One Gloucestershire
Transforming Care, Transforming Communities

NHS

Decision Making Business Case Version 2.0

March 2021

SUBJECT TO DECISION MAKING

Fit for the Future

Developing specialist hospital services in Gloucestershire

Contents

Document Control

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Location:	\\glos.nhs.uk\GCCG\Hub\Strat and Planning\Sustainability & Transformation Plan\10. One Place Programme\12. Fit For the Future\Governance & Assurance\Business Case\DMBC
Status:	v 2.0

Version	Date	Author/Reviewer	Comments
1.1	02/11/20	Micky Griffith	Created draft structure
1.2	25/01/21	Micky Griffith	Sections 2,3,4 & 8
1.3	14/02/21	Micky Griffith	Sections 7 & 9
1.4	22/02/21	Micky Griffith	Sections 5 & 6
1.5	25/02/21	Micky Griffith	Incorporate reviewer feedback (internal & external)
2.0	04/03/21	Micky Griffith	Incorporate legal feedback, ICS & TLT Feedback

Document Distribution:

Forum/Audience	Date	DMBC v#	Comments
NHSE&I	19/02/21	1.2	Draft for 1st check-in meeting
NHSE&I	01/03/21	1.5	Draft for 2nd check-in meeting
ICS Executives	01/03/21	1.5	
GHNHSFT TLT	04/03/21	1.5	
GHNHSFT Board	11/03/21	2.0	
CCG Governing Body	11/03/21	2.0	
Publication onto website	04/03/21	2.0	

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 by prioritising prevention and self-care, and ensuring we deliver the right care in the right place at the right time.

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 is 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 expensive equipment and highly trained staff 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*; centralised services where we can consolidate skills and equipment to provide the very best care. Sometimes these centres will be outside Gloucestershire but, where possible, as an ICS we will develop our specialist services so we can provide specialist care in our county.

Underpinning all of this is our strong commitment to listen to what matters to people, and to join up our data and information to understand how to meet local needs in the best way. Through our broader ICS engagement programme, we have heard that the care experience is better the more we can plan around individuals and carers' needs (personalisation) and when we use new ways to help support care, like using digital technology, to help plan and manage more care journeys. We have heard that travel and access concerns people, but that generally people are prepared to travel a little further to access better health outcomes where it is clearly demonstrated that this will be achieved.

The NHS has made significant improvements in recent years, but continuing to improve health outcomes, health care and ways of working is a challenge in the context of the resources we have available and the growing needs of our local population. 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.

Fit for the Future is part of the One Gloucestershire vision focussing on the medium- and long-term future of specialist hospital services at Cheltenham General Hospital and Gloucestershire Royal Hospital. The NHS in Gloucestershire is ambitious for the people of the county. We want to provide world class, leading edge specialist hospital care for patients that is comparable with the best in England.

To achieve these things and to make the most of developing staff skills, precious resources and advances in medicine and technology, we plan to change some of the ways we provide some of our specialist hospital services at Gloucestershire Royal and Cheltenham General, and make best use of our hospital sites. This move towards creating *Centres of Excellence* at the two hospitals is not new and this approach reflects the way a number of other services are already provided.

It is the Programme's recommendation to the Board of Gloucestershire Hospitals NHS Foundation Trust (GHNHSFT) and the Governing Body of Gloucestershire Clinical Commissioning Group (GCCG) that the following resolutions should be considered for agreement and approval, taking into account all the evidence that has been made available, on the basis that they represent the most appropriate solution to address the case for change and are supported by regulatory assurance.

- **Resolution #1**: Formalise 'pilot' configuration for Gastroenterology inpatient services at CGH, to make this a permanent change
- **Resolution #2**: Formalise 'pilot' configuration for Trauma at GRH and Orthopaedics at CGH, to make this a permanent change
- **Resolution #3**: Centralise Emergency General Surgery at GRH
- **Resolution #4**: Develop an Image Guided Interventional Surgery (IGIS) 'Hub' at GRH and a 'Spoke' at CGH
- **Resolution #5**: Centralise Vascular Surgery at GRH
- **Resolution #6**: Centralise Acute Medicine (Acute Medical Take) at GRH
- **Resolution #7**: Planned General Surgery. The recommendation is that further work should begin to deliver a new option.

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 taking account of the outcome and findings of the recent consultation process that formally closed in December 2020, the additional information, the enhanced integrated impact assessment and the findings of the Citizens' Jury held in February 2021.

2 Background and Case for Change

2.1 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 pre-consultation business case, feedback from consultation and further evidence compiled post-consultation. This DMBC reviews the outcomes from the consultation report and seeks to ensure that progress to decision-making and implementation is fully informed by detailed analysis of consultation 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 FFTF consultation;
- 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

This DMBC is not concerned with the developments for the Forest of Dean Hospital; a separate proposal for this has been developed and presented to decision- makers as required.

2.2 Intended audiences and their decision-making roles

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

- The Governing Body of Gloucestershire Clinical Commissioning Group (CCG) which will decide whether the proposed service changes should be implemented based on the evidence presented. The CCG is the legally accountable Consulting Authority so has final responsibility for approving next steps.
- The Board of the Gloucestershire Integrated Care System (ICS), who will be asked to provide their support and ensure that the proposals are compatible with our shared system strategy.
- 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 already assured that the Fit for the Future Programme has satisfied the government's four tests and NHS England's test for proposed bed changes; the NHS England 'Beds Test' (where appropriate).
- The Gloucestershire Health Overview and Scrutiny committee (HOSC) who will scrutinise the final proposals in line with their responsibilities.

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

2.3 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 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.

2.4 The process we are undertaking

2.4.1 *One Gloucestershire Integrated Care System*

The One Gloucestershire Integrated Care System (ICS) is a partnership between local NHS and care organisations committed to turning the NHS Long Term Plan (LTP) into action for the benefit of local people and our dedicated workforce. Our expectations of healthcare, the demands on health services and the incredible progress made in development of staff skills, medicine and technology mean that we need to continue to adapt to support healthy lives and transform care to meet the needs of people into the future.

Our Vision

To improve 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.

Our Integrated Care System priorities are to:

- Place a greater emphasis on personal responsibility, prevention and self-care, supported by additional investment in helping people to help themselves
- Place a greater emphasis on joined up community-based care and support, provided in patients' own homes and in the right number of community centres, supported by specialist staff and teams when needed
- Continue to bring together specialist services and resources into *Centres of Excellence* that deliver a greater separation of emergency and planned care, and, where possible reduce the reliance on inpatient care (and consequently the need for bed-based services) across our system by repurposing the facilities we have in order to use them more efficiently and effectively in future.
- Develop new roles and ways of working across our system to make best use of the workforce we have, and bring new people and skills into our delivery system to deliver patient care
- Have a continued focus on ensuring parity of esteem for mental health.

As part of our response to the NHS LTP and commitment to the public in Gloucestershire, when patients have serious illness or injury that requires 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 *Fit for the Future Programme* includes looking at how we can develop outstanding specialist hospital care in the future across the Cheltenham General and Gloucestershire Royal Hospital sites; our *Centres of Excellence*.

2.4.2 *Pre-Consultation Business Case*

To develop the Pre-Consultation Business Case, the Fit for the Future programme agreed principles, processes and governance to support the required decision-making. The development of the PCBC was clinically-led, informed by engagement with key stakeholders and the public, and involved working with partners across Gloucestershire. The PCBC can be found at: Fit for the Future: Developing specialist hospital services in Gloucestershire – OneGloucestershire.net

Three key processes supported the development of the pre-consultation business case:

2.4.2.1 The development of the clinical model

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, a citizens jury (#1 Jan 2019) and culminating in an inclusive and transparent solutions appraisal process), a clear governance structure and agreed and delivered outputs.

This has been a structured, clinically-led process to develop potential new approaches for services, the details of which are presented in the PCBC, and comprises:

- Building a clear Case for Change;
- Defining evaluation criteria;
- Developing best practice care pathways and models of care; and
- A transparent solutions appraisal process

Our vision is for a single hospital on two sites, linked by the A40 'corridor', providing the very best care, experience, safety and outcomes for local people.

To date, the hospital's two sites have sometimes been seen as a problem, but we believe they present a huge opportunity to develop our vision of *Centres of Excellence* providing outstanding specialist care where more patients can be treated, waiting times are lower, patient experience is improved and patient outcomes are amongst the best. We aim to maximise the opportunities of the two-site configuration of our acute hospitals through a greater separation of emergency and planned care:

- Separating facilities for emergency care (from planned care) would ensure that, for patients with a life- or limb-threatening emergency, the right facilities and staff would always be available to give the best possible chance of survival and recovery.
- Getting it right could improve patients' chances of survival and recovery, reduce the amount of time they have to spend in hospital, and sometimes even avoid a hospital stay altogether.
- Having separate facilities for planned care (from emergency care) could reduce the number of operations that get cancelled when beds or operating theatres are needed for the most unwell patients who arrive in ED and need urgent operations or treatment

We are not proposing a full hot (emergency)/cold (planned) split across the hospital sites in our county, so the clinical models retain a 24/7 front door (ED/ED+MIIU) and ITU on both sites. Importantly, many patients and families who have to travel out-of-county specialist centres could be treated locally in the county.

We know how important Cheltenham General Hospital Accident & Emergency (A&E) Department is to the people who live in the east of the county; in particular Cheltenham. We agree it is an important part of the future for local health services. We have publicly committed to the future of the Accident and Emergency (A&E) Department in Cheltenham. The service will remain consultant-led and there will be no change to the (pre-COVID-19) opening hours.

2.4.2.2 Public and stakeholder engagement

The Fit for the Future (FFTF) programme has engaged inclusively, 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&I Guidance:

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

The FFTF public and staff engagement programme started in August 2019 to seek views on the future provision of urgent and specialist hospital care in Gloucestershire. All feedback received was collated into a comprehensive Output of Engagement report (Appendix 2 of the PCBC) that has been used to inform the development of our potential solutions for future local NHS services.

2.4.2.3 The solution development process

These are the steps we followed:

Step 1

A 'long list' of potential solutions for *Centres of Excellence* was put together by local NHS staff and clinicians. The long list included 1,297 possible variations for how the specialist services could be organised across the two hospitals in Cheltenham and Gloucester.

Steps 2 & 3

The long list was reduced to a 'medium list' of 29 variations by testing all the potential solutions against a number of key factors called 'hurdle criteria', and also by testing how well the potential solutions could work together. Simply put, each potential solution had to get over the first few hurdles for it to pass the test to carry on to the next stage.

For those options that cleared these hurdle criteria, the next stage was to consider whether they made sense in combination as 'clinically viable' models. This stage was carried out by a wide range of hospital staff who work across the services on a day-to-day basis. Each potential solution which passed this stage was then considered in more detail using a set of 'evaluation criteria' developed using feedback received during the Fit for the Future Engagement and tested at the first Fit for the Future Citizens' Jury (#1).

The remaining 29 potential solutions were grouped into 8 combinations of services (clinical models). The purpose of doing this was to present a range of service combinations that represented the different ways services could be delivered. This enabled them to be more-

easily compared and evaluated against each other, but did not remove any potentially viable solutions from consideration.

Steps 4 - 6

A series of solutions appraisal workshops took place in public. Members of the public, including some Jury Members and Healthwatch Gloucestershire representatives[1], joined clinicians and other NHS and care staff to look in detail at the medium list of potential solutions. Using the evaluation criteria (see below), the workshops reduced the medium list to a short list, which was subject to external review by the South West Clinical Senate before the final shortlisted options went forward to public consultation.

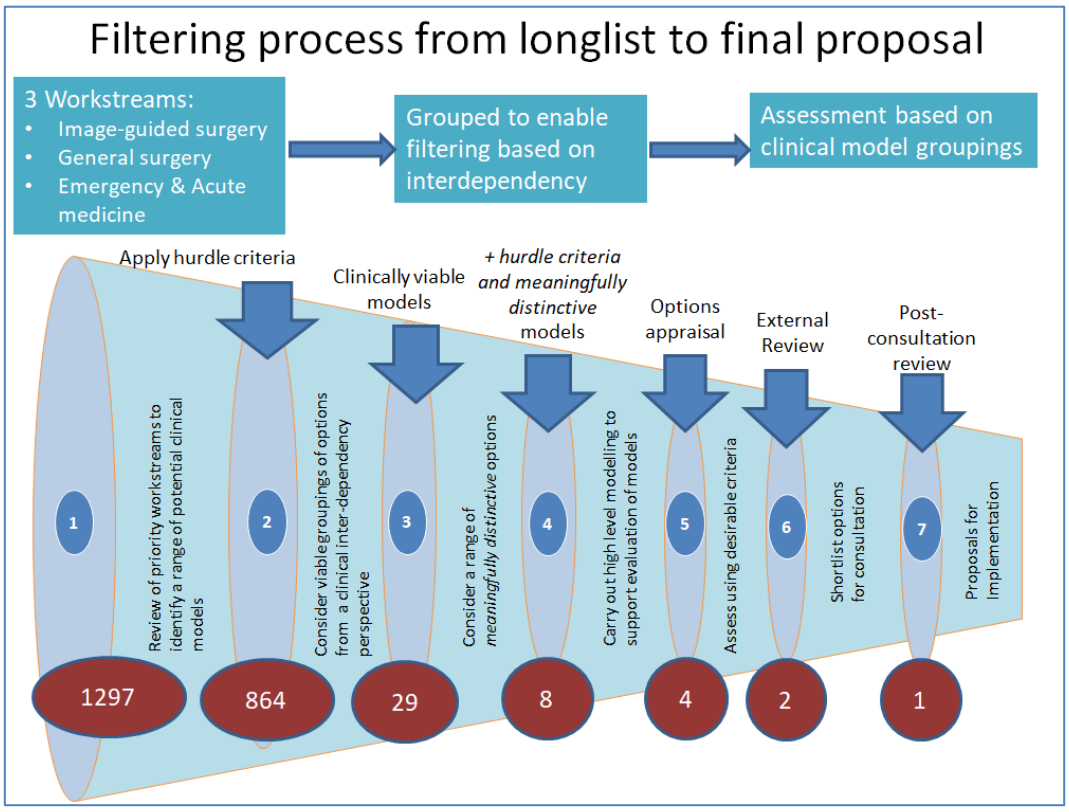
Details of steps 1-6 can be found in the PCBC.

Step 7

Prior to the consultation, the work, including patient, public and staff engagement, had not produced a preferred option for the location of planned Lower GI (colorectal) General Surgery; centralised at either CGH or GRH. Therefore, both options were included in the public consultation (see section 2.6).

Following consultation, an options appraisal process was undertaken using consultation feedback and the desirable criteria domains (see section 4.2.3) to confirm a preferred option.

The diagram below illustrates the stages of our solutions development process.



The six desirable criteria domains listed below were used at steps 4 and 7.

- Quality of care
- Deliverability
- Strategic fit
- Access to care
- Workforce
- Acceptability

[1] Observers were also in attendance including members of Restore Emergency At Cheltenham General Hospital (REACH) campaign

2.4.3 *Consultation*

The Fit for the Future public and staff consultation started on 22 October 2020 and ran until 17 December 2020. The consultation was quality assured by The Consultation Institute[2]

2.4.3.1 Aims of the consultation

The aim of the consultation was to seek the public's views on the proposals in order to inform decision-makers on the acceptability (or otherwise) of the proposed options for service change. The consultation activities therefore aimed to ensure Gloucestershire residents, and people in neighbouring areas who use services in Gloucestershire, were aware of and understood the proposed options for change, by providing information in clear and simple language in a variety of formats. In this way we heard people's views on the proposed reconfiguration of hospital services at GRH and CGH. Decision-makers in the One Gloucestershire system will use evidence from the consultation feedback to inform their decision-making as they discharge their various roles (see section 2.2 for description of roles).

2.4.3.2 Key areas of work and outputs

There have been a number of innovative ways the NHS has involved local people and staff during the consultation, from online events, to a 'socially distanced' Information Bus Tour and a door-to-door mail-drop of an information leaflet delivered by Royal Mail to all households in Gloucestershire. We undertook over 75 virtual and face-to-face events and we received over 700+ survey responses. All the feedback also informed the refresh of the integrated impact assessment (see section 5).

Details of the consultation process can be found in the section 3.1 and in the Final Output of Consultation report in Appendix 1.

2.4.3.3 Impact of Coronavirus (COVID-19) on the consultation

Our consultation plans were designed to deliver a 'socially distanced' consultation, taking into account the impact of COVID-19 on conducting face-to-face consultation activities, in line with NHSE&I guidance issued in August 2020 (*Good practice for stakeholder engagement on service change and reconfiguration during COVID-19* and the *Short guide to socially distanced engagement*). Opportunities for 'virtual' and e-consultation were a key, but not exclusive, part of our consultation methodologies; details of which can be found in section 3.1.2.

Although not directly linked to the longer term proposals set out for consideration in the FFTF programme or the consultation, it should be noted that, in response to the COVID-19 pandemic, GHNHSFT implemented a number of temporary service changes aimed at separating (as much as possible) services caring for COVID-19 and non-COVID-19 patients. Whilst Fit for the Future is not about the COVID-19 temporary changes made in 2020, some of the medium to long term changes proposed relate to some of the same clinical services where temporary changes had to be made in order to keep our hospitals safe.

[2] A UK based not-for-profit organisation specialising in best practice public consultation & stakeholder engagement.

2.4.4 *Decision-making business case*

Following the end of the consultation, the programme has carried out extensive work to understand the evidence and feedback that has been received through consultation. The feedback and responses from the public and stakeholders have been used within this DMBC to inform the development of our final proposals for change.

The process to bring together this evidence and feedback involved several stages, including:

- Collation of the feedback and evidence from consultation into an Interim Output of Consultation report[3];
- Development of the refreshed integrated impact assessment;
- Review and deliberation of consultation findings;
- Development of further analysis and evidence to understand the views and potential effects emerging from consultation; and
- The decision-making process.

This is further described below.

2.4.4.1 Development of the Final Output of Consultation report

The report (Appendix 1) is divided into two parts: Part 1 provides background information about the Fit for the Future Programme, the co-development of the consultation proposals and the consultation planning and activities. Part 2 provides a summary of the feedback received during the consultation. The final section of the report is an evaluation of the consultation activity. There is also a summary of activity post-publication of the Interim Output of Consultation report and signposting to new items.

There are elements of feedback which will be relevant and of interest to all readers and these are presented in the main body of the report. All feedback received can be found in a series of Appendices; all of which are available online[4]. These Appendices include all comments collated during the consultation, including copies of individual submissions received, in addition to the Fit for the Future survey responses.

Some respondents may have answered the formal consultation survey as well as giving feedback in other ways, such as sending a letter or participating in a discussion event. All feedback received has been read and categorised into themes e.g. access, workforce and quality. The theming of the qualitative feedback received through the FFTF survey presented in the report has been undertaken by members of the One Gloucestershire Communications and Engagement Group using SmartSurvey.

2.4.4.2 Development of the DMBC Integrated Impact Assessment

To understand the impacts of the proposals and inform decision-making an Integrated Impact Assessment (IIA) was commissioned from Mid and South Essex University Hospitals Group Strategy Unit. The baseline and pre-consultation IIA were integral to the PCBC and this has been refreshed following the public consultation to take account of:

- Findings from the public consultation process;
- Additional analysis undertaken; and

[3] The Interim Output of Consultation report was published on 11/01/21. The final report was published on 04/03/21

[4] Fit for the Future: Developing specialist hospital services in Gloucestershire – OneGloucestershire.net

- New data sources that have been made available since the publication of the interim report.

Details can be found in section 5 and the full report in Appendices 2a, 2b & 2c.

2.4.4.3 Review and deliberation of consultation findings

The programme team has been through an extensive process of 'socialising', sharing and discussing the consultation findings with a wide range of groups to inform the development of our final proposals for change. This has included:

- Presentation of consultation report and discussion of findings at:
    - Gloucestershire Health Overview and Scrutiny Committee (HOSC)
    - GHNHSFT Board
    - ICS Board and Executives
    - GCCG Governing Body
    - GHNHSFT Council of Governors
    - Citizens' Jury (#2)
    - GHNHSFT Clinical Advisory Group and Service & Transformation Group
    - FFTF IIA Reference Group
- Compilation of key consultation themes and issues that have been taken account of by the DMBC (see section 3.2)
- Engagement with relevant stakeholders to respond to consultation themes and issues.
- Consideration of the impact of consultation findings on service proposals
- Consideration of the impact of further evidence on service proposals

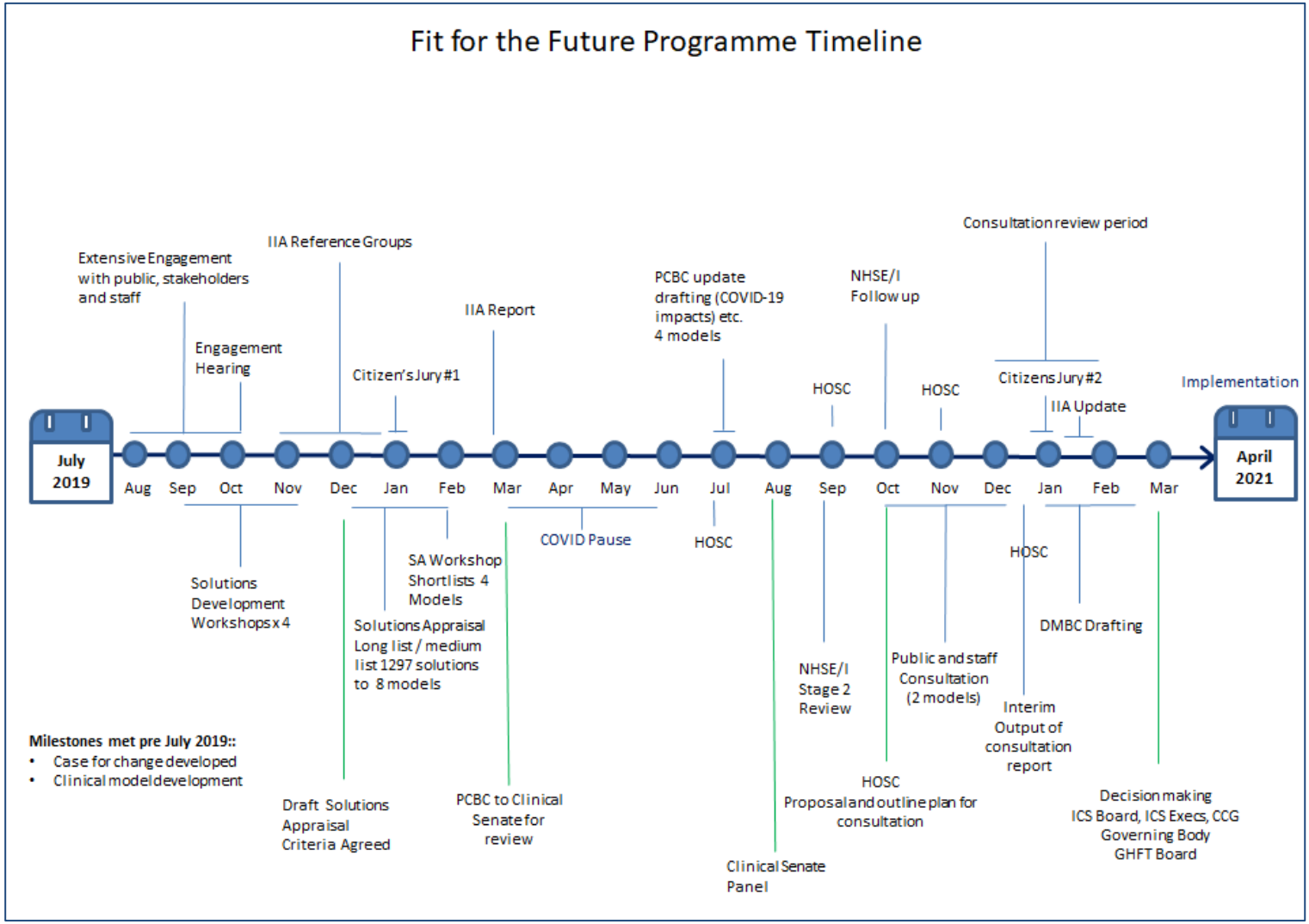
2.4.4.4 Development of further evidence

Within this DMBC, we have used the feedback from consultation to inform the development of our final proposals and solutions. Given this feedback, we have spent particular time reviewing and developing further evidence across a number of areas including Trauma and Orthopaedic and General Surgery. This evidence is summarised in Section 4.

2.4.4.5 Decision-making process

Within this DMBC, we have used the feedback from consultation to help us identify the preferred solutions for our population. This DMBC includes a detailed description of how we have considered the evidence in Section 4. Details of the decision-making process can be found in section 7

2.4.5 *Fit for the Future timeline*



2.5 Case for change

Gloucestershire Hospitals NHS Foundation Trust was formed in 2002 by the merger of Gloucestershire Royal NHS Trust, responsible for GRH, and East Gloucestershire NHS Trust, responsible for CGH. Since that time, several changes have been implemented to offer patients the benefits of improved access and outcomes.

The hospitals are centrally located within the county and are only 8 miles apart. Developing as two district general hospitals has enabled the evolution of two acute hospitals with their own unique characteristics originally serving different parts of Gloucestershire, but, with the development of more complex health interventions, the smaller scale of duplicated services has resulted in patients having to travel to partners in larger regional centres in Oxford, Bristol and Birmingham for more specialist services. For patients who are treated in-county, a hospital covering two sites can dilute the effectiveness of the available resources, compromising quality, productivity and staff recruitment and retention.

The Trust believes that there are both challenges to face and exciting opportunities waiting to be seized. There are challenges to some services related to managing a workforce to stretch across two hospital sites, and splitting specialist high tech equipment across both hospitals does not make best use of resources. The expectations of healthcare, the demands on health services and the incredible progress made through science and technology have dramatically changed the environment, which means that healthcare services need to evolve and change too. The advances in healthcare and staff skills mean that many more services can be provided in people's own homes, in GP surgeries and in the community. There are also real opportunities to take advantage of advances in specialist hospital services. We want our local services to be *Centres of Excellence.*

2.5.1 *Why improvements to current provision are needed*

In the context of the national and county-wide picture of growing demand, improved technology and workforce supply challenges, the Trust's current configuration leads to specific clinical (quality), workforce and financial challenges which were detailed in the PCBC and are summarised below:

2.5.1.1 Clinical Challenges

- 3 in 10 Emergency General Surgery patients have suspected gallstones. Currently less than 50% see an Upper GI specialist (rated 15 on Trust risk register; issues due to staffing challenges working across two sites).
- At times, senior surgical decision-makers are in theatre and unavailable to review patients waiting for specialist surgical assessment in ED or Surgical Assessment Unit, leading to delays in treatment.
- Emergency General Surgery admissions to CGH are not compliant with the South West Clinical Senate's 2017 review requirement for access to a Surgical Assessment Unit, or a 24-hour CEPOD[5] list. There is also no access to ultrasound scans at weekends.
- Shared specialty access to emergency theatres (both sites) can lead to extended 'time to theatre', leading to sub-optimal Emergency General Surgery care (rated 15 on Trust risk register).
- National standards recommend all Acute Medicine patients to undergo a consultant review within 14 hours of arrival. An NHSE&I 7-Day Service self-assessment showed that

[5] National confidential enquiry into patient outcomes and death

67% of patients were seen by a consultant within 14 hours during weekdays, whilst at the weekend this dropped to 48%.

- Every year around 600 patients travel outside of Gloucestershire for image-guided surgical procedures e.g. Cardiology Primary Percutaneous Coronary Intervention (PPCI) that could be offered in-county with the right staff and equipment.
- Existing dispersed configuration of facilities for image-guided surgery reduce our capacity to offer minimally-invasive techniques. There is clear evidence that these can reduce the need for more invasive surgery, reduce the physiological insult to patients and thereby reduce complications and hospital stays.

2.5.1.2 Workforce Challenges

- In a 7-month period in 2019, 15% of shifts for Emergency General Surgery were not covered (390 shifts out of 2,599). Rota gaps have increased by 46% in three years (rated 16 on Trust risk register)
- The Trust has a 43% vacancy rate for acute medical physicians. This is based on an establishment of 14 consultants, with only 8 posts filled.
- GI surgical trainees have reported negative feedback about workload and training environment. If this situation does not improve, the Deanery could withdraw trainees from the GI service in Gloucestershire, impacting further on workforce and safety of care (rated 15 on Trust risk register)
- Due to a shortage of radiologists, we are not compliant with The Royal College of Radiologists' recommendation that provision of a robust 24/7 Interventional Radiology service should be a "priority for all acute hospitals".
- Since May 2019 we have advertised three times for locum and twice for substantive interventional cardiologist recruitment, and have only successfully recruited 1 locum in this time. There are similar challenges with recruiting cardiac catheter lab nurses.

2.5.1.3 Financial Challenges

- Repatriation of patients going out of county for minimally-invasive techniques would bring £460,000 additional income to the county with the potential for this to increase over time.
- The Trust's imaging equipment is recorded on the risk register as being out of date. Work is underway to develop a business case for a Managed Equipment Service contract worth £46m over 15 years to replace and maintain obsolete kit, but decisions are required on where to install the equipment for optimal productivity and improved patient outcomes.
- Image-guided surgery is currently offered in three separate sites in GHNHSFT, driving up the cost of equipment and storage, e.g. £80k consumables waste in 2017/18
- Workforce challenges outlined above lead to high agency and locum costs

2.5.1.4 Performance Challenges

The key performance measures as at December 2019 (at the end of our baseline period) which indicate the need for improvements are:

- Emergency Department (ED) 4 hour target at 83.47%, which although in line with agreed trajectory is short of the national 95% target
- Bed occupancy rate of 95.4% (average) compared with a desired occupancy of <92%

- Rate of emergency admission is slightly higher than peer group[6]
- Over 400 operations cancelled on the day for non-clinical reasons in the most recent 12-month period
- Activity income lost to patients travelling out of area for their procedure
- Staff turnover rate over 11% 2019/20

2.5.2 *Learning from Coronavirus (COVID-19) Temporary Changes*

As stated in Section 2.4.3.3 GHNHSFT implemented a number of temporary service changes in response to the pandemic. In some cases, the temporary changes relate to some of the same clinical services included in our FFTF proposals. Whilst the implementation and context are markedly different to that planned under FFTF changes there have been a number of positive effects on service risks resulting from the temporary changes; these include:

- Reduction in the risk of sub-optimal staffing caused by a combination of insufficient trainees, senior staff and increased demand resulting in compromised trainee supervision
- Reduction in risk to patient safety caused by insufficient senior surgical cover
- Reduction in risk of sub-optimal care for patients with specialist care and other sub-specialty care conditions caused by lack of ability to create sub-specialty rotas
- Reduction in risk of sub-optimal care for emergency surgical patients requiring surgical treatment caused by limited day time access to emergency theatres

2.5.3 *FFTF Proposal Benefits*

In addressing the case for change our proposals are aimed at delivering the following:

What we want to achieve	Benefits
Improved health outcomes…	...ensuring patients are treated by the right specialist team (doctors, nurses and other healthcare professionals) with timely access to treatment and care
Reduced waiting times and fewer cancelled operations…	…leading to a more reliable and positive experience for patients and their families
Timely assessment and decision-making from senior health professionals when you arrive at hospital…	…leading to prompt diagnosis, treatment and recovery
Right staff in the right place at the right time including senior doctors – 24 hours a day, 7 days a week…	…leading to better, safer care with shorter hospital stays while attracting and keeping the very best staff

[6] GHFT is 32% ROA compared with 30% national (2018)

Support for joint working between doctors, nurses and therapists, including links to related services and equipment…	…to avoid the need for more visits and hospital stays
Specialist staff seeing enough patients to maintain their specialist skills…	…so they can provide the very best care and outcomes for patients
Create flagship centres for research, training and learning	…attracting and keeping the best staff in Gloucestershire and ensuring you have access to ground-breaking treatments
Make best use of scarce resources including staff and specialist equipment…	…staff are in the right place, right time, first time to care for patients.

2.6 Consultation proposals

Feedback from engagement showed there is support to continue to develop a *Centre of Excellence* approach, which reflects the way a number of inpatient services are already concentrated in one place – such as oncology (cancer care) in Cheltenham and children's services in Gloucester. For our hospitals, we want to see two thriving, vibrant sites with strong identities with both providing world class treatment.

As we continue to organise services, we believe that one hospital should focus more on emergency care and one hospital should focus on planned care and oncology. This concentration in one place, or *Centre of Excellence*, should help to ensure that the right facilities and specialist staff are always available to give people the best treatment and care, to help reduce the number of planned operations cancelled when beds or operating theatres are needed for the most urgently unwell patients. We want to strike the right, but often difficult, balance between having two world class *Centres of Excellence* in Gloucestershire and providing local access to services.

The consultation proposals were as follows:

- A *Centre of Excellence* for Acute Medicine (Acute Medical Take) at GRH
- An Image Guided Interventional Surgery (IGIS) 'Hub' at GRH and a 'Spoke' at CGH
- A *Centre of Excellence* for Vascular Surgery at GRH
- A *Centre of Excellence* for Gastroenterology inpatient services at CGH
- *Centres of Excellence* for Trauma at GRH and Orthopaedics at CGH.

In addition, the consultation included two proposals for General Surgery which differed in the configuration of planned Lower GI (colorectal) surgery - centralise to CGH or centralise to GRH; these were:

- Create a General Surgery centre of excellence at Gloucestershire Royal Hospital (GRH) comprising a centralised Emergency General Surgery service alongside the already-centralised planned Upper Gastrointestinal (GI) service and a newly-centralised planned Lower GI (colorectal) service. Planned day case Upper and Lower GI (colorectal) surgery would be centralised at CGH

Or

- Centralise Emergency General Surgery at GRH alongside the already-centralised planned Upper GI service and create a *Centre of Excellence* for Pelvic Resection at Cheltenham General Hospital (CGH) comprising a newly-centralised planned Lower GI (colorectal) service alongside Gynae-oncology and Urology. Planned day case Upper and Lower GI (colorectal) surgery would be centralised at CGH.

In these two proposals, the configuration for three service areas is the same: Emergency General Surgery at GRH, planned Upper GI at GRH and day case Upper and Lower GI at CGH.

Key Points

- **The One Gloucestershire ICS is committed to turning the NHS Long Term Plan (LTP) into action for the benefit of local people and our dedicated workforce.**
- **The services included within the DMBC should not be seen in isolation from all the other developments that support the delivery of our LTP.**
- **In Gloucestershire, splitting resources across two hospital sites contributes to quality, workforce, financial and performance issues which affect patient outcomes and staff recruitment and retention and efficient use of resources.**
- **Clinicians have been at the centre of our case for change which is based on the best available evidence.**
- **There is a clear evidence base that greater separation of planned and emergency (elective and non-elective) services in hospitals contributes to improved outcomes for patients and more effective use of resources.**
- **There are strong quality and safety drivers to support proposed changes to the Emergency General Surgery service.**

3 Feedback from Public Consultation

The Fit for the Future public and staff consultation started on 22 October 2020 and ran until 17 December 2020. The planning and delivery of the consultation was supported by a wide range of external groups including:

- The Consultation Institute: The consultation process has been Quality Assured by The Consultation Institute (tCI) with each stage of the consultation planning and activity formally signed-off by a tCI Assessor, ensuring a totally independent assessment of the consultation process.
- Inclusion Gloucestershire: Assisted with the development of Easy Read materials.
- Gloucestershire County Council's Digital Innovation Fund Forum: supported early planning for online activities and assisted with awareness-raising of the consultation to potentially digitally excluded groups.
- Friends from the Friendship Café in Gloucester City: Supported awareness raising within and survey completion by diverse communities.
- Healthwatch Gloucestershire (HWG): HWG Readers' Panel reviewed an early draft of the full consultation booklet and made suggestions for changes, which were incorporated into the final version.
- Know Your Patch (KYP) Coordinators: KYP allowed us space on agendas to share information at online meetings during October and November 2020 to promote the consultation.
- District/Borough Councils and Retail partners: Supported the 'socially distanced' visits of the Information Bus (outside of Lockdown 2) to locations with maximum footfall across the county. District and Borough Councils also hosted members' seminars to discuss the Fit for the Future consultation.
- Local media: Gloucestershire Live, BBC Radio Gloucestershire and GFM Radio
- Others: Many other groups and individuals have helped to raise awareness of the consultation such as GHNHSFT Governors, staff-side representatives, hospital volunteers and community and voluntary sector organisations such as homelessness support charities.

