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Model Reference #	G2 & T&O2
Solution Description	Revert to original Gastroenterology and Trauma & Orthopaedics configurations

Quality of care

#	Questions to test	What would be better if reversed? (show how this would be evidenced)	What would be worse if reversed? (show how this would be evidenced)
1.1	What is the likely effect of this solution on patients receiving equal or better outcomes of care?	**Gastroenterology:** Some patients would be admitted more locally.	**Gastroenterology:** The benefits listed in the 'workshop information pack' summary would be lost– with less Consultant time available to provide specialist services including endoscopy. Specialist care would be diluted, impacting on the waiting times for patients and staff morale.
		Trauma & Orthopaedics: Some patients would be admitted more locally.	**Trauma & Orthopaedics:** The benefits including reduced elective cancellations and daily input to trauma patients would be lost.
1.2	What is the likely effect of this solution on patients being treated by the right teams with the right skills and experience in the right place and at the right time?	**Gastroenterology:** Some patients would be admitted more locally. Data shows that just less than one patient a day would not be transferred to CGH.	**Gastroenterology:** Reversing the pilot would reduce the likelihood that patients with Gastroenterology problems would see a specialist, as the specialists would need to spend more time seeing patients with general medical patients. Specialist nursing care would also be diluted.
		Trauma & Orthopaedics: Some patients would be admitted more locally. 767 per year would have trauma surgery at CGH and 481 patients per year would have elective surgery at GRH.	**Trauma & Orthopaedics:** Yes, the benefits listed in the section above would be lost e.g. number of elective cancellations would rise. Trauma patients would wait longer for surgery and the continuity of care would be lost

#	Questions to test	What would be better if reversed? (show how this would be evidenced)	What would be worse if reversed? (show how this would be evidenced)
1.3	What is the likely effect of this solution on continuity of care for patients?	**Gastroenterology:** Reversal would bring no improvement to continuity of care	**Gastroenterology:** Continuity of care could be adversely affected if the pilot was reversed, with fewer patients seeing a specialist.
		Trauma & Orthopaedics: Reversal would bring no improvement to continuity of care	**Trauma & Orthopaedics:** Continuity of care could be adversely affected if the pilot was reversed, particularly in trauma with fewer patients seeing a senior specialist daily.
1.4	What is the likely effect of this solution on the opportunity to link with other teams and agencies to support patients holistically?	No impact	No impact
1.5	What is the likely effect of this solution on the quality of the care environment?	**Gastroenterology:** Nothing	**Gastroenterology:** Reversing the pilot, would mean Gastroenterology patients once again being spread across site and cared for in less specialist environment.
		Trauma & Orthopaedics: Nothing	**Trauma & Orthopaedics:** Reversing the pilot, would mean Trauma & Orthopaedic patients once again being spread across site. The change in environment would make the elective arthroplasty (joint replacement) patients more likely to be cancelled for winter pressures.

#	Questions to test	What would be better if reversed? (show how this would be evidenced)	What would be worse if reversed? (show how this would be evidenced)
1.6	What is the likely effect of this solution on encouraging patients and carers to manage self-care appropriately?	No impact	No impact
1.7	What is the likely effect of this solution on enabling patient transfers within a clinically safe time frame?	**Gastroenterology:** Minimal change– as reliable methods to transfer patients to CGH are in place	**Gastroenterology:** Minimal change. Existing protocols with ED
		Trauma & Orthopaedics: Minimal change– as reliable methods to transfer patients to CGH are in place	**Trauma & Orthopaedics:** Minimal change.
1.8	What is the likely effect of this solution on enabling emergency interventions within a clinically safe time-frame?	**Gastroenterology:** There would be no benefit from reversing the pilot, as the capacity released through the pilot has enabled greater provision for emergency Gastroenterology procedures on both acute hospital sites.	**Gastroenterology:** Spreading consultants and junior doctors across two sites; means that there would be a detrimental effect to emergency care
		Trauma & Orthopaedics: There is currently a concern that there is sufficient trauma theatre capacity. In the pilot capacity was increased from 29.5 lists a week to 32. However the demand has risen in the past two years.	**Trauma & Orthopaedics:** The continuity and availability to sub specialty care would be lost and wait times for specialist trauma would increase. Also the guarantee of a daily review would be lost.
1.9	What is the effect of this solution on the likelihood of travel time impacting negatively on patient outcomes?	**Gastroenterology:** There has been no evidence that this is the case in the years since the beginning of the trial	**Gastroenterology:** Reversing the pilot would enable some patients to be admitted closer to home, but there has been no evidence that this has caused problems during the trial

#	Questions to test	What would be better if reversed? (show how this would be evidenced)	What would be worse if reversed? (show how this would be evidenced)
		Trauma & Orthopaedics: There has been no evidence that this is the case in the years since the beginning of the trial	**Trauma & Orthopaedics:** There has been no evidence that this is the case in the years since the beginning of the trial
1.10	What is the likely effect of this solution on patient safety risks?	**Gastroenterology:** No risks identified since implementation, or anticipated from continuing the change	**Gastroenterology:** Reversing the pilot would see a rise in endoscopy waiting times and a reduction in the specialist Gastroenterology services for patients.
		Trauma & Orthopaedics: No benefits to pilot reversal. Initially more support for junior doctors at CGH but this has been resolved.	**Trauma & Orthopaedics:** Yes, the current process is working well and teething issues have been resolved. However the unexpected increase in trauma does lead to pressure during peak demand. The elective surgery that remains at GRH is adversely affected by winter pressures and cancelation of surgery and there is a case for more elective surgery to transfer to CGH.

Access to care

#	Questions to test	What would be better if reversed? (show how this would be evidenced)	What would be worse if reversed? (show how this would be evidenced)
2.1	What is the likelihood of this solution meeting the requirements of the NHS Constitution and The NHS Choice Framework?	**Gastroenterology:** No change	**Gastroenterology:** No change
		Trauma & Orthopaedics: No change	**Trauma & Orthopaedics:** No change
2.2	What is the likely effect of this solution on simplifying the offer to patients?	No impact	No impact
2.3	What is the likely effect of this solution on the travel burden for patients?	**Gastroenterology (17/18 pre-pilot analysis)** Reduced travel time for residents of Cheltenham – both car and public transport.	**Gastroenterology (17/18 pre-pilot analysis)** Increased travel time for residents of Gloucester, Forest of Dean and Tewks/Newent/Staunton if driving. All of the above plus Stroud/Berkley Vale if travelling by public transport. Mitigated by early senior review which means fewer emergency patients are transferred than this analysis anticipated.
		Orthopaedics (17/18 analysis) Improved travel time for residents of Cheltenham and the Cotswolds. **Trauma (17/18 analysis)** Positive impact for residents of Gloucester and Forest of Dean.	**Orthopaedics(17/18 analysis)** Increased travel impact for residents of Gloucester, Stroud/Berkley Vale and Forest of Dean. **Trauma (17/18 analysis)** Patients in Cheltenham, North and South Cotswolds would be negatively impacted if they were travelling by public transport. This is unlikely for trauma patients admitted to hospital.

#	Questions to test	What would be better if reversed? (show how this would be evidenced)	What would be worse if reversed? (show how this would be evidenced)
2.4	What is the likely effect of this solution on patients' waiting time to access services?	**Gastroenterology:** No change from present	**Gastroenterology:** Waits for outpatient and endoscopy procedures would get longer, with non-compliance for RTT and cancer targets**.**
		Trauma & Orthopaedics: No change from present	**Trauma & Orthopaedics:** Worse as the winter pressures are more problematic at GRH and more elective cancellations would occur. Also sub-specialty trauma surgeons would be working on one site only and therefore longer waits for highly specialised surgery may reoccur.
2.5	What is the likely effect of this solution on the travel burden for carers and families?	**Gastroenterology:** See 2.3	**Gastroenterology:** See 2.3
		Trauma & Orthopaedics: See 2.3	**Trauma & Orthopaedics:** See 2.3 – impact is greater for carers and families who may be reliant on public transport for visiting.
2.6	What is the likelihood of this solution supporting the use of new technology to improve access?	**Gastroenterology:** No change	**Gastroenterology:** No change
		Trauma & Orthopaedics: No change	**Trauma & Orthopaedics:** No change
2.7	What is the likelihood of this solution improving or maintaining service operating hours?	**Gastroenterology:** No benefit, emergency patients would wait longer	**Gastroenterology:** Both emergency and elective patients would wait longer
		Trauma & Orthopaedics: There would be no benefit in fact this option would be poorer; reverting to less	**Trauma & Orthopaedics:** There would be no benefit in fact this option would be poorer; reverting to less

#	Questions to test	What would be better if reversed? (show how this would be evidenced)	What would be worse if reversed? (show how this would be evidenced)
		out of hours operating and ward rounds	out of hours operating and ward round
2.8	What is the likelihood of this solution improving or maintaining service operating locations?	**Gastroenterology:** If reversed there would be an Inpatient provision on both sites, but the overall specialist service would be reduced.	**Gastroenterology:** Waits for endoscopy procedures and outpatient appointments would increase.
		Trauma & Orthopaedics: If reversed there would be an Inpatient provision for both trauma and elective surgery on both sites but the service would be worse for all.	**Trauma & Orthopaedics:** If reversed there would be an Inpatient provision on both sites but the service would be worse for all. Waits for trauma surgery would increase
2.9	What is the likelihood of this solution having a positive impact on equality and health inequalities as set out in the Public Sector Equality Duty 2011 and the Health and Social Care Act 2012?	**Gastroenterology:** Further analysis required	**Gastroenterology:** Further analysis required
		Trauma & Orthopaedics: Further analysis required	**Trauma & Orthopaedics:** Further analysis required
2.10	What is the likelihood of this solution accounting for future changes in population size and demographics?	**Gastroenterology:** Growth modelling not yet available	**Gastroenterology:** Growth modelling not yet available
		Trauma & Orthopaedics: Growth modelling not yet available	**Trauma & Orthopaedics:** Growth modelling not yet available

Deliverability

#	Questions to test	What would be better if reversed? (show how this would be evidenced)	What would be worse if reversed? (show how this would be evidenced)
3.1	What is the likelihood of this solution being delivered within the agreed timescale?	**Gastroenterology:** There is currently no agreed timescale	**Gastroenterology:** It would take a 6 month period to work up and would impact other services and reduce beds in medical wards at GRH
		Trauma & Orthopaedics: There is currently no agreed timescale	**Trauma & Orthopaedics** It would take a 6 month period to work up and would impact on ED delivery
3.2	What is the likelihood of this solution meeting the relevant national, regional or local delivery timescales?	No impact	No impact
3.3	What is the likelihood of this solution having the implementation capacity to deliver?	**Gastroenterology:** Already delivering	**Gastroenterology:** Already delivering
		Trauma & Orthopaedics: Already delivering. There are initiatives that would further improve the service e.g. more imaging in theatre. However this would be needed regardless of which sites the work is undertaken. The pilot does mean that if an elective patient at CGH is cancelled at the last minute the space cannot be backfilled with a trauma patient. Conversely it has reduced the high number of elective patient cancellations for trauma patients.	**Trauma & Orthopaedics:** Already delivering
3.4	What is the likely effect of this solution on access to the required	**Gastroenterology:** Already delivering, there are no benefits to	**Gastroenterology:** The Gastroenterology Consultant team

#	Questions to test	What would be better if reversed? (show how this would be evidenced)	What would be worse if reversed? (show how this would be evidenced)
	staffing capacity and capability to be successfully implemented?	pilot reversal	have been able to focus on specialist work. Prior to these changes, the Consultants had to care for a large number of patients from a mixture of medical specialties. This impacted on the time that they had available to provide specialist Gastroenterology care (such as outpatient clinics and endoscopy services). The ability to spend more time providing specialist care has improved staff morale. This would be reverting to the previous unsatisfactory state if the pilot was reversed.
		Trauma & Orthopaedics: Already delivering, there are no benefits to pilot reversal	**Trauma & Orthopaedics:** The benefits and improvements described above to nursing, and junior doctor rotas would be reversed.
3.5	What is the likelihood of this solution having access to the required support services to be successfully implemented?	**Gastroenterology:** Already delivering	**Gastroenterology:** Already delivering
		Trauma & Orthopaedics: Already delivering	**Trauma & Orthopaedics:** Already delivering
3.6	What is the likelihood of this solution having access to the required premises/estates to be successfully implemented?	**Gastroenterology:** Already delivering	**Gastroenterology:** Already delivering
		Trauma & Orthopaedics: Already delivering	**Trauma & Orthopaedics:** Already delivering
3.7	What is the likelihood of this solution having access to the	**Gastroenterology:** Already delivering	**Gastroenterology:** Already delivering

#	Questions to test	What would be better if reversed? (show how this would be evidenced)	What would be worse if reversed? (show how this would be evidenced)
	required technology to be successfully implemented?	**Trauma & Orthopaedics:** Already delivering	**Trauma & Orthopaedics:** Already delivering
3.8	Does this solution rely on other models of care / provision being put in place and if so, are they deliverable within the timeframe?	**Gastroenterology:** Already delivering	**Gastroenterology:** Already delivering
		Trauma & Orthopaedics: Already delivering	Already delivering **Trauma & Orthopaedics:**

Workforce

#	Questions to test	What would be better if reversed? (show how this would be evidenced)	What would be worse if reverse? (show how this would be evidenced)
4.1	What is the likely effect of this solution on improving workforce capacity resilience and reducing the risk of temporary service changes?	**Gastroenterology:** Nothing	**Gastroenterology:** The benefits described above would be lost, with a reduction in staff morale and a potential impact on recruitment.
		Trauma & Orthopaedics: A survey was carried out with staff after the pilot.	**Trauma & Orthopaedics:** The benefits described above would be lost
4.2	What is the likely effect of this solution on optimising the efficient and effective use of clinical staff?	**Gastroenterology:** None	**Gastroenterology:** The benefits described above would be lost. More Consultant time would be used to provide general care, impacting on the overall efficiency of the Gastroenterology team to provide specialist care and services.
		Trauma & Orthopaedics: None	**Trauma & Orthopaedics:** The benefits described above would be

#	Questions to test	What would be better if reversed? (show how this would be evidenced)	What would be worse if reverse? (show how this would be evidenced)
			lost
4.3	What is the likely effect of this solution on supporting cross-organisational working across the patient pathway?	**Gastroenterology:** None	**Gastroenterology:** The benefits described above would be lost
		Trauma & Orthopaedics: None	**Trauma & Orthopaedics:** The benefits described above would be lost
4.4	What is the likely effect of this solution on supporting the flexible deployment of staff and the development of innovative staffing models?	**Gastroenterology:** None	**Gastroenterology:** The benefits described above would be lost. There would be reduced flexibility for the Gastroenterology team to adapt to rising demand for services.
		Trauma & Orthopaedics: None	**Trauma & Orthopaedics:** The benefits described above with a dedicated period working on trauma would be reversed and there would be a return to a conflicted care model where a consultant is responsible for patient care when rostered to other duties.
4.5	What is the likely effect of this solution on supporting staff health and wellbeing and their ability to self-care?	**Gastroenterology:** None	**Gastroenterology:** The benefits previously described with staff unable to concentrate on specialist work, quality of care would decrease with an impact on morale.
		Trauma & Orthopaedics: The new 'attending' call rota is more demanding for consultants but is undertaken less than 3 times a year.	**Trauma & Orthopaedics:** If reversed the benefits in patient care would be lost and there would be an impact on morale for all staff groups.

#	Questions to test	What would be better if reversed? (show how this would be evidenced)	What would be worse if reverse? (show how this would be evidenced)
4.6	What is the likely effect of this solution on improving the recruitment and retention of permanent staff with the right skills, values and competencies?	**Gastroenterology:** None	**Gastroenterology:** The benefits described above would be lost. Recruitment would become harder, as posts with reduced time to deliver specialist services are less popular with applicants.
		Trauma & Orthopaedics: None	**Trauma & Orthopaedics:** Since the pilot there has been an improvement in recruitment for nursing and specialty doctors. A reversal would be likely to affect this adversely.
4.7	What is the likely effect of this solution on retaining trainee allocations, providing opportunities to develop staff with the right skills, values and competencies?	**Gastroenterology:** None	**Gastroenterology:** The benefits described above would be lost. Previous trainee feedback was poor, due to service pressure and frustration about lack of time for specialist training.
		Trauma & Orthopaedics: None	**Trauma & Orthopaedics:** Junior Doctors feedback from the deanery was poor in GRH due to heavy workload and patchy supervision. Latest reports are good at both sites and it is believed that the dedicated consultant on trauma allows vastly improved supervision and teaching. As a result of this the service has been allocated an additional GP trainee. These advantages would be lost if the pilot were reversed

#	Questions to test	What would be better if reversed? (show how this would be evidenced)	What would be worse if reverse? (show how this would be evidenced)
4.8	What is the likely effect of this solution on maintaining or improving the availability of trainers and supporting them to fulfil their training role?	**Gastroenterology:** None	**Gastroenterology:** The benefits described above would be lost. Previous trainee feedback was poor, due to service pressure and frustration about lack of time for specialist training
		Trauma & Orthopaedics: None	**Trauma & Orthopaedics:** The benefits described in 4.7 would be lost if the pilot was reversed. Previous trainee feedback was poor, due to the structure of the service and frustration about lack of time for specialist training
4.9	What is the likely effect of this solution on enabling staff to maintain or enhance their capabilities/ competencies?	**Gastroenterology:** None	**Gastroenterology:** The benefits described above would be lost, with a reduction in specialist staff competencies due to reduced time spent providing specialist care.
		Trauma & Orthopaedics: None	**Trauma & Orthopaedics:** If the pilot was reversed allocated training time would be lost.
4.10	What is the likely effect of this solution on enabling staff to fulfil their capability, utilising all of their skills, and develop within their role?	**Gastroenterology:** None	**Gastroenterology:** The benefits described above would be lost. Currently the team are able to dedicate their skills to patients within their specialty and provide better quality of service and improved training.
		Trauma & Orthopaedics: None	**Trauma & Orthopaedics:** Currently sub specialties are working together, this allows for dedicated teams

#	Questions to test	What would be better if reversed? (show how this would be evidenced)	What would be worse if reverse? (show how this would be evidenced)
			to undertake sub specialist work, also for support areas e.g. theatres to be able to rationalise equipment and ensure a better service. This would be lost if the pilot were reversed.
4.11	What is the likely effect of this solution on the travel burden for staff?	**Gastroenterology:** Further analysis required	**Gastroenterology:** Further analysis required
		Trauma & Orthopaedics: Further analysis required	**Trauma & Orthopaedics:** Further analysis required
4.12	What is the likely effect of this solution on maintaining clinical supervision support to staff?	**Gastroenterology:** None, it would be detrimental	**Gastroenterology:** The benefits to recruitment and junior doctor feedback would be lost.
		Trauma & Orthopaedics: None, it would be detrimental	**Trauma & Orthopaedics:** The benefits to nursing and medical recruitment and junior doctor feedback would be lost.

