Reporting to:	**Trust Board, 26 February 2015**
Title	Future Fit Shortlist
Sponsoring Director	Debbie Vogler, Director of Business & Enterprise
Author(s)	Future Fit Programme Team
Previously considered by	Future Fit Programme Board
Executive Summary	The purpose of this report is to: 1. provide a brief summary of the outcomes from the Future Fit February Programme Board meeting, the matters considered and the decisions made 2. present the Programme Board's proposed shortlist of options and to summarise the process undertaken by the Evaluation Panel in developing its recommendations to the Board. The Future Fit Programme Board in February received recommendations from the Evaluation Panel appointed by its sponsors and other stakeholders. The Programme Board had an extensive discussion of the Panel's recommendations in the light of all the evidence provided. Following this discussion the Board agreed the following acute services shortlist: • Emergency Centre (EC) and Diagnostic & Treatment Centre (DTC) on a New site; • EC on a New site, DTC at Princess Royal Hospital (PRH) • EC on a New site, DTC at Royal Shrewsbury Hospital (RSH) • EC at PRH, DTC at RSH • EC at RSH, DTC at PRH • Do minimum (existing dual site acute services maintained, provider and commissioner efficiency strategies implemented but no major services change). The Programme Board also agreed that there should be further debate on the best and safest configuration of obstetric services within these scenarios. This should include reviewing the clinical evidence and workforce models to understand whether obstetrics could operate on a site alongside a DTC, alongside an Emergency Centre or alongside either. On Urgent Care Centres (UCCs) Programme Board agreed to proceed to work on prototyping two urban Urgent Care Centres, one in Shrewsbury and the other in Telford; and exploring the most appropriate rural urgent care solutions in partnership with local communities The Board is asked to: NOTE the summary report of outcomes of the February Programme Board ENDORSE the proposed acute services shortlist and the approach to examining obstetric services options and urgent care centre models.

Strategic Priorities 1. Quality and Safety	☐ Reduce harm, deliver best clinical outcomes and improve patient experience through our Quality Improvement Strategy
2a) Healthcare Standards: Operational Performance Standards	☐ To develop a transition plan, with supporting mitigation actions and contingency plans, that ensures the safety and short term sustainability of challenged clinical services. 2014/15 ☐ To address the existing capacity shortfall and process issues to consistently deliver national healthcare standards. 2014/15 ☐ To undertake a review of all current services at specialty level to inform future service and business decisions. 2015/16
2b) Healthcare Standards: Service Reconfiguration	☐ Complete and embed the successful reconfiguration of Women and Children's services ☒ Develop a sustainable long term clinical services strategy for the Trust to deliver our vision of future healthcare services through our Future Fit Programme
3. People and Innovation	☐ Develop our leaders and promote staff engagement to make our organisation a great place to work through our People Strategy ☐ Develop a robust Investment Strategy to modernise our equipment and estate to support service transformation and increase productivity through the use of technology)
4 Community and Partnership	☐ Embed a customer focussed approach and improve relationships with our GPs through our Stakeholder Engagement Strategy
5 Financial Strength: Sustainable Future	☐ Develop a transition plan that ensures financial sustainability and addresses liquidity issues pending the outcome of the Future Fit Programme
Board Assurance Framework (BAF) Risks	☐ If we do not deliver **safe care** then patients may suffer avoidable harm and poor clinical outcomes and experience ☐ If we do not implement our **falls** prevention strategy then patients may suffer serious injury ☐ Risk to **sustainability** of clinical services due to potential shortages of key clinical staff ☐ If we do not achieve safe and efficient **patient flow** and improve our processes and capacity and demand planning then we will fail the national quality and performance standards ☒ If we do not have a clear **clinical service vision** then we may not deliver the best services to patients ☐ If we do not get good levels of **staff engagement** to get a culture of continuous improvement then staff morale and patient outcomes may not improve ☐ If we are unable to resolve our (historic) shortfall in **liquidity** and the structural imbalance in the Trust's **Income & Expenditure** position then we will not be able to fulfil our financial duties and address the modernisation of our ageing estate and equipment
Care Quality Commission (CQC) Domains	☐ Safe ☐ Effective ☐ Caring ☐ Responsive ☒ Well led
☒ **Receive** ☐ **Review** ☒ **Note** ☒ **Approve**	**Recommendation:** **The Board is asked to:** **NOTE** the summary report of outcomes of the February Programme Board **ENDORSE** the proposed acute services shortlist and the approach to examining obstetric services options and urgent care centre models.

