One Gloucestershire
Transforming Care, Transforming Communities

NHS

FIT FOR THE FUTURE

SOLUTIONS APPRAISAL WORKSHOP INFORMATION PACK

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Contents

1. Introduction

Thank you for taking the time to read this information pack. It has been brought together to help you to assess the working list of ideas/models that has been developed by the Gloucestershire Health and Care System.

1.1. Context

We want local residents to have access to leading edge care and treatment, comparable to the best in England and for our great staff to have the best possible working environments. This means we need to consider how some of our services and sites are organised to ensure they are 'Fit for the Future'. The expectations of healthcare, the demands on health services, and the incredible progress made through science, technology and developing staff skills and expertise has dramatically changed the environment that we are operating in.

As a result, we need to make sure local services are sustainable and can meet the needs of patients, not just now, but long into the future.

As part of the engagement period over the summer and autumn, we set out some thoughts and ideas for how services could develop in an information booklet and supporting materials that can be found at: www.onegloucestershire.net/yoursay/fit-for-the-future

We invited staff, partners and the public to share their own ideas and views and also thoughts on the criteria that will be developed to assess potential solutions.

Thousands of views and ideas were received through a range of opportunities, including a survey, other written submissions, drop in events, independently run workshops and an engagement hearing. The Output of Engagement Report is now publically available on the website above.

2. Solutions Appraisal Workshop

The Fit for the Future (FFTF) Programme requires an evidence-based, transparent and inclusive solutions appraisal process that meets its statutory and assurance requirements, and enables a broad range of participants to help to shape our emerging solutions. The solutions appraisal process needs to enable the programme to sift through a very large number of possible options, the *Long List*, through a smaller number of viable options, the *Medium List,* to allow detailed analysis and modelling of a *Short List* to determine the *Preferred Option* or options that it takes out to consultation.

2.1. Purpose of the Workshop

The objective of the Solutions Appraisal Workshop is to debate, discuss and assess the working ideas (*Medium List)* against a set of evaluation criteria and to discuss and agree what score the group will give to each of the solutions and models.

The process establishes a hierarchy (the *Short List)* and the rationale for them, allowing further detailed analysis to be undertaken that provides material to the decision making body to take account of in deciding which option or options (the *Preferred Option)* is taken forward to consultation.

Any proposals for change are required to undergo a period of formal public consultation, after which due regard is given to the feedback received in the consultation from the public, staff and other interested parties.

2.2. Workshop Format

Schedule	• You will be allocated to a table (4 tables of ~10) • Introduction by external facilitator • Questions on the process/format of the session • Refresher on the Information Pack • Questions of clarification on the Information Pack • Each table will assess a set of solutions, which together comprise a potential Model, against a number evaluation criteria (e.g. Quality of Care) • You will have a print out of your pre-work assessment • Your table facilitator will seek consensus on the score for each question within the selected evaluation domain (e.g. Quality of Care) • The process will be repeated for each of the solutions allocated to your table • Once all solutions are assessed, your table facilitator will seek consensus on the score for the overall Model • There will be a break mid-morning and mid-afternoon and lunch will be provided.
Assessment method	You will be asked to score each Solution to assess if it is: ++ Significantly better than status quo + Slightly better than status quo Similar to status quo - Slightly worse than status quo -- Significantly worse than status quo

2.3. Do I need to do any pre-work?

As stated in the original invitation to the workshop, if you are able to complete your initial assessment of the Solutions prior to the workshop using the web-based application (all the details are in Appendix 1), this will greatly assist the running of the event. Your assistance with this pre-work is much appreciated.

3. How did you get to the current working list of ideas/models?

3.1. Long List

The engagement phase for the Fit for the Future programme has been running since the summer of 2019, and culminated in the Citizens Jury held in January 2020. Online questionnaires and workshops with the public closed at the end of October 2019, with staff engagement through the clinical work streams: General Surgery, Image Guided Interventional surgery (IGIS) and Emergency & Acute Medicine continuing on to January 2020. The clinical working groups, informed by the public engagement (reported in the outcomes of engagement report), developed a long list of possibilities (with no assessment of viability, acceptability or risk), so that "*everything is on the table*" at the start of the process; this included suggestions from the public and groups that were identified through the engagement process.

In some cases Workstreams identified 100s of possibilities which when combined with the other Workstream long lists results in a mathematical possibility in excess of 1600 combinations. In order to have a manageable process for solutions appraisal, some of the possibilities needed to be excluded at this stage to enable a working 'medium list' to be produced, assessed and moved forward to pre consultation business case stage.

3.2. Medium List

The agreed process to *"take solutions off the table"* is to apply hurdle or essential criteria to the individual Workstream Long Lists. These were identified in the draft Pre-Consultation Business Case (PCBC) in July 2019 and following engagement feedback we have added fifth criteria in relation to the Case for Change; these are listed as follows:

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

In addition to application of hurdle/essential criteria, clinicians tested different combinations of solutions to identify interdependencies, ruling out any combinations that would be clinically unviable. The medium list you are reviewing in this workshop therefore presents their worked up proposed medium list and you are now asked to consider which of the medium list options should move forward to be included on our short list.

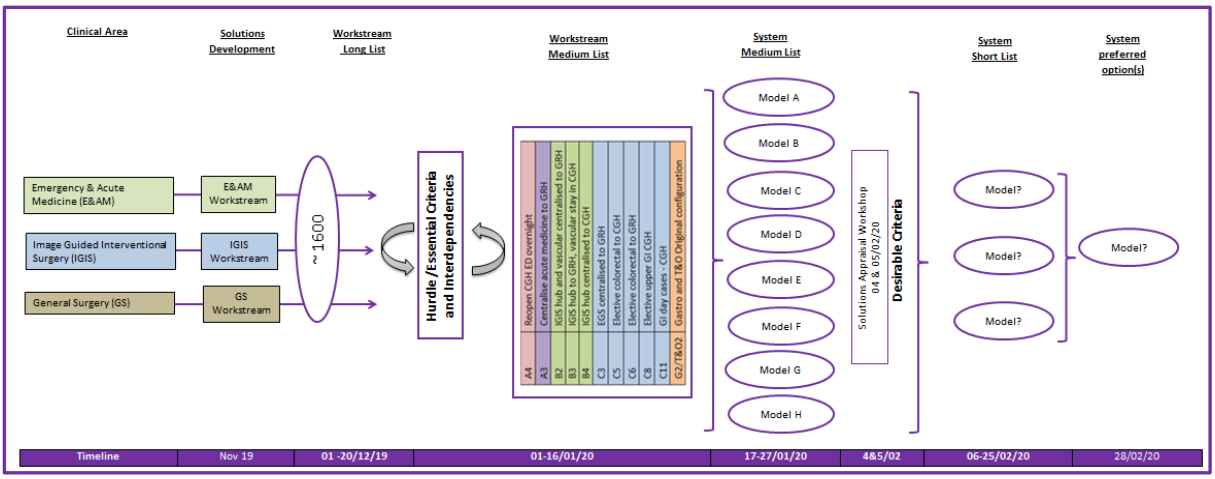
3.3. System Models

As the programme Workstreams are interdependent the process we have undertaken is that, following the application of the hurdle criteria and interdependency assessment, the solutions are bundled/packaged into system models that will then be evaluated using the desirable criteria assessment at the Solutions Appraisal Workshop.

