Workshop Evaluation – rationale behind scores

C8: Centralise elective upper gastrointestinal to Cheltenham General Hospital (CGH) – Models G & H

Quality	Pre Workshop Information - Evidence from Workstreams		Pre Workshop Scores			Pre Workshop Scorer Comments			Workshop Scores				Workshop Scorer comments		
	What would be better	What would be worse	Table 2	Table 3	Table 7	What would be better	What would be worse	Other comment	Table 2	Table 3	Table 6	Table 7	What would be better	What would be worse	Other comment
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	Don't Know	Don't Know	SI Better	Reduction in cancellations. Concentration of experienced staff at one location Slightly better for colorectal pts if centre established at CGH. Colorectal cases are increasing nationally, especially cancer, and more advanced testing (genomic medicine) and treatments emerging. This will require different skills and competencies as well as support from AHPs, e.g. dietitians. If dedicated theatre time for planned surgical lists this should improve wait times for surgical pts.		Reduction in cancellations is offset by looking after the deteriorating patient. The "deteriorating patient" model does not describe surgical input. There is an increased risk to patients safety. Strategy 10 document suggests that high volume, non-complex cases are best suited to geographical separation from EGS Difficult to judge as unclear about the ability to staff the model with Consultant and foundation year doctors so would this model we able to deliver improved quality of care?	Sl Worse	Sig Worse	Sig Worse	Similar	Protected electives, away from EGS would be beneficial (reduced risk of cancellations) Reduced risk of SSI (Surgical Site Infection) and MRSA	Deteriorating Pt, split site with EGS, transfer risks Failure to rescue could lead to poor outcomes - 24/7 emergency Reduction in cancellations Complication rate for upper GI is high - moving away from emergencies might make worse for access to out of hours theatre / diagnostics. Would disrupt existing, effective, well established pathways (and specialist staff eg ITU re Oesophageal patients) Significant concerns around safety of a deteriorating patient out of hours/weekends	3 county centre, spec comm - Glos chosen as resection centre. Enhanced recovery implemented 100 complex cases 25 - 30% return rate Existing cancer centre for S/West (at GRH) No benefit of centralisation, as already centralised (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 time?	Dedicated planned care team protected from EGS demands. Supported by the findings of the Royal College of Surgeons – separating emergency and elective surgical care Report, September 2007.	No impact	SI Better	Don't Know	Sig Better	Dedicated team - not called away to emergencies. For colorectal pts it is a clearer case to assess. For other surgical specialities it will take time to establish especially with staff movement and upskilling requirements. It should improve wait times.		Elective patients are currently seen by the upper GI team	Sl Worse	Sl Worse	Sig Worse	Similar		Significant concerns on model regarding surgical cover overnight and at weekends - May be a hybrid model. increase in major elective surgeries complication rates resulting in further interventional surgery	Significant concerns on model regarding surgical cover overnight and at weekends - May be a hybrid model. Do all UGI patients get reviewed at weekends now?
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.	Don't Know	Don't Know	SI Better		Weekend consultant review would not take place with current staffing levels. If no Consultant available at weekend to support board round it is difficult to comment on impact on continuity of care	Evidence accumulating since 2007 that separating planner from emergency care is effective if there is sufficient theatre, staffing and support services capacity. Will be able to gain reputation as 'surgical centre' for Gloucestershire.	Sl Worse	Sl Worse	Sl Worse	Similar		No w/e cover	dependent on case mix. Royal College guidance suggest that this model may be contradictory to advice
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	Similar	Similar	Similar				Similar	Similar	Similar	SI Better		separated from emergencies	
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	SI Better	Don't Know	Similar	dedicated ward	Planned care minimises disruption and disturbance which is particularly important to dementia patients and those with certain mental health conditions.	No evidence to suggest capacity to deliver this has been identified	SI Better	Don't Know	Similar	SI Better	Planned is ring-fenced Benefits of being away from the emergency site.		New risk of transfer but can be done safely.
1.6 What is the likely effect of this solution on encouraging patients and carers to manage self-care appropriately?	No impact	No impact	Similar	Similar	Similar	Planned nature would mean advice etc. would be automatic.			Similar	Similar	Similar	Similar			
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	Don't Know	SI Worse	Sig Better	all specialised staff at one hospital	Deteriorating patients may require transfer	Further work needed on what happens to re-admissions following surgery in terms of medical continuity/responsibility. Increased number of transfers between sites for deteriorating pts? Will there be dedicated theatre time and expertise? OOH cover?	Sl Worse	Sig Worse	Sl Worse	Similar		Deteriorating Pt, split site with EGS, transfer risks Concerns over complex patients	
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	Don't Know	SI Worse	Sig Better		Patients may require transfer, access to emergency theatre may be compromised weekend issue of staffing may prove a problem	Presuming existing protocols for deteriorating pt will be reviewed and revised if changes supported?	Sl Worse	Sig Worse	Sig Worse	Sig Worse			Can be done but could be more complicated. More complex patients.
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.	Don't Know	SI Worse	SI Better	It will affect pts, carers and staff if transfers between sites. If planned, information should be provided to pts re alternative travel available and car parking costs.	Increased travel times for some should not affect outcomes.	as the treatment is elective, prior planning by the patient and their family/carers should have taken place	Similar	Sl Worse	Similar	Similar			
1.10 What is the likely effect of this solution on patient safety risks?	Reduce the risk of cancellations to planned care.	No impact	Similar	Don't Know	SI Better	Fewer cancellations means less likelihood that patients' condition will deteriorate and become an emergency centralized staffing should improve staff availability	Out of hours cover is not in place weekend cover issue could create safety concerns		Similar	Sig Worse			Reduced elective cancellations	Lack of w/e planned review Separates from emergency services.	

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	What would be better	What would be worse	Table 2	Table 3	Table 7	What would be better	What would be worse	Other comment	Table 2	Table 3	Table 6	Table 7	What would be better	What would be worse	Other comment
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	Don't Know	Don't Know	Similar	Improved waiting times			SI Better	SI Better	SI Better	Similar	Reduced elective cancellations		Centralised now (at GRH) so largely 'same as now' but affects different cohort of people Interdependencies noted Tech: robot in CGH (might need another one)
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	SI Better	Similar	SI Better		no choice of hospital for the patient to decide		Similar	Similar	Similar	Similar			
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	Similar	Similar	Don't Know			No TIA to determine exactly as the treatment is elective planning should have taken place before admission	Similar	SI Worse	Similar	SI Worse	Can be mitigated as planned.		Further analysis on # required
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	Similar	Sig Better	Similar	Improved ability to achieve national waiting times Less cancellations		No true evidence to substantiate this assessment dependant on allocated bed space	SI Better	SI Better	SI Better	SI Better	Reduced elective 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	Similar	Similar	SI Worse		further and more expensive for people in the west of the county and FOD		Similar	Sig Worse	Similar	SI Worse			Further analysis on # required
2.6 What is the likelihood of this solution supporting the use of new technology to improve access?	No impact	No impact	Similar	Similar	Don't Know	only one hospital to equip			Similar	Similar	SI Better	Similar			
2.7 What is the likelihood of this solution improving or maintaining service operating hours?	No impact	No impact	Similar	Similar	Sig Better			What about cover at weekends	Similar	SI Worse	Similar	Similar			No change
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.	Similar	Similar	Sig Better			Swapping single site from GH to CGH Remains on one site just a different one.	Similar	Similar	Similar	Similar			
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	Similar	Similar	Similar			further analysis required	Similar	Similar	Don't Know	SI Worse			insufficient information
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	Don't Know	Don't Know	Don't Know				Similar	Don't Know	SI Better	SI Better			insufficient information

Deliverability	Pre Workshop Information Pack - Evidence from Workstreams		Pre Workshop Scores			Pre Workshop Scorer Comments			Workshop Scores				Workshop Scorer comments		
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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	Don't Know	Similar	Don't Know			What is the timeframe? Currently the model is undeliverable in terms of staffing, theatre space	SI Worse	Similar	Sig Worse	Sig Worse	Capacity moves to free up. Elective rota cover. Interventional Radiology would be available Nutritional team would/could still accompany on ward rounds	some concerns around staffing Junior and lower grade rotas	Priorities 1) EGS 2) Daycase 3) colorectal 4) Upper GI GRH is dedicated cancer centre; would we need to be re-accredited or just 'lift and shift' to CGH? Low priority on the list as already benefits from centralisation
3.2 What is the likelihood of this solution meeting the relevant national, regional or local delivery timescales?	No impact	No impact	Don't Know	Don't Know	Similar			need to ensure sufficient trained staff are available	Similar	Don't Know	SI Worse	Similar			Cancer centre - designated at GRH - would this need to be looked at again
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.	Don't Know	Don't Know	Don't Know		Insufficient F1 staff. Insufficient consultants to provide weekend review of patients		SI Worse	SI Worse	SI Better	SI 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	Similar	Don't Know	Sig Better				Sig Worse	SI Worse	Sig Worse	Similar		Staffing requirements F1 and consultants split across sites	
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.	Don't Know	Similar	Similar				Similar	SI Worse	Sig Worse	Similar			Theatre capacity? DCC element, DCC transfer, IR hub Genomics GRH Access to DCC
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	Don't Know	SI Worse	SI Better		Theatre capacity is lacking		SI Worse	Don't Know	Sig Worse	Don't Know			Theatre capacity required - req further modelling
3.7 What is the likelihood of this solution having access to the required technology to be successfully implemented?	No impact	No impact	Similar	Similar	SI Better				Similar	Similar	Similar	Similar			No additional requirement
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.	Don't Know	Don't Know	Similar			Consultant and F1 rotas would need to be developed. Requires additional staff	SI Worse	Don't Know	SI Worse	SI Worse			Staffing needed Significant interdependencies but insufficient info.

Acceptability	Pre Workshop Information Pack - Evidence from Workstreams	Pre Workshop Scores			Pre Workshop Scorer Comments	Workshop Scores				Workshop Scorer comments
		Table 2	Table 3	Table 7	comment	Table 2	Table 3	Table 6	Table 7	comment
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	SI Better	Similar	Similar	Many respondents will have identified elective surgery cancellations as an issue though many will expect such service to be provided on both sites.	SI Worse	Similar	Sig Worse	Sig Worse	Engagement Report - No specific questions but supports future of CGH Pitch - c.f to current: No clear clinical benefit to change; elective separation positive. Lack of data on deliverability. A lot of upheaval for potentially less gain Not really suggested/supported by UGI team (weekend rota/return to theatre ratio (20-30%) (colocation with EGS) In line with 'pure' CoEx of Elective / Emergency Split Old 'option 4' has been considered (full Eiective / Emergency split) Benefits of EGS/EI split, but negatives is staff impact/workforce restrictions

Workforce	Pre Workshop Information Pack - Evidence from Workstreams		Pre Workshop Scores			Pre Workshop Scorer Comments			Workshop Scores				Workshop Scorer comments		
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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.	Don't Know	Sig Better	Don't Know	Better use of resources workforce, theatres etc.		A single unit already exists. The efficiencies of single unit are offset by the inability to staff the elective and EGS rotas at F1 and consultant level if the unit is on a separate site from EGS. need for transport and staff parking at CGH	SI Worse	Similar	Sig Worse	SI Worse		Split from EGS Not attractive to existing team, and would be hard to attract/retain new people.	Complex patients/specialist skills (already in 1 place) and could risk loss of cancer network status. Similar themes to Colorectal to CGH
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	Don't Know	Sig Better	Sig Better	Specialist nursing staff have significant workloads with patients undergoing both panned and emergency care. Separation of EGS from inpatient CR work will result in inefficiencies with increased travel between sites Planned care without fear of disruption			SI Worse	SI Worse	Sig Worse	Similar		Split from EGS reduces efficiency	
4.3 What is the likely effect of this solution on supporting cross-organisational working across the patient pathway?	No impact	No impact	Similar	Similar	SI Better				Similar	Similar	Similar	Similar			
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	Similar	SI Better	Don't Know	Option to expand role of specialist nurses May be able to incorporate expanded roles for nurses within the team			SI Worse	Similar	SI Worse	Similar		Split from EGS	
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.	SI Better	Similar	Don't Know	Dedicated environment Work load predictability promotes stability			Similar	Similar	Sig Worse	Similar		Split from EGS	
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 on staff retention and the ability to recruit new staff. This would be evidenced by staff rotas, recruitment and retention metrics.	There may be some staff dissatisfaction in respect of staff who prefer GRH as base.	SI Better	Don't Know	Sig Better	Workload predictability promotes stability.		Need to make the county an attractive place to live. Affordable housing etc.	Similar	Similar	Sig Worse	Similar	Positive for Cheltenham staff	negative for any GRH nurses	
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	Don't Know	Similar	SI Better	Planned exposure to clinical procedures ensures training needs will be met.	If on a separate site from EGS this will reduce the learning experience. Feedback likely to be worse. Lack of viable F1 rota puts retention of F1s at risk.		SI Worse	Similar	Similar	Similar		Destabilise F1 rotas	
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.	Don't Know	Similar	SI Better		Trainees and trainers may frequently be working on different sites		SI Worse	Similar	Similar	Similar		Education supervision split on 2 sites	
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	SI Better	Similar	Similar				Similar	Similar	SI Worse	Similar			Cancer status risk
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	Don't Know	Similar	SI Better				Similar	Similar	Similar	Similar	Less cancellations better for a volume of activity		
4.11 What is the likely effect of this solution on the travel burden for staff? e.g. relocation time and cost.	Further analysis required	Further analysis required	Don't Know	Similar	SI Worse			Need for ample transport and staff parking at hospital	Similar	Don't Know	Similar	SI Worse			Lower number of cancer Pts in this cohort so impact on CNS less so GRH - CGH but could offset.
4.12 What is the likely effect of this solution on maintaining clinical supervision support to staff?	No change to current as already centralised to one site (GRH).	No impact	Similar	Similar	SI Better			Clinical supervision will be similar, educational supervision will be diminished	Similar	Similar	SI Worse	SI Better			

A4 - Re-open Cheltenham Emergency Department overnight, with corresponding transfer of capacity from GRH to CGH for acute medical admissions overnight – Model C

Quality	Pre Workshop Information - Evidence from Workstreams		Pre Workshop Scores		Pre Workshop Scorer Comments			Workshop Scores		Workshop Scorer comments		
	What would be better	What would be worse	Table 1	Table 5	What would be better	What would be worse	Other comment	Table 1	Table 5	What would be better	What would be worse	Other comment
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		Don't Know	SI Worse	It will be better for those in urgent A and E need overnight but care is still available overnight and statistics seem to indicate that there has been insignificant mortality consequences with the current system.	It's clear that getting the right clinical staff in CGH will not happen Staffing issues will affect patient care lack of middle grade and senior staff to provide 24/7 cover at both CGH & GRH There is insufficient demand, opening at night would draw resource from GRH to CGH The department cannot me staffed appropriately. Furthermore appropriate support behind the ED will unlikely be available meaning delayed and poorer standard of care	National guidelines are separation of emergency care and to have two centres would not be feasible in terms of co and available staff. Anyone need emergency care for life threatening conditions is likely to be blue lighted anyway. My caveat would be post op for families to visit as this 'feel good' helps recovery. There must be good cause behind closing/ reducing the ED from 8pm, surely if patient care being impacted was occurring or it was felt that patients were being put at risk- then surely it would have stayed open. I would need more information about patient care, before the ED closed versus reopening it. From reading the pack it suggests that there would not be enough staff to provide adequate care.	SI Worse	SI Worse	If it can be staffed it would improve	Much lower throughput Speciality service access not there may increase transfers to Glos Lack of senior medical practitioners - worse. National standards for sepsis, unwell children not met - worse outcomes. Also no Gynae or paeds on CGH. MH liaison team capacity. Walk-in that are v unwell better services at GRH; no 24 hr MRI. Pts behaviours have changed already. Also negative impact on GRH/ overall County compliance	
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		SI Worse	SI Worse	Could lead to quicker diagnosis and reduced hospital stay. If the full ED team is there overnight there is a much better chance of swifter and therefore better care.	It's clear that getting the right clinical staff in CGH will not happen Could be delays in accessing suitably qualified specialisms	Dependent on other service reconfiguration Focusing acute unplanned care in one place is the only option with available resources. I would expect the approach of getting it right first time would reduce double handling, thus using time more efficiently. The end result being that the patient receives a good level of service and care.	SI Worse	SI Worse			
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		Similar	SI Worse		May increase transfers. Unlikely that a single clinician would be available to provide singular cover Specialties increasingly centralise to deliver high quality high volume care. This will result in delay and increased transfer.	There will be a mixture of less transfers from CGH at the walk-in clinic but more within hospital once a patient is admitted. Hard to quantify and also figures should be weighted by the impact of such a transfer Better on site care is clearly better but patients may still be in the wrong place for their specialist needs. I think that emergency cardiac surgery would still need to go out of county at night.	SI Worse	SI Worse			
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	Similar	Sig Worse		ongoing treatment based on different sites Again the lack of sufficient middle & senior staff cover would compromise holistic care	Depends on where the other teams are but few (probably none) can appropriately staff services 24/7 supporting unplanned access to services on both sides of the county.	Similar	Similar			No impact
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		Similar	Similar		Managing two sites for 24 hours would be harder all aspects are seriously affected by staffing issues Two A&E departments would increase the financial impact on all aspects of care.	Impossible to meet needs on two sites in a high quality timely fashion.	Similar	Similar			No change to physical 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	Similar	Similar		Availability 24/7 of ED cover will mean that more minor illnesses & injuries will need to be treated at CGH due to lack of patient understanding of the other alternatives such as MIIU, GP, Pharmacist	Knowing that both hospitals are open 24h will mean patients don't try to hang on until morning to avoid going to Gloucester	Similar	Similar			Not relevant for this cohort
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		Similar	SI Worse	Patients in the Cheltenham area would access appropriate care sooner due to close proximity	More patients will need to be transferred Chaos across the county	At night the distance between the two hospitals is not poor anyway, during the day blue lighted patients should not be seriously affect by traffic. IF they are taken to the right, most appropriate centre in the first place it would be better. The best place might indeed be Cheltenham which is fine but if their speciality is Gloucester then they are in the wrong place	SI Worse	SI Worse	For urology and vascular pts at CGH will reduce transfers	If stroke patient in Cheltenham - worse Interdependent with radiology, spec at GRH only incl stroke, paeds, gynae & frailty so increase transfers. Need to model # impact.	Assuming protocols are same as GRH for SWAST
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		Sig Worse	Sig Worse		There would not always be appropriate senior staff at CGH lack of middle & senior staff cover for 24/7 working Getting patients to services or clinicians to patients will inevitable cause delay.	it would require specialist staff to be at both hospitals 24/7 Better for the emergency intervention but not necessarily for immediate follow up.	SI Worse	SI Worse		Takes longer to do a CT at CGH. Cascade effect on resources, to work well need to "open entire hospital". If not staffed and you fill it - worst of all	
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		Don't Know	SI Worse	Less travel time for those in the East at night	Would result in confusion regarding where paramedic & other emergency ambulance staff take patients .		Similar	SI Worse		Introduces risks If just ED resource then Pts requiring full range of services that attend CGH will need onward transfer to GRH	
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. Evidence: 2 recruitment drives over the past year did not result in recruitment	SI Worse	Sig Worse		There would not always be appropriate senior staff at CGH Rotas will remain impossible to staff		Sig Worse	Sig Worse		Introduces new risks Negative impact on GRH rotas. Impacts clinical risk	

Access	Pre Workshop Information Pack - Evidence from Workstreams		Pre Workshop Scores		Pre Workshop Scorer Comments			Workshop Scores		Workshop Scorer comments		
	What would be better	What would be worse	Table 1	Table 5	What would be better	What would be worse	Other comment	Table 1	Table 5	What would be better	What would be worse	Other comment
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		Don't Know	Similar		Overnight choices limited with some patients having to go outside the county departments split between two hospitals within the county	I personally think that a lot of confusions exits over what constitutes 'emergency' care and the feeling is that the proposal is to remove accident and emergency care when in fact only true emergency car is impacted by the closure. . The overriding opinion of Cheltenham based patients is that CRH is a general hospital and should be kept as such and for that reason not reopening reduces their choice. Whilst recognising the local pride I believe it is however misplaced e.g. pregnant mothers not wanting Gloucester on birth certificates as Cheltenham is regarded as' superior' This is however not a valid reason for making a choice of venue. I believe that showing how the care would be better, quicker etc. could re-educate If ED treatment is quicker overnight in Cheltenham then great but the follow up care needed might be in Gloucester. All depends on individual medical demand. Even if CGH ED was open overnight then it still might make more medical sense to go to Gloucester...or indeed out of county.	SI Better	Similar			Pt choice not relevant to this service. Impact on 4 hr is in NHS constitution
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		SI Better	Don't Know	Patients will know they can always go to their nearest hospital		. If it is opened it stops patients having to think of options but this would not necessarily improve care or flow. Wider education on these matters would help. Maintaining two ED sites 24/7 is just what the public are demanding given the engagement feedback Difficult for patient to weigh up the offer...they just want to be mended.	SI Better	Similar			if changed could simply message but can ED do everything that Pts need Current perception is that ED is closed from 20:00
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.	SI Better	Don't Know	Better for Cheltenham area residents		Clearly less travel to get to nearest hospital, though this will be reduced because some patients will need to be transferred to Gloucester anyway It is purely dependent on the availability travel options of patients and family. This could be overcome with sway increased 99 bus service so many different factors influence this issue Outpatient services will not change. With the exception of a small number of patients who live in walking distance of CGH, most will have travel times for unplanned care but efficient service on arrival.	SI Better	Similar			Depends on the presentation either +tive or -tive
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		Don't Know	Sig Worse	ED waiting time may/would reduce but I have no idea how this would impact on other waiting times.	Much harder to properly staff two ED. Unlikely to achieve waiting times due to lack of middle & senior staff 24/7 unable to staff and manage patient flow.	It is possible that if only true emergency services are closed at Cheltenham and correct triage is in place with supporting services e'g AMII that ED waiting times could be reduced. Referral to treatment, especially with new electronic patient records could be faster with specialist teams in place.	SI Worse	SI Better	May improve RTT If fully staffed	If pulled from GRH, would be worse could lead to cancelled planned care CGH	Depends on staffing - not as efficient.
2.5 What is the likely effect of this solution on the travel burden for carers and families?	See 2.3	See 2.3	SI Better	SI Better	Would reduce travel for Cheltenham area IF Cheltenham is nearer for the patient then it makes sense to assume its easier for relatives.		Admitted patients will be transferred to the most appropriate hospital anyway and this will be the determining factor, rather than which ED they chose	SI Better	Similar			As per 2.3
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 option	No better or worse than the current option	Sig Worse	Don't Know		Harder to resource two locations cost implications and specialist staffing. Cost of maintaining two A&E could limit technological advancement	It would be wrong to assume that Gloucester would have better technology, it depends on the medical need and available technology.	Similar	Similar			
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		Similar	Don't Know		Staffing issues Impossible to support busy out of hours service on multiple sites.	The public is demanding 24/7 ED in CGH & perceive that CGH ED is closed between 8pm & 8am currently Better because ED staff would be there but not necessarily other 'follow up' staff. This issue could be the same in Gloucester	Similar	SI Better	Increase in hours If fully staffed		
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	SI Worse	SI Worse			Two easier than one for patients harder for staff If you open and run an ED department it needs, by its very nature, to be staffed and equipped appropriately.	SI Better	SI Better	If fully staffed adds location after 20:00		
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	Similar	Similar			Both sites should be equally accessible. Transport is again key This is something that would need to be more fully assessed bit whatever happens may need additional accommodation and this would be more fundable on one site than both.	Similar	Similar			
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	Don't Know	Similar		will make us less able to cope with increasing demand.	Given the likely countywide population growth particularly in the over 70's group more services will be required not less	SI Worse	Similar		Reduces resilience	

Deliverability	Pre Workshop Information Pack - Evidence from Workstreams		Pre Workshop Scores		Pre Workshop Scorer Comments			Workshop Scores		Workshop Scorer comments		
	What would be better	What would be worse	Table 1	Table 5	What would be better	What would be worse	Other comment	Table 1	Table 5	What would be better	What would be worse	Other comment
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	Don't Know	Sig Worse		Hard to recruit staff infrastructure inadequate and no space to improve.	Not feasible without numerical evidence and feasibility studies Highly unlikely due to recruitment difficulties & retention of existing staff	Sig Worse	Sig Worse		Deliverability is subject to recruitment (not easy). Clinical view is unanimous and strong feeling against solution. People would leave	
3.2 What is the likelihood of this solution meeting the relevant national, regional or local delivery timescales?	No impact	No impact	Don't Know	Don't Know		There would not always be appropriate senior staff at CGH		Similar	Similar			
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	Sig Worse	Sig Worse		Hard to recruit staff	There appear to be unresolved issues about guaranteeing consistent stiffen levels through recruitment	Sig Worse	Sig 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	Sig Worse	Sig Worse			This seems to be an example of spreading available assets to thinly to be viable in the short term Given the current recruitment and retention issues it is highly unlikely that a 24/7 ED at CGH could be properly & safely staffed	Sig Worse	Sig Worse		Clear requirement for extra staff to deliver. Recruitment is ongoing issue across NHS and locally. A lot of effort and innovation expended. No certainty in achieving.	
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	Sig Worse	Sig Worse			we cannot support all services in all locations. An ED without appropriate support will fail.	SI Worse	Sig Worse		CT lack of availability. Sub specialty not on site (Gynae, Obs, Paeds and stroke)	
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		Similar	Similar			Both EDs currently exist. Splitting the load over he two areas will make use of existing facilities No major changes required to premises at CGH The space does not exist to develop everything that is necessary.	Similar	Similar			No change
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		SI Worse	Don't Know			If the facilities/technology are there to run during the day it should be able to run at night although with greater use there will be greater deterioration.	Similar	Similar		Staffing issue	No change
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	Don't Know	Don't Know			Per capita population we do not have the staff to achieve this. more ED patients need more beds and urgent follow up care. The consequences of extending ED time are far reaching for other connected services	SI Worse	SI Worse		Support services/radiology staffing Transport for assessment Impact on HR function to support recruitment - significant	