Report on the Shortlisting Process

The purpose of this report is to present the Programme Board's proposed shortlist of options and to summarise the process undertaken by the Evaluation Panel in developing its recommendations to the Board.

Sponsor organisations and other stakeholders are invited to consider these proposals as set out in the table below:

Key Decision Documents	Programme Board	CCGs	Other Sponsors	Joint HOSC	Health & Wellbeing Boards
Selection of Short List	Approve	Approve	Endorse	Consider	Receive

Executive Summary

The Programme Board received recommendations from the Evaluation Panel appointed by its sponsors and other stakeholders.

The Board had an extensive discussion of the Panel's recommendations in the light of all the evidence provided (including a minority report for a patient representative). Following this discussion the Board agreed the following acute services shortlist:

- Emergency Centre (EC) and Diagnostic & Treatment Centre (DTC) on a New site;
- EC on a New site, DTC at Princess Royal Hospital (PRH)
- EC on a New site, DTC at Royal Shrewsbury Hospital (RSH)
- EC at PRH, DTC at RSH
- EC at RSH, DTC at PRH
- Do minimum (existing dual site acute services maintained, provider and commissioner efficiency strategies implemented but no major services change).

The Board also agreed that there should be further debate on the best and safest configuration of obstetric services within these scenarios. This should include reviewing the clinical evidence and workforce models to understand whether obstetrics could operate on a site alongside a DTC, alongside an Emergency Centre or alongside either.

On Urgent Care Centres (UCCs) Programme Board agreed to proceed to work on:

- Prototyping two urban Urgent Care Centres, one in Shrewsbury and the other in Telford; and
- Exploring the most appropriate rural urgent care solutions in partnership with local communities and considering current facilities/services. All existing Minor Injuries Units will be considered as potential sites for Urgent Care Centres.

Next steps include:

- A further round of pre-consultation public engagement which kicks off with two 'pop-up shops', one in Telford Shopping Centre on 20/21 Feb and Shrewsbury Darwin Shopping Centre 27/28 Feb. Events in Powys are also being planned. Many more events will follow and will be publicised via the NHS Future Fit website;
- Detailed development of the shortlisted options (including estates, workforce and finance).

It is expected that the Board will be able to propose a preferred option later in the year. Formal Public Consultation would then commence from December 2015 (subject to the timing of national approvals).

Background

Each sponsor and stakeholder organisation was given the opportunity to nominate a member of the Evaluation Panel. Some changes in membership had to be made through the course of the Panel's meetings. The final panel for the shortlisting process was comprised as follows:

Dr Bill Gowans, Vice Chair	Shropshire Clinical Commissioning Group
Chris Morris, Executive Lead for Nursing and Quality	Telford & Wrekin Clinical Commissioning Group
Victoria Deakins, Lead Therapist for North Powys	Powys Local Health Board
Mr Mark Cheetham, Scheduled Care Group Medical Director	Shrewsbury and Telford Hospital NHS Trust
Dr Emily Peer, Assistant Medical Director & GPSI	Shropshire Community Health NHS Trust
Pete Gillard	Shropshire Patient Group
Christine Choudhary *(unable to attend)*	Telford & Wrekin Health Round Table
Vanessa Barrett, Board Member	Healthwatch Shropshire
Kate Ballinger, Manager	Healthwatch Telford & Wrekin
Kerrie Allward, Better Care Fund Manager	Shropshire Council
Liz Noakes, Assistant Director and Director of Public Health	Telford and Wrekin Council
Mark Docherty, Director of Nursing, Quality & Clinical Commissioning	West Midlands Ambulance Service NHS FT
Dave Watkins, Locality Manager, North Powys	Welsh Ambulance Services NHS Trust
John Grinnell, Director of Finance	Robert Jones & Agnes Hunt Hospital NHS FT
Alison Blofield, Associate Clinical Director/Nurse Consultant *(unable to attend)*	South Staffordshire & Shropshire Healthcare NHS FT
Dr Jessica Sokolov	Local Medical Committee/GP Federation
Ian Winstanley, Chief Executive	Shropshire Doctors' Cooperative Ltd.

