style-type: none"> • Team building positive in last 2 years during move. • Overall time allocated Consultant ward consultation remains the same but beneficial for nursing staff and other members of the team. • Significant impact on nursing team when cross site changes are made. • Centralisation means trainees have an opportunity to see a greater number of conditions plus high care. • Recruitment is easier as roles more attractive. Retention of staff felt to be a major factor
Deliverability	Scores	Significantly worse than status quo 
	Comments	<ul style="list-style-type: none"> • If move back significant interruption to other services. • This would affect staff groups, specialist nurses & therapists. • If move back will be without Respiratory High Care. • Dependencies with Acute Take and possibly other services, e.g., cardiology.
Strategic Fit	Scores	Significantly worse than status quo 
	Comments	<ul style="list-style-type: none"> • Current configuration in line with clinical strategy • Respiratory high care is nationally recognised as a standard of care and reversing model would prevent delivery of respiratory high care facilities
Acceptability	Scores	Significantly worse than status quo 
	Comments	<ul style="list-style-type: none"> • 96% of respondents support the proposals.

Based on the above assessment, the preferred option is to maintain the Respiratory Inpatient beds and establish Respiratory High Care at Gloucestershire Royal Hospital with a consult service at CGH.

There will continue to be a choice of outpatient appointments at both acute hospital sites, in the community and virtually when appropriate.

9.7 How does this address the case for change?

Reason for change	How preferred option addresses this
Workforce Challenges	<p>Centralisation allows more efficient staffing of the wards, making it easier to cover gaps in establishment, medical staff rotas and staff absences</p> <p>With the specialist staff in one place, it is easier to co-ordinate care, provide training and improve staff recruitment and retention.</p> <p>Centralisation provides the medical and nursing resource to support the development of a Respiratory High Care unit</p>
Respiratory High Care	<p>Our proposed option would enable us to develop a dedicated enhanced Respiratory High Care area, within one of the respiratory wards with central monitoring facilities.</p> <p>Other than a centralised respiratory service at GRH, there is no realistic alternative location for Respiratory High Care in the short to medium term.</p>
Improved multi-disciplinary team working	<p>Centralisation supports improved multi-disciplinary team working as evidenced by processes for joint working e.g. ward/board rounds, MDT meetings, joint care plans etc</p> <p>Centralisation also supports the implementation of new ACP roles</p>
Support the Centralised Acute Medical Take to GRH	<p>When Cheltenham acute medical take moves to Gloucester there should be less respiratory patients coming through. The risk of the patient in Cheltenham who becomes sick with a respiratory complaint will be lower and a patient on a surgical ward becoming unwell could be seen.</p> <p>Acute respiratory patients represent a significant proportion of the acute medical take, including many of the sickest patients who often require immediate care on a specialist unit.</p>
Compliance with National Recommendations	<p>Other than a centralised respiratory service at GRH, there is no realistic alternative location for Respiratory High Care in the short to medium term.</p>

9.8 Benefits including clinical outcomes

Potential Benefits

- The provision of a respiratory high care unit will enable the service to comply with National Quality Standards for acute non-invasive ventilation (NIV) in adults²⁷ and compliance with recommendations of both the British Thoracic Society and Intensive Care Society and GIRFT for respiratory high care units²⁸.
- The provision of a respiratory high care unit will improve capacity to deliver NIV care in a ward setting. Experience during COVID showed that an 11 bed RHC unit increased capacity to provide NIV in a ward area by 50%, compared to current provision.
- Provide more timely care. Experience during COVID showed that patients could be admitted direct from ED to the RHC Unit.
- Improve clinical outcomes:
 - Reduce mortality rates. Patients with acute respiratory failure requiring NIV have a 25% inpatient mortality, with national audit showing significantly worse outcomes in patients receiving NIV outside designated high care areas.
 - Improve recovery – reducing the need for oxygen at home
- Decrease Length of Stay through additional prescribing and specialist input throughout the Respiratory unit.
- Reduce re-admission rates, through the provision of timely care.
- Reduction in admissions of respiratory patients to DCC and the ability to step down Respiratory patients in an appropriate timeframe. Admissions are seasonal, at its peak it is anticipated that the provision of a RHC Unit would avoid 7 admissions to DCC a month
- Having the specialty respiratory beds in one place makes it easier to staff the wards and makes more efficient use of the specialist team. With the specialist staff in one place, it is also easier to co-ordinate care, provide training and improve staff recruitment and retention.
- Improved cross specialty working, i.e., how respiratory teams work with other acute specialties (service areas).

Potential drawbacks

- The centralisation of specialist respiratory beds at GRH will impact some patient and carer travel times
- The overall impact is <10% of respiratory patients²⁹, families and carers are negatively affected by centralising at GRH
- Additional investment will be required to deliver the new high care service on a permanent basis, but evidence shows that this service increases capacity to provide NIV on the ward, improves the quality of care and patient outcomes, including reducing mortality and reducing the number of respiratory admissions to intensive care.

²⁷ Davies M, Allen M, Bentley A, et al. British Thoracic Society Quality Standards for acute non-invasive ventilation in adults. *BMJ Open Resp Res* 2018;5:e000283. doi:10.1136/bmjresp-2018-000283

²⁸ Guidance on development and implementation - June 2021, ISSN 2040-2023, British Thoracic Society Reports, Vol 12, Issue 3, June 2021

²⁹ Details of the methodology can be found in section 11.5

9.9 Interdependencies

There is a key dependency with the acute medical take. The preferred option would support the planned centralisation of the acute medical take. Respiratory patients form a significant proportion of the acute medical take and are some of the highest acuity patients within the medical take, who require prompt transfer and treatment on specialist respiratory ward areas.

Details of the interdependencies between respiratory high care and DCC can be found in section 5.7.4.

9.10 Workforce

The only staffing changes that are being considered relate to the development of the Respiratory High Care service and include 2 x Advanced Clinical Practitioners and 1.5 x Band 7 physiotherapists. The medical and nursing support can be provided within existing establishments.

The workforce benefits of co-location are detailed in the sections above.

9.11 “Blue light” ambulance travel impact

As with FFTF1, the FFTF programme has worked closely with the South Western Ambulance Service NHS Foundation Trust (SWASFT) and Operational Research in Health (ORH) Limited to model the “blue light” ambulance travel impact. The impact has been assessed for both the ambulance incident response times and the Call to Hospital. The findings for Respiratory are as follows:

- The respiratory emergency patients were diverted to GRH in the model; the C2 mean increases in Gloucestershire CCG by 32 seconds.
- The performance impacts are generally larger than the HASU impacts, though are small in the context of the overall performance.
- The average utilisation of ambulances across SWAST increases by 0.1 percentage points to 68.6%. The increase in travel time to hospital is 6m 26s on average across the 1.5% of transported patients in Gloucestershire CCG who are affected.
- The total time from time of call to handover at hospital increases by 5m19s on average for respiratory patients. This measure is impacted by many factors including resource availability, changes in travel times and stacking of vehicles at hospital during handover.
- An increase of 28 ambulance hours per week is required to mitigate the performance degradation.

9.11.1 2019/20 Arrival to Handover Modelling

- SWAST has experienced increased handover delays in 2021/22 compared to previous years.
- The base position, respiratory emergency modelling scenarios were re-run with 2019/20 handover delays to quantify the effect of longer handover times on response performance.
- In respiratory emergency, the impacts on performance with 2019/20 handover delays are of a similar magnitude to that with 2021 handover delays. With 2019/20 handover delays the mean response time impacts are generally smaller, but the 90th percentile impacts are generally larger.

- The C1 impacts are smaller, potentially as due to the lower strain placed on resources by reduced handover delays, the highest acuity category is protected.

In respect of any emergency inter-site transfers, please see section 5.6.

9.12 Standard Operating Procedures (SOPs)

The current SOP is attached as Appendix 11b. This describes in more detail the pathway process outlined earlier. This SOP will be updated when the acute take centralises at GRH.

9.13 Learning from Temporary Service Change Period

These respiratory proposals have been influenced as a result of temporary service changes made in response to the pandemic, and this provided the opportunity to test and trial service configurations before deciding formally to consider them as permanent change proposals.

Of particular importance was the development of our COVID respiratory high care service. There is a need to develop a respiratory high care service to improve the quality of service for the local population of Gloucestershire; including patient outcomes, continuity of care, patient experience and reductions in mortality.

9.14 South West Clinical Senate Review

The clinical panel made the following comments:

- The Panel believed that the proposals would deliver clear benefits for respiratory patients.
- The panel believed that the development of a Respiratory High Care Unit (RHCU) is an important advance that would have benefits for patients and is likely to have a positive impact on workforce recruitment and development. However, the panel did not think the development of this unit would have the proposed impact on future critical care bed requirement as many patients are currently receiving respiratory support on the respiratory wards.
- The Panel agreed that the proposals resulted in good training opportunities for respiratory registrars working at CGH during the daytime.

For completeness our responses to the Senate Desk-top review report are included in Appendix 17.

9.15 Engagement feedback

As described in section 4 we have undertaken an extensive public and staff engagement programme.

9.15.1 Quantitative Survey responses

The proposal we engaged on was to continue to centralise Respiratory Inpatient beds and establish Respiratory High Care at Gloucestershire Royal Hospital and provide a Respiratory Consult service at Cheltenham General Hospital.

- **97%** of all respondents either **strongly supported** or **supported** the idea
- **100%** of staff respondents either **strongly supported** or **supported** the idea

Respondent type and proportion (%)		Strong support	Support	Oppose	Strongly oppose	Total Support
Not stated	12%	36%	64%	0%	0%	100%
A community partner	4%	50%	50%	0%	0%	100%
A member of the public	43%	41%	51%	5%	3%	92%
An employee working in health or social care	34%	48%	52%	0%	0%	100%
Prefer not to say	6%	40%	60%	0%	0%	100%
Grand Total	100%	44%	53%	2%	1%	97%

Survey respondents were also asked to provide us with the rationale for their response and what information they would like us to consider. A summary of the key themes and some example comments (from staff and the public) are presented below, with our response in section 9.16.

9.15.2 Qualitative Responses - Public and Patient themes

Theme	Survey comment examples
Innovation	<ul style="list-style-type: none"> • More opportunities for self-referral and annual pulmonary rehab
Clinical considerations	<ul style="list-style-type: none"> • Need to ensure that patients on these wards with other health conditions receive good support from other specialties. • If the last 2.5 years has shown this to work and be beneficial, that's a pretty compelling 'inadvertent pilot'!! • Review by same practitioners maintain continuity of care. This gives the patient confidence in their care.
Ward environment	<ul style="list-style-type: none"> • On the whole this idea should be supported however the wards in Gloucester Hospital are poorly ventilated and understaffed.
Integration	<ul style="list-style-type: none"> • Lack of community support is a huge problem • Putting respiratory professionals in GP clinics/hubs rather than only in GRH • Community involvement may be needed, and it is important to introduce them as soon as possible, to maintain quality care.
Travel	<ul style="list-style-type: none"> • Makes good sense and has been 'trialled' through the pandemic, again we need to acknowledge limited resources, and the distance is manageable but could be costly for some.

9.15.3 Qualitative Responses - Staff themes

Theme	Survey comment examples
Clinical considerations	<ul style="list-style-type: none"> • Anyone with a diagnosis of acute respiratory illness having access to relevant teams to avoid A&E attendance, perhaps contact through the direct admission pathway to avoid the emergency department. • Patient transfers from CGH. • Respiratory is a service that has worked well being centralised to GRH site • It seems to make sense to consolidate beds in one site especially with more consultant emergency cover should the patient become acutely unwell
High Care	<ul style="list-style-type: none"> • Respiratory high care service is a needed service to be able to meet the requirements of acutely unwell respiratory patients. • Evidence from COVID suggests a higher level of respiratory care needed.
Workforce	<ul style="list-style-type: none"> • The proposal is exciting, there needs to be consideration of the workforce resource required outside of medics and nursing. • The Respiratory service at the Trust is exceptionally well lead and proactive in its outlook and approach.
Integration	<ul style="list-style-type: none"> • There is further work to be done with improving integration of services across the ICS with further investment for managing respiratory conditions and access to services such as pulmonary rehabilitation and care/support in the community. • Curious as to why some respiratory services couldn't be offered at community level.

9.16 Addressing themes from engagement feedback

Feedback received and FFTF2 response
<p>Respiratory High Care</p> <p>The business case includes on average 11 respiratory high care monitored beds – demand is highly variable. Extra beds are to have monitors in the side rooms for times of high demand of infection control needs. Additional resources required to develop this service are 2 x Advanced Clinical Practitioners and 1.5 x band 7 physiotherapists. The medical and nursing support can be provided within existing establishments.</p>
<p>Patients who come in for surgery may develop other problems that need respiratory help</p> <p>This would be covered by the consultant based at Cheltenham, very sick patients could be looked after in intensive care.</p>
<p>Patients needing transfer</p> <p>At the point that the ED team think that the patient needs to be admitted they would put them on the Acute take list, arrangements would then be made to transfer the patient (via a Trust inter-site ambulance) to Gloucester. The patient would be taken directly to the Acute Medical Unit, avoiding the ED.</p>

Feedback received and FFTF2 response

Community support

Cheltenham outpatient clinics will not be changed.

We are also developing an Acute Respiratory Infection Virtual Ward. This model will be aimed at patients who would otherwise have been admitted to hospital on a <5 Length of Stay (LoS) bed stays and have a News2 score of <4. This model also supports patients being discharged from hospital to the care of this ward who would otherwise have had to remain in hospital longer.

Travel and Transport

The negative impact of increased travel is clearly recognised. Analysis has indicated that ~ 9% of patients will be negatively impacted, with 91% neutral or positive. Our Integrated Impact Assessment would indicate that the benefits (patient outcomes) outweigh the negative travel impact.

Key Points

- **This service change proposal delivers the case for change.**
- **This service change proposal delivers a range of patient and staff benefits, including the significant patient outcomes resulting from the establishment of a Respiratory High Care Unit.**
- **This service change proposal is supported by the Clinical Senate**
- **This service change proposal is supported by respondents to our engagement**
- **The centralisation of Respiratory in-patient beds is currently implemented as a temporary service change.**

10 Stroke

10.1 The 'current state' service model

It should be noted that the "current" service model is a result of temporary service changes and reflects proposals for the future configuration of services as opposed to the pre-COVID configuration which is the "no change" model.

The specialist stroke pathway in Gloucestershire is delivered jointly by Gloucestershire Hospitals NHS FT (GHNHSFT) and Gloucestershire Health and Care NHS FT (GHCFT). The stroke service consists of medical, nursing, therapy and support staff and cares for patients of all ages that present with stroke and/ or Transient Ischaemic Attack (TIA).

The GHNHSFT stroke service manages the largest number of stroke patients in the South West. It is a well-established service with well-developed links to the regional tertiary stroke centre at North Bristol Trust (NBT).

The Gloucestershire stroke pathway comprises the following:

Service	Provider	Pre-COVID location	Current Location
Hyper Acute Stroke Unit (HASU)	GHNHSFT	GRH	CGH ³⁰
Acute stroke Unit (ASU)	GHNHSFT	GRH	CGH ³¹
Community Stroke Rehabilitation unit	GHCFT	The Vale Community Hospital	
Early Supported Discharge (ESD)	GHCFT	Domiciliary / Patient's Home	

Currently (Feb 2023), HASU has 10 beds on the Acute Care Unit and the ASU is located on Woodmancote Ward with 32 beds. Outpatient services are located at CGH and include new and follow up clinics and a transient ischaemic attack clinic. The Stroke service have a funded establishment of six consultants. Details of future bed requirements are provided in section 5.7.

The FFTF2 changes only relate to the location of the HASU and the ASU provided by the Hospitals Trust and do not include any change to the core elements of the Gloucestershire stroke pathway listed above.

Current patient pathway

There is an agreed protocol with South West Ambulance Services Foundation Trust (SWASFT) to take all stroke/query stroke patients direct to CGH.

- SWASFT/GP call via CINAPSIS
- The patient is accepted by the stroke team
- The patient arrives at CGH and is taken directly for a CT scan (no contact with the Emergency Department at CGH)
- The patient is swabbed for COVID. (If a patient requires admission and is negative the patient is admitted to a bed on ACUC. If positive the patient is admitted to Knightsbridge ward.)

³⁰ Relocated in February 2022 (temporary until March 2023). Split site model Jun 2020 to Jan 2022.