Acceptability	Pre Workshop Information Pack - Evidence from Workstreams	Pre Workshop Scores		Pre Workshop Scorer Comments	Workshop Scores		Workshop Scorer comments
		Table 1	Table 5	comment	Table 1	Table 5	comment
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	SI Worse	Don't Know	Most of the 'pressure for this has been from 'interested sources' e.g an MP in a marginal seat looking to be heard. From talking to people, and from his response in parliament it is clear that possible downgrading and overall closure were confused. When the reality of it affecting only those patients with life threatening problems, and children is explained the overall understanding ad feeling is that level of care is more important than place. The public will perceive this as a victorious result of their campaigns due to lack of understanding of the complex factors that resulted in CGH ED becoming a nurse-led unit overnight	Similar	Sig Worse	Responds to engagement Same position as in 2012 - same problems Engagement Report - Vast majority of concerns was not closing CGH ED rather than reinstatement. This solution was added in response. Pitch - Considerable negative aspects across all domains

Workforce	Pre Workshop Information Pack - Evidence from Workstreams		Pre Workshop Scores		Pre Workshop Scorer Comments			Workshop Scores		Workshop Scorer comments		
	What would be better	What would be worse	Table 1	Table 5	What would be better	What would be worse	Other comment	Table 1	Table 5	What would be better	What would be worse	Other comment
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	Sig Worse	Sig Worse		Overnight cover relies heavily on staff goodwill and availability of agency staff		Sig Worse	Sig Worse		Inability to recruit. Already insufficient staff for current service. Split site more difficult to manage	
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	Sig Worse	Sig Worse		getting a fully effective fully trained staff 24/7 will be a challenge.	Staff work better when given a stable environment, having to travel between hospitals regularly is not sustainable	Sig Worse	Sig Worse		As per 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	Don't Know	Don't Know		you will need to do much more multi skilling. Not all staff want to be multi skilled.	Blue and red team. See it first hand,. Never good. An institution should have similar things done by similar people in similar ways in similar places.	Similar	Similar			No change
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.	Similar	Sig Worse		Duplication of services will make this much more challenging.	Staff will need to e more flexible over the two locations, which is good and may help reduce tribalism	Sig Worse	Sig Worse		As per 4.1	
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	Sig Worse	SI Worse			Staff surveys already highlight stress and workload. I can't see this initiative improving this.	Sig Worse	Sig Worse		Staff concern about not practicing to acceptable standards more wait for review/onward management Staff need confidence in a robust rota. This solution increase pressure. Senior decision maker on site. Vulnerability and isolation.	
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	Sig Worse	Sig Worse		Pressure on staff from multiple rotas	Staff need stability and a supportive environment not constant stress	Sig Worse	Sig Worse		As per 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?		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	Sig Worse	Sig Worse		Harder to staff two small EDs than one larger one Specialist departments spread between two sites make all aspects of training more difficult	It will open opportunities for new roles but this comes with a cost and considerable time.	Sig Worse	Sig Worse		Impact on ability to deliver to professional roles especially trainees Deanery - potential to refuse trainees or not on split site. Jr Drs not fully supported if no recruitment and staff split across sites	
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		Don't Know	SI Worse		Harder to train staff for staff two small EDs than one larger one	The best trainers are the ones already doing the job, taking them out of the system leads to vital gaps.	Sig Worse	Sig Worse			
4.9 What is the likely effect of this solution on enabling staff to maintain or enhance their capabilities/ competencies?	No change		Similar	SI Worse			If staff are willing to travel to centres specialising in specific areas training could be better. General training is spread across wards not just in ED. Great opportunities for staff but only with time, money and willingness.	Sig Worse	SI Worse		Less provision/ capacity impacts ability to enhance. Less opportunity	
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.	SI Worse	SI Worse		Harder to train staff for staff two small EDs than one larger one, due to less specialisation		Sig Worse	SI Worse		As per 4.9	
4.11 What is the likely effect of this solution on the travel burden for staff? e.g. relocation time and cost.	Further analysis required	May be some staff dissatisfaction in respect of staff who prefer CGH as base.	SI Worse	SI Worse			There is a bus service between the hospitals My belief is that this would only be a real problem for local staff who have specific person ties e.g caring for elderly relatives with outside carer, or school age children commitments if outside care is time limited	Similar	Similar			Medical workforce already work at CGH
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.	SI Worse	SI Worse		staffing issues make supervision difficult lack of middle & senior staff		SI Worse	Sig Worse			

Revert to original Gastroenterology and Trauma & Orthopaedics configurations – Model A

Quality	Pre Workshop Information - Evidence from Workstreams		Pre Workshop Scores		Pre Workshop Scorer Comments			Workshop Scores		Workshop Scorer comments		
	What would be better	What would be worse	Table 4	Table 8	What would be better	What would be worse	Other comment	Table 4	Table 8	What would be better	What would be worse	Other comment
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. Trauma & Orthopaedics: 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: The benefits including reduced elective cancellations and daily input to trauma patients would be lost.	Don't Know	SI Worse		Current benefits achieved by development would be lost. It appears to be a retrograde step. So many things would be lost that impact on the good outcomes, waiting times would increase and staff satisfaction would go down. the only good thing might be some patients would travel less far, but that would be very few patients.		Sig Worse	SI Worse	Improvements immediately for Ortho Trauma incorrectly sent to CGH avoided		May need more bleed beds Difficult to apply single score to all 3 domains .. Gastro, Trauma, Orthopaedics Would have not much impact on emergency but would be worse for electives
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. 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.	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: 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	Don't Know	SI Worse		Dilution of skills across two sites and loss of specialist clinicians availability is reduced. there would be a reduction in the number of patients that would see specialists higher number of cancellations to accommodate for trauma and some trauma patients waiting longer.		Sig Worse	SI Worse			
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 Trauma & Orthopaedics: 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: Continuity of care could be adversely affected if the pilot was reversed, particularly in trauma with fewer patients seeing a senior specialist daily.	Don't Know	SI Worse	It would appear that there would be fewer transfers between hospitals for patients, and also reduced travel times for both patients and carers.	Access to a specialist is reduced Patients would be less likely to see a senior specialist.		SI Better	SI Worse		If revert back elective services would be worse	Emergency - Pros and cons
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	Don't Know	Similar		with both being across two sites community services would need two teams to support discharges		Don't Know	Don't Know			
1.5 What is the likely effect of this solution on the quality of the care environment?	Gastroenterology: Nothing Trauma & Orthopaedics: Nothing	Gastroenterology: Reversing the pilot, would mean Gastroenterology patients once again being spread across site and cared for in less specialist environment. 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.	Don't Know	SI Worse		less specialist care provided		SI Worse	SI Worse			For planned services, not as sure for emergency services
1.6 What is the likely effect of this solution on encouraging patients and carers to manage self-care appropriately?	No impact	No impact	Don't Know	Similar			neither of these relates to self care	Similar	Similar			
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 Trauma & Orthopaedics: Minimal change– as reliable methods to transfer patients to CGH are in place	Gastroenterology: Minimal change. Existing protocols with ED Trauma & Orthopaedics: Minimal change.	Similar	Similar	Documents indicate little impact not much change because there are already methods for transport where needed.			Similar	Similar			
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. 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.	Gastroenterology: Spreading consultants and junior doctors across two sites; means that there would be a detrimental effect to emergency care 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.	Don't Know	SI Worse		wait times for trauma would increase, daily review lost although there could be a requirement for increased trauma capacity which could be done trough having both sites with the same work, spreading staff across two sites could reduce continuity of care, longer wait times and lack of daily review.		Sig Worse	SI Worse		Trauma going back would be worse Ortho going back would be worse Gastro slightly better/same	Services need to be evaluated seperately
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 Trauma & Orthopaedics: 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 Trauma & Orthopaedics: There has been no evidence that this is the case in the years since the beginning of the trial	Don't Know	Similar		Slightly longer travel times for patients from the East, more than mitigated by better clinical outcomes	stopping patients to be admitted closer to home doesn't appear to have better outcomes for this particular situation	Similar	Similar			
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 Trauma & Orthopaedics: No benefits to pilot reversal. Initially more support for junior doctors at CGH but this has been resolved.	Gastroenterology: Reversing the pilot would see a rise in endoscopy waiting times and a reduction in the specialist Gastroenterology services for patients. 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.	Don't Know	SI Worse		It would clearly negatively impact on staffing levels, morale and the ability to recruit and retain skilled staff. rise in waiting times, reduction of specialist services and winter pressures		Sig Worse	SI Worse			

Access	Pre Workshop Information Pack - Evidence from Workstreams		Pre Workshop Scores		Pre Workshop Scorer Comments			Workshop Scores		Workshop Scorer comments		
	What would be better	What would be worse	Table 4	Table 8	What would be better	What would be worse	Other comment	Table 4	Table 8	What would be better	What would be worse	Other comment
2.1 What is the likelihood of this solution meeting the requirements of the NHS Constitution and The NHS Choice Framework?	Gastroenterology: No change Trauma & Orthopaedics: No change	Gastroenterology: No change Trauma & Orthopaedics: No change	Don't Know	Similar			No apparent change.	Similar	SI Worse		more cancellations	Offer to patients - cannot give 1 answer for so many aspects wait times - elective worse. Emergency slightly better
2.2 What is the likely effect of this solution on simplifying the offer to patients?	No impact	No impact	Similar	Similar		could make it more confusing for patients to have choice between two sites.		Similar	Similar			Inequalities too complex to give simple answer
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. 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.	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) 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.	Similar	Similar	some patients would have an improved time to travel as they would be admitted closer to home			SI Better	SI Better			More locations but worse wait times
2.4 What is the likely effect of this solution on patients' waiting time to access services?	Gastroenterology: No change from present Trauma & Orthopaedics: No change from present	Gastroenterology: Waits for outpatient and endoscopy procedures would get longer, with non-compliance for RTT and cancer targets. 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.	Don't Know	Similar		longer waits, non compliance with cancer targets, longer waits, winter pressure effects worse.		Big Worse	Don't Know	May be slightly better A&E Better	Planned care worse	
2.5 What is the likely effect of this solution on the travel burden for carers and families?	Gastroenterology: See 2.3 Trauma & Orthopaedics: See 2.3	Gastroenterology: See 2.3 Trauma & Orthopaedics: See 2.3 – impact is greater for carers and families who may be reliant on public transport for visiting.	Similar	Similar	most trauma would not be using public transport, but their families and carers might, and this could improve traveling times for them			SI Better	Don't Know			
2.6 What is the likelihood of this solution supporting the use of new technology to improve access?	Gastroenterology: No change Trauma & Orthopaedics: No change	Gastroenterology: No change Trauma & Orthopaedics: No change	Similar	Similar				Similar	Similar			
2.7 What is the likelihood of this solution improving or maintaining service operating hours?	Gastroenterology: No benefit, emergency patients would wait longer Trauma & Orthopaedics: There would be no benefit in fact this option would be poorer; reverting to less out of hours operating and ward rounds	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 out of hours operating and ward round	Don't Know	SI Worse		Longer waits. waiting times would increase		Similar	Similar			
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. 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.	Gastroenterology: Waits for endoscopy procedures and outpatient appointments would increase. 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	Don't Know	Don't Know		any benefit for having both sites would be taken away from longer waiting times and poorer service		SI Better	SI Better			
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 Trauma & Orthopaedics: Further analysis required	Gastroenterology: Further analysis required Trauma & Orthopaedics: Further analysis required	Don't Know	Similar			Can't see any indication that it would have a detrimental effect though ?? T and O on West side of County is located closer to higher concentration of deprived it could allow for easier access for the most vulnerable, but that would be access to a poorer service. Needs evidence for lack of access for the most vulnerable.	Don't Know	Don't Know			Too complex
2.10 What is the likelihood of this solution accounting for future changes in population size and demographics?	Gastroenterology: Growth modelling not yet available Trauma & Orthopaedics: Growth modelling not yet available	Gastroenterology: Growth modelling not yet available Trauma & Orthopaedics: Growth modelling not yet available	Don't Know	Similar			2 It's likely that the current pilot can cope better with growth than reversing it.	SI Worse	Don't Know			

Deliverability	Pre Workshop Information Pack - Evidence from Workstreams		Pre Workshop Scores		Pre Workshop Scorer Comments			Workshop Scores		Workshop Scorer comments		
	What would be better	What would be worse	Table 4	Table 8	What would be better	What would be worse	Other comment	Table 4	Table 8	What would be better	What would be worse	Other comment
3.1 What is the likelihood of this solution being delivered within the agreed timescale?	Gastroenterology: There is currently no agreed timescale Trauma & Orthopaedics: 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 It would take a 6 month period to work up and would impact on ED delivery	Don't Know	Don't Know			It sounds like it would take significant reconfiguration	SI Worse	Don't Know			Staffing for T&O would be difficult to provide on both sites Support services would need to duplicate on both sites
3.2 What is the likelihood of this solution meeting the relevant national, regional or local delivery timescales?	No impact	No impact	Don't Know	Don't Know				Similar	SI Worse		increased cancellations	
3.3 What is the likelihood of this solution having the implementation capacity to deliver?	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.	Gastroenterology: Already delivering Trauma & Orthopaedics: Already delivering	Don't Know	Don't Know			there is nothing to deliver as it is already happening.	Similar	Don't Know			
3.4 What is the likely effect of this solution on access to the required staffing capacity and capability to be successfully implemented?	Gastroenterology: Already delivering, there are no benefits to pilot reversal Trauma & Orthopaedics: Already delivering, there are no benefits to pilot reversal	The Gastroenterology Consultant team 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: The benefits and improvements described above to nursing, and junior doctor rotas would be reversed.	Don't Know	SI Worse	Already implemented	reverting to a previous unsatisfactory model loss of ability to specialise and develop specialised care		SI Worse	SI Worse		ED rota	
3.5 What is the likelihood of this solution having access to the required support services to be successfully implemented?	Gastroenterology: Already delivering Trauma & Orthopaedics: Already delivering	Gastroenterology: Already delivering Trauma & Orthopaedics: Already delivering	Don't Know	Similar	already in place			Similar	Similar			
3.6 What is the likelihood of this solution having access to the required premises/estates to be successfully implemented?	Gastroenterology: Already delivering Trauma & Orthopaedics: Already delivering	Gastroenterology: Already delivering Trauma & Orthopaedics: Already delivering	Don't Know	Similar	already in place however reversing the changes might take some change due to rising demand			Similar	Don't Know			Don't know who has gastro beds etc
3.7 What is the likelihood of this solution having access to the required technology to be successfully implemented?	Gastroenterology: Already delivering Trauma & Orthopaedics: Already delivering	Gastroenterology: Already delivering Trauma & Orthopaedics: Already delivering	Don't Know	Similar		could mean that more equipment will be required to spread across two sites.		Similar	Don't Know			
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 Trauma & Orthopaedics: Already delivering	Gastroenterology: Already delivering Trauma & Orthopaedics: Already delivering	Don't Know	Don't Know	Already in place			Similar	SI Worse			Other services have moved in

Acceptability	Pre Workshop Information Pack - Evidence from Workstreams	Pre Workshop Scores		Pre Workshop Scorer Comments	Workshop Scores		Workshop Scorer comments
		Table 4	Table 8	comment	Table 4	Table 8	comment
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.	Don't Know	Similar	there are very good arguments put in place to keep the pilot as it is.	SI Worse	Don't Know	

Workforce	Pre Workshop Information Pack - Evidence from Workstreams		Pre Workshop Scores		Pre Workshop Scorer Comments			Workshop Scores		Workshop Scorer comments		
	What would be better	What would be worse	Table 4	Table 8	What would be better	What would be worse	Other comment	Table 4	Table 8	What would be better	What would be worse	Other comment
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 Trauma & Orthopaedics: A survey was carried out with staff after the pilot.	Gastroenterology: The benefits described above would be lost, with a reduction in staff morale and a potential impact on recruitment. Trauma & Orthopaedics: The benefits described above would be lost	Don't Know	SI Worse		negative impact on staff morale, staff confidence, change for change sake! reduction in staff morale, spreading staff more thinly		Sig Worse	SI Worse			Could be significanlty worse Rotas were key driver for change already disrupted team. Those upset with new location would have left
4.2 What is the likely effect of this solution on optimising the efficient and effective use of clinical staff?	Gastroenterology: None Trauma & Orthopaedics: 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: The benefits described above would be lost	Don't Know	SI Worse		dilution of specialist clinicians skills to be used across general areas specialists doing more general care or other care		Sig Worse	SI Worse			
4.3 What is the likely effect of this solution on supporting cross-organisational working across the patient pathway?	Gastroenterology: None Trauma & Orthopaedics: None	Gastroenterology: The benefits described above would be lost Trauma & Orthopaedics: The benefits described above would be lost	Don't Know	Similar		less good morale, less training opportunities.		SI Worse	Don't Know			
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 Trauma & Orthopaedics: 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: 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.	Don't Know	SI Worse		current innovations would be lost it would result in the consultants doing two jobs both poorly.		SI Worse	SI Worse			
4.5 What is the likely effect of this solution on supporting staff health and wellbeing and their ability to self-care?	Gastroenterology: None Trauma & Orthopaedics: The new 'attending' call rota is more demanding for consultants but is undertaken less than 3 times a year.	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: If reversed the benefits in patient care would be lost and there would be an impact on morale for all staff groups.	Don't Know	SI Worse		poor morale and decrease in wellbeing so back to struggling to recruit.		Sig Worse	Sig Worse			
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 Trauma & Orthopaedics: 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: Since the pilot there has been an improvement in recruitment for nursing and specialty doctors. A reversal would be likely to affect this adversely.	Don't Know	Don't Know		recruitment has improved since the pilot, so reversing it would be doing away with that.		Sig Worse	SI Worse			
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 Trauma & Orthopaedics: 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: 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	Don't Know	SI Worse		previous configuration had poor feedback which seems to have turned around. It is important for trainees to get the appropriate experience, if they don't then they won't come to Glos to train.		SI Worse	SI Worse		Issue in ED	
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 Trauma & Orthopaedics: 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: 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	Don't Know	SI Worse		as above, harder to train across multiple sites		SI Worse	SI Worse			
4.9 What is the likely effect of this solution on enabling staff to maintain or enhance their capabilities/ competencies?	Gastroenterology: None Trauma & Orthopaedics: 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: If the pilot was reversed allocated training time would be lost.	Don't Know	Similar		lack of time to train and improve		SI Worse	SI Worse			
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 Trauma & Orthopaedics: 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: Currently sub specialties are working together, this allows for dedicated teams 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.	Don't Know	SI Worse		as above		Sig Worse	SI Worse			
4.11 What is the likely effect of this solution on the travel burden for staff? e.g. relocation time and cost.	Gastroenterology: Further analysis required Trauma & Orthopaedics: Further analysis required	Gastroenterology: Further analysis required Trauma & Orthopaedics: Further analysis required	Don't Know	SI Worse		possible that staff that have settled on one site will be uprooted to another decreasing morale and job satisfaction		Don't Know	Don't Know			
4.12 What is the likely effect of this solution on maintaining clinical supervision support to staff?	Gastroenterology: None, it would be detrimental Trauma & Orthopaedics: None, it would be detrimental	Gastroenterology: The benefits to recruitment and junior doctor feedback would be lost. Trauma & Orthopaedics: The benefits to nursing and medical recruitment and junior doctor feedback would be lost.	Don't Know	SI Worse		all the good things that the pilot has done would be lost		SI Worse	SI Worse			

C3: Centralise Emergency General Surgery (EGS) to Gloucestershire Royal Hospital (GRH) - Models B & H

Quality	Pre Workshop Information - Evidence from Workstreams		Pre Workshop Scores								Pre Workshop Scorer Comments			Workshop Scores								Workshop Scorer comments		
	What would be better	What would be worse	Table 1	Table 2	Table 3	Table 4	Table 5	Table 6	Table 7	Table 8	What would be better	What would be worse	Other comment	Table 1	Table 2	Table 3	Table 4	Table 5	Table 6	Table 7	Table 8	What would be better	What would be worse	Other comment
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 CDH (walk in) would need to be transferred to GRH (if well enough to do so, else the consultant would go to CDH). This would be evidenced by monitoring Key Performance Indicators.	Sl Better	Sig Better	Sig Better	Sig Better	Sig Better	Sig Better	Sig Better	Sl Better	Specialisation and reducing the number of centres from 2 to 1 will improve quality of care Gravity improves response to patient by improved availability of relevant medical staff Good for general surgery patients. Access to sub-specialist care Sub-specialist input to care, brings service in line with best standards of care. Specialist rota will make a significant difference Potential to improve outcomes as consolidated service	Less so for surgical specialties patients left at CDH. Small cohort will be impacted negatively - longer distance/waiting for consultant transferred.(number unknown). Likely bigger impact on those that are unaware of pathways/more vulnerable. Increased travelling times from east of the county	Proposal is to centralise EGS to improve the quality of care I need more information as I do not have the specialist knowledge in this area to provide sufficient answer Although some might still present at CDH, with careful management this shouldn't create a problem	Sig Better	Sig Better	Sig Better	Sl Better	Sig Better	Sig Better	Similar	Sl Better	Improve outcomes Easier links with other specialities Some patients would have to travel Right place first time Rapid access Serial review ,14 hours - time to Senior decision maker is the crucial point (99% direct to GRH 8-8 anyway) Dementia friendly Info pack benefits. Opportunity for reduced variation Improved quality Seen quicker even at CDH More rapid reviews by the right team For emergency patient continuity	Sub-spec care Training centre risk Sub specialist care Mitigating elective remainers @ CDH. Knock on effects e.g. gen surg support for other specialties unplanned Pts On call - sub spec access to care	early depends on deteriorating patient model Emergency and Elective Pathway examples Pints in CDH need to consider inter site transfers eg stroke, ptnts transfer Would need to have SOP's for transfers both across to NHS transport and make own way protocols Deteriorating patients model is important Access protocols for surgical spk
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 This would be evidenced by monitoring Key Performance Indicators.	A few patients who self-present to CDH would need to be transferred to GRH (if well enough to do so, else the consultant would go to CDH). This would be evidenced by monitoring Key Performance Indicators.	Sig Better	Sig Better	Sig Better	Sig Better	Sig Better	Sig Better	Sig Better	Sig Better	Specialisation and reducing the number of centres from 2 to 1 will improve quality of care Availability & access to sub-specialist staff is greatly improved Good for General Surgery Patients. Access to subspecialist care Subspecialist care, dedicated EGS theatre, ambulatory pathways Potential to improve outcomes as consolidated service Key benefit of subspecialty care 24/7. Outcomes likely to be significantly improved by early senior decision maker involvement. Specialists in one place, with all the support and equipment, rather than sub-optimal in both locations.	May impact other surgical patients by reducing access to junior staff and anaesthetic support.	Small cohort will be impacted negatively - longer distance/waiting for consultant transferred.(number unknown). Likely bigger impact on those that are unaware of pathways/more vulnerable. Increased travelling times from east of the county Unclear re additional bed capacity at GRH? I need more information as I do not have the specialist knowledge in this area to provide sufficient answer	Sig Better	Sig Better	Sig Better	Sig Better	Sig Better	Sl Better	Sig Better	Sig Better	Potential for walk-ins to CDH needing transfer to GRH (but would give an opinion on the phone before deciding this) Patients at CDH who become EGS (eg Ons/Urology/Gynae/Vasculiar) would need robust protocols/SOPs Avoiding unnecessary planned ops, as treating patients on first admission by right sub- Greatest strength of the model. Provides rota sustainability 1 x site. Safety improved		Little bit of an unknown re numbers arriving through SAU Not perfect (1.1) could be detrimental to small # Pts. Pt view - access to Upper GI and Cancer GI Can CDH ED overnight a.cess CT?
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 weak' in the Royal College of Surgeons – separating emergency and elective surgical care Report, September 2007	No impact	Sig Better	Sl Better	Sig Better	Sig Better	Sig Better	Sig Better	Sl Better	Sl Better	Specialisation and reducing the number of centres from 2 to 1 will improve quality of care continuity of care important to patient and improves their moral & outcome Patients would remain on site under the care of the same clinical team whilst their condition is acute. Patients will be allocated after initial senior review to the right subspecialist who will manage the whole episode instead of the current situation where advice is given but the action is undertaken by the person on call who may not be the subspecialist.		Depending on how service split and pathways for unplanned events in ES patients undergoing planned interventions. Further work needed to understand impact on pts presenting to CDH as an emergency. Transfer arrangements?	Sig Better	Sl Better	Sig Better	Sig Better	Sig Better	Sl Better	Sl Better	Sl Better	Challenging to look at in isolation, as does depend where E/L work is (Continuity of care 1.3) Yes. Eg one team always on ward. 2 x ward rounds/day Transfer between wards would still exist. Early transfer (within 24 hours) to the right team will be better Good for elective, right surgeon	Subject to location of colorectal/upper GI. Transfers between hospitals - relative disbenefit	SAU; does encourage patient self care/management where appropriate Access to senior decision maker earlier has positive impact on outcomes; but if people think they have to travel further, they may delay accessing services and would be negative 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	Similar	Similar	Similar	Similar	Similar	Similar	Sl Better	Similar			No effect No change I am not sure this will have a material impact on links with the community I need more information as I do not have the specialist knowledge in this area to provide sufficient answer	Sig Better	Sl Better	Similar	Sl Better	Similar	Sig Better	Sl Better	Don't Know	1.4 potential to build more relations from single site An emergency service. Greater availability to discuss Pts as not in theatre. Link to CNAPSS Better alignment with frailty services for emergency Easier links with other specialities Centralising offsets the loss of local offer in CDH. Potential to build relationships better with single base. Pathway transformation Cinapsis advice, direct to 2ww, liaising with GPs discharge summary improvement use of cinapsis & centralised SAU team having more time to talk to a dual on call team. Improves ability to provide palliative care input / support to GP's.		No difference with current
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	Sl Better	Sig Better	Don't know	Don't know	Similar	Sl Better	Similar	Similar	Specialisation and reducing the number of centres from 2 to 1 will improve quality of care and the ability to cope with special needs SAU would provide a dedicated unit for assessment an initial treatment of patients. Team available, avoids long waits in ED Fewer transfers, prompt review and intervention, Consultant delivered Remaining in one place under the same team during the period when they are acutely unwell would help maintain stability for patients with dementia or some mental health conditions. More patients will be looked after in an ambulatory unit which will reduce the turnover on the inpatient unit which will improve the environment.		Don't see why an SAU & Hot Clinic is relevant to this Q Unable to comment in absence of estates strategy It is not clear what the environment is like where EGS is to be provided or if additional improvements will be required / can be done or if it is already suitable I need more information as I do not have the specialist knowledge in this area to provide sufficient answer There are many unknowns in the examples above but the care should be better with a dedicated SAU	Sig Better	Sig Better	Don't Know	Sl Better	Similar	Sl Better	Sl Better	Sl Better	2.5 needs estate strategy to work SAU seen much quicker. Dedicated unit Key benefit of SAU - knock on positive impact for ward patients in keeping away from IP wards and moving them through ED. Ensure privacy / dignity is good in SAU.	Onward flow impacts Could be an impact on not following elective pathways. Poor relation risk of being in an emergency setting.	Lots of info that we don't know around estate and environment. Caveat: if new facility If only emergency Needs estates strategy to work Need more information
1.6 What is the likely effect of this solution on encouraging patients and carers to manage self-care appropriately?	No impact	No impact	Similar	Similar	Similar	Similar	Similar	Similar	Similar	Similar	Continuity of specialist & sub-specialist care should result in better patient morale and the likelihood that they will feel valued and will self-care more effectively. Ambulatory pathways encourage patients to manage out of hospital with support I actually think patients treated in an ambulatory fashion are more likely to be encouraged to take responsibility for their own health and patients presenting with conditions that do not need admission will be given better advice rather than reinforcement of the need for admission..		No effect Do not think centralising the service will have an effect on this I need more information as I do not have the specialist knowledge in this area to provide sufficient answer	Sl Better	Sl Better	Don't Know	Similar	Similar	Sl Better	Sl Better	Similar	If seen quickly in SAU reduce admissions, increase self care Dementia friendly environment. Improves for patients coming in to CDH currently who will be managed in an ambulatory environment for self care advice. Right ward - specialist nurses with right skills. When changes implemented will be better. Subject to above in place.	Risk of not incentivising as per elective patients.	No difference with current
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.	Sl Worse	Sl Better	Sig Better	Don't Know	Don't Know	Don't Know	Similar	Similar	should be less	Slightly worse for CDH area patients	For those accessing the service in an unplanned way from outside the organisation. Some challenge with managing similar patient demographic inpatient onother site. Fewer transfers between GI surgical units and EGS units for specialist care. Transfers for other things eg IGS may increase depending on other factors. Attenders at CDH ED and Inpatients at CDH with acute surgical problem would need to be transferred The intention of the change is to improve quality and safety in the EGS assessment pathway	Sig Better	Sl Better	Similar	Don't Know	Similar	Sig Better	Similar	Similar	1.7 positive on pathway transfer negative on intersite transfer 1.7 similar with potential to 'better' Significantly better for people going to GRH - large majority Reduction in pathway transfers 3 cohorts attend via ED 1) ambulance will go direct to GRH 2) GP referral direct to GRH 3) walk-ins on call team SOP review (at either site dependent on case) or GRH transfer next day inpatients at CDH - urology, gynae - pathways in place - surgeon to move or patient transfers Potential to be better	Issue for CDH ED walk-in patients or deteriorating patient on CDH site (<1 per day). Right place first time Small # of transfers for walk-in presenting at CDH Issue of CDH IP emergency elective Pt - reg transfer Concerns around 'place of safety' for self presenters to CDH. Need a robust system to mitigate this.	What is clinically safe? Transfer between upper / lower GI Most transfer times are not clinically critical Clarify medical responsibility Use Joe Bennett's example of patient walk in with peritonitis & perforated bowel walking into CDH. Currently only transfers - renal colic (won't change) Interhospital transfers - not much difference Need operating procedures to cover CDH
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 CDH would be supported by the on-site deteriorating patient team. They may require transfer to GRH if stable, or the surgeon to travel to CDH. This would be evidenced by monitoring Key Performance Indicators.	Don't Know	Sig Better	Sig Better	Sl Better	Sig Better	Sig Better	Sig Better	Sl Better	Specialisation and reducing the number of centres from 2 to 1 will improve quality of care 24/7 emergency theatre a big plus and having a ward based consultant led team is excellent Again for those who need service who are in appropriate environment. Team dedicated to running emergency theatre and a separate team sealing with admissions. Addresses the current patient safety risks. 2 teams working in parallel instead of one. Dedicated operative team, subspecialist care Prompt access to surgery and monitoring/care from the same team during the acute phase of patients' condition.		I need more information as I do not have the specialist knowledge in this area to provide sufficient answer patient nos impacted from CDH need to be better understood to be able to assess impact having a deteratoring patient team to support patients is good, but if a surgeon has to travel to CDH that could mean one less surgeon for the rest of the team.	Sig Better	Sig Better	Sig Better	Sig Better	Sig Better	Sig Better	Sig Better	Sl Better	time to senior maker is important factor Right person quickly	Caveat: dependent upon the effectiveness of the deteriorating patients model	Discussion around deteriorting patient model at CDH.
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.	Similar	Sl Better	Similar	Sl Worse	Sig Better	Sig Better	Don't Know	Similar	time to effective treatment is reduced even if journey times are increased After arrival at hospital patients will be seen by a senior decision maker free from other activities will improve patient outcomes Some patients would have increased travel time however they are likely to have prompter access to senior decision makers. having a deteratoring patient team to support patients is good, but if a surgeon has to travel to CDH that could mean one less surgeon for the rest of the team.	With exception of patients on unplanned site.	More travel from the East Small cohort more affected - numbers effected not cited. Patients from far east of county will have to travel 7 miles further increased travelling times from east of county Patient transfers as now against emergency protocols Offset by reduced time to be reviewed. I need more information as I do not have the specialist knowledge in this area to provide sufficient answer	Similar	Sl Better	Sl Better	Sl Worse	Similar	Similar	Similar	Similar	Outcome impact is assessment by senior decision maker. Travelling to be seen quicker Delays to review improve Balancing of patient outcomes improves v small number of patients travelling further on blue light.	East of county impact and travel times. Evidence of transfer impact on outcomes	Not one of the 3 high risk conditions Not one of the 'time critical' conditions - Artoric aneurism, trauma, MI, stroke. Ambulance transfer not likely to make a difference.
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	Don't Know	Sig Better	Sig Better	Sig Better	Sl Better	Sig Better	Sig Better	Sl Better	Specialisation and reducing the number of centres from 2 to 1 will improve quality of care Reduces risks to patients by providing improved access & reduced time to treatment More staff available to see and treat emergencies will reduce patient safety risks Standardised pathways, subspecialist care Prompt access to surgery and monitoring/care from the same team during the acute phase of patients' condition. Consolidated expertise Major patient safety risk relating to junior cover and balancing needs of operating list against seeing admissions - this would be significantly improved.	For GS though subsequent strain on other surgical specialties not on GRH site.	I need more information as I do not have the specialist knowledge in this area to provide sufficient answer	Sig Better	Sig Better	Sig Better	Sig Better	Sig Better	Sig Better	Sig Better	Sl Better	Delays to review mitigated Workforce issues mitigated Benefits to emergency patients well agreed. A working deteriorating patient model at CDH is key to achieving significantly better. Mitigations for CDH. Positive for centralisation	Trainee issue / fragility of Deanery approval Corporate risk reg records, quality, safety & workforce risks.	Quality - sub specialist Safety review