NHS England and Montgomeryshire Community Health Council declined to nominate members because of their subsequent assurance and scrutiny functions. The Chairs of the

Join Health Overview and Scrutiny Committee for Shropshire and Telford & Wrekin were in attendance as observers.

The Panel's earlier work had included the development of a wide range of potential scenarios from which the longlist was created following the Panel's recommendation to Board. A number of pre-consultation public engagement events also informed the development and evaluation of options.

The Long List

1	**Do Minimum** - Provider & Commissioner efficiency strategies implemented but no major service change. **Existing dual site acute services (including A&E).**		**Four community hospitals and MIUs** providing services as currently.
2	**EC with UCC & LPC at RSH; ***	**DTC with UCC & LPC at PRH;**	**Two to five further UCCs ideally co-located with LPCs & CUs**
3	**EC with UCC & LPC at PRH;**	**DTC with UCC & LPC at RSH;**	
4	**EC with UCC at new site; ***	**DTC with UCC & LPC at PRH; UCC & LPC at RSH;**	
5	**EC with UCC at new site; ***	**DTC with UCC & LPC at RSH; UCC & LPC at PRH;**	
6	**EC & DTC with UCC & LPC at RSH; ***	**UCC & LPC at PRH;**	
7	**EC & DTC with UCC & LPC at PRH;**	**UCC & LPC at RSH;**	
8	**EC & UCC with DTC at new site; ***	**UCC & LPC at PRH & RSH;**	
*** the potential to locate consultant-led obstetrics either at the Emergency Centre or at PRH should be considered as a variant to these options.**			

In December 2014, the Board agreed that there should be a differential approach to the identification of shortlists for the consolidated and dispersed elements of the proposed networks of care.

Evaluation Criteria

The Evaluation Panel was also responsible for recommending the criteria against which longlisted options would be evaluated. A number of pre-consultation public engagement events also informed the development and weighting of the criteria.

Four criteria were proposed initially, to which Board added a fifth by separating out workforce considerations from wider quality impacts. The Board delegated to its Core Group the task of confirming the final set of measures to be used by the Programme Team to provide evidence for the Panel. These measures focused on evidence pertinent to the differentiation of acute scenarios rather than to the overall evaluation of programme proposals. That subsequent evaluation will only be possible once shortlisted options have

been developed in more detail.

The agreed criteria are set out below with a brief explanation of the nature of the information provided to the Panel. That information was presented in three tiers:

- **Tier 1** - an overall summary of acute options and obstetric variants, criterion by criterion, plus the programme Team's proposed approach to a shortlist for UCCs;
- **Tier 2** - a summary description of each option summarising all the measures available; and
- **Tier 3** – the underlying sources of information, including
    - The Clinical Design Report
    - Phase 1 Activity and Capacity Modelling
    - Latest Summary of Phase 2 Activity and Capacity Modelling
    - Baseline Impact Assessment Report
    - Reports on Pre-Consultation Engagement Activities
    - Feasibility Study Report
    - Financial Assessment of Feasibility Study (includes additional scenarios from long list)
    - Acute Services Template (setting out the views of acute clinicians of key co-location issues)
    - Summary Affordability Report
    - Commissioner Funding Scenarios
    - Accessibility analysis.

All three tiers are being made available to Board to inform its decision-making on shortlisting. They will subsequently be made available to the public (where not already published) to help people to form their own views on shortlisted options as part of ongoing pre-consultation engagement and impact assessment activities.