³¹ Relocated in June 2020 (temporary until March 2023)

- Depending on their condition, following their stay on HASU, patients are either transferred to the ASU (~50%) to continue their inpatient treatment and care, transferred to another service provider or able to return home with on-going community support where needed.

If patients with stroke symptoms 'walk in' at the CGH Emergency Department, the stroke team are alerted, the patient is assessed and if appropriate, they are admitted.

If a patient with stroke symptoms 'walks in' at GRH Emergency Department, they receive a priority assessment and there is immediate communication with the stroke team. If appropriate the patient is transferred to CGH for rapid stroke assessment.

There is a consult model in place for GRH, which means that stroke staff will provide advice and support to other specialties (service areas) on the GRH site.

Prior to the relocation of the HASU to CGH the Trust discussed the proposal with the national Getting It Right First Time (GIRFT) clinical lead for stroke services and has been advised that a similar model is currently being used at East Kent Hospitals with direct admissions to a planned care site. Feedback on the proposed model has been positive and supportive.

10.2 Activity

The pathway schematic (Appendix 12a) details the flow and numbers of patients for the period Jun 20- May 21. In summary:

- ~ 1000 strokes including stroke admissions and existing inpatients experiencing a stroke
- ~50% of stroke admissions are transferred to ASU
- A significant proportion of stroke admissions (~30%) are discharged to usual place of residence from HASU

10.3 Clinical Engagement

A Task and Finish group, as a sub-group of the Circulatory CPG, was established to undertake a diagnostic review of current service configuration and with the aim of developing a service model and configuration for the stroke services in Gloucestershire, which will maintain and enhance service performance as measured by the SSNAP³² indicators.

The scope of this review included the optimal number of beds, the longer-term preferred staffing models for each element of the pathway (including opportunities and benefits of enabling staff to work across the whole pathway) and options³³ for improving the non-bedded element (Community Rehabilitation etc.).

Membership of this group included clinical and management representatives from GHNHSFT and GHCFT, CCG commissioning leads, Stroke Association and lay representation.

³² Sentinel Stroke National Audit Programme

³³ This is subject to a separate Business Case process and outside the scope of FFTF2

10.4 Case for change: the problem we are seeking to address

The FFTF2 proposals are concerned with location of the HASU and ASU taking into consideration a number of factors, including:

- Benefits of co-location including workforce
- Removal of stroke from the ED pathway improving outcomes and mitigating ED demand
- Site bed capacity constraints
- Ward environment available at each site

Workforce

Nationally there is a shortage of stroke doctors. The Trust has attempted to recruit to these posts substantively, but this has been difficult as, across the country, Trusts are chasing a limited workforce pool. Strenuous efforts have also been made to backfill these posts, including locum/off framework agency staff. Despite these efforts it has proved difficult to cover these vacancies.

In addition, a combination of planned and unplanned staff changes means the number of stroke medical and nursing staff has reduced. This position made it difficult to provide safe and sustainable staffing levels on stroke wards under the post-COVID split site configuration at GRH and CGH, and to continue to provide outpatient services on both sites.

Given the above position the Trust identified the stroke staffing levels as an intolerable risk (number ID 3706) and, following detailed assessment of the options to reconfigure the service to make the best use of available staff, it determined that centralising stroke services onto one site would help mitigate this risk; the Trust moved HASU to CGH in Feb 2022.

This change has enabled staff covering all stroke areas (stroke doctors, nurses and therapists) to be on same site, so more able to cross cover each other.

ASU Ward Environment

Operating the ASU at CGH has highlighted a number of staff and patient benefits. Feedback from staff and patients is that Woodmancote is much better suited to support acute stroke care and rehabilitation than the previous Tower Block ward as it includes wide spaced bays that are open and light, bathroom facilities include overhead ceiling hoists, an environment that is designed to stimulate physical interaction and cognitive improvement.

Removal of stroke from the ED pathway

GRH and CGH Emergency Departments (EDs) are facing increasing demand due to delayed presentations from the pandemic, continued COVID demand, difficulties in patients accessing other services, difficulties in discharging patients who are medically fit, all of which affects to overall patient flow from the ED and delays in ambulance handovers. This can lead to delays in stroke patients being seen by the correct team impacting the ability to meet national standards for stroke care, for example time to CT scan carrying out thrombolysis³⁴ and admission to a dedicated stroke ward within 4 hours. The timely administration of tPA/ thrombolysis saves lives and because tPA restores blood flow by dissolving the clots in a blood vessel, it may limit the damage from a stroke and protect

³⁴ The medicine itself is called alteplase, or recombinant tissue plasminogen activator (rt-PA). The process of giving this medicine is known as thrombolysis.

against quality of life impacts, like mobility loss or speech difficulties. More benefits can be found in section 10.8).

In its pre-Pandemic configuration (with both HASU and ASU at GRH) the stroke service was rated C (on a scale of A to E), and initially, in its temporary configuration the service was rated B. However, the split site model and system pressures during winter 21/22 resulted in a rating fall to D.

The creation of a direct admit pathway, avoiding the need for patients to be seen in ED has improved the Trust's performance against national SSNAP targets on the time taken to receive a CT scan, to be assessed, to receive thrombolysis and be admitted to a stroke ward. Following the relocation of HASU to CGH the Trust SSNAP scores have improved (to either C or B in the quarters since Mar 2022).

In addition, relocating the HASU to CGH and revising the admission pathway has reduced pressure in GRH ED and GRH cardiology ward/medical bed base. The direct patient pathway to stroke team, that avoids ED, has reduced pressure in GRH and CGH ED.

10.5 Clinical Evidence

There has been strong evidence for many years that treatment at specialised stroke units, offering rapid access to the range of appropriate assessments and multidisciplinary expertise and intervention, is associated with lower mortality and lower rates of post-hospital disability³⁵.

Our current pathway (and proposals) is following NICE guidance (NG128, QS2 and CG 162) and the removal of stroke from the ED pathway is enabling direct to CT, earlier Alteplase (we are starting bolus in CT), a more protected bed capacity and so better access to specialist stroke unit.

As stated in section 10.1 the FFTF2 changes only relate to the location of the HASU and the Acute Stroke Unit ASU provided by the Hospitals Trust and do not include any change to the core elements of the Gloucestershire stroke pathway, which are aligned with best practice³⁶, that is:

- **Hyper-acute care** typically covers the first 72 hours after admission. Every patient with acute stroke should gain rapid access to a stroke unit (<4 hours) and receive an early multidisciplinary assessment.
- **Acute stroke care** immediately follows the hyper-acute phase, usually 72 hours after admission. Acute stroke care services provide continuous specialist input, with daily multidisciplinary care and continued access to stroke trained consultant care, physiological monitoring and urgent imaging as required.
- **Inpatient rehabilitation** is an essential bridge for many stroke survivors between acute stroke care and post-discharge integrated community rehabilitation. Its key outcomes overlap with those for acute stroke care, community rehabilitation and life after stroke.
- **Early Supported Discharge** facilitates early transfer of care to a community setting, where rehabilitation continues at the same intensity and with the same expertise as in the inpatient setting.

³⁵ Stroke: GIRFT Programme National Specialty Report (April 2022)

³⁶ National Stroke Service Model (May 2021)







10.6 How was preferred option evaluated?

The T&F Group applied hurdle criteria to the long-list (of 256 possible permutations)³⁷. This process was undertaken prior to the decision to relocate HASU to CGH (Feb 2022) and before the decision to separate the non-bedded developments into a separate business case process outside of FFTF2. Taking these factors into account, particularly the learning over the past two years that it is more effective to manage and deliver a quality service if both units are on the same site, the medium-list became #3.

As described in section 5.2, the next step was the application of the FFTF desirable criteria. Our solutions appraisal exercise is designed to evaluate proposed changes compared with the status quo. Given that the changes outlined above are already in place, the proposed change evaluated in the case of stroke was **reverting back** to the original configurations, i.e., reversing the current temporary service change.

The scorecard from the solutions appraisal process is presented overleaf.

³⁷ The long-list and original hurdle assessment can be found in Appendix 12a

Revert Hyper-Acute Stroke Unit and Acute Stroke Unit from CGH and back to GRH		
Quality	Scores	Worse than status quo 
	Comments	<ul style="list-style-type: none"> • Key benefit of current model is direct admitted pathway. • SSNAP from Feb access to CT and HASU beds has improved. • Woodmancote purpose built as an acute unit. • CGH gives more opportunity to provide the number of beds required. • Some feedback from vascular but view not essential to have co-location. • No significant "Blue Light" impact
Access	Scores	Broadly similar to status quo 
	Comments	<ul style="list-style-type: none"> • Cinapsis significantly improved • Overall public transport options for services moving to CGH generally worse. • Access to HASU is better on CGH site as well as Woodmancote as less bed pressures and ability to reduce LOS
Workforce	Scores	Similar or slightly worse than status quo 
	Comments	<ul style="list-style-type: none"> • Move positively received by staff. • Issue moving Woodmancote back for rehab colleagues, thrive in a rehab environment. • Better space for training • Woodmancote better environment to develop skills and deliver care
Deliverability	Scores	Worse than status quo 
	Comments	<ul style="list-style-type: none"> • Should not underestimate the space needed, which would be a challenge to provide on the GRH site. • Better access to CT and MRI at CGH.
Strategic Fit	Scores	Similar than status quo 
	Comments	<ul style="list-style-type: none"> • Purist planned and emergency site split - slightly worse. • Innovative model not accepted "norm" but other sites in England
Acceptability	Scores	Similar than status quo 
	Comments	<ul style="list-style-type: none"> • Comments from vascular. Concerns re pathway, but this would not materially change. • 82% of respondents support the proposals

Based on the above assessment, the preferred option is to maintain the Hyper Acute Stroke Unit (HASU) and Acute stroke ward (ASU) at Cheltenham General Hospital.

There will continue to be a choice of outpatient appointments at CGH and virtually when appropriate.

10.7 How does this address the case for change?

Reason for change	How preferred option addresses this
Improved rehabilitation ward environment	Woodmancote at CGH is much better suited to support acute stroke care and rehabilitation than the previous Tower Block ward at GRH, as it includes wide spaced bays that are open and light, bathroom facilities include overhead ceiling hoists, an environment that is designed to stimulate physical interaction and cognitive improvement.
Removal of stroke from the ED pathway	Our current pathway (and proposals) is following NICE guidance (NG128, QS2 and CG 162) and the removal of stroke from the ED pathway is enabling direct to CT, earlier Alteplase (we are starting bolus in CT).
Site bed capacity constraints	The relocation of both HASU and ASU to CGH has created an opportunity for a more protected stroke bed capacity than was achieved on our emergency site (GRH)
Workforce	The co-location of HASU and ASU are essential to mitigating our workforce requirements and risks. The proposal delivers this.

10.8 Benefits including clinical outcomes

Potential Benefits

- Direct admit stroke pathway (avoiding ED) which improves performance against four of ten SSNAP domains, i.e., Domain 1 -time to scan, Domain 2 – admission to a stroke Unit, Domain 3 proportion of patients receiving thrombolysis and timescale and Domain 4 – specialist assessment and timescale.

Overall thrombolysis/ tPA effectiveness:

- 1 in 3 get better
- 1 in 10 get significantly better incl complete recovery
- 1 in 33 get worse including bleeding and/or death
- Every 15 minute delay in re-perfusing an ischaemic stroke equates to 1 extra year of disability

- Both inpatient units are on the same site - which supports a seamless service and means that patients can access the right specialist staff at the right time
- The co-location of HASU and ASU provides improved staff cover and improved staff resilience for sickness and absence
- The ASU would continue to use the specialist Woodmancote Ward and would not need to share space with HASU. This environment is more spacious, it has hoists and provides an area for therapy services. It is also a better and quieter environment for patients receiving rehabilitation care. The quality of this environment is better than the original space available at GRH

- When compared to a split site option it reduces the need to transfer patients receiving inpatient stroke care³⁸
- There would not be the same challenges on bed availability as there would be on the GRH site.
- Reduced pressure in GRH ED and GRH cardiology ward/medical bed base
- Better training of stroke ward juniors
- TIA clinic could be run from Ambulatory Emergency Care Unit (AEC) at CGH – enabling faster access to specialist opinion, ability to train acute medical juniors in stroke.
- Reduced pressure on GRH CT/MRI.

Potential drawbacks

- There will be travel impact for some patients previously attending GRH who will now attend CGH. The overall impact is 15% of HASU and 17% of ASU stroke patients / families/ carers are negatively affected by centralising at CGH³⁹
- There are a number of non-stroke conditions that can present with similar clinical features to stroke and TIA (these patients are known as stroke mimics). These may be taken to CGH and then, once identified, are either managed by the stroke team at CGH or may be required to be transferred to GRH.
- Likewise, there may be patients that develop a stroke whilst an inpatient at GRH and may need to be transferred stroke unit. However, this position would be similar if the stroke service was to revert to being centralised at GRH.
- Whilst the clinical evidence for consolidating stroke services onto a single site (now CGH) shows improved patient outcomes, clinical protocols are in place for any suspected stroke patient presenting at GRH, including advice and support and safe transfer from GRH to CGH.

10.9 Interdependencies with other services

There are a number of interdependencies of operating the HASU at CGH (our planned site), these including medical cover at CGH once the Acute Medical Take (ACUC) moves to GRH (September 2023). Full details of rotas are provided in Appendix 6.

10.10 Workforce

The Stroke service have a funded establishment of 6 consultants.

There are no plans/ requirements to change the clinical or operational staffing as a result of these proposals.

³⁸ There would still be occasions where a patient may 'walk in' at the GRH Emergency Department and would need to be transferred to CGH or an inpatient at GRH has a stroke, while under the care of another service area (specialty) and, based on their clinical needs, it is decided to transfer them to CGH.

³⁹ Details of the methodology can be found in section 11.5

10.11 “Blue light” ambulance travel impact

As with FFTF1, the FFTF programme has worked closely with the South Western Ambulance Service NHS Foundation Trust (SWASFT) and Operational Research in Health (ORH) Limited to model the “blue light” ambulance travel impact. The impact has been assessed for both the ambulance incident response times and the Call to Hospital. The findings for HASU are as follows:

- The impact to response performance of making the proposed changes are generally small, at 18 seconds for both the C2 mean and C2 90th percentile in Gloucestershire CCG.
- Average ambulance utilisation across the model increases by 0.1 percentage points; this is expected as despite travel time to CGH being 3m 37s longer on average, only 1.2% of transported patients in Gloucestershire CCG are affected by the change.
- The total time from time of call to handover at hospital increases by 7m24s for HASU patients. This measure is impacted by many factors including resource availability, changes in travel times and stacking of vehicles at hospital during handover.
- A series of simulation runs were then carried out, adding additional ambulance deployments at Staverton to identify the additional resources required to mitigate the performance impacts.
- An additional 14 ambulance hours per week at Staverton are needed to restore performance, delivered through the extension of shifts. In terms of scale, this is approximately 10% of the overall additional ambulance hours required for FFTF1.

10.11.1 2019/20 Arrival to Handover Modelling

- SWAST has experienced increased handover delays in 2021/22 compared to previous years.
- The base position, HASU modelling scenarios were re-run with 2019/20 handover delays to quantify the effect of longer handover times on response performance.
- In HASU, the impacts on performance with 2019/20 handover delays are of a similar magnitude to that with 2021 handover delays. With 2019/20 handover delays the mean response time impacts are generally smaller, but the 90th percentile impacts are generally larger.
- The C1 impacts are smaller, potentially as due to the lower strain placed on resources by reduced handover delays, the highest acuity category is protected.

In respect of any emergency inter-site transfers, please see section 5.6.

10.12 Standard Operating Procedures (SOPs)

The current SOP is attached as Appendix 12b. This describes in more detail the pathway process outlined earlier. This SOP will be updated when the acute take centralises at GRH.

10.13 Learning from Temporary Service Change Period

These stroke proposals have been influenced as a result of temporary service changes made in response to the pandemic, and this provided the opportunity to test and trial service configurations before deciding formally to consider them as permanent change proposals.