This approach, taking full account of the interdependencies and synergies, have aimed to ensure that the solutions selected for the short list are clinically and operationally viable and potentially deliverable.

3.4. Solutions Development Process – Steps and Timeline

A schematic of the process and high level timeline is presented below:



4. What are the evaluation criteria?

As part of our engagement process we arranged 12 public and stakeholder workshops which considered the question 'what is important to you' to assist with the development of evaluation criteria for potential solutions. A facilitated group exercise at each workshop explored the areas of relative and most importance providing an important step in developing selection criteria for use in our decision-making processes. This feedback had a significant impact on the final set of evaluation criteria; details of which can be found in our Output of Engagement Report (www.onegloucestershire.net/yoursay/fit-for-the-future). We also took account of the draft report of the Fit for the Future Citizens Jury who provided feedback to further shape our criteria.

There are 7 evaluation domains (each with a sub-set of questions). To assist you in scoring each Solution we have presented the information on each of them alongside each question (Appendix 5); however a summary of the 7 evaluation domains is presented below:

Quality of care (10 questions)
This section includes questions to evaluate clinical effectiveness, patient outcomes, patient and carer experience, continuity of care, the quality of the care environment, self-care, patient transfers, travel time impact and the management of risk.
Access to care (10 questions)
This section includes questions to evaluate the impact on patient choice, simplifying the offer to patients, travel burden for patients, carers and families, waiting times, supporting the use of new technology to improve access, improving or maintaining service operating hours and locations, impact on equality and health inequalities and accounting for future changes in population size and demographics.
Deliverability (8 questions)
This section includes questions to evaluate the expected time to deliver, meeting the relevant national, regional or local delivery timescales, access to the required staffing capacity and capability, support services, premises/estates and technology to be successfully implemented.

Workforce (12 questions)
This section includes questions to evaluate the impact on workforce capacity resilience, optimising the efficient and effective use of clinical staff, cross-organisational working across the patient pathway, flexible deployment of staff and the development of innovative staffing models, staff health and wellbeing, recruitment and retention, maintaining or improving the availability of trainers, enabling staff to maintain or enhance their capabilities/ competencies, the travel burden for staff and clinical supervision.
Value for money (5 questions)
This section includes questions to evaluate the affordability, value for money and implementation costs.
Strategic fit (2 questions)
This section includes questions to evaluate compatibility with the One Gloucestershire vision and the NHS Long Term Plan
Acceptability (1 question)
This question seeks to evaluate if the model has satisfactorily taken into account, and responded to, the Fit for the Future Outcome of Engagement Report

5. What is the working list of ideas/models?

The details of each of the eight (8) system models (listed below) are presented in the Section 6.

Model A	• **Revert to original Gastroenterology and Trauma & Orthopaedics configurations**
Model B	• **Centralise emergency general surgery to Gloucester**
Model C	• **Re-open Cheltenham Emergency Department overnight**
Model D	• **Centralise emergency general surgery to Gloucester** • **Centralise elective colorectal and general surgery day cases (colorectal and upper GI) to Cheltenham** • **Centralise acute medicine to Gloucester** • **Centralise image guided interventional surgery hub to Gloucester**
Model E	• **Centralise emergency general surgery to Gloucester** • **Centralise elective colorectal surgery to Gloucester**
Model F	• **Centralise emergency general surgery to Gloucester** • **Centralise elective colorectal and general surgery daycases (colorectal and upper GI) to Cheltenham** • **Centralise acute medicine to Gloucester** • **Centralise image guided interventional surgery hub to Gloucester** • **Vascular arterial hub retained in Cheltenham**
Model G	• **Centralise emergency general surgery to Gloucester** • **Centralise elective colorectal and upper GI to Cheltenham** • **Centralise image guided interventional surgery hub to Gloucester** • **Centralise acute medicine to Gloucester**
Model H	• **Centralise emergency general surgery to Gloucester** • **Centralise image guided interventional surgery hub to Cheltenham** • **Centralise elective colorectal and upper GI to Cheltenham**

It is important to note that at this stage this is a working list of ideas. With the exception of the services described in *Model A,* none of the other ideas has been developed to business case level. The information you have been provided for evaluation is as complete as we could provide within the timeframe and without the benefit of detailed modelling and delivery plans. These will be developed as part of the *Short List* process

6. Assessing the ideas against the evaluation criteria

The proposed models cover four clinical pathway groups:

- Emergency Departments and acute medicine
- Image guided interventional surgery
- General surgery (colorectal and upper gastrointestinal (GI))
- Gastroenterology and trauma & orthopaedics

During our longlisting process we developed a number of 'solutions descriptions'. The models you will review are made up of a combination of the 21 different 'solutions descriptions' that remained following review of hurdle criteria and interdependencies.

Eight of these descriptions relate to 'no change', or current state provision and are therefore not described in detail – these have ticks against them in the 'No Change' column below and are shaded grey.

Eleven of the solutions descriptions are suggested changes to the status quo (gastroenterology and trauma and orthopaedics are presented together as one solution description). These have ticks against them in the 'new proposed models' column below and are colour coded according to the clinical pathway group they belong to.

Clinical pathway group	Ref	Solutions Descriptor	No Change	
				x11
Emergency medicine	A4	Reopen CGH ED overnight		✓
	A5	CGH ED - no change	✓	
	A6	GRH ED - no change	✓	
Acute medicine	A1	No change	✓	
	A3	Centralise acute medicine to GRH		✓
Image guided interventional surgery	B1	No change	✓	
	B2	IGIS hub and vascular centralised to GRH		✓
	B3	IGIS hub to GRH, vascular stay in CGH		✓
	B4	IGIS hub centralised to CGH		✓
General Surgery	C1	EGS both sites	✓	
	C3	EGS centralised to GRH		✓
	C4	Elective colorectal both (no change)	✓	
	C5	Elective colorectal to CGH		✓
	C6	Elective colorectal to GRH		✓
	C8	Elective upper GI CGH		✓
	C9	Elective upper GI GRH (no change)	✓	
	C10	GI daycases - both	✓	
	C11	GI daycases - CGH		✓
Gastroenterology	Gastro 1	Centralised CGH	✓	
	T&O 1	Split O=CGH/T=GRH	✓	
Trauma & Orthopaedics	Gastro 2	Original configuration		✓
	T&O 2	Original configuration		✓

The table below shows which of the *solutions descriptions* are used to compile each of the eight models outlined in Section 5. In some cases there are further variations on these models i.e. there are other viable combinations of solutions similar to this one. The one you are evaluating is the *most distinctive* version when compared with the other models.