Finance/ value for money

#	Questions to test	What would be better? (show how this would be evidenced)	What would be worse? (show how this would be evidenced)
5.1	What is the likelihood of this solution being within the current cost envelope (19/20 forecast outturn cost base)?	Within current cost envelope	

#	Questions to test	What would be better? (show how this would be evidenced)	What would be worse? (show how this would be evidenced)
5.2	What is the likelihood of this solution being affordable i.e. does it deliver benefits within the Gloucestershire financial envelope	The net impact of the two pilots was £434k-worth of additional activity. If they were reversed it is likely capacity would be lost and this benefit would be reversed (at a saving to the system for activity not carried out). Similarly, associated changes to renal capacity may have led to increased activity-b based income which would be reversed by any changes.	GHFT was outsourcing endoscopy procedures to a private provider at an annual cost (17/18) of £659k. Loss of gastroenterologist capacity would mean incurring similar costs to keep up with demand. See 5.2 – negative impact for provider.
5.3	What is the likelihood of this solution increasing net revenue to the system?	None – same activity. Benefits as a result of efficiency rather than additional revenue to the system.	None
5.4	What is the likelihood of significant capital costs over and above current capital allocations that cannot be mitigated?	No impact	No impact
5.5	What is likelihood that this solutions' transition, implementation, double-running or stranded costs cannot be managed/mitigated by system-working?	Low – trial models previously implemented within financial allocations so any reversals would be managed in the same way.	There is a risk that the system cannot afford to buy in additional private capacity to maintain endoscopy waiting times.

Strategic Fit

#	Questions to test	What would be better? (show how this would be evidenced)	What would be worse? (show how this would be evidenced)
6.1	What is the likelihood of this solution being compatible with the One Gloucestershire vision?	No change	Solution not consistent with the ICS *centres of excellence vision.*
6.2	What is the likelihood of this solution being consistent with the NHS Long Term Plan?	No change	

Acceptability

#	Questions to test	What would be better? (show how this would be evidenced)	What would be worse? (show how this would be evidenced)
7.1	What is the likelihood that this solution has satisfactorily taken into account and responded to the Fit for the Future Outcome of Engagement Report	No impact as this solution was not specifically addressed during the Fit for the Future engagement phase.	

Solution description reference #	**C3**
Solution description	Centralise Emergency General Surgery (EGS) to Gloucestershire Royal Hospital (GRH).
Relevant to Model reference #s	**All models A-H**

Quality of care

#	Questions to test	What would be better? (show how this would be evidenced)	What would be worse? (show how this would be evidenced)
1.1	What is the likely effect of this solution on patients receiving equal or better outcomes of care?	Prompt review in SAU by senior decision maker Improved access to sub-specialist care, ensuring equitable pathways for all patients. Reduced delays for emergency operations Supported by the findings of the *Royal College of Surgeons – separating emergency and elective surgical care Report*, September 2007 This would be evidenced by monitoring Key Performance Indicators.	A few patients who self-present to CGH (walk in) would need to be transferred to GRH (if well enough to do so, else the consultant would go to CGH). This would be evidenced by monitoring Key Performance Indicators.
1.2	What is the likely effect of this solution on patients being treated by the right teams with the right skills and experience in the right place and at the right time?	Improved access to sub-specialist care (upper gastro intestinal and colorectal), ensuring equitable pathways for all patients Supported by the findings of the *British Journal of Surgeons – Association between surgeon with special interest and mortality after emergency laparotomy,* 2019*.* Dedicated 24/7 general surgery emergency theatre	A few patients who self-present to CGH would need to be transferred to GRH (if well enough to do so, else the consultant would go to CGH). This would be evidenced by monitoring Key Performance Indicators.

#	Questions to test	What would be better? (show how this would be evidenced)	What would be worse? (show how this would be evidenced)
		This would be evidenced by monitoring Key Performance Indicators.	
1.3	What is the likely effect of this solution on continuity of care for patients?	Emergency (EGS) patients would remain under the care of the appropriate sub-specialist for a complete week before hand over to the incoming sub-specialist. Supported by the findings regarding a 'surgeon of the week' in the *Royal College of Surgeons – separating emergency and elective surgical care Report*, September 2007	No impact
1.4	What is the likely effect of this solution on the opportunity to link with other teams and agencies to support patients holistically?	No impact	No impact
1.5	What is the likely effect of this solution on the quality of the care environment?	This option provides a dedicated Surgical Assessment Unit (SAU), 'Hot clinic' and ambulatory emergency surgical care. Specialist nursing skills provided in one place (SAU staff, Advanced Nurse Practitioner (ANP)). for in a specialist environment	No impact
1.6	What is the likely effect of this solution on encouraging patients and carers to manage self-care appropriately?	No impact	No impact

#	Questions to test	What would be better? (show how this would be evidenced)	What would be worse? (show how this would be evidenced)
1.7	What is the likely effect of this solution on enabling patient transfers within a clinically safe time frame?	No impact	This would result in a small number of inter-site transfers for patients who self-present to the site opposite to the site where a specialist service is located. A Standard Operating Procedure and patient transfer protocols would be in place to ensure best practice.
1.8	What is the likely effect of this solution on enabling emergency interventions within a clinically safe time-frame?	Access to 24/7 dedicated general surgery emergency theatre in GRH One consultant team would be ward-based and therefore free to attend a new or deteriorating patient immediately. This would be evidenced by reviewing time of decision to treat and treatment.	An acute or deteriorating patient at CGH would be supported by the on-site deteriorating patient team. They may require transfer to GRH if stable, or the surgeon to travel to CGH. This would be evidenced by monitoring Key Performance Indicators.
1.9	What is the effect of this solution on the likelihood of travel time impacting negatively on patient outcomes?	No impact	For some patients there would be an increase in travel time to GRH. However, the key influence on patient outcome is time from arrival to being seen and treated. This option would improve access to the senior decision maker. This would be evidenced by monitoring Key Performance Indicators.
1.10	What is the likely effect of this solution on patient safety risks?	Address the patient safety risk EGS currently faces. Address inequity in treatment pathways. Improve recruitment of medical and nursing staff. Comply with Deanery training regulations. This would be evidenced by pre and post	No impact

#	Questions to test	What would be better? (show how this would be evidenced)	What would be worse? (show how this would be evidenced)
		staffing and rota gaps.	

Access to care

#	Questions to test	What would be better? (show how this would be evidenced)	What would be worse? (show how this would be evidenced)
2.1	What is the likelihood of this solution meeting the requirements of the NHS Constitution and The NHS Choice Framework?	Compliance with national guidelines on Emergency Surgery This would be evidenced by comparison with national standards and internal audit.	No impact
2.2	What is the likely effect of this solution on simplifying the offer to patients?	Less confusion as EGS service only offered at one site This would be evidenced by patient pathways.	No impact
2.3	What is the likely effect of this solution on the travel burden for patients?	No further positive impact as service already provided on both sites.	Travel analysis tbc, but any service moving from CGH to GRH will increase travel time for residents of Cheltenham, the Cotswolds, and some areas of Stroud and Berkley Vale.
2.4	What is the likely effect of this solution on patients' waiting time to access services?	Improved waiting time for assessment by senior decision maker. Reduced delay in access to the operating theatre. This would be evidenced by monitoring Key Performance Indicators.	A few patients who self-present to CGH would need to be transferred to GRH (if well enough to do so, else the consultant would go to CGH). This would be evidenced by monitoring Key Performance Indicators.
2.5	What is the likely effect of this solution on the travel burden for carers and families?	No further positive impact as service already provided on both sites.	Travel analysis tbc, but any service moving from CGH to GRH will increase travel time for residents of Cheltenham, the Cotswolds, and some areas of Stroud

#	Questions to test	What would be better? (show how this would be evidenced)	What would be worse? (show how this would be evidenced)
			and Berkley Vale.
2.6	What is the likelihood of this solution supporting the use of new technology to improve access?	Cinapsis could be implemented allowing GPs to access senior decision maker. This would be evidenced by use of Cinapsis (monitored by the commissioners)	No impact
2.7	What is the likelihood of this solution improving or maintaining service operating hours?	No impact	No impact
2.8	What is the likelihood of this solution improving or maintaining service operating locations?	No impact	No EGS at CGH
2.9	What is the likelihood of this solution having a positive impact on equality and health inequalities as set out in the Public Sector Equality Duty 2011 and the Health and Social Care Act 2012?	Further analysis required	Further analysis required
2.10	What is the likelihood of this solution accounting for future changes in population size and demographics?	Growth modelling not yet available	Growth modelling not yet available

Deliverability

#	Questions to test	What would be better? (show how this would be evidenced)	What would be worse? (show how this would be evidenced)
3.1	What is the likelihood of this solution being delivered within the agreed timescale?	Subject to consultation and statutory notice period, this option could be delivered within the agreed timescale. This would be evidenced by statutory timescales and indicative implementation timetable.	No impact
3.2	What is the likelihood of this solution meeting the relevant national, regional or local delivery timescales?	No impact	No impact
3.3	What is the likelihood of this solution having the implementation capacity to deliver?	Medical capacity already exists to deliver this option.	Potential for recruitment of further ANPs may be desirable to further develop the service but not having them would not make the service worse.
3.4	What is the likely effect of this solution on access to the required staffing capacity and capability to be successfully implemented?	See 3.3	See 3.3
3.5	What is the likelihood of this solution having access to the required support services to be successfully implemented?	All support services for EGS currently exist at GRH site.	No impact
3.6	What is the likelihood of this solution having access to the required premises/estates to be successfully implemented?	Additional beds would be provided for EGS on the GRH site. This would be evidenced by the estate plan.	This would be evidenced by monitoring Key Performance Indicators.
3.7	What is the likelihood of this	No impact	No impact

#	Questions to test	What would be better? (show how this would be evidenced)	What would be worse? (show how this would be evidenced)
	solution having access to the required technology to be successfully implemented?		
3.8	Does this solution rely on other models of care / provision being put in place and if so, are they deliverable within the timeframe?		

Workforce

#	Questions to test	What would be better? (show how this would be evidenced)	What would be worse? (show how this would be evidenced)
4.1	What is the likely effect of this solution on improving workforce capacity resilience and reducing the risk of temporary service changes?	By centralising the EGS service, more efficient and effective use can be made of medical and nursing staff. Cohesive group working would reduce absence and improve recruitment Flexibility to cover unexpected absence. Reduce reliance on middle grade locums This would be evidenced by staff establishment	Potential for CGH nursing staff to be reallocated from current wards. May be some staff dissatisfaction in respect of staff who prefer CGH as base This would be evidenced by staff establishment.
4.2	What is the likely effect of this solution on optimising the efficient and effective use of clinical staff?	See 4.1	See 4.1
4.3	What is the likely effect of this solution on supporting cross-organisational working across the patient pathway?	No impact	No impact
4.4	What is the likely effect of this solution on supporting the flexible	Opportunity to introduce more Advanced Nurse Practitioner roles to support the	No impact

#	Questions to test	What would be better? (show how this would be evidenced)	What would be worse? (show how this would be evidenced)
	deployment of staff and the development of innovative staffing models?	junior doctors within the timeframe This would be evidenced by the introduction of new posts	
4.5	What is the likely effect of this solution on supporting staff health and wellbeing and their ability to self-care?	By centralising the team would create greater clinical mass and staff resilience, which should have a positive impact on staff health and well-being. This would be evidenced by staff rotas and staff well-being metrics.	Potential for CGH nursing staff to be reallocated from current wards. This could impact morale and staff health and well-being. This would be evidenced by staff rotas and staff well-being metrics.
4.6	What is the likely effect of this solution on improving the recruitment and retention of permanent staff with the right skills, values and competencies?	Also see 4.1 The expanded/improved opportunities as described above in terms of training and development and advancement of new roles highly likely to have a positive impact on staff retention and the ability to recruit new staff.	See 4.1
4.7	What is the likely effect of this solution on retaining trainee allocations, providing opportunities to develop staff with the right skills, values and competencies?	This option would strengthen training experience offered. Compliance with Deanery regulations Enable the Trust to retain trainee allocations. This would be evidenced by the GMC survey and Deanery feedback.	No impact
4.8	What is the likely effect of this solution on maintaining or improving the availability of trainers and supporting them to fulfil their training role?	See 4.7.	No impact

#	Questions to test	What would be better? (show how this would be evidenced)	What would be worse? (show how this would be evidenced)
4.9	What is the likely effect of this solution on enabling staff to maintain or enhance their capabilities/ competencies?	Centralising EGS would provide a better learning environment and enhance capabilities and competencies for all staff groups	No impact
4.10	What is the likely effect of this solution on enabling staff to fulfil their capability, utilising all of their skills, and develop within their role?	See 4.9	No impact
4.11	What is the likely effect of this solution on the travel burden for staff?	Further analysis required	Further analysis required
4.12	What is the likely effect of this solution on maintaining clinical supervision support to staff?	Trainer available in both EGS consultant-led teams resulting in 24-hour supervision and support All EGS patients on one site allowing senior nursing supervision of all staff in one place.	No impact

Finance/ value for money

#	Questions to test	What would be better? (show how this would be evidenced)	What would be worse? (show how this would be evidenced)
5.1	What is the likelihood of this solution being within the current cost envelope (19/20 forecast outturn cost base)?		There will be some additional medical staff costs for around £100k for middle grade cover.
5.2	What is the likelihood of this solution being affordable i.e. does	No planned impact on affordability.	

#	Questions to test	What would be better? (show how this would be evidenced)	What would be worse? (show how this would be evidenced)
	it deliver benefits within the Gloucestershire financial envelope		
5.3	What is the likelihood of this solution increasing net revenue to the system?	None – same activity would be delivered on a single site	None – same activity would be delivered on a single site.
5.4	What is the likelihood of significant capital costs over and above current capital allocations that cannot be mitigated?		To be confirmed
5.5	What is likelihood that this solutions' transition, implementation, double-running or stranded costs cannot be managed/mitigated by system-working?	Low – detailed implementation plans to be developed to ensure transfer within current resources.	

Strategic Fit

#	Questions to test	What would be better? (show how this would be evidenced)	What would be worse? (show how this would be evidenced)
6.1	What is the likelihood of this solution being compatible with the One Gloucestershire vision?	This option is compatible with the ICS vision and would enable EGS to develop a sustainable local health and care workforce. Provides centralised EGS care with two consultant-led teams, meeting national guidelines and providing a service fit for the future.	No impact

6.2	What is the likelihood of this solution being consistent with the NHS Long Term Plan?	EGS: This option is consistent with the NHS Long-Term Plan: Delivery of Ambulatory Emergency surgical care. Availability of 'hot clinic'. Cinapsis available to GPs.	EGS: No impact

Acceptability

#	**Questions to test**	**What would be better?** (show how this would be evidenced)	**What would be worse?** (show how this would be evidenced)
7.1	What is the likelihood that this solution has satisfactorily taken into account and responded to the Fit for the Future Outcome of Engagement Report	All solutions have been developed with reference to the *Outputs of Engagement Report*. Solutions included/adapted as a result of public feedback are: • Re-open CGH ED overnight • IGIS centralised to CGH site • IGIS hub options	

Solution description reference #	**A4**
Solution description	Re-open Cheltenham Emergency Department overnight
Relevant to Model #s	Model C

Quality of care

#	Questions to test	What would be better? (show how this would be evidenced)	What would be worse? (show how this would be evidenced)
1.1	What is the likely effect of this solution on patients receiving equal or better outcomes of care?	No better or worse than the current model. Small number of residents in the Cheltenham locality may access EM services overnight more quickly, but this does not address the issues of access to specialist advice Evidence – performance against 4 hour target	
1.2	What is the likely effect of this solution on patients being treated by the right teams with the right skills and experience in the right place and at the right time?	see 1.1	
1.3	What is the likely effect of this solution on continuity of care for patients?	Potentially this option may reduce the number of residents in the Cheltenham locality being admitted overnight at GRH and transferred to CGH the next day. Evidence – patient transfers	
1.4	What is the likely effect of this solution on the opportunity to link with other teams and agencies to support patients holistically?	No impact	No impact

#	Questions to test	What would be better? (show how this would be evidenced)	What would be worse? (show how this would be evidenced)
1.5	What is the likely effect of this solution on the quality of the care environment?	No better or worse than the current configuration	
1.6	What is the likely effect of this solution on encouraging patients and carers to manage self-care appropriately?	No impact	No impact
1.7	What is the likely effect of this solution on enabling patient transfers within a clinically safe time frame?	No better or worse than the current model. This option may reduce the number of residents in the Cheltenham locality admitted overnight at GRH and transferred to CGH the next day Evidence: patient transfers	
1.8	What is the likely effect of this solution on enabling emergency interventions within a clinically safe time-frame?	No better or worse than the current model. Patients requiring emergency care would receive the same service	
1.9	What is the effect of this solution on the likelihood of travel time impacting negatively on patient outcomes?	For some patients accessing services overnight, the travel time to the ED may reduce. However the key influence on patient outcome is the time from arrival to being seen and treated by an appropriate clinician with the right competencies. Arguably this will be the same at both hospitals Evidence; travel time analysis	
1.10	What is the likely effect of this solution on patient safety risks?		Existing difficulties in recruiting sufficient medical and nursing staff. This would not be improved with this option.