10.14 South West Clinical Senate Review

The clinical panel made the following comments:

- Whilst most stroke services are co-located with the acute medical take, the Panel believed that the proposals would deliver clear benefits for stroke patients but that there are also some possible disbenefits including for those presenting to GRH who will need to be transferred to CGH for management and rehabilitation and may experience delays in their early management.
- Integration of the ASU and HASU on the same site at CGH in purpose-built accommodation is advantageous for both patients and staff.
- “Direct to CT” pathways will save valuable time in assessing and managing people with a stroke brought to hospital by ambulance.
- It would be preferable for stroke mimic patients to be cared for at GRH under other acute medicine pathways, instead of in the Stroke Unit at CGH, but this may not always be possible, and bed and workforce planning must allow for the continuing management of stroke mimics at CGH.
- The Panel observed that the imaging support at CGH is currently unable to identify late presenting patients who may be suitable for thrombectomy using CT Perfusion Imaging in line with NICE Guidance NG128 and the national optimal stroke imaging pathway. The Panel recommended that this is addressed as soon as possible.

In respect of the point raised above, the clinical teams have indicated the following:

- We are aware of the benefits of CT perfusion scanning and are working with our radiology department to look at how to progress this within GHNHST. This will require training of radiographers and radiologists, which does not have an immediate solution, but we know this is an aim.

For completeness our responses to the Senate Desk-top review report are included in Appendix 17.

10.15 Engagement feedback

As described in section 4 we have undertaken an extensive public and staff engagement programme.

10.15.1 Quantitative Survey responses

The proposal we engaged on is that both the Hyper Acute Stroke Unit and Acute Stroke Unit remain permanently at CGH and the way that patients currently access the service remains the same. The learning over the past two years is that it's easier to manage and deliver a quality service if both units are on the same site (CGH).

- **84%** of all respondents excluding staff either **strongly supported** or **supported** the idea
- **73%** of staff respondents either **strongly supported** or **supported** the idea

Respondent type and proportion (%)		Strong support	Support	Oppose	Strongly oppose	Total Support
Not stated	12%	36%	46%	9%	9%	82%
A community partner	4%	50%	50%	0%	0%	100%
A member of the public	44%	51%	47%	0%	2%	98%
An employee working in health or social care	35%	36%	37%	0%	27%	73%
Prefer not to say	5%	20%	20%	0%	60%	40%
Grand Total	100%	43%	41%	1%	15%	84%

It should be noted that the ideas for stroke received the highest proportion of opposition from survey respondents compared to other services, particularly from staff concerned with the location of stroke at the non-emergency site. Concerns were raised especially regarding co-location with vascular surgery and cardiology. All survey comments were reviewed by the Stroke team and a response is provided in section 10.16. Meetings between the two services have also been undertaken.

All survey respondents were asked to provide us with the rationale for their response and what information they would like us to consider. A summary of the key themes and some example comments (from staff and the public) are presented below, with our response in section 10.16.

10.15.2 Qualitative Responses - Public and Patient themes

Theme	Survey comment examples
Interdependencies	<ul style="list-style-type: none"> Getting a stroke patient to one of these units within the critical 4 hours is another matter given the current demand for ambulances.
Clinical considerations	<ul style="list-style-type: none"> I'm very unsure about this. No mention made of thrombectomy I am concerned that, with the often time critical nature of strokes, the move of in-patient stroke to CGH might lengthen the time before a patient received a necessary thrombolytic agent. The issues of patient transport need to be addressed, especially walk-ins to GRH which are subsequently transferred to CGH. Why would you have Stroke based at Cheltenham General when cardiac, interventional radiology and vascular services are all at Gloucestershire Royal Hospital Happy that CGH has control of stroke admissions. I agree with potential benefits.
Benefits	<ul style="list-style-type: none"> Excellent - good analysis of potential drawback Streamline to get the best optimal service. The better and sooner we treat stroke, the way better the outcomes for patients and their long-term outlook.
Ward environment	<ul style="list-style-type: none"> It makes sense to have both the HASU and ASU on the same site, but also that they are separated so as to have the ASU in the quieter area.

Theme	Survey comment examples
	<ul style="list-style-type: none"> • Vital to have prompt effective assessment and treatment. Good to have a therapy areas on Woodmancote Ward.
Inter-site transfers	<ul style="list-style-type: none"> • There will still be transfers required, but there would be anyway if it was all located at GRH. However, as ever the issues of patient transport need to be addressed, especially walk-ins to GRH which are subsequently transferred to CGH. • Same site for both makes sense and if transport between the 2 hospitals if needed is in place, that should cover the unusual cases

10.15.3 Qualitative Responses - Staff themes

Theme	Survey comment examples
Clinical considerations	<ul style="list-style-type: none"> • The purpose-built ward at CGH is suitable • I share the concern about receiving the correct treatment, diagnosis and transfers to Cheltenham. • The new model for HASU works well having limited beds and a focus on patients being moved on quickly
Interdependencies	<ul style="list-style-type: none"> • Stroke services need to be located where ED, Interventional Radiology, Vascular and cardiology are on the main acute site. • Acute stroke is an emergency service, and it should be based at a site where there is 24 hour ED • What happens to overnight Strokes when ACUC moves to GRH, and the medical cover goes with it? • Removing the service from the main ED and delaying crucial intervention such as thrombolysis.
Workforce	<ul style="list-style-type: none"> • It has hugely helped with staffing and team moral being on the same site. • I point out that, especially for understaffed therapy teams, HASU and ASU being on the same site saves huge amounts of resources as the therapists can help out on each ward depending on staffing and patient demands. • I would also say that the service should have more funding for therapists and assistants and would benefit from an activities coordinator, social work support and complex discharge coordinator
Ward environment	<ul style="list-style-type: none"> • The current HASU ward is not fit for purpose • Larger clinical area for HASU - more room for beginning rehabilitation of patients • Woodmancote is more modern, lighter and purpose built for Stroke rehabilitation. • Woodmancote is well suited to the therapy needs of patients considering the track hoists and large therapy room and Cheltenham hospital is a good environment for these patients with nice outdoor areas that can be accessed.

Theme	Survey comment examples
Health inequalities	<ul style="list-style-type: none"> Stroke services should be at biggest acute hospital in the city where socioeconomic circumstances make stroke most common

10.16 Addressing themes from engagement feedback

Feedback received and FTF2 response
<p>Stroke services need to be located where ED, Interventional Radiology, Vascular and cardiology are on the main acute site.</p> <p>There is currently no interventional radiology input from Gloucester or Cheltenham. The interventional radiology for strokes is carried out at Southmead and there is no intention that that will change. If, and when, GHNHSFT starts providing thrombectomy for strokes, we will revisit our service configurations, but currently and the for the next few years, this is not an issue.</p> <p>The vascular issue is around access to carotid dopplers and carotid endarterectomy for the high TIAs. Surgery is not performed on the same day and best practice is within seven days. The vascular unit at GRH includes patients from Swindon which is acceptable.</p> <p>Cardiology input is for telemetry and tapes and echoes. We will continue to have cardiac investigations on both sites. Furthermore, echoes are never immediate to help guide next steps of treatment. It's not emergency care. We rarely share stroke patients with cardiology. We may occasionally ask for advice on rhythm disturbance, but we have not had a patient that suddenly had a heart attack and needed resuscitating.</p>
<p>Medical cover at CGH</p> <p>Out of hours there is 24/7 medical registrar cover at CGH. This registrar provides cover for the acute take as well as supporting the stroke service. Once the acute take centralises at GRH the responsibilities of this post will reduce. The medical registrar works closely with the specialist nurses and the Advanced Care Response Team. There is a Consultant Specialist regional on call rota for thrombolysis/thrombectomy queries. At weekends there is a Stroke Consultant on site at GRH from 8am – 12.00.</p>
<p>Strokes at GRH</p> <p>If a patient with stroke symptoms 'walks in' at GRH Emergency Department, they receive a priority assessment and there is immediate communication with the stroke team. If appropriate the patient is transferred to CGH for rapid stroke assessment.</p> <p>There is a consult model in place for GRH, which means that stroke staff will provide advice and support to other specialties (service areas) on the GRH site.</p> <p>There is now an agreed protocol for managing COVID positive stroke patients in CGH.</p>
<p>Ambulance travel times</p> <p>As with FTF1, the FTF2 programme has worked closely with the South Western Ambulance Service NHS Foundation Trust (SWASFT) and Operational Research in Health (ORH) Limited to model the "blue light" ambulance travel impact. The impact has been assessed for both the ambulance incident response times and the Call to Hospital. The findings for HASU are as follows:</p>

- The impact to response performance of making the proposed changes are generally small, at 18 seconds for both the C2 mean and C2 90th percentile in Gloucestershire CCG.
- Average ambulance utilisation across the model increases by 0.1 percentage points; this is expected as despite travel time to CGH being 3m 37s longer on average, only 1.2% of transported patients in NHS Gloucestershire are affected by the change.
- The total time from time of call to handover at hospital increases by 7m24s for HASU patients. This measure is impacted by many factors including resource availability, changes in travel times and stacking of vehicles at hospital during handover.
- A series of simulation runs were then carried out, adding additional ambulance deployments at Staverton to identify the additional resources required to mitigate the performance impacts.
- An additional 14 ambulance hours per week at Staverton are needed to restore performance, delivered through the extension of shifts. In terms of scale, this is approximately 10% of the overall additional ambulance hours required for FFTF1.

Ward environment

As part of proposed moves for Cardiology in May 23, the HASU will be able to relocate into the Cardiology ward at CGH, which will provide 21 beds. This ward looks out on to a courtyard garden providing better space for recovery. It will also provide better space for therapy services. Cheltenham has better car parking access for wheelchair users.

Travel and Transport

The negative impact of increased travel is clearly recognised. Analysis has indicated that ~ 15% of patients will be negatively impacted, with 85% neutral or positive. Our Integrated Impact Assessment would indicate that the benefits (patient outcomes) outweigh the negative travel impact.

Inter-site transfers

The Trust currently has a contract with an independent company to provide patient transfers by ambulance. The transfers include transporting patients from the GRH to Hartpury Suite (Cath Lab) at CGH, supporting patient discharge to their place of residence or to other providers and transferring patients between the two hospital sites. As part of FFTF Phase 1, work was carried out to identify the inter hospital demand to support the centralisation of emergency general surgery and the acute medical take at GRH, and the transfer of vascular services and interventional cardiology services to GRH. This work has been updated to reflect the current experience during the temporary service changes and the proposed service changes within FFTF Phase 2, i.e., the centralisation of respiratory, cardiology, diabetes and endocrinology services at GRH and the centralisation of stroke services at CGH.

Key Points

- **This service change proposal delivers the case for change.**
- **This service change proposal delivers a range of patient and staff benefits and supports improvements in SSNAP performance.**
- **This service change proposal is supported by the Clinical Senate**
- **This service change proposal is supported by respondents to our engagement**
- **This service change proposal is currently implemented as a temporary service change.**

11 Integrated Impact Assessment (IIA)

An integrated impact assessment supports decision making by evaluating the impact of a proposal, informing public debate and supporting decision makers to meet their Public Sector Equality Duty (see section 13.3), and their duty to reduce inequalities.

In relation to equality, these responsibilities include assessing and considering the potential impact which the proposed service relocation could have on people with characteristics that have been given protection under the Equality Act, especially in relation to their health outcomes and the experiences of patients, communities and the workforce. With reference to health and health inequalities, the responsibilities include assessing and considering the impact on the whole of the population served by the relevant statutory bodies and identifying and addressing factors which would reduce health inequalities, specifically with regard to access and outcomes.

The assessment uses techniques such as evidenced based research, engagement and impact analysis to understand the impact of change on the population, the impact on groups with protective characteristics and the impact on accessibility and quality of services. The aim of the assessment is to understand and assess the consequences of change whilst maximising positive impacts and minimising negative impacts of the proposed change. The Fit for the Future (FFTF) programme undertakes the following process to develop its IIA.

1. Undertake a baseline IIA for each service based on the proposals, clinical evidence and potential outcomes prior to the engagement process and include recommendations based on the evidence review to inform an action plan.
2. Update the baseline IIA following public involvement to take account of feedback from the public, patients, staff and stakeholders. The IIA report contains evidence that decision-making arrangements will pay due regard to equalities and inequalities issues and the Brown principles⁴⁰.

A full IIA for each service is provided in the relevant appendices (13a-e), which includes all data and evidence-based review. The FFTF IIA uses data and analysis provided by the Office of National Statistics (ONS) to help us understand impacts on those affected by potential change. These IIA's use data from the 2011 Census as this is the most recent Census data that has been robustly analysed by the ONS, who provide a statistical commentary which we have used to help us with our assessments of impact. The IIA's also contain data from GHFT detailing admissions to hospital by protected characteristic and location which helps us analyse impacts of change.

The most recent census also took place in 2021 and the ONS is currently in the process of releasing data, analysis and commentary, however, this is not available for this DMBC as the ONS release schedule is currently planned for:

- Early 2023 - Phase 2: Multivariant data releases and statistical commentary
- Spring 2023 – Phase 3: Alternative population base analysis (workplace etc) and statistical commentary
- Summer 2023 – Phase 4: Comparable data released and statistical commentary

As soon as more data is available it will be used in future IIA's.

⁴⁰ ⁴⁰ R. (Brown) v. Secretary of State for Work and Pensions [2008] EWHC 3158 at paras 90-96.

The FFTF IIA is made up of 3 chapters:

- Equality Impact Assessment
- Health inequalities impact assessment
- Health impact assessment

The proposals presented in the FFTF2 engagement for all groups were found to be either neutral impact, significant positive impact/moderate adverse impact, or significant positive impact.

Our approach to the engagement targeted all groups, ensuring proactive engagement amongst older and disabled residents more likely to be service users and ensuring opportunities for people to have their say were provided in both urban and rural venues through the extensive use of the NHS Information Bus and Get Involved in Gloucestershire (GiG) engagement website.

11.1 IIA Summary

As stated above full IIAs for each service is provided in the relevant appendices, however, the impact assessment for services consolidating on either the CGH or GRH site is often similar including:

- Centralisation of services can improve patient outcomes, continuity of care, length of stay, patient experience and reduces mortality particularly beneficial to patients with protected characteristics including those with long term conditions or co-morbidities which are prevalent in patients with disabilities and those over 65.
- Studies of secondary care usage have found that ethnicity is a significant predictor of acute hospital admission. The district with the highest proportion of ethnic diversity is Gloucester city meaning that a geographical distribution of services to GRH might have a greater positive impact on these communities
- On the basis that there is a higher proportion of the population in the Gloucester district who are living in deprivation (25%) and who suffer from Type 2 Diabetes (6.8%) there is a potential that patients who access the service from Gloucester will be positively impacted by a movement of services to GRH
- The re-location of services from GRH to CGH will impact some patient and carer travel times either positively or negatively (see individual service sections for service impacts)
- There is no conclusive evidence to suggest that access to and experience of acute hospital care differs solely based on a person's sex.
- There is currently limited data to determine any impact of the changes for women during pregnancy.
- There is currently limited data to ascertain any impact of the changes for those who are from any particular marital status.
- According to the Stonewall survey, 13% of LGBTQ+ people have experienced some form of unequal treatment from healthcare staff because they are LGBTQ+
- There is currently limited data to ascertain any impact of the changes for those who are from any particular religious background.
- There is limited evidence regarding the impact to those who have undergone gender reassignment, however, impacts may mirror those of sexual orientation.

- Caring responsibilities can have an adverse impact on the physical and mental health, education and employment potential of those who care, which can result in significantly poorer health and quality of life outcomes.
- Consolidation of the inpatient bed base should provide shorter lengths of stay, faster diagnostics and minimised waiting times which will help carers who have to attend hospital regularly.
- Services centralising at GRH will be located nearer to the highest proportion of homeless people in Gloucestershire. Homeless people are more likely to have long term conditions and multiple conditions which means consolidating and co-locating services will provide support for more complex needs such as these.
- Mortality rates suggest that the district of Gloucester City has the highest rates of deaths due to substance misuse, significantly higher than county and national averages. Relocation of services may therefore be beneficial to this group.
- GHNHSFT admission data demonstrates that more people attend GRH than CGH with mental health related issues. Relocating services to GRH may therefore be beneficial to this cohort.
- The consolidation of relevant specialist services improves training and enhanced understanding of patient conditions, leading to better clinical outcomes and improving access to services with fewer cancellations
- Feedback from staff and patients suggests public transport and parking can be a challenge at both sites.
- Forest of Dean is the only district locally that exceeds the national average in terms of the proportion of residents living with a disability. People with disabilities may have an increased risk of developing secondary conditions that are more likely to result in the need for acute care. This geographical clustering means that geographical changes to where services are delivered may have a disproportionate impact on those with disabilities in terms of access.

