NHS
South West
Clinical Senate

Gloucestershire ICS Service Reconfiguration: Fit for The Future Programme- Centres of Excellence
Clinical Review Panel Report
20th August 2020

1. Executive Summary

The South West Clinical Senate convened a Clinical Review Panel to consider Gloucestershire ICS' proposals for service reconfiguration as part of its Centres of Excellence work under the Fit for the Future Programme. This was undertaken to inform the NHSEI assurance process against tests 3 and 5, prior to approval to go to public consultation.

Key Recommendations

Overall the proposals which are extensive, were considered broadly well thought through and well aligned with national guidance and best practice. Despite some reservations, the Clinical Review Panel (CRP) concluded that it could offer assurance that the proposed clinical models presented are ready to proceed to public consultation, with the following provisos and observations:

- **The centralisation of the acute medical take to GRH was strongly supported, with the view that this should not be delayed until 2022 and that all efforts should be made to accommodate this as soon as possible on the GRH site to reduce the risk to patients and improve the clinical quality of the service provided.**
- **The provision of Emergency General Surgery at GRH was strongly supported, provided that this move is supported by sustainable staffing, with out of hours and weekend consultant reviews and nursing support. Efforts should be made to accommodate this as soon as possible on the GRH site to reduce the risk to patients and improve the clinical quality of the service provided.**
- **The desire to maintain Emergency Department services at CGH was understood and supported by the CRP, but the Panel was mindful of the previous panel's support for reconfiguration of Emergency care pathways in Gloucestershire which included a single site ED. It is recommended that work continues on the development of urgent care in Gloucestershire that optimises clinical outcomes whilst ensuring parity of care and alignment with emerging clinical models.**
- **The panel supported the deteriorating patient model at CGH, with the provision that this is supported by a resident medical registrar.**
- **The panel noted and were concerned by the lack of agreement among clinicians about the location of elective colorectal and vascular surgical services.**
    - **The panel listened to the arguments for and against the options proposed and formed its own opinion about the location of these services, however the final choice must rest with the Gloucestershire team following consultation.**

  - **The panel was furthermore of the opinion that Gloucestershire should only consult the public on a viable model or models that have full clinical support within the system.**
  - **The model with colocation of elective colorectal services at CGH with urology and gynaecology was supported by the CRP to enable the development of CGH as a centre of excellence, with the provisos that there is an ITU at both CGH and GRH; all staffing constraints are mitigated and are sustainable, including elective overnight cover; emergency cover with sub-specialist availability 24/7; weekend consultant patient review and AHP input as per national guidance; and out of hours access to a theatre and CT.**
  - **The model with colocation of vascular services with the IGIS hub at GRH was supported, to support co-dependencies with the IGIS hub, trauma and diabetes for best patient care.**
- **The CRP noted issues and risks around delayed discharged and links with social care. This will impact bed base and staffing and needs to be an area of focus and planning.**
- **The CRP supported making permanent the pilots for gastroenterology and T&O, and retaining the current configuration of Elective Upper Gastrointestinal surgery (GI) (centralised at GRH), all of which were demonstrated to be working well and improving patient care.**
- **As with the previous panel, there continued to be concerns from the CRP that workforce proposals were over-confident in their ambition to recruit staff across all professional teams – medical, nursing and AHP. Clear and realistic mitigation plans for the workforce strategy must be developed.**
- **The CRP noted all of the work that had gone into the PCBC, which provides a wide range of information to different audiences on the proposal. The CRP was of the opinion that the PCBC document remains unnecessarily impenetrable in length and layout and that this impedes its function in sharing the vision for the centres of excellence.**

The Bed Test

- **The panel were told that there was no net change in bed numbers across GRH & CGH and, on this basis, were *provisionally* of the opinion that the "Bed Test" was met. However, details of bed numbers in the PCBC were felt to be unclear and impenetrable.**
- **Clarity and simplicity must be provided around bed numbers to allow definitive confirmation that the bed test is either met or not.**
- **Further details should include in a clear, and preferably graphical, format:**
  - **the anticipated shifts between specialties at CGH and GRH.**
  - **the expected impact from capital funding proposals.**
  - **the expected impact of proposed mitigations including admissions avoidance, shorter**

length of stay and enhanced discharge.