#	Questions to test	What would be better? (show how this would be evidenced)	What would be worse? (show how this would be evidenced)
			Evidence: 2 recruitment drives over the past year did not result in recruitment

Access to care

#	Questions to test	What would be better? (show how this would be evidenced)	What would be worse? (show how this would be evidenced)
2.1	What is the likelihood of this solution meeting the requirements of the NHS Constitution and The NHS Choice Framework?	Arguably this option would provide more capacity to improve performance against this target Evidence: performance against 4 hour target	
2.2	What is the likely effect of this solution on simplifying the offer to patients?	Potentially makes the offer simpler, as the same service description. However some emergency activity e.g. paediatrics, stroke and gynaecology would still go to direct to GRH	
2.3	What is the likely effect of this solution on the travel burden for patients?	Travel analysis tbc, but services moving from Gloucester to Cheltenham will reduce travel time for residents of Cheltenham, the Cotswolds, and some areas of Stroud and Berkley Vale.	Service already in place so no increase in travel burden for patients in the Gloucester catchment area.
2.4	What is the likely effect of this solution on patients' waiting time to access services?	See 2.1. No better or worse than current model for accessing specialist services	
2.5	What is the likely effect of this solution on the travel burden for carers and families?	See 2.3	See 2.3
2.6	What is the likelihood of this	No better or worse than the current option	No better or worse than the current option

#	Questions to test	What would be better? (show how this would be evidenced)	What would be worse? (show how this would be evidenced)
	solution supporting the use of new technology to improve access?		
2.7	What is the likelihood of this solution improving or maintaining service operating hours?	This option would increase the service operating hours for a consultant led ED at CGH	
2.8	What is the likelihood of this solution improving or maintaining service operating locations?	No better or worse than current option	No better or worse than current option
2.9	What is the likelihood of this solution having a positive impact on equality and health inequalities as set out in the Public Sector Equality Duty 2011 and the Health and Social Care Act 2012?	Further analysis required	Further analysis required
2.10	What is the likelihood of this solution accounting for future changes in population size and demographics?	Growth modelling not yet available	Growth modelling not yet available

Deliverability

#	Questions to test	What would be better? (show how this would be evidenced)	What would be worse? (show how this would be evidenced)
3.1	What is the likelihood of this solution being delivered within the agreed timescale?		Based on experience over the past few years it will be difficult to recruit the staff needed to support delivery of this model Evidence: Recruitment rounds in 2019 unsuccessful in recruiting suitable candidates. NCAT report on Gloucestershire Hospitals May 2013
3.2	What is the likelihood of this solution meeting the relevant national, regional or local delivery timescales?	No impact	No impact
3.3	What is the likelihood of this solution having the implementation capacity to deliver?		It is unlikely that there will be the implementation capacity to deliver this option. This is linked to our historical difficulties to recruit. Evidence: Recruitment rounds in 2019 unsuccessful in recruiting suitable candidates. NCAT report on Gloucestershire Hospitals May 2013; NHS Employers Terms and Conditions of Service for NHS Doctors and Dentists in Training (England) Updated 2019
3.4	What is the likely effect of this solution on access to the required staffing capacity and capability to be successfully implemented?	See 3.3	

#	Questions to test	What would be better? (show how this would be evidenced)	What would be worse? (show how this would be evidenced)
3.5	What is the likelihood of this solution having access to the required support services to be successfully implemented?		Additional support staff will be need to be recruited to support this option overnight, This includes laboratory, diagnostic and portering staff
3.6	What is the likelihood of this solution having access to the required premises/estates to be successfully implemented?	It should be possible to accommodate this option within current estate. Some minor works may be required Evidence: Estates plan	
3.7	What is the likelihood of this solution having access to the required technology to be successfully implemented?	No better or worse than current option	
3.8	Does this solution rely on other models of care / provision being put in place and if so, are they deliverable within the timeframe?		Yes it would require a range of support services providing overnight cover

Workforce

#	Questions to test	What would be better? (show how this would be evidenced)	What would be worse? (show how this would be evidenced)
4.1	What is the likely effect of this solution on improving workforce capacity resilience and reducing the risk of temporary service changes?		Worse than current option. There have been difficulties recruiting medical and nursing staff. Evidence: NCAT report on Gloucestershire Hospitals May 2013;Reconfiguration Report to the Health and Care Overview and Scrutiny Committee March 2014

#	Questions to test	What would be better? (show how this would be evidenced)	What would be worse? (show how this would be evidenced)
4.2	What is the likely effect of this solution on optimising the efficient and effective use of clinical staff?		Worse than current option as there will be a need to extend medical, nursing and support staff cover overnight at CGH. Evidence: staffing establishment
4.3	What is the likely effect of this solution on supporting cross-organisational working across the patient pathway?	No better or worse than current option	No better or worse than current option
4.4	What is the likely effect of this solution on supporting the flexible deployment of staff and the development of innovative staffing models?		Worse than current model as it will require greater flexibility from staff to cover rotas on both sites.
4.5	What is the likely effect of this solution on supporting staff health and wellbeing and their ability to self-care?		Likely to be worse than the current option. Already have existing gaps in middle grade rotas and difficulties in recruiting medical and nursing staff. Extending the rotas to include overnight at CGH will place increasing pressure on staff. Highly likely to adversely affect staff morale and health and wellbeing. Evidence: staff rotas
4.6	What is the likely effect of this solution on improving the recruitment and retention of permanent staff with the right skills, values and competencies?	May support retention of nursing and other staff in CGH.	Likely to be worse than current option. Already experiencing difficulties in recruiting middle grades. Likely to place greater pressures on existing staff, which may affect staff retention. Evidence: Current staff vacancies

#	Questions to test	What would be better? (show how this would be evidenced)	What would be worse? (show how this would be evidenced)
4.7	What is the likely effect of this solution on retaining trainee allocations, providing opportunities to develop staff with the right skills, values and competencies?		EM&AM – One of the drivers for change in implementing the current model in 2013 was the risk of losing trainee posts. It is therefore likely that there will be a risk in securing and retaining these additional posts Evidence: NCAT report on Gloucestershire Hospitals May 2013
4.8	What is the likely effect of this solution on maintaining or improving the availability of trainers and supporting them to fulfil their training role?	No change	
4.9	What is the likely effect of this solution on enabling staff to maintain or enhance their capabilities/ competencies?	No change	
4.10	What is the likely effect of this solution on enabling staff to fulfil their capability, utilising all of their skills, and develop within their role?	No change	Highly likely to experience difficulty in the recruiting of staff which in turn has the potential to compromise ability to fully support and develop staff.
4.11	What is the likely effect of this solution on the travel burden for staff?	Further analysis required	May be some staff dissatisfaction in respect of staff who prefer CGH as base.
4.12	What is the likely effect of this solution on maintaining clinical supervision support to staff?		More difficult, as this option increases the need to provide supervision across two sites.

Finance/ value for money

#	Questions to test	What would be better? (show how this would be evidenced)	What would be worse? (show how this would be evidenced)
5.1	What is the likelihood of this solution being within the current cost envelope (19/20 forecast outturn cost base)?		There would be an estimated additional cost of £1.2million per annum above funded baseline. This only takes account of direct staff costs to ensure both sites have sufficient cover. The workforce analysis shows that middle grade staff have been hard to recruit, so middle grade share of the costs at agency rate would be higher. Supporting service costs have not yet been modelled.
5.2	What is the likelihood of this solution being affordable i.e. does it deliver benefits within the Gloucestershire financial envelope		There is no additional activity associated with the costs estimated £1.2m per annum above funded baseline. This only takes account of direct staff costs. Supporting service costs have not yet been modelled.
5.3	What is the likelihood of this solution increasing net revenue to the system?	None	None
5.4	What is the likelihood of significant capital costs over and above current capital allocations that cannot be mitigated?	No – changes would be absorbed into existing department.	
5.5	What is likelihood that this solutions' transition, implementation, double-running or stranded costs cannot be		Increased costs of delivering the same activity could be mitigated by improved awareness of and access to out of hospital urgent care

#	Questions to test	What would be better? (show how this would be evidenced)	What would be worse? (show how this would be evidenced)
	managed/mitigated by system-working?		services. There is a possibility that the increased cost cannot be fully mitigated by system-working.

Strategic Fit

#	Questions to test	What would be better? (show how this would be evidenced)	What would be worse? (show how this would be evidenced)
6.1	What is the likelihood of this solution being compatible with the One Gloucestershire vision?	Compatible with the vision of centres of excellence	Not consistent with the GHFT vision and strategy to develop *centres of excellence.*
6.2	What is the likelihood of this solution being consistent with the NHS Long Term Plan?		This option would not be consistent with the LTP priorities to improve efficiency

Acceptability

#	Questions to test	What would be better? (show how this would be evidenced)	What would be worse? (show how this would be evidenced)
7.1	What is the likelihood that this solution has satisfactorily taken into account and responded to the Fit for the Future Outcome of Engagement Report	All solutions have been developed with reference to the *Outputs of Engagement Report*. Solutions included/adapted as a result of public feedback are: • Re-open CGH ED overnight • IGIS centralised to CGH site • IGIS hub options	

Solution description reference #	**A3**
Solution description	Centralise complex emergency medical admissions to Gloucester (undifferentiated patients). Increase pathways for direct emergency admissions to specialties in Cheltenham (differentiated patients)
Relevant to Model #s	Model D, F and G

Quality of care

#	Questions to test	What would be better? (show how this would be evidenced)	What would be worse? (show how this would be evidenced)
1.1	What is the likely effect of this solution on patients receiving equal or better outcomes of care?	Improve outcomes for AM patients. Centralised AM team and improved access to specialties. CGH admissions – improved capability to admit to specialties where appropriate. Evidence – Patient pathways	
1.2	What is the likely effect of this solution on patients being treated by the right teams with the right skills and experience in the right place and at the right time?	see 1.1 Better co-ordination of AM admissions on one site	
1.3	What is the likely effect of this solution on continuity of care for patients?	Easier access to appropriate specialist senior decision-maker Evidence – Academy of Medical Royal Colleges 2012	
1.4	What is the likely effect of this solution on the opportunity to link with other teams and agencies to support patients holistically?	No impact	No impact

#	Questions to test	What would be better? (show how this would be evidenced)	What would be worse? (show how this would be evidenced)
1.5	What is the likely effect of this solution on the quality of the care environment?	All resources in one place	
1.6	What is the likely effect of this solution on encouraging patients and carers to manage self-care appropriately?	No impact	No impact
1.7	What is the likely effect of this solution on enabling patient transfers within a clinically safe time frame?	The need for transfer is likely to be reduced. However where transfer is needed there will be protocols in place to ensure that transfers are within a clinically safe time frame. Evidence: patient transfer protocols	For patients who walk in to CGH and require acute admission there is an increased requirement for 'treat and transfer' protocols.
1.8	What is the likely effect of this solution on enabling emergency interventions within a clinically safe time-frame?	This option will have protocols to enable emergency interventions within a clinically safe time-frame. Evidence: Protocols and DPM	
1.9	What is the effect of this solution on the likelihood of travel time impacting negatively on patient outcomes?	Travel time is not anticipated to impact negatively on patient outcomes, to a degree that would mitigate the benefits of improved access to the appropriate specialist senior decision maker and therefore ensure that treatment happens quickly. Evidence; travel time analysis, clinical pathways + Royal College evidence of benefits of early senior review.	For some patients there will be an increase in travel time to GRH. However the key influence on patient outcome is the time from arrival to being seen and treated.

#	Questions to test	What would be better? (show how this would be evidenced)	What would be worse? (show how this would be evidenced)
		Effects of driving distance and transport time on mortality among Level I and II traumas occurring in a metropolitan area (2018): A study in Chicago concluded: We find a modest effect of distance on mortality that is approximately linear over a range of 0 to 12 miles. Instrumental variables analysis indicated a corresponding increase in mortality with increasing transport time: https://journals.lww.com/jtrauma/Citation/2018/10000/Effects_of_driving_distance_and_transport_time_on.17.aspx **A matter of life and death: hospital distance and quality of care: evidence of emergency room closures and myocardial infarctions (2014) Health Econmetrics and Data Group University of York:** In Sweden: "patients who experienced an increase in the distance to their home hospital of between 51 and 60 kilometres ran an estimated 15 percent lower risk of surviving the AMI [Acute Myocardial Infarction] than patients who lived within ten kilometres of their home hospital" In the event that one of our receiving Emergency Departments is compromised, e.g. a Major Incident, the alternate site will	

#	Questions to test	What would be better? (show how this would be evidenced)	What would be worse? (show how this would be evidenced)
		be used, or the nearest/quickest alternative where relevant.	
1.10	What is the likely effect of this solution on patient safety risks?	Existing difficulties in recruiting sufficient middle grade medical staff will be reduced by centralising the medical take at GRH.	

Access to care

#	Questions to test	What would be better? (show how this would be evidenced)	What would be worse? (show how this would be evidenced)
2.1	What is the likelihood of this solution meeting the requirements of the NHS Constitution and The NHS Choice Framework?	No change	
2.2	What is the likely effect of this solution on simplifying the offer to patients?	This model makes the offer simpler, as all AM services will be on one site. Evidence – patient pathways	
2.3	What is the likely effect of this solution on the travel burden for patients?	Service already in place in Gloucester so no additional travel benefits for local patients.	Travel analysis tbc, any service moving from Cheltenham to Gloucester will increase travel time for residents of Cheltenham, the Cotswolds, and some areas of Stroud and Berkley Vale.
2.4	What is the likely effect of this solution on patients' waiting time to access services?	Improved access to specialist senior decision-makers. Evidence: patient pathways	
2.5	What is the likely effect of this solution on the travel burden for carers and families?	See 2.3	See 2.3

#	Questions to test	What would be better? (show how this would be evidenced)	What would be worse? (show how this would be evidenced)
2.6	What is the likelihood of this solution supporting the use of new technology to improve access?	No better or worse than the current model	No better or worse than the current model
2.7	What is the likelihood of this solution improving or maintaining service operating hours?	No change	No change
2.8	What is the likelihood of this solution improving or maintaining service operating locations?	Acute admissions would be centralised onto one site.	For some patients there will be a reduction in service operating locations
2.9	What is the likelihood of this solution having a positive impact on equality and health inequalities as set out in the Public Sector Equality Duty 2011 and the Health and Social Care Act 2012?	Further analysis required	Further analysis required
2.10	What is the likelihood of this solution accounting for future changes in population size and demographics?	Growth modelling not yet available	Growth modelling not yet available

Deliverability

#	Questions to test	What would be better? (show how this would be evidenced)	What would be worse? (show how this would be evidenced)
3.1	What is the likelihood of this solution being delivered within the agreed timescale?	The timescale for delivery of this solution is within a 3 year period. Subject to consultation and statutory notice period, this option could be delivered within the agreed timescale Evidence: statutory timescales and indicative implementation timetable	
3.2	What is the likelihood of this solution meeting the relevant national, regional or local delivery timescales?	No impact	No impact
3.3	What is the likelihood of this solution having the implementation capacity to deliver?	This option would improve the capacity to provide specialist medical and nursing cover. Evidence: staff rotas	
3.4	What is the likely effect of this solution on access to the required staffing capacity and capability to be successfully implemented?	This option will improve access to the required staffing capacity and capability to deliver, by centralising the acute medical take onto one site Evidence: staffing rotas	
3.5	What is the likelihood of this solution having access to the required support services to be successfully implemented?	Improved access to other specialties Evidence: clinical pathways and protocols	
3.6	What is the likelihood of this solution having access to the required premises/estates to be	Additional capacity could be provided on the GRH estate within the timeframe Evidence: Estates plan	

#	Questions to test	What would be better? (show how this would be evidenced)	What would be worse? (show how this would be evidenced)
	successfully implemented?		
3.7	What is the likelihood of this solution having access to the required technology to be successfully implemented?	No better or worse than current model	No better or worse than current model
3.8	Does this solution rely on other models of care / provision being put in place and if so, are they deliverable within the timeframe?	Yes, protocols covering direct ward admissions, medical cover, including access to medical opinion, and patient treat and transfer	

Workforce

#	Questions to test	What would be better? (show how this would be evidenced)	What would be worse? (show how this would be evidenced)
4.1	What is the likely effect of this solution on improving workforce capacity resilience and reducing the risk of temporary service changes?	By centralising the service, more efficient and effective use can be made of medical and nursing staff, improving overall capacity. Evidence: Staff establishment	
4.2	What is the likely effect of this solution on optimising the efficient and effective use of clinical staff?	See 4.1	
4.3	What is the likely effect of this solution on supporting cross-organisational working across the patient pathway?	No better or worse than current option	No better or worse than current option
4.4	What is the likely effect of this solution on supporting the flexible deployment of staff and the development of innovative	By centralising the staff establishment there is greater potential for more flexible deployment of staff and the development of innovative staffing models.	.