11.2 Equality Impact assessment

Equality impact assessment (EIA) is a tool which identifies and assesses impacts on a range of affected groups of people with characteristics protected under the Equality Act 2010, namely: age; gender, disability; gender reassignment; marriage and civil partnership; pregnancy and maternity; race and ethnicity; religion and belief; and sexual orientation.

The aim of an EIA is to establish the differential impact of a policy, such as in this case the development of centres of excellence and the proposed relocation or centralisation of services within Gloucestershire, on these groups. It also considers the potential measures which could reduce any negative impacts, especially in relation to health outcomes and the experiences of patients, carers, communities and the workforce. It also seeks to identify opportunities to better promote equality and good relations.

A full EIA for each service is provided in the relevant appendices (13a-e), which includes all data and evidence-based review. The impacts for each EIA domain are presented below; the key indicates the nature of the impact. This key is used throughout this section.

Key	Description
Significant Positive Impact	The positive impact is significant despite small adverse impacts
Significant Positive Impact Moderate Adverse Impact	The positive impacts outweigh the adverse impacts, however the adverse impacts have been identified and recommendations made to mitigate against these
Significant Adverse Impact	The adverse impact is significant and despite positive impacts it is not clear that the adverse impacts are outweighed by the positive impacts
Neutral Impact (no significant change)	No significant change identified for this cohort

Equality Impact Assessment – Summary of Impact by Service Proposal

Fit For the Future Phase 2 Integrated Impact Assessment - Overall Impacts Summary						
	Service	Stroke	Benign Gynaecology	Diabetes & Endocrinology	Non-Interventional Cardiology	Respiratory
Protected Characteristics	Age	Neutral Impact (No Significant Change)	Significant Positive Impact Moderate Adverse Impact	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact Moderate Adverse Impact
	Disability	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact
	Gender	Neutral Impact (No Significant Change)	Significant Positive Impact Moderate Adverse Impact	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact Moderate Adverse Impact
	Pregnancy	Neutral Impact (No Significant Change)	Significant Positive Impact Moderate Adverse Impact	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact
	Marital Status	Neutral Impact (No Significant Change)	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact
	Ethnicity	Neutral Impact (No Significant Change)	Significant Positive Impact Moderate Adverse Impact	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact
	Sexual Orientation	Neutral Impact (No Significant Change)	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact
	Religion	Neutral Impact (No Significant Change)	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact
	Gender reassignment	Neutral Impact (No Significant Change)	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact

11.3 Health Inequalities Impact Assessment

The Health Inequalities Impact Assessment identifies and assesses health inequalities and the impact of the proposed changes for the local community. The aims of a health inequalities impact assessment include identifying and addressing factors which would reduce health inequalities, specifically with regard to access and outcomes.

Unlike the protected characteristics listed in the Equality Act 2010, there are no specific groups identified in Section 14T of the NHS Act 2006 in relation to the duty to reduce health inequalities. However, research has identified that a range of groups and communities are at greater risk of poorer access to health care and poorer health outcomes⁴¹. Groups other than those that have protected characteristics as defined in the Equality Act 2010 who face health inequalities include Looked after and accommodated children and young people, carers (paid/unpaid & family members), homeless people or those who experience

⁴¹ <https://www.england.nhs.uk/wp-content/uploads/2019/01/ehia-long-term-plan.pdf>

homelessness, people with addictions and substance misuse problems, on low incomes, living in deprived areas or remote locations, and those with enduring mental ill health.

A full Health Inequalities Impact Assessment (HIIA) for each service is provided in the relevant appendices, which includes all data and evidence-based review. The impacts for each HIIA domain are presented below; the key indicates the nature of the impact; see key description used above.

Health Inequalities Impact Assessment – Summary of Impact by Service Proposal

Fit For the Future Phase 2 Integrated Impact Assessment - Overall Impacts Summary						
	Service	Stroke	Benign Gynaecology	Diabetes & Endocrinology	Non-Interventional Cardiology	Respiratory
Health Inequalities	Deprivation	Neutral Impact (No Significant Change)	Neutral Impact (No Significant Change)	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact
	Looked After Children (LAC)	Neutral Impact (No Significant Change)	Neutral Impact (No Significant Change)	Neutral Impact (No Significant Change)	Neutral Impact (No Significant Change)	Neutral Impact (No Significant Change)
	Carers and unpaid carers	Neutral Impact (No Significant Change)	Significant Positive Impact Moderate Adverse Impact	Significant Positive Impact Moderate Adverse Impact	Significant Positive Impact Moderate Adverse Impact	Significant Positive Impact
	Homelessness	Neutral Impact (No Significant Change)	Neutral Impact (No Significant Change)	Significant Positive Impact	Significant Positive Impact Moderate Adverse Impact	Significant Positive Impact Moderate Adverse Impact
	Substance Abuse	Neutral Impact (No Significant Change)	Significant Positive Impact Moderate Adverse Impact	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact
	Mental Health	Neutral Impact (No Significant Change)	Significant Positive Impact Moderate Adverse Impact	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact
	People Living in rural and remote areas	Neutral Impact (No Significant Change)	Neutral Impact (No Significant Change)	Significant Positive Impact	Neutral Impact (No Significant Change)	Significant Positive Impact

11.4 Health Impact Assessment

The Health Impact Assessment (HIA) identifies and assesses health outcomes, service impacts and workforce impact of the proposed changes for the local community. The aims of a health impact assessment include assessing and considering the impact on the whole of the population served by the relevant statutory bodies and identifying and addressing factors which would reduce health inequalities, specifically with regard to access and outcomes.

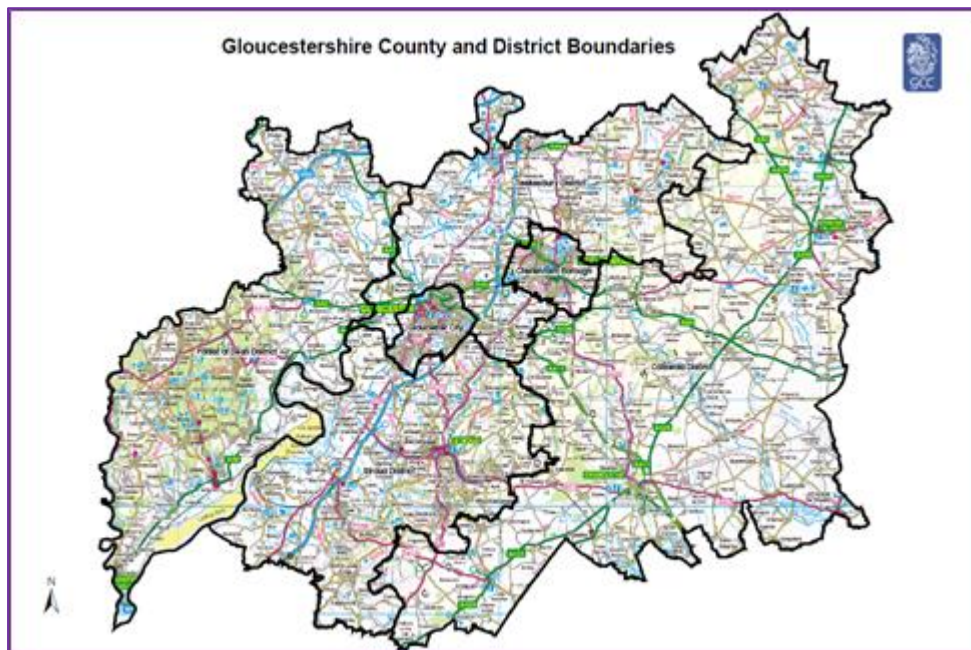
A full Health Impact Assessment (HIA) for each service is provided in the relevant appendices, which includes all data and evidence-based review. The impacts for each HIA domain are presented overleaf; the key indicates the nature of the impact; see key description used above.

Health Inequalities Impact Assessment – Summary of Impact by Service Proposal

Fit For the Future Phase 2 Integrated Impact Assessment - Overall Impacts Summary						
	Service	Stroke	Benign Gynaecology	Diabetes & Endocrinology	Non-Interventional Cardiology	Respiratory
Health Impact	Cardiovascular Disease	Neutral Impact (No Significant Change)	Neutral Impact (No Significant Change)	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact
	Diabetes Mellitus	Neutral Impact (No Significant Change)	Neutral Impact (No Significant Change)	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact
	Neurological Conditions	Neutral Impact (No Significant Change)	Neutral Impact (No Significant Change)	Neutral Impact (No Significant Change)	Significant Positive Impact	Significant Positive Impact
	Falls among the elderly	Neutral Impact (No Significant Change)	Neutral Impact (No Significant Change)	Neutral Impact (No Significant Change)	Significant Positive Impact	Significant Positive Impact
	Overweight and Obesity	Neutral Impact (No Significant Change)	Significant Positive Impact Moderate Adverse Impact	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact

11.5 Patient and Carer Travel

All of the proposed changes involve services being centralised (or consolidated) on one or other of GHNHSFT two main hospital sites, Gloucestershire Royal Hospital (GRH) and Cheltenham General Hospital (CGH), which are 8 miles apart.



Locality Populations	
Cheltenham	117,090
Gloucester	129,285
Tewkesbury	92,599
Cotswolds	89,022
Stroud	119,019
Forest of Dean	86,543

We fully recognise and appreciate that behind every number is a patient and family/carer and that the day to day impact on them will vary dependent on a range of factors including access to car travel, public transport availability and accessibility and differential impact related to protected characteristics.

We have undertaken detailed analysis using anonymised activity for the FTF2 services to assess the impact of our proposals on patients. Using the postcodes in our baseline activity we worked with the NHS South, Central and West Commissioning Support Unit (SCW CSU) to create spatial maps for each service proposal. The analysis was completed for:

- Travel by car (peak)
- Travel by car (off peak)
- Travel by public transport

As the data was anonymised and we therefore do not have access to the specific mode of transport used by patients who currently access services, we have used the following methodology to calculate the impact for each model:

- Step 1.** For all modes of travel (assuming all patients were to access using this mode), calculate the numbers of patients for each service, for each of the following categories
 - a. Positive impact (decrease 20+ minutes)
 - b. Neutral impact (+/- 20 minutes)
 - c. Negative impact (increase 20+ minutes)
- Step 2.** For each service identify the locality within Gloucestershire where the largest number of negatively impacted patients reside.
- Step 3.** Using ONS car ownership data for the relevant locality, calculate the potential number of patients for each service who could be users of public transport (This is likely to overstate the use of public transport as many non-car owners will use other means to get to hospital).
- Step 4.** For each service proposal assess if time of day (peak or off-peak) can be estimated e.g., if emergency (distributed across 24 hrs) or Day-case (2 cohorts a.m. peak and p.m. off-peak).
- Step 5.** Using the data from Step 1 calculate the number of patients for each proposal that will be travelling by car (peak and off-peak) and by public transport.
- Step 6.** Using the data from Step 1 and 5 calculate the number of patients for each proposal who are negatively or positively affected and deduct from the total to find those where the impact is neutral.

The details of the annual travel impact (for peak / off-peak car and for public transport) is provided for each service in the respective service sections above with a more detailed breakdown in the service IIAs (Appendices 13a-e); a summary of impacts is tabled below:

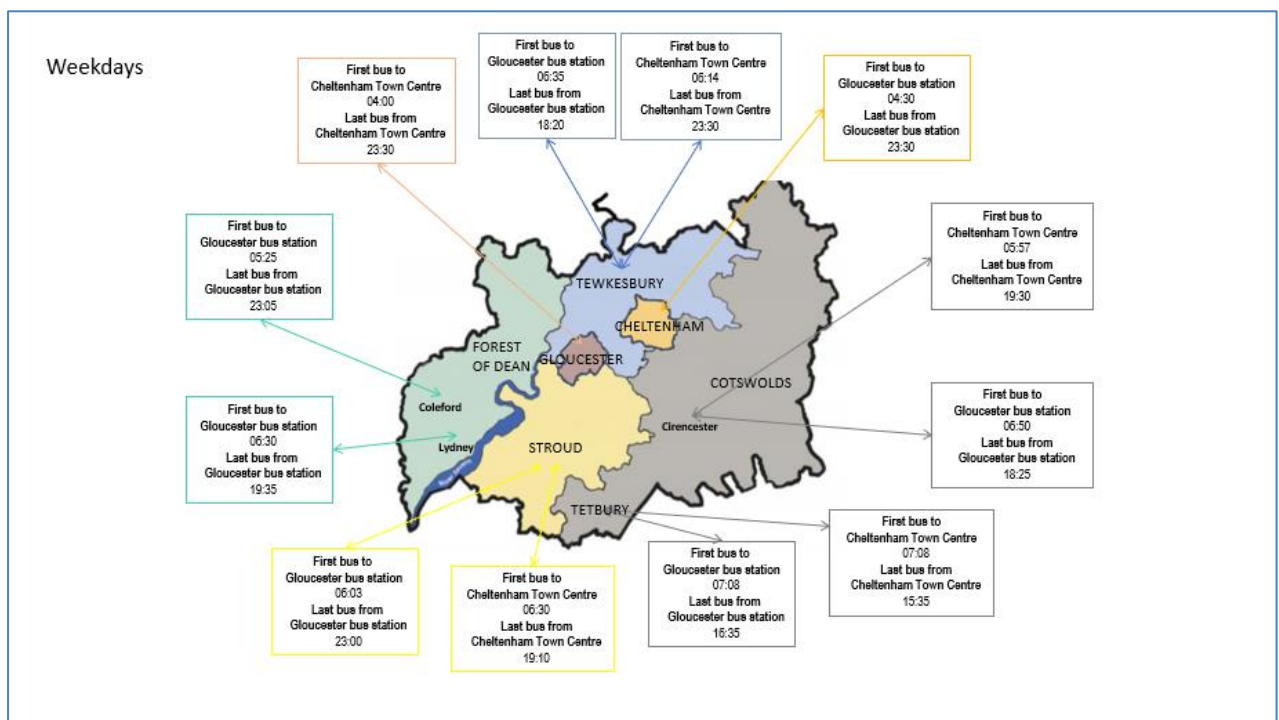
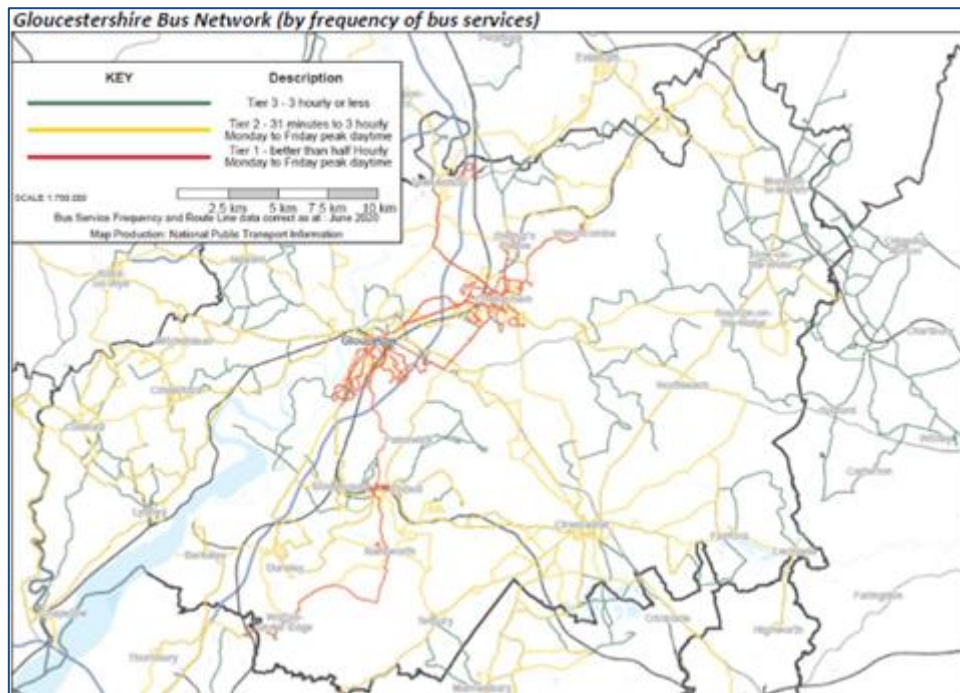
Service	Positive Impact (Decrease 20+ mins)	Neutral Impact (+/- 20mins)	Negative Impact (Increase 20+ mins)
Stroke			
-Hyper-Acute Stroke Unit (all patients)	9.7%	75.2%	15.1%
-Acute Stroke Unit (50% patients ⁴²)	11.0%	72.1%	16.9%
Respiratory	2.0%	89.5%	8.5%
Diabetes and Endocrinology	4.9%	90.9%	4.2%
Non-interventional Cardiology	15.3%	74.7%	10%
Benign Gynaecology	8.6%	73.7%	17.8%

⁴² The other 50% are discharged

11.6 Public transport services to GRH and CGH

Gloucestershire County Council (GCC) leads the Local Transport Plan which has public transport as one of its key themes. Although public transport has been identified as an issue there a range of services in place and proposals to improve access summarised below:

- GCC spend approx. £2.5 million a year on subsidised bus routes across the county. This remains a significant investment in public transport especially as in recent years some Councils have dramatically scaled back their funding.
- The Local Transport Plan is currently being refreshed up until 2041 which will set out strategic ambition for bus travel this sets out a commitment to making GP surgeries accessible with 45 minutes.
- The average journey time by train between Cheltenham Spa and Gloucester is 10 minutes. On an average weekday, there are 60 trains travelling between Cheltenham Spa and Gloucester.
- GCC provides £0.5 million per year in annual grants to support community transport providers, as this is an important provider of transport for vulnerable people. Dial-A-Ride is a bookable door-to-door transport service for those people who do not have their own transport and are unable to use public transport. The following community and Voluntary transport providers operate in Gloucestershire:
 - Connexions – county wide
 - Lydney Dial-A-Ride
 - Cotswold Friends
 - Newent Dial-A-Ride (Shepard House).
- Non-Emergency Patient Service exists for people who are eligible. These services provide free transport to and from hospital.
- GCC is progressing the Thinktravel Total Transport portal which will bring community, voluntary and public transport together under one platform, making accessible transport available to a wider audience who may not previously have considered these options as a travel choice.
- GHNHSFT works closely with a range of partners on transport planning services including GCC.
- GCC currently operates three Park & Ride facilities.
- The 99 bus service connects GRH, Gloucester Bus station, Arle Court Park and Ride, Cheltenham Town Centre and CGH.
- The bus network does have key routes linking Gloucester, Cheltenham and key towns, with services running on a regular basis during peak hours (see maps overleaf).