Access	Pre Workshop Information Pack - Evidence from Workstreams		Pre Workshop Scores								Pre Workshop Scorer Comments			Workshop Scores								Workshop Scorer comments		
	What would be better	What would be worse	Table 1	Table 2	Table 3	Table 4	Table 5	Table 6	Table 7	Table 8	What would be better	What would be worse	Other comment	Table 1	Table 2	Table 3	Table 4	Table 5	Table 6	Table 7	Table 8	What would be better	What would be worse	Other comment
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	Don't Know	Don't Know	Don't Know	SI Better	SI Better	SI Better	Sig Better	Similar	Reduced ED waiting times. Potential positive effect on elective surgery RTT times (fewer cancellations of short stay work if moves to CGH) Centralising emergencies is expected to have a consequent benefit for elective services - in T&O this has been evidenced in better elective performance		would like to see some comparisons I need more information as I do not have the specialist knowledge in this area to provide sufficient answer	SI Better	Similar	Similar	SI Better	Sig Better	SI Better	SI Better	Similar	Overall improvement to services Flexibility of staff to deal with growth, but site restrictions Travel impact by 999/walk ins please and split in & DOHs SAU - speeding up assessment process Switch of EGS to GRH reduces elective cancellations and waits Solution provides capacity of right clinicians. Able to speak to GP, reduce delays. A more robust service to review Pts Would improve flow - KPI's	Clinical need trumps everything; but the Q is re travel burden, not outcomes slightly worse Residents - Cheltenham getting home disadvantages inequality groups Travel looks slightly worse More IA required	Travel - Glos neutral, some travel for Cheltenham residents Emergency is one-off visit Need to manage GP diverts Relies on estate strategy Single point of access fro Primary Care (Direct to SAU/Cinapsis) Some patients assessed in SAU will not need overnight stay, but return next day.... could be deemed as 'inconvenient', but patient voice suggests people would rather go home and come back. (Note, wouldn't send people home in the middle of the night) Not clear on relevance 4 hour standard Discussion reached consensus
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	SI Better	Sig Better	Sig Better	Similar	Sig Better	Sig Better	SI Better	SI Better	Specialisation and reducing the number of centres from 2 to 1 should be easy to communicate Patients will understand that they are in 'the best place' Clear where to go Less confusion as EGS offered at one site Single EGS hub Simplified as no emergency surgery on CGH site. in an emergency the use of the best facility is imperative Patients will not need to understand the configuration of the EGS service in detail as they will not self present to it, they will still come to their emergency department as normal in this model	Would required comms and period of change, initially less simple.	I need more information as I do not have the specialist knowledge in this area to provide sufficient answer Although services are on one site only, which should make it less confusing ,there will be some who will present to the other site and patients will have to remember which site is which, although if all patients to emergency care are triaged by 111 this should eliminate that problem.	SI Better	Sig Better	Similar	Similar	Sig Better	SI Better	SI Better	Similar	Simplifies offer to 1 site Single offer clearer. Also for follow up visits	Some people would rather a local service Will take time	Is it not similar to now? Are GP's confused. Felt not.
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.	Similar	Don't Know	Similar	SI Worse	Similar	Sig Better	SI Worse	SI Worse	Whilst travel times will increase for some count areas, the time to treatment reduction should more than compensate for the additional travel time	It will affect those that might least be able to cope. They may have been taken to hospital via ambulance but might struggle to get home again.	More travel from East GPD remains the same. Minor increased travel for a minority Needs further analysis More parking in GRH, slightly longer travel times for East of county patients. Patients from Cheltenham and the east of the county will be affected. Patients are likely to go where they go now if self presenting, some people in ambulances may travel further from the east of the county.	SI Worse	SI Worse	SI Worse	SI Worse	SI Worse	Similar	SI Worse	Similar	Discussed cholecystomy pathway and the benefits of hot surgery.	Some people travel a bit further Quality impact on those with a disability concentrated on Cheltenham residents. Discussed the cost of getting home. East to GRH Patients impacted during day time Patient groups at CGH	What is split ambulance vs self drive. Also # of red dots that were admitted to GRH. Clinical need justifies it Some confusion over the travel maps. Further modelling required One off journey
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.	Don't Know	Don't Know	Sig Better	Don't Know	Sig Better	SI Better	Similar	SI Better	Specialisation and reducing the number of centres from 2 to 1 will improve speed of care should greatly reduce waiting times for expert diagnosis For GS with improved flow and review times Shortened waiting time for assessment by senior decision maker. Reduced delay in accessing the operating theatre. See above. Fewer admissions, reduced gi stay. Rapid treatment of some conditions eg biliary/gallstone related conditions. Reduced delay in accessing an operating theatre. treatment is essential in an emergency	May negatively impact elective targets if EGS adversely affects elective care	Small cohort will be impacted negatively - longer distance/waiting for consultant transferred.(number unknown). Likely bigger impact on those that are unaware of pathways/more vulnerable. Emergency waiting times significantly reduced. Waiting times for some operations significantly reduced as done on index admission eg. hot gallbladder surgery. Do not have direct evidence it will improve waits but it may be expected to I need more information as I do not have the specialist knowledge in this area to provide sufficient answer	Sig Better	Sig Better	SI Better	Don't Know	SI Better	Sig Better	SI Better	SI Better	Dedicated team. Improve flow, don't require "catch up time" 12 hour standard met People out of ED	Impact in elective if separate ED and Elective High depending on estates strategy	Relationship between ED in clinical model - would have to be direct admission which is very unlikely for gallbladder unless listed. Evidence required. Don't know Potential for improvement in waits but needs detailed theatre modelling - impact of emergency capacity on elective capacity. Further modelling required Need effective pathways
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 and Berkley Vale.	SI Worse	SI Worse	Don't Know	Don't Know	Similar	Similar	SI Worse	SI Worse		1 It will have an impact on those from the east of the county, especially those without transport, or where the main source of transport is the patient in hospital.	More travel from East good for some, not so good for others - eg Chelt area Slightly worse for a minority Majority of patients will have no change. Minority will have to travel further but reduction in admissions and shorter hospital stay should outweigh I need more information as I do not have the specialist knowledge in this area to provide sufficient answer	SI Worse	SI Worse	Sig Worse	SI Worse	SI Worse	Similar	SI Worse	SI Worse	Mitigated by fewer number of attendances with senior decision maker; reduced admissions and LoS	Burden on families / carers is greater than patients as repeat journeys particularly carers East to GRH More impact on carers than Pts as multiple trips Parking GRH	
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	Don't Know	Sig Better	Similar	Don't Know	SI Better	Similar	SI Better	Similar	Specialisation and reducing the number of centres from 2 to 1 will improve ability to introduce technology Streamlined access to diagnostics	Currently available	Solution would not improve access on its own, but implementation of the Cinapsis referral system county wide will reduce waiting times significantly Cinapsis I do not know if any new technology solutions would be involved in a new centralised EGS service I need more information as I do not have the specialist knowledge in this area to provide sufficient answer	SI Better	Sig Better	Similar	Similar	SI Better	SI Better	SI Better	Similar	Access for GPs via CINAPSIS improved Single Team dedicated to admission assessment (avoidance). Facilitate use of CINAPSIS		Define technology
2.7 What is the likelihood of this solution improving or maintaining service operating hours?	No impact	No impact	Sig Better	Similar	Similar	SI Better	Similar	Sig Better	SI Better	Similar	Specialisation and reducing the number of centres from 2 to 1 will improve speed of care FOR GS patients it will be improved out of hours 2 teams on therefore one team always available for review of patients rather than being stuck in theatre Consolidated staffing With consolidated rotas on one site I would expect there to be stronger 24-7 cover		No change I need more information as I do not have the specialist knowledge in this area to provide sufficient answer	Sig Better	Similar	Similar	Similar	SI Better	Sig Better	Similar	Similar	CGH doesn't have 24 hour emergency theatre Now 24/7 dedicated emergency theatre for GS Hot site (GRH) more robust team	Cold site (CGH) some challenges	No change to hours during the day Hours
2.8 What is the likelihood of this solution improving or maintaining service operating locations?	No impact	No EGS at CGH	Don't Know	Don't Know	Don't Know	Similar	Don't Know	Sig Better	SI Better	Similar	Specialisation and reducing the number of centres from 2 to 1 will improve quality of care No emergency surgery at CGH Consolidated service on one site with more infrastructure to support pt outcomes		Worse for Chelt area patients initially but they should see large service improvements depends what is done with elective services. No EGS admissions at CGH Does this mean number or quality of SOL? Number reduced but quality should improve. need more information as I do not have the specialist knowledge in this area to provide sufficient answer Removes EGS from CGH - may be mitigated by other benefits	SI Better	SI Worse	SI Worse	SI Worse	Similar	SI Worse	SI Better	SI Worse	Centralised/better service 2 sites to 1 SAU unit fir for purpose so positive availability /capacity of quality service	Loss of a physical site (2 to 1)	No EGS at CGH. Note no ambulances to CGH after 20:00 currently But this means Gloucester gets better Interpretation of the question is that this is the absolute number of locations. Current situation could lose Spec Registrars
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	Don't Know	Don't Know	Similar	Don't Know	Don't Know	Don't Know	Don't Know	Similar		May disadvantage the homeless outside of the GRH normal catchment.	No effect I am not qualified to answer this Q Further analysis required There is not enough evidence to say if there is a differential impact, some people with protected characteristics find it harder to travel but as before patients will not tend to self present to this service as it is not a front door service, The service will need to consider how to provide a suitable environment to ensure the needs of people with protected characteristics can be met but this would be true whether it is provided on one or on two sites	Similar	Similar	Similar	Similar	Similar	Similar	Don't Know	Similar	Remove inequities in treatment		Insufficient information Neutral for Gloucestershire Would a hub actually benefit disadvantages on disadvantage groups? Similar on the basis of infor available. Needs IIA analysis
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	Don't Know	Don't Know	Don't Know	Don't Know	SI Better	SI Better	Don't Know	Don't Know	Specialisation and reducing the number of centres from 2 to 1 will improve recruitment Support notion od centralisation. A consolidated service may be more robust and better able to cope with peaks in demand / plan for future demographic trends		Need to see more statistics & predictions on growth modelling, particularly in the over 65 age group Growth modelling not available Flexibility of manpower on single site allows increased responsiveness to increases in population. Future planning may need more surgeons which is the case everywhere I need more information as I do not have the specialist knowledge in this area to provide sufficient answer	SI Better	Similar	SI Better	SI Better	SI Better	SI Better	SI Better	Don't Know	Future proofed Growth not modelled but increased capacity through centralisation efficiencies = more flexible to meet demand Resilience.	Physical space a bit limiting	Insufficient information Efficiency of having everything in place led the group to think slightly better. Consolidate and plan for growth

Deliverability	Pre Workshop Information Pack - Evidence from Workstreams		Pre Workshop Scores								Pre Workshop Scorer Comments			Workshop Scores								Workshop Scorer comments		
	What would be better	What would be worse	Table 1	Table 2	Table 3	Table 4	Table 5	Table 6	Table 7	Table 8	What would be better	What would be worse	Other comment	Table 1	Table 2	Table 3	Table 4	Table 5	Table 6	Table 7	Table 8	What would be better	What would be worse	Other comment
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	Don't Know	Don't Know	Don't Know	Don't Know	Similar	SI Better	Don't Know	Don't Know	Deliverable immediately As most of it is in place is should be able to be delivered		Could be limited by any necessary estates work 3 year timescale Any dependence on funding? do not know what is required in terms of accommodating EGS at Gloucester, and therefore how quickly it is likely to be implemented I need more information as I do not have the specialist knowledge in this area to provide sufficient answer	SI Better	Sig Better	SI Better	Don't Know	Sig Better	SI Better	SI Better	Don't Know	Deliverable Ready to go		Is other enabling change needed Theatres and staff there to deliver/implement; would need beds and OCC capacity. Plan required Middle grade registrar rota proposed/developed to cover deteriorating patient in CGH One of the non-contentions solutions clinically, we need to re-assure the public Need to be implemented urgently. Could be implemented rapidly Queries around estates strategy, particularly in Model B Does this require a balancing model? Felt it was possible but concerned about impacts on other services and subject to public consultation needs more detail.
3.2 What is the likelihood of this solution meeting the relevant national, regional or local delivery timescales?	No impact	No impact	Similar	Don't Know	Sig Better	Don't Know	SI Better	Similar	Don't Know	Don't Know	Specialisation and reducing the number of centres from 2 to 1 will improve speed of delivery Improved compliance with Royal College of Surgeon, NICE and NSF standards.		No change I am not aware of any national or regional guidelines I understand that the local intention would be to facilitate the delivery of this solution quickly due to the risks involved. I need more information as I do not have the specialist knowledge in this area to provide sufficient answer	SI Better	Similar	Don't Know	Don't Know	Similar	SI Better	SI Better	Don't Know	Currently high risk service. GHFT priority #1. Consultants support a single Gloucester site	lack of suffient info	Dependant on deteriorating patient model in Cheltenham Lack of a estates delivery plan No regional timescales
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.	Don't Know	Don't Know	Don't Know	Don't Know	Don't Know	Similar	SI Better	SI Better	Staffing capacity already exists as the staff already exist it can be delivered, but there will still be a requirement for more staff to follow the patients over to the new site.		Existing staff numbers & span of grades means that this solution could be staffed without changes. However, the option of recruiting more ANPs not only improves the service it also widens up a career path for the nursing staff 3 year timescale I am not aware of what implementation capacity is available but expect it would be prioritised due to the risks currently flagged in the existing service Bed capacity at GRH is the defining factor for the move of a relatively large volume of bed-day demand	SI Better	SI Better	SI Better	Don't Know	Sig Better	SI Better	SI Better	Don't Know		dependent on financial service provision viability	Financial viability Transport? Radiology Beds Focus resources on priorities a priority for GHFT
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	Don't Know	Don't Know	Don't Know	SI Better	Don't Know	Sig Better	Don't Know	SI Better	Specialisation and reducing the number of centres from 2 to 1 will improve recruitment in pace already Required manpower exists spread across two EGS rotas Already sufficient. Junior rotas much improved.	I worry about the surgical services left behind	Existing staff numbers & span of grades means that this solution could be staffed without changes. However, the option of recruiting more ANPs not only improves the service it also widens up a career path for the nursing staff A key part of the rationale for this proposal is to improve the situation with staffing by enabling staff to be consolidated into one rota I need more information as I do not have the specialist knowledge in this area to provide sufficient answer	Sig Better	SI Better	Sig Better	Sig Better	SI Better	Sig Better	SI Better	SI Better	Staffing not an issue Removes staffing problems of covering two sites Mostly redeployment of existing staff. Req some additional staff (junior Dr/middle grade) for rotas. Also positive impact on trainees and development of ANPs.		Rota description. No better than current
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	Don't Know	SI Better	Similar	Similar	SI Better	SI Better	SI Better	SI Better	Specialisation and reducing the number of centres from 2 to 1 will improve recruitment Might lead to reduction in length of admissions due to better patient outcomes Single service rather than two		Limited by delivering support on the other site needs the co-operation of local authority care facilities EGS already operates at both sites so assume support services are available I need more information as I do not have he specialist knowledge in this area to provide sufficient answer	SI Better	SI Better	Similar	Similar	SI Better	SI Better	SI Better	SI Better	Transport situation		Req surgeons, theatres, anaesthetists and radiology Theatres, anaesthetics, radiology, ITU Discussed 8 patients per day impact on diagnostics / ambulance. Centralised has estate requirements 1) theatres modelled (EE), 2) anaesthetists modelled (EE), 3) Critical Care modelled 4) Diagnostic modelled (single site is helpful) Requires plan for Beds and ITU Radiology
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.	Don't Know	SI Better	Similar	Don't Know	Similar	Don't Know	SI Better	Don't Know	Additional bed would be provided		Would need to see the estates plan before allocating a final rating to this Q. Will need appropriate modelling for theatre/ICU/inpatients bed and movement of day cases to the other site No estates plan I do not know what estates improvements / changes might be needed to accommodate this move I need more information as I do not have the specialist knowledge in this area to provide sufficient answer additional bed requirement, no information on where/how Bed capacity at GRH is the defining factor for the move of a relatively large volume of bed-day demand	SI Better	SI Better	Don't Know	Don't Know	SI Worse	SI Better	SI Better	Don't Know	Enough theatres if reschedule elective capacity	Bed modelling - challenges re capacity. Day Case or other to CGH	Cannot be assessed in isolation - would need to find a way. # of beds changes 12-16. Linked to other FFTF Gen Surgery changes and other non FFTF services Lack of an estates plan. Beds, theatres, diagnostics Would need to make change
3.7 What is the likelihood of this solution having access to the required technology to be successfully implemented?	No impact	No impact	Similar	Don't Know	Don't Know	Similar	Don't Know	Don't Know	SI Better	Don't Know	Specialisation and reducing the number of centres from 2 to 1 will improve ability to install technology		Need to look closely at implementing Cinapsis county wide Efficient IT essential Estates plan and costs not seen I do not think the consolidation of the service would make any difference to the technology available or if any specific technology is required I need more information as I do not have the specialist knowledge in this area to provide sufficient answer	Similar	SI Better	Don't Know	Don't Know	Similar	SI Better	Similar	Similar	CINAPSIS opportunity diagnostics - better		Relevance / information? Other changes needed No additional requirements
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?			Don't Know	Similar	Similar	Don't Know	Don't Know	Don't Know	Don't Know	Don't Know	Centralisation of EGS does not require other services to move on clinical grounds		Not enough info provided on interdependencies Standardised pathways It is not clear if other service change is required to facilitate this move or whether any such change would be deliverable - is there space at GRH? I need more information as I do not have the specialist knowledge in this area to provide sufficient answer	SI Better	Similar	Don't Know	Don't Know	SI Worse	Similar	SI Better	Don't Know	requirement for beds and ITU in Glos - A/N other speciality	requirement for deteriorating patients access in CGH Reliant on deteriorating patient model Co-dependencies e.g. shift in day case to CGH or other specialties for bed capacity Issue with how to create capacity - Radiology.	No premises req clinically, likely to be the physical beds but dependent on what happens to elective Gen Surg - linked Have draft protocols developed No evidence of dependencies Needs seperation of emergency and elective care

Acceptability	Pre Workshop Information Pack - Evidence from Workstreams		Pre Workshop Scores								Pre Workshop Scorer Comments	Workshop Scores								Workshop Scorer comments
			Table 1	Table 5	Table 2	Table 6	Table 3	Table 7	Table 4	Table 8	comment	Table 1	Table 5	Table 2	Table 6	Table 3	Table 7	Table 4	Table 8	comment
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		Sig Better	SI Better	SI Better	Don't Know	Don't Know	Don't Know	Don't Know	SI Better	If promoted correctly to the general public this should be seen to be a positive change that is in line with One Glouc & ICS initiatives	SI Better	SI Better	SI Worse	Similar	SI Better	SI Better	Don't Know	Don't Know	Engagement Report - limited questions in report Pitch - Tough decision but status quo not acceptable. Use of resources for better services. Unanimity of consultants for this solution. Linked to emergency for Paeds. Public - need to reassure, provide evidence, mitigations for any disadvantage, offset by improved outcomes. People opposed in engagment but those who have reviewed it are fully supportive Strong feedback about availability on both site split between don't know and slightly worse. Relationship with CGH ED unknown Engagement - Anxiety re changes at CGH. Is the bed base sufficient. Impact on travel and choice. Solution Fits with CoEx approach. Issues addressed Pitch - strongly positive message, outweigh negatives All GI surgeons agree Well received at Citizens Jury Concern about loss of services at CGH