#	Questions to test	What would be better? (show how this would be evidenced)	What would be worse? (show how this would be evidenced)
	staffing models?		
4.5	What is the likely effect of this solution on supporting staff health and wellbeing and their ability to self-care?	Centralising the team will create greater critical mass and staff resilience, which should have a positive impact on staff health and well-being. Evidence: staff rotas, staff well-being metrics	There may be some staff dissatisfaction in respect of staff who prefer CGH as base.
4.6	What is the likely effect of this solution on improving the recruitment and retention of permanent staff with the right skills, values and competencies?	Centralising the team will enable a more efficient and effective use of the workforce, Avoiding the need to spread resource across two sites. It is anticipated that this will improve the working environment, which should have a positive impact on staff recruitment and retention. Evidence: Recruitment and retention metrics	
4.7	What is the likely effect of this solution on retaining trainee allocations, providing opportunities to develop staff with the right skills, values and competencies?	This option will strengthen training experience offered and therefore will strengthen the Trust's ability to retain trainee allocations.	
4.8	What is the likely effect of this solution on maintaining or improving the availability of trainers and supporting them to fulfil their training role?	See 4.7 Centralising the acute medical take on one site will improve the availability of trainers and through this, support them in fulfilling their training role.	
4.9	What is the likely effect of this solution on enabling staff to	Centralising the acute medical take will provide staff with greater opportunities to	

#	Questions to test	What would be better? (show how this would be evidenced)	What would be worse? (show how this would be evidenced)
	maintain or enhance their capabilities/ competencies?	maintain and enhance their capabilities and competencies and improve access to specialist services	
4.10	What is the likely effect of this solution on enabling staff to fulfil their capability, utilising all of their skills, and develop within their role?	see 4.9	
4.11	What is the likely effect of this solution on the travel burden for staff?	Further analysis required	Further analysis required
4.12	What is the likely effect of this solution on maintaining clinical supervision support to staff?	Same as 4.8 Evidence: staff structure	

Finance/ value for money

#	Questions to test	What would be better? (show how this would be evidenced)	What would be worse? (show how this would be evidenced)
5.1	What is the likelihood of this solution being within the current cost envelope (19/20 forecast outturn cost base)?	Likely to be within the current cost envelope	
5.2	What is the likelihood of this solution being affordable i.e. does it deliver benefits within the Gloucestershire financial envelope	It is likely that this model will be affordable, delivering benefits such as improved access to acute assessment/same day emergency care. There is evidence that this can reduce admissions and/or length of stay.	Modelling not yet carried out to assess tariff implications for different care models, e.g. increase in assessment tariffs and likelihood of decrease in ED costs with implementation of direct admit pathways.

#	Questions to test	What would be better? (show how this would be evidenced)	What would be worse? (show how this would be evidenced)
5.3	What is the likelihood of this solution increasing net revenue to the system?	Low	
5.4	What is the likelihood of significant capital costs over and above current capital allocations that cannot be mitigated?		This solution would require improvement to the estate at GRH to accommodate increased medical admissions capacity – with associated capital cost. This is accounted for in the Trust's Estates Strategy.
5.5	What is likelihood that this solutions' transition, implementation, double-running or stranded costs cannot be managed/mitigated by system-working?	Low	

Strategic Fit

#	Questions to test	What would be better? (show how this would be evidenced)	What would be worse? (show how this would be evidenced)
6.1	What is the likelihood of this solution being compatible with the One Gloucestershire vision?	This option is consistent with the GHFT strategic vision to deliver *centres of excellence* and will enable AM to develop a sustainable local health and care workforce	
6.2	What is the likelihood of this solution being consistent with the NHS Long Term Plan?	We believe that this model is consistent with the NHS Long Term Plan	

Acceptability

#	Questions to test	What would be better? (show how this would be evidenced)	What would be worse? (show how this would be evidenced)
7.1	What is the likelihood that this solution has satisfactorily taken into account and responded to the Fit for the Future Outcome of Engagement Report	All solutions have been developed with reference to the *Outputs of Engagement Report*. Solutions included/adapted as a result of public feedback are: • Re-open CGH ED overnight • IGIS centralised to CGH site • IGIS hub options	

Solution description reference #	**B2**
Solution description	Centralise the image-guided interventional surgery (IGIS) 'hub' to GRH including vascular.
Relevant to Model #s	Model D and G

Quality of care

#	Questions to test	What would be better? (show how this would be evidenced)	What would be worse? (show how this would be evidenced)
1.1	What is the likely effect of this solution on patients receiving equal or better outcomes of care?	Many emergency IGIS interventions are time critical; locating a hub at the County's trauma unit will reduce the average time to intervention for many emergencies. Co-locating IGIS services improves the availability of consultants from adjacent services that may be required in the event of a complication, thereby improving outcomes. Improving our ability to attract and retain staff will reduce gaps in our on call Interventional Radiology rota, improving the robustness of the service and ensuring services are available at all times Co-location of vascular, interventional radiology and interventional cardiology supports the multi-disciplinary approach to the management of primary angioplasty. Evidence on travel times and outcomes suggests that patient outcomes could improve if a primary angioplasty service could be offered locally.	

#	Questions to test	What would be better? (show how this would be evidenced)	What would be worse? (show how this would be evidenced)
		Evidence: **A matter of life and death: hospital distance and quality of care: evidence of emergency room closures and myocardial infarctions (2014) Health Econometrics and Data Group University of York:** In Sweden: "patients who experienced an increase in the distance to their home hospital of between 51 and 60 kilometres ran an estimated 15 percent lower risk of surviving the AMI [Acute Myocardial Infarction] than patients who lived within ten kilometres of their home hospital"	
1.2	What is the likely effect of this solution on patients being treated by the right teams with the right skills and experience in the right place and at the right time?	Establishment of an IGIS hub at the trauma unit will increase the likelihood that both specialist IGIS facilities and clinical expertise are located on the same site where the patient is presenting. Reduce inpatient transfers between sites. Over 90% of inpatient referrals to vascular services do not come from CGH. Reduction in inpatient and emergency transfers for catheter labs (650 transfers from GRH to CGH in 2018/19)	

#	Questions to test	What would be better? (show how this would be evidenced)	What would be worse? (show how this would be evidenced)
1.3	What is the likely effect of this solution on continuity of care for patients?	By improving our ability to expand IGIS provision, patients currently travelling out of County for IGIS procedures could be treated at GHT, allowing follow up care to be provided by the same clinical team.	
1.4	What is the likely effect of this solution on the opportunity to link with other teams and agencies to support patients holistically?	No impact	No impact
1.5	What is the likely effect of this solution on the quality of the care environment?	Establishment of a new IGIS Hub and replacement of outdated and beyond end-of-life facilities will improve the quality of the care environment	
1.6	What is the likely effect of this solution on encouraging patients and carers to manage self-care appropriately?	No impact	No impact
1.7	What is the likely effect of this solution on enabling patient transfers within a clinically safe time frame?	No impact	No impact
1.8	What is the likely effect of this solution on enabling emergency interventions within a clinically safe time-frame?	See 1.1. In-county Primary PCI reduces the distance to travel (and therefore time to intervention) for patients requiring emergency intervention. Average 'call to balloon' response time reduced. Establishment of an IGIS hub at the trauma	

#	Questions to test	What would be better? (show how this would be evidenced)	What would be worse? (show how this would be evidenced)
		unit improves the availability and accessibility of IGIS services to trauma patients requiring emergency intervention; and improves rapid accessibility to source control intervention following diagnosis of sepsis or septic shock.	
1.9	What is the effect of this solution on the likelihood of travel time impacting negatively on patient outcomes?	In-county Primary PCI reduces the distance to travel (and therefore time to intervention) for patients requiring emergency intervention. Establishing a hub at GRH improves accessibility for patients travelling from the Forest of Dean and West of the County, outside of the two urban centres this is where the majority of patients requiring IGIS are travelling from. Evidence: demand map	
1.10	What is the likely effect of this solution on patient safety risks?	No impact	No impact

Access to care

#	Questions to test	What would be better? (show how this would be evidenced)	What would be worse? (show how this would be evidenced)
2.1	What is the likelihood of this solution meeting the requirements of the NHS Constitution and The NHS Choice Framework?	No impact	No impact

#	Questions to test	What would be better? (show how this would be evidenced)	What would be worse? (show how this would be evidenced)
2.2	What is the likely effect of this solution on simplifying the offer to patients?	No impact	No impact
2.3	What is the likely effect of this solution on the travel burden for patients?	Travel analysis tbc, but any service moving from Cheltenham to Gloucester will reduce travel times for residents of Gloucester, the Forest of Dean and parts of Tewkesbury/Newent/Staunton	Travel analysis tbc, but any service moving from Cheltenham to Gloucester will increase travel time for residents of Cheltenham, the Cotswolds, and some areas of Stroud and Berkley Vale.
2.4	What is the likely effect of this solution on patients' waiting time to access services?	The option improves our ability to expand IGIS provision locally. This will increase the regional provision of services, which will reduce regional average waiting times for elective IGIS services that patients must currently travel out of county to receive.	
2.5	What is the likely effect of this solution on the travel burden for carers and families?	See 2.3	See 2.3
2.6	What is the likelihood of this solution supporting the use of new technology to improve access?	No impact	No impact
2.7	What is the likelihood of this solution improving or maintaining service operating hours?	This solution is likely to lead to an acceleration of the implementation of a 24/7 Primary PCI service and fill gaps that are present in the 24/7 Interventional Radiology on call rota	
2.8	What is the likelihood of this solution improving or	No impact	For some patients there will be a reduction in service operating locations

#	Questions to test	What would be better? (show how this would be evidenced)	What would be worse? (show how this would be evidenced)
	maintaining service operating locations?		
2.9	What is the likelihood of this solution having a positive impact on equality and health inequalities as set out in the Public Sector Equality Duty 2011 and the Health and Social Care Act 2012?	Further analysis required	Further analysis required
2.10	What is the likelihood of this solution accounting for future changes in population size and demographics?	Growth modelling not yet available	Growth modelling not yet available

Deliverability

#	Questions to test	What would be better? (show how this would be evidenced)	What would be worse? (show how this would be evidenced)
3.1	What is the likelihood of this solution being delivered within the agreed timescale?	Many of our existing IGIS facilities are soon due or already overdue replacement – providing an opportunity to implement reconfiguration of services and facilities within the next few years.	
3.2	What is the likelihood of this solution meeting the relevant national, regional or local delivery timescales?	No impact	No impact
3.3	What is the likelihood of this solution having the implementation capacity to deliver?	High. Planned procurement of a Managed Equipment Service for Imaging will provide vehicle to enable service reconfiguration.	

#	Questions to test	What would be better? (show how this would be evidenced)	What would be worse? (show how this would be evidenced)
		Many large items of imaging equipment are now due or approaching planned replacement.	
3.4	What is the likely effect of this solution on access to the required staffing capacity and capability to be successfully implemented?	Establishment of an IGIS hub will allow improved efficiency of staff deployment, allowing us to support more activity with existing volumes of staff. The establishment of an IGIS hub is expected to improve our ability to attract and retain staff.	
3.5	What is the likelihood of this solution having access to the required support services to be successfully implemented?	No impact	No impact
3.6	What is the likelihood of this solution having access to the required premises/estates to be successfully implemented?		Some displacement of existing services will be required to establish a sufficient footprint for an IGIS hub at GRH (incl. associated daycase beds), relocation of the hybrid theatre and relocation of the vascular bed base to GRH. Further implementation planning required if this is a shortlisted solution.
3.7	What is the likelihood of this solution having access to the required technology to be successfully implemented?	Many of our existing IGIS facilities are soon due or overdue replacement – providing an opportunity for reconfiguration of services and facilities.	
3.8	Does this solution rely on other models of care / provision being put in place and if so, are they	No impact	See 3.6

#	Questions to test	What would be better? (show how this would be evidenced)	What would be worse? (show how this would be evidenced)
	deliverable within the timeframe?		

Workforce

#	Questions to test	What would be better? (show how this would be evidenced)	What would be worse? (show how this would be evidenced)
4.1	What is the likely effect of this solution on improving workforce capacity resilience and reducing the risk of temporary service changes?	Concentration of IGIS facilities into a hub will improve the resilience of service provision – allowing a more flexible and responsive reaction to cover gaps arising from sickness or other on-the-day issues.	There may be some staff dissatisfaction in respect of staff who prefer CGH as base.
4.2	What is the likely effect of this solution on optimising the efficient and effective use of clinical staff?	Establishment of a hub for IGIS will improve efficient deployment of technical staff – allowing radiographers to quickly move between facilities and support multiple lists. Concentration of IGIS facilities will also reduce the time currently lost as a result of staff travelling between sites.	
4.3	What is the likely effect of this solution on supporting cross-organisational working across the patient pathway?	No impact	No impact
4.4	What is the likely effect of this solution on supporting the flexible deployment of staff and the development of innovative staffing models?	Concentrated co-location of IGIS facilities improves the flexible deployment of staff. The co-location of catheter labs with Interventional Radiology improves the opportunity to develop innovative nursing and technician roles that support both services.	

#	Questions to test	What would be better? (show how this would be evidenced)	What would be worse? (show how this would be evidenced)
4.5	What is the likely effect of this solution on supporting staff health and wellbeing and their ability to self-care?	Improved ability to attract and retain staff will reduce the pressure on existing consultants to fill gaps in on-call rotas in addition to their existing allocation thereby reducing stress and improving staff health	There may be some staff dissatisfaction in respect of staff who prefer CGH as base
4.6	What is the likely effect of this solution on improving the recruitment and retention of permanent staff with the right skills, values and competencies?	Establishment of an IGIS hub is expected to have a significant impact on staff recruitment and retention, providing a much more appealing offer to staff.	There may be some staff dissatisfaction in respect of staff who prefer CGH as base
4.7	What is the likely effect of this solution on retaining trainee allocations, providing opportunities to develop staff with the right skills, values and competencies?	No impact	No impact
4.8	What is the likely effect of this solution on maintaining or improving the availability of trainers and supporting them to fulfil their training role?	The co-location of IGIS facilities will improve the ability to train junior radiographers across all IGIS competencies.	
4.9	What is the likely effect of this solution on enabling staff to maintain or enhance their capabilities/ competencies?	The co-location of IGIS facilities will improve the ability for radiographers to expand their competencies across all IGIS.	
4.10	What is the likely effect of this solution on enabling staff to fulfil their capability, utilising all of their skills, and develop within their	No impact	No impact

#	Questions to test	What would be better? (show how this would be evidenced)	What would be worse? (show how this would be evidenced)
	role?		
4.11	What is the likely effect of this solution on the travel burden for staff?	Further analysis required	Further analysis required
4.12	What is the likely effect of this solution on maintaining clinical supervision support to staff?	No impact	No impact

Finance/ value for money

#	Questions to test	What would be better? (show how this would be evidenced)	What would be worse? (show how this would be evidenced)
5.1	What is the likelihood of this solution being within the current cost envelope (19/20 forecast outturn cost base)?	Detailed business case modelling not yet done, but staffing and resources assumed to be based on current provision.	
5.2	What is the likelihood of this solution being affordable i.e. does it deliver benefits within the Gloucestershire financial envelope	No additional cost to Gloucestershire.	
5.3	What is the likelihood of this solution increasing net revenue to the system?	Medium Potential to repatriate activity from other areas with the potential to generate £1 million (net of costs) for the Gloucestershire system. This has been tested at a high level with specialist commissioners which removed some procedures as not having sufficient population to support a service.	

#	Questions to test	What would be better? (show how this would be evidenced)	What would be worse? (show how this would be evidenced)
		Assumptions and commissioning intentions (i.e. likelihood of repatriating work) would be validated further at business case stage.	
5.4	What is the likelihood of significant capital costs over and above current capital allocations that cannot be mitigated?		This solution would require changes to the estate at GRH to accommodate co-location of IGIS facilities into a hub – with associate capital cost. This is accounted for in the Trust's Estates Strategy.
5.5	What is likelihood that this solutions' transition, implementation, double-running or stranded costs cannot be managed/mitigated by system-working?	Not yet known	

Strategic Fit

#	Questions to test	What would be better? (show how this would be evidenced)	What would be worse? (show how this would be evidenced)
6.1	What is the likelihood of this solution being compatible with the One Gloucestershire vision?	Consistent with vision for *centres of excellence.*	
6.2	What is the likelihood of this solution being consistent with the NHS Long Term Plan?		

Acceptability

#	Questions to test	What would be better? (show how this would be evidenced)	What would be worse? (show how this would be evidenced)
7.1	What is the likelihood that this solution has satisfactorily taken into account and responded to the Fit for the Future Outcome of Engagement Report	All solutions have been developed with reference to the *Outputs of Engagement Report*. Solutions included/adapted as a result of public feedback are: • Re-open CGH ED overnight • IGIS centralised to CGH site • IGIS hub options	

Solution description reference #	**C5**
Solution description	Centralise elective colorectal to Cheltenham General Hospital (CGH).
Relevant to Model #s	Model D, F, G, H

Quality of care

#	Questions to test	What would be better? (show how this would be evidenced)	What would be worse? (show how this would be evidenced)
1.1	What is the likely effect of this solution on patients receiving equal or better outcomes of care?	Improved access to sub-specialist care, ensuring equitable pathways for all patients No cancellations for planned care Benefits of co-location with urology, gynae-oncology and medical gastroenterology Supported by the findings of the New Zealand report *Strategy 10 – Improving elective care through separating acute and elective surgery,* 2012. This would be evidenced by patient pathways and for cancer patients, the cancer patient experience survey.	A few patients who have had planned care and need urgent re-admission might be admitted to GRH and need to be transferred to CGH. The EGS team would not be on the same site as planned patients who become unwell in hospital after their operation. The 'deteriorating patient' model would support all patients on the CGH site with 24/7 specialist care including resident overnight ITU consultant cover. This team would rapidly identify and liaise with the surgical team in GRH, should review or surgery be required. While under the expert care of the deteriorating patient team, a Standard Operating Procedure would define the clinical circumstances under which a surgeon would travel to the CGH site, or the patient would be transferred to GRH.
1.2	What is the likely effect of this solution on patients being treated by the right teams with the right skills and experience in the right place and at the right	Improved access to sub-specialist care, ensuring equitable pathways for all patients Improved access to specialist nursing care Dedicated planned care team protected from EGS demands.	No impact

#	Questions to test	What would be better? (show how this would be evidenced)	What would be worse? (show how this would be evidenced)
	time?	Benefits of co-location with urology, gynae-oncology and medical gastroenterology Supported by the findings of the *Royal College of Surgeons – separating emergency and elective surgical care Report*, September 2007 This would be evidenced by patient pathways and for cancer patients, the cancer patient experience survey.	
1.3	What is the likely effect of this solution on continuity of care for patients?	Planned in-patients in colorectal surgery would have a dedicated specialist team led by a consultant week to week whilst remaining under a single consultant's care.	Planned CGH patients would need to be seen at weekends and a new Consultation rota would need to be agreed to provide this. . Currently the on-call EGS team based on-site is able to review inpatients over the weekend.
1.4	What is the likely effect of this solution on the opportunity to link with other teams and agencies to support patients holistically?	No impact	No impact
1.5	What is the likely effect of this solution on the quality of the care environment?	This option provides a specialist colorectal unit dedicated to planned care Ward environment dedicated to planned care without being adversely impacted by the delivery of EGS Single specialist nursing, ANP and Allied Health Professionals team (AHPs) e.g. physiotherapy, occupational therapy,	No impact

#	Questions to test	What would be better? (show how this would be evidenced)	What would be worse? (show how this would be evidenced)
		nutrition team).	
1.6	What is the likely effect of this solution on encouraging patients and carers to manage self-care appropriately?	No impact	No impact
1.7	What is the likely effect of this solution on enabling patient transfers within a clinically safe time frame?	No impact	Planned patients who become unwell in hospital after their operation may require transfer to GRH (if stable). The 'deteriorating patient' model would support all patients on the CGH site with 24/7 specialist care including resident overnight ITU consultant cover. This team would rapidly identify and liaise with the surgical team in GRH, should review or surgery be required. While under the expert care of the deteriorating patient team, a Standard Operating Procedure would define the clinical circumstances under which a surgeon would travel to the CGH site, or the patient would be transferred to GRH.
1.8	What is the likely effect of this solution on enabling emergency interventions within a clinically safe time-frame?	Improved access to sub-specialist team for patients requiring out of hours emergency treatment having undergone planned care. This would be evidenced by reviewing time of decision to treat and treatment.	An acute or deteriorating patient at CGH would require transfer to GRH or the surgeon to travel to CGH. Access to emergency intervention may be compromised by lack of dedicated emergency theatre in CGH This would be evidenced by monitoring Key Performance Indicators.