- **evidence that capacity modelling has developed in light of population growth.**

2. Chair's Summary

This report has been produced by the South West Clinical Senate for Gloucestershire ICS and provides recommendations following a Clinical Review Panel (CRP) that convened on 20th August 2020 to review Gloucestershire ICS' proposals for service reconfiguration across the Gloucestershire Royal Hospital (GRH) and Cheltenham General Hospital (CGH) sites.

This was an independent clinical review carried out to inform the NHS England stage 2 assurance checkpoint which considers whether proposals for large scale service change meet the Department of Health's 5 tests for service change prior to going ahead to public consultation, which in this case is planned for September 2020. The Clinical Senate principally considers tests 3 and 5; the evidence base for the clinical model and the 'bed test' to understand whether any significant bed closures can meet one of 3 conditions around alternative provision, treatment and bed usage.

The clinical advice within this report is given by external clinicians with a shared interest to the ICS in developing the best services for the population, contributing dispassionately through the value of peer experience and with the intention of supporting the development of clinically sound service models. This report sets out the methodology and findings of the review and is presented to Gloucestershire ICS with the offer of continued support.

3. Background

Gloucestershire Hospitals NHS Foundation Trust (GHNHSFT) currently operates from two main hospital sites, (Cheltenham General Hospital (CGH) and Gloucestershire Royal Hospital (GRH)), 8 miles apart. Since merging to form a single Trust in 2002 many services have been centralised to one of the two sites, including paediatrics, stroke and trauma to Gloucestershire Royal Hospital and ophthalmology, oncology, gynaecology and urology to Cheltenham General Hospital. However, many adult medical and surgical specialties have continued to be delivered on both sites and as demand grows, technology improves and staff availability and specialisation changes, these arrangements are leading to clinical quality, workforce and financial challenges.

The 'Centres of Excellence' element of the wider Fit for the Future Programme (previously called "One Place") focuses on developing Cheltenham General as a centre for planned care and Gloucestershire Royal hospital as a centre for emergency care. The vision is for a single hospital on two sites, linked by the A40 corridor.

4. The Clinical Review Process

The Clinical Senate Review Process is used across England to provide independent clinical review of large-scale service change to ensure there is a clear clinical basis underpinning any proposals for reconfiguration. Reviews are undertaken to inform the NHS England assurance process which signs off proposals for change prior to public consultation.

The Clinical Senate originally undertook a Clinical Review of Gloucestershire STP's urgent and acute care model in 2017, which included community urgent care settings as well as a proposed split of planned and urgent care services between its two acute hospitals. At the time, the panel concluded that it broadly supported the STP's proposals for its urgent and acute care model, noting they were ambitious in their aim to improve patient care and drawing attention in the panel report to a number of recommendations to support the proposals and some areas where further detail was felt to be required to provide assurance around the delivery and implementation of a clinically sound model.

Prior to convening an independent clinical review panel (section 8), a desktop review of initial proposals was undertaken in March 2020 (appendix 5).

The Senate's CRP reviewed the final PCBC document (appendix 3) provided by the ICS to detail their proposals ahead of the panel meeting itself. The panel subsequently fed in comments to the Senate which were shared with the ICS in preparation for the panel meeting itself and which contributed to the key lines of enquiry (KLOEs) used to guide discussion (appendix 2). These were supported by the generic KLOEs for clinical review processes developed from a national guidance document on conducting senate reviews.