3.1 Overview of Consultation

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

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

Our aim with this consultation was to reach a good representation of the local population, whilst making sure we hear from those groups who might be most affected by the proposed changes. We worked closely with Mid and South Essex University Hospitals who, due to their recognised expertise in this area, were commissioned to undertake the Integrated Impact Assessment. This work helped us to identify which particular groups might be

affected, enabling us to actively seek out the views of people in those groups, set out below, during the consultation to gain a better understanding of the potential impact on them and to identify ways to lessen any potential negative effects:

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

The targeted activities are described in section 3.1.2, the consultation responses in section 0 and the potential impact in section 5.

3.1.1 *Consultation materials*

In developing the materials for the consultation, we undertook an Equality and Engagement Impact Analysis (EEIA) to identify issues pre-consultation and took action ahead of consultation. This is presented in the table below:

Issue identified	Consultation Action
Less information, less jargon and easy read	The Consultation booklet was reviewed by the Healthwatch Gloucestershire Lay Readers Panel. An Easy Read version of the consultation booklet and survey was produced by Inclusion Gloucestershire. A summary version of the consultation booklet was produced.
Accompanying glossary recommended	There is an accompanying glossary in the full consultation document (which is available in print and online).
Further engagement to address the homogeneity of participants	Targeted opportunities for consultation with protected characteristic groups identified through the Impact Analysis e.g. via the Homeless Healthcare Team, Carers Forum etc. Alternative formats of all consultation materials available on request. Contract in place with telephone (and face to face) interpreters, incl. BSL and for written translation.
Paper surveys should be replicated as online surveys	Surveys were available online in regular and easy read formats. People were also offered assistance to complete surveys over the telephone.
Different marketing messages required to encourage online participation for 'always'	All forms of media, print, broadcast, and social media were used. An awareness-raising leaflet was delivered to all households by Royal Mail in Gloucestershire telling them

(compete with other opportunities), 'seldom' (relevance, links to pandemic interests) and 'never' online (other opportunities or assistance required).	about the consultation and how they could get involved.
Liaise with community leaders to hold specific workshops within the BAME communities with community support for interpreters	We contacted local groups, including BAME communities to arrange culturally-appropriate opportunities for participation in the consultation e.g. Information Bus visit to Gloucester Mosque at their invitation [Unfortunately we were unable to attend the Mosque visit due to COVID-19 Lockdown 2 restrictions. However, we liaised with local community leaders about alternative ways to promote the consultation, including WhatsApp and interview on local Community Radio]
Use creative and interactive dialogue methods	We used a range of methods: Online, face-to-face (socially distanced), telephone, written.
Online consultations prove to be most successful when used in conjunction with offline methods such as telephone structured interviews/market research techniques/managed exhibitions	We hosted online activities, chat forums and live discussions recorded on YouTube [In response to feedback after the first Live discussion, broadcast was moved to Facebook Live for better reach]. We invited people to call us to leave a message to book telephone interviews. We toured our Information Bus to all localities in the county.
Online forums should be moderated	The Forum function of the Get Involved in Gloucestershire online participation platform is independently moderated. The Gloucestershire Live Facebook events were hosted by an independent chair and questions were moderated.
Varying the times of online events	Events were held at different times of day and different days of the week
Events, e.g. workshops, no longer than 2 hours	All scheduled events were no longer than 90 minutes, with online events mostly lasting 30-45 minutes. Most events were online, and we make it clear that participants could get up to have a comfort/refreshment break
Some individuals or groups feel more comfortable sharing their thoughts on their own platforms, rather than official channels designed explicitly for themed discussions.	We offered to use the platforms, which worked best for the individual or group: Zoom, FaceTime, Microsoft Teams, and WebEx – We completed DPIA (Data Protection Impact Assessments) for any new platforms requested. We also offered more traditional methods such as telephone calls
Target groups identified through the IIA	Representatives from the groups identified in the IIA were contacted to discuss methods to facilitate participation in the consultation. Example: Advice from the Homeless Healthcare Team, Age UK, Carers Hub

The programme developed a wide range of materials for the consultation, including:

- Consultation Booklet (Long)
- Consultation Booklet (Short)
- Consultation Booklet (Easy Read)
- A consultation questionnaire/survey (online and hard copy)
- Range of videos (with local clinicians explaining each of the service proposals)
- Door-to-Door awareness raising leaflet (delivered by Royal Mail)
- Display materials
- Frequently asked questions

3.1.2 *Consultation activities*

A range of communications and consultation channels were used during the Fit for the Future consultation. Full details of the activities can be found in Appendix 1 and a summary list is provided below:

- Fit for the Future Surveys
- Door-to-Door awareness raising leaflet (delivered by Royal Mail)
- Gloucestershire Media: Live social media partnership (@GlosLiveOnline)
- Gloucestershire Hospitals: Facebook Live (@GlosHospitals)
- Hardcopy engagement booklets
- 'Your Say' area on the One Gloucestershire Health website and Get Involved in Gloucestershire online participation platform
- Further engagement to address the homogeneity of participants
    - Young people
    - Adult Carers and Young Carers
    - Gypsy/Traveller communities
    - LGBTQ+ people
    - Gloucestershire Patient Participation Group (PPG) Network
- NHS Information Bus Tour
- Cuppa and Chats
- Media releases and stakeholder briefings
- Social media
- Facebook
- Twitter
- Media advertising
- Other surveys and petitions

3.1.3 *Post-consultation additional information*

During the period between the end of public consultation and completion of the DMBC, we have continued to work on the ongoing development of our proposals, which has resulted in a number of further pieces of information being made available to decision-makers. To ensure transparency is maintained, the FFTF Consultation Team contacted local people, groups and stakeholders who participated in the consultation and for whom we had contact

details (email or postal address) letting them know about the additional information and inviting them to request this information via online links to documents or printed copies as they became available. All of the additional information was posted at www.onegloucestershire.net/yoursay.

This additional information and any further comments received in relation to it have been incorporated into the final Output of Consultation report and this DMBC. The additional information included:

- Fit for the Future Citizens' Jury (#2) – Jurors report (and recordings of presentations)
- Citizens' Jury (#2) report – includes detail of the Jury process
- Final Output of Consultation report
- Recommendation regarding the preferred location for colorectal surgery
- The Consultation Institute Quality Assurance Assessment
- Updated Trauma and Orthopaedic Pilot Evaluation

3.1.4 *Staff communication and engagement*

Four main programmes of internal communication and engagement were rolled out to staff. Full details of the activities can be found in Appendix 1 and a summary list is provided below:

- Corporate communications:
    - Video communication
    - Global emails
    - Intranet
    - Website
- Staff online discussion forum
- Staff drop-in sessions
- Staff ambassadors

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

3.1.5 *Other stakeholder communication and engagement*

Full details of the activities can be found in Appendix 1 and a summary list is provided below:

- Elected Representatives
    - Members of Parliament
    - Gloucestershire County Council (GCC)
    - District and Borough Councils
- REACH Campaign

3.1.6 *Consultation review*

3.1.6.1 The Consultation Institute's assurance process

The Consultation Institute (tCI) has assured the consultation. The tCI assurance process includes 6 checkpoints at different stages of a consultation. The tCI assurance process for this consultation will conclude following tCI review of the Final Output of Consultation report.

3.1.6.2 Citizens' Jury

A second Citizens Jury, independently facilitated by Citizens Juries CIC, was held in January 2021 to consider the consultation process and approach, to highlight key themes. 18 independently-recruited jurors representative of local communities from a broad range of demographics, received evidence from a range of witnesses, recorded their observations and made their recommendations to decision-makers of the NHS organisations involved. This includes key feedback about the way the consultation process has been delivered, and reflections on how we can further improve and develop our consultation methods in the future. These are included within the Jurors' report (Appendix 3a), and the response from the local NHS with respect to the FFTF consultation is included in the Final Output of Consultation report (Appendix 1).

The key recommendations of the Citizens Jury are included below for decision-makers. The full recommendations are included as an Annex to this document and also then in full with a complete NHS response in the Appendix 1. The Jurors worked together to identify the key messages that are important for the NHS Governing Bodies to hear about the FFTF public consultation. Only those that were supported by a majority of the jury are included in the table below. Their reasoning is given in the middle column of the table. A suggested NHS Response is given in the right hand column to support decision-makers deliberations.

Something still missing, needs to be addressed, or requires further clarification re: the FFTF consultation	Why It Matters	NHS Response
We are concerned regarding the number of Royal Mail mailshots actually delivered to homes and wonder if there are better ways to market the initial engagement process, to get more people to know about the consultation, and hopefully contribute to the results. *16 Yes votes / 2 No votes)*	This will get more peoples' opinions and a better representation of the people in Gloucestershire, and would help us to know the majority have had a chance to be part of the consultation.	Jurors were very interested in the impact of the 'door to door' leaflet drop. Concerned that it had either not been delivered on gone unnoticed amongst other items of post. It should be noted that the leaflet was only one aspect of the communications and our approach included a range of other methods such as paid for social media advertising were used and had a wide reach (see section 2.4 of the Output of Consultation report).

The Covid-19 pandemic has changed our way of life considerably - it would have helped for the FFTF consultation to incorporate a response to the pandemic in their presented material. *(15 Yes votes / 3 No votes)*	This matters because the plans drawn up before the pandemic may not be relevant anymore and the pandemic directly affects the day-to-day running of the services.	The consultation materials included a section about the Covid-19 Temporary changes (page 5 in the main consultation booklet). The DMBC also considers the impact of the pandemic on delivery of services during the pandemic and in the future. We are confident that our proposals take account of the future requirements of our services in light of our experiences during the pandemic
We have been assured that the golden thread of patient experience is the reason for this project, but there is nothing about that in the proposals. It is important that at the same time as any re-organisation of medical services, there is a review of the way patients are treated, their dignity and the facilities offered associated with new medical proposals. There is always something about this in external audits. *(16 Yes votes / 2 No votes)*	It's about the patients!	We are considering our next steps with regards to how to further involve local people in our work to develop the detail on the FFTF implementation plans if decisions are made to proceed with changes, especially with regards to our focus on improving the patient experience.

Statements that received 50% of votes "Yes" are included in the table below.

Something still missing, needs to be addressed, or requires further clarification re: the FFTF consultation	Why It Matters	NHS Response
Why Inclusion Gloucestershire was told in mid-2019 that there wasn't enough time to produce more easy read information booklets? *(9 Yes votes / 9 No votes)*	This is important because it might've meant that the disabled population had a better representation and may have led to different results and views on FFTF.	We will follow this comment up with Inclusion Gloucestershire, with whom we work on a regular basis, and who produced the Easy Read Consultation Booklet and Survey for the 2020 consultation. Inclusion Gloucestershire were crucially involved with recruiting participants with a wide range of protected characteristics to take part in the independently facilitated workshops during the FFTF Engagement in 2019.
Data is missing that would give information of how many leaflets were actually delivered by Royal mail. *(9 Yes votes / 9 No votes)*	This matters because it would give more data to know that as many households as possible had received the leaflets that were commissioned to be delivered by Royal Mail (297k).	We will follow up with Royal Mail to discuss their methods for confirming delivery of leaflets to households and their reporting.

The following is an extract from the Jury report: Overall, the jury:

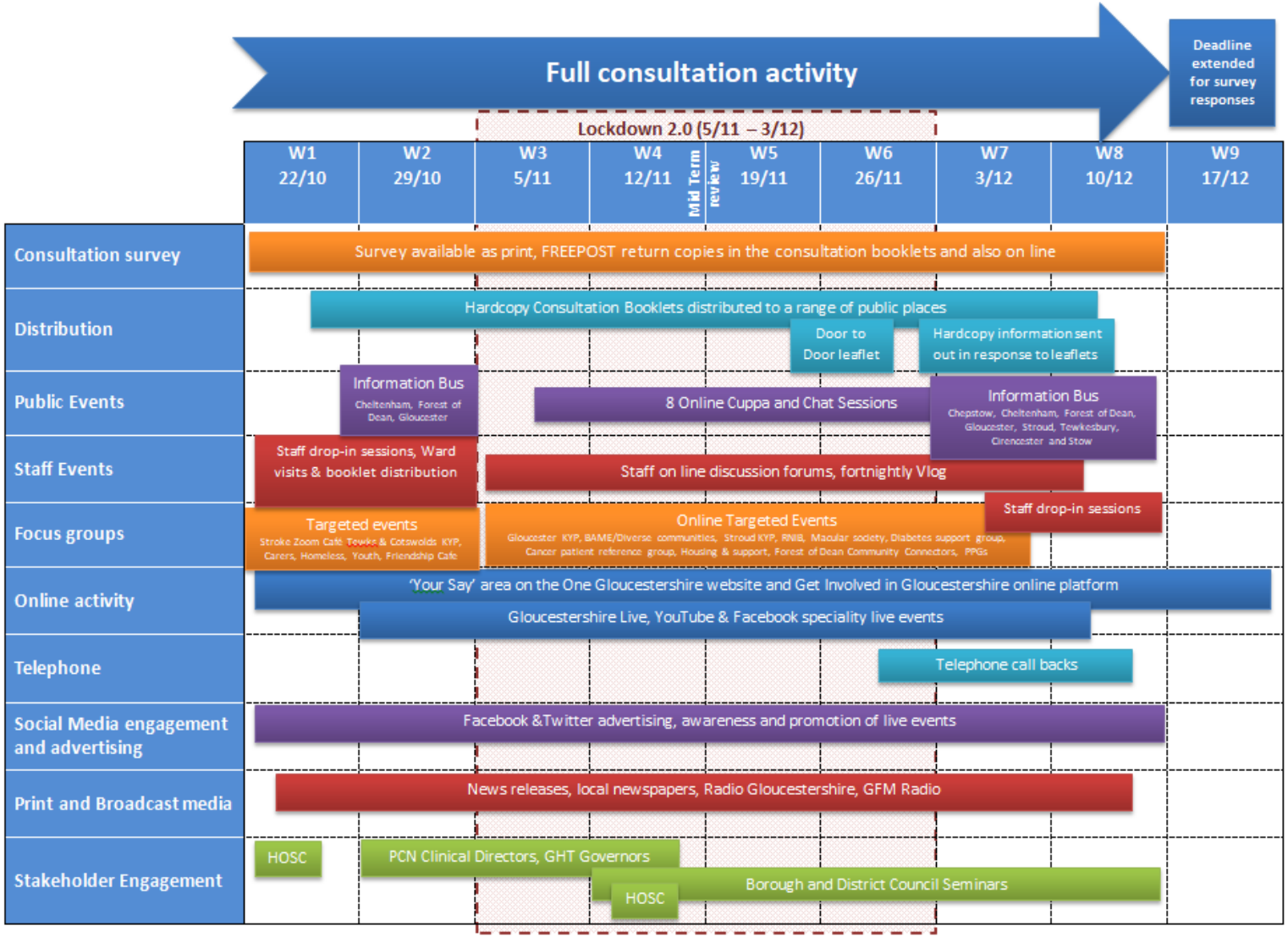
- Was neither confident nor not confident that the consultation process enabled the public to contribute meaningfully to decision making;
    - Gaining in confidence from the clear, concise language and limited jargon in materials
    - Losing confidence from running the consultation during the pandemic thus reducing participation;
- Was more confident than neutral that the information provided as part of the consultation enabled residents to be adequately informed about the proposed service changes thanks to use of plain English and information made accessible across multiple platforms;
- Overall, the jury considered the most important findings from the consultation to be:
    - Though 713 completed surveys may appear unsatisfactory to the general public, it is approximately double the number predicted by sample size calculation software;
    - Respondents did not necessarily reflect the demographics of the county: a significant number of the survey results came from Cheltenham;

    - There are concerns from both staff and patients about bed numbers and the increase of patients to Gloucestershire Royal which is already deemed to be overstretched.
- And a jury majority wanted the NHS Governing Bodies to know:
    - They were concerned about the number of Royal Mail mailshots actually delivered to homes and wondered if there were better ways to market the initial engagement process
    - It would have helped if the FFTF consultation materials incorporated a response to the pandemic;
    - That the proposals should have focused more on patient experience.

Ongoing involvement

The FFTF Programme Team and Consultation Team are grateful to the Jurors for their commitment to the two weeks process. After the conclusion of the Jury we sent a letter to Jurors via Citizens Juries c.i.c. thanking them and encouraging them to continue to be involved in local health services; at the time of writing several have been in touch.

3.1.7 *Consultation activity timeline*



3.2 Summary of Consultation Findings

Feedback to the consultation was received in two main ways:

1. Fit for the Future survey (Main and Easy Read) responses 713 Surveys received (this included 110+ Freepost paper surveys, 1 telephone survey and the remainder online).
2. Other correspondence/written responses

3.2.1 *Demographic information - surveys (Main and Easy Read)*

Demographic information about respondents was collected by the Fit for the Future surveys. Not everyone who responded to the survey completed any/all of the demographic questions; overall average of 82% completed (range across all questions of 75-86%). However, the analysis of the responses indicates that a diverse range of respondents from all protected characteristic groups, and those identified in the Independent Integrated Impact Assessment have provided feedback to the consultation. Full details can be found in Appendix 1 but in summary:

- Proportionally more people from Cheltenham completed the survey (25% of survey respondents compared to the proportion of Gloucestershire population resident in Cheltenham postcodes -18%)
- More women than men completed the survey (55% / 39%)
- Good age range of respondents from Under 18 to Over 75 years
- Between a quarter and a third of responses came from health and social care staff
- Over 20% of responses came from people who considered themselves to have a disability
- Over a quarter of respondents were unpaid carers
- 15% of respondents were not white British

3.2.2 *Survey feedback*

The Fit for the Future analysis includes both quantitative and qualitative responses.

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

- Access
- Capacity
- Centres of excellence/ clinical model
- Diversity
- Efficiency
- Environment
- Facilities
- Integration
- Interdependency
- Patient Experience / Staff Experience
- Pilot
- Quality
- Resources
- Specialist Skills
- Technology
- Transport
- Travel
- Workforce

All written feedback received (redacted for personally identifiable information e.g. names) can be found in the appendices to the Output of Consultation report.

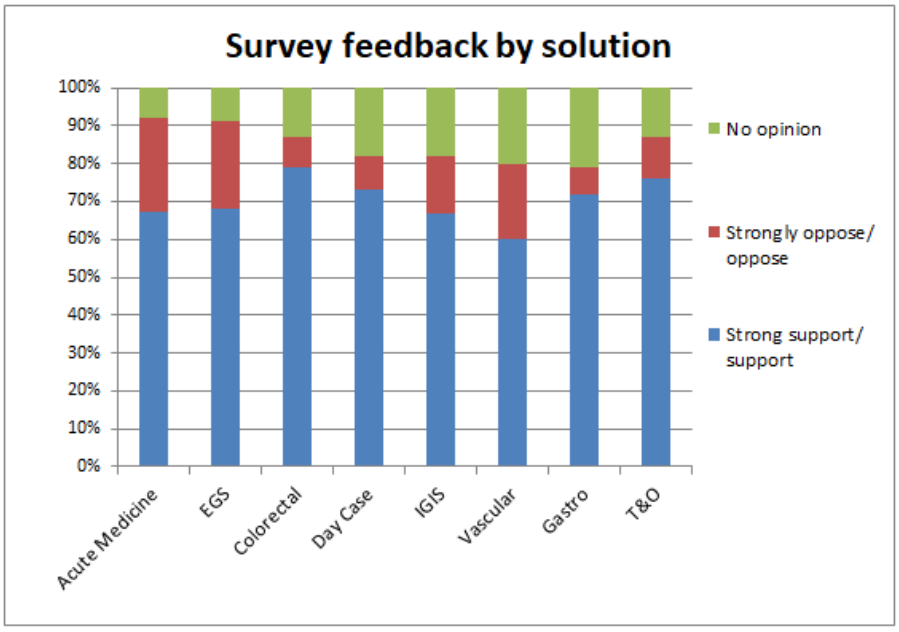
3.2.3 *Feedback by consultation proposal*

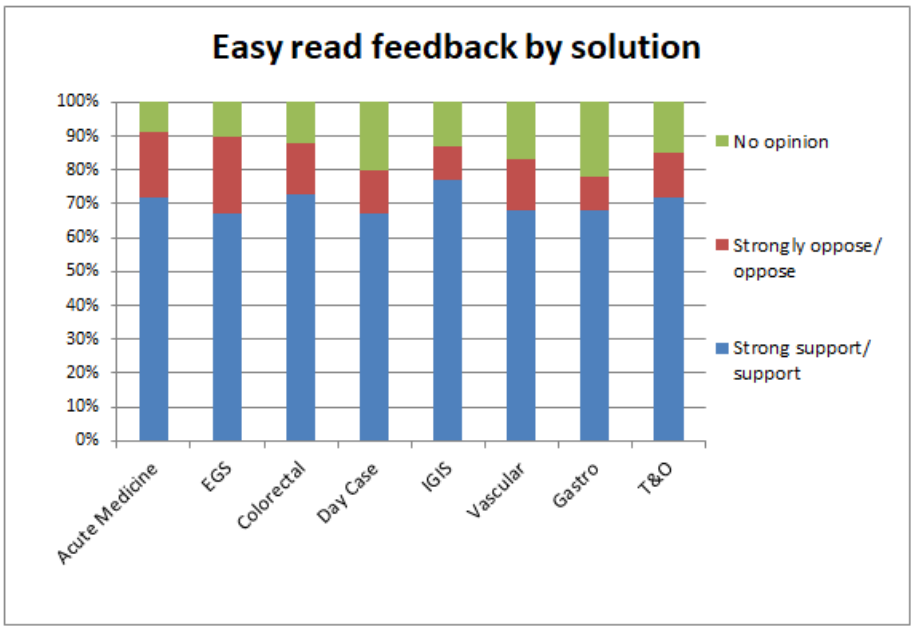
The Final Output of Consultation report provides detailed analysis and presentation of both quantitative and qualitative responses for all consultation proposals, including a selection of qualitative free text responses to illustrate the range of feedback received. It is not the intention of the DMBC to repeat this but rather to focus on the identified themes and specific issues that need to be highlighted to decision-makers and the responses are provided in section 4.

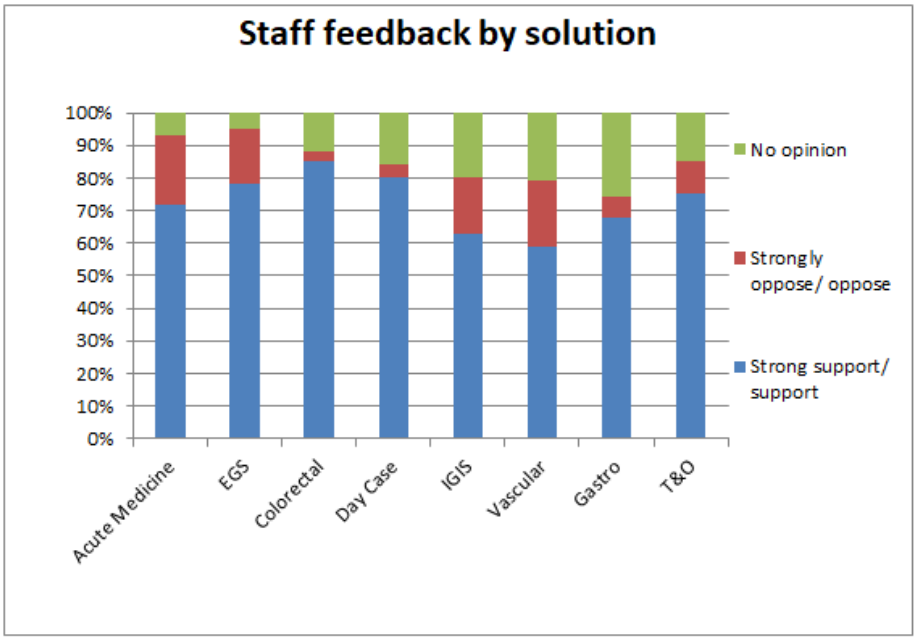
3.2.3.1 Summary of quantitative responses

The table below summarises the quantitative responses by consultation proposal. These are presented for all responses to the survey, staff responses to the survey and all responses to the Easy Read.

Proposal	Strong support/ support			Strongly oppose/ oppose			No opinion		
Group	Survey	Staff	Easy	Survey	Staff	Easy	Survey	Staff	Easy
Acute Medicine to GRH	68%	72%	72%	25%	21%	19%	8%	7%	9%
Emergency General Surgery to GRH	68%	78%	67%	23%	17%	23%	9%	5%	10%
Centralise Planned Colorectal	79%	85%	73%	8%	3%	15%	13%	12%	12%
General surgery Day Cases to CGH	73%	80%	67%	9%	4%	13%	18%	16%	20%
IGIS hub at GRH, spoke at CGH	67%	63%	77%	15%	17%	10%	18%	20%	13%
Vascular Surgery to GRH	60%	59%	68%	20%	20%	15%	20%	21%	17%
Gastroenterology to CGH	72%	68%	68%	7%	6%	10%	21%	26%	22%
Trauma at GRH and Orthopaedics at CGH	76%	75%	72%	11%	10%	13%	13%	15%	15%







Targeted activities aimed to extend the reach of the consultation and to collect data on all protected groups, as recommended in earlier Equality Impact Assessments. Analysis of the survey responses shows there is a broad representation of most groups (response by consultation proposals are presented in the sections below).

Analysis of responses by various demographics, e.g. age, gender, health and care professionals, does not show any significant variation compared with the overall themes, and these are presented graphically for each of the consultation proposals in the sections below. The groups are listed in the table overleaf, and, whilst numbers in some groups are small, it does provide some further information relating to the individuals responding to the survey. It should also be noted that not everyone who responded to the survey completed any/all of the demographic questions (a range across all questions of 75-86%). However, the data presented overleaf indicate the diversity of respondents.

Group	#	Graph axis descriptor
Over 66 years of age	156	> 66 yrs.
Over 66 years of age living with a disability (includes physical impairments; learning disability; sensory impairment; mental health conditions; long-term medical conditions).	60	> 66 yrs. & disability
Black, Asian and Minority Ethnic (BAME)	39	BAME
Black, Asian and Minority Ethnic People living with a disability (includes physical impairments; learning disability; sensory impairment; mental health conditions; long-term medical conditions).	5	BAME & disability
Adult Carers and Young Carers	135	Carers
People living with a disability (includes physical impairments; learning disability; sensory impairment; mental health conditions; long-term medical conditions).	126	Disability
LGBTQ+	19	LGBTQ+
People with mental health conditions and people with learning disability	23	MH & LD
People who live in 12 most deprived wards in Gloucestershire	128	12 wards

3.2.3.2 Qualitative feedback applicable to all consultation proposals

A number of issues identified through the qualitative analysis were applicable to all consultation proposals whilst others were specific to a particular service proposal. This section will present the universally-applicable feedback and followed by the feedback by individual service proposal.

The analysis of the qualitative feedback followed a review of each of the many thousand individual free text comments made by the ~600 long & short survey (only) responses to the 12+ questions in the survey. The review included categorisation of all comments into a series of themes (listed in section 3.2.2) and the identification of issues that needed to be addressed. The findings of this analysis are presented in this section.

The top five categorised themes across all consultation proposals analysed by comments in support or in opposition to the proposals, are listed below:

In support of proposals	In opposition to proposals
Centres of Excellence / clinical model	*Centres of Excellence* / clinical model
Interdependency	Travel
Travel	Facilities
Specialist Skills	Interdependency
Capacity	Capacity

The analysis would indicate that there is high recognition of *Centres of Excellence* / clinical model by survey respondents, as well as the importance of interdependency of services. A common concern shared by respondents (particularly those opposed) related to access to services. Those in support of proposals understood the benefits of proposals on availability/access to specialist skills (that is a key part of the case for change).

The Final Output of Consultation report (and its annexes) provides all the free text comments submitted as part of the consultation. Rather than repeat this, the DMBC has formulated a list of issues from all the comments received that need to be addressed as part of the response to the consultation. These are presented in this section and addressed in section 4.

The importance of both quantitative and qualitative feedback to the decision-making process is clear and well understood by the decision-makers and both are described in the Final Output of Consultation report and this DMBC. As part of this information we have analysed the proportion of respondents providing free text comments for each of the consultation proposals and this is provided for each service proposal.

The issues applicable to all consultation proposals are listed in the table below.

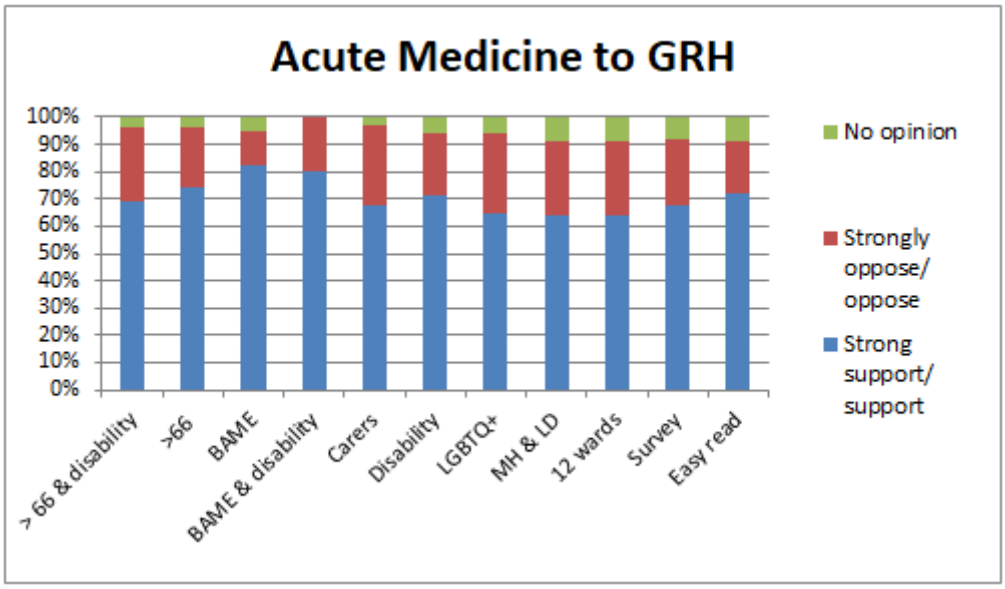
Theme	Issue
COVID-19	Consultation should not have taken place during pandemic
	COVID -19 response – retain improvements to process or service
	COVID-19 has highlighted the need resilience planning for future pandemics
Access/ Travel	Car parking capacity
	Improvements required to public transport services to both GRH and CGH
	Increased patient and carer travel time
	Impact on disadvantaged groups contributes to increasing health inequalities
	Improve communication to the public regarding the location and availability of services
	Greater visibility and support given to people needing to claim travel expenses for hospital visits
	Requests for more outreach services to the homeless, in particular in Cheltenham
	Additional services provided in-county to avoid out-of-county travel
Capacity	Make the most of the CGH site
	Impact of population growth on proposals
	Bed modelling and access to theatres and wards
Facilities	Build a new hospital
	Make better use of virtual technologies
	Make better use of community hospitals
Efficiency	Being done to save money
	Improve recruitment and retention
Quality	Develop a training hospital
	Use the opportunity to improve services
	Hospital discharges
Integration	Work in partnership with community, primary care and the voluntary sector

3.2.3.3 A *Centre of Excellence* for Acute Medicine (Acute Medical Take) at GRH

Quantitative

- 67.6% (Easy read: 72.1%) of survey respondents either strongly supported or supported the proposal
- 24.9% (Easy read: 18.6%) of survey respondents either strongly opposed or opposed the proposal
- 7.6% (Easy Read: 9.3%) of survey respondents had no opinion
- 72.0% of staff respondents either strongly supported or supported the proposal
- 66.2% of respondents excluding staff either strongly supported or supported the proposal

The responses by various demographics are presented in the chart below, with the survey and easy read responses included for comparison.



Qualitative

The top categorised themes for comments made by respondents to the long and short survey (only) on Acute Medicine (Acute Medical Take) analysed by comments in support or in opposition to the proposals, are listed below:

In support of proposals	In opposition to proposals
Centres of Excellence / clinical model	*Centres of Excellence* / clinical model
Specialist Skills	Travel
Access	Capacity
Capacity	Access
Travel	

The proportionality analysis for Acute Medicine (Acute Medical Take) at GRH is provided below.

# of responses	Proportionality
# of quantitative responses	596
# of qualitative responses	299 (51% of quantitative responses)
Support	181 (60% of qualitative responses)
Oppose	112 (38% of qualitative responses)
Neutral	6 (2% of qualitative responses)

In addition to issues applicable to all consultation proposals, the following were specific to Acute Medicine (Acute Medical Take) at GRH.

Theme	Issue
Access	Ambulance response times
Capacity	Bed capacity/ numbers at GRH
	Emergency Department (A&E) capacity at GRH
	Intensive Care capacity at GRH
Efficiency	Ensuring sufficient "flow" through GRH and support to the hospitals 'back door' as this is as important as the 'front door'
Quality	Plans to ensure patients are not moved multiple times between sites or wards at each site, particularly older patients and those with dementia.
	Provision of emergency medical care to support the inpatient population at Cheltenham
	Care of patients presenting with mental health problems

Summary

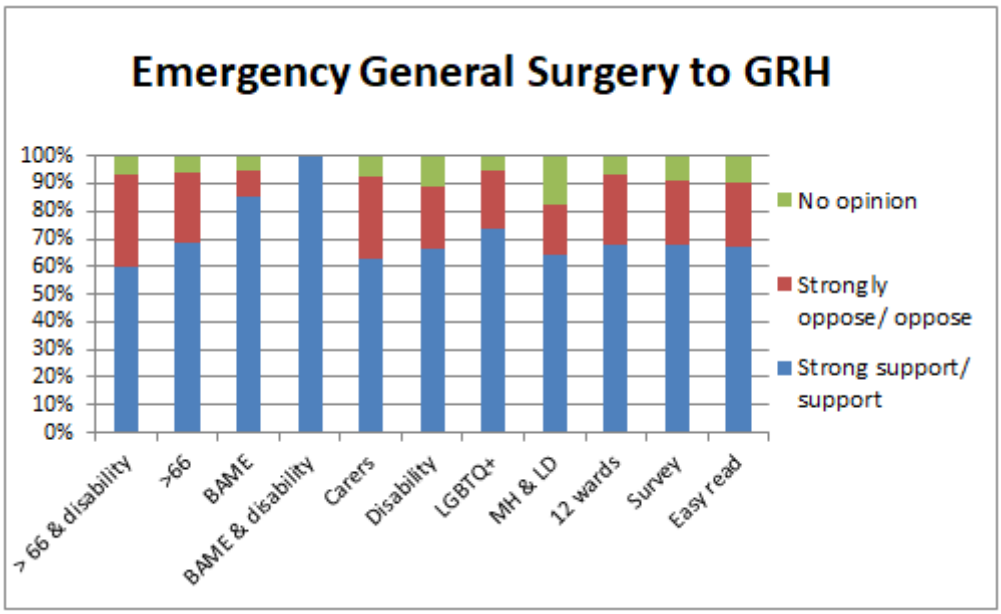
- Numerically well supported across all demographics
- High recognition of centres of excellence/ clinical model
- Recognition of requirement for specialist skills
- Patient and carer travel impact concerns
- Concerns regarding capacity at GRH
- Information required on medical cover at CGH
- Information required on ambulance response times

3.2.3.4 A *Centre of Excellence* for Emergency General Surgery at GRH

Quantitative

- 68.3% (Easy read: 66.7%) of survey respondents either strongly supported or supported the proposal
- 23.4% (Easy read: 23.0%) of survey respondents either strongly opposed or opposed the proposal
- 8.2% (Easy Read: 10.3%) of survey respondents had no opinion
- 77.6% of staff respondents either strongly supported or supported the proposal
- 65.0% of respondents excluding staff either strongly supported or supported the proposal

The responses by various demographics are presented in the chart below, with the survey and easy read responses included for comparison.



Qualitative

The top categorised themes for comments made by respondents to the long & short survey (only) on Emergency General Surgery at GRH analysed by comments in support or in opposition to the proposals, are listed below:

In support of proposals	In opposition to proposals
Centres of Excellence / clinical model	*Centres of Excellence* / clinical model
Specialist Skills	Travel
Workforce	Capacity
Interdependency	
Travel	

The proportionality analysis for Emergency General Surgery at GRH is provided below.

# of responses	Proportionality
# of quantitative responses	546
# of qualitative responses	249 (46% of quantitative responses)
Support	147 (59% of qualitative responses)
Oppose	95 (38% of qualitative responses)
Neutral	7 (3% of qualitative responses)

In addition to issues applicable to all consultation proposals, the following were specific to Emergency General Surgery at GRH.