#	Questions to test	What would be better? (show how this would be evidenced)	What would be worse? (show how this would be evidenced)
1.9	What is the effect of this solution on the likelihood of travel time impacting negatively on patient outcomes?	No impact	For some patients there would be an increase in travel time to CGH for planned care admissions. This would not negatively influence patient outcomes.
1.10	What is the likely effect of this solution on patient safety risks?	Improve recruitment of medical and nursing staff. Reduce the risk of cancellations to planned care. This would be evidenced by monitoring Key Performance Indicators.	No impact

Access to care

#	Questions to test	What would be better? (show how this would be evidenced)	What would be worse? (show how this would be evidenced)
2.1	What is the likelihood of this solution meeting the requirements of the NHS Constitution and The NHS Choice Framework?	Improve ability to achieve national waiting time standards. This would be evidenced by comparison with national standards and internal audit.	No impact
2.2	What is the likely effect of this solution on simplifying the offer to patients?	Single site for delivery of planned inpatient colorectal care. This would be evidenced by patient pathways.	No impact
2.3	What is the likely effect of this solution on the travel burden for patients?	Service currently in place in CGH for local residents – no further improved impact.	Travel analysis tbc, but any service moving from GRH to CGH will increase travel times for residents of Gloucester, the Forest of Dean and parts of Tewkesbury/Newent/Staunton

#	Questions to test	What would be better? (show how this would be evidenced)	What would be worse? (show how this would be evidenced)
2.4	What is the likely effect of this solution on patients' waiting time to access services?	Improve ability to achieve national waiting time standards. This would be evidenced by monitoring Key Performance Indicators (cancellations)	
2.5	What is the likely effect of this solution on the travel burden for carers and families?	See 2.3	See 2.3
2.6	What is the likelihood of this solution supporting the use of new technology to improve access?	No impact	No impact
2.7	What is the likelihood of this solution improving or maintaining service operating hours?	Maintains colorectal presence on CGH site	No impact
2.8	What is the likelihood of this solution improving or maintaining service operating locations?		No planned inpatient colorectal at GRH
2.9	What is the likelihood of this solution having a positive impact on equality and health inequalities as set out in the Public Sector Equality Duty 2011 and the Health and Social Care Act 2012?	Further analysis required	Further analysis required
2.10	What is the likelihood of this solution accounting for future	Growth modelling not yet available	Growth modelling not yet available

#	Questions to test	What would be better? (show how this would be evidenced)	What would be worse? (show how this would be evidenced)
	changes in population size and demographics?		

Deliverability

#	Questions to test	What would be better? (show how this would be evidenced)	What would be worse? (show how this would be evidenced)
3.1	What is the likelihood of this solution being delivered within the agreed timescale?	Subject to consultation and statutory notice period, this option could be delivered within the agreed timescale. This would be evidenced by statutory timescales and indicative implementation timetable.	
3.2	What is the likelihood of this solution meeting the relevant national, regional or local delivery timescales?	No impact	No impact
3.3	What is the likelihood of this solution having the implementation capacity to deliver?	Critical Care and Bed capacity already exists to deliver this option. Staffing capacity at middle grade medical staff level already exists to deliver this option.	Impact on junior doctor rota and possible weekend consultation rota to be determined
3.4	What is the likely effect of this solution on access to the required staffing capacity and capability to be successfully implemented?	See 3.3	
3.5	What is the likelihood of this solution having access to the required support services to be successfully implemented?	All support services for elective colorectal currently exist at CGH site – critical care, nursing team, radiology	Transfer of EGS to GRH reduces demand on CGH Critical Care

#	Questions to test	What would be better? (show how this would be evidenced)	What would be worse? (show how this would be evidenced)
3.6	What is the likelihood of this solution having access to the required premises/estates to be successfully implemented?	All beds and estate already exist at CGH to deliver this option	
3.7	What is the likelihood of this solution having access to the required technology to be successfully implemented?	No impact	No impact
3.8	Does this solution rely on other models of care / provision being put in place and if so, are they deliverable within the timeframe?	Agreed middle grade rota and two consultant on-call rota would provide full cover for planned care centre at CGH This would be evidenced by staff rotas	Planned CGH patients would need to be seen at weekends and a new Consultation and junior doctor rota would need to be agreed to provide this. Currently the on-call EGS team based on-site is able to review inpatients over the weekend.

Workforce

#	Questions to test	What would be better? (show how this would be evidenced)	What would be worse? (show how this would be evidenced)
4.1	What is the likely effect of this solution on improving workforce capacity resilience and reducing the risk of temporary service changes?	A single centre would provide more efficient and flexible use of planned care resources (particularly theatres). Supported by the findings of the New Zealand report *Strategy 10 – Improving elective care through separating acute and elective surgery,* 2012. A single unit would deliver group working optimising the ability to cross cover and back fill sessions Improved flexibility to cover unexpected absence.	Potential for GRH colorectal nursing staff to be reallocated from current wards. This would be evidenced by staff establishment.

#	Questions to test	What would be better? (show how this would be evidenced)	What would be worse? (show how this would be evidenced)
4.2	What is the likely effect of this solution on optimising the efficient and effective use of clinical staff?	See 4.1	See 4.1
4.3	What is the likely effect of this solution on supporting cross-organisational working across the patient pathway?	Benefits of co-location with urology, gynae-oncology and medical gastroenterology	No impact
4.4	What is the likely effect of this solution on supporting the flexible deployment of staff and the development of innovative staffing models?	Benefits of single site working Option to expand the role of nurse specialists and practitioners for delivery of planned care Opportunity to introduce Physician Associate roles to support the delivery of planned colorectal care within the timeframe This would be evidenced by the introduction of new posts	No impact
4.5	What is the likely effect of this solution on supporting staff health and wellbeing and their ability to self-care?	A single unit would deliver group working which should offer better group cohesion, team working and positive work experience This would be evidenced by staff rotas and staff well-being metrics.	Potential for existing GRH nursing staff to be reallocated from current wards. This could impact morale and staff health and well-being. This would be evidenced by staff rotas and staff well-being metrics.
4.6	What is the likely effect of this solution on improving the recruitment and retention of permanent staff with the right skills, values and competencies?	Offering dedicated specialist facility should improve the desirability to work as a colorectal specialist (ward nursing, specialist nursing, medical and support staff) The expanded/improved opportunities as	There may be some staff dissatisfaction in respect of staff who prefer GRH as base.

#	Questions to test	What would be better? (show how this would be evidenced)	What would be worse? (show how this would be evidenced)
		described above in terms of training and development and advancement of new roles highly likely to have a positive impact on staff retention and the ability to recruit new staff. This would be evidenced by staff rotas, recruitment and retention metrics.	
4.7	What is the likely effect of this solution on retaining trainee allocations, providing opportunities to develop staff with the right skills, values and competencies?	A single dedicated colorectal unit would concentrate all available training opportunities to ensure maximum exposure Greater opportunity to provide enhanced sub-specialist colorectal training e.g. early rectal cancer treatment and pelvic floor surgery. Supported by the findings of the New Zealand report *Strategy 10 – Improving elective care through separating acute and elective surgery,* 2012. and the *Royal College of Surgeons – separating emergency and elective surgical care Report*, September 2007 Compliance with Deanery regulations Enable the Trust to retain trainee allocations. Enable development of middle grade fellowships for advanced colorectal specialist training This would be evidenced by the GMC survey and Deanery feedback.	No impact

#	Questions to test	What would be better? (show how this would be evidenced)	What would be worse? (show how this would be evidenced)
4.8	What is the likely effect of this solution on maintaining or improving the availability of trainers and supporting them to fulfil their training role?	See 4.7 All consultants delivering elective training in a single location, separate from EGS, able to offer maximum flexibility in training provision Greater opportunity to provide enhanced sub-specialist colorectal training e.g. early rectal cancer treatment and pelvic floor surgery.	No impact
4.9	What is the likely effect of this solution on enabling staff to maintain or enhance their capabilities/ competencies?	A single dedicated colorectal unit would concentrate all available training & learning opportunities including sub-specialist colorectal services e.g. early rectal cancer and pelvic floor surgery. This option would optimise the learning environment for all staff	No impact
4.10	What is the likely effect of this solution on enabling staff to fulfil their capability, utilising all of their skills, and develop within their role?	See 4.1, 4.8, 4.9	No impact
4.11	What is the likely effect of this solution on the travel burden for staff?	Further analysis required	Further analysis required
4.12	What is the likely effect of this solution on maintaining clinical supervision support to staff?	All consultants providing planned care on a single site would allow tailored and more flexible training opportunities for trainees, dependent on their level of experience and training requirements	No impact

#	Questions to test	What would be better? (show how this would be evidenced)	What would be worse? (show how this would be evidenced)
		All planned colorectal patients on one site would allow senior ward nursing supervision of all ward staff in one place.	

Finance/ value for money

#	Questions to test	What would be better? (show how this would be evidenced)	What would be worse? (show how this would be evidenced)
5.1	What is the likelihood of this solution being within the current cost envelope (19/20 forecast outturn cost base)?		There are likely to be some costs associated with providing medical support to patients on an elective site. These are not yet worked up.
5.2	What is the likelihood of this solution being affordable i.e. does it deliver benefits within the Gloucestershire financial envelope	To be confirmed subject to 5.3.	To be confirmed subject to 5.1 and 5.3
5.3	What is the likelihood of this solution increasing net revenue to the system?	There may be potential for a centralised colorectal service to increase its capacity, particularly to repatriate patients from out of county. This has not yet been modelled.	
5.4	What is the likelihood of significant capital costs over and above current capital allocations that cannot be mitigated?	Not yet known	Ward and theatre capacity would be required – plan for this not yet developed.
5.5	What is likelihood that this solutions' transition, implementation, double-running or stranded costs cannot be managed/mitigated by system-	Not yet known	

	working?		

Strategic Fit

#	Questions to test	What would be better? (show how this would be evidenced)	What would be worse? (show how this would be evidenced)
6.1	What is the likelihood of this solution being compatible with the One Gloucestershire vision?	Provides a *centre of excellence* for planned colorectal surgery patients Provides on-site access to other specialties involved in the care of complex pelvic disease, including cancer Supports the development of the Gloucestershire Cancer Institute Continued provision of tertiary referral services (i.e. out of county patients with early rectal cancer) Provides the opportunity for innovation to enhance patient care (e.g. robotic surgery).	
6.2	What is the likelihood of this solution being consistent with the NHS Long Term Plan?	Consistent with NHS Long Term plan objective to support hospitals that wish to pursue a model of care that separates emergency and planned care Separating planned care at CGH away from the site of EGS (GRH) would reduce the pressure on emergency hospital care Single site of planned colorectal cancer care would improve ability to deliver holistic care This would be evidenced by monitoring of bed escalation status and cancer experience survey	

Acceptability

#	Questions to test	What would be better? (show how this would be evidenced)	What would be worse? (show how this would be evidenced)
7.1	What is the likelihood that this solution has satisfactorily taken into account and responded to the Fit for the Future Outcome of Engagement Report	All solutions have been developed with reference to the *Outputs of Engagement Report*. Solutions included/adapted as a result of public feedback are: • Re-open CGH ED overnight • IGIS centralised to CGH site • IGIS hub options	

Solution description reference #	**C11**
Solution description	Centralise elective daycase surgery for colorectal and upper GI to CGH / dedicated Day Surgery Unit (DSU).
Relevant to Model #s	Model D, E, F, G, H

Quality of care

#	Questions to test	What would be better? (show how this would be evidenced)	What would be worse? (show how this would be evidenced)
1.1	What is the likely effect of this solution on patients receiving equal or better outcomes of care?	No cancellations for planned care This would be evidenced by monitoring Key Performance Indicators.	No impact
1.2	What is the likely effect of this solution on patients being treated by the right teams with the right skills and experience in the right place and at the right time?	No change.	No impact
1.3	What is the likely effect of this solution on continuity of care for patients?	No impact	No impact
1.4	What is the likely effect of this solution on the opportunity to link with other teams and agencies to support patients holistically?	No impact	No impact
1.5	What is the likely effect of this solution on the quality of the care environment?	Day surgery unit dedicated to day surgery, without being adversely impacted by the delivery of EGS or in-patient surgery	No impact

#	Questions to test	What would be better? (show how this would be evidenced)	What would be worse? (show how this would be evidenced)
1.6	What is the likely effect of this solution on encouraging patients and carers to manage self-care appropriately?	No impact	No impact
1.7	What is the likely effect of this solution on enabling patient transfers within a clinically safe time frame?	No impact	No impact
1.8	What is the likely effect of this solution on enabling emergency interventions within a clinically safe time-frame?	No change	No impact
1.9	What is the effect of this solution on the likelihood of travel time impacting negatively on patient outcomes?	No impact	For some patients there would be an increase in travel time to CGH for planned day case procedures. This would not negatively influence patient outcomes.
1.10	What is the likely effect of this solution on patient safety risks?	Improve risk of cancellations to planned care. Supported by the findings of the New Zealand report *Strategy 10 – Improving elective care through separating acute and elective surgery,* 2012 This would be evidenced by monitoring Key Performance Indicators.	No impact

Access to care

#	Questions to test	What would be better? (show how this would be evidenced)	What would be worse? (show how this would be evidenced)
2.1	What is the likelihood of this solution meeting the requirements of the NHS Constitution and The NHS Choice Framework?	Improve ability to achieve national waiting time standards. This would be evidenced by comparison with national standards and internal audit.	No impact
2.2	What is the likely effect of this solution on simplifying the offer to patients?	Single site for delivery of planned daycase care. This would be evidenced by patient pathways.	No impact
2.3	What is the likely effect of this solution on the travel burden for patients?	Travel analysis tbc, but any service moving from GRH to CGH will reduce travel times for residents of Cheltenham, the Cotswolds, and some areas of Stroud and Berkley Vale.	Travel analysis tbc, but any service moving from GRH to CGH will increase travel times for residents of Gloucester, the Forest of Dean and parts of Tewkesbury/Newent/Staunton
2.4	What is the likely effect of this solution on patients' waiting time to access services?	Improve ability to achieve national waiting time standards. This would be evidenced by monitoring Key Performance Indicators (cancellations)	No impact
2.5	What is the likely effect of this solution on the travel burden for carers and families?	See 2.3	See 2.3
2.6	What is the likelihood of this solution supporting the use of new technology to improve access?	No impact	No impact
2.7	What is the likelihood of this	No impact	No impact

#	Questions to test	What would be better? (show how this would be evidenced)	What would be worse? (show how this would be evidenced)
	solution improving or maintaining service operating hours?		
2.8	What is the likelihood of this solution improving or maintaining service operating locations?	No impact	No planned day case care at GRH
2.9	What is the likelihood of this solution having a positive impact on equality and health inequalities as set out in the Public Sector Equality Duty 2011 and the Health and Social Care Act 2012?	Further analysis required	Further analysis required
2.10	What is the likelihood of this solution accounting for future changes in population size and demographics?	Growth modelling not yet available	Growth modelling not yet available

Deliverability

#	Questions to test	What would be better? (show how this would be evidenced)	What would be worse? (show how this would be evidenced)
3.1	What is the likelihood of this solution being delivered within the agreed timescale?	Subject to consultation and statutory notice period, this option could be delivered within the agreed timescale. This would be evidenced by statutory timescales and indicative implementation timetable.	No impact
3.2	What is the likelihood of this solution meeting the relevant national, regional or local delivery timescales?	No impact	No impact
3.3	What is the likelihood of this solution having the implementation capacity to deliver?	No impact	No impact
3.4	What is the likely effect of this solution on access to the required staffing capacity and capability to be successfully implemented?	No impact	No impact
3.5	What is the likelihood of this solution having access to the required support services to be successfully implemented?	All support services for daycases currently exist at CGH site.	No impact
3.6	What is the likelihood of this solution having access to the required premises/estates to be successfully implemented?	Additional daycase beds would be provided on the CGH site.	No impact
3.7	What is the likelihood of this solution having access to the	No impact	No impact