Clinical pathway	Ref	Solutions Descriptor	No Change	New proposed	Model A	Model B	Model C	Model D	Model E	Model F	Model G	Model H
				x11	Revert to original Gastro/T&O configurations	Centralise emergency general surgery	Re-open Cheltenham ED overnight (+ model B)	Centralise general surgery daycases and elective colorectal to Cheltenham. Centralise acute medicine and the IGIS hub to Gloucester (+ model B)	Centralise complex elective GI to Gloucester (+model B)	Centralise IGIS hub to Gloucester with vascular retained in Cheltenham (+ non-IGIS elements of model B)	Centralise IGIS hub and acute medicine to Gloucester; centralise complex elective GI to Cheltenham (+model B)	Centralise IGIS hub and complex elective GI to Cheltenham (+model B)
Emergency medicine	A4	Reopen CGH ED overnight		✓			✓					
	A5	CGH ED - no change	✓		✓	✓		✓	✓	✓	✓	✓
	A6	GRH ED - no change	✓		✓	✓	✓	✓	✓	✓	✓	✓
Acute medicine	A1	No change	✓		✓	✓			✓			✓
	A3	Centralise acute medicine to GRH		✓				✓		✓	✓	
Image guided interventional surgery	B1	No change	✓		✓	✓	✓		✓			
	B2	IGIS hub and vascular centralised to GRH		✓				✓			✓	
	B3	IGIS hub to GRH, vascular stay in CGH		✓						✓		
	B4	IGIS hub centralised to CGH		✓								✓
General Surgery	C1	EGS both sites	✓				✓					
	C3	EGS centralised to GRH		✓	✓	✓		✓	✓	✓	✓	✓
	C4	Elective colorectal both (no change)	✓		✓	✓	✓					
	C5	Elective colorectal to CGH		✓				✓		✓	✓	✓
	C6	Elective colorectal to GRH		✓					✓			
	C8	Elective upper GI CGH		✓							✓	✓
	C9	Elective upper GI GRH (no change)	✓		✓	✓	✓	✓	✓	✓		
	C10	GI daycases - both	✓		✓	✓	✓					
	C11	GI daycases - CGH		✓				✓	✓	✓	✓	✓
Gastroenterology	Gastro 1	Centralised CGH	✓			✓	✓	✓	✓	✓	✓	✓
	T&O 1	Split O=CGH/T=GRH	✓			✓	✓	✓	✓	✓	✓	✓
Trauma & Orthopaedics	Gastro 2	Original configuration		✓	✓							
	T&O 2	Original configuration		✓	✓							

6.1. Model A: Revert to original Gastroenterology and Trauma & Orthopaedics configurations

Where to find evidence against the appraisal criteria
G2 & T&O2A – pages 2 to 17 in Appendix 3
Model description
Gastroenterology: To reverse the Gastroenterology reconfiguration pilot commenced in November 2018, which involved the Gastroenterology service moving from two mixed Gastroenterology /General Medical wards (one at GRH and one at CGH) to one specialised and dedicated ward at Cheltenham General Hospital (CGH). **Trauma & Orthopaedics:** To reverse the movement of Orthopaedic Trauma to Gloucester Royal Hospital (GRH) and the majority of elective surgery to Cheltenham General Hospital. Previously both elective and trauma were carried out at both sites; pilot commenced October 2017.
Clinical services affected
Gastroenterology: • Endoscopy Service • Renal service **Trauma and Orthopaedics:** • Theatres • Support services, Therapy, Radiography, Pharmacy
Key changes
Gastroenterology: If reversed Gastroenterology would be undertaken at both sites without a dedicated ward, and with reduced clinical capacity for endoscopy and training. **Trauma and Orthopaedics:** If reversed both elective and trauma surgery would be undertaken on both sites.
Key impact on residents/service users
**This data is based on 2018/19 patient episodes and may therefore not fully reconcile with travel impact analysis. Data validation required. 2777 patient episodes in total may be subject to change, approximately 8 a day. 876 patient episodes would move from CGH to GRH. 1901 patient episodes would move from GRH to CGH.
Key impact on staff
Gastroenterology developments that would be lost if reversed: • Nursing staff at CGH are settled onto one specialised ward and no longer care for so many acute general medical admissions. The previous Gastroenterology ward at GRH has become an additional renal ward and the nursing staff on that ward have undergone training to care for renal patients. This has been seen positively by staff who are now integrated into the renal nursing team.

- 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.
- Improved training experience for junior doctors.

Trauma and Orthopaedics developments that would be lost if reversed:

- Ward nursing staff are settled on respective wards and recruitment is improving with a successful move to associate nurse posts.
- Advanced Practitioners work on both sites and have become very specialised
- Most consultants now work on both sites. Currently there is one consultant on call rota with dedicated time on call for trauma with no elective work during this period. This allows the consultant to concentrate on the trauma during their on call period.
- Registrars currently work in both Trauma and elective services, but during their 'on-call' periods undertake only trauma and are released from elective duties. If this was reversed, registrars would revert to working within both specialties at the same time.
- Emergency Department (ED) staff currently have a more rapid access to a senior orthopaedic decision maker as the on call consultant and registrar are not otherwise rostered (i.e. in Theatre or clinic) and therefore can attend and give an opinion rapidly. If reversed the waits for patients and staff would increase.
- Junior Doctors have changed rotas on both sites; previously the 'on call' was shared with other specialties. To reverse this would incur changes to several other specialties and consultation with the Deanery.
- Therapy Staff, rotas would have to change if the changes were reversed and it would impact on the specialist services for example with the fractured neck of femur patients in GRH and the 'advanced recovery after elective surgery' project
- Radiography Staff, rotas would have to change and equipment transfer to other sites
- Pharmacy Staff, rotas would have to change to accommodate the work with elective arthroplasty patients.

The above advantages would be lost if the pilot were reversed

Case for change summary	
Rising demand	Rising demand for endoscopies has been addressed by releasing consultant time to provide more lists – this would be lost if reverting to previous arrangements. The new arrangements have contributed towards T&O teams being able to meet increased demand, which would be lost if reversed.
Quality of care	Gastroenterology developments that would be **lost if reversed**: • Improved 7-day specialist care for Gastroenterology inpatients with provision of weekend ward rounds on both sites • More responsive inpatient endoscopy service, improving decision making and reducing length of stay. • More responsive outpatient endoscopy service, improving colorectal 2 week-wait & bowel cancer screening access times. • More support for emergency admissions with 7 day a week 8am consultant review on Acute Medical Unit at GRH - resulting in

