OGC Gateway™ Review 0: Strategic assessment
Programme Title: Future Fit – Shaping Healthcare Together
OGC Gateway™ ID: DH 778
Privacy Marking: UNCLASSIFIED

CabinetOffice

OGC Gateway™ Process
Review 0: Strategic assessment

Version number: Final Issued

Date of issue to SRO: 1st December 2016

SRO: David Evans/Simon Freeman

Department: Shropshire CCG, Telford and Wrekin CCG

OGC Gateway™ Review dates: 28th November to 1st December 2016

OGC Gateway™ Review Team Leader:
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Carrie Armitage
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OGC Gateway Delivery Confidence Assessment

Delivery Confidence Assessment	**AMBER/RED**

The Future Fit Programme presents a major opportunity to deliver the Acute Services element of Shropshire, Telford and Wrekin's, Sustainability and Transformation Plan (STP). Within a financially challenged health economy, and one that is attempting to address a series of deep rooted issues and challenges we considered it commendable that substantial agreement and widespread support had been achieved for original clinical model.

During the last 12 months, the development of this model (in part financially driven) has contributed to concerns over the effectiveness of engagement and the lack of visibility of public facing clinical champions required to ensure continued support. We found the programme has struggled, despite significant communication activity, to convey the vision in relation to current proposals.

Of particular note was the lack of clarity on key questions such as –

- How will the critical dependency which is the Community/Neighbourhood solution be delivered and can we be assured that it will be sufficient and timely?
- What is meant by an Urgent Care Centre, how will the sites differ?
- What will be the impact on Women and Children's service?
- How will this be afforded?

These questions must be addressed clearly and convincingly.

The consultation will take place against a backdrop of current cynicism and lack of belief that Future Fit can deliver this time – and with a clinical emergency service at breaking point.

The demographics differ sharply between Commissioners as do the political agendas and financial challenges. The initial clinical model was regarded as a strength of the programme but this has not been sustained and there are concerns that the model has been modified without appropriate engagement.

The launch of the STP is seen as a further complication and has introduced delay and uncertainty about the relative priorities in the health economy.

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A redefinition of the Future Fit brand and engagement with stakeholders is essential to ensure the proposed solution(s) are made clear during consultation. In addition, a formal process for evaluating and reporting the results of the consultation needs to be agreed in advance.

It is important that the experience to date of Future Fit is used to reduce the challenge to the process in the future and ensure a successful engagement of hearts and minds to the delivery of what is proposed.

Given the nature of the issues above successful delivery of the project/programme is in doubt with major risks or issues apparent in a number of key areas. Urgent action around process, relationships, finance, and message is needed to ensure these are addressed, and whether resolution is feasible.

The Delivery Confidence assessment RAG status should use the definitions below.

RAG	Criteria Description
Green	Successful delivery of the project/programme to time, cost and quality appears highly likely and there are no major outstanding issues that at this stage appear to threaten delivery significantly
Amber/Green	Successful delivery appears probable however constant attention will be needed to ensure risks do not materialise into major issues threatening delivery
Amber	Successful delivery appears feasible but significant issues already exist requiring management attention. These appear resolvable at this stage and if addressed promptly, should not present a cost/schedule overrun
Amber/Red	Successful delivery of the project/programme is in doubt with major risks or issues apparent in a number of key areas. Urgent action is needed to ensure these are addressed, and whether resolution is feasible
Red	Successful delivery of the project/programme appears to be unachievable. There are major issues on project/programme definition, schedule, budget required quality or benefits delivery, which at this stage do not appear to be manageable or resolvable. The Project/Programme may need re-baselining and/or overall viability re-assessed

Summary of Report Recommendations

The Review Team makes the following recommendations which are prioritized using the definitions below.