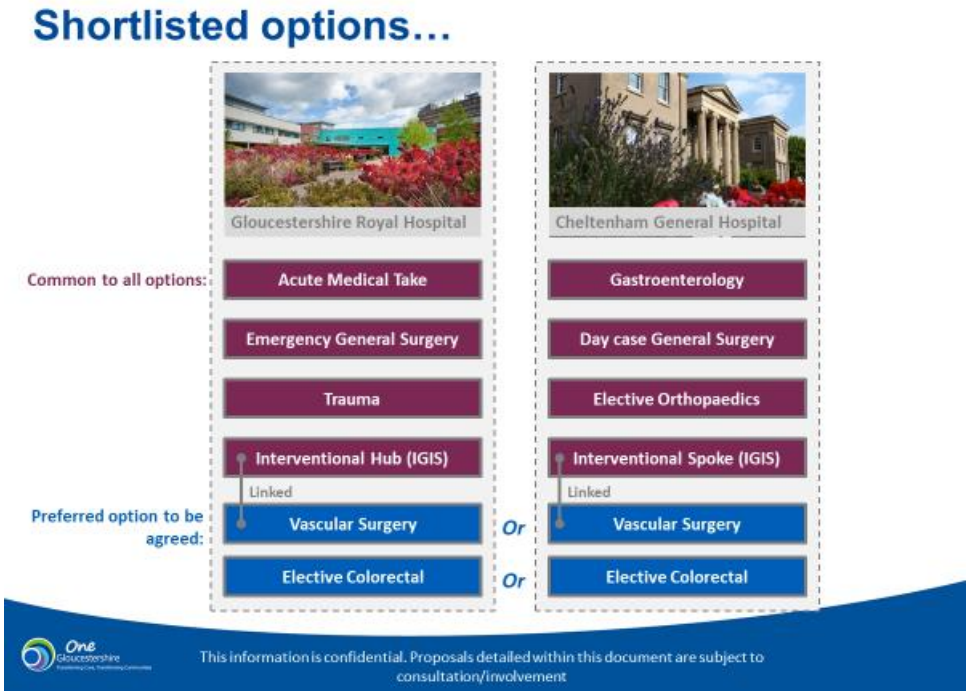
The Head of Senate and Deputy Clinical Chair also held preliminary meeting with the ICS team leading up to the review, before hearing its proposals for change presented formally at the panel meeting. Due to new ways of working as a result of the COVID 19 pandemic, a panel was held virtually for the first time.

The review meeting provided opportunity for the ICS clinical team to present its proposals (appendix 4) and for the panel to discuss the proposals, ask questions and raise concerns. The agenda can be found in appendix 1. (Due to unforeseen clinical commitments the breakout group for EGS/Colorectal could not take place on 20th August and was held on the 24th August).

5. Gloucestershire ICS's Proposal

The proposed clinical models focus on developing Cheltenham General as a centre for planned care and Gloucestershire Royal hospital as a centre for emergency care. GRH would see a centralisation of the acute medical take and EGS moving to its site, along with development of an image-guided interventional surgery (IGIS) hub. Formalisation of the pilots for gastroenterology and T&O and retaining the current configuration of Elective Upper Gastrointestinal surgery (GI) (centralised at GRH) is also included.

An ED that was open 8am-8pm would be maintained in Cheltenham with MIU provision overnight. Options around which site to centralise vascular and colorectal services to were presented, with no preferred option identified, and a request for a steer to be provided by the CRP. As part of the Gloucestershire response to the COVID 19 pandemic, the centralisation of the acute take and EGS to GRH has been temporarily implemented, with CGH run as an MIU. Whilst there was a proposal at desktop review stage to move neurology services to CGH as part of the centralisation of EGS, and to facilitate the fast-tracking of this, neurology is now out of scope for these proposals.



6. Key Themes

The CRP explored the following themes as part of its discussion with the Gloucestershire clinical team, and its scrutiny of the viability and robustness of the proposals and clinical models, in order to inform its overall recommendations to the NHSEI assurance team.

1. Centralisation of the acute medical take to GRH

- The CRP supported this centralisation and discussed the potential to make permanent the temporary centralisation as soon as possible, rather than waiting for a capital build that will create extra capacity and be complete in two years' time. The temporary centralisation under the COVID 19 response has clearly demonstrated the clinical

benefits of this proposal and it was felt that reverting back to a split take would have significant negative consequences.