Weekday bus services (first and last) to Gloucester and Cheltenham

Further information is available in the following appendices:

- Appendix 14a Travel Impact travel analysis includes spatial maps and impact activity (by locality) for each mode of travel for each FTF2 service proposal.
- Appendix 14b public travel info includes information on bus, train, dial-a-ride services available for each locality to access CGH and GRH.

11.7 Car Parking

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.

Prior to COVID GHNHSFT initiated a full review of staff travel and car parking in line with NHS car parking management guidance to identify best practice in car park management and sustainable transport; including:

- Working with patients and staff to make sure that users can get to the site as safely and conveniently as possible;
- Solutions should also be economically viable;
- Travel plan should reduce environmental impact of staff commuting to work;
- Charges should be reasonable for the area;
- Concessions should be available for certain groups of users;
- Other concession, for example for volunteers or staff who car share should be considered locally; and
- Priority for staff parking should be based on need.

The review was paused at the start of the pandemic and has recently been re-started.

The public and staff have the option of using the 99 bus that operates between the two hospital sites. It runs Monday to Friday from 06:20 (first bus) to 20:05 (last departure⁴³), every half an hour and takes 30 minutes. It is free to GHNHSFT staff on production of an ID badge. The bus also stops at other stops between the hospitals with a fee of £1.00 payable at Gloucester Road, Cheltenham, Cheltenham Road and Longlevens. The bus service also collects passengers from the Arle Court Park and Ride in Cheltenham. The cost for this is £1.00 on production of ID badge and the cost for parking your car there is free. Staff impacted by changes may choose to use this service if their base changes from one site to another, but consideration needs to be given to the increase in their daily journey time as a result.

11.8 Carbon Impact

We have estimated the carbon impact using the following methodology:

- Using our travel impact analysis to determine number of patients positively and negatively impacted.
- Using travel time as a proxy for travel distance calculated the net impact (difference between positively and negatively affected)
- Using the 8 mile distance between GRH and CGH calculated the carbon impact

An assessment of the travel impacts on carbon footprint of the proposed changes can be found in Appendix 14c; the overall impact is +1.35 metric tonnes of CO².

We recognise this analysis does not report any other environmental impacts but as the level of activity and therefore resource use is the same as the baseline, travel is the single largest change.

⁴³ Up until March 2023 when the current extended service trial ends (19:05 is the non-trial last departure).

Key Points

- **Equality Impact Assessments (for groups with protected characteristics) have been completed for all service change proposals.**
- **Health Inequalities Assessments (for groups and communities that are at greater risk of poorer access to health care and poorer health outcomes) have been completed for all service change proposals.**
- **Health Impact Assessments (for groups and communities that have specific health needs and are at greater risk of poorer access to health care and poorer health outcomes) have been completed for all service change proposals.**
- **Impact is predominantly positive or neutral with no significant adverse impacts.**
- **Patient and carer travel impact modelling has been undertaken.**

12 Economic and Financial Analysis

12.1 Introduction

The economic and financial analysis has been developed by the Fit for the Future Programme team working with GHNHSFT clinical divisions, reporting to the GHNHSFT Director of Finance, and in collaboration with the Gloucestershire Integrated Care System Resources Steering Group (RSG) which comprises Directors of Finance from ICB, GHNHSFT, and GHCFT. Prior to the decision to stand-down the NHSE Stage 2 process, the programme also engaged with NHSE Finance colleagues.

The programme team included GHNHSFT Finance team, information analysts, a Senior HR Business Partner for Workforce Transformation, as well as the FTF Programme Director and Programme Managers.

12.2 Methodology

The methodology used for FTF1 was repeated for FTF2 and was based on the following principles:

- Identification of the relevant clinical divisions / service areas for solutions in scope
- Identification of the appropriate baseline for activity, workforce and finance
- Identification of shifts of activity for each of the proposed solutions
- “Bottom up” impact assessment for each service proposal to identify changes in workforce or other resource requirements
- Robust “Confirm and Challenge” process to ensure any staffing or resource requirements were essential
- Identification of financial impact (income and expenditure, both recurrent and non-recurrent) of proposed changes
- Combine proposed changes with baseline to determine finance for each service area
- Review of Downside Risk.

As stated in section 3.6, four of the five FTF2 service change proposals are currently already in place under Temporary Service Change arrangements, some since June 2020 and one (stroke HASU) since Feb 2022. The additional resource requirements are significantly less than those identified in FTF1 (see section 12.7) and are presented in the sub-sections below:

12.2.1 Growth

Our assessment of the impact of population growth uses 2018 subnational population projections from the Office of National Statistics (ONS). The management of growth demand is a consistent and ongoing objective within the ICS to ensure that hospital appointments and admissions are appropriate as well as the year-on-year efficiencies within GHNHSFT to deliver productivity improvements.

Whilst the ONS projections are recognised as the usual source for growth assumptions, it should be noted that they were published in 2018 and pre-date the Coronavirus (COVID-19) pandemic. Our proposals are to deliver our case for change over the medium to long-term and we have therefore, in agreement with NHSE&I, excluded impact of COVID-19 from our baseline data, staffing models, resource requirements and finances.

Given the multi-factorial nature of COVID-19 effects and uncertainty as to their impacts, the DMBC has not attempted to inflate resource demand (e.g. bed numbers) based on an unmitigated position. If these proposals are approved and the programme shifts to implementation, decisions will take account of the position at the time, and the developing pandemic recovery paradigm.

12.3 Workforce

Any additional workforce requirements were presented in the individual service sections (6 to 10), and are summarised in the table below:

Service	Additional Workforce
Benign Gynaecology	There are no plans/ requirements to change the clinical or operational staffing as a result of these proposals.
Diabetes and Endocrinology	There are no plans/ requirements to change the clinical or operational staffing as a result of these proposals.
Non-interventional Cardiology	There are no plans/ requirements to change the clinical or operational staffing as a result of these proposals
Respiratory	The only staffing changes that are being considered relate to the development of the Respiratory High Care service
Stroke	There are no plans/ requirements to change the clinical or operational staffing as a result of these proposals.

12.3.1 Respiratory High Care service

Centralising respiratory beds at Gloucestershire Royal Hospital, provides the flexibility and capacity to support the development of a respiratory high care unit. With additional investment in providing 2 x Advanced Clinical Practitioners and 1.5 x Band 7 physiotherapists, the Respiratory service can provide an 11 bedded high care unit. The medical and nursing support can be provided within existing establishments.

12.4 Financial Impact

As stated above the only anticipated additional resources for the delivery of FFTF2 relate to the establishment of a Respiratory High Care unit, which requires a revenue investment of £274,000 and a capital investment of £21,000

Workforce

The recurrent revenue cost of the additional FTE includes pay, staff non-pay and on-costs:

Role	FTE	£ Revenue)
ACP Grade 8A	2	£148,210
Band 7 Physio	1.5	£82,575
Total	3.5	£230,785

Equipment and Set-up Costs

The equipment and set-up costs are:

Item	£ (Revenue)	£ (Capital)
Monitoring Equipment - £17,000 Monitoring Installation - £4,000		21,000
IT Project Management (6mths)	18,000	
5-year Maintenance Contract	22,540	
Equipment depreciation (per year for 10 years)	£1,700	
PDC cost of capital @3.5%	£565	
Total	£42,805	£21,000

The ICB is currently following up funding opportunities through Additional Capacity Investment with NHSE.

12.5 Phasing

Subject to DMBC resolution approval and recruitment, the phasing profile of the costs identified above would be as follows for 2023/24 year and then £59,391 per quarter going forward:

Respiratory High Care	FTE	Total	2023/2024			
			Q1 (Apr-Jun)	Q2 (Jul-Sep)	Q3 (Oct-Dec)	Q4 (Jan-Mar)
Revenue						
ACP Grade 8A	2	£148,210		£37,053	£37,053	£37,053
Band 7 Physio	1.5	£82,575		£20,644	£20,644	£20,644
IT Project Management (6mths)		£18,000	£12,000	£6,000		
5-year Maintenance Contract		22,540	£1,127	£1,127	£1,127	£1,127
Depreciation		£1,700	£425	£425	£425	£425
Cost of capital		£565	£141	£141	£141	£142
Total (Revenue)	3.5	£273,590	£13,693	£65,390	£59,390	£59,391
Capital						
Monitoring Equipment & Installation		£21,000	£21,000			
Total (Capital)		£21,000	£21,000			

12.6 Downside risks

There is one implementation risk (section 15.6), that may result in financial risk if unmitigated.

Implementation Risk	Comment	£
DCC Capacity at GRH if planned mitigations are insufficient to managed demand	Additional staffing cost (Appendix 8) This risk is managed by the Cross Division Task and Finish group (section 15.3.1)	£403,356

There were a number of Downside Risks associated with FFTF1 and these have been assessed in respect of FFTF2 services:

FFTF1 Downside Risk	FFTF2 Update
Inability to achieve repatriated income	There are no assumptions in FFTF2 for repatriated income.
Impact of Inter-site Ambulance Transfers	These have been refreshed for FFTF2 services and are within the funds approved in the FFTF1 DMBC
SWASFT Conveyances to GWH	These have been monitored and have not increased as a result of FFTF changes.
Activity shift to GWH	These have been monitored and have not increased as a result of FFTF changes.

12.7 FFTF 1 Finance Update

This DMBC is concerned only with the proposals for service change within Phase 2 of the FFTF Programme; these are:

- Benign Gynaecology ^{*44}
- Diabetes and Endocrinology *
- Non-interventional Cardiology
- Respiratory *
- Stroke *

The DMBC for FFTF1 was approved in March 2021 and none of the services in Phase 1, their costs or benefits are part of the approval resolutions contained within this DMBC (section 14).

As stated at the start of this section, the FFTF Programme has worked closely with RSG and was requested to include updates/refresh on FFTF1 benefits and costs. These have been presented at:

- ICB Board (Jan 23);

⁴⁴ *Currently subject to Temporary Service Change (for details see individual service sections)

- Resources Steering Group (Jan 23);
- ICS Strategic Executives (Feb 23);
- GHNHSFT Finance & Resources Committee (Feb 23), and;
- GHNHSFT Board briefing session (Feb 23).

A copy of the information shared can be found in Appendix 4b, and the original FTF1 DMBC can be found at [Fit for the Future | Get Involved In Gloucestershire \(glos.nhs.uk\)](https://www.glos.nhs.uk/fit-for-the-future).

A summary of the refresh can be found in the table below:

Service Area	Type	Original FYE (Mar 2021)	Refresh FYE (Feb 2023)
Emergency General Surgery	Investment	£137,000	£81,872
	NCRB ⁴⁵	£314,382	£379,797
Planned General Surgery	Investment	£112,000	£140,612
	NCRB	£216,731	£216,731
Vascular Surgery	Investment	£0	£0
	NCRB	£0	£44,640
IGIS	Income	£463,600	£518,660
	Investment	£559,135	£723,072
	CRB ⁴⁶	£27,000	£27,000
	NCRB	£142,147	£142,147
Acute Care Response Team	Investment	£397,000	£522,169
Acute Medical Take	Income	-£250,000	£0
	Investment	£349,456	£277,000
	CRB	£187,606	£187,606
	NCRB	£144,147	£144,147
Total	Investment	£1,804,591	£1,744,725
	Benefits CRB	£678,206	£733,266
	Benefits NCRB	£817,407	£927,462
	Net excl. NCRB	-£1,126,385	-£1,011,459
	Net incl. NCRB	-£308,978	-£83,997

The refreshed benefit position reduces Phase 1 net investment by £100,000 to £1M. This is further reduced to £84k when Non Cash Releasing Benefits (NCRB) are included.

Key Points

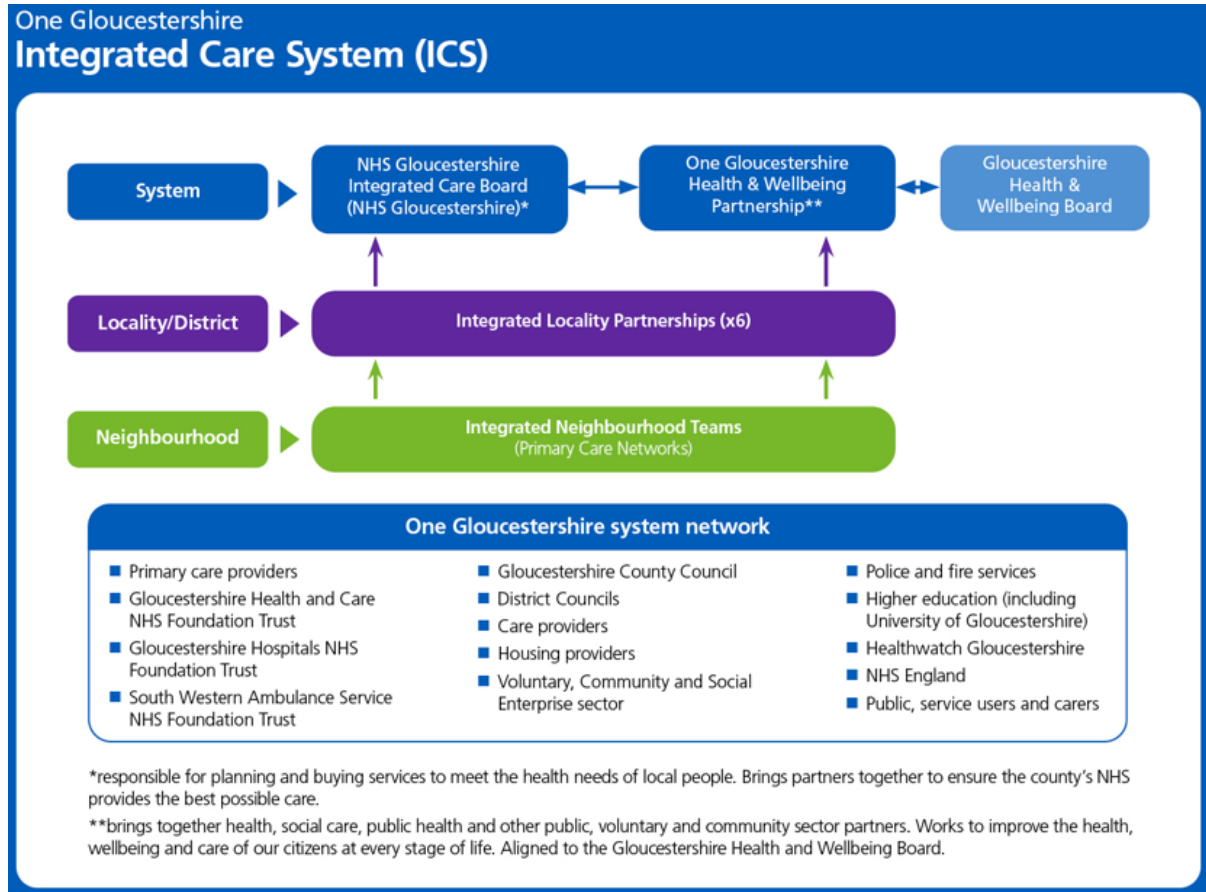
- Four of the five FTF2 service change proposals are currently already in place under Temporary Service Change arrangements.
- The additional resource requirements (<£300,00), are significantly less than those identified in FTF1 and relate only to Respiratory High Care (RHC) Unit.
- Funding is being sourced to support the establishment of RHC Unit.
- For context, update information is provided on FTF1 finances.