Ref. No.	Recommendation	Critical/ Essential/ Recommended
1.	**The SRO should progress an independent review of the non-financial and financial appraisal process with Terms agreed by the Programme Board. Depending on the outcome of this review, the SRO should then consider a re-run of the financial and non-financial**	Essential – prior to OBC

	evaluation with independent facilitation and independent validation when preparing the OBC.	
2.	**The SRO must produce clear and unambiguous communication messages for each target audience endorsed by all programme board members.**	Critical - Prior to starting public consult.
3.	**The SRO should engage external expertise to lead a formal long-term programme of stakeholder relationship development aimed at conciliation and building common purpose across the patch.**	Critical
4.	**The SRO should refresh the approach to risk and ensure that there is active risk management, ownership and control.**	Essential – by end of consultation.
5.	**The SRO should ensure the consultation plan and approach is agreed and jointly owned by the key stakeholders, and assured throughout.**	Critical
6.	**The SRO should ensure that the STP Partnership Board agrees a definition for Future Fit programme closure and identifies the governance and project arrangements (under the Acute Services and Specialist Board) to succeed it.**	Essential – by end of consultation.

Critical (Do Now) – To increase the likelihood of a successful outcome it is of the greatest importance that the programme/project should take action immediately

Essential (Do By) – To increase the likelihood of a successful outcome the programme/ project should take action in the near future. [Note to review teams – whenever possible Essential recommendations should be linked to project milestones e.g. before contract signature and/or a specified timeframe e.g. within the next three months.]

Recommended – The programme/project should benefit from the uptake of this recommendation. [Note to review teams – if possible Recommended recommendations should be linked to project milestones e.g. before contract signature and/or a specified timeframe e.g. within the next three months.]

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Background

The aims of the programme:

The programme documentation sets out how the Future Fit Programme was established in 2013 as part of a system-wide multi-stakeholder service transformation programme in response to the Call to Action Survey. Whilst the original remit of the Future Fit programme was on acute and community hospitals, in the last 12-18 months the programme's focus has been on the reconfiguration of acute hospital services.

The Future Fit proposals are therefore the culmination of 3 years of collective effort across Shropshire and Telford & Wrekin to reform the local model of acute care so that the local populations consistently receive high quality, efficient, sustainable acute hospital services and which contributes to a system wide balanced financial position.

The Programme believes that the new model of acute care will improve services for patients while also tackling the service and workforce challenges facing Shrewsbury and Telford Hospital NHS Trust (SaTH) and which will lead to:

- Better clinical outcomes with reduced morbidity and mortality;
- Bringing specialists together treating a higher volume of critical cases to maintain and grow skills;
- A greater degree of consultant-delivered decision-making and care;
- Improved clinical adjacencies through focused redesign;
- Improved access to multi-disciplinary teams;
- Delivery of care in an environment suitable for specialist care;
- Improved recruitment and retention of specialist's medical and nursing professionals.

The driving force for the programme:

The acute hospital services provided by the Shrewsbury and Telford Hospital NHS Trust (SATH) are of a good standard, recognised in the Care Quality Commission report published in 2015. Most services have developed over many years, with clinicians, managers and staff trying to keep pace with changes in demand, improvements in medicine and technology and increased expectations of the populations served. Nevertheless, all stakeholder partners recognise that the current acute hospital configuration is not sustainable.

When considering the pattern of services provided in 2013, the local clinicians and many members of the public who responded to the Call to Action accepted that there was a case for making significant change to service provision. There was a clear recognition in the Call to Action of the real and pressing local service issues and challenges faced locally including:

- Changes within the medical workforce
- Staffing within the key acute services (A&E; Critical Care; Acute Medicine)
- Changes in the populations profile and patterns of illness
- Higher expectations
- Clinical standards and developments in medical technology
- Economic challenges
- Opportunity cost in quality of service
- Impact of accessing services
- The quality of the patient facilities and the Trust's estate

Running duplicate services on two sites presents many workforce challenges and can result in a poor employee experience for some of the SaTH's medical and non-medical teams across multiple specialities. This compounds an already challenging recruitment environment and leads to difficulty in recruiting the right substantive workforce to provide high quality safe care.

The procurement/delivery status:

At the time of this Review the programme was at the stage of agreeing a Preferred Option with the objective of commencing public consultation in January 2017.

Current position regarding OGC Gateway™ Reviews:

An initial Gateway 0 was carried out in March 2014, followed by a repeat in February 2015. Following the latter an Action Plan was drawn up by the programme team and the recommendations have either been completed or have been superseded by the contents of this report.

A summary of recommendations, progress and status from the previous Gateway Review can be found in Appendix C.