#	Questions to test	What would be better? (show how this would be evidenced)	What would be worse? (show how this would be evidenced)
	required technology to be successfully implemented?		
3.8	Does this solution rely on other models of care / provision being put in place and if so, are they deliverable within the timeframe?	No impact	No impact

Workforce

#	Questions to test	What would be better? (show how this would be evidenced)	What would be worse? (show how this would be evidenced)
4.1	What is the likely effect of this solution on improving workforce capacity resilience and reducing the risk of temporary service changes?	By centralising daycases, more efficient and effective use can be made of daycase nursing staff. Cohesive group working would reduce absence and improve recruitment Flexibility to cover unexpected absence. This would be evidenced by staff establishment	Potential for GRH daycase nursing staff to be reallocated from current unit. This would be evidenced by staff establishment.
4.2	What is the likely effect of this solution on optimising the efficient and effective use of clinical staff?	No impact	No impact
4.3	What is the likely effect of this solution on supporting cross-organisational working across the patient pathway?	No impact	No impact
4.4	What is the likely effect of this solution on supporting the flexible deployment of staff and the development of innovative	Opportunity to introduce Physician Associate roles to support the delivery of daycase care within the timeframe	No impact

#	Questions to test	What would be better? (show how this would be evidenced)	What would be worse? (show how this would be evidenced)
	staffing models?	This would be evidenced by the introduction of new posts	
4.5	What is the likely effect of this solution on supporting staff health and wellbeing and their ability to self-care?	Dedicated daycase unit separate from EGS would deliver a consistent environment for staff to work in	Potential for existing GRH daycase nursing staff to be reallocated from current unit. This could impact morale and staff health and well-being. This would be evidenced by staff rotas and staff well-being metrics.
4.6	What is the likely effect of this solution on improving the recruitment and retention of permanent staff with the right skills, values and competencies?	See 4.1	See 4.1
4.7	What is the likely effect of this solution on retaining trainee allocations, providing opportunities to develop staff with the right skills, values and competencies?	Provide dedicated daycase training. This option would strengthen training experience offered. Compliance with Deanery regulations Enable the Trust to retain trainee allocations.	No impact
4.8	What is the likely effect of this solution on maintaining or improving the availability of trainers and supporting them to fulfil their training role?	No impact	No impact
4.9	What is the likely effect of this solution on enabling staff to maintain or enhance their capabilities/ competencies?	No impact	No impact

#	Questions to test	What would be better? (show how this would be evidenced)	What would be worse? (show how this would be evidenced)
4.10	What is the likely effect of this solution on enabling staff to fulfil their capability, utilising all of their skills, and develop within their role?	See 4.1, 4.8 & 4.9	
4.11	What is the likely effect of this solution on the travel burden for staff?	Further analysis required	Further analysis required
4.12	What is the likely effect of this solution on maintaining clinical supervision support to staff?	No impact	No impact

Finance/ value for money

#	Questions to test	What would be better? (show how this would be evidenced)	What would be worse? (show how this would be evidenced)
5.1	What is the likelihood of this solution being within the current cost envelope (19/20 forecast outturn cost base)?	High	
5.2	What is the likelihood of this solution being affordable i.e. does it deliver benefits within the Gloucestershire financial envelope	High – anticipated activity is the same, but more efficient delivery.	More efficient delivery could lead to increased costs to commissioners – mitigated through modelling and contract negotiations.
5.3	What is the likelihood of this solution increasing net revenue to the system?	None planned	
5.4	What is the likelihood of significant capital costs over and		This solution would require improvements to the estate at CGH to accommodate

	above current capital allocations that cannot be mitigated?		dedicated day surgery facilities – with associated capital cost. This is accounted for in the Trust's Estates Strategy.
5.5	What is likelihood that this solutions' transition, implementation, double-running or stranded costs cannot be managed/mitigated by system-working?	Low	

Strategic Fit

#	Questions to test	What would be better? (show how this would be evidenced)	What would be worse? (show how this would be evidenced)
6.1	What is the likelihood of this solution being compatible with the One Gloucestershire vision?	This option is compatible with the vision and would enable daycases to develop a sustainable local health and care workforce.	
6.2	What is the likelihood of this solution being consistent with the NHS Long Term Plan?		

Acceptability

#	Questions to test	What would be better? (show how this would be evidenced)	What would be worse? (show how this would be evidenced)
7.1	What is the likelihood that this solution has satisfactorily taken into account and responded to the Fit for the Future Outcome of Engagement Report	All solutions have been developed with reference to the *Outputs of Engagement Report*. Solutions included/adapted as a result of public feedback are: • Re-open CGH ED overnight • IGIS centralised to CGH site • IGIS hub options	

Solution description reference #	**C6**
Solution description	Centralise elective colorectal to GRH
Relevant to Model #s	Model E

Quality of care

#	Questions to test	What would be better? (show how this would be evidenced)	What would be worse? (show how this would be evidenced)
1.1	What is the likely effect of this solution on patients receiving equal or better outcomes of care?	Improved access to sub-specialist care, ensuring equitable pathways for all patients Improved access to specialist nursing care (Cancer Nurses / Stoma Nurses) Planned patients who become unwell in hospital after their operation have rapid access to the EGS team Patients who have had planned care and need urgent re-admission would be under the care of the same consultant team. Supported by the findings of the *Royal College of Surgeons – separating emergency and elective surgical care Report*, September 2007 This would be evidenced by patient pathways and for cancer patients, the cancer patient experience survey.	No impact
1.2	What is the likely effect of this solution on patients being treated by the right teams with the right skills and experience in the right place and at the right time?	Improved access to sub-specialist care, ensuring equitable pathways for all patients Improved access to specialist nursing care (Cancer Nurses / Stoma Nurses) Planned patients who become unwell in hospital after their operation have rapid	No impact

#	Questions to test	What would be better? (show how this would be evidenced)	What would be worse? (show how this would be evidenced)
		access to the EGS team Patients who have had planned care and need urgent re-admission would be under the care of the same consultant team. This would be evidenced by patient pathways and for cancer patients, the cancer patient experience survey.	
1.3	What is the likely effect of this solution on continuity of care for patients?	Planned care in Colorectal surgery would have a dedicated team 365 days a year Planned patients at GRH would be reviewed by EGS colorectal consultant at weekends	No impact
1.4	What is the likely effect of this solution on the opportunity to link with other teams and agencies to support patients holistically?	No impact	No impact
1.5	What is the likely effect of this solution on the quality of the care environment?	This option provides a specialist unit dedicated to planned care Single specialist nursing, ANP and Allied Health Professionals team (AHPs) e.g. physiotherapy, occupational therapy, nutrition team).	Planned care ward environment has the potential to be impacted by the delivery of EGS Supported by the findings of the *Royal College of Surgeons – separating emergency and elective surgical care Report*, September 2007
1.6	What is the likely effect of this solution on encouraging patients and carers to manage self-care appropriately?	No impact	No impact

#	Questions to test	What would be better? (show how this would be evidenced)	What would be worse? (show how this would be evidenced)
1.7	What is the likely effect of this solution on enabling patient transfers within a clinically safe time frame?	No impact	No impact
1.8	What is the likely effect of this solution on enabling emergency interventions within a clinically safe time-frame?	Improved access to sub-specialist team for patients requiring out of hours emergency treatment having undergone planned care. This would be evidenced by reviewing time of decision to treat and treatment.	No impact
1.9	What is the effect of this solution on the likelihood of travel time impacting negatively on patient outcomes?	No impact	For some patients there would be an increase in travel time to GRH for planned care admissions. This would not negatively influence patient outcomes.
1.10	What is the likely effect of this solution on patient safety risks?	Improve recruitment of medical and nursing staff. This would be evidenced by staff turnover / vacancy rate	No impact

Access to care

#	Questions to test	What would be better? (show how this would be evidenced)	What would be worse? (show how this would be evidenced)
2.1	What is the likelihood of this solution meeting the requirements of the NHS Constitution and The NHS Choice Framework?	Improve ability to achieve national waiting time standards. This would be evidenced by comparison with national standards and internal audit	No impact
2.2	What is the likely effect of this solution on simplifying the offer to patients?	Single site for delivery of planned inpatient colorectal care. This would be evidenced by patient	No impact

#	Questions to test	What would be better? (show how this would be evidenced)	What would be worse? (show how this would be evidenced)
		pathways.	
2.3	What is the likely effect of this solution on the travel burden for patients?	Travel analysis tbc, but any service moving from CGH to GRH will reduce travel times for residents of Gloucester, the Forest of Dean and parts of Tewkesbury/Newent/Staunton	Travel analysis tbc, but any service moving from CGH to GRH will increase travel time for residents of Cheltenham, the Cotswolds, and some areas of Stroud and Berkley Vale.
2.4	What is the likely effect of this solution on patients' waiting time to access services?	Improve ability to achieve national waiting time standards. This would be evidenced by monitoring Key Performance Indicators (cancellations)	No impact
2.5	What is the likely effect of this solution on the travel burden for carers and families?	See 2.3	See 2.3
2.6	What is the likelihood of this solution supporting the use of new technology to improve access?	No impact	No impact
2.7	What is the likelihood of this solution improving or maintaining service operating hours?	No impact	No impact
2.8	What is the likelihood of this solution improving or maintaining service operating locations?	No impact	No planned inpatient colorectal at CGH
2.9	What is the likelihood of this solution having a positive impact on equality and health	Further analysis required	Further analysis required

#	Questions to test	What would be better? (show how this would be evidenced)	What would be worse? (show how this would be evidenced)
	inequalities as set out in the Public Sector Equality Duty 2011 and the Health and Social Care Act 2012?		
2.10	What is the likelihood of this solution accounting for future changes in population size and demographics?	Growth modelling not yet available	Growth modelling not yet available

Deliverability

#	Questions to test	What would be better? (show how this would be evidenced)	What would be worse? (show how this would be evidenced)
3.1	What is the likelihood of this solution being delivered within the agreed timescale?	Subject to consultation and statutory notice period, this option could be delivered within the agreed timescale. This would be evidenced by statutory timescales and indicative implementation timetable.	No impact
3.2	What is the likelihood of this solution meeting the relevant national, regional or local delivery timescales?	No impact	No impact
3.3	What is the likelihood of this solution having the implementation capacity to deliver?	This option would improve the capacity to provide junior doctor cover without the need to recruit additional medical or nursing support. Collocation with EGS allows "flexing" of rotas to provide safe cover e.g. covering staff illness at short notice.	No impact

#	Questions to test	What would be better? (show how this would be evidenced)	What would be worse? (show how this would be evidenced)
		Supported by the findings of the *Royal College of Surgeons – separating emergency and elective surgical care Report*, September 2007	
3.4	What is the likely effect of this solution on access to the required staffing capacity and capability to be successfully implemented?	See 3.3	See 3.3
3.5	What is the likelihood of this solution having access to the required support services to be successfully implemented?	All support services for elective colorectal currently exist at GRH site.	No impact
3.6	What is the likelihood of this solution having access to the required premises/estates to be successfully implemented?	Additional beds would be provided for elective colorectal on the GRH site. This would be evidenced by the estate plan.	No impact
3.7	What is the likelihood of this solution having access to the required technology to be successfully implemented?	No impact	No impact
3.8	Does this solution rely on other models of care / provision being put in place and if so, are they deliverable within the timeframe?	No impact	No impact

Workforce

#	Questions to test	What would be better? (show how this would be evidenced)	What would be worse? (show how this would be evidenced)
4.1	What is the likely effect of this solution on improving workforce capacity resilience and reducing the risk of temporary service changes?	Colocation of planned colorectal with EGS would allow more efficient and effective use of medical and nursing staff without the need to recruit Cohesive group working would reduce absence and improve recruitment Improved flexibility to cover unexpected absence. This would be evidenced by staff establishment	Potential for CGH nursing staff to be reallocated from current wards. This would be evidenced by staff establishment.
4.2	What is the likely effect of this solution on optimising the efficient and effective use of clinical staff?	Colocation with EGS would avoid the need for frequent changes of site for junior staff	See 4.1
4.3	What is the likely effect of this solution on supporting cross-organisational working across the patient pathway?	No impact	No impact
4.4	What is the likely effect of this solution on supporting the flexible deployment of staff and the development of innovative staffing models?	Opportunity to introduce more Advanced Nurse Practitioner roles to support the junior doctors within the timeframe Opportunity to introduce Physician Associate roles to support the delivery of planned colorectal care within the timeframe This would be evidenced by the introduction of new posts	No impact
4.5	What is the likely effect of this solution on supporting staff health	Colocation of the team with EGS would create greater clinical mass and staff	Potential for existing CGH nursing staff to be reallocated from current wards. This

#	Questions to test	What would be better? (show how this would be evidenced)	What would be worse? (show how this would be evidenced)
	and wellbeing and their ability to self-care?	resilience, which should have a positive impact on staff health and well-being. This would be evidenced by staff rotas and staff well-being metrics.	could impact morale and staff health and well-being. This would be evidenced by staff rotas and staff well-being metrics.
4.6	What is the likely effect of this solution on improving the recruitment and retention of permanent staff with the right skills, values and competencies?	Also see 4.1 The expanded/improved opportunities as described above in terms of training and development and advancement of new roles highly likely to have a positive impact on staff retention and the ability to recruit new staff.	See 4.1
4.7	What is the likely effect of this solution on retaining trainee allocations, providing opportunities to develop staff with the right skills, values and competencies?	Colocation of planned colorectal with EGS would ensure consistent access to educational supervisor. Greater opportunity to provide enhanced sub-specialist colorectal training e.g. early rectal cancer treatment and pelvic floor surgery. This option would strengthen training experience offered. Compliance with Deanery regulations Enable the Trust to retain trainee allocations. Enable development of middle grade fellowships for advanced colorectal specialist training This would be evidenced by the GMC survey and Deanery feedback.	No impact

#	Questions to test	What would be better? (show how this would be evidenced)	What would be worse? (show how this would be evidenced)
4.8	What is the likely effect of this solution on maintaining or improving the availability of trainers and supporting them to fulfil their training role?	Colocation of planned colorectal with EGS would ensure trainers would be on the same site as the trainees each week Supported by the findings of the *Royal College of Surgeons – separating emergency and elective surgical care Report*, September 2007 Greater opportunity to provide enhanced sub-specialist colorectal training e.g. early rectal cancer treatment and pelvic floor surgery.	No impact
4.9	What is the likely effect of this solution on enabling staff to maintain or enhance their capabilities/ competencies?	Would provide dedicated periods of training in planned colorectal surgery Greater opportunity to provide enhanced sub-specialist colorectal training e.g. early rectal cancer and pelvic floor surgery. This option would optimise the learning environment for all staff	No impact
4.10	What is the likely effect of this solution on enabling staff to fulfil their capability, utilising all of their skills, and develop within their role?	See 4.1, 4.8 & 4.9	No impact
4.11	What is the likely effect of this solution on the travel burden for staff?	Further analysis required	Further analysis required
4.12	What is the likely effect of this solution on maintaining clinical	Colocation of planned colorectal with EGS would ensure trainers would be on the	No impact

#	Questions to test	What would be better? (show how this would be evidenced)	What would be worse? (show how this would be evidenced)
	supervision support to staff?	same site as the trainees each week	

Finance/ value for money

#	Questions to test	What would be better? (show how this would be evidenced)	What would be worse? (show how this would be evidenced)
5.1	What is the likelihood of this solution being within the current cost envelope (19/20 forecast outturn cost base)?		
5.2	What is the likelihood of this solution being affordable i.e. does it deliver benefits within the Gloucestershire financial envelope	To be confirmed subject to 5.3.	To be confirmed subject to 5.1 and 5.3
5.3	What is the likelihood of this solution increasing net revenue to the system?	There may be potential for a centralised colorectal service to increase its capacity, particularly to repatriate patients from out of county. This has not yet been modelled.	
5.4	What is the likelihood of significant capital costs over and above current capital allocations that cannot be mitigated?	Not yet known	Ward and theatre capacity would be required – plan for this not yet developed.
5.5	What is likelihood that this solutions' transition, implementation, double-running or stranded costs cannot be managed/mitigated by system-working?	Not yet known	

Strategic Fit

#	Questions to test	What would be better? (show how this would be evidenced)	What would be worse? (show how this would be evidenced)
6.1	What is the likelihood of this solution being compatible with the One Gloucestershire vision?	Provides a *centre of excellence* for planned colorectal surgery patients Provides access to other specialties involved in the care of complex pelvic disease, including cancer Continued provision of tertiary referral services (i.e. out of county patients with early rectal cancer) Provides the opportunity for innovation to enhance patient care (e.g. robotic surgery).	No impact
6.2	What is the likelihood of this solution being consistent with the NHS Long Term Plan?	This option is consistent with the NHS Long-Term Plan: Individual treatment plans Holistic needs assessments	No impact

Acceptability

#	Questions to test	What would be better? (show how this would be evidenced)	What would be worse? (show how this would be evidenced)
7.1	What is the likelihood that this solution has satisfactorily taken into account and responded to the Fit for the Future Outcome of Engagement Report	All solutions have been developed with reference to the *Outputs of Engagement Report*. Solutions included/adapted as a result of public feedback are: • Re-open CGH ED overnight • IGIS centralised to CGH site • IGIS hub options	

Solution description reference #	**B3**
Solution description	Centralise the image-guided interventional surgery (IGIS) 'hub' with the vascular arterial centre remaining at CGH
Relevant to Model #s	Model F

Quality of care

#	Questions to test	What would be better? (show how this would be evidenced)	What would be worse? (show how this would be evidenced)
1.1	What is the likely effect of this solution on patients receiving equal or better outcomes of care?	Many emergency IGIS interventions are time critical; locating a hub at the County's trauma unit will reduce the average time to intervention for many emergencies. Co-locating IGIS services improves the availability of consultants from adjacent services that may be required in the event of a complication, thereby improving outcomes. (This option co-locates Interventional Radiology and Interventional Cardiology, but not Vascular Surgery) Improving our ability to attract and retain staff will reduce gaps in our on call Interventional Radiology rota, improving the robustness of the service and ensuring services are available at all times. Co-location of Interventional Radiology and Interventional Cardiology supports the multi-disciplinary approach to the management of primary angioplasty. Evidence on travel times and outcomes suggests that patient outcomes could improve if a primary angioplasty service	

#	Questions to test	What would be better? (show how this would be evidenced)	What would be worse? (show how this would be evidenced)
		could be offered locally. Evidence: **A matter of life and death: hospital distance and quality of care: evidence of emergency room closures and myocardial infarctions (2014) Health Econometrics and Data Group University of York:** In Sweden: "patients who experienced an increase in the distance to their home hospital of between 51 and 60 kilometres ran an estimated 15 percent lower risk of surviving the AMI [Acute Myocardial Infarction] than patients who lived within ten kilometres of their home hospital"	
1.2	What is the likely effect of this solution on patients being treated by the right teams with the right skills and experience in the right place and at the right time?	Establishment of an IGIS hub at the trauma unit will increase the likelihood that both specialist IGIS facilities and clinical expertise are located on the same site where the patient is presenting. Reduction in inpatient and emergency transfers for catheter labs (650 transfers from GRH to CGH in 2018/19)	
1.3	What is the likely effect of this solution on continuity of care for patients?	By improving our ability to expand IGIS provision, patients currently travelling out of County for IGIS procedures could be treated at GHT, allowing follow up care to be provided by the same clinical team.	
1.4	What is the likely effect of this solution on the opportunity to	No impact	No impact

#	Questions to test	What would be better? (show how this would be evidenced)	What would be worse? (show how this would be evidenced)
	link with other teams and agencies to support patients holistically?		
1.5	What is the likely effect of this solution on the quality of the care environment?	Establishment of a new IGIS Hub and replacement of outdated and beyond end-of-life facilities will improve the quality of the care environment	
1.6	What is the likely effect of this solution on encouraging patients and carers to manage self-care appropriately?	No impact	No impact
1.7	What is the likely effect of this solution on enabling patient transfers within a clinically safe time frame?	No impact	No impact
1.8	What is the likely effect of this solution on enabling emergency interventions within a clinically safe time-frame?	See 1.1. In County Primary PCI reduces the distance to travel (and therefore time to intervention) for patients requiring emergency intervention. Average 'call to balloon' response time reduced. Establishment of an IGIS hub at the trauma unit improves the availability and accessibility of IGIS services to trauma patients requiring emergency intervention; and improves rapid accessibility to source control intervention following diagnosis of sepsis or septic shock.	