⁴⁵ Non-Cash Releasing Benefits

⁴⁶ Cash Releasing Benefits

13 Governance and Decision making

A short introduction to One Gloucestershire Integrated Care System is provided in section 3 (and schematic presented below). We have a strong commitment from all of our system partners to move forwards with this new way of working and believe it will be pivotal to support us to deliver against our challenging performance, financial and delivery objectives more quickly, as embodied by the scale of our Fit for the Future Phase One (FFTF1) implementation and our Fit for the Future Phase Two (FFTF2) proposals for change set out in this document.



13.1 Internal Assurance

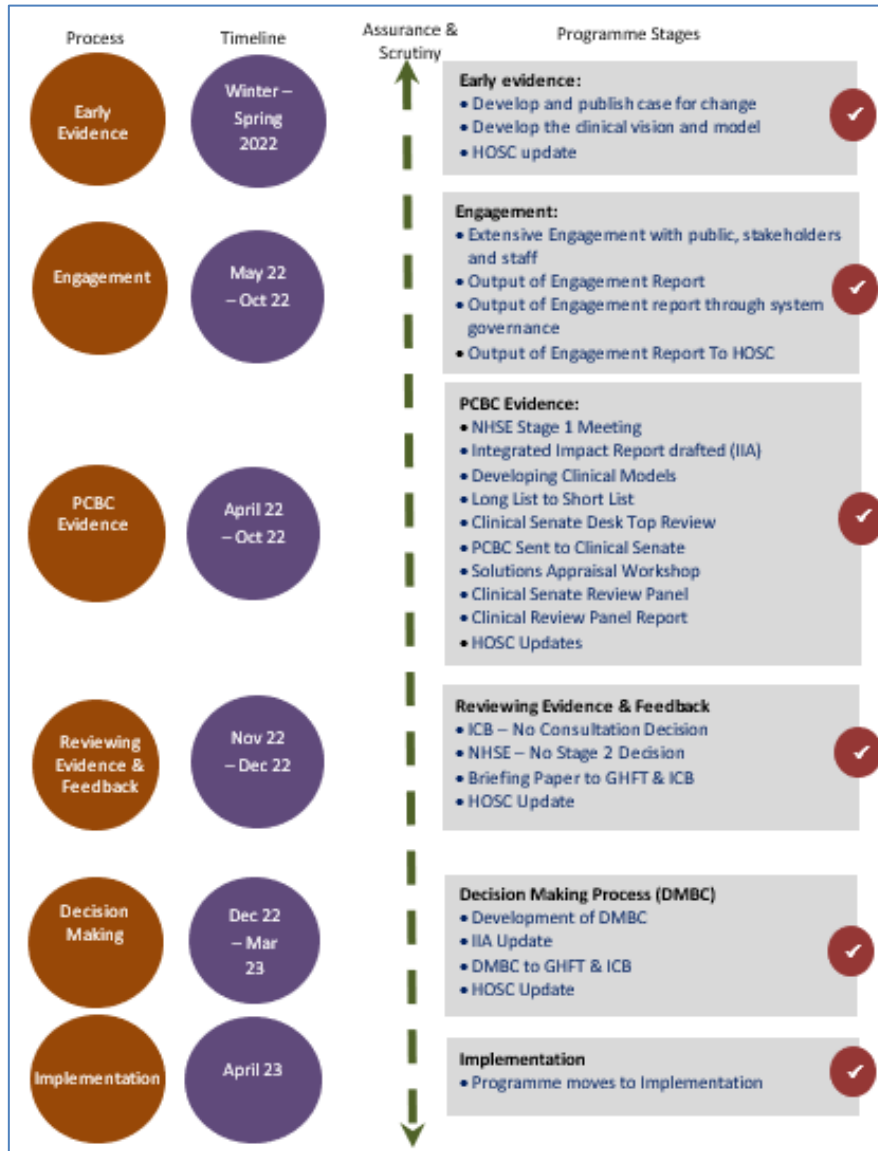
As presented in section 3.1.1 FFTF is a priority programme within our ICS Integrated Delivery Plan, that we will be seeking to deliver as partners across the health and social care system in Gloucestershire. These plans have been worked up with partner organisations and reflect a shared commitment to delivery for the year ahead.

The FFTF programme is embedded into both system and GHNHSFT governance structures. Regular reports have been taken to the NHS Gloucestershire ICB and ICB Strategy Executives GHNHSFT Trust Board and the ICS Resource Steering Group (RSG), as well as system and Board sub-committees.

The programme management arrangements are overseen through the programme Senior Responsible Officers (held jointly by both ICB and GHNHSFT Directors), the ICS Programme Development Group (PDG) including oversight of the Programme Director, the Programme Managers Group, FFTF Communications and Engagement and activity and financial

modelling. Investment is provided by the system to ensure that there are central programme resources in place to ensure delivery of programme objectives.

This DMBC is the result of years of evidence development, assurance and review of proposals to deliver an option that addresses our case for change and delivers our clinical model. The process is summarised below

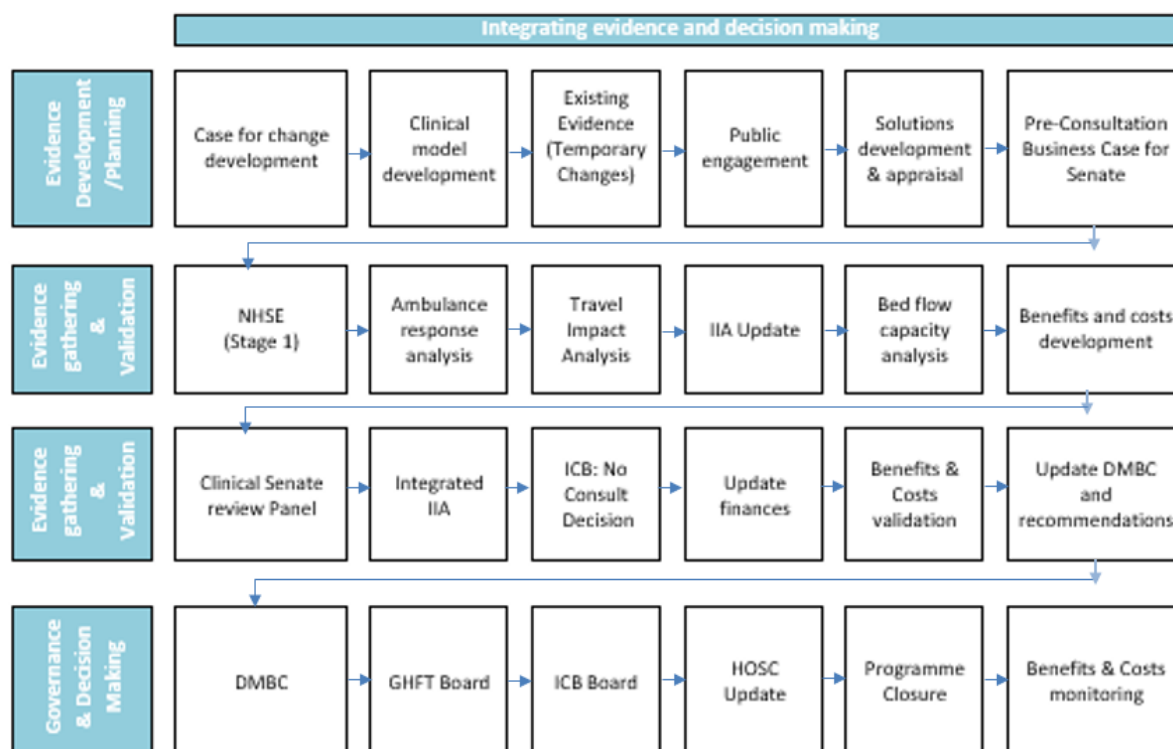


13.1.1 Process for decision-making

As set out in the national guidance on service change in the NHS the ICB’s statutory responsibilities includes their duty to lead involvement on any planned service change in their local systems. In this case, NHS Gloucestershire ICB leads on behalf of the One Gloucestershire Integrated Care System (ICS).

The decision-makers in this regard will be the Board of Gloucestershire Hospitals NHS Foundation Trust and the of Board NHS Gloucestershire ICB.

The process of evidence gathering, validation and decision-making is provided overleaf:



13.2 External Assurance

13.2.1 South West Clinical Senate review

Details of the independent clinical review undertaken by the South West Clinical Senate are provided in section 5.1 and the full report of the Clinical Review Panel (CRP) can be found in Appendix 5. The service specific comments can be found in the individual service sections and titled *South West Clinical Senate Review* and our responses to the Desk-top review can be found in Appendix 17.

13.2.2 NHS England assurance process

NHS England has been continuously involved in the Fit for the Future Programme and assured FFTF1 at our Stage 2 review in September 2020 and the FFTF2 proposals completed their Stage 1 assessment in March 2022. As detailed in section 2, following discussions with the SW Regional NHSE team and the decision by the ICB Board that there should be no further public involvement in Phase 2 of the FFTF programme, NHSE were content and confirmed that a Stage 2 assurance process was not required; therefore the FFTF2 proposals would not be subject to the government’s four tests and NHSE’s test for proposed bed closures (where appropriate) i.e. the “5 Tests”.

Notwithstanding the above, the FFTF Senior Responsible Officers believe it would provide additional assurance for decision-makers on the robustness of these FFTF2 proposals for an assessment against the “5 Tests” to be included in the DMBC; details are provided in the sub-sections below. Furthermore, the FFTF Programme has used the NHSE Stage 2 Key Lines of Enquiry (KLOE) as a reference document.

13.2.3 Test #1: Strong public and patient engagement.

The FFTF Programme has a strong track record in public engagement and involvement, and Section 4 details our FFTF2 engagement including both our activities and the feedback received. FFTF2 engagement built on the extensive engagement and consultation activities

of FFTF Phase 1, which clearly identified that there is high recognition of Centres of Excellence approach amongst those responding to our surveys.

The comprehensive Output of Engagement Report can be found in Appendix 1 and was reviewed by NHS Gloucestershire ICB, Gloucestershire Hospitals NHS Foundation Trust (GHNHSFT), NHSE and our local HOSC.

13.2.4 Test #2: Consistency with current and prospective need for patient choice.

Our solutions appraisal criteria for preferred options always includes a specific assessment of the impact on patient choice i.e. *“What is the likelihood of this option meeting the requirements of the NHS Constitution and The NHS Choice Framework”*.

When considering the impact on patient choice it should be noted that:

- None of the proposed solutions/models will withdraw the number of specialties provided by GHNHSFT.
- There would continue to be a choice of outpatient appointments at both acute hospital sites, in the community and virtually when appropriate.
- For FFTF2 services the potential changes relate to the centralisation of services either on the Gloucester or Cheltenham sites (previous centralisation has resulted in improved outcomes for patients).
- Four of the five FFTF2 service proposals relate to emergency pathways (not elective) where, in accordance with the NHS Choice Framework, patients may not have a choice.
- Whilst the number of sites where patients can choose to have their operation may change, the two hospital sites are only 8 miles apart and we believe that when the impact of the changes is assessed the improved patient outcomes will outweigh the reduction in choice regarding inpatient locations.

13.2.5 Test #3: Clear, clinical evidence base.

Details of the current service, proposed changes, clinical evidence and impacts can be found in the individual service sections. Details of the independent clinical review undertaken by the South West Clinical Senate are provided in section 5.1 and the full report of the Clinical Review Panel (CRP) can be found in Appendix 5.

Overall, the Panel observed that the proposals would deliver some clear benefits for patients, had good clinical leadership, that they had been well thought through and appraised, and that there were clear plans for implementation.

13.2.6 Test #4: Support for proposals from clinical commissioners.

Prior to July 2022, the NHS Gloucestershire CCG undertook a lead role in the FFTF Programme working closely with ICS partners and this role is now the responsibility of the NHS Gloucestershire ICB. In respect of Test#4, the FFTF Programme provides regular updates to ICS, GHNHSFT internal governance forums and the proposals contained within this DMBC will be required to be approved by the NHS Gloucestershire ICB.

Details of our FFTF2 engagement with all of our neighbouring ICBs and Health Boards can be found in section 4.5.1. We have shared information on the programme scope, exchanging of activity information and agreements to build relationships and share information as the preferred option(s) were finalised.

13.2.7 Test #5: Bed modelling

There are no planned reductions in beds available at GHNHSFT as a result of any of the Fit for the Future proposed changes. Full details of our bed demand and capacity modelling can be found in section 5.7.

13.3 Public sector equality duty (PSED)

The Equality Act 2010 requires the ICB, in the exercise of its functions, to have due regard to the need to:

- Eliminate discrimination, harassment, victimisation and any other conduct that is prohibited under the Equality Act;
- Advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;
- Foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

In order to advance equality of opportunity, decision-makers should have due regard in particular to the need to:

- Remove or minimise the disadvantage suffered by persons who share relevant protected characteristics;
- Take steps to meet the needs of those who share such characteristics, and;
- Encourage participation of those who share such characteristics.

The requirements of the Equality Act 2010 also mean that the ICB should ensure that service design and communications should be appropriate and accessible to meet the needs of diverse communities

The requirements of the Public Sector Equality Duties are integral to the Fit for the Future approach. To inform the programme there has been extensive engagement and communications activity seeking to gather the views of seldom heard groups.

Furthermore, our solutions appraisal criteria included a specific assessment of the impact of solutions on accessibility to services and the Public Sector Equality Duty; namely *“What is the likelihood of this option having a positive impact on equality and health inequalities?”*

13.4 Information Governance (IG) issues and privacy impact assessment

Following specialist IG advice, the Data Protection Impact Assessment (DPIA) has been drafted on the basis that the current phase of the FFTF Programme is focusing on a DMBC, and there should be no change to any patient pathways and patient data flows. At no time will any patient identifiable data be held by the programme. The data that will be held by the programme during the next phase are as follows –

- Project Management documentation
- Programme Governance documentation
- Involvement documentation and feedback

The current DPIA is presented in Appendix 15 and will be adapted for each the phase of the programme, including implementation.

It should be noted that all the proposals that form part of this DMBC are not intended to change the provider of the services nor are there changes to clinical systems or record-keeping specific to the FFTF Programme; any changes would be subject to a separate DPIA process.