Purposes and conduct of the OGC Gateway™ Review

Purposes of the OGC Gateway™ Review

The primary purposes of a Gateway Review 0: Strategic assessment, are to review the outcomes and objectives for the programme (and the way they fit together) and confirm that they make the necessary contribution to Ministers' or the departments/organisations overall strategy.

Appendix A gives the full purposes statement for a Gateway Review 0.

Conduct of the OGC Gateway™ Review

This Gateway Review 0 was carried out from 28th November to 1st December 2016 at Royal Hospital Shrewsbury. The team members are listed on the front cover.

The people interviewed are listed in Appendix B.

We would like to thank those who contributed to the Review for their openness, which helped our understanding of the Programme and the outcome of this Review.

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Findings and recommendations

1: Policy

The Future Fit Programme was established in 2013 as part of a system-wide multi-stakeholder service transformation programme in response to the Call to Action Survey. Whilst the original remit of the Future Fit programme was on acute and community hospitals, in the last 12-18 months the programme's focus has been on the reconfiguration of acute hospital services.

The Future Fit proposals are therefore the culmination of 3 years of collective effort across Shropshire and Telford & Wrekin to reform the local model of acute care so that the local populations consistently receive high quality, efficient, sustainable acute hospital services. This aims to contributes to a system wide balanced financial position. It is of note that the local context for the programme has changed since its inception: while Future Fit was not originally designed to address financial issues, the worsening financial position and growing challenges in emergency care have made this imperative.

In December 2015, the NHS shared planning guidance 2016/17 – 2020/21 outlined a new approach to help ensure that health and care services are built around the needs of local populations. To do this, every health and care system in England has had to produce a multi-year Sustainability and Transformation Plan (STP), showing how local services will evolve and become sustainable over the next five years – ultimately delivering the Five Year Forward View vision of better health, better patient care and improved NHS efficiency.

Future Fit now forms part of the delivery of the STP. At the point of the review the governance arrangements and their implementation timetable were still in the process of being agreed and communicated. The result will see Future Fit being managed by the Acute and Specialist Services Board, alongside the three-community based Neighbourhood Boards. We understand that all four Value Streams will report to the newly formed STP Partnership Board.

2: Business Case and stakeholders

We reviewed the pre-consultation business case (PCBC) as well as the SaTH Sustainable Service Plan (SSP) outline business case (OBC). The written evidence to support the case for change is copious and the clinical narrative is strong. There is considerable detail on access and drive times but this has not created a 'compelling story' for everyone around location and access for the preferred option. Access remains a divisive issue with polarised views across the geographic and political landscape. There has been an extensive impact assessment carried out by an external organisation. This has been considered a distinct process and is not reflected in the option evaluation process or the wider communication story.

We did not see the detailed financial appendices in the PCBC, but we heard reservations about the accuracy of financial data and validity of analysis which, for some, has damaged the credibility of the recommended option. For example, an additional £10m extra cost was added to option B which we were told corrected an earlier spreadsheet error.

There were concerns about the analysis of coded emergency activity supporting the assumption that 80% of emergency treatment would continue to be treated in the current locations. There are also concerns that, despite these assumptions, the emergency ambulance service would need increased investment in its fleet to meet the logistical demands of a new single emergency access point. There were also strong feelings that deprivation and other demographic challenges were not represented in the evaluation model. These reservations, when coupled with concerns over bias and lack of precise and objective criteria in the non-financial evaluation process, may expose the economic and financial evaluation exercise in the PCBC to unfavourable scrutiny and challenge. We understand that a written response has been made to address the concerns expressed by Telford and Wrekin Council, but we heard that these concerns are more widely shared.

Recommendation 1: The SRO should progress an independent review of the non-financial and financial appraisal process with Terms agreed by the Programme Board. Depending on the outcome of this review, the SRO should then consider a re-run of the financial and non-financial evaluation with independent facilitation and independent validation when preparing the OBC.

The capital required to deliver the proposed preferred option is £311m. Nobody could give us any assurance that this level of capital would be available to support the delivery of this option. The financial treatment in the PCBC assumes that the capital is available as Public Dividend Capital (PDC) although everybody recognised that in the current NHS national financial situation, this level of PDC was highly unlikely to be made available. We heard that the Trust has identified at a high level several alternative finance options and made some initial assumptions about which elements of the scheme may be attractive to private finance investment. These are not validated; may prove too complex and expensive; may not achieve the off-balance sheet desired outcome; and may not raise sufficient capital to meet the requirement.