	immediate implementation of treatment. • Reduced bed occupancy at GRH, improving safety & patient experience. Trauma and Orthopaedics developments that would be **lost if reversed:** • Consolidating the trauma pathway on one site (already designated as a national trauma unit), providing 2 trauma theatre lists 7 days a week with a timetable to allow completion of sub specialty trauma provision. • Increased consultant level input to the trauma pathway; patients are now reviewed daily. Therefore improved continuity of care. • Creation of more dedicated out of hours trauma lists to reduce time to theatre • Timely Orthopaedic support to ED • Reduced volume of cancelled elective operations due to winter bed pressures. • Reduced length of stay for both elective and emergency patients as a result of more efficient specialty review
Recruitment and retention	Gastroenterology developments that would be **lost if reversed**: • Junior doctor feedback from the deanery has improved considerably following the change. • Improved staff morale and retention, reduced worry about patients not seen (clinic and endoscopy waiting lists). Trauma and Orthopaedics developments that would be **lost if reversed:** • Improved vacancy rate from 22.8 in 2017 to 9 in January 2020. • Consultant numbers remain stable, in the time since the pilot two consultants have retired and there has been excellent competition for their replacements. • Prior to the trial Registrar Deanery feedback was good, this was maintained during the pilot period. Previously the recruitment of specialty doctors was problematic before the trial but has improved since the trial. • 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. • Trust doctor recruitment remains challenging but has improved and the development for Advanced Nurse Practitioners and Physician's Assistant posts has also been successful.
Access to specialist advice	Gastroenterology developments that would be **lost if reversed**: • Dedicated specialist ward for Gastroenterology inpatients. • Patients requiring planned admission can be admitted directly to Snowshill ward where the consultant of the week ensures rapid review and treatment. Pathways have been established to direct patients to CGH within hours, enabling specialist review within 14 hours for all patients thus meeting the national 7 day working standard.

	• Patients attending out of hours (e.g. after 8pm where Cheltenham ED reverts to a nurse led service) are admitted to AMU at GRH, where they receive specialist Gastroenterology review at 8am each morning. All patients seen are triaged to identify those who require transfer to Snowshill ward at CGH for ongoing speciality care and those who can either be treated in a more general ward at GRH, or discharged directly home. Trauma and Orthopaedics developments that would be **lost if reversed:** • The 'on-call' T&O consultant and registrar works within trauma only and therefore can be available to provide specialist advice to the ED. • The 'on-call' T&O consultant undertakes two ward rounds a day (7 days a week) to see all newly admitted patients and a board round to review the progress of every trauma Inpatient (7 days a week) • The 'on-call' consultant undertakes a trauma triage on a daily basis to give advice and treatment for patients who attend the ED (but don't require immediate referral) and to provide specialist advice for the minor injury units within the community hospitals.
Patients travelling out of county	No changes as a result of the pilots or any proposed reversal.
Best use of resources	Gastroenterology developments that would be **lost if reversed**: • Provision of a 365 day acute Gastroenterology review service to GRH, starting with an Acute Medical Unit (AMU) triage round at 8am each day. • Increased support for ambulatory services – Acute Medical Initial Assessment (AMIA), helping to reduce admission for patients who can be managed via an alternative outpatient pathway. • Inpatient endoscopy provision has improved, so that patients requiring an inpatient endoscopy for diagnosis or treatment can be seen quickly, avoiding diagnostic delay and contributing to a reduced length of stay. • Secondary to this is the positive impact to general medicine and renal patients who can receive consistent treatment on ward 7A, releasing dialysis beds on ward 7B. As the renal team's larger bed base gives greater ability to flex capacity across the entire seventh floor as needed. • The change has released 350 consultant sessions, which have been transferred into Endoscopy theatre lists. This has provided an additional 7 lists per week, which support the treatment of an additional 43 patients per week. This has helped the Trust to provide more timely appointments for patients, despite a rising number of referrals. Trauma and Orthopaedics developments that would be **lost if reversed:** • Trauma surgery is becoming increasingly specialised, although there are some operations that can be carried out by all orthopaedic surgeons there are an increasing volume that require a surgeon with sub specialty knowledge. For example the number of patients with

	joint replacements has increased with the aging population and so the numbers who fall and sustain complex fractures which affect those joint replacements have also increased. Prior to the trial the consultants were split on different sites and sometimes there were long waits for surgery that required a sub specialised surgeon. • Elective arthroplasty (joint replacement) is now centralised in CGH. This enables best use of the considerable kit used to undertake this type of surgery. • Consolidating the trauma pathway on one site (already designated as a national trauma unit), providing 2 trauma theatre lists 7 days a week with a timetable to allow completion of sub specialty trauma provision. • Increased consultant level input to the trauma pathway; patients are now reviewed daily. Therefore improved continuity of care.

6.2. Model B: Centralise emergency general surgery

Where to find evidence against the appraisal criteria	
Solution C3 - page 18 to 28 in Appendix 3	
Model description	
Centralise Emergency General Surgery (EGS) to Gloucestershire Royal Hospital (GRH).	
Clinical services affected	
Emergency general surgery	
Key changes	
EGS is currently provided at GRH and Cheltenham General Hospital (CGH) and this option would centralise EGS to GRH.	
Key impact on residents/service users	
**This data may not fully reconcile with travel impact analysis due to some double-counting, and out of area patients. Data validation required. 2812 patients in total may be subject to change, approximately 8 a day. 2080 patient episodes would move from CGH to GRH 732 patient episodes would move from GRH to CGH.	
Key impact on staff	
Two consultant-led teams combined onto one site (GRH) The service would address the inequitable rotas at ALL grades. This would provide a better staffing experience, improving morale and addressing concerns raised by the Deanery. May require re-distribution of nursing staff across sites.	
Case for change summary	
Rising demand	Centralising EGS at GRH using a Surgical Assessment Unit (SAU) enables management of patients on an ambulatory pathway and avoid unnecessary admissions to a hospital bed. Two consultant-led teams allows one team to be operating, whilst the other team has immediate availability for new admissions and current emergency inpatients.
Quality of care	EGS care would be improved by providing a dedicated team on SAU which would review all patients presenting on the same day. This would reduce delays to review, improving patient safety. Reduces delay in assessment by senior decision maker for EGS patients.
Recruitment and retention	Would be improved for nursing staff. Junior doctors: improve rota resilience, support to junior staff, and reduce overload/burnout
Access to specialist advice	Improved by implementing a sub-specialty rota for EGS, enabling access to an Upper or Lower GI consultant as required.
Patients travelling out of county	N/A

Best use of resources	Combining the two on-call teams onto one site would: • Provide flexibility in managing the workload; • Provide a team dedicated to operating, minimising delays due to delineation of tasks. Furthermore, undertaking more operating during the day would reduce the volume of out-of-hours operating, reducing the work burden on the resident junior staff and complying with national guidelines (NCEPOD).

6.3. Model C: Re-open Cheltenham Emergency Department overnight

Where to find evidence against the appraisal criteria
A4 - pages 29 to 38 in Appendix 3
Model description
Re-open Cheltenham ED overnight, with corresponding transfer of ED Consultant and Registrar capacity from GRH to CGH to support Emergency Department attendances overnight.
Clinical services affected
Emergency Departments Acute Medicine
Key changes
Emergency Department at CGH extended to provide 24/7 consultant led service Acute Medicine – rebalance beds/staff across the two hospitals, i.e. move some beds from GRH to CGH to accommodate additional activity.
Key impact on residents/service users
**This data may not fully reconcile with travel impact analysis as it may include duplicate records and out of county patients. Data validation required. 4061 patient episodes in total may be subject to change, approximately 11 a day. 4061 patient episodes would move from GRH to CGH
Key impact on staff
Would need to recruit additional middle grade and junior doctors and nursing staff to cover overnight rota at CGH. Existing gaps in rotas suggest these staff would not be readily available. Additional support service resource would be required overnight, specifically diagnostics and portering staff.
Case for change summary

Rising demand	Provides more capacity to provide emergency care overnight at CGH
Quality of care	Improved local access to emergency care in Cheltenham at night, but the existing issues regarding access to specialist advice remain. This option retains the fragmentation of acute medicine across two sites
Recruitment and retention	Unlikely that the Trust will be able to recruit medical staff to cover the overnight rota for emergency medicine.
Access to specialist advice	No improvement in issues regarding access to specialist advice for acute medicine.
Patients travelling out of county	N/A
Best use of resources	Significant additional staff costs for emergency medicine.