Workforce	Pre Workshop Information Pack - Evidence from Workstreams		Pre Workshop Scores								Pre Workshop Scorer Comments			Workshop Scores								Workshop Scorer comments		
	What would be better	What would be worse	Table 1	Table 2	Table 3	Table 4	Table 5	Table 6	Table 7	Table 8	What would be better	What would be worse	Other comment	Table 1	Table 2	Table 3	Table 4	Table 5	Table 6	Table 7	Table 8	What would be better	What would be worse	Other comment
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.	Don't Know	Big Better	Big Better	Big Better	Don't Know	Big Better	Big Better	SI Better	Specialisation and reducing the number of centres from 2 to 1 will improve recruitment Will improve staff morale by reducing the loads imposed by rota planning. CGH staff required to relocate must be given an incentive such as zero effect on their nett income Reduce reliance on middle grade locums 5 of 14 surgeons less happy probably but all levels in the team better resourced Current workforce risks untenable and this solution address that.		Good for some. Challenging for others. This is the main rationale for making the change I need more information as I do not have the specialist knowledge in this area to provide sufficient answer better working groups, more efficient working, more support and better recruitment, but care would need to be taken with staff at CGH when relocating them.	Big Better	Big Better	Big Better	Big Better	SI Better	Big Better	Big Better	SI Better	Overall improvement Travel burden for some Cheltenham staff 4.2 Upper and Lower GI in right place 4.5 Burden eased by co-location Separation of emergencies is more efficient Improves opportunity for forward training Will received at Citizens Jury Improves resilience Drs significantly better EGS team much better	If we lose trainees, we lose the service Issues/ challenges for rotas other services at CGH	All GI surgeons in agreement re EGS. Some concern in CGH Nursing "No brainer" Acknowledge public concern about 'everything' to GRH Needs to be and could be implemented quickly Theatre/DCC/Interventional radiology; all at GRH Bed capacity can't be reviewed in isolation - links to other GI solutions (DCC and theatre too) Question: impact on staffing on elective care for nursing
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	Don't Know	Big Better	Big Better	Big Better	Similar	Big Better	Big Better	Big Better	Specialisation and reducing the number of centres from 2 to 1 will improve effective use of staff Will improve cohesiveness of the medical team across the grades More efficient and effective use of medical and nursing staff		Good for some staff. Challenging for others I need more information as I do not have the specialist knowledge in this area to provide sufficient answer If staff dealing with elective and emergency centres are dedicated to their tasks - separation is key	Big Better	Big Better	Big Better	Big Better	SI Better	Big Better	Big Better	SI Better	Centralisation For the staff we have at the moment and for the supply of staff.		If dealing purely with emergencies
4.3 What is the likely effect of this solution on supporting cross-organisational working across the patient pathway?	No impact	No impact	Don't Know	Similar	Similar	Similar	Similar	Big Better	Similar	Similar	1		No change I need more information as I do not have the specialist knowledge in this area to provide sufficient answer	Similar	Similar	Similar	Similar	Similar	SI Better	Similar	Don't Know			no change 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 This would be evidenced by the introduction of new posts	No impact	Big Better	Big Better	SI Better	SI Better	Similar	Big Better	Don't Know	SI Better	Would give an opportunity to develop nursing staff. Advanced Nurse Practitioner roles would support junior doctors.	I still worry about rotas for related surgical patients elsewhere.	Only improves if more ANP slots are created to give nursing staff an incentive Introducing new posts of new types would make for innovative staffing, but can they be found?	Big Better	Big Better	SI Better	SI Better	SI Better	Big Better	SI Better		Develop new roles e.g. ANPs Develop ANPs on S&J Better training for elective work. Supports new roles, fellowships etc. could be significantly better in planned care		
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.	Don't Know	Big Better	SI Better	Big Better	SI Better	Big Better	Don't Know	SI Better	Specialisation and reducing the number of centres from 2 to 1 will improve ability of staff to specialise and reach their potential Should improve resilience. Junior doctors report immense pressure from current organization - this would improve	But will be impact on staff transferring from CGH.	A balance between improved staff well-being for GRH based staff and reduced well-being for relocated CGH staff. This will require careful management by supervisors Development of ANP pathways This will be better for the staff at the new site but care needs to be take at CGH as that staff may be worse off.	Big Better	Big Better	SI Better	Big Better	Big Better	Big Better	SI Better	SI Better	Should improve resilience. Postive impact on EGS. Eases burden by collaborating Currently 100's gaps in rotas filled with extra shifts, consultant cover, local trainees or agency. Increases sickness absence. Now solution will improve Big better for Doctors Better support and new ways of working - centralised teams. Clear what the environment is.	Challenging / intense workload.	Q: understand impact on elective workforce Could rotate settings if this is an issue?
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	Don't Know	Big Better	SI Better	Big Better	SI Better	Big Better	Don't Know	SI Better	Specialisation and reducing the number of centres from 2 to 1 will improve recruitment Creation of more senior and specialist slots including ANPs would open up an improved career path for medical staff. This will have beneficial effects on recruitment & retentionbut they will take some time to be realised Good for GS New opportunities for nursing staff. Cohesive team = more resilience.		I need more information as I do not have the specialist knowledge in this area to provide sufficient answer Introducing new posts of new types would make for innovative staffing, but can they be found? Works if EGS is a separate centre; focus on training and skills in EGS should improve	Big Better	Big Better	SI Better	Big Better	SI Better	Big Better	Big Better	SI Better	More recruitment opportunity. Better for ANPs overall positive Explained pressure on GRH current trainees this would spread more evenly within teams available. EGS - solution a must do for trainees (on warning)	Worse for vascular cover. Not attractive CGH - less positive other surgical specialties	Consolidation. Deanery position re current Could be significant if done well
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	Don't Know	Big Better	Big Better	Big Better	SI Better	Big Better	Don't Know	SI Better	Specialisation and reducing the number of centres from 2 to 1 will improve recruitment Better training and compliance with deanery regulations is likely to lead to enhanced feedback. Remove potential for loss of trainees due to current unsafe working practices (level of work at night) Centralising would provide more opportunities' for training and exposure to procedures.		We don't want to upset the Deanery! I need more information as I do not have the specialist knowledge in this area to provide sufficient answer	Big Better	Big Better	Big Better	Big Better	SI Better	Big Better	Big Better	SI Better			
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	Don't Know	Big Better	SI Better	Big Better	SI Better	Big Better	Don't Know	SI Better	Specialisation and reducing the number of centres from 2 to 1 will improve recruitment of trainers Improved further training opportunities by freeing up senior medical staff time due to reduced wastage in travel between sites Within GS. More time for training, less conflict of emergency roles eg theatre not competing with assessment of emergency patients Centralising would increase the range of clinicians/procedures available.		I need more information as I do not have the specialist knowledge in this area to provide sufficient answer Easier for trainers to supervise if all on one site.	Big Better	Big Better	SI Better	Big Better	Big Better	Big Better	Big Better	SI Better	Trainer capacity and access increased		
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	Don't Know	Big Better	SI Better	Big Better	Don't Know	Big Better	Big Better	SI Better	Specialisation and reducing the number of centres from 2 to 1 will improve staff capabilities More opportunities to gain specialist skills Good training in GS emergencies for staff. Better staffed so more time to train. Improved learning environment			Big Better	Big Better	SI Better	Big Better	SI Better	Big Better	Big Better	SI Better	Training will be better EGS - better supervision	Workload implications Trainees at CGH less access but depends on rota esp. antisocial hours	
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	Don't Know	Big Better	Don't Know	Big Better	Similar	Big Better	SI Better	SI Better	Specialisation and reducing the number of centres from 2 to 1 will improve staff capabilities Improved specialism training opportunities by freeing up senior medical staff time due to reduced wastage in travel between sites		As above I need more information as I do not have the specialist knowledge in this area to provide sufficient answer	Big Better	Big Better	SI Better	Big Better	SI Better	Big Better	Big Better	SI Better			
4.11 What is the likely effect of this solution on the travel burden for staff? e.g. relocation time and cost.	Further analysis required	Further analysis required	Don't Know	Big Better	Similar	Don't Know	Similar	Don't Know	Worse	Don't Know	Easier as they will be permanently based at the same location	GRH staff - no change. CGH staff - affects some adversely but not all. Might be useful to look at staff residence location statistics?	Better for some. Worse for others. Further analysis required Winners and losers sufficient transport and staff parking will need to be in place Especially for transferring staff. Impact of travel time, cost and impact on child care. Although some staff from CGH might have to travel to GRH, most staff will already be there anyway.	Worse	Similar	Don't Know	Don't Know	Similar	Don't Know	Worse	Don't Know		Some staff affected, short term CGH staff relocating. Impact of accessing childcare	Nursing impact depends on other Gen Surg changes Need staff travel impact analysis. Some staff relocation esp. nurses but consultants and trainees are cross county already
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	Don't Know	Big Better	SI Better	Big Better	Don't Know	Big Better	SI Better	SI Better	Specialisation and reducing the number of centres from 2 to 1 will improve supervision Improved supervision due to increased availability of supervising 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.		Depends how the remaining services on other sites are supported. I need more information as I do not have the specialist knowledge in this area to provide sufficient answer	Big Better	Big Better	SI Better	Big Better	Similar	Big Better	SI Better	SI Better	Yes theatres, assessing, discharging. Better with single EGS. CGH loss but lower impact		

A3: Centralise complex emergency medical admissions to Gloucester (undifferentiated patients). Increase pathways for direct emergency admissions to specialties in Cheltenham (differentiated patients) – Models D, F & G

Quality	Pre Workshop Information - Evidence from Workstreams		Pre Workshop Scores						Pre Workshop Scorer Comments			Workshop Scores						Workshop Scorer comments		
	What would be better	What would be worse	Table 1	Table 3	Table 4	Table 5	Table 7	Table 8	What would be better	What would be worse	Other comment	Table 1	Table 3	Table43	Table 5	Table 7	Table 8	What would be better	What would be worse	Other comment
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		Sig Better	Sig Better	Sig Better	Sig Better	SI Better	Sig Better	Greater specialisation will improve quality of care Availability of staff and equipment Improve outcomes Centralisation of the acute medicine team at GRH will significantly improve the service to patients due to more focussed teams providing the care		Concentrate all resources on one site enabling efficient well-staffed service This will be totally reliant upon having the necessary estate and supporting pathways to ensure that the additional demand can be appropriately accommodated on one site with no compromise to patient care and experience. Enhancing opportunities for Same Day Emergency Care within the Community could also have a positive impact managing capacity and flow within a one site option. Does this option allow for any SDEC (previously AEC) to be managed on the CGH site?	Sig Better	Sig Better	Sig Better	Sig Better	SI Better	SI Better	Same day emergency care opportunity to be supported. Better outcomes, faster review, senior input, rounded special care. Currently struggle with acute med rota Sub specialities being available Right teams in right places Better outcomes Better patient management by one team Access to other specialities improved Quality of environment Transport - right team - right place	How do you deal with complex health needs in people who are acutely unwell? Concerns: estate and # of beds in order to accommodate. Only achieved if beds are addressed Reliant on sub specialities being available.	how important is 14 hour national standard? What is the impact of complying (or not)? On the Trust or patient outcomes? Ensure published evidence is cited. Evidence that standards improve outcomes Depends on how other services configures Improve ability to meet clinical schedules Meeting clinical schedules will improve clinical outcomes Transporting patients - better if reconfigured pathway Improve coord frailty Critical mass increased ethic/effect/recruit Senior reviews Current inequity across sites
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		Sig Better	Sig Better	Sig Better	Sig Better	Sig Better	Sig Better	Greater specialisation will improve quality of care Centralised teams and improved access to specialists More likely to see the right specialist quicker This is the greatest improvement expected by the public		As long as other services support the unplanned site.	Sig Better	SI Better	SI Better	Sig Better	SI Better	Sig Better	SWAST - this solution makes it easier to decide where to take patients		Some patients would have to transfer if go to CGH ED beds a concern Mixed impact Trusts, carers/families/population needs suitable environment/estate development Need to understand pathways and the offer at CGH Environment - need more info on estates strategy Need right pathways for patients @ CGH
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		Sig Better	SI Better	SI Better	Sig Better	Sig Better	SI Better	All the specialists in one location Improve co-ordination Transfers confuse patients and their carers/families, a reduction would be welcomed Having a single clinician/team responsible provides high reassurance levels When patients are transferred out of county they become mere 'bed numbers' rather than human beings defined clearer and fewer pathways.		will be reliant upon the estate being configured to accommodate both assessment and admission within the GRH site. Will there be any medical patients that are stabilised and transferred to CGH e.g. Care of the Elderly.	Sig Better	Similar	SI Better	SI Better	SI Better	SI Better	Benefit of 1 site working. No out of county impact. Pt perspective - better managed by a single clinical team	Concern: need to understand # of anticipated transfers and impact of travel/transfers. Carers impact Impact of changes on other medical specialties at CDH; potential to increase transfers; need to recognise number of unknowns Risk of transfer back. A few more risks around travelling back.	this depends on the configuration and SOPPs with 'ologies, eg. Gastro works well Would be on the proviso that supporting infrastructure in place, in particular internal transport.
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	Similar	Similar	Similar	SI Better	Similar	Similar	Glouc's Heath & Care NHS Trust are working hard to achieve holistic care in the county, this change will make their work easier by treating the person as a whole including frame of mind, worries and concerns and sign posting to the correct department/agencies to work in conjunction	Other teams will still be located in both hospitals so quick communication may not always be possible		SI Better	Don't Know	Similar	SI Better	SI Better	Don't Know	Access to other specialists easier Discharge links with community groups and voluntary sector; support is easier to 1 x site. IP concentration at GRH would be better Mental Health very important; medical beds at 1 x site easier but will need MH presence on both sites Can also improve discharge / flow & liaison with other teams	Voluntary orgainsations in Cheltenham might be impacted, eg drivers and voluntary organisations - ensure we ask them	Helpful to provide examples of support
1.5 What is the likely effect of this solution on the quality of the care environment?	All resources in one place		Similar	SI Better	SI Better	SI Better	Similar	Similar	There may be an open environment opportunity to plan for dementia friendly wards/areas if this goes ahead, implementing best practice	GRH Tower block needs a lot of work to refresh its shabby appearance and improve infection control - ref recent PLACE 2019 assessments GRH catering needs to be improved - ref recent PLACE 2019 assessments Some areas of GRH are not dementia friendly and have poor facilities for disabled patients - ref recent PLACE 2019 assessments	There is a cost to this to change the environment, train the staff and visitors. Privacy and dignity is down to the environment and working practices and is variable	SI Better	Similar	Similar	SI Better	Similar	Don't Know	Physical changes will be required at GRH; could not fit without investment. New design would take account of needs e.g. dementia. Centralise on 1 x site increases support available e.g. of frailty Pts	Concern: suitable environment needs to be identified. Cannot be accommodated now Dependent on facilities to be delivered	Just needs to be no worse. Expect it to be good eg. Frailty service for everyone Estate plan needs to be clear? Can environment be adapted to be dementia friendly.
1.6 What is the likely effect of this solution on encouraging patients and carers to manage self-care appropriately?	No impact	No impact	Similar	Similar	Similar	Similar	Similar	Similar	Teams can be available to educate , introduce a 'gallery type ward for education whilst inpatient		NHS England initiatives could help here	Similar	SI Better	Similar	Similar	Similar	Similar	Greater chance of starting self-care, eg. Smoking cessation Patient pathways improved by being in an AM setting		Needs to have clear sub speciality pathways.
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.	Don't Know	SI Better	SI Better	Sig Better	Similar	Similar	Patients will be under the care of an experienced and dedicated team at all times		deploy services where the patients enter the hospital and need them. will be dependent upon bed configuration and what medical specialities will be provided within CGH e.g. COE Transfers from GRH reduced but walk-in transfers from CGH increased?	SI Better	SI Better	SI Better	SI Better	Similar	Similar	Fewer transfers needed ie evidence that admissions avoided Evidence of right 1st time transfer - subject to other pathways being in place Improved access to specialist and consultants. Pt transfer risks are greatest for secondary transfers. Time to assess is most important. This model allows stabilisation do for some patients significantly improved. Most Pts not significantly affected.	patients presenting to CGH might be waiting for transfer Intra-hospital transfers - For undifferentiated patient (not clear diagnosis) at CGH maybe requirement to transfer to GRH - increase	Improve communication about transport availability
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		SI Better	Sig Better	Don't Know	Sig Better	Sig Better	SI Better	My understanding is that consultants could be on call and help without necessarily needing to switch between sites, Improved location of equipment and specialists Specialist staff will be available on-site when necessary If staffing is consolidated and diagnostics capacity adequate this should bring services closer to best practice guidelines (NICE, learning from confidential enquires for example) and national service frameworks.		Centralising expertise on one site would suggest an improvement will be secured but this will be dependent on the model being supported by an adequate workforce based upon demand as well as the protection of the ED for life and limb emergencies. Effective pathways will be critical to ensuring this is effectively delivered	Sig Better	SI Better	Similar	Sig Better	SI Better	SI Better	For a reasonable number of PIs/ frequent occasions it will increase speed of intervention e.g. Acute MI, thrombolysis	Walk in to CGH ED - issue. Self presenting to CGH ED need to transfer.	Req clarification on definition of emergency intervention Currently good early care. Not every Pt will have increased speed of intervention Need a protocol for direct admit. Not just front door patients Need all pathways in place
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.	Similar	Similar	Similar	SI Worse	Similar	SI Worse	blue light' presentations require immediate triage, paramedics awaiting transfers in corridors is not acceptable. Perversely, increased travel times would enable emergency surgery staff to be ready and waiting	people in the East will have more travel time Issues will reside with those that do not have ease of own transport and are reliant on carers and relatives to transport. Delay in securing transport may pose increased delays which MAY negatively impact	protocols and capacity matching would need to be in place to ensure safe transfers.	Sig Better	Similar	SI Worse	SI Better	SI Better	Similar	Gain from right place 1st time is greater than loss from travel time Treatment already started on an ambulance Any increase in travel time will be offset by travel outcomes. Evidence of effect of increased travel time on outcomes low; clinical view this solution will not negatively impact outcomes due to location change. Most impt is Pt seeing right person first time., SWAST likely to prefer clearly where to take Pt and transfer into hospital without delay.	East of county impact, negative impact on outcomes. Need evidence of mortality in these cases Travel time was a concern for many during the engagement phase	
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.		SI Better	SI Better	Sig Better	Sig Better	Sig Better	SI Better	Improved staffing Retention of staff (junior doctors and consultants) should improve due to greater opportunities to carry out complex procedures and improved manning of rotas. Patients won't be waiting for specialists from another site.			Sig Better	SI Better	SI Better	Sig Better	SI Better	Sig Better	this would improve the rota issue - more attractive for all staff Recruitment of middle grade staff on Trust risk register Specialist staff focus improves Solution reduces duplication; centralisation improves quality		

Access	Pre Workshop Information Pack - Evidence from Workstreams		Pre Workshop Scores						Pre Workshop Scorer Comments			Workshop Scores						Workshop Scorer comments		
	What would be better	What would be worse	Table 1	Table 3	Table 4	Table 5	Table 7	Table 8	What would be better	What would be worse	Other comment	Table 1	Table 3	Table 4	Table 5	Table 7	Table 8	What would be better	What would be worse	Other comment
2.1 What is the likelihood of this solution meeting the requirements of the NHS Constitution and The NHS Choice Framework?	No change		Sig Better	Similar	Similar	Don't Know	Similar	Similar	Greater specialisation will improve quality of care right team, best knowledge and skills, right equipment, better staffing levels, cost effective and hopefully better communication to other departments/services attract and retain middle grade staff			SI Better	Similar	Similar	Similar	SI Worse	Similar	No impact on Choice Framework as non elective care Better time to be seen for medical patients	Could deteriorate at CGH for patients awaiting admission or onward transport.	SDEC needs to be incorporated into evidence improve time to be seen Critical mass, improves capacity to cover rotas Greater capacity to deliver service Access to specialist services on unplanned pathway Access to specialist services on unplanned pathwa would be better for elderly, frailty and mental health
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		Sig Better	SI Better	Sig Better	SI Better	Sig Better	Similar	One site would reduce confusion, Patients would understand that they will be treated by a dedicated team with excellent facilities A one shop solution will remove the need for the patient and family/carers to decide on which hospital to use		Clear signposting and patient education will be needed, it takes time for the service users to understand how to use services and where to go	Sig Better	SI Better	SI Better	SI Better	SI Better	Similar	A centre of excellence - easier for patients to understand.		Ambulatory offer at CGH would need to be well understood and communicated to achieve this benefit Dependent on communication to explain the offer Some concerns re travel Ambulatory offer not much clearer at CGH Project management capacity lots of dependencies Cheltenham parking Parking - general patient/carer/staff
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.	Don't Know	Similar	Similar	SI Worse	SI Worse	SI Worse	Ensure no wasted trips for services not available. Clear place to deliver.	People in the East will have more travel Worse for Cheltenham area patients, carers & families		SI Worse	SI Worse	SI Worse	SI Worse	SI Worse	SI Worse	There is a benefit of right decision 1st time reducing # of journeys for Pts; 1 vs 2 journeys	For people in Cheltenham it is a longer journey time On average slightly worse across the county East of county impact. Inward/outward impact	Further analysis required particularly around public transport. Need to consider time of day Need to review travel data to consider SWAST need to also consider cost impact for patient travel Need to consider impact on ED Further public transport analysis required Patients don't understand current offer Assumption that sufficient capacity exists
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		Sig Better	Similar	SI Better	Sig Better	SI Better	SI Better	Greater specialisation will improve speed of care Improved access to specialist senior consultants		This will only be the case if the pathway allows for direct referral to the acute medicine facility and Does not require access via ED This is dependent on the trust increasing the bed space available at GRH	SI Better	SI Better	SI Better	Sig Better	SI Worse	SI Better	Improved by flow via ED access to senior decision maker, can concentrate on patient flow	Will require investment in estate to deliver Concern about CGH walk in's.	Consider potential impact on GRH ED of change
2.5 What is the likely effect of this solution on the travel burden for carers and families?	See 2.3	See 2.3	SI Worse	SI Worse	SI Worse	SI Worse	SI Worse	SI Worse	although some people will be disadvantaged I am sure that the fact that they will be in one place and not being transferred between hospitals along with CofE will out way the problems		Need to make standard information about alternatives eg voluntary transport and who eligible for non-emergency hospital transport.	SI Worse	Sig Worse	SI Worse	SI Worse	SI Worse	SI Worse	If clinical model right, fewer attendances at hospital; reduce frequency	More burden on carers and family.	Consider time of day, public transport and parking
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	Sig Better	Similar	Similar	Don't Know	Similar	Similar	Greater specialisation will make it easier to install technology By consolidating services and expertise it supports the development of a 'centre of excellence' for medicine. An innovation hub at GRH would be		Dependant on the Trust investing in the needed technology and training	Similar	Sig Worse	Similar	SI Better	Similar	Similar	Benefits of centralisation	Acute Medicine spec - CINAPSIS is more difficult on 2 x sites. Increase use should reduce attendances at hospital. Switch to clinic or SDEC	Would need to consider better use of tech eg. Skype to keep in touch
2.7 What is the likelihood of this solution improving or maintaining service operating hours?	No change	No change	Similar	Similar	Similar	Sig Better	Sig Better	Similar	Greater specialisation will improve speed of care Subject to staffff availability it should greatly improve service operating hours operating hours in some departments would become 24/7 with staff on site			Sig Better	Similar	Similar	SI Better	Similar	Similar	Increases coverage for 24/7 rotas Acute Medicine – although still 24/7 solution will increase capacity of senior decision making cover on 1 x site, especially later in evening Improved hours in AEC would be better than status quo.		
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	Sig Better	SI Worse	SI Better	Sig Better	SI Better	SI Worse	Focussing on one site enables all specialist equipment to be readily available There will be a reduction in locations.			SI Better	Similar	SI Worse	Similar	SI Better	SI Worse			
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	Don't Know	Similar	Similar	Don't Know	Similar	Similar			Service in one place more equable? Same patient experience?	SI Worse	SI Worse	Similar	Don't Know	Similar	SI Better		People likely to be impacted will be most impacted by increased journey time. Transport issues may affect disadvantage groups.	Need to look at our inequalities
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	Don't Know	Similar	Don't Know	Don't Know	Similar	Don't Know	Demand is going to be greater ensuring one hospital is well staffed instead of having two understaffed will be safer in the long run.		Increases in the aging population need to be factored in carefully when refurbishing or establishing physical locations of the services. Is this in the Estates Strategy? The long term housing plans for the county will need to be taken into account	SI Better	Don't Know	Similar	SI Better	SI Better	Don't Know			Need capacity and demand modelling not enough information

Deliverability	Pre Workshop Information Pack - Evidence from Workstreams		Pre Workshop Scores						Pre Workshop Scorer Comments			Workshop Scores						Workshop Scorer comments		
	What would be better	What would be worse	Table 1	Table 3	Table 4	Table 5	Table 7	Table 8	What would be better	What would be worse	Other comment	Table 1	Table 3	Table 4	Table 5	Table 7	Table 8	What would be better	What would be worse	Other comment
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		Don't Know	Similar	SI Better	Sig Better	SI Better	Similar			This could be a 'quick win' that would boost public confidence in the programme Ambitious plans and difficult to assess without risk mitigations information.	**SI Better**	**Similar**	**Don't Know**	**Similar**	**SI Worse**	**Don't Know**		Workforce ok but transport and infra	Yes deliverable within 3 years this solution will require a lot of changes to make it happen; investment in Acute Medicine. ? 36 mth timeframe for reconfiguration or new build.
3.2 What is the likelihood of this solution meeting the relevant national, regional or local delivery timescales?	No impact	No impact	Don't Know	Don't Know	Don't Know	Sig Better	Don't Know	Similar	This would move the service towards best practice standards.			**Don't Know**	**Don't Know**	**Similar**	**Similar**	**Similar**	**Don't Know**		dependant on estate and contingent on suitable space for facilities	On the whole deliverable Increased recruitment and retention
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		Don't Know	SI Better	Don't Know	Sig Better	SI Better	SI Worse		Would attract more staff, however, there may be some problems with staff not wanting to move hospitals. Attracting middle grade doctors		**SI Better**	**SI Better**	**Don't Know**	**SI Better**	**SI Worse**	**Don't Know**	Clinical consensus very strong		Within 3 years Need to consider DCC beds/beds/co-dependencies Lots of don't knows Need detail on 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		SI Better	SI Better	Sig Better	Sig Better	SI Better	SI Better		Staff may not wish to relocate from CGH to GRH - incentives may be needed		**Sig Better**	**SI Better**	**Sig Better**	**Sig Better**	**SI Better**	**SI Better**	More attractive for recruitment and retention Medical workforce: split site unattractive to staff; 1 x site and specialist work will have positive impact. Potential for increased number of trainees		
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		Don't Know	SI Better	Sig Better	SI Better	SI Better	SI Better		Depends heavily on support services that are co-located		**SI Better**	**SI Better**	**Sig Better**	**SI Better**	**Similar**	**SI Better**	Would improve portering (diagnositcs) provision, eg dept has own porters Benefits for Acute Medicine; fewer Pts direct to CGH MAU at night where CT scan availability is less 1 x site: consolidates imaging resource, mental health avail improved;		
3.6 What is the likelihood of this solution having access to the required premises/estates to be successfully implemented?	Additional capacity could be provided on the GRH estate within the timeframe Evidence: Estates plan		Sig Better	Don't Know	Don't Know	Similar	SI Better	SI Better		Funding?	Both CGH & GRH require significant improvement works	**SI Better**	**Don't Know**	**Don't Know**	**Similar**	**Similar**	**Don't Know**	Definite requirement for additional estate but also more seniors leads to fewer admissions, Emergency admission to SDEC will assist capacity	Overal space across the Trust Dependent on estates solution	
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	Similar	Similar	Similar	Don't Know	SI Better	Similar	required technology would be close to hand/	will there be enough theatres?		**Similar**	**Similar**	**Don't Know**	**Similar**	**Similar**	**Similar**	Benefit of acute general surgery and acute physician on same site Protocols - safety linked.		
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		Don't Know	Don't Know	Don't Know	SI Better	Don't Know	Similar			in any case of relocating services this would be dependent on many factors although services will improve there needs to be a change in aftercare-careers in the community so people don't bed block and can return home with follow up care. This is essential with a growing elder population and for this reason more needs to be done now									

Acceptability	Pre Workshop Information Pack - Evidence from Workstreams		Pre Workshop Scores						Pre Workshop Scorer Comments	Workshop Scores						Workshop Scorer comments
			Table 1	Table 3	Table 4	Table 5	Table 7	Table 8	comment	Table 1	Table 3	Table 4	Table 5	Table 7	Table 8	comment
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		Don't Know	SI Better	SI Worse	SI Better	SI Better	SI Better	The public will see this as a negative move due mainly to increased travel times for those in the Cheltenham area. However, should the service improvements be widely advertised then acceptance will be easier to gain. The public are afraid of significant changes to their care system It does not satisfy those who wish to return to a 24 hour ED/acute service at CGH however unworkable. all ways room for improvement but rewarding that the whole of Gloucestershire has been taken into account and that the views of laypeople have been sort rather than it being only in-house through pop ups in city's, survey's , citizen jury	**SI Better**	**Don't Kno**	**Similar**	**SI Better**	**Similar**	**SI Better**	Divergent views Need to pursue different communication methods eg leaflet drops to houses. Slot on Gloucestershire Life Engagement - Anxiety re capacity at GRH and access to services; also links with oncology unit. Solution Fits with CoEx approach. Issues addressed Solutions need to be better described in terms of benefits for patients and staff.