2. Medical cover at CGH

- The co-dependencies between services at CGH was discussed at some length with support from the panel for maintaining an ICU (at least a level 2 facility) at CGH. The need to maintain sufficient work to maintain staffing competencies and workforce at CGH was noted.
- There had been concern around the level of support for overnight emergencies at CGH, but the introduction of a resident Medical Registrar at CGH was felt to bolster the staffing to a safe level.
- There were some concerns about the viability of overnight ICU consultant cover at CGH and their involvement in the management of deteriorating patients but these were satisfactorily addressed.
- The ability of trainee junior doctors to manage sick colorectal patients at CGH when they deteriorate was discussed.
- Inter-site transfers were discussed and the CRP was reassured that there have been relatively few from CGH to GRH during the temporary changes.
- Relocation of elective colorectal surgery to CGH may increase inter-site transfers and robust processes to manage sick elective patients out of hours need to be developed.

3. ED at CGH

- The CRP recognised the strong commitment made by the system to retaining the ED at CGH, but discussed some concerns regarding the practical implications of this, following support of the 2017 CRP to implement a full hot/cold acute split across the two sites.
- It was discussed that undifferentiated 999 emergencies will go to GRH.
- There is no ED provision overnight at CGH in the current service model. The move of the acute take to GRH reduces the need for this.
- The patient offer will not be the same as at GRH and it was noted that ED doesn't exist in isolation to the rest of the hospital. The Gloucestershire system is encouraged to consider how this service will continue to be well supported in the future, with attention needed to develop clear pathways and appropriate clinical decision support from across the trust.
- Getting the patient to the right place first time is preferable, regardless of site.
- Recruitment may be an issue in the future for two EDs.
- The ED model at CGH is clinically safe and appropriate as it stands.
- More modelling with SWAST for this two ED model should be carried out.

4. Workforce

- The CRP had concerns about the sustainability of the workforce and it was not clear if workforce gaps will be improved in the proposed model, in comparison to the current state. Key areas of risk should be identified for the proposed model.
- There were several references to workforce plans being developed outside of phase 1 of the FFT programme. These were explored in more detail by the CRP, but much work remains to be done to develop these across all staff groups, and plans developed to mitigate risks to services if recruitment and role development does not proceed as hoped. Workforce plans are integral to the success of the FFTF and CoEx work.
- It is planned that there will be two critical care consultants at GRH and one at CGH. Recruitment has already started to increase the number of intensivists from 18 to 24 with a 1 in 8 on call. The CRP remained concerned that the staffing model was not sufficient to support two ICUs when taking into account leave.
- The Gloucestershire team confirmed that there would be on site resident SpRs on both sites.
- The trust policy was described as mixed medical staffing with cross cover and cross training across two sites as part of one trust, with nursing already working to one rota.
- Junior Doctor trainees will also be expected to work cross-county.
- Clarity about the specialities of the resident consultants on call at each site will be required.
- Staffing ratios should be based on the population served, noting whole catchment for different specialties.

5. Beds & Infrastructure

- Some clarification on the changes to beds across sites and across specialities is required as while all proposals are described as increasing capacity overall, the detail and timeline for this is not obvious.
- The need for an increase in beds at GRH and more theatre capacity at CGH was demonstrated with a 78 bed pressure at GRH site. How this pressure will be managed until the beds are created was unclear.
- Further details should include in a clear, and preferably graphical, format:
    - the anticipated shifts between specialties at CGH and GRH.
    - the expected impact from capital funding proposals.
    - the expected impact of proposed mitigations including admissions avoidance, shorter length of stay and enhanced discharge.
    - evidence that capacity modelling has developed in light of population growth.
- It was noted that capital funding to increase the theatre capacity by two at CGH has been approved but opening the extra capacity will take some time.