6.4. Model D: Centralise general surgery daycases and elective colorectal to Cheltenham. Centralise acute medicine and the IGIS hub to Gloucester, Plus Model B

Where to find evidence against the appraisal criteria
A3 - pages 39 to 49 in Appendix 3 **B2 - pages 50 to 61 in Appendix 3** **C3 - pages 18 to 28 in Appendix 3** **C5 - pages 62 to 74 in Appendix 3** **C11 - pages 75 to 83 in Appendix 3**
Model description
Elective patients would be centralised to CGH with the exception of elective upper GI, which would remain at GRH. Dedicated day surgery unit in CGH. Emergency general surgery centralised to GRH. Acute medicine centralised to GRH with the exception of some direct-admission routes to specialties based in CGH. Establish IGIS Hub at GRH, relocating the Regional Vascular Network's Arterial Centre from CGH to GRH.
Clinical services affected
Acute medicine General surgery daycases Elective colorectal surgery Interventional cardiology Interventional radiology Vascular surgery Emergency general surgery
Key changes
CGH This model would centralise general surgery daycases (for colorectal and upper GI) and all elective colorectal surgery to CGH. One image-guided interventional surgery room would be retained at CGH. Direct admission pathways would be put in place to allow some medical/surgical emergency patients to be admitted straight to specialty wards in CGH. **GRH** Acute medicine and emergency surgery patients would be assessed and admitted to GRH. An image guided interventional surgery hub would be established in GRH accommodating interventional cardiology, radiology and vascular surgery. The vascular network arterial centre would move from CGH to GRH, bringing with it the hybrid theatre, complex vascular surgery and vascular ward from CGH.
Key impact on residents/service users
**This data may not fully reconcile with travel impact analysis due to some double-counting, and out of area patients. Data validation required. 16,285 patients in total may be subject to change, approximately 57 a day. 13,605 patients would move from CGH to GRH 2,680 patients would move from GRH to CGH 562 patients would be repatriated to have their care in Gloucestershire
Key impact on staff
• Acute medical ward staff (doctors, nurses and support) move from CGH to GRH

- Arrangements for specialty teams to accept and support direct admission to CGH wards
- This option relocates the catheter labs from CGH to GRH and therefore some staff based solely in the catheter labs (primarily cardiology nurses) would change their working location from CGH to GRH.
- EGS centralisation combines two separate consultant-led teams into one place at GRH. The service would address the inequitable rotas at ALL grades, providing a better staffing experience, improving morale and removing concerns raised by the Deanery.
- EGS centralisation may require re-distribution of nursing staff across sites.
- Elective Colorectal centralisation would move some specialist staff from GRH to CGH. This would provide a better staffing experience, improving morale, improving opportunities for staff retention and attracting specialist expertise. It would enhance training opportunities for junior staff but may require re-distribution of nursing staff across sites.
- The majority of Interventional Radiology and vascular staff already work across both sites; therefore there is no significant impact for most staff in these services. Ward-based staff such as vascular nurses would be required to change their base of work from CGH to GRH.

Case for change summary	
Rising demand	These options all involve a degree of service centralisation and therefore offer opportunities for greater service flexibility to meet rising demand.
Quality of care	Centralised teams are able to offer improved quality of care
Recruitment and retention	Centralised services improve the ability to attract and retain staff in specialist areas, and increases support for training and development.
Access to specialist advice	Some patients who self-present to the ED in CGH may require transfer to GRH for acute medical or surgical assessment following initial review. Patients seen in the centralised services will have improved access to the right specialists to manage their care. GRH is the trauma unit for the County, establishment of a hub in GRH ensures services are located where patients are in most urgent need of care. There are more patients in the West of the county that require emergency IGIS intervention; a hub in GRH therefore reduces the average distance to travel.
Patients travelling out of county	A centralised IGIS hub will provide the capacity and capability to treat more patients' in-county who are currently travelling out of county for their specialist care. There may also be scope for a centralised elective colorectal surgery service to repatriate activity from out of county.
Best use of resources	Will make efficient and effective use of staff and their skills, technical support, expensive consumables and clinical space.

6.5. Model E: Centralise emergency and elective general surgery to Gloucester and all general surgery daycases to Cheltenham, Plus Model B

Where to find evidence against the appraisal criteria
C6 - pages 84 to 94 in Appendix 3 **C3 - pages 18 to 28 in Appendix 3** **C11 - pages 75 to 83 in Appendix 3**
Model description
In this model emergency and elective general surgery (colorectal and upper gastrointestinal) is centralised to GRH, while daycase general surgery is centralised to CGH in a dedicated day surgery unit.
Clinical services affected
Elective colorectal surgery Emergency general surgery Daycase general surgery (colorectal and upper GI)
Key changes
CGH This model would centralise general surgery daycases to CGH **GRH** Emergency surgery patients would be assessed and admitted (if required) to GRH. All elective inpatient colorectal services would be centralised to GRH (currently delivered on both sites).
Key impact on residents/service users
This data may not fully reconcile with travel impact analysis due to some double-counting, and out of area patients. Data validation required. **4349 patients in total may be subject to change, approximately 16 a day. **2535 patients would move from CGH to GRH** **1814 patients would move from GRH to CGH**
Key impact on staff
• Elective Colorectal centralisation would move specialist staff from CGH to GRH. This would provide a better staffing experience, improving morale, improving opportunities for staff retention and attracting specialist expertise. It would enhance training opportunities for junior staff but may require re-distribution of nursing staff across sites. • EGS centralisation combines two separate consultant-led teams onto one site at GRH. The service would address the inequitable rotas at ALL grades, providing a better staffing experience, improving morale and removing concerns raised by the Deanery. • EGS centralisation may require re-distribution of nursing staff across sites.
Case for change summary

Rising demand	• Centralising EGS at GRH using a Surgical Assessment Unit (SAU) enables management of patients on an ambulatory pathway, avoiding unnecessary admissions to a hospital bed.