Workforce	Pre Workshop Information Pack - Evidence from Workstreams		Pre Workshop Scores						Pre Workshop Scorer Comments			Workshop Scores						Workshop Scorer comments		
	What would be better	What would be worse	Table 1	Table 3	Table 4	Table 5	Table 7	Table 8	What would be better	What would be worse	Other comment	Table 1	Table 3	Table 4	Table 5	Table 7	Table 8	What would be better	What would be worse	Other comment
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		Don't Know	SI Better	Sig Better	Sig Better	Sig Better	Sig Better	Teams in right place at right time, working together and after initial changes should have little negative impact but better mutual support Centralising staff will improve working capacity		Service would be much more resilient but I worry about major emergencies overwhelming a single service rationalise to make more robust and flexible.	Sig Better	Sig Better	Sig Better	Sig Better	SI Better	Sig Better	Attracting and retention Resilience / capacity of medics improved; also nursing. Co-location v positive Centralisation works better.		increased capacity, recruitment, resilient teams, rotas increased acred and trainees improves transport for staff avoiding intersite transfer in the day
4.2 What is the likely effect of this solution on optimising the efficient and effective use of clinical staff?	See 4.1		Sig Better	Sig Better	Sig Better	Sig Better	Sig Better	Sig Better	Staff would be much more motivated and will suffer less burnout in a well managed & focussed environment			Sig Better	Sig Better	Sig Better	Sig Better	SI Better	Sig Better		Issue for ED and Care	In short term some staff travel burdens
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	Don't Know	Similar	Similar	Similar	Sig Better	Similar	Facilitates 'medical hub' approach, training rotations, improved MDTs, improved communications, less hand-offs between teams. Flexible rostering.			Similar	Similar	Similar	Similar	Similar	Similar	This will work better with training passports Single site assists building teams		99 bus need to run at weekends and late shift Need more analysis on relocating staff
4.4 What is the likely effect of this solution on supporting the flexible deployment of staff and the development of innovative staffing models?	By centralising the staff establishment there is greater potential for more flexible deployment of staff and the development of innovative staffing models.		Don't Know	SI Better	Sig Better	SI Better	Sig Better	SI Better	This will take time but provides opportunities for 'placements', rotational training, shared contracts.			Sig Better	SI Better	Sig Better	Sig Better	Sig Better	SI Better	Single site reduces workforce inefficiencies increase flexibility		
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.	Sig Better	Similar	Sig Better	Sig Better	SI Better	Similar	Should improve staff morale Motivated and empowered specialist staff with a genuine pride in their work suffer fewer physical and mental health issues fewer demands to unpredictably cover empty slots in unfamiliar places		Well-being is enhanced if you are welcomed, respected and feel part of a service.	Sig Better	SI Better	Sig Better	Sig Better	SI Worse	SI Better	Bigger teams more resilient, can manage the staff more flexibly (take account of individuals) ; more time for staff development	Movement of staff CGH to GRH. Staff impact Risk for ED staff holding patients in place of safety pending admission. Reliant on efficient transfer.	Get parking right for staff to increase recruitment, reduce stress and increase resilience Current challenges for GRH staff in centralised SVC.
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		Sig Better	SI Better	Sig Better	Sig Better	Sig Better	SI Better	Greater specialisation will improve recruitment Better working environment Staff looking for advancement in their careers are more likely to find it in a centre of excellence		Make Gloucestershire a county where people want to live. Increase availability of affordable housing	Sig Better	SI Better	Sig Better	Sig Better	Sig Better	Sig Better	Could be attractive for staff		
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.		Sig Better	SI Better	Sig Better	Sig Better	Sig Better	Sig Better	As has been practised already if staff want a change and to get other perspectives it should be possible to offer breaks to work in other specialities. Better opportunity to train staff		train the nurses to be come specialist carers in the field this would promote the right values for now and the future	Sig Better	SI Better	Sig Better	Sig Better	SI Better	Sig Better			Current issue is availability of senior members of staff for education supervision; centralisation increases hours available, esp. out-of-hours.
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.		Sig Better	SI Better	Sig Better	SI Better	Sig Better	Sig Better	senior staff would be less stressed and more able to provide suitable levels of contact when training junior staff in this more controlled environment			Sig Better	SI Better	Sig Better	Sig Better	SI Better	Sig Better	Current F1 feedback is poor; this solution will improve.	Deanery requirements need to be met. Issue of training facilities/ space	Would this impact on Jnr training at CGH? They rotate.
4.9 What is the likely effect of this solution on enabling staff to maintain or enhance their capabilities/ competencies?	Centralising the acute medical take will provide staff with greater opportunities to maintain and enhance their capabilities and competencies and improve access to specialist services		Sig Better	SI Better	Sig Better	SI Better	Sig Better	Sig Better	More robust service with training and support allowing focused learning. Right training from qualified consultants who are dedicated. working in a team environment while having up to date equipment			Sig Better	SI Better	Sig Better	Sig Better	SI Better	Sig Better			
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		Sig Better	SI Better	Sig Better	SI Better	Sig Better	SI Better	Training should be on going for all allowing staff to develop their skills across the board CofE would give accreditation allowing career progression while reducing turn over of staff. It would allow staff to become knowledgeable and specialists in their field.			Sig Better	SI Better	Sig Better	SI Better	Sig Better	Sig Better	Currently role cross-cover to fill gaps. Solution is clearer, doing what you are supposed to do; critical mass = greater opportunity		
4.11 What is the likely effect of this solution on the travel burden for staff? e.g. relocation time and cost.	Further analysis required	Further analysis required	Don't Know	Similar	Don't Know	SI Worse	SI Worse	SI Worse			Staff relocating from CGH need to be reassured that their net incomes will not change due to increased travel costs	SI Worse	Don't Know	Don't Know	SI Worse	SI Worse	Don't Know		Travel to and from work, travel between sites - real problem	Medical staff work across both sites, nurses work on separate sites consider inter-site bus provision Will be individuals affected. Need staff travel impact assessment to understand
4.12 What is the likely effect of this solution on maintaining clinical supervision support to staff?	Same as 4.8 Evidence: staff structure		Don't Know	SI Better	Sig Better	SI Better	Sig Better	SI Better	Better staffing. More support and supervision Consolidated teams, clear leadership, mentoring and support arrangements should make this more efficient and effective.			Sig Better	SI Better	Sig Better	Sig Better	SI Better	Sig Better	Centralisation creates opportunities		

C11: Centralise elective daycase surgery for colorectal and upper GI to CGH or dedicated Day Surgery Unit (DSU) - Models D & H

Quality	Pre Workshop Information - Evidence from Workstreams		Pre Workshop Scores								Pre Workshop Scorer Comments			Workshop Scores							Workshop Scorer comments		
	What would be better	What would be worse	Table 1	Table 2	Table 3	Table 4	Table 5	Table 6	Table 7	Table 8	What would be better	What would be worse	Other comment	Table 1	Table 2	Table 3	Table 4	Table 5	Table 6	Table 7	Table 8	What would be better	What would be worse	Other comment
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	Sig Better	Sig Better	SI Better	SI Better	Similar	SI Better	SI Better	Sig Better	Specialisation and reducing the number of centres from 2 to 1 will improve this Less risk of cancellations Efficient management of day cases with no threat posed by unplanned care. No cancellations Dedicated day case unit with clear pathways Reduce impact from emergency activity over spilling into elective capacity Reduce risk of cancellation within a dedicated specialist unit. Increased efficiency of a day case or short stay unit separated from complex cases and emergencies.		Forecasting no cancellations for planned care - is this realistic? Dedicated theatre capacity and day case expertise on one site should improve pt experience and outcomes of care via clinical dashboards, audit, etc. This is main driver for the change Planned care in CGH separated from emergency care, so improved service for patients. Also, all sub-specialties together.	Sig Better	Sig Better	SI Better	Sig Better	Sig Better	SI Better	Sig Better	SI Better	Reduced cancellation improves outcomes These Pts are regularly cancelled due to emergency/beds. Solution guarantees access. Also reduce unplanned overnight stays (due to late start) MRSA rate ring-fenced capacity less complications increased efficiency extended roles protocol driven Includes outcome of experience - less cancellations Care closer to home	Risk of transfer between sites	Already have good outcomes Not negatively impacted by EGS Much benefit to those patients planned for GRH where emergency activity results in their surgery being cancelled
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	Sig Better	Similar	SI Better	Similar	Similar	Sig Better	SI Better	Similar	Specialisation and reducing the number of centres from 2 to 1 will improve this Appropriate staff without competition of unplanned care. As per Royal College of Surgeons and Royal College of Nursing guidance. having a separate team from the emergence cases should stop last minute cancellations		Availability of teams likely not to be impacted Protects DSU from EGS/Acute Medicine overspill. Slightly better if day cases alone separated, significantly better if co-located with in-patient planned care - allows overnight and short stay to co-locate	Sig Better	Similar	Similar	Sig Better	Sig Better	Sig Better	Sig Better	SI Better	no cancellations Not negatively impacted by EGS Avoids cancellations Much benefit to those patients planned for GRH where emergency activity results in their surgery being cancelled		No change Dedicated unit = right place Separation from EGS/EMX site would mean protected space
1.3 What is the likely effect of this solution on continuity of care for patients?	No impact	No impact	Similar	Similar	Similar	Similar	Similar	Sig Better	SI Better	Similar	Specialisation and reducing the number of centres from 2 to 1 will improve this Better if co-located with in-patient planned care facilities (for overnight admission or short stay)	Impact on deteriorating patient at night and need to transfer to GRH?	Standardise pt information and standards of care.	Similar	Similar	Similar	Similar	Similar	SI Better	Similar	Similar	Currently a separate team. Need SOP for unplanned overnights - who looks after	Risk of transfer between sites	Day cases so v low transfers Risk of deterioration for Daycase patient is small. Would need DCC in extremes
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	Similar	Similar	Similar	Similar	Similar	Sig Better	Similar	Similar			Specialisation and reducing the number of centres from 2 to 1 will improve this marginally If all services are in the same place wouldn't it make it easier for community, social and volunteer sectors to support patients.	SI Better	Similar	SI Better	Similar	Similar	SI Better	SI Better	Don't Know	Could increase volume patients who could be discharged Separation of urgent/planned improves outcomes for both		Ambulant population/ cohort Reduced risk of SSI (Surgical Site Infection) and MRSA
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	Sig Better	Sig Better	SI Better	Don't Know	SI Better	SI Better	SI Better	Sig Better	Specialisation and reducing the number of centres from 2 to 1 will improve this due to improved access to specialist advice and help Better without day ward full of emergency patients Dedicated unit and staff away from EGS. reduce overspill of emergency activity into day case unit		Commentary in info file refers to dedicated day surgery but does not cover the quality of the care environment - PLACE criteria? The focus is solely on day surgery care No impact from need to divert to emergency surgery Dedicated day surgery units can be designed to specific standards and operating procedures that improve pt and staff experience. Assume a suitable day case environment will be provided however the service is configured	Sig Better	Sig Better	SI Better	Similar	Similar	SI Better	Sig Better	SI Better	Increased quality through separation, dedicated unit and scale Standardise Care Pathway benefits		No new build
1.6 What is the likely effect of this solution on encouraging patients and carers to manage self-care appropriately?	No impact	No impact	Similar	Similar	Similar	Similar	Similar	Similar	Similar	Similar	Specialisation and reducing the number of centres from 2 to 1 will improve this due to improved access to specialist advice and help clear pathways with minimal risk of cancellations		based on the info pack there seems to be no impact	SI Better	Similar	Similar	Similar	Similar	SI Better	Sig Better	Similar	More time, more info, with other d/c patients.		
1.7 What is the likely effect of this solution on enabling patient transfers within a clinically safe time frame?	No impact	No impact	Similar	Similar	Similar	Similar	Similar	Similar	Similar	Similar		Maybe a few operations will go wrong needing transfer to Gloucester? Patients who develop complications that need transfer may wait	Day case care not impacted on by this really. Importance is reducing cancellations. based on the info pack there seems to be no impact Note deteriorating patient Patient transfers unlikely to be associated with day cases	Similar	Similar	Similar	Similar	Similar	Similar	Similar	Similar			Low volume of complications - cohort Provision for overnight stays in CGH Not relevant for this co-hort
1.8 What is the likely effect of this solution on enabling emergency interventions within a clinically safe time-frame?	No change	No impact	Similar	Similar	Similar	Similar	Similar	Similar	Similar	Similar		Transfer may be needed to GRH May involve number of pt transfers which impact staffing/ambulance services	As patients are screened for suitability for day surgery this shouldn't happen.	SI Worse	Similar	Similar	Similar	Similar	Similar	Similar	Similar	Deteriorating patients model supports this.	Lose day team to go to Emergency Theatre	Need SOP/ plan for deteriorating Pt. Although rare (lo #) and lower acuity Pts selection process to reduce risk
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.	Similar	Similar	Similar	Similar	Similar	Similar	SI Worse	Similar	Timeliness of intervention if emergency arises overnight		Presumably rarely emergency cases Depends how unexpected complications are managed and where they need to go. based on the info pack the only negative is the increase in travel time for some patients to CGH- even then the patient's safety is not compromised. No detail on cohort affected by change, likely impact those more vulnerable unless mitigations put in Some patienst will have increased travel time but smaller chance of cancellation on the day and reduced chance of admission Deteriorating pt protocols already in place - would need review. some patients will have to travel further but as care should result in better outcomes this should balance things out.	Similar	Similar	Similar	Similar	Similar	Similar	Similar	Similar			No affect on 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	Don't Know	Sig Better	SI Better	Sig Better	SI Better	Sig Better	SI Better	Similar	Specialisation and reducing the number of centres from 2 to 1 will improve this Reduced number of cancellations Easy to staff with no need for out of hours support. Reduced cancellations Reduced risk of patient becoming an emergency because of delays caused by cancellations. less likely to be cancellations at least minute.			Similar	SI Better	SI Better	Sig Better	SI Better	SI Better	SI Better	SI Better	Centralisation reduces risk. Reduced cancellations e.g. for hernias reduces complications Avoid cancellations Centralisation principle reduces risk, Low cancellations, more efficient, clean process and seamless Decreased risk of cancellation		

Access	Pre Workshop Information Pack - Evidence from Workstreams		Pre Workshop Scores								Pre Workshop Scorer Comments			Workshop Scores								Workshop Scorer comments		
	What would be better	What would be worse	Table 1	Table 2	Table 3	Table 4	Table 5	Table 6	Table 7	Table 8	What would be better	What would be worse	Other comment	Table 1	Table 2	Table 3	Table 4	Table 5	Table 6	Table 7	Table 8	What would be better	What would be worse	Other comment
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	SI Better	SI Better	Don't Know	Don't Know	SI Better	Sig Better	Don't Know	Sig Better	national waiting time standards likely to be met shorter waiting times Improvement in waiting time standards	Loss of DSU option at GRH	The information is saying that the ability to improve would be increased but it is not stated or exemplified the how. Is this actually achievable or is it a hope? Improved accessibility but reduced choice over location	Sig Worse	Sig Better	SI Better	SI Worse	SI Better	SI Better	SI Better	SI Better	Reduction in cancellations = increased capacity = reduced waits Reduction in cancellations - Pts see this v positively May improve waiting list - fewer cancellations	Reduce choice West of region travel concerns	5/7 day case surgery offering now; wouldn't change on day 1 of move Data assume all GRH day cases notes to CGH other options include Ciren, Stroud etc A calmer day case unit will create a feeling of calm resulting in benefit
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	SI Better	Sig Better	SI Better	Don't Know	SI Better	Sig Better	SI Better	Similar	Should be easy to explain Single site will boost patient confidence that they will get their surgery when planned Single site for access Single location		With appropriate literature. Patients will only access this service after referral so will not need to know how it is configured in advance	Sig Better	Similar	Similar	SI Better	SI Better	SI Better	SI Better	Similar			Planned day cases
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	SI Worse	Don't Know	Similar	Don't Know	Similar	Don't Know	SI Worse	Similar	Reduce cancellations. Travel shouldn't be an issue with low risk care.	More travel from West travel times will increase for those who live further away from Cheltenham Parking in CGH needs to be addressed By reducing the locations where services are offered some people (in this case from the West of the county) will have to travel further	Usual mix of good & bad impact on travel depending on the patients home location Easier for pts in Cheltenham and Cotswold, worse for Gloucester pts	SI Worse	SI Worse	SI Worse	SI Worse	Similar	SI Worse	SI Worse	Don't Know		2 sites to 1 site Parking	Is listing site based on patient location TIA. Day case is day only (drop off/pick up). Some Pts further to travel but reduced cancellations means don't have to come back More in peripheral hospitals
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	Don't Know	SI Better	SI Better	Don't Know	SI Better	Sig Better	SI Better	Similar	Specialisation and reducing the number of centres from 2 to 1 will improve this should reduce waiting times & likely to achieve national standards Large number of patients removed from acute hospital (GRH) - reduced cancellation, reduced waiting times and fewer breaches Should improve treatment times improved waiting times due to efficiency.		It is not clear as to how this will be achieved	SI Better	Sig Better	SI Better	SI Better	Sig Better	SI Better	SI Better	Don't Know	Reduction in cancellations = increased capacity = reduced waits Improvement in 18 wk RTT		Add numbers/annum Need information about community hospitals
2.5 What is the likely effect of this solution on the travel burden for carers and families?	See 2.3	See 2.3	SI Worse	Don't Know	Similar	Don't Know	Similar	SI Worse	SI Worse	Similar		more travel from West Slightly worse for people living in Glos/deprived areas	consolidating to CGH would make journeys from the West slightly longer. As it is daycase activity then people are unlikely to be making multiple journeys so the burden is low	SI Worse	SI Worse	SI Worse	SI Worse	Similar	SI Worse	SI Worse	Don't Know			day case not multiple visits
2.6 What is the likelihood of this solution supporting the use of new technology to improve access?	No impact	No impact	Similar	Similar	Similar	SI Better	Similar	Similar	SI Better	Similar			No change stated but would use of Cinapsis reduce waiting times?	Similar	Similar	Similar	Similar	Similar	SI Better	Similar	Similar			
2.7 What is the likelihood of this solution improving or maintaining service operating hours?	No impact	No impact	Don't Know	Similar	Similar	Similar	Similar	Sig Better	Sig Better	Similar	Allows concentration of out of hours service provision elsewhere. fewer cancellations Protected operating time		No change, but there could be an opportunity to offer weekend surgery if not already offered Can overnight service be covered? Don't know if consolidated team will mean extended hours?	SI Better	Similar	Similar	Similar	Similar	Similar	Similar	SI Better	Possible to extend operating hours Operating hours improved (slightly) more production		5 day week. No changes
2.8 What is the likelihood of this solution improving or maintaining service operating locations?	No impact	No planned day case care at GRH	Similar	Similar	Similar	Don't Know	Don't Know	Sig Better	SI Better	SI Worse	Make day case site efficient and productive	Loss of DSU at GRH	Worse for GRH area initially but once public acceptance is gained by an improved service should be better Covering deteriorating patient service overnight. Are staff available?	SI Worse	SI Worse	SI Worse	SI Worse	Similar	SI Worse	SI Better	SI Worse	Less Locations / more quality		Reduces a physical location BUT increases capacity with dedicated unit. Common model is dedicated separate facility - improves access
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	Don't Know	Don't Know	Don't Know	Similar	Don't Know	Similar	Don't Know	Similar		Likely impact on those more vulnerable e.g. travel costs, complex lives, carers although better for the more vulnerable in Cheltenham and the east it could be worse for Gloucester and the Forest for the most vulnerable.	No effect the service will need to ensure it provides equitably for all patients who need to use it	Similar	Similar	SI Better	Don't Know	Similar	SI Better	SI Better	Don't Know			Evidence 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	Don't Know	Don't Know	Don't Know	Don't Know	Don't Know	SI Better	Similar	Similar			Growth models need to be available when planning estate changes in particular Allow centralisation of complex care. The service will need to plan for capacity to meet needs now and into the future If there is a population growth in the west a new service might have to be set up.	SI Better	Similar	Don't Know	SI Better	Similar	SI Better	SI Better	Don't Know			Evidence required

Deliverability	Pre Workshop Information Pack - Evidence from Workstreams		Pre Workshop Scores								Pre Workshop Scorer Comments			Workshop Scores								Workshop Scorer comments		
	What would be better	What would be worse	Table 1	Table 2	Table 3	Table 4	Table 5	Table 6	Table 7	Table 8	What would be better	What would be worse	Other comment	Table 1	Table 2	Table 3	Table 4	Table 5	Table 6	Table 7	Table 8	What would be better	What would be worse	Other comment
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	Don't Know	Similar	Don't Know	Don't Know	SI Better	SI Worse	Don't Know	SI Better			No huge obstacles Much of infrastructure and facilities already in place.	SI Better	SI Better	Don't Know	SI Better	SI Better	SI Better	SI Worse	Don't Know	Gen Surg priorities are 1) EGS 2) Daycase 3) Colorectal. Dedicated day surgery is supported by consultants but no agreement on site	Beds and theatre capacity is an issue	Evidence required Staff in place, just across 2 sites currently 2nd priority after EGS move (and enabler to other moves) Nursing capacity needed Rota required to aid decisions
3.2 What is the likelihood of this solution meeting the relevant national, regional or local delivery timescales?	No impact	No impact	Don't Know	Similar	Don't Know	Don't Know	Similar	Similar	Don't Know	Similar			no impact noted	Similar	Similar	Don't Know	Don't Know	Similar	SI Better	Similar	Don't Know			
3.3 What is the likelihood of this solution having the implementation capacity to deliver?	No impact	No impact	Don't Know	Similar	Similar	Similar	Similar	Similar	Don't Know	Don't Know			no impact noted Implementation capacity would need to be identified	SI Better	SI Better	Similar	Don't Know	SI Better	SI Better	SI Worse	Don't Know			
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	Don't Know	Similar	Similar	Don't Know	Similar	Don't Know	SI Better	Similar	all staff at one location Intended to improve staff resilience by consolidating teams	Risk of being slightly worse if not located with planned in-patient service due to overnight admissions	targeted staff for limited periods.	SI Better	Similar	Similar	Sig Better	Similar	SI Better	Similar	Similar	No change in staffing required	Nursing impact	Adjustments to ward staff. Redeployment of existing
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	Don't Know	Similar	Similar	Similar	Similar	Similar	Don't Know	SI Better			no impact noted everything is already in place	Similar	Similar	Similar	Similar	Similar	SI Better	Similar	Similar			Autonomous activity Depends what else is on the site. Day case wards need modelling on process flow incl parking, drop-off
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	Don't Know	SI Better	Similar	Don't Know	Similar	Don't Know	SI Better	Don't Know		Additional day case beds would be required	Relies on estates strategy to provide space for more daycase beds needs further beds and parking facilities More beds needed at CGH Don't know if any changes to estates are required to accommodate	SI Better	Similar	Similar	SI Better	SI Worse	Similar	Don't Know	Don't Know		Theatre capacity an issue. Day Case bed requirement achieved by moving colorectal	Subject to an adequate capital investment. Dependent on other changes. Dedicated day unit needs bed modelling. Unknown Need to see estates plan.
3.7 What is the likelihood of this solution having access to the required technology to be successfully implemented?	No impact	No impact	Similar	Similar	Similar	Don't Know	Similar	SI Better	Don't Know	Similar			implementation of Cinapsis county wide could help Do not think it will have an effect on technology	Similar	Similar	Similar	Similar	Similar	Similar	Similar	Similar	No additional requirements		None required/ no change
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	Similar	Similar	Similar	Similar	Similar	Similar	Similar	Similar			If other acute services move elsewhere then good access to theatre will be essential and available EGS move to GRH and elective IP colorectal and upper GI to GRH. Ideally move IGIS and acute medicine to GRH too to free up theatre space May be linked to other proposed changes in surgical services	Similar	Similar	Similar	Similar	SI Worse	Similar	Don't Know	Don't Know		Requires operating list shifts to GRH. More info needed	Linked to all other Gen Surgery changes Theatre capacity, bed capacity, dedicated unit? something need to move out to create space