6. Centralisation of elective colorectal surgery

- It was noted that elective colorectal services require ITU access and specialist ward support.
- It was agreed that elective colorectal surgical service should be consolidated on one site.
- An interventional radiology service would be required to be available to support colorectal services, particularly for emergency colorectal issues.
- It was discussed that NBT had trialled splitting emergency and elective colorectal and had instead moved to a 5 day short stay model for lower acuity patients with a low acuity and complex split rather than elective and emergency one; however, on further discussion it was clear that an emergency/elective split could be made to work.
- All other complex elective surgery and pelvic surgery apart from elective UGI and ENT is located at CGH including stoma nursing provision.
- There is a need for a clear plan to manage deteriorating patients with rapid access to support services including CT scanning, including out of hours and at weekends.
- Further work should be undertaken to understand the number of patients at the elective site who would need to return to theatre, both in and out of hours, and plans developed to ensure adequate theatre capacity and staffing (surgical, anaesthetic, nursing and others) to safely support the clinical model.
- The service at the elective site must provide senior weekend review in line with national guidance.
- There is a need to ensure 'hot' colorectal cover at GRH is sustainable.
- Consolidating elective colorectal services at CGH will help maintain sufficient clinical activity to sustain the CGH ICU.

7. Image Guided Interventional Surgery (IGIS) hub and vascular surgery

- Noted that IGIS services (both hub and spoke) can be vulnerable to machine failure and that having more than one set of equipment can mitigate clinical risks associated with this.
- Locating the IGIS hub at GRH with a spoke at CGH makes a lot of sense in terms of working to scale and recruiting.
- IR recruitment is very difficult and therefore a split site model for this speciality would not be attractive.
- Noted that co-location of vascular with cardiology is not a natural coupling of services.
- The CRP was opposed to supporting a split site option for vascular surgery.
- A split-site vascular service would be outside of the NHSE Service Specification (A04) and VSGBI Provision of Vascular Services (2018). An arterial network needs a single arterial centre with 24/7 surgical cover, 24/7 IR cover, a dedicated vascular ward, and a hybrid operating theatre to manage emergency admissions, facilitate daily review of inpatients and for the early detection and management of complications.

- For vascular surgery to be at CGH, a two IGIS hub model would be required rather than hub and spoke as vascular cannot clinically disassociate from the IR hub.
- Vascular surgery at CGH would require a separate middle/junior medical on call rota and it is unlikely that this could be staffed.
- If vascular surgery was based at GRH there would be an impact on the ITU workload at CGH but the CRP felt this should not determine the location of the service.
- Vascular surgery workload comprises approximately 2/3 emergency cases, 90% of which come from GRH.
- Colocation with diabetes, IGIS hub and trauma make GRH favourable for vascular delivery whereas there is less validity for colocation with the IGIS spoke.

8. Centralisation of emergency general surgery to GRH and general surgery day cases to CGH

- The rationale of delivering emergency general surgery at GRH was understood by the panel but concerns around the fit with the bed base were discussed.
- OOH and weekend consultant review and nursing cover is essential for EGS – this could be more easily provided at GRH.
- Undertaking short stay general surgical work at CGH is likely to lead to fewer cancellations and improve the patient experience.
- The temporary centralisation under the COVID 19 response has clearly demonstrated the clinical benefits of this proposal.

9. Reconfiguration of Trauma and Orthopaedics (currently a pilot)

- The pilot has shown that the service works, with clear pathways in place and good staffing, since 2017.
- T & O department works at two sites with Trauma at GRH and elective at CGH.
- Complications of elective surgery like infections are managed at GRH.
- There is an effective handover and regular ward round at GRH. On call consultant provides support to any out of hours issues at CGH and over weekend.
- Fracture neck of femurs are managed with Ortho Geriatric consultants and are under joint care. Although there is ED at both sites, major trauma is diverted to Trauma centre at GRH by ambulance services. There is a cover available for ED from 8 am to 8 pm at CGH. There is no overnight on call team at CGH.
- Imaging facilities such as X rays, USG and CT scan are available at CGH.
- It was also highlighted that it is essential to have ICU/HDU support to continue with complex elective orthopaedic work at CGH.