The Trust has also explored, again at a very high level and in limited detail, the possibility of deferring expenditure through a phased implementation – postponing back-log maintenance until later. We agree with the concern we heard that the inclusion of the back-log maintenance in the Future Fit programme, whilst aiming to ensure the long-term sustainability of the Trust's estate, may have the unintended consequence of making the whole acute services reconfiguration scheme unaffordable. The programme now needs the active support of NHSE and NHSI to 'get it over the line'.

The initial drivers for acute service reconfiguration were fragility of clinical emergency services and issues around recruitment and retention of consultant medical staff particularly in ED, acute medicine and intensive care. The first set of solutions put forward in late 2015 were judged to be unaffordable and did not address the current deficit. The Future Fit programme was 'sent back to the drawing board' and we were told that this has created a loss of purpose as well as a loss of public facing clinical champions over the last 12 to 15 months. We heard strong views that in the reworking of the options, more emphasis is now being placed on finding solutions which also address the system wide financial deficit as part of the STP. In this process the clinical model is perceived as having changed without the same level of engagement and ownership.

Stakeholders and Communications

Future Fit and the reconfiguration of acute services now form the most developed part of the STP proposals. At a system-wide level we heard the need to ensure that the 'left shift in activity' is in place or the reconfiguration of acute services may deliver a service with too few beds or insufficient capacity in five years' time. The reconfigured acute services must incorporate escalation capacity on the emergency site and must be scalable in case the 'left shift in activity' is not delivered.

We found a consistent view that whilst there had been considerable communication activity, the content and the message had been confusing and poor. The language used when communicating to the public is clumsy and often uses NHS jargon. It fails to address concerns and resentment around perceived loss of local services. Furthermore, communication and engagement did not always reach all the key stakeholders. In particular, more work needs to be done with health scrutiny and patient representative bodies. A formal process needs to be put in place to evaluate the effectiveness of all future communication activity.

There is inadequate understanding of what constitutes an Urgent Care Centre and how that differs from the current Accident & Emergency Services. We heard views at each end of the spectrum from "It's pretty much what A&E is now anyway and could potentially still be called an A&E" to "it's a minor injuries unit". Whatever the answer is – a clear, unambiguous and truthful definition needs to be agreed prior to the public consultation.

There also needs to be clarity and more detail about the overall service offering at both sites, more detail about remaining Women and Children's services and the potential use in future of the recently built Women and Children's facility at PRH as well as new services such as dialysis or a diagnostic and treatment centre. There appear to be exciting service developments as part of Future Fit which are not being given sufficient promotion as focus remains on defending the new A&E/Urgent Care model. The complexity and subtleties of a hot/cold versus hot/warm clinical model

need careful explanation to a public who are currently focused on their potential loss of A&E and maternity services.

Recommendation 2: The SRO must produce clear and unambiguous communication messages for each target audience endorsed by all programme board members.

We found major political and geographical differences of opinion across all stakeholders. Many of these tensions are rooted in past organisational structures and exacerbated by current financial tensions. There is a perceived lack of trust between primary and secondary care which will impede the success of the programme if not addressed. Future Fit has had many changes in personnel, lacks a recognisable and charismatic 'public face' and there is widespread cynicism that "we have been here before, and nothing has ever happened. Why will it be different this time?" With local elections looming there is a risk that political expediency will override any system-wide reconfiguration of health services for the greater good of a wider population.

Although the STP now requires all elements of the health economy to work together including Local Authorities, there is still some suspicion and lack of trust between parties. We heard that there is a risk of a judicial review challenge to the process either now or on completion of the public consultation. This is symptomatic of a lack of effective relationship management amongst all parties.

Recommendation 3: The SRO should engage external expertise to lead a formal long-term programme of stakeholder relationship development aimed at conciliation and building common purpose across the patch.