Acceptability	Pre Workshop Information Pack - Evidence from Workstreams		Pre Workshop Scores								Pre Workshop Scorer Comments	Workshop Scores								Workshop Scorer comments
			Table 1	Table 2	Table 3	Table 4	Table 5	Table 6	Table 7	Table 8	comment	Table 1	Table 2	Table 3	Table 4	Table 5	Table 6	Table 7	Table 8	comment
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		Sig Better	SI Better	Similar	Don't Know	SI Better	Sig Better	SI Better	Don't Know	This is the first solution whereby the answers seemed biased in the sense that this option is trying to make itself a front runner. The information is hazy. Some respondents are likely to have hoped for this service to be provided on both sites. There is limited feedback on the specific elements of the different parts of general surgery, not aware of any specific feedback relating to GI day cases it covers all the questions people had. Engagement Report - No specific questions but supports future of CGH. Fits with CoEx approach Better for people in CGH Engagement Report - Balances services at both sites. Supports a vibrant future for CGH. Pitch - strongly positive for staff, positive for outcomes, positive/neutral for access. Which site for Day case not clear Does this look like downgrading CGH Current engagement doesn't talk much about day surgery sell the benefits of the model	Similar	SI Better	Similar	Similar	SI Better	SI Better	SI Better	Don't Know	

Workforce	Pre Workshop Information Pack - Evidence from Workstreams		Pre Workshop Scores								Pre Workshop Scorer Comments			Workshop Scores								Workshop Scorer comments		
	What would be better	What would be worse	Table 1	Table 2	Table 3	Table 4	Table 5	Table 6	Table 7	Table 8	What would be better	What would be worse	Other comment	Table 1	Table 2	Table 3	Table 4	Table 5	Table 6	Table 7	Table 8	What would be better	What would be worse	Other comment
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.	SI Better	SI Better	SI Better	Don't Know	SI Better	Similar	Similar	SI Better	Doesn't need staffing out of hours 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. Centralising services optimises workforce capacity, increases stability and improves resilience Staff changes will be involved from GRH and recruitment may be needed. This would also provide opportunities for staff who want to move into this clinical area to gain experience.	may have negative effect on GRH nursing staff	The pros outweigh the cons- efficency and effectiveness would be improved- this can only be beneficial for the patient. better team work, better recruitment, more flexibility to cover for absence and opportunities for training. Although current RGH staff will have to be relocated.	SI Better	Sig Better	SI Better	Sig Better	SI Better	Similar	SI Better	Similar	Centralisation, reduced absence. Centralise principle positive impact. Day case focussed only		No rota issues Better access to training (dedicated daycase lists) Nursing impact - need to consider rotation May Hill? - what will happen to the ward? Risk of losing training status
4.2 What is the likely effect of this solution on optimising the efficient and effective use of clinical staff?	No impact	No impact	Sig Better	Similar	SI Better	Sig Better	SI Better	Similar	Similar	Similar	Specialisation and reducing the number of centres from 2 to 1 will improve this single site efficiencies will come into play			SI Better	Sig Better	SI Better	Sig Better	SI Better	SI Better	Sig Better	SI Better			
4.3 What is the likely effect of this solution on supporting cross-organisational working across the patient pathway?	No impact	No impact	Don't Know	Similar	Similar	Similar	Similar	Similar	SI Better	Similar	better team working			Similar	Similar	Similar	Similar	Similar	Similar	Similar	Don't Know	Opportunity for more community hospital sessions		
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 Physician Associate roles to support the delivery of daycase care within the timeframe This would be evidenced by the introduction of new posts	No impact	SI Better	Sig Better	SI Better	Similar	SI Better	Don't Know	SI Better	SI Better	I suspect this would improve effective use & improve resilience Opportunity to introduce Physician Associate roles to support the delivery of daycase care within the timeframe New roles could be developed eg physician associate Enhanced recovery pathways Will allow introduction of novel posts and ways of working		reduced demand for out of hours provision. dependant on funding May incorporate enhanced roles eg Physicians' Associates	Similar	Sig Better	Similar	SI Better	SI Better	SI Better	SI Better	Similar			
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.	Sig Better	SI Better	Similar	Similar	SI Better	Sig Better	SI Better	Similar	working in a dedicate and unstressed team will improve self-care & mutual support consistent work environment, this sounds as though it would be less stressful. That can only be a good thing for staff well being. supportive team in a consistent calm environment.		Consistent environment. NO EGS patients in day case beds Support would be needed for transferring staff. Travel costs, caring and childcare arrangements.	Similar	Sig Better	Similar	SI Better	SI Better	SI Better	Similar	Similar	Positive environment, not emergency but some staff moves		
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	SI Better	Sig Better	SI Better	SI Better	SI Better	Sig Better	SI Better	SI Better	efficiency and flexibility- if the staff are happier not overworking because there is enough staff. It would stand that people will want to stay as well as being attractive to potential new recruits. Draws together DSU staff/experience Easier to train, more supportive environment	west of County and FOD staff will have further to travel	could result in requests for transfer out of the team by GRH nursing staff? On the plus side the establishment of a dedicated service may attract staff	SI Better	Sig Better	SI Better	Sig Better	SI Better	SI Better	SI Better	Similar			Nursing impact / rotation
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	Sig Better	Sig Better	Similar	Sig Better	SI Better	Sig Better	SI Better	SI Better	Senior staff would have more time & appropriate opportunities to train junior staff targeted training Provision of dedicated training- developing staff. better opportunities for training to high levels and improve skills, keeps the Deanery happy which is a Good Thing.			SI Better	SI Better	Similar	Similar	SI Better	Similar	SI Better	Similar	Dedicated training environment positive but not beyond tipping point Would improve training		
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	Sig Better	Similar	Similar	Sig Better	Similar	Similar	SI Better	Similar	Senior staff would have more time & appropriate opportunities to train junior staff targeted and emergency free easier to train when all in one site		Specific training in good environment for training	SI Better	SI Better	Similar	SI Better	SI Better	SI Better	SI Better	Similar	Increased capacity - options to repatriate pts. List of same procedure (hi vol) better for learning		
4.9 What is the likely effect of this solution on enabling staff to maintain or enhance their capabilities/ competencies?	No impact	No impact	Don't Know	Sig Better	Similar	SI Better	Similar	Similar	SI Better	SI Better	Staff at all levels would see more variety of day cases in a shorter time period due to reduction in cancellations and not having to provide emergency cover Draws together DSU staff/experience		Dedicated training in day surgery	Similar	Sig Better	Similar	SI Better	Similar	Similar	SI Better	Similar	Dedicated training environment		
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		Sig Better	Sig Better	SI Better	SI Better	SI Better	Sig Better	SI Better	SI Better	If the staff are happier not overworking because there is enough staff. It would stand that people will want to stay as well as being attractive to potential new recruits. Also with the opportunity of new roles being created- staff can progress within the unit, rather than go elsewhere. really good for staff		Fewer cancellations, dedicated training environment	SI Better	Sig Better	SI Better	SI Better	Similar	SI Better	SI Better	Similar	High volumes and low cancellations		
4.11 What is the likely effect of this solution on the travel burden for staff? e.g. relocation time and cost.	Further analysis required	Further analysis required	Don't Know	Don't Know	Don't Know	Don't Know	SI Worse	Don't Know	SI Worse	Similar	Stable base once fully implemented	GRH based staff transferring may have increased travel times & costs	Job planning to reduce travel between sites on individual days Depends on where staff are currently based, where they live and how many have to change their base	SI Worse	Similar	Don't Know	Don't Know	Similar	Similar	SI Worse	Don't Know			Need further information but less Specialty Nurses involved with this cohort so reduced impact Likely to balance out.
4.12 What is the likely effect of this solution on maintaining clinical supervision support to staff?	No impact	No impact	Don't Know	Similar	Similar	Don't Know	SI Better	Similar	SI Better	Similar	team working in a balanced team should result in improved supervision easier to maintain supervision when all staff on same site.			SI Better	Similar	Similar	Sig Better	SI Better	Similar	SI Better	Similar			

C5: Centralise elective colorectal to Cheltenham General Hospital (CGH) - Models D, F G & H

Quality	Pre Workshop Information - Evidence from Workstreams		Pre Workshop Scores								Pre Workshop Scorer Comments			Workshop Scores								Workshop Scorer comments		
	What would be better	What would be worse	Table 1	Table 2	Table 3	Table 4	Table 5	Table 6	Table 7	Table 8	What would be better	What would be worse	Other comment	Table 1	Table 2	Table 3	Table 4	Table 5	Table 6	Table 7	Table 8	What would be better	What would be worse	Other comment
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.	Sig Better	Sig Better	Sig Better	Sig Better	SI Better	Sig Better	Sig Better	Sig Better	Specialisation and reducing the number of centres from 2 to 1 will improve quality of care Better access to sub-specialist care and reduction of cancellations. Some concerns about care of a deteriorating patient Improved access to subspecialty care is offset by looking after the deteriorating patient. The "deteriorating patient" model does not describe surgical input. There is an increased risk to patients safety. Strategy 10 document suggests that high volume, non-complex cases are best suited to geographical separation from EGS CoEx model avoids cancellation of urgent elective cancer cases due to competing pressures on beds, theatre and critical care facilities by an ever rising emergency workload. Improved access to specialist teams would give confidence to the patients Reduction in cancellations = improved access	I do not have confidence in the ability to manage these patients out of hours. In-patients who develop complications and need further intervention (endoscopic or surgical) may need to be transferred to GRH (where the EGS Team are located	The pros and cons table in the info pack regarding this section seem to be evenly weighted. No numbers on those that would need EGS so difficult to weigh pro's and cons Benefits to elective patients would definitely include improved patient experience and some potential to improve outcomes by improving perioperative pathways with standardisation, however there may be some offsetting of this by reducing the benefits experienced by emergency patients who might benefit from the implementation of some of these protocols also. Physical separation of planned in-patient care from emergency care is recommended in the NHS LTPlan, the recommendation of the national GIRFT lead to improve care.	SI Worse	SI Worse	Similar	Sig Better	Similar	Similar	SI Better	SI Better	Centralisation - sub specialty benefits. Enhanced centralisation. Dedicated ward. Physical separation Centralisation benefits. Reduction in elective cancellations Centralisation increases capacity = reduced waits RCS recommend this Colocation with Urology and Gynae would remain Separating elective and emergency patients = benefit.	If EGS has moved onto different site. Pts not reviewed by consultant at w/e. Need plan SOP for deteriorating patient. More handovers. Less w/e cover. Reduce team continuity Deteriorating elective colorectal Pt -access to emergency surgeon Reduction in w/e reviews of planned Pts. People felt uninformed Impact on lower GI cases	there are benefits of a centralised service but resuce patients isolated from emergency site. Intitgate by 1-2 LoS inpatient work moving GRH beds issue discussed, no clear benefits
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 Dedicated planned care team protected from EGS demands. 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.	No impact	Sig Better	SI Better	SI Better	Sig Better	SI Better	Sig Better	Sig Better	Sig Better	Specialisation and reducing the number of centres from 2 to 1 will improve quality of care Availability of theatre space more probable i.e less likelihood of emergency operations needing te theatre Better access to sub-specialist care plus the co-location of urology, gynae & gastro team It would seem that there are only positives and namely that the patient would have the right advice from the right specialist meaning that the most effective course of treatment can be progressed and there seems to be little to no delay. Better outcomes less time in hospital In line with national standards and NICE guidance	Relies on untried models of care out of hours. Patients who develop complications would need to transfer	Elective patients are currently seen by the colorectal team. Opportunity for enhanced subspecialist care I would suggest in hours generally significantly better but this may not be the case OOHs should an elective case deteriorate overnight. Deteriorating patient team to support noted but patient at night in wrong place	SI Worse	SI Worse	SI Worse	Sig Better	SI Better	Similar	SI Better	SI Better	Better for elective Divergent - real benefit for most Improved Access to sub-specialty. Co-location positive for planned - selected site irrelevant Potential transfer for complications of surgery. Emergency care available at CGH.	Worse for recovery (10%) potentially an unacceptable risk	Balance of pro's and cons offsetting each other - centralising benefit.
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.	Sig Better	Sig Better	SI Better	SI Better	SI Worse	SI Better	Sig Better	SI Better	care from a single consultant is a benefit Dedicated elective teams, with no emergency distractions Patients would not need to move between ward or hospitals and would know their team. Would not need out of County transfers Follow up for planned patients @ CGH and rota provision at weekends	some concern about weekend consultant cover Weekend consultant review would not take place with current staffing levels. Transfer of EGS patients requiring specialist colorectal care from GRH and transfer of complications to GRH for surgery. New team each time. May reduce number of cancellations not being in acute centre	Elective patients shouldn't really be moving wards anyway. If I have understood the info pack correctly it seems that you would be worse off if you were a planned CGH as you would have to be seen at the weekend. Whereas planned in patients for colorectal surgery have a dedicated surgical team led by a consultant week to week. I don't know if one case is more severe than the other? One seems to have better continuity of care and I am not sure why. Clearer arrangements for deteriorating patients needed.	SI Worse	SI Worse	Similar	SI Better	Similar	SI Worse	SI Better	SI Better	Less likely to have outliers Less variation and more expertise.	More handovers. Less w/e cover. Reduce team continuity Transfer of patients inability to pick up EGS patients by Specialised nurses If someone deteriorated at CGH - surgeon for EGS must go to Cheltenham Need EGS rota to cover CGH emergency surgery/ to be signed by Deanery	Deteriorating patient model dependency No change to the teams doing the work but concerns re Deteriorating Pt at CGH
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	Similar	Sig Better	Similar	Similar	Similar	SI Better	Don't Know	Similar	The teams would have the improved access to what they already have in place	Splitting the same pathology based on mode of presentation where similar treatments will be undertaken will usually mean tention between pathways. Reduce effective working links with UGI surgery	Hopefully things cannot get worse with this solution. If colorectal operations and general surgery are at different hospitals, consultations between the two teams will not be as easy having all the patients on one site would surely mean that a single social care team to arrange services on discharge would only have to work one site.	Similar	Similar	Similar	Similar	Similar	Similar	SI Better	Don't Know	Benefits of centralisation		No change/ 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, nutrition team).	No impact	SI Better	Sig Better	Don't Know	Similar	Similar	SI Better	Similar	Similar	A highly specialised team from pre surgery to post op- this can only be good for the patient. elective sites allow enhanced quality of care The care environment would be met access to agencies would be available Planned care would lead to less disruption which is beneficial to both dementia patients and those suffering from some mental health conditions.		comments in descriptors refer to clinical care & not the environment	SI Better	SI Better	Don't Know	Similar	SI Better	Similar	SI Better	Don't Know	Enhanced centralisation. Dedicated ward. Physical separation Dedicated team/ward Elective separation positive on ward; nursing care is different between EI and Em so standardise Benefits of being in an elective setting, prehabilitation , enhanced recovery. Seperation of elective and emergency would be better.	relies on estate strategy Relies on a lot of different things	
1.6 What is the likely effect of this solution on encouraging patients and carers to manage self-care appropriately?	No impact	No impact	Similar	Similar	Similar	Similar	Similar	SI Better	Similar	Similar	Specialist teams available to give guidance on ongoing care		info pack says no impact- I assume there are no negatives There is always a problem getting some patients and carers to self-care but hopefully the dedicated teams will be able to advise	Similar	Similar	Similar	Similar	Similar	SI Better	SI Better	Similar	Elective, centralisation benefit		No change/ 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.	SI Worse	Sig Better	SI Worse	Similar	SI Worse	SI Better	SI Better	Similar	Ensures on-site provision of consultants/team available at CGH (GRH provided by EGS team) for other services (oncology, gynaecology, urology) The advantage of moving a patient who has deteriorated from CGH rather than the community to acute/emergency care at GRH is that the move should be more coordinated and safe.	concerned about deteriorating patient surgical support in an emergency requiring transfer to GRH Worried about plans to manage unexpected complications out of ours Deteriorating patients may require transfer Transfer of patients with complications for surgery by ambulance	If a patient needs to be transferred the info pack explains what would happen and the patient would receive the best care.	SI Worse	SI Worse	SI Worse	SI Worse	SI Worse	Similar	Similar	Similar	Introduces new risk of transfer. But can be done safely. Elective patients ok	Deteriorating Pt Potential increased # pf Pt transfers. SOP for emergency team avail if req; poss. travel to Pt	Assume ITU at both
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.	Don't Know	Sig Better	SI Worse	Don't Know	SI Worse	Sig Better	SI Worse	Similar	Emergency patients appropriately treated in emergency centre. Dedicated teams make this possible	concerned about deteriorating patient surgical support in an emergency due to lack of emergency theatre on site at CGH Emergency care elsewhere Limited access to emergency theatre in CGH The pt would be on a different site to emergency surgery facilities?		Big Worse	SI Worse	SI Worse	Similar	Similar	SI Worse	SI Worse	Similar		Deteriorating elective colorectal Pt -access to emergency surgeon Emergency team on other site. But also DPM	Can be done but could involve more complication as involves transfer
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.	Similar	Similar	SI Worse	SI Worse	Similar	Sig Better	SI Worse	Similar	Elective team wouldn't be treating blue light arrivals	More travel from East Pts transfer now against clinical protocols.	Usual mix of positives & negatives for patient travel times in the various parts of the county The Ambulance service would take the patient to Cheltenham initially to save transferring at a later date	Similar	Similar	Similar	Similar	Similar	Similar	Similar	Similar			No travel time outcome impact Electives only
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	Don't Know	Don't Know	SI Better	Similar	SI Better	SI Better	SI Better	SI Better	Reduction in cancellations will be a benefit to patients improvements and minimising patient risk is expected No risk to patients a single centre would be more efficient and have a good working team	Out of hours cover is not in place No material advantage on staffing for co-locating elective and emergency GI surgery Some risk around the deteriorating patient.	Looking forward to see a workable solution out of hours.	SI Worse	Similar	Big Worse	Sig Better	Similar	SI Worse	Similar	SI Better	Centralisation benefits. Reduction in elective cancellations decrease in wound infections improved outcomes DVTs etc	Reduction in w/e reviews of planned Pts.	Overall positive to centralise. Staff resilience and robustness of service. But current service good No better than the current medical w/force. Transfers between hospitals and transfer of responsibility.

Access	Pre Workshop Information Pack - Evidence from Workstreams		Pre Workshop Scores								Pre Workshop Scorer Comments			Workshop Scores								Workshop Scorer comments		
	What would be better	What would be worse	Table 1	Table 2	Table 3	Table 4	Table 5	Table 6	Table 7	Table 8	What would be better	What would be worse	Other comment	Table 1	Table 2	Table 3	Table 4	Table 5	Table 6	Table 7	Table 8	What would be better	What would be worse	Other comment
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	Don't Know	SI Better	Similar	SI Better	SI Better	SI Better	Don't Know	SI Better	Waiting time reductions should be a quick win Improved waiting times Reduced cancellations away from emergency centre	If all at one location choice is removed	most likely the aim is is to make improvement	Sig Worse	SI Better	Similar	SI Worse	Similar	SI Better	SI Better	SI Better	Centralisation increases capacity = reduced waits Pt choice of provider unaffected. Pot improvement in waits 2-1 choice better trt time 18 weeks ca waits fewer 52 week waits	Reduces choice	
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	SI Better	SI Better	SI Worse	Similar	SI Better	SI Better	SI Better	Similar	Simplifies the situation. Should be easy to communicate Less confusion about site Patients would be more comfortable having a dedicated team at a known hospital delivery of a single site should make the patient experience better. Hot cold split makes sense to patients		It is an elective service so patients will be invited for surgery and will not need to know in advance where the service is located, or access it without guidance	Sig Better	SI Better	Similar	Similar	SI Better	SI Better	SI Better	Similar	single site Odd for emergency readmissions. If to a different site better infrastructure / expertise.		people don't understand
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	Similar	Similar	SI Worse	Similar	Similar	SI Better	SI Worse	SI Worse		More travel from East Need TIA to determine but likely to be slightly or significantly worse for patients. increased travelling times from west of county and FOD	some will gain, some will lose, overall no significant change Gloucester residents are unaffected presently- but if the site moved to Cheltenham this would change for Gloucester and Forest of Dean patients. Travel analysis is outstanding.	SI Worse	SI Worse	Similar	SI Worse	SI Worse	SI Worse	SI Worse	SI Worse		<280 negatively impacted Glos/FOD Proportionally more Pts impacted than not. Recognise this is planned operation. OP remains unchanged	Can be mitigated as planned.
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)		Don't Know	SI Better	Don't Know	Similar	SI Better	SI Better	SI Better	SI Better	Waiting times should reduce Prevent impact of emergency care on elective services waiting times expected to decrease Improved ability to achieve national waiting times Referral to treatment and access to services should be reduced Should ensure scheduled theatre time improving treatment standards, especially important in bowel cancer.	Cancellations inevitable if elective and emergency GI surgery co-located	There is always going to be patients that will have to travel further but one centre and one dedicated team should reduce the need for Outpatient appointments	SI Better	SI Better	SI Better	SI Better	SI Better	SI Better	SI Better	SI Better	Centralisation increases capacity = reduced waits Service not in control of whole pathway e.g. diagnostics but centralisation supports capacity which supports reducing waiting times		
2.5 What is the likely effect of this solution on the travel burden for carers and families?	See 2.3	See 2.3	SI Worse	Similar	SI Worse	SI Better	Similar	SI Better	SI Worse	SI Worse		More travel from East Poor parking facilities in CGH	better for some, worse for others It will benefit some and disadvantage others there is no perfect solution Take account of travel impact and costs for people from more deprived areas (inner city and rural)	SI Worse	Sig Worse	Sig Worse	SI Worse	SI Worse	Sig Worse	SI Worse	SI Worse		Carer impact higher Pts in for < 1 week but impact on families	
2.6 What is the likelihood of this solution supporting the use of new technology to improve access?	No impact	No impact	Don't Know	Similar	Don't Know	Similar	Similar	Similar	SI Better	Similar	Co-location with other specialities would be an advantage		no change CGH is already a centre for robotic surgery (urology and gynae onc). This can be expanded to GI appears to be no technological changes involved.	Similar	Similar	Similar	Similar	Similar	Similar	Similar	SI Better	Robotic surgery in CGH Diagnostics - if EGS goes to GRH more capacity for CT for elective		
2.7 What is the likelihood of this solution improving or maintaining service operating hours?	Maintains colorectal presence on CGH site	No impact	Sig Better	Similar	Don't Know	SI Better	Similar	Similar	SI Better	Similar	Likelihood of emergencies interfering is less		Evidenced by patient pathways	SI Better	Similar	Similar	Similar	Similar	Similar	Similar	Similar	Possible to extend operating hours		As current
2.8 What is the likelihood of this solution improving or maintaining service operating locations?		No planned inpatient colorectal at GRH	Don't Know	SI Worse	SI Worse	SI Worse	Similar	Sig Better	SI Better	Similar	Specialist teams would have access to operating theatres when required	worse for Glos area patients, particularly for Forest Duplication of services again a challenge eg stoma support etc	This makes sense as the oncology centre is Cheltenham. No inpatient CR at GRH Keeps colorectal in CGH. Removes essential IP services such as stoma care and CNS input to EGS patients with colorectal problems	SI Worse	SI Worse	SI Worse	SI Worse	SI Worse	SI Worse	SI Better	SI Worse		Capacity of service is not reduced but # of locations 2 to 1	<volume >quality
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	Similar	Don't Know	Similar	Don't Know	Don't Know	Don't Know	Similar	Similar	The teams would identify who needs support and get the appropriate service involved	May have a financial impact on some patients and their families (for travel etc)This will impact those who are already subject to inequality due to the removal of a service from their community	can't see this affecting anything significant	Similar	Similar	Similar	Don't Know	Similar	Don't Know	SI Worse	Don't Know			
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	Don't Know	Don't Know	Similar	Don't Know	Don't Know	Don't Know	SI Better	Similar	Capacity to expand greater on the elective site (and more predictable)		Some protection of elective care but demand will challenge duplication of services. Growth model not available Nil evidence to support assessment having removed a service if the population increases will they be able to reinstate it?	SI Better	Similar	Don't Know	SI Better	Similar	SI Better	SI Better	Don't Know			Single site is better structured to cope but need evidence