To enable a high-level view to be taken of equity impact, the information provided highlighted any adverse differential impacts on particular social groups. The Panel had requested that these groups should include Older People (75+), Children (0-5), people with Long Term Illness, people on Low Income and people with no access to a car or van.

The weighting applied to the criteria was determined by the Panel, informed by public views.

Members initially submitted their own weighting proposals, the results of which were presented to the Panel when it met. Following discussion, a final set of weightings was agreed. These are recorded against the criteria below which appear in ranked order.

1. QUALITY – 29.4%

Evidence for this criterion focused on

- The extent to which each option support the delivery of key programme benefits (which reflect health service need criteria). This was informed by the content of the Clinical Report and by the assessment of acute clinicians. Given that all change options respond to the Clinical Report, which sets out to design quality into the system, only a limited amount of information was available at this stage to support the differentiation of options. When options are fully developed they should be more amenable to a more detailed quality impact analysis.

- The impact on patients with time-critical conditions for the most serious cases conveyed by the ambulance service. The data provided was based on West Midlands Ambulance Service conveyance times. West Midlands Ambulance response time information was also made available to the Panel. Welsh Ambulance Service data has only recently become available and will be used to inform subsequent evaluation.

2. ACCESSIBILITY – 26.5%

The Clinical Model envisages the development of networks of care covering urgent and emergency care, planned care and long term conditions. At the present time it is not feasible to undertake detailed accessibility analysis on these networks, given the number of potential combinations of acute and community options. The system-wide impact will be assessed as part of the full evaluation later in the year. For the time being, the accessibility of consolidated acute services has to be looked at in isolation. This may unavoidably advantage the 'Do Minimum' option (Option 1) but this is not material at this stage given that this option is a required component of the shortlist in any case. The Programme Team expects that subsequent modelling will demonstrate improved overall accessibility for all other options once local facilities are factored in (UCC, LPC, CU). It is in these dispersed facilities that a significant amount of future activity is expected to take place, as demonstrated in the Phase 2 Activity and Capacity modelling. Whilst it has been possible to include theoretical public transport information for the New site, the provision of public transport would clearly be subject to change should a new site be constructed.

The travel time analysis provided was based on Phase 2 activity projections for 2018-19. These were derived by taking SaTH activity levels (using a 2012-13 baseline) and applying to these the expected impact of:

- Provider and commissioner efficiency strategies (as set out in Phase 1 activity and capacity modelling);

- Demographic change (using projections from the Office for National Statistics);
- The Clinical Design Report (as set out in Phase 2 activity and capacity modelling).

The measures reported cover emergency care (ambulance/car only) and planned care (car plus 3 public transport time windows – weekday morning, weekday evening and weekend morning) plus consultant-led obstetrics. Average travel times and distances reflect the potential impact of change (subject to patient choice) on patients and their carers/visitors, including where they may in future travel to out of area hospitals.

3. WORKFORCE – 25.0%

This criterion (previously a component of the Quality criterion) was informed by the assessment of senior local acute clinicians about the advantages and disadvantages of the changes proposed under each option. Again, only a very high-level assessment is possible at this stage but there were three key factors:

- Options consolidating emergency care on a single site are expected to significantly improve recruitment and retention for EC and acute medicine;
- Options locating DTC and EC on separate sites are expected to be attractive for surgical recruitment as a result of separation of planned care services, resulting in a reduced impact from medical outliers; and
- Options with a greater proportion of new facilities are expected to be more beneficial for recruitment of staff.

4. DELIVERABILITY – 10.3%

Evidence under this criterion drew on the Programme's Feasibility Study work (both the original study and as subsequently expanded to cover all longlisted options).

The information provided included high level estates and financial information indicating the likely scale, duration and cost of the physical work required. It was highlighted that this information was not intended to propose final site configurations since these may evolve significantly during subsequent design phases.

In addition to this estates-based information, the Programme Team also provided a view on the likely acceptability of each option so far as it could reasonably be judged at this stage.