The Programme Board appears to have a dual role as the formal programme governance and decision making body as well as a key stakeholder engagement group. We also heard reference to a Core Group – but it is not clear whether this is part of the formal governance of the Programme or still in operation. As Future Fit moves into the project delivery phase after the public consultation it will be beneficial to separate the roles of Programme Board and Stakeholder Engagement group(s).

3: Management of intended outcomes

The benefits management plan attached to the PCBC is not yet fully developed. There are no baseline metrics or clear targets for measurable outcomes. The benefits identified in the benefits management plan are not clearly linked back to the evaluation model in a way that demonstrates that the preferred option achieves maximum defined benefits. There is also no clear linkage between the benefits identified in the benefits management plan and the key communication messages for the public and other stakeholders. This work does not seem to have progressed beyond the position noted at the time of the last review.

4: Risk management

The risk register of November 2016 (made available to the Gateway Team before Programme Board sign off) contains 32 risks, a number of which remain red post mitigation. It is striking that a significant proportion of the risks relates to sponsor, stakeholder, political, public and media engagement or understanding. There is acknowledgement of the need to explain better the Urgent Care proposition but in a number of risk areas the mitigation proposed seems to be 'more of the same'. There does not, for example, appear to be any intention to do some 'what if' thinking on the possibilities for modifying the way ahead to meet concerns. The proposed mitigation of the risk to continuity of services in the Emergency Departments and of the risk of failure to identify capital funding also seems rather limited.

It is clear from Programme Board minutes that the risk register is presented to the Board; it is less clear what value the Board adds to the process or what value the risk register adds to the Board deliberations. This work does not seem to have progressed beyond the position noted at the time of the last review.

The move into consultation, assuming Joint Committee and NHSE agreement, presents the opportunity to review the risk register, to establish the appropriate governance forum, and risk owners to distinguish between those that will affect the consultation process and those that affect continuity of services, community development etc.

Recommendation 4: The SRO should refresh the approach to risk and ensure that there is active risk management, ownership and control.

5: Review of current outcomes

The debate over the reconfiguration of acute provision in Shrewsbury and Telford extends over a number of years. The NHS Call to Action in late 2013 generated fresh impetus to the debate and the Future Fit model produced in 2014 reflected significant clinical engagement and enthusiasm. The subsequent options appraisal, however, concluded that none of the options was affordable and further work was commissioned, in October 2015, on the deficit position facing the local health system and on the options for addressing as a priority the current fragility in emergency provision. The revised model and options now form part of the region's Sustainability and Transformation Plan (STP).

The strength of the Future Fit programme is in its clinical engagement. Commissioners and providers recognise the value of the modelling work and accept that a major Emergency Department in each of the two hospitals is not sustainable. There is also general acceptance that the separation of Emergency from Women

and Children's services would represent an unacceptable risk to patient safety. The programme work is in Stage 2 assurance and has undertaken an independent impact assessment and independent assurance from the Manchester CSU.

There is not, however, unanimity on the robustness of the options appraisal process nor on some of the assumptions on activity levels resulting from implementation of the changes. More generally, the pause after the initial stage of the work has resulted in a loss of momentum resulting in apathy and a current cynicism. The sense of purpose has also been lost with the affordability work, and now the STP, moving the focus from the clinical imperative to the issue of financial viability. There is work in hand on community care (originally Phase 1 of Community Fit and now the pathways work under the Neighbourhoods value streams) but there is tension between the timing of the acute reconfiguration and changes to the community capacity and capability.

These difficulties are compounded by the nature and position of the stakeholder community – a legacy of poor partnership working between Shropshire and Telford and Wrekin and a lack of trust between SaTH and its commissioners. The Shropshire CCG is under direction and has experienced an extraordinary degree of churn of key personnel including four Accountable Officers over the last year. The local health system deficit in 2016/17 is £131m. There is also a perception that SaTH is conventional in its thinking on the development of the clinical workforce and in its preparedness to work more closely with and in community settings. However, we found positive thinking in relation to the adoption of innovative new roles in the SaTH workforce.

Nevertheless, the position in Emergency consultant provision remains extremely fragile and needs addressing urgently. There is also a need to restore momentum and a desire for visible progress. For that reason, there is a consensus that consultation should start as soon as possible.