	• Two consultant-led teams allows one team to be operating, whilst the other team has immediate availability for new admissions and current emergency inpatients. • A centralised colorectal team would help meet increased demand for minimally invasive and new technologies. It also offers greater opportunity for team working and distribution of workload to deal with fluctuations in demand
Quality of care	• EGS care would be improved by providing a dedicated team on SAU which would review all patients presenting on the same day. This would reduce delays to review, improving patient safety. • Reduces delay in assessment by senior decision maker for EGS patients. • Elective colorectal care would be improved by providing a dedicated specialist ward. Separation of specialist ward from SAU within GRH would improve patient experience and environment. • Daycase care would be improved by providing a dedicated specialist unit. Separation from EGS / major resectional work would improve patient experience and environment, and reduce risk of cancellation.

Recruitment and retention	Centralised EGS and colorectal services would:
	• Improve training and experience for nursing staff.
	• Ensure compliance with Deanery requirements for surgical training.
	• Improve recruitment and retention for:
	  o Nursing and specialist support staff.
	  o Consultants.
	• Improve ability to attract trainees and ensure compliance with Deanery requirements for surgical training.
	• A dedicated day surgery unit would enhance the working environment for day surgery staff

Access to specialist advice	Improved by implementing a sub-specialty rota for EGS, enabling access to an upper GI or colorectal consultant as required. For urgent colorectal opinions / operative support, the EGS colorectal consultant would be available.
Patients travelling out of county	The elective colorectal team delivers a service for the South West region and centralising would improve the service offered and further reduce the number of patients travelling out of county.
Best use of resources	Combining the two EGS on-call teams onto one site would: • Provide flexibility in managing the workload; • Provide a team dedicated to operating, minimising delays due to delineation of tasks. Furthermore, undertaking more operating during the day would reduce the volume of out-of-hours operating, reducing the work burden on the resident junior staff and complying with national guidelines (NCEPOD). Centralising the elective colorectal team would: • Provide a single team dedicated to delivering planned care. • Improve efficiency of planned inpatient care ward • Single site stops duplication of resources (ward rounds, specialist

	nurses and junior teams). • Best use of planned theatre space (shared and flexible use). A dedicated day surgery unit would improve efficiency.

6.6. Model F: Centralise image guided interventional surgery hub to Gloucester with vascular retained in Cheltenham. Also includes non-IGIS elements of Model D

Where to find evidence against the appraisal criteria
A3 - pages 39 to 49 in Appendix 3 **B3 - pages 95 to 105 in Appendix 3** **C3 - pages 18 to 28 in Appendix 3** **C5 - pages 62 to 74 in Appendix 3** **C11 - pages 75 to 83 in Appendix 3**
Model description
This model introduces the idea of creating an image guided interventional surgery hub on the GRH site to accommodate interventional radiology and cardiology procedures. However, the vascular arterial centre would remain in CGH. This still delivers many benefits of a centralised team, including the ability to repatriate patients who are treated out of county at the moment. The rest of the clinical model would be as described in Model D: • Elective patients centralised to CGH with the exception of upper GI which would remain at GRH. Dedicated day surgery unit at CGH • Acute medicine and surgery patients centralised to GRH with the exception of some direct-admission routes to specialties based in CGH.
Clinical services affected
Interventional cardiology Interventional radiology General surgery daycases Colorectal elective surgery Emergency general surgery Acute medicine
Key changes
CGH This model would centralise general surgery daycases and all elective colorectal surgery to CGH, which would retain the vascular arterial centre as well. Direct admission pathways would be put in place to allow some emergency patients to be admitted straight to specialty wards in CGH. **GRH** Acute medical and emergency surgical patients would be assessed and admitted to GRH, and an image guided interventional surgery hub would be established in GRH accommodating interventional cardiology and radiology.
Key impact on residents/service users
This data may not fully reconcile with travel impact analysis due to some double-counting, and out of area patients. Data validation required. **15,613 patients may be subject to change, approximately 52 a day. **12,518 patients would move from CGH to GRH** **2,533 patients would move from GRH to CGH** **562 patients would be repatriated to have their care in Gloucestershire**
Key impact on staff
• Acute medical ward staff (doctors, nurses and support) move from CGH to GRH

- Arrangements for specialty teams to accept and support direct admission to CGH wards
- This option relocates the catheter labs from CGH to GRH and therefore some staff based solely in the catheter labs (primarily cardiology nurses) would change their working location from CGH to GRH.
- EGS centralisation combines two separate consultant-led teams onto one site (GRH). The service would address the inequitable rotas at ALL grades, providing a better staffing experience, improving morale and removing concerns raised by the Deanery.
- EGS centralisation may require re-distribution of nursing staff across sites.
- Elective Colorectal centralisation would move some specialist staff from GRH to CGH. This would provide a better staffing experience, improving morale, improving opportunities for staff retention and attracting specialist expertise. It would enhance training opportunities for junior staff but may require re-distribution of nursing staff across sites.
- Interventional Radiology staff already work across both sites, therefore there is no significant impact for staff.

Case for change summary	
Rising demand	These options all involve a degree of service centralisation and therefore offer opportunities for greater service flexibility to meet rising demand.
Quality of care	Centralised teams are able to offer improved quality of care
Recruitment and retention	Centralised services improve the ability to attract and retain staff in specialist areas, and increases support for training and development.
Access to specialist advice	Patients seen in the centralised services will have improved access to the right specialists to manage their care. Some patients who self-present to the ED in CGH may require transfer to GRH for acute medical or surgical assessment following initial review. GRH is the trauma unit for the County, establishment of a hub in GRH ensures services are located where patients are in most urgent need of care. There are more patients in the West of the county that require emergency IGIS intervention; a hub in GRH therefore reduces the average distance to travel. There may be delays in care for emergency vascular patients requiring specialist input from other specialties, e.g. trauma, interventional radiology.
Patients travelling out of county	A centralised IGIS hub will provide the capacity and capability to treat more patients in-county who are currently travelling out of county for their specialist care. There may also be scope for a centralised elective colorectal surgery service to repatriate activity from out of county.
Best use of resources	Will make efficient and effective use of staff and their skills, technical support, expensive consumables and clinical space.

6.7. Model G: Centralise image guided interventional surgery hub and acute medicine to Gloucester; centralise elective colorectal and upper GI and all general surgery daycases to Cheltenham plus Model B

Where to find evidence against the appraisal criteria
A3 - pages 39 to 49 in Appendix 3 **B2 - pages 50 to 61 in Appendix 3** **C3 - pages 18 to 28 in Appendix 3** **C5 - pages 62 to 74 in Appendix 3** **C8 - pages 106 to 117 in Appendix 3** **C11 - pages 75 to 83 in Appendix 3**
Model description
This model introduces the idea of separating planned and emergency general surgery onto different sites. The rest of the clinical model would be as described in Model D: • Elective and daycase general surgery patients centralised to CGH, with dedicated day surgery unit. • Emergency general surgery centralised to GRH. • Acute medicine centralised to GRH with the exception of some direct-admission routes to specialties based in CGH. • Centralised image-guided surgery hub in GRH
Clinical services affected
Colorectal elective surgery Upper gastrointestinal elective surgery Interventional cardiology Interventional radiology Vascular surgery Emergency general surgery Acute medicine General surgery daycases
Key changes
CGH This model would centralise general surgery daycases and all elective colorectal and upper GI surgery to CGH, and retain one image-guided interventional surgery room at CGH. Direct admission pathways would be put in place to allow some acute medical/surgical patients to be admitted straight to specialty wards in CGH. **GRH** Acute medicine and emergency surgery patients would be assessed and admitted (if required) to GRH, and an image guided interventional surgery hub would be established in GRH accommodating interventional cardiology, radiology and vascular surgery. The vascular network arterial centre would move from CGH to GRH, bringing with it the hybrid theatre, complex surgery and vascular ward.
Key impact on residents/service users
**This data may not fully reconcile with travel impact analysis due to some double-

counting, and out of area patients. Data validation required.