5. AFFORDABILITY – 8.8%

The Programme Board determined in December that no options could conclusively be identified as unaffordable on the basis of the information currently available. The affordability criterion was therefore treated in the same way as other criteria. The Panel was provided with:

- High-level estimates of acute costs from the expanded feasibility work;

- Estimates of the investment required in Urgent Care Centres;

Although the Panel were clearly not being asked to undertake an economic appraisal (which will form part of the next stage evaluation), it was invited to view options in the light both of wider demands on the resources of the Local Health Economy and of the relative inferiority of any options when benefits are compared with costs. This was in line with guidance in the DH Capital Investment Manual. Four cost categories were reported in the summary documentation:

- **25 Year Capital Costs**

  These costs set out both the initial capital cost of each option and the impact of future lifecycle costs over the following 25 years (in line with national guidance). This reflects the fact that, under the different options, differing proportions of the facilities will be operating in "New", "Refurbished" or "Retained" condition. Given the age of some of the existing estate, total replacement of some retained facilities is required within the 25 year period. Costs are discounted to current levels. They reflect the total cash investment required over the period. No assumption has been made about the source of this capital funding at this stage (e.g. public funds, private finance or a combination of the two).

- **Net Increase in Capital Charges**

  Capital funding resources are expected to come from outside the Local Health Economy but the relevant provider must be able to service the impact of that funding. This is expressed as an annual charge on the resources available to the provider. Net figures are provided in which the annual impact of new funding is offset by any savings from facilities no longer required under a particular option.

- **Total Change in Acute Revenue Costs**

  These are also annual costs borne by providers. In addition to the net increase in capital charges, these figures also reflect estimates of savings in maintenance energy and utility costs and savings in clinical efficiency (arising from a reduction in two-site working).

- **Estimated Overall Cost Change with 4 UCCs**

  These figures take the total change in acute revenue costs, remove the costs associated with urgent care activity which (under the options for change) would not be provided in an EC and add estimated costs for running 4 UCCs. This gives a view, therefore, on the potential net impact on the Local Health Economy of the Programme's proposals.

Urgent Care Centres (UCC)

The Panel was presented with a proposal from the Programme Team about the potential make up of a shortlist for UCCs. This proposal built on clinical design work, patient and public engagement and financial, activity and travel time modelling. A proposal from Bishops Castle Patient Group was also made available.

The proposed approach took account of the need to understand in greater detail how UCCs would work, how they would relate to other components of the Clinical Model and how they would be staffed. The Programme Team had concluded that there was a need to proceed with caution and to adopt a prototyping approach in setting up an initial number of UCCs. This would allow testing of:

- Whether staff with the right skills can be recruited;
- Whether confidence in the model can be built amongst both patients and ambulance services;
- How a variety of patient pathways would be delivered in a networked EC/UCC model;
- How UCCs would link to 24/7 primary care services;
- What services envisaged in health hubs could be provided from UCCs;
- The need for co-location with beds (CUs) and certain planned care services (LPCs); and
- Whether the number and type of patients who would attend UCCs has been accurately estimated.

The Programme Team's recommendation was that four UCCs should be subject to prototyping initially: one each in Shrewsbury and Telford and two more in rural areas to test the quality, deliverability and viability of the models.

The Evaluation Panel accepted the proposed approach, subject to some amendments, although a minority report was submitted by one patient representative.

Both documents were made available to Programme Board which agreed to proceed to work on:

- Prototyping two urban Urgent Care Centres, one in Shrewsbury and the other in Telford; and
- Exploring the most appropriate rural urgent care solutions in partnership with local communities and considering current facilities/services. All existing Minor Injuries Units will be considered as potential sites for Urgent Care Centres.

Emergency Centre (EC) and Diagnosis & Treatment Centre (DTC)

The Evaluation Panel received a presentation of the summary of acute options. It was then able to put detailed questions (covering all tiers of information provided) to a group of expert advisors who had been involved in the accessibility analysis, feasibility study, affordability analysis and pre-consultation public engagement.