The DPIA describes:

- the data, data flows, and retention period
- any data protection and privacy risks identified
- the risk management measures agreed

Key Points

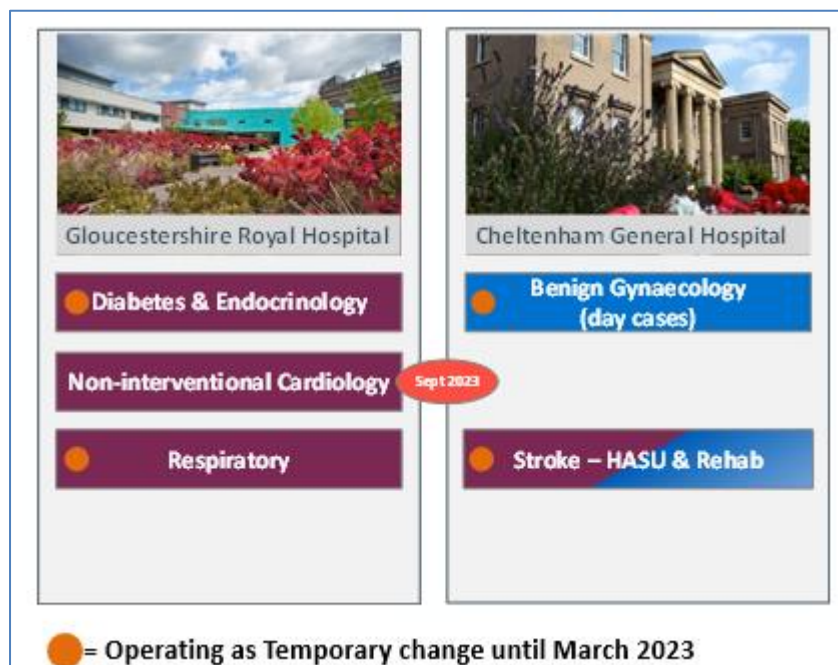
- **The FFTF programme is embedded into both system and GHNHSFT governance structures.**
- **NHS Gloucestershire ICB leads on behalf of the One Gloucestershire Integrated Care System (ICS).**
- **FFTF2 proposals have been subject to independent clinical review by the South West Clinical Senate**

14 Recommendation

14.1 Resolutions to be agreed

It is the Programme’s recommendation to the Board of Gloucestershire Hospitals NHS Foundation Trust (GHNHSFT) and the NHS Gloucestershire Integrated Care Board (GICB) that the following resolutions should be considered for agreement and approval, considering all the evidence that has been made available, on the basis that they represent the most appropriate option to address the case for change.

- **Resolution #1:** To locate the majority of Benign Gynaecology Day Cases at Cheltenham General Hospital.
- **Resolution #2:** To centralise the dedicated Diabetes and Endocrinology Inpatient beds at Gloucestershire Royal Hospital and provide a Diabetes and Endocrinology Consult service at Cheltenham General Hospital.
- **Resolution #3:** To centralise Non-Interventional Cardiology inpatient beds⁴⁷ at Gloucestershire Royal Hospital and provide a Cardiology Consult service at Cheltenham General Hospital.
- **Resolution #4a:** To centralise Respiratory Inpatient beds at Gloucestershire Royal Hospital and provide a Respiratory Consult service at Cheltenham General Hospital.
- **Resolution #4b:** To establish a Respiratory High Care unit at Gloucestershire Royal Hospital.
- **Resolution #5:** To locate the Hyper Acute Stroke Unit (HASU) and Acute Stroke Unit (ASU) at Cheltenham General Hospital.



⁴⁷ Centralisation of Interventional Cardiology Inpatient Beds at GRH was approved as part of FFTF1.

15 Implementation


15.1 Introduction

Our *Fit for the Future Programme*, which incorporates *Centres of Excellence*, is a large scale, long-term change programme which is being delivered through a number of phases over a number of years. Furthermore, the implementation of services within FFTF1 and FFTF2 have and will not be implemented sequentially as, in some cases, we needed to align with the implementation of the GHNHSFTs strategic site development (SSD) programme. This has had to be combined with the phased implementation of FFTF1, in some cases accelerated by the need to respond to the early stages of the COVID pandemic and the development of our FFTF2 programme, which includes a number of services that are subject to temporary service change, having also relocated in response to COVID and other pressures.

The implementation context/ landscape has also changed since the start of the FFTF Programme, which has added additional pressures and challenges that need to be considered and managed by the implementation teams; these are well understood by anyone working in the NHS for the last 36 months and are summarised below:

Changing context from launch of FFTF in 2019...

- **Covid-19** Pandemic
- **Red/Green pathways**
- **ICS UEC performance:**
Ambulance waits and SWASFT capacity
- **Acuity of walk-in patients** to ED
- **Financial challenge:** “gap” and ICB System deficit
- **Collective impact of isolated changes to some services at CGH** impacting other service e.g. blood transfusion
- **Elective Recovery** needs
- **Colleague Health & wellbeing**
- **Vacancy rates**
- **Social care** impacting flow – NCTR patients c200-250
- **Change in FFTF implementation phasing** due to Covid-19:
 - Vascular to GRH
 - Respiratory to GRH
 - Stroke to CGH
 - Diabetes to GRH
- **Centralisation of Acute Medical take** planned for Summer 2023.
- **GHNHSFT CQC** inspection
- **Industrial action** impact



15.2 Implementation Phasing

The factors listed above have created a level of complexity that needs to be carefully presented to ensure all those involved in assessing these proposals are assured. For completeness we have included both FFTF1 and FFTF2 services and these are summarised below:

- **FFTF Phase 1 services – formally implemented following decision-making:** these were services that were in place in March 2021, such as the Trauma and Orthopaedics, Gastroenterology, Emergency General Surgery and Vascular Surgery.
- **FFTF Phase 1 services - Implemented following completion of other enabling workstreams:** these are services that require enabling work to be completed, for

example, estates work, recruitment and training, procurement and installation of equipment. This includes IGIS and Acute Medicine.

- **FFTF Phase 2 services - Temporary service changes formally implemented following decision-making:** these are services that are currently in place (March 2023), including Stroke, Benign Gynaecology, Diabetes and Endocrinology and Respiratory.
- **FFTF Phase 2 services - Implemented following completion of other enabling workstreams:** these are services that require enabling work to be completed and include Non-Interventional Cardiology.

The table below presents a summary of each service and its actual or indicative implementation status.

FFTF Phase	FFTF service	Actual implementation date	Formal or planned implementation date
FFTF1	Trauma at GRH and Orthopaedics at CGH	October 2017	March 2022
FFTF1	Gastroenterology at CGH	November 2018	March 2022
FFTF1	Emergency General Surgery at GRH	April 2020	March 2022
FFTF1	Vascular Surgery at GRH	June 2020	March 2022
FFTF2	ASU at CGH ^[1] HASU at CGH ^[1]	June 2020 February 2022	March 2023 ^[2]
FFTF2	Respiratory at GRH ^[1]	June 2020	March 2023 ^[2]
FFTF2	Benign Gynaecology at CGH ^[1]	June 2020	March 2023 ^[2]
FFTF2	Diabetes & Endocrinology at GRH ^[1]	September 2021	March 2023 ^[2]
FFTF1	Acute Medicine (Acute Medical Take) at GRH	-	September 2023
FFTF1	Image Guided Interventional Surgery 'Hub' at GRH and a 'Spoke' at CGH (including interventional Cardiology)	-	September 2023
FFTF2	Non – Interventional Cardiology at GRH	-	September 2023 ^[2]
FFTF1	Elective General Surgery at GRH and CGH	-	October 2023

^[1] Subject to Temporary Service Change (for details see individual service sections).

^[2] Subject to approval.

15.3 Governance arrangements for implementation

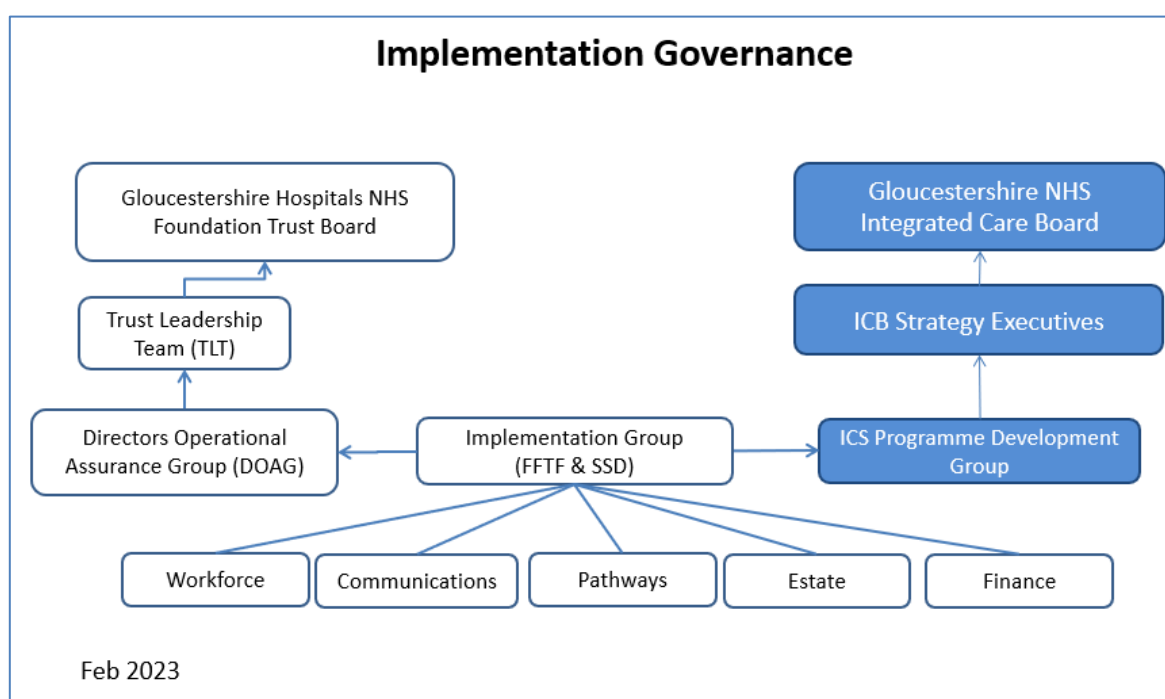
Formal governance arrangements are required to steer and govern the process of service reconfiguration and development of the FFTF programme; to deliver this we have a dedicated FFTF Implementation Group, that is implementing FFTF1 and will be responsible for implementing FFTF2.

In order to oversee the implementation of Phase 1 FFTF GHNHSFT established a working sub-group of the Directors Operational Assurance Group (DOAG). This subgroup was titled

'Phase 1 Implementation Group'⁴⁸, it meets monthly, is chaired by the Deputy COO, with representation from Deputy Divisional Directors of Operations and is tasked with overseeing the implementation of GSSD (Gloucestershire Strategic Site Development) and Phase 1 FFTF; including any interactions between the programmes or with wider strategies and changes being implemented in the Trust. The Phase 1 Implementation Group reports monthly to DOAG; DOAG has a direct reporting line to TLT (Trust Leadership Team) and then Main Board.

A number of workstreams will lead on both the planning and development required to support FFTF2 changes to service provision, as well as the transactional processes of change. Governance arrangements will have clear links within the wider Gloucestershire ICS and individual organisational governance structures to ensure that implementation plans across all areas are aligned.

A robust risk management framework will be implemented to ensure that the principles of measuring, managing and reporting risk are maintained.



15.3.1 Cross Division Task and Finish Group

As part of the implementation planning, particularly focused on the centralisation of the Acute Take in September 2023, GHNHSFT have established the Cross Division Task and Finish group, chaired by the Medical Director. The group's objectives include:

- To consider the FFTF service moves and agree what clinical and support services and processes need to be in place, to ensure the delivery of sustainable services at CGH and GRH.
- To develop *go/no-go* criteria for the centralisation of the acute take to GRH.
- To produce a paper for DOAG setting out recommendations including *go/no-go* criteria, to confirm the date for centralisation of the acute take.

⁴⁸ Subject to DMBC approval the group will be re-named FFTF Implementation Group and cover FFTF 1 & 2.

- Area of scope include:
 - Engagement and communications
 - Patient pathways/operational policies/SOPs⁴⁹
 - Clinical standards/protocols
 - Medical Cover arrangements
 - Medical Training
 - Clinical Support Services
 - Inter site ambulance transfers
 - SWASFT protocols
 - Acuity of Emergency Department walk-in patients
- As detailed in section 5.7.4 the group have agreed DCC metrics to monitor the impact of the current mitigations to assess the confidence that the demand at GRH DCC can be met.

15.4 Communication and engagement plan

One Gloucestershire partners will formally publish the Fit for the Future 2 Decision Making Business Case (DMBC) ahead of the GHNHSFT Board meeting 9th March 2023 and the NHS Gloucestershire Integrated Care Board meeting on 29th March 2023.

The aim of the communications and engagement plan (Appendix 16) is to ensure staff, community partners, the public and media receive information on the outcome of the decision-making process and next steps in a timely and appropriate way.

There are a number of communication and engagement objectives, including:

- To provide clear, consistent and accurate information
- To support the NHS to communicate the outcome and the changes
- To ensure relevant audiences receive the information in the right order e.g. staff first
- To ensure effective media and social media arrangements are in place.

The communications and engagement plan includes a number of key stakeholders that need to be engaged and supported as decisions are made and communicated.

The communication plan will consider the South West Clinical Senate Panel recommendation that the ICB should develop a communications strategy that informs patients about the location of specialist medical services such as cardiology and stroke and encourages patients to present to the most appropriate hospital.

The communication plan will also include the request by the HOSC that updates be brought to future meetings of the committee regarding the implementation of Fit for the Future 2 service changes.

⁴⁹ Standard Operating Procedures

15.5 Benefits Realisation

Details of the benefits are provided in Appendix 4a and 4b⁵⁰, including benefits realised for FFTF2 services already in place through temporary service change. Benefits will be continuously developed and monitored as part of the implementation programme; a summary is provided below:

	Benefits
Improved patient outcomes	<ul style="list-style-type: none"> • Ensuring safe and consistent staffing levels • Reduction in surgical cancellations. • Better coordination of inpatient work • Provide regular daily visits to admission wards on both sites • Improved rehabilitation ward environment • Removal of stroke from the ED pathway • Improve the quality of care provided for respiratory patients • Improved out of hours care for patients • Reduction of mortality due to Respiratory High Care
Improved patient experience	<ul style="list-style-type: none"> • The provision of a protected dedicated day case unit • Improved rehabilitation ward environment • Improve bed capacity constraints • Improved Patient experience • Prevent the need for patient transfer
Improved staff experience	<ul style="list-style-type: none"> • Easier to staff the wards • Better use of the staff groups with significant shortages • Improved staff cover and improved staff resilience for sickness and absence. • Provide enhanced training for junior and middle grade doctors with regular access to the full clinical team
Improved staff recruitment and retention	<ul style="list-style-type: none"> • Improved training • With the specialist staff in one place, it is also easier to co-ordinate care, provide training and improve staff recruitment and retention
Improved efficiency and effectiveness (cash releasing and growth avoidance/non-cash releasing)	<ul style="list-style-type: none"> • More efficient use of the specialist team • Inpatient bed number reduction. • Reduce length of stay for patients. • Prevent the need for patient transfer

The FFTF Implementation Group will work with the clinical divisions to ensure the identified benefits are delivered. The ICS Programme Development Group will link these benefits with the wider system in support of the delivery of our Operational Plan.

⁵⁰ Appendix 4b also includes FFTF1 benefits realisation to date.

15.6 Implementation Risks

The FFTF programme risk register hold risks associated with the DMBC assurance process only⁵¹. Implementation risks are part of the risk management function of the FFTF Implementation Group post decision-making. When assessing implementation risk, it should be noted that four of the five FFTF2 services are already in place through temporary service changes.

The risks regarding DCC are held on Divisional and, where appropriate, GHNHSFT Risk Registers.

The high level risks specifically associated with FFTF2 implementation but excluding GHNHSFT service Business as Usual (BAU) risks, are listed below.

FFTF service	Implementation Risks
Stroke Currently located at CGH as Temporary Service Change	<ul style="list-style-type: none"> Completion of FFTF1 & 2 implementation to allow ward moves at CGH
Respiratory Currently located at GRH as Temporary Service Change	<ul style="list-style-type: none"> Funding for Respiratory High Care (RHC) Unit Impact on DCC capacity at GRH if RHC Unit not implemented
Diabetes & Endocrinology Currently located at GRH as Temporary Service Change	<ul style="list-style-type: none"> None identified
Benign Gynaecology Currently located at CGH as Temporary Service Change	<ul style="list-style-type: none"> Benefits accruing from Chedworth Day Surgery Unit if delays in completion of construction
Non – Interventional Cardiology	<ul style="list-style-type: none"> Bed reduction resulting from planned benefits is not realised leading to bed pressures and outliers on other wards Alignment of FFTF2 implementation with FFTF1 IGIS enabling works DCC capacity at GRH

⁵¹ Available on request

15.7 Outline programme implementation plan

As summarised in the introduction to this section, the implementation of the recommendations contained within this DMBC will be completed in stages over the next 12 months (on the basis that resolutions are approved in March 2023).