17,356 patients may be subject to change, approximately 59 a day.
13,605 patient episodes would move from CGH to GRH
3,189 patient episodes would move from GRH to CGH
562 patients would be repatriated from other areas to have their care in Gloucestershire

Key impact on staff

- Acute medical ward staff (doctors, nurses and support) move from CGH to GRH
- Arrangements for specialty teams to accept and support direct admission to CGH wards
- This option relocates the catheter labs from CGH to GRH and therefore some staff based solely in the catheter labs (primarily cardiology nurses) would change their working location from CGH to GRH.
- EGS centralisation combines two separate consultant-led teams onto one site (GRH). The service would address the inequitable rotas at ALL grades, providing a better staffing experience, improving morale and removing concerns raised by the Deanery.
- EGS centralisation may require re-distribution of nursing staff across sites.
- Centralisation of elective colorectal and upper GI would move some specialist staff from GRH to CGH. This would provide a better staffing experience, improving morale, improving opportunities for staff retention and attracting specialist expertise. It would enhance training opportunities for junior staff but may require re-distribution of nursing staff across sites.
- The majority of Interventional Radiology and vascular staff already work across both sites; therefore there is no significant impact for most staff in these services. Ward-based staff such as vascular nurses would be required to change their base of work from CGH to GRH.

Case for change summary

Rising demand	These options all involve a degree of service centralisation and therefore offer opportunities for greater service flexibility to meet rising demand. A centralised colorectal team would help meet increased demand for minimally invasive and new technologies. It also offers greater opportunity for team working and distribution of workload to deal with fluctuations in demand
Quality of care	Centralised teams are able to offer improved quality of care • Elective Colorectal care would be improved by providing a dedicated specialist ward. Separation of specialist ward from SAU within GRH would improve patient experience and environment. • Daycase care would be improved by providing a dedicated specialist unit. Separation from EGS / major resectional work would improve patient experience and environment, and reduce risk of cancellation.
Recruitment and retention	Centralised services improve the ability to attract and retain staff in specialist areas, and increases support for training and development. A dedicated day surgery unit would enhance the working environment for day surgery staff.
Access to specialist advice	Some patients who self-present to the ED in CGH may require transfer to GRH for acute medical or surgical assessment following initial review. Patients seen in the centralised services will have improved access to the

	right specialists to manage their care. GRH is the trauma unit for the County, establishment of a hub in GRH ensures services are located where patients are in most urgent need of care. There are more patients in the West of the county that require emergency IGIS intervention; a hub in GRH therefore reduces the average distance to travel.
Patients travelling out of county	A centralised IGIS hub and general surgery elective service will provide the capacity and capability to treat more patients in-county who are currently travelling out of county for their specialist care.
Best use of resources	Will make efficient and effective use of staff and their skills, technical support, expensive consumables and clinical space. Centralising the elective colorectal team would: • Provide a single team dedicated to delivering planned care. • Improve efficiency of planned inpatient care ward • Single site stops duplication of resources (ward rounds, specialist nurses and junior teams). • Best use of planned theatre space (shared and flexible use). A dedicated day surgery unit would improve efficiency.

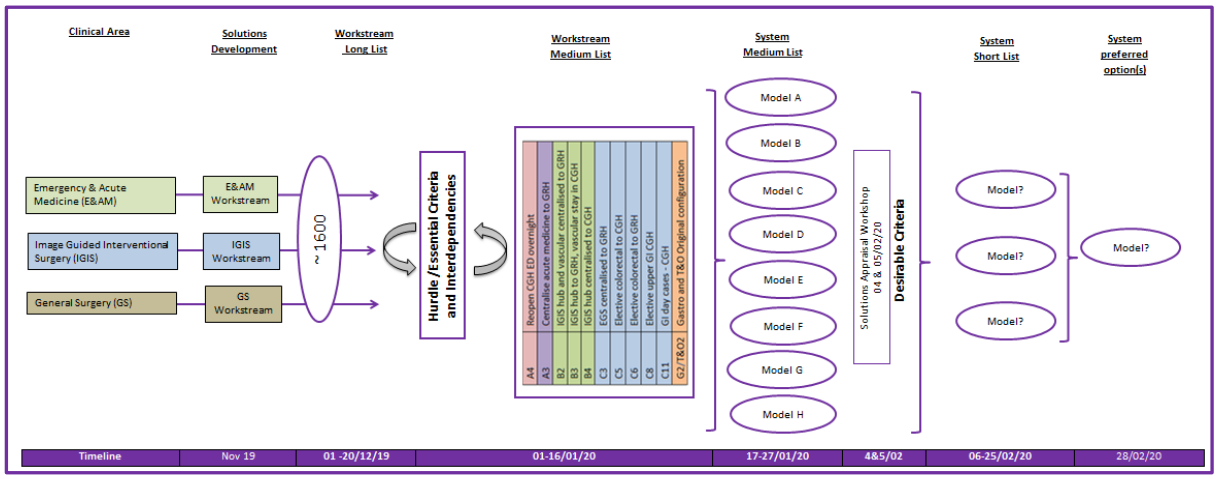
6.8. Model H: Centralise image guided interventional surgery hub and elective colorectal and upper GI surgery to Cheltenham, plus Model B

Where to find evidence against the appraisal criteria
B4 - pages 118 to 127 in Appendix 3 **C3 - pages 18 to 28 in Appendix 3** **C5 - pages 62 to 74 in Appendix 3** **C8 - pages 106 to 117 in Appendix 3** **C11 - pages 75 to 83 in Appendix 3**
Model description
This model is similar to G in that it introduces the idea of separating planned and emergency general surgery onto different sites. However, in this model the IGIS hub is located on the planned care site. Due to a higher volume of acute admissions to CGH as a result, the acute medicine model remains as it is now.
Clinical services affected
General surgery daycases Colorectal elective surgery Upper GI elective surgery Interventional radiology Emergency general surgery
Key changes
CGH This model would centralise general surgery daycases and all elective colorectal and upper GI surgery to CGH, and establish an image-guided interventional surgery hub which would retain the vascular network arterial centre. **GRH** Acute medical and emergency surgical patients would be assessed and admitted to GRH.
Key impact on residents/service users
This data may not fully reconcile with travel impact analysis due to some double-counting, and out of area patients. Data validation required. **11,904 patients may be subject to change, approximately 23 a day. **7,811 patients would move from CGH to GRH** **3,531 patients would move from GRH to CGH** **562 patients would be repatriated to have their care in Gloucestershire**
Key impact on staff
• EGS centralisation combines two separate consultant-led teams onto one site (GRH). The service would address the inequitable rotas at ALL grades, providing a better staffing experience, improving morale and removing concerns raised by the Deanery. • EGS centralisation may require re-distribution of nursing staff across sites. • Centralisation of elective colorectal and upper GI would move some specialist staff from GRH to CGH. This would provide a better staffing experience, improving morale, improving opportunities for staff retention and attracting specialist expertise. It would enhance training opportunities for junior staff but may require re-distribution of nursing staff across sites.