Theme	Issue
Access	Ambulance response times
Quality	Patient transfers between CGH and GRH
	Infection control

Summary

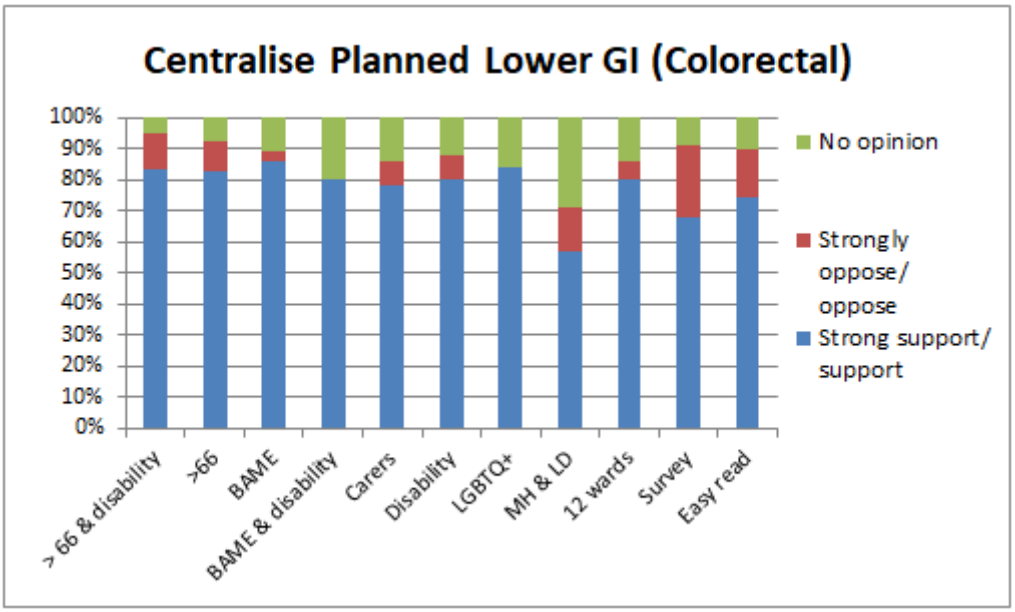
- Numerically well supported across all demographics
- High recognition of centres of excellence/ clinical model
- Recognition of requirement for specialist skills and workforce
- Patient and carer travel impact concerns
- Information required on ambulances and site transfers

3.2.3.5 A *Centre of Excellence* for Planned Lower GI (colorectal) General Surgery

Quantitative

- 79.1% (Easy read: 72.9%) of survey respondents either strongly supported or supported the proposal
- 7.8% (Easy read: 20.3%) of survey respondents either strongly opposed or opposed the proposal
- 13.1% (Easy Read: 12.4%) of survey respondents had no opinion
- 85.3% of staff respondents either strongly supported or supported the proposal
- 76.8% respondents excluding staff either strongly supported or supported the proposal

The responses by various demographics are presented in the chart below, with the survey and easy read responses included for comparison.



Qualitative

The top categorised themes for comments made by respondents to the long & short survey (only) on Planned Lower GI (colorectal) General Surgery analysed by comments in support or in opposition to the proposals, are listed below:

In support of proposals	In opposition to proposals
Centre of Excellence/ clinical model	Centre of Excellence/ clinical model
Interdependency	Travel
Workforce	Workforce
Travel	Interdependency

The proportionality analysis for Planned Lower GI (colorectal) General Surgery is provided below.

# of responses	Proportionality
# of quantitative responses	536
# of qualitative responses	216 (40% of quantitative responses)
Support	168 (78% of qualitative responses)
Oppose	29 (13% of qualitative responses)
Neutral	19 (9% of qualitative responses)

In addition to issues applicable to all consultation proposals, the following were specific to Planned Lower GI (colorectal) General Surgery.

Theme	Issue
Interdependency	Impacts on other surgical specialties including gynae-oncology
	Co-location with Emergency General Surgery
	If centralisation of Emergency General Surgery at GRH then all elective surgical activity is centralised at CGH[7]
	Planned upper and lower GI surgery should be moved to CGH[8]

Summary

- Numerically very well supported across all demographics
- High recognition of centres of excellence/ clinical model
- Recognition of interdependencies with other services
- Patient and carer travel impact concerns
- Request for additional planned care at CGH

[7] This is addressed in section 4.3 "Alternative Suggestions"

[8] This is addressed in section 4.3 "Alternative Suggestions"

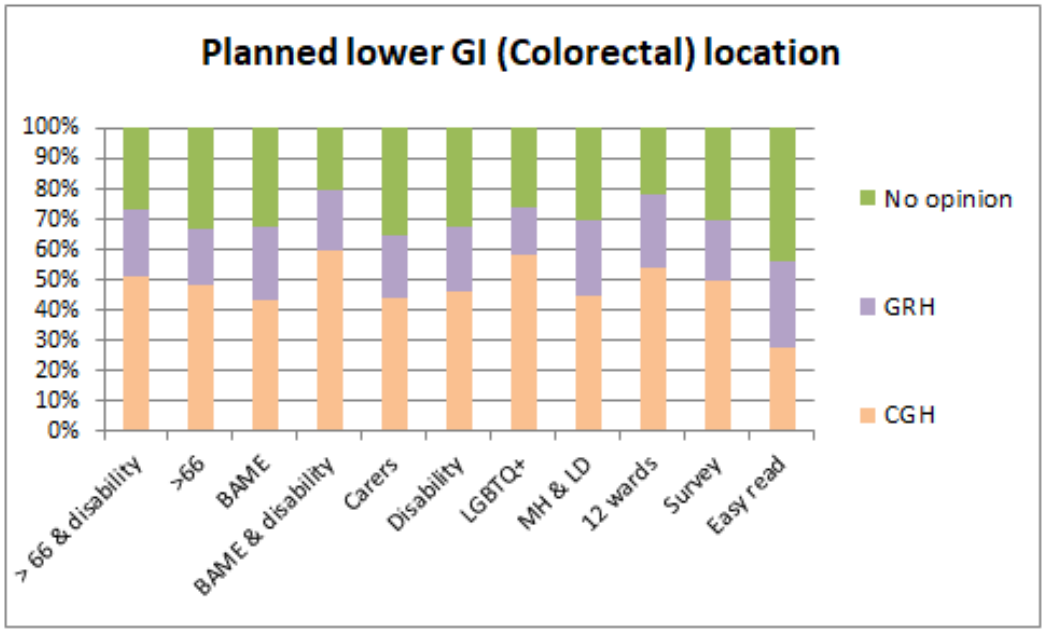
3.2.3.6 Location of Planned Lower GI (Colorectal)

The consultation also asked respondents to provide feedback on the location of the proposed centralised Planned Lower GI (Colorectal) service, either to CGH or GRH.

Quantitative

Group	CGH	GRH	No opinion
All survey responses	50%	20%	30%
Easy Read	28%	28%	44%
Staff	57%	13%	30%
East postcodes	61%	14%	25%
West postcodes	41%	29%	30%
12 most deprived wards	54%	24%	22%

The responses by various demographics are presented in the chart below, with the survey and easy read responses included for comparison.



Qualitative

The Final Output of Consultation report provides a considerable number of qualitative responses grouped by those in support of CGH, in support of GRH and neutral; the themes include:

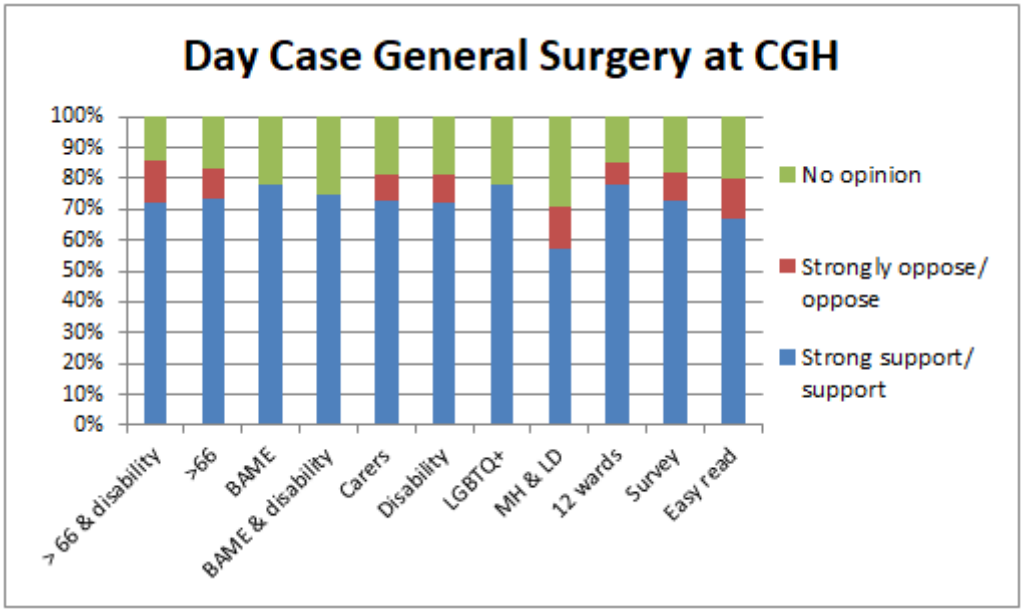
In support of CGH	Neutral	In support of GRH
Ease of access from east of county	Keep service on both sites	GRH facilities better
Co-location with urology, gynae-oncology, oncology and gastroenterology inpatient care	Decision should be based on resources/ capacity available	Elective days-case/short stay surgery in a dedicated unit in CGH. Resectional lower GI surgery co-located with Emergency General Surgery in GRH.
Separate planned and unplanned care (geographically)	Build a new hospital	Experienced high quality of care at GRH
Experienced high quality of care at CGH	Priority is centralised service	Link to Emergency General Surgery at GRH
CGH for all planned activity		Locate with major acute service at GRH
Develop centre of excellence for pelvic resection		Public transport availability better
Link with day cases		Ease of access from west of county
Utilising theatres at CGH		

3.2.3.7 A *Centre of Excellence* for planned day case Upper and Lower GI (colorectal) surgery at CGH

Quantitative

- 73.5% (Easy read: 67.5%) of survey respondents either strongly supported or supported the proposal
- 8.5% (Easy read: 13.3%) of survey respondents either strongly opposed or opposed the proposal
- 18.0% (Easy Read: 19.3%) of survey respondents had no opinion
- 79.6% of staff respondents either strongly supported or supported the proposal
- 71.2% of respondents excluding staff either strongly supported or supported the proposal

The responses by various demographics are presented in the chart below, with the survey and easy read responses included for comparison.



Qualitative

The proportionality analysis for planned day case Upper and Lower GI (colorectal) surgery at CGH is provided below.

# of responses	Proportionality
# of quantitative responses	528
# of qualitative responses	183 (35% of quantitative responses)
Support	134 (73% of qualitative responses)
Oppose	22 (12% of qualitative responses)
Neutral	27 (15% of qualitative responses)

In addition to issues applicable to all consultation proposals, the following were specific to planned day case Upper and Lower GI (colorectal) surgery at CGH.

Theme	Issue
Facilities	Delivery of day case surgery in community hospitals[9] as well as acute hospitals

Summary

- Numerically very well supported across all demographics
- Concerns regarding potential impact on use of community hospitals for day surgery

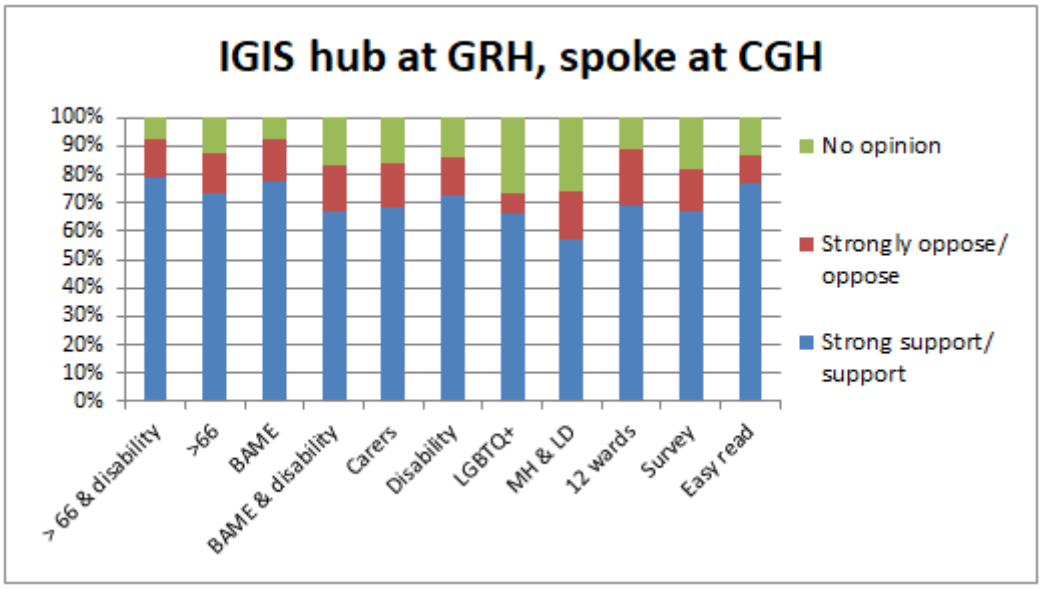
[9] This is addressed in section 4.3 "Alternative Suggestions"

3.2.3.8 An Image Guided Interventional Surgery (IGIS) 'Hub' at GRH and a 'Spoke' at CGH

Quantitative

- 66.5% (Easy read: 76.5%) of survey respondents either strongly supported or supported the proposal
- 15.4% (Easy read: 9.9%) of survey respondents either strongly opposed or opposed the proposal
- 18.1% (Easy Read: 13.6%) of survey respondents had no opinion
- 63.1% of staff respondents either strongly supported or supported the proposal
- 67.8% of respondents excluding staff either strongly supported or supported the proposal

The responses by various demographics are presented in the chart below, with the survey and easy read responses included for comparison.



Qualitative

The top categorised themes for comments made by respondents to the long & short survey (only) on Image Guided Interventional Surgery (IGIS) 'Hub' at GRH and a 'Spoke' at CGH analysed by comments in support or in opposition to the proposals, are listed below:

In support of proposals	In opposition to proposals
Centres of Excellence / clinical model	*Centres of Excellence* / clinical model
Technology	Facilities
Interdependency	Interdependency
Travel	Travel
Facilities	

The proportionality analysis for Image Guided Interventional Surgery (IGIS) 'Hub' at GRH and a 'Spoke' at CGH is provided below.

# of responses	Proportionality
# of quantitative responses	520
# of qualitative responses	183 (35% of quantitative responses)
Support	114 (62% of qualitative responses)
Oppose	47 (26% of qualitative responses)
Neutral	22 (12% of qualitative responses)

In addition to issues applicable to all consultation proposals, the following were specific to an Image Guided Interventional Surgery (IGIS) 'Hub' at GRH and a 'Spoke' at CGH.

Theme	Issue
Facilities	Interventional radiology hub should be located at CGH[10]
	More information on hub and spoke model
Quality	More information regarding impact on cardiology services

Summary

- Numerically supported across all demographics
- High recognition of centres of excellence/ clinical model
- High recognition of technology and equipment required
- Positive aspect of reduced out of county travel
- Concerns regarding use of existing CGH facilities and equipment

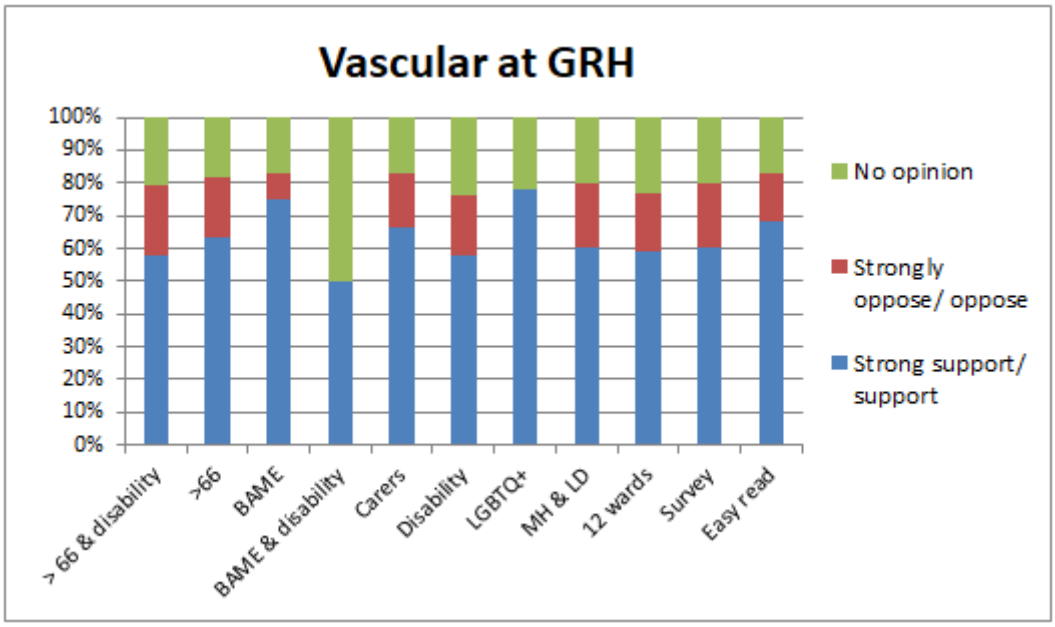
[10] This is addressed in section 4.3 "Alternative Suggestions"

3.2.3.9 A *Centre of Excellence* for Vascular Surgery at GRH

Quantitative

- 60.3% (Easy read: 68.4%) of survey respondents either strongly supported or supported the proposal
- 20.0% (Easy read: 15.2%) of survey respondents either strongly opposed or opposed the proposal
- 19.9% (Easy Read: 17.8%) of survey respondents had no opinion
- 58.9% of staff respondents either strongly supported or supported the proposal
- 60.8% of respondents excluding staff either strongly supported or supported the proposal

The responses by various demographics are presented in the chart below, with the survey and easy read responses included for comparison.



Qualitative

The top categorised themes for comments made by respondents to the long & short survey (only) on Vascular Surgery at GRH analysed by comments in support or in opposition to the proposals, are listed below:

In support of proposals	In opposition to proposals
Interdependency	Facilities
Centres of Excellence / clinical model	*Centres of Excellence* / clinical model
Facilities	Capacity
Travel	Travel
Capacity	Interdependency

The proportionality analysis for Vascular Surgery at GRH is provided below.

# of responses	Proportionality
# of quantitative responses	516
# of qualitative responses	174 (34% of quantitative responses)
Support	92 (53% of qualitative responses)
Oppose	60 (35% of qualitative responses)
Neutral	22 (12% of qualitative responses)

In addition to issues applicable to all consultation proposals, the following were specific to Vascular Surgery at GRH.

Theme	Issue
Capacity	Ward and theatre accommodation for vascular services at GRH.
	Utilisation of the Interventional Radiology/ Hybrid theatre at CGH
Quality	Emergency and elective vascular surgery should be split[11]

Summary

- Numerically supported across all demographics
- Recognition of interdependencies with other services
- Recognition of centres of excellence/ clinical model
- Concerns regarding facilities available at GRH

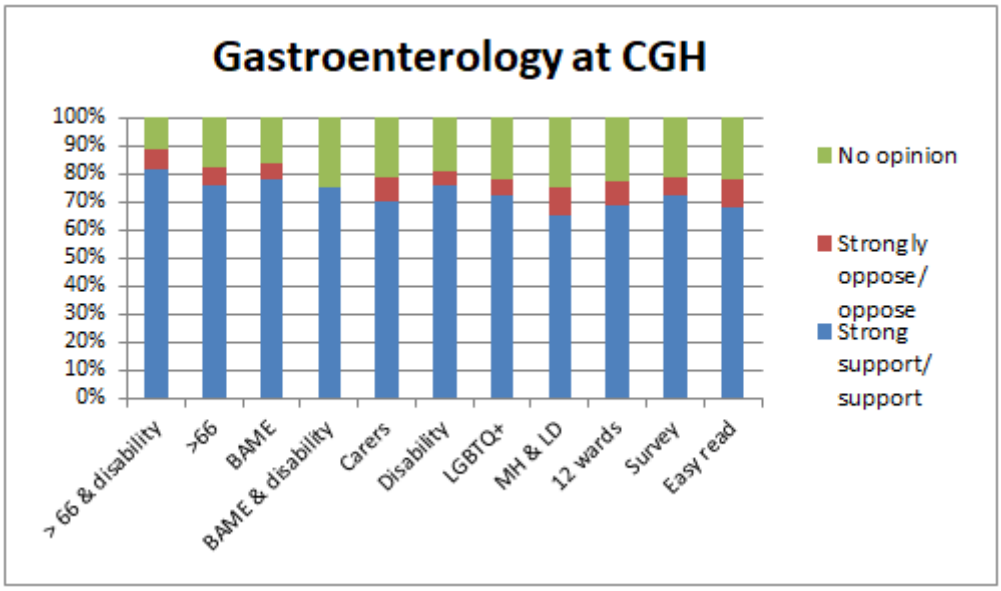
[11] This is addressed in section 4.3 "Alternative Suggestions"

3.2.3.10 A *Centre of Excellence* for Gastroenterology inpatient services at CGH

Quantitative

- 72.0% (Easy read: 68.4%) of survey respondents either strongly supported or supported the proposal
- 6.7% (Easy read: 10.1%) of survey respondents either strongly opposed or opposed the proposal
- 21.4% (Easy Read: 21.5%) of survey respondents had no opinion
- 68.1% of staff respondents either strongly supported or supported the proposal
- 73.4% of respondents excluding staff either strongly supported or supported the proposal

The responses by various demographics are presented in the chart below, with the survey and easy read responses included for comparison.



Qualitative

The top categorised themes for comments made by respondents to the long and short survey (only) on Gastroenterology inpatient services at CGH analysed by comments in support or in opposition to the proposals, are listed below:

In support of proposals	In opposition to proposals
Centres of Excellence / clinical model	Travel
Interdependency	*Centres of Excellence* / clinical model
Specialist Skills	Interdependency
Travel	

The proportionality analysis for Gastroenterology inpatient services at CGH is provided below.

# of responses	Proportionality
# of quantitative responses	510
# of qualitative responses	148 (29% of quantitative responses)
Support	122 (82% of qualitative responses)
Oppose	16 (11% of qualitative responses)
Neutral	10 (7% of qualitative responses)

In addition to issues applicable to all consultation proposals, the following were specific to Gastroenterology inpatient services at CGH.

Theme	Issue
Quality	Care of Gastroenterology inpatients on GRH wards

Summary

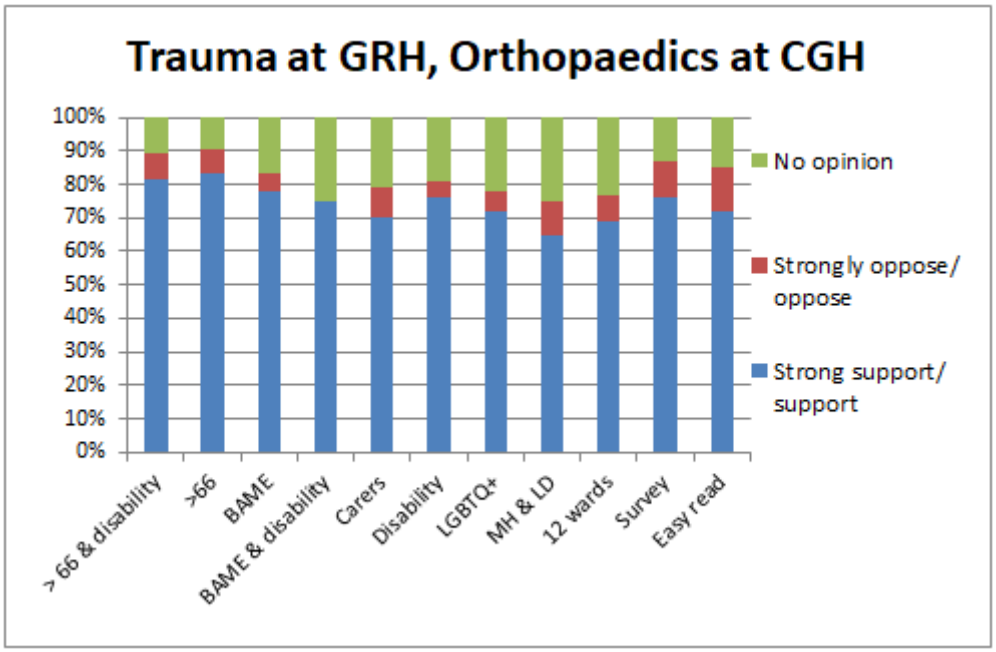
- Numerically very well supported across all demographics
- High recognition of centres of excellence/ clinical model
- Recognition of interdependencies with other services
- Information required regarding service available at GRH

3.2.3.11 *Centres of excellence* for Trauma at GRH and Orthopaedics at CGH

Quantitative

- 76.0% of survey respondents either strongly supported or supported the proposal
- 10.5% of survey respondents either strongly opposed or opposed the proposal
- 13.5% of survey respondents had no opinion
- 75.4% of staff respondents either strongly supported or supported the proposal
- 76.3% of respondents excluding staff either strongly supported or supported the proposal
- Easy read had two questions:
    - Trauma: 70.5% support / 12.8% oppose / 16.7% no opinion
    - Orthopaedics: 73.1% support / 14.1 oppose / 12.8% no opinion

The responses by various demographics are presented in the chart below, with the survey and easy read responses included for comparison.



Qualitative

The top categorised themes for comments made by respondents to the long & short survey (only) on Trauma at GRH and Orthopaedics at CGH analysed by comments in support or in opposition to the proposals, are listed below:

In support of proposals	In opposition to proposals
Centres of Excellence / clinical model	*Centres of Excellence* / clinical model
Efficiency	Pilot
Pilot	Travel
Travel	Capacity
Capacity	

The proportionality analysis for Trauma at GRH and Orthopaedics at CGH is provided below.

# of responses	Proportionality
# of quantitative responses	513
# of qualitative responses	182 (35% of quantitative responses)
Support	130 (71% of qualitative responses)
Oppose	33 (18% of qualitative responses)
Neutral	19 (11% of qualitative responses)

In addition to issues applicable to all consultation proposals, the following were specific to Trauma at GRH and Orthopaedics at CGH.

Theme	Issue
Quality	Pilot evaluation should be presented for scrutiny prior to considering any proposals for a permanent reorganisation
	Management of orthopaedic trauma patients

Summary

- Numerically very well supported across all demographics
- High recognition of centres of excellence/ clinical model
- Request for pilot information to be made available to decision-makers
- Concerns regarding capacity available at GRH

3.3 Alternative suggestions to proposals

The consultation survey included the following question: *Do you have any alternative suggestions for how any of the services covered in the consultation could be organised?*

We also received alternative suggestions submitted in individual correspondence. Full details of all responses can be found in Appendix 1. The table below summarises the suggestions for each service proposal and where applicable to the overall FFTF consultation proposals.

Consultation proposal	Alternative
Applicable to all	Develop centres of excellence on both hospital sites
	Build a new hospital
Image Guided Interventional Surgery (IGIS)	The Interventional Radiology hub should be located at CGH and a spoke at GRH
	Interventional cardiology service could be equally placed at either CGH or GRH
Vascular Surgery	Emergency and elective vascular surgery should be split
	Vascular surgery should remain at CGH.
General Surgery	If centralisation of Emergency General Surgery at GRH then all elective surgical activity is centralised at CGH
	Planned upper and lower GI surgery should be moved to CGH

The response to the alternative suggestions is provided in section 4.3.

3.4 Further areas for consideration

The consultation created an opportunity for the public to provide comments on a range of issues other than those services subject to consultation. Members of the consultation team spoke to participants about matters unrelated to the Fit for the Future proposals, and we received feedback through the survey and individual responses. Other subjects included the national and local response to the Coronavirus pandemic, including practical questions about COVID-19 testing and vaccination, and general comments about services such as primary care (GP) services and mental health services.

Included within these were a number of areas that the respondents would like the NHS in Gloucestershire to consider, and, whilst outside of the Fit for the Future programme, we will carry forward these areas of interest into future work we will do on FFTF in the next phase; they are summarised in the table below and commented on in section 4.4.

Further areas for consideration
• Create a Centre of Excellence for cancer at Cheltenham
• Consider plans for head injuries, chest surgery - including cardiac or neurosurgery.
• Integration of Social Services and the NHS.
• Further develop Care of the Elderly services at CGH.
• Improve the interface with social care services to support patient flow
• Increase the services offered at community hospitals
• Consider centralising other services
• Reinstate Type-1 A&E 24/7 at CGH
• Supporting patients at home, rather than admitting them to hospital.

It should be noted that there were a significant number of messages of thanks to health and care staff and other frontline workers for their efforts during the pandemic.

3.5 Limiting negative impacts

The consultation survey included the following question: *If you think any of our proposals could have a negative impact on you and your family, how should we try to limit this?*

The Final Output of Consultation report (Appendix 1) provides examples of the responses and summarises the mitigations to limit potential negative impacts of centralisation of specialist hospital services as follows and responded to in section 4:

- Retain services on both sites
- Improve patient communications
- Improve integration between hospitals, community services and GP practices
- Reduce the number of patient transfers between acute hospitals
- Build a new acute hospital on a single site
- Improve public transport
- Speed up payment of eligible travel claims
- Encourage more staff to work in Gloucestershire

3.6 Independent Integrated Impact Assessment – consultation review feedback

The Independent Integrated Impact Assessment (IIA) can be found in section 5 and Appendices 2a, 2b & 2c, and is updated to take account of consultation feedback. A summary of their findings is presented below.

- Overall feedback from the consultation was very positive, with the majority of respondents supporting the proposed changes. Feedback from the consultation identified some overall themes.
- **Quality of care** and reduced cancellations and waiting times were perceived to be the benefits of the proposed changes from consultation feedback. These were often the reasons for the high percentage of respondents supporting the changes. Many respondents reported the rationale for the changes were clear.
- **Travel** was identified as theme, particularly for those over 65, those with disabilities and carers. Respondents were concerned about the travel times to the hospital sites from where they live and traffic across the county. Feedback also identified concerns regarding the travel between sites and if public transport is sufficient.
- Those with disabilities and those over 65 and those with long term-conditions identified concerns regarding **transfers** between hospital sites and wards during treatment. This cohort also identified concerns around patients who are very unwell requiring transfer for emergency treatment. This was highlighted in regards to elective colorectal centralisation and Emergency General Surgery centralisation to Gloucestershire Royal Hospital. Some feedback questioned if high risk procedures should be carried out where Emergency General Surgery is centralised.
- **Parking** was identified as an issue for patients, particularly at Cheltenham Hospital, which could become exacerbated by centralisation of elective work.
- **Capacity** was questioned by respondents, with many questioning if the hospitals can cope with the increased demand brought about by centralising services.

- **Both sites** acting as centres of excellence was a suggestion by many respondents who felt that the county was too large to have one centre of excellence located at one site. Some raised concerns regarding the growing population, whereas, others felt that the centralising of services would optimise care quality, increased staff retention and learning for staff which would result in reduced waiting times and cancellations.
- **Community hospitals** were mentioned within feedback, questioning how they will interact with the new models of care.
- Many felt that this could also be a good opportunity to **modernise** areas within the sites as part of this proposal.
- **Subsidised transport** could be explored as many respondents fed back on the cost of transport between hospital sites and home.
- Request to increase **Homeless Outreach**, particularly in Cheltenham. Feedback from the Homelessness Forum and Housing and Support Forum identified that those who are homeless or rough sleeping do not tend to travel outside of their immediate area and so travelling further for medical care may be difficult.
- Many respondents commented that centralising services would support **staff retention** and encourage recruitment.
- **Care quality** was viewed as a benefit by many respondents who felt centralising services would optimise care. Some commented that they were happy to travel for optimised care or that location was less important compared to quality.

Our response to these themes is included in section 4.

3.7 Continued public and stakeholder engagement

As a result of consultation, we have identified a number of areas for ongoing public and stakeholder engagement.

3.7.1 *Planned General Surgery*

As detailed in section 4.2.3 the recommendation following the options appraisal for planned lower gastrointestinal (colorectal) surgery services was that further work should begin with the General Surgery team to define a new, emerging option that includes planned upper gastrointestinal surgery. As this service was not part of the FFTF public consultation there will need to be additional patient, public and stakeholder engagement.

3.7.2 *Citizens' Jury recommendations*

The Jury made recommendations about the public consultation process and information, and about the most important things for the NHS governing bodies to consider from the public responses to consultation. These are included within the Jurors' report (Appendix 3a), and the response from the local NHS with respect to the FFTF consultation is included in the Final Output of Consultation report (Appendix 1).

In response to the Jury observations, the NHS in Gloucestershire has identified a number of considerations/action to support future communications and engagement, including:

- How the input of past, current, and future users of services under consultation and patient experience can be emphasised more in engagement and consultation materials.
- Consider additional methods for signposting to outcomes of earlier engagement activity.
- Pursue further opportunities to promote participation in less well represented districts.
- Establish a 'lay/public' reference group to be involved with reviewing implementation plans for changes approved by decision-makers.
- Investigate 'sampled' market research as an alternative option to consider in future.

3.7.3 *Locality Reference Groups*

As part of the ongoing development of our public engagement and consultation strategy, GCCG is considering expanding the number of locality reference groups across the county. Currently we have a Forest of Dean Locality Reference Group made up of public representatives and community partners with a wide range of interests in healthcare in the Forest of Dean. The group has worked with us to develop our engagement with the local community and have actively contributed to our consultations.

The opportunity to have a process of ongoing engagement with our communities at a locality level to share both the challenges facing health and social care and potential solutions will be extremely valuable.

Key Points

- **The 'socially distanced' consultation and our response are assured by the Consultation Institute.**
- **We targeted particular groups identified in our Integrated Impact Assessment.**
- **We undertook an Equality and Engagement Impact Analysis to identify issues pre-consultation.**
- **The programme developed a wide range of materials and used a variety of channels, including new consultation methods such as live social media events.**
- **Post-consultation a number of additional documents were published.**
- **713 main survey and easy read responses were received.**
- **Consultation proposals were numerically well supported across all demographics.**
- **Qualitative responses identified a range of issues to be addressed, a number of alternative suggestions and some areas for consideration.**

4 Addressing the themes from Consultation

As detailed in section 3.2, following the end of the public consultation there has been an extensive programme to review the findings of the consultation to ensure conscientious consideration[12] of the feedback to inform the recommendations contained within this DMBC.

The outcome of this consideration will be presented using a similar structure[13] as used in Section 3.2:

- Addressing themes applicable to all consultation proposals;
- Addressing themes by individual consultation proposal;
- Responding to alternative suggestions to proposals, and;
- Responding to areas for further consideration

In many cases, our response to feedback from consultation includes reference to either current or proposed activities that seek to address the issues identified. To assist readers of the document, these have been highlighted using the following- Action

4.1 Addressing themes applicable to all consultation proposals

Consultation should not have taken place during pandemic

The decision to proceed to consultation at this point in time was carefully considered and the CCG discussed the approach with NHSE&I, who, as part of the formal process assured the consultation strategy, plan and documentation, and also with The Consultation Institute, which has been providing advice regarding the consultation planning. Neither organisation indicated that a delay to commencing consultation was necessary, or that continuing during the pandemic would compromise our ability to meet our statutory duties for consultation.

The areas of concern mentioned by those respondents with concerns about the consultation taking place during the pandemic can be summarised as:

- The NHS should focus on dealing with COVID-19
- The consultation risked confusing patients and the public, cutting across the key messages and clarity on what needs to be done to fight COVID-19
- The public and other stakeholders may well not be able to focus and give in-depth feedback given they will be focussed on other issues
- We really don't know what the 'new normal' will be and therefore the proposals being consulted upon might no longer be the right ones.

We did pause the programme through the period of the first wave (March - June 2020), but an assessment undertaken of the risks of proceeding were considered to be outweighed by the risks of continuing to pause. A number of services were (and remain) operating under temporary change agreements and this situation perpetuates uncertainty for staff and the public.

We were clear that undertaking the consultation did not put any of our service delivery at risk as the staff involved in the consultation processes are not directly engaged in service delivery. A small amount of clinical time was used to support the consultation but this was

[12] Gunning Principle #4: "conscientious consideration' must be given to the consultation responses before a decision is made.

[13] In some cases the response is presented in more than one sub-section.

outside of patient contact hours for those staff who were involved, typically being senior clinicians who also have management responsibilities factored into their 'day jobs'.

We understood that people were busy and might find it hard to focus on the issues set out in this consultation, but believe the response indicates that this was addressed by offering a comprehensive range of consultation materials, and opportunities to contribute – including online and face-to-face. As detailed in section 2.4.3 we delivered a 'socially distanced' consultation taking account of the needs of groups identified though impact analysis; activities and taking into account the factor of digital exclusion with alternatives to online participation.