6: Readiness for the next phase – Delivery of outcomes

The Programme Board on 30 November agreed to recommend to the Commissioners' Future Fit Joint Committee that consultation should be launched with the preferred option being the collocation of the Emergency Department, Critical Care Unit and Women and Children's services at Shrewsbury. Both sites would provide an Urgent Care service.

We comment above on the shortcomings of the engagement and communications effort to date and about the different perceptions about the robustness of the non-financial options appraisal. The consultation process needs to be robust, transparent and supported. We heard that the team would be working with the Consultation Institute and that the consultation document would meet the Institute's standards, and satisfy the requirements for Wales. The process and consultation document will

need to be shared with and agreed with key stakeholders and it should reflect an understanding of local needs, interests and responsibilities. Care should be taken at every stage to secure independent assurance that the agreed process has been followed. A formal process for evaluating and reporting the results of the consultation needs to be agreed in advance.

Recommendation 5: The SRO should ensure the consultation plan and approach is agreed and jointly owned by the key stakeholders, and assured throughout.

Media coverage of the announcement on 30 November demonstrated the different understandings of the preferred option and what it would entail. The messaging – for example, what is or isn't urgent care – needs to be clear and convincing. It needs to demonstrate consistency with the original Future Fit concept and purpose while recognising that the Future Fit 'brand' may be tainted in terms of public engagement. Whatever is decided it will be important to ensure continuity of the 'golden thread' of original drivers e.g. clinical safety and workforce remains visible.

It is remarkable, given the tensions within and between the stakeholders, that the Future Fit Programme Board has operated with such a broad membership and attendance. The STP Partnership Board has a similarly wide membership and is committed to working inclusively and with shared values. We heard that the work streams were well supported and working constructively. The downside of the collaborative approach, however, can be lack of clarity on leadership and decision making.

At the end of the consultation process, and assuming a successful result, Future Fit will move from programme to project (within the wider STP). SaTH is well placed to deliver the project, drawing on the experience and lessons learned from delivering the Women and Children's Unit at PRH.

In parallel with the consultation process, as SaTH develops the Outline Business Case, the process for closure of the Future Fit programme as currently constructed will need to be defined and agreed. The leadership, governance and stakeholder engagement for the acute re-configuration project delivery (assuming agreement to the way ahead) and the wider STP will need to be identified.

Recommendation 6: The SRO should ensure that the STP Partnership Board agrees a definition for Future Fit programme closure and identifies the governance and project arrangements (under the Acute Services and Specialist Board) to succeed it.

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The programme timeline showed no contingency, but at the time of the Review we understand the team had produced a paper and were considering a two-stage consultation process. Whilst this provided some contingency we understand this would not be ideal.

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The next OGC Gateway™ Review will be a project Gateway 2 and is expected following completion of the OBC.

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APPENDIX A

Purposes of OGC Gateway™ Review 0: Strategic assessment

- Review the outcomes and objectives for the programme (and the way they fit together) and confirm that they make the necessary contribution to overall strategy of the organisation and its senior management.
- Ensure that the programme is supported by key stakeholders.
- Confirm that the programme's potential to succeed has been considered in the wider context of the organisation's delivery plans and change programmes, and any interdependencies with other programmes or projects in the organisation's portfolio and, where relevant, those of other organisations.
- Review the arrangements for leading, managing and monitoring the programme as a whole and the links to individual parts of it (e.g. to any existing projects in the programme's portfolio).
- Review the arrangements for identifying and managing the main programme risks (and the individual project risks), including external risks such as changing business priorities.
- Check that provision for financial and other resources has been made for the programme (initially identified at programme initiation and committed later) and that plans for the work to be done through to the next stage are realistic, properly resourced with sufficient people of appropriate experience, and authorised.
- After the initial Review, check progress against plans and the expected achievement of outcomes.
- Check that there is engagement with the market as appropriate on the feasibility of achieving the required outcome.
- Where relevant, check that the programme takes account of joining up with other programmes, internal and external.