Deliverability	Pre Workshop Information Pack - Evidence from Workstreams		Pre Workshop Scores								Pre Workshop Scorer Comments			Workshop Scores								Workshop Scorer comments		
	What would be better	What would be worse	Table 1	Table 2	Table 3	Table 4	Table 5	Table 6	Table 7	Table 8	What would be better	What would be worse	Other comment	Table 1	Table 2	Table 3	Table 4	Table 5	Table 6	Table 7	Table 8	What would be better	What would be worse	Other comment
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.		Don't Know	Similar	Similar	Don't Know	Similar	Don't Know	Don't Know	SI Better			Some infrastructure present. May need more bed modelling. Will need to find appropriate staffing solutions for out of hours. Shouldn't cause any delivery issues Currently the model is undeliverable in terms of staffing, theatre space Cheltenham is ready to deliver this option	SI Worse	SI Worse	Similar	Don't Know	SI Worse	SI Worse	Don't Know	Don't Know		Gen Surg priorities are 1) EGS 2) Daycase so probably priority #3. Single colorectal location is supported by consultants but no agreement on site	Significant time and work required to model and deliver. Priority hierarchy 1) EGS 2) Day Case 3) colorectal. Require sustainable change. If < 12 mth timescale not deliverable Subject to rescue/ recovery rota
3.2 What is the likelihood of this solution meeting the relevant national, regional or local delivery timescales?	No impact	No impact	Similar	Similar	Don't Know	Similar	Similar	Sig Better	Don't Know	Similar	This would improve the ability to meet National Standards		no change	Similar	Similar	Don't Know	Don't Know	Similar	Similar	Similar	Don't Know			
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	Don't Know	Don't Know	Don't Know	Don't Know	Similar	Sig Better	Don't Know	Similar		Junior doctor & weekend consultant cover is a concern Insufficient F1 staff. Insufficient consultants to provide weekend review of patients Unlikely to be able to deliver weekend in-patient review with current consultant numbers	Very likely as this dept. seem to have all the staff needed and they have enough beds- so need to extend buildings to accommodate.	SI Better	SI Worse	Similar	Don't Know	SI Worse	SI Better	SI Worse	Don't Know			Need to understand estates - probable if EGS is moved out
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		Don't Know	Sig Better	Don't Know	SI Better	SI Worse	Don't Know	SI Better	Similar	Allows safe 24/7 resident middle grade rota at CGH Staffing grades are in place to deliver this option opportunity to introduce other Associate roles	Junior doctor & weekend consultant cover is a concern Unable to deliver an acceptable weekend working rota for consultant review of in-patients		SI Worse	Sig Worse	Similar	Sig Better	Similar	Sig Worse	Don't Know	SI Better	Separation of elective from emergency positive; potential to increase consultant capacity w/e and evenings. AHPs and nurse - greater experience. Develop new skill sets More attractive to get staff working in elective and non elective	Insufficient F1 and consultants	
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	Don't Know	Similar	Similar	Don't Know	SI Better	Similar	Similar	SI Better			dependent on locating EGS at GRH to reduce support services loading Will need facilities to mange unpredictable complications. Rarer in elective cases but still occur. Commitment and availability of care providers	Similar	Similar	SI Worse	SI Better	SI Worse	Similar	Don't Know	SI Better		Radiology/ CT impact needs modelling. Are available on CGH but staffing 24/7 tbc. Theatres need modelling	Already on the CGH site but? Genomics more volume.
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		Don't Know	Similar	Similar	Don't Know	Similar	Similar	SI Better	Similar		Theatre capacity is lacking Inadequate Theatre and Critical Care facilities at GRH at present. ITU patients frequently cared for in Recovery	Much of infrastructure in place. Will need optimising and staffing and maintaining.	SI Better	SI Worse	Similar	SI Better	Similar	SI Better			Theatre capacity required - req further modelling	No new build required Evidence in estates capacity plan required.
3.7 What is the likelihood of this solution having access to the required technology to be successfully implemented?	No impact	No impact	Similar	Similar	Similar	Similar	Similar	Similar	Don't Know	Similar	One place would have the latest technology		no changes	Similar	Similar	Similar	Similar	Similar	SI Better	Similar	SI Better		Would have to invest in laparoscopic equipment	Robotic surgery
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.	Don't Know	Similar	SI Worse	Don't Know	Similar	SI Better	Don't Know	Similar			Relies on introduction of new junior doctor & consultant cover rotas to provide weekend cover Yes DCC, Appropriate anaesthetic support. Junior staff out of hours ?? ANPS ?? how trained. middle grade rota and consultant rota needs to be in place or to evidence that they have full cover. Consultant and F1 rotas would need to be developed. Requires additional staff	SI Worse	SI Worse		SI Worse	Similar	SI Worse				Recovery mechanism not within 1-2 years	Cannot deliver in isolation. ANPs and rotas need to be modelled/ provided Not dependent on other specialties other than GS. Need to create theatre space and small # beds Extra rota / weekend cover

Acceptability	Pre Workshop Information Pack - Evidence from Workstreams		Pre Workshop Scores								Pre Workshop Scorer Comments	Workshop Scores								Workshop Scorer comments
			Table 1	Table 2	Table 3	Table 4	Table 5	Table 6	Table 7	Table 8	comment	Table 1	Table 2	Table 3	Table 4	Table 5	Table 6	Table 7	Table 8	comment
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		Sig Better	Don't Know	Don't Know	SI Better	SI Better	SI Better	SI Better	SI Better	Public see this a means of reducing waiting times I'm not sure there is a good solution for out of hours care. Has been well researched and presented Patients do not want their operations cancelled this change would be a move towards satisfying that issue. There is likely to be positive support for services moving to Cheltenham, there is general support for centres of excellence. There are not a lot of specific references to elective colorectal in the engagement feedback	Similar	SI Worse	SI Better	SI Better	Similar	SI Worse	SI Worse	Don't Know	Engagement report - questions addressed Better for people concerned about CGH downgrade Engagement Report - Balances services at both sites. Supports a vibrant future for CGH. Pitch - not a decisive clinical benefit; a lot of concerns, so harder to identify benefits compared to current. Which site for colorectal not clear If we move elective to CGH we still have the same risk on emergencies so why would we promote?

Workforce	Pre Workshop Information Pack - Evidence from Workstreams		Pre Workshop Scores								Pre Workshop Scorer Comments			Workshop Scores							Workshop Scorer comments		
	What would be better	What would be worse	Table 1	Table 2	Table 3	Table 4	Table 5	Table 6	Table 7	Table 8	What would be better	What would be worse	Other comment	Table 1	Table 2	Table 3	Table 4	Table 5	Table 6	Table 7	Table 8	What would be better	What would be worse	Other comment
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.	Don't Know	SI Better	SI Better	SI Better	SI Better	SI Better	SI Better	SI Better	better overall but may impact GRH colorectal nursing staff who will be transferred. More resilience to absentees will result Greater efficiency due to 'planned' nature of the change	Probably poor due to duplication of staff. reduces flexibility provided by all staff being based in one location and colocated with UGI and EGS	Efficiency and flexibility are the main themes. These factors seem to be inter related- you can't have one without the other. The development of a single unit will lead to greater efficiency/flexibility of working. However, these efficiencies are offset by the inability to staff the elective and EGS rotas at F1 and consultant level if the unit is on a separate site from EGS. There is actually reduced flexibility to cover unexpected absence if separate. This will take time as staff transfers/recruitment/upskilling required.	SI Worse	SI Worse	Similar	Sig Better	SI Better	Sig Worse	Sig Worse	Sig Better	Centralisation positive i.e. dedicated elective time but uses same team allocated based on time (shifts); so split across sites	Single unit positive but separate sites negative Reduced resilience from EGS	Middle grade staff covering EGS?
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	Don't Know	Sig Better	SI Better	SI Better	SI Better	Sig Better	Sig Better	SI Better	Better delivery of service to the patient and I would expect a happier work force. General surgery staff required to support vascular surgery at CGH and to provide a general surgical service to a sick and elderly patient population (medical, CoE, Ortho). Elective GI surgery in CGH will ensure this human resource is gainfully employed, and will enable prompt consultant surgeon review.	Specialist nursing staff have significant workloads with patients undergoing both panned and emergency care. Separation of EGS from inpatient CR work will result in inefficiencies with increased travel between sites	Consolidates skills and experience. Potential to develop 'centre of excellence'	SI Worse	SI Worse	SI Better	Sig Better	SI Better	SI Worse	SI Worse	Sig Better		Single unit positive but separate sites Inefficient - negative Difficulties to cover rescue	
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	Don't Know	Similar	Don't Know	Similar	SI Better	Sig Better	Similar	Similar	benefits from colocation with urology, gynae & gastro Benefits of co-location with urology,gynae-oncology and medical gastroenterology. This would make sense to be working alongside these other departments.			Similar	Similar	Don't Know	Similar	Similar	Similar	Similar	Don't Know			No change to current
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	Sig Better	Similar	SI Better	SI Better	Similar	SI Better	Sig Better	SI Better	improved opportunities for staff development Sharing knowledge- opportunity for career progression/ movement. Potential to expand role of specialist nurses Staff would be able to decide where they want to work and if they wanted to be part of a dedicated specialist team Opportunities to enhance roles due to stable nature of the environment.	Spread too thinly I worry.		SI Better	SI Worse	SI Better	SI Better	SI Better	SI Worse	SI Better	Sig Better	Opportunity	Emergency and planned separation causes issues. Benefits of colorectal on single site.	Needs to be safe
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.	Don't Know	Similar	Similar	SI Better	Similar	SI Better	Similar	SI Better	dedicated group working will reinforce the team working ethos and allow mutual support at difficult times cross cover, multi-site cover. should offer better group cohesion, team working and positive work experience. Dedicated environment Staff have a well being hub and would be supported by the Seniors in the team		Mindful of the support transferring staff would need.	Similar	Similar	Similar	SI Better	SI Better	Similar	SI Better	Sig Better	For medical and nursing staff there is a benefit from the structure due to split of elec from emerg		Take out variability in elective activity
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 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.	There may be some staff dissatisfaction in respect of staff who prefer GRH as base.	Don't Know	Sig Better	SI Better	SI Better	Similar	Sig Better	SI Better	SI Better	improved opportunities for staff development for the majority should improve the desirability to work as a colorectal specialist (ward nursing, specialist nursing, medical and support. Opportunity to progress etc- the unit sounds like somewhere staff would want to stay and attract staff in to work. Elective / Emergent split considered gold standard		Improved infrastructure and working environment to maintain skills and validations.	SI Better	SI Better	SI Better	Sig Better	SI Better	Similar	SI Better	Sig Better	Dedicated ward/ complete separation is positive. Jr Drs excl		Nursing impact / rotation
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.	No impact	Don't Know	Sig Better	SI Better	SI Better	Similar	Similar	SI Better	SI Better	A dedicated team is able to provide training at all levels due to the new working styles provided by the single site If good access to training in both emergency and elective cases can be maintained. Based on the notes above I would expect the unit to be able to retain as well as attract staff in.	If on a separate site from EGS this will reduce the learning experience and puts allocations at risk. Feedback likely to be worse. Lack of viable F1 rota puts retention of F1s at risk. rotas likely to have negative impact on training opportunities		SI Worse	SI Worse	Similar	Similar	Similar	Similar	Similar	Sig Better	staff can concentrate on non-elective; not distracted by emergency	Not enough F1 to staff Model H Rota dependent Who is looking after patients at night? Deanery prefer trainees to work on 1 site only so split in GS is negative	No improvement as bad situation.
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	Don't Know	Sig Better	SI Better	SI Better	SI Better	SI Better	SI Better	SI Better	A dedicated team is able to provide training at all levels due to the new working arrangements allowing more training time Greater opportunity to provide enhanced sub-specialist colorectal training e.g. early rectal cancer treatment and pelvic floor. This can only be a good thing for patients, also an opportunity to continue for Gloucestershire to pioneer in oncology.	Trainees and trainers may frequently be working on different sites	If implemented a 1 in 4 weekend rota would likely mean reduced availability for normal clinical duties and training	SI Better	SI Worse	Similar	SI Better	Similar	Similar	SI Better	Sig Better	More time & focus. Better backfill system.	Education supervision needs time with trainee. New model split site limits contact	
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	Don't Know	Sig Better	SI Better	SI Better	Similar	SI Better	SI Better	SI Better	would provide career development & advancement opportunities at all levels Optimises the learning environment- I imagine this promotes curiosity/ innovation- how can we continually improve patient care/ treatments etc. Greater opportunity to deliver subspecialist training			Similar	Sig Better	Similar	SI Better	Similar	Similar	SI Better	Sig Better	Centralisation		Only if rotating nurses
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	Don't Know	SI Better	SI Better	SI Better	Similar	Similar	SI Better	SI Better	would provide career development & advancement opportunities at all levels More opportunity for training and accreditation and career advancement should improve staff morale Less variation in cases numbers			Similar	Sig Better	SI Better	SI Better	Similar	Similar	SI Better	Sig Better			
4.11 What is the likely effect of this solution on the travel burden for staff? e.g. relocation time and cost.	Further analysis required	Further analysis required	Don't Know	Don't Know	Don't Know	Don't Know	Similar	SI Better	Similar	Similar	Will enable selective site working.	Relocated GRH nursing staff may have increased travel costs that will need to be addressed Specialist nurses will need to see elective and emergency patients - increased travel burden if separate from EGS	further analysis required	SI Worse	SI Worse	Don't Know	Don't Know	Similar	Don't Know	SI Worse	Don't Know		Colorectal staff - CGH	Impact needs to be modelled. Potentially offset as other GS services also switch sites Might be for specific groups, but have the opportunity to stay.
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	Don't Know	Similar	Similar	SI Better	SI Better	SI Better	SI Better	Don't Know	Better access to training opportunities due to the planned nature of the service that is not stressed by the need to provide emergency cover All consultants providing planned care on a single site would allow tailored and more flexible training opportunities for trainees,		Challenge to support complex surgery in multiple locations. Clinical supervision will be similar, educational supervision will be diminished	SI Better	Similar	Similar	SI Better	SI Better	SI Better	SI Better	Sig Better		Split sites impact on Specialist nurses	

C6: Centralise elective colorectal to Gloucestershire Royal Hospital (GRH) – Model E

Quality	Pre Workshop Information - Evidence from Workstreams		Pre Workshop Scores		Pre Workshop Scorer Comments			Workshop Scores		Workshop Scorer comments		
	What would be better	What would be worse	Table 2	Table 6	What would be better	What would be worse	Other comment	Table 2	Table 6	What would be better	What would be worse	Other comment
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	SI Better	Sig Better	Improved access to subspecialty care. Continuity of care. Improved access to specialist care and nursing teams			SI Better	Similar	Subspecialty positive. Same site as EGS positive Deteriorating patient can be managed by EGS sub-spec team (if on same site)	Potential for negative impact on 18 weeks Referral to Treatment (Don't cancel cancers) Potential increased risk of elective cancellations Possibility of elective beds being used for Emergencies (refer to Royal College guidance as counter to this)	Acknowledge risk of EGS encroaching on Elective care. Joint cases at present happen at 'dominant' speciality site; this would continue in this solution Haven't yet experienced centralised take; but knowledge of both CGH and GRH takes; so can envisage solution with Elective Colorectal working
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 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.	No impact	SI Better	Sig Better	Subspecialty medical and nursing care enhanced, safe management of the deteriorating patient. Consultant continuity Definitely better outcomes access to specialist nursing teams. Quick access if re-admission needed			Sig Better	Similar	Deteriorating Pt on same site, sub-spec and enhanced service		
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	Sig Better	Sig Better	Consultant review 365 days a year Patients would not need to move between wards and have access to the same team and reduce need for out of county transfers			SI Better	SI Better	Seen on Sundays		
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	Similar	Similar	Team would have access to the other agencies		No comment	Similar	Similar	Upside with EGS	Downside losing Uro/Gynae	
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	SI Better	Don't Know	Dedicated ward. RCS document - "A physical separation of services, facilities and rotas works best although a separate unit on the same site is preferable to a completely separate location." The care environment is already excellent but specialist teams would benefit all patients			SI Better	SI Worse	Centralisation of service positive	Reduced protection of elective patients from emergency pressure Increased risk of overflow and or cancellation	
1.6 What is the likely effect of this solution on encouraging patients and carers to manage self-care appropriately?	No impact	No impact	Similar	Similar	Encouragement to manage from the team but no real impact		No comment	Similar	SI Better			
1.7 What is the likely effect of this solution on enabling patient transfers within a clinically safe time frame?	No impact	No impact	Similar	Similar	Improved access to other teams		No comment	SI Better	Similar	Sub-spec and emergency team on same site		
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	SI Better	SI Better	Rapid access to staff and theatres is EGS on same site. Subspecialist team available to look after deteriorating patient. Other teams on site			Similar	Sig Better			
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.	Similar	Similar			No comment some patients will travel further no detail on cohort negatively affected	Similar	Similar			
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	SI Better	SI Better	Rotas are in place at all levels, subspecialty care provided Staff rotas would be improved			Sig Better	Similar			

Access	Pre Workshop Information Pack - Evidence from Workstreams		Pre Workshop Scores		Pre Workshop Scorer Comments			Workshop Scores		Workshop Scorer comments		
	What would be better	What would be worse	Table 2	Table 6	What would be better	What would be worse	Other comment	Table 2	Table 6	What would be better	What would be worse	Other comment
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	SI Better	Sig Better	Improved waiting times Meets with the necessary requirement			SI Better	SI Worse	Centralised positive impact	Risk to capacity at GRH for complex electives due to lack of Inpatient beds	Acknowledge extra beds required; mitigating plan needed. Learning from centralisation of vascular is that efficiencies can be made
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	SI Better	Sig Better	Single site of delivery Patients would know where to go and what specialist team they were under			SI Better	SI Better	Single site		
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.	Similar	Similar	Always going to be a problem for some		TBC	SI Worse	Similar	1 site		
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	SI Better	SI Better	Improved ability to achieve national waiting times Reduce waiting times and have specialist treatment promptly			Similar	SI Worse	Centralisation +	Single site impacting elective capacity - need bed modelling	
2.5 What is the likely effect of this solution on the travel burden for carers and families?	See 2.3	See 2.3	Similar	Similar	better parking at GRH	Always going to be a problem for some	TBC	Sig Worse	Similar			twice the impact of 2.3
2.6 What is the likelihood of this solution supporting the use of new technology to improve access?	No impact	No impact	Similar	Similar			No comment Possibility of robotic surgery	Similar	Similar			
2.7 What is the likelihood of this solution improving or maintaining service operating hours?	No impact	No impact	Similar	Don't Know	Any dedicated service is an advantage		No comment	Similar	Similar			
2.8 What is the likelihood of this solution improving or maintaining service operating locations?	No impact	No planned inpatient colorectal at CGH	Similar	Sig Better	Would maintain or increase what is already have in place		No inpatient CR at CGH Day case colorectal work moved to CGH. Subspecialist Consultant cover out of hours	SI Worse	SI Worse		2 to 1 sites	
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	Don't Know	Don't Know			No comment This is already being done	Similar	Don't Know			
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	Don't Know	Similar			No Comment Not yest scoped	Similar	Similar			

Deliverability	Pre Workshop Information Pack - Evidence from Workstreams		Pre Workshop Scores		Pre Workshop Scorer Comments			Workshop Scores		Workshop Scorer comments		
	What would be better	What would be worse	Table 2	Table 6	What would be better	What would be worse	Other comment	Table 2	Table 6	What would be better	What would be worse	Other comment
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	Similar	Don't Know	Deliverable immediately		Subject to consultation and statutory notice period	SI Better	SI Better	Site co-location with EGS increases likelihood of deliverability. Need to model theatre capacity, bed #. Shorter timescale than C5		Potential to implement in timescale Beds/DCC capacity needed. Theatres OK Would be deliverable in the same time as EGS to GRH .. More modelling to confirm, but months, not years Extra beds at GRH needed Rota flexibility Less frequent on-call versus C5
3.2 What is the likelihood of this solution meeting the relevant national, regional or local delivery timescales?	No impact	No impact	Similar	Similar			No comment No impact	Similar	Similar			
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. Supported by the findings of the Royal College of Surgeons – separating emergency and elective surgical care Report, September 2007	No impact	Similar	SI Better	24/7 cover at all levels. Greater ability to "flex rotas" to cover unexpected (short notice) absence. Extra beds can be made available			SI Better	Similar	Bundled with EGS. See 3.1		
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	Similar	SI Better	Opportunity to introduce other grades of Nurses and Physician Associates		As above	SI Better	Sig Better	Increased efficiency and capacity through centralisation		
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	SI Better	Similar			No comment	Similar	Similar		DCC and Beds challenging	
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	Similar	Similar	Additional beds to be provided Already in place extra beds available			Similar	Similar			More modelling required. Theatre capacity could be met through other options at GRH
3.7 What is the likelihood of this solution having access to the required technology to be successfully implemented?	No impact	No impact	Similar	Similar			No comments	Similar	SI Better			
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	Similar	Don't Know	Doesn't rely on other models Relies on colocation of both EGS and inpatient Upper GI Surgery		No comments	Similar	Similar			Theatre requirements, model of care changes elsewhere. Urology and oncology pathways confirmed

Acceptability	Pre Workshop Information Pack - Evidence from Workstreams		Pre Workshop Scores		Pre Workshop Scorer Comments	Workshop Scores		Workshop Scorer comments
			Table 2	Table 6	comment	Table 2	Table 6	comment
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		SI Better	Sig Better	Very well evidenced	Similar	Don't Know	Engagement Report - negative perception of service moving from CGH. Pts transferring from CGH to GRH. Surgeon on site Pitch - c.f to current: 2 x + domains (quality & Workforce), 2 x = domains (access & deliverability) Nett out Acknowledge there is not clinical consensus for this solution (or C5) Not aligned to pure EI/EMX split, but doesn't mean it is not a CoEx for Elective Care (if UGI remains in GRH) Addressed the questions from outcome of engagement Could be perceived as 'yet another' service going to GRH As a Cheltenham resident, would prefer to go to specialist site Differing clinical views for Elective Colorectal, no consensus among clinicians

Workforce	Pre Workshop Information Pack - Evidence from Workstreams		Pre Workshop Scores		Pre Workshop Scorer Comments			Workshop Scores		Workshop Scorer comments		
	What would be better	What would be worse	Table 2	Table 6	What would be better	What would be worse	Other comment	Table 2	Table 6	What would be better	What would be worse	Other comment
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.	Similar	SI Better	The development of a single unit will lead to greater efficiency/flexibility of working. Rotas are in place if on the same site as EGS. Sub specialty CR consultant review at weekends by emergency CR consultant.			Sig Better	SI Better	Centralisation and sub specialisation		Positive for staff in general, once move has taken place (may be some resistance from CGH teams (medical and nursing) initially) Less frequent on-call versus CS Travel burden includes inter-site as well as getting to work Advantages for staff
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	Sig Better	SI Better	Minimises travel between sites. Nursing and medical review of patients facilitated by having planned and emergency patients in the same building albeit separate wards. Staff would be working as a team			Sig Better	SI Better			
4.3 What is the likely effect of this solution on supporting cross-organisational working across the patient pathway?	No impact	No impact	Similar	Sig Better	Training opportunities available		No comment	Similar	Sig Better			
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	Similar	Sig Better	Potential to expand role of specialist nurses	Required funding		Sig Better	Sig Better			
4.5 What is the likely effect of this solution on supporting staff health and wellbeing and their ability to self-care?	Colocation of the team with EGS 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 existing 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.	SI Better	Sig Better	Dedicated environment Well being hub in place and team to support			Similar	Sig Better			
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	SI Better	Sig Better	Dedicated environment Recruitment and retention would improve due to opportunity for training and working within a dedicated team cohesive unit with a clear future vision will attract high quality staff			SI Better	SI Better	Dedicated, complete separation		
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	Sig Better	Sig Better	Consistent access to educational supervisor if on same site as EGS. Enhanced environment likely to result in better feedback. Compliant, less onerous rotas will also improve feedback.		Provision of training times	Sig Better	Sig Better	Availability to Trainee; sub-spec training		
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	Sig Better	SI Better	Trainees and trainers will consistently be on the same site The trainers would have dedicated times for students			SI Better	Sig Better	Education supervision, physical availability		
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	Sig Better	SI Better	Greater opportunity to deliver subspecialist training The opportunity to improve skills and knowledge with support from Seniors in the team			Sig Better	Sig Better			
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	SI Better	SI Better	Less variation in cases numbers		No comment	Sig Better	Sig Better			
4.11 What is the likely effect of this solution on the travel burden for staff? e.g. relocation time and cost.	Further analysis required	Further analysis required	Don't Know	SI Better		There will always be some staff that will be disadvantaged	No comment	Similar	SI Better			
4.12 What is the likely effect of this solution on maintaining clinical supervision support to staff?	Colocation of planned colorectal with EGS would ensure trainers would be on the same site as the trainees each week	No impact	Similar	Sig Better	Both clinical and educational supervision will be maintained The Seniors will be on hand to supervise and advise			Similar	Sig Better			

B2: Centralise the image-guided interventional surgery (IGIS) 'hub' to GRH including vascular; IGIS spoke at CGH – Models D & G

Quality	Pre Workshop Information - Evidence from Workstreams		Pre Workshop Scores				Pre Workshop Scorer Comments			Workshop Scores				Workshop Scorer comments		
	What would be better	What would be worse	Table 3	Table 4	Table 7	Table 8	What would be better	What would be worse	Other comment	Table 3	Table 4	Table 7	Table 8	What would be better	What would be worse	Other comment
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.		Sig Better	Sig Better	Sig Better	SI Better	Positives: Reduction in out of county transfers. Consolidation of inter-related services. Ability to carry out more and different procedures will attract higher quality staff and improve retention centralised hub of expertise	Reduced ability to support essential services on CGH site (oncology, urology, medicine)	Not clear if embolectomy for stroke patient's is planned?	Sig Better	Sig Better	Sig Better	SI Better	Provides 24/7 Significant - 24/7 service that is currently not offered.	Concerns around planned vascular	Query on how staffing will work Need to consider renal - vascular interaction
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)		Sig Better	Sig Better	Sig Better	Sig Better	Co-location of IGIS and Vascular would seem best given that many patients require input from both services.			Sig Better	Sig Better	Sig Better	Sig Better	Better connectivity		Ability to provide staffing to be resolved/confirmed
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.		Sig Better	Sig Better	Sig Better	Sig Better	Significantly better for those patients who would previously have been transferred out of county.	Some patients may have an inter site transfer after their care in the IGIS hub depending on which specialist ward they need to access		Sig Better	Sig Better	Sig Better	Sig Better			Current CA patients going to Leeds (get eg numbers) colorectal / liver mets
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	Similar	Similar	Similar	Similar	more likely to develop links with other agencies that are condition specific	May lose touch with outreach support in local communities		Similar	Similar	Similar	Don't Know			
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		Similar	Sig Better	Similar	Similar	Reducing transfers either between hospital sites or out of county will be beneficial to those with dementia by reducing their confusion and alienation likewise those with other mental health conditions.		The IGIS hub can only progress with capital redevelopment to provide a new IGIS centre. This would provide a much enhanced clinical environment in new build facilities	Don't Know	Sig Better	Sig Better	SI Better	Guilting ward now IGIS refurb positive. Equipment a lot better DC unit for CAR & IR is in the plan Hub will be better		Dependent on the facility used to accommodate Assured Estates plan in place to facilitate - depends on specialist dedicated centre Dependant on new facility Assume estates plan delivery appropriate 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	Similar	Similar	Similar	Similar	Discussions between patients and their family/carers and specialist staff could take place in one location			Similar	Similar	Similar	Don't Know			Pathways are critical
1.7 What is the likely effect of this solution on enabling patient transfers within a clinically safe time frame?	No impact	No impact	Similar	SI Better	Sig Better	SI Better	Overall I expect a net benefit would occur in terms of mean travel times	No on site access to IG/Vasc support at CGH		SI Better	SI Better	SI Better	Sig Better	Not moving patients to Bristol / Swindon Reduction in out of county transfers 24/7 PCI	Occasionally CGH may need Vascular surgery provision.	Some transfers from CGH - 5 ptnts yr? Check and validate. May be more 1 every 2/52 Pathway need to be in place Out of county
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. 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.		SI Better	SI Better	Sig Better	SI Better	Streamlined care pathways and procedures, clearer accountability, consolidated staffing and expertise, should improve timeliness of intervention and improved outcomes.			Sig Better	Sig Better	SI Better	Sig Better			PCI AAA Trauma pathways to be considered Need pathways for Vascular surgery need at CGH
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		Similar	SI Better	Sig Better	SI Better		patients who would previously have been transferred out of county has to be balanced by a potentially longer journey for those that would otherwise have gone to CGH though this is likely to be minimal in a blue light scenario.		SI Better	SI Better	SI Better	SI Better	Travel time to Bristol eliminated Ambulance will know where to go		
1.10 What is the likely effect of this solution on patient safety risks?	No impact	No impact	Similar	Similar	Sig Better	Similar	One hub with enhanced facilities improves patient safety and outcomes			Sig Better	Sig Better	Sig Better	Sig Better	Ref critical incidents relating to services being on a different site, equipment on a different site. Red risk rating & missing consultants on a 24/7 HR rota. Improves environment.		24/7 IGIS on call rota assumptions 24/7 PCI