In respect of 'future proofing' our proposals, we believe that these are the right proposals for development of our hospitals services whether or not COVID-19 is circulating at high or low levels. We wished to firm up our permanent arrangements to give certainty to our staff and the public. Uncertainty over the previous period has, at times, led to speculation in the media / on social media about which services are likely to be subject to change due to this expected consultation, causing significant concern at times for staff and local residents. We did not believe that perpetuating this uncertainty was in the best interests of either group. We tested our proposals against a number of future scenarios and, in all cases, the proposals remain valid.

Finally, when the UK Government announced a 2nd lockdown in England on 31/10/20 (to run from 05/11/20-02/12/20), an assessment of those activities that would be affected was undertaken. As our plans had been designed to deliver a "socially-distanced" consultation, any activities, such as the Information Bus visits and staff drop-ins, were rescheduled and all were provided once lockdown had ended. Following detailed impact assessment the decision was made to continue with the confirmed consultation schedule.

COVID -19 response – retain improvements to process or service

Action

GHNHSFT has put in place a systematic and inclusive process to identify improvements that have been developed as a result of the pandemic that includes an assessment of whether they should be retained. These include improvements to operational processes, ways of working and patient experience, staff health & wellbeing and communication. Whilst the details of these still require further work, examples include:

- A significant increase in 'virtual' outpatient appointments eliminating the need for many patients to travel and creating space on our hospital sites including reducing the pressure on car parking. Benefit of video and telephone consultations to some autistic patients who otherwise struggle in the hospital environment.
- Improved staff health, wellbeing and support, with the potential benefits in terms of sickness absence, retention and recruitment.
- A shift to relatively high levels of home and remote working across a wide range of staff groups, departments and roles (clinical and non-clinical), with potential effects on staff wellbeing and opportunities for more efficient use of our buildings and estate.
- Frequency of laboratory results
- T&O taking and treating minor injuries from ED, and T&O follow-ups by phone/video
- PPE Safety officer role
- Lung Function team video
- Rapid refresher sessions

- Home enteral feeding team videos
- Ophthalmology triage

COVID-19 has highlighted the need resilience planning for future pandemics

Action

As a result of the pandemic, GHNHSFT put in place a number of temporary COVID-19 service changes, some of which relate to a number of the consultation proposals. Whilst the temporary changes were made as a result of the pandemic, there are a number of key principles that can be considered as part of resilience planning for future pandemics, including:

- To separate COVID-19 and non-COVID-19 pathways by site and by pathway to reduce risk of COVID-19 transmission to and between patients and staff.
- To use our two hospital sites to achieve this by making CGH the focus for planned/elective operating, cancer care and non-COVID-19 diagnostic imaging and GRH as the 'front door' for acute emergency medical and emergency surgical pathways.
- To centralise key points of entry including the Emergency Department, Acute Medical Take and Emergency General Surgery so we can better control flow into hospital and separate three key pathways: COVID-19 positive, suspected COVID-19 and non-COVID-19 patients.
- To designate the Intensive Care Unit (ICU) at CGH as a non-COVID-19 unit - this is a key dependency for cancer and planned care.

Our model of care is focused on delivery in the next decade, whereas it may take several years before the longer-term impacts of COVID-19 are understood and how these effects will affect our response to pandemics and the impact on future health service requirements. A joint letter from The Health Foundation, The King's Fund and the Nuffield Trust to the Health and Social Care Select Committee discussed four main challenges:

- the need to understand the full extent of unmet need;
- the public's fear of using NHS and social care services needs to be reduced;
- looking after and growing the workforce; and
- wider reconfiguration and improvement of the health and social care system.

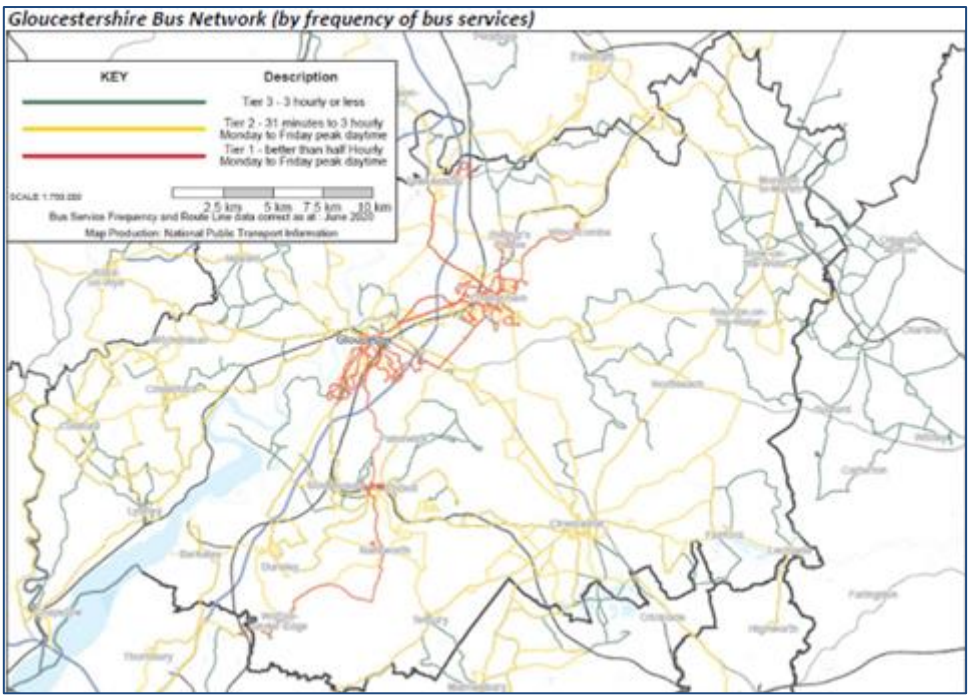
Improvements required to public transport services to both GRH and CGH

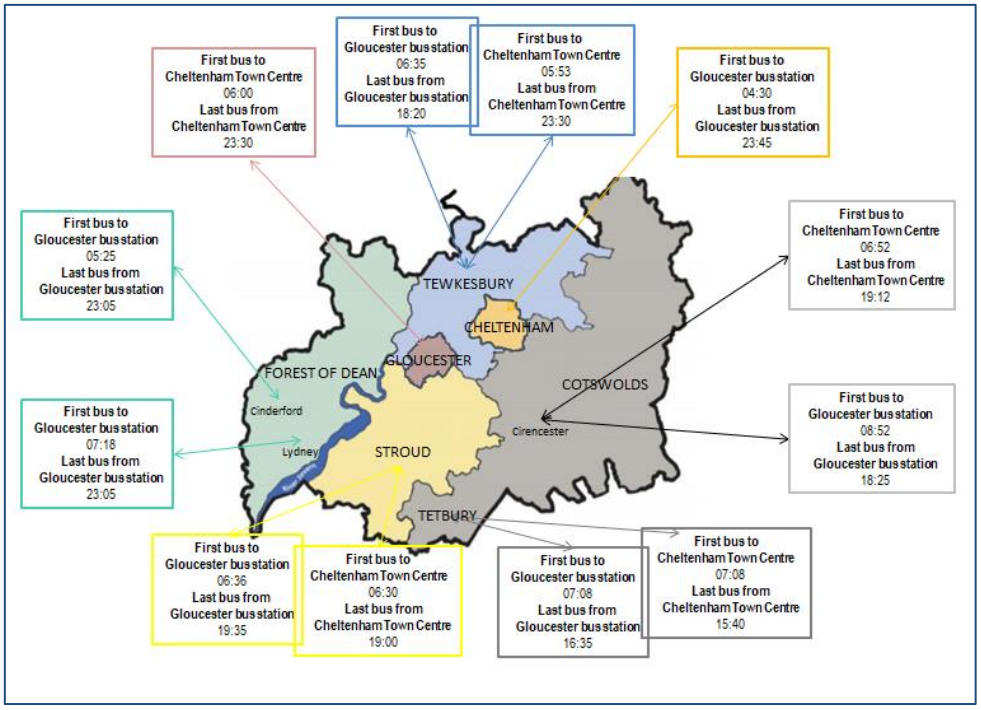
Action

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, details in Appendix 4 and 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. This service runs 06:35 – 19:50 Mon – Fri every 30 mins. This service is free to staff with a valid permit and a charge is made to the public.
- 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 below).





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

Action

Car parking capacity

We appreciate the difficulties that can occur during peak times at both hospital sites. The Trust has worked hard over the last few years to increase the provision of public parking at sites. However, the position of the two sites means that there is minimal spare land capacity to further increase provision of public parking spaces and most of the available land will be used to develop clinical services and building for delivering healthcare services.

As detailed later in this section, we have significantly increased the availability of telephone and video call appointments (particularly for outpatients) and have a target of 30% reduction in on-site outpatient activity. This will reduce the number of visitors to our sites and create more car parking capacity for inpatients, their carers and visitors.

In respect of disabled parking the two hospital sites have a large number of accessible parking spaces throughout the patient and visitor car parks. Disabled users may park for free in accessible spaces across the two hospital sites and, where these designated disabled spaces are not available, blue badge holders attending the hospital for the purposes of attending an appointment or supporting/visiting patients receiving medical care on site; may park in other parking spaces on site for the duration of their visit to the hospital without charge, but must display their up-to-date disabled parking permit.

Increased patient and carer travel time

The PCBC provided full details of the travel impact on patients and carers including the methodology, travel impact maps and numbers by locality and model component. This analysis will be updated relating to planned General Surgery (see section 4.2.3) but a summary from the PCBC is provided below:

	Positive (decrease 20+ mins)	Neutral (+/- 20mins)	Negative (increase 20+ mins)
#	1,663	19,468	3,254
%	6.9%	79.8%	13.3%

In the IIA (section 5), the effects are quantified based on the number of patients likely to be affected by the proposed change, the duration/period of impact and then identifies the overall probability of the impact being beneficial or adverse. Effects are quantified using a combination of data collected by the FFTF programme regarding the total number of patients and patient subsets and paired with evidence review of the impacts based on literature and open source data.

Impact on disadvantaged groups contributes to increasing health inequalities

Action

The Gloucestershire ICS is working together to reduce inequalities (i.e. reducing the differences in health, care and life chances based on where people live or their social circumstances), and looking at how we can improve outcomes for our most vulnerable children, including those with additional needs, disabilities and illnesses.

The Integrated Impact Assessment (IIA) provided in section 5 includes a Health Inequalities Impact Assessment that 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.

As detailed in section 3.1 the consultation targeted groups as informed by the PCBC IIA including BAME communities, LGBQT+, gypsy/traveller community, mental health and learning disability groups, frail elderly, long-term condition groups, low income areas, people living with a disability, adult and young carers, young people and the homeless.

GHNHSFT has also established an Involvement Network to ensure that we are able to engage with local people and make our services more accessible to diverse communities. The Trust works with a large number of community and voluntary organisations to improve the engagement and two-way flow of information for local people.

Improve communication to the public regarding the location and availability of services

Action

GHNHSFT provides a range of information to the public on how, where and when to access services. This includes the Trust's website and partner websites (e.g. GCCG, NHS website), patient information leaflets, events and forums, through social media, and through partner organisations. In addition, the Trust works with a large number of community and voluntary organisations to improve the engagement and two-way flow of information for local people. The NHS in Gloucestershire has established an Involvement Network to ensure that we are able to engage with local people and make our services more accessible to diverse communities, and the Trust is always interested to listen to views from staff and local

people on how we can continue to improve access to information. Some examples of GHNHSFT ongoing work includes:

- The Friendship Café is part of our Gloucestershire Hospitals Voluntary & Community Sector Involvement Network, through which we disseminate and receive information.
- Working in partnership with GARAS (Gloucestershire Action for Refugees and Asylum Seekers) on a funding bid.
- Engagement is planned with the traveller community. A funding application has been made to NHS Charities Together for a Community Outreach Worker in order to make a positive impact in this area.
- Appointment of an Arts Coordinator who will be specifically focused on outreach work with black, Asian and other ethnic minorities.
- Work is also ongoing on cultural diversity within the Better Births Programme and it is hoped that links here will also improve our relationships with more diverse communities.
- The Cancer Team has also made significant progress in this area and links and networks will be shared across GHNHSFT services.

Greater visibility and support given to people needing to claim travel expenses for hospital visits

Action

GHNHSFT offers reductions and exemptions to car parking charges for some categories of carers, visitors and patients. Furthermore, those on a low income or benefits may be able to reclaim transport costs to and from the hospital or other NHS premises, through the Healthcare Travel Cost Scheme (HTCS). Information can be found on the Trust website which includes the leaflet HC11.

We recognise that, as with many means-tested benefits, the process can be confusing particularly where the eligibility criteria are complex and constantly changing. The GHNHSFT PALS team is aware of the process and do support and sign post patients and clinicians to the process and availability. The help with travel costs page is promoted prominently on the platform and accessible via the search functionality and navigation.

Requests for more outreach services to the homeless, in particular in Cheltenham

Action

GHNHSFT have reached out to the Housing & Support Forum and Gloucester Homelessness Forum to engage with those who are homeless or currently rough sleepers. Rates of homelessness are slightly higher in Gloucester than surrounding areas, and this group have a significant requirement for trauma services.

There is increased focus in the Involvement Team on working with people who experience health inequalities and are disadvantaged. Strong relationships have been built with two homelessness focused groups, the Cheltenham Housing & Support Forum and Gloucester Homeless Forum. Additionally, relationships have been established with Cheltenham Open Door, a charity which works to relieve poverty, hardship and social or emotional distress. Through engagement and consultation, we worked with ELIM and our Homelessness Specialist Support Nurse to ensure the homeless people/rough sleepers had a voice in Fit for the Future and further outreach work is planned.

Additional services provided in-county to avoid out-of-county travel

Action

Our consultation proposals for IGIS include the repatriation of patients currently travelling out-of-county for IGIS procedures. By centralising IGIS it improves the ability for this provision to expand, increasing the potential for more patients to be treated in the county, overall reducing travel for some patients. Within the scope of the IGIS service proposals are the current 115 patients who undergo various Interventional Radiology procedures mostly delivered in Birmingham and Oxford, with a few in Bristol, and some as far away as Leeds

In addition to the patients directly benefitting, our IGIS service proposals will contribute towards other initiatives aimed at repatriating patients, including:

- 250 Percutaneous coronary intervention (PCI) / Primary percutaneous coronary intervention **(**PPCI) patients - These almost all go to Bristol. This activity is contained within the separate GHNHSFT PPCI business case.
- 60 trans-catheter aortic valve implantation (TAVI) patients – Currently performed in Bristol. This is a future opportunity to deliver more activity in Gloucestershire.
- >300 Electro Physiology patients - nearly all go to Bristol. This is a future opportunity to deliver more activity in Gloucestershire

Build a new hospital

The NHS in Gloucestershire recognises that the UK government has announced a new hospital building programme and that the Gloucestershire 2050 vision includes having a new hospital as a goal for the future. We will continue to work to secure investment in the county however the delivery timescale (10-12 years i.e. beyond 2030) and the costs (on average half-billion pounds[14]) of a new hospital would create a significant delay to the improvements we want to make. We do not want to stand still in the interim and our FFTF plans determine the use of our two hospital sites for the next 10-15 years whereas any new hospital construction would take place in the 20-30-year timeframe. The current national Health Infrastructure Plan runs to 2030 with hospitals already identified, and it does not include a significant development for Gloucestershire.

Make better use of virtual technologies

Action

The One Gloucestershire ICS is committed to turning the NHS Long Term Plan (LTP) into action for the benefit of local people and our dedicated workforce. An important element of this are objectives that develop information technology, including virtual, to deliver improvements for patients and staff.

Examples include:

Long Term Plan Objective	Delivery
Introduce more telephone and video call appointments.	In response to COVID-19, there has been a significant increase in 'virtual' outpatient appointments (video and telephone). We expect to be able to retain the benefit of the recent 'step change' into the future

[14] For example, Bristol's Southmead Hospital opened in 2014 at a cost of £430m

Continuing to develop our secure electronic system which GPs can use to ask hospital specialists questions and receive responses	The roll out of CINAPSIS, which provides GPs with the ability to speak directly to a consultant and discuss whether a patient needs to be seen by the A&E department or admitted as an inpatient, and if so which hospital to refer to. These communications are improving the co-ordination of the admissions pathway for patients.
	We also have links with GPs via an email system called 'Advice and Guidance' where specialists can advise and GPs can implement the best treatment
Innovative and best use of technology to support our staff and our population	A shift to relatively high levels of home and remote working across a wide range of staff groups, departments and roles (clinical and non-clinical), with potential effects on staff wellbeing and opportunities for more efficient use of our buildings and estate.

Action

Make better use of community hospitals

The consultation proposal is for day case Upper and Lower GI activity currently undertaken at GRH and CGH to be centralised at CGH. The consultation proposal does not include any changes to the delivery of day cases at any of the county's community hospitals.

GHC is fully committed to working with system partners to continue to offer a wide and varied range of local services within each community hospital. However, there are no plans to extend the number of sites that offer minor surgery in the community hospitals. All community hospitals work in partnerships with acute hospital providers (predominately GHNHSFT) to deliver a wide range of outpatient and diagnostic services.

We acknowledge that, during COVID-19 there has been some service disruption with some services moving to different locations – this has been a particular feature at North Cotswold Hospital where services have moved between George Moore clinic and the main hospital site to ensure COVID-19 secure environments and better utilisation of the space available. These changes are temporary, and we aim in the longer term to reinstate services back to the original locations.

As of March 2021 GHNHSFT is working with GP referrers to encourage patients having certain day surgery procedures to have their operation at one of the state-of-the-art community hospital theatre settings in Stroud, Tewkesbury or Cirencester. The day surgery is performed by the same consultant-led specialist team. Patients who choose to have their surgery in these locations can take advantage of benefits including easier parking, shorter waiting times, a quieter environment and a location that may be closer to home.

Action

Make the most of the Cheltenham General Hospital (CGH) site

The FFTF proposals deliver a greater separation of emergency and planned care, and are built on establishing a centre of excellence for emergency, urgent and paediatric care at GRH and planned care and oncology at CGH. This approach enables CGH to focus more, but not exclusively, on planned care whilst maintaining the pre-COVID-19 Accident and Emergency (A&E) Department in Cheltenham with a consultant-led service and no change to the opening hours and the provision of Same Day Emergency Care. FFTF also proposes no change to the availability of outpatient services at CGH.

Our proposals will mean medical and surgical specialties on the CGH site will have reliable access to beds, theatres, day surgery and diagnostics resulting in fewer cancelled operations. Grouping these planned care services together also means we will also be able to improve and standardise our pre- and post-operative care pathways, ensure the necessary equipment is always available, and enable us to rapidly adopt new innovations and best practice, for example robotic surgery or new treatment methods. As part of our strategy, there are approved plans to provide two new theatres and a day surgery suite at CGH.

Impact of population growth on proposals

The impact of population growth is detailed in section 6 and 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 consultation proposals and applied the appropriate growth rates to our baseline activity to assess the impact of cumulative growth for the period 2021 to 2031.

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. As detailed in the PCBC, our consultation 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. However, at the time of writing, the third wave (and lockdown) continues and it is not practicable to reliably estimate the medium-term impact on planned and unplanned activity; only that it is likely to be different from projections made prior to the pandemic.

Action

Bed modelling and access to theatres and wards

Full details are provided in section 9.5.

Being done to save money

Change in the NHS is often associated with saving money and for a small number of respondents it was assumed this was the case for FFTF. Section 6 provides details of the economic and financial analysis of these proposals including investment in staff funded by the repatriation of activity being undertaken outside of the county. Overall the aim is to be cost-neutral and the proposals will deliver a wide range of benefits (see Appendix 5), allowing us to be more efficient and effective through reductions in waste and duplication.

Improve recruitment and retention

Action

In section 2.5 we describe the reasoning behind our proposals (the Case for Change) where the splitting of resources across two hospital sites contributes to quality, workforce, financial and performance issues which affect patient outcomes and staff recruitment and retention. We are already seeing the benefit of being able to communicate our clinical strategy and ambition as part of the FFTF programme, and have seen an increase in application rate for key clinical roles, particularly at consultant level.

Develop a training hospital

Action

Driving Research is one of GHNHSFTs 10 Strategic Objectives and includes the ambition to become an accredited University Hospital Trust which we believe will increase our capacity and capability to deliver best care for everyone.

GHNHSFT is already a research active Trust providing innovative and ground-breaking treatments, where staff from all disciplines contribute to the collective evidence base which should enable the Trust to become one of the best University Hospitals in the UK. This is being progressed through a number of routes, including Research 4 Gloucestershire, which is a system-wide group with representation from GHNHSFT, GHC, University of Gloucester, Cobalt, CCG and Primary Care.

Use the opportunity to improve services

Action

The centralisation of services at either CGH or GRH is the enabler for the delivery of service improvements and the way we address the issues described in the case for change. Full details of these service improvements were provided in the PCBC and are summarised below:

	Benefit
Improved patient outcomes	• Better access to emergency theatres • Increased number of ED attendances managed by SDEC[15] • Length of Stay reductions • Improved senior surgical review • Reduction in trauma admissions • Reduction in surgical cancellations.
Improved patient experience	• Improved access to sub specialty treatment and equity of care • Reduction in cancellations. • Consistent provision of consultant review • Improved patient pathway and patient experience • Improved access • Improved robustness of Out of Hours service • Reduced rates of mortality and morbidity • The provision of a protected dedicated Elective Unit

[15] Same Day Emergency Care (sometimes referred to as Ambulatory Care)

	Benefit
Improved staff experience	• Improvement in staffing workload • Daily Ward/Board Round for Trauma patients • Improved access to specialist Trauma and Orthopaedic clinicians for advice • Improved rota fulfilment • Workforce deployment efficiencies • Reduction in expired IR inventory • Earlier access to 'in reach' advice from other specialties • Standardisation of pathways • More responsive to GP requests
Improved staff recruitment and retention	• Enhanced staff training and support • Improved Junior Doctor training • Staff health and wellbeing

Action

Hospital discharges

There are a number of schemes in place to support patients on discharge from hospital. The Out of Hospital service, provided by Age UK, offers support to older patients who are preparing to leave hospital or have recently been discharged home. GHNHSFT's Enhanced Discharge Service supports patients discharged on "Pathway 0" (home with no formal health or social care input) with a welfare check telephone call 24 hours post-discharge. The service is provided by a clinician who can provide assurance and advice on all aspects of care (e.g. medication management, community referrals, mental health and wellbeing support), to ensure they have the confidence and tools they need to continue their recovery at home.

There are also two leaflets available for patients on discharge: the 'Your hospital discharge' leaflet explains why they are being discharged from hospital and what they can expect after their discharge, including contact details for the Onward Care Team; the 'Staying safe and well at home' leaflet identifies a range of community services who can offer practical support and guidance to patients, as they continue their recovery in the comfort of their own home; these include carer and voluntary sector support as well as mental health and wellbeing resources. Please see Appendix 6. These discharge arrangements are unchanged as a result of the FFTF proposals.

There is a discharge lounge, staffed by nurses, to cater comfortably for people who are waiting to be collected. If a patient is brought to hospital as an emergency in an ambulance and, after assessment and treatment does not need to be admitted, the ambulance service will not be able to take them home as they supply an emergency service only. However staff will help patients to contact family, friends or taxi services as required. Where patients do qualify for patient transport, this will be arranged. There is a shuttle bus that runs between the two hospitals, which also makes stops in the centres of Cheltenham and Gloucester and the Arle Court Park and Ride. This service runs from 6.35am to 7.50pm, Monday to Friday.

Looking ahead, Healthwatch Gloucestershire (HWG) is currently working on a project to gather patient experience around hospital discharge. Their aim is to identify what works well and what needs to be improved for patients and their carers to deliver a more seamless transition between discharge services. HWG are working with GHNHSFT to contact patients and carers, and have attended our carers Hospitals Reflections & Experience Group to

gather information. We look forward to hearing the outcome of this work and the recommendations that HWG propose.

Work in partnership with community, primary care and the voluntary sector

Action

As an integrated care system, our vision is for every person in every community across Gloucestershire to receive really good care and support, when they need it, as close to home as possible. We want to support people to remain independent for longer, reducing the need for hospital stays, and assisting people to return home from hospital sooner.

GP surgeries are working together in groups, called Primary Care Networks (PCNs), alongside a range of community partners, voluntary and community groups and local people, they can provide better care and access to services, closer to people's homes.

Some of the current and proposed improvements include:

- GP surgeries working together to offer more appointments in the daytime, evening and weekends.
- Introducing more health experts to work in, or with, local GP surgeries to provide care and free-up GP time e.g. clinical pharmacists, physiotherapists, paramedics and mental health workers.
- Making use of technology to increase digital access to primary care including online appointment booking and online and telephone GP consultations.
- Continuing to develop Integrated Community Teams, working alongside Primary Care Networks.
- Bringing together hospital and community respiratory teams so people have a better experience of care.
- Joining-up physical and mental health services to improve support and outcomes for people
- Working with partners in fire, housing, leisure, police and education to improve the health and wellbeing of people across Gloucestershire.
- Working together in a more joined-up way to support people living with and beyond cancer across the county.
- The development of Integrated Locality Partnerships (ILPs) as a partnership of senior leaders of providers and local government, supporting clinically-led integration, developing multidisciplinary workforce models and involving staff and residents in decisions, to keep people in the community and out of hospital.

The ICS has an Enabling Active Communities & Individuals Board which specifically focuses on fostering partnerships and building collaboration between the statutory, community and voluntary sector – this is at a county, district and neighbourhood level. Our close working with a broad range of voluntary and community organisations includes: Cheltenham Housing & Support Forum; Cheltenham Open Door; Dementia UK; Friendship Café; Gloucester Homeless Forum; Gloucestershire Action for Refugees and Asylum Seekers; Gloucestershire Hospitals Voluntary & Community Sector Involvement Network; Gloucestershire LGBT+ partnership; Gloucestershire Patient Participation Group; Inclusion Gloucestershire; Know Your Patch; and Suicide Crisis.

4.2 Addressing themes by individual consultation proposal

4.2.1 *A Centre of Excellence for Acute Medicine (Acute Medical Take) at GRH*

Ambulance response times

Since the publication of the PCBC, 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 for **all** of the consultation proposals. The impact was assessed for both the ambulance incident response times and the Call to Hospital times. In summary:

- **Patients attending GRH:** an average of 15.7 patients per day would be conveyed to GRH where previously they had attended CGH
- **Patients attending GWH[16]:** an average 1.7[17] patients per day would be conveyed to GWH where previously they had attended CGH. These are for incidents on the border of Gloucestershire and Wiltshire.
- **Response Performance:** to maintain current Category 1, 2, 3 and 4 performance would require approximately 16-18 hours/day of additional ambulance capacity.
- **Call to Hospital time:** the average (mean) and 90th percentile[18] increase is ~ 7 minutes. Research evidence from a variety of countries, including UK, Scandinavia and the US, reviewing mortality associated with changes in travel, have observed that increases of the order of 10 minutes have an undetectable effect. Further evidence can be found in the PCBC.

Provision of emergency medical care to support the inpatient population at Cheltenham

Action

The proposed deteriorating patient model consists of expanding the Acute Care Response Team (ACRT) to 24/7 on both sites, and providing them with on-site resident ITU consultant support overnight in Cheltenham. The ACRT are specialists in deteriorating patients regardless of specialty or site. They would be led in each site by a band 8a Advanced Clinical Practitioner (ACP) supported by a band 7. For immediate life-threatening issues overnight in Cheltenham, the ACRT practitioners would be supported by a resident Intensive Care Consultant. There would also be a resident junior intensive care doctor onsite.

Alongside the ACRT, there will also be a foundation doctor and a resident medical registrar on the CGH site 24/7 to provide emergency medical care for patients.

We have made a public commitment to maintain the A&E department at CGH. The department will continue to provide consultant-led A&E services 8am to 8pm and a nurse-led service from 8pm to 8am. Under the FFTF proposals, the same day emergency care service at CGH (which is provided by Acute Medicine and is consultant-led) will extend from 8am to 6pm, Mon to Fri to 8am to 8pm Mon to Fri.

Bed capacity/ numbers at GRH

Action

Full details are provided in section 9.5

[16] Great Western Hospitals NHS Foundation Trust, Swindon.

[17] Based on 2019/20 activity and using SWASFT catchment analysis, however the choice of hospital will be determined using a range of factors at the time of the incident.

[18] Indicates the impact for the majority of incidents

Emergency Department (A&E) capacity at GRH

Action

GHNHSFT has recently obtained full planning approval as part of plans to transform facilities at both the CGH and GRH sites. Under the plans, there is an extension and reconfiguration to the emergency department at Gloucestershire Royal Hospital, which will improve streaming and patient flow, plus provide additional minors, majors and resus capacity. This work will be completed by July 2023.

Intensive Care capacity at GRH

Action

Full details are provided in section 9.5

Ensuring sufficient "flow" through GRH and support to the hospital's 'back door' as this is as important as the 'front door'

Action

In line with national challenges, 'flow' through Gloucestershire hospitals has been significantly affected by the COVID-19 pandemic. High numbers of COVID-19 positive patients and increases in the acuity of admissions have driven up the average length of stay and constricted flow. In addition, 160 inpatient beds have been removed as part of infection prevention and control measures, increasing space between beds to reduce nosocomial infection rates. However, GHNHSFT have been able to maintain flow through robust pathways and improved communication between partners and providers. The establishment of the Transfer of Care Bureau, a multi-agency, multi-disciplinary team of health and social care workers, has streamlined the patient referral process, facilitating more timely discharges, and the new 'Home First' pathway (for patients who need formal support from health and/or social care to recover at home) has been instrumental in enabling patients to return home with the support they need to recover. The provision of post-discharge services, such as the Enhanced Discharge Service (a telephone welfare check 24 hours post-discharge) and voluntary sector support have also enabled patients to return home to continue their recovery sooner. These initiatives will continue post-pandemic.

Recent improvement to the interface with social care services to support patient flow have included Adult Social Care (ASC) and Brokerage staff having access to electronic patient records held at GRH and CGH. Aligned with this, the ASC team is sent a daily report of any acute hospital patients who may have a social care need post-discharge. This preliminary notification of potential need allows social care colleagues to engage with patients to facilitate early conversations pertaining to onward care. By including patients in decisions relating to their care, plans can be agreed ahead of discharge; improving patient experience, promoting better flow and providing a smooth transfer of care.

Plans to ensure patients are not moved multiple times between sites or wards at each site, particularly older patients and those with dementia.

As part of FFTF programme, we are identifying the number of beds required on both sites in order to support the proposed changes. We are also developing protocols to ensure that the best care is provided on both sites, and that patients are not moved unnecessarily. In addition, our CINAPSIS system is helping GPs to have conversations with Consultants to determine if a patient needs to be seen in A&E or admitted as an inpatient, and, if so, which hospital they should refer to.

The Same Day Emergency Care service (also known as an ambulatory care service) is provided at both hospitals. There are no plans to change this model. This is a consultant-led service, which is provided Monday to Friday from 8am to 6pm at CGH and Monday to Friday

8am to 11pm and the weekend 8-9pm at GRH. Under FFTF the proposal is to extend the opening hours at CGH to 8pm.

For patients with dementia, we have implemented a protocol to ensure they are not be moved, or only moved under extreme circumstances. This protocol is also supported by having dedicated staff training that will improve the care experience for our patients with dementia/ cognitive impairment, and will help to reassure family / carers that staff are aware of the impact a hospital admission can have on the person. An Admiral Nurse has been appointed, in partnership with Dementia UK, who leads on care, training and treatment of those with dementia. She is available for families and carers affected by dementia in both of our hospitals, and for staff that require support and guidance in caring for people with dementia during their hospital stay.

Care of patients presenting with mental health problems

Action

There are no proposed changes to the current configuration of mental health liaison services, which will still be provided on both sites. However, the centralisation of the acute medical take will support continued development of 'Core 24' requirements and enable timely support and intervention for patients with the greatest need. Following the successful award of national transformation funds, the Gloucestershire Health and Care NHS Foundation Trust (GHCFT) Mental Health Liaison Service is now on the verge of compliance with Core 24 standards. A Cheltenham-based service is currently under development and the investment monies will be used to further improve patient experience and care across both hospital sites. By 2022, we will have onsite services for both hospital sites, which are able to respond proactively and positively to any mental health need.

The GHNHSFT Emergency Department Mental Health Working Party is already progressing with a focused work plan to improve the quality of care and experience of those patients in mental health crisis that attend our Emergency Departments. This collaborative and proactive group is comprised of multiple health care professionals involved in developing and delivering acute mental health services, and recently was joined by two Experts by Experience who are supported by the Involvement Team.

Although the inception of the group pre-dates the recent 2020 report from Healthwatch Gloucestershire, its focus and aims are very much in line with addressing the issues that it raised. These include development of a mental health training programme rolled out to every front-line team member in the Emergency Department, an internal myth-busting campaign led by our Experts by Experience, redesign and redevelopment of the physical spaces within the Emergency Department where mental health assessment takes place, and a particular focus and spotlight on young people's mental health services, to name but a few of the planned initiatives. This comprehensive quality improvement programme is very much a priority for the Trust for the year ahead

We are also continuing to work with Suicide Crisis and people with lived experiences in our Strategic Site Development work, which includes an extension of mental health rooms in our new Emergency Department, with plans to include a sensory room for children and young people.

4.2.2 *A Centre of Excellence for Emergency General Surgery at GRH*

Ambulance response times

Since the publication of the PCBC, 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 for **all** of the consultation proposals. The impact was assessed for both the ambulance incident response times and the Call to Hospital times. In summary:

- **Patients attending GRH:** an average of 15.7 patients per day would be conveyed to GRH where previously they had attended CGH
- **Patients attending GWH[19]:** an average 1.7[20] patients per day would be conveyed to GWH where previously they had attended CGH. These are for incidents on the border of Gloucestershire and Wiltshire.
- **Response Performance:** to maintain current Category 1, 2, 3 and 4 performance would require approximately 16-18 hours/day of additional ambulance capacity.
- **Call to Hospital time:** the average (mean) and 90th percentile[21] increase is ~ 7 minutes. Research evidence from a variety of countries, including UK, Scandinavia and the US, reviewing mortality associated with changes in travel, have observed that increases of the order of 10 minutes have an undetectable effect. Further evidence can be found in the PCBC.

Patient transfers between CGH and GRH

As part of FFTF programme, we are identifying the number of beds required on both sites in order to support the proposed changes. We are also developing protocols to ensure that the best care is provided on both sites and that patients are not moved unnecessarily. In addition, our CINAPSIS system is helping GPs to have conversations with Consultants to determine if a patient needs to be seen in A&E or admitted as an inpatient, and, if so, which hospital they should refer to. Data shows that the tool has achieved the following;

- 22% of referrals were retained in Primary Care avoiding a hospital visit
- 7% were referred to an alternative hospital service
- 51% were able to be sent direct to an assessment unit avoiding the Emergency Department (ED).
- 20% were directed to the Emergency Department
- Therefore, 80% of calls did not result in an Emergency Department visit.

The Same Day Emergency Care service (also known as an ambulatory care service) is provided at both hospitals. There are no plans to change this model. This is a consultant-led service, which is provided Monday to Friday from 8am to 6pm at CGH and Monday to Friday 8a.m. to 11p.m. and the weekend 8a.m. to 9p.m. at GRH. Under FFTF the proposal is to extend the opening hours at CGH to 8pm.

This DMBC includes the additional costs of transferring patients between hospitals by ambulance. It is anticipated that GHNHSFT will require between three and four ambulances

[19] Great Western Hospitals NHS Foundation Trust, Swindon.

[20] Based on 2019/20 activity and using SWASFT catchment analysis, however the choice of hospital will be determined using a range of factors at the time of the incident.

[21] Indicates the impact for the majority of incidents

per day to provide inter-site transfers. This is based on the assumption that approx. 7-8 patient journeys/ vehicle / day.

Infection control

Action

The Trust has not had a patient acquire a MRSA blood stream infection (bacteraemia case) since September 2019; nationally there was a mandatory zero tolerance approach to MRSA bacteraemias. For *Clostridioides difficile* infections from April 1st 2020 to January 31st 2021 GHNHSFT had 56 apportioned cases; when compared with April 1st 2019 to January 31st 2020 with 87 Trust-apportioned cases; this represents a 43.3% reduction in the number of cases of Trust-apportioned *C. difficile.*

The Infection Prevention and Control Team have developed a new tool called the COVID Assurance Framework (CAF) to help wards and department assess against the COVID IPC guidance as a source of internal assurance that quality standards are being maintained. It is also to be used to help us to identify any areas of risk and show the corrective actions taken in response to maintain the safety of both patients and staff.