At the conclusion of these detailed discussions the Panel was asked to undertake an initial scoring of each option (and obstetric variant). It was agreed that would be done individually and confidentially. Panel members awarded a score for each option/variant against each of the evaluation criteria using a scale of 0-7 (where 7 is a stronger score). Initial scores were collated, totalled then weighted to produce a single overall score for each option/variant. Sensitivity analysis was applied to show the effect of changing the weightings of the evaluation criteria. These initial results were reported to the Panel to inform further discussion on the evidence presented, and to begin to enable the Panel to consider which options would best form part of a balanced recommendation to the Board.

Following discussion, individual panel members were then given the opportunity to alter any of their initial scores if they wished to. The revised results were then presented and discussed. The following table summarises those results.

Rank	Option Description (number)	Score	Difference from best	Gap
1	EC, DTC & Obs on new site (8a)	71.9	0.0%	
2	EC/Obs at new site, DTC at RSH (5a)	69.9	2.7%	2.7%
3	EC/Obs at new site, DTC at PRH (4a)	69.4	3.5%	0.8%
4	EC/Obs at PRH, DTC at RSH (3)	67.2	6.4%	2.9%
5	EC/Obs at RSH, DTC at PRH (2a)	65.9	8.3%	1.9%
6	EC & DTC on new site, Obs at PRH (8b)	63.8	11.2%	2.9%
7	EC, DTC & Obs at PRH (7)	63.2	12.1%	0.9%
8	EC at new site, DTC/Obs at PRH (4b)	61.9	13.9%	1.8%
9	EC, DTC & Obs at RSH (6a)	61.3	14.7%	0.8%
10	EC at new site, DTC at RSH, Obs at PRH (5b)	59.3	17.5%	2.8%
11	EC at RSH, DTC/Obs at PRH (2b)	56.4	21.5%	4.0%
12	EC & DTC at RSH, Obs at PRH (6b)	54.5	24.2%	2.7%
13	Do Minimum (1)	51.2	28.8%	4.6%

The Panel felt that the top five ranked options provided a good balance of feasible options for further development and evaluation alongside the 'Do Minimum' comparator.

Sensitivity analysis demonstrated that levelling the weightings did not significantly change the results, although Option 7 (EC and DTC at PRH) rose from 7th to 2nd because of the impact of increasing the relative affordability weighting on the lowest cost option. Option 8a moved from 1st to 6th. When the weighting for affordability is increased to about 25% (and other criteria maintain relative weightings) the most noticeable impact is the reduced performance of New site options which start to fall out of the top five.

Programme Board Report - February 2015

The purpose of this report is to provide a brief summary of the February Programme Board meeting – the matters considered and the decisions taken.

1 DEVELOPING A SHORT LIST

Following the Board's December meeting, further work was undertaken on the range of evidence to be provided against the agreed Evaluation Criteria. This was accepted by the Core Group prior to Panel papers being finalised for the shortlisting meeting on 20th January. The information provided to the Evaluation Panel and to the Board is now being published on the programme website.

At its shortlisting meeting, the Panel agreed weightings for the 5 evaluation criteria, discussed and agreed changes to a proposal for Urgent Care Centres, and agreed a proposed shortlist of options for acute hospital services.

The Board had an extensive discussion of the Panel's recommendations in the light of all the evidence provided (including a minority report for a patient representative). Following this discussion the Board agreed the following acute services shortlist:

- Emergency Centre (EC) and Diagnostic & Treatment Centre (DTC) on a New site;
- EC on a New site, DTC at Princess Royal Hospital (PRH)
- EC on a New site, DTC at Royal Shrewsbury Hospital (RSH)
- EC at PRH, DTC at RSH
- EC at RSH, DTC at PRH
- Do minimum (existing dual site acute services maintained, provider and commissioner efficiency strategies implemented but no major services change).

The Board also agreed that there should be further debate on the best and safest configuration of obstetric services within these scenarios. This should include reviewing the clinical evidence and workforce models to understand whether obstetrics could operate on a site alongside a DTC, alongside an Emergency Centre or alongside either.