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APPENDIX B

Interviewees

Name	Role
Simon Freeman	Interim Chief Officer, Shropshire CCG
Simon Wright	Chief Executive, SATH Chair, Shropshire and Telford STP
Carol Shillabeer	Chief Executive, Powys Teaching Health Board
Vikki Taylor	NHS England, Locality Director
Clive Jones	Telford & Wrekin Council
Andy Begley	Director of Adult Social Care, Shropshire Council
Dr Jo Leahy	Clinical Chair, T&W CCG Futurefit Clinical Design Workstream – Chair
Dr Steve James	Futurefit Clinical Lead, Shropshire CCG LHE Clinical Design Digital Strategy Lead
Harpreet Jutlia	Communications Manager CSU
Alison Smith	Director of Governance and Engagement, Telford & Wrekin CCG Futurefit Workstream Lead – Assurance
Victoria Maher	Director of HR, SaTH Futurefit Workstream Lead – Workforce
Neil Nisbet	Director of Finance, SaTH Futurefit Workstream Lead - Finance
Graham Shepherd/Daphne Lewis	Chairperson, Shropshire Patients Group/Healthwatch
David Bell	Chairperson, Telford Healthwatch
Jayne Thornhill	Powys CHC
Gerald Dakin & Andy Burford	Chairpersons, Joint HOSC
Julian Povey	Clinical Chair, Shropshire CCG
Edwin Borman	Medical Director, SaTH
Debbie Vogler	Programme Director, Future Fit
Andy Layzell	Programme Director, STP
Kate Shaw	Associate Director of Transformation, SaTH
Kevin Eardley	Unscheduled Care Medical Director, SaTH
Mark Docherty	West Midlands Ambulance Service

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APPENDIX C

Recommendations from previous OGC Gateway™ Review

Recommendation	Progress/Status
The SROs should ensure that suitable governance and management arrangements are in place to manage the interdependencies between major change programmes	Linkages and interdependencies defined and governance processes amended to reflect these in 2015. The programme is currently in a phase of transition to the STP governance structure which will further strengthen the placing of the acute reconfiguration within the context of the wider system plan and key enabler workstreams. The programme is aware of the risks inherent in transition from one to another governance system and these are reflected in the programme risk register and project plan.
The SROs should ensure that the requirements of approval bodies are fully understood and addressed in business cases	All approval body requirements have been met to-date, including SOC approval, Senate Stage 1 and 2
The Core Group should ensure that a whole system affordability position is agreed to inform the Programme and the development of business cases	Remodelling work undertaken in phase 2 and subsequent SATH SOC which was approved by both Boards earlier this year and which delivered which result in a recurrent saving for options B, C1 and C2. Now forms part of the STP Deficit Reduction Plan
The SROs should establish an inclusive process for identifying and assessing the benefits of the proposed changes in service delivery	Board has approved the process of option appraisal and the required iteration of the Benefits Realisation Plan in 2015. Options Appraisal now complete and Benefits Realisation Plan will be updated and form part of the OBC. Pre-consultation engagement activities with patients, the public and stakeholders complete and has informed consultation plan.
The Programme Director should review plans for engagement and communications activity in Powys and potential support for the work with Powys THB	The Future Fit Engagement & Communications Team have implemented a specific plan for the Powys area taking into account the needs of this rural community and the requirements of Welsh regulations and legislation.
The SROs should assure themselves	SOC approved by both CCG Boards earlier this

further that the shortlisted options for the EC and D&TC are fit for purpose for development of the SOC	year
The Programme Director should establish the critical path for the development of the SOC for regular review by the SROs and Core Group	As above.
The SROs should ensure plans for 'Future Fit 2' are developed and agreed with stakeholders	Community Fit work programme initiated through Future Fit programme in 2015 but has now transitioned to the STP Neighbourhood workstreams to lead this piece of work
Deliberations on an approach to decision making on the future configuration of services must reach a conclusion well before public consultation, and need to consider the role of Powys tHB	CCG Boards have agreed to establish a joint committee for decision making, terms of reference agreed including the role of Powys THB
Roll out risk management process to all Workstreams. Clarify methodology for escalating Workstream risks to the central register. Review ownership of risks.	Workstream risk registers feed into the Programme main risk register.
The Programme will need to ensure that work continues on plans for implementation of its preferred option.	Ongoing as part of the development and approval processes for the SOC, OBC and FBC
The Programme should note the importance of widening engagement and ownership within primary care in all localities as proposals become refined	Regular updates to GP Locality Boards/Forum and via Clinical Reference Group