10. Reconfiguration of Gastroenterology (currently a pilot)

- This is now regarded as a well run and effective service; working well with colorectal surgery, upper GI and IR and is considered sustainable for the staff where the previous model was not.
- 75% of gastro runs through GRH and the sense is that acute medicine appreciate the daily presence of gastroenterology on their ward.
- Some ward cover was dropped and although in reach is considered effective it was noted that this does not necessarily build an experienced and resilient emergency GI ward.
- All data for GI conditions is not captured which may want to be considered to ensure the quality of gastro under general teams at GRH is maintained.

11. Overall

- How these proposals sit within the wider community model, particularly with regard to urgent care, needs to be briefly and clearly explained.
- The CRP had concerns about the delayed discharge model and had the impression that it is not robust enough.
- The CRP would encourage cross site working for all staff to help unite the hospitals and also cross working into the community for nurses and AHPs to address some of discharge delay issues identified.
- Rise in demand is a key driver for changes so the modelling of this linked to beds and workforce over the next 5 years should be clearly explained.
- The outcome measures from the pilots need to be clearly presented.
- Further work with the ambulance service is required to support the operation of the model.
- Clarity is needed about how the proposals address changes in population, demand and need.
- Clarity is needed about the expected impact of the proposed changes on service quality indicators (as set out in national service specifications).
- Clarity is needed about the clinical governance arrangements for care pathways within the Gloucestershire's trusts and outside of these trusts as part of the wider South West Operational Delivery Networks.

7. Next Steps

The provisional summary recommendations were shared verbally with the FFTF management team on 21st August. These recommendations were then shared with the CRP as part of the full report for comment and

sign off. The draft report was also shared with the ICS for fact checking. The Clinical Senate Council receives the report and is accountable for the advice contained therein.

The final report is then shared with the ICS and NHS England Assurance Team.

Gloucestershire ICS will own the report and be expected to make it publicly available via its governing body or otherwise after which point it will also become available on the Clinical Senate website.

8. Panel Membership

Clinical Review Panel members

Panel Role	Name	Title
Chair	David Halpin	Clinical Vice Chair, South West Clinical Senate
GP	Mary Backhouse	GP Partner, North Somerset
Therapies	Ros Wade	Head of Therapy Services RD&E
Emergency General Surgery	Anne Pullyblank	Medical Director for the WEAHSN
Care of the Elderly	Arvind Kumar	Care of the Elderly Consultant Weston Area Health NHS Trust
Public Health	Nevila Kallfa	Consultant in Public Health
Emergency Medicine	Leilah Dare	Consultant in Emergency Medicine NBT
Social Care	Sharon O'Reilly	Deputy Director,Adult Social Services
Gastroenterologist	Nick Michell	Consultant Gastroenterologist, RCHT
Intensivist	Nick Kennedy	Consultant Anaesthetist and Intensivist

		Taunton and Somerset NHS Trust
Anaesthetist	Zoe Ridgeway	Consultant Anaesthetist/Clinical Lead for Perioperative Care, Great Western Hospital
Interventional radiology	John Hancock	Vascular and Interventional Radiology RCHT
Trauma & Orthopaedics	Dr Paresh Sonsale	Consultant T&O, West Midlands Senate
Patient/public representative	Nick Pennell	Chair, South West Clinical Senate Citizens' Assembly and Healthwatch Plymouth
Patient/public representative	Ann Harding	Healthwatch BSW
SWAST	Alex Sharp	Clinical Lead-Dorset
General Surgery	Katie Cross	Consultant General Surgeon, North Devon Healthcare Trust
Vascular Surgery	Marcus Brooks	Consultant Vascular Surgeon, NBT
Paediatrician	Peter Davis	Consultant Paediatric Intensivist, UHB
Nursing	Caroline Smith	Cons Nurse Stroke and Clinical AF Lead SWAHSN
Managerial Lead	Ellie Devine	Head of South West Clinical Senate

Gloucestershire ICS Team Contributors

Specialty/Category	First	Surname	Job title	Lead for questions on:
ED & Acute Medicine	Andy	Monro	Deputy Chief of Service Medicine	Elderly care, Stroke and out of hours medical cover across both sites
ED & Acute Medicine	Ian	Shaw	Chief of Service – Medicine	Benefits of acute medicine centralisation. Medical cover at CGH. Extension of AEC model at CGH and overall experience of COVID-19