• Interventional Radiology and vascular staff already work across both sites, therefore there is no significant impact for clinical staff. Administrative staff may be affected.	
Case for change summary	
Rising demand	These options all involve a degree of service centralisation and therefore offer opportunities for greater service flexibility to meet rising demand.
Quality of care	Centralised teams are able to offer improved quality of care. Reduced delays for EGS assessment in GRH but retains the fragmentation of acute medicine across two sites.
Recruitment and retention	Centralised services improve the ability to attract and retain staff in specialist areas, and increase support for training and development.
Access to specialist advice	Patients seen in the centralised services will have improved access to the right specialists to manage their care. Some patients who self-present to the ED in CGH may require transfer to GRH for acute surgical assessment following initial review. **No improvement in issues regarding access to specialist advice for acute medicine**. GRH is the trauma unit for the County, establishment of a hub in CGH would require protocols to ensure services are available where patients are in most urgent need of care, which may mean more patient transfers between sites. There are more patients in the West of the county that require emergency IGIS intervention; a hub in CGH therefore potentially increases the average distance to travel. A sub-specialty rota for EGS would be implemented, enabling access to an upper or lower GI surgeon as required.
Patients travelling out of county	A centralised IGIS hub and general surgery elective service will provide the capacity and capability to treat more patients in-county who are currently travelling out of county for their specialist care.
Best use of resources	Will make efficient and effective use of staff and their skills, technical support, expensive consumables and clinical space.

7. Further work to inform evaluation

The output of the Solutions Appraisal Workshop is a *Short List* of models allowing further detailed analysis to be undertaken. This provides material to the decision making body to take account of in deciding which option or options (the *Preferred Option)* is put out to consultation. Further appraisal workshops may be required once all the additional information regarding the *short listed* models is available. A schematic of the process and high level timeline is presented below:



The further assessment of *Short* List solutions includes:

- Clinical review and assurance including clinical senate and network views
- Integrated impact assessment (IIA) Pre-Consultation Report including:
    - Travel and access assessment based on car and public transport for all shortlisted solutions
    - Travel and access assessment for blue light ambulances for all shortlisted solutions
    - Impact on groups vulnerable to service changes (with a focus on those covered by equality legislation) = EIA. For the equality elements of the IIAs, the assessment will identify what the impact of the potential solutions would have in relation to patients who fall in one of the protected characteristic groups, i.e. Disability, Gender reassignment, Marriage and civil partnership, Pregnancy and maternity , Race, Religion or belief, Sex, Sexual orientation and Age.
    - Provider impact assessment – likely impact of proposed solutions on providers both in and out of county.
    - Public engagement activities: Citizens' Jury and Solutions Appraisal in public report outlining how solutions were appraised.
    - **OUTPUTS**: The Scoping Report, IIA report identifying potential positive and negative health impacts; impact particularly on groups vulnerable to service changes (with a focus on those covered by equality legislation); and detailed travel and access impacts for the whole population as well as for vulnerable groups.
- Additional activity and financial modelling analysis

8. Appendices

Appendix 1: User Guide to the web-based assessment tool

See separate Questionnaire Guide

Appendix 2: Integrated Impact Assessment Baseline

See separate document

Appendix 3: Evaluation criteria evidence pack

See separate document

Appendix 4: Attendee table and Solution allocations

See separate document

Appendix 5: Travel Impact Analysis

See separate document (to follow)

Appendix 6: Output of Engagement Report – question responses

See separate document (to follow)

Appendix 7: Glossary of Terms

24/7	Twenty-four hours a day, seven days a week
A&E (ED)	Accident and emergency department (also known as emergency department).
Acute care	Acute care refers to active but short-term treatment, usually in a hospital, for patients with a severe urgent illness or injury.
Acute hospital	A hospital offering inpatient surgical and medical patient care for individuals with an unexpected serious medical problem that needs immediate assessment and treatment.
Acute medicine	Acute medicine is a medical discipline concerned with the immediate and early specialist management of adult patients with a wide range of medical conditions who present in hospital as emergencies
AMU	Acute Medical Unit
AMIA	Acute Medical Initial Assessment
Case for change	The case for change is the document that sets out why things need to change within local health and care services to make sure they are fit for the future.
CCG	Clinical Commissioning Group. CCGs are the GP-led bodies responsible for planning and investing in many local health and care services including the majority of hospital care and stroke services.
Clinical co-dependencies	Some services need to be in the same place, or supported by other services through a network arrangement
Centres of Excellence	The development of the two main hospital sites
CGH	Cheltenham General Hospital
CT scan	CT scans are sometimes referred to as CAT scans or computed tomography scans. CT scans can produce detailed images of many structures inside the body, including the internal organs, blood vessels and bones.
EGS	Emergency General Surgery
FFTF	Fit for the Future Programme
Foundation Trusts (FT)	NHS Foundation Trusts are non-profit making public sector corporations. They are part of the NHS but have greater freedom to decide their own plans and the way services are run. Foundation Trusts have members and a council of governors.
GRH	Gloucester Royal Hospital
IGIS	Image Guided Interventional surgery

Integrated impact assessment	The purpose of the integrated impact assessment is to explore the potential positive and negative consequences of the proposals. IT includes a health impact assessment (HIA), travel and access impact assessment, equality impact assessment (EqIA) (in which the impacts of the proposals on protected characteristic groups and deprived communities are assessed) and sustainability impact assessment.
Models of care	Models of care are the way that way that health and social care services are organised, accessed and delivered.
MRI scan	Magnetic resonance imaging (MRI) is a type of scan that uses strong magnetic fields and radio waves to produce detailed images of the inside of the body. An MRI scan can be used to examine almost any part of the body. The results of an MRI scan can be used to help diagnose conditions, plan treatments and assess how effective previous treatment has been.
One Gloucestershire	The working name given to the partnership between the county's NHS and care organisations to help keep people healthy, support active communities and ensure high quality, joined up care when needed
PCBC	Pre-consultation business case. The document which presents the business case for any changes to services on which the CCGs agree to consult. It shows that CCGs have properly considered the options, undertaken pre-consultation engagement, submitted to the required scrutiny and met the four tests and three conditions required by the Secretary of State.
Primary care	Primary care is the main or first point of contact for the patient, usually through a GP. Other primary care services include community pharmacy, optometry, and dentistry.
Provider	An individual or an organisation that gives a service in return for payment, such as GPs, hospitals and pharmacies.
SAU	Surgical Assessment Unit