#	Questions to test	What would be better? (show how this would be evidenced)	What would be worse? (show how this would be evidenced)
1.9	What is the effect of this solution on the likelihood of travel time impacting negatively on patient outcomes?	In County Primary PCI reduces the distance to travel (and therefore time to intervention) for patients requiring emergency intervention. Establishing a hub at GRH improves accessibility for patients travelling from the Forest of Dean and West of the County, outside of the two urban centres this is where the majority of patients requiring IGIS are travelling from.	
1.10	What is the likely effect of this solution on patient safety risks?	No impact	No impact

Access to care

#	Questions to test	What would be better? (show how this would be evidenced)	What would be worse? (show how this would be evidenced)
2.1	What is the likelihood of this solution meeting the requirements of the NHS Constitution and The NHS Choice Framework?	No impact	No impact
2.2	What is the likely effect of this solution on simplifying the offer to patients?	No impact	No impact
2.3	What is the likely effect of this solution on the travel burden for patients?	Travel analysis tbc, but any service moving from Cheltenham to Gloucester will reduce travel times for residents of Gloucester, the Forest of Dean and parts of Tewkesbury/Newent/Staunton	Travel analysis tbc, but any service moving from Cheltenham to Gloucester will increase travel time for residents of Cheltenham, the Cotswolds, and some areas of Stroud and Berkley Vale.

#	Questions to test	What would be better? (show how this would be evidenced)	What would be worse? (show how this would be evidenced)
2.4	What is the likely effect of this solution on patients' waiting time to access services?	The option improves our ability to expand IGIS provision locally. This will increase the regional provision of services, which will reduce regional average waiting times for elective IGIS services that patients must currently travel out of County to receive.	
2.5	What is the likely effect of this solution on the travel burden for carers and families?	See 2.3	See 2.3
2.6	What is the likelihood of this solution supporting the use of new technology to improve access?	No impact	No impact
2.7	What is the likelihood of this solution improving or maintaining service operating hours?	This solution is likely to lead to an acceleration of the implementation of a 24/7 Primary PCI service and fill gaps that are present in the 24/7 Interventional Radiology on call.	
2.8	What is the likelihood of this solution improving or maintaining service operating locations?	No impact	No impact
2.9	What is the likelihood of this solution having a positive impact on equality and health inequalities as set out in the Public Sector Equality Duty	Further analysis required	Further analysis required

#	Questions to test	What would be better? (show how this would be evidenced)	What would be worse? (show how this would be evidenced)
	2011 and the Health and Social Care Act 2012?		
2.10	What is the likelihood of this solution accounting for future changes in population size and demographics?	Growth modelling not yet available	Growth modelling not yet available

Deliverability

#	Questions to test	What would be better? (show how this would be evidenced)	What would be worse? (show how this would be evidenced)
3.1	What is the likelihood of this solution being delivered within the agreed timescale?	Many of our existing IGIS facilities are soon due or already overdue replacement – providing an opportunity to implement reconfiguration of services and facilities within the next few years.	
3.2	What is the likelihood of this solution meeting the relevant national, regional or local delivery timescales?	No impact	No impact
3.3	What is the likelihood of this solution having the implementation capacity to deliver?		
3.4	What is the likely effect of this solution on access to the required staffing capacity and capability to be successfully implemented?	Establishment of an IGIS hub will allow improved efficiency of staff deployment, allowing us to support more activity with existing volumes of staff. The establishment of an IGIS hub is expected to improve our ability to attract and retain staff.	

#	Questions to test	What would be better? (show how this would be evidenced)	What would be worse? (show how this would be evidenced)
3.5	What is the likelihood of this solution having access to the required support services to be successfully implemented?	No impact	No impact
3.6	What is the likelihood of this solution having access to the required premises/estates to be successfully implemented?		Some displacement of existing services will be required to establish a sufficient footprint for an IGIS hub at GRH (incl. associated daycase beds)
3.7	What is the likelihood of this solution having access to the required technology to be successfully implemented?	Many of our existing IGIS facilities are soon due or overdue replacement – providing an opportunity for reconfiguration of services and facilities.	
3.8	Does this solution rely on other models of care / provision being put in place and if so, are they deliverable within the timeframe?	No impact	No impact

Workforce

#	Questions to test	What would be better? (show how this would be evidenced)	What would be worse? (show how this would be evidenced)
4.1	What is the likely effect of this solution on improving workforce capacity resilience and reducing the risk of temporary service changes?	Concentration of IGIS facilities into a hub will improve the resilience of service provision – allowing a more flexible and responsive reaction to cover gaps arising from sickness or other on-the-day issues.	There may be some staff dissatisfaction in respect of staff who prefer CGH as base.
4.2	What is the likely effect of this solution on optimising the efficient and effective use of clinical staff?	Establishment of a hub for IGIS will improve efficient deployment of technical staff – allowing radiographers to quickly move between facilities and support	

#	Questions to test	What would be better? (show how this would be evidenced)	What would be worse? (show how this would be evidenced)
		multiple lists. Concentration of IGIS facilities will also reduce the time currently lost by travelling between sites. However, retaining the Vascular arterial centre in CGH does not maximise this opportunity as radiographic nurses and radiographers will still be required to support Vascular activity at the arterial centre in CGH.	
4.3	What is the likely effect of this solution on supporting cross-organisational working across the patient pathway?	No impact	No impact
4.4	What is the likely effect of this solution on supporting the flexible deployment of staff and the development of innovative staffing models?	Concentrated co-location of IGIS facilities improves the flexible deployment of staff. The co-location of catheter labs with Interventional Radiology improves the opportunity to develop innovative nursing and technician roles that support both services.	
4.5	What is the likely effect of this solution on supporting staff health and wellbeing and their ability to self-care?	Improved ability to attract and retain staff will reduce the pressure on existing consultants to fill gaps in on-call rotas in addition to their existing allocation thereby reducing stress and improving staff health	There may be some staff dissatisfaction in respect of staff who prefer CGH as base.
4.6	What is the likely effect of this solution on improving the recruitment and retention of permanent staff with the right	Establishment of an IGIS hub is expected to have a significant impact on staff recruitment and retention, providing a much more appealing offer to staff.	There may be some staff dissatisfaction in respect of staff who prefer CGH as base.

#	Questions to test	What would be better? (show how this would be evidenced)	What would be worse? (show how this would be evidenced)
	skills, values and competencies?		
4.7	What is the likely effect of this solution on retaining trainee allocations, providing opportunities to develop staff with the right skills, values and competencies?	No impact	No impact
4.8	What is the likely effect of this solution on maintaining or improving the availability of trainers and supporting them to fulfil their training role?	The co-location of IGIS facilities will improve the ability to train junior radiographers across IGIS competencies.	
4.9	What is the likely effect of this solution on enabling staff to maintain or enhance their capabilities/ competencies?	The co-location of IGIS facilities will improve the ability for radiographers to expand their competencies across IGIS.	
4.10	What is the likely effect of this solution on enabling staff to fulfil their capability, utilising all of their skills, and develop within their role?	No impact	No impact
4.11	What is the likely effect of this solution on the travel burden for staff?	Further analysis required	Further analysis required
4.12	What is the likely effect of this solution on maintaining clinical supervision support to staff?	No impact	No impact

Finance/ value for money

#	Questions to test	What would be better? (show how this would be evidenced)	What would be worse? (show how this would be evidenced)
5.1	What is the likelihood of this solution being within the current cost envelope (19/20 forecast outturn cost base)?	Detailed business case modelling not yet done, but staffing and resources assumed to be based on current provision.	
5.2	What is the likelihood of this solution being affordable i.e. does it deliver benefits within the Gloucestershire financial envelope	No additional cost to Gloucestershire.	
5.3	What is the likelihood of this solution increasing net revenue to the system?	Medium Potential to repatriate activity from other areas with the potential to generate £1 million (net of costs) for the Gloucestershire system. This has been tested at a high level with specialist commissioners which removed some procedures as not having sufficient population to support a service. Assumptions and commissioning intentions (i.e. likelihood of repatriating work) would be validated further at business case stage.	
5.4	What is the likelihood of significant capital costs over and above current capital allocations that cannot be mitigated?		This solution would require changes to the estate at GRH to accommodate co-location of IGIS facilities into a hub – with associate capital cost. This is accounted for in the Trust's Estates

#	Questions to test	What would be better? (show how this would be evidenced)	What would be worse? (show how this would be evidenced)
			Strategy
5.5	What is likelihood that this solutions' transition, implementation, double-running or stranded costs cannot be managed/mitigated by system-working?	Not yet known	

Strategic Fit

#	Questions to test	What would be better? (show how this would be evidenced)	What would be worse? (show how this would be evidenced)
6.1	What is the likelihood of this solution being compatible with the One Gloucestershire vision?	Consistent with vision for *centres of excellence.*	
6.2	What is the likelihood of this solution being consistent with the NHS Long Term Plan?		

Acceptability

#	Questions to test	What would be better? (show how this would be evidenced)	What would be worse? (show how this would be evidenced)
7.1	What is the likelihood that this solution has satisfactorily taken into account and responded to the Fit for the Future Outcome of Engagement Report	All solutions have been developed with reference to the *Outputs of Engagement Report*. Solutions included/adapted as a result of public feedback are: • Re-open CGH ED overnight • IGIS centralised to CGH site • IGIS hub options	

Solution description reference #	**C8**
Solution description	Centralise elective upper gastrointestinal to Cheltenham General Hospital (CGH).
Relevant to Model #s	Model G and H

Quality of care

#	Questions to test	What would be better? (show how this would be evidenced)	What would be worse? (show how this would be evidenced)
1.1	What is the likely effect of this solution on patients receiving equal or better outcomes of care?	No cancellations for planned care Supported by the findings of the New Zealand report *Strategy 10 – Improving elective care through separating acute and elective surgery*, 2012. This would be evidenced by patient pathways and for cancer patients, the cancer patient experience survey.	A few patients who have had planned care and need urgent re-admission might be admitted to GRH and need to be transferred to CGH. Planned patients who become unwell in hospital after their operation would not have on site access to the EGS team. The 'deteriorating patient' model would support all patients on the CGH site with 24/7 specialist care including resident overnight ITU consultant cover. This team would rapidly identify and liaise with the surgical team in GRH, should review or surgery be required. While under the expert care of the deteriorating patient team, a Standard Operating Procedure would define the clinical circumstances under which a surgeon would travel to the CGH site, or the patient would be transferred to GRH
1.2	What is the likely effect of this solution on patients being treated by the right teams with the right skills and experience in	Dedicated planned care team protected from EGS demands. Supported by the findings of the *Royal College of Surgeons – separating*	No impact

#	Questions to test	What would be better? (show how this would be evidenced)	What would be worse? (show how this would be evidenced)
	the right place and at the right time?	*emergency and elective surgical care Report,* September 2007.	
1.3	What is the likely effect of this solution on continuity of care for patients?	Planned in-patients in upper GI surgery would have a dedicated specialist team led by a consultant week to week whilst remaining under a single consultant's care.	CGH patients would need to be seen at weekends and this would possibly require additional weekend working.
1.4	What is the likely effect of this solution on the opportunity to link with other teams and agencies to support patients holistically?	No impact	No impact
1.5	What is the likely effect of this solution on the quality of the care environment?	Ward environment dedicated to planned care without being adversely impacted by the delivery of EGS	No impact
1.6	What is the likely effect of this solution on encouraging patients and carers to manage self-care appropriately?	No impact	No impact
1.7	What is the likely effect of this solution on enabling patient transfers within a clinically safe time frame?	No impact	Planned patients who become unwell in hospital after their operation may require transfer to GRH (if stable). The 'deteriorating patient' model would support all patients on the CGH site with 24/7 specialist care including resident overnight ITU consultant cover. This team would rapidly identify and liaise with the surgical team in GRH, should review or surgery be required. While under the

#	Questions to test	What would be better? (show how this would be evidenced)	What would be worse? (show how this would be evidenced)
			expert care of the deteriorating patient team, a Standard Operating Procedure would define the clinical circumstances under which a surgeon would travel to the CGH site, or the patient would be transferred to GRH
1.8	What is the likely effect of this solution on enabling emergency interventions within a clinically safe time-frame?	No change to current as already centralised to one site (GRH).	An acute or deteriorating patient at CGH may require transfer to GRH or the surgeon to travel to CGH. The 'deteriorating patient' model would support all patients on the CGH site with 24/7 specialist care including resident overnight ITU consultant cover. This team would rapidly identify and liaise with the surgical team in GRH, should review or surgery be required. While under the expert care of the deteriorating patient team, a Standard Operating Procedure would define the clinical circumstances under which a surgeon would travel to the CGH site, or the patient would be transferred to GRH Access to emergency intervention may be compromised by lack of dedicated emergency theatre in CGH This would be evidenced by monitoring Key Performance Indicators.
1.9	What is the effect of this solution on the likelihood of travel time	No impact	For some patients there would be an increase in travel time to CGH for planned

#	Questions to test	What would be better? (show how this would be evidenced)	What would be worse? (show how this would be evidenced)
	impacting negatively on patient outcomes?		care admissions. This would not negatively influence patient outcomes.
1.10	What is the likely effect of this solution on patient safety risks?	Reduce the risk of cancellations to planned care.	No impact

Access to care

#	Questions to test	What would be better? (show how this would be evidenced)	What would be worse? (show how this would be evidenced)
2.1	What is the likelihood of this solution meeting the requirements of the NHS Constitution and The NHS Choice Framework?	Improve ability to achieve national waiting time standards. This would be evidenced by comparison with national standards and internal audit.	No impact
2.2	What is the likely effect of this solution on simplifying the offer to patients?	No change to current as already centralised to one site (GRH).	No impact
2.3	What is the likely effect of this solution on the travel burden for patients?	Travel analysis tbc, but any service moving from GRH to CGH will reduce travel times for residents of Cheltenham, the Cotswolds, and some areas of Stroud and Berkley Vale.	Travel analysis tbc, but any service moving from GRH to CGH will increase travel times for residents of Gloucester, the Forest of Dean and parts of Tewkesbury/Newent/Staunton
2.4	What is the likely effect of this solution on patients' waiting time to access services?	Improve ability to achieve national waiting time standards. This would be evidenced by monitoring Key Performance Indicators (cancellations)	No impact
2.5	What is the likely effect of this solution on the travel burden for carers and families?	See 2.3	See 2.3

#	Questions to test	What would be better? (show how this would be evidenced)	What would be worse? (show how this would be evidenced)
2.6	What is the likelihood of this solution supporting the use of new technology to improve access?	No impact	No impact
2.7	What is the likelihood of this solution improving or maintaining service operating hours?	No impact	No impact
2.8	What is the likelihood of this solution improving or maintaining service operating locations?	Planned inpatient upper GI service at CGH.	No planned inpatient upper GI service at GRH.
2.9	What is the likelihood of this solution having a positive impact on equality and health inequalities as set out in the Public Sector Equality Duty 2011 and the Health and Social Care Act 2012?	Further analysis required	Further analysis required
2.10	What is the likelihood of this solution accounting for future changes in population size and demographics?	Growth modelling not yet available	Growth modelling not yet available

Deliverability

#	Questions to test	What would be better? (show how this would be evidenced)	What would be worse? (show how this would be evidenced)
3.1	What is the likelihood of this solution being delivered within the agreed timescale?	Subject to consultation and statutory notice period, this option could be delivered within the agreed timescale. This would be evidenced by statutory timescales and indicative implementation timetable.	No impact
3.2	What is the likelihood of this solution meeting the relevant national, regional or local delivery timescales?	No impact	No impact
3.3	What is the likelihood of this solution having the implementation capacity to deliver?	Bed capacity already exists to deliver this option. Staffing capacity at middle grade medical staff level already exists to deliver this option.	Insufficient foundation year doctors to provide 24/7 rota at CGH. Insufficient consultant numbers to support weekend review (ward rounds) of elective patients in CGH.
3.4	What is the likely effect of this solution on access to the required staffing capacity and capability to be successfully implemented?	See 3.3	See 3.3
3.5	What is the likelihood of this solution having access to the required support services to be successfully implemented?	All support services for elective Upper GI currently exist at CGH site.	The impact on access to Department of Critical Care would need to be assessed.
3.6	What is the likelihood of this solution having access to the required premises/estates to be successfully implemented?	No impact	Beds and theatre capacity would need to be identified on the CGH site to deliver this option

#	Questions to test	What would be better? (show how this would be evidenced)	What would be worse? (show how this would be evidenced)
3.7	What is the likelihood of this solution having access to the required technology to be successfully implemented?	No impact	No impact
3.8	Does this solution rely on other models of care / provision being put in place and if so, are they deliverable within the timeframe?	Agreed middle grade rota would provide full cover for planned care centre at CGH	Consultant on-call rota for elective centre would need to be agreed as insufficient consultant numbers to support weekend review (ward rounds) of elective patients in CGH (if EGS in GRH). Insufficient foundation year doctors to provide 24/7 rota at CGH.