All wards and departments are required to complete a weekly COVID Assurance Framework audit against COVID IPC practices such as cleaning, personal protective equipment use etc. Results presently demonstrate good compliance to practices across both hospital sites and for those areas that require improvements; action plans have been implemented to support improvement

4.2.3 *A Centre of Excellence for Planned Lower GI (colorectal) General Surgery*

As detailed in section 2.6, the consultation included two options for Planned Lower GI (colorectal) General Surgery, either as part of a General Surgery centre of excellence at GRH or as part of a centre of excellence for Pelvic Resection at CGH. On Thursday 4th February, the Trust Leadership Team (TLT) at Gloucestershire Hospitals NHS Foundation Trust explored in detail the configuration options against six domains: Quality of Care; Access to Care; Deliverability; Workforce; Strategic Fit and Acceptability.

The discussion benefited from presentations followed by a question and answer session, with clinical leads from the multi-disciplinary General Surgery team. Both proposals had better outcomes for patients at their heart and many benefits. However, it was evident as a result of the debate that there was an alternative, potentially even better option, that includes the best elements from the two options presented and notably the opportunity to deliver more planned elective surgery at CGH than either of the two options consulted on. This opportunity to treat more patients in a centre of excellence for planned surgical care was also something that came through the consultation feedback (with over 40 references to increasing planned care at CGH) from both public contributors and staff.

The recommendation was that further work should begin with the General Surgery team to define this new, emerging option. The focus will be to explore the opportunity to deliver:

- Planned “High Risk” Upper Gastrointestinal (GI) and Lower Gastrointestinal (Colorectal) surgery at Gloucestershire Royal Hospital
- Planned complex and routine inpatient and day case surgery in both Upper and Lower GI (Colorectal) at Cheltenham General Hospital

The General Surgery team will now work together to define ‘high risk’ and it is important to note that risk doesn’t equal complexity. A complex operation on an otherwise fit and well patient could be categorised as ‘low risk’ where as a relatively routine operation on a patient with other underlying health conditions could be categorised as ‘high risk’.

From the outset of this process, the ICS partners have been clear that consultation feedback is an essential part of informing the decision-making process and this outcome demonstrates the influence of the public and staff voice on the shape of health services in the county. As a result it is important that more time is taken to explore the new option for Planned General Surgery (for details of the recommendation please see section 8).

Impacts on other surgical specialties including gynae-oncology

Action

The impact on other surgical specialties was a key consideration in the recommendation by TLT (see above) to request the development of an alternative proposal for planned General Surgery and in particular that TLT would want gynae-oncology to remain at CGH, and need assurance this can be achieved.

Co-location with Emergency General Surgery

Action

The potential benefit for a cohort of planned General Surgery patients to be co-located with Emergency General Surgery service at GRH was a key consideration in the recommendation by TLT (see above) to request the development of an alternative proposal.

TLT welcomed the re-introduction of planned upper GI into the Fit for the Future programme with more planned care activity being delivered at CGH. In the options assessment process, TLT wanted to better understand the pathway for 'high risk' colorectal and upper GI patients. TLT also wanted to better understand how the planned care ward could operate at CGH, given complex surgery would continue to be managed at CGH.

It should be noted that any proposed changes to the location of planned Upper GI services would be subject to further public and staff involvement.

4.2.4 *A Centre of Excellence for planned day case Upper and Lower GI (colorectal) surgery at CGH*

As described in section 4.2.3, the consultation included two options for inpatient Lower GI (colorectal), but in both cases the only consultation option for planned day case (Upper and Lower GI) is to centralise at CGH. Whilst the principle underpinning this proposal remains unchanged, the recommendation from TLT is to review all planned General Surgery in order to develop a single new option. For details of the recommendation please see section 8.

Delivery of day case surgery in community hospitals as well as acute hospitals

The consultation proposal is for day case Upper and Lower GI activity currently undertaken at GRH and CGH to be centralised at CGH. The consultation proposal does not include any changes to the delivery of day cases at any of the county's community hospitals.

As of March 2021 GHNHSFT is working with GP referrers to encourage patients having certain day surgery procedures to have their operation at one of the state-of-the-art community hospital theatre settings in Stroud, Tewkesbury or Cirencester. The day surgery is performed by the same consultant-led specialist team. Patients who choose to have their surgery in these locations can take advantage of benefits including easier parking, shorter waiting times, a quieter environment and a location that may be closer to home.

4.2.5 *An Image Guided Interventional Surgery (IGIS) 'Hub' at GRH and a 'Spoke' at CGH*

More information on hub and spoke model

The term 'hub and spoke' is used to describe a model of service delivery which arranges assets into a main site (the hub), complemented by secondary site(s) - the spoke(s). The 'hub' is the centralised provision of the service where the largest throughput of activity and where complex procedures are undertaken 24/7. The 'spoke' or 'spokes' are satellite services typically providing services in a more planned way i.e. booked in advance, away from the primary service hub.

In our IGIS proposals we would locate the cardiac cath labs, two Interventional Radiology (IR) labs and the vascular hybrid theatre facility at the main hub in GRH, to support the 24/7 ED, Acute Medicine, Emergency General Surgery, trauma, hyper-acute stroke and vascular services. The spoke site at CGH would retain one interventional lab which will support oncology and urology patients and provide some day-case Interventional Radiology procedures.

We believe the hub and spoke model will provide us with the critical mass of staff and equipment required to reap the benefits of centralisation, whilst still allowing us to provide elective and day case IGIS procedures in Cheltenham to support oncology and urology services which have already been centralised at Cheltenham.

Our consultation proposal for the centralisation of IGIS to a hub at GRH and spoke at CGH will improve the efficiency and effectiveness of our staff resources.

More information regarding impact on cardiology services

The consultation proposals only include Interventional Cardiology services and exclude medical cardiology. Interventional cardiology forms part of our Image-Guided Interventional Surgery (IGIS) proposals that have been jointly developed by collaborative working of all the services directly involved. Interventional cardiology and Interventional Radiology use similar equipment, similarly-trained support staff and similar recovery processes post-operatively. By co-locating these services to create a new 24/7 hub, we will be able to maximise the use of the support staff and equipment across the two services. This is an innovative, but not unprecedented, solution that we believe has the potential to put GHNHSFT amongst the best in the country for providing a full range of endovascular and interventional services, and our proposals have strong clinical support.

We are looking to identify which services might form part of Phase 2 of FFTF, and inpatient medical cardiology services could be included within Phase 2, but this is subject to a full exploration of possible configuration options and a detailed assessment of the impact and benefits associated with each, and consideration of the requirements to both engage and consult with the public and approval by NHSE&I and South West Clinical Senate support.

4.2.6 *A Centre of Excellence for Vascular Surgery at GRH*

Ward and theatre accommodation for vascular services at GRH

Action

It is important to distinguish between the proposals for service change contained within FFTF consultation proposals and the temporary changes implemented in 2020 that were necessary to manage the impact of COVID-19. If approved, the FFTF proposals will be implemented as part of a planned and coordinated programme and aligned with GHNHSFTs Estates Strategy, Strategic Site Development (SSD) programme and capital expenditure plans. This will allow 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. This will include:

- Investment in the theatres at GRH to provide a vascular environment at least comparable to that already in Cheltenham. We would convert existing theatre facilities at GRH to a full Hybrid IR-Theatre facility ensuring there is no reduction in the quality of the facilities provided to allow complex endovascular procedures to be undertaken.
- The FFTF programme moves more elective surgical activity to CGH which frees up capacity at GRH some of which can be utilised for emergency list use.
- The impact of the FFTF proposals on bed capacity across CGH and GRH has been calculated to ensure it does not create unmanaged 'bed pressures' at either site. Additional capacity at GRH will be provided through the Strategic Site Development (SSD) programme. 41 additional beds at GRH as well as improved day case theatre facilities at CGH will be provided over the next two years through the SSD programme.
- A dedicated vascular ward space for this patient group to ensure services are allocated a sufficient number of beds and other facilities to manage their patient throughput, and that these beds are within an appropriate environment which supports the delivery of excellent care

Utilisation of the Interventional Radiology/ Hybrid theatre at CGH

In 2007, the decision was taken to centralise Vascular Surgery and an options appraisal was undertaken to consider the benefits of centralisation at either CGH or GRH, with CGH selected as the preferred location. A hybrid theatre facility was installed at CGH in 2013 at a cost of ~ £3m, of which £1.8m was required to convert existing facilities to a Hybrid Theatre and the remaining £1.2m related to the purchase and installation of equipment.

The consultation proposals include relocation of the Vascular Hybrid theatre to GRH. The existing Hybrid Theatre at CGH is now 8 years old and the equipment will be approaching planned end of life (typically 10 years for this type of equipment), when the FFTF Phase 1 proposals are implemented and will therefore require replacement. Whilst we acknowledge that replacing this equipment in its current location would be the cheapest solution, we also need to ensure the facility is located in the right place for the expected lifecycle of the equipment being installed. We have taken into account key clinical adjacencies to ensure the location of this highly specialised equipment will be optimised for the future.

To operate a Hybrid Theatre, a multidisciplinary team, including radiographers, is required to utilise the Hybrid theatre as a true endovascular facility. In its current location, limited availability of radiographers at CGH has been a continual challenge restricting our ability to operate this facility as a full hybrid theatre, and reducing the expected benefits from the investment. Our consultation proposal for the centralisation of IGIS to a hub at GRH and spoke at CGH will improve the efficiency and effectiveness of our staff resources.

A hybrid theatre at CGH cannot be fully utilised without both the necessary surgical teams and clinical support staff required to operate it. By locating this facility alongside the IGIS Hub, we will improve the availability of these critical support staff, such as radiographers which are required to operate this facility as a 'Hybrid', and perform endovascular surgery. If the consultation proposals are confirmed, the existing Hybrid Theatre at CGH will be redeveloped to provide additional standard theatre capacity.

4.2.7 *A Centre of Excellence for Gastroenterology inpatient services at CGH*

Care of Gastroenterology inpatients on GRH wards

Although the current Gastroenterology Pilot ward is based at CGH, the service has kept a daily (7/7) Consultant-led referral service at Gloucester. All Gastroenterology patients at GRH can be seen daily as there is an on-call consultant and registrar at GRH who provide a timely opinion to patients coming into ED at GRH. There is also emergency endoscopy cover for both sites. Patients who require assessment and short-term treatment can be seen at GRH and those requiring a longer stay for a more complex condition will be transferred to the specialist ward at CGH. We have two pathways for Gastroenterology patients who are admitted to GRH; patients requiring ongoing Gastro care are moved promptly to CGH and others can continue to be seen on a daily basis at GRH as there is still have a service on both sites.

4.2.8 *'Centres of excellence' for Trauma at GRH and Orthopaedics at CGH*

Pilot evaluation should be presented for scrutiny prior to considering any proposals for a permanent reorganisation

Action

The Trauma and Orthopaedic (T&O) pilot was introduced on 20th October 2017. Prior to the pilot both trauma surgery and planned orthopaedic surgery was carried out at GRH and CGH. Under the pilot, all orthopaedic trauma surgery is now carried out at GRH and as much planned orthopaedic surgery as possible, e.g. hip and knee replacements is carried out at CGH. The T&O service has sole use of 8 theatres (4 at CGH and 4 at GRH), all of which have laminar flow (special high flow air conditioning which minimises the incidence of deep joint infection). As the theatre infrastructure was improved, all elective (planned) arthroplasty (joint replacement surgery) was transferred to CGH however approximately 30% of elective orthopaedic surgery remains at GRH.

As part of the FFTF programme, details including the clinical evidence for the proposal (both desktop and from the pilot), patient and staff (including junior doctor quality panels) experience, an options appraisal assessing the pilot vs. reverting to the previous configuration, and benefits realisation information were included in the FFTF Pre-Consultation Business Case (PCBC). The proposal was also assessed as part of the South West Clinical Senate review.

An updated evaluation report (see Appendix 7) has now been drafted by the T&O team with support from the FFTF Programme Team; it was reviewed by the GHNHSFT Surgical Board and members of the T&O Board received an updated draft of the report and their comments were incorporated. The report was presented and reviewed in public at both the GHNHSFT Board (11/02/21) and Gloucestershire Clinical Commissioning Group (CCG) Governing Body (18/02/21).

A copy of the report (TO-Pilot-Update_-Feb-21.pdf) was published on 08/02/21, and communicated to stakeholders as part of the wider post-consultation updated information (see section 3.1.3). The report was also provided to the Gloucestershire Health Overview & Scrutiny Committee.

The purpose of the report was to provide a systematic evaluation of the T&O pilot structured around the 10 key objectives of the pilot (using the latest available data sets), and latest performance is summarised below:

- 6 of 10 objectives have been achieved
- 3 of 10 objectives show much improved performance
- 1 of 10 objectives has not been achieved.

The objective of the pilot was to address the following areas:

- Co-location of arthroplasty (joint replacement) surgery to allow standardisation of pathways.
- Elective patient operations were often cancelled for emergency (trauma) patients; particularly when complex sub-specialty surgery was required.
- Elective patient operations were often cancelled when the hospitals had periods of high demand.
- Trauma patients did not always receive a timely review by a senior decision-maker in ED because the on-call consultant and registrar could be scheduled to work either in theatre or clinic at the same time. This exacerbated waiting times in ED and at the time of implementation of the pilot Gloucestershire Hospitals were in special measures for poor performance in achieving the 4 hour ED target.
- Once admitted the senior review of trauma patients was variable (depending on the admitting consultant's timetable); this often led to patients staying in hospital longer than necessary.
- There was no routine ward/board Round for Trauma patients which meant delay for patients but also lost opportunity for supervision of junior doctors with poor trainee feedback.
- Junior doctor training, feedback was variable
- Junior doctor recruitment was problematic

The report also makes recommendations for the ongoing monitoring and evaluation of performance of the T&O service and future large-scale service changes.

The publication and review of the evaluation report has provided the opportunity for decision-makers to assess the performance of the pilot and to make recommendations for the ongoing monitoring and evaluation of the service, including regular updates to the GCCG Governing Body.

Management of Orthopaedic Trauma patients

Action

An evaluation report (see Appendix 7) was completed and was presented and reviewed in public at both the GHNHSFT Board (11/02/21) and Gloucestershire Clinical Commissioning Group (CCG) Governing Body (18/02/21), and a copy of the report was published on 08/02/21 at (TO-Pilot-Update_-Feb-21.pdf).

A number of the objectives of the pilot address issues specifically related to Trauma patients including: Trauma patients did not always receive a timely review by a senior decision maker in ED because the on call consultant and registrar could be scheduled to work either in theatre or clinic at the same time; once admitted the senior review of Trauma patients was variable (depending on the admitting consultant's timetable) which often led to patients staying in hospital longer than necessary; inability to cope with Trauma referrals to fracture clinic; and there was no routine Ward/Board Round for Trauma patients which meant delay

for patients but also lost opportunity for supervision of junior doctors with poor trainee feedback.

The pilot achieved these objectives:

- There is now a consultant and registrar as well as a foundation doctor to give an immediate response
- There is now an on-call consultant and Registrar who do not have other duties and so are available for immediate consultation
- There is now a 7-day-a-week Ward/Board round for all Trauma patients
- There is now a new Trauma triage service in place to assist with growing demand

One of the pilot objectives was to improve time to theatre for Trauma patients (at GRH), and the evaluation report categorises this as "Not Achieved" and provides details behind this and the plans in place to improve performance. These plans include more theatre lists being made available at Cirencester Hospital and some non-complex Trauma surgery is undertaken there. In addition, more day cases from the remaining elective work at GRH have been transferred to Cirencester Hospital to create more theatre space within GRH theatres for Trauma patients. There is a further plan to utilise one of the new day surgery theatres at CGH that are to be developed as part of the SSD Programme for Orthopaedics. This will enable the service to further reorganise elective lists and create theatre space at GRH for additional Trauma surgery. The report also makes recommendations for the ongoing monitoring and evaluation of performance of the T&O service and future large-scale service changes.

4.3 Responding to alternative suggestions to proposals

Develop "centres of excellence" on both hospital sites

The feedback from the consultation included a large number of comments describing the excellent care and treatment received by respondents at both CGH and GRH, and requests to leave services unchanged at both sites and thus avoiding any travel impact for patients. 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. 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 expensive equipment and highly trained staff 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*; centralised services where we can consolidate skills and equipment to provide the very best care. Sometimes these centres may be outside Gloucestershire, but, where possible, as an ICS we will develop our specialist services so we can provide specialist care in our county.

We have clearly heard that travel and access concerns people, but that generally people are prepared to travel a little further to access better health outcomes where it is clearly demonstrated that this will be achieved. As described in section 2.5.1, maintaining these services on both sites is increasingly creating pressures for 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.

Details of the patient, staff, efficiency and effectiveness benefits can be found in Appendix 5 which directly or indirectly support our ICS objectives set out in our response to the NHS LTP 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.

The process of short-listing options (see section 2.4.2.3) included a detailed assessment of the option to continue to provide these services at both sites, and, following the solutions appraisal workshop these were discounted. Full details can be found in PCBC at: Fit for the Future: Developing specialist hospital services in Gloucestershire – OneGloucestershire.net

Build a new hospital

The NHS in Gloucestershire recognises that the UK government has announced a new hospital building programme and that the Gloucestershire 2050 vision includes having a new hospital as a goal for the future. We will continue to work to secure investment in the county however the delivery timescale (10-12 years i.e. beyond 2030) and the costs (on average half-billion pounds[22]) of a new hospital would create a significant delay to the improvements we want to make. We do not want to stand still in the interim and our FFTF plans determine the use of our two hospital sites for the next 10-15 years whereas any new hospital construction would take place in the 20-30-year timeframe. The current national Health Infrastructure Plan runs to 2030 with hospitals already identified, and it does not include a significant development for Gloucestershire.

The Interventional Radiology hub should be located at CGH and a spoke at GRH

The option to centralise 24/7 Image-Guided Interventional Surgery hub to CGH and the spoke at GRH was identified during the solutions development phase of the FFTF programme (Solution B4); however it was deemed non-viable in combination with the proposal to centralise acute medical take at GRH (Solution A3). This was due to the clinical linkage between the acute medical take and Interventional Cardiology – if the Acute Take was on one site and the 24/7 IGIS hub on a separate site, there is a risk that 'chest pain' patients routed to the 24/7 IGIS hub that did not need Interventional Cardiology but the services of Acute Medicine would need to be transferred between sites, presenting an unacceptable delay to emergency care. When the process described in section 2.4.2.3 determined that centralising the acute medical take at GRH as the only Acute Take option to proceed beyond shortlisting, the option to locate the IGIS Hub at CGH was therefore discounted.

Emergency and elective vascular surgery should be split

The consultation proposal is to relocate the vascular arterial centre and inpatient bed base to GRH. This will mean that complex endovascular surgery and vascular surgery requiring an overnight stay in hospital will take place in the safest environment, with other emergency services available to assist at the same location 24/7 should complications arise. This model allows patients requiring overnight stay following surgery to also be cared for by nurses experienced in vascular care. Although much of the unscheduled admissions for vascular surgery might be considered 'urgent' rather than a true emergency, during the 12-month

[22] For example, Bristol's Southmead Hospital opened in 2014 at a cost of £430m

baseline period used to model FFTF activity, 49 patients were admitted to vascular surgery on an emergency pathway and went to theatre within 12 hours. The vast majority of this surgery was conducted outside of normal working hours. Of those 49 emergency patients admitted to vascular surgery, 36 were admitted to theatre within 4 hours.

A full separation of all elective and emergency vascular activity would require vascular inpatient facilities at both GRH and CGH. Even planned elective vascular surgery carries risk. If inpatient vascular surgery was undertaken at CGH, an emergency response may be required for post-surgical complications. This would therefore require emergency OOH vascular support at both hospital sites, which would significantly reduce our ability to provide robust and timely emergency vascular intervention.

Approximately one third of surgical interventions undertaken in vascular surgery are conducted as day cases. Elective day case procedures will continue to be undertaken at CGH in the new Day Surgery unit, allowing these vascular patients to benefit from the Centre of Excellence for Elective Care. We will also continue to provide some day case surgery at Community Hospital locations.

There has also been some confusion regarding the Vascular GIRFT[23] report published in June 2020, which was a general national report for the restarting of vascular activity during the COVID-19 pandemic. It recommends clearly defined, separate pathways for emergency (potentially COVID-19 positive) and elective (COVID-19 negative) patients. It did not recommend these being on separate sites, only that providers should explore all options in the local health system if separation of these patients is not possible within their own estate.

The option of vascular surgery remaining at CGH was assessed by the South West Clinical Senate Clinical Review Panel (CRP) on 20/08/20. The panel was a key element of the NHSE&I Stage 2 Assurance process in relation to Test 3 (a clear, clinical evidence base). In respect of vascular surgery, the panel was opposed to a split site option for inpatient vascular surgery.

Vascular surgery should remain at CGH.

The FFTF Programme put in place a rigorous 7-step process to evaluate options prior to consultation (see section 2.4.2.3). The option of vascular surgery remaining at CGH was discounted at Step #6 following the South West Clinical Senate Clinical Review Panel (CRP) on 20/08/20. The panel was a key element of the NHSE&I Stage 2 Assurance process in relation to Test 3 (a clear, clinical evidence base). In respect of vascular surgery, the panel noted:

- The model with colocation of vascular services with the IGIS hub at GRH was supported, to support co-dependencies with the IGIS hub, Trauma and diabetes for best patient care
- Vascular surgery at CGH would require a separate middle/junior medical on call rota and it is unlikely that this could be staffed
- Colocation with diabetes, IGIS hub and Trauma make GRH favourable for vascular delivery whereas there is less validity for colocation with the IGIS spoke
- The CRP was opposed to a split site option for vascular surgery

Following this external review, internal discussions were held with clinical teams and through the GHNHSFT and GCCG governance structures, particularly in relation to the panel's concerns regarding the sustainability of the staffing model required to provide safe

[23] Getting It Right First Time (GIRFT) is an NHS improvement programme.

and robust OOH vascular service at CGH, in conjunction with centralisation of EGS to GRH. The PCBC also included evidence that vascular surgery should be considered an urgent care service and services reconfigured to reflect this, with the Vascular Society of Great Britain recommending that 'designated [vascular] arterial centres are co-located with major Trauma centres or Trauma units.

On the basis of the CRP and evidence presented, the decision was taken to withdraw the option of vascular surgery at CGH from the proposed public consultation.

If centralisation of Emergency General Surgery at GRH then all elective surgical activity is centralised at CGH

Action

As detailed in section 4.2.3, when the Trust Leadership Team (TLT) at GHNHSFT explored in detail the configuration options for Lower GI (colorectal) surgery, it was evident as a result of the debate that there was an alternative, potentially even better option, that includes the best elements from the two options presented 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. The focus will be to explore the opportunity to deliver:

- Planned High Risk Upper Gastrointestinal (GI) and Lower Gastrointestinal (Colorectal) surgery at Gloucestershire Royal Hospital
- Planned complex and routine inpatient and day case surgery in both Upper and Lower GI (Colorectal) at Cheltenham General Hospital

From the outset of this process, the ICS partners have been clear that consultation feedback is an essential part of the decision-making process and this outcome demonstrates the influence of the public and staff voice on the shape of health services in the County. As a result, it is important that more time is taken to explore the new option for Planned General Surgery (for details of the recommendation please see section 8).

Planned upper and lower GI surgery should be moved to CGH

Action

As detailed in section 4.2.3, when the Trust Leadership Team (TLT) at GHNHSFT explored in detail the configuration options for Lower GI (colorectal) surgery, the discussion included consideration of planned Upper GI activity to be undertaken at CGH. The recommendation was that further work should begin with the General Surgery team to define this new, emerging option. The focus will be to explore the opportunity to deliver:

- Planned High Risk Upper Gastrointestinal (GI) and Lower Gastrointestinal (Colorectal) surgery at Gloucestershire Royal Hospital
- Planned complex and routine inpatient and day case surgery in both Upper and Lower GI (Colorectal) at Cheltenham General Hospital

From the outset of this process, the ICS partners have been clear that consultation feedback is an essential part of the decision-making process and this outcome demonstrates the influence of the public and staff voice on the shape of health services in the county. As a result it is important that more time is taken to explore the new option for Planned General Surgery (for details of the recommendation please see section 8).

It should be noted that any proposed changes to the location of planned Upper GI services would be subject to further public and staff involvement.

4.4 Responding to areas for consideration

Create a Centre of Excellence for Cancer at Cheltenham

Action

While it is not yet using the label, our Cancer Services already effectively functions as a 'Centre of Excellence' on the Cheltenham General Hospital site. This centre serves a population of just under a million people with a catchment area stretching from Powys to Stroud. It is staffed by 14 consultant clinical oncologists, 3 consultant medical oncologists, consultant nurses, consultant radiographers, cancer-specific nurse specialists, specialist therapy teams, radiographers, psychologists and allied health professionals. The clinical teams deliver state of the art radiotherapy, systemic anti-cancer therapy and supportive therapy within outpatient and day case settings, and also within a thirty bedded specialist inpatient unit. With a satellite unit in Hereford and a nationally unique mobile chemotherapy unit, we are able to care for patients closer to home across this wide geography.

We have plans in place to develop these services into a Centre of Excellence, The Gloucestershire Cancer Institute, with three broad programmes of work:

- Improving patient experience through Living With and Beyond Cancer, and a patient experience group.
- Modernising services through best practice service developments, integration of advanced care and treatment, and implementing genomics to enhance diagnostics and targeted treatment. We are also reviewing the estate and facilities we deliver our services from.
- Operational delivery including projects to advance earlier diagnoses and adopt best practise

Beyond the technical delivery of cancer treatment, the centre prides itself on an ethos of holistic, patient-centred, multi-disciplinary care. We are now at the threshold of being able to deliver Stereotactic Ablative Radiotherapy (SABR) and widening the reach of cancer research and trials. And after many years of work, we now have tangible momentum towards our vision of improved facilities and a new brand—for this centre of excellence on the Cheltenham site, whose staff work tirelessly to serve patients in Gloucestershire and beyond.

Consider plans for head injuries, chest surgery - including cardiac or neurosurgery.

Specialties including neurosurgery, cardiothoracic surgery, burns and spinal injuries units are highly specialised but have relatively low numbers of patients who need the services. For this reason they are undertaken in regional centres where highly complex work is undertaken. There are no plans to make GHNHSFT a regional centre or to provide these specialised services. However there are links with all regional specialised units and plans in place to repatriate patients back to Gloucestershire and in many cases provide ongoing care within the region.

Integration of the NHS and Social Services

Action

Fit for the Future is a programme of the One Gloucestershire Integrated Care System (ICS), which is a partnership between local NHS and social care organisations committed to turning the NHS Long Term Plan (LTP) into action for the benefit of local people and our dedicated workforce. In an integrated care system, NHS organisations, in partnership with

local councils and others, take collective responsibility for managing resources, delivering NHS care, and improving the health of the population they serve.

As a person's care may be provided by several different health and social care professionals across different providers people can experience health and social care services that are fragmented, difficult to access and not based around their (or their carers') needs. People benefit from care that is person-centred and co-ordinated within healthcare settings, across mental and physical health and across health and social care. Being an Integrated Care System has allowed us to work together and coordinate services more closely, to make real, practical improvements to people's lives. For staff, improved collaboration helps make it easier to work with colleagues from other organisations and make better use of the information we have about local people's health, allowing us to provide care that is tailored to individual needs. To support this we have:

- Strong joint commissioning across Gloucestershire County Council and NHS Gloucestershire CCG, including disabilities, older people, children and families.
- Worked across health, education and social care to support young people who have complex additional needs as they move from childhood to adulthood
- Provided local health and social care professionals shared access to patient electronic records, making patient care safer, more efficient and cost effective
- Placed greater emphasis on prevention and self-care, and joining-up services, community support and information across health and social care.
- Created joint posts, for example a Director of Integration at Gloucestershire CCG and Gloucestershire County Council.

Finally, at the time of writing there are ongoing discussions at national and regional level regarding the next steps in the development of ICSs that opens up a discussion with the NHS and its partners about how ICSs could be embedded in legislation or guidance. This builds on the route map set out in the NHS Long Term Plan, for health and care joined up locally around people's needs. It signals a renewed ambition for how we can support greater collaboration between partners in health and care systems to help accelerate progress in meeting our most critical health and care challenges.

Integrated Care Systems have allowed organisations to work together and coordinate services more closely, and to make real, practical improvements to people's lives. For staff, improved collaboration can help to make it easier to work with colleagues from other organisations, and systems can better understand data about local people's health, allowing them to provide care that is tailored to individual needs.

By working alongside councils, and drawing on the expertise of others such as local charities and community groups, the NHS can help people to live healthier lives for longer, and to stay out of hospital when they do not need to be there.

Further develop Care of the Elderly services at CGH

Action

GHNHSFT is currently developing its strategy for Care of the Elderly (COTE) Services, which will continue to provide COTE services on both hospital sites. Our planned initiatives include developing a direct admissions pathway to the Frailty Assessment Service (FAS)/Care of the Elderly, which will reduce waits in the emergency/urgent care pathways, and enable patients to be seen by experts as quickly as possible. We are also planning to develop an enhanced frailty service at CGH, with access to 'hot' clinics, to support admission avoidance and reduce length of stay.

The Trust is also working with GHCFT on a number of initiatives including redesigning the step-down pathway from acute to community hospital rehabilitation and improving access to community beds. We are currently working on enabling FAS (managed by GHNHSFT) and the Integrated Assessment Team (managed by GHCFT) to work more closely together, to improve patient experience and make better use of our combined resources. They are embracing a philosophy of, "Why not home, why not today?"; with the objective of minimising time spent in hospitals.

Improve the interface with social care services to support patient flow

Action

Recent improvement to the interface with social care services to support patient flow have included Adult Social Care (ASC) and Brokerage staff having access to electronic patient records held at GRH and CGH. Aligned with this, the ASC team is sent a daily report of any acute hospital patients who may have a social care need post-discharge. This preliminary notification of potential need allows social care colleagues to engage with patients to facilitate early conversations pertaining to onward care. By including patients in decisions relating to their care, plans can be agreed ahead of discharge; improving patient experience, promoting better flow and providing a smooth transfer of care.

Information essential to the continued delivery of care and support is also recorded in the Single Referral Form, developed by GHNHSFT to ensure that critical patient information is communicated and transferred to the relevant health and care partners on discharge. This form is saved to the patient's electronic record, and includes details of the agreed discharge pathway.

Increase the services offered at community hospitals

GHC is fully committed to working with system partners to continue to offer a wide and varied range of local services within each community hospital. All community hospitals work in partnerships with acute hospital providers (predominately GHNHSFT) to deliver a wide range of outpatient and diagnostic services.

We acknowledge that during COVID-19 there has been some service disruption with some services moving to different locations – this has been a particular feature at North Cotswold Hospital where services have moved between George Moore clinic and the main hospital site to ensure COVID-19 secure environments and better utilisation of the space available. These changes are temporary, and we aim in the longer term to reinstate services back to the original locations.

As of March 2021 GHNHSFT is working with GP referrers to encourage patients having certain day surgery procedures to have their operation at one of the state-of-the-art community hospital theatre settings in Stroud, Tewkesbury or Cirencester. The day surgery is performed by the same consultant-led specialist team. Patients who choose to have their surgery in these locations can take advantage of benefits including easier parking, shorter waiting times, a quieter environment and a location that may be closer to home.

Consider "centres of excellence"/ centralising other services

Action

The *Centres of Excellence* approach is concerned with configuration of adult acute specialties, i.e. where departments, beds and operating (theatres/day unit) resources are located. This is a large-scale change which we are approaching in three phases. This DMBC relates to the first phase and summarised in section 2.6.

The second phase of *Fit for the Future* will review critical dependencies and enablers associated with the preferred option(s) for the Phase 1 specialties. This could include:

- Clinical support services
- Care of the elderly, medical cardiology, acute stroke, respiratory, nuclear medicine
- Review of any remaining elective Orthopaedics on the GRH site that are not linked to services already centralised at GRH, namely Trauma and paediatrics
- Further adult medical/surgical specialties are in Phase 3 for consideration in light of specialty strategic aims, critical dependencies, developing clinical models for each hospital site and operational capacity.

The phases will not necessarily be implemented sequentially. We are seeking clarity on the preferences for the Phase 1 'sentinel' models before we widen the scope of our clinical model development.

Reinstate Type-1 A&E 24/7 at CGH

We know how important Cheltenham General Hospital Accident & Emergency (A&E) Department is to the people who live in the east of the county; in particular Cheltenham. We agree it is an important part of the future for local health services and we have publicly committed to the future of the Accident and Emergency (A&E) Department in Cheltenham. The service will remain consultant led and there will be no change to the pre-Covid-19 opening hours.

The option of a Type 1 provision overnight, 8pm to 8am, at CGH was ruled out at solutions appraisal stage. For full details please see the Pre Consultation Business Case (Fit for the Future: Developing specialist hospital services in Gloucestershire – OneGloucestershire.net).

Supporting patients at home, rather than admitting them to hospital

Action

As a system, our aspiration is to continue to shift the emphasis away from hospital care and towards supporting people to live independently in their own homes. We will do this by offering personalised care where the person and their family/carers are truly able to take more control of their health and well-being.

We fully recognise that there are times when people may need specialist care or support in an inpatient setting. When people do need hospital care due to acute or complex healthcare needs, then we want this to be accessed in the least restrictive environment to meet their individual needs. Our services support people throughout their recovery pathway, enabling people to return safely to their homes and communities.

4.5 New evidence

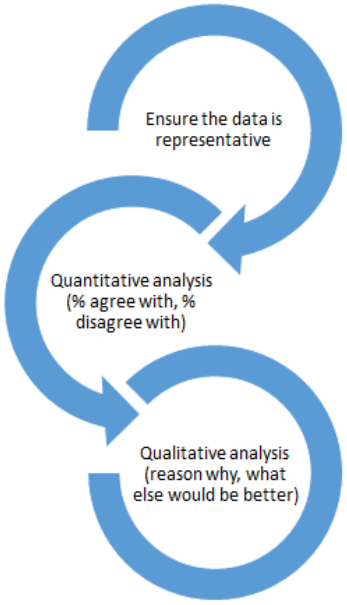
In addition to the qualitative and quantitative feedback received during consultation there are four pieces of new evidence that decision-makers will consider and have influenced the recommendations presented in section 8.

4.5.1 *Enhanced independent Integrated Impact Assessment*

An independent Integrated Impact Assessment (IIA) was a key part of the Pre Consultation Business Case and used the number of people impacted to identify the scale, evidence from literature to determine whether the change would have more positive or adverse impacts and if so, for how long and then an overall assessment was made based on the **scale of the impact, duration of the impact** and therefore the overall **likelihood of the impact.**

Following consultation a process of incorporating consultation feedback into the IIA is undertaken utilising:

- Minutes from engagement events and meetings
- Surveys/ questionnaires sent out to public and patients
- Staff feedback



The process involves breaking down the feedback from the consultation into questions specific to each proposed change and then cohorting the responses e.g. the number of over 65s who agree with proposed change

The IIA (See Appendices 2a, 2b, & 2c) is then enhanced to include **consultation outputs** and **impact based on consultation**. The recommendations are then updated.

Impact of new evidence on our understanding of the options

Details of the recommendations are provided in section 5 and Appendices, and include the following areas:

- Communications
- Delivery of care
- Transport and Accessibility
- On-going patient and public engagement
- COVID-19 pandemic temporary service change learning

How we have listened and the impact of new evidence on decision-making

The impact of the enhanced IIA includes, but not limited to, the following:

- **Planned General Surgery:** It is recommended to explore the possibility of adapting the model of elective colorectal to alleviate some concerns regarding the potential cross-site transfer of high-risk patients. Evidence review suggests there are some clinical benefits to elective colorectal being centralised in GRH with Emergency General Surgery; however, consultation feedback suggests that overall patients would prefer centralisation at CGH, and for this to be extended to other specialties. In order to accommodate patient preference, optimise care and alleviate concerns regarding transfer, it is recommended to explore a model where elective colorectal is

centralised at CGH, but with high-risk patients attending GRH to receive their colorectal treatment. Our response is detailed in section 4.2.3.