15.7.1 *FFTF2 -Formally implemented following decision making*

- **Resolution #1:** To locate the majority of Benign Gynaecology Day Cases at Cheltenham General Hospital.
- **Resolution #2:** To centralise the dedicated Diabetes and Endocrinology Inpatient beds at Gloucestershire Royal Hospital and provide a Diabetes and Endocrinology Consult service at Cheltenham General Hospital.
- **Resolution #4a:** To centralise Respiratory Inpatient beds at Gloucestershire Royal Hospital and provide a Respiratory Consult service at Cheltenham General Hospital.
- **Resolution #4b:** To establish a Respiratory High Care unit at Gloucestershire Royal Hospital.
- **Resolution #5:** To locate the Hyper Acute Stroke Unit (HASU) and Acute Stroke Unit (ASU) at Cheltenham General Hospital.

15.7.2 *FFTF2 - Implemented following completion of enabling workstreams*

- **Resolution #3:** To centralise Non-Interventional Cardiology inpatient beds⁵² at Gloucestershire Royal Hospital and provide a Cardiology Consult service at Cheltenham General Hospital.

Implementation is dependent on a number of enabling workstreams, including:

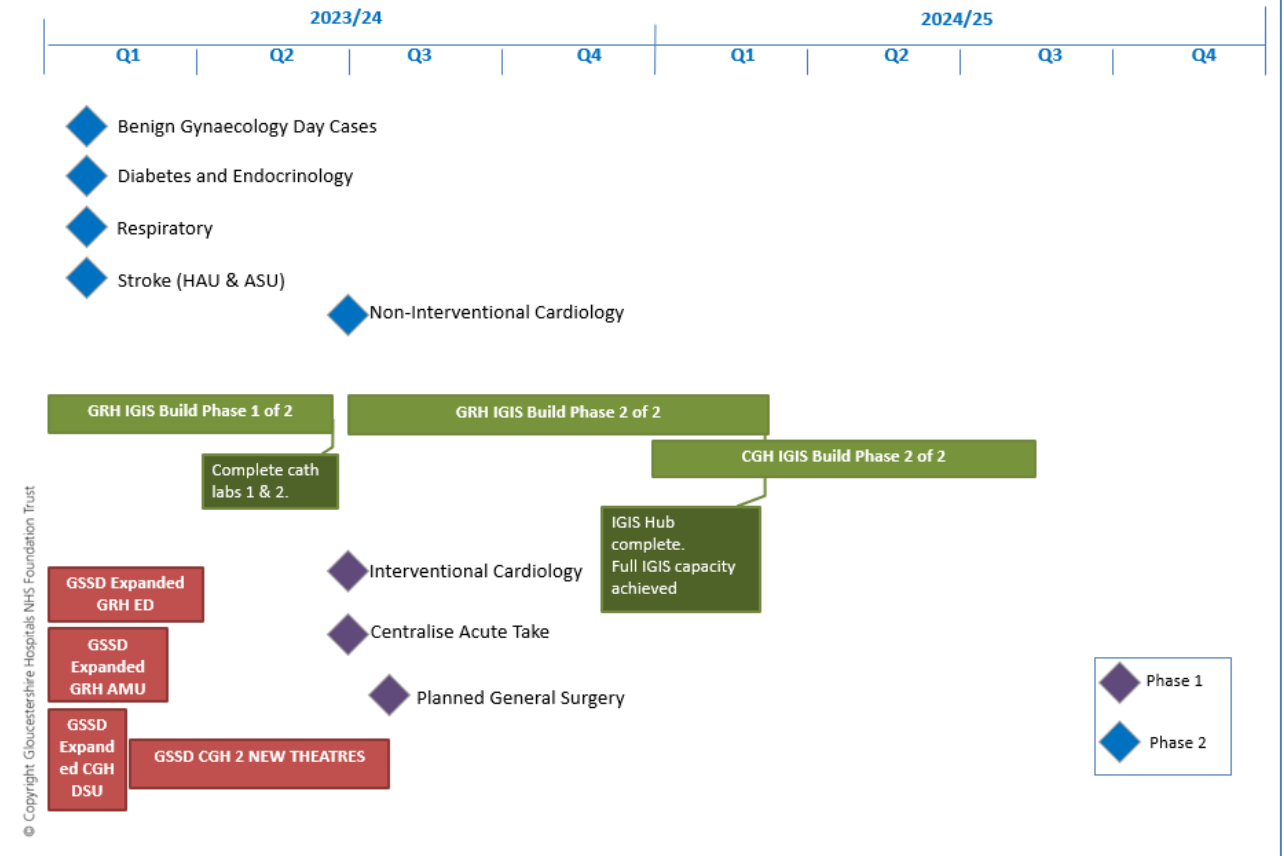
- Changes to the Trust estate – delivered through the Trust Strategic Site Development Programme;
- Workforce – recruitment and training to support new models of care;
- Procurement and installation of new equipment – new Cardiac Cath Labs, additional Interventional Radiology equipment; and,

15.7.3 *Implementation timetable*

A Gantt chart outlining the high-level implementation milestones described above can be found overleaf.

⁵² Centralisation of Interventional Cardiology Inpatient Beds at GRH was approved as part of FFTF1.

Implementation Timeline



Key Points

- Four of the five FTF2 proposals are currently implemented as temporary service changes.
- One of the five FTF2 proposals requires completion of enabling work prior to implementation.
- The dedicated FTF Implementation Group, implementing FTF1, will be responsible for implementing FTF2.

16 Appendices

Appendix 1: FTF2 Output of Engagement Report

See separate document

Appendix 2: Gloucestershire Joint Health and Wellbeing Strategy 2019-2030

See separate document

Appendix 3: Gloucestershire Joint Strategic Needs Assessment (2017)

See separate document

Appendix 4a: FTF2 Benefits Realisation

See separate document

Appendix 4b: FTF1 & 2 Benefits and Costs

See separate document

Appendix 5: South West Clinical Senate Review Panel Report

See separate document

Appendix 6: Out-of-Hours Doctor Rotas

See separate document

Appendix 7: Bed Modelling Paper v1.5

See separate document

Appendix 8: DCC Capacity v4

See separate document

Appendix 9 Diabetes & Endocrinology Supporting Documentation

See separate document

Appendix 10a Non-interventional Cardiology Supporting Documentation

Appendix 10b Non-interventional Cardiology Opinion SOP

See separate documents

Appendix 11a Respiratory Supporting Documentation

Appendix 11b Respiratory SOP

See separate documents

Appendix 12a Stroke Supporting Documentation

Appendix 12b Stroke Pathway SOP

See separate documents

Appendix 13a: Benign Gynaecology IIA

Appendix 13b: Diabetes & Endocrinology IIA

Appendix 13c Non-interventional Cardiology: IIA

Appendix 13d: Respiratory IIA

Appendix 13e: Stroke IIA

See separate documents

Appendix 14a: Travel Impact Analysis

Appendix 14b: Public Travel Information

Appendix 14c: Carbon Footprint

See separate documents

Appendix 15: Data Protection Impact Assessment (DPIA)

See separate document

Appendix 16: DMBC Communications Plan v3

See separate document

Appendix 17: South West Clinical Senate -Desk-top review and responses

See separate document

Appendix 18: Glossary

See overleaf

Appendix 18: Glossary

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’)
A&E	Accident and Emergency department (also known as Emergency Department (ED))
Acute Care Response Team (ACRT)	The ACRT includes technicians, nurse practitioners and advanced nurse practitioners who cover 24/7 both Cheltenham and Gloucester and respond to referrals for unwell and deteriorating patients across all adult wards and departments.
Acute Medical Unit (AMU)	Provides rapid assessment, diagnosis and treatment of patients with urgent medical and surgical conditions.
Acute Stroke Unit (ASU)	Acute stroke care services provide continuous specialist input, with daily multidisciplinary care and continued access to stroke trained consultant care, physiological monitoring and urgent imaging as required.
Addison’s crisis	A life-threatening situation that results in low blood pressure, low blood levels of sugar and high blood levels of potassium
Benign Gynaecology	The medical speciality (area) dealing with the health of the female reproductive system and benign means non-cancerous.
British Geriatric Society:	The professional body of specialists in the healthcare of older people in the United Kingdom
British Thoracic Society (BTS)	A registered charity that aims to improve standards of care for people who have respiratory diseases and to support and develop those who provide that care
Centres of Excellence (CoEx)	The development of the two main hospital sites. Part of the Fit for the Future Programme
CGH	Cheltenham General Hospital
CINAPSIS	A referral system that makes it easy for clinicians to communicate between healthcare organisations
Comprehensive Geriatric Assessment (CGA)	A multidisciplinary assessment designed to evaluate an older person's functional ability, physical health, cognition and mental health, and socioenvironmental circumstances
Community Stroke Rehabilitation unit	Inpatient ward which is dedicated to patients who would benefit from specialist stroke rehabilitation following acute medical treatment
COTE	Care of the Elderly
COVID/ Coronavirus	COVID is a new illness that affects lungs and airways. It is caused by a virus called coronavirus.
CT Scan	A procedure that uses a computer linked to an x-ray machine to make a series of detailed pictures of areas inside the body
CPAP	Continuous positive airway pressure (CPAP) therapy is a common treatment for obstructive sleep apnoea.

Department of Critical Care (DCC)	A special ward in Gloucester that cares for people who are critically ill, in an unstable condition, or need close monitoring after surgery
Diabetes and Endocrinology (D&E)	Diabetes is a serious condition where a person's blood glucose (sugar) levels are too high as a result of their body being unable to produce enough insulin or being unable to produce any insulin at all. Endocrine conditions are where a person's endocrine system (that produces the body's hormones) does not work correctly, causing hormonal imbalances in the body.
Diabetic KetoAcidosis (DKA)	A serious complication of diabetes that occurs when your body produces high levels of blood acids called ketones
Decision-Making Business Case (DMBC)	Prepared following consultation, to support in making a final decision on service change. It will consider all the responses to the consultation
DOAG	GHNHSFT Directors Operational Assurance Group
Early Supported Discharge (ESD)	Facilitates early transfer of care to a community setting, where rehabilitation continues at the same intensity and with the same expertise as in the inpatient setting
ED	Emergency Department
EGS	Emergency General Surgery
EPR	Electronic Patient Record
Frailty Assessment Service/Frailty Assessment Unit (FAS/FAU)	Works with community services to provide specialist assessment and support for older people who attend the Emergency Department with signs of frailty
Clinical Programme Groups (CPGs)	Supports the delivery of the whole pathway transformation across key clinical programme areas in Gloucestershire.
Gloucestershire Clinical Commissioning Group GCCG/CCG	CCGs are the GP-led bodies responsible for planning and investing in many local health and care services, including the majority of hospital care and stroke services.
Gloucestershire Health & Care NHS Foundation Trust (GHCFT)	Formed in 2019 by the merger of 2gether Trust and Gloucestershire Care Services to provide joined up physical health, mental health and learning disability services
Gloucestershire County Council (GCC)	Responsible for a large number of services, including education, health and transport.
Gloucestershire Hospitals NHS Foundation Trust (GHNHSFT)	Provides a wide range of specialist acute services
Gloucestershire Strategic Site Development (GSSD) (SSD)	A £39.5M Programme to improve acute care facilities at Gloucester Royal and day surgery and theatre capacity at Cheltenham General
GI	Gastrointestinal (a planned gastrointestinal service is sometimes referred to as upper GI and a planned colorectal service is sometimes referred to as lower GI).
GIRFT	A national programme designed to improve the treatment and care of patients through in-depth reviews of services.

GRH	Gloucestershire Royal Hospital
GAU	Gynaecology Assessment Unit
Hyper acute stroke unit (HASU)	Provides the initial investigation, treatment and care immediately following a stroke
Health overview and scrutiny committee HOSC	A committee of the relevant local authority, or group of local authorities, made up of local councillors who are responsible for monitoring, and, if necessary, challenging health plans.
Homeward Assessment Team (HAT)	A multi-disciplinary team who assesses and supports people to leave hospital after treatment
Hot and Cold Split	Emergency Care (Hot) and Planned Care (Cold)
IPC	Infection Prevention and Control
Image Guided Interventional Surgery (IGIS)	Surgical procedures where the surgeon uses tracked instruments in conjunction with live images to guide the procedure
Integrated Impact Assessment (IIA)	The purpose of the Integrated Impact Assessment is to explore the potential positive and negative consequences of the proposals. It includes a Health Impact Assessment (HIA), Travel and Access Impact Assessment, Equality Impact Assessment (EqIA) (in which the impacts of the proposals on protected characteristic groups and deprived communities are assessed) and Sustainability Impact Assessment.
Integrated Locality Partnerships (ILPs)	Partnerships made up of senior leaders of health and social care providers and local government.
Intensive Care Society	Representative body and Charity for all intensive care professionals and patients across the UK
Inpatient (IP)	A person who stays one or more nights in a hospital in order to receive medical care or treatment
Joint Strategic Needs Assessment (JSNA)	Looks at the current and future health and care needs of local populations to inform and guide the planning and commissioning (buying) of health, well-being and social care services within a local authority area.
Joint Health and Wellbeing Strategy (JHWS)	The Local Authority and Clinical Commissioning Group (CCG) work together to understand the health and wellbeing needs of their local community and agree joint priorities for addressing these needs to improve health and wellbeing outcomes and reduce inequalities.
Length of Stay (LoS)	The amount of time someone has to stay in hospital for care, treatment, and recovery.
MOFD	Medically Optimised for Discharge, an intensive therapy ward working with patients to focus on improving their capacity in order to facilitate timely discharge.
MFFD/NMCTR	Medically fit for discharge/not meeting the criteria to reside

NaDIA	National Diabetes Inpatient Audit provides a comprehensive view of diabetes care in England and Wales
Non-invasive ventilation (NIV)	The use of breathing support administered through a face mask, nasal mask, or a helmet
NHS Long Term Plan (LTP)	Sets out priorities for the NHS over the next ten years
NHSE	NHS Improvement became part of NHS England in July 2022
NHS South, Central and West Commissioning Support Unit (SCW CSU)	An NHS organisation providing support and transformation services to health and care systems
Operational Research in Health (ORH)	A management consultancy that uses advanced Operational Research techniques to support resource planning in the public sector.
One Gloucestershire Integrated Care System (ICS)	The working name given to the partnership between the county's NHS and care organisations to work in partnership in improving health and care, to help keep people healthy, support active communities and ensure high quality, joined-up care when needed in Gloucestershire
Office of National Statistics (ONS)	The UK's largest independent producer of official statistics and the recognised national statistical institute of the UK
Pre-Consultation Business Case (PCBC)	The document which presents the business case for any changes to services on which the CCGs agree to consult. It shows that CCGs have properly considered the options, undertaken pre-consultation engagement, submitted to the required scrutiny, and met the four tests and three conditions required by the Secretary of State.
PCI	Primary Percutaneous Coronary Intervention. A coronary angioplasty is a procedure used to widen blocked or narrowed coronary arteries
Primary Care Network (PCN)	Groups of GP practices working closely together - along with other healthcare staff and organisations - providing integrated services to the local population
Royal College of Surgeons of England (RCS)	An independent professional body and registered charity that promotes and advances standards of surgical care for patients
Respiratory High Care (RHC) or Support Unit (RSU)	An area of enhanced care that enables a higher level of monitoring and respiratory intervention than would be expected for a routine ward environment
Same Day Emergency Care (SDEC) (SDEC)	This unit provides same day assessments and treatment; without being admitted into hospital overnight
SAU	Surgical Assessment Unit
South West Clinical Senate	Established to be a source of independent, strategic advice and guidance to commissioners and other stakeholders

South West Ambulance Service Foundation Trust (SWASFT)	Provides a wide range of emergency and urgent care services across South West England
SSNAP	Sentinel Stroke National Audit Programme - An audit tool for collecting patient data
Task & Finish Group (T&F)	A time limited group set up as an action sub-group of a larger committee or meeting with the aim of a delivering a specified objective
TrakCare	The electronic patient management system used across NHS
Transient ischemic attack (TIA)	A temporary period of symptoms similar to those of a stroke. A TIA usually lasts only a few minutes and doesn't cause permanent damage
TLT	GHNHSFT Trust Leadership Team
The King's Fund	An English health charity that shapes health and social care policy and practice and provides NHS leadership development
UAU	Urology Assessment Unit
VAU	Vascular Assessment Unit
VCSE	Voluntary Care Sector Enterprise