Access	Pre Workshop Information Pack - Evidence from Workstreams		Pre Workshop Scores				Pre Workshop Scorer Comments			Workshop Scores				Workshop Scorer comments		
	What would be better	What would be worse	Table 3	Table 4	Table 7	Table 8	What would be better	What would be worse	Other comment	Table 3	Table 4	Table7	Table 8	What would be better	What would be worse	Other comment
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	Similar	Similar	Don't Know	Similar				Similar	Similar	Sig Better	SI Better	Choice of local Ca centre locally (not ooA) and EP in Glos. Interventional oncology service will increase patient choice of providers Improve patient access to services locally (not Bristol/Leeds/Birmingham)		need to build more capacity Report OOC More patients in West of county therefore Net benefit
2.2 What is the likely effect of this solution on simplifying the offer to patients?	No impact	No impact	Similar	Similar	Sig Better	Similar	A "one stop shop" would simplify patient decisions		Patients are unlikely to need to know the location of IGIS hub services as they would only access them through other emergency pathways	Similar	Similar	Similar	Similar			Could offer direct access later down line.
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.	Similar	Don't Know	SI Worse	Similar		travel times and costs from the east of the county would rise and frequency of visits from family/carers may reduce, which may increase anxiety in the patient	Even if the net travel time is zero because some patients will be shifted in both directions, we have to remember that for the patient in front of us that travel time might be a big problem.	Similar	SI Better	SI Better	SI Better	Better offer reduces out of county Better for FoD and Glos populations		
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.		SI Better	Don't Know	Similar	Similar	Should improve waits from ED Likely balance - improvements for some IR procedures for acute medicine at GRH, worse for procedures required for CGH patients	Depends on staffing and availability of bed space		SI Better	Don't Know	SI Better	Similar	Evidence from the pack GRH patients for cardio. Some elective done more quickly than Birmingham 24/7 rota		More evidence required incl OOH impact will not impact 18 RTT cancer need more info
2.5 What is the likely effect of this solution on the travel burden for carers and families?	See 2.3	See 2.3	Similar	Don't Know	SI Worse	Similar		net travel might be zero but the individual families may well be highly effected by it.		Similar	Similar	SI Better	SI Better	Significant for OOC		
2.6 What is the likelihood of this solution supporting the use of new technology to improve access?	No impact	No impact	Similar	Don't Know	Sig Better	Similar	New interventional technologies are advancing and a re purposed 'hub' could lead the way in innovation and integration with existing radiological/imaging technologies for example.			SI Better	Sig Better	Similar	SI Better			Caveat is cost of providing kit/ equipment Consolidate.
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		SI Better	Sig Better	SI Better	SI Better	Consolidated expertise, infrastructure and rotas			Sig Better	Sig Better	Sig Better	Sig Better	Step change to a 24/7 rota Consolidate onto 1 location		Consolidate.
2.8 What is the likelihood of this solution improving or maintaining service operating locations?	No impact	For some patients there will be a reduction in service operating locations	Similar	SI Worse	SI Better	SI Worse				Similar	Similar	Sig Better	SI Worse	Quality improved.		
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	Similar	Don't Know	Don't Know	Similar	Overall patient care is enhanced which is good for everyone.	The travel burden will disproportionately affect people with disabilities who are statistically less likely to drive or have access to a car	Those that are already subject to inequalities may be impacted more than those that aren't.	SI Better	Don't Know	SI Better	Similar	Positive impact on right area of need (Glos / West) Some people not getting the service at the moment as out of County. Potential to help disadvantaged groups more.	Population in FOD and Gloucester impacted on.	
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	Similar	Don't Know	SI Better	Don't Know		The IGIS hub would need to be sized to take account of future demography. Setting up a new hub allows for this sizing to be considered. Existing capacity is already under pressure		Don't Know	SI Better	Sig Better	Don't Know	Improved resilience More efficient service		Consolidate.

Deliverability	Pre Workshop Information Pack - Evidence from Workstreams		Pre Workshop Scores				Pre Workshop Scorer Comments			Workshop Scores				Workshop Scorer comments		
	What would be better	What would be worse	Table 3	Table 4	Table 7	Table 8	What would be better	What would be worse	Other comment	Table 3	Table 4	Table7	Table 8	What would be better	What would be worse	Other comment
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.		Similar	Don't Know	Similar	Don't Know			dependant on the Trusts ability to finance the required equipment and staffing	Don't Know	Don't Know	SI Better	Don't Know			Timescale unknown, can start the process Phases fairly clear. Timescale unclear
3.2 What is the likelihood of this solution meeting the relevant national, regional or local delivery timescales?	No impact	No impact	Similar	Don't Know	Don't Know	Don't Know				Don't Know	Don't Know	Similar	Don't Know		PCI time to balloon.	No external drivers. Evidence to incl. more national standards add evidence on primary angioplasty
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. Many large items of imaging equipment are now due or approaching planned replacement.		SI Better	Don't Know	Similar	Don't Know				Don't Know	Don't Know	SI Better	Don't Know		Loss of ambulances out of County.	
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.		SI Better	SI Better	SI Better	Similar	Consolidation of staffing will improve resilience. Exposure to more and different procedures will improved capability of clinicians. Should enhance staffing capacity and recruitment of new staff			Sig Better	Sig Better	SI Better	Don't Know	Only way to get a 24/7 rota. Reduces requirement for vol staff recruitment		
3.5 What is the likelihood of this solution having access to the required support services to be successfully implemented?	No impact	No impact	Similar	Similar	SI Better	SI Better	Easier to provide support services to one hub rather than three IGIS locations as now		Dependant on the ability of other parties (Local government GPs) to provide assistance	Don't Know	SI Better	SI Better	SI Better	Centralised in consolidated hub ED, EGS, Cardiology, Vascular all interrelated. Cardiology needed at GRH - already in place	Vascular more complex	
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.	Don't Know	Don't Know	Don't Know	Don't Know			Estates plans and costs unknown. Can sufficient daycare beds be made available at GRH for this increased demand?	Don't Know	Don't Know	SI Better	Don't Know			Dependent on many other moves and £. Availability of beds Vascular element requires acute site development. CAR / IR scoped and do able. Displace services or new site important but don't know
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.		SI Better	SI Better	SI Better	SI Better		If the IGIS hub was provided new equipment / technology would have to be made available	Equipment replacement programme ongoing	Don't Know	Sig Better	SI Better	Sig Better	New equipment to incorporate into new facility. Technology *** Don't have it currently but if we implement	Funding?	
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	See 3.6	Don't Know	Don't Know	Don't Know	Don't Know			Funding and availability of social care	Don't Know	Don't Know	SI Worse	Don't Know		Lots of co-dependencies relies on vascular workforce issues	bed impact and who moves? Neither better or worse but possible important but don't know

Acceptability	Pre Workshop Information Pack - Evidence from Workstreams	Pre Workshop Scores				Pre Workshop Scorer Comments	Workshop Scores				Workshop Scorer comments
		Table 3	Table 4	Table 7	Table 8	comment	Table 3	Table 4	Table 7	Table 8	comment
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	Similar	Don't Know	SI Better	SI Better	Idealistic patients would prefer all services to be offered on both sites. Need to efficiently show advantage of the change to the public Will need to explain how the IGIS service supports better outcomes for patients, and the fit with the emergency care offer which was a primary concern in the survey responses	Similar	SI Better	Sig Better	SI Better	Subject to: clarify vascular within the model. Explain what is available where. What is retained/not included. How does this fit with the 2013 service change? Need to be clear about interdependincy with other services. Clarify vascular better

Workforce	Pre Workshop Information Pack - Evidence from Workstreams		Pre Workshop Scores				Pre Workshop Scorer Comments			Workshop Scores				Workshop Scorer comments		
	What would be better	What would be worse	Table 3	Table 4	Table 7	Table 8	What would be better	What would be worse	Other comment	Table 3	Table 4	Table 7	Table 8	What would be better	What would be worse	Other comment
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.	SI Better	SI Better	Sig Better	Similar	Consolidation of staffing will improve resilience. Exposure to more and different procedures will improved capability of clinicians. Exposure to more and different procedures will improved capability of clinicians.			SI Better	Sig Better	Sig Better	Sig Better			Caveat: CGH staff to GRH. Impact understood. Staff recruitment offer. Clarify Cheltenham staffing rota Group felt that this was important - but were unable to score lots of overlap in quality would like more evidence Slighthly better for staffing
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.		Sig Better	Sig Better	Sig Better	Sig Better	it will be more efficient to have staff on the same site rather than moving around, and available for more services.			Sig Better	Sig Better	Sig Better	Sig Better			
4.3 What is the likely effect of this solution on supporting cross-organisational working across the patient pathway?	No impact	No impact	Don't Know	Similar	SI Better	SI Better	If all relevant staff are at one location this should be easier			Similar	Similar	SI Better	Similar	Improved / dual training CAR/Vasc/IR		
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.		SI Better	Sig Better	Similar	Sig Better	Exposure to more and different procedures will improved capability of clinicians at all levels making their deployment more flexible.			SI Better	Sig Better	SI Better	Sig Better			Some resistance for some people to overcome.
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	Similar	Sig Better	Similar	SI Better	Improving recruitment and retention of staff will increase the resilience of the team.		Happy staff makes for happy patients.	Similar	SI Better	SI Better	SI Better			
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	Sig Better	Sig Better	SI Better	SI Better	There is likely to be an improvement in the recruitment and retention of staff which will increase the resilience of the team due to enhanced staffing levels and greater opportunities to enhance clinical skills.		Is creating a central hub sufficient to make the Trust attractive enough to be able to recruit in sufficient numbers?	Sig Better	Sig Better	Sig Better	Sig Better	Hub and equipment		
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	Sig Better	Don't Know	SI Better	SI Better	More senior staff to act as clinical supervisors and a greater range of clinical opportunities.		Although some staff from CHG might not be happy, hopefully the training and staff development will work for both hospitals	SI Better	SI Better	Sig Better	Sig Better			Evidence to highlight trainee opportunities and allocation wider question on 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?	The co-location of IGIS facilities will improve the ability to train junior radiographers across all IGIS competencies		Sig Better	Sig Better	SI Better	SI Better	access to train across the domain making it easier to give better training.			SI Better	SI Better	Sig Better	Sig Better			
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.		Sig Better	Sig Better	Sig Better	SI Better	It will make it easier for staff to upgrade and train to higher levels.			SI Better	Sig Better	Sig Better	Sig Better			
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	Similar	Similar	SI Better	SI Better	If they are happier and more fulfilled they are more likely to utilise all their skills.			SI Better	Sig Better	Sig Better	Sig Better			
4.11 What is the likely effect of this solution on the travel burden for staff? e.g. relocation time and cost.	Further analysis required	Further analysis required	Don't Know	Don't Know	SI Worse	SI Worse		Need for improved transportation from CGH and improved stafff parking at GRH	if staff are redeployed from Cheltenham to Glos there may be increased travel time and cost, as some people will have moved to Chelt to be close to work.	Don't Know	Don't Know	SI Worse	Don't Know			Staff impact to be understood CGH to GRH
4.12 What is the likely effect of this solution on maintaining clinical supervision support to staff?	No impact	No impact	SI Better	Don't Know	SI Better	SI Better	If most staff are on the same site then supervision should be easier?			SI Better	Sig Better	Sig Better	Sig Better		Dependent upon supervision of staff	

B3: Centralise the image-guided interventional surgery (IGIS) 'hub' at GRH, with IGIS spoke at CGH and with the vascular arterial centre remaining at CGH – Model F

Quality	Pre Workshop Information - Evidence from Workstreams		Pre Workshop Scores		Pre Workshop Scorer Comments			Workshop Scores		Workshop Scorer comments		
	What would be better	What would be worse	Table 1	Table 5	What would be better	What would be worse	Other comment	Table 1	Table 5	What would be better	What would be worse	Other comment
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 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 could be offered locally.		Sig Better	Similar	colocation of IGIS with the trauma unit will reduce time to intervention for many emergencies hopefully reducing the mortality rate I would expect to see an improvement in patient and visitor satisfaction surveys because they would be closer to home	Vascular Surgery is a largely emergency or elective service. Removing the capacity for endovascular procedures to be undertaken in CGH will result in much poorer outcomes, longer stays and is against the rules!	Full technology available 24/7 is of supreme importance as medicine evolves but basic IGIS as required by vascular team should remain available in CRH so it is accessible should it be needed for ongoing care.	**Sig Better**	**Similar**	300+ out of county repatriated from Bristol/Oxon/Bham. Centralisation PCIs, OOH sepsis.	Lack of co-location with vascular - compromise safety Red Risk. Also separation from Urology	Not clear whether there is a detriment to vascullar by moving. Emergency - access to radiographer 10/year emergency vascular procedures Req IR on both sites Benefits of central merger ? Impact on Vascular - risk register Case for change not clear, staffing issues for radiology and cardiology
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)		Sig Better	SI Better	improves availability of specialist expertise Efficient diagnosis and treatment- recovery rates should improve- ideally less time in hospital for the patient and a reduced likelihood of complications.		IR teams in wrong hospital. Patients have poorer access to IR solutions.	**Sig Better**	**Similar**	Patients repatriated from out of county		SLA required to collocate Vasc and IR Cardiology and IR + especially out of hours
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.		Sig Better	SI Better	Reduce out of county transfers and maintains contact with the local team responsible for the patients care	Travel for IR interventions. Already travel for stroke and renal support. We will definitely lose the right commission c=vascular services with this set up. All arterial cases will be managed elsewhere.	The patient can be treated by Gloucestershire health trust- it will be familiar to the patient as well as to their family members.	**Sig Better**	**SI Better**			
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	Similar	Similar		Much poorer clinical linkages and interfacing with other agencies.		**Similar**	**Similar**		Vascular, ? Mini stroke and corotid artery link slightly worse with Vascular	Planning discharge in place. Recovery support as current Simplifies overall process for SWAST
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		Don't Know	Similar	The technical quality of the care environment will improve due to replacement of obsolete and aging equipment but it will have little impact on the other care factors listed above	travel for treatment both from admission and whilst and inpatient. never good.		**Sig Better**	**SI Better**	Solution will require new kit (MES) so better than current although changes will need to be made for status quo		Note need to improve equipment
1.6 What is the likely effect of this solution on encouraging patients and carers to manage self-care appropriately?	No impact	No impact	Similar	Similar	they will have improved access to the specialists to manage their care.			**Similar**	**Similar**			Better access to PCI
1.7 What is the likely effect of this solution on enabling patient transfers within a clinically safe time frame?	No impact	No impact	Don't Know	SI Better	reduction in out of county transfers will improve outcomes	you are locating a major service away from the patients that use it or, conversely, the patients that use a major service away from it.		**Sig Better**	**Similar**	Better for majority, less transfers 300+ cardiology pts and overnight pts will be improved. Also IR on same site as acute Pts	Vascular separation	Benefits for 300 patients going to Bristol currently Need to upgrade equipment
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.		Sig Better	SI Better	better due to colocation with trauma unit having the hub in Gloucestershire should be of a benefit to the patient in respect of convenience at being treated closer to home.	Complex IR will not be undertaken in a timely fashion on Vascular patients that frequently need it.		**Sig Better**	**Similar**	300+ cardiology pts and improved OOH IR	Vascular separation for minority of Pts	
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		Similar	SI Better	Better access for those in the Forest area etc but concerned that no statistics are referenced to support the statement that "this is where the majority of patients requiring IGIS are travelling from" it should be more convenient not having to travel outside of the county for treatment.	Patients going to the wrong hospital and increased emergency inter-hospital transfers.		**Sig Better**	**Similar**	Significant improvements for patients currently going to Bristol		
1.10 What is the likely effect of this solution on patient safety risks?	No impact	No impact	Don't Know	Don't Know	Should be better due to increased availability of experienced staff	impossible to provide out of hours IR service to the level of complexity on both sites.	I would expect for the hub to have the necessary staff otherwise it is not a solution if it cannot operate.	**Sig Better**	**Similar**	Staffing risks are logged - radiographers Reg: Full provision of IR rota	Risk: Lack of PPCI	

Access	Pre Workshop Information Pack - Evidence from Workstreams		Pre Workshop Scores		Pre Workshop Scorer Comments			Workshop Scores		Workshop Scorer comments		
	What would be better	What would be worse	Table 1	Table 5	What would be better	What would be worse	Other comment	Table 1	Table 5	What would be better	What would be worse	Other comment
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	Similar	Don't Know			There should be no impact- any intended change should either maintain the status or improve it. There is no point making changes for a detrimental outcome.	**SI Better**				No more/different choices Overall improve access especially for patients going to Bristol Need to decide where to put it
2.2 What is the likely effect of this solution on simplifying the offer to patients?	No impact	No impact	Don't Know	Similar			this offer is driven by clinical staff and not patients	**Similar**				Some people disadvanted but many more positive
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.	Don't Know	Don't Know	the service improvements should reduce waiting times and thereby gain public acceptance	multiple inter-hospital transfers.	It is understandable that there will be costs to those who live furthest away from the treatment site.	**Sig Better**				New equipment
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.		SI Better	SI Better	Reducing waiting times will lead to public buy-in waiting times will be greatly improved, and being treated within the county will be favourable to locals.	Delay in interventional treatments.		**Sig Better**				
2.5 What is the likely effect of this solution on the travel burden for carers and families?	See 2.3	See 2.3	Don't Know	Don't Know				**Sig Better**				
2.6 What is the likelihood of this solution supporting the use of new technology to improve access?	No impact	No impact	Similar	Don't Know			more clarity needed around what the new technology being referred to is?	**Sig Better**				
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.		Don't Know	SI Better	If it does lead to a 24/7 primary PCI service then this should improve the overall service but I am concerned about staff shortages		Managing patients with one set of clinical problems on multiple sites difficult to provide plurality of staff.	**Sig Better**				
2.8 What is the likelihood of this solution improving or maintaining service operating locations?	No impact	No impact	Don't Know	Similar	Should result in an improved service that will be less easy to travel to for some patients.	cannot deliver same care on multiple sites.		**Sig Better**				
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	Don't Know	Don't Know				**SI Better**				
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	Don't Know	Similar			Careful planning needs to take into account the duty cycles of the technical equipment to ensure that they would cope with increased demands from an aging and increasing population. Estates would need to allow for expansion space when planning the location in GRH	**Sig Better**		Step change in provision - 24/7 IR new service		

Deliverability	Pre Workshop Information Pack - Evidence from Workstreams		Pre Workshop Scores		Pre Workshop Scorer Comments			Workshop Scores		Workshop Scorer comments		
	What would be better	What would be worse	Table 1	Table 5	What would be better	What would be worse	Other comment	Table 1	Table 5	What would be better	What would be worse	Other comment
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.		Don't Know	Don't Know	This solution would help to accelerate the replacement of aging and obsolete equipment			Sl Better				Overall deliverable, need to consider Vascular SOP. Commissioners? Timeliness of equipment replacement
3.2 What is the likelihood of this solution meeting the relevant national, regional or local delivery timescales?	No impact	No impact	Don't Know	Don't Know				Sl Better				CQC required to deliver 24/7 IR rota
3.3 What is the likelihood of this solution having the implementation capacity to deliver?			Sl Better	Don't Know			It needs significant capital expenditure on new equipment and commitment from the manufacturers to deliver within the required timescales	Sig Better				
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.		Don't Know	Sl Worse	should attract new staff as well as helping to retain existing staff		Whilst staff deployment would be more efficient I am concerned that CGH based staff would be reluctant to relocate	Sl Better				
3.5 What is the likelihood of this solution having access to the required support services to be successfully implemented?	No impact	No impact	Don't Know	Sl Worse		Increasing throughput on a single site will inevitably increase demands on the support services		Sl Better		Clinical adjacancies	Slightly worse in comparision with other models	Ref 1:4 for vascular separation. Would need to have an emergency vasc SOP
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)	Don't Know	Sl Better	The positives outweigh the negatives		Will the 'new' location be available in parallel with existing services during the transition period?	Sig Better				
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.		Don't Know	Similar			Requires replacement of existing aging & obsolete equipment - can the manufacturers meet the required timescales?	Sl Better				
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					I am concerned that the increased service needs from the emergency surgery centre of excellence could negate the service improvements provided by the centralisation of the IGIS services					Workforce (labs) MES

Acceptability	Pre Workshop Information Pack - Evidence from Workstreams		Pre Workshop Scores		Pre Workshop Scorer Comments	Workshop Scores		Workshop Scorer comments
		What would be worse	Table 1	Table 5	comment	Table 1	Table 5	comment
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		Don't Know	Don't Know	The public should see the service improvements quite quickly once the service has settled into its new ways of working. Need to 'advertise' the successes effectively the aim is to get the plans through- this will be harder to do without the engagement process and considering the feedback and concerns raised.	Sl Better		Responds to engagement

Workforce	Pre Workshop Information Pack - Evidence from Workstreams		Pre Workshop Scores		Pre Workshop Scorer Comments			Workshop Scores		Workshop Scorer comments		
	What would be better	What would be worse	Table 1	Table 5	What would be better	What would be worse	Other comment	Table 1	Table 5	What would be better	What would be worse	Other comment
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.	Don't Know	Sg Worse	The vision for the hub would mean that the centre was fully staffed, and there would be better capacity to cope with sickness or other issues which might pop up.		CGH based staff may be reluctant to relocate or change their working hours patterns without a significant incentive which may not be monetary but could be improved job satisfaction	Sg Better	Sg Worse		IGIS hub improves OOH but creates operational difficulties; significant challenge - not deliverable	Overall better. plus for IR and Cardio Some centralisation benefits Almost running a tertiary service – if don't develop will lose staff 24/7 cover required for interventional radiology/cardiology
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 by travelling between sites.		Sg Better	SI Better	The benefits outweigh the negatives- it is a better use of manpower- which can only be beneficial to the patient.		Still includes support of the vascular activities at CGH so the staff flexibility is limited	Sg Better	Sg Worse	Centralisation into hub = efficiencies	separation of vascular, emergency and complex Pts having to travel	? Nursing staff Cheltenham move to Gloucester
4.3 What is the likely effect of this solution on supporting cross-organisational working across the patient pathway?	No impact	No impact	Don't Know	Don't Know	Should improve cross-organisational working since this solution should improve staff knowledge and experience making them more adaptable to different environments			Similar	Similar			
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		Don't Know	Don't Know	increased skills gaining opportunities for staff will greatly assist flexible deployment Opportunity to develop innovative nursing and technician roles that support both services.			Sg Better	Similar	Extended scope nursing and radiographers Hub centralisation benefits	Vascular worse	
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	Sg Better	Don't Know	Any solution that reduces staff stress has to have beneficial effects and will improve internal informal 'advertising' that should result in better retention & recruitment More likely to be fully staffed- so people are covering their roles instead of trying to do their own designated role and cover others- which in turn leads to stress			Sg Better	SI Worse	Better resilience, improved scope for development	Vascular staff - No. Also more time in car	
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.	Sg Better	SI Better	The IGIS hubs sounds like a place you would want to to work at, and if you are existing staff there is the opportunity to grow and develop in your career.	Might be a negative impact on staff retention if CGH staff are reluctant to relocate - knock-on effect on recruitment?		Sg Better	Similar	Cardiology good	Vascular worse	
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	Don't Know	SI Better	Should improve staff development due to lower stresses & greater availability of supervisory/training staff			SI Better	SI Worse	Cardiology hub is good. Varied and complex interventions	IP base separate - catastrophic for vascular trainees	Positive cardiology and radiology, no change vascular
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.		Don't Know	SI Better		Might be a negative impact on staff retention if CGH staff are reluctant to relocate - knock-on effect on recruitment?		SI Better	SI Worse			
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.		Sg Better	SI Better		Reduced access of many staff groups to important facilities.		Sg Better	Similar	Cardiology good, IR good	Split site bad, vascular bad	
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	Don't Know	SI Worse		Reduced ability of Vascular Surgeons to undertake interventional procedures.		Sg Better	Similar			
4.11 What is the likely effect of this solution on the travel burden for staff? e.g. relocation time and cost.	Further analysis required	Further analysis required	Similar	SI Better		Will be worse for CGH staff who agree to relocate and may have increased travel times & costs. Transport is a cross-solution problem for both staff and patients. Working closely with the GCC transport team is a MUST		SI Worse	SI Worse		CGH based nursing staff - short term impact for specific staff relocate cardiology to CGH. Travel is unsustainable	
4.12 What is the likely effect of this solution on maintaining clinical supervision support to staff?	No impact	No impact	Sg Better	SI Better	Consultant and staff together in one place at all times.		I would expect for there to be improvements rather than a negative impact	Sg Better	SI Worse			