- **Virtual appointment:** It is recommended to explore what could be moved to virtual appointment where possible to reduce the need for patients and carers to travel for outpatient appointments. Our response is detailed in section 4.1.
- **Public transport**: It is recommended a review of public transport is conducted to understand if there are limitations, to disseminate information regarding travel to patients to make journey planning easier, and to ensure patients and carers are aware of what services are available. Our response is detailed in sections 4.1 & 7.2.2
- **Proactive engagement**: Ensure sufficient time, resource and focus is allocated to engagement with a range of groups. Our response is detailed in sections 4.1 & 3.7.
- **Communication:** Providing detailed information about what to expect as a patient attending Cheltenham A&E, what is meant by a spoke model for IGIS at Cheltenham, how do the changes link with community hospitals, and how will the hospitals continue to manage demand in the new models. Our response is detailed in sections 4.1 & 7.2.2

4.5.2 *Information regarding Lower GI (colorectal) surgery*

As described in section 4.2.3, GHNHSFTs Leadership Team explored in detail the configuration options regarding Lower GI (colorectal) surgery. As part of this evaluation, information (See Appendix 8) was developed to assess each option against six domains: Quality of Care; Access to Care; Deliverability; Workforce; Strategic Fit and Acceptability.

One of the options (Option B) was an 'acuity'-based model with 'high acuity' colorectal centralised at GRH and 'low acuity' colorectal and upper GI centralised to CGH. The proposal included the development of a number of centres at CGH including:

- Centre for Biliary Disease
- Centre for Pelvic Floor Disease
- Centre for Bariatric Surgery
- Centre for Early Rectal Cancer

Impact of new evidence on our understanding of the options

The TLT discussion concluded that there was an alternative, potentially even better, option that includes the best elements from the two options presented and notably the opportunity to deliver even more planned elective surgery from the Cheltenham General Hospital site.

How we have listened and the impact of new evidence on decision-making

The recommendation was that further work should begin with the General Surgery team to define this new, emerging option. The focus will be to explore the opportunity to deliver:

- Planned High Risk Upper Gastrointestinal (GI) and Lower Gastrointestinal (Colorectal) surgery at Gloucestershire Royal Hospital
- Planned complex and routine inpatient and day case surgery in both Upper and Lower GI (Colorectal) at Cheltenham General Hospital

This opportunity to treat more patients in a centre of excellence for planned surgical care was also something that came through the consultation feedback (with over 40 references to planned care at CGH) from both public contributors and staff.

The changes to the consultation proposals for planned General Surgery are detailed in section 8. It should be noted that any proposed changes to the location of planned Upper GI services would be subject to further public and staff involvement.

4.5.3 *Updated Trauma and Orthopaedic Pilot Evaluation*

As described in section 4.2.8 an updated pilot evaluation report (see Appendix 7) was drafted by the T&O team with support from the FFTF Programme Team. It has been reviewed by the GHNHSFT Surgical Board, T&O Board, GHNHSFT Board and GCCG Governing Body. The report was published and communicated to stakeholders as part of the wider post-consultation updated information.

Impact of new evidence on our understanding of the options

The purpose of the report was to provide a systematic evaluation of the T&O pilot structured around the 10 key objectives of the pilot (using the latest available data sets). A number of the objectives of the pilot address issues specifically related to Trauma patients. The pilot achieved these objectives:

- There is now a consultant and registrar as well as a foundation doctor to give an immediate response
- There is now an on-call consultant and Registrar who do not have other duties and so are available for immediate consultation
- There is now a 7-day-a-week Ward/Board round for all trauma patients
- There is now a new Trauma triage service in place to assist with growing demand

One of the Pilot objectives was to improve time to theatre for Trauma patients (at GRH) and the evaluation report categorises this as “Not Achieved” ad provides details behind this and the plans in place to improve performance. These plans include more theatre lists being made available at Cirencester Hospital, and some non-complex Trauma surgery is undertaken there. In addition more day cases from the remaining elective work at GRH have been transferred to Cirencester Hospital to create more theatre space within GRH theatres for Trauma patients. There is a further plan to utilise one of the new day surgery theatres at CGH that are to be developed as part of the SSD Programme for Orthopaedics. This will enable the service to further reorganise elective lists and create theatre space at GRH for additional Trauma surgery.

How we have listened and the impact of new evidence on decision-making

The publication and review of the evaluation report has provided the opportunity for decision-makers to assess the performance of the pilot and to make recommendations for the ongoing monitoring and evaluation of the performance of the T&O service, including regular updates to the GCCG Governing Body.

The evaluation report was also reviewed by the South West Clinical Senate, and a number of suggestions were made to support the ongoing delivery of the service.

The consultation proposal to retain Trauma (emergency Orthopaedics) at GRH and the majority of elective (planned) Orthopaedics at CGH remains unchanged (see section 8).

4.5.4 *Ambulance response times*

Since the publication of the PCBC, 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 for **all** of the consultation proposals.

Impact of new evidence on our understanding of the options

The impact was assessed for both the ambulance incident response times and the Call to Hospital times. In summary:

- **Response Performance:** to maintain current Category 1, 2, 3 and 4 performance would require approximately 16-18 hours/day of additional ambulance capacity.
- **Call to Hospital time:** the average (mean) and 90th percentile[24] increase is ~ 7 minutes. Research evidence from a variety of countries, including UK, Scandinavia and the US, reviewing mortality associated with changes in travel, have observed that increases of the order of 10 minutes have an undetectable effect.

How we have listened and the impact of new evidence on decision-making

The new evidence supports the consultation proposals, and these remain unchanged (see section 8).

Key Points

- **The DMBC provides a comprehensive response to themes applicable to all consultation proposals, to themes applicable to individual consultation proposals, to alternative suggestions and to areas for further consideration**
- **In many cases our response to feedback from consultation includes reference to either current or proposed activities that seek to address the issues identified**
- **The DMBC responds to new evidence**

[24] Indicates the impact for the majority of incidents

5 Integrated Impact Assessment

This assessment has been completed by **Mid and South Essex NHS Foundation Trust ("MSE") Strategy Un**it in conjunction with the Fit for the Future Programme team. Impact analysis, as part of the evaluation of the two pilot changes (Gastroenterology and Trauma & Orthopaedic inpatient services) has been undertaken locally; this IIA summary document will incorporate findings from both IIAs and includes some text included elsewhere in the DMBC.

5.1 Executive summary

Context

MSE Strategy Unit and Partners were engaged as an independent expert provider by Gloucestershire Integrated Care System (ICS) to undertake an independent Integrated Health Inequalities and Equality Impact Assessment (IHIEIA) of the proposed development of centres of excellence and the resulting proposed relocation of services at GRH and CGH.

Purpose

Through the IHIEIA, the commissioners wanted to ensure that any decisions made by them would support advancing equality and ensure fairness by removing barriers, engaging patients and community and delivering high quality care. This would also help ensure that the commissioners continue to meet their responsibilities under Section 149 of the Equality Act 2010, and demonstrate due regard to the need to eliminate discrimination, harassment, victimisation and any other conduct that is prohibited under the Equality Act; to advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it; and to foster good relations between persons who share a relevant protected characteristic and persons who do not share it. The IHIEIA also helps to ensure that the commissioners continue to meet the duty to reduce inequalities between patients with respect to their ability to access health services, and to reduce inequalities between patients with respect to the outcomes achieved for them by the provision of health services, as set out in s.14T of the NHS Act 2006.

Process

Evidence review, data analysis and feedback from engagement and the consultation feedback, including opinion surveys, panel discussions and focus groups, were considered by the Strategy Unit team to summarise both positive and negative impacts of the proposed changes for people with protected characteristics, as outlined by the Equality Act 2010, the impact on other health inequalities and the general health impact.

The Consultation asked all respondents whether they were in support, neutral or opposed to each proposed change and their reasons, including any alternative ideas or other comments. The feedback from this has been incorporated into the overall assessment of impact.

5.1.1 *Summary of Impact*

The IIA specifically focused on the impact of the proposed changes. The impacts are quantified based on the scale of patients likely to be affected by the proposed change, the duration of the impact e.g. short, medium or long term and this then identifies the overall probability of the impact being beneficial or adverse. Impacts are quantified using a combination of data collected by the Trust regarding the total number of patients and patient subsets and paired with evidence review of the impacts based on literature and open source data. All neutral impacts have been removed from the summary. A detailed

summary of this process is included in the Annex – (Appendix 2b), which includes all data and evidence-based review. The impacts are broken down into two visuals shown overleaf. Figure 1 represents the overall impact of each model and figure 2 represents the impact of each individual proposed solution that makes up a model. The key indicates the nature of the impact. Where there are moderate adverse impacts, these have been highlighted within the document and recommendations have been made.

5.1.2 *Summary of Proposals*

As detailed in section 4.2.3 the recommendation following the options appraisal for planned Lower Gastrointestinal (Colorectal) surgery services was that further work should begin with the General Surgery team to define a new, emerging option that includes planned upper gastrointestinal surgery. Once defined, an IIA will be undertaken but in the meantime the IIA includes the impact of both elective colorectal consultation proposals, with all other services are identical:

- Model D proposes elective colorectal to be centralised at Cheltenham General Hospital (CGH)
- Model E proposes elective colorectal to be centralised at Gloucestershire Royal Hospital (GRH)

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

		Model D	Model E
Protected Characteristics	Age	Significant Positive Impact Moderate adverse impact	Significant Positive Impact
	Disability	Significant Positive Impact Moderate adverse impact	Significant Positive Impact Moderate adverse impact
	Gender	Significant Positive Impact	Significant Positive Impact
	Pregnancy	Neutral Impact (no significant change)	Neutral Impact (no significant change)
	Martial Status	Neutral Impact (no significant change)	Neutral Impact (no significant change)
	Ethnicity	Significant Positive Impact	Significant Positive Impact
	Sexual Orientation	Neutral Impact (no significant change)	Neutral Impact (no significant change)
	Religion	Neutral Impact (no significant change)	Neutral Impact (no significant change)
	Gender Reassignment	Neutral Impact (no significant change)	Neutral Impact (no significant change)
Health Inequalities	Deprivation	Significant Positive Impact Moderate adverse impact	Significant Positive Impact Moderate adverse impact
	Looked After Children	Neutral Impact (no significant change)	Neutral Impact (no significant change)
	Carers and Unpaid Carers	Significant Positive Impact Moderate adverse impact	Significant Positive Impact Moderate adverse impact
	Homelessness	Significant Positive Impact	Significant Positive Impact
	Substance Abuse	Neutral Impact (no significant change)	Neutral Impact (no significant change)
	Mental Health	Significant Positive Impact Moderate adverse impact	Significant Positive Impact Moderate adverse impact
Health Impact	Cardiovascular Disease	Significant Positive Impact Moderate adverse impact	Significant Positive Impact
	Diabetes	Significant Positive Impact	Significant Positive Impact
	Neurological Conditions	Significant Positive Impact Moderate adverse impact	Significant Positive Impact Moderate adverse impact
	Falls among the elderly	Significant Positive Impact	Significant Positive Impact
	Overweight and Obese	Significant Positive Impact	Significant Positive Impact

Figure 1 Summary of Proposals

Proposal Summary

All proposals include the following changes:

- Centralise Acute Medicine to GRH
- Centralise Emergency General Surgery to GRH
- Centralise General Surgery/GI day cases to CGH
- 24/7 Image Guided Interventional Surgery (IGIS) hub and Vascular surgery to GRH with IGIS spoke at CGH
- Gastroenterology at CGH
- Trauma at GRH and Orthopaedics at CGH

These are all significantly positive changes that outweigh the adverse impacts identified. The adverse impacts identify that centralising emergency surgery to Gloucestershire Royal means that patients who deteriorate (e.g. day case patients) at CGH or attend A&E but require emergency surgery may need to be transferred. This has been considered adverse for those who are most vulnerable to deterioration such as those over 65. There were 6,176 emergency admissions to General Surgery last year (Feb 19 to Jan 20), 4,215 of which were at GRH. It is estimated; however, that ~6 patients per day in total will be affected by the new arrangements (1,961 in total) and overall 93% of patients' journeys will remain within +/- 20 mins of their existing journey.

It is also estimated that there will be significantly less than 1 patient per day needing to be transferred in an emergency as a result of inpatient deterioration, and a Standard Operating Procedure will be put in place for this event. This means the impact is relatively small and outweighed by the positive clinical outcomes. Emergency General Surgery care would be improved by providing a dedicated team on the Surgical Assessment Unit, which would review all patients presenting on the same day. This would reduce delays to review, improving patient safety. Evidence suggests patients who are seen quicker have reduced admissions and increased self-care post treatment. The Local IIA found a small adverse impact for those in deprived areas with regards to the proposed change to gastroenterology. This is an important consideration in terms of transport and access.

Coronavirus (COVID-19)

As part of GHNHSFT's COVID response the Trust has been monitoring the patients attending CGH A&E who require a transfer to GRH. On average, during the pandemic, 2 General Surgery patients per week were transferred to GRH, 17 in total between 1st April and 18th June 2020. It is also important to note, it is estimated that significantly less than 1 patient per day will require a transfer as a result of inpatient deterioration.

Model D

In Model D the same adverse impact identified above also relates to elective colorectal surgery patients, who will be centralised to CGH. This means this cohort will also need to be considered as potentially at risk of needing to be transferred if they deteriorate. This risk, however, is estimated to impact significantly less than 1 patient per day, meaning this is outweighed by the positive clinical outcomes of having a centralised clinical response to elective surgeries such as this. By centralising some elective surgery, quality of care could be improved as a result of co-location with other relevant specialties. There is also a reduced

risk of cancellations for patients as they will have access to a ring fenced service. Day case operations e.g. Gastroenterology patients, are currently cancelled frequently due to the need for emergency beds, therefore, by separating elective and emergency there is dedicated resource reducing the number of cancellations for patients.

Coronavirus (COVID-19)

As part of GHNHSFT's COVID response, the Trust temporarily consolidated vascular emergency and elective inpatient pathways to GRH whilst day case venous patients remained at CGH. This temporary change was only implemented in June 2020 and, therefore, the impact on vascular patients is still being monitored. In a 12-month period approximately 500 inpatients would move from CGH to GRH, and approximately 750 day case procedures would continue at CGH.

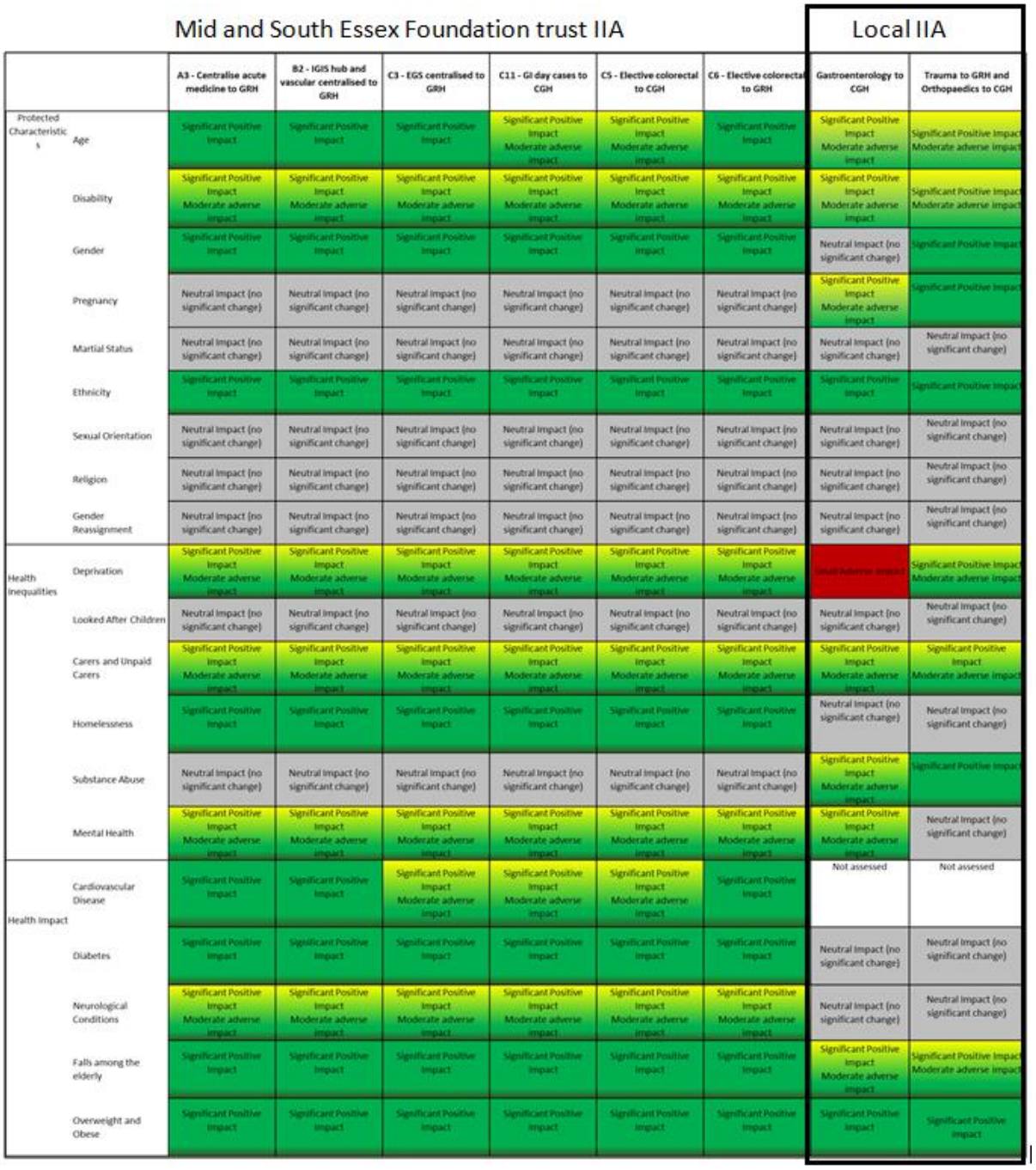
Model E

Model E has the least adverse impacts identified. This model co-locates IGIS and vascular and centralises elective colorectal surgery with Emergency General Surgery at GRH. The adverse impacts for Model E are reflected in the adverse impacts for all models.

Please see a more detailed look at each individual proposed change overleaf;

5.1.3 *Summary of Proposed Solutions*

The following table shows the impact assessment of each proposed change on patient cohorts. The IIA for Gastroenterology and Trauma and Orthopaedics were completed locally within the Trust using a slightly different methodology to Mid and South Essex Foundation Trust's IIA. This is because they were pilots and the local IIA assesses the impacts slightly differently. They have been included in this table to show the overall summary of the findings.



		Mid and South Essex Foundation trust IIA						Local IIA	
		A3 - Centralise acute medicine to GRH	B2 - IGIS hub and vascular centralised to GRH	C3 - EGS centralised to GRH	C11 - GI day cases to CGH	C5 - Elective colorectal to CGH	C6 - Elective colorectal to GRH	Gastroenterology to CGH	Trauma to GRH and Orthopaedics to CGH
Protected Characteristics	Age	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact Moderate adverse impact	Significant Positive Impact Moderate adverse impact	Significant Positive Impact	Significant Positive Impact Moderate adverse impact	Significant Positive Impact Moderate adverse impact
	Disability	Significant Positive Impact Moderate adverse impact	Significant Positive Impact Moderate adverse impact	Significant Positive Impact Moderate adverse impact	Significant Positive Impact Moderate adverse impact	Significant Positive Impact Moderate adverse impact	Significant Positive Impact Moderate adverse impact	Significant Positive Impact Moderate adverse impact	Significant Positive Impact Moderate adverse impact
	Gender	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact	Neutral Impact (no significant change)	Significant Positive Impact
	Pregnancy	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)	Neutral Impact (no significant change)	Significant Positive Impact Moderate adverse impact	Significant Positive Impact
	Martial Status	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)	Neutral Impact (no significant change)	Neutral Impact (no significant change)	Neutral Impact (no significant change)
	Ethnicity	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact
	Sexual Orientation	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)	Neutral Impact (no significant change)	Neutral Impact (no significant change)	Neutral Impact (no significant change)
	Religion	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)	Neutral Impact (no significant change)	Neutral Impact (no significant change)	Neutral Impact (no significant change)
	Gender Reassignment	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)	Neutral Impact (no significant change)	Neutral Impact (no significant change)	Neutral Impact (no significant change)
Health Inequalities	Deprivation	Significant Positive Impact Moderate adverse impact	Significant Positive Impact Moderate adverse impact	Significant Positive Impact Moderate adverse impact	Significant Positive Impact Moderate adverse impact	Significant Positive Impact Moderate adverse impact	Significant Positive Impact Moderate adverse impact	Great Adverse Impact	Significant Positive Impact Moderate adverse impact
	Looked After Children	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)	Neutral Impact (no significant change)	Neutral Impact (no significant change)	Neutral Impact (no significant change)
	Carers and Unpaid Carers	Significant Positive Impact Moderate adverse impact	Significant Positive Impact Moderate adverse impact	Significant Positive Impact Moderate adverse impact	Significant Positive Impact Moderate adverse impact	Significant Positive Impact Moderate adverse impact	Significant Positive Impact Moderate adverse impact	Significant Positive Impact Moderate adverse impact	Significant Positive Impact Moderate adverse impact
	Homelessness	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact	Neutral Impact (no significant change)	Neutral Impact (no significant change)
	Substance Abuse	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)	Neutral Impact (no significant change)	Significant Positive Impact Moderate adverse impact	Significant Positive Impact
	Mental Health	Significant Positive Impact Moderate adverse impact	Significant Positive Impact Moderate adverse impact	Significant Positive Impact Moderate adverse impact	Significant Positive Impact Moderate adverse impact	Significant Positive Impact Moderate adverse impact	Significant Positive Impact Moderate adverse impact	Significant Positive Impact Moderate adverse impact	Neutral Impact (no significant change)
Health Impact	Cardiovascular Disease	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact Moderate adverse impact	Significant Positive Impact Moderate adverse impact	Significant Positive Impact Moderate adverse impact	Significant Positive Impact	Not assessed	Not assessed
	Diabetes	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact	Neutral Impact (no significant change)	Neutral Impact (no significant change)
	Neurological Conditions	Significant Positive Impact Moderate adverse impact	Significant Positive Impact Moderate adverse impact	Significant Positive Impact Moderate adverse impact	Significant Positive Impact Moderate adverse impact	Significant Positive Impact Moderate adverse impact	Significant Positive Impact Moderate adverse impact	Neutral Impact (no significant change)	Neutral Impact (no significant change)
	Falls among the elderly	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact Moderate adverse impact	Significant Positive Impact Moderate adverse impact
	Overweight and Obese	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact

Figure 2: Summary of proposed changes

5.2 Post-Consultation feedback

Full details can be found in Appendices 2a, 2b and 2c. Overall feedback from the consultation was very positive, with the majority of respondents supporting the proposed changes. Feedback from the consultation identified some overall themes;

Quality of care and reduced cancellations and waiting times were perceived to be the benefits of the proposed changes from consultation feedback. These were often the reasons for the high percentage of respondents supporting the changes. Many respondents reported the rationale for the changes were clear.

Travel was identified as a theme, particularly for those over 65, those with disabilities, and carers. Respondents were concerned about the travel times to the hospital sites from where they live and traffic across the county. Feedback also identified concerns regarding the travel between sites, and if public transport is sufficient.

Those with disabilities and those over 65 and those with long term conditions identified concerns regarding **transfers** between hospital sites and wards during treatment. This cohort also identified concerns around patients who are very unwell requiring transfer for emergency treatment. This was highlighted in regards to elective colorectal centralisation and Emergency General Surgery centralisation to GRH. Some feedback questioned if high-risk procedures should be carried out where Emergency General Surgery is centralised.

Parking was identified as an issue for patients, particularly at Cheltenham Hospital, which could become exacerbated by centralisation of elective work.

Capacity was questioned by respondents. Many questioned if the hospitals can cope with the increased demand brought about by centralising services.

Both sites acting as centres of excellence was a suggestion by many respondents who felt that the county was too large to have one centre of excellence located at one site. Some raised concerns regarding the growing population, whereas, others felt that the centralising of services would optimise care quality, increased staff retention and learning for staff, which would result in reduced waiting times and cancellations.

Community hospitals were mentioned within feedback, questioning how they will interact with the new models of care.

Many felt that this could also be a good opportunity to **modernise** areas within the sites as part of this proposal.

Subsidised transport could be explored as many respondents fed back on the cost of transport between hospital sites and home.

Request to increase **Homeless Outreach**, particularly in Cheltenham. Feedback from the Homelessness Forum and Housing and Support Forum identified that those who are homeless or rough sleeping do not tend to travel outside of their immediate area and so travelling further for medical care may be difficult.

Many respondents commented that centralising services would support **staff retention** and encourage recruitment.

Some respondents had questions regarding the inpatient care at GRH for Gastroenterology patients. This is also the case in relation to how the spilt of Trauma and Orthopaedics looks in practice.

Care quality was viewed as a benefit by many respondents who felt centralising services would optimise care. Some commented that they were happy to travel for optimised care or that location was less important compared to quality.

5.2.1 *Recommendations based on evidence review and consultation feedback*

Communication

1. The need for further communication has been identified through consultation feedback. Providing detailed information about what to expect as a patient attending Cheltenham A&E, what is meant by a spoke model for IGIS at Cheltenham, what will remain available at both sites in relation to Trauma and Orthopaedics split and Gastroenterology centralisation, how do these changes link with community hospitals, and how will the hospitals continue to manage demand in the new models, are some examples.
2. Communications will be needed to explain the benefits and mitigate public perceptions of additional risks to patient and visitor wellbeing. Ensure sufficient time, resource and focus is allocated to engagement with a range of groups on travel impacts, both planned and emergency, and for families and visitors as well as patients. Staff travel may also be a factor.
3. Emphasising to the public that current A&E services at CGH will be maintained is important to alleviate concerns around its closure. Feedback from over 65s emphasises the need to ensure all patients are aware of their local A&E and where to go in the event of an emergency. There are concerns around whether they will need to learn the route to a new A&E so ensuring they know A&E is still available at CGH and what to do in the event of an emergency is important.
4. Explaining how specialist staff are spread across the two sites will be beneficial in alleviating concerns around accessibility to specialist care equally across the county.

Delivery of care

5. It is recommended to explore the possibility of adapting the model of elective colorectal to alleviate some concerns regarding the transfer of high-risk patients. The evidence review suggests there are clinical benefits to elective colorectal being centralised in GRH with Emergency General Surgery, however consultation feedback suggests that overall patients would prefer centralisation at CGH. In order to accommodate patient preference, optimise care and alleviate concerns regarding transfer, it is recommended to explore a model where elective colorectal is centralised at CGH but with high-risk patients attending GRH to receive their colorectal treatment.
6. Explore if increasing outreach services for those who are homeless is needed and would be beneficial.
7. It is recommended to explore what could be moved to virtual appointment, where possible to reduce the need for patients and carers to travel for outpatient appointments.
8. As part of the design of services, consultation feedback suggested that this could be an opportunity to modernise areas of the sites.

Transport and Accessibility

9. Assess the parking at each site, including availability of disabled parking bays to understand if this will be negatively impacted by the changes.
10. It is recommended a review of public transport is conducted to understand if there are limitations, to disseminate information regarding travel to patients to make journey planning easier and ensure patients and carers are aware of what services are available.
11. It is recommended to conduct a review of transport options, including subsidised options for transport which can be disseminated to patients to ensure they are aware of all the options they can access.
12. High quality signposting, good quality wheelchair access and interactive information for those with sensory impairments will be necessary to help patients navigate this change. Both sites will already have facilities in place for patients with disabilities, but it is important to ensure these are optimised and, where possible, co-designed with representative organisations and patients with disabilities.
13. It is recommended to work closely with local transport providers and the local authority to understand their forward plans for transport and the impact this will have on the reconfiguration proposals.
14. When centralising services it is important to assess if there is an appropriate number of disabled parking bays to accommodate increases in demand of, for example, specific elective procedures. Engagement with patients with disabilities can help to identify the perceived challenges and what is required.
15. Moving sites can be a challenge for patients with a sensory impairment who may be familiar with their local hospital site but may be required to travel to the other site. Additional support may be needed to help patients navigate this change; engagement through representative organisations for sensory impairments and disabilities would be beneficial to understand the best way to offer support.

5.2.2 *Potential Positive Impacts*

- Centralising acute medicine enhances patient safety, improves outcomes and reduces length of stay as it allows for more patients to be seen by a senior reviewer within 14 hours of arrival, which is associated with increased patient discharges and improved clinical outcomes. 67% of admissions to acute medicine last year were for over 65s, meaning this cohort is significantly impacted by this change and its benefits.
- By centralising the IGIS hub patients will now have a 24/7 service available to them. By co-locating this with the county's Trauma hub patients are more likely to receive emergency intervention faster. By co-locating with vascular the Trust is creating a multi-disciplinary approach to management of primary angioplasty which can improve patient outcomes. 68% of Interventional Cardiology patients and 66% of vascular patients last year were over 65, meaning this cohort is significantly impacted by this change and its benefits.
- The centralisation of services will also mean quality of care and expertise will be enhanced, which is particularly beneficial to patients with long term conditions or co-morbidities which are prevalent in patients with disabilities, those aged >65 and some BAME communities.
- By centralising services, patients will have reduced waiting times, fewer cancellations and fewer unplanned overnight stays. Timely appointments with fewer cancellations mean patients can more effectively plan their travel (e.g. pick up and drop off times if

they are not driving themselves). This will benefit all patients, including those with disabilities who may need to plan travel in advance.

- Reduced unplanned overnight stays may help to limit anxiety and unfamiliarity, particularly important for patients with a learning disability.
- Having a more consistent workforce can make a significant positive impact to patients, specifically those with learning disabilities or from a minority group as consistency allows for ongoing communication with a familiar team and helps build trust for patients.
- 25% of Gloucester city's population are living in deprived areas, approx. 32,000 people. Therefore, centralising Emergency General Surgery, Trauma, Acute Medicine and IGIS to the GRH provides improved access to the right specialists to manage the care of this higher risk community. Deprivation is linked to co-morbidities and poorer health outcomes, therefore, centralising services to form different hubs with co-located specialities across both sites with enhanced quality of care and reduced waiting times will benefit all those living in deprivation across the county.
- The centralisation of services will provide more comprehensive and co-located specialised care, which could be beneficial for carers who are caring for someone with multiple conditions. Centralisation also means services will be ring-fenced, ensuring fewer cancellations, reduced waiting times and improved clinical outcomes, resulting in improved self-care. These benefits will help to support carers to reduce their time attending hospital with the person they are caring for and improve the health outcomes of both the person they are caring for and, in turn, potentially their own health.
- There are 79 people registered with Gloucestershire's Homeless Healthcare Team and it has been identified this cohort are most likely to use A&E and community care services and evidence suggests those who are homeless are more likely to have multiple health conditions. Given rates of homelessness are slightly higher in Gloucester than surrounding areas; centralising Emergency General Surgery to GRH provides improved access to the right specialists to manage the care of homeless people who present with multiple conditions.
- There is a strong association between physical health and mental health. People with long-term conditions, such as diabetes or cardiovascular disease, have significantly raised rates of depression, anxiety and other mental health problems. Evidence suggests they receive poorer quality care than those with a single condition.[25] 1.2% of all A&E attendances last year were for those with mental health conditions, the large majority of these attended GRH A&E. Therefore by centralising services, patients with comorbidities could receive a better quality of specialist care as they will be treated with a multi-disciplinary approach. .
- Diabetes tends to be prevalent with other co-morbidities such as, heart conditions, meaning that this cohort is likely to be impacted by the centralisation of services as they are likely to use several different services due to having multiple conditions. Thus, centralising services will improve their quality of care by reducing waiting times, faster diagnostics and a multi-disciplinary approach to multiple conditions.
- By centralising services, new and innovative training opportunities will be available to staff which will positively impact moral, help to retain existing staff and attract new staff. The co-location of catheter labs with Interventional Radiology improves the

[25] https://www.kingsfund.org.uk/projects/mental-health-and-long-term-conditions-cost-co-morbidity

opportunity to develop innovative nursing and technician roles that would not have been possible before.

- Although the inpatient gastroenterology ward is currently based at CGH there is full access to gastroenterology services at GRH; with 7-day-per-week emergency endoscopy provision and a rostered gastrointestinal consultant and registrar at GRH to assess patients who are referred either from ED or other specialist areas ensuring the same level of emergency care is available at both sites.
- Outpatient gastroenterology and orthopaedic clinics are unaffected, and will be maintained at Cheltenham General, Gloucestershire Royal and community Hospitals creating no impact on travel times.
- Despite some patients from the west of the county having to travel further for elective (planned) orthopaedic surgery the move of planned orthopaedic care to CGH has enabled the provision of ring-fenced wards with an 80% lower chance of cancellation due to emergency trauma patients requiring the attention of specialist staff.
- The way the inpatient beds are organised for trauma and orthopaedics (in the pilot) includes 17 single rooms at CGH and 18 at GRH, which gives flexibility to maintain privacy and dignity.
- Rates of homelessness are slightly higher in Gloucester than surrounding areas; this group have a significant requirement for trauma services and so the centralisation of trauma services there will benefit this cohort.

5.2.3 *Potential Adverse Impacts*

- A centralised hub for IGIS will provide the capacity and capability to provide specialist centralised care for these patients. It is important to consider patients having interventional surgery are often more complex and can be higher risk, often with other co-morbidities and long-term conditions such as cardiovascular conditions. Engagement with staff at Gloucestershire Hospitals Foundation Trust identified some concerns that patient safety may be compromised by having IGIS and vascular separate, as this could result in some complex and emergency vascular patients needing to transfer; identified vulnerable groups are patients who have had a mini stroke or patients with carotid artery disease.
- If Emergency General Surgery is centralised to GRH, people attending A&E at CGH or patients (e.g. day cases and elective colorectal) deteriorating and needing Emergency General Surgery may need to be transferred to GRH. Patients over 65 are most vulnerable to deterioration, and currently 40% of General Surgery patients are over 65, meaning they are disproportionately impacted by this. Currently, however, it is only 6 per day in total who will be impacted by the new arrangements, with significantly less than 1 patient per day needing transfer in an emergency as a result of inpatient deterioration. This means the impact is relatively small and outweighed by the positive clinical outcomes.
- GI day case patients are generally lower acuity and so are less likely to deteriorate; however, in the event a patient does deteriorate they may need to be transferred to GRH. Patients over 65 are more likely to experience co-morbidities and other health conditions and therefore could be more vulnerable to needing transfer; however, transfer as a result of deterioration is already indicated to be low and infrequent. This is outweighed, however, by reduction in waiting times, enhanced quality of care and a reduction in the number of patients who are required to stay overnight unplanned as a result of a late start.

- Feedback from staff and patients suggests parking can be a challenge at both sites. This could prove challenging for patients with a disability who will require a disabled parking bay or drop off point if the demand increases beyond what is currently available as a result of centralising services. Moving sites can also be a challenge for patients with a sensory impairment who may be familiar with their local hospital site but may be require travel to the other site. Additional support may be needed to help patients navigate this change.
- The new proposed models will mean that deteriorating patients may need to be transferred depending on the site they attended and their condition. For patients with a physical, sensory or learning disability, this may mean additional support with transport arrangements on their return home as they may not drive. It is important to note this will likely be in unique circumstances and outweighed by the clinical benefits of centralising services
- Carers and unpaid carers are likely to experience the clinical benefits of better quality of care for the patient, shorter waiting times and specialist services working in a multi-disciplinary approach which could help to reduce their number of hospital visits. It is possible, however, in some instances a carer may need to attend both sites based on the proposed changes (although unlikely), or in the event the patient deteriorates, they may need to transfer to GRH for emergency surgery if they are currently at CGH. These events have been estimated to happen for significantly less than 1 patient a day, meaning that, the benefits outweigh the risks for carers.
- Enhanced clinical outcomes outweigh the negative impacts of travel for the majority of cohorts; however, it is important to consider the possible impact of additional cost in travel for some either through fuel costs or public transport fares for all patients, but particularly considering those in low income households. It is important to consider that this is outweighed by enhanced clinical outcomes as centralising services will likely reduce waiting times and therefore parking fees and in all the proposed solutions, ~80% of all patients impacted will see a neutral impact in travel (a change +/-20 mins).
- There are some patients who attend A&E at CGH who may need to transfer to GRH for admission. This has been mitigated by working with the Ambulance Service to ensure that patients who are likely to require admission are taken directly to GRH. Senior orthopaedic doctor input is available for patients in A&E at both CGH and GRH and there is a process in place to transfer patients who require admission.

5.2.4 *Travel Impacts*

To Patients

- Patients may need to travel to a different site for their treatment in the future. Travel analysis has suggested that approximately 80% of all patients will see minimal change in their journey (+/- 20 mins). This equates to approximately 20,000 people and on average 7% will have a shorter journey, just over 1,600 people
- On average, 13% of patients of the services contained within these proposals will have a negative travel impact. The largest negatively impacted cohorts are those who under the proposals would need to travel to GRH for acute medicine and those travelling to CGH for elective colorectal if this are to be centralised in CGH.
- Gloucestershire Hospitals Trust have assessed the evidence around the extra distance some patients may need to travel in the event of an emergency and the evidence suggests the distance would not impact negatively on mortality or the clinical outcomes of patients.