On Urgent Care Centres (UCCs) Programme Board agreed to proceed to work on:

- Prototyping two urban Urgent Care Centres, one in Shrewsbury and the other in Telford; and
- Exploring the most appropriate rural urgent care solutions in partnership with local communities and considering current facilities/services. All existing Minor Injuries Units will be considered as potential sites for Urgent Care Centres.

This is a major milestone in the NHS Future Fit programme. We will now embark on a programme of public engagement while a large amount of technical work takes place on the shortlisted scenarios to develop them further into the options we will take to consultation.

The Board thanked everyone who had helped the Programme get to this stage including patients, clinicians and the Evaluation Panel. Next steps include:

- A further round of pre-consultation public engagement which kicks off with two 'pop-up shops', one in Telford Shopping Centre on 20/21 Feb and Shrewsbury Darwin Shopping Centre 27/28 Feb. Events in Powys are also being planned. Many more events will follow and will be publicised via the NHS Future Fit website;
- Detailed development of the shortlisted options (including estates, workforce and finance);
- Consideration of the Board's proposals by Programme Sponsor Boards (Commissioners and Providers).

It is expected that the Board will be able to propose a preferred option later in the year. Formal Public Consultation would then commence from December 2015 (subject to the timing of national approvals).

2 WORKFORCE WORKSTREAM

The Workforce workstream held its first meeting in December. It discussed the terms of reference for the workstream, noting that there was not currently an effective workforce planning forum that existed for the local health economy, although workforce planning activity was taking place to meet statutory requirements.

The workstream concluded that the most important contribution that the Future Fit programme could make to support current activities was to develop a clear vision for workforce development in the local area. The following five 5 broad objectives were agreed for the workstream, and it was agreed that the focus should be on the first two initially:

- Developing a vision for the future of the local workforce that supports the clinical design vision (future state)
- Providing more details information on current staffing patterns and issues which supports the Case for Change (Current state)
- Detailing how workforce needs to change in specific areas (prototyping)
- Modelling workforce numbers and types in conjunction with the financial and activity modelling
- Identifying and championing academic and research opportunities (management change).

The membership of the workstream was confirmed.

3 IMPACT ASSESSMENT

Programme Board received an update on plans for the Integrated Impact Assessment of programme proposals. This included a plan for engaging with groups with protected characteristics, as part of the Programme's Equality Analysis. The Impact Assessment workstream will liaise with other workstreams and external partners to ensure that all

relevant impacts are considered (e.g. Quality Impact Assessment, Environmental Impact Assessment, Accessibility/transport Analysis).

4 ASSURANCE

The Assurance workstream had met to consider the process for identifying a shortlist. It confirmed that it was able to provide positive assurance that the process had been conducted in line with what the Board had previously agreed.

External assurance on shortlisting and other matters will be provided through the Health Gateway Review which is scheduled for mid-February. The report of this review, and the associated action plan, will be shared with the Board as soon as it is available.

The report of the Stage One External Clinical Review of the Programme's Clinical Design Report has now been received from West Midlands Clinical Senate, and has been published. The Assurance workstream had asked that clarity be sought from the Senate on a number of the assertions in the report. It has also been forwarded to NHS England as part of its first stage assurance of Programme proposals. A further review is being scheduled to review shortlisted options prior to Public Consultation.

5 PROGRAMME RISKS

The Risk Register continues to be comprehensively reviewed by the Programme Team each month, after which it is published on the Programme website. All workstreams may raise new risks or recommend revision of existing risks at any point.

6 PROGRAMME DECISION MAKING

The Programme Execution Plan sets out that decisions of the Programme Board are to be made by consensus. It also notes that commissioners will seek to agree a method of joint decision making in relation to the final outcome of the programme, and commissioners continue to collaborate on exploring mechanisms for this.

7 IMPACT ON PRIMARY & COMMUNITY CARE SERVICES

The Programme intends to set out the impact of its proposals on other services, including primary and community care services. CCGs are beginning to discuss with partners how they might support the development of primary and community care responses to the Clinical Model. The Core Group will consider the scope of this work, and a progress report will be provided at the next Board meeting.