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Specialty/Category	First	Surname	Job title	Lead for questions on:
ED & Acute Medicine	Rob	Stacey	Consultant in Emergency Medicine	GRH ED model, AEC at CGH. Medical staff cover and sustainability
Executive Team	Steve	Hams	Director of Quality & Chief Nurse/DIPC	Benefits to nursing of centralised acute medical take, EGS. How changes will be managed with nursing teams - Trustwide
Executive Team	Simon	Lanceley	Director of Strategy & Transformation	Overall Centre of Excellence vision and strategy
Executive Team	Mark	Pietroni	Director of Safety & Medical	Overall Centre of Excellence vision and strategy. Specific questions on CGH ED and impact of centralising acute medicine and EGS at GRH
General Surgery	Mags	Coyle	Interim Chief of Service, Surgical Division	Overall surgical strategy – emergency and elective split. Medical staffing requirements if Colorectal and/or Vascular at CGH
General Surgery	Simon	Dwerryhouse	Consultant General & Upper Gastrointestinal Surgeon	Emergency General Surgery and why a 2 site EGS model is untenable. Benefits and risks of 2 Colorectal options and why UGI is out of scope i.e. why it needs to be co-located with EGS
General Surgery	Clare	Fowler	Speciality Director – General Surgery, Breast, Vascular & Urology	Overall surgical strategy – emergency and elective split. Medical staffing requirements if Colorectal and/or Vascular at CGH
General Surgery	Neil	Borley	Consultant General and Colorectal Surgeon	Benefits and risks of 2 Colorectal options
General Surgery	Tim	Cook	Consultant General and Colorectal Surgeon	Benefits and risks of 2 Colorectal options
ICS	Ellen	Rule	FFTF Programme, Executive Lead and Director of transformation and redesign	Strategic context and ICS
ICS	Jeremy	Welch	GP, locality lead and GP trainer	GP view including initiatives such as CINAPSIS and GP AU
IGIS & Vascular	Jane	Benfield	Matron Urology, Breast & Vascular	Impact of Vascular options on nursing team
IGIS & Vascular	Richard	Bulbulia	Consultant Vascular Surgeon	Benefits and risks of 2 Vascular options & link to IGIS. Medical

Specialty/Category	First	Surname	Job title	Lead for questions on:
				staffing requirement if Vascular remains at CGH.
IGIS & Vascular	Rafe	Chamberlain Weber	Clinical Lead, Interventional Cardiologist	Interventional Cardiology model & link to IGIS
IGIS & Vascular	David	Cooper	Clinical Lead Vascular, Consultant Vascular and Endovascular Surgeon	Benefits and risks of 2 Vascular options & link to IGIS. Medical staffing requirement if Vascular remains at CGH.
IGIS & Vascular	Guy	Hickson	Consultant Interventional Radiologist	Clinical lead for IGIS concept – benefits to patients and staff
IGIS & Vascular	Donna	Parkin	Consultant nurse, Vascular	Benefits and risks of two Vascular options
Patient representative	Jenny	Hepworth	Patient representative	Patient perspective on proposals and feedback on engagement process
Support services	Dave	Taylor	Head of Therapy Services	Impact on therapies
Support services	Steve	Twigg	Speciality Director – Anaesthetics, Critical Care & Pain	Impact on DCC – link to national investment programme to increase DCC capacity & learning from COVID-19
Support services	Dave	Windsor	Consultant in Intensive Care and Anaesthesia	Impact on DCC – link to national investment programme to increase DCC capacity & learning from COVID-19
T&O	Jonathan	Mutimer	Speciality Director – Orthopaedics – Elective (planned care)	Trauma & Orthopaedic model, learning from Pilot, link to GIRFT programme

9. Appendices

1. Agenda
2. CRP KLOES
3. PCBC v3.2
4. Presenting Slides
5. Desktop Review
6. 2017 Review