Workforce

#	Questions to test	What would be better? (show how this would be evidenced)	What would be worse? (show how this would be evidenced)
4.1	What is the likely effect of this solution on improving workforce capacity resilience and reducing the risk of temporary service changes?	A single centre would provide more efficient and flexible use of planned care resources (particularly theatres). Supported by the findings of the New Zealand report *Strategy 10 – Improving elective care through separating acute and elective surgery*, 2012. A single unit would deliver group working optimising the ability to cross cover and back fill sessions Improved flexibility to cover unexpected absence.	Potential for GRH Upper GI nursing staff to be reallocated from current wards. Specialist nursing teams would continue to be required to cover both sites. This would be evidenced by staff establishment.

#	Questions to test	What would be better? (show how this would be evidenced)	What would be worse? (show how this would be evidenced)
4.2	What is the likely effect of this solution on optimising the efficient and effective use of clinical staff?	See 4.1	See 4.1
4.3	What is the likely effect of this solution on supporting cross-organisational working across the patient pathway?	No impact	No impact
4.4	What is the likely effect of this solution on supporting the flexible deployment of staff and the development of innovative staffing models?	Option to expand the role of nurse specialists and practitioners for delivery of planned care Opportunity to introduce Physician Associate roles to support the delivery of planned colorectal care within the timeframe	No impact
4.5	What is the likely effect of this solution on supporting staff health and wellbeing and their ability to self-care?	Ward environment dedicated to planned care without being adversely impacted by the delivery of EGS This would be evidenced by staff well-being metrics.	Potential for existing GRH nursing staff to be reallocated from current wards. This could impact morale and staff health and well-being. This would be evidenced by staff rotas and staff well-being metrics.
4.6	What is the likely effect of this solution on improving the recruitment and retention of permanent staff with the right skills, values and competencies?	Ward environment dedicated to planned care without being adversely impacted by the delivery of EGS would improve desirability to work as an upper GI specialist The expanded/improved opportunities as described above in terms of training and development and advancement of new roles highly likely to have a positive impact	There may be some staff dissatisfaction in respect of staff who prefer GRH as base.

#	Questions to test	What would be better? (show how this would be evidenced)	What would be worse? (show how this would be evidenced)
		on staff retention and the ability to recruit new staff. This would be evidenced by staff rotas, recruitment and retention metrics.	
4.7	What is the likely effect of this solution on retaining trainee allocations, providing opportunities to develop staff with the right skills, values and competencies?	No change to current as already centralised to one site (GRH).	No impact
4.8	What is the likely effect of this solution on maintaining or improving the availability of trainers and supporting them to fulfil their training role?	No change to current as already centralised to one site (GRH).	Separation of planned Upper GI from the EGS site would reduce time trainers and trainees are on the same site.
4.9	What is the likely effect of this solution on enabling staff to maintain or enhance their capabilities/ competencies?	Ward environment dedicated to planned care without being adversely impacted by the delivery of EGS This option would optimise the learning environment for all staff	No impact
4.10	What is the likely effect of this solution on enabling staff to fulfil their capability, utilising all of their skills, and develop within their role?	See 4.1, 4.8, 4.9	No impact
4.11	What is the likely effect of this solution on the travel burden for staff?	Further analysis required	Further analysis required
4.12	What is the likely effect of this	No change to current as already	No impact

#	Questions to test	What would be better? (show how this would be evidenced)	What would be worse? (show how this would be evidenced)
	solution on maintaining clinical supervision support to staff?	centralised to one site (GRH).	

Finance/ value for money

#	Questions to test	What would be better? (show how this would be evidenced)	What would be worse? (show how this would be evidenced)
5.1	What is the likelihood of this solution being within the current cost envelope (19/20 forecast outturn cost base)?	Service is already centralised, so likely to be within envelope.	There are likely to be some costs associated with providing medical support to patients on an elective site. The cost of the deteriorating patient model has already been found by the Trust. Further work is required on medical support, subject to confirmation of specialties per site in any preferred model.
5.2	What is the likelihood of this solution being affordable i.e. does it deliver benefits within the Gloucestershire financial envelope	No change – service is currently centralised	
5.3	What is the likelihood of this solution increasing net revenue to the system?	No change – service is currently centralised	
5.4	What is the likelihood of significant capital costs over and above current capital allocations that cannot be mitigated?	Not yet known	Ward and theatre capacity would be required
5.5	What is likelihood that this solutions' transition, implementation, double-running	Not yet known	

#	Questions to test	What would be better? (show how this would be evidenced)	What would be worse? (show how this would be evidenced)
	or stranded costs cannot be managed/mitigated by system-working?		

Strategic Fit

#	Questions to test	What would be better? (show how this would be evidenced)	What would be worse? (show how this would be evidenced)
6.1	What is the likelihood of this solution being compatible with the One Gloucestershire vision?	Provides a *centre of excellence* for planned Upper GI surgery patients Supports the development of the Gloucestershire Cancer Institute Continued provision of tertiary referral services Provides the opportunity for innovation to enhance patient care (e.g. robotic surgery).	No impact
6.2	What is the likelihood of this solution being consistent with the NHS Long Term Plan?	Separating planned care at CGH away from the site of EGS (GRH) would reduce the pressure on emergency hospital care Single site of planned Upper GI cancer care would improve ability to deliver holistic care This would be evidenced by monitoring of bed escalation status and cancer experience survey	

Acceptability

#	Questions to test	What would be better? (show how this would be evidenced)	What would be worse? (show how this would be evidenced)
7.1	What is the likelihood that this solution has satisfactorily taken into account and responded to the Fit for the Future Outcome of Engagement Report	All solutions have been developed with reference to the *Outputs of Engagement Report*. Solutions included/adapted as a result of public feedback are: • Re-open CGH ED overnight • IGIS centralised to CGH site • IGIS hub options	

Solution description reference #	**B4**
Solution description	Centralise the image-guided interventional surgery (IGIS) 'hub' to CGH, retaining the current vascular arterial centre at CGH
Relevant to Model #s	Model H

Quality of care

#	Questions to test	What would be better? (show how this would be evidenced)	What would be worse? (show how this would be evidenced)
1.1	What is the likely effect of this solution on patients receiving equal or better outcomes of care?	Co-locating IGIS services improves the availability of consultants from adjacent services that may be required in the event of a complication, thereby improving outcomes. (This option co-locates Interventional Radiology, Interventional Cardiology, and Vascular Surgery) Improving our ability to attract and retain staff will reduce gaps in our on call Interventional Radiology rota, improving the robustness of the service and ensuring services are available at all times. Co-location of Interventional Radiology, Vascular Surgery and Interventional Cardiology supports the multi-disciplinary approach to the management of primary angioplasty	

#	Questions to test	What would be better? (show how this would be evidenced)	What would be worse? (show how this would be evidenced)
1.2	What is the likely effect of this solution on patients being treated by the right teams with the right skills and experience in the right place and at the right time?		Establishment of an IGIS hub away from the trauma unit could lead to more patients requiring emergency IGIS needing to be transferred across hospital sites, or clinical teams needing to travel to the patient and therefore delaying time to intervention.
1.3	What is the likely effect of this solution on continuity of care for patients?	By improving our ability to expand IGIS provision, patients currently travelling out of County for IGIS procedures could be treated at GHT, allowing follow up care to be provided by the same clinical team.	
1.4	What is the likely effect of this solution on the opportunity to link with other teams and agencies to support patients holistically?	No impact	No impact
1.5	What is the likely effect of this solution on the quality of the care environment?	Establishment of a new IGIS Hub and replacement of outdated and beyond end-of-life facilities will improve the quality of the care environment	
1.6	What is the likely effect of this solution on encouraging patients and carers to manage self-care appropriately?	No impact	No impact
1.7	What is the likely effect of this solution on enabling patient transfers within a clinically safe time frame?	No impact	No impact

#	Questions to test	What would be better? (show how this would be evidenced)	What would be worse? (show how this would be evidenced)
1.8	What is the likely effect of this solution on enabling emergency interventions within a clinically safe time-frame?	In County Primary PCI reduces the distance to travel (and therefore time to intervention) for patients requiring emergency intervention. Average 'call to balloon' response time reduced.	
1.9	What is the effect of this solution on the likelihood of travel time impacting negatively on patient outcomes?	In County Primary PCI reduces the distance to travel (and therefore time to intervention) for patients requiring emergency intervention.	Establishing a hub at CGH reduces accessibility for patients travelling from the Forest of Dean and West of the County, outside of the two urban centres this is where the majority of patients requiring IGIS are travelling from.
1.10	What is the likely effect of this solution on patient safety risks?	No impact	No impact

Access to care

#	Questions to test	What would be better? (show how this would be evidenced)	What would be worse? (show how this would be evidenced)
2.1	What is the likelihood of this solution meeting the requirements of the NHS Constitution and The NHS Choice Framework?	No impact	No impact
2.2	What is the likely effect of this solution on simplifying the offer to patients?	No impact	No impact
2.3	What is the likely effect of this solution on the travel burden for patients?	Service already mostly based in Cheltenham so no additional positive impact.	Service already mostly based in Cheltenham so no additional negative impact.

#	Questions to test	What would be better? (show how this would be evidenced)	What would be worse? (show how this would be evidenced)
2.4	What is the likely effect of this solution on patients' waiting time to access services?	The option improves our ability to expand IGIS provision locally. This will increase the regional provision of services, which will reduce regional average waiting times for elective IGIS services that patients must currently travel out of County to receive.	
2.5	What is the likely effect of this solution on the travel burden for carers and families?	See 2.3	See 2.3
2.6	What is the likelihood of this solution supporting the use of new technology to improve access?	No impact	No impact
2.7	What is the likelihood of this solution improving or maintaining service operating hours?	This solution is likely to lead to an acceleration of the implementation of a 24/7 Primary PCI service and fill gaps that are present in the 24/7 Interventional Radiology on call.	
2.8	What is the likelihood of this solution improving or maintaining service operating locations?	No impact	No impact
2.9	What is the likelihood of this solution having a positive impact on equality and health inequalities as set out in the Public Sector Equality Duty 2011 and the Health and Social	Further analysis required	Further analysis required

#	Questions to test	What would be better? (show how this would be evidenced)	What would be worse? (show how this would be evidenced)
	Care Act 2012?		
2.10	What is the likelihood of this solution accounting for future changes in population size and demographics?	Growth modelling not yet available	Growth modelling not yet available

Deliverability

#	Questions to test	What would be better? (show how this would be evidenced)	What would be worse? (show how this would be evidenced)
3.1	What is the likelihood of this solution being delivered within the agreed timescale?	Many of our existing IGIS facilities are soon due or already overdue replacement – providing an opportunity to implement reconfiguration of services and facilities within the next few years.	
3.2	What is the likelihood of this solution meeting the relevant national, regional or local delivery timescales?	No impact	No impact
3.3	What is the likelihood of this solution having the implementation capacity to deliver?		
3.4	What is the likely effect of this solution on access to the required staffing capacity and capability to be successfully implemented?	Establishment of an IGIS hub will allow improved efficiency of staff deployment, allowing us to support more activity with existing volumes of staff. The establishment of an IGIS hub is expected to improve our ability to attract and retain staff.	
3.5	What is the likelihood of this	No impact	No impact

#	Questions to test	What would be better? (show how this would be evidenced)	What would be worse? (show how this would be evidenced)
	solution having access to the required support services to be successfully implemented?		
3.6	What is the likelihood of this solution having access to the required premises/estates to be successfully implemented?	Reconfiguration of the existing CGH radiology footprint would allow establishment of an IGIS hub at CGH (incl. associated daycase beds) displacing only radiology and radiology back-office facilities.	
3.7	What is the likelihood of this solution having access to the required technology to be successfully implemented?	Many of our existing IGIS facilities are soon due or overdue replacement – providing an opportunity for reconfiguration of services and facilities.	
3.8	Does this solution rely on other models of care / provision being put in place and if so, are they deliverable within the timeframe?	No impact	No impact

Workforce

#	Questions to test	What would be better? (show how this would be evidenced)	What would be worse? (show how this would be evidenced)
4.1	What is the likely effect of this solution on improving workforce capacity resilience and reducing the risk of temporary service changes?	Concentration of IGIS facilities into a hub will improve the resilience of service provision – allowing a more flexible and responsive reaction to cover gaps arising from sickness or other on-the-day issues.	There may be some staff dissatisfaction in respect of staff who prefer GRH as base.
4.2	What is the likely effect of this solution on optimising the efficient and effective use of clinical staff?	Establishment of a hub for IGIS will improve efficient deployment of technical staff – allowing radiographers to quickly	

#	Questions to test	What would be better? (show how this would be evidenced)	What would be worse? (show how this would be evidenced)
		move between facilities and support multiple lists. Concentration of IGIS facilities will also reduce the time currently lost as a result of travelling between sites.	
4.3	What is the likely effect of this solution on supporting cross-organisational working across the patient pathway?	No impact	No impact
4.4	What is the likely effect of this solution on supporting the flexible deployment of staff and the development of innovative staffing models?	Concentrated co-location of IGIS facilities improves the flexible deployment of staff. The co-location of catheter labs with Interventional Radiology improves the opportunity to develop innovative nursing and technician roles that support both services.	
4.5	What is the likely effect of this solution on supporting staff health and wellbeing and their ability to self-care?	Improved ability to attract and retain staff will reduce the pressure on existing consultants to fill gaps in on-call rotas in addition to their existing allocation thereby reducing stress and improving staff health	There may be some staff dissatisfaction in respect of staff who prefer GRH as base.
4.6	What is the likely effect of this solution on improving the recruitment and retention of permanent staff with the right skills, values and competencies?	Establishment of an IGIS hub is expected to have a significant impact on staff recruitment and retention, providing a much more appealing offer to staff.	There may be some staff dissatisfaction in respect of staff who prefer GRH as base.
4.7	What is the likely effect of this solution on retaining trainee allocations, providing opportunities to develop staff with	No impact	No impact

#	Questions to test	What would be better? (show how this would be evidenced)	What would be worse? (show how this would be evidenced)
	the right skills, values and competencies?		
4.8	What is the likely effect of this solution on maintaining or improving the availability of trainers and supporting them to fulfil their training role?	The co-location of IGIS facilities will improve the ability to train junior radiographers across IGIS competencies.	
4.9	What is the likely effect of this solution on enabling staff to maintain or enhance their capabilities/ competencies?	The co-location of IGIS facilities will improve the ability for radiographers to expand their competencies across IGIS.	
4.10	What is the likely effect of this solution on enabling staff to fulfil their capability, utilising all of their skills, and develop within their role?	See 4.9	No impact
4.11	What is the likely effect of this solution on the travel burden for staff?	Further analysis required	Further analysis required
4.12	What is the likely effect of this solution on maintaining clinical supervision support to staff?	No impact	No impact

Finance/ value for money

#	Questions to test	What would be better? (show how this would be evidenced)	What would be worse? (show how this would be evidenced)
5.1	What is the likelihood of this solution being within the current cost envelope (19/20 forecast outturn cost base)?	Detailed business case modelling not yet done, but staffing and resources assumed to be based on current provision.	
5.2	What is the likelihood of this solution being affordable i.e. does it deliver benefits within the Gloucestershire financial envelope	No additional cost to Gloucestershire.	
5.3	What is the likelihood of this solution increasing net revenue to the system?	Medium Potential to repatriate activity from other areas with the potential to generate £1 million (net of costs) for the Gloucestershire system. This has been tested at a high level with specialist commissioners which removed some procedures as not having sufficient population to support a service. Assumptions and commissioning intentions (i.e. likelihood of repatriating work) would be validated further at business case stage.	
5.4	What is the likelihood of significant capital costs over and above current capital allocations that cannot be mitigated?	None	

5.5	What is likelihood that this solutions' transition, implementation, double-running or stranded costs cannot be managed/mitigated by system-working?	Not yet known	

Strategic Fit

#	Questions to test	What would be better? (show how this would be evidenced)	What would be worse? (show how this would be evidenced)
6.1	What is the likelihood of this solution being compatible with the One Gloucestershire vision?	Consistent *centres of excellence vision.*	
6.2	What is the likelihood of this solution being consistent with the NHS Long Term Plan?		

Acceptability

#	Questions to test	What would be better? (show how this would be evidenced)	What would be worse? (show how this would be evidenced)
7.1	What is the likelihood that this solution has satisfactorily taken into account and responded to the Fit for the Future Outcome of Engagement Report	All solutions have been developed with reference to the *Outputs of Engagement Report*. Solutions included/adapted as a result of public feedback are: • Re-open CGH ED overnight • IGIS centralised to CGH site • IGIS hub options	