- By centralising services, a number of patients would see significant reductions in their travel times as they could now be treated locally, whereas at present Primary PCI patients are travelling to other hospitals, such as Bristol, for their treatment.
- There are also currently patients travelling out of county for IGIS procedures. By centralising IGIS it improves the ability for this provision to expand, increasing the potential for more patients to be treated in-county, overall reducing travel for some patients. Within the scope of the IGIS service proposals are the current 115 patients who undergo various Interventional Radiology interventions mostly delivered from Birmingham and Oxford, a few from Bristol, and some travel as far as Leeds. In addition to the patients directly benefitting, our IGIS service proposals will contribute towards to other initiatives aimed at repatriating up to a further 600 patients.

To Staff

- It is important to consider the impact increased travel can have on child care provision or caring responsibilities of staff.
- Despite some staff required to travel more, centralising General Surgery day cases will reduce the number of visits a patient makes which creates more capacity for staff.
- Currently there are challenges in filling rotas, sickness absence and use of agency staff to combat this. This puts staff under pressure and impacts morale. The proposed solutions aim to give staff more dedicated time by making processes more efficient. Some changes will bring teams together and result in less travel and as teams become bigger there will be more opportunity for flexibility of staff. By centralising some emergency and elective cohorts the environment improves for workforce as they have more dedicated capacity, fewer cancellations and less late starts and by creating an IGIS hub, this creates new opportunities for staff to train and develop new specialist skills as well as to attract and retain more staff

Key Points

- **The IIA is an independent assessment that supports decision-making by evaluating the impact of the proposals, informing public debate and supporting decision-makers to meet their Public Sector Equality Duty and their duty to reduce inequalities.**
- **Consultation feedback has been incorporated into the overall assessment of impact.**
- **The consultation proposals are all significantly positive changes that outweigh the adverse impacts identified**
- **The IIA includes recommendations based on evidence review and consultation feedback**

6 Economic and Financial Analysis

6.1 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 (ICS) Directors of Finance (DoF) group which comprises DoFs from GHNHSFT, GCCG and GHCFT.

The programme team included GHNHSFT Finance team, information analysts, a Senior HR Business Partner for Workforce Transformation, an Associate Director of Finance from NHS South, Central and West CSU (SCW), as well as the FFTF Programme Director and Programme Managers.

6.2 Methodology

Full details of the methodology and approach can be found in the PCBC. Since the publication of the PCBC, we have undertaken the following activities:

- Re-validation of clinical model workforce requirements.
- Re-confirmed with NHSE&I the decision to exclude impact of COVID-19 from our baseline data, staffing models, resource requirements and finances; baseline period remains Feb 2019-Jan 2020.
- Responded to impact of consultation feedback and new evidence on consultation proposals.
- Review of Downside Risks and modelling of new evidence.
- Modelling impact of growth on consultation proposals.

6.3 Consultation feedback and new evidence

6.3.1 *Planned General Surgery*

As described in section 4.2.3, GHNHSFTs Leadership Team undertook an appraisal for the configuration options regarding Lower GI (colorectal) surgery, and concluded that there was an alternative, potentially even better, option that includes the best elements from the two options presented 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 for all planned General Surgery. The changes to the consultation proposals for planned General Surgery are detailed in section 8.

As this work will take place in Q1-Q2 2021/22 (see section 9.7.4), and is yet to confirm the activity and staffing requirements, for the purposes of this DMBC the decision has been made to use the higher costs associated with PCBC Model D (4.4): Elective/ planned colorectal surgery centralised to CGH. This included two additional Advanced Nurse Practitioners compared to Model E (5.4).

All other consultation proposals remain unchanged, and therefore no changes have been made to the service revenue or costs.

6.3.2 *South Western Ambulance Service NHS Foundation Trust (SWASFT)*

As described in the PCBC and in section 4.2.1, the FFTF programme has worked closely with SWASFT and Operational Research in Health (ORH) Limited to model the "blue light" ambulance travel impact for **all** of the consultation proposals. The impact was assessed for both the ambulance incident response times and the Call to Hospital times. From a financial impact perspective, the key findings are:

Patients attending GWH[26]: the modelling indicates an average 1.7 patients per day would be conveyed to GWH where previously they had attended CGH (these are for incidents on the border of Gloucestershire and Wiltshire), and is based on 2019/20 activity and using SWASFT catchment analysis. However, the choice of hospital will be determined using a range of factors at the time of the incident.

The financial scale of impact will depend on the actual number of GWH ED attends, the admission conversion rates, the average LoS and therefore the resultant tariff needing to be paid. The impact will also be determined by the contract currency (PbR, block or blended) in place at the time of implementation (2022/23 for Acute Take).

For the purposes of the DMBC a proportion of the potential impact is included as a cost/charge (£250,000) and the remainder is included as a Downside Risk (see below).

Response Performance: to maintain current Category 1, 2, 3 and 4 performance would require approximately 16-18 hours/day of additional ambulance capacity. This analysis will form part of the contract discussions with GCCG and SWASFT. It should be noted that activity numbers are not modelled to change but the resources required to deliver the modelled activity is likely to.

For the purposes of the DMBC, the item remains a Downside Risk but, subject to the above, no financial value has been included.

6.3.3 *Workforce*

Following the re-validation of the clinical models and taking into account the assumptions described in section 6.3.1 above, the financial analysis includes the FTE changes listed below:

	Registered Nurse (FTE)	Non-Registered Nurse(FTE)	Medical Staff (FTE)	Total (FTE)
Emergency and Acute Medicine	0.28	-4.56		**-4.28**
Emergency General Surgery	2.00		2.00	**4.00**
ACRT/Deteriorating Patient	6.80	0.90	-5.60	**2.10**
IGIS	8.32	0.80	1.72	**10.84**
	17.40	**-2.86**	**-1.88**	**12.66**

[26] Great Western Hospitals NHS Foundation Trust, Swindon.

6.3.4 *Downside risks*

Financial Risk	Unadjusted Impact	Likelihood	Consequence	Risk-adjusted Impact	Narrative
Inability to achieve income from additional specialised commissioning activity	£463,600	M	M	£111,813	£300k represents the recurrent cost pressure to SW Spec Comm, as detailed in GHFT/SW Spec Comm joint paper 21/08/20 Adjusted 30Sep-01Oct20 to take account of letter of support and adjusted risk values of specific procedures
Impact of inter-site transfers still to be confirmed - see note f in Surgery tab	£0	H	H	£0	Current expectation is that additional transport requirement will be 3-4 vehicles per day; at current contract value, 3.5 vehicles is ~£350k - **now included within main case for Surgery**
Deteriorating Patient / Acute Care Response Team - junior doctor savings to be identified	£1,069,616	L	L	£84,890	Confidence that these specific posts in the establishment will be identified, but leaving £85k in to reflect ~1.0 of 12.6WTE not coming to fruition
Contingency for staff moves within 'Surgery' element: Colorectal, Upper GI, Emergency Surgery, Day Surgery, T&O	£307,953	L	L	£40,000	Although £30.8m (623.8WTE) is the baseline of the in-scope teams within the 'Surgery' element, the size of the teams whose contractual position is likely to change (ie those not already considered to be 'Trustwide' is £4m (104.5WTE), so contingency has been adjusted to ~1% of this amount
Managed Equipment Service - 5% overspend on IGIS I&E element (if capital scheme, this would be capital charges)	£95,000	L	L	£0	Any overspends would have to be met from within service budgets, as part of usual financial monitoring and approval processes
We continue to work with SWAST (and their modelling partners, ORH) to calculate the financial effect to them of up to 6,554 ambulance arrivals per year at CGH moving to GRH (or other sites, such as GWH, Swindon) If this was new activity, SWAST's contract value would be increased by 50% of the contract value / contractual activity per unit, which for Gloucestershire CCG would be £134 per additional unit of activity for	£878,236	L	M	£0	As there is no new activity, simply redirected activity. Subject to ongoing discussions GCCG and SWASFT
Modelling for SWASFT by ORH has determined that 1.7 ambulance conveyances a day currently arriving at CGH would move to GWH as a result of FftF changes at CGH. This would reduce the A&E activity and subsequent non-elective admissions at GHFT and increase them at GWH, leading to an expectant reduction in income from GCCG to GHFT as the income follows the activity to GWH	£872,249	H	H	£622,249	Impact to be confirmed (for both system and GHNHSFT).
	£3,686,654			**£858,952**	

6.3.5 *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 consultation proposals and applied the appropriate growth rates to our baseline activity to assess the impact of cumulative growth for the period 2021 to 2031. The table below details the mathematical impact of predicted growth for the period 2021-2031; with no growth mitigations in place.

Service	Average Length of Stay	Additional Bed Requirement	Current Bed Base	Required Bed Increase
Cardiology	7.2	9	22.9	41%
Gastroenterology	9.1	8	11.3	75%
Vascular	6.6	5	19.3	25%
General Surgery	3.5	10	55.1	18%
Trauma & Orthopaedic	4.0	16	106.7	15%
TOTAL		**49**	**215.3**	**23%**

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. As detailed in the PCBC, our consultation 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 over the next two years, decisions will take account of the position at the time, and the developing pandemic recovery paradigm. At the time of writing, the third wave (and lockdown) continues, and it is not practicable to reliably estimate the medium-term impact on planned and unplanned activity; only that it is likely to be different from projections made prior to the pandemic.

6.4 Revenue Impact

The financial assumptions are based on the following service configurations:

- **GRH**: centralised Acute Medical Take, Emergency General Surgery, 24/7 Image-Guided Interventional Surgery hub including the Vascular arterial centre and Trauma.
- **CGH**: centralised Orthopaedics, Gastroenterology, Image-Guided Interventional Surgery spoke and the Acute Care Response Team.
- **TBC**: Planned General Surgery using the **cost base** for CGH

£'000	Baseline	Proposal
Revenue Costs		
Clinical Services	£112,148	£113,218
Non-Clinical Costs	£4,940	£4,961
Building Running Costs	£0	£0
Other Revenue Costs	£24,282	£24,558
Total Revenue Costs	**£141,371**	**£142,737**
Additional Costs		**£1,367**
Additional Income		
Additional specialised commissioning activity		£(464)
Reduction due to increased GWH activity		£250
Total Additional Income		**£(214)**
Net Recurrent Revenue Impact		**£1,153**
WTE change		**12.66**
Transitional Costs		
Hybrid Theatre enabling building works - now included within overall MES programme		£0
Moves and enabling works for colorectal		£0
Total Transitional Costs - Non-Recurrent Revenue Impact		**£0**

£'000	Proposal
Net Recurrent Revenue Impact	**£1,153**
WTE change	**12.66**
Non-Cash-Releasing Benefits	**£817**
Cash-Releasing Benefits	**£27**
Net Recurrent Revenue Impact After Benefits (excluding risks)	**£309**
Risk-adjusted Impact	**£859**
Risk-Adjusted With Benefits	**£1,168**

6.5 Phasing

£'000	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8
Recurrent Costs								
Acute		(48)	(115)	(115)	(115)	(115)	(115)	(115)
ACRT			397	397	397	397	397	397
DCC			0	0	0	0	0	0
IGIS		233	559	559	559	559	559	559
Surgery	526	526	526	526	526	526	526	526
TOTAL	**526**	**711**	**1,367**	**1,367**	**1,367**	**1,367**	**1,367**	**1,367**
Recurrent Income								
Acute		104	250	250	250	250	250	250
ACRT			0	0	0	0	0	0
DCC			0	0	0	0	0	0
IGIS		(193)	(464)	(464)	(464)	(464)	(464)	(464)
Surgery	0	0	0	0	0	0	0	0
TOTAL	**0**	**(89)**	**(214)**	**(214)**	**(214)**	**(214)**	**(214)**	**(214)**
Net Recurrent Position								
Acute	0	56	135	135	135	135	135	135
ACRT	0	0	397	397	397	397	397	397
DCC	0	0	0	0	0	0	0	0
IGIS	0	40	96	96	96	96	96	96
Surgery	526	526	526	526	526	526	526	526
TOTAL	**526**	**622**	**1,153**	**1,153**	**1,153**	**1,153**	**1,153**	**1,153**
Transitional Costs								
Acute	0	0	0	0	0	0	0	0
ACRT	0	0	0	0	0	0	0	0
DCC	0	0	0	0	0	0	0	0
IGIS	0	0	0	0	0	0	0	0
Surgery	0	0	0	0	0	0	0	0
TOTAL	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Annual Cost	**526**	**622**	**1,153**	**1,153**	**1,153**	**1,153**	**1,153**	**1,153**

£'000	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8
Benefits								
Acute	0	(60)	(144)	(144)	(144)	(144)	(144)	(144)
ACRT	0	0	0	0	0	0	0	0
DCC	0	0	0	0	0	0	0	0
IGIS	0	(70)	(169)	(169)	(169)	(169)	(169)	(169)
Surgery	(531)	(531)	(531)	(531)	(531)	(531)	(531)	(531)
TOTAL	**(531)**	**(662)**	**(844)**	**(844)**	**(844)**	**(844)**	**(844)**	**(844)**
Benefits-Adjusted Annual Cost	**(6)**	**(40)**	**309**	**309**	**309**	**309**	**309**	**309**
Risk-Adjusted Impact								
Acute	0	0	622	622	622	622	622	622
ACRT	0	0	85	85	85	85	85	85
DCC	0	0	0	0	0	0	0	0
IGIS	0	0	112	112	112	112	112	112
Surgery	40	40	40	40	40	40	40	40
TOTAL	**40**	**40**	**859**	**859**	**859**	**859**	**859**	**859**
Annual Cost Including Benefits and Risks	**34**	**(0)**	**1,168**	**1,168**	**1,168**	**1,168**	**1,168**	**1,168**

Key Points

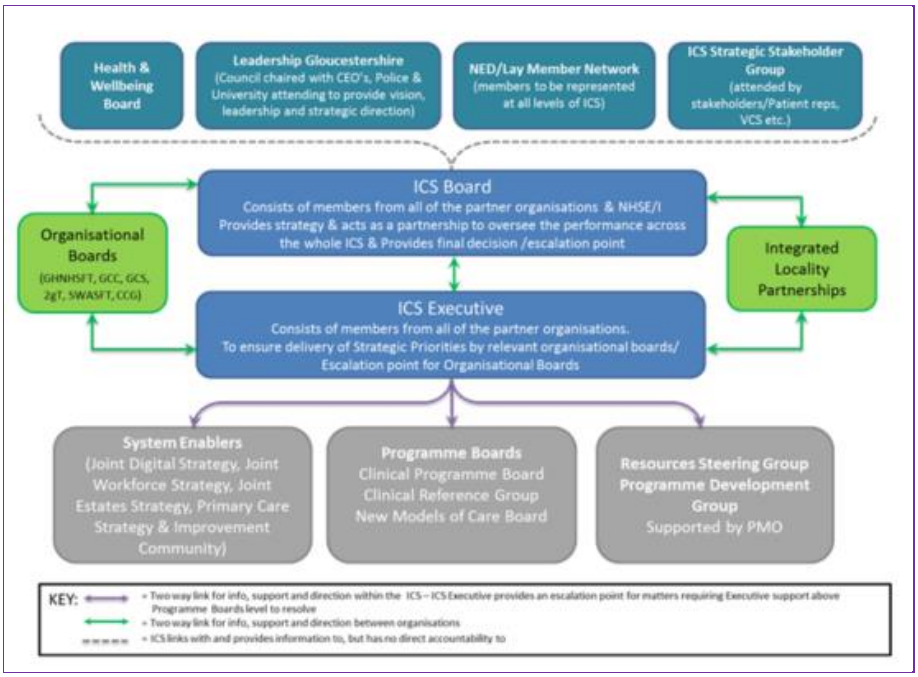
- **We have completed a re-validation of clinical model resource requirements**
- **We have responded to impact of consultation feedback and new evidence on consultation proposals**
- **We have undertaken a review of Downside Risks and re-modelling of impact where appropriate**
- **We have undertaken detailed benefits realisation planning to ensure the expected outcomes for patients, staff and the health economy are deliverable**
- **Our proposals after benefits are within a financial tolerance for which the system would be able to prioritise funding accordingly. The profile of the spend also allows opportunity to deliver further benefits, and the expectation within the system is that the identification and quantification of additional benefits will make our proposals (at least) cost neutral**

7 Governance and Decision Making

7.1 Gloucestershire Integrated Care System (ICS)

Gloucestershire is coterminous as a footprint and has strong partnerships already in place, as demonstrated by our success at working together as Integrated Care System. 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 the proposals for change set out in these proposals.

ICS partnerships continue to need to operate within the existing statutory framework[27], which means that the CCG, Gloucestershire County Council and NHS Trusts (GHNHSFT and GHCFT), remain the statutory accountable bodies within the health and care system. We propose that our organisations will continue to work within our Memorandum of Understanding (MoU) which sets out the principles of collaboration between partners, and which will be the vehicle for the collective delivery of this transformational change at pace and scale. A schematic of the ICS collaboration model is provided below.



The concept of *Centres of Excellence* is consistent with the strategic intent of the ICS. The core purpose of the ICS is to:

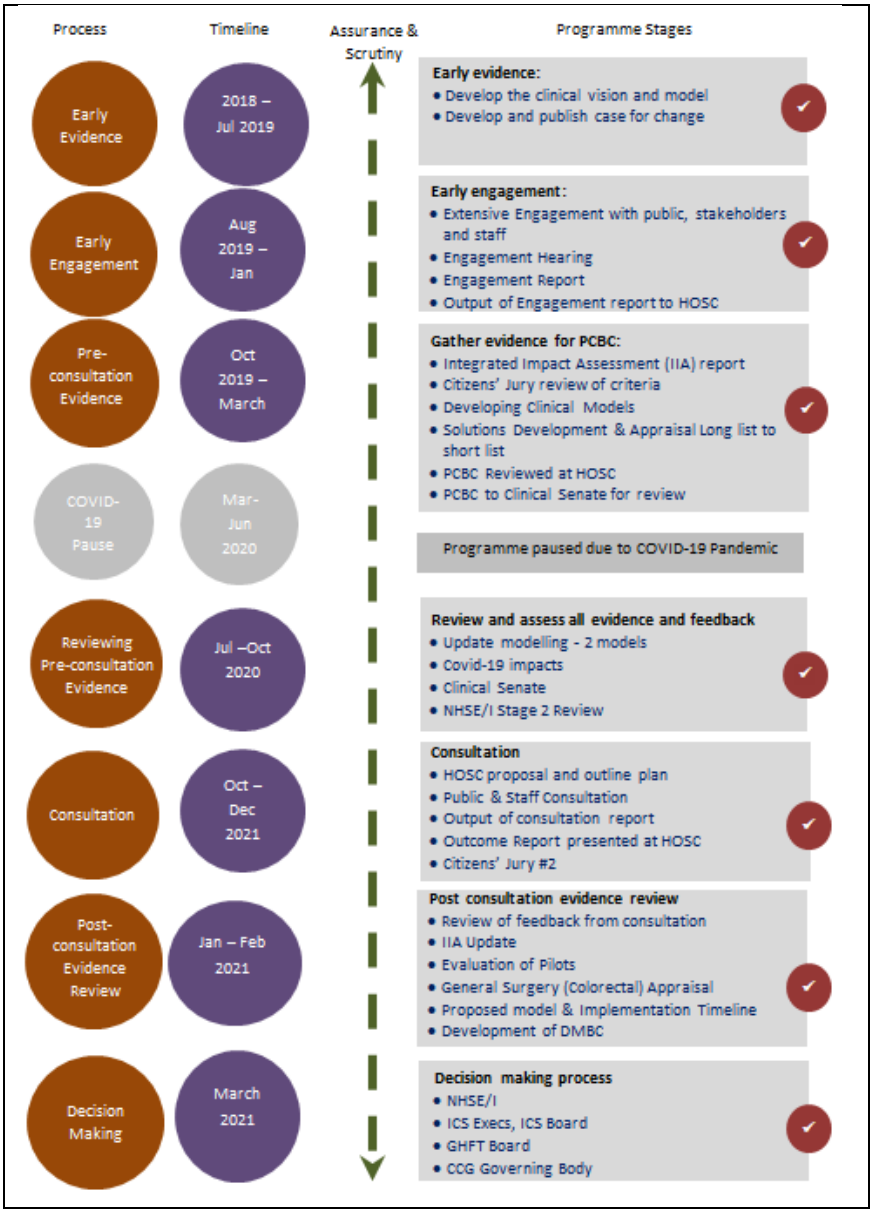
- Maximise ownership and the pace of transformation and associated developments.
- Maximise the value gained from the Gloucestershire NHS and social care pound.
- Reduce areas of service duplication.
- Minimise transactional costs.

[27] As of Feb 2021 there are ongoing discussions at national and regional level regarding the next steps in the development of ICSs

7.2 Internal assurance

The Fit for the Future Programme is overseen by the Gloucestershire ICS, and is embedded into both system and individual organisational governance structures. Regular reports are taken to the ICS Board and ICS Executives, and also to CCG Governing Body, GHNHSFT and GHCFT Trust Boards, as well as system and Board sub-committees.

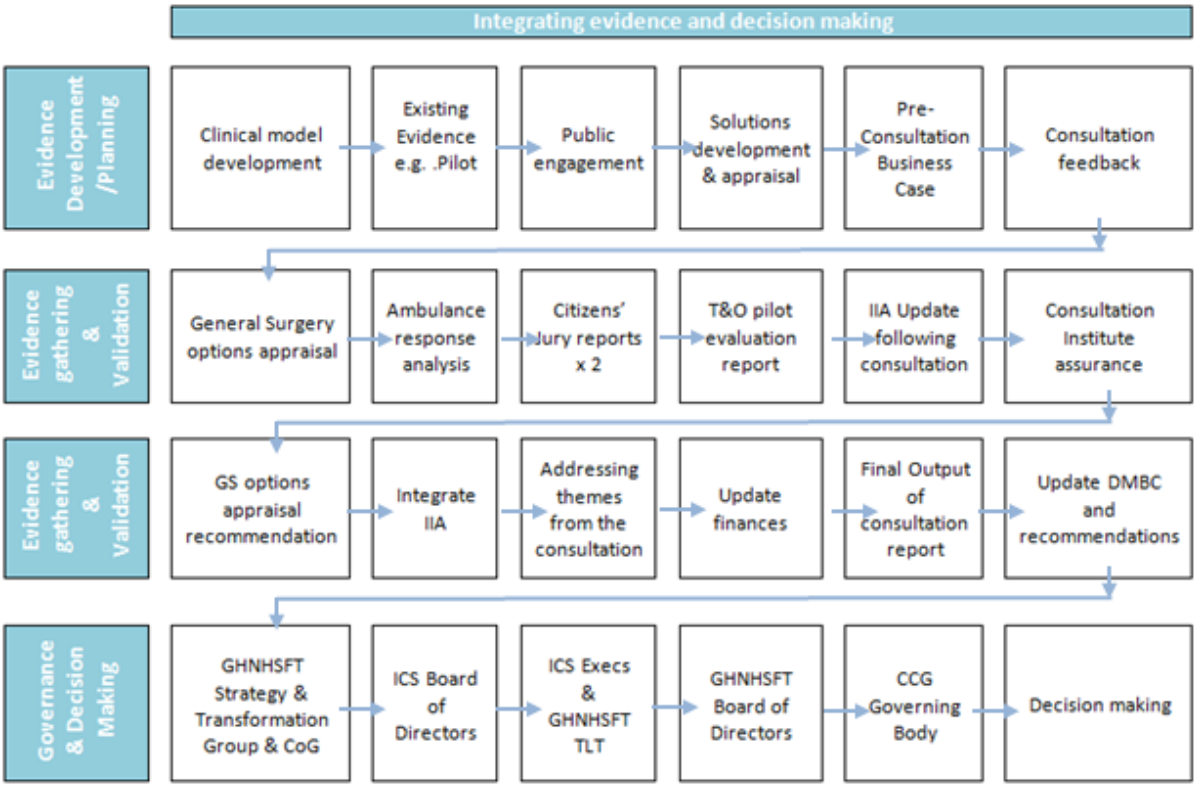
The programme management arrangements are overseen through the Fit for the Future Programme Development Group (PDG), including oversight of the Programme Director, the Programme Managers Group, FFTF Communications and Engagement and activity and financial modelling. Investment is provided by the system to ensure that there are central programme resources in place to ensure delivery of programme objectives.



This DMBC is the result of over two years of evidence development, assurance and review of proposals to deliver a solution that addresses our case for change and delivers our clinical model.

7.2.1 *Process for decision-making*

The consultation proposals were approved as part of the Pre-Consultation Business Case by the ICS, GHNHSFT Board and GCCG Governing Body in October 2020. As detailed in section 2.4.4.3 the consultation feedback and findings, as well as additional information, have been reviewed and discussed by the ICS, GHNHSFT and the CCG. The process of evidence gathering, validation and decision-making is provided below:



As set out in the national guidance on service change in the NHS[28] the CCG's statutory responsibilities includes their duty to lead engagement and consultation on any planned service change in their local systems. In this case Gloucestershire CCG leads engagement and consultation on behalf of the One Gloucestershire Integrated Care System (ICS). The CCG is the decision-making body with regards to any decision to move to consultation on any particular topic, the decision to consult is confirmed in partnership with the Health Overview and Scrutiny Committee of the County Council (HOSC).

The decision-makers in this regard will be the Board of Gloucestershire Hospitals NHS Foundation Trust and the Governing Body of NHS Gloucestershire Clinical Commissioning Group. Independent assurance of the proposals is provided by our regulator NHS England & Improvement, who will ensure that our proposals can be safely and appropriately implemented within available resources.

The timescales for DMBC approval are as follows:

- ICS Executives 04/03/21
- GHNHSFT Board 11/03/21(in public)
- CCG Governing Body 11/03/21 (in public)

[28] https://www.england.nhs.uk/publication/planning-assuring-and-delivering-service-change-for-patients

7.2.2 *Impact of consultation feedback on decision-making*

Within section 4, each theme / issue or alternative identified in section 3 is addressed with an explanation or clarification, and either a description of ongoing or planned action or why alternatives have been discounted. The PCBC had considered the vast majority of the themes/ issues raised during consultation.

Although there is only a single instance where consultation feedback and new evidence has a material impact on a consultation proposal (Planned General Surgery), and therefore on decision making, there are a number of issues identified for consideration/action as part of either ongoing service improvement or FFTF implementation.

Details of the recommendations can be found in section 8 and the implementation plans in section 9.

7.3 External assurance

7.3.1 *NHSE&I*

NHS England and Improvement (NHSE&I) conduct system-level approval on all business cases that need to go to consultation and have been involved in the Fit for the Future Programme from the outset (details are available in the PCBC). The Stage 2 assurance checkpoint took place on 03/09/20, and was confirmed in respect of the "5 tests" in advance of our public consultation (see Appendix 9). We continue to be in regular contact with NHSE&I and had DMBC checkpoint meetings on 24/02/21 and 02/03/21.

As part of the Stage 2 process there were a number of subject areas within the DMBC that required further clarification in the DMBC. These are described below.

Bed capacity during implementation

Full details including the phasing of bed requirements throughout the implementation are provided in section 9.5

Clinical workforce recruitment

The details of the staff requirement (Full Time Equivalents) to deliver the consultation options are provided in the PCBC and for a programme of this scale are relatively small as the majority of the changes are due to centralisation of services; staff can be redeployed and there are consolidation efficiencies. The (net) change in clinical workforce for the consultation proposals is described in the table below:

Role	FTE
Registered Nurse	+10.60
Non Registered Nurse	-3.76
Medical staff	+3.72
Total	**+10.56**

Details of the implementation phasing of the consultation options is presented in section 9, with the impact on recruitment being to benefit from consolidation efficiencies at the start and with the recruitment in the latter stages. This provides time for a planned, phased approach to recruitment to be applied; with identified sources of pipeline and any marketing/advertising identified and planned. Identified pipeline/sources in terms of workforce supply include: redeployment of existing staff (ensuring we support and equip those identified staff to undertake any such move); external recruitment via a dedicated recruitment campaign; international recruitment; and recruitment advertising sources

include various forms of social media, professional publication and journals, national and local press, trust intranet and NHS jobs.

In section 2.5 we describe the reasoning behind our proposals (the Case for Change) where the splitting of resources across two hospital sites contributes to quality, workforce, financial and performance issues which affect patient outcomes and staff recruitment and retention. We are already seeing the benefit of being able to communicate our clinical strategy and ambition as part of the FFTF programme, and have seen an increase in application rate for key clinical roles at GHNHSFT, particularly at consultant level.

Finally, in addition to the above, our proposed deteriorating patient model consists of expanding the Acute Care Response Team (ACRT) to 24/7 on both sites. The (net) change in clinical workforce is described in the table below:

Role	FTE
Registered Nurse	+6.8
Non Registered Nurse	+0.9
Medical staff	-5.6
Total	**+2.1**

Analysis and response to the public consultation

This DMBC, in conjunction with the Final Output of Consultation report (Appendix 1), provides the feedback and analysis from the consultation (section 3), and our responses to this is provided in section 4.

Clinical consensus on the chosen Colorectal Surgical Service Model

The outcome of the General Surgery options appraisal is provided in section 4.2.3 and the recommendation (section 8) is that further work should begin with the General Surgery team to define a new option that includes the best elements from the two options presented and, notably, the opportunity to deliver even more planned elective surgery from the Cheltenham Hospital site. The additional work undertaken since the clinical review panel has identified significant areas of consensus (relating to over 90% of the patient activity), and this will be built on in the coming months as the detail of the new option are developed and finalised. This can be tested at the clinical review panel.

7.3.2 *South West Clinical Senate*

Details of the South West Clinical Senate Clinical Review Panel (including the full report) can be found in the PCBC. The FFTF Programme has continued to engage with the Clinical Senate, including request for participation in the General Surgery options appraisal and agreement to review the T&O Evaluation report. As noted in section 4.2.3, proposed changes to the location of planned Upper GI services are due to be subject to further public and staff involvement, and would include further clinical review by the South West Clinical Senate.

7.4 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
- Consultations documentation and feedback

The current DPIA is presented in Appendix 10 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 Fit for the Future Programme is overseen by the Gloucestershire ICS and is embedded into both system and individual organisational governance structures**
- **The concept of *Centres of Excellence* is consistent with the strategic context of the ICS.**
- **NHSE&I have assured these proposals and confirmed the "5 tests" have been met.**
- **This DMBC is the result of over two years of evidence development, assurance and review of proposals to deliver a solution that addresses our case for change and delivers our clinical model**
- **There is only a single instance where consultation feedback and new evidence has a material impact on a consultation proposal (Planned General Surgery) and therefore on decision making**
- **There are a number of issues identified for consideration/action as part of either ongoing service improvement or FFTF implementation.**

8 Recommendations

The Programme has reviewed the feedback from consultation and the additional evidence developed as part of this DMBC. This has shown that there is clear public support for our case for change, and how public feedback has been taken into account to shape our proposals going forward. For two of our consultation proposals we recommend that additional work be carried to further enhance the benefits of our clinical model.

As an ICS we believe these proposals will deliver robust improvements against the issues set out in our case for change, and will improve health outcomes for our local population across a range of measures.

We recognise that there will be significant work to implement our proposals (see section 9), which will include areas identified through consultation as well as the IIA recommendations.

8.1 Resolutions to be agreed

It is the Programme's recommendation to the Board of the Gloucestershire Integrated Care System (ICS), the Board of Gloucestershire Hospitals NHS Foundation Trust (GHNHSFT) and the Governing Body of Gloucestershire Clinical Commissioning Group (CCG) that the following resolutions should be considered for agreement and approval, taking into account all the evidence that has been made available, on the basis that they represent the best solution to address the case for change.

- **Resolution #1**: Formalise 'pilot' configuration for Gastroenterology inpatient services at CGH, to make this a permanent change
- **Resolution #2**: Formalise 'pilot' configuration for Trauma at GRH and Orthopaedics at CGH, to make this a permanent change
- **Resolution #3**: Centralise Emergency General Surgery at GRH
- **Resolution #4**: Develop an Image Guided Interventional Surgery (IGIS) 'Hub' at GRH and a 'Spoke' at CGH
- **Resolution #5**: Centralise Vascular Surgery at GRH
- **Resolution #6**: Centralise Acute Medicine (Acute Medical Take) at GRH

- **Resolution #7**: Planned General Surgery. The recommendation is that work should continue to develop the option that would deliver:
    - Planned High-Risk Upper Gastrointestinal (GI) and Lower Gastrointestinal (Colorectal) surgery at GRH
    - Planned complex and routine inpatient and day case surgery in both Upper and Lower GI (Colorectal) at CGH

*High-risk to be defined by General Surgery team as part of further work.

9 Implementation

9.1 Introduction

Our *Fit for the Future Programme,* which incorporates *Centres of Excellence,* is a large scale, long-term change programme which will be delivered over a number of years. This DMBC contains our Phase 1 'sentinel' models before we widen the scope of our clinical model development, and the three FFTF phases (as described in the PCBC) will not necessarily be implemented sequentially. Furthermore, the implementation of the recommendations will be completed in stages over the next two years.

The proposed service changes are to deliver our case for change over the medium- to long-term, and we have therefore, in agreement with the Regulator, excluded the impact of the recent COVID-19 pandemic from our baseline data, staffing models, resource requirements (beds, DCC, theatres etc.) and finances, as this would have had the result of significantly understating usual activity levels for emergency and planned care services. As described in section 4.1 we believe that these are the right proposals for development of our hospitals services whether or not COVID-19 is circulating at high or low levels.

That being said, the context for our proposals has changed as a result of the pandemic and this was made visible within our PCBC and was central to our "socially-distanced" consultation. Whilst we have the benefit of lessons learned from the COVID-19 temporary changes and opportunities to test some service improvements, it has to be recognised that the medium-term impact of the pandemic on service demand, operational processes and resource utilisation (e.g. socially distanced beds on wards and theatre throughput) has yet to be fully established at the time of writing, but, given the long-term nature of the FFTF programme, we are confident that it can be developed during implementation to ensure safe and sustainable delivery. We are of the view that the suppression of demand seen during the pandemic is unlikely to be sustained over the longer term, and that our assumption of activity returning to 'normal' levels is the appropriate one to base our future models on.

Details of our phased implementation are provided in section 9.5.2, but they are summarised below:

- **Stage 1 - Implemented following decision-making**: these are services that are currently already in place, such as the Trauma and Orthopaedics and Gastroenterology pilots (Resolutions #1 & #2) and Emergency General Surgery (Resolution #3).
- **Stage 2 - Implemented following additional activities**: these are the planned General Surgery services (Resolution #7), where further work (including public engagement and external approval) will be required prior to implementation.
- **Stage 3 - 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. (Resolutions #4, #5, #6 & #7).

Given the scale, complexity and extended timescales of the FFTF programme, this DMBC is not a final implementation plan for all the service change recommendations, but a decision to proceed will cement the strategic direction for these services to allow resources (internally and externally) to be made available to enact the proposed changes in full. Prior to the completion of the public consultation and the final decision-making process, the FFTF programme has been mindful of the need to avoid pre-determination such that some implementation details remain to be confirmed.

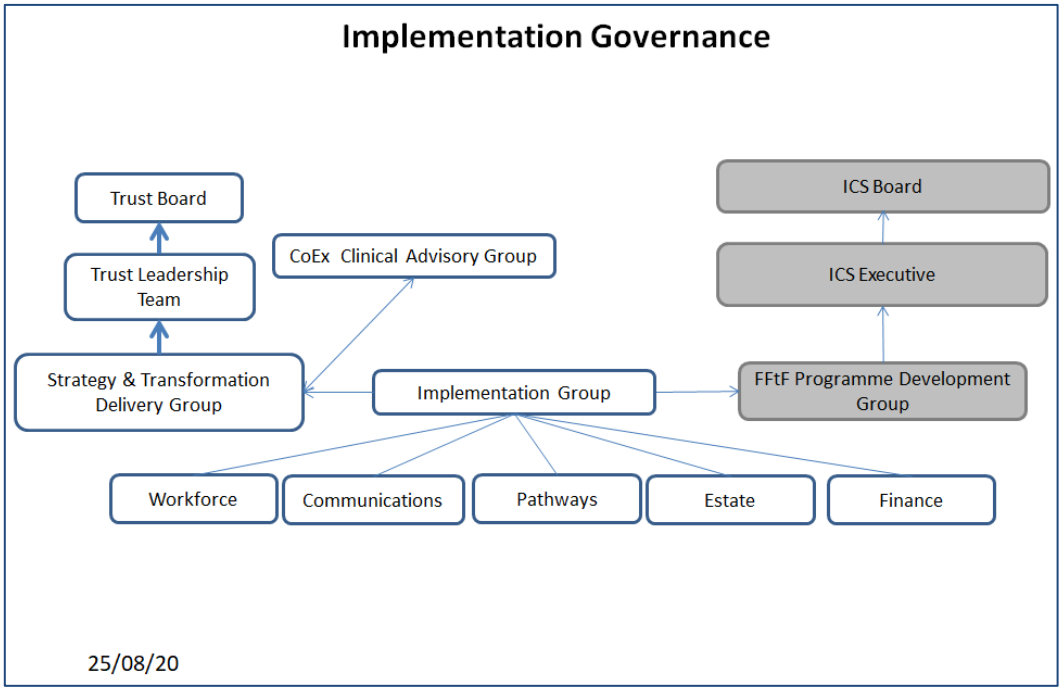
9.2 Governance arrangements for implementation

Formal governance arrangements are required to steer and govern the process of service reconfiguration and development of the FFTF programme; to deliver this we will have a dedicated FFTF Implementation Group that is embedded within existing ICS structures. This will:

- Meet monthly to provide direction, ensure effective co-ordination, resolve issues and manage risks and interdependencies;
- Include representation from GHNHSFT, Gloucestershire CCG, service users and their representatives, and other key stakeholders and leads for each of the workstreams;
- Appoint a senior responsible officer to take on overall accountability for the implementation relating to service changes. They will be responsible for ensuring effective working relationships with the wider sector in planning and implementing changes.
- Agree and monitor performance metrics to track and manage progress against key milestones.
- Align to enabling and other key programmes, for example GHNHSFT Strategic Site Development (SSD) Programme, procurement and installation of new equipment.

A number of workstreams will be established (as presented below) to lead on both the planning and development required to support 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.



9.2.1 *Clinical workstreams*

It is envisaged that there will be a number of clinical workstreams, based on the recommendations, but we recognise the interdependencies between them, and will design our structures to avoid silo working. These will be finalised when the detailed implementation plan is completed.

Each Workstream will be responsible for planning the service transformation and reconfiguration programme, and will report to the Implementation Group. These workstreams will focus on:

- Finalisation of clinical pathways e.g.
    - Development of direct admission pathways, particularly to CGH, and protocols with system partners;
    - Development of enhanced same day emergency care pathways and capacity in CGH;
    - Other 'patient flow' work to support reduced bed occupancy.
- How service reconfiguration will be phased, where will there be dual running and when transition and implementation would occur;
- Management structures, workforce considerations and governance including policies and protocols.
- Full implementation of the 'deteriorating patient' model

9.2.2 *Non-clinical workstreams*

There will be a number of non-clinical workstreams to support the clinical workstreams in implementing the finalised service model and will include (but not limited to):

- Workforce – recruitment and training to support new models of care;
- Estates ensuring direct links to GHNHSFTs estates strategy;
- Equipment;
- Communication and stakeholder engagement; and,
- Finance.

9.3 Monitoring the realisation of benefits

Details of the benefits are provided in Appendix 5, and will be further developed as part of the implementation programme; a summary is provided below:

	Benefit
Improved patient outcomes	• Better access to emergency theatre • Greater capacity to cope with higher levels of demand. • Increased number of ED attendances managed by SDEC • Reduced time to 'be seen' by a gastroenterologist • Reduction in length of stay. • Improved senior surgical review • Reduction in Trauma admissions • Reduction in surgical cancellations.

	Benefit
Improved patient experience	• Improved access to sub specialty treatment and equity of care • To implement ERAS • Reduction in cancellations due to bed pressures. • Consistent provision of consultant review within 14 hours of arrival • Improved patient pathway and patient experience • Improved access • Reduction in patient travel • Reduction in inter-site transfers • Improved robustness of OOH service • Improved rates of mortality and morbidity • Improved access to renal ward • Greater capacity to cope with higher levels of demand. • Achieve the 6-week wait diagnostic target. • Improvement of patient experience. • Improved access to sub-specialty treatment • The provision of a protected dedicated Elective Unit
Improved staff experience	• Improvement in staffing workload • Daily Ward/Board Round for Trauma patients • Improved access to specialist Trauma and Orthopaedic clinicians for advice • Greater capacity to cope with higher levels of demand • Decrease in the number of violence and aggression incidents • Improved access to adjacent specialty advice • Workforce deployment efficiencies • Reduction in expired IR inventory • Earlier access to 'in reach' advice from other specialties • Standardisation of pathways
Improved staff recruitment and retention	• Improvement in trainee environment • Workforce benefits • Enhanced staff training and support • Improved recruitment and retention • Improved Junior Doctor training • Workforce benefits
Improved efficiency and effectiveness (cash releasing and growth avoidance/non-cash releasing)	• Improved senior surgical review • The provision of a protected dedicated Surgical Unit • Reduce the admission rate. • Reduction in length of stay • Workforce efficiencies • Increased revenue • Reduction in spend by no longer outsourcing private services. • Standardisation of Theatre Equipment • Achieve compliance with Regulatory Bodies. • More responsive to GP requests • Increase Efficiency

The FFTF Implementation Group will be responsible for monitoring delivery of benefits and will work closely with GHNHSFT clinical divisions and the SSD Programme. To ensure benefits are not double-counted the FFTF Programme has compared these with other improvement programmes, for example the SSD benefits realisation plans, which is presented below:

			Of which already within GSSD		New / Unclaimed benefits	
	Cash-Releasing Benefit	Growth avoidance/ Non Cash-Releasing Benefits	Cash-Releasing Benefit	Growth avoidance/ Non Cash-Releasing Benefits	Cash-Releasing Benefit	Growth avoidance/ Non Cash-Releasing Benefits
Emergency and Acute Medicine	£793,886	£3,134,353	£793,886	£2,990,210	£0	£144,143
Emergency General Surgery	£0	£314,382	£0	£0	£0	£314,382
Elective Colorectal Inpatient Surgery	£0	£93,054	£0	£49,800	£0	£43,254
General Surgery Day Cases	£150,000	£173,477	£150,000	£0	£0	£173,477
IGIS	£27,000	£142,147	£0	£0	£27,000	£142,147
Total	**£970,886**	**£3,857,414**	**£943,886**	**£3,040,010**	**£27,000**	**£817,404**

9.3.1 *When will benefits be realised?*

The phasing of the benefits is correlated with the implementation stages and included in the financial analysis (section 6).

9.4 Workforce

The details of the staff requirement (Full Time Equivalents) to deliver the consultation options are provided in the PCBC and for a programme of this scale are relatively small, as the majority of the changes are due to centralisation of services; staff can be redeployed and there are consolidation efficiencies.

Details of the implementation phasing of the consultation options is presented in section 9, with the impact on recruitment being a benefit from consolidation efficiencies at the start, and with the recruitment in the latter stages. This provides time for a planned phased approach to recruitment to be applied. As requested by NHSE&I a summary of clinical workforce requirements and recruitment plans are presented in section 7.3.1.

9.5 Beds, Theatres and Dept. of Critical Care (DCC)[29]

9.5.1 *Beds*

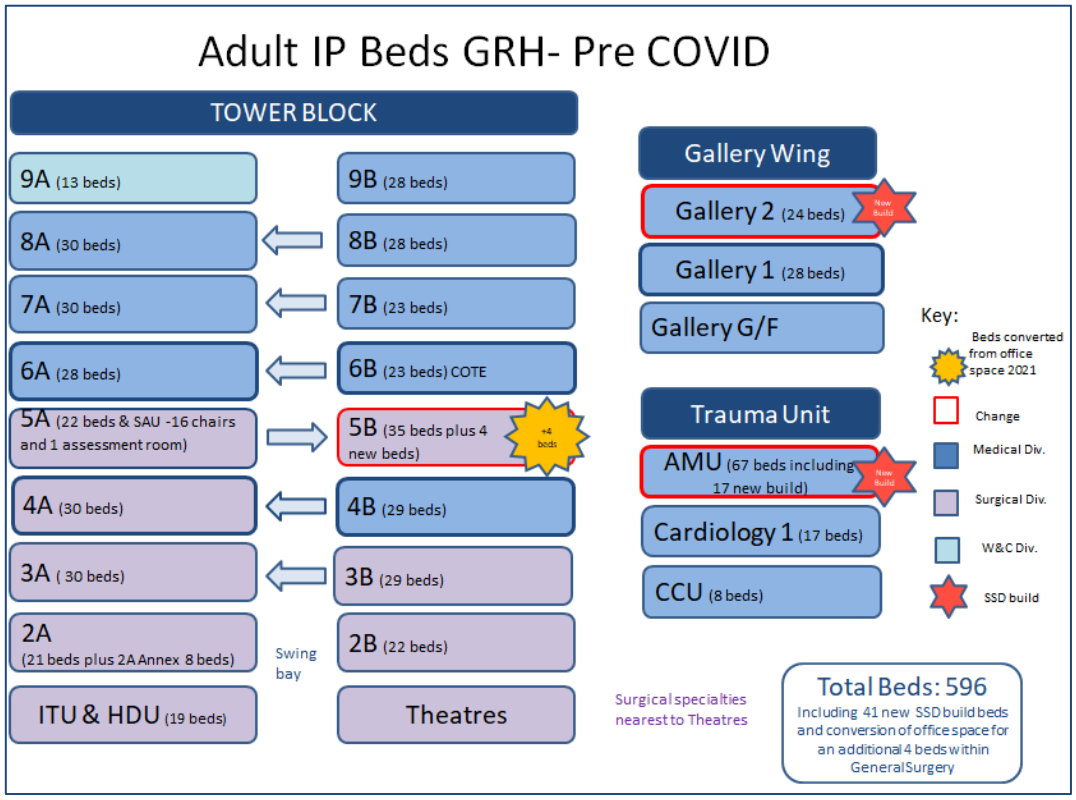
As highlighted in the introduction to this section, in agreement with the Regulator, our activity and resource baseline (Feb 2019-Jan 2020) was deliberately selected to exclude the impact of COVID-19 from our data, and therefore all our analysis and resource modelling does not include the current COVID-19 temporary changes, future pandemic impact on suppression of usual service demand or current COVID-19 infection control protocols e.g. socially distanced beds on wards; currently GHNHSFT have reduced bed number by ~ 160.

Given the multi-factorial nature of COVID-19 effects and uncertainty as to their impacts, the only reasonable option is to exclude it, and therefore the bed number analysis presented below reflects a pre-COVID point in time, and the impact of our recommendations is calculated using pre-COVID demand. If these proposals are approved and the programme shifts to implementation over the next two years, decisions will take account of the position at the time and the developing pandemic recovery paradigm, including defining the new baseline number of inpatient and critical care beds that will include any requirement to maintain infection control measures.

[29] GHNHSFTs Critical Care service is known as Dept. of Critical Care (DCC)

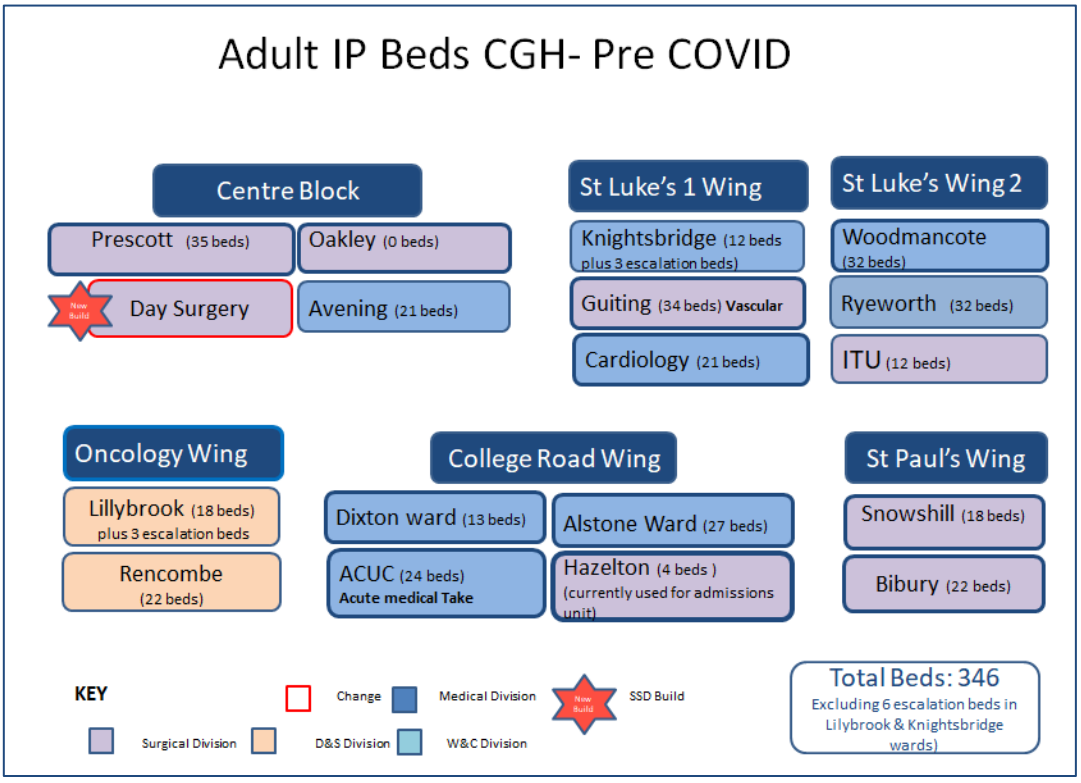
Adult in-patient beds at GRH

The diagram below illustrates the total adult in-patient beds at GRH, the ward locations and configurations and the additional beds (41) delivered by the SSD programme.



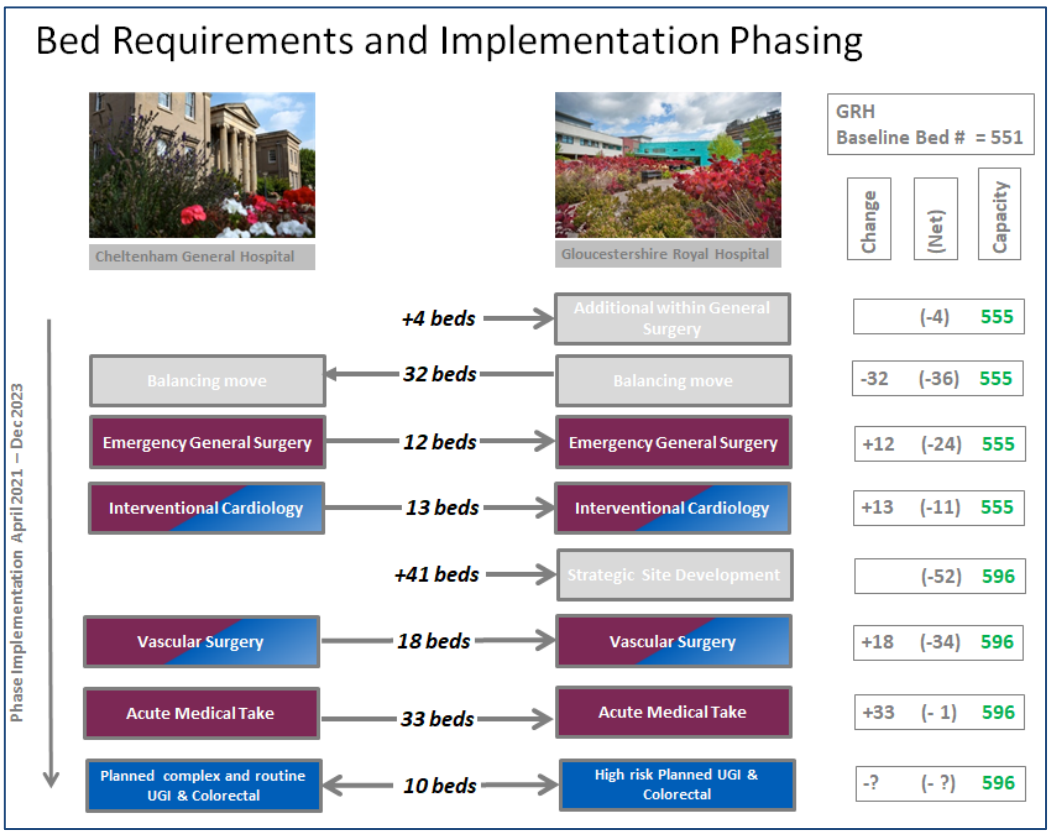
Adult in-patient beds at CGH

The diagram below illustrates the total adult in-patient beds at CGH, the ward locations and configurations and the day surgery unit delivered by the SSD programme.



Impact of recommendations at GRH

The diagram below sets out the requirements for each of the service recommendations and the overall impact on bed capacity at GRH.



Key

	Description	Beds
GS Beds	As part of COVID temporary centralisation of EGS to GRH additional beds	4
Balancing Move	There are number of options being considered for service moves to CGH e.g. an acute stroke pilot to test if the improvements to SSNAP[30] metrics are correlated with the COVID temporary re-location to CGH; enhancements to the frailty service offer at CGH.	32
Emergency General Surgery	The modelled bed requirement= 22 beds. Centralisation has delivered LOS reductions ~ 4 beds. As part of COVID temporary centralisation of EGS, beds in a section of the ward were converted from recliner chairs to provide SAU (#6).	12
Interventional Cardiology	Once the Catheter-lab work is completed and new equipment at GRH in Sept 21 Interventional Cardiology can move to GRH	13
Strategic Site Development	Additional capacity Acute Medical Unit (17 beds), separate Acute Medical Initial Assessment (AMIA) and Gallery Ward (24 beds)	41
Vascular Surgery	Relocation following enabling programmes – SDDP, equipment etc.	18
Acute Medical Take	Relocation following completion of enabling programs. Ongoing work to increase patients seen at CGH includes development of direct admission pathways and protocols; development of enhanced same day emergency care pathways and capacity in CGH; and the required DCC capacity	33
Planned General Surgery	Modelled bed requirement for UGI & LGI = 10 beds. Ongoing work to develop a new model will determine the allocation of beds for high risk patients at GRH. Likelihood is that highest proportion of beds will be at CGH	0-10

[30] Sentinel Stroke National Audit Programme

It should be noted that any proposed changes to the location of planned Upper GI services would be subject to further public and staff involvement. Similarly, any proposals for permanent reconfigurations from Phase 2 that would enable delivery of a balanced beds and operating model would be subject to further public engagement and consultation.

9.5.2 *Theatres*

There is increased emergency and planned theatre capacity required for the proposed recommendations.

At GRH there is an emergency theatre that runs 24/7 for all surgical specialties, so, with EGS at GRH, more emergency theatre requirement is required to provide a second list Mon-Fri from 08.00 to 18.00. This will require theatre nursing staff and anaesthetic staff and is included in our workforce and financial modelling.

When Vascular is relocated to GRH, further emergency theatre capacity would be required. The plan is to use some of the previous CGH emergency list to extend the second emergency list to 08.00 to 20.00 M-F, but additional staff are required to run the second list at GRH on a Saturday and Sunday 08.00-20.00 (is included in our workforce and financial modelling).

The original CGH emergency list is for a half-day list every day and an on-call team at night. The half-day emergency list will be reallocated to provide extended lists for urology to undertake their urgent work and to accommodate vascular emergencies at GRH. The on-call team will be retained at CGH for other emergency out-of-hours surgery at CGH. There is no capital requirement as GHNHSFT has sufficient Theatre capacity e.g. Theatre 2 is available at GRH.

In addition, more day cases from the remaining elective work at GRH have been transferred to Cirencester Hospital to create more theatre space within GRH theatres for Trauma patients.

Investment in the theatres at GRH will provide an environment at least comparable to that already in Cheltenham. We would convert existing theatre facilities at GRH to a full Hybrid IR-Theatre facility, ensuring there is no reduction in the quality of the facilities provided to allow complex endovascular procedures to be undertaken.

There is a further plan to utilise one of the new day surgery theatres at CGH that are to be developed as part of the SSD Programme for Orthopaedics. This will enable the service to further reorganise elective lists and create theatre space at GRH for additional Trauma surgery.

As part of the SSD investment CGH will benefit from better day case surgery facilities with the development of two additional theatres and a Day Surgery Unit.

9.5.3 *Dept. of Critical Care (DCC)*

DCC capacity modelling has been completed and work to date indicates an additional expected requirement for DCC beds on the GRH site in the range of 3 critical care beds aligned to the centralisation of the Acute Take (in Q3 2022/23). The modelling is based on the following assumptions:

- Based on data from 2016 – 2018 so assumes no change in delayed discharges
- Based on average 70% Critical Care bed occupancy rates
- All patients from the planned care speciality transferring to CGH will move to CGH Critical Care with the exception of those acutely admitted directly from GRH Emergency Department or Acute Medical Unit
- All patients repatriated from other providers will go to Critical Care at CGH.

As noted earlier, the medium-term impact of COVID-19 on service demand and efficiency is yet to be fully defined, but lessons from the pandemic have included that there may be requirement to factor in a cohort of ongoing circulating background COVID with a cohort of patients who may require additional DCC capacity. The intended solution is to build more DCC beds in Gloucester, with the appropriate number of side rooms, funded through the national programme to increase ITU capacity; GHNHSFT have already undertaken a feasibility study. The implementation timeline for acute medical take does provide time to assess the model assumptions and the legacy of COVID-19, and identify and deliver in full the modelled requirement for new DCC provision. 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.

9.6 Implementation risks

The implementation programme will use a risk management framework aligned to the corporate risk management protocols and recorded on a programme risk register. The risks associated with implementation predominantly relate to the identification of location for services displaced by Catheter Lab development at GRH, options considered for service moves to CGH to facilitate full implementation of FFTF phase 1 (~ 32 beds) and DCC capacity.

9.7 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 two years (on the basis that resolutions are approved in March 2021).

9.7.1 *Stage 1 - Implemented following decision making*

The first group of recommendations will be the formalisation of 'Pilot' configurations where no further actions are required prior to implementation; these are:

- **Resolution #1**: Gastroenterology inpatient services at CGH from 01/04/2021.
- **Resolution #2**: Trauma at GRH and Orthopaedics at CGH from 01/04/2021.

As detailed in section 9.2.1, as with all clinical services, there are ongoing service improvement activities which will continue post-implementation.

The next recommendation to be implemented is **Resolution #3**: Centralise Emergency General Surgery at GRH, which is currently a Coronavirus (COVID-19) temporary service change (see section 2.5.2) and is already centralised on the GRH site, and it will therefore be formalised as a permanent service change from 1st April 2021.

9.7.2 *Stage 2 - Implemented following additional activities*

As described in section 4.5.2 and recommended in section 8, the proposal for all planned General Surgery (**Resolution #7**) is that further work should begin to develop a new option to deliver:

- Planned High Risk Upper Gastrointestinal (GI) and Lower Gastrointestinal (Colorectal) surgery at GRH
- Planned complex and routine inpatient and day case surgery in both Upper and Lower GI (Colorectal) at CGH

The work will begin following decision-making, is expected to last up to six months and will be dependent on the scale of public engagement required once the clinical model has been

defined. The additional work will include modelling of theatre and bed requirements across both sites and any other dependencies for implementation. Until such time as the clinical model development is complete, we have assumed implementation will be linked to SSD (2022/23). Furthermore, the 'Deteriorating Patient' model (24/7 ITU consultation & ACRT) will be fully established from December 2022.

Whilst the new clinical model will be subject to Clinical Senate and NHSE&I approval, some elements e.g. planed day cases centralised to CGH, have already been externally assured and through public consultation, so could be implemented earlier as theatre capacity allows.

9.7.3 *Stage 3 - Implemented following completion of enabling workstreams*

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, for example expansion of the Trust's Acute Care Response Team (ACRT);
- Procurement and installation of new equipment – new Cardiac Cath Labs, additional Interventional Radiology equipment; and,
- Clinical Pathways design – to support direct admit pathways for example.

The 'IGIS hub' is enabled by capital investment as part of the phased implementation of the Trust Estates Strategy. Full implementation of the IGIS and vascular proposals require us to locate the cardiac catheter labs, establish an additional Interventional Radiology (IR) labs and the vascular hybrid theatre facility at the main hub in GRH.

On the basis that resolutions are approved in March 2021, our implementation plan includes:

- Catheter-Lab Pre-enabling: Jan 2021 to Jun 2021
- Catheter-Lab relocation (IGIS Phase 1): Apr 2021 to Oct 2021
- Additional IR Lab (IGIS Phase 2): Oct 2021 to Apr 2022
- Hybrid theatre at GRH (IGIS Phase 3): Apr 2022 to Oct 2022
- IGIS 24/7 Hub enabling works and displacements: Apr 2021 to May 2022

In term of making changes to the Trust estate, independent to the Fit for the Future programme and subject to a completely separate internal and external NHS England & Improvement and Department of Health and Social Care assurance process, GHNHSFT has obtained full planning approval as part of plans to transform CGH and GRH as part of a £40m investment. Under the plans CGH will benefit from better day case surgery facilities with the development of two additional theatres and a Day Surgery Unit.

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. This investment will help to relieve crowding ED during busy periods which is something both patients and staff have flagged as a priority. As part of this programme the bed capacity at GRH will be increased.

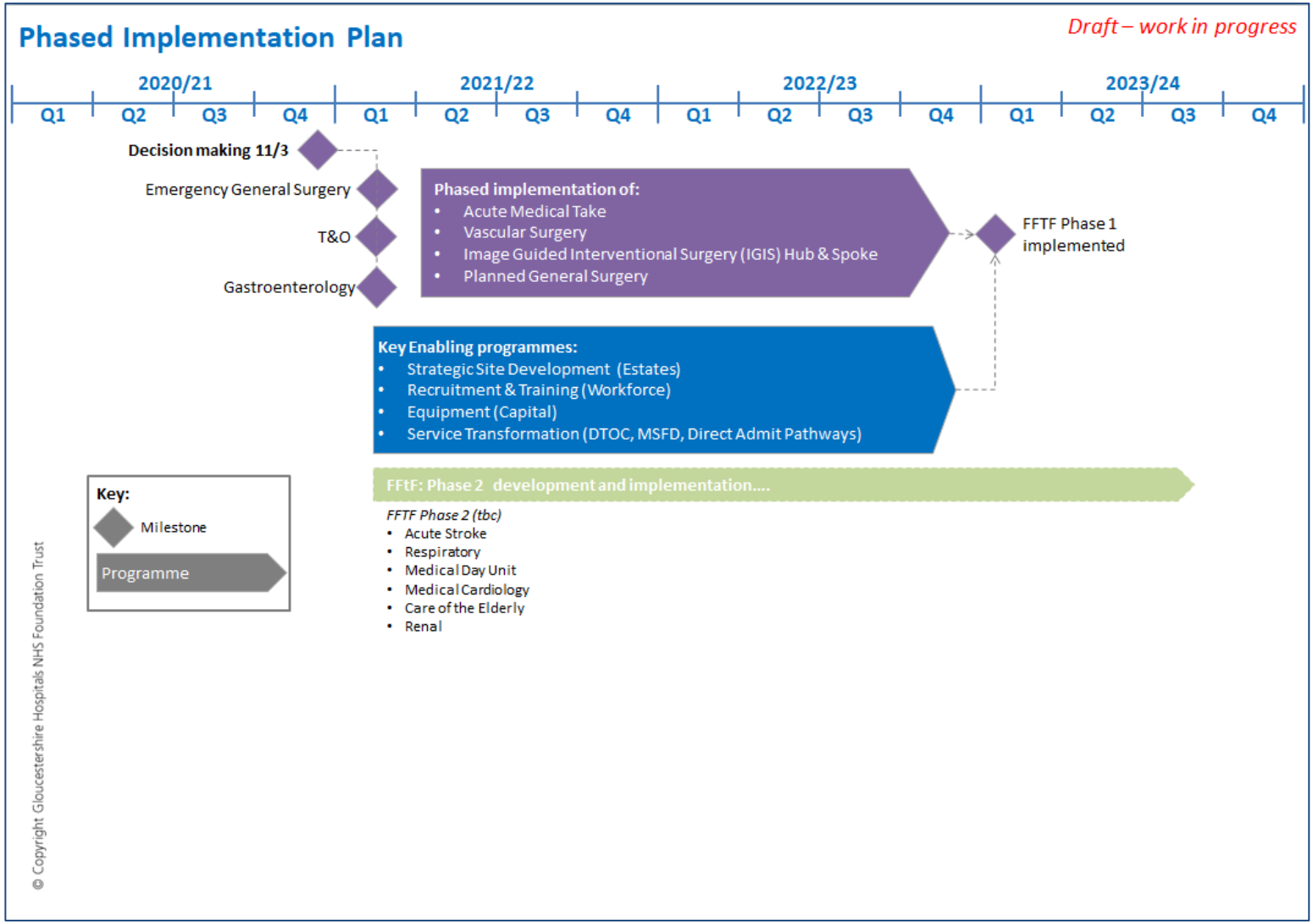
The final business case is now navigating through the various NHSE/I and DHSC checkpoints with construction work due to commence during the summer of 2021 with beds/wards being available from Oct 2022/23, theatres Jan 2023 and ED Apr 2023. On the basis of these

delivery timescales our recommendations for the following will be implemented in a phased approach from decision-making through to 2022/23:

- **Resolution #4**: An Image Guided Interventional Surgery (IGIS) 'Hub' at GRH and a 'Spoke' at CGH
- **Resolution #5**: Centralise Vascular Surgery at GRH
- **Resolution #6**: Centralise Acute Medicine (Acute Medical Take) at GRH
- **Resolution #7**: Planned General Surgery

9.7.4 *Implementation timetable*

A Gantt chart outlining the implementation described above can be found overleaf.


Phased Implementation Plan
Draft – work in progress
2020/21
2021/22
2022/23
2023/24
Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4
Decision making 11/3
Emergency General Surgery
T&O
Gastroenterology
Phased implementation of:
• Acute Medical Take
• Vascular Surgery
• Image Guided Interventional Surgery (IGIS) Hub & Spoke
• Planned General Surgery
FFTF Phase 1 implemented
Key Enabling programmes:
• Strategic Site Development (Estates)
• Recruitment & Training (Workforce)
• Equipment (Capital)
• Service Transformation (DTOC, MSFD, Direct Admit Pathways)
Key:
Milestone
Programme
FFtF: Phase 2 development and implementation....
FFTF Phase 2 (tbc)
• Acute Stroke
• Respiratory
• Medical Day Unit
• Medical Cardiology
• Care of the Elderly
• Renal
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9.8 Communication and engagement plan

One Gloucestershire partners will formally publish the Fit for the Future Decision Making Business Case (DMBC) on 4 March 2021, ahead of the CCG Governing Body meeting on 11 March 2021.

The aim of the communications and engagement plan (Appendix 11) 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.

Key Points

- **The proposed service changes are to deliver our case for change over the medium-to long-term**
- **Our phased implementation will be in three stages**
- **The FFTF Implementation Group will be responsible for monitoring delivery of benefits**
- **Our plans detail the bed requirements and phasing**
- **Our implementation timetable starts in April 2021 and runs through to 2022/23.**

10 Appendices

Appendix 1: Final Output of Consultation Report See separate document
Appendix 2a: Integrated Impact Assessment Post-Consultation See separate document
Appendix 2b: Annex IIA Post-Consultation See separate document
Appendix 2c: Annex IIA Post-Consultation (Pilots) See separate document
Appendix 3a: Citizens' Jury - Jurors' report See separate document
Appendix 3b: Citizens' Jury - Jury report See separate document
Appendix 4: Public Transport Information See separate document
Appendix 5: Benefits Realisation See separate document
Appendix 6: Discharge documents See separate document
Appendix 7: T&O Pilot Evaluation See separate document
Appendix 8: Planned General Surgery information See separate document
Appendix 9: NHSE&I Stage 2 Assurance letter See separate document
Appendix 10: Data Protection Impact Assessment See separate document
Appendix 11: Communications and Engagement Plan See separate document

Appendix 12: Glossary of Terms and Abbreviations

24/7	Twenty-four hours-a-day, seven days-a-week
A&E	Accident and Emergency department (also known as Emergency Department (ED)).
ACRT	Acute Care Response Team
Case for Change	The case for change is the document that sets out why things need to change within local health and care services to make sure they are fit for the future.
Centres of Excellence (CoEx)	The development of the two main hospital sites. Part of the Fit for the Future Programme
CEPOD	A permanently staffed operating theatre that can run on a 24 hour basis
CGH	Cheltenham General Hospital
CINAPSIS	A referral system that makes it easy for clinicians to communicate between healthcare organisations
Citizens' Jury (CJ)	A Citizens' Jury is a small group of selected citizens, representative of the demographics in the area, that come together to reach a collective decision or recommendation through informed deliberation.
Cobalt	Medical imaging centre in Cheltenham
COTE	Care of the Elderly
COVID-19/ Coronavirus	COVID-19 is a new illness that affects lungs and airways. It is caused by a virus called coronavirus.
Deanery	A regional organisation responsible for postgraduate medical and dental training
DCC	Department of Critical Care
Dial-A-Ride	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.
DMBC	Decision-Making Business Case prepared following consultation, to support in making a final decision on service change. It will consider all the responses to the consultation
ELIM	Christian Church in Cheltenham
ED	Emergency Department
EGS	Emergency General Surgery
FAS	Frailty Assessment Service
FFFT	Fit for the Future Programme
Friendship Café	Provides youth & community-based activities in Gloucester and surrounding areas
GCCG/CCG	Gloucestershire Clinical Commissioning Group. 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.
GHC	Gloucestershire Health & Care NHS Foundation Trust - Formed in

	2019 by the merger of 2gether Trust and Gloucestershire Care Services
GHNHSFT/GHFT	Gloucestershire Hospitals NHS Foundation Trust
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	Getting It Right First Time programme is helping to improve the quality of care within the NHS by bringing efficiencies and improvements.
GRH	Gloucestershire Royal Hospital
GWH	Great Western Hospital
Healthwatch Gloucestershire (HWG)	An independent service which exists to speak up for local people on Health and Social Care in Gloucestershire
Health & Social Care Select Committee	A Departmental Select Committee of the British House of Commons
HOSC	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.
Hot and Cold Split	Emergency Care (Hot) and Planned Care (Cold)
ICS	Gloucestershire Integrated Care System Bringing together NHS providers and commissioners and local authorities to work in partnership in improving health and care
IGIS	Image Guided Interventional Surgery
IIA	Integrated Impact Assessment. 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.
Inclusion Gloucestershire	A charity run by disabled people for disabled people
ITU	Intensive Treatment Unit
Know Your Patch (KYP)	Aims to bring organisations together in order to raise awareness of the good work taking place in Gloucester
MIIU	Minor Injury & Illness Unit
Local Transport Plan	The Local Transport Plan (LTP) sets the long-term transport strategy for Gloucestershire up to 2031. It aims to influence how and when people choose to travel so that individual travel decisions do not cumulatively impact on the desirability of Gloucestershire as a place to live, work and invest
NHS Long Term Plan (LTP)	The NHS Long Term Plan sets out priorities for the NHS over the next ten years

NHSE&I	NHS England and NHS Improvement came together on 1 April 2019 as a new, single organisation
Nuffield Trust	An independent health think tank aiming to improve the quality of health care in the UK by providing evidence-based research and policy analysis and informing and generating debate
Operational Research in Health (ORH)	ORH is a management consultancy that uses advanced Operational Research (OR) techniques to support resource planning in the public sector.
One Gloucestershire	The working name given to the partnership between the county's NHS and care organisations to help keep people healthy, support active communities and ensure high quality, joined-up care when needed
Office of National Statistics (ONS)	The UK's largest independent producer of official statistics and the recognised national statistical institute of the UK
PALS	Patient Advisory and Liaison Service
PCBC	Pre-Consultation Business Case. 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.
PPCI/PCI	Primary Percutaneous Coronary Intervention. A coronary angioplasty is a procedure used to widen blocked or narrowed coronary arteries
PPE	Personal Protective Equipment
REACH	The REACH campaign was founded to secure the re-establishment of a full 24/7 Accident and Emergency department at Cheltenham General Hospital. The campaign has expanded to keep a watching brief on the related A&E services
SmartSurvey	Online survey tool that can analyse results graphically
South West Clinical Senate	Established to be a source of independent, strategic advice and guidance to commissioners and other stakeholders
SWASFT	South West Ambulance Service Foundation Trust
The Consultation Institute (tCI)	A UK based not-for-profit organisation specialising in best practice public consultation & stakeholder engagement
TLT	Trust Leadership Team
T&O	Trauma and Orthopaedics
The King's Fund	An English health charity that shapes health and social care policy and practice and provides NHS leadership development
The Health Foundation	An independent charity committed to improving health care for people in the UK